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

Executive Summary

Introduction

This is the 14th Implementation Panel Report, presented by the Implementation Panel (IP) regarding the status of compliance with the Settlement Agreement (SA) by the South Carolina Department of Corrections (SCDC) enacted in May, 2016. This report is based on a virtual site visit by IP members Emmitt Sparkman and Raymond Patterson, MD, subject matter expert Jeffrey Metzner, MD and IP coordinator Tammie Pope. Sally Johnson, MD, subject matter expert and consultant to SCDC also participated virtually. COVID 19 restrictions and considerations impacted this visit to be conducted virtually, from December 6-9, 2021. As with all previous visits and reviews, documents and information requested by the IP and provided by SCDC and others were also reviewed for the monitoring period from April through September, 2021.

Clinical Programs and Services

The impact of the COVID 19 pandemic has impacted clinical services and operations since March, 2020. The IP reports for the past three visits have all reflected the challenges and unprecedented impact on all clinical services and programs, including behavioral health, medical and nursing services, as well as operations, administrative support and quality management. Medical services have been reorganized since the last visit and monetary incentives, including salary increases, bonuses and recruitment and retention strategies implemented. Unfortunately, the impact of COVID on staffing, which was not adequate before COVID, remains very problematic in various facilities and basic programmatic activities have suffered. Compliance with the provisions of the SA have been affected as reflected in this and past reports.

The IP has continued to encourage maintaining safe and effective clinical services while mitigating the impact of COVID-19 and problematic conditions of confinement. As previously reported, the staffing deficiencies, quarantine and isolation practices and space limitations have continued to impact processes, including suicide prevention and management, transfers to and from the Crisis Stabilization Units, Reception and Evaluation services, transfers to higher levels of care and services, mortality and morbidity reviews, out of cell time for structured and unstructured therapeutic activities, and medication administration and monitoring. Staffing levels for behavioral health have declined to critical levels. The suicide prevention committee met only once during the monitoring period, and did not conduct morbidity reviews for several cases where indicated. SCDC reported six completed suicides for calendar year 2021, with two additional deaths in December, 2021 that are highly likely to have been suicides but have not been confirmed as such. The annualized suicide rate for SCDC for 2021, with an ADP of approximately 15,000 would be estimated to be between 47-53 per 100,000

inmates. The national annualized rate of completed suicides in U.S. prisons is 17 per 100,000. The SCDC annualized suicide rates were approximately as follows:
2018: 63 per 100,000;
2019: 53 per 100,000;
2020: 31 per 100,000;
2021: 47 per 100,000 (7 deaths) or 53 per 100,000 (8 deaths).

Quality Management

The IP has previously commended the quality management components of SCDC, and continues to appreciate the high quality work done by QIRM and their leadership, as well as RIM and IT services. These components have also been impacted by staffing deficiencies and continue to have the need for greater collaboration from Behavioral Health, as the services provided are extremely valuable for SCDC and inmates, including the reporting requirements of the SA, reliable and consistent data collection and self critical analyses and reviews.

SCDC strives for progress in the Operations area for the reporting period of April 1, 2021 through September 30, 2021. Progress is hampered by critical security and other discipline (i.e. Classification and IT) staffing shortages and the COVID 19 Pandemic. Security Staffing vacancies increased from 1451 positions in April 2021 to 1719 positions in September 2021. This in spite of SCDC Director Stirling's efforts to improve recruiting, retention and salaries. The beginning salary for a South Carolina Correctional Officer has increased from approximately $25,000 in Fiscal Year 2016 to over $36,000 in Fiscal Year 2022.

Significant work remains for the Agency to achieve substantial compliance for all the provisions of the Settlement Agreement. The correctional facilities for enhanced review during the December 6-9, 2021 IP Site Visit were Kirkland CI, Broad River CI, Lee CI, Lieber CI, and Camille Graham CI.

Restrictive Housing Units (RHUs)

SCDC continues to experience extreme difficulty providing required services and programs for inmates housed in RHUs. Some correctional facilities demonstrated more progress and a higher degree of compliance than others. Specific areas that have unacceptable compliance levels are: classification reviews, department RHU visits, out of cell time, showers, welfare checks, 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. There has been a reduction in the number of inmates in RHU for over 365 days from 87 inmates in April 2021 to 47 inmates in September 2021, at the end of the reporting period. The number of Mental Health Level 3 inmates in Security Detention status (RHU over 60 days) has decreased from 15 inmates at the beginning to the reporting period to 9 inmates currently.

The Broad River RHU and Secure Mental Health Unit Programs continue to experience difficulty achieving compliance in providing required services and programs. The Office of Operations has brought in new leadership for the area in September 2021 and recent compliance reports indicate improved compliance in services and programs.

Use of Force

The IP is recommending Settlement Agreement Provision Use of Force 2.c.vi.i Prohibit the Use of Force in Absence of a reasonably perceived immediate threat move from partial compliance to substantial compliance. SCDC has developed and implemented procedures to review, investigate, and provide dispositions for referrals alleging physical abuse and excessive force of inmates by staff. The data compiled since the beginning of the *Settlement Agreement* reveals use of force has been reduced from an average of 120 plus use of force incidents per month to an average of 56 use of force incidents per month from April 2021 to September 2021. This represents a reduction of approximately 54 percent in use of force incidents. There were only two (2) uses of the restraint chair this reporting period and the 2 inmates were removed within 2 hours.

Inmate Crisis Procedures

Systemwide SCDC compliance with the crisis program procedures for inmates that are involved in self injurious program remains problematic. The provided documentation demonstrates:

- Inmates are placed on 15-minute observation without an appropriate suicide risk assessment;
- Time frames for inmates on crisis are not followed, particularly, transfer of inmates to the Broad River CI CSU if the inmate is on crisis for over 60 hours or as an alternative, initiate 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, 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 intended to divert inmates that are held in RHU for safety concerns. SCDC continues to have a significant number of inmates housed in RHUs for safety concerns. There were 143 inmates in RHU for safety concerns as of December 2021. SCDC could substantially reduce their RHU population by removing inmates placed for safety concerns.

Kirkland High Level BMU

The HLBMU (Kirkland High Level BMU) remains in operation. The HLBMU population increased from 10 the last reporting period to 18 this reporting period with a waiting list of 25 inmates.

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, mental health designated inmates with a Guilty Disciplinary result from April 2021- September 2021, SCDC was found in compliance with the policy. 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 who receive disciplinary sanctions be reviewed by a MHDTT. The prior reporting period, SCDC provided documentation that the MHDTT reviews were not consistently occurring. Compliance Reports indicate this deficiency has been corrected. The Assistant Deputy Director for Operations revised and implemented procedures to ensure the MHDTT reviews are conducted as required. The revised procedures included conversion from a manual to an electronic system for data entry that enhanced correctional facility accountability and headquarters' review.

Offender Automated Tracking System (OATS)

The Inmate Profile Section remains an underdeveloped part of the OATS. The IP recommends enhancements to include Medical, Mental Health, and Security alerts that would assist in inmate supervision.

Screening for Inmates Placed in RHU

SCDC is not in compliance with Health Services Policy 19.04 that establishes healthcare screening procedures for inmates being placed in RHU. Corrective action is necessary to ensure compliance with this policy. A quality assurance mechanism to ensure the procedures are followed has not been developed.

Kirkland SSR Unit

The Kirkland SSR's permanent heating system is non-operational. SCDC received authorization from the responsible authority to utilize an 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 continues to house inmates with a mental health designation who have been in the unit for over 60 days. SCDC acknowledges inmates with a mental health designation in the unit must receive their required level of mental health services. A proposed program that ensures inmates housed at the SSR receive the required level of mental health services has not been provided to the IP .

Females Requiring Long Term Removal from the General Population

The issue 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 remains a concern. The RHU Policy currently under revision will need to address female inmates with a mental health designation that cannot be returned to the general population and have been held in the RHU for over 60 days.

Tablets

SCDC's inmate computer tablet program for inmates in general population and RHU remains a positive incentive. The tablets mitigate limited services and programs due to critical staff shortages and the pandemic. The SCDC *Tablet Policy* was developed during the reporting period. The IP encourages SCDC to expand the accessibility of tablets and expand the hours per day and include weekends and holidays that inmates have access to tablets, especially in RHUs.

Staff Training

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 number of CIT-Trained Staff has decreased from 374 the last reporting period to 325 in this reporting period. The number of SCDC staff with a current CIT certification has also decreased from 190 to 132 staff. The certification for over 59 percent of the SCDC CIT-Trained staff has lapsed, representing 193 of 325 CIT trained staff.

	Current CIT Certification	**Lapsed CIT Certification**	**Total CIT Trained**
TOTAL	**132**	**193**	**325**

SCDC demonstrated progress to move from partial compliance to substantial compliance for *Settlement Agreement provision 2.c.viii Develop a mandatory training plan for correctional officers concerning appropriate methods of managing mentally ill inmates.* The SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates requires

newly hired correctional officers receive 10.5 hours of initial training. Permanent correctional officers' annual training concerning the appropriate methods of managing mentally ill inmates is 6 hours. The SCDC has achieved substantial compliance for this provision as 90.5 percent of the security staff received the required training regarding the appropriate methods of managing mentally ill inmates in the Calendar Year 2021.

General Information

SCDC continues to implement the revised behavior driven classification system. The pandemic has slowed full implementation. The behavior management Structured *Living Unit* inmate population has been reduced from 876 inmates the last reporting period to 140 inmates this reporting period.

Findings

The Implementation Panel has provided extensive feedback and technical assistance regarding our analysis and recommendations during this, and past, visits. We have noted those areas in need of improvements, as well as those where maintaining adequacy of services and compliance with the Settlement Agreement are difficult and encourage mitigation efforts. We recognize the need to encourage and support hard working and dedicated staff to best address their health care needs as well as those of the inmate population as we all deal with the COVID 19 pandemic and sequelae.

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 December 9, 2021 are as follows:

1. Substantial Compliance (active)----10
2. Substantial Compliance (sunset/greater than 18 months)---22
3. Partial Compliance---22
4. Non-Compliance---5

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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 December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: As per status update**.** From the audit:

> Inevitably when working with a transient and survival-based population, inmates will often underreport symptoms as a means to get to a Level 1 institution, avoid classification delays, and/or attempt to get to certain dorms/institutions. Other barriers identified include not having access to charted mental health history, inmate symptoms being dormant or stabilized at county leading to higher med classifications upon SCDC reception, and delayed times in inmate classifications for proper referrals to mental health programming. The R&E MH team works hard to request documentation of previous mental history with community partners and stakeholders to include county jails, hospitals, and any Warden Jacket information. Additionally, the R&E MH team makes effort to conduct ongoing assessment of inmates residing on the KCI yard until they are discharged**.**

Our July 2021 reported included the following:

> 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.

As summarized in the status update section, little has changed for similar reasons (staffing and Covid-19 issues).

Implementation Panel December 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 December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: An adequate QI process has been developed to monitor this provision. Partial compliance remains because the identified deficiencies remain.

Implementation Panel December 2021 Recommendations: Continue to QI the process and implement the corrective action plan(s).

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: The improvement in receiving CoC documentation is noted. The negative impact of the above vacancies are also noted and mitigated by the hiring of Mr. Budz.

Implementation Panel December 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 December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: As per status update section. Compliance with development of a program that regularly assesses inmates within the general population for evidence of developing mental illness and partial compliance with providing timely access to mental health care.

Implementation Panel December 2021 Recommendations: The decision by SCDC to decentralize MH3 (L3) level of care inmates will require documentation for inmates who are receiving enhanced programmatic services, including group therapies.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 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, with some exceptions, specific to QMHPs.
3. Treatment plan updates were not timely for RHU and SMHU inmate. Data was not presented for other housing locations.
4. Lack of compliance re: mental health rounds in the segregation housing units being regularly performed on a timely basis.
5. Lack of compliance with confidentiality of sessions with QMHP and Psychiatrist for Inmates on CI/SP-RHU
6. Lack of compliance with access to yard time and showers for segregation inmates.
7. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
8. Lack of compliance with security checks in RHU.
9. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
10. 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.
11. Lack of compliance with RHU visitation.
12. 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. Treatment plan updates were not timely at all LOC being offered.
4. Lack of compliance with access to yard time and showers for segregation inmates and patients in the RHU.
5. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
6. Lack of compliance with security checks in RHU.
7. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
8. 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.
13. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells, although significant improvement was noted.

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 for QMHPs.
2. Lack of compliance with clinical contact being held in a confidential setting, which varied by level of care being provided.
3. Lack of compliance with treatment plan updates were not timely at all LOC being offered.
4. Lack of compliance re: mental health rounds in the segregation housing units.
5. Lack of compliance with access to yard time and showers for segregation inmates.
6. Lack of compliance with suicide risk assessments for inmates while on suicide precautions in the RHU.
7. Lack of compliance with security checks in RHU.
8. Lack of compliance with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
9. 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.
10. Lack of compliance with temperature and sanitation checks in CSU and RHU safe cells.

Lee Correctional Institution

Review of the Lee 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. Treatment plan updates were not timely,
4. Lack of compliance re: mental health rounds in the segregation housing units.
5. Lack of compliance with access to showers for segregation inmates in the RHU.
6. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
7. Lack of compliance with security checks in RHU.
8. Lack of compliance, but with improvement, with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
9. 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.
10. Lack of compliance with temperature and sanitation checks in the RHU.

Lieber Correctional Institution

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

1. Lack of compliance with timely clinical contacts with clinicians QMHPs.
2. Lack of compliance with clinical contact being held in a confidential setting (when clinical contacts occurred), with QMHPs.
3. Treatment plan updates were not timely,

4. General compliance, with some exceptions, re: mental health rounds in the segregation housing units,
5. Lack of compliance with access to showers for segregation inmates in the RHU.
6. Lack of compliance with access to yard time for segregation inmates in the RHU.
7. Lack of compliance with suicide risk assessments for inmates in the RHU on suicide precautions.
8. Lack of compliance with confidential sessions by the QMHP and Psychiatrist for inmates being seen due to a crisis.
9. Lack of compliance with security checks in RHU.
10. Lack of compliance, but with improvement, with classification reviews re: placement in Short Term Detention (ST), Security Detention (SD), and Disciplinary Detention (DD).
11. 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.
14. Compliance with temperature and sanitation checks in CSU and RHU safe cells.

Implementation Panel December 2021 Recommendations: Continue to QI the actual frequency of clinical contacts.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: As stated during previous assessments, inmates requiring a L2 level of care are generally expected to represent 10-15% of the total mental health caseload. The percentage of female inmates meeting this figure is close. The percentage of male inmates meeting this figure is not close. Providing sufficient facilities for such services remains problematic due to resource issues.

Our December 2020 recommendations included the following:

> 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.

SCDC also provided data that indicated timeliness of clinical sessions for inmates receiving a L2 level of care is problematic due to staffing vacancies and Covid issues.

Implementation Panel December 2021 Recommendations: For the next site assessment, please provide an update regarding the above housing issue at CGCI.

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

Implementation Panel December 2021 Assessment: Partial compliance

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

Implementation Panel December 2021 Recommendations: Complete the feasibility assessment.

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

Implementation Panel December 2021 Assessment: Partial Compliance

Implementation Panel December 2021 Findings: As per status update section. See 2.b.ii. findings.

Implementation Panel December 2021 Recommendations: See 2.b.ii. findings.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: As per status update. Providing adequate out of cell time remains problematic related to custody staffing and COVID 19 issues. Access for inmates to tablets is a significant mitigating factor. It is our understanding that this access of four hours per day is related to re-charging of the tablets issues.

Implementation Panel December 2021 Recommendations: Consider increased access to tablets for inmates in segregation due to the need for mitigation related to the limited out of cell time.

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

Implementation Panel December 2021 Assessment: Noncompliance

Implementation Panel December 2021 Findings: As per status update section. Barriers to compliance are predominantly Covid related (e.g., movement restrictions, quarantine issues, staffing vacancies).

Implementation Panel December 2021 Recommendations: Continue to monitor and mitigate.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: During the monitoring period, the number of inmates in the RHU transferred to a higher level of care was as follows:

HLBMU	18
LLBMU	9
CHOICES	1
GPH	29
SMHU	10

Partial compliance is related to providing adequate and timely treatment following transfer to a higher level of care.

Implementation Panel December 2021 Recommendations: Continue to monitor and implement adequate treatment within these higher levels of care.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: SCDC Operations continues improvement in conducting required correctional facilities RHU and Crisis temperature checks and cell inspections. The aggregate percentage of cells recording temperature checks and conducting cleanliness inspections at Camille Graham, Lee, Kirkland, Lieber, and Broad River from May 2020 – September 2021 was: Temperatures 91.24 percent and Cleanliness 98.76 percent. Overall between May 2020 – September 2021 Broad River CI, Camille Graham CI, Lee CI, Kirkland CI, and Lieber CI have an aggregated average of 89% compliance with completed Temperature and Sanitation Daily Checks in Segregation Cells. Staff documenting appropriate comments when temperatures are out of range and cells are unclean remain problematic. The Office of Operations and IT have not developed the previously reported plan to include a selection menu on the Zebra device for staff to electronically select specific options when temperatures and cleanliness are out of compliance. This was due to staffing shortages and the workload of the SCDC IT Department. Staff documenting appropriate comments when cells have temperatures out of range and are unclean in May 2021 and August 2021 remains significantly below the required compliance levels. 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 December 2021 Recommendations: Continue compliance with conducting the required RHU cell temperature and cell cleanliness checks. SCDC Office of Operations and RIM address the deficiency of not having appropriate comments when cell temperatures are out of range and cells are unclean. Develop an action plan with the IT Department to automate temperature and cell check comments utilizing a selection menu for staff to utilize when temperatures and/or cell inspections identify deficiencies. Train correctional staff on the revised procedures to document cell temperatures and inspections using a selection menu on the Zebra device to record comments.

The Operations Division continue quality improvement efforts to ensure correctional staff document appropriate comments when cell temperatures are out of range and/or a cell is not in an acceptable condition. Headquarters and Correctional Facility Management conduct timely follow up and take corrective action when compliance issues are identified. Continue to conduct temperature and cleanliness checks for each institutions' CI cells and 4 random RHU cells.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings:
The implementation of a formal quality management program under which segregation practices and conditions are reviewed remains. The Division of Operations has 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) allows Operations to track services and programs provided in RHUs.

The following is a summary of the RHU findings for these sections:

- Inmates in RHU over 365 days;
  - As of September 2021, less than 50 inmates were in RHU over 365 days.
- Seven (7) Day Short Term Inmate Reviews;
  - 48 percent of the inmates in RHU received their required 7-day review.
- RHU Short Term Status for less than 30 days;
  - 58 percent of the inmates remained in RHU for less than 30 days.
- RHU Inmates in Security Detention Status that received required 90-day reviews;
  - 74 percent of the Inmates in Security Detention Status received their required 90-daya reviews.
- RHU Inmates in Disciplinary Detention Status 60 days or less;
  - 5 percent of the inmates in RHU for Disciplinary Detention exceeded the maximum 60 days.

QIRM and Operations have developed and implemented a formal quality management program under which segregation practices and conditions are reviewed. The QI program has multiple indicators for segregation practices and conditions. Staffing shortages prevent compliance with the majority of the segregation practices and conditions reviewed i.e., security checks, temperature and cell cleanliness checks, recreation, showers, staff visits, classification reviews, medical and mental health contacts/assessment, etc. Compliance for this provision will be achieved when the QI process demonstrates improvement in the context of the various indicators.

Implementation Panel December 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 December 2021 Assessment: Substantial compliance.

Implementation Panel December 2021 Findings: The provision was found in substantial compliance in July 2021. The SCDC Plan to eliminate the disproportionate use of force against inmates with mental illness remains implemented and continues in substantial compliance. 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 Mental Health inmate population remained stable during the reporting period. The average percentage of UOF incidents occurring in Mental Health inmates was 0.80% and the average in the Non-Mental Health inmate population was 0.17%.

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.

Implementation Panel December 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.vi. Prohibit the use of force in the absence of a reasonably perceived immediate threat

Implementation Panel December 2021 Assessment: Substantial Compliance.

Implementation Panel December 2021 Findings: The necessary progress has been made to move the provision to substantial compliance. SCDC has addressed the IP concerns regarding review, investigation, and disposition of allegations/complaints of excessive force and physical abuse of

inmates. Revised procedures were necessary for SCDC to demonstrate that staff force is prohibited unless, there is a reasonably perceived threat. A review has been developed and implemented for SCDC to determine if a reasonably perceived threat existed in use of force incidents. Data is compiled and reported for monthly review providing the percent of all use of force instances with reasonably perceived threat, percent of immediate uses of force with an immediate threat, and percent with corrective action taken related to perceived threat violations.

SCDC has developed and implemented procedures to review, investigate, and provide dispositions for referrals alleging physical abuse and excessive force of inmates by staff. The data compiled since the beginning of the *Settlement Agreement* reveals use of force has been reduced from an average of 120 plus use of force incidents per month to an average of 56 use of force incidents per month from April 2021 to September 2021. This represents a reduction of approximately 54 percent in use of force incidents.

The Office of Investigation and Intelligence data related to Use of Force for April 2021 through September 2021 is below.

Police Service Referrals	April	May	June	July	August	September
UOF Review for Investigation	11	2	6	2	2	2
UOF Opened of Investigation	7	1	4	2	2	2
UOF Investigations Pending	22	17	17	16	15	14
UOF Investigations Closed	5	6	4	3	3	3

For the April 2021 to September 2021 Reporting Period, there were 14 inmate grievances alleging excessive force.

SCDC continues to utilize 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 on 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 DDOII 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 refers issues raised in the grievance that should be addressed by the warden or other staff at the institution. Recommendations reflected in the UOF Review Team's determination are forwarded to the Chief, Inmate Grievance Branch.

The following review of use of force incidents continue:

- 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 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 to provide 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 are discussed at all monthly UOF MINs meetings.

SCDC Use of Force MINS for April 2021 to September 2021:

Month	Year	Number of UOF MINS
April	2021	72
May	2021	63
June	2021	53
July	2021	59
August	2021	37
September	2021	56

During the current reporting period, four institutions provided documentation that employee corrective action was taken for policy violations in thirteen use of force incidents.

Implementation Panel December 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 QI Inmate Grievances submitted alleging staff excessive force and physical abuse;
6. QIRM QI incidents and grievances referred to the Office of Investigations and Intelligence related to UOF and Physical Abuse;
7. Continue referrals to the Office of Investigations and Intelligence, Inmate Grievance Program, and Use of Force Review Team for excessive force and physical abuse and document the reasons an investigation is not opened;
8. QIRM to include the UOF violations QIRM identified in their review of use of force incidents in each reporting period UOF Reports; and
9. Require meaningful corrective action for employees found to have committed use of force violations.

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

mental illness;

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: Per the 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 has made progress with attempts to contact clinical counselors (QMHPs) prior to planned use of force. The mean compliance rate for April 2021 through September 2021 was 86.0 percent, an improvement from 79.2 percent the last reporting period. The Office of Operations continues to take corrective action when staff fail to contact a QMHP prior to a planned UOF. There were 11 staff corrective actions related to documenting attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates during the reporting period.

Implementation Panel December 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 December 2021 Assessment: Substantial Compliance.

Implementation Panel December 2021 Findings: The SCDC has achieved substantial compliance for this provision as 90.5 percent of the security staff received the required training regarding the appropriate methods of managing mentally ill inmates in the Calendar Year 2021.

The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates requires newly hired correctional officers receive 10.5 hours of initial training. Permanent correctional officers' annual training concerning the appropriate methods of managing mentally ill inmates is 6 hours.

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.

Implementation Panel December 2021 Recommendations:

1. Continue to recommend an evaluation by Training, Operations and 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. Continue to ensure correctional officers receive 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 December 2021 Assessment: Substantial compliance (December 2020).

Implementation Panel December 2021 Findings: Per SCDC Update. No information has surfaced in the reporting period to prevent the provision from remaining in substantial compliance.

Implementation Panel December 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 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 December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: The frequent absence of psychiatrists in the treatment planning meeting is particularly problematic.

Our July 2021 findings included the following:

> 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 December 2021 Recommendations: Remedy the above.

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

Implementation Panel December 2021 Assessment: Partial compliance

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

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

Implementation Panel December 2021 Findings: We have reviewed the templates' capacity for generating relevant reports.

Implementation Panel December 2021 Recommendations: Continue to develop relevant reports using this template.

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

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

Implementation Panel December 2021 Findings: Substantial compliance continues.

4.a.ix. Quality management documents; and

Implementation Panel December 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 December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings:
The July 2021 IP findings identified SCDC correctional facilities were not consistently reviewing disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3. The Assistant Deputy Director for Operations developed and implemented a tracking system to ensure each SCDC correctional facility's Mental Health Disciplinary Treatment Team (MHDTT) reviews disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3. The tracking system includes a report that verifies MHDTTs review disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3. (*Disciplinary Sanctions Modified by MHDTT Report*).

Issues related to eZmars being used for all administered medications remain.

Implementation Panel December 2021 Recommendations:

1. Remedy and QI eZmars issues related to administered medications.
2. SCDC continue to track and ensure each correctional facility's MHDTT reviews disciplinary sanctions imposed for inmates with a Mental Health Designation Level 1, 2, and 3 utilizing the *Disciplinary Sanctions Modified by MHDTT Report*.

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

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

Implementation Panel December 2021 Findings: Substantial compliance continues.

5.a. Improve the quality of MAR documentation;

Implementation Panel December 2021 Assessment: Partial compliance

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

Implementation Panel December 2021 Recommendations: Implement the bar code system.

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

Implementation Panel December 2021 Assessment: Noncompliance

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

Implementation Panel December 2021 Recommendations: Develop and implement the above QI process.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: As per status update section. HS medications should occur after 8 p.m.

Implementation Panel December 2021 Recommendations: Implement the referenced analysis.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Assessment: As per status update section.

Our July 2021 findings included the following:

> 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 December 2021 Findings: Develop and implement the data model as per the current status section.

6. A basic program to identify, treat, and supervise inmates at risk for suicide:

6.a. Locate all CI cells in a healthcare setting;

Implementation Panel December 2021 Assessment: Noncompliance

Implementation Panel December 2021 Findings: Staff reported that many of the transfer timeline delays were due to Covid testing issues, which have recently been decreased. Staff also described issues related to not transferring inmates due to them not needing a CSU level of care but threatening self-harm for reasons other than being related to a mental illness.

Implementation Panel December 2021 Recommendations: Need to address the issues related to not transferring inmates due to them not needing a CSU level of care but threatening self-harm for reasons other than being related to a mental illness.

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

Implementation Panel December 2021 Assessment: Noncompliance

Implementation Panel December 2021 Findings: See status update section.

Our July 2021 findings included the following:

> See status update section. The lack of compliance with suicide prevention, management watch procedures is very alarming and potentially dangerous.

Our assessment remains the same.

Implementation Panel December 2021 Recommendations: Remedy the above ASAP.

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

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

Implementation Panel December 2021 Findings: Per SCDC Update. Substantial Compliance was achieved in December 2020 and continues. Not identified in the SCDC update, female hygiene items are included in the review of suicide supplies at Camille Graham Correctional Institution. A required inventory of female hygiene is maintained and available for issue to female inmates on crisis status.

Implementation Panel December 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 supplies.

6.e Increase access to showers for CI inmates;

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: Per the SCDC Status Update and review of provided documents, the provision remains in partial compliance. Inmates on CI status are not receiving increased showers necessary to meet compliance with the provision. The inability for SCDC correctional facilities to provide inmates on CI status increased showers appears to be due to significant security staffing shortages. The only correctional facility achieving compliance was Camille Graham CI.

To assess compliance and ensure that inmates on CI are provided increased shower access the following is 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 cell, 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.

Implementation Panel December 2021 Recommendations: Remedy the Above. Ensure inmates on CI status receive increased showers necessary to meet compliance with the provision.

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

Implementation Panel December 2021 Assessment: Noncompliance

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

Implementation Panel December 2021 Recommendations: Remedy the above.

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

Implementation Panel December 2021 Assessment: Partial compliance

Implementation Panel December 2021 Findings: Per SCDC Update and 2.b.vi. Findings. SCDC Operations continues to make improvement in conducting required correctional facilities CI temperature checks and cell inspection. There was an 85% average compliance with the checks in the RHU safe cells. The rate was determined from the Broad River, Camille, Kirkland, Lieber, and Lee aggregated weekly data from April 2021-September 2021. Staff failure to document appropriate comments when a CI cell temperature is out of range and/or the inspected cell is unclean remains problematic. Appropriate comments were only provided an average of 11% of the time when a temperature was out of range and 0 percent of the time when a cell was not clean. The Office of Operations and IT have not developed the previously reported plan to include a selection menu on the Zebra device for staff to electronically select specific options when temperatures and cleanliness are out of compliance. This was due to staffing shortages and the workload of the SCDC IT Department.

Implementation Panel December 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;
3. SCDC QIRM to continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperature and cleanliness inspections;
4. IT develop an action plan to automate temperature and cell check comments utilizing a selection menu for staff to utilize when temperatures and/or cell inspections identify deficiencies; and
5. Train correctional staff on the revised procedures to document cell temperatures and inspection using a selection menu on the Zebra device to record comments.

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

Implementation Panel December 2021 Assessment: Partial compliance

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

Implementation Panel December 2021 Recommendations: Compliance will be found when the QI process results in significant positive changes toward compliance with crisis intervention practices.

Conclusions and Recommendations:

This is the 14th report by the Implementation Panel (IP) regarding the South Carolina Department of Corrections' compliance with the Settlement Agreement enacted on May 2, 2016. As always, this report is based on the IP review and analysis of the documents and other materials requested and received from SCDC, as well as plaintiffs, inmates and their families. This review was conducted virtually by IP members Emmitt Sparkman and Raymond Patterson, MD, IP subject matter expert Jeffrey Metzner, MD, and IP coordinator Tammie Pope. In addition, Sally Johnson, MD, SCDC

subject matter expert and consultant participated in this virtual site visit. This virtual site visit was conducted from December 6-9, 2021.

The IP has previously reported, and remains keenly aware of the unprecedented impact of the COVID 19 pandemic and the challenges and obstacles related to the progression in correctional systems throughout the country, including SCDC.

The access to higher levels of care and provision of structured therapeutic activities and unstructured out of cell activities have been compromised due to quarantines, lock downs, staffing shortages and restructuring. For example, the consolidation of inmate patients at the MH3 or L3 level of care at BRCI (Area Mental Health, or Enhanced Outpatient) was restructured and a specific designated unit undesignated; it was unclear as to how these inmate patients would receive higher levels of programmatic services.

Other programs reported on the impacts of COVID 19 restrictions and inadequate staffing, including inadequate services for ICS, Choices, HLBMU, GPH, and CSU. Unoccupied beds, significant waiting lists and long wait times were reported for these programs, again related to quarantine/isolation, and inadequate staffing and space. QIRM reporting is essential to ensuring adequate, reliable, consistent and timely data collection and self critical analyses.

As the COVID 19 pandemic becomes endemic and under better and consistent control, the long standing and underlying staffing, space and other resource concerns will remain problematic in achieving substantial compliance with the provisions of the Settlement Agreement.

On a final note from Dr. Ray Patterson:
As announced prior to this scheduled visit, this will be my last visit to SCDC and final report as an IP member. I want to again express my thanks and appreciation for being a part of this remarkable endeavor to improve and support the mental healthcare needs of inmates living in SCDC with mental illness, and by extension the quality of life in the working environment for staff. I hope for, and wish all the best to those really hard working staff and consultants, inmates and their families, advocates and communities, and to my exceptional colleagues on the IP Team. Thank you.

Respectfully submitted,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and Emmitt Sparkman