

**South Carolina Department of Corrections
Implementation Panel Report of Compliance
November 2019**

Executive Summary

Introduction

This 10th Implementation Panel Report is presented by the Implementation Panel (IP) regarding the South Carolina Department of Corrections' (SCDC's) compliance with the Settlement Agreement (SA) enacted in May 2016 based on review of documents and information provided since the Panel's last report based on our March, 2019 site visit and review. The IP requested and received a substantial number of documents as is consistent with previous site visits, as well as specific documents regarding mental health services at Camille Graham Correctional Institution (CGCI) and regarding the increase in completed suicides and efforts by SCDC to address very serious concerns generated by legislative inquiries and IP requests. There have been some improvements over time in the delivery of mental health services, however significant deficiencies and progress remain problematic as described in this and previous IP reports.

This site visit included visits to the following institutions: Broad River Correctional Institution (BRCI), Kirkland Correctional Institution (KCI), Lieber Correctional Institution (LCI), Perry Correctional Institution (PCI), and CGCI, as well as meetings with Director Stirling and/or his staff, and a presentation by the Medical University of South Carolina (MUSC) regarding collaboration on suicide prevention and management within SCDC. As has been customary, the IP presented its preliminary findings on the last day of the visit, which included a limited number of participants from SCDC's staff, as designated by the Director, as well as counsel for the parties and the mediator, Judge William Howard. Judge Howard has announced his retirement from this case and therefore this will be his last review and analysis of the SCDC responses to compliance with the provisions of the SA in the IP final report. The IP wishes to thank Judge Howard for his consistent leadership, direction and review of this process and the SA from the initial mediation throughout the ten onsite visits as proscribed by the SA. This visit is the first of two scheduled for the fourth year of this SA. A Third Amendment to the SA has named Robert Erwin, Esq. as the new mediator as the SA enforcement continues until SCDC demonstrates Substantial Compliance with the provisions.

This report will return to the original format for onsite visits and review of systems, documents and interviews with staff and inmates at the facilities visited. Due to time constraints, the IP visited selected programs and units, with special attention to "new" programs reported to have a focus on mental health, and/or step down and other units reported to address continuing inmate concerns regarding their safety if housed in general population with resultant placements in Restricted Housing Units (RHU's) or protective custody. The IP has noted significant changes in staff at the leadership levels in Operations and Health Services, and changes within clinical programs, and it supports these efforts by Director Stirling to address identified concerns. The IP was apprised of testimony provided to the SC legislature regarding inadequate services and punitive practices at CGCI and held meetings and reviewed the Crisis Stabilization Unit and other programs at CGCI, including corrective actions by SCDC. Consistent with our past assessments and reports, the IP continues to be very positively impressed by the efforts of the Quality Improvement Risk Management (QIRM) program and staff, and their direction to assist and support SCDC during this process.

Resources

The IP has re-emphasized during every site visit and in every report the resource deficiencies, particularly Operations correctional officer and supervisory staff, and clinical mental health, nursing and medical staff. We have also reported on known space deficiencies, including dedicated sufficient numbers of beds for mental health programs at various levels of care and necessary spaces for sound confidential assessment and treatment. Although SCDC has substantially met the agreed upon staffing numbers for mental health staffing at mediation, those numbers were based on a compromise to fill existed and funded positions and an estimated mental health caseload of 13%. Over the years, and to their credit, SCDC has improved their processes for the identification of inmates with mental health and/or behavioral needs resulting in approximately 25% of the inmate population being on the caseload and in need of mental health and/or behavioral management services. The staffing for mental health needs to be increased to address inmate needs, and the identified nursing shortages, particularly at CGCI have reached crisis levels despite Health Services' sincere efforts to address these deficiencies. The staffing deficiencies for correctional officers remain at inadequate to critical levels at several facilities which continues to compromise basic services such as recreation and showers for inmates. The IP has been apprised of budget requests to improve mental health services, including staffing, which have not been approved.

Suicides

The average daily population (ADP) has continued to decrease at SCDC to approximately 18,449 inmates at the time of this visit. Unfortunately, the number of reported suicides at SCDC is unacceptably high. The number of suicides by inmates at SCDC was 12 for calendar year 2018 and 10 for calendar year 2019 through November, 2019. The most recent national average annual suicide rate for prisons published by the Department of Justice Bureau of Justice Statistics was 17/100,000 for calendar year 2017. With ADP's of 19,000+ and 18,000+ for calendar years 2018 and 2019 the annual suicide rates for SCDC are approximately 63/100,00 for 2018 and 53/100,00 for 2019. These high rates are of grave concern to the staff at SCDC and to the IP, as they are three to four times the national average. Inmates who report and/or are observed to be at increased risk for self harm have had inadequate access to higher levels of care, timely and adequate assessments, and direct observation and treatment services. These areas of required provisions remain problematic as described in this and past reports.

Building Schedules and Out of Cell Time for Prisons

SCDC is tracking daily individual prison modifications of activities and services if it occurs. Movement schedules were provided to the IP by SCDC to identify each prison's activities and services under normal conditions. The IP has requested SCDC QIRM conduct Quality Improvement (QI) studies to identify the scheduled out of cell time for inmates at each prison and the actual time out of cell due to any modification from the normal daily prison schedule. This will allow the IP to identify how many actual hours per day inmates average out of cell Monday through Sunday and on holidays for the next relevant Settlement Agreement period.

Safety Precaution (SP) Population

SCDC had a population of approximately 157 SP classification inmates in RHU as of November 21, 2019. The Restorative Unit was initiated at Lieber CI and has a capacity of 45 inmates in single cells. The population during the IP Site Visit was 33 inmates. IP interviews with SCDC staff and inmates identified the program has been successful diverting SP inmates from RHU and

the majority of the Restorative Unit inmates had been frequently placed in the Broad River CI Crisis Stabilization Unit (“CSU”). The current SCDC plan is to remove SP inmates from RHU and place all of them in a new program (Star Program) that is being initiated at the Evans CI. The IP has the following concerns regarding the housing of all SP inmate at Evans CI: 1) Evans does not have sufficient staffing to manage an SP Program and 2) placing all SP inmates at one location will prevent flexibility in transferring SP inmates that develop issues requiring their transfer another prison. Policies and Procedures, Staff Training and Inmate Orientation must be developed for any program that diverts the large number of SP inmates from RHU. Expanding programs to remove SP inmates from RHU has the potential to reduce inmates requesting crisis and reducing the number of inmates requiring use of the Broad River CI CSU program. This can result in significant savings of staff resources at the majority of the SCDC prisons reducing transportation of inmates to and from Broad River’s CSU. Development and Implementation of a program to divert SP inmates from RHUs should be expeditiously pursued due to the ability to significantly reduce the RHU population with the removal of SP inmates. Programs used to divert SP inmates from RHU need to include the flexibility to double cell SP inmates and require a thorough and complete review to prevent inappropriate placements and removals.

Inmates Confined in RHU over 60 days on Short Term and/or Disciplinary Detention

The SCDC RHU Policy prohibits confining inmates in RHU for over 60 continuous days on Short Term and/or Disciplinary Detention status. As of November 21, 2019, SCDC had 27 inmates in RHU on Disciplinary Detention and Short Term status over 60 days. This has been an ongoing issue since the beginning of the Settlement Agreement monitoring period. There are a number of reasons inmates are held in RHU over 60 days on short term and/or disciplinary detention status i.e.: 1) Investigation Status by Police Services or another entity; 2) prison management waiting until 60 days has expired before developing alternative housing; 3) a lack of program space to remove the inmate from RHU; and 4) continuing rule violations that prevent removal to the general population for safety and security reasons. Recommended Remedies to address this issue are:

- Develop written policies and procedures for inmates placed on investigative status including documenting specific reasons for continued confinement in RHU on investigation, require face to face inmate reviews by the responsible investigator and establish times frames an inmate can be held on short term status for an investigation;
- Develop a review process for inmates held in Short Term and Disciplinary Detention Status requiring involvement of Headquarters Classification and Prison Management to reduce the number of inmates held over 60 days in Short Term and Disciplinary Detention status.
- Consider reducing the maximum amount of Disciplinary Detention time from 60 day to 30 days except in exigent circumstances;
- Consider reducing the maximum amount of Disciplinary Detention for Inmates with a L1, L2, and L3 Mental Health Designation to 15 days, which is more consistent with National Commission on Correctional Health Care (NCCHC) Standards;
- Develop specific codes for inmates in RHU on Short Term and Disciplinary Detention Status over 60 days identifying them in Awaiting Placement (AP) with an appropriate code, i.e. AP- Investigation, AP-HLBMU

Restrictive Housing Units

The IP November 2019 Site Visit found SCDC has made progress in providing RHU inmates showers and recreation, but significant work remains. It was discovered that Classification Staff's RHU seven-day and thirty-day reviews are manually documented in the SCDC Inmate File on the Progress Notes Form. The IP recommends that SCDC develop an electronic system for Classification Staff to document RHU seven-day and thirty-day inmate reviews to ensure responsible Headquarters and QIRM staff can readily monitor compliance of the Classification seven-day and thirty-day RHU reviews.

SCDC Prisons do not utilize a Cell Inspection Form to document staff inspections of RHU cells before an inmate is placed or removed. The IP recommends the inspection of an RHU cell before an inmate is placed in a cell and after their removal with documentation of the inspection on an approved SCDC form.

SCDC RHU staff continue to struggle meeting the RHU requirement to conduct two irregular rounds per hour with no round exceeding 40 minutes primarily due to staff shortages. This is a serious life and safety concern. Headquarters and Prison Management need to develop a workable plan to address RHU staff's inability to make required life and safety rounds every hour.

The IP November 2019 Site Visit found there are SCDC prisons that continue to take RHU inmates' recreation for minor violations unrelated to the recreation. It is recommended that SCDC discontinue taking RHU inmates' mandated Settlement Agreement recreation for minor violations unless the violation is related to RHU Recreation.

Structured Living Units (SLU)

SCDC has implemented Structured Living Units that limit inmates' activities and out of cell time. The IP found the SLU are not operated consistently and do not have approved policies and procedures. Policies and Procedures, Staff Training and Inmate Orientation must be developed for the program and require approval of the IP and Plaintiffs' Attorneys because the SLU houses inmates with a mental health designation.

Broad River Diversionary Housing Unit (DHU)

The Broad River Diversionary Housing Unit was developed and implemented to divert inmates with a mental health designation from RHU. The DHU has eleven (11) inmates assigned. Currently, inmates assigned to the DHU remain on RHU status and are operated under the Operations Division umbrella. The program schedule is for the inmates to receive ten (10) hours structured and ten (10) hours unstructured out of cell time five days a week. The program meets the criteria to divert inmates from RHU status. It appears to have the necessary components to qualify as a mental health program diverting inmates with a mental health designation from lockup status. Policies and Procedures, Staff Training and Inmate Orientation must be developed and require approval of the IP and Plaintiffs' Attorneys because the DHU houses inmates with a mental health designation.

Classification

The IP continues to find Security Level I and Level II inmates with an area mental health designation in Level III RHUs. The Security Level I and Level II inmates report they are housed

at Security Level III prisons to receive area mental health services and were generally found to be unable to adjust at the higher Security Level III prisons. The IP strongly recommends SCDC provide Area Mental Health at Security Level I and II prisons and discontinue housing Security Level I and II inmates at Security Level III prisons for mental health services.

Tablet and Crank Radio Policies, Procedures and Practices

SCDC is issuing identified inmates crank radios and tablets. The practice is a positive move to improve inmate conditions of confinement. It is imperative that SCDC have policies and procedures for the crank radios and tablets that includes staff and inmate accountability.

Crisis Placement, Continuous Observation, and Suicide Risk Assessments

The IP discovered during the November 2019 Site visit that SCDC Headquarters, Prison Operations, and Prison Behavior Healthcare Staff do not have a consistent understanding of the SCDC Inmate Crisis Intervention Program management in regard to placement, continuous staff observation, and suicide risk assessments. Applicable policies and procedures need to be reviewed to ensure staff in all areas are provided clear direction on their crisis intervention duties and responsibilities. Additional training is necessary for all staff once the applicable policies and procedures have been reviewed and revised to address the identified staff confusion.

SSR Unit

The Kirkland Maximum Security Unit (SSR) remains in operation and had a population of 18 during the November 2019 site visit. The responsible IP member toured the unit and found it is operated using a hodgepodge of policies and procedures. Propane heat is being used to supplement the primary heating system because the floor heating system is not operational. It does not appear the State Fire Marshall has approved the use of propane heat to supplement the primary heating system. Policies and Procedures, Staff Training and Inmate Orientation must be developed for the program and will require approval of the IP and Plaintiffs' Attorneys because the Maximum Unit houses inmates with a mental health designation.

Preventive Maintenance

The IP found preventive maintenance issues during the November 19 Site Visit, particularly at the Broad River CI's Saluda RHU and Lieber CI's SLU and RHU. It is recommended that SCDC review their overall Preventive Maintenance Program and address any identified deficiencies.

Food Service for Inmates not utilizing the Food Service Dining Rooms

SCDC continues to serve meals to inmates on styrofoam in General Population and RHU Housing Units. IP inspections have found the food frequently is not delivered or served at safe temperatures. SCDC Leadership is striving to allow more inmates to consume meals in the Food Service Dining Rooms. Invariably, a segment of the inmate population will require service of meals in their housing units, i.e. RHUs and SLUs. The IP strongly encourages SCDC to purchase heating carts and thermal trays for serving food in housing units and discontinue serving food on Styrofoam except in emergency situations.

Findings

The Implementation Panel has provided its analyses, findings, recommendations and technical assistance/consultation prior to and during all onsite visits. Many of the IP's findings are very consistent with the findings reported by QIRM and in some cases Health Services. Support from

Operations has improved at the facility, regional and central levels. The IP has and will continue to reemphasize the need to correct the resource deficiencies in staffing and programs necessary to provide adequate mental health services to the SCDC inmate populations. SCDC has not yet achieved substantial compliance in the majority of the Settlement Agreement requirements which remains problematic, despite some noted improvements as reported below.

The findings of the Implementation Panel with regard to compliance on the provisions as of November 22, 2019 are as follows:

1. Substantial Compliance—22
2. Partial Compliance—32
3. Non-Compliance—5

A detailed discussion of each component follows.

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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As above. We are encouraged by the QI process that has identified this issue. It was our understanding that CGCI R&E is also experiencing difficulties with compliance in the context of meeting required timelines for completion of initial assessments.

November 2019 Implementation Panel Recommendations: Educate/supervise the clinicians re: the urgent/emergent referral issues. Continue to monitor the relevant timeframes for the mental health screening process.

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

Implementation Panel November 2019 Assessment: substantial compliance (November 2018)

November 2019 Implementation Panel findings: The increase in the mental health caseload population since 2016 was reported to be ~ 1500 inmates.

As per SCDC status update. Compliance continues.

November 2019 Implementation Panel Recommendations: As per SCDC update.

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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: The QI process was very comprehensive in identifying the issues re: mental health screening processes. Partial compliance remains in the context of correcting the identified issues.

November 2019 Implementation Panel Recommendations: Correct the identified issues.

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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. The unresolved issues re: lack of bridge orders is very concerning.

November 2019 Implementation Panel Recommendations: Remedy the identified lack of a consistent bridging order process.

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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: See 1.a.i.

November 2019 Implementation Panel Recommendations: As per 1.a.i.

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

2.a. Access to Higher Levels of Care

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

Implementation Panel November 2019 Assessment: noncompliance

Camille Graham CI

We site visited CGCI during the morning of November 22, 2019. During November 22, 2019 the total inmate count was 711, which included 18 RHU inmates. Fourteen of the RHU inmates were on the mental health caseload. The mental health caseload included 393 inmates with the following level of care designations:

Classification	Total
L1 inpatient	2
L2 ICS	52
L3 Area MH	73
L4 outpatient	233
L5 stable, but being monitored	33
Non-mental health	368
Crisis level	10

Staffing was as follows:

Psychiatrists: 3 psychiatrists plus a psychiatric nurse practitioner providing a total of 1.5 FTE coverage.

Psychologists: 1.0 FTE

QMHPs: 7.0 FTEs (3.0 FTE vacancies)

MHOs: 3.0 FTEs

On-site clinical supervisor: 1.0 FTE

14.0 FTE RNs (9.0 FTE vacancies with another 3.0 FTEs in the process of resigning)

13 FTE LPNs (3.0 FTE vacancies)

We observed a treatment team meeting during the morning of November 22, 2019, which was performed in a very competent manner.

November 2019 Implementation Panel findings: As per status update section. The number of Intensive Outpatient inmates has not significantly changed since our last complete site assessment. Significant issues remain in providing sufficient facilities for treatment with specific reference to staff resources as evidenced by partial compliance in meeting clinical timeframes.

Staffing allocation issues are apparently significantly contributing to the lack of timeliness of many clinical contacts as per status update section.

Broad River Correctional Institution (BRCI)

During the morning of November 19, 2019, the Implementation Panel (IP) met with most of the New Direction inmates in a community group setting. Inmates confirmed that their out of cell time was no longer tiered. Common complaints included being disrespected by certain correctional staff and the 3 a.m. pill call line. The weekly community meetings were described

as being helpful as was the transfer of various problematic inmates. Some inmates individually complained of limited access to job and various property issues.

Inmates reported meeting with the telepsychiatrist every 90 days but complained that the sessions were not confidential due to the presence of two correctional officers.

We also observed the drill team performing in the yard.

Assessment: Significant improvements in the therapeutic milieu was apparent in this program.

Lieber CI

The inmate count at Lieber CI during November 20, 2019 was 1106 inmates. There were 358 inmates on the mental health caseload, which represented 32.4% of the total population, which included 28 L3 inmates, 300 L4 inmates and 30 L5 inmates.

The correctional officer vacancy rate was 47%.

The mental health staffing was as follows:

- 1.0 FTE MH Administrator (who covers three institutions)
- 4.0 FTE QMHPs
- 5.0 FTE MHOs (1.0 FTE vacancy)
- 32 hours/week of psychiatric coverage by one psychiatrist, 8 hrs/week by two psychiatric providers and 20 hrs/month coverage by another psychiatrist
- 2 hrs/week coverage for group treatment by a Ph.D. psychologist

Issues related to a lack of clinical contacts in a confidential setting were related to the correctional officer vacancies.

We interviewed 10 MH L3 inmates in a group setting during the afternoon of November 20, 2019. These inmates were very unhappy with the mental health treatment provided to them for reasons that included the following:

1. Reported poor access to mental health clinicians.
2. Lack of access to group treatment.
3. Lack of access to out of cell time—many inmates reported out of cell time in the housing unit to be limited to 2 hours per day on an every other weekday basis.
4. Transfer to Lieber for reasons that reportedly were unknown to them.

At least several of these inmates had been transferred to Lieber CI from the Murray dorm at BRCI.

During the morning of November 20, 2019, we observed a treatment team staffing of four inmates, which was attended by the appropriate disciplines. Treatment plans were discussed with the inmates during these staffings. The staffing was performed in a very competent manner.

Perry CI

The total count during our site visit was 835 inmates with 32% (269) of the inmates on the mental health caseload. There were 205 general population inmates (L3=9, L4=154, L5=42).the correctional officer vacancy rate was 28.9%. The capacity of the prison was 1018 inmates.

Mental health staffing allocations were as follows:

- 4.0 FTE QMHPs (1.0 FTE vacancy)
- 12. 0 FTE MHOs (7 FTE vacancies)
- 1.0 FTE psychiatrist (However, only 9 hours/week of psychiatric coverage was being provided with 6 of those hours via telepsychiatry)

During the morning of November 21, 2019, we interviewed 6 GP MH L3 inmates in a group setting. These inmates complained about poor access to their mental health counselors, lack of meaningful counseling sessions and lack of sound privacy when meeting with their mental health counselors. Two of these inmates were recently transferred and were upset that their tablets were taken away from them when they arrived at Perry CI. The access problems were consistent with data in the status update section and healthcare record reviews. They also reported issues with the 2:30-3:00 a.m. morning pill call process.

We also observed a treatment team staffing of five inmates. A psychiatrist was not present since the staffing was scheduled for the IP's visit, which was not on a day when psychiatric coverage was regularly provided. We did learn that the psychiatric coverage during regularly scheduled staffings included inmates who were not assigned to the psychiatrist attending the staffing.

During the afternoon of November 21, 2019, we interviewed 6 inmates in the step-down unit. These inmates complained about access issues to the mental health clinicians and reported that many of the correctional officers were not supportive of the program and were inappropriately provocative with them.

Assessment: Access issues to mental health treatment were significant, which were related to staffing allocation/vacancy issues.

November 2019 Implementation Panel Recommendations:

The telepsychiatry sessions should not be conducted in the presence of correctional officers related to confidentiality issues.

The early morning pill call process and the too early "nighttime" pill call process are very problematic and should be remedied.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: Our November 2018 findings included the following: As per status update section, which summarizes SCDC's plans for significantly increasing the number of male and female inmates receiving intermediate care services and provide sufficient facilities therefore. Increased staffing allocations have been requested as part of SCDC's budget request that has been submitted to the governor.

Our previous two reports included the following:

We discussed with staff issues related to the current number of inmates determined to be in need of an ICS level of care. For purposes of this provision, inmates in any type of mental health residential level care (e.g., a BMU) should be included in the statistics relevant to receiving an ICS level of care. It has been our experience that 10% to 15% of the total mental health caseload population is usually in need of an ICS level of care at any given time, which is significantly more than the current percentage of caseload inmates receiving an ICS level of care.

Our opinion re: the above remains unchanged.

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

Kirkland Correctional Institution

During the afternoon of November 19, 2019, we attended an ICS treatment team meeting/staffing. Significant issues were identified re: GPH not accepting referrals from ICS or returning such inmates prior to significant clinical improvement.

Clinical Staffing for the ICS was reported as follows:

1.375 FTE psychiatrists (# Hours/week on-site = 55)
8.0 FTE Mental Health Counselor (1.0 FTE vacancy)
4.0 FTE MHOs

The census during the site visit was 173 inmates.

CHOICES

Staffing was reported as follows:

1.0 FTE Program Manager
3.0 FTE QMHPs
0.7 FTE psychiatric nurse practitioner (0.3 vacancy)
4.0 FTE MHOs

HLBMU

Staffing was reported as follows:

- 1.0 FTE Program Manager (vacant)
- 2.0 FTE QMHPs (1.0 FTE vacancy)
- 1 psychiatrist (10 hours/week)
- 3.0 FTE MHOs

The census was 22 inmates with a capacity of 24.

We did not have time to site visit either the HLBMU or the CHOICES program. However, we did observe and were greeted by inmates from the HLBMU program who were outside at a pill line window receiving their meds and asking if we were coming to their program. Such an achievement would not have been instituted without the active support of Operations and clinical staff at KCI.

Camille Griffin Graham Correctional Institution

During the afternoon of November 20, 2019, the IP met with key administrative staff from CGCI and central office as well as key clinical staff from CGCI to discuss issues related to inappropriate and punitive treatment of inmates at CGCI. The discussion focused on the dynamics that led to such interactions and the subsequent corrective interventions. We also discussed future processes to prevent a recurrence of similar issues.

During the morning of November 22, 2019, we interviewed 12 ICS inmates (D side) in a community meeting-like setting. They reported during the past 6 months being offered 2-3 groups (30-60 minutes) per week of structured therapeutic group activities, which was a decrease from the previous site assessment. They complained of frequently being locked out of the dayroom area and problems with a particular inmate, who was being intermittently very disruptive and threatening. They also described very limited access to the yard. The inmates indicated that nursing staff were frequently disrespectful to them.

We also interviewed most of the Blue Ridge (C-Wing) inmates in a community-like setting. Mental health level 2 inmates reported receiving 3 hours or less per week of structured therapeutic activities and limited access to outdoor recreation related to custody officer shortages. L3 inmates described minimal access to group treatments. In general, these inmates reported receiving individual counseling sessions consistent with their mental health classifications. Issues with confidentiality during these sessions were intermittently present. Inmates in this unit described increased stress related to the increased census and “behavior problems” and “drug addicts” on this unit.

Medication continuity issues were present re: psychotropic medications.

C-Wing inmates briefly summarized issues related to the death of an inmate on the unit within the past seven days due to an apparent accidental opioid overdose. Related to custody officer

shortages, there was a significant delay in the emergency response. The inmates needed to pull the fire alarm in order to notify the custody staff of the emergency.

These inmates also indicated that they did not report past problems in the CSU (e.g., receiving nutraloaf for their meals) because they thought such procedures were part of an acceptable CSU protocol.

November 2019 Implementation Panel Recommendations:

1. Continue to advocate for the needed staffing allocations.
2. Continue to increase the number of hours of structured therapeutic activities being offered to ICS inmates.
3. Referrals to Wellpath, the hospital level provider that are rejected should be reviewed by the Denials Committee and referred for legal action if they are violating their contract.

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 November 2019 Assessment. partial compliance

November 2019 Implementation Panel findings: As per current status section.

Our last report included the following:

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

Our opinion re: this issue remains unchanged.

We did not have time to site visit the GPH.

November 2019 Implementation Panel Recommendations:

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

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

Implementation Panel November 2019 Assessment: substantial compliance (November 2018)

November 2019 Implementation Panel findings: Compliance remains in the context of meeting the goals of the Settlement Agreement staffing plan.

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

November 2019 Implementation Panel Recommendations: Continue to advocate for needed mental health staff and nursing staff allocations and salary increases as necessary.

2.a.v. The implementation of a formal quality management program under which denial of access to higher levels of mental health care is reviewed.

Implementation Panel November 2019 Assessment: substantial compliance (July 2017)

November 2019 Implementation Panel findings: As per status update section. However, we learned that the Denials committee does not review "denials" in the context of referrals to GPH, which is needed for reasons previously referenced earlier in this report.

November 2019 Implementation Panel Recommendations: Expand the committee's mission to include denials in the context of inmates referred to GPH for admission.

2b. Segregation:

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. The data re: lack of compliance with timely HLBMU mental health contacts remains extremely problematic and continues to be related to correctional staff vacancies.

We are encouraged by the development of new programs/housing units that have resulted in decreasing the number of inmates in RHU on Security Detention status with the Mental Health Designation Levels 2 & 3. The findings of the QI study specific to the inmates discharged from the HLBMU is encouraging as well.

Broad River CI DHU

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

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

DHU would be a temporary (e.g. 90 days) transitional unit to another housing unit or program. They perceived the DHU to be too similar to a RHU.

Restorative Living Unit at Lieber Correctional Institution

During the morning of November 20, 2019, we interviewed ~ 26 inmates in a community meeting-like setting. All of these inmates had previously been housed in various RHUs throughout the system due to different safety concerns. Nearly all of them reported having had multiple CSU admissions and self-harming behaviors prior to their transfer to the Restorative Living Unit. Only two inmates reported having had a CSU admission since their admission to the Restorative Living Unit. The vast majority of these inmates reported being in the Restorative Living Unit for seven months (since this unit was opened).

All of these inmates were single celled. Most expressed significant reservations about having a cellmate.

Most of these inmates were prescribed medications. They reported that the pill call was at 3 a.m. and around 2 p.m. Breakfast was served at 5 a.m.. Except for weekends, these inmates described significant out of cell time. They reported good access to the mental health services, although they requested access to more group treatments. They stated they met with their treatment team and were aware of their treatment plan.

All these inmates had access to tablets.

Assessment: The Restorative Living Unit appears to be very successful and cost-effective—it has significantly reduced CSU admissions for this small number of inmates who had access to this program or unit.

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

Mental Health Officers

We reviewed the job description of the MHOs, which had some significant differences from the mental health technicians' job description. Specifically, the educational requirements were less for the MHOs in the context of mental health experience and/or mental health curriculum and the correctional officer duties were expanded for the MHOs as compared to the mental health technicians. In practical terms, correctional officers were converted to MHO's; the understanding and endorsement of the IP was for this change to provide SCDC the opportunity to "extend" correctional officer duties to MHO's given the severe correctional officer shortage, but not to "substitute" the duties of mental health staff, such as clinical rounds, to essentially custody/operations staff.

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

1. Inadequate educational credentials.

2. Dual agency issues.

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

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

Broad River Correctional Institution RHU

During the morning of November 19, 2019, we site visited the RHU. The RHU was the cleanest and the quietest since we began our site visits. In general, inmates reported access to showers one to three times per week and significantly improved access to out of cell recreational time. Staff indicated that access to escort correctional officers continued to limit out of cell clinical contacts with inmates, although such access had significantly improved during the past four to five months. Inmates continued to report access issues to mental health staff and some continuity of medication issues, although these issues were significantly less as compared to prior site visits. One inmate continued to experience property issues (i.e., lack of clothing).

Lieber Correctional Institution RHU

The count was 33 inmates with 25 of these inmates being on the mental health caseload, which included the following classifications:

- 1 DD
- 13 SD
- 1 Max
- 1 ST
- 2 AP

On average, RHU inmates were reported to be offered 2-3 hours per week of recreational time and showers on a 3 times per week basis. RHU inmates currently did not have access to tablets.

During the afternoon of November 20, 2019, we made “rounds” in the RHU. There were significant maintenance issues (e.g., cell lights not working, showers very unclean, etc.) that had been pending for at least many weeks. Inmates generally reported access to showers on a three times per week basis. Access to outdoor recreation was reported to be about once per week at best.

Perry Correctional Institution

There were 134 regular beds in the RHU with a count of 115 during our site visit. There were 64 mental health caseload inmates in the RHU during November 21, 2019. Ten of these inmates were MH L3.

During the afternoon of November 21, 2019, we walked the D unit wing of the RHU and briefly interviewed the inmates at the cell front. Inmates uniformly reported that they generally refused showers due to feeling humiliated by the required cell removal/returning process that included a complete strip search and generally a cell search while they were showering. They reported poor access to the yard related, in part, to not having yard “privileges” (as compared to “rights” agreed upon by SCDC) for many reasons that included not standing for count, not making their bed, etc. They also reported that they were not provided opportunities to clean their cells.

November 2019 Implementation Panel Recommendations:

1. Continue to increase access to outdoor recreation.
2. Continue to increase access to showers.
3. Continue to increase access to tablets for RHU inmates.

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 November 2019 Assessment: noncompliance

November 2019 Implementation Panel findings: See 2.b.i. and status update section, which documents issues with meeting timeline requirements.

November 2019 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2019 Assessment: partial compliance

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

November 2019 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

As per status update. QIRM continues to perform studies regarding correctional staff conducting daily inspections to monitor prison RHU cells for acceptable cleanliness and temperature levels. QI data was provided for BRCI, BRCI Congaree, CGI, KCI, Lieber, and Perry B, C, D. Findings were the majority of the prisons are not consistently performing temperature checks on the

evening and day shifts. The only exception was CGI. A low number of cells were identified as requiring cleaning. The IP identified the Lieber RHU had sanitation issues providing evidence that the daily cell conditions at that location are not accurately recorded. The QIRM studies found that when temperature and cleanliness deficiencies are identified, 73% had required comments. However, only 15% provided an appropriate response to address the temperature and/or cleanliness deficiency.

November 2019 Implementation Panel Recommendations:

Continue:

- 1) Operations Management ensure all prisons are performing daily inspections for cleanliness and taking temperatures of random cells (improvement is needed);
- 2) Ensure deficiencies identified in the cell inspections for cleanliness and temperature checks are followed up on and the action taken is documented on the Cell Temperature and Cleanliness Logs (improvement is needed)
- 3) Ensure Daily Cell Temperature and Cleanliness data is uploaded in the shared file;
- 4) SCDC QIRM continue to perform QI Studies regarding Correctional Staff performing daily, random cell temperatures and cleanliness inspections.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: SCDC continues to develop their formal quality management program under which segregation practices and conditions are reviewed.

November 2018 Implementation Panel Recommendations: Continue to develop the SCDC formal quality management program to review segregation practices and conditions.

2.c. Use of Force:

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

Per status update. The SCDC Division of Behavioral Health has completed the policy and is moving forward to implement procedures to review UOF involving inmates with a mental health designation. The IP has reviewed the policy and provided comments. The MH UOF Coordinator, Operations Administrative Regional Director and QIRM UOF Reviewers are working closely together and with the responsible IP member to address UOF issues.

QIRM UOF Reviewers report by institution: the number of uses of force, type of use of force, plan or unplanned, type of chemicals used, and use of force discrepancies that violate policy and

procedure. Disproportionate UOF involving inmates with mental health designation remains an issue.

November 2019 Implementation Panel Recommendations:

Continue:

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, Division of Mental Health 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. Finalize the revised UOF Policy and Procedure establishing the review of UOF incidents involving inmates with a mental health designation.
4. QIRM perform a QI Study regarding the Division of Behavioral Health reviewing UOF 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 November 2019 Assessment: substantial compliance (November 2019)

November 2019 Implementation Panel findings:

Per Status Update. SCDC has achieved compliance with the provision by full implementation of a plan requiring that all instruments of force, (e.g., chemical agents and restraint chairs) are employed in a manner fully consistent with manufacturer's instructions, and tracking such use in a way to enforce such compliance.

SCDC Operations Leadership and QIRM continues to address Chemical Agent MK9 use through additional oversight and training. Housing Unit Post Orders have been revised requiring Cover Teams to use MK-9 consistent with manufacturer's instructions. The revised Post Orders were submitted to the IP and approved.

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

QIRM UOF Reviewers completed assessments and began tracking the amount of time inmates remained in hard restraints and to determine if SCDC guidelines for hard restraint use were followed. A review of hard restraints since October 2018 identified a total of eight uses of hard restraint incidents at five SCDC institutions. Operations is in the process of creating a form to allow staff to effectively document observation when hard restraints are used.

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

November 2019 Implementation Panel Recommendations:

1. Operations, the MH UOF Coordinator and QIRM continue to review use of force incidents through the automated system to ensure instruments of force are fully consistent with the manufacturer's instructions;
2. Operations and QIRM continue tracking the amount of time inmates remained in hard restraints and restraint chairs. Perform assessments to determine if SCDC guidelines for hard restraint and the restraint chair were followed;
3. QIRM continue to meet with Operations leadership and the MH UOF Coordinator to discuss UOF and other relevant issues;
4. Required Staff complete Use of Force Training in Calendar Year 2019.

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

Implementation Panel November 2019 Assessment: substantial compliance (March 2018)

November 2019 Implementation Panel findings:

As per status update and 2.c.v. SCDC restraint chair and hard restraint use incidents are rare events with only two (2) restraint chair and eight (8) hard restraints incidents since October 2018.

QIRM reviews each reported restraint chair and hard restraints incident to determine, based on information provided, if staff adhered to policy guidelines. QIRM UOF Reviewers assess information to determine if the timeframe of placement in the restraint chair and hard restraints was indicated and if documentation indicated that use was implemented based on an established UOF continuum.

November 2019 Implementation Panel Recommendations:

QIRM continue to track and monitor compliance with use of the restraint chairs and hard restraints.

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

Implementation Panel November 2019 Assessment: substantial compliance (December 2017)

November 2019 Implementation Panel findings:

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

minutes and 1/2/19-143 minutes. For the January 2, 2019, incident, the length of time the inmate was placed in the restraint chair was outside policy guidelines.

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

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

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

November 2019 Implementation Panel Recommendations:

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

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: Per status update.

The IP continues to monitor SCDC Use of Force MINS Narratives monthly and identify incidents where there did not appear to be a reasonably perceived immediate threat that required a use of force. Headquarters Operations Leadership continues meetings with Institution Management staff where high numbers of problematic UOF incidents are identified to develop strategies to address inappropriate UOF. QIRM, Operations Leadership and the Behavioral Health UOF Coordinator regularly meet to discuss Agency UOF issues. The IP Use of Force Reviewer, QIRM UOF Reviewers, the Behavioral Health UOF Reviewer and SCDC Operations Leadership also continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force. Operations continues to provide training and assistance to their staff regarding UOF. The Agency staff has provided annual in-service UOF training to 1602 employees and is on track to ensure the majority of their required employees receive the annual in-service UOF training in the Calendar Year 2019.

A review of the CQI Division of Police study from October 2018 to December 2018 regarding referrals for excessive force and physical abuse has identified issues. It appears Police Services focuses on excessive force and physical abuse that reach to the level of criminal conduct and rarely

conduct administrative investigations for incidents referred for excessive force and physical abuse of inmates. The QIRM CQI Study recommended the Division of Police Services revise their tracking system to include: 1) nature of the referral and 2) who made the referrals. The revision will ensure the number and the type of referrals are easily identifiable and trackable. As reported to QIRM, Police Services staff reported that grievances and Use of Force System referrals are tracked; however, every phone call and email is not included in the tracking.

The Grievance Branch has revised the Inmate Grievance Disposition Codes to address the high number of inmate grievances coded as processed/returned. Inmate Grievance Coordinators and Inmate Grievance Administrators will use the revised codes to reflect the specific action taken on a grievance. Optimistically, the revised protocol enables the Inmate Grievance Branch to collect and report data that will more definitively describe how and why grievances are processed/returned.

Based on the number of UOF violations identified by responsible SCDC Officials and the responsible IP member, it is apparent the Agency needs to have independent staff, policies, procedures, and practices addressing administrative investigations of reported excessive force and physical abuse. QIRM identified 319 UOF violations from January 2019 through August 2019. Police Services focuses on UOF violations for possible criminal conduct and rarely conducts administrative UOF investigations. SCDC Leadership was receptive to developing an interim plan to perform administrative UOF investigations and budgeting additional staff and resources during the next budget year.

In September 2019, the Division of Behavioral Health began preparing a written report for all incidents involving UOF to prevent inmate self-injury. The initial written report for the August 2019 UOF MINS was forwarded to the responsible IP member for review and discussion. The planned procedure is to incorporate the monthly written report of all UOF incidents to prevent inmate self-injury in the conference call where the IP Member and SCDC discuss all monthly UOF MINS findings. The Division of Behavioral Health has not submitted their written report for September 2019 review of UOF MINS to prevent inmate self-injury.

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

Month	Year	Number of UOF MINS
October	2018	128
November	2018	101
December	2018	118
January	2019	102
February	2019	117
March	2019	112
April	2019	124
May	2019	122
June	2019	093
July	2019	095
August	2019	104
September	2019	097

For the last four (4) months UOF incidents are significantly lower than the 128 UOF incidents that occurred in October 2018.

The number of Police Services UOF investigations remains alarmingly low for a system that averages approximately 100 UOF incidents per month. QIRM UOF Reviewers continue to report a significant number UOF Policy violations finding 319 potential UOF violations from January 2019 through August 2019. This provides additional evidence the number of Police Services UOF investigations are low.

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

There have been no UOF incidents involving canines reported to the responsible IP Member during the relevant period to assess if there are any issues or concerns.

In an IP community meeting with Broad River CI Diversionary Housing Unit inmates, the inmates complained of being subjected to reported and unreported UOF that was excessive. The inmates alleged general excessive force and a specific date where excessive force was used by staff.

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

November 2019 Implementation Panel Recommendations:

1. Operations, the Behavior Health UOF Coordinator and QIRM continue to review use of force incidents utilizing the automated system to identify use of force violations;
2. QIRM, the Behavior Health UOF Coordinator and Operations leadership continue frequent meetings to discuss UOF and other relevant issues;
3. IP continue to review SCDC Use of Force reports and monthly Use of Force MINS Narratives and provide SCDC feedback;
4. The IP Use of Force Reviewer, QIRM, the Behavior Health UOF Coordinator and SCDC Operations Leadership continue to jointly review Monthly Use of Force MINS to discuss issues and attempt to reduce the inappropriate use of force;
5. QIRM and the Agency Grievance Coordinator continue to QI Inmate Grievances related to UOF and Physical Abuse;
6. QIRM QI incidents and grievances referred to Police Services related to UOF and Physical Abuse;
7. Revise the Police Services tracking system utilized to track UOF referrals for excessive force and physical abuse and document the reasons an investigation is not opened;
8. QIRM and Operations conduct a joint investigation into the Broad River CI DHU inmates' allegations they are being subjected to excessive force and report the findings to the IP. The investigation is to include specific incidents the inmates reported to the IP in the November 2019 Site Visit DHU Inmate Community Meeting.

9. SCDC develop an interim plan to perform administrative UOF investigations and budget additional staff and resources to perform administrative investigations for the next budget year.
10. Track formal and informal corrective action for employees identified committing UOF violations;
11. Require meaningful corrective action for employees found to have committed use of force violations;

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

Implementation Panel November 2019 Assessment: substantial compliance (November 2019)

November 2019 Implementation Panel findings: Per status update.

SCDC has been successful in addressing the misuse of MK9 and achieved compliance. Close monitoring, a significant improvement in reducing UOF incidents involving MK9 and a reduction in incidents where MK9 volumes used exceeded SCDC guidelines justifies compliance.

QIRM and Operations is closely monitoring Correctional Staff MK9 use. SCDC averaged less than ten (10) UOF incidents with MK9 per month from October 2018 through September 2019.

MK9 use was:

% of time MK9 identified being used within SCDC guidelines October 2018 through August 2019: Mean-69%.

% of time MK9 was used in volumes consistent with manufacturer instructions October 2018 through August 2019: Mean-75%

The majority of correctional staff has received UOF training for the calendar year. Housing Unit Post Orders as they pertain to *Cover Teams* were revised to qualify that MK-9 use will be consistent with manufacturer's instructions.

November 2019 Implementation Panel Recommendations:

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

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

Per the update Section. SCDC continues to struggle with documenting attempts to contact clinical counselors (QMHPs) to request their assistance prior to a planned use of force involving mentally ill inmates. SCDC data identifies attempts to contact clinical counselors (QMHPs) were only made 57.8 percent of the time (*Statistical Mean from June 2018 through August 2019*). There continue to be planned UOF incidents where Operations Staff document that a QMHP was contacted and Behavioral Health staff refute that contact was made.

November 2019 Implementation Panel Recommendations:

Remedy the above. Procedures need to be revised providing clear direction to Division of Behavioral Health and Division of Operations staff on their duties and responsibilities as it relates to notification of clinical counselors prior to a planned use of force. The revised procedures and practices need to include a remedy for the ongoing issue of Operations Staff reporting a QMHP was contacted and Behavioral Health Staff denying any contact. As identified in previous reports, additional training to Operations Supervisory and Behavior Staff on their duties and responsibilities in a planned use of force is needed. Employees must be held accountable when the required assistance from QMHPs is not requested prior to a planned UOF incident involving mentally ill inmates. When operations employees notify mental health staff of a planned UOF, the mental health staff must complete a face to face interaction to assist or document reasons the interaction was not completed.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

Per status update. The current SCDC training program for correctional officers concerning the appropriate methods of managing mentally ill inmates remains an 11-hour program for new correctional officers. Permanent correctional officers receive 4 hours annual training concerning the appropriate methods of managing mentally ill inmates. The revised training program was rolled out in October 2018. Per the SCDC Update, 77.2 percent of the required employees have received annual training concerning the appropriate methods of managing mentally ill inmates thus far for the Calendar Year 2019.

November 2019 Implementation Panel Recommendations:

- 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 2019; and
- Ensure the required SCDC employees complete the required Calendar Year 2019 training.

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

Implementation Panel November 2019 Assessment: substantial compliance (March 2017)

November 2019 Implementation Panel findings:

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

November 2019 Implementation Panel Recommendations:

Continue to produce and disseminate the monthly UOF Mentally Ill vs. Non-Mentally Ill Report.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings:

Per update. The MH UOF Coordinator is monitoring UOF incidents involving inmates with a mental health designation. A QI study was conducted and examined current placement (lock up, institution, program,) for inmates involved in 3 or more uses of force (*April 2019-June 2019*). Increased monitoring is planned with a revision of SCDC UOF policy specifying increased duties and responsibilities for Behavioral Health staff to review inmates with a mental health designation involved in UOF incidents. The revised SCDC UOF Policy Mental Health procedures have been revised and approved by the parties and are in the process of being implemented by SCDC.

November 2019 Implementation Panel Recommendations:

1. QIRM perform QI studies assessing the Department of Behavioral Health review of UOF incidents involving inmates with a mental health designation once the revised SCDC UOF Policy is finalized and implemented.
2. SCDC continue monitoring inmates with a mental health designation identified as high risk for use of force and repeat the High Risk UOF Case Study for the next relevant period.
3. Responsible officials continue to monitor inmates with a mental health designation involved in UOF incidents in RHU and recommend placement in a mental health residential program when appropriate, and track their status while awaiting placement.

3. Employment of enough trained mental health professionals:

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

Implementation Panel November 2019 Assessment: substantial compliance (November 2018)

November 2019 Implementation Panel findings: As per status update section.

November 2019 Implementation Panel Recommendations: Continue with advocacy efforts to obtain needed staffing allocations.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. It was unclear from the update whether the reasons for the partial compliance were staffing vacancies, scheduling issues, or something else.

November 2019 Implementation Panel Recommendations: Assess the causes of the partial compliance and devise a corrective course of action.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. We received updated data that indicated a 74.2% rate of compliance at the time of the site assessment.

November 2019 Implementation Panel Recommendations: Remedy the above.

3.e Require appropriate credentialing of mental health counselors;

Implementation Panel November 2019 Assessment: substantial compliance (March 2017)

November 2019 Implementation Panel findings: As per status update section Compliance continues.

November 2019 Implementation Panel Recommendations: Continue to monitor.

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

Implementation Panel November 2019 Assessment: substantial compliance (July 2018)

November 2019 Implementation Panel findings: As per status update section.

November 2019 Implementation Panel Recommendations: Continue to monitor.

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

Implementation Panel November 2019 Assessment: substantial compliance (July 2018)

November 2019 Implementation Panel findings: See 3.f.

November 2019 Implementation Panel Recommendations: See 3.f.

**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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. In addition, staff described significant issues with the electronic medical record in the context of orders, changing mental health classification levels and other “bugs.”

November 2019 Implementation Panel Recommendations:

1. Implement as per status update section.
2. Fix the “bugs” in the system.
3. Establish an electronic notification process for users to report suspected or actual system “bugs” or other problems.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section.

November 2019 Implementation Panel Recommendations: Compliance will be achieved when such reports described in the status update section are produced and reviewed by the IP.

4.a.ix. Quality management documents; and

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update. Improvement is noted.

November 2019 Implementation Panel recommendations: Compliance will be achieved after reports specific to offered structured and unstructured time for L2 and L1 inmates are produced.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. The capacity to track disciplinary records via the electronic record is absent.

November 2019 Implementation Panel Recommendations: Implement as per status update section.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: See 4.a.iv.

November 2019 Implementation Panel Recommendations: See 4.a.iv.

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

5.a. Improve the quality of MAR documentation;

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update.

November 2019 Implementation Panel Recommendations: Continue to advocate for needed resources as summarized above.

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

Implementation Panel November 2019 Assessment: noncompliance

November 2019 Implementation Panel findings: 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.

November 2019 Implementation Panel Recommendations: Remedy the nursing shortage.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: The pill line schedules at several facilities, especially the 2:30-3:30 a.m. ("morning") pill line and the 12 noon-2 p.m. ("evening" or "night")

pill call lines in some of the prisons for psychotropic medications are unreasonable and contra-therapeutic. These times for medication administration are not clinically indicated, contribute to inmate nonadherence to taking their medications, and appear to be solely based on staffing deficiencies. This provision borders on noncompliance if not corrected.

November 2019 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. The audit findings, although disappointing, are essential and should be a starting point for corrective actions and improvement. This provision is dangerously close to noncompliance such that full and robust support for the corrective action recommendations is very strongly recommended.

November 2019 Implementation Panel Recommendations: As per status update section and IP findings.

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 November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: Compliance is present re: all CSU cells being located in a healthcare setting. Due to custody staffing shortages, it was common for QMHP clinical contacts to not occur in the CSU settings with adequate confidentiality. CI cells in RHUs were a compromise by SCDC and plaintiffs, provided specific requirements for internal SCDC direct observations, timely transfers, and reporting and monitoring were provided. The above requirements, as well as others discussed onsite and in this report, demonstrate serious problems with this process. Other than CGCI and PCI, the average for inspections above is 29% completion which will place this provision in noncompliance if not corrected.

Broad River CI CSU

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

Our March and July 2018 findings included the following:

It was very common that CSU patients had been admitted following a self-harming event or suicide attempt which was later assessed to have been directly related to safety and security concerns or other custodial issues. Interventions within the CSU frequently involved a "therapeutic transfer" that was often only a temporary solution as evidenced by subsequent repeat CSU admissions within the next six months. Such interventions turned out to be temporary solutions due to resource issues at the

receiving institution that resulted in recommended interventions not being implemented.

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

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

Our November 2019 assessment remains unchanged from the above assessment.

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

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

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

Camille Graham CI CSU

During the morning of November 22, 2019, we briefly interviewed seven CSU inmates. The CSU did not have an assigned treatment team. CSU inmates were not routinely evaluated by a psychiatrist and, even when referred, were not seen in a timely manner. For example, one inmate interviewed was not seen by a psychiatrist until day 14 of her admission, and another inmate, who was in need of a medication evaluation, had not yet been seen by a psychiatrist, despite her current 15 days stay in the CSU.

Inmates described limited access to group therapy. None of the inmates received daily counseling, although they apparently were seen by a clinician briefly via rounds on a daily basis.

November 2019 Implementation Panel Recommendations:

1. Resolve the above issues.
2. All inmates admitted to the CSU should be evaluated by a psychiatrist within 24 hours or sooner when clinically indicated.
3. The CGCI CSU needs to be adequately staffed.
4. CSU inmates should be reviewed by the treatment team on at least a weekly basis and generally on a twice per week basis.
5. Provide requested data, information and analysis regarding ALL CI cells in RHU's or other non-healthcare settings.

6.b Prohibit any use for CI purposes of alternative spaces such as shower stalls, rec cages, holding cells, and interview booths;

Implementation Panel November 2019 Assessment: substantial compliance
(December 2017)

November 2019 Implementation Panel findings: As per status update section.

November 2019 Implementation Panel Recommendations: As per status update section.

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

Implementation Panel November 2019 Assessment: noncompliance

November 2019 Implementation Panel findings: As per status update section. SCDC appears to have recognized the under-reporting by some facilities and inadequate performance by others. For this to have gone on for months is problematic and appears to reflect supervisory and systemic issues of very serious concern.

November 2019 Implementation Panel Recommendations: As per status update section.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: Under this provision clean, suicide-resistant clothing should include necessary hygienic supports, such as sanitary napkins or other provisions for women in crisis during menstruation which were not adequately not provided during this monitoring period.

November 2019 Implementation Panel Recommendations: Continue to monitor reported corrective actions and ongoing very serious concerns.

6.e Increase access to showers for CI inmates;

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. CSU RHU inmates at CGCI were only being offered showers on a three times per week basis, in contrast to the Settlement Agreement's requirement of daily showers.

November 2019 Implementation Panel Recommendations: As per status update section. Remedy the above.

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

Implementation Panel November 2019 Assessment: noncompliance

November 2019 Implementation Panel findings: As per status update section. Access to confidential spaces continues to be problematic.

November 2019 Implementation Panel Recommendations: Remedy the above.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: As per status update section. See 2 b.vi.

November 2019 Implementation Panel Recommendations: As per status update section. See 2 b.vi.

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

Implementation Panel November 2019 Assessment: partial compliance

November 2019 Implementation Panel findings: The relevant QI processes continue to evolve in a very positive manner as summarized in the status update section.

November 2019 Implementation Panel Recommendations: As per status update section.

Conclusions and Recommendations

The Implementation Panel has expressed and reported our substantial concerns regarding the failure of SCDC to attain Substantial Compliance with the provisions and requirements of the Settlement Agreement through nearly four years of implementation. The IP recognizes and has supported the improvements in SCDC's meeting substantial compliance for several provisions and partial compliance in others, and will continue to provide technical assistance and consultation. The IP and SCDC administrative and clinical staff were deeply disappointed and very concerned to learn of unreported deficiencies and punitive practices at CGCI. Corrective actions were implemented by SCDC. The need for honest and transparent reporting of information and practices is essential for the success of any collaborative and monitoring process in providing and assuring

a competent and adequate mental health services delivery system. To fail to appropriately address these requirements is extremely problematic and contributes to inmates living with mental illness in the South Carolina Department of Corrections to continue to suffer harm including inappropriate housing and restrictions in Restricted Housing Units and other segregation units, lack of access to mental health care at all levels of care, inadequate assessments including suicide risk assessments and management, and inappropriate treatment services including medication management and out of cell therapeutic and basic services.

The IP has provided recommendations throughout this process, while onsite, via conference calls and through our reports, and much of what the IP has reported and recommended is consistent with the analyses by QIRM. We remain hopeful that with adequate resources and financial support, the SCDC leadership and clinical and operations staff will identify problematic areas and continue to strive for improvements in the conditions of confinement and the mental health services delivery system. Implementation of the recommendations by SCDC's staff, SCDC's consultants regarding mental health, suicide prevention and management, and classification, and the Implementation Panel will hopefully result in a comprehensive and adequate mental health services delivery system for all inmates living with mental illness in the SCDC.

Sincerely,

Raymond F. Patterson, MD

Implementation Panel Member

On behalf of himself and Emmitt Sparkman