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Statement of Michael E. Horowitz Inspector General, U.S. Department of Justice before the U.S. Senate Committee on the Judiciary concerning Examining and Preventing Deaths of Incarcerated Individuals in Federal Prisons

Results of the Evaluation, Page 5

Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee:
Thank you for inviting me to testify at today's important hearing about preventing inmate deaths in federal prisons, and to discuss the Office of the Inspector General's (OIG)'s "Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons (BOP) Institutions" (Deaths in Custody report), which we released earlier this month.

Before turning to the Deaths in Custody report, it is important to put its findings into a broader context, and to emphasize the recurring, chronic nature of many of the issues we identified. I have been the Inspector General at the Justice Department for almost 12 years, and every year I have included the BOP in my annual report of the top management and performance challenges facing the Department. Yet, with some notable exceptions, the problems at the BOP have generally increased over the years. Indeed, last year, the Comptroller General for the first time added the BOP to the Government Accountability Office's (GAO) high-risk list due to its "long-standing challenges with **managing staff** and **resources**, and **planning and evaluating programs t**hat help incarcerated people successfully return to the community."

To be clear, **these are not new problems,** but rather problems that are over a decade in the making. In that vein, yesterday the OIG released a compendium of 117 primarily non-investigative reports and other OIG products that we have publicly issued since 2002 detailing the OIG's extensive oversight of the BOP's programs and operations, and reflecting the systemic challenges at the BOP that have significantly increased over the past two decades.

The compendium organizes these oversight products into four themes:
(1) the **Safety and Security** of BOP Institutions,
(2) the **Health and Welfare of Inmates**,
(3) **Staffing and Inmate Management Programs**, and
4) **Cost Management.**
These oversight products have identified recurring issues that impede the BOP's efforts to consistently ensure the health, safety, and security of all sta8 and inmates within its custody. The OġG' Deaths in Cus Custody report is a continuation of the OġG's extensive BOP oversight work.

In **the OIG's 2023** Limited-Scope Review of the Federal Bureau of Prison's Strategies to Identify Communicate and Remedy Operational Issues (Limited Scope review), we provided a high-level overview of some of the foundational challenges currently facing the BOP. We highlighted long-standing failures in four areas, with recommendations to address:
(1) staffing challenges,
(2) a crumbling infrastructure,
(3) deficiencies in the BOP's internal audit function, and
(4) an ineffective staff disciplinary process.
Many of the homicides, suicides, and overdoses we reviewed in the Deaths in Custody report have a direct connection to one or more of these long-standing, systemic challenges.

As our continuing BOP oversight and investigative work demonstrates, these issues are interrelated. We have consistently seen how understaffed prisons with overburdened employees create security and safety issues. And the recruitment and retention of competent staff becomes increasingly difficult when the facilities where they work are, in many instances, literally falling apart. Yet, as we have noted in multiple reports, including the OIG's 2023 Audit of the Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions (BOP Infrastructure Report), the BOP has not had a comprehensive plan to fix, or even maintain, its aging institutions, which also has limited its ability to sufficiently identify and request funding through the budget process. And, as our Limited Scope review confirmed, the BOP's various internal audit and inspection functions often do not identify institutional failures, compounding problems that could potentially be remedied with less cost if identified sooner.

Additionally, holding staff accountable for criminal and administrative misconduct is a critical part of improving the safety and security of BOP institutions for both inmates and the overwhelming majority of BOP employees who do their jobs every day with honesty and integrity. Yet we have found that an ineffective staff disciplinary process can create safety and security issues and exacerbate staffing challenges by failing to hold individuals accountable for egregious misconduct.

The sexual assault of inmates by BOP personnel continues to be a top challenge for the Department and the BOP, and the OIG continues to dedicate significant investigative resources to these cases. That is why I was pleased when the Deputy Attorney General convened an important working group to review the BOP's and DOJ's response to sexual misconduct by DOJ personnel; in November 2022, the Working Group issued a Report that contained numerous recommendations and reforms, which the OIG supports. The need for these reforms is exemplified by our ongoing investigative efforts at Federal Correctional Institution (FCI) Dublin, where the Warden, Chaplain, and other staff have been convicted on sex abuse charges. Our **FCI Dublin** investigation has shown what happens when misconduct is not timely identified and addressed, and instead spirals and poisons the culture at an institution.

Indeed, the failure to address the rampant proliferation of contraband into USP Atlanta, including dozens of cell phones and large amounts of drugs, prompted the BOP to partially close that institution in 2021, shortly after an inmate died by suicide while under the influence of methamphetamine. **As our Deaths in Custody report notes, USP Atlanta had the highest number of deaths** during the time period of our evaluation. And, as we noted in our BOP Infrastructure Report, the failure to effectively maintain Metropolitan Correctional Center (MCC) New York resulted in BOP having to close it because the substantial building deficiencies jeopardized the safety and security of the staff and inmates.

Relatedly, we are conducting an audit of the BOP's use of restraints that was prompted in large part by allegations that inmates in the Special Management Unit (SMU), a type of restrictive housing, at **U.S. Penitentiary (USP) Thomson were r**
1. routinely placed in four-point restraints for extended periods of time, so
2. sometimes even days, and otherwise mistreated while restrained.

In 2023, in response to these and other allegations of misconduct, as well as a series of deaths at the facility, several of which we reference in our Deaths in Custody report, **Director Peters closed the SMU at USP Thomson.** The BOP acknowledged significant concerns with the institutional culture at USP Thomson and a lack of compliance with its own policies. The OIG had previously identified concerns in the BOP's administration of the SMU at USP Lewisburg and recommended in our 2017 report on the BOP's Use of Restrictive Housing for Inmates with Mental Illness that the BOP "conduct a comprehensive review of [USP] Lewisburg's [SMU] that addresses the staffing, treatment, conditions of confinement, and performance metrics of the program." That OIG recommendation was open when the **BOP began transitioning the SMU from USP Lewisburg to USP Thomson in 2018,** and it remains open today, nearly 7 years after our report's publication, underscoring the range of serious issues that can arise with the BOP's use of this type of restrictive housing. As is clear from our oversight work, these problems –from understaffing and aging infrastructure to safety, security, and contraband threats – will continue to surface and re-surface if left unaddressed.

While the BOP has generally been responsive to our findings and recommendations, numerous important recommendations remain open, including the SMU-related recommendation from our 2017 Restrictive Housing report and five other recommendations from that same 2017 report, including two concerning the BOP's use of single-cell confinement. Further, high-priority recommendations addressing issues that we identified 8 years ago regarding the BOP's searching of staff entering BOP facilities to preempt contraband introduction and the BOP's security camera system upgrades remain open. We will continue to push the BOP to finalize changes to address these important areas. Full implementation of the OIG's recommendations, in addition to the GAO's staffing-related and other open recommendations, are the building blocks to begin to address the chronic challenges facing the BOP.

To further enhance our oversight of the BOP, last year we launched our unannounced inspections of BOP facilities, as well as creating a BOP interdisciplinary oversight team at the OIG, which was made possible because of the support our office received from the Judiciary and Appropriations Committees.

Under our **unannounced inspection protocol,** we typically provide an institution's warden 4-hour notice of our plan to begin a multiday inspection of the institution. We have already completed four inspection site visits – three last year at **FCI Waseca, FCI Tallahassee, and FCI Sheridan, and one earlier this month at USP Lewisburg.** Our reports on FCI Waseca and FCI Tallahassee – including an extensive collection of photographs documenting our findings – can be found on our website and in the compendium that I mentioned earlier. We anticipate publicly releasing reports of our findings at FCI Sheridan and USP Lewisburg in the coming months.

As we noted in our FCI Waseca and FCI Tallahassee reports, the problems we identified were glaring and disturbing. For example, at **FCI Waseca, we found serious infrastructure issues that significantly impact staff and the conditions of inmate confinement.** We observed roofs in serious disrepair, that routinely leaked, had caused damage to facilities, and needed immediate repair. Notwithstanding the evident nature of these problems, we found that these repairs remain unaddressed due to the BOP's lack of a well-defined infrastructure and budgeting strategy to address what the **BOP currently estimates to be a more than $3billion backlog in major repair projects** across institutions. We also observed inmates living in basements, with some inmate bunk beds positioned in very close proximity to pipes that occasionally leaked and were covered in plastic to control the leaking. Following our inspection, the BOP took action to relocate inmates from top bunks in close proximity to pipes to other areas of the institution. We also found at

FCI Waseca
that significant **Correctional Officer** and
healthcare staffing shortages have had a cascading effect on institution operations, and that,

because of Correctional Officer shortages, **FCI Waseca** routinely uses overtime, which can negatively affect staff morale and attentiveness and, therefore, institution safety and security. Further, these **staffing shortages have required the institution to temporarily reassign non-Correctional Officer staff to work in Correctional Officer posts** (a practice **known as augmentation**), **negatively affecting the ability of these non- Correctional Officers to conduct their routine duties,** which include performing maintenance and teaching inmate programs, including First Step Act programs. And, as we know from our past work, augmentation is a long-standing and widespread problem for the BOP. We also observed the challenges the institution has had in preventing contraband from entering the facility.

At FCI Tallahassee, our inspection also identified, among other things, serious staffing shortages, substantial infrastructure problems, and contraband issues. Once again, we saw a facility with significant Correctional Officer shortages resulting in **large amounts of overtime and augmentation.** Additionally, we observed **Health Services Department staff shortages** that are negatively affecting inmate healthcare treatment. We found that these staff shortages have caused staff to modify the time of day it distributes insulin and drugs to female inmates, which may limit the therapeutic benefit of these drugs for certain inmates. Separately, we observed a **healthcare provider failing to ask required questions during inmate intake** screenings and omitting guidance on how to access healthcare services. Further, like at FCI Waseca, we observed buildings that were in serious disrepair, with damaged roofs and leaking windows, causing female inmates to use feminine hygiene products to try to control the leaks. We also saw how damaged infrastructure can be exploited by inmates to hide contraband or create dangerous weapons. Additionally, we identified extraordinarily **serious issues with the Food Service** Department; this included moldy bread being served to inmates as well as discolored and rotting vegetables in a food preparation refrigerator at the female prison. In the food storage warehouses, we found what appeared to be **rodent droppings, as well as bags of cereal with insects in them** and warped food containers.

The glaring, serious issues identified in these unannounced inspections reinforce the need for the BOP to act quickly to address the weaknesses in its internal audit and review functions, and to implement the 10 recommendations from the OIG's 2023 Audit of the Federal Bureau of Prisons' Contract Awarded to the American Correctional Association (ACA). In that audit, we found that, although the BOP contracts with the ACA to accredit and reaccredit its institutions, the ACA process was reliant on the BOP's own problematic internal reviews and therefore raised concerns regarding ACA's third-party independence, and that because of this the process did not valuably enhance BOP's operations and programs.

National attention to the BOP's operation and management challenges followed from the high-profile deaths of BOP inmates James "Whitey" Bulger in 2018 and of Jeffrey Epstein in 2019. In June 2023, the OIG issued an investigative report on the custody, care, and supervision of Epstein, which identified numerous and serious failures by Metropolitan Correctional Center New York staff, including that staff did not assign Epstein a cellmate as directed by the institution's Psychology Services Department. The report also found that staff failed to undertake required measures designed to ensure that Epstein and other inmates in restrictive housing were accounted for and safe, such as conducting inmate counts and 30-minute rounds; searching inmate cells; and ensuring adequate supervision of the housing unit, as well as the security camera system functionality.

In December 2022, the OIG issued an investigative report on the circumstance[illegible]rounding the transfer and subsequent homicide of Bulger, finding serious job performa[illegible]id management failures at multiple levels within the BOP. Those failures included p[illegible]olonged single-cell confinement in restrictive housing, the transfer of Bulger to a facility with a lower level of medical care (USP Hazelton) than his prior facility without adequate consideration of

his medical records, and shortcomings in communication among BOP personnel regarding the transfer process. The OIG concluded that staff and management performance failures; bureaucratic incompetence; and flawed, confusing, and insufficient policies and procedures pose risks not just to notorious offenders like Bulger but to all inmates in the midst of a facility transfer.

In addition to concerns over these high-profile incidents, Members of Congress, including the Chairman, and prisoner advocacy groups have expressed concern about the BOP's efforts to prevent inmates' deaths. Based on these and other concerns, the OIG initiated its Deaths in Custody review. The results of that review are summarized below.

As the committee is aware, the OIG released our Deaths in Custody report on February 15, 2024. The OIG initiated this evaluation to assess the circumstances surrounding deaths among inmates at BOP institutions that occurred from FY 2014 through FY 2021 and to evaluate how the BOP seeks to prevent future deaths. We analyzed the frequency and pattern of deaths among the BOP inmates in four categories: (1) suicide, (2) homicide, (3) accident, and (4) those resulting from unknown factors. We also identified potential management deficiencies and systemic issues related to those deaths, including the prevalence of long- standing operational challenges highlighted in prior OIG work.

Factual Findings

Our review of records provided by the BOP identified a total of 344 inmate deaths at BOP institutions from FY 2014 through FY 2021 in the four categories I just mentioned: **suicide, homicide, accident, or unknown factors**. **Suicides comprised the majority** of these deaths, with **homicides the next** most prevalent. Many of the deaths that occurred under accidental or otherwise unknown circumstances involved drug overdoses. We identified several operational and managerial deficiencies, which created unsafe conditions prior to and at the time of these deaths, that the BOP must address. We also identified recurring conditions following an inmate's death that limited the BOP's ability to identify measures that would help minimize future risks to inmates in its custody.

Results of the Evaluation

Suicide *Represents a Significant Risk Area for BOP, Which the BOP Can Help Mitigate through Compliance with Existing Policies*

Suicide accounted for just over half of the 344 inmate deaths that we reviewed, and more than half of those who died by suicide were in single-cell confinement, or housed alone in a cell. **Multiple BOP policies** – in areas such as **identifying potentially suicidal inmates**, managing **inmate medication**, and making inmate housing decisions -- may help staff mitigate certain risks associated with inmate suicide. However, we found that a combination of recurring policy violations and operational failures contributed to inmate suicides. Specifically, deficiencies in staff completion of inmate assessments have prevented some institutions from adequately identifying and proactively addressing inmate suicide risks. We also found numerous instances of potentially **inappropriate Mental Health Care Level assignments** for some inmates who later died by suicide. In addition, almost half of the suicides occurred in a restrictive housing setting, where about 8 percent of inmates across the BOP were housed as of August 2018. The BOP has recommended against single-celling, noting that it increases the risks of inmate suicide, and **OIG reports have raised concerns** with the BOP's single-celling of inmates, including those in restrictive housing.

Further, while existing **BOP policies direct institutions to**

1. **train staff on identifying signs** of suicide,
2. **make appropriate referrals** when staff identify suicidal inmates, and
3. provide appropriate counseling and treatment, w
4. we found that some institution sta8 failed to communicate with each othe and
5. coordinate e8orts across departments t provide necessary treatment or follow-up with inmates in in distress.

We also found that staff did not sufficiently conduct required inmate rounds or counts in over a third of the inmate suicides during our scope. Finally, while the BOP requires institutions to conduct mock drills to prepare staff to respond to a potential suicide, we found that the BOP was unable to provide evidence that most of its facilities met this requirement. These deficiencies helped foster conditions in which inmates were able to advance their suicidal ideation and created increased opportunities for them to die by suicide.

The BOP's Response to Medical Emergencies Was Often Insufficient *Due to Lack of Clear Communication, Urgency, or Proper Equipment*

To properly respond to high-stress, extraordinary inmate emergency situations such as inmate hanging, attempted homicide, or drug overdose, **BOP staff must be prepared to follow correct protocols** and use proper, easily accessible, functioning equipment. Mere seconds in response time can potentially mean life or death for an afflicted inmate. While multiple staff we interviewed generally believed that staff responded quickly to emergencies, we found significant shortcomings in BOP staff's emergency responses to nearly half of the inmate deaths that we reviewed, ranging from a lack of urgency in responding, failure to bring or use appropriate emergency equipment, unclear radio communications, and issues with naloxone administration in opioid overdose cases. Improvements in these areas would help prepare BOP personnel to address future inmate emergency scenarios.

A ***Lack of Available Information About Inmate Deaths*** *Limit the BOP's Ability to Potentially* ***Prevent*** *Future Inmate Deaths*

BOP policies and procedures require certain actions and reports in the event of an inmate death. However, for many of the inmate deaths we reviewed, we found that the BOP was unable to produce documents required by its own policies. Moreover, the BOP requires in-depth After Action Reviews only following inmate suicides; it does not require them for inmate homicides or deaths resulting from accidents and unknown factors.

Together, **these factors limit the BOP's ability to** fully understand the circumstances that led to inmate deaths and to identify steps that may **help prevent future deaths.** To better enable it to identify and address issues surrounding inmate deaths in these circumstances, the BOP must improve its completion and organization of the mandatory records currently required by policy for all inmate deaths. Further, we believe the BOP should conduct After Action Reviews not only for suicides, but also for inmate deaths due to homicide and accident or unknown factors to help it better understand the circumstances surrounding these deaths and potentially prevent future inmate deaths.

In addition, we found that, even when the BOP obtains insights on contributing factors and recommendations for improvement following an inmate's death, the impact of that information is curtailed by the decentralization of the BOP's processes. We believe that the BOP should assess this information more broadly and consistently to help identify, track, and address recurring factors and challenges that may contribute to deaths among inmates in its custody.

Long-standing Operational Challenges, Such as ***Contraband*** *Interdiction, Further* ***Impair the BOP's Ability to Reduce the Risk of Inmate Deaths***

As I noted in the first half of this statement, the OIG has repeatedly identified long-standing operational challenges, including contraband interdiction, that negatively affect the BOP's ability to operate its institutions safely and securely, some of which may increase the risk of inmate deaths.

We found that, in nearly one-third of the inmate deaths in our scope, contraband drugs or weapons contributed, or appeared to contribute, to the death, including 70 inmates who died from drug overdoses. Other operational challenges include staffing shortages, including for both physical and mental healthcare; an outdated security camera system; staff failure to follow BOP policies and procedures; and an ineffective, untimely staff disciplinary process. One or more of these challenges was a contributing factor in many of the inmate deaths in our scope, and these long-standing challenges continue to present a significant and critical threat to the BOP's safe and humane management of inmates in its care and custody.

We made **12 recommendations** to assist the BOP in addressing risk factors that contribute to inmate deaths.

1. Develop strategies to ensure that staff assign accurate, consistent, and timely Mental Health Care Level designations to inmates.
2. Ensure that all institutions conduct required mock suicide drills and develop strategies to increase staff participation in those drills.
3. Ensure that all appropriate staff are trained in automated external defibrillator use and that automated **external defibrillators are strategically placed, readily available, and regularly checked** to ensure that they are in working order at each BOP institution.
4. Ensure that cut-down tools in working order are accessible to staff in each housing unit at each institution, that staff are trained on proper use of the tool, and that the BOP determines whether staff should be issued and required to keep their own cut-down tool on their duty belts during their entire shift.
5. Ensure that each institution has a sufficient number of maneuverable gurneys in strategic locations to provide proper medical response during inmate transport.
6. Issue standard, enterprise-wide guidance and training to staff on using the radio to communicate clear, descriptive information during inmate medical emergencies.
7. Ensure that staff receive both the **initial and refresher naloxone training** and are fully prepared to administer naloxone to an unresponsive inmate suspected of having experienced a drug overdose.
8. Ensure that all Evidence Recovery Teams are properly trained on post-incident evidence recovery protocols.
9. Develop procedures to ensure that all required death-related records are completed and collected consistently and in accordance with established deadlines.
10. Assess the benefit and feasibility of expanding its policy requiring After Action Reviews to include reviews of all inmate homicides and deaths by accidental and unknown factors, not just for inmate suicides.
11. Clarify responsibility for tracking at an enterprise level the reports and recommendations required in the wake of an inmate death by suicide, homicide, accident, or unknown factors, and assess the information contained therein for broader trends, applicability, and implementation.
12. Evaluate existing electronic devices used for inmate screening to identify whether they are functioning as intended, and, if necessary, implement any needed adjustments or upgrades.

The BOP concurred with each of our recommendations. Consistent with our oversight responsibilities, we intend to carefully monitor the BOP's implementation of the recommendations to ensure the BOP fully addresses the issues we identified.

Conclusion

Effectively addressing these widespread, systemic issues at the BOP that the OIG has identified through our oversight work over the past two decades requires a long-term vision and strategy from BOP and Department leadership, with support from the Office of Management and Budget, Congress, and other important stakeholders.

To be clear, the problems that we have identified in our oversight work over the past 20 years, as detailed in the compendium we released yesterday, **will not be solved overnight**, but they **must be addressed with urgency to protect the health, safety, and security of BOP staff and inmates,** and to enable inmates to successfully return to our communities upon their release from prison.

Toward that end, Director Peters and I meet quarterly to discuss the wide variety of issues and challenges that the OIG's oversight work is identifying, as well as our open recommendations,

the first time in my almost 12 years as Inspector General that a BOP Director has committed to regular oversight-focused meetings with me. The OIG will continue to conduct our oversight, as well as to closely monitor the BOP's implementation of our recommendations, to ensure that reforms are taking place at the BOP. I also look forward to continuing to work with this Committee and other Congressional stakeholders as you perform your critical oversight and legislative efforts.

I war ee for its support for our mission and for the opportunity to testify on this impc leased to answer any questions you may have.

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