LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Violations Across the Federal Bureau of Prisons

December 15, 2025

INTRODUCTION

This report documents widespread, recurring, and systemic failures across multiple facilities operated by the Federal Bureau of Prisons (BOP). The allegations detailed herein reflect conditions that are no longer isolated incidents, temporary disruptions, or facility-specific anomalies, but rather indicators of an institutional system operating beyond its functional capacity.

Across regions and security levels, incarcerated individuals and cooperating staff report conditions including unsafe food service, unsanitary lockdown practices, extreme temperature exposure, medical and mental health neglect, unlawful communication restrictions, coercive labor practices, sexual abuse and retaliation, obstruction of statutory release mechanisms, and preventable deaths. The evidence and facility-specific findings supporting these allegations are documented in detail throughout this report.

A consistent and unavoidable theme emerges: current Bureau of Prisons facilities cannot safely sustain their existing populations under present staffing, infrastructure, and oversight conditions.

Chronic staffing shortages have resulted in prolonged lockdowns, suspended sanitation, delayed medical care, inadequate supervision, and failures to prevent violence and sexual abuse. Despite ongoing recruitment efforts, facilities continue to operate with insufficient staffing to meet even baseline safety, health, and constitutional obligations. There is no credible indication that staffing levels will stabilize at a scale sufficient to safely manage the current incarcerated population.

Compounding these failures is the Bureau’s continued practice of holding individuals past their lawful or conditional release eligibility. The Loved Ones Coalition has identified dozens of individuals who remain incarcerated months beyond their conditional release dates due to First Step Act miscalculations, administrative obstruction, delayed recalculations, and reliance on

court intervention to correct Bureau errors. Each instance of overdetention exacerbates overcrowding, strains already overwhelmed staff, and increases the risk of harm inside facilities.

Taken together, the conditions documented in this report demonstrate that population reduction is no longer discretionary—it is necessary to prevent further loss of life.

Incremental administrative changes, internal process updates, or future infrastructure plans cannot address the present crisis. Preventable deaths, serious injuries, and systemic rights violations are occurring now. The Bureau of Prisons cannot recruit, retain, or supervise its way out of a system operating beyond sustainable limits.

The evidence supporting these conclusions is provided below.

Systemic Food Safety Violations and Lockdown Sanitation Failures Across the Federal Bureau of Prisons

Summary of Allegations

Inmates and staff across multiple Bureau of Prisons facilities report the routine service of unsafe, undercooked, and visibly contaminated food, alongside lockdown practices that exacerbate unsanitary living conditions and increase health risks. Evidence reviewed by the Loved Ones Coalition (LOC) includes photographic documentation of visibly raw poultry served for consumption, staff statements regarding orders to serve questionable food regardless of safety concerns, and reports of repeated short-term lockdowns during which waste removal and sanitation are suspended.

These conditions appear to be systemic rather than isolated, reflecting institutional practices that prioritize expediency and cost containment over basic food safety standards, sanitation, and inmate health.

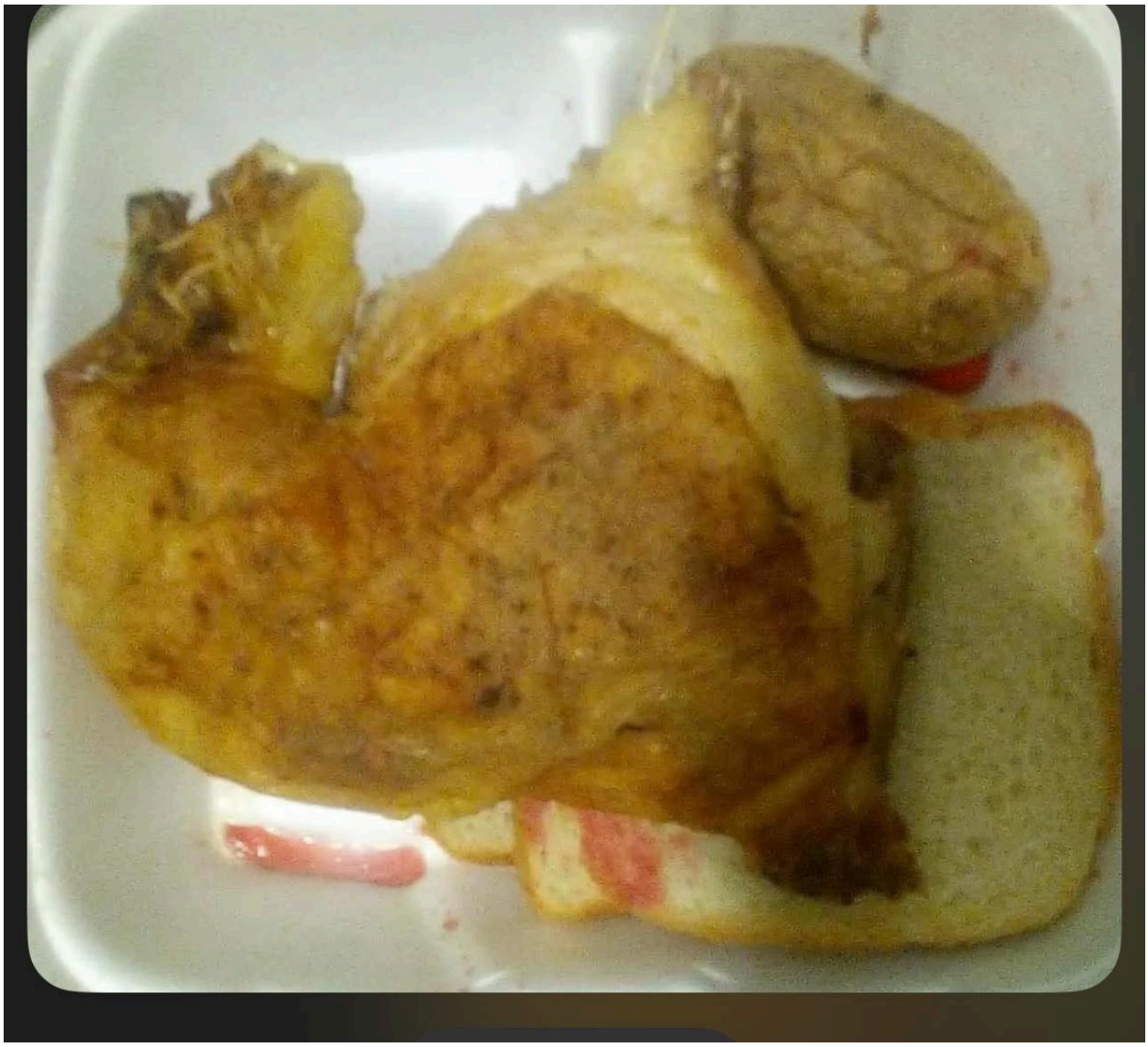
Unsafe and Undercooked Food Service

LOC has reviewed photographic evidence depicting a meal tray containing a large portion of chicken with visible blood pooling and seepage into surrounding food items, including potatoes and bread. While the portion size may appear adequate at first glance, the presence of visible blood strongly indicates undercooked poultry, rendering the meal unsafe for consumption.

Inmates report that such meals are routinely served, and staff sources confirm that kitchen operations have been instructed to serve food regardless of visible quality or safety concerns.

Leadership has allegedly dismissed objections by stating that meals must be served as prepared, even when food is visibly undercooked or contaminated.

The service of raw or undercooked poultry presents a serious risk of foodborne illness, including salmonella and campylobacter infections, particularly in congregate living environments where illness can spread rapidly.



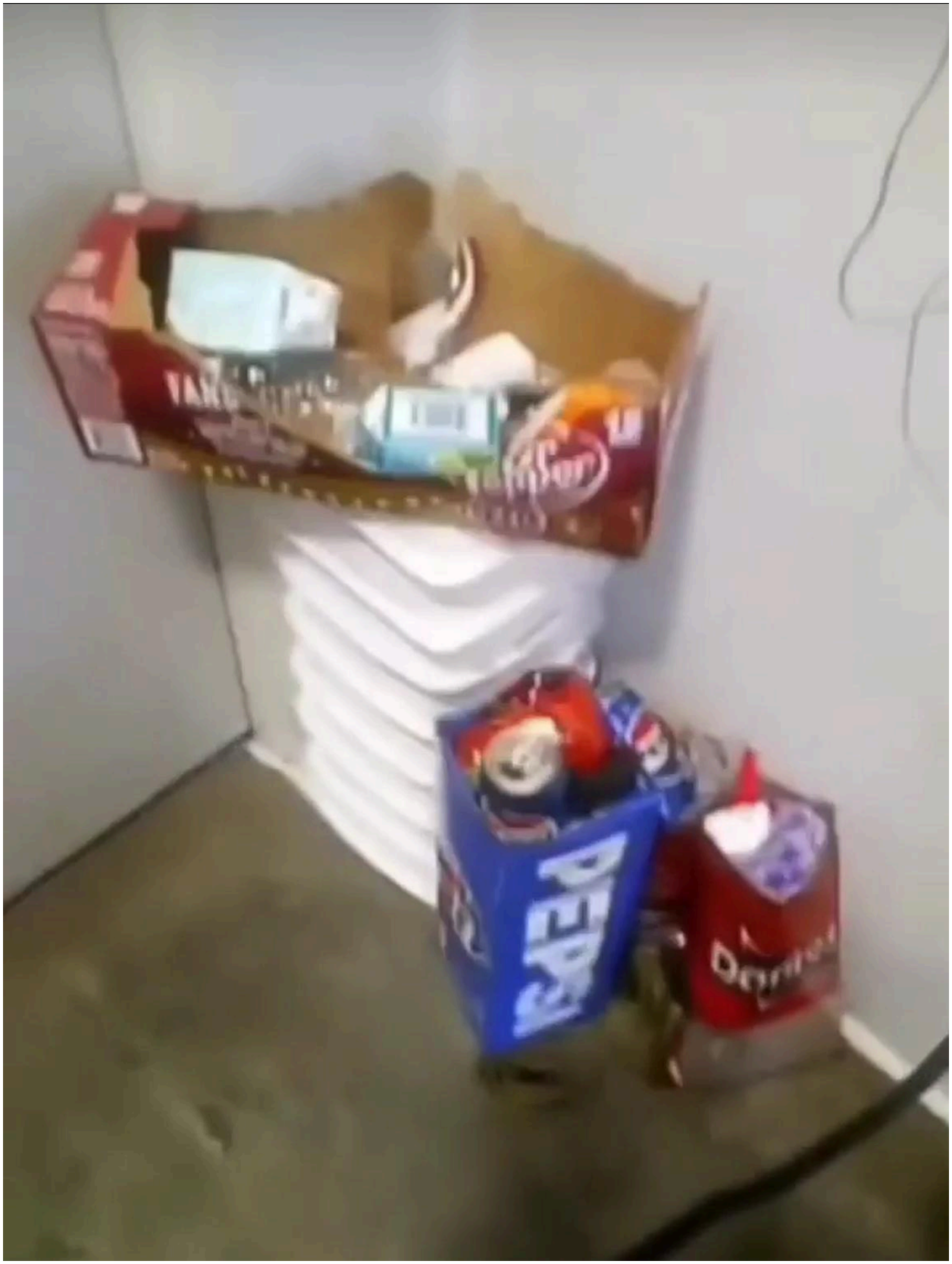
Lockdown Meal Distribution and Sanitation Conditions

In addition to unsafe food preparation, inmates report that frequent short-term lockdowns—often lasting approximately 24 to 36 hours—create unsanitary conditions that compound health risks. During these lockdowns:

- Meals are distributed in bagged form with limited oversight.
- Trash collection is suspended for the duration of the lockdown.
- Multiple individuals confined in small cells are required to store food waste, packaging, and leftovers in close quarters.
- Accumulated trash produces strong odors and attracts pests.
- No sanitation mitigation measures are implemented during the lockdown period.

Staff sources confirm that these lockdowns constitute mass punishment rather than responses to individualized security threats. The lack of trash removal and sanitation during lockdowns is

not an oversight but a predictable consequence of institutional policy decisions.



Health Impacts

The combined effects of unsafe food service and unsanitary lockdown conditions have resulted in widespread reports of gastrointestinal illness, nausea, vomiting, and general deterioration of health. Inmates report being forced to choose between consuming visibly unsafe food or going without adequate nutrition. These conditions are especially dangerous for individuals with compromised immune systems, chronic illnesses, or existing medical conditions.

Serving raw or contaminated food and suspending sanitation during lockdowns violates basic public health principles and creates foreseeable medical harm.

Systemic Pattern

LOC's review indicates that these practices are not confined to a single facility. Similar food safety complaints and lockdown sanitation failures have been reported across multiple institutions, suggesting a systemic failure in oversight, food service accountability, and institutional leadership.

The routine normalization of unsafe food service and unsanitary confinement conditions reflects a broader culture of indifference to inmate health and safety within the Bureau of Prisons.

Oversight Concerns

These conditions raise serious concerns regarding compliance with:

- Federal food safety standards
- Bureau of Prisons health and sanitation policies
- Constitutional protections against cruel and unusual punishment

The continued service of visibly undercooked food and the intentional suspension of sanitation during lockdowns represent preventable risks that leadership has failed to address.

SYSTEMIC HEAT DEPRIVATION, RETALIATORY ENVIRONMENTAL CONTROL, AND RESULTING HEALTH IMPACTS — BUREAU OF PRISONS (NATIONWIDE)

SUMMARY OF ALLEGATIONS

Inmates across multiple Bureau of Prisons facilities have consistently reported freezing temperatures inside housing units for extended periods of time. These reports have been received week after week, across multiple regions, security levels, and climates, including facilities experiencing freezing temperatures and snowstorms.

Inmates report prolonged exposure to cold conditions inside housing units, with heat either absent entirely or shut off for extended periods. These conditions persist despite outdoor temperatures reaching freezing levels and despite staff areas within the same institutions maintaining heat.

Cooperating Bureau of Prisons staff have corroborated these reports and confirmed that heating systems are operational but are activated selectively on a unit-by-unit basis rather than institution-wide. Staff report that inmate housing units are routinely left without heat while administrative and staff-controlled areas remain heated.

Staff further report that denial of heat is, in some instances, used as a retaliatory or punitive measure against specific housing units or populations. In other instances, staff report being told that heating repairs or continued operation are “not in the budget,” despite the known health risks and ongoing cold exposure.

Correctional officers at multiple facilities have reportedly attempted to address heating failures themselves due to prolonged administrative inaction, including making informal or unauthorized repairs. These efforts reflect the severity, duration, and normalization of unsafe conditions.

Taken together, these reports demonstrate a systemwide pattern of environmental control being used punitively, deliberate failure to maintain habitable temperatures, and administrative indifference to inmate health and safety.

HEALTH IMPACT

Inmates report becoming sick as a direct result of prolonged cold exposure, including respiratory illness, persistent coughing, worsening of chronic conditions, and weakened immune response. Inmates report being unable to adequately warm themselves, particularly during overnight hours and extended lockdown conditions.

The prolonged denial of heat exacerbates existing medical vulnerabilities, increases the risk of infection, and contributes to physical deterioration and psychological distress. Staff report observing widespread illness among inmates during periods when housing units lacked heat.

The continuation of these conditions despite repeated reports indicates a failure to meet basic habitability standards and a disregard for foreseeable harm.

POLICY & LEGAL CONCERNS

These allegations raise serious concerns regarding violations of:

- 18 U.S.C. § 4042(a)(2) — Duty to protect inmate health and safety
- BOP Program Statement 1600.11 — Environmental Health & Safety
- 28 C.F.R. § 551.10–551.16 — Habitability and sanitation standards
- Eighth Amendment — Deliberate indifference to conditions of confinement

The selective provision of heat, particularly where staff areas remain heated, undermines any claim that heating failures are unavoidable or purely mechanical.

CONCLUSION

Inmates and staff report a systemwide pattern of freezing housing conditions, selective heat distribution, and administrative refusal to remedy known hazards. The repeated use of heat deprivation—whether for retaliation, cost avoidance, or administrative neglect—constitutes unsafe conditions of confinement and deliberate indifference to inmate health.

The Bureau of Prisons is now on notice of a nationwide issue. Continued inaction will be treated as ongoing noncompliance with federal law, Bureau policy, and constitutional obligations.

FCI LEWISBURG (TRANSFER CENTER) — Sewage-Contaminated Showers, Drainage Failure, and Unsafe Sanitation Conditions

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received reports from incarcerated individuals, their families, and cooperating staff regarding unsanitary and hazardous shower conditions inside the Lewisburg Transfer Center. Reports specifically describe first-floor shower facilities that do not drain properly during use.

According to the testimony provided, when these showers are used, water accumulates to ankle level. Individuals report that this standing water contains bodily waste and residue, including fecal matter, urine, sweat, and other biological contamination. These conditions are described as unavoidable for individuals attempting to bathe.

The presence of standing water mixed with human waste in shower facilities constitutes an environmental health hazard and a failure to maintain minimally sanitary living conditions. These conditions place incarcerated individuals at risk of exposure to biological contaminants and violate basic sanitation and safety obligations.

This report places the Bureau of Prisons on notice of conditions at the Lewisburg Transfer Center that require immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Shower facilities fail to drain properly, causing standing water	BOP P.S. 1600.11 (Environmental Health & Safety)
Standing water contaminated with fecal matter and bodily waste	28 C.F.R. § 551.10–551.16 (Sanitation Standards)
Exposure to biological contaminants during bathing	18 U.S.C. § 4042(a)(2) (Duty to Protect)
Failure to provide sanitary shower facilities	Eighth Amendment — unsafe living conditions

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at the Lewisburg Transfer Center:

- “The showers on the first floor don’t drain properly.”
- “When the showers are used, the water comes up to ankle level.”
- “The water contains fecal matter, urine, sweat, and other contamination.”
- “It’s extremely unsanitary.”

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4. OVERSIGHT DEMANDS — FCI LEWISBURG (NORTHEAST REGION)

The Loved Ones Coalition states that FCI Lewisburg must immediately take the following actions:

1. Immediate Environmental Health Inspection

   The facility is required to inspect all first-floor shower areas to identify drainage failures and sanitation hazards.

2. Immediate Corrective Maintenance

   Shower drainage systems must be repaired or removed from service until standing-water conditions are fully eliminated.

3. Sanitation and Biohazard Remediation

   Affected shower areas must be professionally cleaned and sanitized to remove biological contamination and restore sanitary conditions.

4. Verification of Compliance

   Facility leadership is required to ensure that shower facilities meet minimum sanitation

standards under federal regulations and BOP policy.

5. Accountability Review

   Failure to correct these conditions after notice constitutes continued noncompliance with environmental health and safety obligations.

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5. CONCLUSION

Forcing individuals to bathe in standing water contaminated with fecal matter and bodily waste presents a serious sanitation and environmental health risk. Federal standards require that incarcerated individuals be provided access to sanitary bathing facilities.

The conditions reported at the Lewisburg Transfer Center require immediate corrective action. Continued inaction after notice will be treated as ongoing noncompliance with federal sanitation requirements and constitutional obligations.

FCC HAZELTON (WV) — Extreme Cold Exposure, Heating Failures, and Degrading, Sexually Intrusive Visitation Practices

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received multiple reports from incarcerated individuals, their families, and cooperating staff describing freezing housing conditions inside FCC Hazelton during winter weather, including reports that cells are “literally like being outside.” Testimony indicates that cold air is entering living areas, creating conditions comparable to outdoor exposure during a period that included a substantial snowstorm.

Multiple reports state that no heat is being provided, and that incarcerated individuals are freezing inside their cells. These reports raise serious concerns regarding the failure to maintain habitable temperatures during winter conditions.

In addition to environmental conditions, the Coalition received detailed testimony describing degrading, inconsistent, and sexually intrusive visitation screening practices. Reports describe visitors being subjected to multiple clothing changes, extended delays, denial of jackets despite

freezing temperatures, and invasive scrutiny of visitors' bodies in response to normal physiological reactions to cold.

One account describes a visitor being denied access because nipples were visible due to cold exposure, despite the absence of contraband, and being required to remove clothing, remove a non-wire bra, change outfits multiple times, and ultimately tape nipples in order to be permitted entry. During this process, staff reportedly questioned whether the visitor's nipples were pierced and made comments unrelated to security needs.

Despite repeated searches, scans, and pat-downs, no contraband was found. These practices are described as inconsistent across days, with markedly different procedures applied on different visitation days without explanation.

This report places the Bureau of Prisons on notice of conditions at FCC Hazelton involving unsafe cold exposure and degrading visitation practices that require immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Housing units reported as freezing with no heat during winter conditions	18 U.S.C. § 4042(a)(2) (Duty to Protect and Provide Safe Conditions)
Exposure of incarcerated individuals to extreme cold	Eighth Amendment — unsafe and inhumane living conditions
Failure to maintain habitable indoor temperatures	BOP P.S. 1600.11 (Environmental Health & Safety)
Ongoing cold conditions during snowstorm	28 C.F.R. § 551.10–551.16 (Facility Habitability Standards)

Arbitrary, degrading, and intrusive visitation screening	28 C.F.R. § 540 (Visitation Regulations)
Sexually intrusive questioning and body-focused scrutiny unrelated to security	Due Process; BOP Standards of Conduct
Inconsistent enforcement of visitation rules	BOP Visitation Policy; Equal Treatment Obligations

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at FCC Hazelton:

- “It felt like the doors were open and all the cold air was just coming inside.”
- “We just had a substantial snowstorm and inmates are freezing.”
- “I had to change clothes multiple times just to get scanned.”
- “They made me take my bra off even though it wasn’t a wire bra”
- “They wouldn’t let me in because my nipples were hard from the cold.”
- “I had to tape my nipples just to be allowed in.”
- “One officer asked if my nipples were pierced.”
- “They talked to me like I was the problem.”
- “The delays were excessive and humiliating.”

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4. OVERSIGHT DEMANDS — FCC HAZELTON (MID-ATLANTIC REGION)

The Loved Ones Coalition states that FCC Hazelton must immediately take the following actions:

1. Immediate Heating System Verification and Repair
    - Confirmation that heat is functioning in all housing units
    - Immediate correction of any heating failures
2. Cold-Weather Habitability Assessment
    - Documentation of indoor temperatures during winter conditions
    - Verification that housing areas meet minimum habitability standards
3. Immediate Review of Visitation Screening Practices
    - Review of body-focused screening practices for compliance and necessity
    - Prohibition of sexually intrusive or humiliating questioning unrelated to security
4. Standardization of Visitation Procedures
    - Elimination of arbitrary or inconsistent enforcement across visitation days
    - Written guidance to ensure uniform application of rules
5. Staff Conduct Review
    - Review of interactions involving degrading language, body-focused scrutiny, or unnecessary intrusion
    - Corrective action where conduct violates standards of professionalism
6. Corrective Action Plan
    - Written plan addressing heating failures and visitation compliance
    - Immediate safeguards to prevent recurrence

Failure to correct these conditions after notice constitutes continued noncompliance with federal safety, habitability, and constitutional obligations.

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5. CONCLUSION

Reports of freezing housing conditions during winter weather, combined with degrading and sexually intrusive visitation practices, raise serious concerns regarding conditions of confinement and treatment of the public at FCC Hazelton.

The Bureau of Prisons is now on notice of these conditions. Continued inaction exposes the Bureau to liability and will be treated as ongoing deliberate indifference to health, safety, and due process obligations.

FCI GILMER (WV) — Excessive Forced Labor During Lockdown and Violation of Inmate Work Hour Limits

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received reports from incarcerated individuals, their families, and cooperating staff regarding extreme and excessive work assignments imposed during a lockdown at FCI Gilmer (Medium) involving the forced reassignment of camp-level incarcerated individuals to the medium facility.

According to consistent testimony, during a lockdown at the medium facility, camp-level individuals were pulled into the medium while medium-level individuals were confined to their housing units. Reports state that the reassigned individuals were required to work from approximately 4:30 a.m. until 10:30–11:00 p.m., spanning Saturday, Sunday, and part of Monday.

These work shifts reportedly extended far beyond standard workday limits, with little to no rest, and without individualized assessment of physical capability. Reports raise concern that some individuals were not physically able to sustain such prolonged labor but were nonetheless required to do so during lockdown conditions.

The described conditions indicate systemic overwork, coercive labor practices, and disregard for established Bureau of Prisons work-hour policies, particularly during a period when normal institutional operations were restricted.

This report places the Bureau of Prisons on notice of potential violations of inmate work regulations and health and safety obligations at FCI Gilmer.

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Incarcerated individuals required to work from early morning to late night	BOP Program Statement 5251.06 (Inmate Work and Performance Pay)
Work assignments vastly exceeding normal daily limits	18 U.S.C. § 4042(a)(2) (Duty to Protect Health and Safety)
Forced labor during lockdown conditions	Eighth Amendment — unsafe and coercive conditions
Failure to assess physical ability to perform prolonged labor	BOP Work Assignment Standards
Disparate treatment between camp and medium populations during lockdown	Due Process; Equal Protection Principles

Policy Reference (as provided):

BOP Program Statement 5251.06 establishes that the standard scheduled inmate workday is normally seven (7) hours per day for institutional job assignments.

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at FCI Gilmer:

- “They worked from 4:30 in the morning until 10:30 or 11 at night.”

- “This went on Saturday, Sunday, and part of Monday.”
- “Some of these guys can not physically do all that work.”

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4. OVERSIGHT DEMANDS — FCI GILMER (MID-ATLANTIC REGION)

The Loved Ones Coalition states that FCI Gilmer must immediately take the following actions:

1. Immediate Review of Lockdown Labor Practices
    - Documentation of work assignments imposed during the reported lockdown
    - Verification of hours worked per individual
2. Compliance Audit With BOP Program Statement 5251.06
    - Confirmation that inmate work assignments comply with the seven-hour standard workday
    - Identification of deviations and authorization records
3. Health and Safety Assessment
    - Review of whether individuals were medically and physically capable of performing extended labor
    - Evaluation of injury, exhaustion, or medical risk exposure
4. Policy Clarification for Lockdown Conditions
    - Written clarification regarding permissible labor hours during lockdowns
    - Assurance that lockdown status is not used to justify excessive or coercive labor
5. Corrective Action Plan
    - Immediate safeguards to prevent recurrence
    - Oversight mechanisms to ensure work assignments remain compliant with policy

Failure to correct these practices after notice constitutes continued noncompliance with federal work-hour regulations and health and safety obligations.

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5. CONCLUSION

Requiring incarcerated individuals to work from early morning until late night over multiple consecutive days—particularly during a lockdown—raises serious concerns regarding coercive labor practices, physical safety, and compliance with Bureau of Prisons policy.

The Bureau of Prisons is now on notice of allegations that inmate work assignments at FCI Gilmer exceeded lawful limits and failed to account for physical capability. Continued inaction exposes the Bureau to legal and constitutional liability and requires immediate corrective action.

FCI JESUP (LOW & CAMP) — Extreme Cold Exposure, Infrastructure Failures, Food Shortages, FSA Obstruction, and Documented Staff Misconduct

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received detailed reports from incarcerated individuals, their families, and cooperating staff describing systemic failures at FCI Jesup (Low and Camp) involving unsafe cold exposure, broken water heaters, food shortages, abusive staff behavior, and widespread obstruction of First Step Act (FSA) time credit processing.

Reports indicate that temperatures inside housing units have been extremely low, coinciding with outdoor temperatures in the high 20s to low 30s. Individuals report that water heaters failed in at least one unit, resulting in no hot water and leading many to avoid showering altogether due to the cold. A short-term repair was reportedly performed by a staff member acting outside their normal duties, leaving the underlying infrastructure issue unresolved.

Additional reports describe chronic food shortages, including situations where mainline meals do not open due to staffing shortages, leaving food availability at “critical levels.” Testimony further describes a work environment characterized by bullying, disrespectful conduct, and abusive behavior by staff toward incarcerated individuals.

The Coalition also received extensive testimony regarding systemic obstruction of First Step Act implementation, including reports that over 22 individuals with PS 2241 filings are past their FSA dates, with projected release dates reportedly being extended by an average of approximately 18 months. The case manager assigned to the camp is described as providing inconsistent and

confusing information, frequently stating “I don’t know what’s going on,” while directing individuals to TEAM without resolution.

Specific staff members are named in connection with alleged misconduct, abuse, and open defiance of Bureau directives. Reports include allegations that a Camp Administrator openly dismissed BOP administrative memoranda in front of 60–80 incarcerated witnesses, stating that leadership “didn’t care what was written” and that individuals should contact her office directly if they had a problem.

This report places the Bureau of Prisons on notice of serious, multi-layer systemic failures at FCI Jesup requiring immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Exposure to extreme cold and lack of hot water	18 U.S.C. § 4042(a)(2) (Duty to Protect Health & Safety)
Broken water heaters and failure to maintain habitable conditions	BOP P.S. 1600.11 (Environmental Health & Safety)
Individuals avoiding showers due to cold temperatures	Eighth Amendment — unsafe living conditions
Food shortages and mainline meal failures	28 C.F.R. § 551.10–551.16 (Sanitation & Basic Needs)
Staff bullying, disrespect, and abusive conduct	BOP P.S. 3420.09 (Standards of Conduct)
Systemic obstruction of First Step Act credits	First Step Act; BOP FSA Implementation Directives

Excessive extensions of release dates	Due Process; Arbitrary & Capricious Administrative Action
Open defiance of BOP administrative memoranda	Insubordination; Failure of Leadership Oversight

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at FCI Jesup:

- “The temperatures have been super low.”
- “The water heaters broke in one of the units.”
- “People weren’t even showering because it’s been in the high 20s and low 30s.”
- “It took a humane staff member who it wasn’t even his job to fix the water heaters, and it was only a short-term fix.”
- “Food has become a problem.”
- “Food is at critical levels.”
- “There are staff members who are absolute bullies.”
- “They are disrespectful and vicious in their behavior.”
- “There are over 22 2241s for people past their FSA date.”
- “The case manager keeps saying ‘I don’t know what’s going on.’”
- “Dates are being pushed back an average of about 18 months.”
- “The camp administrator said she didn’t care about the administrators’ memo.”

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4. STAFF IDENTIFIED IN TESTIMONY

The following staff members are specifically named in reports provided to the Coalition:

- Millwood — alleged staff misconduct and bullying
- Licklighter — alleged staff misconduct
- K. Smith (RDAP) — identified as a bully; subject of a BP-10 grievance reportedly ignored
- Case Manager Weird — alleged mismanagement and obstruction of FSA processing
- Camp Administrator Randolf — alleged open defiance of BOP administrative memoranda in front of incarcerated individuals

These names are included based solely on testimony received and warrant immediate review.

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5. OVERSIGHT DEMANDS — FCI JESUP (SOUTHEAST REGION)

The Loved Ones Coalition states that FCI Jesup must immediately take the following actions:

1. Emergency Infrastructure and Heating Review
    - Inspection of housing temperatures and water heater functionality
    - Permanent repair of heating and hot water systems
2. Food Service Audit
    - Immediate review of meal service disruptions
    - Assurance that staffing shortages do not result in denial of meals
3. Staff Conduct Investigation
    - Review of allegations involving named staff

- Examination of bullying, abusive behavior, and ignored grievances

4. First Step Act Compliance Audit
    - Immediate review of all individuals past their FSA eligibility dates
    - Correction of improper extensions and recalculation delays
5. Administrative Oversight Review
    - Investigation into reported open defiance of BOP memoranda
    - Accountability for leadership statements undermining policy compliance
6. Corrective Action Plan
    - Written plan addressing infrastructure, food service, staff conduct, and FSA compliance
    - Ongoing monitoring to prevent recurrence

Failure to take corrective action after notice constitutes continued noncompliance with federal law, BOP policy, and constitutional obligations.

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6. CONCLUSION

Reports from FCI Jesup describe a facility experiencing systemic breakdowns in basic living conditions, food access, staff professionalism, and statutory sentence administration. Allegations of open defiance of Bureau policy by leadership are particularly concerning and undermine institutional accountability.

The Bureau of Prisons is now on notice of these conditions. Continued inaction exposes the Bureau to significant legal and constitutional liability and demands immediate intervention.

FCI TALLADEGA (AL) — PREA INTERFERENCE, WITNESS INTIMIDATION, RETALIATION, AND ADMINISTRATIVE OBSTRUCTION

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received disturbing reports from incarcerated individuals, their families, and cooperating staff alleging direct interference with a PREA compliance review, retaliation against individuals attempting to report sexual abuse, and systemic intimidation orchestrated by facility leadership at FCI Talladega.

According to testimony, PREA auditors from Washington, D.C. conducted a compliance visit. Prior to the auditors' arrival, facility administration addressed the population and explicitly warned individuals to "behave" and not disclose negative information, stating that "bad things would happen" if they spoke openly.

Reports indicate that although PREA auditors sought to speak with incarcerated individuals, administration pre-selected four individuals and summoned them to Unit Manager Gillman's office, where they were instructed to say only positive things to the auditors under threat of retaliation affecting them and the compound.

Multiple incarcerated individuals attempted to speak directly with PREA auditors and were actively denied access.

One incarcerated individual, who had previously reported two separate PREA incidents, attempted to speak with the auditors. These incidents included:

- An alleged non-consensual strip search conducted by CO Mugol, where no contraband was found.
- A separate PREA-related incident involving Case Manager Nettles, previously reported to administration and the Office of the Inspector General (OIG).

During a prior administrative inspection walk, the incarcerated individual raised concerns directly to the Warden, stating that Case Manager Nettles was not performing her duties. Testimony states that Nettles responded with overt threats, telling the individual to keep her name "out of his mouth" or she would "put both her feet up his ass", allegedly in front of the Warden.

When PREA auditors arrived, the same incarcerated individual again attempted to speak with them regarding these incidents and his previously submitted OIG paperwork. The Assistant

Warden personally intervened, refused to allow communication with the PREA auditors, and ordered the individual to leave, stating the denial was “because I said so.”

Reports indicate PREA auditors visited only once during the entire year, raising further concerns regarding the integrity of compliance monitoring at FCI Talladega.

These allegations describe deliberate obstruction of federal oversight, retaliation for reporting sexual abuse, and leadership-level misconduct incompatible with PREA requirements and Bureau of Prisons policy.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Interference with PREA audit process	Prison Rape Elimination Act (34 U.S.C. § 30301 et seq.)
Threats prior to PREA interviews	PREA Standard § 115.67 (Protection from Retaliation)
Witness intimidation and coaching	PREA Standard § 115.86
Denial of access to PREA auditors	PREA Audit Integrity Requirements
Retaliation for prior PREA complaints	First Amendment; PREA § 115.67
Threats by staff toward incarcerated individuals	BOP P.S. 3420.09 (Standards of Employee Conduct)
Administrative obstruction and abuse of authority	18 U.S.C. § 4042(a); Due Process

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony received regarding FCI Talladega:

- “Admin talked to us first before the PREA people came in.”
- “They told us to behave and don’t say anything or bad shit was going to happen.”
- “Inmates tried to talk to the PREA people and were denied.”
- “Administration selected four people and told them to say good things.”
- “Bad things were going to happen to them and the compound if they didn’t.”
- “The PREA people wanted to talk to inmates.”
- “The Assistant Warden said no and told him to leave.”

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4. STAFF IDENTIFIED IN TESTIMONY

The following staff members are specifically named in reports received:

- CO Mugol — alleged PREA-related strip search without cause
- Case Manager Nettles — alleged PREA incident, retaliation, and verbal threats
- Unit Manager Gillman — alleged coordination of coached interviews
- Assistant Warden (name not provided) — alleged direct interference with PREA auditors

All names are included based solely on testimony provided and require immediate review.

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5. OVERSIGHT DEMANDS — FCI TALLADEGA (SOUTHEAST REGION)

The Loved Ones Coalition formally demands the following actions:

1. Immediate Independent PREA Review
    - External investigation into audit interference
    - Review of PREA access denials and coached interviews
2. Anti-Retaliation Investigation
    - Examination of threats made before and after PREA visits
    - Protection of individuals who previously reported abuse
3. Staff Conduct Review
    - Investigation into conduct of CO Mugol, Case Manager Nettles, Unit Manager Gillman, and the Assistant Warden
    - Review of alleged threats made in the presence of supervisory staff
4. Audit Integrity Safeguards
    - Assurance that future PREA audits allow unrestricted, confidential inmate access
    - Written corrective action plan submitted to Central Office
5. Disciplinary Accountability
    - Appropriate corrective or disciplinary action for substantiated violations

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6. CONCLUSION

The allegations at FCI Talladega describe systemic PREA noncompliance, leadership-level obstruction, and retaliation against individuals attempting to report sexual abuse. Such conduct undermines the integrity of federal oversight and exposes the Bureau of Prisons to serious legal and constitutional liability.

The Bureau of Prisons is now on notice. Continued inaction constitutes willful noncompliance with federal law.

FCI EDGEFIELD (SC) — CONTINUED SHU DETERIORATION, UNLAWFUL COMMUNICATION RESTRICTIONS, AND ESCALATING ADMINISTRATIVE FAILURE FOLLOWING PRIOR NOTICE

1. SUMMARY OF ALLEGATIONS

Last week, the Loved Ones Coalition formally notified the Bureau of Prisons of raw sewage exposure and unsanitary conditions in the SHU at FCI Edgefield. While the reported sewage issue has since been addressed, the Coalition notes that the delay itself was unacceptable and posed a serious health risk that should have been remedied immediately upon discovery.

Despite this limited corrective action, conditions in the SHU have continued to worsen, and new violations have emerged or intensified. Reports received this week from incarcerated individuals, their families, and cooperating staff describe ongoing and unlawful restrictions on mail, continued denial of phone access, and systemic failure by case management staff to intervene, compounding isolation and harm for individuals housed in the SHU.

Families report that correspondence has been withheld for weeks at a time without explanation, including instances where more than twenty letters were mailed without delivery, while only a single delayed response was received, postmarked weeks earlier. The lack of correspondence caused significant distress, with the incarcerated individual believing their family member may have been harmed due to the complete communication blackout.

In addition, reports confirm that phone access remains denied, further isolating individuals in the SHU from family, legal representatives, and outside oversight. These restrictions appear to exceed what is permitted under Bureau policy and are not accompanied by documented disciplinary justification.

Testimony further indicates persistent inaction by case management, with multiple reports stating that case managers are not responding, not advocating, and not correcting known communication failures, allowing violations to continue even after the facility was placed on notice.

Taken together, these reports demonstrate continued noncompliance following prior notice, raising serious concerns of deliberate indifference and systemic administrative failure at FCI Edgefield.

2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Delayed remediation of hazardous SHU conditions after notice	18 U.S.C. § 4042(a)(2)
Withholding incoming and outgoing mail	BOP P.S. 5265.14 (Correspondence)
Extended mail delays without justification	First Amendment; Due Process
Denial of phone access while in SHU	28 C.F.R. § 540.100
Isolation preventing outside reporting or legal contact	Eighth Amendment; Due Process
Case manager inaction after notice	BOP Standards of Professional Responsibility
Continued violations following corrective warning	Deliberate Indifference Standard

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony received after the sewage issue was reported:

- “He still hasn’t received a letter from me.”

- “I finally got one letter from him, postmarked weeks
- “They need help in Edgefield.”
- “The case managers aren’t doing anything.”

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4. SYSTEMIC IMPACT

Although one environmental hazard was eventually addressed, the overall SHU environment at FCI Edgefield continues to deteriorate, marked by:

- Prolonged isolation beyond authorized limits
- Unlawful interference with correspondence
- Denial of phone communication
- Breakdown of case management accountability
- Escalation of harm after formal notice

The Coalition emphasizes that correcting one violation does not cure ongoing or subsequent violations, particularly where the facility was already aware of heightened scrutiny.

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5. OVERSIGHT DEMANDS — FCI EDGEFIELD (SOUTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Immediate SHU Operations Review
    - Assessment of all current SHU conditions following prior notice
2. Mail Handling Audit

- Release of all withheld correspondence
- Review of SHU mail delays and staff compliance

3. Restoration of Phone Access
    - Immediate reinstatement of phone privileges consistent with policy
4. Case Management Accountability Review
    - Investigation into case manager inaction following notice
    - Corrective action where neglect is substantiated
5. Written Assurance of Compliance
    - Confirmation that SHU communication restrictions comply with law and policy
    - Preventive measures to avoid recurrence

Failure to act at this stage constitutes continued deliberate indifference and exposes the Bureau of Prisons to heightened legal and constitutional liability.

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6. CONCLUSION

While the sewage issue previously reported at FCI Edgefield was eventually addressed, conditions in the SHU have continued to worsen in other critical areas, particularly with respect to communication rights and administrative oversight. The Bureau of Prisons remains on notice that partial fixes do not absolve ongoing violations.

FCI LEAVENWORTH (KS) — Negligent SHU Housing Override Resulting in Preventable Homicide

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received credible reports alleging a severe safety failure and leadership negligence involving an Assistant Warden assigned to FCI Leavenworth who was

temporarily detailed to FCI Greenville as Acting Warden. While on detail, the Assistant Warden allegedly overrode Central Office–approved single-cell status for a known violent incarcerated individual housed in the Special Housing Unit (SHU), despite explicit warnings from multiple departments. This decision allegedly resulted in the murder of another incarcerated individual.

Following the incident, the Assistant Warden reportedly returned to FCI Leavenworth, where he continues to serve in a leadership role.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Override of Central Office–approved single-cell status	BOP Classification & Central Office Authority Protocols
Ignoring multidisciplinary safety warnings	BOP SHU Operations & Inmate Safety Policies
Placement of a cellmate with a known violent individual	18 U.S.C. § 4042(a) (Duty to Protect)
Resulting homicide inside SHU	Eighth Amendment — Deliberate Indifference
Leadership override resulting in preventable harm	BOP P.S. 1210.25 (Employee Misconduct & Accountability)

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding this incident:

- “Central Office approved single-cell status.”
- “Psychology, SIS, and the SHU Lieutenant all objected.”
- “They warned it would result in violence.”
- “He said nobody was going to tell him how to run his prison.”
- “The inmate killed his cellmate.”
- “He went back to Leavenworth after.”

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4. OVERSIGHT DEMANDS — FCI LEAVENWORTH (NORTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate investigation into the Assistant Warden’s actions while detailed as Acting Warden at FCI Greenville;
2. Review of Central Office documentation approving single-cell status for the involved individual;
3. Preservation of all SHU housing logs, emails, and meeting records related to this decision;
4. Assessment of the Assistant Warden’s continued suitability for leadership at FCI Leavenworth;
5. Independent review of SHU housing override authority to prevent recurrence.

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5. CONCLUSION

This homicide was not unforeseeable. Central Office approvals, professional assessments, and explicit safety warnings were allegedly ignored. When leadership overrides safeguards designed to prevent violence, the resulting harm is preventable and inexcusable. Continued

inaction will be treated as ongoing noncompliance with federal safety and accountability obligations.

USP BEAUMONT (TX) — Extended Lockdown, Utility Failures, SHU Misuse, and Suspension of Family Visitation

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received credible reports documenting severe and ongoing conditions at USP Beaumont, including prolonged lockdowns, loss of electricity, denial of hot water, inadequate food, improper housing of SHU-designated individuals in general population units, and suspension of weekend visitation due to staffing shortages. These conditions collectively amount to systemic deprivation, collective punishment, and interference with family contact.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
SHU inmates housed in general population units	28 C.F.R. § 541 (Restrictive Housing Standards)
Collective lockdowns of non-SHU units	Due Process; BOP Housing Protocols
Extended lockdown exceeding one week	Eighth Amendment — Conditions of Confinement
Loss of electricity in housing units	18 U.S.C. § 4042(a) (Duty of Care)

Denial of hot water	BOP P.S. 1600.11 (Environmental Health & Safety)
Inadequate and poor-quality food	28 C.F.R. § 551.10–551.16
Suspension of weekend visitation	28 C.F.R. § 540 (Visitation Regulations)
De facto denial of family visitation	First & Fifth Amendments

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at USP Beaumont:

- “The unit has been locked down for over a week.”
- “There is no electricity.”
- “There is no hot water.”
- “The food is bad and inadequate.”
- “SHU inmates were placed in regular housing units.”
- “Weekend visits are suspended. They said visits won’t be back until February 2026.”

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4. OVERSIGHT DEMANDS — USP BEAUMONT (SOUTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate restoration of electricity and hot water in all affected housing units;

2. Cessation of housing SHU-designated individuals in general population units;
3. Review of lockdown duration and justification, including out-of-cell time compliance;
4. Independent food safety and nutrition review during lockdown periods;
5. Restoration of weekend visitation or implementation of equivalent alternatives;
6. Preservation of staffing, lockdown, and visitation suspension records for oversight review.

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5. CONCLUSION

Extended lockdowns combined with loss of utilities, inadequate food, and suspension of family visitation represent systemic failure, not temporary operational strain. Families and incarcerated individuals should not bear the consequences of staffing shortages. Continued inaction will be treated as ongoing noncompliance with federal law and Bureau policy.

FCI EL RENO (OK) — Heating Failures, Cold Exposure, and Systemic Property Deprivation During Transfers

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received reports from incarcerated individuals, their families, and cooperating staff regarding unsafe living conditions and systemic administrative failures at FCI El Reno. Reports describe a lack of heat in housing units during cold weather, resulting in illness and prolonged exposure to low temperatures. Additional reports document repeated failures in the handling of incarcerated individuals' personal property during inter-facility transfers originating from FCI El Reno.

Individuals report remaining housed in units without heat despite dropping temperatures. Families report increased sickness among the population, raising concerns about prolonged cold exposure and failure to maintain habitable living conditions.

Separate and recurring reports describe individuals transferred from FCI El Reno to other federal facilities arriving without their personal property. In multiple cases, individuals reportedly received only minimal items upon arrival, while essential personal belongings remained missing

for extended periods. This pattern has occurred repeatedly and has affected transfers to multiple facilities.

These conditions indicate failures in basic habitability, health protection, and property accountability and place the Bureau of Prisons on notice of conditions at FCI El Reno requiring immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Lack of heat in housing units during cold weather	18 U.S.C. § 4042(a)(2) (Duty to Protect Health & Safety)
Prolonged exposure to cold resulting in illness	Eighth Amendment — unsafe living conditions
Failure to maintain habitable temperatures	BOP P.S. 1600.11 (Environmental Health & Safety)
Transfer of individuals without personal property	BOP P.S. 5580.08 (Inmate Personal Property)
Extended deprivation of personal belongings after transfer	Fifth Amendment — Due Process
Repeated property failures across multiple transfers	Failure of Administrative Oversight

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at FCI El Reno:

- “There is no heat in the unit.”
- “People are getting sick.”
- “They transferred him and his stuff never came.”
- “All he got was a wind-up radio.”
- “This keeps happening to people transferred from El Reno. Some people wait months to get their property.”

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4. OVERSIGHT DEMANDS — FCI EL RENO (SOUTH CENTRAL REGION)

The Loved Ones Coalition states that FCI El Reno must immediately take the following actions:

1. Immediate restoration of heat in all affected housing units and verification that temperatures meet habitability standards;
2. Medical assessment of individuals exposed to prolonged cold conditions;
3. Immediate inventory, tracking, and delivery of missing personal property for all individuals transferred from FCI El Reno;
4. Review of transfer and property-handling procedures to prevent continued loss or delay of personal belongings;
5. Accountability review for repeated failures to safeguard inmate property during transfers.

Failure to correct these conditions after notice constitutes continued noncompliance with federal safety, habitability, and due process obligations.

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5. CONCLUSION

Reports from FCI El Reno describe unsafe cold exposure and recurring administrative failures resulting in prolonged deprivation of personal property. Federal standards require that incarcerated individuals be housed in habitable conditions and that their personal property be safeguarded during transfers. Continued inaction after notice will be treated as ongoing noncompliance with federal law and Bureau of Prisons policy.

FMC CARSWELL (TX) — Pattern of Staff Sexual Abuse, Retaliation, and Institutional Failure After Repeated Prior Notice

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has previously reported sexual abuse, retaliation, and PREA-related failures at FMC Carswell to the Bureau of Prisons. Despite those reports, new and public allegations confirm that sexual abuse by staff has continued and that institutional failures remain uncorrected.

Public reporting now documents that multiple incarcerated women have filed lawsuits alleging sexual assault by staff members at FMC Carswell over recent years. These allegations include claims that facility leadership and the Bureau of Prisons were slow to investigate reports, failed to intervene when accused staff had been reported previously, and allowed abuse to continue despite warning signs.

The Coalition has been in direct contact with women impacted by these conditions and has raised concerns regarding sexual misconduct at FMC Carswell prior to these allegations becoming public. The emergence of public lawsuits and media reporting represents an escalation of issues that were already known to the Bureau of Prisons through prior reporting.

These allegations involve a facility with a documented history of staff sexual abuse, prior convictions of staff members, and repeated assurances of reform that have not resulted in sustained prevention or accountability.

This report places the Bureau of Prisons on notice of continued sexual abuse allegations at FMC Carswell following repeated prior notice, requiring immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Staff-on-inmate sexual abuse	PREA (34 U.S.C. § 30301 et seq.)
Continued abuse following prior reporting	Deliberate Indifference Standard
Retaliation and coercion tied to reporting	PREA Standard § 115.67
Failure to protect a medically vulnerable population	18 U.S.C. § 4042(a)(2)
Inadequate or delayed investigations	BOP P.S. 1210.25
Allowing accused staff to resign or retire without completed findings	Failure of Oversight Obligations
Pattern of abuse despite years of notice	Eighth Amendment

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony and public reporting regarding FMC Carswell:

- “It’s like human trafficking behind prison walls.”
- “Everyone keeps passing the buck.”
- “There hasn’t been any massive change that anybody can see.”

4. STAFF IDENTIFIED IN TESTIMONY

Public reporting and lawsuits identify alleged perpetrators in the following roles:

- Medical staff
- Chaplaincy staff
- Correctional officers
- Supervisory staff associated with the BioMed office

Names are omitted here due to ongoing litigation and retaliation risk. These allegations warrant immediate review.

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5. OVERSIGHT DEMANDS — FMC CARSWELL (SOUTH CENTRAL REGION)

The Loved Ones Coalition states that FMC Carswell must immediately take the following actions:

1. Independent PREA Compliance Review addressing failures after prior notice;
2. Immediate anti-retaliation protections for individuals who have reported abuse;
3. Audit of all sexual abuse and “inappropriate relationship” investigations, including cases closed due to resignation or retirement;
4. Leadership accountability review for failures to act after repeated reporting;
5. Written corrective action plan with timelines addressing prevention, reporting, investigations, and staff discipline.

Failure to take corrective action after repeated notice constitutes continued deliberate indifference and exposes the Bureau of Prisons to heightened legal and constitutional liability.

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6. CONCLUSION

Sexual abuse allegations at FMC Carswell are not new, isolated, or unknown. The Loved Ones Coalition has previously reported these concerns, and public litigation now confirms that abuse continued despite those warnings. Prior notice without corrective action reflects institutional failure, not lack of awareness.

The Bureau of Prisons is now on notice — again.

USP ATWATER (CA) — Denial of Medication-Assisted Treatment, Suicide Attempt, and Failure of Mental Health Crisis Response

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received reports from incarcerated individuals, their families, and cooperating staff regarding a serious mental health and medical care failure at USP Atwater involving the denial of Medication-Assisted Treatment (MAT), a suicide attempt, and an inadequate post-attempt mental health response.

According to testimony, an incarcerated individual with a documented substance use disorder and approximately one year remaining on his sentence was denied placement in the MAT program despite clear clinical need. Reports indicate the individual experienced acute psychological distress following the denial of treatment.

Subsequently, the individual attempted suicide by tying a sheet around his neck, securing it to an upper-tier railing approximately 15–20 feet above the lower tier, and throwing himself from the tier. The attempt was interrupted only because other incarcerated individuals intervened and physically pulled him back to safety before a fatal injury occurred.

Despite the severity of the attempt, reports state the individual was returned to the housing unit the following day, without being placed on suicide watch for a clinically appropriate duration and without evidence of sustained mental health stabilization.

These allegations raise serious concerns regarding denial of addiction treatment, failure to provide adequate mental health crisis intervention, and disregard for suicide prevention protocols.

This report places the Bureau of Prisons on notice of potentially life-threatening failures at USP Atwater requiring immediate corrective action.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Denial of Medication-Assisted Treatment (MAT)	BOP Clinical Guidance on Substance Use Disorder Treatment
Failure to provide adequate addiction care	18 U.S.C. § 4042(a)(2) (Duty to Protect & Provide Medical Care)
Suicide attempt following treatment denial	Eighth Amendment — Deliberate Indifference
Inadequate suicide watch following attempt	BOP Suicide Prevention & Mental Health Policies
Premature return to general population	Clinical Standards of Care
Failure to provide ongoing stabilization	Due Process; Medical Neglect Standards

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at USP Atwater:

- “They wouldn’t put him in the MAT program. He tied a sheet around his neck and jumped from the top tier.”
- “Other inmates had to pull him up before he broke his neck.”
- “He was back out the next day. At most prisons he would have been on suicide watch for days.”

- “They don’t want to provide the care he needs.”
- “I’ve seen so many cases where people are not provided medical care.”

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4. SYSTEMIC CONCERNS

The Coalition notes the following systemic failures reflected in this incident:

- Denial of evidence-based addiction treatment;
- Failure to recognize MAT as suicide prevention care;
- Reliance on incarcerated individuals to intervene in medical emergencies;
- Inadequate post-attempt suicide monitoring;
- Pattern of medical neglect reported across cases.

The absence of appropriate intervention after a near-fatal suicide attempt reflects a breakdown in both medical and mental health safeguards.

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5. OVERSIGHT DEMANDS — USP ATWATER (WESTERN REGION)

The Loved Ones Coalition formally demands:

1. Immediate review of MAT eligibility and denial practices at USP Atwater;
2. Independent clinical review of the suicide attempt response, including housing decisions made afterward;
3. Audit of suicide watch protocols, including minimum observation periods following attempts;
4. Mental health staffing and training assessment related to addiction and suicide risk;

5. Written corrective action plan addressing addiction treatment access and suicide prevention compliance.

Failure to act following notice constitutes continued deliberate indifference to serious medical and mental health needs.

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6. CONCLUSION

Denying addiction treatment and returning a suicide-attempt survivor to regular housing within 24 hours places lives at risk. Suicide prevention and substance use treatment are inseparable medical obligations.

The Bureau of Prisons is now on notice of serious mental health and medical care failures at USP Atwater. Continued inaction exposes the agency to grave legal, ethical, and constitutional liability.

FCI HERLONG (CA) — Systemic First Step Act (FSA) Miscalculations, Administrative Obstruction, and Deliberate Release Delays

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received multiple reports from incarcerated individuals, their families, and cooperating staff regarding systemic misapplication of First Step Act (FSA) time credits at FCI Herlong Camp. Reports describe the use of outdated calculation methods, refusal to manually recalculate credits, and administrative obstruction resulting in individuals being held past their lawful release eligibility.

According to testimony, unit staff are allegedly submitting referrals using old FSA calculation methods that generate inaccurate and artificially extended release dates. The Bureau's Time and Attendance System (TAS) reportedly displays only credits already earned, without projecting total FSA credits an individual is eligible to earn, creating the appearance of compliance while concealing earlier lawful release eligibility.

Families report that as a result, incarcerated individuals are forced to file 28 U.S.C. § 2241 habeas petitions simply to compel manual recalculation of credits. Even when such filings occur, delays persist for months due to administrative inaction and failure to timely submit required documentation.

Testimony further identifies a Unit Manager who allegedly refuses to approve referrals or recommendations for manual FSA recalculation, asserting unchecked authority and acting with apparent disregard for governing directives. Reports describe this conduct as intentional delay designed to keep individuals incarcerated as long as possible, including attempts to generate infractions or administrative barriers to justify continued confinement.

These allegations place the Bureau of Prisons on notice of systemic First Step Act noncompliance and deliberate administrative obstruction at FCI Herlong.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Policy / Statute Violated
Use of outdated FSA calculation methods	First Step Act; BOP FSA Implementation Directives
Failure to project total eligible FSA credits	Due Process; Arbitrary Administrative Action
Refusal to manually recalculate credits	18 U.S.C. § 3624(g)
Holding individuals past lawful eligibility dates	Fifth Amendment — Due Process
Forcing individuals to file § 2241 petitions	Access to Courts; Administrative Exhaustion Abuse
Delays caused by missing or untimely documentation	BOP Case Management Responsibilities
Intentional administrative delay of release	Deliberate Indifference Standard

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3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding FCI Herlong:

- “They’re using the old method of FSA calculations.”
- “They submit referrals with dates far out just to make it look right.”
- “Everyone has to file a 2241 to force a manual calculation.”
- “My LO has been waiting on the court for four months now.”
- “They say documents weren’t turned in on time, but it’s their delay.”
- “They keep people as long as they can.”

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4. STAFF IDENTIFIED IN TESTIMONY

The following staff member is specifically identified in reports:

- Unit Manager Moore — alleged refusal to approve or allow manual FSA recalculation referrals; alleged obstruction and delay of lawful release processing.

This name is included based solely on testimony received and warrants immediate review.

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5. OVERSIGHT DEMANDS — FCI HERLONG (WESTERN REGION)

The Loved Ones Coalition formally demands:

1. Immediate FSA Compliance Audit
    - Review of all FSA calculations conducted at FCI Herlong Camp
    - Identification of cases using outdated or improper calculation methods

2. Mandatory Manual Recalculation Review
    - Immediate recalculation of FSA credits for all affected individuals
    - Correction of release dates where improper delays occurred
3. Staff Conduct Investigation
    - Review of allegations involving Unit Manager Moore
    - Examination of refusal to process referrals and alleged intentional delays
4. 2241 Delay Accountability Review
    - Audit of cases requiring court intervention due to administrative inaction
    - Identification of documentation failures attributable to staff
5. Written Corrective Action Plan
    - Clear guidance on FSA calculation procedures
    - Safeguards preventing discretionary obstruction of release eligibility

Failure to correct these practices after notice constitutes continued noncompliance with federal law and deliberate interference with lawful release.

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6. CONCLUSION

Reports from FCI Herlong describe a pattern of First Step Act obstruction designed to delay release through outdated calculations, administrative delay, and refusal to perform required manual reviews. The First Step Act was enacted to reduce unnecessary incarceration, not to create procedural barriers that keep people confined past their lawful eligibility.

The Bureau of Prisons is now on notice of these conditions at FCI Herlong. Continued inaction will be treated as ongoing, deliberate noncompliance with statutory release obligations.
