LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Concerns Across the Federal Bureau of Prisons

May 18, 2026

The Loved Ones Coalition continues to document recurring concerns, systemic conditions, and firsthand testimony submitted by incarcerated individuals, family members, internal sources, and individuals with direct firsthand knowledge of conditions within Federal Bureau of Prisons facilities nationwide.

After more than 30 consecutive weekly oversight reports, the Loved Ones Coalition's reporting continues reaching thousands of readers each week through our website, social platforms, incarcerated support networks, advocacy organizations, congressional oversight staff, investigators, media contacts, and other oversight stakeholders.

The month of May has been especially active, involving multiple conversations and meetings with congressional oversight staff, investigators, media members, and the BOP Support Coordinators Office regarding recurring concerns repeatedly raised by incarcerated individuals and affected families across multiple institutions.

The Loved Ones Coalition wants to acknowledge the offices, staff, and individuals who have continued engaging directly, asking difficult questions, listening respectfully, and responding to concerns brought forward by incarcerated individuals and their loved ones. Those conversations matter deeply to impacted communities, particularly individuals who often feel ignored, unheard, uncertain where to turn for help, or fearful that nobody is paying attention.

Recent discussions focused heavily on recurring concerns involving:

- First Step Act confusion,
- sentence calculation concerns,
- halfway house and home confinement questions,
- compassionate release misinformation,
- administrative remedy barriers,
- policy interpretation confusion,

- and increasing reports of scams and financial exploitation targeting incarcerated individuals and their families.

One issue that continues to grow at an alarming rate is the monetization of desperation within the federal prison community.

Families and incarcerated individuals continue reporting situations involving individuals or organizations allegedly charging money for:

- policy interpretation,
- “special access” or influence,
- compassionate release filings,
- First Step Act guidance,
- sentence calculation assistance,
- transfer requests,
- clemency assistance,
- administrative remedy guidance,
- and communications sent to institutions or staff.

The Loved Ones Coalition has also received repeated complaints involving allegedly inaccurate filings, allegedly AI-generated motions, misleading legal guidance, exaggerated claims of influence, and situations where vulnerable families paid significant amounts of money while receiving little meaningful assistance in return.

Families are strongly encouraged to exercise caution when interacting with anyone claiming guaranteed outcomes, insider access, special relationships, or paid influence within the Bureau of Prisons or federal court system.

No outcome within the federal system can legitimately be guaranteed.

Individuals and families who believe they may have been victims of scams, fraud, financial exploitation, impersonation, or deceptive prison-related services may consider reporting concerns through:

- Federal Trade Commission (FTC): https://reportfraud.ftc.gov
- FBI Internet Crime Complaint Center (IC3): https://www.ic3.gov
- Local law enforcement agencies where applicable

The Loved Ones Coalition also continues encouraging increased transparency, clearer public guidance, and stronger educational outreach regarding:

- FSA credits,
- PATTERN scoring,
- administrative remedies,
- compassionate release,
- sentence calculations,

- halfway house eligibility,
- home confinement eligibility,
- and federal prison procedures generally.

When confusion exists, misinformation fills the gap.

The Loved Ones Coalition remains committed to documenting conditions, elevating credible testimony, identifying systemic patterns, encouraging transparency, and advocating for safe, humane, lawful, and accountable conditions throughout the Federal Bureau of Prisons.

The following report contains allegations, testimony, and concerns submitted to the Loved Ones Coalition during the past reporting period. All allegations are presented as reported and reflect patterns and concerns repeatedly communicated to our organization.

NORTH CENTRAL REGION

FCI Thomson (IL)

Medical Accommodation Concerns, Time Credit Disputes, SHU Communication Restrictions, Commissary Shortages, and Conditions of Confinement Concerns

1. Summary of Allegations

The Loved Ones Coalition has received corroborated reporting from incarcerated individuals and family members regarding ongoing concerns at FCI Thomson related to medical accommodations, sentence computation and prerelease custody concerns, SHU communication restrictions, commissary shortages, and institutional responsiveness.

Reporting includes concerns involving an incarcerated individual with an implanted cardiac monitoring device who reportedly experienced conflict with staff regarding possession and use of an electrical cord associated with the device. According to testimony, the individual stated that the cord had been issued through Bureau of Prisons medical channels and was necessary for operation of the implanted monitoring equipment. The interaction reportedly caused significant stress and confusion regarding access to medically necessary accommodations and equipment.

Additional reporting raises concerns regarding case management practices and perceived inconsistencies in prerelease custody consideration. Multiple individuals report ongoing difficulty obtaining clarification or assistance related to earned time credits, Second Chance Act placement, home confinement eligibility, and sentence computation issues.

One case manager identified as “Mr. Stuner” (as reported) was repeatedly referenced in complaints involving dismissive communication, refusal to assist with prerelease placement concerns, and failure to provide clarification regarding time credit calculations or halfway house eligibility. Individuals report being informed they would not qualify for prerelease placement despite extensive time served and low PATTERN risk classifications.

Additional concerns involve allegations of inconsistent application of prerelease custody opportunities. One individual alleged that similarly situated incarcerated individuals received home confinement placement while others with comparable time served and classification levels were denied consideration.

Further reporting raises concerns regarding SHU conditions and communication limitations. One family member reports that an incarcerated individual has remained in SHU under investigative status since March 2026, with continued delays involving mail delivery, publication access, and receipt of photographs. Reports indicate mail has allegedly been rejected for technical reasons, while magazines and approved publications were inconsistently delivered.

Additional testimony raises concerns regarding food adequacy within SHU conditions, with reports describing inconsistent meal portions and individuals remaining hungry during confinement.

Operational concerns also extend to commissary availability. Multiple reports indicate recurring shortages involving basic and medically relevant items, including shoes, inserts, and allergy medication.

Taken together, the consistency and overlap of reporting suggest broader concerns involving medical accommodation responsiveness, case management consistency, prerelease custody review practices, SHU communication access, and access to basic necessities within the facility.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Medical accommodation concerns	Conflict regarding possession/use of medical device cord	Medical Care / Accessibility

Implanted device support issues	Individual reports stress regarding medically necessary equipment access	Continuity of Care
Time credit disputes	Reports of uncredited or improperly applied time	Sentence Computation / First Step Act
Home confinement concerns	Individuals report denial of prerelease placement consideration	Second Chance Act / Prerelease Custody
Case management complaints	Reports of dismissive or unhelpful responses from case management staff	Institutional Operations
Staff conduct concerns	“Mr. Stuner” repeatedly referenced in complaints	Staff Professionalism
SHU communication restrictions	Reports of delayed or rejected mail and publications	Communication Access
Publication delivery concerns	Magazines and photos reportedly withheld or limited	Mailroom / Administrative Practices
Food adequacy concerns	Reports of inconsistent meals and hunger during SHU placement	Conditions of Confinement

Commissary shortages	Reports of unavailable shoes, inserts, and allergy medication	Access to Basic Necessities

---

3. Direct Testimony

“The medical officer gave me hell about the cord for my implanted device.”

“The BOP gave me that cord — it’s not like I can just go buy another one.”

“They’re not crediting my time.”

“My caseworker won’t help with Second Chance Act or home confinement.”

“I’ve almost done 16 years and they still won’t put me in.”

“They gave another inmate home confinement with similar time.”

“He talks to people crazy and doesn’t help nobody.”

“My husband has been in SHU under investigation since March.”

“They keep sending the mail back.”

“He’s only received one magazine out of seven.”

“Sometimes they feed them good, otherwise he’s starving back there.”

“They’ve been out of shoes, inserts, and allergy meds.”

---

4. Systemic Concerns

The reporting from FCI Thomson raises concerns across several operational areas, including medical accommodation responsiveness, case management practices, prerelease custody review procedures, SHU communication access, and commissary availability.

Concerns involving medically necessary equipment associated with implanted monitoring devices raise questions regarding continuity of care and staff familiarity with accommodation-related medical needs. Interference, confusion, or inconsistency involving access to medically issued equipment may create unnecessary stress and potential health risks for incarcerated individuals with serious medical conditions.

Case management-related reporting raises broader concerns regarding transparency and consistency in sentence computation and prerelease custody review practices. Multiple individuals report difficulty obtaining clarification regarding earned time credits, halfway house placement, and home confinement eligibility, despite extended periods of incarceration and low PATTERN classifications.

The repeated reference to a specific case manager in multiple complaints raises additional concerns regarding professionalism, communication practices, and consistency in case management support.

SHU-related reporting further raises concerns regarding communication restrictions and access to approved publications and correspondence. Delayed or rejected mail, inconsistent publication delivery, and limitations involving photographs may significantly impact morale, communication access, and family connection during prolonged restrictive housing placement.

Additional concerns involving food adequacy and commissary shortages suggest ongoing issues involving access to basic necessities, particularly where medically relevant items such as allergy medication and footwear-related products are reportedly unavailable for extended periods.

Taken together, the consistency of reporting suggests potential systemic concerns involving institutional responsiveness, prerelease custody review practices, communication access, and conditions of confinement within the facility.

---

5. Oversight Questions for Clarification — FCI Thomson (NORTH CENTRAL REGION)

1. What policies govern access to medically necessary equipment and accessories associated with implanted monitoring devices?
2. What procedures are in place to ensure incarcerated individuals with chronic or serious medical conditions maintain uninterrupted access to medically authorized equipment?
3. What oversight mechanisms are in place to ensure accurate application of earned time credits and prerelease custody eligibility reviews?
4. How are disputes involving sentence computation, Second Chance Act placement, and home confinement eligibility reviewed and resolved?
5. What training or guidance is provided to case management staff regarding communication and prerelease custody review procedures?
6. Have complaints or concerns regarding staff conduct involving case management personnel been reviewed internally?
7. What policies govern mail rejection, publication access, and photograph limitations for individuals housed in SHU status?
8. What oversight mechanisms ensure timely delivery of approved mail and publications during investigative SHU placement?

9. What steps are being taken to address recurring commissary shortages involving medically relevant or basic necessity items?
10. What measures are in place to ensure individuals housed in SHU maintain adequate access to food, communication, and basic living necessities?

FCI THOMSON UPDATE — ONE YEAR SINCE FINAL EXTENDED LOCKDOWN

On May 7, 2026, FCI Thomson marked one full year since its last prolonged extended lockdown period — a significant operational change following years of repeated institutional restrictions, communication blackouts, and widespread reporting regarding conditions of confinement concerns.

The Loved Ones Coalition acknowledges that the absence of another prolonged facility-wide lockdown over the past year represents a meaningful shift compared to prior operational patterns documented throughout 2024 and 2025. Reporting reviewed by the Loved Ones Coalition, corroborated family testimony, and independent reporting previously described repeated lockdown cycles occurring with extreme frequency, at times reportedly ranging from approximately 8 to 31 days at a time over an approximately 18-month period.

During that period, reports repeatedly described:

- prolonged communication blackouts,
- commissary restrictions and shortages,
- bagged cold meals and nutritional concerns,
- extended movement restrictions,
- lack of programming access,
- delayed medical care,
- mental health deterioration,
- excessive lockdown frequency,
- and operational conditions inconsistent with a low-security designation.

The Thomson oversight file now reflects a substantial body of corroborated reporting documenting allegations involving:

- medical neglect and delayed emergency response concerns,
- communication system failures,
- legal mail interference,
- retaliation concerns,
- collective punishment practices,
- prolonged restrictive conditions,

- infrastructure failures,
- case management breakdowns,
- and recurring allegations involving staff misconduct and operational instability.

The Loved Ones Coalition further acknowledges the efforts of oversight bodies, media organizations, advocacy groups, family members, incarcerated individuals, and Bureau of Prisons personnel who have continued monitoring conditions at the institution. The absence of another prolonged extended lockdown over the past year is notable given Thomson's documented operational history and prior reporting patterns.

However, despite the reduction in prolonged lockdown frequency, the institution continues to generate a significant volume of concerning reports. The broader Thomson oversight record — including independent reporting, BOP press releases, DOJ OIG-referenced concerns, and thirty consecutive Loved Ones Coalition weekly oversight reports spanning July 2025 through April 2026 — reflects persistent allegations involving conditions of confinement, operational instability, communication failures, medical concerns, and systemic institutional dysfunction.

The Thomson file now documents:

- one BOP-confirmed in-custody death with FBI notification,
- independently reported emergency-response concerns,
- repeated communication outages,
- allegations of nutritional deprivation,
- recurring commissary shortages,
- prolonged SHU-related complaints,
- infrastructure failures,
- allegations involving retaliation and coercive disciplinary practices,
- and ongoing concerns regarding staffing, oversight, and institutional accountability.

Taken together, the cumulative reporting raises continuing concerns regarding whether FCI Thomson can safely and consistently operate in a manner aligned with Bureau of Prisons policy, humane-treatment standards, and the operational expectations of a federal low-security institution.

The Loved Ones Coalition continues to urge sustained independent oversight, operational review, and external accountability regarding conditions and practices at FCI Thomson and Thomson Federal Prison Camp.

SOUTH CENTRAL REGION

FCC Yazoo (MS)

PREA-Related Safety Concerns, Excessive SHU Placement Complaints, DSCC Processing Delays, and Institutional Oversight Concerns

1. Summary of Allegations

The Loved Ones Coalition has received reporting regarding ongoing concerns at the Yazoo City Federal Correctional Complex involving PREA-related safety concerns, excessive SHU placement practices, and administrative delays involving paperwork processing and DSCC-related matters.

One report received by the Loved Ones Coalition alleges that an incarcerated individual at Yazoo Low was sexually assaulted by another incarcerated individual after an alleged weapon-related confrontation inside a housing unit. According to reporting provided to the Loved Ones Coalition, the incident reportedly resulted in an SIS response and evidence collection within the housing area.

At this time, the Loved Ones Coalition cannot independently verify all details of the reported incident. However, the seriousness of the allegations raises significant concerns regarding institutional safety, supervision, emergency response procedures, and PREA-related protections within the facility.

Additional reporting from incarcerated individuals and family members raises concerns regarding what is described as excessive use of SHU placement and prolonged restrictive housing exposure. Complaints further indicate ongoing frustration involving delayed review of paperwork, transfer-related concerns, and alleged failures involving DSCC processing and responsiveness.

Taken together, the reporting raises broader concerns regarding institutional safety procedures, administrative responsiveness, housing practices, and oversight mechanisms within the Yazoo City Complex.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area

PREA-related safety concerns	Reported sexual assault involving alleged weapon use	PREA / Institutional Safety
Emergency response concerns	SIS reportedly responded and secured area	Institutional Operations
Housing supervision concerns	Questions regarding monitoring and prevention measures	Facility Security
Excessive SHU placement complaints	Reports of prolonged or excessive restrictive housing use	Conditions of Confinement
DSCC processing concerns	Complaints involving paperwork review delays	Administrative Operations
Transfer-related concerns	Reports of unresolved classification or transfer matters	Case Management
Administrative responsiveness concerns	Complaints regarding lack of communication or follow-up	Institutional Accountability

---

3. Direct Testimony

“They taped off the room and started gathering evidence.”

“Paperwork isn’t getting looked at at DSCC.”

---

4. Systemic Concerns

The reporting from FCC Yazoo raises concerns regarding institutional safety procedures, restrictive housing practices, and administrative responsiveness.

Allegations involving sexual assault within a housing unit — particularly where a weapon was reportedly involved — raise serious concerns regarding supervision, emergency response procedures, vulnerability assessments, and PREA-related protections within the institution. While the Loved Ones Coalition cannot independently verify all aspects of the reported incident at this time, the allegations are sufficiently serious to warrant attention and clarification.

Additional reporting involving excessive SHU placement raises concerns regarding the prolonged use of restrictive housing and the potential psychological and operational impacts associated with extended segregation practices.

Concerns involving DSCC paperwork review and administrative processing delays further raise questions regarding institutional responsiveness, communication practices, and the timely handling of classification, transfer, or administrative matters affecting incarcerated individuals.

Taken together, the consistency of reporting suggests broader concerns regarding institutional oversight, safety procedures, restrictive housing practices, and administrative processing within the Yazoo City Complex.

---

5. Oversight Questions for Clarification — FCC Yazoo (SOUTH CENTRAL REGION)

1. What PREA response procedures were initiated following the reported incident referenced in reporting received by the Loved Ones Coalition?
2. Were SIS investigators, medical personnel, and outside investigative agencies notified consistent with BOP policy?
3. What measures are currently in place to evaluate housing-unit safety and supervision practices within the institution?
4. What oversight mechanisms govern placement and duration of SHU confinement within the Yazoo City Complex?
5. How does the institution review complaints alleging prolonged or excessive restrictive housing placement?
6. What procedures are in place to ensure timely review and processing of DSCC-related paperwork and classification matters?
7. Are delays involving transfer reviews, classification updates, or administrative paperwork currently being tracked or addressed internally?

8. What safeguards are in place to ensure incarcerated individuals can report safety concerns without fear of retaliation or unnecessary restrictive placement?

SOUTHEAST REGION

FCI Williamsburg (SC)

Extreme Heat Exposure, Lack of Air Conditioning, Mold Concerns, Food Sanitation Issues, and Conditions of Confinement Complaints

1. Summary of Allegations

The Loved Ones Coalition has received reporting from incarcerated individuals and family members regarding ongoing environmental and sanitation-related concerns at FCI Williamsburg involving prolonged lack of air conditioning, mold exposure, food safety concerns, and extreme indoor heat conditions.

According to reporting received by the Loved Ones Coalition, portions of the institution have allegedly remained without functioning air conditioning for multiple days during periods of elevated outdoor temperatures exceeding 90 degrees in South Carolina. Individuals report extreme indoor heat, excessive sweating, sleep disruption, and growing frustration regarding living conditions inside the facility.

Additional reporting raises concerns regarding visible mold throughout portions of the institution, with individuals describing ongoing exposure to unsanitary environmental conditions.

The Loved Ones Coalition also received reports alleging a significant food sanitation incident involving rodents discovered inside an oatmeal container or preparation vat after breakfast service had already occurred. According to reporting, two rats were allegedly discovered after incarcerated individuals had already consumed the meal. Reports further indicate that several incarcerated individuals were subsequently transported to the infirmary, though the extent of any medical evaluation or treatment remains unclear at this time.

Taken together, the reporting raises broader concerns regarding environmental health conditions, food sanitation practices, infrastructure maintenance, and institutional responsiveness to potentially hazardous living conditions.

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Lack of air conditioning	Reported prolonged AC outage during extreme temperatures	Environmental Health / Conditions
Extreme heat exposure	Reports of excessive indoor heat and physical discomfort	Heat Safety / Living Conditions
Mold concerns	Alleged mold exposure throughout portions of facility	Sanitation / Environmental Safety
Food sanitation concerns	Rodents reportedly discovered in food preparation area after meal service	Food Safety
Possible contaminated food exposure	Individuals reportedly consumed food prior to discovery	Health & Safety
Medical response concerns	Multiple individuals reportedly transported to infirmary	Medical Operations

Infrastructure maintenance concerns	Ongoing complaints regarding environmental conditions	Facility Maintenance

---

3. Direct Testimony

“No AC in FCI Williamsburg for days.”

“Mold everywhere.”

“They found two rats in the oatmeal vat after we already ate breakfast.”

“A couple were taken to the infirmary.”

“We are all getting extremely frustrated and sweating their ass off.”

“It’s 91 degrees in South Carolina today.”

---

4. Systemic Concerns

The reporting from FCI Williamsburg raises concerns regarding environmental safety, sanitation standards, infrastructure maintenance, and institutional responsiveness during elevated heat conditions.

Reports involving prolonged loss of air conditioning during periods of extreme outdoor temperatures raise concerns regarding heat-related illness risks, especially within confined institutional settings where airflow and cooling options may be limited. Extended exposure to excessive indoor temperatures may create heightened health risks for medically vulnerable or aging incarcerated populations.

Additional allegations involving widespread mold exposure raise broader concerns regarding ventilation systems, maintenance practices, sanitation oversight, and long-term environmental health conditions within the facility.

The reported discovery of rodents within a food preparation area after meal service had already occurred raises particularly serious concerns regarding food sanitation procedures, kitchen oversight, contamination prevention measures, and emergency response practices following potential exposure incidents.

Reports that incarcerated individuals were transported to the infirmary following the incident further raise questions regarding medical evaluation protocols and the institution's response to potential foodborne contamination concerns.

Taken together, the consistency and seriousness of reporting suggest broader concerns regarding environmental conditions, infrastructure reliability, sanitation oversight, and health and safety protections within the institution.

---

5. Oversight Questions for Clarification — FCI Williamsburg (SOUTHEAST REGION)

1. How long have portions of the institution reportedly operated without functioning air conditioning?
2. What emergency heat mitigation measures were implemented during the reported outage period?
3. What procedures are in place to monitor indoor temperatures during extreme weather conditions?
4. Have environmental inspections or mold remediation efforts recently been conducted within the institution?
5. What food safety protocols were initiated following reports of rodents being discovered in a food preparation area?
6. Were contaminated food items immediately removed from service and preserved for review?
7. How many incarcerated individuals were medically evaluated following the reported incident?
8. What pest-control and sanitation measures are currently in place within food preparation and storage areas?
9. What maintenance or infrastructure deficiencies may have contributed to the reported environmental and sanitation concerns?
10. What corrective actions are being taken to ensure safe living conditions during ongoing elevated heat conditions?

SOUTHEAST REGION

FPC Jesup / FCI Jesup (GA)

First Step Act Application Complaints, SHU Placement Concerns, Administrative Delays, Staff Conduct Allegations, and Prerelease Custody Disputes

1. Summary of Allegations

The Loved Ones Coalition has received continued reporting from incarcerated individuals and family members regarding ongoing concerns at FPC Jesup and FCI Jesup involving First Step Act application disputes, prerelease custody calculations, SHU placement concerns, staff conduct allegations, and institutional accountability issues.

Multiple reports raise concerns regarding incarcerated individuals allegedly remaining in SHU status for extended periods while awaiting redesignation or ICE-related transfer processing. One family member reported that an incarcerated individual with low PATTERN scores and no disciplinary concerns had allegedly remained in SHU for several weeks awaiting redesignation, while also experiencing limited access to communication materials such as stamps and correspondence.

Additional reporting raises concerns regarding the application and interpretation of First Step Act and Second Chance Act provisions at the institution. Multiple individuals allege that prerelease custody dates, halfway house eligibility calculations, and home confinement determinations are being inconsistently applied or delayed.

Several complaints specifically reference a staff member identified as “Case Manager Wired” (as reported), alleging arbitrary extensions of prerelease placement timelines, dismissive communication practices, and alleged refusal to meaningfully address disputes involving First Step Act calculations or paperwork review requests.

Additional reporting references a staff member identified as “Counselor Forsyth” (as reported), with allegations involving unprofessional conduct, inappropriate interactions with incarcerated individuals, and misuse of inmate orderlies for personal purposes. The Loved Ones Coalition cannot independently verify all allegations described in testimony; however, the consistency and specificity of the reporting raise broader concerns regarding professionalism and institutional oversight.

Additional testimony alleges that incarcerated individuals attempting to question or challenge prerelease custody calculations are met with dismissive responses and lack meaningful avenues for review or clarification.

The Loved Ones Coalition also reviewed documentation circulated among incarcerated individuals concerning BOP First Step Act credit application procedures. Reporting indicates ongoing confusion and disputes regarding when credits begin accruing, whether credits continue during prerelease custody placement, and how community-placement eligibility is being calculated at the institution.

Taken together, the consistency and overlap of reporting raise broader concerns regarding prerelease custody practices, sentence computation transparency, staff professionalism, SHU placement procedures, and institutional accountability within the Jesup Complex.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Extended SHU placement concerns	Reports of prolonged SHU placement during redesignation process	Conditions of Confinement
Communication access restrictions	Individuals reportedly unable to obtain stamps or correspondence materials	Communication Access
FSA calculation disputes	Alleged inconsistencies involving earned time credit application	Sentence Computation / First Step Act
Second Chance Act concerns	Complaints regarding prerelease placement calculations	Prerelease Custody
Home confinement delays	Reports of extended or altered prerelease placement dates	Reentry Placement
Staff conduct concerns	Allegations involving dismissive or	Staff Professionalism

	confrontational staff behavior	
Administrative review concerns	Complaints regarding unresolved paperwork disputes	Institutional Operations
Oversight and accountability concerns	Reports describing lack of meaningful review processes	Institutional Accountability

---

3. Direct Testimony

“My husband is in the SHU almost 3 weeks now he hasn’t been able to get stamps so can’t get any letters to me.”

“He’s adding anywhere from six to fourteen months to inmates’ time behind the wall.”

“If you question his methodology, the situation only worsens.”

“There appear to be no checks and balances.”

“It’s up to me, and I do what I want.”

“They changed his date from July to late October.”

“These people are just openly shitting on the law and directives with no repercussions.”

“They basically say that FSA starts when you get to your designated facility.”

“They then say that you cannot earn FSA once you’re in prerelease custody.”

“How do these people say one thing publicly and behind our backs do another?”

---

4. Systemic Concerns

The reporting from FPC Jesup and FCI Jesup raises concerns regarding transparency and consistency in First Step Act implementation, prerelease custody determinations, SHU placement practices, and institutional professionalism.

Multiple reports allege confusion and inconsistency involving sentence computation and prerelease custody review procedures. Complaints specifically reference disputes involving when earned time credits begin accruing, whether credits continue during prerelease custody placement, and how halfway house and home confinement eligibility dates are being calculated.

The Loved Ones Coalition reviewed BOP First Step Act instructional materials circulated in relation to these concerns. The reporting suggests that incarcerated individuals continue experiencing difficulty obtaining clear explanations regarding sentence-credit calculations and prerelease placement determinations.

Additional concerns involve allegations that incarcerated individuals questioning calculations or requesting clarification may experience dismissive treatment or lack meaningful review mechanisms. Repeated references to specific staff members in multiple complaints raise broader concerns regarding communication practices, professionalism, and supervisory oversight.

SHU-related reporting involving redesignation and ICE-detainer placement further raises concerns regarding prolonged restrictive housing exposure and limitations involving communication access during pending transfer or administrative review periods.

Taken together, the consistency of reporting suggests broader concerns regarding prerelease custody implementation, administrative transparency, institutional professionalism, and accountability mechanisms within the Jesup Complex.

---

5. Oversight Questions for Clarification — FPC Jesup / FCI Jesup (SOUTHEAST REGION)

1. What procedures are currently used to calculate and review First Step Act earned time credits at the Jesup Complex?
2. What oversight mechanisms exist to ensure prerelease custody determinations are applied consistently across incarcerated populations?
3. How are disputes regarding earned time credits, halfway house placement, and home confinement eligibility reviewed and resolved?
4. What policies govern placement of incarcerated individuals in SHU status while awaiting redesignation or ICE-related transfer review?
5. Are incarcerated individuals in SHU provided adequate access to communication materials, including stamps and correspondence supplies?
6. Have complaints regarding staff professionalism or communication practices involving unit-team personnel been reviewed internally?

7. What supervisory review processes exist regarding prerelease placement extensions or altered placement timelines?
8. What guidance has been provided to staff regarding interpretation and application of First Step Act and Second Chance Act provisions?
9. What safeguards exist to ensure incarcerated individuals can seek clarification regarding sentence computation without fear of retaliation or adverse treatment?
10. What mechanisms are in place to ensure accountability and consistency regarding prerelease custody determinations within the institution?

WESTERN REGION

USP Victorville (CA)

Visitation Restrictions, Family Access Concerns, Bathroom Access Complaints, and Treatment of Child Visitors

1. Summary of Allegations

The Loved Ones Coalition has received reporting from family members regarding concerns involving visitation conditions and treatment of visitors at USP Victorville, including allegations involving restricted bathroom access, limitations placed on child visitors, and concerns regarding staff discretion during visitation operations.

According to reporting received by the Loved Ones Coalition, one family reportedly traveled more than 1,000 miles to attend a visitation weekend involving an incarcerated loved one and a young child. The family reported that the initial visitation day proceeded without incident; however, concerns reportedly arose during the following day's visitation period after changes in visitation supervision and operational restrictions.

Reporting alleges that child visitors were prohibited from bringing toys from the designated play area to visitation seating areas and that snack items belonging to a young child were discarded during the visitation period.

Additional concerns involve allegations that visitor restrooms were closed well before the end of visitation hours, resulting in distress for visitors, including a toddler reportedly needing to be changed and another visitor reportedly experiencing a medical condition requiring frequent restroom access.

According to testimony, requests to reopen restroom facilities were allegedly denied despite concerns involving children and medically vulnerable visitors. One reporting party described the situation as causing significant distress and discomfort during the visitation process.

Taken together, the reporting raises broader concerns regarding visitation management practices, treatment of family members and child visitors, access to basic accommodations during visitation, and institutional discretion regarding visitor welfare.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Visitation restriction concerns	Reports of restrictive or inconsistent visitation practices	Family Access
Child visitation concerns	Young child reportedly restricted from accessing toys/snacks	Visitor Welfare
Bathroom access complaints	Visitor restrooms reportedly closed before visitation ended	Accessibility / Visitor Conditions
Medical accommodation concerns	Visitor with medical condition reportedly denied restroom access	Accessibility Concerns
Visitor treatment concerns	Reports of distress involving families and children	Institutional Professionalism

Supervisory discretion concerns	Requests for accommodation reportedly denied	Visitation Operations

---

3. Direct Testimony

“The baby couldn’t bring toys from the playroom.”

“They closed the visitors’ bathrooms at 1:30 even though visits were not over.”

“They wouldn’t let baby’s mom use the restroom to change her.”

“They made her throw away the baby’s snack.”

“One visitor with a medical condition that has to use the restroom frequently wasn’t allowed to either.”

“She couldn’t even hug her son goodbye because she was afraid to move.”

---

4. Systemic Concerns

The reporting from USP Victorville raises concerns regarding visitation management procedures, accommodation practices for families and children, and access to basic necessities during visitation periods.

Family visitation plays a critical role in maintaining community connection, emotional stability, and successful reintegration outcomes for incarcerated individuals. Reports involving restrictive conditions impacting children, parents, and medically vulnerable visitors raise concerns regarding whether visitation operations are being administered in a manner consistent with safety, professionalism, and humane treatment standards.

The reported closure of restroom facilities prior to the conclusion of visitation hours raises additional concerns regarding accessibility, sanitation, and visitor welfare — particularly where children or individuals with medical conditions may require immediate restroom access.

Additional concerns involving restrictions on children’s toys, snacks, and movement within visitation spaces raise questions regarding operational discretion and the balance between institutional security and family-centered visitation practices.

Taken together, the reporting suggests broader concerns regarding visitation conditions, accommodation procedures, and consistency in visitor treatment practices at the institution.

---

5. Oversight Questions for Clarification — USP Victorville (WESTERN REGION)

1. What policies govern restroom availability for visitors during scheduled visitation periods?
2. Under what circumstances may visitor restroom facilities be closed prior to the conclusion of visitation hours?
3. What accommodations are available for visitors with medical conditions requiring frequent restroom access?
4. What guidance is provided to staff regarding visitation procedures involving infants and young children?
5. What policies govern access to toys, snacks, and child-related items during family visitation?
6. Are visitor complaints regarding visitation conditions formally documented and reviewed by supervisory staff?
7. What oversight mechanisms exist to ensure visitation operations are conducted consistently and professionally?
8. Have recent complaints involving visitor treatment or accommodation concerns at USP Victorville been reviewed internally?
9. What training is provided to visitation staff regarding family-centered visitation practices and visitor accessibility concerns?
10. What corrective measures, if any, are being considered to address concerns involving visitation conditions and family access at the institution?

WESTERN REGION

FPC Sheridan (OR)

Medical Access Concerns, Food Quality Complaints, Nutritional Concerns, and Conditions of Confinement Issues

1. Summary of Allegations

The Loved Ones Coalition has received reporting from incarcerated individuals and family members regarding ongoing concerns at FPC Sheridan involving alleged lack of medical access, food quality complaints, nutritional concerns, and deteriorating conditions of confinement.

Multiple reports allege that incarcerated individuals at the camp have experienced limited or nonexistent access to routine sick call services and medical evaluation processes. According to testimony received by the Loved Ones Coalition, incarcerated individuals were allegedly informed that medical staffing shortages have resulted in the suspension or severe limitation of sick call operations. Reporting further alleges that individuals may only be receiving medication distribution without meaningful access to medical assessment or treatment services.

Additional concerns involve food quality and nutritional adequacy. Reporting alleges that incarcerated individuals are routinely being served undercooked or inedible bread products, including reportedly raw dinner rolls during meal service. Family members describe growing frustration regarding food quality, nutritional intake, and overall morale within the camp.

One family member reported that their incarcerated loved one has significantly reduced food intake and increasingly avoids chow hall participation altogether.

Additional testimony raises concerns regarding fear of retaliation or interpersonal consequences connected to staff relationships and institutional dynamics, resulting in reluctance among some individuals to formally report concerns.

Taken together, the reporting raises broader concerns regarding medical staffing availability, continuity of care, food service quality, nutritional adequacy, and institutional responsiveness within the camp setting.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Medical access concerns	Reports alleging limited or unavailable sick call services	Medical Care

Staffing shortage concerns	Individuals reportedly informed no staff available to operate sick call	Healthcare Operations
Continuity of care concerns	Reports alleging medication distribution without broader medical access	Medical Oversight
Food quality complaints	Reports of undercooked or inedible bread products	Food Service
Nutritional concerns	Individuals reportedly avoiding meals or reducing food intake	Conditions of Confinement
Institutional morale concerns	Reports describing frustration and deteriorating morale	Institutional Operations
Fear of retaliation concerns	Reluctance to report concerns due to institutional dynamics	Institutional Accountability

---

3. Direct Testimony

“They get raw dinner rolls.”

“They’re feeding the uncooked rolls to the birds.”

“My husband eats once a day and never goes to chow anymore.”

“Sheridan has no medical sick call at all.”

“He was told there is no one to work it.”

“They get their meds — that’s it.”

---

4. Systemic Concerns

The reporting from FPC Sheridan raises concerns regarding continuity of medical care, healthcare staffing levels, food quality standards, and overall institutional conditions within the camp environment.

Allegations involving the absence or severe limitation of sick call operations raise significant concerns regarding access to timely medical evaluation, continuity of care, and institutional capacity to address routine or emerging health concerns. Reporting suggesting that incarcerated individuals may only be receiving medication distribution without meaningful access to broader medical services raises additional questions regarding healthcare staffing and operational adequacy.

Food-related complaints involving allegedly undercooked or inedible bread products further raise concerns regarding meal preparation standards, nutritional adequacy, and quality-control procedures within institutional food service operations.

Additional reporting indicating that some incarcerated individuals are avoiding chow hall participation altogether due to food quality concerns raises broader questions regarding nutritional intake, morale, and conditions of confinement.

The reporting also suggests that some individuals may be reluctant to formally report concerns due to fear of interpersonal consequences or retaliation, raising additional concerns regarding institutional transparency and accountability.

Taken together, the consistency of reporting suggests broader concerns regarding healthcare operations, food service standards, institutional morale, and responsiveness to incarcerated individuals’ basic health and nutritional needs.

---

5. Oversight Questions for Clarification — FPC Sheridan (WESTERN REGION)

1. What is the current operational status of routine sick call services at FPC Sheridan?
2. Are there current staffing shortages impacting access to medical evaluation or treatment services within the camp?
3. What procedures are in place to ensure incarcerated individuals maintain timely access to non-emergency medical care?

4. Have food service operations recently received complaints involving undercooked or inedible food products?
5. What quality-control procedures govern preparation and inspection of institutional meal service items?
6. What steps are being taken to address concerns regarding food quality and nutritional adequacy?
7. Are incarcerated individuals currently avoiding chow hall participation due to food-related concerns, and if so, has this been reviewed internally?
8. What oversight mechanisms are in place to ensure continuity of care despite reported staffing shortages?
9. What protections exist for incarcerated individuals who report institutional concerns involving medical care or food service conditions?
10. What corrective actions, if any, are being implemented to address reported healthcare and food service concerns at the camp?

MID-ATLANTIC REGION

USP Lee (VA)

Repeated Lockdown Concerns, Restricted Movement Complaints, Communication Limitations, and Institutional Instability Concerns

1. Summary of Allegations

The Loved Ones Coalition has received reporting from family members regarding ongoing concerns at USP Lee involving repeated lockdowns, restricted movement practices, communication limitations, and deteriorating morale among incarcerated individuals.

According to reporting received by the Loved Ones Coalition, portions of the institution were reportedly placed under continued lockdown conditions throughout the weekend, with only select housing units allegedly permitted limited movement for programming purposes while other units remained confined.

Family members describe growing frustration regarding recurring lockdown conditions and inconsistent movement practices within the institution. One reporting party alleged that the restrictions were not associated with active emergency incidents or ongoing violence, though

the Loved Ones Coalition cannot independently verify the operational basis for the restrictions at this time.

Additional concerns involve the emotional and psychological impact associated with repeated lockdown conditions and communication disruptions. One family member reported being unable to notify an incarcerated loved one about the death of a close family member due to ongoing lockdown conditions and communication limitations.

Reporting further reflects declining morale and growing desperation among incarcerated individuals and families regarding operational conditions within the institution.

Taken together, the reporting raises broader concerns regarding lockdown frequency, institutional stability, communication access, and the psychological impact of prolonged or repeated movement restrictions.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Repeated lockdown concerns	Reports of ongoing or recurring lockdown conditions	Institutional Operations
Restricted movement concerns	Only select units reportedly permitted movement	Conditions of Confinement
Communication limitation concerns	Family reportedly unable to relay emergency family information	Communication Access
Emotional distress concerns	Reports describing declining morale and frustration	Mental Health / Institutional Climate

Institutional instability concerns	Families describe growing desperation regarding conditions	Institutional Accountability

---

3. Direct Testimony

“Another weekend it appears locked down.”

“They let the units that program out but every other unit was locked yesterday and so far today.”

“His aunt passed and he doesn’t know.”

“I got the call after they locked in for the night on Friday.”

“Anywhere else has to be better than Lee.”

---

4. Systemic Concerns

The reporting from USP Lee raises concerns regarding repeated lockdown practices, movement restrictions, communication limitations, and overall institutional climate.

Repeated or prolonged lockdown conditions may significantly impact incarcerated individuals’ mental health, communication access, family stability, and daily functioning — particularly where restrictions extend across multiple days or occur with significant frequency.

The inability of family members to communicate urgent family emergencies due to lockdown-related restrictions raises additional concerns regarding emergency communication procedures and institutional responsiveness during periods of restricted movement.

Additional reporting suggests growing frustration and declining morale among incarcerated individuals and family members regarding operational instability and the cumulative impact of recurring restrictions.

Taken together, the reporting suggests broader concerns regarding institutional operations, communication access, emotional wellbeing, and consistency in movement-related practices within the facility.

---

5. Oversight Questions for Clarification — USP Lee (MID-ATLANTIC REGION)

1. What operational circumstances prompted the reported lockdown conditions over the weekend referenced in reporting received by the Loved Ones Coalition?
2. What criteria determine which housing units are permitted movement or programming access during partial lockdown conditions?
3. What procedures are in place to ensure incarcerated individuals receive timely notification regarding family emergencies during lockdown periods?
4. How frequently has USP Lee operated under modified movement or lockdown conditions during the past six months?
5. What mental health or wellness considerations are evaluated during prolonged or repeated lockdown periods?
6. What oversight mechanisms exist regarding continuation or extension of lockdown restrictions?
7. Are incarcerated individuals maintaining regular access to communication systems during movement restrictions?
8. What measures are being taken to address concerns regarding institutional morale and psychological strain associated with repeated lockdown conditions?
9. How are family members informed regarding communication limitations during lockdown periods?
10. What corrective actions, if any, are being considered to reduce operational instability and improve communication access during future restrictions?

MID-ATLANTIC REGION

FCI McDowell (WV)

Mattress Shortage Concerns, Property Loss Allegations, SHU Property Procedures, and Commissary Restriction Complaints

1. Summary of Allegations

The Loved Ones Coalition has received reporting from family members regarding ongoing concerns at FCI McDowell involving alleged mattress shortages, property loss following SHU

placement, commissary restriction concerns, and procedural issues related to property accountability.

According to reporting received by the Loved Ones Coalition, newly arrived incarcerated individuals have allegedly gone extended periods without receiving mattresses upon arrival at the institution. One reporting party alleged that their loved one had been housed at the institution for nearly two weeks without a mattress and further reported that multiple individuals within the same housing unit were allegedly experiencing the same issue. According to testimony, incarcerated individuals were reportedly informed that the institution lacked sufficient mattresses and that senior management had allegedly been notified.

Additional concerns involve allegations regarding personal property accountability following placement in the Special Housing Unit (SHU). One family member reported that after their loved one was removed to the SHU, his secured locker was later found open and multiple personal belongings were allegedly missing. Reporting further alleges that the incarcerated individual was not provided an inventory sheet to review or sign while housed in the SHU.

The reporting additionally raises concerns regarding commissary restrictions following SHU placement, including allegations that individuals are limited to purchasing only minimal hygiene items and writing materials despite the loss of previously purchased personal property.

According to testimony received by the Loved Ones Coalition, impacted individuals may be unable to replace allegedly lost or stolen property because commissary restrictions prevent them from repurchasing necessary items beyond a minimal spending limit. Family members describe this as creating a compounding hardship in which incarcerated individuals allegedly lose personal property while simultaneously being restricted from replacing it through commissary access.

Taken together, the reporting raises broader concerns regarding intake conditions, access to basic bedding, SHU property accountability procedures, property security practices, commissary restriction policies, and institutional responsiveness to property-related grievances.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Mattress shortage concerns	Newly arrived individuals reportedly without mattresses for extended periods	Conditions of Confinement

Bedding access concerns	Multiple individuals allegedly affected within housing unit	Basic Living Conditions
SHU property accountability concerns	Reports alleging missing property following SHU placement	Property Procedures
Inventory procedure concerns	Allegation that no inventory sheet was provided for review/signature	Administrative Procedures
Property security concerns	Reports of allegedly unsecured or opened lockers	Institutional Accountability
Commissary restriction concerns	Individuals reportedly unable to repurchase lost property due to spending limitations	Commissary Operations
Financial hardship concerns	Previously purchased items allegedly lost without replacement options	Property Loss / Financial Burden

---

3. Direct Testimony

“He has yet to receive a mattress to sleep on.”

“He says there is approximately 5–10 guys in his pod alone that don’t have one.”

“They’ve been told there is a lack of them and senior management has been advised.”

“His locker was secured, but it was unlocked and all his belongings were gone.”

“While in the hole he was never brought an inventory list to sign off on.”

“He’s lost all his belongings.”

“He is only allowed to buy hygiene, paper, stamps, and pens from commissary at a limit of $25.”

“When he went in I sent him enough money to get everything he needed.”

“He has a copy of all transactions.”

---

4. Systemic Concerns

The reporting from FCI McDowell raises concerns regarding basic intake conditions, institutional resource management, SHU property procedures, commissary restrictions, and accountability practices involving incarcerated individuals’ personal property.

Allegations involving incarcerated individuals going extended periods without mattresses raise significant concerns regarding basic living conditions, sanitation, sleep deprivation risks, and institutional preparedness to accommodate incoming population levels.

Additional reporting involving allegedly missing property following SHU placement raises broader concerns regarding chain-of-custody procedures, inventory documentation practices, property storage security, and procedural safeguards designed to protect incarcerated individuals’ personal belongings.

The allegation that individuals were not provided inventory documentation for review or signature during SHU placement raises additional questions regarding compliance with standard property accountability procedures and grievance resolution mechanisms.

Particularly concerning are allegations that individuals who allegedly lose property during SHU placement may simultaneously be placed under commissary restrictions preventing them from replacing those same essential items. Reporting suggests some individuals may be left without meaningful access to replacement clothing, personal items, or commissary necessities despite documented prior purchases and alleged institutional property loss.

Taken together, the reporting suggests broader concerns regarding institutional operations, intake preparedness, property accountability procedures, commissary restriction policies, and responsiveness to conditions-of-confinement complaints.

---

5. Oversight Questions for Clarification — FCI McDowell (MID-ATLANTIC REGION)

1. Is FCI McDowell currently experiencing shortages involving mattresses or other basic bedding supplies?
2. How many incarcerated individuals are currently awaiting mattress assignment upon intake or transfer?
3. What procedures are in place to ensure all newly arrived individuals receive timely access to basic bedding?
4. What are the institution's required procedures regarding property inventory documentation during SHU placement?
5. Are incarcerated individuals routinely provided inventory forms for review and signature following removal to the SHU?
6. What safeguards exist to protect incarcerated individuals' personal property during housing transfers or SHU placement?
7. How are allegations involving missing or unsecured property investigated and documented?
8. What mechanisms exist for incarcerated individuals to replace allegedly lost property while under commissary restrictions?
9. What policies govern commissary restrictions following SHU placement or transfer-related confinement?
10. What corrective actions, if any, are being considered to address reported bedding shortages, property accountability concerns, and replacement-access limitations at the institution?

MID-ATLANTIC REGION

FCC Hazleton (WV)

Mail Delays, Medical Neglect Concerns, Administrative Remedy Complaints, and Healthcare Treatment Issues

1. Summary of Allegations

The Loved Ones Coalition has received reporting from incarcerated individuals and family members regarding ongoing concerns at FCC Hazleton involving delayed mail distribution,

unresolved medical complaints, administrative remedy concerns, and allegations of inadequate medical treatment practices.

According to testimony received by the Loved Ones Coalition, multiple incarcerated individuals have reportedly raised concerns regarding incoming mail delays involving family photographs and personal correspondence. Reporting alleges that letters and photographs mailed by family members weeks earlier had neither been delivered to incarcerated individuals nor returned to senders, creating uncertainty regarding the location and processing status of personal mail.

Additional reporting raises concerns involving administrative remedy responsiveness and unresolved medical complaints. One incarcerated individual alleged that repeated BP-8 submissions regarding medical concerns had gone unanswered for an extended period despite ongoing health-related symptoms.

Particularly concerning are allegations involving reports of gastrointestinal bleeding symptoms and black stool allegedly being reported without meaningful intervention or follow-up care. Additional testimony further alleges concerns involving improper respiratory treatment procedures and inadequate adherence to outside medical instructions regarding breathing-treatment equipment and infection prevention measures.

The reporting additionally reflects growing frustration among incarcerated individuals regarding perceived lack of institutional responsiveness to medical grievances and healthcare-related complaints.

Taken together, the reporting raises broader concerns regarding mail processing operations, administrative remedy responsiveness, continuity of medical care, and institutional healthcare oversight practices.

---

2. Key Allegation & Violation Table

Allegation	Description	Potential Concern Area
Mail delay concerns	Incoming letters and photographs reportedly undelivered for extended periods	Mail Operations

Communication concerns	Families uncertain whether mail was processed or returned	Communication Access
Administrative remedy concerns	BP-8 complaints allegedly unanswered	Administrative Procedures
Medical neglect concerns	Reports involving unresolved gastrointestinal symptoms	Medical Care
Respiratory treatment concerns	Allegations regarding improper breathing-treatment setup and infection risks	Healthcare Operations
Continuity of care concerns	Reports alleging inadequate follow-up regarding medical complaints	Medical Oversight
Institutional responsiveness concerns	Individuals describe lack of response to grievances and healthcare complaints	Institutional Accountability

---

3. Direct Testimony

“Families have sent letters and pictures a month ago and they haven’t got them.”

“Nor have they been returned to their families.”

“He has been filing on the medical department for a long time and they never answered his BP-8s.”

“He has been having problems with bleeding when he went to the bathroom and his stool was black.”

“They haven’t been giving me the proper breathing treatments.”

“They didn’t have the proper setup the hospital said to use.”

“They left me wide open for an infection.”

---

4. Systemic Concerns

The reporting from FCC Hazleton raises concerns regarding institutional mail processing procedures, responsiveness to administrative remedies, and continuity of medical care for incarcerated individuals reporting serious health-related symptoms.

Mail delays involving personal correspondence and family photographs may significantly impact morale, family stability, and communication access — particularly where mail is reportedly neither delivered nor returned to senders within a reasonable timeframe.

Additional concerns involving unanswered BP-8 filings raise broader questions regarding accessibility and responsiveness of administrative remedy procedures, particularly where grievances involve ongoing medical complaints.

Particularly concerning are allegations involving gastrointestinal bleeding symptoms and black stool reportedly not receiving timely or meaningful medical intervention, as such symptoms may potentially indicate serious underlying medical conditions requiring prompt evaluation.

Reporting involving respiratory treatment concerns and alleged failure to follow outside medical guidance raises additional questions regarding continuity of care, infection prevention practices, and adherence to prescribed medical-treatment protocols.

Taken together, the consistency of reporting suggests broader concerns regarding healthcare responsiveness, administrative accountability, communication access, and institutional oversight practices within the complex.

---

5. Oversight Questions for Clarification — FCC Hazleton (MID-ATLANTIC REGION)

1. What is the current average processing time for incoming personal mail and photographs at FCC Hazleton?
2. What procedures exist for tracking incoming mail that is delayed, rejected, or returned to sender?

3. Are incarcerated individuals currently experiencing delays involving receipt of family correspondence or photographs?
4. What oversight mechanisms exist regarding unanswered BP-8 filings involving medical complaints?
5. How are reports involving gastrointestinal bleeding symptoms evaluated and prioritized by medical staff?
6. What procedures are in place to ensure continuity of care for incarcerated individuals receiving respiratory treatments or outside medical recommendations?
7. What infection-prevention protocols govern respiratory treatment equipment and related medical procedures?
8. How are incarcerated individuals informed regarding the status of unresolved medical grievances or administrative remedy filings?
9. Have recent complaints involving healthcare responsiveness at FCC Hazleton been reviewed internally?
10. What corrective actions, if any, are being considered to address reported mail delays, medical-care concerns, and administrative remedy responsiveness within the institution?

The Loved Ones Coalition will continue documenting recurring concerns, systemic patterns, and firsthand testimony submitted by incarcerated individuals, families, internal sources, and individuals with direct firsthand knowledge of conditions throughout the Federal Bureau of Prisons.

Many of the issues reflected throughout this report are not being reported as isolated incidents, but rather as recurring operational concerns described across multiple facilities, institutions, and reporting periods. The consistency of these reports continues raising broader concerns regarding conditions of confinement, communication access, medical responsiveness, prerelease custody practices, institutional transparency, and accountability mechanisms throughout the federal prison system.

The Loved Ones Coalition further recognizes that transparency, oversight, and open communication ultimately benefit everyone involved — including incarcerated individuals, families, staff, administrators, and the institutions themselves. Meaningful oversight and accountability are essential components of institutional safety, public trust, and lawful correctional operations.

The Loved Ones Coalition encourages incarcerated individuals, families, and individuals with direct firsthand knowledge of institutional conditions to continue documenting concerns, preserving records, maintaining communication, and reporting credible information through appropriate channels whenever possible.

Documentation matters. Patterns matter. Transparency matters.

Christine Amador
Founder & Executive Director
Loved Ones Coalition

Website: lovedonescoalition.org
Email: c.amador@lovedonescoalition.org

The Loved Ones Coalition remains open to continued communication, review of documentation, oversight dialogue, and good-faith engagement regarding concerns impacting incarcerated individuals and their families throughout the Federal Bureau of Prisons.