

LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Concerns Across the Federal Bureau of Prisons

June 29, 2026

This week's reporting reflects concerns from federal institutions across the Northeast, Mid-Atlantic, Southeast, South Central, and North Central Regions of the Bureau of Prisons.

While this reporting period contains fewer submissions than recent weeks, the concerns received continue to raise serious questions regarding the Bureau's ability to maintain basic institutional operations during lockdowns, staffing shortages, medical concerns, restrictive housing placement, and facility disruptions.

The central issue in this report is not one isolated complaint or one institution.

The central issue is continuity.

Continuity of medical care.

Continuity of meals.

Continuity of mail.

Continuity of visitation.

Continuity of programming.

Continuity of accessibility accommodations.

Continuity of basic living conditions.

Across multiple institutions, reporting raises questions about whether essential services continue when normal operations are disrupted. Lockdowns, staffing shortages, transfer status, restrictive housing placement, and facility maintenance issues cannot become explanations for interrupted medical care, missed meals, delayed mail, canceled programming, inaccessible housing, or unanswered health concerns.

This report is based upon information submitted to the Loved Ones Coalition by incarcerated individuals, family members, and reporting sources. LOC documents reported concerns for oversight, review, clarification, and corrective action. LOC does not make findings of fact regarding individual allegations. The purpose of this report is to identify patterns, elevate recurring concerns, request clarification from Bureau leadership, and document both unresolved issues and reported corrective action where applicable.

The question presented by this week's reporting is straightforward:

When institutional operations are disrupted, what safeguards exist to ensure that basic services do not stop?

Because medical care should not stop.

Meals should not stop.

Mail should not stop.

ADA accommodations should not stop.

First Step Act implementation should not stop.

Family communication should not stop.

And accountability should not stop.

The Loved Ones Coalition submits this report for review by Bureau leadership, regional leadership, oversight entities, lawmakers, and all decision makers responsible for ensuring that federal prisons operate safely, humanely, and consistently.

NORTHEAST REGION

FCI ALLENWOOD MEDIUM

Conditions of Confinement, Institutional Operations, Property Accountability, and Housing Conditions

1. Summary of Concerns

LOC received reporting during this reporting period regarding institutional operations, conditions of confinement, and the issuance of damaged institutional property at FCI Allenwood Medium.

Reporting received alleges that incarcerated individuals are routinely secured in their housing units beginning at approximately 5:45 p.m. each evening. These reports raise questions regarding the frequency of these early lockdowns, the operational justification for their implementation, and whether they unnecessarily limit access to recreation, programming, employment assignments, and other out-of-cell activities.

LOC additionally received reporting alleging that a newly arrived incarcerated individual was issued a damaged mattress with exposed interior stuffing upon arrival at the institution. The reporting further raises concerns that incarcerated individuals may be held financially or administratively responsible for damaged government property while allegedly being issued property already in a deteriorated condition.

These allegations raise broader questions regarding institutional quality control, property inspection procedures, and accountability measures. Specifically, what procedures are in place to ensure that mattresses and other essential living items are inspected prior to issuance, documented when damaged, and replaced before being assigned to an incarcerated individual?

Adequate bedding is a basic component of safe, sanitary, and humane living conditions. If damaged mattresses remain in circulation, questions naturally arise regarding property management practices, replacement schedules, and institutional oversight.

Taken together, the reporting received regarding FCI Allenwood Medium raises broader questions regarding conditions of confinement, institutional accountability, property issuance practices, and whether existing procedures adequately ensure that incarcerated individuals are provided safe and serviceable government-issued property.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Institutional Operations	Reporting alleges routine housing unit lockdowns beginning at approximately 5:45 p.m. each evening.	Conditions of Confinement
Movement Restrictions	Questions regarding the impact of extended evening lockdowns on recreation, programming, work	Institutional Operations

	assignments, and daily movement.	
Property Issuance	Reporting alleges a newly arrived incarcerated individual was issued a damaged mattress with exposed interior stuffing.	Housing Conditions
Property Accountability	Questions regarding inspection procedures for institutional property prior to issuance and replacement of damaged items.	Institutional Maintenance
Living Conditions	Concerns regarding whether issued bedding meets reasonable standards for safe and sanitary housing.	Conditions of Confinement

3. Direct Testimony

“They lock us down at 5:45 p.m. every day.”

“When I got here they gave me the stuffing out of a mattress instead of an undamaged mattress.”

“Yet they write you up for destroying one.”

4. Systemic Concerns

The reporting received regarding FCI Allenwood Medium raises concerns extending beyond an isolated complaint and instead presents broader questions regarding institutional operations, property management, and conditions of confinement.

If incarcerated individuals may be held financially or administratively responsible for damaged government property, safeguards should exist to ensure that property is inspected, documented, and determined to be serviceable before it is issued. Issuing damaged property while later holding individuals accountable for its condition raises questions regarding fairness, documentation practices, and institutional accountability.

The reported routine implementation of early evening lockdowns also raises questions regarding staffing, operational practices, and whether these restrictions unnecessarily limit access to programming, recreation, employment assignments, and other activities intended to support institutional operations and rehabilitation.

Taken together, the reporting received regarding FCI Allenwood Medium raises broader questions regarding property management, institutional operations, conditions of confinement, and oversight practices.

5. Questions for Clarification

1. Are housing units at FCI Allenwood Medium routinely secured beginning at approximately 5:45 p.m., and if so, what operational factors necessitate this practice?
2. How do these routine lockdowns affect access to recreation, programming, education, employment assignments, religious services, and other out-of-cell activities?
3. What procedures are currently in place to inspect mattresses and other issued property before they are assigned to incarcerated individuals?
4. What documentation is maintained when damaged property is issued or exchanged?
5. Under what circumstances may an incarcerated individual be held financially or administratively responsible for damaged institutional property?
6. What safeguards exist to ensure an incarcerated individual is not held responsible for damage that existed before the property was issued?
7. How frequently are mattresses inspected for damage, sanitation, and replacement?
8. Following review of the concerns outlined above, what corrective actions, if any, will be implemented regarding property inspection procedures and institutional operations at FCI Allenwood Medium?

NORTHEAST REGION

FCI McKEAN

Mail Policy Compliance, Access to Publications, Dental Care Delays, and Administrative Accountability Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding mailroom procedures, access to publications, and prolonged delays in dental care at FCI McKean.

Reporting received alleges that the institution's mailroom is not consistently following Bureau policy governing rejected, returned, or damaged mail. Specifically, reporting parties allege that incarcerated individuals are not receiving the required notification forms when incoming mail is denied, returned, or otherwise withheld. If accurate, these allegations raise questions regarding compliance with Bureau policy and whether incarcerated individuals are being afforded the opportunity to challenge mail-related decisions through the Administrative Remedy Program.

LOC additionally received reporting alleging that the institution continues to restrict incoming books to one paperback at a time and only when purchased through ThriftBooks or directly from an approved publisher. According to the reporting received, books purchased through Amazon or other third-party retailers are reportedly not accepted. These allegations raise questions regarding whether local institutional practices are consistent with Bureau policy and whether access to educational, rehabilitative, and self-improvement materials is being unnecessarily restricted.

LOC also received reporting regarding significant delays in dental treatment. Reporting parties allege that incarcerated individuals on the National Dental Wait List have remained without treatment for periods ranging from three to five years despite reportedly suffering from advanced tooth decay, gum disease, significant tooth loss, chronic pain, and the need for dentures.

Further reporting alleges that, rather than documenting ongoing requests for treatment, institutional records may inaccurately reflect that incarcerated individuals refused dental care or failed to report serious dental concerns. Reporting parties further advised that they are actively pursuing relief through the Administrative Remedy Program but have been unable to obtain meaningful resolution.

Taken together, the reporting received regarding FCI McKean raises broader questions regarding policy compliance, access to healthcare, institutional recordkeeping, administrative transparency, and accountability.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Mail Policy Compliance	Reporting alleges required notification forms are not	Policy Compliance

	provided when mail is denied, returned, or damaged.	
Due Process	Concerns regarding the ability to appeal mail decisions without required documentation.	Administrative Due Process
Publication Restrictions	Reporting alleges incoming books are limited to one paperback and only accepted from specific vendors.	Access to Educational Materials
Dental Care Delays	Reports allege incarcerated individuals remain on the National Dental Wait List for three to five years despite significant dental needs.	Health Care Services
Dental Documentation	Reporting raises concerns regarding records allegedly reflecting treatment refusals or failure to report concerns that reporting parties dispute.	Medical Documentation
Administrative Remedy Process	Reporting indicates concerns have continued through the Administrative Remedy Program without meaningful resolution.	Institutional Accountability

3. Direct Testimony

“The mailroom refuses to follow policy and doesn’t give us the forms that are supposed to be delivered when our mail is denied, returned or damaged.”

“Mailroom still only allows one book to be received in the mail at a time, and it must be paperback from ThriftBooks or an official publisher.”

“Amazon, or any other third-party source, is not allowed.”

“People on the National Dental Wait List have gone three to five years without any care whatsoever.”

“These are people who have serious dental issues like rotted teeth, gum disease, or a severe lack of teeth and who are in dire need of dentures.”

“To get away with it, staff say they denied or refused dental care, or that they haven’t reported to Dental with any serious or immediate dental concerns.”

“We are currently pushing through the administrative remedy process but have yet to make any headway.”

4. Systemic Concerns

The reporting received regarding FCI McKean raises concerns extending beyond individual complaints and instead presents broader questions regarding institutional compliance with Bureau policy, access to healthcare, and administrative accountability.

If incarcerated individuals are not receiving the required documentation when mail is rejected, returned, or withheld, questions arise regarding transparency, procedural compliance, and whether they are being afforded a meaningful opportunity to challenge those decisions through established Bureau procedures.

Similarly, the reported restrictions on incoming publications raise questions regarding whether local institutional practices are consistent with Bureau policy or whether incarcerated individuals’ access to educational, vocational, and rehabilitative reading materials is being unnecessarily limited.

The allegations involving dental care are particularly concerning. Reporting describing delays of three to five years for individuals suffering from advanced dental disease, chronic pain, missing teeth, or requiring dentures raises broader questions regarding staffing levels, treatment capacity, prioritization of care, and management of the National Dental Wait List.

The reporting also raises significant questions regarding documentation practices. If institutional records inaccurately reflect that treatment was refused or that concerns were never reported

when incarcerated individuals contend they repeatedly sought care, the integrity of the medical record, continuity of treatment, and the Administrative Remedy Program may all be impacted. Accurate documentation is fundamental to quality healthcare, meaningful administrative review, and institutional accountability.

Taken together, the reporting received regarding FCI McKean raises questions regarding policy compliance, healthcare delivery, medical documentation, administrative transparency, and whether existing oversight mechanisms are sufficient to identify and correct systemic deficiencies before they become longstanding institutional practices.

5. Questions for Clarification

1. What procedures are currently in place at FCI McKean to ensure incarcerated individuals receive written notification when incoming mail is rejected, returned, withheld, or damaged?
2. Has institution leadership reviewed whether current mailroom practices comply with applicable Bureau policy governing inmate correspondence?
3. What policy or institutional supplement authorizes restricting incoming books to one paperback at a time and limiting approved vendors?
4. Are books purchased through Amazon or other third-party retailers prohibited by Bureau policy or by local institutional practice?
5. How many incarcerated individuals are currently on the National Dental Wait List at FCI McKean?
6. What is the current average wait time for routine dental treatment, restorative treatment, extractions, periodontal care, and dentures?
7. What procedures are in place to ensure individuals experiencing chronic pain, advanced decay, significant tooth loss, or gum disease receive timely evaluation and treatment?
8. How does institution leadership verify the accuracy of dental records documenting treatment refusals or an individual's failure to report concerns?
9. Has institution leadership reviewed the allegations that incarcerated individuals requiring significant dental treatment have remained without care for periods of three to five years?
10. Following review of the concerns outlined above, what corrective actions, if any, will be implemented to address mail policy compliance, publication access, dental services, and documentation practices at FCI McKean?

NORTHEAST REGION

FCI FORT DIX

Conditions of Confinement, Facility Maintenance, Climate Control, First Step Act Implementation, and Infrastructure Concerns

1. Summary of Concerns

LOC continues to receive reporting regarding conditions of confinement, deteriorating infrastructure, climate control deficiencies, and First Step Act implementation at FCI Fort Dix.

During this reporting period, LOC received additional reports alleging that some housing units continue to experience inadequate heating during colder months, inadequate cooling during warmer months, and deteriorating living conditions. Reporting parties further allege that some housing units contain broken or missing cell windows, raising concerns regarding temperature control, weather exposure, and the overall habitability of the affected housing areas.

LOC also received reporting alleging that recent maintenance projects consisted of temporary or cosmetic repairs rather than permanent corrective action. Reporting parties specifically questioned recent ceiling repairs, alleging that underlying issues may not have been fully addressed despite work reportedly being completed.

Additionally, LOC received reporting alleging ongoing concerns regarding First Step Act implementation. Reporting parties allege that some Unit Team staff are unwilling to assist incarcerated individuals with Federal Time Credit-related matters, raising questions regarding consistency in First Step Act implementation, communication, and case management practices.

Taken together, the reporting received during this reporting period raises continuing questions regarding infrastructure maintenance, environmental conditions, institutional accountability, and consistent implementation of the First Step Act at FCI Fort Dix.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Climate Control	Reports allege inadequate heating during cold weather and inadequate cooling during warm weather.	Conditions of Confinement
Housing Conditions	Reporting alleges some housing units contain	Facility Maintenance

	broken or missing cell windows.	
Infrastructure Repairs	Concerns that recent ceiling repairs may have been temporary or cosmetic rather than permanent.	Institutional Maintenance
Facility Deterioration	Reports continue to raise concerns regarding the overall condition of housing units.	Infrastructure
First Step Act Implementation	Reporting alleges Unit Team staff are not consistently assisting incarcerated individuals with Federal Time Credit matters.	Reentry & Programming

3. Direct Testimony

“That place is so bad. No heat, no air, and some units have missing windows on the cells.”

“Unit Team doesn’t want to do FSA.”

“They came in and fake fixed some ceilings at Fort Dix.”

4. Systemic Concerns

The reporting received regarding FCI Fort Dix continues to reflect concerns that extend beyond isolated maintenance issues and instead raises broader questions regarding long-term infrastructure management, conditions of confinement, and institutional operations.

Reports alleging inadequate heating, inadequate cooling, and broken or missing windows raise questions regarding whether housing units are being maintained in a manner that provides safe

and habitable living conditions throughout changing seasonal conditions. If accurate, these reported conditions may affect both incarcerated individuals and institution staff.

The reporting also raises concerns regarding maintenance practices. Allegations that repairs are temporary or cosmetic rather than addressing the underlying condition raise questions regarding the effectiveness of facility maintenance, quality assurance, and long-term infrastructure planning.

Additionally, reporting regarding First Step Act implementation raises questions regarding consistency among Unit Teams and whether incarcerated individuals are receiving appropriate assistance in understanding and applying Federal Time Credit provisions. Given the Bureau's continued emphasis on successful implementation of the First Step Act, consistency in case management practices remains essential.

Taken together, the reporting received during this reporting period raises broader questions regarding infrastructure investment, maintenance practices, environmental conditions, and consistent implementation of the First Step Act at FCI Fort Dix.

5. Questions for Clarification

1. Have reports regarding inadequate heating, inadequate cooling, and broken or missing cell windows been reviewed by institution leadership?
2. How many housing units are currently awaiting repair for broken windows, climate control systems, or other significant maintenance deficiencies?
3. Have recent ceiling repairs fully corrected the underlying maintenance issues, or are additional repairs planned?
4. What quality assurance procedures are used to verify that maintenance projects permanently resolve reported deficiencies?
5. What guidance has been provided to Unit Team staff regarding assisting incarcerated individuals with Federal Time Credit calculations, eligibility, and First Step Act programming?
6. How does institution leadership ensure consistent implementation of the First Step Act across all Unit Teams?
7. What long-term infrastructure improvements are currently planned to address recurring maintenance concerns at FCI Fort Dix?
8. Following review of the concerns outlined above, what corrective actions, if any, will be implemented to address facility conditions, infrastructure maintenance, and First Step Act implementation at FCI Fort Dix?

FCI McDOWELL

Institution-Wide Lockdown, Communication, Visitation Disruptions, and Operational Transparency Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding an institution-wide lockdown, visitation disruptions, limited out-of-cell time, and concerns regarding communication with incarcerated individuals and their families at FCI McDowell.

Reporting received alleges that the institution entered a facility-wide lockdown beginning Saturday afternoon. According to reporting parties, visitation proceeded as scheduled on Friday and Sunday; however, Father's Day visitation was reportedly canceled. Reporting further alleges that incarcerated individuals remained confined to their housing units for an extended period, with one reporting source indicating that the first opportunity for release from their housing area consisted of approximately 30 minutes of out-of-cell time.

Reporting parties further advised that incarcerated individuals were informed the lockdown was related to radio communication issues. However, reporting sources questioned that explanation after allegedly observing staff members continuing to utilize their radios during the lockdown. While LOC cannot verify the operational reasons for the lockdown, the differing explanations reported by incarcerated individuals and family members raise questions regarding institutional communication and transparency.

LOC also received reports that families were initially advised the lockdown would be lifted earlier in the week, only to later receive updated information indicating the restrictions could continue for several additional days. The changing timelines reportedly created confusion and uncertainty for both incarcerated individuals and their loved ones.

Taken together, the reporting received regarding FCI McDowell raises broader questions regarding prolonged institution-wide lockdowns, communication with families, visitation disruptions, operational transparency, and the impact of extended restrictions on incarcerated individuals.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
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Institution-Wide Lockdown	Reports allege the entire institution has remained on lockdown for an extended period.	Institutional Operations
Limited Out-of-Cell Time	Reporting alleges incarcerated individuals received minimal out-of-cell time during the lockdown.	Conditions of Confinement
Visitation Disruptions	Father's Day visitation was reportedly canceled during the lockdown.	Family Engagement
Communication Concerns	Reporting indicates conflicting explanations regarding the reason for the lockdown and anticipated duration.	Institutional Transparency
Family Notification	Families reportedly received changing information regarding when restrictions would be lifted.	Institutional Communication

3. Direct Testimony

"McDowell's entire facility has been on lockdown since Saturday afternoon."

"They allowed visits Friday and Sunday but canceled Father's Day."

"The first time they were let out was yesterday for 30 minutes."

"The guys are being told it's due to down radios but have seen officers communicating fine on their radios."

“Families were told lockdown would be lifted Tuesday and are now being told maybe Monday.”

4. Systemic Concerns

The reporting received regarding FCI McDowell raises concerns extending beyond the implementation of a temporary lockdown and instead presents broader questions regarding institutional communication, operational transparency, and the management of extended facility-wide restrictions.

LOC recognizes that lockdowns may be necessary to address legitimate safety, security, staffing, or operational concerns. However, prolonged restrictions accompanied by inconsistent or changing explanations may create unnecessary confusion for incarcerated individuals and their families.

The reporting also raises questions regarding communication during significant operational events. Timely, accurate, and consistent communication can help reduce uncertainty, manage expectations, and maintain confidence in institutional decision-making during extended lockdowns.

Additionally, the reported cancellation of Father’s Day visitation highlights the significant impact that extended institutional restrictions may have on family engagement and reunification efforts. When visitation is disrupted, clear communication regarding the reasons for those decisions and anticipated timelines becomes especially important.

Taken together, the reporting received regarding FCI McDowell raises broader questions regarding lockdown procedures, communication practices, visitation management, and institutional transparency.

5. Questions for Clarification

1. What operational circumstances resulted in the institution-wide lockdown at FCI McDowell?
2. What factors were considered in determining the duration of the lockdown?
3. How much out-of-cell time was provided to incarcerated individuals during the reported lockdown period?
4. Why was Father’s Day visitation canceled, and what criteria were used in making that decision?
5. What communication procedures are in place to ensure incarcerated individuals and their families receive timely and accurate information regarding extended institutional restrictions?
6. Were alternative forms of family communication considered while visitation remained suspended?
7. What steps are being taken to minimize the impact of prolonged lockdowns on incarcerated individuals and their families while maintaining institutional security?

8. Following review of the concerns outlined above, what improvements, if any, will be implemented regarding communication, visitation, and transparency during future institution-wide lockdowns?
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MID-ATLANTIC REGION

FCI HAZELTON

Medical Care, Conditions of Confinement, Mail Distribution, Classification, Staffing, First Step Act Programming, and Retaliation Concerns

1. Summary of Concerns

LOC received extensive reporting during this reporting period regarding medical care, mail distribution, institutional operations, facility conditions, classification procedures, staffing shortages, First Step Act programming, and allegations of retaliation at FCI Hazleton.

Reporting received continues to raise concerns regarding timely medical treatment for serious and chronic medical conditions. LOC received reporting regarding an incarcerated individual reportedly diagnosed with squamous cell carcinoma of the tongue and mouth who alleges significant delays in diagnosis and treatment. Reporting further alleges the individual was prescribed a medically ordered soft diet but was routinely provided foods such as peanut butter and tomato-based products that appeared inconsistent with that medical order. These reports raise questions regarding continuity of medical care, implementation of provider orders, and coordination between Health Services and Food Service.

LOC also received repeated reports regarding mail distribution. On June 8, June 18, June 22, and June 23, reporting parties alleged they were advised that no mail was available because the United States Postal Service had allegedly failed to deliver mail. The frequency of these reports raises questions regarding mailroom operations, mail accountability, and institutional communication.

Reporting further alleges deteriorating conditions within N-1 Housing Unit, where only six of twelve showers were reportedly operational. Additional reports describe ongoing mold remediation efforts within housing units and allege that incarcerated individuals assigned to clean mold were not provided masks, gloves, or other personal protective equipment while performing the work.

LOC additionally received repeated reports regarding institution-wide lockdowns. Reporting parties allege lockdowns occurred between June 12 through June 14 due to reported staffing shortages, again on June 18 for alleged staffing shortages, and again on June 23 following

reports of a cellular phone incident and a reported overdose. Reporting parties expressed concern that repeated lockdowns continue to interfere with movement, programming, education, recreation, and completion of First Step Act programming, including the Academic Success Program.

Reporting also raises concerns regarding institutional classification practices. Reports allege that Team reviews were completed without the incarcerated individual's presence, complete Team paperwork was allegedly withheld, custody points were incorrectly calculated, and one wheelchair-dependent incarcerated individual reported being denied placement in an Honor Unit because staff allegedly failed to recognize accessible housing needs.

Additional reports allege that incarcerated individuals have had TRULINCS messaging and computer access suspended without notice or explanation from SIS.

LOC also received allegations of retaliation involving an incarcerated individual who reportedly filed an administrative remedy. According to the reporting received, the individual was allegedly assaulted inside the Lieutenant's Office, an area the reporting party alleges is not covered by camera surveillance. Reports further allege repeated cell searches, disciplinary action believed by the reporting party to be unfounded, and subsequent placement in the Special Housing Unit following the filing of administrative remedies.

Taken together, the reporting received regarding FCI Hazleton raises broader questions regarding medical care, staffing shortages, institutional operations, mail accountability, environmental health, classification practices, First Step Act implementation, retaliation safeguards, and institutional accountability.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Delayed Medical Care	Reports allege delays in diagnosis and treatment of serious medical conditions, including tongue cancer.	Medical Services

Medical Diet Compliance	Questions regarding implementation of physician-ordered soft diets.	Medical Care / Food Service
Mail Distribution	Multiple reports alleging mail was repeatedly not distributed throughout June.	Mail Operations
N-1 Housing Unit	Reports allege only six of twelve showers are operational.	Conditions of Confinement
Mold Remediation	Reports allege incarcerated individuals cleaned mold without PPE.	Environmental Health & Safety
Staffing Shortages	Repeated lockdowns reportedly attributed to staffing shortages.	Institutional Operations
First Step Act Programming	Lockdowns reportedly interfered with Academic Success programming.	Reentry & Programming
Classification Procedures	Allegations involving Team reviews conducted without inmate participation and inaccurate custody scoring.	Classification
Accessibility Concerns	Questions regarding housing assignments for	ADA Compliance

	wheelchair-dependent incarcerated individuals.	
TRULINCS Restrictions	Reports allege messaging and computer access suspended without explanation.	Institutional Operations
Retaliation Concerns	Allegations involving administrative remedies, repeated cell searches, disciplinary action, and SHU placement.	Institutional Accountability

3. Direct Testimony

“How is sticky peanut butter appropriate for someone who has difficulty swallowing?”

“How is acidic tomato sauce appropriate for someone with painful cancer of the mouth?”

“Only 6 of the 12 showers in N-1 work.”

“Some inmates have their email and accounts locked out without having been given a notification as to why.”

“Unit staff claim they cannot give us the complete Team paperwork.”

“They teamed me in March without me being there.”

“They changed my custody points.”

“We have been unable to complete our Academic Success class due to constantly being locked down.”

“Sleep apnea is not an acute medical need.”

“They didn’t realize I was in a wheelchair and don’t have a bottom cell for me.”

“An inmate was beaten in the Lieutenant’s Office where there isn’t a camera.”

“Since he filed a BP-8, his cell has repeatedly been torn apart.”

“They gave him a ghost write-up and took him to the SHU.”

“Most are too scared to report anything because of retaliation.”

4. Systemic Concerns

The reporting received regarding FCI Hazleton reflects recurring concerns across multiple operational areas rather than isolated incidents.

The repeated reports involving delayed medical care, implementation of physician-ordered diets, untreated sleep-related breathing concerns, and chronic healthcare delays raise broader questions regarding continuity of care, specialty referrals, chronic care management, and oversight of medically vulnerable incarcerated individuals.

The frequency of reported lockdowns attributed to staffing shortages raises additional concerns regarding institutional staffing levels, operational capacity, and the ability to consistently provide programming, recreation, education, mail distribution, and other essential institutional services. Repeated interruptions to Academic Success programming also raise questions regarding an incarcerated individual’s ability to participate in First Step Act programming and earn Federal Time Credits.

Reports involving N-1 Housing Unit, mold remediation efforts, and environmental conditions raise questions regarding facility maintenance, environmental health, and worker safety when incarcerated individuals are assigned institutional work involving potential environmental hazards.

The reporting further raises concerns regarding classification procedures, Team documentation, accessibility for incarcerated individuals with disabilities, and the accuracy of custody scoring decisions that directly affect institutional placement and transfer eligibility.

Finally, allegations involving retaliation following use of the Administrative Remedy Program warrant careful review. The effectiveness of any grievance system depends upon incarcerated individuals being able to report concerns without fear of retaliation. Reports suggesting individuals may hesitate to report institutional concerns because of perceived retaliation raise broader questions regarding institutional culture, accountability, and confidence in internal oversight processes.

5. Questions for Clarification

1. What is the current average wait time at FCI Hazleton for specialty medical care involving oncology, dental services, sleep disorders, and other chronic medical conditions?
 2. What procedures are in place to ensure physician-ordered therapeutic diets are consistently implemented by Food Service?
 3. Has institution leadership reviewed the allegations regarding delays in diagnosing and treating serious medical conditions, including reported cases involving cancer?
 4. What factors contributed to the repeated reports that incoming mail was allegedly not distributed on June 8, June 18, June 22, and June 23?
 5. Have mailroom operations been reviewed to determine whether incoming correspondence was delayed at the institution or elsewhere in the mail delivery process?
 6. What is the current status of repairs in N-1 Housing Unit, where reporting parties alleged only six of twelve showers were operational?
 7. Are incarcerated individuals assigned to environmental cleanup or mold remediation provided appropriate personal protective equipment, training, and supervision?
 8. What staffing shortages contributed to the repeated institution-wide lockdowns reported throughout June, and what corrective measures are being implemented to reduce operational disruptions?
 9. Approximately how many hours of First Step Act programming, including the Academic Success Program, were canceled or interrupted because of repeated lockdowns?
 10. What procedures ensure Team reviews, custody classification decisions, custody point calculations, and Team documentation are completed accurately and with the incarcerated individual's participation?
 11. What policies govern suspension of TRULINCS messaging or computer access, and are incarcerated individuals provided written notification explaining the reason for those restrictions?
 12. What procedures are in place to ensure wheelchair-accessible housing is available and appropriately assigned to incarcerated individuals with mobility impairments?
 13. Has institution leadership reviewed the allegations regarding incomplete Team paperwork, inaccurate custody scoring, and reports that Team reviews were completed without the incarcerated individual's participation?
 14. What corrective actions, if any, have been implemented to address the recurring concerns involving medical care, mail distribution, staffing shortages, institutional operations, environmental conditions, and classification practices at FCI Hazleton?
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6. Updates Since Previous Reporting Period

LOC also received reporting indicating that M-2 Housing Unit is reportedly being closed to facilitate repairs. Reporting parties viewed this as a positive step toward addressing longstanding maintenance concerns within the institution.

Additionally, reporting indicates that remediation efforts addressing reported mold concerns are currently underway. While these corrective actions are encouraging, reporting parties also allege that incarcerated individuals assigned to perform mold remediation were not provided masks, gloves, or other personal protective equipment during the cleanup process. Continued attention to worker safety and environmental health remains important as these repairs move forward.

LOC appreciates receiving reports when institutions take corrective action in response to identified concerns. Documenting both ongoing challenges and measurable improvements provides a more complete picture of institutional operations and helps recognize progress where it is occurring.

LOC will continue monitoring conditions at FCI Hazleton and will provide updates on both unresolved concerns and reported corrective actions in future oversight reports

SOUTHEAST REGION

FCI COLEMAN MEDIUM

Excessive Heat, Climate Control, Environmental Conditions, and Conditions of Confinement Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding excessive heat, inadequate climate control, and environmental conditions within the housing units at FCI Coleman Medium.

Reporting parties allege that the housing units are operating without air conditioning despite summer temperatures in central Florida. Reports describe extremely hot and humid living conditions, alleging that condensation forms on the walls and floors throughout the housing units due to the excessive humidity.

The reporting raises fundamental questions regarding climate control within the institution. Specifically, whether the housing units are equipped with air conditioning, whether any installed systems are currently inoperable, or whether the housing units were never designed with air conditioning. Regardless of the explanation, the reported conditions raise questions regarding the institution's ability to maintain safe and habitable living conditions during periods of extreme heat.

Reporting parties further allege these conditions are not new and have reportedly persisted for an extended period.

Taken together, the reporting received regarding FCI Coleman Medium raises broader questions regarding climate control, environmental health, institutional infrastructure, and conditions of confinement.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Excessive Heat	Reports allege housing units experience excessive indoor temperatures during the summer months.	Conditions of Confinement
Climate Control	Questions regarding whether housing units are equipped with functioning air conditioning.	Environmental Health
Excessive Humidity	Reports allege humidity is causing condensation on walls and floors.	Environmental Conditions
Facility Infrastructure	Questions regarding the institution's climate control systems and long-term infrastructure planning.	Institutional Maintenance
Health & Safety	Concerns regarding prolonged exposure to excessive heat and humidity for incarcerated individuals and staff.	Health & Safety

3. Direct Testimony

“FCI Coleman Medium has no AC.”

“Apparently it’s been that way.”

“It’s Florida and it’s June.”

“The walls and floors are sweating.”

4. Systemic Concerns

The reporting received regarding FCI Coleman Medium raises concerns extending beyond seasonal discomfort and instead presents broader questions regarding institutional infrastructure, environmental conditions, and conditions of confinement.

The reporting raises a fundamental question regarding climate control within the institution. Do the housing units at FCI Coleman Medium have air conditioning? If so, are those systems currently inoperable or operating below capacity? If the housing units were not designed with air conditioning, what measures are in place to maintain safe indoor temperatures during periods of extreme heat and humidity?

Reports describing condensation accumulating on walls and floors also raise questions regarding ventilation, moisture control, environmental conditions, and the long-term impact of prolonged humidity on both the physical infrastructure and living conditions within the institution.

Taken together, the reporting received regarding FCI Coleman Medium raises broader questions regarding climate control, environmental health, institutional infrastructure, and the Bureau’s ability to provide safe and habitable living conditions during periods of extreme heat.

5. Questions for Clarification

1. Do the housing units at FCI Coleman Medium have air conditioning?
2. If air conditioning is installed, is the system currently inoperable or only partially operational?
3. If the housing units do not have air conditioning, what measures are in place to maintain safe indoor temperatures during periods of extreme heat and humidity?
4. What indoor temperatures and humidity levels have been recorded within the affected housing units during the current reporting period?

5. How are medically vulnerable, elderly, or heat-sensitive incarcerated individuals identified and protected during periods of excessive heat?
 6. Have the reported conditions involving excessive humidity and condensation on walls and floors been evaluated by institution leadership or Facilities staff?
 7. What long-term plans, if any, exist to improve climate control within the housing units at FCI Coleman Medium?
 8. Following review of the concerns outlined above, what corrective actions, if any, will be implemented to address the reported environmental conditions at FCI Coleman Medium?
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SOUTH CENTRAL REGION

FCI POLLOCK

Visitation Policy, Family Engagement, and Environmental Conditions Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding visitation practices and environmental concerns at FCI Pollock.

Reporting received alleges that the institution has implemented a visitation policy advising that if a child is observed running during visitation, families will receive two warnings and that a third occurrence may result in the visit being terminated.

The reporting raises questions regarding how this policy is implemented, particularly in light of the limited recreational opportunities reportedly available for children within the visitation area. Reporting parties expressed concern that families may face termination of visits for normal childhood behavior despite limited space or activities available to occupy young children during extended visits.

Family visitation remains one of the Bureau's most important rehabilitative tools. Policies intended to maintain safety and order are important; however, they should also balance the realities of family visitation, particularly when young children are involved. The reporting raises questions regarding whether additional child-friendly accommodations or activities could reduce behavioral concerns while preserving valuable family contact.

LOC also received continued reporting regarding the presence of a blue residue in the institution's water supply. Reporting parties allege that this concern remains ongoing and

continues to generate questions regarding water quality and environmental conditions within the institution.

Taken together, the reporting received regarding FCI Pollock raises broader questions regarding family engagement, visitation practices, environmental conditions, and institutional operations.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Visitation Policy	Reporting alleges visits may be terminated after repeated warnings involving children running during visitation.	Visitation Operations
Family Engagement	Questions regarding balancing institutional order with meaningful family visitation involving young children.	Family Reunification
Children's Activities	Reports allege limited activities are available for children in the visitation area.	Visitation Services
Water Quality	Continued reports alleging blue residue in the institution's water.	Environmental Health

Environmental Conditions	Questions regarding evaluation of reported water quality concerns.	Facility Operations
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3. Direct Testimony

“They have a sign that now says if your child is running around you will get two warnings and the third time your visit is terminated.”

“In the kids room it’s barely anything for them to do.”

“Still have that blue residue from water.”

4. Systemic Concerns

The reporting received regarding FCI Pollock raises questions regarding how institutional policies affecting family visitation are implemented and whether sufficient consideration is given to the realities of visits involving young children.

Maintaining safety and order during visitation is an important institutional responsibility. At the same time, meaningful family engagement is recognized as an important component of rehabilitation and successful reentry. Reporting indicating that children’s visits may be terminated for repeated running, while limited age-appropriate activities are reportedly available, raises questions regarding whether additional family-friendly accommodations could better support both institutional order and positive family interaction.

The continued reports involving blue residue in the institution’s water also warrant review. If accurate, recurring reports regarding water quality raise questions regarding environmental monitoring, maintenance, and whether additional evaluation or communication regarding the reported condition is appropriate.

Taken together, the reporting received regarding FCI Pollock raises broader questions regarding visitation practices, family engagement, environmental conditions, and institutional accountability.

5. Questions for Clarification

1. What is the current visitation policy regarding children in the visiting room at FCI Pollock?
2. What factors led to the implementation of the reported three-warning policy for children running during visitation?
3. What age-appropriate activities, play areas, or accommodations are currently available for children visiting incarcerated family members?
4. Has institution leadership evaluated whether additional children's activities or designated play spaces could improve family visitation while maintaining institutional security?
5. Has the institution investigated the continued reports of blue residue in the water?
6. Has the water been tested to determine the cause of the reported discoloration or residue?
7. Have incarcerated individuals, staff, or visitors been informed of any findings regarding the reported water concerns?
8. Following review of the concerns outlined above, what corrective actions, if any, will be implemented regarding visitation practices and the reported environmental concerns at FCI Pollock?

SOUTH CENTRAL REGION

FEDERAL TRANSFER CENTER (FTC) OKLAHOMA CITY

Emergency Medical Response, Timeliness of Care, and Medical Triage Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding emergency medical response and access to medical care at the Federal Transfer Center (FTC) Oklahoma City.

Reporting received alleges that an incarcerated individual experienced what he believed to be an allergic reaction that resulted in significant swelling involving the area of his prosthetic eye. According to the reporting received, the swelling developed during the evening and the individual immediately notified correctional staff. Reporting parties allege no immediate medical evaluation or treatment was provided at that time.

According to the reporting received, the individual again sought medical attention the following morning due to continued swelling and reportedly spoke with Health Services during pill line.

Reporting parties allege that no treatment was provided at that time and that medication was not administered until approximately 36 hours after symptoms first began.

Although reporting indicates the swelling gradually improved, the reporting raises broader questions regarding emergency medical triage, timely clinical assessment, and institutional response to reported acute medical concerns. Regardless of whether symptoms ultimately resolve, reports involving significant facial or eye swelling raise questions regarding how potentially urgent medical complaints are evaluated and prioritized.

Taken together, the reporting received regarding FTC Oklahoma City raises broader questions regarding emergency medical response, timeliness of care, clinical triage procedures, and access to healthcare.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Emergency Medical Response	Reporting alleges delayed response to a reported allergic reaction.	Medical Services
Timeliness of Care	Reports allege treatment was not provided until approximately 36 hours after symptoms began.	Health Services
Medical Triage	Questions regarding evaluation of acute allergic reactions and facial or eye swelling.	Clinical Operations
Access to Care	Reporting alleges concerns were reported on multiple	Patient Care

	occasions before treatment was provided.	
Continuity of Medical Services	Questions regarding access to timely evaluation during intake and transfer operations.	Medical Operations

3. Direct Testimony

“Last night I had an allergic reaction to something and my eye was swollen shut.”

“I said something to the CO but they blew me off.”

“This morning I said something to them again because the swelling was just as bad.”

“I ended up talking to Medical when they did pill line but they never did anything.”

“The swelling has gone down after 24 hours but it’s still not like it should be.”

“It took 36 hours for them to give him some Benadryl.”

4. Systemic Concerns

The reporting received regarding FTC Oklahoma City raises concerns extending beyond an individual medical complaint and instead presents broader questions regarding emergency medical response, clinical triage, and access to timely care.

Acute allergic reactions and reports of significant facial or eye swelling require appropriate clinical assessment to determine the severity of the condition and whether immediate treatment is necessary. The reporting raises questions regarding the institution’s triage procedures, communication between correctional staff and Health Services, and the timeframe in which individuals reporting potentially urgent medical conditions are evaluated.

The reporting also raises broader questions regarding continuity of medical services within a federal transfer center, where incarcerated individuals often have complex medical histories and

may be in transit between institutions. Timely assessment and treatment of acute medical concerns remain important regardless of an individual's transfer status.

Taken together, the reporting received regarding FTC Oklahoma City raises broader questions regarding emergency medical response, clinical triage procedures, timely access to healthcare, and institutional medical oversight.

5. Questions for Clarification

1. What protocols are in place at FTC Oklahoma City for evaluating reports of acute allergic reactions or significant facial and eye swelling?
2. What is the expected timeframe for an incarcerated individual reporting an acute medical concern to be evaluated by Health Services?
3. What procedures govern communication between correctional staff and medical personnel when an incarcerated individual reports symptoms that may require prompt evaluation?
4. Has institution leadership reviewed the reported delay in treatment described above to determine whether existing medical response protocols were followed?
5. What guidance is provided to correctional staff regarding when an incarcerated individual should receive immediate medical evaluation rather than waiting until routine pill line or sick call?
6. Are medical response times for urgent complaints monitored or reviewed as part of the institution's quality assurance process?
7. Following review of the concerns outlined above, what corrective actions, if any, will be implemented to ensure timely evaluation and treatment of future acute medical complaints at FTC Oklahoma City?

NORTH CENTRAL REGION

FCI THOMSON

Medical Care, Accessibility, Mobility Accommodations, Special Housing Unit Conditions, and Continuity of Care Concerns

1. Summary of Concerns

LOC received reporting during this reporting period regarding medical care, accessibility accommodations, continuity of treatment, and conditions within the Special Housing Unit (SHU) at FCI Thomson.

Reporting received alleges that an older incarcerated individual with multiple chronic medical conditions has remained housed in the SHU for more than one month while awaiting multiple surgical procedures. According to the reporting received, the individual has significant mobility impairments requiring the use of both a wheelchair and walker in general population. However, reporting parties allege those mobility devices were removed following placement in the SHU despite the individual's ongoing medical needs.

Additional reporting alleges the individual remains housed in an accessible SHU cell but is required to ambulate without the assistive devices previously prescribed or utilized. According to the reporting received, the individual is handcuffed behind his back while being escorted to the shower twice weekly and reportedly requires staff assistance because he is unable to safely ambulate under those conditions. The reporting raises questions regarding fall prevention, accessibility accommodations, and continuity of medically necessary mobility assistance while housed in restrictive housing.

LOC also received reporting alleging the individual's medical conditions continue to worsen while awaiting treatment. Reporting indicates the individual reportedly requires hip and knee replacement surgery and has also been advised that an existing hernia has progressed to the point where surgical intervention may now be necessary. According to the reporting received, the individual previously underwent dental clearance for surgery but reportedly was not informed which surgical procedure was being planned.

The reporting raises broader questions regarding continuity of care when medically vulnerable incarcerated individuals are placed in restrictive housing, including whether mobility accommodations, specialty care, surgical planning, and chronic medical management continue uninterrupted during SHU placement.

Taken together, the reporting received regarding FCI Thomson raises broader questions regarding medical continuity of care, accessibility accommodations, specialty medical treatment, restrictive housing practices, and institutional oversight of medically vulnerable incarcerated individuals.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
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Continuity of Medical Care	Reports allege worsening chronic medical conditions while housed in the SHU.	Medical Services
Mobility Accommodations	Reporting alleges a wheelchair and walker were removed following SHU placement.	Accessibility / ADA Compliance
SHU Medical Management	Questions regarding continuation of prescribed accommodations and treatment while in restrictive housing.	Restrictive Housing Operations
Pending Surgical Care	Reports allege the individual is awaiting multiple potential surgical procedures.	Specialty Medical Care
Fall Prevention	Concerns regarding safe ambulation while restrained and without assistive devices.	Patient Safety
Accessibility	Questions regarding accommodations for incarcerated individuals with significant mobility impairments.	ADA Compliance

3. Direct Testimony

“He’s been in the SHU for over a month.”

“They have taken both his wheelchair and walker away in the SHU.”

“He needs a hip and knee replacement.”

“They handcuffed him behind his back to go to his shower twice a week, and he can’t walk like that.”

“The guards are practically holding him up and half dragging him.”

“He has a hernia that now reportedly requires surgery.”

“Before he was sent to the SHU, they sent him for a dental exam to clear him for surgery, but they wouldn’t tell him which surgery.”

4. Systemic Concerns

The reporting received regarding FCI Thomson raises concerns extending beyond an individual medical case and instead presents broader questions regarding how medically vulnerable incarcerated individuals are managed while housed in restrictive housing.

Placement in the SHU should not interrupt medically necessary treatment, specialty referrals, mobility accommodations, or continuity of care. Reporting alleging the removal of previously utilized assistive devices raises questions regarding the criteria used to determine whether mobility equipment remains appropriate during restrictive housing placement and how institutions balance security considerations with documented medical necessity.

The reporting also raises broader questions regarding accessibility within restrictive housing units. If incarcerated individuals with significant mobility impairments require assistance to safely ambulate while restrained, institutions should have clear procedures to minimize fall risks and ensure reasonable accommodations consistent with their medical needs.

Finally, reporting involving multiple pending surgical conditions raises questions regarding continuity of specialty care, communication with patients regarding treatment planning, and whether placement in restrictive housing affects access to medically indicated procedures.

Taken together, the reporting received regarding FCI Thomson raises broader questions regarding continuity of healthcare, accessibility accommodations, restrictive housing practices, specialty medical services, and institutional oversight of incarcerated individuals with significant chronic medical conditions.

5. Questions for Clarification

1. What policies govern the use of wheelchairs, walkers, and other medically necessary assistive devices for incarcerated individuals housed in the SHU?
2. Under what circumstances may prescribed mobility equipment be removed following placement in restrictive housing?
3. What procedures are in place to ensure continuity of specialty medical care and scheduled surgical treatment for incarcerated individuals while assigned to the SHU?
4. How are incarcerated individuals with significant mobility impairments safely escorted while restrained to reduce the risk of falls or injury?
5. What accessibility accommodations are available within SHU housing units for incarcerated individuals with documented disabilities or significant mobility limitations?
6. Does placement in the SHU delay or otherwise affect access to medically necessary surgical procedures or specialty consultations?
7. What procedures are in place to ensure incarcerated individuals awaiting surgery receive timely updates regarding their treatment plan and anticipated care?
8. Following review of the concerns outlined above, what corrective actions, if any, will be implemented to ensure continuity of medical care, accessibility accommodations, and patient safety for medically vulnerable incarcerated individuals housed in the SHU at FCI Thomson?