



LOVED ONES COALITION

Weekly Oversight Report

Documenting Systemic Concerns Across
the Federal Bureau of Prisons

September 28, 2026

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Last week, Loved Ones Coalition departed from our normal weekly reporting format to publish a Special Oversight Investigation focused exclusively on conditions at FCC Forrest City.

This week, we return to our regular reporting.

The purpose of these reports remains the same: identify problems, document patterns, bring credible concerns to the people positioned to address them, and—most importantly—see those problems fixed.

We also believe it is important to recognize improvement when we see it.

FCI Thomson is a good example.

Loved Ones Coalition has a substantial number of members connected to Thomson, including incarcerated individuals and family members, and historically the facility generated significant reporting regarding visitation, communication, lockdowns, and other institutional concerns.

The reporting we are receiving now looks very different.

Families and incarcerated individuals continue sending positive feedback regarding visitation. Visitors describe clearer procedures, better organization, respectful and helpful staff, improved processing, and a visiting experience that is considerably more predictable than what was reported previously.

That contrast matters.

When an institution improves, families notice.

When staff make an effort, families notice.

And when reporting shifts from repeated complaints to repeated positive feedback, Loved Ones Coalition will document that just as clearly.

Other institutions should take notice.

This is what successful oversight is supposed to look like: a problem is identified, practices improve, and eventually the reporting changes because the conditions changed.

At the same time, Loved Ones Coalition needs clarification from Bureau leadership regarding where organizations like ours are now expected to direct verified concerns.

For more than a year, the Bureau's Support Support Coordinators Office function served as an important bridge between families, outside advocates, incarcerated individuals, institutions, Regional Offices, and senior Bureau leadership. That channel allowed concerns to be elevated, clarified, and in many instances addressed without unnecessary escalation.

For approximately the past month, however, Loved Ones Coalition has experienced little or no communication through that channel.

We are therefore asking directly:

Is the Support and Advocacy Coordinator function still operating?

If its responsibilities have changed, where have those responsibilities moved?

And if the Bureau no longer intends for that office to serve as a point of contact for families and advocacy organizations, what is the replacement?

This question is especially timely given the Bureau's newly announced Division of Compliance and Oversight, which is described as the Bureau's internal watchdog and is intended to strengthen compliance, internal controls, external auditing, risk management, and accountability.

Loved Ones Coalition welcomes stronger oversight.

But oversight also requires a functioning pathway for information to reach the people responsible for acting on it.

Organizations like ours routinely receive detailed, real-time information from incarcerated individuals and families that may never reach Central Office through ordinary institutional channels. We verify what we can, identify patterns across facilities, protect our sources, and bring those concerns forward in a format that can be reviewed and acted upon.

So the question is simple:

Who at the Bureau is responsible for receiving that information now?

If that is the Division of Compliance and Oversight, provide the appropriate point of contact.

If it is Support and Advocacy, confirm that the office remains active and tell us how to reach it.

If it is another Central Office division or official, identify that channel.

We are not asking for special access.

We are asking for a clear, functioning point of contact so that verified concerns can continue moving from the people experiencing them to the people capable of fixing them.

That bridge worked.

If the Bureau has changed it, tell us what replaced it.

And if it still exists, help us use it.

NORTHEAST REGION

FCI ALLENWOOD LOW — PENNSYLVANIA

Restrictive Housing, Disciplinary Sanctions, Good Conduct Time Loss, Medical Care, Drug Testing, Medication Review, and Conditions of Confinement

1. Summary of Concerns

Loved Ones Coalition received reporting raising serious concerns regarding restrictive-housing practices, disciplinary sanctions, loss of Good Conduct Time, medical care, medication management, drug-testing procedures, and basic living conditions at FCI Allenwood Low.

The reporting describes a system in which incarcerated individuals may spend prolonged periods in the Special Housing Unit, including allegations that newly arriving individuals may be placed in restrictive housing while awaiting ordinary bed space and that disciplinary cases can result in SHU placement lasting well beyond 100 days.

Additional concerns involve substantial losses of Good Conduct Time associated with disciplinary proceedings. Reporting describes sanctions involving months of lost Good Conduct Time, including an allegation that one disciplinary matter resulted in approximately eighteen months of Good Conduct Time being removed.

Loved Ones Coalition cannot independently determine from the information presently available whether the disciplinary charges, sanction calculations, or resulting Good Conduct Time losses were properly imposed in any individual case.

That is not the end of the oversight question.

If individuals at FCI Allenwood Low are routinely losing substantial amounts of Good Conduct Time through disciplinary proceedings, the institution should be able to identify the charges involved, the sanctioning authority, the applicable policy basis, whether sanctions fall within authorized ranges, and what review process exists when an incarcerated individual disputes the result.

The reporting also raises significant concerns regarding medical care and the interaction between prescribed medication and institutional drug testing.

According to the information received, incarcerated individuals report difficulty obtaining meaningful medical attention even when experiencing significant health concerns. More troubling, the reporting alleges that prescribed medications may contribute to positive drug-test results and that individuals may subsequently face disciplinary action and placement in restrictive housing without adequate consideration of their documented prescriptions.

If that is occurring, the problem is not merely a disputed drug test.

It raises questions regarding whether Health Services, Correctional Services, and disciplinary personnel are adequately communicating before punitive sanctions are imposed.

A person should not be punished for taking medication the Bureau itself prescribed.

If a positive test can potentially be explained by a documented prescription, that information should be reviewed before an incarcerated individual loses liberty, programming, Good Conduct Time, or placement in general population.

The reporting further describes extremely thin and inadequate mattresses within restrictive housing and raises concerns regarding the basic physical conditions experienced by individuals confined there for extended periods.

Taken together, these allegations raise broader questions regarding restrictive-housing management, disciplinary proportionality, medical responsiveness, medication reconciliation, drug-testing procedures, Good Conduct Time administration, and whether punitive systems at FCI Allenwood Low contain adequate safeguards against preventable error.

Restrictive Housing and Bed-Space Management

Reporting received by Loved Ones Coalition alleges that individuals arriving at FCI Allenwood Low may be placed in the Special Housing Unit for approximately thirty days while waiting for available general-population bed space.

If accurate, that practice requires explanation.

Restrictive housing should not quietly become overflow housing.

If individuals who have not committed disciplinary infractions are routinely placed in SHU because ordinary housing space is unavailable, the Bureau should identify the authority for that practice, how frequently it occurs, the average duration of such placements, and what conditions distinguish administrative bed-space placement from punitive restrictive housing.

The distinction matters.

An incarcerated person does not experience twenty-three-hour confinement differently merely because the paperwork calls it administrative.

Prolonged SHU Placement and Disciplinary Sanctions

Reporting further alleges that disciplinary charges—including serious prohibited-act charges—may result in individuals remaining in restrictive housing for more than 100 days.

Loved Ones Coalition recognizes that serious misconduct may justify significant disciplinary consequences and that particular sanctions depend upon the offense, evidence, security circumstances, and applicable Bureau policy.

The concern is whether prolonged restrictive-housing placement has become routine, whether sanctions are consistently applied, and whether individuals remain in SHU beyond the period actually required by their disciplinary status because of population-management or bed-space limitations.

If an individual has completed the disciplinary portion of a sanction but remains in restrictive housing because the institution has nowhere else to place him, that is no longer solely a disciplinary issue.

It becomes an institutional-capacity issue.

Good Conduct Time Loss

The reporting received also alleges substantial forfeiture of Good Conduct Time, including sanctions reportedly measured in months and, in one reported instance, approximately eighteen months.

That allegation warrants direct review against disciplinary records.

The Bureau should be able to establish exactly how much Good Conduct Time was disallowed or forfeited, under what authority, for which prohibited act, whether multiple sanctions were aggregated, and whether all available procedural protections and appeal rights were provided.

When the government removes months of liberty through an administrative disciplinary process, the record should be clear enough to withstand scrutiny.

Medical Care, Prescribed Medication, and Drug Testing

The most troubling allegation involves the intersection between medical treatment and disciplinary enforcement.

Reporting alleges that incarcerated individuals may receive prescribed medication, later test positive during institutional drug testing, and then face disciplinary consequences despite the potential for an authorized medication to affect the result.

Loved Ones Coalition is not presently asserting that any specific positive drug test at Allenwood Low was caused by a prescribed medication.

We are asking a question that should have a very simple answer:

What procedure ensures that an incarcerated person is not punished for taking medication prescribed by Bureau medical personnel?

Before a positive drug test results in SHU placement, loss of Good Conduct Time, or other significant disciplinary sanctions, the institution should have a reliable mechanism for determining whether prescribed medication, documented treatment, cross-reactivity, laboratory confirmation, or another legitimate medical explanation requires further review.

Health Services and disciplinary operations cannot function as separate universes when one system may directly affect the outcome of the other.

Medical Responsiveness

Separate concerns involve the overall responsiveness of Health Services.

Reporting describes individuals experiencing significant medical problems while believing that their complaints are not being taken seriously or adequately evaluated.

Loved Ones Coalition cannot assess the clinical circumstances of unidentified individuals from this reporting alone.

But the Bureau can.

Sick-call records exist.

Medication records exist.

Clinical encounter records exist.

Emergency evaluations exist.

Referral histories exist.

The question is whether those systems show timely evaluation and appropriate follow-up—or a pattern of people repeatedly seeking help without meaningful resolution.

SHU Living Conditions

Reporting also describes mattresses issued in restrictive housing as extremely thin and inadequate for prolonged confinement.

A mattress may sound minor beside a disciplinary sanction or medical-access problem.

It becomes less minor when someone is confined to a cell for weeks or months and spends the overwhelming majority of each day on that mattress.

If FCI Allenwood Low is routinely housing individuals in SHU for extended periods, the Bureau should evaluate the physical condition of bedding, sanitation, recreation access, medical access, communication opportunities, and the cumulative living conditions experienced during those placements.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Restrictive Housing	Reporting alleges prolonged SHU placements, including stays exceeding 100 days.	Correctional Services / SHU Operations
Bed-Space Placement	Individuals are reportedly placed in SHU while awaiting ordinary housing space.	Population Management / Institutional Operations
Good Conduct Time	Reporting describes substantial disciplinary losses of Good Conduct Time.	Discipline / Sentence Administration
Drug Testing	Concerns involve positive drug tests potentially	Correctional Services / Health Services

	affected by prescribed medications.	
Medication Review	Reporting raises questions regarding whether prescriptions are reviewed before drug-related sanctions are imposed.	Health Services / Disciplinary Process
Medical Access	Reporting describes difficulty obtaining meaningful medical evaluation and treatment.	Health Services
SHU Conditions	Extremely thin mattresses and prolonged confinement raise basic conditions-of-confinement concerns.	SHU Operations / Conditions of Confinement
Procedural Safeguards	Significant liberty consequences raise questions regarding review, documentation, and appeal protections.	Institutional Accountability

3. Systemic Concerns

The concern at FCI Allenwood Low is not whether the Bureau possesses authority to discipline incarcerated individuals.

It does.

The concern is whether the systems surrounding that authority are functioning with sufficient accuracy, proportionality, and oversight.

Restrictive housing, loss of Good Conduct Time, and disciplinary findings can have significant consequences for an incarcerated individual's daily life and eventual release.

Those consequences demand reliable procedures.

If prescribed medication can potentially affect a drug test, medical records must matter.

If SHU is being used because general-population beds are unavailable, population-management records must matter.

If individuals are remaining in restrictive housing beyond the period justified by discipline, placement records must matter.

If months of Good Conduct Time are being removed, sanction calculations and review procedures must matter.

And if individuals are reporting significant medical concerns while confined for prolonged periods, clinical records must matter.

Loved Ones Coalition is not asking FCI Allenwood Low to accept every allegation as established fact.

We are asking the institution to open its own records and prove that these systems are functioning correctly.

Because when the government controls a person's housing, medication, disciplinary process, and release-related credits, "trust us" is not sufficient oversight.

4. Questions for Clarification

1. How many individuals are currently housed in the FCI Allenwood Low SHU?
2. How many are there for disciplinary reasons, administrative detention, protective purposes, transfer purposes, or because general-population bed space is unavailable?
3. During the previous six months, how many individuals remained in SHU longer than 30, 60, 90, and 100 days?
4. Are individuals routinely placed in SHU upon arrival while awaiting general-population bed assignments?
5. What is the average length of such bed-space-related placements?
6. How many disciplinary cases during the previous twelve months resulted in the loss or forfeiture of Good Conduct Time?
7. What was the largest Good Conduct Time sanction imposed during that period?
8. What procedures ensure Good Conduct Time sanctions remain within applicable statutory and Bureau-authorized limits?
9. What procedures are followed when an incarcerated individual disputes a positive drug test because of a prescribed medication?

10. Are active prescriptions reviewed before disciplinary sanctions are imposed following a positive drug test?
11. Is confirmatory laboratory testing used when medication cross-reactivity or another medical explanation is raised?
12. What role does Health Services play before drug-related disciplinary findings become final?
13. How many drug-related disciplinary findings during the previous twelve months were modified, dismissed, or overturned after medical or laboratory review?
14. Have institution leadership or Northeast Regional personnel reviewed medical-access complaints involving individuals housed in SHU?
15. What standards govern mattresses and bedding issued within restrictive housing?
16. Has leadership physically inspected the mattresses currently being issued to individuals housed in SHU?
17. What safeguards ensure that individuals experiencing serious medical problems while housed in restrictive housing receive timely clinical evaluation?
18. Has Northeast Regional leadership reviewed whether the combined practices involving prolonged SHU placement, bed-space limitations, disciplinary sanctions, Good Conduct Time losses, medical access, and drug-testing procedures indicate a broader institutional problem at FCI Allenwood Low?

MID-ATLANTIC REGION

FCC HAZELTON / FCI HAZELTON — WEST VIRGINIA

Repeated Short-Staffing Lockdowns, Disparate Housing-Unit Restrictions, Operational Continuity, Staff Conduct, and Regional Staffing Oversight

1. Summary of Concerns

Loved Ones Coalition continues to receive reporting regarding staffing shortages and resulting restrictions on normal institutional operations at FCI Hazelton.

This is not the first time.

LOC previously documented reports that short staffing had resulted in substantially restricted operations, with incarcerated individuals reportedly allowed out primarily for meals and approximately one additional hour of movement. At that time, LOC specifically raised questions regarding staffing levels, vacancy rates, augmentation, overtime, recruitment, retention, and the effect staffing shortages were having on institutional operations.

The current reporting indicates the problem is continuing.

According to information received by Loved Ones Coalition, on Friday, September 25, incarcerated individuals were reportedly confined to their housing units until approximately 5:00 p.m. because of short staffing.

On Saturday, September 26, reporting again described lockdown or substantial restriction until approximately 5:00 p.m. for the same reason.

Additional reporting received the following morning stated that N1 was the only housing unit restricted because of short staffing on September 26 and that the same unit was reportedly scheduled to be locked down again on Sunday, September 27, from approximately 10:00 a.m. until 5:00 p.m.

If accurate, that raises a question extending beyond staffing numbers:

Why is one housing unit repeatedly absorbing the consequences of an institution-wide staffing problem?

Repeated Short-Staffing Restrictions

Staffing shortages are a management problem.

They should not quietly become a recurring condition of confinement.

Federal correctional institutions inevitably experience call-outs, vacancies, training demands, leave, emergencies, and other staffing pressures.

The relevant oversight question is what happens next.

If the institution repeatedly responds by locking down incarcerated individuals, reducing movement, interrupting programming, restricting recreation, delaying unit-team access, and limiting other routine operations, then staffing shortages are no longer merely a human-resources issue.

They become an institutional operations issue affecting the incarcerated population.

Hazelton has now appeared repeatedly in LOC reporting for precisely this concern.

At some point, Regional leadership needs to determine whether the institution has sufficient personnel to operate normally.

Disparate Impact on N1

The newest reporting raises an additional concern because the restrictions were reportedly not applied evenly across the institution.

Individuals in N1 report that their housing unit was the only unit locked down during at least one short-staffing period and was then advised that the same thing would happen again the following day.

If accurate, the Bureau should explain the operational basis for repeatedly selecting one housing unit to absorb staffing-related restrictions.

There may be legitimate reasons.

Perhaps particular posts could not be filled.

Perhaps movement patterns or physical layout made one unit the operationally necessary choice.

Perhaps security circumstances unique to that housing unit existed.

But if the only explanation is “we are short staffed,” then repeatedly confining the same population while other units operate more normally requires justification.

Staffing shortages should not create an arbitrary rotation of deprivation — or worse, no rotation at all.

Staff Response to Concerns

Reporting further alleges that incarcerated individuals questioned why N1 was repeatedly being restricted while other housing units remained operational.

According to the submission, a lieutenant responded with profanity and language that reporting parties perceived as dismissive and provocative.

Loved Ones Coalition cannot independently verify the precise words used or the full context of that interaction.

The allegation nevertheless warrants supervisory review.

People confined to a housing unit because the institution lacks sufficient staff are entitled to ask why.

The appropriate response is an explanation.

Not escalation.

Not antagonism.

And certainly not language that could reasonably be interpreted as inviting incarcerated individuals to “do something about it.”

Correctional staff are responsible for maintaining order, including during frustrating operational conditions.

That responsibility becomes more important — not less — when an institution is already short staffed.

Staffing Shortages Are Not a Sustainable Lockdown Policy

Hazelton cannot solve a workforce problem by indefinitely transferring the consequences to incarcerated people.

Lockdowns and movement restrictions affect:

- recreation;
- education;
- programming;
- employment;
- showers;
- telephones and electronic communication;
- unit-team access;
- medical movement;
- legal access;
- religious services; and
- family communication.

Short-term restrictions may occasionally be unavoidable.

Recurring restrictions because normal posts cannot be filled are something different.

If staffing shortages are occurring often enough that housing units repeatedly lose ordinary operations, Mid-Atlantic Regional leadership should determine whether the institution is experiencing a chronic staffing deficit requiring intervention beyond the local level.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Short Staffing	Reporting describes repeated restricted operations attributed specifically to insufficient staffing.	Institutional Operations / Human Resources

Repeated Lockdowns	Restrictions reportedly occurred on consecutive or near-consecutive days.	Correctional Services
N1 Housing Unit	Reporting alleges N1 was uniquely restricted during at least one short-staffing period.	Institutional Operations
Disparate Restrictions	The same housing unit was reportedly selected again for subsequent restrictions.	Operational Accountability
Staff Conduct	A lieutenant reportedly responded to questions with profanity and language perceived as provocative.	Professional Conduct / Supervision
Program Disruption	Staffing-related restrictions may affect recreation, programming, communication, medical movement, and unit-team access.	Institutional Operations
Recurring Pattern	LOC has previously documented short-staffing restrictions at Hazelton.	Mid-Atlantic Regional Oversight
Workforce Capacity	Continuing reliance on lockdowns raises questions regarding vacancies,	Human Resources / Regional Administration

	overtime, augmentation, recruitment, and retention.	
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3. Direct Testimony

Reporting submitted to Loved Ones Coalition stated:

“Friday... we were confined to the units until 5pm due to short staff.”

The following day:

“Saturday... we were lockdown until 5pm due to short staff.”

Additional reporting stated that N1 was the only unit restricted because of staffing shortages and was advised that it would again be confined for much of the following day.

LOC is withholding all identifying information concerning the incarcerated reporting parties.

4. Systemic Concerns

Hazelton keeps appearing in these reports.

That matters.

LOC has documented concerns there involving mail, medical care, staffing, administrative remedies, basic supplies, unit-team access, disability accommodation, programming, and staff conduct.

Now we are again documenting short staffing producing restricted operations.

At some point, leadership has to stop treating each disruption as the problem of the day and examine the institution as a whole.

A facility cannot operate indefinitely by deciding which housing unit loses normal movement whenever enough employees do not report for duty.

That is not a staffing strategy.

It is operational triage.

And if the same unit is repeatedly selected, the Bureau should be prepared to explain why.

The incarcerated population did not create the vacancy rate.

They did not determine recruitment levels.

They did not establish retention policies.

They did not schedule staff.

Yet they repeatedly absorb the consequences when those systems fail.

Short staffing is a Bureau problem. It should not become a permanent condition of confinement.

5. Questions for Clarification

1. Did FCI Hazelton operate under substantially restricted conditions because of short staffing on September 25, 26, and/or 27, 2026?
2. How many correctional and non-correctional posts were unfilled during each affected shift?
3. Which housing units were restricted during those periods?
4. Was N1 the only housing unit placed under lockdown or substantial restriction on September 26?
5. Was N1 again selected for restriction on September 27?
6. If so, why was the same housing unit repeatedly selected?
7. What criteria determine which housing unit loses movement when staffing is insufficient?
8. Is there a rotation system intended to prevent the same incarcerated population from repeatedly absorbing staffing-related restrictions?
9. How many days during the previous 60 and 90 days has FCI Hazelton imposed lockdowns or substantially restricted movement because of staffing shortages?
10. What programming, recreation, medical movement, education, unit-team access, religious services, or communication opportunities were canceled or reduced during those periods?
11. What is FCI Hazelton's current authorized staffing level compared with actual onboard staffing?
12. How many correctional-services positions are presently vacant?
13. How much mandatory overtime and augmentation has been required during the previous 90 days?
14. Has Mid-Atlantic Regional leadership conducted a staffing assessment addressing recruitment, retention, vacancies, overtime, augmentation, and operational disruptions?
15. Has supervisory staff reviewed the reported interaction in which a lieutenant allegedly responded with profanity when individuals questioned repeated N1 restrictions?
16. What direction is provided to supervisors regarding professional communication with incarcerated individuals during staffing-related lockdowns?
17. What concrete staffing plan exists to reduce Hazelton's continuing reliance on restricted operations?

MID-ATLANTIC REGION

FCI MEMPHIS — TENNESSEE

Reported Triple-Celling, Rated Housing Capacity, Sanitation, Personal Space, Fire and Life Safety, and Population Management Concerns

1. Summary of Concerns

Loved Ones Coalition has received multiple reports alleging that FCI Memphis is beginning, or preparing, to house three incarcerated individuals in cells traditionally occupied by two people.

The reporting describes these cells as relatively small and raises concerns regarding whether they were designed, rated, or otherwise approved to accommodate three individuals on a continuing basis.

Loved Ones Coalition has not independently verified the dimensions, rated occupancy, current population count, or official housing plan for the affected units.

We are therefore asking the Bureau directly:

Is FCI Memphis implementing triple-celling?

And if so:

Were these cells actually designed and approved to house three people?

That distinction matters.

The issue is not simply whether a third bunk can physically fit inside a room.

The issue is whether adding another person to a cell preserves sufficient living space, sanitation, ventilation, sleeping arrangements, access to the toilet and sink, emergency egress, fire safety, and basic habitability.

If the institution is increasing occupancy within cells originally operated as double-occupancy spaces, the Bureau should be able to explain the operational and safety assessment supporting that decision.

Reported Triple-Celling

Multiple sources have independently reported to LOC that FCI Memphis is moving toward three-person occupancy in cells historically used for two incarcerated individuals.

One submission described the cells as approximately 8 feet by 13 feet, although LOC has not independently measured the spaces and does not present that dimension as verified fact.

The concern is straightforward:

How much usable living space remains when three adults, three sleeping assignments, personal property, a toilet, sink, and other fixed fixtures occupy the same cell?

Federal incarceration necessarily involves shared living space.

That does not mean population pressure eliminates the need for reasonable occupancy standards.

Sanitation and Hygiene

Triple-celling also raises obvious sanitation questions.

Three individuals sharing a small enclosed space means increased use of:

- the toilet;
- sink;
- floor area;
- storage areas;
- bedding;
- ventilation;
- waste receptacles; and
- limited personal space.

The issue is not whether three people are inherently incapable of keeping a cell clean.

The issue is whether the physical space and sanitation infrastructure were designed to support that level of occupancy.

If a cell built and operated for two people is suddenly expected to accommodate three, cleaning frequency, toilet access, ventilation, moisture, odor, personal-property storage, and general sanitation all deserve review.

An institution should not solve a population-management problem by creating a sanitation problem.

Personal Space and Conditions of Confinement

A third person inside a small cell substantially changes the usable space available to everyone assigned there.

The Bureau should identify how beds are being configured, where personal property is stored, whether any individual is required to sleep close to the toilet or floor level, and whether occupants can safely move through the cell without obstruction.

If triple-celling is intended only as a temporary emergency measure, the Bureau should state that clearly and identify the expected duration.

If it is becoming routine housing practice, then FCI Memphis should explain what formal review determined these cells remain appropriate for three-person occupancy.

Fire and Life Safety

Increased occupancy also warrants review from a fire and life-safety perspective.

Additional beds and property can reduce available floor space and potentially affect movement during an emergency.

The institution should confirm that any triple-celling arrangement has been evaluated for:

- unobstructed movement;
- emergency evacuation;
- access by responding staff;
- fire-code considerations;
- bed placement;
- electrical access;
- ventilation; and
- required occupancy limitations.

The question should not be answered simply by saying that a third bunk fits.

Capacity is not the same thing as habitability.

Population Pressure and Institutional Capacity

If triple-celling is being implemented because the institution lacks sufficient ordinary bed space, that itself deserves examination.

How far above its intended or rated population is FCI Memphis currently operating?

Is the additional occupancy temporary?

Is population expected to increase further?

Are communal areas also being converted to sleeping space?

Are programming, recreation, dining, medical, shower, and unit-team resources sufficient for the increased population?

Adding a third person to individual cells affects more than the cell.

Every additional person also increases demand on toilets, showers, phones, recreation space, Food Service, Health Services, laundry, programming, and institutional staffing.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Triple-Celling	Multiple reports allege three individuals are being assigned to cells traditionally occupied by two.	Population Management
Rated Capacity	It is unclear whether affected cells are designed or approved for three-person occupancy.	Facilities / Institutional Administration
Living Space	Increased occupancy may significantly reduce usable personal and movement space.	Conditions of Confinement
Sanitation	Three-person occupancy increases demand on toilets, sinks, cleaning, waste disposal, and ventilation.	Environmental Health
Bed Configuration	It is unclear how a third sleeping assignment is being safely accommodated.	Housing Operations / Safety

Fire/Life Safety	Additional beds and property may affect movement and emergency egress.	Safety / Facilities
Institutional Capacity	Triple-celling may indicate broader population-capacity pressures.	Regional / Population Management
Resource Demand	Additional population affects showers, meals, healthcare, programming, recreation, and staffing.	Institutional Operations

3. Systemic Concerns

Loved Ones Coalition is not claiming that placing three people in a cell is automatically unlawful.

We are asking whether FCI Memphis has actually determined that the affected cells can safely and humanely accommodate three people.

There is a difference.

A cell does not become suitable for three occupants simply because management needs another bed.

If the Bureau designed a space for two people, operated it for two people, and is now placing three people inside it because population pressure has increased, then someone should have evaluated what that change means.

For sanitation.

For ventilation.

For personal space.

For sleeping arrangements.

For fire safety.

For emergency access.

And for the broader operation of the institution.

Population pressure cannot simply be solved by compressing people into smaller and smaller spaces.

If FCI Memphis has a capacity problem, then Mid-Atlantic Regional leadership should address the capacity problem.

The answer should not automatically be: put another person in the cell.

4. Questions for Clarification

1. Is FCI Memphis currently assigning, or planning to assign, three incarcerated individuals to cells traditionally occupied by two?
2. Which housing units are affected?
3. How many cells are currently being used for three-person occupancy?
4. What is the designed or rated occupancy of those cells?
5. Were the affected cells originally constructed or configured for three occupants?
6. If not, what formal review authorized their use for triple occupancy?
7. What are the actual dimensions and usable floor area of the affected cells?
8. What sleeping configuration is being used for the third occupant?
9. Is anyone required to sleep on a floor-level bunk, temporary bunk, or other arrangement not originally part of the cell configuration?
10. Has Environmental Health reviewed sanitation and ventilation within triple-occupied cells?
11. Has Safety reviewed fire protection, emergency movement, and egress for the new configuration?
12. How are personal property and institutional supplies stored without obstructing movement?
13. How is access to the toilet and sink maintained with three individuals assigned to the same cell?
14. Is triple-celling intended to be temporary or permanent?
15. If temporary, what is the anticipated end date?
16. What is FCI Memphis's current population compared with its rated or design capacity?
17. Is the institution experiencing a shortage of ordinary housing space?
18. Are any other areas not originally intended for sleeping being converted to housing?
19. Has Mid-Atlantic Regional leadership reviewed the proposed or current triple-celling arrangement?
20. What assessment supports the conclusion that these cells remain sanitary, safe, and appropriate for three-person occupancy?

NORTH CENTRAL REGION

FCI THOMSON — ILLINOIS

Visiting Operations — Continued Improvement, Numbering System, Processing Efficiency, Family Access, and Positive Staff Interactions

1. Positive Follow-Up

Loved Ones Coalition is pleased to report continued positive feedback regarding visitation operations at FCI Thomson.

Over recent reporting periods, LOC has received increasing reports describing meaningful improvement in the visiting process. The current reporting continues that trend and includes multiple accounts from visitors describing a more organized arrival process, clearer expectations, improved processing, and professional interactions with visiting-room staff.

This is important because visitation at Thomson has previously generated significant frustration for families.

When those conditions improve, that improvement deserves to be documented just as clearly as the problems that preceded it.

Recent visitors report that families are again being permitted to park along the roadway before entering institutional grounds and that staff are issuing numbered places in line. The numbering system appears to have substantially reduced uncertainty regarding arrival order and provides families with a clearer understanding of when they will be processed.

One visitor arriving at approximately 7:30 a.m. reported receiving number nine, with approximately fourteen numbers issued for the morning visitation group. Although processing initially moved somewhat slowly while two apparently newer staff members handled arrivals, the visitor reported that nine people had been processed by approximately 9:15 a.m.

Visitors who are not processed during the morning group reportedly retain their number and are given priority when processing resumes at approximately 11:00 a.m.

That continuity matters.

Families traveling significant distances should not have to guess whether arriving early will preserve their place in line or whether they will be required to restart the process later in the day.

Visiting Processing and Staff Conduct

Additional reporting from Sunday visitation was particularly positive.

Visitors described three staff members processing families efficiently and reported that the morning group had been successfully processed by the time the next group arrived.

Multiple visitors independently described visiting staff as helpful, kind, respectful, and efficient.

That deserves recognition.

Loved Ones Coalition frequently receives reports regarding institutional operations when something has gone wrong. It is equally important to recognize employees who are helping an institutional process work the way it should.

Families report that the current visiting staff provided clear direction, answered questions, and maintained an orderly process without unnecessary hostility or confusion.

One visitor described being “pleasantly surprised” by the experience after hearing that previous weekends had been chaotic.

Another visitor similarly reported that the process went smoothly, that staff were helpful and kind, and that knowing what to expect significantly improved the experience.

Visitor Forms and Waiting-Area Procedures

Visitors also reported being permitted to complete required visitation forms within the entry or waiting area before final processing.

Families described this as a particularly helpful operational improvement because it allows paperwork to be completed without delaying the primary processing line.

Loved Ones Coalition encourages visitors to follow staff instructions regarding when they may enter the building and obtain forms.

Reporting indicates that some visitors entered the building before the designated time in order to retrieve paperwork. Families themselves expressed concern that disregarding the established process could jeopardize a privilege that is currently making visitation easier for everyone.

When an institution establishes a procedure that is working, cooperation from both staff and visitors helps preserve it.

Minor Food-Service Concern

The only notable concern raised during the current reporting involved limited availability of sandwiches in the visitation vending machines.

Visitors characterized this as a relatively minor issue and did not describe it as substantially affecting the quality of the visit.

LOC nevertheless notes the concern because families and incarcerated individuals may spend several hours in the visiting room, and reliable vending availability helps support longer visits.

2. Positive Operational Developments

Area	Current Reporting	Observed Improvement
Arrival Procedures	Visitors report roadway parking is again permitted before entry.	Reduced confusion before visitation begins
Numbering System	Staff reportedly issue numbers establishing processing order.	Greater predictability and fairness
Morning Processing	Number holders who are not processed initially reportedly retain priority for the next group.	Families do not lose their place
Staff Conduct	Multiple visitors describe staff as helpful, respectful, kind, and efficient.	Improved visitor experience
Visitor Forms	Forms are reportedly available in the waiting/entry area.	Faster and more organized processing
Staffing	Sunday processing reportedly involved three	Improved throughput

	staff members and moved efficiently.	
Visitor Expectations	Families report knowing what to expect upon arrival.	Reduced uncertainty and conflict
Vending	Limited sandwich availability was reported.	Minor operational issue

3. Why This Matters

Visitation is not simply an institutional convenience.

For many families, visiting a federal prison requires hours of driving, hotel costs, fuel, childcare arrangements, missed work, and substantial planning.

A chaotic visiting process can turn an already difficult trip into an unnecessarily stressful experience.

A predictable one can make an enormous difference.

The changes being described at Thomson are not complicated:

Issue numbers.

Explain the process.

Honor the order.

Make forms available.

Staff the processing area adequately.

Treat families respectfully.

And move people through efficiently.

Those basic practices appear to be producing noticeably better results.

Loved Ones Coalition has previously acknowledged that Thomson has made meaningful improvements and that continued oversight should recognize progress rather than treating improvement as irrelevant.

The current visitation reporting is another example of why that approach matters.

When something improves, we should say so.

Families are noticing.

The difference is being reported back to us.

And institutional staff responsible for making that process more organized and respectful deserve credit for it.

4. Continued Monitoring

Loved Ones Coalition will continue monitoring visitation at FCI Thomson to determine whether these improvements remain consistent across future weekends and higher-volume visiting periods.

We particularly hope the current numbering system, waiting-area form access, orderly processing practices, and respectful staff interactions remain in place.

The goal of oversight has never been to keep an institution permanently on a list of problems.

The goal is to identify what is not working, see it corrected, and then be able to report:

This is better.

At FCI Thomson, families are telling us that visitation is better.

And we are happy to say so.

NORTH CENTRAL REGION

FCI WASECA — MINNESOTA

Recurring Roof and Ceiling Leaks, Dining-Area Disruption, Recreation-Floor Damage, Deferred Maintenance, and Horticulture Program Update

1. Summary of Concerns

Loved Ones Coalition continues to receive reporting regarding persistent roof and ceiling leaks at FCI Waseca, with current information indicating that the problem is affecting multiple institutional areas rather than a single isolated location.

Reporting describes significant water intrusion within the kitchen and dining area, where a large section of seating has reportedly remained unavailable for an extended period because of continuing leaks.

Additional concerns involve the recreation department, where recurring water intrusion has reportedly damaged portions of the gym's hardwood flooring.

According to the reporting received, the gym floor is divided between exercise equipment and open recreational space, and portions of the hardwood have become unusable because of repeated exposure to water.

One section is reportedly affected by a board that has lifted approximately two feet upward, creating an obvious physical defect within the recreational floor. Other raised or damaged boards were reportedly removed more than a year ago and have never been replaced, leaving additional portions of the floor unavailable for normal use.

The concern at FCI Waseca is therefore no longer simply that the roof leaks.

The concern is what those leaks are doing to the institution over time.

Water intrusion that continues long enough to eliminate dining space, damage hardwood flooring, create unusable recreation areas, and require repeated temporary responses is evidence of a maintenance problem that has not been permanently resolved.

Roof and Ceiling Leaks

Reporting describes leaks occurring in multiple locations throughout the institution, including recreation areas and the kitchen/dining environment.

If accurate, the scope of the leakage raises questions regarding whether FCI Waseca is experiencing isolated roof failures or a broader roofing, drainage, flashing, or building-envelope problem.

Temporary patching may stop an individual leak for a period of time.

It does not constitute permanent remediation when water continues entering the facility in other locations—or returns to previously affected ones.

At some point, repeated patches become evidence that the underlying problem remains unresolved.

Kitchen and Dining-Area Impact

A particularly significant concern involves the reported loss of seating within the kitchen and dining area.

Reporting indicates that a substantial section of the dining area has remained without usable seating for an extended period because of the continuing leaks.

That matters because a facility's dining area is a high-use institutional space.

If water intrusion has removed a meaningful portion of seating from normal use, the Bureau should be able to explain:

- how long the affected area has been unavailable;
- whether the area has been inspected for moisture-related damage;
- what repair work has been completed;
- what remains outstanding; and
- when full use of the dining area is expected to be restored.

A section of the chow hall should not simply remain indefinitely unusable because a leak has become normalized.

Recreation and Gym-Floor Damage

The reporting concerning the recreation department illustrates the cumulative effect of unresolved water intrusion.

Water leaks have reportedly damaged hardwood flooring within the gym to the point that portions of the floor are no longer safely usable.

One board is described as having lifted approximately two feet.

Other damaged or raised flooring sections were reportedly removed more than a year ago and have never been replaced.

That suggests the institution may be addressing the immediate hazard by removing damaged material without restoring the affected space to full use.

Removing a damaged board may eliminate one immediate tripping hazard.

It does not repair the roof.

It does not restore the floor.

And it does not return the recreational area to the incarcerated population.

If repeated water intrusion continues destroying hardwood flooring, institution leadership should evaluate whether continuing to replace isolated boards is a reasonable long-term approach or whether the damaged flooring system itself requires comprehensive replacement or redesign.

Deferred Maintenance and Temporary Repairs

The repeated theme in the Waseca reporting is straightforward:

Band-aids are not fixing the problem.

Loved Ones Coalition has documented this pattern at multiple federal institutions.

A leak occurs.

A temporary repair is made.

Damaged materials are removed.

The underlying system continues failing.

Another area becomes unusable.

And eventually temporary measures become the permanent condition of the facility.

That is deferred maintenance.

If FCI Waseca has experienced recurring leaks over an extended period, North Central Regional leadership should determine whether the institution requires a broader roof and building-envelope assessment rather than continued individual work orders.

Positive Institutional Update — Horticulture Program

The current reporting also includes a positive development that deserves recognition.

Individuals at FCI Waseca describe the institution's horticulture program as outstanding.

Reporting describes colorful flowers throughout the grounds and an active vegetable garden that supplies produce to the institution's kitchen.

Loved Ones Coalition believes positive programs should be acknowledged when they are functioning well.

A successful horticulture program provides more than appearance.

It can offer meaningful work, practical skills, routine, responsibility, and an opportunity for incarcerated individuals to contribute directly to the institution.

The fact that produce from the garden is reportedly being used in the kitchen is a particularly positive example of institutional programming producing a tangible benefit.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Roof/Ceiling Leaks	Reporting describes recurring leaks throughout multiple institutional areas.	Facilities / Physical Plant
Dining Area	A substantial portion of kitchen/dining seating is reportedly unavailable because of continuing water intrusion.	Food Service / Facilities
Recreation Floor	Repeated leaks have reportedly damaged hardwood flooring within the gym.	Recreation / Facilities
Raised Flooring	One hardwood board is reportedly lifted approximately two feet, while other damaged sections were previously removed.	Safety / Facility Maintenance
Unrestored Areas	Flooring removed more than a year ago has reportedly not been replaced, leaving portions of recreation space unusable.	Deferred Maintenance
Temporary Repairs	Reporting describes recurring problems despite	Preventative Maintenance

	prior repairs or removal of damaged materials.	
Horticulture	The institution reportedly maintains a strong horticulture program, including flowers and a vegetable garden supplying the kitchen.	Recreation / Vocational Programming

3. Systemic Concerns

The central issue at FCI Waseca is not the existence of an occasional roof leak.

Buildings develop maintenance problems.

The oversight question is whether those problems are being permanently corrected before they damage additional parts of the institution.

At Waseca, the reporting suggests the consequences are accumulating.

Dining space has reportedly been lost.

Gym flooring has reportedly been damaged.

Sections of recreational space have reportedly remained unusable for more than a year.

Additional leaks continue.

If that reporting is accurate, the Bureau should stop treating each damaged ceiling tile or floorboard as a separate event and examine the common source.

The roof.

The drainage system.

The building envelope.

Whatever system is permitting water to repeatedly enter the institution.

Continuing to remove damaged materials without correcting the condition causing the damage simply allows the usable footprint of the institution to shrink over time.

And that is not maintenance.

That is managed deterioration.

At the same time, the horticulture program demonstrates that Waseca is capable of providing meaningful, well-run programming that incarcerated individuals value.

That positive work should continue.

So should the expectation that the physical plant surrounding it be maintained to the same standard.

4. Questions for Clarification

1. How many active roof, ceiling, or water-intrusion work orders currently exist at FCI Waseca?
2. Which institutional buildings or departments are presently affected by recurring leaks?
3. Has the institution conducted a comprehensive roof or building-envelope assessment during the previous two years?
4. What is causing the recurring leakage affecting the kitchen, dining area, recreation department, and other reported locations?
5. How long has the affected portion of the kitchen/dining area been unavailable for normal seating?
6. What percentage of dining capacity is currently unavailable because of water intrusion or related maintenance?
7. Has the affected dining area been evaluated for moisture damage, microbial growth, or deterioration of underlying building materials?
8. What repairs are currently planned or underway to restore full dining-area use?
9. Has the recreation gym floor been professionally evaluated for water damage and structural integrity?
10. How much of the hardwood floor is currently unusable?
11. Has the reportedly raised board creating a substantial floor defect been removed or repaired?
12. Why have flooring sections reportedly removed more than one year ago not been replaced?
13. Has the institution evaluated whether replacement of the damaged hardwood with a more durable flooring system would be more appropriate given the history of recurring water intrusion?
14. What permanent roofing or drainage repairs are planned to prevent continued damage to interior spaces?
15. What funding, contracting, staffing, or procurement barriers—if any—are delaying permanent remediation?
16. What is the anticipated timeline for restoring all currently unusable dining and recreation areas?

17. What steps are being taken to preserve and support the horticulture program, including the vegetable garden reportedly supplying produce to Food Service?

SOUTHEAST REGION

FCI TALLADEGA — ALABAMA

Alleged Staff Introduction of a Firearm and Ammunition, Contraband Controls, Staff Screening, Prior Search-Procedure Concerns, and Institutional Accountability

1. Summary of Concerns

Loved Ones Coalition received serious reporting concerning an alleged staff-related security incident at FCI Talladega involving the introduction of a firearm and ammunition into the institution.

According to the reporting received, a correctional employee assigned to FCI Talladega was allegedly discovered bringing a firearm and two magazines onto institutional property or into the secure institution.

The employee was reportedly removed from normal duties or removed from the property following the discovery. Subsequent reporting indicates the matter remains under investigation and that the employee may presently be assigned away from normal correctional duties.

Loved Ones Coalition has not obtained official investigative records establishing precisely where the firearm was discovered, whether it entered the secure perimeter, whether it was loaded, what ammunition was present, whether criminal charges were initiated, or what administrative action has ultimately been taken.

Those facts require confirmation.

The allegation itself, however, is serious enough to require direct institutional and Regional review.

A firearm introduced into a federal correctional institution by an employee is not an ordinary contraband incident.

It raises immediate questions regarding staff screening, perimeter security, weapons-control procedures, employee accountability, investigative referral, supervisory oversight, and whether security procedures are being applied consistently to staff and visitors.

Staff Screening and Contraband Prevention

Federal correctional institutions devote substantial resources to preventing weapons, drugs, cellular telephones, and other prohibited items from entering secure environments.

Those security systems cannot focus solely on incarcerated individuals and visitors.

Staff access represents a separate institutional security pathway and must be subject to meaningful safeguards.

If an employee was able to enter—or approach entry into—a secure correctional environment while possessing a firearm and ammunition, FCI Talladega should determine exactly how that occurred.

Was the weapon detected through routine screening?

Was it discovered accidentally?

Did another employee report it?

Was the employee already inside a secure area when it was discovered?

Did existing screening procedures function as designed, or did another safeguard prevent a substantially more serious event?

Those distinctions matter.

The Bureau should not simply conclude that the weapon was eventually found.

The oversight question is whether the security system prevented entry before the weapon could present a threat inside the institution.

Administrative Status and Accountability

Reporting received by Loved Ones Coalition further alleges that the employee has not been terminated and may have been reassigned to administrative or desk duties while the investigation proceeds.

LOC recognizes that employees are entitled to applicable investigative and employment procedures and that the existence of an allegation does not establish misconduct.

At the same time, an allegation involving a firearm and ammunition entering a correctional environment requires more than an informal personnel response.

The Bureau should be able to identify:

- whether the incident was formally documented;

- whether investigative authorities were notified;
- whether the employee's correctional duties were restricted;
- whether weapons-access privileges were affected;
- whether criminal referral was considered or made;
- whether disciplinary proceedings were initiated; and
- what conditions must be satisfied before any return to normal correctional duties.

The public does not need private personnel information.

But there should be accountability for an incident potentially involving a firearm inside a federal prison.

Prior Search-Procedure Allegations

Separate reporting concerning the same unidentified employee alleges prior concerns involving strip searches of incarcerated individuals.

The reporting characterizes those searches as unnecessary or excessive and alleges that the employee had previously generated concern because of the frequency or circumstances of those searches.

Loved Ones Coalition has not independently verified those allegations and does not present them as established findings.

Because the allegations involve the same employee now reportedly under investigation for a separate and extremely serious security matter, however, institutional leadership should determine whether prior complaints exist and whether those complaints were appropriately reviewed.

This is precisely why complaint history matters.

An institution should not wait until a major security incident occurs before determining whether the same employee has previously been the subject of repeated concerns.

Broader Staff-Accountability Concerns

Reporting also alleges that employees at FCI Talladega who have previously been implicated in contraband-related incidents may sometimes receive extended suspension or reassignment and later return to duty.

Loved Ones Coalition does not presently have personnel records sufficient to establish how frequently that has occurred.

That allegation nevertheless raises a legitimate systemic question:

What happens after staff are found to have violated institutional contraband rules?

The Bureau maintains significant disciplinary systems for incarcerated individuals found with contraband.

Staff misconduct involving contraband must likewise produce meaningful review and proportionate consequences.

Different employment-law procedures obviously apply to federal employees.

But due process does not eliminate accountability.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Firearm Introduction	Reporting alleges an employee was discovered bringing a firearm onto or into the institution.	Institutional Security / OIA
Ammunition	Reporting further alleges two magazines accompanied the firearm.	Weapons Control / Institutional Security
Staff Screening	The incident raises questions regarding how the weapon was detected and whether ordinary employee screening procedures functioned properly.	Correctional Services / Security
Investigative Status	Reporting indicates the matter remains under investigation.	OIA / Professional Responsibility

Duty Status	The employee is reportedly no longer performing ordinary correctional duties while review continues.	Human Resources / Institutional Administration
Prior Search Concerns	Separate allegations involving the same unidentified employee describe questionable strip-search practices.	Correctional Services / Professional Conduct
Complaint Tracking	The overlap between prior complaints and the current reported incident raises questions regarding how recurring concerns involving personnel are identified.	Institutional Administration
Staff Contraband Accountability	Reporting alleges previous staff contraband incidents have sometimes resulted in suspension followed by return to duty.	Professional Responsibility / Human Resources

3. Systemic Concerns

The Talladega reporting presents an unusually simple security principle:

A firearm should not enter a federal prison unintentionally.

The Bureau cannot simultaneously treat weapons possession by incarcerated individuals as one of the most serious institutional security threats while regarding the alleged introduction of a firearm by an employee as an ordinary personnel matter.

If the allegation is confirmed, institutional leadership should determine not only what happened to the employee involved, but how the institution's security system permitted the situation to develop at all.

That means examining screening.

Entry procedures.

Supervisor responsibility.

Weapons policies.

Employee access.

Incident reporting.

Investigative referral.

And complaint history.

There is another reason this requires comprehensive review.

When serious allegations involving an employee emerge after earlier concerns regarding that employee's conduct, leadership should determine whether information already existed that warranted closer supervision or intervention.

Loved Ones Coalition is not asserting that prior allegations predicted or caused the reported firearm incident.

We are asking whether the institution has a functioning system for identifying patterns before they become larger problems.

If staff are repeatedly accused of serious misconduct, leadership should know.

If staff are found introducing contraband, leadership should know.

If employees return to sensitive correctional duties following serious disciplinary matters, leadership should know what review supports that decision.

And if a firearm and ammunition reached institutional property in the possession of an employee, the Southeast Regional Office should know exactly how far that weapon got and exactly why.

4. Questions for Clarification

1. Did FCI Talladega recently identify an employee in possession of a firearm and ammunition while entering or present at the institution?
2. Where specifically was the firearm discovered?
3. Had the employee entered the secure perimeter when the weapon was identified?
4. Was the firearm loaded?
5. How many magazines and rounds of ammunition were present?

6. What screening procedure identified the weapon?
7. Was the weapon detected through ordinary employee screening or through another means?
8. Was the employee immediately removed from correctional duties?
9. What is the employee's present duty status?
10. Was the incident referred to the Office of Internal Affairs, Office of Inspector General, FBI, local law enforcement, or another investigative authority?
11. Was any criminal referral or arrest made in connection with the incident?
12. What Bureau policy governs an employee bringing a personally owned firearm or ammunition onto institutional property or inside the secure perimeter?
13. Has Southeast Regional leadership reviewed whether staff-entry screening procedures at FCI Talladega are sufficient to detect firearms, ammunition, drugs, cellular telephones, and other prohibited contraband?
14. Were any deficiencies in screening procedures identified as a result of this incident?
15. Has the institution reviewed prior complaints concerning the unidentified employee's search practices or other professional conduct?
16. What procedures exist for identifying employees who are repeatedly named in complaints involving searches, contraband, retaliation, force, or other serious conduct?
17. During the previous five years, how many FCI Talladega employees have been investigated for introducing or attempting to introduce contraband?
18. How many such investigations resulted in suspension, reassignment, termination, resignation, criminal referral, or eventual return to regular correctional duties?
19. What review occurs before an employee disciplined for a serious contraband-related offense is returned to a position involving direct access to incarcerated individuals?
20. What corrective measures has FCI Talladega implemented following the reported firearm incident?

SOUTH CENTRAL REGION

FMC FORT WORTH — TEXAS

Worsening Moisture Intrusion, Apparent Fungal Growth, Deteriorating Walls, Environmental Health, Deferred Maintenance, and Conditions Within a Federal Medical Center

1. Summary of Concerns

Loved Ones Coalition is again documenting serious environmental and infrastructure concerns at FMC Fort Worth.

This is not the first time.

Over the past year, LOC has received and submitted repeated photographic documentation from this institution depicting water intrusion, damaged ceilings and walls, exposed infrastructure, deteriorating building materials, apparent organic growth, unfinished maintenance work, and other environmental concerns within occupied areas. Previous LOC reporting already identified moisture damage and apparent organic growth at FMC Fort Worth and specifically questioned whether conditions were being adequately remediated.

The current photographs indicate that the underlying problem is not improving.

It appears to be getting worse.

New photographs provided to Loved Ones Coalition depict substantial moisture-related deterioration along interior wall surfaces, including extensive blistering and bubbling of paint or wall coating, separation and peeling of finish material, dark discoloration within wall seams, brown moisture staining, and black organic material protruding directly from a deteriorated wall joint.

Reporting accompanying the photographs describes the material as mushrooms growing from the wall.

Loved Ones Coalition cannot determine biological species from photographs alone and will not characterize the material as laboratory-confirmed mold or any particular fungal organism.

But we also do not need a laboratory report to recognize what these photographs show:

Something organic is visibly growing out of a wall inside an occupied federal medical institution.

That should not be normal.

Apparent Fungal Growth and Moisture Intrusion

Several photographs show dark, stem-like and cap-like organic material emerging from a wall seam surrounded by extensive brown staining and deteriorated building material.

Other photographs show widespread bubbling, blistering, peeling, and separation across the adjacent wall surface.

Taken together, the images strongly suggest prolonged moisture exposure within or behind the wall assembly.

The precise source of that moisture cannot be determined visually.

It could involve plumbing leakage.

Roof or exterior-envelope intrusion.

Condensation.

HVAC-related moisture.

A hidden leak.

Or another source.

That determination belongs to qualified Facilities and Environmental Health personnel.

But the visible damage is not subtle.

Paint does not ordinarily bubble across large wall sections without an underlying condition.

Wall seams do not ordinarily remain dark, wet-stained, and deteriorated.

And organic growth does not emerge from building materials in a properly maintained dry interior environment.

This Is a Federal Medical Center

That distinction matters.

FMC Fort Worth is not simply another federal correctional institution.

It is a Federal Medical Center housing individuals with significant medical needs.

LOC has already raised concerns involving delayed medical evaluation and deteriorating environmental conditions at this facility. Previous reporting emphasized that conditions at a federal medical center should remain safe, sanitary, and consistent with the institution's healthcare mission.

That makes the current documentation especially difficult to understand.

This is where the Bureau houses sick people.

Individuals with chronic illnesses.

Individuals with compromised health.

Individuals requiring ongoing medical treatment.

Individuals who may be more vulnerable to poor environmental conditions than the general population.

And LOC is now receiving photographs of apparent fungal growth emerging from deteriorated interior walls.

At some point the question becomes painfully simple:

Is this really the physical environment the Bureau considers appropriate for housing medically vulnerable people?

Repeated Documentation Without Meaningful Improvement

The most troubling part of the current Fort Worth reporting is not the appearance of one damaged wall.

It is the history.

LOC has sent photographs from this institution repeatedly.

Previous documentation showed missing ceiling materials, exposed wiring, unfinished repairs, moisture damage, deteriorated surfaces, apparent organic growth, and other physical-plant concerns.

Now the documentation shows conditions severe enough that organic material is reportedly growing directly from the building structure.

That suggests the problem is moving in the wrong direction.

The Bureau cannot continue responding to visible moisture damage as a cosmetic issue.

Painting over a wall does not stop water intrusion.

Scraping away damaged material does not identify the source.

Removing visible growth does not remediate a wet wall cavity.

And repeatedly repairing the surface while moisture remains behind it simply guarantees that the problem will return.

If this institution has been experiencing repeated water intrusion for months or years, then Facilities personnel should already know where the water is coming from.

If they do not, that itself is an oversight problem.

Environmental Health and Habitability

The current photographs raise legitimate questions concerning:

- hidden moisture within wall assemblies;
- fungal or microbial growth;
- deterioration of drywall, insulation, framing, or other interior materials;
- indoor air quality;
- plumbing or roof leakage;
- HVAC moisture control;

- sanitation;
- whether affected areas remain occupied; and
- whether medically vulnerable individuals are being housed immediately adjacent to these conditions.

Loved Ones Coalition is not diagnosing an environmental hazard from a photograph.

We are saying the obvious:

The photographed condition requires professional environmental assessment.

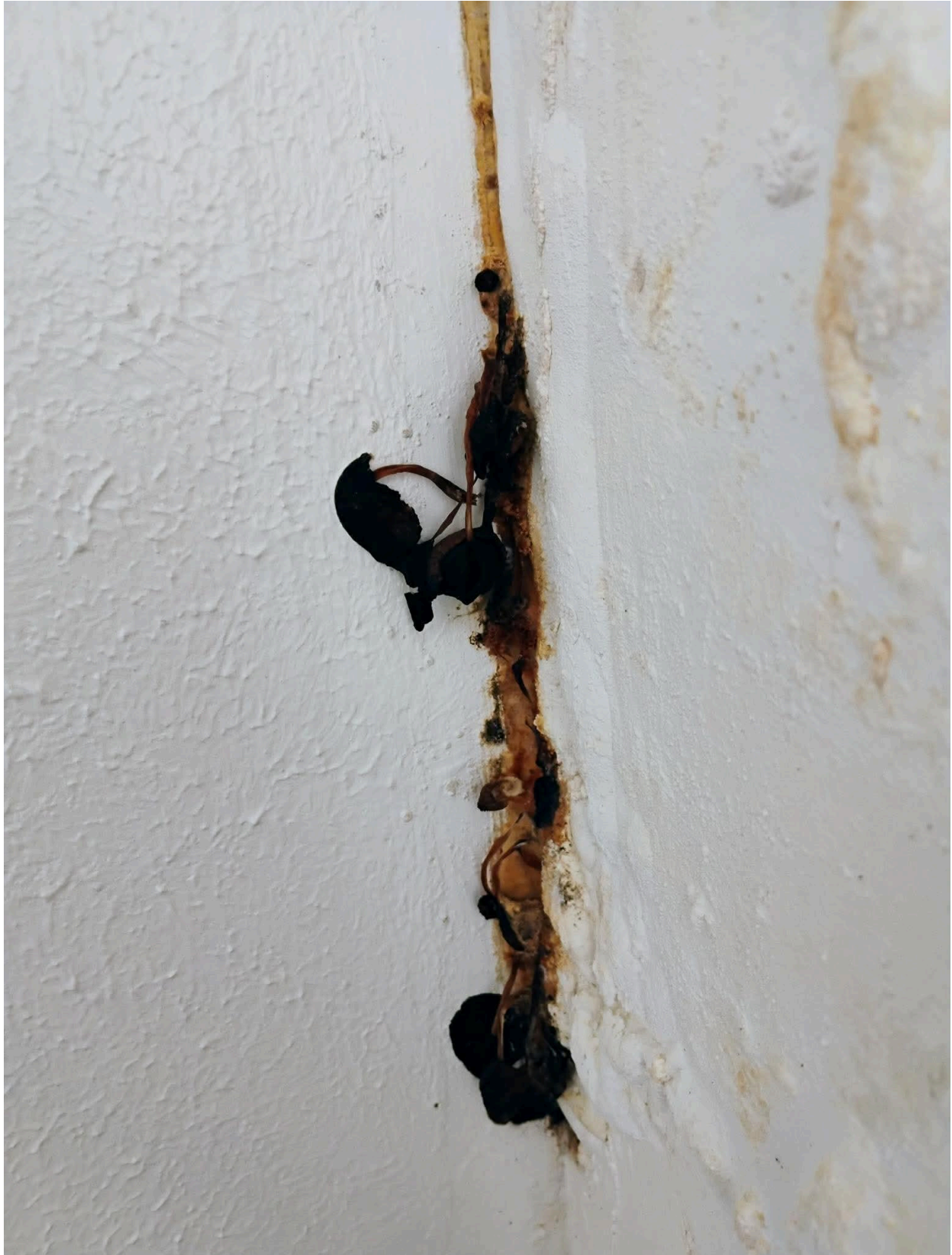
Not another coat of paint.

Not another patch.

Not another temporary repair.

An actual assessment.

2. Photographic Documentation









The current photographs depict:

- dark organic material protruding from an interior wall seam;
- extensive brown and yellow moisture staining along the seam;
- substantial bubbling and blistering across painted wall surfaces;
- peeling and separating wall finish;
- deterioration extending across a significant portion of the wall;
- dark discoloration around seams and affected materials; and
- debris from deteriorating wall finishes accumulating below the affected surface.

Loved Ones Coalition cannot determine from photographs alone the age, species, toxicity, or environmental composition of the visible organic material.

Those questions require inspection and, where appropriate, testing.

The photographs nevertheless directly establish significant moisture-related building deterioration requiring corrective action.

3. Key Concern Table

Concern Area	Description	Potential Concern Area
Apparent Fungal Growth	Photographs depict dark organic material reportedly growing directly from an interior wall seam.	Environmental Health
Moisture Intrusion	Brown staining and deteriorated seams suggest persistent moisture exposure.	Facilities / Physical Plant
Wall Deterioration	Extensive bubbling, blistering, peeling, and separation are visible across wall surfaces.	Facility Maintenance

Recurring Conditions	LOC has previously documented moisture damage and apparent organic growth at FMC Fort Worth.	Preventative Maintenance
Medical Population	Environmental deterioration is occurring within a federal medical center housing individuals with significant health needs.	Health Services / Environmental Health
Possible Hidden Damage	Visible surface deterioration raises questions regarding moisture or microbial growth within wall cavities.	Facilities / Environmental Health
Remediation Effectiveness	Continued deterioration raises concern that prior repairs have not addressed the underlying moisture source.	Institutional Administration
Habitability	Current conditions raise questions regarding whether affected spaces remain appropriate for continued occupancy.	Conditions of Confinement

4. Systemic Concerns

FMC Fort Worth has moved beyond the point where individual maintenance requests are enough.

LOC has documented this institution repeatedly.

We have submitted photographs.

We have documented moisture intrusion.

We have documented damaged ceilings.

We have documented exposed infrastructure.

We have documented deteriorating walls.

We have documented apparent organic growth.

And now we have photographs of material reportedly growing **out of the wall itself**.

How many photographs are necessary before this becomes a comprehensive facility-condition problem?

At what point does the Bureau stop treating each new damaged surface as a separate work order and examine the building systems creating the damage?

This is precisely how deferred maintenance compounds.

Water enters.

Drywall absorbs it.

Paint bubbles.

Materials deteriorate.

Organic growth develops.

Another patch is applied.

The moisture returns.

And the occupied building continues deteriorating around the people housed inside it.

That approach is unacceptable anywhere.

It is especially unacceptable in a federal medical center.

FMC Fort Worth exists specifically to house individuals requiring enhanced healthcare services.

The physical environment should reflect that mission.

Instead, LOC continues receiving documentation suggesting that portions of the institution are deteriorating faster than they are being repaired.

That requires more than another maintenance ticket.

It requires South Central Regional attention and a comprehensive environmental and facilities review.

5. Questions for Clarification

1. Have Facilities and Environmental Health personnel inspected the wall areas depicted in the current photographs?
2. Has the dark organic material protruding from the wall been collected, identified, or tested?
3. What is the source of the moisture responsible for the extensive bubbling, staining, and deterioration visible in these areas?
4. Has the affected wall cavity been opened and inspected to determine the extent of hidden moisture damage?
5. Have surrounding materials been evaluated for mold, fungal growth, microbial contamination, deterioration, or other moisture-related damage?
6. Are the affected areas presently occupied by incarcerated individuals?
7. Are medically vulnerable individuals housed immediately adjacent to the photographed conditions?
8. Has indoor air quality been evaluated within affected housing or treatment areas?
9. How many active work orders at FMC Fort Worth currently involve roof leaks, plumbing leaks, water intrusion, moisture damage, mold, suspected microbial growth, ceilings, or deteriorating wall systems?
10. How many of those concerns have remained unresolved for more than 30, 60, 90, or 180 days?
11. What repairs were previously completed in areas where LOC documented moisture damage and apparent organic growth?
12. Why have environmental conditions continued to deteriorate despite prior reporting and maintenance activity?
13. Has the institution conducted a comprehensive moisture-intrusion assessment rather than responding to affected surfaces individually?
14. Has South Central Regional leadership physically inspected the environmental conditions documented at FMC Fort Worth?
15. What corrective action is currently underway?
16. What is the timeline for permanent remediation?
17. If the Bureau maintains that the affected areas remain appropriate for medically vulnerable individuals to occupy, what environmental assessment supports that conclusion?

We have sent enough pictures from Fort Worth.

The next photographs should show repaired walls.

Dry building materials.

Completed ceilings.

Corrected leaks.

And a medical facility that actually looks appropriate for housing people who are sick.

Not mushrooms growing out of the walls.

SOUTH CENTRAL REGION

FCC FORREST CITY — FCI FORREST CITY MEDIUM — ARKANSAS

Unit-Team Staffing and Case-Management Delays, Community-Placement Planning, Halfway-House Dates, Food-Service Adequacy, and Continuing Institutional Dysfunction

1. Summary of Concerns

Loved Ones Coalition continues to receive reporting from FCI Forrest City Medium, this time raising concerns involving unit-team operations, case-management staffing, delayed community-placement planning, prolonged uncertainty surrounding halfway-house dates, and food-service adequacy.

These concerns arrive immediately following LOC's extensive special reporting on FCC Forrest City and add another dimension to the problems already documented at the complex.

The physical deterioration at Forrest City has been extensively documented.

The current reporting raises a different question:

Are the administrative systems responsible for getting people out of the institution functioning any better than the physical systems keeping the institution running?

Reporting received by Loved Ones Coalition alleges that individuals approved for or anticipating community placement have experienced prolonged delays obtaining projected halfway-house or Residential Reentry Center dates.

Some individuals are reportedly waiting many months for basic information concerning when they may transition from secure custody, with reporting alleging that certain individuals have remained without a clear placement date for approximately one year.

Additional reporting alleges that some housing units lack consistent access to either a case manager, correctional counselor, or both, creating further difficulty for individuals attempting to obtain answers regarding release planning, community placement, sentence administration, paperwork, and other unit-team responsibilities.

Separately, LOC received photographs reportedly depicting meals distributed at FCI Forrest City Medium that appear extremely limited in variety and quantity.

The photographs include combinations consisting largely of bread, cereal, fruit, an egg, and limited accompanying items. One submission specifically raised concern that a meal consisted of cereal and bread without milk.

Loved Ones Coalition cannot calculate caloric content, nutritional adequacy, serving weights, or menu compliance from photographs alone.

But the Bureau can.

And considering Forrest City's extensive history of food-service, sanitation, infrastructure, and operational concerns, these photographs warrant review rather than dismissal as another isolated complaint.

Unit-Team Staffing and Access

Reporting received by Loved Ones Coalition alleges significant gaps in unit-team staffing at FCI Forrest City Medium.

Individuals report that some units may lack an assigned case manager or counselor for meaningful periods, while others describe difficulty obtaining responses from existing unit-team personnel.

That is not a minor administrative inconvenience.

Unit teams are responsible for matters directly affecting an incarcerated individual's progression through federal custody, including classification, release preparation, sentence-related documentation, programming, community placement, administrative requests, and communication concerning future custody decisions.

When those positions are vacant, inaccessible, or overwhelmed, the consequences accumulate.

Paperwork waits.

Questions go unanswered.

Placement planning stalls.

Release-related decisions become increasingly uncertain.

And the incarcerated person absorbs the consequences of an administrative system he has no ability to replace.

If staffing vacancies exist, that is a Bureau workforce problem.

It should not become additional incarceration by administrative delay.

Halfway-House and Community-Placement Delays

The most significant administrative concern involves individuals reportedly waiting extended periods for halfway-house or community-placement information.

Reporting alleges that some individuals who expected to transition toward community custody remain without firm dates for months, with at least some cases reportedly extending toward a year.

Loved Ones Coalition is not asserting that every individual reporting a delay is legally entitled to placement on a particular date.

Community-placement decisions involve individualized assessments, statutory considerations, bed availability, release planning, and other legitimate administrative factors.

But people should be able to receive an answer.

If a person is not being placed yet, explain why.

If the referral is pending, identify where it is pending.

If RRC bed space is unavailable, say that.

If additional documentation is required, identify it.

If a decision has been made, communicate it.

What should not happen is for people approaching release to remain in an indefinite administrative holding pattern because no one can tell them where their case stands.

The Bureau has placed enormous emphasis on reentry.

Reentry cannot begin with “we don’t know when you’re leaving because nobody has processed it.”

Release Planning Is an Operational Responsibility

The consequences of delayed community-placement decisions extend beyond inconvenience.

Families make plans.

Housing arrangements are made.

Employment opportunities may depend upon anticipated transition dates.

Treatment and healthcare continuity may require coordination.

Transportation must be arranged.

Identification documents may be needed.

Supervision requirements must be understood.

And individuals preparing to return to the community need enough certainty to build an actual transition plan.

If someone has spent years in federal custody, the final months should not be consumed by unanswered questions because a housing unit lacks adequate case-management staffing.

The Bureau expects incarcerated people to plan responsibly for release.

The Bureau has the same responsibility.

Food-Service Documentation

Loved Ones Coalition also received multiple photographs reportedly depicting meals currently being distributed at FCI Forrest City Medium.

The photographs appear to show meals consisting of limited combinations such as:

- cereal;
- sliced bread;
- fruit;
- a boiled egg;

- small packaged items; and
- other relatively limited breakfast components.

One submitted image shows cereal apparently served in a plastic container with bread separately packaged. Another depicts bread, an apple, an egg, and a substantial quantity of dry cereal within a foam tray. A separate photograph similarly depicts bread, cereal, fruit, and a small packaged butter portion.

LOC cannot determine from photographs whether additional items were distributed separately or whether the photographed meals represent complete trays.

We therefore will not claim from images alone that the meals fail nutritional requirements.

But these are exactly the kinds of questions that Food Service records can answer.

Production sheets exist.

Approved menus exist.

Serving-size requirements exist.

Nutritional calculations exist.

The institution should compare those records to what was actually distributed.

A Continuing Pattern at Forrest City

Food service at FCC Forrest City has already appeared repeatedly in LOC reporting.

So has staffing.

So has infrastructure.

So has sanitation.

So has medical access.

So has administrative responsiveness.

That cumulative history matters.

Loved Ones Coalition recently devoted an entire special investigation to Forrest City because the volume of evidence had reached a point where individual maintenance complaints could no longer reasonably be considered in isolation.

The current Medium reporting reinforces the same broader concern from another direction.

A federal correctional institution is not functioning properly merely because the doors lock and the count clears.

A functioning institution must maintain its buildings.

Feed people adequately.

Provide healthcare.

Operate its programs.

Staff its unit teams.

Process release-related decisions.

And move eligible people through the custody system without avoidable administrative paralysis.

When failures repeatedly appear across unrelated departments, the question becomes one of institutional management, not isolated employee performance.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
Unit-Team Staffing	Reporting alleges some housing units lack consistent case-manager or counselor coverage.	Correctional Programs / Staffing
Case-Management Access	Individuals report difficulty obtaining answers regarding release and community-placement planning.	Unit Management

RRC / Halfway-House Dates	Reporting alleges individuals remain without placement dates for extended periods.	Reentry Services / Community Placement
Extended Administrative Delays	Some reported delays allegedly approach one year.	Correctional Programs / Reentry
Release Planning	Uncertainty may interfere with housing, employment, transportation, treatment, and family preparation.	Reentry / Unit Team
Food-Service Adequacy	Photographs depict limited combinations of cereal, bread, fruit, eggs, and related breakfast items.	Food Service
Menu Compliance	Photographs warrant comparison with approved menus, production sheets, and serving requirements.	Food Service / Nutrition
Institutional Management	Concerns add to recurring reports across infrastructure, sanitation, medical, food-service, and administrative systems at Forrest City.	Institutional / Regional Oversight

3. Photographic Documentation







Loved Ones Coalition is including photographs reportedly depicting meals distributed at FCI Forrest City Medium.

The images should not be used to make unsupported nutritional calculations.

They should be used to ask a much simpler factual question:

Do these photographs accurately represent complete meals currently being served, and if so, do those meals match the Bureau's approved menu and required portions?

That can be answered through institutional records.

Rather than debating whether a tray "looks small," Food Service should identify the prescribed menu, required serving quantities, actual production records, and nutritional values for the meals depicted.

If something was missing from the photograph because it was distributed separately, the Bureau can document that as well.

LOC is interested in accuracy, not exaggeration.

4. Systemic Concerns

Forrest City is increasingly becoming an example of what happens when problems in separate departments are allowed to accumulate.

A broken ceiling is a Facilities problem.

A sewage leak is a plumbing problem.

A missed medication is a Health Services problem.

A questionable meal is a Food Service problem.

An unanswered halfway-house referral is a unit-team problem.

Until all of them are occurring inside the same institution.

Then it becomes a leadership problem.

The reporting concerning community placement deserves particular attention because this is one of the few institutional processes where administrative dysfunction can directly affect how long someone remains in secure federal custody.

Again, LOC is not claiming that every person awaiting an RRC date is being unlawfully confined.

We are saying that release-related processing should not disappear into an administrative void.

The Bureau should know how many people are awaiting referrals.

How long they have been waiting.

Whether staffing vacancies are producing backlogs.

Where those referrals are sitting.

And why some individuals report approaching release without clear information about what happens next.

That information should already exist.

If it does not, that is part of the problem.

5. Questions for Clarification

1. How many case-manager and correctional-counselor positions at FCI Forrest City Medium are presently vacant?
2. Are any housing units currently operating without a permanently assigned case manager or counselor?
3. If so, how long have those vacancies existed?
4. What coverage is provided to individuals assigned to units experiencing staffing vacancies?
5. How many individuals at FCI Forrest City Medium are presently awaiting RRC, halfway-house, home-confinement, or other community-placement determinations?
6. What is the current average processing time between referral initiation and communication of a placement decision?
7. How many referrals have remained unresolved for more than 30, 60, 90, 180, or 365 days?
8. Are staffing shortages contributing to delays in community-placement referrals or release planning?
9. What mechanism allows individuals to determine the current status of their referral when their assigned unit-team position is vacant?
10. Has South Central Regional leadership reviewed whether unit-team staffing at Forrest City Medium is sufficient to process release-related work within appropriate timeframes?
11. Do the meals depicted in LOC's current photographic documentation represent complete meals distributed at FCI Forrest City Medium?
12. What approved menus correspond to the photographed meals?
13. What serving quantities and nutritional values were required for those meals?
14. Were milk or other items intended to accompany the photographed cereal meals, and if so, were they distributed separately?
15. Have Food Service production sheets and actual meal distribution recently been reviewed for consistency?
16. Given the continuing reporting across numerous departments at FCC Forrest City, has South Central Regional leadership conducted a broader operational assessment of FCI

Forrest City Medium, separate from individual facilities work orders or isolated departmental complaints?

17. What specifically is being done to correct the recurring operational problems that LOC continues documenting from this complex?

WESTERN REGION

FCI SHERIDAN — SATELLITE CAMP — OREGON

Visitor Search and Detention Concerns, Retention of Identification, Repeated Negative Searches, Uncertain Visitation Status, Subsequent SHU Placement, and Retaliation Safeguards

1. Summary of Concerns

Loved Ones Coalition received detailed documentation concerning a September 26, 2026 visit at FCI Sheridan Camp involving a visitor who subsequently filed a formal complaint with the institution, a FOIA/Privacy Act request, a complaint to the DOJ Office of Inspector General, and a signed declaration describing the incident.

The documentation raises concerns regarding visitor screening, retention of identification, repeated searches following an initial negative search, communication with outside law enforcement, treatment of a family after the visit, uncertainty regarding future visitation, and the subsequent placement of the incarcerated individual in the Special Housing Unit.

Because this matter is now documented through multiple written submissions, LOC is not relying solely on an informal account.

At the same time, several important facts remain unresolved.

The submitted materials do not establish whether the visitor's identification was actually misplaced, whether its retention was intentional, what information formed the basis for the contraband allegation, whether any formal visitation restriction was imposed, what the incarcerated individual's urine-test result was, or what official basis was used for his subsequent placement in SHU.

Those issues require independent review.

Visitor Search and Retention of Identification

According to the signed declaration, the visitor was searched upon entry after staff advised that information had been received alleging that she was bringing contraband into the institution.

No contraband was reportedly found during that entry search.

Following completion of the visit, however, the visitor states that her identification was not returned for approximately 45 minutes and that she was told:

“We lost your ID.”

During that period, she reports repeatedly asking for the identification back and explaining that her two children were waiting in the vehicle and could not tolerate an extended delay.

The visitor’s documentation states that a lieutenant later arrived at approximately the same time as a state trooper.

Her identification was ultimately returned before the later vehicle searches occurred.

The central oversight question is straightforward:

Was the identification genuinely misplaced, or was it retained in order to prevent or delay the visitor’s departure while additional investigative steps were being arranged?

LOC does not presently know the answer.

That is precisely why the records should be preserved and independently reviewed.

Multiple Searches With No Reported Contraband

The documentation describes multiple layers of screening and search activity.

The visitor reports that:

- she was searched upon entry and no contraband was found;
- she later requested that a state trooper search her vehicle;
- that search reportedly found no contraband; and
- BOP personnel subsequently conducted another vehicle search, which also reportedly found no contraband.

The existence of repeated negative searches matters.

Security staff are entitled to investigate credible information regarding contraband.

But once searches repeatedly fail to corroborate an allegation, supervisory review should determine whether continued detention, additional searching, or future visitation restrictions remain supported by an articulable factual basis.

An accusation is not proof.

And repeated negative searches should become part of the institutional record just as clearly as the original allegation.

Involvement of Outside Law Enforcement

The visitor's declaration also describes the arrival of a state trooper during the post-visit delay.

According to her account, the trooper questioned whether he should have been called and discussed jurisdictional concerns regarding the federal property.

LOC is not treating that conversation as a legal finding.

It does, however, raise a legitimate question regarding why outside law enforcement was contacted, what information was provided, and what authority or operational need supported that request.

Those facts should be ascertainable from dispatch records, staff communications, incident logs, and any preserved call records.

Uncertain Future Visitation Status

The visitor reports that after the searches produced no contraband, she was nevertheless told to call before returning because she might not be permitted to visit again.

That is a serious concern.

If a visitor has been formally suspended or restricted, the institution should provide a clear written basis, identify the authorizing official, state the effective period, and explain any available reconsideration or review process.

If no formal restriction exists, that should also be communicated clearly.

A family should not be left in a state of uncertainty where the answer is essentially:

Call us next time and find out whether we let you in.

Visiting restrictions should be documented, individualized, and reviewable.

Subsequent SHU Placement

Additional reporting provided to Loved Ones Coalition indicates that the incarcerated individual was called forward after the visit to provide a urine sample, returned to the yard, and was later placed in the Special Housing Unit.

The information presently available does **not** establish the urine-test result.

It also does not establish the official reason for SHU placement.

LOC is therefore not presenting either a positive test or a substantiated disciplinary violation as fact.

The concern is the sequence.

A visitor is accused of bringing contraband.

Multiple searches reportedly locate nothing.

The incarcerated individual is then tested and later placed in SHU.

That sequence warrants verification because it raises the possibility of pretext, collective punishment, retaliatory action, or administrative detention unsupported by substantiated evidence.

That does not mean those things occurred.

It means the Bureau should be able to produce the actual basis for what happened next.

Disability-Related Family Concerns

The documentation also states that the visitor informed staff that her two children had disabilities and were struggling with the extended wait.

Regardless of the legitimacy of the underlying security inquiry, supervisory review should determine whether that information was considered appropriately and whether reasonable accommodations or practical assistance could have reduced the burden on the family while preserving legitimate security measures.

Families visiting federal institutions already face substantial logistical burdens.

Security procedures may be necessary.

Unnecessary confusion, unexplained delays, and uncertainty about whether they will be permitted to return are not.

2. Key Concern Table

Concern Area	Description	Potential Concern Area
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Visitor Screening	Visitor was reportedly searched following a contraband allegation; no contraband was found.	Visiting / Correctional Services
ID Retention	Identification was reportedly withheld for approximately 45 minutes after the visit.	Visiting Operations / Staff Conduct
Repeated Searches	State police and BOP vehicle searches reportedly also produced no contraband.	Institutional Security / Visiting
Outside Law Enforcement	Records should clarify why state police were contacted and what information was provided.	Institutional Administration
Visiting Status	Visitor was reportedly told she might not be permitted to return but received no clear written restriction.	Visiting / Due Process
SHU Placement	Incarcerated individual was subsequently placed in SHU; official basis remains unclear from current documentation.	Special Housing / Institutional Operations
Urine Testing	Reporting indicates a urine sample was requested, but the result is not established	Correctional Services / Health Services

	in the materials currently available.	
Retaliation Concerns	Sequence of events raises concern regarding whether adverse action followed an unsubstantiated contraband allegation.	Staff Accountability
Disability Accommodation	Visitor reported that her children had disabilities and difficulty tolerating the extended delay.	Visiting / Accessibility

3. Documentary Record

This matter is supported by an unusually substantial paper trail.

The materials provided to LOC include:

- a formal visitor complaint;
- a signed visitor declaration;
- a FOIA/Privacy Act records request;
- a DOJ Office of Inspector General complaint;
- requests for preservation of surveillance, staff communications, ID-handling records, search logs, visitor-status records, and law-enforcement communications; and
- written correspondence requesting supervisory review of the incarcerated individual's SHU placement and the visitor's future visiting status.

That documentation matters because the key factual disputes should be resolvable from existing records.

Either the identification was logged as lost or it was not.

Either a visitation restriction exists or it does not.

Either the searches were negative or they were not.

Either a documented basis exists for SHU placement or it does not.

This does not require speculation.

It requires the Bureau to look at its own records.

. Questions for Clarification

1. What information formed the basis for the allegation that the visitor was bringing contraband into FCI Sheridan Camp on September 26, 2026?
2. What corroboration, if any, existed before the visitor was subjected to enhanced screening?
3. Was the visitor's identification actually misplaced after the visit?
4. If so, where was it located and why did approximately 45 minutes pass before it was returned?
5. If it was not actually lost, why was the visitor told that it was?
6. Was the visitor considered free to depart while staff retained her identification?
7. Why was outside law enforcement contacted?
8. What information was communicated to state police before their arrival?
9. Did the state-police vehicle search result in the discovery of any contraband?
10. Did the subsequent BOP vehicle search result in the discovery of any contraband?
11. Were those negative results documented in the institution's investigative records?
12. Has any formal visitation suspension, restriction, or removal been imposed on the visitor?
13. If so, what is the non-confidential basis, who authorized it, when did it become effective, and what review or reconsideration procedure is available?
14. If no formal restriction exists, why was the visitor advised that she might not be allowed to return?
15. What was the official reason for the incarcerated individual's subsequent placement in SHU?
16. What was the result of the reported urine test?
17. Was SHU placement based on the test result, an incident report, an investigation, administrative detention, or another basis?
18. Has the incarcerated individual received the required written explanation and periodic review of his SHU status?
19. Does a continuing authorized basis for segregation presently exist?
20. Has Western Regional leadership reviewed whether the visitor complaint and the incarcerated individual's subsequent treatment raise retaliation or pretext concerns?
21. Were the visitor's statements regarding her children's disabilities documented and considered during the extended delay?
22. What accommodations or procedures are available when a visitor responsible for children with disabilities is subjected to an extended post-visit security delay?
23. Have relevant surveillance, ID-handling records, visitor logs, search records, staff communications, law-enforcement communications, and visitor-status records been preserved?

Requested Action

Loved Ones Coalition requests independent supervisory review by personnel not directly involved in the September 26 incident; preservation of all relevant records; written clarification of the visitor's current visiting status; review of the factual and policy basis for the incarcerated individual's SHU placement; confirmation of the urine-test result and any resulting disciplinary process; and assurance that good-faith complaints or requests for review will not result in retaliation against the visitor, her children, or the incarcerated individual.

Security concerns should be investigated.

But once the searches come back negative, the Bureau still has to follow the evidence.

An accusation cannot become its own proof.