LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Violations Across the Federal Bureau of Prisons

Reporting Period: November 17–December 1, 2025

The Loved Ones Coalition submits this Oversight Report to document current conditions inside the Federal Bureau of Prisons — not rumors, not recycled stories, but the real-time testimony coming in daily from families, incarcerated individuals, and cooperating staff.

In the last two weeks, federal leadership has shown a level of transparency we have never seen before — sitting down with us, hearing our concerns directly, responding with public videos the next day, and keeping communication open. The Support Coordinators' Office continues to step up, act on cases, and build trust with families who have been ignored for years.

That is what change at the top looks like.

But here's the truth:

Change at the top does not stop the violence, corruption, and collapse playing out on the ground.

Inside the facilities, the culture has not shifted.

Every day we are getting reports from people who should already be home but can't get a case manager to show up for work. People who can't afford a prison consultant — and shouldn't need one — because unit team staff refuse to follow federal directives. People terrified to report directly to the Bureau because the retaliation is instant and predictable.

And while those cases sit untouched, this is what's happening inside:

- Men beaten to death and left on floors while paperwork is rewritten to cover tracks
- Human beings shitting in cans and chip bags because cells have no working water or toilets
- Women sleeping in wheelchairs, paralyzed, denied basic medical care

- Disabled people extorted, punished, and ignored
- Entire prisons with no heat, no hot water, mold, asbestos, rats, and birds flying inside dorms
- Staff posting joke “work schedules” on their office doors while people miss release windows
- Mail shut down because a printer is broken
- FSA/SCA credits withheld like a bargaining chip
- Case managers openly saying they’ll only follow the law if a “task force” forces them
- Chronic lockdowns because staff “don’t want to deal”
- Food contamination, infrastructure collapse, failing electrical systems, flooded hallways, ceilings falling in
- People left to die, rot, or deteriorate inside buildings the federal government already knows are unsafe

This is not a staffing issue.

This is not a resource issue.

This is a culture issue — and culture comes from accountability.

Right now, incarcerated people do not feel safe reporting directly to the Bureau. They do not believe they’ll be protected. And until leadership starts firing, disciplining, and prosecuting the people responsible for the conditions documented in this report, nothing inside these facilities is going to change.

The system is crumbling from the inside out — structurally, medically, ethically, and operationally.

So until the change at the top trickles down, LOC will continue acting as the frontline oversight body, because families have no one else.

Our membership is growing at a pace that should alarm anyone watching.

We will keep reporting every beating, every lie, every death, every retaliation, every withheld credit, every collapsed ceiling, every broken medical system, every ADA violation, every FSA

obstruction — until federal leadership steps in and the people running these facilities are actually held to the law they're sworn to enforce.

This is the federal prison system today.

This is what families are living with.

And this is why we refuse to shut up.

FCI FORT DIX

---

1. SUMMARY OF ALLEGATIONS

Multiple independent witnesses — including one incarcerated individual and two verified staff members — report that on the evening of November 27, a 25-year-old man (last name Morales) was pepper-sprayed, beaten, and killed by officers in the basement of Building 5811.

Key allegations include:

- Officers pepper-sprayed and brutally beat two young men after they surrendered.
- One individual (Morales) became unresponsive and died on scene.
- His body was allegedly left in the basement between 8:15–8:45 PM.
- Staff allegedly conducted four additional recounts (9:30 PM, 12:00 AM, 12:30 AM, 1:00 AM) and a 2:00 AM ID-folder count to create a delay window to remove the body undetected.
- The surviving victim (Mendoza) was allegedly beaten unconscious and moved to SHU in a cart.
- Morales' father was reportedly taken to SHU or the "psycho room" to suppress a potential witness.
- Staff questioned the entire building the next day to coordinate "what lie would benefit them."

- Witnesses strongly refute BOP's claimed incident time (2:45 AM) and state the assault began at 8 PM.
- Officers repeatedly named: De Jesus ("601," described as the main aggressor), Silva, Morales, and other compound staff.

All witnesses request anonymity due to fear of retaliation.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Excessive Force Resulting in Death	18 U.S.C. § 4042(a)(2); 28 C.F.R. § 552.20; P.S. 5566.06 (Use of Force)
Failure to Render Aid / Medical Neglect	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10
Evidence Tampering & Cover-Up	18 U.S.C. § 1519; P.S. 1210.25 (Employee Misconduct Investigations)
False Reporting	18 U.S.C. § 1001; P.S. 1210.25
Retaliation / Witness Suppression	P.S. 3420.12; First Amendment protections
Physical Abuse of Second Individual (Mendoza)	28 C.F.R. § 552.20; P.S. 5566.06
Retaliatory SHU Placement of Father	28 C.F.R. § 541.22; P.S. 5270.09

Pattern of Officer Misconduct (De Jesus, Silva, others)	P.S. 3420.12 (Standards of Conduct)

---

3. DIRECT TESTIMONY FROM INSIDE

“I don’t want this to go back at us, but I don’t want this to happen to anyone here again.”

“The kid and an accomplice found a way out through the basement while we were locked down. Cameras saw them outside, we ran toward them, and then locked down the whole building”

“The other kid was killed from the brutality. They left him down there dead around 8:15–8:45 PM.”

“They took the father to SHU or the psycho room. Father and son were here together — he basically saw how officers killed his son.”

---

4. OVERSIGHT DEMANDS

LOC formally requests the following immediate actions:

1. Evidence Preservation

   Preserve all relevant materials, including:

   - All basement, hallway, and exterior camera footage
   - Count sheets from 8 PM–3 AM (Nov 27–28)
   - Movement logs for Officers De Jesus, Silva, Morales
   - SHU intake logs for Mendoza and Mr. Morales (father)
   - Use of Force reports
   - Medical and EMS records

2. Immediate OIA and DOJ OIG Investigation

Launch a formal investigation into a potential staff-involved homicide, evidence manipulation, and false reporting.

3. Independent Autopsy

   Conduct a full autopsy by an outside medical examiner to determine cause of death, including blunt-force trauma and respiratory failure.

4. Welfare Checks

   Immediate verification of the health and safety of:

   - Mendoza (surviving victim)
   - Mr. Morales (father)

5. Interim Staff Restrictions

   Remove all named officers from contact with incarcerated individuals pending investigation.

FPC POLLOCK

---

1. SUMMARY OF ALLEGATIONS

Incarcerated individuals at FPC Pollock report that Case Manager Ray has openly refused to perform required case-management duties, including FSA credit reviews, halfway house referrals, classification responsibilities, and daily availability to the population.

A publicly posted “work schedule” on his office door — photographed and verified — states:

- Sunday: Off
- Monday: “Rarely at work”
- Tuesday: “If you’re lucky”

- Wednesday: “Sometimes”
- Thursday: “What do you think”
- Friday: Off
- Saturday: Off

It ends with: “Schedule subject to change depending on the weather or the amount of sick or annual leave available.”

This sign is not satire — it is displayed on an official BOP office door. Families report Ray is “never there,” preventing residents from receiving FSA reviews, prerelease planning, case updates, or team meetings. This constitutes overt noncompliance with federal law and a complete failure of supervisory accountability.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Failure to Perform Required Duties	P.S. 5322.13 (Classification & Program Review); P.S. 5100.08
FSA Noncompliance	First Step Act (18 U.S.C. § 3632); June 17, 2025 Directive
Dereliction of Duty / Abuse of Position	P.S. 3420.12 (Standards of Employee Conduct)
Obstruction of Release Planning	18 U.S.C. § 4042(a)(1)-(2)

Retaliatory Neglect / Avoidance of Mandated Reforms	FSA/SCA Implementation Requirements

---

3. DIRECT TESTIMONY / EVIDENCE

Text of the sign posted on Case Manager Ray's door:

"Case Manager Ray's work hours are as follows:

Sunday: Off

Mondays: Rarely at work

Tuesdays: If you're lucky

Wednesday: Sometimes

Thursday: What do you think

Friday: Off

Saturday: Off

Schedule subject to change depending on the weather or the amount of sick or annual leave available."

---

4. OVERSIGHT DEMANDS

The Loved Ones Coalition formally requests:

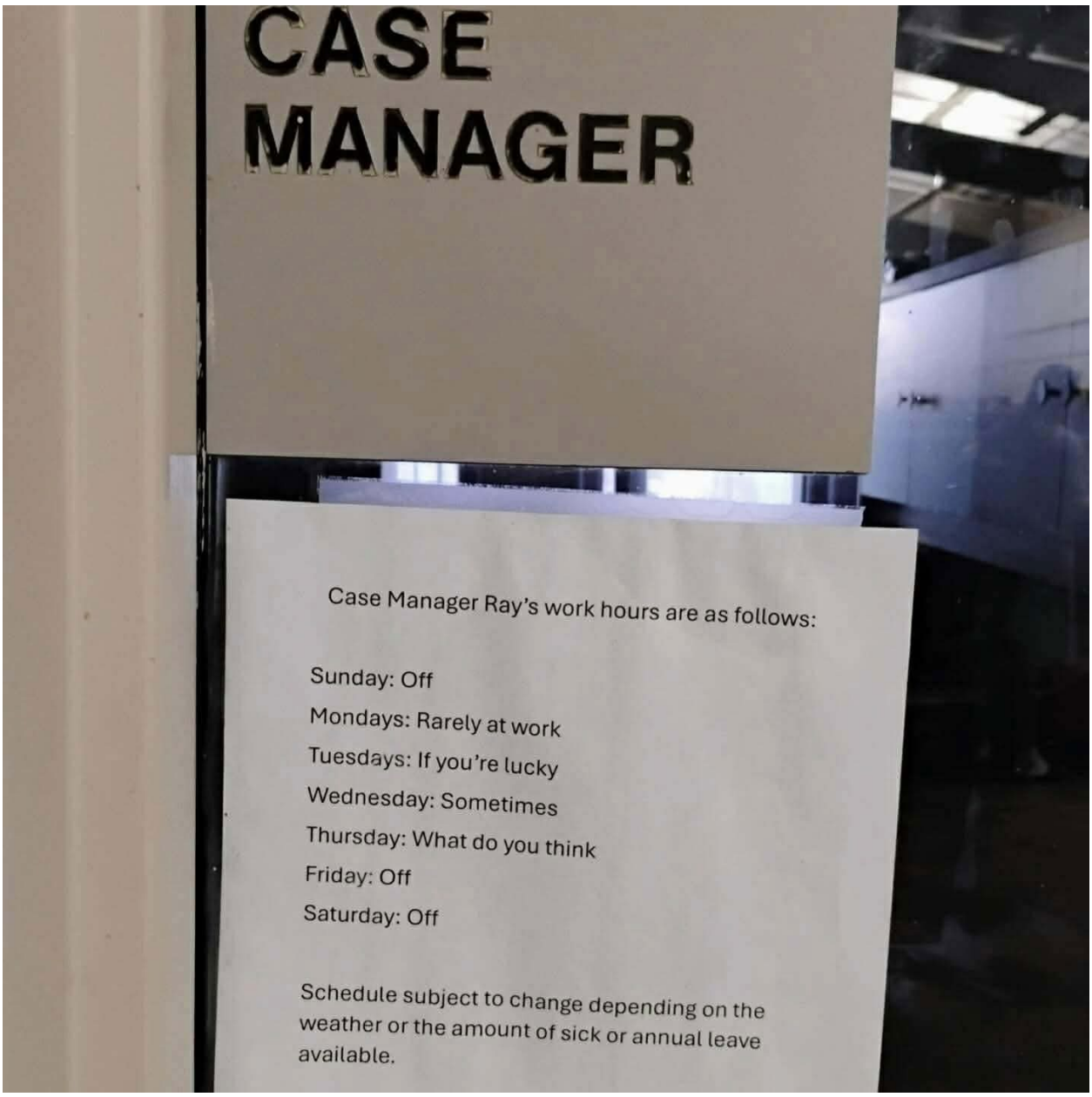
1. Immediate investigation into Case Manager Ray's attendance records, casework activity, and supervisory oversight.

2. Immediate review and correction of all delayed FSA/SCA credit calculations and release-related tasks impacted by Ray's unavailability.

3. Temporary reassignment of a qualified case manager to process the backlog of cases and ensure continuity of services.

4. Supervisory accountability review to determine why this conduct was tolerated and why no corrective action occurred.

5. Written explanation from facility leadership confirming removal of the sign, corrective measures taken, and whether disciplinary action has been initiated.



FCI OAKDALE

---

1. SUMMARY OF ALLEGATIONS

A verified statement from inside FCI Oakdale reports that staff are fabricating “staffing shortage” claims to justify routine, twice-weekly lockdowns every Wednesday and Saturday. Witnesses state the exact same staff work all other days, with no change in staffing levels between lockdown and non-lockdown days. Individuals who question the practice are met with dismissive responses such as, “Welcome to Oakdale.”

Reports also indicate that administrative remedies are being discarded, with incarcerated individuals stating staff “collude and throw away” grievances.

Additionally, kitchen operations appear to be functioning far below federal standards: individuals are routinely denied cups, spoons, napkins, condiments, and basic sanitary supplies — not as a temporary shortage, but as an ongoing facility practice.

A new female Warden has recently arrived, and incarcerated individuals express hope that external oversight may support needed changes.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
False staffing narrative to justify routine lockdowns	18 U.S.C. § 4042(a)(2); P.S. 5500.14
Arbitrary / punitive twice-weekly lockdowns	Constitutional protections; P.S. 5521.05
Food service failures — no utensils, cups, napkins, condiments	P.S. 4700.06 (Food Service Manual); P.S. 1600.11 (Environmental Health & Safety)

Retaliation: “write it up and they throw it away”	P.S. 3420.12; P.S. 1330.18; Ross v. Blake
Grievance system obstruction	P.S. 1330.18 (Administrative Remedy Program)
Culture of dismissal (“Welcome to Oakdale”)	P.S. 3420.12 (Standards of Employee Conduct)

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“We are being told to lock them down every Wednesday and Saturday due to shortage of staff. This is a false narrative.”

“The kitchen doesn’t provide cups, spoons, napkins, condiments, anything.”

“We have a new female warden and I’m hoping she will help us.”

---

4. OVERSIGHT DEMANDS

The Loved Ones Coalition formally requests:

1. Investigation into fabricated “staff shortage” claims
    - Review staffing rosters for Wed/Sat vs. all other days.
    - Document justification and frequency of weekly lockdowns.
2. Comprehensive inspection of Food Service operations
    - Verify reports that utensils, cups, napkins, and condiments are routinely denied.
    - Conduct compliance review under P.S. 4700.06.
3. Intervention into grievance system obstruction

- Investigate allegations that staff discard grievances.
- Conduct an Administrative Remedy tracking audit.

4. Accountability for retaliatory and dismissive conduct
    - Investigate culture of retaliation including “Welcome to Oakdale.”
    - Interview incarcerated individuals confidentially.
5. Immediate communication & corrective planning with the new Warden
    - Require leadership response outlining steps to end unnecessary lockdowns and restore services.
6. OIA/OIG Notification

    Given deliberate misuse of staffing claims and alleged interference with grievances, this meets the threshold for formal investigation.

FCI FORREST CITY — ANONYMIZED VERSION

---

1. SUMMARY OF ALLEGATIONS

LOC received a detailed written statement from the wife of an incarcerated individual confirming severe systemic violations at FCI Forrest City (Medium/Camp). Allegations include:

- Ongoing medical neglect of a terminal patient with a documented, life-threatening vascular condition.
- Unlawful withholding of FSA and Second Chance Act credits, granted only after family contacted Region.
- Retaliation and verbal abuse by Counselor Rendon.
- Threats to manipulate FRP, cancel medical idle, or place the individual in SHU.

- Obstruction of the grievance process, including refusal to accept BP-8, BP-9, and Region's refusal to accept a sensitive BP-10.
- Unlawful detention beyond prerelease eligibility.
- Refusal to comply with Director Josh Smith's June 17, 2025 credit-implementation directive.
- Allegations that Counselor Rendon has a widespread reputation for planting contraband.
- Tampering with computer records while threatening the incarcerated individual.

This case represents one of the clearest and most documented examples of FSA obstruction + medical neglect + targeted retaliation in recent LOC oversight submissions.

---

2. KEY ALLEGATION & VIOLATION TABLE

(unchanged — no identifying information present)

---

3. DIRECT TESTIMONY / DIRECT QUOTES — ANONYMIZED

Medical Neglect

"Nothing about his medical condition has changed — and his condition is terminal."

"Since arriving at Forrest City almost four months ago, his blood pressure has been taken only once."

"There have been no blood tests, no monitoring, and no follow-up of any kind."

Physician Recommendation Ignored

"The doctor agreed the BOP cannot manage his condition and documented that he needed to be sent back to his specialists. Nothing has been scheduled."

Retaliation & Harassment by Counselor Rendon

When attempting to file a BP-8:

"You're not going to work the shit out of me just because you want to go home early."

When citing BOP policy:

“Stop barking numbers at me and get out of my office.”

When attempting again:

“Since you like filing paperwork so much, I like filing paperwork too.”

Rendon then threatened:

“I will cancel your medical idle, double your FRP, and monitor you 24/7 until we find something to ship you off or send you to SHU.”

Final remark:

“Get the f*** out of my office!”

Grievance Obstruction

“We attempted to mail a Sensitive BP-10 twice — UPS and USPS — and the Regional Office refused to accept it both times.”

“Tracking confirms this.”

Unlawful Detention

“At this point, he is well past his lawful prerelease window and is being unlawfully detained.”

---

4. SYSTEMIC FSA OBSTRUCTION — ANONYMIZED

The individual has received two consecutive Low PATTERN assessments, qualifying him for mandatory 15 days per month of Earned Time Credits:

- June 29, 2025 (previous facility)
- September 17, 2025 (Forrest City)

Under 18 U.S.C. § 3632(d)(4)(A), this requires full application of credits.

Instead, Forrest City is applying 6.3 days per month, below even the statutory minimum.

Case Manager Ms. Mormon fabricated FSA requirements not found anywhere in law or policy, claiming that assessments must be:

- At the same facility
- Under the same case manager
- At least six months apart

These rules are false, unlawful, and contradicted by binding case law.

---

5. OVERSIGHT DEMANDS — FCI FORREST CITY (SCR)

(Only victim name removed; otherwise unchanged)

1. Medical Emergency Intervention
    - Immediate evaluation by an external specialist for distal basilar artery stenosis.
    - Full review of medical omissions, ignored recommendations, and continuity-of-care failures.
2. FSA Credit Reconciliation
    - Immediate recalculation of the individual's FSA credits.
    - Verification of prerelease eligibility and release if required under federal law.
3. Investigation Into Counselor Rendon

    For retaliation, verbal abuse, threats, grievance obstruction, alleged contraband planting, and record tampering.
4. Investigation Into Case Manager Mormon

    For creating fictitious FSA rules, obstructing mandatory credits, violating 18 U.S.C. § 3632(d)(4), and ignoring national directives.
5. Grievance System Restoration
    - Immediate review of all blocked BP-8, BP-9, and BP-10 attempts.
    - Documentation of Region's refusal to accept Sensitive BP-10 submissions.

6. Review of Unlawful Detention

   The incarcerated individual appears to be held beyond his lawful prerelease window. Immediate legal review is required.

7. OIA/OIG & Congressional Notification

   - Referral to OIA
   - Referral to OIG
   - Notification to Congressman David Kustoff, who has already initiated inquiry

---

FCI EL RENO

---

1. SUMMARY OF ALLEGATIONS

LOC received reports that FCI El Reno is experiencing a facility-wide breakdown of outgoing mail operations after the Leisure Center — the only location where mailing labels are printed — was closed.

The printer used for label production is reportedly down, and staff are enforcing a rule that mail cannot be sent without a printed label, leaving individuals with no access to outgoing mail if they do not already possess labels.

No alternative process (handwritten labels, staff-generated labels, or temporary procedures) has been offered, resulting in:

- Complete loss of outgoing mail for many incarcerated people
- Disruption of communication with family, legal counsel, and courts
- Violations of federal mail policy requiring reasonable access to correspondence

This constitutes a facility-created communication barrier inconsistent with BOP policy and constitutional standards.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Mail suspension due to Leisure Center closure and broken printer	28 C.F.R. § 540.14; P.S. 5265.14 (Correspondence)
Facility-created communication barrier (printed label requirement with no ability to print)	First Amendment Rights; Due Process; P.S. 5265.14
Prolonged loss of mail access with no contingency system	Right to access courts; Turner v. Safley

---

3. DIRECT TESTIMONY / DIRECT QUOTE

“Leisure center closed at El Reno, which is where they print out mailing labels”

“The printer for that is down so no outgoing mail for those who don’t have labels.”

---

4. OVERSIGHT DEMANDS

The Loved Ones Coalition formally requests:

1. Immediate repair or replacement of the mailing-label printer.
2. Temporary alternative systems — such as handwritten labels or staff-generated labels — until full service is restored.
3. Compliance review under P.S. 5265.14, confirming that individuals have meaningful access to outgoing mail as required.

4. Written notification to the population with updated mailing procedures and expected restoration timelines.

5. OIG inquiry into why no contingency plan existed for core mail operations and why access was suspended without alternatives.

FCI BASTROP CAMP

---

1. SUMMARY OF ALLEGATIONS

LOC received multiple independent reports alleging that Case Management Coordinator (CMC) Mills is intentionally withholding or “stealing” FSA (First Step Act) and SCA (Second Chance Act) credits from incarcerated individuals at both FCI Bastrop and Bastrop Camp.

Families report a pattern:

- Individuals with verified home addresses are being denied SCA placements.
- Those same individuals are being cut short on FSA credits without explanation.
- Camp residents describe widespread deprivation, including food shortages and overall reduced access to resources compared to the main compound.

Witnesses state this is a long-standing, systemic issue specifically linked to the actions and decisions of CMC Mills, raising concerns of deliberate credit obstruction and abuse of position.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated

Withholding or stealing FSA credits	June 17, 2024 & June 17, 2025 FSA Directives; 18 U.S.C. § 3624(g); P.S. 5410.01
Blocking SCA placement for individuals with verified addresses	Second Chance Act; P.S. 7320.01 (Home Confinement); Reentry Preparation Policy
Systemic deprivation at the camp (credits, food, resources)	18 U.S.C. § 4042(a)(2); Eighth Amendment standards
Misconduct by CMC Mills (abuse of authority, deprivation of lawful credits)	P.S. 3420.09 (Employee Standards of Conduct); Staff Misconduct & Abuse of Position

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“CMC Mills is stealing the inmates’ FSA and SCA”

“If they have an address, they don’t get SCA and get cut short on FSA credits.”

“The inmates are being deprived of their SCA and FSA… getting the short end of the stick plus many more things — food, etc.”

---

4. OVERSIGHT DEMANDS — FCI BASTROP (SCR)

The Loved Ones Coalition formally requests:

1. Immediate audit of credit application practices
    - Review all cases handled by CMC Mills.
    - Identify patterns of withheld or altered FSA/SCA credits.
2. Retroactive correction

- Apply all improperly withheld credits.
- Adjust release dates, pre-release placements, and home confinement eligibility accordingly.

3. OIG referral
    - Investigate potential misconduct, abuse of authority, or falsification of records by CMC Mills.
4. Reentry compliance inspection
    - Ensure SCA placement rules are being communicated and applied correctly, regardless of whether an individual has a home address available.
5. Camp-wide review of conditions and resource distribution
    - Evaluate food quality, access to programming, and disparity between camp and main compound.
6. DOJ Reentry Office notification
    - Report systemic obstruction of earned credits and the targeting of individuals with home addresses.

FCI LEAVENWORTH

---

1. SUMMARY OF ALLEGATIONS

During this reporting period, LOC received multiple credible reports from families and incarcerated individuals detailing significant safety, sanitation, medical, and administrative breakdowns at FCI Leavenworth, including:

- A facility-wide power outage lasting nearly 24 hours due to a blown breaker.
- A lockdown justified by staff claiming “radios were down”, preventing any movement.

- Medical neglect, including a person with a severe headache being offered only Pepto-Bismol.
- Ongoing rodent infestation and moldy food, with no corrective action.
- Mailroom dysfunction, including individuals reporting no mail for weeks and visible backlogs in the mail area.
- Administrative remedy obstruction, including BP forms not being answered, processed, or possibly not mailed out.
- FSA/SCA noncompliance, including staff ignoring time-served reviews and obstructing credit application.
- One individual actively fighting for time-served credit but facing continuous staff inaction.

Reports indicate a systemic pattern of negligence, inadequate emergency response, and potential deliberate obstruction of First Step Act implementation.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
24-hour power outage affecting safety, sanitation, and communication	18 U.S.C. § 4042(a)(2); P.S. 4200.12 (Facility Operations)
Improper lockdown due to “radios down”	18 U.S.C. § 4042(a)(1); Duty to Protect
Medical neglect (Pepto for severe headache)	P.S. 6031.04; 28 C.F.R. § 549.10
Rodent infestation & moldy food	18 U.S.C. § 4042(a)(2); OSHA standards; food safety requirements

Mail interference / prolonged mail delays	P.S. 5265.14 (Correspondence)
Nonprocessing of BP forms	28 C.F.R. § 542.10–542.19; Administrative Remedy Program
FSA/SCA credit obstruction	18 U.S.C. § 3632; June 17, 2025 Directive
Retaliatory inaction / dereliction	P.S. 3420.12 (Standards of Employee Conduct)

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“We were locked down yesterday and told the radios were down so they couldn’t come out”

“Someone had a severe headache, went to medical, and they would only offer Pepto.”

“The rats and moldy food are still an issue.”

---

4. OVERSIGHT DEMANDS — FCI LEAVENWORTH (NCR)

The Loved Ones Coalition formally requests:

1. Written explanation from facility leadership regarding the 24-hour power outage and why contingency plans were not activated.

2. Inspection and verification of radio and emergency communication equipment, confirming operational readiness.

3. Medical review of all individuals seen during the outage and lockdown to ensure compliance with patient-care standards.

4. Emergency sanitation inspection addressing rodent infestation, mold, and food safety compliance.

5. Full mailroom audit, including:
    - Incoming and outgoing mail logs
    - Staffing levels
    - Causes of weeks-long delays
6. Administrative Remedy audit, reviewing all pending BP forms that appear unprocessed or unsent.
7. Mandatory FSA/SCA compliance review for all individuals whose calculations or reviews were delayed or obstructed.
8. Supervisory accountability measures for leaders who have failed to correct ongoing systemic failures.

MCFP SPRINGFIELD — ANONYMIZED VERSION

---

1. SUMMARY OF ALLEGATIONS

Loved ones report extreme, life-threatening medical neglect and inhumane confinement conditions involving a partially paralyzed individual at MCFP Springfield who has been held in the SHU for over 75 days with:

- No incident report / no hearing / no disciplinary determination
- No medical care despite documented paralysis and mobility impairment
- No communication access, with all contacts removed upon arrival
- Forced dependence on his wheelchair for all Activities of Daily Living (ADLs), including:
    - Sleeping
    - Showering
    - Using the bathroom

Staff allegedly refuse to assist with bed transfers, shower access, toileting, or any basic ADLs, despite the individual being medically incapable of independent movement. His condition has deteriorated severely, including extreme swelling, unmanaged pain, and high risk for blood clots or infection.

He has repeatedly requested medical care and emergency evaluation, yet medical staff, SIS, and counselors reportedly refuse all communication — with him and with his family.

This case represents a critical federal emergency involving ADA violations, Eighth Amendment concerns, due-process violations, and medical neglect at the federal system's designated medical facility.

---

2. KEY ALLEGATION & VIOLATION TABLE

(unchanged — contains no victim-identifying details)

---

3. DIRECT TESTIMONY / DIRECT QUOTES — ANONYMIZED

"He has been having to sleep in his wheelchair, take showers in his wheelchair, and use the bathroom in his wheelchair."

"They tell him he needs to get in the bed by himself, take a shower by himself, and use the bathroom by himself — but he is partially paralyzed. He cannot do that."

"His legs are extremely swollen, very painful, and he has been begging to see a doctor for weeks."

"Medical will not speak to the family. SIS will not answer. Counselors will not respond."

"They removed everyone from his email list and call list as soon as he arrived here."

"He feels like they are trying to kill him."

---

4. OVERSIGHT DEMANDS — MCFP SPRINGFIELD (NCR) — ANONYMIZED

The Loved Ones Coalition formally requests:

1. Immediate removal of the individual from SHU

Transfer to a medically appropriate, ADA-compliant unit.

2. Emergency medical evaluation, including:
    - DVT/clotting assessment
    - Circulation exam
    - Infection screening
    - Pain management
    - Mobility and transfer needs
3. Full ADA and Rehabilitation Act compliance review for MCFP Springfield.
4. Comprehensive investigation into:
    - SHU placement without due process
    - Denial of medical care
    - Interference with communication
    - Retaliatory removal from call/email lists
5. Mandatory oversight from BOP Health Services Division and OIA

    due to the life-threatening nature of the medical neglect.
6. Immediate restoration of all approved communication access for the individual.
7. Review of all staff involved, including those responsible for:
    - Denying medical care
    - Blocking communication
    - Refusing assistance with ADLs
    - Failing to follow disability and medical-care requirements

---

FCI WASECA

---

1. SUMMARY OF ALLEGATIONS

A detailed firsthand report from inside FCI Waseca describes a facility in severe operational collapse, with virtually no functioning mental-health or rehabilitative infrastructure. Key allegations include:

- No psychological support for trauma, addiction, or crisis intervention
- Only one psychologist for 900+ women, described as inaccessible and unresponsive
- A woman returning from a cardiac-related medical trip suffered a PTSD episode and received no assistance
- Widespread drug use with zero treatment or recovery options
- Women “wandering the halls in a fog” due to untreated trauma, addiction, and mental-health needs
- Daily threats and fights, including weapons such as “locks in socks”
- Disciplinary shots routinely expunged, enabling violent behavior without accountability
- Stingers banned due to electrical misuse, leaving women unable to heat commissary food
- Frequent class cancellations, resulting in FSA programming collapse
- A pervasive sense of hopelessness among residents and staff

The report indicates a facility in crisis, with major safety risks and no functional mental-health or programmatic infrastructure.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
No PTSD or mental-health support	P.S. 5310.16; P.S. 6031.04; Eighth Amendment
One psychologist for 900+ residents	Psychology Services staffing requirements
PTSD crisis ignored	Deliberate Indifference Standard; Eighth Amendment
Widespread drug use with no treatment	First Step Act (EBRR/PA programming requirements)
Daily violence, weapon use	18 U.S.C. § 4042(a)(2) (Duty to Protect)
Disciplinary shots routinely expunged	P.S. 5270.09 (Inmate Discipline)
No ability to heat commissary food	Basic sanitation and living standards
Programming constantly canceled	FSA compliance violations
Facility-wide breakdown	Duty of care; system management failures

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“Conditions here have greatly gone downhill.”

“There’s no psych support for people addicted to drugs or dealing with threats.”

“We have one person in psych for over 900 people and she is NOT user friendly.”

“People wander the halls lost in a fog.”

“There are daily threats and fights using locks in socks.”

“If staff writes a shot, it gets expunged so the behaviors continue.”

“Classes get canceled constantly because staffing is low.”

---

4. OVERSIGHT DEMANDS — FCI WASECA (NCR)

The Loved Ones Coalition formally requests:

1. Immediate deployment of a mental-health triage team to stabilize conditions and assess urgent cases.

2. Emergency review of PTSD-response failures, including the cardiac medical-return incident and related negligence.

3. Comprehensive safety audit addressing violence, weapon use, and the practice of expunging disciplinary reports.

4. Restoration of FSA programming, with an audit of all class cancellations and staffing gaps.

5. Implementation of mandatory drug-treatment programming required under the First Step Act.

6. Written corrective plan from the Warden addressing:

    - Psychology staffing shortages

    - Safety failures and daily violence

    - Program cancellations

    - Facility-wide disorder and operational decline

FCI OXFORD LOW

---

1. SUMMARY OF ALLEGATIONS

Multiple incarcerated individuals at FCI Oxford Low report catastrophic sanitation failures, environmental hazards, and serious safety concerns. Testimony indicates that during frequent lockdowns:

- Units have no access to functioning toilets or running water, sometimes for extended periods
- Individuals are forced to store human waste (urine and feces) in coffee cans and chip bags
- Staff reportedly unlock cell doors quietly overnight, raising concerns about unauthorized access and security violations
- HAZMAT crews were observed working on the roof in full protective suits
- Incarcerated individuals were told there is exposed asbestos inside and outside buildings
- Men describe the compound as “always locked down,” with no reasonable access to basic hygiene

Several individuals report that multiple lawsuits have been filed or are in progress, confirming the severity and systemic nature of the crisis.

These allegations represent extreme violations of federal sanitation laws, environmental health regulations, and constitutional protections under the Eighth Amendment.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated

No toilets or running water during lockdowns	18 U.S.C. § 4042(a)(2); 28 C.F.R. § 551.100; Eighth Amendment
Forced human waste storage (coffee cans, chip bags)	Eighth Amendment; P.S. 1600.11; OSHA sanitation requirements
Secret, unauthorized overnight cell-door manipulation	P.S. 3420.11; P.S. 5500.14 (Security & Control)
HAZMAT crews working on roof	Environmental hazard requiring testing and notification
Reported asbestos exposure	EPA & OSHA asbestos standards; P.S. 1600.11
Chronic, unannounced lockdowns	Duty to maintain sanitation and safe operation
Multiple lawsuits being filed	Indicates widespread, systemic breakdown; FTCA/Bivens relevance

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“the compound is always locked down and there are no toilets or running water in the cells. They are forced to piss and shit in coffee cans and chip bags.”

“There are specialists in HAZMAT suits fixing something on the roof. Inmates were told there is asbestos exposed in and on the buildings.”

“There are several lawsuits regarding these issues already filed or about to be filed.”

---

4. OVERSIGHT DEMANDS — FCI OXFORD LOW (NCR)

The Loved Ones Coalition formally requests:

1. Immediate environmental health inspection by EPA, Wisconsin Environmental Health Division, or another independent agency.

2. Emergency asbestos testing and transparent disclosure to incarcerated individuals and families.

3. Immediate restoration of sanitation access during all lockdowns, including portable toilets, water, and hygiene supplies.

4. Suspension of any lockdown protocol that deprives individuals of toilet access or running water.

5. Investigation into unauthorized overnight cell-door manipulation, including staff involved and safety impacts.

6. Public release of maintenance records, roof repair documents, and environmental hazard assessments for FCI Oxford.

7. OSHA involvement to ensure compliance with hazardous exposure standards.

8. Medical evaluations for all individuals potentially exposed to asbestos, contaminated water, or waste-related illness.

FCI FLORENCE

---

1. SUMMARY OF ALLEGATIONS

Multiple incarcerated individuals at FCI Florence report retaliatory discipline, coordinated misuse of the UDC process, and unauthorized confiscation of commissary privileges. Reports indicate:

- Mass incident reports issued for commissary stored in net bags under bunks, even though lockers lack shelves

- No posted cell standards or written notice of prohibited storage practices
- Counselor and Assistant Warden jointly conducting searches and writing over 20 incident reports
- UDC members threatening, “Do not argue or it will be 90 days commissary restriction”
- Assistant Warden allegedly predetermining sanctions before any hearing
- Incident reports being left on bunks without verbal service or explanation
- Counselor who helped search and issue write-ups also sitting on UDC, a prohibited conflict of interest

These allegations reveal a pattern of retaliation, coercion, and due-process violations within the disciplinary system.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Law Violated
Mass write-ups for commissary stored in net bags, with no posted rules	P.S. 5521.06 (Cell Standards); Wolff v. McDonnell (Due Process – notice requirement)
Counselor & Assistant Warden conducted search together and wrote 20+ incident reports	P.S. 5270.09 – prohibits staff involved in an incident from adjudicating it
UDC threats: “Argue and it will be 90 days commissary loss”	P.S. 5270.09; 28 C.F.R. § 541 – retaliation & intimidation prohibited
Assistant Warden pre-deciding punishment before UDC	P.S. 5270.09 – UDC must be impartial & independent

Improper service of incident reports (left on bunks)	P.S. 5270.09; Due Process requirements for proper notice
Counselor who issued incident report also sat on UDC	P.S. 5270.09, Ch. 3 – adjudicator cannot participate in incident
Threats of harsher punishment for exercising right to speak	First Amendment Retaliation; P.S. 3420.11 (Standards of Conduct)

---

3. DIRECT TESTIMONY / DIRECT QUOTES

“Our counselor and the assistant warden searched our cells and gave over 20 of us write-ups for having commissary in a net bag under our beds — because our lockers have no shelves.”

“They never posted anything about cell standards. No rules, no bulletin, nothing.”

“Before we even went to the UDC, my counselor told us our commissary was already taken for 60 days, and that if we argued, it would be 90.”

“They didn’t even serve me the write-up. They left it on my bunk when I came in from rec.”

“My counselor helped issue the incident report, and then he sat on my UDC. How is that allowed?”

---

4. OVERSIGHT DEMANDS — FCI FLORENCE (NCR)

The Loved Ones Coalition formally requests:

1. Immediate suspension of all sanctions issued in this mass incident
    - These reports violate due-process requirements and must be overturned.
2. Removal of the Counselor and Assistant Warden from all disciplinary roles pending investigation

- Their involvement as both accusers and adjudicators violates P.S. 5270.09.

3. Full review of UDC/DHO procedures at FCI Florence
    - Confirm compliance with P.S. 5270.09, service requirements, and inmate rights during hearings.
4. Posting of all required cell standards under P.S. 5521.06
    - If standards are not posted, they cannot be enforced.
5. Investigation into coercion and retaliation
    - Threatening harsher punishment for speaking during UDC is a clear constitutional and policy violation.
6. Notification to Regional and Central Office
    - Abuse of disciplinary authority must be reviewed at higher levels due to conflict of interest concerns.

FCI BUTNER MEDIUM I

PART I — THE CASE OF "GRACE"

Staff Violence • MRSA/Sepsis • Retaliation • Unlawful Strip Search • SHU Abuse

---

1. SUMMARY OF ALLEGATIONS — GRACE

Two independent sources — Grace's mother and an incarcerated witness — report a pattern of extreme abuse, deliberate medical neglect, and retaliation by staff at FCI Butner Medium I, including:

- Lieutenant violently breaking Grace's hand and arm during handcuffing
- False incident reports filed by the lieutenant, later contradicted by video footage
- Forced top-bunk assignment, resulting in a fall and serious injury
- Ten days of ignored medical requests, leading to MRSA, sepsis, shock, and emergency airlift
- Strip search and digital rectal cavity search performed without cause and without Regional Director authorization
- Placement in isolated "short range" SHU with:
    - No hygiene items
    - No toilet paper
    - No legal papers or books
    - Covered windows
- Retaliation by Captain S. Hock for reporting PREA violations
- Issuing seven fabricated incident reports after Grace's mother contacted OIG
- Denial of:
    - Showers
    - Recreation
    - Law library access
    - Bedding and linens

Grace nearly died from neglect and continues to face coercion and retaliatory confinement.

---

2. KEY ALLEGATION & VIOLATION TABLE — GRACE

Allegation	Policy / Statute Violated
Lieutenant broke her hand and arm	P.S. 5566.06 (Use of Force); 18 U.S.C. § 4042(a)(2)
False incident reports disproven by camera	P.S. 3420.12; P.S. 1210.25
Forced top-bunk assignment despite fall risk	ADA Title II; Eighth Amendment
Ten days of ignored medical pleas → MRSA & sepsis	Eighth Amendment; Estelle v. Gamble; P.S. 6031.04
Strip search & digital cavity search without cause or authorization	PREA Standards; P.S. 5521.01
Isolation in SHU without hygiene, toilet paper, or legal access	Eighth Amendment; P.S. 5270.11
Captain Hock threatening to remove halfway house time	Retaliation; P.S. 3420.12
Taunting a naked inmate during strip search	PREA — sexual harassment
Seven fabricated incident reports	P.S. 5270.09; P.S. 3420.12
Denial of showers, rec, law library access	Constitutional access-to-courts; humane standards

3. DIRECT TESTIMONY — GRACE

“A lieutenant broke my trans daughter’s hand and arm when he handcuffed her and leveraged them against the bars.”

“She begged them for 10 days to help her and they basically told her to go ahead and die already.”

“She was airlifted to Raleigh with a 103.9 fever and sepsis.”

“They put her in the SHU short range with no hygiene, no legal papers, no toilet paper, and covered windows.”

“Captain Hock came in the shower while she was naked and said he was going to take her halfway house time.”

“After her mom called OIG, they retaliated with seven fake incident reports.”

PART II — THE BLOOD CLOT CASE

Untreated Medical Emergency • Permanent Disability • ADA Failures

---

1. SUMMARY OF ALLEGATIONS — BLOOD CLOTS

A second incarcerated individual reports:

- He entered BOP custody in good health
- Developed severe blood clots in his leg
- FCI Butner failed to provide timely or adequate medical intervention
- As a result, he is now:
    - Wheelchair-bound
    - On multiple medications

- Living with a leg “swollen and infected beyond recognition”

This indicates long-term, systemic medical neglect with permanent physical consequences.

---

2. KEY ALLEGATION & VIOLATION TABLE — BLOOD CLOTS

Allegation	Policy / Statute Violated
Failure to treat blood clots in time	P.S. 6031.04; Eighth Amendment
Resulting permanent disability	Failure of duty of care
Severe swelling & infection	Deliberate indifference to medical emergency
Wheelchair confinement due to neglect	ADA Title II; Rehabilitation Act

---

3. DIRECT TESTIMONY — BLOOD CLOTS

“I came to prison a healthy man. Then blood clots formed in my leg and the prison didn’t give me timely or adequate medical care. Now I am confined to a wheelchair and my leg is swollen and infected beyond recognition.”

---

4. OVERSIGHT DEMANDS — FCI BUTNER MEDIUM I

The Loved Ones Coalition formally requests:

1. Immediate OIA & OIG Investigation

Into:

- Lieutenant who broke Grace's arm
- Captain S. Hock for PREA violations & retaliation
- Unlawful cavity search
- Fabricated incident reports
- SHU conditions and restricted access

2. Emergency Medical Intervention

- Independent medical evaluation for Grace
- Independent medical evaluation for blood-clot patient
- Audit of MRSA, sepsis, and emergency-response protocols

3. Full PREA Investigation

Including:

- Staff entering shower area
- Sexual harassment during strip search
- Retaliation following PREA report

4. Immediate Restoration of Basic Conditions

- Showers
- Bedding and linens
- Recreation
- Hygiene supplies

- Law library and legal access

5. Review and Nullification of Fabricated Incident Reports

Particularly those issued after the family contacted OIG.

6. Written Corrective Action Plan from the Warden

Addressing:

- SHU compliance
- Medical protocols
- Staff training
- Use-of-force policy enforcement
- PREA compliance

FCI HAZELTON

---

1. SUMMARY OF ALLEGATIONS

Multiple family members report that the women's facility at Hazelton has been without heat and hot water since Thursday night/Friday morning. Temperatures have dropped below freezing, and staff reportedly told women to "suck it up" and wait until after the weekend for repairs. Women report shivering through the night with only two thin blankets and no access to warm water for hygiene.

Additional complaints from the Hazelton Complex include:

- Men on Unit L2 also report no heat with dangerously low temperatures expected
- Rats running indoors; birds flying inside and defecating in common areas

- Staff and administrative complaints going unanswered
- A family member has already filed complaints with the ACLU of West Virginia and FBOP over unsafe and unsanitary conditions

These conditions constitute severe environmental and sanitation hazards, failures of basic health protections, and disregard for emergency safety concerns.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Details Provided	Potential Violations
Total loss of heat	Women's facility and L2 men's unit without heat for multiple days in below-freezing weather	18 U.S.C. § 4042(a)(2); Eighth Amendment
No hot water	Women unable to wash; hot water out for days	28 C.F.R. § 551.12 – sanitation requirements
Staff dismissing safety complaints	Women told repairs would wait until after weekend and to "suck it up"	Dereliction of duty; failure to protect
Insufficient bedding	Only two thin blankets provided despite freezing conditions	PS 4500.11 – facility management & bedding
Rodent and bird infestation	Rats running indoors; birds defecating in units	28 C.F.R. § 551.20 – sanitation & health safety

Ignored grievances & complaints	Reports that administrators refused to act on repeated concerns	PS 1330.18 Administrative Remedy Program

---

3. DIRECT QUOTES FROM LOVED Ones

“The women’s facility at Hazelton has been without heat and hot water… They were told it wouldn’t be fixed until after the weekend and to suck it up.”

“They are sooo cold.”

“Talked to my LO today and he said they have no heat on L2… concerned for his health.”

“Rats running around and birds flying inside defecating everywhere is unacceptable.”

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

The Loved Ones Coalition formally requests:

1. Immediate restoration of heat and hot water for all Hazelton housing units.
2. Emergency wellness checks for all individuals exposed to freezing temperatures.
3. Distribution of adequate cold-weather bedding and clothing until heating systems are restored.
4. Full sanitation remediation, including rat removal and prevention of bird intrusion.
5. Formal inquiry into facility leadership’s response, including failure to act on repeated safety complaints.
6. Clear repair timelines and direct communication to families regarding restoration of heat and water.
7. Regional Office and OIA review due to potential Eighth Amendment violations and environmental hazards.

USP McCREARY

---

1. SUMMARY OF ALLEGATIONS

Families report that USP McCreary has been placed under near-continuous lockdown, including a new “major lockdown” with no clear explanation provided. According to statements relayed by incarcerated individuals, staff have said they are short-staffed and “don’t want to deal,” resulting in arbitrary lockdowns that appear to be driven by convenience rather than legitimate security concerns.

During these extended confinement periods, incarcerated individuals report:

- No showers for days or entire weeks
- Forced “birdbaths” using sinks in their cells
- No access to basic hygiene
- Hours-to-days of complete confinement with zero out-of-cell time

This pattern reflects severe operational failure, denial of basic human needs, and potential deliberate misuse of lockdown authority.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Description	Potential Violations
Chronic, arbitrary lockdowns	Staff reportedly place units on lockdown repeatedly, stating they “don’t want to deal.”	18 U.S.C. § 4042(a)(2); Eighth Amendment
No showers / “birdbaths” only	Individuals forced to wash in sinks during prolonged lockdowns.	PS 1600.11; 28 C.F.R. § 551.15; Eighth Amendment

Prolonged confinement for days to weeks	Reports of not being out “a whole day or even week.”	PS 5566.06; Eighth Amendment
Staff refusal to operate the facility	Officer allegedly stated they are short-staffed and simply “don’t want to deal.”	PS 3420.09 Standards of Conduct; dereliction of duty

---

3. DIRECT QUOTES FROM INSIDE

“A guard told me they were short-staffed and just didn’t wanna deal.”

“When on lockdowns they have to take birdbaths until they let them up.”

“So frustrating… it seems like they haven’t been out a whole day or even week.”

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

1. Immediate investigation into arbitrary and retaliatory lockdown patterns at USP McCreary.
2. Hygiene compliance order, requiring access to showers during any lockdowns extending beyond 48 hours.
3. Full staffing audit to determine whether shortages are real or used as a pretext for not operating the facility.
4. Review and enforcement of all lockdown justification requirements under BOP policy.
5. Disciplinary review of staff engaging in dereliction of duty or misuse of lockdown authority.
6. Notification to Congress and OIG due to prolonged confinement, lack of hygiene access, and systemic staff refusal to perform duties.

FCI HERLONG SATELLITE CAMP

---

1. SUMMARY OF ALLEGATIONS

Multiple families and internal sources report that Case Manager Carey, Unit Manager Moore, and CMC Finch are collectively refusing to implement the June 17, 2025 Directive issued by BOP leadership. Instead of recalculating credits, processing prerelease paperwork, or complying with FSA/SCA requirements, the unit team is allegedly:

- Ignoring mandatory federal directives
- Deliberately withholding FSA credits
- Using unnecessary disciplinary “shots” to extend custody
- Obstructing transfers and prerelease reviews
- Spending entire shifts in their offices without performing required duties
- Retaliating against incarcerated individuals by slowing or blocking release
- Coordinating with each other to avoid accountability

As a result, men at Herlong Camp are being wrongfully held beyond their lawful prerelease windows, with staff openly stating they will not implement the Director’s orders. The conduct described reflects intentional noncompliance, misuse of authority, and coordinated obstruction of liberty.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Description	Potential Violations
Refusal to implement June 17 Directive	Unit Team openly ignoring mandatory recalculations and prerelease requirements.	18 U.S.C. § 3624(g); PS 5410.01; BOP Director’s Directives

Intentional obstruction of FSA credits	Withholding credits, delaying paperwork, and falsely claiming inability to process.	PS 5410.01; Fifth Amendment Due Process
Retaliatory disciplinary “shots” to extend confinement	Using write-ups to prevent release or manipulate timelines.	PS 5270.11; 28 C.F.R. § 541; Abuse of Authority
Staff misconduct / time theft	Reports that Carey, Moore, and Finch “sit in their offices all day” doing no casework.	PS 3420.12; 5 C.F.R. § 2635.101
Collusion to block accountability	Staff covering for one another and refusing to address directives.	PS 1210.25 (Employee Misconduct Investigations)

---

3. DIRECT QUOTES FROM INSIDE

“They refuse to follow the directives from the Director. All they care about is giving people shots and keeping them longer.”

“Carey, Moore, and Finch just sit in their offices all day. They don’t do any casework, they don’t process anything.”

“Everyone here knows they’re covering each other. They won’t implement the FSA credits because they don’t want anyone going home.”

“Instead of doing what they’re supposed to do, they’re making it harder for people to leave.”

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

1. Immediate misconduct investigation into Case Manager Carey, Unit Manager Moore, and CMC Finch under PS 1210.25.

2. Full recalculation and application of all FSA credits owed per the June 17 Directive.

3. Audit of all disciplinary incident reports issued by these staff for evidence of retaliation, manipulation, or falsification.

4. Regional Office intervention to enforce statutory and policy compliance across FSA, SCA, and prerelease procedures.

5. Protection from retaliation for incarcerated individuals providing testimony or documentation.

6. Work performance review, including confirmation of whether required case management duties are being completed and logged.

Herlong Satellite Camp's sustained refusal to follow federal directives — paired with active retaliation and unlawful custody extension — demands urgent corrective action from BOP leadership and oversight bodies.

FPC ANDERSON

---

1. SUMMARY OF ALLEGATIONS

Multiple incarcerated individuals at FPC Anderson report that case management staff have openly refused to implement the June 17, 2025 Directive regarding FSA Earned Time Credits. According to consistent reports:

- Staff have stated:

  "We're not stacking credits until the task force comes and makes us."

- Individuals with verified home plans are being told they will receive only their 10% home confinement date, regardless of how many credits they earned.

- Staff are refusing to process recalculations, not responding to inquiries, and stalling all case management functions.

- There has been no transparency regarding release dates or prerelease processing.

This reflects willful policy defiance, delayed releases, and intentional obstruction of federally mandated credit application.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Description	Policy / Statute Violated
Refusal to Apply FSA Credits	Staff telling individuals they will not “stack credits” unless forced by the national task force.	First Step Act (18 U.S.C. § 3632); June 17, 2025 Directive
Arbitrary Home Confinement Restrictions	Individuals with housing being told they only get 10% HC regardless of eligibility.	Second Chance Act; 18 U.S.C. § 3624(c)
Insubordination / Policy Defiance	Staff openly refusing to follow BOP leadership directives.	P.S. 3420.12 Standards of Employee Conduct
Obstruction of Release Dates	Recalculations stalled or denied, delaying lawful release.	FSA Implementation Guidance; 18 U.S.C. § 4042
Lack of Transparency	No communication on timelines, reviews, or required paperwork.	Administrative Remedy Program; Due Process considerations

---

3. DIRECT QUOTE FROM INSIDE

Anonymous statement from an incarcerated individual (Dec 1, 2025):

> “Case management at Anderson told inmates they are not going to stack our credit until the so-called task force comes and makes them. If you have a home, they said you are only getting your 10% home confinement date.”

Multiple individuals confirm hearing identical instructions.

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

The Loved Ones Coalition formally demands:

1. Immediate FSA/SCA compliance review at FPC Anderson, including credit calculations and release timelines.

2. Recalculation of all Earned Time Credits for individuals whose prerelease dates were improperly delayed.

3. Written explanation from facility leadership addressing why staff are refusing to follow national directives.

4. Audit of all home confinement determinations to confirm the 10% HC rule is not being used as a blanket, unlawful restriction.

5. Misconduct investigation into staff issuing knowingly false or misleading information.

6. Mandatory corrective action to bring FPC Anderson into compliance with the June 17 Directive and statutory requirements.

FPC Anderson’s explicit refusal to apply FSA credits and reliance on unauthorized “task force” justification represents serious insubordination and unlawful obstruction of release.

FCI EDGEFIELD

---

1. SUMMARY OF ALLEGATIONS

Incarcerated individuals at FCI Edgefield report a pattern of retaliation, unsafe facility conditions, and misuse of authority by staff. Allegations include:

- Two officers verbally abusing residents and threatening SHU placement for minor issues.
- Food service retaliation, including confiscating workers' bowls and threatening SHU placement for bringing personal items to chow.
- A severely leaking hot water line—previously "patched"—now pushing water up through the ground near the chow hall walkway.
- Imminent risk of flooding affecting the walkway, law library, and chow hall if not repaired.
- Thanksgiving meal deprivation, where the facility served breakfast, lunch, and dinner all at 8 AM on Thanksgiving Day, violating federal meal timing standards and holiday meal protocol.

These conditions reflect systemic neglect, retaliation, and disregard for basic federal standards of care and safety.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Description	Policy / Statute Violated
Threatening Incarcerated Workers	Officers threatened to send workers to SHU for bringing bowls to chow.	28 C.F.R. § 541.10; P.S. 3420.12
Food Service Retaliation	Confiscation of bowls; punitive behavior; claims that cooks are "cooking too much."	P.S. 4700.06 (Food Service Manual)

Infrastructure Failure – Hot Water Line	Main hot water line leaking through ground; earlier patch failed.	18 U.S.C. § 4042(a)(2); OSHA Standards; P.S. 1600.11
Risk to Walkways & Program Areas	Water threatening walkway, law library, and chow hall.	P.S. 4200.12 (Facility Operations)
Holiday Meal Deprivation (Thanksgiving)	Breakfast, lunch, and dinner all served at 8 AM on Thanksgiving Day.	P.S. 4700.06; ACA Meal Standards
Hostile Environment / Abuse of Authority	Officers “running it like a low or medium,” creating intimidation culture.	P.S. 3420.12

---

3. DIRECT QUOTES FROM INSIDE

Food Service Retaliation & SHU Threats

“Two officers try to run it like it’s a low or medium. The way they talk to us and treat us…”

“came into chow and took all the workers’ bowls.”

“After chow he told us if he catches anybody taking bowls into the chow hall again, he will do everything in his power to make sure we end up in the SHU that night.”

“Things are so messed up here that they served us breakfast, lunch, and dinner all at 8 AM — on Thanksgiving.”

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

The Loved Ones Coalition formally demands:

1. Immediate investigation into officer misconduct, including SHU threats toward food service workers.

2. Engineering review and emergency repair of leaking hot water lines affecting walkways and program areas.

3. Sanitation and safety inspection of all areas impacted or at risk of flooding.

4. Food Service compliance audit, including meal timing, holiday protocol, and retaliation risks.

5. Accountability measures for staff weaponizing SHU placement for minor infractions.

6. Written corrective plan outlining repair timelines, staff retraining, and renewed adherence to federal policy.

FCI MIAMI CAMP

---

1. SUMMARY OF ALLEGATIONS

Multiple handwritten statements and emails from incarcerated individuals at FCI Miami Camp report extreme, retaliatory, and life-threatening conditions under the authority of Lt. Gonzalez and other staff. Across all testimonies, consistent themes include:

- Total denial of drinking water and ice during lockdowns, even during 90–100° Miami heat.

- Staff declaring they “don’t care if they lose their job” and will continue abusing power.

- Retaliatory lockdowns lasting days for incidents residents could not have participated in.

- Mass punishment restricting water, movement, and access to medical services.

- Documented medical neglect, including:

    - A person with leukemia being denied necessary medical care.

    - Multiple individuals getting sick after being forced to drink contaminated sink water.

- Severe infrastructure failure, including:
    - Broken AC
    - Broken showers and urinals
    - Rusted lockers
    - Only 5 of 14 computers working
    - Kitchen equipment nonfunctional; flies throughout food prep areas
    - Library, music, leather, and programming rooms routinely closed
- Staff refusing to allow water retrieval despite medically vulnerable conditions.
- J-side targeted with constant shakedowns, more frequent than some low-security prisons.

These conditions pose immediate risks to health, safety, and life, particularly for individuals with chronic or immune-compromised medical needs.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Denial of drinking water and ice during lockdowns	Eighth Amendment; 18 U.S.C. § 4042(a)(2); PS 1600.11; PS 5566.06
Retaliatory lockdowns & mass punishment	PS 5521.05; Constitutional protections against collective punishment

Staff misconduct & threats (“I don’t care if I lose my job”)	PS 3420.12 (Employee Conduct); PS 1210.25 (Investigations)
Medical neglect including leukemia patient	PS 6031.04; Deliberate Indifference Standard (Estelle v. Gamble)
Forcing inmates to drink contaminated water	PS 1600.11; 28 C.F.R. § 551.100
AC failure, sanitation hazards, broken infrastructure	18 U.S.C. § 4042; PS 1600.11; PS 4200.12
Blocked access to medical care for chronic conditions	PS 6031.04
Failure to provide programming	First Step Act mandated programming; PS 5410.01

---

3. DIRECT QUOTES FROM INSIDE

“We are not animals. This is no way to treat us.”

“We have to drink water from the sink and a few people are sick with the runs due to the water.”

“I have a chronic condition and need to drink a lot of water.”

“Lt. Gonzalez told us he does not care about losing his job — ‘write it up.’ After threatening to lock us down.”

“We thought we would be safe here. We were wrong.”

“Now we are being treated inhumane on top of everything.”

“We have no AC, no working showers, no urinals, everything is broken.”

“Library is closed even on days it’s supposed to be open.”

“Staff shows up when they want. Most days we don’t have a counselor.”

“Kitchen equipment is broken. Food is affected. Flies everywhere.”

“We are on lockdown for something on the roof none of us even did — we can’t even get up there.”

“They told her to lock all doors and not let us get water or ice.”

---

4. OVERSIGHT DEMANDS — LOVED ONES COALITION

1. Immediate investigation into Lt. Gonzalez, including:
    - Abuse of authority
    - Retaliation
    - Deprivation of basic human needs
    - Violations of BOP policy and constitutional protections
2. Immediate restoration of essential services, including:
    - Clean drinking water
    - Ice during lockdowns
    - Functioning AC
    - Repair of showers, urinals, and hot water systems
3. Emergency medical review for:
    - The leukemia patient denied care
    - All individuals reporting illness from contaminated water
    - Those with chronic health conditions requiring hydration
4. Full environmental health & sanitation inspection, including:

    - Water quality testing
    - Kitchen inspection
    - HVAC assessment

5. End to unlawful mass punishment practices, including retaliatory lockdowns and collective discipline.
6. Restoration of FSA-required programming, including library access, education rooms, and rehabilitative spaces.
7. Referral to OIA/OIG based on staff threats, misconduct, and intentional violations of safety and medical policy.

USP COLEMAN I

---

1. SUMMARY OF ALLEGATIONS

A medically dependent incarcerated individual at USP Coleman I reports severe medical negligence involving catheter care. According to the individual's testimony, staff:

- Provided a catheter of the wrong size
- Provided no lubrication, instead instructing the individual to "spit in it"
- Caused a painful bladder infection due to unsanitary and improper insertion
- Ignored repeated medical pleas and written requests
- Allowed three weeks to pass before an outside specialist received the individual's letters requesting help
- Forced a medically vulnerable person to endure prolonged infection and fear
- Allowed this to occur despite Warden Withers and Warden White being fully aware and documentation confirming the complaints

The conduct described represents deliberate medical indifference, violation of federal medical standards, and knowing neglect of a disabled, medically dependent individual.

---

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Catheter inserted with no lubrication	P.S. 6031.04 (Patient Care); ADA; Eighth Amendment
Wrong catheter size supplied	Medical duty of care; malpractice-level negligence
Staff instructing inmate to “spit in it”	Eighth Amendment violation; unsafe, unsanitary medical practice
Infection resulting from improper procedure	P.S. 6031.04; deliberate indifference
Three-week delay before specialist received letter	Interference with medical care; Eighth Amendment
Wardens Withers & White aware but took no action	Administrative misconduct; P.S. 3420.12
Individual medically dependent on staff	Heightened ADA obligations; constitutionally protected duty of care
Documented suffering and fear	Eighth Amendment deliberate indifference standard

---

3. DIRECT QUOTES FROM INSIDE

“I was left in a cell. I catheter and they gave me no lube and the wrong size.”

“They told me to spit in it.”

“I got an infection.”

“I filed and filed. It took 3 weeks for my specialist to get my letter and help me.”

“I had a bladder infection. They are corrupt.”

“Warden Withers and Warden White were aware — it’s all documented.”

“I suffered. I am dependent on them. This was so scary to be left like that.”

---

4. OVERSIGHT DEMANDS — USP COLEMAN I

1. Immediate external medical review

   Independent assessment of catheter use, infection treatment, and ongoing medical needs.

2. Investigation into staff medical abuse

   Including:

   - Use of wrong catheter size
   - Ordering a medically dependent person to “spit” into a catheter
   - Failure to provide sterile supplies

3. Administrative accountability for Wardens Withers & White

   Verify all documentation showing they were aware and failed to intervene.

4. Investigation into medical communication delays

   The three-week delay before a specialist received the individual’s request poses serious

risk.

5. ADA compliance review

   Ensure protections for medically dependent individuals are being followed.

6. OIA/OIG referral

   The combination of improper medical procedure, documented infection, neglect, and administrative awareness meets federal misconduct investigation thresholds.

FCI Atlanta

Summary of Allegations

A testimony from a family member reports that FCI Atlanta is experiencing severe infrastructure breakdowns, electrical hazards, dangerous leaks, elevator failures, contaminated food, and chronic lockdowns due to ongoing staffing issues. The conditions described present major environmental, health, and safety risks and indicate a facility operating far below constitutional and regulatory standards.

Key Allegation & Violation Table

Allegation	Description	Potential Violations
Health & Environmental Hazards	Facility reportedly leaks everywhere when it rains; holes in ceilings; elevators constantly broken.	PS 1600.11 Environmental Health; OSHA workplace safety standards; 18 U.S.C. § 4042(a)(2)

Electrical Problems	Structural and electrical issues pose immediate safety risks.	OSHA electrical hazard standards; 28 C.F.R. § 541.31
Unsanitary & Unsafe Food	Food “not suitable to be fed to prisoners” and reportedly making incarcerated people sick.	28 C.F.R. § 547.20; PS 4700.06 Food Service Manual; Eighth Amendment
Chronic Lockdowns Due to Staffing	Locked down “most of the time” because staff do not report to work.	18 U.S.C. § 4042(a)(1) duty to operate facility safely; failure to provide adequate staffing
Failure of Staff to Report to Work	Workers “never come to work when they’re supposed to.”	Possible time fraud, administrative misconduct, PS 3420.09 Standards of Employee Conduct

---

Direct Testimony

> “The Fed prison in GA. The place is a health hazard as well as electricity problems. Place leaks everywhere when rains. Holes in ceilings. Elevators break all time.”
>
> “Food is not suitable to be fed to prisoners as far as it making them sick.”
>
> “The whole place should be closed down.”
>
> “Workers never come to work when they supposed to. They stay on lockdown most of the time due to staff issues.”

Oversight Demands

1. Immediate structural integrity inspection by an independent engineering/environmental firm.

2. Electrical hazard assessment and mandatory repairs coordinated with OSHA and BOP Facilities Management.

3. Emergency food safety review, including kitchen sanitation audit and food sourcing verification.

4. Staffing audit to determine chronic absenteeism and misconduct.

5. Public accountability report from the Warden and Southeast Region regarding operational safety.

6. Temporary facility downgrade or partial closure until safety standards are restored.

7. Medical review for all individuals reporting illness due to food or environmental conditions.

8. Congressional inquiry into why a facility with a documented history of collapse remains open without federal intervention.

FCI JESUP (LOW)

---

1. SUMMARY OF ALLEGATIONS

A wheelchair-bound, mentally ill, fall-risk incarcerated individual at FCI Jesup Low has reportedly endured significant harm, retaliation, and disability-related barriers since arriving in June. According to his mother:

- All property from FCI Thomson was lost or arrived destroyed.

- He was extorted for “rent” and “protection,” paying approximately $3,000 from disability funds.

- When he reported the extortion, he was placed in Protective Custody (PC), not the perpetrators.
- While in PC for months, he has had no phone access, no email access, and extremely limited communication.
- His wheelchair prevents him from reaching phone banks or accessing services.
- Newly purchased property (tablet, radio) is missing or broken.
- His letters are almost unreadable due to improper scanning.
- He is skipped by the library cart or given inappropriate books he did not request.
- The Executive Assistant acknowledged the complaint but no corrective action has followed.

---

2. KEY ALLEGATION & POLICY REFERENCE TABLE

Allegation	Description	Relevant Policies / Standards
Loss & destruction of property	Property lost or damaged between transfers	PS 5580.08; 18 U.S.C. § 4042
Extortion & forced payments	Vulnerable, disabled inmate extorted for “rent” & “protection”	PREA safety obligations; 28 C.F.R. § 541
Retaliatory PC placement	Reporter of abuse placed in PC instead of protected	PS 3420.12; 28 C.F.R. § 541
Denied disability accommodations	Wheelchair user unable to reach phones or services	ADA; Rehabilitation Act

Blocked communication	No phone/email; unreadable letters due to scanning issues	PS 5265.14; PS 4500.11
Discriminatory library access	Library cart skipping him; inappropriate materials given	PS 5360.09; Equal Protection
Mail handling issues	Letters scanning blank or unreadable	PS 5265.14
Failure to protect	Disabled person exposed to predatory extortion	18 U.S.C. § 4042

---

3. DIRECT QUOTES FROM FAMILY

- “We had to repurchase everything he bought at Thomson. It either never arrived or arrived broken.”
- “My son is in a wheelchair… bipolar 1 with psychosis, PTSD, and dissociative disorder.”
- “He had to pay rent for his cell and pay for protection. When he reported it, he was punished instead.”
- “He has no phone privileges because he can’t reach the phone banks.”
- “His tablet and radio are gone—or broken.”
- “His letters scan as blank pages.”
- “The library cart skips him and gives him books he didn’t request.”
- “The Executive Assistant acknowledged my complaint but nothing has changed.”

---

4. OVERSIGHT DEMANDS — FCI JESUP (LOW)

A. Safety, Housing, and Accommodations

- Review whether current housing and PC placement meet disability and mental-health needs.
- Ensure ADA-required accommodations for phone, communication, and mobility.

B. Response to Extortion Allegations

- Confirm whether extortion reports were processed according to policy.
- Assess whether the facility adequately protected a vulnerable individual.

C. Communication Access

- Review phone/email restrictions for PC placement involving individuals with mobility limitations.
- Investigate mail-scanning issues resulting in unreadable letters.

D. Property Handling

- Review transfer records from FCI Thomson.
- Determine whether repeated loss/damage indicates systemic issues.

E. Library and Programming Access

- Confirm equal access to library services and appropriate reading materials.

F. Family Communication

- Clarify current communication restrictions and whether alternative accommodations are possible within BOP policy.
