South Carolina Department of Corrections
Implementation Panel Report of Compliance
April 2020

Executive Summary

Introduction

This is the 11th 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 last IP visit in November 2019. Unlike any previous IP Report, this report does not include on site visits or review of any SCDC facilities because of postponement of the onsite visit due to the novel corona virus COVID 19. The IP requested and received a substantial number of documents prepared by SCDC and the Quality Improvement Risk Management (QIRM) staff consistent with previous visits, and the IP and SCDC Mental Health, QIRM, and administrative and operations staff had several conference calls to discuss the status of compliance. The IP and SCDC staff and consultants have also begun the process of review and recommendations regarding an updated and comprehensive staffing plan and those discussions will continue via conference calls. The current plan for going forward is the rescheduling of the onsite IP visit in June or July, 2020, pending the status of attempts to control, limit and treat the spread of COVID 19. The IP is deeply concerned for the inmates and staff living and/or working in SCDC and encourage robust adherence to recommendations by the CDC and WHO in addressing the impact of COVID 19 on all who are at risk for infection, illness and death.

Based on the above process and limitations, the IP recognizes significant improvement in some areas as indicated in this report and discussions, however there remain multiple areas that are not in Substantial Compliance and others that have declined and remain problematic for this monitoring period from October, 2019 thru February, 2020. This report will follow the same format as previous reports with the exceptions and limitations of being unable to have onsite review and discussions regarding mental health care with SCDC staff and inmates. There have been significant personnel changes at SCDC since the last onsite visit and associated report, including the appointment of Dr. Christopher Kunkle as the Deputy Director for Behavioral Health. As noted in our last IP Report, Robert Erwin, Esq. is now the Mediator for the SA as the enforcement of the SA continues until SCDC demonstrates Substantial Compliance with the provisions. The process for submission of this IP report and review and comment by the parties will continue as has been done previously and those areas that may require further review and discussion onsite will be addressed during the postponed onsite visit as described above, as will anticipated scheduling of the next regular onsite visit.

COVID 19

The impact of the pandemic of COVID 19 is being experienced by correctional systems and facilities throughout the United States. The reality of the pandemic began realization in SCDC during the latter months of this monitoring period and continues to impact inmate health care as well as SCDC staff health and availability to provide services and security, given efforts to implement social distancing, testing and contact tracing. The IP has provided analyses of the

reporting of information impacting levels of compliance that have been, and will remain, in effect unless there are modifications and/or changes at the direction of the mediator. The IP is providing review and comments on specific areas of concern as we have in past reports, and are hopeful SCDC will do what it can to address these concerns and compliance criteria during this ongoing and unprecedented health care crisis.

Resources

The IP continues to report the resource deficiencies of SCDC, particularly with regard to Operations staff and Mental Health Care staff and associated medical and nursing staff. A working group, comprised of the IP, SCDC and consultant staff has been established and will continue to review and develop recommendations for SCDC programs and related activities. The current SCDC leadership for both Operations and Mental Health, under the direction of Director Bryan Stirling, are working in an effective manner to address staffing, space for treatment activities and programmatic needs. However, the baseline numbers of staff and needs to remedy these deficiencies remain problematic in several areas. The IP has consistently reported these concerns and must measure compliance based on the SA criteria. While there has been progress in the identification of inmates that should be on the mental health caseload and receiving adequate mental health services, currently comprised of 25% of the SCDC population, the number and percentage of inmates receiving higher levels of care and/or behavioral health unit services remains inadequate and less than those projected by SCDC. This has resulted in under-utilization of identified beds in specific programs as well as limited services in the existing programs. The IP has been informed of budget requests that have been recommended and submitted, but have not been approved or allocated which will remain problematic for compliance with the SA.

Suicides

In its last report, the IP reported suicide rates of approximately 63 per 100,00 inmates for 2018 and 53 per 100,00 inmates for 2019. These annualized rates far exceed the average annual suicide rates for prisons as reported by the Department of Justice Bureau of Justice Statistics as 17 per 100,000 inmates for their most recent report. There have been 2 reported suicides for SCDC inmates in 2020 thru February 2020. The IP repeats its concerns for inmates in need of higher levels of care, and for those who are determined to have increased risks for suicide, to have adequate access to higher levels of care, timely and adequate assessments, direct observation and treatment services and timely transfer to necessary treatment and management of their risks factors and mental health needs.

Safety Precaution (SP) Population

The IP remains concerned that Evans CI does not have the correctional and mental health staffing to manage the SP population. SCDC indicated inmates in the SP Program at Evans will be double celled. The IP agrees with double celling most of the SP population; however, there will be SP inmates that require single celling based on their special circumstances. The SCDC Evans SP Housing Plan needs to include single celling where appropriate. As of March 26, 2020 there were 190 inmates classified SP in SCDC RHUs.

Inmates Confined in RHU Over 60 days on Short Term and/or Disciplinary Detention (DD)

The IP respectfully requests that SCDC reconsider the intent not to modify time frames for maximum time on disciplinary detention. It is recognized that American Correctional Association Standards limit Restricted Housing Unit time to 30 days and that beyond 30 days is defined as Extended Restrictive Housing. Based on SCDC's inability to provide significant services and

privileges established by the Settlement Agreement and RHU policies, limiting disciplinary detention to 30 days is recommended, particularly for inmates with a mental health designation.

Restrictive Housing Units
The IP is pleased with SCDC's plan to implement an inspection form for RHU cells and require an inspection of cells prior to inmate removal or placement. The IP encourages SCDC to require cell inspections for all other SCDC cells and completion of the form prior to placement or removal of an inmate from any cell.

Structured Living Units (SLUs)
The IP has continued concerns regarding SCDC's SLUs. The SLUs were implemented without an approved policy and inmates with a mental health designation are housed in the program. The SCDC SLU Report provided for the IP April 2020 review identified 815 inmates assigned to SLUs at SCDC institutions. The report did not include the behavior level of the inmate, the last review date, or the reason for placement. It was indicated placement of inmates in a SLU was at the direction of the wardens. Inmates who did not have recent disciplinary reports were identified on the SLU Report. It is recommended that QIRM perform a QI Study of the SCDC SLU Program as soon as possible.

Classification
The IP is encouraged by the development of the new classification system, particularly with mentally ill inmates' custody and institution (or unit) matching their security level. The assignment of QMHPs to Manning for minimum custody inmates is another encouraging development.

Crank Radios and Tablets
The IP strongly supports issuing inmates crank radios and tablets. It is agreed that policies and procedures are needed that include staff and inmate accountability.

Crisis Placement, Continuous Observation, and Suicide Risk Assessments
The IP discovered during the November 2019 Site visit that SCDC Headquarters, Prison Operations, and Prison Behavior Health Staff do not have a consistent understanding of the SCDC Crisis Intervention Program in regard to placement, continuous staff observation, and suicide risk assessments. Applicable policies and procedures need to be reviewed to ensure staff in all areas are provided clear direction on their crisis intervention duties and responsibilities. Additional training is necessary for all staff once the applicable policies and procedures have been reviewed and revised to address the identified staff confusion. The IP remains extremely concerned with regard to SCDC's protocols for Crisis Placement, Continuous Observation, and Suicide Risk Assessments. From October 2019 through February 2020 there were 906 CISP admissions with an average length of stay of 10.42 days and a median length of stay of 5.0 days. Reviewed reports since the IP November 2019 site visit reveal continued serious issues and concerns.

Preventive Maintenance
The IP appreciates SCDC's response to the concerns regarding institutions' preventive maintenance. It is requested that QIRM conduct a QI Study to evaluate the effectiveness and efficiency of SCDC institutions implementing and improving their preventive maintenance program.

Control Cell Placement
Ensure inmates on control cell status do not exceed 72 hours and emphasize to institution staff the inmate is to be removed from control cell status earlier than 72 hours if his behavior no longer requires placement.

Behavior Modification Units (LLBMU, HLBMU, and DHU)
SCDC needs to develop a plan to remove SD status inmates with a mental health designation from RHUs with placement in alternative mental health residential units.

RHU Stepdown Programs
Of the 173 inmates on SD status as of March 25, 2020, it appears there are 69 inmates who are eligible to be considered for RHU Stepdown Programs.

Mental Health Disciplinary Treatment Teams for Mentally Ill Inmates Receiving Disciplinary Sanctions
The IP recommends that on the List of Mentally Ill inmates showing instances when the Disciplinary Treatment Team modified the sanctions imposed by the SCDC Disciplinary Hearing Officer, the inmate's original sanction and the modified sanction be included.

Inmates' Out of Cell Time
Provide the IP a SCDC Report identifying, by institution and housing unit, the number of hours inmates receive out of cell time on Monday through Friday, Weekends and Holidays.

Findings
The Implementation Panel has provided its analysis, recommendations and consultation prior to, and during the week of the scheduled onsite visit by teleconferences. Regrettably, the IP was unable to conduct onsite review and discussions that are vital to the completion of the established process. The IP is hopeful for a rescheduled onsite visit during June or July 2020. The rescheduled visit will be determined by factors related to the COVID 19 pandemic and status of this crisis. As has been consistently reported by the IP, many of our findings are consistent with those of QIRM and we continue to recognize and appreciate their hard work and contributions. There has been variability in the data reporting by Health Services which has improved in some areas and remains problematic in others. As reported previously, the collaboration and contributions of Operations has also improved, despite the noted resource limitations.

SCDC has not achieved Substantial Compliance in the majority of the Settlement Agreement requirements which remains problematic. The restrictions and modifications in response to the COVID 19 pandemic are necessary to limit and respond to this ongoing crisis and we encourage SCDC to continue to monitor their own performance and document the impact while providing their very best efforts to provide adequate mental health care in these very difficult times.

The findings of the Implementation Panel with regard to compliance on the provisions as of April 10, 2020 are as follows:

1. Substantial Compliance (active)—5
2. Substantial Compliance (sunset/greater than 18 months)—17
3. Partial Compliance—32
4. Non-Compliance--5

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: The guidelines referenced above appeared to have significantly improved the R&E mental healthcare triage system. Lengths of stay remain problematic with some improvement noted at KCI; however length of stay at CGCI has extended beyond 30 days for a significant number of inmates. We agree with the QI recommendation that indicates "Mental Health should develop an internal monitoring system that will allow staff to identify inmates who have received a MH classification and track until they are removed from R& E. This should ensure inmates who have been identified as requiring MH services are being seen according per policy as it pertains to their assigned level of care."

Implementation Panel April 2020 Recommendations: As above.

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

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

Implementation Panel April 2020 Findings: The increase in the percentage of inmates on the mental health caseload continues and is close to the expected percentage, which is likely a reflection of an adequate mental health screening system in the R&E. However, the QI study referenced above is difficult to interpret due to the lack of clarity regarding the changes over time in the context of the mental health classifications. Specifically, it is not clear whether a percentage of the changes were to a higher level of care.

Implementation Panel April 2020 Recommendations: Clarify the above findings.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: We are encouraged regarding the audit process but concerned regarding the lack of corrective action documentation.

Implementation Panel April 2020 Recommendations: Follow-up regarding the corrective action process.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: The CoC issues described are concerning. We agree with the plan to contact the involved counties.

The data reviewed did not address issues related to bridge orders.

Implementation Panel April 2020 Recommendations: Provide information regarding the use of bridge orders for psychotropic medications.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per 1.a.i.

Implementation Panel April 2020 Recommendations: As per 1.a.i.

2. The development of a comprehensive mental health treatment program that prohibits inappropriate segregation of inmates in mental health crisis, generally requires improved treatment of mentally ill inmates, and substantially improves/increases mental health care facilities within SCDC.

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 April 2020 Assessment: Noncompliance

Implementation Panel April 2020 Findings:

Camille Graham CI

Review of the Camille Graham Compliance report indicated the following:

1. Lack of compliance with timely treatment plans in all levels of mental health care.
2. Lack of compliance with the treatment team via documentation in NextGen using the appropriate template and visit type.
3. Lack of compliance with documentation of weekly rounds being conducted for all inmates in the RHU.
4. Lack of compliance with CSU inmates receiving between 5 and 10 hours of structured out of cell time during the monitoring period.

5. Lack of compliance with RHU inmates receiving showers on a three times per week basis.
6. Lack of compliance with inmates in the RHU being offered outside recreation five times per week during their length of stay in the RHU.
7. Lack of compliance with inmates receiving security checks as per policy.
8. Compliance with temperature checks and cleaning of safe cells. However, it was not uncommon for the temperature to be out of the required range.
9. Issues were present re: inmate access to cleaning supplies and weekly laundry exchange.
10. Lack of compliance with time reviews of inmates on ST or DD status.
11. Lack of compliance with 15-minute checks in the CSU.
12. Tracking re: compliance specific to the 60 hour timeframe for transfers to the CSU was incomplete.
13. Problems with documentation re: medication administration continued to be present as were other medication administration issues (e.g., frequently missed medications).
14. A few Blue Ridge ICS inmates reported seeing their counselors on a consistent basis but most of them do not.
15. Inmates arrived at the CSU without an M-120 in the months of October, November, and December.
16. Tracking of suicide resistant property in the RHU was non-existent in contrast to the CSU, which tracked such property.

Broad River Correctional Institution (BRCI)

Review of the BRCI Compliance report indicated the following:

1. Lack of compliance with timely treatment plans in all levels of mental health care.
2. Lack of compliance with the treatment team via documentation in NextGen using the appropriate template and visit type.
3. Lack of compliance with documentation of weekly rounds being conducted for all inmates in the RHU.
4. Lack of compliance with CSU inmates receiving between 5 and 10 hours of structured out of cell time during the monitoring period.
5. Lack of compliance with RHU inmates receiving showers on a three times per week basis.
6. Lack of compliance with inmates in the RHU being offered outside recreation five times per week during their length of stay in the RHU.
7. Lack of compliance with inmates receiving security checks as per policy.
8. Lack of compliance with temperature checks and cleaning of safe cells. It was also not uncommon for the temperature to be out of the required range.
9. Lack of compliance with cleaning the safe cells.
10. Issues were present re: inmate access to cleaning supplies and weekly laundry exchange.
11. Compliance issues with CSU inmates receiving showers.
12. Lack of compliance with time reviews of inmates on ST or DD status.
13. Lack of compliance with 15-minute checks in the CSU.
14. Compliance issues specific to the 60 hour timeframe for transfers to the CSU.
15. Problems with documentation re: medication administration continued to be present as were other medication administration issues (e.g., frequently missed medications).
16. Lack of compliance with inmates arriving at the CSU with an M-120 during the monitoring period.

17. Consideration for higher levels of care for inmates in the CSU for 10 or more days was often not documented in NextGen.
18. Compliance with constant observation by inmate companions in the CSU.
19. RHU inmates without access to cleaning supplies.
20. Tracking of suicide resistant property in the RHU was non-existent in contrast to the CSU, which tracked such property.

Kirkland Correctional Institution (KCI)

Review of the KCI Compliance report indicated the following:

1. Lack of compliance with timely treatment plans in all levels of mental health care.
2. Lack of compliance with the treatment team via documentation in NextGen using the appropriate template and visit type.
3. Lack of compliance with documentation of weekly rounds being conducted for all inmates in the RHU.
4. Lack of compliance with RHU inmates receiving showers on a three times per week basis.
5. Lack of compliance with inmates in the RHU being offered outside recreation five times per week during their length of stay in the RHU.
6. Lack of compliance with inmates receiving security checks as per policy.
7. Lack of compliance with temperature checks and cleaning of safe cells.
8. Lack of compliance with cleaning the safe cells.
9. Issues were present re: inmate access to cleaning supplies and weekly laundry exchange.
10. Lack of compliance with time reviews of inmates on ST or DD status.
11. Lack of compliance with 15-minute checks on crisis status and lack of compliance with checks when an inmate is on constant observation status.
12. Lack of compliance concerning issues specific to the 60-hour timeframe for transfers to the CSU.
13. Problems with documentation re: medication administration continued to be present as were other medication administration issues (e.g., frequently missed medications).
14. Tracking of suicide resistant property in GPH and in the infirmary was non-existent.

Lee Correctional Institution (LCI)

Review of the LCI Compliance report indicated the following:

1. Significant medication management issues were reported by inmates that included placing meds on the cuff port.
2. Very poor access to a QMHP.
3. Lack of adequate access to cleaning supplies.
4. The inmates at Lee do not have tablets. Radio contracts for 2018 were received, and staff stated radios have not been received since 2018.
5. Poor access to laundry services.
6. During the review, security staff reported that blankets were no longer issued to inmates placed on crisis intervention or suicide precaution (CI/SP) but did not know the reason why.

7. Problems with documentation re: medication administration continued to be present as were other medication administration issues (e.g., frequently missed medications, administering medications without the MAR being present).

The QIRM reviews reported significant deficiencies in the delivery of mental health services to inmates at CGCI, BRCI, KCI and LCI. Many of these deficiencies are very basic processes such as medication administration, providing access to cleaning supplies and laundry, and basic documentation issues. These problems appear to represent a serious backsliding in the context of compliance as compared to our prior site assessment.

Implementation Panel April 2020 Recommendations: Develop a corrective action plan to address the issues summarized in the relevant QIRM review reports.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: The number of hours of structured therapeutic activities being offered/received to ICS inmates and other MH L2 inmates remains very problematic. Staffing allocation issues remain a significant barrier to increasing the capacity of beds/programs available to inmates in need of a MH L2 level of care.

Implementation Panel April 2020 Recommendations: Develop and implement a corrective action plan to remedy the above.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: Our last two 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.

Implementation Panel April 2020 Recommendations:

1. Remedy the lack of adequate access for inmates to out of cell time (both structured and unstructured activities).
2. Remedy the lack of adequate access for women to inpatient beds.

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

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

Implementation Panel April 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 April 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 April 2020 Assessment: **P**artial compliance

Our November 2019 report included the following:

Broad River CI DHU

The census was 11 inmates with a capacity of 19 inmates.

We interviewed eight inmates in a group setting during the morning of November 19, 2019. They confirmed access to out of cell structured and unstructured activities but were very unhappy with the DHU. They explained that what they were told prior to admission to the DHU was very misleading because most of what they were "promised" was not implemented. It was unclear to them whether the DHU was just a housing unit or a "program." Many reported being told that the DHU would be a temporary (e.g. 90 days) transitional unit to another housing unit or program. They perceived the DHU to be too similar to a RHU.

November 2019 Implementation Panel Recommendations: A policy and procedure needs to be developed for the DHU, which needs to include a mission statement and criteria for admission.

Mental Health Officers

We reviewed the job description of the MHOs, which had some significant differences from the mental health technicians' job description. Specifically, the educational requirements were less for the MHOs in the context of mental health experience and/or mental health curriculum and the correctional officer duties were expanded for the MHOs as compared to the mental health

technicians. In practical terms, correctional officers were converted to MHO's; the understanding and endorsement of the IP was for this change to provide SCDC the opportunity to "extend" correctional officer duties to MHO's given the severe correctional officer shortage, but not to "substitute" the duties of mental health staff, such as clinical rounds, to essentially custody/operations staff.

We informed the mental health leadership that the MHOs should not be performing RHU mental health rounds for the following reasons:

1. Inadequate educational credentials.
2. Dual agency issues.

In addition, since the QMHPs are not meeting with RHU caseload inmates on at least a monthly basis, rounds conducted by the QMHPs will ensure that the inmates are at least being screened by a QMHP on a regular basis.

Implementation Panel April 2020 Findings: It is encouraging that the number of mental health inmates in SD custody has decreased.

Based on the data provided, we are unable to update our findings re: the DHU and the functioning of mental health officers.

Implementation Panel April 2020 Recommendations: Provide documentation of specific duties performed in the DHU by mental health officers.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: Based on review of the previously referenced QIRM institutional audit reports, this provision remains in partial compliance.

Implementation Panel April 2020 Recommendations: Provide documentation of the implementation of the 10 hours of structure therapeutic activities and 10 hours unstructured services provided for each inmate placed in the DHU.

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 April 2020 Assessment: Noncompliance

Implementation Panel April 2020 Findings: Timely individual clinical contacts with a QMHP and psychiatrist were very problematic in the RHUs. However, such sessions were generally conducted in a confidential setting.

Implementation Panel April 2020 Recommendations: Remedy the above.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update section and unchanged from November 2019. Bed capacity and staffing issues are the major barriers for providing adequate access to higher levels of care when clinically indicated.

Implementation Panel April 2020 Recommendations: Remedy the above.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
Institutions continue to perform temperature and cleanliness checks for all CI cells and four random RHU cells. QIRM provided QI Studies for BRCI Saluda, Kirkland F1, and D and Camille Graham. It was reported Perry CI is not conducting temperature and cleanliness check in all three RHU Buildings. Institutions continue to struggle to achieve consistent compliance with conducting required daily temperature and cleanliness checks for four random cells and all CI cells:

From 1/31/2020 to 2/29/2020 Daily Temperature Checks

Day Shift	
Broad River Saluda	0-88%
Camille Graham RHU	84-100%
Kirkland F1	0-94%
Kirkland D	0-97%
Evening Shift	
Broad River Saluda	12-88%
Camille Graham RHU	79-100%
Kirkland F1	0-94%
Kirkland D	0-94%

Camille Graham continues with the highest percentage of compliance in performing temperature and cleanliness checks. Broad River (2-60%) and Camille Graham (1-60%) temperature checks identified cells with temperatures outside the acceptable range. QI studies for the identified revealed a very low number of cells that were not clean. This finding needs to be verified by the IP with onsite inspections due to previous inspections identifying sanitation issues in the majority of the RHUs.

Implementation Panel April 2020 Recommendations:

1) Operations Management ensure all prisons are performing required daily inspections for cleanliness and taking temperatures of random cells;
2) Institution Management should conduct periodic QI Audits to ensure line staff are accurately recording and documenting required cell temperature and cleanliness checks.

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 Logs;
4) Ensure Daily Cell Temperature and Cleanliness data is uploaded in the shared file;
5) Perry CI should conduct the four random RHU and corresponding safe cell checks in each of their three RHU buildings. This is based on the information provided by SCDC Facilities Management that there would be a variation in temperatures in each building.
6) 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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: SCDC continues to develop their formal quality management program under which segregation practices and conditions are reviewed.

Implementation Panel April 2020 Recommendations: Continue to develop the SCDC formal quality management program to review segregation practices and conditions.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per the Status Update, the Behavioral Health Services completed a draft update for Section 14 of the Operations Policy 22.01 "Use of Force" and it has been approved by the IP and Plaintiffs. Revisions are currently being formatted and will thereafter be distributed for signatures. Once the revised Section 14 of the Operations Policy 22.01 "Use of Force" is distributed, all SCDC staff will need to receive training on the revised policy.

UOF workshops were completed at (4) institutions: Kershaw CI, Lee CI, Camille Graham CI, and Kirkland CI. These workshops appear to be successful in assisting institution staff address UOF issues.

QIRM completed a review of the Division of Mental Health's review of UOF incidents involving inmates with a mental health designation completed by the Use of Force Coordinator (UOFC) for September 2019 – January 2020. The study examined Planned v. Immediate UOF and QMHP contact after hours and on weekends. From the review, QIRM made recommendations for future UOFC Reports.

The Division of Operations, Behavioral Health Services, UOF Coordinator and QIRM Use

of Force Reviewers continue to meet regularly to address issues and concerns regarding disproportionate UOF.

Implementation Panel April 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 revised Section 14 of the Operations Policy 22.01 "Use of Force" and 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.

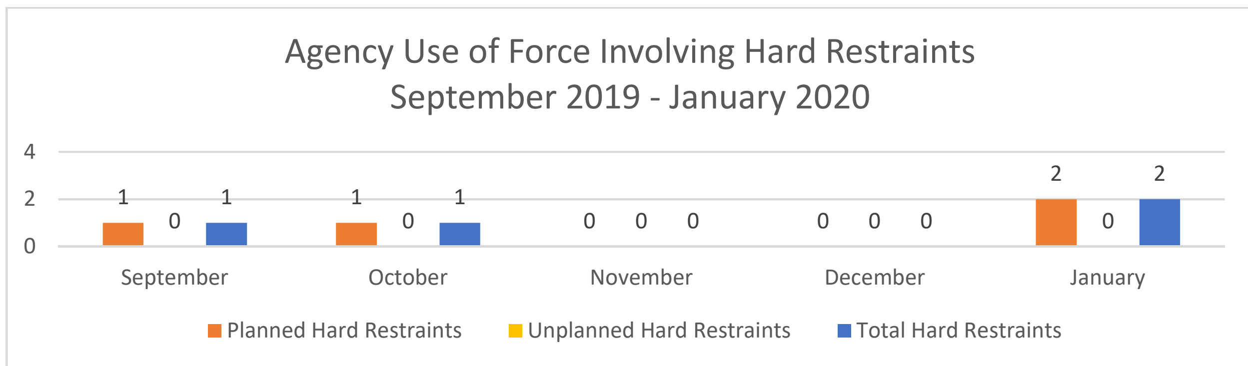
2.c.ii. The plan will further require that all instruments of force, (e.g., chemical agents and restraint chairs) be employed in a manner fully consistent with manufacturer's instructions, and track such use in a way to enforce such compliance;

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

Implementation Panel April 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 11/22/19 by full implementation of 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 2848 employees completed the SCDC Annual In-Service UOF Training in 2019.

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.

QIRM UOF Reviewers are tracking the amount of time inmates remained in hard restraints and to determine if SCDC guidelines for hard restraint use were followed. There were no use of force incidents involving the restraint chair from September 2019 to January 2020. A review of hard restraints from September 2019 to January 2020 identified a total of four uses of hard restraint incidents at SCDC institutions. The amount of time the inmate remained in hard restraints was not identified in the provided SCDC UOF Report.



SCDC has been successful in providing UOF Training for In-Service for existing employees. 1,620 SCDC employees had completed the required the necessary UOF training for Calendar Year 2019 as of October 18, 2019. The Agency is on track for the training to be received by the majority of the required employees.

Implementation Panel April 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. Required staff complete Use of Force Training in Calendar Year 2020.

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 April 2020 Assessment: Substantial compliance (March 2018)

Implementation Panel April 2020 Findings: As per the status update, there were no documented uses of the restraint chair for the current reporting period. Hard Restraints were utilized in four (4) incidents from September 2019 to January 2020 (see 2.c.iv). The amount of time in hard restraints was not included in the provided SCDC Use of Force Report for Use of Hard Restraints.

SCDC continues to minimally use Restraint Chairs and Hard Restraints.

Implementation Panel April 2020 Recommendations: QIRM to track and monitor compliance with use of the restraint chairs and hard restraints, including when the inmate is placed and removed.

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 April 2020 Assessment: Substantial compliance (December 2017)

Implementation Panel April 2020 Findings: Our November 2019 findings were as follows:

Per SCDC update. QIRM collects data and issues quarterly reports identifying the length of time and mental health status of inmates placed in restraint chairs. SCDC restraint chair use rarely occurs. There were only two restraint chair uses from November 2018 to October 2019. For the two-restraint chair uses in the relevant period, the time in the restraint chair was: 12/6/18-10 minutes and 1/2/19-143 minutes. For the January 2, 2019, incident, the length of time the inmate was placed in the restraint chair was outside policy guidelines.

The QIRM October 2019 Restraint Chair Report identified recommendations for Operations to implement for restraint chair use:

- Documentation of the incident, in its entirety, should be uploaded into the Automated Use of Force system, to include the video(s) and all 19-29A/B "Incident Reports." The documentation should clearly state all facts of the incident to include the events leading up to the use of force.
- The Automated Use of Force System, NextGen, 19-29As, and MIN should all agree on the timeframes as well as major details. It is not expected that they should all be written the same; however, they should include the same and/or similar facts.
- Documentation should clearly articulate why the inmate was placed in a restraint chair.
- Per policy, mental health professionals should be consulted prior to placing an inmate with a mental health classification in a restraint chair.

The responsible IP member agrees with the QIRM Restraint Chair use recommendations made to Operations.

There were no documented uses of the restraint chair during the current reporting period.

Implementation Panel April 2020 Recommendations:

1. QIRM to continue to prepare a Restraint Chair Report for each monitoring period.
2. Operations to implement the QIRM recommendations made in the October 2019 Restraint Chair Report.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
Per status update. 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.

The Division of Police study from October 2019 to February 2020 regarding referrals for excessive force and physical abuse was reviewed. Police Services focuses on excessive force and physical abuse that reach to the level of criminal conduct and continues to rarely conduct administrative investigations for incidents referred for excessive force and physical abuse of inmates. See below.

Police Services Investigations
October 2019 to February 2020

Police Services Investigations	October 2019	November 2019	December 2019	January 2020	February 2020
UOF incidents reviewed for investigation	5	3	2	5	2
UOF investigations opened	2	1	5	5	1
UOF investigations pending	16	12	14	12	9
UOF investigations closed	0	5	3	7	4

A previously conducted QIRM CQI Study recommended the Division of Police Services revise their tracking system to include: 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. Based on the Police Services information provided for this reporting period, the QIRM recommendations have not been followed.

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 budgeting additional staff and resources during the next budget year. This is due to Police Services focusing on excessive force and physical abuse that reach to the level of criminal conduct and rarely conducting administrative investigations for incidents referred for excessive force and physical abuse of inmates.

The QIRM provided UOF Report identified there were 234 grievances filed from September 2019

through January 2020 related to excessive use of force, unprofessional conduct and physical abuse. This is evidence there are a high number of inmate complaints related to excessive use of force, unprofessional conduct and physical abuse.

QIRM did not provide the number of UOF violations they identified from September 2019 to January 2020. The last reporting period, QIRM reported 319 UOF violations from January 2019 through August 2019. For this reporting period, 23 employees received corrective action for 21 UOF Incidents.

SCDC Use of Force MINS for October 2018 through September 2019:

Month	Year	Number of UOF MINS
October	2019	102
November	2019	79
December	2019	79
January	2020	102
February	2020	81

As identified in *Section 2.c.i,* the Division of Mental Health completed a report of UOF incidents involving inmates with a mental health designation for September 2019 – January 2020. The study examined Planned v. Immediate UOF and QMHP contact after hours and on weekends. QIRM reviewed the UOFC Report and made recommendations for future reports.

SCDC provides monthly documentation on the number of employees receiving formal corrective action for UOF violations.

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

Implementation Panel April 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 to develop an interim plan to perform administrative UOF investigations and budget additional staff and resources to perform administrative investigations for the next budget year.
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 April 2020 Assessment: Substantial compliance (November 2019)

Implementation Panel April 2020 Findings: Per status update. SCDC has been successful in addressing the misuse of MK9 and achieved compliance 11/22/19.

QIRM and Operations is closely monitoring Correctional Staff MK9 use. SCDC had 22 UOF incidents involving MK9 from September 2019 through January 2020.

The Operations Administrative Regional Director (ARD) sent an email to all Wardens on March 18, 2020, emphasizing the importance of continuing the Agency's overall compliance with MK-9 use during UOF incidents. He provided guidance that Wardens and their Executive Staff were to review:

1. Unplanned use of the MK-9, in RHU;
2. The use of the MK-9 for inmates refusing to remove their arm(s) from the food flap;
3. Supervisors monitor the use of MK-9 internally to ensure that it was used per manufacturer's instructions (at least 6 feet distance from the inmate) and that an explanation is provided when it was not;
4. When chemical munitions are used, documentation should clearly specify MK-4 and /or MK-9 , instead of just stating that chemical munitions were used;
5. Supervisors should monitor /review documentation to ensure staff are including all necessary information in the MIN's narrative and that the documentation is written in chronological order and accurately.

Implementation Panel April 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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
Per the Section 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 June 2018 – January 2020 had not statistically improved. Attempts to contact clinical counselors (QMHPs) occurred 60.8 percent of the time according to the provided chart.

The Deputy Director for Operation's office developed and implemented a QMHP contact form which is required to be completed by the shift supervisor or control room officer who makes the call to the designated QMHP. The QMHP contact form is to be uploaded into the AUOF system along with all other UOF reports.

QIRM's analysis found there were discrepancies between the QMHP and Operations staff whether the QMHP was contacted prior to the planned use of force and additional protocols were needed for Operations and Behavioral Health Staff.

Implementation Panel April 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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 findings:
Per status update. The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates remains an 11-hour program for new correctional officers. Permanent correctional officers receive 4 hours annual training concerning

the appropriate methods of managing mentally ill inmates; primarily related to suicide prevention.

According to the SCDC *C.O.s Required to take Managing MI Offenders Training in CY 2019 report,* of the required 2,155 staff required to take the training, only 1,498 (69.5%), fully completed the training.

Behavioral Health Services completed a CQI study to assess RHU custody staff mental health training. The study consisted of a review of training for Lee CI, Camille Graham CI, Broad River CI, and Kirkland CI custody staff members primarily assigned to RHU. A review of the findings indicated:

Lee CI- 16 custody staff

- Of the 16 staff members, 14 met the criteria for "Recognizing & Responding" training and all 14 completed the training.
- One staff member, hired prior to 2019, failed to complete the 2019 Suicide video trainings 1 & 2.

Camille Graham CI-16 custody staff

- One of the 16 could not be found in the computer system, therefore the total audited was 15. Four of the 15 staff completed CIT.
- None of the 15 completed MHFA.
- Of the 15 staff members, 10 met the criteria for "Recognizing & Responding" training and 8 completed the training.
- Three staff members, hired prior to 2019, failed to complete the 2019 Suicide video trainings 1 & 2.

Broad River CI- 15 custody staff

- Five of the 15 staff completed CIT.
- Four staff members completed MHFA.
- Of the 15 staff members, 6 met the criteria for "Recognizing & Responding" training and 4 completed the training.
- Ten (10) staff members, hired prior to 2019, failed to complete the 2019 Suicide video trainings 1 & 2.
- Three (3) staff members, hired prior to 2019, failed to complete the 2019 Instructor Led Suicide training.

Kirkland CI-29 custody staff members

- Six (6) of the 29 staff completed CIT.
- Two (2) staff members completed MHFA.
- Of the 29 staff members, 22 met the criteria for "Recognizing & Responding" training and 17 completed the training.
- Eight (8) staff members, hired prior to 2019, failed to complete the 2019 Suicide video trainings 1 & 2.
- Two (2) staff members, hired prior to 2019, failed to complete the 2019 Instructor Led Suicide training.

QIRM recommended in the status update that Custody staff primarily assigned to RHU participate in CIT and MHFA, and complete mandatory training "Recognizing the Signs & Symptoms of Mental Illness and Appropriately Responding", and annual suicide trainings (2 videos & 1 instructor led). It was recommended employees failing to complete the mandatory

training be given corrective action per the Employee Corrective Action.

The *SCDC List of All Employees who have had CIT Training as of Close of Business February 29, 2020 Report* indicated that 528 employees had completed Crisis Intervention Training (CIT). A review of the report further indicated that a high number of employees who were CIT trained in 2016 and 2017 had not completed the 8 hour refresher training that is required every 2 years.

SCDC Executive staff should evaluate the training provided correctional staff to ensure sufficient training is provided 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 April 2020 Recommendations:

1. Conduct an evaluation and consult with Behavior Health Staff to determine if correctional staff is 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 2020;
3. Ensure SCDC employees complete the required Calendar Year 2020 training. Follow QIRM recommendations Custody staff primarily assigned to RHU should participate in CIT and MHFA, and complete mandatory training "Recognizing the Signs & Symptoms of Mental Illness and Appropriately Responding", and annual suicide trainings (2 videos & 1 instructor led). It was recommended employees failing to complete the mandatory training be given corrective action per the Employee Corrective Action.

2.c.x. Collection of data and issuance of quarterly reports concerning the use-of-force incidents against mentally ill and non-mentally ill inmates;

Implementation Panel April 2020 Assessment: Substantial compliance (March 2017)

Implementation Panel April 2020 Findings:
Per status update. SCDC continues to generate a monthly UOF Report Mentally Ill vs. Non-Mentally Ill. No issues were identified with the use of force data utilized to produce the report.

Implementation Panel April 2020 Recommendations:
Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
Per update. The MH UOF Coordinator is monitoring UOF incidents involving inmates with a mental health designation. The revised SCDC UOF Policy Mental Health procedures have been revised and approved by the parties and are in the process of being implemented by SCDC.

QIRM completed a review of the Division of Mental Health's review of UOF incidents involving inmates with a mental health designation completed by the Use of Force Coordinator (UOFC) for September 2019 – January 2020. The study examined Planned v. Immediate UOF and QMHP contact after hours and on weekends. From the review, QIRM made recommendations for future UOFC Reports.

The Division of Operations, Behavioral Health Services, UOF Coordinator and QIRM Use of Force Reviewers continue to meet regularly to address issues and concerns regarding disproportionate UOF involving mentally ill and non mentally ill inmates.

Implementation Panel April 2020 Recommendations:
1. QIRM perform QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation once the revised SCDC UOF Policy is implemented and staff are trained on the revisions.
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 with a mental health designation involved in UOF incidents in RHU and 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. 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 April 2020 Assessment: Substantial compliance (November 2018)

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

Implementation Panel April 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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update section. It was unclear from the update whether the reasons for the partial compliance were staffing vacancies, scheduling issues, or something else.

Implementation Panel April 2020 Recommendations: Assess the causes of the partial compliance and devise a corrective course of action. This provision is dangerously close to noncompliance based on NexGen reported percentages of staff participation; must improve.

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 April 2020 Assessment: Partial compliance

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

Implementation Panel April 2020 Recommendations: Remedy the above.

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

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

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

Implementation Panel April 2020 Recommendations: Continue to monitor

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

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

Implementation Panel April 2020 Findings: See previous provision.

Implementation Panel April 2020 Recommendations: See previous provision.

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 April 2020 Assessment: Partial compliance

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

Implementation Panel April 2020 Recommendations: Provide documentation and utilization of

OATS installation as per deployment schedule.

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

Implementation Panel April 2020 Assessment: Partial compliance

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

Implementation Panel April 2020 Recommendations: Compliance will be achieved when such reports described in the status update section are produced and reviewed by the IP.

4.a.ix. Quality management documents; and

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update.

Implementation Panel April 2020 Recommendations: Continue to work with IT to resolve the issues referenced.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: See 4.a.iv.

Implementation Panel April 2020 Recommendations: See 4.a.iv.

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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: See 4.a.iv.

Implementation Panel April 2020 Recommendations: See 4.a.iv.

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

5.a. Improve the quality of MAR documentation;

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update.

Implementation Panel April 2020 Recommendations: Continue to advocate for needed resources as summarized above.

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

Implementation Panel April 2020 Assessment: Noncompliance

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

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

Implementation Panel April 2020 Assessment: Partial compliance

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

Implementation Panel April 2020 Recommendations: Implement the processes as per the status update section and continue to monitor.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: As per status update section. Medication administration issues remain extremely problematic.

Implementation Panel April 2020 Recommendations: We need to discuss this issue further with leadership staff.

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 April 2020 Assessment: Partial compliance

Our November 2019 report included the following:

Broad River CI CSU

During the afternoon of November 18, 2019, we observed a staffing of one inmate in the BRCI CSU. Similar to our past observation of such staffing, the inmate's precipitating factor for the admission appeared to be primarily a safety concern.

Our March and July 2018 findings included the following:

It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the receiving institution that resulted in recommended interventions not being implemented.

The CSU at BRCI has essentially been functioning as a clearing house for the entire system in the context of admitting many inmates who have security issues that were either not being adequately addressed or perceived by the inmates as not being adequately addressed. The CSU is hampered in adequately intervening for the following reasons:

1. The lack of a central office classification officer, who could implement appropriate interventions specific to safety concerns; and
2. Lack of timely access to specific treatment programs such as the LLBMU and the HLBMU due to waiting list issues.

Our November 2019 assessment remains unchanged from the above assessment.

During the afternoon of November 21, 2019, we met with Drs. Taylor and Wood to discuss issues relevant to the suicide risk assessments. The suicide risk assessment appeared to be unclear. We recommended that **all** suicide risk assessments include a Lifetime/Recent Columbia-Suicide Severity Rating Scale (C-SSRS).

There are three versions of the Columbia. The "Lifetime/Recent" version allows practitioners to gather lifetime history of suicidality as well as any recent suicidal ideation and/or behavior. The "Since Last Visit" version of the scale assesses suicidality since the patient's last visit. The "Screener" version of the C-SSRS is a truncated form of the full version. We are open to SCDC proposing a protocol for use of these different versions.

It was our understanding that one reason so many inmates who are not suicidal get transferred to the CSU was directly related to the policy requirement that suicide precautions can only be discontinued by a psychologist or psychiatrist, which has been problematic due to coverage issues. We recommend that such coverage be provided by the CSU psychologists and/or psychiatrists, which should actually save these clinicians time since they would not have to do an admission assessment if they decide

that such inmates do not require a CSU admission.

Implementation Panel April 2020 Findings: We need information specific to our prior recommendations re: assignment of a central office classification officer to the CSU as well as our above recommendations. As per status update section.

Implementation Panel April 2020 Recommendations: As above.

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

Implementation Panel April 2020 Assessment: Noncompliance

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

Implementation Panel April 2020 Recommendations: Implement the pilot .

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
Clean, suicide-resistant clothing should include necessary hygienic supports, such as sanitary napkins or other provisions for women in crisis during menstruation. In the prior monitoring report, it was identified hygiene support was not adequately provided to females on crisis at Camille Graham CI. The April 2020 SCDC Status Update did not provide information if this serious concern was addressed at Camille Graham CI. Future reports should include information regarding females inmates in CI having access to necessary hygiene support.

A review of the QIRM Report for the identified institutions revealed an adequate number of suicide resistant smocks blankets and mattresses in each area except Broad River RHU where there were no *all in mattresses* or *regular mattresses* in storage. The report identified the number of items in disrepair, number of clean items available at the time of the audits, number of out for repair, storage, maintenance and availability of clean items and the institution's internal tracking system for items sent out and returned for cleaning.

Camille Graham CI RHU, Broad River CI RHU, and Lee CI RHU did not have a tracking system for items sent out for cleaning and when they are returned. Broad River CI CSU staff reported having a tracking system; however, the tracking system could not be produced or described.

Implementation Panel April 2020 Recommendations:
1. Continue to monitor the provision and correct any identified concerns.
2. 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 April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings:
As per status update section. Inmates housed in the CSU will be offered showers each weekday, Monday - Friday. On Saturdays, Sundays, and holidays, showers in the CSU will be offered if security staffing presence permits. The status update reveals the percentage of inmates in CSU receiving required daily showers at Broad River CI and Camille Graham CI.

Broad River CI CSU averaged providing less than 50 percent of the inmates daily showers from October 2019 through February 2020: October 2019-60%, November 2019-25%, December 2019-27%, January 2020-33% and February 2020-41%. The month of October 2019 was the only month Broad River CI CSU provided more than 50 percent of inmates daily showers.

Camille Graham CI CSU for the first three months of the reporting period averaged providing less than 50 percent of the inmates daily showers. There was a significant increase in providing inmates daily showers at Camille Graham CI CSU in January 2020 (88%) and February 2020 (97%).

Implementation Panel April 2020 Recommendations: Remedy the above. Ensure inmates housed in the CSU are offered showers each weekday, Monday - Friday. On Saturdays, Sundays, and holidays, offer showers in the CSU if security staffing presence permits.

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

Implementation Panel April 2020 Assessment: Noncompliance

Implementation Panel April 2020 Findings: Need relevant data for this provision

Implementation Panel April 2020 Recommendations: Provide necessary data to demonstrate compliance.

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

Implementation Panel April 2020 Assessment: Partial compliance

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

Implementation Panel April 2020 Recommendations: As per status update section. See 2 b.vi.

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

Implementation Panel April 2020 Assessment: Partial compliance

Implementation Panel April 2020 Findings: The relevant QI processes continue to evolve in a very positive manner as summarized in the status update section. Review and discussion of suicide prevention and management program, and psychological autopsies to occur onsite at rescheduled onsite visit.

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

Conclusions and Recommendations

The Implementation Panel has conducted 10 previous onsite visits and, based on the documents requested and reviewed prior to and during those visits, provided our reports. This review was compromised by the COVID 19 pandemic and the IP being unable to conduct the onsite component and rely on conference calls with SCDC and plaintiffs without the benefits of interviewing staff and inmates or discussing documentation, programmatic and performance issues and concerns on site. Despite the limitations, the IP has conducted our intensive review as stated in this report and during discussions.

The IP appreciates and recognizes the challenges SCDC currently and for some of the monitoring period is faced with, as are correctional systems throughout the country. The provisions of the Settlement Agreement have not changed and we have provided technical assistance and consultation to the extent possible and will continue to do so as we all face the crisis of the corona virus COVID 19. This report is relative to the time period October 2019 thru February 2020 and our findings and recommendations are for that period.

The IP has been conducting Settlement Agreement compliance reviews for 4 years and many of the deficiencies, especially regarding resources including insufficient staffing for mental health, nursing and operations, as well as programmatic space and support services remain. The IP has long ago identified the impact of RHU housing of mentally ill caseload inmates and other inmates with behavioral health needs as extremely problematic. Some of these problems have been identified as more compromising at specific facilities, including the IP's RHU focused reviews during the 9th onsite visit and CGCI during the 10th onsite visit. The conditions of confinement and systemic issues remain problematic. Unfortunately, substantial compliance has not been achieved in the majority of the provisions of the Settlement Agreement and inmates in the South Carolina Department of Corrections continue to suffer harm, including annual suicide rates that have been three to four times the annual rates for prisons in the United States.

The IP also recognizes several areas of improvement, specifically in quality assessment and management by QIRM, changes in direction and leadership by Director Stirling and his executive staff and notable efforts for improvements by some clinical and operations staff. The IP remains hopeful that, with the provision of adequate resources as identified by SCDC, SCDC consultants, plaintiffs' counsel and the IP, the adequate provision of mental health services and compliance with the requirements of the Settlement Agreement will be achieved.

Respectfully,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and Emmitt Sparkman