FOR IMMEDIATE RELEASE

DOJ OIG Releases Report of Investigation and Review of the Federal Bureau of Prisons' Handling of the Transfer of Inmate James "Whitey" Bulger

Department of Justice (DOJ) Inspector General Michael E. Horowitz announced today the release of a report regarding the DOJ Office of Inspector General's (OIG) Investigation and Review of the Federal Bureau of Prisons' (BOP) Handling of the Transfer of Inmate James "Whitey" Bulger from U.S. Penitentiary (USP) Coleman II (Coleman) to USP Hazelton (Hazelton). Bulger died in BOP custody at Hazelton on October 30, 2018. Bulger, who was 89 years old, used a wheelchair, and had heart conditions, had been housed at Hazelton for less than 12 hours before he died. On August 18, 2022, three individuals, all inmates at the time of Bulger's death, were criminally charged in connection with his death.

Background

The OIG initiated this investigation and review following questions regarding Bulger's death based on the following circumstances:

- Bulger's transfer to Hazelton and placement in the general population appeared unusual in view of his age, his health, his notoriety and history as an FBI informant, and the record of violence among inmates at that facility. His violent death less than 12 hours after arriving at Hazelton affirmed these concerns.
- Days before Bulger was transferred to Hazelton, news stories were already reporting of his impending transfer.
- BOP documentation showed that the BOP's transfer of Bulger from Coleman to Hazelton was based on a determination that he required a lower level of medical care than he was receiving at Coleman. This determination was made even though he was elderly and continued to suffer from cardiac-related health problems which required medical intervention at Coleman and for which hospitalization was frequently recommended.

Findings

The DOJ OIG did not find that any BOP employees acted with a malicious intent or an improper purpose. However, we identified serious job performance and management failures at multiple levels within the BOP as well as confusing and insufficient BOP policies and procedures. The specific management and performance failures we identified included:

- BOP personnel did not adequately communicate and were confused about the transfer process.

- BOP medical professionals did not adequately review Bulger's medical records and failed to consider Bulger's ongoing cardiac and other medical incidents when making decisions about his medical care level and transfer.
- BOP officials did not accurately represent Bulger's medical condition in BOP transfer paperwork.
- The BOP did not timely update Bulger's medical care level.
- BOP Medical Care Level Guidelines were flawed and lacked clarity.
- Due to BOP's standard procedures, well over 100 BOP officials were made aware in advance of Bulger's impending transfer to Hazelton.
- BOP personnel spoke openly about Bulger's upcoming arrival in the presence of Hazelton inmates, which was contrary to BOP policy and subjected Bulger, due to his history, to enhanced risk of imminent harm upon his arrival at Hazelton.
- The steps taken by BOP personnel to assess whether Bulger faced harm from other inmates at Hazelton were lacking.

Moreover, we found it deeply troubling that BOP personnel placed an 89-year-old BOP inmate who used a wheelchair and had serious heart conditions in a single cell in the Special Housing Unit (SHU) at Coleman for 8 months while the BOP was bureaucratically struggling with deciding how to transfer him to a new facility. This lengthy SHU placement caused Bulger to state in a Psychology Services Suicide Risk Assessment that "he had lost the will to live," and may have affected his persistence upon arriving at Hazelton with his request to be assigned to general population.

The fact that the serious deficiencies we identified occurred in connection with a high-profile inmate like Bulger was especially concerning given that the BOP would presumably take particular care in handling such an inmate's case. We found that did not occur here, not because of an improper intent or failure to comply with BOP policy, but rather because of staff and management performance failures; bureaucratic incompetence; and flawed, confusing, and insufficient policies and procedures. In our view, no BOP inmate's transfer, whether they are a notorious offender or a non-violent offender, should be handled like Bulger's transfer was handled in this instance.

The DOJ OIG made eleven recommendations to the BOP to address the concerns we identified. The BOP agreed with all eleven recommendations.

Report: Today's memorandum and an interactive timeline of key events are available on our website at the following link: https://oig.justice.gov/reports/investigation-and-review-federal-bureau-prisons-handling-transfer-inmate-james-whitey

Video: To accompany today's report, the OIG has released a 2-minute video of the Inspector General discussing the report's findings. The video and a downloadable transcript are available at the following link: https://oig.justice.gov/news/multimedia/video/message-inspector-general-report-investigation-and-review-federal-bureau