Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Sheridan

★ ★ ★

EVALUATION AND INSPECTIONS DIVISION

24-070

MAY 2024

Executive Summary

The DOJ OIG's Inspections Program

Between Monday, November 27, and Friday December 1, 2023, the Department of Justice (DOJ) Office of the Inspector General (OIG) conducted an unannounced, on-site inspection of Federal Correctional Institution (FCI) Sheridan in Oregon. The institution is composed of three sub-facilities: a medium-security prison, a minimum-security prison camp, and a detention center. All three of these facilities house male inmates

This was the third unannounced inspection of a Federal Bureau of Prisons (BOP) institution under the OIG's new on-site inspections program. The first two institutions we inspected, FCI Waseca and FCI Tallahassee, housed female inmates. We selected FCI Sheridan as the site of our third inspection because we wanted to better understand and assess the conditions of confinement for male inmates. We also note that the OIG's BOP Interdisciplinary Team (which facilitates inter-OIG collaboration on BOP oversight issues) contributed to the inspection team's site selection decision.

We identified significant issues at FCI Sheridan, many of which were consistent with BOP-wide issues on which we have made recommendations in prior work. Because those prior recommendations direct the BOP to address these issues at an enterprise level, we do not make new ones in this report but instead repeat our prior ones and highlight throughout this report how those prior recommendations relate to FCI Sheridan. Through our efforts to resolve those recommendations, we will monitor the BOP's efforts to address these issues at all of its institutions, including FCI Sheridan.

Our unannounced inspection identified several serious safety and security issues at FCI Sheridan affecting both employees and inmates. Most significantly, substantial shortages of Correctional Officers and healthcare workers—which is an issue at many BOP institutions—have created widespread and troubling operational challenges at FCI Sheridan that substantially impact the health, welfare, and safety of employees and inmates.

For example, healthcare staffing challenges seriously impact FCI Sheridan's ability to provide adequate healthcare to inmates. In particular, this affects the performance of routine, daily functions such as drawing blood for laboratory tests, triaging patient requests for care, and ensuring that medical equipment and supplies are ready to be used for routine care and in the event of a medical emergency. Especially alarming was our finding that the institution had a backlog of 725 laboratory orders for blood draws or urine collection and 274 pending x-ray orders. These backlogs cause medical conditions to go undiagnosed and leave providers unable to appropriately treat patients. Specifically, an FCI Sheridan physician told us that the backlog of laboratory orders for blood draws or urine collection has compromised his ability to treat patients and has prevented him from monitoring the effects of medication on his patients' kidney and liver functions. These limitations are concerning for the treatment of any medical condition, but especially concerning for the treatment of chronic conditions, such as diabetes and hepatitis C, that regularly affect inmates. We note that FCI Sheridan took action to decrease these backlogs after our on-site inspection and after we expressed concern about these issues to the BOP; as of May 2024, the backlog of laboratory orders stood at 44 and the backlog of pending x-ray orders stood at 84.

Delayed medical treatment can lead to more serious medical conditions for an inmate, as well as substantially increased costs for the institution. For example, we found that, just prior to our inspection, an inmate feigned a suicide attempt in order to receive medical attention for an untreated ingrown hair that had become infected. When finally examined after the feigned suicide attempt, he required hospitalization for 5 days to treat the infection. Separately, while not directly

related to staff shortages, we also observed a variety of potentially dangerous medication distribution practices.

We also found that, due to substantial staff shortages, FCI Sheridan did not always have available Correctional Officers to escort inmates to external medical providers. At the time of our inspection, 101 outside appointments had been canceled between January and November 2023 due to the lack of available employees to escort inmates to these appointments. We note that, after receiving a draft of the report, the BOP reported that 89 of the 101 consultations had been completed since our inspection.

Additionally, due to a critical shortage of dental equipment and supply items, dental care at FCI Sheridan was limited to intake examinations, clinical examinations, and walk-in clinic triage. As a result of these modified operations, in October 2023 approximately 350 inmates were on a waitlist for routine dental care and 41 percent had been on the waitlist for 2 years or more.

Further, we found that Psychology Services Department and Education Department staff shortages resulted in significant wait times for important programs, including 600 inmates waiting to participate in the first phase of the BOP's Resolve Program, a cognitive behavioral therapy program designed to address trauma-related mental health needs; 500 inmates waiting to participate in an anger management program; and 300 inmates waiting to participate in a foundational work skills class. Further, we found that more than 1,200 inmates had been determined by the BOP to have a need for programming to increase their ability to maintain employment upon release but only 58 were enrolled in a vocational training program.

We also were disturbed to find that serious shortages among FCI Sheridan employees who facilitate the BOP's Residential Drug Abuse Program (RDAP)—only 5 of 16 of these employee positions were filled at the time of our visit—have resulted in the institution being unable to offer the program to many eligible inmates who had been transferred from other institutions specifically to participate in FCI Sheridan's program. As a cumulative result of these issues, we found that FCI Sheridan has offered inmates limited opportunities to prepare for successful reentry into our communities. Three days after our inspection concluded, BOP Director Colette Peters suspended the RDAP at the FCI Sheridan's minimum-security prison camp.

In addition, FCI Sheridan's Correctional Officer vacancy rate has meant that institution management is not always able to fill all inmate-monitoring posts and therefore lacks the employees it needs to safely supervise inmates. As a result, inmates must routinely be confined to their cells during daytime hours and are therefore often unable to participate in programs and recreational activities. As we have detailed in our prior work, including our recent report on inmate deaths in custody, when inmates are not appropriately monitored the chance that they will engage in self-harm, violence, and other illicit activities increases.[1]

In an effort to staff correctional posts, institution leadership requires all Correctional Officers to perform mandatory overtime. Correctional Officers told us, consistent with information from our prior oversight work, that high levels of overtime can negatively affect morale and their attentiveness when supervising inmates. Institution management also requires non-correctional employees, many of whom facilitate or

[1] Appendix 2, Item III.

teach inmate programming, to serve in correctional posts rather than attend to their regular duties. However, doing so may cause them to cancel classes, further limiting inmate access to programming.

During our inspection, we also found that FCI Sheridan did not centrally track the number of all allegations of inmate-on-inmate sexual misconduct reported to employees. As a result, we were unable to determine the total number of reported allegations of inmate-on-inmate sexual misconduct. Ultimately, the failure to accurately track these allegations undermines the ability of both FCI Sheridan and the BOP to collect data consistent with Prison Rape Elimination Act of 2003 (PREA) standards that would allow them to assess and improve the effectiveness of sexual misconduct prevention efforts.

Finally, whereas our prior BOP inspections found significant concerns relating to infrastructure, security cameras, and food service, we identified comparatively fewer concerns in these areas at FCI Sheridan. For example, we did not identify widespread infrastructure issues that were actively affecting the conditions of confinement for inmates. We did identify water pipe failures that caused occasional flooding in inmate areas, deteriorated building siding that caused water intrusion into inmate areas, and exposed electrical wires throughout the institution. In addition, we were told that many of the institution's systems, including heating and cooling systems, are approaching the end of their projected lifespan and need to be updated. Officials estimated the cost of this work to be $21.6 million.

Report Highlights

Safety, Security, and Healthcare

Significant staff shortages have cascading effects on institution operations.

- Correctional Officer shortages require the institution to:
  - routinely use overtime, which can negatively affect employee attentiveness and therefore institution safety and security;
  - temporarily reassign non-Correctional Officers to Correctional Officer posts, negatively affecting their ability to perform their regular duties (e.g., teaching inmate programs); and
  - leave inmates with little or no monitoring.
- Staff shortages in the Health Services Department compromise FCI Sheridan's ability to provide adequate healthcare to inmates.

Sexual Misconduct Reporting

FCI Sheridan did not centrally track the number of all allegations of inmate-on-inmate sexual misconduct reported to employees.

- The failure to accurately track these allegations undermines the BOP's ability to collect data that would allow it to assess and improve the effectiveness of sexual misconduct prevention efforts under the PREA.

Inmate Programming

Staff shortages limit opportunities for inmates to participate in programs designed to prepare them for successful reentry.

- Shortages of drug treatment program employees resulted in the institution being unable to offer the RDAP to many eligible inmates who had been transferred from other institutions specifically to participate in FCI Sheridan's program.
- Long waitlists, some exceeding 500 names, delay inmate participation in trauma-related mental health, anger management, and work skills classes.

Infrastructure

FCI Sheridan has many infrastructure needs that, if left unaddressed, may negatively impact the conditions of confinement for inmates and working conditions for employees.

- Many of the institution's systems, including heating and cooling systems, are approaching the end of their projected lifespan and need to be updated.
- Officials estimated the cost of this work to be $21.6 million.

Table of Contents

Introduction

This report details the results of the U.S. Department of Justice (DOJ) Office of the Inspector General's (OIG) unannounced inspection of a Federal Bureau of Prisons (BOP) prison, Federal Correctional Institution (FCI) Sheridan located in Sheridan, Oregon, which is approximately 50 miles south of Portland. FCI Sheridan is composed of three facilities, a medium-security prison, a Federal Detention Center, and a minimum-security prison camp, all of which house male adults. This is the third unannounced inspection under the OIG's new on-site inspections program. In May and November 2023, respectively, we issued separate reports detailing our inspections of FCI Waseca and FCI Tallahassee, both low-security female institutions with the latter home to an adjacent male detention center. We selected FCI Sheridan as the site of our third inspection because we wanted to better understand the conditions of confinement for male inmates and assess an institution of greater size than those we previously inspected.

The OIG conducted its unannounced, on-site inspection of FCI Sheridan between Monday, November 27, and Friday, December 1, 2023. While on site, we made physical observations; interviewed employees and inmates; reviewed security camera footage; and collected records related to inmate programming and education, institution staffing levels, conditions of confinement, inmate medical and mental healthcare, and employee and inmate misconduct, including sexual misconduct. We also made follow-up requests of the institution, BOP Western Region, and BOP Central Office for additional data, interviews, and documents, which we used to further inform our inspection (see Appendix 1 for more details on the methodology).

FCI Sheridan Main Entrance

Source: OIG, November 2023

FCI Sheridan

FCI Sheridan's medium-security prison and minimum-security prison camp opened in 1989, and the detention center opened in 1995. Whereas the medium-security prison and minimum-security camp house inmates serving the pendency of their sentence, the Federal Detention Center houses inmates who are awaiting sentencing or transfer. FCI Sheridan leadership uses a centralized roster to assign employees to all three facilities. (For the remainder of this report, we refer to the overall institution as FCI Sheridan, the medium-security prison as the "MSP," the Federal Detention Center as the "FDC," and the minimum-security prison camp as the "Camp.")

FCI Sheridan is a Medical Care Level 2 and a Mental Health Care Level 3 institution. In the BOP, Medical Care Level 2 institutions should have the capabilities and resources to provide care for stable outpatients whose medical conditions can be monitored and managed through routine appointments. Mental Health Care

Level 3 institutions have the capabilities and resources to provide care for inmates who have complex, and usually chronic, mental health conditions that require frequent clinical contacts to maintain the stability of their condition.

As of November 28, 2023, the MSP housed 988 inmates and was at full capacity. The MSP has eight general population units and one Special Housing Unit (SHU). The general population housing units have two floors with double occupancy cells. Cells contain bunk beds, a sink, and a toilet. Cells remain unlocked during the day so inmates can use common shower and recreation areas. The SHU houses inmates that need to be separated from the general population and contains double occupancy cells with a sink and toilet. Inmates remain locked in these cells except for when they are escorted to shower and recreation areas.

FCI Sheridan: Institution Profile

Location
Sheridan, OR

Medical Care Level
2 of 4

Mental Health Care Level
3 of 4

Employees
Total Positions: 357
On Board: 290
81 Percent Filled

	MSP	FDC	Camp
	Population	**Population**	**Population**
	Physical Capacity: 988 Actual Headcount: 988	Physical Capacity: 280 Actual Headcount: 271	Physical Capacity: 384 Actual Headcount: 366
	100% Capacity	*97% Capacity*	*95% Capacity*
	Security Level	**Security Level**	**Security Level**
	Medium	Administrative	Minimum
	Housing Units	**Housing Units**	**Housing Units**
	8 General Population Units and 1 SHU	2 General Population Units	2 Buildings with Open Concept Living Spaces

As of November 28, 2023
Source: FCI Sheridan documentation

At the time of our inspection, the FDC housed 271 inmates, approximately 97 percent of its physical capacity of 280. The FDC has two main housing units, and the interior conditions are similar to those of housing units at the MSP. The Camp housed 366 inmates, which was 95 percent of its physical capacity of 384. Unlike inmates housed at the MSP and the FDC, those at the Camp live in open concept living spaces. The living spaces are spread across two different housing buildings, and each living space contains bays with inmate bunk beds, as well as communal areas for bathrooms, showers, and recreation. The Camp does not have a SHU; when institution employees must separate Camp inmates from the general population, they move them to the SHU inside the MSP.

At the time of our inspection, inmates at the MSP and Camp could participate in residential mental health and drug treatment programs, as well as FIRST STEP Act-required Evidence-Based Recidivism Reduction programming and Productive Activities. Given that most inmates at the FDC are housed there only on a

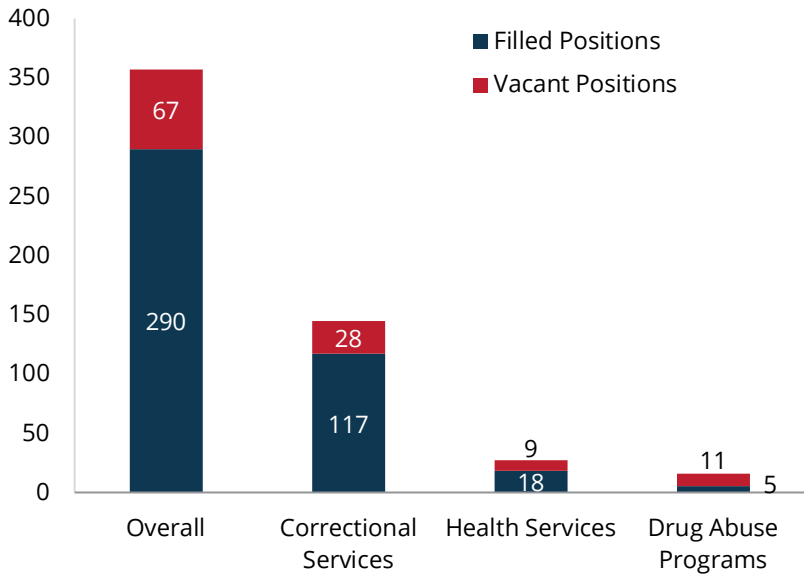
short-term basis, programming available to them is limited compared to that available to inmates housed at the MSP and Camp.

FCI Sheridan Staffing Challenges

Like many BOP institutions, which are experiencing issues recruiting and retaining employees, FCI Sheridan was struggling to maintain a staffing complement consistent with the BOP's determination of the needs of the institution. Overall, FCI Sheridan had a total of 81 percent (290 of 357) positions filled as of November 2023. Staff shortages have particularly affected the Correctional Services Department, which is composed primarily of Correctional Officer positions. Correctional Officers are vital to the safety and security of the institution, as they are responsible for providing round-the-clock supervision of inmates. Specifically, FCI Sheridan had only 81 percent of its Correctional Services positions filled at the time of our inspection (see Figure 1). As we describe later in the report, we found that, due to staff shortages, in order to fully staff Correctional Officer posts the institution required significant use of overtime, as well as augmentation—a staffing technique whereby non-Correctional Officer personnel are reassigned from their regular duties to serve in Correctional Officer posts. Even with the use of overtime and augmentation, we found that institution management is not always able to fill all Correctional Officer posts, which has caused inmates to be minimally supervised or, in certain instances, not supervised at all.

Figure 1

FCI Sheridan Staffing Level Overview



Source: FCI Sheridan staffing data as of November 2023

Moreover, we found that FCI Sheridan's staffing challenges were not limited to its Correctional Services Department. For example, FCI Sheridan's Health Services Department was 67 percent (18 of 27) filled at the time of our inspection, and we found that the staff shortage in this department has contributed to significant delays in the delivery of healthcare to inmates. We also found that only 5 of FCI Sheridan's 16 positions for drug treatment program employees were filled at the time of our inspection. This shortage significantly limited the institution's ability to offer drug treatment programs to eligible inmates. We discuss in greater detail how staffing issues affect inmate healthcare and inmate programming in the Inspection Results below.

Inspection Results

Safety and Security

We identified serious safety and security issues at FCI Sheridan. Most significantly, we found that, due to Correctional Officer shortages, institution management is not always able to fill all Correctional Officer posts, which has caused inmates to be minimally supervised or, in certain instances, not supervised at all. This condition creates a number of safety and security risks, including the risks of inmate self-harm; violence toward employees or other inmates; and other illicit activities, including the introduction and use of illegal drugs. FCI Sheridan's Correctional Officer shortage has further cascading effects on institution operations. Specifically, to decrease the risks associated with limited supervision, institution management has had to habitually confine (or lock down) inmates to their cells during daytime hours. This decision in turn prevents inmates from participating in institution programming and recreational activities. Additionally, to fill as many Correctional Officer posts as possible, institution leadership mandates Correctional Officers to perform high levels of overtime and requires non-Correctional personnel to temporarily stop performing their regular duties to fill Correctional Officer positions through a practice known as augmentation. According to FCI Sheridan employees, the excessive use of these staffing techniques has left them exhausted (See Figure 2).

Figure 2

FCI Sheridan Correctional Officer Recruiting and Retention Efforts

The institution has undertaken efforts to recruit and retain Correctional Officers. Specifically:

FCI Sheridan holds monthly recruitment events and recruits from local universities.

FCI Sheridan offers retention incentives of $10,000 or 25 percent of base pay (whichever is higher) for all employees who have completed 1 year of employment.

The week following our inspection, FCI Sheridan onboarded 11 new Correctional Officers.

Despite these efforts, FCI Sheridan management said that it was difficult to find talented individuals willing to work in Correctional Officer positions, largely due to the lack of competitive salaries for new recruits and the slow hiring process.

Source: FCI Sheridan management

Correctional Officer Staffing Deficiencies

Correctional Services Department employees, who are primarily Correctional Officers, are responsible for the daily management and supervision of inmates and the implementation of policies and procedures to maintain a safe and secure environment for inmates and employees. At the time of our inspection, FCI Sheridan's Correctional Services Department was staffed at 81 percent (117 filled vs. 145 authorized positions). Vacancies in Correctional Officer positions make it difficult for an institution to provide round-the-clock supervision of inmates. To compensate for vacancies in these critical positions at FCI Sheridan, institution management has adopted two stopgap measures used widely across the BOP to maintain coverage of correctional posts: (1) use of mandated and voluntary overtime and (2) temporary assignment of non-Correctional Officer personnel into Correctional Officer positions, a practice known as augmentation. Through these two measures, FCI Sheridan employees performed more than 88,400 hours of work covering Correctional Officer posts—equivalent to approximately 43 full-time positions—from November 2022 to November 2023.

Even if FCI Sheridan's Correctional Services Department filled all of its vacancies, we question whether it would be able to appropriately staff all three facilities without the continued use of overtime and/or augmentation. At the time of our inspection, 117 of 145 Correctional Services Department positions had been filled, which amounts to 28 vacancies. However, in the year prior to our inspection, FCI Sheridan management used overtime and augmentation to fill the equivalent of approximately 43 of these full-time positions.[2] Given that the extent of staffing gaps the institution covered through overtime and augmentation represents 15 positions greater than its official number of vacancies less than a year later, we believe that the 145 positions officially allocated to the Correctional Services Department may be too low.

Indicating the potential need for more authorized positions in the Correctional Services Department, we found that, even with the use of overtime and augmentation, institution management still cannot provide round-the-clock coverage of all Correctional Officer posts in medium-security prison (MSP) inmate housing units. This negatively affects the conditions of confinement for MSP inmates mostly during the day, when they must be confined to their cells to mitigate the security concerns associated with limited supervision. Due to this daytime confinement, they are unable to access common and outdoor recreation areas and they cannot attend programs. As we discuss in the Inmate Programming section of the report, this issue, combined with the effects of low staffing in the departments that facilitate inmate programming, as well as the routine augmentation of employees in those departments, limits the opportunities for FCI Sheridan inmates to participate in programs designed to prepare them for successful reentry into our communities.

The effects of low Correctional Officer staffing also create serious safety concerns. FCI Sheridan employees told us that excessive mandated overtime has left them exhausted. As a result, we believe that they may become less observant when conducting inmate-monitoring rounds. We independently reviewed MSP general population housing unit video footage from an evening just prior to our inspection and found that Correctional Officers conducted less than half of the required twice-hourly rounds in three housing units between 9:30 p.m. and 6 a.m. The issue of little or no inmate supervision is not limited to the MSP. In fact, we learned that on certain evenings the sole employee assigned to supervise the Camp may need to respond to the MSP or FDC in the event of an emergency. When this happens, Camp inmates are left unsupervised. Although we did not collect evidence to determine the exact number of times this has occurred, FCI Sheridan employees told us that it happens regularly.

The statements of FCI Sheridan employees and our observations of incomplete inmate-monitoring rounds are consistent with findings in our prior work, in which we reported that staff shortages and excessive use of overtime and augmentation decrease Correctional Officer attentiveness. We have also reported that the failure to complete inmate-monitoring rounds can increase the risks of inmate self-harm; violence toward employees or other inmates; and other illicit activities, including the introduction and use of illegal drugs.

[2] See past OIG work on the BOP's use of overtime at Appendix 2, Item IV.

Relevant Prior OIG Work and Related Recommendations: Correctional Officer Shortages Affecting Safety and Security

The OIG's June 2023 report on its investigation and review of the BOP's custody, care, and supervision of Jeffrey Epstein at Metropolitan Correctional Center New York found that staffing deficiencies at the institution contributed to the failure of its employees to perform inmate-monitoring rounds during the evening of Epstein's death. A 2024 OIG report on inmate deaths in custody also found that the failure to appropriately complete inmate-monitoring rounds was a contributing factor to 86 BOP inmate deaths, including Epstein's, between 2014 and 2021.

To address the effects of staff shortages on institution safety, in the Epstein report the OIG recommended that the BOP continue to develop and implement plans to address staff shortages at its prisons. As of the publication of this report on FCI Sheridan, this recommendation remains open.

See Appendix 2, Items III and V, for more information about these reports.

Contraband

The introduction of contraband, including illicit drugs, is a persistent and significant challenge for FCI Sheridan. This challenge is most acute at the Camp because, unlike at the other two FCI Sheridan facilities, inmates can freely move throughout the Camp during the day. Additionally, FCI Sheridan's outer perimeter closest to the Camp is marked by a fence that is easily accessible from a municipal park, which would make it easy for associates of inmates to throw contraband over the fence for inmates to retrieve. Further, it is much easier for inmates to retrieve such contraband in those situations, described above, when they are left unsupervised.

FCI Sheridan employees also told us that inmates at all three facilities receive contraband through the mail. While mail room employees screen incoming inmate mail and packages, it is difficult for them to identify all illicit drugs being sent to the institution due to the novel ways some drugs can be concealed. For example, synthetic cannabinoids can be sprayed onto paper, while buprenorphine and naloxone can be transmitted via small, dissolvable strips that can easily fit behind a stamp or in the binding of a book. In our recent report on BOP inmate deaths in custody, we described how the BOP is piloting a program in which employees digitally process mail (by scanning) at two institutions with a high incidence of drug overdoses. The BOP stated that this method eliminated synthetic and opioid drugs from coming into the facilities via general nonlegal mail but

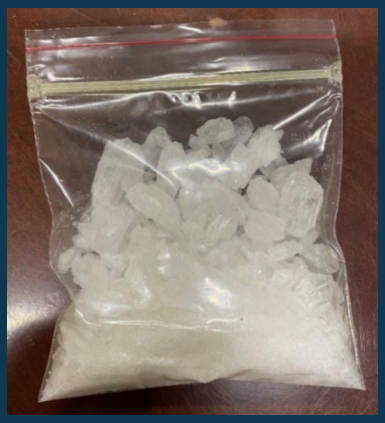
Commonly Introduced Contraband Drugs

Employees told us that synthetic cannabinoids and illicitly acquired and combined buprenorphine/naloxone were commonly introduced into the institution.

Synthetic Cannabinoids (colloquially known as K2 or spice) do not have a medical purpose. They are a category of synthetic drugs that mimic tetrahydrocannabinol, or THC, the main ingredient in marijuana. Abuse of these products can cause severe side effects, including nausea, vomiting, agitation, anxiety, seizures, stroke, coma, and death by heart attack or organ failure. Typically, synthetic cannabinoids are sprayed onto plant matter and smoked.

Buprenorphine and naloxone are medications that can be combined and ingested orally through pills or dissolvable strips. When used appropriately, they can help treat opioid abuse disorder by helping patients manage withdrawal symptoms and reduce cravings. Though the "high" is less intense than the high from opioids, "the medication can still produce a euphoric effect, as it still acts on the same opioid receptors in the brain and creates a flood of dopamine in the brain."

Sources: Interviews with FCI Sheridan employees, National Institutes of Health, and the Drug Enforcement Administration



An Estimated 62 Grams of Methamphetamine Seized from Inmate Mail

Source: OIG, November 2023

acknowledged that mail digitization could risk burdening employee resources and would require significant budget resources that have not yet been allocated.[3]

We also found that not all contraband mailed to the institution is concealed in a novel fashion; for example, mail room employees found 62 grams of methamphetamine just prior our inspection. Finally, we note that BOP mail room employees implement safety precautions to limit exposure to drugs; however, due to the amount of illicit drugs in the institution, some non-mail room employees told us that they were concerned about potentially being exposed to contraband substances that could cause severe medical complications if touched.

Security Cameras

Functional security cameras that produce clear footage are an important tool to help the BOP maintain institutional safety and security and provide evidence in criminal and disciplinary investigations. During our review of security camera footage and the associated software management system at FCI Sheridan, we found that the footage was of high quality and the software management system was easy to use. We were able to access footage captured more than 2 months prior to our inspection. At the time of our inspection, FCI Sheridan's MSP had 154 cameras, the Federal Detention Center (FDC) had 50, and the Camp had 21. We note that 60 of these 225 cameras are digital and the remainder are analog. A BOP employee responsible for FCI Sheridan's security camera system estimated that FCI Sheridan will upgrade the remaining analog cameras to digital cameras over the next 2 years. While institution investigative employees told us that they are satisfied overall with the quality and coverage of security cameras, we observed several blind spots, at both the MSP and the FDC, where unwitnessed assaults could potentially take place. FCI Sheridan employees told us that they have received funding to purchase and install additional cameras to increase coverage throughout all three facilities.

[3] Appendix 2, Item III.

Relevant Prior OIG Work and Related Recommendations: Security Cameras

The OIG has long identified insufficient camera coverage and recording system storage limitations as challenges, both for the BOP, throughout its institutions, and for the OIG in its own investigative capacity. In a June 2016 report, we found that "deficiencies within the BOP's security camera system have affected the OIG's ability to secure prosecutions of employees and inmates in BOP contraband introduction cases, and these same problems adversely affect the availability of critical evidence to support administrative or disciplinary action against employees and inmates." Following the issuance of our 2016 report, the BOP completed a multiyear update to cameras at 45 institutions; however, serious issues with the BOP's security camera systems remained. In October 2021, we issued a Management Advisory Memorandum finding that the BOP's camera systems continued to need significant infrastructure and equipment upgrades. In that memorandum, we also found that the BOP lacked a comprehensive strategic plan to address the significant deficiencies of its institution camera systems.

As a result of our finding from the 2021 Management Advisory Memorandum, we recommended that the BOP develop a comprehensive strategic plan for transitioning to a fully digital security camera system. As of the publication of this report on FCI Sheridan, this recommendation remains open.

We also note that Congress passed, and the President signed, the Prison Camera Reform Act of 2021, which requires the BOP Director to ensure that BOP facilities have security camera coverage and capabilities necessary to ensure the documentation and accessibility of video evidence pertaining to misconduct, maltreatment, or criminal activity within correctional facilities.

See Appendix 2, Items VI and VII, for more information about these reports.

Inmate Healthcare

At the time of our inspection, FCI Sheridan's Health Services Department was staffed at 67 percent (18 filled positions out of 27). Employee shortages were most acute among nurses, with only three of seven positions filled. Additionally, only one of three mid-level provider positions were filled, two of three physician positions were filled, and the institution was without a phlebotomist to draw blood for laboratory tests. According to employees in the Health Services Department, low department staffing levels make it difficult to perform routine, daily functions, such as drawing blood for laboratory tests, triaging patient requests for care, and ensuring that medical equipment and supplies are ready to be used for routine care and in the event of a medical emergency. We also note that, due to overall institution staff shortages, particularly those in the Correctional Services Department, FCI Sheridan did not always have employees available to escort inmates to community-based medical providers, which resulted in 101 canceled inmate medical appointments between January and November 2023. Finally, and while not directly related to staff shortages in the Health Services Department, we also observed a variety of potentially dangerous medication distribution practices.

Backlog of Laboratory Tests

At the time of our inspection, FCI Sheridan had been without a phlebotomist, a medical professional responsible for drawing blood samples and preparing the samples for testing, since March 2022. As a result, FCI Sheridan had a backlog of 725 laboratory orders for which blood had not yet been drawn or urine collected. According to Health Services Department internal meeting minutes from October 2023, the "delay in blood work collection is delaying patient care and is a liability for the department." Further, the minutes specify that "medical conditions are going undiagnosed, and providers are left unable to treat patients appropriately." One FCI Sheridan physician told us that the backlog has compromised his ability to treat patients and has prevented him from monitoring the effects of medication on his patients' kidney and liver functions. These limitations are

concerning for the treatment of any medical condition, but especially concerning for the treatment of chronic conditions, such as diabetes and hepatitis C, that regularly affect inmates.

We note that, in the event of an acute medical issue, other clinical employees can draw inmate blood for laboratory tests but do not routinely perform this task given their other responsibilities. Further, the BOP's Western Regional Office has been aware of the phlebotomist vacancy and the resulting backlog and has attempted to triage it by temporarily assigning employees from other BOP duty locations to FCI Sheridan to draw blood for laboratory tests. Specifically, between October 2022 and September 2023, employees were deployed five times to FCI Sheridan to work a total of 40 days to address the backlog. Notwithstanding this effort, the large number of backlogged laboratory tests indicated a need for an on-site employee to both clear the existing backlog and ensure that the Health Services Department can keep up with the demand for laboratory tests in the future. Following our on-site visit in November 2023, during which we expressed concern about this backlog, FCI Sheridan hired an on-site phlebotomist to address the backlog of laboratory orders; in May 2024, the BOP reported that the backlog stood at 44—a 94 percent decrease.

Relevant Prior OIG Work: Medical Personnel Shortages

Medical personnel shortages have been a long-standing challenge for the BOP. In a March 2016 DOJ OIG report, we found that medical personnel positions were filled at only 83 percent across the BOP. As we observed during our inspection of FCI Sheridan, the BOP's medical personnel vacancies persist. According to a September 2023 Pandemic Response and Accountability Committee report to which the DOJ OIG contributed, at that time the BOP's medical personnel shortage stood at 82 percent. That report detailed a variety of contributing factors, including noncompetitive pay, limited career advancement opportunities, and the additional stressors and responsibilities associated with working in a correctional setting compared to those associated with working in the community. The report also detailed how these shortages contributed to decreases in patient satisfaction and delays in routine and preventive care during the coronavirus disease 2019 (COVID-19) pandemic. As noted previously, the OIG's Epstein report recommended that the BOP continue to develop and implement plans to address staff shortages at its prisons, including medical staff shortages, and, as of the publication of this report on FCI Sheridan, that recommendation remains open.

See Appendix 2, Items VIII and IX, for more information about these reports.

Requesting and Accessing Care

Due to a variety of reasons, FCI Sheridan inmates may have difficulty requesting and accessing medical care for routine conditions. The most common way inmates would access medical care would be to visit the walk-in clinic at their facility. However, due to a shortage of nurses, who initially triage inmate medical conditions, the Health Services Department is unable to meet its internal goal of offering a walk-in clinic 4 days a week. According to Health Services Department internal meeting minutes, this negatively affects the quality of care the department provides to inmates.

On days that the walk-in clinic is not offered, inmates can submit a request for medical attention through an inmate computer; however, given routine lockdowns, particularly at the FDC and MSP, inmates housed there may be unable to access computers, located in common areas, when they need to request medical attention. If unable to attend a walk-in clinic or access an inmate computer, inmates can provide a paper request to an FCI Sheridan employee; however, we learned that Health Services Department employees are not taking appropriate steps to ensure that paper requests are assessed in a timely manner, or at all.

Specifically, Health Services Department employees told us that paper requests accumulate in medical offices and are not reconciled with scheduled appointments. Because Health Services Department employees subsequently shred paper requests, neither FCI Sheridan nor the OIG can determine whether all inmates who request care are afforded an opportunity to meet with a provider.

Illustrative of what can happen if a routine medical condition is not treated in a timely manner, we learned that a Special Housing Unit (SHU) inmate admitted to having feigned a suicide attempt (he placed a fabric noose around his neck) in order to force institution employees to provide medical attention for an ingrown hair that became infected just prior to our inspection. When he was examined following the feigned suicide attempt, swelling on his face had become so severe that he needed to be hospitalized for 5 days. We observed video of his medical examination and found it disturbing that an inmate experienced such a readily discernable medical condition in an environment like a SHU, where Correctional Officers are required to perform twice-hourly rounds to observe inmate activity and a Health Services Department clinical employee is required to perform daily rounds to assess inmate health.

Delays in Medical and Dental Care Due to Lack of Medical Equipment and Supplies

On Tuesday, November 28, 2023, when touring the MSP room that clinical employees use to treat inmates with emergency medical conditions (referred to as the trauma room), we found that the room's oxygen tank was empty. Despite employees notifying Health Services Department leadership of the issue, the tank was not replaced until Friday, December 1, 2023. During the 3-day period before the oxygen tank was replaced, had an MSP inmate required supplemental oxygen, a replacement tank would have had to be brought from elsewhere in the Health Services Department, potentially delaying lifesaving oxygen administration. We note that, during those 3 days, clinicians continued to evaluate MSP inmates who had emergency medical conditions. The absence of supplemental oxygen in FCI Sheridan's MSP trauma room relates to a broader issue that the OIG identified in a February 2024 report on inmate deaths in custody.[4] In that report, we found that, when responding to medical emergencies, BOP employees did not always bring or use appropriate medical equipment. Given that mere seconds in response time can potentially mean life or death for afflicted inmates, the availability and use of appropriate medical equipment, including supplemental oxygen, is paramount to ensuring that inmates experiencing an emergency have the best chance of a positive medical outcome.

Ensuring that oxygen tanks are available and filled is one element of a BOP requirement to daily determine whether the trauma room is supplied and equipped to manage a medical emergency.[5] According to Health Services Department internal meeting minutes dated October 23, 2023, trauma room checks were not being completed in the trauma rooms at all three FCI Sheridan facilities. Further, upon our review of trauma room check logbooks at the MSP, we found that trauma room checks had not been recorded as complete since April 2022. The internal department meeting minutes indicate that trauma room checks were not being completed due to a lack of staffing within Health Services, and the Health Services Administrator told us that such checks are "something that easily falls to the wayside when you're overwhelmed with other tasks that need to be completed."

[4] Appendix 2, Item III.

[5] Appendix 3 (Patient Care).

In addition to the unavailability of filled oxygen tanks in the MSP trauma room, we found additional medical equipment operational issues that potentially affect inmate care. Specifically, two of FCI Sheridan's x-ray machines were nonoperational: the machine at the MSP since July 2022 and the machine at the FDC since December 2022. As a result, the institution had 274 pending x-ray orders at the time of our inspection. Similar to issues caused by the laboratory testing backlog, the backlog of x-ray orders makes it difficult to diagnose and address inmate health issues in a timely manner. We expressed our concerns about this backlog at the time of our inspection, and we note that, after receiving a draft of the report, the BOP reported that it took multiple steps to address the backlog of x-ray orders, including assigning temporary duty employees to FCI Sheridan to perform x-rays and deploying a mobile x-ray machine to the institution. As a result, the BOP reported that as of May 2024 the backlog was reduced to 84—a 69 percent decrease.

Additionally, due to what the BOP's Western Region Chief Dentist described as a critical shortage of dental supply items, the Chief Dentist recommended that FCI Sheridan's dental operations be significantly modified. As a result, dental care at FCI Sheridan is limited to intake examinations, clinical examinations, and walk-in clinic triage. This means that inmates could not receive routine care such as a teeth cleaning, cavity filling, or root canals. Due to these modified operations, as of October 2023 approximately 350 inmates were on a waitlist for routine dental care, 41 percent of whom had been on the waitlist for 2 years or more. In the event of an oral health emergency, inmates are transferred to the hospital or other community care; however, doing so creates a logistical burden for the already short-staffed institution as employees must escort the inmates to their outside medical visits. It also creates a financial obligation for the BOP that it otherwise could avoid if FCI Sheridan's dentist was able to address the issue at the institution. Finally, we note that, at the time of our inspection, 30 dental intake examinations for newly incarcerated inmates had not been completed within the 30 days prescribed by BOP policy.[6]

Relevant Prior OIG Work and Related Recommendations: Availability of Medical Equipment and Supplies

The lack of supplemental oxygen in the MSP trauma room, as well as other medical equipment and supply issues at FCI Sheridan, represents a broader issue we identified in a February 2024 report on BOP inmate deaths in custody. In that report, we found that, when responding to medical emergencies, BOP employees did not always bring timely or use appropriately medical equipment and supplies such as automatic external defibrillators (AED), gurneys, and backboards. We also identified deficiencies with the availability and administration of naloxone, an opioid overdose reversal medication. Given that mere seconds in response time can potentially mean life or death for afflicted inmates, the availability and use of appropriate medical equipment is paramount to ensuring that inmates experiencing an emergency have the best chance of a positive medical outcome.

As a result of the February 2024 report's findings, we recommended that all employees be trained on AED use and that AEDs be strategically placed at each BOP institution, that each institution has a sufficient number of maneuverable gurneys to provide proper medical response during inmate transport, and that employees receive both initial and refresher naloxone training and are prepared to administer it on an unresponsive inmate suspected of having experienced a drug overdose. As of the publication of this report on FCI Sheridan, these recommendations remain open.

See Appendix 2, Item III, for more information about this report.

[6] Appendix 3 (Dental Services).

Backlog of Outside Medical Visits

When inmates require nonemergency medical treatment beyond that which can be performed at FCI Sheridan, inmates must be scheduled to see an outside medical provider. At the time of our inspection, BOP medical records indicated that 500 outside medical appointments that had been ordered for inmates were yet to be scheduled. After receiving a draft of the report, the BOP told the OIG that the list of outstanding appointments included information about appointments that had already been completed or for which an inmate decided they no longer wanted the appointment. FCI Sheridan updated its medical records system to reflect these administrative changes and reported that the actual backlog, at the time of our inspection, of unscheduled outside medical appointments was 387. We also identified two contributing factors for the backlog: first, medical providers canceled appointments; second, FCI Sheridan had difficulties finding employees to escort inmates to scheduled appointments. Illustrative of these issues, between January and November 2023, 73 scheduled consultations were canceled by medical providers and 101 scheduled consultations were canceled because FCI Sheridan did not have a sufficient number of employees available to escort an inmate on the day of his appointment. While inmate medical escort responsibilities are not reserved exclusively for Correctional Officers, they are the employees at FCI Sheridan most commonly assigned to serve as medical escorts. Therefore, these cancellations, and the resulting delays in inmate medical care, are another cascading effect of the Correctional Officer shortages we described in the Safety and Security section of this report. We note that, after receiving a draft of the report, the BOP reported that 89 of the 101 consultations that had been canceled, due to availability of employees to escort inmates, had been completed since our inspection.

Relevant Prior OIG Work and Related Recommendations: Canceling and Rescheduling Outside Medical Visits

In a March 2022 audit report on the BOP's use of comprehensive medical services contracts to facilitate outside medical care for inmates, we found that, due to the limited availability of employees to escort inmates, the BOP was not always able to transport inmates to scheduled outside medical appointments. BOP officials also told us that appointments are rescheduled for other unanticipated reasons, such as inmate refusal to attend the appointment, illness of the inmate, or rescheduling required by the medical provider. During our audit, we found that the BOP does not adequately track canceled or rescheduled inmate appointments, and we were unable to determine the effect these cancellations and rescheduling had on the delivery of timely medical care to inmates. As a result, we recommended that the BOP implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for inmates' outside appointments and the causes for canceled or rescheduled appointments in order to ensure that inmates receive timely medical care. As of March 2024, this recommendation remains open.

See Appendix 2, Item X, for more information about this report.

Potentially Dangerous Medication Distribution Practices

We identified a number of practices that were potentially dangerous and in violation of BOP policy when we observed the distribution of medication to inmates, a process known as "pill line," at all three FCI Sheridan facilities. According to BOP policy, institutions must "ensure that the medications are stored in appropriate packaging and clearly labeled until administration" and must "identify each patient by examining two forms

of identification."[7] However, we found the following examples of noncompliance among Health Services Department employees:

- They removed medication from its packaging hours before the next pill line was set to commence. This practice alone is a violation of policy and increases the risk of administration errors. However, the risk of an administration error becomes even greater because the employee who removes the medication from the packaging is not always the employee who later dispenses the medication.

- They reused the same bag when crushing different medications. This can cause drug cross-contamination, which can cause an inmate to have adverse reaction to the contaminated medication.

- They did not consistently identify each patient by examining two forms of identification before dispensing medication to them.

We also determined that drug administration issues were neither limited to the period of our inspection nor unknown to Health Services Department leadership. We reviewed quarterly reports generated by department employees and circulated to department leadership and found that, between January 2023 and September 2023, the department self-identified multiple medication administration errors, including two inmates receiving an extra and unnecessary injection of a prescribed medication and an inmate being injected with the incorrect type of medication to address his opioid abuse disorder.

Inmate Programming

Employee shortages in the Psychology Services and Education Departments, as well as the augmentation of non-custody employees into Correctional Officer posts, created significant backlogs for inmate programs. These backlogs are further exacerbated when inmates must be confined to their cells and are thus unable to attend classes. As a cumulative result of these issues, FCI Sheridan offered inmates limited opportunities to prepare for successful reentry into our communities, which is inconsistent with the goals of the FIRST STEP Act of 2018. The most concerning example of this was that more than 70 Camp inmates were unable to participate in the BOP's Residential Drug Abuse Program (RDAP), despite many inmates having been expressly transferred to FCI Sheridan to participate.

[7] Appendix 3 (Pharmacy Services).

Drug Abuse Programming

Residential Drug Abuse Program

RDAP is a 9-month program designed to help inmates address substance abuse disorder. Each RDAP cohort is composed of approximately 24 inmates. Upon successful program completion, inmates with no histories of violent offenses may earn up to a 1-year reduction in their sentence length. As of September 2023, the BOP reported that 70 of its institutions, including FCI Sheridan, offered RDAP.

Source: BOP

At the time of our inspection, FCI Sheridan's ability to offer RDAP and other non-residential drug treatment programs was seriously limited because only 5 of 16 positions were filled for drug treatment program employees in the Psychology Services Department.[8] This limitation most acutely affected 70 inmates at the minimum-security Camp who were waiting to begin the program at the time of our inspection. Many of these inmates had been transferred from other institutions to participate in the RDAP and were frustrated that they had been moved farther from their homes and families only to arrive at Sheridan and learn that the institution was struggling to offer the program. Some inmates also told us that their release dates were approaching and they were concerned that they would be released without being able to participate fully in the program and gain all of its therapeutic benefits. Other inmates complained that they may not be able to take advantage of all 12 months of the sentence reduction credit they would earn by completing the program because they would complete it with less than 12 months remaining on their sentence. As a way to express their frustration with the situation, Camp inmates modified a Halloween decoration, shown in the image on the right.

A Halloween Decoration at the Camp

Source: OIG, November 2023

During our inspection, institution leadership told us that, due to the persistent challenges of hiring drug treatment program employees, they had submitted a request through the BOP's Western Regional Director to suspend the RDAP program at the Camp. Three days after the on-site portion of our inspection concluded, FCI Sheridan received approval from the BOP Director to suspend the RDAP at the Camp. During a follow-up call in January 2024 with the Western Regional Director, we learned that RDAP-eligible Camp inmates would be transferred to other BOP institutions that offer the RDAP; as of March 1, 2024, over 80 percent of those had been transferred.

Psychology Services and Education Department Programming

Other inmate programs, in addition to drug abuse treatment programs, are primarily administered by the Psychology Services and Education Departments. However, 3 vacancies in the Psychology Services Department (in addition to 11 vacancies among drug treatment employees), as well as 3 vacancies in the Education Department, limited program offerings and contributed to waitlists. The availability of programs is

[8] Appendix 3 (Psychology Treatment).

further limited by factors, including the routine use of augmentation to assign non-Correctional Officers to Correctional Officer posts, as well as the restriction of inmates to their cells, both of which we described above.

At the time of our inspection, waitlists for inmate programs were lengthy. For example, we found that:

- over 600 inmates were waiting to participate in the first phase of the BOP's Resolve Program, a cognitive behavioral therapy program designed to address trauma-related mental health needs;
- over 500 inmates were waiting to participate in an anger management program; and
- over 300 inmates were waiting to participate in a foundational work skills class.

Further, skills-based vocational trainings at FCI Sheridan were limited; we found that, when assessing inmate needs to reduce recidivism, the BOP determined that more than 1,200 inmates at the MSP and Camp needed programming to increase their ability to maintain employment upon release; however, at the time of our inspection, only 58 were enrolled in a vocational training program (57 in a carpentry program and 1 in an electrician apprenticeship) and 92 were participating in the foundational work skills class. After receiving a draft of this report, in April 2024, the BOP reported that it had started a welding program at FCI Sheridan and that the number of inmates enrolled in vocational programs had increased to a total of 78 participants (52 in a carpentry program, 20 in a welding program, and 6 in varied vocational apprenticeships). The BOP also reported that the number of inmates in the foundational work skills class had decreased to 83. Further, the BOP reported that it was in the process of establishing a horticulture program but that it was not yet open for enrollment.

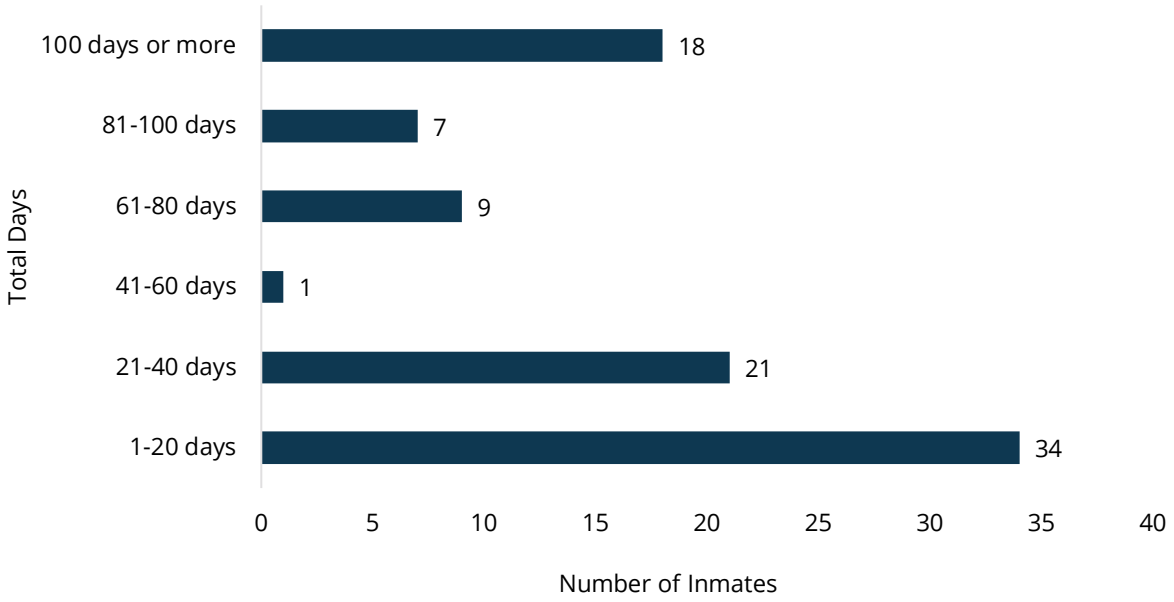
We note that the Psychology Services Department did have sufficient employees to administer a program of note: the BOP's Mental Health Step Down Program. Step Down is a unit-based program through which inmates with severe mental illness receive intensive cognitive and behavioral therapies to help them address their mental health issues, minimize their need for inpatient hospitalization, and function in the general inmate population. At the time of our inspection, 53 inmates were participating in the program and FCI Sheridan was 1 of only 5 BOP institutions that offered this program.

Use of Restrictive Housing

At the time of our inspection, 90 inmates were in restrictive housing in FCI Sheridan's SHU. The average amount of time these inmates were housed in the SHU was 54 days. Of the 90 inmates, 34 had been housed in the SHU for less than 20 days while 18 had been housed there for at least 100 days. See Figure 3 below for a more detailed analysis of the durations that FCI Sheridan inmates were housed in the SHU.

Figure 3

FCI Sheridan Inmates in Restrictive Housing and Duration of Their Stay as of November 28, 2023



Source: FCI Sheridan records as of November 28, 2023

Inmates are generally housed in the SHU if they:

- are suspected of having committed serious misconduct and are awaiting the completion of an investigation and disciplinary hearing;
- are serving a disciplinary sanction after having been found to have committed misconduct at the completion of an investigation and disciplinary hearing;
- have been assessed by employees to pose a safety risk to the institution and are awaiting transfer to another institution (certain inmates in this status may have already completed their disciplinary sanction); or
- request, or are determined by employees, to need to be separated from another inmate or employee for their own safety (commonly referred to as protective custody).

SHU inmates are generally double-celled; but FCI Sheridan employees told us that in certain situations SHU inmates are single-celled. These situations include when there is an odd number of inmates in the SHU or when an inmate must be separated for protective custody. We also found that, due to capacity issues in the SHU, inmates may be temporarily single-celled in a holding cell with only a portable commode and portable urinal. At the time of our inspection, five SHU inmates were single-celled. The BOP recommends against single-celling, noting that it increases the risk of inmate suicide. All SHU single-cell decisions must be approved by the Warden.

Similar to inmates in general population housing units, we found that SHU inmates are not always receiving recreation opportunities. According to BOP policy, SHU inmates have an opportunity for at least 5 hours per week of exercise outside their cells.[9] To do so, Correctional Officers must escort an inmate from his cell to the SHU recreation area. However, a SHU Correctional Officer told us that, due to staff shortages, Correctional Officers cannot always ensure that inmates in the SHU have the opportunity to participate in 5 hours of recreation per week. Further, multiple SHU inmates communicated their concerns regarding the lack of recreation opportunities when OIG employees toured the SHU. See the image on the right of an inmate's handwritten note requesting recreation access.

A SHU inmate wedged a handwritten note through his cell door to request "yard." In prison parlance, "yard" is a term for recreation.

Source: OIG, November 2023

[9] Appendix 3 (Special Housing Units).

Relevant Prior OIG Work and Related Recommendations: Single-Celling of Inmates in Restrictive Housing

In a 2017 report that evaluated the BOP's use of restrictive housing for inmates with mental illness, we found that placement in restrictive housing, even for short periods of time, can be particularly harmful for inmates' mental health. The report found that the BOP was not tracking inmates' single-cell confinement or assessing cumulative time that inmates spent in restrictive housing and that its policy neither limited the length of time inmates spent in restrictive housing nor defined or addressed extended placement in restrictive housing. We recommended that the BOP establish in policy the circumstances that warrant the placement of inmates in single-cell confinement, as well as tracking all inmates in single-cell confinement and monitoring the amount of time that inmates with mental illness spend in restrictive housing, including single-cell confinement. We also recommended that the BOP define and establish in policy extended placement in measurable terms, as well as evaluating and limiting as appropriate the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing.

More recent OIG work has shown how single-celling presents a significant risk of inmate suicide. A February 2024 OIG report on issues surrounding inmate deaths in BOP institutions found that more than half (102 of 187) of the BOP inmates who died by suicide between fiscal years 2014 and 2021 were single-celled at the time of their deaths. The report found that suicide risk is further compounded when inmates are single-celled while in restrictive housing settings such as a SHU; 86 of the 187 suicides occurred in a restrictive housing setting, and over two-thirds (60 of 86 suicides) happened while the inmate was single-celled in a restrictive housing setting. A 2023 capstone review of the BOP's response to the COVID-19 pandemic found that seven BOP inmates died by suicide during a 14-month period while housed in single-cell confinement in quarantine units related to COVID-19. In the capstone report, we recommended that the BOP thoroughly assess single-celling policies and processes (including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide) and ensure that actions, including any policy revisions, the BOP takes to close the two open recommendations from our 2017 restrictive housing report that reference single-celling also apply to single-celling during quarantine and medical isolation.

In March 2024, the BOP updated its SHU policy to require BOP employees to place SHU inmates with a cellmate unless there are unique circumstances that warrant single-cell placement; the policy requires the Warden's written approval in all such circumstances. The new policy includes requirements for monitoring SHU inmates, including those in single-cell confinement, as well as evaluating and limiting the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing. The new policy also defines extended placement as occurring when an inmate is continuously housed in a SHU for 6 months or longer. Additionally, new policy provisions discourage the placement of inmates with serious mental illness in a SHU and require that Psychology Services Department employees conduct initial and 30-day psychological assessments of such inmates. As a result of the SHU policy revisions, in April 2024 we closed three of the six recommendations from the 2017 report. The two recommendations related to single-cell confinement from the 2023 capstone report remained open as of March 2024.

See Appendix 2, Items III, XI, and XII, for more information about these reports and Appendix 3 (Special Housing Units) for the policy.

Employee Misconduct

As of November 27, 2023, there were 98 open misconduct investigations involving FCI Sheridan employees. Of those cases, 89 were still being investigated. In the remaining eight cases, the underlying misconduct had been substantiated but the cases were pending a disciplinary sanction decision. We found that the average time employee misconduct cases have been ongoing exceeds 1.5 years. In prior work, the OIG has documented how delays in the BOP's staff discipline process have made it difficult to enforce employee standards of conduct.[10] One reason for the backlog at FCI Sheridan is that the institution had been without a Special Investigative Agent (SIA) to investigate employee misconduct for an extended period (the current

[10] Appendix 2, Item XIII.

SIA started in that position in August 2023). The SIA estimated that it will take a year to investigate all backlogged employee misconduct cases at the institution and stated that reducing the backlog is a priority.

Depending on the severity of employee misconduct allegations and the risk that an employee may pose to the institution, the Warden may elect to remove an employee from regular duty pending the outcome of a misconduct investigation. At the time of our inspection, nine employees had been removed from regular duty while investigations into their alleged misconduct were ongoing.

Relevant Prior OIG Work and Related Recommendations: Employee Misconduct

In a 2023 report on systemic BOP operational issues, we detailed how the BOP had a backlog of nearly 8,000 employee discipline cases because it had historically lacked a sufficient number of employees to conduct investigations. While we were writing that report, the BOP told us that it was trying to hire additional employees to investigate these cases and was also increasing the authority of the BOP's Central Office-based Office of Internal Affairs (OIA) to supervise investigators located at institutions.

As a result, we recommended that the BOP develop a specific, multiyear plan for how it would evaluate its ongoing and proposed changes to the employee discipline process, as well as key performance indicators, to decrease the backlog of its employee misconduct cases and adjudications. As of the publication of this report on FCI Sheridan, this recommendation remains open.

See Appendix 2, Item XIII, for more information about this report.

Sexual Misconduct

Of the 98 misconduct investigations involving FCI Sheridan employees that were open at the time of our inspection, 20 related to sexual misconduct directed at an inmate.[11] After our inspection, FCI Sheridan and the BOP's Office of Internal Affairs (OIA) reexamined the universe of allegations of sexual misconduct directed at an inmate. Through this effort, the OIA opened additional investigations related to allegations of sexual misconduct that were reported prior to our inspection. As a result, the BOP reported that, as of May 13, 2024, the number of open investigations of FCI Sheridan employee sexual misconduct directed at an inmate increased to 31. We report this data for informational and transparency purposes and note that the volume of sexual misconduct allegations, especially those for which the underlying investigation has yet to be concluded, should not be used, alone, to assess the pervasiveness of sexual misconduct or absence thereof at an institution.

We were unable to determine the total number of allegations of inmate-on-inmate sexual misconduct reported to FCI Sheridan employees. Instead of centrally tracking all allegations, FCI Sheridan centrally tracks only those that institution employees believe merit a full investigation following a preliminary review of evidence. They do not centrally track those allegations believed to lack sufficient evidence to merit a full investigation. While FCI Sheridan could presumably reconstruct existing records to populate the full universe of inmate-on-inmate sexual misconduct allegations, we are concerned that the procedure it was using to track these allegations was inconsistent with Prison Rape Elimination Act (PREA) National Standards, which are incorporated into BOP policy. PREA standards state that correctional agencies "shall collect accurate, uniform data for every allegation

[11] For the purposes of this report, we use the term "sexual misconduct" to encompass all forms of sexual misconduct, including harassment and assault.

of sexual misconduct at facilities under its direct control using a standardized instrument and set of definitions."[12] Ultimately, these standards are designed to ensure nationwide that correctional agencies, including the BOP, are able to aggregate sexual misconduct allegations to assess and improve the effectiveness of their sexual misconduct prevention efforts. During a discussion with FCI Sheridan's PREA Coordinator held after the on-site portion of our inspection, we learned that the institution had modified its allegation-tracking method to include all allegations of sexual misconduct.

Physical Conditions and Infrastructure

At the time of our inspection, we did not identify widespread infrastructure issues that were actively affecting the conditions of confinement for inmates at FCI Sheridan. However, Facilities Department employees told us that many of the institution's systems, including its heating and cooling systems, are approaching the end of their projected lifespan and need to be updated. They estimated the cost of this work to be $21.6 million. FCI Sheridan requested funds from the Western Regional Office to address these issues; however, due to the BOP's limited budgetary resources for infrastructure repair and replacement, the request was unfunded at the time of our inspection.

We are concerned that, if these repairs are not made soon, equipment will fail, which would not only negatively affect the conditions of confinement for inmates but would also cause repair and replacement costs to exceed current estimated levels. This is issue is not unique to FCI Sheridan. The BOP currently estimates that it has a $3 billion backlog of unfunded infrastructure repairs across all of its institutions.

In and around the time of our inspection, Facilities Department employees were also triaging leaks in pipes that brought public utility-provided water into the institution. According to a Facilities employee, when these pipes were installed and buried, a coarse material was placed around the pipes. Over time, that material has compromised the integrity of the pipes, causing the leaks. The effects of pipe leaks are most serious when the leaks occur in close proximity to institution buildings. Just prior to our inspection, an inmate housing area temporarily flooded due to this issue. Given the recent identification of this problem, and the potential scale of work necessary to repair or replace large amounts pipe, at the time of our inspection FCI Sheridan was unable to estimate the cost to address this problem. This cost would be in addition to the $21.6 million previously requested. See the image on the right showing the aftermath of a leak and repair efforts.

Aftermath of Pipe Leak and Repair Efforts

Source: OIG, November 2023

[12] See 28 C.F.R. § 115.87 and Appendix 3 (Sexually Abusive Behavior Prevention and Intervention Program).

We also found a number of unaddressed minor repair issues at FCI Sheridan. These issues included the deterioration of building siding at the MSP, which in turned caused leaks in the gymnasium. See images of these issues below.

Left, Deteriorating Building Siding, *Right*, Temporary Leak Remediation in the MSP Gymnasium Building

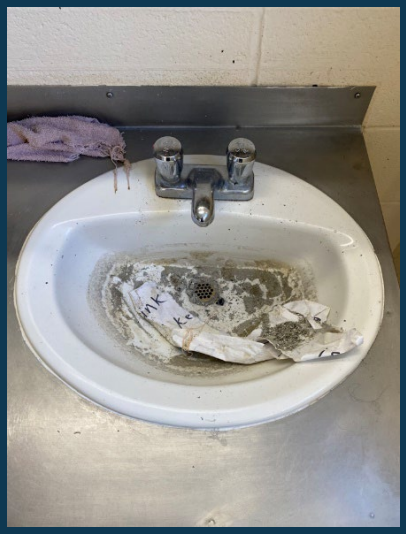
Source: OIG, November 2023

Further, to prevent inmates from hiding contraband behind recessed, ground-level lighting, Facilities Department employees removed lights, which exposed a recessed wall box housing electrical connections and wires. We also found that plates that cover other electrical components had been removed for similar reasons. According to FCI Sheridan leadership, these exposed endpoints and wires were no longer receiving electricity; but we did not test the endpoints or wires to confirm this. See the images below for examples of exposed, recessed wall boxes that house electrical connections and wires.

Left and Right, Former Ground-level Lighting with Exposed Wall Boxes That House Electrical Connections and Wires

Source: OIG, November 2023

At the Camp, we observed poor physical conditions including broken toilets and sinks. We also found some areas, including the bathrooms, to be unclean and found a dark substance on a shower floor. We note that inmate orderlies are responsible for ensuring that inmate areas are kept clean, but it is also incumbent on institution employees to hold inmates accountable for cleaning inmate areas.



Left, Broken Sink at the Camp, *Right*, Dark Substance on a Shower Floor at the Camp

Source: OIG, November 2023

Relevant Prior OIG Work and Related Recommendations: Infrastructure

In May 2023, the OIG reported that BOP institutions had a large and growing list of unfunded modernization and repair needs and that the BOP was unable to address these needs because it lacked a strategy to do so. Further, we found that the BOP had historically failed to request funding to address its infrastructure needs.

To address this issue, the OIG recommended that the BOP develop an infrastructure strategy to increase the overall effectiveness of facilities management and to develop and implement key performance indicators to track whether the BOP is meeting its infrastructure goals. As of the publication of this report on FCI Sheridan, these recommendations remain open.

See Appendix 2, Item XIV, for more information about this report.

Food Service

We found FCI Sheridan's food service and storage warehouses to be clean and functioning well. At the time of our inspection, FCI Sheridan employees told us that some institution equipment was inoperable, but, while inconvenient, did not prevent the institution from preparing and serving meals. Following our on-site inspection, FCI Sheridan management told us that repairs to food service equipment to support effective food service operations were ongoing. We note that one particular strength of FCI Sheridan's food service operations was its bakery, where inmate workers prepare fresh breads and cakes for meals. The images below show the preparation and service of fresh bread at FCI Sheridan.

Left, Bread Preparation at FCI Sheridan, *Right*, Baked Bread

Source: OIG, November 2023

Inmate Court Visits

The U.S. Marshals Service (USMS) is responsible for transporting to court those FCI Sheridan inmates who have court appearances. Most of these inmates are housed at the FDC and are awaiting trial, actively being tried, or awaiting sentencing. According to a USMS official from the District of Oregon who is responsible for prisoner transportation, the USMS had historically housed inmates who were not routinely appearing in court (e.g., inmates who were detained before their trials began or who were awaiting sentencing following a conviction) at the FDC at FCI Sheridan. This USMS official further explained that the USMS housed inmates routinely attending court (e.g., inmates whose criminal trials were in progress) in facilities other than FCI Sheridan, i.e., detention centers operated by local governments that are in closer proximity, than is FCI Sheridan, to federal district courts in Oregon. Given this arrangement, the USMS had to transfer inmates to and from the FDC only on a monthly basis. Due to operational changes, in 2023 the USMS decreased its use of local government-operated detention centers and in turn increased its use of the FDC at FCI Sheridan as a place to house inmates who were routinely attending court. To transport these inmates to court, the USMS and FCI Sheridan officials agreed to a twice-weekly inmate transport schedule whereby FCI Sheridan employees would both discharge inmates to the custody of the USMS for transport to court and receive inmates from the custody of the USMS following the inmates' court appearances.

The U.S. Marshal for the District of Oregon told us that, under this recently updated arrangement, the USMS had to find housing in locations other than the FDC at FCI Sheridan for inmates in advance of their court appearances under two circumstances: (1) if their appearances were not scheduled for the same day on which they were retrieved from the FDC, and (2) if a return trip to the FDC was not scheduled on the same day as their court appearances. We found that this dynamic had some effects on the operations of health services for FCI Sheridan and its inmates. Specifically, because inmates who attended court could be away from the FDC for multiple days, FCI Sheridan Health Services Department employees had to provide inmates

who required daily medication with enough medication to cover the number of days they would be away from the institution. Further, FCI Sheridan employees had to re-screen inmates who left the FDC for more than 24 hours for potential health issues before those inmates could be readmitted. We found that this increased burdens on already short-staffed Health Services Department employees. This arrangement also presented potential risks for inmates with chronic health issues because the continuity of their care could have been interrupted when they were temporarily transferred to a different detention facility staffed by clinicians who may have been unfamiliar with their conditions and healthcare needs.

After the BOP received a draft of this report, we learned that the twice-weekly inmate transport schedule has increased to 4 times per week. According to an official for the USMS District of Oregon, the USMS is hopeful that the increased transport schedule will allow for FCI Sheridan FDC inmates to be picked up and returned to the FDC on the same day as their court appearances, thereby decreasing the burden and risks associated with housing inmates away from the FDC for multiple days.

Conclusion

Our unannounced inspection identified several serious safety and security issues at FCI Sheridan affecting both employees and inmates. Most significantly, substantial shortages of Correctional Officers and healthcare workers have created widespread and troubling operational challenges that substantially affect the health, welfare, and safety of employees and inmates.

For example, healthcare staffing challenges seriously affect FCI Sheridan's ability to provide adequate healthcare to inmates. One area affected by staffing challenges is the performance of routine, daily functions, such as drawing blood for laboratory tests, triaging patient requests for care, and ensuring that medical equipment and supplies are ready to be used for routine care and in the event of a medical emergency. Particularly alarming was our finding that the institution had a backlog of 725 laboratory blood test or urine collection orders and 274 pending x-ray orders. These backlogs cause medical conditions to go undiagnosed and leave providers unable to appropriately treat patients. Specifically, an FCI Sheridan physician told us that the backlog of laboratory orders for blood draws or urine collection has compromised his ability to treat patients and has prevented him from monitoring the effects of medication on his patients' kidney and liver functions. We note that, after receiving a draft of the report, and after the OIG expressed concerns about the issue to the BOP, FCI Sheridan took action to decrease these backlogs; specifically, as of May 2024 the backlog of laboratory orders stood at 44 and the number of pending x-ray orders stood at 84. These limitations are concerning for the treatment of any medical condition, but especially concerning for the treatment of chronic conditions, such as diabetes and hepatitis C, that regularly affect inmates. We also found that, just prior to our inspection, an inmate feigned a suicide attempt in order to receive medical attention for an untreated ingrown hair that had become infected. When finally examined after the feigned suicide attempt, he required hospitalization for 5 days to treat the infection. Additionally, while not directly related to staff shortages, we observed a variety of potentially dangerous medication distribution practices.

We also found that FCI Sheridan did not always have available Correctional Officers to escort inmates to external medical providers. At the time of our inspection, 101 outside appointments had been canceled between January and November 2023 due to the lack of available employees to escort inmates to these appointments. Additionally, due to a critical shortage of dental supply items, dental care at FCI Sheridan was limited to intake examinations, clinical examinations, and walk-in clinic triage. As a result of these modified operations, in October 2023 approximately 350 inmates were on a waitlist for routine dental care and 41 percent of them had been on the waitlist for 2 years or more.

Further, we found that Psychology Services Department and Education Department staff shortages resulted in significant wait times for psychological, educational, and vocational programs. We also were disturbed to find that serious shortages among FCI Sheridan employees who facilitate the BOP's Residential Drug Abuse Programs (RDAP)—only 5 of 16 positions for drug treatment program employees were filled at the time of our visit—has resulted in the institution being unable to offer the program to many eligible inmates who had been transferred from other institutions specifically to participate in FCI Sheridan's program. As a cumulative result of these issues, we found that FCI Sheridan offered inmates limited opportunities to prepare for successful reentry into our communities. Three days after our inspection concluded, BOP Director Colette Peters suspended the RDAP at the Camp.

In addition, FCI Sheridan's Correctional Officer vacancy rate has meant that institution management is not always able to fill all inmate-monitoring posts and therefore lacks the employees it needs to safely supervise

inmates. As a result, inmates must routinely be confined to their cells during daytime hours and are therefore often unable to participate in programs and recreational activities. As we have detailed in our prior work, when inmates are not appropriately monitored the chance that they will engage in self-harm, violence, and other illicit activities increases.

In an effort to staff correctional posts, institution leadership requires all Correctional Officers to perform mandatory overtime. FCI Sheridan Correctional Officers told us that high levels of overtime can negatively affect morale and their attentiveness when supervising inmates. Institution management also requires non-correctional employees, many of whom facilitate or teach inmate programming, to serve in correctional posts rather than attend to their regular duties. However, doing so may cause them to cancel classes, further limiting inmate access to programming.

During our inspection, we also found that FCI Sheridan did not centrally track the number of all allegations of inmate-on-inmate sexual misconduct reported to employees. As a result, we were unable to determine the total number of allegations of inmate-on-inmate sexual misconduct reported to FCI Sheridan employees. Ultimately, the failure to accurately track these allegations undermines the ability of both FCI Sheridan and the BOP to collect data consistent with Prison Rape Elimination Act standards that would allow them to assess and improve the effectiveness of sexual misconduct prevention efforts.

Whereas our prior inspections of BOP institutions found significant concerns relating to infrastructure, security cameras, and food service, we identified comparatively fewer concerns in these areas at FCI Sheridan. For example, we did not identify widespread infrastructure issues that were actively affecting the conditions of confinement for inmates. Nonetheless, we did identify water pipe failures that caused occasional flooding in inmate areas, deteriorated building siding that caused water intrusion into inmate areas, and exposed electrical wires throughout the institution. We also were told that many of the institution's systems are approaching the end of their projected lifespan and need to be updated. Officials estimated the cost of this work to be $21.6 million.

Ultimately, many of the significant issues we identified at FCI Sheridan were consistent with BOP-wide issues on which we have made recommendations in prior work. Because those prior recommendations direct the BOP to address these issues of concern at an enterprise level, we do not make new recommendations in this report that would be duplicative of them but instead repeat our prior ones and highlight throughout this report how the prior recommendations relate to FCI Sheridan. Through our efforts to resolve the prior recommendations, we will monitor the BOP's efforts to address the identified issues at all of its institutions, including FCI Sheridan.

Appendix 1: Purpose, Scope, and Methodology

Standards

The DOJ OIG conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation (December 2020).

Purpose and Scope

The OIG has determined that it can enhance the effectiveness of its oversight, as well as its ability to alert the BOP of concerns, by conducting short-notice and unannounced inspections of BOP facilities, as appropriate. Pursuant to the OIG's planned procedures for initiating an inspection, which we had previously shared with the BOP, the OIG notified FCI Sheridan at approximately 8 a.m. on November 27, 2023, that it would be initiating an inspection beginning at noon that day. The OIG team, which consisted of 10 OIG employees and 2 medical subject matter experts contracted by the OIG, conducted the on-site inspection Monday, November 27, through Friday, December 1, 2023. The focus of our inspection was the state of institution operations at the time of our inspection; although, for certain portions of our analysis, our scope included roughly the year that preceded our inspection, beginning in November 2022.

We selected FCI Sheridan as the site of our third inspection because we wanted to better understand and assess the conditions of confinement for male inmates. We also note that the OIG's BOP Interdisciplinary Team (which facilitates inter-OIG collaboration on BOP oversight issues) contributed to the inspection team's site selection. Specifically, the Interdisciplinary Team created a forum for DOJ OIG Special Agents, who investigate criminal and administrative misconduct at BOP institutions, to communicate their general concerns regarding FCI Sheridan's operations to the inspection team.

The scope of this inspection did not include specialized testing to definitively determine, for example, the potential presence of mold and other hazardous substances. In addition, although this report includes information on allegations of sexual abuse, we report this data for informational and transparency purposes and note that the volume of sexual abuse investigations (especially those for which the underlying investigation has yet to be concluded) should not be used, alone, to assess the pervasiveness of sexual abuse or absence thereof at an institution.

Inspection Methodology

To better understand FCI Sheridan's operations, we toured the institution, interviewed its inmates and employees, and reviewed its operational records.

Observations

We toured the interior and exterior of the medium-security facility and its adjacent detention center and camp, including general population inmate housing units; the Special Housing Units (SHU); Health Services Department spaces; front lobby employee entrances and screening areas; programming areas used by the Psychology, Education, and Recreation Departments; the mail room; the commissary; laundry areas; the evidence storage area; the visitation room; inmate intake and screening areas; Facilities Department areas; food storage warehouses; and food preparation and dining areas.

We also reviewed security camera footage, as well as the functionality of the security camera system. Further, we tested ambient temperatures throughout the institution, as well as the functionality of showers, sinks, and toilets in inmate housing areas.

Interviews

We conducted on-site interviews with FCI Sheridan inmates who were housed in both the general population and the SHU, as well as on-site interviews with institution employees. Employees we interviewed included the Warden; Associate Wardens, one of whom serves as the institution's Prison Rape Elimination Act Coordinator; supervisory and nonsupervisory Correctional Officers; healthcare providers; case managers; teachers; food service workers; and employees responsible for institution safety, facilities management, and the trust fund program. Following our on-site work at FCI Sheridan, we conducted virtual follow-up interviews with select FCI Sheridan employees, select employees at the BOP's Western Regional Office, and select employees at the BOP's Central Office. We also interviewed select employees at the U.S. Marshals Service.

Document Review and Analysis

We reviewed FCI Sheridan records related to facilities management, staffing levels, use of overtime and augmentation, use of restrictive housing, provision of inmate healthcare, food service, inmate discipline, employee misconduct, sexual abuse reporting and tracking, inmate programming, and FIRST STEP Act implementation.

External Subject Matter Experts Assisting the OIG

To assist the OIG in its efforts to assess the provision of healthcare to FCI Sheridan inmates, the OIG contracted the services of two healthcare subject matter experts: one physician and one registered nurse.

Appendix 2: DOJ OIG Related Work

I. For the FCI Waseca **inspection report**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Waseca*, Evaluation and Inspections (E&I) Report 23-068 (May 2023), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-waseca.

II. For the FCI Tallahassee **inspection report**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Tallahassee*, E&I Report 24-005 (November 2023), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-tallahassee.

III. For prior OIG reporting on BOP inmate **deaths in custody**, see DOJ OIG, *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, E&I Report 24-041 (February 2024), oig.justice.gov/reports/evaluation-issues-surrounding-inmate-deaths-federal-bureau-prisons-institutions.

IV. For prior OIG reporting on the BOP's use of **overtime,** see DOJ OIG, *Management Advisory: Analysis of the Federal Bureau of Prisons' Fiscal Year 2019 Overtime Hours and Costs*, Audit Report 21-011 (December 2020), oig.justice.gov/reports/management-advisory-analysis-federal-bureau-prisons-fiscal-year-2019-overtime-hours-and.

V. For additional prior OIG reporting on the BOP's **staffing challenges**, see DOJ OIG, *Investigation and Review of the Federal Bureau of Prisons' Custody, Care, and Supervision of Jeffrey Epstein at the Metropolitan Correctional Center in New York, New York*, Investigations Report 23-085 (June 2023), oig.justice.gov/reports/investigation-and-review-federal-bureau-prisons-custody-care-and-supervision-jeffrey.

VI. For prior OIG reporting on the insufficiency of the BOP's **security camera systems** and **contraband introduction** at BOP institutions, see DOJ OIG, *Review of the Federal Bureau of Prisons' Contraband Interdiction Efforts*, E&I Report 16-05 (June 2016), oig.justice.gov/reports/review-federal-bureau-prisons-contraband-interdiction-efforts.

VII. For additional prior OIG reporting on the insufficiency of the BOP's **security camera systems**, see DOJ OIG, *Management Advisory Memorandum: Notification of Needed Upgrades to the Federal Bureau of Prisons' Security Camera System*, E&I Report 22-001 (October 2021), oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security.

VIII. For prior OIG reporting on the BOP's **medical staffing challenges**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges*, E&I Report 16-02 (March 2016), oig.justice.gov/reports/review-federal-bureau-prisons-medical-staffing-challenges.

IX. For additional prior OIG reporting on the BOP's **medical staffing challenges**, see Pandemic Response Accountability Committee, *Federal Telehealth Report, Insights on Utilization and Program Integrity Risks Across Selected Health Care Programs in Six Federal Agencies* (September 2023), www.pandemicoversight.gov/oversight/our-publications-reports.

X. For prior OIG work on the BOP's scheduling of **outside medical visits**, see DOJ OIG, *Audit of the Federal Bureau of Prisons Comprehensive Medical Services Contracts Awarded to the University of Massachusetts Medical School*, Audit Report 22-052 (March 2022), oig.justice.gov/reports/audit-federal-bureau-prisons-comprehensive-medical-services-contracts-awarded-university.

XI. For prior OIG reporting on the use of **restrictive housing** for inmates with mental illness and **single-celling**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness*, E&I Report 17-05 (July 2017), oig.justice.gov/reports/review-federal-bureau-prisons-use-restrictive-housing-inmates-mental-illness.

XII. For prior OIG reporting on **single-celling**, see DOJ OIG, *Capstone Review of the Federal Bureau of Prisons' Response to the COVID-19 Pandemic*, E&I Report 23-054 (March 2023), oig.justice.gov/reports/capstone-review-federal-bureau-prisons-response-coronavirus-disease-2019-pandemic.

XIII. For prior OIG reporting on the BOP's **investigative backlog of employee misconduct cases**, see DOJ OIG, *Limited-Scope Review of the Federal Bureau of Prisons' Strategies to Identify, Communicate, and Remedy Operational Issues*, E&I Report 23-065 (May 2023), oig.justice.gov/reports/limited-scope-review-federal-bureau-prisons-strategies-identify-communicate-and-remedy.

XIV. For prior OIG reporting on the BOP's **infrastructure management challenges**, see DOJ OIG, *The Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions*, Audit Report 23-064 (May 2023), oig.justice.gov/reports/federal-bureau-prisons-efforts-maintain-and-construct-institutions.

Appendix 3: BOP Policies Cited

Topic Discussed in Report	Relevant Program Statement	Link
Patient Care	6031.04 Patient Care June 3, 2014	www.bop.gov/policy/progstat/6031_004.pdf (accessed February 26, 2024)
Dental Services	6400.03 Dental Services June 10, 2016	www.bop.gov/policy/progstat/6400_003.pdf (accessed February 26, 2024)
Pharmacy Services	6360.01 Pharmacy Services January 15, 2005	www.bop.gov/policy/progstat/6360_001.pdf (accessed February 26, 2024)
Residential Drug Abuse Program	5330.11 Psychology Treatment Programs March 16, 2009	www.bop.gov/policy/progstat/5330_011.pdf (accessed February 26, 2024)
Special Housing Units	5270.12 Special Housing Units March 5, 2024	www.bop.gov/policy/progstat/5270.12.pdf (accessed March 7, 2024)
Sexual Abuse	5324.12 Sexually Abusive Behavior Prevention and Intervention Program June 4, 2015	www.bop.gov/policy/progstat/5324_012.pdf (accessed February 26, 2024)

Appendix 4: The BOP's Response to the Draft Report

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director *Washington, DC 20534*

May 20, 2024

MEMORANDUM FOR ALLISON RUSSO
DEPUTY ASSISTANT INSPECTOR GENERAL,
EVALUATION AND INSPECTIONS

FROM: Colette S. Peters, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Report: Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Sheridan, Assignment Number A-2024-001

The Federal Bureau of Prisons (FBOP) values the opportunity to formally respond to the Office of the Inspector General's (OIG) above-referenced draft report (Report). FBOP also appreciates OIG's acknowledgement that the FBOP has taken several proactive measures to enhance operations at the Federal Correctional Institution, Sheridan (FCI Sheridan) and that no recommendations have been issued with this report. FBOP offers specific comments regarding the following issues noted in the Report: healthcare, staffing, misconduct reporting, programming, and infrastructure.

Ensuring that adults in custody receive vital medical and mental healthcare services is a critical element of FBOP's mission and one that it takes seriously. Following OIG's inspection, FCI Sheridan took immediate action to reduce any backlogs in the healthcare arena. Specifically, and as noted by OIG, FCI Sheridan "took multiple steps to address the backlog of x-ray orders, including assigning temporary duty employees to FCI Sheridan to perform x-rays and deploying a mobile x-ray machine to the institution. As a result, the BOP reported that as of May 2024 the backlog was reduced to 84—a 69 percent decrease." Report at 11. Additionally, regarding the backlog of outside medical trips, OIG indicates that "after receiving a draft of the report, the BOP reported that 89 of the 101 consultations that had been canceled . . . had been completed since our inspection." Report at ii, 12. And lastly, as of May 2024, the backlog of laboratory orders had dropped to 44, down from 725 – reflecting a 94 percent decrease. See id. at i.

Regarding staffing, FBOP continues to face challenges in hiring new employees. The FBOP is

committed to recruiting and retaining staff to work as federal law enforcement officers and increase our staffing levels. To that end, the FBOP is taking a multistep approach to filling all funded vacancies across the agency that includes increased marketing and branding; utilization of recruitment and retention incentives where warranted; and the utilization of pay flexibilities within budgetary constraints. These initiatives have resulted in additional hires at FCI Sheridan. As of early May, FCI Sheridan had filled 87.9% of all positions, up from 81% as of November 2023.

Regarding sexual misconduct reporting, FBOP ensures compliance with Prison Rape Elimination Act (PREA) National PREA Standards and conducts all tracking and reporting as required. As acknowledged by OIG, FCI Sheridan currently tracks all allegations of sexual misconduct. Report at 20.

Furthermore, FBOP continuously strives to achieve its vision of developing good neighbors through the principles of humanity and normalcy. Reentry planning is a core element of this work and FBOP continues to maximize programming opportunities for adults in custody across its institutions. For example, two additional vocational programs (welding and horticultural) have been added to FCI Sheridan since OIG's inspection. Report at 15. FCI Sheridan also offers several other programs such as Resolve, a cognitive behavioral therapy program designed to address trauma-related mental health needs, anger management programming, and a foundational work skills course. Id. at 15.

Regarding infrastructure, OIG indicates that, "whereas our prior BOP inspections found significant concerns relating to infrastructure, security cameras, and food service, we identified comparatively fewer concerns in these areas at FCI Sheridan. For example, we did not identify widespread infrastructure issues that were actively affecting the conditions of confinement for inmates." Report at 26. Although OIG declined to issue recommendations with this report, FBOP remains committed to communicating with OIG regularly regarding its infrastructure-related activities.

FBOP also remains committed to addressing any resolved recommendations from related products and looks forward to continuing its work with OIG on the onsite inspections program.

Appendix 5: OIG Analysis of the BOP's Response

In its formal response, the BOP acknowledged the serious issues identified in this report and reiterated its commitment to addressing open recommendations from previous OIG reports. The BOP also stated that it appreciated that the OIG did not make recommendations in this report. As mentioned multiple times in this report, we did not make separate recommendations specific to FCI Sheridan because the significant concerns we uncovered at this institution were consistent with systemic issues that the OIG has identified in its prior work, which resulted in the OIG making numerous recommendations directing the BOP to address these issues at an enterprise-wide level. The lack of recommendations in this report is not an indication that our findings at FCI Sheridan are not serious, or that they do not require immediate action from the BOP.

While we are encouraged by the steps the BOP has taken to address healthcare backlogs and other issues identified in our report, the OIG notes that the progress cited in the BOP's formal response occurred after the OIG inspection identified these issues of significant concern. It is critical that the BOP address the OIG's open recommendations related to staffing, infrastructure, and other foundational challenges so that the concerns identified in this inspection are addressed by the BOP in a proactive manner across the entirety of the BOP.

We will closely monitor the BOP's efforts to remedy the issues identified at FCI Sheridan as part of our oversight of the BOP's corrective actions to address the systemic issues identified in our prior work.