Federal Prisons:
Improved Reviews of Natural Deaths and Communications with Families Needed

GAO-27-108744

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Fast Facts

From 2016-2025, about 3,000 people died from natural causes while in the custody of the Federal Bureau of Prisons.

The Bureau must investigate most deaths and notify family members, including sharing the circumstances surrounding the death. But it doesn't define what it means by circumstances of a death—so Bureau staff didn't always know what information to share with families.

Additionally, the Bureau may identify issues during an investigation that contributed to a death, like delayed medical appointments. But it doesn't always track those issues or if they were resolved.

Our recommendations address such concerns.

NPR: There is little scrutiny of 'natural' deaths behind bars

Autopsies are not required for federal prison deaths that are classified as natural. NPR found cases where medical neglect, poor prison conditions and a lack of resources contributed to these deaths. But families were given little information.

January 2, 20245:00 AM ET
Heard on Morning Edition, By Tirzah Christopher

Federal Bureau of Prisons (BOP) policies do not automatically require an autopsy for every death classified as "natural," though wardens have authority to order one in cases of fatal illness or unexplained death

Key Factors in BOP Autopsy Determinations
• Warden Authority (PGRGRAM STATEMENT (NEW) 2026: 28 C.F.R. § 549.80): Wardens can mandate autopsies or medical evaluations for unexpected, accidental, suicidal, homicidal, or otherwise unexplained deaths to investigate crimes, ensure safety, or address potential liability

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U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

PROGRAM STATEMENT
Autopsies

Approved by	William K. Marshall III Director, Federal Bureau of Prisons
DPI	HSD
Number	6080.02
Date	May 7, 2026

Summary of Changes

Program Statement Rescinded:

- 6080.01 Autopsies (5/27/1994)

Changes:

- Language was updated to "post-mortem forensic tests" to encompass both autopsy and toxicology testing.
- The purpose of the document was widened to include the process of ordering, procuring, and storing post-mortem forensic test reports.
- A Definitions section was added to help clarify concepts.
- Language was strengthened around the purpose and benefits of ordering post-mortem forensic tests.
- Language was strengthened around the Warden consulting with the Clinical Director on a recommendation related to ordering post-mortem forensic tests.
- Toxicology testing is recommended even if an autopsy is deemed unnecessary.
- A reference Wardens may use to authorize post-mortem forensic tests was added to the BP-A0797, Autopsy and Toxicology Authorization form.
- A recommendation for the expanded/comprehensive toxicology test to be ordered, versus a basic panel, has been added.
- Post-mortem toxicology tests should be performed by a coroner or medical examiner and not be performed at Bureau of Prisons facilities.
- Alternatives to next-of-kin notification or response telegram notification are broadened and clarified, including fax, letter, or email communication.
- The responsibility for adhering to state laws regarding mortality reporting has shifted from the Health Services Administrator to the Warden or designee.
- States may vary in their mandatory mortality reporting requirements, and additional language was added to this effect to emphasize the importance of familiarity with one's state laws on this topic.

1. **PURPOSE AND SCOPE**

To prescribe the decision-making authority of Bureau of Prisons (Bureau) personnel to order post-mortem forensic tests, including autopsies and toxicology testing, and to describe the process of ordering, procuring, and storing post-mortem forensic test reports.

An autopsy examination is ordinarily done in the interest of practicing a high standard of medicine and given the high civil liability associated with work in a correctional environment. 18 USC 4045 authorizes the Bureau broad discretion to order an autopsy as defined in situations outlined in Sections 2.a. and 2.b. of this program statement.

a. **Program Objectives.**

- Staff will receive the knowledge needed for their current positions, as well as for professional growth and advancement.

b. **Institution Supplement.** None.

c. **Definitions.**

- **Cause of death.** The underlying condition, disease, or injury that leads to a mortality.
- **Expected death.** The death of an individual who is diagnosed with a terminal illness or condition and whose health status, based on current medical knowledge, is not expected to improve but likely deteriorate. The illness or condition is expected to be fatal within a reasonable period, and the determination is supported by the individual's treatment record and course of treatment.
- **Manner of death.** A classification of the circumstances surrounding a mortality (e.g., natural, accidental, suicide, homicide).
- **Post-mortem forensic testing.** Studies such as autopsy and toxicology performed following a mortality to help determine the circumstances and cause of death.
- **Unexpected death.** A death that was not the result of a known and documented terminal illness or condition and was not anticipated until the onset of the acute terminal episode.

2. **§ 549.80 Authority to conduct autopsies.**

(a) The Warden may order an autopsy and related scientific or medical tests to be performed on the body of a deceased inmate of the facility in the event of homicide, suicide, fatal illness or accident, or unexplained death. The autopsy or tests may be ordered in one of these situations only when the Warden determines that the autopsy or test is necessary to detect a crime, maintain discipline, protect the health or safety of other inmates, remedy official misconduct, or defend the United States or its employees from civil liability arising from the administration of the facility.

Post-mortem forensic testing provides additional insight into the conditions that lead to mortality. When the cause of death is not clear, this additional information is particularly important in determining the immediate and underlying causes. Given the communal risks inherent to a correctional environment, post-mortem forensic testing can assist in understanding causes of death and preventing future deaths in a correctional setting.

The Warden will consult with the Clinical Director for an autopsy recommendation for any death related to medical conditions, including unexpected deaths and deaths of unknown cause. Circumstances are rare in which both the manner of death and cause of death are certain in the absence of an autopsy. The Clinical Director's expertise will assist the Warden in determining the need for an autopsy, which could uncover contributing factors and/or previously undiagnosed medical conditions.

In addition to the autopsy and under the category of "related scientific or medical tests," in consultation with the Clinical Director, Wardens will order post-mortem toxicology tests, even if a complete autopsy is determined to be unnecessary. These tests assist in the identification of illegal or legal drugs, alcohol, or other chemicals or substances that may have contributed directly to the death or indirectly to the circumstances surrounding the death (e.g., ingestion of illicit substances that altered behavior and contributed to a homicide or suicide). Given that many new and evolving illicit drugs may be contributory to a mortality, the expanded/comprehensive toxicology panel is recommended (versus a more basic toxicology panel). A BP-A0797, Autopsy and Toxicology Authorization form will be utilized for the Warden to document the authorization of post-mortem forensic tests. Post-mortem toxicology tests are performed by the local jurisdiction's medical examiner or coroner and must not be collected at the Bureau facility, as this would constitute a violation of an inmate's right to consent and could interfere with forensic evidence collection.

(1) The authority of the Warden under this section may not be delegated below the level of Acting Warden.

(2) Where the Warden has the authority to order an autopsy under this provision, no non-Bureau of Prisons authorization (e.g., from either the coroner or from the inmate's next-of-kin) is required. A decision on whether to order an autopsy is ordinarily made after consultation with the attending physician, and a determination by the Warden that the autopsy is in accordance with the statutory provision. Once it is determined that an autopsy is appropriate, the Warden shall prepare a written statement authorizing this procedure. The written statement is to include the basis for approval.

While next-of-kin permission is not required in these circumstances, an attempt should always be made to inform the next-of-kin. The autopsy and any necessary forensic tests will proceed with or without the next-of-kin's consent, but if the next-of-kin does not desire testing, the Warden's statement will note that the attempt was made to explain rationale for testing.

(b) In any situation other than as described in paragraph (a) of this section, the Warden may order an autopsy or post-mortem operation, including removal of tissue for transplanting, to be performed on the body of a deceased inmate of the facility with the written consent of a person (e.g., coroner, or next-of-kin, or the decedent's consent in the case of tissue removed for transplanting) authorized to permit the autopsy or post-mortem operation under the law of the State in which the facility is located.

Requirements for posthumous organ donation are addressed in Program Statement **Patient Care**.

(1) The authority of the Warden under this section may not be delegated below the level of Acting Warden.

(2) When the conducting of an autopsy requires permission of the family or next-of-kin, the following message is to be included in the telegram notifying the family or next-of-kin of the death: "Permission is requested to perform a complete autopsy". Also inform the family or next-of-kin that they may telegraph the institution *collect* with their response. Where permission is not received from the person (e.g., coroner or next-of-kin) authorized to permit the autopsy or post-mortem operation, an autopsy or post-mortem operation may not be performed under the conditions of this paragraph (b).

In addition to telegram (telephonic) notification, any dated method of electronic or written communication, such as fax, letter, or email, would be acceptable for next-of-kin notification or their response.

(c) In addition to the provisions of paragraphs (a) and (b) of this section, each institution also is expected to abide by the following procedures.

(1) Staff shall ensure that the state laws regarding the reporting of deaths are followed.

The Warden is responsible for ensuring adherence to state laws requiring reporting of deaths but may delegate notification responsibilities to others as outlined in Program Statement **Escapes/Deaths Notifications**.

Notification to the medical examiner or coroner is ordinarily made by the Warden or designee, as outlined by Program Statement **Escapes/Deaths Notifications**, and the responsibilities and process should be clearly outlined in the Institution Supplement covering procedures for serious illness, serious injury, and death, as required by Program Statement **Patient Care**. Some states require post-mortem forensic testing on all inmate deaths and may require an independent medical examination for all deaths occurring while in law enforcement custody.

(2) Time is a critical factor in arranging for an autopsy, as this ordinarily must be performed within 48 hours. While a decision on an autopsy is pending, no action should be taken that will affect the validity of the autopsy results. Therefore, while the body may be released to a funeral home, this should be done only with the written understanding from the funeral home that no preparation for burial, including embalming, should be performed until a final decision is made on the need for an autopsy.

The Warden will determine the best method for disposition of the body prior to an autopsy. Unless otherwise directed by the Warden under this rule, the disposition of a body within a Bureau facility should be clearly outlined in the Institution Supplement covering procedures for serious illness, serious injury, and death, as required by Program Statement **Patient Care**.

(3) Medical staff shall arrange for the approved autopsy to be performed.

(4) To the extent consistent with the needs of the autopsy or of specific scientific or medical tests, provisions of state and local laws protecting religious beliefs with respect to such autopsies are to be observed.

In cases where an autopsy is determined to be necessary, the institution will consult with the chaplains in the local Chaplaincy Services department to identify any relevant religious considerations. The Supervisory Chaplain, or designee, will provide a written recommendation to the Warden. If the local Chaplaincy Services department does not include a Subject Matter Expert (SME) within the deceased inmate's documented religious preference, the Warden will consult the Central Office Chaplaincy Services Branch. The Chaplaincy Administrator, or designee, will then consult with an SME within the deceased inmate's stated religious preference, and provide a written recommendation to the requesting Warden.

3. RECORDKEEPING

All post-mortem forensic documentation, including autopsy and toxicology reports, will be scanned or uploaded into the inmate's electronic health record, in a readily retrievable manner, in accordance with Program Statement **Health Information Management**.

For all deaths in Bureau facilities, Health Services Division maintains a mortality file for the length of time required by the current Records and Information Disposition Schedule (RIDS).

Copies of post-mortem forensic test reports (if applicable), to include any autopsy, toxicology and/or other tests/pathology, and copies of death certificates for all deaths in Bureau facilities, will be provided to the Population & Correctional Health Branch, Health Services Division, as required in Program Statement **Health Services Quality Management**.

REFERENCES

Program Statements
Escapes/Deaths Notifications
Health Information Management
Health Services Quality Management
Patient Care

Bureau Forms Prescribed by XXXX.XX
BP-A3797 Autopsy and Toxicology Authorization

Federal Statutes
18 USC 4045

Federal Regulations
28 CFR 549.80

ACA Standards
Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ACI-6C-16

Performance-Based Standards and Expected Practices for Adult Correctional Institutions (5th Edition): 5-ALDF-4D-30

Records Retention Requirements
Requirements and retention guidance for records and information applicable to this program are available in the Records and Information Disposition Schedule (RIDS) on the Bureau's intranet site.



Source: Gorodenkoff/stock.adobe.com.

Highlights

What GAO Found

The Federal Bureau of Prisons (BOP) reported that about 3,000 people died from natural causes while in its custody in fiscal years 2016 through 2025. GAO reviewed death investigation records for the natural deaths in BOP custody in fiscal year 2024. The documents showed that BOP identified health care deficiencies in 45 percent of these deaths, and that some of these deficiencies contributed to the natural deaths. BOP identified deficiencies such as delayed offsite medical appointments, failures to order necessary medical tests, and shortcomings in emergency responses.

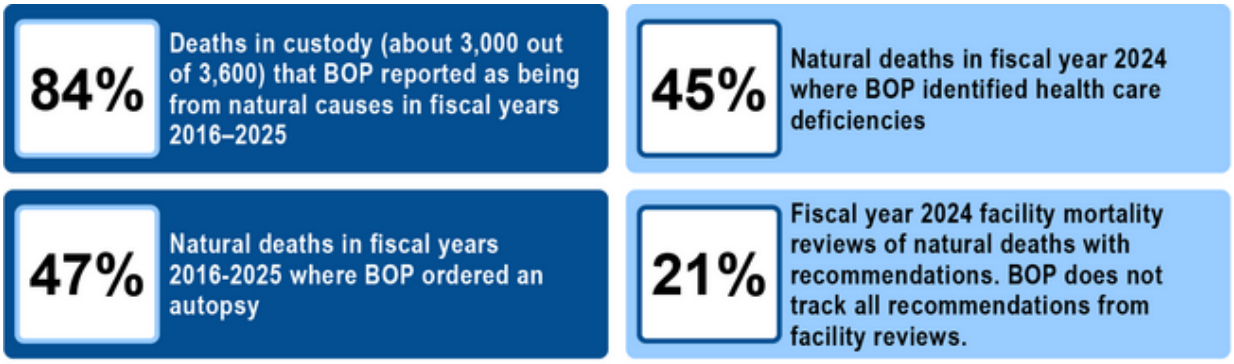
After a death in custody, BOP requires staff to notify the decedent's emergency contacts and next of kin. However, BOP could not confirm how many of these individuals received such notifications because it did not require that staff document (nor require that BOP management monitor) that these notifications took place. To help address this issue, in May 2026, BOP began requiring staff to document attempts to notify next of kin. However, BOP did not require staff to

document attempts to notify emergency contacts or require management to monitor notifications. By taking these steps, BOP management can better ensure that emergency contacts and next of kin receive notifications.

BOP policy requires staff to share the circumstances surrounding a death with the emergency contacts and next of kin. However, BOP policy does not define what is meant by circumstances surrounding a death, and as a result, staff do not have a consistent understanding of what information to share during death notifications. In addition, GAO found that staff do not always share this information even when it is immediately available or when it becomes available later. Monitoring whether staff share the circumstances, and better defining circumstances surrounding a death for staff, would reduce the risk that families will not receive this consequential information from BOP.

BOP policy requires staff to investigate every death that occurs in BOP facilities, excluding legal executions. However, GAO found that BOP does not record all recommendations resulting from these investigations or whether a facility has implemented them. Doing so would give BOP a more complete picture of deficiencies in its health care delivery and enhance its ability to analyze and address deficiencies, while potentially reducing the government's liabilities.

GAO Findings from Bureau of Prisons (BOP) Investigations of Natural Deaths in Custody



Source: GAO analysis of BOP data and documents. | GAO-27-108744

Why GAO Did This Study

Federal law enforcement agencies reported that nearly 4,000 people died in their custody in fiscal years 2016 through 2023. Most of these deaths were reported by BOP (85 percent). BOP is responsible for the care and custody of about 155,000 incarcerated people.

GAO was asked to review BOP's efforts to investigate natural deaths in custody and notify families of these deaths. This report examines what BOP data show about people who died in BOP custody (i.e., in its facilities) from natural causes in fiscal years 2016 through 2025; what deficiencies in care BOP identified that contributed to natural deaths; the extent to which BOP ensures facilities notify families consistently and in a timely manner; and the extent to which BOP investigated natural deaths in its custody.

GAO reviewed BOP policies and documents, and BOP data on deaths in custody. In addition, GAO selected three BOP facilities and interviewed their leadership and staff. GAO selected locations based on variation in the type of facility (penitentiaries versus medical centers) and number of natural deaths. GAO also interviewed BOP headquarters officials responsible for overseeing death investigations and family notifications.

Recommendations

GAO is making 13 recommendations to DOJ, including to ensure BOP tracks and monitors family notifications, defines and monitors the sharing of circumstances surrounding a death, and records all recommendations from death investigations. BOP concurred with our recommendations.

Recommendations for Executive Action

Agency Affected	Recommendation	Status
Department of Justice	The Attorney General should ensure the BOP Director clarifies whom staff are to contact during the initial notification phone call following a death in custody. (Recommendation 1)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will

Agency Affected	Recommendation	Status
		provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director issues guidance on how staff are to locate the next of kin. (Recommendation 2)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director directs staff to track notifications to both emergency contacts and next of kin after an in custody death—including the time and method of notification, as well as unsuccessful and successful attempts to make contact. (Recommendation 3)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director directs management to monitor staff compliance with this requirement to document attempts to contact emergency contacts and next of kin following a death in custody. (Recommendation 4)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.

Agency Affected	Recommendation	Status
Department of Justice	The Attorney General should ensure the BOP Director defines the phrase "circumstances surrounding a death" included in the Bureau's family notification policy. (Recommendation 5)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director monitors whether the circumstances of a death in custody are shared with emergency contacts and next of kin. This includes monitoring whether information is immediately shared with emergency contacts and next of kin, when possible, or shared at a later date when the information becomes available. (Recommendation 6)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director develops an information-sharing mechanism that includes guidance and resources to help inform families about BOP processes following a death in custody. (Recommendation 7)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director takes	Open

Agency Affected	Recommendation	Status
	steps to better assist families in obtaining medical records after the death of an individual in custody. (Recommendation 8)	BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should direct the BOP Director to develop and implement a corrective action plan that addresses the root causes of facility mortality reviews not being completed within the timeframes required by BOP policy or the timeframes required by a waiver. (Recommendation 9)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure that the BOP Director records recommendations from facility mortality reviews and whether a facility has implemented them. (Recommendation 10)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director updates its standard operating procedures for a recurring bureau-wide trend analysis of deaths in custody, to include procedures for identifying	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions

Agency Affected	Recommendation	Status
	nationwide patterns in deficiencies and issuing recommendations. (Recommendation 11)	BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director tracks when a warden requests an autopsy and whether the request is denied by a state or local authority. (Recommendation 12)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.
Department of Justice	The Attorney General should ensure the BOP Director issues guidance to clarify that facilities may pursue an autopsy if a request is denied by a state or local authority, including guidance about possible actions facilities may take after a denial. (Recommendation 13)	Open BOP concurred with this recommendation and said it would take steps to implement it. When we confirm what actions BOP has taken in response to this recommendation, we will provide updated information.

See All 13 Recommendations

Full Report

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Accessible PDF (69 pages)

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