LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Concerns Across the Federal Bureau of Prisons

April 13, 2026

Following a brief pause in reporting during the Easter holiday period, the Loved Ones Coalition resumes its weekly oversight reporting.

Over the past several weeks, the organization has experienced a significant increase in engagement from congressional offices, legal advocates, and media. The Loved Ones Coalition has been requested by multiple offices to be in Washington, D.C. to discuss specific institutional concerns, reporting patterns, and the structure and impact of this work. Due to the volume of requests, scheduling capacity has been exceeded, and not all meetings can be accommodated during this visit.

As a result, this report also serves to provide context and clarity regarding the most common questions being raised — including how these reports are developed, how concerns are escalated, and what occurs after submission.

The Loved Ones Coalition operates as a structured reporting and documentation body. Information included in these reports is based on corroborated reporting from incarcerated individuals, family members, and individuals with direct knowledge of institutional operations. As a standard practice, concerns are included only when supported by multiple independent sources or documentation. The organization does not conduct formal investigations; it documents patterns, verifies reporting, and elevates systemic concerns through established channels.

All reports are submitted to the Bureau of Prisons Support Coordinator program, which serves as the primary point of contact for review, coordination, and dissemination. That office has demonstrated consistent responsiveness and plays a central role in ensuring that concerns are directed to the appropriate channels. In addition to report distribution, the Support Coordinator program regularly assists with individual-level advocacy, including escalation of urgent matters and facilitation of responses where appropriate.

Through this process, reporting is elevated to Bureau leadership, including the Deputy Director, who has established direct communication with the Loved Ones Coalition. Engagement at this level has been consistent, with ongoing communication and observable follow-up in response to reported concerns.

At the same time, questions remain regarding the role and visibility of additional oversight mechanisms. External oversight entities, including the Office of the Inspector General, often refer matters back through internal channels, and the extent to which those processes result in timely, consistent resolution is not always clear at the reporting level.

What is clear is this:

Where institutions are responsive, concerns are addressed, resolved, and do not continue to reappear in reporting.

Where institutions are not responsive, they continue to appear — repeatedly.

Reporting trends reflect a growing concentration of concerns within a smaller number of facilities. These same institutions have been reported on consistently across multiple reporting periods, by different individuals, across separate units, and involving varying issues that reflect broader, ongoing concerns.

This distinction is critical.

The issue is not whether concerns are being elevated. The issue is whether they are being implemented and resolved where they originate.

The facilities that continue to appear in these reports are not unknown. They are not new. They are the same institutions that have generated consistent reporting over time.

Those are the facilities that require focused attention, direct oversight, and corrective action.

For those meeting with the Loved Ones Coalition in Washington, D.C., additional detail and documentation will be provided during those discussions.

These reports are intended to document those patterns clearly and consistently.

NORTH CENTRAL REGION

FCI Thomson (Illinois)

Facility Design Misalignment, Communication Failures, Operational Deficiencies, and Administrative Remedy Barriers

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1. SUMMARY OF ALLEGATIONS

The Loved Ones Coalition has received multiple corroborated reports from incarcerated individuals and their family members regarding ongoing systemic concerns at FCI Thomson. Reports received between April 1, 2026 and April 11, 2026 indicate patterns affecting institutional operations, access to basic services, and conditions inconsistent with a Low Security facility designation.

FCI Thomson was originally constructed as a United States Penitentiary (USP), and reporting indicates the facility continues to operate with structural and operational characteristics consistent with a higher-security institution, including locked housing units, controlled movement, and the absence of dormitory-style housing. These conditions raise concerns regarding alignment with established standards for Low Security facilities.

Additional reporting reflects widespread concerns regarding limited access to communication, including a significant multi-day communication outage occurring between approximately April 6, 2026 and April 10, 2026. During this period, families reported being unable to contact incarcerated individuals. Attempts to contact the institution reportedly went unanswered despite confirmation that communications were received. Outreach to BOP Support Coordinators did not initially yield confirmation or a resolution timeline. Reporting indicates that communication services were restored shortly after external media outreach was initiated.

Further concerns include significant limitations in visitation capacity and processing, with reports indicating that only approximately 15–20 visitors are processed at a time despite a population nearing 2,000 individuals. Visitors report extended wait times, often exceeding 1.5 to 2 hours, and describe interactions with staff as overly strict or unprofessional.

Reporting also includes concerns regarding food service operations, including allegations that meals do not align with established National BOP Menu standards. Additional concerns include inconsistent access to religious services, with reports that scheduled services are frequently unavailable or not conducted, limiting individuals' ability to observe religious practices and holidays.

Sources further report a lack of meaningful programming and limited work opportunities, as well as restricted access to library resources.

Concerns have also been raised regarding barriers to the Administrative Remedy Program, including difficulty obtaining BP-8 and BP-9 forms, and lack of support from case management staff. Additional reporting reflects unresolved issues related to sentence computation and

earned time credit application, with individuals reporting delays, lack of clarity, and inability to obtain assistance.

Collectively, these concerns impact broad portions of the population and reflect systemic patterns rather than isolated incidents.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Description	Potential Concern Area
USP-design structure at Low facility	Facility built as USP with locked housing units and non-dormitory structure	Classification / Operations
Collective restriction practices	Unit-wide restrictions applied in response to individual conduct	Policy Adherence
Religious service access limitations	Inconsistent or unavailable chapel services; inability to observe holidays	Religious Accommodation
Food service noncompliance	Reports of failure to follow National BOP Menu standards	Food Service Compliance
Communication access limitations	Limited phone access relative to population size	Communication Access
Multi-day communication outage	Phone outage (April 6–10) with no notification; restored after media outreach	Communication Systems / Responsiveness

Visitation limitations	Limited capacity, long wait times, strict processing	Visitation Operations
Staff conduct toward visitors	Reports of unprofessional or overly strict treatment	Staff Conduct
Mail and photo handling concerns	Personal photos printed on paper, sometimes double-sided	Mail Handling
Sanitation restrictions	Reports of limitations on restroom access prior to count	Living Conditions
Lack of programming and jobs	Minimal programming and limited work opportunities	Programming / Reentry
Library access limitations	Insufficient reading materials and access	Access to Resources
Leadership instability concerns	Reports of inconsistent or unclear facility leadership	Institutional Management
Obstruction of administrative remedies	Difficulty obtaining BP-8 and BP-9 forms	Administrative Remedy Process
Sentence computation concerns	Unresolved issues with time credits and calculations	Case Management

3. DIRECT TESTIMONY / REPRESENTATIVE QUOTES

“We’re being treated like this place is a max instead of a low.”

“No matter what happens if one person does something, we all pay the price.”

“They don’t even respect your religion unless you’re a certain one.”

“They show up for chapel and the chaplain isn’t there.”

“I’ve been here almost a year and haven’t had a hot breakfast yet.”

“We have close to 100 inmates on a range and are forced to share one phone.”

“Expect to stand outside for 1.5–2 hours just to get into visitation.”

“Why do we only get two visitation days with close to 2,000 inmates?”

“Our loved ones come to visit and are treated poorly by staff.”

“Programming is almost non-existent and jobs are very limited.”

“The library is very lacking in selection.”

“They won’t give you BP-8 or BP-9 forms when you have a problem.”

“The caseworker doesn’t help at all.”

“I’ve done almost 15 years and I’m trying to get my time credited, but they won’t help me.”

“They say they don’t understand the paperwork and nothing gets resolved.”

“We couldn’t reach our loved ones for days and nobody would respond.”

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4. SYSTEMIC CONCERNS

The consistency and volume of reporting regarding FCI Thomson indicates systemic operational concerns rather than isolated incidents.

Reports suggest that the facility’s structure and operational practices may not align with expectations for a Low Security institution, particularly given its origin as a USP and continued use of higher-security controls.

Concerns regarding collective restriction practices raise questions about policy adherence and proportional response measures.

The reported communication outage, combined with lack of notification and lack of response to external inquiries, raises concerns regarding institutional communication protocols and transparency. The reported restoration of services following media outreach suggests a need for review of escalation and responsiveness procedures.

Additional concerns regarding limited visitation access, inconsistent religious services, lack of programming and employment opportunities, and restricted access to resources further indicate potential gaps in operational standards.

Barriers to the Administrative Remedy Program and unresolved sentence computation concerns raise additional issues related to procedural access and case management effectiveness, particularly where such delays may impact release timelines.

Taken together, the reporting reflects broader concerns regarding operational consistency, transparency, and alignment with established standards for Low Security institutions.

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5. OVERSIGHT QUESTIONS FOR CLARIFICATION — FCI THOMSON (NORTH CENTRAL REGION)

1. Given that FCI Thomson was constructed as a USP, how is the Bureau ensuring that current operations align with Low Security standards, particularly regarding controlled movement and locked housing units?

2. What policies govern the application of unit-wide restrictions in response to individual conduct?

3. What measures are in place to ensure consistent access to religious services and observance of major holidays?

4. How is the Bureau ensuring compliance with National BOP Menu standards at this facility?

5. What is the current ratio of incarcerated individuals to available telephone resources within housing units?

6. What caused the communication outage between April 6–10, 2026?

7. What protocols exist for notifying families and stakeholders during extended communication disruptions?

8. Why were external inquiries reportedly unanswered during this period?

9. What steps are being taken to improve visitation capacity, processing times, and visitor experience?

10. What standards govern staff conduct toward visitors?

11. What programming and work opportunities are currently available, and what percentage of the population has access?

12. What resources are currently available within the facility library?

13. What is the current status of Warden leadership at FCI Thomson?

14. What procedures are in place to ensure consistent access to BP-8 and BP-9 forms?

15. How are sentence computation concerns reviewed and resolved at the facility level?

16. What oversight mechanisms exist to address delays or disputes related to earned time credit application?

SOUTHEAST REGION

FCI Edgefield Camp (South Carolina)

Administrative Remedy Barriers, Staff Conduct, Confiscation of Medically Necessary Equipment, and Housing Unit Search Practices

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1. SUMMARY OF ALLEGATIONS

Loved Ones Coalition has received corroborated reporting from multiple incarcerated individuals, family members, and individuals with direct knowledge of institutional operations regarding conditions at FCI Edgefield Camp.

Reporting raises concerns related to barriers to the Administrative Remedy Program, staff conduct, confiscation and delayed return of medically necessary equipment, and conditions following housing unit search operations.

Multiple sources report ongoing difficulty obtaining BP-8 and BP-9 Administrative Remedy forms. Individuals state requests for forms are denied, delayed, or discouraged. Reporting further indicates that submitted grievances are frequently not processed or are lost, and in some cases may be routed through or handled by the same staff member the complaint is regarding, raising concerns about the integrity of the process.

Reporting also raises concerns regarding staff conduct, specifically identifying staff members including Counselor Tolbert (D2 Unit) and staff member Santana, identified by sources as head of a search team. Sources describe dismissive, hostile, and unprofessional interactions, particularly when individuals attempt to address issues or initiate the grievance process.

In one reported incident, an incarcerated individual states that a personal blood pressure machine, used daily following a prior stroke, was confiscated by Officer Tolbert during a search. The individual reports that despite informing staff of its medical necessity, the device was removed and not returned for several days. During this time, the individual reports he was unable to initiate the Administrative Remedy process due to lack of access to BP-8 forms.

Following escalation through Loved Ones Coalition and outreach to the BOP Support Coordinator Program, the blood pressure machine was ultimately returned. During that interaction, Officer Tolbert reportedly stated that he did not appreciate receiving calls from his supervisor regarding the situation and expressed frustration about oversight involvement.

Additional reporting from separate sources describes a large-scale search operation in the camp, identified as occurring in the D3 housing unit and led by Santana. Sources describe the search as excessively disruptive, stating that lockers were pulled down, personal property was disturbed or damaged, and dorm areas were “turned upside down.” Reports include accounts of personal photographs being removed from walls, crumpled, and covered with food and trash.

Sources further report that staff made aggressive and dismissive statements during the search, including comments perceived as retaliatory in nature following outside complaints and media contact.

Additional reporting reflects ongoing concerns with case management practices, including failure to process BP-8 and BP-9 submissions, repeated loss of paperwork, and lack of follow-up by staff. Individuals report being told that forms were never received despite submitting them, and that repeated attempts to follow up result in no resolution.

Taken together, the reporting raises broader concerns regarding access to grievance procedures, staff conduct, protection of medically necessary equipment, and the manner in which search operations are conducted within the camp.

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2. KEY ALLEGATION & VIOLATION TABLE

Allegation	Staff Involved	Policy / Standard Implicated
Denial / delay of BP-8 and BP-9 forms	Unit Team (including Counselor Tolbert)	Administrative Remedy Program requirements
Failure to process or loss of grievance submissions	Unit Team staff	Administrative Remedy compliance standards
Grievances handled by staff subject of complaint	Unit Team staff	Due process / procedural integrity concerns
Confiscation of medically necessary blood pressure machine	Counselor Tolbert	Eighth Amendment – medical care obligations
Delay in return of medical equipment	Counselor Tolbert / institutional staff	Continuity of care standards
Unprofessional / hostile staff conduct	Counselor Tolbert, Santana	BOP staff conduct standards
Property destruction / disruption during search	Santana (search team lead)	Inmate property policy
Aggressive / retaliatory statements during search	Santana and search team	Retaliation / conditions of confinement concerns

Loss or mishandling of Administrative Remedy submissions	Unit Team staff	Administrative Remedy Program compliance

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3. DIRECT TESTIMONY / DIRECT QUOTES

“They won’t give you BP-8s or BP-9s when you have a problem with them.”

“How is it supposed to work if the form goes to the same person it’s about?”

“I use my blood pressure machine every day and they took it.”

“I haven’t received medical care for my stroke — I rely on that machine.”

“He said he didn’t appreciate getting calls from his supervisor about it.”

“They ripped everything up and turned the dorm upside down.”

“They took photos off the wall and threw trash on them.”

“They act like they never got the paperwork when you turn it in.”

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4. SYSTEMIC CONCERNS

The reporting received regarding FCI Edgefield Camp reflects concerns that extend beyond isolated incidents and suggests potential systemic issues related to access to grievance procedures, staff conduct, and institutional accountability.

Barriers to obtaining Administrative Remedy forms, combined with reports of lost or unprocessed submissions and concerns regarding impartial review, raise questions about whether the grievance process is functioning as required.

The confiscation and delayed return of medically necessary equipment raises concerns regarding continuity of care, particularly where individuals rely on such equipment to manage serious medical conditions. The fact that the equipment was only returned following external escalation further raises concerns regarding responsiveness at the institutional level.

Reported statements from staff expressing frustration with supervisory involvement may indicate broader concerns regarding accountability and oversight within the institution.

Reports describing search operations involving significant disruption and damage to personal property, combined with alleged aggressive or retaliatory conduct, raise concerns regarding compliance with established procedures and professional standards during such operations.

Ongoing reports regarding loss of Administrative Remedy submissions and lack of follow-up by case management staff further suggest potential breakdowns in procedural reliability and documentation practices.

Taken together, the reporting raises broader concerns regarding access to grievance procedures, continuity of care, staff conduct, and institutional accountability within FCI Edgefield Camp.

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5. OVERSIGHT QUESTIONS FOR CLARIFICATION — FCI EDGEFIELD CAMP (SOUTHEAST REGION)

1. What procedures are in place to ensure timely and consistent access to BP-8 and BP-9 Administrative Remedy forms?

2. How does the institution track and ensure processing of submitted grievance forms?

3. What safeguards exist to ensure grievances are not handled by the staff member who is the subject of the complaint?

4. Under what policy authority was the blood pressure machine confiscated, and what review process governs its return?

5. What is the required timeframe for review and return of medically necessary equipment?

6. What review has been conducted regarding staff conduct in this incident, including statements made following supervisory contact?

7. What policies govern housing unit search procedures within the camp, and how is property protection addressed?

8. Was the D3 housing unit search reviewed for compliance with policy, and were any concerns identified?

9. What oversight mechanisms are in place to address repeated reports of lost or unprocessed Administrative Remedy submissions?

10. What steps are being taken to ensure individuals can access grievance procedures without fear of retaliation?

SOUTHEAST REGION

FPC Jesup (GA)

Administrative Remedy Obstruction, FSA Misapplication, Retaliation Concerns, Medical Care Irregularities, and Institutional Oversight Failures

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1. Summary of Allegations

The Loved Ones Coalition has received continued and expanding reports from incarcerated individuals and their families regarding systemic concerns at FPC Jesup. These concerns build upon previously reported issues related to the calculation and application of First Step Act (FSA) earned time credits and prerelease placement.

These matters have already been formally reported to Bureau of Prisons leadership. The Loved Ones Coalition acknowledges and appreciates the response from Deputy Director Joshua J. Smith, who indicated that a team is currently reviewing the situation.

However, additional reports received since that time indicate that the issues at the facility remain ongoing and have expanded beyond the original scope of concern.

Reports now include obstruction of the administrative remedy process, including returned or delayed filings due to uncommunicated address changes, as well as inconsistent or dismissive responses from case management staff. Individuals report attempting to resolve these concerns internally through their Unit Teams prior to escalation.

Further reports indicate that after names and register numbers were requested in connection with these concerns, several individuals were subsequently confronted by staff and warned against continuing to pursue the matter, resulting in a heightened fear of retaliation.

Additional concerns include reported irregularities in medical care, where individuals were scheduled for sick call but were not seen, followed by documentation indicating that medical encounters had occurred. Reports also describe delays in access to care and individuals being left waiting without treatment.

The Loved Ones Coalition has also received allegations regarding conduct within facility workspaces that raise additional oversight concerns.

These reports are supported by multiple independent sources, including written statements signed by incarcerated individuals, direct testimony, and family member communications. The consistency and expansion of reporting suggest these concerns are not isolated.

While leadership awareness and review are acknowledged, the current volume and nature of reports indicate conditions at the facility may require immediate on-site assessment to ensure concerns are being accurately evaluated and addressed.

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2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
FSA misapplication	Ongoing concerns regarding calculation and application of earned time credits and prerelease placement	Sentence Computation / Case Management
Administrative remedy obstruction	Filings returned or delayed due to uncommunicated changes in submission procedures	Administrative Remedy Process
Mail handling issues	Administrative filings returned after extended delays, resulting in loss of time and postage	Mail Handling / Due Process
Retaliation concerns	Individuals report being confronted after participating in complaints	Staff Conduct / Retaliation

Case management deficiencies	Reports of inconsistent, dismissive, or unclear guidance from staff	Case Management
Medical care irregularities	Individuals not seen during scheduled sick call	Medical Care
Documentation discrepancies	Reports that medical encounters were recorded despite individuals not being seen	Documentation Integrity
Delayed access to care	Individuals left waiting extended periods without treatment	Medical Access
Institutional oversight concerns	Reports of inappropriate conduct occurring within facility workspaces	Institutional Oversight
Staff professionalism concerns	Reports of hostile or dismissive staff interactions	Staff Conduct

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3. Direct Testimony / Representative Quotes

“My loved one mailed his BP-10 and it was returned 38 days later because they changed the address and never told anyone.”

“People are sending in remedies and getting them back weeks later. They’re losing time and money.”

“When he asked the case manager about it, he said, ‘How am I supposed to know?’”

“They asked for names and numbers, and then people started getting confronted.”

“There is a real fear of retaliation now.”

“They later documented that everyone was seen when they weren’t.”

“This place is completely out of control.”

“They act like they’re doing people a favor instead of doing their jobs.”

“They were modifying firearms in the machine shop.”

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4. Systemic Concerns

The reports received regarding FPC Jesup indicate a pattern of operational breakdown across multiple areas, including administrative remedies, case management, medical services, and institutional oversight.

Reports suggest that individuals attempting to utilize the administrative remedy process are encountering procedural barriers that delay or prevent resolution, including uncommunicated changes to submission requirements. The return of filings after extended periods raises concerns regarding access to due process.

Additionally, reports indicate that individuals who participated in complaint efforts experienced staff confrontation following disclosure of identifying information, contributing to a broader fear of retaliation.

Medical-related concerns include both access to care and documentation accuracy, with reports indicating discrepancies between scheduled care and recorded encounters.

The consistency of reporting across multiple sources, including signed statements, suggests these issues are systemic rather than isolated.

While leadership review is acknowledged and appreciated, the continued volume and expansion of these concerns indicate that conditions at the facility may not yet be stabilized.

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5. Oversight Questions for Clarification

1. What steps are currently being taken by the review team assigned to FPC Jesup?

2. Why were administrative remedy submission procedures changed without clear notification to the incarcerated population?

3. What measures are in place to ensure timely processing of BP-8, BP-9, and BP-10 filings?

4. What safeguards exist to prevent retaliation against individuals who submit complaints?

5. How is case management oversight being conducted to ensure accurate guidance is provided?

6. What review processes are in place to address reported discrepancies in medical care documentation?

7. How is the Bureau ensuring that individuals are being seen during scheduled medical appointments?

8. What oversight exists regarding activities conducted within facility workspaces?

9. Has consideration been given to conducting an on-site review in light of the volume and consistency of reports?

SOUTHEAST REGION

FPC Talladega (AL)

Lockdown Communication Failures, Recreation Restrictions, Administrative Barriers, Case Management Inconsistencies, and Staff Accountability Concerns

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1. Summary of Allegations

The Loved Ones Coalition has received multiple corroborated reports from incarcerated individuals and their families regarding ongoing concerns at FPC Talladega Camp affecting communication, recreation, administrative processes, and case management.

Reports indicate that individuals were placed on a lockdown lasting approximately 3 to 4 hours following what was described institutionally as a tornado drill or weather-related event. During

this period, individuals report receiving little to no information regarding the nature of the lockdown, resulting in confusion and heightened anxiety across the population.

Following the lockdown, individuals report continued uncertainty regarding institutional operations and expectations. The lack of communication during and after the event contributed to distress and speculation among the population.

Additional reporting reflects concerns regarding recreation access. Individuals report that the facility does not provide adequate fitness equipment, including lack of free weights and functional exercise equipment. Reports further indicate that signage has been posted warning that individuals found with homemade exercise equipment may receive disciplinary action, further limiting access to physical activity and stress relief.

Concerns have also been raised regarding inconsistencies in case management guidance related to eligibility timelines for prerelease placement. Individuals report receiving conflicting information and unclear direction when attempting to obtain clarification.

Further reports indicate ongoing barriers related to administrative processes, including lack of clear communication and limited support when individuals attempt to address concerns through institutional channels.

The Loved Ones Coalition has also received reports raising concerns regarding staff accountability. Sources indicate that individuals associated with repeated complaints remain in their roles, and additional reporting indicates that staff member Nettles, who has been the subject of prior complaints submitted through multiple channels, may be under consideration for advancement. These reports have raised concerns among incarcerated individuals and their families regarding oversight, accountability, and review processes.

These concerns have been reported through appropriate channels. While acknowledgment has been received and review has been indicated, the continued volume and consistency of reporting suggest that underlying issues remain unresolved at the facility level.

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2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Short-term lockdown	3–4 hour lockdown with limited explanation	Institutional Operations / Communication

Lack of communication	No clear information provided during or after lockdown	Transparency / Institutional Communication
Population anxiety	Individuals report heightened stress due to lack of information	Institutional Stability
Restricted recreation access	Lack of adequate fitness equipment (weights, benches)	Programming / Wellness
Disciplinary threats for equipment	Warnings issued regarding homemade weights	Disciplinary Practices
Case management inconsistency	Conflicting guidance regarding eligibility timelines	Case Management
Administrative process barriers	Limited support and unclear guidance when addressing concerns	Administrative Processes
Staff accountability concerns	Ongoing complaints regarding staff conduct without visible resolution	Institutional Oversight
Potential advancement of staff under complaint	Reports of staff under prior complaint being considered for advancement (Nettles)	Accountability / Oversight

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3. Direct Testimony / Representative Quotes

“They locked us down and nobody told us what was going on.”

“We were told it was a tornado drill but didn’t get any real explanation.”

“People were getting anxious because nobody had answers.”

“There’s no weights, no real equipment, nothing to even work out with.”

“They’re telling people they’ll get shots if they have homemade weights.”

“We’re just trying to relieve stress and they won’t let us do anything.”

“One person tells you one thing, another tells you something else about eligibility.”

“I’m just waiting with no real answers.”

“Nothing gets fixed and nobody actually comes to see what’s going on.”

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4. Systemic Concerns

The consistency of reports received regarding FPC Talladega indicates concerns related to communication transparency, operational clarity, access to programming, and institutional accountability.

The reported lockdown, combined with limited communication, raises concerns regarding institutional protocols for informing individuals during operational disruptions. The resulting anxiety among the population highlights the impact of unclear communication on institutional stability.

Restrictions on recreational resources, combined with disciplinary threats related to alternative exercise methods, may limit individuals’ ability to maintain physical and mental well-being.

Inconsistent case management guidance regarding eligibility timelines further contributes to uncertainty and may impact reentry preparation.

Reports indicating ongoing concerns regarding staff accountability, combined with allegations that staff subject to repeated complaints may be under consideration for advancement, raise additional questions regarding oversight and review processes.

While leadership has been made aware of these concerns and has indicated that the matter is under review, the continued volume and consistency of reports suggest that conditions at the facility may not yet be stabilized.

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5. Oversight Questions for Clarification

1. What protocols govern lockdowns conducted for drills or weather-related events, and how are individuals informed during such events?

2. What procedures are in place to ensure clear communication to the population during operational disruptions?

3. What recreational equipment is currently available at FPC Talladega?

4. What policies govern restrictions on exercise equipment, including homemade alternatives?

5. What guidance is provided to ensure consistency in case management communication regarding eligibility timelines?

6. What processes are in place to assist individuals attempting to resolve concerns through institutional channels?

7. What oversight mechanisms are in place to review staff conduct when repeated complaints are raised?

8. Are staff subject to repeated complaints reviewed prior to reassignment or advancement?

9. What review has been conducted regarding staff member Nettles in light of prior complaints?

10. Has any on-site review or inspection been conducted in response to the volume of concerns submitted?

MID-ATLANTIC REGION

FCI Hazelton (WV)

Environmental Conditions, Medical Neglect, Mail Process Failures, Communication Barriers, Staff Non-Responsiveness, and Safety Concerns

1. Summary of Allegations

The Loved Ones Coalition has received multiple corroborated reports from incarcerated individuals and their families regarding serious and ongoing concerns at FCI Hazelton affecting environmental conditions, medical care, mail handling, communication processes, and overall institutional responsiveness.

Reports indicate that individuals are being housed in cells described as extremely cold, with water intrusion reportedly entering from walls, ceilings, and plumbing fixtures. Individuals further report extended periods without electricity, lasting multiple days, as well as poor air quality attributed to lack of maintenance of ventilation systems and failure to replace air filters.

Concerns have also been raised regarding mail handling procedures. Individuals report that the facility is not maintaining proper legal mail logbooks, resulting in an inability to document outgoing legal or certified mail. This raises concerns regarding individuals' ability to verify court deadlines and maintain access to the courts.

Additional reports indicate prolonged delays in medical care. One individual reports waiting since April 2025 for prescribed eyeglasses without resolution. Other reports describe serious dental concerns, including untreated infections and visible swelling, with individuals reporting they were denied antibiotics and left without appropriate medical intervention.

Further reporting reflects concerns regarding staff responsiveness across multiple departments. Individuals report that electronic communication requests (cop-outs) are not being responded to, and when written requests are submitted, they are reportedly discarded. This has resulted in the absence of a paper trail, limiting individuals' ability to document attempts to seek assistance.

Reports also indicate barriers related to compassionate release processes, with individuals stating that required forms or requests are not being responded to, preventing them from moving forward in the process.

Additional concerns involve institutional safety and housing conditions. One report describes a vulnerable individual housed in a cell with another incarcerated individual exhibiting erratic and unsafe behavior. Despite staff awareness, it is reported that no action has been taken, creating ongoing safety risks for the individual involved. The reporting party indicated fear of retaliation if concerns were formally raised through internal channels.

Reports also describe use of unit-wide lockdowns as a response to isolated incidents, resulting in entire housing units being restricted for extended periods. These actions are described as punitive in nature and not clearly communicated to the population.

Collectively, these reports indicate patterns affecting basic living conditions, access to care, administrative processes, and institutional accountability.

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Environmental conditions	Cold cells, water intrusion from walls/ceilings, plumbing issues	Living Conditions / Facility Maintenance
Power outages	Extended loss of electricity lasting multiple days	Infrastructure / Safety
Air quality concerns	Lack of ventilation maintenance and filter replacement	Environmental Health
Legal mail failures	No logbooks for legal/certified mail tracking	Access to Courts / Mail Compliance
Medical delays	Extended wait for eyeglasses (since April 2025)	Medical Care
Dental neglect	Untreated infections, swelling, lack of antibiotics	Medical Care
Staff non-responsiveness	Electronic requests ignored; written requests reportedly discarded	Administrative Processes

Lack of documentation trail	No record of submitted requests due to non-processing	Accountability / Oversight
Compassionate release barriers	Lack of response preventing process progression	Case Management / Reentry
Unsafe housing conditions	Reports of individuals housed in unsafe environments without intervention	Safety / Duty of Care
Fear of retaliation	Individuals reluctant to report internally due to past retaliation	Staff Conduct / Retaliation
Unit-wide lockdown practices	Entire units restricted in response to isolated incidents	Institutional Operations

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3. Direct Testimony / Representative Quotes

“We’ve been living in freezing cells with water coming in from the walls and ceilings.”

“We went days without electricity.”

“The air is filthy because they won’t change the filters.”

“There’s no legal mail logbook — how are we supposed to prove anything to the courts?”

“I’ve been waiting since April 2025 for glasses.”

“They won’t give antibiotics — his face is swollen.”

“They don’t respond to cop-outs and throw away written ones.”

“There’s no paper trail for anything.”

“He’s scared to report because he’ll be labeled a snitch.”

“They lock down the whole unit for something one person did.”

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4. Systemic Concerns

The volume and consistency of reports received regarding FCI Hazelton indicate systemic concerns impacting basic living conditions, access to medical care, administrative processes, and institutional accountability.

Particularly concerning are reports of environmental conditions involving water intrusion, lack of heat, and extended power outages, which may impact health and safety. Reports of poor air quality due to lack of ventilation maintenance further raise concerns regarding environmental health standards.

Barriers to legal mail documentation present significant concerns regarding access to the courts and due process protections. Without proper tracking mechanisms, individuals may be unable to verify compliance with legal deadlines.

Reports of delayed and denied medical care, including untreated infections and prolonged lack of prescribed medical devices, raise concerns regarding adequacy of healthcare services.

Administrative barriers, including lack of response to both electronic and written requests, suggest systemic issues with institutional communication and accountability. The reported absence of documentation trails further limits individuals’ ability to escalate concerns appropriately.

Reports involving unsafe housing conditions and fear of retaliation indicate potential gaps in institutional oversight and protection mechanisms.

While these concerns have been submitted through reporting channels, the consistency and severity of the issues described suggest the need for further review and assessment of conditions at the facility.

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5. Oversight Questions for Clarification

1. What steps are being taken to address reported water intrusion, heating issues, and environmental conditions within housing units?

2. What caused the reported multi-day power outages, and what contingency plans are in place to prevent recurrence?

3. What maintenance protocols are in place for ventilation systems and air filter replacement?

4. What procedures govern legal mail tracking, and why are logbooks reportedly not being maintained?

5. How are individuals expected to verify legal deadlines without documented mail tracking?

6. What is the current status of medical care access, including provision of eyeglasses and treatment of dental infections?

7. What oversight exists to ensure timely and appropriate medical intervention?

8. What processes are in place to ensure staff respond to electronic and written requests submitted by incarcerated individuals?

9. How are administrative requests tracked to ensure accountability and documentation?

10. What procedures are in place to address reports of unsafe housing conditions?

11. What safeguards are in place to protect individuals from retaliation when raising concerns?

12. What policies govern the use of unit-wide lockdowns in response to isolated incidents?

13. Has any recent on-site review or inspection been conducted in response to the volume of concerns submitted?

NORTHEAST REGION

FCI McKean (PA)

Staff Conduct, Administrative Remedy Obstruction, Leadership Visibility Concerns, and Food Service Issues

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1. Summary of Allegations

The Loved Ones Coalition has received multiple reports from incarcerated individuals at FCI McKean describing ongoing concerns related to staff conduct, obstruction of the administrative remedy process, lack of leadership presence, and deficiencies in basic services.

Across these reports, individuals consistently describe daily interactions with staff as disrespectful, intimidating, and dismissive. These concerns are reported as ongoing and widespread rather than isolated incidents.

Multiple individuals further report barriers when attempting to utilize the administrative remedy process, including being discouraged from filing, experiencing delays, or alleging that submitted paperwork is not processed or goes missing. These patterns raise concerns regarding access to and integrity of the grievance system.

Concerns have also been raised regarding limited visibility of senior leadership within housing units. According to multiple reports, individuals rarely observe the Warden or senior staff conducting rounds, contributing to a perception of disconnect between leadership and conditions on the ground.

Additionally, individuals report issues with basic services, including food not being served at appropriate temperatures.

Reports also reference a recent inspection or review conducted in March 2026, during which individuals and staff were interviewed regarding facility conditions. It is reported that the facility received a negative evaluation requiring corrective action within a specified timeframe.

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2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Staff conduct	Repeated reports of disrespectful, intimidating, and dismissive behavior	Staff Conduct / Culture

Administrative remedy obstruction	Individuals report being discouraged or blocked from filing remedies	Access to Grievance Process
Disappearance of paperwork	Allegations that submitted remedies are not processed or go missing	Accountability / Due Process
Lack of leadership visibility	Senior staff reportedly rarely present on housing units	Leadership Oversight
Disconnection from conditions	Perception that leadership is not engaged with daily operations	Institutional Management
Food service issues	Meals reportedly not served at proper temperature	Basic Living Conditions
Post-inspection concerns	Facility reportedly received negative evaluation requiring corrective action	Compliance / Oversight

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3. Direct Testimony / Representative Quotes

“Every day in here, we deal with staff who treat us like we aren’t human.”

“The unprofessionalism is constant — disrespect, intimidation, indifference.”

“When we try to file administrative remedies, we get blocked or discouraged, or our paperwork disappears.”

“That’s supposed to be our legal right.”

“We rarely, if ever, see the Warden or any senior staff walking the units.”

“It feels like nobody in charge actually knows what’s happening.”

“Even something as basic as hot food being served at the right temperature is a problem.”

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4. Systemic Concerns

The consistency of reporting across multiple individuals suggests these concerns may reflect broader systemic issues rather than isolated incidents.

Allegations regarding obstruction of the administrative remedy process raise concerns about due process and the ability of individuals to formally document and resolve grievances.

Repeated descriptions of staff conduct indicate potential cultural issues within the facility that may impact overall institutional climate.

Limited visibility of leadership within housing units may contribute to gaps in oversight and accountability.

Additionally, reported deficiencies in basic services, including food quality, reinforce broader concerns about institutional operations and standards.

The reported outcome of a recent inspection further underscores the need for continued monitoring to ensure that identified deficiencies are addressed.

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5. Oversight Questions for Clarification

1. What findings resulted from the reported March 2026 inspection at FCI McKean?
2. What corrective actions have been implemented in response to those findings?
3. What safeguards are in place to ensure individuals can access the administrative remedy process without obstruction?
4. How are administrative remedies tracked to prevent loss or non-processing of submissions?
5. What oversight measures are in place to address reported staff conduct concerns?
6. What expectations exist regarding leadership presence within housing units?

7. How frequently are senior staff required to conduct rounds?

8. What quality control measures are in place for food service standards?

SOUTH CENTRAL REGION

FCI Pollock (LA)

Plumbing Failures, Sanitation Concerns, Visitation Disruptions, HVAC Issues, and Medical Access Delays

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1. Summary of Allegations

The Loved Ones Coalition has received multiple reports from incarcerated individuals and family members regarding ongoing infrastructure failures and service disruptions at FCI Pollock.

Reports indicate that the facility has been experiencing persistent plumbing issues for multiple weeks, resulting in flooding, sewage backup, and the closure of restrooms, including within the visitation area. These conditions have reportedly led to repeated disruptions and early termination of scheduled visitation.

According to multiple accounts, during one weekend visitation period, visits were ended early due to sewage entering the visitation area. In subsequent weekends, visitation was either shortened, restricted, or impacted by restroom closures, with visitors reportedly being required to leave the facility if restroom access was needed.

Sources further report that plumbing issues have not been resolved through outside repair services, and that incarcerated individuals have been utilized to attempt repairs instead of licensed professionals.

Additional concerns include reports of lack of hot water since January 2026, and air conditioning failures, resulting in excessively hot living conditions inside housing units.

Medical concerns have also been raised, including reports that individuals are not receiving timely medical attention for serious conditions, including untreated injuries.

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2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Plumbing failures	Ongoing plumbing issues causing flooding and sewage backup	Facility Infrastructure
Sanitation concerns	Sewage entering visitation areas and units	Environmental Health / Safety
Visitation disruption	Visits ended early or restricted due to facility conditions	Family Access / Operations
Restroom access restrictions	Visitors reportedly required to leave if needing restroom access	Basic Accommodation
Use of incarcerated labor for repairs	Reports of incarcerated individuals tasked with plumbing fixes	Maintenance Practices
Lack of hot water	No hot water reported since January 2026	Living Conditions
HVAC failure	Lack of air conditioning leading to extreme heat in housing units	Environmental Conditions

Medical access delays	Reports of delayed or denied medical care for injuries	Medical Care Access

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3. Direct Testimony / Representative Statements

“FCI Pollock has been having plumbing issues for weeks… sewage was coming into the visitation room.”

“Visits were ended early due to the same issue multiple weekends.”

“If you had to use the bathroom, you were escorted out and had to leave.”

“They are using prison plumbers instead of hiring professionals.”

“There’s been no hot water since January.”

“The units are extremely hot due to A/C issues.”

“They are still not treating my husband for his appointments related to a facial injury.”

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4. Systemic Concerns

The reports from FCI Pollock reflect ongoing infrastructure failures that are not only persistent, but significantly impacting sanitation, visitation, and daily living conditions.

While it is understood that facilities may utilize internal work assignments to assist with maintenance, the reported conditions raise concerns regarding whether current repair efforts are sufficient to address the scope and severity of the issues. The continued reliance on incarcerated individuals for complex plumbing repairs, without resolution over multiple weeks, suggests that additional resources or professional intervention may be necessary.

The duration of these issues — including prolonged lack of hot water, repeated sewage-related disruptions, and ongoing HVAC failures — indicates that these are not isolated maintenance incidents, but rather unresolved operational deficiencies.

At the same time, the continuation of visitation, even under limited or modified conditions, is acknowledged and appreciated by families and incarcerated individuals. However, the expectation remains that visitation areas and housing units meet basic sanitation and safety standards.

Given the facility's operational resources, these conditions raise broader questions regarding allocation of maintenance support and the timeliness of corrective action. The current situation underscores the need for immediate and adequate investment in repairs to ensure safe, functional, and humane conditions.

The Loved Ones Coalition has received and reviewed multiple photographic submissions documenting these conditions firsthand. At this stage, the existence of these issues is not in question. The outstanding question is clear: what is the timeline for resolution, and when will conditions be restored to a safe and functional standard?

Timely intervention is necessary. Continued delays in resolving these issues will only compound their impact on both facility operations and the well-being of those inside.

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5. Oversight Questions for Clarification

1. What is the current status of the plumbing system at FCI Pollock, and what repairs have been completed or are pending?

2. Have licensed professionals been engaged to address the reported sewage and flooding issues?

3. What protocols are in place to ensure sanitation and safety when sewage backup occurs?

4. Why were visitation areas impacted by plumbing failures, and what steps are being taken to prevent recurrence?

5. What policies govern restroom access for visitors during facility disruptions?

6. What is the status of hot water restoration within the facility?

7. What actions are being taken to address reported HVAC failures and extreme heat conditions?

8. What is the process for ensuring timely medical care for individuals reporting injuries or ongoing health concerns?

9. What oversight mechanisms are in place to ensure timely resolution of critical infrastructure failures?

Updates on Previously Reported Concerns — Southeast Region

FCI Miami (FL) — Dental Care Access Concerns and Reported Delays in Treatment

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Update: Dental Provider Access

The Loved Ones Coalition has received updated reporting indicating that a dental provider is expected to return to FCI Miami, following an extended period of limited or no access to dental care services.

According to multiple reports, incarcerated individuals had experienced approximately seven months without consistent access to dental care, during which time individuals reported ongoing pain, difficulty eating, and delays in receiving evaluation and treatment.

The reported return of a dental provider represents a notable development and potential improvement in access to care, particularly in light of prior concerns regarding prolonged delays and untreated dental conditions.

Context and Continued Concerns

While the anticipated return of dental services is acknowledged as a positive step, questions remain regarding:

- The capacity and consistency of dental coverage moving forward
- Whether the current provider availability will be sufficient to address the existing backlog of unmet dental needs
- How individuals experiencing ongoing or severe dental pain will be prioritized for treatment

Given the length of time individuals reportedly went without access to dental services, it is likely that a significant number of cases may require immediate attention.

Follow-Up Oversight Considerations

1. What is the current and ongoing schedule for dental provider coverage at FCI Miami?
2. What plan is in place to address the backlog of individuals awaiting dental evaluation and treatment?
3. How will individuals reporting severe or urgent dental conditions be prioritized?
4. What measures are being implemented to prevent future gaps in dental care access?

Updates on Previously Reported Concerns — Southeast Region

FCI Forrest City Low (AR) — Conditions and Administrative Oversight

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Update: Regional Presence and Facility Review

The Loved Ones Coalition has received multiple reports indicating that regional officials recently conducted walkthroughs at FCI Forrest City Low, following ongoing reporting regarding facility conditions.

According to sources, individuals from regional leadership engaged with incarcerated individuals and staff, and significant concerns were raised directly during these interactions. Reporting suggests that the issues presented were not isolated, but rather consistent across multiple individuals within the facility.

Sources further indicate that the walkthroughs resulted in visible concern from visiting officials, with discussions reportedly focused on conditions and operational issues previously raised through external reporting channels.

Reported Administrative Developments

Additional reporting suggests that, following these visits:

- There have been internal discussions regarding conditions and operations within the facility
- Concerns raised by incarcerated individuals appear to have been acknowledged during direct engagement with regional officials
- There are indications that expectations for corrective action have been communicated at the facility level

While these reports remain unconfirmed, they are consistent across multiple sources and reflect increased attention to conditions within the institution.

Context and Continued Concerns

The reported presence of regional officials may indicate that concerns raised regarding FCI Forrest City Low are being taken seriously at higher levels.

However, it remains unclear:

- What specific findings were identified during the walkthroughs
- What corrective actions have been formally implemented
- Whether there will be ongoing oversight to ensure sustained improvements

Given the volume and consistency of prior reporting, continued monitoring of conditions at the facility remains critical.

Follow-Up Oversight Considerations

1. What findings resulted from the recent regional walkthroughs at FCI Forrest City Low?
2. What corrective actions have been formally implemented following these visits?
3. What oversight mechanisms are in place to ensure compliance and sustained improvements?
4. How will identified concerns be addressed to ensure conditions improve moving forward?

Updates on Previously Reported Concerns — Northeast Region

FPC McKean (PA) — Conditions and Administrative Oversight

Update: Regional Presence and Facility Engagement

The Loved Ones Coalition has received multiple reports indicating that regional officials recently conducted walkthroughs at FPC McKean, following prior reporting regarding facility conditions.

According to sources, regional representatives conducted direct engagement with incarcerated individuals, including discussions after count, where individuals were given the opportunity to raise concerns.

Sources report that the issues presented were not isolated, but instead reflected consistent concerns expressed across a large portion of the camp population. Reporting indicates that multiple individuals communicated similar experiences and concerns during these interactions.

Sources further indicate that visiting officials appeared to acknowledge the seriousness of the concerns raised, with visible attention given to the volume and consistency of the reporting.

Reported Administrative Developments

Additional reporting suggests that, following these visits:

- There have been internal discussions regarding conditions and facility operations
- Concerns raised appear to have been communicated broadly across the population during walkthrough engagement
- There are indications that changes at the administrative level may be under consideration

While these reports remain unconfirmed, they are consistent across multiple sources and reflect increased scrutiny of conditions within the facility.

Context and Continued Concerns

The reported presence of regional officials and direct engagement with incarcerated individuals may indicate that concerns raised regarding FPC McKean are receiving attention at higher levels.

However, it remains unclear:

- What specific findings resulted from these walkthroughs
- What corrective actions, if any, have been formally implemented
- Whether there will be ongoing oversight to ensure sustained improvements

Given the volume and consistency of prior reporting, continued monitoring of conditions at the facility remains critical.

Follow-Up Oversight Considerations

1. What findings resulted from the recent regional walkthroughs at FPC McKean?
2. What corrective actions have been implemented following these engagements?
3. What oversight measures are in place to ensure conditions improve moving forward?
4. Will there be continued regional engagement to monitor progress and accountability?
