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

Executive Summary

Introduction

This is the 13th 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. This report is based on the on-site review by the IP members Emmitt Sparkman, Ray Patterson, MD and oordinatorTammie Pope and includes the virtual participation of the IP's subject matter expert, Jeffrey Metzner, MD. Sally Johnson, MD, SCDC consultant, also participated in this review on-site. The two previous IP reviews were conducted via virtual reviews due to COVID restrictions and considerations. This review, as with all previous reviews, included reviews of documents and information provided by SCDC at the request of the IP, and others. This report covers the monitoring period from October 2020 through March 2021.

Clinical Programs and Services

The previous two virtual site visits were conducted via multiple conference calls and/or video teleconferencing during April 2020 and December 14-16, 2020. In our reports based on those visits, the IP recognized and expressed concerns regarding the challenges and unprecedented impact of the COVID-19 pandemic, including mental health, medical and most strikingly nursing services, as well as operations and administrative supports in the provision of adequate care and compliance with the provisions of the SA. SCDC reported 56% of inmates had been vaccinated; no data was reported regarding percentages of staff and contractors who had been vaccinated. Visitation for inmates had been discontinued, but began being offered again at four of the lower security facilities with strict testing and vaccination rules in place in June before the visit . The IP has encouraged maintaining safe and effective clinical services while mitigating obstacles and problematic conditions of confinement. The SCDC's clinical services have continued to struggle with meeting necessary requirements of the SA during this monitoring period as reflected in this report.

There are areas, particularly in Operations, where progress has been noted and encouraged; however, the staffing deficiencies, difficulties in the overall management of COVID-related processes (including transfers for crisis management, transfers to higher levels of care, crisis cell monitoring and lengths of stay), lengths of stay in R & E, morbidity reviews, out of cell time for therapeutic services and medication administration and management were all compromised or restricted during this time period. The suicide prevention and management centralized program and processes were very problematic and did not meet the requirements of the SA. These areas of concern are reflected in the IP reports from those visits and have been discussed in multiple calls. The IP has acknowledged SCDC's efforts to restore and/or improve services since this monitoring period ended in March 2021 and we strongly encourage continuation and expansion of those efforts including proposals for salary increases and restructuring of medical services.

SCDC reported four completed suicides of inmates between October 2020 through March 2021. The Average Daily Population (ADP) was approximately 15,804. The annualized suicide rate for 2020 was reported in the last IP report as approximately 31/100,000 which represents a continuing decline from 2018 (63/100,000) and 2019 (53/100,000). The national annualized suicide rate for prisons is approximately 17/100,000. The annualized rate for 2021 will be calculated at the end of 2021.

Quality Management

The IP continues to commend SCDC on the diligence and reporting on quality management activities and efforts by the Quality Improvement Risk Management (QIRM), RIM and IT services because these components have served SCDC, inmates and the reporting requirements of the SA with data collection and analyses demonstrating high quality, reliability and consistency. Their efforts and resources have been stretched during this unprecedented time and their continued diligence and dedication have been extraordinary and essential. The IP remains encouraged by the restructuring of behavioral health leadership and are hopeful the collaboration between QIRM, Operations, Medical and Behavioral Health will focus on self-critical analyses when problems or opportunities to improve care are identified.

SCDC has demonstrated progress in the Operations area for the reporting period of October 1, 2020 through March 31, 2021. The ability to achieve limited progress during the difficult times of a pandemic and limited resources is recognized. Significant work remains for the Agency to achieve substantial compliance for all the provisions of the Settlement Agreement. The five (5) correctional facilities for enhanced review during the July 12-16, 2021 IP Site Visit were Kirkland CI, Broad River CI, Leath CI, Perry CI, and Camille Graham CI.

Culture Change

The July 12-16, 2021 IP Site Visit produced evidence SCDC is making progress towards a culture change. Operation staff at all levels, particularly at the correctional facilities, appear more engaged in striving to successfully implement existing and revised procedures to improve overall operations and move SCDC toward overall compliance with the Settlement Agreement. Examples are:

- Leath CI Warden Yeldell recognized the IP's concerns that RHU inmates were only allowed to have their tablets four (4) hours per day Monday through Friday and that night-time medications given in the late afternoon and early evening presented issues for inmates who were sleeping during the 9:00 p.m. standing count. The Warden approached the IP prior the conclusion of the Leath CI site visit on July 14th and stated the intention to expand RHU inmates tablet time to seven (7) days a week including holidays and move the 9:00 p.m. standing count to an earlier time.
- Perry CI Warden Williams and his staff have made marked improvement in the RHU operation at the correctional facility. More showers and recreation times are offered inmates and security staff are consistently making the required security checks. The Perry CI RHUs were cleaner and quieter and had a completely different atmosphere than in past visits. Although significant work remains for the required services and programs, Perry CI is moving in the right direction.

Restrictive Housing Units (RHUs)

SCDC continues to experience extreme difficulty providing required services and programs for inmates housed in RHUs. The pandemic created additional difficulties for the correctional facility RHUs that already could not provide required programs and services. The Office of Operations has demonstrated a degree of progress during the reporting period even with the challenge of limited resources and a pandemic. The Operations Quality Assurance Program continues to be developed and correctional facilities are being held more accountable and are having to respond to identified deficiencies. The five (5) correctional facilities selected for this reporting period demonstrated

progress in providing required showers for inmates in RHU. Some correctional facilities demonstrated more progress and a higher degree of compliance than others. Specific areas that have unacceptable compliance levels area: classification reviews, department RHU visits, out of cell time, showers, welfare checks, laundry access, cell cleaning access, Inmate crisis procedures, and responses to temperature and cell check deficiencies. Correctional facilities are consistently conducting the required RHU cell daily temperature and cleanliness checks. SCDC continues to house inmates with a mental health designation in RHU for over 60 days without providing the required level of mental health services. The revision of the SCDC RHU Policy remains in progress. The goal of the revised RHU Policy is to establish procedures that will ensure inmates with a mental health designation receive the required level of mental health services in the RHU and/or to remove the inmate to an appropriate alternative program.

Quite concerning was the Broad River RHU's and Secure Mental Health Program's low level of compliance in providing required services and programs. SCDC had an external review of these programs conducted in May 2021 and had already identified issues and concerns. The external review confirmed required services and programs were not being provided at the required level, but discovered the extremely low compliance levels were due to line staff and mid managers not consistently documenting services and programs when they were provided. The external review identified significant operational issues including staff performance and the need for additional resources. The Office of Operations is moving to address the external review findings.

Use of Force

The IP is recommending Settlement Agreement Provision 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 move from *partial to substantial compliance*. SCDC has fully operationalized their master plan making procedural revisions to the Offices of Investigations and Intelligence (OII) and Inmate Grievance System review and processing of excessive force and physical abuse complaints. SCDC has developed a Use of Force Review Team consisting of a QIRM Use of Force Reviewer, the Behavioral Health UOF Coordinator, and the Operations' Administrative Director for a decision whether a Use of Force matter should be referred to OII as excessive UOF. The UOF Team reviews the documentation provided and collects other information necessary for a referral decision and either recommends referral to OII for investigation or declines to recommend referral using the same email string. If a referral to OII is recommended, the inmate is notified by the Inmate Grievance Coordinator that the grievance will be held in abeyance during the OII investigation. The data shows that the actual use of force numbers of mentally ill inmates statistically decreased from January 2020 to March 2021 from an average of 0.26% to 0.17%.

Inmate Crisis Procedures

Systemwide SCDC continues to experience difficulty complying with the crisis program procedures for inmates that are involved in self injurious program. The provided documentation demonstrates:

- Inmates are placed on 15-minute observation without an appropriate suicide risk assessment;
- Operations and Behavioral Health staff do not have a clear understanding of observation requirements for inmates on crisis;
- Time frames for inmates on crisis are not followed, particularly, those requiring the transfer of inmates to the Broad River CI CSU if the inmate is on crisis for over 60 hours or as an alternative, the initiation of direct observation of the inmate.

Broad River Secure Mental Health Unit (SMHU)

The SMHU Policy was finalized and approved during the reporting period. The SMHU is located at the Broad River Correctional Institution and on May 17, 2021 it had a population of 7 inmates. The SMHU is experiencing operational issues and experiencing difficulty implementing required programs and services. Although significant work remains to achieve the full benefit of the program removing long term inmates with serious mental illness from RHUs, SCDC Behavioral Health and Operations Management are aware of the issues. SCDC Behavioral Health and Operations Management are moving to address the issues and make the SMHU a successful program. For the SMHU Program to be successful, the identified issues must be corrected including deployment of additional resources and Behavioral Health assuming more direct responsibility for oversight of the program and Operations staff providing a supporting role.

Special Concerns Offender Reintegration (SCOR) program

The Special Concerns Offender Reintegration (SCOR) program officially opened on March 1, 2021, at Evans CI. The program is to divert inmates that are held in RHU for safety concerns. The goal is to enable these inmates to re-enter general population once the SCOR Program is completed. As of April 13, 2021, there were 41 participants in Phase 1 of the program. The Office of Programs reports that inmates have varying reactions to placement in the program. Some inmates are unsure about the placement but agreed to participate while some refuse to participate. There are other inmates who refuse to come out of the cell and threaten self-harm. The SCDC Program Staff have plans to place SCOR program information on the inmate tablets to ensure the inmate population is accurately informed about the new program that assists diversion of inmates with safety concerns out of RHU. Inmates are allowed access to tablets for 4 hours each day. Although access to entertainment on the tablets is limited in Phase 1, phone calls are not impacted. SCOR inmates can participate in video visitation. The Office of Programs continues to assess the SCOR program to determine adjustments based on programming needs, resources, and results of program evaluations.

Kirkland High Level BMU

The re-opening of the HLBMU (Kirkland High Level BMU) after a two month closure is a positive development with a population of five (5) inmates at the end of the monitoring period. Another five (5) inmates entered the program in April 2021. At the end of April 29, 2021, the HLBMU had a waiting list of twenty-one (21) inmates.

RHU Inmates in the RHU over 365 days

SCDC initiated special reviews for inmates held in RHU for over 365 days. The first reviews were conducted on February 19, 2021. Staff representing the Offices of Operations and Behavioral Health and the Division of Inmate Records and Classification serve on the review committee. The committee meets biweekly and reviews every inmate who has been housed in RHU for one year or more to assess the reasonableness of their continued placement in RHU or whether other options/placements are more appropriate. SCDC had 97 inmates that had been in an RHU over 365 days on October 1, 2020. As of July 22, 2021, the SCDC RHU Review Committee has been successful in reducing the number of inmates in RHU for over 365 days to 59 inmates. This is a reduction of 36 inmates with an RHU stay of over 365 days.

Inappropriate Phone or Visitation Sanctions

The SCDC Policy OP 22.14 Inmate Disciplinary System establishes that mental health designated inmates with a mental health classification cannot have telephone or visitation sanctions imposed

unless the disciplinary infraction involved a telephone or visitation incident. In a review of the applicable SCDC Report entitled "Mental health designated inmates with a Guilty Disciplinary result from October 2020 through March 2021," ten inmates were identified with telephone or visitation sanctions imposed for administrative resolutions. The responsible SCDC official distributed an email on May 5, 2021, reminding correctional facility leadership of the policy requirements. The Office of Operations includes a monthly review of identified RIM reports to ensure improper sanctions are not imposed for inmates with MH classifications. The IP will continue to review reports to verify inappropriate telephone or visitation sanctions are not imposed for inmates with mental health designations.

Mental Health Disciplinary Treatment Team (MHDTT)

Policies and procedures require inmates with a mental health designation of Level 1, 2, or 3 that receive disciplinary sanctions are reviewed by a MHDTT. SCDC provided documentation that the MHDDT reviews are not consistently occurring. The Leath Assistant Warden for Programs, through her own initiative, identified that Leath CI did not have the MHDTT in place. The Assistant Deputy Director for Operations has developed revised procedures to ensure the MHDTT reviews are conducted as required. The revised procedures include conversion from a manual to an electronic system for data entry that will enhance correctional facility accountability and headquarters review.

Offender Automated Tracking System (OATS)

The continued development of OATS is one of the most notable accomplishments SCDC has made to improve overall operations in RHU and Crisis Units while assisting with the quality management process. The OATS provides a means to monitor and review required services and programs provided in RHU and Crisis Units. It is shared in weekly reports to wardens, and establishes a process that ensures that wardens "inspect what they expect." RHU and Crisis Unit staff use an electronic device to make a data entry as services and programs are provided. A bar code is utilized to identify the staff member and the inmate that is provided the service and/or program. The OATS includes an inmate profile of the inmate with basic information. The Inmate Profile Section is an underdeveloped part of the OATS that has tremendous potential. The OATS Inmate Profile could be expanded to include Medical, Mental Health, and Security alerts that would assist in inmate supervision. The IP encourages SCDC to expand the OATS Inmate Profile to include the inmates' alerts to provide staff at all levels with ready critical information to assist in the supervision of RHU and Crisis inmates. The inmate profile information automatically displays on the electronic device when the inmate bar code at the cell is scanned.

Screening for Inmates Placed in RHU

The IP identified during the site visit that SCDC is not following Health Services Policy 19.04 that establishes healthcare screening procedures for inmates being placed in RHU. It is recommended that SCDC immediately initiate corrective action to ensure compliance with Health Services Policy 19.04 requiring healthcare staff to screen inmates placed in RHU and establish a quality assurance mechanism to ensure the procedures are followed.

Kirkland Substantiated Security Risk (SSR) Unit

An IP member toured the Kirkland SSR Unit on Monday, July 12, 2021. The Kirkland SSR's permanent heating system is non-operational. SCDC received authorization from the responsible authority to utilize an alternative heat source. The responsible IP Member reviewed the documentation and verified SCDC had received authorization to utilize the alternative heat source.

SCDC has included in their capital improvement plan a request to repair/replace the permanent Kirkland SSR heating system. The estimated cost for the requested project is 3.3 million dollars.

The Kirkland SSR houses inmates with a mental health designation who have been in the unit for over 60 days. SCDC acknowledges that inmates with a mental health designation in the unit must receive their required level of mental health services. Potential means to provide the level of services required were discussed by Operations and Behavioral Health Officials and the IP member during the SSR site visit. SCDC officials agreed to develop and propose a program that ensures inmates housed at the SSR unit receive the required level of mental health services. SSR Program space is limited but possible areas were identified to provide inmate programs out of cell.

Females Requiring Long Term Removal from the General Population

The IP and SCDC identified that female correctional facilities do not have procedures for inmates with a mental health designation that reach sixty (60) days in RHU and cannot be released to the general population. The RHU Policy currently under revision also does not have any provisions for that population. There are no female inmates that currently meet these criteria; however, SCDC and the IP agreed the revised RHU Policy would need to include procedures for females with a mental health designation that reach sixty (60) days in RHU and cannot be released to the general population.

Tablets

SCDC has distributed a significant number of computer tablets to inmates including those in RHU. This is a positive effort to mitigate limited services and programs due to the lack of resources and the pandemic. A Tablet Policy remains under development to establish staff and inmate procedures for the tablets. SCDC reported to the IP that inmate access to the tablets has not been formally established. The IP discovered during site visits to the selected five (5) facilities that inmates in RHU are only allowed to have the tablets four (4) hours per day Monday through Friday. SCDC Officials provided no legitimate reason RHU inmates could not utilize the tablets for more hours during the day and on weekends and holidays. The only issue with expanding tablet use in RHU is the battery life of the devices. There are solutions for recharging the tablets and expanding the hours of tablet use by RHU inmates. The IP strongly recommends SCDC finalize the Tablet Policy as soon as possible and expand the number of hours per day and the days that Inmates have access to tablets to include weekends and holidays.

Comprehensive Hospital Services

SCDC entered an interagency agreement with the Medical University of South Carolina on April 26, 2021 to provide comprehensive hospital services for SCDC inmates via a secure offsite point of care at Chester Hospital. Chester Hospital will provide 32 acute care beds which may be used for other levels of care when necessary and 4 intermediate/progressive care beds. The secure unit will allow SCDC to conserve staff and other resources.

Staff Training

SCDC provided documentation that 374 staff have received Crisis Intervention Training (CIT). There are 190 staff with a current CIT certification and 184 staff has CIT certification that is lapsed. The IP encourages SCDC to take steps to have staff with lapsed CIT Certification become re-certified.

The IP continues to encourage SCDC Management and responsible training staff to consult with Behavior Health Staff to determine if correctional staff are receiving sufficient training to manage and

appropriately respond to mentally ill inmates, particularly staff performing duties in housing units that are designated as residential mental health programs.

The IP discovered during the July 12-16, 2021 Site Visit that contract nurses do not receive formal SCDC Orientation Training prior to assuming their duties. SCDC began efforts to establish contract nurses receive formal orientation training before assuming their duties when the IP brought this concern to their attention. The IP highly recommends that SCDC immediately establish that contract nurses are required to complete orientation training before assuming their duties. Also, the IP discovered SCDC has authorized Certified Nursing Assistants (CNAs) to administer medications with additional training; this appears beyond the scope of their licensure, and requires documentation of training and supervision.

Findings

The Implementation Panel has provided extensive feedback and technical assistance regarding its analysis and recommendations during this onsite visit. Dr. Johnson has also provided her input and recommendations. SCDC has not achieved Substantial Compliance in the majority of Settlement Agreement provisions and requirements. As reported, several provisions have remained problematic and require improvement. There have been some improvements in Operations, and QIRM analysis and reporting remains very helpful and essential for SCDC's quality management programs.

The impact of the COVID-19 pandemic has been unprecedented and has required facilities and systems to address their challenges and develop strategies to mitigate the consequences and provide behavioral health, operations, medical and nursing, and administrative and support services that are necessary for inmates. These times have been exceptionally difficult for inmates who must rely on staff for services and requirements, and for staff who are working and living with pandemic realities in their own lives.

The findings of the Implementation Panel with regard to compliance on the provisions of the Settlement Agreement based on the review and site visit concluded on July 16, 2021 are as follows:

1. Substantial Compliance (active)---7
2. Substantial Compliance (sunset/greater than 18 months) ---21
3. Partial Compliance---24
4. Non-Compliance---7

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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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update. Daily rounds have not been occurring by mental health staff due to access issues related to COVID-19 and staffing issues. The delays in classification and transfers to adequate mental health services and programs has remained problematic at both KCI and CGCI. Unless these delays are corrected, R&E will need to implement treatment services.

Implementation Panel July 2021 Recommendations: Continue to monitor and consider increased mitigation efforts as COVID-19 issues will remain for the foreseeable future.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Additional QI studies focused on MARs documentation, training and use of safe cells. Findings included the following:

MARs

Since April 2020, the Nurse Analyst for QIRM has conducted twenty-two audits of eighteen institutions. During these eleven months, audit findings have consistently demonstrated inconsistent and missing medication administration documentation.

Safe cells

Study was originally designed to review safe cell use at Camille Graham and Turbeville. QA monitor began collecting data for other institutions on a rotating basis starting December 2020. Many male inmates remained in safe cells exceeding 60 hours due to Broad River CSU closure from July to December for COVID-19 quarantine preventing transfer. COVID-19 procedures required all inmates to self-quarantine and have testing done prior to transfer, leading to a wait of approximately 2-3 weeks since CSU reopened December 7, 2020.

Training

The RIM report, Mental Health General Provisions Training taken (as of COB 4/6/2021) by Current Mental Health Staff who were Hired or Transferred to Mental Health between January 1, 2020 - December 31, 2020, shows the total

number of new hires is 65. The completion percentage for the required training was 73.8%. This is up from 39.3%. The 17 staff who have not completed the training have been notified by the QA manager to complete the training within a designated date/time.

Implementation Panel July 2021 Recommendations: The above QI plan is comprehensive in scope. Compliance will be achieved following successful implementation.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per SCDC update. The fixes have included improved communication between mental health staff and operations staff, including supervisors and development of a better tracking system.

Implementation Panel July 2021 Recommendations: Improve transfer times from R&E for males and females to meet the requirements of the SA and/or provide treatment services in R&E.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per SCDC update.

Implementation Panel July 2021 Recommendations: The tracking solution will, in part, be related to improvements in the NextGen templates.

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 July 2021 Assessment: Noncompliance

Implementation Panel July 2021 Findings: The QIRM reviews reported significant deficiencies in the delivery of mental health services to inmates at BRCI, CGCI, KCI, LCI and Perry 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:

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 contact being held in a confidential setting, which was 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 of mental health inmates who received timely initial QMHP sessions while in the CSU from December 2020 – March 2021.
8. Lack of compliance with inmates being assessed using the C-SSRS Discharge Screener prior to discharge from CSU.
9. Lack of compliance with inmates receiving daily QMHP rounds while on CISP status.
10. Lack of compliance with inmates receiving QMHP sessions timely after being removed from crisis.
11. Lack of compliance with confidentiality of sessions with QMHP and Psychiatrist for Inmates on CI/SP-RHU
12. Lack of compliance with access to yard time and showers for segregation inmates.
13. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
14. Lack of compliance with 15-minute security checks in the RHU for inmates requiring such checks.
15. Lack of compliance with inmate access to laundry and cleaning supplies.
16. Lack of compliance with security checks in RHU.
17. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
18. 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.
19. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells.

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. Continued lack of compliance with clinical contact being held in a confidential setting, with QMHPs, including in the RHU.
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 with MAR documentation.

7. Lack of compliance re: mental health rounds in the segregation housing units.
8. Lack of compliance with inmates receiving timely initial QMHP sessions after RHU Placements from October 2020 – March 2021.
9. Lack of compliance with access to yard time and showers for segregation inmates and patients in the RHU.
10. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
11. Lack of compliance with QMHP Daily Rounds completed on inmates while on CI/SP Status at Camille Graham for the months of October 2020 - March 2021.
12. Lack of compliance with suicide risk assessments being completed daily on inmate while on crisis in the CSU.
13. Lack of confidential sessions by the QMHP and Psychiatrist for inmates in the CSU.
14. Lack of compliance with inmates receiving daily QMHP rounds while on CISP.
15. Lack of compliance with inmates being assessed using the C-SSRS by Discharge Screeners prior to discharge from crisis.
16. Lack of compliance with inmates receiving 24-hour and 7-day follow-ups after being removed from crisis in the RHU from October 2020 – March 2021.
17. Lack of compliance with inmate access to laundry and cleaning supplies.
18. Lack of compliance with security checks in RHU.
19. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
20. Lack of compliance with Crisis 15-Minute Observation in the RHU.
21. Lack of documentation re: Constant Observation in the CSU
22. 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.
23. Lack of compliance with the executive staff who were to visit the RHU on separate days of the week.
20. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells.

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 contact 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 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 inmates being assessed using the C-SSRS by Discharge Screeners prior to discharge from crisis.

7. Lack of compliance with QMHP Daily Rounds completed while on CI/SP Status at Kirkland for the months of October 2020 - March 2021.
8. Lack of compliance with inmates receiving 24-hour and 7-day follow-ups after being removed from crisis in the RHU.
9. Lack of compliance with access to yard time and showers for segregation inmates.
10. Lack of compliance with suicide risk assessments for inmates while on suicide precautions.
11. Lack of compliance with inmate access to laundry and cleaning supplies.
12. Lack of compliance with security checks in RHU.
13. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
14. 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.
15. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells.

Leath Correctional Institution

Review of the Leath Correctional Institution Compliance report indicated the following:

1. Lack of compliance with timely clinical contacts with clinicians both QMHPs and psychiatrists (excluding L3 inmates) at all levels of care (LOC) and housing unit placements.
2. General compliance with clinical contact being held in a confidential setting (when clinical contacts occurred), with QMHPs and psychiatrists in the RHU,
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,
5. General compliance re: mental health rounds in the segregation housing units.
6. Lack of compliance with inmates receiving timely initial QMHP sessions after RHU Placements from October 2020 – March 2021.
7. Recent lack of compliance with access to showers for segregation inmates and patients in the RHU.
8. Limited Compliance with access to yard time for segregation inmates and patients in the RHU.
9. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
10. Compliance with confidential sessions by the QMHP and Psychiatrist for inmates in a safety cell,
11. Lack of compliance with inmates receiving daily QMHP rounds while on CISP.
12. Compliance with inmates being assessed using the C-SSRS by Discharge Screeners prior to discharge from crisis. *N=1 ?*
13. Compliance with inmates receiving 24-hour and 7-day follow-ups after being removed from crisis in the RHU from October 2020 – March 2021.
14. Intermittent lack of compliance with inmate access to laundry and cleaning supplies.
15. General compliance with security checks in RHU.

16. Lack of compliance, but with improvement, with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
17. Lack of compliance with Crisis 15-Minute Observation in the RHU.
18. Lack of documentation re: Constant Observation.
19. Lack of data re: inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.
21. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells.

Perry Correctional Institution

Review of the Perry Correctional Institution 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. Lack of compliance with clinical contact being held in a confidential setting (when clinical contacts occurred), with 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,
5. General compliance, with some significant exceptions, re: mental health rounds in the segregation housing units,
6. Lack of compliance with inmates receiving timely initial QMHP sessions after RHU Placements from October 2020 – March 2021.
7. Intermittent access to showers for segregation inmates and patients in the RHU.
8. Lack of compliance with access to yard time for segregation inmates and patients in the RHU.
9. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
10. Lack of compliance with confidential sessions by the QMHP and Psychiatrist for inmates in a safety cell.
11. Lack of compliance with inmates receiving daily QMHP rounds while on CISP.
12. Compliance with inmates being assessed using the C-SSRS by Discharge Screeners prior to discharge from crisis.
13. Lack of compliance with inmates receiving 24-hour and 7-day follow-ups after being removed from crisis in the RHU from October 2020 – March 2021.
14. Lack of compliance with inmate access to laundry and cleaning supplies.
15. Intermittent compliance with security checks in RHU.
16. Lack of compliance, but with improvement, with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
17. Lack of compliance with Crisis 15-Minute Observation in the RHU.
18. Lack of compliance with Constant Observation.
19. Lack of data re: inmates being transferred to the CSU or removed from crisis or constant observation status within the required 60-hour time frame.
22. Compliance with temperature and sanitation checks in CSU and RHU safe cells.

Implementation Panel July 2021 Findings: As per SCDC status update and onsite review. Several of these parameters are related to the highest levels of care and cannot be insufficient.

Implementation Panel July 2021 Recommendations: Until staff report compliance with meeting clinical contact timeframes, QI the actual frequency of clinical contacts. In addition, measure and track all clinical monitoring and contacts for these provisions.

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

Implementation Panel July 2021 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.

Implementation 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.

Implementation Panel July 2021 Findings: No significant changes in the number of male inmates receiving intermediate care services. An increase in the number of female inmates receiving intermediate care services is noted. As COVID restrictions are modified and classification and housing considerations included in placements, the IP anticipates comprehensive mental health programs for female inmates, consistent with needs.

Implementation Panel July 2021 Recommendations: Until staff report compliance with meeting clinical contact timeframes, QI the actual frequency of clinical contacts.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update section. Proposals involving the GPH and MUSC are dependent on receiving additional funding, which will not be an easy task to complete.

Implentation Panel July 2021 Recommendations: Provision of adequate functioning by CSU and provision of necessary services, including adequate contractual services for women, is required for

substantial compliance with the SA.

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

Implementation Panel July 2021 Assessment: Partial Compliance

Implementation Panel July 2021 Findings: As per current status. Out of cell time for segregated inmates has remained very problematic. A review of the Compliance Reports for Leath CI and Perry CI revealed a positive development with the two (2) correctional facilities demonstrating progress in providing the opportunity for inmates to receive outside recreation on the average of one (1) time a week. Although that shows progress, significant work remains as segregated inmates are to receive a minimum of one hour of exercise out of cell per day five (5) days a week.

Implementation Panel July 2021 Recommendations: Increased mitigation efforts need to be implemented for inmates in segregation.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: The out of cell time for inmates in segregation remains abysmal. The ability of Leath CI and Perry CI to at least begin to offer inmates out of cell exercise one (1) time a week is recognized. The lack of progress at Kirkland CI, Broad River CI and Camille Graham CI is troubling.

Implementation Panel July 2021 Recommendations: Increased mitigation efforts need to be implemented for inmates in segregation.

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 July 2021 Assessment: Noncompliance

Implementation Panel July 2021 Findings: Timeliness of mental health clinical contracts was very problematic.

Implementation Panel July 2021 Recommendations: Begin to QI the actual frequency of clinical contacts in contrast to whether or not timeframes are being met. Consider increasing the frequency of mental health rounds based on the QI results.

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

Implementation Panel July 2021 Assessment: Noncompliance

Implementation Panel July 2021 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. These factors have resulted in lack of timely

access to higher LOC's, extended stays on C.I. status in RHU's and insufficient monitoring and treatment services during the monitoring period. The re-opening of the HLBMU is a positive development with a population of five (5) inmates at the end of the monitoring period. Another five (5) inmates entered the program in April 2021. At the end of April 29, 2021, the HLBMU had a waiting list of twenty-one (21) inmates.

Implementation Panel July 2021 Recommendations: Mitigate the above access issues.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: SCDC Operations has demonstrated marked improvement in conducting required correctional facilities RHU and Crisis temperature checks and inspections. Broad River CI, Camille Graham CI, Perry CI, Kirkland CI, and Leath CI have an aggregated average of 92% compliance between May 2020 – March 2021 with completed Temperature and Sanitation Daily Checks in Segregation and Crisis Cells. The Office of Operations is working with RIM to place a selection menu on the Zebra device for staff to electronically select specific options when temperatures and cleanliness are out of compliance. Staff will be required to choose appropriate responses from a defined list of corrective actions, eliminating free-text entries. This list would significantly decrease the number of inappropriate responses and other data entry errors. SCDC remains unable to demonstrate compliance in documenting appropriate comments when RHU and Crisis cell temperatures are out of range and/or cells do not meet the required sanitation level.

Implementation Panel July 2021 Recommendations: Continue compliance with conducting the required RHU cell temperature and cell cleanliness checks. SCDC Office of Operations and RIM complete the planned revision for the automated temperature and cell check procedures to utilize a selection menu for staff to utilize when temperatures and/or cell inspections identify deficiencies. Eliminate free text entries that have resulted in ongoing issues documenting and following up on deficiencies when they are identified.

1) Continue to develop the Operations Division quality management process to improve the required temperature and cleanliness checks procedures for each institutions' CI cells and 4 random RHU cells with follow up and an appropriate 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; and
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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: The implementation of a formal quality management program under which segregation practices and conditions are reviewed has occurred. The Division of Operations monitors a quality management process that reviews and monitors segregation practices and conditions. QIRM completes regular audits of several categories within the RHU at each institution. These areas include timeliness and location of QMHP and Psychiatry sessions, timeliness of treatment plans, participation in treatment team, mental health reviews of Mental Health and Non-Mental Health inmates, segregation rounds, security checks, showers, temperature and sanitation, recreation, laundry services, cell cleaning supplies, RHU staff visitation, and RHU inmates on crisis. The Offender Automated Tracking System (OATS) has contributed to the ability to establish and formalize a quality management process. Compliance for this provision will be achieved when the QI process demonstrates improvement in the context of the various indicators.

Implementation Panel July 2021 Recommendations: Continue to improve and implement the QIRM and Office of Operations formal quality management program reviewing SCDC 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 July 2021 Assessment: Substantial compliance.

Implementation Panel July 2021 Findings: The SCDC Plan to eliminate the disproportionate use of force against inmates with mental illness has been implemented. 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 and has achieved the necessary requirements to achieve substantial compliance.

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.

The Offices of Operations, Behavioral Health Services, Medical, Programs, Reentry and Rehabilitative Services, continue to 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 by the IP Member for the previous month.

The data shows that the actual use of force numbers of mentally ill inmates statistically decreased from January 2020 – March 2021 from an average of 0.26% to 0.17%.

The Behavioral Health Use of Force Coordinator (UOFC) continues to review UOF data each month. The UOFC should continue to collaborate with QIRM to include a methodology for his report and follow QIRM recommendations.

Implementation Panel July 2021 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. QIRM continue QI studies regarding the Division of Behavioral Health reviewing UOF incidents involving inmates with a mental health designation; and
4. The MH UOF Reviewer follow QIRM recommendations for future UOFC Reports and ensure follow up is documented regarding any Division of Behavioral Health deficiencies identified in the review of Use of Force incidents involving inmates with a mental health designation.

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 July 2021 Assessment: Substantial compliance (November 2019)

Implementation Panel July 2021 Findings: 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.
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. A SCDC Hard Restraint Report was provided for this reporting period.

Implementation Panel July 2021 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; and
5. Ensure staff complete Use of Force Training in Calendar Year 2021.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Per the SCDC Update. SCDC has revised procedures to address IP concerns regarding review, investigation, and disposition of allegations/complaints of excessive force and physical abuse of inmates. The revisions were necessary for SCDC to demonstrate that staff force is prohibited unless, there is a reasonably perceived threat. Once SCDC can demonstrate successful implementation of the revised procedures regarding the review, investigation, and disposition of referrals for allegations of physical abuse and excessive force of inmates by staff, consideration should be given to move the provision to substantial compliance.

As of April 21, 2021, the SCDC Office of Investigation and Intelligence formally tracks any allegation of excessive force and assault on an inmate by staff received via phone calls, requests to Staff, the AUOF or any other method other than inmate grievances. Once an allegation is received, a case is opened under the appropriate regional case number in the DDOII case management system. A review is followed by an investigation if warranted. The below Office of Investigation and Intelligence reflects a significant increase in referrals related to Use of Force.

Police Service Referrals	Oct	Nov	Dec	Jan	Feb	Mar
UOF Reviewed for Investigation	5	6	2	0	8	10
UOF Opened of Investigation	5	3	2	3	6	4
UOF Investigations Pending	16	19	13	12	16	20
UOF Investigations Closed	1	0	8	4	2	0

Per the update, SCDC has developed additional processes to refer excessive UOF and physical abuse grievance allegations to the Office of Investigation and Intelligence for review and investigation. For the October 2020 to March 2021 Reporting Period, there were 32 inmate grievances alleging excessive force.

SCDC has developed a Use of Force Review Team consisting of a QIRM Use of Force Reviewer, the Behavioral Health UOF Coordinator, and the Operations' Administrative Director for a decision whether a Use of Force matter should be referred to DDOII as excessive UOF. The UOF Team reviews the documentation provided and collects other information necessary for a referral decision and either recommends referral to DDOII for investigation or declines to recommend referral using the same email string. If referral to DOII is recommended, the inmate is notified by the IGC that the grievance will be held in abeyance during the DDOII investigation.

The SCDC Use of Force Review Team may not recommend referral to DDOII but may recommend that issues raised in the grievance should be addressed by the warden or other staff at the institution. Any recommendations are reflected in the UOF Review Team's determination that is forwarded to the Chief, Inmate Grievance Branch. The Chief will also recommend to the warden or associate warden, by email or telephone conversation, protocols or action that should be considered to enhance and promote desired behavior.

The IP continues to monitor SCDC Use of Force MINS Narratives monthly to 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 into the conference call where the IP Member and SCDC discuss all monthly UOF MINs findings.

SCDC was averaging approximately 118 Use of Force incidents per month when the Settlement Agreement was initiated in May 2016. For the October 2020 to March 2021 Reporting Period, SCDC averaged 58 Use of Force incidents per month which is an average of 60 fewer Use of Force incidents per month from when monitoring under the Settlement Agreement began in May 2016.

SCDC Use of Force MINS for October 2020 to March 2021:

Month	Year	Number of UOF MINS
October	2020	63
November	2020	50
December	2020	55
January	2021	69
February	2021	47
March	2021	64

Implementation Panel July 2021 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 to QI Inmate Grievances submitted alleging staff excessive force and physical abuse;
6. QIRM to QI incidents and grievances referred to the Office Investigations and Intelligence related to UOF and Physical Abuse;
7. Fully implement the revised Office of Investigations and Intelligence, Inmate Grievance Program, and Use of Force Review Team procedures regarding referrals for excessive force and physical abuse and document the reasons an investigation is not opened;
8. QIRM to include in each reporting period UOF Report, the UOF violations QIRM identified in their review of use of force incidents; and

9. 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 July 2021 Assessment: Substantial compliance (November 2019)

Implementation Panel July 2021 Findings: Per June 2021 SCDC Status Update: SCDC continues their success in addressing the misuse of MK9 and achieved compliance November 22, 2019.

Implementation Panel July 2021 Recommendations:

1. Operations and QIRM to continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM Use of Force Reviewers to continue to generate reports involving crowd control canisters including MK-9;
3. QIRM and Operations leadership to continue regular meetings to discuss UOF and other relevant issues;
4. IP to continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback; and
5. The IP Use of Force Reviewer and SCDC Operations Leadership to 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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Per the June 2021 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. SCDC continues to struggle with attempts to contact clinical counselors (QMHPs). The mean compliance rate for October 2020 through March 2021 was 79.2 percent. The mean compliance rate for the previous time period of February 2020 through September 2020 was 74 percent. The Office of Operations has developed a quality management plan to increase compliance that includes increased review of Planned Use of Force Incidents and progressive corrective actions that are required when staff fail to contact a QMHP prior to a planned UOF.

Implementation Panel July 2021 Recommendations: Remedy the above.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Per the June 2021 SCDC Status Update. The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates decreased from sixteen- and one-half hours to a sixteen (16) hour program. Newly hired correctional officers receive eleven (11) hours of initial training. Permanent correctional officers annual training concerning the appropriate methods of managing mentally ill inmates has increased from four (4) hours to five (5) hours.

In the calendar year 2020, that ran through February 2021 due to the COVID-19 Pandemic, 78.7 percent of the required security staff completed the required SCDC training program concerning the appropriate methods of managing mentally ill inmates. SCDC failed to achieve the required compliance level during Calendar Year 2020.

The Chart below reflects the percentage of SCDC staff that have a current CIT certification, a lapsed CIT certification and the total number of CIT-Trained staff . The certification for almost fifty (50) percent of the SCDC CIT-Trained staff has lapsed.

	Current CIT Certification	**Lapsed CIT Certification**	**Total CIT Trained**
TOTAL	**190**	**184**	**374**

The IP continues to encourage SCDC Management and responsible training staff to consult with Behavior Health staff to determine if correctional staff are receiving sufficient training to manage and appropriately respond to mentally ill inmates, particularly staff performing duties in housing units that are designated as residential mental health programs.

For SCDC to achieve substantial compliance for this provision during the next reporting period, a minimum of ninety (90) percent of the security staff must complete the required training regarding the appropriate methods of managing mentally ill inmates.

Implementation Panel July 2021 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-Trained employees to maintain their certification; and
4. Remedy the issue of correctional officers not receiving the required SCDC mandatory training concerning the appropriate methods of managing mentally ill inmates and suicide prevention for Calendar Year 2021.

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 July 2021 Assessment: Substantial compliance (December 2020).

Implementation Panel July 2021 Recommendations:

1. QIRM to 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 to monitor inmates with a mental health designation identified as high risk for use of force;
3. The Behavioral Health UOF Reviewer to 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 to ensure Use of Force compliance reviews and reports are completed on a consistent and timely basis; and
5. The Behavioral Health UOF Reviewer to follow QIRM recommendations for future UOFC Reports.

3. Employment of enough trained mental health professionals:

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update section which demonstrates significant issues re: timeliness issues concerning the development of treatment plans as well as behavioral health determinations and direction regarding treatment.

Implementation Panel July 2021 Recommendations: Increase training and/or supervision of staff in the context of correctly using NextGen. The current treatment planning process, group therapy and security requirements should be reviewed.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update section. The training issues appear to be mainly related to newly hired staff and COVID-19 issues.

Implementation Panel July 2021 Recommendations: Remedy the above.

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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: The pilot project re: crisis care has been completed and the new template has been rolled out to the other prisons.

Implementation Panel July 2021 Recommendations: Compliance will be present once we view the reports based on the new template.

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

Implementation Panel July 2021 Assessment: Substantial compliance (December 2020)

Implementation Panel July 2021 Findings: Substantial compliance continues.

4.a.ix. Quality management documents; and

Implementation Panel July 2021 Assessment: Substantial compliance (December 2020).

Implementation Panel July 2021 Findings: Substantial compliance continues.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Partial compliance is warranted based on the findings. The IP Member responsible for Inmate Discipline has identified inconsistency regarding Correctional Facility Mental Health Disciplinary Treatment Team reviewing disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3. The Assistant Deputy Director for Operations has developed a corrective action plan that includes a report to enhance staff accountability and verify MHDTTs perform their duties and responsibilities.

The scan technology is impressive and progressive. Unfortunately, with regard to medication administration SCDC medical violated policies and procedures, and the SA, by providing keep on person (KOP) psychotropic medications to inmates. In addition, significant problems were identified with medication administration at CGCI that need resolution.

Implementation Panel July 2021 Recommendations:

1. Implement the corrective action plan developed by the Assistant Deputy Director for Operations that addresses inconsistency in correctional facility MHDDTs reviewing disciplinary sanctions imposed for inmates with a Mental Health designation Level 1, 2, and 3; and

2. Corrective actions regarding KOP psychotropic medications were implemented after this monitoring period ended and should be carefully monitored.

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 July 2021 Assessment: Substantial Compliance (July 2021)

Implementation Panel July 2021 Findings: As per status update section. Compliance is now present.

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

5.a. Improve the quality of MAR documentation;

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update section.

Implementation Panel July 2021 Recommendations: This provision is dangerously close to noncompliance. The IP recognizes the challenges SCDC has faced during COVID restrictions, however authorizing CNA's to administer medications and the authorization of KOP psychotropic medications are not consistent with the requirements of the SA and SCDC policies. Remedy the above.

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

Implementation Panel July 2021 Assessment: Noncompliance

Implementation Panel July 2021 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. In addition, see findings and recommendations in 5.b.

Implementation Panel July 2021 Recommendations: Remedy the above.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: As per status update section.

Implementation Panel July 2021 Recommendations: Remedy the above.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 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. See 5.b. and 5.c. above.

Implementation Panel July 2021 Recommendations: Remedy the deficiencies identified by the QI process as noted above.

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 July 2021 Assessment: Noncompliance

Implementation Panel July 2021 Findings: As per status update section. The breakdowns in the provision of crisis care services within SCDC have been unprecedented and clearly in violation of the provisions of the SA. We understand the reasons for noncompliance but remain very concerned due to the conditions of confinement and lack of compliance with suicide prevention policies **(**See next provision).

Implementation Panel July 2021 Recommendations: Remedy the above ASAP.

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

Implementation Panel July 2021 Assessment: Noncompliance

Implementation Panel July 2021 Findings: See status update section. The lack of compliance with suicide prevention, management watch procedures is very alarming and potentially dangerous.

Implementation Panel July 2021 Recommendations: Remedy the above ASAP.

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

Implementation Panel July 2021 Assessment: Substantial Compliance (December 2020).

Implementation Panel July 2021 Findings: Per SCDC Update. Substantial Compliance was achieved in December 2020 and continues.

Implementation Panel July 2021 Recommendations:

1. Continue to monitor and verify compliance with the provision and correct any identified deficiencies;
2. Continue the use of a tracking system to ensure compliance; and
3. SCDC to 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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Per the June 2021 SCDC Status Update. 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 revealed the following:

Broad River
- CSU average percentage receiving the required showers was 16%.
- Safe Cell average percentage receiving the required showers was 22%.

Camille Graham
- CSU average percentage receiving the required showers was 68%.
- Safe Cell average percentage receiving the required showers was 81%.

Kirkland
- Safe Cell average percentage receiving the required showers was 76%.

Leath
- Safe Cell mean percentage was not provided. Week 4 December to Week 4 January 2021 100%. Week 3 March 2021 was o%.

Perry
- Safe Cell mean percentage receiving the required showers was 58%.

Implementation Panel July 2021 Recommendations: 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 July 2021 Assessment: Noncompliance

Implementation Panel July 2021 Findings: Significant issues continue to exist in the context of confidential sessions with QMHPs. Clinical contacts with psychiatrists were generally less problematic.

The above issue appears, in part, related to all inmates in a CI cell being treated as segregation inmates from a custody classification perspective, which is very problematic. During this monitoring period inmates were confined in CI cells for extended periods of time, far in excess of 60 hours, and treatment services in a confidential setting were very limited and variable by facility. Clinical and security staffing deficiencies, and space limitations contributed to noncompliance in these vital areas.

Implementation Panel July 2021 Recommendations: Remedy the above.

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

Implementation Panel July 2021 Assessment: Partial compliance

Implementation Panel July 2021 Findings: Per SCDC June 2021 Update and 2.b.vi Findings. SCDC Operations has demonstrated marked improvement in conducting required correctional facilities RHU and Crisis temperature checks and inspections. Broad River CI, Camille Graham CI, Perry CI, Kirkland CI, and Leath CI have an aggregated average of 92% compliance between May 2020 – March 2021 with completed Temperature and Sanitation Daily Checks in Segregation and Crisis Cells. The Office of Operations is working with RIM to place a selection menu on the Zebra device for staff to electronically select specific options when temperatures and cleanliness are out of compliance. Staff will be required to choose appropriate responses from a defined list of corrective actions, eliminating free-text entries. This list would significantly decrease the number of inappropriate responses and other data entry errors. SCDC remains unable to demonstrate compliance in documenting appropriate comments when RHU and Crisis cells temperatures are out of range and/or cells do not meet the required sanitation level.

Implementation Panel July 2021 Recommendations:

1. Continue to develop and improve the Operations Division's temperature and cleanliness check quality management process for each institution's CI cells and 4 random RHU cells and address the identified deficiencies with comments;
2. All prisons to continue performing required daily inspections for cleanliness and taking temperatures of random cells; and
3. SCDC QIRM to 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 July 2021 Assessment: Partial compliance

Implementation Panel July 2021 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 July 2021 Recommendations: Implementation and QI adequacy of services to address deficiencies.

Conclusions and Recommendations:

This is the 13th report by the Implementation Panel (IP) regarding the South Carolina Department of Corrections compliance with the provisions of the Settlement Agreement enacted in May 2016. This report is based on our review of the documents and materials requested from SCDC and other information provided to the IP as a part of our reviews. This 13th visit was conducted by monitors Emmitt Sparkman and Raymond Patterson, MD, and coordinator Tammie Pope on site, and Jeffrey Metzner, MD, subject matter expert, by virtual telemetry. Sally Johnson, MD, SCDC consultant, also participated and contributed on site. The visit took place from July 12-16, 2021, and was the first on site visit since the restrictions enacted because of the COVID-19 pandemic in 2020-2021.

The unprecedented impact of the COVID-19 pandemic has affected medical and mental health services throughout the country and most certainly in corrections. The Implementation Panel is keenly aware of the challenges and strivings of systems to provide the necessary and required services to those individuals in custody. The IP has taken into consideration those challenges as we can, and acknowledged efforts to move forward by SCDC. That having been said, the requirements of the Settlement Agreement are the guiding provisions of this process. With these realities in mind the IP has strived to provide an informative report in the service of meeting the requirements of the Settlement Agreement.

We remain hopeful that the country determines it is indeed necessary to move forward as a public health requirement and we will continue to assist SCDC in meeting the mental health needs of their inmates and the requirements of the Settlement Agreement.

Respectfully submitted,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and Emmitt Sparkman