South Carolina Department of Corrections
Implementation Panel Report of Compliance
January 2021

Executive Summary

Introduction

This is the 12th Implementation Panel Report presented by the Implementation Panel (IP) regarding the South Carolina Department of Corrections' (SCDC) compliance with the Settlement Agreement (SA) enacted in May 2016 based on review of documents and information provided since the previous IP virtual site visit in April 2020. The April 2020 virtual site visit was conducted via multiple telephone calls between IP and SCDC staff. This current virtual site visit was conducted via ZOOM meetings from December 14-16, 2020. This monitoring period covered March, 2020 thru October, 2020.

The South Carolina Department of Corrections (SCDC) has experienced unprecedented times since the Implementation Panel Remote Site Visit in April 2020 at the onset of the COVID-19 Pandemic. As throughout the nation and world, SCDC employees and inmates have been dramatically impacted by the pandemic. Programs, activities, and services have been curtailed in an attempt to protect inmates, employees and the public from the spread of COVID-19. SCDC extended suspensions of visitation, volunteers, work-release and labor crews through December 31, 2020. All routine transfers between institutions remained suspended. Transfers for security and medical reasons continued only on an as needed basis. Inmates attended court and parole hearings virtually and requests for hearing attendance in person was handled on a case-by-case basis. The measures remained necessary due to the threat posed from COVID-19 and the potential impact on SCDC's staff, inmates and the public.[1] Even with the SCDC and their stakeholders' efforts to control the spread of the virus, 2,454 inmates and 662 employees have contracted the virus. There have been 34 inmate and 2 employee deaths. SCDC had 88 active inmate and 84 active employee COVID-19 cases on December 24, 2020.[2]

SCDC has an Agency COVID-19 Action Plan that began in February 2020. There has been coordination with the South Carolina Governor's Office, Department of Health and Environmental Control (DHEC), Emergency Management Division, and other state agencies to respond to the pandemic.[3] SCDC has a COVID-19 Guidelines Policy, HS18.20 issued on October 6, 2020.[4]

The impact of COVID-19 and efforts to continue to provide adequate mental health services and comply with the provisions of the Settlement Agreement has been very challenging and in some areas particularly problematic. Balancing the implementation of restrictions and other limitations, including impact on staff and inmates, with the requirements for specific programs and services has been insufficient in several areas. These areas of very serious concern include the provisions of programmatic activities, timeliness of mental health contacts, transfers to and from designated programs, out of cell time, medication management and most specifically access for inmates to the

[1] www.doc.sc.gov/covid19_visitation_113020.pdf
[2] www.doc.sc.gov/covid.html. 12.24.2020.
[3] www.doc.sc.gov/scdc_covid-19_action_plan_31620.pdf.
[4] SCDC.HS-18.20 COVID-19 Guidelines issued October 6, 2020.

men's Crisis Stabilization Unit (CSU) and related suicide prevention and management practices. The closure of access to the CSU for the majority of the monitoring period is akin to closing a central medical infirmary with very limited access to hospital services, such that inmates remain in their home institutions that are not able to provide extended crisis or hospital level services. Facilities, as well as specific programs have been on quarantine and/or "semi-quarantine" at various times since March 2020.

SCDC reported five completed suicides from January thru mid-December 2020. The Average Daily Population (ADP) for SCDC was approximately 16,224 inmates. The annualized suicide rate for calendar year 2020 was approximately 31 per 100,000. This annualized suicide rate represents a continuing decline from 2018 (63 per 100,000) and 2019 (53 per 100,000), however is nearly twice the national average for prisons. As the SCDC ADP has declined since 2014, the identified percentage of inmates on the mental health caseload has doubled from 14.2% to 28.4%.

The IP recognizes and appreciates the "new" mental health leadership team, restructuring of mental health services, and improvements in the collaboration with Operations and their leadership team, as well as the long standing excellent support by QIRM and RIM.

SCDC has worked diligently to meet the challenges of a global pandemic and should be recognized for their efforts. There has been progress to improve SCDC overall in specific areas. SCDC has revised their classification system to a behavior-based one. The revised classification system has the potential to make the corrections system safer for inmates, staff and the public. Once fully implemented, inmates will have an increased incentive to improve their behavior for promotion to custody levels that have more incentives and less restrictive environments. While rewarding positive behavior, inmates that continue to commit rule violations will graduate to prisons with fewer incentives and more restrictive environments. The COVID-19 Pandemic has impacted implementation; however, SCDC indicates a significant number of inmates will be eligible for custody levels with increased incentives and less restrictive environments. Unfortunately, the revised classification system cannot be fully implemented until inmates can be safely transferred without the fear of spreading the COVID-19 virus. Below is a table depicting the revised classification system impact on the number of inmates in each custody:

	Total					
	1-Apr-2020		1-Aug-2020		1-Dec-2020	
Custody Level	#	% of Pop.	#	% of Pop.	#	% of Pop.
Minimum	3,755	20.5%	3,611	22.0%	3,149	19.6%
Medium	8,962	49.0%	10,575	64.4%	10,246	63.6%
Close	4,497	24.6%	2,015	12.3%	1,713	10.6%
Unclassified	1,063	5.8%	222	1.4%	993	6.2%
	18,277		16,423		16,101	

The revised classification will reduce the number of required close custody beds from 24.6 percent to 10.6 percent. The table also reflects that the SCDC inmate population has dropped from 18, 277 on April 1, 2020 to 16,101 on December 1, 2020.

In conjunction with the revised classification system, SCDC Director Stirling has revised the SCDC earned time policy, allowing inmates to earn lost time for identified rule infractions based on positive behavior. This policy change also provides an incentive for inmates to have positive behavior, making prisons safer for inmates and staff. Previously, inmates losing earned time had no mechanism to have lost earned time restored. The potential impact of inmates' ability to have earned time restored based on good behavior is depicted in the table below.

Inmates who had Good Time Restored	August	September	October	November	December
GT Restoration Resulted in Earlier Release Date					
Yes	**357**	**51**	**46**	**33**	**28**
Resulted in Immediate Release	11	2	0	2	0
Has Been Released	52	3	0	3	0
Still Incarcerated	294	46	46	28	28
No	**1,059**	**129**	**96**	**62**	**45**
Total	**1,416**	**180**	**142**	**95**	**73**

SCDC has plans to provide mental health treatment programs for inmates at Level I (least restrictive) prisons. Historically, SCDC has required all inmates requiring mental health treatment to be assigned to Level III (most restrictive) prisons. The offering of mental health treatment at Level I prisons will effectively remove minimum custody inmates requiring mental health treatment from Level III prisons, providing additional bed space for inmates that require higher security.

SCDC has made efforts to mitigate the impact of the COVID-19 pandemic on inmate activities and programs. Over 17,086 tablets have been distributed to SCDC prisons. Tablets are assigned to every inmate except for those in specialized units such as restrictive housing and crisis intervention. Charging carts are installed in those units with shared tablets for checkout. All SCDC prisons have tablets except Allendale CI due to the lack of new fiber optic cable which will need to be installed. Allendale CI is projected to have tablets on-line by January 26, 2021. Tablets allow inmates to place telephone calls, receive / reply to electronic messages, submit requests to staff, conduct legal research using Westlaw, read books from a free e-book library, and participate in educational programming / soft skills development using a customized Learning Management System (LMS). Optional paid subscriptions are available for access to streaming music, movies / TV shows, and games.

SCDC has started a pilot project to allow inmates to visit their families virtually. The project is beginning at Camille Graham Correctional Institution. Virtual visits can be done on any kind of computer, android tablet or android phone. Normal visitation has been suspended at SCDC since March 2020 because of the COVID-19 pandemic. SCDC plans to have regular visitation once it becomes safe to do so and will have virtual visitation as an additional method for inmates to remain in contact with their approved visitors.

The Operations Division has made significant progress in developing their internal quality assurance

programs. There has been improvement in the Offender Activity Tracking System (OATS) that electronically records inmate activities and services. Operations staff have made progress in capturing data and then utilizing the data to measure individual and overall prison performance in providing required inmate activities and services. Although much improvement is needed, this reporting period, the Operations Division demonstrated their ability to utilize the OATS as a quality assurance tool.

As outlined above, SCDC has demonstrated progress and improvement in areas during the reporting period; however, there remain areas that are in critical need of improvement. While not all inclusive, they should be a priority in the next reporting period:

- Revise the Behavioral Health Crisis Intervention Policy, train staff and educate inmates;
- Remove Mental Health Designation Level 1, Level 2, and Level 3 from Restrictive Housing Unit (RHU) Security Detention status;
- Implement the Secure Mental Health Unit (SMHU);
- Maximize the placement of eligible inmates in the High-Level Behavior Modification Unit (HLBMU), Low-Level Behavior Unit (LLBMU) and Secure Mental Health Unit (SMHU);
- Finalize and implement the Structured Living Unit Policy including training staff and educating inmates;
- Develop and implement the RHU Security Detention Stepdown Program;
- Develop and implement the Security Concerns Offender Reintegration (SCOR) Program to remove this population from RHUs (224 inmates as of December 24, 2020);
- Develop and implement a formal enhanced review process for inmates held in RHU for over 365 days;
- Develop and formalize a documented weekly review of RHU inmates conducted by each prison's management team;
- Continue steps to implement an interim plan to perform administrative UOF investigations and budget additional staff and resources to perform administrative investigations moving forward;
- Develop and implement a plan to address the Kirkland CI Substantial Security Risk Unit physical plant deficiencies;
- Develop a plan to address the long-standing issue of necessary equipment for satellite delivery of inmate meals.

Findings

Consistent with all past visits, the IP has provided its analysis, recommendations and consultation prior to, and during the virtual site visit.

Further, the final report by the Implementation Panel, as required by the Settlement Agreement was provided as IP Report #11 and approved by Robert Erwin, Mediator.

SCDC has not achieved Substantial Compliance in the majority of Settlement Agreement requirements. Despite the COVID-19 pandemic SCDC has demonstrated improvement in several areas, however compliance has declined in others, as discussed during the visit and as detailed in this report. The IP recognizes the pandemic has impacted us all, and the challenges we continue to face in these very difficult times.

The Implementation Panel conducted a conference call on February 10, 2021 with Director Stirling and SCDC administrative staff to discuss their objections to the draft 12th Implementation Panel Report and the impact of the COVID-19 pandemic. The IP acknowledges the challenges in providing adequate mental health services for SCDC and other correctional systems in the United States as an unprecedented crisis and also the need for demonstrating and documenting their responses and mitigation efforts to provide adequate mental health services during this ongoing pandemic. The IP has determined three provisions (2.b.i., 2.b.ii. and 2.b.iv.) will remain in Partial Compliance based on consideration for addressing and managing the "new" pandemic; however the IP is deeply and seriously concerned that these and other provisions not in Substantial Compliance must be addressed effectively and consistently, including adequate resources as the pandemic continues. These specific provisions may be highly likely to be found in Noncompliance, and others may also be found in Noncompliance unless adequately addressed in upcoming monitoring periods.

The findings of the Implementation Panel with regard to compliance on the provisions of the Settlement Agreement as of December 16, 2020 are as follows:

1. Substantial Compliance (active)---7
2. Substantial Compliance (sunset/greater than 18 months)---20
3. Partial Compliance---26
4. Non-Compliance---6

1. The development of a systematic program for screening and evaluating inmates to more accurately identify those in need of mental health care:

1.a. Develop and implement screening parameters and modalities that will more accurately diagnose serious mental illness among incoming inmates at R&E with the stated goal of referring inmates to the appropriate treatment programs.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: We agree that the data from these two studies indicated a robust reception center process for assigning Mental Health Levels and diagnoses. Length of stay in the reception units remained problematic due to COVID-19 pandemic issues.

Mental health involvement in the reception center during the first 14 days of quarantine was minimal due to apparent custody restrictions.

Implementation Panel December 2020 Recommendations: Mental health staff should be rounding the reception units during quarantine periods.

1.a.i. Accurately determine and track the percentage of the SCDC population that is mentally ill

Implementation Panel December 2020 Assessment: Substantial compliance (November 2018)

Implementation Panel December 2020 Findings: Substantial compliance remains.

1.b. The implementation of a formal quality management program under which mental health screening practices are reviewed and deficiencies identified and corrected in ongoing SCDC audits of R&E counselors.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: The above QI plan is comprehensive in scope. Compliance will be achieved following successful implementation.

Implementation Panel December 2020 Recommendations: Implement the above plan.

1.c. Enforcement of SCDC policies relating to the timeliness of assessment and treatment once an incoming inmate at R&E is determined to be mentally ill;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: Identified issues included difficulties with timely mental health contacts in reception, continued difficulties with receiving continuity of care forms from sending jails and bridge orders not, at present, involving the psychiatrists. Many of these issues were exacerbated by the COVID-19 pandemic.

The process specific to scheduling psychiatric appointments in a timely manner after bridge orders are received appeared to be problematic.

Implementation Panel December 2020 Recommendations: Remedy the above issues.

1.d. Development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and provides timely access to mental health care.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: See 1.a.i. and status update section. Indicators for this provision include changes in an inmate's level of mental health care and timeliness of response to either inmate mental health care requests or to staff referrals. Data re: such response times have not yet been computerized and analyzed.

December 2020 Implementation Panel Recommendations: Begin to collect and assess the above referenced data.

2.a. Access to Higher Levels of Care

2.a.i. Significantly increase the number of Intensive Outpatient inmates vis-a-vis outpatient mental health inmates and provide sufficient facilities therefore;

Implementation Panel December 2020 Assessment: Noncompliance

Implementation Panel December 2020 Findings: As per the status update in provision1.a.i., there has been a significant increase in the number of Intensive Outpatient inmates since 2014.

The QIRM reviews reported significant deficiencies in the delivery of mental health services to inmates at CGCI, BRCI, KCI, LCI and Lieber CI. Many of these deficiencies are very basic processes such as timeliness of clinical contacts, treatment plans, mental health rounds, providing access to cleaning supplies and laundry, and basic documentation issues. QIRM findings included the following:

Camille Graham CI

Review of the Camille Graham Compliance report indicated the following:

1. Lack of compliance with timely clinical contacts with clinicians, both QMHPs and psychiatrists, at all levels of care (LOC) and housing unit placements.
2. Alarming lack of compliance with clinical contacts being held in a confidential setting, especially sessions with QMHPs.
3. Lack of compliance with the composition of the multidisciplinary team members actually attending the treatment planning meetings.
4. Lack of compliance with treatment plans being documented for patients in the CSU.
5. Treatment plan updates were not timely at all LOC being offered.
6. Lack of compliance re: mental health rounds in the segregation housing units.
7. Lack of compliance with access to yard time and showers for segregation inmates and patients in the CSU.
8. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
9. Lack of compliance with inmate access to laundry and cleaning supplies.
10. Lack of compliance with security checks in RHU.
11. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
12. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

Broad River Correctional Institution (BRCI)

Review of the BRCI Compliance report indicated the following:

1. Lack of compliance with timely clinical contacts with clinicians, especially QMHPs, at all levels of care (LOC) and housing unit placements.
2. Lack of compliance with clinical contacts being held in a confidential setting, which was generally specific to QMHPs.
3. Lack of compliance with the composition of the multidisciplinary team members actually attending the treatment planning meetings.
4. Lack of compliance with treatment plans being documented for patients in the CSU.
5. Treatment plan updates were not timely at all LOC being offered.

6. Intermittent lack of compliance re: mental health rounds in the segregation housing units.
7. Lack of compliance with access to yard time and showers for segregation inmates.
8. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
9. Lack of compliance with inmate access to laundry and cleaning supplies.
10. Lack of compliance with security checks in RHU.
11. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
12. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

Kirkland Correctional Institution (KCI)

Review of the KCI Compliance report indicated the following:

1. Lack of compliance with timely clinical contacts with clinicians, especially QMHPs, at all levels of care (LOC) and housing unit placements. It was particularly problematic at GPH.
2. Lack of compliance with clinical contacts being held in a confidential setting, which was generally specific to QMHPs.
3. Lack of compliance with the composition of the multidisciplinary team members actually attending the treatment planning meetings.
4. Treatment plan updates were not timely at all LOC being offered, especially at GPH.
5. Intermittent lack of compliance re: mental health rounds in the segregation housing units.
6. Lack of compliance with access to yard time and showers for segregation inmates.
7. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
8. Lack of compliance with inmate access to laundry and cleaning supplies.
9. Lack of compliance with security checks in RHU.
10. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
11. Lack of compliance with inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.

Very similar issues were present at Lee Correctional Institution (LCI) and Lieber Correctional Institution.
Compliance has not improved for QMHP contacts since the previous visit.

Implementation Panel December 2020 Recommendations: Remedy the above.

2.a.ii. Significantly increase the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: There has not been a significant increase in the number of male and female inmates receiving intermediate care services. Providing sufficient facilities for such services remains problematic due to resource issues.

Implementatioin Panel December 2020 Recommendations: The historical reason for housing L2, L3 and L4 female inmates in the same housing unit involved predominantly bed issues at CGCI. Specifically, empty beds in Blue Ridge, due to lack of inmates assessed to require an ICS LOC, were filled by L3/4 inmates due to bed shortages with CGCI. There is no longer a shortage of ICS inmates at CGCI. A plan should be devised to discharge L3/4 inmates from Blue Ridge in order to open up beds for L2 inmates who are housed in general population housing units. This should not be done abruptly, and adequate termination work needs to be done.

A solution needs to be developed and implemented to deal with the housing of L2 inmates with mutual enemy concerns.

2.a.iii. Significantly increase the number of male and female inmates receiving inpatient psychiatric services, requiring the substantial renovation and upgrade of Gilliam Psychiatric Hospital, or its demolition for construction of a new facility;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: The number of male and female inmates receiving inpatient psychiatric services has not significantly increased. Programming for male GPH patients remains inadequate.

Our last three reports included the following:

> The amount of out of cell time, both structured and unstructured, actually used by GPH inmates remains alarmingly small. This issue is predominantly related to inadequate staffing allocations (both correctional and mental health staff) although institutional cultural issues likely contribute.

Our opinion re: this issue remains unchanged; however, this provision is dangerously close to noncompliance based on the timeliness of QMHP sessions and inadequate programming.

Implementation Panel December 2020 Recommendations: Remedy the lack of adequate access for inmates to out of cell time (both structured and unstructured activities).

2.a.iv. Significantly increase clinical staffing at all levels to provide more mental health services at all levels of care;

Implementation Panel December 2020 Assessment: Substantial compliance (November 2018)

Implementation Panel December 2020 Findings: Compliance remains in the context of meeting the allocation goals of the Settlement Agreement staffing plan.

Our previous report included the following:

However, SCDC continues to be aware of the need for increased mental health staffing allocations based on the significantly increased numbers of inmates identified with mental health problems that require psychiatric intervention. This need is demonstrated by the budget request submitted to the governor's office for such increased allocations. The nursing shortages are at critical levels and SCDC staff report their concerns this crisis will further deteriorate as other nurses are anticipated to be leaving SCDC.

Implementation Panel December 2020 Recommendations: Continue to advocate for needed mental health staff and nursing staff allocations and salary increases as necessary.

2b. Segregation:

2b.i. Provide access for segregated inmates to group and individual therapy services

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per current status. Out of cell time for segregated inmates has remained very problematic. We agree with the above plan in the context of the BRCI RHU. The Secure Mental Health Unit (SMHU) will be replacing the DHU.

Implementation Panel December 2020 Recommendations: Implement the above referenced plan.

2.b.ii. Provide more out-of-cell time for segregated mentally ill inmates;

Implementation Panel December 2020 Assessment: Partial compliance
Implementation Panel December 2020 Findings: The out of cell time for inmates in segregation was extremely problematic.

Implementation Panel December 2020 Recommendations: Remedy the above.

2b.iii. Document timeliness of sessions for segregated inmates with psychiatrists, psychiatric nurse practitioners, and mental health counselors and timely review of such documentation;

Implementation Panel December 2020 Assessment: Noncompliance
Implementation Panel December 2020 Findings: Timeliness of mental health clinical contracts was very problematic.

Implementation Panel December 2020 Recommendations: Remedy the above.

2b.iv. Provide access for segregated inmates to higher levels of mental health services when needed;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per status update. Access for segregated inmates to higher levels of mental health services during the monitoring period has been extremely limited due predominantly to COVID-19 issues and vacancies.

Implementation Panel December 2020 Recommendations: Mitigate the above access issues.

2b.vi. Undertake significant, documented improvement in the cleanliness and temperature of segregation cells; and

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
SCDC continues to require Institutions to perform temperature and cleanliness checks for all CI cells and four random RHU cells. The Operations Division has implemented an improved quality management process spearheaded by the Director of Special Projects that reviews and monitors temperatures and sanitation reports weekly with Institution Wardens. Regional Directors are involved ensuring the institutions know that they are responsible for meeting expectations. Institution Wardens that fail to meet a goal of 95 percent are highlighted and accountability measures are implemented. The SCDC Offender Automated Tracking System (OATS) is an instrumental part of the quality management process and continues to improve and assist in the demonstration of the level of compliance.

QI Studies conducted at Broad River CI, Camille Graham CI, Kirkland CI, Lee CI and Lieber CI verify institutions need improvement in conducting the required temperature and cleanliness checks and provision of follow up and responses to identified temperature and cleanliness deficiencies. The Operations Division is aware of the need for improvement in addressing identified temperature and cleanliness deficiencies and further developing mechanisms to enhance their quality management process.

The Operations Division temperature and cleanliness checks summary report for October 12, 2020 – October 18, 2020 demonstrated the quality management process is having an impact with 15 of 19 institutions meeting the goal of completing 95 percent or more of the required cell and temperature checks.

Implementation Panel December 2020 Recommendations:

1) Continue to develop the Operations Division quality management process to improve the required temperature and cleanliness checks for each institutions' CI cells and 4 random RHU cells with follow up and a response for identified deficiencies;
2) Operations Management ensure all prisons are performing required daily inspections for cleanliness and taking temperatures of random cells;
3) Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness applicable records;
4) Ensure Daily Cell Temperature and Cleanliness data is recorded and maintained;
5) SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperature and cleanliness inspections.

2b.vii. The implementation of a formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: The implementation of a formal quality management program under which segregation practices and conditions are reviewed has occurred. Compliance for this provision will be achieved when the QI process demonstrates improvement in the context of the various indicators.

Implementation Panel December 2020 Recommendations: As above.

2.c. Use of Force:

2.c.i. Development and implementation of a master plan to eliminate the disproportionate use of force, including pepper spray and the restraint chair, against inmates with mental illness;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
Per the October 2020 SCDC Status Update. As identified, a plan has been initiated and is being implemented to eliminate the disproportionate use of force against inmates with mental illness. The plan includes coordinating efforts across multiple disciplines including Operations, Behavioral Health, and QIRM, as oversight bodies for monitoring, reporting, and providing recommendations based on data and audit outcomes.

The revision for Section 14 of OP-22.01 Use of Force Policy was completed on October 30, 2020 and signed by Director Stirling November 10, 2020. Section 14 addresses the responsibilities of Medical/Behavioral Health staff for all uses of force. All applicable staff will require training on the revised OP 22.01 UOF Policy.

The Offices of Operations, Behavioral Health Services, Medical, Programs, Reentry and Rehabilitative Services, meet biweekly to discuss findings of collaborative work of Division of Mental Health's UOF Coordinator and QIRM Use of Force Reviewers, and address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates. SCDC Representatives from QIRM, Operations, and Behavioral Health meet with the designated IP member to discuss the UOF MINs comments provided to the IP Member for the previous month.

A positive achievement is the UOF data for the period January 2018 - September 2020 demonstrates a significant decrease in the mean percentage of Mental Health inmates who experienced a UOF incident. The mean was 1.55% and fell to 1.02% by the end of September 2020. The percentage of UOF incidents in Non-Mental Health inmates has remained at a stable level at .30% over the period January 2018 – September 2020.

The Behavioral Health Use of Force Coordinator (UOFC) continues to review UOF data each month. For this reporting period, the months of March – September 2020 were included in the SCDC update. The UOFC has not implemented recommendations made by QIRM to include a methodology for his report. It is strongly recommended by the IP that the Behavioral Health Division follow the QIRM recommendations regarding the UOFC Report.

Implementation Panel December 2020 Recommendations:

1. SCDC QIRM, Operations, and Behavioral Health monitor all UOF incidents to identify and address the reasons for disproportionate Use of Force involving inmates with mental illness;
2. The Division of Operations Administrative Regional Director, Behavioral Health Services UOF Coordinator and QIRM Use of Force Reviewers collaboratively work together to address issues and concerns that contribute to disproportionate UOF involving mentally ill inmates;
3. Distribute the October 30, 2020 Operations Policy 22.01 "Use of Force" that includes revised Section 14 that addresses Medical/Behavioral Health responsibilities in all uses of force. Ensure all SCDC staff are scheduled and receive training on the revised policy;
4. QIRM continue QI studies regarding the Division of Behavioral Health reviewing UOF incidents involving inmates with a mental health designation;
5. The MH UOF Reviewer follow QIRM recommendations for future UOFC Reports.

2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

Implementation Panel December 2020 Assessment: Substantial compliance (November 2019)

Implementation Panel December 2020 Findings:
Per Status Update. QIRM staff continues to meet with Operations leadership to discuss UOF and other relevant issues. SCDC achieved compliance with the provision November 22, 2019 by fully implementing a plan requiring that all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and tracking such use in a way to enforce such compliance.

The SCDC RIM Training Report identified 343 employees completed the SCDC UOF Policy Change and Basic Training January 1, 2020 through September 30, 2020. The number of SCDC employees completing UOF Training In-Service and Basic from April 1, 2020 through September 30, 2020 was 161 employees. Based on the SCDC having a total of 4,475 employees on October 1, 2020 the number of employees that have not received in-service training regarding UOF in 2020 is very concerning. Although the COVID 19 Pandemic has dramatically impacted the delivery of training to employees, they must continue to receive required training necessary to perform their duties and responsibilities.

SCDC continues to monitor to ensure all instruments of force, (e.g., chemical agents, restraint chairs, and hard restraints) are employed in a manner fully consistent with manufacturer's instructions and are tracked to enforce compliance. Reports are compiled and distributed weekly and monthly containing the summaries for types of force utilized as well as the MINs summaries.

The IP did not find a SCDC Hard Restraint Report for this reporting period.

Implementation Panel December 2020 Recommendations:
1. Operations, the MH UOF Coordinator and QIRM continue to review use of force incidents through the automated system to ensure the use of instruments of force are

fully consistent with the manufacturer's instructions;

2. Operations and QIRM continue to track the amount of time inmates remained in hard restraints and restraint chairs. Perform assessments to determine if SCDC guidelines for hard restraint and the restraint chair were followed;
3. QIRM continue to meet with Operations leadership and the MH UOF Coordinator to discuss UOF and other relevant issues;
4. QIRM ensure a Hard Restraint Report is prepared and provided for the next reporting period;
5. Develop and implement a plan to ensure staff complete Use of Force Training in Calendar Year 2021.

2.c.iv. Prohibit use of restraints for pre-determined periods of time and for longer than necessary to gain control, and track such use to enforce compliance;

Implementation Panel December 2020 Assessment: Substantial compliance (March 2018)

Implementation Panel December 2020 Findings:
As per the status update, there were three (3) documented uses of the restraint chair for the current reporting period March throughSeptember 2020. There were two (2) incidents that involved one inmate who had a mental health classification of L3, and the third involved an MH inmate.

Restraint Chair Usage

MIN Number	Date	Institution	MH Status	Time in Chair
20-08-0211-0010	08/11/2020	Broad River	L3	220 Minutes
20-09-0211-0041	09/17/2020	Broad River	L3	120 Minutes
20-09-0191-0044	09/25/2020	Perry	MH	115 Minutes

QIRM reviewed each of the three (3) incidents and made recommendations. In one (1) incident the inmate remained in the restraint chair beyond the maximum three (3) hours.

20-08-0211-0010	08/11/2020	Broad River	L3	220 Minutes

The responsible IP Member agrees with the QIRM recommendations of:

- Per policy, mental health professionals should be consulted prior to placing an inmate with a mental health classification in a restraint chair. This notification, as well as the medical personnel notification should be written in the MIN narrative.
- Staff should document and record any indication or attempt that they make to review the inmate's behavior while placed in the restraint chair. Secondly, they should terminate the use of the chair beyond the time where the inmate's behavior is noticeably adjusted. Also, the restraint chair should not be used more than 3 hours for security purposes.
- The SCDC Force Continuum requires that an inmate be placed in hard restraints prior to being placed in the restraint chair to alter his or her behavior. While the restraint chair is not used frequently, staff should be aware that when it is used, policy requires that hard restraints are to be applied first for up to two hours, and then escalate to the restraint chair, if necessary (IP

Member Note: *Unless documented circumstances prevent placing the inmate in hard restraints prior to escalating to the restraint chair*).

The IP was not provided a Hard Restraint Report for the reporting period; however, the responsible IP Member reviews the use of hard restraints when reviewing the UOF MINs each month.

SCDC continues to minimally use Restraint Chairs and Hard Restraints and remains in substantial compliance.

Implementation Panel December 2020 Recommendations:

1. QIRM to track and monitor compliance with use of the restraint chairs and hard restraints, including when the inmate is placed and removed;
2. SCDC follow the QIRM recommendations made in the QIRM Restraint Chair March through September 2020 Report;
3. QIRM ensure a Hard Restraint Report is provided to the IP the next reporting period.

2.c.v. The collection of data and issuance of quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs.

Implementation Panel December 2020 Assessment: Substantial compliance (December 2017)

Implementation Panel December 2020 Findings:
As per the October 2020 status update, there were three (3) documented uses of the restraint chair for the current reporting period March through September 2020. There were two (2) incidents that involved one inmate who had a mental health classification of L3, and the third involved an MH inmate.

QIRM prepared a SCDC Restraint Chair Report for March through September 2020 and reviewed each of the three (3) incidents and made recommendations.

The responsible IP Member agrees with the QIRM recommendations made in the QIRM prepared SCDC Restraint Chair Report for March through September 2020.

- Per policy, mental health professionals should be consulted prior to placing an inmate with a mental health classification in a restraint chair. This notification, as well as the medical personnel notification should be written in the MIN narrative.
- Staff should document and record any indication or attempt that they make to review the inmate's behavior while placed in the restraint chair. Secondly, they should terminate the use of the chair beyond the time where the inmate's behavior is noticeably adjusted. Also, the restraint chair should not be used more than 3 hours for security purposes.
- The SCDC Force Continuum requires that an inmate be placed in hard restraints prior to being placed in the restraint chair to alter his or her behavior. While the restraint chair is not used frequently, staff should be aware that when it is used, policy requires that hard restraints are to be applied first for up to two hours, and then escalate to the restraint chair, if necessary (IP Member Note: *Unless documented circumstances prevent placing the inmate in hard restraints prior to escalating to the restraint chair*).

Implementation Panel December 2020 Recommendations:

1. QIRM to continue to prepare a Restraint Chair Report for each monitoring period.
2. SCDC implement the QIRM recommendations made in the SCDC Restraint Chair Report for March through September 2020.

2.c.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. Headquarters Operations Leadership continues meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF. QIRM, Operations Leadership and the Behavioral Health UOF Coordinator regularly meet to discuss Agency UOF issues. The IP Use of Force Reviewer, QIRM UOF Reviewers, the Behavioral Health UOF Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force. The Division of Behavioral Health continues a written report for all incidents involving UOF to prevent inmate self-injury. The written report of all UOF incidents to prevent inmate self-injury has been incorporated in the conference call where the IP Member and SCDC discuss all monthly UOF MINs findings.

SCDC has developed plans to address administrative investigations. The IP UOF Reviewer, SCDC Chief of Legal & Compliance, Interim Director of Police Services and Police Services Staff Attorney held a productive meeting during the December 14-16, 2020 virtual site visit and discussed SCDC administrative investigations. SCDC officials and the responsible IP member have agreed the Agency needs to have independent staff, policies, procedures, and practices addressing administrative investigations of reported excessive force and physical abuse. SCDC Leadership has begun developing an interim plan to perform administrative UOF investigations and requesting budgeting for additional staff and resources. Police Services rarely conducting administrative investigations for incidents referred for excessive force and physical abuse of inmates is problematic. The Division of Police study from March 2020 to September 2020 regarding referrals for excessive force and physical abuse was reviewed. Police Services continues to focus on excessive force and physical abuse that reach the level of criminal conduct and rarely conducts administrative investigations for incidents referred for excessive force and physical abuse of inmates. See below.

Police Service Referrals	Apr	May	June	July	Aug	Sept
UOF Reviewed for	1	1	2	2	2	2
UOF Opened of Investigation	1	1	1	2	1	1
UOF Investigations Pending	4	5	4	6	6	6
UOF Investigations Closed	0	0	2	0	1	1

Police Services still has not implemented QIRM recommendations for their tracking system: 1) nature of the referral and 2) who made the referrals. The revision would ensure the number and the type of referrals are easily identifiable and trackable. As reported to QIRM, Police Services staff reported

that grievances and Use of Force System referrals are tracked; however, every phone call and email is not included in the tracking.

The QIRM provided UOF Report identified there were 25 grievances filed from September 2019 through January 2020 related to excessive use of force.

SCDC identified five (5) Use of Force incidents from April 2020 to September 2020 with use of force policy violations. The SCDC Employee Disciplinary Report did not identify any use of force related corrective actions for employees from April 2020 to September 2020. SCDC reported two (2) UOF incidents where potential employee corrective action for use of force is pending. SCDC provides monthly documentation on the number of employees receiving formal corrective action for UOF violations.

SCDC Use of Force MINS for April 2020 to September 2020:

Month	Year	Number of UOF MINS
April	2020	67
May	2020	84
June	2020	78
July	2020	71
August	2020	73
September	2020	82

The Division of Behavioral Health continues to provide a monthly report of UOF incidents involving inmates with a mental health designation. The months for this reporting period covered March 2020 to September 2020. (see 2.c.i SCDC October 2020 Update).

SCDC continues to develop strategies to address inappropriate and excessive use of force by employees. The IP remains encouraged by the Agency's efforts regarding UOF.

Implementation Panel December 2020 Recommendations:

1. Operations, the Behavior Health UOF Coordinator and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM, the Behavior Health UOF Coordinator and Operations leadership continue frequent meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer, QIRM, the Behavior Health UOF Coordinator and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM and the Agency Grievance Coordinator continue to QI Inmate Grievances related to UOF and Physical Abuse;
6. QIRM QI incidents and grievances referred to Police Services related to UOF and Physical Abuse;
7. Revise the Police Services tracking system utilized to track UOF referrals for excessive force and physical abuse and document the reasons an investigation is not opened;

8. SCDC continue steps to implement an interim plan to perform administrative UOF investigations and moving forward budget additional staff and resources to perform administrative investigations.
9. Track formal and informal corrective action for employees identified committing UOF violations;
10. QIRM include in each reporting period UOF Report, the UOF violations QIRM identified in their review of use of force incidents.
11. Require meaningful corrective action for employees found to have committed use of force violations.

2.c.vii. Prohibit the use of crowd control canisters, such as MK-9, in individual cells in the absence of objectively identifiable circumstances set forth in writing and only then in volumes consistent with manufacturer's instructions;

Implementation Panel December 2020 Assessment: Substantial compliance (November 2019)

Implementation Panel April 2020 Findings:
Per October 2020 SCDC status update. SCDC continues their success in addressing the misuse of MK9 and achieved compliance November 22, 2019.

QIRM and Operations is closely monitoring Correctional Staff MK9 use. SCDC provided data for February 2020 through April 2020 identifying the UOF incidents where MK9 was utilized and assessing if the use of crowd control canisters in individual cells was in accordance with required SCDC guidelines. The SCDC has established written guidelines when crowd control canisters can be used in individual cells and has implemented a matrix establishing guidelines for the amount of `crowd control chemical agents that can be deployed for each application.

Implementation Panel December 2020 Recommendations:
1. Operations and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership continue regular meetings to discuss UOF and other relevant issues;
4. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
5. Institution Wardens follow the guidance provided by the Operations ARD in his 3/18/2020 email.
6. The IP Use of Force Reviewer and SCDC Operations Leadership continue jointly reviewing Monthly Use of Force MINS to discuss issues involving use of crowd control canisters including MK-9.

2.c.viii. Notification to clinical counselors prior to the planned use of force to request assistance in avoiding the necessity of such force and managing the conduct of inmates with mental illness;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
Per the October 2020 SCDC status update. SCDC remains in partial compliance with documenting attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. QIRM provided a chart that identified the percentage of time a QMHP was contacted prior to a planned UOF from February 2020 – September 2020. SCDC continues to struggle with attempts to contact clinical counselors (QMHPs). The compliance rate ranged from a low of 50 percent in March 2020 to 100 percent in March and July 2020. Overall, the attempt to contact a QMHP for inmates with a mental health designation before a planned Use of Force had a compliance rate of 74 percent from February 2020 to September 2020.

Implementation Panel December 2020 Recommendations:
1. Remedy the above.
2. Operations and Behavioral Health Staff follow QIRM's recommendations to correct identified deficiencies to ensure there are attempts to contact clinical counselors (QMHPs) and request their assistance prior to a planned use of force involving mentally ill inmates.
3. Responsible Institution staff ensure the developed *QMHP Contact Form* is completed for Planned UOF incidents involving mentally ill inmates and uploaded in the AUOF system.

2.c.ix. Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
See October 2020 SCDC status update. The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates remains an eleven-hour program for new correctional officers. Permanent correctional officers receive four hours of annual training concerning the appropriate methods of managing mentally ill inmates; primarily related to suicide prevention.

5(a) Managing Mentally Ill Offenders Curriculum

Program/Code	Course/Class Code	Hours	Total
Agency Orientation - 1.00	Intro to Mental Health	1.5	5.5
Live Stream Orientation - 1.20	Suicide	4	
Basic Training - 3.00, 3.60, 3.96, 3.97, & 3.99	Pre-Crisis Intervention (Communication)	3.0	7.0
	Mental Health	2.0	
	Suicide (include 3.28)	2.0	

Annual In-Service*	Suicide (Instructor Led) Basic	2.0	4.0
	Inmate Suicide Prevention Part 1	1.0	
	Inmate Suicide Prevention Part 2	1.0	

According to the SCDC *C.O.s Required to take Managing MI Offenders Training in CY 2020 report,* of the required 1,677 staff required to take the training, 1,527 (91.1%), fully completed the training.

	# Staff Required to Complete		
Institutional Total	**1,677**	**1,527**	**91.1%**

The *SCDC List of All Employees who have had CIT Training as of Close of Business September 30, 2020 Report* indicated that 378 current employees had completed Crisis Intervention Training (CIT). A review of the report indicated 200 of the employees had current CIT certification and 178 needed to complete a 8-hour refresher training that is required every 2 years. SCDC training policies and procedures do not address what occurs if an employee does not complete the required CIT 8 hour refresher training every two years.

	Current CIT Certification	**Lapsed CIT Certification**	**Total CIT Trained**
TOTAL	**200**	**178**	**378**

A high number of custody staff have not completed the required SCDC Suicide Prevention Training in CY 2020. As indicated, in the table below only 671 of the 2124 employees have completed the required Suicide Prevention Training in CY 2020 as of December 15, 2020.

Institutional Custody Staff Required to take Suicide Prevention Training in CY 2020 and Training Completion from January 1-December 15, 2020

Custody Staff Required to take Training	**NONE Completed**		**Partial Completion**		**Fully Completed**	
	#	**%**	**#**	**%**	**#**	**%**
2,124	**546**	**25.7%**	**907**	**42.7%**	**671**	**31.6%**

The IP continues to recommend SCDC Executive staff evaluate the training provided to correctional staff to ensure sufficient training is provided for the employees to recognize and appropriately respond to mentally ill inmates. The high percentage of SCDC inmates with a mental health designation increases the likelihood most correctional officers will have daily contact with inmates that have a mental health designation and the SCDC RHU population consists of a significant number of inmates with a mental health designation. Sufficient training to manage and supervise this special population is critical to operating a safe correctional system for staff, inmates and the public.

Implementation Panel December 2020 Recommendations:

1. Conduct an evaluation and consult with Behavior Health Staff to determine if correctional staff are receiving sufficient training to manage and appropriately respond to mentally ill inmates;
2. Continue to document and track the number of required employees completing the mandatory training for appropriate methods of managing mentally ill inmates in the Calendar Year;
3. Revise SCDC Training Policies to formally establish what is required for CIT employees to maintain their certification;
4. Remedy issue of correctional officers not receiving the required SCDC mandatory training concerning the appropriate methods of managing mentally ill inmates and suicide prevention.

2.c.xi. The development of a formal quality management program under which use-of-force incidents involving mentally ill inmates are reviewed.

Implementation Panel December 2020 Assessment: Substantial Compliance (December 2020).

Implementation Panel December 2020 Findings:
SCDC has achieved substantial compliance with the revision of OP-22.01 Section 14 Use of Force Policy establishing medical/behavioral health staff requirements and responsibilities for all use of force incidents involving inmates with a mental health designation.

SCDC has a coordinated effort to assess, monitor and track Use of Force incidents involving mentally ill inmates across multiple disciplines, including Operations, Behavioral Health, and QIRM. The IP UOF Reviewer and SCDC Management for these disciplines have a monthly conference call to discuss and review the IP UOF Reviewer Monthly UOF MINs comments and address identified issues and concerns. *Section C.1* further describes the SCDC quality management program for use of force incidents involving mentally ill inmates. SCDC continues to generate a Monthly UOF Report for Mentally Ill and Non-Mentally Ill Inmates that provides use of force details and assists in the assessment of use of force incidents involving mentally ill inmates' assessment.

QIRM's review of use of force incidents through the automated system continues to ensure the use of instruments of force are fully consistent with the manufacturer's instructions, tracks the amount of time inmates remain in hard restraints and restraint chairs, and performs assessments to determine if SCDC guidelines for hard restraint and the restraint chair were followed based on SCDC policies. QIRM collects data and issues UOF reports to the Offices of Operations and Behavioral Health.

The process of Use of Force Reviewers completing audits of uses of force to determine compliance with policy remains in place. The reviews are completed monthly and provided to the necessary Operations and Behavioral Health leadership. QIRM reported, in this reporting period, newly hired Use of Force Reviewers were training, learning policy, and becoming acclimated to their roles in QIRM. This caused delays in compliance reviews and reports being completed on a consistent basis. Use of Force Reviewers did complete a monthly MINS report, which included a review of the MINS and any policy violations identified in the MINS, through the month of August 2020.

The revision to OP-22.01 Section 14 Use of Force Policy was completed on October 30, 2020 and signed by Director Stirling November 10, 2020. The revision of Section 14 further enhances the SCDC quality assurance program establishing medical/behavioral health staff requirements and responsibilities for all use of force incidents involving inmates with a mental health designation.

QIRM continues to review the UOFC Division of Behavioral Health Monthly Reports involving inmates with a mental health designation. The QIRM recommendations for the UOFC Reports have not been implemented by the Division of Behavioral Health.

Implementation Panel December 2020 Recommendations:

1. QIRM continue QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation.
2. The Behavioral Health UOF Reviewer monitor inmates with a mental health designation identified as high risk for use of force and repeat the High Risk UOF Case Study for the next relevant period.
3. The Behavioral Health UOF Reviewer monitor inmates involved in UOF incidents with a mental health designation, recommend placement in a mental health residential program when appropriate, and track their status while awaiting placement.
4. QIRM continue QI studies regarding the Division of Behavioral Health reviewing UOF incidents involving inmates with a mental health designation;
5. QIRM ensure Use of Force compliance reviews and reports are completed on a consistent and timely basis;
6. The Behavioral Health UOF Reviewer follow QIRM recommendations for future UOFC Reports.

3. Employment of enough trained mental health professionals:

3.a Increase clinical staffing ratios at all levels to be more consistent with guidelines recommended by the American Psychiatric Association, the American Correctional Association, and/or the court-appointed monitor;

Implementation Panel December 2020 Assessment: Substantial compliance (November 2018)

Implementation Panel April 2020 Findings: see 2a.iv.

Implementation Panel December 2020 Recommendations: Continue with advocacy efforts to obtain needed staffing allocations.

3.b Increase the involvement of appropriate SCDC mental health clinicians in treatment planning and treatment teams

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per status update section which demonstrates significant issues re: multidisciplinary attendance at treatment planning meeting and timeliness issues re: development of treatment plans.

Implementation Panel December 2020 Recommendations: re: attendance: as per status update. Re: timeliness--- assess the causes of the partial compliance and devise a corrective course of action.

3.c Develop a training plan to give SCDC mental health clinicians a thorough understanding of all aspects of the SCDC mental health system, including but not limited to levels of care, mental health classifications, and conditions of confinement for caseload inmates;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update section. Partial compliance.

Implementation Panel December 2020 Recommendations: As per status update section.

3. f. Develop a remedial program with provisions for dismissal of clinical staff who repetitively fail audits; and

Implementation Panel December 2020 Assessment: Substantial compliance (July 2018)

Implementation Panel April 2020 Findings: As per status update section.

3.g. Implement a formal quality management program under which clinical staff is reviewed.

Implementation Panel December 2020 Assessment: Substantial compliance (July 2018)

Implementation Panel December 2020 Findings: Substantial compliance continues.

4. Maintenance of accurate, complete, and confidential mental health treatment records:
4.a Develop a program that dramatically improves SCDC's ability to store and retrieve, on a reasonably expedited basis:
4.a.iii. Segregation and crisis intervention logs;

Implementation Panel December 2020 Assessment: Partial compliance

Information was provided re: the use of OATS re: segregation logs. Upgrades to NextGen will address the crisis intervention logs.

Implementation Panel April 2020 Findings: Segregation logs are maintained via OATS. Crisis intervention logs will be eventually maintained via NextGen.

Implementation Panel December 2020 Recommendations: Implement the planned NextGen upgrade.

4.a.iv. Records related to any mental health program or unit (including behavior management or self-injurious behavior programs);

Implementation Panel December 2020 Assessment: Substantial compliance (December 2020)

Implementation Panel December 2020 Findings: As per status update section.

4.a.ix. Quality management documents; and

Implementation Panel December 2020 Assessment: Substantial compliance (December 2020).

Implementation Panel December 2020 Findings: See 4.a.iv findings.

4.a.x. Medical, medication administration, and disciplinary records

Implementation Panel December 2020 Assessment: Substantial Compliance (December 2020)

Implementation Panel December 2020 Recommendations: As per status update section.

4.b. The development of a formal quality management program under which the mental health management information system is annually reviewed and upgraded as needed.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: See status update section. The data being gathered is very helpful but the individual institutions appeared to be frequently unaware of much of the data.

Implementation Panel December 2020 Recommendations: Remedy the above.

5. Administration of psychotropic medication only with appropriate supervision and periodic evaluation:

5.a. Improve the quality of MAR documentation;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per current status section. Partial compliance.

Implementation Panel December 2020 Recommendations: As per current status section.

5.b Require a higher degree of accountability for clinicians responsible for completing and monitoring MARs;

Implementation Panel December 2020 Assessment: Noncompliance

Implementation Panel December 2020 Findings: As per current status section. Our March 2018 findings included the following:

> Due to the very significant nursing vacancies and systemic deficiencies previously summarized that are not due to individual nursing staff, it is not reasonable to hold nursing staff responsible for completing and monitoring MAR's under these conditions. It is reasonable to expect nursing staff to continually advocate for necessary staff, supplies and equipment.

Our opinion remains the same.

Implementation Panel December 2020 Recommendations: Remedy the above.

5.c Review the reasonableness of times scheduled for pill lines; and

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per current status section.

Implementation Panel December 2020 Recommendations: Remedy the above.

5.d. Develop a formal quality management program under which medication administration records are reviewed.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per status update section. Numerous medication administration deficiencies have been identified by SCDC via their QI system. Compliance will be achieved when the QI process demonstrates significant improvement re: these deficiencies.

Implementation Panel December 2020 Recommendations: Continue to monitor.

6. A basic program to identify, treat, and supervise inmates at risk for suicide:
6.a. Locate all CI cells in a healthcare setting;

Implementation Panel December 2020 Assessment: Noncompliance

Implementation Panel December 2020 Findings: Due to COVID-19, the Men's CSU was closed to new admissions and retained discharged inmates for extended time periods during most of the monitoring period, which made it essentially not possible to be in compliance with this provision. This appeared to be due to lack of isolating CSU inmates who were found to be COVID-19 positive.

We are also very concerned about the lack of adequate mitigating and treatment services offered to inmates in need of a CSU LOC and remained in their home institutions during this time. See SCDC data in provision 2.a.i.

We appreciate the efforts to improve the CSU program by including Central Classification in the process.

Implementation Panel December 2020 Recommendations: remedy the above.

6.c. Implement the practice of continuous observation of suicidal inmates;

Implementation Panel December 2020 Assessment: Noncompliance

Implementation Panel December 2020 Findings: As per status update section.

Implementation Panel December 2020 Recommendations: As per status update section.

6.d. Provide clean, suicide-resistant clothing, blankets, and mattresses to inmates in CI;

Implementation Panel December 2020 Assessment: Substantial Compliance (December 2020).

Implementation Panel December 2020 Findings:
SCDC has achieved compliance with the provision based off provided reports and videos verifying an inventory exists to provide inmates on CI status clean suicide-resistant clothing, blankets and a mattress. Clean, suicide-resistant clothing should include necessary hygienic supports, such as sanitary napkins or other provisions for women in crisis during menstruation.

QIRM staff completed a review of suicide supplies for eight (8) institutions identified in the October 2020 SCDC staff update. QIRM staff was unable to complete on-site visits due to agency COVD-19 mitigating protocols, the institutional provided information is self-reported by institutional staff. The reported inventories were as follows:

Inventory

All-in-one	Blanket	Smock	Mattress
Kirkland CI			
10	13	12	6
Camille Graham CI RHU			
4	4	3	2
Camille Graham CI CSU			
15	21	9	15
Broad River CSU			
32	64	64	12
Broad River RHU			
0	Unknown	12	4
Lee CI RHU			
5	5	10	5
All-in-one	Blanket	Smock	Mattress
Lieber CI			
0	13	9	7

Camille Graham Correctional Institution utilizes Crisis Hygiene Form (19-194) to track and monitor that female inmates in CI are provided hygienic support items such as sanitary napkins or other provisions during menstruation. The form was updated in August 2020 to monitor the individual distribution of female hygiene products as needed for each female offender.

The responsible IP Member reviewed SCDC videos for the following institutions to verify the institutions had an inventory of clean suicide-resistant clothing, blankets and mattresses for inmates on CI status:

- Broad River CI CSU
- Broad River CI RHU
- Camille Graham CI CSU
- Camille Graham CI RHU
- Kirkland CI F1(inventory for the institution)
- Lee CI RHU
- Lieber CI RHU

The reviewed videos verified that all the institutions had an inventory of clean suicide-resistant clothing, blankets and mattresses for inmates on CI status.

Implementation Panel December 2020 Recommendations:

1. Continue to monitor and verify compliance with the provision and correct any identified deficiencies;
2. Continue to develop and implement a tracking system to ensure continued compliance;
3. SCDC report each monitoring period if female inmates in CI have access to necessary hygiene support.

6.e Increase access to showers for CI inmates;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings:
Per the October 2020 SCDC Status Update. In August 2020, SCDC established inmate shower requirements for inmates assigned to CSU and RHU Safe Cells. To assess compliance and ensure that inmates on CI are provided increased shower access the following will be utilized:

- Showers conducted on Saturday, Sunday, or Monday count towards the first shower (Monday) of the week.
- Showers conducted on Tuesday or Wednesday count towards the second shower of the week.
- Showers conducted on Thursday or Friday count towards the third shower of the week.
- For inmates arriving or departing an RHU, a shower is not required to be provided that day.
- All inmates in RHU, to include those in a safe cells, are required to be provided a shower three times per week during the periods indicated above.
- All inmates in CSU are required to be provided a shower every weekday M-F and on weekends if staffing permits.

A review of the provided SCDC shower reports revealed inmates on CI status are not receiving increased showers necessary to meet compliance with the provision. A review of the shower reports for inmates on CI status at the identified institutions from March 2020 to September 2020 revealed the following:

Broad River

- CSU average percentage receiving the required showers was 47%.
- Safe Cell average percentage receiving the required showers was 4%.

Camille Graham

- CSU average percentage receiving the required showers was 85%.
- Safe Cell average percentage receiving the required showers was 48%.

Kirkland

- Safe Cell average percentage receiving the required showers was 15%.

Lee

- Safe Cell mean percentage receiving the required showers was 14%.

Lieber

- Safe Cell mean percentage receiving the required showers was 47%.

Implementation Panel December 2020 Recommendations:

1. Remedy the above. Ensure inmates housed in the CSU and RHU Safe Cells receive the required number of showers each week.

6.f Provide access to confidential meetings with mental health counselors, psychiatrists, and psychiatric nurse practitioners for CI inmates;

Implementation Panel December 2020 Assessment: Noncompliance

Implementation Panel December 2020 Findings: Significant issues exist in the context of confidential sessions with QMHPs. Clinical contacts with psychiatrists were generally in a confidential setting.

Implementation Panel December 2020 Recommendations: Remedy the above.

6.g Undertake significant, documented improvement in the cleanliness and temperature of CI cells;

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: As per status update section. See 2 b.vi.

Implementation Panel December 2020 Recommendations:

1. Continue to develop the Operations Division quality management process to improve the required temperature and cleanliness checks for each institution's CI cells and 4 random RHU cells with follow up and a response for identified deficiencies;

2. Operations Management ensure all prisons are performing required daily inspections for cleanliness and taking temperatures of random cells;
3. Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on;
4. Ensure Daily Cell Temperature and Cleanliness information and responses to deficiencies are recorded and maintained;
5. SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperature and cleanliness inspections.

6.h Implement a formal quality management program under which crisis intervention practices are reviewed.

Implementation Panel December 2020 Assessment: Partial compliance

Implementation Panel December 2020 Findings: The relevant QI processes continue to evolve in a very positive manner as summarized in the status update section. Compliance will be achieved when the QI process demonstrates significant improvement re: the various indicators.

Implementation Panel December 2020 Recommendations: As above.

Conclusions and Recommendations

This is the 12th Implementation Panel Report of Compliance with the Settlement Agreement. The first 10 Reports were based on the review of requested documents and other information provided by SCDC, the parties, and the inmates and families, and on-site visits to SCDC facilities. The 11th and 12th Reports were based on reviews of the documents and information, and virtual (off-site) discussions and reviews as described in the Reports. The changes in process were directly caused by the impact of the COVID-19 pandemic. Despite the limitations and restrictions, the IP has conducted our intensive review.

While we understand and appreciate the challenges presented and efforts to limit infectious spread and consequences for staff and inmates, the IP has encouraged SCDC to follow CDC and WHO guidelines as they evolve to mitigate the negative impact of the pandemic and develop strategies to continue to provide services safely. We have also provided technical assistance and recommendations including consulting with other systems to share experiences and information regarding treatment and management of inmates living with mental illness. The requirements of the Settlement Agreement remain unchanged; and, based on agreement by the parties, the monitoring process will continue until the requirements of the Settlement Agreement are satisfied.

The IP has reported on compliance for 4+ years, and many of the deficiencies continue to be related to insufficient resources, including clinical, nursing and operations staff, as well as long standing correctional culture. The more recent changes in administrative staff, programming, and classification appear to be very positive. These improvements and the ongoing contributions by QIRM and leadership by Director Stirling, and with additional resources as discussed and reported, we expect there will be a more positive impact on the provision of comprehensive mental health care for inmates living with mental illness in SCDC facilities as well as toward substantial compliance with the Settlement Agreement.

We are all hopeful the COVID-19 pandemic is coming under control and we all can begin to adjust to the "new normal." As this process continues, the IP strongly encourages SCDC to mitigate the impact of COVID-19 where and when possible, follow CDC and WHO guidelines and recommendations, and to continue to develop the continuum of mental health services and meet the other provisions as required by the Settlement Agreement. We hope our recommendations are helpful and we look forward to visiting SCDC in person for the next visit. The parties and the Implementation Panel have agreed and Mr. Erwin, our Mediator, has agreed the next site visit will be scheduled to occur in June 2021. Hoping we all remain safe and healthy,

Respectfully,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and Emmitt Sparkman