UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina; 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	)	Civil Action No. 8:22-cv-01358-MGL-BM **PLAINTIFF DISABILITY RIGHTS SOUTH CAROLINA'S MOTION FOR INJUNCTIVE RELIEF**

Plaintiff Disability Rights South Carolina[1] ("Plaintiff" or "DRSC"), by and through its undersigned counsel, respectfully submits this Motion for Preliminary Injunctive Relief.

I. INTRODUCTION

For over a decade, rotating members of Richland County Council and county administrators failed to heed dire warnings of emergencies at the Alvin S. Glenn Detention Center ("ASGDC") due to critical staffing shortages, physical plant failures, uncontrolled detainee violence, and the unmet need for a therapeutic environment and services for detainees with serious mental illnesses ("SMI Detainees"). The confluence of these severe operating deficiencies has created an environment that, notwithstanding Defendant's representations of attempting to mitigate, continues to subject SMI Detainees to a substantial risk of serious harm in violation of their constitutional rights.

Since the filing of this litigation, Defendant has insisted that it has made substantive changes to its practices and the physical facility to fix the constitutional violations detailed in the pleadings. However, through recently produced discovery along with observations at the Expert

[1] Because a class has not yet been certified in this matter, Plaintiff DRSC files this motion on behalf of the individual interests of SMI Detainees.

Site Inspection in January 2024, Plaintiffs have confirmed that the constitutional infirmities detailed in the Complaint and Amended Complaint are ongoing, emergent, and necessitate court intervention. As such, Plaintiff DRSC asks the Court to grant injunctive relief preliminarily to protect the rights and wellbeing of SMI Detainees while the parties continue to litigate the merits of their claims.

II. LEGAL ANALYSIS

A. Preliminary Injunction Standard

A court should grant a motion for preliminary injunction where the movant shows "[1] that he is likely to succeed on the merits, [2] that he is likely to suffer irreparable harm in the absence of preliminary relief, [3] that the balance of the equities tips in his favor, and [4] that an injunction is in the public interest." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

B. Plaintiff Can Show a High Likelihood of Success on the Merits

The Eighth Amendment prohibits cruel and unusual punishment, and requires prison officials to provide "humane conditions of confinement[,]" ensuring that "inmates receive adequate food, clothing, shelter, and medical care, and must take reasonable measures to guarantee the safety of inmates." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994). Importantly, the rights of pretrial detainees are "*at least* as great as the Eighth Amendment protections available to the convicted prisoner." *Martin v. Gentile*, 849 F.2d 863, 870 (4th Cir. 1988) (emphasis added). When a jail adopts policies or practices "incompatible with the concept of human dignity," the "courts have a responsibility to remedy the resulting [constitutional] violation." *Brown v. Plata*, 563 U.S. 493, 511 (2011).

The Due Process Clause guarantees that a pretrial detainee will be "free from punishment before his guilt is adjudicated" *Tate v. Parks*, 791 Fed. App'x 387, 390 (4th Cir. 2019). The Court of Appeals for the Fourth Circuit recently confirmed the objective standard for deliberate

indifference applies to pretrial detainees' Fourteenth Amendment claims. *Short v. Hartman*, 87 F.4th 593 (4th Cir. 2023). Accordingly, pretrial detainees meet their burden on the "purely objective basis" that the challenged governmental action is not "rationally related to a legitimate governmental purpose" or is "excessive in relation to that purpose." *Id.* at 611 (quoting *Kingsley v. Hendrickson*, 576 U.S. 389, 398 (2015). The standard for each of the constitutional violations alleged herein[2] requires pretrial detainees to show: (1) the existence of a condition that posed a substantial risk of serious harm; (2) defendant intentionally, knowingly, or recklessly acted or failed to act to appropriately address the risk that the condition posed; (3) defendant knew or should have known (a) that the detainee had the condition and (b) that the defendant's action or inaction posed an unjustifiably high risk of harm; and (4) as a result, the detainee was harmed. *Short*, 87 F.4th at 611. Stated differently, Plaintiffs must show that Defendant acted or failed to act "in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known." *Id.*

In this case, Plaintiff can show that Defendant is deliberately indifferent to the substantial risk of serious harm caused by its failure to provide necessary care to SMI Detainees with serious medical needs, its subjection of SMI Detainees to inhumane living conditions, and its failure to protect SMI Detainees from rampant violence.

1. Defendant's Failure to Provide Necessary Mental Health Servies Constitutes Unconstitutional Deliberate Indifference

The government is required to provide adequate care to meet the serious medical needs of incarcerated individuals. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976). There is no distinction between the right to medical care and the right to mental health care. *Bowring v. Godwin*, 551 F.2d

[2] *See Short*, 87 F.4th at 611 (deliberate indifferent to medical needs), *Anderson v. Patton*, No. 1:22-cv-515, 2024 U.S. Dist. LEXIS 80047 (M.D.N.C. May 2, 2024) (conditions); *Savage v. Jolley*, No. JRR-23-2056, 2024 U.S. Dist. LEXIS 84964 (D. Md. May 10, 2024) (failure to protect).

44, 47 (4th Cir. 1977); *see also DePaola v. Clarke*, 884 F.3d 481, 486 (4th Cir. 2018). This obligation remains even if it has contracted with a private party to provide medical care. *West v. Atkins*, 487 U.S. 42, 56 (1988); *Braggs v. Dunn*, 257 F. Supp. 3d 1171, 1188 (M.D. Ala. 2017). In actions challenging systemic health care deficiencies, deliberate indifference can be shown by proving there are such "systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care." *Baxley v. Jividen*, 508 F. Supp. 3d 28, 55 (S.D. W. Va. 2020) (quotation omitted). Plaintiff can successfully show systemwide deficiencies in the provision of mental health care at ASGDC that, taken as a whole, subject mentally ill detainees to substantial risk of serious harm and cause the delivery of care to detainees to fall below the evolving standards of decency that mark the progress of a maturing society.

i. Defendant's Longstanding Failure to Provide Adequate Mental Health Services

a. SMI Detainees have Serious Medical Needs

Plaintiff DRSC brings this action in a representative and associational capacity on behalf of SMI Detainees. There is no dispute that SMI Detainees have serious mental health needs. A medical need is serious if it "has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Iko v. Shreve*, 535 F.3d 225, 241 (4th Cir. 2008). "Serious mental illness" is a term of art used in the field of psychiatry which refers to "a subset of particularly disabling conditions . . . defined by the diagnosis, duration, and severity of the symptoms." *Braggs v. Dunn*, 257 F. Supp. 3d at 1246; (*see also* **Ex. 1**, Proposed Consent Decree to Resolve DOJ Investigation of Hampton Rds. Reg'l Jail, ¶ 18 (defining SMI)).

As defined in the Second Amended Complaint, SMI Detainees are individuals who, at any time since April 28, 2022, have been or will be confined at ASGDC and who have been or will be:

(1) assigned to a "mental health" housing unit at ASGDC; (2) diagnosed by a psychiatrist or other licensed clinical mental health professional with certain mental illnesses; (3) diagnosed by a psychiatrist or other licensed clinical mental health professional with another mental disorder that has resulted in significant functional impairment (as defined therein); or (4) has been admitted to a licensed behavioral health or psychiatric hospital. (Dkt. No. 99, at ¶ 33.) Based on this definition, SMI Detainees must have a psychiatric diagnosis, a history of psychiatric admission, or sufficient indicia of mental illness to warrant a special housing assignment. Accordingly, SMI Detainees clearly have a serious need for mental health services during their detention.

b. SMI Detainees are Housed Throughout ASGDC in Large Numbers

While no exact count of individual with serious mental illness on the jail's mental health caseload has been identified, one thing is clear: It's a large number. They are present in every housing unit and every phase of the facility. Virtually anything that affects the operations of the jail affects them. During the January 2024 site inspection of Plaintiffs' subject matter experts ("Expert Site Inspection"), ASGDC Director Crayman Harvey informed one of the Plaintiff's experts that detainees with mental illness were being housed in virtually all housing units throughout the facility, comprising 60 to 70% of the population. (*See* **Ex. 2,** Ray Report at 36.) Similarly, Laurrinda Saxon-Ward, ASGDC site manager for mental health services, testified that 608 of the 960 detainees in the jail's custody during November 2023 received mental health services. (**Ex. 3**, Saxon-Ward Dep. at 134:8–10, 152:14–17.) Further evidencing the placement of SMI Detainees across ASGDC is the Mental Health Housing Activity Report prepared by the County's IT Department. (**Ex. 4**.) Importantly, a large percentage of those with mental illness qualify as seriously mentally ill. For example, in 2020, then-ASGDC Director Ronaldo Myers reported to Richland County Council that out of the 336 identified detainees with mental health needs 223 were seriously mentally ill. (**Ex. 5**, Myers Briefing at 3.)

c. Defendant Systematically Fails to Provide Necessary Treatment to SMI Detainees

Courts have identified certain minimally necessary components for a correctional facility's mental health program, including the provision of mental health services and treatment planning that involves more than segregation and close supervision of the mentally ill. *See, e.g.*, *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D. Tex. 1980) *aff'd in part and rev'd in part on other grounds*, 679 F.2d 1115 (5th Cir. 1982); *Coleman v. Wilson*, 912 F. Supp. 1282, 1298 n.10 (E.D. Cal. 1995); (*see also* **Ex. 6**, Johnson Report at 2–3 (setting forth essential elements).) In this case, Dr. Nicole Johnson, Plaintiff's forensic psychiatrist, who has served as an investigator for the Department of Justice and a consultant examining some of the largest jails in the nation, found significant deviations from the standards generally recognized and accepted in correctional facilities, including minimal to no behavioral health treatment, no therapeutic programming, and little to no differentiation in delivery of care or treatment planning. (*Id.* at 4–9.) Defendant's failure to address SMI Detainees' mental health needs is objectively unreasonable on a systemic level.

i. Inadequate Treatment

Importantly, correctional facilities must provide not only psychotropic medication but also appropriate psychotherapy or counseling to detainees who need it to treat their serious mental health needs. *See Braggs v. Dunn*, 257 F. Supp. 3d at 1190 n.11 (crediting expert testimony that "treatment of serious mental illnesses requires, *at a minimum*, multidisciplinary efforts to coordinate and implement interventions, including psychotherapy or counseling, psychotropic medications, and monitoring for signs of decompensation or progress."). "Minimal and triage-based services" are not sufficient. *Braggs v. Dunn*, 257 F. Supp. 3d at 1197; *see also Jensen v. Shinn*, 609 F. Supp. 3d 789, 853 (D. Ariz. 2022) (discussing inadequacy of "drive-by mental health encounters"). This means Defendant must make available a range of mental health services to provide when and if such services are needed by SMI Detainees.

Defendant does not provide constitutionally required care to SMI Detainees. This is made clear by detainee medical records, as well as testimony of ACH staff. Site Manager Saxon-Ward was unequivocal in describing what she directs her clinicians to do, stating that "I don't expect my clinicians to sit down and have a one to one with the patients." (Saxon-Ward Dep. at 240:9–11.) She further testified that they do "crisis management," not individual therapy, because "[t]here's no privacy, there's no safe zone or safe place for that to happen." (*Id.* at 91:15–17, 240:21–241:1.) In sharp contrast to the non-therapeutic services at ASGDC, Ms. Saxon-Ward discussed her extensive experience with individual counseling programs at the South Carolina Department of Mental Health, which incorporated a broad range of therapeutic models based on individual patient needs. (*Id.* at 13:11–15:25.) In explaining the distinction between crisis management provided at ASGDC and individual therapy, Ms. Saxon-Ward observed that "[i]ndividual counseling, it gives you privacy; it gives you a safe environment so you can express your feelings and thoughts without being judged or, you know, your privacy being violated. It's more intimate, you know, individual counseling." (*Id.* at 17:8–13.) The testimony of ACH clinician Judy Lassiter confirmed her experience with the limited treatment provided at ASGDC. (**Ex. 7**, Lassiter Dep. at 114:5–8.) ("Q. …And as you've said before, those sessions did not involve individual therapy, is that right? A. Correct.").)

Former ACH clinician Patti Green further corroborated Ms. Saxon-Ward's testimony that the available scope of mental services expressly excluded traditional therapeutic treatment modalities. Ms. Green was hired by ACH in July 2022 as discharge planner responsible for community coordination and referrals. (**Ex. 8,** Green Dep. at 12:13–25.) Ms. Green testified that she learned during her first day on the job that she was also expected to provide clinical mental health services to SMI Detainees. (*Id.* at 14:5–8.) Even though Ms. Green had no education,

experience, or training to perform psychotherapy (*id.* at 26:19–20, 27:5–8), it was immaterial to the services she provided to SMI Detainees because her supervisor, Ms. Saxon-Ward, told her ACH mental health staff do not provide therapy at ASGDC (*id.* at 27:11).

In limiting services to crisis management, Defendant withholds other vital and well recognized forms of treatment from SMI Detainees. For example, in her deposition, Ms. Saxon-Ward described that individual counseling could incorporate different kinds of therapeutic models depending on patient need, including, for example, cognitive behavioral therapy, trauma therapy, and life skills coaching. (**Ex. 3**, Saxon-Ward Dep. at 15:3–25.) An integrated system of mental health care "using a variety of mental health therapies, including biological, psychological, and social therapies" is imperative to the provision of necessary care in a correctional setting. (Johnson Report at 3.) Appropriate care mandates a "continuum of behavioral health programming," including group therapy, individual counseling, substance abuse treatment and medication. (*Id.*) ASGDC systematically fails to provide necessary treatment to SMI Detainees.

Because ASGDC does not do formal treatment plans for SMI Detainees, there cannot be individualized treatment. (Johnson Report at 6 ("Without individualization, everyone is treated the same and that is NOT treatment.").) Treatment planning is necessary for the provision of minimally adequate care because mental health treatment cannot begin unless providers are aware of who needs treatment and for what. *Braggs v. Dunn*, 257 F. Supp. 3d at 1201, 1206. As explained by SME Dr. Johnson, instead of being provided individualized treatment, SMI Detainees are provided the same services regardless of diagnosis and acuity. (Johnson Report at 5, 17.) In fact, as Dr. Johnson observed, it appears that the worse someone is in terms of the acuity of their mental illness, the less engagement is performed by the mental health clinicians. (*Id.* at 7.) Defendant also

systemically fails SMI Detainees by not determining what treatment is medically necessary through the development of treatment plans

ii. Inadequate Out-of-Cell Time

Defendant's practice of placing SMI Detainees in housing where they are locked in cells or pods for more 23 or more hours a day ("Restricted Housing") without providing adequate time out of their cells amounts to categorically prohibited punishment. Detainees with serious mental illness do not receive minimally adequate care when they spend "months in administrative segregation" with "harsh and isolated conditions" and "limited mental health services." *Brown v. Plata*, 563 U.S. at 503–04. Regardless of where SMI Detainees are housed or why, they must be provided adequate opportunity for out-of-cell time weekly. *See, e.g.*, *Georgia Advocacy Office v. Jackson*, No. 1:19-CV-1634-WMR-JFK, 2019 U.S. Dist. LEXIS 238805, *49–50 (N.D. Ga. Sept. 23, 2019); *Shorter v. Baca*, 895 F.3d 1176, 1185–86 (9th Cir. 2018).

As SME Dr. Johnson explains, "[b]oth unstructured and structured therapeutic interventions are necessary medical treatments for this population to help decrease the risk that behaviors related to their mental illness will put them at risk of violating the rules of the facility resulting in ongoing restrictions." (Johnson Report at 12.) Structured programming consists of planned therapeutic out-of-cell activities, which can include group therapy, individual skills sessions, and certain recreational activities. (*Id.* at 11–12.) ASGDC currently provides no structured out-of-cell programming because it does not provide any social or psychosocial groups or individual treatment sessions. Unstructured programming can include time for shower, phone call to supports, visits with family and supports from the community, watching television or socializing with peers. (*Id.* at 11.) SMI Detainees are currently receiving approximately one hour

a day of unstructured time out-of-cell which is inadequate to assist with recovery.[3] (*Id.*) ASGDC must provide more than one hour a day of out of cell time to SMI Detainees, including both structured and unstructured activities.

iii. Inadequate Suicide Watch Practices

ASGDC's supervision of detainees at risk for suicide is facially deficient. Dr. Johnson's review of ASGDC's own suicide watch logs showed that there were hours unaccounted for and watches were done in exact intervals or done in longer intervals than required—in dereliction of ASGDC policy and accepted standards of care. (Johnson Report at 10 (detailing specific examples).) Further, SMI Detainees on suicide watch are not consulted with in a private, confidential therapeutic setting, which renders any assessment of those individuals questionable at best. (*Id.* at 9.) The substantial deviation here constitutes a systemic practice of constitutional violation. As discussed below, such deviations from the standard of care illustrate the deliberate indifference that creates a substantial, and at times fatal, risk of harm to SMI Detainees.

ii. Defendant's Long-Standing Knowledge of Significant, Obvious Risk

As early as 2011, Richland County Council acknowledged the need for a dedicated mental health unit and services by appropriating millions of dollars for a facility expansion for this purpose. (*See* **Ex. 5**, Myers Briefing at 1; **Ex. 13**, Feb. 18, 2020 Meeting Minutes at 1.) In 2013, Defendant commissioned a management operations study by Pulitzer/Bogard Associates, LLC which found that ASGDC did not have "sufficient and appropriate beds" to accommodate detainees with serious mental illness, advising that its efforts to "make do" through patch work measures were having "deleterious effects" on vulnerable detainee populations.[4] (**Ex. 14**, 2014

[3](*See, e.g.*, **Ex. 9**, CR2 Decl. at 2; **Ex. 10**, CR12 Decl. at 1; **Ex. 11**, CR18 Decl. at 2; **Ex. 12**, CR19 Decl. at 4.)

[4] Notably, this study followed a 2008 assessment commissioned encompassing multiple dimensions, with particular emphasis on critical staffing shortages. (*See* Ray Report at 16.)

Management Study at 97.) In 2016, not prepared to act based on the findings of the earlier study, Defendant commissioned yet another assessment, this time by Carter Gable Associates, LLC. (**Ex. 15**, 2016 Needs Assessment.) The 2016 Needs Assessment found, as had the 2014 Management Study, that Defendant was failing to meet the needs of detainees with mental illness in part because of inappropriate housing. (*Id.* at 1-17.)

In 2020, more than three years later, Defendant still had taken no steps to mitigate the daily harm to which its vulnerable population are exposed. In a February 20, 2020 meeting of Defendant's Detention Center Ad Hoc Committee, then-ASGDC Director Ronaldo Myers submitted a briefing paper in which he made the case for the construction of a dedicated unit for the large population of SMI Detainees at ASGDC. (Feb. 18, 2020 Meeting Minutes at 2 (stating they were "attempting to build something more therapeutic[,]" where they could do group and individual therapy.).)

Even though Defendant was clearly on notice that it was systematically exposing SMI Detainees to harm, another two years passed before Defendant took any action whatsoever. Defendant's knowledge of the harm presented by not reasonably responding to SMI Detainees' need for mental health care is longstanding and well-documented.

iii. Defendant's Objectively Unreasonable Response to Substantial Risk of Harm

Importantly, Defendant cannot escape liability simply by attempting to show that they eventually took some form of "corrective action" in response to a risk of harm. *Lewis v. Cain*, No. 15-318-SDD-RLB, 2021 U.S. Dist. LEXIS 63293, *125 (M.D. La. Nov. 6, 2023) (citing *Bradley v. Puckett*, 157 F.3d 1022, 1026 (5th Cir. 1998)). "Efforts to correct systemic deficiencies that 'simply do not go far enough,' when weighed against the risk of harm, also constitute deliberate indifference," because such insufficient efforts are not "reasonable measures to abate" the known risk of harm. *Id.* at *125–26 (citing *Laube v. Haley*, 234 F. Supp. 2d 1227, 1251 (M.D. Ala. 2002)).

Prior to the filing of this lawsuit, Defendant had not taken any reasonable steps to mitigate the substantial risk of harm to SMI Detainees in its custody, as evidenced by the numerous warnings discussed above. Since this suit was filed, and to their credit, ASGDC and county officials have presented ideas and plans for addressing the woefully inadequate treatment of mentally ill detainees. However, the longstanding nature of these deficiencies, the substantial notice to Defendant, and the ongoing and current harm make clear that such ideas, without meaningful progress, are surface level attempts to evade liability for ongoing constitutional harm.

On November 17, 2022, then-Interim Director Crayman Harvey announced the "historic closing" of the special housing unit. (**Ex. 16**, Crayman Harvey Email.) The occasion for self-congratulations was, however, misguided and illusory. As Defendant's own advisors have explained for more than a decade, the principal purpose in designating a discrete mental health unit is to create a "therapeutic environment" for SMI detainees, not to merely segregate them from the general population. (*See, e.g.*, **Ex. 5**, Agenda Briefing at 3, Attachment 5 at 1-17.) This is also the constitutional standard. *Wyatt v. Aderholt*, 503 F.2d 1305, 1309 n.4 (5th Cir. 1974) (without out-of-cell time and effective treatment, housing severely mentally ill prisoners in a mental-health unit is tantamount to "warehousing" the mentally ill).

Although ASGDC purports to have created specialized mental health units, it does not provide mental health programming *even in the so-called mental health unit*. (*See* Johnson Report at 8 ("no groups conducted to help them learn about their medications, appropriate social skills, adequate hygiene care, emotional control like anger management, current events, etc.").) Merely creating new units to deposit mentally ill detainees to languish is not a reasonable response to systemic deficiencies in the provision of mental health services. The complete lack of therapeutic programming and treatment planning equates to unconstitutional warehousing of the mentally ill.

Defendant has not made any material changes to the mental health services it provides and SMI Detainees, particularly those in Restricted Housing for prolonged periods are at substantial risk of decompensating while detained at ASGDC without access to necessary mental health services.

iv. Ongoing, Substantial Risk of Harm to SMI Detainees

Inadequacies in mental health policies and practices, "alone and in combination, subject mentally ill prisoners to actual harm and a substantial risk of serious harm." *Braggs v. Dunn*, 257 F. Supp. 3d at 1193; *see also United States v. Hinds Cnty.*, No. 3:16-CV-489-CWR-RHWR, 2022 U.S. Dist. LEXIS 135504, at *9 (S.D. Miss. July 29, 2022) SMI Detainees suffer further harm and the continued substantial risk of harm caused by Defendant's practice of allowing them to languish in isolation without proper mental health care as evidenced by preventable deaths by suicide, exhibition of deteriorating behaviors, and symptoms of psychosis. For example, Dr. Johnson met with a detainee who presented as "actively psychotic and responding to internal stimuli, disorganized in her thought process and presentation, delusional, and combative." (Johnson Report at 7; *see also id.* ("Having active symptoms of a mental illness has been described as painful and miserable by individuals who have experienced symptoms[.]").) Despite these symptoms, Dr. Johnson's review of the medical records of this detainee and others showed almost identical treatment to detainees without such acute symptoms. (*Id.* at 8.)

Staff inattention and absence can and does have a fatal effect on incarcerated men and women in crisis. On March 2, 2024, the body of a grieving 20-year old woman was found in her cell hours after she pleaded with officers not to be put alone on lockup. (*See* **Ex. 17**, CR16 Decl. No. 1 at 2.) This young woman's death is a text-book case of foreseeable missed opportunities to save her life. At the time of her death, Jamila[5] had been incarcerated for three tempestuous days.

[5] Jamila is a pseudonym used to protect the privacy of this detainee and her family.

After her bond was denied, she was observed to be "very upset," crying and screaming because she could not attend her boyfriend's funeral. (*Id.* at 1; **Ex. 18**, CR17 Decl. at 2.) No officer was present in the unit to observe Jamila's outburst. Hours later, Jamila became involved in an altercation with a detainee who spit on her. Officers moved her to the female lock-down unit without consulting mental health professionals. Had they done so, they would have learned that Jamila had been placed on "observation" for nearly 10 hours at Intake, a status normally assigned to individuals at suicide risk. (**Ex. 19**, Mental Health Records at 7–9.) They also would have seen that during confinements at ASGDC in the preceding 18 months, Jamila had been assigned an MH-2 code, meaning "serious mental illness" on 3 occasions, and an MH-1 code, mild mental illness, at 2 other times. (*Id.* at 3–9.) Moreover, they would have learned that Jamila had been placed on suicide watch approximately 8 months earlier. (*Id.* at 7–8.) Despite these readily available warning signs, Jamila was moved to Juliet and, at 10:34 p.m., a nurse discovered her body hanging from a sheet wrapped around her neck and tied through broken light fixture in the ceiling. (**Ex. 20**, Incident Report.)

As evidenced generally and specifically herein, the substantial risk of harm caused to SMI Detainees from Defendant's longstanding deficiencies in mental health services is obvious and known to Defendant, who has failed to reasonably respond to the risk, leaving SMI Detainees to deteriorate and die in its custody. Plaintiff can clearly show a high likelihood of success on the merits of this claim.

2. Inhumane Living Conditions at ASGDC Deprive SMI Detainees of Minimal Civilized Measures of Life's Necessities

The Constitution does not permit inhumane living conditions for incarcerated men and women. *Farmer v. Brennan*, 511 U.S. at 832. Correctional officials must furnish prisoners with "the minimal civilized measure of life's necessities." *Rhodes v. Chapman*, 452 U.S. 337, 349

(1981). Such necessities include access to working toilets, drinking water, lights, sanitary products, and safe and sanitary living quarters. *Manon v. Hall*, No. 3:14-CV-1510, 2015 U.S. Dist. LEXIS 163812, at *15 (D. Conn. Dec. 7, 2015) (citing *LaReau v. MacDougall*, 473 F.2d 974, 977–79 (2d Cir. 1972)) ("It cannot seriously be disputed that access to a functioning toilet constitutes a basic human need."); *Keenan v. Hall*, 83 F.3d 1083, 1090 (9th Cir. 1996) (quotations omitted) ("Adequate lighting is one of the fundamental attributes of 'adequate shelter' required by the Eighth Amendment.").

i. Defendant Houses SMI Detainees in Cells Without Access to Basic Necessities

Defendant deprives SMI Detainees of life necessities including ready access to drinking water, personal hygiene, toilets, sinks, and showers, privacy for bodily functions, light, and recreation as well as protection from fire, electrical shock, vermin, mold, and human waste. Such conditions serve no legitimate correctional purpose and are "so far beyond the pale of civilized standards that they would be unjustified even if they did serve some such purpose." *Palmigiano v. Garrahy*, 443 F. Supp. 956, 980 (D.R.I. 1977). Multiple independent examinations of the facility, as well as reports from staff and detainees, provide first-hand accounts of the unsanitary and unsafe conditions that place confined men and women in an environment that is uncivilized, degrading, and dangerous.

Having served for 10 years as Deputy Commissioner for the Mississippi Department of Corrections and—for over 30 years—as a consultant investigating and monitoring correctional institutions nationwide, Emmett Sparkman knows the complex and intricate systems necessary to protect incarcerated persons, security staff, and the public. (**Ex. 21**, Sparkman Report at 3–4.) At the Expert Site Inspection in January 2024, Mr. Sparkman observed serious sanitation and maintenance deficiencies in cells where detainees were left to languish without access to drinking

water, and staff were absent for hours, at times for entire shifts. (*Id.* at 16.) With regard to ASGDC's physical plant and environmental health, Mr. Sparkman found that the housing conditions "observed during the on-site inspections are deplorable with housing units that fail to meet basic living standards." (*Id.* at 6.) Mr. Sparkman concluded that "[a]llowing these conditions in any living and working environment is unacceptable and unconscionable." (*Id.* at 16.)

Defendant's records also document years of a practice of housing detainees in units that are unfit for human habitation. Housing detainees, and SMI Detainees specifically, in single cells without working toilets or open cells with an insufficient ratio of working toilets to detainees is a clear deprivation of a basic human need. The testimony of detainees is even more telling. Locked in cells for hours on end with no officer present in their units, detainees have endured frequent and prolonged periods when they were not released to relieve themselves. (*See, e.g.*, **Ex. 9**, CR2 Decl. at 2 ("Some days they don't let us out at all.").) Under such dire circumstances, these men and women have been forced to humiliate themselves by urinating in their sinks and defecating in the cardboard containers in which their meals are served. (*See, e.g.*, *id.* at 3 ("I have had to poop in a tray because the officer on duty wouldn't let me out to use the restroom."); (**Ex. 10**, CR12 Decl. at 3 (reporting having in defecate into a Styrofoam container and urinate into a sink").) Forcing SMI Detainees to defecate into cardboard and urinate into sinks is inexcusable.

The same is true for clean and consistent drinking water. As stated by Plaintiffs' SME Sparkman, "[m]any cells do not have a service port which prevents other inmates out of their cells from delivering water and food to these inmates. The inmates are literally at the mercy of a staff member making an appearance in the housing unit to obtain water to survive." (Sparkman Report at 16.) Detainee declarations also detail extensive drinking water insecurity. (*See, e.g.*, **Ex. 18**, CR17 Decl. at 1 ("I haven't had enough water to drink since I arrived at the ASGDC [on December

31, 2023.]"); **Ex. 11,** CR18 Decl. at 2–7 (recording repeated instances of water insecurity); **Ex. 22**, CR16 Decl. No. 2 at 3–7 (describing numerous times where she reported felt dizzy, lightheaded, and saw spots the resulting impact on her blood pressure).)

The lack of lighting in units across ASGDC is also constitutionally deficient. The South Carolina Department of Corrections (SCDC) November 2023 Security Audit Report found ASGDC to be noncompliant with lighting requirements throughout the facility and in detainee cells.[6] (*See* **Ex. 23**, SCDC 2023 Security Audit Report Summary at 4.) This was confirmed during the January 2024 Expert Inspection, for example, when only 2 of the 56 cells in X-Ray had working light fixtures. (Sparkman Report at 25.) This is a Restricted Housing unit, meaning the female detainees in this unit, including those in administrative segregation because of their mental health diagnosis, are locked in cells for over 23 hours a day without access to light.

In addition to the failure to provide SMI Detainees with adequate access to usable toilets, drinking water, and lights, SMI Detainees live in units plagued with mold and infestations, standing water, and human waste. Based on his inspection, Dr. Ray found that: "The overall environment is poorly maintained, leading to unsanitary and unsafe conditions that expose SMI and non-SMI inmates and staff to pervasive risks of harm." (Ray Report at 57.)

The conditions detailed above are ongoing across the physical facility, as illustrated by the male detainee declarations attached as exhibits to this motion. (*See* **Ex. 9** CR2 Decl. at **2** (Hotel) (no running water, no working toilet, no lights, bare wires hanging from the ceiling); **Ex. 12**, CR19 Decl. at 2 (Golf) (flooding, lack of toilets, sinks, lights, flooding); *id.* (Papa) (only one working toilet, standing feces, forced to use trays as toilets).) Female detainees provide similar descriptions

[6] SCDC has statutory oversight of South Carolina's jails through annual inspections designed to ensure compliance with minimum standards. S.C. Code Ann. §§ 24-9-10, *et seq.*

of the horrible conditions. (**Ex. 24**, CR1 Decl. at 2 (rooms full of mold, feces, broken sinks and toilets); **Ex. 11**, CR18 Decl. at 2 ("They kept me in cell for 6 days, no running water in sink and toilet did not flush."); **Ex. 18**, CR17 Decl. at 1 ("feces was all in the toilet[,]" "toilet leaked, so every day my cell was flooded in a pool of water."); **Ex. 11**, CR18 Decl. at 3–8 (flooding and inoperable toilets in X-Ray and Juliet); **Ex. 22**, CR16 Decl. No. 2 at 10 (mold and mildew in Delta); **Ex. 25**, CR20 Decl. at 1 (same).) Disturbingly, female detainees are not provided with necessary feminine hygiene products. (*See, e.g.*, **Ex. 18**, CR17 Decl. at 1; **Ex. 26**, CR21 Decl. at 2.) These conditions are subhuman and constitutionally deficient.

ii. Defendant's Long-Standing Awareness of Substantial Risk is Well-Documented

"A prison official's subjective actual knowledge can be proven through circumstantial evidence," *Makdessi v. Fields*, 789 F.3d 126, 133 (4th Cir. 2015), which may be inferred "from the fact that the risk of harm is obvious," *Hope v. Pelzer*, 536 U.S. 730, 738 (2002), such that no official "could not have failed to know of it." *Brice v. Virginia Beach Corr. Ctr.*, 58 F.3d 101, 105 (4th Cir. 1995). Defendants therefore cannot "simply bury their heads in the sand and thereby skirt liability," *Makdessi*, 789 F.3d at 133, by "hid[ing] behind an excuse that [they were] unaware of a risk." *Brice*, 58 F.3d at 105. Defendant's evidence provides indisputable proof that Defendant has longstanding, pervasive, well-documented, and expressly noted knowledge of the substantial risk to detainees living in these subhuman conditions.

In 2021, a document memorializing a "town hall" meeting with Richland County Administrator Leonardo Brown and ASGDC employees identified horrible work conditions, filthy facilities, rooms in one housing unit with what "look[ed] like feces growing out of toilet", mice running through units, mold and puddles of water, delays in fixing broken light fixtures, and staff flushing toilets manually with buckets of water. (**Ex. 27**, Town Hall Meeting Notes at 1.)

In August 2022, recently appointed ASGDC Director Tyrell Cato reported progress on the considerable infrastructure problems he had inherited. (**Ex. 28**, 2022 Cato Status Report.)

On January 23, 2023, in correspondence to Richland County Council Chairperson Overture Walker regarding its October 24, 2022, site inspection, SCDC Division Director of Compliance, Standards, and Inspections Blake Taylor stated: "It shall come as no surprise to you that the conditions at your Detention Center are in need of immediate attention and improvement." (**Ex. 29**, Letter from Blake Taylor to Overture Walker, Jan. 23, 2023.) The "Narrative Report" identified 17 violations of the *Minimum Standards for Local Detention Facilities in South Carolina*. (**Ex. 30**, SCDC 2022 Inspection Report.) In contrast, in its inspections over the prior three years, ASGDC had been charged with no more than six violations of the *Minimum Standards*. (*See* **Exs. 31-33**, SCDC Inspection Reports for 2019, 2020, and 2021.) As such, the conditions at ASGDC are growing more dire, not less.

On July 26 and 27, 2023, SCDC returned to ASGDC to conduct a security and technical assistance audit, in which the security audit team identified numerous maintenance issues related to plumbing, electrical, and structural concerns. (**Ex. 23**, SCDC 2023 Security Audit Summary at 4–5.) The Report described "deplorable" conditions creating "a disgusting environment for individuals to live[,]" and commented that many of the issues identified were considered "Corrections Basic 101" that "should be obvious to the eyes of security personnel at all levels of experience." (*Id.* at 5.) The Report went on to "encourage the ASG administration to conduct a self-examination of their commitment to the operation of the facility, their employees, and the inmates for which they are responsible." (*Id.* at 6.)

In January 2024, over 18 months after the filing of this action and years after concerns about the physical plant were brought to Defendant's attention, a jail survey documented that more

than 100 toilets—approximately one-third of detainee toilets—in the facility's housing units were inoperable. (**Ex. 34**, Jan. 2024 Toilet Survey Emails.) Defendant's historic and current knowledge of the harm and substantial risk of harm cannot be genuinely denied.

iii. Defendant's Objectively Unreasonable Response Fails to Address Long-Standing Issues

The inhumane and unsafe living conditions discussed herein have existed for years and persist despite Defendant's knowledge and purported efforts to correct the deficiencies. Most recently, SCDC's November 2023 inspection revealed some progress towards improving the facility. However, SCDC still found 19 violations of the *Minimum Standards*. (**Ex. 35**, SCDC 2023 Inspection Report at 1.) The 19 violations were greater than the 17 found the prior year and included many of the same areas of non-compliance identified in the October 2022 Inspection **(Ex. 30**) and in the July 2023 Security Audit (**Ex. 23**), including issues related to light fixtures, toilets, and sinks. Again, Defendant continues its practice of housing SMI Detainees in cells that are non-compliant with the *Minimum Standards* and incompatible with human decency. Closing units for repair while ignoring the daily reality of people living in uninhabitable conditions is not a reasonable response. While Defendant may assert good intentions and steps taken towards future remedies, it is still liable for acts and omission within its control—here, not placing detainees in constitutionally unacceptable conditions.

iv. Defendant's Deliberate Indifferent Subjects SMI Detainees to Ongoing, Substantial Risk of Serious Harm

SMI Detainees housed in cells and dorms without access to drinking water, adequate toilets, and lighting are deprived of life's basic necessities in blatant violation of their constitutional rights. These conditions are inconsistent with the evolving standards of decency that mark the progress of a maturing society and contribute to their poor mental health overall. As Plaintiff's Expert Dr.

Johnson states in her report: "There is an overall lack of dignity and respect for individuals living in these conditions." (Johnson Report at 14.)

Plaintiff's Expert Dr. Ken Ray, a nationally recognized correctional and law enforcement professional who has completed over 50 evaluations of correctional operations in the United States and abroad, found that ASGDC "stands out as particularly hazardous and inappropriate for the management and protections of inmates with Serious Mental Illness" based on his identification of "persistent, severe issues of critical shortages of adequate staffing, consistent lack of necessary mental health services for SMI inmates, and a history of poorly maintained and unsafe living conditions." (Ray Report at 76.) Dr. Ray concluded that "[i]ssues such as overcrowding, poor lighting, and exposure to hazardous materials are pervasive, falling short of accepted standards and posing severe health and safety risks to both SMI inmates and staff." (*Id.* at 75.)

Dr. Johnson observed that the conditions of confinement are significant to treatment of mentally ill detainees in that "[t]he deterioration of the environment in which an individual is confined can contribute to deterioration of mental health resulting in harm to the detainee and undermines the therapeutic milieu necessary to adequately treat the mentally ill." (Johnson Report at 12.) As a specific example of the compounding effects of substandard conditions of confinement, Dr. Johnson states that "lack of adequate drinking water for someone taking psychotropic medications is inhumane," explaining that such medications are "known to cause the sensation of dryness in many patients" and that "thirst, nasal passages and dry eyes are all symptoms of dehydration which can be attributed to many psychotropic medications." (*Id.* at 13.) Dr. Johnson characterizes as "dangerous" the jail's failure to supply sufficient supplies for water needed by detainees who are taking medications. (*Id.*)

Dr. Johnson also reports that psychotropic medications can cause difficulty with urination, constipation, and nausea. (Johnson Report at 13.) She explains that these conditions are embarrassing and not having consistent access to a private or semi-private working toilet can contribute to medication noncompliance resulting in further deterioration of mental illness. (*Id.* at 13.) Dr. Johnson also observed that the lack of sanitary napkins and tampons reported in detainee declarations was disturbing, stating that "[i]t is demoralizing to walk around in bloody clothes," and that feminine hygiene supplies should be readily accessible as needed. (*Id.* at 13.) Ultimately, Dr. Johnson found that the cumulative effect of "these unsanitary conditions make it difficult to ensure a therapeutic environment where treatment can be provided." (*Id.* at 14.)

The harm caused by Defendant's deprivation of basic humane living conditions is multifaceted. Initially, such deprivation violates detainees' constitutional right to be free from punishment. Compounding this initial harm, SMI Detainees exposed to such living conditions have a high risk of exacerbated symptomology and deterioration. (Johnson Report at 13.) Finally, because ASGDC exposes many SMI Detainees to these substandard conditions in restrictive housing, based on their diagnosis and for other reasons, they are subjected to these subhuman conditions for over 23 hours per day.

In sum, the totality of circumstances at ASGDC deprive SMI Detainees of the minimal measure of life's necessities. These detainees live in subhuman conditions that are patently inconsistent with modern standards of decency and result in punishment in violation of the Fourteenth Amendment. Further, Defendant's records establish its longstanding knowledge of such issues and the resulting harm, its unreasonably deficient response over several years, and further harm caused to SMI Detainees. Accordingly, Plaintiff can foreshadow a high likelihood of success on the merits of this claim.

3. Defendant's Failure to Protect SMI Detainees from Pervasive and Substantial Risk of Bodily Harm Constitutes Deliberate Indifference.

i. The Conditions at ASGDC Pose an Ongoing, Substantial Risk of Serious Harm

ASGDC conditions are unsafe by any objective measure. Under the Constitution, officials must take precautions to protect prisoners from violence, and are "not free to let the state of nature take its course." *Farmer*, 511 U.S. at 833. This means officials must have systems in place to ensure objectively reasonable levels of safety and supervision. *Tillery v. Owens*, 719 F. Supp. 1256, 1275 (W.D. Pa. 1989). In assessing whether a risk exists, "it does not matter whether the risk comes from a single source or other multiple sources, any more than it matters whether a prisoner faces an excessive risk of attack for reasons personal to him or because all prisoners in his situation face such a risk." *Farmer*, 511 U.S. at 843. To that end, jail officials must supervise prisoners by providing adequate numbers of qualified security staff and may not leave prisoner safety to the prisoners themselves. *See Hinds Cnty.*, No. 3:16-CV-489-CWR-RHWR, 2022 U.S. Dist. LEXIS 69057, at *53 (S.D. Miss. April 13, 2022) ("Sufficient staffing is essential for safeguarding detainees' constitutional right to protection from harm."); *see also United States v. Hinds Cnty.*, 2022 U.S. Dist. LEXIS 135504, at *11 (discussing widespread impact of understaffing).

For over a decade, Defendant has consistently demonstrated a pattern and practice of failing to maintain adequate staffing levels and to implement minimally adequate staffing practices at ASGDC. This persistent practice has directly compromised the ability to provide detainees with objectively reasonable and consistent monitoring, supervision, and care necessary to protect them from harm. (*See* Ray Report at 15–36.) The staffing deficiencies at ASGDC impact every facet of its operation. The system-wide impact of understaffing cannot be overstated. At ASGDC, lack of staffing causes situations where detention center staff fail to make housing unit security rounds for extended periods, officers are tasked with covering multiple units, inability to respond quickly to

medical and safety emergencies, inability to conduct searches and take other measures to control weapons and other contraband. (Sparkman Report at 58–60.) Overall, issues stemming from understaffing combine with other inadequate safety measures to create an environment permeated by violence and fear.

Expert review and analysis of more than 400 ASGDC shift rosters from 2020 to 2023 reveals a consistent pattern and persistent practice of Defendant's failure to adhere to minimum staffing guidelines. (Ray Report at 52–54.) Dr. Ray's analysis discloses 3,778 instances (42.3% of the shifts) during this period where staffing levels fell below the standard threshold of one officer on each unit. (*Id.* at 53.) The data further reveals that on 1,527 occasions housing units were not staffed at all, which accounts for 17.2% of the total shifts during the period. (*Id.*)

ASGDC's chronic shortage of security officers has caused the collapse of its direct supervision security model. The Constitution does not mandate direct supervision, but where, as here, "an institution is designed to operate as a direct supervision facility, direct supervision is the minimum constitutional requirement." *Hinds Cnty.*, No. 2022 U.S. Dist. LEXIS 69057, at *57. "Direct supervision" is a term of art used by corrections professionals and refers to a model for safely operating and supervising a correctional facility. *Hinds Cnty.*, 2022 U.S. Dist. LEXIS 69057, *54. The direct supervision method for supervising a correctional facility requires placing detention officers inside housing units, where such officers have continuous direct contact with prisoners and are not routinely separated from prisoners by physical barriers. *Id.* at *55 (crediting expert testimony that "direct supervision," as opposed to camera surveillance, "is the only practical way to run a jail.").

ASGDC housing units are designed for direct supervision of pretrial detainees by detention officers, meaning detention officers must be present 24-hours a day, 7 days a week. (*See generally*

Ex. 36 Post Orders.) Without them, the units become rudderless and dysfunctional. ASGDC policy also requires detention officers to conduct safety patrols or rounds by patrolling their assigned units every 30 minutes. (*See* Ray Report at 54.) ASGDC records, however, reveal that officers throughout the facility seldom perform the watch tours as expected. For the period in January 2024 examined by Dr. Ray, Defendant's own policy required detention officers to conduct approximately 1,176 rounds in each housing unit; however, fewer than 17% of the required rounds were conducted. (*Id.* at 55.) Of the rounds that were clocked, less than half (approximately 44.1%) of them met the 30-minute policy requirement. (*Id.* at 54–57.)

By operating unsupervised housing units, Defendant is forcing detainees to provide for their own safely and security as best as they can. Roving officers cannot detect or address violence or threats of violence that happen in their absence. Victims cannot report threats and assaults without considerable risk of further violence by perpetrators. Detainee victims understand that the detention officer will soon be gone again, the unit will be unguarded, and that they will once again be at the mercy of predators. (*See, e.g.*, **Ex. 37**, CR5 Decl. at 2; **Ex. 10**, CR12 Decl. at 2–3.)

As Defendant's security staff declined over the last three years to dangerously low levels, ASGDC records document a substantial increase in reported incidents of inmate-on-inmate violence, including assaults, stabbings, fights, and armed robberies. Dr. Ray's review found that the average number of Serious Incidents per month more than doubled from 17.5 in 2021 to 45.9 in 2023, an increase of 162.2%. (Ray Report at 40.) An examination of reported incidents of contraband reflects a similar growth pattern. The monthly average of contraband incidents increased from 10 in 2022 to 36 through July 2023. (*Id.* at 47.)

Plaintiff's subject matter experts have concluded that ASGDC is in crisis. Supervisors find their day filled with plugging staffing holes, helping the detention officers, and dealing with daily

crises. The critical staffing shortage set against the backdrop of increasing 911 call volumes indicates that each staff member faces significantly higher workloads, especially in handling critical situations. (*See, e.g.*, Ray Report at 73.)

ii. Defendant has Long-Standing Knowledge of the Threat to SMI Detainees

ASGDC lacks basic systems for ensuring detainee safety. These deficiencies are long-standing, and Defendant's awareness cannot genuinely be denied. In fact, these severe and chronic staffing problems have been thoroughly documented for over a decade. In studies Defendant commissioned in 2008 and again in 2014, Defendant's own consultants emphasized the urgent need to address extant, persistent, and pervasive staffing and operational deficiencies required to improve the care, custody, and management of inmates. In 2019, Richland County Interim Administrator Edward Gomeau presented a recruiting and retention project in response to what he called a "dangerous and importunate situation which demands prompt significant action to mitigate." (**Ex. 38**, ASGDC Recruiting & Retention Project at 2.) In July 2021, County Administrator Leonardo Brown conducted jail listening sessions during which staff identified numerous threats to safety, including staffing shortages. (*See* **Ex. 27**, 2021 Town Hall Meeting.)

In a February 2022 memorandum to the County Administrator, ASGDC Interim Director Shane Kitchen categorized the jail's shortage of detention office as a "crisis" that warranted a call to the National Guard to provide emergency staffing. (**Ex. 39**, Kitchen Memo.) On March 24, 2022, South Carolina's chief jail inspector at SCDC, Blake Taylor, stated in correspondence to Administrator Brown that "the low level of security staffing has created what must be labelled as a control and safety emergency." (**Ex. 40**, Blake Taylor March 24, 2022 Letter at 1.) Since that letter, ASGDC's ratio of security staff to detainees has only declined. (*See generally* Ray Report.) In April 2022, ASGDC's medical provider, Wellpath, chose not to renew its contract after its clearly communicated safety concerns were not addressed. (**Ex. 41**, Wellpath Communications.)

In June 2022, ASGDC's current healthcare provider, ACH, communicated to Defendant that ASGDC had a "degrading emergency staffing issue" that must be addressed immediately. (**Ex. 42**, ACH Email (detailing consequences of staffing deficiencies).) Yet, the emergency persists.

iii. Defendant's Response to Pervasive Issues is Objectively Unreasonable

Measures that are not reasonably calculated to provide safety from violence do not establish a reasonable response to the risk. *Riley v. Oik-Long*, 282 F.3d 592, 597 (8th Cir. 2002). If protective measures prove inadequate, failure to take additional measures may be evidence of deliberate indifference. *See Jensen v. Clarks*, 94 F.3d 1191, 1200 (8th Cir. 1996). "For over a decade, Richland County and ASGDC have consistently demonstrated a pattern and practice of failing to maintain adequate staffing levels and to implement minimally adequate staffing practices at ASGDC." (Ray Report at 15); *see Wilson v. S.C. Dep't of Corr.*, No. 0:19-2107-JFA-MGB, 2019 U.S. Dist. LEXIS 230568, at *67 (Nov. 25, 2019) (crediting expert's findings on impacts of severe understaffing).

SCDC's most recent inspection report shows Defendant's lack of progress in correcting enduring staffing deficiencies. (**Ex. 35**, SCDC 2023 Inspection Report.) Further evidencing the insufficient response, the South Carolina Association of Counties' staffing analysis conducted on October 26, 2023, found that ASGDC needs 294 certified detention officers. (**Ex. 43**, SCAC Staffing Analysis at 11.)[7] However, in the last 8 years, the actual number of certified security officers has ranged from 168 to the 88 noted in SCDC's November 30, 2023 Inspection Report. Given the nature and extent of the crisis and its duration, it is simply not possible to credit arguments that Defendant entertains a good faith belief that its efforts have been sufficient.

[7] Dr. Ray reviewed the October 2023 Staffing Assessment and concluded that, while it is a step in the right direction, the study overlooks many of factors that must be considered to accurately calculate correctional staffing levels. (Ray Report at 50–52.)

In fact, Defendant decreased authorized ASGDC security and custody staff from 301 positions in 2021 to 252 positions in 2022. (Ray Report at 50.) Dr. Ray found that "[t]he disparity between the rates of decrease in staff numbers versus inmate numbers known by [Defendant] at the time staffing reductions were approved raises serious concerns regarding the priority [Defendant] places on inmate protection, care and custody service." (*Id.* at 19.) Persistent failure to supervise detainees exacerbates violence and, accordingly, unconstitutional harm to detainees. Defendant has reduced staffing levels by 38.6% over a period of 6 years, from 264 officers in 2018 to 162 officers in 2023. (*Id.* at 19.) The detainee population skyrocketed to approximately 948 as of January 24, 2024 and is expected to continue to increase in the immediate future. (*See* **Ex. 44**, Harvey Jan. 16, 2024 Dep. at 234:16–235:12.)

In its March 15, 2024 response to SCDC's 2023 Inspection Report, ASGDC again stated plans to fix the issues sometime in the future, but failed to address the immediate need for direct supervision. (Sparkman Report at 91–97); *see Coleman v. Wilson*, 912 F. Supp. at 1318 ("Defendants are not free to disregard the constitutional rights of mentally ill inmates for three to four years."). Again, Defendant's purported efforts to correct systemic deficiencies "simply do not go far enough" when weighed against the substantial risk of harm. *Braggs v. Dunn*, 257 F. Supp. 3d at 1252 (such efforts are not "reasonable measures to abate" the identified substantial risk of serious harm). Defendant cannot continue to rely on patently ineffective gestures to sidestep liability for acts and omissions with its control.

iv. SMI Detainees at ASGDC Face Ongoing, Substantial Risk of Harm

According to 911 call data maintained by Richland County Emergency Medical Services, Fire Department, and Sheriff's Department, a total of 1,247 Serious Incidents[8] occurred at ASGDC

[8] Emergency response agencies categorize 911 call responses from P0 to P6. The P0 to P2 categories ("Serious Incidents") are assigned to the most critical incidents. (Ray Report at 65.)

from 2020 to 2023, including physical injuries and security and medical emergencies. (Ray Report at 68.) Notably, there was a 138% increase in Serious Incidents from 2020 to 2023. (*Id.*) In his report, Dr. Ray identifies a "concerning upward trajectory in grave risks and incidents" to which individuals with serious mental illness are exposed with alarming regularity. (*Id.* at 73.) Reports of inmate-on-inmate assaults with a weapon and stabbing/puncture incidents are staggering, with the former rising 1600% (from nonexistent to 16 instances) from 2020 to 2023 and the latter increasing 1800% (2 to 16 incidents) during the same period. (*Id.* at 73–74.) As Dr. Ray observes, "these figures are not mere numbers; they represent a clear and present escalation in violence and health-related emergencies that necessitated urgent and decisive action by Richland County officials to safeguard the wellbeing of SMI inmates." (*Id.* at 73.) Dr. Ray notes that the "staggering rise in call volume, juxtaposed with the falling staff numbers, underscores a significant rise in workload per staff member. The emerging picture is one that clearly evidences that existing staff faced and continue to face heightened pressures, raising important questions about Richland County's priorities and the degree to which it failed to recognize and reasonably address the growing urgency in potential and actual harm to SMI detainees." (*Id.* at 70.)

The ongoing risk of harm and daily fear is particularly detrimental to SMI Detainees. Dr. Johnson identified specific ways in which Defendant's failure to protect SMI Detainees threatens their mental health and places them at substantial risk of serious harm, including increased paranoia, sleep deprivation, and medication noncompliance. (Johnson Report at 12.) Testimony from individual detainees illustrates the daily fight for survival at ASGDC. On January 3, 2024, CR10 was stabbed 11 times during an armed robbery of his canteen property. (**Ex. 45**, CR10 Decl. at 3.) No officer was in the unit to prevent or to stop this assault or to call for assistance. (*Id.*) CR10 was bleeding heavily after the stabbings, but had to wait for nurses to conduct their med passes,

rather than rely on the designated security staff. (*Id.*) Similarly, in March 2024, after being awoken from sleep to three men with knives robbing him, Detainee CR12 was too frightened to go back to sleep, so he packed his belongings and stood at the unit's entrance door. (C12 Decl. at 2.) He waited three hours for a supervisor to arrive and begged to be moved to another housing unit. (*Id.*) His request to press charges were ignored was refused. (*Id.*)

In sum "[d]etainees depend on the jail systems for their very lives[,]" *Hinds Cnty.*, 2022 U.S. Dist. LEXIS 135504, at *13–14 (quotations omitted), and Defendant disregards this responsibility. Defendant's unjustifiably insufficient response to the dangerous threat of violence at ASGDC and the particular threat to SMI Detainees disregards the lives and health of SMI Detainees in its charge, causes substantial harm and risk of harm, and violates their Fourteenth Amendment rights.

4. Defendant Discriminates Against SMI Detainees in Violation of the ADA

Title II of the Americans with Disabilities Act provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Congress found that such protection is necessary to address pervasive discrimination in critical areas including "institutionalization." *Id.* § 12101(a)(2); *see Pa. Dep't of Corr. v. Yeskey*, 524 U.S. 206, 210 (1998) (quoting 42 U.S.C. § 12131 (1)(b)) (holding ADA applies to state prisons).

To establish a claim under Title II of the ADA, a plaintiff must show: (1) he has a disability; (2) he is otherwise qualified to receive the benefits of a public service, program, or activity; and (3) he was excluded from participation in or denied the benefits of such service, program, or activity, or otherwise discriminated against, on the basis of his disability. *Constantine v. Rectors & Visitors of George Mason Univ.*, 411 F.3d 474, 498 (4th Cir. 2005). "Unjustified isolation . . . is

properly regarded as discrimination based on disability." *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999).

First, SMI Detainees have disabilities that substantially limit one or more of their major life activities. As set forth above, SMI Detainees include individuals with clinically diagnosed mental illnesses including those that have resulted in significant functional impairment. (*See* Section II.B.1.i., *supra*.) This definition includes those with mental illnesses acknowledged by the ADA's regulations as impairments that "it should be easily concluded . . . will, at minimum, substantially impair the major life activity of 'brain function,' known to substantially limit brain activity, including major depressive disorder, bipolar disorder, post-traumatic stress disorder, traumatic brain injury." 28 CFR § 35.108(d)(2)(iii)(K). Further, the Second Amended Complaint identify individuals on whose behalf Plaintiff filed this action who have serious mental illnesses and histories of necessary mental health treatment, and Dr. Johnson's Expert Report sets forth case studies based on medical records and observations of SMI Detainees whose disabilities substantially limit their life activities. (Johnson Report at 7 (describing meetings with detainees who were "actively psychotic" and "actively delusional").) SMI Detainees also include those assigned to "mental health" housing by ASGDC or who have been admitted to a licensed behavioral health or psychiatric hospital, meaning they are regarded as being impaired by their disabilities by ASGDC or psychiatric professionals. As such, SMI Detainees have disabilities that trigger the protections of the ADA.

Second, as detainees at ASGDC, SMI Detainees who are not in Restrictive Housing for disciplinary infractions ordinarily would be deemed "qualified" to receive several hours per day of out-of-cell time and access to out-of-cell activities because being a person confined at ASGDC is the essential eligibility requirement for these programs and services. *See* 42 U.S.C. § 12131(2);

see also Ga. Advocacy Office, 2019 U.S. Dist. LEXIS 238805, at *36. Instead, SMI Detainees in restrictive housing are isolated for 23 hours per day. While in Restrictive Housing units, SMI Detainees are denied access to activities, resulting in a "predictable decline in mental functioning that results from prolonged solitary confinement of people who experience psychiatric disabilities." *Georgia Advocacy Office*, 2019 U.S. Dist. LEXIS 238805, at *36.

Third, Defendant denies such services to SMI Detainees because of their disabilities by placing SMI Detainees in Restrictive Housing units solely based on their disabilities and related symptoms. *See, e.g.*, *Shields v. Prince George's Cnty.*, No. GJH-15-1736, 2019 U.S. Dist. LEXIS 129529, at *44 (D. Md. Aug. 2, 2019); *Biselli v. Cnty. of Ventura*, No. CV 09-08694 CAS (Ex), 2012 U.S. Dist. LEXIS 79326, at *45 (C.D. Cal. June 4, 2012). Other than in the recently opened behavioral management unit, a housing unit for men only, there is no distinction in housing placement, conditions, or services between individuals placed in Restrictive Housing for disciplinary or maximum-security classification reasons and those placed in Restrictive Housing based on mental health diagnosis and associated symptoms. As such, ASGDC's policies and practices punish SMI Detainees and deny them services because of their disabilities in violation of the ADA.

C. SMI Detainees Will Continue to Suffer Irreparable Harm Absent Injunctive Relief

As set forth above, SMI Detainees will suffer immediate and irreparable harm without court intervention based on Defendant's practice of locking detainees in cells and housing units without access to running water, lights, and a sufficient number of working toilets, by locking detainees in units without direct supervision in violation of its own policies and despite known danger, in keeping SMI Detainees in locked down units without providing minimally required time out of cells and pods, and by failing to provide minimally adequate mental health services to SMI Detainees. When "the cumulative impact of the conditions of incarceration threatens the physical,

mental, and emotional health and well-being of the inmates and/or creates a probability of recidivism and future incarceration," the court must conclude that the conditions violate the Constitution. *Rhodes*, 452 U.S. at 364 (concurrence). As the evidence shows, these injuries and Defendant's knowledge and inaction are both longstanding and ongoing. Defendant's constitutionally deficient practices continue to present a substantial risk of serious harm to these detainees necessitating emergency intervention.

Moreover, because ASGDC has and continues to violate detainees' constitutional rights, the irreparable harm factor is clearly satisfied. *Leaders of a Beautiful Struggle v. Baltimore Police Dep't*, 2 F.4th 330, 346 (4th Cir. 2021) ("It has long been established that the loss of constitutional freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury.") (quotation omitted); *Thomas v. Bryant*, 614 F.3d 1288, 1322 (11th Cir. 2010) (No remedy at law will provide protection for unconstitutional condition of confinement in the future.).

Importantly, a trial in this matter is likely to take weeks. Scheduling and preparing for such a trial will take months. Based on the current scheduling order and the time necessary for the Court to issue an order in this factually complex matter, it is not inconceivable that a year could pass, during which time SMI Detainees will continue to suffer harm that cannot be remedied later. The fundamental constitutional guarantees of SMI Detainees are violated daily and a dire emergency exists for SMI Detainees at ASDGC that warrants court intervention.

D. The Risk of Harm to SMI Detainees Significantly Outweighs Any Harm to Defendant

The significant risk of harm to SMI Detainees far exceeds any harm Defendant will suffer if the injunction issues. SMI Detainees are suffering concrete and serious psychological harm that amounts to cruel and unusual punishment. They are subject to inhumane, unlivable conditions. Preventable deaths continue to occur because of Defendant's indifference to known constitutional

violations. Importantly, Defendant cannot be harmed by issuance of a preliminary injunction that prevents practices likely to be found unconstitutional. "If anything, the system is improved by such an injunction." *Leaders of a Beautiful Struggle*, 2 F.4th at 346. In this case, Defendant cannot argue it will be harmed by an injunction preventing further violations of SMI Detainees' constitutional rights. And, even if it could, the physical and emotional hardships to SMI Detainees are clear and not remediable once suffered. There is no comparable harm to Defendant.

E. Injunctive Relief Serves the Public Interest

Finally, an injunction will serve the public interest. SMI Detainees are members of the public. Their loved ones are members of the public. The public at large benefits from remedying egregious violations of constitutional rights. *Leaders of a Beautiful Struggle*, 2 F.4th at 346 ("It is well-established that the public interest favors protecting constitutional rights."). The public also has an interest in having SMI Detainees leave the jail reasonably healthy and with the capacity to hold productive jobs, or, at the very least, leave the jail alive and not completely deteriorated. *See, e.g.*, *C.P.M. v. D'Ilio*, 916 F. Supp. 415, 422 (D.N.J. 1996) ("no question that society has an interest in the rehabilitation and reassimilation of offenders into productive, employed, tax-paying citizens") (citing *Morrissey v. Brewer*, 408 U.S. 471, 484 (1972)). As such, the requested relief will benefit the public interest.

1. Scope of Relief under the Prison Litigation Reform Act

Under the PLRA, a court granting prospective relief must find "that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right." 18 U.S.C. § 3626(a)(1)(A). However, recognizing the extensive nature of the findings required, Congress provided a safe-harbor provision in the PLRA that permits a district court to enter a preliminary injunction and defer making those findings for up to 90 days. *See* 18 U.S.C. § 3626(a)(2). Thus,

the Court can grant the relief requested herein and order Defendant to submit a plan for meeting the requirements within a set timeframe. The precise method by which Defendant accomplishes these requirements should be left to Defendant. *See Lewis v. Casey*, 518 U.S. 343, 362 (1996) (explaining that correctional defendants should be given the first opportunity to correct their own constitutional violations). The Court cannot allow these constitutional violations to continue simply because a remedy would involve intrusion into the realm of correctional administration.

III. CONCLUSION AND REQUESTED RELIEF

For the foregoing reasons, Plaintiff respectfully requests emergency injunctive relief requiring Defendant to:

1. Provide therapeutic services necessary to treat the full range of medical needs of SMI Detainees;
2. Provide adequate structured and unstructured out-of-cell therapeutic activities for SMI Detainees in all Restricted Housing units;
3. Refrain from placing SMI Detainees in cells or pods without access to running water, working toilets, working light fixtures, clean and mildew-free showers with adequate hot and cold water, and access to feminine hygiene products; and
4. Refrain from placing SMI Detainees in housing units without direct supervision.

Respectfully submitted by:

s/

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ATTORNEYS FOR PLAINTIFFS

Columbia, South Carolina

July 22, 2024

Appendix I
Alvin S. Glenn Detention Center
Detainee
Identifier Codes

Detainee	Identifier Code	Associated Document
[redacted]	CR1	Ex.24 Declaration of [redacted]
[redacted]	CR2	Ex.9 Declaration of [redacted]
[redacted]	CR5	Ex. 37 Declaration of [redacted]
[redacted]	CR10	Ex. 45 Declaration of [redacted]
[redacted]	CR12	Ex. 10 Declaration of [redacted]
[redacted]	CR16	Ex. 17 Declaration of [redacted] Ex. 22 Declaration of
[redacted]	CR17	Ex. 18 Declaration of [redacted]
[redacted]	CR18	Ex. 11 Declaration of [redacted]
[redacted]	CR19	Ex. 12 Declaration of [redacted]
[redacted]	CR20	Ex. 25 Declaration of [redacted]
[redacted]	CR21	Ex.26 Declaration of [redacted]
[redacted]	Jamila	Ex. 19 Mental Health Intake (Jamila) Ex. 20 Incident Report (Jamila)

PLAINTIFF DISABILITY RIGHTS SOUTH CAROLINA'S
MOTION FOR INJUNCTIVE RELIEF

EXHIBIT LIST

EX NO.	DESCRIPTION
1	DOJ Consent Decree
2	Declaration of Kenneth A. Ray, DBH, MEd **(REDACTED)**
3	Excerpts from the Deposition of Laurrinda Saxon-Holmes dated January 2, 2024
4	Mental Health Housing Activity Report **(REDACTED)**
5	Myers Briefing
6	Declaration of Nicole R. Johnson, MD**(REDACTED)**
7	Excerpts from the Deposition of Judy Lassiter dated January 3, 2024
8	Excerpts from the Deposition of Patti Green dated April 29, 2024
9	Declaration of CR2 **(REDACTED)**
10	Declaration of CR12 **(REDACTED)**
11	Declaration of CR18 **(REDACTED)**
12	Declaration of CR19**(REDACTED)**
13	February 2020 Meeting Minutes
14	ASGDC Management and Operations Study dated April 18, 2014
15	ASGDC Needs Assessment Final Report dated October 2016
16	Crayman Harvey Email re closing SHU dated November 2022
17	First Declaration of CR16 **(REDACTED)**
18	Declaration of CR17 **(REDACTED)**
19	Mental Health Intake (Jamila) **(REDACTED)**
20	Incident Report (Jamila) **(REDACTED)**
21	Expert Witness Report of Emmit L. Sparkman **(REDACTED)**
22	Second Declaration of CR16 **(REDACTED)**
23	SCDC 2023 Security Audit
24	Declaration of CR1 **(REDACTED)**
25	Declaration of CR20 **(REDACTED)**
26	Declaration of CR21 **(REDACTED)**
27	Town Hall Meeting with County Administrator July 2021
28	Cato Status Report
29	Letter from Blake Taylor to Overture Walker dated January 23, 2023.
30	SCDC 2022 Site Inspection Report
31	SCDC 2019 Site Inspection Report
32	SCDC 2020 Site Inspection Report
33	SCDC 2021 Site Inspection Report
34	January 2024 Toilet Survey Emails
35	SCDC 2023 Site Inspection Report
36	Post Orders
37	Declaration of CR5 **(REDACTED)**

38	ASGDC and HRSD Recruiting and Retention Project 2020
39	Shane Kitchen Memorandum to Leonard Brown dated February 14, 2022
40	Blake Taylor letter dated March 24, 2022
41	Wellpath Communications
42	ACH Email
43	SCAC Staffing Analysis
44	Harvey Depo Excerpts
45	Declaration of CR10 **(REDACTED)**

EXHIBIT 1

AGREEMENT
TO RESOLVE THE DEPARTMENT OF JUSTICE'S INVESTIGATION OF HAMPTON ROADS REGIONAL JAIL

I. INTRODUCTION

1. This matter involves the medical and mental health care that the Hampton Roads Regional Jail Authority ("HRRJ" or "Jail" or "Regional Jail") provides to prisoners, HRRJ's use of restrictive housing for prisoners with serious mental illness ("SMI"), and HRRJ's provision of services, programs, and activities to prisoners with mental health disabilities.

2. In 2016, the United States initiated an investigation pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997, and Title II of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12131. The investigation focused on HRRJ's provision of medical and mental health care, its use of restrictive housing for prisoners who had mental illnesses, and its provision of access to services, programs, and activities to prisoners with mental health disabilities.

3. On December 19, 2018, the United States issued a CRIPA Notice to HRRJ, concluding that there is reasonable cause to believe that conditions at HRRJ violate the Eighth and Fourteenth Amendments of the U.S. Constitution through HRRJ's failure to provide adequate medical and mental health care to prisoners and its placement of prisoners with serious mental illness in restrictive housing for prolonged periods of time. The United States concluded that these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth and Fourteenth Amendments. The United States also determined there is reasonable cause to believe that HRRJ violates the ADA by denying prisoners with mental health disabilities access to services, programs, and activities because of their disabilities.

4. HRRJ and the United States ("the Parties") are committed to remedying the conditions identified in the CRIPA Notice and achieving compliance with Title II of the ADA. The purpose of this Agreement is to ensure the conditions at HRRJ respect the rights of prisoners confined there. By ensuring that the conditions at HRRJ meet the Jail's constitutional and statutory requirements, HRRJ will also provide for greater staff safety and promote public safety in the communities it serves. This Agreement has the following goals: (1) ensure that appropriate medical and mental health care are provided to prisoners at HRRJ; (2) ensure that restrictive housing is used appropriately with respect to prisoners with serious mental illnesses; and (3) ensure that prisoners with mental health disabilities are given non-discriminatory access to the Jail's services, programs, and activities.

5. In order to resolve the issues pending between the Parties without the expense, risks, delays, and uncertainties of litigation, the Parties agree to the terms of this Agreement as stated below. This Agreement resolves the United States' investigation of HRRJ's alleged constitutional and ADA violations. The Parties agree that this Agreement does not constitute an admission by Hampton Roads Regional Jail Authority of the truth of any of the conclusions contained in the United States' December 19, 2018 CRIPA Notice.

6. The Parties stipulate that this Agreement complies in all respects with the Prison Litigation Reform Act, 18 U.S.C. § 3626(a). The Parties stipulate that the requirements of this Agreement are narrowly drawn, extend no further than necessary to correct the violations of federal rights as alleged by the United States in its Complaint and CRIPA Notice, are the least intrusive means necessary to correct these alleged violations, and will not have an adverse impact on public safety or the operation of a criminal justice system. The Parties further stipulate that this Agreement is structured to ensure that it terminates upon HRRJ's showing that it has achieved durable

compliance and the injuries caused by the alleged violations identified in the CRIPA Notice have been fully remedied.

7. This Agreement is enforceable only by the Parties. No person or entity is intended to be a third-party beneficiary of the provisions of this Agreement for purposes of any civil, criminal, or administrative action. Accordingly, no person or entity may assert any claim or right as a beneficiary or protected class under this Agreement.

II. DEFINITIONS

8. **Effective Date** refers to the date when this Agreement is approved by the Court.

9. **Extraordinary Circumstances** refers to circumstances when a prisoner is too dangerous to be in any type of mental health unit and is characterized by recent and consistent acts of violence or consistent verbalization of violent intentions.

10. **Feeder Jails** refer to the five jails that comprise the Hampton Roads Regional Jail Board. At the time of Agreement execution, those jails are Newport News Jail, Hampton Jail, Norfolk City Jail, Portsmouth City Jail, and Chesapeake City Jail. If the Board adds or removes a jail, this definition will automatically include the addition or exclude the removal.

11. **Hampton Roads Regional Jail ("HRRJ") or "Jail" or "Regional Jail"** refers to all existing jail facilities operated by the Hampton Roads Regional Jail Authority, as well as any other facilities built, leased, or otherwise used to house the population committed to the Hampton Roads Regional Jail Authority.

12. **Implementation Plan** refers to a document that enumerates the tasks the Jail will undertake to fulfill its obligations under this Agreement and includes deadlines and responsible individuals for each task.

13. **Medical Provider** refers to a physician, physician assistant, or nurse practitioner.

14. **Mental Health Professional** refers to an individual with a minimum of a masters level education and training in social work; who has received instruction and supervision in identifying and interacting with individuals in need of mental health services; and who has earned 1,500 of the supervised hours required for a licensed clinical social worker within the previous three years. It may also refer to an individual working towards becoming a licensed professional counselor who has received instruction and supervision in identifying and interacting with individuals in need of mental health services and has earned 1,700 of the supervised hours required for a licensed professional counselor within the previous four years.

15. **Monitor** is an individual chosen by the Parties with expertise in correctional medical and mental health care. This individual will assess and report on whether the provisions of this Agreement have been implemented and provide technical assistance to the Jail as set forth in the Agreement.

16. **Qualified Mental Health Professional** refers to an individual with a minimum of a masters level education and training in psychiatry, psychology, social work, or psychiatric nursing; who has received instruction and supervision in identifying and interacting with individuals in need of mental health services; and is currently licensed by the Commonwealth of Virginia to deliver those mental health services he or she has undertaken to provide. For social workers, the

individual must be a licensed clinical social worker. For professional counselors, the individual must be a licensed professional counselor.

17. **Restrictive Housing** is the removal from the general prisoner population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another prisoner; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more.

18. **Serious Mental Illness ("SMI")** is a mental, behavioral, or emotional disorder of mood, thought, or anxiety that significantly impairs: judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life. Those disorders include, but are not limited to, Schizophrenia Spectrum Disorders, other Psychotic Disorders, Bipolar Related Disorders, and Major Depressive Disorders.

III. SUBSTANTIVE PROVISIONS

POLICIES AND PROCEDURES

19. **Policies and Procedures:** Within six months of the Effective Date, the Jail will consult with the Monitor to draft and/or revise policies and procedures to incorporate and align them with the provisions in this Agreement.

20. Within one year of the Effective Date, all policies and procedures that needed to be drafted and/or revised to incorporate and align them with the provisions in this Agreement will be adopted by the Jail. The Jail will consult with the Monitor to prioritize policies and procedures to accomplish the timeframes in this Agreement (e.g., Paragraph 100).

    a. Prior to adoption, the Jail will provide a copy of the policy or procedure to the United States for review, comment, and approval. The United States will not unreasonably refuse to approve submitted policies or procedures. The Jail will address all comments or make any changes requested by the United States within thirty (30) days after receiving the comments and resubmit the policies and procedures to the United States for review and approval.

21. No later than three months after the United States' approval of each policy and procedure (except as otherwise stated in the Agreement), the Jail will adopt and begin implementing the policy and procedure, which requires modifying all post orders, job descriptions, training materials, and performance evaluation instruments in a manner consistent with the policies and procedures.

22. Unless otherwise agreed to by the Parties, all new or revised policies and procedures that were changed or created to align with this Agreement will be fully implemented (including completing all staff training) within six months of the United States' approval of the policy or procedure (except as otherwise stated in the Agreement).

23. The Jail will annually review its policies and procedures, revising them as necessary. Any revisions to the policies and procedures will be submitted to the United States for approval in accordance with Paragraph 20.a above.

STAFFING PLAN

24. **Staffing Plan Development:** Within four months of the Effective Date, and annually thereafter, the Jail will submit to the Monitor and the United States a staffing plan for security, medical, and mental health staff adequate to achieve compliance with this Agreement on the timelines set out in this Agreement. Each staffing plan shall be subject to review and approval by the United States, which approval shall not be unreasonably withheld.

25. **Staffing Plan Implementation:** The Jail will staff the facility based on each staffing plan within one fiscal year of the completion of each staffing plan.

TRAINING

26. **Training:** The Jail will provide pre-service and annual in-service training, using competency-based adult learning techniques, to security, medical, and mental health staff on new policies, mental health care and suicide prevention, and de-escalation techniques.

27. Within six months of the Effective Date, the Jail will incorporate any relevant Agreement requirements and any recommendations from the Monitor into its annual training plan that indicates the type and length of training and a schedule indicating which staff will be trained at which times.

28. The annual in-service training will ensure that all current security, medical, and mental health staff are trained within six months after new policies have been approved by the United States, with all training completed no later than 18 months after the Effective Date. New staff will receive this training as part of pre-service training.

29. Training on mental health care, suicide prevention, and de-escalation techniques will be provided by trainers with contemporary evidence-based standards on these issues.

SECURITY

30. **Security Staffing:** The Jail will increase security staffing to ensure that there are sufficient staff to escort medical staff during pill pass and during any visits to prisoners in restrictive housing, escort prisoners to the medical clinics for their appointments, transport prisoners to outside medical appointments, and maintain security watch over hospitalized prisoners.

MEDICAL AND MENTAL HEALTH CARE

31. **Medical and Mental Health Prior Records:** The Jail will ensure that all reasonable efforts are made to obtain a prisoner's medical and mental health records from the most recent admission to the referring Feeder Jail, and when possible from other previous jail admissions or from community providers such as the Community Services Boards.

32. The Jail will ensure that medical and mental health records from a Feeder Jail are provided to the Regional Jail upon admission of the prisoner to the Regional Jail. The Regional Jail will ensure that pertinent information is incorporated into prisoners' medical and mental health charts.

33. **Continue Medications**: The Jail will ensure that prisoners entering the Jail continue to receive, without delay, prescribed medications or acceptable alternate medications, unless the Jail physician makes and documents an alternative clinical judgment.

34. **Medical or Mental Health Request/Sick Call Process:** The Jail will ensure that the sick call process provides prisoners with adequate access to medical and mental health care. This process will include:

    35. Collection: a confidential collection method in which designated staff members collect sick call requests every day to ensure they are triaged.

    36. Triage: a Registered Nurse, psychiatrically trained, triages the sick call requests based upon the seriousness of the medical or mental health issue as described below in Medical and Mental Health Assessments: Emergent; Urgent; or Routine. The Jail will ensure that medical or mental health requests submitted in the form of a grievance or through another mechanism are appropriately triaged, even if submitted through improper channels.

    37. Tracking: a logging and tracking system that includes the date the prisoner was examined and treated by the Medical Provider (which includes psychiatrists and psychiatric nurse practitioners) if it was clinically appropriate for the prisoner to be treated by a Medical Provider. This tracking will be regularly audited to ensure compliance with this process.

    38. Sick Call Oversight: a sick call oversight system, periodically reviewed by physicians, with nursing protocols and clinical assessment forms that guide the nurses performing sick call.

MEDICAL CARE

39. The Jail will provide constitutionally adequate medical care.

40. **Medical Staffing:** To meet the requirements of this Agreement and ensure that prisoners receive constitutionally adequate medical care, the Jail will increase medical staffing by hiring sufficient additional staff with appropriate credentials (*e.g.*, MDs, RNs, and LPNs) and increasing the hours that current staff with higher credentials are onsite on evenings and weekends.

41. **Medical Intake:** The Jail's medical intake may take place as part of the Jail's general initial intake screening. The Jail will ensure that the medical screening aspect is completed within four hours of admission, or as soon as practicable if there are a large number of prisoners being processed through intake, by a Registered Nurse in a confidential setting, fully documented and available to medical staff in each prisoner's file as soon as possible.

    42. Medical screening factors: The Jail will ensure that the Registered Nurse utilizes an appropriate medical intake screening instrument to identify and record observable and non-observable medical issues, and seek the prisoner's cooperation to provide information, regarding:

        a. medical, surgical, and mental health history, including current or recent medications;

b. current injuries, illnesses, evidence of trauma, and vital signs, including recent alcohol and substance use;

c. history of substance abuse and treatment;

d. substances ingested in the past 24 hours (drugs, alcohol, *etc.*);

e. pregnancy; and

f. history and symptoms of communicable disease.

43. **Medical Assessments:** In order to provide prisoners timely access to a physician as is clinically appropriate, the Jail will refer prisoners for medical assessments based on the results of the medical intake or sick call process set forth above and in accordance with the following:

44. Emergent Medical Assessments: The Medical Director and Director of Nursing will develop protocols identifying potentially life-threatening medical emergencies that require immediate consultation with a physician or immediate transfer to a hospital emergency room.

a. These protocols will include, but are not limited to: Hypertensive emergencies, Cardiac emergencies, Diabetic emergencies (Hyperglycemia and Hypoglycemia), Alcohol and Drug Overdose/Detoxification emergencies, Acute Severe Asthma, Status Epilepticus, and Acute Psychosis.

b. The Medical Director and Director of Nursing will develop nursing protocols to identify prisoners requiring these Emergent Medical Referrals.

45. Urgent Medical Assessments: A medical assessment will be provided by a Medical Provider within a working shift (which as of the Effective Date of this Agreement is 12 hours) for each prisoner whose medical intake or sick call process triggers the factors below. These prisoners must be placed in a setting with adequate monitoring pending the assessment, and the assessment itself will take place in the clinic.

a. The factors are: uncontrolled hypertension, uncontrolled diabetes mellitus, heart failure, poorly controlled epilepsy, poorly controlled asthma, alcohol and drug withdrawal, prisoners receiving dialysis, and prisoners with unstable psychiatric syndromes.

46. Routine Medical Assessments (Intake): For all other prisoners, the Jail will ensure that comprehensive health assessments of all prisoners are conducted within 14 calendar days of entering the facility, which will include a complete medical history, physical examination, current medications (amount, frequency and time of last dosage), mental health history, and current mental health status. The physical will be conducted by a Medical Provider or a Registered Nurse, as long as the Registered Nurse is trained on medical assessment intake by a physician and the medical record documenting the physical is reviewed and signed-off by a physician. Records documenting the assessment and results will become part of each prisoner's medical record.

47. Routine Medical Assessments (Sick Call): For all other prisoners, whose sick call process does not trigger an emergent or urgent response, but does require a medical assessment by a Medical Provider, that medical assessment shall take place within 72 hours of the sick call request.

48. **Acute Care:** The Jail will address serious acute medical needs of prisoners immediately upon notification by the prisoner or HRRJ staff, providing acute care for those prisoners by a Medical Provider.

49. **Chronic Care:** The Jail will ensure that prisoners with chronic conditions, including, but not limited to, HIV, hypertension, diabetes, asthma, and elevated blood lipids, are examined by a Medical Provider within 14 calendar days of admission, or sooner based on the Medical Intake, to evaluate the status of their health and the effectiveness of the medication administered for their chronic conditions.

50. Chronic Care Registry: The Jail will maintain a chronic care registry that identifies all prisoners receiving chronic care, the diagnosis, the date of their last visit with a physician, and the date of their next visit.

51. Chronic Care Plan of Care: The Jail will ensure that a Medical Provider develops a chronic care plan of care for each prisoner with a chronic condition at the time of the initial chronic care visit.

52. Chronic Care Protocol: Within 90 days of the Effective Date, the Medical Director will develop a chronic care protocol. The Jail will follow a chronic care protocol requiring Medical Providers to clinically evaluate prisoners regularly and a Chronic Care Coordinator to monitor chronic care prisoners regularly and order a follow-up visit based upon the prisoner's status at the time of the evaluation, but no later than 90 calendar days from the initial clinical evaluation. For example, each prisoner should be assessed, according to the protocol, as to whether his/her condition is "poor," "fair," or "good." If his/her condition is "poor" or "fair," then a follow-up visit should occur sooner than 90 calendar days as directed by the protocol.

53. **Medical Diagnoses:** The Jail will ensure that prisoners are provided with diagnoses for identified medical problems and problem lists are developed and updated in prisoners' medical charts.

54. **Medical Specialist Appointments:** The Jail will ensure timely medical specialist appointments, as outlined below, including those scheduled outside of the Jail.

55. Medical Specialist Registry: The Jail will maintain a specialty appointment registry that identifies all prisoners recommended for a specialist within or outside the Jail, the specialty to which they are being referred, the date of referral, whether the referral was approved or denied by the medical contractor, the date the appointment is scheduled to occur, and the date the appointment was completed. Urgent specialty consultations will occur within 14 calendar days and routine specialty consultations will occur within 45 calendar days, or as soon as the appointment is available beyond the 14 and 45 calendar day requirements. Any further requested follow-up appointments will be entered as new specialty requests on this registry. The medical director will review this registry on a weekly basis to ensure that delays in care are addressed promptly, with documented actions.

56. **Medical Follow-Up Care:** The Jail will ensure that prisoners who receive specialty, emergency room, or hospital care are examined and evaluated by a Registered Nurse upon their return to the Jail and that the Registered Nurse reviews all accompanying documentation available from the visit before the prisoner is returned to his/her housing unit. This review and the outside provider's documentation will be recorded in the prisoner's medical record, and appropriate follow-up, including referrals to a Medical Provider, will be scheduled.

57. **Medical Treatment Plans:** The Jail will develop and implement appropriate treatment plans that track active problems.

58. **Medical Treatment:** The Jail will ensure that prisoners receive treatment that adequately addresses their serious medical needs in a timely and appropriate manner.

MENTAL HEALTH CARE

59. The Jail will provide constitutionally adequate mental health care and suicide prevention practices.

60. **Mental Health Staffing:** To meet the requirements of this Agreement and ensure that prisoners receive constitutionally adequate mental health care, the Jail will increase mental health staffing by hiring sufficient additional staff with appropriate credentials, including psychiatrists, psychiatric nurse practitioners, and psychiatry support staff, and increasing the hours that current staff with higher credentials are onsite on evenings and weekends.

61. **Mental Health Intake:** The Jail's mental health intake may take place as part of the Jail's general initial intake screening. The Jail will ensure that the mental health screening aspect is completed within four hours of admission, or as soon as practicable if there are a large number of prisoners being processed through intake, by a Qualified Mental Health Professional to identify mental health issues, in a confidential setting. The mental health intake will be fully documented and available to mental health staff in each prisoner's file as soon as possible.

62. Mental health screening factors: The Jail will ensure that the Qualified Mental Health Professional utilizes an appropriate mental health intake screening instrument to identify and record observable and non-observable mental health issues, and seeks the prisoner's cooperation to provide information, regarding:

a. past suicidal ideation or attempt(s);

b. current suicidal ideation, threat, or plan;

c. history of mental illness and treatment, including medication and hospitalization;

d. recent significant loss such as the death of a family member or close friend;

e. history of suicidal behavior by family members or close friends;

f. suicide risk during any prior confinement;

g. any observations by the transporting officer, court, transferring agency, or similar individuals regarding the prisoner's potential suicidal risk or mental health;

h. substance(s) or medication(s) used, including the amount, time of last use, and history of use;

i. any physical observations, such as shaking, seizing, or hallucinating;

j. history of drug withdrawal symptoms, such as agitation, tremors, seizures, hallucinations, or delirium tremens; and

k. history or serious risk of delirium, depression, mania, or psychosis.

63. **Mental Health Assessments:** In order to provide prisoners timely access to a Qualified Mental Health Professional as is clinically appropriate, the Jail will refer prisoners for mental health assessments based on the results of the mental health intake or sick call process set forth above and in accordance with the following:

64. Emergent Mental Health Assessments: The Mental Health Director and lead psychiatrist will develop protocols identifying potentially life-threatening mental health emergencies that require immediate consultation with a Qualified Mental Health Professional or referrals to a Community Services Board for a Temporary Detention Order or transfer to a hospital emergency room.

a. These protocols will include, but are not limited to: prisoners who report any suicidal ideation or intent, or who attempt to harm themselves; prisoners about whom the transporting officer reports a threat or attempt to harm themselves; or prisoners who are so psychotic they are at imminent risk of harming themselves.

65. Urgent Mental Health Assessments: A mental health assessment will be provided by a Qualified Mental Health Professional within a working shift (which as of the Effective Date of this Agreement is 12 hours) for each prisoner whose mental health intake or sick call process includes one of the factors below. Note that on weekends, the timeframe may be within 16 hours to account for overnight. These prisoners will be placed in a setting with adequate monitoring pending the assessment and the assessment itself will take place in a private, confidential space.

a. signs and symptoms of acute mental illness;

b. disorientation/confusion;

c. inability to respond to basic requests or give basic information; or

d. suicide attempt within the past 30 days.

66. Routine Mental Health Assessments (Intake): A mental health assessment will be provided by a Mental Health Professional within 72 hours for each prisoner whose mental health intake includes one of the following factors:

a. a request to see mental health

b. jail history of placement on mental health units

c. past suicide attempt;

d. suicidal ideation, with intent or plan within the past 30 days; or

e. a combination of the following:

1. suicidal ideations within the past year, with or without intent or plan;
2. suicidal gestures within the last year;
3. a diagnosis of one or more of the following: bipolar disorder, major depression with or without psychotic features, schizophrenia, schizoaffective disorder, any diagnosis within the pervasive developmental disorder spectrum, and any other factor(s) contributing to suicide risk (*e.g.*, recent loss, family history, *etc.*).

67. 14-Day Mental Health Check-in Following Intake: All prisoners who were not assigned to the mental health caseload following intake, will be briefly screened by a Mental Health Professional within 14 days of intake to identify any mental health issues that could have developed since intake. The Mental Health Director and lead psychiatrist will develop protocols to implement this provision.

68. Routine Mental Health Assessments (Sick Call): All other prisoners who are identified as needing a mental health assessment through the sick call process but do not require an Emergent or Urgent assessment will receive a mental health assessment conducted by a Mental Health Professional within 5 calendar days.

69. Nature of Mental Health Assessment: Mental health assessments will include a structured, face-to-face interview with inquiries into the following:

a. a history of psychiatric hospitalization, psychotropic medication, and outpatient treatment; suicidal behavior; violent behavior; victimization; special education treatment; cerebral trauma or seizures; and sex offenses;

b. the current status of mental health symptoms and psychotropic medications; suicidal ideation; drug or alcohol abuse; and orientation to person, place, and time;

c. psychosocial stressors (*e.g.*, recent significant loss such as the death of a family member or close friend);

d. emotional response to incarceration; and

e. intellectual functioning (*e.g.*, intellectual disability, developmental disability, learning disability).

70. **Mental Health Treatment Plans:** The Jail will ensure that appropriate, individualized treatment plans are developed for prisoners with mental health needs.

71. Timing for initial treatment plan: Within 14 calendar days of a prisoner's mental health assessment, a Mental Health Professional will develop a mental health treatment plan for prisoners with mental health needs. A Qualified Mental Health Professional must approve the plan.

72. For prisoners with serious mental illness, within 30 calendar days of a prisoner's mental health assessment, a multidisciplinary team will update the prisoner's mental health treatment plan. This multidisciplinary team will include a Mental Health Professional, a security staff member, and when applicable, a substance use staff member. For prisoners on medications prescribed by a psychiatrist or psychiatric nurse practitioner, a psychiatrist or psychiatric nurse practitioner and a

nurse must be a part of the multidisciplinary team. When possible, the Jail will include a community mental health provider representative in the development of the plan and inform that representative of the plan during the discharge process, and will document its efforts to do so. A Qualified Mental Health Professional must approve the plan. This process is required for prisoners newly admitted to the Jail after the Effective Date, and the Jail will make its best efforts to convene multidisciplinary teams when updating mental health treatment plans for prisoners housed at the Jail prior to the Effective Date.

73. Requirements for treatment plan: Individualized mental health treatment plans will be developed for each prisoner on the mental health caseload. Each plan will include treatment goals and objectives. Specific components will include:

a. documentation of involvement/discussion with the prisoner in developing the treatment plan, including documentation if the prisoner refuses involvement;

b. frequency of follow-up for evaluation and adjustment of treatment modalities;

c. adjustment of psychotropic medications, if indicated;

d. when clinically indicated, referrals for psychological testing, medical testing and evaluation, including blood levels for medication monitoring as required;

e. when appropriate, instructions about diet, exercise, personal hygiene issues, and adaption to the correctional environment;

f. documentation of treatment goals and notation of clinical status progress (stable, improving, or declining); and

g. adjustment of treatment modalities, including behavioral plans.

74. Timing for treatment plan review: The Director of Mental Health will provide guidelines for individual treatment plan review, which will occur with at least the following frequency:

a. For prisoners whose medication (prescribed by a psychiatrist or psychiatric nurse practitioner) is stable, every 90 calendar days, or whenever there is a substantial change in mental health status;
b. for all other prisoners on medication (prescribed by a psychiatrist or psychiatric nurse practitioner) whose medication is not yet stable, every 30 calendar days.

75. **Mental Health Treatment:** The Jail will ensure that prisoners receive treatment that adequately addresses their serious mental health needs in a timely and appropriate manner, in a clinically appropriate setting.

76. Mental Health Therapy: The Jail will ensure that all prisoners with serious mental health needs receive regular, consistent therapy and counseling, in group and individual settings, as clinically appropriate.

77. Mental Health Inpatient Care: The Jail will initiate a Temporary Detention Order or transfer to a hospital offering the needed services when a prisoner is in need of an inpatient level of care.

78. Confidential Mental Health Treatment: The Jail will ensure that conversations between mental health professionals and prisoners are conducted in a confidential setting to allow for effective information sharing and treatment.

79. **Psychotropic Medications:** The Jail will ensure that psychotropic medications are ordered in a timely manner, are consistently delivered to prisoners on lockdown status, and are administered to prisoners in the correct dosages.

80. Psychotropic Medication Follow-up: For prisoners beginning a new psychotropic medication or new dosage, a registered nurse, psychiatrically trained, the prescribing psychiatrist, or psychiatric nurse practitioner will conduct a follow-up assessment within 14 calendar days of the prisoner's initial prescription, and thereafter every 30 calendar days until the prisoner's psychotropic medication is stable. For prisoners whose psychotropic medication is stable, the medication follow up will occur every 90 calendar days. If the medication follow-up is conducted by a psychiatrically trained registered nurse, the nurse shall refer to the prescribing psychiatrist, or psychiatric nurse practitioner, when necessary.

81. Psychotropic Medication Compliance: The Jail will ensure that health care staff (e.g., nurse, certified medication technician) document when prisoners refuse prescribed psychotropic medications and follow up by scheduling an appointment with a psychiatrist or psychiatric nurse practitioner after four refusals of the same medication in a one-week time period or three consecutive refusals of the same medication in a one-week time period (unless the medication is monitored by phlebotomy such as Depakote, Lithium, or Clozapine, which will have an appointment scheduled after one refusal for once a day dosing or after two refusals for twice a day dosing).

82. Anti-Psychotic Medication Use: The Jail will maintain an anti-psychotic medication registry that identifies all prisoners receiving two or more anti-psychotic medications, the names of medications, the dosage of medications, and the date when each was prescribed. The lead psychiatrist will review this registry every two weeks to determine continued justification for medication regimen, if one medication could be used to address symptoms, and whether medication changes are needed due to an adverse reaction. All determinations and required actions will be documented.

83. Medication Administration Records Audits: The Jail will ensure that psychotropic medication administration records are audited every 90 calendar days for completeness and accuracy.

84. **Serious Mental Health Registry:** The Jail will maintain a mental health registry that identifies all prisoners with serious mental illness, the diagnosis, the date of their last visit with a Qualified Mental Health Professional or Mental Health Professional, and, when applicable, the date of their next visit.

85. **Suicide Prevention:** The Jail will ensure that it identifies suicidal prisoners and intervenes appropriately.

86. Suicide Prevention Training: The Jail will ensure that all security, medical, and mental health staff have the adequate knowledge, skill, and ability to respond to the needs of prisoners at risk for suicide.

a. The Jail will continue its Crisis Intervention Training, a competency-based interdisciplinary suicide prevention training program for security staff, and medical and mental health staff, where appropriate.

b. Within six months of the Effective Date, the Jail will review and revise, if appropriate, its current suicide prevention training curriculum to include the following topics, taught by Department of Criminal Justice Services certified trainers or qualified professionals in the field.

1. suicide prevention policies and procedures;
2. analysis of facility environments and why they may contribute to suicidal behavior;
3. potential predisposing factors to suicide;
4. high-risk suicide periods;
5. warning signs and symptoms of suicidal behavior (including the suicide screening instrument and the medical intake tool);
6. observing prisoners on suicide watch and, if applicable, step-down unit status
7. case studies of recent suicides and serious suicide attempts;
8. practical exercises regarding the proper response to a suicide attempt; and
9. the proper use of cut-down tools.

c. Within 18 months of the Effective Date, all security staff will complete training on all of the suicide prevention training curriculum topics at a minimum of eight hours for the initial training and two hours of in-service training annually for officers who work in intake, mental health, and restrictive housing units and biennially for all other officers.

d. Within six months of the Effective Date (12 months for new hires), the Jail will ensure all security staff are certified in cardiopulmonary resuscitation ("CPR").

87. Suicide Risk Assessment: Within three months of the Effective Date, the Jail will provide quality suicide risk assessments of suicidal prisoners by a Qualified Mental Health Professional on a daily basis in a confidential setting.

88. Suicide Watch: This system will include constant direct supervision of actively suicidal prisoners when necessary and close supervision of prisoners with lower levels of risk (*e.g.*, 15 minute irregular checks). Officers will document their checks.

a. The Jail will ensure that video surveillance will not be used for a prisoner on "constant" observation nor for the 15 minute irregular checks on "close" observation.

b. The Jail will ensure that an order of "constant" observation requires that a staff member have an unobstructed view of the prisoner at all times.

c. The Jail will ensure that any staff member conducting "constant" observation has no other duties to complete during the time they are conducting the observation. This means that the staff member cannot observe more than two prisoners on "constant" observation at a time, subject to the approval of the Qualified Mental Health Professional, and the staff member must have direct line of sight to both prisoners.

89. Suicidal Prisoner Housing: Within 30 days of the Effective Date, the Jail will ensure that prisoners expressing suicidality are provided access to clinically appropriate mental health care in suicide resistant housing with sight lines that permit the appropriate level of staff supervision. If no suicide resistant cell is available, a suicidal prisoner must be placed on "constant" observation until such housing is available.

90. Suicidal Prisoner Treatment: Within three months of the Effective Date (except as stated in Paragraph 90 c. below), the Jail will ensure that suicidal prisoners receive access to adequate mental health treatment and follow-up care, including out-of-cell counseling:

a. The Jail will ensure that placement on suicide precautions is made only pursuant to an adequate, timely (within four hours of identification, or sooner if clinically indicated), and confidential assessment and is documented, including level of observation, housing location, and conditions of the precautions.

b. Prisoners requiring suicide watch will be seen by a Qualified Mental Health Professional as soon as reasonably possible but no later than within a working shift (which as of the Effective Date of this Agreement is 12 hours). Note that on weekends, the timeframe may be within 16 hours to account for overnight.

c. In accordance with Paragraph 100, prisoners on suicide precautions will be offered out-of-cell time for clinically appropriate activities and showers, at least 4 hours per day.

d. Qualified Mental Health Professionals will assess and interact with (not just observe) prisoners on suicide precautions on a daily basis and will provide adequate treatment to such prisoners.

e. The Jail will ensure that prisoners are discharged from suicide precautions or crisis level care as early as possible, and for prisoners with serious mental illness and/or on psychotropic medications such discharge will be approved by a licensed Qualified Mental Health Professional, in consultation with a psychiatrist or psychiatric nurse practitioner when clinically indicated. All prisoners discharged from suicide precautions or crisis level of care must

continue to receive timely and adequate follow-up assessment and care, at a minimum of within 24 hours and again 7 days following discharge. A Qualified Mental Health Professional may schedule additional follow-ups within the first 7 calendar days of discharge if clinically indicated. A Qualified Mental Health Professional will update a treatment plan within 7 calendar days following discharge when necessary.

91. **Psychiatric Hospitalization/Crisis Services:** The Jail will ensure that prisoners requiring emergency psychiatric hospitalization or who are acutely mentally ill receive timely and adequate treatment by initiating a Temporary Detention Order or transferring to a hospital offering the needed services.

92. **Mental Health Achievement Awards**: The Jail will develop and implement a mental health achievement award program.

93. **Mental Health Release Planning:** The Jail will provide release planning for prisoners with a serious mental illness, including the following:

94. Release Plan: Developing a release plan, in conjunction with the appropriate Community Services Board in the member jurisdictions, no later than 30 days after the prisoner's Mental Health Treatment Plan is developed, which will include collecting information regarding the prisoner's needs in "release planning areas" (housing, transportation, bridge psychotropic medications, medical/mental health/substance abuse services, income/benefits establishment, and family/community/social supports) and preliminary recommendations for services to address those needs;

95. Warm Hand-Off: Arranging an appointment with community mental health providers and ensuring, to the extent possible, that prisoners meet with that community mental health provider prior to or at the time of discharge to facilitate a warm hand-off;

96. State Prisons Notification: When state prisoners are transferred, the Jail will transfer medical and mental health records prior to or at the same time prisoners are transferred;

97. Discharge Medications and Renewals: Providing a minimum of 14 days of psychotropic medication to prisoners prescribed such medication and released from the facility (excluding those released to another correctional facility), by providing these prisoners with their remaining psychotropic medication upon release and arranging with local pharmacies to have prisoners' prescriptions filled when fewer than 14 days of psychotropic medications remain.

98. **Collaboration between Mental Health, Security Staff, and Jail Leadership:** The Jail will ensure adequate collaboration between mental health staff (especially psychiatry and psychology), security staff, and Jail leadership, including ensuring adequate multidisciplinary treatment plans, the collaborative planning of the clinical treatment of prisoners' mental health needs, the collaborative use of mental health records, and collaborative management of mental health services generally. Mental health staff, security staff and Jail leadership will be informed of the policies, procedures, and practices on all housing units and, when appropriate, the mental health needs of prisoners

transferring between housing units. Adequate communication between mental health staff, security staff and Jail leadership will involve, in part, ensuring that leadership is routinely informed of the resource needs of the Jail's mental health program.

99. Mental Health Training for Security Staff: Security staff providing security for prisoners with SMI will receive documented training regarding security and supervision issues specific to prisoners with mental illness, including:

a. Use of de-escalation techniques to calm prisoners who have or may have SMI before resorting to use of force, discipline, or restrictive housing; and

b. Signs of mental illness and indications of when referrals should be made to mental health staff.

HOUSING FOR PRISONERS WITH SERIOUS MENTAL ILLNESS

100. **Housing for Prisoners with SMI:** Within one year of the Effective Date, housing for prisoners with SMI will be provided in general population, mental health units, secure mental health units, and acute mental health units as outlined below.

101. **Policies and Procedures for Mental Health Units**: Following the process outlined in the Policies and Procedures section above, policies and procedures will detail the criteria for admission into the mental health units, secure mental health units, and acute mental health units and the levels of care provided to prisoners in those units.

102. **Mental Health Units:**

a. Mental health units function similar to a general population unit in which prisoners are out of their cells the majority of the day.

b. There may be multiple mental health units, each serving a different sub-population of prisoners depending on the level of mental health acuity (*e.g.*, step-down from inpatient psychiatric hospitalization or suicide watch, active psychosis but not a threat to themselves or others, *etc.*).

c. Mental health units will have dedicated mental health staffing in accordance with the staffing plan described at Paragraph 24 to provide dedicated mental health programming available to all prisoners in these units.

103. **Secure Mental Health Units:** Secure mental health units are dedicated to providing the necessary mental health services and other accommodations needed by prisoners with SMI who have been identified as having engaged in violent acts and who require additional security staff/measures.

a. Prisoners who are placed in a secure mental health unit will be offered a minimum of:

1. at least 10 hours of *structured* out-of-cell activities each week, with two of the 10 scheduled hours used for individual or group therapeutic treatment sessions Monday through Friday, with each session lasting approximately one hour and detailed in that prisoner's individualized treatment plan. At least one hour of *structured* out-of-cell activity will occur on Saturdays, and

2. at least two hours of *unstructured* out-of-cell recreation with other prisoners each day, including exercise, dining, and other leisure activities that provide opportunities for socializing, for a total of 14 hours per week. In the event of an emergency lockdown or similar occurrence, the Jail will make its best efforts to make up the missed hours within a week.

3. The Jail will make its best efforts to offer more out-of-cell activities than the minimum 24 hours per week for each prisoner.

b. All out-of-cell time in the secured mental health unit will be documented, indicating the type and duration of activity.

104. **Acute Mental Health Unit**

a. An acute mental health unit is for suicide watch observation and can be combined with a medical or mental health unit or have cells on other housing units that are designated as suicide watch observation cells.

b. Prisoners on an acute mental health unit will be offered out-of-cell time for clinically appropriate activities and showers, at least 4 hours per day Monday through Friday and two hours per day on Saturday and Sunday, with activities determined by a Qualified Mental Health Professional and detailed in that prisoner's individualized treatment plan.

RESTRICTIVE HOUSING

105. **Restrictive Housing Use on Prisoners with Serious Mental Illness:** The Jail will ensure that practices regarding the use of restrictive housing for prisoners with serious mental illness comport with the Constitution and the Americans with Disabilities Act.

106. Jail Staff will ensure that restrictive housing is not used as an alternative to adequate mental health care and treatment.

107. Within 24 hours of placement in any form of restrictive housing, all prisoners on the mental health caseload will be screened by a Mental Health Professional to determine whether the prisoner has a SMI, and whether there are any other acute mental health contraindications to restrictive housing.

108. If a prisoner with SMI in restrictive housing suffers a deterioration in his or her mental health, engages in self-harm, or develops a heightened risk of suicide, or if a prisoner in restrictive housing develops signs or symptoms of SMI where such signs or symptoms had not previously been identified, the prisoner will immediately be referred for appropriate assessment and treatment from a Qualified Mental Health Care Professional who will recommend appropriate housing or recommend initiating a Temporary Detention Order.

109. The Jail will document the placement and removal of all prisoners to and from restrictive housing.

110. For prisoners with SMI, restrictive housing units will provide: (a) meals that meet the same standards for general population prisoners; (b) access to showers not less than three days per week; (c) rights of visitation and communication by those

properly authorized as clinically indicated; (d) access to reading and writing materials unless clinically contraindicated; and (e) access to a radio or television if confinement exceeds 30 days.

111. No prisoners with SMI will be placed in restrictive housing on administrative restriction status absent Extraordinary Circumstances which are approved with documented reasons by the Superintendent and Director of Mental Health Services.

a. In addition to the Extraordinary Circumstances, prisoners who request to be placed on administrative restriction status will not be subject to this provision, but will be monitored according to Paragraph 115.

b. For prisoners who request to be placed on administration restriction status, the Jail will investigate the reason for the request to determine if there is an institutional problem that the Jail needs to address.

112. If a prisoner with SMI is placed in restrictive housing on administrative restriction status, approval will be renewed with documented reasons by the Superintendent and Director of Mental Health Services, or their designee, weekly.

113. In accordance with Paragraph 100, any prisoners with SMI in restrictive housing on administrative restriction status will be moved to the appropriate mental health unit unless there are Extraordinary Circumstances in which case the above process in Paragraph 112 applies, and each prisoner will be evaluated every 30 days thereafter to determine whether he or she could be moved to a less restrictive housing unit.

114. Any determination not to divert or remove a prisoner with SMI from restrictive housing on disciplinary restriction status will be documented in writing and include the reasons for the determination.

115. Prisoners with SMI who are not diverted or removed from restrictive housing will be offered a heightened level of care that includes the following:

a. If on medication, will receive at least one daily visit from a Registered Nurse.

b. Will be offered a face-to-face, therapeutic, confidential, out-of-cell session with a Mental Health Professional at least once per week.

c. Mental Health Professionals will conduct rounds three times a week, or more if clinically indicated, to assess the mental health status of all prisoners in restrictive housing and the effect of restrictive housing on each prisoner's mental health to determine whether continued placement in restrictive housing is appropriate.

d. Mental Health Professionals rounds will not be a substitute for treatment and will be documented.

116. Prisoners with SMI who are housed in restrictive housing for more than 30 days will have their cases reviewed by the Superintendent and Director of Mental Health Services, or their designee, weekly following the 30 days and will only remain in restrictive housing after the Superintendent and Director of Mental Health Services,

or their designee, approve the continued placement every week with documented reasons.

117. **Restrictive Housing Placement Based on Disability:** The Jail will ensure that prisoners with mental health disabilities are not unnecessarily placed in restrictive housing based on their disabilities, and will provide appropriate treatment.

118. No prisoners with mental health disabilities will be placed in restrictive housing for "mental deficiencies" or the equivalent.

QUALITY ASSURANCE

119. **Quality Assurance Program:** The Jail will ensure that its quality assurance program is adequately maintained and identifies and corrects deficiencies with the medical and mental health care system. The Jail will develop, implement, and maintain a system to ensure that trends and incidents involving deficiencies in medical and mental health care are identified and corrected in a timely manner.

120. Within six months of the Effective Date, the Jail will draft and/or revise Quality Assurance policies and procedures, consistent with the process in the Policies and Procedures Section above, to identify and address serious deficiencies in medical and mental health care, including sick call, health assessments, intake, chronic care, medication administration, emergency care, and infection control.

121. Within three months of the Effective Date, the Jail will begin to implement monthly quality assurance mechanisms at the individual and system levels to prevent or minimize harm to prisoners. It is understood that these quality assurance mechanisms will mature and become more sophisticated over time. These quality assurance mechanisms will track and analyze patterns and trends regarding the provision of medical and mental health care. On an annual basis, this data will be reviewed for its effectiveness in order to modify, add, or delete data, subject to the approval of the United States, which approval shall not be unreasonably withheld. Each monthly report will include:

a. Relevant aggregate data, including:

1. the time elapsed between prisoners' requests for medical or mental health services and the provision of services by a Registered Nurse, Medical Provider, or Qualified Mental Health Professional/ Mental Health Professional, separated by the following categories (as well as the triage categories):

i. nurse sick call;

ii. Medical Provider referral;

iii. psychiatrist or psychiatric nurse practitioner referral;

2. for prisoners on the Serious Mental Illness Registry, the Chronic Care Registry, and the Medical Specialist Registry, a delinquency report that shows how many prisoners with scheduled appointments missed those appointments and why;

3. the number of prisoners sent to outside facilities and "admitted" for inpatient care;
4. the number of prisoners sent to the emergency room and the number "admitted" for inpatient care, with the reason admitted and the clinical diagnosis and prognosis for each prisoner if known by the Jail, as well as the reasons not admitted for those prisoners who were not admitted if known by the Jail;
5. the number of prisoners being treated for HIV;
6. the number of pregnant prisoners and the number referred for obstetrics services;
7. the number of prisoners who are PPD positive and the number of chest x-rays performed to assess for tuberculosis;
8. the number of prisoners treated for possible substance abuse withdrawal, with clinical diagnosis and prognosis listed;
9. the number of prisoners prescribed psychotropic medications;
10. the average amount of time between visits with a Qualified Mental Health Professional/ Mental Health Professional for prisoners on psychotropic medications;
11. the number of prisoners placed on suicide watch;
12. the average length of time prisoners are kept on suicide watch;
13. the number of times the restraint chair was used on prisoners with SMI;
14. the number of OC spray uses on prisoners with SMI;
15. the number of suicides;
16. the number of suicide threat incidents;
17. the number of self-harm incidents;
18. the number of psychiatric hospitalizations;
19. the Medical/Mental Health Grievance Substantiation Report;
20. the number of prisoner on prisoner assaults by and on prisoners with SMI;
21. the number of prisoner on staff assaults by prisoners with SMI;
22. the number of prisoners with SMI in restrictive housing, broken down by status of restrictive housing;
23. the length of stay for each of the prisoners with SMI in restrictive housing;
24. the number and type of educational or mental health achievements for prisoners with SMI;

25. a list of prisoners who have SMI that includes their diagnoses, their current charges, and the Feeder Jail;

26. for medical and mental health staff, the vacancy report with positions and days vacant;

27. a list of new hires and terminations for medical and mental health staff identified by position;

28. a list of all medical and security staff who have undergone training required under this Agreement and the training that was provided; and

29. the number of hours of training each staff member receives on suicide prevention and mental health matters each year (this will be reported annually).

122. Within three months of the Effective Date, the Jail will develop and implement a Quality Improvement Committee that will:

a. review and analyze the data collected pursuant to Paragraph 121;

b. identify trends and interventions;

c. make recommendations for further investigation of identified trends and for corrective action, including system changes; and

d. monitor implementation of approved recommendations and corrective actions.

123. Based on these monthly assessments, the Jail will recommend and implement changes to policies and procedures as needed.

124. All monthly reports will be provided to the Monitor and the United States.

125. The Jail will ensure that medical and mental health staff are included as part of the continuous improvement and quality assurance process.

126. **Morbidity-Mortality Reviews:** The Jail will conduct timely and adequate multidisciplinary morbidity-mortality reviews for all prisoner deaths, including suicides, and serious suicide attempts (*i.e.*, suicide attempts requiring medical hospital admission).

127. The Morbidity and Mortality Review Committee will include one or more members of Jail operations, the medical department, the mental health department, and related clinical disciplines as appropriate. The Morbidity and Mortality Review Committee will:

a. ensure the following are completed, consistent with National Commission of Correctional Health Care standards, for all prisoner deaths and serious suicide attempts:

1. a *clinical mortality/morbidity review* (an assessment of the clinical care provided and the circumstances leading up to the death or serious suicide attempt) is conducted within 30 days;

2. an *administrative review* (an assessment of the correctional and emergency response actions surrounding a prisoner's death or serious suicide attempt) is conducted in conjunction with corrections staff;
3. a *psychological autopsy* (a written reconstruction of an individual's life with an emphasis on factors that led up to and may have contributed to the death or serious suicide attempt) is performed on all deaths by suicide or serious suicide attempts within 30 days;
4. treating staff are informed of pertinent findings of all reviews;
5. a log is maintained that includes:
    i. patient name or identification number;
    ii. age at time of death or serious suicide attempt;
    iii. date of death or serious suicide attempt;
    iv. date of clinical mortality review;
    v. date of administrative review;
    vi. cause of death (e.g., hanging, respiratory failure) or type of serious suicide attempt (e.g., hanging, overdose);
    vii. manner of death, if applicable (e.g., natural, suicide, homicide, accident);
    viii. date pertinent findings of review(s) shared with staff; and
    ix. date of psychological autopsy, if applicable; and

b. ensure that the Jail takes action to address systemic problems identified during the reviews.

128. Ensure the senior Jail staff have access to all such reviews conducted by the Jail's medical or mental health provider.

IV. MONITOR

129. The Parties agree that James Conrad Welch will be the Monitor retained by the Jail to assess and report whether the provisions of the Agreement have been implemented and to provide technical assistance to help HRRJ comply with its obligations under the Agreement. The Parties agree to file a joint motion asking the Court to appoint the Monitor.

130. The Monitor will be appointed for a period of three years from the Effective Date, subject to an evaluation by the Court to determine whether to renew the Monitor's appointment until the termination of this Agreement. In evaluating the Monitor, the Court will consider the Monitor's performance under this Agreement, including whether the Monitor is completing its work in a cost-effective manner and on budget, and is working effectively with the Parties to facilitate the Jail's efforts to comply with the Agreement's terms, including by providing technical assistance to the Jail. The Monitor may be removed for good cause by the Court at any time, on motion by any of the Parties or the Court's own determination.

131. The Jail will pay the Monitor an amount per year to be agreed upon by the Parties for performing all of the Monitor's duties under this Agreement.

132. The Monitor will only have the duties, responsibilities, and authority conferred by this Agreement. The Monitor will be subjected to the supervision and orders of the Court.

133. The Monitor will conduct compliance reviews. The purpose of the compliance reviews is to determine compliance with the material requirements of this Agreement. Compliance reviews will be conducted in a reliable manner based on accepted means and methods. The Monitor will provide the Parties with the underlying analysis, data, methods, and sources of information relied upon in the reviews.

134. Neither HRRJ, the United States, nor any of their staff or agents will have any supervisory authority over the Monitor's activities, reports, findings, or recommendations to implement the Agreement.

135. The Monitor may contract or consult with other persons or entities to assist in the evaluation of compliance. The Monitor will pay for the services out of his/her budget. The Monitor, and any staff or consultants retained by the Monitor, will comply will HRRJ's PREA disclosure form. The Monitor is ultimately responsible for any compliance assessments made under this Agreement.

136. The Monitor will be permitted to engage in ex parte communications with the Jail, the United States, and the Court regarding this Agreement.

137. In the event the Monitor is no longer able to perform its functions, is removed, or is not extended, within 60 days thereof, the Parties will together select and advise the Court of the selection of a replacement Monitor, acceptable to both. If the Parties are unable to agree on a Monitor, each Party will submit the names of up to two candidates, along with the resumes and cost proposals, to the Court, and the Court will select and appoint from among the qualified candidates.

138. Should a Party to this Agreement determine that the Monitor has exceeded its authority or failed to satisfactorily perform the duties required by the Agreement, the Party may petition the Court for such relief as the Court deems appropriate, including replacement of the Monitor, and/or any individual members, agents, employees, or independent contractors of the Monitor. In addition, the Court, on its own initiative and in its sole discretion, may replace the Monitor or any member of the Monitor's team for failure to adequately perform the duties required by this Agreement.

139. The Monitor and the United States (and its agents) will have full access to persons, employees, facilities, buildings, programs, services, documents, data, records, materials, and things that are necessary to assess HRRJ's progress and implementation efforts with this Agreement. Access will include departmental or individual medical and other records. The United States and/or the Monitor will provide reasonable notice of any visit or inspection. Advance notice will not be required if the Monitor or the United States has a reasonable belief that a prisoner faces a risk of immediate and serious harm. Access is not intended, and will not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with information disclosed to the Monitor or the United States under this paragraph.

140. In completing his or her responsibilities, the Monitor may require written reports and data from HRRJ concerning compliance, as outlined in the Agreement. HRRJ will provide to the Monitor and the United States a confidential, bi-annual Status Report detailing progress at the Jail, until the Agreement is terminated, the first of which shall be filed within 30 days of the Effective

Date. Status Reports shall make specific reference to the Agreement provisions being implemented. The report shall also summarize audits and continuous improvement and quality assurance activities, and contain findings and recommendations that would be used to track and identify data trends.

141. Monitor Reports

142. Within 60 days of the Effective Date, the Monitor will conduct a baseline site visit of HRRJ to become familiar with HRRJ and this Agreement.

143. Within 90 days of the Effective Date, the Monitor will provide his or her preliminary observations and recommendations in a baseline Monitoring Report (which will follow the same draft and comment process as in Paragraph 144).

144. The Monitor will conduct an on-site inspection and issue a Monitoring Report for HRRJ six months after the baseline Monitoring Report, and then every six months thereafter. A draft Report will be provided to HRRJ and the United States in draft form for comment at least 30 days prior to its issuance. HRRJ and the United States will provide comments, if any, to the Monitor within 15 days of receipt of the draft Report. The Monitor will consider the responses of HRRJ and the United States and make appropriate changes, if any, before issuing the final Report.

145. The Monitoring Reports will describe the steps taken by HRRJ to implement this Agreement and evaluate the extent to which HRRJ prisons have complied with each substantive provision of the Agreement. Each Monitoring Report:

a. Will evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) Partial Compliance; and (3) Non-compliance. "Substantial Compliance" indicates that HRRJ has achieved material compliance with the components of the relevant provision of the Agreement. "Partial Compliance" indicates that HRRJ has achieved material compliance with some of the components of the relevant provision of the Agreement, but significant work remains. "Non-compliance" indicates that HRRJ has not met the components of the relevant provision of the Agreement. "Material Compliance" requires that, for each provision, HRRJ has developed and implemented a policy incorporating the requirement, trained relevant personnel on the policy, and relevant personnel are complying with the requirement in actual practice. The Monitor will review a sufficient number of pertinent documents and interview a sufficient number of staff and prisoners to accurately assess current conditions;

b. Will describe the steps taken by each member of the monitoring team to analyze conditions and assess compliance, including documents reviewed and individuals interviewed, and the factual basis for each of the Monitor's findings;

c. Will contain the Monitor's independent verification of representations from HRRJ regarding progress toward compliance, and examination of supporting documentation; and

d. Will provide recommendations for each of the provisions in the Agreement outlining proposed actions for at least the next six months for HRRJ to complete toward achieving compliance with the particular provision.

146. These Monitoring Reports will be filed with the Court and will be written with due regard for the privacy interests of individuals and will not include any information that could jeopardize the institutional security of HRRJ, or safety of HRRJ staff or prisoners. The Monitoring Reports provide relevant evidence regarding compliance. The Court determines the facts regarding compliance and the status of compliance pursuant to Sections VI and VII of the Agreement.

147. Nothing in this Section prohibits the Monitor from issuing interim letters or reports to the United States, HRRJ or the Court in this case should s/he deem it necessary.

148. If, at any time during the term of this Agreement, the Parties agree that any substantive section (i.e. any small capitalized section tabbed on the far left of the Agreement, such as "SECURITY," "MEDICAL AND MENTAL HEALTH CARE," "MEDICAL CARE," etc.) has reached Substantial Compliance, that section will cease to be subject to active monitoring.

149. In completing his or her responsibilities, the Monitor may testify in enforcement proceedings regarding any matter relating to the implementation, enforcement, or dissolution of the Agreement, including, but not limited to, the Monitor's observations, findings, and recommendations in this matter.

150. The Monitor, and any staff or consultants retained by the Monitor, will not: (a) be liable for any claim, lawsuit, or demand arising out of their activities under this Agreement (this paragraph does not apply to any proceeding for payment under contracts into which they have entered in connection with their work under the Agreement); (b) be subject to formal discovery in any litigation involving the services or provisions reviewed in this Agreement, including, but not limited to, deposition(s), request(s) for documents, and request(s) for admissions, interrogatories, or other disclosure; (c) testify in any other litigation or proceeding with regard to any act or omission of HRRJ or any of HRRJ's agents, representatives, or employees related to this Agreement, nor testify regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement, nor serve as a non-testifying expert regarding any matter or subject that he or she may have learned as a result of his or her performance under this Agreement.

151. The Monitor will not enter into any additional contract with HRRJ while serving as the Monitor. If the Monitor resigns from his or her position as Monitor, the former Monitor may not enter any contract with HRRJ or the United States on a matter related to this Agreement without the written consent of the other Party while this Agreement remains in effect. HRRJ will not otherwise employ, retain, or be affiliated with the Monitor, or professionals retained by the Monitor while this Agreement is in effect, and for a period of at least one year from the date this Agreement terminates, unless the United States gives its written consent to waive this prohibition.

V. IMPLEMENTATION

152. Within 30 days of the Effective Date, HRRJ will designate an Agreement Coordinator to coordinate compliance with this Agreement and to serve as a point of contact for the Parties and the Monitor.

153. Early on and throughout the planning and implementation process, HRRJ will, as appropriate, engage with stakeholders including those types of entities involved in their Forensic Advisory Team (*e.g.*, Community Services Boards and Mental Health Courts) to identify their goals, concerns, and recommendations regarding implementation of this Agreement.

154. HRRJ will create an annual Implementation Plan that describes the actions it will take to fulfill its obligations under this Agreement. Implementation of this Agreement will be completed in phases as outlined in the Agreement and the Implementation Plan.

155. Within 30 days of the Effective Date, HRRJ will provide the first Implementation Plan ("Implementation Plan #1") to the United States and the Monitor. In its Implementation Plan, HRRJ will develop a specific schedule and deadlines for the upcoming year and a general schedule for successive years. In Implementation Plan #1, HRRJ will develop a specific schedule and deadlines for the first twelve months, in which HRRJ will: (a) draft or revise policies and procedures; (b) complete a staffing plan, (c) develop and deliver training to HRRJ staff and providers concerning the provisions of this Agreement and HRRJ's commitment to fulfilling its obligations under the Constitution and the ADA; (d) develop and implement a Quality Improvement Committee; (e) and develop and implement monthly quality assurance mechanisms to report on aggregate relevant data to prevent or minimize harm to prisoners.

156. The United States and the Monitor will provide comments regarding Implementation Plan #1 (and any further Implementation Plans) within 30 days of receipt. HRRJ will timely revise its Implementation Plans to address comments from the United States and the Monitor; the Parties and the Monitor will meet and consult as necessary.

157. Annually, HRRJ, in conjunction with the United States and the Monitor, will supplement Implementation Plan #1 with further Implementation Plans (#2, #3, *etc.*) to focus on and provide additional detail regarding implementation activities. HRRJ will address in its further Implementation Plans any areas of non-compliance or other recommendations identified by the Monitor in his or her reports.

VI. ENFORCEMENT

158. The United States District Court for the Eastern District of Virginia will retain jurisdiction over this matter for the purposes of enforcing this Agreement as an order of this Court.

159. During the period that the Agreement is in force, if the United States determines that HRRJ has not made material progress toward substantial compliance with a significant obligation under the Agreement, and such failure constitutes a violation of prisoners' constitutional rights, the United States may initiate enforcement proceedings against HRRJ in Court for an alleged failure to fulfill its obligation under this Agreement.

160. Prior to taking judicial action to initiate enforcement proceedings, the United States will give HRRJ written notice of its intent to initiate such proceedings, and the parties will engage in good-faith discussions to resolve the dispute.

161. HRRJ will have 30 days from the date of such notice to cure the failure or otherwise resolve the dispute through the good-faith discussions. The Parties may agree to extend this time, as reasonable, due to the nature of the issue(s). At the end of the 30-day period (or such additional time as is reasonable due to the nature of the issue(s) and agreed upon by the United States), in the event that the United States determines that the failure has not been cured or that adequate remedial

measures have not occurred, the United States may initiate contempt proceedings. The United States commits to work in good faith with HRRJ to avoid enforcement actions.

162. In case of an emergency posing an immediate threat to the health or safety of any prisoner or staff member at HRRJ, however, the United States may omit the notice and cure requirements herein and seek enforcement of the Agreement.

VII. TERMINATION

163. Except where otherwise agreed to under a specific provision of this Agreement, HRRJ will implement all provisions of this Agreement within 4 years of the Effective Date.

164. This Agreement will terminate in five years, or earlier, if the Parties agree that HRRJ has attained substantial compliance with all provisions of this Agreement and maintained that compliance for a period of one year, or as outlined in Paragraph 167, by order of the Court.

165. HRRJ may seek termination of any substantive section (i.e. any small capitalized section tabbed on the far left of the Agreement, such as "SECURITY," "MEDICAL AND MENTAL HEALTH CARE," "MEDICAL CARE," etc.) by filing with the Court a motion to terminate that section. The burden will be on the Jail to demonstrate that it has attained and maintained its substantial compliance as to that section for at least one year.

166. Regardless of this Agreement's specific requirements, this Agreement will terminate, or substantive sections as described in Paragraph 165 may terminate, upon a showing by the Jail that it has come into durable compliance with the requirements of the Constitution and the ADA that gave rise to this Agreement. In order to demonstrate durable compliance, HRRJ must establish with the Court that it is operating in accordance with these requirements and has been doing so continuously for one year.

167. The burden will be on HRRJ to demonstrate that it has maintained substantial compliance with each of the provisions of this Agreement. Non-compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, will not constitute failure by HRRJ to maintain substantial compliance. At the same time, temporary compliance during a period of sustained non-compliance will not constitute substantial compliance.

168. The burden will be on HRRJ to demonstrate they have achieved substantial compliance with a particular section of this Agreement.

169. Should any provision of this Agreement be declared or determined by any court to be illegal, invalid, or unenforceable, the validity of the remaining parts, terms, or provisions will not be affected. The Parties will not, individually or in combination with another, seek to have any court declare or determine that any provision of this Agreement is invalid.

170. The Parties agree to work collaboratively to achieve the purpose of this Agreement. In the event of any dispute over the language, requirements or construction of this Agreement, the Parties agree to meet and confer in an effort to achieve a mutually agreeable resolution.

171. This Agreement will constitute the entire integrated agreement of the Parties.

172. Any modification of this Agreement will be executed in writing by the Parties, will be filed with the Court, and will not be effective until the Court enters the modified agreement and retains jurisdiction to enforce it.

VIII. GENERAL PROVISIONS

173. If necessary, HRRJ will coordinate with or enter into Memoranda of Understanding with all appropriate State, County, or City agencies in order for HRRJ to comply with provisions of this Agreement.

174. The United States and HRRJ will each bear the cost of their own fees and expenses incurred in connection with this case.

175. All services mentioned or described in this Agreement are subject to reasonableness standards and nothing herein will be interpreted to mean that the provision of services are unlimited in amount, duration, or scope.

176. The Agreement is binding on all successors, assignees, employees, agents, contractors, and all others working for or on behalf of HRRJ to implement the terms of this Agreement.

177. The Parties agree that, as of the Effective Date of this Agreement, litigation is not "reasonably foreseeable" concerning the matters described in this Agreement. To the extent that any Party previously implemented a litigation hold to preserve documents, electronically stored information, or things related to the matters described in this Agreement, the Party is no longer required to maintain such a litigation hold. Nothing in this paragraph relieves any Party of any other obligations imposed by this Agreement, including the document creation and retention requirements described herein.

178. HRRJ will not retaliate against any person because that person has filed or may file a complaint, provided assistance or information, or participated in any other manner in the United States' investigation or the Monitor's activities related to this Agreement. HRRJ will timely and thoroughly investigate any allegations of retaliation in violation of this Agreement and take any necessary corrective actions identified through such investigations.

179. Failure by any Party to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision herein will not be construed as a waiver, including of its right to enforce other deadlines and provisions of this Agreement.

180. The Parties will promptly notify each other of any court or administrative challenge to this Agreement or any portion thereof.

181. The Parties represent and acknowledge this Agreement is the result of extensive, thorough, and good faith negotiations. The Parties further represent and acknowledge that the terms of this Agreement have been voluntarily accepted, after consultation with counsel, for the purpose of making a full and final compromise and settlement of the allegations set forth in the Department of Justice's CRIPA Notice dated December 19, 2018. Each Party to this Agreement represents and warrants that the person who has signed this Agreement on behalf of a Party is duly authorized to enter into this Agreement and to bind that Party to the terms and conditions of this Agreement.

182. This Agreement may be executed in counterparts, each of which will be deemed an original, and the counterparts will together constitute one and the same Agreement, notwithstanding that each Party is not a signatory to the original or the same counterpart.

183. The performance of this Agreement will begin immediately upon the Effective Date.

184. HRRJ will maintain sufficient records and data to document that the requirements of this Agreement are being properly implemented and will make such records available to the Monitor

and the United States for inspection and copying on a reasonable basis. Such action is not intended, and will not be construed, as a waiver, in litigation with third parties, of any applicable statutory or common law privilege associated with such information. Other than to carry out the express functions as set forth herein, both the United States and the Monitor, and any staff or consultants retained by the Monitor, will hold such information in strict confidence to the greatest extent possible.

185. "Notice" under this Agreement will be provided by email to the signatories below, and their counsel, or their successors.

FOR THE UNITED STATES:

ERIC S. DREIBAND
Assistant Attorney General
Civil Rights Division

STEVEN H. ROSENBAUM
Chief, Special Litigation Section

JUDY C. PRESTON
Principal Deputy Chief, Special Litigation Section

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/s/ Clare Wuerker
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FOR HAMPTON ROADS REGIONAL JAIL AUTHORITY:

/s/ Sharon Scott
SHARON P. SCOTT
Chairman
Hampton Roads Regional Jail Authority

/s/ Christopher Walz
CHRISTOPHER WALZ
Superintendent
Hampton Roads Regional Jail

/s/ Jeff Rosen
JEFF W. ROSEN
Attorney
Hampton Roads Regional Jail Authority

EXHIBIT 2

PLAINTIFFS' SUBJECT MATTER EXPERT

DECLARATION OF DR. KENNETH A. RAY, DBH, MEd

In re Disability Rights South Carolina, et al. v. Richland County,
(Alvin S. Glenn Detention Center) (Civil Action Number. 8:22-1358-BM).

Submitted June 29, 2024

DECLARATION OF DR. KENNETH A. RAY, DBH, MEd
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DECLARATION OF DR. KENNETH A. RAY, DBH, MEd

I, Dr. Kenneth A. Ray, pursuant to 28 U.S.C. § 1746, declare as follows:

I. SUBJECT MATTER EXPERT (SME) ENGAGEMENT

1. I am more than 21 years old and was retained by the Plaintiffs' Counsel, Burnette, Shutt, McDaniel, PA, as a Subject Matter Expert (hereafter referred to as SME) in re Disability Rights South Carolina, et al. v. Richland County, (Alvin S. Glenn Detention Center) (Civil Action Number. 8:22-1358-BM).
2. I will be compensated by Plaintiffs' at the rate of $275.00 per hour and for authorized travel expenses related to work performed in this case.
3. My primary area of work in this case includes, but is not narrowly limited to, assessing ASGDC staffing levels to determine the extent to which staffing levels and conditions of confinement at ASGDC have been and are adequate to ensure that inmates with serious mental illness (SMI), as defined in plaintiff's original and amended complaints, are protected from harm by being provided objectively reasonable and consistent monitoring, supervision, and care.
4. The statements, opinions, and conclusions contained in this report are based on my personal knowledge, examination of records and data provided to me by Plaintiff counsel, onsite visit and assessment of Alvin S. Glenn Detention Center (hereafter referred to as ASGDC) conditions of confinement and SMI inmate care, onsite conversations with ASGDC staff and

SMI inmates, independent topic research; analysis of ASGDC staffing rosters, Watch Tour electronic rounds data[1], reported incident data sets, and other information that qualified corrections experts, correctional mental health professionals, corrections and jail health care quality assurance and evaluation professionals, and corrections staffing experts would reasonably rely on in forming opinions and are true to the best of my knowledge. I am aware that they may be used in a court of law for this case.

5. My opinions and conclusions herein are made to a reasonably degree of professional certainty. However, I reserve the right to amend this report, my findings, opinions, and conclusions if I become aware of new and/or additional facts for which I relied on to determine findings, opinions, and or conclusions herein.

II. SUBJECT MATTER EXPERT (SME) EXPERIENCE AND QUALIFICATIONS

1. I am a career criminal justice and behavioral health professional with over 48 years of combined professional work experience in law enforcement operations and administration, corrections administration, behavioral and mental health practice, and operational compliance and performance improvement consulting. I earned associate degrees in criminal justice and law enforcement management emphasizing community policing and management from Lane Community College, Eugene, OR; a bachelor's degree in criminal justice administration emphasizing community relations and police administration from Lamar University, Beaumont, TX; a master's degree in counseling and human development emphasizing clinical and forensic assessment and treatment from Lamar University, Beaumont, TX.; and a doctorate

[1] Watch Tour is technology used by ASGDC to electronically track when SMI inmate welfare checks (rounds) are conducted by ASGDC staff. System functionality involves an officer pressing buttons mounted on walls in housing units when rounds being and are completed. Rounds data are recorded and maintained in the Watch Tour data base. A PDF report of Watch Tour data for 01/01-25/24 was provided this SME for examination and analysis.

in behavioral health emphasizing clinical quality improvement and practice management consulting in correctional settings from Arizona State University, Tempe, AZ.

2. I completed numerous academic and professional internships in my fields of study and professional work. These include, for example, internships in law enforcement and corrections management and administration and clinical and forensic mental health assessment, diagnosis, and treatment, including pediatric behavioral health clinical practice supervision for Washington State Child and Adolescent Mental Health Treatment Specialist Credentialing, behavioral health clinical practice supervision in Texas and Washington States, Outpatient Behavioral Health Clinical Practice at the Family and Children's Center, Catholic Dioceses, Yakima, WA; law Enforcement & forensic counseling, Orange County Sheriff's Office / Lamar University Graduate School of Counseling & Development / Life Resources of Southeast Texas MHMR, Orange, TX; forensic behavioral health clinical practice residency/supervision, Texas Department of Corrections / University of Texas Medical Branch Skyview Psychiatric Prison; law enforcement management, Lamar University, Beaumont, TX; elementary school teaching at Pioneer Montessori Children's House, Lane College, Eugene, OR; and law enforcement management, Eugene, OR Metropolitan Police Department.
3. I have completed over 4,000 hours of professional development training since 1977 in the areas of administration, criminal justice, community & public relations, corrections, emergency management, security management, instruction & teaching, labor relations, law enforcement, leadership, management, clinical and programmatic behavioral health. I completed this training from numerous higher education and professional training institutions.
4. I am licensed by the Washington State Board of Health to diagnose and treat mental illness (License LH00011228, CMS National Provider ID 1659415759) , and certified by the National Board of Certified Counselors. I have held professional credentials in the State of Texas as a licensed master police officer, law enforcement communications officer, licensed corrections

officer, licensed criminal justice instructor, certified crime prevention inspector, certified emergency management director; in the State of Washington as a certified criminal justice executive, manager, and supervisor; as a certified jail manager, American Jail Association; certified correctional health professional, National Commission on Correctional Health Care.

5. I began my career in 1976 as a police officer and communications officer in Oregon. I served as a law enforcement officer, supervisor, emergency management coordinator, and administrator in Texas and Washington States from 1977 to 2005. As law enforcement supervisor, supervisor, and emergency management coordinator, I was responsible for ensuring staff compliance with a variety of operational and administrative policies and procedures, developing, and implementing various policies and procedures, implementing, and evaluating the effectiveness of different policies and practice reforms, and investigate and implement corrective measures for violations of said policies and procedures.

6. From 1989 through 2004, I served as a sheriff's chief deputy, jail administrator, corrections director, criminal justice academy training director and trainer, and county security policy administrator in Texas and Director of County Corrections in Washington State. My jail administration responsibilities included direct oversight of medium and large local correctional agencies that incarcerated from 250 to 3,000 detainees and inmates and ensuring Constitutional care and custody of incarcerated persons and the safety and security of all persons and facilities under my responsibility. My role as corrections administrator included budget development, implementation, and management; oversight and leadership of subordinate leaders and administrative staff; research, development, performance, and implementation of a variety of disciplinary policies, procedures, and practices, including inmate and staff security, inmate classification, inmate medical and mental health care, conditions of confinement, segregation, inmate discipline, facility health, and hygiene, etc., and to ensure compliance with all federal, state, and local laws and regulations pertinent to operating a correctional facility and the care

and custody of incarcerated persons. It was also my duty to oversee and direct administrative and internal investigations; plan, develop, implement, and evaluate jail renovations and new construction; develop, implement, and evaluate a variety of contracts and agreements related to staffing, inmate healthcare, facility maintenance, etc.

7. In my criminal justice training role, I was responsible for ensuring that all law enforcement and correctional training programs and curricula met or exceeded state licensing standards, selecting, overseeing, and evaluating subordinate trainers and learning facilitators, evaluating student performance; and maintaining a highly professional training program and environment. The training curriculum included, for example, basic and advanced law enforcement and corrections officer certification and licensure, leadership and supervision, inmate civil rights, and a host of other topics related to law enforcement operations and management.

8. My experience as a professional behavioral and mental health practitioner began in 2003 for adults, children, and families individually in group treatment settings. I furthered this experience in the States of Washington and Kentucky until 2011, working in community outpatient clinic settings. I performed mental health assessment, testing, diagnosis, and treatment of individuals with situational mental health problems and persons with serious mental illness. In Washington State, I was appointed Designated Mental Health Professional responsible for evaluating individuals with severe mental health episodes and involuntary psychiatric commitment of individuals when indicated. Additionally, I was accountable for re-activating providing school-based child and adolescent mental health treatment services in rural Washington and Appalachian Kentucky.

9. Since 1986, I completed numerous consulting engagements involving a variety of subjects regarding policies, practices, and performance of local, state, and federal agencies that included, for example, local school districts, county, and municipal law enforcement agencies, county commissions, state appropriation committees, local justice councils, state departments

of social and health services for the protection of children, and departments of corrections and jails.

10. My primary work in correctional consulting began in 2010 with the United States Department of Justice National Institute of Corrections (NIC). I have consulted with correctional agencies throughout the United States to improve inmate conditions of confinement and protection from harm, facilities, policies, practices, and clinical and non-clinical performance outcomes on various administrative, operational, and inmate health care issues. Over the past 13 years, I have completed over fifty evaluations of correctional agency operations, practices, policies and procedures in Alabama, California, Florida, Georgia, Indiana, Illinois, Kentucky, Mississippi, New Mexico, New York, Pennsylvania, Tennessee, The Territory of the United States Virgin Islands, Washington State, and Wisconsin.

11. From 2011 through 2019, I served as the mutually agreed independent compliance coordinator in In re the United States v. Lake County, IN (10-CV-00476-TLS-PRC, United States District Court Northern District of Indiana). In this capacity, I ensured compliance with this inmate Civil Rights Settlement Agreement involving over ninety substantive provisions for improving prisoner medical and mental health, suicide prevention, protection from harm, use of force, segregation, classification, training, life and fire safety, and facility health and hygiene; managed a compliance team of national topic experts, provided ongoing technical assistance, and served as liaison to the United States Department of Justice regarding all compliance matters.

12. In 2012, the United States Department of Justice National Institute of Corrections retained me to assess plans and proposed jail construction and provide recommendations to improve prisoner medical and mental health care at the Dallas County, TX Sheriff’s Office. This work assisted Dallas County in resolving their prisoner Civil Rights Settlement Agreement in In re

the United States vs. Dallas County, TX Sheriff, and County, et al. (3:07-CV-1559-N, United States District Court Northern District of Texas).

13. From 2013 to the present, I have served as the Independent Monitor appointed by the United States District Court of the Territory of the US Virgin Islands in In re The United States v. the Territory the US Virgin Islands (1:86-cv-00265-WAL-GWC, United States District Court US Virgin Islands Division of St. Croix.). In this capacity, I monitor and evaluate compliance with this prisoner Civil Rights Settlement Agreement containing over one hundred substantive provisions to improve prisoner medical and mental health, suicide prevention, training, protection from harm, use of force, segregation, classification, life and fire safety, and facility health and hygiene. I manage a compliance team of national topic experts and report compliance findings to the court.

14. In 2014, the Los Angeles County, CA Board of Supervisors retained me to evaluate plans proposed by the Los Angeles County Sheriff designed to address prisoner Constitutional Rights violations in In re United States vs. Los Angeles County, CA Sheriff, and County et al. (CV 15-5903, United States District Court Central District of California Western Division). I evaluated proposed programs and jail construction to improve inmate medical and mental health care and reported my findings to the Board.

15. From 2014 through 2019, I served as defendants' compliance monitor and advisor in In re McClendon et al., vs. City of Albuquerque et al. (CV 95-24 JAP/KBM, United States District Court District of New Mexico). I monitored and evaluated compliance with this prisoner Civil Rights Settlement Agreement containing over one hundred substantive provisions improving prisoner medical and mental health, suicide prevention, protection from harm, use of force, segregation, training, classification, life, and fire safety facility health and hygiene. I managed a compliance team of national topic experts and reported compliance findings to defendants and plaintiffs.

16. From 2016 to the Present, I have served as the independent performance monitor for the Cook County, IL Department of Corrections. In this role, I initially assisted the defendants in resolving and terminating the prisoner Civil Rights Settlement Agreement in In re the United States vs. Cook County, IL Sheriff, and County et al. (1:10-cv-02946, United States District Court for the Northern District of Illinois). Since the termination of the Agreement, my role has been to evaluate prisoner conditions of confinement and provide technical assistance for improving and maintaining durable performance.
17. From 2017 through 2018, I was retained by defendants to assist with achieving compliance with their inmate Civil Rights Settlement Agreement in In re Huerta, et al., vs. Vigo County, IN Sheriff Greg Ewing, et al. (2:16-CV-00397-JMS-MJD, United States District Court Southern District of Indiana Terre Haute Division). I evaluated and provided technical assistance to improve compliance performance in jail overcrowding, staffing, jail capacity, and conditions of confinement.
18. From 2019 through 2021, I was retained by defendants to assist with achieving compliance with their inmate Civil Rights Settlement Agreement in In re Trevor Richardson, et al., vs. Monroe County, IN Sheriff and County (1:08-CV-174-RLY-JMS, United States District Court Southern District of Indiana Indianapolis Division).
19. From 2019 to the present, I have served as the defendant's compliance monitor in In re Georgia Advocacy Office vs. Fulton County, GA, Sheriff, et al.(1:19-CV-01634-WMR-JFK, United States District Court of Georgia Atlanta Division). In 2021, the parties mutually appointed me as compliance monitor to evaluate compliance with this prisoner Civil Rights Settlement Agreement involving prisoner mental health, conditions of confinement, discipline, segregation, and training.
20. From 2020 to 2024, I served as the mutually agreed subject matter expert for the United States Department of Justice and Boyd County, KY, regarding the resolution of prisoner Civil Rights

violations regarding inmate protection from harm and use of force. I evaluate compliance with agreed settlement terms, provide recommendations, and report my findings to the parties in this role.

21. In 2021, I was retained by the United States Department of Justice as a Subject Matter Expert in re The United States v. the State of Alabama Department of Corrections (2:20-CV-01971-RDP, United States District Court for the North District of Alabama (Southern). In this role I evaluated prisoner protection from harm and staffing.

22. In 2022, the United States Department of Justice retained me to assessment compliance with their Memorandum of Understanding involving the Oklahoma County, OK Detention Facility. My role involved assessing inmate protection from harm, staffing, and conditions of confinement.

23. In 2023, I was appointed by the Federal District Court of the Southern District of Florida as the Independent Monitor in re the United States v. Miami-Dade County, Florida et al (1:13-CV-21570 CIV). In this capacity I assess and evaluate defendants' compliance with two settlement agreements involving inmate civil rights violations pertaining to use of force, segregation, medical and mental health care, suicide prevention, classification, and overall conditions of confinement.

24. In addition to assisting these jurisdictions to improve incarceration conditions of confinement and the care and custody of prisoners stated above, I have consulted with several other jurisdictions on similar jail operations, administration, inmate health care, conditions of confinement, care and custody, and performance improvement matters since 2010.

25. In addition to my qualified expertise in evaluating correctional staffing, conditions of confinement, inmate care and custody, and conditions of confinement, I was affirmed as a qualified expert, despite plaintiffs' objections, to opine on inmate mental health care and services programming by the United States District Court for the Northern District of Georgia

Atlanta Division in re Georgia Advocacy Office v. Patrick Labot, et. al. (case 1:19-cv-01634-WMR).

III. ASSESSMENT METHODOLOGY

1. Onsite Visit ASGDC from January 22-25, 2024:

   A. Facility tours
   B. Housing unit inspections
   C. Interviews with inmates and discussions with staff members
   D. Review of logbooks and inmate rosters

2. Examination and Review of Records:

   A. Plaintiffs' original and amended complaints.
   B. ASGDC and ASGDC Health policies and procedures
   C. ACH contract – Notice to Proceed
   D. Allied Security Contract
   E. Inmate deaths and suicide reported 2018-2023.
   F. Various defendant emails
   G. Defendant depositions:
      1) Leonardo Brown
      2) Crayman Harvey
      3) Colie Rushton
      4) Blake Taylor
      5) Laurinda Saxon-Ward
      6) Gilmore
      7) Sutton
      8) Kitchens
   F. Inmate custody files
   G. Inmate head count sheets
   H. Inmate grievances
   I. Inmate handbook
   J. SCDC Inspection reports
   K. Richland County responses to SCDC inspection reports and findings
   L. ASGDC inspections corrective actions plan(s), remedial action plan
   M. SCDC Security Audit of ASGDC
   N. Richland County Sheriff's Department press released from January 1 to November 14, 2023.
   O. List of detainees currently received mental health services.
   P. ASGDC forensic and mental health contracts report
   Q. Mental health caseload redacted.

R. Various detainee mental health records
S. 2014 ASGDC Management and Operations Study
T. 2023 ASGDC Staffing Needs Assessment
U. ASGC current staffing training report
V. Various housing unit logbook pages
W. Various shift rosters for 2020-2023
X. Watch Tour electronic report for January 1-25, 2024

3. Data Analytics – Quantitative Descriptive Analyses:

A. Sampled Shift Roster Staffing Levels (2020-2023)
B. Watch Tour System (Security Rounds) Data (January 1-25, 2024)
C. Richland County 911 Call Reports
D. Defendant's Answers to Second Interrogatories: 1. Detention Officers and Sergeants Employed as of the First of Each Month from January 1, 2022, to the present (05/10/24). Dated May 13, 2024.
E. Defendant's Answers to Amended and Supplemental Answers to Second Interrogatories: 3. Identify the Number of Detainees Housed by Unit, Including Intake, on the First of Each Month from January 1, 2022, to the present (05/01/24). Dated May 22, 2024.
F. Defendants MH Caseload Housing Data

IV. INTRODUCTION

26. The critical necessity for adequate jail staffing and rigorous safety and security measures is paramount in ensuring the operational effectiveness and humane management of correctional facilities. These are affirmative duties of local government operating a jail. These components are vital not only for maintaining order and preventing violence but also for guaranteeing inmate access to health care, protection from harm, access to services and programs, and maintaining appropriate jail conditions.

27. Adhering to industry and other related professional standards of practice, particularly in the face of staffing shortages, is crucial. Staffing deficits severely impair the ability to safeguard the health and welfare of both SMI inmates and correctional officers, exacerbating risks of security breaches, including violence, riots, and escapes. Correctional officers are pivotal in supervising inmates, facilitating rehabilitation programs, managing conflicts, and executing emergency responses. Insufficient staffing undermines these critical functions, compromising the quality and effectiveness of care and services provided to inmates.

28. Moreover, staffing shortages and inadequate safety measures detrimentally impact jail conditions, limiting inmates' access to essential services and programs. This has broader implications, including adverse effects on inmates' mental and physical health, potential long-term psychological issues, increased healthcare costs, and diminished effectiveness of

rehabilitation efforts. The latter increases the likelihood of recidivism, posing additional challenges to public safety.

29. To comprehensively address these issues, correctional facilities must adhere to industry standards and professional standards of practice, implement robust data management systems for operational and compliance tracking monitoring, focusing on staffing, safety measures, and ensuring inmates' rights to health care, protection, and access to rehabilitative services and programs. This approach necessitates policy and practice reforms aimed at alleviating staffing shortages, significant investments in staff training programs (covering aspects such as conflict resolution, mental health awareness, and emergency preparedness), and the integration of advanced security technologies. Implementing such strategies is essential for improving jail conditions, enhancing the safety and security of correctional facilities, ensuring the well-being of inmates and staff, and effectively contributing to the protection, care, and rehabilitation of offenders and defendants and the safeguarding of public safety.

V. FINDINGS AND CONCLUSIONS

30. **For over a decade, Richland County and ASGDC have consistently demonstrated a pattern and practice of failing to maintain adequate staffing levels and to implement minimally adequate staffing practices at ASGDC. This persistent practice has directly compromised the ability to provide inmates with the objectively reasonable and consistent monitoring, supervision, and care necessary to protect them from harm.**

A. In 2008, Richland County commissioned Hammett Associates to conduct a comprehensive performance evaluation of the ASGDC. The scope of this study encompassed multiple dimensions of the facility's operations, with an emphasis on addressing the critical staffing shortages prevalent during that period. The findings of the evaluation highlighted a significant vacancy rate of 25-30% across all positions within the facility. Furthermore, the study devoted special attention to strategies aimed at mitigating these vacancies, focusing

on enhancements in recruitment processes, employee training, and overall work environment improvement.[2]

B. In 2013, Richland County commissioned another study by Pulitzer / Bogard and Associates (referenced above) regarding ASGDC management and operations. The final study was issued to Richland County and ASGDC officials in 2014. This study similarly encompassed multiple dimensions of the facility's operations and staffing and considered the 2008 study findings for background information stating, *"…many of the findings and recommendations that were provided to the county five years ago [the 2008 study] are still very relevant."* [3] This study also found staffing levels to be problematic but not as much as that reported in the 2008 study.

C. In the 2014 study referenced above, comprehensive analysis and recommendations were provided to correct problematic ASGDC practices pertaining to adequate staffing levels and inmate protection from harm. Key findings and recommendations, specifically focusing on staffing issues and their impact on security management, inmate supervision, and the overall care and custody of inmates was issued to Richland County. The report delineates over 100 findings and more than 200 recommendations aimed at improving operational practices, with a significant emphasis on staffing-related issues related to this SME's declaration:

1) Finding 2 (Section A.1) describes the inadequacy of current inmate supervision practices in fostering positive staff-inmate interactions. Recommendation 4 advocates for conducting thorough reviews of staff-inmate interactions, employing measurable and relevant performance indicators to assess and improve these interactions.[4]

[2] As stated in a 2014 ASGDC Management and Operations Study (p.2) commissioned by Richland County, S.C. and completed by Pulitzer / Bogard and Associates, LLC, Lido Beach, New York.
[3] Ibid., p.2.
[4] Ibid., p.9.

2) Finding 3 (Section A.1) pointed out the important need for enhancing safety, security, and inmate supervision. Recommendation 2 suggests the need for diligent monitoring of inmate supervision practices through enhanced staff supervision and the utilization of Watch Tour and barcode system data. It also recommends replacing the existing housing unit security journal book with a more comprehensive housing unit shift activity log to better document and analyze inmate supervision.[5]

3) Finding 2 (Section A.2) revealed the lack of meaningful and sufficient opportunities for inmates in the Special Housing Unit (SHU) to engage in programs, services, and exercise their qualified rights and privileges. The report identifies several restrictive practices in the SHU, including extensive lockdown periods, limited movement, and inadequate access to rehabilitation or therapeutic services. These conditions highlight the need for a more differentiated approach to managing inmate confinement in the SHU.[6]

4) Finding III.A.1 (Section III) addresses the failure of ASGDC to implement critical staffing recommendations from the 2008 audit, particularly those related to recruitment and retention. Persistent vacancies have led to excessive overtime, stressed officers, and inconsistent post assignments, which collectively undermine the effective supervision of inmates.[7]

D. The 2008 and 2014 studies commissioned by Richland County both emphasize the ***urgent need for ASGDC to address extant, persistent, and pervasive staffing and operational deficiencies required to improve the care, custody, and management of inmates***. Implementing these recommendations requires a concerted effort to reform staffing

[5] Ibid., p.10.
[6] Ibid., p.11.
[7] Ibid., p.80.

practices, enhance security and inmate supervision methodologies, and provide inmates with adequate opportunities for engagement, care, and to ensure objectively reasonable and consistent protection from harm. ASGDC inspections conducted by the South Carolina Department of Corrections (SCDC) from 2018 onwards further corroborate the findings and recommendations contained in the 2008 and 2014 findings and clearly evidence extant and deleterious staffing deficiencies that continue to expose ASGDC inmates, particularly SMI inmates, to actual and ongoing risks of serious harm.

E. SCDC inspection findings consistently identify extant and persistent failure to meet the mandated staffing levels as required by Minimum Standards for Local Detention Facilities in South Carolina, Regulation 1031. This regulation mandates that ASGDC ensures 24-hour supervision and processing of incarcerated individuals by maintaining fully staffed security posts and fulfilling essential support functions. The SCDC's inspections have documented ongoing non-compliance with these critical safety and inmate protection standards over the last six years (2018-2023).[8] Since at least 2018, SCDC has repeatedly found Richland County in violation of this requirement stating that ***"[ASGDC] is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded in order to enable proper facility operation, and recruitment and retention of employees must be improved…."***[9]

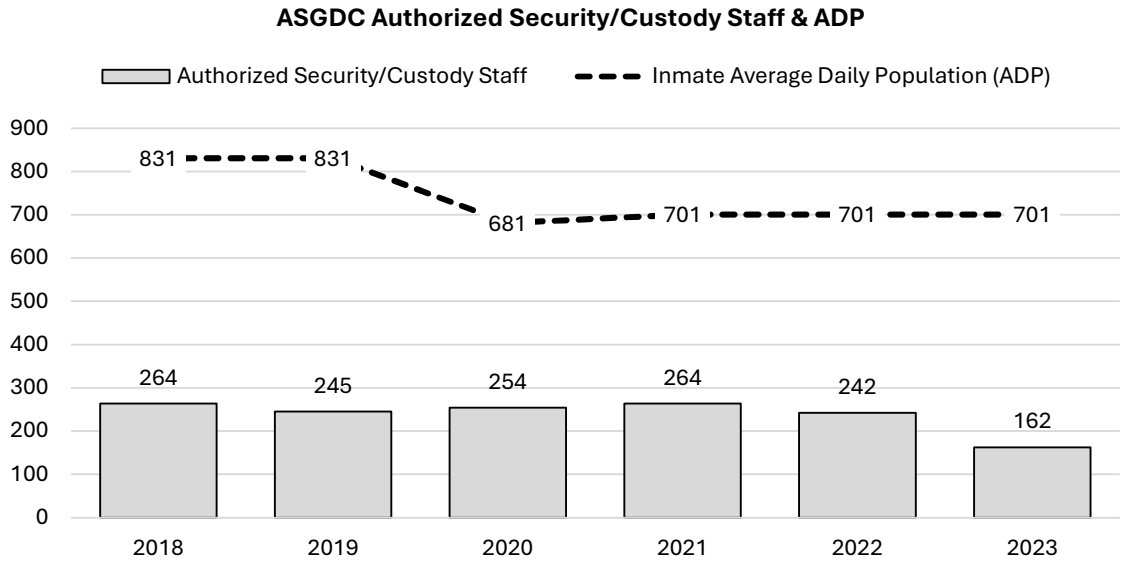
F. The provided data from SCDC inspection reports reveals that Richland County's decision-making in relation to security and custody staffing at ASGDC has led to a significant

[8] Based on SME examination of SCDC inspections and Narrative Reports of ASGDC (2018-2023), and review of Minimum Standards for Local Detention Facilities in South Carolina: Type II and / or Type IV Facility, City, County, or Regional Jail and / or Combined Jail / Prison Camp. Retrieved from https://dc.statelibrary.sc.gov/items/56d8ee2c-dcc4-4a26-9afb-af73da423b49.

[9] SCDC ASGDC 2018-2023 Inspection Reports.

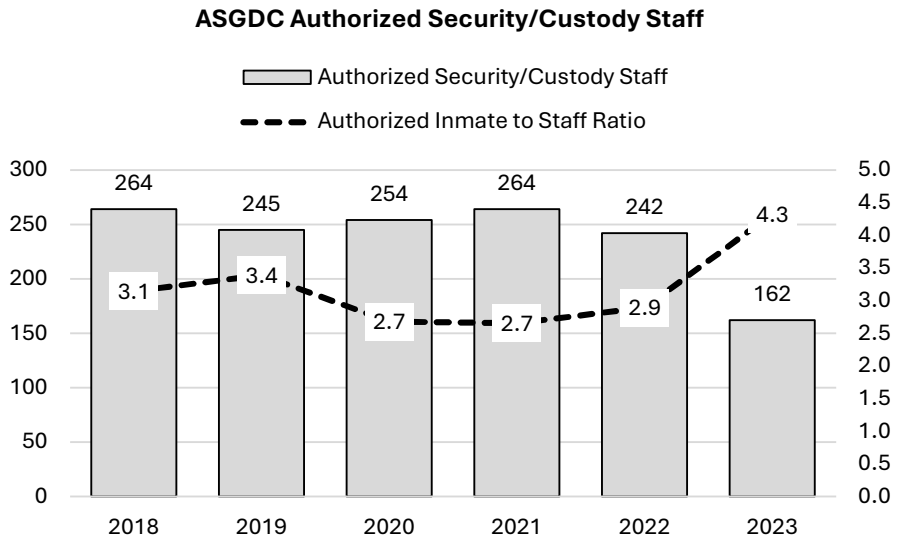
reduction in inmate protection. The authorized staffing levels were reduced by 102 positions, a 38.6% decrease, over a period of six years, from 264 in 2018 to 162 in 2023. This planned reduction in staff allocation emerges as a serious issue when juxtaposed with the inmate population's decrease, which is notably far lower at approximately 15.6%, from an average daily population of 831 in 2018 to 701 in 2023. However, the inmate population has skyrocketed to approximately 948 as of January 24, 2024.

G. The disparity between the rates of decrease in staff numbers versus inmate numbers known by Richand County at the time staffing reductions were approved raises serious concerns regarding the priority Richand County places on inmate protection, care and custody service. The Visual below compares ASGDC authorized staffing levels and inmate population as reported in SCDC inspection reports from 2018 to 2023.



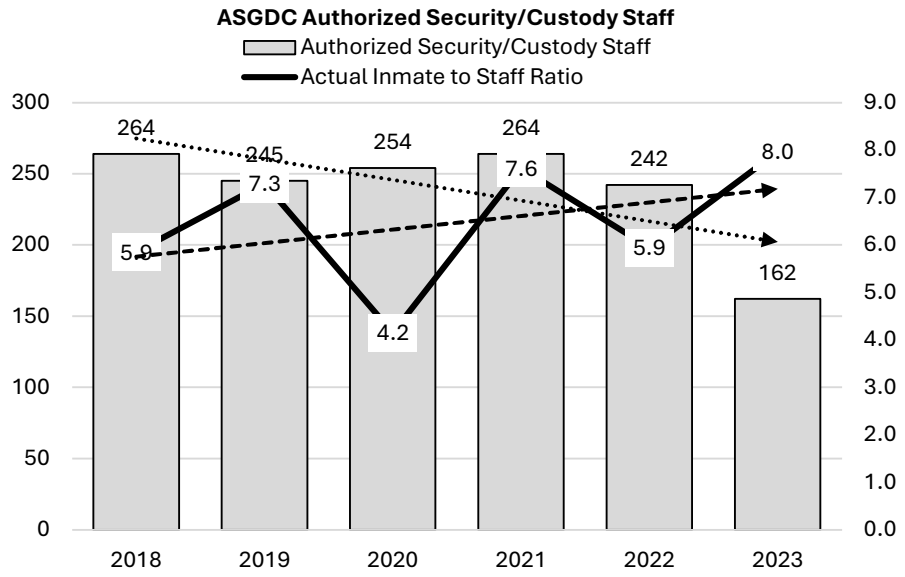
H. The planned decrease in authorized security and custody staffing levels within Richland County's SMI inmate protection practices has led to a deliberate and calculable augmentation in the inmate to staff ratios. This adjustment is quantified by a 37.5% increase in the ratio, rising from 3.1 inmates per authorized security and custody staff member in 2018 to 4.3 inmates per allocated position in 2023. Furthermore, a more pronounced

escalation of approximately 63% was observed within a shorter period, with the ratio expanding from 2.9 in 2022 to 4.3 in 2023. These changes are illustrated in the accompanying Visual, underscoring the official decisions that adversely impacting SMI inmate protection levels and the corresponding adjustments in staffing allocations.[10]



I. Closer examination of actual staffing levels, as reported by the South Carolina Department of Corrections (SCDC), reveals a more pronounced and dangerous impact of the reduction in SMI inmate protection measures. Specifically, in 2018, the SCDC disclosed that the Alvin S. Glenn Detention Center (ASGDC) was operating with 122 staff members out of an authorized complement of 264. This equates to a vacancy rate of 46.2%. By 2023, SCDC reported that actual staffing decrease to 88 employees, a 38% decrease from 2018 with a parallel ADP decrease of 15.6%. Accordingly, actual inmate to staff ratios increased 36.1%, from 5.9 inmates per security and custody staff in 2018 to 8.0 inmates per staff in 2023.

[10] Inmate-to-staff ratio is calculated by dividing ADP by total staff.

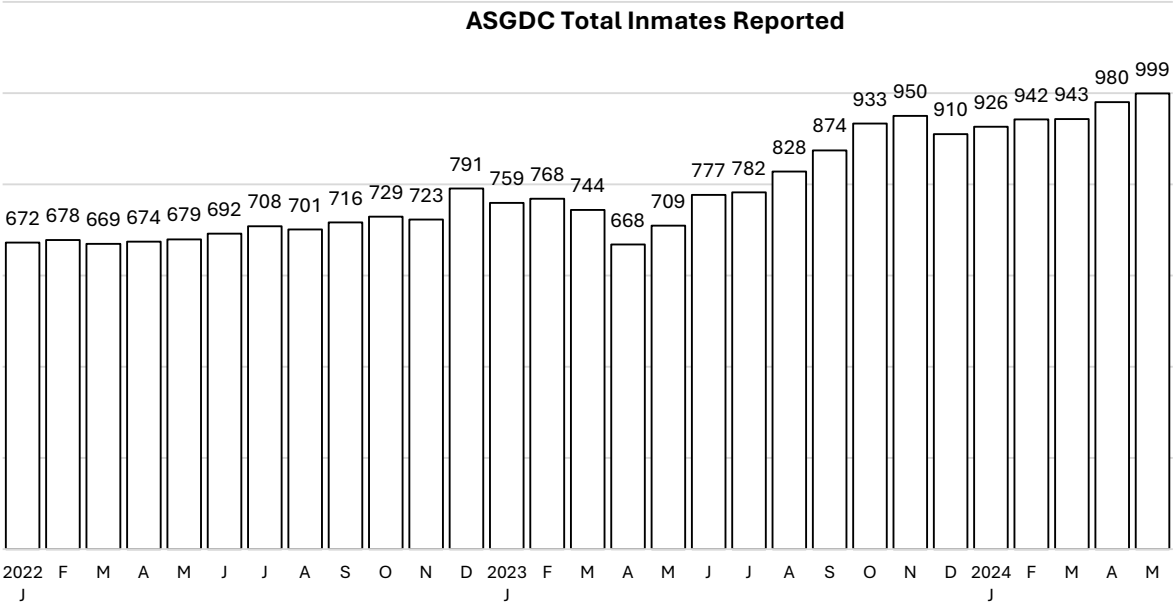


J. The detailed scrutiny of staffing levels at the Alvin S. Glenn Detention Center (ASGDC), as reported by the South Carolina Department of Corrections (SCDC), reveals both the known and foreseeable deficiencies in staffing that have persisted since at least 2018. This examination does more than merely quantify the gap between planned and actual staff numbers; it also measurably clarifies the tangible, enduring, and predictable harm experienced by SMI inmates as a direct consequence of these staffing shortfalls. By contrasting the actual harm faced by SMI inmates with the intended security and custody staffing provisions of Richland County, the analysis brings to light the critical need for addressing these discrepancies to mitigate the risks and enhance the well-being of the SMI inmate population.

K. Examination of the Defendant's response to the Second Interrogatories (1. Detention officers and sergeants employed as of the first of each month from January 1, 2022, to the present [May 10, 2024], dated May 13, 2024), and the Defendant's response to the Amended and Supplemental Answers to Second Interrogatories (3. Identify the number of detainees housed by Unit, including Intake, on the first of each month from January 1, 2022, to the present [May 01, 2024], dated May 22, 2024).

L. Each month from January 1, 2022, to May 1, 2024, reveals similar and worsening inmate population growth, minimal improvement in staffing levels, and skyrocketing inmate-to-staff ratios, compared to those calculated using SCDC Inspection Reports:

1) From January 1, 2022, to May 1, 2024, total inmate counts show a known sharp upward trend that far out-paced staffing gains for that period.[11], [12] Starting at 672 inmates on January 1, 2022, the count increased by 17.7% to 791 by December 1, 2022. This upward trend continued in 2023, albeit with fluctuations: a significant decrease of 12% from January 1, (759) to April 1, (668), followed by a sharp increase of 42.2% to 950 in November 1, ending the year at 910. In 2024, the inmate count continued to rise, reaching 999 by May, an increase of 7.9% from January 2024 and an overall 48.7% increase (+327) from January 2022 to May 2024.



[11] Defendant's interrogatory response includes inmate counts for the first day of each month from January 1, 2022, to May 1, 2024 (29 records). Their response to staffing interrogatory includes sergeant and corrections officer counts per bi-weekly pay period from January 18, 2022, to May 10, 2024 (60 records).

[12] Total inmate count includes all inmates physically located at ASGDC and inmates in transport (TRANS) status. Approximately 96% of total inmates are physically located at ASGDC for each day reported.

2) Examination of the maximum, minimum, and average number of inmates reported for January 1, 2022, to May 1, 2024, also shows a dangerous trend:

   a. In 2022, the highest reported number of inmates was 791, while the lowest was 669. The average inmate count for the year was 702.7. This indicates that while the inmate population fluctuated, it generally stayed within a manageable range. The gap between the minimum and average counts suggests some variability but not extreme. In 2023, there was a noticeable increase in the inmate population. The maximum number of inmates climbed to 950, a significant rise from the previous year. The minimum number of inmates remained relatively stable at 668, almost identical to the lowest count in 2022. However, the average number of inmates jumped to 808.5, marking a substantial increase from 2022's average. This rise in both the maximum and average counts reflects an overall growth in the inmate population, indicating that the facility was housing more inmates on average throughout the year. The first five months of 2024 reveal a continued upward trajectory in inmate numbers. The maximum number of inmates reported was 999, the highest in the observed period. Notably, the minimum number of inmates during this period was 926, which is strikingly close to the average count of 958. This proximity between the minimum and average counts is particularly concerning as it indicates that the inmate population is consistently high with little fluctuation.

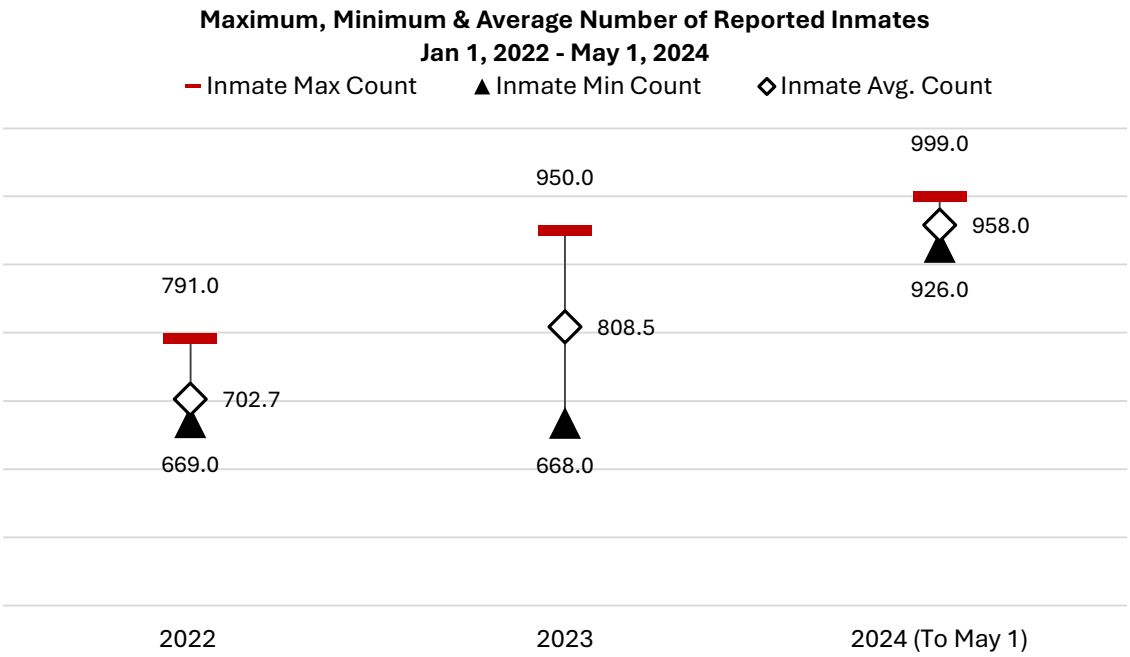
   b. The significant rise in the minimum inmate count in 2024, close to the average, suggests a critical situation. Unlike in previous years where there was a notable difference between the minimum and average counts, indicating periods of lower inmate populations, 2024 shows a compressed range. In 2022, the minimum count was 669, which was 33.7 inmates lower than the average of 702.7. In 2023, the minimum was 668, considerably lower than the average of 808.5 by 140.5 inmates

However, in 2024, the minimum count of 926 is only 32 inmates lower than the average of 958, evidencing a steadily increasing inmate population.

c. This pattern of an increasing minimum count closer to the average reveals a more consistently high inmate population. This implies several serious issues that need urgent attention. The consistently high inmate numbers suggest that the facility is operating far beyond its effective operational and functional capacity, which can lead to severe overcrowding. Overcrowding can have numerous negative impacts, including increased tension and violence among inmates, greater difficulty in managing the population, and heightened stress on both inmates and staff. Furthermore, the high baseline number of inmates demands continuous and substantial resources, such as staffing, medical care, food, and other essentials. This constant demand can strain existing resources and infrastructure, making it challenging to maintain adequate living conditions and support services for inmates. The rising inmate population may also reflect broader systemic issues, such as increased incarceration rates, longer sentences, or insufficient use of alternative sentencing options. These trends necessitate comprehensive policy interventions, such as prison reform, the implementation of alternative sentencing measures, and initiatives to reduce recidivism.

d. Operationally, consistently high inmate numbers can pose significant challenges. Managing a large and steady population requires robust administrative and logistical frameworks to ensure safety, order, and the provision of essential services. Overburdened facilities may struggle to offer effective rehabilitation programs, which are crucial for reducing reoffending rates and facilitating inmate reintegration into society. The Visual below highlights a troubling and serious trend of increasing inmate numbers, with a particular emphasis on the rising minimum

count in 2024 that closely aligns with the average. This situation underscores the urgent need for strategic planning, resource allocation, and policy changes to address the challenges posed by a growing and consistently high inmate population. Immediate and effective action is necessary to prevent further deterioration of conditions and to manage the inmate population in a humane and sustainable manner.



3) Total inmates reported by defendants includes those physically located at ASGDC and inmates in a transport status on the day reported. Approximately 96% of total inmates reported are physically located at ASGDC. Physical locations reported include housing units (A-M,P,U,X-Y, and SHU[13], JUV), Intake, and Infirmary.

4) All of the adult housing units (A-M,P,U,X-Y, and SHU),have a maximum of 56 beds (inmates). However, the adult inmate populations reported reveals an increasing trend that

[13] The SHU was closed December 2022 and reopened an renamed BMU in late 2023.

exceed the 56-inmate capacity across various housing units from 2022 through the first part of 2024.

a. Specifically, 2022 saw four instances, 2023 saw 35 instances, and the first five months of 2024 already recorded 28 instances of housing units exceeding 56 inmates. This pattern highlights the need for continuous monitoring and effective resource allocation to manage the growing inmate populations.

b. In 2022, the housing units saw a few instances where inmate populations exceeded 56 inmates. Unit P surpassed this threshold once in December, with a count of 67 inmates. Unit SHU exceeded the 56-inmate mark three times during the year, recording 57 inmates in January, 58 in October, and 62 in December. Overall, there were four instances of housing units exceeding 56 inmates in 2022.

c. The year 2023 experienced a significant increase in the number of times housing units exceeded the 56-inmate threshold. Unit A consistently surpassed this mark throughout the entire year, ranging from 61 to 76 inmates each month, making it 12 times in total. Unit B saw counts over 56 inmates twice, in November and December. Unit D exceeded the threshold once in December. Unit F stayed above 56 inmates in November and December. Unit G and Unit I each recorded one instance of exceeding 56 inmates in December. Unit J had numerous months where inmate counts were over 56: January, February, July, August, September, October, November, and December, totaling eight times. Unit K recorded inmate counts above 56 in February, May, October, November, and December, making it five times. Unit L surpassed the 56-inmate mark in July, September, October, November, and December, also five times. Despite the frequent instances in other units, Unit SHU did not record any instances of exceeding 56 inmates in 2023. Thus, the total number of instances in 2023 where housing units exceeded 56 inmates was 35 times across various units.

d. In the first five months of 2024, there continued to be a notable number of instances where inmate populations exceeded 56 inmates. Unit A had high counts each month from January to May, totaling five times, with a peak of 93 inmates in April. Unit B also exceeded the threshold twice, in April and May. Unit D recorded inmate counts above 56 four times, in January, March, April, and May, with a notable peak of 91 inmates in May. Unit E surpassed the 56-inmate mark in January, March, April, and May, four times, peaking at 81 inmates in April. Unit F exceeded this threshold twice, in March and May. Unit G did not record any instances above 56 inmates. Unit I had inmate counts above 56 in March and May, making it two times. Unit J had fluctuating numbers, exceeding 56 inmates in January, February, March, April, and May, five times in total. Unit K consistently recorded inmate counts above 56 from January to May, with five instances, peaking at 81 inmates in March and April. Unit L saw inmate counts above 56 twice, in March and April. SHU experienced significant peaks, with inmate counts exceeding 56 in March, April, and May, three times in total, reaching 109 inmates in May.

5) The implications of housing units exceeding their maximum capacity are severe and multifaceted. Overcrowding leads to several adverse consequences:

a. When inmate populations exceed capacity, the risk of inmate-on-inmate violence increases significantly. Overcrowded conditions create high-stress environments where tensions can escalate quickly. Limited space exacerbates conflicts over resources, privacy, and personal space. Consequently, physical altercations, assaults, and other forms of violence become more frequent and harder to control. This not only endangers inmates but also puts correctional staff at greater risk.

b. Additionally, overcrowded facilities face challenges in contraband control. With more inmates than the facility is designed to accommodate, it becomes increasingly

difficult to monitor and manage inmate activities effectively. The higher inmate-to-staff ratio reduces the ability of correctional officers to conduct thorough searches and maintain surveillance, making it easier for contraband, such as drugs, weapons, and other prohibited items, to be smuggled and circulated within the prison. The presence of contraband exacerbates violence and undermines the overall security of the facility.

c. Moreover, inmates with serious mental illness (SMI) are particularly vulnerable in overcrowded settings. These individuals often require specialized care and attention, which becomes challenging to provide when resources are stretched thin. Overcrowding can lead to inadequate access to mental health services, insufficient psychiatric care, and a lack of appropriate accommodations. Inmates with SMI may experience exacerbated symptoms, increased risk of self-harm, and a higher likelihood of victimization by other inmates. The inability to provide proper care for these individuals not only violates their rights but also undermines efforts at rehabilitation and can lead to tragic outcomes.

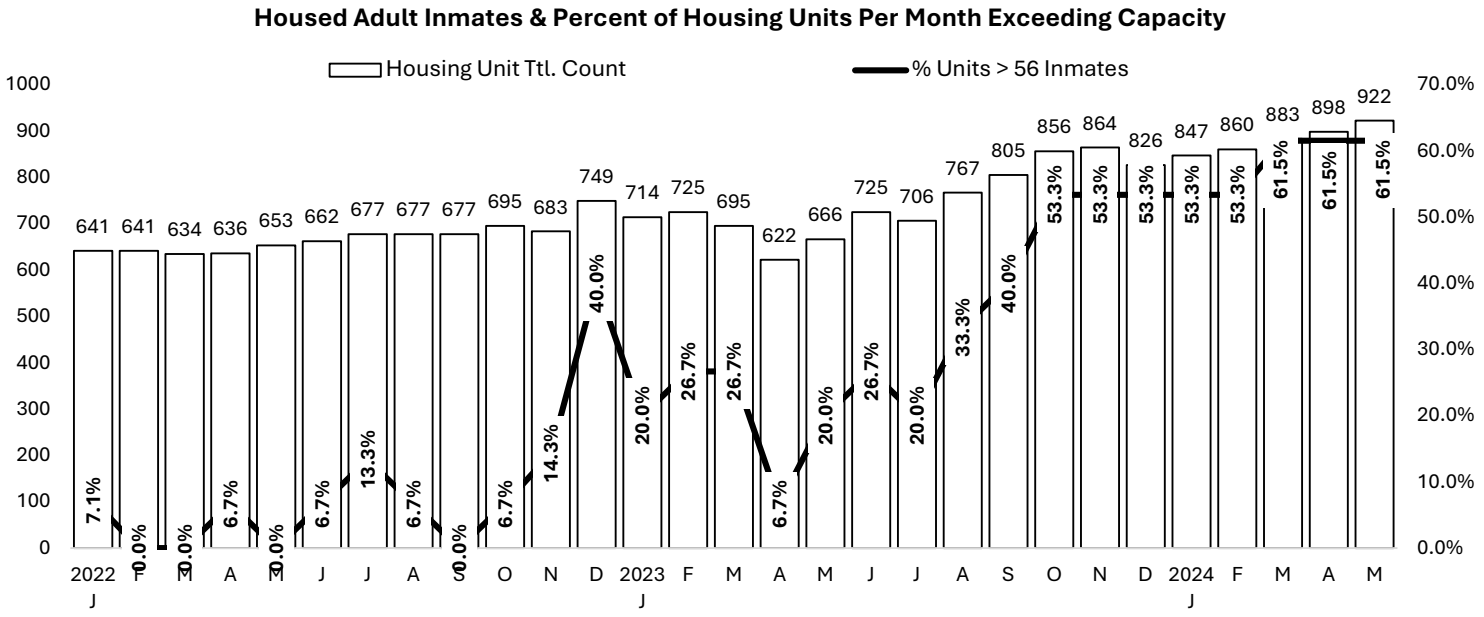
d. The consistently high numbers suggest that the facility is operating at or near full capacity almost continuously, which can lead to severe overcrowding. Overcrowding can have numerous negative impacts, including increased tension and violence among inmates, greater difficulty in managing the population, and heightened stress on both inmates and staff.

e. The high baseline number of inmates demands continuous and substantial resources, such as staffing, medical care, food, and other essentials. This constant demand can strain existing resources and infrastructure, making it challenging to maintain adequate living conditions and support services for inmates. The rising inmate population may also reflect broader systemic issues, such as increased

incarceration rates, longer sentences, or insufficient use of alternative sentencing options. These trends necessitate comprehensive policy interventions, such as prison reform, the implementation of alternative sentencing measures, and initiatives to reduce recidivism.

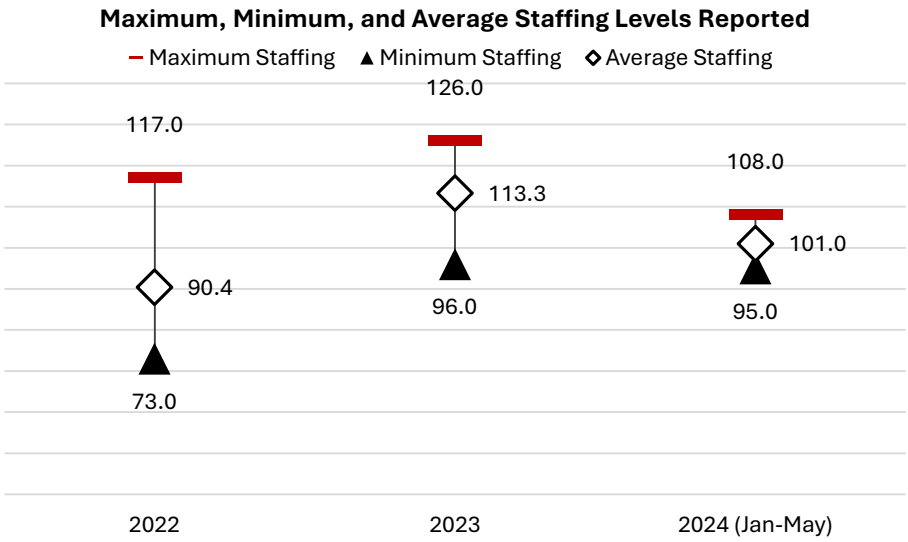
f. Operationally, consistently high inmate numbers can pose significant challenges. Managing a large and steady population requires robust administrative and logistical frameworks to ensure safety, order, and the provision of essential services. Overburdened facilities may struggle to offer effective rehabilitation programs, which are crucial for reducing reoffending rates and facilitating inmate reintegration into society.

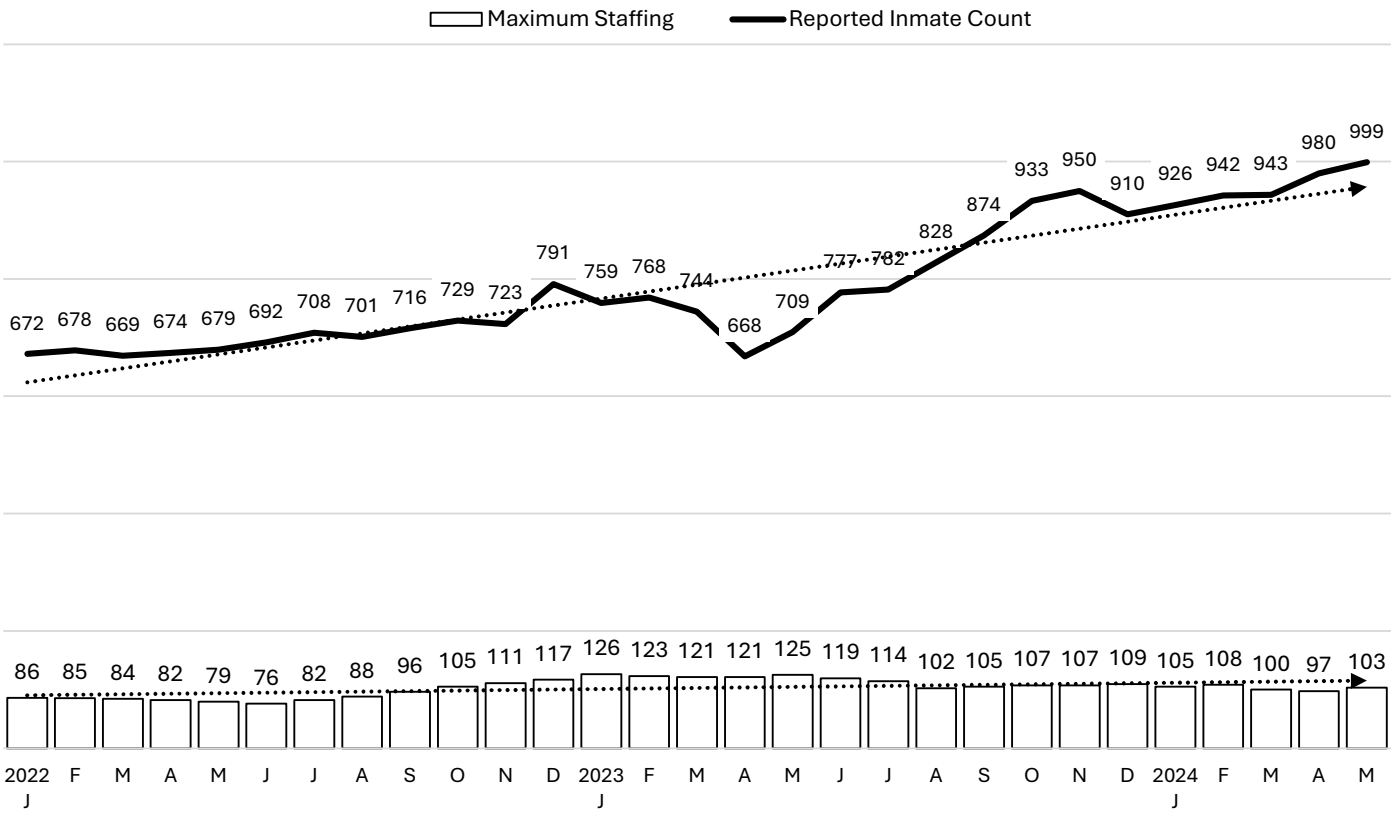
g. The visual below shows total housed adult inmates and the percentage of inmate-occupied adult housing units that exceeded capacity each day reported. It highlights a troubling and serious trend of increasing inmate numbers, with a particular emphasis on the rising minimum count in 2024 that closely aligns with the average. This situation underscores the urgent need for strategic planning, resource allocation, and policy changes to address the challenges posed by a growing and consistently high inmate population. Immediate and effective action is necessary to prevent further deterioration of conditions and to manage the inmate population in a humane and sustainable manner. This includes addressing inmate-on-inmate violence, improving contraband control, and ensuring adequate care and access to services for inmates with serious mental illnesses.



6) Maximum security staffing levels exhibited significant variability. In 2022, maximum staffing decreased by 11.6% from January (86) to June (76) before rising sharply by 53.9% to 117 in December. In 2023, staffing levels peaked at 126 in January, gradually decreased by 5.6% to 119 in June, and then stabilized around 105-109 towards the year's end. In 2024, maximum staffing ranged from 105 in January to 103 in May, peaking at 108 in February. Minimum staffing followed a similar trend, starting at 86 in January 2022, decreasing by 12.8% to 75 in June, and then increasing by 50.7% to 113 in December. In 2023, minimum staffing peaked at 124 in January and February, then fell by 22.6% to 96 in August before ending the year at 105. In 2024, minimum staffing fluctuated between 95 and 103. Average staffing mirrored these trends, beginning at 86 in January 2022, decreasing by 12.2% to 75.5 in June, and rising by 51.9% to 114.7 by December. In 2023, average staffing started high at 125 in January and gradually stabilized around 105-107 by December. In 2024, it started at 104 in January, peaked at 105 in February, decreased by 8.6% to 96 by April, and stabilized at 103 in May. The visuals below compare reported maximum, minimum, and average

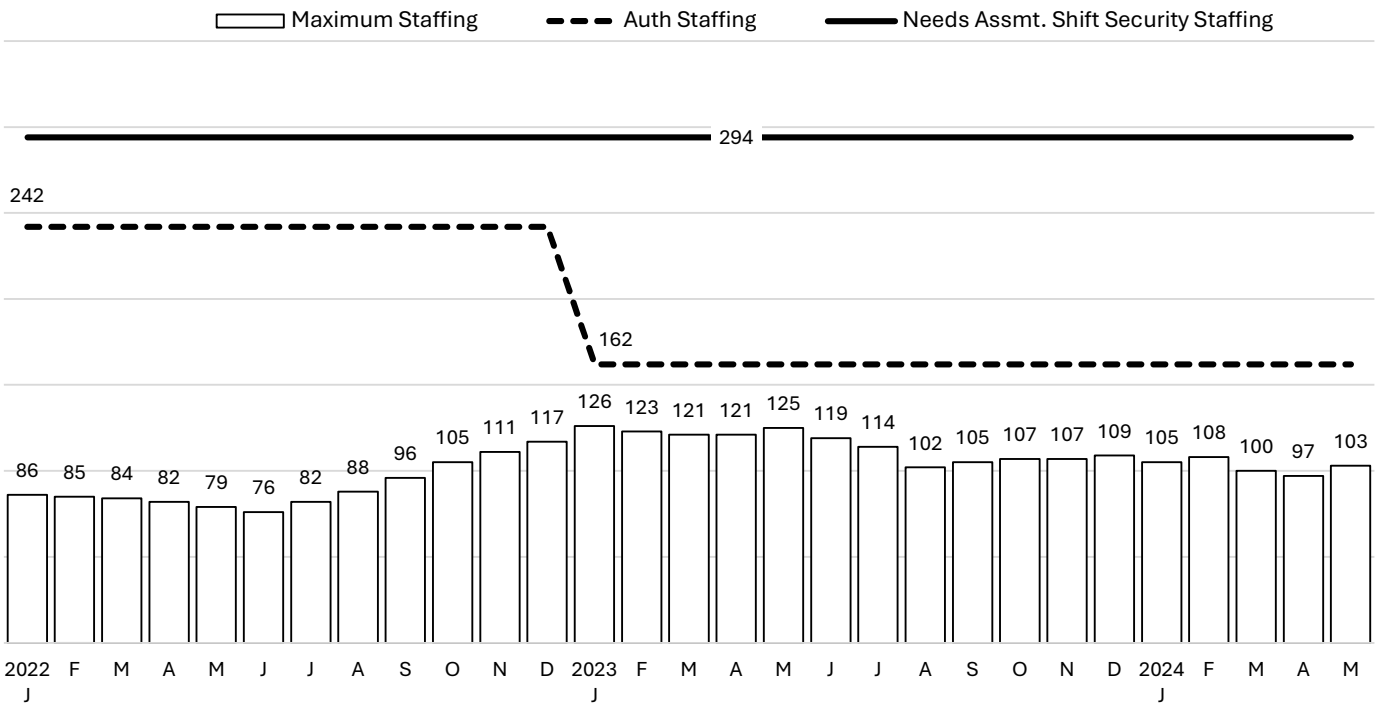
monthly staffing levels, and reported monthly total inmate county and maximum staffing levels.





7) Reported maximum staffing levels continued to fall far below authorized staffing levels and staffing levels for supervisors and corrections officers that are recommended in the Staffing Needs Assessment. Authorized staffing levels reported in the SCDC inspection reports that were previously discussed ranged from 242 in 2022 then decreased to 162 in 2023. The Staffing Needs Assessment requires a minimum of 294 [14] to provide shift security only. Notably, recommended staffing is considerably higher than what Richland County authorized and significantly higher that actual maximum staffing levels reported.

Reported Actual Monthl Actual Maximum Staffing, Authorized & Needs Assessment Shift Security Staffing Recommended



[14] SME previous stated that the Needs Assessment is a conservative estimate and should not be used for final, reliable staffing levels because it fails include all custody staffing requirements required by ASGDC policy and NIC requirements. It shown here because it is the only staffing analysis that has been conducted.

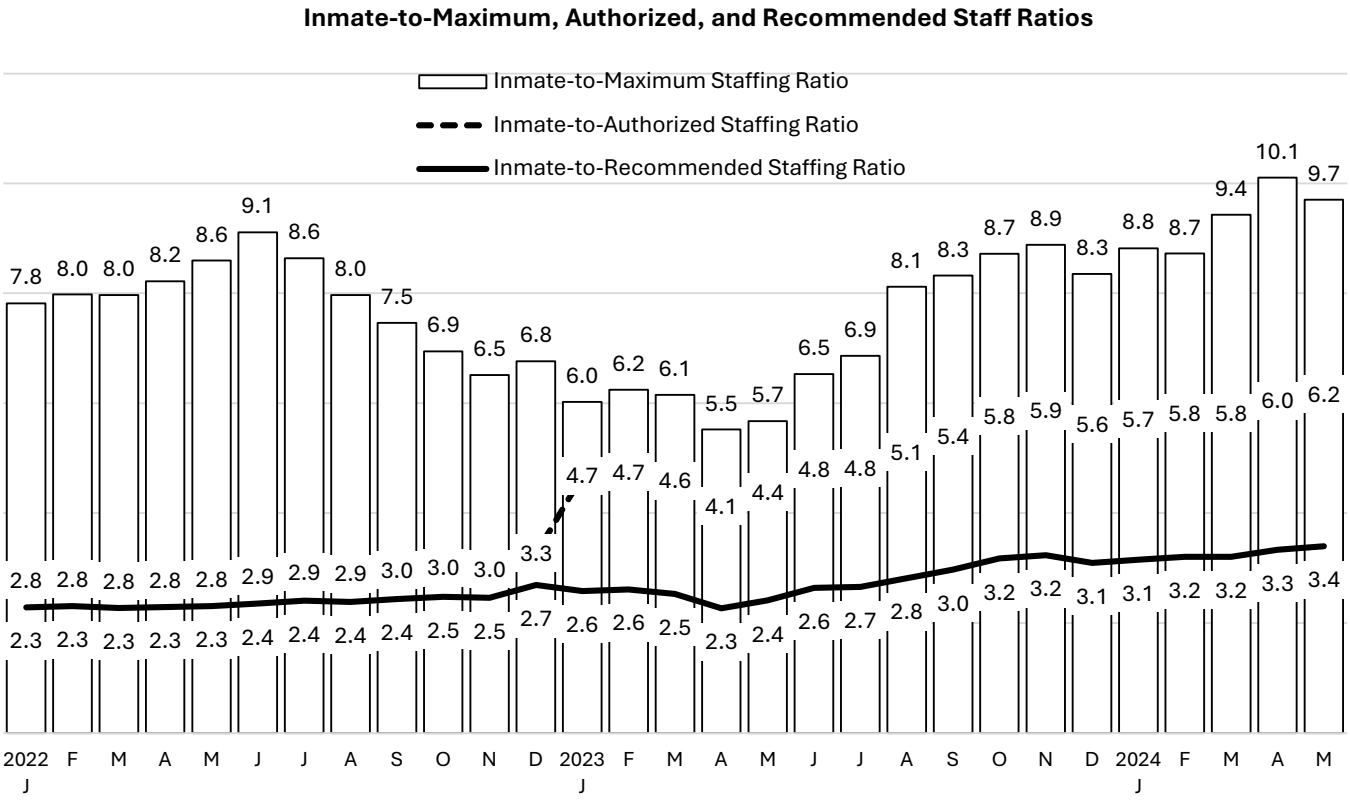
8) Finally, synthesis of the defendant's inmate count and staffing responses reveals an escalating and significant risk of harm to inmates, particularly those with serious mental illnesses (SMI), as well as to staff, from January 2022 through May 10, 2024. This period has seen a consistent increase in inmate populations exceeding the housing units' maximum capacities, leading to overcrowded conditions that exacerbate tensions and pose substantial challenges to maintaining safety and security:

   a. The inmate-to-staff ratios at ASGDC from January 2022 to May 2024 present a serious picture of the discrepancies between actual staffing levels, authorized staffing levels, and recommended staffing levels. Analyzing these ratios underscores the potential implications for security, safety, and operational efficiency.

   b. In 2022, the inmate-to-max actual staffing ratio started at 7.8 in January and increased to a high of 9.1 in June. This means that each staff member was responsible for supervising significantly more inmates than recommended by staffing needs assessment and the number authorized. Actual staffing was consistently far lower than both authorized and recommended levels. For instance, in January 2022, with an inmate-to-max actual staffing ratio of 7.8, the authorized staffing ratio was 2.8, meaning each authorized staff member would handle 5 fewer inmates compared to the actual ratio. Similarly, the assessment ratio was 2.3, suggesting that each assessed staff member would handle 5.5 fewer inmates compared to the actual ratio. By June, when the actual ratio peaked at 9.1, the authorized ratio remained at 2.9 and the assessment ratio at 2.4, highlighting even more stark differences of 6.2 and 6.7 inmates per staff member, respectively.

   c. In 2023, the authorized staffing level was reduced, which significantly impacted the ratios. The inmate-to-max actual staffing ratio improved initially, starting at 6.0

in January, but worsened as the year progressed, reaching 8.9 in November. The inmate-to-authorized staffing ratio reflected this reduction in authorized staffing, starting at 4.7 in January and increasing to 5.9 by November. The inmate-to-staffing ratio, according to the staffing assessment, also showed a gradual increase from 2.6 in January to 3.2 in November. In January 2023, the actual ratio was 6.0, while the authorized ratio was 4.7, meaning each authorized staff member would handle 1.3 fewer inmates than the actual ratio. The assessment ratio was 2.6, suggesting each assessed staff member would handle 3.4 fewer inmates compared to the actual ratio. By November, the actual ratio had worsened to 8.9, with the authorized ratio at 5.9 and the assessment ratio at 3.2, meaning authorized and assessed staff would handle 3 and 5.7 fewer inmates per staff member, respectively. From January to May 2024, the inmate-to-max actual staffing ratio continued to deteriorate, starting at 8.8 in January and reaching a critical high of 10.1 in April. By May, it slightly improved to 9.7. The inmate-to-authorized staffing ratio and the inmate-to-staffing assessment ratio continued to rise, starting at 5.7 and 3.1 in January and reaching 6.2 and 3.4 by May, respectively.



M. The observed discrepancies in staffing levels relative to inmate counts pose serious security and safety risks. Inadequate staffing during periods of high inmate population can lead to increased tension, potential for violence, and reduced ability to effectively manage and supervise inmates. Overworked and overstressed staff are less able to maintain control, which increases the risk of violent incidents among inmates. Low staffing levels directly contribute to the risk of harm to SMI inmates (and all inmates). Without adequate supervision and intervention, disputes among inmates can escalate unchecked, resulting in physical harm or even fatalities. The psychological stress on SMI inmates due to insufficient oversight can also lead to increased incidents of self-harm and suicide. The lack of adequate medical and psychological support during times of low staffing exacerbates these risks, leaving vulnerable inmates (including disabled and SMI inmates) without the necessary care and intervention. Additionally, lower staffing levels severely

impair the facility's ability to control contraband. With fewer staff members available to perform searches and maintain surveillance, the likelihood of contraband items being smuggled into the facility increases. This can lead to further violence, drug use, and other illegal activities within the inmate population, exacerbating the already heightened tensions due to overcrowding. Concomitantly, any physical improvements made to the facility without adequate staffing levels to maintain those improvements will be fruitless.

As stated previously in this report, Richland County must rapidly implement a predictive and proactive approach to staff recruitment and retention. Implementing data-driven staffing models that anticipate changes in inmate populations and adjust staffing levels accordingly can help mitigate risks. Additionally, maintaining a higher and more consistent baseline staffing level, particularly for minimum staffing, can ensure that the facility remains adequately staffed during periods of fluctuating inmate counts. This will enhance the facility's ability to prevent violence, control contraband, and provide necessary care to inmates.

31. Richland County was aware and had substantial grounds to anticipate that reducing the authorized security and custody staffing, and or continuing to operate the ASGDC at inmate population levels with progressively lower actual security and custody levels beyond its protective capacity, would significantly expose SMI inmates to increasingly heightened risks of substantial and serious harm.

A. Richland County is aware how the care and custody of SMI is inadequately managed. Specifically, SME was informed during the January 2024 onsite inspection by Director Harvey that the SMI inmate population was being housed in virtually all housing units throughout the facility, include solitary confinement / segregation, and comprised approximately 60 to 70 percent of the ASGDC total inmate population. The size of the SMI population was similarly stated by the ASGDC Mental Health Coordinator in her

deposition[15]. Incarcerating seriously mentally ill individuals in jails throughout a jail facility, particularly in solitary confinement, raises significant concerns related to both the well-being of the SMI inmates and the operational challenges faced by the facilities. For example:

1. ASGDC is not adequately equipped with the resources or environments necessary to provide adequate mental health care. The environment in jails, characterized by high stress, limited privacy, and often an absence of routine mental health services, can exacerbate existing mental health conditions. Symptoms such as psychosis, depression, and anxiety can worsen, leading to a deteriorating state of mental health.
2. It is well documented in the scientific research that inadequate facilities and lack of adequate supervision and inappropriate housing SMI inmates (as well as non-SMI inmates) can have severe psychological effects, particularly on those with pre-existing mental illnesses. The isolation can lead to an increase in symptoms such as hallucinations, paranoia, and suicidal thoughts. The lack of meaningful social interaction and sensory stimulation in solitary confinement is particularly detrimental to mental health, often resulting in long-term psychological impact.
3. Managing seriously mentally ill inmates in a general jail population at ASGDC can pose safety risks to both the inmates themselves and to others, including other inmates and jail staff. Behavioral unpredictability associated with some mental health conditions can lead to conflicts and violence, complicating management and safety protocols within the facility.
4. ASGDC inmates with serious mental illnesses are at a higher risk of self-harm and suicide, especially when placed in solitary confinement. The solitary environment,

[15] Laurrinda Saxon-Ward, Deposition, January 2, 2024, p.136, 2-13.

lacking in supervision and mental health support, may lead to harmful behaviors that are not promptly addressed.

5. The lack of adequate care and housing of SMI inmates at ASGDC can raise legal and ethical issues, including violations of the Eighth and Fourteenth Amendments of the U.S. Constitution, which prohibits cruel and unusual punishment and affords specific rights to pretrial SMI inmates whose rights have not been restricted by a criminal conviction. There have been numerous lawsuits and criticisms from human rights organizations regarding the treatment of mentally ill inmates, particularly concerning the use of solitary confinement.
6. The ASGDC environment, particularly when it involves solitary confinement, is not conducive to the rehabilitation of mentally ill individuals. The lack of appropriate and constitutionally mandated mental health care and rehabilitative programs can hinder the prospects for successful reintegration into society, increasing the likelihood of recidivism.
7. Despite these concerns, examination of records, onsite assessment of ASGDC conditions of confinement, and discussions with staff and SMI inmates clearly finds that Richland County has either not accurately interpreted the urgency of these basic jail management issues, and/or not taken the basic and reasonable measures to mitigate the real and potential harm that these issues impose on SMI inmates:
    - Richland County does not provide comprehensive mental health services that provide a basic array of individualize care and treatment options.
    - Despite the very late development of “quasi-specialized” housing units for this population, inadequate custody and health care staffing levels continue to impede realization of known benefits of true specialized housing units.

- SMI found from the ASGDC staffing training report reflects insufficient pre and in-service training on the care, custody, and management of an SMI population and there is virtually no in-service or other specialized training related to this issue.

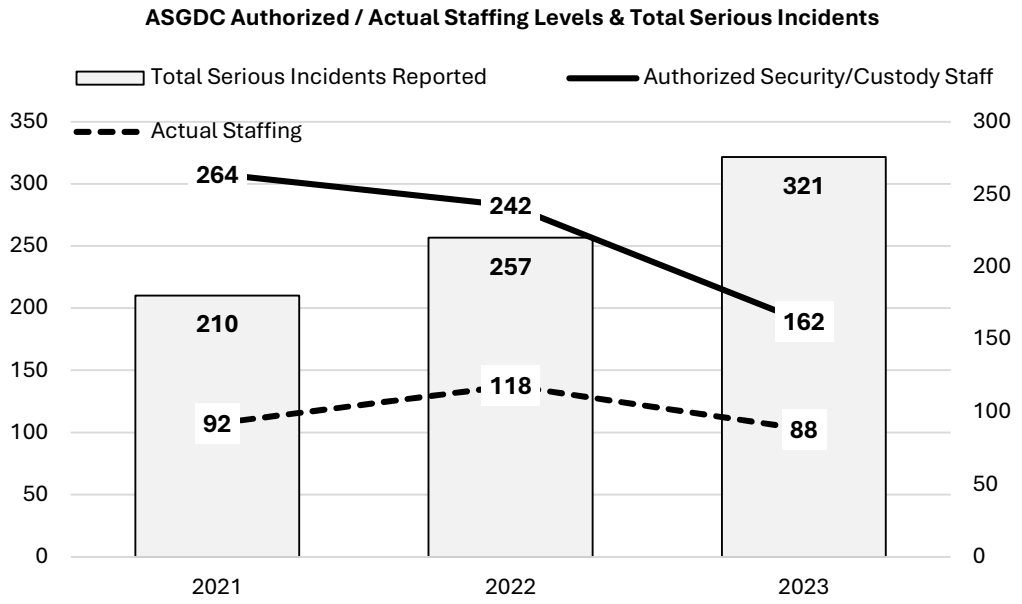
B. Comprehensive studies conducted in 2008 and 2014, under the commission of Richland County, systematically highlighted significant staffing inadequacies within ASGDC. These assessments not only diagnosed serious shortfalls but also offered a suite of professional recommendations aimed at enhancing staffing practices intended to safeguard the well-being, custody, and protection of SMI inmates. Notably, the 2014 analysis revealed a concerning trend: Richland County had yet to act on several critical suggestions provided five years prior, in 2008, to address and ameliorate these pressing conditions.

C. The South Carolina Department of Corrections (SCDC) has consistently raised red flags about Richland County through its annual inspections of ASGDC, specifically pointing out severely insufficient staffing levels since at least 2018. Despite these clear warnings, Richland County made decisions to decrease security and custody levels in 2019, 2022, and once more in 2023. These actions, authorized at the county level, directly contradicted the advisories aimed at rectifying the identified staffing deficits.

D. Since at least 2021, Richland County has been in possession of data and intelligence underscoring the risks of actual and potential harm to SMI inmates, which correlate with the reductions in authorized staffing levels. This information explicitly indicates a disturbing upward trend in, for example, the presence of contraband, weapons, controlled substances, and assaults on both SMI inmates and staff within the facility. The persistence of these issues, despite clear evidence and warnings, underscores a significant lack of effective oversight by both county and ASGDC officials regarding the direct impact of staffing level adjustments on safety and security within the facility. Examination of these

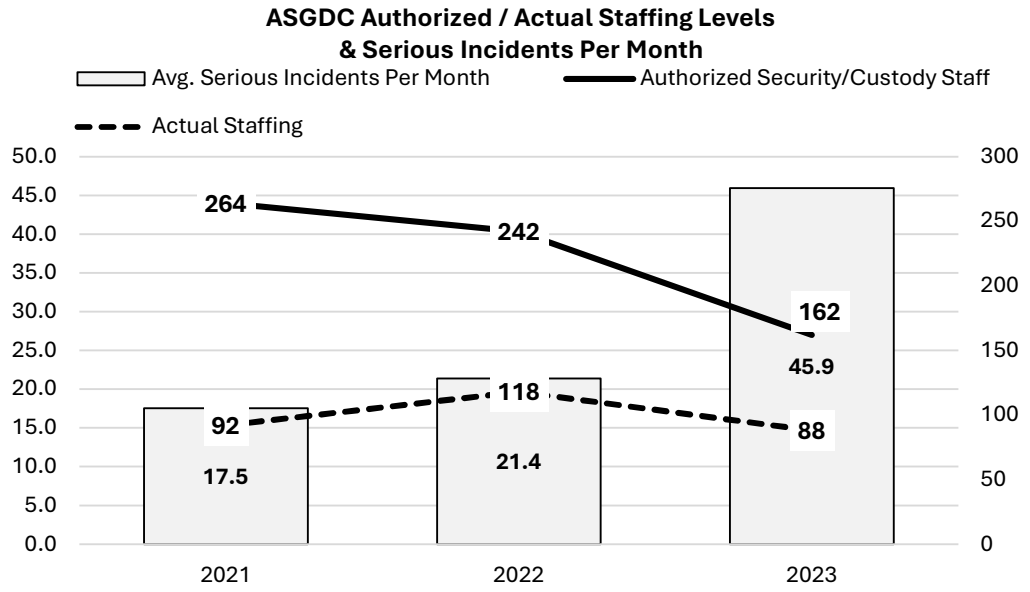
2021 through July 2023 data identified the presence of known and increase levels of harm risks and actual incidents of harm:[16]

1) According to data maintained by Richland County, approximately 788 serious incidents occurred at ASGDC from 2021 to July 2023.[17] Serious incidents reported surged from 210 in 2021 to 321 in 2023, an increase of 111 incidents (52.9% increase). Average Serious Incidents Per Month more than doubled from 17.5 in 2021 to 45.9 in 2023, an increase of 28.4 incidents (162.2% increase).

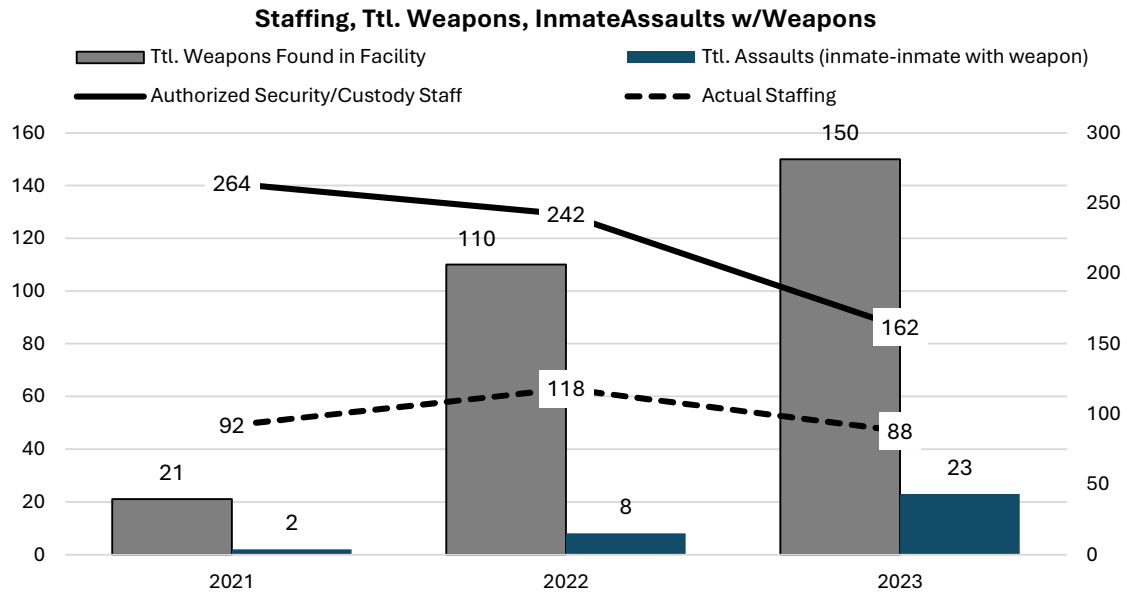


[16] The data was sourced from the annual incident datasets provided by ASGDC officials covering the period from January 2021 to July 2023. To facilitate more precise comparisons, average monthly incident rates were computed. These data are used by ASGDC in accordance with American Correctional Association (ACA) accreditation standards. It is important to note that the average monthly figures, especially for the year 2023, may appear elevated relative to the total number of incidents due to the dataset for 2023 was provided for only seven months.

[17] Serious incidents herein include weapons and controlled substances found with the facility, inmate-on-inmate and inmate-on-staff assaults with and without weapons.



2) There were 281 weapons retrieved with ASGDC between January 2021 and July 2023. Total Weapons Found in Facility jumped from 21 in 2021 to 150 in 2023, an increase of 129 weapons (614.3% increase). Average Weapons Found in Facility Per Month escalated from 1.8 in 2021 to 21.4 in 2023, an increase of 19.7 weapons (1124.5% increase). As authorized staffing levels were reduced and actual staffing levels decreased during this period, a substantial increase of weapons at ASGDC corresponds to a substantial increase in inmates using weapons to assault other inmates.



3) The increasing presence of weapons within ASGDC poses a substantial risk of harm to both staff and SMI inmates, causing an environment fraught with actual and potential violence and undermining the overarching goals of safety, security, and rehabilitation. Examples of potential and actual harm include:

a. Risks to SMI Inmates

i. Increased Violence: Weapons escalate the potential severity of inmate-on-inmate violence. Incidents of assault can lead to serious injuries or fatalities, significantly endangering the lives of those within the facility. The fear of violence can also pervade the inmate population, contributing to a stressful and hostile environment that is antithetical to rehabilitative efforts.

ii. Power Imbalances: Weapons can be used to establish and maintain power hierarchies within the inmate population. These dynamic fosters coercion, exploitation, and bullying, severely affecting the mental health and well-being of vulnerable inmates and disrupting the social order within the facility. This is particularly concerning considering the fact the staffing levels provide very little supervision of organized gang members and their activities, such has the "[the] large majority of the contraband is orchestrated through gangs in some for or fashion."[18]

b. Retaliatory Actions: The presence of weapons often leads to cycles of retaliation and vendettas among inmate groups, escalating conflicts and making them more difficult for staff to manage and resolve.

c. Risks to Staff: The high prevalence of contraband, particularly weapons, combined with severe staff shortages place staff at extreme risk of harm. For example, the

[18] Crayman Harvey, Deposition, December 15, 2023, p.301, 3-12.

October 2023 Staffing Needs Assessment for the Richland County Detention Center included an analysis of Worker's Compensation Claims. This analysis reported there were 177 claims from 2018 through 2022. This analysis found that 80 (45%) involved staff injuries resulting from being struck by a person or object, and that the most frequent staff injury at ASGDC was being struck or assaulted by inmate. The report concludes that analysis stating, "[u]derstaffing, [o]fficer fatigue, and mandatory overtime are contributing to the increase in [o]fficer assaults." [19]

i. Direct Assaults: Staff are at a heightened risk of being assaulted by inmates armed with weapons. Such assaults can result in serious physical injuries, long-term psychological effects, and, in extreme cases, death. The threat of violence against staff also creates an atmosphere of fear and anxiety, which can impact their performance and overall well-being.

ii. Hostage Situations: Inmates with access to weapons pose a risk of taking staff members hostage as a means of bargaining with prison authorities. These situations are highly volatile and can lead to severe trauma for hostages and significant security challenges for the institution.

iii. Compromised Security and Control: The ability of inmates to acquire and conceal weapons undermines the authority of staff and the overall security of the facility. It signals vulnerabilities in security protocols and can lead to a decrease in staff morale and confidence.

d. Operational and Systemic Implications: The risks associated with inmates possessing weapons extend beyond immediate physical harm, affecting the broader operational and systemic functions of correctional facilities:

[19] Staff Needs Assessment for the Richland County Detention Center (Alvin S. Glenn) October 26, 2023, p.2

i. Resource Allocation: Increased violence and the threat thereof necessitate greater allocation of resources towards security measures, potentially diverting funds from rehabilitative programs and services.

ii. Legal and Ethical Ramifications: Incidents involving weapons can lead to legal actions against the facility, including lawsuits for failing to protect SMI inmates and staff. Such situations also raise ethical questions regarding the duty of care owed by correctional institutions to those under their charge.

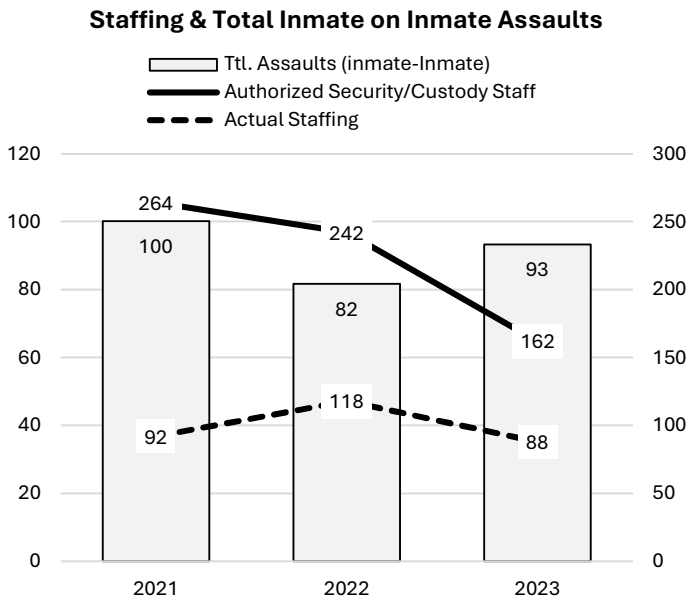
iii. Public Perception and Trust: High-profile incidents of violence facilitated by inmate possession of weapons can erode public trust in the correctional system, questioning its effectiveness in maintaining safety and security.

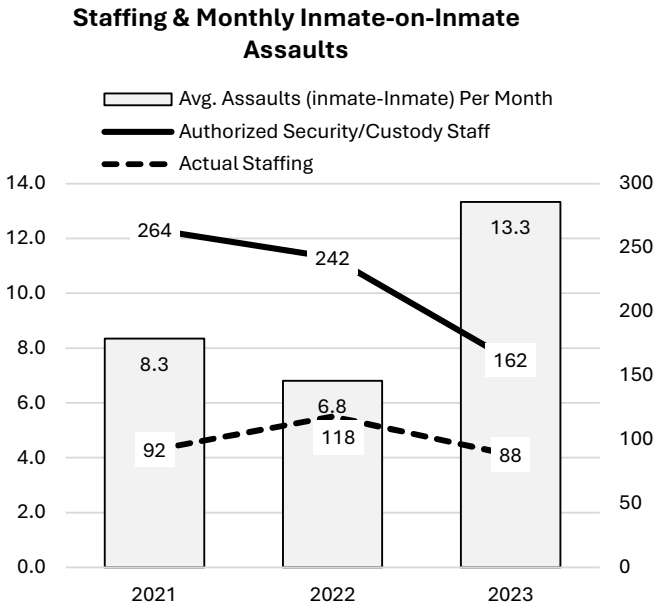
4) Total Controlled Substances Found in Facility increased from 3 in 2021 to 38 in 2023, up by 35 substances (1166.7% increase). Average Controlled Substance Found in Facility Per Month increased from 0.25 in 2021 to 5.43 in 2023, up by 5.2 substances (2071.4% increase).

5) There were 457 inmate-on-inmate and inmate-on-staff assaults from January 2021 through July 2023. Total assaults decreased from 186 in 2021 to 133 in 2023, down by 52.7 assaults (28.3% decrease). Average Assaults (inmate-inmate / inmate-staff) Per Month increased from 15.5 in 2021 to 19.1 in 2023, up by 3.5 assaults (22.9% increase).[20]

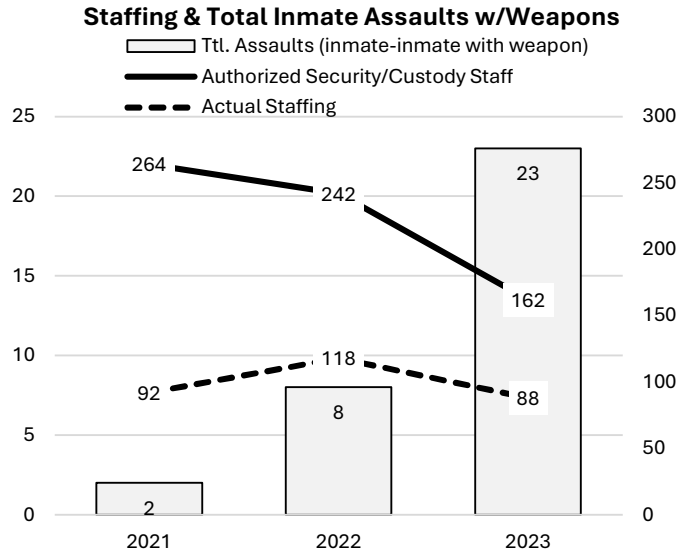
6) Total Assaults (inmate-inmate) slightly decreased from 100 in 2021 to 93 in 2023, down by 6.9 assaults (6.9% decrease). Average Assaults (inmate-Inmate) Per Month increased from 8.3 in 2021 to 13.3 in 2023, up by 5.0 assaults (59.7% increase).

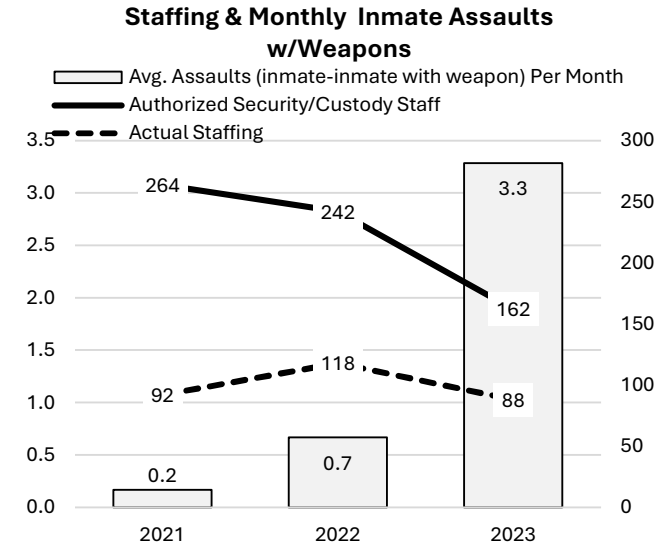
[20] Total incident data was provide for January 2021 through July 2023. Charts showing monthly incidents are used to measure incident trends over equivalent periods.





7) Total Assaults (inmate-inmate with weapon) increased from 2 in 2021 to 23 in 2023, up by 21 assaults (1050.0% increase). Average Assaults (inmate-inmate with weapon) Per Month increased from 0.2 in 2021 to 3.3 in 2023, up by 3.1 assaults (1871.4% increase).





8) Total Assaults (inmate-staff) decreased from 86 in 2021 to 40 in 2023, down by 45.9 assaults (53.3% decrease). Average Assaults (inmate-staff) Per Month increased from 7.2 in 2021 to 45.9 in 2023, an increase of 28.4 assaults (162.1% increase).

9) The first inmate assault on staff that involved a weapon was reported in 2023.

10) Contraband is not always considered a serious incident and is likely to be included in some of the data described above. Regardless, the presence of contraband within jail facilities poses significant risks to both inmates and staff. Known examples of principal hazards associated with contraband in a jail include:

e. Risks to SMI Inmates:

i. Violence and Coercion: Contraband, especially weapons and illicit substances, can escalate violence among inmates. Weapons facilitate assault and intimidation, while drugs contribute to dependency and associated violent behavior for procurement. This environment undermines safety and can lead to serious injuries or fatalities.

ii. Health Complications: Illicit drugs and non-approved medications pose serious health risks, including overdose, adverse reactions, and the spread of infectious diseases through shared usage implements. Additionally, contraband substances often lack purity, increasing the risk of poisoning.

iii. Undermining Rehabilitation: The availability of drugs and other prohibited items compromises the rehabilitative objectives of correctional facilities. Substance abuse hampers participation in educational and therapeutic programs designed for rehabilitation and successful reintegration into society.

f. Risks to Staff:

i. Physical Harm: Staff are at risk of physical assault involving contraband weapons. Such incidents not only affect physical well-being but also psychological health, leading to increased stress, burnout, and job dissatisfaction.

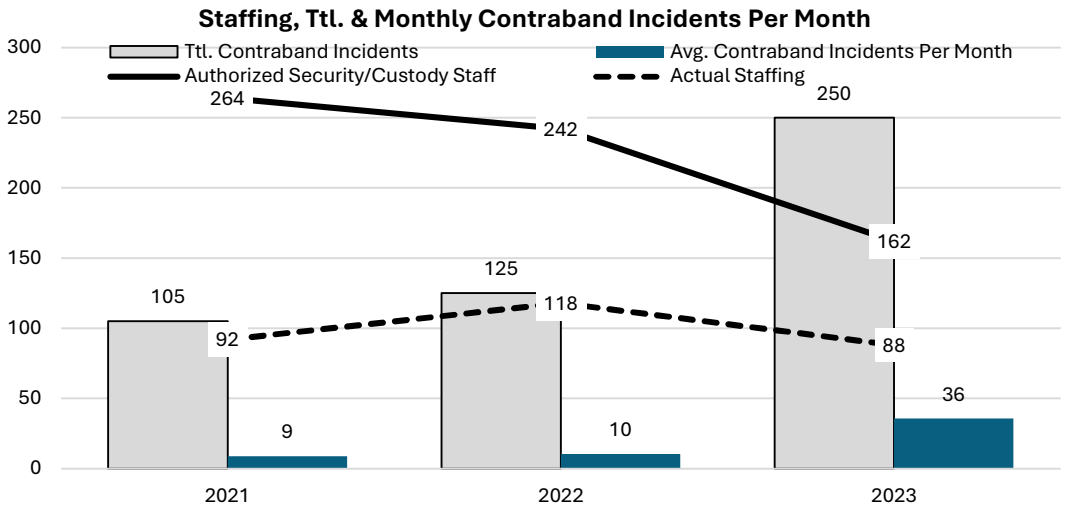
ii. Corruption and Coercion: The introduction and distribution of contraband can corrupt staff, undermining the integrity of correctional institutions. Coercion by inmates or external entities can lead to unethical behavior, including smuggling of contraband.

iii. Legal and Professional Repercussions: Staff implicated in contraband activities face legal consequences, including criminal charges, job loss, and reputational damage. Such incidents also erode public trust in correctional systems.

g. Operational Impacts

The presence of contraband significantly strains institutional resources, diverting attention from rehabilitation to containment and control. Increased surveillance, searches, and disciplinary actions escalate operational costs and complicate the management of inmate populations.

11) There were 480 contraband incidents from January 2021 through July 2023. Contraband Incidents increased from 105 in 2021 to 250 in 2023, up by 145 incidents (138.1% increase). Average Contraband Incidents Per Month rose from 9 in 2021 to 36 in 2023, an increase of 27 incidents (308.2% increase).



12) This analysis of ASGDC data sets supports an imperative for Richland County to reassess and enact the recommendations outlined in both the 2008 and 2014 studies. Additionally, it emphasizes the importance of heeding the consistent warnings issued by the South Carolina Department of Corrections (SCDC) and addressing the pervasive risks identified through known internal data and other credible sources of information.

13) It is crucial for Richland County to prioritize these recommendations and warnings, and rapidly implement a comprehensive remediation plan. Failing to do so not only continue to persistently jeopardize the safety and well-being of the SMI inmate population but also risks breaching the jurisdiction's affirmative duty to adequately protect its SMI inmates.

14) Furthermore, operating a facility with an inmate population that exceeds the capacity to ensure their safety due to insufficient staffing levels is untenable. Richland County must recognize the ethical and legal obligations associated with SMI inmate welfare and take proactive measures to align staffing levels with the needs of the population.

32. Richland County's extant failure to adhere to its long-established policies and procedures regarding three crucial aspects—namely, 1) accurately determining required security staffing levels, 2) maintaining consistently required staffing levels within housing units, and 3) conducting required mandatory inmate welfare checks—has significantly exacerbated the likelihood and increased occurrence of serious harm to SMI inmates.

A) To its credit, Richland adopted jails standards promulgated by the American Correctional Association (ACA) since at least 2006 and was previously awarded Accreditation by the ACA for complying with these industry standards. ASGDC policies and procedure 900+ page operations manual is written virtually verbatim to ACA standards.

B) Failure to determine required security and custody staffing levels in accordance with ASGDC policies and procedures:

1) ASGDC Security Staffing Analysis Policy section 2A-14.I. states, *"[a] comprehensive staffing analysis is conducted annually. The staffing analysis is used to determine*

staffing needs and plans. Relief factors are calculated for each classification of staff that is assigned to relieved posts or positions. Essential posts and positions, as determined in the staffing plan, are consistently filled with qualified personnel." Section VII.A. states, *"[as] part of the annual review of the Policy and Procedures Manual, operations and programs, and budget process, the Director or designee will evaluate staffing levels and personnel requirements, to include civil service and positions under contract such as Health Services."* Section VII.B. requires that *"[a] systematic determination of personnel requirements is completed by the Director using the "Shift Relief Factor" formula as recommended by the National Institute of Corrections to determine the number of staff needed for essential positions. This formula considers, at a minimum, holidays, regular days off, personal, vacation, and sick leave."* Finally, Section VII.K. requires the following to be considered when calculating adequate staffing levels:

a. Generally accepted correctional practices;
b. Any findings of inadequacy from internal or external oversight bodies;
c. All components of the facility's physical plant (including "blind spots" or areas where staff and Detainees may be isolated);
d. The composition of the Detainee population;
e. Designated posts as gender specific (gender specific posts and assignments apply only to security staff at the Correctional Officer level and with the exception of Control room assignments and Detainee escort officers. These posts are not to be designated as gender specific to the Detainee(s) being supervised. No supervisory post will be designated as gender specific.);
f. The number and placement of supervisory staff;
g. Institutional programs;
h. Any applicable Federal, State or local laws, regulations, or standards;
i. The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
j. Any other relevant factors.

2) Based on records provided to this SME for review, Richland County did not complete any of the required annual staffing analyses from 2018 through 2022 per ASGDC Security Staffing Analysis Policy section 2A-14.I. If accurate, this finding is exceptionally troubling, consider that fact that Richland County decreased authorized

ASGDC security and custody staff from 301 positions in 2021 to 252 positions in 2022.[21] Furthermore, an additional 65 security and custody positions were frozen in 2023 to divert funding to increase officer salaries and hire additional management staff. Although this may have been a potentially positive move, it resulted in an 114 (38%) absolute decrease in authorized security and custody positions from 2022 to 2023.[22] Such a reduction in SMI inmate protection by Richland County may have had a short term benefit, it was an extraordinarily dangerous decision, particularly considering that it was done in the absence of the required staffing analysis to inform the decision and known increase in ASGDC reported serious incidents.

3) To its credit, Richland County commissioned a staffing analysis in 2023 that was completed October 26, 2023, by the Director of Insurance Services, South Carolina Association of Counties. According to this report, [redacted]”[23] This report provides a good description of ASGDC housing units and calculates a shift relief factor. However, the assessment excludes the most of relevant factors required to be considered when calculating adequate staffing levels in accordance with ASGDC Policy Section VII.K. Specially, the assessment is silent regarding analysis of:

[21] Finding based on analysis of Richland County Detention Center Position Control Reports ending July 1, 2021, and 2023.
[22] In public administration, “Frozen” typically refers to an official hiring moratorium and or defunding of authorized positions to balance approved budgets and or redirect funds to other local government priorities.
[23] Staffing Needs Assessment for the Richland County Detention Center (Alvin S. Glenn), October 26, 2023, p.1.

a. All components of the facility's physical plant (including "blind spots" or areas where staff and detainees may be isolated);
b. The composition of the Detainee population; (there is no discussion on the prevalence of mentally ill / disabled inmates, risks and needs and required levels of care)
c. The number and placement of supervisory staff; (The relief factor calculation combines all security and custody staff rather than separated supervisory from line staff for accurate staffing needs calculations of each).
d. Institutional programs;
e. Any applicable Federal, State or local laws, regulations, or standards; (There is no discussion about ASGDC policy requirements, ACA standards levels of services, NCCHC levels of inmate health care, provision of adequate care, treatment and custody of mentally ill / disabled inmates).
f. The prevalence of substantiated and unsubstantiated incidents of sexual abuse; and
g. Any other relevant factors.(Which should include examination of the prevalence and changes in the volume of serious incidents).

4) The evaluation of the staffing needs for Richland County, as conducted, does not align with the established guidelines set forth by the ASGDC policy, nor does it meet the criteria for comprehensiveness as stipulated by the National Institute of Corrections (NIC). The NIC articulates a staffing analysis as "a comprehensive and systematic process of determining staff needs, which adapt in response to shifts in the facility's philosophy, operations, or physical structure, and the development of corresponding staff assignment patterns." While the methodology implemented in this assessment exhibits systematic characteristics, it fails to encapsulate the breadth required for a comprehensive analysis.

5) It is advisable that Richland County exercise caution in depending on this assessment for determining its ASGDC staffing requirements. A notable shortfall is observed in the "Selected Activity Schedule," which lacks inclusion and reference to critical activities associated with the assessment and treatment of inmates with mental health issues. Essential processes such as mental health evaluations, individual and group therapy, crisis services, and tailored treatment plans, and other significant interactions necessitating the presence of security and custody staff are conspicuously absent.

Furthermore, the assessment does not account for the time required by officers to manage various spontaneous incidents, including inmate riots and other serious or minor disruptive events caused by inmates.

6) Given these omissions, the assessment fails to provide a fully accurate or reliable basis for calculating the staffing needs essential for the safe, efficient, and humane operation of the ASGDC facility. It is imperative for Richland County to seek a more thorough analysis that conforms to ASGDC policy requirements and NIC's comprehensive framework to ensure staffing levels are effectively aligned with operational demands and SMI inmate care standards.

C) Failure to maintain required staffing levels within housing units required by ASGDC policy.

1) ASGDC Policy 2A-03 Security Housing Units Officer Posts / Locations, states that officer posts [redacted][25] Being a "direct supervision facility, ASGDC [redacted]

[26] Richand County's extant staffing practices routinely prohibit reliably prompt response in emergency situations involving SMI inmates, adequate SMI inmate

[24] Policy Section 2A-03, Section I as stated.
[25] Ibid. Section II.
[26] Ibid. Section IV.A.

monitoring and accessibility services, surveillance of SMI inmates, and thus, ASGDC does not provide minimally adequate supervision and protection of SMI inmates.

2) ASGDC Policy 2A-03 IV.C. mandates a strict staffing requirement for, stipulating the continuous presence of at least one officer on duty around the clock, every day of the year. This directive is foundational to maintaining security, SMI inmate protection, order, and accessibility to emergency assistance within these facilities.[27] Despite the clarity and imperative nature of this policy, a thorough review and analysis of 401 shift rosters spanning from 2020 to 2023[28] reveal a consistent pattern and persistent practice of Richland County failing to adhere to these minimum staffing guidelines. The analysis, which meticulously evaluated data from 22 shifts in 2020, 191 shifts in 2021, 43 shifts in 2022, and 145 shifts in 2023 (N=401 Rosters), provides compelling evidence of a systemic issue of non-compliance to long-standing inmate protection policy. This pattern not only undermines the policy's objective but also potentially jeopardizes the safety and well-being of both inmates and staff within the housing units.

3) The analysis of the 401 shift rosters from 2020 to 2023 reveals significant failure to comply with policy. Specifically, the data indicates that housing units were not staffed at all on 1,527 occasions, which accounts for 17.2% of the total shifts examined. Furthermore, there were 3,778 instances (42.3% of the shifts) where staffing levels fell below the threshold of one officer. Conversely, shifts were staffed by at least one officer 5,185 times, representing 58% of the total shifts analyzed. This evidence indicates that Richland County on average provides just over a 50% probability that ASGDC inmates will receive adequate and timely supervision, care, and protection due to persistent non-compliance with policy. The data

[27] Ibid

[28] Data were excluded for housing units reported as "Closed" on shift rosters. Therefore, the number of shifts included in the analysis will differ.

underscores the imperative need for strategic interventions to enhance staffing consistency, thereby ensuring the safety and well-being of both inmates and staff.

ASGDC Housing Unit Staffing 2020-2023 (401 Shift Rosters)[29]

Unit	Ttl Shifts	No Staff	Less Than One Staff	At Least One Staff	% No Staff	% Less Than One Staff	% At Least One Staff
A	401.0	54	176	225	13.5%	43.9%	**56.1%**
B	401.0	36	165	236	9.0%	41.1%	**58.9%**
D	401.0	62	168	233	15.5%	41.9%	**58.1%**
E	401.0	261	364	37	65.1%	90.8%	**9.2%**
F	401.0	68	189	212	17.0%	47.1%	**52.9%**
G	401.0	2	320	320	0.5%	79.8%	**79.8%**
H	401.0	1	76	325	0.2%	19.0%	**81.0%**
I	401.0	1	78	323	0.2%	19.5%	**80.5%**
J	401.0	0	80	321	0.0%	20.0%	**80.0%**
K	401.0	21	137	264	5.2%	34.2%	**65.8%**
L	401.0	21	139	262	5.2%	34.7%	**65.3%**
M	401.0	11	35	366	2.7%	8.7%	**91.3%**
P	401.0	1	41	360	0.2%	10.2%	**89.8%**
P Suicide	400.0	164	199	201	41.0%	49.8%	**50.3%**
U	401.0	151	230	171	37.7%	57.4%	**42.6%**
X	401.0	10	71	330	2.5%	17.7%	**82.3%**
Y	295.0	39	53	242	13.2%	18.0%	**82.0%**
SHU	295.0	39	39	256	13.2%	13.2%	**86.8%**
MAX	318.0	39	155	163	12.3%	48.7%	**51.3%**
Juv A	401.0	69	275	126	17.2%	68.6%	**31.4%**
Juv B	401.0	69	331	70	17.2%	82.5%	**17.5%**
Juv C	401.0	55	99	99	13.7%	24.7%	**24.7%**
Juv Suicide	401.0	353	358	43	88.0%	89.3%	**10.7%**
Total	**8,927**	**1,527**	**3,778**	**5,185**	**17.1%**	**42.3%**	**58.1%**

4) ASGDC Policy 2A-03 IV.F. requires [redacted]. [30] [31] A fundamental purpose of this policy is to maintain consistent and frequent observation of inmates, their safety and

[29] Juvenile housing unit data are included as it was part of the data set provided. Inclusion of these data intends to represent analysis completeness, not to exaggerate the findings.
[30] Ibid.
[31] ASGDC Policy 2A-02 III. defines Special Management Units as [redacted] This includes mentally ill / disabled, vulnerable, predatory, violent, etc.

security, and to detect and prevent harm. However, analysis of electronic safety and welfare checks records (Watch Tour) from 02:13am, January 1 through 3:02pm, January 25 (approximately 24.5 days) strongly evidences that Richland County fails to adhere to this inmate protection policy:

a. According to ASGDC policy, there should have been approximately 1,176 rounds clocked for each housing unit occupied by inmate during the 24.5 days examined.[32] This first requirement was not met for any housing unit, with only a maximum number of rounds clock of 442 (G Unit) and a minimum number of rounds clocked of 28 (L Unit). The average number of total rounds clocked during this period was 196 or approximately 17% percent of required clocks being done as shown in the Visual below. [33]

ASGDC Clocked Rounds 01/01-25/2024

Housing Unit	Required Clocked Rounds (approx.)	Total Rounds Clocked	Percent of Required Clocked Rounds Done
A Unit	1,176	94	**8.0%**
B Unit	1,176	78	**6.6%**
D Unit	1,176	83	**7.1%**
E Unit	1,176	392	**33.3%**
F Unit	1,176	73	**6.2%**
G Unit	1,176	442	**37.6%**
H Unit	1,176	378	**32.1%**
I Unit	1,176	392	**33.3%**
J Unit	1,176	353	**30.0%**
K Unit	1,176	51	**4.3%**
L Unit	1,176	28	**2.4%**
M Unit	1,176	207	**17.6%**
U Unit	1,176	83	**7.1%**
X Unit	1,176	112	**9.5%**
Z Unit	1,176	169	**14.4%**
Total	17,640	2,935	**16.64%**

b. Next, of the clocks that were done, less than half (approximately 44.1%) of them were within the [redacted] policy requirement, as shown in the Visual below.[34]

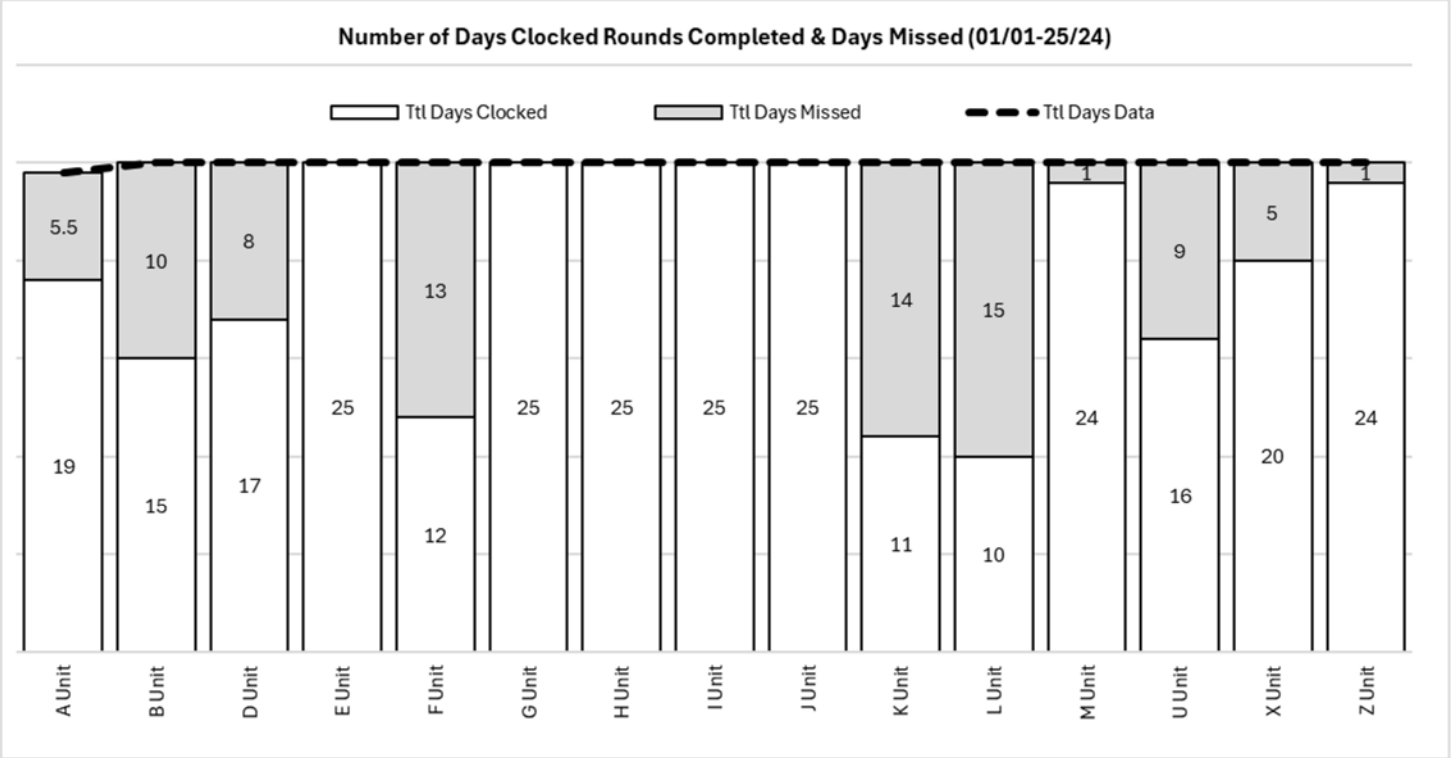
[32] [redacted]

[33] Papa (P Unit) is excluded because it was closed.

[34] Data are not include for days when housing units were closed.

ASGDC Housing Unit Rounds Clocked January 1-23, 2024																
Clocking Frequency	**A Unit**	**B Unit**	**D Unit**	**E Unit**	**F Unit**	**G Unit**	**H Unit**	**I Unit**	**J Unit**	**K Unit**	**L Unit**	**M Unit**	**U Unit**	**X Unit**	**Z Unit**	**Total**
<=Every 30 Minutes	**39**	**33**	**37**	**195**	**34**	**212**	**156**	**180**	**148**	**24**	**10**	**101**	**37**	**49**	**40**	**1296**
> 1 to 2 Hrs	11	7	5	108	7	131	124	114	109	3		28	4	17	50	718
> 2 Hrs. to 4 Hrs.	5	6	10	51	9	56	51	49	45	4		24	6	9	26	351
> 4 Hrs. to 8 Hrs.	21	20	18	34	16	40	44	45	46	11	9	47	23	18	39	432
> 8 Hrs. to 12 Hrs.	3	1	3	1	2	3	3	3	1	1	1	1	3	4	8	38
> 12 Hrs. to 18 Hrs.	10	6	3	2	2			1	4	2	4	2	3	8	2	49
> 18 Hrs. to 24 Hrs.	2	3	1								1	1	2	2	3	15
> 24 Hrs. to 36 Hrs.			2	1								2		3		8
> 36 Hrs. to 48 Hrs.	1		1							3	1	1	3		1	11
> 48 Hrs. to 72 Hrs.	1		2		1					1				2		8
>72 Hrs.	1	2	1		2					2	2		2			14
Ttl. Rounds Clocked	94	78	83	392	73	442	378	392	353	51	28	207	83	112	169	2,940
Ttl. Rounds Required	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	1,176	17,640
Required Rounds Done	**8.0%**	**6.6%**	**7.1%**	**33.3%**	**6.2%**	**37.6%**	**32.1%**	**33.3%**	**30.0%**	**4.3%**	**2.4%**	**17.6%**	**7.1%**	**9.5%**	**14.4%**	**16.7%**
Done <=Every 30 Mins.	**41.5%**	**42.3%**	**44.6%**	**49.7%**	**46.6%**	**48.0%**	**41.3%**	**45.9%**	**41.9%**	**47.1%**	**35.7%**	**48.8%**	**44.6%**	**43.8%**	**23.7%**	**44.1%**
Not Done Every 30 Mins.	**58.5%**	**57.7%**	**55.4%**	**50.3%**	**53.4%**	**52.0%**	**58.7%**	**54.1%**	**58.1%**	**52.9%**	**64.3%**	**51.2%**	**55.4%**	**56.3%**	**76.3%**	**55.9%**

c. Finally, analysis of clocked rounds data indicate that rounds were not clocked from one to several days during this period as shown in the Visual below.[35]



5) Richland County's persistent practice and pattern of non-compliance with its long-established inmate protection policies has, and continues to significantly amplify the risk of harm, both actual and potential, to its inmate population. The failure to

[35] P (Papa Unit) was close most of January 2024 and is not shown on this chart.

adequately assess and sustain requisite staffing levels, coupled with the continuation of inmate population levels that far surpass the facility's capacity for reliable protection, has markedly increased inmates' vulnerability to a spectrum of risks. These risks include, but are not limited to, violence, medical emergencies, and mental health crises. Additionally, the inconsistency in conducting mandatory welfare checks exacerbates the situation, potentially subjecting inmates to extended durations without essential intervention or support. This disregard for procedural adherence undermines the safety and well-being of the inmate population, necessitating immediate rectification to mitigate the heightened risk exposure.

33. This SME has personal knowledge that supports and substantiates the facts and conclusions stated in this report.

A) This SME participated in a four-day tour of the ASGDC facilities from January 22 to January 25, 2024. This visit included observations of the facility conditions of confinement and the operational practices within the housing units. Additionally, the SME engaged in discussions with staff members and interviews with SMI inmates to gather in-depth insights into the facility's operations, conditions, risks, and needs.

B) The assessment of the conditions at the ASGDC and its impact on both SMI inmates and staff revealed a series of significant concerns. The findings indicate that the overall environment is poorly maintained, leading to unsanitary and unsafe conditions that expose SMI and non-SMI inmates and staff to pervasive risks of harm. Across most inmate living areas (units), there is a consistent failure to uphold basic cleanliness and maintenance standards. This includes, for example, the presence of dirt, clutter, and food waste accumulation, alongside hazardous conditions such as standing water, exposed and active electrical wires, and significant mold growth in living and communal areas. The pervasive odor of burnt smoke and filth further diminishes the

living conditions and exacerbates risk of violence and harm; and contravene ASGDC policy, state regulations, and international standards for confinement.[36] Examples witnessed include:

1. A Unit: This unit is severely overcrowded, with 81 inmates housed in a facility designed for 56, leading to inadequate sleeping arrangements where numerous inmates resort to sleeping on the floor on plastic beds that are not secured, posing significant safety and hygiene concerns.
2. Unit X: Houses inmates with serious mental illnesses, this lockdown segregation unit is notable for its inadequate lighting—most ceiling lights are missing, and exposed electrical wires present a severe hazard. The lack of proper lighting and the presence of hazardous conditions are particularly concerning given the vulnerability of the inmate population within this unit.
3. B Unit (Male Inmate Medical Unit): Exhibits alarming neglect in a medical care setting, with only two out of six toilets operational. The shower stalls are poorly lit, dark, and unsanitary, conditions that are compounded by the presence of crusted soap, clutter, and mold on the floors, presenting significant health risks to inmates requiring medical care.
4. M Unit (Mental Health Dorm): Overcrowded with 62 inmates in a space designed for 56, this unit also has inmates sleeping outside designated cell areas on the floor on unsecured plastic beds, particularly in the B8 section. Such conditions in a

[36] Mandella Rules 15,16, and 17 state that *"… sanitary installations shall be adequate to enable every prisoner to comply with the needs of nature when necessary and in a clean and decent manner (15"). That "[a]dequate bathing and shower installations shall be provided so that every prisoner can, and may be required to, have a bath or shower, at a temperature suitable to the climate, as frequently as necessary for general hygiene according to season and geographical region, but at least once a week in a temperate climate (16"), and that "[a]ll parts of a prison regularly used by prisoners shall be properly maintained and kept scrupulously clean at all times".* The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).(at:https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf). See also, ACA Correctional and South Caroline Jail Standards.

mental health care environment can exacerbate the challenges and risks associated with providing adequate mental health support.

5. D Unit: Communication is severely hampered with only two of three wall phones operational. The safety and well-being of inmates are further compromised by several lights being covered with paper, reducing visibility and creating a fire hazard.
6. U Unit (Open Bunk Dorm): Characterized by a lack of orderliness, with personal items and trash cluttering the living areas. The practice of covering lights and bunks with blankets and sheets not only poses a fire hazard but also reflects the inadequate living conditions and the inmates' attempts to create privacy, underscoring the fundamental issues of overcrowding and lack of personal space.
7. Janitorial Closets: The lack of security in janitorial closets allows inmates access to potential weapons and hazardous cleaning materials. Additionally, maintenance issues such as dripping sinks and the use of buckets to collect dirty water signal a disregard for even the most basic standards of sanitation and facility upkeep.

C) These conditions across the various housing units not only fail to meet basic health and safety standards but also highlight a systemic neglect of SMI inmate welfare. The cumulative effect of these deficiencies presents significant risks to the health, safety, and dignity of the SMI inmate population, demanding urgent and targeted interventions to rectify these critical issues.[37]

[37] V. St. J., Saint Louis. (2023) examined the influence of place management on victimization within jails and found ineffectively managed facilities may set the stage for victimization by exposing persons in custody to coercive interactions, inadequately surveilled places, deplorable physical conditions, and limited access to quality health services. The study concludes that mismanaged jails influence the perpetuation of violent victimization. Correctional administrations may foster positive relationships between persons in custody and other occupants as well as minimize the occurrence of violent victimization by ensuring that persons in custody: (a) receive access to quality health services; (b) are exposed to physical and sensory conditions that do not corrode an individual's sense of humanity; (c) live in facilities where drug distribution is properly

a. During the inspection on January 24, 2024, critical staffing shortages were identified across several housing units within the correctional facility, presenting substantial risks to both the safety of the inmate population and the staff. The examination revealed that a solitary officer was tasked with monitoring 143 inmates across three units (A, B, and C), and another officer was responsible for supervising 129 inmates in two units (K and L). This staffing level is markedly inadequate considering the extensive responsibilities necessary to ensure the inmates' safety, security, and fundamental needs are met. Furthermore, the inspection found that 10 (60%) of 17 housing units were operating at or above their designed capacities, with occupancy rates ranging from 100% to an unprecedented 176%, as shown in the table below.[38]

ASGDC 01/24/24 Unit Head Count

Unit	Inmates	Beds Capacity	Over Capacity	% Capacity
A	79	56	23	141.1%
BMU	82	56	26	146.4%
E	60	56	4	107.1%
F	73	56	17	130.4%
I	57	56	1	101.8%
J	56	56	0	100.0%
K	62	56	6	110.7%
L	67	56	11	119.6%
M	99	56	43	176.8%
U	79	56	23	141.1%
Total	714	560	154	

b. This resulted in an excess of 154 inmates beyond capacity for these housing units. Such overpopulation severely complicates the task of effective SMI inmate supervision and significantly heightens the risks to the health, safety, and general welfare of both SMI inmates and staff.

managed; and (d) live in facilities where blind spots are limited. (At https://www.qualitativecriminology.com/pub/lbd1xfet/release/2).

[38] Official ASGDC inmate headcount sheet provided by ASGDC officials.

c. The inspection findings reveal a significant operational challenge within the segregation units (BMU,X), underscoring a critical shortfall in the capacity to meet mandated [redacted] supervisory rounds. These units accommodate a diverse population of inmates, encompassing individuals with special needs, medical conditions, serious mental health issues, those exhibiting predatory behaviors, and those deemed highly vulnerable. The confluence of understaffing, overcrowding, and the resultant incapacity to conduct essential oversight rounds compromises the facility's operational effectiveness and poses substantial risks to mental health inmates who are essentially locked down and isolated in their cells for excessive long periods.[39] This concern is exemplified, for example by the documentation—or lack thereof—pertaining to the BMU segregation unit for the evening of January 22, 2024. Records indicate a gap in "Watch Tour" rounds or welfare checks from 02:35 am until 07:00 am, when the morning shift officer initiated such activities. The subsequent security check was not recorded until 04:43 am on the following day. This gap highlights a critical oversight in the execution of necessary supervisory duties, reflecting the broader systemic issues that threaten both the integrity of correctional operations and the safety and wellbeing of the incarcerated population.[40]

[39] Scientific research published by Nurse J, Woodcock P, Ormsby J (2003) found that *"Prisoners reported that long periods of isolation with little mental stimulus contributed to poor mental health and led to intense feelings of anger, frustration, and anxiety. Prisoners said they misused drugs to relieve the long hours of tedium. Most focus groups identified negative relationships between staff and prisoners as an important issue affecting stress levels of staff and prisoners. Staff groups described a "circle of stress," whereby the prison culture, organization, and staff shortages caused high staff stress levels, resulting in staff sickness, which in turn caused greater stress for remaining staff. Staff shortages also affected prisoners, who would be locked up for longer periods of time, the ensuing frustration would then be released on staff, aggravating the situation still further. Insufficient staff also affected control and monitoring of bullying and reduced the amount of time in which prisoners were able to maintain contact with their families."* (at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC188426/)

[40] It is important to point out the high volume of activities documented on the log during this period, including emergencies occurring in other housing units, shower head being broken by an inmate, medication

d. Addressing these deficiencies requires immediate attention to staffing levels, operational protocols, and the implementation of measures to ensure consistent and thorough supervision of SMI inmates, particularly in units housing individuals with complex and significant needs. The evidence uniquely and unequivocally demonstrates that without prompt and decisive action to rectify these shortcomings, the facility will continue to fail in its duty to provide a safe and secure environment for both SMI inmates and staff.

D) During the onsite interviews with SMI inmates, a prevalent and strongly negative consensus was identified regarding several aspects of their confinement. These concerns encompassed a broad spectrum of issues, including but not limited to the overall conditions of confinement, insufficient staffing levels, inadequate access to basic necessities, and a significant lack of mental health services. Specifically, the reported conditions of confinement highlighted numerous and varied problems:

a. Conditions of Confinement Examples Reported by SMI Inmates:

- Frequent flooding in cells.
- Insect and vermin infestations in living areas.
- Unsanitary or inoperative shower facilities.
- Limited access to drinking water.
- Lack of recreational time for segregated SMI inmates.
- Broken lighting fixtures.
- Mold growth in showers.
- Leaking or clogged plumbing fixtures.
- Exposed electrical hazards.
- Unavailable phone services in cells.
- General disarray and neglect affecting cleanliness.
- Poor cell lighting conditions.
- Unavailability of hot water.
- Service of cold meals.
- Inoperative communication systems in cells.

administration, meal distribution, request for unit shakedown due to smoke emanating from several cells, water flooding six cells, inmate counts. It is impossible for a single officer to provide effective supervision of inmates given these and numerous other tasks and responsibilities during their shift.

- Overall conditions reflect significant non-compliance with confinement standards.
- High incidence of inmate violence.

b. Insufficient staffing levels Examples Reported by Inmates:

- Very little or having no out of cell time for inmates housed in segregation.
- Housing units go without staff for hours or no staff at all.
- Slow response by officers during emergencies.
- Having to use officer's desk phone in housing unit to call for help or response to other inmate needs when officers are not in units.

c. Significant Lack of Mental Health Treatment and Services Reported Examples by Inmates:

- Absence of individual mental health treatment for serious conditions.
- No provision of mental health group therapy.
- Medication administration without water due to restricted access.
- Insufficient assessment or review during suicide watch in segregation.
- Extended suicide watch confinement in segregation.
- Delayed response to mental health service requests.
- Prolonged wait times for mental health evaluations and assessments.
- No follow-up care for mental health issues.
- Untreated acute mental health symptoms with minimal contact with mental health professionals.
- Mental health treatment predominantly restricted to medication and segregation.
- Assaults on mentally ill inmates.
- Segregation of mentally ill inmates with limited out-of-cell time and lack of essential services or recreational activities.

34. Richland County subjects inmates with serious mental illnesses and disabilities to hazardous and squalid conditions for prolonged periods, and without sufficient monitoring or mental health services.

A) SME analyzed approximately 901 records involving the ASGDC housing practices for approximately 473 unique inmates on the mental health caseload.[41] The data provided by Richland County included:

1) Offender ID
2) Inmate Full Name

[41] There were 901 records provided by Richland County. There OffenderIDs for all 901 records but only 884 names, 755 booking times, and 407 actual release times. Housing location times were similarly affected by these data omissions.

3) Booking and Release Dates and Times[42]
4) Inmate Housing Location
5) Date and Time of Housing Placement
6) Date and Time of Housing Location Change

B) Bookings for these inmates on the mental health caseload ranged from May 5, 2018, through January 15, 2024. Release dates ranged from December 16, 2023, through May 3, 2024.

C) The 473 inmates on the mental health case load were incarcerated throughout ASGDC for 255.83 days on average. The longest incarceration was for 2,186.63 days. The average length of stay that an inmate on the mental health caseload was housed in a specific housing unit was 94.4 days on average and a maximum of 574.80 days. These length of stays (LOS) are considered extreme, particularly considering the poor conditions of confinement and the severely inadequate staffing levels and mental health care delivery system. Segregating and isolating mentally ill inmates under these deleterious conditions of confinement is unconscionable.

D) The risk of harm to mentally ill inmates kept in isolation for prolonged periods in unsafe living conditions, without proper monitoring and supervision by corrections officers, is significant. Isolation can exacerbate mental health issues, leading to severe psychological distress, including anxiety, depression, and psychosis. Unsafe living conditions further deteriorate their mental and physical health, increasing the likelihood of self-harm and suicidal behavior. The absence of regular monitoring and supervision by corrections officers means that these inmates are not receiving the necessary care and intervention, which can result in untreated medical and mental health emergencies, ultimately endangering their lives and well-being.

[42] May 3, 2024, is used for release dates for inmates who were not yet released or when there was no housing unit change reported. This was done to calculate how long each inmate has been incarcerated

E) Furthermore, the lack of adequate mental health assessment and treatment for mentally ill inmates (as was found by this SME and Dr. Nicole Johson) in isolation worsens their conditions in several ways. Without proper assessment, their mental health issues may go undiagnosed or misdiagnosed, leading to inappropriate or inadequate care. This lack of treatment can result in the progression of mental illnesses, making symptoms more severe and difficult to manage over time.

F) Without appropriate intervention, inmates may experience heightened levels of anxiety, depression, and psychosis, which can further deteriorate their mental stability. The absence of treatment means that coping mechanisms and therapeutic support are unavailable, increasing feelings of hopelessness and desperation. This exacerbation of mental health conditions can lead to an increased risk of self-harm and suicidal behavior.

G) Concomitantly, untreated mental health issues can manifest in physical symptoms, worsening overall health and potentially leading to chronic medical conditions. The lack of regular mental health assessments also means that any changes or deterioration in an inmate's mental state may go unnoticed, delaying critical interventions that could prevent further harm.

H) Overall, the absence of adequate mental health assessment and treatment creates a cycle of worsening mental and physical health, significantly increasing the risk of harm and reducing the chances of recovery and rehabilitation for mentally ill inmates. As shown in the visual below, the length of stay (LOS) for ASGDC inmates on the mental health caseload is clearly adequate to develop, implement, and monitor individualized treatment plans and treatment for these inmates.

Mental Health Caseload Inmates Lengths of Stay by Housing Unit

SMI Inmate Location	Total Records	Unique Inmates	Average of Ttl. Days Housing LOS	Max of Ttl. Days Housing LOS
ALPHA	80.00	73.00	70.25	282.86
BMU	76.00	62.00	28.24	146.68
BRAVO	32.00	32.00	120.46	295.89
DELTA	53.00	50.00	99.44	203.03
ECHO	95.00	88.00	96.34	574.80
FOXTROT	32.00	29.00	152.78	568.01
GOLF	25.00	25.00	38.08	148.87
HOTEL	34.00	31.00	74.65	304.85
INDIA	40.00	35.00	130.88	351.51
INTAKE	10.00	10.00	18.65	51.65
JULIET	37.00	35.00	49.58	169.04
KILO	35.00	35.00	142.85	533.04
LIMA	33.00	31.00	129.02	430.72
MIKE	70.00	64.00	116.17	545.88
TRANSFER	6.00	6.00	29.47	123.23
UNIFORM	53.00	50.00	111.80	203.05
XRAY	43.00	42.00	144.37	392.88
Grand Total	755.00	473.00	94.54	574.80

35. Richland County's Emergency Medical Services, Fire Department, and Sheriff's Department 911 calls from 2020 through 2023 were examined. This examination clearly evidences foreseeable and significant escalation in the actual and potential risks of serious harm to ASGDC SMI inmates. This information was known or knowable to Richland County for its administration of ASGDC before and during these years.

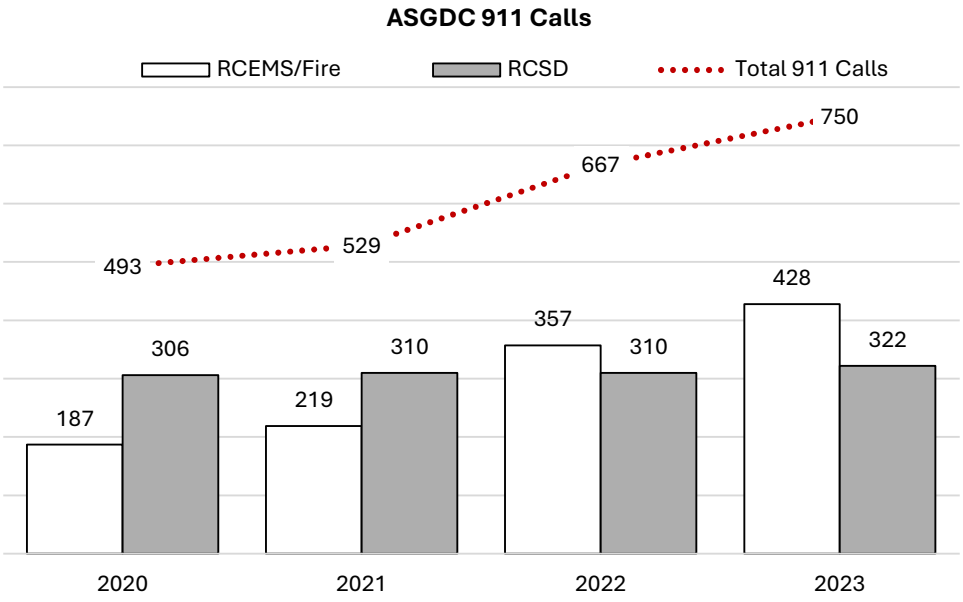
A) The data was methodically reviewed to assess trends in emergency calls relating to the ASGDC, focusing on incidents that required medical, fire, or law enforcement responses. The findings reveal a noticeable increase in the frequency and severity of incidents over the four-year period. This trend not only underscores a growing concern for the safety and welfare of SMI inmates but also highlights a lack of urgency on the part of Richland County to recognize and address these growing risks to SMI inmates.

B) The implications of this data are twofold. First, the increasing number of emergency responses suggests that Richland County did not consider this information and address its urgent nature. Secondly, the trend evidences broader systemic failures regarding the management and County oversight of ASGDC that seriously compromised the safety and protection of ASGDC SMI inmates.

C) There were 2,439 total 911 responses to ASGDC from 2020 through 2023. This included 1,191 911 responses by EMS/Fire services (RCEMS/Fire) and 1,248 911 responses from the Richland County Sheriff's Department (RCSD). Total 911 calls increased approximately 52.1% (+257), from 439 calls in 2020 to 750 in 2023. RCEMS/Fire experienced the largest growth in 911 calls, increasing approximately 128.9% (+241), from 187 in 2020 to 428 in 2023. RCSD experienced a mild increase of 5.2% (+16) from 306 to 322.

ASGDC 911 Calls / Responses

Agency / Year	2020	2021	2022	2023	Total	Diff 20-23	% Diff
RCEMS/Fire	187	219	357	428	1,191	241	128.9%
RCSD	306	310	310	322	1,248	16	5.2%
Total 911 Calls	493	529	667	750	2,439	257	52.1%

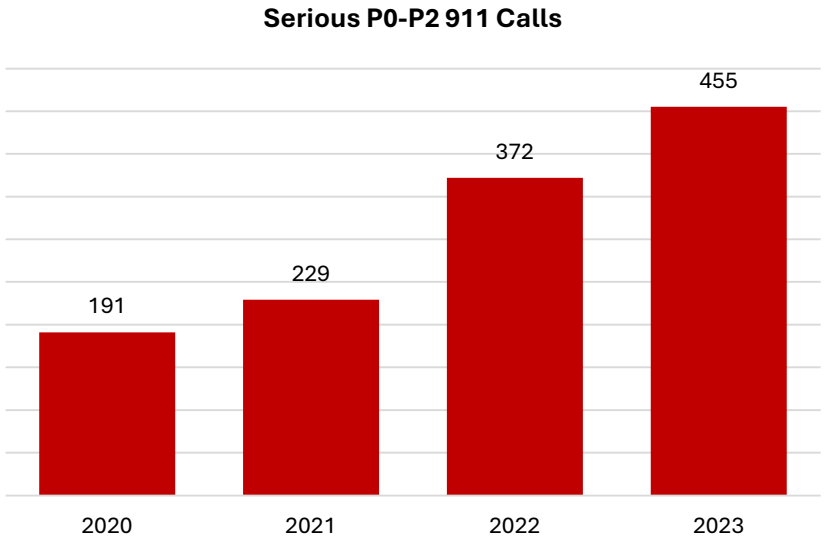


D) 911 responses are categorized into priority levels from P0 to P6 based on the severity and urgency of the event. P0 to P2 priorities are assigned to the most serious incidents, including serious physical injuries, medical emergencies like stabbings or heart attacks, or security emergencies such as riots and bomb threats. Occasionally, P1 to P2 levels may also cover non-serious situations such as reports of suspicious individuals or vandalism.

E) Of the 2,439 total calls from 2020 through 2023, there were 1,281 (52.5%) total P0-P2 calls, including 1,247 (51.1%) serious P0-P2 calls and 34 (1.4%) non-serious calls. Serious calls increased 138.2% (+264), from 191 in 2020 to 455 in 2023. This clearly substantiates a significant increase in the frequency and severity of risks to SMI inmates during this period.

ASGDC 911 Calls

ASGDC 911 Calls	2020	2021	2022	2023	Ttl.	% Ttl.	Diff 19-23	% Diff
Serious P0-P2 911 Calls	**191**	**229**	**372**	**455**	**1,247**	**51.1%**	**264.0**	**138.2%**
Non-Serious P0-P2 911 Calls	8	9	11	6	34	1.4%	-2.0	-25.0%
Ttl. P0-P2 911 Calls	**199**	**238**	**383**	**461**	**1,281**	**52.5%**	**262.0**	**131.7%**
Total 911 Calls	**493**	**529**	**667**	**750**	**2,439**	**100.0%**	**257.0**	**52.1%**



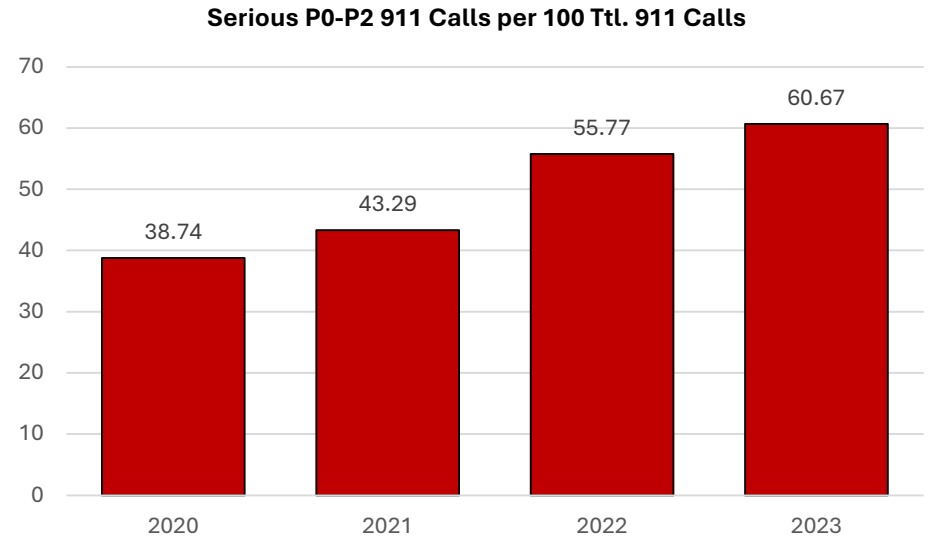
F) Since at least 2020, there has been a significant escalation in known serious P0-P2 calls 1) per 100 total 911 calls, 2) serious P0-P2 calls per 100 average daily inmate population (ADP), 3) serious P0-P2 calls per 100 custody staff, and 4) daily 911 calls. This increase should have prompted Richland County to implement emergency plans to mitigate potential and actual harm to ASGDC SMI inmates before worsening.

1) As total 911 calls increased 52.1%, from 2020 through 2023, total P0-P2 calls per 100 total calls increased 52.3% (+204.2) from 40.4 P0-P2 per 100 total 911 calls to 61.5.

Worse, total serious P0-P2 calls per 100 total 911 calls jumped 56.6% (+198.5), from 38.7 to 60.7 during the same period.

Serious P0-P2 Calls Per 100 911 Calls

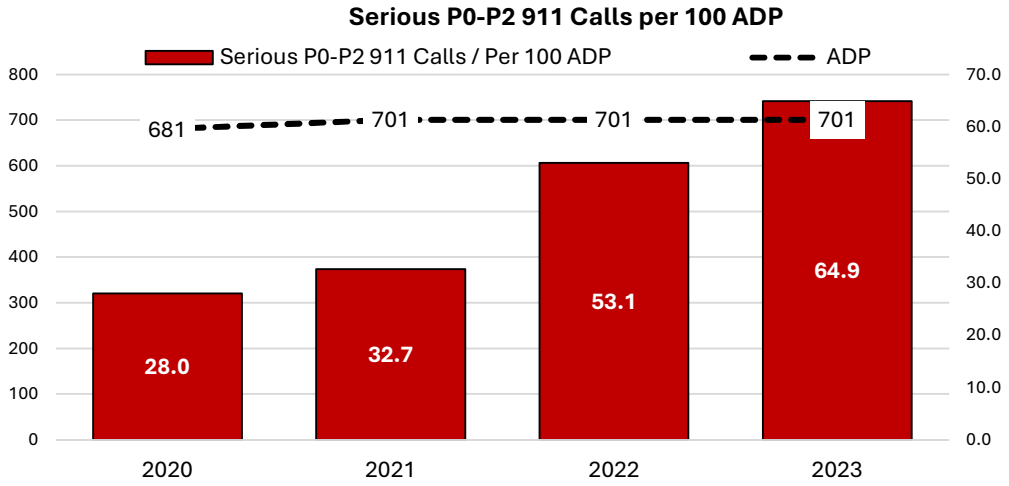
P0-2 Calls Per 100 911 Calls	2020	2021	2022	2023	Ttl.	Diff 19-23	% Diff
Serious P0-P2 911 Calls per 100 Ttl. Calls	**38.7**	**43.3**	**55.8**	**60.7**	**198.5**	**21.9**	**56.6%**
P0-P2 911 Calls (not Serious) Per 100 Ttl. Calls	1.6	1.7	1.6	0.8	5.8	-0.8	-50.7%
Ttl. P0-P2 911 Calls per 100 Ttl. Calls	**40.4**	**45.0**	**57.4**	**61.5**	**204.2**	**21.1**	**52.3%**



2) Between 2020 and 2023, the average daily inmate population (ADP) saw a modest increase of 2.9%. However, during the same period, the total 911 calls per 100 ADP increased by 47.8%, total P0-P2 calls per 100 ADP rose by 125.0%, and serious P0-P2 calls per 100 ADP surged by 131.4%. This disproportionate escalation in serious and potentially life-threatening incidents per 100 ADP, which increased more than 45 times relative to the ADP growth, highlights the extreme risk of harm to SMI inmates that Richland County knew of but failed to adequately address early on.

911 Calls Per 100 ADP

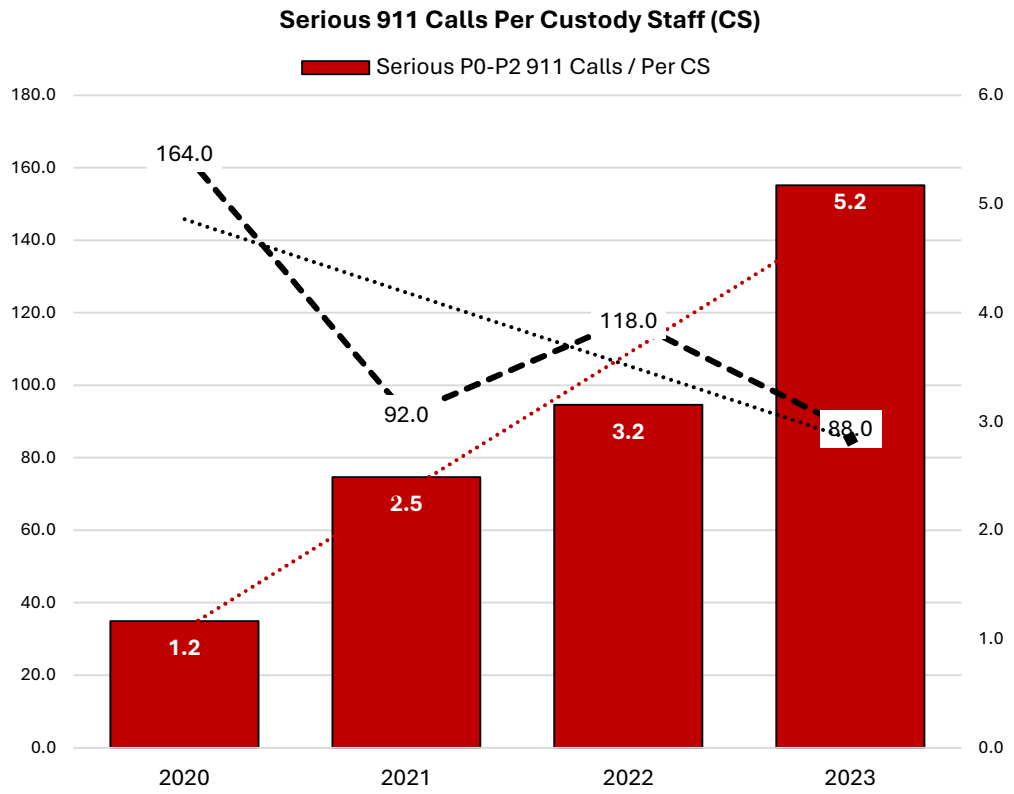
ASGDC ADP / 911 Calls	2020	2021	2022	2023	Diff 19-23	% Diff
ADP	**681**	**701**	**701**	**701**	**20.0**	**2.9%**
Serious P0-P2 911 Calls / Per 100 ADP	**28.0**	**32.7**	**53.1**	**64.9**	**36.9**	**131.4%**
Non-Serious P0-P2 911 Calls / Per 100 ADP	1.2	1.3	1.6	0.9	-0.3	-27.1%
Ttl. P0-P2 911 Calls / Per 100 ADP	29.2	34.0	54.6	65.8	36.5	125.0%
Total 911 Calls Per 100 ADP	**72.4**	**75.5**	**95.1**	**107.0**	**34.6**	**47.8%**



3) From 2020 through 2023, there is a marked 46.3% reduction in custody staffing (CS) levels, dropping from 164 staff members to just 88. While staff numbers dwindle, the volume of 911 calls tells a story of escalating urgency and serious risk of harm to SMI inmates; serious 911 calls per custody staff soared by 344.0%, from 1.2 to an overwhelming 5.2. When considering all P0-P2 911 calls, there is an evident surge, climbing by 331.7% over the same period. Moreover, the total 911 call volume underscores the known and growing risk to SMI inmates, jumping by 183.5%, from 3.0 to 8.5 calls per custody staff. This staggering rise in call volume, juxtaposed with the falling staff numbers, underscores a significant rise in workload per staff member. The emerging picture is one that clearly evidences that existing staff faced and continue to face heightened pressures, raising important questions about Richland County's priorities and the degree to which it failed to recognize and reasonably address the growing urgency in potential and actual harm to SMI inmates.

911 Calls Per Custody Staff

ASGDC 911 Calls Per Custody Staff (CS)	2020	2021	2022	2023	Diff 19-23	% Diff
Custody Staff (CS)	**164.0**	**92.0**	**118.0**	**88.0**	**-76.0**	**-46.3%**
Serious P0-P2 911 Calls / Per CS	**1.2**	**2.5**	**3.2**	**5.2**	**4.0**	**344.0%**
Non-Serious P0-P2 911 Calls / Per CS	0.05	0.10	0.09	0.07	0.02	39.8%
Ttl. P0-P2 911 Calls / Per CS	1.2	2.6	3.2	5.2	4.0	331.7%
Total 911 Calls Per CS	**3.0**	**5.8**	**5.7**	**8.5**	**5.5**	**183.5%**

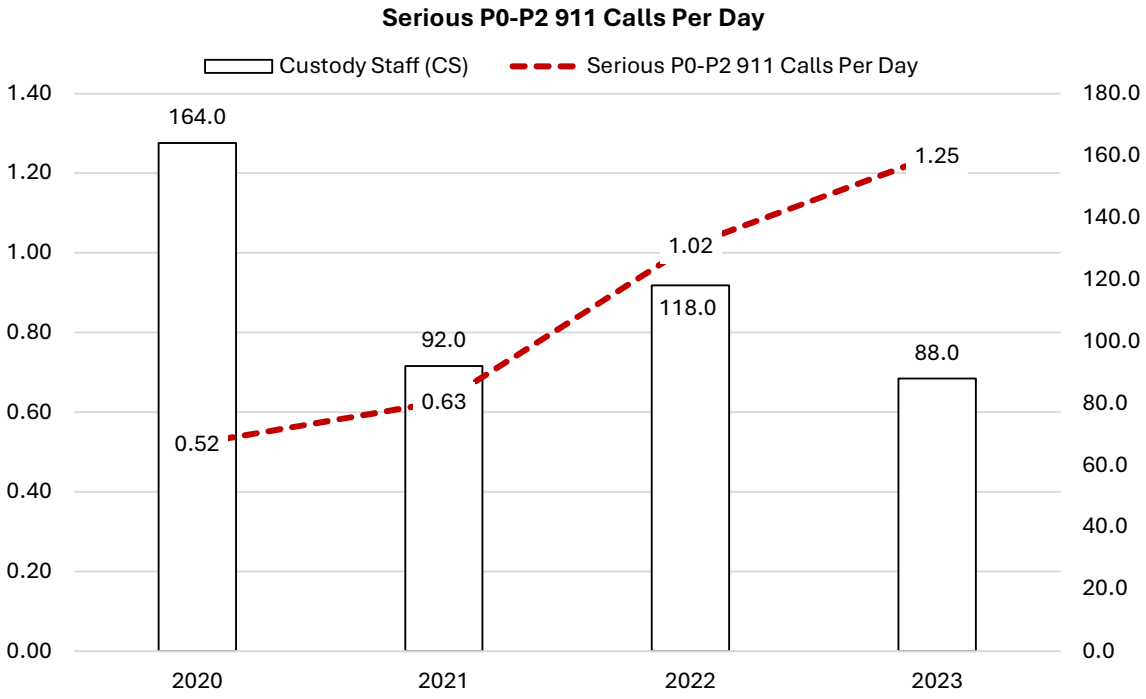


4) Over these four years (2020-2023), a steep increase occurred in the average number of daily serious P0-P2 911 calls, surging by 138.9% from 0.52 calls per day to 1.25. said differently, serious P0-P2 911 calls increased from approximately one every other day to more daily on average. This rise illustrates a dangerous pace in daily demands for serious response and custody staff resources.

   a. The total P0-P2 911 calls per day demonstrate a pronounced upward trend of 132.3%, indicating an overall increase in SMI inmate risk of harm and burden on shrinking custody staffing levels. The broader scope of total daily 911 calls also increased notably by 52.5%, from 1.35 to 2.05 calls per day, reinforcing the growing demand for emergency services and custody staff resources to manage 911 events.

911 Calls Per Day

ASGDC 911 Calls Per Day	2020	2021	2022	2023	Diff 19-23	% Diff
Days in Year	**366**	**365**	**365**	**365**		
Serious P0-P2 911 Calls Per Day	**0.52**	**0.63**	**1.02**	**1.25**	**0.72**	**138.9%**
Non-Serious P0-P2 911 Calls Per Day	**0.02**	**0.02**	**0.03**	**0.02**	**-0.01**	**-24.8%**
Ttl. P0-P2 911 Calls Per Day	**0.54**	**0.65**	**1.05**	**1.26**	**0.72**	**132.3%**
Total 911 Calls Per Day	**1.35**	**1.45**	**1.83**	**2.05**	**0.71**	**52.5%**
Custody Staff (CS)	**164.0**	**92.0**	**118.0**	**88.0**	**-76.0**	**-46.3%**

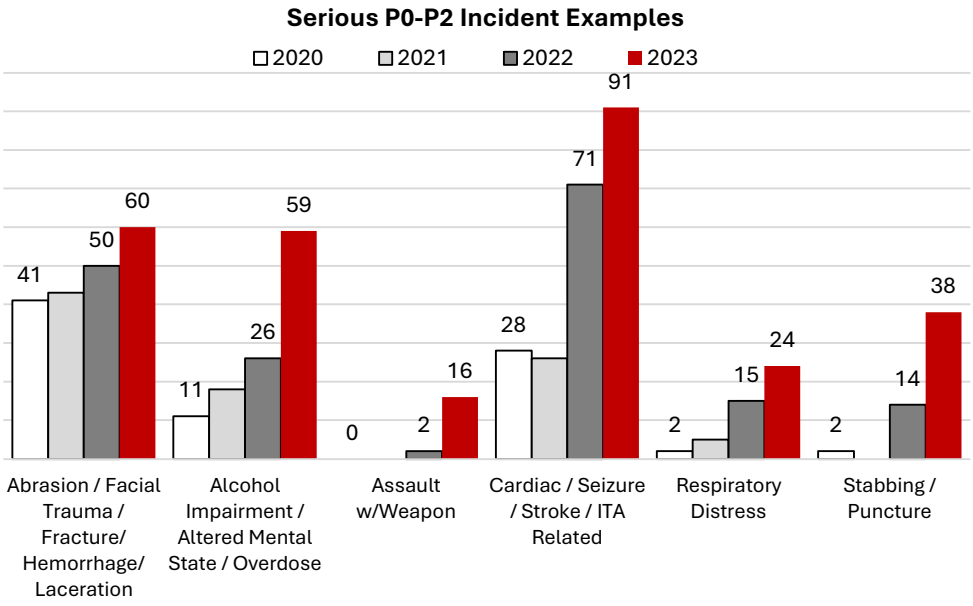


b. However, the staffing situation presents a stark contrast. Custody staff numbers have seen a marked reduction of 46.3%, with the workforce diminishing from 164 to 88 individuals. This decrease in staff numbers set against the backdrop of increasing 911 call volumes indicates that each staff member face significantly higher workloads, especially in handling serious situations.

c. ASGDC official 911 records clearly underscore a persistent and dangerous situation for SMI inmates and staff from at least 2020, where emergency call volumes escalated while available custody staff were diminishing. This growing imbalance was known or knowable to Richland County officials and necessitated their urgent attention and response to mitigate the well documented harm to SMI and other inmates.

5) Meticulous review of the serious P0-P2 911 calls underscores a concerning upward trajectory in grave risks and incidents that SMI inmates are encountering with alarming regularity. By 2023, the frequency of severe medical emergencies such as cardiac events, seizures, strokes, and transient ischemic attacks has surged dramatically by 225%, rising from 28 instances to 91. This is not an isolated pattern; the combined instances of emergencies due to alcohol impairment, altered mental statuses, and overdoses have witnessed a staggering 436% increase, escalating from 11 to 59 incidents. Furthermore, reports of respiratory distress have skyrocketed by an astonishing 1100%, from 2 to 24 incidents.

   These statistics, however, only begin to scratch the surface of the mounting crisis within the facility. Instances of stabbings and puncture wounds have experienced an astronomical rise of 1800%, from a mere 2 to 38 incidents. This is paralleled by the sharp rise in inmate-on-inmate assaults involving weapons, which have gone from non-existent to 16 reported cases, marking a 1600% increase. These figures are not mere numbers; they represent a clear and present escalation in violence and health-related emergencies that necessitated urgent and decisive action by Richland County officials to safeguard the wellbeing of SMI inmates. Richland County either failed to consider this basic jail administration information and or failed to accept the imperative to recognize these trends early on and with a reasonable degree of urgency to prevent and mitigate harm and to ensure a secure and humane environment for all inmates.



All Serious P0-P2 911 Call Problems Reported

911 Call Critical P0-P2 Event Catagories	2020	2021	2022	2023	Ttl.	Diff 19-23	% Diff
Abrasion / Facial Trauma / Fracture/ Hemorrhage/ Laceration	41	43	50	60	194	19	46.3%
Alcohol Impairment / Altered Mental State / Overdose	11	18	26	59	114	48	436.4%
Anaphylactic/Toxin/Poison	1	0	1	3	5	2	200.0%
Assault	0	0	0	1	1	1	100.0%
Assault w /Weapon	0	0	2	16	18	16	1600.0%
Cardiac / Seizure / Stroke / ITA Related	28	26	71	91	216	63	225.0%
Civil / Domestic Disturbance	2	7	8	4	21	2	100.0%
Death	0	2	2	4	8	4	400.0%
Emergency Meeting	2	2	3	3	10	1	50.0%
EMS / Fire Standby	2	7	6	10	25	8	400.0%
GI/Stomach	1	3	4	4	12	3	300.0%
Medical Device Failure	0	1	4	2	7	2	200.0%
Mental Health/Psychiatric	6	10	9	2	27	-4	-66.7%
Other Emergency	34	32	36	24	126	-10	-29.4%
Other Medical Emergency	5	11	13	7	36	2	40.0%
Other Serious Physical Injury / Pain	35	23	53	41	152	6	17.1%
Person Dow n/Unconscious/Fainting	18	36	51	51	156	33	183.3%
Pregancy Related	1	2	3	9	15	8	800.0%
Respiratory Distress	2	5	15	24	46	22	1100.0%
Riot	0	1	0	1	2	1	100.0%
Sexual Assault	0	0	1	1	2	1	100.0%
Stabbing/Puncture	2	0	14	38	54	36	1800.0%
Total	191	229	372	455	1,247	264	138.2%

VI. SUMMARY OF CONCLUSIONS

36. This Subject Matter Expert (SME) provides a serious analysis of the ASGDC, revealing systemic operational and environmental shortcomings that jeopardize SMI inmate safety, health, and dignity. The documented findings highlight urgent needs in staffing, SMI inmate welfare, and facility conditions.

A) Staffing levels and practices at the ASGDC are alarmingly deficient, compromising the facility's ability to ensure adequate inmate supervision and safety. The lack of necessary personnel and failure to perform welfare checks are leading to increased risks to the SMI inmate population.

B) The physical state of the facility is of grave concern, with rampant unsanitary conditions and structural neglect. Issues such as overcrowding, poor lighting, and exposure to hazardous materials are pervasive, falling short of accepted standards and posing severe health and safety risks to both SMI inmates and staff.

C) Regarding mental health and welfare, the SME finds a stark neglect for SMI inmates' needs, particularly for those with severe mental health issues. The lack of mental health services, compounded by overcrowding and inadequate resources, results in untreated conditions and the negative impact of prolonged segregation.

D) SMI inmate discussions and interviews align with these findings, painting a picture of an environment riddled with flooding, pest infestations, and inoperative facilities. Such conditions foster a climate where violence is prevalent, further straying from the benchmarks of safety and well-being.

E) The SME strongly recommends immediate and comprehensive action to remedy these serious deficiencies. At a minimum, priorities must include reducing the ASGDC SMI inmate population to a level that can be effectively supervised and protected with existing custody staffing levels, rapidly boosting staffing close to the number of positions budgeted, consistently adhering to all administrative and operational policies and procedures and ensuring consistent SMI inmate oversight. The evidence calls for urgent and targeted improvements in living conditions, safety measures, and mental health provisions for the inmates within serious mental illness community.

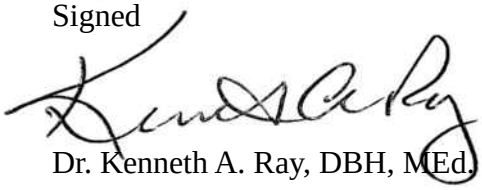
F) Throughout numerous years of providing Federal Court-ordered monitoring, expert technical assistance via the United States Department of Justice National Institute of Corrections, conducting investigations into complaints related to the care and custody of SMI inmates, and providing risk management consulting to correctional facilities and local governments in the United States and abroad, this subject matter expert has evaluated a wide array of institutions and practices involving the care and custody of SMI inmates. Among these, the Richland County Correctional Facility stands out as particularly hazardous and inappropriate for the management and protection of inmates with Serious Mental Illness (SMI). This assessment is rooted in a detailed review that identifies persistent, severe issues including critical shortages of adequate staffing, a consistent lack of necessary mental health services for SMI inmates, and a history of poorly maintained and unsafe living conditions. Moreover, Richland County has consistently failed to adhere to its own jail policies and procedures for years. This includes a failure to recognize and promptly address the prolonged and severe risks posed to its SMI population, which are inexplicable and alarming. The approach taken by Richland County in addressing the needs of SMI inmates is profoundly inadequate and stands as unparalleled in its deficiencies, based on extensive professional observations.

G) In conclusion, this summary crystallizes the urgent and systemic issues at the ASGDC, demanding prompt and resolute measures to overhaul the current state of affairs for the betterment of those confined within its walls.

END

SME conclusions and opinions stated herein are based on a reasonable degree of professional certainty.

Signed



Dr. Kenneth A. Ray, DBH, MEd.

June 29, 2024

EXHIBIT 3

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION
C/A No.: 8:22-cv-1358-MGL-JDA

A.C., J.H. AND H.M. on behalf of themselves and others similarly situated; Disability Rights South Carolina,

Plaintiffs,

v.

Richland County,

Defendant.

DEPOSITION OF

LAURRINDA SAXON-WARD

****

Tuesday, January 2, 2024

9:06 a.m. - 5:27 p.m.

The deposition of LAURRINDA SAXON-WARD was taken before Kimberly C. Young, a notary public in and for the State of South Carolina, commencing on January 2, 2024, at the offices of Turner, Padget, Graham & Laney, PA, 1901 Main Street, Suite 1700, Columbia, SC 29201, pursuant to Notice of Deposition and/or agreement of counsel.

LAURRINDA SAXON-WARD TRANSCRIPT

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treatments and the plan? Or were you simply the -- and I don't mean simply, but were you responsible for the coordination of all of that?

A. No, I participated. I had to write behavior plans. I had to do sometimes family counseling or whatever was required by the physician.

Q. So you were, you functioned as the lead --

A. Yes.

Q. -- therapist as well?

A. As well.

Q. Okay. All right. And when you went to the Columbia Area Mental Health Center and participated in the adult clinical services, how did your roles change?

A. Well, actually, I became a clinical -- well, a mental health counselor and I saw patients one to one. I did individual counseling, I did family counseling, and whatever that individual needed.

Q. And what was the scope of the individual counseling services you provided? How would you describe that?

A. Some patients, it was intense. My caseload was, at Columbia Area was about 100. So I would, it depends on the patient, some would be seen weekly, some would be seen every two weeks, and

then the more stable ones would be seen on a monthly basis.

Q. And you'd work in coordination presumably with a physician in the same way that you described before?

A. A physician and a nurse.

Q. Okay. What would the role of the nurse be?

A. To monitor the medications and manage symptoms.

Q. So again, a team approach?

A. Team approach.

Q. Okay. When did the -- did your services, when you were providing the individual counseling, include different forms of therapy?

A. It did.

Q. And how would you describe those?

A. Kind of eclectic. Some people would need CBT.

Q. And I'm sorry. For the record, would you explain that?

A. Cognitive behavioral therapy. Some would need trauma. I used to work with the Trauma Resource Center for someone who needed to deal with trauma. Some would need life skills. It depends. Some would just need individual counseling.

Q. How is that different, just so I can understand

it, CBT, trauma, therapy, life skills, and then individual counseling?

A. CBT is usually somebody that's pretty high functioning that can, you know, process the information who can understand what's going on. Life skills is people who have poor coping skills, so they have a lot of anxiety, difficult problem solving and making decisions. Trauma is usually somebody who has experienced an event of violation.

Q. For example -- I'm sorry, I just don't mean to interrupt, but for example, then someone with a diagnosis of post traumatic stress syndrome would be -- would need trauma therapy or would benefit from trauma therapy, would that --

A. Uh-huh, they would.

Q. -- be related?

A. Uh-huh. Or, you know, build life skills.

Q. Or maybe both?

A. Both, uh-huh.

Q. Okay.

A. Yeah.

Q. And so I suspect that the individual counseling would incorporate, over time, different kinds of therapeutic models.

LAURRINDA SAXON-WARD TRANSCRIPT

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role?

A. Yes.

Q. And what's the benefit of group therapy?

A. Support.

Q. And I'm sorry, I wasn't very clear. But what's the benefit as distinguished from individual counseling?

A. Individual counseling, it gives you privacy, it gives you a safe environment so that you can express your feelings and thoughts without being judged or, you know, your privacy being violated. It's more intimate, you know, individual counseling.

Q. Okay. And what distinguishes group in a way that's beneficial?

A. Group you have peers that's experiencing the same --

Q. Sorry, excuse me, just a second. It's my new Christmas present, I have no idea how to operate it. I don't know why it's talking to me. I actually don't know how to turn it off. Dangerous. So excuse me for that interruption.

A. Okay.

Q. So the question was the benefits of group therapy that, as the same, from individual counseling?

LAURRINDA SAXON-WARD TRANSCRIPT

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A. No.
Q. What have you drafted?
A. What we would need, which would be we talked about groups, therapeutic groups, we talked about activity therapists, we talked about counselors that could come in and do groups as far as addiction groups, relapse prevention, life skills, just different types of groups that would be beneficial to that population.
Q. And individual counseling and therapy as well?
A. You're in a jail and when you do a lot of individual counseling and you take off a band aid, it's very difficult for the patient to process that in the jail but it's also very difficult to keep them safe. So individual -- we do crisis management. When we do individual therapy, I call it crisis management. And it's -- and some of them are there for a lengthy amount of time, some of them are there short term.
Q. So would it be fair to say that the only kind of individual counseling that's performed is crisis management?
MR. COX: Object to the form.
MR. GODDARD: Object to the form.
A. No.

LAURRINDA SAXON-WARD TRANSCRIPT

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you implying that it's a better course of action to not to engage in that therapy because it is dangerous and it's not as long term?

A. If they're going to be there short term, I don't recommend, you know, intense counseling. I don't recommend individual. But we do do crisis management. We do do brief therapy, brief solution therapy.

Q. You said grief or brief?

A. We do grief and brief.

Q. Both?

A. Uh-huh. If there is a problem, I mean, we talk about it and we seek the solution to it. We help them process what's going on. Grief therapy, we do the seven stages of grief. We give them exercises is to do, homework to do, to process their feelings and their thoughts. But individual, when you start dealing with, you know, the childhood trauma or the trauma itself, you know, that's, you know, jail is not the best place for that. We do medication management. We do symptom management. We do -- we teach coping skills. We help them to, like I said, deal with grief. We help them to decide what they're going to do next, if they need substance abuse

LAURRINDA SAXON-WARD TRANSCRIPT

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A. Yes.
Q. And so when -- you haven't -- I actually haven't seen any data, and we've made this request, that identifies the total number of individuals at any one time, on a monthly basis for example, at the jail who are receiving mental health care. Do you know that number?
A. I know that number. Not for December, but I think we had 960 something patients, and 608 were identified as being mental health.
Q. And are you saying you don't know December, but are you implying that was the number in November?
A. Yes.
Q. This past November?
A. Yes.
Q. And when -- how were they identified? I know there are multiple ways. But is there a common element in which everyone on your caseload has at some point during their incarceration at the jail been diagnosed by a mental health provider as being in need of mental health services?
A. A majority of them will have seen the psych provider who would do the diagnosis and the medication that follows, if need be.
Q. Why only a majority? What are -- who are those

LAURRINDA SAXON-WARD TRANSCRIPT

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MR. COX: Object to the form.

Q. Never mind, you don't have to answer that. So let's -- which do you feel the bottom line number is, being someone real familiar with this, or closer to the real number, Ms. Saxon-Ward, which is that it's closer to the -- the jail is near 1,000 folks now, isn't it?

A. But in April I don't think it was there.

Q. I know. Just think about November, December, near 1,000?

A. Oh, yeah. It's been climbing.

Q. Been going up?

A. Yes.

Q. Yeah. Do you have a sense -- well, in November it was 608 out of 960 something, I think you said?

A. Yes.

Q. And --

A. Now, it moves all the time because of patients leaving and patients coming. You might have ten that leave and one come in. Or you might have one to leave and ten to come in, so.

Q. Understood. So it's a good bit of daily fluctuation?

A. Yes.

LAURRINDA SAXON-WARD TRANSCRIPT

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and provide?

A. And this is the part that we have to understand, we are a detention center, not a facility, so we have to be careful as to what we do because a lot of the patients, especially the younger ones, they have a lot of trauma that's inside and they don't want to deal with it. But sometimes, you know, if it comes out, they are not prepared to deal with what's coming out. So I don't expect my clinicians to sit down and have a one to one with the patients. But I do expect them to be able to identify what they need. I expect them to be able to coordinate services to meet their needs. And I expect them to be able to, once they get out, do the referral that they need in the community to maintain themselves.

Q. When you say coordinate services that they need, do you basically mean the referral and information process?

A. Yes.

Q. Okay. So when you say you don't expect the clinicians to have -- to sit down and have a one on one with patients, you mean in a traditional therapeutic counseling session?

A. Right. There's no privacy, there's no safe zone

or safe place for that to happen.

Q. And you communicate that to the clinicians, they're aware of it certainly?

A. Yes. Yes, of course they are.

Q. So when you're evaluating the performance of the clinicians, then what are you evaluating them for objectively?

A. There's about ten categories that are sent to me for the evaluation and I evaluate them on the categories.

Q. There's a form, obviously, to that effect. Is that a standard ACH HR form?

A. Probably, yes.

Q. Okay.

A. Because I've seen it for every one.

Q. And you complete that for each of your clinicians and then send it to Mr. Young?

A. Yes.

Q. Okay. Do you know the name of the form?

A. No, I don't, but I just received two of them.

Q. Do you complete them for annual evaluation or 180 days?

A. I do the 90 days, 180, and the annual.

Q. Same form?

A. Yes.

EXHIBIT 4

)ffenderID	FullName	BookingID	BookingTime	ReleaseTime	HousingDormitory	InitiatedTime	CompletedTime
[redacted]		1733789	10/7/23 12:10 AM	12/19/23 3:54 AM	ALPHA	10/10/23 5:11 PM	
		1736416	1/10/24 4:49 PM		ECHO	1/13/24 1:46 PM	
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		1735559	12/10/23 1:26 PM	1/10/24 8:36 PM	UNIFORM	12/13/23 4:04 PM	
		1731194	8/9/23 8:40 PM		ECHO	8/11/23 7:43 PM	12/21/23 3:59 PM
		1731194	8/9/23 8:40 PM		ALPHA	12/21/23 3:59 PM	4/2/24 8:26 PM
		1734289	10/24/23 4:11 PM	1/19/24 8:01 PM	HOTEL	12/12/23 3:50 PM	
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					NO DORM RECORD(S) FOR DATE RANGE		
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		1701188	11/11/20 3:41 PM		MIKE	12/21/23 12:14 PM	
		1735066	11/22/23 10:22 AM		LIMA	12/12/23 3:44 PM	
		1731442	8/18/23 7:24 PM		UNIFORM	10/20/23 5:05 PM	
		1735694	12/15/23 11:21 AM		KILO	12/17/23 1:56 PM	2/3/24 12:46 PM
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		1733918	10/11/23 10:48 AM	3/20/24 3:47 AM	FOXTROT	10/12/23 3:18 PM	
		1735695	12/15/23 12:32 PM	2/6/24 4:18 PM	ALPHA	12/16/23 3:16 PM	1/10/24 11:12 AM
		1735695	12/15/23 12:32 PM	2/6/24 4:18 PM	JULIET	1/10/24 11:12 AM	1/11/24 9:16 AM
		1735695	12/15/23 12:32 PM	2/6/24 4:18 PM	ALPHA	1/11/24 9:16 AM	
		1717455	9/2/22 12:12 PM		FOXTROT	11/20/23 12:05 PM	
		1729872	6/23/23 10:03 AM		FOXTROT	12/1/23 7:41 PM	1/27/24 10:43 AM
		1728110	4/18/23 1:36 PM		FOXTROT	4/24/23 5:45 PM	
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		1703952	3/3/21 6:52 PM		MIKE	1/12/24 10:53 AM	1/18/24 5:44 PM
		1735456	12/7/23 12:25 AM	1/31/24 2:57 PM	ECHO	12/8/23 3:44 PM	12/21/23 3:51 PM
		1735456	12/7/23 12:25 AM	1/31/24 2:57 PM	ALPHA	12/21/23 3:51 PM	
		1732258	9/16/23 8:37 PM	4/12/24 10:49 AM	UNIFORM	10/13/23 11:00 AM	2/14/24 11:46 AM
		1735987	12/27/23 5:57 PM	1/16/24 6:53 PM	DELTA	12/30/23 9:24 AM	
		1720627	1/4/23 7:48 PM		INDIA	4/26/23 4:30 PM	3/23/24 3:18 AM
		1734179	10/20/23 12:04 PM	2/12/24 4:32 PM	FOXTROT	10/28/23 4:58 PM	
		1709908	10/28/21 12:59 PM		FOXTROT	10/13/22 11:44 AM	
		1736348	1/8/24 12:57 PM	4/18/24 9:39 AM	UNIFORM	1/9/24 3:29 PM	
		1735415	12/5/23 10:15 AM	1/26/24 3:42 PM	GOLF	12/6/23 3:04 PM	
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[redacted]

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1736231	1/4/24 11:41 AM		GOLF	1/6/24 5:07 PM	2/14/24 5:15 PM
1735101	11/23/23 10:54 PM	12/18/23 2:52 PM	ALPHA	11/30/23 3:31 AM	12/18/23 10:23 AM
1735101	11/23/23 10:54 PM	12/18/23 2:52 PM	JULIET	12/18/23 10:23 AM	
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			NO DORM RECORD(S) FOR DATE RANGE		
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1716856	8/12/22 2:18 AM		ALPHA	1/5/24 6:11 PM	1/29/24 11:42 PM
1734612	11/4/23 12:12 PM		ECHO	11/6/23 5:04 PM	
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1732403	9/22/23 4:20 PM	4/12/24 12:20 PM	ECHO	10/5/23 6:10 PM	1/5/24 6:08 PM
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1695118	4/3/20 9:13 PM		KILO	11/17/22 10:56 AM	
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1735906	12/23/23 11:10 AM		JULIET	1/6/24 3:30 PM	1/18/24 2:55 PM
1735262	11/30/23 4:16 PM	2/1/24 10:32 AM	ECHO	12/4/23 3:41 PM	
1732103	9/11/23 5:15 PM	1/11/24 5:41 PM	INDIA	9/19/23 3:44 PM	
1735850	12/21/23 12:15 PM	1/3/24 2:28 PM	ECHO	12/23/23 5:58 PM	
1736238	1/4/24 2:03 PM	1/24/24 1:15 PM	ALPHA	1/6/24 5:12 PM	
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1735575	12/11/23 4:33 PM	1/25/24 6:41 PM	MIKE	1/10/24 11:07 AM	
1735820	12/20/23 1:28 PM	3/14/24 3:51 AM	HOTEL	12/22/23 5:06 PM	12/23/23 11:06 AM
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			NO DORM RECORD(S) FOR DATE RANGE		
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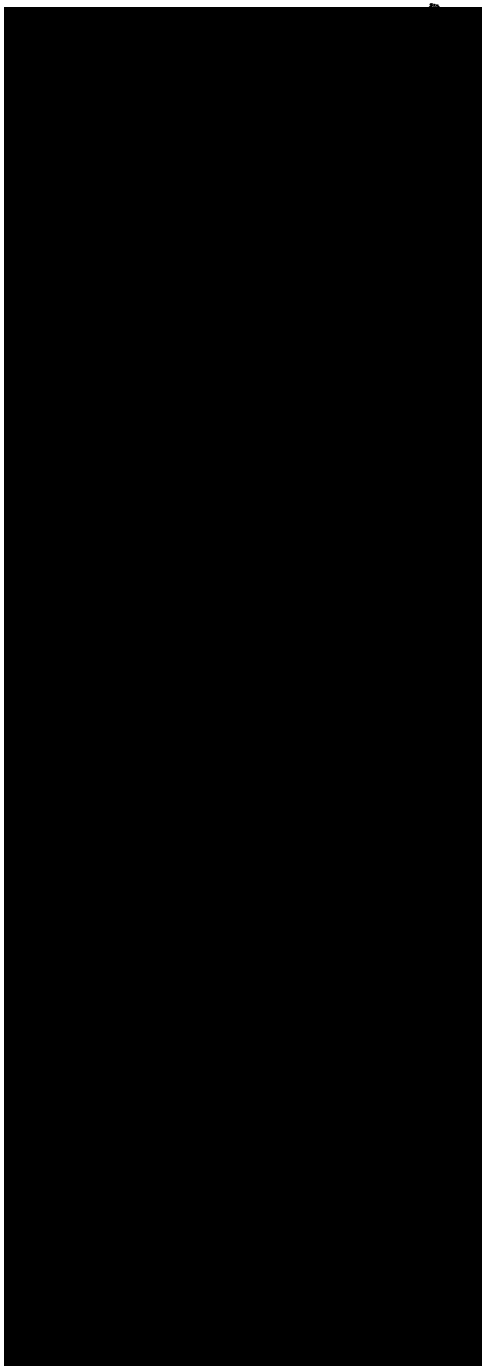

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1736301	1/6/24 10:39 AM		HOTEL	1/14/24 1:14 AM	3/28/24 5:49 PM
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1731965	9/6/23 8:58 PM	2/2/24 10:15 AM	DELTA	10/13/23 11:14 AM	
1729418	6/6/23 12:21 PM	1/23/24 4:10 AM	UNIFORM	12/12/23 3:40 PM	1/9/24 6:30 PM
1729418	6/6/23 12:21 PM	1/23/24 4:10 AM	JULIET	1/9/24 6:30 PM	1/20/24 11:13 AM
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1698532	8/9/20 8:19 PM		MIKE	12/21/23 3:17 PM	2/3/24 10:29 PM
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1735960	12/26/23 9:02 PM	1/13/24 8:51 PM	ALPHA	12/28/23 4:07 PM	1/8/24 7:45 AM
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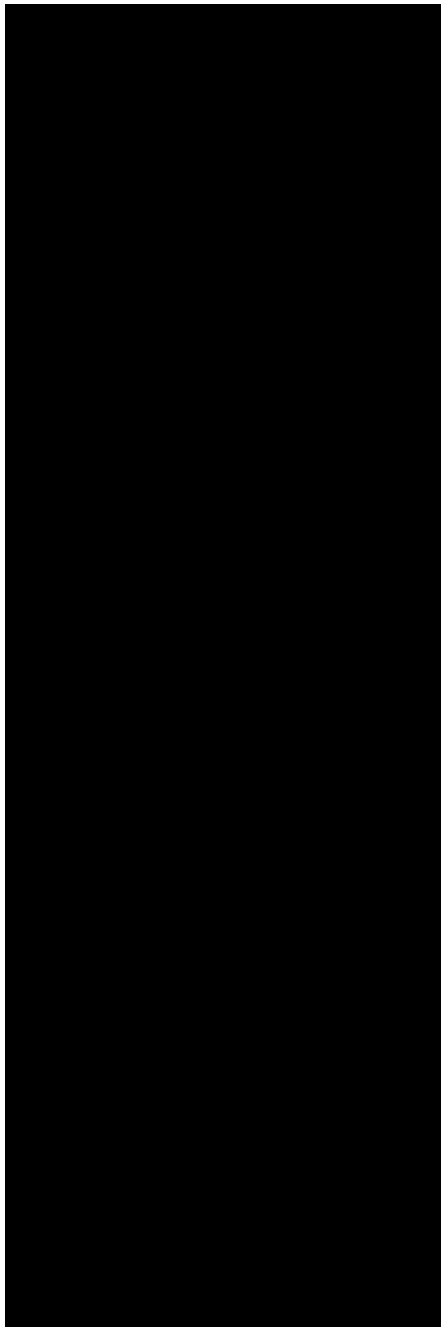

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1733920	10/11/23 12:48 PM	1/24/24 7:49 PM	DELTA	10/13/23 11:14 AM	12/17/23 12:53 AM
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1731446	8/18/23 9:48 PM	1/18/24 7:15 PM	XRAY	8/20/23 4:17 PM	
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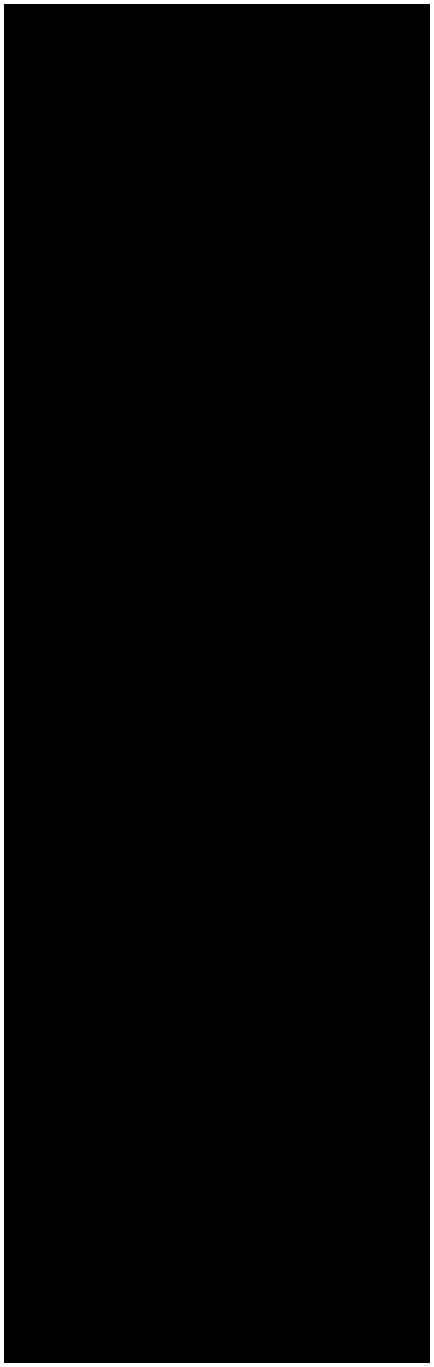

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1729845	6/22/23 4:07 PM		ECHO	12/21/23 3:22 PM	1/11/24 9:20 AM
1729845	6/22/23 4:07 PM		BMU	1/11/24 9:20 AM	1/15/24 12:38 PM
1729845	6/22/23 4:07 PM		ECHO	1/15/24 12:38 PM	1/17/24 10:49 AM
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1731396	8/16/23 9:09 PM		INDIA	10/4/23 3:09 PM	12/24/23 2:37 PM
1731396	8/16/23 9:09 PM		BMU	12/24/23 2:37 PM	1/2/24 5:24 PM
1731396	8/16/23 9:09 PM		INDIA	1/2/24 5:24 PM	1/28/24 8:40 AM
1735360	12/3/23 9:39 PM		FOXTROT	12/6/23 7:51 AM	4/19/24 8:15 AM
1735764	12/18/23 1:28 PM	2/6/24 4:48 PM	BRAVO	12/21/23 7:55 AM	
1736018	12/28/23 9:41 PM		HOTEL	12/30/23 9:47 AM	1/4/24 5:12 PM
1736018	12/28/23 9:41 PM		JULIET	1/4/24 5:12 PM	1/8/24 1:22 AM

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1736018	12/28/23 9:41 PM		BMU	1/8/24 1:22 AM	2/1/24 4:01 PM
1736089	12/31/23 3:37 AM	1/1/24 10:56 PM	ECHO	12/31/23 9:20 PM	
1734016	10/14/23 8:13 PM	2/2/24 4:48 AM	XRAY	10/17/23 10:27 AM	
1734952	11/18/23 4:55 AM		UNIFORM	11/29/23 11:15 AM	
1735256	11/30/23 12:25 PM		ALPHA	12/4/23 3:51 PM	12/21/23 3:26 PM
1735256	11/30/23 12:25 PM		ECHO	12/21/23 3:26 PM	
1736069	12/30/23 7:17 PM		UNIFORM	1/1/24 5:51 PM	1/13/24 1:47 PM
1736069	12/30/23 7:17 PM		ECHO	1/13/24 1:47 PM	1/17/24 5:22 AM
1717994	9/21/22 5:51 PM	2/8/24 7:11 PM	UNIFORM	10/20/23 10:21 AM	
1734313	10/25/23 11:20 AM	2/15/24 8:31 AM	UNIFORM	10/27/23 3:11 PM	
1688077	8/15/19 8:51 PM		MIKE	12/12/23 7:48 PM	1/11/24 2:37 PM
1688077	8/15/19 8:51 PM		BMU	1/11/24 2:37 PM	2/8/24 2:19 PM
1735751	12/18/23 1:44 AM	1/10/24 12:54 PM	XRAY	1/4/24 8:25 AM	
1734099	10/17/23 4:19 PM	2/29/24 8:13 PM	ALPHA	10/20/23 7:53 AM	12/21/23 3:28 PM
1734099	10/17/23 4:19 PM	2/29/24 8:13 PM	ECHO	12/21/23 3:28 PM	1/6/24 8:30 PM
1734099	10/17/23 4:19 PM	2/29/24 8:13 PM	JULIET	1/6/24 8:30 PM	1/8/24 6:48 AM
1734099	10/17/23 4:19 PM	2/29/24 8:13 PM	ECHO	1/8/24 6:48 AM	
1717630	9/8/22 11:26 AM		XRAY	10/11/23 11:33 AM	1/18/24 7:22 AM
1734229	10/22/23 8:50 AM	4/12/24 11:17 AM	HOTEL	10/23/23 10:22 PM	
1727800	4/5/23 12:31 PM		MIKE	5/15/23 5:58 PM	1/5/24 6:26 PM
1727800	4/5/23 12:31 PM		ALPHA	1/5/24 6:26 PM	1/5/24 7:07 PM
1727800	4/5/23 12:31 PM		MIKE	1/5/24 7:07 PM	
1731931	9/5/23 11:38 PM		ECHO	9/8/23 3:42 PM	
1730211	7/4/23 6:33 PM	2/6/24 8:37 PM	FOXTROT	8/1/23 5:13 PM	
1736463	1/12/24 11:13 AM		FOXTROT	1/15/24 3:25 PM	
1733634	10/1/23 2:08 AM	1/19/24 10:13 AM	KILO	10/3/23 1:32 PM	
1736024	12/29/23 1:12 AM	1/2/24 10:38 AM	LIMA	1/1/24 11:13 AM	
1720282	12/19/22 3:22 AM		BRAVO	12/12/23 5:28 PM	1/6/24 9:28 PM
1720282	12/19/22 3:22 AM		JULIET	1/6/24 9:28 PM	2/14/24 10:24 AM
1730338	7/9/23 4:25 PM	1/16/24 6:53 PM	MIKE	12/8/23 9:21 PM	
1719532	11/18/22 5:45 AM	1/25/24 8:50 AM	LIMA	2/27/23 6:43 PM	
1731563	8/23/23 5:20 PM	1/23/24 4:53 PM	BRAVO	8/25/23 5:03 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1736425	1/10/24 10:29 PM	1/16/24 3:04 PM	GOLF	1/13/24 9:30 AM	
1733956	10/13/23 12:15 AM	2/28/24 4:51 AM	UNIFORM	11/17/23 11:04 PM	2/9/24 9:50 PM
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1735778	12/19/23 1:31 AM	12/27/23 5:50 PM	ALPHA	12/21/23 7:54 AM	12/21/23 3:31 PM
1735778	12/19/23 1:31 AM	12/27/23 5:50 PM	ECHO	12/21/23 3:31 PM	
1735864	12/21/23 8:38 PM		DELTA	12/22/23 5:21 PM	
1728701	5/9/23 4:33 PM		BMU	12/8/23 9:51 PM	1/12/24 3:23 PM
1728701	5/9/23 4:33 PM		INDIA	1/12/24 3:23 PM	1/31/24 12:01 PM
1719496	11/16/22 6:28 PM	2/28/24 12:26 PM	UNIFORM	10/13/23 11:03 AM	
1727758	4/3/23 3:04 PM	2/29/24 8:20 AM	BMU	12/8/23 10:23 PM	1/12/24 5:33 PM

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1727758	4/3/23 3:04 PM	2/29/24 8:20 AM	KILO	1/12/24 5:33 PM	
1680213	12/14/18 12:21 AM	2/15/24 8:32 AM	KILO	12/1/23 5:11 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1735744	12/17/23 8:19 AM	1/10/24 1:50 PM	ECHO	12/19/23 7:32 AM	12/19/23 7:46 AM
1735744	12/17/23 8:19 AM	1/10/24 1:50 PM	FOXTROT	12/19/23 7:46 AM	12/19/23 7:59 AM
1735744	12/17/23 8:19 AM	1/10/24 1:50 PM	MIKE	12/19/23 7:59 AM	
1736254	1/5/24 4:54 AM	4/4/24 4:17 PM	DELTA	1/6/24 4:23 PM	2/6/24 7:49 PM
1735539	12/9/23 11:03 AM	1/22/24 3:24 PM	DELTA	12/11/23 5:25 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1696440	5/21/20 12:40 PM		FOXTROT	2/10/23 2:37 PM	
1720693	1/7/23 9:31 AM		LIMA	10/6/23 5:33 PM	1/9/24 4:11 PM
1720693	1/7/23 9:31 AM		BMU	1/9/24 4:11 PM	1/11/24 6:01 PM
1720693	1/7/23 9:31 AM		KILO	1/11/24 6:01 PM	1/12/24 3:05 PM
1720693	1/7/23 9:31 AM		BMU	1/12/24 3:05 PM	3/27/24 8:11 AM
1730148	7/2/23 2:36 PM	3/15/24 12:55 PM	MIKE	11/2/23 2:08 PM	1/16/24 5:13 PM
1730148	7/2/23 2:36 PM	3/15/24 12:55 PM	BMU	1/16/24 5:13 PM	1/16/24 5:30 PM
1730148	7/2/23 2:36 PM	3/15/24 12:55 PM	MIKE	1/16/24 5:30 PM	2/4/24 12:55 PM
1736177	1/2/24 11:27 PM	1/6/24 5:07 PM	DELTA	1/4/24 10:14 AM	
1736247	1/4/24 9:46 PM	4/18/24 9:39 AM	UNIFORM	1/6/24 5:14 PM	1/25/24 5:04 PM
1731774	8/31/23 1:31 PM		FOXTROT	9/2/23 5:30 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1735188	11/27/23 3:19 PM	3/7/24 7:53 PM	XRAY	12/5/23 4:59 PM	12/23/23 12:36 PM
1735188	11/27/23 3:19 PM	3/7/24 7:53 PM	DELTA	12/23/23 12:36 PM	1/8/24 11:33 PM
1735188	11/27/23 3:19 PM	3/7/24 7:53 PM	XRAY	1/8/24 11:33 PM	1/25/24 1:20 PM
1732431	9/23/23 3:02 PM	2/9/24 7:26 PM	UNIFORM	10/29/23 9:41 AM	
1735387	12/4/23 3:22 PM		GOLF	12/12/23 11:07 AM	12/20/23 4:46 PM
1735387	12/4/23 3:22 PM		JULIET	12/20/23 4:46 PM	1/6/24 2:14 PM
1735387	12/4/23 3:22 PM		MIKE	1/6/24 2:14 PM	2/5/24 5:52 PM
1690078	10/17/19 7:12 AM	3/14/24 8:00 AM	ECHO	8/10/23 5:13 PM	1/13/24 2:56 AM
1690078	10/17/19 7:12 AM	3/14/24 8:00 AM	BMU	1/13/24 2:56 AM	2/1/24 6:21 PM
1735293	12/1/23 12:30 PM	1/10/24 12:50 PM	DELTA	12/2/23 1:06 PM	
1674463	6/28/18 10:59 PM		BRAVO	7/12/23 5:13 PM	
1735644	12/13/23 7:17 PM	12/16/23 4:10 PM	DELTA	12/15/23 7:34 AM	
1730587	7/19/23 2:07 AM		BRAVO	9/15/23 4:01 PM	
1732182	9/14/23 2:49 PM	2/8/24 8:50 AM	BMU	12/8/23 8:25 PM	12/20/23 9:36 PM
1732182	9/14/23 2:49 PM	2/8/24 8:50 AM	UNIFORM	12/20/23 9:36 PM	
1734783	11/11/23 12:19 PM	4/22/24 3:37 PM	UNIFORM	11/13/23 8:15 AM	12/24/23 1:12 PM
1734783	11/11/23 12:19 PM	4/22/24 3:37 PM	KILO	12/24/23 1:12 PM	12/24/23 1:15 PM
1734783	11/11/23 12:19 PM	4/22/24 3:37 PM	UNIFORM	12/24/23 1:15 PM	1/10/24 7:42 PM
1734783	11/11/23 12:19 PM	4/22/24 3:37 PM	ECHO	1/10/24 7:42 PM	1/11/24 8:57 AM
1734783	11/11/23 12:19 PM	4/22/24 3:37 PM	UNIFORM	1/11/24 8:57 AM	

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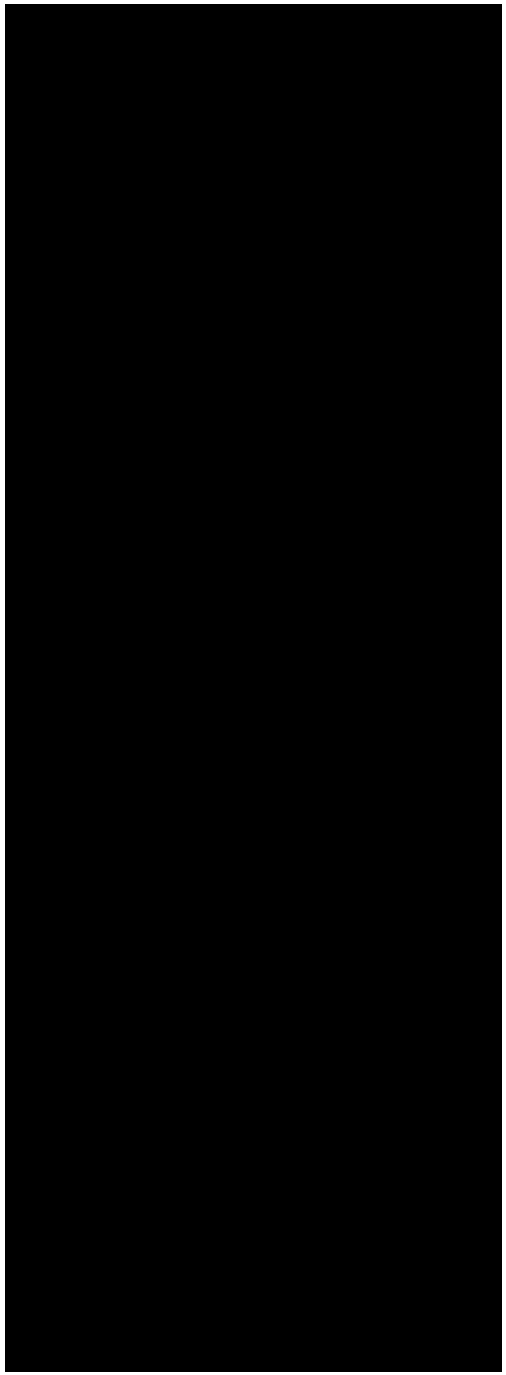
1735833	12/20/23 6:42 PM		KILO	12/22/23 3:44 PM	
1735124	11/24/23 9:47 PM		ALPHA	11/27/23 3:49 PM	12/21/23 3:23 PM
1735124	11/24/23 9:47 PM		ECHO	12/21/23 3:23 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1710364	11/16/21 2:17 PM		INDIA	10/27/23 10:59 AM	2/18/24 9:58 AM
1710391	11/17/21 1:55 PM		MIKE	7/12/23 4:32 PM	12/21/23 12:15 PM
1710391	11/17/21 1:55 PM		BMU	12/21/23 12:15 PM	1/12/24 3:05 PM
1710391	11/17/21 1:55 PM		MIKE	1/12/24 3:05 PM	4/9/24 8:10 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1731322	8/14/23 4:50 AM	12/28/23 4:56 PM	MIKE	9/12/23 6:36 PM	
1720368	12/22/22 5:37 PM		JULIET	8/29/23 5:05 PM	1/13/24 2:18 AM
1720368	12/22/22 5:37 PM		BMU	1/13/24 2:18 AM	1/18/24 2:59 PM
1730633	7/20/23 7:30 AM		LIMA	8/2/23 1:18 PM	
1735865	12/21/23 10:29 PM	1/24/24 1:35 PM	MIKE	12/22/23 5:34 AM	
1717269	8/26/22 3:25 PM		INDIA	6/30/23 8:23 AM	2/23/24 11:37 AM
1733813	10/7/23 4:26 PM		BRAVO	12/4/23 6:15 PM	1/6/24 12:19 PM
1733813	10/7/23 4:26 PM		BMU	1/6/24 12:19 PM	1/7/24 9:15 AM
1733813	10/7/23 4:26 PM		ECHO	1/7/24 9:15 AM	
1736008	12/28/23 2:06 PM	2/1/24 10:29 AM	INDIA	12/29/23 5:16 PM	
1735439	12/6/23 11:58 AM		DELTA	12/8/23 3:39 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1736261	1/5/24 12:08 PM	1/23/24 2:29 PM	LIMA	1/8/24 8:24 AM	
1731519	8/22/23 1:01 AM		HOTEL	12/12/23 3:43 PM	2/8/24 4:41 PM
1712922	3/8/22 7:09 PM		XRAY	5/29/23 6:42 PM	2/22/24 3:06 PM
1706716	6/17/21 4:16 PM		XRAY	4/6/23 2:49 PM	2/22/24 3:06 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1735715	12/16/23 3:09 AM	12/19/23 5:17 PM	KILO	12/17/23 1:55 PM	12/18/23 5:04 PM
1735715	12/16/23 3:09 AM	12/19/23 5:17 PM	JULIET	12/18/23 5:04 PM	
1725583	2/16/23 5:13 AM		BMU	12/8/23 7:37 PM	12/20/23 8:09 PM
1725583	2/16/23 5:13 AM		KILO	12/20/23 8:09 PM	3/22/24 11:42 PM
1729447	6/7/23 5:05 AM		LIMA	12/12/23 3:41 PM	12/18/23 11:50 AM
1729447	6/7/23 5:05 AM		JULIET	12/18/23 11:50 AM	2/14/24 5:41 PM
1703466	2/11/21 1:32 PM		BMU	12/8/23 7:38 PM	
1734607	11/4/23 5:41 AM		UNIFORM	11/5/23 1:45 PM	2/23/24 10:13 AM
1731968	9/6/23 9:59 PM		LIMA	11/1/23 12:29 PM	12/20/23 8:43 PM
1731968	9/6/23 9:59 PM		BMU	12/20/23 8:43 PM	12/24/23 1:49 PM
1731968	9/6/23 9:59 PM		LIMA	12/24/23 1:49 PM	2/9/24 4:41 PM
1731439	8/18/23 2:13 PM	2/29/24 8:23 AM	MIKE	12/13/23 12:35 PM	1/3/24 5:37 AM
1731439	8/18/23 2:13 PM	2/29/24 8:23 AM	TRANSFER	1/3/24 5:37 AM	1/3/24 5:47 AM
1731439	8/18/23 2:13 PM	2/29/24 8:23 AM	MIKE	1/3/24 5:47 AM	1/11/24 3:42 PM
1731439	8/18/23 2:13 PM	2/29/24 8:23 AM	BRAVO	1/11/24 3:42 PM	1/24/24 3:05 AM
1714209	4/26/22 6:32 AM	2/15/24 4:29 PM	MIKE	5/25/23 6:05 PM	
1733741	10/4/23 11:15 PM	4/16/24 10:55 AM	ECHO	10/6/23 5:43 PM	12/21/23 3:46 PM



1733741	10/4/23 11:15 PM	4/16/24 10:55 AM	ALPHA	12/21/23 3:46 PM	2/8/24 8:33 AM
1736052	12/30/23 1:38 AM		HOTEL	12/31/23 12:30 PM	12/31/23 5:18 PM
1736052	12/30/23 1:38 AM		BMU	12/31/23 5:18 PM	2/4/24 4:55 PM
1735398	12/4/23 7:06 PM	12/29/23 4:33 PM	UNIFORM	12/12/23 3:41 PM	
1736161	1/2/24 12:56 PM	1/24/24 1:16 PM	ECHO	1/12/24 11:21 AM	1/17/24 10:59 PM
1736183	1/3/24 1:33 AM	3/4/24 7:31 PM	ECHO	1/4/24 3:32 PM	
1734995	11/19/23 9:57 AM	12/18/23 2:52 PM	ALPHA	11/22/23 3:55 PM	
1735978	12/27/23 3:05 PM	1/23/24 5:56 PM	MIKE	1/2/24 6:32 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1735563	12/10/23 5:49 PM		LIMA	12/14/23 8:20 AM	12/25/23 4:54 AM
1735563	12/10/23 5:49 PM		JULIET	12/25/23 4:54 AM	12/28/23 5:26 PM
1735563	12/10/23 5:49 PM		UNIFORM	12/28/23 5:26 PM	2/12/24 7:52 AM
			NO DORM RECORD(S) FOR DATE RANGE		
1734502	10/31/23 6:56 PM		ALPHA	11/28/23 10:11 PM	12/21/23 3:33 PM
1734502	10/31/23 6:56 PM		ECHO	12/21/23 3:33 PM	12/31/23 3:38 AM
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1734502	10/31/23 6:56 PM		BMU	1/5/24 3:53 PM	2/15/24 10:34 AM
1735353	12/3/23 1:25 PM	2/9/24 4:44 PM	ALPHA	12/6/23 7:50 AM	12/21/23 3:29 PM
1735353	12/3/23 1:25 PM	2/9/24 4:44 PM	ECHO	12/21/23 3:29 PM	12/24/23 7:55 PM
1735353	12/3/23 1:25 PM	2/9/24 4:44 PM	MIKE	12/24/23 7:55 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1734893	11/16/23 9:44 AM		ALPHA	11/17/23 12:53 PM	4/2/24 8:19 PM
1734959	11/18/23 12:59 PM	1/10/24 8:36 PM	DELTA	11/20/23 10:59 PM	
1736422	1/10/24 9:27 PM		GOLF	1/13/24 9:30 AM	2/14/24 5:50 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1736362	1/8/24 7:18 PM	1/18/24 1:25 PM	DELTA	1/11/24 9:05 AM	
1736508	1/13/24 12:49 PM	2/1/24 10:33 PM	LIMA	1/15/24 3:04 PM	1/24/24 5:04 PM
1711847	1/25/22 9:10 AM		BMU	12/8/23 7:49 PM	4/5/24 1:47 PM
1728700	5/9/23 4:22 PM	1/18/24 4:56 PM	HOTEL	11/25/23 3:28 PM	
1735589	12/12/23 11:18 AM		UNIFORM	12/13/23 4:04 PM	
1736193	1/3/24 11:01 AM		ECHO	1/5/24 5:19 PM	
1735950	12/25/23 8:20 PM		FOXTROT	12/27/23 1:28 PM	12/27/23 1:36 PM
1735950	12/25/23 8:20 PM		INTAKE	12/27/23 1:36 PM	12/28/23 4:06 PM
1735950	12/25/23 8:20 PM		FOXTROT	12/28/23 4:06 PM	
1724337	2/5/23 11:49 AM	3/21/24 9:57 AM	INDIA	11/25/23 3:15 PM	1/16/24 4:46 PM
1724337	2/5/23 11:49 AM	3/21/24 9:57 AM	HOTEL	1/16/24 4:46 PM	1/24/24 5:13 PM
1720226	12/16/22 12:11 PM		KILO	2/18/23 3:44 PM	12/20/23 7:46 PM
1720226	12/16/22 12:11 PM		BRAVO	12/20/23 7:46 PM	12/20/23 7:46 PM
1720226	12/16/22 12:11 PM		BMU	12/20/23 7:46 PM	12/25/23 4:03 PM
1720226	12/16/22 12:11 PM		UNIFORM	12/25/23 4:03 PM	
1736205	1/3/24 2:40 PM	2/28/24 11:16 PM	DELTA	1/4/24 10:14 AM	1/7/24 2:27 PM
1736205	1/3/24 2:40 PM	2/28/24 11:16 PM	XRAY	1/7/24 2:27 PM	1/10/24 4:33 PM
1736205	1/3/24 2:40 PM	2/28/24 11:16 PM	DELTA	1/10/24 4:33 PM	1/27/24 2:12 PM

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			NO DORM RECORD(S) FOR DATE RANGE		
1736292	1/6/24 3:57 AM	2/28/24 4:55 AM	ECHO	1/7/24 4:44 PM	
1735716	12/16/23 3:22 AM	12/18/23 4:23 AM	ALPHA	12/17/23 3:30 PM	
1736516	1/13/24 7:11 PM	1/17/24 7:28 PM	DELTA	1/15/24 3:23 PM	
1736327	1/7/24 7:49 AM	4/29/24 11:33 AM	GOLF	1/9/24 1:25 PM	1/13/24 11:15 AM
1736327	1/7/24 7:49 AM	4/29/24 11:33 AM	UNIFORM	1/13/24 11:15 AM	
1736103	12/31/23 8:00 AM	1/5/24 8:47 PM	GOLF	1/1/24 5:14 PM	
1708594	9/1/21 4:00 PM		LIMA	10/18/23 9:08 AM	1/2/24 9:49 PM
1708594	9/1/21 4:00 PM		BMU	1/2/24 9:49 PM	3/22/24 8:00 PM
1730306	7/8/23 2:19 PM		BMU	12/8/23 7:33 PM	12/20/23 9:35 PM
1730306	7/8/23 2:19 PM		GOLF	12/20/23 9:35 PM	12/22/23 2:17 PM
1730306	7/8/23 2:19 PM		JULIET	12/22/23 2:17 PM	12/23/23 1:15 AM
1730306	7/8/23 2:19 PM		BMU	12/23/23 1:15 AM	12/23/23 8:08 AM
1730306	7/8/23 2:19 PM		JULIET	12/23/23 8:08 AM	12/25/23 12:05 PM
1730306	7/8/23 2:19 PM		BMU	12/25/23 12:05 PM	4/27/24 11:51 AM
			NO DORM RECORD(S) FOR DATE RANGE		
1736430	1/11/24 2:30 AM	1/13/24 3:57 AM	ECHO	1/12/24 1:05 PM	
1735717	12/16/23 4:04 AM	12/17/23 6:33 PM	ALPHA	12/17/23 1:57 PM	
1715077	6/2/22 6:18 AM		BMU	12/12/23 3:26 PM	1/5/24 3:18 PM
1715077	6/2/22 6:18 AM		INDIA	1/5/24 3:18 PM	2/20/24 2:41 AM
1704334	3/16/21 8:42 AM		BMU	12/8/23 10:25 PM	3/22/24 8:36 PM
1720092	12/11/22 12:55 AM	4/10/24 12:45 PM	XRAY	11/1/23 10:20 PM	2/22/24 3:04 PM
1736146	1/2/24 12:17 AM	1/31/24 1:57 PM	ECHO	1/5/24 10:07 AM	
1734720	11/8/23 9:54 PM		BRAVO	12/12/23 5:28 PM	
1709734	10/20/21 3:08 PM		INDIA	9/28/23 11:56 AM	3/8/24 9:16 AM
1736457	1/12/24 5:19 AM	5/3/24 7:52 AM	DELTA	1/13/24 11:03 AM	
1731325	8/14/23 8:59 AM	3/5/24 11:24 AM	INDIA	10/26/23 8:36 AM	
1728588	5/5/23 2:49 PM	3/14/24 8:01 AM	INDIA	5/12/23 6:12 AM	3/4/24 4:39 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1736268	1/5/24 2:23 PM	1/17/24 4:52 PM	GOLF	1/7/24 4:46 PM	
1735501	12/8/23 10:48 AM		UNIFORM	12/10/23 7:44 AM	1/8/24 1:21 PM
1735501	12/8/23 10:48 AM		JULIET	1/8/24 1:21 PM	2/14/24 5:51 PM
1730906	7/30/23 4:54 PM		MIKE	9/28/23 4:12 PM	3/27/24 11:33 AM
1688079	8/15/19 9:41 PM		MIKE	12/14/23 9:54 AM	2/8/24 2:06 PM
1688080	8/15/19 9:52 PM		MIKE	11/1/23 1:28 AM	1/11/24 2:38 PM
1688080	8/15/19 9:52 PM		BMU	1/11/24 2:38 PM	2/9/24 12:55 PM
1735728	12/16/23 7:42 PM		XRAY	12/17/23 5:27 PM	2/22/24 3:04 PM
1735618	12/13/23 4:19 AM	3/19/24 3:16 PM	INDIA	12/14/23 4:16 PM	
1735798	12/19/23 1:30 PM	1/8/24 7:11 PM	LIMA	12/21/23 8:03 AM	12/24/23 5:20 PM
1735798	12/19/23 1:30 PM	1/8/24 7:11 PM	GOLF	12/24/23 5:20 PM	
1735821	12/20/23 1:39 PM	1/10/24 8:36 PM	DELTA	12/22/23 5:21 PM	12/27/23 2:08 PM
1735821	12/20/23 1:39 PM	1/10/24 8:36 PM	XRAY	12/27/23 2:08 PM	
			NO DORM RECORD(S) FOR DATE RANGE		

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1731692	8/28/23 4:21 PM	1/10/24 8:36 PM	LIMA	9/12/23 1:27 PM	
1733725	10/4/23 1:11 PM	4/24/24 1:47 PM	ALPHA	10/6/23 5:43 PM	12/21/23 3:25 PM
1733725	10/4/23 1:11 PM	4/24/24 1:47 PM	ECHO	12/21/23 3:25 PM	3/24/24 5:06 PM
1731719	8/29/23 2:16 PM		MIKE	9/6/23 3:42 PM	
1693500	2/8/20 11:55 PM		INDIA	4/6/23 2:32 PM	2/9/24 12:37 PM
1716827	8/10/22 10:11 PM		MIKE	1/26/23 2:13 PM	
1714880	5/25/22 11:38 AM		BMU	12/15/23 5:03 PM	1/2/24 6:48 PM
1714880	5/25/22 11:38 AM		MIKE	1/2/24 6:48 PM	2/5/24 5:52 PM
1735508	12/8/23 3:20 PM	3/1/24 8:16 PM	UNIFORM	12/9/23 4:30 PM	2/18/24 6:57 AM
1735847	12/21/23 10:23 AM	1/24/24 1:16 PM	MIKE	12/22/23 3:29 PM	
1732266	9/17/23 12:42 AM	3/21/24 9:59 AM	FOXTROT	9/19/23 1:38 PM	
1732176	9/14/23 11:32 AM	2/8/24 2:34 PM	XRAY	10/24/23 8:14 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1731650	8/26/23 6:27 PM	3/26/24 8:01 PM	KILO	9/11/23 2:13 PM	3/17/24 12:31 AM
1707213	7/7/21 5:40 AM	5/2/24 9:31 AM	MIKE	7/27/23 9:22 AM	5/1/24 9:19 AM
1733537	9/27/23 2:47 PM	1/18/24 9:39 AM	FOXTROT	12/8/23 2:31 PM	
1735383	12/4/23 1:37 PM	12/28/23 11:35 AM	XRAY	12/14/23 10:40 AM	
1736267	1/5/24 2:22 PM	1/16/24 3:03 PM	DELTA	1/6/24 4:21 PM	
1735835	12/20/23 7:06 PM	3/8/24 11:17 PM	DELTA	12/22/23 5:22 PM	12/26/23 4:05 PM
1735835	12/20/23 7:06 PM	3/8/24 11:17 PM	XRAY	12/26/23 4:05 PM	2/22/24 3:06 PM
1735515	12/8/23 7:07 PM	1/2/24 5:43 PM	UNIFORM	12/14/23 4:42 PM	12/18/23 3:59 PM
1735515	12/8/23 7:07 PM	1/2/24 5:43 PM	MIKE	12/18/23 3:59 PM	
1736227	1/4/24 7:39 AM	1/27/24 4:41 AM	UNIFORM	1/6/24 5:15 PM	1/9/24 6:30 PM
1736227	1/4/24 7:39 AM	1/27/24 4:41 AM	JULIET	1/9/24 6:30 PM	
1735986	12/27/23 5:33 PM		ECHO	12/29/23 5:16 PM	1/5/24 11:59 PM
1735986	12/27/23 5:33 PM		FOXTROT	1/5/24 11:59 PM	1/6/24 1:13 AM
1735986	12/27/23 5:33 PM		ALPHA	1/6/24 1:13 AM	4/2/24 8:26 PM
1729133	5/25/23 9:37 PM	2/7/24 3:56 AM	BRAVO	10/6/23 5:57 PM	1/9/24 1:05 PM
1729133	5/25/23 9:37 PM	2/7/24 3:56 AM	MIKE	1/9/24 1:05 PM	2/5/24 5:53 PM
1735192	11/27/23 4:23 PM	12/24/23 1:27 PM	ALPHA	11/30/23 5:00 PM	12/21/23 3:23 PM
1735192	11/27/23 4:23 PM	12/24/23 1:27 PM	ECHO	12/21/23 3:23 PM	12/21/23 11:28 PM
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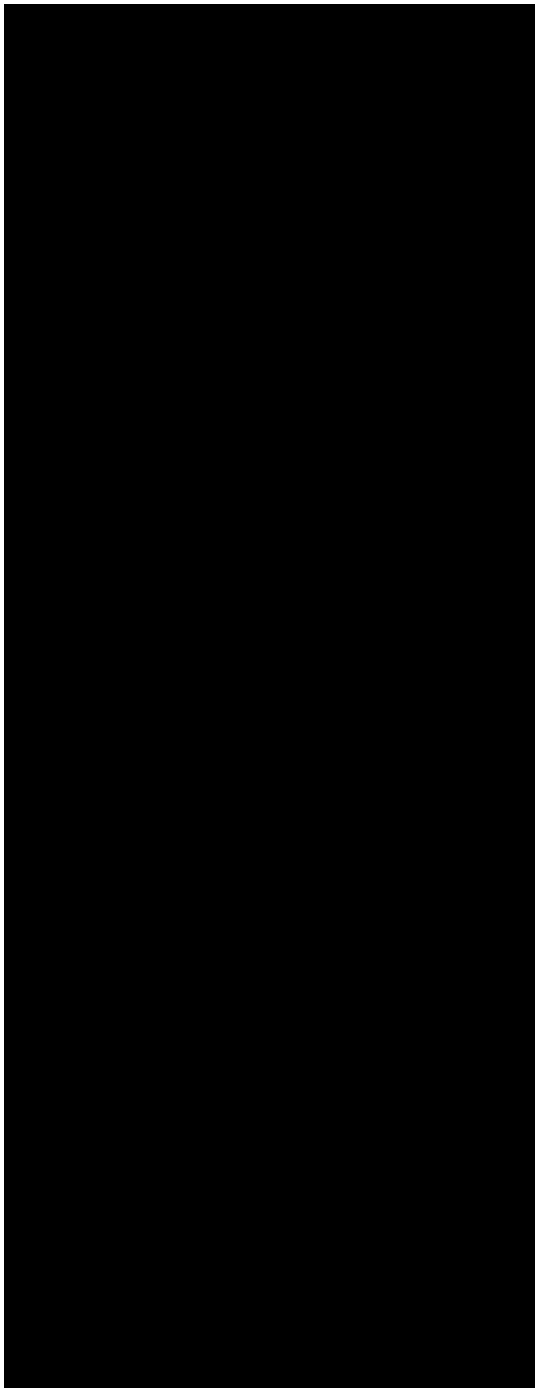
1736117	12/31/23 9:34 PM	1/18/24 4:56 PM	ECHO	1/2/24 5:34 PM	
1734297	10/24/23 6:58 PM		LIMA	10/28/23 4:27 PM	
1727505	3/23/23 3:21 PM		BMU	12/8/23 7:49 PM	12/21/23 3:36 PM
1727505	3/23/23 3:21 PM		HOTEL	12/21/23 3:36 PM	1/12/24 11:00 PM
1727505	3/23/23 3:21 PM		BMU	1/12/24 11:00 PM	1/25/24 6:39 PM
1735565	12/10/23 8:48 PM	1/4/24 7:50 PM	MIKE	12/13/23 9:26 AM	12/19/23 11:17 AM
1735565	12/10/23 8:48 PM	1/4/24 7:50 PM	GOLF	12/19/23 11:17 AM	12/28/23 6:43 PM
1735565	12/10/23 8:48 PM	1/4/24 7:50 PM	MIKE	12/28/23 6:43 PM	1/2/24 5:42 PM
1735565	12/10/23 8:48 PM	1/4/24 7:50 PM	BRAVO	1/2/24 5:42 PM	
1736388	1/9/24 3:12 PM	3/21/24 5:08 PM	ECHO	1/13/24 3:58 AM	



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1736274	1/5/24 3:58 PM	1/20/24 4:06 PM	UNIFORM	1/9/24 6:59 PM	
1734650	11/6/23 12:30 AM		ALPHA	11/9/23 9:53 AM	12/22/23 5:19 PM
1734650	11/6/23 12:30 AM		ECHO	12/22/23 5:19 PM	1/5/24 4:39 PM
1734650	11/6/23 12:30 AM		BMU	1/5/24 4:39 PM	2/16/24 5:03 PM
1701838	12/7/20 5:08 PM		INDIA	5/15/23 2:15 PM	1/9/24 5:00 PM
1701838	12/7/20 5:08 PM		JULIET	1/9/24 5:00 PM	2/14/24 4:54 PM
1729097	5/24/23 2:27 PM	2/11/24 5:49 PM	KILO	12/12/23 3:42 PM	12/20/23 3:38 PM
1729097	5/24/23 2:27 PM	2/11/24 5:49 PM	MIKE	12/20/23 3:38 PM	
1735801	12/19/23 2:12 PM	1/10/24 1:49 PM	MIKE	12/20/23 3:34 PM	
1729788	6/20/23 2:39 PM	1/29/24 7:58 PM	MIKE	10/29/23 6:00 PM	
1702280	12/23/20 6:30 PM		ECHO	11/17/22 2:38 PM	
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1731733	8/29/23 9:52 PM		ALPHA	1/8/24 1:15 PM	4/2/24 8:22 PM
1736266	1/5/24 1:59 PM		GOLF	1/6/24 5:10 PM	1/17/24 3:24 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	ALPHA	12/17/23 7:34 AM	12/18/23 7:16 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	JULIET	12/18/23 7:16 AM	12/19/23 3:34 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	BMU	12/19/23 3:34 AM	12/19/23 3:34 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	TRANSFER	12/19/23 3:34 AM	12/19/23 5:33 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	BMU	12/19/23 5:33 AM	12/19/23 7:41 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	JULIET	12/19/23 7:41 AM	12/19/23 11:56 AM
1735674	12/14/23 9:43 PM	1/10/24 2:49 PM	MIKE	12/19/23 11:56 AM	
1735500	12/8/23 9:06 AM	12/29/23 4:31 PM	ALPHA	12/10/23 2:58 PM	12/22/23 5:19 PM
1735500	12/8/23 9:06 AM	12/29/23 4:31 PM	ECHO	12/22/23 5:19 PM	
1736346	1/8/24 12:31 PM		FOXTROT	1/15/24 4:14 PM	1/15/24 4:58 PM
1736346	1/8/24 12:31 PM		LIMA	1/15/24 4:58 PM	1/15/24 5:03 PM
1736346	1/8/24 12:31 PM		FOXTROT	1/15/24 5:03 PM	1/15/24 5:28 PM
1736346	1/8/24 12:31 PM		LIMA	1/15/24 5:28 PM	2/9/24 10:48 AM
1711124	12/20/21 1:56 PM		MIKE	12/11/23 1:23 PM	3/15/24 2:02 PM
1734023	10/14/23 9:55 PM	3/15/24 7:27 PM	UNIFORM	10/20/23 5:30 PM	
1735904	12/23/23 9:15 AM		ALPHA	12/24/23 4:29 PM	12/25/23 4:30 PM
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1731589	8/24/23 7:32 PM	3/22/24 9:34 AM	DELTA	10/13/23 11:10 AM	
1735934	12/24/23 12:47 PM	12/26/23 5:57 PM	ECHO	12/26/23 1:21 PM	
1727139	3/9/23 3:17 PM		BMU	12/15/23 5:04 PM	1/5/24 3:18 PM
1727139	3/9/23 3:17 PM		LIMA	1/5/24 3:18 PM	1/18/24 11:58 PM
1732423	9/23/23 6:50 AM	1/8/24 5:58 PM	MIKE	12/8/23 9:21 PM	1/2/24 11:18 AM
1732423	9/23/23 6:50 AM	1/8/24 5:58 PM	BRAVO	1/2/24 11:18 AM	
1736323	1/7/24 2:32 AM	1/19/24 4:30 AM	BRAVO	1/8/24 8:25 AM	1/11/24 9:47 PM
1736323	1/7/24 2:32 AM	1/19/24 4:30 AM	MIKE	1/11/24 9:47 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1707607	7/23/21 10:42 AM	2/29/24 8:22 AM	HOTEL	10/9/23 11:01 AM	
1707943	8/6/21 12:40 AM		KILO	3/11/23 9:54 AM	

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1735671	12/14/23 8:50 PM	3/19/24 4:19 PM	INDIA	12/16/23 4:10 PM	1/20/24 6:16 PM
1709626	10/15/21 10:09 AM	2/2/24 10:15 AM	XRAY	4/6/23 2:47 PM	
1730254	7/6/23 10:55 AM		BMU	12/15/23 5:33 PM	1/3/24 5:07 PM
1730254	7/6/23 10:55 AM		LIMA	1/3/24 5:07 PM	2/27/24 10:16 AM
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1709433	10/6/21 7:33 PM		BRAVO	7/12/23 2:37 PM	
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1709565	10/12/21 6:42 PM		ALPHA	12/21/23 3:59 PM	12/21/23 6:42 PM
1709565	10/12/21 6:42 PM		ECHO	12/21/23 6:42 PM	
1709663	10/17/21 12:34 AM	1/10/24 2:54 PM	KILO	8/31/23 4:40 PM	
1726919	3/1/23 10:01 AM		LIMA	7/10/23 2:08 PM	
1731953	9/6/23 3:29 PM	3/28/24 7:51 AM	ALPHA	12/12/23 1:13 PM	12/21/23 3:29 PM
1731953	9/6/23 3:29 PM	3/28/24 7:51 AM	ECHO	12/21/23 3:29 PM	3/14/24 7:00 PM
1727760	4/3/23 3:50 PM	4/19/24 4:48 AM	BRAVO	10/24/23 4:25 PM	
1735967	12/27/23 4:53 AM	1/22/24 5:03 PM	MIKE	1/3/24 12:26 PM	
1736109	12/31/23 11:52 AM	1/10/24 11:24 AM	ALPHA	1/2/24 2:09 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1711479	1/5/22 11:37 PM	4/5/24 7:52 AM	XRAY	9/12/23 9:01 PM	2/22/24 3:07 PM
1711806	1/23/22 12:24 AM		INDIA	10/12/23 6:52 PM	12/29/23 10:00 PM
1711806	1/23/22 12:24 AM		BMU	12/29/23 10:00 PM	1/7/24 9:13 AM
1711806	1/23/22 12:24 AM		HOTEL	1/7/24 9:13 AM	1/7/24 10:07 AM
1711806	1/23/22 12:24 AM		BMU	1/7/24 10:07 AM	1/12/24 3:23 PM
1711806	1/23/22 12:24 AM		INDIA	1/12/24 3:23 PM	2/22/24 8:25 AM
1735528	12/9/23 1:46 AM	12/29/23 4:31 PM	ALPHA	12/10/23 2:59 PM	12/21/23 3:24 PM
1735528	12/9/23 1:46 AM	12/29/23 4:31 PM	ECHO	12/21/23 3:24 PM	
1714377	5/3/22 1:08 PM		BMU	12/12/23 11:09 PM	1/11/24 3:24 PM
1714377	5/3/22 1:08 PM		GOLF	1/11/24 3:24 PM	1/16/24 12:53 AM
1714377	5/3/22 1:08 PM		BMU	1/16/24 12:53 AM	2/13/24 5:01 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1712202	2/8/22 9:44 AM		XRAY	4/6/23 2:44 PM	2/22/24 3:04 PM
1712358	2/14/22 6:02 PM		BMU	12/14/23 5:21 PM	1/19/24 12:39 AM
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1719436	11/14/22 2:17 PM		INDIA	12/4/23 5:56 PM	2/22/24 8:25 AM
			NO DORM RECORD(S) FOR DATE RANGE		
1730449	7/13/23 11:04 AM	12/21/23 10:58 AM	MIKE	10/4/23 5:01 PM	
1733635	10/1/23 2:51 AM	1/21/24 8:22 PM	JULIET	12/4/23 10:35 AM	
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1727254	3/13/23 10:36 PM		UNIFORM	12/20/23 9:35 PM	2/14/24 4:47 PM
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1735372	12/4/23 6:30 AM		KILO	12/6/23 7:53 AM	
1715355	6/15/22 8:33 AM		MIKE	11/4/22 2:52 PM	
1714551	5/11/22 7:58 AM	2/2/24 1:29 PM	XRAY	10/30/23 11:54 AM	
1735711	12/16/23 1:21 AM	12/19/23 5:17 PM	DELTA	12/17/23 10:23 AM	

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1734746	11/9/23 4:22 PM		INTAKE	11/30/23 2:47 PM	1/3/24 10:34 AM
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1715402	6/16/22 6:16 PM		ECHO	10/6/22 4:55 PM	
1735748	12/17/23 8:23 PM	1/10/24 12:34 PM	MIKE	12/28/23 5:27 PM	1/1/24 6:31 AM
1735748	12/17/23 8:23 PM	1/10/24 12:34 PM	TRANSFER	1/1/24 6:31 AM	
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1735972	12/27/23 1:28 PM	1/17/24 7:28 PM	XRAY	12/29/23 6:51 PM	
1733979	10/13/23 3:53 PM	12/22/23 2:50 PM	XRAY	10/28/23 9:26 AM	
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1735673	12/14/23 9:06 PM	12/21/23 12:40 PM	MIKE	12/17/23 4:15 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1735289	12/1/23 9:35 AM	3/25/24 4:15 PM	ECHO	12/2/23 4:16 PM	12/21/23 3:42 PM
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1728829	5/13/23 7:18 PM	1/10/24 8:32 PM	INDIA	5/22/23 2:34 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
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1719411	11/13/22 3:45 PM	2/8/24 8:47 AM	LIMA	4/12/23 3:22 PM	
1733898	10/10/23 7:35 PM		ALPHA	10/20/23 5:03 PM	1/5/24 6:18 PM
1733898	10/10/23 7:35 PM		ECHO	1/5/24 6:18 PM	
1734716	11/8/23 4:30 PM		ECHO	11/12/23 6:59 AM	1/5/24 6:27 PM
1734716	11/8/23 4:30 PM		ALPHA	1/5/24 6:27 PM	4/2/24 8:28 PM
1724323	2/4/23 7:18 PM	2/2/24 7:26 PM	ECHO	11/29/23 9:34 AM	
1720100	12/11/22 5:39 AM	2/1/24 10:25 AM	LIMA	11/2/23 11:10 PM	
1735052	11/21/23 8:17 PM	2/28/24 5:00 PM	DELTA	11/23/23 7:20 AM	1/8/24 11:33 PM
1735052	11/21/23 8:17 PM	2/28/24 5:00 PM	XRAY	1/8/24 11:33 PM	2/22/24 3:06 PM
1720371	12/22/22 8:44 PM		LIMA	4/12/23 3:22 PM	
1736285	1/5/24 8:57 PM	1/11/24 7:08 PM	ECHO	1/7/24 4:40 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1721964	1/20/23 1:42 PM		LIMA	6/4/23 5:39 PM	2/9/24 4:47 PM
1730647	7/20/23 5:14 PM		UNIFORM	11/22/23 11:40 AM	4/8/24 5:18 PM
1725499	2/13/23 4:11 AM		KILO	5/15/23 12:05 PM	1/23/24 11:45 AM
1725589	2/16/23 11:10 AM		INDIA	10/12/23 6:53 PM	12/21/23 11:14 PM

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1725589	2/16/23 11:10 AM		BMU	12/21/23 11:14 PM	12/21/23 11:20 PM
1725589	2/16/23 11:10 AM		INDIA	12/21/23 11:20 PM	1/9/24 3:47 AM
1725589	2/16/23 11:10 AM		BMU	1/9/24 3:47 AM	1/9/24 5:31 AM
1725589	2/16/23 11:10 AM		INDIA	1/9/24 5:31 AM	2/10/24 5:12 PM
1735472	12/7/23 12:58 PM		KILO	12/9/23 4:29 PM	2/7/24 5:07 PM
1728816	5/13/23 11:03 AM	2/21/24 12:27 PM	MIKE	10/17/23 12:45 PM	
1734185	10/20/23 2:58 PM	1/17/24 4:51 PM	HOTEL	12/12/23 3:43 PM	1/13/24 5:10 PM
1734185	10/20/23 2:58 PM	1/17/24 4:51 PM	JULIET	1/13/24 5:10 PM	1/13/24 6:41 PM
1734185	10/20/23 2:58 PM	1/17/24 4:51 PM	BMU	1/13/24 6:41 PM	
1736421	1/10/24 8:11 PM		MIKE	1/12/24 10:54 AM	3/12/24 5:18 PM
1735944	12/25/23 11:48 AM	12/27/23 12:35 PM	DELTA	12/26/23 3:18 PM	
1727452	3/21/23 3:39 PM		MIKE	11/12/23 11:29 PM	
1727497	3/23/23 10:49 AM		DELTA	11/20/23 9:03 PM	12/23/23 12:37 PM
1727497	3/23/23 10:49 AM		XRAY	12/23/23 12:37 PM	1/8/24 11:33 PM
1727497	3/23/23 10:49 AM		DELTA	1/8/24 11:33 PM	
1727701	3/31/23 7:37 PM	2/22/24 9:39 AM	BMU	12/15/23 5:03 PM	1/11/24 5:18 PM
1727701	3/31/23 7:37 PM	2/22/24 9:39 AM	KILO	1/11/24 5:18 PM	
1729303	6/2/23 10:46 AM		ECHO	9/25/23 4:12 PM	12/18/23 3:47 PM
1729303	6/2/23 10:46 AM		INTAKE	12/18/23 3:47 PM	12/26/23 3:18 PM
1729303	6/2/23 10:46 AM		ALPHA	12/26/23 3:18 PM	4/2/24 8:24 PM
1727960	4/11/23 6:09 PM		BMU	12/8/23 7:37 PM	12/21/23 3:37 PM
1727960	4/11/23 6:09 PM		INDIA	12/21/23 3:37 PM	2/26/24 9:57 AM
1729006	5/20/23 4:43 PM	1/18/24 2:48 PM	UNIFORM	12/12/23 5:27 PM	
1735829	12/20/23 5:05 PM	1/2/24 1:44 AM	DELTA	12/22/23 5:22 PM	
1728469	5/1/23 1:07 PM		KILO	12/11/23 5:38 PM	2/21/24 2:46 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1728715	5/10/23 3:22 AM	3/27/24 2:34 PM	MIKE	8/31/23 2:53 PM	
1728874	5/15/23 3:06 PM	1/19/24 8:02 AM	DELTA	10/13/23 11:14 AM	
1735236	11/29/23 10:56 AM	2/27/24 3:35 PM	ALPHA	11/30/23 4:26 PM	
1729051	5/22/23 4:39 PM	2/22/24 9:39 AM	INDIA	5/28/23 6:12 PM	1/5/24 12:00 PM
1729051	5/22/23 4:39 PM	2/22/24 9:39 AM	BMU	1/5/24 12:00 PM	1/5/24 3:20 PM
1729051	5/22/23 4:39 PM	2/22/24 9:39 AM	INDIA	1/5/24 3:20 PM	1/5/24 3:46 PM
1729051	5/22/23 4:39 PM	2/22/24 9:39 AM	JULIET	1/5/24 3:46 PM	2/14/24 4:47 PM
1729062	5/23/23 1:07 AM		XRAY	12/1/23 10:48 AM	2/22/24 3:03 PM
1731793	9/1/23 9:44 AM	4/25/24 11:04 AM	XRAY	9/24/23 3:57 PM	2/16/24 4:38 PM
1729490	6/8/23 7:51 PM		XRAY	6/22/23 11:19 PM	2/22/24 3:07 PM
1736286	1/5/24 9:12 PM	1/19/24 4:48 PM	ECHO	1/7/24 4:41 PM	
1729625	6/14/23 3:06 AM	1/10/24 8:33 PM	XRAY	6/28/23 7:32 PM	
1735485	12/7/23 8:02 PM	12/29/23 4:30 PM	ALPHA	12/10/23 6:18 PM	12/18/23 2:05 AM
1735485	12/7/23 8:02 PM	12/29/23 4:30 PM	JULIET	12/18/23 2:05 AM	12/18/23 4:28 PM
1735485	12/7/23 8:02 PM	12/29/23 4:30 PM	UNIFORM	12/18/23 4:28 PM	
1730024	6/28/23 10:41 AM	12/20/23 7:46 PM	KILO	12/12/23 3:40 PM	12/19/23 10:15 AM
1730024	6/28/23 10:41 AM	12/20/23 7:46 PM	BMU	12/19/23 10:15 AM	

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1730031	6/28/23 12:32 PM	4/4/24 1:10 PM	BMU	12/15/23 5:30 PM	1/17/24 4:41 PM
1730177	7/3/23 2:10 PM	1/25/24 8:52 AM	UNIFORM	10/29/23 9:41 AM	
1735416	12/5/23 11:46 AM		MIKE	12/14/23 4:50 PM	
1730339	7/9/23 5:27 PM	1/18/24 9:38 AM	MIKE	12/11/23 5:00 PM	
1735812	12/20/23 2:34 AM	1/24/24 2:36 PM	ALPHA	12/21/23 3:45 PM	1/5/24 6:22 PM
1735812	12/20/23 2:34 AM	1/24/24 2:36 PM	ECHO	1/5/24 6:22 PM	1/15/24 3:11 PM
1735812	12/20/23 2:34 AM	1/24/24 2:36 PM	JULIET	1/15/24 3:11 PM	
1730545	7/17/23 7:56 AM		MIKE	11/8/23 5:09 PM	
1734860	11/14/23 6:38 PM	1/3/24 3:48 AM	DELTA	11/16/23 6:14 PM	
1736212	1/3/24 5:04 PM	1/25/24 12:24 PM	DELTA	1/6/24 4:22 PM	1/8/24 12:48 PM
1736212	1/3/24 5:04 PM	1/25/24 12:24 PM	XRAY	1/8/24 12:48 PM	
1730920	7/31/23 10:22 AM		INTAKE	12/8/23 6:22 PM	12/22/23 3:30 PM
1730920	7/31/23 10:22 AM		MIKE	12/22/23 3:30 PM	
1733732	10/4/23 4:49 PM		BRAVO	12/12/23 5:29 PM	4/4/24 11:15 AM
1731356	8/15/23 12:20 PM	1/19/24 4:43 AM	BRAVO	9/28/23 5:14 PM	
1731427	8/18/23 12:56 AM	3/20/24 1:58 PM	JULIET	10/6/23 7:24 PM	2/7/24 5:28 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1736166	1/2/24 3:44 PM	1/17/24 7:30 PM	BRAVO	1/4/24 3:30 PM	
1731877	9/4/23 1:44 AM		KILO	9/7/23 5:10 PM	3/25/24 9:45 PM
1731999	9/7/23 4:43 PM		ALPHA	11/29/23 8:51 AM	12/21/23 3:31 PM
1731999	9/7/23 4:43 PM		ECHO	12/21/23 3:31 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1734437	10/29/23 3:46 PM	4/10/24 5:12 PM	FOXTROT	11/2/23 5:03 AM	
1732179	9/14/23 12:27 PM		ALPHA	9/15/23 11:14 PM	12/21/23 3:27 PM
1732179	9/14/23 12:27 PM		ECHO	12/21/23 3:27 PM	
1732216	9/15/23 2:07 PM		ALPHA	9/18/23 3:09 PM	12/21/23 3:22 PM
1732216	9/15/23 2:07 PM		ECHO	12/21/23 3:22 PM	
1732422	9/23/23 6:19 AM	3/19/24 11:37 AM	LIMA	11/16/23 3:46 PM	
1732427	9/23/23 11:03 AM		KILO	9/26/23 5:28 PM	4/16/24 2:38 PM
1732452	9/24/23 2:15 AM		XRAY	9/26/23 8:35 AM	2/12/24 4:22 PM
1732469	9/24/23 2:43 PM	3/7/24 4:41 PM	XRAY	11/27/23 11:01 PM	2/4/24 8:27 AM
1735199	11/27/23 9:09 PM	2/28/24 11:55 AM	ALPHA	11/30/23 4:23 PM	
1733765	10/5/23 9:39 PM		BMU	12/12/23 3:44 PM	1/5/24 4:10 PM
1733765	10/5/23 9:39 PM		MIKE	1/5/24 4:10 PM	1/10/24 2:58 PM
1733765	10/5/23 9:39 PM		BMU	1/10/24 2:58 PM	2/8/24 2:19 PM
1733822	10/8/23 1:50 AM	1/23/24 10:04 AM	ALPHA	10/11/23 5:05 PM	1/16/24 12:40 AM
1733822	10/8/23 1:50 AM	1/23/24 10:04 AM	JULIET	1/16/24 12:40 AM	1/16/24 2:02 AM
1733822	10/8/23 1:50 AM	1/23/24 10:04 AM	ECHO	1/16/24 2:02 AM	
1733922	10/11/23 3:32 PM		ALPHA	10/13/23 5:30 PM	12/20/23 10:33 PM
1733922	10/11/23 3:32 PM		BRAVO	12/20/23 10:33 PM	
1735473	12/7/23 1:23 PM	3/8/24 5:10 PM	UNIFORM	12/10/23 2:59 PM	
1734228	10/22/23 7:53 AM		UNIFORM	10/29/23 9:41 AM	2/4/24 10:04 AM
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[redacted]

1734705	11/8/23 10:39 AM		HOTEL	11/12/23 4:01 PM	
1734497	10/31/23 5:32 PM	1/6/24 7:52 PM	DELTA	11/1/23 2:17 AM	
1734533	11/1/23 4:16 PM		BRAVO	12/12/23 5:28 PM	
1734544	11/1/23 10:45 PM		XRAY	11/25/23 6:54 AM	12/23/23 12:37 PM
1734544	11/1/23 10:45 PM		DELTA	12/23/23 12:37 PM	1/20/24 11:08 AM
			NO DORM RECORD(S) FOR DATE RANGE		
1735963	12/26/23 10:56 PM		TRANSFER	1/2/24 12:49 AM	1/4/24 5:20 PM
1735963	12/26/23 10:56 PM		INTAKE	1/4/24 5:20 PM	1/19/24 2:33 PM
1734689	11/7/23 2:54 PM	2/15/24 3:52 AM	ALPHA	11/9/23 10:19 AM	1/5/24 6:19 PM
1734689	11/7/23 2:54 PM	2/15/24 3:52 AM	ECHO	1/5/24 6:19 PM	
1734733	11/9/23 9:51 AM		BMU	12/12/23 3:58 PM	2/21/24 3:00 PM
1734882	11/15/23 3:03 PM		HOTEL	11/27/23 1:38 PM	
1735863	12/21/23 8:26 PM	4/1/24 8:33 PM	LIMA	12/23/23 5:23 PM	2/4/24 5:30 PM
1734981	11/19/23 2:01 AM	1/25/24 12:38 PM	ALPHA	11/22/23 3:54 PM	1/5/24 4:20 PM
1734981	11/19/23 2:01 AM	1/25/24 12:38 PM	BMU	1/5/24 4:20 PM	1/5/24 6:18 PM
1734981	11/19/23 2:01 AM	1/25/24 12:38 PM	ECHO	1/5/24 6:18 PM	1/6/24 4:36 PM
1734981	11/19/23 2:01 AM	1/25/24 12:38 PM	BMU	1/6/24 4:36 PM	1/11/24 5:19 PM
1734981	11/19/23 2:01 AM	1/25/24 12:38 PM	KILO	1/11/24 5:19 PM	
1735172	11/26/23 8:40 AM	2/6/24 5:47 PM	ECHO	11/28/23 1:09 PM	12/25/23 4:52 PM
1735172	11/26/23 8:40 AM	2/6/24 5:47 PM	MIKE	12/25/23 4:52 PM	12/25/23 11:17 PM
1735172	11/26/23 8:40 AM	2/6/24 5:47 PM	BMU	12/25/23 11:17 PM	
1735174	11/26/23 2:42 PM		MIKE	11/29/23 1:25 PM	
1735240	11/29/23 1:12 PM		INDIA	12/4/23 5:02 PM	3/8/24 9:21 AM
1735261	11/30/23 3:58 PM		DELTA	12/2/23 8:34 AM	3/3/24 6:54 PM
			NO DORM RECORD(S) FOR DATE RANGE		
1735329	12/2/23 7:37 PM	12/23/23 9:28 AM	DELTA	12/3/23 5:20 PM	
1735354	12/3/23 1:48 PM	12/18/23 7:40 PM	ECHO	12/6/23 7:51 AM	
1735380	12/4/23 1:06 PM		DELTA	12/8/23 9:05 AM	2/5/24 1:12 PM
1735397	12/4/23 6:52 PM		HOTEL	12/6/23 3:03 PM	12/21/23 6:42 PM
1735397	12/4/23 6:52 PM		JULIET	12/21/23 6:42 PM	12/25/23 4:19 AM
1735397	12/4/23 6:52 PM		BMU	12/25/23 4:19 AM	1/2/24 3:03 PM
1735397	12/4/23 6:52 PM		GOLF	1/2/24 3:03 PM	1/2/24 3:28 PM
1735397	12/4/23 6:52 PM		BMU	1/2/24 3:28 PM	1/5/24 3:19 PM
1735397	12/4/23 6:52 PM		KILO	1/5/24 3:19 PM	
1735413	12/5/23 7:44 AM		GOLF	12/7/23 8:20 AM	1/1/24 4:46 PM
1735413	12/5/23 7:44 AM		KILO	1/1/24 4:46 PM	1/8/24 11:06 AM
1735413	12/5/23 7:44 AM		JULIET	1/8/24 11:06 AM	1/20/24 11:13 AM
1735483	12/7/23 5:48 PM		INTAKE	12/12/23 2:51 PM	12/23/23 5:25 AM
1735483	12/7/23 5:48 PM		TRANSFER	12/23/23 5:25 AM	12/23/23 10:23 PM
1735483	12/7/23 5:48 PM		BRAVO	12/23/23 10:23 PM	12/26/23 9:32 PM
1735483	12/7/23 5:48 PM		BMU	12/26/23 9:32 PM	12/26/23 10:33 PM
1735483	12/7/23 5:48 PM		MIKE	12/26/23 10:33 PM	2/4/24 11:30 AM
1735491	12/7/23 11:51 PM	3/12/24 11:00 AM	XRAY	12/13/23 5:39 PM	2/22/24 3:06 PM

[redacted]	1735552	12/10/23 1:58 AM		INDIA	12/11/23 1:19 PM	3/23/24 2:20 AM
[redacted]	1735876	12/22/23 11:09 AM	1/24/24 1:18 PM	BRAVO	1/4/24 9:35 AM	1/7/24 12:04 AM
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[redacted]	1735657	12/14/23 8:36 AM	1/10/24 12:51 PM	ALPHA	12/16/23 7:52 AM	12/21/23 3:32 PM
[redacted]	1735657	12/14/23 8:36 AM	1/10/24 12:51 PM	ECHO	12/21/23 3:32 PM	1/8/24 1:19 PM
[redacted]	1735657	12/14/23 8:36 AM	1/10/24 12:51 PM	JULIET	1/8/24 1:19 PM	
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[redacted]	1735712	12/16/23 1:56 AM	12/18/23 6:58 PM	KILO	12/17/23 3:30 PM	
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[redacted]	1735771	12/18/23 4:52 PM	4/2/24 7:30 PM	INTAKE	12/19/23 5:26 PM	2/1/24 4:11 PM
[redacted]	1735792	12/19/23 11:43 AM		INDIA	12/21/23 1:05 PM	3/8/24 8:54 AM
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[redacted]	1735899	12/23/23 3:33 AM	1/3/24 8:06 PM	XRAY	12/28/23 9:10 PM	
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1735990	12/27/23 9:36 PM		ALPHA	12/29/23 5:17 PM	4/2/24 8:19 PM
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			NO DORM RECORD(S) FOR DATE RANGE		
1736033	12/29/23 8:53 AM		HOTEL	12/31/23 12:31 PM	3/22/24 9:40 PM
1736037	12/29/23 1:23 PM	12/31/23 7:57 PM	ECHO	12/31/23 12:29 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1736047	12/29/23 9:09 PM	3/11/24 5:02 PM	KILO	12/31/23 12:32 PM	1/9/24 1:14 AM
1736047	12/29/23 9:09 PM	3/11/24 5:02 PM	JULIET	1/9/24 1:14 AM	2/14/24 6:00 PM
1736053	12/30/23 1:59 AM	1/22/24 10:36 AM	ECHO	12/31/23 12:30 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1736066	12/30/23 5:42 PM	1/17/24 7:27 PM	ECHO	1/1/24 4:47 PM	
1736110	12/31/23 2:50 PM		BRAVO	1/2/24 12:49 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
1736118	12/31/23 11:34 PM	1/11/24 6:12 AM	GOLF	1/1/24 5:14 PM	1/6/24 2:18 PM
1736118	12/31/23 11:34 PM	1/11/24 6:12 AM	UNIFORM	1/6/24 2:18 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736132	1/1/24 12:07 PM	4/11/24 7:29 PM	GOLF	1/2/24 2:08 PM	2/14/24 5:42 PM
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			NO DORM RECORD(S) FOR DATE RANGE		
1736163	1/2/24 2:50 PM	3/20/24 5:17 PM	ECHO	1/3/24 3:48 PM	
1736167	1/2/24 4:00 PM		GOLF	1/6/24 9:00 AM	1/16/24 5:05 AM
1736167	1/2/24 4:00 PM		BMU	1/16/24 5:05 AM	1/24/24 5:47 PM
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			NO DORM RECORD(S) FOR DATE RANGE		
1736208	1/3/24 4:27 PM		GOLF	1/6/24 5:09 PM	2/14/24 5:42 PM
1736219	1/3/24 11:50 PM	1/17/24 9:42 PM	KILO	1/6/24 5:17 PM	1/16/24 5:19 PM
1736219	1/3/24 11:50 PM	1/17/24 9:42 PM	UNIFORM	1/16/24 5:19 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736232	1/4/24 12:35 PM		BRAVO	1/6/24 5:16 PM	
1736271	1/5/24 2:43 PM	1/8/24 11:34 AM	DELTA	1/6/24 4:22 PM	
1736275	1/5/24 4:23 PM	1/8/24 4:18 PM	DELTA	1/8/24 9:22 AM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736317	1/6/24 11:25 PM	1/30/24 1:56 PM	ALPHA	1/9/24 1:06 PM	1/10/24 10:24 PM
1736317	1/6/24 11:25 PM	1/30/24 1:56 PM	MIKE	1/10/24 10:24 PM	

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1736341	1/8/24 4:38 AM		DELTA	1/9/24 3:28 PM	3/3/24 8:21 AM
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
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			NO DORM RECORD(S) FOR DATE RANGE		
1736366	1/8/24 9:13 PM	4/8/24 3:59 PM	DELTA	1/11/24 9:04 AM	1/14/24 1:23 PM
1736366	1/8/24 9:13 PM	4/8/24 3:59 PM	XRAY	1/14/24 1:23 PM	2/22/24 3:05 PM
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736432	1/11/24 9:52 AM	2/22/24 3:55 AM	DELTA	1/13/24 11:02 AM	
1736443	1/11/24 4:17 PM		INDIA	1/12/24 3:15 PM	1/17/24 10:38 AM
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736497	1/13/24 4:12 AM	2/7/24 10:48 AM	ECHO	1/15/24 3:24 PM	1/17/24 10:59 PM
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
1736526	1/14/24 12:56 AM	1/25/24 12:51 PM	LIMA	1/15/24 3:05 PM	
1736559	1/15/24 7:24 AM	1/30/24 3:46 PM	ECHO	1/16/24 2:30 PM	
			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		
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			NO DORM RECORD(S) FOR DATE RANGE		
			NO DORM RECORD(S) FOR DATE RANGE		

EXHIBIT 5

RICHLAND COUNTY ADMINISTRATION
2020 Hampton Street, Suite 4069
Columbia, SC 29204
803-576-2050

Agenda Briefing

To:	Committee Chair Dalhi Myers and Members of the Committee
Prepared by:	Ronaldo D. Myers, Director
Department:	Alvin S. Glenn Detention Center
Date Prepared:	February 20, 2020 **Meeting Date:** February 25, 2020

Legal Review		**Date:**	
Budget Review	James Hayes via email	**Date:**	February 20, 2020
Finance Review	Stacey Hamm via email	**Date:**	February 20, 2020
Other Review:	Jennifer Wladischkin via email	**Date:**	February, 2020
Approved for consideration:	Assistant County Administrator	John M. Thompson, Ph.D., MBA, CPM	

Committee	Detention Center Ad Hoc Committee
Subject:	Architect firm to Design a Medical and Mental Health Housing Unit for the ASGDc

Recommended Action:

Staff recommends approval of the contact for Mosley Architect Firm to design the medical and mental health housing units as part of the Alvin S. Glenn Detention Center expansion project.

Motion Requested:

1. Motion to approve the contract to for Mosley Architect Firm to design the medical and mental health units as part of the Alvin S. Glenn Detention Center expansion project; or,
2. Move to deny the request to contact with Mosely Architect Firm

Request for Council Reconsideration: ☐Yes

Fiscal Impact:

This project was funded in FY 2011/12 for $12,500,000. The Office of Budget and Grants Management is coordinating with Operational Services, Procurement, and the Detention Center to ensure the funds are available in the current year.

Motion of Origin:

There is no associated Council motion of origin.

Council Member	
Meeting	
Date	

Discussion:

In FY 2011/12 Richland County Council approved funding to build an expansion for bedspace for the Alvin S. Glenn Detention Center (ASGDC). Carter Goble Lee, LLC (CGL) completed a Needs Assessment in 2016 to study current and projected needs of the ASGDC based upon current and historical data. As a result of the assessment, CGL recognized a need for additional single cell housing to address difficulties in effective inmate classification. CGL recommended the following:

- The construction of a purpose housing unit for inmates with acute mental health needs.
- The construction of a purpose built housing units for inmates with acute medical needs.
- The conversion of 2 or 3 of the Phase 1, open dormitory housing units to single bed cells.
- The update or replacement of facility security electronics, to include video surveillance.

The Alvin S. Glenn Detention Center was built in several phases over multiple years to address the needs of the facility at the time. Each construction phase is independent in design and functionality, and phase is labeled and referred to by the ASGDC Staff in its chronological phase number.

- Phase I, opened in 1995, included 336 open bay beds for minimum and low medium custody offenders charged with non-violent crimes. The beds were distributed throughout 6 housing units containing 56 beds each.

- Phase II, opened in 1996, included 168 beds distributed throughout 3 housing units.
  - 56 single bed inmate orientation/initial classification unit
  - 56 bed special housing unit (SHU) that holds disciplinary inmates, administrative segregation inmates, and a de facto special needs unit
  - 56 bed maximum custody unit for detainees charged with violent offensives

- Phase III, opened in 1998, included 224 beds distributed throughout 4 housing units which house high medium and maximum custody level detainees.
  - 2 housing units containing 23 cells each with double bed occupancy for high medium custody level inmates
  - 2 housing units containing 56 cells each with single bed occupancy for higher custody level inmates.

- Phase IV, opened in 1998, included 112 beds distributed throughout two 56 bed open bay housing units for minimum custody inmate workers.
  - The unit was closed in 2014 due to plumbing/sewer issues and a decease in population
  - This unit has been repurposed into office space and staff training facilities

- Phase V, opened in 2005, included a 280 beds distributed throughout 5 housing units in a hybrid design that enable the housing of detainees with multiple custody levels.
  - 112 beds for females detainees
  - 56 beds for a de facto medical unit
  - 112 beds for medium custody inmates

As the medical and mental health needs of the inmate population have increased, the facility has shifted the population to accommodate those needs. However, the ASGDC has received citations from the SC Fire Marshall for fire code violations as well as the SC Dept. Of Corrections Compliance, Standards, and Inspections Division for compliance violations to the SC Minimum Standards for Local Detention Facilities for custody level classification issues. To accommodate the medical needs of some inmates, Facility Administration has had to authorize the use of heavy duty extension cords for required medical equipment such as CPAP machines and nebulizers. On many occasions the hospital has deemed an inmate well enough to be discharged from the medical facility; however, upon the inmate's return to the facility, it is determined the inmate requires a higher level of medical care than the Detention Center is capable of providing due to a lack of required medical equipment, such as medical beds, nurses stations, and monitoring equipment.

Mental health needs are high for all detention centers throughout the United States. Currently, law enforcement has two alternatives to address a person in a mental health crisis: the emergency room or jail. Of the two, confinement in a jail setting is the easiest and quickest way to get a person in crisis in custody and off the street. In 2018, the Bureau of Justice Statistics (BJS) reported 14 percent of prisoners in state and federal facilities met the criteria for having serious mental health conditions. In local jails the number was 26 percent. Only five percent of the general population meets those criteria, according to the BJS. Mental illness also affects a higher percentage of female prisoners than males.

According to federal data, 40 percent of prisoners were diagnosed with a mental health disorder between 2011 and 2014. Every year, two million people with psychological problems are jailed based on estimates by the National Alliance on Mental Illness. A 2016, report by the Treatment Advocacy Center found that mentally ill prisoners are detained longer, cost more to house, are more likely to commit suicide, and be placed in solitary confinement.

The ASGDC has a large population of detainees with mental health needs. There are currently 336 identified inmates who have mental health needs; of those, 223 are seriously mental ill. Serious mental illness (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment which substantially interferes with or limits one or more major life activities. Because some SMI detainees cannot be placed in general population housing units, they are assigned to the special management unit. However, the unit is not conducive to housing detainees with mental health needs. In fact, the lack of appropriate housing negatively impacts a detainee's mental health state due to prolonged confinement of 22-23 hours per day.

Detainees with SMI have taken critical single cell space from special management unit. Approximately 42%, or 24 beds, of our special management bed space is currently allocated to detainees with SMI. The facility was not designed to house inmates in this way. As previously mentioned, these inmates cannot be housed in general population with their respective custody level due to risk of victimization. A dedicated mental health housing unit will be conducive to treatment of those detainees with mental health needs. The detainees can participate in group and individual therapy sessions, which are presently unavailable. The underlying assumption is that by providing necessary treatment while in the custody of the Detention Center, the inmate's condition will improve, and with the continuity of care through existing community partnerships, there will be lower recidivism rates for those with a serious mental illness.

Attachments:

1. Medical and mental health stats for 2019
2. Medical and mental health stats for 2020
3. RFQ
4. Mosley Agreement
5. CGL Needs Assessment
6. Companies that Submitted Proposals
7. Consolidated Evaluations and Bid Tabulation

Attachment 5

RICHLAND COUNTY, SOUTH CAROLINA
Alvin S. Glenn Detention Center
Needs Assessment

FINAL REPORT – October2016

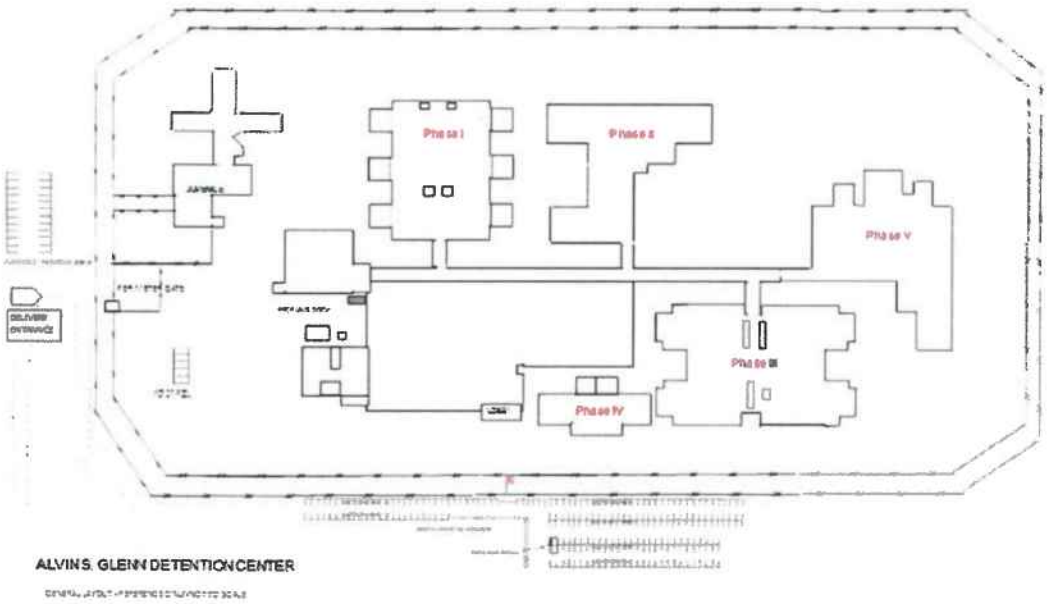
Prepared by:
CGL Companies
1619 Sumter Street
Columbia, SC 29201
CGLCompanies.com
803-765-2833

Current Inmate Housing Assessment

The Detention Center was constructed in five phases that comprise a total of 20 housing units and a total of 1,120 beds. Phase I was constructed in 1994, and consists of six dormitory housing units with a total of 336 beds. Like all of the housing locations at ASGDC, each of these units contains 56 inmate beds. The custody levels of these housing units include minimum, low medium and medium custody inmates. There have reportedly been consistent disciplinary infractions by the medium custody inmates in this area. These medium custody inmates may be better served in celled housing rather than dormitories.

Finding: The open environment of the dormitories in Phase I may not be appropriate for medium custody inmates. Celled housing units may be more appropriate for this population.

Figure 1-1
Current Housing Layout



Phase II was constructed in 1995, and has three 56-bed celled housing units, for a total of 168 beds. One housing unit serves as an orientation unit for new inmates, one unit houses maximum security inmates, and the third housing unit is known as the SHU. The SHU houses a variety of inmates including those in disciplinary segregation, administrative segregation and protective custody status.

Finding: Many of the inmates housed in the SHU are inmates on suicide prevention status and those inmates with acute mental illness. The SHU is not an appropriate environment for inmates with suicidal tendencies or advanced mental illness, which need a more therapeutic environment.

Phases III and IV were both built in 1997. Phase III contains four 56-bed celled housing units that house both medium and maximum custody inmates. Phase IV has two dormitories that have historically housed inmate workers and inmates serving weekend sentences.

EXHIBIT 6

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8-cv-01358-MGL-BM **DECLARATION OF NICOLE R. JOHNSON, MD**

I, Nicole R. Johnson, MD., pursuant to 28 U.S.C. § 1746, declare as follows:

I. Introduction.

A. Contracted Assignment

I am contracted to serve as a subject matter expert in the field of general and forensic psychiatry in a correctional setting for the Plaintiffs in *Disability Rights South Carolina, et al v. Richland County*. United States District Court for the District of South Carolina. Civil Action No. 8:22:cv-1358-MGL-BM, My work included an extensive review of policies, procedures, practices, on-site touring, review of medical records for numerous detainees, and interviews with Alvin S. Glenn Detention Center (ASGDC) staff and inmates. My expert report includes findings and observations and the basis for my opinions regarding ASGDC detention center's treatment and care of detainees suffering from mental health issues.

B. Methodology

My methodology for the investigation was to review pertinent documents/medical records, conduct interviews with ASGDC former and current staff and detained individuals, and conduct an ASGDC on-site visit. My expert report findings, observations, and opinions are from the documents/medical records provided by Plaintiffs' counsel, interviews with ASDGC former and current staff and detained individuals, and the on-site visit to ASGDC in January 2024 along with my education, training, and experience in forensic psychiatry.

C. Qualifications

I am a double boarded, licensed forensic psychiatric. I have served as a subject matter expert for mental health services for a number of correctional facilities across the country

and the United States Department of Justice. My educational background includes a Bachelor of Science in Psychology from Duke University in Durham, North Carolina and a Doctor of Medicine from New York Medical College in Valhalla, New York. I completed both an adult general residency and a forensic psychiatry fellowship and successfully passed the adult general and forensic psychiatry board certification examinations. I have worked in a consultative capacity, investigating and providing feedback regarding behavioral health services within correctional facilities for over 10 years. I have provided subject matter mental health expert services for the Philadelphia Department of Prisons, Orleans Justice Center, and Los Angeles County Jail. I have conducted numerous posthumous investigations of suicides occurring within correctional facilities. I have provided consultative services for the Department of Justice when an investigation is undertaken based on alleged civil rights violations of detained individuals in a correctional facility, including at Hampton Roads in Virginia and Parchman in Mississippi. I currently work in a maximum-security psychiatric hospital providing care and treatment for pretrial and post-adjudicated individuals with mental illness who have become involved in legal system. I am on the faculty at Saint Elizabeths Hospital in Washington, DC, where I annually teach forensic fellows about mental health in correctional settings.

D. Document Review

I reviewed a copious number of documents, including medical records of current, former and deceased detainees, to compile my expert opinion for the case. The documents are identified in Appendix I.

II. Overview and Findings of ASGDC:

A. Essential Elements of Correctional Mental Health Services

There are essential elements to an effective and therapeutic delivery of behavioral health services in a correctional setting, including detention centers and jails. All behavioral health services must begin with a comprehensive intake process where discharge needs are considered. Discharge planning is essential at intake as some of these individuals may spend a short amount of time at the facility and therefore each day is critical in ensuring a plan is in place to help them remain in the community after discharge. There is a large number of individuals who are at ASGDC for extended periods of time and discharge planning from intake is also critical as resources may be limited in the community. The intake process should begin with a comprehensive receiving screening which will identify the mental health and medical needs of the detainee. This screening is used to ensure urgent mental health needs are met. Ideally, the mental health screening should be conducted by a qualified mental health professional or psychiatric practitioner. Items that should be included, but not limited to, in the screening include psychiatric history, substance use history, victimization history, suicidal thoughts and behaviors, sexual offenses, cerebral trauma, violent behavior, status of psychotropic medications, mental state, current substance use and orientation.

Secondly, all individuals in need of ongoing mental health services should be referred for a comprehensive mental health assessment which should be completed within 14 days of admission to the facility. The comprehensive mental health assessment, along with the screening

information, should inform the treatment plan for each individual. Everyone receiving mental health services needs a multidisciplinary treatment plan which provides a framework for the therapeutic work needed for the individual to assist with healing and recovery.

A third essential component of an effective behavioral health system in jail is therapeutic programming. A continuum of behavioral health programming is necessary to address needs, concerns, and compliance in this setting. Group therapy, individual counseling, substance abuse treatment and medication are all necessary elements for treatment in a correctional facility. In addition to structured therapeutic activities, unstructured engagement is also a key component to an effective mental health system. Unstructured activities include adequate time of showers, phone call, supportive visits, leisure activities outside of the cell and recreation daily.

The final essential component of a functional and therapeutic system of behavioral health services in a correctional facility is a Continuous Quality Improvement (CQI) program. CQI monitors and improves the quality of healthcare delivered in the system. The is no way to improve a system without collecting adequate information about the system. There is no way to know whether the treatment being rendered is effective without collecting information and investigating current practices.

The American Psychiatric Association in 2016 described mental health treatment in a correctional facility as the use of a variety of mental health therapies, including biological, psychological, and social therapies, to alleviate symptoms that cause distress or interfere with a person's ability to function. It should be provided in an atmosphere of empathy and respect for the dignity of the person. It should be strength-based and focused on recovery and tailored to meet the needs of the inmate.

Correctional mental health services should provide an integrated system of mental health care aligned with good correctional management designed to empower offenders with mental illness to attain their maximum level of crime-free employment, self-care, interpersonal relationships, and community participation. It would promote individual recovery and resilience while protecting the public (Powitzky, 2008).

The mission of mental health services in corrections should be to provide those programs and services which are designed to evaluate, prevent, and treat mental health problems and which contribute to safe, humane corrections environment (Powitzky, 2008, p.5).

B. Mental Health Services at ASGDC

In contrast to the essential components needed to have an effective behavioral health system, the most glaring issue I discovered at ASGDC was the overall lack of therapeutic mental health services or treatment being provided to the detainees. It appeared that everyone was treated the same regardless of presentation; monthly visits, speak with someone on the pod if they identify they want to speak, subjective suicide assessment cell side, and provider visits every 90 days. There was a list of individuals ACH generated of touches mental health had over the past 30 days, yet there was no discernable caseload of patients at ASGDC. If someone wasn't seen in the last 30 days, for any number of reasons, but was receiving medication, they would not be on the list generated of mental health encounters over the last 30 days therefore I would not know they are

being treated. Without a set caseload, it is impossible to know the universe of people who are receiving treatment and what is needed overall for programming.

In a correctional setting, the immediate objective is to alleviate symptoms and prevent relapses so patients can function safely in their environment. This is not happening at ASGDC for the following reasons:

1. There is minimal to no behavioral health treatment occurring at ASGDC. There are four stages for psychiatric treatment – crisis, acute, maintenance and health promotion. During a crisis stage, the patient is in need of intense supervision for crisis resolution. This can include suicidal patients. During the acute phase of psychiatric treatment, the patient is in need of frequent interactions and a plan for resolution. This can include someone who is experiencing active symptoms of their mental illness which interfere in their ability to function. The maintenance phase is someone who is stabilized on medication and can consistently attend and participate in structured programming where psychoeducation and building insight into their mental illness can occur. Finally, in health promotion, the patient is stable and continues to need education and resources, like coping skills, to navigate changes in the environment and daily life stressors. Treatment is not merely medications and monthly check-ins. Mental health treatment is based upon an individualized plan developed collaboratively with mental health clinicians and an individual with the goal to assist in recovery and return to a baseline level of function. Unfortunately, the basic fundamentals of mental health treatment are lacking at ASGDC.

   In the deposition of Laurrinda Saxon, director of mental health, she stated the clinicians do not engage in therapy as there is not sufficient time to address issues which may arise. There is a need, however, for a continuum of services that is absent at ASGDC, including individual therapy and group therapy. Therapy could be used to help protect inmates from deteriorating in response to the threatening and at times dangerous ASGDC environment. There is more to individual therapy than bringing up childhood issues or trauma situations with limited time to engage a patient. For example, people with schizophrenia have trouble adapting to environmental change and may require a great deal of support. One benefit of psychotherapy is to provide the seriously mentally ill inmate with a touchstone to aid reality testing, to avoid withdrawal into psychosis in response to both real and imagined fears of staff or other inmates. Individual therapy can also address traumatic events which have happened in the jail, like an inmate witnessing a stabbing or being victimized. Patient D001 spoke with this writer and indicated having witnessed various stabbings throughout his time at ASGDC yet there is no indication in the records that a mental health clinician ever addressed this issue with him. Based on a review of the records, it took over a year after admission to ASGDC for him to see a provider although he reported anxiety and a history of taking psychotropic medication for months prior to being seen. In October 2023, when he did meet with a provider, the plan was to gain access to community mental health records to verify his medications. This should have been completed during the year he was at ASGDC rather than delay treatment more at this juncture. Patient D002 mentioned having experienced traumatic events at ASGDC, including watching another detainee pass away in his housing unit, yet there is no indication in the medical records that any of these events have been addressed by a mental health clinician.

2. As there is no delineation as to the level of acuity of patients at ASGDC, most patients receive the same level of engagement. This engagement is basically checking in with the patient once or twice a month and seeing a psychiatric provider every two to three months. In reviewing medical records, including records of individuals who have died while incarcerated at ASGDC, regardless of presentation, patients were seen every two to four weeks. It was only more frequent if the detainee announced a need to see the clinician while the clinician happened to be in the housing unit.

    a. D003, who was at ASGDC during my site visit in January 2024, had recently miscarried prior to admission to the facility and there was no indication this issue was ever addressed by the mental health staff. There were reports that staff witnessed her pocketing her medication rather than ingesting it yet there was no change in the engagement with her and the mental health staff nor was there any formal informed consent documentation in the records. In December 2023, she was found to have 265 pills in her possession, yet this incident did not appear to trigger any changes in her engagement with mental health or a formal discussion regarding her noncompliance. D004 was actively psychotic at the time of the site visit in January2024. She had been at ASGDC since September 2023 and presented as hostile, aggressive and refusing medication throughout the time she has been at ASGDC yet there was no change in the level of engagement from mental health staff for this acutely psychotic female. There was no documented plan of how the mental health staff may address her needs and presentation to aid in recovery.

    b. D005 was seen at the site visit in January 2024 and was clearly demonstrating signs and symptoms of dementia. She has been at ASGDC since August 2023 and suspected of having dementia in September 2023. In December 2023, there remained a rule out dementia diagnosis on her chart. There was no change in mental health staff engagement or attempts to provide treatment for dementia during her stay at ASGDC. She was seen, as appears to be standard practice, every two weeks to a month for follow-up appointments. It does not take 3 months to diagnosis someone with dementia and provide appropriate treatment to aid in recovery.

    c. D001 was basically seen monthly by mental health staff and given five different diagnoses, including bipolar, PTSD, anxiety, schizophrenia and self-reported mood disorder, since his admission to ASGDC in June 2023 through January 2024 (7 months). The outstanding diagnoses did not trigger mental health staff to engage more with the patient or to try and communicate with each other to establish a diagnosis for improved recovery. There does not appear to have been any discussion among the mental health staff concerning his treatment or how to proceed with someone who is generating different diagnoses with different clinicians. The lack of intentional communication whether by reviewing the medical record or a formal communication process is quite troubling which leads to the need for treatment planning services at ASGDC.

3. Lack of a treatment plan process for detainees. It was also confirmed in the deposition of Laurrinda Saxon, director of mental health, that there are no formal treatment plans done at ASGDC. A formal treatment plan is a multidisciplinary, i.e., participation by various clinical staff including psychiatrists, nurse practitioners, nurses, mental health professionals and medical staff when necessary, document which directs treatment and care for an individual. Custody staff should also participate regarding housing considerations, and other issues as are relevant for custodial/security management including the custody staff's observations of inmates on constant observation or in any other housing situation, as well as other activities and behaviors by the inmates including during mealtimes, use of recreational time, taking showers, visitations, etc. Without a formal treatment plan, there is no understanding or expectation for what is being done for an individual. It is basically each clinician operating in a silo without a collaborative plan where the patient is at the center. Without individualization, everyone is treated the same and that is NOT treatment.

   In a fluid environment, like a detention center, a treatment plan helps assigned clinicians quickly implement necessary treatment to aid in recovery. Patients move from housing unit to housing unit and without a treatment plan, therapeutic interventions begin from scratch each time the person is moved, losing precious time to make a difference. Patients should be involved with the treatment team to create a treatment plan. Engaging the patient in the development of their treatment plan helps the patient gain a degree of ownership of their treatment. This leads to better compliance and better treatment results. If the patient is unable or refuses, this should be clearly documented with engagement attempts.

   Treatment plans should consist of measurable and patient unique goals and interventions. There should be clear documentation in subsequent progress notes reflecting the progress and achievement of goals. The progress notes should reflect the specific clinical and therapeutic interventions which were performed during the session which should coincide with the treatment plan. Goals should not be changed without documentation of how the original goal was met. If goals were not met and remain on the treatment plan, there should be clear documentation describing how the clinician will assist in attaining the goal and what will be different during the next time block to achieve the stated goal. The progress notes should reflect what the clinician did during the session to address the treatment goals and how they provided the intervention which is listed on the treatment plan. It is not enough to have a treatment plan without the necessary components to make it an effective tool in assisting in recovery and collaboration among staff. Without a treatment plan there is no unified direction regarding the expectations and progress being made by a patient. There is no therapeutic treatment being done if there is no understanding of what the patient needs and how the staff will provide support. The lack of organized treatment results in mere check ins which is not appropriate for vulnerable patients in need of help. In the reviewed medical records, there was no formal treatment plan seen nor was there any indication there was a formal process in place for collaboration between mental health, medical services and custody.

4. Detainees being left to languish with symptoms of their mental illness. It appears that the worse someone is in terms of the acuity of their mental illness, the less engagement is performed by the mental health clinicians. Having active symptoms of a mental illness has been described as painful and miserable by individuals who have experienced symptoms and are now in recovery and operating at their baseline. The manager for Mental Health, Laurrinda Saxon, was deposed in January 2024 and stated patients with active symptoms of mental illness were seen more frequently by mental health clinicians and brought to the clinic more frequently for follow up. She also stated those who are the most ill are referred to Bryan for treatment. While this was said, it doesn't appear to be the practice at ASGDC. I met with numerous detainees who were actively experiencing symptoms of their mental illness and were receiving minimal, if any, interventions from mental health. In Phase III and V, detainees are generally confined in their cells or pods over 23 hours a day without care, depending on the officer assigned, if there is one.

    a. This writer met with D005 during the ASGDC inspection. D005 presented as actively psychotic and responding to internal stimuli, disorganized in her thought process and presentation, delusional and combative. She appeared unable to provide consent for treatment. She was unable to confirm having interactions with mental health. She is not receiving treatment for her mental illness. In review of her medical records, even though she was actively psychotic, her interactions with mental health were no more frequent than a more stable individual. She was not seen more frequently in the mental health clinic than other patients who were more stable.

    b. D006 met with this writer and appeared to have symptoms of dementia. She has not received any therapeutic services from mental health for her rule out dementia diagnosis, which has been a rule out diagnosis for over four months. Therapeutic interventions for dementia include cognitive stimulation therapy, reality orientation, physical exercise and validation therapy. She believed the year was 1920 and could not recall when she was last took a shower or how frequently she is allowed out of her cell. She has not been offered medication to help slow the progression of her dementia. D006 was seen and she was actively experiencing symptoms of a mental illness. She was actively delusional and believed she was being "scolded by the military". She reported having taken 5 showers in the past 4 months and being restricted from using the phone. She reported being let out of her cell a total of 3-4 times since her arrival at ASGDC in September 2023 for recreation.

These individuals would be considered in need of the acute phase of psychiatric treatment. While the accuracy of these statements is irrelevant, what is relevant is the fact that they are actively psychotic and receiving no treatment for their illness. Their presentations warrant an intense treatment protocol. While these three examples are used to demonstrate the lack of mental health treatment available, even for the most ill, it is imperative that ALL individuals receiving mental health services be provided adequate treatment to address their individual therapeutic needs.

5. The existing system in place to categorize patients based on level of acuity is inadequate. While staff stated they know their patients and decide who needs to be seen more frequently than monthly, the existing system in place for a follow-up clinician to know how frequently someone should be seen is also inadequate. Patients are seen monthly regardless of acuity and individual need. Some jail systems use a Level of Care system. They assign a number to a particular presentation which lets all clinicians know what is expected. For example – Level 0-4, where Level 0 is someone who has had no contact with mental health; Level 1 is someone who may or may not be on medication but is being monitored due to history or current concern but is able to function in the general population and can be treated as someone on an outpatient status, seen monthly/treatment plan every 6 months; Level II is someone who is on medication and is able to function in general population and can be treated as an outpatient, seen once or twice a month/treatment plan every 3-6 months, depending on clinical need; Level III is someone on medication who needs more frequent contact due to having active symptoms, changes in medication regimen, behavioral problems, strong consideration to reside in mental health housing, return from the hospital after receiving mental health treatment (competency or inpatient) who should be treated as an acute patient, seen weekly with a monthly treatment plan; Level IV is someone who is on suicide watch, in need of inpatient treatment, has active symptoms which interfere with ability to function who would be seen daily and have a treatment plan updated as frequently as the presentation changes, up to twice a month. Individuals could move along the Level continuum based on presentation and clinical assessment.

   The level of care system outlined above stands in stark contrast to the Alvin S. Glenn Detention Center. Although the current system utilized at ASGDC classifies patients in 4 categories – MH-0, MH-1, MH-2a, MH-2b, after review of numerous medical records, conducting detainee interviews and review of mental health staff depositions, it is clear these classifications have no meaningful effect on the delivery of mental health services at ASGDC. Therefore, there is no functional differentiation of services based on acuity level.

   Please see section 1 which outlines examples of several patients who were are all engaged in the same manner regardless of acuity.

6. There is a complete absence of programming for ASGDC detainees receiving mental health services. I visited the Mike unit which has been designated as a housing unit for the mentally ill. In speaking with various detainees and staff members, they confirmed there is no mental health programming provided for them on the unit. There are no groups conducted to help them learn about their medications, appropriate social skills, adequate hygiene care, emotional control like anger management, current events, etc…The overall goal should be to help the detainees recover from the symptoms of their mental illness so as to decrease the probability of return and likelihood of harm. This can only happen with adequate therapeutic involvement and psychoeducation of the detainees. The detainees were standing around, watching television and sleeping. With no programming and no increased consistent frequency of mental health clinical visits for detainees housed here, this housing unit appeared like all the rest that this writer visited other than isolating those with mental illness away from other detainees. Having someone who is mentally ill and

unengaged in treatment increases the risk of substantial harm for the patient. These patients should be engaged daily in structured programming aimed at education, recovery and improved ability to function in a correctional setting.

While the idea of having a mental health unit is great, it does not negate the need for all patients who are on the behavioral health caseload or in need of mental health services to be engaged in therapeutic treatment. Any individual who comes into contact with behavioral health, whether through medication prescriptions, crisis occurrence, behavioral dysregulation or just needing someone to talk with, is a candidate and in need of a comprehensive continuum of mental health programming, to include groups to aid in recovery.

In the declaration of D007, she reiterated the lack of mental health programming at ASGDC and recounted what is considered treatment – coping skills sheet, coloring pages and some sort of guidelines. She confirmed there is no therapy or therapeutic engagements occurring at ASGDC. Handouts are not standard treatment for mental illness in any setting, especially in a correctional setting, where the need for physical engagement is paramount.

In a second declaration of D003, she spoke about the lack of consistent mental health services at ASGDC and only being seen by mental health when a detainee requests it. She spoke about sick call requests never being addressed. She stated the focus of mental health appears to be placing detainees on medication rather than providing therapeutic services.

7. Inadequate suicide watches and assessment are concerning. Suicide assessments are conducted cellside at ASGDC. I watched the social worker come to Mike unit and conduct her suicide assessment. She came to the cell door, which was opened by the security staff, and the officers and mental health staff stood in the dayroom area and conducted the assessment with numerous other detainees in the area. There was no attempt at providing privacy or confidentiality during the assessment. The lack of privacy leads to questions regarding the reliability and accuracy of the assessment. Many inmates will not admit or confirm sensitive information in the presence of other detainees for fear of their safety. Suicide assessments need to be conducted in private areas to allow there to be more accurate exchange of information. There should also be a formal assessment, like the Columbia Assessment that can be modified, used to assess the detainees. Depending on subjective findings alone can place the detainee at harm as the clinician may miss a key component of the assessment which would be critical to ensure the safety of the patient. In a review of the medical records, including those who died via suicide in the last couple of years, there was no formal, standard suicide assessment in the chart.

   Suicide watches: As per the ASGDC suicide watch logs I reviewed, the watches were to be performed within 15 minutes at irregular intervals. I reviewed numerous suicide logs and there were hours unaccounted for, watches done on exact intervals, or done in longer intervals than required, i.e. a watch completed 30 minutes apart. Watches are inadequate and inconsistent for the most vulnerable detainees. A detainee on suicide watch needs to be seen as prescribed, in a non-scheduled manner (should not be seen at :00; :15; :30;

:45 every hour or :00; :05; :10; :15, etc.) for their safety. This area raises grave concerns as to the risk the detainees are exposed to. There is a risk of substantial harm if someone who voices a threat to self is not properly monitored.

[redacted] was placed on suicide watch on February 11, 2022. On the morning of February 12, 2022, he was seen by the officer at 6:20am and didn't take his breakfast, the officer wrote he was sleeping. At 7:20am he was found dead in his cell. There was no indication that a check was performed between 6:20am and 7:20am, although he was on watch. There is no indication that he was properly checked at 6:20am to ensure he was sleeping then.

A recent suicide in March 2024 contained disturbing accounts from detained individuals who experienced the demise. In review of 5 declarations regarding the suicide of Ms. [redacted] all the witnesses reported there were signs of disturbances in her emotional regulation, prior to the suicide, including crying on the day of the suicide about the loss of her boyfriend. The witnesses corroborated that the officer left the housing unit prior to her shift being completed and the young lady hung in her cell for a significant period of time prior to being cut down. The declarations also made it clear that mental health clinicians have not increased their engagement with the detainees to assist with grief and other concerns which have arisen from this incident. [redacted] stated in her declaration that she has seen mental health clinicians once since the suicide and felt the clinicians are not around enough to address the needs of the population. The physical lack of custody staff on housing pods increases the risk of self-harm behaviors which could result in more fatalities due to unsupervised time. If there was an officer on the housing unit when a self-harm incident happens, medical assistance can be summoned immediately which may help in resuscitation and survival, rather than the alternative which is someone dies a slow death in a cell alone.

8. Untimely addressing of sick calls throughout the facility. I spoke with at least 15 detainees who stated they have placed sick calls in to have medical and mental health issues addressed and have never received a response. Many said it has taken months to have a sick call addressed and by then the issue has resolved itself. I reviewed 8 sick call submissions which were being triaged on January 24. The following dates were on the sick call request when signed by the inmate – January 24, 2024; undated; January 21, 2024; January 13, 2024; January 20, 2024; January 19, 2024; January 10, 2024; undated. The sick call requests were for various things including a request for a diet change, complaints of pain, request for reading glasses, and heartburn. **Sick call requests need to be triaged within 24 hours of receipt.**

   These requests are the way detainees are able to receive medical and mental health assistance for issues. Great harm can be avoided if the sick call process is operational and timely. Detainees should not have to wait up to 14 days for a nurse to triage a sick call. Triage simply means they are initially seen by the nurse to decide next steps, it does not include necessary treatment or the added wait to see if a provider, if necessary. This untimely triaging of sick calls could result in serious harm to a patient. Detainees may be experiencing side effects from their prescribed psychotropic medication and if they have to wait days for their issue to be addressed, it is likely they will refuse to take the medication resulting in a deterioration of their mental health. If a detainee knows their sick call will not

be properly triaged, it is likely they will be noncompliant with treatment from the outset because they will not receive the attention they need. This results in untreated detainees who are unable to appropriately function in the detention environment. This results in more mentally ill detainees in disciplinary housing due to being unable to properly function in the detention environment due to symptoms of their mental illness and/or being victimized.

9. Use of isolative or restrictive measures to control the mentally ill population. Deprived of normal human interaction, many segregated prisoners suffer from mental health problems including anxiety, panic, insomnia, paranoia, aggression and depression. At ASGDC, the patients I spoke with reported spending countless weeks in segregated housing without mental health intervention. There is no formal system in place to consult with mental health clinicians prior to someone with a mental illness being placed in segregated housing. Placement in segregated housing is known to cause substantial harm to those with mental illness, especially when it is untreated. Deterioration and/or emergence of new symptoms are both possible outcomes when someone with a mental illness is placed in isolation. At a minimum, there should be formal input from mental health regarding the placement of someone they are providing services to prior to placement in disciplinary housing. Placing someone on restriction in their existing unit, which is currently done on single cell units, is just as deleterious as placing someone on a segregation unit and presents the same level of harm. As stated in #2, the three women I spoke with appeared to be separated from the typical interactions on X-ray due to management issues.

    a. I reviewed the case of [redacted] who was placed in a restraint chair after voicing suicidal ideation as there was no appropriate place to put him to be monitored. This is not a proper use of a restrictive measure for someone who is experiencing a crisis related to his mental illness. A restraint chair should never be used for management of someone who is in crisis related to self-harm.

We are discussing treatment in a correctional setting where safety is paramount. There will be some who, even with having a mental illness, will require segregation due to their heightened risk to self or others. While ideal to not be segregated, segregation cannot be completely avoided in this environment. It is paramount that individuals in segregated housing, especially those with mental health challenges, are provided with therapeutic programming. There is a need to provide adequate structured and unstructured out of cell therapeutic programming for this population. Out of cell unstructured programming can include time for shower, phone call to supports, visits with family and supports from the community, watching television or socializing with peers. Patients are currently receiving an hour a day of unstructured time out of cell which is inadequate to assist with recovery and progress in this population. An hour a day is tantamount to being in segregation which is known to have negative effects on individuals with mental illness. Therapeutic unstructured time affords opportunities to address social needs which helps with mood. There is currently no structured therapeutic programming out of cell, with the exception of the visit to the psychiatric provider every 90 days and the monthly check ins with the mental health staff, usually done cellside, which is not adequate treatment.

Structured out of cell programming can include groups therapy sessions like anger management and the importance of compliance with all forms of treatment, groups activity sessions like art therapy, music therapy (which helps reduce anxiety and depression) or

a recreational activity, individual psychotherapy which could be focused on how to live in the carceral environment or helping someone navigate the environment with symptoms of their mental illness, substance use groups focused on the importance of abstinence or education regarding mental illness and substances, education and psychoeducation groups. These are just examples of therapeutic activities but what is actually needed at ASGDC will depend on the population and a needs-based assessment. There should be ongoing assessments/surveys of the population to determine what is needed for therapeutic growth of patients at any given time.

Both unstructured and structured therapeutic interventions are necessary medical treatments for this population to help decrease the risk that behaviors related to their mental illness will put them at risk of violating the rules of the facility resulting in ongoing restrictions. Keeping this population mentally stimulated and learning about how to live with their mental illness in a carceral setting will help keep them out of trouble. DOJ is currently using the following guidelines for jails and prisons - 10 hours of structured and 10 hours of unstructured programming for incarcerated individuals, especially in segregation. Without adequate therapeutic interactions while in segregated housing, there is substantial risk of decompensation and worsening of mental health symptoms.

10. The deterioration of the environment in which an individual is confined can contribute to deterioration of mental health resulting in harm to the detainee and undermines the therapeutic milieu necessary to adequately treat the mentally ill.

    a. The unsafe conditions at ASGDC have contributed to an increase in mental health symptoms in individuals. I spoke with patients who reported increased paranoia due to inoperable locks on the unit. I spoke with patients who report having sleep difficulties for fear of their safety. Sleep deprivation is directly linked to deterioration of one's mental health. The inoperable locks mean detainees are able to come and go from their cells without appropriate supervision. A patient who has anxiety or paranoia as a part of their illness could be triggered by knowing other detainees could have access to their cell and person which could result in higher level of anxiety and paranoia. According to the deposition of Ms. Gilmore and direct observation, a majority of the cells on the units had inoperable locks. This not only made staff feel unsafe, but it would also make vulnerable detainees feel unsafe and unable to focus on recovery. The inoperable locks have reportedly led to increased inmate on inmate violence further destabilizing the environment and leaving the vulnerable at risk. The frequent occurrence of contraband, to include weapons and drugs, puts the stability of one's mental health at risk. This all contributes to feeling unsafe which can exacerbate the symptoms of one's mental illness.

    b. Medications can make one feel drowsy therefore a patient may refuse to take prescribed medication for fear of someone having access to take advantage of them. There is a substantial risk these conditions could cause further deterioration of one's mental health. The lack of safety also contributes to access to care issues when staff doesn't feel safe on the unit and therefore interactions with patients are limited. If detainees are out and about on the unit, staff may not feel safe being on

the unit to interact with patients and therefore will conduct sessions at the sally port or via microphone into cells, which is substandard care.

c. The lack of basic necessities at the jail can contribute to deterioration of mental illness. For example - lack of adequate drinking water for someone taking psychotropic medication is inhumane. Psychotropic medications are known to cause the sensation of dryness in many patients. Thirst, dry nasal passages and dry eyes are all symptoms of dehydration which can be attributed to many psychotropic medications. The lack of adequate water being provided for the detainees at ASGDC for taking medication and remaining hydrated throughout the day is dangerous.

   This lack of water can occur in a number of ways – a. there is no officer assigned to the unit to allow the detainees to leave their cells and get water or b. the water cooler is not filled with water on the unit or c. the sinks are inoperable in the cells or d. the officer assigned is not diligent in ensuring everyone on the unit has access to come out their cells throughout the day to get water. This breeds noncompliance which in turn increases the risk of untreated mental illness and behavioral issues throughout the facility. In the declaration of D011, she discussed the lack of adequate hydration on the housing unit, which should be a basic right for everyone in the facility.

d. Many psychotropic medications can cause difficulty with urination, constipation and nausea. These conditions can be embarrassing. Having to use a neighbor's toilet and/or struggling to use the bathroom can contribute to detainees being noncompliant with medicine. Not having constant access to a private or semi-private working toilet and sink can contribute to noncompliance and deterioration of one's mental illness. Medicine can be given for constipation and nausea which will increase the frequency of needing to use the bathroom. There are long stretches of time where an officer is not present on the unit therefore not having constant access to a working toilet can increase the risk of patients using what they have available to them for relief. They may relieve themselves in the sink, on the floor, in leftover food trays and even in inoperable toilets. I saw many toilets with resting fecal matter due to the toilet being inoperable and the detainee needing to use the bathroom. This contributes to poor overall mental health. In addition, many units only had one working shower to be shared by over 50 men. Fear of victimization and paranoia could contribute to someone with an inadequately treated mental illness avoiding the shower and not attending to hygiene making them a further target on the unit and contributing to harm.

e. In review of the declarations of D012 and D007, it was disturbing to know there is a lack of sanitary napkins and tampons for the female detainees. D012 reported going for days after intake in a soiled uniform due to a lack of access to a sanitary napkin. It is demoralizing to walk around in bloody clothes. Feminine hygiene products are a basic need which should be readily accessible and available for every detainee in need.

These unsanitary conditions make it difficult to ensure a therapeutic environment where treatment can be provided. Trash on the floors in the main living area, standing water throughout the facility, sleeping in a cell with the possibility of getting wet due to leakage from the ceiling when it rains, blocked toilets with fecal matter visible and insects/bugs in the shower area all contribute to poor inhumane, living conditions and negative effects on one's mental health. There is an overall lack of dignity and respect for individuals living in these conditions.

One area of grave concern was the practice of all the patients on the cart for each phase using the same inhaler for asthma or respiratory conditions without a spacer or disinfecting between uses. Many would use their balled fist to make space between the inhaler and their mouth. With a rise in respiratory infections, including the introduction of COVID, it is unsanitary and harmful to allow patients to use the same inhaler without proper infection control techniques.

In review of the 5 declarations in relation to the March 2024 suicide, the detainees spoke about the inhumane conditions they have experienced at ASGDC. These conditions include fecal matter in broken toilets, broken lighting, inoperable sinks. While all these complaints were observed during the site visit in January 2024, the declarations helped to reiterate the poor conditions experienced by the detainees at ASGDC.

11. It is imperative that necessary laboratory follow up for patients taking psychotropic medication is normal operating practice. Psychotropic medications are well known to cause metabolic dysregulation including impaired glucose levels, medication toxicity, liver injury, thyroid dysfunction, cardiovascular disease and lipid dysfunction. Laboratory collection is necessary to monitor for these side effects, many of which cannot be determined based solely on a physical examination. If a patient refuses, there needs to be adequate informed consent on record regarding the risks and benefits and explanation given to the patient regarding their choice. A number of detainees told me they had had no laboratory work done since being at ASGDC yet were on psychotropic medications. During chart reviews at ASGDC, there was insufficient time to review the system which houses laboratory results therefore the veracity of the patients' accounts could not be verified. Regardless of the patient's account, it is mandatory that laboratory work be included in the treatment for all individuals prescribed medications for a mental illness.
The following is a recommendation for monitoring parameters for most psychotropic medications prescribed for patients.

Table 2

Recommended monitoring for a patient taking an atypical antipsychotic

Parameter	Baseline	1 Mo	2 Mo	3 Mo	6 Mo	Annually
Body mass index[a]	X	X	X	X	X	X
Waist circumference	X	X	X	X	X	X
HbA_{1c}[b]	X			X		X
Fasting plasma glucose	X			X		X
Fasting lipid panel	X			X		X

[a]Encourage patients to monitor their weight in addition to being weighed at the clinic

[b]Unless patient develops diabetes mellitus, in which case American Diabetes Association guidelines for managing diabetes are recommended

Source: References 2,10

A recommended plan for monitoring a mood stabilizer:

BASIC PARAMETERS FOR ALL PATIENTS: History Medical history (including CVD risk factors), smoking status, alcohol intake, family history of CVD, pregnancy status, over-the-counter medications

Investigations - Waist circumference and/or BMI, blood pressure, CBC, electrolytes, BUN, creatinine, LFTs, fasting glucose, fasting lipid profile
LITHIUM: Baseline - TSH, ECG (for patients over age 40); Serum level At steady state, then every 3 to 6 months or as clinically indicated. Longitudinal monitoring - BUN/creatinine, TSH every 3 months initially, then every 6 to 12 months or when clinically indicated. Weight after 6 months, then annually.
VALPROIC ACID AND ITS DERIVATIVES: Baseline - Hematologic and hepatic history; Serum level at steady state, then as clinically indicated. Longitudinal monitoring - Weight, CBC, LFTs, and menstrual history every 3 months for the first year and then annually; blood pressure, bone densitometry, fasting glucose, lipid profile if there are risk factors.
CARBAMAZEPINE OR OXCARBAZEPINE: Baseline - Hematologic and hepatic history; Serum level 2 levels to establish dose (4 weeks apart to account for autoinduction), then as clinically indicated. Longitudinal monitoring CBC, LFTs, electrolytes, BUN/creatinine monthly for 3 months, then annually.

a. D013 was admitted in August 2023 and prescribed valproic acid. There is no indication on review of his medical records that laboratory work was ordered and collected. There was no notation that he refused collection of blood for lab work.

Medical records provided for my review contained no evidence of routine lab work to monitor the effects of psychotropic medications on ASGDC detainees.

12. Lack of a rigorous Continuous Quality Improvement (CQI) program. A CQI is an essential component to monitor and improve health care delivery in the facility. The limited relevant

data which is collected is insufficient to help improve the quality of behavioral health services available at ASGDC. The data that is collected does not constitute a functional, informed CQI program. Simply collecting statistics on how many people came to offered services is insufficient to inform a cohesive system of behavioral health services. There is no indication that timeliness is considered in this data or number of refusals and why. Ther is no data to help determine timeliness of interventions and follow up appointments. There should be clear data collected regarding access to care and whether this is a challenge at ASGDC, especially with security staffing deficits. ACH is unable to identify and implement strategies for improvement without collecting relevant information regarding the current system. The collected data looks like demographics of the population rather than statistics which can be analyzed and aggregated to inform the system of service delivery. This will then be used to inform changes and decisions regarding the behavioral health system. One startling point to be made is the lack of identifying medication variances, deviances from the expectations regarding medication administration, in the system which will improve administration of medications and safety. One of the benefits of a CQI program is the early identification and strategy development to address problems before they become worse. The following measures should be addressed to evaluate the programs provided by the health care professionals – accessibility, timeliness, effectiveness, safety, and appropriateness of clinical decisions.

C. Appropriate Correctional Mental Health Services

As a subject matter expert in the matter of behavioral health services in a correctional facility, I have had the opportunity to observe and provide feedback regarding this subject in numerous facilities. In other jail facilities, the essential components identified above are standard features.

At these jails, services provided include:

1. Therapeutic programming specifically tailored for mentally ill individuals in restrictive housing providing them daily contact with mental health in structured activities including group therapy and individual therapy. Group therapy includes art therapy, music therapy and tailored programs that run for a number of weeks covering various mental health topics. This helps alleviate the deleterious effects of isolation on someone who suffers with a mental illness.

2. Therapeutic programming on the mental health unit(s) throughout the day, so detainees are engaged in therapeutic exercises rather than being distracted by their symptoms or merely watching television. This also allows the clinical staff more observation time to help more vulnerable individuals who are struggling with functioning in the facility. This can include more targeted interventions for the population including anger management, medication education, psychoeducation regarding mental illness, art therapy, music therapy, and various groups based on the needs of the detainees.

3. Active treatment plans that can be identified and used by another clinician who may inherit the case. In an environment where a person is frequently moved, it is imperative that a treatment plan is in place so everyone who is or may become involved in the treatment is aware of what is being done.

4. Collection of data on measures that help provide timely treatment and allows for the production of corrective action plans to improve the delivery of services. This data can include comparing the schedule for interactions with when they actually occurred, looking at documentation to ensure accuracy and completion, various chart audits looking for ways to improve the delivery of service.

5. It all begins with adequate screening at intake to ensure all issues and concerns are identified and a plan is put in place for them to be addressed. A medical workup with appropriate laboratory draws are essential to prevent long term consequences of psychotropic medications. At the forefront of everyone's mind should be that mental health appointments target improving the patient's overall functioning in the jail setting with programming in place to make it a reality.

D. Conclusions

In review of over 20 medical records of ASGDC detainees in various ranges of acuity levels confined in housing units throughout the facility and 5 declarations, there are a number of disturbing trends which places anyone with a mental illness at a substantial risk of serious harm, which are even greater for those with serious mental illness. There is a lack of communication and continuity of care among the mental health clinicians. For a patient to have five different diagnoses documented in his record, for example, within a six-month period by various clinicians perpetuates a system of haphazard, siloed engagements without focus on patient-centered treatment and recovery. The lack of assigned acuity to patients without any material adjustment in treatment planning or service delivery means everyone is basically being treated the same regardless of their needs, which places the seriously impaired at great risk. The delay in starting psychotropic medication after admission to ASGDC places an individual at risk of decompensation which places them at risk of being placed in seclusion due to untreated mental health symptoms. The lack of formal suicide assessments and appropriate watch and unsanitary environment both increase the substantial risk of harm to detainees at ASGDC,

Overall, there is a fundamental lack of therapeutic care for mentally ill detainees at ASGDC. The lack of individualized treatment planning, the refusal to provide therapeutic programming services, and the presence of pervasive unsafe environmental conditions all contribute to detainees being in a milieu which is neither helpful to aid in recovery nor stabilizing. In fact, the total environment at the jail is more likely to increase rather than decrease the risk of harm to detainees with serious mental illness.

I have not encountered a system where there is such a dearth in comprehensive mental health delivery of services that poses the unmitigated, substantial risk of serious harm to which detainees at the Alvin S. Glenn Detention Center are exposed.

My work on this matter is ongoing. I reserve the right to make any additions, deletions, or other revisions to my statement in response to additional information I receive concerning the operations and services at ASGDC.

June 26, 2024
Date

Nicole R. Johnson, MD

Appendix I
Alvin S. Glenn Detention Center
Detainee
Identifier Codes

Detainee	Identifier Code	Records Bates Range
[redacted]	D001	County 179982-180061
	D002	County 183257-183241
	D003	County 169947-170048
	D004	County 169847-169893
	D005	County 183855-183976
	D006	County 180372-180418
	D007	PLF_000054-000062
	D008	County 40386-40440 County 68700-68983
	D009	County 191402-191422
	D010	County 170596-170777
	D011	PLF_000063-000067
	D012	PLF-000068-000073
	D013	County 169613-169648

EXHIBIT 7

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION

A.C., J.H. and H.M. on behalf of themselves and others similarly situated; Disability Rights South Carolina,	)	Case No.: 8:22-cv-1358-MGL-JKA
Plaintiffs,	)	
vs.	)	
Richland County,	)	
Defendant.	)	

DEPOSITION OF

JUDY LASSITER

****

Wednesday, January 3, 2024

9:00 a.m. - 3:45 p.m.

The deposition of JUDY LASSITER was taken before Mary H. Occhipinti, a notary public in and for the State of South Carolina, commencing on Wednesday, January 3, 2024, at the offices of Turner Padget Graham & Laney, PA, 1901 Main Street, Suite 1700, Columbia, South Carolina, pursuant to Notice of Deposition and/or agreement of counsel.

average?
A. Yeah, average.
Q. Give or take a few minutes either way?
A. Yeah.
Q. All right. And as you've said before, those sessions did not involve individual therapy, is that right?
A. Correct.
Q. And you've provided individual therapy as well in the past, right?
A. In other jobs?
Q. Yes, in other jobs.
A. Yes.
Q. And you know what that is as well?
A. Yes.
Q. And you don't do that at the jail?
A. No.
Q. And in the mental health unit which is, for the women, in X-ray, there are no groups, no therapy groups or other social or psychosocial groups?
A. No, there are no groups.
Q. And on the individuals that you do meet with in X-ray, let's stay focused there, where do you meet with them?

EXHIBIT 8

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION
C/A No.: 8:22-cv-1358-MGL-JDA

A.C., J.H. AND H.M. on behalf of themselves and others similarly situated; Disability Rights South Carolina,

Plaintiffs,

v.

Richland County,

Defendant.

DEPOSITION OF

PATTI GREEN

****

Monday, April 29, 2024

9:29 a.m. - 4:50 p.m.

The deposition of PATTI GREEN was taken before Kimberly C. Young, a notary public in and for the State of South Carolina, commencing on April 29, 2024, at the offices of Burnette Shutt McDaniel, 912 Lady Street, Columbia, South Carolina, pursuant to notice of deposition and/or agreement of counsel.

Because at the Public Defenders Office I could only help the public defender clients. So by becoming the discharge planner at the jail, I'd be able to help everybody, even people that had private attorneys. So I felt like it was a fantastic opportunity because I always wanted to be -- I always felt bad when the people at the jail that had private attorneys couldn't get the same services that I was offering the public defender clients. So I didn't -- I don't think it was a shift. It felt to me like it was just rolling over to the same thing.

Q. Okay. And what were your responsibilities when you took the position as the discharge planner? How were they explained to you?

A. Now, I was told I was going to do discharge planning the same -- because I had already had a working relationship with the site manager, I worked closely with her when I was with the Public Defenders Office, she told me I would be doing the same thing at the jail. You're going to come on, you're going to connect the clients to services, you're going to build reentry plans and you're going to focus on our mentally ill clients as well as the other clients.

have any understanding that your responsibilities would include a caseload beyond discharge planning?

A. No.

Q. Did you ultimately have responsibility for providing services to folks on the mental health caseload?

A. Day one.

Q. Okay.

A. Yeah.

Q. And so it was discharge planning plus?

A. When I got there, discharge planning --

MR. MITCHELL: Object to the form.

A. -- plus.

Q. Okay. And describe what those responsibilities were.

A. So I was assigned three dorms that I was responsible to see clients in, write progress notes on them. I mean a real caseload. I had never done that before, so I was -- well, for a social worker, it wasn't something I wouldn't have welcomed had I known it was going to happen because it also expands my experience. But it's not something I expected to do and had never done it before. But on day one, I was assigned dorms

Q. -- referred to is a list of whom? Individuals receiving mental health services?
A. Yes, who they're treating, currently treating, yes.
Q. Okay. And so there was a history of that and that was you were given access to that history and that would identify individuals by dorm who received mental health services --
A. Yes.
Q. -- is that correct?
A. That's correct.
MR. MITCHELL: Object to the form.
Q. Okay. Now, and so you understood from Ms. Saxon that it was your responsibility to see them; is that correct?
MR. MITCHELL: Object to the form.
A. That's correct.
Q. Did you know how often to see them?
A. Yes. You had to see them every 30 days.
Q. How did you know that?
A. That's what she said.
Q. Okay.
A. They had to be seen every 30 days.
Q. All right. Did she explain to you what you needed to do when you saw them every 30 days?

A. You have to meet with them, find out how they're doing in the dorms, find out how they're doing on their medicine. If they needed to see the provider, which you could find that in the system, then you could schedule them with the provider. A lot of times, though, what happened when you went in the dorm is you found people who weren't on the system, who weren't already there, so that always created another problem.

Q. Okay. But before we get to that, let's talk about what she, Ms. Saxon, told you to do once you saw these individuals. So you'd find out how they were doing, you'd find out how their meds were; is that correct?

A. Right.

Q. Anything else?

A. We always asked them if they were suicidal. She wanted to make sure they didn't need to go on watch.

Q. Uh-huh. Anything else?

A. That was pretty much it.

Q. All right.

A. Just a check-in.

Q. And did she give you any direction concerning the length of the time that she expected you to spend

with each individual?
A. No.
Q. Okay. Did you later determine that from conversations with the QMHPs?
A. Kind of.
MR. MITCHELL: Object to the form.
Q. And what did you learn?
A. I learned that it was more of a check-in than what -- because my way of doing social work is to sit down and have a conversation with the person but I was spending too much time with each person because I was having full conversations. And the other QMHPs told me, where I got the term check-in is that's how I'm supposed to be doing it, it's just -- you're just checking in to make sure everything's okay, meds managing, and if they need to see the provider, you schedule them with the provider.
Q. Had you ever performed therapy before?
A. No.
Q. Okay. Based on your training, what was your understanding of what therapy would consist of?
MR. MITCHELL: Object to the form.
Q. Do you have an understanding, through your training --

A. I don't --
Q. -- as a social worker?
A. I didn't -- I don't do therapy. I didn't do therapy.
Q. Okay. So you haven't been trained as a --
A. No.
Q. -- as a social worker to do therapy?
A. No.
Q. Were you -- did Ms. Saxon ask you to perform therapy?
A. No. Ms. Saxon told me we don't do therapy.
Q. Did she explain what she meant by that?
A. She said it's not the place for that; if you open wounds, you can't close them; we don't have time for that so we don't do therapy.
Q. Did you ever explain to her why you came to the jail and took the position in the first place?
A. Yes. She knows why. She knew.
Q. Why was that?
A. So that I could help the people at the jail, connect them to their services and try to help them stop coming back and forth to the jail, maybe provide some of the reentry structure that they needed. She knew that. That was my passion, that's what I was doing.

EXHIBIT 9

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 4:22-cv-01358-MGL-TER **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I am writing this letter to the courts about my experience here at ASGDC in hopes that the courts can help us. ASGDC is the third largest jail in South Carolina and the most dangerous I have ever been in. I've witnessed 10 stabbings in the 20 months I've been here and I myself have been robbed, threatened and assaulted several times on different occasions. There has been 11 officers fired here in the past 20 months for bringing in drugs and contraband. Most of the dorms have are run by gangs. Most all gang members here have cell phones and knifes. For my first year here the food was so bad and we were given very little to eat. We wasn't given the adequate amount of portions by law and the kitchen was so nasty that DHEC came in and shut the kitchen down. The food company working here for the jail to bring a trailer in and serve food out of it. Our food portions was so little it was like being in kindergarten again. One of the nurses here told me one time that this was the only jail that she ever worked at that instead of inmates gaining weight here they were losing weight. I was sent here from Kershaw County Jail because of my heart condition and am under the care of a cardiologist. When I first got here it took months for me to get my first follow-up appointment and the only reason I got that was

because I was passing out in the dorm because of my heart. I had an appointment in February and it was cancelled due to short of security and not sure when it would be rescheduled. I've been treated for bipolar disorder since I was 10 years old and have been on medication by mental health since then. When I first got here I was taken off my meds and told I couldn't take them unless it was approved by my cardiologist. I got my medications approved and it took me about eight months later to get back on them because I have been denied access to mental health. I've been lied to over and over that I would been seen and have never been seen until a week ago 3-7-2024 that I was seen early because they found out I would be testifying against them in federal court. I have only seen the counselor here twice. The whole time I have been here, I have no one to talk to. I am suffering from nightmares and can't sleep because of the things I have witnessed here at ASGDC. I have panic attacks and stress everyday that I'm going to get stabbed. I have been robbed for my canteen at knife point and extorted for money to keep me from being jumped on. I fear for my life everyday and pray that I make it through this. The living conditions here in Hotel Phase 3 are so bad that it is hard to describe. There is two of us here in cell 14 with no running water and our toilet doesn't work. There is no lights in this room and there is bare wires hanging from the ceiling. When we need to use the restroom we have to beat on the door until an officer comes to let us use a designated cell used for the restroom. We are locked down 23 hours a day and one hour to use the phone and get a shower. Some days they don't let us out at all. Most officers have their favorite picks who they let out. Most are all gang related. I'm an Caucasian white male in a predominantly all Black jail so we are chosen last on everything and sometimes completely left out. We get our food in our cells and some times we have been skipped at supper time. From our cell we can see no TV and our recreational yard has been closed due to being in so bad of shape. There is holes all in the roof of this dorm/hotel that when it rains outside if pours inside.

2. About two months ago I slipped in water on the floor and hurt my ribs. It was reported to medical and I was not seen for two days and only seen because I called my lawyer Ashley Pennington and told him I have been in the floor for two days and haven't been seen. My stay here at ASGDC I have been neglected by medical and mental health services. We also have no access to a law library here at ASGDC and have no way to prepare for our cases for the charges we are here for. There is puddles of water on the rock coming out of the closets from where the plumbing is leaking. Some of it is raw sewer and the inside is full of black mold. The shower drains do not drain and when you shower you have to stand in water that doesn't drain. There is also Black mold in the showers and the shower head sprays out very little water. There is black mold coming out of the air duct work. There is only one shower for the whole dorm. 56 rooms and two people to a room that is designated to hold only one person to a room. On several occasions, I have had to poop in a tray because the officer on duty wouldn't come let me out to use the restroom. I'm am being treated as an outcast here because of being White and I experience a lot of hate. If I say anything about what's going on at this jail, I have been told to bond out. It is not often that we get to cut our fingernails or hair. While in Phase 1, I was in Bravo dorm for a while and there was no officers in the dorm on first or second shift and time that we had to do dorm count. Most of the lights in the dorm don't have bulbs in them and the exit lights don't work. This jail is very short on security and there has been stabbings, murders, rapes. .

3. The air doesn't work in the room either.

4. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration. I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

4-23-2024
Date

[redacted]

(1)

My Name is [redacted] AND im writing this letter to the COURTS About my experience here AT ASG Detention center in hopes that the courts can help us. ASG is the Third largest Jail in S.C and the most Dangerest Ive ever been in. Ive witnessed 10 Stabbings in the 20 months Ive been here and I myself have been Robbed, threatened and Assaulted several times on different occasions. There has been 11 officers Fired here in the 20 months Ive been here For bringing in drugs and contraband. Most of the claims here are Run by Gangs and Most of the officers here are Gang Affeleated. Most all Gang members here have cell phones and knifes. For my First year here the Food was so bad and we was gave very little to eat. We wasen't given the Addiquite Amount of portions by law and the Kitchen was so nasty that DHEC came in and Shut the Kitchen down. The Food Company working here For the Jail had to bring a trailer in and serve Food out of it so our Food portions was so little it was like being in →

(2)

Kindergarden again. At night we got A brown bag with 2 Baloney Sandwiches, 1 Apple, 2 Cookies, And A Few chips in A bag. One of the Nurses here told me one time that this was the only Jail the she ever worked At that instead of inmates ~~losing~~ gaining weight here they lose weight. I was sent here From Kershaw County Jail because of my heart Condiction And am under the care of A Cardiologest. When I First got here it took Months For me to get my First Follow up Appointment And the only reason I got that was because I was passing out in the dorm because of my heart. I had An appointment in Feburary and it was counseled due to short of security And not sure when It will be Rescheduled. Ive been treated For Bipolor disorder since I was 10 years old And have been on medication by Mental Health since then. When I First got here I was taken off of my meds And told I couldn't take them unless It was Approved by my Cardiologest. I ~~Dont~~ got My Medications Approved And It took me About eight Months later To get back on them because Ive been Denied Access to Mental Health. Ive been lied to over And over that I would be seen And have never been

(3)

seen until a week ago 3-7-2024 that I was seen only because they found out I would be testifing against them in Federal court. ~~Barely do~~ Ive only seen the counselor here twice the whole time Ive been here so I have no one to talk to. Im suffering from night mares and ~~can't~~ cant sleep because of the things Ive witnessed here at ASC. I have panic attacks and stress everyday that Im going to get stabbed. Ive been robbed for my canteen at knife point and extorted for money to keep me from being jumped on. I fear for my life everyday and pray that I make it through this. The living condictions here in Hotel ~~Five~~ 3 are so ~~bad~~ bad that it is hard to describe. There is two of us here is cell 14 with no running water and our tolit doesn't work. There is no lights in this room and there is bare wires hanging from the ceiling. When we need to use the restroom we have to beat on the door until and officer comes to let us use a desegnated cell used for the restroom. We are locked down 23 hours ~~a~~ a day and one hour to use the phone and get a shower. Some days they dont let us out at all. Most officers have there favored picks who they →

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is Full of Black mold. The shower drains do not drain And when you shower you have to stand in water that doesn't drain. There is also BLACK mold in the showers And the shower head sprayes out very little water. The is Black mold coming out of the AiR duck work. There is only one shower FOR The whole Dorm, 56 Rooms and two people to A Room. that is designed to hold only one person to A Room. On several ACCASIONS Ive had to deffacate in A ~~STIRAFOAM~~ STIRAFOAM TRAY because the officer on Duty wouldn't come let me out to use the ~~RESROOM~~. Im An treated AS AN out CAST here because of being white And I experance A lot of hate. If I say Anything About whats going on At this JAil Ive been told to bond out. It is not often that we get to cut our Finger ~~NAILS~~ OR hAiR. I FASE I I WAS IN BRAVO dorm FOR A while ANd there WAS NO officers in the Dorm First OR SECOnd Shift And time that we had to do dorm count. Most of the Lights in the dorm dont have Bulbs in them And the EXIT Lights dont WORK. This JAil is very short on Security And the has been Stabbings, Muders, RAPes, misconduct in office EXTORTION, officers stabbed And officers trying to bribe inmates FOR SEX →

EXHIBIT 10

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 4:22-cv-01358-MGL-TER **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been locked up since May 1, 2023. Since being locked up, I have been robbed twice and have been once by multiple guys with a broom stick. The first time I was robbed and beaten was June 13. I was beaten by four guys with a broom stick as I got out the shower in Hotel unit. I then told the officer. I wanted to leave the dorm and be put in another dorm. The officer said I should just fight the guys and just stay in the dorm. But, I refused and asked to be moved. The officers never asked if I wanted to do anything about the situation so I told them I wanted to press charges on the guys who assaulted me. The officer wouldn't have cared what have happened if I didn't push the issue. I then gave a video statement and pointed out the guys who assaulted me. When arriving in my new dorm which was Indie, I was then approached by two guys with knives saying I had to leave the dorm and give up everything I owned or I would be stabbed for telling on the guys who assaulted me. They got word of what happened in Hotel unit by a cell phone call from another inmate. I felt like the jail put my life in danger and weren't able to protect me. I was then transferred to unit Juliet. I was put in a room with a toilet that didn't work and was full of feces and urine. While in Hotel and Juliet, any time it rained my room would

flood out. The toilet always leaked in unit Juliet as well. In Hotel unit a quarter of the ceiling tiles were missing and when it rained outside it literally rained in the inside of the dorm because of the holes in the ceiling. There were also leaks in the unit Juliet but not as bad as Hotel. I was moved from Juliet to Lima dorm, for maintenance reasons. I have been in Lima dorm since Feb 14, 2024. I was put in a pod where the sink didn't work and the shower water pressure was so low it made it hard to take a shower. I was robbed by knife point by three guys while I was sleeping. After being robbed, I told the officer I wanted to be moved. She then called the Sgt. on duty. She said the Sgt. said she wasn't coming down and that I should go back to sleep. I stayed at the door with my stuff packed for about three hours until the Sgt. finally came. I had to beg to be moved because they were going to leave me in the pod. I told her I was robbed by knife point and she did move me to another pod. Someone was supposed to come in the morning shift change because it was 4 a.m. in the morning. The same day I asked all day to speak with Sgt. or a Lt., but no one followed up on what happened. I wanted to press charges and point out the guys who robbed me but nothing happened. I was robbed the second time on March 11, 2024.

2. I'm not sure what meds I'm on. I am diagnosed with PTSD, anxiety, and major depression, severe with psychotic features. The meds are not working. Every time I talk to the doctor, she just up my dosage and give me another pill to try to help with sleep. My side effects to the medicine are weight change. My weight keeps going up and down. I get meds pretty regularly. Its only been three times I haven't received my meds.

3. I have been locked up ten and a half months and I have seen mental health 5 times for about two minutes each time. All she asks is how I feel and do I feel like hurting myself or anyone else. I went to lock up once for one day because I refused to go in a room with no toilet when I was getting classified to my first dorm. When I first got locked up, the locks did not work in lock up. Everyone had knives and moved around freely. It was multiple fights. In lock up I had a toilet that worked but no sink that worked. While in Hotel, Juliet, and Indie, units locks didn't work. That's why I was robbed. They were able to come in my room in front of the officers. While

in Juliet, I would have to go to the restroom by making a number 2 in a Styrofoam container and urinating in the sink. Sometimes we would get no recreation for 5 to 6 days at a time. I would have Styrofoam containers full of feces in my room for days. While in Juliet and Hotel unit, some time I couldn't get a shower for 5 to 6 days. Sometimes they don't have soap and tissue for us. I have gone a month without a clean uniform a few times. They only washed my blanket only 3 times in the last ten and a half months. Some time I may turn in my sheet and towel and wash cloth to get washed and they never give it back. So, I'll have to beg the officers for weeks to get my linen, towel, and washcloth back so I can wash properly. While in Juliet, we only get REC for only 30 minutes every two days and some time we didn't come out for 5 or 6 days. Had enough water to drink but not enough food to eat. I lost 50 pounds my first 4 months. They were feeding us like 5 year old kids. An officer and an inmate brought our food to us. While in Lima dorm, I was told I had to give up my lunch and [redacted] to stay in the pod. In Juliet the lights were out and hanging from the ceilings with wire out. There were also wires coming from the wall where the contact box was. In Juliet and Hotel some time we had no officer at night or during the day. When they were there, all they did was sleep. There were all types of contraband from weapons, drugs and cell phones. The officers were the ones bringing in the contraband.

4. The officers seen drugs, cell phones, weapons, and people getting beaten up. And they done nothing. I have been threatened, beaten, robbed and almost stabbed. I am afraid for my life at all times. I told the officers about everything I have been through and nothing has been done about it. I've wrote many grievances with no response or follow-up. This experience has been one of the worse experiences I have ever been through. My mental state is really bad. Someone has to come in and fix this place before more people lose their life.

5. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration. I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

4-23-2024
Date

[redacted]

I have been locked up since May 1 2023. Since being locked up I have been Robbed Twice and have been once by Multiple guys with a broom stick. The first time I was robbed and beaten was June 13. I was beaten by four guys with a broom stick as I got out the Shower in Hotel Unit. I then told the officer I wanted to leave the dorm and be put in another dorm. The officer said I should just fight the guys and Just stay in the dorm. But I refused and asked to be move. The officers never asked if I wanted to do anything about the situation. So I told them I wanted to press Charges on the guys who assaulted me. The officer wouldn't have cared What have happened If I didn't push the Issue, I then gave a video Statement and pointed out the guys who assaulted me. When arriving in my new dorm which was Indie. I was then approached by two guys with knives saying I had to leave the dorm and give up everything I owned or I would be stabbed for telling on the guys who assaulted me. They got word of what happened in Hotel Unit by a cell phone call from another inmate. I felt like the put my life in danger and weren't able to protect me. I was then transfered to Unit Juliet. I was put in a room with a toilet that didn't work and was full of Feses and Urine. While in Hotel and Juliet any time it rained my room would flood out. The toilet always leaked in Unit Juliet aswell. In Hotel Unit a quarter of the ceiling tiles where missing and When rained outside it literally rained in the Inside of the Dorm because of the holes in the ceiling. There were also leaks in Unit Juliet but not as bad as Hotel. I was moved from Juliet to Lima Dorm, for maintence reasons. I've in Lima dorm since Feb 14 2024. I was put in a pod where the sink didn't work and the shower water pressure was so low it made it hard to take a shower. I was robbed by Knife point by three guys while I was sleeping. After being robbed I told the officer I wanted to be moved. She then called the Sgt. on duty. She said the Sgt Said she wasn't coming down and that I should go back to sleep. I stayed at the door with my stuff packed for about three hours until the Sgt final came. I had to begged to be moved because they Where going to leave me in the Pod. I told her I was robbed by Knife point and She did was move to another Pod. Someone was supposed to come in the morning come shift change because it was 4 am in the morning. The same day I asked all day to speak with Sgt or a Lt, but know ever followed up on what happened. I wanted to press charges and point out the guys who robbed me but nothing happened. I was robbed that second time March 11, 2024. Im not Sure what meds I m on. I am diagnosed with PTSD, Anxiety, and major depression Severe with physcotic features. The Meds are not working. everytime I talk to the doctor she just up my doseage and gave another pill try to help with sleep. My side effects to the medicine are weight change. My weight Keeps going up and down. I get meds pretty regularly. It's on been three times I haven't received my meds.

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EXHIBIT 11

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-MB **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. Hello, my name is [redacted], I have been inmate at Alvin S. Glenn since December 3, 2023. The conditions that we are living in are inhumane and others very hazardous. I see favoritism with CO with other inmates. I have witnessed death twice. The lack of organization of this detention center has caused health, mental and physical damage to us living here currently. After 2 days of being here I started a timeline and wrote down every major error I could keep track of.

2. I started being housed on Delta Unit, December 6, 2023 was the first major incident I experienced at ASGDC. Another inmate was found unconscious laying on another bunk. Inmates ran to officer station yelling code blue while another inmate performed CPR and others grabbed cooler for ice. During this time 5-6 officers stood around watching inmates save a life, not 1 attempted CPR. 1 officer had Narcan he administered it after us working on her for 10-15 minutes. After the total of 30-35 minutes EMS showed and took her. After this terrible incident I started keeping track.

3. I was in Delta from December 5-13th, 2023 Delta is open dorms that housed about 35-40 female inmates. During this time no working lights in either bathrooms, including the showers. Several male inmates climbed through our ceiling which could of raped or harmed us. We went days without toilet paper and was told there wasn't any. Providing 1 water cooler, there was several times I was able to get 1 cup per day. December 13, 2023 at 3:30 p.m. I still had not received lunch. I attempted to escape the detention center on December 13, 2023.

4. After being recaptured, December 13, 2023, my new housing unit was X-Ray. They put me in room X-Ray 34. The conditions of cell was horrible. They kept me in cell for 6 days, no running water in sink and toilet did not flush. I asked for grievances and to be moved. Never received a grievance it took for officer from Richland County Sheriff Department request my move to new cell and that didn't happen to next day.

5. X-Ray is a behind the door unit, not 1 cell had working lights. Water puddles laid on floor due to all the bad toilets and sinks from our cells. There has been several days no water is available for us. I had put in several sick calls for lower back pain. It took for my mother to call for them to pull me. They attempted to draw blood for testing of kidneys both attempts failed due to dehydration this was in January. They never tired again. They sent me back to give urine sample in cup was instructed to give to CO. Urine sample was thrown out. Sat for days never gave to nurse. We would go days of being locked down without any rec time. We would go hours in between meals without a CO event on unit. In Delta a CO was only present during med pass. During my stay here I have went 3 times without being fed. We would eat dinner in the dark due to no lights. We would put stuff under our doors to keep rats out of cells.

6. February 22, 2024, the women in X-ray moved to Juliet which I am currently being housed in a cell that water leaks from toilet and again no working lights. They struggle to keep water on the unit and we have days no rec is given. On March 2, 2024 another terrible incident took place that could have been avoided or helped. Inmate [redacted] committed suicide in cell next to me. I am in X-36, she was in X-37. That day CO Dukes came on unit we was locked

down. Inmate [redacted] asked if she was mental health. She was told no. CO served us dinner locked down she left. I hard [redacted] on tablet talking. Then it became silent until I heard light fixture sound of falling. Didn't know at time that was noise I was hearing. This day after CO fed us no other CO came on what time that was noise I was hearing. This day after CO fed us no other CO came on until almost 11 p.m. for med pass. Nobody checked on us and due to there lack of staff and again conditions because light fixtures are exposed with wire hanging etc. has resulted in the death of a 22 year old girl.

7. I have re-wrote my timeline to provide you a copy of a more day to day troubles of my current stay at Allen S. Glenn that are below.

8. December 3, 2023 – Came to Alvin S. Glenn on an unknown warrant for FLA.

9. December 5, 2023 – Heard noises in ceiling and was told male inmates travel through our dorm ceiling to get outside.

10. December 5 – 10th – Asked for grievances from several different officers; no one ever brought me any back. Was worried with male inmates traveling through ceiling after being raped by someone who was then an inmate (before we were incarcerated).

11. December 6, 2023 – Inmate [redacted] was found O.D. Code Blue was yelled. There happened to be guard on unit at time. Not 1 CO attempted any CPR on her. CO had Narcan who waited 10-15 minutes to use it. Inmates performed CPR for 30-40 minutes before any EMS came and took her to hospital. The only time a guard was on Delta was during med pass, other than that inmates was alone in open dorm.

12. December 11 and 12, 2023 – Several male inmates have been traveling through ceiling.

13. December 13, 2023 – I asked officer for grievances, water cooler, and toilet paper at 3:30 p.m. before deciding to try and leave. I did not get a grievance form. No toilet paper or water was brought to unit.

14. December 13, 2023 – After being recaptured, no dinner was given. I was moved to Unit X-Ray for 15 day lock-up. X-Ray 34 toliet did not flush. I was told to be there just for the night.

15. December 14, 2023 – Never served me breakfast; gave me double lunch tray; but no dinner.

16. December 15, 2023 – Turned on sink, it flooded. Told CO sink was about to overflow. She asked my name and said welcome to X-Ray. Asked for grievance. None was ever brought. Never moved me or allowed to clean cell for 2 days water on floor. I was in X-Ray 34 without a flushing toilet or running sink water for 5 days before moving me to X-Ray 20.

17. December 13-16th – Every time I asked for water, I was told they had no cup for me. After a full 2 days, an inmate put water in a baggie for me to drink out of. And after a day or two inmates found me a cup to use.

18. December 17, 2023 – Went to bond court. Went back to booking with other women. Officer Gray made several flirtatious remarks to us in kitchen. Got us 2 trays and 2 juices a piece. He told me to look him up after I made bail that he would like to do some things to me.

19. December 17, 2023 – Ask for grievances again request denied.

20. December 18, 2023 – Started period asked for underwear due to they took mine and never provided me with any. Was told they didn't have any pads only tampons and no underwear. I bled through 2 uniforms. Asked for grievances CO had none.

21. December 21, 2023 – Write a request about money all missing from account as well as it saying bad pin. Trying to order hygiene.

22. December 22, 2023 – Asked CO for grievance and to check about my pin. She had no grievances and said no response about my bad pin.

23. December 22, 2023 – Lawyer came to see me. He was very nice!

24. December 22, 2023 – First time eating a tray, food is gross.

25. December 23, 2023 – Moved into cell X-Ray 28, Cell flooded upstairs.

26. December 24, 2023 – Locked down all day. No hour out!

27. December 25, 2023 – Put another request in about money missing in account and bad pin.

28. December 27, 2023 – Received new pin still doesn't work/was to get out of 15 day lock up at 18:00, was told I am on administrative hold. Showed officer my paper CO Jefferson. Delta Unit – No officer ever there except med pass!!!

- X-Ray unit first 6 days was only out 2 times. No cell has any lights inside wires hanging out from most light fixtures in cells.
- She said she would show it to Lt. Pickney. When Jefferson returned to unit without paper in hand, I asked for it in return. She never brought it back.

29. December 28, 2023 – Asked Jefferson for paper with sanction on it. She said Lt. Pinkney has yet to give it back to her. I am still on 23- hour lockdown.

- C/O asked grievance form from – Lt. Holmes; CO – pregnant one? Johnson; Corpal Davis – when he shut water off. Told him about missed meals, etc.; CO Jeffersons; CO Hayden; Hardwell.

30. December 31, 2023 – Put in another request for pin - $ on account. Also, put request into classification about still being on lockdown after my 15 days. We did not get fed lunch until 4:15 p.m. No CO came on unit since breakfast that was served at 7:30 a.m. No water was given, not even our 1 hour out was given. They gave us a bag lunch and dinner tray at same time since lunch was forgotten.

31. January 1, 2024 – Nobody came out for recreation time. Forgot our dinner. We finally got dinner after 7:00 p.m.

32. January 2, 2024 – Was told by Lt. Williams I'm off pre-hearing lockdown after I was out for 20 minutes was told to go back to cell. Turned in sick call about hep. B.

33. January 3, 2024 – No recreation given; laundry day never happened; short on CO. Inmate worker came back to our unit X-Ray stated she had tried to get a CO to come feed us our

dinner. It had been sitting in Sally Port for a hour already. The CO stated she will get to us when she gets to us. It took another hour and 10 minutes for CO to come. Our dinner sat in Sally Port for over 2 hours. It was cold and due to no lights in cells, we eat in dark. Dinner was served at 8:06 p.m.

34. January 4, 2024 – Got 2 hours out/dinner at 5:00 p.m.

35. January 5, 2024 – No recreation time (no staff) heard there was another attempt escape during the night!

36. January 6, 2024 – 2 hours out/no water unit after 5.

37. January 7, 2024 – No recreation/no water till dinner.

38. January 8, 2024 – CO Mitchell refused my recreation due to my celly.

39. January 10, 2024 – Nurse came to get me. I lost 13 lbs since I been here. I'm 181.0 lbs. came in at 193.6. Also could not draw blood to dehydrated, supposed to try again Sunday.

40. January 11, 2024 – Must have no staff. Breakfast wasn't served until 8:30 a.m. hour 3 ½ late. No recreation.

41. January 14, 2024 – Breakfast came at 9:15 a.m. due to no CO to feed us. No recreation.

42. January 16, 2024 – Still no blood was drawn from nurse. Was informed by [redacted] that my urine sample sat for two days on CO desk. They threw it away!! Mother called. No return call to her.

43. January 17, 2024 – Nurses came. Took another urine sample. They tried to draw blood for cultures. Still to dehydrated.

44. January 19, 2024 – No recreation/nurse gave me bottle of water at 11:25 p.m.

45. January 20, 2024 – No recreation/Sgt. Pinckney took bottle of water. Said it was contraband.

46. January 21, 2024 – We had 30 minutes of recreation time. Breakfast at 8:10 a.m. Lunch at 11 and dinner at 3:45 p.m. Sgt. Pinckney.

47. January 22, 2024 – P.M. there was several lawyers that came on unit looking inside unit and cells. Moved to X-15.

48. January 23, 2024 – AM – the same people returned expecting cells and was watching med pass. My celly [redacted] takes meds. She asked for water and Sgt. Holmes told her just act for the white people.

49. January 24, 2024 – 30 minute recreation.

50. January 25, 2024 – No recreation/water given once.

51. January 26, 2024 – No recreation.

52. January 27, 2024 – 30 minutes of recreation. Breakfast at 9:16 a.m. CO Mitchell did not give water with lunch; refused it to everyone who asked.

53. January 28, 2024 – No recreation/Sgt. Holmes gave water at dinner. Inmates asked for pads and tampons. Told we didn't have any left handed out what was left already.

54. January 31, 2024 – No nurse still has tried to draw blood again!

55. February 1, 2024 – No recreation.

56. February 2, 2024 – No recreation.

57. February 3, 2024 – 2 hours out recreation/no laundry done.

58. February 4, 2024 – 2 hours recreation.

59. February 5, 2024 – No recreation.

60. February 6, 2024 – No recreation/CO left at 1:00 p.m. No CO came back until dinner which was served at 6:15 p.m.

61. February 8, 2024 – No recreation.

62. February 9, 2024 – No recreation.

63. February 10, 2024 – 1 hour recreation; no water; moved to X-Ray 36 which was a room with black spots on walls and ceiling due to fire.

64. February 11, 2024 – No recreation – water served during dinner.

65. February 17 – No recreation.

66. February 22, 2024 – No recreation; had preliminary; moved to Juliet (J-36) toilet leaks from bottom to flush, and its completely removed from wall. No lights in cell.

67. Attached hereto is my own hand-written statement that is the same in all material respects as this Declaration.

6-11-2024
Date

[redacted]

Mr. Stuart 3-12-24

Hello, my name is [redacted] I have been inmate at Alvin S. Glenn since December 3, 2023. The conditions that we are living in our inhumane and others very hazardous. I see favoritism with c/o's with other inmates. I have witnessed death twice. The lack of organization of this detention Center has caused health, mental and physical damage to us living here currently. After 2 days of being here I started a timeline and wrote down ever major error I could keep track of.

I started being housed on Delta unit, December 6. 2023 was the first major incident I expierenced at ASGDC. Another inmate was found unconcious laying on another bunk. Inmates ran to officer station yelling code blue while another inmate performed CPR and others grabbed cooler for ice. During this time 5-6 officers stood around watching inmates save a life not 1 attempted CPR. 1 officer had narcan he administraded it after us working on her for 10-15 mins, after the total of 30-35 mins EMS showed and took her. After this terrible incident I started keeping track.

I was in Delta from December 5-13th, 2023. Delta is open dorm that housed about 35-40 female inmates. During this time no working lights in either bathrooms, including the showers. Several male inmates climbed through our ceiling which could of raped or harmed us. We went days without toliet paper was told there wosn't any. Roviding 1 water cooler there was several times I was able to get 1 cup per day. December 13 at 3:30pm I still had not recieved lunch. I attempted to escape the detension center on December 13, 2023.

After being recaptured December 13, 2023 my new housing unit was X-ray. They put me in room X-ray 34 the conditions of cell was horrible. They kept me in cell for 6 days, no running water in sink & toliet did not

3.12.24

flush. I asked for grievices and to be moved. Never recieved a grievience and it took for officer from Richland Co Sheriff Dept request my move to new cell, and that didnt happen to next day.

X-ray is a behind the door unit, not 1 cell had working lights. Water puddles layed on floor due all the bad toliets and sinks from our cells. There has been several days no water is available for us. I had put in several sick calls for lower back pain. It took for my mother to call for them to pull me. They attempted to drawblood for testing of Kidneys both attemps failed due to dehydration this was in Janduary, they never tried again. They sent me back to give urine sample in cup was instructed to give to clo. Urine Sample was throw out, sat for days never gave to nurse. We would go days of being locked down without any rec time. We would go hours in between meals without a c/o even on unit. Delta a c/o was only present during med pass. During my stay here I have went 3 times without being fed. We would eat dinner in the dark due to no lights. We would stuff under our doors to keep rats out of cells.

Febraury 22, 24, X-ray moved to Juliet which I am currently being housed in a cell that water leaks from toliet and again no working lights. They struggle to keep water on unit and we have days no rec is given. On march 2, 2024 another terrible incident took place that could of been avoided or helped. Inmate [redacted] committed sucide in cell next to me. Iam in X-36, she was in X-37. That day c/o dukes came on unit we was locked down inmate [redacted] asked if she was mental Health she was told No. c/o served us dinner locked down and she left. I heard [redacted] on tablet talking, then in became silient until

3-12-24

I heard light fixture sound of falling. Didn't Know at time that was noise I was hearing. This day after c/o fed us no other c/o come on unit until almost 11pm for med pass. Nobody checked on us and due to there lack of staff and again conditions because light fixtures are exposed w/ wire hanging etc. has resulted in the death of a 22 year old girl.

I have re-wrote my timeline to provide you a copy of a more day to day troubles of my current stay at Allen S. Glenn. If you have any questions or like to speak to me I have no issues with doing so.

Thank You,

[redacted]

December 3, 2023 - Came to Alvin S Glenn on a unknown warrent for FLA. [redacted]

December 5, 2023 - heard noises in ceiling was told male inmates travel through our dorm ceiling to get outside. [redacted]

Dec 5 - 10th - Asked for grievences from several different officers no one ever brought me any back. Was worried w/ male inmates trawling through ceiling of being raped by inmate.

December 6? 2023 - Inmate [redacted] was found O.D. Code Blue was [redacted] yelled there happened to be guard on unit @ time. Not 1 C/O attempted any CPR on her out of Several C/O I had narcan who waited 10-15 mins to use it. Inmates performed CPR for 30-40 mins before any EMS came & took her to hospital

The Only time a guard was on Delta was during med pass, other then that inmates was alone in open dorm.

December 11 & 12, 2023 - Several male inmates have been trawling through ceiling.

December 13, 2023 - Am I asked officer for grievences, water Cooler, and toliet paper @ 3:30 before deciding to try and leave no toliet paper or water was brought to unit.

December 13, 2023 after being recaptured no dinner was given I was moved to unit X-Ray for 15 day lock up. X-Ray 34 toliet did not flush I was told to be there Just for the night.

December 14th 2023 - Never Served me breakfast, gave me double lunch tray, but no dinner.

December 15th 2023 - turned on sink it flooded told C/O sink was about to overflow she asked my name & said Welcome to X-Ray. Never moved me or allowed to clean cell for 2 days water on floor. I was in Xray 34 without a flushing toliet or running sink water for 5 days before moving me to X-ray 20. Asked for grievence noone ever brought it.

December 13-16th - Everytime I asked for water I was told they had no cup for me. After a full 2 days a inmate put water in a baggie for me to drink out of. And after a day or 2 inmates found me a cup to use.

December 17, 2023 - Went to bond Court, went back to booking officer Gray made several flirtatious remarks to us to Kitchen got us 2 trays & 2 juices apieces. Told one to look him up after I made bail that he would like to do some things to me.

December 17 2023 - Ask for grievces again request denied.
December 18, 2023 - started Period asked for underwear due to they took mine & never provided me w/ any. Was told they didn't have any pads only tampons & no underwear. I bleed through 2 uniforms. Asked for gievences c/o had none.
December 21, 2023 - Wrote a request about money all missing from account as well as it saying bad pin. Trying to order hygiene.
December 22 2023 - Asked c/o for grience and to check about my pin she had no grievces & said no response about my bad pin.
December 22, 2023 - Lawyer came to see me. He was very nice!
December 22, 2023 - first time eating a tray food is Gross!
December 23, 2023 - moved into cell X-ray 28, cell flooded upstairs
December 24, 2023 - Locked down all day No hour Out!
December 25, 2023 - Put another request in about money missing in account & Bad Pin
December 27, 2023 - Recieved new pin still doesn't work / Was to get out of 15 day lock up @ 18:00, was told I'm on Admin hold showed officer my paper c/o Jeffe Della Unit - No officer ever was there except med pass!!!
she said she would show it to Lt Pickney. When Jefferson returned to unit w/o pape X-Ray Unit - first 6 days was only out 2 times. No Cell has any lights inside wires hanging out from most light fixtures in cell.
in hand I asked for it in return. She never brought it back
December 28, 2023 - Asked Jefferson for paper w/ Sanction on it she said Lt Pickne has yet to give it back to her. I am still on 23 hr lock down
- C/O Asked Grience form from -

Lt: Holmes
C/O: Pregnant One? Johnson
Corpal Davis when he shut water off. Told him about missed meals etc..
C/O - Jeffersons
C/O - Hayden
Hardwell

12-31-23 put in another request for Rec on account. Also put request into classifaction about still being on lockdown after my 15 days. We did not get fed lunch until 1415 pm no c/o came on unit since breakfast that was served @ 730 am. No water was given, not even our 1 hour but was given. They gave us a bag lunch @ dinner tray @ same time since lunch was forgotten.

1-1-24 - Nobody came out for Rec time. Forgot our dinner we finally got dinner after 7 pm

1-2-24 - was told by Lt Williams I'm off pre-hearing lockdown after I was out for 20 mins was told to go back to cell. Turned in Sick Call about H+B

1-3-24 - No Rec given / Laundry day never happened Shot on c/o. Inmate worker came back to our unit x-Ray stated she had tried to get a c/o to come feed us our dinner it had been sitting in Sally Port for a hour already, they (c/o) stated she will get to us when she gets to us. It took another hour ? 10 mins for c/o to come. Our dinner sat in Sally Port for over 2 hours it was cold ? due to no lights in cells we eat in dark. Dinner was served @ 8:00 pm

1-4-24 - Got 2 hours out / dinner @ 5 pm

1-5-24 - No Rec time (no staff) heard there was another attempt escape during the night!

1-6-24 - 2 Hours out / No water until after 5

1-7-24 - No Rec / No water till dinner

1-8-24 - C/O Mitchell refused my rec due to my cell#

1-10-24 - Nurse came to get me I lost 13lbs since I been here I'm 181.0 lbs came in 193.6. Also could not draw blood to dehydrated, suppossed to try again Sunday.

1-11-24 - Must have no staff breakfast wasn't served until 8:30 Am hour 3 1/2 late. No Rec

1-12-24 - No Rec

1-14-24 - Breakfast came @ 915 due to no c/o to feed us. No Rec

1-16-24 - Still no blood was drawn from Nurse, Was informed by Taylor Washington that my urine sample sat for 2 days on c/o desk they threw it away. Mother called no returned call to her.

1-17-24 - Nurses came took another urine sample they tried to draw blood for cultures still to dehydrated.

1-19-24 - NO REC / Nurse gave me bottle of water @ 11:25 pm

1-20-24 - NO REC / Sgt Pickney took bottle of water said it's Contraband

1-

[redacted]

	1-21-2024- We had 30 mins of rec time. Breakfast @ 8:10 Lunch @ 11 dinner @ 3:45 Sgt Pickney
1-22-24	P.M. there was several lawyers that came on unit looking inside unit & cells. moved to X-15
1-23-24	AM the same people returned inspecting cells and was watching med pass. My Celly Jaqualine Kirpatrick takes meds she asked for water & Sgt holmes told her just act for the white people. 1-24-24 30 min Rec
1-25-24	No Rec / water given once
1-26-24	No Rec
1-27-24	30 mins of Rec, Breakfast @ 9:16 am. C/O Mitchell did not give water w/ lunch & refused it to everyone who asked.
1-28-24	No Rec / Sgt Holmes gave water @ dinner, Inmates asked for pads & Tp was told we didn't have any left handed out what was left already.
1-31-24	No nurse still has tried to draw blood again!
2-1-24	No Rec
2-2-24	No Rec
2-3-24	2 Hours out Rec / No laundry done
2-4-24	2 Hour Rec
25-24	No Rec
2-6-24	No Rec / C/O left @ 1pm no C/O came back until dinner which was served @ 6:15 pm
2-8-24	No Rec
2-9-24	No Rec

[redacted]

2-10 - 1 hr Rec - No water - moved to X-ray 36 which was a room w/ black soot on walls & ceiling due to fire.
2-11 - No Rec - water served during dinner
2-17 - No Rec.
2-22 - No Rec - had Prelim - moved to Joliet (J-36) toilet leaks from button to flush, and it's completly removed from wall. No light in cell.

EXHIBIT 12

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-MB **DECLARATION OF** [redacted]

I, [redacted] pursuant to 28 U.S.C. § 1746, declare as follows:

1. The jail needs more improvement. They need to have more officers or should I say staff that cares more about their job. Instead, we have people that work here and all they care about is just getting a check. That's the only thing it seems like they care about and that's the only thing that matters to them. But, as far as the mental health services, I seen the mental health doctor only two times within a year and I only seen my mental health counselor only 4 times within a year. At first when I got here I was sent with meds and I still didn't get my meds until a week later. They need to have more mental health staff here than what they have here. They seem to only have three counselors here for the whole jail. The best mental health counselor we had was Ms. Green but she had quit because the way the officers was treating us.

2. When I first got here, I was in (A-Dorm) and that was in 2/10/2023. When I was in there, it was over 80 people in the whole dorm and all they had that work was two toilets one

upstairs and one downstairs. And the officers were never in the dorm. The only time they came to the dorm was when they needed to pass out meds and if there wasn't an officer to bring them or ensure to give us our meds we wouldn't have gotten our meds. And sometimes we go without our meds for days. That whole time I was in Phase 1 there was people beating people, taking people food, people getting stabbed up and there was nothing the officers was doing to help. These things was going on a daily basis. And we only had two showers that worked and there was no sinks that worked at all. But I had got transferred out of here on 3/1/2023 to another state and I came back here 7/20/23.

3. And when I came back the jail seemed like it had gotten worse. They put me in a holding cell in intake where there was 50 other people in that cell. And they kept us in there for two weeks without no shower or clean clothes. After being in there for two weeks they sent me back to Phase 1 which was (A-Dorm) and when I got there it was packed.

4. I got sent to Phase 3 to (G-Dorm) and when I got there it was worse in the dorm was flooded with water, the rooms didn't have any working toilets or sinks and lights. We had one toilet that worked for the whole dorm and that was room 4 which was always flooded with water every day. Even my room was like that to which was room 6. I had to clean out the room from the water at least six times a day and I slept on the floor. But, I moved to room 25 upstairs because I didn't want to deal with the water coming in my room. But around a month later I got jumped by three people and got robbed for my stuff. But, I told the officer that was on and she just sent me to medical.

5. And then from there, they put me in Papa so I can get reclassified. And when I got to Papa, they put me in (E-Pod) which (E-Pod) had only one toilet that worked and the rest of the room the toilets and sinks didn't work. The toilets were full of poop. They put me in room 31 where there was no toilet that worked. They left me in that room for a week.

6. I asked to get moved to a room with a toilet that has a working toilet and they said that they didn't have one to put me in. So, I had to start using trays to poop in. But they moved

me into Room 29 which it had the same problems as the rest of the rooms the only thing that the door didn't close. But officer Gray he was cleaning out trays for me so I can use for when I had to poop. He also gave me bags so I could put it in and throw it out for me.

7. But the people in Papa they broke all the doors in Papa and also broke the middle door that connect E and F Pod and they didn't do anything about fixing the doors. In (F-Pod) they had jumped on Sgt. ~~Cullum~~ Coleman [redacted] then they had fixed the doors only for them to be broken a few days later. I did not feel safe in Papa because anybody could of went in my room while I was sleeping. So, I really didn't get that much sleep. They were getting the drugs through a nurse. They will have somebody to do a ~~fact~~ fake code blue so the nurse could come to Papa and drop off the drugs [redacted] and staff.

8. But then in (H-Pod) there was something going on everybody got down on the floor and Sgt. Pugh had kicked someone when they was laying on the floor. And that's when people started going crazy and that's when the people in (F-Pod) came to (E-Pod) and started the fire and started the riots. This was last October.

9. So, they moved some of us to (Mike-Dorm) and when we got moved to (Mike-Dorm) we were in there two days before the people from Papa started acting up and started breaking the doors there. And at the same time, I was asking why I haven't been moved that I was only there to get reclassified and that I should have never been put in Papa. But, they still ain't do anything about me getting jumped and robbed.

10. I got moved out of (Mike-Dorm) the day before Thanksgiving last year and they moved me to Phase 5 which was worse they had me in (U-Dorm). When I got there, the toilet didn't work and I only had cold water. And it took them a month before they even tried to fix the toilet. Then after being here in (U-Dorm) the jail closed down two dorms in Phase 3 which was [redacted]-J Dorm and all that did was make it more packed in Phase 5 now instead of having 8 people in each Pod now its 12-18 people in each Pod.

11. And down here in Phase 5, they don't never have any officers in the dorm which they should because its 7 pods in each dorm, which are K, L, U dorms. And there is a lot of things that go on that they don't see because they not in here to witness it. They still haven't been on time with my meds. I've been going three days without my meds now and my Boss have to go to medical to see why I'm not getting my meds almost every day. And in Phase 3 they should be 15 min. count or 15 min. security check which they don't and that's why the things go on here. And in Phase 3 they shut the dorm down at 4:30 p.m. They turn the phones off and everything.

12. I feel the violence conditions and living conditions at this jail has messed with my mental state a lot while I've been here because I can't sleep comfortable anymore while I'm in here because all the beatings and people being robbed, doors don't lock or anything.

13. I told my family because there ain't nobody here that I can talk to about it so I keep it to myself.

14. I'm now in BMU where there are 87 detainees. I talk with the officers about the overcrowding that's going on in other units too. They've told me that Yankee, which is a lockup dorm similar to BMU, has 116 in 56 cells.

15. BMU is having problems with the toilets in some of the rooms they have two rooms that had poop coming up out of it where they had to close the rooms. At first they didn't move the people in the rooms which were rooms 41, 42, [redacted] and 56. They also had to close two other rooms because a detainee had took out a block out of the wall and was beating on the door with it so there is two rooms that are missing a block out of the wall.

16. I've been back here in BMU since April 8, 2024, and they have not given any recreation like they suppose to. So that means we have been in the room 24 hours every day. We ask about going out to rec and they don't say anything about letting us go outside to get any fresh air. They have people in BMU that do not have any write ups or anything. They just holding them back here. One of the detainees that I know his name is [redacted] He has been back here for 39 days without no writeup or anything.. He ask everyday why he is back here and they

don't tell him anything. They just walk right by his room like he wasn't trying to find out why they have him in BMU. They do not let us order deodorant, soap, or toothpaste while we are in BMU and that's something that we should be allowed to order while we in BMU. That is something is in the handbook.

17. Also, as in the rooms being fixed, all they did was painted and put new toilets in here. As far as beds, they are not safe. A detainee ripped the beds out of the ground. So room one don't have a bed in it and also room 4 doesn't. Since I have been back here the detainees were calling for a code blue [redacted] for a detainee that was in room 3 because he fell out of the bed. The officer went to his flap and open it and looked in the room and then closed it and we still was calling for a code blue for the detainee and 10 minutes later Sgt. Noble came and went to the room.

18. There is a lot that happens here and they always try to cover it up or put the blame on the detainees when it's really them because they don't be doing their job like they supposed to. I said earlier they only here to get a check. So, they really don't care what goes on in here. How I know a lot of the things that goes on here is because I used to work handing out supplies for the whole jail. I got to see a lot and hear a lot of things that go on here. The things that go on here shouldn't be going on here. It's just a big mess.

19. They still packing people in BMU so its two people in each cell when it's a one man cell. So, they got people sleeping on the floor. And in my room which is room 47 on the bottom of the back of the room have a big hole in the wall and floor where you can see outside which that should have been fixed because if you can break the bed off the floor you can do the same with the table and can use that to make the hole bigger and try to leave. Like I said they didn't fix everything like they supposed to do where it will be able to have people living in the rooms.

20. As far as the nurses are concerned, some of them do their job and some of them don't. Like I am supposed to get my meds at 8:00 a.m. but I don't get my meds until 12:00 p.m. in the afternoon. Sometimes not until 1:00 p.m. and they have to take my blood pressure when I

take my meds in the morning and at night and it really don't get done. The only time it gets done is when Ms. Butler, Ms. Sanders, and Ms. Wolf are here. There is another nurse but I don't know her name. But Ms. Butler already put her two week's notice to quit and for the same reason Ms. Green quit too. So now, they starting to get low on staff with the nurses.

21. I have been asking to be seen by the mental health counselor since I have been back in BMU and I still haven't seen a counselor or doctor because I really need to talk to them so I can get help with my meds because I have been going through a lot from being in here and everything that I have been going through since I have been in here which has been a lot on my mental health state.

22. Since I'm talking about mental health...well, they have somebody on suicide watch and they have the CO's watch. The guy that is on suicide watch and they really don't be watching him like they supposed to. In the dorm every body just started saying that the detainee in room 1 was trying to hang himself and when I went to the door they did not have a CO watching him like they supposed to. Today is 4/24/2024 around 5:30 p.m. and 6:30 p.m. and they have a camera by the room and it will show everything that I have been telling you about. You can watch it and will show the CO's who was watching him or I should say supposed to be watching him. But, like what we have been talking about, they just show and tell people what they think they want to hear. CO Jowers be mostly sleeping on duty when they supposed to be watching the detainee that's in room 1 which that's one of the rooms that do not have a bed in it so they really isn't supposed to have anybody in that room but they do.

23. They did come and fix room 56 toilet and that's it. They didn't fix any other rooms like 41 and 42 which don't have anybody in it. They just have those two rooms closed. With them having the rooms closed, they still have 88 people housed in BMU and they still bring people to BMU on this day of 4/24/2024. But, also as you are walking down to BMU, you can look up and see that there is a leak from the pipes. So, that is really dangerous because the sheetrock ceiling can fall on somebody and hurt somebody.

24. If you was to ask them to take you through Phase 5 units K, L, and U, you will see that everything is packed, even Phase 1. That's why they moved the people from A-Dorm to C-Dorm so you won't be able to see how packed it really is. The last count I got was 88 people in A-Dorm. And, also the food that they give us don't be all the way cooked. The meat still be pink when they serve us. They don't give us no food with nutrition at all and don't give us milk at all and that is something that our bodies need and they stop just as they changed food companies. They also don't do laundry like they should because most of the time we have to dry off with our dirty uniform because they don't never have any clean towels for us to use. So, we are having to wash our stuff by hand which it shouldn't have to be like that. If we don't wash our stuff we have to use dirty stuff when we get out the shower which is wrong because they are dirty. So what is the sense to taking a shower if we got to dry off with dirty clothes.

25. Today 4/25/2024, I was told by the nurse that I was going to be seen by mental health today and it didn't happen. I have been patient to be called for mental health and I am to the point I don't know what to do anymore. Now, it is after 1:00 p.m. and they are just passing out my meds when I was supposed to get them at 8:00 a.m. In the morning. I just talked to the nurse (Ms. Jameison) and was explaining to her that mental health was supposed to see me today and the officer isn't doing their job right and when I was telling her CO Grey turned off his body camera. They really need to get people that want to work here instead of just here to get a check.

26. Officer Grey stayed at work late yesterday so he could give detainees things that they isn't supposed to get. He brings it to room 35 and 37 if you look at the video for 4/24/24 from 6:00 p.m. to 8:00 p.m. it looks like he is passing out roll ups but it was stuff that he was giving to the detainees that they wasn't supposed to have. If you look at the camera by cell 1 of you will see C.O. Jowers sleeping instead of watching the detainee that is on suicide watch and this goes on almost everyday. They also don't have any hot water because they said they had to fix the boiler but they never came to fix it so that means we been having to take cold showers in BMU.

The water has been cold since 4/22/24 and today is 4/26/24 and we still have cold water to take showers in. So now the weekend is coming up so there isn't no telling when they going to fix the boiler or replace it. This is what goes on when something don't work they don't get it fixed right away. It takes two to three weeks to get things fixed around here.

27. I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

6/24/24
Date

[redacted]

3/16/24

Dear Stuart Andrews

Like we have talked about that the jail neededs more improvement. They need to have more officers or should I say Staff that cares more about there job instead we have people that work here all they care about is just getting a check. Because thats the only thing it seems like the only thing they care about and thats the only thing that matters to them. But as for the mental health services. I seen the mental health doctor only two times with in a year and I only seen my mental health [redacted] counselor only like 4 times with in a year. At first when I got here I was sent with meds and I still didnt got my meds intil a week later. They need to have more mental health staff here then what they have here. They only have three counselor here for the whole jail. The best mental health counselor we had was Ms. Green but she had quite because the way the officers [redacted] treating us. When I got here I was in (A-Dorm) and that was in 2/10/23. When I was in there it was over 80 people in the whole dorm and all they had that work was two toilets one up stairs and one down stairs. And the officers was never in the dorm

the only time they came to the dorm was when they needed to pass out meds and if there wasn't an officer to bring the nurse to give use our meds we ~~[illegible]~~ wouldnit have gotten our meds. And Sometimes we go with out our meds for days. That whole time I was in phase 1 there was people beating people taking people food people getting stabbed up. And there was nothing the officer was doing to these and these things was going on the daylie baisees. And we only had two showers that work and there was no sinks that work at all. But I' had got transfer out of here on 3/1/23 to another state and I came back here 7/20/23. And when I came back the jail seemed like it gotten worst. They put me in a holding cell where there was 50 other people in that cell. And they kept us in there for two weeks with out no shower or clean clothes. After being in there for two weeks they sent me back to phase one which was (A-Dorm) and when I got there it was packed. But I got sent to phase 3 to (G-Dorm) and when I got there it was worst in there the dorm was flooded with water the rooms didn't have any working toilets or sinks and lights we had one toilet that

worked for the whole dorm and that was room 4 which was always flooded with water even my room was like that to which was room 6. I had to clean out the room from the water at least six time's a day cuz I slept on the floor. But I moved to room 25 up stairs cuz I didn't wont to deal with the water coming in my room But around a month later I got jumped by three people and got robbed for my stuff. But I told the officer that was on and she just sent me to medical. And then from there they put me in papa So I can get reclassified. And when I got to papa they put me in (E-POD) which (E-POD) had only one toilet that work and the rest of the room's the toilet's and sink's didn't work the toilet's was full of poop- they put me in room 31 where there was no toilet that work, They left me in that room for a week, I asked to get moved to a room with a toilet that ~~he~~ have a working toilet and they said that they didn't have one to put me in. So I had to start using trays to poop in. But they moved me in to room 29 which it had the same problem's as the rest of the room's the only thing that the

door didn't close. But officer Gray he was cleaning out trays for me so I can use for when I had to poop he also gave me a bag so I can put it in and throw it out for me. But the people in papa they broke all the doors in papa and also broke the middle door that connect to E and F POD and they didn't do anything about fixing the doors. IN (F-POD) they had jumped on Sgt. Coltman then they had fix the doors only for them to be broken a few days later. I did not feel safe in papa because anybody could of went in my room while I was sleeping So I really didn't get that much sleep. Then they was getting they drugs threw a Nurse. They will have somebody to do a fact Code blue so the nurse could come to papa and drop off the drugs and staff. But then in (H-POD) there was something going on a everybody got down on the floor and Sgt. Pugh had kick someone when they was laying on the floor. And that's when people started going crazy and that's when the people in (F-POD) came to (E-POD) and started the fire and started the fight. So they moved some of us to (Mike-Dorm) and when we got moved

to (mike-Dorm) we was in there two days before the people from papa started acting up and started broking the doors there. And at the same time I was asking why I haven't been moved that I was only there to get reclassif.. and that I should of never been put in papa but they still ain't do anything about me getting jumped and robbed, I got moved out of (Mike-Dorm) the day before Thanksgiving and they moved me to phase 5 which was worst they had me in (U-Dorm) and when I got there they toilet didn't work and they only had cold water. And it took them a month before they even try to fix our toilet. Then after being here in (U-Dorm) the jail closed down two dorms in phase 3 which was G-J Dorm and all that did was make it more pack in phase 5 Now instead of having 8 people in each pod now it's 20 people in each pod. And down here in phase 5 they don't never have any officers in the dorm which they should because it's (Z-PODS) in each dorm which are (Ugly U-dorms). And there is a lot of things that go on that they don't see cuz they not in here to witness it, And to let know that they still haven't been any time

with my meds I've been going three days with out my meds now and my Boss have to go to medical to see why I'm not getting my meds almost every day. And in phase 3 they should be 15 min count or 15 min security check which they don't and that's why the things go on here. And in phase 3 the shut the dorm down at 4:30 pm they turn the phones off and everything. Yes I feel the violence conditions and living conditions at this jail has messed with me mental stage a lot while I've been here. Because I can't sleep comfortable any more while I'm in here because all the beating and people being robbed doors don't lock or anything. Yes I told my family cuz there ain't nobody here that I can talk to about it so I keep it to myself. So I've got a lot going on with my case don't know charges have not been dismissed yet because they don't have evidence to hold but they are but that something else there is a lot more that will be discuss between me and you So have a bless day

[redacted]

[redacted]

Addition to 1st Statement of 3/18/24

[redacted]

And BMU is having problems with the ~~plaintiffs~~ toilets in some of the rooms they have ~~two~~ two rooms that had poop coming up out of it where they had to close the rooms at first they didn't move the people in the rooms which was room ~~41~~ 41+42+46 and 56. And they also had to close two other rooms because ~~a~~ a detaine had took out a block out of the wall and was beating on the door with it. So there is two rooms that are missing a block out of the wall. And I've been back here since 4/8/24 and they have not given any rec for an hour like they suppose to. So that means we have been in the room 24 hours everyday. we ask about going out to rec and they don't say anything about letting us go outside to get any fresh air. They have people in BMU that do not have any write up's of anything they just holding them back here, one of the detaine that I know his name is [redacted] he has been back here for 39 days with out no write up or anything. And he ask everyday why he is back here and they don't tell him anything they just walk right by his room like he wasn't trying to find out why they have him in

deodorant

BMU for, They do not let us order deodorant, soap or toothpast while we in BMU and that something that we ~~should~~ should be allow to order while we in BMU. And that something that ~~is~~ is in the hand book. And also as in the rooms being fixed all they did was painted and put new toilets in here as for the beds, They ~~was~~ are not safe a detaine ~~took while~~ rip the beds out of the ground. So Room one don't have a bed in it and also room ~~3~~ 4. And Since I've been back here the detaine was calling for a Code blue for a detaine* that was in room 3 * [redacted] because he fell out the bed. And the officer went to his flap and open it and looked in the room and then closed it and we still was calling for a code blue for the detaine and 10 min's later the Sgt, Noble came and went to the room and had called for the code blue. There is a lot that happens here and they always trying to cover it up or put the blame on the detaines when it really is them because they don't be doing they job like they suppose to. Like I said earlier they only here to just get a check

(3)A

and that's it so they really don't care what goes on in here. How I know a lot of the things that goes on here is because I use to work handing out supplys for the whole jail, so I got to see a lot and hear a lot of things that goes on her. And the things thats goes on here shouldn't be going on here it just a big mess. They still packing people in B1C so its two people in each cell when its a one man cell so they got people sleeping on the floor. And in my room which is room 47 on the bottom of the back of the room have a big hole in the wall and floor where you can see outside. Which that should of been fix because if you can brake the bed of the floor you can do the same with the table and can use that to make the hole bigger and try to leave. So like I said they didn't fix everything like they suppose to do where it will be able to have people living in the rooms. But as for the Nurse some of them do they job and some of them don't, Like I suppose to get my meds at 8:00AM but I don't get my

(4) A

my meds intil 12:00pm in the [redacted] afternoon sometimes not intil 1:00pm and they have to take my blood pressure when I take my meds in the morning and at night and it really don't get done. The only time it gets done is when Ms. Buttler, [redacted] Ms. Sanders and Ms. Wolf another Nurse but I don't know they name. But Ms. Buttler already put her two weeks notice to quit and for the same reason Ms. Green quit for. So now they starting to get low on staff with the Nurses. And I've been asking to be seen by the mental health counselor since I've been back and I still haven't seen a counselor or doctor because I really need to talk to them so I can get help with my meds because I've been going thru a lot from being in here and everything that I have been going through since I've been in here which has been a lot on my mental health stages. Since I'm talking about mental health well they have somebody on suicide watch and they have the C.O's watch the guy that is on suicide watch and they really don't be watching him like they suppose to. C.O. Towers [redacted] be mostly sleeping on duty when

5A

they Suppose to be watching the detainee that's in room one, which that's one of the room's that do not have a bed in it so they really aint Supposed to have anybody in that room but they do. But they did come and fix room 56 toilet and that's it they didn't fix any other rooms like 41 and 42 which don't have anybody in it they just have them two room closed. And with them having them room closed they still have 88 people housed in BMU and they Still bring people to BMU on this day of 4/24/24. But also as you are walking down to BMU you can look up and see that there is a leak from the pipes. So that is really dangerous because the sheetrock ceiling can fall on somebody and hurt somebody. well in the dorm everybody just started saying that the detainee in room one was trying to hang him self and when I went to the door they did not have a C.O watch him like they Suppose to, Today is 4/24/24 around 5:30 pm and 6:30 pm and they have a camera by the room and it will show everything that I've been telling you about you can watch it and it will show the C.O's who was watching

(6A)

him or I Should Say suppose tobe watching him, But like what we have been talking about they just show and tell people what they think they won't to hear. If you was ta ask them to take you thru Phase 5 K, L, and U you will see that everything is packed even Phase 1. That's why they moved the people from A-Dorm to C-Dorm so you won't be able tu see how packed it really is. Because the last count I got was 88 people in A-Dorm. And also the food that they give us don't be all the way cook the meat still be pink when they serve us. And they don't give us no food with Nutritions at all and don't give us milk at all and that is something that our bodys need and they stop just as they changed companys. And they also don't do laundry like they should because most of the time we have to dry off with our dirty ~~clo~~ uniform because they don't never have any clean ~~tow~~ towles for us to use. So we be having to wash our ~~Stuff~~ stuff by hand which it shouldn't have to be like that and if we don't wash our Stuff we have to use dirty Stuff. When we get out the Shower which is wrong because they are dirty.

4/24/24 From 6.00,pm to 8:00 pm it looks like he is passing out roll ups but it was stuff that he was giving to the detainees that they wasn't suppose to have. And if you look at the camara by cell one you will See C.O Towers Sleeping instead of watching the detainee that's on Suicide watch and this goes on almost everyday. And they also don't have any Hot water because they said they had to fix the boiler but they never came to fix it so that means we been having to take cold Showers in 13Mu. the water has been cold since 4/22/24 and today is 4/26/24 and we still have cold water to take Showers in. So now the weekend is coming up so there ain't no telling when they going to fix the boiler or replace it this is what goes on when Something don't work they don't get it fix right away it takes two to three weeks to get things fix around here, well my days are up on Sundays let's See if I get out on Monday

so what is the [illegible] to taking a shower if we got to dry off with dirty clothes. And today 4/25/24 I was told by the nurses that I was going to be seen by mental health today and it didn't happen. I have been patient to be called for mental health and I'm to the point I don't know what to do anymore. Like now it is after 1:00pm and they are just passing out my meds when I was suppose to get them at 8:00 Am in the morning. I just talk to the nurses Ms. Jameson and was explaining to her that mental health was suppose to see me today and how the officers aint doing they job right and when I was telling her C.O Grey turned off his body camera off. They really need to get people that's wants to work here instead of just here to get a check. But yesterday officer Grey stayed at work late so he can give detines things that they ain't suppose to get he bring it to room 38 or 39 if you look at the video for

EXHIBIT 13

DETENTION CENTER AD HOC COMMITTE
February 18, 2020 – 1:00PM
Administration Conference Room
2020 Hampton Street, Columbia, SC 29204

COMMITTEE MEMBERS PRESENT: Dalhi Myers, Chair, Yvonne McBride and Allison Terracio

OTHERS PRESENT: John Thompson, Michelle Onley, Ronaldo Myers, Hayden Davis, Shane Kitchen, Randy Pruitt, and Fielding Pringle

1. **CALL TO ORDER** – Ms. Myers called the meeting to order at approximately 1:04 p.m.

2. **ADOPTION OF AGENDA** – Ms. Terracio moved, seconded by Ms. Myers, to adopt the agenda as published. The vote in favor was unanimous.

3. **ELECTION OF THE CHAIR** – Ms. Terracio moved, seconded by Ms. Myers, to nominate Ms. Myers for the position of Chair. The vote in favor was unanimous.

4. **ALVIN S. GLENN DETENTION CENTER EXPANSION**

   a. **Introduction**

   b. **Background** – Mr. Myers stated they are a direct-supervision facility, which basically means the officers are in the housing units' day-in/day-out. The officers control the activities of the inmates.

      - In FY11-12 Council approved a $12.5M bond to build additional jail space.
      - The project was previously was bid out; the 2 companies that were to be negotiated with were Carter Goble Lee and Moseley Architects.
      - The project was put on hold and the County brought in a management consultant in 2014. The consultant was to determine if the jail was doing everything that needed to be done. At that time, there had been a couple of jail deaths, and they wanted to insure the jail was being managed properly.
      - The management consultant determined the jail was being managed properly, but they recommended additional medical and mental health beds be constructed.
      - In 2016, SCDC was sued, and lost, because they were not providing the proper services for mental health patients and not meeting the medical needs of the inmates.
      - Carter Goble Lee recommended to construct medical and mental health beds, and to renovate 3 open bay dormitories. The reason for renovating the open bay dormitories is because of the population changing over the years. There has been an increase in inmates charged with violent crimes, which necessitates the need for more single cells to accommodate those individuals who do not want to follow the "rules."

- The 2014 and 2016 needs assessment studies each took approximately 3 months.
- Mr. Hayden Davis has a copy of the 2016 Needs Assessment.
- It was recommended to construct 36 medical unit beds. They will not be building an infirmary because that would increase the medical contract, and would require specialized equipment. In addition, an infirmary has to be certified through DHEC.
- Currently there are no true mental health beds. Their "Special Housing Unit" is a hodgepodge of disciplinary, administrative separation, medical and mental health detainees. At last count, there are 56 cells with approximately 25 – 26 detainees suffering with mental health issues.
- They are attempting to build something more therapeutic. Currently, there are 3 – 4 mental health counselors on contract with their medical provider, Wellpath. This would place the counselor(s) in the unit with the detainees so they can do group and individual therapy.
- There are currently no suicide cells. When they have an inmate that is at risk, an officer is assigned to that cell. The officer sits and monitors the inmate one-on-one.

Ms. Terracio inquired as to what would make a cell a "suicide cell".

Mr. Myers responded it is basically a padded room where the inmate cannot hang themselves. There is no ligature points, the walls are smooth, and the ceilings are higher to prevent hanging.

Mr. Davis stated there are also no bathroom fixtures or corners, which could be used to self-harm.

Mr. Myers stated the Dept. of Mental Health does not have that many forensic beds; therefore, they have to find a way to accommodate. They currently have an inmate that self-mutilates to gain attention. The inmate had to have a blood transfusion because he has lost so much blood. They have tried to get him committed, but because of a space issue he has not been.

Ms. Terracio inquired about the difference between a medical unit and an infirmary.

Mr. Myers stated an infirmary would have "hot" oxygen coming off the walls, which is similar to a hospital setting.

Mr. Davis stated it would be more expensive than a hospital room because all of the equipment would have to be secured. The medical unit would more closely resemble a jail cell, but there would only be one inmate per cell.

Mr. Myers stated in addition, the medical unit would have electrical outlets coming out of the wall. Currently they do not electrical outlets and they have been cited by SCDC, and the Fire Marshal's Office, because they have cords running across the floor for the medical equipment. There is no cost for the fines, but it is noted in case something does happen.

Ms. Myers inquired if a cost has been determined for the construction/renovations.

Mr. Myers stated the main priorities is building the medical and mental health units, which could utilize most of the $12.5M set aside.

Ms. Myers inquired if the $12.5M was segregated.

Dr. Thompson stated to his knowledge it was not. He will confirm with James if the funds are in the Detention Center budget.

Mr. Myers stated they need to update security and electronics. They would like to put additional cameras in. Currently there in one camera in each housing unit, which is a pan and tilt camera.

c. Scope of Service

- 2019 – Procurement issued a RFP for the design of the expansion
- Most responsive vendor was Moseley Architect, which has previously completed jobs at the Detention Center
- Nationally, approximately 30% of the inmates in the jail population have mental health issues
- There are currently 236 inmates at the Detention Center that receive medication for mental health issues
- By removing inmates from the Special Housing Unit and putting them in a medical unit, and then, removing the inmates with mental health issues and placing them in a mental health unit, it will free up additional cell space.
- There is also an increase in the number of gang-related issues.
- Inmates with violent offenses remain in jail longer, and restrictive housing should not be used to house inmates with minor violations or inmates with mental health issues.

Mr. Myers stated he is a supporter of the National Alliance of Mentally Ill, and has worked with them in the past.

Ms. Myers inquired if the Detention Center is currently delineating where inmates are housed.

Mr. Myers responded there is a classification process to place the inmates, but because they cannot place inmates with severe mental health issues in the general population, those inmates have to be placed where no one can take advantage of them. The only place to house these inmates is in a single-cell in the Special Housing Unit.

Ms. Myers requested additional feedback on inmates with violent offenses, which have a higher bond and are not able to meet the bond, and if the County should continue to with cash bonds. She inquired about what would be different if Mr. Myers had all of the money he has requested, and where inmates would be housed.

Mr. Myers stated, to be honest, it would not be different, unless the criminal justice system itself is fixed because the jail is a catchall for everybody. He stated the Detention Center, along with the Public Defender's Office and the Courts, try to research the background information on the detainees in order to set a better bond. The inmates that need to released are being

released, but the inmates that have been charged with violent offenses typically have committed murder or some other egregious crime.

Ms. Myers stated these individuals have only been charged with the offense, so she is concerned with how we are classifying these individuals.

Mr. Myers stated they do an objective jail classification study, which is basically a decision tree of the charges, criminal history, educational level, etc.

Mr. Davis stated the County is looking at doing a design-bid-build process, which would bring in an architectural firm to design, and then have them put it out to bid. He stated the proposal from Moseley was, knowing there was a $10M budget, with an option to do some other things with the remaining funds, to focus on the mental health and medical facility portion. The design process is typically divided into four (4) sections: schematic design, design development, construction documents, and bid oversight. The schematic design is what this proposal is for, which will evaluate the process, do a site study, space utilization, and how it fits on the site. It will also review the assessment needs recommendation and go through the Detention Center's daily processes.

At this point, Moseley is willing to honor their proposal to the February 2019 solicitation.

Ms. Myers stated, with a year old process, there could be other companies that may be able to provide a viable bid.

The information will be presented for Council's approval through the D&S and/or A&F Committees. Once Moseley is put under contract, they would anticipate a 4 – 6 month design time for the schematic design.

Ms. Myers inquired if there are any internal restrictions regarding bid solicitations.

Mr. Myers responded that he had spoken with Procurement, and the County could process with the award of the contract, if the vendor wishes to honor their bid.

Ms. Myers stated her question is related to other potential bidders, who were not successful, since we are beginning the process a year after the bid solicitation. There could be local companies who have an interest in this work, as well. She was curious if there was anything we need to look at from that perspective.

Mr. Myers stated there is only one local company that is qualified, which is Carter Goble Lee, and they did not bid. Of the five (5) bidders, there was one local "firm" that submitted a bid. The "firm" consisted of 2 -4 companies cobbled together to submit the bid. Each of the companies had experience, but a lot of their work would have been contracted out to other companies.

Ms. Myers inquired as to who reviewed the bid.

Mr. Myers responded that Mr. Kitchens, Mr. Niermeier and himself reviewed the bid.

Ms. Myers inquired if they were blind bids.

Mr. Myers stated they were provided their qualifications, and the names of the companies. The reviewers then contacted the companies' references to determine how responsive they were, and how the designs worked out for their previous clients. The reviewers were not provided the funding portion of the proposal.

Ms. Terracio stated she believes these companies would need to have a high level of expertise because these are very specific requests.

Mr. Davis stated he previously worked for an architectural firm that specialized in jails, and Moseley was their main competitor. Moseley is known internationally for their work on jails.

Ms. Myers stated there are three (3) local companies that she has represented that have constructed federal jails, and they build reputable jails.

Ms. McBride stated that not having a blind bid troubles her. In terms of companies that specialize in building facilities, certain companies monopolize and do not give other companies that have the same experience an opportunity. She inquired if there is a "pre-bid" process where companies are certified for eligibility.

Mr. Myers responded there is not a pre-bid process.

Mr. Davis stated this was a publicly advertised RFQ, which was open to anyone.

Mr. Myers stated they would like to move forward, so they can begin the design-build process within the next six (6) months.

Ms. Myers stated the committee needs to be able to review the numbers and the solicitation information before they can make a recommendation to full Council.

Mr. Davis asked for clarification on what the committee specifically is looking for in the briefing document.

Ms. Myers stated she would like to see the following:

- The bidders;
- The scores;
- The bid prices; and
- The members of the review committee

The requested information will give the ad hoc committee an understanding of the process, and if the process was fair and followed the procurement guidelines.

Ms. Terracio inquired if the proposal increases the number of beds at the Detention Center, or does it help to rearrange where detainees are housed.

Mr. Myers stated it will increase the total number of beds.

Ms. Terracio inquired if the Detention Center has an overcrowding problem.

Mr. Myers stated they have a classification issue. The jail was built in phases. Phase I was 336 open-bay beds, which is the part they are requesting to renovate. The facility has a total of 1,100 beds, which was reduced when they closed down the "Inmate Working Unit" because of plumbing issues.

Ms. Terracio stated, for clarification, we are not looking to jail more people.

Mr. Myers stated he is attempting to separate detainees better, and house them humanely.

Ms. McBride inquired if there is a limited amount of inmates that should be safely housed at the Detention Center.

Mr. Myers responded in the affirmative, but for clarification, it is not the population, but how they are classified.

Ms. McBride inquired which classification the expansion is for.

Mr. Myers stated they are requesting to construct medical and mental health units, which will free up additional beds to assist with "problem" inmate housing.

Ms. McBride stated her main concern is the mental health component, and making sure the detainees get the appropriate treatment.

Mr. Myers stated that is one of the things the architects will take into consideration. Even though we have a feasibility study, they are going to do an additional assessment.

Mr. Davis stated there were four (4) items identified in the solicitation (i.e. mental health facility, medical facility, camera system, and the renovation of Housing I from a bunk area to individual cells).

Ms. Myers stated, for clarification, the RFQ was a direct outgrowth of the feasibility study.

Mr. Myers responded in the affirmative.

Ms. Myers thanked Ms. Pringle for attending the meeting, and requested her comments on the proposed project.

Ms. Pringle stated she supports Mr. Myers, and reiterated the mental health unit is desperately needed. It has caused concern for a long time, and she looks forward to movement on the matter.

Ms. Myers requested a standard meeting time, so we can be kept up to date on Detention Center issues. In addition, she requested the daily cost of housing a detainee is, and how much each municipality is paying.

Mr. Myers stated the cost to house each detainee is fluid. The average cost is $72/day.

Ms. Myers stated the number to house someone at the Detention Center could potentially be different than the "budgeted" amount. She is requesting the cost to run the Detention Center.

Mr. Myers stated if included all the ancillary costs it would likely cost upward to $90/day.

Ms. Myers stated the taxpayers of Richland County are housing Lexington County's detainees, as well, in some instances. If the "real" cost is "X" and we are charging them "Y", we are subsidizing the cost to some places, and overcharging in others.

Ms. McBride inquired if we legally have to accept detainees from other jurisdictions.

Mr. Myers responded the only thing they are legally required to do is house detainees with General Sessions' charges.

Ms. McBride stated she believes it is time the County looks at the process and start focusing on Richland County because things are almost out of hand. We are currently shortchanging the Richland County residents.

Ms. Myers inquired if it was possible for the Public Defender's Office to provide information on county's that have gone to a "no cash bail system".

Ms. Pringle stated she will bring back information at the next ad hoc meeting.

Ms. Myers inquired about the staff retention at the Detention Center.

Mr. Myers stated it is a national crisis in law enforcement; however, they are doing better now.

Ms. Myers inquired if it is still a revolving door.

Mr. Myers responded in the affirmative. A part of it is that employees do not know what they are getting into until they get on the job. The other part is hiring the right people. He noted that some of those that left in the past have begun returning.

Indirective supervision facilities, which Mr. Myers does not care for, seem to keep their employees much longer.

Ms. Myers inquired about the education and training programs available.

Mr. Myers stated they have a GED program, as well as other programs; however, because of the staff shortage some have been put on hold. He is looking at hiring a Retention Specialist to assist with retaining employees, which in turn will open these programs back up. A lot time we concentrate on the inmates and not what the staff needs. Another issue they face with retention is that there is no real progression.

Ms. Myers stated there are some really creative programs which allows the detainees to do knowledge economy work (i.e. coding). There are real salaries banked for the detainees, so when they have money and a job skill.

Mr. Myers stated he will do some further research on the coding job skills.

Ms. McBride expressed her concern with the mental health and substance abuse issues of the detainees.

Mr. Myers stated they have a lot of community-based programs that deal with substance abuse, as well as a professional relationship with LRADAC.

Ms. McBride inquired about how many youth detainees ASGDC has.

Mr. Myers stated they average about 6 -8 juvenile detainees, but there is room to house 24.

5. **Questions & Answers**

6. **ADJOURNMENT** – The meeting adjourned at approximately 2:14 p.m.

EXHIBIT 14

Richland County

Alvin S. Glenn Detention Center Management and Operations Study

FINAL REPORT

April 18, 2014

Prepared by:

PULITZER/BOGARD & ASSOCIATES, LLC
8 Saratoga Street
Lido Beach, New York 11561
516-432-9007

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EXECUTIVE SUMMARY

EXECUTIVE SUMMARY

A. Purpose and Methodology

In October 2013, the Richland County Board of County Commissioners, through the County Administrator's Office, issued an invitation for criminal justice consulting firms, with specific expertise in preparation of jail management studies and audits, to submit proposals to perform an operational/management study of the Alvin S. Glenn Detention Center (ASGDC) in Columbia, South Carolina.

The County's Scope of Work was as follows:

1. Initiate Project
2. Interview Staff/Administer Organizational Climate Survey
3. Review Information Technology/Automation
4. Review Current Operations and Work Processes
5. Conduct Observations
6. Meet with Criminal Justice System Officials, Review Inmate Population Management, and Need for Expansion Based on Classification Needs; the Prison Rape Elimination Act (PREA); and Medical Needs
7. Review Organizational Structure and Staffing
8. Conduct Progress Meetings, Prepare Draft and Final Reports

In November 2013, the County retained the services of Pulitzer/Bogard & Associates, LLC (P/BA) to perform the Study. P/BA, a New York based consulting firm, had previously conducted numerous audits and operations reviews of large jails throughout the country. P/BA's work on this assignment was undertaken by a team of five corrections professionals, all of whom possess substantial first-hand experience working in jail systems as well as decades of corrections consulting practice.

Work began in early December 2013, with an extensive request from P/BA for documents and data from the ASGDC. The Team then conducted two site visits, in December 2013 and February 2014. Field visits entailed tours of the jail facility, observations of staff and inmate activities, review of selected use of force incident reports, review of health and security related records and review of other forms of documentation maintained by the Detention Center. Approximately 100 line staff and 30 supervisors were interviewed formally or informally, as were several representatives of the jail's contract health care provider. And, we informally interviewed more than 300 inmates in the course of our walk-throughs of the ASGDC.

Another key aspect of our methodology included the administration of a survey to current employees. One hundred sixty four staff completed the on-line survey, a response rate of approximately 50%.

Stakeholders from five local law enforcement agencies were interviewed, as were representatives of the County Solicitor's Office, Public Defender, County Solicitor, County Bond Court, and Fifth Judicial Circuit Court.

As a precursor to this Study, in 2008, the County contracted with Hammett Associates to prepare a Performance Audit of the Detention Center. While that Audit was comprehensive, significant focus was directed at the acute staffing shortage being experienced at that time. The 2008 Audit was used as background information for this Study, and several of the findings and recommendations that were provided to the County then are still very relevant.

The Study Team received total cooperation from ASGDC staff during this effort. Personnel responded to data and document requests in a timely manner and submitted to interviews willingly and, in many cases, enthusiastically. We were provided unfettered access at all times to all areas of the Detention Center.

B. Major Findings

This Study includes over 100 findings and 200-plus recommendations. While the actual findings and recommendations set forth in the Study are categorized among many different content areas, the below findings are synthesized from the larger list and represent the major findings of the Study.

1. **Staff at all levels of the organization, including the director and assistant director, welcomed the scrutiny of an outside entity as an opportunity to improve.** Throughout the process of undertaking this Study, we have been uniformly impressed with the commitment and desire on the part of staff to improve the operations and working conditions in the ASGDC. While there is no shortage of complaints on the part of staff, as we heard in person and via the results of the on-line employee survey, there is, at the same time, a general attitude of striving for improvement rather than seeking merely to criticize. This conclusion is supported by the very high number of responses on the employee survey, and by the generally helpful comments and recommendations received. The Study Team also encountered examples of staff taking it upon themselves to modify and improve practices based solely on questions or comments we made during our initial site visit.

2. **The current Jail Management System (JMS) does not serve the needs of the ASGDC for reliable and comprehensive data for management and decision making.** This hampers virtually every aspect of the facility's operations and management. The lack of a functional, comprehensive JMS means that ASGDC does not currently have access to credible and complete data about incidents that are necessary to inform decision making. As a result, the facility has no readily available accurate and reliable system of tracking the characteristics of and numbers of incidents occurring in the facility. This means ASGDC management cannot employ data-driven management systems to review operations and inform decision making about resource allocation, needs for intervention, efficacy of programs, etc. In fact, the ASGDC relies on handwritten or manual systems for reporting and recording most shift activities; maintenance orders; inmate requests; daily activity schedules—transports, programs; incident reports; documentation from courts; etc.

3. **Because of a lack of adequate, specially designed housing options for myriad inmate classifications, segregation housing has become the inappropriate default option for all specialized inmate requirements, which presents many concerns.** The Special Housing Unit (SHU) is a maximum security housing area that was designed for and is appropriate for inmates who have exhibited violent behavior in jail or who have committed serious infractions. While inmates meeting those criteria are housed in the SHU, so are inmates who have been diagnosed with serious mental illness, inmates who are on suicide watch, inmates who are transgender and inmates needing protection from others. Because of the mix of dissimilar populations and a 'one size fits all' security approach whereby all inmates housed in the SHU, regardless of the reason, are treated as maximum security with severe restrictions on out of cell time, movement, access to services, ability to retain personal items, etc., approximately half of all use of force incidents occur in the SHU.

4. **Large numbers of inmates with mental illness are straining ASGDC resources, compounding overall inmate supervision challenges and this problem, which is being experienced in jails nationwide, will only become more challenging in the coming years.** Timely identification of inmates who have histories of serious mental illness or suicide attempts at the time of admission is difficult because of the reluctance of detainees to self-identify as having a mental illness and the lack of appropriate flags in the JMS to alert staff of previous serious mental health events involving the inmate in ASGDC. Mental health treatment is limited to crisis intervention, stabilization and psychiatric medication management. There is no dedicated and appropriate mental health housing for inmates whose acute symptoms require special housing and close proximity to mental health staff. Current mental health training for officers has good information, but it is not oriented toward building skills toward effective interacting, intervening and managing behaviors with the least possible force. Despite housing Inmates on suicide watch in non-suicide resistant cells, the frequent safety observations have helped to keep the number of suicides (three deaths from suicide since 2009) to a low figure in a facility with 900-1000 inmates.

5. **Future facility needs are not so much population driven as they are necessary to improve inmate housing options and remedy other facility shortfalls.** The average daily population of the ASGDC has decreased over the past seven years as the number of admissions to the facility and the average length of stay have trended downward as well. Absent population forecasts that can support an upward trend, population pressures alone do not support the need for an expansion of beds. However, there is a pronounced lack of specialized beds for inmates with mental illness, inmates requiring protection, and for 17 year olds who must be housed separately from those 18 and over under the recent Federal Prison Rape Elimination Act. The current booking and release area is problematic as its physical space limitations and insufficient equipment resources delay law enforcement officers from returning to patrol in a

timely manner. Additionally, it has inadequate waiting areas for inmates awaiting delayed releases. And there is a pronounced lack of program space in the ASGDC to support reentry services and programs for inmates.

6. **The Study revealed several areas of obvious staffing deficiencies and also inherent problems with the organizational structure that interfere with effective supervision of inmates and management of the facility.** While the focus of this Study was not to perform a formal staffing analysis, nevertheless, our work did reveal a need for additional staff in several key inmate supervision and management areas. These include detention officers to assist direct supervision officers within zones of the facility, as well as additional staff for juvenile detention social services/counseling, inmate classification, inmate grievance system, policies and procedures, and kitchen security. The current ASGDC organizational structure and distribution of responsibilities does not allow for top management to spend sufficient time inside the Detention Center, for the purpose of observing operations and interacting with and supporting line staff and supervisors.

7. **The ASGDC has shown a significant commitment to implementing direct supervision principles as the best practices approach to inmate behavior management, although the optimal level of positive staff-inmate interactions has not been achieved.** ASGDC has established a broad spectrum of administrative directives as the formal system of accountability; and it comprises all policies, procedures, post orders, and rules and regulations that articulate parameters for the facility's operations. Inadequacies and inconsistencies in administrative directives serve to make inmate supervision difficult. The training for new detention officers reflects an emphasis on topics such as use of force, self-defense tactics, restraining devices and weapons qualifications, while only nominal attention is given to topics such as direct supervision, inmate behavior management, and effective communication skills. And staff training does not sufficiently address the skills needed to manage inmates with mental illness. There are opportunities available to enhance safety and security and improve inmate supervision.

8. **While the percentage of detention officer vacancies has dropped significantly since the time of the 2008 Audit, the ASGDC continues to operate with a very high 13% vacancy rate.** The high vacancy rate is attributable to a variety of factors including low pay and recruitment inadequacies. Excessive vacancies result in mandatory overtime, stressed officers, and inconsistent post assignments, which hamper effective supervision of inmates. Despite the ongoing problem of vacancies, the ASGDC has not implemented several recommendations outlined in the 2008 Audit related to recruitment and retention, including increasing staff assigned to recruitment, redesign of the job application (currently 22 pages long), and enhancing the ASGDC website. Compounding the problem is the issue of comparatively low pay for ASGDC officers, which has been an ongoing recruitment obstacle, has negatively

impacted staff morale and retention, and has, reportedly, caused some good employees to avoid promotions to supervisory positions because the supervisory pay does not exceed that which they can make in a line position with overtime.

9. **With the vast majority of ASGDC inmates eventually returning to the community—many far sooner than later—the ASGDC does not currently maintain a robust, highly organized reentry program and continuum of services.** Regardless of whether inmates are detained and quickly released or remain weeks or months, there is a need to provide some level of reentry services before they are released to the community. The ASGDC currently is able to provide only minimal in-jail programs for inmates to prepare them for a constructive return to the community and offers only limited services to link inmates being released with housing, employment, and health care resources (including Medicaid, substance abuse treatment or social security) upon their release. Current reentry services are not tailored to inmates' specific risks and needs.

C. Key Recommendations

1. ASGDC and County Administration should evaluate the recommendations in this Study and develop a plan to implement those that are deemed highest priority or can be achieved most expeditiously.
2. A major overhaul or outright replacement of JMS is required and should be made a high priority.
3. Complete the current compensation study and raise pay at line and supervisory levels, including creating incentives for good employees to seek promotional opportunities.
4. Review current classification needs and housing options to remove inmates from the SHU who do not require high security housing and management.
5. Plan a facility expansion to include specially designed beds for inmates with acute mental illness, those requiring protection, and 17 year olds and other PREA protected classifications, and address deficiencies in space for booking and release, inmate reentry programs and official visitation.
6. Implement all 2008 Audit and current Study recommendations relative to staff recruitment.
7. Undertake a formal staffing analysis to determine actual staff needs in both security and management categories, including positions identified in this Study.
8. Increase training for all staff relative to managing inmates with serious mental illness.
9. Seek federal funding or otherwise provide financial support to implement comprehensive reentry services and community transition for inmates being released. This should include ASGDC working with the Department of Health and Human Services (DHHS) to sign up inmates deemed by DHHS to be eligible for Medicaid and other services (such as social security disability, veterans' benefits) before their release to the community.
10. Conduct a review of all administrative directives and make revisions as

necessary to enhance direct supervision policy and practice, and remove inconsistencies between policies, post orders and rules and regulations.

I. INTRODUCTION

I. INTRODUCTION

A. Background

In October 2013 the Richland County Board of County Commissioners, through the County Administrator's Office issued a scope of work and an invitation for criminal justice consulting firms, with specific expertise in preparation of jail management studies and audits, to submit proposals to prepare an Operational/ Management study of the Alvin S. Glenn Detention Center (herein after referred to as "ASGDC or Detention Center") in Columbia, South Carolina.

The County's Scope of Work called for the following tasks to be completed:

1. Initiate Project
2. Interview Staff/Administer Organizational Climate Survey
3. Review Information Technology/Automation
4. Review Current Operations and Work Processes
5. Conduct Observations
6. Meet with Criminal Justice System Officials, Review Inmate Population Management, and Need for Expansion Based on Classification Needs; the Prison Rape Elimination Act (PREA); and Medical Needs
7. Review Organizational Structure and Staffing
8. Conduct Progress Meetings, Prepare Draft and Final Reports

In November 2013, the County retained the services of Pulitzer/Bogard & Associates, LLC (P/BA) to perform the Study of the Detention Center. P/BA, a New York based consulting firm, had previously conducted numerous audits and operations reviews of large jails throughout the country. And all of P/BA's personnel have decades of public sector hands-on jail management and consulting experience.

B. 2008 Audit

In 2008, the County contracted with Hammett Associates to prepare a Performance Audit of the Detention Center. The 2008 Audit addressed numerous aspects of the operation of the Detention Center and provided 65 observations and recommendations to enhance the efficiency and effectiveness of the facility. While the 2008 Audit was far reaching and comprehensive, significant focus was directed at the acute staffing shortage that was being experienced at that time. With 25-30% of all positions vacant, the Audit paid particular attention to vacancy reduction strategies issues such as improved recruitment and retention, training and work environment.

The 2008 Audit was used as background information for the current study, and many of the findings and recommendations that were provided to the County five years ago are still very relevant. Several of those issues are discussed and updated in this current report. That said, there are several different circumstances at play now that differentiate this study from the previous one, most notably the fact that while there continue to be staff vacancies, the numbers are not nearly as substantial as they were previously.

A second factor that is at play in this Study, but which was not a factor previously, is the impact on the organization as a result of certain highly publicized incidents that have received considerable public and legal scrutiny. Most notable among these was a vicious assault on a mentally ill inmate by a detention officer that occurred in February 2013. This incident, for which one officer was recently found guilty of Federal Civil Rights violations and six others were terminated for not having come forward to report the incident, has cast a negative light on the Detention Center and its staff.

C. Methodology

1. P/BA Team

P/BA's work on this assignment was undertaken by a team of five corrections professionals, all of whom possess both substantial first-hand experience working in jail systems as well as decades of corrections consulting practice. The team members and their respective primary assignments on this project were as follows:

- David Bogard, MPA, JD- (Project Principal-in-charge); PREA; internal investigations; inmate grievance system, management systems; juvenile detention,
- Karen Albert, MA- Population management; criminal justice system stakeholders; classification; programs
- Cheryl Gallant, MPA- Staffing; training; recruitment and retention; information technology; inmate labor
- Michael Gatling, MA- Security management; policies and procedures
- Judith Regina-Whiteley, RN, MS- Health Care; staff climate on-line survey

At the outset, a key decision was made to designate the facility director, Mr. Ronaldo Myers, as the primary contact and liaison at the Detention Center. P/BA was informed that all formal document requests and meeting schedules would be facilitated by Mr. Myer's office. While Assistant County Administrator Sparty Hammett initiated the Study, Assistant County Administrator Warren Harley served as the primary contact for the contract for the County Administrator's Office.

2. Data Collection and On-Site Methodology

Work began in December 2013, with an extensive request from P/BA for documents and data from the jail. Despite a relatively tight schedule for production of these items, the Detention Center staff provided P/BA with the majority of the requested items by the requested deadline and the remainder upon our visit to the facility. In addition, a lengthy proposed schedule of internal (Detention Center) and external (criminal justice stakeholders) interviews and facility tours was submitted to Mr. Myers and arrangements were made accordingly as requested.

After a brief period of data and document review and analysis, field work commenced in December 2013 when the P/BA team was in Columbia for three days. During that first

visit we initially met with the Project Advisory Group,[1] which shared with us their perspectives on the Study before we embarked on the myriad interviews and record reviews. A subsequent on-site visit of four days occurred in early February 2014. Field visits entailed extensive interviews (detailed below), tours of the jail facility, observations of staff and inmate activities, and other activities such as the review of selected use of force incident reports, review of medical and mental health records and review of other kinds of routine documentation maintained by the jail.

In the course of these visits, we conducted numerous interviews with key officials and stakeholders included representatives of: the Richland County Sheriff, Public Defender, County Solicitor, County Bond Court, Fifth Judicial Circuit Court, County Solicitor's Office, City of Columbia Police, State Highway Patrol, South Carolina Department of Corrections, University of South Carolina and others.

We had two lengthy one-on-one meetings with Detention Center Director Myers and one with Assistant Director Harrell. We also met with the heads of all ASGDC divisions and sections. Approximately 100 line staff were also interviewed informally in the course of our tours of the facility, plus informal or formal interviews with 13 sergeants, 10 lieutenants, 3 captains and multiple other supervisors. We also interviewed several representatives of the jail's contract health care provider (Correct Care Solutions).

Consistent with our practices and the contractual requirement, we informally interviewed more than 300 inmates in the course of our walk-throughs of the jail. While many of these were one-on-one conversations, others were conducted in small groups outside the hearing of the unit officer in order to encourage candor without fear of repercussion.

Another key aspect of our methodology included the administration of surveys to current employees. More detailed information about the survey design and the process we used to collect survey data is included in the discussion of our findings from those survey forms. 164 staff responded to the on-line survey, a response of nearly 50%.

Prior to the submission of a Draft Report, on February 7, P/BA presented to the Advisory Group a comprehensive oral briefing of the major findings and recommendations developed to date. This oral briefing was fast-tracked in advance of the issuance of the written report so that the group would have an overview of the key issues and the magnitude of recommendations that were to be included in this report.

A Draft Report was submitted to the Project Advisory Group, through Assistant County Administrator Warren Harley, on March 18; comments were returned to us via Mr. Harley on April 2. ASGDC Director Myers expressed some disagreement with a few of the findings and/or recommendations set forth in the Draft Report and these were

[1] This working group was comprised of the following members: Assistant County Administrator Warren Harley; Assistant County Administrator Sparty Hammett; ASGDC Director Ronaldo Myers; Deputy Chief Sheriff Stephen Birnie; Assistant Solicitor William Bilton; Chief Richland County Public Defender E. Fielding Pringle,

considered, as this Final Report was prepared.

3. Comments on Interview and Survey Protocol

A few notes about our interviewing practices warrant mention. Our practice is to avoid the use of names in this report wherever possible, although where data or documents were provided to us by a particular Detention Center official, we may cite them as the source. We offered this as a means to make people feel more comfortable speaking with us. With very few exceptions, staff of the Detention Center did not appear reticent to speak with us, even as they discussed issues that were sometimes controversial.

When issues were raised during the course of interviews that served as a cause for concern, much effort was made to verify the information to ensure that we were not basing any conclusions on the word of one individual. Validation came in the form of our receiving the same response from multiple individuals or our finding of documentary evidence to support the claim. Where validation was not obtained, the allegation was not incorporated into the report.

A number of employees presented us with grievances concerning their employment by the Detention Center and, as would be expected, many inmates also had individual complaints surrounding such issues as inconsistencies between shifts, unwritten rules, food quality and quantity, temperatures, high canteen prices, and others. Our role was not to serve as investigators or ombudsmen, however, so while we listened to these complaints and took them into consideration in our analysis, they were not individually investigated. However, we considered whether these complaints were generally indicative of trends and patterns that could shed light on the operations of the jail and lead to recommendations for improvements in operations.

The County Administrator's Office provided the Study Team with a limited amount of correspondence from inmates and, in one case, the mother of an inmate, expressing serious concerns about aspects of the Detention Center. While we did review the individual concerns in some depth, the results of those inquiries were not passed on to the individuals who authored the letters but were, instead, incorporated in findings and recommendations set forth throughout this Study.

D. ASGDC Cooperation

The Study Team received total cooperation from ASGDC staff during this effort. Personnel responded to data and document requests in a timely manner and submitted to interviews willingly and, in many cases, enthusiastically. The Study Team did not perceive that anything was being concealed, or held back.

Moreover, staff at all levels of the organization, including the director and assistant director, welcomed the scrutiny of an outside entity as a way to learn and improve and we frequently were asked how other jails do a certain function. The Study Team also encountered examples of staff taking it upon themselves to modify and improve practices based solely on questions or comments we made during our initial site visit.

Throughout the process of undertaking this Study, we have been uniformly impressed with the commitment and desire on the part of staff to improve the operations and working conditions in the Detention Center. While there is no shortage of complaints on the part of staff, as we heard in person and via the results of the on-line employee survey, there is at the same time a general attitude of striving for improvement rather than seeking to tear things down. This conclusion is supported by the very high number of responses on the employee survey, and by the generally helpful comments and recommendations provided in the open narrative component of the survey.

E. Organization of this Report

This Introduction is Chapter I of the Study. It serves as an overview and provides background about this project and the methodology we used.

Chapter II is the Operations Review and Assessment. This chapter is organized around five major areas of inquiry including: Security and Inmate Management; Inmate Health Care; Reentry Preparation and Recidivism Reduction; Professional Operations; and, Employee Morale.

Chapter III addresses Staffing. This chapter addresses Recruitment and Retention; Promotions; Use of Overtime; and, Staff Deployment.

Chapter IV addresses Population Management of the Jail. It includes: Population trends; Impact of Classification on bed needs; Criminal Justice System Coordination; and, the Need for Jail Expansion.

Appendices to the report include:

A. List of interview subjects
B. Data and Document request

F. Study Context

Readers of this Study should be aware of three important caveats. First, while this Study includes over 100 findings and 200-plus recommendations, the sheer quantity of these should not suggest that the ASGDC is not a professional organization staffed by a large number of very dedicated and committed staff. While a substantial number of our critical findings are reflective of challenges the Department is confronting, others highlight the positives that exist, while others simply point out opportunities for improvement.

Second, not all findings are of equal value or concern and it will require a considerable effort for the ASGDC management and staff to evaluate them and then digest, refute and/or embrace the recommendations. Those recommendations that are embraced should be prioritized in order to not overwhelm staff and to assure a methodical and appropriate process for allocating resources and implementing change.

Third, despite a few highly publicized negative incidents that have occurred in the

ASGDC or involved ASGDC staff, the Study Team believes that the actions of a few should not tarnish the good work done by the vast majority of staff in this organization. ASGDC employees work in a difficult field and under difficult circumstances and conditions. On a daily basis they have to manage an inmate population that includes many inmates with mental illness, others who are violent, and others who are vulnerable, scared or in need of assistance. Through all of these challenges, they are expected to maintain high degrees of professionalism, work significant mandatory overtime, and get to work on time. And while there are, of course, exceptions, for the most part, this is what they do.[2]

The leadership and supervisory staff of ASGDC are committed to improvement and have articulated and demonstrated a willingness to address the negative incidents that occurred, and initiate proactive and accountable measures to deter and minimize the risks of such incidents in the future.

[2] One anecdote which is perhaps emblematic of the positive attitude of staff and commitment to the organization is that we were informed that in the midst of a sudden and unusual snow and ice storm the week of February 27, of three shifts required to work during the storm's duration only two employees did not report to work.

II. OPERATIONS REVIEW AND ASSESSMENT

II. OPERATIONS REVIEW AND ASSESSMENT

A. Security Management

A.1. Inmate Supervision

Finding 1: Inadequacies and inconsistencies in administrative directives serve to make inmate supervision more difficult.

Discussion: The parameters and expectations for inmate supervision are stated or implied in the Detention Center's policies and procedures manual(s), post orders, and rules and regulations and other administrative directives. These administrative directives are predicated on applicable legal requirements and professional standards concerning direct and indirect supervision of inmates. As constructed, current administrative directives contain and articulate some inmate supervision performance requirements and expectations that institutionalize errors, contradictions and inconsistencies enough to dilute their value and efficacy. Staff struggles to set limits and define boundaries because of these inherent flaws. Inmates are confused about certain expectations when limits and boundaries are not clearly established and implemented into consistent practice — which negatively affects perceptions about inmate supervision, treatment, fairness and accountability for compliance with rules and regulations.

Recommendation 1: Consider a plan to carefully and comprehensively review and address inadequacies in administrative directives that pertain to inmate supervision, particularly those involving rights and privileges; rules and sanctions; staff empowerment; control; and accountability.

Finding 2: Present inmate supervision practices have not achieved the desired positive staff-inmate interactions.

Discussion: Direct supervision principles, Minimum Standards, professional standards and administrative directives promote and establish expectations for ideal staff-inmate interactions, which are cornerstones for effective inmate supervision. Staff-inmate interactions are clearly influenced by line staff empowerment, authority, control, accountability, and their supervision. Yet, they are also influenced by the type of inmate supervision that is imposed - direct, indirect or some combination thereof. Staff and inmate perceptions and conduct, inmate classification, and programs and services based on special needs affect conditions of confinement.

Our documents review, interviews with inmates and staff, and observations confirm that staff-inmate interactions are strained and that an ongoing power struggle has emerged in some housing units for at least three alleged reasons. First, staff assert that inconsistencies exist among shifts and between individual officers, including but not limited to lax and/or strict application and enforcement of rules violations and sanctions, which purportedly contribute to myriad tensions involving staff-inmate interactions. Second, the established and potentially evolving gang presence within the Detention

Center strains staff-inmate interactions via disruptive activities by inmates that are gang-involved. Third, inmates report that staff inconsistencies in housing unit operations between shifts and individual staff impact respectful interpersonal communications and the application and enforcement of rules and sanctions. Inmates also allege that these inconsistencies by staff exacerbate stressful conditions.

Recommendation 1: Consider mechanisms to offer structured opportunities for housing unit officers to interact, discuss supervision issues and unit rules, and work to promote greater consistency in supervision among shifts.

Recommendation 2: Consider a plan to increase staff training on interpersonal communication, staff conduct, officer safety, and rule violations and sanctions; and continue to reinforce these expectations during roll call and supervisory meetings.

Recommendation 3: Continue to ensure the Inmate Guidebook and unit bulletin board materials are free of errors, deficiencies and inconsistencies, particularly where rule violations and sanctions, and need-to-know information are concerned.

Recommendation 4: Conduct adequate quality reviews pertaining to staff-inmate interaction practices using measurable and relevant performance indicators.

Finding 3: There are opportunities available to enhance safety and security and improve inmate supervision.

Discussion: There are artificial and actual barriers to inmate supervision including, but not limited to: (1) red lines painted around the work stations indicating inmate-restricted areas and discouraging pro-social interpersonal communication; (2) self-contained multi-occupancy pods located within certain housing units that involve direct, indirect and remote supervision; (3) some staff on each shift purposely engage in minimal interactive contact with inmates and only leave their work station to perform required tasks and scheduled activities; (4) there are blind-spots for the remote camera surveillance located in the housing unit dayrooms as a result of design features; (5) inmates cover cell viewports—a practice that is inconsistently disallowed for reasons of privacy and/or officer discretion; (6) some staff have not received specialized training in order to adequately supervise and respond to the needs of inmates who determined to be acutely mentally ill; and (7) fixtures and furnishings in housing pods and cells used by inmates determined to be suicidal are not suicide-resistant and may actually facilitate successful attempts (i.e., bars, door handles, sprinkler heads, hinges, bunk-bed ladders.) These are illustrative of some artificial and physical barriers that can impede inmate supervision and impact operations.

Recommendation 1: Require housing unit staff to engage, interact and respond to more inmate requests and needs while outside the red lines of their work station.

Recommendation 2: Sufficiently monitor inmate supervision practices via staff supervision and Watch Tour and barcode system data; and, consider replacing the current housing unit security journal book with a housing unit shift activity log.

Recommendation 3: Consider a plan to evaluate all housing unit, dayroom, pod, and cell design features that preclude adequate inmate supervision; and determine the feasibility of modifying, removing, replacing or installing fixtures and furnishings that negatively impact safety and security.

A.2. Special Housing Unit Operations

Finding 1: The present practice of housing a wide range of classifications and sub-classifications of male inmates in the Special Housing Unit (SHU) creates substantial challenges for staff to effectively supervise and manage the unit.

Discussion: Based on the most recent data reports the Department prepared and provided to us for analysis, 31 (53%) of the inmates assigned to the SHU were there for reasons of disciplinary detention (i.e., as a result of post-disciplinary hearing sanctions or pre-hearing detention status).[3] However, the SHU unit not only houses inmates who are awaiting hearings or found guilty of disciplinary infractions, but it is also used to house a wide variety of inmates who are not implicated in any such behavior. Inmates for whom the SHU is not appropriate include suicide watch; those requiring special management housing for certain ADA-related physical disabilities and/or other special health needs for medical conditions; those subject to the ASGDC transgender accommodation plan; certain sub-classifications of protective custody; and inmates awaiting a mental health evaluation.[4]

Housing such divergent inmate classifications, with very different needs and behaviors presents an untenable challenge to staff that must constantly be aware of the particular circumstances of each sub-group and each inmate. Housing inmates who require protective custody with those charged with the most serious institutional infractions is precarious for several reasons, not the least of which is because it forces staff to be ever vigilant to ensure necessary separations between the vulnerable and those who might wish to harm them. And housing inmates with mental illness in the same location as those who present behavioral problems exacerbates the already difficult challenges of managing a segregation unit. By way of illustration, the SHU accounts for approximately 50% of all use of force incidents[5] even though the inmate population represents approximately only 5% of the total population. Co-location of all these different classifications also presents significant challenges to ensure that inmates in each group are treated according to the rights, privileges and needs associated with their respective classifications.

[3] The data reports on the SHU's population that are referenced by The Study Team were provided by the Operations Captain on February 5, 2014. The total number of inmates assigned to the SHU for that date was 58 for the 56-celled unit. These data reports did not distinguish pre- and post-disciplinary hearing detention. They also did not include the specific date for those named inmates assigned to the SHU for disciplinary confinement to be released from that status upon completion of their sanction(s). They also did not include a tentative disciplinary hearing date for that any inmate assigned to the SHU on pre-hearing detention status.
[4] Inmates designated as potential or validated gang leaders are also placed in the SHU.
[5] Source: 2013 Use of Force statistical report prepared by Professional Standards Unit.

Recommendation 1: The ASGDC should examine the existing housing plan and take all necessary measures to restrict SHU housing to inmates who have been found guilty of serious institutional infractions, those awaiting disciplinary hearings, or those who have proven to be high security and chronic behavioral problems not related to mental health issues.

Recommendation 2: Consider a plan for physical plant repurposing, renovations and/or expansion to adequately resolve housing issues for the specific-categories of segregated inmates not suitable for housing assignments in the SHU's living space.

Finding 2: Opportunities exist to afford inmates constructive, meaningful and sufficient opportunities to engage in programs, services, 'qualified rights' and privileges for which they are eligible that presently do not exist due to the 'one size fits all,' extremely restrictive conditions of confinement in the SHU.

Discussion: As discussed in Finding 1 above, the SHU is a repository for a wide array of inmates classified as non-disciplinary administrative segregation, including suicide watch, mental health, transgender inmates, etc. Staff interviews, review of administrative directives and observation of practice validate that all inmates assigned to the SHU are treated as if they are definitively assaultive or violent. But, because staff cannot reasonably address the unique needs of each sub-classification housed in the SHU, the unit is operated in a uniform manner, treating all inmates in an ultra-restrictive manner. In some instances, they are subjected to treatment that can contravene legal requirements, professional standards, and the Department's own administrative directives.

As it is currently operated, the SHU is a way station for most of these non-punitive sub-classifications. Their housing placement in the SHU can begin at intake and continue until they are discharged from the Detention Center. Inmates who were identified in management reports and administrative directives as 'medical transit', 'medical hold', 'awaiting mental health evaluation', protective custody, 'suicide watch', and the diagnosed acute mentally ill can experience indeterminate waiting periods when assigned to the SHU.[6]

The Study Team verified the environmental conditions that each inmate housed in the SHU, including those on non-punitive administrative segregation, may experience, which include:

- 23-hour per day lockdown in their cell (except for authorized movement for activities outside the cell that do not occur during the 1 hour of daily out-of-cell time);[7]

[6] Section II.B. Inmate Health Care of The Study provides specific findings, descriptive analysis and summaries concerning the inmates assigned to the SHU for mental health- and medical- related reasons.
[7] Policy 2A-63 states that "Inmates in special management units receive a minimum of one (1) hour of exercise per day outside their cells (rooms), five (5) days per week, unless security and safety considerations dictate otherwise." The policy seemingly provides discretion for staff to not permit inmates in the SHU at least 1 hour of out-of-cell time on a daily basis. Per SHU Post Order (#59): The one hour

- consuming all meals inside their cell using Styrofoam trays and harm-resistant eating utensils;
- no freedom of movement outside the cell; including, cannot move outside the cell for any reason unless wearing mechanical restraints (handcuffs and leg irons);
- be escorted by two ASGDC staff whenever moved outside of the cell, regardless of custody classification, special needs and/or risks;
- only permitted to shower every other day during the 1-hour of out-of cell time and must be locked inside a shower when bathing;[8]
- remain in mechanical restraints during all out-of-cell recreation (including outdoor and indoor recreation activities that can occur during the one hour of out-of cell-time—use of telephone, visitation, dayroom, ordering hygiene items from canteen, and receiving hair care services);[9]
- not allowed to participate in programs and services inside the SHU with more than two other inmates; not allowed to interact with or participate with any other compatible inmates outside the SHU;
- indirect supervision by housing unit staff inadequately trained to respond appropriately to the needs of acutely mentally ill inmates;
- behaviors related to the mental health issues are routinely addressed with the imposition of disciplinary measures;
- are not allowed access to a razor except as needed for a court appearance;
- totally dependent on staff to maintain basic sanitation, hygiene and care responsibilities, and for access to ASGDC-defined qualified rights and allowable privileges within or outside of their cells on a daily basis; and
- if placed on suicide watch, cannot have access to read or keep personal mail; cannot retain any personal property while on suicide watch in the SHU;[10]
- sealed and unopened food and beverages purchased at commissary belonging to all inmates, including those on Suicide Watch are destroyed instead of being stored with other personal property.

Recommendation 1: Develop and implement a plan that ensures that the specifically identified categories of inmates on non-punitive administrative segregation are provided conditions of confinement, and opportunities for 'qualified rights', privileges, programs and services that approximate those of inmates in general population.

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of daily out-of-cell-time is forfeited if the inmate does not wish to participate in the out of cell time when it is offered by the SHU officers and that time is not rescheduled;

[8] Inmates in general population and other special management units have opportunities to shower daily and are not locked inside the showers.

[9] SHU Post Order (#41) states:"… At a minimum, offenders are permitted one (1) ten (10) minute telephone call per week (presently on Fridays); Offenders are permitted to receive only hygiene canteen items (soap, toothpaste and toothbrush) from the canteen once per week (food and snack type items are not permitted). "

[10] Per the post order for Suicide Watch Officer (page 5 #16): "Inmates on Suicide Watch are not permitted recreation, television, telephone or canteen privileges." Per post order Suicide Watch Officer (page 5 #14) …If instructed by Medical/Mental Health Authority the inmate may be allowed to take a shower…." Per Policy 5B-05 IV.B.10: "Offenders on Suicide Watch are not permitted to have access to mail or publications…."

Recommendation 2: Review, revise and address institutionalized errors in applicable administrative directives that concerning the specified sub-classifications of inmates on non-punitive administrative segregation in the SHU to comply with legal requirements, PREA-national standards, Minimum Standards, and ACA standards.

Recommendation 3: Establish a multidisciplinary team of appropriately qualified professionals and ASGDC personnel to consult and provide oversight for improving the conditions of confinement inmates in the SHU and changing the cultural norms of the SHU.

Finding 3: The SHU should be referred to in a consistent manner (nomenclature, acronym) in order to minimize confusion regarding SHU-specific operational responsibilities and accountabilities, and rules and regulations.

Discussion: Administrative directives currently refer to this unit as the "special housing unit," or the "security housing unit," or the "segregation housing unit," or by other names. The plethora of titles given to this unit may cause confusion regarding the applicability of individual administrative directives, and its meaning as a data variable within the JMS.

Recommendation 1: Develop and implement a plan that adequately addresses the nomenclature, synonymous terms/phrases, definitions, acronyms and inconsistent language regarding the SHU for all applicable administrative directives, corresponding forms, appendices and JMS content.

Finding 4: The principles of direct supervision, under which the Detention Center operates, do not support the use of a cool down sanction such as that in use at the ASGDC.

Discussion*:* One of the critical principles of direct supervision is "justice and fairness." That principle is the cornerstone for many other direct supervision principles related to staff's ability to manage inmate behavior throughout the Detention Center. The Study Team verified from interviews with staff at all levels of the ASGDC, inmates in numerous housing units (including the SHU), and upon review of applicable administrative directives that it is a common permissible practice for the SHU to be used for temporary segregation of inmates--for what is known as a 'cool down' sanction. This particular sanction results from one or more violations of the Detention Center's written and/or unwritten rules and regulations by an inmate. It is not considered pre-hearing detention or disciplinary confinement; but it is an ambiguous punitive measure that is frequently used and has a host of negative consequences for the affected inmate. The watch commander is the only designated authority for each shift that is permitted to place an inmate on cool down sanction in the SHU.

The cool down sanction in the SHU has a number of characteristics. An affected Inmate will either be locked inside an individual cell or shower stall of the SHU. The period for each cool down sanction cannot exceed 12 continuous hours, regardless of the placement location within the SHU. All of the inmate's personal property is confiscated and all food items are destroyed (regardless of whether the canteen items

are sealed and irrespective of the quantity, cost or worth of these items to the inmate.)[11] The inmate is not permitted to participate in any activities outside the SHU cell or shower where he is confined for the duration of the sanction. The affected inmate is not allowed to retain or be issued any bedding and may encounter difficulty obtaining basic hygiene items.

Recommendation 1: ASGDC should conduct an independent review of the legality, liabilities and appropriateness of the cool down sanction in the Detention Center's SHU as it is currently administered. Determine compliance with South Carolina Minimum Standards and applicable case law on such matters. Determine compliance with ACA standards.

Recommendation 2: An individual policy and procedures should be developed if this cool down sanction is to be maintained. It should adequately address: legal requirements; standards; documentation and reports; prohibitions; medical/mental health protocols; limitations; accountabilities; and any other applicable conditions of confinement issues related to this sanction. It should also address whether a similar sanction is applicable to female inmates and youthful offenders.

Recommendation 3: Revise other applicable administrative directives and forms to ensure they contain accurate, consistent, complete and cross-referenced information concerning the cool down sanction in the SHU, including but not limited to post orders and the Inmate Guidebook.

Recommendation 4: Train staff as needed to ensure compliance with all legal requirements, standards and updated administrative directives on cool down sanctions.

A.3. Booking and Discharge

Finding 1: Major events that result in a high volume of arrests stress the ASGDC's access points for law enforcement and emergency personnel.

Discussion: The Detention Center provides booking and admission services for at least 18 different arresting agencies and authorities. Under normal circumstances, neither the access road nor the vehicle sallyport area is congested. Vehicle congestion that affects the Detention Center access road and the corresponding point of entry/exit occur when there are verifiable peaks in the volume of arrests associated with large planned community activities (e.g., major college sports and social events, county/state fairs, convention center events, city celebrations, concerts, etc.)

The access road serves two-way vehicular traffic. Inbound access road traffic and the paved area for parking directly outside (and inside) the vehicular sallyport are limited. The perimeter officer must search each outbound vehicle using the access road at the secure gated checkpoint, which can be time-intensive depending on the amount of traffic volume. Under normal circumstances, access to the Detention Center via this

[11] As per the ASGDC Inmate Property Confiscation Sheet

gated checkpoint includes use by the personnel in fire department and EMS vehicles, delivery trucks, ASGDC transport vehicles and other authorized County vehicles.

Recommendation 1: Consider devising a plan to create a temporary pre-booking area inside the secure perimeter gate to minimize congestion and delays in the flow of authorized vehicle traffic to and from the Detention Center as a result of a high volume of arrests (e.g., major college sports events and other community activities.)

Recommendation 2: Consider a plan to assemble and stage a temporary pre-booking space (e.g., a tent) on-site in the parking area of large sporting venues to process book-and-release offenders. This could also relieve the heavy vehicular traffic that impedes efficient access to and use of the ASGDC booking area.

Recommendation 3: If adopted, plans for Recommendation 1 or 2 should address all temporary resources (i.e., personnel, equipment, furnishings, fixtures, phones, etc.) needed to perform the pre-booking functions in concert with law enforcement authorities' responsibilities for completing all required paperwork.

Recommendation 4: During high volume periods, assign an additional trained staff member at the secure perimeter gated checkpoint to assist with efficiently conducting adequate searches of all vehicles entering or exiting the facility.

Recommendation 5: Coordinate with law enforcement agencies to establish and maintain quantifiable and accurate data concerning valid improvements in vehicular traffic to determine if there are individual and/or shared efficiencies and cost savings.

Finding 2: The pre-booking workspace intended for law enforcement officials and other officials is inadequate to meet demand.

Discussion: The design features and current technology available inside the pre-booking space are inadequate for the needs of various users, particularly law enforcement personnel and other authorities. The Department has established an orderly and uniform process for all pre-booking activities based on where initial admissions screening criteria (i.e., medical clearance) and commitment document(s) requirements are designated to take place. However, this area/work space is under-resourced in terms of networked computers, appropriate automated and/or manual commitment documents, appropriate and sufficient work space furnishings, sufficient CCTV surveillance of holding cells for arrestees, fax machines and telephones.

The inadequacy of the pre-booking space results in officials from law enforcement and other authorities migrating into the main booking area to complete their commitment documents and other paperwork. Consequently, the booking staff are tasked with performing security/safety checks on arrestees that are placed in holding cells while they are technically still under the custody of the arresting officer and addressing other basic needs of arrestees. During periods of high volume, these diffused responsibilities and practices can negatively implicate the congestion and gravity of incidents that occur in the respective pre-booking and booking areas.

Recommendation 1: Consider developing a comprehensive plan to renovate the pre-booking area, which addresses desired goals and all appropriate needs. This plan should involve input from appropriate law enforcement entities and other authorities.

Recommendation 2: Until and unless Recommendation-1 is approved, funded and implemented, designate specific area(s) in the booking area for law enforcement officials to efficiently complete their commitment paperwork and communications.

Recommendation 3: Ensure the pre-booking area is adequately stocked with appropriate commitment documents for use by law enforcement and other entities.

Recommendation 4: Continue to ensure that appropriate medical personnel reconcile initial medical clearance issues during the pre-booking process.

Recommendation 5: Ensure that adequate security and well-being checks are maintained for arrestees placed in holding cells in the pre-booking area. Consider installing surveillance cameras in each of the pre-booking area holding cells.

Finding 3: The lack of redundant processing workstations has created protracted delays and/or impacts efficiencies related to the booking process.

Discussion: Based on staff interviews and our observation of practice, there are some protracted wait periods and congestion at the point when assigned staff are involved in processing detainees at one critical work station located at the booking counter. Digital photographs, data entry for commitment document(s), and an extensive structured interview of each detainee must occur at this workstation.

Law enforcement officials wait in succession to present their commitment documents for each of their arrestees to the Booking Counter staff at the above-described workstation. The accuracy of the charging information on the commitment documents must be verified prior to the officer leaving the Detention Center; otherwise, delays in processing are created while staff attempts to obtain and verify the essential information by contacting the official by phone or other means after she/he has left. Based on our calculations, we believe there is currently sufficient staff assigned to Booking to perform all tasks and activities if a redundant workstation with technological capabilities of the first were added.

Recommendation 1: Consider establishing an additional computerized work station at the booking counter, as necessary for current staff to complete all redundant processes related to this area of booking operations (e.g., taking digital photos, performing JMS data entry requirements, conducting interviews, queries, etc.)

Recommendation 2: Establish and maintain data pertaining to efficiency and delays in this area of booking processes and use the data to inform future decisions concerning performance, accountability and need for other resources.

Finding 4: ASGDC has attempted to align its policies, procedures and practices with the courts of jurisdiction for detainees and inmates in its custody. Court officials do not issue written and signed court orders until all court proceedings on the daily calendar for a respective court session are completed. This particular chokepoint negatively impacts the final discharge of detainees and/or inmates from the Detention Center.[12]

Discussion: On a national scale, it is not uncommon for judges in certain jurisdictions to sign all release-related paperwork at the end of a court session. 'Batching', as it is commonly referred to, may occur for the convenience, discretion and efficiency of the courts.[13] However, its unintended consequence is that regardless of the time when a defendant's/inmate's case is heard and a decision is rendered, she/he must wait until the judge signs the paperwork for all other cases heard during that particular court session, including (if applicable) conditional release documents. This often entails 30 or more individual hearings and involves more than a six-hour period prior to the bond office receiving the signed release documents to begin processing. Family members and friends of an affected inmate often attend these hearings, are aware of the outcomes, plan and make arrangements for bond, and then must wait for undefined periods for action to be taken on signed court documents that will result in an eventual release.

Recommendation 1: Consider addressing with the chief judge the issue by reengineering the court release process to enhance greater efficiency and minimize delays in final discharge from the Detention Center.

Recommendation 2: Consistently update the ASGDC website to provide appropriate and pertinent information to the public (i.e., family and friends of inmates) concerning the process for release and what to expect (including reasonable delays).

Finding 5: The ASGDC has established a practice of preparing to release inmates in 'batches' of no more than five at a time, irrespective of the type of release or the order in which cases were heard.

Discussion: According to documents reviewed, staff interviewed and observation of practice, no more than five inmates are permitted to be prepared for release at one time (for security and safety reasons.) This practice also applies to inmates whose 'final release' results from "time served", and those being transferred to other facilities or agencies. The checks and balances to avoid an erroneous release are prudent and understandable. However, they can result in additional delays in the final discharge processing for inmates who have completed sentences or have court outcomes directing that they be released forthwith from the ASGDC custody.

[12] Findings 4 and 6 only relate to offender releases/discharges that are deemed ATW (all-the-way). Offender transfers are included in the Finding 5, including the discussion and recommendations.
[13] This practice permits court clerks and others the opportunity to perform required task and activities associated with their function.

We recognize and appreciate that delays resulting from family or friends not being able to post bond for the affected detainee/inmate in a timely manner are not the responsibility of the Department. Notwithstanding that point, families and friends of these inmates should be able to rely on some reasonable time frames for when the detained person will be released since it may affect their own needs to coordinate arrangements for bond payments, child care, leave from work, transportation, etc.

Recommendation 1: Determine whether more than five inmates can be safely released and/or transferred at one time without compromises to the integrity of the Detention Center's discharge processes and security protocols.

Recommendation 2: Prioritize releases based on some system that assures that there is verifiable fairness (e.g., time stamps with signoffs) and more efficiency at various stages and operational functions involved in discharge out-processing.

Recommendation 3: Establish or maintain adequate safeguards for positive I.D., outstanding warrant/detainer checks, victim notification(s), return of property and funds (via debit cards), continuity of care referrals, and other requirements.

Finding 6: ASGDC staff delays transporting some 'detained' persons from the facility to the homeless shelter via its courtesy shuttle. These individuals have been otherwise legally released but remain in custody.

Discussion: Once it is determined that a person who was incarcerated has completed all other ASGDC release procedures but does not have a means of leaving the facility other than on foot, administrative directives require that the person will be transported to a homeless shelter by ASGDC staff via the courtesy shuttle van. In an effort to minimize costs associated with fuel and wear-and-tear on the transport vehicle, the person's final discharge may be delayed by 2-3 hours until there are enough persons needing such transport.

The practice of substantially delaying the final discharge of any person who is otherwise legally released until she/he can arrange for non-ambulatory transportation from the ASGDC is questionable. This rings true even if the articulated reason for doing so is for the expressed safety of the affected person. Based on our research and interviews with ASGDC staff and County officials, we are aware there was a tragic historical reference point behind this practice.

Recommendation 1: Review and reconcile any legal risk management issues involved in delaying and impeding the final discharge of formerly incarcerated persons until they can be transported to the homeless shelter whenever they are not able to arrange for alternative transportation from the facility.

Recommendation 2: If the courtesy shuttle to the homeless shelter is going to continue, increase the number of trips in order to reduce the delay time for persons otherwise legally released. Consider operating these courtesy transport shuttles every 45-60 minutes and update administrative directives to reflect this requirement.

Recommendation 3: The County should make arrangements for released persons to have access to extended bus service and taxi service to and from the facility.

Finding 7: Inadequate inmate supervision practices exist and occur in Hallway 32 of the Detention Center.

Discussion: During our on-site work, we observed persons awaiting courtesy transports and/or rides prior to 'final' discharge from the facility being locked in rooms or holding cells, then left without staff supervision in the Hallway 32. Persons awaiting final discharge (who were previously evaluated and assigned housing consistent with being determined to be suicidal) were placed in a holding cell that is not suicide-resistant and are allowed to possess articles of personal property that could easily be used to facilitate a successful suicide attempt (e.g., belts, ties, shoe laces, other clothing) beyond the purview of staff and supervision protocols. Our review of documentation indicates that there has been at least one suicide attempt from Hallway 32 holding cell.

Recommendation 1: Consider the need for enhanced inmate supervision in Hallway 32 involving detainees who are otherwise administratively discharged, yet are locked in rooms or non-suicide resistant cells awaiting courtesy van transports or rides arranged with family members or friends in order to officially leave the facility.

Recommendation 2: Consider addressing the issues surrounding detaining persons identified as being suicidal in Hallway 32 holding cells that are not suicide-resistant and who are in possession of personal property that can be used to facilitate suicide attempts.

Finding 8: There is no appropriate seating in the one locked holding cell used for women being held in ASGDC custody while awaiting transportation arrangements. This practice occurs following their completion of all other discharge out-processing.

Discussion: Women who have been released by the courts and who have completed all other stages of the Detention Center's discharge process other than securing transportation arrangements are placed in a locked holding cell. The only seating available in this cell is a concrete slab. Men who are released but await transportation are placed in a large and typically unlocked room with plastic chairs.

Based on staff interviews and observation, the holding cell (C) where women awaiting discharge are placed is supposedly subject to supervision by the booking staff responsible for security checks of all holding cells. There are no provisions that ensure that male officers are limited from supervising and performing routine security checks on this particular holding cell. Since bringing this issue to staff's attention, this holding cell has now been designated (with a sign) that it is to be exclusively used for 'discharged' females. However, this sign does not address privacy and supervision issues.

Recommendation 1: Place a suicide resistant mattress or other such cushioned material on the concrete slab or provide equivalent seating for women being released that their male counterparts currently are permitted.

Recommendation 2: Ensure adequate supervision and safety/well-being checks for women placed in the discharge holding cell are conducted by female officers.

Recommendation 3: Adequate supervision for women placed in this holding cell awaiting final discharge should continue to take into account issues such as suicide risk precautions, mental health issues, and other special needs custody issues.[14]

Recommendation 4: Review all appropriate administrative directives to address the need for revisions and updates to this area of operations.

A.4. Classification

Finding 1: The ASGDC utilizes an inmate classification system that is objective and evidence informed but is not updated to reflect the most recent Northpointe instrument, consistent with current inmate classification system and validated for the ASGDC population.

Discussion: The ASGDC deserves praise for implementing a classification system that is generally validated for detention populations. The instrument, developed by Northpointe/Corrections Management, Inc., is research-tested, evidence-informed and predictive classification tool. This model determines an inmate's custody level based on predictive risk factors that correlate with point value. The classification (undated) and reclassification (dated 1996) instruments currently used by staff do not reflect the most current editions available through Northpointe (i.e., classification, 2009; reclassification 2012).

Staff is not aware if the classification instrument has been validated to verify that the assessment scores indeed reflect the classification needs of the ASGDC. An unvalidated classification system can result in arbitrary classifications and housing assignments. Appropriately, 5-10% of the classifications/reclassifications result in an override of the decision tree score reportedly based on the Northpointe recommendation that it enhances the classification system validity.

The lack of an integrated and robust inmate records management system results in reclassifications focused primarily on disciplinary action rather than positive behavior such as program attendance to meet inmate substance abuse, educational and vocational needs.

Moreover, although inmate needs are identified during the classification interview, this information does not inform decision-making. Inmate needs, such as substance abuse

[14] Staff should be aware of similar precautions and needs based on individual characteristics for men placed in holding rooms awaiting transportation for final discharge.

or medical issues, inform best inmate management practices. For example, substance abusers are often more likely to be a higher security risk because of their drug-seeking behavior (e.g., they may be more likely to attempt to introduce contraband into the facility).

Recommendation 1: Update the classification instrument to reflect the most current Northpointe instruments available.

Recommendation 2: Validate the classification instruments and point values currently in use. Consider contracting with a professor at the University to assist with the statistical analysis to verify that the classification scores are consistent with and support ADGDC operations

Recommendation 3: Ensure both positive behavior and disciplinary action are considered in making reclassification, override, and special management risk and need decisions.

Recommendation 4: Implement the recommendations listed under II.D.2, Technology to address the information technology concerns.

Recommendation 5: Implement reentry/case management planning to address inmates' needs as well as risk. The specifics of this recommendation are outlined in II.C.2 Reentry and Alternative Programs.

Finding 2: The classification policy and procedures meet both the South Carolina Minimum Standards for Local Detention Facilities and the American Correctional Association Performance-Based Standards for Adult Local Detention Facilities, but do not provide direction to staff to fully implement the classification system.

Discussion: The current policies and procedures are in compliance with state and national standards. The Classification Post Orders better describe how to implement the classification system. In fact, the current policy and procedures governing classification (ASGDC Policy 2A-30) makes no mention of the objective classification instrument, and in large measure leaves the decision making to interpretation (e.g. the officer conducting the book-in makes the initial housing decision).

The Classification Post Order is comprehensive and includes the goals, classification staff responsibilities, and training requirements, and documents that classification staff are to maintain and the "classification plan." It appears that all information known regarding classification is incorporated in the Post Order so much so that there is some redundancy (e.g., duties, and daily duties) that may lead to staff confusion as to which section should guide their daily activities.

Recommendation 1: Outline the classification procedural steps in the policies and procedures, and include references to documents/instruments used at each point of the classification process.

Finding 3: An objective classification manual specific to the ASGDC that provides detailed instructions on how to complete the classification and reclassification process would promote accurate and consistent inmate classifications.

Discussion: The document referenced as the "classification plan" includes some of the components of the Classification Post Order but is not appropriately directive and informative as to how inmates are to be classified. For example, the Northpointe system includes a document that describes the decision splits for the classification decision tree instrument. This document is not included in the "classification plan" or the Classification Post Order.

The Classification Post Order is the more comprehensive document, but it also includes information that is not germane to a typical post order (e.g., fire extinguisher use, duties and responsibilities of detention officers – including operation of interlocked doors and inmate rules relating to identification cards).

Recommendation 1: Draft a classification manual/plan that focuses specifically on the purpose of the classification system and the procedural steps for when and how to complete the classification instruments.

Finding 4: The classification and housing assignment process is cumbersome and bifurcated.

Discussion: Classification decisions about custody levels and housing locations are not necessarily followed by accurate and appropriate cell and bunk assignments because there are limited criteria for such decisions and unit officers making housing assignment decisions do not receive adequate training and do not have access to the same data used by classification staff. This can compromise security and safety in the housing units.

The officer who completes the book-in process determines initial housing placement. This decision considers: gender, behavior, work release status, and special risk factors as noted in policy 2A-30 Security Classification Process. The procedure does not specify the appropriate housing assignment for these populations, or even mention that barring any special considerations, inmates will be housed in classification/orientation housing (Yankee or Papa). Inmates who require alternative housing are almost exclusively placed in the Special Housing Unit, regardless of their specific need (e.g., suicide ideation, recalcitrant behavior, etc.).

Classification staff completes the decision tree prior to the inmate interview. Once the interview is completed, the classification staff then notes any special concerns that may prompt an override of the recommended custody level or information that may be entered in the inmate records management "alert" system. This alert system is not

regularly updated, resulting in medical or other notes remaining beyond the need.[15]

Housing unit officers are tasked with making cell assignments without any criteria for doing so or appropriate training. Despite a lack of detailed information about the inmate, this practice creates the potential for risky mistakes in housing and bed space assignments that may not consider compatibility with cell-mates.

Recommendation 1: Criteria should be developed to assist staff that perform book-ins to make initial classification decisions (i.e., a determination of whether inmates should be housed in classification/orientation housing or alternative housing). Staff should receive specific training to make these placements, and supervisory staff should approve such placements in advance.

Recommendation 2: Enhance the inmate records management system to allow for management reporting of inmates due classification as well as notification systems that would inform classification/orientation housing of the anticipated classification interviews.

Recommendation 3: Terminate or significantly restrict the authority of housing officers to make cell assignments. Classification staff should make these assignments; if this is not always feasible, criteria should be established, and training provided to housing staff to make these assignments. In such cases, classification staff should be advised directly.

Finding 5: There is insufficient staffing to meet the intent of the classification system.

Discussion: Due in part to the lack of an integrated inmate records management system, classification officers must perform manual and time-consuming duties, including:

- Retrieve the headcount sheet from operations (identifying available housing unit space);
- Review computer records to compile a list of assessments to be completed in Yankee and Papa units;
- Hand carry the assessment lists to the respective housing units and later conduct the classification interview on the unit;
- Issue/replace inmate identification cards;
- Generate a special housing unit file when inmates are placed in this housing;
- Conduct reclassifications every 90 days;
- Screen for volunteer admittance into the facility.

These processes are unduly time consuming and are not an effective use of classification staff time.

[15] In one case an inmate requiring an ice pack for two weeks carried the alert indication for more than a year.

Along with classification and ancillary duties, classification staff is responsible for assisting with preliminary hearing court once a week and county bond court as needed. Although the court responsibility is shared by various ASGDC divisions, it takes away time for classification staff to proactively perform case management.

Recommendation 1: Conduct a job task analysis to determine the number of staff required to fully perform all of the functions assigned to classification staff. If necessary, reassign some of the tasks to other, more appropriate functions (e.g., court security).

A.5. Juvenile detention

Finding 1: The County's juvenile Detention Center is operated by the ASGDC consistent with South Carolina Minimum Standards and pursuant to a set of professional policies and procedures.

Discussion: ASGDC operates the County's juvenile Detention Center, which has a capacity of 24 beds and typically houses some 14-15 youth, both boys and girls, who are under 17 years old.[16] All youth are charged with adult offenses, except for the very occasional status offender, who may only be held pursuant to a court order. Staff assigned to the center have been certified to work with juveniles and are permanently assigned there, although they are called upon to work in the Detention Center for overtime.

The Richland County School District provides two teachers and juveniles typically attend school for six hours a day, including during summer break. Aside from education, programming is extremely limited, with only bible study a few times a week and an occasional guest speaker. A program designed to steer youth away from gangs was discontinued. Juveniles are afforded outdoor recreation time daily and can receive contact visits from parents, grandparents and legal guardians.

Although the juvenile Detention Center is inspected by the Department of Corrections annually, apparently reports of these reviews have not been made available to the Detention Center for several years.[17]

Recommendation 1: It is recommended that a juvenile advisory committee be named with both oversight responsibilities and a charge to advise the ASGDC management as to opportunities to reduce idleness and enhance programmatic opportunities for juveniles.

[16] SC Code of Laws § 63-19-20 defines a "juvenile" as a person less than seventeen (17) years of age
[17] In accordance with South Carolina Code of Laws, Section 24-9-20, staff from the Jail and Prison Inspection Division of the Department of Corrections will conduct an annual inspection of each local juvenile detention facility.

Finding 2: Staffing levels of the juvenile Detention Center meets or exceeds national best practices, but is exclusively focused on custody and security.

Discussion: National best practices and PREA Standards[18] typically require that there be one direct care staff for 8 juveniles during waking hours, and one per 16 during sleeping times. South Carolina Minimum Standards for Local Juvenile Detention facilities does not proscribe a ratio, although the definitions section of the Standards appears to require that direct supervision living units have a 1:12 ratio during waking hours and up to 1:24 when the rooms are secured.[19] The Study team was informed that night shift staffing reflects a ratio of one detention officer per eight juveniles, which would exceed national and state standards.

ASGDC policies 5B-01 and 6A-01describe a robust social service, counseling and treatment program to be available for this population. However, there are no positions dedicated to provide these services. While assigned security staff appears to be sensitive to the needs of juveniles, they are not experts in juvenile counseling. Given the importance of intervening with youth before they graduate to adult status and more extreme behavior, having a multi-disciplinary staff providing a range of necessary social and treatment services is critically important for juvenile Detention Centers.

Recommendation 1: Consideration should be given to a small reduction in night-time security staffing with the personnel funds used to provide a social worker and counselor positions for the juvenile population. This position would run programs relative to gang membership, assist juveniles with behavior issues and concerns, provide liaison services to family services and community services, and provide individual counseling.

Finding 3: Mental health services that are provided by CCS/Columbia Area Mental Health Center to the Juvenile Detention Center are limited to intake screening, suicide watch reviews, and medication appointments.

Discussion: The intake screening instrument used by CCS is the same as the one used for adults at ASGDC. Best practices[20] indicate that since 60 to 70% of juveniles in the justice system have diagnosable mental health issues (as opposed to 20% of the entire population), a validated mental health screening tool or procedure developed specifically for juveniles should be used at intake in the juvenile Detention Center. Based on the outcome of the juvenile specific screening, appropriate comprehensive mental health services should be provided.

[18] See PREA Standard §115.313.
[19] See definition "w" on page 8 of Minimum Standards.
[20] Skowyra, K. R.; Cocozza, J. J. 2006. Blueprint for Change: A Comprehensive Model for the Identification and Treatment of Youth with Mental Health Needs in Contact with the Juvenile Justice System . Delmar, NY: The National Center for Mental Health and Juvenile Justice and Policy Research Associates, Inc.

Recommendation 1: Utilize resources available through the Models for Change: Systems Reform for Juvenile Justice to explore options for the identification and appropriate treatment of juveniles with mental health issues who are in detention.[21]

B. Inmate Health Care[22]

B.1. Mental Health Care

Finding 1: There is no dedicated mental health housing for those inmates with acute care needs. Therefore, inmates with acute and subacute symptoms of mental illness are housed in the Special Housing Unit (SHU).

Discussion: A major change in the inmate population over the last twenty years is that they are now much more likely to be mentally ill. County correctional populations are also affected by this change, with some reports indicating that mental illness rates in county jails have increased by over 50% in the last five years.[23] [24]

As is discussed in Section II.A.2 of this Study, inmates who have mental illnesses are frequently housed in the SHU with a number of disparate types of inmates, all of whom are supervised and managed the same. Although the SHU is not conducive to improving mental health,[25] the Study Team identified 22 inmates with mental illness on this 56-bed unit.[26]

Best practices in contemporary corrections has determined that those inmates who have acute, subacute and chronic symptoms of mental illnesses are best housed and managed in small designated mental health housing with subpods for necessary separation. In addition, these offenders should be located in close proximity to professional mental health staff and be supervised by officers who have special mental health training.

It is important to consider the impact of being locked down 23 hours per days when one is also suffering from acute symptoms of mental illnesses. Whether the inmate has major depression with suicide thoughts and/or intent or schizophrenia and other psychotic disorders with hallucinations and delusions, isolation from others only serves to increase the anxiety and fears and thus the symptoms. Most of these inmates are

[21] Available at http://www.modelsforchange.net/index.html.
[22] Health care is provided by Correct Care Solutions (CCS), a national correctional health care vendor. The health care at ASGDC is accredited by the National Commission on Correctional Health Care (NCCHC). Mental health services at ASGDC are provided by Columbia Area Mental Health, a subcontractor to CCS.
[23] Hirschkorn, P. & Mitchell, R. (2011, January 24). Mentally ill crowd America's jails. Retrieved from http://www.cbsnews.com/2100-18563_162-7273149.html
[24] Wiener, J. (2012, May 27). Mentally ill inmates on the rise in California prisons and jails. Retrieved from http://www.sacbee.com/2012/05/27/4519117/mentally-ill-inmates-on-the-rise.html
[25] New Video: Dr. Terry Kupers on Solitary Confinement and Mental Health. Retrieved from http://solitarywatch.com/2013/04/24/new-video-dr-terry-kupers-on-solitary-confinement-and-mental-health/
[26] Based on the SHU census sheet on February 6, 2014.

housed in the SHU based on their mental illness alone; in a few cases they also have disciplinary charges.

When a person with mental illness is subjected to a SHU environment that is extremely loud, managed as a maximum security unit, and highly restricted it is not only likely that their symptoms will exacerbate, but they may also become suicidal, aggressive or assaultive. In an environment such as the SHU, inmates are more likely to refuse or continue to refuse medication. In addition, unless they have worked in psychiatric facilities, nurses are less likely to take the time to interact and engage the inmate into taking prescribed medication.

Inmates who are transferred into the SHU from other housing (except intake) may not be correctly identified as needing a mental health evaluation. No referral or notice is sent to the mental health professionals. Mental health professionals will only know about the pending evaluation if it is correctly entered into the SHU census sheet as such.

Inmates who are in the SHU with known or suspected mental illnesses have a number of designators such as “mental,” “pending mental evaluation,” “mental illness,” “medical transit.” It is also suspected that some inmates who are designated as administrative segregation may also have underlying, undiagnosed mental illnesses.

SHU inmates who have mental illnesses, but who are not on suicide watch, are seen by mental health professionals only once per week as part of Special Housing Unit mental health rounds. Given the acuity of many of these individuals, best practices would suggest that mental health rounds be done at least daily.

Inmates who return to ASGDC from a psychiatric hospital where they have been stabilized are housed in the SHU until mental health professionals have cleared them for population.

Recommendation 1: A short term recommendation would be to house persons with acute mental illness in a single bed subpod of a larger housing unit in which additional subpods may be designated for inmates who are on suicide watch or whose symptoms are under some level of control (subacute) and others who are stable but too vulnerable to be placed in general population.

Recommendation 2: A long term recommendation is to build additional mental health beds that will appropriately house inmates who have mental illness who are not stable enough to be housed in general population.

Recommendation 3: If an inmate who has acute symptoms of mental illness receives disciplinary segregation due to a serious charge, they should serve this time in an appropriate mental health setting. Officers who hold disciplinary hearings should review these cases with the mental health professionals to ensure that disciplinary hearings are not conducted where the inmate’s behavior is solely due to mental illness.

Recommendation 4: Develop a system of officer notification that an individual has been transferred to the SHU pending being seen by mental health.

Recommendation 5: Increase mental health rounds for individuals with acute and subacute symptoms of mental illness who are housed in the SHU.

Recommendation 6: Since there is a small subpod of inmates who have stable mental illnesses in the M-Unit, those returning from psychiatric hospitalizations should be housed in the M-Unit until seen by mental health professional.

Recommendation 7: Encourage nurses who are less experienced with inmates who have mental illnesses to seek training about engaging inmates to take prescribed medication.

Finding 2: There is excellent supervision of inmates who are placed on suicide watch.

Discussion: Inmates who are placed on suicide watch are typically housed in the Special Management Unit (SHU). They are given suicide resistant gowns and blankets and are placed on a welfare check by a suicide watch assigned officer every five minutes. It is important to note that these cells are not suicide resistant. It is laudable that ASGDC management recognizes the need for five minute staggered welfare checks.

Unfortunately, since these inmates are in the SHU they are under the same restrictions as those inmates who are serving disciplinary time. In addition, they have no access to mail or reading materials. When observing the suicide watch officer and inmates, most inmates were laying down staring at the ceiling for long periods of time. Although they are able to have access to dayroom based TV, it is seldom turned on because it would then be available to inmates who are serving disciplinary time. The long-term isolation and lack of social interaction or activities will only increase depression and suicidal ideation.

There is a history of suicide watch inmates being placed in the M-unit in a subpod with a dedicated suicide watch officer. This was apparently in place three years ago, but was changed in order to consolidate staffing in the SHU. Since there is a dedicated officer for those inmates who are on suicide watch, it would seem that wherever the inmates are located, that same officer would be assigned.

Mental health professionals make daily rounds to see all inmates who are on suicide watch. Once they have been released from suicide watch, they are seen again in 24 hours, once again within a week, and then again in 30 days. This suicide watch follow-up schedule is inconsistent with recent best practice recommendations.

Recommendation 1: Develop appropriate housing for inmates who are on suicide watch. For staff efficiency it would be best co-located with other inmates who have mental illnesses.

Recommendation 2: Provide access to safe reading materials, television, movies and so forth that would engage the inmate in interaction with other inmates as well as staff.[27]

Recommendation 3: If mental health housing is built in the future it should be designed to be suicide resistant.

Recommendation 4: Based on recent best practice recommendation, follow-up after release from suicide watch should be daily for 5 days, once a week for 2 weeks, and then once a month until release.[28]

Finding 3: Identification of inmates who have mental illnesses is inconsistent.

Discussion: When an inmate is committed to ASGDC there is currently no health care flag at intake to indicate that the inmate has a mental illness or has been suicidal or made suicide attempts in the past. Law enforcement officers are required to ask this information and then pass it on to the intake officers; however, inmates are not always willing to discuss this information with law enforcement officers.

Intake officer screening and health screening also asks these questions, but it would be helpful if a generic flag "Health Care Issue" was in the Jail Management System that would notify the officer to contact the intake health care worker. The intake certified medical assistant would then have access to medical records, or perhaps a "Flag List" to determine the history of the health care issue.

Without such an identifier, there may delays in identifying inmates who have mental illnesses. This may also be also be contributing to the high numbers of inmates who have mental illnesses being placed on "medical transit" status in the SHU.

Recommendation 1: If current JMS system can accommodate a notification flag, it should be implemented as soon as possible. If not, any updated/new JMS should have this capability.

Finding 4: Mental health treatment at ASGDC is limited to crisis stabilization and medication management.

Discussion: The focus of mental health treatment at ASGDC is limited to crisis intervention, stabilization and psychiatric medication management. There is little opportunity for ongoing counseling, no group counseling, and no special mental health programs. The one exception is that a caseworker from Columbia Area Mental Health sees those inmates who are on the mental health center's special needs caseload once every thirty days to support planning for reentry into the community upon release.

[27] Hayes, Lindsay M. (April 2010) National Study of Jail Suicide 20 Years Later. NIC Accession Number 024308, U.S. Department of Justice, p. 50.
[28] Hayes, Lindsay M. (April 2010) National Study of Jail Suicide 20 Years Later. NIC Accession Number 024308, U.S. Department of Justice, p. 51.

Recommendation 1: Many jails and prisons have special programs for inmates who have mental illnesses consisting of a number of small group discussions using modified versions of the Illness Management and Recovery Model,[29] an evidence based program that is used to teach people who have mental illnesses strategies to manage their illnesses. The kit that provides materials for this ten-topic program is available at no cost from the Substance Abuse Services and Mental Health Administration (SAMHSA).

Recommendation 2: There are a number of promising mental health support programs that are emerging in the literature for justice involved consumers of mental health services, including those that are gender responsive and trauma informed. Descriptions of these programs are available online.[30]

Finding 5: There is access to a statewide mental health treatment information database, which is an asset to ensuring continuity of care between the community and the Detention Center.

Discussion: This database has information about any consumer who has received mental health services in the state. This information includes medications, hospitalizations, appointments and other information. This not only assists with the continuity of care, but also greatly decreases any lag time in providing appropriate medications to inmates at the ASGDC who have mental illnesses and who have received community-based services.

Recommendation 1: Utilize this database at the earliest possible point in the incarceration process to identify those inmates who have diagnosed mental illnesses.

Finding 6: There is a good system in place to continue verified bridge medications that are on the formulary. The system for continuing non-formulary medications, however, is time consuming and may interfere with continuity of inmates' receiving their medications once incarcerated.

Discussion: When a person with mental illness is incarcerated, one of the concerns is the ability to quickly verify the medication prescription and receive a provider's order to continue the medication. ASGDC's mental health providers have a good system is place for any medication that is on their formulary.[31] If the medication is verified as a recent prescription, or if the inmate has been prescribed the medication previously at ASGDC a seven-day automatic order is in place so that the medication is continued and the inmate is seen by the psychiatrist within a week.

Unfortunately if the medication is verified but not on the formulary, there is no automatic

[29] Illness Management and Recovery. Practitioner Guides and Handouts. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center of Mental Health Services.
[30] Policy Research Associates. (2012) Promising Practices Guide: Supporting the Recovery of Justice Involved Consumers. National Alliance on Mental illness (NAMI).
[31] A formulary is the approved list of medications that can be prescribed within that facility.

order. The psychiatrist will be notified and in many cases the individual will be scheduled to see the psychiatrist within a week.[32] This compromises the continuity of care for these individuals and may contribute to mental status deterioration during the period of time before they are seen by the psychiatrist.

It is notable that some medications such as long-term injectable antipsychotic medication and other expensive psychiatric medications are obtained from Columbia Area Mental Health Center

Recommendation 1: With the increased number of ASGDC inmates who have mental illnesses, the psychiatry hours should be changed so that there is not a lag time of 6 days before being seen for a medication evaluation for those inmates who are prescribed verified, but non-formulary medications.

Finding 7: Consistent with best practices, Columbia Area Mental Health Center prioritizes access to community-based services for those inmates with serious mental illnesses who are released from ASGDC.

Discussion: Consistent with best practices, Columbia Area Mental Health Center prioritizes inmates released from jail at the same priority as those who are released from psychiatric hospitalization. This practice recognizes that many inmates who have serious mental illnesses are in great need for continuity of care. They can be seen immediately in the emergency services to continue their medications and they will receive priority access to other services.

Recommendation: None.

Finding 8: There is limited access to psychiatric hospital beds, which results in long waiting lists for both hospital level care and court-ordered forensic evaluations.

Discussion: There are limited psychiatric beds available to ASGDC inmates. Both hospitals that accept inmates provide emergency psychiatric care although only one, GeoCare, provides forensic evaluations. The system to access these beds is bifurcated. Access to emergency care is managed by the mental health system, while access to forensic evaluation is managed by the court system.

Bryan Hospital accepts only inmates who have misdemeanor charges for emergency hospitalization. ASGDC inmates are a priority for care at Bryan. GeoCare accepts inmates who have felony charges for emergency hospitalizations. It can take 10 to 14 days to transfer an inmate from ASGDC to a hospital for care because hospital bed space is so limited.

In addition, court ordered forensic evaluations are completed by trained forensic evaluators at GeoCare. The waiting list for forensic evaluations is long and it may take

[32] The psychiatrist is only scheduled to be at ASGDC on Tuesday and Wednesdays of each week.

up to six months from the time the court orders the evaluation until the evaluation is completed. In the meantime, these individual are incarcerated while waiting for the evaluation.

Recommendation 1: Many states now operate an outpatient community-based forensic evaluation system where the evaluator comes to the Detention Center to provide the evaluation to the inmate. If the evaluator finds that the evaluation cannot be completed, a recommendation is then made to hospitalize the inmate for the evaluation. In these models, the evaluators are trained by the state for forensic evaluations. The evaluators may be employees of community mental health centers or private mental health professionals. The fee to provide the evaluations is set by the state.[33] Encourage the court system to explore this option with the state. This may also be a topic for a Justice Coordinating Council.

Finding 9: There are opportunities to strengthen the mental health training officers receive to better equip them with knowledge and skills to effectively manage individuals with a mental illness.

Discussion: Mental health training for officers should be mandated on an annual basis and generally includes an overview of identifying and managing inmates who have mental illnesses and developmental disabilities (or both). It should also include annual training about suicide in a correctional facility. While it is common to have officers spend 6 to 8 hours on these topics, a review of the current curriculum found that both of these topics are covered in only two hours. While the current curriculum has good information, it is not oriented toward building skills. It does not provide opportunity for scenario-based role playing where officers develop skills in interacting with a variety of behaviors and learn how to intervene and manage behaviors with the least possible force.

Recommendation 1: Current training objectives are trainer and information based. It is recommended that these be changed to learner-officer and outcome based to focus on the skills that the officer needs when interacting with an inmate who have mental illness.

Recommendation 2: One element of potential training enhancements is to include stable consumers of mental health services who have experienced psychotic symptoms or suicidal thoughts while incarcerated and talk to the officers about their experience and their perceptions.

Recommendation 3: An additional tool provides an opportunity for officers to experience what it is like to have auditory hallucinations through the use of head phones and video one example is provided.[34]

Recommendation 4: Use co-training as a model for new officers. Training should be provided by both an experienced officer and a mental health professional that work

[33] Examples are available in Virginia and in Florida.
[34] Access from: https://www.youtube.com/watch?v=0vvU-Ajwbok

in ASGDC. Using an experienced officer with the mental health professional lends credibility to the importance of the topic and the need to learn skills to manage these inmates who have mental illnesses.

B.2. Medical Care

Finding 1: The recent implementation of electronic medical record by the health care provider will prove to be a real asset to enhancing care at the ASGDC.

Discussion: In November 2013, CCS implemented the use of ERMA, a proprietary electronic medical record. In January 2014, CCS added medication administration electronic documentation. The use of an electronic medical record will vastly improve staff efficiency and the quality and accuracy of health care documentation. This ability should be maximized over time, as older records are scanned into ERMA.

Recommendation 1: Once the use of the record is completely implemented, there should be an ability to retrieve information electronically that can be used to document the work of the health care staff as well as trends related to inmate health care.

Finding 2: There are no properly located and designed infirmary beds available in the ASGDC.

Discussion: Due to a number of lifestyle issues (poor health care history, chronic substance abuse, poverty, etc.) many inmates who are coming into corrections have chronic medical conditions that are far more serious in acuity. In addition, with the aging population and the impact of these chronic conditions on their physical health, a geriatric inmate is considered as over the age of fifty.

There were a limited number of medical beds built within the clinic. However, these beds are now used for medical records and supply storage. And, while there are a number of beds located in M-Unit that are used for mobility challenged inmates, elderly inmates and others with chronic medical conditions, this unit is not located near the clinic nor staffed by health care personnel, which significantly compromises its utility.

Recommendation 1: In the short-term, the Detention Center should consider reactivating the medical beds within the clinic for medical observation and subacute infirmary care.

Recommendation 2: In the long term, appropriate numbers and types of medical beds need to be built and located adjacent to the clinic to maximize the efficiency of health care staff

Finding 3: A review of a number of inmate health records and CCS reports indicate that inmates' access to health care services falls within standards.

Discussion: Inmates must be able to request health care via sick call requests seven days a week. All requests must be triaged within 24 hours and responded to within 48

hours (or 72 hours on weekends). Inmates who were interviewed generally stated that they were able to see a health care professional within that timeframe.

Some inmates raised concerns about other inmates' health care quality, such as "he needs more medication," and "she shouldn't be in here, she's sick." It is not unusual for inmate's to advocate for the health care of inmate's that they recognize have serious health conditions.

A review of the number of grievances from January 1 through November 20, 2013 indicated than nearly 25% of those were simply requests for sick call.

Recommendation 1: Ensure that information of how to access sick call is discussed with all inmates, including those with previous incarceration, during health care intake screening.

Recommendation 2: Include sick call requests that are sent directly to health care staff as part of the transaction kiosk system.

Recommendation 3: Review and update as necessary the inmate handbook to ensure that information about how to access sick call is accurate.

Finding 4: Some medical personnel are not comfortable with interacting with inmates.

Discussion: Observations indicated that especially when in the housing units, some medical staff are not comfortable interacting with inmates. This was substantiated with review of grievances and interviews with inmates. There were a number of complaints about the "conduct of staff." When working in a correctional environment, it is important for health care staff to view the inmate as a patient as well as an inmate.

Recommendation 1: In a direct supervision environment, it is important that all staff, including contract staff, be trained and understand management of inmate behavior, acceptable interactions and maintaining professionalism. It is recommended that all health care staff receive training about safety and managing inmate behavior as part of their orientation.

Finding 5: A review of selected medical records found that health care documentation is generally thorough.

Discussion: The Study Team's review of selected medical records, including those associated with eight deaths (since 2009), 16 incidents within 2013 and four placements into the Special Housing Unit (SHU) in 2014, revealed that health care documentation is thorough. The records review determined that the documentation in the health care records answered the range of questions we would have about incidents such as these.

The only identified deficiency in documentation was undocumented reasons for delays in medical screening at intake and undocumented discussions between the Certified

Medical Assistant (CMA) health care intake screener and the Registered Nurse (RN) in charge when SHU housing[35] is recommended by that nurse. This is important because the RN, with the higher level of training and authority needs to be making the decision that the inmate needs to be placed in SHU housing.

Recommendation 1: When an inmate refuses a medical screening due to intoxication or other reasons, the interaction with the inmate including the reason for refusal should be documented in the record.

Recommendation 2: When an inmate's behavior indicates a need for observation, the health care intake screener certified medical assistant (CMA) should document the discussion with the Registered Nurse (RN) who is in charge. In addition, the reason for the SHU housing should be documented as well.

Finding 6: Since 2009, there have been eight inmate deaths, three from suicide and five from natural causes in the Detention Center.

Discussion: The number of ASGDC inmate deaths is not inconsistent with national numbers for a facility of this size. As was noted earlier in this Study, due to a number of lifestyle issues (poor health care history, chronic substance abuse, poverty, etc.) an increasing number of inmates are being incarcerated who have serious acute and chronic medical and mental health conditions. Many of these conditions, for a variety of issues including lack of access to either medical or mental health care or lack of caring for one's health care needs, have gone untreated when living in the community. In addition, with the aging population and the impact of these chronic conditions on their physical health, a geriatric inmate is considered any inmate over the age of 50. The inmates' physical and mental functioning is frequently advanced by 15 to 20 years, thus a 50 year old inmate's health is the same as that generally found in a 65 to 70 year old who is not incarcerated. Therefore, five deaths from natural causes would not be unexpected over a five year period of time.

Every inmate is screened for suicide risk when incarcerated by health care screener. When there is concern expressed by anyone (inmate, another inmate, security, health care personnel, other staff and family members or friends) the inmate is further evaluated by a mental health professional. In addition they will also be seen at any time during incarceration at their request or if there is an identified risk for self-harm. Every suicide that does occur is carefully studied to learn what may have been missed, and if an issue is identified it is addressed and incorporated into suicide prevention policies and procedures. There were only three suicides at ASGDC since 2009, two in 2009 and one in 2012, which can be partially attributed to the supervision of inmates identified as suicidal.[36]

Recommendation: None

[35] As discussed elsewhere in this Study, this should not be construed as a recommendation that SHU housing is the preferred location for inmates requiring medical or mental health care.
[36] See discussion of this in B.1. Finding 2.

Finding 7: A review of the health care grievance logs from January through November 20, 2013, revealed a reasonable number of grievances to suggest that the system is working well and did not present any worrisome patterns of dissatisfaction about health care.

Discussion: CCS keeps logs of all inmate grievances including the type of grievance, response, resolution and particular health care issues. In 2013 there were 211 such grievances received from January 1 through November 20 addressing such issues as: requesting to be seen; problems with medication; problems with diet; conduct of health care staff; dissatisfaction with the quality of medical care; being wrongfully charged for health care; grieving issues not related to health care; problems with medical supplies or equipment and other miscellaneous issues such as requests for shoes or an extra blanket or mattress. The types of grievances received over the year are available in Table II.B.7.

The various types of grievances are coded. However, the form and methodology used for logging was changed in August 2013 and at that same time the coding of the grievances and the categories of grievances changed so there is some inconsistency in the data that was received. For example, being wrongfully charged for health care services is no longer a category, although the table would indicate that there were no such complaints from September to November. At the same time, with the log change, when an issue of staff conduct is raised, the staff name was also documented as well as what corrective action was taken. The forms used to log the grievances have been inconsistent since the change was implemented.

More than 23% of the grievances are actually requests for health care services rather than a complaint about such services. While, it is not unusual for grievance to be used to access health care (use of the wrong form) it cannot be overlooked as a possible flag that inmates are not sure how to access care.

At nearly 18%, the second most common grievance was problems with medications. These fell into two categories: the most common was “delay in receiving medications” and “medication not working.” Delays in medications generally relate to the period of time before a provider prescribes a medication and its arrival from the pharmacy. For routine medications, this would be up to 24 hours. For emergent medications such as antibiotics, there is access to a local pharmacy.

Over 14% of grievances were related to “problems with diet” related to either a request for a special diet or complaints about the food.

Over 12% of grievances were related to conduct of staff. As noted above, this has been flagged as a potential issue and documentation of the staff name and corrective action, if any is needed, is also documented. This finding may also be related to earlier comments in study about some health care staff needing to improve their communication skills when interacting with inmates.

Additionally, another 12% of the grievances were related to dissatisfaction with the

quality of health care. These grievances were further explored and interviews with the inmates were documented. There were no identifiable trends of a particular type of inmate dissatisfaction.

The remaining grievances were about being wrongfully charged with resolution of such documented, grievances not related to health care (food, security, etc.), delays in receiving medical equipment and requests for shoes, blanket and mattresses. These are common grievances within jails and do not raise flags.

Recommendation 1: CCS should select one grievance logging methodology and use it consistently in order to look at monthly and annual trend analysis that may raise flags for needed changes or other interventions. The trends can be used to identify problems that result in corrective action including policy and procedure changes.

Recommendation 2: CCS and ASGDC should work to ensure that inmates know how to access health care. This may require patient education every time an inmate sends in grievance forms. It also requires that sick call request forms be readily accessible to inmates.

Recommendation 3: Many of the grievances are a reflection of inmates doing whatever they believe is necessary to get their perceived health care needs met. It is important for correctional health care personnel to understand this underlying motivation for what may appear to be difficult behavior. It needs to be viewed as an opportunity to regularly provide information and education to inmates about their health care and the reality of their expectations. It is important to use these opportunities to engage the inmate/patient as an active partner in their health care and to set the stage for improved self-care upon reentry into the community.

Finding 8: There is minimal reentry planning to ensure that inmates with chronic health care treatment needs have continuity of care upon release.

Discussion: As noted before, many of the inmates have chronic medical and mental health care needs that will require continued care once released into the community. Many inmates fail to keep those appointments that are made prior to release, and more fail to seek further treatment that is recommended because they are uninsured and do not have the funds necessary to pay for treatment. Helping these inmates find ways to pay for medical and mental health care and living expenses is thought to be a crucial part of ensuring their successful reentry into the community. Some of these releases may be eligible for disability benefits available through Federal entitlement programs, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, Medicare and Veterans benefits. Making these types of benefits available to qualifying releases as soon after release as possible is believed to be critical to preventing relapse and recidivism.[37] Many jails are developing working relationships with government agencies that employ staff skilled at determining eligibility

[37] Community Oriented Correctional Health Services. (2013). The Affordable Care Act (ACA) and Justice-Involved Populations.

for benefits and assist with completing necessary applications prior to the inmate's release from the facility.

The Affordable Care Act will provide new health insurance coverage options for enrolling qualified individuals held in county jails as pre-trial detainees and inmates preparing to reenter the community.[38]

Recommendation 4: ASGDC should seek partnerships with the appropriate county resources to develop a mechanism to evaluate inmates' (who are soon to be released) eligibility to enroll in federal, state or local healthcare benefits that will increase access to treatment in the community and may prevent relapse and recidivism.[39]

Recommendation 5: ASGDC should develop a working relationship with the Richland County Health Connections Office regarding eligibility for federal benefits such as social security disability.

C. Reentry Preparation and Recidivism Reduction

C.1. Inmate Work Opportunities

Finding 1: There is an inmate worker program that provides a variety of work opportunities consistent with South Carolina Minimum Jail Standards and applicable State statute.

Discussion: The ASGDC maintains an active inmate worker program, which provides facility operational support work opportunities in the areas of foodservice, sanitation and housekeeping, maintenance, grounds keeping and laundry, and community service work projects for federal and state agencies, cities, counties, school districts and other entities organized for a charitable and public interest purpose.

Inmate workers are selected based on established eligibility criteria, and assigned jobs by the facilities maintenance manager. There are approximately 75 jobs for inmate workers. ASGDC staff report a high turnover in inmate workers with most workers available an average of three-four weeks. Possible contributors to the high turnover include a revocation process that is not consistent and new directives that have not been fully vetted, which can lead to inadvertently placing inmate workers in a position of not being able to complete their assignment without breaking the rules, e.g., directive that male inmate workers will not go in the sallyport leading to the female dorm to deliver meals, laundry, etc.

Recommendation 1: Examine and revise, as necessary, inmate worker eligibility

[38] Cardell, Anita and Gilmore, Maeghan. (2012). County Jails and the Affordable Care Act: Enrolling eligible Individuals in Health Coverage. National Association of Counties.
[39] In South Carolina, information about the Health Insurance Marketplace is available from a federal call center (800-318-2596). In addition, the local 2-1-1 line operated by the United Way and staffed in part by state Medicaid workers may provide Richland County specific Information.

criteria for requirements that may be unnecessarily limiting the applicant pool and/or that do not serve a valid correctional purpose.

Recommendation 2: Establish a formal inmate worker revocation process that includes a review component by a staff person or committee not directly involved in the circumstances that led to initiating revocation of the inmate worker's status.

Recommendation 3: Establish a committee that evaluates operational directives that have unintended consequences or outcomes and recommends steps to mitigate or remedy these as indicated to the ASGDC Director.

Finding 2: Inmate work opportunities lack parity between male and female inmates.

Discussion: At 73 inmates, the female population accounted for approximately 8% of the total average daily population in 2013.[40] There are no inmate worker posts available for female inmates outside of their assigned housing pod. There are two inmate worker posts per each of the two female housing pods, which amounts to work assignments for 5% of the female population.

There are an estimated 110+ possible work assignments for male inmates - 75+ in facility operational support (outside the housing pods), and 34 housing pod workers, which amounts to work assignments for 13.4% of the male population. ASGDC officials reported difficulty in maintaining a full complement of inmate workers, citing the high turnover in inmate workers as a factor.

ASGDC officials indicated the need to keep male and female inmates separate to safeguard against sexual misconduct or assault as the primary reason for not allowing female inmates to work outside the housing pod. Presently, only male inmates are given work assignments outside of the housing pod.

Both pretrial and sentenced male inmates who meet eligibility criteria may be considered for inmate worker status. Though policy (5C-08) does not prohibit the assignment of eligible pretrial female inmates to a work assignment, the inmate worker guidelines provided the Study Team does.

Prohibiting female inmates from working outside the housing pod unnecessarily limits the inmate worker pool. This blanket policy also results in lost opportunities for female inmates to learn vocational skills, and to earn reductions in their sentences.

Recommendation 1: Create work opportunities for female inmates outside of the housing pod. Consideration should be given to designating specific inmate worker posts as female such as the library post, or designating a shift/crew as "female only" such as a nightshift housekeeping crew. In addition, new work opportunities may be added such as uniform repair, envelope stuffing, pamphlet folding, etc.

[40] See section IV. Population Management, A. Population Trends

Recommendation 2: Eliminate disparate eligibility criteria that are gender based, and reconcile discrepancies between policy and procedure and published guidelines regarding inmate worker eligibility criteria.

C.2. Reentry Services

Finding 1: A formal reentry program that links inmates to community services is limited.

Discussion: There are several programs for male inmates offered in the ASGDC that focus, in part, on reentry planning--life skills, coping with AIDS/HIV, and anger management.

Reentry planning and programming is more than addressing inmate's immediate release needs. Research tells us that if we address an offender's needs then we also address the offender's risk to re-offend. An Urban Institute analysis of the costs and benefits of providing jail reentry services suggests that reentry programs need only reduce recidivism rates by two percent to offset the cost of providing programming.[41] Further reductions in recidivism beyond that level represent the potential 'profit' to the public from the investment in jail reentry programming.

Several members of the judiciary and ASGDC staff see the need for a day report and/or residential reentry center. The model for this type of program already exists in Columbia for federal offenders.[42] Programs such as these are typically less expensive and provide supervision for pretrial or convicted offenders.

Recommendation 1: Consider using the Criminal Justice Coordinating Committee (described in Section IV.C.) to formulate a plan for connecting services and programs provided in the ASGDC to the services and programs available in the community.

Recommendation 2: Explore opportunities for improving reentry planning through the Second Chance Act funding that provides reentry demonstration grants to localities for the development of comprehensive reentry initiatives.

Recommendation 3: Investigate the cost-benefit of contracting with existing services or developing new programs to provide day reporting and/or residential reentry facilities for pretrial and convicted inmates as an alternative to incarceration.

[41] Roman, John and Aaron Chalfin. 2006. "Does It Pay to Invest in Reentry Programs for Jail Inmates?" Paper presented at the Jail Reentry Roundtable, June 27-28, 2006, Washington, DC. http://www.urban.org/projects/reentry-roundtable/upload/roman_chalfin.pdf.

[42] The Alston Wilkes Society currently operates three adult residential facility that house federal offenders through contracts with the Federal Bureau of Prisons. 24-hours supervision, housing, food and intense case management are provided. Programs include anger management, cultural diversity training, life skills training, money management, parenting and substance abuse counseling. Obtained from the Internet on 2/20/14 at http://www.alstonwilkessociety.org/Re-Entry_Centers_Columbia_SC.html

Finding 2: Reentry planning is not tied to inmates' risk or needs.

Discussion: There are many systems throughout the County that identify risk and needs including: mental health, criminal justice, education, social services, and employment services. Each of these systems performs some type of screening and assessment that can guide transition/reentry planning. There are currently no consistent mechanisms in place to share such information between agencies. The lack of information sharing results in multiple screening/assessments being conducted. One prime exception to this phenomenon is that health care staff in the ASGDC and the community are collaborating regarding mental health care as noted in Section B.

The ASGDC completes a risk and needs assessment for managing the inmate while incarcerated, although it does not take the next step to identify which institutional programs and services would be needed to aid the inmate's reentry to the community. The needs assessment information is not used to inform decision-making regarding programs and services, although, in reality, services and programs are extremely limited because of space and other factors.

Recommendation 1: Determine the types of programs that would best meet inmates' needs in the facility and those that would allow for ease of transition/reentry back to the community.

Recommendation 2: Expand the ASGDC service capacity by providing opportunities for community-based organizations to bring more needs-focused services into the Detention Center. This approach can also reduce interruptions in treatment for inmates who were undergoing care in the community prior to their incarceration.

C.3. Programs

Finding 1: There are limited programs and services available to inmates.

Discussion: There are three designated program areas including the law library, which has minimal space available for other programs. The two classrooms generally hold programs throughout the day. Based on the program participation figures provided for 2013, the average daily program participation was 28.7 inmates per day.[43] This should be contrasted with the fact that there are some 900 inmates in the ASGDC

Waiting lists are extensive and are updated on a monthly basis. Approximately 180[44] new program requests are entered each month (manually) in a database that was created by the program staff. As space is available in a program and eligibility is verified, a list of potential program candidates is provided to the program leader to determine final acceptance.

[43] Program attendance figures are based on number of inmates participating each day rather than the number of inmates who attend or complete programs. Limited programming is provided on the weekend, thus driving the figures slightly lower.
[44] This figure was extrapolated from a partial listing of program requests. The full listing could not be printed. The request list was reported by program staff to represent a typical month of program requests.

Staff have expressed reluctance to conduct programs in multipurpose space available at the housing units because the location does not lend itself to good supervision. Some programs, such as inmate coordinated prayer groups, are held in housing units, although not in the multipurpose space.

Men and women inmates are not permitted to participate in programs together which further limits program access. If inmates were left unsupervised and in a remote location, the concern to separate the populations would hold greater credibility. On the contrary, virtually all programs are held in a central location with program leaders in the room at all times, and the programs and escort staff are almost always stationed in the immediate area in order to be able to respond promptly to any request for assistance.

The two program staff are often tasked with escorting offenders back to their housing units, monitoring pencil sharpening, and holding writing instruments when inmate use the restroom. These tasks take away from programming planning and other administrative duties.

Recommendation 1: The ASGDC should examine whether there are appropriate and safe ways that the multipurpose rooms can be used for conducting programs. This may require that additional escorts be provided to allow hallway officers greater proximity to the respective housing units and the multipurpose rooms.

Recommendation 2: Consider allowing men and women inmates the opportunity to program together when adequate supervision is provided.

Recommendation 3: Explore opportunities for housing inmates with similar needs together, as custody and classification permits, so that inmates do not have to leave their housing units to attend programs. Examples can include a substance abuse treatment community, which was reported by staff, inmates and the judiciary as a significant need.

Recommendation 4: Program/case management/classification staff should participate in the selection of inmates for programs so that there is verification that an inmate's needs are being addressed.

Finding 2: Programs are not directly tied to assessments of inmate risk and needs.

Discussion: Approximately 15 different programs are available to the inmate population. Many of the programs are traditional in a Detention Center setting (e.g., General Education Development, anger management, and faith based programs). Two in-house programs are the Men's Reentry Initiative and Turning Leaf Project.[45] The former, developed in cooperation with the University of South Carolina and based on ASGDC inmates' needs, has been modified and it is unclear whether it is still sufficiently

[45] These programs were reported to be very similar but one program was identified as successful in another SC jurisdiction and the other program is volunteer-managed.

responsive. The latter was a program initially developed for Charleston County and was adopted in the ASGDC. Both of these are promising programs, but it is not clear whether they meet the risks and needs of ASGDC inmates.

The "reentry" and education programs are longer term (12 - 14 weeks), which may more appropriate for longer periods of incarceration than is typical in the Detention Center. Given the state requirement that inmates sentenced to more than 90 days are State responsible inmates, it is unlikely that the lengthier programs can be completed by inmates in jail. Inmates who are likely to receive lengthier sentences would probably best be served attending these programs in the Department of Corrections. The shorter term sentenced inmates will likely be released prior to program completion, and it is unlikely that the appropriate connections with community services will be made.

Program options that may be more appropriate for these inmates will be ones that focus on how inmates can access services in the community and what steps they should be taking to prepare for release. Some of these programs exist, for example the Austin Wilkes Society provides services to persons in need and they come to the facility weekly to respond to inmate requests. However, even this program is word-of-mouth and some inmates in need of services may not know how to make a specific request.

Due in part to the lack of program space, programming for women and special populations is limited or may be provided solely on a one-to-one basis. These populations, though smaller than general population males, typically have more needs that must be addressed if inmates are to successfully transition to the community.

Recommendation 1: Provide services and programs that focus directly on offender risk and needs. Moreover, the focus must be on arrestees/offenders who are moderate or high risk. Focusing on low-risk low needs offenders can create a self-fulfilling prophecy or generally waste valuable community and service resources.

Recommendation 2: Conduct a comprehensive inventory of existing programs to identify gaps (e.g., needs, access by all populations where appropriate, etc.) or duplication. Restructure the programs function to be responsive to the inmate needs and space availability, including providing programs in housing unit multipurpose rooms.

Finding 3: Staff must manage program requests, participation and completion through manual logs rather than the Jail Management System, which creates unnecessary delays in program access.

Discussion: Although there is a program component in the Jail Management System, the system only allows for program requests to be entered but not updated. Therefore, staff have no means to retrieve previous program attendance and completion information to assist with case management and reentry planning. This type of information is essential in determining an inmate's reclassification and case management.

Staff currently create their own data management system using Microsoft Excel that

includes one workbook for tracking a waiting list. As program openings become available, the waiting list(s) is provided to the program leaders to select participants.

A separate summary MS Excel workbook that includes the number of inmates attending programs is also generated. Summary data is entered into the workbook after each inmate participation is manually counted.

Recommendation 1: Program attendance, completion and failures should become a part of an inmate's permanent record (ideally electronically) so that this information can aid in reclassification decision-making.

D. Professional Operations

D.1. Use of Data to Inform Decision Making

Finding 1: The ASGDC does not currently have available through its JMS system reliable data about incidents that is necessary to inform decision making.

Discussion: While the facility has myriad systems of documenting activities and actions, little of it can be mined so as to provide information for decision makers. Perhaps the clearest example of this is the thousands of incident reports that are handwritten each year by officers and then verbatim transcribed into an excel spreadsheet. When asked by the study team for metrics of incidents, ASGDC staff supplied a vast spreadsheet that lists every incident from November 14, 2013 going back to November 22, 2010. This spreadsheet was created with the assistance of County IT specifically to respond to the study team's incident data request because the JMS system as presently configured cannot produce such routine reports. At first glance, this report was unwieldy and not at all responsive to the study team's request, although we reviewed the report and found that it provided the following data on each incident:

- Incident number
- Date
- Time
- Incident Category, e.g., use of force, disturbance, medical, theft of offender/County property, assault of offender/staff, damage to offender/County property, suicide/attempted suicide
- Location
- Officer's Name
- Inmate's Name
- Incident description

Ironically, this spreadsheet contains a huge amount of raw data but, as currently configured and utilized, provides very little usable information. Unfortunately, there has apparently been very little quality assurance relative to the data entered into this spreadsheet and the entries are so suspect as to be unreliable.

For example, there is a wide disparity between the number of use of force incidents that we counted in the excel data taken from the JMS system, the number we counted, and the number of use of force incidents that were reported by PSU after its efforts to count and document cases. While our attempt to organize the use of force data initially revealed more than 1059 cases in 2013, once we organized them into *events* (rather than individual incident reports) the figure was reduced to approximately 950 use of force incidents. However, the PSU's report counted just 119. PSU staff believes that the discrepancy is due to the fact that every routine handcuffing event is technically a use of force per policy and is documented in an incident report, which is entered into JMS; the far lower figure in PSU's documents excludes handcuffing incidents in which there was no resistance by the inmate.

Recommendation 1: Ultimately, the JMS system must be enhanced or replaced so as to be able to provide the information necessary for decision makers. Incident reports should be completed in the JMS system for a variety of reasons including consistency of information, the ability to capture incident characteristics and to avoid the implications of misspellings and misidentification of incident types. In the interim, there are short-term fixes that can improve the current status of the data. The data needs to be scrubbed first to eliminate duplicate entries or those that are clearly erroneous. After that the excel sort feature can be applied to better organize the entries, followed by application of the "pivot table " function, which can then count and sort incidents in multiple ways; this would allow for the creation of usable reports and information about what kinds of incidents occurred where, when and involved which officers and inmates.

Recommendation 2: As a component of the data scrubbing effort, it is essential that clear and consistent definitions be agreed upon and incorporated into policy for different forms of incidents and how they are documented and counted.

Finding 2: The ASGDC management does not employ well established data driven management systems to review operations and inform decision making.

Discussion: Many large jails have adopted techniques that were initially used in law enforcement to track where crimes are being committed and to hold commanders accountable to address and reduce such crimes. Based on the success of such systems such as New York City Police Department's CompStat's program, large and small jail systems began to develop similar systems, adapting law enforcement approaches to the jail environment. One example of a performance management system that has been in place for almost two decades is that employed by the New York City Department of Correction, known as TEAMS.[46] TEAMS is organized around three major concepts: (1) collection and analysis of key jail data, (2) high level forums conducted by the Agency head to review and probe performance indicators and trends, and (3) close review of follow-up and implementation of changes. The program is credited with reducing serious inmate-on-inmate violence by 97%, overtime by 34%, and sick leave by 38%.[47] Similar programs are in place in large jail agencies in

[46] Total Efficiency Accountability Management System.
[47] See: http://www.nyc.gov/html/doc/html/about/teams.shtml.

Philadelphia and Washington, DC.

Recommendation 1: Once the ASGDC has cleaned up its data regarding incidents, it will have an opportunity to establish a program, modeled after TEAMS, that emphasizes review and analysis of timely and accurate data about incidents in jail (and other management performance criteria), accountability of managers, and follow-up regarding improvements achieved.

D.2. Technology

Finding 1: The ASGDC uses a bifurcated approach to managing and maintaining its information technology (IT) system.

Discussion: ASGDC relies on the Richland County IT department for its jail management (JMS) infrastructure, which includes system enhancements, and other IT needs, i.e., email addresses, SharePoint access, etc. There are unfulfilled system enhancements dating back to 2011, and one requested system enhancement dated 2009 that was fulfilled in late 2013. While there is a staff person within the Richland County IT department designated for the ASGDC, this person is also responsible for a number of other County departments. As a result, ASGDC's information technology priorities compete with those of other county departments. The result is a JMS that has never achieved full functionality and which severely limits and hampers the operations of the Detention Center.

Actual hardware is selected and purchased directly by the ASGDC. Before new computers may be assigned or used computers reassigned, they require configuration or reconfiguration by the Richland County IT department. Again, this activity may not be considered a priority when considered in concert with all of Richland County's IT needs and results in delays in operationalizing new equipment.

Selection and purchase of IT equipment is an added duty since the ASGDC does not have a staff position dedicated solely to the IT needs of the Detention Center. Consequently, the specifications for new IT hardware may not reflect updates to the IT infrastructure designed to enhance system capacities, e.g., processing speeds, software, etc.

Recommendation 1: Create an IT section within the ASGDC responsible for working with the Richland County IT department to facilitate a coordinated approach to meet the IT needs of ASGDC in a comprehensive and timely manner. It is recommended that two positions be allocated to this department – an Information Systems Manager and an IT Technician. The Information Systems Manager would be the coordinator for all ASGDC hardware and software; integration and/or interface with other computer systems, i.e., courts, local law enforcement, contracted service providers; other technology, such as the electronic key control management system; and management reporting and planning. The IT Technician would be responsible for setting up replacement computers, responding to technical assistance questions, and delivering IT-related training.

Recommendation 2: Develop, fund and implement an ASGDC IT plan that includes a fully functioning JMS having robust reporting capabilities; an agency-wide email communication system; updated high-speed processing hardware; integration with security electronics, etc. Any IT plan should include provisions for adequate cyber security protocols and protection safeguards, and should consider the feasibility of creating an interface with other user agencies' computer systems, i.e., courts, bond offices, law enforcement agencies, local and state correctional facilities, and SLED.

Finding 2: The ASGDC lacks the basic user capacities in JMS that are found in contemporary correctional facilities.

Discussion: The JMS utilized by the ASGDC is a system built and installed in 2000 by the Cottrell Consulting Group, Inc.[48] Once it was made operational, the Richland County IT department excluded ASGDC users from being able to access or generate reports based on software. This has resulted in a system that is not user intuitive, requires significant system enhancements, and does not allow data to be retrieved in a meaningful format that lends itself to analysis.[49]

The present system does not support basic document and/or data generation. Data is being entered, yet is not retrievable. For example, there is an incident reporting module. However, there is no mechanism by which supervisors may review and approve submitted incident reports, nor can the system generate reports that allow managers to identify patterns and trends or incident clusters, e.g., use of force in a specific area, gauge staff productivity, or establish peak activity periods.

Notwithstanding the above-described themes and examples, incident reports continue to be entered into the JMS – officers manually prepare incident reports that are submitted to the supervisor; supervisors review[50] and approve completed reports; and clerical staff enters approved incident reports into the JMS. Again, reports are being entered into the JMS without the ability to check for omissions, inaccuracies and inconsistencies. The decision to enter incident reports into the JMS is based on the assumption that at some future point, data migration from the present JMS to a new JMS will occur. However, questions will likely arise as to the accuracy, validity, integrity and/or reliability of the incident report data entries being migrated to a new system.

Another example is the offender program modules. As discussed in Section II.C.3, staff can input request for programs, yet the requests cannot be updated to reflect whether the inmate was approved or denied, attended, refused, or completed an authorized program.

Recommendation 1: Establish a JMS committee representative of JMS users[51] to

[48] Source: February 26, 2014 phone call with ASGDC Director Myers.
[49] Ibid.
[50] The review stage may involve returning the report to the author for additional details, clarification, and/or required information
[51] JMS users may include security staff (supervisors and line staff), human resources, training, programs, classification, booking/intake/discharge, records management, administration, support services, etc.

identify the unique and evolving needs of each constituent group, to determine what and how information is used/shared, and to establish how the current JMS presently meets or does not meet identified needs. As part of the JMS committee's work, a plan should be developed that guides use of the JMS, in particular, the consistent coding of incidents[52] in the computer.

Recommendation 2: ASGDC administration, informed by the JMS committee's work, should move forward with either a complete overhaul or replacement of the existing JMS. Decisions made should consider the extent that other technologies may be integrated with the JMS for data mining, analysis, and reporting purposes.

Finding 3: The ASGDC relies on handwritten or manual systems for reporting and recording shift activities, maintenance orders, inmate requests, incident reports, daily activity schedules—transports, programs, and documentation from courts, etc.

Discussion: Because the JMS has never achieved full functionality, it has led to the development of myriad standalone reporting systems by individual staff members. The primary reporting systems used are manual systems oftentimes consisting of handwritten entries into a post journal. Because there is no mechanism to extract data from these journals in a format that lends itself to analysis or reporting, many times this same information is then entered into MS Excel spreadsheet files or other electronic collection formats. The individual user is then able to sort and retrieve basic information. However, this information may or may not be shared with other users. This duplication of effort is a common occurrence across all functional areas.

Another contributing factor leading to the establishment of standalone reporting systems is the continuing use of outmoded computer equipment. As noted in the 2008 Audit,[53] some computers are too old and slow to operate the JMS without problems. The lack of sufficient processing speed on computers results in handwritten documentation, frequently deemed quicker by most staff. Assignment of computer equipment is generally based on organizational hierarchy with supervisors and managers using the latest computers with older computers passed down the hierarchical chain. This results in the housing pods using the most antiquated and incompatible computers in terms of functional capabilities.

Daily activities schedules—transports, programs, classification screenings, health care clinic, are created on the computer and then printed and manually distributed. Should the schedule change, changes are communicated via a telephone call to the affected staff and/or housing pod or distribution of an updated schedule. This method is inefficient and reduces staff productivity.

Recommendation 1: Until such time the JMS can generate schedules or data

[52] Presently, disturbances are not consistently coded and have been coded as a use of force, as a disturbance, or as a specific or general rule violation
[53] Hammett Consulting. Alvin S. Glenn Detention Center Performance Audit. Clover, SC. 2008.

reports, establish and implement a system whereby activity schedules, daily logs, maintenance orders, etc. are maintained in real time on a shared intranet site such as MS SharePoint, and accessible by all staff directly from their posts or work areas.

Finding 4: The ASGDC integrates contemporary technology in its operations to enhance efficiencies and effectiveness with mixed results.

Discussion: The ASGDC has implemented a number of technology innovations designed to make operations more effective and/or efficient, such as AFIS live scan fingerprinting;[54] finance kiosks for deposit of inmate funds, video court hearings, electronic submission of commissary orders, digital recording surveillance cameras, video visitation, a guard tour system that records and authenticates security checks, and a bar code scanner (used for suicide watch checks), to name a few.

Of particular note are the technologies associated with the personal alarm system, the electronic key control/management system, and the inmate grievance system, which have yet to realize the desired outcomes.

Personal Alarm System - The personal alarm system, monitored by central control staff, is displayed on a separate monitor that requires the operator to leave the main control panel in order to respond to an active alarm. Once an alarm is activated, the operator must scan a handwritten list to identify what staff member is assigned to the activated alarm, which will give the staff's assigned post. While the alarm identifies the person assigned, it does not identify the person's actual location.

Electronic Key Control/Management System - An electronic key control/management system,[55] while installed over a year ago, has not yet been activated or made operational.

Grievance System - The grievance system provides three methods for inmates to submit a grievance—handwritten, electronic, and audio.[56] The inmate receives a response via any one of the grievance submission methods. This hybrid grievance system does not channel itself through a centralized grievance tracking process, thereby lacking the ability to monitor grievance processing or analyze grievance patterns and trends.

Recommendation 1: Conduct a status inventory of technologies presently in use to include a brief assessment outlining whether the technology is fully functional and

[54] Live scan fingerprinting refers to both the technique and the technology used to electronically capture photos, and fingerprints and palm prints, without the need for the more traditional method of ink and paper

[55] An electronic key control/management system is a secure key cabinet that requires the user to enter a code before being allowed to access authorized keys. It is designed to allow direct distribution of keys without requiring the aid of a second person.

[56] At the time of this study, the ASGDC was implementing, via the inmate telephone contract, a mechanism whereby inmates could submit an audio grievance using the inmate telephone system, which would then be auto-converted to an email and forwarded to the grievance officer and jail administration.

identification of any shortcomings/deficiencies. Based on results, develop action plans that will lead to optimal functional utility of individual technologies. Consideration should be given to whether technologies used are integrated, and if not, whether they can be, with the JMS for data collection and reporting purposes.

D.3. Organization Chart

Finding 1: The current ASGDC organization chart and distribution of responsibilities does not allow for top management to spend sufficient time inside the Detention Center.

Discussion: All jail administrators struggle with the competing time demands associated with, paperwork and administrative responsibilities versus the need to spend time inside the jail in order to be very familiar with day-to-day operations. Certainly, achieving this balance is partially a question of individual time management skills. And, it is important to delegate decision making to subordinate operational supervisors, although delegation does not remove the need to provide management oversight that requires a strong degree of knowledge about what is actually going on inside the jail.

An additional consideration relates to what jail administrators should actually do when they are inside the jail, especially given the very important premise that the housing officers must have the authority and be perceived by the inmates as being in charge of their units. Administrators must be very careful when walking around to not undermine the officers' authority by stepping in and resolving any and all complaints that will be directed at them by inmates.

Based on interviews with line staff, survey results and the Team's interviews with top administrators (captains, assistant director and director), it became apparent that those managers are only infrequently inside the housing units and other areas of the Detention Center. Administrative and office-based functions are clearly dominating their time relative to observing and assessing operations on a regular basis. Walking and talking inside the jail should be prioritized to occur far more frequently than once a week or once every couple of weeks, yet that seems to be the current norm.

While there are multiple factors to consider, the current organization chart does play a role in exacerbating this situation.

Recommendation 1: The Operations Captain currently has ten important and widely disparate functions under her command, including Reception/Evaluation/Discharge, training, pre-trial, juvenile detention, victim services, inmate discipline, inmate grievance, programs, recruitment and transportation.[57] Management oversight of Transportation, Reception and D should be transferred from the current Operations Captain to the Security Captains in order to consolidate management of day-to-day security/operations functions. This would also allow the Operations Captain to better focus on the remaining eight or nine more

[57] Source: ASGDC organization chart and interviews with the incumbent employee.

programmatic/administrative functions.

Recommendation 2: One Security Captain should be designated as the Administrative Security Captain to manage the paperwork, staffing, security cameras, incident reports, quality assurance and other related functions. The second Security Captain should be designated as the Operations Security Captain, with the focus being on *daily* tours of the facility, walking and talking with staff, conversations with inmates (although not in a manner so as to undermine unit officers or subordinate supervisors). Reception and discharge would become the responsibility of the Operations Security Captain, while transportation might fall under the Administrative Security Captain.

Recommendation 3: Professional Standards oversight and supervision currently falls to the Assistant Director and consumes a very significant amount of her time, especially when combined with the personnel disciplinary process. We recommend that the Professional Services Unit, including its internal investigations and PREA implementation, be transferred to a direct report to the facility Director. This would align the investigations function where it more typically falls in jails, while freeing up time for the Assistant Director to be able to make a complete tour and inspection of the Detention Center each week, in addition to the routine checks on health care and food service that are currently made.

D.4. Quality Assurance

Finding 1: The ASGDC has exhibited a clear commitment to seeking external review of operations through a variety of sources, including accreditation by the American Correctional Association (ACA) and the National Commission on Correctional Health Care (NCCHC).

Discussion: The ASGDC has embraced the notion of external quality assurance in several contexts, not the least of which is seeking accreditation by the ACA and NCCHC. These accreditation processes require enormous levels of effort by staff at all levels of the Department and subject the Detention Center to comprehensive scrutiny that can be used for self-improvement and emulating best practices.

At the same time, the ASGDC has also employed such external mechanisms as the National Institute of Corrections Self-Audit for Direct Supervision Jails as a way to audit its compliance with the principles of direct supervision (see Finding 3). And the extremely high degree of openness and cooperation with this Study, despite its highly probing and in-depth nature, further exemplifies the appreciation for and willingness to open up the Detention Center to outside scrutiny in order to improve the organization and its operations.

An additional source of external quality assurance is the annual audit provided by the South Carolina Department of Corrections' Division of Compliance, Standards and

Inspections.[58]

Recommendation 1: Continue to develop and implement plans related to attaining or maintaining professional accreditation by the American Correctional Association and National Commission on Correctional Health Care, to include complying with all applicable mandatory and non-mandatory outcome-based standards.

Recommendation 2: In light of the expansive nature of these external audits, the ASGDC should prepare implementation plans that prioritize and ensure there is sufficient space among and/or between activities that require follow-up to avoid overwhelming the organization.

Finding 2: The ASGDC does not yet have in place a formalized and ongoing system of internal quality assurance to monitor operational compliance with policies and procedures, other internal rules and regulations, standards, and state and federal laws.

Discussion: While the ASGDC embraces external auditing and quality assurance, it does not currently have in place a comprehensive and ongoing internal capacity for quality assurance. In section II.D.1, the Study Team discussed challenges experienced by the ASGDC due to the lack of reliable data to inform internal operations. Associated with that is the absence of key performance indicators used for the purposes of data mining and analytics to evaluate efficiency, quantity, quality and productivity pertaining to: program and service delivery; recordkeeping; inmate and staff supervision models; classification; intake and discharge processes; community reentry and release preparation programs; inmate welfare fund; interactions with the public and inmates, etc.

Moreover, some of the informal and discretionary systems are generally not evaluated; and their efficacy, accountability and/or capacity for accuracy have not been validated or even subjected to legal risk management scrutiny. This is most evident in some of the ASGDC's combined informal and formal systems of accountability (e.g., inmate discipline.)

Recommendation 1: Consider establishing a quality assurance committee to address the quality systems needs of the Detention Center. This should involve collaboration with appropriate internal and external stakeholders with professional expertise and experience in establishing such systems in large local Detention Centers.

Recommendation 2: Consider a plan to establish key performance indicators for all operations, management and administration processes. All functional units and positions of the Detention Center should be subject to this type of performance measurement system.

[58] The Study Team was informed by the facility Director that the ASGDC had not received copies of the inspection reports for several years. When we contacted the South Carolina Department of Corrections, the inspection reports were promptly provided to us for 2012 and 2013.

Recommendation 3: Develop and implement a quality assurance for the entire formal system of accountability (administrative directives, including policies, procedures, post orders, Inmate Guidebook, Officer's Manual, ASGDC Personnel Manual, etc.) to achieve compliance with applicable legal requirements and compliance standards and resolve institutionalized errors.

Recommendation 4: Provide appropriate and adequate training for all staff responsible for the ASGDC quality assurance functions, to include appropriate and adequate training for supervisors and managers regarding key performance indicators and quality data management systems.

Finding 3: The Department's leadership has taken the initiative to undergo the National Institute of Corrections (NIC) Self-Audit for Administrators of Direct Supervision Jails. Completing this self-assessment reflects yet another example of commitment toward continuous improvement in the total operation, management and administration of the Detention Center.

Discussion: The NIC Self-Audit for Administrators of Direct Supervision Jails is based on the measurable elements of direct supervision. It serves as an invaluable resource that provides opportunities for each administrator to self-appraise all facets of direct supervision as it is implemented in their Detention Center. It a standardized instrument designed to enable its users to examine the alignment of their processes and practices with an effective, evidence-informed model for operating, managing and administering direct supervision Detention Centers.

The Study Team is aware that the Department completed a time- and labor-intensive Self-Audit on December 1, 2013. The format for the Self-Audit is a series of detailed questionnaires and a broad-reaching facility checklist. This targeted critical review permitted the leadership to solicit and engage staff at all levels of the Department and from all of its functional units, in addition to a representative sampling of the inmate population. The primary focus and goal was to determine levels of implementation by the ASGDC of the eight principles of direct supervision (i.e., effective control; effective supervision; competent staff; safety of staff and inmates; effective communication; classification and orientation; and justice and fairness).

While the Department's findings related to the completed Self-Audit on direct supervision may not always agree with those contained in various sections of this Study Report, they unequivocally reflect the committed efforts and initiative by the ASGDC leadership as it seeks to continuously improve. Moreover, disparities between the findings of the Self-Audit and this Study report are based on a formulaic approach by NIC, which incorporated relatively few of the other methods that the Team had at its disposal. We were also informed that numerous stages involving total implementation of direct supervision at the Detention Center are incomplete or are in-progress according to competing priorities.

Recommendation 1: Continue to use the NIC Self-Audit tool to identify areas where improvements are necessary to fulfill the mission and goals of the Detention

Center with regards to direct supervision.

Recommendation 2: Develop and implement a plan that addresses relevant findings and recommendations from The Study Report into the Department's use of the NIC Self-Audit for direct supervision.

D.5. Internal Investigations

Finding 1: The internal affairs function as it relates to non-criminal staff or inmate conduct resides with the Professional Standards unit, which is staffed by two investigators.

Discussion: The Professional Standards Unit is charged with proactively identifying staff misconduct and potentially surreptitious inmate conduct and conducting investigations of non-criminal conduct. Any alleged staff or inmate misconduct that is likely to be classified as criminal is immediately referred to Sheriff's Department investigators. PSU investigators review all Incident reports and obtain and observe all available video recordings of any incidents involving use of force or others that could require further analysis and scrutiny.

PSU investigators will typically investigate allegations of staff having improper relationships with inmates, although if sexual activity is thought to have occurred, the case will be referred to the Sheriff's Department. Similarly, if improper force, as opposed to excessive force is alleged or thought to have occurred, PSU investigators will handle those cases. Other forms of improper staff conduct, such as policy violations, forged documents, etc., will be investigated by PSU and/or referred to supervisors.

In 2013, PSU performed eight internal investigations, 37 Employee Protection Hotline investigations (see discussion below), reviewed 119 use of force incidents, and conducted investigations as part of 14 employee disciplinary actions.

Recommendation: None

Finding 2: The Professional Standards Unit has only recently established a case management /tracking system for investigations.

Discussion: PSU's workload appears to be quite formidable. Yet, until recently the only mechanism available to track the quantity and substance of the unit's work was to count file folders piled on the office floor and open and read each one. In response to questions posed by the Study team at the time of the first site visit, PSU staff proactively developed spreadsheets with 2013 data identifying several key aspects of the Unit's functions including investigations conducted, use of force incidents, etc. These spreadsheets were presented to the Study team during the second site visit some eight weeks later.

Recommendation 1: Ultimately, the case tracking and incident data being

collected on the new spreadsheets needs to be replaced and incorporated into a fully functioning JMS system. In the meantime, PSU staff developed new Excel spreadsheets to track activity and incidents; these can be improved and enhanced by someone who is fully adept at using Excel and knows how to design the spreadsheets so as to allow for cells to be populated through drop downs and also allowing for pivot tables to better organize and present information.

Finding 3: The Professional Standards Unit expends far too many resources investigating anonymous and typically unfounded claims of employee misbehavior that are called into a countywide hotline.

Discussion: In 2013, the PSU investigated 37 Employee Protection Line (EPL) allegations. All such allegations were called in anonymously in keeping with the County's policy. Most were determined to be unfounded and involved primarily such allegations as fraternization between supervisors and subordinates, harassment and unprofessional conduct. The vast majority of allegations were determined to be unfounded or there was insufficient evidence to take any action, and investigators believe that many anonymous allegations are made for purposes of retaliation against employees or supervisors.

Recommendation 1: ASGDC investigative staff should consult with their counterparts at other County agencies to determine whether there are methods or systems being employed to lessen the resource burden implicated by this well-intentioned County policy.

D.6. The Inmate Grievance System

Finding 1: The grievance system is operated consistent with Minimum Standards and ASGDC policy and inmates use it regularly to address complaints.

Discussion: In the period January-October 2013 there were more than 1,000 grievances filed by inmates. The primary categories of grievances include day shift security (33%), night shift security (20%), health care (19%), and food service (11%). Although some inmates expressed a lack of trust in the grievance system, the high number of grievances suggests that the majority of inmates do have a confidence level in the process. In fact, from September-November this year, a significant percentage of grievances alleging improper staff misconduct were decided in favor of the inmate.

The grievance system operates in a manner consistent with South Carolina Minimum Standards and generally with ASGDC policy 6B-01 and the Inmate Handbook.

Recommendation 1: A quality assurance audit comparing ASGDC policy 6B-01 and statements in the inmate handbook about the grievance system should be undertaken by ASGDC management to insure accuracy and consistency relative to such issues as timeframes and access to forms and how they are submitted.

Finding 2: The grievance system is understaffed and paperwork laden, which results in delays processing grievances.

Discussion: Jail based grievance systems, unlike those used in state prisons, are time sensitive due to the relatively shorter periods of time the inmates are incarcerated. Timeframes set forth in ASGDC Policy 6B-01 and limited staff resources do not currently allow for expeditious processing of grievances.

Currently, one Lieutenant, tasked with numerous other major duties including security threat group coordination and inmate disciplinary hearings, serves as a part-time grievance officer. He spends one day a week retrieving, logging, disseminating grievances for responses, and delivering completed grievances to inmates. The grievance system involves a cumbersome, paper intensive, and time-consuming set of processes, which negatively impacts the efficiency of the one officer assigned. As a result, an inmate can routinely wait two weeks or longer if he does not submit his grievance on a Wednesday in time for pickup by the Grievance Officer.

In fact, during the course of interviewing the Accreditation Lieutenant as part of this Study, a grievance concerning a need for treatment for dental pain was slipped under the official's door by an unknown person (i.e., the inmate or an officer acting on his behalf); apparently the grievance was prepared after the Grievance Officer made his once a week Wednesday collection and an informal method was used.

Recommendation 1: Grievances should be collected from housing units at least three times each week in order to expedite the resolution of complaints.

Recommendation 2: The grievance process should be automated and operated via the JMS system.

Recommendation 3: Additional staffing or a volunteer should be considered to supplement the one part-time supervisor overseeing this function.

Finding 3: The Inmate handbook does not address or adequately explain certain key aspects of the grievance process.

Discussion: Inasmuch as the grievance system is a crucial vehicle for inmates to register complaints and seek remedies in an appropriate and non-destructive manner, it is critical that all necessary information be accurately available to them through the inmate handbook. At the same time, there needs to be consistency and uniformity of information between the Inmate Handbook and other key sources to include the applicable policy (6B-01) as well as all related forms, to include the grievance form itself.

Recommendation 1: The handbook should be revised to include and reconcile with Policy 6B-01 and forms, issues such as how inmates can obtain a grievance form if you are in general population or housed in SHU, how and where to submit completed forms, how frequently and on what day(s) grievances are collected and processed, how

long it should take to receive a response, what issues are and are not grievable, what to do in case of an emergency grievance issue that cannot wait weeks for resolution, whether there is an appeal process and how to access it, and how to confidentially contact Professional Standards in the event that the grievance addresses an issue that cannot be processed through the standard grievance process.

Finding 4: Information about the quantity of grievances and the operational areas that are the subject of grievances is a key metric for management oversight of the facility that should be subject to quality assurance scrutiny.

Discussion: A brief review of the 2013 Inmate Grievance Report revealed that the overall number of grievances was being vastly exaggerated due to double counting of grievances filed against the shifts. We were not able to determine the degree to which management referred to this key report as a method of tracking complaints.

The Grievance Report does not identify the numbers of grievances that were rejected as non-grievable (per ASGDC policy) and for what reason. It also does not contain any metrics about the numbers of grievances responded to in different time frames, e.g., 7 days, 14 days, 21 days or longer.

Recommendation 1: The formulas on the Excel grievance report should be revised to delete the rows counting overall grievances against the day and night shifts since grievances against day shift A, night shift A, day shift B and night shift B already appear as separate rows. In addition, the year to date data that appears on the continuation of the split excel tables is not actually year to date but is instead for the previous six months only.

Recommendation 2: Spreadsheets detailing the numbers of grievance each month, by area, should be reviewed and corrected to make sure that the data presented is accurate.

Recommendation 3: Management should review this report on at least a monthly basis to review trends and potential problem areas.

Recommendation 4: Additional data elements concerning rejected grievances (and reasons) and timeframes for resolving grievances should be added to the Grievance Report as a quality assurance measure.

D.7. Policies and Procedures

Finding 1: A broad spectrum of administrative directives is established as the formal system of accountability; and it comprises all policies, procedures, post orders, and rules and regulations that articulate parameters for the Detention Center's operations and administration.

Discussion: The collective of policies, procedures, post orders, and rules and regulations are developed and updated for alignment with the Department's stated

mission and strategic goals for the Detention Center. These administrative directives are also designed to ensure compliance with applicable legal requirements (including Minimum Standards), court rulings, national standards and County ordinances. The Detention Center's leadership is preparing for an accreditation audit by the American Correctional Association. One key component of ACA accreditation requires that applicable administrative directives conform to its performance-based standards.

These administrative directives direct, guide and influence the Detention Center staff in the performance of all assigned work. They are communicated as written documents (via manuals, plans, bulletin board and website postings); and orally (via training, roll call briefings, orientations, tours, other meetings and staff supervision.) Automation of critical administrative directives enhances their availability and accessibility to authorized parties in accordance with applicable legal requirements, yet must be strengthened. The structure, transparency, quality, and integrity of the administrative directives result in varying degrees of adequacy and completeness.

Recommendation 1: Consider a plan to expand the use of automation in the development, dissemination, implementation and review of administrative directives.

Recommendation 2: Consider expanding the capacity to establish administrative directives that implicate adequate data mining, outcome measurements, and data-informed decision-making initiatives.

Recommendation 3: Consider a plan to hyperlink all appropriate administrative directives for the purpose of ensuring accurate and adequate modifications, reorganization, updates and cross-referencing to this system of accountability.

Finding 2: While there are established means for participation by appropriate internal stakeholders in developing key administrative directives, similar opportunities for involvement of authorized external stakeholders in the process should be delineated for purposes of collaboration and partnering.

Discussion: Policies and procedures describe the parameters for collaboration, and engagement of internal stakeholders in opportunities to improve the formal system of accountability. The scope and methods for dissemination of administrative directives to internal stakeholders are also delineated in administrative directives.

Currently, written policies and procedures do not include information pertaining to collaboration and participation by external stakeholders. Some involvement by external stakeholders in the Detention Center's process for development and review of policies and procedures is already occurring, *vis-a-vis* issues such as fire safety, health code inspections, criminal investigations, personnel matters, legal risk management, gangs intelligence-sharing, community outreach, emergency response management system, etc. External stakeholder collaboration and partnering has profound implications for potential liabilities, operational efficiency and effectiveness, and ultimately, accountability. They can make the difference between transparently sound practices or those perceived as murky, insular and unsound.

Recommendation 1: Continue to enhance involvement of appropriate internal stakeholders in the process for developing, reviewing and revising policies, procedures, post orders, as well as inmate rules and regulations.

Recommendation 2: Consider a plan that establishes and adequately addresses parameters for collaboration with appropriate external stakeholders in the development, implementation, and review of the formal system of accountability.

Finding 3: Post orders are available and accessible to Detention Center staff at their respective workstations or work areas; however, as written, they present opportunities for improvements.

Discussion: Post orders are a set of highly relevant written procedures, position requirements, guidelines and tasks that inform, assert and affirm job expectations to Detention Center staff when they are assigned to a specific post or designated work area. When adequately established, post orders support strategic efforts by the Department to influence outcomes for accuracy, efficiency, effectiveness, consistency and accountability in all operations and administration.

Interviews with Detention Center staff, reviews of relevant data and documentation, as well as observations of practice revealed and confirmed that imbalances exist involving the current post orders. The most illustrative and recurring issues with the post orders include, but are not limited to, (1) failure to establish clear parameters for the context and content of each type of post order; (2) random sequence in which critical information is presented or inexplicably interrupted; (3) repetitive and exhaustive caveats; (4) errors resulting from inaccuracies, contradictions, and contravening information; (5) ambiguous and misleading statements; and (6) diffused accountability. These issues have the potential to compromise the integrity of Detention Center operations at a functional and individual level, including contributing to inconsistent workplace practices and negative staff morale. Management must find a way to strike that delicate balance regarding the context and content for respective post orders, including the manner in which they are developed for uniformed and civilian personnel.

Recommendation 1: Consider a plan to review the content of post orders.

Recommendation 2: Consider establishing a specified page limit for all post orders and include samples of post orders as attachments to the policy on post orders.

Recommendation 3: Consider where displaced information currently contained in the post orders should be relocated and cross-referenced (e.g., specific policy and procedures; staff training materials; officer's manual; ASGDC personnel manual; employee handbook; staff-only bulletin board postings; and/or appendices.)

Recommendation 4: Consider a plan to review the consistent usage of terms referred to within post orders that establish specific performance requirements, expectations and accountabilities (i.e., word choices that state what is/is not: mandatory, advisable, permissible, discretionary, authorized, or approved.)

Recommendation 5: Review post orders and ensure titles, terms, acronyms and definitions are consistently clear and accurate (across all administrative directives.)

Finding 4: There is an opportunity to strengthen the rules and regulations that inmates must abide by, thereby supporting an environment of self-responsibility and accountability.

Discussion: Rules and regulations contained in the Inmate Guidebook are designed to provide inmates with: (1) general and specific information concerning the Detention Center's operations, administration and its structured activities; (2) a guide to make them aware of expectations and accountabilities for their actions; (3) information that is legally required, accreditation-centered, and/or authorized by other administrative directives; and (4) orientation(s) to the Detention Center's rules and regulations. The Inmate Guidebook is available and readily accessible in housing units (via automated self-service kiosks; manual versions are located at the detention officer's work station, and as posted bulletin board memoranda).

The network of rules and regulations used by the Detention Center to address inmate conduct is underdeveloped. It is replete with a number of issues of omissions, inconsistencies, conflicts and inaccuracies. Unfortunately, these concerns are problematic given that inmates and detention officers are tasked with trying to discern which set(s) of inmate rules and regulations apply.

Recommendation 1: Consider a review and update of inmate rules and regulations to adequately address the issues specific to this finding and discussion (i.e., Inmate Welfare Fund; statutory good time accrual, credit and forfeitures; complete listing of categorized rule violations, informal and formal disciplinary sanctions; etc.)

Recommendation 2: Consider a plan to expand methods and formats for addressing the ongoing needs and challenges for inmates (e.g., illiteracy, language barriers, ADA-disabilities, gender-responsiveness, interpretive and other assistive services and devices, etc.) which pertain to their awareness and understanding of the inmate rules and regulations throughout any given period of incarceration

Finding 5: It is crucial that the Detention Center's formal system of accountability be adequately resourced from a staffing perspective.

Discussion: The need for new and revised administrative directives that impact Detention Center operations emerges on a continuous basis. That need is driven by unaddressed issues and/or changes in federal and state laws; Minimum Standards; court rulings; other applicable legal requirements; County ordinances; national accreditation standards; information technology advances; personnel rules and regulations; and the dynamic nature and culture of Detention Center operations and administration. Adequate staffing is essential to sustainable improvements in the quality of the Detention Center's formal system of accountability.

The Accreditation Manager serves as chairperson for the Policies and Procedures

Committee that is involved with formulating new policies, procedures, post orders and associated ASGDC forms. This lieutenant is tasked with ensuring that all applicable administrative directives comprising the Department's formal system of accountability are Minimum Standards- and ACA-compliant. The position monitors ongoing staff training activities, materials and practices for all operations and administration functions for compliance. This lieutenant is also singularly tasked with performing all researching editing, proofing, formatting, cross-referencing, maintenance, recordkeeping and storage of the majority of the Detention Center's administrative directives. Furthermore, this position monitors the content of the Detention Center's personnel manual for inconsistencies with the other administrative directives.

Recommendation 1: Consider hiring one qualified administrative assistant to support efforts to improve the adequacy of the formal system of accountability within the context of our other recommendations for this area of the Detention Center's operations and administration.

Recommendation 2: Consider the need to expand the use of the County's legal review assistance for certain administrative directives that may involve significant legal risk management implications, particularly if they may potentially contravene or overstate the County's established position and rules concerning specific topics.

D.8. Training

Finding 1: Newly promoted supervisors receive supervisory training consistent with ASGDC policy, and ACA and South Carolina jail standards.[59]

Discussion: Management and supervisory training is required for all newly promoted supervisors. ASGDC policy and ACA standards require at least 40 hours of training within the first year following promotion. South Carolina jail standards require management training within the first year following promotion or within the three years prior to promotion. Although the ASGDC does not have a specific management and supervisory training curriculum for newly promoted supervisors, new supervisors are required to attend a course entitled *Supervisory 101* sponsored by Richland County, and to complete the National Sheriff's Association's First/Second Line Supervisor Training, a correspondence training program for which they are credited 65 training hours. Newly promoted watch commanders are required to attend a supervisory course that is available through Midland Technical College.

The present training for newly promoted supervisors meets the requirements established by policy and standards; however, the training does not provide training specific to being a supervisor in a direct supervision environment, nor does it include training that reflects ASGDC-specific supervisory duties and responsibilities, e.g., scheduling, performance evaluations, investigations. Unique to being an effective supervisor in a direct supervision jail is the role of manager versus decision maker, which include a focus on core tasks such as educating, coaching, supporting, leading,

[59] ASGDC Policy 7B-11; ACA 4-ALDF-7B-11; SC 1032

and motivating staff, not overruling officers' decisions and undermining an officer's ability to manage a housing unit.

Recommendation 1: ASGDC should develop a standard training program for newly promoted supervisors that reflect ASGDC's identified priorities for these critical positions. The Professional Standards Unit and Training section can develop such curricula based on their instructional knowledge of operations and responsibilities of supervisors.

Recommendation 2: Supervisory training should include a focus on methods and means, including specific strategies and techniques, of supervising in a direct supervision jail. The focus should be on how to support and coach officers in fulfilling their responsibilities instead of directly intervening in or undermining the officers' decisions regarding inmate management. Sample training topics specific to direct supervision for first line supervisors include:

- Direct supervision principles and their implications for jail design and operations
- The role of the housing unit officer
- The role of the first line supervisor in coaching and supporting housing unit officers in implementing direct supervision
- Interpersonal communication skills
- Role modeling
- Operational assessment within the framework of the direct supervision principles
- Operational indicators that housing officers are or are not implementing direct supervision effectively
- Assessment of staff performance as it relates to implementing direct supervision
- Decision making within the framework of the direct supervision principles
- Analysis of incidents within the framework of the direct supervision principles

Finding 2: There is a mismatch between ASGDC's stated and documented compliance with annual supervisory training required by ASGDC policy and ACA standards.[60]

Discussion: ASGDC policy and ACA standards require supervisory staff to receive at least 24 hours of management training each year following promotion to a supervisory or management position. South Carolina jail standards do not require continuing education specifically tailored for supervisors. ASGDC's stated practice is to send supervisors to supervisory and management classes that are offered at the South Carolina Criminal Justice Academy; to host supervisory training delivered by AJA or ACA instructors;[61] to allow supervisor attendance at correctional conference training; and to encourage online training through the National Institute of Corrections, Sam Houston University and the American Jail Association. In addition, ASGDC credits supervisors with training hours for attending mandatory monthly supervisor meetings. ASGDC officials claim each supervisor receives at least 24 hours of supervisory training

[60] ASGDC Policy 7B-11; ACA 4-ALDF-7B-11
[61] AJA = American Jail Association; ACA = American Correctional Association

annually.

While it is a stated practice, a review of training records revealed inconsistent documentation of supervisory training, with some records not reflective of the requisite training on an annual basis. ASGDC's access to diverse options for supervisory training is notable; yet, it is important to tailor supervisory training to meet the needs of the ASGDC's cadre of supervisors, which may or may not be met through the external trainings being offered.

Recommendation 1: Enforce *Policy 7B-11: Supervisory Training,* which requires the training section to document supervisory training.

Recommendation 2: In developing the annual training plan, include supervisory training that addresses/targets identified supervisor-related issues and concerns.

Finding 3: The pre-service training curriculum for new detention officers reflects an emphasis on topics such as use of force, self-defense tactics, restraining devices and weapons qualifications, while only nominal attention is given to topics such as direct supervision, inmate behavior management, and effective communication skills.

Discussion: Pre-service training for new detention officers is a seven-day training program. Of the 56 hours of training instruction, 22% of training hours are dedicated to preparing officers with a physical response to situations they will encounter—generally when the situation has evolved into a crisis, while only 2.5 hours of training is dedicated to direct supervision and interpersonal communication skills.

Inmate supervision is a primary duty of a detention officer, which includes holding inmates individually accountable for their behavior in a manner that models adult normal behavior. Effective inmate behavior management requires officers to possess effective decision-making and problem-solving skills; to have the ability to communicate, listen, and provide direction; and to have the ability to treat people fairly and motivate them to engage in positive behavior.

Those portions of the training curriculum dedicated to the skills deemed necessary for effective inmate behavior management, as outlined above, provide the new officer with only a general overview of expectations, it does not include clear strategies and approaches that can be used to manage situations without the use of force or a command/control approach. Nor does the instructional method include role-plays whereby trainees are provided the opportunity to practice these critical skills in a safe, nonjudgmental environment.

Recommendation 1: Increase the number of training hours dedicated for direct supervision and interpersonal communication skills, and add training hours for problem-solving, decision-making, motivational techniques, and other skills to effectively manage inmate behavior. Incorporate proven strategies and techniques within the training curriculum that is dedicated to these critical skill sets, which, when properly applied,

effectively manage inmate behavior in a correctional setting.

Finding 4: The ASGDC has a formal system for maintaining training records. The training records management system lacks a quality assurance mechanism and does not always provide sufficient detail necessary to cross-reference training programs with training documented for an individual officer.

Discussion: Records are maintained for training programs that include agendas, sign-in sheets, lesson plans, handouts, audio/visual aids, field training checklists, and/or tests. A permanent training record is maintained for each individual employee, which includes documentation of training completed such as training program agendas, sign-in sheets, checklists, tests, and/or certificates of completion.

ASGDC training records reflect the basic elements and components typically found in a comprehensive training documentation system, i.e., sign-in sheets, tests, certificates of completion, lesson plans with objectives and associated handouts and tests. A review of random employee training records revealed inconsistencies in documentation such as lack of test scores, test dates, and training received/attended.

Attendance at pre-service training is documented in an employee's training record by a pre-service training program checklist that identifies the pre-service training class number, the topics taught, and the employee and trainers' initials. The checklist, as formatted, includes all potential classes that may be taught and not what is actually taught. This creates confusion for the reader when there are blank lines as to whether or not the individual employee should have and didn't attend or it was a class that was not taught during that specific pre-service training program.

In addition, the pre-service training program checklist maintained for each program does not include identifiers for the specific instructional materials used. For example, the lesson plan that is documented on the pre-service training program checklist does not have a unique identifier that distinguishes it from previous or subsequent versions.

Recommendation 1: Create unique identifiers for instructional materials, which are then included in all records documenting delivery of training where the materials are used, which may include employees' training records.

Recommendation 2: Establish a quality assurance system to periodically review training records, both training program records and employees' records, for completeness and accuracy of documentation.

Finding 5: The training coordinator has yielded responsibility for new detention officer field training to individual officers' supervisors.

Discussion: ASGDC policy series 7B-05 through 16 outline training requirements for new and veteran staff, and establishes that the training coordinator is responsible for organizing and managing all training. ASGDC practice is such that the training coordinator manages the initial seven days of pre-service training that is classroom

based, and the watch commanders coordinate the field training whereby new staff participates in post specific on-the-job training (OJT).

Each post has an established minimum number of hours that must be spent in OJT before an officer is cleared to work the particular post. Once the assigned field training officer (FTO) has signed off, the new officer is eligible to work the post. Post-specific minimum training hours range from 12 to 120 hours (housing pod and inmate records, respectively).

The training policies do not establish guidelines for completing post-specific OJT within a specified period. Oftentimes, a new officer will complete a single post-specific OJT, typically a housing pod, and then be assigned to that post until such time that the watch commander makes arrangements for additional post-specific OJT. In speaking with detention officers, a number of officers had been working in excess of one year without having been trained in all detention officer posts. Without a fully trained staffing complement, the ability to optimize deployment of staffing resources is diminished.

The training coordinator relies on the watch commanders and does not follow up with them to verify new detention officers have completed the entire post-specific OJT training.

Recommendation 1: Revise the training policies to clearly establish the timeframe by which new detention officers will complete post-specific OJT training.

Recommendation 2: Reinforce *Policy 7B-06: Training Coordinator* that requires the training coordinator to schedule and monitor training for staff. This is especially important as it relates to the OJT training component for new detention officers. The training coordinator, in collaboration with the watch commanders, should track the progression of new detention officers through the entire post-specific OJT training, taking the necessary steps for them to complete the training within their first year of employment or within the time parameters established by ASGDC policy.

Finding 6: A checklist system is used to document post-specific OJT. The checklists used are general in nature and do not adequately capture a new detention officer's competencies.

Discussion: Post-specific OJT consists of a new detention officer working with an FTO for the required number of training hours, which are post dependent. The OJT checklist outlines a four-step training process:

Step One: Discussion of the task by the trainer

Step Two: Performance of task by the trainer while observed by trainee

Step Three: Performance of task by trainee while observed by trainer

Step Four: Discussion and feedback by both trainee and trainer

The performance tasks to be discussed and performed are general in nature and lack the requisite specificity necessary for a new detention officer to operate the given post. For example, the OJT checklist for Housing Unit Officer Phase I (Units A-F) includes the following performance task,

"*Discussion and familiarization of the location and purpose of the Post Orders for Phase I (Units A-F). Discussion, review, and familiarization of the information covered in the Post Orders*."

As written, this performance task is cognitive based and not something that can be "performed," and can only be evaluated through a form of mental testing (written or oral). While important, this information can be more economically conveyed in a classroom setting with multiple trainees and does not require one-on-one training. In addition, without reference to specific policies or instructional materials, there is no assurance as to what information the FTO is conveying to new detention officers leading to inconsistent direction and performance.

The primary purpose of OJT checklists is typically to document development of a new officer's competencies. A generally accepted premise is that a new officer cannot demonstrate long-term competency the same day they are shown a new task. Rather, they are shown the task and may perform the task while observed by the trainer, yet are not tested on competency until they have had an opportunity to practice it multiple times. How much practice is required is dependent upon the complexity of the task. Competency is generally demonstrated at a later date. ASGDC practice is for new detention officers to be cleared to work a new post, oftentimes, the same day they first work the post with an FTO.

Recommendation 1: Revise the OJT checklists to reflect action-oriented content, citing applicable policy and procedure (including policy effective date). Such checklists should include the steps necessary to carry out particular duties/functions. The expectation is that the new detention officer will complete the steps in the requisite order without assistance before being signed off as demonstrating competency in the task.

Recommendation 2: Establish for each post an OJT checklist that outlines the requisite post duties along with the action-oriented steps necessary to carry out the duties/functions. Before being signed off as competent, require the new detention officer to correctly perform the duty on a date different from which they were actually trained or practiced with the FTO.

D.9. Prison Rape Elimination Act of 2003

Finding 1: The ASGDC has begun to address the standards of the Federal Prison Rape Elimination Act of 2003 (PREA).[62]

[62] While PREA Standards do apply to local jails, there is no direct financial penalty in the form of lost grant funding for local facilities not under the control of the governor. However, local jails that do not comply

Discussion: PREA standards became effective on June 20, 2012. Standards address the following issues: (1) Prevention Planning, (2) Responsiveness Planning, (3) Training and Education, (4) Screening for Risk of Sexual Victimization and Abusiveness, (5) Reporting, (6) Official Response Following an Inmate/Detainee Report, (7) Investigations, (8) Discipline, (9) Medical and Mental Care, and (10) Data Collection and Review.

The Detention Center has taken several important steps to implement PREA Standards including designating the Lieutenant in charge of the Professional Standards Unit to be the Detention Center's PREA Coordinator. Several key policies have been updated to reflect PREA Standards, and an internal hot line has been integrated into the inmate phone system to allow one touch dialing and transcription of calls of PREA allegations directly into the PSU and Director's office. Posters informing inmates about their rights under PREA have been posted throughout the ASGDC and brochures printed to be handed out to newly arriving inmates during the intake process. In addition, discussions are underway with the Rape Crisis Network for that organization to serve as the required community-based phone hotline alternative to reporting allegations to ASGDC personnel, and also for them to serve as a counseling partner when required.

Training for staff is slated to begin in April of this year.

Recommendation 1: While many important implementation steps have been initiated and others are in progress, there is not an overall implementation plan. This comprehensive plan should detail all measures that are required to implement PREA, who is responsible, and what the timeframes are for completion of each step.

Recommendation 2: Equal attention should be paid, and a separate implementation plan developed for the juvenile Detention Center and implementation of PREA Standards for Juvenile Facilities.

Finding 2: Newly arrested 17 year olds and youth who turn 17 while housed in the juvenile Detention Center are housed in the adult Detention Center, according to South Carolina Minimum Standards. This requirement raises concerns, however, about proper housing conditions for this population in the Detention Center as set forth in the Prison Rape Elimination Act (PREA).

Discussion: The Detention Center's policies and practices relative to housing youthful offenders (17 year olds) in the adult facility are in concert with state requirements. PREA standards for Adult Prisons and Jails, however, require that youth under the age of 18 that are held in adult facilities have sight and sound separation and no physical contact with adults in shared dayrooms, shower areas or sleeping areas.[63] Standards

with the standards will likely not be able to contract for housing state or Federal inmates. And while there is no legal cause of action established by the Standards' publication, it is likely that failure to comply with PREA standards will be used as evidence in individual cases alleging sexual assault against inmates in jails. Source: PREA Resource Center website http://www.prearesourcecenter.org/training-technical-assistance/prea-essentials.

[63] See PREA Standard § 115.14

also require programs and work opportunities for these youth as well as daily large muscle activity and required education services.[64] In addition, the standards require that youthful offenders not be placed in isolation in order to avoid contact with adults.[65]

Policy 2A-38 sets forth the classification and placement criteria for youthful offenders housed in the Adult Detention Center. This policy refers to and generally reflects the PREA requirement, although it introduces certain exceptions that are not recognized in the applicable PREA standard such as allowing housing of youthful offenders in the SHU if they are particularly violent or predatory or if medical or mental health staff document that the youth would benefit from being housed outside the youthful offender unit.

Currently, the adult Detention Center houses 17 year olds in general population, which does not comport with PREA standards.

Recommendation 1: Consideration should be given to housing 17 year olds in the Juvenile Detention Center rather than in the adult portion of ASGDC. This could require a waiver from the South Carolina Department of Corrections Inspection Unit, but would allow for compliance with the applicable PREA standards for adult jails and juvenile facilities. Alternatively, while this would *not* comply with PREA Standards, it would be preferable to house male youthful offenders together in one sub-unit within the adult Detention Center rather than to house them in multiple locations as is currently the case.[66] While this would not comply with PREA housing standards, it would allow for enhanced compliance with *other* PREA standards relative to management of youthful offenders in adult jails.

D.10. Interaction with Criminal Justice Stakeholders and the Public

Finding 1: ASGDC public lobby staff fulfills their responsibility in an attentive, polite manner in spite of the configuration of the public reception desk, which limits staff efficiencies and effectiveness.

Discussion: Reception staff greets all persons (staff and visitors) entering the facility and responds to their inquiries and/or clears them for admission through security screening. The reception desk is designed as a one-person post, though oftentimes two people are assigned to handle peak periods. This can result in delays in processing people because there is only one of each log type, e.g., professional visitors, public visitors; one computer; one telephone.

All persons entering the facility are security screened once they have checked in with reception staff. Security screening consists of passage through a walk-through metal detector and manual search of personal items such as briefcases, knapsacks, and

[64] Ibid.
[65] Ibid.
[66] As of February 19, 2014, male youthful offenders were all classified as medium security and were housed in seven different locations in the ASGDC. Source: Report provided via email by Captain Moye.

purses. Unless there is two staff assigned, the reception post must be left unattended in order to complete security screening and vice versa. The functions, while proximal, are configured such that it requires staff to turn their back to one function while fulfilling the other function. Consequently, during peak periods two staff must be assigned to accommodate the increase in activity, and supervision of public waiting and video visitation areas.

Security screening is performed from a raised workstation. This requires that persons seeking admission into the facility must lift their personal items onto a counter that is approximately five feet high, items that may be of substantial weight or shape. Putting these items on the raised search area may not be possible for someone who is short in stature or physically limited.

The Study Team's observations of lobby staff on multiple shifts revealed that officers conducted themselves in a friendly and professional manner, not just with the Study Team, but with members of the public as well. During one such period, the public lobby officer revealed that she serves as one of the lead trainers for the public lobby post. Based on conversation and subsequent observations of this officer performing her duties, both as a trainer and as a public lobby officer, she was calm and thoughtful in her approach, and demonstrated a willingness to go beyond the obvious in attempting to resolve a visitor's issue. She is a positive role model for officers newly assigned to the public lobby post, exemplifying the traits and characteristics sought for in a person who is very often the first point of contact with the agency, providing a positive impression.

It is certainly possible that interactions may be of a different nature when the lobby is extremely crowded or when the configuration of the desk means that the officer is not paying attention to a visitor at a particular time.

Recommendation 1: Renovate the reception desk and security screening post so it is configured such that staff may operate both functions from a single post while maintaining sightlines of the entire public lobby.

Recommendation 2: Renovate the reception desk to include two redundant workstations that allow two officers to fully process visitors simultaneously. This will provide capacity to process visitors during busy times without undue delay.

Recommendation 3: Renovate the reception desk and security screening post to include ADA-compliant accommodations.

Finding 2: While law enforcement agencies report that there is some inconsistency among the shifts, which can affect their work, they also point to a general responsiveness of staff to address issues when they arise.

Discussion: Several participating law enforcement agencies report inconsistency among the shifts as it relates to property allowed in the facility and the criteria for accepting their arrestee into the ASGDC based on potential medical issues. While this

is not atypical of any organization with staff working shift work and rotating on a monthly basis, the law enforcement agencies acknowledged that, regardless of the operational problems they might have encountered, they were able to get resolution when they spoke with executive management staff. In fact, each complaint expressed to the Study Team about a specific area of the Detention Center was followed by assurances that there was at least one person in the office/area/function that they could turn to for action/resolution.

The 2008 Performance Audit referenced the cooperation between criminal justice agencies, more than likely the law enforcement agencies that hold quarterly meetings. These meetings continue currently and have proven a good mechanism to address issues particularly related to the operations division and specifically booking area.

Recommendation 1: Continue to hold the quarterly meetings of law enforcement personnel to address operational issues, particularly in booking.

Recommendation 2: ASGDC should consider longer staff assignments in the booking and discharge areas to promote consistency.

Finding 3: The judiciary indicates that ASGDC staff are responsive to requests and meet the needs of the judges.

Discussion: Member of the judiciary were interviewed and report no concerns regarding the timeliness of inmates transported to court or the responsiveness of staff to requests. Directives of the judges are followed even when certain programs are no longer operated by the ASGDC. Examples of flexibility and responsiveness of ASGDC staff were cited: one member of the judiciary was not aware that a release alternative program (electronic monitoring) previously operated by the ASGDC was suspended, yet the ASGDC agreed to work with the inmate and bonding agencies to carry out the court ordered placement.

Recently ASGDC has asked the judiciary to respond to sentencing and court order questions when they arise, especially those that involve sentencing orders. The judiciary indicated support for the interpretations and expertise of ASGDC staff but encouraged them to raise questions when they arise.

Recommendation 1: The ASGDC should continue to approach the judiciary when questions about judicial intent on sentencing orders arise that cannot be resolved in-house.

Finding 4: Agencies that have clients in the ASGDC often have difficulty meeting with their clients in appropriate settings within the ASGDC.[67]

Discussion: Concerns about meeting with clients in the ASGDC were expressed by the

[67] Private legal counsel and volunteer/agency representatives for programs were not interviewed as part of this Study.

Richland County Public Defender's Office and the South Carolina Department of Probation, Parole and Pardon Service. Representatives of these agencies typically have to meet with their clients directly in the housing units within the dayroom area itself or in a multipurpose room adjacent to each unit; either option presents significant issues of safety, security and confidentiality. Agency representatives have indicated that they are sometimes fearful of being in the housing units because inmates are permitted to approach them without notice.

The practice of interviewing in the housing units was enacted in response to prior problems concerning delays in getting inmates to the contact visitation area when requested by professional visitors. Agency representatives report calling in advance to facilitate getting the inmate to the contact visitation area, with little or no success. Regardless, these representatives indicated that they appreciate the responsiveness of the ASGDC administration to explore alternatives, even if the alternative approach is wrought with a different set of problems.

Recommendation 1: The ASGDC administration should meet with professional visitors and discuss ways to improve access to clients, including increasing staffing during periods of increased access needs.

Recommendation 2: The ASGDC should consider the benefit of modifying the video visitation rooms located on the upper level of housing[68] to improve client access for professional visitors.

E. Employee Morale

E.1. Employee Survey Findings

A survey was developed and implemented as part of the Alvin S. Glenn Detention Center (ASGDC) Operational/Management Study. The goal of the survey was to seek input from current employees regarding their experience working in the Detention Center. The survey used a combination of 23 Likert scale items (strongly disagree, disagree, neutral, agree, strongly agree) that had to be answered. There was one free form response where employees were encouraged to comment on any questions or any other issue that they believed would be useful information for the study

Statistical Analysis for the Social Sciences (SPSS) software was used to complete the quantitative analysis for the Likert scale items. The free form text responses were analyzed quantitatively by using methods such as word count (identifying the number of times a particular word or phrase appears) and qualitative methods including theme identification. The analysis results were combined to identify the most significant strengths and opportunities of the ASGDC.

The survey was intended to measure employee perceptions in the areas of training, safety, communication, management, job satisfaction, and job related resources. The

[68] Phase V housing does not have the upper level video visitation access.

results of the Likert scale items can be found in Table II.E.1 below. 164 employees responded to the survey, while 114 also responded to the free form comments section with a total of twenty single spaced pages of comments. The average score (mean) and most common score (mode) were examined to identify strengths and opportunities of the Detention Center from the perspective of the employees. Based on the results of this survey, items with a mean score of 3.5 or above were identified as strengths while means scores of 2.5 or below were identified as opportunities for improvement.

Finding 1: Approximately 50% of employees responded to the survey, which is an excellent response rate and indicative of ASGDC employees' commitment to improving operations.

Discussion: This rate of response exceeds the norm for such surveys of fifteen to twenty percent. The Study Team took various measures to encourage response to the survey including closed ended questions, promised confidentiality of all respondents to the survey, easily accessible online, questions that focused on issues that employees care about and a brief survey that could be completed in ten or fewer minutes. In addition, the Director encouraged all briefed all shifts and encouraged staff to respond to the survey.

Based on the response rate and general comments received it is clear that the employees of ASGDC are committed to making improvements in the operations of the Detention Center.

Recommendation 1: Additional opportunities for employee to provide input to management concerning what is working well and what needs to be improved should be developed and implemented.

Finding 2: Five questions received a mean score of 3.5 or better and are identified as strengths of the ASGDC: understanding job responsibilities, relevant annual in-service training, employees are adequately trained to manage a broad range of inmate behaviors, employees consider security a major priority, and supervisor is available when employee needs assistance.

Discussion: The following strengths of the ASGDC were identified by the respondents.

- 85.36% of the respondents stated that they agreed or strongly agreed with the statement "I have a clear understanding of my job responsibilities."
- 68.9% of respondents stated that they agreed or strongly agreed with the statement "Annual in-service training for employees addresses pertinent issues and relevant problems experienced by the employees."
- 64.03% of respondents stated that they agreed or strongly agree with the statement "Employees in the Detention Center consider security a major priority."
- 63.41% of respondents stated that they agreed or strongly agreed with the statement "I have been adequately trained to manage a broad range of inmate behaviors (e.g. manipulations, aggression, mental illness, substance abuse withdrawal, suicide threats, vulnerability, etc."

- 60.98% of respondents stated that they agreed or strongly agreed with the statement “My supervisor is available to help me when I need assistance.”

Recommendation 1: The employee perceived strengths of the ASGDC should be recognized and further developed.

Finding 3: Three Likert scale questions received a mean score of 2.5 or below on the survey. The Detention Center employees that responded to the survey believe that there are opportunities for improvement in building effective employee communication, fair pay and adequate staffing.

Discussion: The following opportunities for improvement at the ASGDC were identified by the employees.

- 53.66% of respondents stated that they disagreed or strongly disagreed with the statement “Employees at this facility communicate effectively with each other.”
- 76.78% of respondents stated that they disagreed or strongly disagreed with the statement “The Detention center is adequately staffed."
- 85.37% of respondents stated that they disagreed or strongly disagreed with the statement "I am paid fairly for the work that I do."

The ability to interpret the intent of the employees from a Likert scale questions is difficult. Many employees added comments in the free form section of the survey that identified specifics about these opportunities for improvement.

There are perceived difficulties with communication between management and supervisory staff about policy and procedure changes, expectations, and new directives. Line employees perceive that they don’t all receive consistent information or are given opportunity to give input, as evidenced by:

- “My immediate supervisor is always available; however, many opportunities to communicate my concerns and ideas to my supervisor have been disregarded.”
- “Communication between detention officers needs to be a little more precise and adequate. Without communication, the inmates might as well run themselves.”
- “Supervisors and officers do not communicate enough. Officers do not get enough information out of the officers they are relieving.”
- There were numerous comments about the perceived lack of adequate staffing that were often expressed as difficulty recruiting appropriate candidates due to poor pay. Comments often suggested that perceived poor pay contributed to low morale as a result of adequate staffing. These are suggested by:
- ”…if we were paid for the job that we do, a lot of officers will be more motivated to come to work and do a great job that reflects our pay.”
- “First and foremost the pay is ridiculously low the type of work we do. The facility itself is not fully staffed to maintain a secured work environment.”
- “A suggestion to keep professional, qualified, and dependable employees here at ASGDC would be to compensate them for the work that they do.”
- “We have been promised a raise for the last year and have yet to receive

anything. I have been employed at the jail for five plus years and have only received the county mandated cost of living raise. This is unacceptable and as a result lowers the morale of the facility."

- "Maybe if we made more money, we could keep quality officers."

Recommendation 1: It is essential that employees fully understand that the salary increase that was promised in 2013 was deferred pending a compensation study that we understand has just been initiated. The Study Team was advised that implementation of the pay increase last year would have been to the detriment of ASGDC staff and that they should fare far better when the compensation study is completed.[69]

Recommendations regarding staffing will be found in Section III of this study.

Finding 4: While the mean scores fell above the 2.5 cut point, employees also perceive opportunities for improving effective teamwork between all employees and contractors and also enhancing consistency within and between shifts.

Discussion: 43.29% of the respondents stated that they disagreed or strongly disagreed with the statement "There is effective teamwork by officers, medical, mental health and all other employees working within the Detention Center.

Nearly fifty percent (49.56%) of respondents stated that they disagreed or strongly disagreed with the statement "Detention Center operations are consistent within and between each shift."

Recommendation 1: Effective teamwork and consistent operations are impacted by many factors, including deficiencies in policies and procedures and post orders, different approaches and mindsets of supervisors, and a lack of opportunities for staff to communicate with others on their shifts and on others. Various aspects of this are addressed throughout this Study.

Table II.E.1 Results of Likert Questions on the Employee Survey

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean (Mode) Scale: 1-5
Orientation and pre-service training adequately prepares employees to meet the requirements and responsibilities of working in this Detention Center.	4.88%	17.07%	19.51%	41.46%	17.07%	3.49 (4)
Annual in-service training for employees addresses pertinent issues and relevant problems experienced by the employees.	4.27%	7.93%	18.90%	49.39%	19.51%	3.72 (4)
I have been adequately trained to manage a broad range of inmate behaviors (e.g.,	4.27%	10.37%	21.95%	42.68%	20.73%	3.65 (4)

[69] Source: Conversation with ASGDC Director Myers.

Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Mean (Mode) Scale: 1-5
manipulations, aggression, mental illness, substance abuse withdrawal, suicide threats, vulnerability, etc.).						
Employees in the Detention Center consider security a major priority.	7.32%	15.24%	13.41%	35.37%	28.66%	3.63 (4)
Gang activity is kept under control by employees in the Detention Center.	9.76%	24.39%	35.98%	23.17%	6.71%	2.93 (3)
Contraband is kept under control at this Detention Center.	6.10%	18.29%	27.44%	41.46%	6.71%	3.24 (4)
Employees are in control of the inmate population in the Detention Center.	5.49%	21.12%	25.61%	39.02%	9.76%	3.27 (4)
I feel equally safe in all areas of the Detention Center.	10.37%	24.39%	20.73%	33.54%	10.98%	3.10 (4)
Employees at this facility communicate effectively with each other.	26.22%	27.44%	23.17%	21.34%	1.83%	2.45 (2)
Employees at this facility communication effectively with inmates.	7.93%	14.63%	39.02%	36.59%	1.83%	3.10 (4)
There is effective teamwork by officers, medical, mental health and all other employees working within the Detention Center.	19.51%	23.78%	26.22%	25%	5.49%	2.73 (3)
My supervisor keeps me informed about things I need to know.	9.15%	15.24%	15.24%	37.80%	22.56%	3.49 (4)
My supervisor is available to help me when I need assistance.	6.71%	12.20%	20.12%	37.20%	23.78%	3.59 (4)
Management staff (Director, Captains and Sergeants) have a positive effect on employee morale.	18.29%	22.56%	23.78%	26.83%	8.54%	2.85 (4)
Management, including the Director, is regularly visible around the Detention Center.	18.29%	15.85%	17.07%	23.70%	11.59%	3.08 (4)
Detention Center operations are consistent within and between each shift.	26.22%	21.34%	19.51%	29.27%	3.66%	2.63 (4)
I have a clear understanding of my job responsibilities.	2.44%	2.44%	9.76%	45.12%	40.24%	4.18 (4)
I am paid fairly for the work that I do.	55.49%	29.88%	7.93%	6.71%	0%	1.66 (1)
My evaluation fairly reflects my job performance.	12.80%	19.51%	18.29%	37.80%	11.59%	3.16 (4)
Overall, I am satisfied with my job.	10.98%	15.24%	29.88%	34.76%	9.15%	3.16 (4)
I would recommend the Detention Center to family and friends as a great place to work.	21.95%	18.29%	29.27%	25.61%	4.88%	2.73 (3)
I have the resources (e.g. equipment, tools, supplies, information, technology) I need to do my job effectively.	12.80%	17.68%	27.44%	32.93%	9.15%	3.08 (4)
The Detention Center is adequately staffed.	48.17%	28.66%	10.37%	12.20%	0.61%	1.88 (1)

Finding 5: An analysis of the free form comment question on the survey found responses addressing issues of "pay", "supervision" and "morale" as the ones most frequently written about.

Discussion: Employees also had an opportunity to provide additional information and they contributed a number of comments that they wanted to be considered during the survey process. Many of these comments served to inform interviewer questions during the second on-site review by the Study Team. An analysis of the additional information revealed several themes than may be considered opportunities for improvement of ASGDC. The most common theme expressed by employees is that they believe that they are underpaid which decreases staffing, morale, and safety. The free form comments section of the survey was responded to by 114 employees, and consists of 20 pages of comments. Most employees commented on more than one topic. An analysis was completed to determine what percentage of respondents commented on each of the nine issues as noted in Table II.E.2 below.

Table II.E.2: Results of Free-Form Comments Question on Survey

Issue	Percentage of Respondents
Job Satisfaction	11%
Training	20%
Safety	21%
Communication	27%
Morale	27%
Resources	32%
Management	35%
Supervision	39%
Fair Pay	59%

Comments were both positive and negative. It is interesting that instead of complaining or pointing fingers, most of the employees offered suggestions for improvement. Also the employees clearly differentiated between management and supervisory staff. The most frequent comment about management was that employees would like to see top management more often in the facility. The most frequent comments about supervisors were related to communication and training with recommendations that supervisors receive supervisory training including appropriate supervisory communication skills prior to being placed in the position. There is a perception of favoritism in making promotions that is addressed in Section III of this report. There was also overlap in the comments about job satisfaction, morale, and fair pay relating one to another.

Recommendation 1: Management should consider employees' perceptions about issues such as presence in the facility. This issue is also discussed under II.D.3.

Recommendation 2: Employees' perceptions of supervisors should be fully evaluated in the context of recommendations the Study Team offers about supervisory

training in section II.D.8.

III. STAFFING

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A. Recruitment and Retention

Finding 1: The ASGDC has not implemented critical recommendations outlined in the 2008 Audit related to recruitment and retention.

Discussion: The Audit recommended enhancing the website to improve recruitment efforts. Specifically,

- The (ASGDC) homepage should have a clearly visible link that states, "Start a Career with the Alvin S. Glenn Detention Center."
- A link should be included for the ASGDC application for employment.
- Pictures of the facility should be included on the website.
- Other information should be provided similar to Spartanburg County including a virtual tour of the ASGDC.
- The positive aspects of ASGDC operations should be highlighted and emphasized to try to market the Detention Center as a place where employees would desire to work.

None of the recommendations related to website development have been implemented. The ASGDC is missing out on a far-reaching opportunity by not creating a web-based recruitment strategy.

As noted in the discussion regarding the job application below, the detention officer application continues to require applicants to have a "drug free background," a requirement that was recommended for deletion by the 2008 Audit.

The 2008 Audit also recommended increasing staff assigned to recruiting, which has not occurred. The ASGDC presently has a single sergeant assigned to recruiting. Though there has been a decrease in the detention officer vacancy rate, from 27% at the time of the Audit to 13% at this time, vacancies continue to be problematic.[70]

Recommendation 1: Consider implementing the recruitment strategies recommended in the 2008 Audit related to website development, job application revisions, and number of staff assigned to recruitment.

Finding 2: The recruitment video places an emphasis on soliciting veterans and criminal justice graduates for employment. It also promotes the ASGDC as an exciting work environment by primarily portraying situations requiring a physical, hands on approach to managing inmate behavior.

Discussion: The recruitment video may be inadvertently eliminating potential candidates in one of two ways. First, the recruitment video targets veterans and criminal justice graduates. A person who is neither may be left with the impression that

[70] Source: Jerilyn Jones, ASGDC Personnel Specialist; February 2014

without either of these qualifications, he/she might not be considered a viable candidate and, therefore, not apply.

Second, in contemporary correctional facilities, recruitment efforts focus on attracting candidates who possess effective decision-making and problem-solving skills; have the ability to communicate, listen, and provide direction; and have the ability to treat people fairly and motivate them to engage in positive behavior. The recruitment video disproportionately emphasizes those aspects of a detention officer's job that involve the use of force and responding to emergency situations. In reality, ASGDC needs to recruit candidates who have both skill sets, which are necessary to be an effective detention officer.

Recommendation 1: Rework the recruitment video to provide more balance between the two major skills sets required of an effective detention officer.

Recommendation 2: The video should encourage all qualified applicants to apply for the position of detention officer, and not focus exclusively on veterans and criminal justice graduates.

Finding 3: The application used for hiring detention officers is limiting the applicant pool.

Discussion: The application for detention officer is 22 pages in length and must be completed manually. It is arduous to fill out, requiring redundant information, requiring information that is not considered in the hiring process, or contains information that is contradictory. The application itself is not well organized and provides information that is generally found in a job description or policy and procedure manual. We note that the detention officer application available on the Richland County website differs from the paper version available at Richland County's human resources department or at the ASGDC.

Both versions of the detention officer application contains minimum qualifications that are unrealistic, e.g., drug free background, or inaccurate—while the application says no criminal history, only certain convictions are automatic disqualifiers.

The job application also requires an applicant to provide an all-encompassing release that allows the ASGDC, as part of the hiring process, to access personal information that is not job related. The release states, in part,

"…*financial statements or records whatever filed; medical and psychiatric treatment and/or consultation, including hospitals, clinics, private practitioners, and the US Veterans Administration, employment and pre-employment records, and recollections of attorneys at law, or of other counsel, whether representing me or another person in any case, either civil or criminal, in which I have or have had and interest*."

Recommendation 1: Review and revise as indicated, the minimum qualifications for detention officer, ensuring each qualification is objective and verifiable, and serves a

job-related purpose.

Recommendation 2: Until such time that the detention officer application is evaluated, the basic Richland County job application should be used for the detention officer position.

Recommendation 3: Conduct a comprehensive assessment of the detention officer application, with the goal of streamlining the application and only requesting information that meets an articulated objective of the hiring process.

Recommendation 4: Eliminate discrepancies in detention officer applications, and create the ability to complete the application electronically.

Finding 4: The ASGDC does not maintain or analyze data related to detention officer applications.

Discussion: Data is maintained on how many detention officer applications are received; yet data on who successfully completes the hiring process or who is not hired and the reason for not being hired is not maintained. This type of information is useful for tracking patterns and trends, particularly as it relates to specific reasons for not being hired, i.e., qualification, hiring process step—polygraph, physical fitness, written test, which allows administrators to make informed decisions regarding any application modifications being considered.

Recommendation 1: Establish a database that tracks detention officer applications received and the final outcome as it relates to hired or not hired. The final outcome for applicants not hired should include a level of detail that lends itself to categorization and analysis.

Finding 5: Though there has been a decrease in the detention officer vacancy rate—from 27% at the time of the 2008 Audit to 13% at the time of this Study, vacancies continue to be problematic.

Discussion: In 2008 there were 76 detention officer vacancies and at the time of this Study there were 35. Excessive vacancies result in mandatory overtime, stressed officers, and inconsistent post assignments, which hamper effective supervision of inmates. Information regarding resignations and terminations is informally maintained, and is not recorded in a format that lends itself to analysis.

Each employee leaving ASGDC employment is offered an exit interview. The practice is for the supervisor to provide a written exit interview to the employee, who has the option to complete it. There is no effort made to actually interview the employee. Consequently, the completion rate is not high. Of the 97 employees who left ASGDC in 2013, 35 completed the exit interview.

Data available for the period 2010-2011 reveals that the number of new hires peaked at 126 in 2011, while 2013 experienced the lowest number of new hires at 74 since 2010.

For years 2011 through 2013, slightly fewer than 100 employees left ASGDC employment each year. The percentage of detention officers who left ASGDC employment within the first 12 months of employment has decreased 24.3% since 2011. In 2013, 44.3% of detention officers who left ASGDC employment were within the first 12 months of their employment, compared to the 2011 rate of 58.5%. This means that more veteran staff are leaving now than previously.

Establish a formal database that tracks detention officer resignations and terminations, including the reason for each. The reasons for detention officers leaving ASGDC employment should include a level of detail that lends itself to categorization and analysis.

Recommendation 1: Develop a process where an impartial person personally conducts exit interviews with employees leaving ASGDC employment.

Recommendation 2: Information gleaned from the collected data and exit interviews, along with the information obtained from the recruitment data, should be routinely evaluated to identify patterns and trends. This information should inform administrators regarding improvements and/or enhancements that will improve detention officer recruitment and retention.

B. Promotions

Finding 1: The promotional process is perceived by some staff to lack integrity and credibility.

Discussion: The employee climate survey conducted as part of this study revealed a perception that the promotional process is not objective and does not always result in the selection of the best candidate. Not unique to ASGDC, the perception is that persons selected for promotion are promoted for a couple of different reasons, "*who you know*" or "*they pick who they want.*" Both imply preferential treatment based on personalities, not knowledge and skills. In addition, a large number of survey responses noted the ineffectiveness of supervisors, particularly in areas related to managing staff.

Policy 7B-18: Promotions and Transfers outlines an objective, point-additive promotional process, with the highest points receiving first consideration for promotion. The promotional process includes a scored interview (verbal board), a score that could be considered subjective. Presently, ASGDC supervisors and managers conduct promotional interviews. This may be a contributing factor to staffs' perception of a biased promotional process.

Recommendation 1: Consider the use of assessment centers in the promotional process. Assessment centers involve a series of tests, mock scenarios, activities, and simulation exercises that allow the organization to see how candidates react in an environment similar to the one they would be working in.

Recommendation 2: Include professionals from other jails in the composition of

the board that conducts promotional interviews.

Finding 2: Newly promoted supervisors are not subject to a probationary period.

Discussion: *Policy 7B-18: Promotions and Transfers* requires newly promoted employees to meet any probation and training requirements of the new position. However, there are no promotional probation periods listed. During the course of this Study, the Study Team was informed that the County adopted a countywide policy that states newly promoted staff will not be subject to a probationary period.[71] Without a probationary period, the ASGDC lacks an important mechanism to remove an unsuitable supervisor during a period in which they are receiving training in their new position and being evaluated as to their suitability for the new position.

Recommendation 1: Petition the County for restoration of probationary periods for newly promoted staff.

C. Staff Deployment

Finding 1: The deployment of staff is not governed by a formal staffing plan.

Discussion: The authorized staffing complement for the ASGDC in December 2013 was 342 employees, of which 267 are detention officers.[72]

There is no consolidated staffing plan that outlines all positions and posts within the two facilities, including what hours and days they must be covered, whether they must be relieved, and whether there are special qualifications needed to carry out the requirements of that post. In addition, there is no document that identifies *essential posts*—those that must be staffed during established hours of operation; *pull posts*—those that can be left temporarily unstaffed due to inactivity; or *shutdown posts*—those posts that can be consolidated on a short-term basis with another post. Nor is there a policy that effectively guides watch commanders in making these determinations. Furthermore, there is no priority ordering for the pulling or shutting down of posts.

A staffing plan is a reflection of having the right number and type of staff in the right place at the right time doing the right thing. It considers any special qualifications needed to carry out the various functions associated with operating a contemporary correctional facility while accommodating peaks and valleys in activity levels/workload.

Recommendation 1: Retain external resources to undertake a comprehensive staffing analysis, including calculation of Net Annual Work Hours (shift relief factor). Work closely with County fiscal staff to adequately fund the resultant staffing plan.

Recommendation 2: Develop and implement a shift roster management policy and procedure that guides allocation of staff resources. At a minimum, the shift roster

[71] Warren Harley, Assistant County Administrator
[72] Source: Jerilyn Jones, ASGDC Personnel Specialist

management policy and procedure should identify by shift, essential posts, pull posts and shutdown posts. In addition, it should include the priority order that posts will be shut down.

Finding 2: Although a formal staffing plan was not prepared as part of this Study, several areas were identified as requiring additional personnel to adequately fulfill key ASGDC functions.

Discussion: A formal staffing analysis was beyond the scope of this Study. However, based on the Study Team's observations, interviews, and review of provided materials, and survey results, the following comments are offered regarding select staff resource allocation and deployment.

- There is insufficient staff to meet the intent of the classification system.
- There are no dedicated staff associated with the social service, counseling and treatment programs for juvenile detainees.
- The operations captain is presently responsible for ten important and widely disparate functions that serve cross sections, i.e., programs, administrative, and security. This substantial portfolio is too extensive for one person to be effective.
- The grievance system is understaffed, which results in delayed processing of inmate grievances.
- There is a need for administrative assistant support on an ongoing basis to adequately sustain new and revised policies and procedures.
- The number of utility officers assigned to each Housing Phase is inadequate to meet the workload demands and still provide adequate back up to the housing officers. Responsibilities associated with these posts require the officer to leave the Housing Phase area to escort inmates throughout the building, leaving no immediate backup staff available.
- The foodservice area has no security staff allocated. This impacts the supervision of inmate workers with sharps and tools, as well as a lack of point-to-point personal searches to preclude movement of contraband throughout the facility.

Recommendation 1: In advance of completing a formal staffing plan, consider making adjustments in staffing resource allocation or deployment to resolve the identified concerns/issues.

Finding 3: The supervisory span of control meets appropriate professional levels.

Discussion: The ratio of assistant watch commanders to detention officers on each of the four squads approximates 1:10-11. This is a level that provides sufficient opportunity for adequate supervision of subordinate staff. Supervisors should have sufficient availability to work with each officer in developing his/her knowledge and skills necessary to be an effective detention officer.

Recommendation: None

D. Overtime

Finding 1: The system for assigning mandatory overtime is fair and equitable.

Discussion: A challenge for any correctional facility is to effectively assign staff to duty posts and schedule them in a manner that provides adequate coverage across all shifts. Often staff is not available to work assigned shifts because of vacation or sick leave or training, or a staff vacancy may exist. Both situations require that alternate coverage be provided. This is typically achieved through a combination of shutting down posts, having additional staff regularly assigned to a shift, and/or assigning overtime. If an agency experiences a high vacancy rate, the use of overtime will likely be the primary method for filling vacant shifts.

In the fall of 2013, the ASGDC implemented a new procedure for the assignment of detention officers' overtime, which was developed with the input of staff. Each shift squad[73] maintains an overtime list containing the names of the detention officers assigned to the respective shift. Each person on the list is given a number that is increased by one for every shift that the person is not assigned overtime. The person with the highest number is the person who will be assigned overtime. Once assigned overtime, the person's number is reset to zero. It is the watch commanders' responsibility to maintain their respective shift's overtime list.

This method of assigning overtime has been well received by staff since it allows an employee to project the days they may be subject to overtime, which alleviates the uncertainty about whether employees will be able to go home at the conclusion of their shift or disrupting plans made for a day off.

When queried, staff gave mixed responses whether they could make arrangements with another officer from their shift squad to assume the mandatory overtime should the mandated overtime occur on a day that the employee had a preplanned appointment/event. The response was varied. Initially, this was possible under the new system. Now it has been modified and any modifications seem dependent upon unique rules that individual watch commanders may have put in place.

Recommendation 1: Continue the assignment of mandatory overtime using the assignment system implemented in the fall of 2013.

Recommendation 2: Create provisions for employees to fulfill their mandatory overtime obligation without having to actually work the overtime assignment that will apply to all shifts. These provisions should limit the circumstances, frequency and/or situation, under which an employee can exercise this option. And, in exercising this option, establish where the employee falls on the overtime list, i.e., does the employee continue to increase in number or are they are reset to zero.

Finding 2: With few exceptions, the watch commander determines the

[73] ASGDC's shifts: Shift A-am; Shift A-pm; Shift B-am; Shift B-pm

circumstances when overtime is utilized.

Discussion: Watch commanders may assign overtime to six people without first seeking administration approval. The reasons for overtime are varied and include an inmate housed at the hospital requiring security supervision, staff vacation or sick leave, staff training, and inmate transport to name a few.

In filling shift post vacancies, watch commanders determine what posts, if any, will be shutdown or operate with reduced staffing. Select post orders identify mandatory staffing levels. The decision regarding whether staffing levels mandated by post orders are maintained and/or the actual post(s) that will be/are shutdown varies according to the assigned watch commander. It was observed during tours of the ASGDC that central control was staffed with one officer, even though post orders mandate it be staffed on a 24-hour/7-day basis. The public lobby post was similar in that, though two officers were assigned initially, one officer was "pulled" during the shift to perform other duties.

Recommendation 1: Develop and implement a shift roster management policy and procedure that guides watch commanders across all shifts in making consistent decisions regarding the allocation of staff resources and the need for overtime (see section III.C Finding 1).

Finding 3: The ASGDC currently lacks a mechanism to track and analyze the factors contributing to overtime.

Discussion: The director monitors overtime usage by reviewing monthly budget reports and, when there is a concern, a review of shift rosters. However, there is no tracking of overtime by employee, by reason, by shift, or by date, which would be useful in identifying and analyzing patterns and trends. This information is useful for administrators in determining whether the workload patterns have changed over time such that a particular activity/duty now supports the assignment of a full time post or there are opportunities to realign activities/duties. For example, data that shows an average of two people on a 24-hour/7-day basis being assigned to supervise inmates at the hospital on overtime might result in a request for two full time staff, which may reduce overall expenditures when compared to the present practice of paying overtime at premium rates.

Recommendation 1: Explore whether the capabilities of the existing payroll system allow for the tracking of overtime, particularly by reason, in a manner that lends itself to analysis. In the absence of any such capability, create an electronic reporting system whereby overtime is documented and tracked in a manner that lends itself to analysis in the aggregate, so that patterns and trends may be identified.

IV. POPULATION MANAGEMENT

IV. POPULATION MANAGEMENT

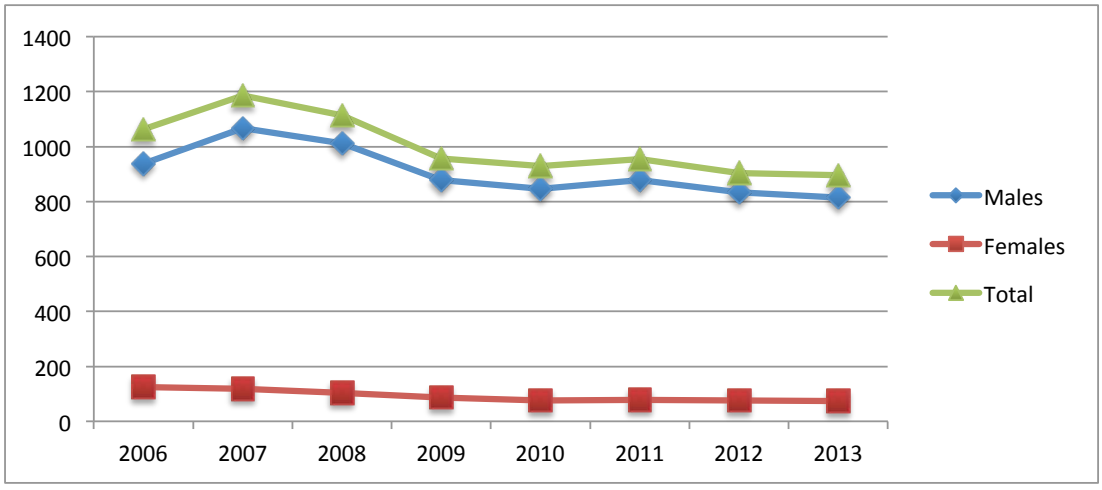
A. Population Trends

Finding 1: The average daily population of the ASGDC has decreased over the past seven years, reflecting shorter lengths of stay in custody and decreased numbers of jail admissions during this period.

Discussion: The population in Richland County as a whole has increased by 19.9% since 2000. According to the Columbia Crime Rate Report[74], there is an overall upward trend in crime based on data from 12 years with violent crime decreasing and property crime increasing. Based on this trend, the crime rate in Columbia is expected to be higher in 2014 than in 2010. Several officials interviewed, including the judiciary, also noted this increase in property crimes, particularly burglaries. It is also important to note that the violent crime and property crime rates for Columbia in 2010 (incidents per 100,000 inhabitants) were higher than the national average by 147.93% and 105.73% respectively.[75]

Despite the increase in the total population and the increase in the crime rate over the past several years, the inmate population in the ASGDC continues to gradually drop. Table IV.A.1 below illustrates the average daily population (ADP) in the facility from 2006 – 2013. The highest population was noted in 2007 at 1187, and the lowest population in 2013 at 896.

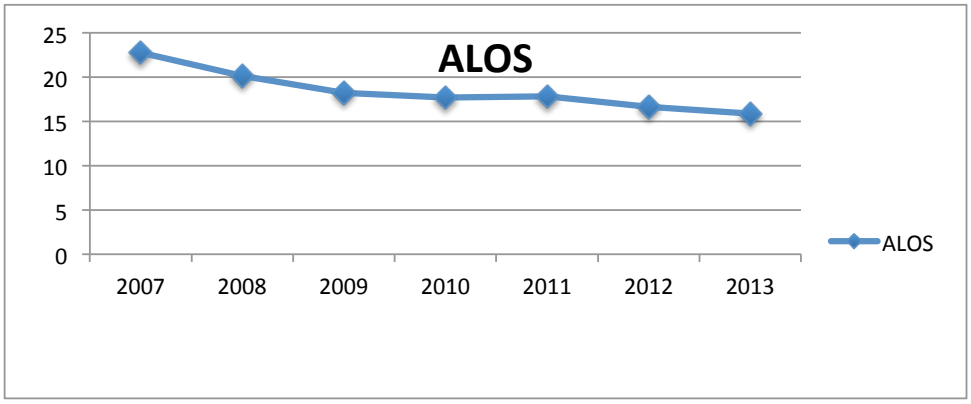
Table IV.A.1: Average Daily Population



[74] Source: Obtained from the Internet 2/17/2014 from htt://www.cityrating.com/crime-statistics/south-carolina/Columbia.html#.UwJs2kJdWeA.
[75] Source: Obtained from the Internet 2/17/2014 from htt://www.cityrating.com/crime-statistics/south-carolina/Columbia.html#.UwJs2kJdWeA

The average length of stay (ALOS) is a key indicator and component of ADP. Table IV.A.2 illustrates that the ALOS has also decreased from a high of 22.79 average days incarcerated in 2007 to a low of 15.89 ALOS in 2013. The 2008 Performance Audit noted that the judiciary was targeting cases of offenders who have been detained for over two years pending trial, which can severely skew the mathematical calculation of ALOS even though it may not affect large numbers of inmates.[76] These reports continue to be generated and several judges indicate that they review and considered the delays.

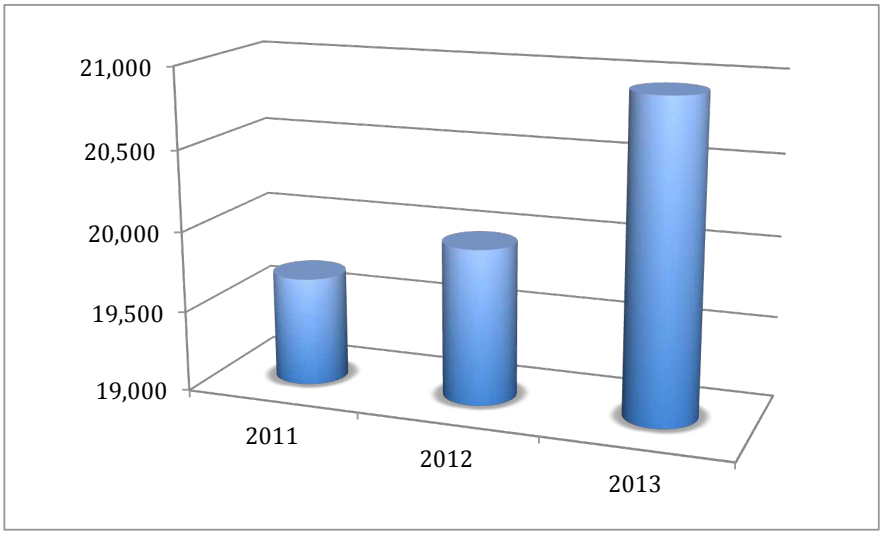
Table IV.A.2: Average Length of Stay



Coupled with ALOS, as one of two primary components of ADP, is the number of admissions to a jail. It is important to note that the number of admissions has increased from 2011-2012 (1.2% increase) and from 2012 – 2013 (4.5% increase). So far, the number of discharges has been consistent with or higher than the admissions; therefore the average daily population and average length of stay continue to slightly decline.

[76] Hammett Consulting. Alvin S. Glenn Detention Center Performance Audit. September 16, 2008. P10.

Table IV.A.3: Total Bookings 2011 – 2013



Other than the increase in burglaries reported by several officials, there were also recent cases of concern regarding bonds. A recent panel organized by the City of Columbia Mayor made recommendations regarding violent crime and bond review, which include legislative initiatives designed to impose stricter state laws on releasing violent, repeat offenders awaiting trial.[77] Initiatives such as these may have a significant impact on releases, particularly if there is no supervision mechanism while these offenders are released on bond.

Recommendation 1: Data captured by staff (manually) was used to create these tables in MS Excel. Similar analyses should be conducted of existing data to determine if particular trends require further investigation or if policy decisions can be made around the trends (e.g., allowing for more staff vacations during the holiday season since the volume of work decreases).

Recommendation 2: Make population data available to the criminal justice system members so that potential increases in the ASGDC population can be projected and appropriate measures taken to address potential crowding.

Finding 2: The ASGDC has a full-time population manager who performs a variety of tasks that relate to documenting the flow of inmates and the jail population.

Discussion: Employing a population manager presents opportunities for the ASGDC to actively manage jail population internally and to make sure that there is appropriate and effective information flow about population trends to other members of the criminal

[77] Obtained from the Internet on February 20, 2014. http://www.thestate.com/2014/01/21/3219995/columbia-mayor-talks-safety-as.html

justice community.

Although the population manager maintains population data, there appears to be limited data driven decision making regarding either the impact of population changes internally (e.g., fluctuations in custody levels and classifications), or externally by advising the director and other criminal justice partners of the changes in the overall population – particularly the demographics.

Tasks performed by the population manager include recording current population counts on the computer spreadsheet, completing forms for inmates desiring to plead guilty to their charges, and compiling pretrial reports as required. The population manager also performs some duties that assist with expediting bench trials (i.e., those who want to plead guilty) or those that have a City Municipal court date over 21 days past. Yet along with these duties, the population manager may be assigned to County bond court or assist with facility tours.

Data driven decision making at all levels aids in ensuring that the appropriate arrestees are confined for public safety, but provides alternatives (i.e., bond, personal recognizance, program participation, supervision while on bond) when defendants have the means for stability in the community and do not present a danger to the community.

Recommendation 1: The population management function should be a priority for improving the jail management system. The population manager should be using data that would ideally be obtained through management reporting software to inform the classification staff internally and the director and other criminal justice partners of trends or other noteworthy changes in the population that may impact the need for additional jail beds or additional community alternative programming.

B. Impact of Classification

Finding 1: Although the facility is operating below its overall capacity, there are instances where housing units operate either well below or above their capacity due to mismatches between capacity and inmate classification/custody needs.

Discussion: While the total number of beds is an important indicator of capacity, so is the distribution of bed types, which are necessary to match the classification of inmates. Specific housing areas and bed types (single cells, multiple occupancy cells, and dormitories) must be reserved for an appropriate to safety and security needs of different inmate subpopulations. Harder, single cells are required for segregation populations, dormitories are appropriate for minimum and perhaps medium security inmates and separate areas must be reserved for male inmates and others for female inmates. In other words, not all beds can be used for all populations and to the degree that there is not a precise match (and never can be) capacity can go unused and crowding can occur despite there being seemingly an adequate total number of beds.

Despite the lower population levels, several housing units are crowded, which presents potential safety and security concerns. As was discussed earlier in this Study, The

Special Housing Unit is perhaps the most extreme example whereby double occupancy housing must be implemented because of the large numbers of inmates who are currently identified as needing to be housed in this area.

Conversely, a minimum custody housing unit only has 35 of 56 beds filled, but the custody levels range from Level 3 (high-medium custody) to level 8 (low minimum custody).

Equally significant is that 17 year old inmates are currently housed in the general population and not separated by sight and sound from adult inmates as required by PREA standards.[78] Most, if not all of the 17 year old inmates (currently all males) are classified as medium custody, and therefore, barring separation requirements, could be housed together in a subunit.

Moreover, and perhaps more importantly, there is not an adequate mechanism to capture classifications of inmates.[79] Therefore, it is often the inmate's housing placement that determines their classification and how they are managed; this is particularly true of the Special Management. Classification decisions typically override custody level, but the housing must be appropriate for the need. For example, persons with mental illness are more likely to be managed in a more typical setting if the appropriate practitioners and programs are available.

The lack of a robust jail records management system makes it very difficult to determine specific bed needs to then ensure that inmates are placed in an appropriate bed.

Recommendation 1: Evaluate the housing needs for special population classifications to provide the appropriate housing configuration (e.g., single or double occupancy), programmatic requirements (e.g., access to adjacent program space, dayroom access, etc.) and staffing requirements (e.g., readily available mental health treatment personnel).

Recommendation 2: Establish procedures and data management practices to identify all inmate classifications and custody levels, and then overlay the bed needs with the available beds. If necessary provide the necessary operational modifications to meet the housing needs for special populations.

C. Criminal Justice System Coordination

Finding 1: There are opportunities to increase cooperation and coordination among the Richland County criminal justice system partners.

Discussion: Virtually all criminal justice system partners who were interviewed by the

[78] PREA Standard 115.14
[79] Custody level is often referred to as the security risk of the offender; while, classification includes the specialize management that may be required (e.g., medical, mental health, protective custody, disciplinary and administrative segregation, etc.). Inmates of the same classifications may have varied custody levels.

Study Team acknowledged significant gaps in operating as a "system." Decision-making often occurs in a vacuum without input from other stakeholders. In some cases decision makers were not aware that ASGDC programs had been suspended or that other agencies were contemplating programs that may benefit the community and the efficiency or effectiveness of the criminal justice system.

There are also myriad matters that arise in the day-to-day operations of the criminal justice system that cannot necessarily be resolved properly by one single member of the system. For example, there are many issues that arise with respect to sentence calculations and interpretations of judicial orders and expectations. ASGDC records staff must insure that their interpretations of such orders does not result in errors that could either result in a defendant being released from jail prematurely or, conversely, confined longer than is legally permitted. One example is in the case of an inmate who may be held in a pretrial status for a longer period of time than the maximum amount of time the defendant would have received if convicted for the offense(s).[80] There is also a South Carolina Supreme Court opinion that requires that persons on bond who are rearrested on new charges, but their previous bond was revoked, are eligible for credit for time spent in jail on all of the charges.[81] While the judges rely on ASGDC staff to use their experience and make appropriate interpretations to resolve such matters, or to contact the individual judge if an interpretation is necessary, there is no established process to resolve systemic questions as they arise.

Moreover, decisions to expand the jail should be made with full input from criminal justice system stakeholders and with full consideration of approaches to limit or control the jail population as well as factoring in issues that could increase jail populations.

Recommendation 1: The stakeholder members of the criminal justice system should consider establishing a Criminal Justice Coordinating Committee consisting of, at a minimum, the following criminal justice partners:

- ASGDC
- Richland County Sheriff's Office
- City of Columbia Police Department
- South Carolina Department of Probation, Parole and Pardon Services
- Richland County Probate Court
- Fifth Judicial Circuit Public Defender
- South Carolina Department of Mental Health
- South Carolina Department of Education, District One
- Richland County Magistrate Court

[80] A Supreme Court Order directs that where a defendant incarcerated on a summary level offense(s), is unable to make bond, and is detained pretrial for the maximum amount of time that the defendant would be subject to if convicted for the offense(s), the on-call bonding magistrate or municipal court judge shall immediately convert the defendant's surety bond to a personal recognizance bond and discharge the defendant. Printed from http://m.sccourts.org/whatsnews/displaywhatsnew.cfm?indexID=689 dated November 1, 2010.

[81] Opinion No. 25086 Ricky Lee Allen, Petitioner, v. State of South Carolina, Respondent. 339S.C.393; 529 S.E. 2d 541; 2000 S.C. LEXIS 62.

- South Carolina Department of Corrections
- Fifth Judicial Circuit Solicitor
- Alston Wilkes Society
- Richland County Administrator's Office
- Victims' Advocates

Recommendation 2: This committee should meet at least quarterly and, with a planned agenda, address current issues impacting the criminal justice system and appropriate reentry planning. Status reports, with outcomes, should be expected from the committee members. Expectations, action plans and minutes should be components of the committee.

Finding 2: Pretrial release options are limited and do not include information verification.

Discussion: The Pre-Trial Release Program, once noted as a "crucial part of …inmate population management"[82] no longer provides the same benefit to the criminal justice system. Although criminal histories are still obtained, the interviews performed by three assigned ASGDC staff appear to be more about eligibility to have a public defender appointed rather than to provide verified information to the judiciary for bonding decisions. The Program's 2013 third quarter report indicates that of the 5214 offenders booked, 15.4% (801) were eligible for screening. Of those screened, 77.8% were given a personal recognizance bond. The procedures (5B-14) do not outline the criteria for eligibility.

Private attorneys generally provide employment histories and other community stability information that is used by the judiciary to make bonding decisions. Several judges report that they are confident that they generally receive accurate information directly from the inmate, thus making the pretrial interview unnecessary except for determining eligibility for financial aid/public defender.

Typically pretrial programs include a validation component and the potential for pretrial supervision in lieu of bond. Programs such as these provide better access to release prior to trial regardless of an inmate's financial status.[83] Many pretrial program models exist, and assistance in developing pretrial programs can be obtained through the National Association of Pretrial Services Agencies or the National Institute of Corrections.

Recommendation 1: The judiciary, County Council and the Detention Center should discuss the merit of focusing the pretrial staff to provide validated information to the judiciary and supervision of pretrial offenders in lieu of bond.

[82] Hammett Consulting. Alvin S. Glenn Detention Center Performance Audit. September 16, 2008. P10.
[83] The Solicitor operates a Pretrial Intervention program, however this program typically requires that the inmate first make bond prior to program placement. Source: Interviews with Campbell L. Streater, Solicitor's Office, and Chief Judge Robert Hood.

D. Need for Jail Expansion

Finding 1: The average daily population of the ASGDC has decreased over the past seven years as the number of admissions to the facility and the average length of stay are trending down as well. Absent population forecasts that can support an upward trend, population pressures alone do not support the need for an expansion of beds.

Discussion: The capacity of the ASGDC is 1,116.[84] The average daily population of the ASGDC has remained below 1,000 for the past six years and averaged just fewer than 900 in 2013. This is a reflection of the decrease in both annual admissions and the average length of stay, both of which have decreased consistently and precipitously since 2007.

The mere fact that the capacity exceeds the average daily population of a jail does not necessarily suggest that there is adequate capacity. For example, jails typically require at least a 10% flexibility factor to accommodate different inmate classifications; an empty bed in a women's unit cannot be filled with a male inmates, a minimum security bed cannot be filled by a maximum custody inmate, etc. So a certain percentage of beds, typically 10-20% in jails, must always be available to accommodate not just these classification differences, but there are also seasonal and event driven peaking factors that do cause fluctuations in the calculated "average."

There are other potential factors that could enter into the picture which would reverse the six-seven year population trend and take the facility back to previous very crowded conditions, although this does not appear to be an imminent concern such that it *alone* would justify construction of new beds. Moreover, current trends have been accomplished without the benefit of an overarching comprehensive strategy to control jail population growth.

Recommendation 1: The County should closely monitor jail population levels, admissions and length of stay to determine whether they are trending up, which could suggest the need for additional jail beds or the development and implementation of additional diversion or alternatives initiatives.

Finding 2: Although population pressures alone do not necessarily justify the imminent need for additional beds, there is a pronounced need for construction of new spaces, including beds for specific sub-populations.

Discussion: While the current and recent population has been significantly below the rated capacity, that factor alone does not mean that additional beds are not required for some special populations. Elsewhere in this report we discuss the need for specially planned and designed beds for a number of populations to include:

[84] Source: document prepared by ASGDC in preparation for 2013 South Carolina Department of Corrections Inspection report. This includes adult beds only and does not include 44 beds designated as special purpose, holding or infirmary.

- Inmates with mental illness
- Inmates who require protective custody
- Youthful offenders (17 year olds), both male and female
- Inmates who require substance abuse treatment and support
- Inmates on suicide watch
- Women

The existing facility does not currently have sufficient and appropriate beds to accommodate inmates in these categories and there is a deleterious effect associated with current efforts to "make do" in these areas.

In addition to housing needs for these special populations, there are other specific needs that are currently problematic and cause significant operational drawbacks. For example, the current admission and discharge area is significantly too small for the peak flows of inmates into and out of the Detention Center. This causes delays in law enforcement officers being able to drop off their prisoners and return to the streets. In addition, public defenders and other attorneys and official visitors are currently visiting with their clients inside the secure perimeter of the Detention Center in multipurpose rooms that are adjacent to and accessible from the housing units; this is a particularly unsafe condition. Similarly, two centralized classrooms are far from sufficient to meet the needs for inmate education and programming. Although the multipurpose rooms associated with the housing units could be used for programs, the space for professional visitors would be even further limited.

Recommendation 1: The County should carefully consider an expansion plan that would allow for the creation of special housing environments for the populations identified in this Study as well as to remedy some key facility deficiencies identified above.

V. APPENDICES

A. List of Interview Subjects

ASGDC Interviews:

Betty Fairmont, Support Services
Capt. Curtis Bufford, Security
Capt. Michael Higgins, Security
Capt. Washava Moye, Operations
Dori Jones, Admin/Records
Jerilyn Jones, Personnel Specialist
Karen Barnes, Operations/Records for Booking and Discharge
Kathy Harrell, Assistant Director
Keisha Solomon, Pretrial Program Staff
Lt. Sligh, Grievances, Security Threat Groups, Discipline
Lt. Craig Shaylor, Training
Lt. Donald Weston, Juvenile Detention
Lt. James L. Hayes, Programs Manager
Lt. Joli Rish, P&P Development Coordinator; Accreditation Manager
Lt. Jonathan Williams, Security-Watch Commander
Lt. Lippett, Shift Commander/Watch Commander
Lt. Margita Friedley, Director of Professional Standards
Lt. Tamika Legette, Operations Watch Commander
Lt. Walter Smith, Shift/Watch Commander
Michael Smith, Facility Maintenance Manager
Paige Boddie, Contract Manager/Quality Assurance
Ronaldo Myers, Director
Sgt. Charles Lott, Security
Sgt. Erin Truesdale, Operations/Assistant Watch Commander
Sgt. Freeman, Security/ Assistant Watch Commander
Sgt. John Monroe, Operations/ Assistant Watch Commander
Sgt. Kenneth Scott, Operations – Transportation
Sgt. Maurice Callahan, Training Manager/Firearms Instructor
Sgt. McCollough, Operations
Sgt. McNice, Security
Sgt. Samuel Jackson, Operations- Assistant Watch Commander
Sgt. Saunders, Security/Assistant Watch Commander
Sgt. Teraine Brown, Recruiter
Sgt. Valerie Suttle, Security/Shift Sgt.
Sgt. Walters, Professional Standards
More than 100 line employees

Stakeholder and Other Interviews:

Anastasia Walker, Public Defender, SCCID
Andrew Kelley, Mental Health Professional, Columbia Area Mental Health Center

Blake Taylor, South Carolina Dept. of Corrections Division Director, Compliance, Standards and Inspections
Campbell L. Streater, Investigator, Fifth Judicial Circuit Solicitor's Office
Carolyn Yon, Richland County Information Technology
Chief Judge Robert Hood, Fifth Judicial Circuit, South Carolina
Chief Stephen G. Birnie, Deputy Chief, Sheriff's Dept.
Constantine Pournaras, Public Defender, SCCID
Corretta Kea, Mental Health Professional, Columbia Area Mental Health Center
Dan Cole, Richland County Information Technology
Diane Simpkins, CCS Health Services Administrator
E. Fielding Pringle, Chief Richland County Public Defender
Glen Levin, South Carolina Highway Patrol
Judge Kirby Shealy, Associate Judge County Bond Court
Julius Jones, Mental Health Professional, Columbia Area Mental Health Center
Lt. Teena Gooding, University of South Carolina Division of Law Enforcement and Safety
Major Wesley Luther, Director of Training & Employment, Sheriff's Dept.
Robyn Richburg, Mental Health Professional, Columbia Area Mental Health Center
Ruben Santiago, Interim Chief of Police, City of Columbia
Stacy Bartkovich, Asst. AIC, South Carolina Dept. of Probation, Parole and Pardon Services
Wanda Streeter, R.N., CCS Regional Manager

B. Data and Document Request

Alvin. S. Glenn Detention Center Operational/Management Study

Initial P/BA Data and Document Request

November 12, 2013

1- ASGDC Policies and Procedures (download CD version from online system or send hard copy—preference for the former)
2- Appendices and Attachments (including forms particularly related to work processes for booking, security custody and care operations; inmate request form, incident report form, daily/periodic inspections checklists)
3- Current organizational chart for ASGDC
4- Post orders
5- Housing Unit Manual
6- Inmate Handbook
7- Past two S.C. accreditation results on ASGDC operations (including findings, recommendations and responses)
8- County rules, regulations and ordinances affecting operation of the jail
9- Interagency governmental agreements related to booking and security operations (including mutual aid agreement)
10- Floor Plan/Housing Plan/Facility Layout
11- Facility Activity Schedule
12- Housing Unit Activity Schedule (for regular housing unit, open bay dorm, SHU)
13- Booking/Intake Forms and Checklists for Booking Process (screening, admissions documents, property inventory)
14- Job/Position Descriptions for Detention Center Security Staff
15- Quality Assurance Data related to jail operations
16- Key Performance Indicators relevant to jail operations
17- Past three years of incident data by location including fights between inmates, staff use of force, contraband found.
18- Other more recent operational audits on any areas of ASGDC
19- Diversion Programs available to ASGDC/in place in the criminal justice system. Include all programs that may be used to divert offenders from the jail including pre-trial programs, sentencing alternatives and reentry programming.
20- Most recent annual ASGDC report, if available.
21- Description of type of inmates housed in each unit (pod), e.g., by custody level, gender and adult vs. juvenile. Number of beds per pod.

22- Copy of classification plan and description of each classification designation, e.g., minimum, medium, maximum, special management, special needs (medical, mental health) community, etc.
23- Population Breakdown: County, state, revenue, male/female, adult/juvenile, pretrial/sentenced, etc. Identify any significant changes in population breakdown over previous year.
24- Average Daily Population- By month for past three years.
25- Average Daily Population Profile -Number of inmates for each classification designation for at least the past year.
26- Average Number of Daily Admissions For past three years (identify peak periods during the day, week, year)
27- Average Number of Daily Releases For past three years (identify peak periods during the day, week, year)
28- Identity technology current in use
    a. JMIS
    b. PDA
    c. Video conference
    d. RFID technology
    e. Full body scanning
    f. Security screening
    g. Biometrics
    h. Telehealth
    i. Security technology
29- Listing of inmate worker assignments
    a. location and number of inmate workers assigned
    b. eligibility criteria
30- Current staffing plans identifying all custody posts and civilian posts by shift and assignment
31- Monthly statistical reports for last two years addressing such data as: use of force, use of restraints, inmate/inmate assaults, inmate/staff assaults, sexual assaults, suicide attempts, etc., by location and time of day
32- Annual training plan by job classification, to include individual training module titles (and hours) and training delivery method, i.e., classroom, FTO, e.g., Corrections Officer: suicide prevention, 4 hours, on-line training; PREA, 2 hours, classroom
33- Pre-service training plan by job classification, to include individual training module titles (and hours) and training delivery method, i.e., classroom, FTO
34- Job descriptions and required qualifications
35- Description of staff hiring process
36- For past 3 years and by job classification/position:
    a. Number of authorized positions
    b. Number of new hires
    c. Number of separations by separation type, e.g., probationary, resignation, termination, layoff, and length of employment

d. Promotions and demotions
e. Monthly staff vacancy rates
f. Current salary ranges for each job title

37- Performance evaluation instrument for each position
38- Inmate grievance reports/data for past three years, e.g., showing inmate's name, area being grieved, date filed, date resolved, resolution
39- SHU data regarding admissions, reasons, releases or length of stay data if available otherwise
40- Sample of completed incident report for use of force incident.
41- Summary report, without names if you prefer, of internal affairs investigations completed in past three years including allegations and findings and actions taken.
42- ASGDC budget for current year and two previous. Identify overtime expenditures by pay period for past three years.

MEDICAL AND MENTAL HEALTH CARE

1. Organization chart with names; also specific to health care
2. Who provides health care? (County Jail Employees, County Health Department Employees, Contract Vendor, Other)
3. Health care policy manual if available electronically
4. Health care statistics of care provided x 3 years
5. Any pending law suits specific to health care? Please provide summaries.
6. Clinic size; number of offenders seen per day (M-F); types of appointments (medical, dental, mental health)
7. Average number of off-site health appointments per month x 1 year
8. Health care policies and procedures TOC (provide manual electronically if available)
9. Opportunities for reentry into community via other Richland County programs; agreements or MOUs with other agencies
10. Number and type of health care grievances per month for the last 12 months

Staffing

1. Health care staffing plan
2. Actual health care personnel schedules for September, October and November

Training

1. Training opportunities offered to health care staff regarding jail operations
2. Training offered to officers related to offenders who have medical and/or mental health needs, specific to suicide watch and offenders who are suicidal, CPR training, and use of AEDs.

Recruitment

1. Job descriptions and required qualifications for health care positions

Retention of Health Care Staff (ONLY if NOT county jail employees)

1. For past 3 years and by job classification/position:
   a. Number of authorized positions
   b. Number of new hires
   c. Number of separations by separation type, e.g., probationary, resignation, termination, layoff, and length of employment
   d. Promotions and demotions
   e. Monthly staff vacancy rates

EXHIBIT 15

RICHLAND COUNTY, SOUTH CAROLINA
Alvin S. Glenn Detention Center
Needs Assessment

FINAL REPORT – October2016

Prepared by:
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CGL: Alan Richardson – William Clarke, AIA NCARB – Chris Monsma, AICP
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Acknowledgements

The CGL team would like to acknowledge and thank staff of Richland County and the Alvin S. Glenn Detention Center for their assistance with this project.

Chad Fosnight, with Richland County Government was very helpful with the guidance and information provided to the Consultant team.

Director Ronaldo Myers was a great host during our interviews, tours and information gathering. The staff at Alvin S. Glenn were very open in our interviews and provided data in a prompt and efficient manner that made this project possible.

Alvin S. Glenn Needs Assessment

EXECUTIVE SUMMARY

The firm of Carter Goble Associates, LLC, a member of the CGL Companies, was commissioned by Richland County to conduct a needs assessment of the Alvin S. Glenn Detention Center (ASGDC) in June 2015. The purpose of the needs assessment was to assess the current conditions of the physical plant, the bedspace utilization, the current staffing numbers, and project the inmate population and resulting capacity requirements for the next 20 years. This study projects future space needs, security enhancements, operational requirements and programming classifications for all security levels in an effort to plan for the next two decades of growth.

The Detention Center saw its highest monthly inmate population at 14,238 in December 2007. Since that time, as in most large jurisdictions across the United States, the inmate population has decreased significantly. For 2015 the average daily inmate population had fallen to 864 inmates. This situation presented an opportunity for Richland County to assess their operations, staffing and future needs at a time when their detention center was not overly burdened as it has been in the past.

Current Conditions Assessment

The first phase of the needs assessment was an assessment of the current conditions of the physical plant, a review of the bedspace usage, and staffing numbers and deployment.

Physical Plant

In partnership with CGL, Buford Goff & Associates, Inc. (BGA) reviewed the existing mechanical systems to develop an understanding of the systems and how they might be impacted by an expansion and/or renovation of the facility. The purpose of this review was not intended to develop a list of required repairs or develop a list of improvements to the existing engineered systems; as such a review has already been completed by the facility's staff.

The existing facility appears to be well maintained with regards to the electrical, mechanical, plumbing, and fire protection systems. A local mechanical contracting company maintains the majority of the HVAC equipment and a local controls company maintains the building controls.

The biggest problems with existing systems appear to be access to systems, such as piping for showers and sprinkler lines above ceilings, access to utilities in cell chases, and issues related to the sprinkler system, such as zoning and durability of sprinkler heads. There were a number of locations in the facility, primarily Phases I and II, where the humidity appeared to be higher than acceptable as evidenced by condensation on the supply air grilles.

The Detention Center is relatively new with the first phase constructed in 1994. Very few systems or pieces of equipment have met or exceeded their life expectancy although some equipment will exceed their life expectancy in the next five (5) years or so. Over the next few years the County should begin to identify equipment that needs to be replaced. It is important in a correctional facility that equipment replacement be scheduled in lieu of replaced upon failure. Presently only the Phase I cooling tower is recommended for replacement.

The Phase I Energy Plant has redundant boilers and chillers. The Phase V Energy Plant has redundant boilers but only a single chiller and cooling tower. We recommend that the County review the implications of a chiller or cooling tower failure during hot weather and whether a system upgrade to provide redundancy is necessary.

Current Staffing Assessment

As a part of the needs assessment, a staffing analysis was conducted for current operations in the fall of 2015. The purpose of the analysis was to establish the necessary staffing level(s) required for the safe and efficient operation of the facility considering all required posts, necessary operations, and needed support.

The process used for conducting this staffing study was based on the *Staffing Analysis Workbook for Jails: Second Edition*, which was produced by the National Institute of Corrections, and is considered the "industry standard" process for determining appropriate staffing for local corrections.

Industry Standards

The project team reviewed the most recent South Carolina standards for local detention facilities and the current Core Jail Standards identified by the American Correctional Association (ACA). The purpose of the review was to gain a better understanding of existing state and national standards related to jail staffing and to ensure recommendations took into consideration those standards.

Based on existing staffing practices, there appeared to be a general level of compliance with both State Minimum Jail Standards and the ACA Core Jail Standards during the review period.

Authorized Positions

There are currently 342 authorized positions in the Detention Center. This is comprised of 338 full-time staff and 4 part-time staff. There were 267 Detention Officer positions, and 39 vacancies at the time of reporting.

Table ES-1
Alvin S. Glenn Authorized Positions

Position	Qty
Director	1
Assistant Director	1
Captain	3
Lieutenant	11
Sergeant	26
Detention Officer	267
Non-Uniformed	33
Total Staff Positions	**342**

Source: Alvin S. Glenn, August 2015

Post Assignments

It was determined that the security posts currently utilized in the Detention Center are appropriate for the physical design of the facility, the operational philosophy, and for the various custody and classification levels of inmates housed.

Staffing Relief Factors

A relief factor was calculated to determine the number of staff that must be employed to efficiently fill all security posts, even when some staff are absent. Data was collected for time taken off for all jail employees from 2012, 2013 and 2014. Data provided by the County includes time away for vacation, sick leave, and military leave as well as the average time taken to cover staff vacancies. For the majority of staffing studies conducted for other local detention agencies, the consultant typically has "time off data" provided for more than these three categories. In addition to these categories, data is usually provided for holiday pay, comp time, leave without pay, worker's compensation, and the Family Medical Leave Act to name a few. However, the consultant was informed that these additional categories of "time off data" are not captured for the staff at Alvin S. Glenn.

Using the categories of "time off data" provided, it was determined that for every security post that must be staffed 24 hours a day/ 7 days a week, there is a requirement of 4.88 full-time equivalent staff (FTE). This number is lower than many previous staffing studies conducted by CGL which usually require 5.0 to 5.5 FTEs for each 24/7 security post.

Recommended Staffing

Due to the low relief factor, the recommended number of staff for the Alvin S. Glenn Detention Center is just 7 more FTEs than the current staffing level. If the relief factor for Detention Officers were more comparable to what is often seen in other jurisdictions, the resulting recommended number of Detention Officers could be as high as 295, or a 28 FTE increase over today's staffing level.

Table ES-2
Alvin S. Glenn Recommended Positions for 2016

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	271	4
Non-Uniformed	33	32	-1
Total Staff Positions	**342**	**349**	**7**

Source: CGL, January 2016

Current Inmate Housing Assessment

The Detention Center was constructed in five phases that comprise a total of 20 housing units and a total of 1,120 beds. While the majority of the beds, and housing units, appear appropriate for the type and custody level of the inmates housed, there are several problems that the Consultants feel need to be addressed.

Phase I Housing consists of six dormitory housing units with a total of 336 beds. There have reportedly been consistent disciplinary infractions by the medium custody inmates in this area. These inmates may be better served in celled housing rather than dormitories. The open environment of the dormitories in Phase I may not be appropriate for medium custody inmates. Celled housing units may be more appropriate for this population.

Phase II Housing has three 56-bed celled housing units, for a total of 168 beds. One housing unit serves as an orientation unit for new inmates, one unit houses maximum security inmates, and the third housing unit is known as the SHU. The SHU houses a variety of inmates including those in disciplinary segregation, administrative segregation and protective custody status. Many of the inmates housed in the SHU are inmates with acute mental illness and those that have been assessed and placed on suicide prevention status. The SHU is not an appropriate environment for inmates with suicidal tendencies or advanced mental illness, which need a more therapeutic environment.

Phase III Housing has two dormitories that have historically housed inmate workers and inmates serving weekend sentences. As of the summer of 2015, both of the Phase IV dormitories have been closed for inmate housing and will be repurposed in the future.

Phase V Housing consists of five housing units that are a mixture of celled and dormitory housing. "Unit M" houses all custody levels of male inmates, most of which have some time of medical problem or mental illness. "Unit M" is not appropriate to house inmates with medical needs along with general population inmates. The distance of this unit from the medical department and the lack of features designed for inmates with a medical or mental health condition present constant operational issues for both custody and health services staff.

Inmate Population Projections

The second phase of this project was a projection of the County and inmate growth for through 2035. This projection considered not only how many inmates will be housed, but also the character and needs of the population.

Meetings were held at the Alvin S. Glenn Detention Center in the summer and fall of 2015 to identify historical and existing data for use in the population assessment and projections. Historical data and trends were discussed with jail staff. The data gathered was analyzed and twenty year detention populations and resulting bed space needs are presented in this section of the needs assessment.

County Population

Since 2005, the resident population in Richland County has increased 15.1 percent, from 349,003 in 2005 to 401,566 in 2014. This represents an annual increase of 1.6 percent.

The annual percentage population growth in Richland County exceeded two percent from 2006 to 2008. However, the growth has slowed from 2009 to 2014, with 2014 having the slowest growth rate at 0.9 percent.

Reported Crimes

Since 2005, total crimes in Richland County have increased 6.6 percent, from 9,537 to 10,171. The total crimes in Richland County averaged 11,199 annually, with a peak of 12,320 in 2011.

Violent Crimes in Richland County increased 18.9 percent from 2005 to 2014, an annual increase of 1.9 percent. Violent crimes in Richland County averaged 2,169 per year, with a peak of 2,438 in 2008. These crimes increased at a higher rate than property crimes from 2005 to 2014, mirroring a national trend.

Jail Bookings and Releases

In the last ten years the annual jail bookings per 1,000 Richland County residents fell by 19.2 percent, from 57.2 to 46.2. The annual jail bookings per 1,000 residents aged 15 to 44 decreased 15.8 percent. Both populations increased concurrently with decreases in jail bookings.

Release data was available from 2010 to 2014. Annual releases decreased by 6.3 percent, or 1.3 percent annually. The number of annual jail releases averaged 19,121, slightly less than the number of annual bookings which averaged 19,758.

Average Daily Population

The average daily population (ADP) has decreased 19.7 percent from 2005 to 2014, an annual decrease of 2.4 percent. The peak ADP year in Richland County was 2007 at 1,232. The most recent year (2014) is the lowest ADP year, with an ADP of 883.

Average Length of Stay

An important statistic for inmate population projections is the average length of stay (ALOS). This is a significant driver of the number of inmates in the system, as a higher ALOS will keep inmates in the system longer. The ALOS decreased 19.8 percent from 2005 to 2014 from 21.7 days to 17.4 days.

Projections of Capacity Requirements

The ADP Projections are status quo projections for the next ten years in Richland County. The projection models do not factor in any policy or legislative changes that may impact the jail populations.

Projection Models

The projections for average daily population and bed space needs are based on three major factors: system based statistical models, demographic based statistical models, and time series modeling.

The development of the Alvin S. Glenn ADP and bed space projections uses thirteen models to forecast population levels to the year 2035. The primary factors employed for the models were the total ADP, bookings, ALOS, reported crimes, and county population projections in Richland County.

Projected Bookings and Average Daily Population

While the projected bookings increase 3.5 percent, the adult ADP projection for Richland County increases by 8.1 percent to 954 in 2035. The incarceration rate per 1,000 residents is projected to decrease slightly, by 1.6 percent from 2014 to 2035.

The numbers of juveniles is very small historically, ranging from 7 in 2014 to 19 in 2008. The projected juvenile ADP increases from 7 in 2014 to 10 in the next twenty years.

Bed Space Projections

Criminal justice facilities cannot be planned for the ADP solely; peaks in population along with beds for differing inmate classifications must be accommodated. The peaking value of the Alvin S. Glenn Detention Center is calculated using monthly data from 2006 to 2014 and the first four months of 2015. The three highest months of ADP were averaged and then compared to the annual ADP.

While the projected ADP for 2035 is 954 inmates, applying peaking and classification percentages throughout the next twenty years show a bed space need of 1,076 by 2035.

Project Proposals

The third phase of the needs assessment looked at the future facility needs. Plans to accommodate the future inmate population are proposed that examine the spaces needed to house a diverse number of inmates and effectively accommodate their needs in a progressive manner.

In the course of assessing the current conditions of the facility, staffing, and inmate housing at the Alvin S. Glenn Detention Center; three primary project proposals emerged which address the current liabilities of assigning inmates to housing units that are not appropriate for their custody levels and their identified risks and needs. These liabilities are not due to improper classification by Detention staff. Rather they exist because the facility does not currently have sufficient type and quantity of beds to address the needs of the inmate population. These proposals are not presented as phases, as each proposal equally stands on its own as a necessity to meet both the current and future needs of the inmate population.

Project Proposal #1: Renovate and convert three dormitory housing units into celled housing. This project will increase the number of secured beds for the medium custody inmate population that has demonstrated the inappropriateness for dormitory housing. This proposal will not require additional Detention Officers.

Project Proposal #2: Construct a 32 bed purpose-built housing unit for the inmate population with acute medical needs. This housing unit will house inmates with medical needs that prevent them from being safely housed in a general population housing unit. This proposal will add one new security post, resulting in the need for 4.88 additional FTEs.

Project Proposal #3: Construct a mission specific, self-contained Mental Health Services Center that will provide a blend of secure housing with both secure and public treatment spaces that are aligned with current and forecasted needs. It will be self-contained in that the mental health providers will be located within this housing area. This proposal will add two new security posts, resulting in the need for 9.76 additional FTEs.

The staffing recommendation for the complete operation of the ASGDC, including all three of the project proposals is 364 staff. This includes four additional Detention Sergeants (a result of proper application of the current relief factor), 19 additional Detention Officers (a result of four additional posts in the Project Proposals plus the proper application of the current relief factor) and the reduction of one non-uniformed position.

Table ES-3
Total Staffing Recommendations

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	286	19
Non-Uniformed	33	32	-1
Total Staff Positions	342	364	22

Source: CGL, February 2016

Estimated Project Costs

The estimated project costs for the three Project Proposals are as follows.

Table ES-4
Estimated Project Costs

Project	Cost / SF	Est. SF Per	Qty	Total SF	Total Cost
1. Dormitory Renovations	$ 135	9,700	3	29,100	$ 3,928,500
2. New Medical Housing	$ 225	6,315	1	6,315	$ 1,420,875
3. Mental Health Services Center	$ 225	19,085	1	19,085	$ 4,294,125
Sub-Total				**54,500**	**$ 9,643,500**
	Contingency			15%	$ 1,446,525
	Architectural & Engineering			6%	$ 665,402
	Total				**$ 11,755,427**

Source: CGL, February 2016

The estimated cost for new construction on the site of the Alvin S. Glenn Detention Center is $225 per square foot.

The cost of renovating the dormitories into celled housing units will be less than the price of new construction, and is estimated to be $135 per square foot.

A 15 percent contingency has been factored into the total estimated costs for these four projects. Given the level of detail provided in this needs assessment, 15 percent may be a high estimate. However, the Consultants feel this to be a safe percentage for budgeting at this point in the planning process.

Architectural and engineering fees are factored at 6 percent of the construction and contingency estimated costs. This brings the total estimated project cost for all components to $11,755,427 in 2016 dollars.

Alvin S. Glenn Needs Assessment

INTRODUCTION

Introduction

In December 2007 the Alvin S. Glenn Detention Center (ASGDC) saw its highest monthly inmate population at 14,238. Since that time, as in most large jurisdictions across the United States, the inmate population has fallen significantly. For 2015 the average daily population of the ASGDC had fallen to 864 inmates. The Detention Center was constructed in five phases that comprise a total of 20 housing units and a total of 1,120 beds. At the beginning of 2015, 560 inmate beds (exactly half) were in dormitory housing units, and the other 560 beds were in celled housing units. This situation presented an opportunity for Richland County to assess their operations, staffing and future needs at a time when their detention center was not overly burdened as it has been in the past.

In June 2015, Richland County hired CGL Companies to develop a space needs assessment for the Detention Center. The purpose of the needs assessment was to assess the current conditions of the physical plant, the bedspace utilization, the current staffing numbers, and project the inmate population and resulting capacity requirements for the next 20 years. This study projects future space needs, security enhancements, operational requirements and programming classifications for all security levels in an effort to plan for the next two decades of growth.

This project was conducted in three phases.

Phase I was an assessment of the existing facility. The physical plant was assessed to determine the type, age and life expectancy of the mechanical/HVAC equipment as well as the capacity for future growth. The housing units were assessed for utilization, capacity, types of inmates being housed, and assigned staffing.

Phase II was a projection of the County and inmate growth for through 2035. This projection considered not only how many inmates will be housed, but also the character and needs of the population.

Phase III looked at the future facility needs. Plans to accommodate the future inmate population are proposed in the form of project proposals that examine the spaces needed to house a diverse number of inmates and effectively accommodate their needs in a progressive manner.

The report concludes with the staffing implications of the various project proposals as well as the estimated cost for each of the proposals in 2016 dollars.

Alvin S. Glenn Needs Assessment

CURRENT CONDITIONS

Physical Plant Assessment

Introduction

In partnership with CGL, Buford Goff & Associates, Inc. (BGA) reviewed the existing mechanical systems installed at the Alvin Glenn Detention Center, Columbia, SC, to develop an understanding of the systems and how they might be impacted by an expansion and/or renovation of the facility. The purpose of this review was not intended to develop a list of required repairs or develop a list of improvements to the existing engineered systems; as such a review has already been completed by the facility's staff.

In addition to assessing the existing conditions, BGA also provided recommended system upgrades for any new facilities proposed by CGL.

Existing Conditions

Phase I Construction

This phase was the original Detention Center which was constructed in 1994. It included the following building areas:

- Phase I, Area 1A Housing (Dormitory Style)
- Phase I, Area 1B Energy Facility and Sallyport
- Phase I, Area 2 Administration (Intake, Booking, Receiving, Laundry, Courts, Administrative Offices)
- Phase I, Area 3 Administration (Medical, Training)

The dormitory has six chilled water and hot water air handlers to serve the six dorms. Each dorm has 56 inmates located on two levels. There are three fire risers with two serving the six dorms and one serving the core area of this building. The water closets and lavatories are porcelain and are located on accessible chases. The plumbing for the showers is installed within the walls making repairs difficult.



The administration areas are conditioned with variable air volume (VAV) air handlers with chilled water coils. The air terminal units have hot water heating.

Central control is located in Phase I. Central control directly monitors the fire alarm from Phases I, II, and III and receives alarms from the fire alarm systems in Phases IV and V. Also, the building automation control system for the heating, ventilation, and air conditioning systems is located here.

During the time of BGA's visit on July 29, 2015, condensation was noted on many grilles primarily in corridor, laundry, and kitchen areas. This condensation was occurring due to high space humidity.

Phase I Energy Plant

All equipment was installed in 1994 except as noted otherwise.

Generator

- Serves Phases I, II, and IV.
- Detroit Diesel Spectrum generator Model 400086071.
- Capacity of 400 KW (500 KVA).
- Runs on diesel fuel and is backed up with natural gas.
- The underground fuel oil storage tank is 3000 gallons.
- The generator supports the HVAC system (Phases I and II heating only), freezers and coolers, pneumatic door locks, building HVAC controls, air compressors and lighting.

Heating Plant

- Two (2) boilers serve Phases I, II, and III.
- The boilers are Cleaver Brooks, hot water, gas fired boilers, model CB 700-80.
- The burners have a capacity of 3350 MBH input each.
- The pumping configuration is a primary/secondary pumping arrangement utilizing base mounted, end suction boiler pumps and constant speed, base mounted, end suction building loop pumps.

Chillers

- Three (3) water cooled chillers serve Phases I, II, and III.
- The two (2) chillers originally installed in 1994 are:
  - Trane RTHA 450 (450 tons)
  - Trane RTHB 300 (300 tons)
- In 2011 a York (Johnson Controls) water cooled chiller, model YKKQK3H9 was installed (assumed to be a nominal 800 ton chiller). This chiller was apparently installed as a backup for the Trane chillers.

- The two Trane chillers or the York chiller can handle the entire chilled water demand of Phases I, II, and III. At the time of this meeting, (August 25, 2015 @ 1 p.m.), the outdoor temperature was in the low 90's and only the 450 ton machine was running.
- The piping configuration is a primary/secondary pumping arrangement utilizing base mounted end suction chiller pumps and base mounted end suction building loop pumps.

Cooling Tower

- A single cooling tower supports the water cooled chillers.
- The tower is a Marley induced draft tower, Serial No. NC5001CM.
- The tower capacity is assumed to be approximately equal to the two Trane chillers or 750 tons.
- The tower is galvanized with a stainless steel basin. The stainless steel basin appears to be in very good condition. The galvanized panels are rusting through in some areas.
- The tower pumps are constant speed, base mounted, end suction pumps.
- The tower fans are constant speed.

Phase II Construction

Phase II was constructed in 1995. This phase included the following building areas:

- Phase II, Area 4 Kitchen
- Phase II, Area 5 Juvenile Housing
- Phase II, Area 6 Adult Housing

Juvenile Housing includes individual cells for twenty-four male inmates and dormitory housing for four female inmates. The building has a single fire riser. The HVAC includes a multizone air handler and a VAV air handler. Plumbing fixtures are stainless steel with utilities accessible in chases.

Adult Housing includes three cell blocks each with fifty-six inmates located on two levels. The cell block is maximum security. Combination stainless steel water closet/lavatories are located on triangular chases. Accessibility to utilities is difficult due to the amount of utilities and duct located in each chase. This building is served by a single fire riser. When sprinkler heads are damaged by inmates or sprinkler lines need repair, the entire system must be shut down. Sprinkler discharge has become such a problem that almost all of the VCT tile has been pulled up from this building. Access to get to sprinkler piping and duct above the ceiling is very difficult due to the confined space above the ceilings. The plumbing for the showers is installed in inaccessible locations.

Phase III Construction

This phase includes Adult Housing (Phase III, Area 7) and was constructed in 1997.

The Adult Housing includes four cell blocks. Two cell blocks have fifty-six inmates located on two levels and the other two cell blocks have twenty-eight (28) inmates located on two levels. Combination stainless steel water closet/lavatories are located on triangular chases. Accessibility to utilities is difficult due to the amount of utilities and duct located in each chase. The plumbing for the showers is installed in inaccessible locations.

Phase III Generator

- The Phase III generator supports Phase III and Phase V.
- A Blanchard Caterpillar generator installed in 1996.
- The capacity is 500 KW (625 KVA).
- It runs on diesel fuel and is backed up with natural gas.
- The underground fuel oil storage tank is 1500 gallons.
- The generator supports Phase III HVAC (heating only), Phase V HVAC (heating and cooling), pneumatic door locks, building HVAC controls, air compressors and lighting.

Phase IV Construction

This phase includes Work Release Housing building (Phase IV, Area 8) and was constructed in 1997. The Work Release Housing building includes two dormitories for forty-eight inmates each. It is conditioned with heat pumps. The building's ventilation is poor in the shower and toilet area which causes humidity to be high and the building is served by a single fire riser with its own fire alarm control that reports the Central Control.

This building was closed to inmate housing in 2015. A repurposing plan will be discussed in Section 3 of this report.

Phase V Construction

This phase includes Adult Housing units and the Phase V Energy Plant (Phase V, Area 9) and was constructed in 2005.

The Housing units have a medical unit (fifty-six inmates in cells on two levels), two dorms with fifty-six males each on two levels, one dorm with fifty-six females on two levels and one cell block with fifty-six females on two levels.

Combination stainless steel water closets/lavatories are located on triangular chases in the cells.

This building has its own fire alarm system that reports to Central Control.

Access to plumbing is from outside the building on the second level. There is no stair or permanent ladder to access this space.

Phase V Energy Plant

All equipment was installed in 2006 except as noted otherwise.

Heating Plant

- Two (2) boilers serve Phase V.
- The boilers are Hurst, hot water, gas fired boilers, with Power Flame Burners, Model CR2-G15.
- The burners have a capacity of 1450 MBH input each.
- The pumping configuration is a primary/secondary pumping arrangement utilizing base mounted, end suction boiler pumps and variable speed, base mounted, end suction building loop pumps.
- On a previous visit in July, the boilers were energized during 95 degree weather. It was assumed that the boilers were running to provide reheat for humidity control.

Cooling Plant

- A single water cooled chiller provides cooling for Phase V construction.
- The chiller is a Trane model RTWA 125 (125 tons).
- The pumping configuration is a primary/secondary pumping arrangement utilizing base mounted, end suction chiller pumps and variable speed, base mounted, end suction building loop pumps.

Cooling Tower

The cooling tower is an EVAPCO induced draft cooling tower, model USS 19-76. The assumed capacity is 125 tons to match the single chiller. The tower pumps are constant speed, base mounted, end suction pumps and the tower fans are constant speed.

Water Heaters

The water heaters are gas fired storage type. They have had some problems, possibly tripping out on low gas pressure.

Domestic Water and Fire Riser

Building Maintenance

HVAC service, as of July 2015, is provided by W.B. Guimarin, Columbia, SC. Their service includes check air handlers, fan belts, changing filters, etc. They also perform regular service on the chillers.

The boilers are not on a service contract and are serviced on an as-need basis.

Controls are serviced by Honeywell Inc.

Other Related Issues

Kitchen

The kitchen apparently cannot support more inmates than are presently housed at the Alvin Glenn Detention Center, and there does not appear to be an easy way to expand the current kitchen.

The grease trap is presently cleaned once per month. When it is cleaned, the grease trap is near capacity. This indicates that if cooking capacity was increased, the grease trap would have to be increased in size (i.e., another grease trap installed) or the frequency at which the grease trap is cleaned would have to be increased.

Some of the kitchen appliances are gas.

Laundry

The laundry operation is struggling to keep up with the demand. The current hours of operation are 7:30 a.m. to 2:30 p.m., Monday through Saturday. The Detention Center needs 53 inmates to maintain normal operations, with 39 inmates the minimum required. They are currently averaging less than 35 inmates. If capacity is needed to handle additional inmates, additional inmates will be needed to work in the laundry.

Recently a gas fired boiler with storage tanks was added to serve the laundry to provide the required domestic hot water.

Life Expectancy

The County has developed a list of maintenance and repair needs. Except for the Phase 1 cooling tower, none of the major mechanical, electrical, or plumbing equipment is shown as needing replacing at this time.

Manufacturer's published equipment life expectancy is only one parameter used to predict when equipment should be replaced. Frequency and types of equipment repairs performed by maintenance personnel is often a better predictor of when equipment should be replaced.

Phases I, II, and III

Chilled water air handlers have a life expectancy of at least 20 years and up to 30 years. Existing air handlers are approximately 20 years old. Unless maintenance indicates otherwise, the County should plan on replacement in ten (10) years.

The cooling towers have a life expectancy of approximately 25 years. The cooling tower is approximately 20 years old and showing some signs of heavy rusting. It might be possible to repair the cooling tower to get 5 or 10 more years of life on the tower. If not, the tower will probably need to be replaced with the next five (5) years.

The boilers have a life expectancy of approximately 25 years. The boilers are approximately 20 years old but appear in good condition. Unless maintenance indicates otherwise, the County should plan on replacement in five (5) to ten (10) years.

The chillers have a life expectancy of approximately 25 years. The two (2) original Trane chillers are approximately 20 years old. The York chiller is approximately five (5) years old. Unless maintenance indicates otherwise, the County should plan on replacement of the Trane chillers in five (5) to ten (10) years.

Phase IV

Packaged Dx units have a life expectancy of 12-15 years. They were not designed to properly control space humidity and have exceeded their life expectancy. The County should plan on replacing these units in the next one (1) to three (3) years.

Phase V

Equipment in this phase is approximately ten (10) years old. No replacement of boilers, air handlers, chillers, or cooling towers is anticipated for ten (10) to twenty (20) years.

Physical Plant Assessment Summary

The existing facility appears to be well maintained with regards to the electrical, mechanical, plumbing, and fire protection systems. A local mechanical contracting company maintains the majority of the HVAC equipment and a local controls company maintains the building controls.

The biggest problems with existing systems appear to be access to systems, such as piping for showers and sprinkler lines above ceilings, access to utilities in cell chases, and issues related to the sprinkler system, such as zoning and durability of sprinkler heads. Although staff mentioned humidity problems in areas such as T Building showers, we noticed a number of locations in the facility, primarily Phases I and II, where the humidity appeared to be higher than acceptable as evidenced by condensation on the supply air grilles.

The Detention Center is relatively new with the first phase constructed in 1994. Very few systems or pieces of equipment have met or exceeded their life expectancy although some equipment will exceed their life expectancy in the next five (5) years or so. Over the next few years the County should begin to identify equipment that needs to be replaced. It is important in a correctional facility that equipment replacement be scheduled in lieu of replaced upon failure. Presently only the Phase I cooling tower is recommended for replacement.

The Phase I Energy Plant has redundant boilers and chillers. The Phase V Energy Plant has redundant boilers but only a single chiller and cooling tower. We recommend that the County review the implications of a chiller or cooling tower failure during hot weather and whether a system upgrade to provide redundancy is necessary.

Current Staffing Assessment

As a part of the needs assessment, a staffing analysis was conducted for current operations of the Alvin S. Glenn Detention Center in the fall of 2015. The purpose of the analysis was to establish the necessary staffing level(s) required for the safe and efficient operation of the facility considering all required posts, necessary operations, and needed support.

The average daily inmate population in 2007 numbered 1,232 inmates. Having at total of 1,120 beds, the facility averaged 112 inmates over their maximum capacity on a daily basis. By 2014 the inmate population had fallen to a daily average of 883. Given the reduced burden on the facility, the County decided to examine their staffing, operations and facilities to identify opportunities for improvement.

Unlike most other government or justice functions the Jail is a 24-hour, around-the-clock, 365 days-a-year operation that has substantial security and life safety requirements. The security-related positions or posts in the Detention Center must be staffed even when the scheduled officer calls in sick, takes vacation or is away on required training. Too often this is accomplished by an on-duty officer covering an additional post or by calling-in off-duty staff to work overtime. Both options can be costly, particularly in the light of impacts felt beyond the budget. Overtime, while expensive, may be seen as a cost-saving measure in meeting staffing needs, but an officer working extremely high/long hours or staff that is handling multiple security posts at once jeopardizes the safety and security of the facility and those within it. In contrast, hiring adequate numbers of staff to provide necessary relief will make up for the potentially higher cost in added efficiency, security, and staff well.

The process used for conducting this staffing study was based on the *Staffing Analysis Workbook for Jails: Second Edition*, which was produced by the National Institute of Corrections, and is considered the "industry standard" process for determining appropriate staffing for local corrections.

The following passage is an excerpt from the *Staffing Analysis Workbook for Jails: Second Edition, 2003:*

> "Many staffing issues and problems jails face, such as high overtime costs, the inability to cover needed posts, or the inability to free staff from their posts for training can be attributed to inaccurate calculation of the actual number of hours staff is available to work in the jail. This critical step requires collecting and analyzing information that will provide an accurate depiction of the real number of staff hours that are available to be scheduled for each full-time position in the jail budget. It produces accurate net annual work hours (NAWH) for each position....
>
> Calculating an accurate NAWH will help control such costs as overtime pay, because realistic and accurate figures will be used to calculate the number of FTEs required to provide needed coverage.
>
> An accurate NAWH for each job classification requires information on all possible time-off categories. Different classifications of employees will have different NAWH, because of the amount of vacation time or training time that is allotted and used."

Influencing Factors

The analysis of staffing needs was based upon a review of facility design, interviews with command staff, and evaluation of the following key factors:

Facility Layout. The design of the facility lays out the framework in which the jail will operate. Corridors and internal travel distances for staff and inmates must be factored into operational decisions, such as whether to escort internal inmate movement and how inmate activities are scheduled and supervised. The physical design of the facility in large measure determines the minimum number of posts required to provide adequate supervision of the population.

Inmate Classification. The type of inmates housed or assigned to an area has a large bearing on the need for supervision and the potential risk level present. The standard classification system (maximum, medium, and minimum security) has a direct bearing on the staffing required.

Inmate Movement Patterns and Policy. The degree of inmate movement and the nature of that movement (escorted or unescorted) relate directly to the degree of control exercised over inmate behavior and the staffing required to enforce the desired level of control.

Technology. Technology, which can be deployed to provide ongoing surveillance of inmate activity, can increase the efficiency of staff used to monitor multiple locations or blind spots in a facility or work area.

Time Spent Away from Posts. The degree to which personal leave, training, and other activities take staff away from their duties will create a demand for relief staff or for the use of overtime.

Prioritization of Posts. The ability of management to objectively evaluate its post requirements and to determine whether any posts can be safely closed under certain circumstances can impact the efficient allocation of staff for a facility or work area.

Operating Procedures/Standards. A jail's operating procedures and standards set out a blueprint for staffing by outlining the duties required of them in the conduct of their jobs.

Considering these factors, staffing requirements were developed based upon a determination of operational needs.

Current Staffing Overview

The Detention Center operates under the direct on-site supervision of several key personnel that are assigned to core administrative positions. The lead position includes the Director who is responsible for the overall day-to-day operations of the Alvin S. Glenn Detention Center. The Director reports to the Richland County Administration. Assisting the Director is one Assistant Director and three Captains. One Captain focuses primarily on security, one focuses on operations and the juvenile inmate population, and the third Captain focuses on administration, programs and training. Each of the Captains has one or more Lieutenants who assist them in providing management and oversight of their area.

One of the primary characteristics of the Detention Center's organizational structure is the consistent application of a narrow span of supervisory control with a focus on meeting a wide variety of established responsibilities. In a narrow span of supervision the number of people reporting to a supervisor is often customized when compared with a wide span of control. Not only must administrative personnel supervise a large number of inmates, but they must also manage a diverse workforce that has unique

responsibilities that include maintaining security, providing programs, delivering services and meeting professional standards. The more efficient and organized the command and supervisory personnel are at performing their tasks, the more effective the system operates. The staff currently provides proper division of administrative responsibilities and effective oversight while also striving to maintain a team concept with the ultimate goal of meeting the overall established mission of the Detention Center.

Figure 2-1
Alvin S. Glenn Administrative Core Positions

Jail Standards

The project team reviewed the most recent South Carolina standards for local detention facilities and the current Core Jail Standards identified by the American Correctional Association. The purpose of the review was to gain a better understanding of existing state and national standards related to jail staffing and to ensure recommendations took into consideration those standards.

South Carolina Minimum Jail Standards. The Minimum Standards for Local Detention Facilities in South Carolina were formed for the purpose of developing minimum standards for detention facilities to follow and to assist local agencies by providing guidelines to ensure the proper planning, operation and maintenance of facilities. These standards were reviewed during the assessment process and each recommendation presented in this report took into consideration maintaining compliance with the current jail standards.

The South Carolina jail standards address staffing levels both generically and by gender with reference to the word "sufficient." The following guidelines which apply to personnel and staffing are cited in the South Carolina jail standards:

Number of Personnel

1031(b). Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

Gender

1031(c). If one (1) or more female inmate(s) is/are in custody, there shall be at least one (1) female security officer on duty, who shall be immediately available and accessible to female inmates.

Staffing Plan

1031(d). A staffing analysis (using NIC Staffing Analysis Workbook or other industry recognized plan) shall be conducted to determine facility staffing needs. The staffing analysis shall be reviewed annually and updated as needed.

Based on existing staffing practices, there appeared to be a general level of compliance with the above cited state guidelines during the review period.

American Correctional Association. The American Correctional Association Core Jail Standards were developed in 2010 and represent the collaborative efforts of corrections practitioners and representatives of the American Correctional Association, National Sheriffs' Association, National Institute of Corrections (NIC) and the Federal Bureau of Prisons. The core standards were established as guidelines for the improvement of correctional operations, services and programs. They provide a framework for presenting the needs and concerns of local correctional agencies and set minimum levels of compliance. The key core jail standards regarding jail staffing include the following:

1-Core-2A-02, Correctional Officers' Posts. Correctional officers' posts are located adjacent to inmate living areas to permit officers' to see or hear and respond promptly to emergency situations. There are written orders for every correctional officer's post;

1-Core-2A-05, Female Inmates and Female Staff. When a female inmate is housed in a facility, at least one female staff member is on duty at all times; and

1-Core-2A-09, Staffing – Sufficient Staff. Sufficient staff including a designated supervisor are provided at all times to perform functions relating to the security, custody, and supervision of inmates and, as needed to operate the facility in conformance with the standards.

Based on existing staffing practices that were observed during the review period, a general level of compliance appeared to be in place.

Authorized Positions

An interview was conducted in order to gain a better understanding of authorized staffing levels for the Detention Center. The Administration reports that there are currently 342 authorized positions. This number is comprised of 338 full-time staff and 4 part-time staff. There were 267 Detention Officer positions, and 39 vacancies at the time of reporting.

Table 2-1
Alvin S. Glenn Authorized Positions

Position	Qty
Director	1
Assistant Director	1
Captain	3
Lieutenant	11
Sergeant	26
Detention Officer	267
Non-Uniformed	33
Total Staff Positions	**342**

Source: Alvin S. Glenn, August 2015

Post Assignments

In addition to reviewing authorized and actual staffing levels an analysis was conducted on the deployment practices of existing staff. Included in the review was an examination of post assignments and the days and hour's security personnel are initially scheduled to work. One of the essential elements of completing a staffing analysis and determining the most cost-effective staffing level is the importance of evaluating how staff are being deployed. The Alvin S. Glenn Detention Center like most local detention facilities operates 24 hours per day, 365 days a year. Given the fact that employees are scheduled to work a set number of hours per week and have regularly scheduled days off, vacations, utilize sick time, etc., staffing any given post assignment throughout the year requires more than one staff member.

Effective roster management systems maximize the efficient use of staff resources through the use of post analyses, master rosters, daily rosters, and an ongoing recapitulation of actual staff utilization. When properly applied, roster management systems create the means by which administrators can ensure existing staff resources are allocated appropriately and staffing needs are communicated effectively to major stakeholders.

It was determined that the security posts currently utilized in the Detention Center are appropriate for the physical design of the facility, the operational philosophy, and for the various custody and classification levels of inmates housed. The two housing units that comprise Phase IV have recently been closed. Staffing for these units have been removed from the recommended staffing numbers. There are three posts that are staffed on a PRN (as needed) basis. These are the SHU Suicide, Unit P Suicide, and PRMH (hospital duty) posts. As PRN posts, staff are not planned for these positions on a daily basis. Instead, staff must be reallocated from other areas as needed when inmates are placed on suicide watch or must be transported and/or admitted to the local hospital. Unfortunately, these posts must be filled more often than not which places an additional burden on the staffing compliment for the remainder of the facility. Providing staff coverage for these "unplanned" posts is even more difficult with 39 staff vacancies, which is 11% of the authorized staffing compliment.

Staffing Relief Factors

In order to describe/recommend appropriate staffing for the Detention Center, a relief factor was calculated to determine the number of staff that must be employed to efficiently fill all security posts, even when some staff are absent. Data was collected for time taken off for all jail employees from 2012, 2013 and 2014. Data provided by the County includes time away for vacation, sick leave, and military leave as well as the average time taken to cover staff vacancies. For the majority of staffing studies conducted for other local detention agencies, the consultant typically has "time off data" provided for more than these three categories. In addition to these categories, data is usually provided for holiday pay, comp time, leave without pay, worker's compensation, and the Family Medical Leave Act to name a few. However, the consultant was informed that these additional categories of "time off data" are not captured for the staff at Alvin S. Glenn.

Using the categories of "time off data" provided, it was determined that for every security post that must be staffed 24 hours a day/ 7 days a week, there is a requirement of 4.88 full-time equivalent staff (FTE). This number is lower than many previous staffing studies conducted by CGL which usually require 5.0 to 5.5 FTEs for each 24/7 security post.

Recommended Staffing

Due to the low relief factor, the recommended number of staff for the Alvin S. Glenn Detention Center is just 7 more FTEs than the current staffing level. If the relief factor for Detention Officers were more comparable to what is often seen in other jurisdictions, the resulting recommended number of Detention Officers could be as high as 295, or a 28 FTE increase over today's staffing level.

Table 2-2
Alvin S. Glenn Recommended Positions for 2016

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	271	4
Non-Uniformed	33	32	-1
Total Staff Positions	**342**	**349**	**7**

Source: CGL, January 2016

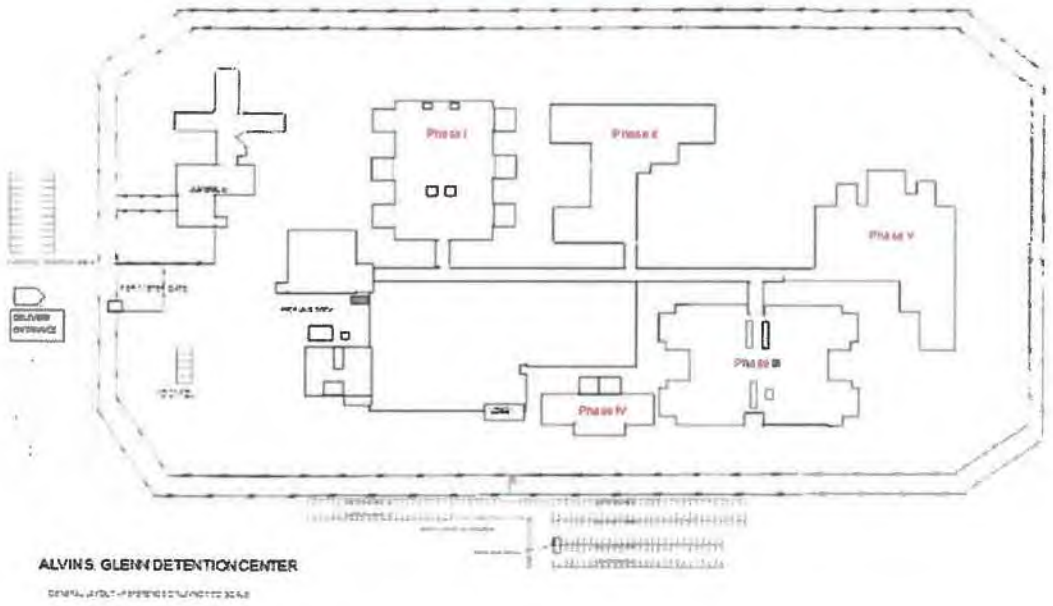
The complete table of recommended positions for today's operations is included in Appendix 1 of this report.

Current Inmate Housing Assessment

The Detention Center was constructed in five phases that comprise a total of 20 housing units and a total of 1,120 beds. Phase I was constructed in 1994, and consists of six dormitory housing units with a total of 336 beds. Like all of the housing locations at ASGDC, each of these units contains 56 inmate beds. The custody levels of these housing units include minimum, low medium and medium custody inmates. There have reportedly been consistent disciplinary infractions by the medium custody inmates in this area. These medium custody inmates may be better served in celled housing rather than dormitories.

Finding: The open environment of the dormitories in Phase I may not be appropriate for medium custody inmates. Celled housing units may be more appropriate for this population.

Figure 1-1
Current Housing Layout



Phase II was constructed in 1995, and has three 56-bed celled housing units, for a total of 168 beds. One housing unit serves as an orientation unit for new inmates, one unit houses maximum security inmates, and the third housing unit is known as the SHU. The SHU houses a variety of inmates including those in disciplinary segregation, administrative segregation and protective custody status.

Finding: Many of the inmates housed in the SHU are inmates on suicide prevention status and those inmates with acute mental illness. The SHU is not an appropriate environment for inmates with suicidal tendencies or advanced mental illness, which need a more therapeutic environment.

Phases III and IV were both built in 1997. Phase III contains four 56-bed celled housing units that house both medium and maximum custody inmates. Phase IV has two dormitories that have historically housed inmate workers and inmates serving weekend sentences.

Finding: The configuration and security levels of the Phase III housing units appear to be appropriate for this portion of the inmate population. As of the summer of 2015, both of the Phase IV dormitories have been closed for inmate housing and will be repurposed in the future.

Phase V was built in 2005 and consists of five housing units that are a mixture of celled and dormitory housing. Two of these units house all custody levels of female inmates, and two units are designated to house medium custody males. The 5th housing unit ("Unit M") houses all custody levels of male inmates, most of which have some time of medical problem or mental illness.

Finding: "Unit M" is not appropriate to house inmates with medical needs along with general population inmates. The distance of this unit from the medical department and the lack of features designed for inmates with a medical or mental health condition present constant operational issues for both custody and health services staff.

As of January 2015, exactly half of the inmate beds (560) were in dormitory housing units, and the other 560 beds were in celled housing units.

Table 1-1
ASGDC Beds as of January1, 2015

Phase	Beds	%
Phase 1	336	30%
Phase 2	168	15%
Phase 3	224	20%
Phase 4	112	10%
Phase 5	280	25%
Total:	**1,120**	**100%**

Classification	Beds	%
WE/Worker	112	10%
Orientation	56	5%
Minimum	99	9%
Low Medium	168	15%
Medium	473	42%
Maximum	156	14%
Max/MH	56	5%
Total:	**1,120**	**100%**

Bed Type	Beds	%
Cell	560	50%
Dorm	560	50%
Total:	**1,120**	**100%**

Source: Alvin S. Glenn Detention Center, July 2015

Table 1-2
ASGDC Beds as of July 1, 2015

Phase	Beds	%
Phase 1	336	33%
Phase 2	168	17%
Phase 3	224	22%
Phase 4		0%
Phase 5	280	28%
Total:	**1,008**	**100%**

Classification	Beds	%
WE/Worker		0%
Orientation	56	6%
Minimum	99	10%
Low Medium	168	17%
Medium	473	47%
Maximum	156	15%
Max/MH	56	6%
Total:	**1,008**	**100%**

Bed Type	Beds	%
Cell	560	56%
Dorm	448	44%
Total:	**1,008**	**100%**

Source: Alvin S. Glenn Detention Center, July 2015

By July of 2015 the Phase IV dormitories had been taken off-line, and were no longer used to house inmate workers or inmates serving weekend sentences. Those inmates have since been redistributed into other housing units within the facility. With these closures, the percentage of beds in dormitory housing was reduced from 50% to 44%. This is still a high percentage of inmates in dormitory housing. With the frequency of incidents with the medium custody inmates that are housed in dormitories, it

may increase the safety and security of the staff and inmates if all medium custody inmates were housed in celled housing units.

Finding: The inmate population has fallen below the number of beds in the ASGDC. Richland County is commended for examining the facility, inmate projections and needs, and the number of staffing that will be required for future operations.

Alvin S. Glenn Needs Assessment

INMATE POPULATION PROJECTIONS

Introduction and Methodology

The second phase of the needs assessment consisted of an examination of the inmate populations and a projection of what the population will look like, in both size and composition, in the next 20 years.

Meetings were held at the Alvin S. Glenn Detention Center in the summer and fall of 2015 to identify historical and existing data for use in the population assessment and projections. Historical data and trends were discussed with jail staff. The data gathered was analyzed and twenty year detention populations and resulting bed space needs are presented in this section of the needs assessment.

Population Analysis

External factors that influence the inmate population are independent variables in multiple population projection models. The overall resident population in Richland County, the 15-44 year olds "at-risk" population in Richland County, and the reported crime rate in Richland County were used as external factors for the jail population analysis.

County Population

Growth in the county resident population is a driving factor in the size of the criminal justice system. Since 2005, the resident population in Richland County has increased 15.1 percent, from 349,003 in 2005 to 401,566 in 2014, see Table 2-1. This represents an annual increase of 1.6 percent. The historical data is from the US Census.

The annual percentage population growth in Richland County exceeded two percent from 2006 to 2008. However, the growth has slowed from 2009 to 2014, with 2014 having the slowest growth rate at 0.9 percent.

Table 2-1
Historical Resident Population

Year	Population	# Change	% / Year
2005	349,003		
2006	357,096	8,093	2.3%
2007	366,111	9,015	2.5%
2008	373,789	7,678	2.1%
2009	380,245	6,456	1.7%
2010	385,745	5,500	1.4%
2011	389,600	3,855	1.0%
2012	393,677	4,077	1.0%
2013	397,893	4,216	1.1%
2014	401,566	3,673	0.9%
Total % Change 2005-14:		**15.1%**	
Annual % Change:		**1.6%**	

Source: US Census Bureau, July 2015.

The projected Richland County population information was calculated by the South Carolina Revenue and Fiscal Affairs Office. The Richland County resident population is projected to increase 9.8 percent from 2014 to 2035, an annual population increase of 0.4 percent. The 0.4 percent annual projected population growth is less than the 1.6 percent growth seen from 2005 to 2014. The 2035 projected resident population is 440,940; see Table 2-2 for the projected population in five year increments.

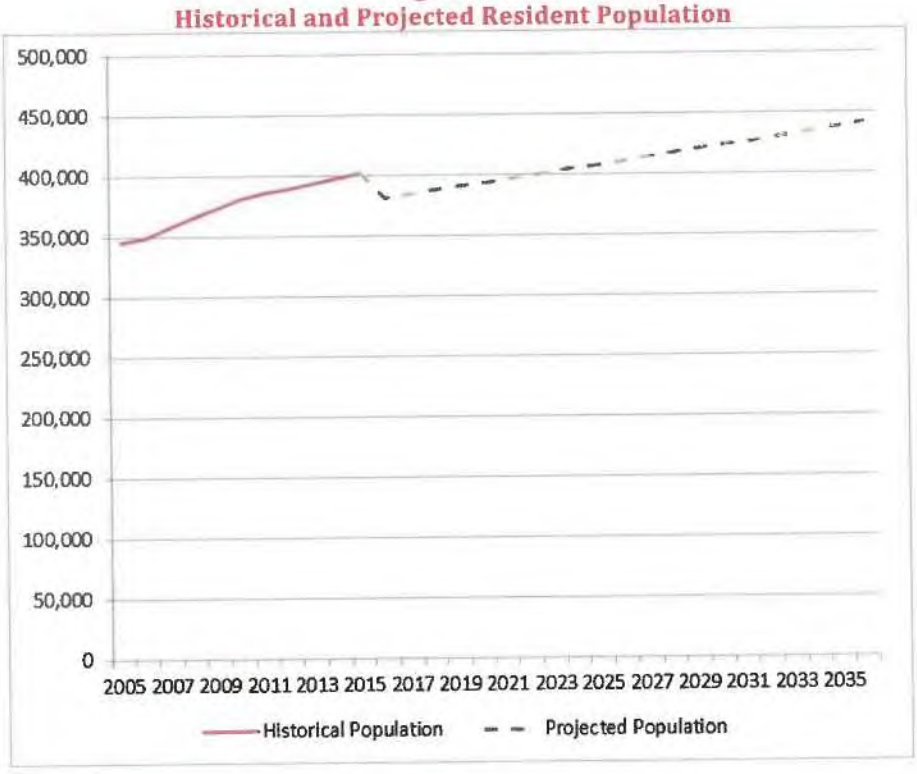
Table 2-2
Projected Resident Population

Year	Population	# Change	% / Year
2014	401,566		
2020	395,920	(5,646)	-0.2%
2025	410,610	14,690	0.7%
2030	425,960	15,350	0.7%
2035	440,940	14,980	0.7%
Total % Change 2014-35:		**9.8%**	
Annual % Change:		**0.4%**	

Source: SC Revenue and Fiscal Affairs Office

The historical and projected population data is graphed on Figure 2-1. This graph shows a drop in population in 2015, and the gradual increase in resident population the next twenty years. The reason for the dip in population is that the current (2014) population in Richland County exceeds the projected population figure.

Figure 2-1
Historical and Projected Resident Population



County At-Risk (Ages 15-44) Population

Crime is not evenly distributed through the resident population. The group considered to be the most "at-risk" for criminal behavior is the population between the ages of 15 to 44 years old. Individuals in this age group make up the majority of jail populations.

Table 2-3 shows that the 15 to 44 year old population in Richland County increased 10.3 percent from 2005 to 2014, a slower growth rate to the county population as a whole. Table 2-4 shows the projected population of the at risk population, from the South Carolina Revenue and Fiscal Affairs Office. The at-risk population in Richland County is projected to increase 26.4 percent from 2014 to 2035, an annual increase of 1.1 percent. The at-risk population is projected to grow from 185,459 to 234,512.

Table 2-3
Historical At-Risk (Ages 15-44) Population

Year	Population	# Change	% / Year
2005	168,133		
2006	167,950	(183)	-0.1%
2007	171,421	3,471	2.1%
2008	175,354	3,933	2.3%
2009	178,496	3,142	1.8%
2010	180,219	1,723	1.0%
2011	182,003	1,784	1.0%
2012	182,577	574	0.3%
2013	183,835	1,258	0.7%
2014	185,459	1,624	0.9%
Total % Change 2005-14:		**10.3%**	
Annual % Change:		**1.1%**	

Source: US Census Bureau, July 2015.

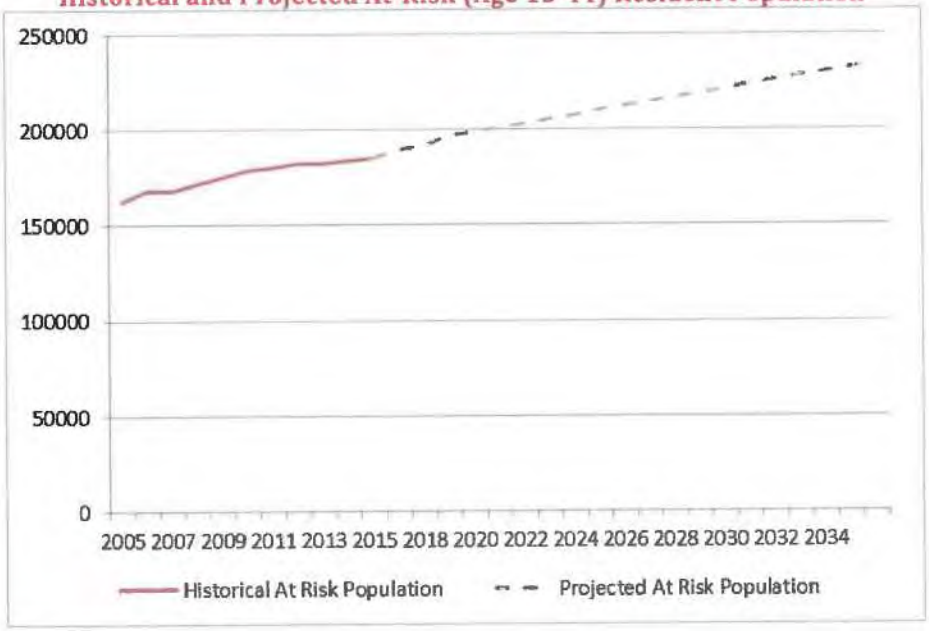
Table 2-4
Projected At-Risk (Ages 15-44) Population

Year	Population	# Change	% / Year
2014	185,459		
2020	200,865	15,406	1.4%
2025	212,081	11,216	0.9%
2030	223,296	11,216	0.9%
2035	234,512	11,216	0.8%
Total % Change 2014-35:		**26.4%**	
Annual % Change:		**1.1%**	

Source: CGL Companies, October 2015.

Figure 2-2 graphs the historic and projected population of the 15 to 44 year old demographic in Richland County. Unlike the population projections for the resident population as a whole, the population projections for the at risk population have not been exceeded, so there is no dip in population in 2014 in the graph.

Figure 2-2
Historical and Projected At-Risk (Age 15-44) Resident Population



Reported Crimes

The annual number of reported crimes in Richland County is shown on Table 2-5. The annual number of violent and property crimes are reported to the FBI by local law enforcement agencies.

Since 2005, total crimes in Richland County have increased 6.6 percent, from 9,537 to 10,171. The total crimes in Richland County averaged 11,199 annually, with a peak of 12,320 in 2011.

Table 2-5
Historical Data – Reported Crimes

Year	Violent Crimes	Property Crimes	Total Crimes
2005	1,668	7,869	9,537
2006	1,882	8,115	9,997
2007	2,282	8,715	10,997
2008	2,438	9,785	12,223
2009	2,414	9,510	11,924
2010	2,390	9,681	12,071
2011	2,366	9,954	12,320
2012	2,266	9,747	12,013
2013	1,998	8,743	10,741
2014	1,983	8,188	10,171
# Change	**315**	**319**	**634**
% Change	**18.9%**	**4.1%**	**6.6%**
Annual % Chg	**1.9%**	**0.4%**	**0.7%**
Average	**2,169**	**9,031**	**11,199**

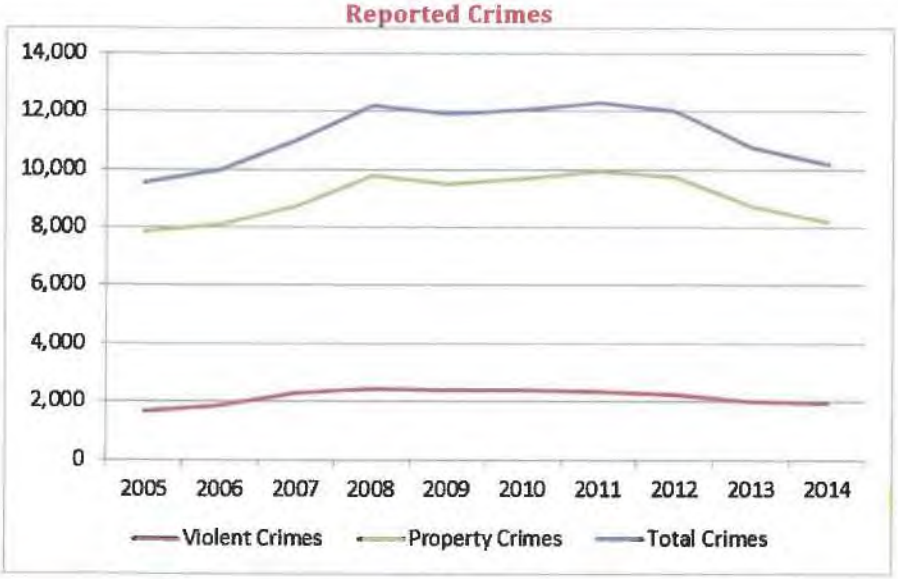
Source: FBI, UCR Reports. September 2015.

Violent Crimes in Richland County increased 18.9 percent from 2005 to 2014, an annual increase of 1.9 percent. Violent crimes in Richland County averaged 2,169 per year, with a peak of 2,438 in 2008. These crimes increased at a higher rate than property crimes from 2005 to 2014, mirroring a national trend.

Property Crimes in Richland County increased 4.1 percent from 2005 to 2014, an annual increase of 0.4 percent. Property crimes averaged 9,031 annually from 2005 to 2014, with a peak of 9,954 in 2011.

Figure 2-3 graphs the annual reported crime in Richland County. The violent crime, property crime and total crimes are plotted. Total crimes reported peaked in 2011, and has decreased since then.

Figure 2-3
Reported Crimes



Makeup of the Jail Population

Population projections for the jail are based on the historical data and trends observed in the system. Ten years of historical data was requested for the projection models. For the analysis the following data was examined: jail bookings, jail releases, average daily population (ADP), a four day snapshot of jail population, and the average length of stay (ALOS). Additionally, research was completed on jail diversion programs in the county, the filings and dispositions of criminal cases in Richland County, and the local admissions and caseloads for probation, parole and Youth Offender Act.

Jail Bookings

After an individual is arrested, they are most often booked into the Detention Center. At booking, the individual is usually fingerprinted, photographed, and processed into the system. However, not all individuals arrested are booked into the Detention Center. Officers can give a citation requiring the arrestee to appear in court without being booked into the Detention Center and thus not appearing as bookings in the data.

Bookings are different than the population in the Detention Center. Bookings are usually examined as annual figures, while the population in the Detention system is expressed as a daily average. The population of the Detention Center is affected by bookings and the length of stay of the inmates. A large number of bookings do not necessarily increase the population of the Detention Center. If many of the bookings are released the day of the booking, the population in the Detention Center would not increase proportionally with the number of bookings.

Annual county-wide bookings in Richland County decreased 7.1 percent from 2005 to 2014. The largest number of annual bookings was in 2007 with 21,016. In the last complete year of bookings data (2014), the annual bookings were 18,563. The average number of annual bookings for this ten year period is 20,015.

In the last ten years the annual number of bookings per 1,000 Richland County residents fell by 19.2 percent, from 57.2 to 46.2. The annual bookings per 1,000 residents aged 15 to 44 decreased 15.8 percent. Both populations increased concurrently with decreases in bookings, see Table 2-6.

Table 2-6
Annual Bookings

Year	Bookings Total	Bookings Male	Bookings Female	Bookings Per 1,000 Population	Bookings per 1,000 At Risk Pop (15-44)
2005	19,978	15,702	4,279	57.2	118.8
2006	19,706	15,438	4,268	55.2	117.3
2007	21,016	16,757	4,259	57.4	122.6
2008	20,807	16,587	4,220	55.7	118.7
2009	19,851	15,843	4,008	52.2	111.2
2010	19,767	16,061	3,706	51.2	109.7
2011	19,657	15,655	4,002	50.5	108.0
2012	19,918	15,754	4,164	50.6	109.1
2013	20,886	16,507	4,379	52.5	113.6
2014	18,563	14,363	4,200	46.2	100.1
# Change	**-1,415**	**-1,339**	**-79**	**-11.0**	**-18.7**
% Change	**-7.1%**	**-8.5%**	**-1.8%**	**-19.2%**	**-15.8%**
Annual % Chg	**-0.8%**	**-1.0%**	**-0.2%**	**-2.3%**	**-1.9%**
Average	**20,015**	**15,867**	**4,149**	**52.9**	**112.9**

Source: US Census Bureau, Alvin S Glenn Detention Center, July 2015.
Notes: Filings and Disposition Data is Fiscal Year Data (July 1- June 30)

Bookings by gender are also shown in Table 2-6. Both male and female bookings decreased from 2005 to 2014. Male bookings fell from 15,702 in 2005 to 14,363 in 2014, the lowest number of bookings in the past decade. Female bookings decreased from 4,279 in 2005 to 4,200 in 2014. The female bookings range from 3,706 in 2010 to 4,379 in 2013. The percentage decrease in female bookings was 1.8 percent, which was a smaller percentage decrease than the male bookings at 8.5 percent.

Detention Releases

Along with the number of annual bookings, the number of annual releases is examined. The number of releases often mirrors the number of bookings, with a slight time lag based on the average length of stay (ALOS). Release data from the Alvin S. Glenn Detention Center was available from 2010 to 2014. Annual releases decreased by 6.3 percent, or 1.3 percent annually. The number of annual releases averaged 19,121, slightly less than the number of annual bookings which averaged 19,758; see Table 2-7.

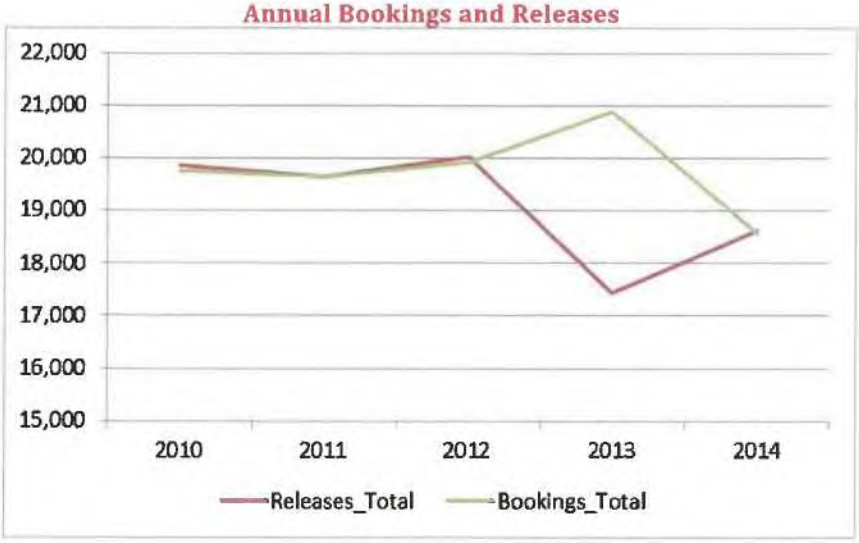
Table 2-7
Annual Bookings and Releases

Year	Releases_Total	Bookings_Total
2010	19,863	19,767
2011	19,649	19,657
2012	20,028	19,918
2013	17,447	20,886
2014	18,617	18,563
# Change	-1,246	-1,204
% Change	-6.3%	-6.1%
Annual % Chg	-1.3%	-1.6%
Average	19,121	19,758

Source: Alvin S Glenn Detention Center, July 2015.

Figure 2-4 plots the annual bookings and releases from 2010 to 2014. From 2010 to 2012, the line trends very similar. However, in 2013 there were a substantially more bookings than releases.

Figure 2-4
Annual Bookings and Releases



Average Daily Population

The county Detention Center average daily population (ADP) is calculated from the daily population counts at the Alvin S. Glenn Detention Center. The annual ADP is calculated from the monthly counts from 2005 to 2014.

Table 2-8 shows the annual ADP of the ASGDC. The ADP has decreased 19.7 percent from 2005 to 2014, an annual decrease of 2.4 percent. The peak ADP year in Richland County was 2007 at 1,232. The most recent year is the lowest ADP year, with an ADP of 883.

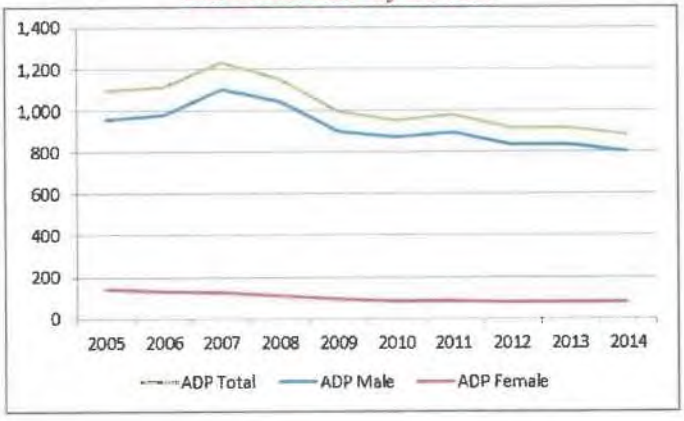
Table 2-8
Historical Annual ADP

Year	ADP Total	ADP Male	ADP Female	IR per 1,000 Population	IR per 1,000 At Risk Pop
2005	1,099	956	143	3.1	6.5
2006	1,112	979	133	3.1	6.6
2007	1,232	1,103	128	3.4	7.2
2008	1,153	1,042	111	3.1	6.6
2009	995	901	94	2.6	5.6
2010	954	871	82	2.5	5.3
2011	979	894	86	2.5	5.4
2012	913	832	81	2.3	5.0
2013	913	833	79	2.3	5.0
2014	883	802	81	2.2	4.8
# Change	**-216**	**-154**	**-63**	**-1.0**	**-1.8**
% Change	**-19.7%**	**-16.1%**	**-43.7%**	**-30.2%**	**-27.2%**
Annual % Chg	**-2.4%**	**-1.9%**	**-6.2%**	**-3.9%**	**-3.5%**
Average	1,023	921	102	2.7	5.8

Source: Alvin S Glenn Detention Center, July 2015.

The ADP per 1,000 residents and the ADP per 1,000 at risk aged residents, also known as the incarceration rate for Richland County, is shown in Table 2-8. The ADP per 1,000 residents decreased 30.2 percent from 2005 to 2014, an annual decrease of 3.9 percent. The ADP per 1,000 at risk aged residents decreased 27.2 percent from 2005 to 2014, an annual decrease of 3.5 percent. The incarceration rate's steep declines for both the total resident population and the at risk population reflect the growth of the county coupled with the decrease in inmate numbers. Figure 2-5 graphs the annual ADP of the jail. The ADP trend line is decreasing, with the total ADP reflecting the changes in the male ADP, which is the driver of the jail population.

Figure 2-5
Historical ADP by Gender



Snapshot Data

Jail population snapshots were provided for the following dates in 2015: Monday, May 4 through Thursday, May 7, 2015. The snapshot data shows the population of the jail by housing unit and corresponding security custody level.

Table 2-9
Jail Population Snapshot

HOUSING UNIT	CUSTODY LEVEL	5/4/15	5/5/15	5/6/15	5/7/15	AVERAGE
UNIT ALPHA	MED	33	33	32	30	32.0
UNIT BRAVO	MIN	25	23	27	23	24.5
UNIT CHARLIE	MED	42	41	39	39	40.3
UNIT DELTA	MED	40	41	40	41	40.5
UNIT ECHO	MED	38	37	37	34	36.5
UNIT FOXTROT	MED	36	37	38	36	36.8
UNIT GOLF	MED	50	50	49	49	49.5
UNIT HOTEL	MAX	48	48	48	49	48.3
UNIT INDIA	MED	48	49	49	50	49.0
UNIT JULIET	MED	50	50	51	49	50.0
UNIT KILO	MED	51	51	52	52	51.5
UNIT LIMA	MED	53	52	51	51	51.8
UNIT MIKE	MIN/MED/MAX	40	42	39	38	39.8
UNIT PAPA	MED/MAX	39	37	38	30	36.0
UNIT T-1	MIN/MED	37	38	43	42	40.0
UNI T-2	N/A	0	0	0	0	0.0
UNIT UNIFORM	MIN/MED	33	34	31	29	31.8
UNIT XRAY	MAX	49	49	49	46	48.3
UNIT YANKEE	N/A	37	28	38	45	37.0
UNIT SHU	MIN/MED/MAX	56	56	57	59	57.0
INTAKE	N/A	2	3	4	5	3.5
TOTAL		807	799	812	797	803.8

Source: Alvin S Glenn Detention Center, July, 2015.

Jail population snapshots are used for the disaggregate population projections by security classification. Additionally, the Unit Mike houses a large number of inmates with medical conditions and Unit SHU houses inmates with acute mental illness in addition to inmates on segregation status. There is not specific data on the number of mental health inmates or beds available, as both Unit Mike and Unit SHU also house inmates that are not sick or mentally ill, and those numbers fluctuate. Unit Mike and Unit SHU populations are projected out to 2035.

Average Length of Stay

An important statistic for inmate population projections is the average length of stay (ALOS). The ALOS of inmates in the system is a calculated figure using the annual number of bookings and the ADP. The ALOS is a driver of the number of inmates in the system, as a higher ALOS will keep inmates in the system longer. The ALOS decreased 19.8 percent from 2005 to 2014 from 21.7 days to 17.4 days. The lowest ALOS was in 2013 at 15.9 days. The bookings in 2013 were the highest since 2005, so the lower ALOS kept the ADP stable. The longest ALOS was 21.7 days in 2005.

Table 2-10
Jail Average Length of Stay

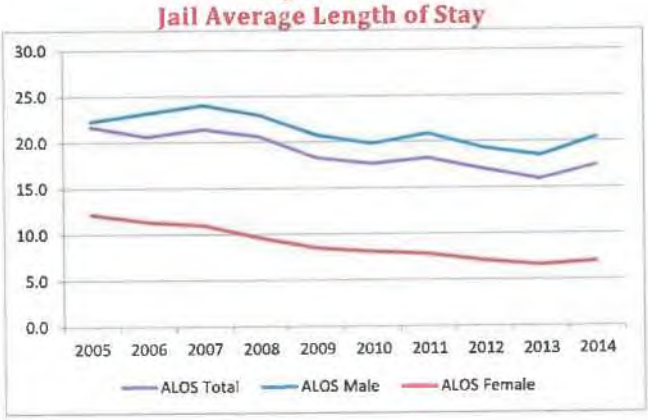
Year	ALOS in Days	ALOS Male	ALOS Female
2005	21.7	22.2	12.2
2006	20.6	23.2	11.4
2007	21.4	24.0	11.0
2008	20.6	22.9	9.6
2009	18.3	20.7	8.5
2010	17.6	19.8	8.1
2011	18.2	20.8	7.8
2012	17.0	19.3	7.1
2013	15.9	18.4	6.6
2014	17.4	20.4	7.0
# Change	**-4.3**	**-1.8**	**-5.2**
% Change	**-19.8%**	**-8.3%**	**-42.6%**
Annual % Chg	**-2.4%**	**-1.0%**	**-6.0%**
Average	**18.9**	**21.2**	**8.9**

Source: Alvin S Glenn Detention Center, July 2015.

The male inmate ALOS decreased by 8.3 percent from 2005 to 2014, an annual decrease of 1.0 percent. The female inmate ALOS decreased by 42.6 percent from 2005 to 2014, an annual decrease of 6.0 percent. The female ALOS decreased from over 12 days in 2005 to 7 days in 2014, see Table 2-10.

Figure 2-6 shows the ALOS by gender and the system ALOS. The male ALOS is highest, with the system wide ALOS slightly below the male ALOS.

Figure 2-6
Jail Average Length of Stay



Jail Diversion Programs

The Fifth Judicial Circuit for South Carolina, which includes Richland County and Kershaw County, offers seven jail diversion programs: Alcohol Education, Pre Trial Intervention, Traffic Education, Youth Arbitration, Drug Court, Veterans Court, and DUI Treatment Court.

Diversion programs are a form of sentencing, often designed to enable offenders to avoid criminal charges. Another benefit of efficient diversion programs is relieving stress on the local courts and detention centers.

The jail ADP in Richland County has decreased by 19.7 percent from 2005 to 2014. While it is not possible to assign direct correlations with this population decrease to jail diversion programs, it is in the best interest of the county to continue the jail diversion programs to keep jail population numbers as low as possible without sacrificing public safety.

Filings and Dispositions

The jail population is effected by several factors in the criminal justice system outside the jail. Jail diversion programs are one external factor. Another major influence on jail populations is the efficiency of the local courts. If courts have large backlogs of cases, or if cases are taking longer to dispose, the ALOS in the jail and the ADP will rise. Table 2-11 presents historical data on criminal filings and dispositions in Richland County from 2005 to 2014.

Table 2-11
Historical Data – Criminal Filings and Dispositions

Year	Pending Criminal Filings (July 1)	Criminal Filings (Added During FY)	Criminal Filings Total	Criminal Dispositions	Pending End of Period	Dispositions/ New Filings
2005	5,951	8,946	14,897	8,905	5,992	99.5%
2006	6,958	9,413	16,371	9,270	7,101	98.5%
2007	7,284	9,301	16,585	8,942	7,643	96.1%
2008	8,050	9,150	17,200	9,170	8,030	100.2%
2009	8,419	8,470	16,889	9,004	7,917	106.3%
2010	8,468	8,240	16,708	7,974	8,805	96.8%
2011	9,082	8,405	17,847	7,556	9,992	89.9%
2012	8,849	8,703	17,552	8,738	8,814	100.4%
2013	9,212	8,956	18,168	9,886	8,282	110.4%
2014	8,798	8,706	17,504	9,353	8,151	107.4%
# Change	**2,847**	**-240**	**2,607**	**448**	**2,159**	**7.9%**
% Change	**47.8%**	**-2.7%**	**17.5%**	**5.0%**	**36.0%**	**7.9%**
Annual % Chg	**4.4%**	**-0.3%**	**1.8%**	**0.5%**	**3.5%**	**0.9%**
Average	**8,107**	**8,829**	**16,972**	**8,880**	**8,073**	**100.6%**

Source: South Carolina Judicial Deprartment, Alvin S Glenn Detention Center, December 2015.
Notes: Filings and Disposition Data is Fiscal Year Data (July 1- June 30)

The pending criminal filings on July 1 of each year are shown in the first column. The criminal filings added during the fiscal year decreased 2.7 percent from 2005 to 2014. The criminal dispositions increased 5.0 percent from 2005 to 2014, an increase of 0.5 percent annually.

The disposition rate, which is the number of dispositions divided by the new filings, is ideally near 100 percent. This would indicate all criminal filings are disposed during the year and the case back log would not increase. The disposition rate of criminal cases in Richland County courts ranged from 89.9 percent in 2011 to 110.4 percent in 2013. The disposition rates higher than 100 percent show a clearing of the

criminal case back log. The high number of cases pending at the end of the fiscal year (June 30) raises concerns. But there is no evidence that the court's criminal filings and dispositions data are impacting the jail populations in a negative manner.

Local Probation Caseloads

The South Carolina Department of Probation, Parole and Pardon Services (SCDPPS) is charged with the responsibility of supervising those offenders placed on probation by the Court. Probation is a court-ordered community sanction which suspends the imposition of all or part of the original sentence of incarceration. It requires the offender, under SCDPPPS supervision in the community, to adhere to a set of conditions which limit the offender's freedom, reparation to victims if so ordered, and to provide for judicial revocation for violation of those conditions.[1]

Inmates between ages 17 through 24 who are sentenced under the South Carolina Youthful Offender Act (YOA) to an indeterminate period of incarceration not to exceed six years within the South Carolina Department of Corrections (SCDC), may be conditionally released prior to that time based on offense category, adjustment, and evaluation while incarcerated.[2]

The active caseloads for probation, parole and YOA are shown in Table 2-12. Active probation cases have decreased 8.4 percent from 2005 to 2014, while parole declined 4.8 percent, and YOA declined 56.1 percent.

Active probation cases dipped below 2,000 cases in 2011 and 2012, but have rebounded recently. Active parole cases averaged 358, which is also the most recent caseload in 2014. The number of YOA cases has dropped significantly, from 214 in 2005 to 94 in 2014. The reduction in YOA caseload happened as the jail's juvenile ADP declined.

Table 2-12
Historical Active Offender Caseloads

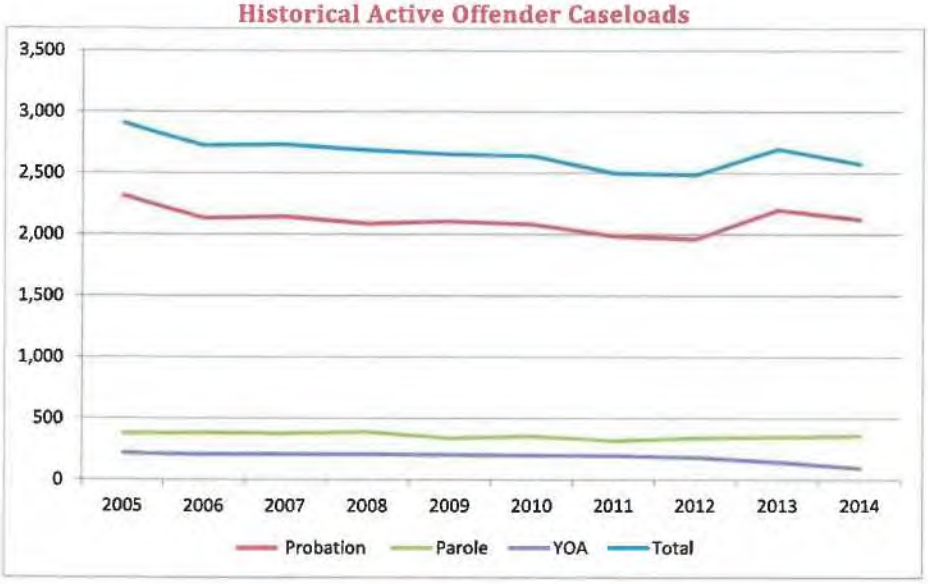
	Active Offender Caseload			
Year	Probation	Parole	YOA	Total
2005	2,316	376	214	2,906
2006	2,133	382	208	2,723
2007	2,146	375	208	2,729
2008	2,089	390	207	2,686
2009	2,109	338	206	2,653
2010	2,084	357	200	2,641
2011	1,987	317	195	2,499
2012	1,964	340	182	2,486
2013	2,203	347	145	2,695
2014	2,122	358	94	2,574
# Change	**-194**	**-18**	**-120**	**-332**
% Change	**-8.4%**	**-4.8%**	**-56.1%**	**-11.4%**
Annual % Chg	**-1.0%**	**-0.5%**	**-8.7%**	**-1.3%**
Average	**2,115**	**358**	**186**	**2,659**

Source: South Carolina Department of Probation, Parole and Pardon Services, Annual Statistical Reports, July 2015.
Notes: Data is Fiscal Year Data (July 1 - June 30)

[1] SCDPPS website: http://www.dppps.sc.gov/
[2] SCDPPS website: http://www.dppps.sc.gov/

Figure 2-7 graphs the active caseloads for probation, parole, YOA and the sum of the three components caseload. Probation caseload is the majority and trends the total caseload line.

Figure 2-7
Historical Active Offender Caseloads



The annual admissions for probation, parole, and YOA are shown in Table 2-13. Admissions to probation have decreased 20.0 percent from 2005 to 2014, while parole increased 43.0 percent, and YOA declined 93.1 percent.

The reduction in admissions to the probation and YOA programs is reflected in the lower active caseload numbers. However the admissions are down at a higher percentage than the active caseload data. Parole's admissions are increasing, however the active caseload numbers declined.

The YOA admissions fell to 8 in 2014, down from the high of 115 in 2005.

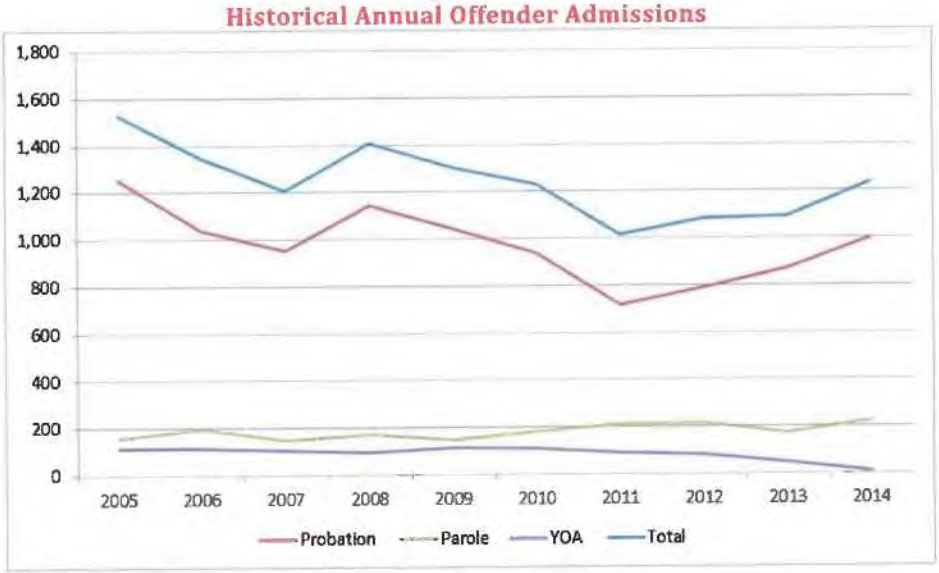
Table 2-13
Historical Offender Admissions

	Annual Admissions			
Year	Probation	Parole	YOA	Total
2005	1,252	158	115	1,525
2006	1,039	194	113	1,346
2007	951	150	103	1,204
2008	1,143	173	93	1,409
2009	1,043	146	113	1,302
2010	938	182	108	1,228
2011	717	209	91	1,017
2012	788	213	82	1,083
2013	872	172	45	1,089
2014	1,001	226	8	1,235
# Change	**-251**	**68**	**-107**	**-290**
% Change	**-20.0%**	**43.0%**	**-93.0%**	**-19.0%**
Annual % Chg	**-2.5%**	**4.1%**	**-25.6%**	**-2.3%**
Average	**974**	**182**	**87**	**1,244**

Source: South Carolina Department of Probation, Parole and Pardon Services, Annual Statistical Reports, July 2015.
Notes: Data is Fiscal Year Data (July 1 - June 30)

Figure 2-8 graphs the annual admissions for probation, parole, YOA and the sum of the three. Again, admissions to probation are the majority of the admissions and trends the total admissions line. Admissions to the three programs combined averaged 1,244.

Figure 2-8
Historical Annual Offender Admissions



Projections of Capacity Requirements

The ADP Projections are status quo projections for the next ten years in Richland County. The projection models do not factor in any policy or legislative changes that may impact the jail populations.

Projection Models

The projections for average daily population and bed space needs are based on three major factors: system based statistical models, demographic based statistical models, and time series modeling.

The development of the Alvin S. Glenn ADP and bed space projections uses thirteen models to forecast population levels to the year 2035. The primary factors employed for the models were the total ADP, bookings, ALOS, reported crimes, and county population projections in Richland County. The calendar year data from 2014 served as the base year for the projections models. The following is a description of each model considered, broken into the three modeling categories.

System Based Statistical Models

- Model 1 - Historical Trend Percentage Change calculates the total percentage change from the beginning point to the end point of the historical data series. The annual percentage increase rate used in the model is applied to the base year and subsequent years to calculate future ADP levels.
- Model 2 - Historical Compound Annual Growth Rate (CAGR) uses the historic annual growth rates to determine a percentage of growth. Often used in financial forecasting, the CAGR is applied to the projection end date of calendar year 2035.

- Model 3 - Mean Deviation compares the peak year population to the average from the historic data. The model is standardized by dividing the number of years observed. The mean deviation model shows the high points in most models as it is projected forward.

Demographic Based Models

- Models 4 and 5 - Incarceration Rate Percentage Change uses the historic change in ADP per 1,000 residents of Richland County, also known as the Incarceration Rate, and extends the change in incarceration rate to the year 2035. The percentage is then applied to the Richland County population projections. Model 4 uses the county-wide population while Model 5 uses the at risk population of 15 to 44 year olds.

- Models 6 and 7 - Ratio to Population is dependent on annual population projections for residents of Richland County (Model 6) and the 15 to 44 year old population (Model 7). The difference in models 6 and 7 is that the percentage change is not considered, as the existing, high, average and low historic incarceration rates are applied to the population projections.

- Model 8 - Ratio to Offenses Known to Law Enforcement uses the historic ratios of violent and property crimes to inmate population and misdemeanor arrests to inmate population. The ratio is then applied to projected arrests based on historic reported crimes trends.

- Model 9 - ALOS to Projected Bookings applies existing, high, average, and low ALOS rates from the base year and applies it to projected booking to 2035.

Time Series Modeling

- Model 10 - Linear Regression determines a best fit line considering the historic ADP over time. This best fit line is extended to 2035.

- Model 11 - Multiple Regressions determines a best fit line considering the ADP over time and Richland County population and the 15 to 44 year old population. This best fit line is extended to 2035.

- Model 12 - Box-Jenkins Autoregressive Integrated Moving Average (ARIMA) uses a regression technique that weighs all years equally. The Box-Jenkins model of ARIMA is used typically for accurate short-term projections of data that shows predictable repetitive cycles and patterns.

- Model 13 - Exponential Smoothing ARIMA identifies levels and trends by smoothing the latest data points to decrease irregularity and adds a seasonality factor. The seasonal indexes are obtained by smoothing seasonal patterns in the historical data. The exponential smoothing model gives older data progressively-less weight while new data is weighted more.

While thirteen models are run, not all are used in the averaging of model for ADP projections. Models determined to have appropriate statistical reliability and significance were weighted equally to determine forecast figures. For the ARIMA models, the r-squared values below 0.8 were not used in the

final average. R-squared shows the amount of explained variance in the statistical model. There are no concrete levels for acceptable r-squared.

Historical trend analysis models and ratio models were included unless the population forecast looked unrealistic. An unrealistic forecast, for example, would be downward trends that fell below zero and ARIMA models with r-squared values lower than 0.8. These were not considered in the final models.

A total of six to eight models, with at least one from each of the three subsections, were selected and averaged. Each model presents a different snap shot to the future that is beneficial to the final projection. To dampen the limitations of the forecast models, equal weighting and averaging of models is used. The averaging of the models, while not perfect, does reduce some of the flaws of the individual forecasting models and shows patterns of model agreement. Targeting models from each of the three subsections produces a more robust model. Models selected are not as subject to volatility of historic trends as those models excluded.

Jail Population Projection

The projection models were run for jail bookings and jail ADP. The first step was calculating the projected bookings to 2025, as the projected bookings is one of the models used in the ADP projection model.

As a variable, bookings are difficult to project for jail purposes since it is not a controlled variable for analysis. Bookings are dependent on police policies, local attitude to crime, criminal activity, citation releases, and many other factors outside the facilities.

Projected Bookings

Bookings in Richland County decreased 7.1 percent from 2005 to 2014, from 19,978 to 18,563. The projection model for bookings averaged seven models: historic trend percentage increase, compound annual growth rate, mean deviation from the average, ratio to general population growth, ratio to at risk population growth, ratio to arrests, and multiple regressions. The bookings in Richland County are projected to increase to 19,214 in 2035, an increase of 3.5 percent from 2014. Table 2-14 shows the five-year projection increments for jail bookings and ADP. The projected bookings increases due to the projected population increases in Richland County.

Table 2-14
Projected Jail Bookings

Bookings	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Richland County Population	401,566	381,230	395,920	410,610	425,960	440,940	9.8%	0.9%	410,479
Bookings	18,563	18,265	18,430	18,633	18,935	19,214	3.5%	0.3%	18,684
Bookings / 1,000 Population	46.23	47.91	46.55	45.38	44.45	43.57	-5.7%	-0.6%	45.57

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Projected Adult ADP

While the projected bookings increase 3.5 percent, the ADP projection for Richland County increases by 8.1 percent. The ADP increase is driven by population growth in Richland County. The ADP projection model is an average of seven models: historic trend percentage increase, compound annual growth rate, mean deviation from the average, ratio to general population growth, ratio to general population growth, ratio to at risk population growth, and bookings to ALOS model.

The projected ADP increases to 954 in 2035, an ADP lower than the ADP in Richland County from 2005 to 2009. The average ADP from 2014 to 2035 is 901, see Table 2-15. The projected ADP increases each projection interval to 2035, while the county populations are increasing, resulting in stable incarceration rates for Richland County. The incarceration rate per 1,000 residents is projected to decrease slightly, by 1.6 percent from 2014 to 2035.

Table 2-15
Projected Jail Adult ADP

ADP Projections	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Richland Population	401,566	381,230	395,920	410,610	425,960	440,940	9.8%	0.4%	410,479
Age 15-44	185,459	189,650	200,865	212,081	223,296	234,512	26.4%	1.1%	210,871
ADP	883	864	877	897	923	954	8.1%	0.4%	901
Bookings Total	18,563	18,265	18,430	18,633	18,935	19,214	3.5%	0.2%	18,684
IR per 1,000 Population	2.20	2.27	2.22	2.18	2.17	2.16	-1.6%	-0.1%	2.20

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Table 2-16 shows the upper bound and the lower bound for the projection model. The upper and lower bounds are calculated by using the 95 percent confidence interval bounds for the regression model, and the corresponding lower and upper scenarios for the ratio based models. The lower bound ADP projection is 836 in 2035, while the upper bound is 1,114. The range between the low and high models is 278.

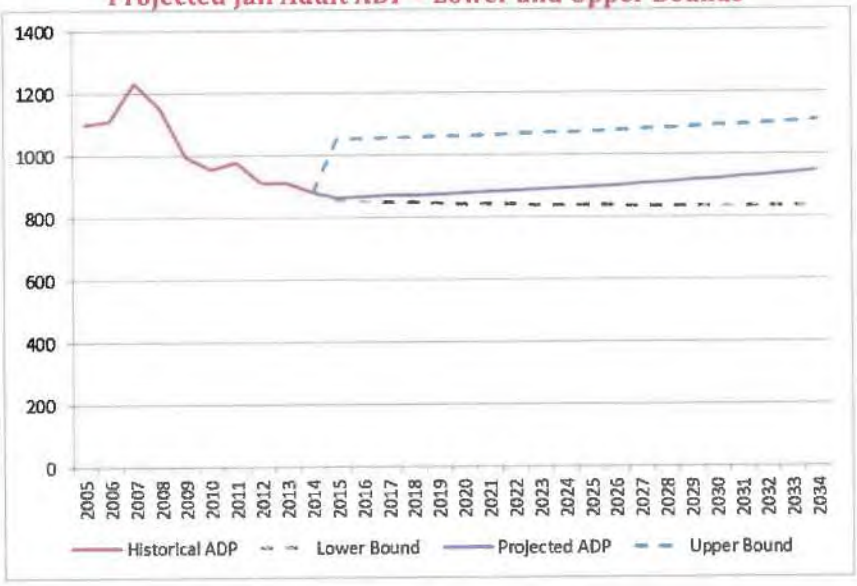
Table 2-16
Projected Jail Adult ADP – Lower and Upper Bounds

ADP Lower and Upper Bounds	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
ADP - Lower Bound	883	854	843	836	834	836	-5.3%	-0.3%	841
ADP - Projected	883	864	877	897	923	954	8.1%	0.4%	901
ADP - Upper Bound	883	1,052	1,061	1,075	1,093	1,114	26.2%	1.1%	1,069
Lower and Upper Bounds Range	0	198	218	239	259	278			

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Figure 2-9 graphs the historical and projected jail ADP for Richland County including the upper bound and the lower bound for the projection model. The upper and lower bounds are calculated by using the 95 percent confidence interval bounds for the regression model, and the corresponding lower and upper scenarios for the ratio based models.

Figure 2-9
Projected Jail Adult ADP – Lower and Upper Bounds



Projected Juvenile ADP

The juvenile population in the Alvin S. Glenn Detention Center is separate from the adult population and is projected separately as well. The numbers of juveniles is very small historically, ranging from 7 in 2014 to 19 in 2008. The trend in juvenile ADP is decreasing, similar to many jurisdictions in the US.

Table 2-17 shows the projected juvenile ADP in Richland County increasing from 7 to 10 in the next twenty years. The incarceration rate to the at-risk population is projected to remain at 0.04 juveniles per 1,000 from 2014 to 2035.

Table 2-17
Projected Jail Juvenile ADP

ADP Juvenile	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Richland County Population	401,566	381,230	395,920	410,610	425,960	440,940	9.8%	0.4%	410,479
Richland At Risk Population	185,459	189,650	200,865	212,081	223,296	234,512	26.4%	1.1%	210,871
Juvenile ADP	7	7	7	8	9	10	39.9%	1.6%	8
IR per 15-44 Population	0.04	0.04	0.04	0.04	0.04	0.04	10.6%	0.5%	0.04

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Bed Space Projections

Criminal justice facilities cannot be planned for the ADP solely; peaks in population along with beds for differing inmate classifications must be accommodated. The peaking value of the Alvin S. Glenn Detention Center is calculated using monthly data from 2006 to 2014 and the first four months of 2015. The three highest months of ADP were averaged and then compared to the annual ADP. The percentage difference for each year was calculated.

A peaking factor accounts for seasonal variations in the inmate population. There must be enough beds to accommodate seasonal increases without overcrowding. The actual factor is the percentage above the average daily population. Data was analyzed to ascertain the actual peaking factor for Richland County. For the monthly data set, the average peaking percentage was 5.3 percent. This means that the largest number of inmates held in Richland County was 5.3 percent higher than the average inmate population during the time period examined. Table 2-18 shows the monthly ADP for Richland County and the peaking factor.

Table 2-18
Historical Monthly ADP and Peaking

ADP	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	Average
January	1,022	1,092	1,219	921	924	894	892	849	894	825	**953**
February	983	1,095	1,198	941	984	901	879	862	908	888	**964**
March	979	1,141	1,173	922	888	891	914	812	853	805	**938**
April	1,038	1,157	1,208	991	914	951	898	802	874	870	**970**
May	1,061	1,132	1,126	996	916	957	911	880	885	NA	**985**
June	1,101	1,172	1,139	992	925	964	924	902	846	NA	**996**
July	1,144	1,201	1,134	972	957	957	895	912	856	NA	**1,003**
August	1,076	1,207	1,086	969	959	968	896	956	864	NA	**998**
September	1,068	1,262	1,136	1,000	941	1,027	925	954	850	NA	**1,018**
October	1,100	1,306	1,076	904	944	1,048	912	940	841	NA	**1,008**
November	1,099	1,244	960	960	925	994	963	943	847	NA	**993**
December	1,086	1,229	917	917	884	903	829	895	844	NA	**945**
Average	**1,063**	**1,187**	**1,114**	**957**	**930**	**955**	**903**	**892**	**864**	**847**	**971**
3 Month High	**1,115**	**1,271**	**1,208**	**996**	**967**	**1,023**	**937**	**951**	**896**	**879**	**1,024**
Peaking Factor	**4.9%**	**7.1%**	**8.4%**	**4.1%**	**3.9%**	**7.2%**	**3.8%**	**6.6%**	**3.7%**	**3.8%**	**5.3%**

Source: Alvin S Glenn Detention Center, May 2015.

A classification factor accounts for a fluctuation in the type of inmates held at any given time. There may be times where there are more maximum security inmates than the average number; conversely there may be times when there are more minimum security inmates than the average. There needs to be enough flexibility in the type of beds needed at any given time to be able to provide appropriate separations between the classification levels of inmates. Drawing from past studies and industry standards, CGL has applied a 7.5 percent classification factor for bed space need.

The peaking and classification factors are added together and then added to the projections to give a number for beds needed.

The projected ADP for 2035 is 954 inmates. Applying the peaking and classification percentages throughout the next twenty years show a bed space need of 1,076 by 2035 (see Table 2-19).

Table 2-19
Projected Adult Bed Space Need

Bed Space Projections	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
ADP	883	864	877	897	923	954	8.1%	0.4%	901
Peaking (5.3%)	47	46	46	48	49	51	8.1%	0.4%	48
Classification (7.5%)	66	65	66	67	69	72	8.1%	0.4%	68
Bed Space Needed	996	975	990	1,012	1,041	1,076	8.1%	0.4%	1,016

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Table 2-20 applies the lower and upper percent peaking and the 7.5 percent classification figures to the lower and upper bound ADP projections. The lower bound bed space projection uses the lowest peaking percentage from the monthly data, which is 3.7 percent. The upper bound bed space projection uses 8.4 percent peaking, the highest peaking year. The lower bound bed space projection is 930 beds in 2035, and the higher bound bed space projection is 1,291 beds in 2035.

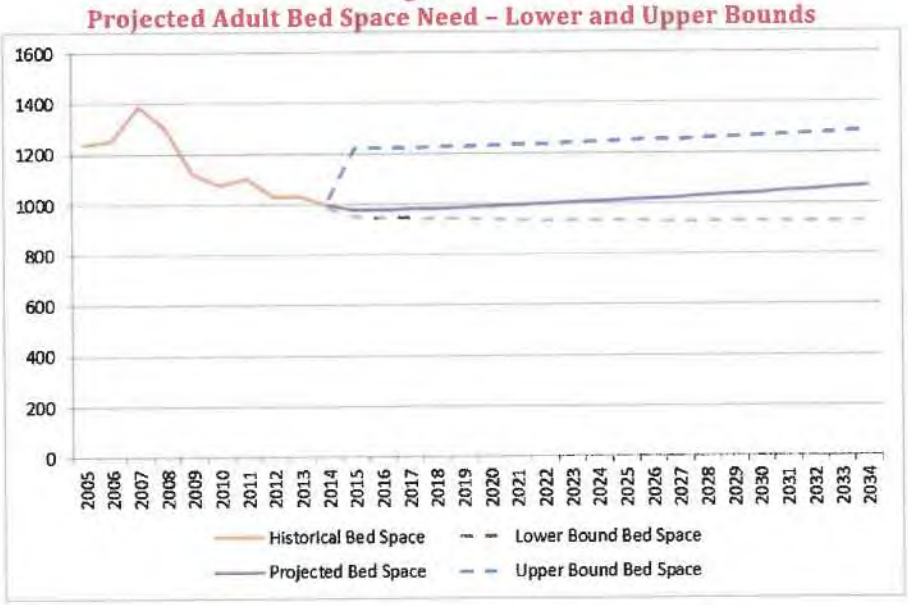
Table 2-20
Projected Adult Bed Space Need – Lower and Upper Bounds

Bed Space Lower and Upper Bounds	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Bed Space Needed - Lower Bound (3.7% Peaking)	982	950	937	930	928	930	-5.3%	-0.3%	936
Bed Space Needed - Projected (5.3% Peaking)	996	975	990	1,012	1,041	1,076	8.1%	0.4%	1,016
Bed Space Needed - Upper Bound (8.4% Peaking)	1,023	1,219	1,230	1,246	1,267	1,291	26.2%	1.1%	1,239
Lower and Upper Bounds Range	42	269	293	316	339	362			

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Figure 2-10 plots the historical and projected bed space need to the year 2035.

Figure 2-10
Projected Adult Bed Space Need – Lower and Upper Bounds



The juvenile bed space needs applies the 5.3 percent peaking and 7.5 percent classification factors. The bed space need grows from 8 currently to 11 by 2035, see Table 2-21.

Table 2-21
Projected Juvenile Bed Space Need

Bed Space Juveniles	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Juvenile ADP	7	7	7	8	9	10	39.9%	3.4%	8
Peaking (5.3%)	0	0	0	0	0	1	39.9%	3.4%	0
Classification (7.5%)	1	1	1	1	1	1	39.9%	3.4%	1
Bed Space Needed -Juveniles	8	8	8	9	10	11	39.9%	3.4%	9

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

Because the population is so small for juveniles in the Alvin S. Glenn Detention Center, the lower bound and upper bound projections were not significantly different.

Custody Type

Table 2-22 breaks down the jail inmate ADP by custody groups identified by the snapshot data provided by the jail staff. The projections are not bed space projections, they are ADP projections based on the current operations of the jail and the classification system used. The data is from the average of the four day snapshot in May 2015, not on the annual ADP used in the other population projections. Because each custody level and units were projected individually, the sum of these projections is not equal to the ADP projection of the jail as a whole. These disaggregated projections yield a higher total ADP in 2035 (1,140) than the projected ADP (954).

The security classification levels are split between minimum, medium, and maximum security. The largest section of the jail population is classified as medium custody, currently at 438 and projected to increase to 536 in 2035. The maximum custody level is projected to increase from 114 to 133, and the minimum custody level projected to increase from 33 to 44.

Table 2-22
Projected Jail ADP by Custody Type

ADP by Classification (Unit)	2014	2015	2020	2025	2030	2035	%Chg	%Chg/Yr	Average
Minimum Custody Level	33	32	35	38	41	44	35.2%	1.4%	37.8
Medium Custody Level	438	428	444	468	499	536	22.3%	1.0%	471.6
Maximum Custody Level	114	110	111	116	124	133	17.0%	0.7%	117.9
Min/Med/Max (Unit M & SHU)	99	100	119	143	175	218	118.8%	3.8%	146.4
Women's Special MGMT (Unit P)	43	42	42	42	43	44	0.3%	0.0%	42.5
Min/Med (Unit T-1, U)	84	82	83	86	90	94	11.4%	0.5%	86.6
Intake	7	7	8	9	10	11	51.5%	2.0%	9.0
NA (Unit T-2, Y)	44	43	46	50	55	61	37.4%	1.5%	50.8
Custody Level (Unit) Sum	863	845	889	953	1,037	1,140	32.1%	2.3%	962.7

Source: Alvin S Glenn Detention Center, SC Revenue and Fiscal Affairs Office, CGL Companies, October 2015.

There are units in the detention center that house multiple levels of classification. Unit U houses both minimum and medium classification, Unit P houses females with both medium and maximum classification, and Unit M houses males of all classification levels. Unit M houses all classifications of male inmates. While there are some general population inmates housed here, the vast majority of these inmates have various medical conditions that require special housing. The SHU also houses a variety of inmates, including protective custody, administrative segregation, disciplinary segregation, and inmates with severe mental illness.

Inmates that require special housing due to medical conditions and mental illness continue to receive much attention in Richland County, as it does across the nation. However, the current data does not allow for a clean separation of the projected medical/mental health inmates in Units M and SHU from

the remainder of the inmate population. The projected ADP of these two units increases from 99 currently to 218 by 2035. This is projected to be the largest growth of units in the jail, with a 118.8 percent increase.

Meetings with the detention center health care providers have determined that currently, approximately 10 percent of the inmate populations are in need of specialty housing. In Section 4 of this report, we will propose a plan that was developed with assistance from the detention center that properly addresses the health concerns and housing needs of this rapidly growing and high liability population.

Summary

The assessment of the jail population and the corresponding jail population projections is crucial for jail planning. The jail ADP for Richland County is projected to increase 8.1 percent from 2014 to 2035, with the ADP growing from 883 to 954. Using a 5.4 percent peaking factor derived from monthly jail data and a 7.5 percent classification factor, the jail bed space need by 2035 is projected to be 1,076.

The continued analysis of jail population requires a solid foundation of jail statistics that is repeatable and consistent. The data collection at the jail is the crucial factor for inmate population modeling. The Detention Center being able to reproduce consistent jail data is paramount for producing valid forecasts. Expanding the data collection in the facility to accurately count the number of inmates with medical conditions and mental illness that require special housing in the Alvin S. Glenn Detention Center is paramount for projecting this population in the future.

The relatively low projected growth of jail population and corresponding bed space need allows Richland County to refocus jail operations without having the scramble to accommodate large increases in the jail population.

Alvin S. Glenn Needs Assessment

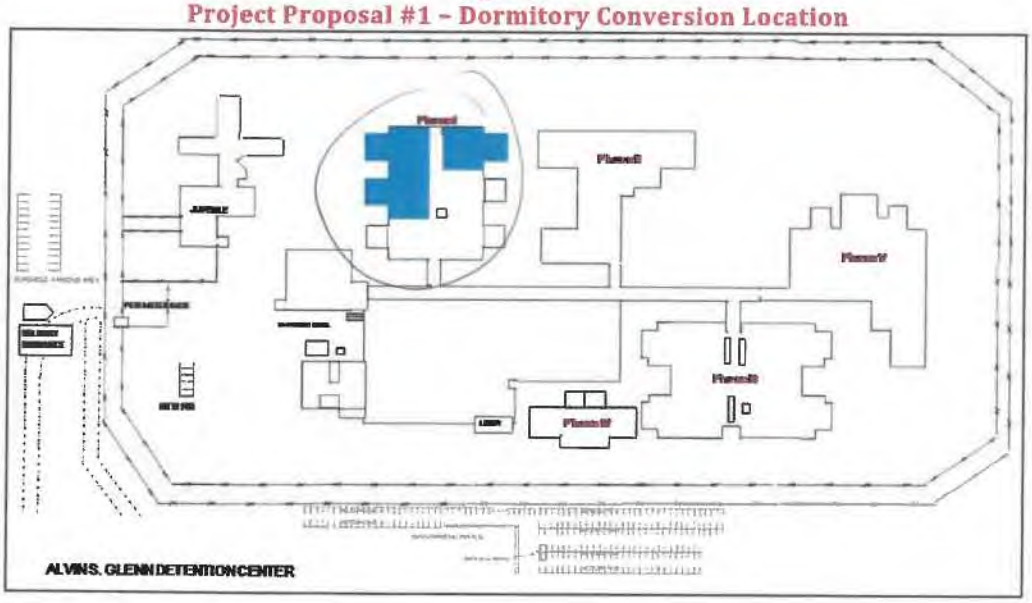
PROJECT PROPOSALS

In the course of assessing the current conditions of the facility, staffing, and inmate housing at the Alvin S. Glenn Detention Center; four primary project proposals emerged. Three of the project proposals address the current liabilities of assigning inmates to housing units that are not appropriate for their custody levels and their identified risks and needs. These liabilities are not due to improper classification by Detention staff. Rather they exist because the facility does not currently have sufficient type and quantity of beds to address the needs of the inmate population. These proposals are not presented as phases, as each proposal equally stands on its own as a necessity to meet both the current and future needs of the inmate population.

Project Proposal #1 – Dormitory Conversion

Inmate beds in dormitory housing account for 44 percent of the total beds at ASGDC; a larger percentage for most local detention centers. The facility experiences ongoing inmate disciplinary infractions from medium custody inmates that are located in dormitory housing units. Proposal #1 is to convert three of the dormitory housing units into celled housing units. The three housing units would be located in the Phase I portion of the complex to contain the construction, and disruption during renovations, to a central location.

Figure 3-1
Project Proposal #1 – Dormitory Conversion Location



Mechanical Systems Assessment

As described in Section 1, Buford Goff & Associates, Inc. (BGA) was requested to review the existing mechanical systems and determine how they might be impacted by an expansion and/or renovation of the facility. Concerning the converting dormitory housing into celled housing units, the following observations were made.

HVAC

Existing Conditions: The existing six (6) dormitories are each heated and cooled by a constant volume air handler with chilled water and hot water coils. The air handler is located in an upper level mechanical room. The supply is ducted to general supply grilles throughout the dormitory. Return air is provided via a return plenum on the back of the air handler. Outside air is provided from a rooftop intake hood and appears it is sized to allow economizer operation. Minimum outside air is listed on the equipment schedule as 1100 CFM.

Toilets and showers are exhausted by a rooftop exhaust fan. One smoke exhaust fan is located over the middle of the dormitory. Transfer openings on the lower level into the corridor apparently are used to transfer makeup air from the corridor into the dormitory when the smoke exhaust fan is energized.

Renovation: The existing systems, with the exception of the toilet and shower exhaust system, are not suitable for the new wet cell configuration. The air handler should be replaced with a similar constant volume air handler with chilled water and hot water coils. To maintain good humidity control within the building in the South Carolina environment, we propose replacing the existing rooftop intake hood with a new Dx rooftop 100% outside air dehumidification unit.

Supply air will be ducted to each chase to serve the upper and lower cells and also be ducted to ceiling or sidewall grilles to serve the dayroom.

A new smoke exhaust system will replace the existing smoke exhaust fan on the roof. The new smoke exhaust system shall be ducted to each chase to exhaust the cells as well as ducted to exhaust the dayroom. It is unlikely that we will be able to continue to use the main corridor as a source of makeup air, and new makeup air will have to be introduced into the housing unit.

Cells should be exhausted as required by Code.

Plumbing

Existing Conditions: The showers and toilets for two dormitories are piped (sanitary server) from one dormitory through the adjacent dormitory and out of the building.

Domestic hot water was originally provided by a gas fired water heater located in each dormitory's mechanical room. They have since been replaced with a plate heat exchanger (Hx) utilizing building heating hot water as the heat source. One Hx serves two adjacent dormitories.

Renovation: With the addition of wet cells, new sanitary sewer lines will need to be run. The existing 4" SS line serving two housing units can handle approximately 45 water closets. When the two adjacent housing units are converted to wet cells, there will be more than 70 water closets. Another reason the existing sanitary sewer line cannot be used for the new wet cells is that it would likely not be deep enough below grade to pick up the new fixtures. The existing 4" SS line serving showers and water closets should remain.

With the addition of wet cells, a new cold water line should be run. The existing 2½" cold water line serving two housing units can handle approximately 45 water closets. When the two adjacent housing units are converted to wet cells, there will be more than 70 water closets.

The existing plate heat exchanger should be replaced with a heat exchanger sized for the showers and the lavatory hot water load.

Other Systems

The sprinkler system for the renovated housing units will have to be completely replaced.

The electrical system will have to be further studied to determine the extent of electrical upgrades required, but it is anticipated the existing normal and emergency power systems are adequate for the renovation.

Summary

The dormitories can be converted to wet cell housing units but extensive plumbing, HVAC, electrical, and fire protection work is required. The existing chilled water, hot water system, fire protection, and electrical utilities can support the renovations with the utilities located within the housing units. The new cold water and sanitary sewer must extend outside the housing units to tie into the existing cold water and sanitary sewer systems with sufficient capacity.

Dormitory Conversion

Each dormitory has the capacity to house 56 inmates. Therefore during the renovation period as many as 168 inmates will be displaced and reassigned to other housing units.

The current dormitory configuration is shown on the lower right side of the figure below, and has the capacity to house up to 56 inmates. The other three housing units show how the dormitories can be converted to celled housing units. Some bedspace may be lost on the mezzanine level due to the addition of mechanical spaces.

Figure 3-2
Dormitory Conversion Ground Floor Configuration

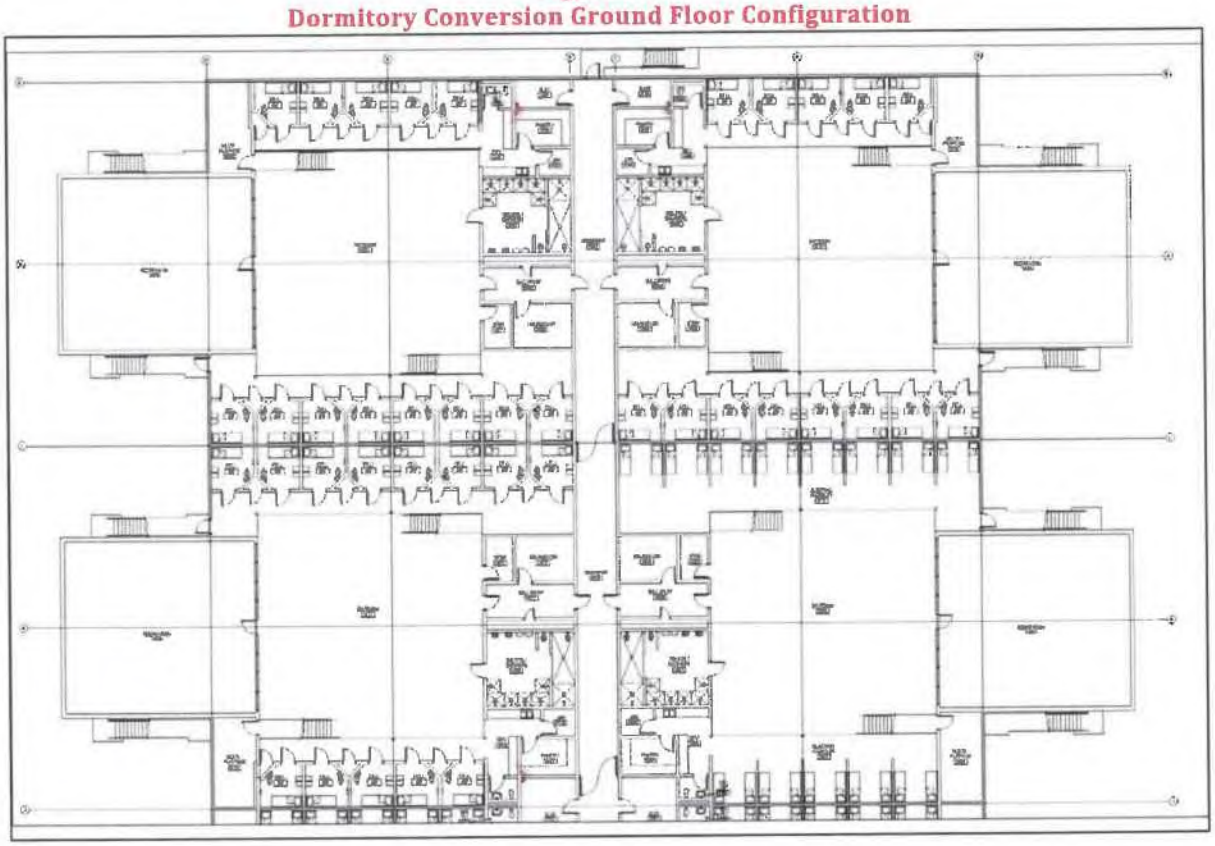
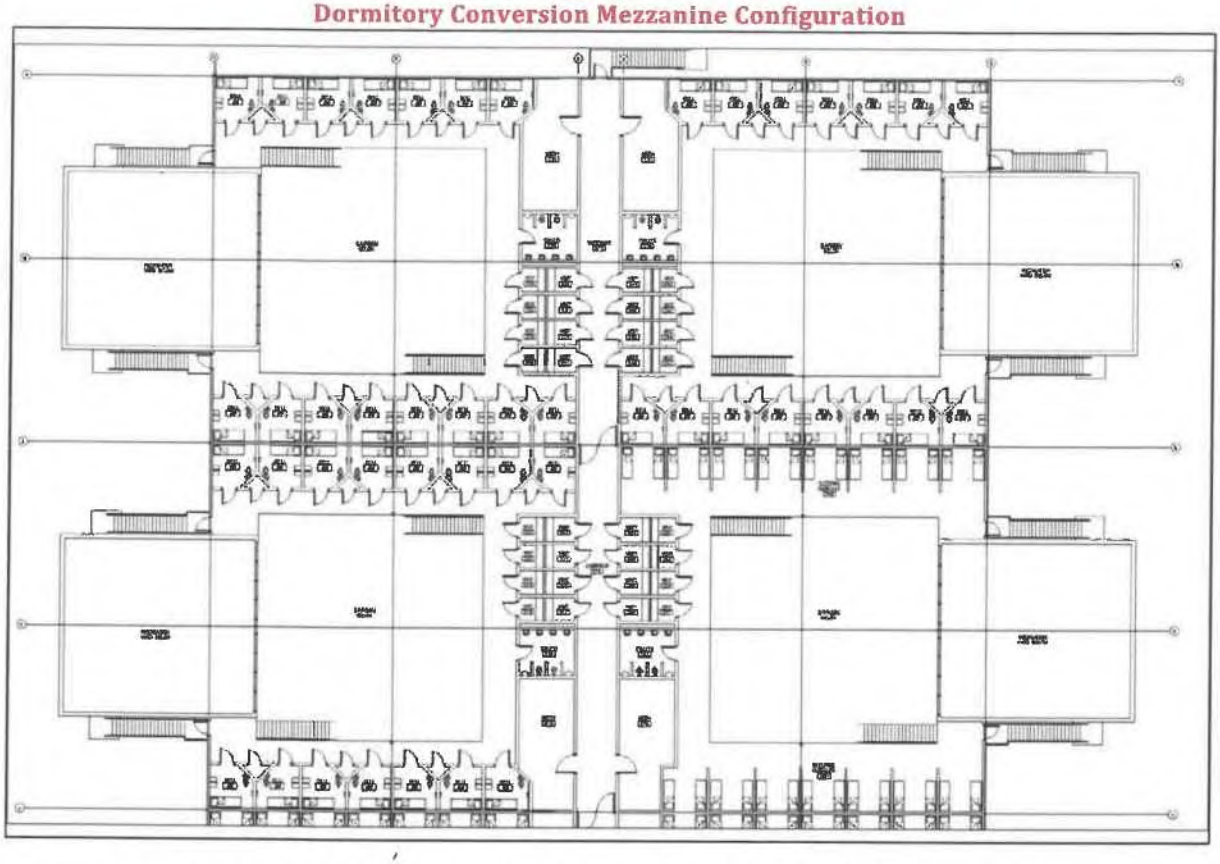


Figure 3-3
Dormitory Conversion Mezzanine Configuration



The resulting bedspace capacity is projected to be 50 beds in each of these converted units. The estimated time required to convert three housing units is approximately one year. With each housing unit encompassing approximately 9,700 square feet, the remodeling of three dormitory units will entail the renovation of approximately 29,100 square feet.

Special Needs Inmates

As discussed in Section 2 of this report, the inmate population in Richland County is projected to slowly grow over the next 20 years. But while the total number of inmates will grow at a gradual rate, the age of the population is expected to grow at a faster rate. Also, the prevalence of mental illness and medical issues among the inmate population is anticipated to grow at a much higher rate than in the past.

Mentally ill offenders possess a unique set of circumstances and needs. However, all too often, they cycle through the criminal justice system without appropriate care to address their mental health. According to the Bureau of Justice Statistics, individuals with mental health needs make up a large proportion of the US correctional population. An estimated 56 percent of state prisoners, 45 percent of federal prisoners, and 64 percent of jail inmates have a mental health problem. These individuals often receive inadequate care, with only one in three state prisoners and one in six jail inmates having received mental health treatment since their admission (James and Glaze 2006). Offenders with severe mental illness place even more strain on the criminal justice system as a whole, in terms of their unique case - processing requirements and treatment needs and their increased risk of recidivism (Baillargeon et al. 2009; Cloyes et al. 2010; Feder 1991). Housing mentally ill offenders in the criminal justice system is costly. In addition to high health care costs, mentally ill inmates tend to have higher rates of prison misconduct and recidivism (Fellner 2006; Toch and Adams 2002)[1]

Even though an estimated 64 percent of inmates in local facilities have a mental illness, not all of these individuals require medication or specialty housing. But for those inmates that do require a higher level of care, a facility must be prepared to address those needs or risk further decompensation and/or victimization from other inmates. The Alvin S. Glenn Detention Center currently has no specialty housing for inmates with medical or mental health issues. Most inmates with medical needs that require special care are housing in Housing Unit M. This is a general population housing unit that also housing inmates in wheelchairs, have casts, uncontrolled diabetes, or have recently returned from the hospital. Inmates that are detoxing are often housed in the HSU, which has become a "catch all" housing unit for inmates with severe mental illness, administrative segregation, disciplinary segregation, and inmates on suicide watch.

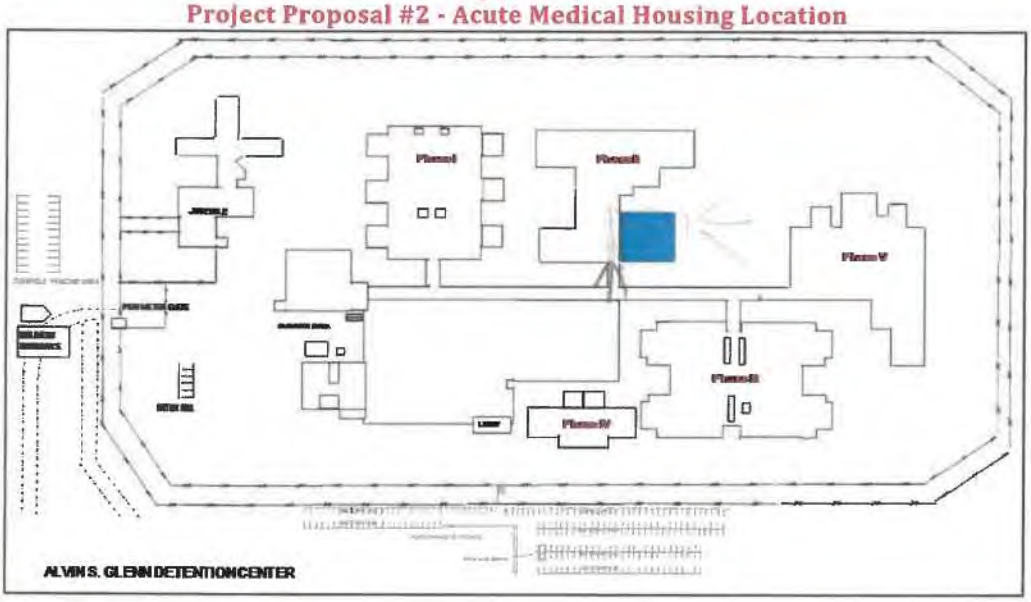
After meeting with Administration, Security staff, Medical staff and Mental Health personnel, it was determined that approximately 10 percent of the current inmate population would qualify for specialty housing due to acute medical needs or acute/sub-acute mental health issues. CGL has projected the bedspace need for 2035 to be 1,076 beds. Ten percent of this total equates to 108 beds. The following section will detail a proposal to construct a housing unit for inmates with need for acute medical care that will be located in close proximity of the existing health care section of the Detention Facility, as well as a Mental Health Services Center to properly care for inmates with mental illnesses.

[1] http://www.urban.org/research/publication/processing-and-treatment-mentally-ill-persons-criminal-justice-system/view/full_report

Project Proposal #2 – Acute Medical Housing

A purpose-built housing unit is proposed to address the inmate population with acute medical needs. This is not an area for inmates that require in-patient hospital care. Those inmates will still be transported to the local hospital for care. Instead, the acute medical housing unit will house inmates with medical needs that prevent them from being safely housed in a general population housing unit. These inmates may have just returned from the hospital, are in wheelchairs, have casts, or may be detoxing. There will also be two negative pressure cells in this area to temporarily house inmates with infectious diseases. This housing area should be planned for 32 inmates in double-occupancy cells.

Figure 3-4
Project Proposal #2 - Acute Medical Housing Location



This unit will be attached to the Phase II housing section. This location is advantageous as it will be close to the medical department, providing rapid response and ease of access for medical staff. Custody staffing will require one Detention Officer per shift, and the size of the new unit will be approximately 6,315 square feet.

Mechanical System Needs

HVAC

The Medical Housing Unit can be served with a multizone air handler with chilled water and hot water coils or three (3) or four (4) small constant volume air handlers with chilled water and hot water coils. The units can be rooftop or located in a mechanical room.

To maintain good humidity control within the building in the South Carolina environment, we propose that a Dx rooftop 100% outside air dehumidification unit be provided. Cells and toilet areas should be exhausted as required by Code.

A smoke exhaust system shall be ducted to each chase to exhaust the cells as well as ducted to the dayroom.

The original Phase II, Area 6 design included chilled water and hot water lines stubbed out for an additional housing unit where the Medical Housing Unit is proposed to be built. The chilled water and hot water capacity of the lines will be sufficient for the new HVAC equipment.

Plumbing

The original design for the Phase II, Area 6, Adult Housing building included a 6" SS line stubbed out for a future housing unit. Assuming the 6" line was installed deep enough (which it should have been since it was designed to pick up a large housing unit with wet cells), the line has sufficient capacity to pick up the Medical Housing Unit fixtures.

The original design included a 3" cold water line for a future housing unit. This line has sufficient capacity to pick up the Medical Housing Unit fixtures.

The original design included a 1" gas line for a future housing unit (we assume for a gas water heater). The domestic hot water for the Medical Housing Unit can be provided by a gas water heater or a plate heat exchanger utilizing building heating hot water as the heat source.

Other Systems

It appears that the main electrical switchboard has a space for a breaker to serve the Medical Housing Unit.

Sprinklers will have to tie into the existing fire riser line.

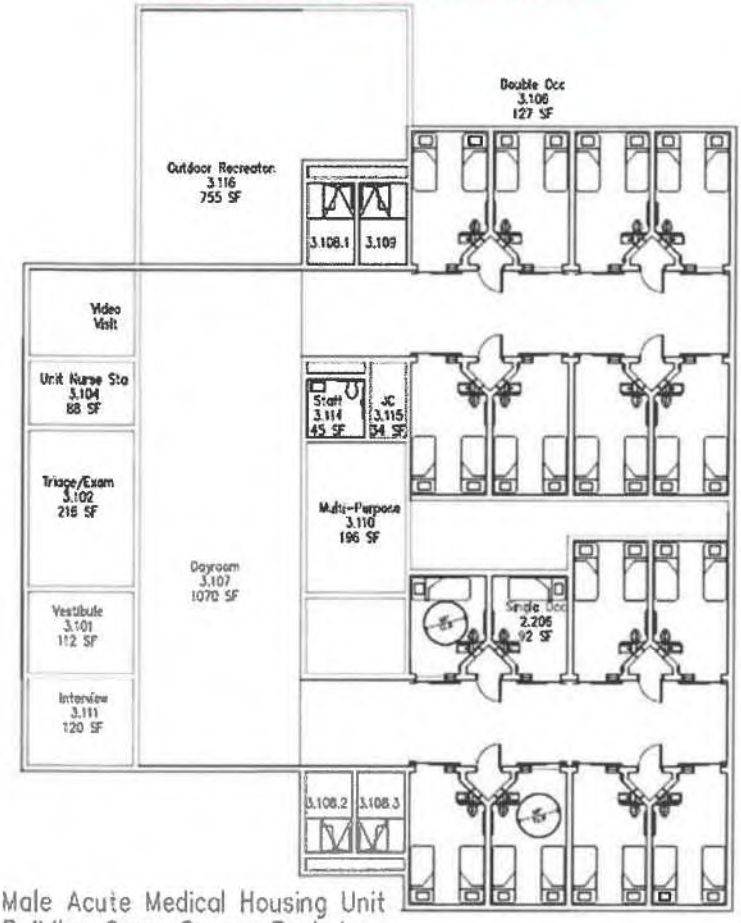
Summary

The new Acute Medical Housing Unit can be added relatively easily to the Phase II, Area 6, Adult Housing as the proposed location of the Medical Housing Unit is where the original Adult Housing project design stubbed out utilities (chilled water, hot water, gas, cold water, and sanitary sewer) for a future housing unit.

Acute Medical Housing Configuration

While not an infirmary the housing, common space and finishes will more closely resemble a medical facility than a local detention center. The goal is to create a self-contained unit that will care for the medical needs of those inmates that cannot safely be housed within the general inmate population due to their medical condition.

Figure 3-5
Acute Medical Housing Configuration

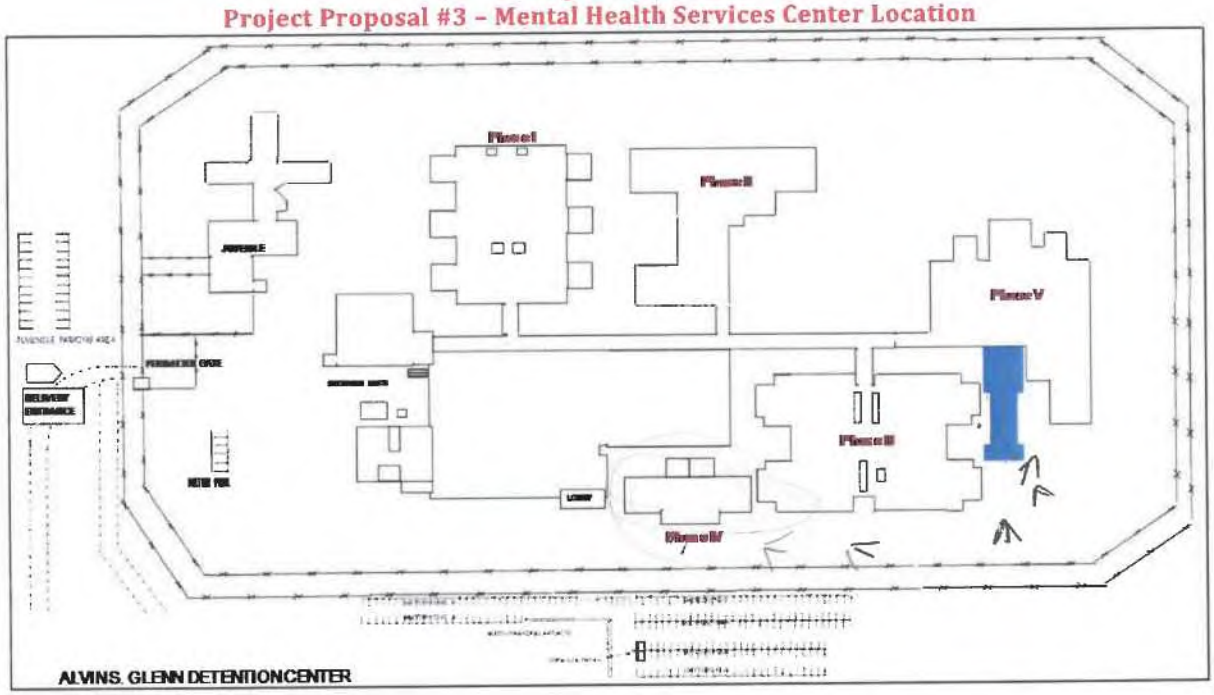


By providing a purpose-built area for this segment of the population, the inmates can be safely treated, and then returned to a general population housing unit when medically cleared.

Project Proposal #3 – Mental Health Services Center

The construction of a mission specific, self-contained Mental Health Services Center will provide a blend of secure housing with both secure and public treatment spaces aligned with current and forecasted needs. This secure addition will be attached to the Phase V section of the facility. as will most modern secure facilities.

Figure 3-6
Project Proposal #3 – Mental Health Services Center Location



This new section will be a self-contained area that focuses on the treatment of the specialized population that will be housed here. This space will also have staff offices, counseling spaces and suicide prevention rooms.

Custody staffing requirements will be two Detention Officers on each shift.

Mechanical System Needs

Cooling Plant

The new Mental Health Services Center is estimated to be approximately 19,085 GSF. Several different types of mechanical systems/cooling plants could be used for this building including packaged rooftop units, air cooled chillers, and water cooled chillers. To be consistent with the systems at the existing Detention Facility, we assume a chiller system is preferred by the County and Facility staff. For this size building, we estimate the cooling load will be approximately 125 tons.

Several possible scenarios are viable to handle the cooling needs, including the following:

a. Provide standalone air cooled chillers for the new Mental Health Services Center. Two chillers are recommended to provide some level of redundancy for cooling for when one chiller fails for the new building (example, 2 chillers at 90 tons, etc.). If standalone chillers are provided for the new Mental Health Services Center, it is recommended that a second water cooled chiller and cooling tower be provided for the Phase V building to provide redundancy for that facility.

b. Provide standalone water cooled chillers with cooling towers for the new Mental Health Services Center. Two chillers and cooling towers are recommended to provide some level of redundancy (example, 2 chillers/towers at 125 tons each). If standalone chillers are provided for the new Mental Health Services Center, it is recommended that a second water cooled chiller and cooling tower be provided for the Phase V building to provide redundancy for that facility.

c. Provide two new chillers at the Phase V existing chiller plant. Chilled water would have to be piped below grade from the Phase V building to the new Mental Health Services Center. The chiller options would be the same as listed above—water or air cooled. This approach is more expensive than the standalone options for just the new building but at the same time adds redundancy to the Phase V chiller plant. Currently Phase V is served by a single chiller/cooling tower. Failure of either of these will render Phase V without cooling until the equipment is either fixed or replaced. If the Phase V chiller plant is to serve the new Mental Health Services Center, it is recommended that a new 125 ton water cooled chiller and 125 ton cooling tower are added to the Phase V chiller plant as well as a 100 ton air cooled chiller. This will result in a connected cooling load of approximately 250-275 tons served by three (3) chillers totaling 350 tons. The third chiller provides some redundancy to maintain a reasonable level of cooling should one chiller or cooling tower fail or require servicing. The chilled water pumping system should be changed from a primary/secondary system to a variable flow primary pumping system.

d. From a cost standpoint, standalone air cooled chillers for the new Mental Health Services Center (approximately 100 tons each) provide the most economical first cost option and a good level of redundancy. An upgrade to magnetic bearing air cooled chillers provide a first cost lower than a water cooled chiller system but also provides greater operating efficiency than standard air cooled chillers.

Heating Plant

A new heating plant should be located at the new Mental Health Services Center.

The heating plant should include two fuel fired, condensing boilers each sized for 100% of the heating load. The boilers should be designed to operate on dual fuels.

Air Handling Systems

Air handlers for housing areas should be single zone air handlers or multizone air handlers with chilled water and hot water coils. A separate DX outside air ventilation air handler should be used to provide the Code required quantity of outside air to each of the air handlers or multizone units. This will provide good humidity levels in the Housing Unit. Air handlers should be located in mechanical rooms easily accessible for servicing. If needed to reduce costs, units could be roof mounted.

Smoke control and exhaust systems should be provided as required for each type of housing (maximum security, dormitory, etc.) and based upon Use Condition.

Plumbing Systems

Water heaters can be a central storage hot water heating system with gas burners or gas instantaneous hot water heaters. Two water heaters should be provided each sized at 70% of the domestic hot water load for redundancy. The burner sizing and storage capacity should be based upon the procedure for inmate showering. Sizes can be reduced if inmates shower according to a schedule and/or if showering times are limited. If preferred, domestic hot water can be provided through plate heat exchangers such as are used in the Phase I, Area 1A Dormitory. This will require running the boiler year round.

Plumbing piping for water closets, lavatories, and showers should all be accessible either in mechanical rooms or plumbing chases. Where plumbing is located in cell chases, the size of the chases should be reviewed to determine minimum acceptable size to access chase utilities such as sprinkler piping, plumbing piping, HVAC ducts, etc.

Fire Protection (Sprinkler) Systems

The sprinkler system should be zoned to minimize the impact of a discharge (break, fire, etc.) of the system. If a building or multiple housing units are on a single riser, every time there is a discharge of any type or if the system must be serviced where water must be turned off, the building or multiple housing units are left without fire protection until the water can be turned back on. This could be a time frame from a few minutes to many hours. A better design approach would be to zone the building to minimize the areas that are impacted by a discharge.

The routing of fire lines above inaccessible ceilings or difficult to access ceilings should be avoided.

The types of sprinkler heads in each type of location (cell, dorm, corridors, etc.) should be reviewed with the County before a final selection is made during design.

General

The routing of piping or ducts above inaccessible or difficult to access ceilings should be avoided to reduce long-term maintenance issues.

Cell chases should be sized to allow adequate space for servicing. Plumbing for showers should be accessible for servicing.

A generator operating on diesel and natural gas should be provided along with an aboveground or underground fuel oil storage tank.

Mental Health Services Center Configuration

The secure housing area of the Center will provide a total capacity of 32-beds to accommodate inmates with either acute or sub-acute mental illness. The size of the Mental Health Services Center would be reduced to approximately 19,085 square feet.

Figure 3-7
Mental Health Services Center Configuration

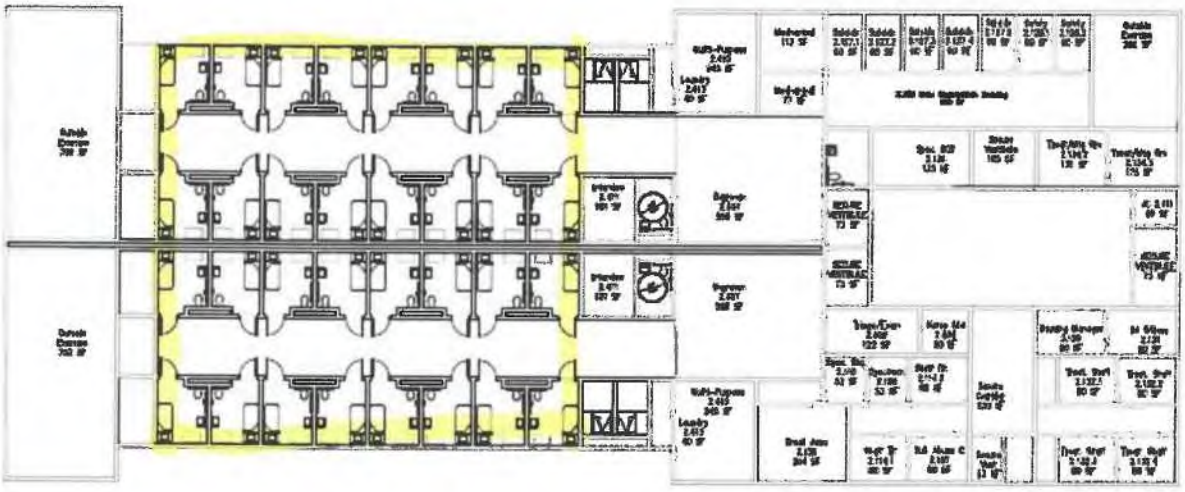


Image 3-1
Cell Interior Concept

Image 3-2
Cell Interior Concept

Staffing Impact of Proposals

Unlike the one-time cost of new construction, the operational cost of adding new staff is an on-going expense that continues year after year. Therefore, any new structures must carefully consider the salary and benefits impact of adding staff positions.

The dormitory renovations in Project Proposal #1 should not result in any additional staffing requirements. Only the housing unit configuration will change.

The new acute medical housing unit in Project Proposal #2 will require the addition of one security post that will need to be staffed 24 hours a day. Using the current relief factor, an additional 4.88 FTE will be required to properly staff this addition.

The Mental Health Services Center in Project Proposal #3 will house both acute and sub-acute inmates. Due to the type of inmate being housed in this section, at least 2 staff should be on duty at all times. These posts will require 9.76 FTE to operate around the clock when applying the current relief factor.

Table 3-1
Additional Staff Required

Project Proposal	Location	Required Position	Number of New Posts	Recommended Additional FTE
#1	Dormitory Renovations	Detention Officer	0	0.00
#2	New Medical Unit	Detention Officer	1	4.88
#3	New Mental Health Units	Detention Officer	2	9.76
Total New Staff Positions			3	14.64

Source: CGL, February 2016

The staffing recommendation for the complete operation of the ASGDC, including all three of the project proposals is 364 staff. This includes four additional Detention Sergeants (a result of proper application of the current relief factor), 19 additional Detention Officers (a result of three additional posts in the Project Proposals plus the proper application of the current relief factor) and the reduction of one non-uniformed position.

Table 3-2
Total Staffing Recommendations

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	286	19
Non-Uniformed	33	32	-1
Total Staff Positions	**342**	**364**	**22**

Source: CGL, February 2016

The complete table of recommended positions for future operations, including the Project Proposals, is included in Appendix 2 of this report.

Estimated Project Costs

The estimated project costs for the three Project Proposals are as follows.

Table 3-3
Estimated Project Costs

Project	Cost / SF	Est. SF Per	Qty	Total SF	Total Cost
1. Dormitory Renovations	$ 135	9,700	3	29,100	$ 3,928,500
2. New Medical Housing	$ 225	6,315	1	6,315	$ 1,420,875
3. Mental Health Services Center	$ 225	19,085	1	19,085	$ 4,294,125
Sub-Total				**54,500**	**$ 9,643,500**
	Contingency			15%	$ 1,446,525
	Architectural & Engineering			6%	$ 665,402
	Total				**$ 11,755,427**

Source: CGL, February 2016

The estimated cost for new construction on the site of the Alvin S. Glenn Detention Center is $225 per square foot. This will involve the construction of the new Medical Housing Unit and the Mental Health Services Center. Together, these two new structures will total approximately 25,400 square feet and the construction cost will be about $5.71 million.

The cost of renovating the dormitories into celled housing units will be less than the price of new construction, and is estimated to be $135 per square foot. Three renovated dormitories will total 29,100 square feet and the construction cost should total $3,928,500.

A 15 percent contingency has been factored into the total estimated costs for these three projects. Given the level of detail provided in this needs assessment, 15 percent may be a high estimate. However, the Consultants feel this to be a safe percentage for budgeting at this point in the planning process.

Architectural and engineering fees are factored at 6 percent of the construction and contingency estimated costs. This brings the total estimated project cost for all components to $11,755,427 in 2016 dollars.

Alvin S. Glenn Needs Assessment

APPENDIX 1

STAFFING FOR CURRENT OPERATIONS

Appendix 1: Staffing Recommendations for Current Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
Director		Dir	Dir	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Director:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**
Assistant Director		AD	Dir	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Asst. Director:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**
Captain													
Security Captain		Cpt	Sec	1	0	0	5	42.50	2,215.95	No	-	1.00	
Juvenile/Operations Captain		Cpt	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Administrative Captain (Programs/Training)		Cpt	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Captain:				**3**	**0**	**0**		**127.50**	**6,647.85**			**3.00**	**3**
Lieutenant													
Shift Lieutenant (Watch Commander)		Lt	Sec	0	1	1	7	175.00	9,124.50	Yes	2,078.89	4.39	
Prof. Standards Lieutenant		Lt	Dir	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Accreditation Lieutenant		Lt	Dir	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Juvenile Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Operations Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Hearing Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Training Lieutenant		Lt	Adm	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Programs Lieutenant		Lt	Adm	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Subtotal Lieutenant:				**7**	**1**	**1**		**297.50**	**15,511.65**			**11.39**	**11**
Sergeant													
Juvenile Sergeant (Asst. Watch Commander)		Sgt	Dir	0	1	1	7	175.00	9,124.50	Yes	1,918.14	4.76	
Security/Shift Sergeant (Asst. Watch Commander)		Sgt	Sec	0	3	3	7	525.00	27,373.50	Yes	1,918.14	14.27	
Operations Sergeant (Asst. Watch Commander)		Sgt	Ops	0	1	1	7	175.00	9,124.50	Yes	1,918.14	4.76	
Prof. Standards Sergeant		Sgt	Dir	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Transportation Sergeant		Sgt	Sec	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Operations Sergeant		Sgt	Ops	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Classification Sergeant		Sgt	Ops	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Training Sergeant		Sgt	Adm	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Recruiting Sergeant		Sgt	Adm	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Subtotal Sergeant:				**6**	**5**	**5**		**255.00**	**13,295.70**			**29.78**	**30**
DIRECTOR													
Juvenile Control		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Alpha - Medium (8 Single Cells)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Bravo - Medium (8 Single Cells)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Charlie - Medical/Max/Female Dorm (8 Beds)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Accreditation Officer		DO	Dir	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Director Section DO:				**1**	**4**	**4**		**742.50**	**38,713.95**			**20.51**	**21**
Commissary Account		Civ	Dir	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Director Section Civilian:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**

Appendix 1: Staffing Recommendations for Current Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
SECURITY													
Central Control		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Transport Hall (32)		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT A - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT B - Minimum (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT C - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT D - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT E - Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT F - Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 1 (31/61)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT X - Max (56 bed -Cells)	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT Y Orientation (56 bed - Cells)	2	DO	Sec	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
SHU Max/MH (56 bed - Cells)	2	DO	Sec	0	3	3	7	525.00	27,373.50	Yes	1,870.42	14.63	
SHU Suicides	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
SHU Control	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 2 (43/44)	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT G - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT H - Max (56 bed - Cells)	3	DO	Sec	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
UNIT I - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT J - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 3 (42)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT T-1 Inmate Worker (56 Bed Dorm)	4	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT T-2 Weekenders (56 Bed Dorm)	4	DO	Sec	0	0	0	7	0.00	0.00	Yes	1,870.42	0.00	
UNIT K - Medium (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT L - Medium (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT M - Min/Med/Max (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT P - Female Med/Max (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT P Suicide	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT U - Female - Min/Med (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 5 (64)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Transportation Officer 1		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 2		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 3		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 4		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 5		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 6		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 7		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 8		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 9		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 10		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 11		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Perimeter Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Lobby Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Visitation Officer		DO	Sec	0	1	0.5	7	131.25	6,843.38	Yes	1,870.42	3.66	
PRMH Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Subtotal Security: DO				**11**	**36**	**35.5**		**6,723.75**	**350,576.33**		**82,298.57**	**187.43**	**187**
Operations													
Pre Booking		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Intake Counter		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Intake		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Inmate Property		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Discharge		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Bond Court Security		DO	Ops	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
Operations (Movement Coordinators)		DO	Ops	0	2	1	7	262.50	13,686.75	Yes	1,870.42	7.32	
Records		DO	Ops	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
Classification		DO	Ops	0	2	0	7	175.00	9,124.50	Yes	1,870.42	4.88	
Population Officer		DO	Ops	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Operations DO:				**1**	**13**	**10**		**2,055.00**	**107,147.70**		**18,704.22**	**57.10**	**57**
Victim Witness Supervisor		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Victim Witness Advocate - Full Time		Civ	Ops	2	0	0	5	85.00	4,431.90	No	-	2.00	
Victim Witness Advocate - Part Time		Civ	Ops	2	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Supervisor		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Worker - Full Time		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Worker - Part Time		Civ	Ops	2	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Operations Civilian:				**9**	**0**	**0**		**297.50**	**15,511.65**			**7.00**	**7**

Appendix 1: Staffing Recommendations for Current Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
Administration													
ID/Billing Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Programs Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Library Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Training Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Administration DO:				**4**	**0**	**0**		**170.00**	**8,863.80**			**4.00**	**4**
Switchboard		Civ	Adm	2	0	0	5	85.00	4,431.90	No	-	2.00	
Quality Control		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Office Manager		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Receptionist		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Accounts		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Data Entry		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Human Resources		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Payroll		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Juvenile Secretary		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Training Secretary		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Mail Clerk - Training		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Administration Civilian:				**12**	**0**	**0**		**510.00**	**26,591.40**			**12.00**	**12**
Maintenance													
Floors Officer		DO	Mnt	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Inmate Workers Officer		DO	Mnt	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Maintenance DO:				**2**	**0**	**0**		**85.00**	**4,431.90**			**2.00**	**2**
Maintenance Supervisor		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Maintenance Mechanic		Civ	Mnt	5	0	0	5	212.50	11,079.75	No	-	5.00	
Electrician		Civ	Mnt	2	0	0	5	85.00	4,431.90	No	-	2.00	
Plumber		Civ	Mnt	2	0	0	5	85.00	4,431.90	No	-	2.00	
Housekeeping		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Maintenance Secretary		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Maintenance Civilian:				**12**	**0**	**0**		**510.00**	**26,591.40**			**12.00**	**12**

Source: CGL, September 2015

Position	FTE
Director	1
Assistant Director	1
Captain	3
Lieutenant	11
Sergeant	30
Detention Officer	271
Non Uniformed	32
Total FTE Requirement:	349

Source: CGL, January 2016

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	271	4
Non-Uniformed	33	32	-1
Total Staff Positions	**342**	**349**	**7**

Source: CGL, January 2016

Alvin S. Glenn Needs Assessment

APPENDIX 2

STAFFING FOR FUTURE OPERATIONS

Appendix 2: Staffing Recommendations for Future Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
Director		Dir	Dir	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Director:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**
Assistant Director		AD	Dir	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Asst. Director:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**
Captain													
Security Captain		Cpt	Sec	1	0	0	5	42.50	2,215.95	No	-	1.00	
Juvenile/Operations Captain		Cpt	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Administrative Captain (Programs/Training)		Cpt	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Captain:				**3**	**0**	**0**		**127.50**	**6,647.85**			**3.00**	**3**
Lieutenant													
Shift Lieutenant (Watch Commander)		Lt	Sec	0	1	1	7	175.00	9,124.50	Yes	2,078.89	4.39	
Prof. Standards Lieutenant		Lt	Dir	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Accreditation Lieutenant		Lt	Dir	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Juvenile Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Operations Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Hearing Lieutenant		Lt	Ops	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Training Lieutenant		Lt	Adm	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Programs Lieutenant		Lt	Adm	1	0	0	5	42.50	2,215.95	No	2,078.89	1.00	
Subtotal Lieutenant:				**7**	**1**	**1**		**297.50**	**15,511.65**			**11.39**	**11**
Sergeant													
Juvenile Sergeant (Asst. Watch Commander)		Sgt	Dir	0	1	1	7	175.00	9,124.50	Yes	1,918.14	4.76	
Security/Shift Sergeant (Asst. Watch Commander)		Sgt	Sec	0	3	3	7	525.00	27,373.50	Yes	1,918.14	14.27	
Operations Sergeant (Asst. Watch Commander)		Sgt	Ops	0	1	1	7	175.00	9,124.50	Yes	1,918.14	4.76	
Prof. Standards Sergeant		Sgt	Dir	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Transportation Sergeant		Sgt	Sec	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Operations Sergeant		Sgt	Ops	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Classification Sergeant		Sgt	Ops	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Training Sergeant		Sgt	Adm	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Recruiting Sergeant		Sgt	Adm	1	0	0	5	42.50	2,215.95	No	1,918.14	1.00	
Subtotal Sergeant:				**6**	**5**	**5**		**255.00**	**13,295.70**			**29.78**	**30**
DIRECTOR													
Juvenile Control		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Alpha - Medium (8 Single Cells)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Bravo - Medium (8 Single Cells)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Juvenile Charlie - Medical/Max/Female Dorm (8 Beds)		DO	Dir	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Accreditation Officer		DO	Dir	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Director Section DO:				**1**	**4**	**4**		**742.50**	**38,713.95**			**20.51**	**21**
Commissary Account		Civ	Dir	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Director Section Civilian:				**1**	**0**	**0**		**42.50**	**2,215.95**			**1.00**	**1**

Appendix 2: Staffing Recommendations for Future Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
SECURITY													
Central Control		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Transport Hall (32)		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT A - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT B - Minimum (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT C - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT D - Low Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT E - Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT F - Medium (56 Bed Dorm)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 1 (31/61)	1	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT X - Max (56 bed -Cells)	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT Y Orientation (56 bed - Cells)	2	DO	Sec	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
SHU Max/MH (56 bed - Cells)	2	DO	Sec	0	3	3	7	525.00	27,373.50	Yes	1,870.42	14.63	
SHU Suicides	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
SHU Control	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
New Male Acute Medical Housing (32 Bed - Cells)	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 2 (43/44)	2	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT G - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT H - Max (56 bed - Cells)	3	DO	Sec	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
UNIT I - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT J - Medium (56 bed - Cells)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 3 (42)	3	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT T-1 Inmate Worker (56 Bed Dorm)	4	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT T-2 Weekenders (56 Bed Dorm)	4	DO	Sec	0	0	0	7	0.00	0.00	Yes	1,870.42	0.00	
UNIT K - Medium (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT L - Medium (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT M - Min/Med/Max (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT P - Female Med/Max (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT P Suicide	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
UNIT U - Female - Min/Med (56 Bed - Pods)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort Phase 5 (64)	5	DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Housing Manager - New MH Facility		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Escort - New MH Facility		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Transportation Officer 1		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 2		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 3		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 4		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 5		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 6		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 7		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 8		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 9		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 10		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Transportation Officer 11		DO	Sec	1	0	0	5	42.50	2,215.95	Yes	1,870.42	1.18	
Perimeter Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Lobby Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Visitation Officer		DO	Sec	0	1	0.5	7	131.25	6,843.38	Yes	1,870.42	3.66	
PRMH Officer		DO	Sec	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Subtotal Security: DO				**11**	**39**	**38.5**		**7,248.75**	**377,949.83**		**87,909.84**	**202.07**	**202**
Operations													
Pre Booking		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Intake Counter		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Intake		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Inmate Property		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Discharge		DO	Ops	0	1	1	7	175.00	9,124.50	Yes	1,870.42	4.88	
Bond Court Security		DO	Ops	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
Operations (Movement Coordinators)		DO	Ops	0	2	1	7	262.50	13,686.75	Yes	1,870.42	7.32	
Records		DO	Ops	0	2	2	7	350.00	18,249.00	Yes	1,870.42	9.76	
Classification		DO	Ops	0	2	0	7	175.00	9,124.50	Yes	1,870.42	4.88	
Population Officer		DO	Ops	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Operations DO:				**1**	**13**	**10**		**2,055.00**	**107,147.70**		**18,704.22**	**57.10**	**57**

Appendix 2: Staffing Recommendations for Future Operations

Alvin S. Glenn - Recommended Posts/Positions

Post/Position	Phase	Job Class	Dept	M-F Days	12 Hr Days	12 Hr Nights	Days/ Week	Hours/ Week	Hours/ Year	Relief	NAWH	Total FTE	Rounded FTE
Victim Witness Supervisor		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Victim Witness Advocate - Full Time		Civ	Ops	2	0	0	5	85.00	4,431.90	No	-	2.00	
Victim Witness Advocate - Part Time		Civ	Ops	2	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Supervisor		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Worker - Full Time		Civ	Ops	1	0	0	5	42.50	2,215.95	No	-	1.00	
Pre-Trial Worker - Part Time		Civ	Ops	2	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Operations Civilian:				9	0	0		297.50	15,511.65			7.00	7
Administration													
ID/Billing Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Programs Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Library Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Training Officer		DO	Adm	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Administration DO:				4	0	0		170.00	8,863.80			4.00	4
Switchboard		Civ	Adm	2	0	0	5	85.00	4,431.90	No	-	2.00	
Quality Control		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Office Manager		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Receptionist		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Accounts		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Data Entry		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Human Resources		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Payroll		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Juvenile Secretary		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Training Secretary		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Mail Clerk - Training		Civ	Adm	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Administration Civilian:				12	0	0		510.00	26,591.40			12.00	12
Maintenance													
Floors Officer		DO	Mnt	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Inmate Workers Officer		DO	Mnt	1	0	0	5	42.50	2,215.95	No	1,870.42	1.00	
Subtotal Maintenance DO:				2	0	0		85.00	4,431.90			2.00	2
Maintenance Supervisor		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Maintenance Mechanic		Civ	Mnt	5	0	0	5	212.50	11,079.75	No	-	5.00	
Electrician		Civ	Mnt	2	0	0	5	85.00	4,431.90	No	-	2.00	
Plumber		Civ	Mnt	2	0	0	5	85.00	4,431.90	No	-	2.00	
Housekeeping		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Maintenance Secretary		Civ	Mnt	1	0	0	5	42.50	2,215.95	No	-	1.00	
Subtotal Maintenance Civilian:				12	0	0		510.00	26,591.40			12.00	12

Source: CGL, January 2016

Position	FTE
Director	1
Assistant Director	1
Captain	3
Lieutenant	11
Sergeant	30
Detention Officer	286
Non Uniformed	32
Total FTE Requirement:	364

Source: CGL, January 2016

Position	Current FTE	Recommended FTE	Difference
Director	1	1	0
Assistant Director	1	1	0
Captain	3	3	0
Lieutenant	11	11	0
Sergeant	26	30	4
Detention Officer	267	286	19
Non-Uniformed	33	32	-1
Total Staff Positions	342	364	22

Source: CGL, February 2016

CGL Companies
1619 Sumter Street
Columbia, SC 29201
CGLCompanies.com
803-765-2833
CGLcompanies.com

EXHIBIT 16

CRAYMAN HARVEY

From: CRAYMAN HARVEY
Sent: Thursday, November 17, 2022 7:31 PM
To: Capt. Kenneth Sligh
Cc: CAPT. CURTIS BUFFORD; CAPT. HIGGINS; Capt. Washava Moye; LT. DONALD WESTON; LT. JEFFREY WALKER; Lt. Chiquita Dawkins-West; Lt. Ernest Starling; Lt. Jonathan Williams; Lt. Kevin McCollough; Lt. Latoya Williams; Lt. Marcus Burnette; Lt. Robert Waters; Lt. Timothy Lippett; Lt. Tynika Legette; Sgt. Melissa Vinson; Sgt. Saterrica Thompson; Sgt. Teraine Brown; Sgt. Valarie Suttle
Subject: Re: SHU CLOSED

Awesome job team!! You just made history.

Crayman J Harvey, MS
Interim Director
ALVIN S. GLENN DETENTION CENTER
HARVEY.CRAYMAN@richlandcountysc.gov
Office Line: 803 576-3210 Cellphone: 803-240-2875
201 John Mark Dial Drive
Columbia, SC 29209

Sent from my iPhone

> On Nov 17, 2022, at 7:17 PM, Capt. Kenneth Sligh <SLIGH.KENNETH@richlandcountysc.gov> wrote:
>
> SHU has been closed. All detainees were moved from SHU to unit Poppa. All female detainees have been moved to unit India and unit Golf. Unit India is the mental health unit for females.
>
> Sent from my Galaxy

CRAYMAN HARVEY

From: CRAYMAN HARVEY
Sent: Friday, November 4, 2022 2:39 PM
To: Lt. Kevin McCollough; Capt. Kenneth Sligh; CAPT. CURTIS BUFFORD; Capt. Washava Moye; CAPT. HIGGINS; Shanae Green; Lt. Robert Waters
Cc: LT. JEFFREY WALKER; Lt. Latoya Williams; Lt. Marcus Burnette; Lt. Timothy Lippett; Sgt. Melissa Vinson; Sgt. Kelvin Lark; Sgt. Saterrica Thompson; SGT. DERRICK ANDERSON; SGT. IESHA DUPREE; Sgt. Valarie Suttle; Sgt. Johnette Pinckney; Sgt. Tormesha Haynes; Sgt. Magdelayna Govan; Sgt. Gerald Hardwell; Sgt. Gregory Noble, Jr.; Sgt. Nathaniel Smith; Sgt. Teraine Brown; Sgt. Reggie Faulks; Sgt. Monica Owens; ABL Kitchen
Subject: RE: Mental Health Unit

Huge shout to this team for making this happen. You all are the best. The sky is the limit....

Thanks
Cjh

From: Lt. Kevin McCollough <McCollough.Kevin@richlandcountysc.gov>
Sent: Friday, November 4, 2022 2:38 PM
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>; Capt. Kenneth Sligh <SLIGH.KENNETH@richlandcountysc.gov>; CAPT. CURTIS BUFFORD <BUFFORD.CURTIS@richlandcountysc.gov>; Capt. Washava Moye <Moye.Washava@richlandcountysc.gov>; CAPT. HIGGINS <HIGGINS.MICHAEL@richlandcountysc.gov>; Shanae Green <Green.Shanae@richlandcountysc.gov>; Lt. Robert Waters <Waters.Robert@richlandcountysc.gov>
Cc: Lt. Kevin McCollough <McCollough.Kevin@richlandcountysc.gov>; LT. JEFFREY WALKER <WALKER.JEFFREY@richlandcountysc.gov>; Lt. Latoya Williams <WILLIAMS.LATOYA@richlandcountysc.gov>; Lt. Marcus Burnette <Burnette.Marcus@richlandcountysc.gov>; Lt. Timothy Lippett <LIPPETT.TIMOTHY@richlandcountysc.gov>; Sgt. Melissa Vinson <Vinson.Melissa@richlandcountysc.gov>; Sgt. Kelvin Lark <Lark.Kelvin@richlandcountysc.gov>; Sgt. Saterrica Thompson <THOMPSON.SATERRICA@richlandcountysc.gov>; SGT. DERRICK ANDERSON <ANDERSON.DERRICK@richlandcountysc.gov>; SGT. IESHA DUPREE <DUPREE.IESHA@richlandcountysc.gov>; Sgt. Valarie Suttle <Suttle.Valarie@richlandcountysc.gov>; Sgt. Johnette Pinckney <Pinckney.Johnette@richlandcountysc.gov>; Sgt. Tormesha Haynes <Haynes.Tormesha@richlandcountysc.gov>; Sgt. Magdelayna Govan <GOVAN.MAGDELAYNA@richlandcountysc.gov>; Sgt. Gerald Hardwell <HARDWELL.GERALD@richlandcountysc.gov>; Sgt. Gregory Noble, Jr. <Noble.Gregory@richlandcountysc.gov>; Sgt. Nathaniel Smith <Smith.Nathaniel@richlandcountysc.gov>; Sgt. Teraine Brown <Brown.Teraine@richlandcountysc.gov>; Sgt. Reggie Faulks <Faulks.Reggie@richlandcountysc.gov>; Sgt. Monica Owens <Owens.Monica@richlandcountysc.gov>; ABL Kitchen <Kitchen.ABL@richlandcountysc.gov>
Subject: Mental Health Unit

All detainee that is on medical hold in Unit Mike has been move to Unit Bravo. All detainee that is on Medical transit in unit shu has been place in unit Mike. Mike is now your Mental Health unit. We are currently speaking with Ms. Saxon to figure out the rec schedule.

EXHIBIT 17

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-BM **SECOND DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. [redacted] was my roommate in unit Delta. She was in bed 26 where it leaks water from the ceiling. [redacted] reported this issue to a guard who never got her a clean/dry sheet cover. The guard that she spoke directly to was Sgt. McClendon. McClendon told her to get a boat (stack a bunk) and sleep on the floor and she will see about getting her a new sheet and cover. The night went on.

2. The next day [redacted] had bond court. She told me she was scared, nervous, upset and had mixed feelings about what the judge would say because she was already on an ankle monitor (which she had on in the dorm). When [redacted] came back, she was very upset. She cried, screamed, and just wanted to talk about the fact the judge denied her bond. She was very upset that she was going to miss her boyfriend's funeral. She was crying because she felt like she was the cause of her brother being in jail and you could tell she needed some type of mental evaluation.

3. That night we talked and prayed and cried together. [redacted] wanted to be around me because she said she was so upset and I was the only person she remembered from the last time

she came to jail when we was in unit Uniform. That night [redacted] was very stressed and upset she wanted to just take a nap and have peace and quiet. However, a lady name [redacted] was smoking some type of drugs and was being very loud and disrespectful to [redacted]. They began to argue and [redacted] spit on [redacted] and [redacted] hit her. Detainees people separated the two. There were no officer in the unit.

4. [redacted] then called 3261 on the officer phone and told that [redacted] hit her. Sgt. McClendon came in and asked what happened. [redacted] told her side. Afterward, [redacted] told her side. McClendon left. Then, came back and told [redacted] to pack her stuff. At this time my head was covered the entire time because I was scared at what McClendon would do to her. [redacted] told her its best for her to not be removed because her bond just got denied. Her man just died and she had a lot going on at this time. [redacted] told her she also didn't think it was fair to just remove her because [redacted] spit on her first.

5. [redacted] clearly stated she don't need to be by herself and McClendon told her since she is calm what she can do for her is not handcuff her but she is still going to lock up. McClendon then told her she will get all privileges denied until the hearing officer Mrs. Dukes talk to her. [redacted] begged McClendon not to remove her from this dorm. She felt safe in. The next day we heard [redacted] committed suicide. This crushed me. The fact that they left her personal items in bunk 26 was so sad. I then requested to speak to mental health a few days later.

6. Mental health then documented that I was hearing voices and placed me on an anti-psychotic medicine that supposed to help me sleep. I then told mental health that I'm not interested in the medicine and to please take me off. Mrs. Lassiter told me she is going to place me on the list to tell the doctor that. The fact that I had to reach out to mental health myself is sad. The fact that mental health avoids speaking to detainees and avoids properly documenting the information is sad. The mental health counsel Mrs. Lassiter isn't organized with information. She takes information and put it on little corners of scratch paper. She talks to me often because I request her all the time and she still can't remember my name.

7. I have been here a year and haven't been provided proper care. I was once told I have to let my lawyer handle that. Dr.. Potter the mental health doctor is a joke. She is more focused on why you're in jail. It's like every time I talk to her, she says things to trigger me to become more upset. Every time me or another detainee leaves from her office, it's like we are more upset than before. Mental health doesn't provide enough information to contribute to good mental health. It is always about putting us on medicines. We also write grievances and requests on the Kiosk to speak to mental health, dental, staff, security and other options that go unnoticed.

8. I have an electronic request to dental that I placed on February 8th that hasn't been answered yet. They have not addressed my broken tooth. Before the option was on Kiosk, I wrote multiple grievance/request daily on paper that never was reviewed or answered. I wrote multiple request/grievance regarding needing medical attention when I was bleeding out blood clots that caused extreme cramps and a heavy flow for a few weeks. That never was addressed.

9. I later found out I had a miscarriage that caused calamity in my life. I really believe due to having less food, being dehydrated and not have any prenatal care after asking, contributed in my loss. I went to the ER I believe in July. I have medical records from Prisma Richland that shows dehydration and extreme high blood pressure. At this time, I was really ill. I had already placed multiple sick calls regarding me having miscarriage symptoms and multiple sick calls about feeling faint, dehydrated no prenatal care and high blood pressure symptoms. Per the medical records at Alvin S. Glenn, I loss over 30 pounds and during each visit I was diagnosed with high blood pressure. I experienced miscarriage symptoms in April of 2023 and was never seen by Alvin S. Glenn doctor. I later had an appointment at the end of the year of 2023 at 1801 Sunset Blvd. with Dr. Harper. The exact date was November 29, 2023 where she verified a miscarriage took place. It is unbelievable that I was really seen almost 9 months after I was complaining about all of these issues I was having. It is depressing that I went through all of this alone in a cold jail cell with cold blooded inmates and employees. After begging for days just for water to drink, complaining about pain, feeling like I was about to die, developing a large mass in my stomach

that is still here getting bigger. I have placed multiple sick calls and grievances on the Kiosk about this issue and even after stating this mass is affecting my ability to walk, urinate, and poop, I still have not been seen again for it. I am still suffering from my loss and it has been told to mental health as well. At this point my mental state is 100% worse than what it was when I entered Alvin S. Glenn.

10. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration.

May 10th 2024
Date

[redacted]

(1) [redacted] #2

[redacted] was my roomate in unit Delta. She was in bed 2/6 where it leaks water from the ceiling. Ro reported this issue to a guard who never got her a clean/dry sheet & cover. The guard that she spoke directly to was Sgt. McClendon. McClendon to her to get a boat (stack or bunk) and sleep on the floor and she will see about getting her a new sheet and cover. The night went on and the next day [redacted] had bond court she told me she was scared, nervous upset and had mixed feelings about what the judge would say because she was already on an ankle monitor (which she had on in the dorm) When [redacted] came back she was very upset she cried screamed and just wanted to talk about the fact the judge denied her bond. She was very upset that she was going to miss her boyfriends funeral. She was crying because she felt like she was the cause of her brother being in jail and you could tell she needed some type of mental evaluation. That night we talked and prayed and cried together. [redacted] wanted to be around me because she said she ~~just~~ was so upset and I was the only person she remembered from the last time she came to jail when we was in unit uniform. That night [redacted] was very stressed and upset. She wanted to just take a nap and

have peace and quiet. However a lady name [redacted] was smoking some time of drugs and was being very loud and disrespect to [redacted]. They began to argue and [redacted] spit on [redacted] and [redacted] hit her. People separated the two. Cawood then called 3261 and told that [redacted] hit her. Sgt. McClendon came in and asked what happend [redacted] told her side after Cawood told her side. McClendon left then came back and told [redacted] to pack her stuff. At this time my head was covered the entire time because I was scared at what McClendon would do to her. [redacted] told her its not best to be removed because her bond just got denied her man just died and she had alot going on at this time. [redacted] told her she also didnt think it was fair to just remove her because [redacted] spit on her first. She clearly stated she dont need to be by herself and McClendon told her since she is calm what she can do for her is not hand cuff her but she is still going to lock up. She then told her she will get all privilages denied until the hearing officer Mrs. Dukes talk to her. [redacted] begged McClendon not to remove her from this dorm she felt safe in. The next day we heard [redacted] commited suicide. This crushed me. The fact that they left her personal items in bunk 26 was so sad. I then requested to speak to mental health a few days later

BG

mental health then documented that I was hearing voices and placed me on an anti psychotic medicine that suppose to help me sleep. I then told mental health that Im not intrested in the med. and to please take me off. Mrs. Lasiter told me she is going to place me on the list to tell the doctor that. The fact that I had to reach out to mental health my self is sad. The fact that mental health avoid speaking to detainees and avoid properly documenting the information is sad. The mental health counseler Mrs. Lasitor isnt organized with info. She takes information and put it in little corners of scratch paper. She talks to me often because I request her all the time and still cant remember my name. I have been here a year and havent be provided proper care. I was once told I have to let my lawyer handle that. Mrs. Potter the mental health doctor is a joke she is more focused on why youre in jail. Its like everytime I talk to her, she say things to trigger me to become upset. Everytime me or another detainee leaves from her office its like we are more upset then before. Mental health doesnt provide enough information to contribute to good mental health. Its always about putting us on meds. We also write grievances and request

(4)

on the Kiosk to speak to mental health, dental, staff/security and other options that go unnoticed. I have an electric [redacted] request to dental that I place Feb 8th that hasn't been answered yet. Before the option was on Kiosk I wrote multiple grievance/request daily on paper that never was reviewed or answered. I wrote multiple request/grievance regarding needing medical attention when I was bleeding on blood clots that caused extreme cramps and a heavy flow for a few weeks. That never was addressed. I later found out I had a miscarriage that caused calamity in my life. I really believe due to having less food, being dehydrated and not having any prenatal care after asking contributed in my loss. I have had multiple ~~three~~ successful pregnacies so I dont see why I would have had any issues, other than not having prenatal care. I am still suffering from my loss and it has been told to mental health as well. At this point my mental state is 100% worse than what it was when I entered Alvin S Glenn.

[redacted]

(5) I have [illegible] drink or crackers at a check to take my medicine with. I could have drank sink water however that is very unsanitary & I was sceptical about the water because Lt. William told me the water was contaminated. I later found out the water was shut off prior to me getting to that dorm so the line wasn't giving us clean water when it was turnt back on. I was extremely hot in this cell 29. I couldnt breath properly and one night I woke up in a cold sweat. I may have fainted or became over heated because I felt terrible once I woke up. I told my roomate [redacted] that I think I fainted she then began to tell me how she passed out a few weeks prior and she burst her lip. She then told me the medical team called a code blue & gave her fluids her @ the jail. This scared me so bad because when I passed out last time I broke bones and the staff was very dismissive and treated me like dirt. Yes dirt! Nothing! I clicked the help button to ask for water & I didnt recieve an answer. [redacted] then told me I was wasting my time pushing the button because it doesnt work. I then yelled out the door begging for water & was told, I can not open your door, you are not allowed out! Multiple ofcs were pure rude and disrespectful to detainees. OFC Johnson told a detainee she was going to get another detainee to beat her ass. She aroused, cursed and threatened the detainee. OFC Nagash told a detainee 'She don't care, she's only here to baby sit' she called a detainee a homeless crack head & told multiple detainees they are crazy bitches. I have heard alot of rude comments from ofcs. I have an issue with not being able to shower when needed. Like when my cycle came on I asked ofc Nagash for pads and a shower she refused. The next day I had an hour rec, which I called my family because they hadnt heard from me in over 30 hours. Then I went to take a shower and was threatened with a write up. I have place sick calls & grivences on the Kiosk since 23rd January 2024. Most of them dont have a responce. I have complained about the mold, bugs, insects, laundry, mental health, medical, staff, AREA

and many other things. Most of our issues have ASWell We
also get responces from Capt. K. Sligh that are hard to read
because of improper grammar & he only respond to one
issue when we write a or more per grievance. The
disapointment comes in when he doesnt fix the issues but
tell us he will. Another issue I personally have is the long
waits to see a medical provider outside of this facility. By
the time we get to the appointment theres a strong posibility
that the issue @ hand would be worse or gone. I'm still
questioning if this jail has insurance. The vents are so
backed up with dust, the windowsills are covered with
dust & spider webs. Holes in the ceiling, paint chipping, rust
on the stair case. I mean this is just 1% of the issues
here that concering me and my health conditions. The
staff has no direction or structure. From intake to the
kitchen, to programs, to medical, to the dorms; everything
is ran improperly! My current & future health will be
effected from these living conditions. I have developed issues
I have never had in over 30 years. Im afraid I may die in
this jail and my family probably will recieve a fabricated
story about what happend. Help is needed however the
conditions are far to gone. Shut this place down!

[redacted]

June 18th 2024

I am highly disappointed in the medical team! After months of requesting a healthy diet, begging for electrilites and requesting a multivitiam. I finally was placed on a multi vit. and started to get a snack bag to eat which @ first started with 2pc of bread, a pc of cheese, a pc of lunch meat, 1 fruit and 1 juice. As time went on the snack bag got smaller & smaller. The latest one I got had two pc of bread and a pack of peanut butter. The Dr I see for my previously fractures bones, Dr Wager & Dr Jackson @ Prisma Ortho prescribed me pain pills that require a snack or meal. This jail has neglected to provide me with a snack or meal for ~~almost~~ over 6 months now, even after being diagnosed with gastritis - placing multiple sick calls & grievances about stomach issues and requesting to be placed back on the snack bag list. I recieved a responce telling me the pain pills I take is not a reason to get a snack bag. So if thats the case why was I placed on it in the 1st place. I asked the Dr and his reason is because I was under weight. Well I have lost 20 more pds Since being removed off the snack bag. I requested to be placed on a multi vit. because I took vits. everyday outside of this jail and because the lack of nutrition this jail provides. We dont get fruits, milk or other nutritional value food. The quality & quantity is below the state requirements Im not sure where the menu or recipes come from. Its like someone wake up and say they dont feel like cooking so they end up throwing slop together. Over cook the rice & noodles and under cook veggies, meat, cake or bread. There is no

2)
Way this can be legal to feed detainees a 3 slot togo plate
ay with undone mystery meat, over cooked mushy noodles with
o seasoning, with undercooked veggies and bread or cake in
he last slot. My 2 year old eats healthier and more than this.
have never broke a bone in my life until I came to ASCDC~
~~Digested a multiple sporadic~~ Never have I been this unhealthy.
Now this goes to a major Red Flag and a major issue as to
why I'm not getting my multi vit to supplement the lack of
everything Im not being provided with through the food. Any
One in there right mind would reccommend a vitiam & not question
Why or try to justify why a multi vit cant no longer be provided.
Also passed out from dehydration 2 times & continue to
be dehydrated on a daily. I have requested gatoriad and was
told by Dr schaferred he will write the prescription after being
told he put the order in each & everytime I ask why havent
I got it yet Im always told Nurse Williams will look into it.
Dr Schaferred tells me he did his part & its up to her to put it
in the system. I had a personal conversation with Nurse
Williams once I reported dehydration to mental health. Mrs
Potter & Lasitor was present and Nurse Williams told me
it is hard to get gatoraid and the Kitchen really wont give
me more food because they just dont have the funds or
Suttimal team for that. After I told her that multiple detainees get
double portions and the plates are labled she told me 'its
really just a lable' I then started asking the people about
the trays & I have heard them say they complain when their
tray look like our tray & pregant women complain about
the tastless Food & how they arent giving fruit and most

3) of the time the milk packs aren't in their tray. I also asked Nurse Williams during the mental health visit complaint about medical about the gatoraid. She then mysterisly found a gatoraid mix and made it for me. Im totally diqused by the mental health and medical treament. Its really unbelievable! I have wrote sick calls and grivances on the Kiosk all year 2024. I have sick calls & grivances directed to medical, mental health, Security & staff, canteen, programs, maintance, Kitchen, mail, canteen/commissarry, and PREA. Alot of these go unopened! The staff is very dismissive. I have talked to Captin Maye personally about PREA as well as my family! I was asked questions 3 months later After the report was made by me to the ofc, who reported to To the Sgt. who reported it to Lt. Walker. I was then told the report will go to RCPD however I havent heard anything. I have mental health request that went unnoticed after I lost my grandfather and begged to just 'talk' to someone All I wanted was to talk in a private area to vent and some theaputic Couseling. Instead they ignored my Kiosk request so I asked an ofc to contact mental health and Mrs Nixon I believe thats her name came in and said Ms Lastor is gone for the day its after 4:30 so she will tell her to follow up with me tommarrow. I was so hurt & Confused. Like why do I have to wait. I literally told this lady the man that raised me just died & I need to talk to someone. She told me to wait until another day?! She didnt even have the damn repect to say sorry for your loss or are you okay or do you need a book or crossword puzzle to keep your mind

busy. Like this is unexceptable seriously. I have never exprienced anything of such in my life. It makes me question how many homicides and suicides took place in this jail that could have been avoided simplily by speaking with mental health. A simple talk, a simple sense of care. Instead of mental health having a conversation with me. I was instead placed in Unit Juliet with out a write up. I was hand cuffed, lied on and left in a daze about the movement. I sat in this lock up dorm that was extremely hot. I slept on the floor by the toilet that leaked and squirted water. This cell 29 had spiders flies, nats and bugs in it. The light fixture was burnt, it literally previously caught on fire. There was smoke damage on the ceiling and a melted hole in the light. Which we sat in for 23 hours a day. On the weekend we didnt get rec or able to shower. I hurt my knee getting up off the floor one day. I told the nurse during med pass and I placed a sick call request in. After it went un noticed I placed a grievance about the living conditions. I havent recieved a response yet. After I spoke to Sgt Owres about not getting water to drink. I explained to her that every day I go hours with out water. I explained that most days the water cooler doesnt make it to the top tier so all detainees upstairs are left without cooler water. I also told her that I needed to get off the floor because its bringing pain to my entire body & I hurt my knee trying to get up. In Juliet the times to get breakfast, lunch and dinner was always inconsistant. We didnt get 3 juices 4oz every day for breakfast. No drink for lunch or dinner. Med pass came at different times as well. One night the medical team gave me my night meds after 11pm and to make matters worse I wasnt

EXHIBIT 18

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-MB **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. Hey, my name is [redacted] I was reaching out in regards of condition and treatment of jail. I came to ASGDC on 12/31/2023. I was in intake for about 3 days. I slept on the floor with just a blanket. Once dressed out I was taken to a dorm called X- Ray and I was placed in a cell where feces was all in the toilet. The toilet leaked, so every day my cell was flooded in pool of water.

2. My first day in X-Ray my cycle started. I wasn't provided with necessary things to properly take care of my womanly duties. I asked for 3 straight days for a new jumpsuit and underwear. No luck with these things. I had been here for week now I still wasn't able to bathe at all. There was no officer available.

3. I haven't had enough water to drink since I arrived at the ASGDC. As my days continue, I still don't have enough water to bathe or wash underwear, or clean my jump suit. I finally was able to use someone's tablet to reach out to my family regarding to my situation. I honestly felt very disgusted as a woman. I feel the women officer should understand how

uncomfortable it was to be bleeding on myself with the necessary things I need like pads. I was using tissue to catch my blood. This is first jail I seen that do not provide these items at the door.

4. Another situation that I experienced was when I first got here I signed a medical release form. I still wasn't provided with my meds, because the jail kept misplacing my release. I had signed two more releases. I didn't receive my meds until after about 2 months of me being here. My experience without my meds was very overwhelming, and draining. I was feeling very suicidal, like feeling like no one cares, sadness, depression, anxiety.

5. When we arrived in Juliet around the middle of February 2024, raw sewage with feces was shooting out of a pipe in the wall of Cell #47 where the toilet had been removed. Two women were placed in there for a couple of days. After they were removed, the feces had been left on the floor of the cell along with pads and tissue. No one has cleaned it up. The cell stinks and attracts rats and other insects. Women in the dorm have recently gotten sick from the smell of feces from cell 47 and other cells.

6. The last experience I endured was very saddened. A young woman name [redacted] commit suicide on March 2, 2024. The officer that work that particular day was officer Johnson, she conducted Rec around about 12:44-1:44 for General Pop, before Rec was over [redacted] came over to speak to [redacted] and I and advised us she was crying because her boyfriend was being buried today (3-2-2024) and she was carrying his kid. She didn't want to see the baby every day. [redacted] was crying so hard. Around about 4:30 p.m. [redacted] and I was let out for Rec. [redacted] kept stopping by checking on her but when she peeked in the room [redacted] was sleeping. After we finish showering we was placed back into our cells and Ms. Johnson left the unit and never returned. Next time we seen an officer was around 11:00 p.m. conducting med pass.

7. I seen the officer drop her head. A lot of the detainees actually seen this scary and unreal event. My heart was heavy. I never experienced something like this so up and close. My honest opinion is that if the officer was present this could have been prevented. That day the

count didn't clear until 7:00 p.m. around the time the event did happen. It going around the jail saying the officer was in the office just partying.

8. After this event I was triggered to want to harm myself. I'm diagnosed with PSTD, anxiety, depression bipolar mood disorder. [redacted] tried to comfort me, and stopped me from banging my head. It really hurt me seeing and being around something like that. I was scared to tell anyone about how I feel because they think by putting you in a green suit on suicide watch they've fixed the problem at hand. I feel they just make it worse.

9. Attached hereto is my own hand-written statement that is the same in all material respects as this Declaration.

6/11/2024
Date

[redacted]

3/12/24

[redacted] Hey My Name is [redacted] I was reaching out in regards of Condition and treatment of jail I came to ASCDC on 12/31/2024 I was in intake for about 3 days I slept on the floor with just a blanket, once Dress out I was taking to a Dorm Called X Ray I was placed in a Cell where it was feces was all in the toilet, the toilet leaks, so everyday my cell was flood in pool of water. My 1st day in X Ray my Cycle Start I wasn't provided with necessary things to properly take care of my womenly duties I ask for 3 Days straight for a new jumpsuit and underwear go back with those things I had been here for week now I still wasn't able to bath at all it was no officer available. I didn't have water to Drink Since I arrived at the ASCDC, as my days Continue still on bath or underwear or clean jumpsuit I finally was able to Use someone tablet to reach out to my

family regarding to my Situtor, I honestly felt very Digested as woman I feel the women officer Shoulde understand how uncomfortable it was to be bleeding on myself with the necessary things I need like pads, I was using tissue to catch my blood. This is first Jail I seen that do not provide these items @ the Door.

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The last experience I endure was [redacted] found a young woman name [redacted] commit Suicide, on March 2, 2024, the officer that work that particular day was Officer Johnson, she conducted Rec around about 12:44 - 1:44 for General Pop, before Rec was over [redacted] came over to Speak to [redacted] and I and advised Us She was crying because her boyfriend was being buried today (3-2-24) and She was crying this bc She didn't want see him everyday. [redacted] was crying so hard. Around about 4:30pm [redacted] and I was Let out for Rec. [redacted] keep Stopping by Checking on here but when She peeked in the room [redacted] was sleeping. After we finish Showering we was placed back into our Cells and Mr. Johnson left the unit and never returned. Next time we Seen an officer was @ 11:00 Conducting Med Pass.

I Seen the officer Drop her head
was alot of the Detainee actually
seen this scary and unreal
event, my heart was heavy I never
experience something like this
so up close. In my honest opinion
is that if the officer was
present this couldve been
prevented. That Day the Count
didnt Clear until 10 P.M pm around
the time the event did happen.
It going around the jail saying
the officer was in the office
just partying. After this event
I was triggered an cost me to
want to harm myself. Im ~~dias~~ diagnosed
with PSTD, Anxiety, depression, Biplor
mood disorder. [redacted] comfort
me, and stop me from bagging my
head it really hurt me seeing
and being around something like
that I be scared to tell anyone
about how I feel Because they think
by putting you in a Green Suit fix the
problem at hand I feel it enhance
it.

EXHIBIT 19

Mental Health Screening Interview

Patient Name	ID Number	DOB	County, State, or Federal Patient	Date of Screening
[redacted]	659544	[redacted]	County	10/25/2022 2:31:21 PM

New		X	Follow-up		Referral From:	Medical	X	Jail		Patient		Other	

Marital Status							Highest Grade Completed	Special Education				Facility
Single	x	Married		Div/Sep		Partnered	High School gradu	Yes		No	x	Richland County SC

PLACEMENT IN A JUVENILE CORRECTIONAL FACILITY					Number of Adult Incarcerations	Current Offense(s)				Sentence	Living Unit (GP or Seg)
Yes		No			1x	Charges	Assault of a high aggravated nature	Convictions			seg

PROBATION/PAROLE VIOLATION(S) (TYPE)	Cases Pending

1 Are you now taking psychiatric medication to help you with anxiety, depression, mood swings, thinking problems, hearing voices or seeing things, or controlling your behavior?

Yes		No	x	
What is the name of your medication(s)	No			
Why was it prescribed for you?				
How long have you been taking it?		Where was it started?	County Jail		Prison		Community

2 Have you taken psychiatric medication in the past?

Yes		No	x	
What is the name of your medication(s)	No			
Why was it prescribed for you?				
How long ago did you stop taking it?				

3 Have you ever been hospitalized or treated for psychological problems?

Yes		No	x	
If yes, describe:	No			

4 Have you ever attempted to kill or hurt yourself? (If no, skip to 5)

Yes		No	x	
How many times have you tried?				
Methods?	No			
When was the last time?				
How did you attempt it?				

5 Have you been thinking about hurting or killing yourself recently? (If no, skip to 6) (describe on next page)

Yes		No	x		No
Do you have a plan in mind? If yes, describe:					
Yes		No	x		No
Are you intending to hurt yourself? If so, how?					
Yes		No	x		

6 Were you on suicide watch or any other special status while incarcerated? If Yes, when/why?

Yes		No	x		No

7 Family or significant others who have committed suicide? Who?

Yes		No	x		No

8 Have you been feeling really depressed or sad? Reasons?

Yes		No	x		No
Have you been crying? How often?					No

9 Problems with your appetite? Weight loss or gain in recent weeks?

Yes		No		No	Energy level?	

10 Do you have trouble sleeping? Why?

Yes	x	No		Patient stated that she is experiencing sleep disturbance due to flashbacks

11 Have you been feeling really tense or nervous? If yes, why?

Yes		No	x	No

12 Do you hear voices or see visions that others don't see or hear? If yes,

	Yes		No	x				
13	Have you had problems getting along with staff or other patients, in recent or past incarcerations?							
	Yes	x	No					
	If yes, describe:	Patient stated that she has issues with agitation and anger issues						
14	Have you ever been in trouble for getting into fights or hurting anyone? If yes, describe:	Patient stated that she was placed on restriction due to being physically aggressive with a peer						
	Yes	x	No					
15	Have you ever been the victim of violence or assault? If yes, describe:	No						
	Yes		No	x				
16	Have you ever had alcohol or drug problems?	Treatment? None			Last use? When/ What	Patient reported that she is a social drinker and the last time she drink alcohol was 7/22		
	Yes		No	x				
17	Do you have any medical problems? If yes, describe:	No						
	Yes		No	x				
18	Have you ever seriously injured your head? If yes, describe:	Patient stated that she had a concussion due to a car accident in 2019			Loss of consciousness?	Yes but for a short while		
	Yes		No	x				

19 Mental Health Status:

Consciousness/ Orientation	Alert		Person		Time		
	Fully Oriented		Place		Situation		
		X					
Appearance	Normal	X	Disheveled		Other		
	Poor Hygiene		Inappropriate				
Motor Activity	Normal	X	Slowed		Other		
	Agitated		Repetitive				
Speech	Normal	X	Slowed		Other		
	Pressured		Mute				
Affect	Appropriat	X	Labile		Other		
	Restricted		Blunted				
Mood	Euthymic	X	Dysphoric		Other		
	Elevated		Depressed				
Memory	Normal	X	Immediate Impaired		Other		
	Recent Impaired		Remote Impaired				
Judgement/Insight	Intact	X	Impaired		Other		
	Denial of Disorder		External Focus				
Attention/Concentration	Good	X	Inattentive		Other		
	Confused		Vigilant				
Thought Form	Linear/Goa	X	Circumstantial		Other		
	Tangential		Loosening				
Thought Content	No		Poverty of		Other		
	Delusion (Clarify)						
Perception	No	X	Disassociation		Other		
	Hallucinati ons						

4

Mental Health Screening Interview

	(Clarify)					
Suicidal Ideation	None	X	Passive		Active (Clarify)	
Reliability	Appears Reliable	X	Reason to Fake Bad		Reason to Fake Good	
Other						

20 List other important issues:

Adjustment Disorder
Patient is a 19 year old female who reported experiencing racing thoughts, flash backs related her crime and insomnia. She reported that she has never been treated for mental health issues but needs to speak with a Psych Provider regarding her current symptoms. She also reports that she is easily agitated, which result into anger issues.

MH CLASSIFICATION: TO BE FILLED OUT BY QUALIFIED MENTAL HEALTH PROFESSIONAL, PHYSICIAN

MH Code			Common Symptom Profiles/Diagnoses
MH-0		No Mental Health need	None
MH-1	x	Mental health need, not serious	Adjustment symptoms/disorder, mild to moderate depression or symptoms, anxiety, or PTSD, ADHD, Impulse control disorder, mild to moderate personality disorder.
MH-2a		Serious Mental Illness	Psychotic disorders, Major Depression, Bipolar disorder, Dementia, severe anxiety disorder and severe PTSD.
MH-2b		Serious Mental Illness, Personality Disorder	Patients with a primary personality disorder that is severe, accompanied by significant functional impairment, and subject to periodic decompensation (i.e. psychosis, depression, or suicidality).

SPECIAL CLASSIFICATION

	Developmental Disability
GAF	50

FOLLOW-UP

MHU Level of Service

None (per staff referral or patient request) | High | <2 weeks | x | Other

Next Follow-Up 11/11/2022

Record Request | Have patient complete a Release of Information Request

Patient reported that she has not prior mental health treatment (inpatient/outpatient)

x Referral for psychotropic medication consideration

STATUS (Housing) *Consult with Security Staff about options and contraindications.

OTHER

x Stable in General Population | 1 | Stable in Special Population

Unstable; needs special placement

Place on Observation Status

Referral Medical

QMHP

Referral Reason

Due Date

Prepared By:
Judy Lassiter QMHP 10/25/2022 3:31:22 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 1/25/2023 8:03:52 AM

MENTAL HEALTH SERVICES CLINICAL CONTACT

Patient Name [redacted]

ID Number	Facility	Date
659544	Richland County SC	11/11/2022

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			

Other (e.g., security and/or medical consult):

Visit Type

New	Follow-Up
	X

Referral from

Medical	Jail	Patient	Other
			Mental Health

Reason for Contact/Referral Source

Patient was a Clinical Mental Health follow-up to assess mental status, behaviors and adaptive coping skills.

RELEVANT HISTORY/ PATIENT'S REPORT

Patient reported that she was never on any psych medication but was on medication for ADHD (cannot recall the name) when she was younger. She reported that her symptoms are racing thoughts, anxiety and anger. During this session, QMHP educated patient on ways to recognize anger trigger and physical symptoms of anger and she was receptive of information provided. Patient requested to be seen in Psych clinic, which she was referred.

MENTAL STATUS (Check All That Apply)

Consciousness/Orientation:		alert	X	fully oriented		-person		-place		-time		-situation
Appearance:	X	normal		poor hygiene		disheveled		inappropriate		Other:		
Motor Activity:	X	normal		agitated		slowed		repetitive		Other:		
Speech:	X	normal		slowed		pressured		mute		Other:		
Affect:	X	appropriate		labile		restricted		blunted		Other:		
Mood:	X	euthymic		dysphoric		elevated		depressed		Other:		
Memory:	X	normal		immediate impaired		recent impaired		remote impaired		Other:		
Judgment/Insight:	X	intact		impaired insight		denial of disorder		external locus		Other:		
Attention/Concentration:	X	good		inattentive		confused		vigilant		Other:		
Thought Form:	X	linear/goal directed		circumstantial		tangential		loosening		Other:		
Thought Content:		no abnormalities		poverty of thought		delusion (clarify):				Other:		
Perception:	X	no abnormalities		disassociation		hallucinations (clarify)				Other:		
Suicidal Ideation:	X	none		passive		active (clarify):						
Reliability:	X	appears reliable		reason to fake bad		reason to fake good						

Other:

DIAGNOSES (Provisional?) Yes [ ] No [X]

Diagnosis: Adjustment Disorder

Psychosocial/Contextual Factors: Lacks social skills, incarceration

Disability/Functional Impairment*: 60

*Correctional Global Assessment of Functioning

STATUS (Housing)

Can remain in general population	Stable in special population	Unstable; needs special placement
X		

ACTION TAKEN (Check All That Apply)

**Clinician Instructions: MH codes are based on current evaluation.

MH Code	MH-0		MH-1		MH-2A	X	MH-2B	
Special Class	DD/Cognitive Impairment		Other					
MHU Monitoring	None (per staff or patient request)		High (< or equal to 2 weeks)	X				
Refer to Medical for psychotropic medication consideration/medical review								
Other: (List)								

TREATMENT PLAN/FOLLOW-UP

Educate patient anger management and healthy coping strategies to reduce anxiety.

This contact, the following were discussed:

Psycho-Education	Coping Skills	Safety for self and others
X	X	

Referral: Medical [ ] QMHP [ ]

Referral Reason

Due Date

Prepared By:
Judy Lassiter QMHP 11/11/2022 12:42:39 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 1/25/2023 8:08:50 AM

MENTAL HEALTH SERVICES CLINICAL CONTACT

Patient Name [redacted] [redacted]

ID Number	Facility	Date
659544	Richland County SC	11/29/2022

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			

Other (e.g., security and/or medical consult):

Visit Type

New	Follow-Up
	X

Referral from

Medical	Jail	Patient	Other
			Mental Health

Reason for Contact/Referral Source

Patient was seen for a routine Mental Health Follow-up to assess mental status, behaviors, adaptive coping skills.

RELEVANT HISTORY/ PATIENT'S REPORT

Patient verbalized that she has anger issues but no mental health issues. She reported that she has never been on any psychotropic medication and grow up with anger issues. QMHP educated patient on triggers of anger and recognizing anger warning signs. She was receptive to the information provided. He denies suicidal/homicidal ideations.

MENTAL STATUS (Check All That Apply)

Consciousness/Orientation:		alert	X	fully oriented		-person		-place		-time		-situation
Appearance:	X	normal		poor hygiene		disheveled		inappropriate		Other:		
Motor Activity:		normal	X	agitated		slowed		repetitive		Other:		
Speech:	X	normal		slowed		pressured		mute		Other:		
Affect:	X	appropriate		labile		restricted		blunted		Other:		
Mood:	X	euthymic		dysphoric		elevated		depressed		Other:		
Memory:	X	normal		immediate impaired		recent impaired		remote impaired		Other:		
Judgment/Insight:	X	intact		impaired insight		denial of disorder		external locus		Other:		
Attention/Concentration:	X	good		inattentive		confused		vigilant		Other:		
Thought Form:	X	linear/goal directed		circumstantial		tangential		loosening		Other:		
Thought Content:	X	no abnormalities		poverty of thought		delusion (clarify):				Other:		
Perception:	X	no abnormalities		disassociation		hallucinations				Other:		
Suicidal Ideation:	X	none		passive		active (clarify):						
Reliability:	X	appears reliable		reason to fake bad		reason to fake good						

Other:

DIAGNOSES (Provisional?) Yes [ ] No [X]

Diagnosis: Adjustment Disorder

Psychosocial/Contextual Factors: Lacks social skills, anger issues and incarceration

Disability/Functional Impairment*: 60

*Correctional Global Assessment of Functioning

STATUS (Housing)

Can remain in general population	Stable in special population	Unstable; needs special placement
X		

ACTION TAKEN (Check All That Apply)

**Clinician Instructions: MH codes are based on current evaluation.

MH Code	MH-0		MH-1	X	MH-2A		MH-2B	
Special Class	DD/Cognitive Impairment		Other					
MHU Monitoring	None (per staff or patient request)	X	High (< or equal to 2 weeks)					
Refer to Medical for psychotropic medication consideration/medical review								
Other: (List)								

TREATMENT PLAN/FOLLOW-UP

Anger management, healthy coping skills

This contact, the following were discussed:

Psycho-Education	Coping Skills	Safety for self and others

Referral: Medical [ ] QMHP [ ] Referral Reason ____ Due Date ____

Prepared By:
Judy Lassiter QMHP 11/29/2022 2:29:21 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 1/25/2023 8:12:25 AM

MENTAL HEALTH SERVICES CLINICAL CONTACT

Patient Name	ID Number	Facility	Date
[redacted] [redacted]	659544	Richland County SC	12/20/2022

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			

Other (e.g., security and/or medical consult):

Visit Type

New	Follow-Up
	X

Referral from: Medical [ ] Jail [ ] Patient [ ] Other: Mental Health

Reason for Contact/Referral Source

Patient was seen for a Clinical Mental Health Follow-up to assess mental status, behaviors and adaptive coping skills.

RELEVANT HISTORY/ PATIENT'S REPORT

Patient verbalized that she has been agitated and has anger issues. She denies suicidal/homicidal thoughts at this time. According to patient, she has impulse and anger issues. QMHP discussed the following information regarding constructive alternative to destructive anger by giving a description of positive alternative. Also discussed triggers and anger warning signs with patient. She was receptive to some the information provided and stated she will try to improve. Patient denies suicidal/homicidal thoughts at this time.

MENTAL STATUS (Check All That Apply)

Consciousness/Orientation:		alert	X	fully oriented		-person		-place		-time	-situation
Appearance:	X	normal		poor hygiene		disheveled		inappropriate		Other:	
Motor Activity:		normal	X	agitated		slowed		repetitive		Other:	
Speech:	X	normal		slowed		pressured		mute		Other:	
Affect:	X	appropriate		labile		restricted		blunted		Other:	
Mood:	X	euthymic		dysphoric		elevated		depressed		Other:	
Memory:	X	normal		immediate impaired		recent impaired		remote impaired		Other:	
Judgment/Insight:	X	intact		impaired insight		denial of disorder		external locus		Other:	
Attention/Concentration:	X	good		inattentive		confused		vigilant		Other:	
Thought Form:	X	linear/goal directed		circumstantial		tangential		loosening		Other:	
Thought Content:	X	no abnormalities		poverty of thought		delusion (clarify):				Other:	
Perception:	X	no abnormalities		disassociation		hallucinations (clarify):				Other:	
Suicidal Ideation:	X	none		passive		active (clarify):					
Reliability:	X	appears reliable		reason to fake bad		reason to fake good					

Other:

DIAGNOSES (Provisional?) Yes [ ] No [X]

Diagnosis: Adjustment Disorder

Psychosocial/Contextual Factors: Anger issues, impulsivity and incarceration

Disability/Functional Impairment*: 60

*Correctional Global Assessment of Functioning

STATUS (Housing)

Can remain in general population: X | Stable in special population: | Unstable; needs special placement:

ACTION TAKEN (Check All That Apply)

**Clinician Instructions: MH codes are based on current evaluation.

MH Code	MH-0		MH-1		MH-2A	X	MH-2B	
Special Class	DD/Cognitive Impairment		Other					
MHU Monitoring	None (per staff or patient request)		High (< or equal to 2 weeks)	X				

Refer to Medical for psychotropic medication consideration/medical review:

Other: (List):

TREATMENT PLAN/FOLLOW-UP

Improve mood, healthy coping skill and relaxation techniques

This contact, the following were discussed:

Psycho-Education: X | Coping Skills: X | Safety for self and others:

Referral: Medical [ ] QMHP [ ] Referral Reason: Due Date:

Prepared By:
Judy Lassiter QMHP 12/20/2022 1:15:12 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 1/25/2023 8:24:16 AM

PLACEMENT / REVIEW OF PATIENT IN OBSERVATION

TO BE COMPLETED BY QUALIFIED MENTAL HEALTH PROFESSIONAL,
A PHYSICIAN, OR MEDICAL STAFF (NURSING) IN CONSULTATION WITH
MENTAL HEALTH PROFESSIONAL /PHYSICIAN
USE FOR INITIAL PLACEMENTS OR REVIEWS

CONFIDENTIAL

Patient Name: [redacted]

ID Number	Facility	Date
659544	Richland County SC	06/28/2023

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			

Other (e.g., security and/or medical consult):

REFERRAL SOURCE	STAFF MAKING PLACEMENT
Jail staff	**Jail staff**

TYPE OF REVIEW

Initial placement	X
Follow-up Review	

REASON FOR PATIENT IN OBSERVATION STATUS

Dangerous to Self		May have a Medical Problems that requires separation from population	X
Mentally Ill and Dangerous to Self	X	Has a Medical Problem that requires separation from population	
		Refusing testing for communicable disease	

PATIENT BEHAVIOR / MEDICAL CONDITION THAT RESULTED IN PLACEMENT

Patient endorsed suicidal thoughts and was placed on suicide watch in X-ray Dorm.

CURRENT EVALUATION OF PATIENT / MENTAL STATUS

Patient stated that she has been agitated because she was placed on suicide watch as she denies wanting to harm herself. She reported that she was on the phone talking to her mother and said that she wanted to die because mother refused to pay bond. Patient stated that security heard her tell her mother that she wanted to die but she was being manipulative to get out of jail. Patient denies suicidal/homicidal ideations with no intent or plan.

DECISION

Place in Observation	X
Continue Observation	
Release from Observation	

Date / Time of Release: 12:00 AM

FOR MENTAL HEALTH PLACEMENTS - LEVEL OF OBSERVATION

Constant (1:1 Observation):	
Close (15 Minute Checks):	X
Intermediate (30 Minute Checks):	
None:	
Other:	

Suicide Attire (smock/blanket)

Patient will remain on suicide watch in X-ray Dorm.

Referral: Medical ☐ QMHP ☐ Referral Reason _____ Due Date _____

Prepared By:
Judy Lassiter QMHP 6/28/2023 1:55:28 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 6/29/2023 8:27:10 AM

PLACEMENT / REVIEW OF PATIENT IN OBSERVATION

TO BE COMPLETED BY QUALIFIED MENTAL HEALTH PROFESSIONAL, A PHYSICIAN, OR MEDICAL STAFF (NURSING) IN CONSULTATION WITH MENTAL HEALTH PROFESSIONAL /PHYSICIAN

USE FOR INITIAL PLACEMENTS OR REVIEWS

CONFIDENTIAL

Patient Name: [redacted]

ID Number	Facility	Date
659544	Richland County SC	06/29/2023

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			

Other (e.g., security and/or medical consult):

REFERRAL SOURCE	STAFF MAKING PLACEMENT
Jail staff	**Jail Staff**

TYPE OF REVIEW

Initial placement	
Follow-up Review	X

REASON FOR PATIENT IN OBSERVATION STATUS

Dangerous to Self		May have a Medical Problems that requires separation from population	X
Mentally Ill and Dangerous to Self	X	Has a Medical Problem that requires separation from population	
		Refusing testing for communicable disease	

PATIENT BEHAVIOR / MEDICAL CONDITION THAT RESULTED IN PLACEMENT

Patient endorsed suicidal thoughts and was placed on suicide watch in X-ray Dorm.

CURRENT EVALUATION OF PATIENT / MENTAL STATUS

During the observation, patient was alert and calm. She stated that she has no thoughts to harm self or others at this time. She stated that she is ready to be remove from suicide watch and wants to take a shower. QMHP educated patient on ways to in corporate healthy coping strategies to improve mood. Patient was receptive to this information. Patient denies suicidal/homicidal ideations with no intent or plan. Per Mental Health, patient has been discharged from suicide watch and placed on medical transit in X-ray Dorm.

DECISION

Place in Observation	
Continue Observation	
Release from Observation	X

Date / Time of Release: 06/29/2023 10:30 AM

FOR MENTAL HEALTH PLACEMENTS - LEVEL OF OBSERVATION

Constant (1:1 Observation):	
Close (15 Minute Checks):	
Intermediate (30 Minute Checks):	X
None:	
Other:	

Suicide Attire (smock/blanket) Since patient has been discharged from suicide watch, she can be dressed in regular issues uniform.

At this time, patient does not appear to be in any imminent danger of harm to self or others. Per Mental Health, patient has been discharged from suicide watch and placed on medical transit in X-ray Dorm.

Referral: Medical [ ] QMHP [ ] Referral Reason _____ Due Date _____

Prepared By:
Judy Lassiter QMHP 6/29/2023 11:07:48 AM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 6/30/2023 8:19:09 AM

MENTAL HEALTH SERVICES CLINICAL CONTACT

Patient Name [redacted]

ID Number	Facility	Date
659544	Richland County SC	06/30/2023

SOURCES OF INFORMATION

Clinical Interview	X	MHU Record	
Community Records		Medical Chart	
Psychological Testing			
Other (e.g., security and/or medical consult):			

Visit Type

New	Follow-Up
	X

Referral from

Medical	Jail	Patient	Other
		X	

Reason for Contact/Referral Source

Patient was seen for a twenty-four hour Post Suicide Watch Follow-up to assess mental status, behaviors and adaptive coping skills.

RELEVANT HISTORY/ PATIENT'S REPORT

Patient verbalized that her mood has been good and she has been calm. She denies suicidal/homicidal ideations. Patient stated that she was not suicidal and pleased to be off suicide watch. QMHP educated patient regarding angry management and healthy coping skills.

MENTAL STATUS (Check All That Apply)

Consciousness/Orientation:		alert	X	fully oriented		-person		-place		-time		-situation
Appearance:	X	normal		poor hygiene		disheveled		inappropriate		Other:		
Motor Activity:	X	normal		agitated		slowed		repetitive		Other:		
Speech:	X	normal		slowed		pressured		mute		Other:		
Affect:	X	appropriate		labile		restricted		blunted		Other:		
Mood:	X	euthymic		dysphoric		elevated		depressed		Other:		
Memory:	X	normal		immediate impaired		recent impaired		remote impaired		Other:		
Judgment/Insight:	X	intact		impaired insight		denial of disorder		external locus		Other:		
Attention/Concentration:	X	good		inattentive		confused		vigilant		Other:		
Thought Form:	X	linear/goal directed		circumstantial		tangential		loosening		Other:		
Thought Content:	X	no abnormalities		poverty of thought		delusion (clarify):				Other:		
Perception:	X	no abnormalities		disassociation		hallucinations				Other:		
Suicidal Ideation:	X	none		passive		active (clarify):						
Reliability:	X	appears reliable		reason to fake bad		reason to fake good						

Other:

DIAGNOSES (Provisional?) Yes [ ] No [X]

Diagnosis: Adjustment Disorder

Psychosocial/Contextual Factors: incarceration

Disability/Functional Impairment*: 60

*Correctional Global Assessment of Functioning

STATUS (Housing)

Can remain in general population	Stable in special population	Unstable; needs special placement
	X	

ACTION TAKEN (Check All That Apply)

**Clinician Instructions: MH codes are based on current evaluation.

MH Code	MH-0		MH-1		MH-2A	X	MH-2B	
Special Class	DD/Cognitive Impairment		Other					
MHU Monitoring	None (per staff or patient request)		High (< or equal to 2 weeks)	X				
Refer to Medical for psychotropic medication consideration/medical review								
Other: (List)								

TREATMENT PLAN/FOLLOW-UP

Improve mood, anger management and healthy coping skills

This contact, the following were discussed:

Psycho-Education	Coping Skills	Safety for self and others
X	X	

Referral: Medical [ ] QMHP [ ] Referral Reason: Due Date:

Prepared By:
Judy Lassiter QMHP 6/30/2023 12:31:03 PM

Reviewed/Electronically Signed By:
Heinz-Peter Schafer PH 6/30/2023 2:44:58 PM

EXHIBIT 20

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Suicide Attempt Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet C37

Staff Member Reporting Incident: Christopher Rhodes RN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** 659544 **Charge:**

2nd Inmate Involved: **Inmate #:** **Charge:**

I Christopher Rhodes RN was working in Intake when at 2234 on 3-2-2024 a Code Blue was called over the radio for unit Juliet. I immediatly left Intake and headed to unit Juliet. Myself and nurse Peat arrived on the unit together and ran upto cell 37. When we arrived at the cell the patient was hanging from the ceiling light from a sheet that had been tied around her neck. LT. Anderson, Sgt Taylor, and nurse Martin were already in the cell. I lifted the patient from the lower half while Nurse Peat stood upon the bed and lifted the patients upperhalf. Lt Anderson then cut the sheet, and we lowered the patient to her mattress, removed the sheet from around her neck. We then lowered the patient to the Floor and immediatly started CPR. I placed the AED pads on the patients chest and activated it. Myself along with Nurses....

Reporting Staff Member's Signature: Christopher Rhodes RN **Report Completion Date:** 3-3-2024

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes ✓ No **Use of Force Necessary:** Yes No

Supervisor's Narrative

Information -

Supervisor's Signature: [signature] Date: 3-3-24

Inmate Movement and Status Information

1st Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

2nd Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

Watch Commander's Review and Narrative

Watch Commander's Signature: [signature] Date: 3-3-24

Incident Report Distribution

Medical: ____ Maintenance: ____ Operations: ____ Classification: ____ Professional Standards: ____ RCSO: ____

Administration: ____ Hearing Officer: ____ Other Distribution: _____

Division Manager's Review and Narrative

Division Manager's Signature: _____ Date: _____

ALVIN S. GLENN DETENTION CENTER
INCIDENT REPORT SUPPLEMENT

Incident Category: Suicide Attempt Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet

Staff Member Reporting Incident: Christopher Rhodes RN

Supplement Narrative

Peat, Martin, Brunson, Roberts & T. Walker preformed CPR until EMS Arrived on the unit at 2306 and instructed me to stop compressions. EMS placed their EKG Leads on the patient and turned their monitor on. Within 10 seconds EMS declared her dead. According to Central Control EMS was called at 2242. I advised custody staff to place her two brothers that are in custody on suicide watch.

Reporting Staff Member's Signature: [signature] RN

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code Blue

Incident Time: 22:34 PM **Incident Date:** 03/02/24 **Incident Location:** Juvie

Staff Member Reporting Incident: L. Martin LPN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** _____ **Charge:** _____

2nd Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

Nurse entered into Juvie to conduct PM medication pass. When Nurse and Sgt. Mcclendon reached cell 37 inmate could be seen hanging from light fixture in ceiling with a sheet wrapped around her neck. Code Blue was called over radio by Sgt. Nurse instructed Sgt to open cell door. Sgt was unable to open door. Lt Anderson entered dorm and was instructed to move quickly in order to gain access into cell. Lt Anderson opened cell door. Nurse Brunson entered unit and arrived to cell door. Sgt Taylor and Nurse Peat Rhodes and Roberts enters unit. Medical and security enters cell and immediately lifts inmate body to reduce tension. Pt was laid down and CPR was initiated. AED was placed on patient and oxygen

Reporting Staff Member's Signature: L. Martin **Report Completion Date:** 3/2/24

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes _____ No _____ **Use of Force Necessary:** Yes _____ No _____

Supervisor's Narrative

Supervisor's Signature: _____ Date: 3-3-24

Inmate Movement and Status Information

1st Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

2nd Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

Watch Commander's Review and Narrative

Watch Commander's Signature: _____ Date: 3-3-24

Incident Report Distribution

Medical: _____ Maintenance: _____ Operations: _____ Classification: _____ Professional Standards: _____ RCSO: _____

Administration: _____ Hearing Officer: _____ Other Distribution: _____

Division Manager's Review and Narrative

Division Manager's Signature: _____ Date: _____

ALVIN S. GLENN DETENTION CENTER
INCIDENT REPORT SUPPLEMENT

Incident Category: Code Blue

Incident Time: 12:34 PM **Incident Date:** 03/02/24 **Incident Location:** Juliet

Staff Member Reporting Incident: L. Martin, LPN

Supplement Narrative

was found unresponsive. CPR was continued by medical staff and C. Walker. EMS arrived unit housing unit at approximately 23:04 pm EMS took over scene and stated "DOA" at 23:06 pm. CPR was ceased at this time.

Reporting Staff Member's Signature: L Martin

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code Blue

Incident Time: 2234 **Incident Date:** 3/2/2024 **Incident Location:** Juliet #37

Staff Member Reporting Incident: Iesha Brunson LPN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

2nd Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

On the above date, at the approximate time, a code blue was called in Unit Juliet. This nurse observed Lt. Anderson Sgt Mclendon and nurse martin at cell #37 I approached the cell with nurse martin I observed patient with sheet around her neck attached to above light fixture, hanging. Lt. Anderson gained access to cell. Medical Staff raised patient to ~~relieve~~ lift relieve tension. Patient was cut down and CPR initiated. AED applied. CPR continues performed by medical staff and i/c Walker. EMS arrived and took control of life saving measures. EMS stated "DOA" at 2356. CPR ceased

Reporting Staff Member's Signature: I. Brunson **Report Completion Date:** 3/2/2024

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes _____ No _____ **Use of Force Necessary:** Yes _____ No _____

Supervisor's Narrative

Information

Supervisor's Signature: [signature] Date: 3-3-24

Inmate Movement and Status Information

1st Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

2nd Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

Watch Commander's Review and Narrative

Watch Commander's Signature: [signature] Date: 3-3-24

Incident Report Distribution

Medical: _____ Maintenance: _____ Operations: _____ Classification: _____ Professional Standards: _____ RCSO: _____

Administration: _____ Hearing Officer: _____ Other Distribution: _____

Division Manager's Review and Narrative

Division Manager's Signature: _____ Date: _____

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet 37 #

Staff Member Reporting Incident: Tanasia Peat

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** 689544 **Charge:**

2nd Inmate Involved: _____ **Inmate #:** _____ **Charge:**

I Nurse Peat was working in medical when I heard a code blue called over the radio. I immediately went to respond. I arrived on the unit with Nurse Rhodes. we both ran up to cell 37. We found Pt hanging from light fixure. Pt had sheet tightly tied around her neck and light frame. Nurse Peat and Rhodes lifted Pt up to stop further asfixation Lt Anderson, Sgt taylor, and nurse Martin All in cell. Security then Cut sheet from light fixure. Pt lower to bed, then to Floor. CPR was immediatly started by medical. AED Placed CPR continued, while life saving measures were placed. EMS Called at 2242 by central control. Nurse Martin, Brunson, Barrett, Rhodes, Peat, and Sgt walker all preformed CPR until ems came @ 2306 and told us to end CPR they then place Ekg leads, within 10 second they stated "DOA" time of Death:

Reporting Staff Member's Signature: Tanasia Peat **Report Completion Date:** 3/3/2024

Other Staff Members Involved

_____

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes ✓ No _____ **Use of Force Necessary:** Yes _____ No ✓

Supervisor's Narrative

Information

Supervisor's Signature: _____ Date: 5-3-24

Inmate Movement and Status Information

1st Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

2nd Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

Watch Commander's Review and Narrative

Watch Commander's Signature: _____ Date: 5-3-24

Incident Report Distribution

Medical: _____ Maintenance: _____ Operations: _____ Classification: _____ Professional Standards: _____ RCSO: _____

Administration: _____ Hearing Officer: _____ Other Distribution: _____

Division Manager's Review and Narrative

Division Manager's Signature: _____ Date: _____

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Suicide Attempt Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet C37

Staff Member Reporting Incident: Christopher Rhodes RN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** 659544 **Charge:**

2nd Inmate Involved: **Inmate #:** **Charge:**

I Christopher Rhodes RN was working in Intake when at 2234 on 3-2-2024 a Code Blue was called over the radio for unit Juliet. I immediatly left Intake and headed to unit Juliet. Myself and nurse Peat arrived on the unit together and ran upto cell 37. When we arrived at the cell the patient was hanging from the ceiling light from a sheet that had been tied around her neck. LT. Anderson, Sgt Taylor, and nurse Martin were already in the cell. I lifted the patient from the lower half while Nurse Peat stood upon the bed and lifted the patients upperhalf. Lt Anderson then cut the sheet, and we lowered the patient to her mattress, removed the sheet from around her neck. We then lowered the patient to the Floor and immediatly initated CPR. I placed the AED pads on the patients chest and activated it. Myself along with Nurses.....

Reporting Staff Member's Signature: Christopher Rhodes RN **Report Completion Date:** 3-3-2024

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes ✓ No _____ **Use of Force Necessary:** Yes _____ No _____

ALVIN S. GLENN DETENTION CENTER
INCIDENT REPORT SUPPLEMENT

Incident Category: Suicide Attempt Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet

Staff Member Reporting Incident: Christopher Rhodes RN

Supplement Narrative

Peat, Martin, Brunson, Roberts & CRT. Walker preformed CPR until EMS Arrived on the unit at 2306 and instructed me to stop compressions. EMS placed their EKG Leads on the patient and turned their monitor on. Within 10 seconds EMS declared her dead. According to Central Control EMS was called at 2242. I advised custody staff to place her two brothers that are in custody on suicide watch.

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code Blue

Incident Time: 22:34 PM **Incident Date:** 03/02/24 **Incident Location:** Juliet

Staff Member Reporting Incident: L. Martin, LPN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** _____ **Charge:** _____

2nd Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

Nurse entered into Juliet to conduct PM medication pass. When nurse and sgt. McClendon reached cell 37 inmate could be seen hanging from light fixture in ceiling with a sheet wrapped around her neck. Code Blue was called over radio by sgt. Nurse instructed sgt. to open cell door. Sgt was unable to open door. Lt Anderson entered dorm and was instructed to move quickly in order to gain access into cell. Lt Anderson opened cell door. Nurse Brunson entered unit and arrived to cell door. Sgt Taylor and nurse Pratt, Rhodes, and Roberts enters unit. Medical and security enters cell and immediately lifts inmate's body to reduce tension. Pt was wt down and CPR was initiated. AED was placed on patient and oxygen

Reporting Staff Member's Signature: L. Martin **Report Completion Date:** 3/2/24

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes _____ No _____ **Use of Force Necessary:** Yes _____ No _____

ALVIN S. GLENN DETENTION CENTER
INCIDENT REPORT SUPPLEMENT

Incident Category: code BLUE

Incident Time: 22:34 PM **Incident Date:** 03/02/24 **Incident Location:** JULIET

Staff Member Reporting Incident: L. MARTIN, LPN

Supplement Narrative

was administered. CPR was continued by medical staff and Lt. Walker. EMS arrived onto housing unit at approximately 23:05 PM EMS took over scene and stated "DOA" at 23:06 PM. CPR was ceased at this time.

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code blue

Incident Time: 2234 **Incident Date:** 3/2/2024 **Incident Location:** Juliet #37

Staff Member Reporting Incident: Iesha Brunson LPN

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

2nd Inmate Involved: _____ **Inmate #:** _____ **Charge:** _____

On the above date, at the approximate time, a code blue was called in Unit Juliet. This nurse observed Lt. Anderson, Sgt Mclendon and nurse martin at cell #37. I approached the cell with nurse martin. I observed patient with sheet around her neck, attached to above light fixture, hanging. Lt. Anderson gained access to cell. Medical Staff raised patient to ~~relieve~~ lift relieve tension. Patient was cut down and CPR initiated. AED applied. CPR continues, performed by medical staff and Lt. Walker. EMS arrived and took control of life saving measures. EMS stated "DOA" at 2306. CPR ceased.

Reporting Staff Member's Signature: I. Brunson **Report Completion Date:** 3/2/2024

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes _____ No _____ **Use of Force Necessary:** Yes _____ No _____

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: Code Blue

Incident Time: 2234 **Incident Date:** 3-2-2024 **Incident Location:** Juliet 37 #

Staff Member Reporting Incident: Tanasia Peat

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** 659544 **Charge:**

2nd Inmate Involved: **Inmate #:** **Charge:**

I Nurse Peat was working in medical when I heard a code blue called over the radio. I immediately went (to) to respond. I arrived on the unit with Nurse Rhodes. we both ran up to cell 37. We found Pt hanging from light fixure. Pt had sheet tightly tied around her Neck and light frame. Nurse Peat and Rhodes lifted Pt up to stop further strixation Lt Anderson, Sgt taylor, and nurse Martin All in cell. Security then Cut sheet from light fixure. Pt lower to bed, then to Floor. CPR was immediatly started by medical. AED Placed CPR continued, while life saving measures were placed. EMS called at 2242 by central control. Nurse Martin, Brunson, Robert, Rhodes, Peat, and Sgt walker all preformed CPR until ems came @ 2306 and told us to end CPR they then placed Ekg leads, within 10 second they stated "DOA" time of Death

Reporting Staff Member's Signature: Tanasia Peat **Report Completion Date:** 3/3/2024

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes ✓ No ____ **Use of Force Necessary:** Yes ____ No ✓

ALVIN S. GLENN DETENTION CENTER
RICHLAND COUNTY
INCIDENT REPORT

Incident Category: CODE BLUE

Incident Time: 10:34 **Incident Date:** 3/2/24 **Incident Location:** JULIET

Staff Member Reporting Incident: D. Roberts

Reporting Staff Member's Narrative and Inmates Involved

1st Inmate Involved: [redacted] **Inmate #:** 659542 **Charge:**

2nd Inmate Involved: **Inmate #:** **Charge:**

NURSE report to unit JULIET to find inmate with sheet around her neck hanging from the light fixture medical staff & LT Anderson Lift inmate up to prevent further affixation. Inmate was then cut down, placed on the floor CPR administered immediately Oxygen placed & AED Medical Staff & Officer LT Walker performed CPR until EMS Arrived on the unit and Retrived care of Inmate

Reporting Staff Member's Signature: **Report Completion Date:** 3-4-24

Other Staff Members Involved

Medical and/or Use of Force Narrative

Assessed by Medical Personnel: Yes ____ No ____ **Use of Force Necessary:** Yes ____ No ____

Supervisor's Narrative

Information.

Supervisor's Signature: [signature] Date: 3-4-24

Inmate Movement and Status Information

1st Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

2nd Inmate: _____ Inmate Number: _____ Moved to Unit: _____

Pre-Hearing: _____ Cool Down: _____ Suicide Watch: _____ Medical Watch: _____ Protective Custody: _____

Administrative: _____ Classification: _____ Other Movement Reason: _____

Property Inventoried By: _____ Inmate Moved By: _____

Watch Commander's Review and Narrative

Watch Commander's Signature: [signature] Date: 3-4-24

Incident Report Distribution

Medical: _____ Maintenance: _____ Operations: _____ Classification: _____ Professional Standards: _____ RCSO: _____

Administration: _____ Hearing Officer: _____ Other Distribution: _____

Division Manager's Review and Narrative

Division Manager's Signature: _____ Date: _____

EXHIBIT 21

Alvin S. Glenn Detention Center Investigation
Expert Report
Emmitt L. Sparkman
April 29, 2024

Table of Contents

I. Introduction

A. Contracted Assignment

I am contracted to serve as an expert in the field of corrections for the Plaintiffs in Disability Rights South Carolina v. Richland County. United States District Court for the District of South Carolina. Civil Action No. 8:22:cv-1358-MGL-JDA. My work included an extensive review of policies, procedures, practices, on-site touring, and interviews with Alvin S. Glenn Detention Center (ASGDC) staff and inmates. My expert report includes findings and observations and the basis for my opinions regarding ASGDC detention center operations, inmate safety risk and their protection from harm including those with serious mental illness. The majority of the ASGDC inmates are on the mental health caseload based on deposition testimony by the Advanced Correctional Healthcare (ACH) mental health site manager.[1]

Methodology

My methodology for the investigation was to review pertinent documents/materials, conduct interviews with ASGDC, conduct staff and incarcerated people interviews, and conduct an ASGDC on-site visit. My expert report findings, observations, and opinions are from the documents/materials provided by Plaintiffs' counsel, interviews with ASGDC staff and incarcerated people, and the on-site visit to ASGDC with my education, training, and experience in correctional system operations.

[1] ACH ASGDC Mental Health Site Manager Laurrinda Saxon-Ware January 2, 2024 Deposition Page 131 Lines 8-10.

B. Qualifications

I am an expert in corrections and a conditions of detention consultant. My educational background includes a Bachelor of Science in Criminology and Corrections from Sam Houston State University and a Master of Science in Criminal Justice from Eastern Kentucky University. My adult and juvenile corrections' career spans over 48 years working in correctional facilities and community corrections. I served as the Deputy Commissioner of Institutions for the Mississippi Department of Corrections for over ten years where I was instrumental in implementing reforms to reduce the use of restrictive housing. I was a key figure in the development of capacity plans for the State of Mississippi that managed the growth in the overall inmate population without new prison construction. Other projects in which I have participated include the assessment of administrative segregation practices in the Colorado, Illinois, New Mexico, Maryland, Oklahoma, and the Federal correctional systems. I have extensive experience in providing expert reports and testimony for prison and jail related litigation. Most recently, I assisted in an assessment on restrictive housing unit use by the Sacramento County Jails, an evaluation of the Louisiana Department of Public Safety and Corrections' correctional treatment and rehabilitation programs, an assessment of Pulaski County, Little Rock, Arkansas Criminal Justice System and an assessment of the Jackson County, Missouri Jail. I currently serve as a subject matter expert for Monitors in the Nunez v. City of New York Consent Judgment involving the New York City Department of Corrections (Jails) and United States of America v. Territory of the Virgin Islands, et. al., Consent Judgement involving the Virgin Islands Bureau of Corrections. I

also participate in oversight of the South Carolina Department of Corrections implementation of settlement agreement reforms regarding mental health treatment for inmates.

C. Document Review

I reviewed a copious number of documents to compile my expert for the case. The documents are identified in Appendix I.

II. Alvin S. Glenn Detention Center

A. Executive Summary

ASGDC fails to adequately safeguard inmates from harm and mitigate unreasonable risks to inmates' safety. To protect inmates from harm and unreasonable risk of harm, ASGDC will be required to drastically change how it operates and implement revised strategies and operations.

The current state of the detention center reveals a myriad of critical deficiencies and non-compliance issues, posing severe risks to the safety and security of both inmates and staff. These issues span across various aspects of operation, from facility infrastructure to staff management and inmate welfare. The following deficiencies were identified through on-site inspection, interviews with inmates, review of documentation, review of inspection findings, and discussions with staff:

1. **Indirect-Direct Supervision**- ASGDC is designed and is required by the *Minimum Standards for Local Detention Facilities in South* Carolina to operate as a "Direct Supervision" Jail which is defined by the entity in Standard 1005 (w) definitions as

meaning, " management of inmates in which security personnel are not separated by a barrier that prohibits visual and audio interactions with the inmates. The detention center routinely and consistently operates as an "Indirect Supervision" facility that does not provide regular visual and audio interactions of inmates as required by the "Direct Supervision" Model.

2. **Policies and Procedures** - ASGDC's existing policies are written to comply with American Correctional Association (ACA) standards and *Minimum Standards for Local Detention Facilities in South* Carolina, however the policies lack specificity and do not contain all required elements. The deficient policies and procedures hinder the safe and secure operation of the detention center. See further discussion in Section II.G.1 herein.

3. **Staffing** - ASGDC lacks adequate staff to maintain a safe and orderly facility that protects inmates from harm. Interviewed inmates, South Carolina Department of Corrections' annual inspections, independent security audits, review of incident reports and investigations, etc. describe a violent facility with a complete lack of institutional control due to insufficient staffing. Based on media reports of staff arrests as well as inmate interviews, ASGDC also appears to have serious issues with staff corruption. See further discussion in Section II.G.3 herein.

4. **Overcrowding** - The inmate population consistently surpasses the rated and operational capacity, leading to compromised living conditions and increased risks of violence. See further discussion in Section II.G.4 herein.

5. **Security** - Unsafe conditions, deficient cell locks, and inadequate security measures contribute to violent assaults on both inmates and staff, posing a substantial threat to overall safety. Furthermore, ASGDC's sexual assault prevention policies and procedures are insufficient to protect inmates from sexual assault based on inmate interviews and review of incident reports. ASGDC's ability to manage and control inmates effectively is negatively impacted by the use of Indirect Supervision in a facility designed for Direct Supervision. Both the contraband control and search programs also consistently fail to prevent the introduction and possession of contraband. See further discussion in Section II.G.5 herein.

6. **Physical Plant and Environmental Health Deficiencies** – Housing Unit conditions observed during the on-site inspection are deplorable with housing units that fail to meet basic living standards. Housing unit deficiencies include inoperative toilets, sinks, and lights as well as ASGDC not providing sufficient toilets for the inmates in each housing unit. See further discussion in Section II.G.13 and Section 11.G.14 herein.

7. **Intake/Admission, Classification, Security Threat Groups (STG) and Restricted Housing Unit** – ASGDC fails to protect inmates from the moment they arrive at the facility. The inmate admission/intake process falls short of industry standards, resulting in unacceptable delays and extended confinement in inadequate conditions. Further, the current classification system fails to manage inmate risk effectively. See further discussion in Section II.G.6 herein. For those inmates housed in restricted housing unit due to their classification, the restricted housing unit fails

to provide industry-standard conditions for all inmates including seriously mentally ill inmates. See further discussion in Section II.G.8 herein. A formal security program to manage security threat groups (gangs) is also nonexistent, thus exposing inmates and staff to violence from these groups. See further discussion in Section II.G.9 herein.

8. **Use of Force, Grievances and Due Process** – Interviewed inmates and reviewed incident reports and other documents provide evidence that inmates are routinely subjected to unnecessary and excessive force, raising concerns about human rights violations. See further discussion in Section II.G.10 herein. Inmates are also inhibited from reporting use of force issues and other ASGDC issues as the existing grievance system does not provide an adequate mechanism for inmates to submit and address their complaints. ASGDC has initiated a new electronic grievance system, however it has not been fully implemented and staff and inmates have not been trained in its utilization. See further discussion in Section II.G.12 herein. The inmate disciplinary system lacks assurance that all inmates receive due process. See further discussion in Section II.G.11 herein. The combination of these issues results in ASGDC failing to protect the Constitutional rights of inmates in their custody.

Given the urgency and severity of the issues noted at ASGDC, immediate action and comprehensive reform are imperative to ensure the safety, security, and well-being of all individuals within ASGDC.

B. Description of Facility

The Alvin S. Glenn Detention Center is defined as a Type IV Facility by the Minimum

Standards for Local Detention Facilities In South Carolina. A "Type IV Facility" is a facility (combined County or Multi-Jurisdictional Jail/Prison Camp) which houses persons awaiting court action, civil contempt, and inmates sentenced to three (3) months or less, and which may also house inmates with longer sentences under a designated facilities agreement with the Department of Corrections.[2] The mission statement of the ASGDC is to provide for the incarceration of adult and juvenile offenders in a fashion that provides for the protection of the public safety, the protection of the institutional safety, and the delivery of a constitutional level of services to those incarcerated. The Richland County Detention Center serves as the intake center for un-sentenced misdemeanors as well as a facility designated for the incarceration of sentenced offenders (felony detainees/inmates). It provides facilities for the detention of both un-sentenced detainees/inmates and sentenced inmates in a minimum, medium, and maximum security environment. The current detention facility was built in five (5) phases. The majority of support locations, including intake, Juvenile, Kitchen, etc., were built in the first two phases, Phase 1 in 1994 and Phase 2 in 1995. Phases 3 (1997), 4 (1997), and 5 (2005) were comprised of the construction of housing, electrical support, and machinery rooms. In 2013, ASGDC received national accreditation by the ACA following a review of its detention center operations. The ASGDC is no longer accredited by the ACA Commission on Accreditation.

The detention center, located off Bluff Road in Lower Richland, reportedly houses a daily

[2] Minimum Standards for Local Detention Facilities In South Carolina.

average of 800 detainees, consisting of people arrested in the unincorporated areas and the municipalities in Richland County. The ASGDC population on January 24, 2024 was 948 inmates.[3] In addition to over 1,100 beds for adults, the facility also has 24 beds for juveniles. Richland County provides the following but not limited background information regarding the detention center background:

> "The detention center will have sufficient security to prevent escapes by foreseeable means;
>
> Security will be maintained by assignment of detainees/inmates to minimum, medium, or maximum security based upon the application of a thorough and rational classification and assignment system;
>
> Safety The protection of the public, staff, detainees/inmates in their person and property will be the highest priority when operating the ASGDC;
>
> Services The ASGDC will strive, as a goal, to ensure those confined are no worse off upon release than prior to incarceration;
>
> The achievement of this goal is to be promoted by staff through the humane and dignified treatment of detainees/inmates, along with adequate space, privacy

[3] ASGDC January 24, 2024 Dormitory Head Count.

and personal necessities, provisions for adequate exercise, visitation and access to services of outside agencies;

The facility is to provide programs and services to promote self-development and religious worship. In order to aid with future management of the ASGDC;

Provisions will be made for routine collection of data pertaining to persons served by the facility. The data includes, but is not limited to, type of offense, sentencing status, length of stay in the detention center, and effectiveness of detainee and inmate programs. The information collected will be evaluated by the administration on a regular basis and utilized to improve operational standards whenever necessary."[4]

The most recent South Carolina Department of Corrections ASGDC inspection conducted on November 30, 2023 revealed the following staffing information:

Table 1

	Positions	Filled	Vacant
Security/Custodial Staff	162	88	74
Administrative Staff	78	70	8
Total	240	158	82

The ASGDC security/custodial vacancy rate is 46 percent (74/162). The administrative vacancy rate is 11 percent (8/78) giving ASGDC a total staffing vacancy rate of 34

[4] DetentionCenterJD.pdf (richlandcountysc.gov)

percent.

C. Plaintiff Expert Inspection Tour and Observations

The Plaintiff Experts: Dr. Ken Ray, Dr. Nicole Johnson and I conducted an inspection of the ASGDC January 22 through 25, 2024. The following activities were accomplished during the inspection:

- Detention Center Tour
- Document Inspection
- Inmate Interviews
- Staff Conversations

The ASGDC staff and their attorneys provided requested assistance during the January 22-25, 2024 inspection. The assistance and cooperation were beneficial in conducting the inspection.

1. Tour

The majority of the detention center inside physical plant was visited during the ASGDC site inspection to include:

- Lobby/Security Checkpoint
- Administration Areas
- Corridors
- Main Control
- Intake/Booking/Sally Port
- Healthcare Department

- Food Service
- Charlie Housing Unit Interview Area
- Housing Units:
- Phase I-Alpha, Echo and Foxtrot
- Phase III-Golf, Hotel and India
- Phase V-Kilo, Lima, and Uniform
- Special Housing-BMU, Bravo, Mike, and Juliet
- Females-Delta and X Ray
- Closed-Yankee and Papa
- Charlie-Housing Unit used as a multi-purpose area for inmate individual and group interviews.

2. Document Inspection

I inspected and requested multiple documents during the site inspection. Examples of documents inspected and requested were:

- Booking
- Classification
- Logbooks
- Staff Rosters
- Inmates Rosters

3. Staff Conversation

I held brief conversations during January 22-25, 2024 inspection with the below ASGDC staff members and their attorneys to include but not limited to:

- Private Attorneys

- Director
- Assistant Director
- Chief of Security
- Compliance Director
- Lieutenant for Investigations/Accreditation
- Intake Captain
- Intake Detention Officers
- Shift Supervisor
- Housing Unit Officers
- Main Control Officers
- Allied Main Entry Security Officers

4. Inspection Observations

The following general observations are described or identified from the January 22-24, 2024 ASGDC inspection:

A. Visitor screening process - The ASGDC screens persons entering the detention center: checking identification, and logging persons in. The security screening requires persons to produce all items entering the detention center for inspection including any items in their pockets. Persons are searched with a full body scan before and must clear before entering the detention center. ASGDC Private Security (Allied) staff man the Lobby Area Security Post.

The screening is inadequate to prevent persons from introducing contraband in the facility. [redacted] All inmate visits with their approved general visitors are by

video; therefore, general visits are not a means to introduce contraband for inmates.

B. Food Service - Trinty is the food service provider for ASGDC. Food is plated in Styrofoam trays in the food service department. It is concerning by the time food service reaches the housing unit for the inmates, the food temperature does not meet health department regulation. Multiple inmates complained in interviews about the quantity and quality of food as well as receiving religious and medical diets. Inmate interviews also appeared to indicate a deficiency with food security due to lack of supervision with inmates selling or having their food trays stolen. [redacted]

C. Healthcare Unit-The healthcare unit was briefly toured during the January 22-25, 2024 inspection. The area consists of offices, examination and storage rooms. No inmates are housed in the healthcare area. The November 30, 2023 South Carolina Department of Corrections Inspection identified two (2) isolation cells in the medical area have been converted to storage and need to be returned to use as medical isolation.

D. Intake/Admission - Intake has a total of twelve holding cells. ASGDC does not have an established capacity for any of the holding cells. Inmates routinely and consistently remain in Intake for days awaiting classification. As noted in Table 2 below, there were 47 inmates in Intake as of January 24, 2024. The inmates most

affected are inmates with special medical, mental health, classification or security needs. Inmates are crammed in cells with no classification screening exposing them to harm. Inmates were sleeping on mattresses directly on the floor in violation of the Minimum Standards for Local Detention Facilities Standard 1005 (am).

ASGDC has an electronic inmate management system (Jail Management System), but the system is not utilized in placing inmates in holding cells or by a bed/cell. The inmate management system is only used to designate a housing unit. The Intake Captain acknowledged the area has become a de facto housing unit and the ASGDC Reception and Orientation 2A-19 policies and procedures are not being followed.

E. Control Center-The ASGDC Control Center was toured during the inspection and brief conversations were held with the two (2) officers assigned on the day shift. The control center has the capability to assume control of all electronic doors in the facility and activates/deactivates the electronic detention officer rounds conducted by detention staff in the housing units. The ASGDC video surveillance system is monitored from Central Control. There are one hundred twenty six (126) cameras to monitor and fourteen (14) were reported inoperable when the Control Center was inspected on January 24, 2024. Control Center staff advised cameras operability is inspected three (3) times each shift and a work order is generated for inoperable cameras. All housing unit cameras were reported as operable.

F. Housing Units - ASGDC secure areas and housing units where inmates were confined had serious sanitation and maintenance deficiencies and the inmate population exceeds the rated capacity in multiple housing units.

There are multiple inmates that languish in their cells without access to water for drinking, operable sinks and toilets for body functions and hygiene. Also see toilet inspection findings in Section 5 below. Staff are absent for hours, at times for an entire shift, confining inmates in cells without a sink and/or a toilet thus requiring inmates to exit to obtain access to drinking water, toilet for body functions, sink for hygiene and lights to complete daily tasks.

Many cells do not have a service port which prevents other inmates out of their cells from delivering water and food to these inmates. The inmates are literally at the mercy of a staff member making an appearance in the housing unit to obtain water to survive. Allowing these conditions in any living and working environment is unacceptable and unconscionable.

Observations by Housing Unit[5]:

(1) Phase I-One officer was responsible for monitoring all 5 housing units in Phase I according to ASGDC on January 22, 2024[6].

(a) Alpha (male)-Capacity 56 and Population 81. An open dormitory with lower and upper tiers. Interlock sallyport for entry and exit of the

[5] All housing units were occupied at the date of observation unless otherwise noted.
[6] Capacity for each housing unit provided by ASGDC.

housing unit. There are an insufficient number of tables (9) for all the inmates to receive and consume their meals when they are delivered to the housing unit. Each of the nine (9) tables will only allow four (4) inmates to sit at a table comfortably. The exact number of chairs inside the housing unit was not determined although there did not appear to be a chair for each inmate.

The housing unit has a walled recreation yard joining the housing unit. The roof is enclosed with cyclone fencing providing a view to the sky. Inmate beds were rusted and floors had water puddled on the floor in places. The housing unit exceeds the rated capacity of fifty-six (56) resulting in twenty five (25) inmates sleeping on portable beds on the floor.

(b) Bravo (male)-Capacity 56 and Population 39. An open dormitory with lower and upper tiers. Interlock sallyport for entry and exit of the housing unit. There are an insufficient number of tables (7) for all the inmates to receive and consume their meals when they are delivered to the housing unit. Each of the seven (7) tables will only allow four (4) inmates to sit at a table comfortably. The exact number of chairs inside the housing unit was not determined although there did not appear to be a chair for each inmate.

The housing unit has a walled recreation yard joining the housing unit. The roof is enclosed with cyclone fencing providing a view to the sky.

Bravo is designated for male inmates with medical needs. The upper tier of the housing unit is not utilized. The actual capacity of Bravo is 28 inmates as the upper tier beds are offline. The housing unit had a population of thirty nine (39) inmates resulting in eleven (11) inmates sleeping in portable beds on the floor. Bravo is the only general population housing unit designated for inmates that require American Disabilities Act accommodations.

(c) Delta (female)-Capacity 56 and population 28. The housing unit is an open dormitory with lower and upper tiers. There is an interlock sallyport for the housing unit's primary entry and exit. The housing unit was not toured during the January 22-25, 2024 inspection.

(d) Echo (male)-Capacity 56 and Population 60. The housing unit is an open dormitory with lower and upper tiers. There is an interlock sallyport for the housing unit's primary entry and exit. Inmates complained showers only had cold water. The housing unit has a walled recreation yard joining the housing unit. The roof is enclosed with cyclone fencing providing a view to the sky.

(e) Foxtrot (male)-Capacity 56 and Population 76. The housing unit is an open dormitory with lower and upper tiers. There is an interlock sallyport for the housing primary entry and exit. The housing unit has a walled recreation yard joining the housing unit. The roof is enclosed with cyclone fencing providing a view to the sky.

(2) Phase III

(a) Golf (male)- 56 Capacity Population 44. The housing unit has cells on lower and upper tiers that can be double bunked using portable beds placed on the floor. The housing unit has a rated capacity of fifty-six (56) inmates with one inmate per cell. The ASGDC Classification provided documentation high, medium and maximum custody inmates are housed in Golf.[7] The housing unit has a large hole in the drop ceiling. The janitor closet light is non-operational and the mop sink is leaking water.

A breach of security is inmates are allowed to freely move in and out of cells they are not assigned and enter the cells of other inmates. Failure to control cell to cell movement provides an opportunity for incidents to occur inside cells out of view of the officer and the opportunity for inmates to compromise door locks. Inmates began flooding cells on the top tier during the January 24, 2024 tour resulting in lower tier cells also flooding from the upper tier water. Only a small number of cells were inspected during the housing unit tour on January 24, 2024.

(b) Hotel (male)-56 Capacity Population 50. The housing unit has cells on lower and upper tiers that can be double bunked using portable beds placed on the floor. The housing unit has a rated capacity of fifty-six

[7] ASGDC Classification Diagram provided during the January 22-25, 2024 ASGDC Inspection.

(56) inmates with one inmate per cell. The ASGDC Classification provided documentation maximum custody inmates are housed in Hotel.[8] Cell H9 was vacant and had water standing in the floor. Cell H38 had a damaged light and in H43 the floor was covered with water. The cells have porcelain sinks and toilets. The housing unit janitor closet light internal parts were missing. Cells were observed with obstructed windows. Only a small number of cells were inspected during the housing unit tour on January 24, 2024.

(c) India (male)-56 Capacity Population 59. The housing unit has cells on lower and upper tiers with some double bunked using portable beds placed on the floor. The housing unit has a rated capacity of fifty-six (56) inmates with one inmate per cell. The ASGDC Classification provided documentation maximum custody inmates are housed in India.[9] Cell I7 did not have a sink, toilet or light. The janitor closet light was inoperable and the sink drain was clogged. The storage room fire extinguisher was last inspected in August 2023. Several cells did not have lights and smoke was smelled in the housing unit. Only a small number of cells were inspected during the housing unit tour on January 24, 2024.

[8] ASGDC Classification Diagram provided during the January 22-25, 2024 ASGDC Inspection.
[9] Ibid.

(3) Phase V

(a) Juliet (male)-56 Capacity Population 62. The housing unit has cells on lower and upper tiers that are double bunked and can have three (3) using portable beds placed on the floor. Inmates housed in Juliet require authorization from security, medical and mental health.[10] The fire alarm went off during the tour on January 24, 2024 and the assigned officer did not make rounds to determine if there was an actual fire. Cell J15 did not have a toilet. Janitorial equipment was observed uncontrolled in the housing unit. Only a small number of cells were inspected during the housing unit tour on January 24, 2024.

(b) Uniform (male)- Capacity 56 and Population 81. ASGDC Classification provided documentation medium custody inmates are housed in Uniform. Cells are located on lower and upper tiers on both sides of the housing unit with the officer station in the middle of a common area. Inmates were observed sleeping on double bunks and temporary beds on the floor in the common area in front of the cell. Detention staff appeared to allow inmates to place obstructions that prevented viewing the bottom beds. Clothes lines were observed in the housing unit.

[10] Ibid.

(4) Special Housing

(a) BMU (male)-56 Capacity Population 65. BMU is the ASGDC designated Special Housing Unit. The housing unit design has a secure control center for Indirect Supervision. ASGDC is not approved to operate as an Indirect Supervision Jail by the South Carolina Department of Corrections. The BMU was renovated and just became operational again in December 2023.

An inmate activated a sprinkler system in cell during the January 24, 2024 tour. Detention staff had no urgency in turning the sprinkler system off, resulting in the housing unit flooding and upsetting all the other inmates. The inmate that activated the sprinkler system in his cell was not immediately removed from his cell. The ASGDC Director erroneously advised the sprinkler system would automatically shut off in a couple of minutes.

(b) Mike (male)-56 Capacity Population 62. Mike is designated by ASGDC to house inmates with severe mental health issues. It was reported by ASGDC that the cell doors on the housing unit cannot be locked manually and are operated electronically. Cells are located on lower and upper tiers on both sides of the housing unit with the officer station in the middle of a common area. Inmates were observed sleeping on double bunks and temporary beds on the floor in the common area in front of cells.

An inmate was on suicide watch in a cell. He was not under direct observation by staff, providing other inmates the opportunity to pass him items he could utilize to harm himself. Exposed electrical wires were observed in the housing unit placing both inmates and staff at risk of harm.

(c) X Ray (female)- 56 Capacity Population 43. X Ray is designated by ASGDC to house female inmates with severe mental illness, disciplinary issues, and higher custody. The housing unit physical plant needs major renovations with the majority of the cell lights missing and/or inoperable. Females are housed in cells without operable sinks and toilets.

(5) Closed Housing Units

(a) The Yankee housing unit is under renovation and is scheduled to become operational in approximately 2-3 weeks (February 2024) with a capacity of 56 inmates. The renovated housing unit will have the same design as the BMU and will be utilized as a Special Housing Unit Stepdown. As with BMU, the Yankee Housing Unit design has a secure control center for Indirect Supervision and ASGDC is not approved to operate as an Indirect Supervision Jail by the South Carolina Department of Corrections.

(b) Papa-The housing unit is closed and not in operation.

Table 2 below shows the population of each housing unit as of January 24, 2024, and Table 13 herein includes the rated capacity, actual capacity, operational capacity and actual population by housing unit. Note there are minor differences in actual population in narrative descriptions of housing units above and Tables 2 and Table 13 due to headcounts being performed on different dates (narrative – January 22, 2024, Tables 2 and 13 – January 24, 2024).

Table 2

Housing Unit	Population January 24, 2024[11]	Rated Capacity
Alpha	79	56
BMU	82	56
BRAVO	36	56
DELTA	28	56
ECHO	60	56
FOXTROT	73	56
GOLF	40	56
HOTEL	48	56
INDIA	57	56
INTAKE	42	N/A
JULIET	56	56
KILO	62	56
LIMA	67	56
MIKE	62	56
TRANSFER	37	N/A
UNIFORM	79	56
X-RAY	40	56
Grand Total	**948**	**840**

[11] ASGDC January 24, 2024 Dormitory Head Count.

5. Toilet Inspection

A. Expert Toilet Inspection - I conducted an X-Ray and BMU Cell Sink, Toilet and Light Inspection on January 23, 2024 during the ASGDC January 22-25, 2024 inspection. The results are depicted in Table 3. The X-Ray housing unit had 12 of 56 (22%) toilets, 26 of 56 (46%) sinks and 54 of 56 (96%) lights inoperable. The recently renovated BMU reopened in January 2024 and did not have any inoperable toilets or lights. There were 2 of the 56 sinks that were inoperable. X-Ray had twenty cells unoccupied due to inoperable fixtures. The twenty (20) unoccupied cells due to inoperable cell fixtures reduce the unit operational capacity to twenty eight (28) inmates (80 percent of 36 cells).

Table 3

Location	Toilets		Urinals		Sinks		Lights	
	Working	Broken	Working	Broken	Working	Broken	Working	Broken
X Ray	44	12	N/A	N/A	30	26	2	54
BMU	53+	3	N/A	N/A	51+	2	53+	0

+ 3 of 56 cells the occupants refused to demonstrate if the sink, toilet and light was operational.[12]

Random cell inspections were conducted during the Golf, India, Juliet and Hotel with observations that included the following:

[12] Plaintiff Expert Xray and BMU Cells Sink, Toilet and Light Inspection.

Golf Housing Unit

- Cells G3 and G6 have to be designated as restroom due to occupied cells not having an operable toilet.
- Cell G25 on the upper tier was observed with an inoperable toilet and light.
- Multiple cells had inoperable lights.

Hotel Housing Unit

- H43 on the upper tier is designated as restroom due to the housing unit having occupied cells that have inoperable toilets. The toilet was overflowing and flooding the upper and lower tiers. It is unknown how inmates in cells without operable toilets had access to toilet facilities since the H43 cell designated as restroom cell for inmates with an inoperable toilet was overflowing.

Juliet Housing Unit

- Multiple cells had inoperable sinks, toilets and lights.

India Housing Unit

- Assigned Officer R advised cells can have one to three occupants.
- The drain outside India cell #10, in the common area was overflowing and flooding in the cell.

B. Richland County Toilet Inspection – A Richland County South Carolina toilet and urinal inspection was conducted in January 2024 with serious maintenance issues identified regarding operational toilets and urinals. The inspections revealed ASGDC operational housing units had 104 of 315 toilets or thirty three (33) percent that were inoperable and 14 of 18 urinals or seventy eight (78) percent that were inoperable. The reported ninety-eight (98) inoperable cell toilets reduce the ASGDC operational beds by 98 cells.

Table 4

Location	**Toilets**		**Urinals**	
	Working	**Broken**	**Working**	**Broken**
X Ray	33	23	na	Na
Kilo	7	0	na	Na
Lima	7	0	na	Na
Uniform	7	0	na	Na
Golf+	16	11	na	Na
India+	19	8	na	Na
Juliet+	28	27	na	Na
Hotel+	30	25	na	Na
Mike	52	4	na	Na
Alpha	3	1	0	4
Bravo	2	0	0	2
Delta	2	2	2	2
Echo	3	1	1	3
Foxtrot	2	2	1	3
Total	**211**	**104**	**4**	**14**

+ Golf, Hotel, India and Juliet each had one cell door in the housing unit that could not be opened to inspect if the toilet was operational.[13]

[13] Richland County Housing Unit Toilet Inspection January 2024 Bates Count 168623 to County 16632

6. Inmate Interviews

I conducted interviews with twenty-four male (21) and female (3) inmates during the January 22-25, 2024 ASGDC Inspections. The interviews were conducted in a private setting in the Charlie Closed Housing Unit. (See Section D Below).

D. Inmate Interviews

1. The majority of the inmates interviewed during January 22-25 inspection had a history of mental illness. The inmates voiced concerns for their safety and protection from harm due to the ASGDC operational deficiencies.

2. Lack of staff presence – During interviews, 15 of 24 inmates interviewed specifically cited a lack of adequate staffing. Seven (7) of the interviewed inmates described staff not being present in the housing units and inmates having to wave in front of the camera or call for help using the officer phone line.

In one concerning allegation, Incarcerated Person (IP) 078 claimed that the officer phone was removed from the Bravo housing unit because inmates used it to call for help. ASGDC did leave the phone base which allows calling to Main Control only.

Female IP 184 described an extremely dangerous situation, where there is no staff in the housing unit except once per shift during medicine pass. As such, the inmates are trapped in their cells without means of emergency assistance. According to IP 184, during the day inmates will use officer phone during out of cell times to call for assistance, but at night everyone is locked up and cannot summon assistance if needed.

3. Protection from harm – 22 of the 24 inmates interviewed described being the victim of an assault or multiple assaults while at ASGDC and the 2 remaining inmates that did not allege they were assaulted either admitted to assault or were accused of assault.

   One example of ASGDC's failure to protect inmates from harm is IP 081 who was reportedly the victim of an assault in November 2023. IP 081 was housed in Unit Kilo and "went on the door"[14] because of fearing for his safety after allegedly being threatened with knives. A sergeant refused to let IP 081 out of the housing unit because of the nature of IP 081's charges (Criminal Sexual), but later came back and put him in Papa (Specialized Management Unit). While in Papa Housing Unit for one week, IP 081 was moved to three different pods. In the 2nd pod, IP 081 was stabbed and stomped, and it took several hours and a call from his family to ASGDC before he was taken to medical. Upon his return, he was placed in a different pod designated as mental health and allegedly had to sleep on a mattress on a table. Another inmate, IP 812 alleges he warned officers and others that he was in danger prior to being severely assaulted in December 2022 by STG members. IP 812 was then assaulted and sustained a back fracture and head injury. He was filmed and posted online by inmates.

[14] "Inmates slang for requesting emergency removal from a housing unit due to fear of harm or other reasons is "on the door".

IP 214 claims he left Golf housing unit in January 2023 because he was almost stabbed by the whole housing unit and the officer present did nothing to prevent the attempted assault. IP 214 asserts there was no alarm activated for the incident and he notified his family that he'd almost been stabbed using the electronic tablet in his cell. IP 214 was interviewed by staff and transferred to another housing unit after his family called ASGDC. IP 214 was previously stabbed in November 2023, and he believes that stabbing was ordered by an ASGDC correctional officer.

4. Mental Health - Over half of the interviewed inmates described not receiving appropriate mental health care. IP 812 has a history of psychiatric treatment but is not on the mental health caseload and has been waiting on a mental health evaluation for seven months. IP 471 claims to have been placed on suicide watch by a nurse, but he never saw mental health while on suicide watch for 30 days. IP 471 stated that cell intercom was used by mental health to check on him once per week for 33 days.

5. Medical – Multiple interviewed inmates described slow or no responses to sick calls. For example, IP 596 stated he has made approximately six Sick Calls and it has taken over 2 weeks for a response or no response was received. IP 471 claimed that upon his release from the hospital from a stabbing he did not receive the ordered follow-up care upon his return to ASGDC.

6. Security -

   A. Counts and Rounds– ASGDC appears to lack sufficient staff to perform regular scheduled rounds based on inmate interviews. The majority of interviewed

inmates noted that counts are not regularly performed, and inmates are regularly outside their assigned placement. Interviewed inmates also described being prevented from sleeping in their assigned bed, sleeping on the floor, etc.

B. Door locks – IP 889 described that his cell door does not have to have a key to be opened. Anyone can place a finger in the lock mechanism and open it and IP 471 described that at the time of the November 2023 riot, his Housing Unit Papa Cell door lock was broken and could be opened by other inmates.

C. Searches – IP 081 claimed to have only seen one search in six months while IP 257 stated there have recently been more searches. IP 079 stated there was a major search in Bravo about a week before his interview, but it had been months since the last search before that.

D. Contraband - The majority of the interviewed inmates described rampant access to contraband including drugs , weapons, and cell phones. For example, IP 081 claimed marihuana, crack, methamphetamine and knives (free world) were available contraband. He also claimed that inmates go through the ceiling in the Echo Unit to get contraband outside and that a lot of drugs came in a package the day of his interview, but he doesn't know who transported or how the drugs were introduced into ASGDC.

Multiple inmates also alleged that staff were involved in smuggling contraband into the facility. For example, IP 552 admits to smuggling contraband and claims to have paid an officer $3000 for a cell phone, one pound of marihuana and 13

pounds of cigarettes. IP 552 also described that drones would drop contraband on the roof of the facility.

E. Physical assault - The majority of interviewed inmates alleged being the victim of assault, witnessing an assault or being threatened with assault by other inmates. The physical assaults described were often severe enough to require hospitalization outside ASGDC. IP 947 described being assaulted in October 2023 when inmates came in his cell and assaulted him with a pipe. Papa inmates gained access to the maintenance plumbing chase, started fires and the officer left the housing unit. IP 947 claims he wasn't seen by medical for his injuries and no reports were filed.

IP 471 was stabbed 11 times on January 3, 2024 and taken to hospital by ambulance.

7. PREA (Sexual Assault/Sexual Abuse) - Three of the interviewed inmates described PREA incidents. One of the interviewees, IP 878 allegedly was sodomized with a broomstick on October 21 and 22, 2023. He notified his fiancé of his attack and she contacted ASGDC. ASGDC interviewed him then and carried him to hospital. While in the hospital a rape kit was performed, and a report was filed with the Richland County Sheriff. IP 878 identified his assailants, but he believes they were not sent to restricted housing and are now in the general population. To IP 878's knowledge, there is no keep separate from his assailants. Further, upon IP 878's return from the hospital, ASGDC attempted to place him in the Housing Unit Hotel, but an Intake

Officer would not allow it and kept him in Intake until he could be transferred to Housing Unit Bravo.

In another concerning incident, female IP 257 claims in March 2023 she was placed in a cell with a male IP that was masturbating. IP 257 stated that she didn't know the outcome of the PREA investigation and that her grandmother had told her "someone" (she didn't know who) was supposed to have talked to her about the PREA investigation in September 2023.

8. Use of Force by Staff - Interviewed inmates revealed issues with staff on inmates use of force. IP 552 made multiple allegations of violations of use of force policies including use of Electronic Disabling Device (EDD) Gloves without use of force report, disciplinary, or medical. IP 552 also claimed to have been placed in the restraint chair for seven straight days in 2022 and four straight days in 2023. IP 466 claims to have observed multiple inmates in the restraint chair for 74 hours, but this changed recently to 4 hours because "Feds" were coming.

9. Staff corruption - Numerous inmates described inappropriate or illegal staff conduct. For example, IP 812 described a recently employed nurse that brings contraband marihuana and cigarettes in Phase III and BMU. According to IP 812, the nurse was caught with contraband on med cart, but it was covered up because the nurse is in a sexual relationship with Lieutenant correctional officer. Further, IP 552 claims to have a child with a former correctional officer that was conceived at ASGDC in 2022.

10. Grievance System - Interviewed inmates reported difficulty gaining access to grievance forms and that submitted grievances are not responded to in a timely

manner, or a response Is never provided. IP 081 claims to have submitted 50 grievances and only received one response from medical acknowledging he has not been receiving meds. The Grievance Coordinator allegedly told IP 081 “not on her” because she [the Grievance Coordinator] forwarded [grievances] to the person responsible.

11. Physical Plant and Environmental Health - Interviewed inmates described physical plant deficiencies and environmental health concerns. For example, IP 081 described his housing unit only has one shower and two toilets working for 75-80 inmates and does not have handicapped toilets and showers. IP 222 described an appalling situation where another inmate is resorting to drinking water from the toilet because she did not have access to water in the cell and the inmate was thirsty. IP 257 described having no water or light in her X-ray cell. IP 257 also claims to have been bitten by a spider and that there is mold in the housing unit causing her breathing problems. A determination was not made if ASGDC was providing ADA compliant toilets, sinks, and showers for inmates that required the accommodations.
12. Fire Safety - Interviewed inmates described fire suppression systems not operating properly during fires in housing units. IP 047 admitted during his interview to starting a fire in BMU and he passed out and was sent to hospital as a result of the fire-sprinkler not going off. IP 047 claimed the fire sprinkler did not deploy because an officer turned off water because an inmate threatened to activate the sprinkler. IP 184 also stated there was a fire in her cell and the sprinkler system did not deploy. I was able to corroborate that there was still smoke damage in her cell.

E. ASGDC South Carolina Department of Corrections Annual Inspections, Fire Marshall Annual Inspection, the SCDC July 26-27, 2023 Security Audit and ASGDC Corrective Action Plan

1. ASGDC is subject to annual inspections conducted by the South Carolina Department of Corrections (SCDC).

   ASGDC non-compliance with *Minimum Standards for Local Detention Facilities in South Carolina* increased in the November 30, 2023 South Carolina Department of Corrections Inspection, increased to nineteen (19) standards from fourteen (14) standards in non-compliance found in the October 22, 2022 South Carolina Department of Corrections Inspection. The *Minimum Standards for Local Detention Facilities in South Carolina* found in non-compliance in the November 30, 2023 South Carolina Department of Corrections Inspection were (standards also found non-compliant in 2022 audit indicated with *):

   A. **"Standard 1005 (h) Definitions-"**Holding Cells in the Intake Area are frequently used to house inmates for more than six hours in violation of the standard."

      Standard 1005 (w) Definitions-"ASGDC was designed for operation with Direct Supervision Management. Due primarily to staffing shortages Direct Supervision Management is not taking place. This will be monitored on future inspections and if this process continues a complete re-evaluation of the facility's rated capacity (that is based on the requirements of Indirect Supervision Management will be necessary. Inspectors also observed renovation in "Y" Yankee housing unit that involved creation of an enclosed control room which will separate staff

from inmates and would therefore cause the housing unit to be classified as Indirect Supervision Management."

B. ***Standard 1021 Manual of Policies and Procedures**-"Policies and Procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis and documentation should be retained as to all dates when the policies and procedures were reviewed."

C. ***Standard 1022 Emergency Pre-Planning**- "Policies and Procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis and documentation should be retained as to all dates when the policies and procedures were reviewed."

D. ***Standard 1031 Number of Personnel (a) (b) and (d)**- (a) "The facility operated for a lengthy period without a recognized Detention Director and is currently once again operating with an Interim Director[15]. (b)The facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded to enable proper facility operation, and recruitment, and retention of employees must also be improved. At the time of the inspection, several housing units were closed due to staffing shortage or repairs. (c) A current staffing analysis is needed. The latest staffing analysis was conducted years ago and does not reflect current operations at the facility."

[15] The Interim Director, Crayman Harvey was named Permanent Director in August 2023.

E. ***Standard 1035 In-Service Training**-"Several items need to be added to the in-service training agenda. They include:

> Training on the operation of fire extinguishers and automatic suppression systems in the kitchen; (2) Training on the operations of pull stations in the housing units; (3) Procedures to alert the rest of the facility of a fire or other emergency; and (4) Procedures for reporting maintenance concerns."

F. **Standard 1063 Key Control (d)**-"Key control procedures has improved somewhat since the previous inspection. However, staff training on daily logging of keys issued and returned, and accountability of keys held by individual officers, is needed."

G. ***Standard 1065 Facility Security (b)**-"Some of the cell and passage door locks in Phase III (and elsewhere in the facility) are malfunctioning and need to be repaired or replaced."

H. ***Standard 1082 Classification**-"Pretrial and sentenced females are being housed together in violation of the standard."

I. ***Standard 1094 Females (b)**-"The fact that all female inmates (both sentenced and pre-trial) are housed in the same living unit, they are not being afforded the same privileges as the male inmates are."

J. **Standard 2012 Rated Capacity**-"The rated capacity has been adjusted to reflect housing at the time of this inspection. Two former housing units, T-1 and T-2 have not been utilized for housing in several years and there are no plans to use this building for housing in the future, so these two housing units have been

removed from the official rated capacity of the facility. Housing Units that are unoccupied due to staffing shortage have previously remained as part of the facility's official rated capacity. On future inspections unoccupied housing units will be omitted from the official rated capacity."

The South Carolina Department of Corrections October 24, 2022 and November 30, 2023 Inspections rated capacity and average daily population for ASGDC are displayed in Table 5.

Table 5

Inspection	10/24/2022	11/30/2023
Rated Capacity	1116	1008
Average Daily Population	701	701
Facility High Count	752	752

K. ***Standard 2014-1 Special Purpose Cells**-The male special purpose cells are in Housing Unit P (Papa). Construction of the cells to dayroom separation (walls) are primarily glass or Lexan and provide direct sight from a twenty-four (24) hour staff position.[16]

All female inmates are now housed in Unit X. Inmates housed for Special purpose reasons (suicide watch, etc.) are placed in cells in this unit that do not

[16] ASGDC staff reported, and the Expert Inspection Team observed that special purpose cells are now designated in the renovated BMU Housing Unit cells designated for single and/or double occupants. It was observed Intake Area holding cells are being utilized to special purpose cells to house inmates.

provide staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position."

L. ***Standard 2014-2 Fire Codes** – "Several items that were noted by the Deputy State Fire Marshal need to be addressed. The fire apparatus access road that encircles the complex needs to be maintained to be accessible in all weather conditions as per the requirements of the South Carolina Fire Code, Sections 503.2.1 through 503.2.8." Further, the report details include the following comment "Unable to verify the approved from the fire code official to include the use of the officer duress button as a form of communication in unstaffed pods for inmates to notify staff of an emergency."

M. **Standard 2014-7 Security** – "Several security issues were noted during the inspection as follows; 1) Lack of lighting in bathrooms presents a security hazard to inmates (i.e. contact with other inmates, safety hazard due to slips/falls, etc.), 2) Females in one of the housing units stated that a male inmate had entered the housing unit through the ceiling. This must be investigated in order to identify and seal a possible security breach, 3) Inmates in several housing units reported that the count, which is scheduled for certain times during the day was being conducted by an inmate due to the absence of an officer on the unit, presumably due to staffing shortages."

N. ***Standard 2014-16 Toilets** – "The Phase V addition to the facility has sub-housing units that are designed for eight inmates but contain only one (1) toilet. Several housing units other than Phase V, there were missing or damaged toilets

and at least one unit that housed females contained urinals, which cannot be used by females or included in the ratio of inmates to toilets requirement in standards."

O. **Standard 2014-23 Indoor Air Quality** – "Air flow in several housing units in Phase I and in the Main Control Room was inadequate. Repairs or adjustment are needed."

P. ***Standard 2014-40 Maintenance** – "Numerous maintenance related violations were noted during the building tour as listed: 1) Corroded sprinkler escutcheons throughout, 2) Writing surfaces are missing from cells, 3) Water damage to ceilings, 4) Paint peeling in showers, 5) Showers need to be thoroughly scoured on a more regular basis, 6) Ceramic tiles are missing in the showers, 7) Ceiling tiles are missing or damaged, 8) There are missing and inoperable plumbing fixtures (toilets, urinals, sinks and showers) in the housing unit, 9) There are missing toilets in several units, 10) There are accumulations of trash in several pipe chases, 11) The manual pull stations for the fire extinguishing system(s) in the kitchen hood(s) need to be identified as to which it hood it activates, 12) "Loaded" sprinkler heads that need to be cleaned were noticed in several areas of the facility, 13) Escutcheons were missing from sprinkler heads through the facility, 14) Numerous were not functional throughout the facility, 15) Unit D (female housing at the time of the inspection) had several maintenance issues at the time of the inspection: a) There were no light fixtures in the shower area, b) Two of the urinals were not operational, c) One of the two sinks downstairs was

not operational or continually running, d) One of the two toilets downstairs was not operational, e) One of the four showerheads downstairs was not operational, f) Bugs were observed in the bathroom area of this housing unit, g) Inmates housing in the unit stated that a male had come into the unit through a missing ceiling tile, h) See comments under Standard 2014-23 above regarding indoor air quality, i) Sprinkler head coverage in Unit K (and possibly other housing units) may have been compromised with the addition of new LED fixtures. This needs to be evaluated and repaired, if necessary, and j) The isolation cells in the medical area have been converted to storage. These two rooms need to be returned to use as medical isolation."

Q. **Standard 2072 Laundry** – **"**Laundering of inmate uniforms etc. are occurring once a week in violation of this Standard."

R. **Standard 2074 Personal Care Items** – "Personal hygiene items were said to not be available at all times. When these items were available damaged or missing plumbing fixtures or improper lighting etc. in the bathrooms made use of the items was difficult."

S. ***Standard 3003 Vermin, Insects, and Pests** - "This situation appeared to be greatly improved since the last inspection. However, continued focus needs to be maintained on this issue."

2. State Fire Marshall Report

The South Carolina Office of State Fire Marshall conducted an inspection of ASGDC on November 30, 2023. The inspection report identified the following ASGDC deficiencies:

A. "Ceiling tiles were missing throughout the facility to include around sprinkler heads and smoke detectors;

B. In the server room inside Central, several boxes were stacked on top of the data servers, providing less than 18 inches in a sprinklered room;

C. The inspection was unable to verify the approved fire safety and evacuations plans were trained on in accordance with South Carolina Fire Code (SCFC) 401.2 and 403.7. Unable to verify the approval from the fire code official, to include the use of the officer duress button as a form of communication in unstaffed pods for inmates to notify staff of an emergency.

D. The inspection was unable to verify the approved fire safety and evacuations plans were on site, maintained and trained in accordance with SCFC 401.2 and 403.7;

E. The inspection was unable to verify the approved fire safety and evacuation plans were trained on in accordance with the section;

F. No fire drill records were maintained on the premise on the adult side of the facility in accordance with SCFC Section 109.3;

G. Open wiring and junction boxes were found throughout the premises including, but not limited to: Pods A-F, Pod J, Pod M, and Pod U.;

H. The circuit breaker for the alarm panel in the Juvenile Building (XJLA) was not clearly marked to indicate its purpose;

I. Multiple stationary appliances were plugged in using extension cords and surge protectors. The areas included but not limited to: refrigerator in Room P near the laundry room and microwave in the room labeled “Supply”;

J. In the Central room where data servers were located, extension cords were extended through the floor;

K. Records for the inspection of the hood system were not on the premises in accordance with Section SCFC 109.1;

L. Records of the fire wall inspections were not maintained on the premises in accordance with SCFC 109.3;

M. The fire door leading into Room 1 outside the laundry area had a broken door closure, and the door was not able to be closed automatically. The fire door in the laundry area labeled “Door P” had multiple holes drilled on the bottom right corner. The fire door on the inside of the “Door P” within the laundry area was tied into an open position making it unable to close.

N. Damper inspection and maintenance records were not maintained on premises in accordance with SCFC 109.3;

O. On the alarm panel in Central, the “Trouble”, “Supervisory” and “Silence” lights were all activated.

P. Multiple sprinkler heads in the laundry room were loaded with lint and maintenance needs to be conducted in accordance with National Fire Protection

Association (NFPA) 25 Section 5.2.1.1.1. The sprinkler room did not have a spare of each type of sprinkler head in accordance with NFPA 25 Section 5.4.5;

Q. Records of hood cleaning were not maintained on the premises in accordance with 606.3.3.3. Tags on the hood systems indicate the systems were checked on 8/3/2022 by Hoodez Professional Cleaning;

R. The manual pull stations in the kitchen did not identify the hazards protected;

S. Number 2:A10.BC extinguisher was installed withing the central monitoring room. In the electrical room in the Juvenile Building, Number 2:A 10:BC extinguisher was installed;

T. A Class K extinguisher was not present in the kitchen;

U. Records of the inspection, testing, and maintenance of the fire alarm systems, including but not limited to fire alarm systems, smoke detector sensitivity, and other documents required by NFPA 72 were not maintained on premises in accordance with SCFC Section 109.3;

V. The smoke control system testing and maintenance was not maintained on premises three (3) years in accordance with the section and SCFC 109.3;

W. Multiple exit signs throughout the premises were not illuminated. The locations included but are not limited to: Juvenile Classrooms A and B, Pods A through F, Pod J, Pod M, and Pod U;

X. A curtain was placed over the egress side of a marked exit door in the Tango Building in the room behind the media room;

Y. Records of the power system testing and maintenance were not maintained on premises in accordance with the section and SCFC 109.3;

Z. A 704 Placard was missing for the laundry to identify hazardous materials are stored, dispensed, used or handled in quantities requiring a permit and at specific entrances and locations designed by the fire code official."

3. SCDC July 26-27, 2023 Security Audit

A. Physical plant observations – The SCDC Security Audit team denoted in their observations that the detention center lacked attention to detail and gave the appearance of abandonment. The team's initial observations were that overgrown vegetation exceeding six feet in height had overtaken both the inner and outer perimeter fence line to include the dog run (area located between the inner and outer perimeter fence) creating blind spots, posing risks of concealment, contraband introductions, and escapes.

The security team also noted security concerns related to the perimeter fencing including the outer fence drive through gate being broken and unable to be secured in the closed position. Employees told the security team that the fence was damaged for several months and has not been secured closed for a minimum of two (2) months. As such, each time the inner fence gate is opens, it creates a breach in perimeter security. Additionally, razor wire at various locations is in poor condition, either stretched during installation or collapsed due to being stepped on, diminishing its effectiveness.

During the walk-through of the facility security audit team members identified numerous issues including plumbing, electrical and structural concerns. Examples of the issues observed by the audit team were damaged light fixtures, exposed wiring, inoperable urinals and toilets, water running into common areas when a toilet was flushed, and toilets stopped up with feces in cells. The plumbing issues were deemed "deplorable" and "disgusting" by the audit team and cause unsanitary conditions in the facility.

The security audit team also noted that general housekeeping could use improvement. The team specifically noted several air returns heavily coated in dust and dirt suggesting air filters may not be changed on a scheduled basis as they should be.

B. Security – In addition to the physical plant issues noted in the facility perimeter, the facility does not have a roving perimeter patrol officer. The security audit team observed several drain grates located within the inner perimeter yard that are not secured and outfalls observed unsecured allowing inmates access outside the facility perimeter. The security audit team also observed multiple construction vehicles inside the perimeter fence without steering wheel clubs or locks. The vehicles were observed unattended with windows down allowing easy access to the interior of the vehicle. There were also multiple tools located on or in the unattended vehicles. The security audit team referred to the security issues observed as "Corrections Basic 101 issues [that] should be obvious to the eyes of security personnel at all levels of experience."

C. Staffing – During the Security Audit Teams observations, it was noted that not all housing units were staffed/posted with an officer. There were circumstances in which one (1) officer was assigned to cover a minimum of two (2) housing units. The security audit team also found that ASGDC had no current trainer certified to conduct firearms recertification training. As such, the interim director informed the audit team that when officers transport inmates outside the officers were armed with pepper spray and a taser.

4. Corrective Action Plan – I reviewed the July 26, 2023 Security Audit Report ASGDC Corrective Action Plan, noting that the plan does not adequately address the significant deficiencies to protect inmates and staff from unreasonable harm.[17]

F. Review of ASGDC Records

1. Staffing – Watch Log Results January 1 – 25, 2024. A watch tour is where an officer utilizes an electronic tool to record their 30 minute security rounds. A review of the watch tour electronic rounds provides additional evidence detention staff routinely and consistently fail to make required security rounds. The data displayed below depicts the lack of timely security rounds.

[17] SCDC July 26-27, 2023 Security Audit.

Table 6

Housing Unit	Actual # of Watch Tours January 1 – 25, 2024	Expected Watch Tours (Every 30 minutes x 25 days)	Watch Tour Deficiency	% of Expected Watch Tours Completed
WatchTour UNIT A	33	1,200	(1,167)	2.8%
WatchTour UNIT B	30	1,200	(1,170)	2.5%
WatchTour UNIT D	31	1,200	(1,169)	2.6%
WatchTour UNIT E	186	1,200	(1,014)	15.5%
WatchTour UNIT F	29	1,200	(1,171)	2.4%
WatchTour UNIT G	193	1,200	(1,007)	16.1%
WatchTour UNIT H	156	1,200	(1,044)	13.0%
WatchTour UNIT I	172	1,200	(1,028)	14.3%
WatchTour UNIT J	139	1,200	(1,061)	11.6%
WatchTour UNIT K	18	1,200	(1,182)	1.5%
WatchTour UNIT L	10	1,200	(1,190)	0.8%
WatchTour UNIT M	80	1,200	(1,120)	6.7%
WatchTour UNIT U	32	1,200	(1,168)	2.7%
WatchTour UNIT X	41	1,200	(1,159)	3.4%
WatchTour UNIT Z (BMU)	18	1,200	(1,182)	1.5%
Grand Total	**1,169**	**19,200**	**(18,031)**	**6.1%**

2. Logbooks – A review of AGSDC Logbooks revealed the following but not limited to:

Detention staff failed to make housing unit security rounds for extended periods,

- Shift where detention officers were covering multiple housing units,
- Broken cell door locks and,
- Inmates able to manipulate door locks in cell housing units and exit unauthorized.

Housing unit logbooks reviewed were:

- ASGDC BMU Logbook 01.17.2024 to 01.23.2024 and 01.07.2024 to 01.10.2024

- ASGDC Golf Logbook 01.19.2024 to 01.25.2024
- ASGDC Hotel Logbook 01.20.2024 to 01.25.2024
- ASGDC India Logbook 01.20.2024 to 01.25.2024
- ASGDC Juliet Logbook 01.21.2024 to 01.25.2024
- ASGDC Mike Logbook 01.15.2024 to 01.24.2024
- ASGDC Uniform Logbook 01.14.2024 to 01.24.2024.[18]

3. Illustrative Incidents

Incident Report Summaries –

Table 7

	Total #	Avg. Per Day
9/21/22 - 3/15/23 Incidents	2,224	12.71
3/15/23 – 6/15/23 Incidents	1,367	14.86
7/6/23 – 12/28/23 Incidents	2,109	12.05

A. Protection from Harm – My review of ASGDC incident reports reveals numerous instances where ASGDC staff were unwilling or unable to protect inmates from harm. The following illustrative examples demonstrate ASGDC's failure to protect inmates from harm.

(1) Incident #180086. 8/6/2022. Units Mike and Uniform. A nurse advised a lieutenant that an inmate patient – who had been a CODE BLUE with multiple seizures related to heroin and opiate withdrawal just a few hours prior – should be reassigned to Mike dorm for closer monitoring/

[18] ASGDCC Logbooks

observation. The lieutenant notified of concerns related to patient safety – and that another seizure without medical intervention could result in serious injury or death of patient. The lieutenant states that " there is no room on Mike," and that "He is going back to Uniform, Period." On call MD consulted at 5pm, and a verbal order was obtained for patient to be moved to Mike dorm on bottom bunk/bottom tier. Order placed into system and copy provided to the lieutenant who states, " What do you want me to do, there is no room on Mike."

(2) Incident #181412. 11/21/2022. ASGDC received calls from outside the facility that an inmate was being assaulted and the assault was being streamed on Facebook live. An officer responded to the scene of the assault in response to the call and found the inmate with facial bruising. This incident is illustrative of a lack of inmate supervision resulting in harm as detention officers were not in the housing unit to identify an assault had taken place and had to rely on an outside source to identify the concern.

(3) Incident #191877. 10/23/2023. An officer was notified by a detainee in Unit Delta of another detainee having a seizure. The officer checked the camera and observed a detainee being assisted by another detainee and called a code blue in unit. This incident also indicates a lack of supervision of inmates resulting in a failure to protect inmates from harm as a detention officer was not present in the housing unit to provide or summon medical assistance to an inmate in medical distress.

B. Security

The following summaries reflect the prevalence of contraband, assaults, and disturbances as reflected in incident reports. Note incident types were ASGDC designations, however no ASGDC policy or procedure with incident type definitions was identified.

Contraband – The following table reflects the number of incidents involving contraband for September 2022 – December 2023:

Table 8

	Number of Incidents	Incidents Per Day
September 2022 – March 2023[19]	260	1.49
March 2023 – June 2023[20]	122	1.33
July 2023 – December 2023[21]	300	1.71
Total September 2022 – December 2023	**682**	**1.54**

[19] 199-Incidents (09-21-22 through 03-15-23)
[20] Incidents from 3/15/2023 to 6/15/2023
[21] Incidents from 7/6/2023 to 12/28/2023

Assault – The following table reflects the number of incidents involving assault for September 2022 – December 2023:

Table 9

	Number of Incidents	Incidents Per Day
September 2022 – March 2023[22]	176	1.01
March 2023 – June 2023[23]	152	1.65
July 2023 – December 2023[24]	296	1.69
Total September 2022 – December 2023	**624**	**1.41**

Disturbance – The following table reflects the number of incidents involving a disturbance for September 2022 – December 2023:

Table 10

	Number of Incidents	Incidents Per Day
September 2022 – March 2023[25]	390	2.23
March 2023 – June 2023[26]	204	2.22
July 2023 – December 2023[27]	481	2.75
Total September 2022 – December 2023	**1,075**	**2.43**

[22] 199-Incidents (09-21-22 through 03-15-23)
[23] Incidents from 3/15/2023 to 6/15/2023
[24] Incidents from 7/6/2023 to 12/28/2023

[25] 199-Incidents (09-21-22 through 03-15-23)
[26] Incidents from 3/15/2023 to 6/15/2023
[27] Incidents from 7/6/2023 to 12/28/2023

C. PREA – Incident reports indicated allegations of inmate on inmate sexual assault as well as staff on inmate sexual assault. The following illustrative incidents revealed an allegation of a sexual assault:

(1) Incident #191681. 10/6/2023. An inmate informed an officer that another officer had performed oral sex on him while the inmate was on suicide watch in Unit Papa.

(2) Incident #191872 and #191873. 10/21/2023 and 10/22/2023. An inmate alleged that he was attacked and sexually assaulted with a broomstick. Note – Incident #192601 is the documentation of the inmate's interview by an officer and incorrectly lists the date of the incident as 10/20/2023.

D. Use of Force

The following table reflects the number of incidents where officers identified a Use of Force for September 2022 – December 2023 incidents:

Table 11

	Number of Incidents	**Incidents Per Day**
September 2022 – March 2023[28]	207	1.18
March 2023 – June 2023[29]	*25	0.27
July 2023 – December 2023[30]	*36	0.21
Total September 2022 – December 2023	**268**	**0.61**

[28] 199-Incidents (09-21-22 through 03-15-23)
[29] Incidents from 3/15/2023 to 6/15/2023
[30] Incidents from 7/6/2023 to 12/28/2023

Table 11 reflects incidents identified by ASGDC in incident reports as a use of force. The incidents designated as use of force by ASGDC staff summarized in Table 11 are significantly lower than the sum of the use of force types in Table 12 (Oleoresin Capsicum (O.C.), Taser, and Restraint Chair). This data discrepancy calls into question the accuracy of the use of force reporting in the incident reports. Further, the use of force in X-Ray and Intake observed by the experts during the inspection (See Item G. 10 below) as well as the dramatic decline in reported use of force raise the same questions regarding the accuracy of ASGDC's use of force reporting.

The following incidents reflect types of Use of Force able to be readily determined by common search terms. Other types of force were not extracted and summarized due to the volume of possible terms that could indicate a use of force or another situation not involving a use of force.

Table 12

	O.C.	Taser	Restraint Chair
September 21, 2022 – March 15, 2023[31]	5	23	77
March 15, 2023 – June 15, 2023[32]	2	13	34
July 6, 2023 – December 28, 2023[33]	7	33	15
Total September 2022 – December 2023	14	69	126

[31] 199-Incidents (09-21-22 through 03-15-23)
[32] Incidents from 3/15/2023 to 6/15/2023
[33] Incidents from 7/6/2023 to 12/28/2023

(1) Taser and OC – Incident #192707. 12/15/2023. An inmate was talking with mental health and became upset and refused to lock down. The sergeant gave several directives that were refused, so she first deployed chemical agent and then her taser. The inmate went to the ground and became compliant after administration of the taser. This represents a use of force that was not in compliance with ASGDC policies and procedures.

(2) Neck/Throat hold – Incident #192189. 11/15/2023. An officer (Officer #1) documented observing another officer (Officer #2) responding to a disturbance had an inmate laid out across the dayroom table with the Officer #2's hand gripping the inmate's throat. Officer #1 removed Officer #2's grip from the inmate's throat and applied leg restraints without further incident. This represents a use of force that was not in compliance with ASGDC policies and procedures.

(3) Restraint Chair – The following incidents represent illustrative examples of instances where the incident reports indicate the restraint chair was utilized while waiting on an available cell placement in violation of ASGDC policy:

(a) Incident #178949. 4/11/2022. Medical. Inmate was placed on constant suicide watch by Mental Health. The inmate was placed in the restraint chair until space was available. Utilizing the restraint chair in place of appropriate cell assignment is not in accordance with ASGDC policy 2B-03.

(b) Incident #180879. 9/27/2022. Inmate told officer he as having suicidal thoughts and wanted to kill himself using the t-shirt he had wrapped around his neck. The inmate was escorted to SHU and placed in a restraint chair due to no room in unit SHU. Utilizing the restraint chair in place of appropriate cell assignment is not in accordance with ASGDC policy 2B-03.

G. Summary

The discussion below represents my analysis of the site visit, interviews, SCDC Inspections, SCDC Security Audit, South Carolina Office of State Fire Marshall Inspection, Incident reports, Richland County and ASGDC Responses to the inspections and other ASGDC records detailed above and how such evidence demonstrates ASGDC's failure to comply with relevant standards.

1. Policies and Procedures

ASGDC has a full range of policies and procedures written to comply with American Correctional Association standards and *Minimum Standards for Local Detention Facilities in South Carolina*. A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC staff have a pattern and practice of failing to adhere to their policies and procedures in operating the detention center thus placing inmates, staff and the public at risk of harm. The ASGDC policies and procedures do not comply with and/or include all Minimum Standards for Local Detention Facilities in South Carolina.

2. Quality Assurance Program

ASGDC is implementing a quality assurance program and has recently hired a Compliance Director. A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC staff have a pattern and practice of failing to adhere to their policies and procedures in operating the detention center placing inmates, staff and the public at risk of harm. Policies and Procedures necessary for an effective quality assurance program have not been developed to improve ASGDC operations.

The ASGDC ACA maintained report data is inconsistent with my analysis of the provided detention center incidents from September 2022 to December 2023. The ASGDC ACA reports dramatically under report the number of incidents that have occurred at the detention center. The ASGDC administrative lieutenant, responsible for maintaining incident documentation, advised during the January 22-25, 2024 inspection that he did not maintain a contraband log and incident reports were only maintained in individual inmate files. ASGDC does not have a unified system to assess detention center operations overall and determine trends that are occurring in all areas.

ASGDC does not have an Early Warning System tool to identify and mitigate employee and inmate inappropriate behavior or trends before they escalate to serious misconduct, thus exposing staff and inmates to risk of harm.

Crayman Harvey while serving as Interim Director of ASGDC in October 2022 prepared an improvement plan for ASGDC. The improvement plan identified key concerns as being:

Staffing updates
- Hiring Initiatives
- Personnel needs remaining
- Facility Updates
- Medical Health Initiatives
- Food provider
- Physical Structure enhancement
- Telecommunication Provider
- Technology initiatives
- Technology needs remaining
- Officer/Detainee Safety, Security and Wellness initiatives
- Physical structure enhancements (Dormitories)[34]

Although over a year has passed since the Improvement Plan was prepared, the concerns remain indicating that the improvement efforts have not been successful.

3. Staffing

The ASGDC is extremely short staffed. Hiring, training, and supervision of existing staff is problematic. Since January 1, 2024, there have been eleven (11) ASGDC employees arrested. The current ASGDC staffing analysis has 240 authorized positions (162 authorized security/custodial positions) and 78 administrative positions). The ASGDC security/custodial vacancy rate is 46 percent (74 vacant positions/162 authorized positions). The administrative vacancy rate is 11 percent giving ASGDC a total staffing vacancy rate of 34 percent (see Table 1). Allied Security

[34] Alvin S. Glenn Overview and Improvement Plan. County 47620 – County 47645

is contracted with Richland County on June 1, 2022 to provide ASGDC approved security services as follows:

- Security professional is to perform assigned duties of patrolling and observing ASGDC locations as directed by ASGDC.
- Any unusual incidents detected or reported will be reported to the client via the designated client contact. An incident report will be filled out and a copy forwarded to the client. The security professional creating the report will be available to explain the incident report during their shift.
- The security professional will also report criminal activity and/or visible hazards observed and/or reported while on post.

The Allied Security staff do not receive the required ASGDC full time employee training and cannot perform security functions. However, even including Allied Security Staff there is insufficient staff to cover all security posts.

ASGDC Director Crayman Harvey testified in his December 15, 2023 deposition that staffing in July 2023 did not meet the standards in his personal and professional opinion.[35]

Richland County requested an updated ASGDC Staff Analysis from the South Carolina Association of Counties. A draft Staffing Needs Assessment for the Richland County Detention Center (Alvin S. Glenn conducted by Robert Benfield, ARMa, AINS,

[35] Crayman Harvey December 15, 2023 Deposition Page 21 Lines 15-17.

Director of Insurance Services, and Cliff Miller, Risk Manager for the South Carolina Association of Counties in June 2023 indicated the staffing needs for the detention center were at a minimum: 231 security/shift worker and 80 administrative/support positions for a total of 311 positions. The staffing assessment did not include food service, healthcare and maintenance. The plaintiff expert preliminary review of the staffing assessment found it does not appear to comport with existing ASGDC policies and procedures in providing required programs and services. ASGDC and Richland County need to conduct additional assessments to determine the necessary staffing to provide necessary programs and services to the inmate population that protects inmates and staff from harm. Further, the Minimum Standards for Local Detention Facilities in South Carolina Standard require a ratio of no less than one (1) security personnel per every sixty four (64) inmates or portion thereof. When the entire inmate population in a living unit is in a secured mode, the ratio may be altered provided that adequate supervision is maintained in each living unit. The January 22-25, 2024 inspection identified three (3) housing units with a population exceeding sixty four (64) inmates: Alpha-81, Uniform-81, and BMU-65. The ASGDC current staffing plan and the draft South Carolina Association of Counties ASGDC Staffing Assessment conducted in June 2023 do not provide additional staff as required when the housing unit population exceeds sixty four (64) inmates.

In my professional opinion, ASGDC lacks adequate staff to operate the facility safely and securely.

4. Operational Capacity

"Operational Capacity" is the optimum number of inmates that a facility can efficiently and effectively manage and classify. Operational capacity is usually expressed as a percentage of design or rated capacity (e.g., 80% of rated capacity). This percentage will vary from one facility to another, based on factors such as the types of inmates held, housing unit design, and proximity of staff.[36]

The correct ASGDC rated capacity is 840 using all available detention center housing unit beds. The removal of inoperable and unavailable beds gives ASGDC a rated capacity of 680.

The Minimum Standards for Local Detention Facilities in South Carolina Definition Standard 1005 (ae) defines "Operational Capacity" the optimum number of inmates that a facility can efficiently and effectively manage and classify. Operational capacity is usually expressed as a percentage of design or rated capacity (e.g., 80% of rated capacity). The percentage will vary from one facility to another, based on factors such as the types of inmates held, housing unit design, and proximity of staff.[37] The ASGDC operational capacity is currently 535 inmates. It is undetermined how many additional cells should also be excluded due to

[36] "Resource Guide for Jail Administrators", Mark D. Martin & Thomas A. Rozazza, NIC, December 2004, Page 52. (Revised August 2005). Minimum Standards for Local Detention for Local Detention Facilities In South Carolina. 7/26/2013 Version.

[37] "Resource Guide for Jail Administrators", Mark D. Martin & Thomas A. Rozazza, NIC, Decemb5er 2004, Page 52. (Revised August 2005). Minimum Standards for Local Detention for Local Detention Facilities In South Carolina. 7/26/2013 Version.

compromised cell door locks. Table 13 below depicts the rated capacity, actual capacity, operational capacity, and actual population by housing unit as of January 24, 2024.

Table 13

Location	Type/#	Rated Capacity	Actual Capacity	Operational Capacity[38]	Actual Population[39]
Alpha	56 Dorm beds	56	56	44	79
Bravo	56 Dorm beds	56	28	22	36
Charlie	56 Dorm beds	NA	NA	NA	NA
Delta	56 Dorm beds	56	56	44	28
Echo	56 Dorm beds	56	56	44	60
Foxtrot	56 Dorm beds	56	56	44	73
Golf	28 cells	56	32	25	40
Hotel	56 cells	56	25	20	48
India	56 cells	56	38	30	57
Juliet	56 cells	56	28	22	56
Kilo	56 beds	56	56	44	62
Lima	56 beds	56	56	44	67
Mike	28 cells	56	48	38	62
Papa	56 cells	NA	NA	NA	NA
Uniform	56 beds	56	56	44	79
Yankee	56 beds	NA	NA	NA	NA
BMU	56 cells	56	56	44	82
X-Ray	56 cells	56	33	26	40
Intake	NA	NA	NA	NA	42
Transfer*	NA	NA	NA	NA	37
Total	1008	840	680	535	948

* Unable to determine where "Transfer" housed inmates were physically located based on January 24, 2024 Dormitory Head Count report.

The ASGDC inmate count on January 24, 2024 was 948 inmates.[40]

5. Security

A. Inmate Supervision - A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC staff does not reasonably supervise inmates placing inmates and staff at risk of harm. ASGDC does not have specific policies and procedures for video surveillance use to assist in detention center operations including but not limited: fixed, handheld and body worn cameras. Policies and procedures are critical to detention staff utilizing video surveillance to appropriately supervise inmates.

B. Counts - ASGDC Policy IV.D Institutional Counts establishes the system for physically counting inmates. The system includes strict accountability for inmates assigned work and educational release, furloughs, and other temporary approved absences. [redacted].[41]

[38] ASGDC eighty (80) percent of the operational beds.
[39] ASGDC January 24, 2024 Dormitory Head Count.
[40] ibid.
[41] ASGDC Policy 3A-14.IV Institutional Counts.

ASGDC staff discussions, inmate interviews and personal observations during the January 22-25, 2024 inspection indicate ASGDC is not in compliance with their Institutional Count procedures. Inmate identification cards are not utilized for conducting counts. Housing unit officers advised inmates on occasion do not live in the assigned bed/cell. The ASGDC practice of allowing inmates to live in bed/cells, where they are not assigned, places inmates and staff at risk of harm. The correct whereabouts of inmates is critical to ASGDC safety and security. Discussions with ASGDC security and classification staff during January 22-25, 2024 inspection revealed detention officers inside housing units from bed/cell to bed/cell to cell/Housing Units can move inmates from one bed/cell to another bed/cell without approval of classification or security supervisor approval. Housing Unit officers advised that even though it is against policy and procedures inmates on occasion do not live in their assigned bed/cell housing unit.

Inmates confirmed this practice is allowed during interviews conducted during the January 22-25, 2024 inspection. The majority of interviewed inmates noted that counts are not regularly performed, and inmates are regularly outside their assigned placement.

ASGDC failing to ensure inmates are living in the assigned housing bed is a security risk as inmates with different classification needs and inmates with conflicts against one another can interact. Further, uncontrolled movement facilitates inmates' ability to distribute contraband.

C. Cell door security

ASGDC Policy 2A-03.IV.J prohibits inmates from entering another inmate's cell. I observed inmates in multiple general population housing units, both male and female, entering and exiting other inmates' cells in violation of the policy without detention officers intervening. It was also observed that the detention officer did not always secure doors after inmates entered and exited their cells. This practice allows inmates the opportunity to tamper with the cell door lock and prevent it from securing.

The housing unit officer station electronic door control panels have light indicators to depict if a cell door is secure or unsecured. The status of the cell door can also be monitored from the Main Central Control. A number of the housing unit door control panels were inoperable. On January 25, 2024, at my request, random housing officers communicated with the Main Control to determine the status of the cell doors closed by the officer and viewed as secure. The following was revealed: Hotel had (24) cell doors and Juliet (21) cell doors that the cell door lock did not properly secure. This provides evidence the operational capacity is even lower than the 535 inmates discussed in Section II.G.4 as the cells should not be utilized until the compromised locks are repaired or replaced.

ASGDC staff discussion, inmate interviews, incident reports, expert observations and other independent inspection substantiate inmates consistently and frequently have the ability to exit their cells unauthorized. The serious breach of

security places inmates and staff at risk of harm. The plaintiff expert housing unit cell door lock inspection was random and did not include all housing units or cell door locks. Although ASGDC is reportedly expending approximately 2.5 million dollars to replace 448 cell door locks, inmates will be able to compromise the new locks if staff do not properly supervise inmates and practice sound security practices opening and closing cell doors.

D. Security Rounds - ASGDC 2A-05 Security Staff/Detainee Interaction requires housing unit officers to provide Direct Supervision to inmates within their assigned units and will conduct rounds of all housing units occupied by inmates under their supervision. [redacted]

Housing unit officers should maintain ongoing communication with other shift officers assigned to their housing unit.[42]

ASGDC is required *Minimum Standards for Local Detention Facilities in South Carolina* to operate as a "Direct Supervision" Jail which is defined by the entity in Standard 1005 (w) definitions as meaning:

> "management of inmates in which security personnel are not separated by a barrier that prohibits visual and audio interactions with the inmates. Officers work directly in housing units and provide frequent, non-scheduled observation of and personal interaction with inmates. Each housing unit has at least one (1) security officer posted to supervise the unit twenty four (24) hours

[42] ASGDC 2A-05 Security Staff/Detainee Interaction effective July 1, 2011.

> a day, seven (7) days a week. Security personnel are assigned/posted to housing units at a ratio of no less than one (1) per every sixty four (64) inmates or portion thereof. When the entire population in a living unit is in a secured mode (e.g. cells/rooms are locked for sleeping, etc.) the ratio may be altered, provided that adequate supervision is maintained in each living unit."[43]

The ASGDC Policy 2A-03.IV Security Housing Units Officer Post Location requires [redacted] In detainee special management housing units, safety and security checks may be required more often.[44] Industry standards require at a minimum for general population units rounds one (1) time per hour with no more than one (1) hour. Special Housing Unit (i.e. Segregation, Medical, Intake) require two (2) times per hour with no more than forty (minutes) between rounds. Logbooks and Tower Watch electronic round documentation verify ASGDC detention officer consistently and routinely fail to conduct safety and security checks [redacted].

E. Obstructed viewing - The Plaintiff Expert Inspection of the ASGDC housing units January 22-25, 2024 revealed detention officers do not have sound security practices allowing inmates to place obstructions on cell doors, beds, light fixtures, door locking mechanism. Allowing inmates to obstruct viewing exposes

[43] *Minimum Standards for Local Detention Facilities in South Carolina,* Standard 1005 (w) Definitions revised August 2005, July 26, 2013 Version.
[44] ASGDC Policy 2A-03 Security Housing Units Officer Posts/Location, effective July 1, 2011.

inmates and staff to harm. Obstructions prevent detention staff from adequately supervision inmates in the housing units.

F. Contraband - ASGDC has search policies and procedures to control contraband at the detention center. A review analysis of detention center incidents from June 2022 through December 2023 revealed the contraband is frequently observed and detected including illegal intoxicants, weapons and electronic devices. The ASGDC contraband prevention strategies have been unsuccessful in preventing large amounts of contraband being present in the detention center.

As noted in Table 8, the daily rate of contraband detection increased from an average of 1.49 instances per day for September 21, 2022 to March 15, 2023 to an average of 1.71 instances per day for the period July 6, 2023 to December 28, 2023. This represents an approximately 15% increase. The January 22-25, 2024 inspection observations further revealed security staff fail to properly monitor inmates receiving medication from medical staff to ensure it is taken as required. Failure to do so can result in inmates concealing the medication and giving/selling it to other inmates or failing to take the medication as prescribed. Unauthorized and/or inappropriate use of prescribed medication can cause harm to inmates and staff.

G. Searches - Staffing shortages prevent frequent daily inmate and area searches from being conducted at the detention center to control contraband. Reviewed ASGDC logbooks did not identify detention officers are conducting frequent daily searches of inmates and housing unit areas. A contraband control strategy

requires operationalized search plans. Large special search operations are part of an overall plan but not a substitute for daily inmate and area searches necessary to control contraband. ASGDC does not maintain a contraband/evidence log with contraband reports maintained in individual inmate files.

A successful contraband control strategy requires a means to analyze contraband incidents and the effectiveness of contraband control strategies. Currently. ASGDC does not have a system to analyze contraband incidents and the effectiveness of their contraband control strategies. A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC staff does not control dangerous contraband at the detention center placing inmates and staff at risk of harm.

H. Janitorial Equipment control

The Plaintiff Expert Inspection of the ASGDC housing units January 22-25, 2024 revealed detention officers do not have accountability or control of janitorial equipment. Janitorial equipment not in use was observed unattended in the housing unit common areas, bed areas and cells. Failure to account for and control janitorial equipment place inmates and staff at risk of harm. Janitorial equipment can be utilized as a weapon to assault inmates and/or staff.

As noted herein, ASGDC has experienced serious and dangerous operational issues since approximately March 2018. Former ASGDC Assistant Director Donald S. Kitchens testified that the detention center was 80-120 officers short and he became

concerned with safety and quality of security. ASGDC began experiencing increased violence and discovery of dangerous contraband described as fabricated weapons and drugs.[45] The critical staffing shortages resulted in the detention center converting to Indirect Supervision when the detention center is designed to operate for Direct Supervision.[46] At times the detention center from 2018 to 2021 would only have seven (7) or eight (8) officers for 600 inmates.[47] On September 3, 2021, the detention center had a riot in the Hotel Housing Unit where detention staff sustained injuries and outside agencies had to respond to assist with the riot.[48] He recalled the detention center was over 200 officers short in April 2022 when he resigned his ASGDC position.[49] Mr. Harvey also testified that the Direct Supervision model of supervision was the most appropriate model for ASGDC in his personal and professional opinion.[50]

Further corroborating the violent nature of ASGDC, Advanced Correctional Healthcare Program Consultant Ana Franklin sent Richland County South Carolina Assistant Administrator John Thompson an email on June 28, 2022. In the email, Ms. Franklin noted that ASGDC safety risk had risen to a dangerous situation. The email described emergency staffing issues with multiple dangerous incidents that

[45] Donald S. Kitchens January 30, 2024 Deposition Page 39 Lines 3-20.
[46] Donald S. Kitchens January 30, 2024 Deposition Page 42 Lines 20-21.
[47] Donald S. Kitchens January 30, 2024 Deposition Page 95 Lines 17-20.
[48] Donald S. Kitchens January 30, 2024 Deposition Pages 53-56.
[49] Donald S. Kitchens January 30, 2024 Deposition Page 78 Lines 11-12.
[50] Crayman Harvey December 15, 2023 Deposition Page 26 Lines 7-12.

presented serious safety risks and needed to be addressed immediately. Nurses were being put at risk of harm.[51]

6. Classification System

Mr. Harvey during his December 15, 2023 deposition described classification as the "backbone" of any jail facility.[52]

ASGDC utilizes a classification instrument to determine inmate risk upon their admission to the detention center. Northpoint is the classification system is utilized by jails and prisons throughout the United States. The ASGDC inmate custody classifications are minimum, medium and maximum. A Sexual Aggressor/Vulnerability PREA[53] Screening Checklist is required to be completed for admissions to ASGDC. A review of ASGDC documents and January 22 through 25, 2024 discussions with Administrative, Intake, Classification and Security staff during detention center inspection revealed the classification and Sexual Aggressor/Vulnerability PREA Screening Checklist has not been operationalized to prevent risk from harm.

ASGDC Classification staff classify inmates and complete Sexual Aggressor/Vulnerability PREA Screening Checklist; however, they only determine the inmate housing units. Housing Unit Detention Officers determine cell/bed an inmate is assigned in the housing unit. Classification staff manually complete classification,

[51] Advance Correctional Healthcare June 28, 2022 email to Richland County, SC. (Bates ACH_110723_000825).
[52] Crayman Harvey December 15, 2023 Deposition Page 41 Lines 21-23.
[53] PREA is an acronym for Prison Rape Elimination Act.

reclassification and the Sexual Aggressor/Vulnerability PREA Screening Checklist Sexual Aggressor/Vulnerability PREA Screening Checklist. It is not shared with ASGDC staff making housing unit bed/cell assignment. Security Supervisors and Housing Unit Officer during the January 22-25, 2024 inspection advised bed/cell are maintained manually in the housing unit and not entered in the detention center JMS inmate management system.

Interviewed inmates reported that frequently inmates live in a bed/cell they are not assigned and housing unit staff rarely conduct inmate roster to identification cards to verify inmates are in the correct bed/cell. The report appears accurate as the majority of the inmates were not displaying identification and many interviewed inmates claimed they did not have an identification card.

A classification staff person advised reclassifications for inmates are conducted every 90 days and after special events (i.e. incidents, disciplinary reports, new criminal charges); however, the reclassification is not done face to face due to staff shortages.

Inmate Security Threat Group affiliation and involvement is not a classification responsibility. STG is the responsibility of a lieutenant who advises classification staff inmates to be moved from one housing unit to another because of STG issues. Classification does not maintain a STG list and an alert is not entered in the JMS management system to identify an inmate's STG affiliation. The November 30, 2023 South Carolina Department of Corrections ASGDC Inspection revealed Standard

1082-Pretrial and sentenced females are being housed together in violation of the standard.

7. PREA (Sexual Assault and Sexual Abuse)

ASGDC Policy 2A-29 Sexual/Assault Information and Policy establishes inmates receive information regarding sexual abuse/assault upon arrival at the detention center.[54] ASGDC policies, procedures and practices do not mandate zero tolerance toward all forms of sexual abuse and sexual harassment. The policies and procedures are insufficient in preventing, detecting, and responding to such conduct. The United States Department of Justice Final Rule for the Prison Rape Elimination Act (PREA) was finalized in May of 2012.[55] ASGDC Policy 2A-29 Sexual/Assault Information and Policy was last revised April 11, 2011 and last reviewed on February 24, 2024 last approved by Director Harvey on February 28, 2023[56]. Also see Section II.G.16 for expert's discussion of the responses to the November 30, 2023, SCDC Inspection.

Discussions with housing unit detention officers during the inspection revealed they have the authority to move inmates from bed/cell to bed/cell. ASGDC does not utilize their Prison Rape Elimination Act screening instrument to place inmates in

[54] ASGDC Policy 2A-29 Sexual Abuse/Assault Information, effective April 1, 2011.
[55] Prison Rape Elimination Act. Prison and Jail Standards. United States Department of Justice Final Rule. 28 C.F.R. Part 115 Docket No. OAG-131. RIN 1105-AB34. May 17, 2012.
[56] Richland County March 15, 2024 Response to the November 30, 2023 South Carolina Department of Corrections Inspection.

beds and cells. Discussions with ASGDC staff, inmate interviews, and review of documents demonstrated a pattern and practice of failing to protect inmates from harm as it relates to sexual abuse and sexual assault. ASGDC does not appear to conduct follow up monitoring after the initial inmate Sexual Aggressor/Vulnerability PREA Screening Checklist. ASGDC is not certified in compliance with DOJ PREA and the forty five (45) required standards.

8. Restrictive Housing Units (RHU)

The ASGDC BMU housing unit is utilized as the detention center segregation unit. The BMU housing unit was inspected during January 22-25, 2024 inspection. The housing unit was recently renovated re-opened in January 2024. The renovation includes a secure control center where the detention officer will be stationed resulting in the housing unit having Indirect Supervision in violation of the *Minimum Standards for Local Detention Facilities in South Carolina* Standard 1005 (w), 7/16/2013 Version. ASGDC was designed for operation with Direct Supervision Management. The applicable ASGDC Restrictive Housing Unit policies and procedures have not been revised to reflect the BMU operations.

The BMU has 56 cells with a rated capacity of 56 inmates. The population of the BMU on January 23, 2024 was 65 inmates with multiple cells having double occupants. *Minimum Standards for Local Detention Facilities in South Carolina* Standard 2017-4 requires single cells for inmates assigned maximum security unless it has been determined through classification, screening, and evaluation that it is not

necessary for specific inmates who are identified as suitable for shared housing.[57] ASGDC does not conduct classification, screening, and evaluation that it is not necessary for specific inmates who are identified as suitable for shared housing as classification staff advised they do not determine inmate bed/cell assignments. ASGDC staffing has one (1) officer designated for the BMU security post. The population of 65 found during January 22-25, 2024 inspection exceeds the 56 rated capacity and required the assignment of two (2) officers.[58]

Interviewed inmates complained during the January 22-25, 2025 that inmates in segregation do not receive outside recreation one (1) per hour per day five (5) days a week. A review of the BMU logbooks and tour watch documentation indicated detention officers consistently and routinely do not conduct [redacted] safety and security checks as required by ASGDC Policy 2A-03.IV Security Housing Units Officer Post Location and Policy 2A-52.I Observation of Special Management.[59] [60]ASGDC 2A-45 Security Transfer to Restrictive Policy requires [redacted]. If

[57] *Minimum Standards for Local Detention Facilities in South Carolina* Standard 2017-4. Revised July 2013.
[58] *Minimum Standards for Local Detention Facilities in South Carolina* Standard 1005 (w), 7/16/2013 Version.
[59] ASGDC Policy 2A-03.IV Security Housing Units Officer Post Location, effective July 1, 2011.
[60] ASGDC Policy 2A-52.I Observation of Special Management, effective November 1, 2011.

contraindications or accommodations are noted, the healthcare professional will notify the appropriate facility staff. The policy does not prohibit inmates with contraindication from being assigned to the BMU and/or the license level of the healthcare professional conducting the assessment.

ASGDC records indicate inmates with serious mental illness are routinely placed on segregation status and do not receive required mental health services while on the status. Mr. Kitchens also testified in his deposition that during his tenure seriously mentally ill inmates were housed in the SHU and suicide watches were conducted in the SHU for the time frame of September 2021 until April 2022.[61] Mr. Kitchen also testified that while serving as interim director from 2021 to 2022 he discovered a lieutenant was using SHU showers to house inmates for days. The showers were not equipped to be utilized for housing and did not have toilets for body functions.[62] The ASGDC Restrictive Housing Unit policies, procedures, and practices are insufficient to protect inmates from harm.

9. Security Threat Groups - A discussion was held with the lieutenant responsible for managing the ASGDC STG Program during the January 22-25, 2024 inspection. The lieutenant maintained ASGDC has security threat group policies and procedures; however, a review of policies and procedures did not identify specific ASGDC policies and procedures related to security threat group management.

[61] Donald S. Kitchens January 30, 2024 Deposition Page 110 Lines 3-21.
[62] Donald S. Kitchens January 30, 2024 Deposition Page 123 Lines 13-25.

A review of ASGDC incidents from September 2022 through December 2023, discussions with ASGDC staff and inmate interviews revealed the detention center has a large number of inmates affiliated with security threat groups. ASGDC incidents reveal a high number of incidents involved inmates affiliated with security threat groups and these inmates intimidate, extort and assault other inmates. In Mr. Harvey's December 2023 deposition, he estimated that 85 percent of inmates were affiliated with an STG[63]. ASGDC does not have policies, procedures and practices to protect inmates and staff from harm as it relates to the management of inmates affiliated with and members of STGs.

10. Use of Force by Staff

Unnecessary or excessive use of force - Interviews with inmates and review of discovery documents revealed allegations of staff excessive and unnecessary use of force. A review of incident reports revealed actual excessive and unnecessary use of force incidents. The rate of use force by ASGDC staff on inmates is very high. A review of incidents reveals strong evidence of unnecessary and excessive: physical force, chemical munitions, EDD gloves, tasers, and the restraint chair.

Restraint chair - ASGDC incident reports indicate a lack of compliance with Use of Restraint policies and procedures as it relates to use of a restraint chair. According to incident reports and inmate interviews the restraint chair is frequently utilized by ASGDC when there is no space available, when less restrictive interventions have not

[63] Crayman Harvey December 15, 2023 Deposition Page 330 lines 5-6.

been attempted and for extended periods of time. These practices are in violation of ASGDC's policy 2B-03 *Security Use of Four/Five Point Restraints* (effective March 1, 2011) which states:

"[redacted]:

a. [redacted].

b. [redacted].

c. [redacted]"[64]

Use of force procedures and reporting - There is evidence ASGDC staff fails to report all uses of force. On the January 22-25, 2024 ASGDC inspection I observed two (2) use of force incidents: 1) January 22, 2024 X Ray involved a female inmate having to be guided back in her cell by a detention sergeant and 2) In Intake January 25, 2024 a male officer detention officer having to physically remove clothing from a male inmate. The force appeared necessary and appropriate; however, it did not appear ASGDC viewed the incidents as force. ASGDC use of force procedures did not appear

[64] 2B-03 *Security Use of Four/Five Point Restraints* (effective March 1, 2011)

to be followed: i.e. immediately take the inmates to medical, notify a supervisor, prepare incident reports. These procedures were not observed by the expert inspection group. The intake officer advised an incident report was not necessary for the incident where he physically removed the inmate's clothes. ASGDC staff never requested expert inspection group members prepare and submit a witness statement for the two (2) incidents witnessed.

ASGDC does not have an Early Warning System to monitor employees and inmates involved in use of force incidents. ASGDC failing to consistently conduct administrative investigations also results in staff not being held accountable for performing their duties and responsibilities in accordance with policies and procedures at all levels.

11. Inmate Disciplinary System

ASGDC has multiple policies and procedures related to inmate rule violations and disciplinary procedures. The identified policies and procedures are:

3A-01Rules of Detainees
3A-2 Disciplinary Procedures
6C-01 Resolution of Minor Infractions
6C-02 Criminal Violations
6C-03 Disciplinary Reports (Ref to 3A-02)
6C-04 Disciplinary Reports/Information (Ref to 3A-02
6C-05 Investigative Timing for Rules Violations
6C-06 Pre-Hearing Detention/Review
6C-07 Pre-Hearing Actions
6C-08 Detainee's Presence at Hearing
6C-09 Disciplinary Hearing
6C-10 Postponement or Continuance of Hearing
6C-11 Conduct of Hearing
6C-12 Conduct of Hering, Defense by Detainee
6C-13 Conduct of Hearing, Detainee Assistance at Hearing
6C-14 Conduct of Hearing, Disciplinary Decision

6C-15 Record of Hearing
6C-16 Record of Hearing, Found Not Guilty
6C-17 Record of Hearing Disposition
6C-18 Appeal

The policies establish the disciplinary procedures governing inmate rule violations and to provide written guidelines to ensure that inmate control and discipline are established and maintained in accordance with the following objective: 1) require individual inmate compliance with reasonable behavior standards and limitations, 2) ensure the general welfare and safety of all persons living and working within the institution, 3) establish and maintain fair disciplinary procedures and practice based on due process and 4) ensure progressive levels of discipline are practiced. The policies are intended to describe the inmate disciplinary system used by the detention center to enforce institutional rules and regulations. The policies are designed to meet requirements of the American Correctional Association. Performance Based Standards for Adult Local Detention Facilities, Fourth Edition and *Minimum Standards for Local Detention Facilities in South Carolina,* July 26, 2013 Version.[65]

The SCDC August 7, 2023 Security Audit Report noted that the ASGDC Security and Emergency Response Team Captain was not aware the detention center had policies for inmate Rules and Disciplinary Procedures. The Captain even stated, "there are no

[65] ASGDC Policies and Procedures 3A-01, 3A-02 and 6C-01 through 6C-18.

guidelines for inmate disciplinary penalties".[66] The Captain's comments raise questions as to whether an inmate disciplinary system is actually in place.

There are no provisions to protect seriously mentally ill inmates charged with rule violations. The ASGDC policies do not establish that mental health professional, preferably the treating clinician, is consulted for inmates diagnosed with a mental illness or mental disability, or demonstrates symptoms of mental illness or mental disability to provide input as to the inmate's competence to participate in a disciplinary hearing, any impact the inmate's mental illness may have had on his or her responsibility for the charged behavior, and information about any known mitigating factors in regard to the behavior for detainees.

12. Grievance System

ASGDC has inmate grievances policies and procedures. The detention center inmate Guidebook includes the procedures for inmates to submit grievance and receive staff responses. Inmates can submit complaints utilizing paper or electronically utilizing a housing unit inmate kiosk. Inmates complained during interviews conducted during the January 22-25, 2024 inspection their grievances are not responded to timely or not at all.

A sample of grievances were reviewed and a number of staff responses were nonresponsive or inadequate including a number that were serious placing inmates potentially at risk of harm. An example of a very problematic response was an IP 438

[66] August 7, 2023 SCDC Security Audit Report SCDC 000154 and SCDC 000155.

on November 10, 2020 alleging complaining in Issue ID 21728268[67], "room 16 raped me". The captain staff response on November 12, 2020 was, "not a grievance". The grievance was closed the same day. ASGDC has initiated a new electronic grievance system, however it has not been fully implemented and staff and inmates have not been trained in its utilization.

13. Physical Plant

ASGDC inmates are subjected to deplorable and unacceptable conditions of confinement that can negatively impact their physical and mental health. These conditions have continued for years without correction as a result of a lack of supervision, prolonged periods of confinement, and a lack of consequences. The maintenance issues observed in the Plaintiff Expert Inspection conducted January 22-25, 2024 include multiple electrical and plumbing issues such as non-operational housing unit/cell sinks, toilets, showers, and lights. Standing water, inability to access drinking water and a range of sanitation problems are unacceptable conditions of confinement and expose inmates to extreme and dangerous harm. The conditions observed during the expert inspection were corroborated by SCDC annual inspection results, Coley Rushton security audit and inmate interviews. 448 cell door locks at ASGDC are being replaced at a cost of 2.5 million dollars. Replacement of the locks is commendable; however, ASGDC failing to have sufficient staff to supervise and control inmates will provide the opportunity for them to

[67] Bates County 38781

damage and break the replaced locks making this large expenditure to protect staff and inmates a potential failure.

Interviews with ASGDC staff, inmates, review of documents including SCDC annual inspection findings demonstrate ASGDC has a pattern and practice of failing to comply with their own policies and procedures and operate a safe and secure detention center, protecting inmates from harm as it relates to their facility physical plant.

14. Environmental Health

A. Policy - ASGDC does not comply with but no limited the following policies related to environmental health:

- 1A-01 Sanitation Inspections
- 1A-04 Facility Housekeeping
- 1A-11 Room/Cell Furnishing
- 1A-14 Facility and Cell Lighting

A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC has serious environmental health deficiencies placing inmates and staff at risk of harm.

A qualified ASGDC inspector does not conduct quality sanitation inspections of all the detention center areas. A safety and sanitation specialist does not conduct a quality comprehensive and thorough monthly inspection. ASGDC does

not ensure a healthy and sanitary living and working environment for inmates and staff exists by maintaining sanitation practices that comply with ACA standards, local, state, and federal health and sanitation codes.[68] ASGDC is not clean and not in a state of good repair.

Housekeeping and maintenance plans routinely and consistently fail to provide daily housekeeping and regular maintenance by assigning specific duties and responsibilities to staff and inmates. ASGDC has been unsuccessful in maintaining clean and sanitary conditions. The building and equipment are not maintained in good condition and repair.[69] All inmates confined in cells are not afforded access to an operable sink and toilets.[70] The ASGDC policy allowing the detention center to assign more than the rated capacity of two (2) inmates per cell during periods of overcrowding does not comply with *Minimum Standards for Local Detention Facilities in South Carolina* Standard 2012 Rated Capacity.[71] ASGDC has multiple cells with inoperable lights in violation policy that requires light levels in cells/rooms are least 20 foot candles in personal grooming areas and at writing surface.[72] In fact, ASGDC has a high number of cell with lights not working. Also see Table 3 herein for expert's observation of broken lights.

[68] ASGDC 1A-01 Sanitation Inspections, effective January 1, 2011.
[69] ASGDC 1A-04 Facility Housekeeping, effective January 1, 2011.
[70] ASGDC 1A-11 Room/Cell Furnishing, effective January 1, 2011.
[71] *Minimum Standards for Local Detention Facilities in South Carolina,* July 26, 2013 Version.
[72] ASGDC 1A-14 Facility and Cell Lighting January 1, 2011.

15. Fire Safety

A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC staff has dangerous fire safety deficiencies placing inmates, staff and the public at risk of harm. The November 30, 2023 South Carolina Officer of the State Marshall identified twenty-six (26) serious fire and safety deficiencies. The majority of the same serious deficiencies were observed during the January 22-25, 2024 Plaintiff Expert ASGDC Inspection: exposed wiring, fire extinguisher not inspected, detention office failure to conduct inspections when fire alarms were activated, management unfamiliar with fire suppression systems. The ASGDC Compliance Director reported detention center is without a designated trained and qualified fire and safety officer.

The importance of a fire and safety program to protect inmates and staff from is reflected in the number of incidents involving fires at ASGDC from September 2022 to December 2023:

Table 13

	Number of Incidents	**Incidents Per Day**
September 2022 – March 2023[73]	33	0.19
March 2023 – June 2023[74]	20	0.27

[73] 199-Incidents (09-21-22 through 03-15-23)
[74] Incidents from 3/15/2023 to 6/15/2023

July 2023 – December 2023[75]	47	0.21
Total September 2022 – December 2023	**100**	**0.23**

ASGDC does not practice fire prevention to ensure the safety of staff, inmates and visitors. Practices do not provide for prevention and prompt control of fire and safety and the safety of the staff, inmates and visitors.[76] A review of the documents including independent inspections, the January 22-25, 2024 inspection observations, conversations with staff and inmate interviews reveal ASGDC is not in compliance with their Fire Safety and Prevention Inspection Policy.

ASGDC does not appropriately conduct comprehensive and thorough monthly inspections of the detention center by a qualified fire and safety officer for compliance with safety and prevention standards. Quality weekly fire and safety inspections of the detention center are not completed by a qualified staff member. Fire and safety equipment is not tested at least quarterly.[77] In addition, there is no "panic" button in cells to notify someone of an emergency when no officer is present in the unit. The dire ASGDC staffing shortages make the detention center fire and safety deficiencies more critical as insufficient security staff are on duty to respond to fire and safety emergencies including unstaffed housing units.

[75] Incidents from 7/6/2023 to 12/28/2023
[76] ASGDC Policy 1C-08 Fire Safety, effective January 1, 2011.
[77] ASGDC Policy 1C-09 Fire Safety, effective January 1, 2011.

16. ASGDC Management

ASGDC has been in a state of crisis for years with conditions continuing to deteriorate, exposing inmates and staff to harm. Richland County and ASGDC efforts to mitigate the harm to inmates and staff have been unsuccessful. The Richland County response to the November 30, 2023, South Carolina Department of Corrections Inspection provides further evidence ASGDC is ill prepared to correct the dangerous conditions that began in March 2018[78]. Former ASGDC Assistant Director Donald S. Kitchens testified in his deposition that in March 2018, the detention center was 80-120 officers short and he became concerned with safety and quality of security. ASGDC began experiencing increased violence and discovery of dangerous contraband described as fabricated weapons and drugs.[79]

A review of the March 15, 2024, Richland County responses to the November 30, 2023, South Carolina Department of Corrections Inspection found inadequate responses to the following *Minimum Standards for Local Detention Facilities in South* Carolina non-compliant standards. Among these deficiencies are, but are not confined to, the following instances:

[78] Richland County March 15, 2024 Response to the November 30, 2023 South Carolina Department of Corrections Inspection.
[79] Kitchens January 30, 2024 Deposition Page 39 Lines 3-20

A. **1005-Definitions: (h) Holding Cells**

Finding: "Holding cells in the intake area are frequently used to house inmates for more than six hours for observation etc. in violation of this Standard."

Response: “Richland County recognizes the importance of ensuring detainees are classified out of intake within a six-hour time period. Currently Alvin S. Glenn Detention Center (ASGDC) has an influx of detainees with mental health issues that require close monitoring. This population of detainees may require a uniquely quick response, depending on their condition. ASGDC has taken the position of placing these detainees in intake for monitoring, until it can be established that they are not in mental health crisis. ASGDC is actively moving forward with plans to create safe cells within Behavior Health Unit {Mike) that will house detainees who may be in mental health crisis rather than having them in intake. This project is part of the overall physical plant renovations in progress at ASGDC.

Additionally, bond hearings for crimes with victims only happen once a day, by design of the Magistrate Judge and the Solicitor's Office. In complying with Constitutional Victim's Rights Amendments, inherently Defendants who are charged with victim-based crimes may be kept in holding longer than six hours, depending on their arrest time and the next time a bond hearing is set where victim notification is required.”

ASGDC’s response does not ensure inmates in Intake do not remain more than six (6) hours. The response does not address that inmates are crowded in holding

cells for more than six (6) hours without any formal review to safely assign inmates to holding cells. The holding cells are temporary and do not have beds for sleeping. The plaintiff experts observed inmates that had been in holding cells for days sleeping directly on the floor. The proposed plan action to create safe cells for inmates in mental health crisis does not include time frames to implement the safe cells.

B. **1005 - Definitions: (w) Direct Supervision**

Finding: "This facility was designed for operation with Direct Supervision Management. Due primarily to staffing shortages Direct Supervision Management is not taking place. In some cases, one officer is supervising two housing units."

Response: “Richland County recognizes the importance of creating a safe and secure environment at ASGDC for detention officers and detainees located in housing units, along with establishing and maintaining safety protocols that help mitigate security breaches. There is a national staffing crisis that is affecting detention and correction facilities across South Carolina. Richland County is not unique in facing this crisis. However, Richland County is unique in the number and variety of initiatives it has implemented in addressing the staffing shortage. Richland County has previously shared the details of its recruitment and retention plan for ASGDC, to include: a fulltime dedicated recruiter, implementing on the spot hiring (contingent on successful

background screenings), Increasing the minimum starting salary from $32,000 to $36,500 to $40,000, to approximately $45,000, implementing $1,000 employee referral bonus, Implementing a $5,000 new hire bonus, Implementing a $5,000 retention bonus, Implementing a $2,000/month stipend for Detention Officers classified as Exempt, Implementing a pay plan that rewards years of continuous service, Implementing a pay plan that rewards education and certification attainment, Implementing a pay plan that pays for performance and anticipates an annual percentage increase, Implementing a pay plan that allows detention supervisors previously classified as FLSA-Exempt to earn overtime wages, and Contracting for additional security staff through an agreement with Allied Universal.

The creation of a secured control room within each housing unit will allow ASGDC staff to safely operate and warehouse security cameras and cell door electronic management controls within the unit. This will increase the safety and security of officers and detainees within the housing unit, by physically preventing available access to security equipment that only staff should have access to. Richland County's plan anticipates staffing a person to manage each control room and separately assigni~~ng~~ a detention officer to monitor the housing unit. Richland County believes adding a secured control room within each housing unit will enhance officer and detainee safety."

ASGDC's response is inadequate only discussing plans for the detention center to address non-compliance. However, it neglects to address the immediate

need for ensuring that current procedures and practices align with the required standard of direct supervision, which is currently not occurring.

C. **1021- Manual of Policies and Procedures**

Finding: "Policies and procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis, and documentation should be retained as to all dates when the policies/procedures were reviewed."

Response: "ASGDC policies are undergoing review by the Facility Manager/Detention Center Director. Policies that have been reviewed and approved by the Detention Center Director have been forward to the ASGDC Training Administrator to conduct training with staff. All policies will be loaded into and maintained in Power DMS. All detention officers have access to policies through Power DMS. Policies will be regularly reviewed, at least on an annual basis. ASGDC Compliance Director Lipscomb provided SCDC lnspector(s) with access to the detention center's Power DMS site for the purpose of reviewing the policies and procedures as they are updated."

ASGDC's response is inadequate. The response does not provide an explanation why the detention center practices do not align with policies and procedures. The plan of action does not have time frames for when the deficiencies will be corrected and how they will be sustained.

D. **1022 Emergency Pre-Planning**

Finding: "Policies and procedures need to be reviewed and updated to reflect

current operations at the facility. This should be done on a regular ongoing basis, and documentation should be retained as to all dates when the policies/procedures were reviewed."

Response: "AII emergency situations will be addressed initially by utilizing the lncident Command System methodology, after which the policies/procedures on Power DMS will be followed. These policies/procedures will be reviewed and updated on a continuous basis in Power DMS with staff interaction."

The ASGDC response is inadequate; failing to verify the emergency policies and procedures reflect current detention center practices.

E. **1031 Number of Personnel**

Finding: "The facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded to enable proper facility operation, and recruitment and retention of employees must also be improved. At the time of the inspection, several housing units were closed due to the staffing shortage or repairs."

Response: "While we have experienced improvements in hiring detention officers, Richland County is experiencing the same challenges with recruiting and retaining detention personnel as similarly situated law enforcement agencies locally, regionally, and nationally. The Facility Administrator/County Administrator approved additional personnel for ASGDC and Richland County

Council authorized funding to enable proper facility operation and recruitment and retention of employees. No housing units are closed due to staffing shortages. Any housing unit that is closed at this time is solely for the purpose of being renovated."

The ASGDC response is inadequate and not accurate. The response does not address what the detention center is doing to mitigate the lack of staff to supervise inmates thereby protecting staff and inmates from harm. Housing Units and other areas of the detention center routinely and consistently do not have required staff supervision to protect inmates from harm.

F. **1065-Facility Security**

Finding: "Some of the cell and passage door locks in Phase Ill (and elsewhere in the facility) are malfunctioning and need to be repaired or replaced."

Response: "ASGDC has previously shared its plan to renovate all the locks within each housing unit. It ii unfortunate that some of the detainees housed in ASGDC do not treat the housing unit with the appropriate level of care and concern that would allow for a routinely clean and fully functional housing unit. Far too often, ASGDC is being required to repair cell doors and repetitively replace locks that are malfunctioning due to detainees intentionally compromising the locking mechanism. In an effort to better prevent detainees from causing the cell locks to malfunction in any unit, each housing unit will have its pneumatic locks removed and replaced with an upgraded locking

mechanism known as the Willa Wedge locking system. This renovation project is already well underway with lock replacements completed in five (5) housing units. So far, 252 locks have been fully upgraded out of the 448 locks scheduled to be removed and replaced, representing a 56% project completion rate. With only four (4) housing units remaining in this initial lock renovation project, Richland County is excited about the progress of this safety and security initiative."

The ASGDC response is inadequate and does not address the current procedures and practices the detention center is utilizing fail to protect staff and inmates from harm due to malfunctioning door locks.

G. **1082-Classification Categories**

Finding: "Pretrial and sentenced female inmates are being housed together in violation of this Standard; [and] Due to the fact that all female inmates (both sentenced and pre-trial) are housed in the same living unit, they are not being afforded the same privileges as the male inmates are."

Response: "As a part of ongoing renovations, ASGDC has designated two housing units (Delta & Juliet) for the female population. ASGDC will follow established security protocols to prevent any interaction between pretrial and sentenced female inmates, as mentioned in the inspection report."

The response is inadequate failing to describe the procedures that will be utilized to ensure the sentenced and pretrial females will be separated and the

procedures to house inmates by their risk and needs.

H. **2012-Rated Capacity**

Finding: "Two former housing units, T-1 and T-2 have not been utilized for housing in several years and there are no plans to use this building for housing in the future, so these two housing units have been removed from the official rated capacity of the facility."

Response: "On April 17, 2023, Compliance Division Director Blake Taylor, Jr. was notified in writing that Richland County acknowledged the loss of bed space in Tango Unit, as the unit would be remodeled to establish an Attorney-Client Visitation Center. This renovation project will significantly increase the safety and security of visits for both attorneys and detainees. Attorneys who want to visit their clients in person will no longer have to enter into a housing unit, with multiple detainees present in the same space. Detainees will be able to have confidential discussions with their attorneys. The center will have non-contact visit rooms and contact visit rooms, and they will be designed to be ADA accessible."

The response is inadequate; failing to address the detention center currently has insufficient beds for its population. The detention center inmate population has increased in the last 12 months from approximately 750 inmates to over 900 in January 2024. ASGDC has provided no detailed, reasonable and sound operational plan to address their insufficient bed capacity.

I. **2014-1- Special Purpose Cells**

Finding: "The male Special Purpose cell(s) are in Housing Unit P (Poppa). Construction of the cell(s) to dayroom separation (walls) are primarily glass or Lexan and provide direct sight from a twenty-four (24) hour staff position. All female inmates are now housed in Unit X. Inmates housed for Special Purpose reasons (suicide watch, etc.) are placed in cells in this unit that do not provide staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position."

Response: "ASGDC is currently fully renovating both units Papa and X-Ray. Male inmates that under the guidelines of special purpose cells are housed in the Behavior Health Unit, Unit Mike, Intake, or the Behavior Management Unit (BMU). The indicated units are staff accordingly."

The ASGC response is inadequate failing to address what is in place currently to provide special purpose cells for female inmates. To protect both males and females from harm, safe and sanitary special purpose housing must always be available. It is not.

J. **2014-2-Fire Codes**

Finding: "Several items that were noted by the Deputy State Fire Marshal need to be addressed.

The fire apparatus access road that encircles the complex needs to be maintained to be accessible in all weather conditions as per the requirements

of the South Carolina Fire Code, Sections 503.2.1 through 503.2.8."

Response: "ASGDC has listed the fire apparatus access road on its capital projects list to be budgeted for repair and maintenance. Responses to the Inspection from the Office of State Fire Marshal are included as attachments to this letter."

The ASGDC response is inadequate. The response does not address what action has been implemented to ensure necessary fire protection until the access road is repaired and maintained.

K. **2014-7-7 Security**

Finding: "Several security issues were noted during the inspection as follows: Lack of lighting in bathrooms presents a security hazard to inmates (i.e. contact with other inmates, safety hazard due to slips/falls, etc.), Female inmates in one of the housing units stated that a male inmate had entered the housing unit through the ceiling. This must be investigated in order to identify and seal a possible security breach, Inmates in several housing units reported that the Count, which is scheduled for certain times during the day was being conducted by an inmate due to the absence of an officer on the unit, presumedly due to staffing shortages."

Response: "1) ASGDC is fully renovating all housing units to include replacing old light fixtures with new lighting units. 2) All housing units have been checked by staff and any deficiencies/breach of security have been repaired by

the onsite contractor. Additionally, a second layer of fencing has been installed on the perimeter of ASGDC. Detention Center personnel conduct the Count, we do not have inmate workers performing security work."

The ASGDC response is adequate. The response does not describe procedures and practices that will be utilized to sustain the corrective action.

L. **2014-40-Maintenance**

"Finding: "Numerous maintenance related violations were noted during the building tour."

Response: "Richland County recognizes that deferred maintenance has resulted in the need for repairs and replacements at ASGDC. The full renovation of each housing unit will address the concerns noted in this section of the report."

The ASGDC response is adequate. The response does not describe procedures and practices that will be utilized to sustain the corrective action.

M. **2072-Laundry**

Finding: "Laundering of inmate uniforms etc. are occurring once a week in violation of this standard."

Response: "ASGDC launders inmate uniforms more than once a week. Laundry is routinely done three (3) times per week."

The ASGDC response is inadequate. The response provides no description of how required laundry services meet the standard.

N. **2074-Personal Care Items**

Finding: "Personal hygiene items were said to not be available at all times. When these items were available damaged or missing plumbing fixtures or improper lighting etc. in the bathrooms made use of the items was difficult."

Response: "Scheduled renovations for the facility will address lighting and plumbing issues. Indigent persons needing Personal Care Items need only to follow the established procedure -the commissary kiosk-for requesting an indigent packet and one will be provided to qualifying requestors."

The ASGDC response is adequate. The response does not describe procedures and practices that will be utilized to sustain the corrective action.

The Richland County and ASGDC inadequate responses to the November 30, 2023 South Carolina Department of Corrections demonstrate a failure by management to recognize the dire and serious harm inmates and staff are being exposed to at the detention center. The responses exhibit unacceptable inaction to mitigate the harm. The facility is critically short staffed, preventing necessary inmate supervision. The detention center is over capacity by approximately 400 beds with policies and procedures that do not reflect actual detention center practices. Classification policies, procedures, and practices are not properly utilized to house inmates based on their risk and needs. The inmate disciplinary system is not functioning, and the grievance systems are not fully implemented for inmates to address complaints. The detention center physical plant has life threatening fire/safety and maintenance deficiencies placing inmates and staff in harm's way. ASGDC consistently does not

provide inmates with access to operational sinks, toilets and lights.

Management has not been proactive by having criminal justice assessments and jail population projections conducted to develop an overall Richland County criminal justice strategic plan. The actions that Richland County has implemented are also insufficient to ensure improvements are sustained over time. An example is spending millions on a door repair project when the detention center does not have the necessary staff to supervise inmates and prevent them from damaging the newly replaced locks, thus placing inmates and staff at risk of harm again. A reactive culture must be replaced with a proactive culture for the detention center to begin operating safely and maintain sustained safe operations.

III. Conclusions

My conclusions are that ASGDC is failing, and for years has failed, to protect men and women confined there from inmate-on-inmate violence, inmate-on-inmate sexual abuse, staff on inmate excessive and unnecessary use of force, and to provide safe and sanitary living conditions. These failures do occur in other correctional facilities, however, the extent and magnitude of these failures by ASGDC sets it apart. The operational and security deficiencies, hazardous physical plant conditions, and denial of basic life necessities in totality are unique to Alvin S. Glenn Detention Center. My specific factual determinations are:

A. The detention center has been consistently out of compliance with multiple Minimum Standards for Local Detention Facilities in South Carolina standards and South Carolina Office of the Fire Marshall fire safety codes.

B. The inmate population is not reasonably supervised to ensure their safety and access to basic needs (water, food, medical, and mental health).

C. The fire safety program is inadequate and multiple fire safety deficiencies are present placing staff and inmates at risk of harm. Required fire protection is not provided inmates and staff.

D. The number of staff to provide safety and security for inmates and staff is insufficient. ASGDC does not have the necessary security staff to protect inmates and staff from harm.

E. The inmate population consistently exceeds its rated and operational capacity. ASGDC is unable to provide required programs and services and protect inmates and staff from harm because the inmate population exceeds the detention center operational capacity.

F. Inmates and Staff are subjected to violent assaults due to unsafe conditions and inadequate security at the detention center.

G. The detention center has deficient cell and door locks that cannot secure inmates resulting in unsafe conditions for inmates and staff including violent assaults.

H. Inmates are confined in cells without operating toilets, sinks, and lights.

I. The detention center is utilizing Indirect Supervision and is designed for Direct Supervision.

J. Staff hiring, training, and supervision are inadequate.

K. Policies and Procedures are inadequate and/or do not exist to operate the detention center safely and securely. ASGDC's existing policies are written to comply with American Correctional Association (ACA) standards and *Minimum Standards for Local Detention Facilities in South* Carolina, however the policies lack specificity and do not contain all required elements.

L. The classification system is not functioning to manage inmates' risk.

M. Unnecessary and excessive force is routinely utilized by staff on inmates.

N. The sexual assault prevention program does not protect inmates from sexual abuse and sexual assault.

O. The inmate admission/intake process does not meet industry standards and/or comply with the existing ASGDC policies and inmates are confined in the area for unacceptable length of stays (days).

P. The environmental health program is inadequate and multiple environmental health deficiencies exist.

Q. The restricted housing unit (segregation) is utilized to house seriously mentally ill inmates and does not provide industry standard conditions of confinement. Inmates are not provided due process when placed and retained in the restrictive housing unit.

R. The inmate disciplinary system does not ensure all inmates receive due process.

S. The contraband control program routinely and consistently fails to prevent contraband from being introduced in the detention center and possessed by inmates.

T. The existing search program routinely and consistently fails to search inmates and detention center areas necessary to control contraband.

U. A formal security program to manage security threat groups (gangs) does not exist;

V. The existing grievance system is inadequate to provide inmates with a mechanism to submit and address their complaints.

W. My corrections work experience and training has consistently found correctional facility operational and security deficiencies have a greater negative impact on seriously mentally ill inmates because of their increased needs for programs and services to provide them safety and protection from harm. I found this to be particularly true at ASGDC.

IV. Urgent Threats to Harm

A. The threats to inmate harm are serious and ongoing. The county has been aware of them for years.[80] Every day they continue exposes even more men and women to harm.

B. ASGDC housing inmates in cells without operational sinks or toilets is unacceptable and must cease immediately. Depriving inmates of access to water for drinking and hygiene and toilets for bodily functions places inmates at serious risk of harm from unsanitary conditions, dehydration, and disease. The lack of an operational sink and/or toilet can harm inmates' physical and mental health. There is no shortage of factual evidence that shows the extent of the problem. The Expert Toilet Inspection that found X-Ray housing unit had 12 of 56 (22%) toilets, 26 of 56 (46%) sinks and 54 of 56 (96%) lights inoperable.

[80] Bates County 0144921 to 0144925, Richland County administrator's Town Hall Meeting with ASGDC employees, July 21, 2021.

Richland County's own toilet and urinal inspection, also conducted in January 2024, identified serious maintenance issues regarding operational toilets and urinals, revealing that ASGDC operational housing units had 104 of 315 toilets or thirty-three (33) percent that were inoperable and 14 of 18 urinals or seventy-eight (78) percent that were inoperable. The practice of placing inmates in cells where lights are non-operational for weeks at a time, along with exposed electrical wiring places inmates at risk of harm. *(See Expert Report II.C.5).*

C. ASGDC's failure to supervise inmates places them at serious risk of harm and must cease immediately. The facility is being operated with indirect staff supervision. The ASGDC physical plant design and policies are for the facility to be operated as a direct supervision jail. Housing Units go for hours without staff supervision resulting in serious risk of harm to include but not limited to access to medical and mental health care. ASGDC has not implemented an immediate plan of action to mitigate the risk of harm to inmates. The evidence of staff failing to appropriately supervise housing units is verified by reviewing electronic rounds documentation and housing unit logbooks. ASGDC has not implemented any immediate action to mitigate the lack of continuous supervision of inmates in the housing units and ensure that staff make rounds in the housing units a minimum of two (2) times per hour. *(See Expert Report II.F.1-2)*

D. Men and women in housing unit cells throughout the facility and in intake cells are confined in their cells over twenty-two (22) hours a day under restrictive housing unit conditions of confinement with little to no access to programs and services. Most of the inmates are confined in this manner due to inadequate supervision. The majority of

these inmates have not been afforded due process to restrict their out of cell time and programs and services provided to general population inmates. *(See Expert Report III.G.8)* Too many are also confined in their cells over twenty-two (22) hours day without an operational sink and/or toilet. *(See Expert Report II.C.5)*

V. Closing Statement

My work in this matter is ongoing. My report summarizes my current opinions given the available information I have received to date. As additional information becomes available, I reserve the right to modify or supplement my analyses and opinions accordingly.

Emmitt L. Sparkman
Consultant/Expert

Date: April 29, 2024

Appendix I
Documents Reviewed

1. Prison Rape Elimination Act. Prison and Jail Standards. United States Department of Justice Final Rule. 28 C.F.R. Part 115 Docket No. OAG-131. RIN 1105-AB34. May 17, 2012.
2. American Correctional Association. Performance Based Standards for Adult Local Detention Facilities, Fourth Edition.
3. *Minimum Standards for Local Detention Facilities in South Carolina,* July 26, 2013 Version.
4. 2022-04-28 Plaintiff Complaint
5. 2022-06-13 Plaintiff Amended Complaint
6. 2024-01-30 Motion for Leave to File 2nd Amended Complaint
7. 199-Incidents (9-21-2022 through 3-5-2023)
8. 194 Confidential PREA Investigations (Bates County 88302 to County-89142)
9. 128-SCDC Inspection Reports 2018-2022 (Bates County 68636 to County-68699)
10. Incident Reports July-December 2023 (Bates County-166206)
11. Donald S. Kitchen January 30, 2024 Deposition
12. Crayman Harvey December 15, 2023 Deposition
13. ACH ASGDC Mental Health Site Manager Laurrinda Saxon-Ware January 2, 2024 Deposition
14. ASGDC Current Policies and Procedures (Bates County-161206 to Bates County-161943
15. Richland County Toilet Inspection Bates (County 168623 to County- 68632)
16. ASGDC BMU Logbook 1.17.2024 to 1.23.204
17. ASGDC BMU Logbook 1.7.2024 to 1.10.2024
18. ASGDC Golf Logbook 1.25 to 1.19.2024
19. ASGDC Hotel Logbook 1.25. to 1.20.2024
20. ASGDC India Logbook 1.25.2024 to 1.20.2024
21. ASGDC Juliet Logbook 1.25.2024 to 1.21.2024
22. ASGDC Mike Logbook 1.24.2024 to 1.15.2024
23. ASGDC Uniform Logbook 1.24.2024 to 1.14.2024
24. Advance Correctional Healthcare June 28, 2022 email to Richland County, SC. (Bates ACH_110723_000825).
25. Grievance Files for 13 Detainees-Redacted (Bates No. County-38612 to County-38799).
26. SCDC August 7, 2023 Security Audit Report (SCDC 000134 to SCDC 000179).
27. Alvin S. Glenn Overview and Improvement Plan (County 47620 – County 47645).
28. ASGDC March 15, 2024 response to SCDC November 30, 2023 Inspection Report.
29. ASGDC Classification Diagram provided during the January 22-25, 2024 ASGDC Inspection.
30. ASGDC January 24, 2024 Dormitory Head Count
31. July 2021 Minutes from Richland County Administrator Town Hall Meetings with ASGC Employees. Bates County 0144921 to County 0144925

Appendix II
Alvin S. Glenn Detention Center
Inmate
Identifier Codes

Inmate Name	Identifier Code
[redacted]	082
	081
	471
	079
	878
	078
	812
	889
[redacted]	243
	214
	923
	596
	320
	176
	947
	952
	466
	047
	994
	552
	430
	184
	222
	257
	438

Appendix III
Alvin S. Glenn Detention Center
Listing of Tables

EXHIBIT 22

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-BM **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. My name is [redacted]. I am 31 years old. I was detained and placed here at Alvin S. Glenn Detention Center on March 23, 2023. When I arrived at the jail, I was immediately terrorized. The guards were extremely rude and disrespectful. The intake cell had vomit, mold, urine, trash and insects everywhere. Once I came back from bond court, which I was denied a bond, I was very upset. I was then seen by a nurse who I informed of my medical conditions and whom verified I was pregnant by urine. I was then given a sandwich and taken back to a dorm called X-Ray. This dorm was inhumane. I was stripped in the intake from head to toe but was not provided with any bra, socks, shirt, panties, soap, deodorant, lotion or comb. I also kept my snow boots on and was not provided any shower shoes. On this day, a lady that going home soon provided me with a note pad because at this moment I knew I had to document my entire experience at this facility.

2. On 3-24-2023, I woke up to a rat running across the mat above my head. I was in room 22 and in this cell the lights didn't work, wires was hanging out of the ceiling, the help speaker button was removed with wires sticking out. Neither the sink nor toilet was working and

the cell had black bugs that crawled on the cracks of the walls and window seal. During my stay in X-Ray, I saw multiple spiders (big and small), frogs, snakes, rats, mice, flies, maggots and other unidentifiable creepy crawlers! I developed dark spots on my face, neck, arms and entire body. Some was boil-like bumps that leaked fluid, some itched, some hurt and some caused extreme pain. I was bit by what I believed to be a spider. I wrote multiple grievances complaining about the bites and I also informed each nurse that came in during med pass. I never received a proper diagnosis because my grievance was never formally answered.

3. On 5-8-2023, I asked the a.m. nurse about not getting my blood pressure meds yet. She informed me to place a sick call. I did the sick call on 5-8-2023. The sick call wasn't answered.

4. On 5-10-2023 I was brought from Unit Uniform to intake. OFC Church came to get me from this unit while OFC Harns was on duty. When I asked her what was I going up there for, she told me I will find out! Once I got there to intake, OFC Clark and OFC Gold wire were the main 2 officers in contact with me. OFC Clark placed me in the cell with a man. Once Officer Clark left, the man said his name was Gregory and he was going to have fun. At this time, I was scared and stood at the window eating my food waiting on someone to walk back past so I could ask to be removed from this cell. During the time I was in there, Gregory touched me with his hand on my leg and ankle. He asked me to come closer and then he pulled out his white penis and started to masturbate. Shortly after I saw OFC Clark walk back past and I bammed on the door/window to let me out. He opened the door and OFC Goldwire was beside him. I told them I was scared and then OFC Goldwire told me to sit in the camera area in the red chair. He placed me next to another man which was a very scary moment although this guy didn't do anything to me. After about 2 hours, they took me back to the unit. I cried all night.

5. The next day I informed the a.m. OFC Montgomery of what took place. She was shocked and called Sgt. Summers to inform her of the info. I just told her. Sgt. Summer then called intake and spoke to Goldwire. Goldwire told her I was only placed in the cell with the man

for a short period of time. Sgt. Summers was very upset and she called back to the unit and advised OFC Montgomery to write the incident up on a yellow 31 paper. Montgomery did as told then she also gave me a grievance paper to write in detail about what took place. Once we both did the report, Lt. Walker then called me to his office. OFC Montgomery was in there with me. Along with Lt. Walker was OFC Goldwire and OFC Clark. Lt. Walker asked me was I okay with being recorded. I said no. I had a problem with it and I wanted my lawyer present. However, he told me he needed to record. He asked me questions about what happened and I told him. He asked me why didn't I tell Goldwire and I told him because I was scared so I told my female OFC. Oh yeah, I also went on 5-10-2023 to see the psych, Dr. Potter, after this incident occurred. I was still traumatized about what this man did to me. I'm traumatized about the staff's reaction the act that took place. I'm traumatized by people especially men!

6. I told Mrs. Potter along with Mrs. Lasiter the mental health counselor that comes in the mental health meetings about how I have the shakes, can't sleep, scared, and when I do go to sleep I have nightmares. I'm extremely scared of all of the officers here and I do not feel safe.

7. After a few days on 5-29-2023, I asked Sgt. Govan along with Lt. Walker what are the next steps to my report. Sgt. Govan told me this is a PREA report and its reported to the police department and the police investigator will reach out to me. Lt. Walker told me my lawyer will have to request a copy of my grievance along with the yellow 31 report the OFC wrote. I said okay – however, the police has not reached out to me yet. After this mistreatment, I knew it was very important to document everything and to get every name involved.

8. On 6-1-2023, I was denied pads while my cycle was on 6-7-2023. Still no BP meds. Wrote another grievance about feeling light headed, seeing black and white spots and about not having water all day. 6-8-2023, placed grievance about no pads or tissue. 6-18-23, I refused to go in the pod until the Sgt. brought tissue. The Sgt on duty was McClendon and the OFC wo called was OFC Simonville. McClendon then brought 6 rolls of tissue and gave one to

each pod. On 6-20-23, wrote a grievance about no water and wrote a sick call about stomach pain and the abdominal bleeding that was very heavy and bad clots. Also, wrote another grievance about all the mold. Then wrote a call stating it was hard for me to breathe and I needed to go the ER. 6-23-2023, had a nightmare and woke up in a cold sweat about the intake incident and the guards that I can't trust. 6-23-23 no meds. 6-23-2023, food was uncooked and I didn't notice until I had already ate a piece and the milk was spoiled. Talked to Mrs. Lasiter about everything going on with me and about the mistreatment and abuse. 6-24-23, BP 154/129 @ 10:46 am, 6-25-23 BP 157/109 @ 10:48 am, 6-26-23 144/103 @ 9:56 am 6-26-23 during pm med pass, I informed Nurse Dinnall about how I felt dizzy light headed and my head was tight and hurting. She told me she was not in there to handle my needs she was only there for med pass.

9. I then informed the OFC Bowsman that I didn't feel well and she said she documented it in the book and how rude the nurse was to me. About 20 minutes later, I fainted. I had a huge knot on my right temple when they called a code blue when I woke up. I was in a cold sweat. I asked for water and an ice pack. The nurse said she was going to come back with it but never came back. On 6-27-23, Dr. Shaefer placed me on new BP meds – labatonal (sp) plus placed an order for my BP to be checked 3x/wk.

10. On 6-27-23 gave Sgt. Dupree grievance about not having a water cooler for over 24 hours. On 6-29-23, informed nurse that came in with the officer that I needed to see the doctor to follow up about passing out Monday because I was still feeling bad. 6-30-23, no BP check; 7-10-23, turned in grievance to Sgt. McClendon about undone/raw lunch and dinner. 7-11-23 didn't get am meds; mid-day med pass nurse said she didn't have the order and she didn't see the order that Dr. Shaefer placed about giving me Gatorade 3 times/day. 7-12-23, after multiple attempts to get the Gatorade, the am nurse told me the jail doesn't give Gatorade Dr. Shaeffer placed. When asked now what to do, I was told to call my family. When family called to see if they could send the Gatorade they were told no by officer Green and that if Dr. put in the order, I will get it. I only got the Gatorade once and that was when I went to medical complaining about dehydration.

Nurse Williams fixed it for me 7-14-2023. Asked OFC Grady for a sick call and grievance from. She said she will get them later.

11. On 7-18-23 OFC conducted a shake down and they took pads that was ordered off canteen then gave them out to other detainees. They took my food tray, soap and put my tooth brushes on the floor. Asked was there another way to put in a grievance they said tablet. However, the tablet doesn't work. The Kiosk doesn't have the option.

12. On 7-18-2023, went 24 hours without water. Still no grievance form 7-19-2023, asked OFC Harris for pads and water she said she will get some later. For dinner, OFC Harris did not feed me and a few others. She said she will call the kitchen. She left and when 2nd shift came in at 8:16 pm, I was told by OFC Roblocks that Harris put in the book our food came, which had not happened. She then called Sgt. Dupree and she then told me she will contact Harris. Harris then told her she called the kitchen. However, the food never came back. Dupree told me she will bring me a snack bag. I never got the snack bag! 7-19-23, gave Dupree the grievance about not getting my dinner tray. Didn't get any water all day or meds. Nurse didn't check BP all day. 7-23-23 No night BP meds, no Gatorade all day. 7-24-23 Nurse didn't have the blood pressure cuff to check BP. 7-24-23 gave Public Defender form to OFC Robar. However, months later my attorney stated he never received the form. 7-25-2023, officer Harris allowed her favorite detainees to eat my diner tray and laughed about it together while she pulled up my personal information on the computer and shared it with them. During the next few days, they picked with me each day about my charges and they would write my full name on the windows with disrespectful remarks attached to it. 7-26-2023, didn't get night meds.

13. On 7-27-23 wrote a grievance about all the mold in the pod. This pod (f) also had wires coming out of the walls. The lights were out and damaged. The sink did not work. The shower had black and green mold from top to bottom and we didn't have a shower curtain up so everybody could see us in the shower and when we used the restroom. 7-27-23 wrote a grievance about the mistreatment.

14. On 8-3-2023, Harris didn't feed me again for dinner. 8-4-2023 wrote a request to speak to Cpt. Sligh regarding the mistreatment – call around. (PREA, No dinner) and incidents that happened on 5-10-23, 7-19-23, 8-3-23, 8-4-23, write grievance sick call about high BP and dehydration. 8-10-23, finally made it to medical. Spoke to Dr. Shaefer about the head tension, blurry vision seeing spots and the heaving bleeding. Signed papers to release medical records. Advised he is placing me on the list to follow up in a month. 8-11-23, 8-13,23, 8-14-23, no BP meds or BP check. 814-23, I was charged $15 by medical. However, high BP is a chronic issue and I was not supposed to be charged. 8-15-23 nurse Berry come in and provided crackers with her bare hands. Sgt. Turpin refused to give our pod cooler water because a girl was telling her loudly that we haven't had water all day. 8-23-2023 dorm workers [redacted] and [redacted] carried on threats from information that OFC Harris told them about me. I was told in front of OFC Harris that they was going to get the pod to jump me. On 8-23-2023, [redacted] threatened me in front of Sgt. Govan and the entire dorm that she was going to stab me, slap me and kill me. She also said she is going to make sure our pod don't eat or get clean laundry.

15. On 8-29-23, No water all day. Asked Sgt. Pinkney, Lt. Walker and OFC Wannamaker. 9-1-2023, gave grievance to OFC Holmes about the threats the detainees made in front of Sgt. Govan 9-4-23. Even though Unit Uniform is a pod for pod dorm meaning only one pod out at a time, the OFC on duty let me out to get in the line for meds pass while I was getting meds. She let out the pod [redacted] and [redacted] was in. [redacted] then pushed me. We began to argue while the OFC just stood there watching. Detainee [redacted] then punched me in the head 2 times and then began to jump on me. A shank was used and I was cut in multiple areas – on my right arm and head. I also received a fracture in my right hand.

16. I was placed on restriction and all privileges denied. However, [redacted] and [redacted] continued to have their privileges. I wasn't seen by the doctor here at the jail until 9-12-2023 and didn't go the ER to have the fracture cared for. The only reason I went to the hospital was because I had another code blue. I passed out, hit my head and when I woke up I complained about

extreme pain in my head, knee, ankle and begged to go to the ER. I instantly saw my ankle swell while nurse Harris (different from OFC Harris). However, I believe they are related; told me I wasn't going to the ER and what I have going on is not an emergency. I then got approved to go the ER after refusing to return back to the dorm on 9-15-23. During my visit they took images of CT Abdomen, Pelvis w/ IV contrast only; XR ankle 2 Vw Right; XR ankle 3+ VW Right; XR Hand 3+ VW right performed 2 times; XR knee 3 VW right; XR Sacrum and Coccyx; XR Spine lumbar 2 or 3 VW; and XR Tibia Fibula 2VW Right.

17. I was given Norco, Omnipaque, Toradol, morphine and Zofran. I was placed in a boot for my broken ankle and a hard mole for my hand. I also was advised to follow up with Arthur Kyle E, MD in one week per ortho, Follow up with Reynolds, Freddie, MD per OBGYN. 9-17-23 – was told by nurse no order for pain meds. 9-1823 – didn't get daily meds or pain meds. 9-1923, spike to Cpt. Moye about no meds, PREA, no water, etc. 9-23-23 still no pain meds. Asked nurse Butler and she said no order is placed. 10-1-23, nurse Harris tried to make me take some powder formed pills. I refused to take it and told her I'm not on crushed pills she told me nurse Green told her to do. I then called my family and nurse. Green came to talk to me and verified I am not on crushed pills and told me she wasn't mad. I didn't take that powder substance.

18. Went to medical Dr. Shaefer informed me my due date was 10-14-2023. I told him about all the things I had experienced as well as all the pain. He then ordered blood work and informed me I had a miscarriage. I explained to him I believe it happened back in April – June 2023 when I had extremely heavy bleeding. 10-24-23, went to Ortho well over the week as requested. Looked at hand, knee, and ankle. Hand verified as fractured and cast replaced, ankle broke and MRI scheduled. MRI scheduled for knee. Prescribed Naproxen Prednisone eat with food. 10-25-23 No meds, no Gatorade, no snack bag, 10-26, no meds. 10-27-23, no meds. 10-29-23 turned in grievance about not getting BP meds, pain meds, etc. 11-3-23, spoke to nurse Green about not getting my meds, she said she will get all the prescription. Spoke to

transportation to ask Mrs. Slight did she turn in the return to jail requirements that the ortho doctor sent. She said yes and she would check.

19. Then on 11-4-23, wrote another grievance gave to Sgt. Homes about not getting my meds and about the extreme pain I am going through. 11-5-23 wrote another grievance and gave it to OFC Gladyn. 11-7-23, nurse Green told me the OFC reported that I didn't get my meds from the nurse, however, the nurse documented that she gave them to me. Nurse Green refilled my prescription and told me it would start on 11-8-23 or 11-9-23. I started the meds on 11-8-23. 11-10-23 went to Dr. Shaefer and complained about all of the pain in my hand, knee, back, and ankle.

20. Also advised nurse Williams and nurse. Brown about the mass in my stomach. 11-12-23 no night meds asked for pads/tampons all day. 11-15-23, no officer need pads/tissue. 11-16-23, no officer called 3260 to request pads/tampons and water. 11-17-23 no officer/no pads. 11-18-23, no officer. Fight broke out. 11-20-23 wrote a grievance about the 2 public defenders numbers at the bottom of the request form that doesn't work. 11-20-23 wrote a grievance on Ms. Yolanda Mitchell. She snatched the crate I was elevating my leg on which caused my leg to hit the floor very hard. Informed all the officers and its that I had throbbing pain. 11-21-23 I wrote a sick call about the pain. 11-24-23 had a MRI appt. for knee and ankle at Medical Park, 1 Richland, Prisma.

21. 11-29-23 went to OB-GYN – verified no longer pregnant prescribed Tylenol and requested to follow up with doctor to maybe increase the blood pressure meds. 12-10-2023, no meds. The doctor increased my blood pressure meds without speaking to me which was not a good idea because I'm not getting the meds every day like I'm supposed so why would he increase my meds instead of assuring I get my meds like I'm supposed to. 12-7-23, No meds or BP check (light headed). Asked for a hot cold compress for my healing ankle that has been

hurting for days. 12-15-23, went to ortho appt. to follow up with MRI for knee and ankle. Advised I will need to see the surgeon for my hand. Was given physical therapy instructions along with a band. I was told by the nurse I will come up their 3 times a day with wound care to use the band. However, that never took place. 12-15-23 complained about not getting Naproxen or Tylenol. 12-15-23, didn't get am meds. 12-16-23, write a sick call about my follow up appt. with Dr. Shaefer and about BP being high. 12-17-2023, write a grievance about feeling dehydrated about the mass on my stomach. Has gotten bigger and more painful.

22. 12-23-2023 OFC Yolanda Mitchell hit me with a metal lock on her key ring. The incident was reported. However, I was placed on restriction for 15 days, and I stayed in Unit X-Ray for 16 days. Without a shower, no water to drink, the sink or toilet work and the lights were broke, wires hanging out the ceiling and wall and I needed help 6 times but no one responded to the help button. I passed out on 12-29-2023. However, when I woke up, there still wasn't an officer to report it to.

23. 12/24/23 - wrote a grievance about OFC Mitchell allowing the detainees to steal my canteen. On 12/25 - Nurse Dinnial dropped my night meds on the floor and told me I had one choice pick it up or don't take it at all. This nurse also refused to give me my snack bag every time she worked.

24. 12/25/23 - wrote a grievance about not getting meds (Pain) prescribed by the ob-gyn B ortho doctor.

25. 12/26/23 - Didn't get meds and asked for a cold or warm compress for my hand that the OFC assaulted me on. 12/26/23 gave grievance to Lt Williams about Y. Mitchell actions towards me. Wrote a sick call about hand hurting and numb.

26. 1/8/24 - OFC Mitchell got into it with another detainee and when she came in front of my cell door she yelled 'she is going to fuck somebody up with her key' Sgt Lavont, Lt. Dupree and Lt. Leppett all heard her say this and they had on their body cameras they laughed when she made her statement at 6:03 p.m. 1/16/24 - Didn't get meds did a sick call about ankle, hand, head

and stomach pains. 1/28/24 – Finally made a sick call on the kiosk. I have multiple grievances, sick calls, dental request and PREA grievances that have not been responded to.

27. In this Delta dorm there is mold everywhere, the sally port to enter floor is coming up and leaks water. When you enter the dorm you will instantly smell mold/mildew and see dirt on the walls, dust on the desk area and in the vents. The ceiling has holes in multiple areas and have water damage spots. Only one phone works properly the other 2 shock you when you call out. The paint is chipped everywhere and every bunk area has mold and dust.

28. Bunk 26 where I stay leaks water from ceiling on to the bunk and fluid drips down the wall. On the top floor the bathroom toilets don't flush properly, the sinks are flooded and leak. The visitation booths smell bad and aren't clean. Outside the booth area there are floods of water that comes from the floor that is cracked and coming up. The steps are rusted. On the bottom floor in the bathroom, the ceiling leaks and drips on your head at times, only one sink works and only one toilet work. The shower button works however the water isn't hot when needed and the ceiling drips water while you are trying to wash. There is SOOO much mold, rust and mildew in there.

29. In this dorm we never have officers. We have to beg for water by calling central control 3261. Last week Lt. Dupree was so angry we kept calling for water she came in with a cooler that had bugs and mold in it, she even kicked the cooler on the floor to us!

30. There have been multiple fights that go un-reported. Days without water and officers. Days with uncooked food. Some trays look different from others. Some trays are hot and most are cold. The meat is unidentifiable and smells like pet food. None of the meals go together. We had the same slop all week and 7 girls in the dorm have a stomach virus that the nurses ignore. A lot of people don't have a cup to drink water out of and have to beg for tissue and soap. The supply team does not provide us with enough of anything (chemicals, soap, tooth brushes etc). The OFC Saldana who is supposed to provide us with underwear, socks, tee shirts and water cooler will bluntly tell us no. Sometimes she curses at us and walks around with alcohol breath.

She has a very dismissive attitude and she is also over the work program. Well she is the person who pays us. OFC Saldana has a team of males and females who run a drug ring in this jail. They have certain things to on certain days in order to stay in the program. Lots of money is involved and it can get very dangerous if you don't follow the rules. The front line workers transport the drugs. [redacted], [redacted] and a few men I'm unsure of there names. These 2 females are nasty! I have seen them spit in a dorms food because they didn't pay the drug money. I have seen them not feed a dorm because something went wrong with the drugs/money. I have seen these 2 females take bugs and put them in dorms food before they push the cart out. I have heard them talk about drug transactions in front of Mrs. Saldana and she threaten to take their pay if she doesn't get paid. The females that are cart runners are the issue when it comes to late food, messy and drugs being transported. OFC Saldana even allow the drug runners/contraband runners to eat staff trays for lunch and dinner everyday. The are very scary to work with or be around.

31. The laundry clothes are not being properly washed and dryers don't work. There is one working dryer and there isn't any bleach or smell good being placed in the clothes. When I worked in the kitchen the fryers had build up. The station that they served our food had food from the previous day and the workers had the juice out all night. The ice machine works sometimes (which is the excuse about why the water coolers never get replaced refilled). Those coolers are never cleaned! The officers, Lts., Sgts., Captains and allied workers treat us inhumanely! They talk to us like we are dirt.

32. The only people who get respect is the men who have female officers that bring them in drugs and contraband. If you aren't paying them or getting them paid, you are a target. I can go on and on about the abuse I have experienced. The actions of a staff member directed towards a detainee, missing or damaged personal property caused by staff, denial of medical treatment, dietary food requirements not being met, mistreatment by other detainees, denial of

religious request, denial of the law library and disciplinary hearing resulting from not guilty pleas not being handled properly. I would like my voice to be heard.

33. This jail is not right and I have a mass that went from a pea size to the size of a golf ball size that causes extreme pain. The head nurse Mrs. M-Foxx-Brown placed a surgical consult that I have yet made it to.

34. Please note there have been multiple code blues reported without officers in the dorm. Detainees including myself have passed out, had seizures and have no person to turn to for help. The medical team dispenses medicine without gloves on. Touching the prescriptions with their bare hands. They have long nails on and long hair down their back. The entire staff is unprofessional. I was told by the nurse that the reason some of the scheduled med pass times are not met is because we don't have an officer to be present in the dorm.

35. The washcloths and towels look filthy. The mail room is extremely slow. Our family can send us a money order and it doesn't get posted until weeks later. Transportation for court is slow and I was taken to the wrong courthouse once. When we have attorney visits/court, we don't find out until the last minute of the time. Then, we are rushed to get prepared and dressed. Detainees run the dorm and it is up to us to provide and care for ourselves. There isn't any protection or guidance in here.

36. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration.

May 10th 2024
Date

[redacted]

Hello, and Thank you for the opportunity to be heard. My name is [redacted] I am 31 years old. I was detained and place here at Alvin S Glenn detention center on March 23rd 2023. When I arrived at the jail I was immediately terrorized. The guards were extremely rude and disrespectful. The intake cell had vomit, mold, urine, trash and insects everywhere. Once I came back from bond court - which I was denied a bond I was very upset. I was then seen by a nurse who I informed my medical conditions and whom verified I was pregnant by urine. I was then given a sandwhich and taken back to a dorm called X-RAY. This dorm was inhuman. I was stripped in the intake from head to toe but was not provided with any bras, socks, shirt, panties, soap, or deodorant, lotion or comb. I also kept my snow boots on and was not provided any shower shoes. On this day a lady that was going home soon provided me with a notepad because at this moment I knew I had to document my entire experience at this facility. On 3-24-2023 I woke up to a rat running across my head. I was in room 22 and in this cell the lights didnt work, wires was hanging out of the ceiling, the help speaker button was removed with wires sticking out. The sink nor toilet was working and the cell had

black bugs that crawled on the cracks of the walls and window seal. During my stay in XRAY I saw multiple spiders (big & small), frogs, snakes, rats, mice, flies, maggots and other unidentifiable creepy crawlers! I developed dark spots on my face, neck, arms and entire body. Some was boil-like bumps that leaked fluid, some itched, some hurt and some caused extreme pain. I was bit by what I belived to be a spider. I wrote multiple grievances complaining about the bites and I also informed each nurse that came in during med pass. I never received a proper diagnose because my grievance was never formally answered On 5-8-2023 I asked the a.m nurse about not getting my blood pressure meds yet. She informed me to place a sick call. I did the sick call 5-8-2023. The sick call wasn't answered. On 5-10-2023 I was brought from unit Uniform to intake. OFC Church came to get me from this unit while OFC Harris was on duty. When I asked her what was I going up there for she told me "I will find out! Once I got up there to intake OFC Clark and OFC Goldwire were the main 2 officers in contact with me. OFC Clark placed me in the cell with a man. Once he left the man said his name was Gregory and we was going to have fun. At this time I was scared and stood at the window eating my food waiting on someone to walk back past so I could ask to

be removed from this cell. During the time I was in there Gregory touched on my leg and ankle he asked me to come closer and the he pulled out his white penis and started to masterbate. Shortly after I saw OFC Clark walk back pass and I banged on the door/window to let me out. He opened the door and OFC Goldwire was beside him. I told them I was scared and then OFC Goldwire told me to sit in the camera area in the red chair. He placed me next to another man which was a very scary moment although this guy didnt do anything to me. After about 2 hours they took me back to the unit. I cried all night. The next day I informed the a.m OFC Montgomery of what took place she was shocked and called Sgt. Summers to inform her of the info I just told her Sgt Summer then called intake and spoke to Goldwire and asked ~~him~~ him what happend Goldwire to her I was only placed in the cell with the man for a short period of time Sgt Summers was very upset and she called back to the unit and advised OFC Montgomery to write the incident up on a yellow 31 paper. Montgomery did as told then she also gave me a grievance paper to write in detail about what took place. Once we both did the

repat. Lt. Walker then called me to his office OFC Montgomery was in there with me. Along with Lt. Walker was OFC Goldwire & OFC Clark. He asked me was I okay with being recorded I said yes I had a problem with it and I wanted my lawyer present, however he told me he need to record he asked me questions about what happend and I told him. He asked me why didnt I tell Goldwire and I told him because I was scared so I told my female OFC. Oh yeah I also went on 5-10-2023 to see the pysch Dr. Potter after this incident occured. I was & Still am traumatized about what this man did to me. Im traumatized about the staffs reaction to the act that took place. I'm traumatized by people especially men! I told Mrs. Potter along with Mrs. Lasiter the mental health Causler that comes sit in the mental health meetings about how I have the shakes, cant sleep, scared and when I do go to sleep I have nightmares. im extremely scared of all the officers here and I do not feel safe. After a few days on 5-29-2023 I asked Sgt Govan along with Lt Walker what are the next steps to my repat. Sgt Govan told me this is a PREA report and its reported to the police department and the police investigator will reach out to me. Lt. Walker told me my lawyer will have to request a copy of my grievance along with the yellow 31 report the OFC wrote. I said Okay - however the police

has not reached out to me yet. After this treatment I knew it was very important to document everything and to get every name envolved. On 6-1-2023 I was denied pads while my cycle was on. 6-7-2023 still no BP meds - wrote another grievance about feeling light headed, seeing black & white spots and about not having water all day. 6-8-2023 - still no pads 6-9-23 - No water all day. 6-10-23 - Placed grievance about no pads or tissue. 6-18-231 refused to go in the pod until the Sgt brought tissue. The Sgt on duty was McClendon and the OFC who called was OFC Simianville. McClendon the brought 6 rolls of tissue and gave one to each pod. On 6-20-23 wrote a grievance about no water and wrote a sick call about stomach pain and the adnormal bleeding that was very heavy and had clots. Also wrote another grievance about all the mold. Then wrote a sick call stating it was hard for me to breath and I needed to go to the ER. 6-23-2023 had a nightmare & woke up in a cold sweat about the intake incident and the guards that I cant trust. 6-23-23 No meds. 6-23-2023 Food was uncooked and I didnt noticed until I had already ate a piece & the milk was spoiled Talked to Mrs. Lasiter about everything going on with me & about the mistreatment and

abuse. 6-24-23 BP 154/129 @ 10:46 AM, 6-25-23 BP 157/109 @ 10:48 AM, 6-26-23 144/103 @ 9:56 AM 6-26-23 during PM med pass I informed Nurse Dinnall about how I felt dizzy light headed & my head was tight and hurting - She told me she was not in there to handle my needs she was only there for med pass. I then informed the OFC Bowsman that I didnt feel well and she said she documented it in the book & how rude the nurse was to me. About 20 mins later I fainted. I had a huge Knot on my head when they called a Code Blue when I woke up I was in a cold sweat. I asked for water & an ice pack. The nurse said she was going to come back with it but never came back. On 6-27-23 Dr Shaefer placed me on new BP meds labootnol (sp) & Norvask (sp) plus placed an order for my BP to be checked 3x/wk. 6-27-23 Gave Sgt Dupree grievance about not having a water cooler for over 24 hours. On 6-29-23 Informed Nurse that came in with Ms Stone that I need to see the doctor to follow up about passing out Monday because I was still feeling bad. 6-30-23 - No BP Check 7-10-23 turned in grievance to Sgt McClendon about undone/raw lunch & dinner 7-11-23 Didnt get am meds. mid day med pass nurse said she didnt have the order and She didnt see the order that Dr Shaefer placed about giving me gatorade 3 times/day. 7-12-23 After multiple attempts to get the gatorade the Am nurse told

me the jail doesn't supply the order Dr Shaffer placed. When asked now what to do I was told call my family. When family called to see if they could sent the gatorade they was told no by Ms Green and that if the Dr put in the order I will get it. I only got the gatoraid once and that was when I went to medical complaining about dehydration. Nurse Williams fix it for me. 7-14-2023 Ask OFC Grady for a sick call and grievance form - she said she will get them later. 7-18-23 OFC conducted a shake down and they took pads that was ordered off canteen then gave them out to other detainees, they took my food tray, soap and put my tooth brushes on the floor. Asked was there another way to put in a grievance they said tablet however the tab doesn't work & the Kiosk doesn't have the option. 7-18-2023 went 24 hours without water. Still no grievance form S. 7-19-2023 Asked OFC Harris for pads and water she said she will get some later. For dinner OFC Harris did not feed me & a few others she said she will call the Kitchen. She left and when 2nd shift came in @ 8:16 pm I was told by OFC Robbocks that Harris put in the book our food came. She then called

Sgt Dupree & she then told me she will contact Harris - Harris then told her she called the Kitchen however the food never came back. Dupree told me she will bring me a snack bag. I never got the snack bag! 7-19-23 Gave Dupree the grievance about not getting my dinner tray. Didnt get any water all day or meds. Nurse didnt check BP all day. 7.23.23 No night BP meds - no gatoraid all day 7.24.23 Nurse didnt have the BP cuff to check BP 7.24.23 Gave Public Defender form to OFC Robar however months later my attorney stated he never rec. the form. 7.25.2023 Harris allowed her favorite detainees to eat my dinner tray and the ~~laughth~~ laughed about it together while she pulled up my personal informations on the computer & shared it with them. During the next few days they picked with me each day about my charges and they would write my full name on the windows with disrespectful remarks attatched to it. 7.26.2023 Didnt get night meds. 6.27.23 wrote a grievance about all the mold in the pod. This pod(F) also had wires coming out of the walls, the lights were out and damaged the sink did not work, the shower had black and green mold from top to bottom and we didnt have a shower curtain up so the everybody could see us in the shower & when we used the restroom. 7.27.23 wrote a grievance about mistreatment

[redacted]

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9 ... I really believe due to having less food, being dehydrated and not having any prenatal care after asking, contributed in my loss. I went to the ER I believe in July. I have medical records from Prisma Richland that shows dehydration and extreme high blood pressure. At this time I was really ill. I had already placed multiple sick calls regarding me having miscarriage symptoms and multiple sick calls about feeling faint, dehydrated no prenatal care and high blood pressure symptoms. Per the medical records @ Alvin S Glenn I loss over 30 pounds and during each visit I was diangised with high blood pressure. I expirenced miscarriage symptoms in April of 2023 was never seen by Alvin S Glenn doctor. I later had an appointment at the end of the year of 2023 at 1801 Sunset Blvd, [redacted] with Dr Harper. The exact date was Nov 29th 2023 where she verified a miscarriage took place. It is unbelieveable that I was really seen almost 9 months after I was complaining about all of these issues I was having. It is depressing that I went through all of this alone in a cold jail cell with cold blooded inmates and employees. After begging for days just for water to drink, complaining about pain, feeling like I was about to die, developing a large mass in my stomach

that is still here getting bigger. I have placed multiple sick calls and grievances on the kiosk about this issue and even after stating this mass is affecting my abillity to walk urinate and poop I still have not been seen again for it.

8-3-2023 Harris didnt fed me again for dinner 8-4-2023 Wrote a request to speak to Captin Sigh regarding the mistreatment (All around) (PREA, NO dinner) and incidents that happend on 5-10-23 7-19-23, 8-3-23 8-4-23 Wrote grievance & sick call about high BP & dehydration. 8-10-23 Finally made it to medical Spoke to Dr Shaefer about the head tension, blurr vision seeing spots and the heavy bleeding. Signed papers to release medical records advised he is placing me on the list to follow up in a month. 8-11-23, 8-13-23, 8-14-23 NO BP meds or BP check. 8-14-23 I was charged 15$ by medical however high BP is a chronic issue and I was not suppose to be charged. 8-15-23 Nurse Berry came in a provided crackers with her bare hands. Sgt Turpin refused to give our pod cooler water because a girl was telling her loudly that we havent had water all day. 8-22-2023 [redacted] & [redacted] canned on threats from information that OFC Harris told them about me. I was told in front of OFC Harris that they was going to get the pod to jump me. On 8-23-2023 [redacted] threaten me in front of Sgt Govan and the entire dorm that she was going to stab me stap me & kill me. She also said she is going to make sure our pod dont eat or get clean laundry.

(10)

On 8-09-23 No water all day Ask Sgt Pinkery, Lt Walker and OFC Wannamaker. 9-1-2023 Gave grievance to OFC Holmes about the threats the detainees made in front of Sgt Govan. 9-4-23 Even though unit Uniform is a pod for pod dorm meaning only one pod out at a time the OFC on duty Let me out to get in the line ~~for~~ for med pass while I was getting meds She let out the pod [redacted] & [redacted] was in [redacted] then pushed me & we began to argue while the OFC just stood there watching Lewis the punched me in the head 2 times and the began to jump on me during the lunch a Shank was used and I was cut in multiple areas. I also rec a fracture in my hand I was placed on restriction and all privileges denied however [redacted] and [redacted] continued to have their privileges. I wasnt seen by the Dr here at the jail until 9-12-2023 and didnt go to the ER to have the fracture cared for [redacted]. The only reason I went to the hospital was because I had another cold blue. I passed out hit my head and when I woke up I complained about extreme pain in my head, knee, ankle and begged to go the the ER I instantly saw my ankle swell while Nurse Harris (different from OFC Harris) however I believe they are related; told me I wasnt going to the ER and what I have going on is not an emergency. I then got

approved to go to the ER after refusing to return back to the dam on 9-15-23. During my visit they took images of CT Abodomen Pelvis w IV contrast only ECG 12 Lead ~~Redacted~~ (Once) XR Ankle 2 Vw Right XR Ankle 3+ Vw Right XR Hand 3+ Vw right performed 2 times XR Knee 3 Vw right XR Sacrum and Coccyx XR Spine Lumbar 2 or 3 Vw XR Tibia Fibula 2 Vw Right I was given Norco, Omnipaque, Toradol, morphine and zofran. I was place in a boot for my broken ankle and a hard mold for my hand I also was advised to follow up with Arthur Kyle E, MD in one week per Ortho, follow up with Reynolds, Freddie, MD per Obgyn. 9-17-23 - Was told by nurse no order for pain meds. 9-18-23 - Didn't get daily meds or pain meds. 9-19-23 - Spoke to Captin Maye about no meds, PREA, no water etc. 9-23-23 Still no pain meds. Asked Nurse Butler B she said no order is placed. 10-1-23 Nurse Harris tried to make me take some powder formed pills. I refused to take it and told her I'm not on crush pills she told me Nurse Green told her to do it I then called

my family and Ms Green came to talk to me a verified I am not on crushed pills and told me she wasn't made I didn't take that powder substance. Went to medical Dr shaefer informed me my due date was 10-14-2023 I told him about all the things I had exprienced as well as all the pain. He then ordered blood work and informed me I had a miscarriage. I explained to him I believed it happend back in June when I had extremely heavy bleeding. 10-24-2023 went to Ortho well over the week as requested. Looked @ hand, knee and ankle. Hand verified as fractured & cast replaced, ankle broke and MRI scnld. MRI scnld for knee Prescribed Naproxen & Protazon (Eat with food) 10-25-23 No Meds, No gatorade, no snack bag 10-26 No meds 10-27-23 - No meds 10-29-23 Turned in Grievance about not getting BP meds, pain meds etc 11-3-23 spoke to Nurse Green about not getting my meds She said she will get all the prescriptions looked into. Spoke to trenspartation to ask Mrs. Silgh did she turn in the return to jail requirements that the Ortho Dr sent she said yes and she would Check. Then on 11-4-23 wrote another grievance gave to Sgt Holmes about not getting my meds and about the extreme pain I am going through 11-5-23 wrote another grievance and gave it to OFC Gladyn. 11-7-23 Nurse Green told me the OFC reported

that I didnt get my meds from the nurse, however the Nurse documented that she gave them to me Nurse Green refilled my prescription and told me it would start on 11-8-23 or 11-9-23. I started the meds on 11-8-23 11-10-23 Went to Dr. Shafeed and complained about all of the pain in my hand, knee back and ankle Also advised Nurse Williams and Mrs. Brown about the mass in my stomach. 11-12-23 No night meds asked for pads/tampons all day. 11-15-23 No officer need pads/tissue. 11-16-23 No officer called 3260 to request pads tampons and water 11-17-2023 No officer/no pads 11-18-23 No officer fight broke out. 11-2023 wrote a grievance about the 2 public defenders numbers at the bottom of the request form that doesnt work. 11-20-23 Wrote a grievance on Ms. Yolanda Mitchell she snatched the crate I was elevating my leg on-which caused my leg to hit the floor very hard. Informed all the officers and Lt's that I had throbbing pain. 11-21-23 I wrote a sick call about the pain 11-24-23 Had a MRI appt for Knee & Ankle Med Park 1 Richland ~~Richland~~ Prisma. 11-29-2023-[redacted] went to Obgyn -verified no longer pregnant prescribed tylenol and requested to follow up with Doctor to maybe increasing the blood pressure meds 12-10-2023 No meds. The Dr increased my BP meds without speaking to me. Which was not a good idea

because if Im not getting the meds everyday like Im suppose to why would he increase my meds instead of assuming I get my meds like Im supposed to. 12.7.23 No meds or BP check (15th headache) ASKed for a hot or cold compress for my healing ankle that has been hurting for days 12.15.23 Went to Ortho appt to follow up with MRI for knee & ankle. Advised I will need to see the surgen for my hand was given physical therapy instructions alone with a band. I was told by the nurse I will come up the 3 times a day with womb care to do/use the band. However that never took place. 12.15.23 Complained about not getting Naproxen or tylenol. 12.15.23 Didnt get Am meds 12.16.23 Wrote a sick call about my follow up appt with Dr Shaefer & about BP being high. 12.17.2023 Wrote a grievance about feeling dehydrated & about the mass on my Stomach- has gotten bigger & more painful. 12.23.2023 OFC Yolanda Mitchell hit me with a metal lock. The incident was reported - however I was place on restriction for 15 days, and I stayed in Unit XRAY for 16 days. Without a shower, no water to drink, the Sink nor toliet work and the lights were broken, wires hangging out the Ceiling & wall and I needed help 6 times but no one responded to the help button. I passed out on 12.29.2023 however when I woke up there still wasnt an officer to report it to.

12.24.2023 wrote a grievance about OFC Mitchell allowing the detainees to steal my canteen. On 12.25 Nurse Dinnial dropped my night meds on the floor and told me I had one choice pick it up or dont take it at all. This nurse also refused to give me my snack bag everytime she worked. 12.25.23 Wrote a grievance about not getting meds (pain) prescribed by the obgyn & othro dpctor. 12.26.23 Didnt get meds and asked for a cold or warm compress for my hand that the OFC assaulted me on. 12.26.23 Gave grievance to Lt. Williams about Y. Mitchelle actions towards me. Wrote a sick call about hand hurting and numb. 1-8-24 OFC Mitchell got into it with another detainee and when she came in front of my cell door she yelled 'she is going to fuck somebody up with her key' Sgt. Lavont, Lt. Dupree and Lt Leppett all heard her say this and they had on their body cameras they laughed when she made her Statement @ 6:03PM 1-16-24 Didnt get meds did a sick call about ankle, hand, head and stomach pains. 1-28-24 Finally made a sick call on the kiosk I have multiple grievances, sick calls, dental request and PREA grievances that have not been responded to. In this Delta dorm there is mold everywhere, the sally port to enter floor is coming

up and leaks water. When you enter the dorm you will instantly smell mold/mildew and see dirt on the walls dust on the desk area and in the vents. The ceiling has holes in multiple areas and have water damage spots. Only one phone works properly the other 2 shock you ~~when~~ when you call out. The paint is chipped every where and every bunk ~~area~~ area has mold and dust. Bunk 216 leaks from the ceiling on to the bunk and fluid drips down the wall. On the top floor the bathroom toilets dont flush properly, the sinks are flooded and leak. The visitation booths smell bad and arent clean. Out side the booth area there are floods of water that comes from the floor that is cracked and coming up. The steps are rusted. On the bottom floor in the bathroom, the ceiling leaks and drips on your head at times, only one sink work and only one toliet work. Only 2 shower buttons work however the water isnt Hot when needed and the ceiling drips water while you are trying to wash. There is soooo much mold, rust and mildew in there. In this dorm we never have officers. We have to beg for water by calling central control 3261. Last week Lt. Dupree was so angry we kept calling for water she came in with a cooler that had bugs and mold in it, she even kicked the cooler on the floor to us!

(16)

(17)

There has been multiple fights that go un-reported. Days with out water and officers. Days with un cooked food. Some trays look different from others. Some trays are hot and most are cold. The meat is unidentifiable and smells like pet food. None of the meals go together. We had the same slop all week and 7 girls in the dorm have a stomach virus that the nurses ignore. Alot of people come in a dont have a cup to drink water out of and have to beg for tissue. The supply team does not provide us with enough of anything. (Chemicals soap, tooth brushes etc.) The ofc Saldana who is suppose to provide us with underwear, socks, tee shirts and water cooler will bluntly tell us no. Sometime she curse at us and walks around with alcohol breath. She have a very dismissive attitude and she is also over the work program. Well she is the person who pays us. OFC Saldana has a team of males and females who run a drug ring in this jail. They have certain things to on certain days in order to stay in the program. Lots of money is [redacted] involved and it can get very dangerous if you dont follow the rules. The front line workers transport the drugs. [redacted] and a few men Im unsure of

of there names. These 2 females are nasty! I have seen them spit in a dorms food because they didnt play the drug money. I have seen them not feed a dorm because something went wrong with the drugs/money. I have seen these 2 females take bags and put them in dorms food before they push the cart out. I have heard them talk about drug transactions in front of Mrs. Saldana and she threaten to take their pay if she doesnt get paid. The females that are cart runners are the issue when it comes to late food, messy and drugs being transported. Ofc Saldana even allow the drug runners/contriband runners to eat staff trays for lunch and dinner everyday. The are very scary to work with or be around. The laundry clothes are not being properly washed and the dryers dont work. There is one working dryer and there isnt any bleach or smell good being placed in the clothes. When I worked in the kitchen the fryers had build up the station that they served our food had food from the previous day and the workers had the juices juice out all night. The ice machine works sometime (which is the excuse about why the water coolers never get replaced/refilled) those coolers are never cleaned! The officers, Lts, Sgts, Captins and allied workers treat us inhuman! The talk to us like we are dirt and

the only pepple who get respect is the men who have femate officers that bring them in drugs and contraband. If you arent paying them or getting them paid you are a target. I can go on and on about the abuse I have exprienced. The actions of a staff member directed towards a detainee, missing or damaged personal property caused by staff, denial of medical treatment, dietary food requirements not being met, mistreatment by other detainees, Denial of religious request, denial of the law library and disciplinary hearing results resulting from not guilty pleas not being handled properly. * I would like my voice to be heard. I also would like to know what can I do to be removed from this jail. I have a bond hearing in May. What can I do to get out of here sooner this jail is not right and I have a mass that went from a pea size to how a golf ball size that causes extreme pain. The head nurse Mrs. M-Fox-Brown placed a surgical consault that I have yet made it to. Is this legal? I need help! Sorry if there are any mispelled words I did not proof read. I simply wrote if you have any questions feel free to ask. Thank you for your time. I also would like for you to type a letter I can provide to my

attorney with the concerns to be approved to present to my criminal case judge. Thank you!

· Can I get a writ of habeas corpus even though Im not convicted at this time? Can I get a petition of release for medical issues, and simply because the jail neglected to follow the min. standard of care.

*Please note there has been multiple code blues reported with out officers in the dorm. Detainees including myself have passed out had seizures and have no person to turn to for help. The medical team dispense medicine with out gloves on. Touching the prescriptions with there bare hands. They have long nails on and long hair down there back. The entire staff is unprofessional. I was told by the nurse that the reason some of the scheduled med pass times are not met is because we dont have an officer to be present in the dorm. The wash cloths and towels look fifty. The main room is extremely slow our family can send us a money order and it doesnt get posted until weeks later. Transportation for court is slow and I was taken to the wrong court house once. When we have atty visits/court we dont find out until the last min of the time. Then we are rushed to get prepared and dressed. Detainees run the dorm and its up to us to provide and care for our selves. There isnt any protection or guidance here

EXHIBIT 23

SCDC 000134

SOUTH CAROLINA DEPARTMENT OF CORRECTION
DIVISION OF SECURITY
MEMORANDUM

TO: Blake E. Taylor, Division Director of Compliance, Standards, and Inspections

FROM: Colie L. Rushton, Director, Division of Security and Emergency Operations

Subject: Security Audit Alvin S. Glenn Detention Center

Date: August 7, 2023

Please find attached the report detailing the observations and findings of the Alvin S. Glenn Detention Center Security Audit. This audit was conducted on July 26-27, 2023.

Colie L. Rushton

Colie L. Rushton

The Security Audit Team arrived at the Alvin S. Glenn Detention center on the morning of July 26, 2023. The introductory meeting was scheduled with Interim Director, Mr. Harvey Crayman for 9:00 a.m. The security audit team was greeted and welcomed by Mr. Harvey and several members of his staff. I explained to Mr. Harvey and his staff that we were there to conduct a security audit of the facility for the purpose of identifying opportunities to enhance the security operations of the Alvin S. Glenn Detention Center. I shared with ASG staff that each member of the security audit team had an extensive background in corrections and security operations. After the introductory meeting, Mr. Harvey facilitated a tour of the facility so that security audit team members could gain familiarity with the physical plant of ASG.

Upon arrival at the detention center and prior to entering the facility, it was immediately obvious by the outwardly appearance of the facility that attention to detail was lacking. A single inmate had just begun mowing grass inside the fenced area in front of the ASG entrance. Massive overgrowth of weeds, grass and saplings had overtaken both the inner and outer perimeter fence line to include the dog run (area located between the inner and outer perimeter fence). Growth of weeds and saplings within the dog run had exceeded six (6) feet within the dog run. These conditions create massive blind spots allowing for a person or persons to be completely concealed from view. The height and density of vegetation overgrowth could easily help facilitate contraband introductions as well as escapes. To further escalate the security concerns created by the lack of attention to ground maintenance, the facility does not have a roving perimeter patrol officer. Alvin S. Glenn is a sizeable facility with a population of eight hundred and thirty-three inmates during our security audit. The physical plant footprint coupled with the numerous blind spots created by the multiple buildings demands a 24/7 continuous perimeter patrol. The lack of sufficient perimeter security reduces the opportunity for the facility to protect the public, the facility employees, and the inmates. Intruders could easily approach and breach the fence facilitating an escape or to introduce contraband inside the facility. Given the overgrowth surrounding the outer perimeter and contained within the fence provides ample concealment for those approaching the facility perimeter. This concern is further exacerbated by the proximity of the heavily wooded area surrounding the facility perimeter. If the facility owns the immediate surrounding property, it is recommended that the wood line be taken back as far as possible to make intruders more easily detectable.

As with the outer perimeter fence line and the dog run, there was massive neglect in ground maintenance of the inner yard areas. Grass had been allowed to reach near knee height in many areas. This too could easily facilitate providing cover for inmates attempting to escape or retrieve contraband during hours of darkness. It is strongly encouraged that facility identify trustee inmates to maintain the grounds under security supervision. In the absence of suitable inmate labor, utilize facility maintenance employees or contract ground maintenance through a reputable vendor.

There are several security concerns with the existing conditions of the perimeter fencing. The outer fence drive through gate is broken and unable to be secured in the closed position. Employees state the fence was damaged for several months and has not been secured closed for a minimum of two (2) months. This circumstance is unacceptable in that each time the inner fence gate is opens, it creates a breach in perimeter security. It is imperative that repairs to this gate be made immediately.

There are multiple locations in which the razor wire is in poor condition. The wire has been stretched to a point (possibly during installation) reducing the function and effectiveness of the razor wire. There are

also locations in which the wire appears to have been stepped on and collapsed reducing its effectiveness. Other fence deficiencies are noted in the audit report.

To further enhance perimeter security, it is recommended that the facility add a perimeter surveillance camera system integrated with a fence alarm system. With installation of this type of system, supported by a 24/7 roving perimeter security officer, and continuous ground maintenance Alvin S. Glenn Detention Center would elevate their perimeter security standards to an industry level standard. The security audit team made a several observations of the drain grates and outfalls. There are drain grates located within the inner perimeter yard that that are not secured. These grates should be pad locked and/or welded to prevent inmates from accessing the drain grates and escaping the facility. There were outfalls observed unsecured allowing inmates access outside the facility perimeter as well as allowing access to individuals from the outside. This access could be used for the purpose of facilitating escape or contraband introduction. One outfall grate was secured only with a bolt that could be easily removed.

The security audit team observed multiple vehicles inside the perimeter fence during the audit process. These vehicles belonged to the construction personnel working on the housing unit. While these vehicles were approved by the ASG to drive inside the facility perimeter, there were multiple security violations observed. The vehicles were not equipped with steering wheel clubs or locks. Vehicles were left unattended with windows down allowing easy access to the interior of the vehicle. There were also multiple tools located on or in the unattended vehicles. When staff were questioned about the unsecured/unattended vehicles, the response was there are no inmates back here. That is not an acceptable response in that no one can predict if in fact an inmate may or may not gain access to this area while the vehicles are left unattended/unsecured.

The security audit team also observed numerous combustible fuel containers unsecured and openly displayed and accessible to anyone. The large emergency generator fuel tank did not have a lock on the fueling neck and was therefore accessible to anyone in the area as well. Numerous tools were also accessible to any individual that approached the maintenance/tool storage area as well.

During the audit process the audit team visited numerous housing units. It is noted that construction workers were in the process of making repairs and upgrades to enhance security to inmate cell doors and upgrading the control room. The administration also informed us that the facility would be installing Willow Wedge locks to all cell doors. These style locks are a much-needed security upgrade to the existing locks that inmates have been breaching. Once the Willow Wedge locks are installed and operable, employee and inmate safety and security will be enhanced in the housing units.

The audit team was informed that facility administration would notify maintenance personnel of issues via email. It is strongly recommended that a facility maintenance work order request system be instituted to insure a one way in, one way out information flow. This system should allow for tracking any progress or delays in facilitating repairs of the facility. This system should also allow for prioritizing repairs based on level of security risks, health, and sanitation endangerment, etc.

During the walk-through of the facility security audit team members identified numerous issues plumbing requiring attention of maintenance personnel. These issues include but are not limited to electrical, and structural concerns. Some of these concerns are documented with photographs attached to this document

Observations include damaged light fixtures within inmate housing units damaged/missing with exposed wires creating a potential hazard.

Wall switch plates missing with exposed wires, creating safety hazards.

The security audit team observed a housing unit with only one operable common toilet. Both urinals and the only other toiled were covered with plastic due to being out of service. We were informed that the housing unit housed fifty-six (56) inmates. When asked we were informed the inoperable fixtures had been out of service for an extended period, (up to two months). This ratio of toilets/urinals to occupants is not acceptable.

In another housing unit visited, water was constantly running from behind a mechanical closet onto the dayroom/rock area. Each time a toilet was flushed water would flow from under the door onto the common area. There were numerous inoperable toilets in this housing unit. One inmate brought his toilet out of the cell to show the security audit team members the conditions in which the inmates were living. Team members observed that inmates were assigned to one cell in which the toilet containing feces would not flush. The inmates stated they had been living in this cell under this condition for approximately one week. The inmates had cardboard covering the toilet in efforts to reduce the emitting odor. Water was also flowing from the upper tier down to the lower-level common area. These conditions create unsanitary living conditions. Potential health risks and should be corrected immediately.

The security audit team observed that opportunities for improvement in housekeeping existed in living areas, throughout the facility. While some areas were better than others, given the number of inmates housed in this facility there should be no labor shortage when it comes to cleanliness, sanitation, facility maintenance and ground maintenance (under direct supervision of ASG employees). Upon inmate intake, a skills assessment could help identify if inmates possess maintenance experience that might be useful in assisting ASG maintenance employees. Observations were made of several air returns heavily coated in dust and dirt. This causes to question if air filters are being changed on a scheduled basis as they should be.

During the Security Audit Teams observations, it was noted that not all housing units were staffed/posted with an officer. There were circumstances in which one (1) officer was assigned to cover a minimum of two (2) housing units. This situation creates concern for the safety and security of the employees as well as the inmate's welfare. A copy of the current staffing is attached to this report. Clearly the facility should focus on hiring and retention efforts. It is recommended that the facility host ASG specific recruiting fairs, attend local multi-agency recruiting fairs at military bases, colleges, high schools etc., maximize media opportunities to advertise vacancies, promotional opportunities with emphasis on benefits and retirement.

When we questioned the ASG Administration about security cameras the security audit team was informed that the facility is scheduled to get new cameras for the facility. It is highly recommended that this installation includes cameras for every housing unit, all hallways, and all common areas with inmate access. Camera coverage should also include but be limited to the food service area, maintenance area, visitation area, inmate intake/processing area. Your camera system should also provide coverage of the entire facility perimeter covering both the outer and inner perimeter fences, and drive through gates. Camera coverage should also display the exterior of your housing units to include the rooftops (in that

you have had security breaches with inmates accessing rooftops for the purpose of escape and contraband retrieval).

Upon visiting the ASG training area we were informed that ASG had lost their lead trainer and the assistant trainer. During the discussion with the employee designated to conduct training, the security audit team was informed that ASG had no current trainer certified to conduct firearms recertification training. As such, the interim director informed us that no other officer was currently firearms certified. Upon hearing this, the question was asked, "when inmates were transported outside the facility for medical appointments or for court, with what weapons were the transporting officers armed?" The interim director replied that the officers were armed with pepper spray and a taser. This response is cause for great concern. In the event the transporting officers are confronted by an individual possessing a firearm attempting to assist the inmate in an escape or for other nefarious reasons, the officers are defenseless to respond against deadly force. The security audit team strongly recommends that the ASG administration correct this deficiency immediately. To place transporting officers in this position is dangerous and reckless.

The security audit team observed one inmate count during the security audit process. The team divided up and positioned themselves at various housing units and in the records room where count is reported/recorded. The employee located in the records room that received the phone calls reporting counts from various locations was well versed in the count process and explained the procedures with proficiency. The count software utilized by ASG was easy to understand and use. The count as reported to the records room cleared in an acceptable time frame. There were officers that were responsible for counting multiple units due to staff shortages. It was reported by security audit team members observing count in the housing units, that there was confusion with some officers as to the designated time for count. The security audit team received conflicting times for designated count time as being 11:00am vs. 12:00 noon. We recommend that designated count times be posted for inmates and staff alike. Doing so may eliminate confusion as to designated count times.

In summary, the security audit team members wish to express our appreciation for the hospitality shown by ASG employees, as well as for the opportunity to conduct the security audit at the Alvin S. Glenn Detention Center. Our purpose was to make observations of the physical plant, engage in conversations with both staff and the inmate population, to observe and assess security practices conducted by employees, and to determine if security practices were in compliance with written policies, procedures, and post orders. The attached audit tool indicates the areas and items reviewed as well as the findings of the security audit team.

Reviewers of this audit tool will find there are a number of opportunities for improvement. Many of the noted issues are considered "Corrections Basic 101" issues. These items should be obvious to the eyes of security personnel at all levels of experience. At first glance of the facility fence line, it has the appearance of abandonment. Not only is the physical appearance highly unacceptable, most importantly the level of security breaches created by this overgrowth is negligent on behalf of the facility security administration. Overall, the condition of the perimeter fence to include the dysfunctional outer drive through gate is primed for potential escapes. Repairs to the gate, fencing fabric, and elimination to the intrusive overgrowth of foliage should be addressed and corrected immediately. Attention to detail is instrumental in providing and maintaining effective correctional security practices. There are no shortcuts to good security. Additionally, the findings of the security

audit team during the tour of the housing units were found to be deplorable in some locations. The continuous flow of toilet water onto the floor of common areas in the housing unit creates a disgusting environment for individuals to live. Observations were made that indicated each time toilets were flushed; discharge wastewater was spilled onto the walkway upstairs and onto the common area on the ground floor. This situation creates a hygiene and sanitation hazard for all individuals living and working within this housing unit. There are a number of toilets and plumbing fixtures in need of replacement and repair. This is a prime example supporting the need of a maintenance work order tracking system.

There are a number of areas throughout the facility in need of ceiling repair/tile replacement. This is yet another example in which a maintenance work order system would be beneficial to the physical plant operation and upkeep.

The condition of the physical plant and the minimal focus on sanitation, cleanliness, housekeeping and ground maintenance could easily give the appearance of an operation lacking in administrative oversight and ownership. I encourage the ASG administration to conduct a self-examination of their commitment to the operation of the facility, their employees, and the inmates for which they are responsible.

EXHIBIT 24

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 4:22-cv-01358-MGL-TER **DECLARATION OF [redacted]**

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. My name is [redacted]. I have been incarcerated here at Alvin S. Glenn Detention Center since January 5, 2022. I have been housed in 5 different units but moved 7 different times. These units include Unit Papa, India, Juliet, X-Ray, uniform back to X-ray and moved to Juliet again. Conditions of Unit Papa weren't the worst at the time of my arrival it was decent and almost all cells were livable. Unit India a few cells weren't livable. There were water leaks here and there but it was livable as well. My first time being Juliet was only an overnight stay and the females in Unit Juliet were moved to Unit X-Ray. Unit X-Ray by far has been the worst unit I have ever been in. The living conditions were horrible, a majority of the rooms were unlivable there was a lot of contraband within the light fixtures, mats and visitation booths. We were given a directive by Captain Sligh and Lt. McCollough not to bring our mats that there would be mats given to us in Unit X-Ray. When we arrived at the unit it was full of garbage and contraband numerous amounts of weapons, phones, chargers. Multiple toilets have been snatched off of the wall as holding spots for contraband. Multiple rooms were with broken windows for "fishing rooms". I have found multiple fishing hooks.

2. A couple of months of being in X-Ray they did another mass move of the female to Unit Uniform and moved the "mental Health" females from Unit India into Unit X-Ray as Unit Uniform became the intake dorm for the females. I have been a trustee here for about a year and a half. However, I have been an in dorm trustee and a out-dorm trustee getting paid twenty-one dollars weekly. I have delivered chemicals to all fifteen dorms on a daily basis, folded laundry, pass out dorm supplies, dispose of trash, and clean and mop sally ports 7 days a week from 5 a.m. to 6:00 p.m. for twenty-one dollars a week as an out of dorm trustee. Working as an in-house trustee I serve chow to detainees, hand out the supplies, clean out cells as detainees come and go, refresh cells for mental health detainees who are incapable of doing for themselves, clean the day room and showers, hand out and assign tablets and handle laundry for free. As a dorm worker in the dorm I have bathed mental health patients covered in feces, I have cleaned rooms covered in feces. I have broken up endless amounts of fights to protect other detainees.

3. I am diagnosed with anxiety and depression. I am currently taking 40 mg of busbar, 50 mg of Visteril, and 5 mg of Ziprexa daily. Some days I have to remind the nurses my dosage. Mental health does not come see us as much as they should. When they do come to see us it is only one person and we don't have their full and undivided attention and the maximum amount of time may be about 15 minutes if that. We don't have any type of therapeutic programs. The most they will do is give us a coping skill sheet, coloring pages and some sport of guidelines, no real counseling nor any real therapy. We are only allowed to see the mental health doctor every three months.

4. When on disciplinary there is not much structure. They do not pay attention to the keep separate list, they do not move people back to their original housing arrangements. When placed on disciplinary, we are supposed to be dressed out into a stripe uniform. Speaking of disciplinary my friend that I consider my cousin [redacted] was housed in Unit Juliet on "disciplinary charges" she was spit on by another detainee. She received no days on disciplinary but was still housed in a lock-up unit. They are supposed to move the aggressor. On March 2, 2024, [redacted] hung herself from the light fixture that was hanging prior to her arrival. Her death could have been avoided if they would have properly housed her and had officer Johnson stayed at her post and not left early. [redacted] took her life around 7:00 p.m. that night. The officers are not supposed to leave their assigned post until the count clears. Earlier in that day the officer seen that she was in distress and didn't call mental health. From 4:00 pm. Up until 10-11 p.m.. we did not have an officer. Sergeant McClendon found her hanging during med pass. They took about 20-30 minutes to call the ambulance and the coroner removed the body around 1 or 2 a.m. I watched every single minute of it. The next day mental health came in and hasn't been back as often as they should be. I haven't been able to sleep since that day. I have seen mental health one time since then and have seen the mental health doctor once more. The proper protocol for disciplinary is to be moved back into General Population 90 days after your last write up. They do not follow these procedures. When charged with any in-house charges, you are supposed to see a hearing officer and they are supposed to hear your side of the incident but than likely they side with the officer who wrote the report and our days come from how the incident report was generated. Fifteen to twenty days no matter the charge. When on lockdown, we are locked down for twenty-three hours a day and receive REC for one hour if they feel like RECing the Pods, no television, no phones, and no commissary food, only stale food.

5. In Unit X-Ray, we were three to a room because there was no space in the unit to place others. The rooms in Unit X-Ray are unlivable. The rooms are full of mold, feces, either the sink and toilets are broken completely or either leaking. Some of the toilets don't flush, some sinks do not produce water. On most days in Unit X-Ray, we didn't have any officers and I had to run the unit if we wee let out by Lt. Williams. For the most part we have never ran out soak, tissue or toothbrushes and toothpaste. The things that are mandatory are the things we ran out of the most! Tissue, pads and tampons. On the days we didn't have tissue, they had us wiping with pads. Some days you were left in bloody or soiled uniforms. Detainees have been left in the rooms for days, weeks, months at a time without water, showers, outside time. [redacted], [redacted] and more. [redacted] has been left in her own feces for days. I had to bathe her no help from staff. [redacted] use to smudge the feces on her door.

6. When it comes to protecting the detainees, the officers don't interfere they call for assistance and the higher ups respond to it. Ever since [redacted] committed suicide we have had an officer in the unit at all times. Another detainee [redacted] attempted to set herself on fire with the exposed wires from the lights after she got into a verbal altercation with an officer that almost lead into a physical altercation after that she attempted to set herself on fire. We barely

have had adequate supervision in X-Ray. Females have been jumped, doors have been popped by detainees. Some officers have popped doors and allowed detainees to fight. When there are drugs in the unit most officers allow them to smoke and remain high. I am the only female that I know of that has gotten stabbed as of recently when I got into a fight with another detainee. I was defending myself and the other detainee was given the opportunity to press charges against me when I wasn't the aggressor. As far as the stabbing with the men I've known for it to be on the news but I am unsure of incident reports or charges or any incident reports beyond Alvin S. Glenn Detention Center.

7. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration.

3/20/2024
Date

[redacted]

To whom it may concern March 22, 2022

My name is [redacted]. I have been incarcerated here at Alvin S Glenn Detention Center since January 5 2022. I have been housed in 5 different units but moved 7 different times. These units include Units Papa, India, Juliet, X-Ray and Uniform back to X-Ray and moved to Juliet again. Conditions of Unit Papa weren't the worst at the time of my arrival it was decent and almost all cells were livable. Unit India a few cells weren't livable. There were water leaks here and there but it was livable as well. My first time being in Juliet was only an overnight stay and the females in Unit Juliet were moved to Unit X-Ray. Unit X-Ray by far has been the worst unit I have ever been in. The living conditions were horrible, a majority of the rooms were unlivable there was alot of contraband within the light fixtures, mats and visitation booths. We were given a directive by Captain Sligh and LT Mc Collough not to bring our mats that there would be mats given to us in Unit X-Ray. When we arrived at the unit it was full of garbage and contraband numerous amounts of weapons, phones and chargers. Multiple toilets have been snatched off of the wall as holding spots for contraband. Multiple rooms were with broken windows for "fishing rooms". I have found multiple fishing hooks.

A couple of months of being in X-Ray they did another mass move of the females to Unit Uniform and moved the "mental health" females from Unit India into Unit X-R

is Unit Uniform became the intake dorm for the females. I have been a trustee here for about a year and a half. However, I have been an in dorm trustee and an out dorm trustee getting paid twenty-one dollars weekly. I have delivered chemicals to all fifteen dorms on a daily basis, folded laundry, pass out dorm supplies, dispose of trash, and clean and mop daily posts 7 days a week from 5 am to 6 pm for twenty one dollars a week as an out dorm trustee. Working as an in house trustee I serve chow to detainees, hand out the supplies, clean out cells as detainees come and go, refresh cells for mental health patients [redacted] who are incapable of doing for themselves, clean the day room and showers, hand out and assign tablets and handle laundry on here. As a dorm worker in the dorm I have bathed mental health patients covered in feces, I have cleaned rooms covered in feces. I have broken up endless amounts of fights to protect other detainees.

I am diagnosed with anxiety and depression. I am currently taking 40 mg of busbar, 50 mg of Vistaril, and 5 mg of Zipraxa daily. Some days I have to remind the nurses of my dosage. Mental health does not come see us as often as they should. When they do come to see us it is only one person and we dont have their full and undivided attention and the maximum amount of time may be about 15 minutes of that. We dont have any type of therapeutic programs. The most they will do is give a coping skill sheet, coloring pages and some sort of guidelines, no real counseling nor any real therapy. We are only allowed to see the mental health doctor every three months.

When on disciplinary there is not much structure. They do not pay attention to the keep seperate list, they do not move people back to their original housing arrangements. When placed on disciplinary, we are supposed to be dressed out into a stripe uniform. Speaking of disciplinary my friend that I consider my cousin [redacted] was housed in Unit Juliet on "disciplinary charges" she was spit on by another detainee. She recieved no days on disciplinary but was still housed in a lock up unit They are supposed to move the aggressor. On March 2 202[redacted] hung herself from the light fixture that was hanging prior to her arrival. Her death could have been avoided if they would have properly housed her and had office Johnson stayed at her assigned post and not left early and hid in the supervisor office until count cleared. [redacted] took her life around 7pm that night. The officers are not supposed to leave their assigned post until their relief arrives and the count clears. Earlier in that day the officer seen that she was in distress and didnt call mental health. From 4pm up until 10-11pm we didnt have an officer. Sergeant Mc Clendon found her hanging during med pass. They took about 20-30 minutes to call the ambulance and the coroner removed the body around 1 or 2 am. I watched every single minute of it. The following day we had officer Johnson, she woke me up for med pass and I had an emotional breakdown I cried, I sobbed and refused my mental health medicine. Officer Johnson rubbed my back, dropped her head and cried on my back. I eventually got up and took my medicine. This same day Johnson expressed that she couldnt sleep and cried at the desk. Mental Health also came the day after and havent

seen back as often as they should be. I havent been able to sleep since that day. I can vision her hanging and I can hear the ceiling cracking. I have seen mental health one time since then and have seen the mental health doctor once more. The proper protocol for disciplinary is to be moved back into General Population 90 days after your last write up. They fail to follow these procedures. When charged with any in house charges, you are supposed to see a hearing officer and they are supposed to hear your side of the incident but more than likely they side with the officer who wrote the report and can days come from how the incident report was generated. fifteen to twenty days no matter the charge. When on lockdown, we are locked down for twenty three hours a day and recieve REC for one hour if they feel like RECing the pods, no television, no phones, and no commisary and only state food.

In Unit X-Ray, we were three to a room because there was no space in the unit to place others. The rooms in Unit X-Ray are unlivable. The rooms are full of live wires, mold, feces either the sink and toilets are broken completely on either leaking. Some of the toilets don't flush, some sinks do not produce water. I have shocked myself with the live wires before on the wall by the door. I have saved detainees life from a fire from the wires in X 36. On most days in Unit X-Ray we didnt have an officer LT Williams would unlock the cells and I would run the unit. The intercoms do not work on are missing from the wall. For the most part we have never ran out of soap, toothbrushes or toothpaste.

The things that are mandatory are the things that we run out of the most which are tissue, pads and tampons. On the days that we didnt have tissue they had us wiping with pads. Some days we were left in bloody or soiled uniforms. Detainees have been left in the rooms for days, weeks, months at a time without wate showers or outside time, [redacted] and more. [redacted] has been left in her own feces for days. I had to bathe her on my own with no help from the staff. [redacted] use to smudge the feces on her door.

When it comes to protecting the detainees, the officers dont intefere they call for assistance and the highe ups respond to it. Even since [redacted] committed suicide we have had an officer in the unit at all times. Another detainee [redacted] attempted to set herself on fire with the exposed wires from the lights after she got into a verbal altercatio with an officer that almost lead into a physical altercation after that thats when she attempted to set herself on fire. We barely have had any adequate supervision in X-Ray. Females have been jumped, doors have been popped by detainees by either the panel not being disabled or by calling Central Control on the officers phone. Some officers have popped doors and allowed detainees to fight. When there are drugs in the unit most officers allow them to smoke and remain high. I am the only female that I know of that has gotten stabbed as of recently when I got into a fight with another detainee. I was defending myself and the other detainee was given the opportunity to press charges against me when I went the

aggression. As far as the stabbing with the men Ive known for it o be on the news but I am unsure of incident reports or charges on any incident reports beyond Alvin S. Glenn Detention enter.

[redacted]

EXHIBIT 25

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-MB **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following true and correct:

1. Hi, my name is [redacted] and I am currently an Alvin S. Glenn inmate. As I am sure you know that the organization of this jail is all out of order. Not only that but the conditions are...leaking toilets, cells with no lights. Some of our sinks have no water, so we go all day without cold water to hydrate our bodies. Sometimes we don't even have a water cooler with water in it and if we do we MIGHT get to come out of our cell to retrieve some of that water, if the correctional officer lets us. Our food is still slop sometimes the meats we get served is still pink and red on the inside. The showers are disgusting. Nats stay lingering in our cell rooms. Some of the CO's at times don't even give us our mandatory 1 hour REC. A lot of times me and my roommate take "sink wash offs" because of the mildew and mold in our showers.

2. Oh yeah also with the CO's not always being present in and an our unit/pod we had a dear friend of our's pass away/commit suicide. [redacted], She was in Room 37 right next to me and my celly. She was a very beautiful young black woman, age 22. Same age as I, there was a lot going on with her and her family, that drove her into her decision. Later on the evening

of March 2, 2024 [redacted] hung herself in place of where there should have been a plastic piece. Should have been over the light. It was a little after 4:30 p.m. after we were fed chow. After that the CO. left and not another one showed up till after 11 p.m. that night. God rest her soul. # Black Lives Matter.....

3. Also, there has been a CO by the name of Mr. Gray that has made several flirtatious comments to me and told me to look him up after I made bail like to "get up with me."

4. So, as you read this letter, please take in everything that I'm letting you know. And, yes, its all true and it's so sad that even though it's our faults we are even in jail, jails aren't supposed to be like this. It's so inhumane. Hopefully, this will help you out on some known experienced logic that's going on in Alvin S. Glenn.

5. Attached hereto is my own hand-written statement that is the same in all material respects as this Declaration.

6-11-2024
Date

[redacted]

Dear Mr. Stewart,

Hi my name is [redacted] and I am currently an Alvin S. Glenn inmate. As im sure you know that the organization of this jail is all out of order. Not only that but the conditions are... Leaking toilets, cells with no lights. Some of our sinks have no water, so we go all day without cold water to hydrate our bodies. Sometimes we don't even have a water cooler with water in it and if we do we MIGHT get to come out of our cell to retrieve some of that water, if the Co lets us. Our food is still slop sometimes the meats we get served is still pink and red on the inside. The showers are disgusting. Nats stay lingering in our cell rooms. Some of the Co's at times don't even give us our manditory 1 hour Rec. A lot of times me and my roomate take "sink wash offs" because of the mildew & mold in our showers. Oh yeah also sir with the co's not always being present in and on our unit/pod we had a dear friend of our's pass away / committ suicide. Ms. [redacted], She was in Room 37 right next to me and my celly. She was a very beautiful young black woman, age 22. Same age as I, there was a lot going on with her and her family, that drove her into her decision. Later on the evening of March 2, 2024 [redacted] hung herself in place of where there should have been a plastic piece should have been over the light. It was a little after 4:30pm after we were fed chow. After that the Co left and not another on showed up til after 11pm that night God Rest her soul. #BlackLivesMatter

Also there has been a Co by the name of Mr. Gray that has made several flirtatious comments to me and told me to look him up after I made bail. He'd like to "Get up with me!!" →

So as you read this letter Sir please take in everything that I'm letting you know. And yes it's all true and it's so said that even though it's our faults we are even in jail, jails aren't supposed to be like this. It's so inhumane. Hopefully this will help you out on some known & experienced logic that's going on in Alvin S. Glenn. Have a great day Mr. ~~Edwards~~ Stuart,

[redacted]

EXHIBIT 26

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
GREENWOOD/ANDERSON DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 8:22-cv-01358-MGL-MB **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare under penalty of perjury that the following is true and correct:

1. My name is [redacted]. I am a high school graduate and I am currently incarcerated a ASGDC. I have been here for 2 years and 9 months. When I first got here on June 17, 2021 I was housed in PAPA unit. In the fall of 2022, I was moved to India unit. In the spring of 2023, I was moved to X-Ray unit. Then in the beginning of 2024, I was moved to Juliet unit. I have been a dorm worker for extended periods of time since X-Ray unit. Dorm working includes feeding, and cleaning but during my time working my duties extended far beyond that. Dorm work does not include any monetary for women in ASGDC. However, it does include dealing with may physically dangerous situations. It also demands facing many situations that are mentally damaging.

2. I myself am diagnosed with bipolar disorder, as well as some personality disorder issues. I am on Tegretol which serves as a mood stabilizer for me. There were times, especially during my time being housed in X-Ray that I did not receive my medication for many nights in a row. Sometimes I would have to utilize the security phone in order to get an officer to come down

to administer our medication. Some nights no one came at all. I received no form of therapy. There is none available. They offer printed word searches or printed lists of coping skills that is the extent of therapy. My mind is active and there is very little to stimulate it here. It seems to me that they are under the impression that mental illness and mental retardation are mutually exclusive. The two obviously do not go hand in hand. To be mentally ill here is to be treated like your suffering from an intellectual malady instead of an emotional one. I see my clinician every few months if I am lucky. I'm asked a few questions. My PTSD needs are often ignored as long as I'm not have any outburst. No outbursts here equals a happy staff and an unhappy detainee.

3. I live in the "lock-up" unit. I have my entire stay. I could be placed on 23 and 1 rec reschedule for a disciplinary sanction but most days that is my schedule when I am not on a sanction. My canteen could be removed if I were on sanction and I could rec alone. That rarely happens though. I have been living in a high security unit for 33 months. I have ben given no option to step down or to earn any better housing. People with similar charges and more disciplinary actions have been giving the opportunity I now could not imagine living in an open dorm. The thought of not having a door cause me stress. I do not "like to be in lock up" but I can't imagine not being in lock-up. As I said I have been behind a door for a very long time. The thought of not having a door gives me bad anxiety.

4. During my time as a dorm worker and even during my times off I have watched women go months without an opportunity to wash, without hygiene or feminine suppose, and without running water. I have seen women locked in rooms with toilets full of feces or without a sink or toilet in the room at all. I have had to help shower women like [redacted] who were in states of deep psychosis. Other women weren't lucky enough to receive help from anyone. [redacted], [redacted], [redacted], [redacted], those are a few names of women whom I have seen endure conditions that would have animal activists up in arms and a zoo closed down if its animals were treated so badly. I have seen them endure neglect that would send a pet owner seen them endure neglect that would send a pet owner to jail. Do we deserve that?

5. [redacted]. She was my friend. She was a young mother. She was full of life. Now she is a memory. On her last day she sobbed. She was far from the usual firey, energetic, young woman we knew and loved. When I served her meals, I knew she was not herself. I tried to comfort her. The officer working that day rushed me out of her room. She said "come on I ain't got time to deal with all that." Officer Johnson left her shift early that as she does most days. At around 4 we were left alone. Around 7 they cut my friend down from her light fixture. It could have been avoided.

6. I lost my husband in October 2023 on Board River Prison yard. His name was [redacted] the same way. How many of us have to die? Our lives matter. My husband was a white man convicted of murder. [redacted] was a spirited young black woman convicted of nothing. Their lives mattered. So do their deaths. We ask that [redacted] name be added to the list of names of other young black lives list to blue on black crime and negligence.

7. Stabbings and fights are often a part of life here. Investigations into those situations are not. Many of us will carry physical and mental scars from this place for the rest of our lives. There is nothing here to better us. It I often a fight for survival. We came to a county detention center to await trial for a few months and we stay here for extended periods of time. Many people show up here accused of a crime and in their fight to survive leave guilty of crimes worse than the ones they were accused of. I hope this letter helps.

8. Attached hereto is my own hand-written statement that is the same in all material respects as this Declaration.

June 11, 2024
Date

[redacted]

3-12-2024

To whom it may concern,

My name is [redacted]. I am a highschool graduate and I am currently incarcerated a ASGDC. I have been here for 2 years and 9 months. When I first got here on June 17, 2021 I was housed in PAPA unit. In the fall of 2022 I was moved to India unit. In the spring of 2023 I was moved to X-RAY unit. Then in the beginning of 2024 I was moved to Juliet unit. I have been a dorm worker for extended periods of time since X-Ray unit. Dorm working includes feeding, and cleaning but during my time working my duties extended far beyond that. Dorm work does not include any monetary for women in ASGDC, however it does include dealing with many physically dangerous situations. It also demands facing many situations that are mentally damaging.

I myself am diagnosed with bipolar disorder, as well as some personality disorder issues. I am on tegeratol which serves as a mood stabalizer for me. There were times, especially during my time beeing housed in X-ray that I did not recieve my medication for many nights in a row. Sometimes I would have to utilize the security phone in order to get an officer to come down to administer our medication. Some nights no one came at all. I recieve no form of therapy. There is none available. They offer printed word searches or printed lists of coping skills. That is the extent of therapy. My mind is active and there is very little to stimulate it here. It seems to

me that they are under the impression that mental illness and mental retardation are mutually exclusive. The two obviously do not go hand in hand. To be mentally ill here is to be treated like your suffering from an intellecutal mallady instead of an emotional one. I see my clinician every few months if I am lucky. Im asked a few questions. My PTSD needs are often ignored as long as Im not having any outbursts. No outbursts here equalls a happy staff and an unhappy detainee.

I live in the "lock-up" unit. I have my entire stay. I could be placed on 23 and 1 rec schedule for a diciplinary sanction but most days that is my schedule when I am not on a sanction. My canteen could be removed if I were on sanction and I could rec alone. That rarely happens though. I have been living in a high security unit for 33 months now. I have been given no option to step down or to earn any better housing. People with similar charges and more diciplinary action have been given the opportunity. I now could not immagine living in an open dorm. The thought of not having a door causes me stress. I do not "like to be in lock up" but I cant imagine not being in lock-up. As I said I have been behind a door for a very long time. The thought of not having a door gives me bad anxiety.

During my time as a doorm worker and even during my times off I have watched women go months without an opportunity to wash, without hygine or feminine supplies, and without running water. I have seen women locked in rooms with toilets full of feces or without a sink or toilet in the room at all. I have had to help shower women like [redacted] who were in states

of deep psychosis. Other women weren't lucky enough to recieve help from anyone. [redacted], [redacted], [redacted], [redacted], those are a few names of women whom I have seen endure conditions that would have animal activists up in arms and a zoo closed down if it's animals were treated so badly. I have seen them endure neglect that would send a pet owner to jail. Do we deserve that?

[redacted]. She was my friend. She was a young mother. She was full of life. Now she is a memory. On her last day she sobbed. She was far from the usual firey, energetic, young woman we knew and loved. When I served her meals I knew she was not herself. I tried to comfort her. The officer working that day rushed me out of her room. She said "come on I aint got time to deal with all that". Officer Johnson left her shift early that day as she does most days. At around 4 we were left alone. Around 7 they cut my friend down from her light fixture. It could have been avoided.

I lost my husband in Oct of 2023 on Broad River Prison Yard. His name was [redacted] the same way. How many of us have to die? Our lives matter. My husband was a white man convicted of murder. [redacted] was a spirited young black woman convicted of nothing. Their lives mattered. So do their deaths. We ask that [redacted] name be added to the list of names of other young black lives lost to blue on black crime and neglegence.

Stabbings and fights are often a part of life here. Investigations into those situations are not. Many of us will carry physical and mental scars from this place for the rest of our lives. There is nothing here to better us. It is often a fight for survival. We came to a county detention center to await trial for a few months and we stay here for extended periods of time. Many people show up here accused of a crime and in their fight to survive leave guilty of crimes worse than the ones they were accused of. I hope this letter helps.

Sincerely,

[redacted]

EXHIBIT 27

Alvin S. Glenn Detention Center
Town Hall Meetings with the County Administrator
July 2021

Resources

- Get N95 masks

Infrastructure

- Plumbing issues (puddles of water)
- Mold
- Manual flushes of toilets
- Outdated facilities are not in service because there are no parts to fix inoperable equipment.
    - Broken items - outdated and can't fix (plumbing)
- How long can we delay to fix a broken light fixture, etc.?
- Mental Health Unit - how many detainees would be housed in it? Occupancy cap? Construction costs? Operating costs?
- Maintenance staff states that there is a lack of supplies to perform their duties.
    - Broken items - no money to replace
- Cut the air off during the day - why can't maintenance work be done in the evenings?
- Maintenance workers come when they want to (to respond to maintenance requests)
- No upgrades
- Computers don't half work
- Phones out every other day
- What new technologies did ASGDC receive?
- Horrible work conditions - turn on exhaust fan for five mins at a time (heats up room; sucks out air)
- Radio system does not work in Central
- Unit Yankee - 5 rooms: look like feces growing out of toilet…..mice running through units
- Jail is so filthy - kitchen smells terrible - don't know how we pass accreditation
- Look into procuring ballistic lights $1,500 - can't tamper with it
- Plumbing issues in the unit

Safety

- Request for body camera
- Tasers - lost certification

- Safety is a huge issue - 7 cell phones in one dorm.
- Perform K9 search frequently
- Need shakedowns
- Units full of smoke; can't give officers a break - 16 hours in dorm
- CO having to rove between one form and another….safety issue
- Inmate died in SHU Unit - 2 vs 4 COs - lack of supervision of detainees/officers
- Jail is so confrontational
- Why don't all officers have a body camera?
- One officer was assaulted 2X in a week; stays home to avoid assaulting detainees.
- Officers assaulted in SHU - nothing done
- Poor living conditions for the units
- K2 - detainees/prisoners buy as much tissue as they want, which is what they use to smoke
- Do whatever they want to do. Assault officers and nothing happens to them
    - Inmates can do whatever they want to do. Officers feel like the prisoners.
- Masturbation - get no charge
    - Detainees masturbating on female officers.
- 4 hour stay over (OT) - working 16 hours w/o a break
- Doors are not secured - using ID card to jam door ——-inconsistent reading on panel
- Address safety concerns, which is adversely impacting morale and give raises

Policy

- Memo reflecting detainees can watch TV late (some staff members posit that the memo conflicts with policy)
- Inconsistent policy administration as policies in one unit are different than the policies in another unit.
- Incident report - DO witnesses a DO giving contraband to detainees and write up report and nothing is done
- Polygraph and psychological tests stopped
- COs bring in contraband and allowed to resign.
- Why can't days do tier for tier like nights? (Letting folks out cells)
- Go to SHU and come straight back out
- Need a MD's note for one day out of sick leave (is this County policy?)
- Restraint Policy: Detainee assaulted another detainee and officer and should have been placed in restraint and sent to SHU

- Cpt Buford says they can watch late games
- Lock doors at 10:30 PM - watching late games on the west coast

Communication

- Myers and Bufford tell detainees things; COs have no clue.

Leadership

- Moye, Leggett, - don't come out on the floor to help
  - Leggett does not even come out of the office.
- What is Sly doing all day?
- Holmes, Sly, Wanamaker, Vincent, Bufford, Myers, Kitchen - walk part of the day and go home during pandemic
  - During pandemic, command staff worked half a day every other day
- Favoritism seems rampant
- Allow people to constantly "call out" (not coming to work) - about 10 people in this situation
- Lack of knowledge on FMLA
- My leadership is on vacation and they know the condition that we're in
- Morale up when Myers was gone in 2018….used tier for tier
- Care more about detainees than officers
- Captains have more authority than Kitchen
- Kitchen tries
- Tier for Tier: Bottom tier - day shift; top tier - night shift; switch shift on next day ——- why did you stop it?
- Removal of tier for tier because it is not direct supervision - led to more Code Red, assaults on officers
- Rewarded for bad behavior: phone call privilege, not going to lockup for smoking K2, take paraphernalia from detainees and no consequence
- Supervisors' hands are tied; bunch of puppets like they don't have a brain
- You are going to be tagged until you're out the door.
- Cpt. Buford suggests getting detainees handballs
- No incentive to be a trainer; senior officers making less money than new folks coming in the door
- Morale improved when Myers left
- More supervisors than officers - why can't they work the dorms?
- Fraternization - big issue
  - Cpts, Lts, and Sgts fraternizing with officers repeatedly

- Unfair promotion system - short pd of time to get promotion; veterans not getting promoted
- Long process for bringing in a new officer - how can we expedite the hiring process?
- Dirty officers are caught for contrabands, but are not charged
- Reprimands involve five-six managers on one officer
- Go to supervisors' offices and speak and they won't speak to you
- 95% of supervisors are unprofessional; no class; supervisors don't communicate with each other; pertinent info not shared in briefing such as detainee running to central control or assaults on officers
- Officer sick and requested relief never received it. Sick the next day. Written up. Told to wear N95 mask.
- Supervisors barely coming to dorms
- Ms. Harrell left - all discipline was gone
- SHU is disciplinary unit and they get high in there
- DO brought in 5 cells - able to resign
- Two officers knew about upcoming gang fight and eventually resign

Personnel

- While maintenance crew members are on call, they only get paid for the hours worked, not paid for the entire time on call.
- Supervisor need training
- Need ERT Team - same officer on unit serve on team
- Sue Brown uses FMLA for last 3-4 years
- DOs arguing with inmates/detainees
- ERT Team - pay for own uniform, training, hotel accommodation
    - ERT Team - pay for own equipment/shirts; DOC and RCSD's response team get paid (give incentive to join….incorporate money into pay scale)
- We need 5 maintenance workers: manager, 2 plumbers, 2 electricians; hire certified professionals; 2 more plumbers and 1 more electrician
- Grievance Process: what does it entail? Steps? Length of time?
- Why can't salaried employees get paid for working outside of the normal tour of duty?

Solutions

- Contracted workers or National Guard personnel to serve as COs

EXHIBIT 28

Progress

Director Tyrell Cato

Alvin S. Glenn Detention Center

Abstract

This report will give you all an update on the things that have been underway at Alvin S. Glenn Detention Center over the past few months. The facility has done several things that has made it better for the detainees and staff at the detention center. ASGDC, has made it a mission to make conditions better and will continue to move forward with that mission in the coming months and years, as we improve as a whole.

Progress

Over the past few months the facility has been moving forward with upgrades and repairs to the facility. We have moved forward with many items that make for a better environment for the detainees and staff at the detention. The items that we have addressed were needed immediately and shows that we are committed to the humane care of the detainees that are under the watch of Alvin S. Glenn Detention Center. The improvement will be laid out below and will give insight into what has taken place and the things that are in progress to make the facility better for the detainees and the public.

Lighting & Cleanliness

The housing unit which is often referred to as SHU (Special Housing Unit) has had numerous maintenance issues. One of those issues centered on the lighting in the unit. For years detainees had damaged the light fixtures and the wiring for the lights. This resulted in the rooms in the SHU area to not have the lighting that was needed for the safety and security of the facility. ASGDC has fixed that issue and has begun the installation of the new maximum security LED lighting for the rooms in the SHU unit and these lights will be installed throughout the entire facility within the next few months. Within 2 weeks the lighting project will be completed in the SHU unit and we can move over to the Yankee unit to begin upgrades there. These lights allow for staff to see the detainees clearly while housed in the rooms and assist with doing security and medical checks on detainees. We have the bottom tier (28 rooms) completed and are about to begin the installation of the top tier (28 rooms). September 1, 2022 anticipated completion date.

Cleaning was the other issue that has been on the forefront of the conditions in the SHU unit. We had an all hands on deck cleaning day of the unit, which consisted of 20 or more staff

members. These members swept, mopped, and removed all debris from the unit to ensure that the area was adequate for detainees and staff. We then pressure washed rooms and removed markings and graffiti from the walls. We will being painting the unit once the installation of the lights are complete. Begins the first week of September once fixtures have been installed.

Mental Health Unit

We have begun the initial steps to create a mental health unit at the ASGDC. This unit will house detainees with mental illnesses who cannot be housed in general population due to the guidance of our mental health provider. The unit will be designed with the assistance of our mental health provider. The painting of the rooms will be guided by them on what colors are needed to make it a therapeutic area and calming for the detainees housed there. The psychiatrist will have an office located within the unit so that guidance and consultations can be given on a daily basis to the detainees. Correctional staff working the unit will be trained in Crisis Intervention, Dealing with the Mentally Ill, and other training deemed necessary by the facility and mental health provider. This unit should be up and operational with 3 to 4 months and has been submitted to administration for approval of some cosmetic items that are needed before we begin housing the mentally ill in the unit.

Plumbing

Many of the plumbing fixtures were inoperable due to years of use and some due to detainee misuse of the fixtures. Currently the facility has outsourced the repair of these fixtures and has a certified plumbing company on hand fixing all of the plumbing issues that we have. These issues include showers, toilets, fountains, and sinks. The plumbers come onsite Monday through Friday all day and will continue this same trend for the next few months until the plumbing issues have been rectified and are then manageable by ASGDC maintenance staff. The

plumbers are moving methodically through the facility and have made a tremendous impact on several housing units over the past two weeks. We currently have done 2 housing units and have and 15 more to go. We anticipate to have this completed in 2 months.

Attorney Visits

Attorney visits has also been a hot topic when it comes to ASGDC and the shortage of staff at the facility. This area was affected drastically during the height of the pandemic and the issues lingered even after things got back to the new normal. ASGDC has made it a common practice to ensure that detainees are able to meet with their legal counsel by allowing legal counsel to schedule regular visits and by providing a unit for them to come onsite and meet with their clients. This system has shown to work and continues to work even as covid has spiked at certain times during the use of this process. We have had to quarantine housing units due to covid cases being identified in several housing units. To ensure the attorney visits continued with implemented a testing process of the detainees to identify cases and continue visits as normal for the detainees.

Phone/Video System

We have begun the installation of the phone/video system for the detainees at ASGDC. The installation of the new system began at the end of July and should be completed by the end of August. The installation of the new phone/video system, will allow for the detainees to have ties to the community. They will be able to talk to family members and also have video visitation with loved ones during scheduled hours as they deem necessary. We are making it easier for the detainees to stay in contact with their support systems, even while incarcerated at the ASGDC. The new video portion of the installation also allows for the detainees to have unrecorded video visitation with their legal counsel from within the housing unit. These visits can be scheduled by

the attorney and the detainee will be notified of the visit and will have more access to their legal representation. We have done the wireless internet install and have put the phones in the units. We are currently working on and have put the kiosk in 6 out of the 17 units. We are looking to have this completed by September 9, 2022.

The phone install also comes with tablets that allow access to the law library and educational programming as well. Detainees can use the tablets for GED Prep and also research information on the charges for which they have been detained. We are also restarting the GED Program in September and which will give detainees the ability to educate themselves while at ASGDC.

Camera System & Door Locks

Alvin S. Glenn Detention Center has begun putting together a scope of work presentation to secure a vendor for the new camera installation at ASGDC. The new camera system will add an extra layer of safety and security for detainees and staff at the facility. Staff will be able to identify areas of concern by monitoring the detainees by using the new camera system. The cameras will be able to see things 24/7 and will provide an avenue for us to go back and review to confirm what took place when an incident occurs and is being investigated. Scope has been sent to procurement as of 8/19/2022.

Door locks have been a safety and security concern for staff and the detainees. The locks we currently have are antiquated and are in need of upgrade. ASGDC has found a solution to this matter and is working with county government to get the proper wiring so that the locks can be installed. These locks are of maximum security quality and reduces the ability for the detainees to evade the system. These locks have been tested and allows for staff to easily secure a detainee behind a door and ensure that they remain there. These locks will reduce the security breaches

that have occurred in the past at the detention center. We are sending the scope of work for the RFP process for some electrical upgrades so that the locks can be installed. Scope has been sent to procurement as of 8/19/2022.

Staffing

ASGDC has made a tremendous effort to reduce staffing deficiencies. We started July 1, 2022 with 160 vacant positions and currently with the new hires that we have starting on the 29th of August we will be down to 122 vacancies and we count to see increased activity by way of recruiting and retention. We streamlined our hiring process to allow us to attend job fairs and have applicants apply by the use of laptops. We then conduct background checks while onsite and then if they pass that process we conduct an interview at the job fair. Applicants are tentatively hired and are sent for drug screening. They also have a follow up interview a day or two later and are made an offer.

We have also partnered with Allied Barton Security to give us a higher level of officer presence within the facility. We currently have 26 Allied Barton Officers working onsite at this time and look forward to increasing to 40 in the next few weeks. The contractors assist with various tasks within the facility, while showing a level of professionalism that we demand at ASGDC. The increased officer presence has allowed for incidents to remain low and for more tasks to be completed throughout the day, so that the detainees receive the services and programs that are needed to provide them a better quality of life while at ASGDC.

Lighting

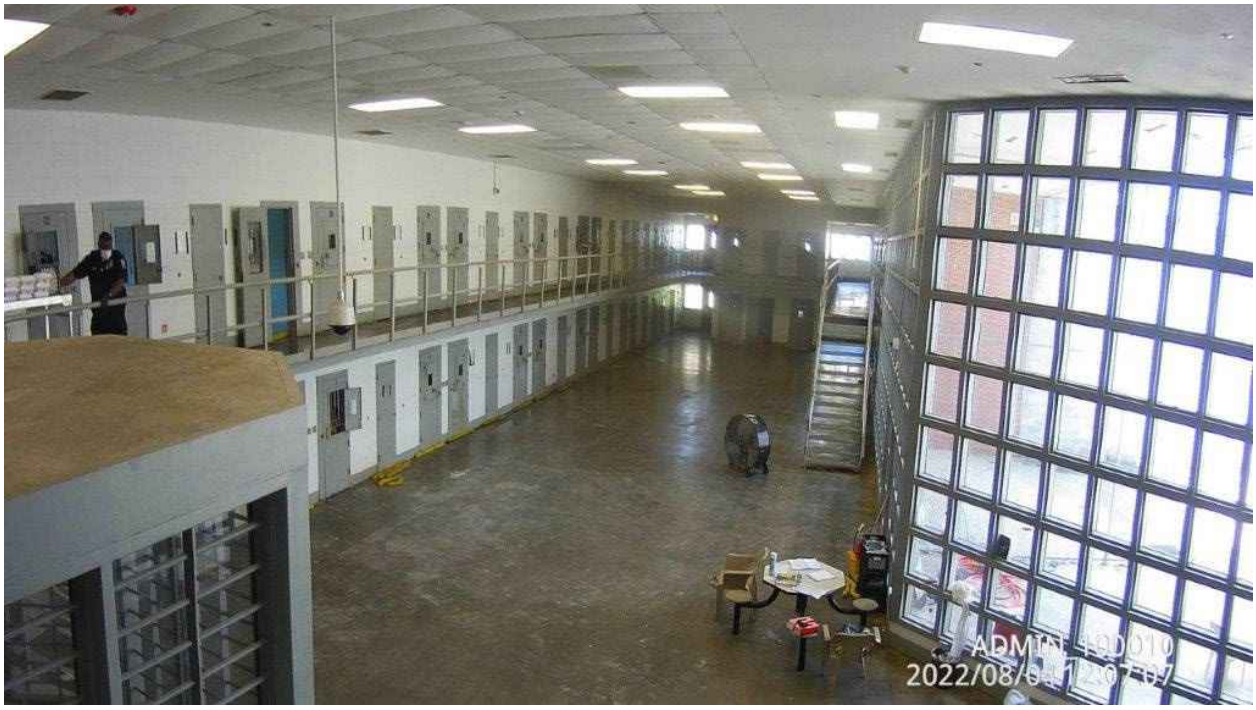

ADMIN_100010
2022/08/19 08:59:08

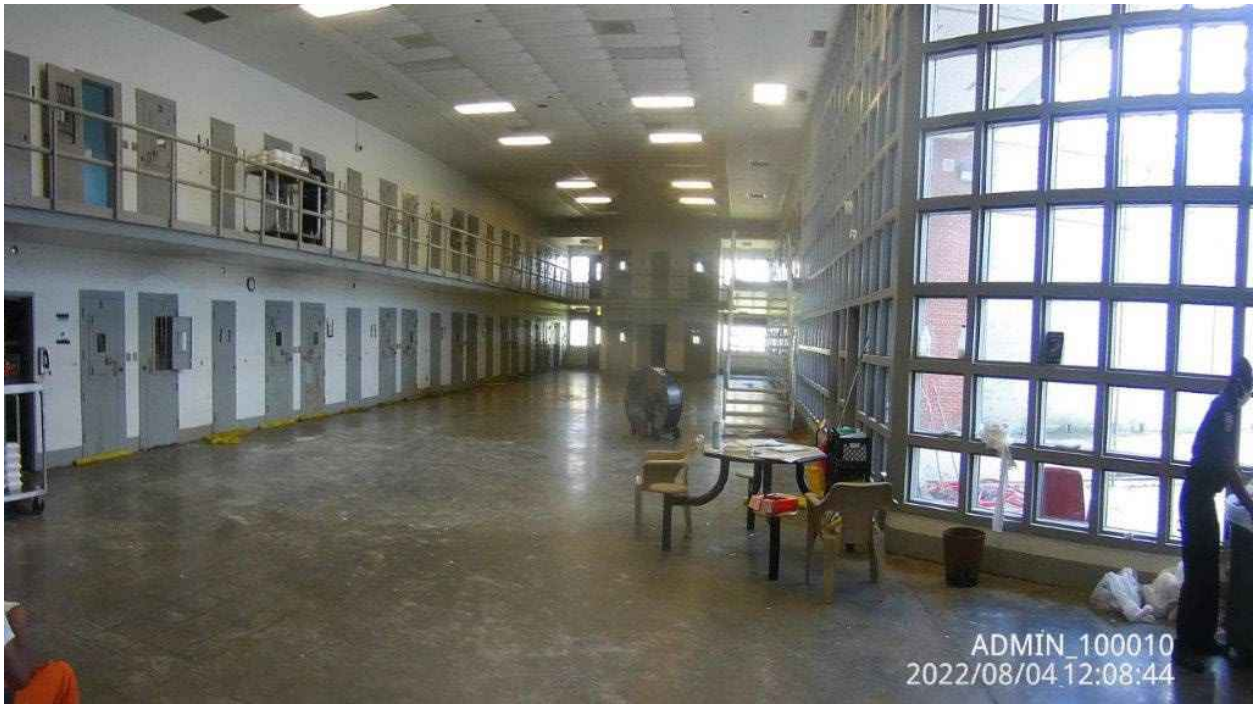

ADMIN_100010
2022/08/19 08:59:40


ADMIN_100010
2022/08/19 08:55:52


ADMIN_100010
2022/08/19 08:58:59

Common Area of SHU




ADMIN_100010
2022/08/04 12:08:44

ASGDC 12

EXHIBIT 29

South Carolina Department of Corrections

HENRY McMASTER, Governor
BRYAN P. STIRLING, Director

January 19, 2023

Mr. Overture E. Walker, Chairman
Richland County Council
Post Office Box 192
Columbia, South Carolina 29202

Re: Richland County (Alvin S. Glenn) Detention Center

Dear Mr. Walker:

A copy of our report from an inspection which was conducted at the Richland County (Alvin S. Glenn) Detention Center is attached. Also included are inspection reports from the Office of State Fire Marshal and the Department of Health and Environmental Control. These are provided so that Richland County Council as the responsible governing body has the specific information needed to initiate and to implement your corrective action as required by the South Carolina Code of Laws.

It should come as no surprise that the conditions at your Detention Center are in need of immediate attention and improvement. We have been communicating with management at the facility and the County Administrator for some time now in an effort to assist them with options for making progress and for addressing urgent, time sensitive problems. In addition to examples of various correspondence which are enclosed, the County Administrator and I have had a few conversations and at least one virtual meeting. However, there are also needs which only County Council can meet. Some of those should be obvious from a review of our report and the other documents attached, but further explanation/amplification will be offered upon request.

Please let us know your strategy for remedial action. A response is needed no later than April 18, 2023, pertaining to how you intend to proceed and all that will be achieved under your plan, including a timetable for accomplishing each step. In the absence of a satisfactory reply, we would then have to stipulate specific changes with deadlines required in order for this facility to remain open. Of course, it is most definitely our hope and preference to avoid the necessity of taking such extreme action.

If County Council so desires, I would be glad to meet in person and discuss the issues and options. In the meantime, please do not hesitate to seek or request any additional information or clarification. We are prepared to cooperate while Richland County Council pursues a reasonable approach for eliminating all violations of the fire/life safety codes, the food service regulations, and the Minimum Standards for Local Detention Facilities in South Carolina so as to address the best interests of affected parties.

Sincerely,

Blake E. Taylor, Jr., Division Director
Compliance, Standards, and Inspections

BETJr/rbs

Attachments: 4 sets

cc: Mr. Leonardo Brown, County Administrator
Mr. Crayman J. Harvey, Interim Detention Director

EXHIBIT 30

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County (Alvin S. Glenn) Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3259 Home Detention Program **Yes** Work/Punishment Program **Yes**

Type I ___ II ___ III ___ IV **X** V ___ VI ___ VII ___ JuvHold **No** DesignatedFac **Yes** FedContract **Yes**

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Crayman J. Harvey, Interim Detention Director

Governing Body: County Council Chairperson: Mr. Overture E. Walker

Date of Last Inspection: 09/28/21 Year Built: 1994 1998, 2007 Last Year Remodeled: 2007

	Adult M	Adult F	Juvenile M	Juvenile F		
Rated Capacity:	1,060	56			1,116	(Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):	657	44			701	(Total Avg. Daily Pop)
High Count (past 12 mos.):	692	60			Facility High Count	752

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	8	8	11	9	36	FT	118
Full-time Female	26	18	20	18	82	PT	0
Part-time Male					0	=	118
Part-time Female					0	Vacant	124
Vacant Positions	33	31	30	30	124	Reserve	0
Reserve Officers					0	Slots	242

II. Administrative Staff (denotes number and full-time(**FT**) or part-time(**PT**))

Administration		Support		Treatment		Program		Total	
Director		Maint	13FT	Doctor	Contract	Education	Contr.	FT	44
AsstDir	1FT	FoodServ	Contr.	RN	Contract	Classific	3FT*	PT	5
Sen/Chief	5FT	Records	*	LPN	Contract	Training	1FT	=	49
Clerical	6FT	Prop/Sup	3FT	MntlHlth		Religious		Contract	
Other	12FT, 5PT	Other		SocWork	Contr.	Other		Volunteers	
Vacant		Vacant	8FT	Vacant		Vacant		Vacant	8

*** Employee(s) also work a shift.**

III. Total Full-time (I&II) 162 **Total Part-time** (I&II) 5 **Grand Total** (I&II) 167

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
1021, 1022, 1031(a)(b)(d), 1035, 1065(b)(e), 1082(a), 1094(b), 2014-1, 2014-2, 2014-13, 2014-16, 2014-40, 2017-5, 3003

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
X Fire Inspection Report
X DHEC Inspection Report

Inspected by: Robert E. Ellerson
Inspection Date: October 24, 2022
Reviewed by: Blake E. Taylor, Jr.
Division Director
Compliance, Standards, and Inspections

NARRATIVE REPORT
RICHLAND COUNTY (ALVIN S. GLENN) DETENTION CENTER
October 24, 2022

On October 24, 2022, an onsite inspection of this facility was conducted by Mr. Robert E. Ellison, Jr., and Mr. Scott E. Morehead, Detention and Correctional Inspectors, with the below listed violations noted:

1021 - Manual of Policies and Procedures:

(a) Each facility shall have a written manual of all policies and procedures for the operation of the facility. Each policy and procedure should be reviewed annually and updated as needed. Documentation of these reviews shall be maintained. These policies and procedures shall be made readily available to all personnel.

(b) The following standards require written policies and procedures:

1022	1066	2034
1036	1067	2035
1037	1068	2036
J1041.J	1081	2037
1042	1083	2051
1043	1091	2052
1044	1092	2053
1045	1093	2054
1046	2001	2055
1051	2002	2056
1061	2014-24	2070
1062	2030	2080
1063	2031	2090
1064	2032	3001.
1065	2033	

(c) Comprehensive post descriptions for each facility operational position shall be in writing and made available to each employee performing the function.

Policies and procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis, and the documentation must be retained as to each of those dates when the respective policies/procedures were reviewed.

1022 - Emergency Pre-Planning:

Each facility shall have current written procedures to be followed in emergency situations. These plans shall include procedures for the following emergency situations:

fires	disturbances
escapes	suicides and attempted suicides
taking of hostages	power failures
group arrests	natural disasters
bomb threats	homeland security issues.

Discussion:
The facility should detail in writing specific procedures which can be implemented quickly when an emergency occurs. The procedures should contain provisions for sounding an appropriate alarm, alerting officials, mobilizing needed resources, and ending the alert. For example, a fire suppression plan would be coordinated with, and recognized by, the local fire department and would include a fire prevention plan in the policies and procedures manual; regular facility inspections by staff; fire prevention inspections by the fire department having jurisdiction; an evacuation plan; and a plan for the emergency housing of inmates in case of a fire.

Policies and procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis, and the documentation must be retained as to each of those dates when the respective policies/procedures were reviewed.

1031 - Number of Personnel:

(a) The Facility Administrator shall designate a Facility Manager qualified by training and experience to supervise staff and inmates.

The facility was previously operated for a lengthy period without a recognized Detention Director, and is currently once again operating with an Interim Director.

(b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

The facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded in order to enable proper facility operations, and recruitment and retention of employees also needs to be improved. At the time of the latest inspection, Richland County had one hundred and twenty-four (124) Detention Officer vacancies. Five (5) of the housing units were closed due to the staffing shortage. There was not an Officer present in Foxtrot Unit, even though inmates were being housed there. It was also noted upon entrance into the kitchen that there was no Officer present to supervise inmate workers.

(d) A staffing analysis (using NIC Staffing Analysis Workbook or other industry recognized plan) shall be conducted to determine facility staffing needs. The staffing analysis shall be reviewed annually and updated as needed.

A current Staffing Analysis by a qualified third party is needed. The County has been reminded of this requirement on more than one occasion. A thorough Staffing Analysis can be obtained from the South Carolina Association of Counties at no cost to Richland County upon submission of a written request by the County Administrator.

1035 - In-Service Training:

All non-security personnel shall be required to complete in-service training which has been approved by the Facility Manager.

All security personnel shall successfully complete required in-service training of no less than forty (40) hours each year. This training shall be approved by the South Carolina Criminal Justice Academy. Such training should include but not be limited to:

(a) Review and update of safety and security procedures, regulations, and equipment
(b) Recent legal decisions on the confinement and treatment of all types of persons detained
(c) Report writing
(d) Sexual harassment
(e) Suicide prevention
(f) Inmate supervision
(g) Use of force regulations and tactics

(h) Emergency plans and procedures
(i) Interpersonal communication
(j) Cultural diversity
(k) CPR and first aid training
(l) Sexual abuse/assault awareness and response/PREA
(m) Facility specific issues.

Discussion:
The purpose of the in-service training is to keep the employees up to date on procedures and incidents and methods of handling them. This may be accomplished by sessions scheduled on a weekly or monthly basis.

Several items need to be added to the in-service training agenda. They include:

1. Training on operation of fire extinguishers and automatic suppression systems in the kitchen,
2. Training on operation of pull stations in the housing units,
3. Procedures to alert the rest of the facility when there is a fire or other emergency,
4. Procedures for reporting maintenance concerns.

1065 - Facility Security:

(b) All security locks and doors shall be regularly inspected and operated (by remote and manual means) from both the interior and exterior of the doors to ensure proper working order at all times, including in emergency situations.

Some of the cell and passage door locks in Phase IV are malfunctioning and need repair.

(e) All facilities shall have two-way intercom systems for emergency communications. This shall not substitute for security personnel, as required in Standard 1031.

Some of the intercom stations in all areas of the facility are not operational and need to be repaired.

1082 - Classification Categories:

(a) The facility provides for the separate management of the following categories of inmates in accordance with the facility's classification plan:

* female and male inmates
* sentenced and non-sentenced inmates
* other classes of detainees (i.e., witnesses, informants, and protective custody inmates)
* community custody inmates (work releasees, weekenders, trusties)
* inmates requiring disciplinary detention
* inmates requiring administrative separation
* juvenile detainees
* other categories that may pose a security problem which include but are not limited to: high profile cases; geriatric inmates; sexual deviants; sex offenders; predators; and inmates undergoing sex changes.

Pretrial and sentenced female inmates are being housed together in Housing Unit P (Papa) in violation of this Standard.

1094- Females:

(b) Female inmates shall be afforded the same rights and privileges as male inmates.

Due to the fact that all female inmates (both sentenced and pre-trial) are living in the same housing unit, they are not being afforded the equivalent opportunities and privileges as can be provided for male inmates.

2014-1 - Special Purpose Cells:

Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to an inmate who is under the influence of alcohol or narcotics, or for inmates who are uncontrollably violent or self-destructive. This room shall be subject to staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

The male Special Purpose Cell(s) are in Housing Unit Z (SHU). The cells are not subject to observation from a twenty-four (24) hour staff position, and the observation requirements noted by this Standard are not available. Staff stated that if the cell(s) are utilized for suicide watch, etc., there is an Officer stationed at the door of

the cell(s). Staffing shortages, along with multiple cells being utilized for Special Purpose function, make compliance with this Standard doubtful.

Female inmates being housed for Special Purpose reasons (suicide watch, etc.) are located in Housing Unit P (Papa). Construction on those cell(s) with dayroom separation (walls) are primarily glass or Lexan and do provide sight by a twenty-four (24) hour staff position.

2014-2 - Fire Codes:

The facility conforms to applicable federal, state, and/or local building and fire safety codes. Compliance is documented by the authority having jurisdiction. A fire alarm and automatic smoke detection system are required, as approved by the authority having jurisdiction. (See Appendix B.)

Discussion:
The applicable code(s) should be applied to all areas of the facility. Reports of periodic inspections and any actions taken in respect to those inspections must be available. The authority having jurisdiction in South Carolina is the State Fire Marshal.

Several items that were noted on the Deputy State Fire Marshal's report need to be addressed promptly.

In some of the housing units, the keys to activate the fire alarm pull stations were not on the Officers' keyrings.

The fire apparatus access road that encircles the complex needs to be maintained so that it is accessible in all weather conditions, and as per the requirements of the South Carolina Fire Code.

2014-13 - Housing for the Handicapped:

Handicapped inmates are housed in a manner that provides for their safety and security. Rooms, cells, or housing units used by the handicapped are designed for their use and provide for integration with the general population. Appropriate facility programs and activities are accessible to handicapped inmates who are confined in the facility.

Discussion:

If the facility accepts handicapped individuals, it must provide for their housing and use of/access to facility resources.

A handicapped inmate who was located in Phase V was being housed in a non-ADA equipped cell.

2014-16 - Toilets:

Inmates have access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one (1) for every twelve (12) inmates in male facilities, and one (1) for every eight (8) inmates in female facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets.

The Phase V addition to the facility has sub-housing units that were designed to hold eight (8) inmates but contain only one (1) toilet.

2014-40 - Maintenance:

All portions of existing buildings, both interior and exterior, are maintained in such manner that structural strength, stability, sanitation, indoor air quality, and safety of life and property are free from fire and other hazards. Repairs and upkeep are provided to ensure public safety, health, and general welfare.

Discussion:

The building structural system is maintained structurally sound with no evidence of deterioration, and capable of supporting the load of normal use. All exterior walls are free of holes, breaks, loose or rotting boards or timbers, and any other conditions which might admit rain or dampness to the interior portions of the walls or to the occupied spaces of the building. All siding materials are kept in repair. Roofs are structurally sound and maintained in a safe manner and have no defects which might admit rain or cause dampness in the walls or interior portion of the building.

Numerous maintenance related violations were noted during the building tour, some of which are listed below:

1. There are corroded sprinkler escutcheons throughout,
2. Writing surfaces are missing from some cells,
3. There is water damage to ceilings,
4. There is paint peeling in showers (India Unit),
5. Showers need to be thoroughly scoured on a more regular basis,
6. Ceramic tiles are missing in the showers,
7. There are missing and inoperable plumbing fixtures in the housing units,
8. There are missing toilet fixtures in several units,
9. There had been a fire in Cell Z-5 (SHU). Severe smoke damage is still evident to Cell Z-5 and there is no bed in the cell. Yet an inmate was housed in this cell at the time of our inspection. The same scenario was noted for Cell Z-8,
10. There are accumulations of trash in several pipe chases,
11. There are leaking pipes and what appeared to be raw sewage in some of the pipe chases in SHU,
12. Various physical plant issues were observed in the kitchen area, including:

    a. Grout is missing around floor tiles,
    b. Drains are obstructed,
    c. Cooler doors are binding on the uneven kitchen floor,
    d. There are leaks in drainpipes,
    e. There is ceiling damage.

2017-5 - Inmate Housing (Minimum & Medium Security):

Single cells/rooms and multiple occupancy cells/rooms may be used for housing inmates in medium/minimum custody when the classification system, cell/room size, and level of supervision meet the following requirements:

(a) - Number of Occupants	Amount of Unencumbered Space*
1	35 square feet per occupant
2-64	25 square feet per occupant**

*"Unencumbered space" is that usable space which is not encumbered by furnishings or fixtures. In determining unencumbered space in the cell or room, the total square footage is obtained and the square footage of fixtures and equipment is subtracted. All fixtures and equipment must be in operational position and must provide the following minimums per person: permanent sleeping surface, plumbing fixtures (if inside the cell/room), desk or approved writing surface, and seat.

**Sleeping area partitions are required if more than six (6) people are housed in one sleeping area. At least one dimension of the unencumbered space is no less than seven feet.

(b) When confinement exceeds 16 hours per day, there is at least 70 square feet of total floor space per occupant.

(c) Housing is in compliance with Standards SC 1082, SC 2014-16, 2014-17, 2014-18, and 2014-20.

A classification system is used to divide the occupants into groups which reduce the probability of assault and disruptive behavior. At a minimum, the classification system evaluates the following:

* mental and emotional stability
* escape history
* history of assaultive behavior
* medical status
* age
* enemies of record
* other categories that may impact facility security.

Medium security inmates housed in multiple occupancy cells/rooms require direct supervision. (See glossary for definition of direct supervision.)

At the time of the inspection, several living units were housing a number of inmates in excess of their rated capacities. This was due at least in part to the fact that some of the other housing areas were closed.

3003 - Vermin, Insects, and Pests:

(a) Each facility shall have a regularly scheduled program of pest and vermin control and extermination.

(c) Effective measures shall be taken to keep flies, rodents, and other vermin out of the confinement facility and to prevent

their breeding or continued presence on the premises. The facility shall be kept neat, clean, and free of litter. All openings to the outer air shall be effectively protected against the entrance of insects and rodents by self-closing doors, closed windows, sixteen (16) mesh or finer screening, or other effective means.

It was noted during this inspection that pest control efforts need to be upgraded throughout the facility.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
RATED CAPACITY SHEET

Facility: Richland County (Alvin S. Glenn) Detention Center **Type:** IV **Date:** October 24, 2022

Cell Block/ Housing Unit:	Pre-Trial Adult Male R/C	Pre-Trial Adult Male A/C	Pre-Trial Adult Female R/C	Pre-Trial Adult Female A/C	Sentenced Adult Male R/C	Sentenced Adult Male A/C	Sentenced Adult Female R/C	Sentenced Adult Female A/C	Juvenile Male R/C	Juvenile Male A/C	Juvenile Female R/C	Juvenile Female A/C
Spec. Purpose *	0	0										
Holding * **	60	3		1								
Infirmary *												
Unit A	56	55										
Unit B					56	12						
Unit C	56	0										
Unit D	56	51										
Unit E	56	40										
Unit F	56	41										
Unit G	56	46										
Unit H	56	39										
Unit I	56	43										
Unit J	56	43										
Unit K	56	51										
Unit L	56	0										
Unit M	56	53										
Unit P			56	66								
Unit T-1					54	0						
Unit T-2					54	0						
Unit U	56	38										
Unit X	56	37										
Unit Y	56	0										
Unit Z(SHU)	56	59										
Subtotal:	896	599	56	67	164	12	0	0	0	0	0	0

Total R/C: 1,116 Total A/C: 678 (Total the date of the inspection)

NOTE: R/C = Rated Capacity; A/C = Actual Count
* = Special Purpose Cells, Holding Cells, and Infirmary Beds are not part of the facility's rated capacity for permanent housing.
** = Either/Or
# = Utilized for PREA housing of 17 year old detainees at time of the inspection.

EXHIBIT 31

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County (Alvin S. Glenn) Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3259 Home Detention Program **Yes** Work/Punishment Program **Yes**

Type I ___ II ___ III ___ IV **X** V ___ VI ___ VII ___ JuvHold **No** DesignatedFac **Yes** FedContract **Yes**

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Ronaldo D. Myers, Detention Director

Governing Body: County Council Chairperson: Mr. Paul Livingston

Date of Last Inspection: 09/08/18 Year Built: 1994 1998,2007 Last Year Remodeled: 2007

	Adult M	Adult F	Juvenile M	Juvenile F		
Rated Capacity:	1,060	56			1,116	(Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):	753	78			831	(Total Avg. Daily Pop)
High Count (past 12 mos.):	818	90			Facility High Count	908

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	8	12	7	7	34	FT	114
Full-time Female	19	18	22	21	80	PT	0
Part-time Male					0	=	114
Part-time Female					0	Vacant	131
Vacant Positions	33	34	33	31	131	Reserve	0
Reserve Officers					0	Slots	245

II. Administrative Staff (denotes number and full-time(**FT**) or part-time(**PT**))

Administration		Support		Treatment		Program		Total	
Director	1FT	Maint	12FT	Doctor	Contract	Education	Contr.	FT	41
AsstDir	1FT	FoodServ	Contr.	RN	Contract	Classific	3FT	PT	5
Sen/Chief	5FT	Records		LPN	Contract	Training	1FT	=	46
Clerical	2FT	Prop/Sup		MntlHlth		Religious		Contract	
Other	16FT,5PT	Other		SocWork	Contr.	Other		Volunteers	
Vacant		Vacant	1FT	Vacant		Vacant		Vacant	1

III. Total Full-time (I&II) 155 **Total Part-time** (I&II) 5 **Grand Total** (I&II) 160

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
1031(b), 2014-1, 2014-2, 2014-16, 2014-40, 2017-5

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
To Follow Fire Inspection Report
To Follow DHEC Inspection Report

Inspected by: Robert Ellison Jr. Inspection Date: December 18, 2019

Reviewed by: Blake E. Taylor Jr.

Division Director
Compliance, Standards, and Inspections

NARRATIVE REPORT
RICHLAND COUNTY (ALVIN S. GLENN) DETENTION CENTER
December 18, 2019

On December 18, 2019, an inspection of the Richland County (Alvin S. Glenn) Detention Center was conducted by Mr. Robert E. Ellison, Jr., Detention and Correctional Inspector, with the below listed violations noted:

1031 - Number of Personnel:

(b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

This facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded in order to enable proper facility operation, and the recruitment and retention of employees also needs to be improved. At the time of this latest inspection, the facility had one hundred and thirty-one (131) Detention Officer vacancies. Four of the housing units were actually closed due to the staffing shortage.

2012 - Rated Capacity:

The Director of the Jail and Prison Inspection Division shall ascertain the maximum number of inmates, of whatever classifications, based upon square footage and other relevant requirements that can properly be housed in each facility and in the various living areas within each facility. After determining the rated capacity, the Director shall notify, in writing, the Facility Manager, the Facility Administrator, and the governing body which has responsibility for the facility. These numbers shall be reviewed annually.

While not a Standards violation, it was noted that female inmates were now being housed in Unit U, which had previously been male living space. This change will not alter the facility's total rated capacity but does cause an adjustment within the official authorization.

2014-1 - Special Purpose Cells:

Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to an inmate who is under the influence of alcohol or narcotics, or for inmates who are uncontrollably violent or self-destructive. This room shall be subject to staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

Special Purpose cell(s) for males are in Housing Unit Z (SHU). These cells are not subject to observation from a twenty-four (24) hour staff position. Thus observation requirements expected by this Standard are not available. Staff stated that if the cell(s) are utilized for suicide watch, etc., that there is an Officer stationed at the door of the cell(s). Staffing shortages, and multiple cells being utilized for Special Purpose function, make compliance with this Standard doubtful.

2014-2 - Fire Codes:

The facility conforms to applicable federal, state, and/or local building and fire safety codes. Compliance is documented by the authority having jurisdiction. A fire alarm and automatic smoke detection system are required, as approved by the authority having jurisdiction. (See Appendix B.)

Discussion:
The applicable code(s) should be applied to all areas of the facility. Reports of periodic inspections and any actions taken in respect to those inspections must be available. The authority having jurisdiction in South Carolina is the State Fire Marshal.

All violations that have been cited by the Office of State Fire Marshal need to be addressed.

2014-16 - Toilets:

Inmates have access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one (1) for every twelve (12) inmates in male facilities, and one (1) for every eight (8) inmates in female

facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets.

The Phase V addition to the facility has sub-housing units that are designed for eight (8) inmates, but contain only one (1) toilet.

2014-40 - Maintenance:

All portions of existing buildings, both interior and exterior, are maintained in such manner that structural strength, stability, sanitation, indoor air quality, and safety of life and property are free from fire and other hazards. Repairs and upkeep are provided to ensure public safety, health, and general welfare.

Discussion:
The building structural system is maintained structurally sound with no evidence of deterioration, and capable of supporting the load of normal use. All exterior walls are free of holes, breaks, loose or rotting boards or timbers, and any other conditions which might admit rain or dampness to the interior portions of the walls or to the occupied spaces of the building. All siding materials are kept in repair. Roofs are structurally sound and maintained in a safe manner and have no defects which might admit rain or cause dampness in the walls or interior portion of the building.

The floor in a food preparation area of the kitchen is in a deteriorated condition and needs repair or replacement.

2017-5 - Inmate Housing (Minimum & Medium Security):

Single cells/rooms and multiple occupancy cells/rooms may be used for housing inmates in medium/minimum custody when the classification

system, cell/room size, and level of supervision meet the following requirements:

(a) - Number of Occupants	Amount of Unencumbered Space*
1	35 square feet per occupant
2-64	25 square feet per occupant**

*"Unencumbered space" is that usable space which is not encumbered by furnishings or fixtures. In determining unencumbered space in the cell or room, the total square footage is obtained and the square footage of fixtures and equipment is subtracted. All fixtures and equipment must be in operational position and must provide the following minimums per person: permanent sleeping surface, plumbing fixtures (if inside the cell/room), desk or approved writing surface, and seat.

**Sleeping area partitions are required if more than six (6) people are housed in one sleeping area. At least one dimension of the unencumbered space is no less than seven feet.

(b) When confinement exceeds 16 hours per day, there is at least 70 square feet of total floor space per occupant.

(c) Housing is in compliance with Standards SC 1082, SC 2014-16, 2014-17, 2014-18, and 2014-20.

A classification system is used to divide the occupants into groups which reduce the probability of assault and disruptive behavior. At a minimum, the classification system evaluates the following:

* mental and emotional stability
* escape history
* history of assaultive behavior
* medical status
* age
* enemies of record
* other categories that may impact facility security

Medium security inmates housed in multiple occupancy cells/rooms require direct supervision. (See glossary for definition of direct supervision.)

At the time of this inspection, several living units were housing a number of inmates in excess of their respective rated capacities.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
RATED CAPACITY SHEET

Facility: Richland County (Alvin S. Glenn) Detention Center **Type:** IV **Date:** December 18, 2019

Cell Block/ Housing Unit:	Pre-Trial Adult Male R/C	Pre-Trial Adult Male A/C	Pre-Trial Adult Female R/C	Pre-Trial Adult Female A/C	Sentenced Adult Male R/C	Sentenced Adult Male A/C	Sentenced Adult Female R/C	Sentenced Adult Female A/C	Juvenile Male R/C	Juvenile Male A/C	Juvenile Female R/C	Juvenile Female A/C
Spec. Purpose *	0	0										
Holding *	60 **	0	**	0								
Infirmary *												
Unit A	56	43										
Unit B					56	22						
Unit C	56	0										
Unit D	56	36										
Unit E	56	0										
Unit F	56	48										
Unit G	56	47										
Unit H	56	58										
Unit I	56	41										
Unit J	56	58										
Unit K	56	54										
Unit L	56	55										
Unit M	56	29										
Unit P			56	42								
Unit T-1					54	0						
Unit T-2					54	0						
Unit U			56	13								
Unit X	56	61										
Unit Y	56	22										
Unit Z(SHU)	56	64										
Subtotal:	840	616	112	55	164	22	0	0	0	0	0	0

Total R/C: 1,116 Total A/C: 693 (Total the date of the inspection)

NOTE: R/C = Rated Capacity; A/C = Actual Count
* = Special Purpose Cells, Holding Cells, and Infirmary Beds are not part of the facility's rated capacity for permanent housing.
** = Either/Or
# = Utilized for PREA housing of 17 year old detainees at time of the inspection.

EXHIBIT 32

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County (Alvin S. Glenn) Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3259 Home Detention Program **Yes** Work/Punishment Program **Yes**

Type I ___ II ___ III ___ IV **X** V ___ VI ___ VII ___ JuvHold **No** DesignatedFac **Yes** FedContract **Yes**

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Ronaldo D. Myers, Detention Director

Governing Body: County Council Chairperson: Mr. Paul Livingston

Date of Last Inspection: 12/18/19 Year Built: 1994 1998,2007 Last Year Remodeled: 2007

	Adult M	Adult F	Juvenile M	Juvenile F		
Rated Capacity:	1,060	56			1,116	(Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):	631	50			681	(Total Avg. Daily Pop)
High Count (past 12 mos.):	761	71			Facility High Count	832

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	11	11	15	11	48	FT	164
Full-time Female	30	26	30	30	116	PT	0
Part-time Male					0	=	164
Part-time Female					0	Vacant	90
Vacant Positions	23	24	20	23	90	Reserve	0
Reserve Officers					0	Slots	254

II. Administrative Staff (denotes number and full-time(**FT**) or part-time(**PT**))

Administration		Support		Treatment		Program		Total	
Director	1FT	Maint	13FT	Doctor	Contract	Education	Contr.	FT	41
AsstDir	1FT	FoodServ	Contr.	RN	Contract	Classific	3FT	PT	5
Sen/Chief	5FT	Records		LPN	Contract	Training	1FT	=	46
Clerical	1FT	Prop/Sup		MntlHlth		Religious		Contract	
Other	16FT,5PT	Other		SocWork	Contr.	Other		Volunteers	
Vacant		Vacant	1FT	Vacant		Vacant		Vacant	1

III. Total Full-time (I&II) 205 **Total Part-time** (I&II) 5 **Grand Total** (I&II) 210

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
1031(b), 2014-1, 2014-2, 2014-16, 2017-5

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
To Follow Fire Inspection Report
To Follow DHEC Inspection Report

Inspected by: Robert E. Ellison Jr.
Reviewed by: Blake E. Taylor Jr.
Inspection Date: December 18, 2020

Division Director
Compliance, Standards, and Inspections

NARRATIVE REPORT
RICHLAND COUNTY (ALVIN S. GLENN) DETENTION CENTER
December 18, 2020

On December 18, 2020, a site inspection of the Richland County (Alvin S. Glenn) Detention Center was conducted by Mr. Robert E. Ellison, Jr., Detention and Correctional Inspector, with the below listed violations noted:

1031 - Number of Personnel:

(b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

This facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded in order to enable proper facility operation, and recruitment and retention of employees must also be improved. At the time of this inspection, the Detention Center had ninety (90) Officer vacancies. Three (3) of the housing units were even closed due to the staffing shortage.

2014-1 - Special Purpose Cells:

Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to an inmate who is under the influence of alcohol or narcotics, or for inmates who are uncontrollably violent or self-destructive. This room shall be subject to staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

The male Special Purpose cell(s) are in Housing Unit Z (SHU). These cells are not subject to observation from a twenty-four (24) hour staff position. Thus observation requirements expected by this Standard are not available. Staff stated that if the cell(s) are utilized for suicide watch, etc., there is an Officer stationed at the door of the cell(s). Personnel shortages, along with multiple cells being utilized for Special Purpose function, make compliance with this Standard very doubtful.

2014-2 - Fire Codes:

The facility conforms to applicable federal, state, and/or local building and fire safety codes. Compliance is documented by the authority having jurisdiction. A fire alarm and automatic smoke detection system are required, as approved by the authority having jurisdiction. (See Appendix B.)

Discussion:
The applicable code(s) should be applied to all areas of the facility. Reports of periodic inspections and any actions taken in respect to those inspections must be available. The authority having jurisdiction in South Carolina is the State Fire Marshal.

All violations that have been cited by the Office of State Fire Marshal during inspections need to be addressed.

2014-16 - Toilets:

Inmates have access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one (1) for every twelve (12) inmates in male facilities, and one (1) for every eight (8) inmates in female facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets.

The Phase V addition to the facility has sub-housing units that are designed for eight (8) inmates, but contain only one (1) toilet, thereby constituting non-compliance.

2017-5 - Inmate Housing (Minimum & Medium Security):

Single cells/rooms and multiple occupancy cells/rooms may be used for housing inmates in medium/minimum custody when the classification system, cell/room size, and level of supervision meet the following requirements:

(a) - Number of Occupants	Amount of Unencumbered Space*
1	35 square feet per occupant
2-64	25 square feet per occupant**

*"Unencumbered space" is that usable space which is not encumbered by furnishings or fixtures. In determining unencumbered space in the cell or room, the total square footage is obtained and the square footage of fixtures and equipment is subtracted. All fixtures and equipment must be in operational position and must provide the following minimums per person: permanent sleeping surface, plumbing fixtures (if inside the cell/room), desk or approved writing surface, and seat.

**Sleeping area partitions are required if more than six (6) people are housed in one sleeping area. At least one dimension of the unencumbered space is no less than seven feet.

(b) When confinement exceeds 16 hours per day, there is at least 70 square feet of total floor space per occupant.

(c) Housing is in compliance with Standards SC 1082, SC 2014-16, 2014-17, 2014-18, and 2014-20.

A classification system is used to divide the occupants into groups which reduce the probability of assault and disruptive behavior. At a minimum, the classification system evaluates the following:

* mental and emotional stability
* escape history
* history of assaultive behavior
* medical status
* age
* enemies of record
* other categories that may impact facility security

Medium security inmates housed in multiple occupancy cells/rooms require direct supervision. (See glossary for definition of direct supervision.)

At the time of this inspection, some of the living units were housing a number of inmates in excess of their rated capacities.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
RATED CAPACITY SHEET

Facility: Richland County (Alvin S. Glenn) Detention Center **Type:** IV **Date:** December 18, 2020

Cell Block/ Housing Unit:	Pre-Trial Adult Male R/C	Pre-Trial Adult Male A/C	Pre-Trial Adult Female R/C	Pre-Trial Adult Female A/C	Sentenced Adult Male R/C	Sentenced Adult Male A/C	Sentenced Adult Female R/C	Sentenced Adult Female A/C	Juvenile Male R/C	Juvenile Male A/C	Juvenile Female R/C	Juvenile Female A/C
Spec. Purpose *	0	0										
Holding * **	60	1	**	0								
Infirmary *												
Unit A	56	35										
Unit B					56	18						
Unit C	56	0										
Unit D	56	16										
Unit E	56	0										
Unit F	56	40										
Unit G	56	43										
Unit H	56	52										
Unit I	56	46										
Unit J	56	54										
Unit K	56	57										
Unit L	56	57										
Unit M	56	31										
Unit P			56	44								
Unit T-1					54	0						
Unit T-2					54	0						
Unit U	56	22										
Unit X	56	51										
Unit Y	56	40										
Unit Z(SHU)	56	57										
Subtotal:	896	602	56	44	164	18	0	0	0	0	0	0

Total R/C: 1,116 Total A/C: 664 (Total the date of the inspection)

NOTE: R/C = Rated Capacity; A/C = Actual Count
* = Special Purpose Cells, Holding Cells, and Infirmary Beds are not part of the facility's rated capacity for permanent housing.
** = Either/Or
# = Utilized for PREA housing of 17 year old detainees at time of the inspection.

EXHIBIT 33

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County (Alvin S. Glenn) Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3259 Home Detention Program **Yes** Work/Punishment Program **Yes**

Type I ___ II ___ III ___ IV **X** V ___ VI ___ VII ___ JuvHold **No** DesignatedFac **Yes** FedContract **Yes**

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Ronaldo D. Myers, Detention Director

Governing Body: County Council Chairperson: Mr. Paul Livingston

Date of Last Inspection: 12/18/20 Year Built: 1994 1998, 2007 Last Year Remodeled: 2007

	Adult M	Adult F	Juvenile M	Juvenile F		
Rated Capacity:	1,060	56			1,116	(Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):	657	44			701	(Total Avg. Daily Pop)
High Count (past 12 mos.):	692	60			Facility High Count	752

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	5	8	6	6	25	FT	92
Full-time Female	16	15	17	19	67	PT	0
Part-time Male					0	=	92
Part-time Female					0	Vacant	172
Vacant Positions	45	43	43	41	172	Reserve	0
Reserve Officers					0	Slots	264

II. Administrative Staff (denotes number and full-time(**FT**) or part-time(**PT**))

Administration		Support		Treatment		Program		Total	
Director	1FT	Maint	12FT	Doctor	Contract	Education	Contr.	FT	44
AsstDir	1FT	FoodServ	Contr.	RN	Contract	Classific	3FT*	PT	5
Sen/Chief	5FT	Records	*	LPN	Contract	Training	1FT	=	49
Clerical	2FT	Prop/Sup	3FT	MntlHlth		Religious		Contract	
Other	16FT,5PT	Other		SocWork	Contr.	Other		Volunteers	
Vacant		Vacant	1FT	Vacant		Vacant		Vacant	1

*** Employee(s) also work a shift.**

III. Total Full-time (I&II) 136 **Total Part-time** (I&II) 5 **Grand Total** (I&II) 141

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
1031(b), 2014-1, 2014-2, 2014-16, 2017-5

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
To Follow Fire Inspection Report
To Follow DHEC Inspection Report

Inspected by: Robert E. Ellison
Reviewed by: Blake E. Taylor, Jr.
Inspection Date: September 28, 2021

Division Director
Compliance, Standards, and Inspections

NARRATIVE REPORT
RICHLAND COUNTY (ALVIN S. GLENN) DETENTION CENTER
September 28, 2021

On September 28, 2021, a site inspection of the Richland County (Alvin S. Glenn) Detention Center was conducted by Mr. Robert E. Ellison, Jr., Detention and Correctional Inspector, with the below listed violations noted:

1031 - Number of Personnel:

(b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

This facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded in order to enable proper facility operation, and the recruitment and retention of employees must also be improved. County Council needs to approve incentive pay beyond what has been authorized in the past. At the time of the latest inspection, Richland County had one hundred and seventy-two (172) Detention Officer job vacancies. Four (4) of the housing units were actually closed due to the staffing shortage.

2014-1 - Special Purpose Cells:

Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to an inmate who is under the influence of alcohol or narcotics, or for inmates who are uncontrollably violent or self-destructive. This room shall be subject to staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

The Special Purpose Cells for males are in Housing Unit Z (SHU). These cells are not subject to observation from a twenty-four (24) hour staff position. Thus observation requirements expected by this Standard are not available. Staff stated that if the cell(s) are utilized for suicide

watch, etc., then there is an Officer stationed at the door of the cell(s). Personnel shortages, while multiple cells are being utilized for a Special Purpose function, make compliance with this Standard very doubtful.

Female inmates classified for Special Purpose reasons (suicide watch, etc.) are placed in Housing Unit P (Poppa). Construction of the cell to dayroom separation walls are primarily glass or Lexan, and therefore provide direct sight from a twenty-four (24) hour staff position.

2014-2 - Fire Codes:

The facility conforms to applicable federal, state, and/or local building and fire safety codes. Compliance is documented by the authority having jurisdiction. A fire alarm and automatic smoke detection system are required, as approved by the authority having jurisdiction. (See Appendix B.)

Discussion:
The applicable code(s) should be applied to all areas of the facility. Reports of periodic inspections and any actions taken in respect to those inspections must be available. The authority having jurisdiction in South Carolina is the State Fire Marshal.

All violations that have been cited by the Office of State Fire Marshal during inspections need to be eliminated.

2014-16 - Toilets:

Inmates have access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one (1) for every twelve (12) inmates in male facilities, and one (1) for every eight (8) inmates in female facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets.

The Phase V addition to the facility has sub-housing units which are designed for eight (8) inmates but contain only one (1) toilet, creating a violation of this Standard.

2017-5 - Inmate Housing (Minimum & Medium Security):

Single cells/rooms and multiple occupancy cells/rooms may be used for housing inmates in medium/minimum custody when the classification system, cell/room size, and level of supervision meet the following requirements:

(a) - Number of Occupants	Amount of Unencumbered Space*
1	35 square feet per occupant
2-64	25 square feet per occupant**

*"Unencumbered space" is that usable space which is not encumbered by furnishings or fixtures. In determining unencumbered space in the cell or room, the total square footage is obtained and the square footage of fixtures and equipment is subtracted. All fixtures and equipment must be in operational position and must provide the following minimums per person: permanent sleeping surface, plumbing fixtures (if inside the cell/room), desk or approved writing surface, and seat.

**Sleeping area partitions are required if more than six (6) people are housed in one sleeping area. At least one dimension of the unencumbered space is no less than seven feet.

(b) When confinement exceeds 16 hours per day, there is at least 70 square feet of total floor space per occupant.

(c) Housing is in compliance with Standards SC 1082, SC 2014-16, 2014-17, 2014-18, and 2014-20.

A classification system is used to divide the occupants into groups which reduce the probability of assault and disruptive behavior. At a minimum, the classification system evaluates the following:

* mental and emotional stability
* escape history
* history of assaultive behavior
* medical status
* age
* enemies of record
* other categories that may impact facility security

Medium security inmates housed in multiple occupancy cells/rooms require direct supervision. (See glossary for definition of direct supervision.)

At the time of this inspection, several living units were housing a number of inmates in excess of their rated capacities.

Additional Comments:

As noted elsewhere within this report, four (4) housing units were closed due to personnel limitations. If this practice continues, it will become necessary to re-evaluate the rated capacity for this facility based upon the bedspace actually available and in use.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF COMPLIANCE, STANDARDS, AND INSPECTIONS
RATED CAPACITY SHEET

Facility: Richland County (Alvin S. Glenn) Detention Center **Type:** IV **Date:** September 28, 2021

Cell Block/ Housing Unit:	Pre-Trial Adult Male R/C	Pre-Trial Adult Male A/C	Pre-Trial Adult Female R/C	Pre-Trial Adult Female A/C	Sentenced Adult Male R/C	Sentenced Adult Male A/C	Sentenced Adult Female R/C	Sentenced Adult Female A/C	Juvenile Male R/C	Juvenile Male A/C	Juvenile Female R/C	Juvenile Female A/C
Spec. Purpose *	0	0										
Holding * **	60	5		3								
Infirmary *												
Unit A	56	52										
Unit B					56	14						
Unit C	56	0										
Unit D	56	0										
Unit E	56	0										
Unit F	56	42										
Unit G	56	49										
Unit H	56	0										
Unit I	56	41										
Unit J	56	50										
Unit K	56	58										
Unit L	56	58										
Unit M	56	45										
Unit P			56	58								
Unit T-1					54	0						
Unit T-2					54	0						
Unit U	56	39										
Unit X	56	58										
Unit Y	56	53										
Unit Z(SHU)	56	55										
Subtotal:	896	605	56	61	164	14	0	0	0	0	0	0

Total R/C: 1,116 Total A/C: 680 (Total the date of the inspection)

NOTE: R/C = Rated Capacity; A/C = Actual Count
* = Special Purpose Cells, Holding Cells, and Infirmary Beds are not part of the facility's rated capacity for permanent housing.
** = Either/Or
# = Utilized for PREA housing of 17 year old detainees at time of the inspection.

Exhibit 34

From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Wednesday, January 10, 2024 8:21 AM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: PAPA toilet's

A inspection of unit PAPA toilets by cell number

1. Works
2. Works
3. Works
4. Works but needs diaphragm
5. Works
6. Works
7. Works
8. Works
9. Works
10. Works
11. Works
12. Works but needs diaphragm
13. Works but needs diaphragm
14. Wont flush- needs new flush valve
15. Works
16. Works
17. Works
18. Works
19. Push button to toilet missing, cant flush
20. Works
21. Works
22. Works but needs diaphragm
23. Works
24. Works
25. Works
26. Works
27. Works
28. Works
29. Works
30. Works
31. Works
32. Works
33. Works
34. Wont flush-needs new flush valve
35. Works
36. Works
37. Works
38. Works
39. Works
40. Wont flush- needs new flush valve
41. Works
42. Works
43. Works
44. Works
45. Works
46. Works
47. Works
48. Works
49. Works
50. Works
51. Works
52. Works
53. Works
54. Works
55. Works
56. works

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From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Friday, January 05, 2024 10:15 AM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: phase 2 xray

XRAY cell toilet

1. Not working whole flush valve needed
2. Not working whole flush valve needed
3. Works
4. Works
5. Works
6. Works
7. Works
8. Works
9. Works
10. Works
11. Broken
12. Works
13. Works
14. Works
15. Works
16. Broken
17. Not working whole flush valve needed
18. Works
19. Broken
20. Broken
21. Broken
22. Works
23. Works
24. Works
25. Works
26. Works needs new diaphragm
27. Works
28. Works
29. Broken
30. Fixable with diaphragm
31. Not working needs whole new flush valve
32. Works
33. Works
34. Broken
35. Works
36. Works
37. Works
38. Works
39. Works
40. Works
41. Not working, push button has been removed
42. Works
43. Broken
44. Broken
45. Broken
46. Broken
47. Broken
48. Works
49. Broken
50. Broken
51. Broken
52. Broken
53. Works
54. Works
55. Broken
56. broken

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From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Tuesday, January 16, 2024 12:16 PM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: phase 5 toilet inspection

Unit Kilo toilet inspection by pod

a. Works
b. Works
c. Works
d. Works
e. Works
f. Works
g. Works

Unit Lima inspection by pod

a. Works
b. Works
c. Works
d. Works
e. Works
f. Works
g. Works

Unit Uniform toilet inspection by pod

a. Works
b. Works
c. Works
d. Works
e. Works
f. Works
g. works

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From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Wednesday, January 17, 2024 11:18 AM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: toilet inspections P3

Toilet inspection for phase 3
Golf unit

1. Works
2. Works
3. Works
4. Works
5. Broken(button missing)
6. Works- leaks
7. Broken toilet
8. Works
9. Don't work- flush valve needs to be replaced
10. Works
11. Works
12. Works-leak
13. Works-leak
14. Works-leak
15. Works
16. No toilet
17. No toilet
18. Works
19. Don't work-spud needs replaced
20. Don't work-spud needs replaced
21. Works
22. Don't work-flush valve needs replaced
23. Don't work-flush valve needs replaced
24. Works
25. Don't work-flush valve needs replaced
26. Works
27. Don't work-flush valve needs replaced
28. Works

India unit by cell

1. No toilet
2. Works
3. Door wont open
4. Works-needs new waxring possible spud
5. Don't work- flush valve needs replaced
6. Works
7. No toilet
8. Works
9. Works
10. Works
11. Works
12. Works
13. Works
14. Works
15. Don't work- flush valve needs replaced
16. Works
17. No toilet
18. No toilet
19. Works-waxring needs replaced
20. Don't work- flush valve needs replaced
21. Works
22. Works
23. Works
24. Works
25. Don't work-flush valve needs replaced
26. Works
27. Works
28. Works

Juliet toilet inspection

1. Works
2. Works
3. Works
4. No toilet
5. Works

6. Works
7. Toilet broken
8. Works
9. Works
10. Don’t work- spud needs replaced
11. Don’t work- missing push button and needs need flush valve
12. Works
13. Don’t work-flush valve needs replaced
14. Don’t work-flush valve needs replaced
15. No toilet
16. Works
17. Works
18. Works
19. Don’t work-flush valve needed
20. No toilet
21. Works
22. Works
23. Works
24. Works
25. Works
26. Works
27. Don’t work- needs vacuum breaker replaced
28. Don’t work-flush valve needs replaced
29. Works
30. No toilet
31. Don’t work-flush valve needs replaced
32. Don’t work-flush valve needs replaced
33. Works
34. Don’t work-flush valve needs replaced
35. No toilet
36. Works
37. Don’t work-flush valve needs replaced
38. Works
39. Works
40. No toilet
41. Door wont open
42. Works
43. Works
44. Works
45. Works
46. Works
47. No toilet
48. Broken
49. Works
50. Works
51. Works
52. Works
53. Don’t work-flush valve needs replaced
54. works
55. don’t work-flush valve needs replaced
56. works

Hotel toilet inspection

1. works
2. no toilet
3. works
4. works
5. don’t work-flush valve needs replaced
6. works
7. don’t work-flush valve needs replaced
8. don’t work-flush valve needs replaced
9. no toilet
10. works
11. works
12. works- short flush, diaphragm needs replaced
13. don’t work-flush valve needs replaced
14. works
15. don’t work-flush valve needs replaced
16. works
17. works
18. works
19. works

20. works
21. works
22. don't work-flush valve needs replaced
23. no toilet
24. works
25. don't work-flush valve needs replaced
26. works
27. don't work-flush valve needs replaced
28. don't work-flush valve needs replaced
29. don't work-flush valve needs replaced
30. works
31. don't work-flush valve needs replaced
32. don't work-flush valve needs replaced
33. works
34. works
35. don't work-flush valve needs replaced
36. works
37. works
38. works
39. works
40. works-missing flange bolts
41. no toilet
42. door wont open
43. works
44. works
45. don't work-flush valve needs replaced
46. don't work-flush valve needs replaced
47. don't work-flush valve needs replaced
48. don't work-flush valve needs replaced
49. don't work-flush valve needs replaced
50. works
51. don't work-flush valve needs replaced
52. no toilet
53. works
54. don't work-flush valve needs replaced
55. works
56. don't work-flush valve needs replaced

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From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Friday, January 05, 2024 10:04 AM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: toilets in phase one

H.S.I walked phase one checking urinals and toilets
ALPHA downstairs
Urinal 1-broken
Urinal 2-broken
Toilet 1- works
Toilet 2-not working. needs whole new flush valve
Alpha upstairs
Urinal 1-broken
Urinal 2- broken
Toilet 1-works
Toilet 2- fixable with new diaphragm
BRAVO downstairs
Urinal 1- broken
Urinal 2- broken
Toilet 1-works
Toilet 2-works
CHARLIE downstairs
Urinal 1- works
Urinal 2- works
Toilet 1- works
Toilet 2- broken
CHARLIE upstairs
Urinal 1- works
Urinal 2- works
Toilet 1- works
Toilet 2- not working needs whole new flush valve
DELTA downstairs
Urinal 1- broken
Urinal 2- broken
Toilet 1- works
Toilet 2- broken
DELTA upstairs
Urinal 1- works
Urinal 2- works
Toilet 1- works
Toilet 2- fixable with new diaphragm
ECHO downstairs
Urinal 1- broke
Urinal 2- fixable with diaphragm and vacuum breaker
Toilet 1- works
Toilet 2- works
ECHO upstairs
Urinal 1- broke
Urinal 2- works
Toilet 1- not working need whole new flush valve
Toilet 2- works
FOXTROT downstairs
Urinal 1- broke
Urinal 2- broke
Toilet 1- works
Toilet 2- not working needs whole new flush valve
FOXTROT upstairs
Urinal 1- works
Urinal 2- fixable with diaphragm
Toilet 1- works
Toilet 2- broken

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From: Richard Pampel <Pampel.Richard@richlandcountysc.gov>
Sent: Wednesday, January 17, 2024 11:23 AM EST
To: CRAYMAN HARVEY <HARVEY.CRAYMAN@richlandcountysc.gov>
Subject: unit Mike toilet inspection

Unit Mike toilet inspection by cell

1. Works
2. Works
3. Works
4. Works
5. Works
6. Works
7. Works
8. Works
9. Works
10. Works
11. Works
12. Works
13. Works
14. Works
15. Works
16. Works
17. Works
18. Works
19. Works
20. Works
21. Works
22. Works
23. Works
24. Works
25. Works
26. Works
27. Works
28. Works
29. don’t work-flush valve needs replaced
30. works
31. works
32. works
33. works
34. works
35. works
36. don’t work-flush valve needs replaced
37. works
38. works
39. works
40. works
41. works
42. don’t work-flush valve needs replaced
43. works
44. works
45. works
46. don’t works-flush valve needs replaced
47. works
48. works
49. works
50. works
51. works
52. works
53. works
54. works
55. works
56. works

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Exhibit 35

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County (Alvin S. Glenn) Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3259 Home Detention Program **Yes** Work/Punishment Program **Yes**

Type I ___ II ___ III ___ IV **X** V ___ VI ___ VII ___ JuvHold **No** DesignatedFac **Yes** FedContract **Yes**

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Crayman J. Harvey, Interim Detention Director

Governing Body: County Council Chairperson: Mr. Overture Walker

Date of Last Inspection: 05/26/23 Year Built: 1994 1998, 2007 Last Year Remodeled: 2007

	Adult M	Adult F	Juvenile M	Juvenile F	
Rated Capacity:	896	112			1,008 (Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):	657	44			701 (Total Avg. Daily Pop)
High Count (past 12 mos.):	692	60			Facility High Count 752

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	5	7	5	5	22	FT	88
Full-time Female	18	15	19	14	66	PT	0
Part-time Male					0	=	88
Part-time Female					0	Vacant	74
Vacant Positions					74	Reserve	0
Reserve Officers					0	Slots	162

II. Administrative Staff (denotes number and full-time(**FT**) or part-time(**PT**))

Administration		Support		Treatment		Program		Total	
Director	1FT	Maint	3FT	Doctor	Contract	Education	Contr.	FT	59
AsstDir	1FT	FoodServ	Contr.	RN	Contract	Classific	3FT*	PT	11
Sen/Chief	5FT	Records	*	LPN	Contract	Training	1FT	=	70
Clerical		Prop/Sup	3FT	MntlHlth		Religious		Contract	
Other	42FT, 3PT	Other		SocWork	Contr.	Other		Volunteers	
Vacant	6	Vacant	5	Vacant		Vacant		Vacant	8

*** Employee(s) also work a shift.**

III. Total Full-time (I&II) 147 **Total Part-time** (I&II) 11 **Grand Total** (I&II) 158

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
1021, 1022, 1031(a)(b)(d), 1035, 1063(d), 1065(b), 1082, 1094(b), 2014-1, 2014-2, 2014-7, 2014-16, 2014-23, 2014-40, 2072, 2074, 3003

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
X Fire Inspection Report
X DHEC Inspection Report

Inspected by: Robert Ellison Inspection Date: November 30, 2023

Reviewed by: R.B. Pugh

Branch Chief
Division of Inspections

NARRATIVE REPORT
RICHLAND COUNTY (ALVIN S. GLENN) DETENTION CENTER
November 30, 2023

On November 30, 2023, an inspection of this facility was conducted by Mr. Robert E. Ellison, Jr., and Mr. Rodney Pigford, and Ms. Pequita Bradley, Detention and Correctional Inspectors, with the below listed violations noted:

1005 - Definitions:

The following definitions shall apply:

(h) "Holding Cell" is a facility (City/County/Multi-Jurisdictional Lockup) for the temporary holding of persons for detoxification or who are awaiting bond, other judicial action, or transportation. If a person is to be detained longer than six (6) hours, he/she shall be transferred to a Type I or Type II facility. "Holding Cell" also refers to secure space within a facility which is set aside for the temporary detention of persons who are newly admitted or who are in transition, pending movement within or outside of the facility. A Holding Cell within a facility is not considered to be part of an inmate housing unit and is not counted as bed space for purposes of determining rated capacity.

FINDING: Holding cells in the intake area are frequently used to house inmates for more than six hours for observation etc. in violation of this Standard.

(w) "Direct Supervision" means management of inmates in which security personnel are not separated by a barrier that prohibits visual and audio interactions with the inmates. Officers work directly in housing units and provide frequent, non-scheduled observation of and personal interaction with inmates. Each housing unit has at least one (1) Security Officer posted to supervise the unit twenty-four (24) hours a day, seven (7) days a week. Security Personnel are assigned / posted to housing units at a ratio of no less than one (1) per every sixty-four (64) inmates or portion thereof. When the entire inmate population in a living unit is in a secured mode (e.g., cells/rooms are locked for sleeping, etc.), the ratio may be altered, provided that adequate supervision is maintained in each living unit.

FINDING: This facility was designed for operation with Direct Supervision Management. Due primarily to staffing shortages Direct Supervision Management is not taking place. In some cases, one officer is supervising two housing units. This will be monitored on future inspections and if this process continues a complete re-evaluation of the facility's rated capacity (that is based on the requirements of Indirect Supervision Management) will be necessary.

Inspectors also observed renovation in "Y" (Yankee) housing unit that involves creation of an enclosed Control Room, which will separate staff from inmates and would therefore cause this housing unit to be classified as Indirect Supervision Management.

1021 - Manual of Policies and Procedures:

(a) Each facility shall have a written manual of all policies and procedures for the operation of the facility. Each policy and procedure should be reviewed annually and updated as needed. Documentation of these reviews shall be maintained. These policies and procedures shall be made readily available to all personnel.

(b) The following standards require written policies and procedures:

1022	1066	2034
1036	1067	2035
1037	1068	2036
J1041.J	1081	2037
1042	1083	2051
1043	1091	2052
1044	1092	2053
1045	1093	2054
1046	2001	2055
1051	2002	2056
1061	2014-24	2070
1062	2030	2080
1063	2031	2090

1064 2032 3001.
1065 2033

(c) Comprehensive post descriptions for each facility operational position shall be in writing and made available to each employee performing the function.

FINDING: Policies and procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis, and documentation should be retained as to all dates when the policies/procedures were reviewed.

1022 - Emergency Pre-Planning:

Each facility shall have current written procedures to be followed in emergency situations. These plans shall include procedures for the following emergency situations:

fires	disturbances
escapes	suicides and attempted suicides
taking of hostages	power failures
group arrests	natural disasters
bomb threats	homeland security issues.

Discussion:
The facility should detail in writing specific procedures which can be implemented quickly when an emergency occurs. The procedures should contain provisions for sounding an appropriate alarm, alerting officials, mobilizing needed resources, and ending the alert. For example, a fire suppression plan would be coordinated with, and recognized by, the local fire department and would include a fire prevention plan in the policies and procedures manual; regular facility inspections by staff; fire prevention inspections by the fire department having jurisdiction; an evacuation plan; and a plan for the emergency housing of inmates in case of a fire.

FINDING: Policies and procedures need to be reviewed and updated to reflect current operations at the facility. This should be done on a regular ongoing basis, and documentation should be retained as to all dates when the policies/procedures were reviewed.

1031 - Number of Personnel:

(a) The Facility Administrator shall designate a Facility Manager qualified by training and experience to supervise staff and inmates.

FINDING: The facility operated for a lengthy period without a recognized Detention Director and is currently once again operating with an Interim Director.

(b) Each facility shall have sufficient personnel to provide twenty-four (24) hour supervision and processing of inmates, to arrange full coverage of all identified security posts, and to accomplish essential support functions.

FINDING: The facility is continuing, of necessity, to encumber overtime for existing employees; and, even then, staff coverage is inadequate. Additional personnel need to be authorized and funded to enable proper facility operation, and recruitment and retention of employees must also be improved. At the time of the inspection, several housing units were closed due to the staffing shortage or repairs.

(d) A staffing analysis (using NIC Staffing Analysis Workbook or other industry recognized plan) shall be conducted to determine facility staffing needs. The staffing analysis shall be reviewed annually and updated as needed.

FINDING: A current Staffing Analysis is needed. The latest Staffing Analysis was conducted years ago and does not reflect current operations at the facility.

1035 - In-Service Training:

All non-security personnel shall be required to complete in-service training which has been approved by the Facility Manager.

All security personnel shall successfully complete required in-service training of no less than forty (40) hours each year. This training shall

be approved by the South Carolina Criminal Justice Academy. Such training should include but not be limited to:

(a) Review and update of safety and security procedures, regulations, and equipment
(b) Recent legal decisions on the confinement and treatment of all types of persons detained
(c) Report writing
(d) Sexual harassment
(e) Suicide prevention
(f) Inmate supervision
(g) Use of force regulations and tactics
(h) Emergency plans and procedures
(i) Interpersonal communication
(j) Cultural diversity
(k) CPR and first aid training
(l) Sexual abuse/assault awareness and response/PREA
(m) Facility specific issues.

Discussion:
The purpose of the in-service training is to keep the employees up to date on procedures and incidents and methods of handling them. This requirement may be met by sessions scheduled on a weekly or monthly basis.

Several items need to be added to the in-service training agenda. They include:

1. Training on operation of fire extinguishers and automatic suppression systems in the kitchen;
2. Training on operation of pull stations in the housing units;
3. Procedures to alert the rest of the facility of a fire or other emergency; and
4. Procedures for reporting maintenance concerns.

1063 - Key Control:

(d) An inventory and log of all keys shall be made at the beginning of each shift.

FINDING: Key control procedures has improved somewhat since the previous inspection. However, staff training on daily logging of keys issued and

returned, and accountability of keys held by individual Officers, is needed.

1065 - Facility Security:

(b) All security locks and doors shall be regularly inspected and operated (by remote and manual means) from both the interior and exterior of the doors to ensure proper working order at all times, including in emergency situations.

FINDING: Some of the cell and passage door locks in Phase III (and elsewhere in the facility) are malfunctioning and need to be repaired or replaced.

1082 - Classification Categories:

(a) The facility provides for the separate management of the following categories of inmates in accordance with the facility's classification plan:

* female and male inmates
* sentenced and non-sentenced inmates
* other classes of detainees (i.e., witnesses, informants, and protective custody inmates)
* community custody inmates (work releasees, weekenders, trusties)
* inmates requiring disciplinary detention
* inmates requiring administrative separation
* juvenile detainees
* Other categories that may pose a security problem which include but are not limited to: high profile cases; geriatric inmates; sexual deviants; sex offenders; predators; and inmates undergoing sex changes.

FINDING: Pretrial and sentenced female inmates are being housed together in violation of this Standard.

1094 - Females:

(b) Female inmates shall be afforded the same rights and privileges as male inmates.

FINDING: Due to the fact that all female inmates (both sentenced and pre-trial) are housed in the same living unit, they are not being afforded the same privileges as the male inmates are.

2012 - Rated Capacity:

The Director of the Jail and Prison Inspection Division shall ascertain the maximum number of inmates, of whatever classifications, based upon square footage and other relevant requirements that can properly be housed in each facility and in the various living areas within each facility. After determining the rated capacity, the Director shall notify, in writing, the Facility Manager, the Facility Administrator, and the governing body which has responsibility for the facility. These numbers shall be reviewed annually.

FINDING: It should be noted that the rated capacity has been adjusted to reflect housing at the time of this inspection.

Two former housing units, T-1 and T-2 have not been utilized for housing in several years and there are no plans to use this building for housing in the future, so these two housing units have been removed from the official rated capacity of the facility.

Housing units that are unoccupied due to staffing shortages or for repairs have previously remained as part of the facility's official rated capacity. On future inspection unoccupied housing units will be omitted from the official rated capacity.

2014-1 - Special Purpose Cells:

Each facility shall have at least one (1) special-purpose cell or room that is designed to prevent injury to an inmate who is under the influence of alcohol or narcotics, or for inmates who are uncontrollably violent

or self-destructive. This room shall be subject to staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

FINDING: The male Special Purpose cell(s) are in Housing Unit P (Poppa). Construction of the cell(s)-to-dayroom separation (walls) are primarily glass or Lexan and provide direct sight from a twenty-four (24) hour staff position.

All female inmates are now housed in Unit X. Inmates housed for Special Purpose reasons (suicide watch, etc.) are placed in cells in this unit that do not provide staff observation or be continuously monitored by camera from a twenty-four (24) hour staff position.

2014-2 - Fire Codes:

The facility conforms to applicable federal, state, and/or local building and fire safety codes. Compliance is documented by the authority having jurisdiction. A fire alarm and automatic smoke detection system are required, as approved by the authority having jurisdiction. (See Appendix B.)

Discussion:
The applicable code(s) should be applied to all areas of the facility. Reports of periodic inspections and any actions taken in respect to those inspections must be available. The authority having jurisdiction in South Carolina is the State Fire Marshal.

FINDING: Several items that were noted by the Deputy State Fire Marshal need to be addressed.

The fire apparatus access road that encircles the complex needs to be maintained to be accessible in all weather conditions as per the requirements of the South Carolina Fire Code, Sections 503.2.1 through 503.2.8.

2014-7 - Security:

The facility has adequate exits that are properly positioned, unobstructed, and distinctly and permanently marked to ensure the timely evacuation of inmates and staff in the event of fire or other emergency.

Discussion:

Exits should be provided to ensure the safety of inmates, staff, and visitors. All exits should be kept clear and free of obstructions and maintained in a usable condition. They should lead directly to a hazard-free area where adequate supervision can be provided.

FINDINGS: Several security issues were noted during the inspection as follows:

1 Lack of lighting in bathrooms presents a security hazard to inmates (i.e..: contact with other inmates, safety hazard due to slips/falls, etc.)

2 Female inmates in one of the housing units stated that a male inmate had entered the housing unit through the ceiling. This must be investigated in order to identify and seal a possible security breach.

3 Inmates in several housing units reported that the Count, which is scheduled for certain times during the day was being conducted by an inmate due to the absence of an officer on the unit, presumedly due to staffing shortages.

2014-16 - Toilets:

Inmates have access to toilets and hand-washing facilities twenty-four (24) hours per day and are able to use toilet facilities without staff assistance when they are confined in their cells/sleeping areas. Toilets are provided at a minimum ratio of one (1) for every twelve (12) inmates in male facilities, and one (1) for every eight (8) inmates in female facilities. Urinals may be substituted for up to one-half of the toilets in male facilities. All housing units with three (3) or more inmates have a minimum of two (2) toilets.

FINDING: The Phase V addition to the facility has sub-housing units that are designed for eight (8) inmates but contain only one (1) toilet.

It was noted that in several housing units other than Phase V) there were missing or damaged toilets, and at least one unit that housed females contained urinals, which cannot be used by females or included in the ratio of inmates to toilets requirement in Standards.

2014-23 - Indoor Air Quality:

Ventilation system(s) is/are in compliance with the applicable Standard Mechanical Code and standard Building Codes or portions thereof adopted by the State of South Carolina.

Forced air circulation of at least ten (10) cubic feet per minute of fresh or purified air per inmate.

FINDING: Air flow in several housing units in Phase I and in the Main Control Room was inadequate. Repairs or adjustment are needed.

2014-40 - Maintenance:

All portions of existing buildings, both interior and exterior, are maintained in such manner that structural strength, stability, sanitation, indoor air quality, and safety of life and property are free from fire and other hazards. Repairs and upkeep are provided to ensure public safety, health, and general welfare.

Discussion:

The building structural system is maintained structurally sound with no evidence of deterioration, and capable of supporting the load of normal use. All exterior walls are free of holes, breaks, loose or rotting boards or timbers, and any other conditions which might admit rain or dampness to the interior portions of the walls or to the occupied spaces of the building. All siding materials are kept in repair. Roofs structurally sound and maintained in a safe manner and have no defects which might admit rain or cause dampness in the walls or interior portion of the building.

FINDING: Numerous maintenance related violations were noted during the building tour as listed below:

1. There are corroded sprinkler escutcheons throughout,
2. Writing surfaces are missing from some cells,
3. There is water damage to ceilings,
4. There is paint peeling in showers (India Unit),
5. Showers need to be thoroughly scoured on a more regular basis,
6. Ceramic tiles are missing in the showers,
7. Ceiling tiles are missing or damaged,
8. There are missing and inoperable plumbing fixtures (toilets, urinals, sinks and showers) in the housing units,
9. There are missing toilet fixtures in several units,
10. There are accumulations of trash in several pipe chases,
11. The manual pull stations for the fire extinguishing system(s) in the kitchen hood(s) need to be identified as to which hood it activates.
12. "Loaded" sprinkler heads that needed cleaning were notice in several areas of the facility.
13. Escutcheons were missing from sprinkler heads throughout the facility.
14. Numerous were not functional throughout the facility
15. Unit D had several maintenance issues as follows (this unit was female housing at the time of this inspection):
    a. There were no light fixtures in the shower area,
    b. Two of the urinals were not operational,
    c. One of two sinks' downstairs was not operational, or ran constantly,
    d. One of two toilets' downstairs was not operational,
    e. One of four showerheads downstairs was not operational,
    f. Bugs were observed in the bathroom area of this housing unit,
    g. Inmates housed in the unit stated that a male inmate had come into the unit through a missing ceiling tile.
    h. See comments under Standard 2014-23 above regarding indoor air quality, and
    i. Sprinkler head coverage in Unit K (and possibly in other housing units) may have been compromised with the addition of new LED fixtures. This needs to be evaluated and repaired if necessary.

j. The Isolation Cells in the Medical Area have been converted to Storage. These two rooms need to be returned to use as medical isolation.

2072 - Laundry:

Inmate clothing, whether personal or institutional, shall be exchanged and cleaned at least twice weekly unless work, climatic conditions, or illness necessitate more frequent exchange.

FINDING: Laundering of inmate uniforms etc. are occurring once a week in violation of this Standard.

2074 - Personal Care Items:

Each inmate detained longer than twenty-four (24) hours shall be provided the following items, as appropriate:

(a) Toothbrush
(b) Toothpaste or tooth powder
(c) Soap
(d) Shaving implements
(e) Comb
(f) Feminine hygiene items (if female).

Inmates may be required to purchase personal care items. However, basic hygiene items shall be provided to indigent inmates by the facility.

FINDING: Personal hygiene items were said to not be available at all times. When these items were available damaged or missing plumbing fixtures or improper lighting etc. in the bathrooms made use of the items was difficult.

3003 - Vermin, Insects, and Pests:

(a) Each facility shall have a regularly scheduled program of pest and vermin control and extermination.

(c) Effective measures shall be taken to keep flies, rodents, and other vermin out of the confinement facility and to prevent

their breeding or continued presence on the premises. The facility shall be kept neat, clean, and free of litter. All openings to the outer air shall be effectively protected against the entrance of insects and rodents by self-closing doors, closed windows, sixteen (16) mesh or finer screening, or other effective means.

FINDING: This situation appeared to be greatly improved since the last inspection However, continued focus needs to be maintained on this issue.

At the conclusion of the inspection, Inspector Ellison, Branch Chief Pigford met with Mr. Crayman Harvey, Detention Center Director, Mr. James Lipcomb, Compliance Director and members from the State Fire Marshal and reviewed the tentative findings and to inform them of any Standards that need immediate action. Mr. Harvey was informed that a final report with details of the violations will be sent by the Branch Chief of Inspections.

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF INSPECTIONS
LOCAL DETENTION FACILITY INSPECTION REPORT

County: Richland Facility: Richland County Juvenile Detention Center

Street Address: 201 John Mark Dial Drive, Columbia, South Carolina 29209

Telephone: 803-576-3200 Home Detention Program No Work/Punishment Program No

Type I ___ II ___ III ___ IV ___ V ___ VI ___ VII X JuvHold Yes DesignatedFac No FedContract No

Responsible Official: Mr. Leonardo Brown Title: County Administrator

Administrator/Director: Mr. Crayman J. Harvey, Juvenile Administrator

Governing Body: County Council Chairperson: Mr. Overture Walker

Date of Last Inspection: 05/26/23 Year Built: 1995 Last Year Remodeled: N/A

	Adult M	Adult F	Juvenile M	Juvenile F		
Rated Capacity:			20	4	24	(Total Rated Capacity)
Avg. Daily Pop (past 3 mos.):			18	2	20	(Total Avg. Daily Pop)
High Count (past 12 mos.):			36	6	Facility High Count	37

I. Security/Custodial Staff
(includes shift supervisors-excludes senior/chief security officers)

# Corr Officers	Day Shift A	Night Shift A	Day Shift B	Night Shift B	Sub Total	Total	
Full-time Male	0	1	1	0	2	FT	9
Full-time Female	1	1	1	4	7	PT	0
Part-time Male					0	=	9
Part-time Female					0	Vacant	0
Vacant Positions					0	Reserve	0
Reserve Officers					0	Slots	9

II. Administrative Staff (denotes number and full-time(FT) or part-time(PT))

Administration		Support		Treatment		Program		Total	
Director	1FT	Maint		Doctor	Contract	Education	Contr.	FT	2
AsstDir		FoodServ		RN	Contract	Classific		PT	0
Sen/Chief		Records		LPN	Contract	Training		=	2
Clerical	1FT	Public Wks		MntlHlth		Religious		Contract	
Other		Other		SocWork	Contr.	Other		Volunteers	
Vacant		Vacant		Vacant		Vacant		Vacant	

III. Total Full-time (I&II) 11 **Total Part-time** (I&II) 0 **Grand Total** (I&II) 11

___ This facility was found in compliance with Standards.
X This facility was found in non-compliance with the Standards listed below:
5380, 5590(a)(b)(5)

ATTACHMENTS:

X Rated Capacity Sheet
X Narrative Report
X Fire Inspection Report
N/A DHEC Inspection Report

Inspected by: _____ Inspection Date: November 30, 2023

Reviewed by: _____
Branch Chief
Division of Jail Inspections

SOUTH CAROLINA DEPARTMENT OF CORRECTIONS
DIVISION OF INSPECTIONS
RATED CAPACITY SHEET

Facility: Richland County Juvenile Detention Center **Type:** VII **Date:** November 30, 2023

Cell Block/ Housing Unit:	Pre-Trial Adult Male R/C	Pre-Trial Adult Male A/C	Pre-Trial Adult Female R/C	Pre-Trial Adult Female A/C	Sentenced Adult Male R/C	Sentenced Adult Male A/C	Sentenced Adult Female R/C	Sentenced Adult Female A/C	Juvenile Male R/C	Juvenile Male A/C	Juvenile Female R/C	Juvenile Female A/C
Spec. Purpose *												
Holding *									1	0	1	0
Infirmary *												
Unit A									8	8		
Unit B									8	8		
Unit C (Max.)									4	8		
Unit C (Female)											4	0
Subtotal:	0	0	0	0	0	0	0	0	20	24	4	0

Total R/C: 24 Total A/C: 24 (Total the date of the inspection)

NOTE: R/C = Rated Capacity; A/C = Actual Count
* = Special Purpose Cells, Holding Cells, and Infirmary Beds are not part of the facility's rated capacity for permanent housing.
** = Either/Or

NARRATIVE REPORT
RICHLAND COUNTY JUVENILE DETENTION CENTER

November 30, 2023

On November 30, 2023, an inspection of this facility was conducted by Mr. Robert E. Ellison, Jr., Mr. Rodney Pigford and Ms. Latoya Able, Detention and Correctional Inspectors, with the following violation noted:

5380 - Key Control:

The facility shall have a written policy and procedure governing the following:

(a) Facility and vehicle keys shall be inventoried and stored in a secure area when not in use.

(b) There shall be one (1) full set of well-identified facility keys, other than those in use, secured in a place accessible only to authorized personnel for use in the event of an emergency.

(c) No juveniles shall be permitted access to, nor allowed to handle, facility or vehicle keys.

(d) An inventory and log of all keys shall be made at the beginning of each shift.

(e) Keys necessary for unlocking doors installed in a means of egress shall be individually identifiable by both touch and sight, as mandated by Standard 408.7.4 of the International Fire Code.

FINDING: Keys for the cell and exit doors were found to be unsecured in a drawer at the main desk in the intake area.

5590 - Facilities From July 1980 Through June 2007:

Unless otherwise noted, this standard applies to all facilities which became operational or for which plans were submitted and approved after June 1980, and prior to July 2007.

(a) All cells, rooms, or dormitories shall have access to natural light and have, at a minimum, fifty (50) square feet of unencumbered floor space per juvenile if single occupancy. For multiple occupancy cells, rooms, or dormitories there shall a minimum of thirty-five (35) square feet of unencumbered floor space per juvenile.

Some of the rooms are housing two (2) juveniles in violation of this Standard.

(b) All housing units and activities areas shall have, at a minimum:

(5) Bed; desk, table, or shelf; storage space or hooks; and adequate accessible seating; and

Writing surfaces are not available in all juvenile housing rooms.

South Carolina Department of Labor, Licensing and Regulation

Office of State Fire Marshal

141 Monticello Trail • Columbia, S.C. 29203. Phone: (803) 896-9800

www.statefire.llr.sc.gov

INSPECTION REPORT

DEFICIENCIES CITED

Inspection Report Number	Inspection Type	Date Completed	Permit/Decal #
I-23-008609-1	BUILDING INSPECTION	11/30/2023	
Name		**Phone**	**Alternate Phone**
ALVIN S. GLENN DETENTION CENTER		(803) 576-3259	
Address		**Determination**	
203 JOHN MARK DIAL DR., COLUMBIA, SC 29209		NOT IN COMPLIANCE (12/07/2023)	

Contact Information

Role	Name	Phone	Address
OWNER/OWNER'S REPRESENTATIVE	CRAYMAN HARVEY	(803) 576-3259	201 JOHN MARK DIAL DR., COLUMBIA, SC 29209
Submitted By	ROBERT ELLISON JR	(803) 896-1626	1501 MULLER RD, BLYTHEWOOD, SC 29016

Year Built	Number of Stories	Number Buildings	Construction Type	Capacity	Building Power
1994	1	3	4	1,116	
Smoke Detector	**Automatic Sprinkler**	**Fire Alarm**	**Gas Certificate**	**Electrical Certificate**	**Fire Drill**
COMPLETE	COMPLETE	COMPLETE			

Occupancy Details

Occupancy Type	Square Feet	Details
INSTITUTIONAL	1	INSTITUTIONAL BUILDING TYPE: GROUP I-3 (DETENTION/CORRECTION); DETENTION/CORRECTION FACILITY TYPE: CONDITION 4

Codes

1	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 109.1 **Maintenance of safeguards.** Where any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this code, or otherwise installed, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be continuously maintained in accordance with this code and applicable referenced standards. **Comments: Ceiling tiles were missing throughout the facility to include around sprinkler heads and smoke detectors.**
2	REFERENCE ONLY - SOUTH CAROLINA FIRE CODE 2021, 109.3 **Recordkeeping.** A record of periodic inspections, tests, servicing and other operations and maintenance shall be maintained on the premises or other approved location for not less than 3 years, or a different period of time where specified in this code or referenced standards. Records shall be made available for inspection by the fire code official, and a copy of the records shall be provided to the fire code official on request.

3	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 315.3.1 **Ceiling clearance.**Storage shall be maintained 2 feet (610 mm) or more below the ceiling in non sprinklered areas of buildings or not less than 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. Exceptions: 1. The 2-foot (610 mm) ceiling clearance is not required for storage along walls in non-sprinklered areas of buildings. 2. The 18-inch (457 mm) ceiling clearance is not required for storage along walls in eras of buildings equipped with an*automatic sprinkler system* in accordance with Section 903.3.1.1, 903.3.1.2 or 903.3.1.3. **Comments: In the server room inside Central, several boxes were stacked on top of the data servers, providing less than 18 inches in a sprinklered room.**
4	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 403.7.3.1 **Fire safety and evacuation plans.** The fire safety and evacuation plans required by Section 404 shall include a description of special staff actions. Plans shall include all of the following in addition to the requirements of Section 404: 1. Procedures for evacuation of detainees with needs for containment or restraint and post-evacuation containment, where present. 2. Procedures for a defend-in-place strategy. 3. Procedures for a full-floor or building evacuation, where necessary. **Comments: Unable to verify the approved fire safety and evacuations plans were on site, maintained, and trained on in accordance with SCFC 401.2 and 403.7. Unable to verify the approved from the fire code officialto include the use of the officer duress button as a form of communication in unstaffed pods for inmates to notifystaff of an emergency.**
5	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 403.7.3.2 **Fire safety plan.** A copy of the fire safety plan shall be maintained at the facility at all times. The plan shall include both of the following in addition to the requirements of Section 404.2.2: 1. Location and number of cells. 2. Location of special locking arrangements. **Comments: Unable to verify the approved fire safety and evacuations plans were on site, maintained, and trained on in accordance with SCFC 401.2 and 403.7**
6	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 403.7.3.3 **Staff training.** Staff shall be periodically instructed and kept informed of their duties and responsibilities under the (fire safety) plan. Records of instruction shall be maintained. Such instruction shall be reviewed by staff at intervals not exceeding three months. Training of new staff shall be provided promptly upon entrance to duty. Staff shall be instructed in the proper use of portable fire extinguishers and other manual fire suppression equipment. **Comments: Unable to verify the approved fire safety and evacuations plans were trained on in accordance with this section.**
7	REFERENCE ONLY - SOUTH CAROLINA FIRE CODE 2021, 403.7 **Group I occupancies.** An approved fire safety and evacuation plan in accordance with Section 404 shall be prepared and maintained for Group I occupancies.
8	REFERENCE ONLY - SOUTH CAROLINA FIRE CODE 2021, 403.1 **Approval.** Where required by this code, fire safety plans, emergency procedures and employee training programs shall be approved by the fire code official.

9	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 405.6 **Recordkeeping.** Records shall be maintained of required emergency evacuation drills and include the following information: 1. Identity of the person conducting the drill. 2. Date and time of the drill. 3. Notification method used. 4. Employees on duty and participating. 5. Number of occupants evacuated. 6. Special conditions simulated. 7. Problems encountered. 8. Weather conditions when occupants were evacuated. 9. Time required to accomplish complete evacuation. **Comments: No fire drill records were maintained on the premises on the adult side of the faculty in accordance with SCFC Section 109.3**
10	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 603.2.1 **Open electrical terminations.** Open junction boxes and open-wiring splices shall be prohibited. Approved covers shall be provided for all switch and electrical outlet boxes. **Comments: Open wiring and junction boxes were found throughout the premises including, but not limited to: Pods A-F, Pod J, Pod M, and Pod U.**
11	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 603.4.1 **Labeling.** Doors into electrical control panel rooms shall be marked with a plainly visible and legible sign stating "ELECTRICAL ROOM" or similar approved wording. The disconnecting means for each service, feeder or branch circuit originating on a switchboard or panelboard shall be legibly and durably marked to indicate its purpose unless such purpose is clearly evident. Where buildings or structures are supplied by more than one power source, markings shall be provided at each service equipment location and at all interconnected electric power production sources identifying all electric power sources at the premises in accordance with NFPA 70. **Comments: The circuit breaker for the alarm panel in the Juvenile building (panel XJLA) was not clearly marked to indicate its purpose.**
12	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 603.6 **Extension Cords.** Extension cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords shall not be affixed to structures, extended through walls, ceilings, or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. **Comments: Multiple stationary appliances were plugged in using extension cords and surge protectors. These areas were including, but not limited to: refrigerator in Room P near laundry room and microwave in room labeled "Supply".**
13	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 603.6 **Extension Cords.** Extension cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. Extension cords shall not be affixed to structures, extended through walls, ceilings, or floors, or under doors or floor coverings, nor shall such cords be subject to environmental damage or physical impact. Extension cords shall be used only with portable appliances. Extension cords marked for indoor use shall not be used outdoors. **Comments: In the central room where the data servers were located, extension cords were extended through the floor.**

14	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 606.3.3.3 **Records.** Records for inspections shall state the individual and company performing the inspection, a description of the inspection and when the inspection took place. Records for cleanings shall state the individual and company performing the cleaning and when the cleaning took place. Such records shall be completed after each inspection or cleaning and maintained. **Comments: Records for the inspection of the hood system in were not on premises in accordance with this section and SCFC 109.1.**
15	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 701.6 **Owner's responsibility.**The*owner*shal maintain an inventory of all required*fire-resistance-rated*construction, construction installed to resist the passage of smoke and the construction included in Sections 703 through 707 and Sections 602.4.1 and 602.4.2 of the*International Building Code.*Such construction shall be visually inspected by the*owner*annually and properly repaired, restored or replaced where damaged, altered, breached or penetrated. Records of inspections and repairs shall be maintained. Where concealed, such elements shall not be required to be visually inspected by the*owner*unless the concealed space is accessible by the removal or movement of a panel, access door, ceiling tile or similar movable entry to the space. **Comments: Records of the fire wall inspections were not maintained on premisesIn accordance with SCFC Section 109.3**
16	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 705.2 **Inspection and maintenance.** Opening protectives in fire-resistance-rated assemblies shall be inspected and maintained in accordance with NFPA 80. Opening protectives in smoke barriers shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Openings in smoke partitions shall be inspected and maintained in accordance with NFPA 105. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. Fusible links shall be replaced promptly whenever fused or damaged. Opening protectives and smoke and draft control doors shall not be modified. **Comment A: The fire door leading into Room L outside of the laundry area had a broken door closer, and the door was not able to close automatically.** **Comment B: The fire door in the laundry area labeled "Door P" had multiple holes drilled on the bottom right corner.** **Comment C: The fire door on the inside of the Room P (within laundry area) was tied into an open position, making it unable close.**
17	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 706.1 **Maintaining protection.** Dampers protecting ducts and air transfer openings shall be inspected and maintained in accordance with NFPA 80 and NFPA 105. Other products or materials used to protect the openings for ducts and air transfer openings shall be securely attached to or bonded to the construction containing the duct or air transfer opening, without visible openings through or into the cavity of the construction. Any damaged products or materials protectingduct and air transfer openings shall be repaired, restored or replaced. **Comments: Damper inspection and maintenance records were not maintained on premises in accordance with 109.3.**

18	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 901.4.1 **Required fire protection and life safety systems.***Fire protection and life safety systems* required by this code or the *International Building Code* shall be installed, repaired, operated, tested and maintained in accordance with this code. *A fire protection or life safety system* for which a design option, exception, or reduction to the provisions of this code of the *International Building Code* has been granted shall be considered to be a required system. **Comments: On the alarm panel in Central, the "Trouble", "Supervisory", and "Silence" lights were all activated.**
19	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 901.6.1 **Standards.** Fire protection systems shall be inspected, tested and maintained in accordance with the referenced standards listed in Table 901.6.1. **Comment A: Multiple sprinkler heads in the laundry room were loaded with lint and maintenance needs to be conducted in accordance with NFPA 25 section 5.2.1.1.1.** **Comment B: The sprinkler room did not have a spare of each type of sprinkler head in accordance with NFPA 25 section 5.4.5.**
20	REFERENCE ONLY - NFPA 25 2017, 5.2.1.1.1 Any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion detrimental to sprinkler performance (3) Physical damage (4) Loss of fluid in the glass bulb heat-responsive element (5) Loading detrimental to sprinkler performance (6) Paint other than that applied by the sprinkler manufacturer.
21	REFERENCE ONLY - NFPA 25 2017, 5.4.5.1 A supply of at least six spare sprinklers shall be maintained on the premises so that any sprinklers that have operated or been damaged in any way can be promptly replaced.
22	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 901.6.3 **Records.** Records of all system inspections, tests and maintenance required by the referenced standards shall be maintained. **Comments: Records of hood cleaning were not maintained on premises in accordance with 606.3.3.3. Tags on the hood systems indicate the systems were checked on 8/3/22 by Hoodez professional cleaning.**
23	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 904.13.1 **Manual system operation.** A manual actuation device shall be located at or near *a means of egress* from the cooking area not less than 10 feet (3048 mm) and not more than 20 (6096 mm) from the kitchen exhaust system. The manual actuation device shall be installed not more than 48 inches (1200 mm) nor less than 42 inches (1067 mm) above the floor and shall clearly identify the hazard protected. The manual actuation shall require a maximum force of 40 points (178 N) and a maximum movement of 14 inches (356 mm) to actuate the fire suppression system. Exception: Automatic sprinkler systems shall not be required to be equipped with manual actuation means. **Comments: The manual pull stations in the kitchen did not identify the hazards protected.**
24	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 906.1 **Where required.** Portable fire extinguishers shall be installed in all of the following locations: 1. In new and existing Group A, B, E, F, H, I, M, R-1, R-2, R-4 and S occupancies. Exceptions: 1. In Group R-2 occupancies, portable fire extinguishers shall be required only in locations specified in Items 2 through 6 where each dwelling unit is provided with a portable fire extinguisher having a minimum rating of 1-A:10-B:C. 2. In Group E occupancies, portable fire extinguishers shall be required only in locations specified in Items 2 through 6 where each classroom is provided with a portable fire extinguisher having a minimum rating of 2-A:20-B:C. 3. In storage areas of Group S occupancies where forklift, powered industrial truck or powered cart operators are the primary occupants, fixed extinguishers, as specified in NFPA 10, shall not be required where in accordance with all **Comment A: No 2:A 10:BC extinguisher was installed within the central monitoring room.** **Comment B: In the electrical room in the Juvenile building, no 2:A 10:B:C extinguisher was installed.**

25	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 906.4.2 **Class K portal fire extinguishers for deep fat fryers.**Where hazard areas include deep fat fryers,*listed*Class K portal fire extinguishers shall be provided as follows: 1. For up to four fryers having a maximum cooking medium capacity of 80 pounds (36.3 kg) each: one Class K portal fire extinguisher of a minimum 1.5-gallon (6 L) capacity. 2. For every additional group of four fryers having a maximum cooking medium capacity of 80 pounds (36.3 kg) each: one additional Class K portable fire extinguisher of a minimum 1.5-gallon (6 L) capacity shall be provided. 3. For individual fryers exceeding 6 square feet (0.55 m2) in surface area: Class K portable fire extinguishers shall be installed n accordance with the extinguisher manufacturer's recommendations. **Comments: A Class K extinguisher was not present in the kitchen.**
26	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 907.8.4 **Inspection, testing and maintenance.** The building owner shall be responsible to maintain the fire and life safety systems in an operable condition at all times. Service personnel shall meet the qualification requirements of NFPA 72 for inspection, testing and maintenance of such systems. Records of inspection, testing and maintenance shall be maintained. **Comments: Records of the inspection, testing, and maintenance of the fire alarm systems, including but not limited to fire alarm systems, smoke detector sensitivity, and other documents required by NFPA 72 were not maintained on premises in accordance with SCFC Section 109.3**
27	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 909.22.2 **Records.** Records of smoke control system testing and maintenance shall be maintained. The record shall include the date of the maintenance, identification of the servicing personnel and notification of any unsatisfactory condition and the corrective action taken, including parts replaced. **Comments: Smoke control system testing and maintenance was not maintained on premises in not than three years in accordance with this section and SCFC 109.3.**
28	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 1013.3 **Illumination.** Exit signs shall be internally or externally illuminated. **Comments: Multiple exit signs throughout the premises were not illuminated. These locations include, but are not limited to: Juvenile Classrooms A and B, Pods A through F, Pod J, Pod M, and Pod U.**
29	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 1032.6 **Finishings, furnishings, and decorations.**Means of egress doors shall be maintained in such a manner as to be distinguishable from the adjacent construction and finishes such that the doors are easily recognizable as doors. Furnishings, decorations or other objects shall not be placed so as to obstruct exits, access thereto, egress therefrom, or visibility thereof. Hangings and draperies shall not be placed over exit doors or otherwise be located to conceal or obstruct an exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of egress. **Comments: A curtain was placed over the egress side of a marked exit door in the Tango building in the room behind the media room.**

30	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 1203.5 **Operational inspection and testing.** Emergency power systems, including all appurtenant components, shall be inspected and tested under load in accordance with NFPA 110 and NFPA 111. **Exception:** Where the emergency power system is used for standby power or peak load shaving, such use shall be recorded and shall be allowed to be substituted for scheduled testing of the generator set, provided that appropriate records are maintained. **Comments: Records of the power system testing and maintenance were not maintained on premises in accordance with this section and SCFC 109.3.**
31	DEFICIENT - SOUTH CAROLINA FIRE CODE 2021, 5003.5 **Hazard identification signs.** Unless otherwise exempted by the fire code official, visible hazard identification signs as specified in NFPA 704 for the specific material contained shall be placed on stationary containers and above-ground tanks and at entrances to locations where hazardous materials are stored, dispensed, used or handled in quantities requiring a permit and at specific entrances and locations designated by the fire code official. **Comments: A 704 placard was missing for the laundry room.**
32	REFERENCE ONLY - ENGINEERING 2023, SCDC 1 Enforcement of the South Carolina Fire Code in local detention centers and State Prisons is the sole responsibility of the South Carolina Department of Corrections (SCDC) in accordance with South Carolina Code of Laws § 24-9-30. Please contact SCDC administration to discuss time frame for compliance, appeals process, and consequences of continued non-compliance of the South Carolina Fire Code and applicable standards.

Inspector Information		
Name: KENNETH FISK	Badge Number: 233	Inspector Signature:

Person to whom requirements were explained		
Name:	Title:	Signature:

Appeal Notice:

YOU ARE HEREBY NOTIFIED that this is an official ORDER of the South Carolina State Fire Marshal, in accordance with Chapter 9 of Title 23, stating deficiencies are found to exist in the herein referenced structure, building, or premise and further requiring that you as owner, agent, or person in control of said structure, building or premise have 30 days to complete the specified repairs or improvements. Appeals shall be in accordance with:

SC Code 23-9-70 [...] If such order is issued by any deputy or resident fire marshal, such occupant or owner may, within thirty days, appeal to the State Fire Marshal, who shall, within ten days of receiving notice of the appeal, during which time the order appealed from shall be stayed, review the order and file his decision. The appeal period shall not be allowed if the building or any other structure is deemed to be an imminent danger pursuant to Section 23-9-160. A person who feels himself aggrieved by any order or affirmed order of the State Fire Marshal may, within thirty days after the making or affirming of such order, appeal to an administrative law judge, as provided under Article 5, Chapter 23, Title 1, for review of such order and it shall be heard at the first convenient day. [...]

EXHIBIT 36

of receipt acknowledging that they have received a copy or have been provided access to the Post Orders/Policy Manual and understand they are responsible to read and become familiar with its contents.

DUTIES AND RESPONSIBILITIES of the Classification Officer include but are not limited to:

1. Detention Officers will remain courteous and exhibit a professional demeanor at all times with others (offenders, staff and public) while performing their duties, will treat offenders in a fair and consistent manner, and communicate in a tactful and professional manner. Personal relationships and favors between staff and offenders are strictly prohibited. Detention Officers will handle offender's requests, concerns, and complaints in a timely and professional manner. Detention Officers will honestly answer offender questions.

2. Detention Officers will report to and attend roll call meetings at the appropriate time in proper uniform, receive assignment, and note all pertinent information received from the Shift Commander pertaining to the post and duties. Unless instructed otherwise, at the conclusion of roll call, officers must immediately report to their assigned post.

3. At the conclusion of the roll call meeting or when instructed by the supervisory personnel to do so, Classification Officers are to immediately report to their post or designated work area. On the way to Classifications, the officer will go to central control and pick up a set of keys for the classification office. The Classification Officer must sign for and be responsible for the keys and turn them in at the end of the shift. If you mistakenly take the keys home, you must return them immediately, same day.

4. Prior to working the post alone, officers must complete and be signed off on all required training for Classification.

5. Detention Officers will become familiar with, understand, and follow the Post Orders for Classification and review them on a regular basis. When in doubt about something or about a situation, the officer assigned will ask questions for clarification. Employees are required to submit to their Supervisor any operational changes that have occurred, or that they recommend should occur, in the operation of their post.

6. Do not leave Classification without proper relief, permission and/or authorization from the Supervisor. On taking breaks, return to Classification as instructed by the Supervisor.

7. Detention Officers will monitor, supervise, and maintain custody, control, safety, and accountability of the offenders. It is essential that the officers assigned to Classification closely monitor and maintain a high level of observation of the

behavior of the offenders. Use only the amount of force absolutely necessary to control a situation.

8. Detention Officers will monitor, supervise, and control, the movement of all persons (staff, visitors, etc.) entering, exiting, or in the Classification Office. Detention Officers will ensure that no unauthorized person gains entry into the Classification Officer without the proper authorization.

9. Detention Officers will be familiar with and enforce the offender rules and regulations, and any imposed offender sanctions; ensure that the offenders assigned to Unit Y have been familiarized with the rules and regulations of the Detention Center; ensure that offenders are counseled or that the appropriate disciplinary action is taken for violations of rules; and prepare, maintain, and pass on the appropriate documentation of violations of rules and any sanctions imposed.

10. Detention Officers will maintain custody and control of office keys, key rings, radio (portable radio), and other safety and security equipment**.** Portable radios will be secured in the officer's radio pouch and is never to be left on a table or at a workstation. Portable radios will be secured in the pouch with the snap at all times while the radio is holstered.

11. Detention Officers are not permitted to hang items from their duty belt and/or shirts. Unit and/or cuff keys are to be secured in the officer's pocket along with door access card keys. Ink pens are also to be secured in a pocket. Non-issue items are not authorized to be attached to an officer's duty belt and/or shirt. Refer to Policy 7C-04 Dress and Grooming for specific information regarding officer uniform guidelines.

12. Detention Officers will maintain door security at all times. At no time shall a security door that is interlocked with another door (a vestibule), whether interior or exterior, be allowed to open before the person or party is inside the vestibule and the exterior door is locked. If the person or party is exiting an area, the procedure shall be reversed. The only exception to this procedure is in the event of and emergency situation such as a fire when equipment (fire hose, etc) must pass through an area without interruption.

13. Detention Officers will properly report and document any found or discovered problems or concerns. Equipment problems or failures will immediately reported and the appropriate documentation completed (incident report and maintenance work order).

14. The Classification Officer is responsible for properly reporting all maintenance problems with safety and security equipment and devices, electrical and plumbing fixtures and devices. Problems needing immediate attention (repair) will be immediately reported to the Shift Commander, a Maintenance Work Order generated by the Officer, and turned in to the Shift Commander during that shift.

15. Detention Officers will prevent escapes, disturbances, injuries, deaths, or

problems by identifying and reporting security breaches or unsound security practices that violate ASGDC Policies and Procedures. Immediate steps will be taken to close any avenues of escape.

16. Detention Officers will notify the on duty Shift Commander immediately when an emergency situation occurs; ensure that all areas are secure; adhere to emergency policies; and follow the instructions of the Shift Commander or other on scene authority. When an incident occurs that requires an investigation, detention officers will ensure that the crime scene and evidence is preserved.

17. Detention Officers will follow the orders and instructions of the Shift Commander and/or other supervisory personnel in authority and follow and enforce all established Policies and Procedures, Rules and Regulations, Post Orders, Offender Rules, and Departmental Directives.

18. The Classification Supervisor has the authority and responsibility of the Classification Officers. However, the Shift Commander has overall authority and responsibility of the entire Detention Center of which the Classification Division is a part.

19. The Classification Officer must be familiar with and enforce the offender rules and regulations, and ensure that all imposed offender sanctions are upheld and enforced. The Classification Officer must counsel offenders and/or take disciplinary actions for violations of rules. The Classification Officer prepares, maintains, and passes on the appropriate documentation of violations of rules and any sanctions imposed.

20. The Classification Officer must take immediate corrective actions for offenders who are violating Detention Center rules; violations will not be overlooked. The Classification Officer determines what type of corrective action will be taken, which could be a verbal counseling of the offenders or a written disciplinary action. The Classification Officer is limited in the type and length of sanctions that can be taken against the offender. Other types of sanctions and longer time limits will be determined by the Shift Commander or the Hearing Officer with recommendations from the Classification Officer involved.

21. Classification officers will also assist the security and administration section when needed.

Classification Officer
Activity Discussion

Officer's Workstation

ALVIN S. GLENN DETENTION CENTER
DORMITORY A

POST ORDERS

POST NAME: Housing Unit A (Dormitory A)

SUPERVISED BY: Watch Commander / Assistant Watch Commander

SUPERVISES: Offenders Assigned to Housing Unit A

NUMBER OF OFFICERS: One (1) Officer - Male or Female

SHIFT ASSIGNMENT: Day and Night Shifts – 24 Hours Per Day

DATE: August 1, 2012

POST A DESCRIPTION:

Housing Unit A is a Medium Security Direct Supervision Dormitory style housing unit with the Housing Unit Officer's post inside the housing unit. There is no separation (walls, bars, doors, etc.) between the Housing Unit Officer and the inmates assigned to the unit. Inmates are not assigned separate rooms or cells for sleeping. Instead inmates are assigned to two (2) inmate open bay type cubicle sleeping areas separated by three (3) foot high block walls. Under normal conditions, Unit A houses fifty-six (56) male inmates. However, due to possible overcrowding, additional inmates may be assigned to Unit A. If Unit A exceeds fifty-six (56) inmates, portable beds (bunks) will be used in the unit for the additional inmates. In a dormitory type setting, the Housing Unit Officer does not have inmate lockdown capabilities. Inmates who cause problems and/or are disciplinary problems are sanctioned with the loss of unit privileges or are restricted to their cubicle area for cool down. Inmates that are determined to be a threat and/or danger to the safety and security of Unit A may be transferred to more security housing for cool down and/or further disciplinary action. This transfer to a more secure housing unit is recommended by the Housing Unit Officer, but final determination and authorization is approved by the Watch Commander, Assistant Watch Commander, Classification, or Hearing Officer. It is essential that the Housing Unit Officer utilizes good communication skills (verbal and listening) in the performance of the day to day operations and duties of the unit.

STATEMENT OF RESPONSIBILITIES:

The Housing Unit Officer assigned to Dormitory A staffs this post twenty-four (24) hours per day, seven (7) days per week, working various days and/or night shifts. Unless instructed otherwise by authorized authority, Unit A is designated as a one (1) officer post. The Housing Unit Officer is responsible for the monitoring, supervision, custody, control, accountability, security, and safety of the inmates assigned to the housing unit.

These Post Orders are general in direction and do not attempt to cover every contingency and/or situation that may arise during the performance of the officer's duties. Nothing in any part of these Post Orders shall be construed to relieve the officer of their primary charge concerning the safety and security of the facility or from their constant obligation to render good judgment. Each Housing Unit Officer as well as the Shift's Watch Commander/Assistant Watch Commander must read and be thoroughly familiar with and follow these Post Orders. These Post Orders will remain on the post at the officer's workstation, readily available for review by all assigned officers on a regular basis. Each officer working this post as well as each Watch Commander/Assistant Watch Commander is required to read and then sign the Post Orders.

This directive is for departmental use only and procedures will be strictly adhered to. Violations of this directive may form the basis for departmental administrative sanctions, up to and including termination.

Situations Not Covered

Instructions, procedures and regulations, as set forth in this post order, are not totally encompassing of all situations that may arise. In questionable situations, the Shift Commander should be contacted for instruction and clarification.

Rights Reserved

The Facility Administrator reserves the right to modify, suspend or cancel any provision herein in part or entirety, without advance notice, unless prohibited by law.

Training

The Facility Administrator, Assistant Facility Administrator, Division Managers, Training Coordinator, and Watch Commanders will ensure that and training on the provisions of this directive is provided to facility staff.

DUTIES AND RESPONSIBILITIES of the Housing Unit Officer for Unit A include but are not limited to:

1. Detention Officers will remain courteous and exhibit a professional demeanor at all times with others (offenders, staff and public) while performing their duties, will treat offenders in a fair and consistent manner, and communicate in a tactful and professional manner. Personal relationships and favors between staff and offenders are strictly prohibited. Detention Officers will handle offender's requests, concerns, and complaints in a timely and professional manner. Detention Officers will honestly answer offender questions.

2. Detention Officers will report to and attend roll call meetings at the appropriate time in proper uniform, receive assignment, and note all pertinent information

received from the Shift Commander pertaining to the post and duties. Unless instructed otherwise, at the conclusion of roll call, officers must immediately report to their assigned post.

3. Prior to working the post alone, officers must complete and be signed off on all required training for Unit A.

4. Detention Officers will become familiar with, understand, and follow the Post Orders for Unit A and review them on a regular basis. When in doubt about something or about a situation, the officer assigned will ask questions for clarification. Employees are required to submit to their Shift Commander any operational changes that have occurred, or that they recommend should occur, in the operation of their post.

5. Upon reporting to Unit A for assignment, detention officers will conduct a change of shift briefing with the off-going officer and complete the change of shift process (physical offender head count, equipment check and inventory, safety and security check) prior to the off-going officer's relief, noting any safety or security concerns or violations in the post log and ensure these concerns are addressed and handled properly.

6. Do not leave Unit A without proper relief, permission and/or authorization from the Shift Commander. On taking breaks, return to Unit A as instructed by the Shift Commander, or the relieving officer.

7. Detention Officers will monitor, supervise, and maintain custody, control, safety, and accountability of the offenders assigned. It is essential that the officers assigned to Unit A closely monitor and maintain a high level of observation of the unit's atmosphere and the behavior of the offenders. Use only the amount of force absolutely necessary to control a situation.

8. Detention Officers will monitor, supervise, control, and document the movement of <u>all persons</u> (offenders, staff, visitors, etc.) entering, exiting, or in the housing unit. Detention Officers will ensure that no unauthorized person gains entry into or leaves the housing unit without the proper permission or enters an unauthorized area of the housing unit.

9. Detention Officers will monitor and supervise all unit activities scheduled or taking place in the unit (distribution of meals, medication, laundry, use of televisions, telephones, and showers, recreation, visitation, religious services, security checks, Watch Tours, etc.), while showing or training the detainees in how these activities are conducted.

10. The officer assigned ensures that all established timetables for unit activities are met. During any and all unit activities the officer assigned maintains complete order and control of the offenders, unit, and continues to ensure the proper

EXHIBIT 37

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 4:22-cv-01358-MGL-TER **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. I have been detained at Alvin S. Glenn Detention Center since April 2023. This is the only time I've ever been in jail and I am shocked at what the experience has been. Not that I expected it to be a walk in the park, but at the same time I didn't realize I would be walking through the valley of the shadow of death either, and mean that literally! Before I state my experience and observed violations, I would like to say there are staff members here who care or at least have the decency to take preventative actions.

2. The first dorm I was in was Uniform. It was my first day at ASGDC and I slept it away. The next day I was threatened by a group of guys on the REC yard and was placed in a pod alone until someone came for me. I was taken to medical, after leaving medical I was placed in Juliet dorm, Room 1 I believe it was. I was there for a few days before being threatened again. I informed the dorm officer and shortly thereafter I was taken to Papa dorm. I was there for 2 or 3 days and then I was placed in Golf dorm. I only spent the night in Golf dorm. The next morning I was to taken to speak to Lt. McCullough who asked me about the threats I received. During this meeting he suggested I be placed in protective custody having no criminal background and no

gang affiliations. I did not know why that mattered at the time but I am forever grateful that Lt. McCullogh did not just allow me to be placed in danger. From that meeting I was taken to Papa and the chaos began for me. I was in Papa for 1 month and some days but it felt like an eternity in the pits of hell. Firstly, I wasn't allowed to get my belongings from Golf dorm so I arrived in Papa with nothing. I practically begged Officers Calloway and Sholar to retrieve my things. They did not. That first night I had no mattress, no sheet or blanket! The next day while in medical, I spoke with Sgt. Levant who had taken me from Juliet dorm to Papa a few days earlier and told him I had nothing and he went and got me a roll up and mattress and was performing a shake down when I returned to Papa from medical. As I had also informed him how my night in Papa had gone. That 1st night I awoke to 2 detainees at my door. [redacted] and [redacted]. It looked like they were trying to break in my room, when I went to the door, [redacted] tried to grab me through the flap but I moved back and that's when I saw they both had long, pointed shanks and began threatening and taunting me and claiming there was a price on my head. I hit the button for the officer but there was no officer in the dorm at the time and wasn't for about an hour. Officer finally came back in and I told him it was 2 guys at my door trying and threatening to get in and stab me. He and officer Darley returned with Lt. DuPree and Sgt. Noble, neither of whom did anything about the two guys or the shanks, they simply asked did they get in my room and did they harm me through the open flap. No documentation by the officers at all. The next day Cpt. Sligh brought me protective custody papers and I was moved to Room 3 in Papa where I'd spend the duration of my time there. The room had no light, the sink's water pressure was so low the water barely came out. We were not allowed to (REC) when Pugh worked although he did allow us to call our mother on Mother's Day. Officer Sholar would allow us to (REC) depending on the behavior of the dorm. The 2 showers a week we were supposed to get did not always happen. One morning a detainee was brought in from another pod to the shower in my pod. He urinated and desecrated in the shower and in a fury broke the shower head which in turn caused the shower to flood out into our pod and rooms and officer Pugh made us sit in our rooms with this

water, browned by feces for hours. I literally had to climb onto the sink and nearly fall in the fecal water to retrieve my lunch tray from the door flap. When we were allowed to attend to the matter, so many hours had passed that most of the water had dried leaving our floors stained with brown fecal matter and officers gave us mop water and a mop, no chemical to sanitize the rooms and pod. I asked for a grievance, none was provided!

3. While in Papa, I couldn't get water, juices came with lunch and dinner chow, and milk with breakfast. The food portions were never enough. I was constantly threatened and bullied by my Pod mates because I didn't smoke as they did and they feared I would rat them out. I became dangerously and scarily depressed and asked counselor Lassiter for anti-depressant one day during med pass. That woman didn't even inquire about my mental health, she asked me if I knew what anti-depressant was as if I didn't know what I was asking for. Then she slammed my door fap closed before I could respond. I had almost given up all hope until I met Mrs. Patti Green. She was like an answered prayer. She came to lock up (Papa) and inquired about my mental state and Papa conditions for two weeks. The last time she brought Mr. Saxon and the next week I was moved to Mike dorm. Before meeting Mrs. Patti Green, I did not regularly see or speak with a mental health counselor, in fact the counselor assigned to Papa dorm, Ms. Gilmore did not ever come to meet with me once, not at any time while I was in Papa. So I began at ASGDC in Phase 5 in Uniform dorm. Was moved to Phase 3 in Juliet dorm and Golf dorm, then placed in Papa for a month and a half and finally to Mike dorm. Before coming to Mike dorm I couldn't get any mental health assistance and I was in a dangerous mental state given the circumstances of my being arrested and the dangerous unorganized, disorderly, unhealthy conditions in which I was detained. I was suicidal on more than one occasion but I couldn't tell the staff because I hadn't seen anyone take suicide seriously. In fact, quite the opposite. I'd overheard officers and supervisors alike joking about suicidal detainees, and that hasn't changed even as I write these words. The only thing that prevented me from attempting suicide while in Papa was my inability to get my hands on something sharp or piercing. There were moments

while in Papa when the night officer might break and leave the dorm unsupervised which was terrifying because there was no shortage of weapons and drugs. No limits to the things detainees would do to pass them and too many doors that either didn't secure or easily popped open. The time I spent in Papa I witnessed 3 fires, 6 floods and 3 overdoses and also 2 stabbings!

4. Once coming to Mike dorm, I began receiving mental health treatment and Mrs. Green regularly came to the dorm to speak with anyone until her resignation. She was instrumental in getting me back on track and without her help and sound advice I don't know how I would have made it through the trials of detainment. Since being in Mike dorm, I have been attacked twice once by [redacted], once by [redacted]. In both instances, I opted to press charges but received no follow up on the matters. My health privacy has been violated with no follow-up and resolution. The HIPAA violation occurred shortly after coming to Mike dorm in May. I was not provided a grievance until August 2023 and still yet nothing.

5. I have been threatened on several occasions by [redacted], usually because he felt/thought I was reporting his drug usage or having weapons, etc. 3 times he threatened me in front of the Sergeant of Mike dorm with no repercussion. I was also assaulted by [redacted] on body cam while passing out chow on evening in Nov. 2023, he threw water on both myself and officer. He on the occasion yelled my health information to other detainees amongst other obscenities. The week prior [redacted] along with [redacted] conspired and stole my journal out of my room with the help of detainee [redacted]. Nothing was done about this by either Officer Bonaparte or Sgt. Owens, both aware of the situation and who were responsible. I requested a grievance for this matter and one was never provided. Lastly in Feb 2024 officer Walker showed and discussed my charges to and with detainee [redacted] who informed me of the situation. A grievance was filed via the Kiosk machine. However, Officer Walker left ASGDC shortly thereafter. I don't discuss my charges with anyone at ASGDC. Therefore, they should not be discussed and especially not between staff and inmates. This leads me to my conclusion. ASGDC is a very dangerous place. I have observed many things, I am aware of many things but

I can only address that which has happened to me and even this is dangerous because someone cannot like what I have shared and make their own arrangements. Thank you and your colleagues for hearing the stories of the detainees. We could not make this stuff up with even our wildest imaginations. I do not aim to bring anyone any ill will with this testimony, I simply seek the correction of errors made.

6. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration. I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

23 APRIL 2024
Date

[redacted]

16 MAR 2024

DEAR STUART,

I HAVE BEEN DETAINED AT ALVIN S. GLENN DETENTION CENTER SINCE APRIL 2023. THIS IS THE ONLY TIME I'VE EVER BEEN IN JAIL AND I AM SHOCKED AT WHAT THE EXPERIENCE HAS BEEN. NOT THAT I EXPECTED IT TO BE A WALK IN THE PARK, BUT AT THE SAME TIME I DIDNT REALIZE I'D BE WALKING THROUGH THE VALLEY OF THE SHADOW OF DEATH EITHER, AND I IMPLY THAT LITERALLY! BEFORE I STATE MY EXPERIENCED AND OBSERVED VIOLATIONS I WOULD LIKE TO SAY THERE ARE STAFF MEMBERS HERE WHO CARE OR AT LEAST HAVE THE DECENCY TO TAKE PREVENTATIVE ACTIONS.

THE FIRST DORM I WAS IN WAS UNIFORM. IT WAS MY FIRST DAY AT ASGLC AND I SLEPT IT AWAY. THE NEXT DAY I WAS THREATENED BY A GROUP OF GUYS ON THE REC YARD AND WAS PLACED IN A POD ALONE UNTIL SOMEONE CAME FOR ME. I WAS TAKEN TO MEDICAL, AFTER LEAVING MEDICAL I WAS PLACED IN JULIET DORM, ROOM 1 I BELIEVE IT WAS. I WAS THERE FOR A FEW DAYS BEFORE BEING THREATENED AGAIN, I INFORMED THE DORM OFFICER AND SHORTLY THEREAFTER I WAS TAKEN TO PAPA DORM. I WAS THERE FOR 2 OR 3 DAYS AND THEN I WAS PLACED IN GOLF DORM. I ONLY SPENT 1 NIGHT IN GOLF DORM. THE NEXT MORNING I WAS TAKEN TO SPEAK TO LT. MCCULLOGH WHO ASKED ME ABOUT THE THREATS I'D RECEIVED. DURING THIS MEETING HE SUGGESTED I BE PLACED IN PROTECTIVE CUSTODY HAVING NO CRIMINAL BACKGROUND AND NO GANG AFFILIATIONS. I DID NOT KNOW WHY THAT MATTERED AT THE TIME BUT I AM FOREVER GRATEFUL

THAT LT. MCCULLOGH DID NOT JUST ALLOW ME TO BE PLACED IN DANGER. FROM THAT MEETING I WAS TAKEN TO PAPA AND THE CHAOS BEGAN FOR ME. I WAS IN PAPA FOR 1 MONTH AND SOME DAYS BUT IT FELT LIKE AN ETERNITY IN THE PITS OF HELL. FIRSTLY I WASNT ALLOWED TO GET MY BELONGINGS FROM GOLF DORM SO I ARRIVED IN PAPA WITH NOTHING. I PRATICALLY BEGGED OFFICERS CALLOWAY AND SHOLAR TO RETRIEVE MY THINGS. THEY DID NOT. THAT FIRST NIGHT I HAD NO MATTRESS, NO SHEET OR BLANKET! THE NEXT DAY WHILE IN MEDICAL I SPOKE WITH SGT. LEVANT WHO HAD TAKEN ME FROM JULIET DORM TO PAPA A FEW DAYS EARLIER AND TOLD HIM I HAD NOTHING AND HE WENT AND GOT ME A ROLL UP AND MATTRESS AND WAS PERFORMING A SHAKE DOWN WHEN I RETURNED TO PAPA FROM MEDICAL AS I HAD ALSO INFORMED HIM HOW MY NIGHT IN PAPA HAD GONE. THAT 1ST NIGHT A AWOKE TO 2 DETAINEES AT MY DOOR, [redacted] AND [redacted]. IT LOOKED LIKE THEY WERE TRYING TO BREAK IN MY ROOM, WHEN I WENT TO THE DOOR, [redacted] TRIED TO GRAB ME THROUGH THE FLAP BUT I MOVED BACK AND THATS WHEN I SAW THEY BOTH HAD LONG, POINTED SHANKS AND BEGAN THREATENING AND TAUNTING ME AND CLAIMING THERE WAS A PRICE ON MY HEAD. I HIT THE BUTTON FOR THE OFFICER BUT THERE WAS NO OFFICER IN THE DORM AT THE TIME AND WASNT FOR ABOUT AN HOUR. OFFICER A FINALLY CAME BACK IN AND I TOLD HIM IT WAS 2 GUYS AT MY DOOR TRYING AND THREATENING TO GET IN AND STAB ME. HE AND OFFICER DARLEY RETURNED WITH LT. DUPREE AND SGT. NOBLE, NEITHER OF WHOM DID ANYTHING ABOUT THE 2 GUYS OR THE SHANKS, THEY SIMPLY

ASKED DID THEY GET IN MY ROOM AND IF THEY HARMED ME THRU THE OPEN FLAP. NO DOCUMENTATION AT ALL. THE NEXT DAY CPT. SUGH BROUGHT ME PROTECTIVE CUSTODY PAPERS AND I WAS MOVED TO ROOM 3 IN PAPA WHERE I'D SPEND THE DURATION OF MY TIME THERE. THE ROOM HAD NO LIGHT, THE SINK'S WATER PRESSURE WAS SO LOW THE WATER BARELY CAME OUT. WE WERE NOT ALLOWED TO WRECK (REC) WHEN PUGH WORKED ALTHOUGH HE DID ALLOW US TO CALL OUR MOTHER'S ON MOTHER'S DAY. OFFICER SHOLAR WOULD ALLOW US TO WRECK (REC) DEPENDING ON THE BEHAVIOR OF THE DORM. THE 3 SHOWERS A WEEK WE WERE SUPPOSED TO GET DID NOT ALWAYS HAPPEN. ONE MORNING A DETAINEE WAS BROUGHT IN FROM ANOTHER POD TO THE SHOWER IN MY POD. HE URINATED AND DESECRATED IN THE SHOWER AND IN A FURY BROKE THE SHOWER HEAD WHICH IN TURN CAUSED THE SHOWER TO FLOOD OUT INTO OUR POD AND ROOMS AND OFFICER PUGH MADE US SIT IN OUR ROOMS WITH THIS WATER, BROWNED BY FECES FOR HOURS. I LITERALLY HAD TO CLIMB ONTO THE SINK AND NEARLY FALL IN THE FECAL WATER TO RETRIEVE MY LUNCH TRAY FROM THE DOOR FLAP. WHEN WE WERE ALLOWED TO ATTEND TO THE MATTER, SO MANY HOURS HAD PASSED THAT MOST OF THE WATER HAD DRIED LEAVING OUR FLOORS STAINED WITH BROWN FECAL MATTER AND OFFICER PUGH HAD THE AUDACITY TO GIVE US JUST MOP WATER AND A MOP, NO CHEMICAL TO SANITIZE THE ROOMS AND POD. I ASKED FOR A GRIEVANCE, NONE WAS PROVIDED!

WHILE IN PAPA I COULDNT GET WATER. JUICES CAME WITH LUNCH AND DINNER CHOW, AND MILK WITH BREAKFAST. THE FOOD PORTIONS WERE

NEVER ENOUGH. I WAS CONSTANTLY THREATENED AND BULLIED BY MY POD MATES BECAUSE I DIDNT SMOKE AS THEY DID AND THEY FEARED I WOULD RAT THEM OUT. I BECAME DANGEROUSLY AND SCARILY DEPRESSED AND ASKED COUNSELOR LASSITER FOR AN ANTI DEPRESSANT ONE DAY DURING MED PASS. THAT WOMAN DIDNT EVEN INQUIRE ABOUT MY MENTAL HEALTH, SHE ASKED ME IF I KNEW WHAT AN ANTI DEPRESSANT WAS, AS IF I DIDNT KNOW WHAT I WAS ASKING FOR AND SLAMMED MY DOOR FLAP CLOSED BEFORE I COULD RESPOND. I HAD ALMOST GIVEN UP ALL HOPE UNTIL I MET MRS. PATTI GREEN. SHE WAS LIKE AN ANSWERED PRAYER. SHE CAME TO LOCK UP (PAPA) AND INQUIRED ABOUT MY MENTAL STATE AND PAPA CONDITIONS FOR TWO WEEKS, THE LAST TIME SHE BROUGHT MRS. SAXON AND THE NEXT WEEK I WAS MOVED TO MIKE DORM. BEFORE MEETING MRS. PATTI GREEN I DID NOT REGULARLY SEE OR SPEAK WITH A MENTAL HEALTH COUNSELOR, IN FACT THE COUNSELOR ASSIGNED TO PAPA DORM, MS. GILMORE DID NOT EVER COME TO MEET WITH ME ONCE, NOT AT ANY TIME WHILE I WAS IN PAPA.

SO I BEGAN AT ASGDC IN PHASE 5 IN UNIFORM DORM. WAS MOVED TO PHASE 3 IN JULIET DORM AND GOLF DORM, THEN PLACED IN PAPA FOR A MONTH AND A HALF AND FINALLY TO MIKE DORM. BEFORE COMING TO MIKE DORM I COULDNT GET ANY MENTAL HEALTH ASSISTANCE AND I WAS IN A DANGEROUS MENTAL STATE GIVEN THE CIRCUMSTANCES OF MY BEING ARRESTED AND THE DANGEROUS, UNORGANIZED, DISORDERLY, UNHEALTHY CONDITIONS IN WHICH I WAS DETAINED. I WAS SUICIDAL ON MORE THAN ONE OCCASION BUT I COULDNT TELL THE STAFF BECAUSE I HADNT SEEN ANYONE TAKE SUICIDE SERIOUSLY, IN FACT, QUITE THE OPPOSITE, I'D OVERHEARD

OFFICERS AND SUPERVISORS ALIKE JOKING ABOUT SUICIDAL DETAINEES, AND . . . THAT HASNT CHANGED EVEN AS I WRITE THESE WORDS. THE ONLY THING THAT PREVENTED ME FROM ATTEMPTING SUICIDE WHILE IN PAPA WAS MY INABILITY TO GET MY HANDS ON SOMETHING SHARP OR PIERCING. WHILE IN ALL DORMS PRIOR TO COMING TO MIKE THERE WAS USUALLY AN OFFICER PRESENT. HOWEVER THERE WERE MOMENTS WHILE IN PAPA WHEN THE NIGHT OFFICER MIGHT BREAK AND LEAVE THE DORM UNSUPERVISED WHICH WAS TERRIFYING BECAUSE THERE WAS NO SHORTAGE OF WEAPONS AND DRUGS, NO LIMITS TO THE THINGS DETAINEES WOULD DO TO PASS THEM AND TOO MANY DOORS THAT EITHER DIDNT SECURE OR EASILY POPPED OPEN. THE TIME I SPENT IN PAPA I WITNESSED 3 FIRES, 6 FLOODS AND 3 OVERDOSES AND ALSO 2 STABBINGS!

ONCE CONING TO NIKE DORM I BEGAN RECEIVING MENTAL HEALTH TREATMENT AND MRS. GREEN REGULARLY CAME TO THE DORM TO SPEAK WITH ANYONE UNTIL HER DEPARTURE. SHE WAS INSTRUMENTAL IN GETTING ME BACK ON TRACK AND WITHOUT HER HELP AND SOUND ADVICE I DONT KNOW HOW I WOULD HAVE MADE IT THROUGH THE TRIALS OF DETAINMENT. SINCE BEING IN NIKE DORM I HAVE BEEN ATTACKED TWICE ONCE BY [redacted], ONCE BY [redacted], IN BOTH INSTANCES I OPTED TO PRESS CHARGES BUT RECEIVED NO FOLLOW UP ON THE MATTERS. MY HEALTH PRIVACY HAS BEEN VIOLATED WITH NO FOLLOW UP AND RESOLUTION. THE HIPAA VIOLATION OCCURED SHORTLY AFTER COMING TO MIKE DORM IN MAY, I WAS NOT PROVIDED A GRIEVANCE UNTIL AUGUST 2023 AND STILL YET NOTHING.

I HAVE BEEN THREATENED ON SEVERAL OCCASIONS BY [redacted], USUALLY BECAUSE HE FELT/THOUGHT I WAS REPORTING HIS DRUG USAGE OR HAVING WEAPONS ECT. 3 TIMES HE THREATENED ME IN FRONT OF THE SERGEANT OF MIKE DORM WITH NO REPRICUSSION. I WAS ALSO ASSAULTED BY [redacted] ON BODY CAM WHILE PASSING OUT CHOW ONE EVENING IN NOV. 2023, HE THREW WATER ON BOTH MYSELF AND THE OFFICER. HE ON THE OCCASION YELLED MY HEALTH INFORMATION TO OTHER DETAINEES AMONGST OTHER OBSCENITIES. THE WEEK PRIOR [redacted] ALONG WITH [redacted] CONSPIRED AND STOLE MY JOURNAL OUT OF MY ROOM WITH THE HELP OF DETAINEE [redacted]. NOTHING WAS DONE ABOUT THIS BY EITHER OFFICER BONAPARTE OR SGT. OWENS, BOTH AWARE OF THE SITUATION AND WHO WERE RESPONSIBLE. I REQUESTED A GRIEVANCE FOR THIS MATTER AND ONE WAS NEVER PROVIDED. LASTLY IN FEB 2024 OFFICER WALKER SHOWED AND DISCUSSED MY CHARGES TO AND WITH DETAINEE [redacted] WHO INFORMED ME OF THE SITUATION. A GRIEVANCE WAS FILED VIA THE KIOSK MACHINE, HOWEVER OFFICER WALKER LEFT ASGDC SHORTLY THEREAFTER. I DONT DISCUSS MY CHARGES WITH ANYONE AT ASGDC, THEREFORE THEY SHOULDNT BE DISCUSSED AND ESPECIALLY NOT BETWEEN STAFF AND INMATES. THIS LEADS ME TO MY CONCLUSION. ASGDC IS A VERY DANGEROUS PLACE. I HAVE OBSERVED MANY THINGS, I AM AWARE OF MANY THINGS BUT IN THIS LETTER STUART, I CAN ONLY ADDRESS THAT WHICH HAS HAPPENED TO ME AND EVEN THIS IS DANGEROUS BECAUSE SOMEONE CAN NOT LIKE WHAT IVE SHARED AND MAKE MAKE THEIR OWN ARRANGEMENTS. I HOPE WHAT I'VE SHARED

IS OF USE TO YOU. THANK YOU AND YOUR COLLEAGUES FOR HEARING THE STORIES OF THE DETAINEE. WE COULDNT MAKE THIS STUFF UP WITH EVEN OUR WILDEST IMAGINATIONS. I DO NOT AIM TO BRING ANYONE ANY ILL WILL WITH THIS TESTIMONY, I SIMPLY SEEK THE CORRECTION OF ERRORS MADE AND VINDICATION. I DIGRESS.

Much Obliged,

[redacted]

EXHIBIT 38

Asgdc

&

HRSD

2020 Project plan

Published 2009

Revised march 2019

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

The number and length of Detention Officer (DOs) position vacancies and turnover rates among DOs over the years has reached the point of a dangerous importunate situation which demands prompt significant action to mitigate. In addition, long term success will necessitate strategic, persistent, and consistent investment of the appropriate resources. The Director of the ASGDC and Director of Human Resource Services Department have determined immediate change will require financial incentives to applicants and a thoughtful schedule for pay increase opportunities for current DOs aimed at increasing retention. The County also needs to implement a Total Rewards strategy to stabilize vacancies at a satisfactory level. Upon implementation of a Total Rewards strategy - the initial level of financial incentives should not be necessary and may not be prudent to continue at the rates once overtime has been reduced.

There are currently approximately 100 vacancies, the DO turnover rate was 36% for 2018, and the DO vacancy rate in 2018 was 34%. Additionally, approximately 211 positions were filled in 2016, 2017, and 2018. These levels of vacancies and turnover represent a tremendous demand on existing DOs, an extremely serious potential safety risk, less than effective and efficient operations, and a huge expenditure in overtime wages.

DO vacancies create a dire threat to the safety and cost-effectiveness of the ASGDC. One way in which they do this is by creating a need for excessive overtime. The ASGDC needs to be adequately staffed at all times for the safety and security of employees and the public. One consequence of the sustained high number of vacancies is that the County has decided to assign mandatory overtime to fill in the necessary staffing for vacant positions. The overtime, although necessary in these importunate circumstances, can have ill effects on employee health and job performance. Working excessive hours is correlated with cardiovascular issues, unhealthy weight gain, burnout, and a higher number of on-the-job accidents. In detention and correctional environments, fatigue and accidents can have especially dangerous consequences.

Recruiting and retaining detention and correctional officers is challenging for all employers. An occupation in a detention facility is often not viewed as most desirable, due to negative perception of low pay, long work hours, and/or unsafe working conditions. When the unemployment rate is at historical lows, these perceptions make it even more challenging to recruit and retain detention officer candidates. There are many factors that lead to high DO turnover. The “chronic and serious” job stress DOs can constantly experience often leads to what is known as “burnout.” Excessive overtime exacerbates the development of burnout among employees and further increases turnover in a profession that is already marked by intense stressors. The detention center can be a challenging and dangerous environment. In addition, there are not many opportunities to develop professionally and resources available to help officers deal with high stress/mental health issues are often not utilized.

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In a survey of correctional administrators and human resources managers in forty-four correctional systems, conducted by the American Correctional Association and funded by the Bureau of Justice Assistance, respondents noted that inadequate pay and benefits, burdensome work hours and shift work, a shortage of qualified applicants, and undesirable location of correctional facilities are factors that render recruitment difficult. Richland County is competing against the private sector, as well as other public safety jobs such as SLED, city police officers, county deputy officers, and the federal government, who offer what appears to be more attractive jobs, with higher starting pay rates, and/or sign on incentives or bonuses. Therefore, RCG must offer significant sign-on incentives, referral fees, and encourage strategic pay increase opportunities for current DOs.

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

☐ **Define Issue**

- Alvin S. Glenn Detention Center has more than 100 vacant positions
- Employee Turnover is high
- There are not enough new hires to fill open positions
- Department is relying on overtime to fill open slots
- Department has decreased training time
- These issues could lead to increased safety risks at the department

☐ **Project Goals and Objectives**

1. Identify reason for voluntary terminations
2. Reduce the number of vacancies
3. Increase the number of qualified applicants
4. Decrease the number of voluntary terminations (i.e. resignations)

☐ **Success Criteria**

1. Accurately articulated reason(s) for voluntary terminations
2. Comparison of current to future vacancies
3. Compare number of current to future new hires
4. Compare number of current to future voluntary terminations
5. Compare current to future number of applications

☐ **Project Scope**

- To develop and implement recruiting and retention action items

☐ **Project Assumptions/Constraints**

- Financial Resources – assumption is that money will be available to fund approved recommendations
- Human Resources – will have limited time to work on study due to other obligations and Total Rewards Study; however, dedicated HRSD resources are a necessity
- Perception of current ASGDC personnel

☐ **Project Roles/Responsibilities**

- Human Resources
  - ☐ Develop program recommendations
  - ☐ Support implementation
  - ☐ Conduct data analysis
  - ☐ Oversee program goals and metrics
- ASGDC
  - ☐ Partner in program development
  - ☐ Implement program ideas

- ☐ Manage program logistics
- Administration
  - ☐ Approve/Deny recommendations
  - ☐ Support program goals and objectives
  - ☐ Ensure funding for program

☐ **Project Funding**

- Utilize overtime savings to help fund plan
- Fund programs with current salaries from open positions

Current ASGDC R and R Activities

- ASGDC Pay Plan
- ASGDC Referral Plan
- Continuous Outside Advertising (Indeed)

Data Analysis that needs to be completed

- Drill down on turnover data to identify reason for turnover
- Locate successful detention/correctional retention programs and models
- Analyze current employee data
- Partner with local colleges and universities to develop comprehensive plan
- Identify recruiting obstacles
- Determine where detention officer's go
- Determine when detention officer's leave
- Recover training cost from other agencies
- Take pulse of current employees
- Review exit interviews

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

Immediate Action Items:

Recommendation #1: Implement Total Rewards Strategy with Employer of Choice Objective

Recommendation #2: New Hire Sign On Incentive Bonus in the amount of $7500

The magnitude of current vacancies (approximately 100), the historical low unemployment rates, and high turnover necessitates the County get the attention of potential new hires. Significant bonuses will help to get the attention of potential applicants. However, it will not add to the base pay rate of the new hires. The Director of the ASGDC and the Director of HRSD propose the $7,500 bonuses will be strategically staggered over a period of three years. Below is an example of a payment schedule. Logistics and final details will be worked out with the ASGDC Director.

- The $7,500 incentive can be modified, reduced, or even eliminated at any point the County deems appropriate.

- $7,500 Sign-On and Retention Bonus
  - Payable over a period of 3 years
    - First payment after NEO
    - Second payment upon completion of CJA
    - Third payment at one year
    - Fourth payment at two years
    - Fifth payment at three years
    - If voluntarily resign within *two* years, must repay sign-on bonus

Recommendation #3: Increased Salaries and Add Detention Officer II plus Dentition Officer III

By establishing two additional levels of DOs and increasing the hiring rate, we will help reduce turnover and increase retention. The third solution is a monetary investment from the County to raise the overall salary of DOs in order to improve recruitment and retention for the department. Our recommendation is to utilize part of the funding that is currently spent on overtime and instead use that money to hire and retain more employees. Increasing salaries will improve recruitment difficulties. Additionally, by not paying as much in overtime, the County will save money. The recommendation is to reinvest into covering proposed salary increases.

- HRSD structured the proposed pay plan in the Total Rewards Study in a manner that can be integrated without making any other significant changes

to the proposed structure. Below is an example, the final logistics and details will be worked out with the ASGDC Director.

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

- Detention Officer II and DO III
  - DO I – Grade 6
  - DO II – After 2 years and Fully Proficient PEP - Grade 7 or 10% (whichever is higher) (no disciplinary probation for one year)
  - DO III – After 5 years and Fully Proficient PEP - Grade 8 or 10% (whichever is higher) (no disciplinary probation for one year)
  - Assistant Watch Commander – Grade 9

Grade	Minimum
8	$39.0
7	$35.4
6	$32.2

Recommendation #4: Referral and Retention Fee of $2,500: Eligible to All Employees

We need all hands on deck - not just ASGDC personnel to help us find DOs. Therefore, we propose increasing the Referral Fee to $2,500 and making all employees eligible with limited exclusions. The Referral Fee can be modified, reduced, changed, and/or eliminated at any time. Below is an example of a payment schedule. Logistics and final details will be worked out with the ASGDC Director.

- $2,500 Employee Referral and Retention Fee
  - Use current rules and modify to include:
  - Payable over a period of 3 years
    - First payment after NEO
    - Second payment upon completion of CJA
    - Third payment at one year
    - Fourth payment at two years
    - Fifth payment at three years
    - If voluntarily resign within *two* years, must repay sign-on bonus

Recommendation #5: Recruiter in HRSD

Use funding from open position to hire professional trained recruiter.

Recommendation # 6: Mentorship

Research demonstrates one of the most prominent stressors in a detention environment are weak or inconsistent management and supervision practices. In order to better integrate the relationship between supervisors and line staff, leadership should become more involved with providing training to the DOs on a consistent basis (i.e. monthly) in the areas of civility, inclusion procedural justice, active listening, emotional intelligence, conflict resolution and mediation, stress

management, and effective communication. Through closer interactions, upper level management would help improve morale and build a greater rapport between detention officers and supervisors. In doing so, they would strengthen the organizational commitment of their supervisees and increase retention rates.

Recommendation #7: Public Imaging Campaign
RCG recognizes working at the ASGDC is currently not a very glamorous or desirable occupation. Therefore, after implementing recommendations from the Total Rewards Study, we propose a public imaging campaign to address this negative perception. This recommendation will provide insight into the meaningful work DOs perform and accomplish. Unfortunately, this valuable work often goes unnoticed by potential applicants, the public, and by the media. It has come to our attention that careers in the police force and other public service areas are currently more desirable than DO career opportunities. This is due in part to misinformation and a missed opportunity for the ASGDC to capitalize on employment and career opportunities.

Recommendation # 7: Comprehensive List of Recommendations from HRSD
HRSD has invested a tremendous amount of time over the past ten years researching, studying, working with the ASGDC, and publishing a 20 page proposal in 2009. HRSD has updated the recommendations from 2009 and will work with the ASGDC to refine and finalize our updated recommendations in April 2019.

ASGDC and HRSD determined it was most important for recommendations to be effective in promptly reducing the number of vacancies and present common sense practical solutions that will address both short and long-term needs for both the department as well as the current and future employees of the department. Therefore, we are proposing to implement recommendations # 2, # 3, and # 4 immediately upon finalizing the details and funding. Then implement the remaining recommendations as a package. Each of these solutions builds on the other and is part of an overall strategy to save the County money and repurpose funds into long-lasting solutions. These recommendations are also intended to alleviate the current level of overtime wages without costing the County additional long term funding. The current expenditures in overtime can instead be redirected into the recommendations. Increased salaries along with better public imaging and advertisement will increase DO recruitment and retention, and over time, the County should not have to invest additional money by no longer having to pay expensive overtime wages at the same levels as we do today. More importantly, the County strategically mitigates the potential of dangerous incidents occurring which could be even more expensive as well as potentially harmful to employees and/or detainees.

The importunate situation initially necessitates significant financial incentives to jump start meaningful reduction of the approximately 100 vacancies. Money alone is neither the solution nor sustainable permanently. Therefore, we must implement a Total Rewards strategy to sustain success. Addressing workforce shortages at

the ASGDC is critical to ensuring safety for SOs, the citizens of Richland County and detainee populations. Improving recruitment and retention will greatly benefit the DO morale and ensure a productive and positive work environment for these public servants. Richland County is the Capital County is South Carolina and our detention center must be staffed.

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

Programs Used to Attract & Retain Employees

Future Potential Action Items:

- Market adjustments/increase to base salary
- Spot bonus (individual)
- Part-time employment with benefits
- Exempt overtime pay or time off
- Utilize FTE for Employee Advocate
- Utilize FTE for HR Employee Relations
- Ask Employees for Recruiting & Retention Ideas
  - Recognize and Give Prize for Most Effective Idea(s)
- Develop near site daycare center
- Job Fairs focused on detention jobs
- Assessment centers for new hire and promotions
- Testing/Assessment of Applicants - IPMA
  - Evaluate current testing tools to determine validity
  - Examine other tools if necessary
  - Establish process for conducting periodic reviews of the job analysis and the test
- Promoting job as a profession
- Update ASGDC website
- "2nd Chance" program- hiring former detainees
- "Direct Recruiting" – Using the recruiting brochure, let's target some employees based on our need and the job.
- Recognize years of service milestones
- Partner with Local Colleges and Universities for Recruiting
- Review Recruiting Sources
  - Recruit in High Unemployment Counties
  - Churches / Schools
  - Organizations
  - Military Centers
  - Temporary Help Agencies
  - Other newspapers / radio ads/ TV Channel
- Recruit Correctional Officers from State Retirement
- Recruit from retired northern police officers
- Recruit from Puerto Rico
- Award for Employees with Highest Level PEP Annually
- Develop Employee Recognition Program:
  - Provide Movie/Show Tickets

  - Award Coupon to Nice Restaurant
  - Free Magazine Subscription
  - Award Day Off with Pay
  - Electronic Merchandise
- Plan Group Activities
- Establish a Wall of Fame
- Establish Competitions Between Shifts/Supervisors (i.e. Attendance, Punctuality) and Award Trophy and/or Prize
- Sponsor Fun Events and/or Sports Team (i.e. softball, bowling, volleyball, etc.)
- Have Employees Vote for Best Supervisor
- Personalize Birthday Recognition
- Retention training for Supervisors
- Create Interviewing /Realistic Job Preview Process
- Offer Relocation Incentive
- Consider Using Part Time Personnel
- Use Direct Recruiting
- Market Criminal Justice Profession
- Hold Job Fair
- Consider Pay Differentials
  - Work Unit
  - Holiday
  - Weekend
  - Night Shift
- Conduct Hiring Seminars in Communities
- On the Job Mentoring
- Pay degreed or experienced officers more
- Communication directly from Senior Management – recognition by administration to current employees
- HR Newsline Recognition
- Management training for supervisors
- Diversity training for gender, generational, and racial differences
- Focus on employee complaints, concerns, grievances
- Send gifts to husbands/wives of employees working overtime
- Hiring seminars with realistic job previews
- Examine and address working conditions
  - Apprehension about safety
  - Perceived lack of respect
  - Working overtime
  - Equipment status
- Review hours of overtime to ensure fairness/consistency
  - Methodology for overtime

ASGDC AND HRSD
RECRUITING AND RETENTION PROJECT 2020

- Max number of additional overtime hours per shift/week

- Interview and Selection training
- Ensure enough in-service training
- Buddy System for New Hires
- Evaluate meal service and quality
- Officer of the Quarter – gets recognition and parking space
- Give increase after academy certification
- Focus on programming and training for: civility, inclusion, active listening and emotional intelligence

Approved by:

_____ _____

Edward Gomeau Date
Interim County Administrator

EXHIBIT 39

RICHLAND COUNTY GOVERNMENT
ALVIN S. GLENN DETENTION CENTER
201 John Mark Dial Drive, Columbia, SC 29209
T 803-576-3200 | F 803-576-3292 | TDD 803-576-2045
richlandcountysc.gov

To: Leonardo Brown, MBA, CPM
Richland County Administrator

From: D. Shane Kitchen, CJM
Interim Director
Alvin S. Glenn Detention Center

Date: February 14, 2022

Subject: Request for Immediate Assistance from the National Guard for the Secure and Safe Operation of Alvin S. Glenn Detention Center

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As you are aware, the Alvin S. Glenn Detention Center is experiencing a severe detention officer shortage of astronomical proportions. We are currently operating with approximately 38% of our allocated uniformed staff. To put that in perspective, ASGDC currently has 77 of the most dedicated and hardworking detention staff attempting to fulfill the responsibilities of the 205 positions. However, the extended and extra shifts to keep the facility operating are taking its toll on those that have decided to weather the storm. The evidence of staff burnout is rapidly increasing as the staff show signs of fatigue and errors in judgement. With the increase in call outs and resignations, the cycle spirals and the problem continues to get worse.

In an attempt to assist with the demand on the staff, administrative adjustments were made last year in our supervision methods to seemingly lessen the demand for the number of personnel on shift. We changed our supervision style from direct to indirect supervision. Direct supervision requires a detention officer to supervise one detainee housing unit for a twelve hour shift. Indirect supervision requires less staff due to one detention officer supervises multiple detainee housing units for an entire shift. It should be noted that the facility was not constructed, nor the staff trained in, the concept of indirect supervision. What was not taken into consideration was the effects the increased work load would have on the detention officers by having to work multiple units that are not necessarily in close proximity to each other. These factors also make effective detainee supervision a difficult task and complicate the delivery constitutionally required services (food service, medical care, and access to legal counsel) to the detainee housing units in a timely and efficient manner. Additionally, indirect supervision requires more lock down time for the detainees, causing added tension in the detainee pollution. The added tension and stress results in an increase in reports of non-compliance, violent behaviors, and damage caused to the facility's plumbing, electrical and mechanical systems.

We have also seen an increase in dangerous contraband items in the detainee population. While the implementation of body scanners will aid us in detecting contraband and address the individuals responsible for introducing these items in the population, we still lack adequate staffing levels to effectively secure detainees and search for these contraband items. We have enlisted the assistance

from other counties in completing these searches, however we cannot depend on the availability of those counties for continued support in the future.

Recruiting efforts have increased with the reassignment of our Facility Recruiter, who has been active in the immediate and surrounding communities. We have seen some increase in applicants, although many applicants are disqualified during the pre-employment background check. We are finding great difficulty in recruiting and hiring enough qualified people to make any progress on this issue.

Several attempts have been made to find some relief in response to the staffing crisis. We are currently engaging in negotiating a Memorandum of Understanding with Kershaw County to provide five supplemental detention officers per shift to assist us in our operation. I have contacted the Director of the SC Department of Corrections (SCDOC) for any possible assistance the agency may be able to offer. At most, SCDOC would be able to entertain an MOU that would provide emergency response in the event of a riot and assisting us with facility contraband searches. There is currently no resource available that would provide supplemental staff to respond to our facility in support of our daily operation. Private security firms are another possibility; however, the use of such personnel is hindered in this environment due to the fact that they are not employed as detention staff through Richland County and are limited in custody situations unless accompanied by an ASGDC detention officer. We are also looking into ways we can lower the detainee population to a manageable level where possible. This may require some assistance from the Public Defender and Solicitor's Office. This may also be achieved through contract housing with outside agencies.

Sir, to my knowledge I have exhausted all means available to me to obtain immediate temporary relief for the staff and detainees at the Alvin S. Glenn Detention Center. The simple fact is that we cannot continue to operate the facility in our current state. The staff have been forced to work in unfavorable conditions for far too long and morale has plummeted to an all-time low. They are tired, frustrated, and angry. Most detainees have been understanding of the staffing shortage, but their patience is wearing thin. It has become more and more difficult to manage the simple disturbances encountered in a normal shift. The atmosphere is volatile. I feel the probability of another riot occurring within our facility in the very near future is high and I fear our ability to effectively manage such an event is hindered significantly if we are unable to receive immediate relief. I am asking for your help in requesting temporary assistance from the National Guard in the secure and safe operation of the detention center on behalf of all staff and detainees. My research indicates that the request must come from the Director of Richland County's Emergency Management Division, with the approval of County Council, to the South Carolina Emergency Management Division. I am willing to do whatever is necessary of me to get some help as we are in desperate need.

Thank you for your time and consideration in this matter.

EXHIBIT 40

South Carolina Department of Corrections

HENRY McMASTER, Governor
BRYAN P. STIRLING, Director

March 24, 2022

Mr. Leonardo Brown, County Administrator
Richland County Government
2020 Hampton Street
Post Office Box 192
Columbia, South Carolina 29204

Re: Richland County (Alvin S. Glenn) Detention Center

Dear Mr. Brown:

Thank you for speaking with me a few days ago when I called to express my concerns about the Richland County (Alvin S. Glenn) Detention Center and to inquire whether a plan is in place for remediation of conditions as well as management going forward. I certainly appreciated the fact that you seem interested in becoming more knowledgeable about detention operations as well as the opportunity to draw on the expertise of others who may have appropriate training and experience in this specialized function of local government.

The current low level of security staffing has created what must be labelled as a control and safety emergency. Multiple inmate housing units have been taken out of service for the last few years due to insufficient Detention Officer coverage, leading to overcrowding in some living areas and reducing the options for separating inmates based on classification categories and other special circumstances. Even that temporary strategy is no longer adequate because of the acceleration and worsening of employee vacancy rates. Unfortunately, it would not be an exaggeration to label the situation as desperate and vulnerable to imminent catastrophe.

Compounding the problem, and making matters worse, is the absence of properly sustained and supported management. Prior to your arrival, there was a period of more than a year when the position of Detention Director was vacant, leaving the Assistant Detention Director to fulfill duties of both roles. The former Detention Director then returned and was placed back in the position. He subsequently retired six (6) months ago, and once again the Assistant Detention Director has been called on to handle all responsibilities. Now even that individual will be departing in about a week, causing both positions to be vacant. There has apparently been no hiring of a professional, qualified person to begin work in either slot.

I respectfully call your attention to Section 24-5-20 of the South Carolina Code of Laws: "Except as otherwise provided, every sheriff in this State who has control of a jail shall appoint a qualified person as facility manager. This person shall have the control and custody of the jail

P.O. Box 21787 - 4444 Broad River Road - Columbia, SC 29221-1787 - Telephone (803) 896-8555
http://www.doc.sc.gov E-mail: corrections.info@doc.sc.gov

under the supervision of the sheriff. However, should the sheriff not have control of the jail, then this appointment falls to the chief administrative officer of the county in whose jurisdiction the jail lies." In Richland County, obviously this requirement and the obligation become that of the County Administrator to discharge.

The Minimum Standards for Local Detention Facilities in South Carolina further addresses this matter in Standard 1031(a), which reads as follows: "The Facility Administrator shall designate a Facility Manager qualified by training and experience to supervise staff and inmates." Again, in Richland County, the Facility Administrator is the County Administrator; and the Facility Manager is the Detention Director.

Please let us know as soon as possible who will be the new Detention Director, when that person will begin his/her duties, and the timeline for then having a new Assistant Detention Director selected. In addition, please share the strategy Richland County will use to reduce the dangerously high vacancy rate of security personnel and a projected schedule for accomplishing that goal.

If we may be of assistance for you in discharging your own responsibilities pertaining to the Richland County (Alvin S. Glenn) Detention Center, please do not hesitate to contact me and advise how we might do so. It is definitely our desire to support your efforts going forward.

Sincerely,

Blake E. Taylor, Jr.

Blake E. Taylor, Jr., Division Director
Compliance, Standards, and Inspections

BETJr/rbs

EXHIBIT 41

From: Katherine Stone <KOStone@Wellpath.us>
Sent: Tuesday, April 5, 2022 5:29 PM
To: moye.washava@richlandcountysc.gov; Yolanda Davis
Cc: brown.leonardo@richlandcountysc.gov
Subject: Richland County Safety Notice
Attachments: Richland County Safety Notice.pdf

Please see the attached letter regarding conditions at Alvin S. Glenn Detention Center.

Regards,
Katie Stone

Katie Stone
Associate General Counsel

wellpath

1283 Murfreesboro Rd, Suite 500
Nashville, TN 37217
Office: 615.324.5703
Mobile: 615.319.7076
kostone@wellpath.us
WellpathCare.com

wellpath
To hope and healing.

April 5, 2022

SENT VIA EMAIL AND FIRST-CLASS CERTIFIED MAIL, RETURN RECEIPT REQUESTED

Mail to: Yolanda Davis, Procurement Agent
Richland County Office of Procurement & Contracting
2020 Hampton Street, Suite 3064 (Third Floor)
Columbia, South Carolina 29204

Email to: Interim Director Washava Moye
Moye.washava@richlandcountysc.gov

RE: Notice of Security and Employee Safety Concerns Pertaining to the Inmate Healthcare Services and Medical Services Agreement ('Agreement") between Richland County, SC ("County") and Wellpath LLC ("Wellpath").

Dear Interim Director Moye:

This letter is being sent to notify you of concerns Wellpath has related to conditions at Richland County's Alvin S Glenn Detention Facility, and the safety and security issues that those conditions pose. We are concerned about the welfare and safety of both the Wellpath staff and our patients.

Recently, Wellpath Senior Vice President Stan Wofford visited the facility.[1] He noted that the facility is facing a severe staffing shortage. Additionally, he expressed concerns for the physical condition of the facility, including standing water and trash in SHU, and the unmistakable odor of both cigarettes and marijuana in the facility. Mr. Wofford met with facility leadership during a subsequent visit and expressed his concerns. During that meeting, then Interim Director Shane Kitchen acknowledged Mr. Wofford's concerns and assured him that the issues were being addressed.

Unfortunately, since his visit, conditions have continued to deteriorate at the facility. These conditions not only affect the patients housed in the facility, but they also affect our staff. One Wellpath staff member has suffered multiple asthma attacks from the smoke in the facility. Other staff members have been assaulted by patients, due we believe, at least in part, to the officer shortage. Staff members have had objects and unknown liquids thrown at them, and they have been physically attacked and groped. And this week, just hours before an inmate was stabbed in a housing unit, one of our nurses had her life threatened by inmates in the same unit while conducting a med pass.

Recently, our staff have reported that, at times, officers do not keep their radios on them when they go into the dorms. Additionally, phones and computers are turned off in the dorms unless an officer is

[1] Mr. Wofford's visit was triggered by reports of deteriorating conditions in the facility from site-level Wellpath staff. Specifically, they reported increasing RCSO staffing shortages affecting Wellpath's ability to see patients in a timely manner and creating increased fears for safety among Wellpath staff. These RCSO staffing shortages have been increasing for a number of months.

Wellpath[SM]
1283 Murfreesboro Road, Suite 500
Nashville, TN 37217
www.wellpathcare.com

sitting in the dorm. Due to the officer shortage, it is necessary for officers to watch multiple dorms at once, causing phones and computers to remain off. This poses a safety risk as this leaves no way to call for help in the event of an emergency. This is of even greater concern after the events of this week, in which large amounts of contraband were discovered during a search, including large quantities of drugs, several cell phones, and several weapons. And unfortunately, it appears that in spite of several weapons being confiscated, not all were found, as an inmate was stabbed multiple times just one day after the search was conducted.

We are concerned that these safety and security issues could lead to more frequent and more severe injuries in the future. We are also concerned that, if this continues, we will have a harder time filling vacancies as medical staff are unwilling to put themselves in situations that compromise their safety and security.

The custody staffing shortage is also hampering our ability to see and treat patients. Last week alone, numerous appointments were cancelled due to the unavailability of security staff, and that trend has continued into this week. Some of the most recent issues of concern are discussed below.

- On Tuesday, March 29, 2022, we had medical clinic and dental clinic scheduled. However, the transport officers were absent, so none of the scheduled dental patients or scheduled medical clinic patients were brought to the clinics to be seen. We were able to see two patients via "house call" who had urgent needs, but these other cancellations cause severe backups in patient care as well as unnecessary costs due to having providers on site.

- On Wednesday, March 30, 2022, we had medical and psychiatric clinics scheduled. Two of the three transport officers were on a patient transport that lasted the entire day, and the third officer was off. After contacting the liaison and director, one officer was sent to assist with psychiatric clinic visits. However, manpower was still significantly lacking, and only a limited number of medical clinic patients were able to be seen via "house call" again.

- Additionally, as briefly touched on above, on March 30th, as Nurse Mullens was conducting the 9am med pass, detainees would not return to their cells, refused to listen to the officer inside the unit, and began yelling racial slurs and threats at Ms. Mullen. She left the dorm, and then returned to compete the med pass with an officer who was able to control the unit. Later that day, an inmate was stabbed in the same unit. This incident highlights the danger our staff is in. And this happened only one day after a search of that unit in which several weapons were found and confiscated.

- On Thursday, March 31, 2022, we had medical, dental, and psychiatric clinics scheduled. Again, there was a shortage of transport officers, and once again, none of the dental patients were seen, even though the dentist was on duty all day. Further, a competency to stand trial evaluation was cancelled because no officers were available to transport the inmate to the clinic.

- On Monday, April 4, 2022, a "code blue" was called at India dorm. When the nurses arrived, there was an undeniable haze of marijuana smoke emanating from inside the dorm, with the smoke being thick enough to make then cough.

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- On Tuesday, April 5, 2022, only one transport officer was on duty and was occupied off-site with a dialysis patient for the day. This prevented our dentist and his assistant from seeing patients for the third time in a row, resulting in a total of close to 30 patients not receiving dental care. Further, medical patients were not able to be seen in the clinic again, and Dr. Schafer could only see patients via "house call." In spite of calling first to ensure that an officer would be available in the dorm, he had to wait up to 20 minutes for an officer to show up. These same issues are occurring with wound care and H&Ps.

These safety and security issues are extreme and must be addressed immediately. We request material progress on these safety and security issues and a meeting to update us on how these concerns are being addressed no later than April 13, 2022.

If you have any questions or concern, please do not hesitate to contact me.

Best,

DocuSigned by:
Cindy Watson
8BA0FD966BB14B4...

Cindy Watson
President, Local Government Healthcare Division

Cc: Leonardo Brown, County Administrator

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Nashville, TN 37217

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wellpath℠
To hope and healing.

April 26, 2022

Yolanda Davis, Procurement Agent
Richland County Office of Procurement & Contracting
2020 Hampton Street, Suite 3064 (Third Floor)
Columbia, South Carolina 29204

Re: Inmate Health Care and Medical Services Contract

Greetings Ms. Davis,

Wellpath is in receipt of your letter of April 21, 2022, requesting an extension of the Inmate Health Care and Medical Services Contract to September 12, 2022. As you know, in our letters dated April 5th and 15th (attached hereto for ease of reference), we requested the County's urgent attention to specified deficiencies, as well as a meeting to discuss, but we have not yet been provided with a response to same. As such, we are unable to agree to an extension of the existing agreement (which expires on June 12, 2022).

We strongly urge and request a meeting with the county council (or those councilmembers who have authority to discuss the deficiencies documented at the Alvin S. Glenn Detention Center) no later than Friday, May 6, 2022, so that we may discuss the County's intentions and progress concerning conditions at the Detention Center. Absent a productive meeting by this date, we will be unable to provide a contract extension.

If you have any questions, or wish to discuss the matter directly with me, please do not hesitate to contact me at 678-481-1037 or ciwatson@wellpath.us. We look forward to your response to our concerns.

Sincerely,

DocuSigned by:
Cindy Watson
8BA0FD966BB14B4...

Cindy Watson, President
Local Government Division-East

Cc: Katie Stone, Wellpath Associate General Counsel
Linda Ross, Wellpath Regional Director of Operations
Stan Wofford, Wellpath Senior Vice President, Local Government Healthcare
Patrick Wright, Richland County Attorney
Leonardo Brown, Richland County Administrator
Overture Walker, Richland County Council Chair
Jesica Mackey, Richland County Council Vice Chair
Washava Moye, Alvin S. Glenn Detention Center Interim Director
Jennifer Wladischkin, Procurement Manager

Enclosures

wellpath
To hope and healing.

April 15, 2022

Yolanda Davis, Procurement Agent
Richland County Office of Procurement & Contracting
2020 Hampton Street, Suite 3064 (Third Floor)
Columbia, South Carolina 29204

Re: Inmate Health Care and Medical Services Contract

Greetings Ms. Davis,

On April 5, 2022, Wellpath sent a letter detailing several of our concerns regarding the Alvin S. Glenn Detention Center, including severe staffing shortages and contraband in the facility. In that letter, we asked that material progress be made to address the safety and security issues and a meeting be held to update us on the progress no later than April 13, 2022. As of the writing of this letter, these concerns have not been addressed, no communication regarding a meeting has occurred, and conditions have not improved. The only communication we have received was from Interim Director Washava Moye, indicating that "all engagements will proceed through [Richland County's] legal department."

Further, as you know, per Section 9 of the Agreement for Inmate Health Care and Medical Services (the "Agreement"), the current 12-month period of our contractual engagement will end June 12, 2022. To date, this engagement has not been extended for another 12-month period.

At this time, Wellpath respectfully submits that material changes in the following areas must be made in the next 30 days, by May 15, 2022, in order for Wellpath to renew the Agreement for another 12-month period:

- Physical plant issues in housing units, including flooding and standing water, must be corrected;
- Contraband, including weapons and drugs, must be eliminated; and
- Adequate custody staff must be provided on every shift to allow our staff to safely deliver patient medications and services, both in the housing units and in the clinics.

Additionally, as a condition of renewal, Wellpath will require the Agreement be amended to include a clause allowing for the termination of the Agreement by Wellpath both for cause and for convenience.

In the event Richland County does not agree to the conditions above or is unable to meet the conditions within the timeframe provided, Wellpath will elect not to renew the Agreement for an additional 12-month period.

Wellpath is proud to have partnered with the County in the provision of quality healthcare services, and we remain grateful to have been given the opportunity to serve the County and its patients. We remain hopeful that these conditions will be acceptable and that we are able to maintain our partnership. In the event this is not the case, Wellpath remains committed to the continued provision of services through the date of termination, and we look forward to working together toward transition.

Please do not hesitate to reach out with any additional questions or concerns.

Sincerely,

DocuSigned by:
Cindy Watson
8BA0FD966BB14B4...

Cindy Watson, President
Local Government Health Division

RICHLAND COUNTY FINANCE DEPARTMENT
PROCUREMENT DIVISION
2020 Hampton Street, Suite 3064
Columbia, SC 29201
803-576-2130

Request for Contract Extension

April 21.2022

Wellpath LLC
Cindy Watson
President, Local Government Healthcare Division
1283 Murfreesboro Road
S. 500 Nashville, TN 37217

Dear Ms. Watson,

With regard to your letter of April 15, 2022, Richland County is attentively working towards improvements to the Alvin S. Glenn Detention Center (ASGDC). The letter indicates that Wellpath is the sole arbiter in assessing any material changes requested in the next thirty (30) days. This puts the County in a position to potentially need to solicit a replacement healthcare provider and transition to that provider within thirty days, due to the contract expiration date of June 12, 2022.

In order to avoid the potential for the current contract to expire and leave the County without a healthcare provider, the County is formally requesting that the contract be extended by three months to September 12, 2022. We appreciate your attention and assistance to this matter.

Please indicate your acceptance of this extension by executing this letter and returning it to me. .

Thank you for your immediate attention. If you have any questions or concerns I can be reached at 803-576-2127 or by email at Davis.Yolanda@richlandcountysc.gov

Acknowledgement Acceptance

Sincerely,

_____

Yolanda Davis — Print or Type name of authorize representative

Contract Specialist

_____

Signature of authorize representative

_____

Date

Cc: Jennifer Wladischkin, Procurement Manager
Washava Moye, Interim Director for ASGDC

From: Katherine Stone <KOStone@Wellpath.us>
Sent: Tuesday, April 26, 2022 9:32 PM
To: Yolanda Davis
Cc: wright.patrick@richlandcountysc.gov; walker.overture@richlandcountysc.gov; mackey.jesica@richlandcountysc.gov; wladischkin.jennifer@richlandcountysc.gov; Capt. Washava Moye; LEONARDO BROWN; Linda Ross; Stan Wofford; Cindy Watson
Subject: Response to Request to Extend Inmate Health Care and Medical Services contract
Attachments: Richland SC Response to Request to Extend.pdf; Richland, SC -Renewal with conditions (1).pdf; Richland County Safety Notice.pdf; Wellpath-Request for Contract Extension.pdf

Dear Ms. Davis and additional Richland County Officials,

Attached you will find a letter from Cindy Watson responding to Richland County's request to extend the current Inmate Health Care and Medical Services contract beyond the current expiration date of June 12, 2022. Also attached for ease of reference are the April 5, 2022 and April 15, 2022 letters along with the Request for Contract Extension sent to Wellpath on April 21, 2022.

Best,
Katie Stone

Katie Stone
Associate General Counsel

wellpath

1283 Murfreesboro Rd, Suite 500
Nashville, TN 37217
Office: 615.324.5703
Mobile: 615.319.7076
kostone@wellpath.us
WellpathCare.com

EXHIBIT 42

From: Amanda Miller <Amanda.Miller@advancedch.com>
Sent: Tuesday, June 28, 2022 10:16 PM EDT
To: Matt Shults <Matt.Shults@advancedch.com>
Subject: FW: Richland Co SC - emergent need

Respectfully,

Amanda Miller RN BSN CCHP
Chief Nursing Officer
USA Medical & Psychological Staffing S.C.
Cell (816) 519-4755
Fax (801) 807-6749

-------- Original message --------
From: Ana Maria Franklin <Ana.Maria.Franklin@advancedch.com>
Date: 6/28/22 8:23 PM (GMT-06:00)
To: JOHN THOMPSON <THOMPSON.JOHN@richlandcountysc.gov>, "Capt. Washava Moye" <Moye.Washava@richlandcountysc.gov>
Cc: Amanda Miller <Amanda.Miller@advancedch.com>, Karen Fowler <Karen.Fowler@advancedch.com>, Shannon Babb <Shannon.Babb@advancedch.com>, Jessica Young <jessica.young@advancedch.com>, "Dr. Jillian Bresnahan" <Jillian.Bresnahan@advancedch.com>, "Dr. Melissa Caldwell" <Melissa.Caldwell@freedom-bh.com>
Subject: Richland Co SC - emergent need

Good evening.

I know we are scheduled for a meeting on June 8 to discuss action plans Re some of the issues that I will be sending this week

But - we have a degrading emergency staffing issue that we have to address immediately if possible. There is a serious safety risk in the facility that has risen to a dangerous situation there.

The shortage of Correctional staff is dangerous not only to the jail staff and inmates but also to the nurses. It's at a severely dangerous level now - We cannot have nurses put in serious risk of harm.

Today we recieved notice from a supervisor at the staffing agency that one of the nurses could no longer return due to the dangerous conditions in the facility. We had just gotten the staffing agency to agree to send nurses back to the jail - after they pulled them previously due to the conditions. They agreed to staff due to ACH being a new provider that they trusted. If they pull all agency staffing - we will be unable to staff to any appropriate level there.

These are the immediate reasons for concern and they have escalated this week due to dangerous CO staffing levels - tonight we received multiple complaints and resignations from staff there due to the conditions.
Some examples of recent incidents since our last meeting include:

1. Multiple inmate stabbings have occurred. Shanks and dangerous weapons are in the cells with inmates - serious safety concerns for the nurses as they enter the housing units to perform medical duties.
2. An inmate was assaulted and beaten severely and left injured for an extended period of time - there was no CO in the housing unit. He was unable to call for help or medical attention. He was not found until later
3. The inmates are allowed to masturbate when the nurses come in - now some of the nurses have been touched inappropriately by the inmates during pill pass and seg rounds - the only recourse that has been taken is to lock the entire cell block down and discontinue the med passes. This is barrier to care for those inmates that need medication and are not the offenders.
4. The water remains cut off to various cell blocks. The nurses are reporting that in some housing units the inmates have no fresh water to drink or to take their medication with. The toilets are not able to be flushed for periods of time.
5. The lighting in the cells remain off and needed to be repaired. Today a code blue was called to the SHU dorm and Shannon Babb had to respond and asses the inmate via a flashlight. Proper cell checks cannot be made with no light. It is dangerous to enter a darkened cell with an unstable inmate. This also causes concern for continued mental health deterioration of the the inmates that are housed there. The inmates that are housed there are already under special needs via mental health concerns. The inmates cannot remain in the dark cells.
6. We have gotten a report tonight that on Saturday the night shift had one CO available on staff and 3 CO's during day shift. Please confirm the actual staff that were present in the facility on each shift and if anyone was available for

security for the medical staff ? Med passes could not be completed - apparently our nurse manager was unable to leave the facility on Saturday night due to some type of refusal by the corrections staff to let her leave for safety reason ? I am unclear and awaiting further information on that incident.

7. One nurse was passing meds last week in the open dorm when an inmate fight broke out - she was locked inside the housing unit with one CO To try to gain control of the situation.
8. Smoking In the housing units is still ongoing. The fire department responds daily. There doesn't appear to have been any corrective action to stop this - this is a very dangerous situation for all that are in that facility- the staffing levels are so low that there is no way to safely evacuate the inmates from the housing unit- and no place to put them if a fire occurres

We want to be partners to help as we are able with this facility. But we also have a very clear directive that inmates must have no barrier to care and must be provided a safe and humane environment. Our nurses must feel safe to do their jobs as well. I apologize for the late hour / we had hope that the situation could hold steady and improve until we could help develop a plan of action together. We have several suggestions that may help and adjustments that could be made / but only after the facility is secure enough to work through. This evenings latest information has caused the emergent need to have some action plan in place immediately for safety purposes. We cannot expect the nurses to continue when there is such a potential risk of harm.

Please contact me or any of our corp staff. Dr Bresnahan has made the decision to pull the staff this evening until which time we can address this.

Thank you for your help - we hope that we can work with you to find an immediate solution to these issues.

Respectfully,
Sheriff Ana Franklin (Retired)
Southeastern Program Consultant

Advanced Correctional Healthcare

256-316-2822

“Seek Justice, love mercy , and walk humbly” … Micah 6:8

EXHIBIT 43

STAFFING NEEDS

ASSESSMENT FOR THE

RICHLAND COUNTY

DETENTION CENTER

(Alvin S. Glenn)

Conducted by: Robert Benfield, ARM, AINS, Director of Insurance Services
Cliff Miller, Risk Manager
South Carolina Association of Counties

October 26, 2023

STAFFING NEEDS ASSESSMENT

This assessment is based upon conditions, blueprints, discussions with staff, and the best information available at the time the report was written. Risk Management reports provided by the South Carolina Association of Counties Risk Management Staff are advisory and not intended to replace County risk management efforts. This report was prepared solely for use by Richland County.

INTRODUCTION

This staffing needs assessment was conducted at the request of Mr. Leonardo Brown, Richland County Administrator.

This assessment was conducted to review the overall operations of the facility and to determine the minimum staffing level required to ensure the safety and security of employees, inmates, and the citizens of Richland County while complying with mandated state and federal standards. Proper staffing should reduce overtime expenditures and decrease the County's liability exposures.

FACTORS IMPACTING STAFFING LEVELS

Detention Center staffing is a complicated and continually evolving issue that impacts several areas of operation. These areas can include unexpected overtime costs, overworked staff, inability to adequately cover mandated positions with current staffing levels, inadequate inmate supervision due to staff shortages, increased workers' compensation claims, medical and intrastate transport of inmates, military activation, and staff turnover.

The minimum staffing level identified in this assessment is based on several factors. These factors include but are not limited to: Inmate classification; Actual inmate count; Physical plant facility limitations; meeting the mandated requirements of the *Minimum Standards for Local Detention Facilities in South Carolina;* and covering mandatory posts and positions that are outlined in this assessment. Several of these factors are detailed in Appendix A.

The current staffing level does not provide for a shift relief factor, and the facility is constantly understaffed. The proposed minimum staffing level has been formulated to address this issue.

Understaffing is impacting the safety and security of the Officers and inmates across facilities in South Carolina and the nation. The level of understaffing at the Alvin S. Glenn Detention Center did not happen overnight and mitigating this exposure will take significant resources and time. County and Detention Center Administration are working diligently to address this issue.

As the inmate population changes, staffing levels will have to be re-evaluated to meet the needs of the facility. Yearly staffing reviews are also mandated by the *Minimum Standards for Local Detention Facilities in South Carolina* to address this issue.

WORKERS' COMPENSATION INJURY ANALYSIS

ALVIN S. GLENN DETENTION CENTER WC CLAIMS FREQUENCY 7/1/2018 – 6/30/2023		
POLICY YEAR	**NUMBER OF WC CLAIMS**	**GROSS INCURRED COST**
2018	24	$309,940
2019	46	$847,644
2020	46	$354,755
2021	41	$584,271
2022	27	$45,789
TOTAL	**177**	**$2,142,399**

The frequency of officer workers compensation claims rose significantly from 2018 to 2021 and declined in 2022. **Although private security staff are providing assistance, it is critical that additional staff be hired as soon as possible.**

ALVIN S. GLENN DETENTION CENTER WC CLAIMS NATURE OF INJURY 7/1/2018 – 4/30/2023		
NATURE OF INJURY	**NUMBER OF WC CLAIMS**	**GROSS INCURRED COST**
STRUCK BY PERSON / OBJECT	80	$740,992
SPRAINS / STRAINS	30	$478,500
SLIP / FALL	21	$746,566
CAUGHT IN/UNDER OBJECT	10	$4,500
TOTAL	**141**	**$1,970,558**

In this chart, the top four (4) reasons that Officers are injured while working in the Alvin S. Glenn Detention Center have been identified. The most frequent injury is caused by Officers being struck/assaulted by the inmates. **Understaffing, Officer fatigue, and mandatory overtime are contributing to the increase in Officer assaults. Additional staff should be hired as soon as possible.**

OVERTIME HOURS

The Alvin S. Glenn Detention Center is operating under mandatory overtime to try and staff all mandated posts and positions required by the *Minimum Standards for Local Detention Facilities in South Carolina*. In addition, the county has contracted with Allied Universal Security Services to provide additional support.

AGENCY	**OVERTIME COST**
DETENTION CENTER – 1/1/2021 – 12/31/2022	$222,108
ALLIED SERVICES – 6/30/2022 – 4/27/2023	$1,042,555

TOTAL COST	**$1,264,663**

The continued use of necessary overtime to fill mandated posts and positions can result in increased Officer injuries and workers' compensation claims, increased usage of sick time, increased litigation from inmates, a potential rise in Officer substance abuse, and a deterioration of the Officer's personal and family life. It is clear from the Overtime Usage Chart that additional Officers should be hired to mitigate these exposures.

DETENTION CENTER DESIGN AND LAYOUT

The Richland County Detention Center (Alvin S. Glenn) has been assigned a rated capacity by the Jail and Prison Inspection Division of the Department of Corrections to house one thousand, one hundred sixteen (1,116) inmates. The average number of inmates housed in the facility in the past three months (based on the date of the last inspection – 10/24/2022) was seven hundred and one inmates (701), with a high count of seven hundred ninety (790). The population at that time was lower than usual due to the pandemic, but it is likely to rise again when societal conditions return to normal. It had already increased significantly by the time of this staffing analysis. Even though the facility total was still less than the overall rated capacity, three housing units were exceeding their respective rated capacities and a fourth one had all beds filled. This is also an indication that the classification plan cannot be followed effectively.

Inmates are located in different types of multi-occupancy units and single cells throughout the facility based on their classification levels. Due to the design of the facility, inmates are monitored by direct supervision, indirect supervision, by Officers making rounds, and by cameras. **However, the use of cameras cannot be substituted to reduce minimum staffing requirements or to eliminate mandatory rounds.** Officers are still required to make rounds throughout the facility and to enter each living area.

The housing units, along with their rated capacities (RC) and actual inmate count (AC) on May 1, 2023, are listed below:

Dormitory A (Phase 1 Area): Male Pre-Trial Housing Unit - RC 56 / AC 59

Dormitory A is rated to house fifty-six (56) pre-trial male inmates classified as medium security. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. The housing unit has a common area to which inmates have access. **Due to the design of this unit, these inmates cannot be locked into their rooms in the event of an emergency and at night.**

Dormitory B (Phase 1 Area): Male Pre-Trial Violent & Medical Housing Unit - RC 56 / AC 27

Dormitory B is rated to house fifty-six (56) pre-trial male inmates classified as violent or needing medical care. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. The housing unit has a common area to which inmates have access. **Due to the design of this unit, these**

inmates cannot be locked into their rooms in the event of an emergency and at night.

Dormitory C (Phase 1 Area): RC 56 / AC 0 Closed for Renovations

Dormitory D (Phase 1 Area): Male Pre-Trial Cellblock - RC 56 / AC 63

Dormitory D is rated to house fifty-six (56) male inmates classified as medium security. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. The housing unit has a common area to which inmates have access. **Due to the design of this unit, these inmates cannot be locked into their rooms in the event of an emergency and at night.**

Dormitory E (Phase 1 Area): Male Pre-Trial Cellblock RC 56 / AC 48

Dormitory E is rated to fifty-six (56) pre-trial male inmates classified as medium security. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. The housing unit has a common area to which inmates have access. **Due to the design of this unit, these inmates cannot be locked into their rooms in the event of an emergency and at night.**

Dormitory F (Phase 1 Area): Male Pre-Trial Cellblock RC 56 / AC 48

Dormitory F is rated to house fifty-six (56) pre-trial male inmates classified as medium security. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. The housing unit has a common area to which inmates have access. **Due to the design of this unit, these inmates cannot be locked into their rooms in the event of an emergency and at night.**

Dormitory G (Phase 3 Area): Male Pre-Trial Cellblock RC 56 / AC 49

Dormitory G is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory H (Phase 3 Area): Male Pre-Trial Cellblock - RC 56 / AC 44

Dormitory H is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of

their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory I (Phase 3 Area): Male Pre-Trial Cellblock - RC 56 / AC 36

Dormitory I is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory J (Phase 3 Area): Male Pre-Trial Cellblock - RC 56 / AC 17

Dormitory J is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory K (Phase 5 Area): Male Pre-Trial Cellblock - RC 56 / AC 61

Dormitory K is rated to house fifty-six (56) pre-trial male inmates. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory L (Phase 5 Area): Male Pre-Trial - RC 56 / AC 50

Dormitory L is rate to house fifty-six (56) pre-trial male inmates. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory M (Phase 5 Area): Male Pre-Trial - RC 56 / AC 43

Dormitory M is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not

locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory P (Phase 5 Area): Male Pre-Trial - RC 56 / AC 56

Dormitory P is rated to house fifty-six (56) pre-trial male inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory U (Phase 2 Area): Female Pre-Trial Orientation - RC 56 / AC 36

Dormitory U is rated to house fifty-six (56) pre-rial female inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory X (Phase 2 Area): Female Pre-Trial - RC 56 / AC 28

Dormitory X is rated to house fifty-six (56) pre-trial female inmates in secured cells. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

Dormitory Y (Phase 2 Area): RC 56 / AC 0 Closed for Renovations

Dormitory Y is rated to house fifty-six (56) male inmates; however, it is currently closed due to renovations.

Dormitory SHU (Phase 2 Area): RC 56 / AC 0 Closed for Renovations

Dormitory SHU is rated to house fifty-six (56) male inmates; however, it is currently closed due to renovations.

Juvenile Detention Center: RC 24 / AC 21

The Juvenile housing building is actually a distinct facility which must be operated and managed separately from the adult facility. It is rated to house twenty-four (24) juveniles. The inmates in this unit are monitored by direct supervision, Officers making rounds, and by camera. In direct supervision Officers must be located inside the living area at all times when the inmates are not locked down to monitor and supervise the inmates. These inmates are allowed to move out of their sleeping area into the unit dayroom and exercise area under normal conditions. Due to the design of this unit, these inmates can be locked into their rooms in the event of an emergency and at night.

TOTAL INMATE COUNT ON 6/13/2023: 760

The *Minimum Standards for Local Detention Facilities in South Carolina* mandate that **pre-trial and sentenced inmates cannot be housed in the same cell and they must be managed separately with respect to dayroom access, indoor exercise/recreation, and outdoor exercise.**

Other Cells: Holding & Special Purpose Cells – RC 60

There are both holding cells and observation cells located in the facility. These require different levels of supervision specific to their uses.

STAFFING PLAN

This staffing plan was formulated based on a review of the facility's layout and design blueprints, site visits, discussions with the staff, and an evaluation of the County's vacation and sick leave policies. Essential posts and job functions, including all staff supervision and support functions, were identified and analyzed.

The Detention Center is currently funded to staff two hundred forty-two (242) Security Officers and fifty-seven (57) Administrative Staff. Due to numerous vacancies, the facility is currently staffed by only **one hundred eighteen (118) Security Officers and forty-nine (49) Administrative Staff.** Security Officers work twelve (12) hour shifts and are split into four (4) squads that are supposed to provide twenty-four (24) hour coverage, seven (7) days a week.

The current staffing level does not provide for a shift relief factor, and the facility is constantly understaffed. Due to this shortage, Officers are forced to leave mandated security posts and positions to perform other functions. These deficiencies create a safety hazard for employees, inmates, and the citizens of Richland County, along with increasing the County's liability exposure. The proposed staffing level has been formulated to address these issues.

Appendix B provides a list and timeline for selected facility activities.

This assessment does not address the staff needed to supervise inmates while they are working outside of the Detention Center. <u>It is presumed that County department heads</u>

and their authorized employees who check out and/or use these inmates are being held responsible for their supervision and are being properly trained prior to inmate utilization.

STAFFING AVAILABILITY AND SHIFT RELIEF FACTOR

Once the posts and positions required to cover all facility operations have been identified, the total number of personnel needed ***to ensure coverage as required in an operation that is open every day of the year, twenty-four (24) hours a day, must be determined.*** To project sufficient staffing and ensure continuous coverage without the necessity of overtime, a **shift relief factor** must be calculated.

To determine the staffing requirements to fill one (1) post, around the clock, every day of the year, two (2) factors are considered:

Staffing Availability

The base number of hours that one (1) staff member is available to work is called staffing availability. This is derived by subtracting all leave options (such as holiday, sick, vacation, etc.) and training requirements from the scheduled working hours.

Shift Relief Factor

The number of personnel required to provide continuous coverage of one (1) post or position, given their availability, is called the Shift Relief Factor. This figure is derived by dividing staffing availability into the total hours required to staff a post for 365 days a year.

Although some employees may not take all leave which is available to them, planning for continuous coverage of critical positions must be done on the basis of potential absences. Even then the factors affecting availability do not take into consideration some shortages such as those due to workers' compensation leave, unauthorized absences, and suspensions; and the factors do not consider turnover rates and the time it takes to train a new Officer prior to being able to supervise inmates.

Security Officers work twelve (12) hour shifts, for a total of eighty-five (85) hours per pay period unless absent due to leave, training, or other approved reasons. **Appendix A** lists the factors and steps that were used to determine the Shift Relief Factor.

To determine the **Shift Relief Factor** needed to cover each post or position per twelve (12) hour shift, the following factors were taken into consideration:

85 hours of vacation earned a year;

119 hours of holiday time earned a year;

102 hours of sick leave earned a year;

40 hours of in-service training received per year;

154 hours of meals and breaks that must be relieved per year.

Based on the information outlined above, the shift relief factor for the Richland County Detention Center (Alvin S. Glenn) is **2.6 Officers per shift for a twenty-four (24) hours per day, seven (7) days a week, post or position. Using this formula, the minimum number of personnel required to provide continuous coverage for each post or position is represented in the following chart:**

PROPOSED MINIMUM STAFFING PLAN FOR THE ALVIN S. GLENN DETENTION CENTER				
POSITION	**1ST SHIFT 6:00 AM -6:00 PM**	**2ND SHIFT 6:00 PM-6:00 AM**	**SHIFT RELIEF**	**TOTAL STAFF**
SECURITY/SHIFT WORKERS				
CENTRAL CONTROL	2	2	2.6	10.4
LOBBY	2	1	2.6	7.8
BOOKING SGT.	1	1	2.6	5.2
PRE-BOOKING	1	1	2.6	5.2
BOOKING COUNTER	2	2	2.6	10.4
PROPERTY	1	1	2.6	5.2
BOOKING SECURITY	1	1	2.6	5.2
BOND COURT	1	1	2.6	5.2
DISCHARGE	1	1	2.6	5.2
OUTSIDE PERIMETER	1	1	2.6	5.2
CLASSIFICATION	2	2	2.6	10.4
CHARLIE OFFICER ATTY.	2	0	2.6	5.2
*TANGO OFFICER ATTY.	2	0	2.6	5.2
SHIFT LT.	1	1	2.6	5.2
SHIFT SGT.	3	3	2.6	15.6
PHS 1 HALLWAY	1	1	2.6	5.2
PHS 2 HALLWAY	1	1	2.6	5.2
PHS 3 HALLWAY	1	1	2.6	5.2
PHS 5 HALLWAY	2	2	2.6	10.4
FLOATER	3	3	2.6	15.6
DORM A	1	1	2.6	5.2
DORM B	1	1	2.6	5.2
DORM C - CLOSED	0	0	2.6	0
DORM D	1	1	2.6	5.2
DORM E	1	1	2.6	5.2
DORM F	1	1	2.6	5.2

DORM G	1	1	2.6	5.2
DORM H	1	1	2.6	5.2
DORM I	1	1	2.6	5.2
DORM J	1	1	2.6	5.2
DORM K	1	1	2.6	5.2
DORM L	1	1	2.6	5.2
DORM M	2	2	2.6	10.4
DORM P	2	2	2.6	10.4
DORM U	1	1	2.6	5.2
DORM X	1	1	2.6	5.2
*DORM Y – CLOSED	1	1	2.6	5.2
*DORM SHU - CLOSED	3	3	2.6	15.6
JUVENILE FACILITY	5	5	2.6	26
J FLOATER	1	1	2.6	5.2
J SGT.	1	1	2.6	5.2
TOTAL SECURITY/SHIFT WORKERS				**294**
***Future Needs**				
ADMINISTRATION/SUPPORT				
DIRECTOR		1		1
ASST. DIRECTOR		1		1
ADMINISTRATION MANAGER		1		1
ADMINISTRATIVE CAPTAIN		1		1
PROGRAMS LT.		1		1
PROGRAMS OFFICERS		2		2
ACCREDITATION LT.		1		1
ACCREDITATION OFFICERS		2		2
CLASSIFICATION SGT.		1		1
VICTIMS ADVOCATE		2		2
PRE-HEARING GRIEVANCE SGT.		1		1
RECORDS LT.		1		1
RECORDS SGT.		1		1
RECORDS CIVILIANS		6		6
MAINTENANCE SUPPORT		5		5
ADMINISTRATIVE ASSISTANT		1		1
OPERATIONS CAPTAIN		1		1
ERT LT.		1		1
ERT SGT		2		2
ERT OFFICERS		5		5
TRANSPORT LT.		1		1
TRANSPORT SGTS.		3		3
TRANSPORT OFFICERS		24		24
SERVICES CAPTAIN		1		1
JUVENILE LT.		1		1
RECRUITMENT LT.		1		1
RECRUITMENT SGT.		1		1
TRAINING LT.		1		1
TRAINING SGT.		1		1
TRAINING OFFICERS		3		3
PROFESSIONAL STANDARDS CAPT.		1		1

PROFESSIONAL STANDARDS LT.	1		1
PROFESSIONAL STANDARDS STAFF	2		2
PROFESSIONAL STANDARDS ADMIN	1		1
CONTRACT MONITOR	1		1
VIRTUAL HEARING OFFICER	3		3
BEHAVIORAL HEALTH SUPERVISOR	1		1
INMATE MEDICAL	CONTRACT		0
INMATE FOOD SERVICE	CONTRACT		0
TOTAL ADMINISTRATION/SUPPORT:			**84**
TOTAL FACILITY STAFFING:			**378**

STAFFING SUMMARY

As illustrated in the chart, the proposed minimum staffing level for the Richland County Detention Center (Alvin S. Glenn) is **two hundred ninety-four (294) Security Officers and eighty-four (84) Administrative Officers/Support Staff positions.**

While it is impossible to eliminate overtime and unexpected costs, this is the minimum level of staffing that would be necessary to fully cover all mandated and critical posts and positions while providing for the safety and security of employees, inmates, and the citizens of Richland County.

RECOMMENDATIONS

The Alvin S. Glenn Detention Center is significantly understaffed, and Officer hiring/retention is a challenge across South Carolina. Richland County has implemented several incentives to help recruit new officers and retain their current staff:

1. Increased new officer starting salary to $40,000. While this is an improvement, Alvin S. Glenn is competing against Lexington and Sumter County for officers. Starting salaries may need to be adjusted as other detention centers adjust their salaries.

2. Officer retention bonuses of $5,000. This is a great incentive to help retain your already trained staff.

3. Consider providing take-home vehicles and phones for Command staff/Administration.

4. Prioritize promotion/special job assignments to those Officers who have proven to be reliable and gone above and beyond what is required of them.

5. Consider providing education incentives to Officers. Many counties are offering to cover the cost of college/certificate classes depending on how long the Officer stays at the

facility.

6. Many facilities are offering retired Officers the opportunity to work part-time to help meet staffing needs.

APPENDIX A RICHLAND COUNTY DETENTION CENTER SHIFT RELIEF FACTOR WORKSHEET			
STEP#	DESCRIPTION	HOURS	LETTER
1	# OF HOURS AGENCY CLOSED PER YEAR	0 hrs	A
2	# OF HOURS AGENCY OPEN PER YEAR (8,760 HOURS - A)	8,760 hrs	B
3	# OF PAID HOURS PER EMPLOYEE PER YEAR	2,210 hrs	C
4	# OF NON-PAID HOURS PER EMPLOYEE PER YEAR	6,550 hrs	D
5	# OF VACATION HOURS EARNED PER YEAR Per HR	85 hrs	E
6	# OF HOLIDAY HOURS EARNED PER YEAR (14 Days X 8.5 hrs)	119 hrs	F
7	# OF COMPENSATORY HOURS PER YEAR	0 hrs	G
8	# OF SICK LEAVE HOURS EARNED PER YEAR Per HR	102 hrs	H
9	# OF OTHER HOURS OFF PER YEAR	0 hrs	I
10	# OF TRAINING HOURS TAKEN PER YEAR (Minimum # hours mandated by Standards)	40 hrs	J
11	# OF HOURS UNAVAILABLE FOR DUTY POST (Sum of D through J)	6,896 hrs	K
12	# OF ACTUAL DUTY HOURS PER EMPLOYEE (B minus K)	1,864 hrs	L
13	# OF HOURS RELIEVED FOR MEALS/BREAKS	155 hrs	M
14	# OF HOURS ACTUALLY ON DUTY POST (L minus M)	1,709 hrs	N
15	SHIFT RELIEF FACTOR (B divided by N) = 5.2 divided by 2 Shifts = 2.6	N/A	O

1. NUMBER OF HOURS AGENCY IS CLOSED PER YEAR = 0 HRS

2. 365 DAYS A YEAR X 24 HRS/DAY = 8,760 HRS PER YEAR

3. WORK HOURS = 85 HRS/PER PAY CYCLE X 26 PAY CYCLES/YEAR = 2,210 HRS PER YEAR

4. HOURS OFF WORK = 8,760 HRS/YEAR - 2,210 HRS/YEAR = 6,550 HRS PER YEAR

5. VACATION HRS = 85 HRS PER YEAR

6. HOLIDAY HRS = 119 HRS PER YEAR

7. COMPENSATION HRS = 0 HRS PER YEAR

8. SICK HRS = 102 HRS PER YEAR

9. OTHER HOURS OFF = 0

10. TRAINING HRS = 40 HRS PER YEAR
(*This is the minimum number of training hours mandated per year by the Minimum Standards for Local Detention Facilities in South Carolina)*

11. SUM OF D THROUGH J = 6,896 HRS

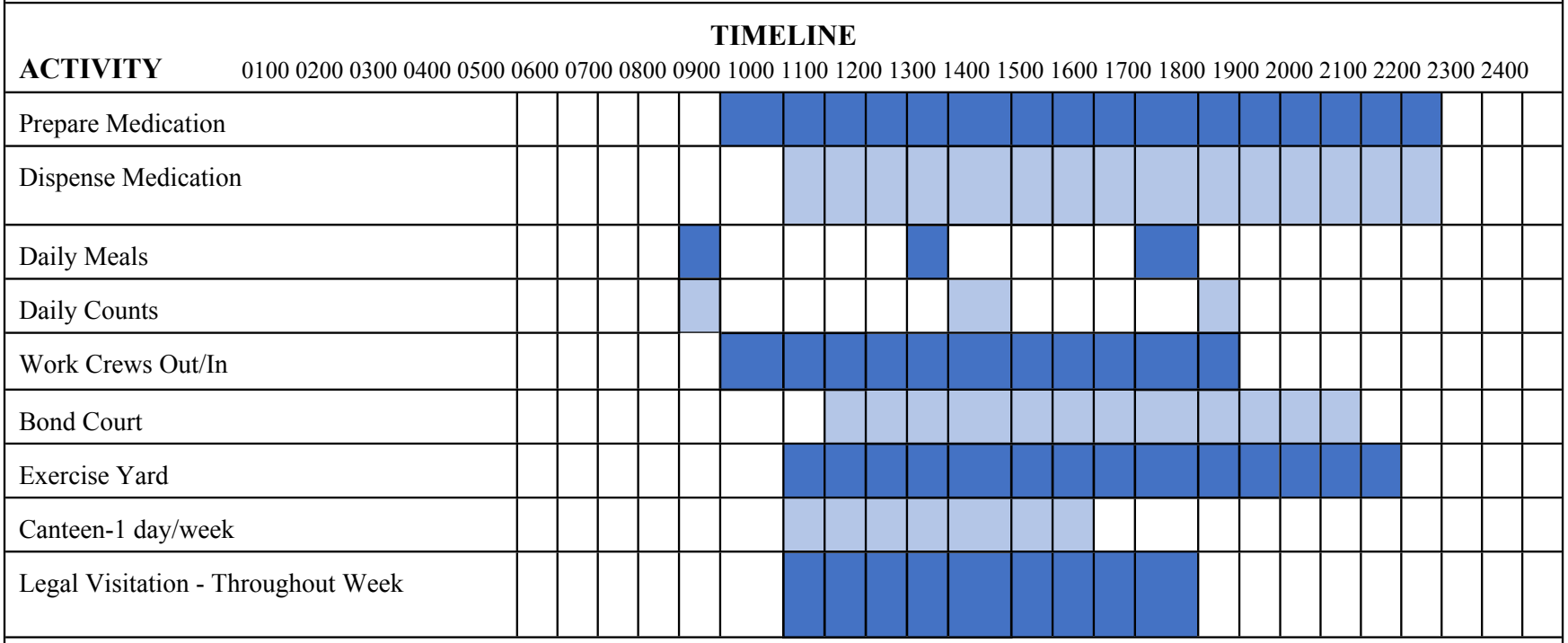
12. 8,760 HRS - 6,896HRS = 1,864 HRS AVAILABLE FOR DUTY POST

13. RELIEVED MEALS & BREAKS = 1,864 HRS/YEAR DIVIDED BY 12 HRS/DAY = 155 DAYS. 155 DAYS/YEAR X (30 Min Lunch + 30 Min Breaks = 1 HR) = 155 HRS

14. 1,864 HRS - 155 HRS = 1,709 HRS ACTUALLY ON DUTY POST

15. 8,760 HRS DIVIDED BY 1,709 HRS = 5.12 OFFICERS REQUIRED TO COVER ONE (1) PERMANENT POST OR POSITION
5.12 DIVIDED BY 2 SHIFTS **= 2.6 SHIFT RELIEF FACTOR**

APPENDIX B: RICHLAND COUNTY DETENTION CENTER (Alvin S. Glenn) SELECTED ACTIVITY SCHEDULE*



***Other activities including general sessions court, in-facility inmate movements, medication inventory, sick call, attorney visits, non-scheduled inmate counts, Officer training, and other day to day activities are not reflected on this chart.**

EXHIBIT 44

IN THE UNITED STATES DISTRICT COURT
DISTRICT OF SOUTH CAROLINA
COLUMBIA DIVISION
C/A No.: 8:22-cv-1358-MGL-JDA

A.C., J.H. and H.M. on behalf of themselves and others similarly situated; Disability Rights South Carolina,

Plaintiffs,

v.

Richland County,

Defendant.

30(b)(6) DEPOSITION OF RICHLAND COUNTY DESIGNEE

CRAYMAN HARVEY

****

Tuesday, January 16, 2024

9:11 a.m. - 1:51 p.m.

The 30(b)(6) deposition of Richland County Desginee CRAYMAN HARVEY was taken before Kimberly C. Young, a notary public in and for the State of South Carolina, commencing on January 16, 2024, at the offices of GALLIVAN, WHITE AND BOYD, P.A., 1201 Main Street, Suite 1200, Columbia, South Carolina 29201, pursuant to Notice of Deposition and/or agreement of counsel.

They are not classifying that person to a housing unit.

Q. Is there a difference between the -- and I may have just misunderstood you, the pre-booking process for the booking officer and the interview process for the booking officer?

A. Not really, sir. It's just, due to this large jail, we designated what they call a pre-booking. Most jails don't have a pre-booking. They just go straight into booking.

Q. Okay.

A. The pre-booking is just for that one officer or two officers to meet that law enforcement officer and engage him or her. Majority of the jails in South Carolina, that process is very -- it's not as -- it's not as long as it would be for us. It could be because of the size of our jail and the amount of admission detainees that we get on a daily basis.

Q. Okay. But there is a limited pre-booking officer, and then there is a booking officer?

A. Yes, sir.

Q. And is a booking officer a gatekeeper? Does an individual have to be seen by the booking officer before he or she is then seen by classification?

A. Yes, sir. So before -- the pre-booking officer is the one that comes on -- that's on the scene first. Then that pre-booking officer is pretty much like the gatekeeper saying, yeah, this person's well enough for us to transmit through the system. And then they will go to the booking officer, which is the counter officer, booking officer, or booking staff.

Q. Okay.

A. Those words interchangeably.

Q. And is it -- is it Officer Dukes who is the principal individual serving as that booking officer?

A. It could be any one of them.

Q. So it could be the sergeant or the --

A. Yes, sir.

Q. -- detention officer?

A. Yes, sir.

Q. Do they have assignments? How is their determination made?

A. Lieutenant Legette is the one who assigns them based on the workload of the day and the shift and --

Q. All right. Okay. And is there -- there is a -- I know there's an interview form?

A. Yes, sir, there is.
Q. And is -- are there any exceptions to the use of that form? Or is that form a form that's -- that the booking officer then applies to each classification in their unit?
A. The classification officer uses that form for every detainee. That form is a standardized form. And that form is used to ensure that that detainee is placed in the most appropriate housing unit. So it's pretty -- it's pretty standard.
Q. Okay.
A. Yeah.
Q. All right. And what are the outcomes as an individual goes through that process? What are the different classifications within the detention center that may be assigned to an individual?
A. Typically, just like majority of the jails in South Carolina, we have a minimum, medium, and maximum. Minimum is low custody, medium is medium custody, and maximum is, of course, maximum custody. Those are your ones that have a high level of -- whether it's violence or whether it's a history that it has potential of violence.

So just three level classification levels. And within those classification levels, certain housing units affiliated with those classification levels.

Q. So you -- I didn't, and I may have just missed it, but I didn't hear you mention history of a criminal history, a history of -- or only convictions considered or arrests and convictions?

A. We take in both of those. Due to not having a speedy trial in South Carolina, a detainee may come in with a bunch of arrests, but there may not be no convictions. But even with those, we have to -- those are indicators that we have to look at.

Q. Okay. Do you consider any other community history --

A. Yes, sir.

Q. -- other than mental health and medical?

A. Yes, sir. We look at education level. We also look at -- I think programs is one of them as well. I have to be -- I'm not quite sure, but I think programs was on that form as well.

Q. All right. And gang affiliation?

A. Yes, sir. That's part of it as well.

Q. Do you consider -- does the County consider -- when I'm saying you, I'm asking, as you know, about the --
A. Yes, sir.
Q. -- County's position on all of these questions --
A. Yes, sir.
Q. -- the intake tool to be a risk assessment?
A. It is, yes, sir. It's one of -- it's the largest risk assessment that any jail can incorporate into their operation.
Q. What do you mean the largest?
A. It's -- without it, you won't to be able to determine what type of risk level the detainee is and one that the detainee can have towards the facility. So it is the end all be all for any detainee that comes into any jail custody.
Q. What's your source of it? That is, what's the -- you know what I'm asking by that? I mean, where was the intake process and your classification system derived from?
A. It was basically derived from standard, minimal standards of detention centers within the state of South Carolina.
Q. You're referring to the regulatory framework that is applied by SCDC in its review of detention

facilities --

A. Yes, sir.

Q. -- in South Carolina?

A. Yeah. Yes, sir, that custody level framework or form is pretty standard throughout the jail -- throughout South Carolina jails.

Q. Yeah. And I'm asking for more than that, not just the form, but the determination of the factors taken into consideration in making a judgment about classification?

A. It's based on South Carolina minimum standards. There's a litany of the indicators that I explained. They're in actually our minimum standard standards. So those are the minimum standards that we have to have when determining a classification level of a detainee.

Q. All right. And do you regard the classification assessment process as objective or subjective or a combination of both?

MR. COX: Object to the form.

A. It's very subjective in the aspect of when you're looking at certain indicators, but it's objective when you go by certain things; meaning certain indicators it's very objective. The charge that the detainee comes in with, that's -- there's no

way subjective about that. It's very objective. You come in here, you have a murder warrant, it's a murder warrant.

Q. Right.

A. It's subjective if we look at, okay, the -- if that detainee is manageable based on their height, their weight. Those are also indicators that we take into consideration. And that may be subjective, because a person who's 5'2", 150 pounds, though he may be low in stature and height and everything, he still probably can carry himself in an area where he's -- where there are bigger people. So that's the subjective part. But it's very objective when you just go by the indicators that's in the minimum standards.

Q. What sort of training has your classification team received with regard to the application of those standards?

A. The first training that my team, and when I mean my team, I mean the senior managers is to include myself, we went to Colorado last year. And from the American Jail Association, we participated in their classification system, which is nationally known. That was also given to Lieutenant

Legette, Captain Moye, and myself. And we took that training back to our facility to ensure that we put best practices in place. Majority of the information that we learned in Colorado we already had in place. It was just a good refresher for us to go back and learn and to re-teach our staff that are new and to help them with that information.

Q. Did the members of the classification team that you've identified receive -- participate directly in that training in Colorado?

A. Not as of yet, no, sir, they have not.

Q. Have they received any training other than on-the-job training?

A. No, sir.

Q. Okay.

A. No, sir. And the team, meaning those that are under the Lieutenant Legette. Lieutenant Legette and Captain Moye have received direct training from the American Jail Association when it pertains to classification.

Q. Has the jail incorporated any of those best practices into the policies and procedures of the detention center?

A. Yes, sir. When I started, we immediately

BY MR. ANDREWS:

Q. All right. Let's go back on the record. I'll let Mr. Harvey weigh in on that. So the question, Mr. Harvey, is whether or not I would be able in reviewing the policies to tell which components the policies you've revised.

A. If it's a significant change, there's a box at the end of the policy, and I will indicate what the significant change was. If it's a little change, change in verbiage from "inmate" to the "detainee," you will not -- you will not see that on face value.

Q. If you regard it as something significant, you've provided an explanation?

A. Yes, sir. I provided an explanation.

Q. Okay. All right. Thank you. Okay. There's a paragraph relating to overcrowding. The question relates to as a result of the increase in your detainees, because of the changes in the law, the population is clearly increasing in the jail. Is that correct?

A. I agree, yes, sir.

Q. All right. Do you know what the average daily census for the last month has been roughly?

A. Nine hundred plus, 20, 30, yeah.

Q. And you testified earlier 998 was a number yesterday?
A. Yes, sir, 998.
Q. Have you undertaken a process of forecasting where that's likely to be in three months, six months, a year?
A. Yes, sir.
Q. And what's it looking like?
A. We're gonna be over 1,000.
Q. Yeah. Well, you're nearly over 1,000 now. It won't -- it won't take long --
A. It won't take long.
Q. -- for you to get over 1,000.

MR. PENNINGTON: Didn't need a crystal ball for that.

MR. COX: Well, we do if some people get out.

MR. ANDREWS: Yeah. But under the new law people are not going to be released soon.

THE WITNESS: They're not.

BY MR. ANDREWS:

Q. And so have you projected in undertaking that review the likelihood that you'll be at capacity within a year?
A. Probably less than that. But yes, sir.

EXHIBIT 45

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF SOUTH CAROLINA
FLORENCE DIVISION

Disability Rights South Carolina and 15 Unnamed Plaintiffs as Class Representatives on behalf of themselves and others similarly situated, Plaintiffs, v. Richland County, Defendant.	Civil Action No. 4:22-cv-01358-MGL-TER **DECLARATION OF** [redacted]

I, [redacted], pursuant to 28 U.S.C. § 1746, declare as follows:

1. On October 28, 2023, the first day at Alvin S. Glenn Det. Center, I had to spend 5 days in the holding ~~takins~~ THANKS [redacted] with 30 to 40 detainees that was there for about 2 weeks and more. My time in the holding tank was the worst time ever. I and several detainees had to sleep on the concrete cold floor and use the same toilet number (1 and 2) with no privacy.

2. In those 5 days I saw the nurse only one time. I told her about my broke left leg that I have and my history of mental health issue that I have. There still was nothing done about it while my time in the holding tank. They didn't even give me medication after I told them that I should still be in their system because I was here at the jail 4 months earlier.

3. On my 5th day I was moved to unit Bravo the medical dorm. When I got in the dorm, I notice that about 25 to 30 detainee sleeping on the floor on stacked bunks and the top (floor) was off limits. Then I realize that my "keep away" or "keep separate" was in the same dorm. That was negligence to my safety and security. I stayed 5 days in Bravo because I felt unsafe.

4. I then was moved to unit Kilo a dorm that had drugs, extortion, and violence. I was in the dorm for only three days after being bullied and every time I was being bullied there was no CO. I see detainees get stabbed, beat up, and their canteen taken.

5. One day I had enough and wrote the nurse Ms. Sanders a suicide note that I was going to kill myself. Just so they can help me get out the Pod I was in because I was not safe without a CO in the dorm with a broke leg.

6. Ms. Sanders then gave the note to CO and she then removed me from the pod. They took me to [redacted] lock up (Papa). My first day in lock-up was horrible. The inmates had pop the sprinkler and made the whole unit (Papa) flood up to my ankles. The rooms downstairs and the [redacted] whole (Rock) had water in them and the CO still did nothing to get the problem under control.

7. Everyday we had a CO or a Sgt. In the dorm but they ignored every time we call them or when it was time to feed us. In the daytime, we will have officer Gray he was okay to us. But, Sgt. Pugh did not help us o[illegible] did anything for us if we was sick or hurt, he ignored us. He did not care if we ate on time. He would let the food sit and get cold.

8. On my 4th day there in Papa there was a riot in the Pod above mine. I was in B pod and there was a big fire. The inmates had set their mattress on fire because the way the officers was treating us that day. While the fire was going on they only remove some Pod detainees. B. pod and C pod was the only Pod they didn't remove and we had to stay in all that smoke. Inhale it in all night and had water all over our floor again from the fire.

9. I spent 33 days [redacted] on suicide watch. When I only suppose to spend 72 hours. The whole time I been in lock-up I have not seen the mental health lady once. I suppose to have seen mental health within 72 hours. I stayed in B-6 without no working lights and my door lock was broke when I got in the Pod.

10. They did not give us REC like they supposed to and the drugs and the making of the weapons that's all I saw the inmates did. I was trying my best to stay safe. When the CO not looking or in the unit the inmates from upstairs will get in the chase. By breaking the lock off get

the stuff from the plumbing to make knives and to come into the Pod down stairs to get drugs or to harm an inmate.

11. On Dec. 12, I was released from lock-up and put back in unit Bravo (Medical dorm). My "keep away" was not in the dorm. But when I got in the dorm again I realized that they didn't fix the ceiling in the bathroom or the ceiling on the top floor after someone has escape from. It's still about 25 people sleeping on the floor on stack-a-buck that have physical body problems or injuries till this day.

12. The upstairs in unit Bravo been off limits to the detainee for about 10-12 months and they still have not put any effort to try to fix this problem. There are expose wire, a metal plate that coming halfway off the wall, where detainees use to cut things with

13. The fire extinguisher handle are broken off after detainee try to make (knives out of them. There are only two working toilets, they have the mental health and the medical patients in the same unit. Some of the mental health people if they don't take their medicine, they start acting crazy and having the whole dorm out of place.

14. On Jan 3, 2024 in unit Bravo (medical) dorm I was stabbed 11 times over some canteen. At the time of the incident there was no CO in the unit to help prevent or call for more officers to help stop the fight. After the time of the incident, Mrs. Sanders and Sgt. Coleman happened to enter the dorm to do med-pass. I was bleeding from head to toe and they had to wheel me to medical because I was stabbed and bleeding really bad and I could not walk.

15. When I got into medical the nurse's observed and bandaged my wounds. Then Lt. Anderson took pictures and got a brief statement of the incident. Then Richland County Sheriff came in and talked to Lt. Anderson. Then, the nurses were still trying to figure out whether or not they wanted to transport me to the hospital or let the EMS come.

16. I went to the hospital. Then I was placed back in the same unit that I was stabbed in. They had moved the two inmates that stabbed me.

17. The third day after I was stabbed I didn't see or hear from wound care or mental health or Capt. McCullough, the head of security Now it was Jan 8 and finally I made a statement and asked to press charges on those two inmates. Til this day I still haven't heard anything back on the pressing charges and I put in several grievances to Lt. Anderson and McCullough.

18. Every day since my stabbing has been traumatize mentally and physically. I don't think my body will be the same anymore the way I been stabbed and where I been stabbed at.

19. 12 days after my stabbing another detainee was stabbed in unit Bravo the medical dorm over canteen again and still no CO in the dorm. The inmates have press the emergency button for someone to come to our unit. Still no one responds.

20. Still the violence in the Jail has not stop and the CO still bring in all the drugs and weapons to hurt each other. It's now March and my unit I'm living in still have people sleeping on the floor where there's 26 beds open upstairs.

21. There has been 4 fights in my unit and still no CO. I have yet to see a mental health doctor to talk to about my disability and my thoughts that goes on in my head.

22. I don't take meds and its hard for me to handle the environment that I'm in after being stabbed. I'm very traumatized and scared for my life back here.

23. From the bottom of my heart, I hope my letter and other detainee letters help bring this jail house corruption to a stop. I hope that the one's that been hurt physically and have been mentally abused see that they get some kind of justice from this.

24. I wish I could write more because I have a lot to say and tell. Goes all the way back from 2016 to now. This not just happening this been going on and same of the Sgt., Lt., and Cpt. Are behind a lot of this corruption too. Just hope one day they be brought to justice as well.

25. I feel like violence and conditions have affected my mental many many times. Its been women in here going bonkers and going crazy in here physically and verbally to each other. Many fights are brutal and at the end it ends bloody even got tasing them to calm down. I have

staples in my head, [redacted]

also been threatened and beaten to a pulp had ~~stitches for my being opened had to get stitches.~~ It affected my mental seriously messed up my confidence and movement. People think they can harm you and they won't get really in trouble cause nothing worse than jail. Feel like they already doing time.

26. Attached hereto is my own hand-written statement that is identical in all material respects to this Declaration. I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct.

4-23-24
Date

[redacted]