

LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Violations Across the Federal Bureau of Prisons

January 5, 2026

This submission is not a compilation of complaints.

It is a consolidated oversight record documenting a pattern-and-practice failure across the Federal Bureau of Prisons.

The allegations and documentation contained herein are structured, corroborated, legally framed, and cross-regional. They are presented in a consistent format to establish notice, preserve records, and demonstrate recurrence. This report reflects conditions observed across multiple regions, security levels, and facility types, with materially similar failures appearing regardless of geography or population.

The repetition is the evidence.

What emerges from this record is not misconduct by isolated staff, nor discrete operational lapses. It is a system operating beyond sustainable capacity, relying on deprivation, delay, and collective restriction as substitutes for lawful custody and care.

Across facilities, lockdowns have ceased to function as emergency responses. They are now employed as default governance mechanisms — used to manage staffing shortages, infrastructure failure, population volume, and administrative burden. Modified operations, tier-based movement, SHU overflow, and prolonged behind-the-door confinement are not temporary measures; they are the operating norm.

Individualized discipline has been replaced with collective punishment.

Entire units are restricted for the conduct of one individual. Commissary access, hygiene, programming, movement, and communication are suspended facility-wide without individualized findings. Mass transfers occur without documented due process. These practices violate the Bureau's own disciplinary framework and reflect a loss of managerial control rather than enforcement of policy.

Medical care across facilities is reactive, not preventive.

This record documents repeated absence of overnight medical coverage, delayed response to emergent conditions, and reliance on count-time discovery rather than active monitoring. Injuries, infections, and medical deterioration are consistently reported as addressed only after visible collapse. Individuals with known vulnerabilities are confined in restrictive housing despite heightened risk. This is not substandard care — it is triage-by-neglect.

Infrastructure failure is not isolated; it is normalized.

Water outages, sewage flooding, mold exposure, HVAC failures, loss of heat, electrical shutdowns, unsanitary kitchens, and rodent infestations appear repeatedly across institutions. The common feature is not the failure itself, but the institutional response: continued confinement without relocation, mitigation, or urgency. Facilities remain occupied despite conditions that would render comparable civilian structures uninhabitable.

Retaliation is systemic and multi-layered.

The record reflects a consistent sequence: grievance activity, outside communication, or advocacy is followed by lockdowns, SHU threats, disciplinary escalation, hygiene deprivation, or communication restriction. In multiple instances, retaliation is corroborated by currently employed staff. This establishes a culture problem, not individual misconduct.

Deaths documented in this report occur under predictable conditions.

They appear during prolonged lockdowns, medical understaffing, sanitation collapse, and isolation. They are discovered during count, not prevented through care. These are not unforeseeable events; they are foreseeable outcomes of sustained neglect under known risk conditions.

Collectively, these patterns establish more than noncompliance. They establish notice.

This record identifies exposure under the Eighth Amendment (conditions of confinement, medical care, sanitation), First Amendment retaliation, Due Process violations, ADA/Rehabilitation Act obligations, PREA standards, Federal Tort Claims Act liability, Bivens exposure, and pattern-and-practice indicators sufficient to trigger Department of Justice Civil Rights review.

After notice, continued inaction constitutes deliberate indifference.

What this documentation reveals, stripped of rhetoric, is a Bureau operating beyond functional capacity. Staffing shortages, aging infrastructure, budget constraints, medical complexity, and population management pressures have resulted in a contraction of services rather than a reduction of confinement intensity. Care, hygiene, movement, food, programming, and accountability have been scaled down to manage volume.

The response has shifted from custody to containment.

Oversight has therefore become external by necessity. Staff bypass internal reporting channels. Families act as information couriers. Advocates function as clearinghouses. Attorneys proactively seek documentation. Internal accountability mechanisms are no longer trusted by those inside the system — a condition Congress and the Department of Justice recognize as a critical red flag.

This report marks an escalation.

Each facility named herein is now on record.

Each region implicated is on notice.

Each failure documented will be treated as knowing noncompliance if allowed to persist.

The calendar year has changed.

The legal obligations have not.

MID-ATLANTIC REGION

FCC Butner — Retaliation for Protected Speech, Excessive Force, Sexual Abuse, Prolonged SHU Confinement, Property Deprivation, and Retaliatory Loss of Halfway House Time

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received detailed testimony alleging severe retaliation, excessive force, sexual abuse, prolonged isolation, and administrative punishment at FCC Butner following an incarcerated individual's attempt to communicate with an outside advocate regarding staff misconduct at a separate Bureau of Prisons facility. Testimony indicates that shortly after attempting to report staff intimidation elsewhere through monitored communication channels, the individual was escorted to a lieutenant's office and subjected to retaliatory disciplinary action under a false pretext.

The individual reports being charged with a fabricated disciplinary infraction alleging extortion or blackmail based solely on a stated intent to pursue legal action against a staff member for professional misconduct. Shortly thereafter, the individual was placed in a Secure Mental Health Unit (SMHU), despite the absence of legitimate disciplinary or safety justification.

While confined in isolation, the individual reports being subjected to excessive force by a lieutenant, resulting in a broken right arm and hand. Following the use of force, the individual was reportedly placed in restraints for more than ten hours while completely naked. A subsequent disciplinary charge alleging “assaultive” behavior was issued; however, testimony states that the charge was never clearly defined during disciplinary proceedings and that the issuing officer refused to explain the alleged conduct, despite the existence of camera footage.

The individual further reports a prolonged period of retaliatory harassment, including sexual harassment by a captain who threatened to revoke halfway house eligibility, repeated cell searches, and a digital rectal cavity search described as degrading and sexually abusive. The individual remained in the Special Housing Unit (SHU) for an extended period and required multiple suicide risk assessments due to the psychological impact of prolonged isolation — a risk the Bureau allegedly knew was heightened for this individual.

Upon release from isolation, the individual reports that all previously awarded halfway house time — totaling nearly one year — was stripped based on disciplinary charges for which the individual was acquitted and on mental health care level. The individual further reports near-total loss of personal property and severe financial deprivation due to an “investigation hold” placed on their inmate account, preventing communication with family or outside support and forcing reliance on others to obtain basic hygiene items and clothing during cold conditions.

These allegations place the Bureau of Prisons on notice of serious violations involving retaliation for protected speech, excessive force, sexual abuse, misuse of mental health and restrictive housing, destruction or loss of property, and retaliatory deprivation of lawful prerelease opportunities at FCC Butner.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Retaliation for attempting to report staff misconduct | First Amendment; Retaliation Prohibition |
| Fabricated disciplinary charges | Due Process; Arbitrary & Capricious Action |
| Placement in SMHU without legitimate basis | BOP Mental Health & Restrictive Housing Policies |

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|--|---|
| Excessive force causing broken arm and hand | Eighth Amendment — Excessive Force |
| Prolonged restraint while completely naked | Eighth Amendment; PREA Standards |
| Sexually degrading searches | PREA (34 U.S.C. § 30301 et seq.) |
| Prolonged SHU confinement despite known mental health risk | Deliberate Indifference Standard |
| Retaliatory loss of halfway house eligibility | First Step Act; Due Process |
| Destruction or loss of personal property | BOP P.S. 5580.08 (Inmate Personal Property) |
| Freezing of inmate funds to block communication | Due Process; Access to Communication |

3. DIRECT TESTIMONY / DIRECT QUOTES

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

- “I was escorted to the lieutenant’s office right after trying to report what happened.”
- “They wrote me up with a fictitious charge of extortion.”
- “A lieutenant broke my arm and hand.”
- “They restrained me for over ten hours while I was completely naked.”
- “He charged me with being ‘assaultive’ but refused to explain what that meant.”

- “I was sexually harassed and threatened with losing my halfway house date.”
 - “All my halfway house time was taken even though I was acquitted.”
 - “Almost all of my property is gone.”
 - “They froze my money so I couldn’t email or call anyone.”
 - “I had to ask my mom and friends for money just to buy soap and clothes.”
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4. SYSTEMIC CONCERNS

This testimony reflects broader systemic concerns, including:

- Use of disciplinary charges and mental health units as retaliation tools;
 - Excessive force followed by fabricated charges to justify staff misconduct;
 - Sexual humiliation and abuse conducted under the guise of security procedures;
 - Prolonged isolation of mentally vulnerable individuals despite known risk;
 - Retaliatory manipulation of halfway house eligibility and prerelease placement;
 - Administrative loss or destruction of inmate property;
 - Financial “investigation holds” used to isolate individuals from outside contact and advocacy.
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5. OVERSIGHT DEMANDS —

FCC BUTNER (MID-ATLANTIC REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all camera footage, restraint logs, use-of-force reports, medical records, mental health assessments, SHU and SMHU placement documentation, disciplinary records, and related emails concerning this incident;
2. Referral of allegations involving excessive force, sexual abuse, and retaliation to the Office of the Inspector General and appropriate investigative authorities;
3. Independent review of the use of force, prolonged restraints, and nudity for compliance with constitutional standards and PREA requirements;
4. Administrative review of all disciplinary actions and loss of halfway house eligibility imposed despite acquittals;
5. Medical and mental health review of injuries sustained and suicide risk assessments conducted during prolonged isolation;
6. Inventory and accounting for all missing or destroyed personal property, including identification of points of loss;
7. Review of inmate account holds used to block communication and access to funds, including justification and duration;
8. Disclosure of findings to appropriate oversight bodies, including congressional offices and external stakeholders.

Failure to preserve records or permit independent review after notice constitutes continued deliberate indifference and obstruction of oversight.

6. CONCLUSION

The allegations at FCC Butner describe a pattern of retaliation, excessive force, sexual abuse, prolonged isolation, and administrative punishment following protected speech and legal advocacy. The misuse of mental health and restrictive housing, combined with retaliatory loss of prerelease opportunities and deprivation of basic necessities, represents serious violations of federal law, Bureau policy, and constitutional protections. The Bureau of Prisons is now on notice. Continued inaction or non-cooperation will be treated as ongoing noncompliance.

MID-ATLANTIC REGION

FCI McDowell — Prolonged Commissary Suspension, Unsafe Drinking Water, and Health Risks to Confined Population

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing prolonged denial of commissary access and ongoing exposure to contaminated drinking water at FCI McDowell. Reports indicate that access to commissary has been suspended for approximately one month, with repeated delays and shifting explanations provided by facility staff.

Reports further indicate that access was represented as resuming on a specific day, only for orders to be canceled at the last moment and postponed again. If access resumes as most recently stated, the duration without commissary will total approximately forty-nine (49) days.

In addition to prolonged commissary suspension, reports indicate that the facility's water supply is contaminated and has caused illness. Despite these reports, individuals are still expected to consume the water, with no consistent provision of safe alternative potable water.

The combined deprivation of commissary access and exposure to unsafe drinking water has created conditions in which basic hygiene, health maintenance, and access to necessities are compromised. These conditions place the Bureau of Prisons on notice of serious and ongoing risks to health and safety at FCI McDowell.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Prolonged denial of commissary access | BOP Commissary Operations Standards |
| Repeated postponement without justification | Due Process; Arbitrary & Capricious Action |
| Deprivation of hygiene and basic necessities | Eighth Amendment — Conditions of Confinement |

| | |
|---|--|
| Exposure to contaminated drinking water | 18 U.S.C. § 4042(a)(2) |
| Expectation that unsafe water be consumed | Deliberate Indifference Standard |
| Failure to provide safe alternative water | BOP Environmental Health & Safety Policies |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI McDowell:

- “They were told they were going to get commissary today, then they said no.”
 - “Now they’re saying maybe next Monday. If they do get it then, it’ll be 49 days without commissary.”
 - “The water is contaminated and making people sick.”
 - “They still expect them to drink it.”
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4. SYSTEMIC CONCERNS

Reports reflect broader systemic concerns, including:

- Prolonged suspension of commissary access without transparency or accountability;
- Administrative delays that deprive access to hygiene and nutritional supplementation;
- Exposure to potentially unsafe drinking water;
- Failure to provide safe alternatives despite reports of illness;

- Indifference to predictable health risks created by compounded deprivation.
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5. OVERSIGHT DEMANDS —

FCI McDOWELL (MID-ATLANTIC REGION)

The Loved Ones Coalition formally demands:

1. Immediate disclosure of the justification for prolonged commissary suspension and related decision-making documentation;
2. Verification of commissary restoration timelines and duration of disruption;
3. Immediate testing and disclosure of water quality results for all housing units;
4. Provision of safe alternative drinking water where contamination or illness is reported;
5. Preservation of records related to water testing, maintenance, and health complaints;
6. Independent review of health impacts associated with water exposure and commissary deprivation;
7. Notification of appropriate oversight authorities regarding health and safety risks.

Failure to address these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI McDowell describe prolonged deprivation of commissary access combined with exposure to potentially contaminated drinking water, creating foreseeable and preventable health risks. Denial of basic necessities while requiring consumption of unsafe water violates minimum standards of care. The Bureau of Prisons is now on notice. Continued inaction will be treated as ongoing noncompliance.

MID-ATLANTIC REGION

FPC Alderson — Unsafe Use of Industrial Adhesives in Cosmetology Program Resulting in Injury and Constitutional Violations

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received reports concerning unsafe and medically negligent practices within the cosmetology training program at FPC Alderson. Reports indicate that an individual participating in the program was subjected to the application of industrial-strength cyanoacrylate adhesive directly to the scalp and hair to secure a wig or hair tracks.

Cyanoacrylate adhesive is not approved for cosmetic, dermatological, or medical use and presents a foreseeable risk of skin tearing, chemical burns, infection, and permanent injury when applied to human skin or hair.

Reports further indicate that the individual subjected to this practice has a documented medical condition involving hair loss and increased scalp sensitivity. Despite this known vulnerability, the use of industrial adhesive proceeded without medical clearance, safety protocols, or adherence to professional cosmetology standards. Injury, pain, and scalp irritation were reported.

These reports reflect a failure to adhere to basic health, safety, and professional norms and raise serious concerns regarding deliberate indifference, unsafe conditions of confinement, negligent supervision, and exposure to constitutional and federal tort liability at FPC Alderson.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Use of industrial adhesive on scalp | Eighth Amendment — Conditions of Confinement |
| Failure to accommodate known medical condition | 18 U.S.C. § 4042(a)(2) |

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|---|--|
| Deliberate indifference to risk of harm | Farmer v. Brennan, 511 U.S. 825 (1994) |
| Unsafe vocational program practices | BOP Occupational Safety & Training Standards |
| Negligent supervision of cosmetology program | Federal Tort Claims Act |
| Aggravation of pre-existing medical condition | Medical Negligence; Deliberate Indifference |
| Exposure to unnecessary pain and injury | Eighth Amendment |
| Constitutional tort under color of law | Bivens v. Six Unknown Named Agents |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding the incident at FPC Alderson:

- “They used super glue on her scalp to attach a wig.”
 - “Super glue is not made for hair and can rip skin off.”
 - “This happened in the cosmetology training program.”
 - “She has alopecia and her scalp is very sensitive.”
 - “She experienced pain, irritation, and injury.”
 - “This was completely preventable.”
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4. SYSTEMIC CONCERNS

Reports reflect broader systemic concerns, including:

- Absence of basic safety standards in vocational programs;
- Approval or tolerance of practices prohibited in licensed cosmetology settings;
- Failure to accommodate known medical conditions;
- Inadequate training and supervision of program staff;
- Normalization of unsafe practices under the guise of programming.

The cosmetology program, as administered in this instance, constituted an objectively dangerous condition of confinement.

5. OVERSIGHT DEMANDS —

FPC ALDERSON (MID-ATLANTIC REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all records related to the cosmetology program, including training materials, inventories, supervision logs, and incident reports;
2. Referral of this matter to the Department of Justice Office of the Inspector General;
3. Medical documentation and evaluation of injuries, including assessment of aggravation of pre-existing conditions;
4. Identification of staff involved in approving, supervising, or performing the unsafe practice;
5. Immediate suspension of the cosmetology program pending safety review;
6. Verification that industrial or non-cosmetic adhesives are no longer accessible or used;

7. Disclosure of findings to appropriate oversight authorities.

Failure to preserve evidence or remediate unsafe practices after notice may constitute continued deliberate indifference.

6. CONCLUSION

The application of industrial adhesive to the scalp within a prison training program is not a discretionary error. It is a clear violation of basic health, safety, and professional standards. This conduct constitutes unsafe conditions of confinement, deliberate indifference to medical vulnerability, and actionable negligence. The Bureau of Prisons is now on notice. Continued inaction will be treated as ongoing noncompliance.

MID-ATLANTIC REGION

FCC Hazelton — Sewage Flooding, Medical Neglect, Extreme Sanitation Failures, and Systemic Endangerment of Medically Vulnerable Individuals

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple, consistent reports describing severe sanitation failures, medical neglect, and conditions posing an immediate risk to life and health across FCC Hazelton. Reports indicate widespread sewage flooding inside housing units, including toilets backing up and cells flooded with contaminated water containing human waste.

Reports further indicate that individuals were forced to remain inside cells with standing sewage water measuring several inches deep, without timely remediation, sanitation response, or relocation. In one reported incident, an individual recovering from serious cardiac complications was denied adequate access to clean shower facilities and was ultimately forced to shower in a handicap-accessible stall where sewage water backed up around his feet.

Shortly thereafter, the individual reportedly developed a severe infection, was transported to an outside hospital, and required invasive surgical intervention involving chest incision and wound vacuum placement. Reports further indicate the individual experienced a cardiac event during treatment and required emergency resuscitation.

Additional reports describe significant weight loss, physical deterioration, depression, and prolonged lack of communication with outside contacts during hospitalization. Reports indicate that medical status updates and care decisions were not adequately communicated, preventing external oversight or advocacy during a critical medical emergency.

Further reports from FCC Hazelton describe systemic accessibility failures involving wheelchair users. Reports indicate that individuals using wheelchairs are housed in cells too small to accommodate mobility devices and that accessible cells are controlled informally through coercive or improper means, leaving medically vulnerable individuals in unsafe housing conditions.

These reports reflect ongoing sanitation collapse, medical neglect, disability discrimination, and administrative failure across FCC Hazelton. The Bureau of Prisons is now on notice of conditions presenting an immediate and substantial risk of serious harm.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Cells flooded with sewage and standing waste water | Eighth Amendment — Conditions of Confinement |
| Failure to remediate sewage exposure | 18 U.S.C. § 4042(a)(2) |
| Forcing individuals to shower in contaminated water | Deliberate Indifference Standard |
| Severe infection following unsanitary exposure | Eighth Amendment; Medical Neglect |
| Inadequate or delayed medical intervention | Estelle v. Gamble, 429 U.S. 97 (1976) |

| | |
|--|--|
| Lack of transparency during medical emergency | Due Process; Right to Communication |
| Housing wheelchair users in inaccessible cells | Rehabilitation Act; ADA Standards |
| Coercive or improper control of accessible housing | Due Process; Abuse of Authority |
| Prolonged lockdowns with no showers or hot water | BOP Sanitation & Habitability Policies |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCC Hazelton:

- “Entire cells are flooded with dirty sewage water.”
- “There were two to three inches of standing water in the cell.”
- “The water was backing up around his feet with waste.”
- “He was rushed to the hospital.”
- “They had to cut a large opening in his chest and place a vacuum device.”
- “He coded for nearly a minute.”
- “He’s lost a lot of weight and sounds terrible.”
- “No one explains what’s happening medically.”
- “Wheelchair users can barely fit in their cells.”

- “Accessible cells are controlled informally.”
 - “There are constant lockdowns with no showers and no hot water.”
-

4. SYSTEMIC CONCERNS

The volume and consistency of reports indicate systemic failures rather than isolated incidents, including:

- Chronic sewage and plumbing failures;
- Delayed or absent sanitation remediation;
- Medical neglect following exposure to contaminated environments;
- Endangerment of individuals with serious medical conditions;
- Failure to accommodate disabled and wheelchair-bound individuals;
- Improper or coercive control over housing assignments;
- Prolonged lockdowns eliminating access to hygiene;
- Administrative opacity during medical emergencies.

Collectively, these conditions demonstrate an environment operating below minimum constitutional, medical, and human safety standards.

5. OVERSIGHT DEMANDS —

FCC HAZELTON (MID-ATLANTIC REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all maintenance logs, plumbing work orders, sanitation reports, and incident records related to sewage flooding;
2. Preservation of all medical records related to infections, hospitalizations, surgical interventions, and emergency responses;
3. Independent medical review of infection cases linked to environmental exposure;
4. Immediate environmental health inspection of all affected housing units;
5. Review of accessibility compliance, including housing assignments for wheelchair users;
6. Preservation and review of housing assignment records to assess allegations of coercive or improper cell allocation;
7. Disclosure of any corrective actions taken to appropriate oversight authorities.

Failure to preserve records or address ongoing sanitation and medical risks after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCC Hazelton describe conditions that are unsafe, unsanitary, and life-threatening. Exposure to sewage, denial of hygiene, inadequate medical response, and failure to protect medically vulnerable and disabled individuals violate fundamental standards of confinement. The Bureau of Prisons is now on notice of systemic conditions at FCC Hazelton requiring immediate external scrutiny. Continued inaction will be treated as ongoing noncompliance with federal law and constitutional obligations.

MID-ATLANTIC REGION

USP Lee — Prolonged SHU Confinement, Sewage Exposure, Nutritional Deprivation, Severe Mental and Physical Deterioration, and Escalating External Legal Scrutiny

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing prolonged and inhumane conditions inside the Special Housing Unit (SHU) at USP Lee. Reports indicate that individuals were confined in SHU for extended periods under conditions that failed to meet even the most basic standards of sanitation, nutrition, and humane treatment.

Reports describe malfunctioning toilets that overflowed and flooded cells with feces and contaminated water. Individuals were reportedly forced to remain inside these cells while exposed to human waste, without timely sanitation, relocation, or environmental remediation.

Additional reports indicate that individuals housed in SHU were not fed adequately and that basic needs were routinely unmet. Food service was insufficient in both quantity and quality, and access to necessities was denied or severely restricted. These conditions persisted over a prolonged period.

Following release from SHU, reports describe a dramatic and alarming deterioration in both mental and physical health. Individuals reportedly emerged visibly altered, exhibiting significant psychological distress, physical decline, and behavioral changes consistent with the effects of prolonged isolation, deprivation, and environmental exposure.

The Bureau of Prisons is further on notice that these conditions are not being raised solely through internal or advocacy reporting channels. Multiple attorneys have independently contacted the Loved Ones Coalition seeking testimony, documentation, and corroborating reports related to conditions at USP Lee. This outreach reflects escalating legal concern tied to prolonged lockdowns, restrictive housing conditions, sanitation failures, and resulting harm.

Given the volume, consistency, and seriousness of reports now circulating beyond the Bureau, senior Bureau of Prisons leadership is strongly urged to conduct an immediate, on-site inspection of USP Lee. Conditions described warrant direct observation rather than reliance on internal summaries or administrative assurances.

These reports reflect sustained inhumane treatment and place the Bureau of Prisons on notice of serious risks to health, safety, and human dignity at USP Lee.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---------------------------|--|
| Prolonged SHU confinement | Eighth Amendment — Conditions of Confinement |

| | |
|---|--|
| Exposure to sewage and contaminated water | 18 U.S.C. § 4042(a)(2) |
| Failure to remediate overflowing toilets | BOP Sanitation & Environmental Health Policies |
| Nutritional deprivation and inadequate meals | Eighth Amendment; BOP Food Service Standards |
| Denial of basic human needs | Deliberate Indifference Standard |
| Severe deterioration of mental health | Eighth Amendment; Mental Health Care Obligations |
| Physical decline following isolation | Medical Neglect Standards |
| Failure to mitigate harm of prolonged isolation | Deliberate Indifference; Due Process |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at USP Lee:

- “The toilet ran over and flooded the cell with feces.”
- “The water was contaminated.”
- “He was a different person when he came out.”
- “There was a dramatic change in his mental health.”
- “His physical appearance was completely different.”

4. SYSTEMIC CONCERNS

The consistency of reports indicates systemic failures rather than isolated incidents, including:

- Prolonged and harmful use of restrictive housing;
- Exposure to sewage and contaminated environments;
- Failure to provide adequate nutrition;
- Denial of basic human needs during isolation;
- Severe and lasting mental health deterioration following SHU confinement;
- Physical decline consistent with neglect and deprivation;
- Absence of meaningful safeguards for individuals subjected to long-term isolation.

These conditions reflect confinement practices operating below constitutional and human safety standards.

5. OVERSIGHT DEMANDS —

USP LEE (MID-ATLANTIC REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of SHU maintenance logs, plumbing work orders, sanitation reports, and incident records;
2. Preservation of food service logs, meal records, and nutritional documentation for SHU housing units;
3. Preservation of medical and mental health records for individuals subjected to prolonged SHU confinement;

4. Independent review of SHU placement duration, conditions, and compliance with policy;
5. Environmental health inspection of SHU housing units;
6. Review of mental and physical health outcomes associated with prolonged isolation;
7. Disclosure of findings to appropriate oversight authorities, including Central Office and external stakeholders.

Failure to preserve records or address ongoing SHU conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from USP Lee describe prolonged SHU confinement marked by sewage exposure, nutritional deprivation, and profound deterioration of mental and physical health. These conditions are not incidental or unavoidable; they are the foreseeable result of sustained neglect and inhumane isolation practices.

The Bureau of Prisons is now on notice that conditions at USP Lee are subject to escalating legal scrutiny. Continued inaction, reliance on internal reporting, or failure of leadership to directly assess conditions on-site will be treated as ongoing noncompliance with federal law and constitutional obligations.

MID-ATLANTIC REGION

USP McCREARY — Retaliation, Medical Neglect, Extreme Cold Exposure, Coercive Interrogation, and Systemic Deprivation of Basic Human Needs

1. SUMMARY OF ALLEGATIONS

USP McCreary is engaging in a pattern of institutional abuse involving retaliatory SHU placements, coercive interrogations, denial of hygiene and sanitation, exposure to extreme cold, obstruction of family communication during holidays, and medically dangerous neglect of known injuries.

Multiple incarcerated individuals report being subjected to intimidation and threats by staff, including being told to provide information under duress, threatened with violence, and placed in unsafe conditions. Individuals are being denied basic hygiene supplies, showers, and adequate food, and are restricted to “bird baths” in their cells for extended periods.

Medical care is routinely delayed or denied even where visible signs of infection and serious injury are present. Staff responses to family concerns demonstrate indifference and dismissiveness toward life-threatening conditions inside housing units.

These conditions collectively constitute deliberate indifference to health and safety, retaliation for perceived noncompliance, and violations of federal law, Bureau of Prisons policy, and constitutional standards.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|---|
| Denial of medical treatment for infected gunshot wound | 18 U.S.C. § 4042(a)(2); Estelle v. Gamble |
| Exposure to extreme cold / lack of heat in housing units | 18 U.S.C. § 4042; Eighth Amendment |
| Retaliatory SHU placement for clothing violation | BOP Program Statement 5270.09 |
| Coercive interrogation and threats to obtain information | Fifth Amendment; BOP Code of Conduct |
| Denial of hygiene supplies and showers | BOP Program Statement 6031.04 |
| Restriction of family communication during holidays | 28 C.F.R. § 540.100 |

Use of holding cells without due process 28 C.F.R. § 541

Failure to provide adequate nutrition BOP Program Statement 4700.06

3. DIRECT TESTIMONY / DIRECT QUOTES

- “They don’t give them soap. They eat nasty sandwiches for lunch. It’s horrible. They are not dogs.”
 - “He said the only thing they get is bird baths in their cells. They don’t take them out to shower.”
 - “He said he was walking to chow and guards took him to holding to go to SHU for his sweatpants.”
 - “He told me he had to go politic because he said they’ll kill him.”

 - “The CO said, ‘It’s pretty warm in here.’ I said, ‘It’s warm in your office, not in a cell.’
 - “He has a gunshot wound that is leaking pus.”
 - “He requested medical care.”
 - “Delay in treatment places him at risk of serious harm.”
-

4. SYSTEMIC CONCERNS

- Pattern of retaliation for perceived noncompliance using SHU threats.
- Coercive interrogation tactics used to extract information under duress.
- Chronic denial of hygiene, showers, and basic sanitation.

- Extreme temperature exposure without mitigation.
- Obstruction of family communication, particularly during holidays.
- Deliberate indifference to medical emergencies, including infected open wounds.
- Culture of intimidation that forces incarcerated individuals to seek protection through informal means for fear of violence.

These are not isolated incidents. They reflect institutional practice.

5. OVERSIGHT DEMANDS — USP McCREARY (MID-ATLANTIC REGION)

Immediate preservation and production of the following:

- Medical records, sick-call requests, and treatment logs for Cantrell Harris
- Incident reports, holding logs, and SHU placement records related to sweatpants incident
- Video footage from holding areas and housing units involved
- Temperature and HVAC maintenance logs for affected units
- Commissary, hygiene distribution, and shower access records
- Staff duty rosters and interrogation logs
- All communications related to contraband investigations tied to coercive questioning

This matter is formally escalated to BOP Central Office, OIG, DOJ Civil Rights Division, and congressional oversight.

6. CONCLUSION

USP McCreary is on notice.

Failure to immediately correct these conditions and provide documented medical care, protection from retaliation, and humane living standards will result in continued escalation, public disclosure, and referral for civil and criminal review.

Noncompliance will be treated as willful disregard for human life.

SOUTHEAST REGION

FCI Jesup — Collective Punishment, Food Deprivation, Retaliation for Grievances, Visitation Restrictions, and Systemic Administrative Breakdown

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing escalating systemic failures at FCI Jesup, including collective punishment practices, food deprivation, retaliation for grievance activity, and administrative obstruction affecting transfers and classification decisions.

Reports indicate that mass punishment is routinely imposed on entire units or populations even after individual disciplinary matters have already been addressed. Rather than limiting sanctions to the individual involved, restrictive measures are reportedly extended broadly, creating a climate of collective punishment inconsistent with individualized discipline standards.

Reports further indicate ongoing food shortages and nutritional deprivation. Meals are reportedly reduced to minimal portions, including as little as a single slice of bread per meal, alongside an overall reduction in daily caloric intake. These conditions have raised concerns regarding inadequate nutrition and failure to meet basic dietary requirements.

Additional reports describe retaliation against individuals who submit grievances or attempt to utilize administrative remedy procedures. Retaliatory practices reportedly include increased restrictions, adverse treatment, and obstruction of opportunities such as transfers and classification reviews.

Reports also describe inconsistent and punitive visitation practices. Individuals are reportedly prohibited from eating in the visiting room while their families are permitted to do so, creating unnecessary hardship during visitation and reinforcing arbitrary enforcement rather than legitimate security needs.

More broadly, reports describe a facility experiencing rapid institutional decline. Once described as a desirable assignment for staff and a stable environment for confinement, FCI Jesup is now reportedly characterized by high staff turnover, early retirements, transfer requests, and

deteriorating morale. Reports indicate that individuals seeking transfers through appropriate channels face obstruction by unit teams, with allegations that favorable consideration is conditioned on cooperation unrelated to legitimate institutional criteria.

Taken together, these reports reflect a facility operating through retaliation, deprivation, and administrative breakdown rather than policy-driven management. The Bureau of Prisons is now on notice of systemic conditions at FCI Jesup requiring immediate scrutiny.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Collective punishment beyond individual discipline | Due Process; Individualized Discipline Standards |
| Reduced food portions and lowered caloric intake | Eighth Amendment; BOP Food Service Standards |
| Nutritional deprivation | 18 U.S.C. § 4042(a)(2) |
| Retaliation for grievance activity | First Amendment; Retaliation Prohibition |
| Arbitrary visitation restrictions | 28 C.F.R. § 540 (Visitation Regulations) |
| Obstruction of transfer and classification reviews | Due Process; BOP Classification Policies |
| Administrative coercion tied to compliance | Abuse of Authority; Deliberate Indifference |

Systemic staffing instability and morale collapse

Failure of Institutional Oversight

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI Jesup:

- “Mass punishment happens even after someone is already punished individually.”
 - “We only get one slice of bread per meal.”
 - “They lowered the daily calorie amount.”
 - “There’s retaliation for writing grievances.”
 - “We’re not allowed to eat in the visiting room, but families can.”
 - “This place used to be the jewel of the South.”
 - “We’re trying to retire or transfer.”
-

4. SYSTEMIC CONCERNS

The volume and consistency of reports indicate systemic institutional failure, including:

- Use of collective punishment in place of individualized discipline;
- Food deprivation and reduced caloric intake;
- Retaliation against grievance activity;
- Arbitrary and punitive visitation practices;
- Administrative obstruction of legitimate transfers;

- Breakdown of staff retention and institutional stability;
- Erosion of trust in unit team decision-making.

These conditions reflect an environment governed by coercion and retaliation rather than lawful policy enforcement.

5. OVERSIGHT DEMANDS —

FCI JESUP (SOUTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Preservation of records related to disciplinary actions, unit-wide restrictions, and collective punishment practices;
2. Preservation of food service records, menus, caloric calculations, and supply documentation;
3. Review of grievance handling and allegations of retaliatory treatment;
4. Audit of visitation restrictions and enforcement practices;
5. Review of transfer and classification decision-making by unit teams;
6. Assessment of staffing stability, turnover, and institutional morale indicators;
7. Disclosure of findings to appropriate oversight authorities.

Failure to address these conditions after notice constitutes continued deliberate indifference and administrative noncompliance.

6. CONCLUSION

Reports from FCI Jesup describe a facility marked by collective punishment, food deprivation, retaliation for grievance activity, and administrative obstruction. The decline in institutional

stability and erosion of lawful management practices present serious risks to safety, health, and due process. The Bureau of Prisons is now on notice of systemic conditions at FCI Jesup. Continued inaction will be treated as ongoing noncompliance with federal law and Bureau policy.

SOUTHEAST REGION

FCI Edgefield — Retaliation, Abuse of Authority, Disciplinary Manipulation, Family Contact Interference, and Staff-Confirmed Misconduct

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition (LOC) has received multiple corroborated reports, including direct communications from currently employed Bureau of Prisons staff, documenting a pattern of retaliation, abuse of authority, and disciplinary manipulation by named staff at FCI Edgefield.

These reports establish that retaliatory conduct was known to LOC through staff sources prior to impacted families being informed, demonstrating a serious breakdown of internal accountability and a growing reliance on external oversight to curb staff misconduct.

Named officers Officer Glass and Officer Williams are repeatedly identified in reports involving:

- Retaliatory disciplinary actions following protected family advocacy;
- Verbal intimidation and threats of SHU placement;
- Disciplinary escalation without factual or procedural justification;
- Continued contact with impacted individuals after retaliation concerns were formally reported.

Despite prior notice to Bureau leadership and Internal Affairs, the conduct continued, placing incarcerated individuals at heightened risk and exposing the institution to significant constitutional and federal liability.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Named Staff | Policy / Statute Violated |
|---|---------------------------------|----------------------------------|
| Retaliatory discipline following protected advocacy | Officer Glass; Officer Williams | First Amendment Retaliation |
| Verbal threats of SHU placement as intimidation | Officer Glass | Abuse of Authority |
| Escalation and stacking of incident reports | Officer Glass | Due Process |
| Ignoring exculpatory statements | Officer Glass | Wolff v. McDonnell |
| Continued staff contact after retaliation notice | Officer Glass; Officer Williams | Deliberate Indifference |
| Failure of leadership intervention | Facility Administration | 18 U.S.C. § 4042(a)(2) |

3. STAFF-CONFIRMED WHISTLEBLOWER REPORTING

LOC confirms that currently employed staff at FCI Edgefield contacted LOC directly, outside of family advocacy channels, to report that disciplinary actions taken by Officer Glass were retaliatory, improper, and unsupported.

These staff communications:

- Occurred before families were notified of the disciplinary actions;
- Described the incident reports as retaliation-driven;
- Confirmed that exculpatory information was disregarded;
- Warned that retaliation was escalating following prior reporting.

This reporting did not originate solely from families.

It was initiated and confirmed by staff.

4. RETALIATORY DISCIPLINARY ACTION — ESTABLISHED PATTERN

LOC has documented a recurring pattern involving Officer Glass:

- During a dormitory search, contraband was discovered in shared living space.
- Another individual explicitly accepted responsibility for the item.
- Despite this admission:
 - Officer Glass issued disciplinary action to both individuals;
 - One individual received a standard charge;
 - A second, more severe charge was added only to the individual associated with prior family advocacy.
- Staff later confirmed to LOC that this escalation was not justified.

Reports further state that Officer Glass verbally threatened SHU placement, stating he could do so “because he can”, including in front of others.

This conduct reflects retaliatory enforcement, not neutral discipline.

5. CONTINUED RETALIATION AFTER FORMAL NOTICE

Prior to the above actions, LOC formally placed the Bureau of Prisons on notice regarding retaliation risk at FCI Edgefield, including the identification of Officer Glass and Officer Williams.

Despite this notice:

- No documented staff separation occurred;
- No interim protections were implemented;
- Retaliatory conduct continued and escalated.

The continuation of this conduct after notice constitutes deliberate indifference.

6. SYSTEMIC CONCERNS

The volume, consistency, and staff-confirmed nature of these reports indicate systemic issues, including:

- Retaliation culture among line staff;
- Use of disciplinary authority as punishment for advocacy;
- Failure of supervisory intervention;
- Staff willingness to bypass internal channels due to lack of trust;
- Administrative tolerance of retaliatory conduct.

These conditions undermine institutional integrity and safety.

7. OVERSIGHT DEMANDS — FCI EDGEFIELD

The Loved Ones Coalition formally demands:

1. Immediate preservation of all incident reports, disciplinary records, SIS notes, and camera footage involving Officer Glass and Officer Williams;
2. Immediate separation of Officers Glass and Williams from enforcement authority pending review;
3. Independent review of retaliatory discipline patterns at FCI Edgefield;
4. Disclosure of steps taken after prior retaliation notice;
5. Regional leadership review conducted on-site;
6. Written confirmation that staff retaliation will not be tolerated or concealed.

Failure to act after staff-confirmed reporting will be documented as institutional complicity.

8. CONCLUSION

This entry reflects more than a single incident.

It documents a known, ongoing pattern of retaliation at FCI Edgefield involving named staff, confirmed by currently employed BOP personnel, and allowed to continue after formal notice.

The Bureau of Prisons is now unequivocally on notice.

Continued inaction will be treated as willful noncompliance with constitutional obligations and federal law.

SOUTHEAST REGION

Yazoo City Low I — Mississippi

Expired Food Service, Rodent Infestation, Sexual & Racial Abuse by Staff, Property Theft During SHU Placement, Corrupt Housing Practices, and Leadership Vacuum

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition (LOC) has received multiple corroborated reports, including direct staff confirmations, documenting systemic health violations, staff abuse, corruption, and administrative collapse at Yazoo City Low I, part of the Yazoo City Federal Correctional Complex.

Reports indicate that incarcerated individuals have been routinely served expired and outdated food, while the chow hall has operated without eating utensils for more than one month. Simultaneously, mice have been observed crawling across food service areas, tearing open bread, and contaminating meal trays—creating an immediate public health risk.

In addition to food safety failures, reports describe unauthorized nighttime intrusions by officers into inmate living areas between 2:00 a.m. and 4:00 a.m., outside of count times. Officers reportedly stand inside cubicles and observe individuals while they sleep, conduct that is non-routine, intimidating, and inconsistent with security protocols.

LOC has further received consistent reports of corruption in housing assignments, where head orderlies sell preferred cubicle spaces to favored individuals or in exchange for money. Reports state that counselors knowingly allow this practice, effectively monetizing housing conditions inside the unit.

Staff misconduct at Yazoo Low I includes explicit sexual harassment, homophobic slurs, racial abuse, and physical violence by named officers. One officer reportedly assaulted an incarcerated individual, causing visible injury, while using racial slurs during the incident.

Property theft and loss during SHU placement is also reported as routine and deliberate, with staff failing to pack property as required by policy and allowing other incarcerated individuals to access and steal belongings. Inventory procedures are reportedly conducted out of view, with individuals denied the opportunity to witness or verify their property.

Compounding these failures, all wardens assigned to the Yazoo City Federal Correctional Complex have reportedly departed their positions, leaving Yazoo Low I operating without permanent executive leadership. This leadership vacuum has coincided with escalating misconduct, lack of oversight, and complete breakdown of accountability.

These conditions collectively demonstrate an institution operating without effective control, supervision, or compliance with federal law.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Service of expired and outdated food | Eighth Amendment; BOP Food Service Standards |
| Lack of eating utensils for over one month | 28 C.F.R. § 551.10–551.16 |
| Rodent infestation in chow hall | BOP Environmental Health & Safety Policies |
| Mice contaminating food and bread | 18 U.S.C. § 4042(a)(2) |
| Unauthorized nighttime cubicle intrusions | Fourth & Eighth Amendments |
| Officers observing individuals while sleeping | Abuse of Authority |
| Sale of housing assignments by head orderlies | Due Process; Corruption |
| Counselor tolerance of housing corruption | Failure of Supervision |
| Sexual harassment and homophobic slurs by staff | PREA; BOP Standards of Conduct |
| Racial slurs and physical assault by officer | Eighth Amendment; Civil Rights Violations |

Failure to pack property during SHU placement

BOP P.S. 5580.08

Property inventory conducted outside inmate presence

Due Process

Loss and theft of property during SHU transfers

Fifth Amendment

Absence of warden leadership

Failure of Institutional Oversight

3. STAFF IDENTIFIED IN REPORTS

The following staff are specifically named in reports received by LOC:

- Officer Ms. Mumford — Repeated sexual harassment, homophobic slurs, verbal abuse, and degrading language toward incarcerated individuals.
- Officer Thomas (SHU Property Officer) — Failure to properly pack, inventory, and safeguard property during SHU placement and transfers.
- Lieutenant Incantamit — Conducting SHU property inventory without inmate presence and denying verification of property.
- Unidentified Officer (A Unit) — Physical assault resulting in a black eye and use of racial slurs toward a white incarcerated individual.
- Counselors (Multiple) — Allowing head orderlies to sell housing assignments and ignoring reported corruption.

All names are included based on repeated, corroborated reports, including staff-confirmed information, and warrant immediate review.

4. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding Yazoo City Low I:

- “They’ve been serving expired food.”
- “We haven’t had utensils in the chow hall for over a month.”
- “Mice crawl over the food and tear open the bread.”
- “Officers come in our cubicles at 2, 3, 4 in the morning and just stand there watching.”
- “Ms. Mumford calls people snitches, chomos, faggots, dick eaters.”
- “She tells people to ‘put your celly’s dick in your mouth and shut up.’”
- “An officer slammed a guy and called him a cracker.”
- “When people
- “All the wardens are gone.”

5. SYSTEMIC CONCERNS

Reports from Yazoo City Low I reflect institution-wide failure, including:

- Public health hazards due to contaminated food service;
- Normalization of sexual and racial abuse by staff;
- Corrupt housing practices enabled by staff;
- Property theft facilitated by policy violations;
- Use of intimidation and harassment as control tools;

- Total absence of executive leadership;
- Staff whistleblowers bypassing internal channels due to fear of retaliation.

These conditions are not isolated incidents. They represent systemic collapse.

6. OVERSIGHT DEMANDS — YAZOO CITY LOW I (SOUTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Immediate environmental health inspection of food service and chow hall operations;
2. Preservation of food service logs, pest control records, and vendor contracts;
3. Immediate investigation into Officer Ms. Mumford's conduct, including PREA review;
4. Independent review of the reported physical assault and racial abuse incident;
5. Audit of SHU property handling procedures, including Officer Thomas and Lt. Incantamit;
6. Preservation of all SHU inventory logs, transfer records, and camera footage;
7. Investigation into housing assignment corruption and counselor involvement;
8. Emergency appointment of interim executive leadership;
9. On-site Central Office review of institutional control failures.

Failure to act after notice will be treated as continued deliberate indifference.

7. CONCLUSION

Yazoo City Low I is operating under conditions that are unsafe, unlawful, and uncontrolled. Expired food, rodent infestation, staff abuse, property theft, corruption, and the complete absence of leadership collectively demonstrate a facility in crisis.

The Bureau of Prisons is now on notice.

Continued inaction will be documented as institutional complicity.

NORTHEAST REGION

USP Canaan — Prolonged Modified Lockdowns, Misuse of SHU Capacity, Collective Punishment, Restricted Movement, and Death Under Unusual Circumstances

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple consistent reports describing prolonged and routine use of “modified lockdown” at USP Canaan, resulting in collective punishment, restricted movement, and denial of meaningful out-of-cell activity for entire housing units.

Reports indicate that modified lockdown has become the default operating condition at USP Canaan, rather than a temporary response to specific incidents. Individuals report that when the institution is not on modified status, it feels “abnormal,” underscoring the normalization of restrictive conditions.

According to reports, modified lockdowns are frequently justified by claims that the Special Housing Unit (SHU) is full. However, during the same periods, more than twenty-five individuals have reportedly been released from SHU, while entire housing units remain on modified status. Despite this, units continue to be restricted solely due to the presence of a single individual whom staff state they are attempting to move to SHU.

Under modified lockdown, reports state that units are split by tier, with only half the unit permitted out at a time for approximately three hours, after which the other half is released. This rotation reportedly continues daily, severely limiting access to movement, programming, yard, religious services, and normal daily activities.

Reports further indicate that during these periods, individuals are only permitted out for recreation, with no access to full programming or meaningful movement. Religious services, including Jumu’ah, yard access, and routine activities are disrupted or eliminated. Reports

emphasize that while some individuals are able to tolerate short-term restrictions, the majority are unable to remain productive or mentally stable during prolonged modified lockdowns.

In addition to ongoing lockdown practices, USP Canaan experienced a reported melee in the chow hall, followed by additional incidents of violence on subsequent days. Reports emphasize that collective punishment following these incidents has not reduced violence, but instead has contributed to a cycle of escalating tension and instability.

Separately, the Bureau of Prisons has publicly acknowledged a death at USP Canaan on December 19, 2025. According to official statements, an incarcerated individual was found unresponsive, life-saving measures were unsuccessful, and the FBI was notified. The Bureau has confirmed that press releases are typically issued only for deaths involving “unusual circumstances,” placing this death within that category.

Taken together, these reports reflect an institution relying on collective punishment, prolonged restrictions, and administrative convenience rather than individualized management, while simultaneously operating under conditions serious enough to result in a death classified as unusual.

The Bureau of Prisons is now on notice of systemic conditions at USP Canaan requiring immediate scrutiny.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Prolonged modified lockdown as routine practice | Eighth Amendment — Conditions of Confinement |
| Collective punishment of entire units | Due Process; Individualized Discipline Standards |
| Misuse of SHU capacity to justify lockdowns | BOP Restrictive Housing Policies |
| Restricting movement based on one individual | Arbitrary & Capricious Action |

| | |
|--|----------------------------------|
| Limited out-of-cell time and tier-based release | Eighth Amendment |
| Denial of access to programming and religious services | First Amendment; RFRA |
| Lockdowns contributing to violence | Deliberate Indifference Standard |
| Death under “unusual circumstances” | 18 U.S.C. § 4042(a)(2) |
| Failure to mitigate known risks | Duty to Protect Health & Safety |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding USP Canaan:

- “The new normal here is modified lockdown.”
 - “When we’re not on modified, it feels abnormal.”
 - “They say the SHU is full, but they let over 25 people out.”
 - “They still have our unit on modified for one guy.”
 - “Bottom tier gets three hours, then top tier gets three hours.”
 - “They just let us out on rec.”
 - “Most people can’t be productive during lockdowns.”
 - “Collective punishment doesn’t work. It just creates more violence.”
-

4. SYSTEMIC CONCERNS

The consistency of reports indicates systemic operational failures, including:

- Normalization of prolonged modified lockdowns;
- Use of collective punishment as a default control mechanism;
- Administrative misuse of SHU capacity claims;
- Arbitrary restriction of movement affecting entire units;
- Denial of meaningful programming and religious access;
- Escalation of violence rather than prevention;
- Failure to address underlying safety and staffing issues;
- A death classified by the Bureau as occurring under “unusual circumstances.”

These conditions reflect management practices operating below constitutional, policy, and safety standards.

5. OVERSIGHT DEMANDS —

USP CANAAN (NORTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all lockdown logs, SHU capacity records, movement schedules, and incident reports;
2. Disclosure of SHU population data during periods of claimed “full capacity”;
3. Review of modified lockdown duration, justification, and compliance with Bureau policy;
4. Preservation of all records related to the December 19, 2025 death, including medical, security, and response documentation;

5. Independent review of whether collective punishment practices are contributing to institutional violence;
6. On-site regional leadership inspection of housing operations and movement restrictions;
7. Disclosure of corrective actions taken, if any, to oversight authorities and external stakeholders.

Failure to preserve records or address these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from USP Canaan describe an institution where prolonged modified lockdowns and collective punishment have become routine operating conditions. The misuse of SHU capacity claims, restriction of movement for entire units, and denial of meaningful activity have failed to reduce violence and instead appear to exacerbate instability.

The Bureau of Prisons is further on notice that USP Canaan has experienced a death classified as occurring under unusual circumstances. These facts demand direct leadership attention, not administrative deflection.

The Bureau of Prisons is now on notice. Continued reliance on collective punishment and prolonged lockdowns will be treated as ongoing noncompliance with federal law and constitutional obligations.

NORTHEAST REGION

FCI Schuylkill — Extended Loss of Hot Water, Sanitation Failures, Chronic Infrastructure Breakdown, and Indifference to Health Risks

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing a complete loss of hot water at FCI Schuylkill affecting both housing units and shower facilities. Reports indicate that the outage began overnight and has continued into the following day, extending well beyond a temporary or routine maintenance disruption.

According to reports, staff have communicated internally that hot water may not be restored until the following Friday or up to ten (10) days, leaving several hundred individuals confined to a housing unit without the ability to shower using hot water or maintain basic hygiene.

Reports indicate that while short-term disruptions may occasionally occur, the duration now projected far exceeds reasonable maintenance windows and presents serious sanitation and health concerns. Individuals report being confined without the ability to take a hot shower, clean themselves properly, or maintain hygienic living conditions.

Further reports indicate that this is not an isolated incident. Individuals report that FCI Schuylkill has previously experienced multi-day hot water outages, with recurring pipe failures and infrastructure breakdowns. These issues are described as chronic, predictable, and inadequately addressed by facility leadership.

Reports further state that staff have acknowledged the issue while simultaneously expressing frustration and disengagement, with statements reflecting an intent to leave rather than address ongoing conditions. This reinforces concerns that institutional maintenance failures are being normalized rather than remediated.

The prolonged denial of hot water for showers and sanitation places confined individuals at increased risk of skin infections, illness, and unsanitary living conditions. The failure to address these conditions promptly reflects deliberate indifference to basic health and safety obligations.

The Bureau of Prisons is now on notice of ongoing sanitation failures and infrastructure neglect at FCI Schuylkill.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Prolonged loss of hot water in housing units | Eighth Amendment — Conditions of Confinement |
| Inability to shower with hot water | BOP Sanitation & Habitability Policies |

| | |
|--|---|
| Extended sanitation deprivation affecting hundreds | 18 U.S.C. § 4042(a)(2) |
| Chronic plumbing and pipe failures | Deliberate Indifference Standard |
| Failure to timely repair essential utilities | Environmental Health & Safety Obligations |
| Repeated outages without remediation | Pattern of Neglect |
| Indifference to predictable health risks | Eighth Amendment |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI Schuylkill:

- “We have no hot water in the cells or the showers.”
 - “They said we might be without hot water until next Friday — maybe ten days.”
 - “That’s three to four hundred inmates without hot water.”
 - “This isn’t the first time we’ve gone days without hot water.”
 - “The pipes are always busting.”
-

4. SYSTEMIC CONCERNS

Reports indicate systemic failures rather than an isolated maintenance issue, including:

- Chronic plumbing and infrastructure breakdowns;
- Repeated loss of essential utilities;
- Extended sanitation deprivation affecting large populations;
- Failure to implement emergency mitigation measures;
- Normalization of unsafe living conditions;
- Staff disengagement and lack of accountability;
- Indifference to foreseeable health and hygiene risks.

These conditions reflect an institutional failure to meet minimum sanitation and habitability standards.

5. OVERSIGHT DEMANDS —

FCI SCHUYLKILL (NORTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Immediate disclosure of the cause of the hot water failure and projected repair timeline;
2. Preservation of all maintenance logs, work orders, and contractor communications related to plumbing failures;
3. Documentation of prior hot water outages and corrective actions taken;
4. Immediate mitigation measures to ensure access to hygienic bathing and sanitation;
5. Independent inspection of plumbing and infrastructure systems;
6. Review of leadership response to recurring maintenance failures;
7. Notification of appropriate oversight authorities regarding sanitation risks.

Failure to remediate sanitation conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI Schuylkill describe prolonged loss of hot water affecting hundreds of confined individuals, compounded by a history of recurring plumbing failures and inadequate response. Denial of hot water for showers and hygiene is not a minor inconvenience — it is a serious sanitation failure that exposes individuals to preventable health risks.

The Bureau of Prisons is now on notice of ongoing infrastructure neglect and sanitation violations at FCI Schuylkill. Continued inaction will be treated as ongoing noncompliance with constitutional standards, federal law, and Bureau policy.

NORTHEAST REGION

FCI McKean — Extreme Prolonged Lockdowns, Structural Decay, Unsanitary Living Conditions, Programmatic Shutdown, and Ongoing Health & Safety Risks

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple recent and corroborated reports describing near-constant lockdown conditions at FCI McKean, combined with severe structural decay, unsanitary housing environments, and a continued breakdown of basic institutional operations.

Reports indicate that over the past several weeks, the facility has remained largely confined behind doors, with only brief and inconsistent releases from lockdown. When limited movement does occur, it is reportedly short-lived, followed by immediate re-confinement justified by claims that the Special Housing Unit (SHU) is full. These claims persist despite other institutional functions continuing under what staff describe as “modified operations.”

As a result of these prolonged lockdowns, reports indicate that all meaningful programming has effectively ceased, including educational, vocational, rehabilitative, and religious services. Individuals report being unable to engage in productive activity, meet legal deadlines, or maintain basic routines necessary for mental stability.

In addition to movement restrictions, reports describe severe environmental and structural deterioration, particularly within sleeping areas. Reports indicate:

- Ceilings deteriorating and visibly failing;
- Chronic moisture, leaks, and mold-like conditions;
- Unsanitary dorm environments described as gross, foul, and unsafe;
- Longstanding infrastructure neglect contributing to worsening conditions.

Reports emphasize that these conditions are not new, but have escalated in recent weeks due to prolonged confinement, lack of maintenance access, and absence of corrective intervention. Individuals confined for extended periods are forced to live continuously in these deteriorating environments without relief.

Medical access during lockdown periods remains limited. Reports indicate continued delays in routine medical and dental care, compounded by restricted movement and staffing shortages. Families report difficulty obtaining information or assistance, while individuals report going weeks without meaningful access to care or counseling.

Taken together, recent lockdown practices and collapsing infrastructure have created living conditions that pose ongoing risks to health, safety, and human dignity. The Bureau of Prisons is now on notice that FCI McKean is operating under conditions that exceed temporary disruption and reflect sustained institutional failure.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Prolonged and recurring lockdowns | Eighth Amendment — Conditions of Confinement |
| Collective confinement due to SHU capacity claims | Due Process; Arbitrary & Capricious Action |

| | |
|--|--|
| Complete suspension of programming | First Step Act; BOP Programming Standards |
| Structural decay and unsafe housing conditions | BOP Environmental Health & Safety Policies |
| Deteriorating ceilings and moisture exposure | 18 U.S.C. § 4042(a)(2) |
| Unsanitary dormitory conditions | Eighth Amendment |
| Limited access to medical care during lockdowns | Estelle v. Gamble |
| Failure to remediate known infrastructure issues | Deliberate Indifference Standard |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect recent reports regarding conditions at FCI McKean:

- “This place is locked down more than I’ve ever seen.”
- “They say the SHU is full, so it’s back behind the door.”
- “We can’t program at all.”
- “The dorms are disgusting.”
- “The ceiling is falling apart.”
- “Everything is always leaking and falling apart.”
- “Living here like this all day is terrible.”

4. SYSTEMIC CONCERNS

Recent reports indicate systemic institutional failures, including:

- Reliance on prolonged lockdown as a standard operating condition;
- Misuse of SHU capacity limitations to justify collective confinement;
- Total disruption of rehabilitative and constructive activity;
- Exposure of individuals to deteriorating, unsanitary living environments;
- Failure to address known structural and maintenance hazards;
- Compounded health risks created by confinement within unsafe housing;
- Leadership failure to correct predictable and worsening conditions.

These conditions reflect an institution operating below minimum constitutional, health, and safety standards.

5. OVERSIGHT DEMANDS —

FCI McKEAN (NORTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of lockdown logs, operational status records, and SHU capacity documentation from the past 60 days;
2. Environmental and structural inspection of housing units, including ceilings, moisture damage, and sanitation conditions;
3. Preservation of maintenance requests, work orders, and inspection reports related to infrastructure failures;
4. Disclosure of programming suspensions and justification during lockdown periods;

5. Review of medical access and care delays during prolonged confinement;
6. On-site inspection by Regional and Central Office leadership;
7. Disclosure of corrective actions taken or planned to address unsafe living conditions.

Failure to act after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI McKean describe a facility operating under prolonged lockdown while housing individuals in visibly deteriorating, unsanitary environments. Structural decay, collapsed maintenance response, and suspension of programming have combined to create conditions that threaten health, safety, and basic human dignity.

The Bureau of Prisons is now on notice that conditions at FCI McKean require immediate inspection and intervention. Continued inaction will be treated as ongoing noncompliance with federal law and constitutional obligations.

NORTHEAST REGION

FCI Otisville — Collective Punishment, Mass Transfers Without Due Process, Retaliatory Confinement Conditions, Denial of Outdoor Exercise, and Property Deprivation

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple corroborated reports concerning mass punitive transfers, collective punishment, and severe conditions of confinement following a December 1, 2025 institution-wide notice issued at FCI Otisville regarding alleged extortion, threatening behavior, and assaults.

The written bulletin stated that the facility was placed under “modified operations” while administration conducted interviews to identify individuals allegedly involved in extortion-related

activity. The notice emphasized cooperation, stated that interviews would be conducted, and implied individualized assessment prior to resumption of normal operations.

Despite these representations, reports indicate that over 100 individuals were transferred en masse to FCI Berlin, a disciplinary facility, without evidence, without individualized findings, and in many cases without interviews. Numerous individuals report being abruptly ordered to pack and transferred without explanation, documentation, or opportunity to contest the allegation that they were connected to any extortion activity.

Reports further indicate that those transferred are now subjected to punitive confinement conditions, including:

- Complete denial of outdoor recreation and fresh air, as the yard is closed from late fall through late spring;
- Continuous confinement indoors with recycled air 24 hours per day;
- No access to weights, pull-up bars, or physical exercise equipment to mitigate stress;
- Property deprivation, with individuals remaining more than two weeks without receiving personal property from Receiving & Discharge (R&D).

These conditions are not tied to individual misconduct findings but are imposed categorically following the mass transfer. Reports indicate that individuals are effectively being punished for alleged conduct they were never shown to have engaged in.

The combination of mass transfers without due process, restrictive conditions, denial of exercise, and continued property deprivation places the Bureau of Prisons on notice of serious constitutional and policy violations arising from collective punishment practices initiated at FCI Otisville.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|----------------------------------|
| Mass transfer without individualized findings | Due Process Clause |

| | |
|---|------------------------------------|
| Collective punishment based on unproven allegations | Eighth Amendment |
| Failure to interview individuals prior to transfer | Arbitrary & Capricious Action |
| Retaliatory placement at disciplinary facility | First Amendment Retaliation |
| Denial of outdoor recreation | Eighth Amendment |
| Continuous exposure to recycled air | BOP Environmental Health Standards |
| Denial of exercise equipment | Conditions of Confinement |
| Property deprivation exceeding two weeks | BOP P.S. 5580.08 |
| Failure to deliver R&D property | Due Process |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions following the FCI Otisville transfers:

- “Over 100 inmates were moved without proof.”
- “Many were never interviewed at all.”
- “They were just told to pack up.”

- “They’re being punished for something they weren’t part of.”
 - “They can’t go outside at all.”
 - “This is collective punishment.”
-

4. SYSTEMIC CONCERNS

Reports indicate systemic institutional failures, including:

- Use of mass transfers as punishment rather than individualized discipline;
- Circumvention of due process through administrative labeling;
- Reliance on “modified operations” to justify collective sanctions;
- Denial of outdoor exercise and physical outlets necessary for mental health;
- Extended property deprivation following transfer;
- Escalation of confinement severity without documented misconduct.

These practices reflect disciplinary action without adjudication and raise serious concerns regarding abuse of authority and institutional retaliation.

5. OVERSIGHT DEMANDS —

FCI OTISVILLE (NORTHEAST REGION)

The Loved Ones Coalition formally demands:

1. Preservation of all documentation related to the December 1, 2025 modified operations notice, including interview logs and transfer lists;
2. Disclosure of individualized findings (if any) used to justify each transfer to FCI Berlin;

3. Review of due process compliance prior to mass transfers;
4. Immediate audit of recreation access and exercise denial at receiving facilities;
5. Accounting for all delayed or missing R&D property;
6. Review of environmental conditions involving prolonged indoor confinement and air circulation;
7. Regional and Central Office inspection of collective punishment practices.

Failure to produce individualized justification after notice will be treated as continued deliberate indifference.

6. CONCLUSION

The actions taken following the December 1 notice at FCI Otisville reflect collective punishment disguised as administrative response. The transfer of more than 100 individuals without proof, interviews, or due process — followed by restrictive confinement, denial of outdoor exercise, and prolonged property deprivation — constitutes a serious violation of constitutional protections and Bureau policy.

The Bureau of Prisons is now on notice. Continued reliance on mass punishment rather than individualized accountability will be treated as ongoing noncompliance with federal law.

NORTH CENTRAL REGION

FCI Leavenworth Camp —

Retaliation for Protected Complaints, Food/Nutrition Deprivation, Communication & Computer System Shutdown, Deprivation of Bedding in Freezing Weather, and Discriminatory Enforcement

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition received multiple reports alleging widespread retaliation impacting the entire satellite camp at FCI Leavenworth following complaints and paperwork submitted to supervisors regarding food portions and alleged food tampering/shorting. Reports indicate staff openly linked collective restrictions and deprivation measures to the filing of complaints.

According to testimony, retaliation measures include:

- Food portion reductions and additional restrictions inside the dining area, including removal of TVs and limiting time to obtain and eat meals (approximately 10 minutes to get food and clear the dining area).
- Abrupt schedule changes (including morning chow procedures and serving times) without notice, creating confusion and missed meals.
- Intentional removal of spices/flavor allegedly stated as punishment, making food “remotely edible” only at best.
- A prolonged computer system outage reportedly ongoing since approximately 11/24/2025 (week before Thanksgiving) and still not functional, which directly interferes with administrative communication and access. Reports indicate the system is being kept down to prevent individuals from submitting complaints or communicating information externally.
- Tablets rendered unusable because they require syncing with the computer system, resulting in disrupted contact with families and interference with legal communication and information access.

Reports further allege a serious escalation involving removal/confiscation of blankets and mattresses, leaving individuals exposed to extreme cold conditions. One report states blankets were confiscated around 12/17/2025, leaving some individuals with only a top sheet while temperatures were reported around 28°F with snow, and additional reports cite lows in the 20-degree range, with individuals described as freezing inside.

Additional reporting indicates the restrictions are being applied across the camp, but that the Hispanic housing area (“car”) is impacted more frequently/harsher, accompanied by racist comments by staff.

These allegations place the Bureau of Prisons on notice of serious violations involving retaliation for protected complaint activity, deprivation of basic necessities, interference with communication and access to courts, and discriminatory enforcement.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Retaliation against entire camp following complaints about food | First Amendment Retaliation Prohibition; Protected Petition/Grievance Activity |
| Reduced portions / shortened chow access (approx. 10 minutes) | Eighth Amendment — Conditions of Confinement; BOP Food Service Standards |
| Unannounced meal schedule changes / failure to call chow normally | Due Process; Arbitrary & Capricious Administrative Action |
| Intentional removal of spices/flavor as punishment | Eighth Amendment; Deliberate Indifference Standard |
| Computer system kept down since ~11/24/2025 | Access to Courts; Due Process; Administrative Remedy Access |
| Tablets rendered useless due to inability to sync | Access to Communication; Due Process; Interference with Family Contact |
| Confiscation/removal of blankets and mattresses in freezing temperatures | Eighth Amendment — Basic Needs (Warmth/Bedding); Deliberate Indifference |
| Discriminatory targeting of Hispanic housing area | Equal Protection; Civil Rights Violations; Discriminatory Enforcement |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony provided regarding conditions at FCI Leavenworth Camp:

- “COs are mad because inmates told their superiors and submitted paperwork saying COs are not feeding us right and have been cutting food short.”
- “Now the COs are retaliating... cutting the TVs, no one is allowed in the dining area.”
- “Food portions are even much smaller than they used to be.”
- “We only have ten minutes to get our food and clear the dining area.”
- “They don’t even call for morning chow or change the serving times without notifying us.”
- “They said they are intentionally not allowing any spices or flavor on the food.”
- “They want to punish us all because of the reports/complaints.”
- “They said they are going to keep the computers down so no one can complain or communicate any information.”
- “The system has been down since the week before Thanksgiving.”
- “Guys are missing legal information and communications with their families.”
- “All of the tablets do not work anymore because they have to be synced with the computer system.”
- “COs are taking blankets and mattresses... It is snowing... lows in the 20-degree zone. The guys are freezing inside.”
- “The blankets were confiscated 12/17/2025... some guys with just a top sheet in 28-degree and snowing weather.”

- “All cars are impacted but the Hispanic car gets hit harder/more frequently and there are racist comments that COs make.”
-

4. SYSTEMIC CONCERNS

These reports reflect broader systemic concerns, including:

- Use of collective punishment as retaliation for complaint activity;
 - Food service practices that appear punitive and deprivation-based rather than policy-driven;
 - Prolonged loss of operational systems impacting administrative remedy access, communication, and legal rights;
 - Use of bedding deprivation in freezing weather as a coercive control tactic;
 - Discriminatory enforcement patterns disproportionately impacting Hispanic individuals;
 - Staff reportedly acknowledging retaliation motives, indicating a breakdown of oversight and supervision.
-

5. OVERSIGHT DEMANDS

FCI LEAVENWORTH CAMP (NORTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of chow hall logs, meal schedules, menu plans, portion standards, and any written directives altering dining procedures or time limits;
2. Immediate preservation of all documentation related to the reported computer system outage, including IT tickets, repair requests, vendor service logs, and supervisory communications concerning the outage beginning around 11/24/2025;

3. Written confirmation of steps taken to ensure incarcerated individuals retain access to administrative remedies, legal materials, and family communication during system outages;
4. Immediate investigation into allegations that the system is being kept offline to obstruct complaints, including referral to appropriate oversight authorities if substantiated;
5. Immediate prohibition and review of any bedding/mattress confiscation practices in freezing temperatures, including preservation of property logs, staff authorizations, and dates of removal (including 12/17/2025 as reported);
6. Immediate verification of indoor temperatures, heating function, and emergency mitigation measures for any individual left without adequate bedding;
7. Independent review of discriminatory enforcement allegations, including reports that the Hispanic housing area is targeted more frequently, and preservation of all related housing restriction logs and staff assignments;
8. Written assurance of non-retaliation protections for individuals and families reporting these conditions, including confirmation that no adverse action will be taken for contacting oversight entities.

Failure to preserve records or address these conditions after notice constitutes continued deliberate indifference and obstruction of oversight.

6. CONCLUSION

Reports from FCI Leavenworth Camp describe retaliation against an entire camp population following protected complaint activity, including food deprivation practices, shutdown of communication and computer systems, interference with legal and family contact, and deprivation of basic bedding during freezing weather. Allegations of disproportionate targeting of Hispanic individuals further raise serious civil rights concerns.

The Bureau of Prisons is now on notice. Continued inaction, failure to preserve evidence, or continued collective punishment will be treated as ongoing noncompliance with constitutional obligations, federal law, and Bureau policy.

NORTH CENTRAL REGION

USP Terre Haute — Unsanitary Food Service Conditions, Rodent & Insect Infestation, Unsafe Kitchen Practices, and Resulting Illness

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received recent testimony concerning severe sanitation failures and unsafe food service conditions at USP Terre Haute, specifically within the facility’s kitchen and food preparation areas.

According to reports, food service operations are occurring under visibly unsanitary conditions, including widespread cockroach infestation throughout kitchen areas. Reports further indicate that food service workers are not consistently using gloves or basic sanitary precautions during food preparation and service, despite the known presence of insects and contamination risks.

Testimony indicates that food served to incarcerated individuals is frequently spoiled. As a result of these conditions, at least one incarcerated individual became ill with symptoms consistent with food poisoning after consuming meals prepared by the facility.

These conditions reflect a failure to adhere to basic food safety standards and present a foreseeable risk of illness, infection, and systemic health harm. The reported presence of insects, lack of protective food handling practices, and service of spoiled food places the Bureau of Prisons on notice of conditions that violate minimum health, safety, and sanitation requirements at USP Terre Haute.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Cockroach infestation in kitchen areas | Eighth Amendment — Conditions of Confinement |
| Unsanitary food preparation environment | 18 U.S.C. § 4042(a)(2) |

| | |
|--|---|
| Failure to use gloves during food handling | BOP Food Service & Sanitation Standards |
| Service of spoiled food | Eighth Amendment; Food Safety Obligations |
| Resulting food poisoning | Deliberate Indifference Standard |
| Failure to prevent foreseeable illness | BOP Environmental Health Policies |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony received regarding conditions at USP Terre Haute:

- “There are cockroaches all over the kitchen.”
 - “They are not using gloves when handling food.”
 - “The food is spoiled.”
 - “My husband got food poisoning from the meals.”
 - “The kitchen conditions are horrible.”
-

4. SYSTEMIC CONCERNS

Reports from USP Terre Haute reflect broader systemic concerns, including:

- Failure to maintain sanitary kitchen and food service environments;
- Inadequate pest control within food preparation areas;

- Disregard for basic food safety protocols such as glove use;
- Service of spoiled or unsafe food to confined populations;
- Exposure of incarcerated individuals to preventable illness;
- Lack of effective internal oversight or corrective response once conditions are known.

These conditions indicate institutional tolerance of unsafe food service practices rather than isolated or accidental lapses.

5. OVERSIGHT DEMANDS —

USP TERRE HAUTE (NORTH CENTRAL REGION)**

The Loved Ones Coalition formally demands:

1. Immediate environmental health inspection of all kitchen and food service areas at USP Terre Haute;
2. Preservation of pest control logs, inspection reports, and sanitation records;
3. Preservation of food service logs, meal preparation records, and vendor documentation;
4. Independent review of food handling practices, including compliance with glove and sanitation requirements;
5. Medical review of reported food poisoning incidents and related sick call records;
6. Immediate remediation of pest infestation and unsanitary conditions;
7. Disclosure of corrective actions taken to Regional and Central Office oversight authorities.

Failure to remediate known food safety hazards after notice constitutes continued deliberate indifference to health and safety.

6. CONCLUSION

Reports from USP Terre Haute describe food service conditions that are unsafe, unsanitary, and directly linked to illness. The presence of cockroaches, failure to use basic protective measures, and service of spoiled food violate fundamental standards of confinement and public health.

Food safety is not discretionary. Illness caused by preventable sanitation failures is a serious constitutional and statutory concern. The Bureau of Prisons is now on notice of these conditions at USP Terre Haute. Continued inaction will be treated as ongoing noncompliance with federal law and Bureau policy.

NORTH CENTRAL REGION

FCI Thomson — Systemic Nutritional Deprivation, Extended Commissary Restrictions, Collapse of Mental Health Services, Exposure to Coercive Restraint Infrastructure, and Ongoing Medical Neglect

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing severe and ongoing deprivation of adequate nutrition, collapse of meaningful mental health services, and systemic medical neglect at FCI Thomson. Reports indicate that food portions are consistently inadequate in both quality and quantity, leaving individuals unable to meet basic nutritional needs through meals alone.

Reports further indicate that commissary access is routinely unavailable or severely restricted for large portions of the population due to extended disciplinary sanctions, lockdowns, or administrative practices. As a result, individuals are left without any reliable means to supplement inadequate meals, creating conditions of chronic hunger across the facility rather than isolated hardship.

Mental health services at FCI Thomson are described as effectively nonfunctional. Reports indicate that on-site mental health staffing has dramatically diminished or fully withdrawn, with services reduced to remote or intermittent virtual encounters. Individuals report extended waits for mental health contact, lack of continuity of care, and absence of meaningful crisis intervention. These failures are particularly alarming given the well-documented psychological toll of prolonged confinement and isolation at the facility.

Reports further describe exposure to coercive restraint infrastructure within the institution, including observation of restraint rooms equipped with concrete slabs and full-body shackling systems historically used for extended immobilization. While reports indicate these restraints may no longer be actively used, their continued presence within a federal training environment contributes to psychological distress and reinforces a culture of control rather than care.

In addition, reports describe widespread medical neglect, including delayed diagnosis, untreated conditions, and prolonged waits for routine and specialty care. Individuals report difficulty accessing medical staff, delayed responses to sick call requests, and lack of transparency regarding treatment decisions.

Taken together, these reports reflect systemic failures at FCI Thomson involving nutrition, mental health care, medical access, and conditions of confinement. The Bureau of Prisons is now on notice of conditions that present serious and ongoing risks to physical and psychological health.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Inadequate food portions and poor food quality | Eighth Amendment — Conditions of Confinement |
| Systemic nutritional deprivation | 18 U.S.C. § 4042(a)(2) |
| Reliance on commissary to meet basic caloric needs | Deliberate Indifference Standard |
| Extended or widespread loss of commissary access | Due Process; Arbitrary & Capricious Action |
| Collapse of on-site mental health staffing | Eighth Amendment; Mental Health Care Obligations |

Reliance on remote-only mental health services

Deliberate Indifference

Exposure to coercive restraint infrastructure

Conditions of Confinement

Failure to provide timely medical care

Estelle v. Gamble, 429 U.S. 97 (1976)

Chronic delays in diagnosis and treatment

Medical Neglect Standards

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI Thomson:

- “The food portions are so small people are basically starving.”
 - “The food is nasty and not enough to live on.”
 - “Commissary isn’t available for long stretches, so there’s no way to make up for the food.”
 - “Mental health here is a joke — there’s no one actually here.”
 - “People have to talk to someone on a screen, if they get to talk to anyone at all.”
 - “There’s a room with a concrete slab and full shackles — seeing that alone messes with your head.”
 - “Medical care takes forever, if it happens at all.”
 - “Everything here feels like neglect stacked on neglect.”
-

4. SYSTEMIC CONCERNS

The volume and consistency of reports indicate systemic failures rather than isolated incidents, including:

- Chronic underfeeding and inadequate meal portions;
- Institutional reliance on commissary to offset insufficient nutrition;
- Widespread deprivation when commissary access is unavailable;
- Collapse of in-person mental health services;
- Use of remote mental health care as a substitute for adequate staffing;
- Psychological harm caused by exposure to restraint infrastructure;
- Persistent medical delays and untreated conditions;
- Institutional indifference to predictable physical and mental health consequences.

These conditions reflect confinement practices operating below minimum constitutional, medical, and human safety standards.

5. OVERSIGHT DEMANDS —

FCI THOMSON (NORTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all food service records, menus, portion standards, and nutritional audits;
2. Review of commissary restrictions and their cumulative impact on nutrition and health;
3. Disclosure of current mental health staffing levels, vacancies, and service delivery models;
4. Independent review of compliance with mental health care standards;

5. Inventory and assessment of restraint infrastructure and its continued presence within the facility;
6. Preservation of medical request logs, sick call records, and treatment timelines;
7. Independent medical review of delays and untreated conditions;
8. On-site inspection by Regional and Central Office leadership;
9. Disclosure of corrective actions taken or planned to address systemic failures.

Failure to preserve records or address these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI Thomson describe an institution where inadequate nutrition, restricted access to commissary, collapsed mental health services, exposure to coercive restraint environments, and ongoing medical neglect have become normalized conditions of confinement. These failures are not isolated or accidental — they are systemic, predictable, and preventable.

The Bureau of Prisons is now on notice that conditions at FCI Thomson present serious risks to health, safety, and human dignity. Continued inaction will be treated as ongoing noncompliance with federal law, Bureau policy, and constitutional obligations.

NORTH CENTRAL REGION

FCI Waseca — Extreme Cold Exposure, Loss of Heat & Hot Water, Unsafe Living Conditions, Medical & Psychiatric Staffing Collapse, and Administrative Shutdown

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple reports describing severe environmental failures, unsafe living conditions, and administrative breakdown at FCI Waseca during winter

operations. Reports indicate that incarcerated individuals have been subjected to prolonged exposure to extreme cold temperatures, inadequate heating, lack of hot water, and deteriorating housing conditions.

Reports state that during periods when outside temperatures reached approximately –22°F, water inside housing units was only lukewarm or became fully cold, including in showers. Multiple showers reportedly remain ice cold and unrepaired, leaving individuals unable to maintain basic hygiene during extreme winter conditions. Windows are reported to be iced over, further demonstrating inadequate insulation and environmental control within housing units.

Reports further indicate that mattresses provided are severely inadequate, often repurposed from SHU inventory or less than one inch thick. These conditions contribute to chronic pain, sleep deprivation, and physical deterioration, particularly during cold weather months. Facility staff reportedly state that there is “no money” to replace mattresses or address these deficiencies.

The facility has also reportedly eliminated access to televisions after switching to DirecTV HD service while maintaining non-HD compatible televisions. Staff have reportedly stated there are no funds to replace the televisions, resulting in complete loss of access. Reports indicate that this has caused increased tension, conflict, and instability within housing units.

Medical and mental health care at FCI Waseca is described as severely compromised. Reports indicate the facility currently has no on-site psychiatrist, with psychiatric medications managed by non-specialist providers. Reports further describe delayed medical response following injuries, including individuals waiting a week or longer for evaluation after falls or injuries, only to receive minimal assessment and dismissal without follow-up care.

Reports also describe institutional shutdown during holiday periods, including refusal to wash personal clothing while simultaneously disciplining individuals for washing their own clothes. In addition, reports indicate widespread staff absence, with unit teams reportedly instructed not to report to work without explanation, leaving housing units without functional administrative oversight.

Collectively, these reports describe an institution operating under environmental failure, staffing collapse, and administrative dysfunction, placing the confined population at serious risk of physical harm, illness, and psychological distress.

2. KEY ALLEGATION & VIOLATION TABLE

Allegation

Policy / Statute Violated

| | |
|--|--|
| Exposure to extreme cold with inadequate heating | Eighth Amendment — Conditions of Confinement |
| Lack of hot water and ice-cold showers | BOP Sanitation & Habitability Policies |
| Failure to repair plumbing during winter | 18 U.S.C. § 4042(a)(2) |
| Iced-over windows and poor insulation | Deliberate Indifference Standard |
| Inadequate mattresses causing physical harm | Eighth Amendment |
| Elimination of televisions without mitigation | Conditions of Confinement |
| Increased violence due to deprivation | Failure of Institutional Control |
| Absence of on-site psychiatrist | Eighth Amendment — Mental Health Care |
| Psychiatric meds managed without specialist | Medical Neglect |
| Delayed medical response to injuries | Estelle v. Gamble |
| Laundry access restrictions during shutdown | BOP Sanitation Standards |
| Staff absence and administrative shutdown | Failure of Institutional Oversight |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI Waseca:

- “It was –22 degrees outside and the water was barely warm.”
- “Some showers are ice cold and they won’t fix them.”
- “The windows are iced over.”
- “They switched to DirecTV HD but the TVs don’t support it, so now we have nothing.”
- “It’s causing fights and problems.”
- “We don’t have a psychiatrist at all.”
- “A regular doctor handles psych meds.”
- “People wait a week to be seen after getting hurt.”
- “They only wash institutional clothes during holidays but yell if we wash our own.”
- “The unit team said they were told not to come in.”

4. SYSTEMIC CONCERNS

The volume and consistency of reports indicate systemic institutional failure, including:

- Inability to maintain safe temperatures during extreme winter conditions;
- Denial of hot water and functional showers;
- Deteriorating housing infrastructure;
- Use of substandard bedding contributing to pain and injury;
- Deprivation of basic recreation and stability due to loss of televisions;

- Collapse of psychiatric staffing and specialty care;
- Delayed and dismissive medical treatment;
- Holiday shutdowns eliminating basic services;
- Staff absenteeism and lack of administrative control.

These conditions reflect confinement practices operating below minimum constitutional, medical, and human safety standards.

5. OVERSIGHT DEMANDS —

FCI WASECA (NORTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate environmental inspection of heating, plumbing, and insulation systems;
2. Restoration of reliable hot water and repair of all non-functional showers;
3. Preservation of maintenance logs and work orders related to heating and plumbing failures;
4. Replacement of substandard mattresses and disclosure of bedding procurement records;
5. Disclosure of funding decisions related to television removal and recreation access;
6. Immediate disclosure of psychiatric staffing levels and vacancies;
7. Independent review of psychiatric medication management practices;
8. Preservation of medical response logs related to injuries and delayed care;
9. Review of holiday shutdown procedures affecting hygiene and services;
10. On-site Regional and Central Office inspection of institutional operations.

Failure to address these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI Waseca describe an institution operating under extreme environmental stress, inadequate heating and sanitation, collapsed medical and psychiatric services, and administrative withdrawal. Exposure to freezing temperatures, denial of hot water, lack of medical care, and absence of staff oversight place incarcerated individuals at serious and foreseeable risk of harm.

The Bureau of Prisons is now on notice.

Continued inaction will be treated as ongoing noncompliance with federal law, Bureau policy, and constitutional obligations.

SOUTH CENTRAL REGION

FCI Pollock — SHU Conditions: Extreme Heat, Lack of Air & Water, Mold Infestation, Unsanitary Cells, Insect Infestation, Medical Neglect, and Prolonged Physical Harm

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received direct written testimony describing severe and dangerous conditions inside the Special Housing Unit (SHU) at FCI Pollock. Reports indicate that incarcerated individuals are being held in environments that lack basic sanitation, climate control, and medical care, resulting in ongoing physical harm.

According to the testimony, most SHU cells do not have working water, leaving individuals unable to wash, drink adequately, or clean their living spaces. Individuals report that they are not provided with proper cleaning supplies and are forced to live in filthy cells, often without clean clothing or the ability to maintain hygiene.

Reports describe extreme heat with no air circulation, creating suffocating conditions. These conditions are compounded by black mold throughout the unit, roach infestations, and persistent unsanitary surroundings. Individuals report roaches “running around” cells and mold present “everywhere,” indicating a long-term environmental failure rather than an isolated issue.

Medical neglect is a central concern. The testimony reports that individuals experiencing serious physical pain and injury are denied timely medical care. In one reported instance, an individual slipped and fell, sustaining injury, yet was left in the SHU for two additional days before any response. The individual reports ongoing severe pain, inability to sleep at night, and worsening symptoms, including issues affecting vision and eye health.

Reports further indicate that medical staff minimize or dismiss complaints, telling individuals they are “good” despite obvious and worsening symptoms. This has led to fear of permanent injury and irreversible damage. The conditions described suggest that confinement in the SHU is actively causing physical deterioration rather than serving any legitimate safety purpose.

The testimony reflects a sense of urgency and fear, stating that the situation is “out of control” and that individuals feel their health is being sacrificed through neglect and inhumane confinement conditions.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--------------------------------------|--|
| Extreme heat with no air circulation | Eighth Amendment — Conditions of Confinement |
| Lack of running water in SHU cells | BOP Sanitation Standards |
| Denial of cleaning supplies | BOP Program Statement on Hygiene |
| Black mold throughout housing | Deliberate Indifference |
| Roach and pest infestation | Public Health & Safety Standards |
| Unsanitary living conditions | Eighth Amendment |

| | |
|---|---------------------------------|
| Failure to provide clean clothing | BOP Sanitation Policies |
| Delayed medical response after injury | Estelle v. Gamble |
| Prolonged confinement while injured | Deliberate Indifference |
| Dismissal of worsening medical symptoms | Eighth Amendment — Medical Care |
| Risk of permanent injury | 18 U.S.C. § 4042(a)(2) |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements are taken directly from written testimony regarding SHU conditions at FCI Pollock:

- “Most of the cells don’t have working water.”
- “They don’t even have clean clothes to give you.”
- “It’s black mold everywhere.”
- “Roaches running around.”
- “I slipped and fell and they left me in SHU two days.”
- “I feel like I may have some brain damage.”
- “I’m in so much pain I can’t sleep at night.”
- “Everything that’s wrong with my eyes and my head.”

4. SYSTEMIC CONCERNS

The reports from FCI Pollock indicate systemic failures, including:

- Long-term neglect of SHU infrastructure and sanitation;
- Inadequate plumbing and lack of potable water;
- Unsafe heat exposure without ventilation;
- Mold growth and pest infestation posing serious health risks;
- Denial of basic hygiene and clean clothing;
- Failure to provide timely medical evaluation after injuries;
- Prolonged confinement in harmful conditions despite medical need;
- Dismissive and negligent medical responses;
- Risk of permanent physical and neurological harm.

These conditions reflect punitive confinement practices that exceed constitutional limits and place incarcerated individuals at serious risk of irreversible injury.

5. OVERSIGHT DEMANDS —

FCI POLLOCK (SOUTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate environmental and health inspection of the SHU;
2. Restoration of working water in all SHU cells;
3. Mold testing and remediation by an independent contractor;

4. Pest control inspection and treatment;
5. Provision of adequate cleaning supplies and clean clothing;
6. Inspection of HVAC and ventilation systems in SHU;
7. Immediate medical evaluation of all individuals reporting injuries;
8. Preservation of medical records and incident reports related to falls and injuries;
9. Review of SHU confinement durations where medical issues are present;
10. Regional and Central Office oversight visit to FCI Pollock.

Continued confinement under these conditions constitutes deliberate indifference to health and safety.

6. CONCLUSION

The conditions described within the SHU at FCI Pollock represent extreme environmental neglect, medical indifference, and systemic failure. Exposure to mold, lack of water, insect infestation, untreated injuries, and excessive heat place incarcerated individuals at serious risk of permanent harm.

The Bureau of Prisons is now on notice.

Failure to intervene will be treated as continued constitutional and statutory violations.

SOUTH CENTRAL REGION

FCI Oakdale — Recurrent Multi-Day Lockdowns, Collective Punishment, Communication Blackouts, and Arbitrary Movement Restrictions

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received recent testimony describing routine, recurring multi-day lockdowns at FCI Oakdale that function as collective punishment rather than temporary security measures. Reports indicate that these lockdowns occur on a predictable weekly schedule and are routinely justified by staff as a “staffing shortage,” despite testimony indicating that staffing levels have remained unchanged for over a year.

According to reports, individuals are routinely locked down beginning Tuesday night, with confinement continuing until Thursday morning, and again from Friday through Sunday. During these extended lockdown periods, individuals are confined to housing units or cells with no access to phone calls, email, or normal movement, resulting in prolonged isolation and complete communication blackouts.

Reports further indicate that these lockdowns affect both dorm-style and cell-style housing, with some units fully locked behind doors while others remain partially open without clear or consistent criteria. Individuals report that no individualized misconduct precedes these restrictions and that the population is being punished “for nothing.”

Testimony further disputes the staffing shortage justification, stating that officers are consistently present and that the same explanation has been used for more than a year without any meaningful change or hiring increase. Individuals report that the restrictions were supposedly intended to be temporary and resolved months ago, yet continue without explanation, documentation, or accountability.

The denial of communication, prolonged confinement, and repetitive lockdown schedule reflect an institutional reliance on collective punishment and administrative convenience rather than policy-driven security management. The Bureau of Prisons is now on notice of ongoing conditions at FCI Oakdale that implicate constitutional protections, due process standards, and basic conditions of confinement.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Routine multi-day lockdowns as standard practice | Eighth Amendment — Conditions of Confinement |
| Lockdowns imposed without individual misconduct | Due Process; Individualized Discipline Standards |

| | |
|--|--|
| Lockdown schedule spanning Tues–Thurs and Fri–Sun | Arbitrary & Capricious Action |
| Complete denial of phone and email access during lockdowns | First Amendment; Access to Communication |
| Collective punishment of entire units | Eighth Amendment |
| Inconsistent housing restrictions (cells vs. dorms) | Equal Protection; Due Process |
| Use of “staffing shortage” justification for over one year | Deliberate Indifference Standard |
| Failure to restore normal operations after promised resolution | Abuse of Administrative Authority |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect testimony received regarding conditions at FCI Oakdale:

- “They been saying it’s a staff shortage
- “They lockdown all day Wednesday and Saturday. Tuesday night they don’t come back out until Thursday morning.”
- “Then again from Friday till Sunday.”
- “No phone call or nothing.”
- “No email either.”
- “They punishing them for nothing.”

- “Officers are always there — it’s never a shortage.”
 - “Some units are behind the door, some dorms open — it don’t make sense.”
-

4. SYSTEMIC CONCERNS

Reports from FCI Oakdale reflect broader systemic failures, including:

- Normalization of recurring, scheduled lockdowns;
- Use of collective punishment in place of individualized discipline;
- Communication blackouts that isolate individuals from family and support;
- Arbitrary and inconsistent housing restrictions across units;
- Repeated reliance on an unsubstantiated staffing shortage explanation;
- Failure to resolve conditions despite claims the issue was temporary;
- Erosion of trust and stability within the confined population.

These conditions indicate institutional practices operating below constitutional and policy standards rather than isolated or emergency measures.

5. OVERSIGHT DEMANDS —

FCI OAKDALE (SOUTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all lockdown logs, movement schedules, and unit status reports for the past six months;
2. Disclosure of staffing rosters and vacancy data used to justify lockdowns;

3. Written explanation of the recurring Tuesday–Thursday and Friday–Sunday lockdown schedule;
4. Review of communication restrictions imposed during lockdowns, including denial of phone and email access;
5. Assessment of compliance with BOP policy regarding individualized discipline versus collective punishment;
6. On-site regional review of housing operations and movement decisions;
7. Written assurance that individuals will not face retaliation for reporting these conditions.

Failure to preserve records or address these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI Oakdale describe an institution where multi-day lockdowns, communication blackouts, and collective punishment have become routine operating conditions rather than temporary security responses. The continued use of an unsubstantiated staffing shortage explanation, combined with denial of phone and email access, raises serious constitutional and policy concerns.

The Bureau of Prisons is now on notice of ongoing conditions at FCI Oakdale. Continued reliance on prolonged lockdowns and communication deprivation will be treated as ongoing noncompliance with federal law, Bureau policy, and constitutional obligations.

SOUTH CENTRAL REGION

FCC Forrest City — Absence of Overnight Medical Coverage, Deliberate Indifference to Medical Emergencies, and Systemic Risk of Preventable Death

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received credible, corroborated reports indicating that FCC Forrest City operates without medical staff during overnight hours, leaving incarcerated individuals without access to timely medical evaluation or emergency care during nighttime periods.

Reports indicate that individuals experiencing acute medical distress during overnight hours are routinely left without direct medical assessment, intervention, or monitoring. Medical services are reportedly unavailable throughout the night, creating a prolonged window during which emergencies may go untreated until morning hours — if addressed at all.

The absence of overnight medical coverage places incarcerated individuals at foreseeable risk of serious injury or death, including but not limited to medical crises that require immediate evaluation. The inability to access care during these hours is not isolated or incidental, but described as a standard operating condition at the facility.

Reports further indicate that individuals experiencing medical events overnight are forced to wait until morning medical rounds, regardless of severity, or rely on non-medical staff without appropriate training to assess or respond to emergencies. This practice creates a predictable risk environment in which deterioration, collapse, or death can occur unseen and untreated.

The Bureau of Prisons is now on notice that operating a federal correctional facility without overnight medical coverage constitutes deliberate indifference to serious medical needs and exposes confined individuals to preventable harm. Medical emergencies do not stop at night, and the failure to provide continuous access to care reflects a systemic breakdown in basic medical safeguards.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|---------------------------------------|
| Absence of overnight medical staff | Eighth Amendment — Medical Care |
| Lack of emergency medical response during nighttime hours | 18 U.S.C. § 4042(a)(2) |
| Forced delays in medical evaluation until morning | Estelle v. Gamble, 429 U.S. 97 (1976) |

| | |
|---|----------------------------------|
| Reliance on non-medical staff for medical crises | Deliberate Indifference Standard |
| Foreseeable risk of untreated medical emergencies | Eighth Amendment |
| Failure to ensure continuous access to care | BOP Health Services Policies |
| Systemic exposure to preventable injury or death | Constitutional Duty of Care |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding overnight medical access at FCC Forrest City:

- “There is no medical at night.”
 - “If something happens overnight, there’s no one to see you.”
 - “Medical isn’t there all night long.”
 - “You have to wait until morning no matter what.”
 - “People are scared because anything can happen at night.”
-

4. SYSTEMIC CONCERNS

Reports indicate systemic institutional failures, including:

- Complete absence of overnight medical staffing;
- Delayed or denied response to medical emergencies during nighttime hours;
- Predictable risk of untreated medical events, including loss of consciousness or death;
- Reliance on non-medical staff to manage medical crises;
- Failure to implement basic emergency medical safeguards;
- Normalization of delayed care despite known risks;
- Indifference to the reality that medical emergencies occur at all hours.

These conditions reflect a facility operating below minimum constitutional and medical safety standards.

5. OVERSIGHT DEMANDS —

FCC FORREST CITY (SOUTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate disclosure of overnight medical staffing policies, including staffing schedules and coverage gaps;
2. Preservation of all medical staffing rosters, emergency response logs, and incident reports for overnight hours;
3. Independent review of all medical emergencies occurring during nighttime periods;
4. Written confirmation of emergency medical response procedures when no medical staff are present;
5. Immediate implementation of 24-hour medical coverage or equivalent emergency medical safeguards;
6. Disclosure of any prior internal warnings, complaints, or audits related to overnight medical access;

7. Notification of Regional and Central Office oversight authorities regarding systemic risk conditions.

Failure to provide continuous access to medical care after notice constitutes continued deliberate indifference.

6. CONCLUSION

FCC Forrest City is operating under conditions in which medical emergencies occurring overnight may go untreated, placing incarcerated individuals at serious and foreseeable risk of preventable harm or death. The absence of overnight medical staffing is not a minor administrative issue — it is a systemic life-safety failure.

Medical crises do not pause at night.

Federal custody does not excuse abandonment.

The Bureau of Prisons is now on notice. Continued inaction will be treated as ongoing noncompliance with constitutional medical obligations.

SOUTH CENTRAL REGION

FCI El Reno — Power Failure at Commissary, Loss of Heat, Food Access Disruption, Cold Exposure, and Unsanitary Food Service Conditions

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received reports describing a critical infrastructure failure at FCI El Reno resulting in loss of power to the commissary area, disruption of food access, exposure to extreme cold conditions, and ongoing unsanitary food service practices.

According to reports, the generator servicing the commissary and associated areas was nonfunctional, leaving the facility without power in areas essential to food access and basic

operations. As a result, individuals were unable to obtain commissary items, including food and necessities, for an extended period.

Reports further indicate that during this power failure, there was no heat, exposing incarcerated individuals to cold indoor temperatures during winter conditions. Individuals describe the environment as extremely cold, with no mitigation measures provided.

In addition to infrastructure and heating failures, reports describe roach infestation in the food service operation, including insects present during chow service. The presence of roaches in food areas raises serious public health concerns and indicates ongoing sanitation failures rather than an isolated incident.

The combined loss of power, inability to access food, exposure to cold temperatures, and unsanitary chow conditions reflect systemic operational failures that place the confined population at risk of illness, malnutrition, and physical harm. These conditions indicate institutional neglect rather than temporary inconvenience.

The Bureau of Prisons is now on notice of serious health, safety, and habitability failures at FCI El Reno.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Loss of power to commissary due to generator failure | 18 U.S.C. § 4042(a)(2) |
| Inability to access food and necessities | Eighth Amendment — Conditions of Confinement |
| Lack of heat during winter conditions | Eighth Amendment — Basic Needs |
| Exposure to cold indoor temperatures | Deliberate Indifference Standard |

| | |
|---|---|
| Failure to provide contingency food access | BOP Operational Continuity Standards |
| Roaches present in food service during chow | BOP Food Service & Sanitation Standards |
| Unsanitary food preparation and service | Eighth Amendment; Public Health Obligations |
| Failure to remediate known sanitation risks | Deliberate Indifference |

3. DIRECT TESTIMONY / DIRECT QUOTES

The following statements reflect reports received regarding conditions at FCI El Reno:

- “The generator is off where commissary is at.”
 - “There’s no power so they can’t get food or nothing.”
 - “There’s no heat — it’s cold.”
 - “Roaches were in the food during chow.”
 - “This isn’t safe or normal.”
-

4. SYSTEMIC CONCERNS

Reports from FCI El Reno reflect broader systemic concerns, including:

- Failure to maintain critical infrastructure necessary for food access;
- Absence of contingency planning when power and generators fail;

- Exposure of incarcerated individuals to cold temperatures without heat;
- Disruption of nutrition and access to basic necessities;
- Ongoing pest infestation and unsanitary food service conditions;
- Lack of timely corrective action once conditions were known;
- Institutional tolerance of health and safety risks during winter operations.

These failures indicate systemic breakdown rather than an isolated mechanical issue.

5. OVERSIGHT DEMANDS

FCI EL RENO (SOUTH CENTRAL REGION)

The Loved Ones Coalition formally demands:

1. Immediate disclosure of the cause, duration, and scope of the generator and power failure affecting commissary operations;
2. Preservation of all maintenance logs, generator inspection records, repair requests, and work orders related to the outage;
3. Documentation of contingency measures taken (or not taken) to provide food and necessities during the power failure;
4. Verification of indoor temperatures and heating system functionality during the outage period;
5. Immediate environmental health inspection of food service areas;
6. Preservation of pest control records, sanitation inspections, and vendor service reports;
7. Independent review of food safety compliance during reported roach contamination;
8. Disclosure of corrective actions taken to prevent recurrence;

9. On-site inspection by Regional and Central Office leadership.

Failure to preserve records or remediate these conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

Reports from FCI El Reno describe a facility experiencing critical infrastructure failure, loss of heat, disruption of food access, and unsanitary food service conditions during winter operations. Exposure to cold temperatures, inability to obtain food, and roach contamination of meals are not acceptable conditions of confinement.

These failures present foreseeable and preventable risks to health and safety. The Bureau of Prisons is now on notice. Continued inaction will be treated as ongoing noncompliance with federal law, Bureau policy, and constitutional obligations.

SOUTH CENTRAL REGION

FCC BEAUMONT (LOW & CAMP) — MULTIPLE IDENTIFIED IN-CUSTODY DEATHS, MEDICAL NEGLECT, AND SYSTEMIC CONDITIONS OF CONFINEMENT FAILURES

1 **Name:** FELIX LERMA
Register Number: 17600-579
Age: 78
Race: White
Sex: Male
Deceased: 01/02/2026

1 **Name:** DESTERYN ARNOLD
Register Number: 55182-074
Age: 36
Race: White
Sex: Male
Deceased: 12/29/2025

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition documents multiple identified inmate deaths at FCC Beaumont facilities occurring days apart, alongside extensive, corroborated testimony establishing systemic medical neglect, prolonged restrictive confinement, infrastructure failures, and retaliation against complaints.

On December 29, 2025, Desteryn Arnold, age 36, died after being found unresponsive at FCI Beaumont Low. Federal officials confirmed the death publicly, and the FBI was notified.

Within days, a second in-custody death occurred at the Beaumont Federal Prison Camp. Felix Lerma died on January 2, 2026, following documented allegations of prolonged medical neglect despite visible and escalating medical distress, including terminal illness and neurological emergencies.

These deaths occurred during periods of extreme operational lockdowns, severe movement restrictions, denial of grievance access, and inhumane living conditions, including loss of running water and electrical power in housing units.

The proximity, nature, and surrounding conditions of these deaths establish a pattern-and-practice failure at FCC Beaumont, not isolated incidents.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|----------------------------------|
| Death of Desteryn Arnold following in-custody medical emergency | 18 U.S.C. § 4042(a)(2) |
| Death of Felix Lerma following alleged prolonged medical neglect | 18 U.S.C. § 4042(a)(2) |
| Deliberate indifference to serious medical needs | Eighth Amendment |
| Failure to respond to terminal and neurological medical conditions | BOP Program Statement 6031.04 |
| Delayed emergency transport after loss of responsiveness | BOP Clinical Practice Guidelines |
| Prolonged restrictive confinement preventing access to care | 28 C.F.R. § 541 |

Retaliation for complaints classified as “group demonstration” 28 C.F.R. § 542

Denial of grievance forms 28 C.F.R. § 542.10–542.19

Loss of running water and electricity in housing units BOP Program Statement 4200.12

Unsanitary and unsafe living conditions Eighth Amendment

3. DIRECT TESTIMONY / DIRECT QUOTES

- “They let a man with terminal cancer rot in his bed begging for medical attention.”
- “Inmates had to send requests to medical, the warden, and staff just to get him seen.”
- “Two days later he dies.”
- “Another inmate had multiple strokes and they did nothing.”
- “They just turned him around and let him walk the compound.”
- “He was found unresponsive in his bed during count.”
- “It took him being unresponsive during count to finally send him to the hospital.”
- “I’ve been here four months and my unit has only been out 11 days.”
- “No hot meals, no library, no outdoor rec, no religious services.”
- “We’re only let out 20 minutes three days a week.”
- “Some guys haven’t showered in months.”

- “If we complain, they stop letting us out completely.”
 - “They lock us in the showers.”
 - “We ask for grievance forms and they say they’ll bring them — but they never do.”
 - “Our complaints were labeled a group demo and we were locked down again.”
 - “I haven’t had running water in my cell for weeks.”
 - “Some cells have no power.”
 - “It’s like living in a porta potty.”
-

4. SYSTEMIC CONCERNS

- Two named inmate deaths within four days at the same federal prison complex.
- Publicly confirmed death (Arnold) and internally documented death (Lerma).
- Medical distress known prior to death in both cases.
- Medical emergencies discovered during count, not active monitoring.
- Movement restrictions preventing timely care.
- Retaliatory lockdowns following complaints.
- Obstruction of grievance access.
- Loss of sanitation, water, and electricity.
- Extended denial of showers, programming, and religious services.
- Staffing shortages used to justify unconstitutional confinement.

This constellation of failures reflects institutional deliberate indifference.

5. OVERSIGHT DEMANDS — FCC BEAUMONT (SOUTH CENTRAL REGION)

The Loved Ones Coalition demands:

1. Immediate preservation of all records related to:
 - Desteryn Arnold (Dec. 29, 2025)
 - Felix Lerma (Jan. 2, 2026)
2. Medical files, sick-call requests, and emergency response logs.
3. Staff duty rosters and medical staffing schedules (including overnight).
4. Surveillance footage from housing units and corridors.
5. Count sheets and incident reports.
6. Lockdown orders and “group demonstration” determinations.
7. Infrastructure maintenance records for water and power outages.
8. Independent external medical review of both deaths.
9. Referral to DOJ OIG, Civil Rights Division, and Congressional oversight.

6. CONCLUSION

FCC Beaumont is now on formal notice regarding the deaths of Desteryn Arnold and Felix Lerma, occurring days apart amid documented medical neglect and unconstitutional conditions.

Failure to preserve evidence, correct conditions, or cooperate with oversight will constitute additional violations and be escalated accordingly.

This record is ongoing.

WESTERN REGION

FCI SHERIDAN — Total Water System Failure, Sanitation Collapse, Prolonged Utility Outage, Forced Exposure to Human Waste, and Institutional Indifference

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received corroborated reports describing a complete failure of essential utilities at FCI Sheridan, resulting in the collapse of sanitation, hygiene, ventilation, and basic habitability across housing units.

Reports indicate that following a power outage, air circulation systems in housing units ceased functioning due to a broken component awaiting replacement. Shortly thereafter, the facility experienced a total loss of water service. Individuals were notified in advance of the initial outage, allowing limited preparation, but the water loss has since become indefinite following damage to a major water pipe during a landslide in the surrounding area.

As a result, incarcerated individuals are confined in shared bathroom-style cells without running water, unable to shower, wash hands, or flush toilets at will. Toilets reportedly can only be flushed three times per day during scheduled lockdown counts after temporary system pressurization. Outside of those limited periods, human waste accumulates in cells and common areas.

The housing unit affected contains approximately 130 individuals living under these conditions. The inability to flush toilets, combined with the absence of showers and ventilation, has resulted in severe unsanitary conditions, pervasive odors, and exposure to human waste. Reports state that individuals are effectively living inside nonfunctional bathrooms.

Visitation operations have also been impacted. Restrooms in the visiting room are reportedly unusable due to the water outage. Visiting has been modified such that visitors must leave the facility entirely if they need to use a restroom, despite the holiday period and long-distance travel by families.

Staff have reportedly been provided with portable toilets for their use, while incarcerated individuals remain confined to housing units without functional sanitation. Individuals are reportedly limited to a small number of bottled waters per day, while external agencies intermittently assist with waste disposal.

These conditions reflect prolonged exposure to unsanitary confinement, denial of hygiene, and institutional failure to protect health and safety.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Complete loss of running water | Eighth Amendment — Conditions of Confinement |
| Inability to flush toilets except limited intervals | 18 U.S.C. § 4042(a)(2) |
| Exposure to human waste | Eighth Amendment; Helling v. McKinney |
| Denial of showers and handwashing | BOP Sanitation & Habitability Policies |
| Failure of ventilation/air systems | Environmental Health & Safety Standards |
| Prolonged confinement in unsanitary conditions | Deliberate Indifference Standard |
| Unequal sanitation access between staff and inmates | Equal Protection; Abuse of Authority |
| Disrupted visitation due to restroom closures | 28 C.F.R. § 540 (Visitation Regulations) |
| Indefinite duration of utility outage | Failure of Institutional Oversight |

3. DIRECT TESTIMONY / DIRECT QUOTES

- “The air in our unit has been off since the power went out.”
- “The water went off Friday and now it’s going to be off indefinitely.”
- “I live in a bathroom.”
- “There are 130 people in the unit.”
- “When nature calls, you have to go.”
- “We cannot take showers.”
- “You can imagine the smell in the unit.”
- “They’re only letting us flush toilets three times a day.”
- “We’re locked down when we can flush.”
- “Visiting has to be modified because the bathrooms don’t work.”
- “If visitors need to use the bathroom, they have to leave.”
- “It’s the holidays and people traveled far.”
- “They brought in porta-potties for staff.”
- “Inmates get only a few bottles of water.”
- “The fire department is bringing water to dump waste.”
- “It’s been out all day and likely for a while.”

4. SYSTEMIC CONCERNS

- Total breakdown of essential sanitation infrastructure
- Forced exposure to human waste and bodily fluids
- Denial of hygiene, showers, and handwashing
- Lack of ventilation during unsanitary confinement
- Indefinite utility outage without relocation or mitigation
- Differential treatment between staff and incarcerated individuals
- Health risks including infection, respiratory illness, and disease spread
- Institutional normalization of uninhabitable living conditions

These conditions reflect a pattern-and-practice failure to maintain minimum constitutional standards of confinement.

5. OVERSIGHT DEMANDS — FCI SHERIDAN (WESTERN REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all maintenance logs, work orders, and contractor communications related to power, HVAC, and water failures
2. Preservation of emergency response records related to the landslide and pipe destruction
3. Disclosure of water outage duration estimates and contingency planning
4. Environmental health inspection of all affected housing units
5. Documentation of sanitation mitigation measures implemented for incarcerated individuals
6. Records of bottled water distribution and quantity limits
7. Preservation of visitation modification directives and related communications

8. On-site inspection by Regional and Central Office leadership

Failure to preserve records or remediate conditions after notice constitutes continued deliberate indifference.

6. CONCLUSION

The conditions at FCI Sheridan constitute a sanitation collapse and expose incarcerated individuals to human waste, unsanitary confinement, and serious health risks. Living without water, showers, flushing toilets, or ventilation is not a temporary inconvenience — it is an unconstitutional condition of confinement.

The Bureau of Prisons is now on formal notice.

Continued inaction or reliance on partial mitigation will be documented as ongoing noncompliance with federal law and constitutional obligations.

WESTERN REGION

FCC VICTORVILLE — Prolonged Denial of Showers, Withholding of Hygiene & Menstrual Products, Retaliatory Sanitation Deprivation, and Recurrent Policy Noncompliance

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received corroborated reports documenting systemic and prolonged denial of basic hygiene at FCC Victorville, including extended deprivation of showers during lockdowns and the withholding or delayed distribution of essential hygiene supplies, including toilet paper and menstrual products.

Reports indicate that since December 23, 2025, hundreds of incarcerated individuals have not been permitted to shower during extended lockdown conditions. These reports have been independently corroborated by currently employed correctional staff at the institution. The number of impacted individuals is substantial and spans multiple housing units.

In addition to denial of showers, reports describe a pattern of staff withholding or delaying access to basic hygiene necessities. Toilet paper and sanitary pads are reportedly not provided in a timely, adequate, or nondiscriminatory manner. Incarcerated women report that menstrual products are distributed only after repeated requests, often in insufficient quantities, and that requests are ignored or treated punitively.

These practices occur despite clear and non-negotiable Bureau of Prisons policy requiring access to hygiene during lockdowns. Lockdowns do not suspend sanitation obligations. The recurrence of these conditions indicates a pattern of institutional noncompliance rather than an isolated operational disruption.

The denial of showers and hygiene supplies constitutes unconstitutional conditions of confinement, exposes individuals to health risks, and reflects deliberate indifference to basic human needs.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|--|--|
| Denial of showers for periods exceeding three days | BOP P.S. 5500.14 (Correctional Services Procedures Manual) |
| Failure to provide showers during lockdowns | BOP Policy; No Lockdown Exception |
| Prolonged deprivation of basic hygiene | Eighth Amendment — Conditions of Confinement |
| Failure to safeguard health and sanitation | 18 U.S.C. § 4042(a)(2) |
| Withholding or delaying toilet paper | 28 C.F.R. § 551.100 |
| Withholding or restricting menstrual products | Eighth Amendment; Deliberate Indifference |

Retaliatory denial of hygiene items

First Amendment Retaliation

Discriminatory or punitive distribution practices

Equal Protection; Abuse of Authority

Recurrent sanitation violations

Pattern-and-Practice Noncompliance

3. DIRECT TESTIMONY / DIRECT QUOTES

- “Hundreds of people haven’t been allowed to shower since December 23.”
 - “This has been verified by staff.”
 - “There are no exceptions — lockdowns don’t cancel shower policy.”
 - “People are going more than three days without showers.”
 - “Toilet paper is withheld or delayed.”
 - “Sanitary pads are only given after repeated demands.”
 - “They don’t give enough.”
 - “Requests are ignored or treated like punishment.”
 - “This isn’t the first time this has happened here.”
 - “Staff use hygiene as leverage.”
-

4. SYSTEMIC CONCERNS

- Normalization of hygiene deprivation during lockdowns
- Disregard for explicit BOP sanitation policy
- Use of basic necessities as a control or punishment tool
- Gender-based health neglect through menstrual product denial
- Retaliatory staff behavior tied to requests or complaints
- Repeated violations indicating institutional tolerance
- Failure of supervision to enforce non-discretionary standards

These conditions reflect a pattern-and-practice failure to meet minimum constitutional and regulatory requirements.

5. OVERSIGHT DEMANDS — FCC VICTORVILLE (WESTERN REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all lockdown logs, shower schedules, and movement restriction records dating from December 23, 2025 to present
2. Preservation of all hygiene distribution logs, including toilet paper and menstrual product issuance records
3. Disclosure of staff directives governing shower access during lockdowns
4. Identification of staff responsible for hygiene distribution decisions
5. Review of compliance with Program Statement 5500.14 across all housing units
6. Independent audit of menstrual product access and distribution practices
7. Written assurance of non-retaliation for individuals requesting hygiene items
8. On-site inspection by Regional and Central Office leadership

Failure to preserve records or restore compliance after notice constitutes continued deliberate indifference.

6. CONCLUSION

The conditions documented at FCC Victorville reflect systemic sanitation deprivation, policy defiance, and misuse of basic hygiene as a control mechanism. Denial of showers and essential hygiene items is not discretionary, not situational, and not excusable by staffing or lockdown status.

The Bureau of Prisons is now on formal notice.

Continued noncompliance will be documented as an ongoing constitutional violation and escalated accordingly.

WESTERN REGION

FCI HERLONG — Contaminated Water Exposure, Sanitation System Collapse, Unsafe Food Service Operations, and Ongoing First Step Act Noncompliance

1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple corroborated reports documenting severe sanitation failures, unsafe food service operations, contaminated water exposure, and continued noncompliance with First Step Act (FSA) implementation requirements at FCI Herlong, including the satellite camp.

Reports indicate the camp kitchen has experienced flooding, with dirty water backing up through floor drains. Despite this, food service operations reportedly continue using malfunctioning equipment, including a dishwasher that does not operate properly, resulting in food being served on visibly dirty trays. These conditions create an immediate health risk and violate basic sanitation standards.

Additional reports describe widespread plumbing failures across the facility. Urinals are reportedly backed up with urine, toilets are flooding, and wastewater is not draining properly.

These failures have resulted in exposure to contaminated water within living and food service areas, raising serious public health concerns.

Beyond sanitation failures, reports indicate ongoing First Step Act noncompliance. Individuals approved for release reportedly had their departures abruptly canceled due to administrative delays in updating FSA credits. Reports indicate the facility continues to apply credits month-by-month rather than implementing projected credits as required, directly preventing timely release.

The combination of environmental contamination, unsafe food handling, collapsing infrastructure, and unlawful FSA implementation reflects systemic institutional failure rather than isolated maintenance or clerical issues. The Bureau of Prisons is now on notice of conditions at FCI Herlong presenting serious health, safety, and liberty risks.

2. KEY ALLEGATION & VIOLATION TABLE

| Allegation | Policy / Statute Violated |
|---|--|
| Flooding in camp kitchen with dirty water | Eighth Amendment — Conditions of Confinement |
| Dirty water backing up through drains | 18 U.S.C. § 4042(a)(2) |
| Use of non-functional dishwasher | BOP Food Service & Sanitation Standards |
| Serving food on dirty trays | Eighth Amendment; Public Health Standards |
| Backed-up urinals and flooding toilets | BOP Environmental Health Policies |
| Exposure to contaminated water | Deliberate Indifference Standard |

| | |
|---|--|
| Failure to remediate known plumbing collapse | Eighth Amendment |
| Cancellation of release due to FSA credit delay | First Step Act |
| Failure to apply projected FSA credits | BOP FSA Implementation Guidance |
| Month-by-month credit application | Arbitrary & Capricious Administrative Action |
| Unlawful extension of confinement | Due Process Clause |

3. DIRECT TESTIMONY / DIRECT QUOTES

- “The camp kitchen has flooded and dirty water is coming out of the drains.”
- “The dishwasher does not work and they’re using dirty trays.”
- “Nothing has changed at Herlong.”
- “The camp is falling apart.”
- “All the urinals are backed up with urine.”
- “The toilets are flooding.”
- “Someone was supposed to go home but they canceled it because FSA didn’t update.”
- “That update should not have stopped him from going home.”
- “They’re still doing FSA month by month.”
- “They are not fully implementing FSA.”

4. SYSTEMIC CONCERNS

- Chronic plumbing and wastewater system failure
- Exposure of incarcerated individuals to contaminated water
- Unsafe food service practices in flooded environments
- Continued operation of kitchen despite sanitation hazards
- Institutional tolerance of public health violations
- Failure to remediate known infrastructure collapse
- Ongoing First Step Act noncompliance
- Administrative practices unlawfully extending incarceration
- Failure to apply projected earned time credits
- Breakdown of oversight and accountability

These conditions reflect pattern-and-practice institutional neglect affecting health, safety, and liberty interests.

5. OVERSIGHT DEMANDS — FCI HERLONG (WESTERN REGION)

The Loved Ones Coalition formally demands:

1. Immediate preservation of all plumbing maintenance logs, work orders, and environmental health reports
2. Preservation of kitchen inspection records, dishwasher maintenance logs, and sanitation reports

3. Immediate independent environmental health inspection of kitchen, housing, and wastewater systems
4. Immediate suspension of food service operations in flooded or contaminated areas pending inspection
5. Preservation of water quality testing records and contamination assessments
6. Full audit of First Step Act credit calculations and release determinations
7. Disclosure of policies governing projected credit application at FCI Herlong
8. Identification of administrative decisions that resulted in canceled or delayed releases
9. On-site inspection by Regional and Central Office leadership

Failure to preserve records or correct these conditions after notice constitutes continued deliberate indifference and unlawful confinement.

6. CONCLUSION

Reports from FCI Herlong describe an institution operating amid environmental contamination, collapsing sanitation infrastructure, unsafe food service practices, and continued defiance of First Step Act requirements. Exposure to contaminated water, service of food under unsanitary conditions, and unlawful extension of incarceration represent serious violations of federal law and constitutional protections.

The Bureau of Prisons is now on notice.

Continued inaction will be documented as ongoing noncompliance and escalated accordingly.
