

**EXAMINING AND PREVENTING DEATHS
OF INCARCERATED INDIVIDUALS
IN FEDERAL PRISONS**

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WEDNESDAY, FEBRUARY 28, 2024

UNITED STATES SENATE,
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Committee met, pursuant to notice, at 10 a.m., in Room G50, Dirksen Senate Office Building, Hon. Richard J. Durbin, Chair of the Committee, presiding.

Present: Senators Durbin [presiding], Coons, Blumenthal, Booker, Ossoff, Welch, Butler, Grassley, Hawley, Cotton, Kennedy, and Blackburn.

**OPENING STATEMENT OF HON. RICHARD J. DURBIN,
A U.S. SENATOR FROM THE STATE OF ILLINOIS**

Chair DURBIN. This meeting of the Senate Judiciary Committee will come to order.

The Committee's going to consider a troubling report recently issued by the Justice Department's Inspector General regarding the deaths of incarcerated individuals in the Federal Bureau of Prisons. I welcome Director Peters and Inspector General Horowitz back to the Committee.

In recent years, more than 300 people have died of unnatural causes in custody of the Bureau of Prisons—deaths that too often have been the result of mismanagement and operational failures.

An investigation by The Marshall Project and National Public Radio 3 years ago found that the Thompson Federal Prison in my home State of Illinois had become one of the deadliest prisons in America because of the now defunct Special Management Unit.

I was shaken by the allegations in that article and immediately asked Inspector General Horowitz to examine them. We will discuss the results today.

After media reports late last year alleged that some adults in custody died while waiting for necessary medical care, I called on BOP to change its procedures, staff, and supply medical units so that incarcerated individuals could receive the care they needed.

It is evident that many of the issues the Committee has highlighted over the years, including understaffing, overuse of restrictive housing, and employee misconduct, will continue to have deadly consequences if they go unaddressed.

The Inspector General's report identified 344 non-medical deaths of adults in custody in its review period 2014 to 2021. A number

of trends emerged that demonstrated increased risk to safety of individuals in BOP care.

For example, 20 percent of these deaths were overdoses from contraband and prescription drugs. BOP continues to struggle with contraband interdiction, and lacks adequate treatment for thousands of individuals fighting addiction.

Understaffing, particularly in health and psychology services, strains their ability to provide quality care. Violations of BOP policy by staff, quote, “present significant barriers to the BOP’s ability to ensure institutional safety.”

This afternoon, my colleague, Senator Booker, Chair of the Criminal Justice Subcommittee, will hold a specific hearing on prison staffing crisis. I thank him for his leadership.

BOP’s lengthy and ineffective discipline process fails to bring accountability for staff misconduct, and BOP consistently fails to use post-death reviews and proper record keeping to identify corrective actions.

This failure to learn from past mistakes is most troubling when examining the role of restrictive housing in custodial deaths. Suicides accounted for just over half of the 344 deaths CIG reviewed. Almost half of those suicides occurred in restrictive housing, which is more commonly known as solitary confinement.

We have a stark reality when it comes to solitary confinement. This is cruel and unusual punishment that has been the norm in the United States for way too long.

In 2012, I held the first ever congressional hearing on solitary confinement. At the time, nearly 8 percent of federally incarcerated individuals were in restrictive housing.

After some progress under President Obama, we’ve returned to roughly the same percentage of people in solitary today.

We know that overuse of solitary confinement causes lasting irreparable physical, emotional, and mental harm to incarcerated people. Moreover, it threatens public safety and strains prison budgets.

I want to add, too, parenthetically, I understand some of the individuals we’re talking about are dangerous people who need to be isolated under certain circumstances. I’m a realist about that. But this consistent reference of 8 percent is unacceptable.

Earlier this month, the General Accounting Office released a report which I requested with Senator Coons. It found that the Bureau of Prisons has failed to implement 54 of the 87 recommendations from two prior studies on restrictive housing.

Let’s be clear. The failure to decrease our over-reliance on restrictive housing is deadly. Deadly. That is why I held a follow-up hearing on the dangers this spring.

Director Peters, I understand many issues we’re discussing today have been problems for years, long before you arrived. But it’s time for solutions and change. The lives of hundreds of Americans in Bureau of Prisons custody are at risk.

My colleague, Ranking Member Senator Graham, is under the weather today and won’t be able to join us this morning. And Senator Grassley was here momentarily to acknowledge the opening of this Committee meeting. He has another conflict in his schedule, as well. But I want to proceed.

We're going to swear in the witnesses. Each will have 5 minutes to provide an opening statement, then rounds of questions for each Senator present of at least 5 minutes.

So I ask the individuals to please stand. Raise your right hand. [Witnesses are sworn in.]

Let the record reflect that both have answered in the affirmative, I should say. And we will start with Inspector General Horowitz. You may proceed.

Inspector General HOROWITZ. I'm sorry. Couldn't hear.

Chair DURBIN. Oh, I'm sorry.

Inspector General HOROWITZ. There you go. Calling on me first, was that it?

Chair DURBIN. Yes, it is.

Inspector General HOROWITZ. Thank you, perfect. Appreciate it.

STATEMENT OF HON. MICHAEL E. HOROWITZ, INSPECTOR GENERAL, U.S. DEPARTMENT OF JUSTICE, WASHINGTON, DC

Inspector General HOROWITZ. Thank you, Chairman Durbin, and thank you to Members of this Committee for holding today's important hearing.

I also want to acknowledge, with me are the team that worked on the Deaths in Custody Report and went to visit sites including USP Thompson, the prison that you mentioned in your opening statement.

I've been Inspector General now for almost 12 years, and every year I've included the BOP in my annual report of the top management and performance challenges facing the Department of Justice.

Yet, with some notable exceptions, the problems at the BOP seemed to only increase. Indeed, last year, the BOP was added to the GAO's high-risk list. To be clear, these are not new problems.

Indeed yesterday, we released a compendium of over 100 publicly issued OIG reports since 2002, reflecting the systemic challenges at the BOP that we've identified over the past two decades.

Many of the 344 deaths that you mentioned that we found were due to suicide, homicide, drug overdose, or other unknown factors that we reviewed in the Deaths in Custody Report have a direct connection to these challenges.

And by the way, as we reference in our report, so did the high-profile deaths of inmates Jeffrey Epstein in 2019 and James "Whitey" Bulger in 2018, as we detailed in those public reports that we issued.

When the public wonders whether the treatment of those two high-profile inmates was unique, the answer sadly, from our Deaths in Custody Report, is that it was not. Many of the 344 inmate deaths we discuss in the report were the result of similarly serious management and operational failures.

These include long-standing management and operational challenges that involve serious staffing shortages including for correctional and healthcare positions, single-celling of inmates, inappropriate mental healthcare designations of inmates, ineffective contraband interdiction, an outdated camera security system, staff failure to follow BOP policies and procedures, and an ineffective untimely staff disciplinary process.

Indeed, one or more of these challenges was a contributing factor in many of the inmate deaths in our scope. And these long-standing challenges continue to present a significant and critical threat to the BOP's safe and humane management of inmates in its care and custody.

For example, we found that in nearly one third of the inmate deaths within our scope, contraband drugs or weapons contributed or appeared to contribute to the death.

The rampant proliferation of contraband is a major challenge for the BOP resulting in the BOP partially closing its Federal penitentiary in Atlanta in 2021.

And as our report notes, USP Atlanta had the highest number of deaths during the time period of our review. Ensuring that staff follows policies and procedures and are held accountable for serious wrongdoing is critical to improving the safety and security of BOP institutions for both inmates and the overwhelming majority of BOP employees who do their jobs with honesty and integrity.

The OIG dedicates significant resources to investigate alleged criminal wrongdoing at BOP facilities, particularly sexual assault, and contraband smuggling.

As we've seen through our ongoing criminal investigation at FCI Dublin, where the warden, chaplain, and several other inmates have been convicted of sexual assault charges, failing to timely identify and address criminal wrongdoing can spiral and poison an institution's culture.

Relatedly, our ongoing use—our audit of BOP's use of restraints was prompted in large part by allegations that inmates at USP Thompson, which you referenced, and their Special Management Unit were routinely placing four-point restraints for extended periods of time and that inmates were otherwise mistreated while restrained. This unit was recently closed by Director Peters in response to these and other concerns.

Let me now turn to suicide, which comprised, as you noted, the majority of the deaths we reviewed. More than half of those who died by suicide, as you noted, were in single-cell confinement, despite BOP policy that strongly disfavors the use of single-celling.

Further, almost half the suicides, as you noted, occurred in restrictive housing units. Moreover, over 60 percent of inmates who died by suicide had been designated at the lowest mental health treatment level.

None of these are new issues. The OIG has repeatedly identified them in our prior reports, and the GAO has also raised them.

We made 12 new recommendations in our Deaths in Custody Report, and the BOP agreed with all of them. And we will carefully monitor the BOP's implementation of them.

Effectively addressing these widespread systemic issues at the BOP requires a long-term vision and strategy from BOP and Department leadership, with support from the Office of Management and Budget, the Congress, and other important stakeholders.

To be clear, the problems we've identified in our oversight work over the past 20 years won't be solved overnight. But they must be addressed with urgency to protect the health, safety, and security of BOP staff and inmates, and to enable inmates to successfully return to our communities upon their release from prison.

And toward that end, I very much have appreciated my quarterly meetings with Director Peters and her desire to meet with me regularly. It's the first time in my 12 years as IG where that's occurred and we've, I think, made some important progress working together.

Thank you, and I'd be pleased to answer any questions the Committee may have.

[The prepared statement of Inspector General Horowitz appears as a submission for the record.]

Chair DURBIN. Thank you, General. Director Peters.

**STATEMENT OF HON. COLETTE S. PETERS, DIRECTOR,
FEDERAL BUREAU OF PRISONS, WASHINGTON, DC**

Director PETERS. Good morning, Chairman Durbin, Ranking Member Graham, who's not with us today, and Members of the Committee. I am pleased to be here with you and Inspector General Horowitz to discuss the Deaths in Custody Report. We welcome, agree with and——

Chair DURBIN. Could you pull the microphone just a little closer to you? Thank you.

Director PETERS. Yes. We welcome, agree with, and are implementing the report's recommendations and have plans to go even further and take additional steps to mitigate unexpected deaths in custody.

I have spent my entire professional career working in the public safety field, including as a victim advocate, working with victims who lost loved ones. I know any unexpected death of an adult in our care and custody is tragic and it changes the lives of that person's family and loved ones forever.

We also experience these deaths as a heavy blow. I have been in our institutions in the days following unexpected deaths, and I have seen our employees suffering due to the loss.

Our core mission always is to care for those in our custody in hopes that they leave our facilities prepared to be good neighbors. When our best efforts are not successful and death does occur, we initiate review processes to understand the cause of these deaths so that we can prevent similar deaths going forward.

But we can do better here and must ensure that our reviews go deep enough and our documentation is clear enough to support those reviews.

Our psychological assessments conclude that many individuals who come to us come with mental illness and substance use disorders, making them more susceptible to suicide, overdose, and homicide. So to combat these deaths, we work on root causes and have incorporated evidence-based treatments like medication-assisted treatment.

We train our employees to recognize those at risk of attempting suicide, refer at-risk people for help, and respond to suicide attempts. And also train on the appropriate use of CPR, AEDs, Naloxone, and cut down tools, ensuring our employees have access to those tools in the workplace.

The report notes that suicides occurred when people were single-celled or in restrictive housing. That is why we now provide special

training to those who work in restrictive housing and limit the use of single-celling.

We have restrictive housing reforms underway now that will reduce the amount of time adults in custody spend in restrictive housing for disciplinary violations. We are creating a special post and restrictive housing to help those in custody transition from that restrictive housing environment to the general population, and we're going to add employees in restrictive housing during the overnight shift.

We continuously work to combat contraband to reduce homicides and overdoses. This includes heightened screening of mail, detecting and intercepting drones, monitoring or terminating cellular communications, and continually monitoring intelligence and gang activity.

To harness all of this intelligence, we are creating a new Chief Inspector position to identify system-wide patterns and problems, including that that would prevent deaths in our custody.

On a departmental level, the Deputy Attorney General has also formed a working group of experts to better prevent suicides. Again, I want to be perfectly clear, our employees are our everything and fully staffed institutions and well-trained employees save lives. Yet it is no secret that our agency is in crisis as it relates to recruitment and retention.

We are aggressively recruiting and utilizing incentives to maintain the employees we have, and while our efforts over this past year have gleaned results, we are still faced with an inability to compete with the private sector and other law enforcement agencies.

As an example, at a Federal prison about an hour outside of Boston, a correctional officer recently quit his job for a better offer with better pay. The better offer, working at the local grocery store.

On the law enforcement side, an ad running in the New York City Subway is advertising that city correctional officers can make around \$130,000 after a few years on the job.

While in the same amount of time, our officers, after we've implemented the 35 percent retention bonus, would be making about \$90,000. The story is the same throughout the country. We need more resources to carry out our mission, implement our vision, and reach our goals.

Chairman Durbin, Ranking Member Graham, and Members of the Committee, thank you, once again, for this opportunity to speak on behalf of the Federal Bureau of Prisons, and I welcome your questions.

[The prepared statement of Director Peters appears as a submission for the record.]

Chair DURBIN. Thank you very much. My interest in this issue started many years ago when I read an article in *The Atlantic* magazine by Atul Gawande, a doctor in Boston, about the impact of isolation and solitary confinement on the human mind, not just in this correctional setting, but prisoners of war.

He referenced our former colleague, John McCain, and what he went through after 5 years of that type of treatment, and what impact it had on him. And Dr. Gawande, who now works for the USAID, reminded us that the majority of prisoners will ultimately

be released. If they're damaged in the process of serving time in prison, they'll take that damage out into the open society and others may suffer.

So this has been a long-time issue. It's been 12 years since the first hearing under my leadership occurred in this Committee. I voiced concerns over reliance on solitary confinement, pleaded with the Directors—now and before you—to do something about it. I'm going to reintroduce my legislation, Solitary Confinement Reform Act, to limit the use of the practice.

Director Peters, the latest statistics show that despite the decrease in Bureau of Prison's total population, since you were sworn in as Director in August 2022, the percentage and total number of individuals in restricted housing is actually higher than it was at that time.

As of this month, approximately 7.9 percent, or 11,179 people, are currently being held in some form of restrictive housing, an increase of 0.6 percent since September 2022.

Director Peters, you previously pointed to your contract with the National Institute of Justice when asked about your plans to address restrictive housing. What is the status of that study?

Director PETERS. Thank you, Senator. So the study is underway, NIJ has issued the contract, the individuals studying our restrictive housing have actually been onsite and are visiting facilities, looking at our policies, our practices, and interviewing employees.

We've also—we're also not just waiting for the results of that report. We're beginning to implement restrictive housing reform.

Currently, we have plans to approve a new policy that will actually reduce the amount of time an individual can be sanctioned to restrictive housing for disciplinary purposes. As I mentioned in my opening comments, we're adding additional resources to solve this problem, and in the short-term, as you well know, in your very own State, we shut down the Special Management Unit in quick order last year.

Chair DURBIN. Here's my concern. Since my first hearing on this issue in 2012, there have been multiple reviews of BOP policy.

The latest came out earlier this month when the GAO published a report I requested. According to their report, BOP has not fully implemented 54 of the 87 recommendations from two prior studies on improving restrictive housing practices. One of those studies from 2014 was conducted by an external consultant. It made 34 recommendations, only 16 have been fully implemented.

And a 2016 evaluation completed by the Department of Justice under the Obama administration, which President Biden ordered the Attorney General to implement in 2022, made 53 recommendations and only 17 have been implemented.

The time for studies is over. The death rate in our prisons is unacceptable. Damage to mental health is unacceptable. My question to you is, what steps can you commit to today to immediately reduce restrictive housing populations?

Director PETERS. Thank you, Senator. I think there are a variety of things that we're doing today, including proving that policy that's been long-standing negotiated with our national union, and that will decrease the amount of time that individuals can actually be sanctioned to restrictive housing for disciplinary purposes.

The data also reveals that many of the individuals that are in restrictive housing, are in there many times at their own choice because they fear their ability to walk in general population.

So we are working on creating cultures and environments that are more normal and humane, so those individuals actually feel comfortable in general population.

And then, as I mentioned in my opening remarks, we're creating positions who will work in restrictive housing and their sole responsibility will be working with those individuals who don't want to leave restrictive housing and help them transition into general population.

We did this in the State of Oregon and it was very successful. So we're looking forward to rolling that out this year. We are also looking at best practices across the country and around the globe to implement changes.

As I shared with you the last time that we met, this last year has been filled with strategic planning for the Department. We've rebooted our mission, our vision, our values, and many of the goals that we're working on will tie into restrictive housing, both a strong plan around restrictive housing reform, and building morale and working on our recruitment and retention issues, which are at the core of many of the issues, as the Inspector General pointed out.

Chair DURBIN. What percentage of people in restrictive housing volunteer to be in that housing?

Director PETERS. That number is almost 40 percent. And we are looking at the data as we get even closer into the data. It might even be higher than that, because we have individuals that are categorized as PC status, which falls into that 40 percent, but also individuals that are on transition status. And those two could fit into that category.

Chair DURBIN. Aside from that category and those that are incarcerated because of their danger to cell—other prisoners and cellmates, I'd like to ask you, do you accept the premise that those who are put in restrictive housing involuntarily run the very real risk of serious mental illness or worse?

Director PETERS. Senator, I would argue that everyone who is in restrictive housing has the—will suffer from some form of mental or physical damage. I think even those that are agreeing or wanting to be in restrictive housing need to be educated on the fact that that isn't where they belong and that we need to be able to safely house them in GP.

Just because they're volunteering to be there doesn't mean that the physical and mental wear and tear isn't happening for them, as well. And I think that's what that position that we're wanting to create to put into restrictive housing will help combat.

We also have reintegration units for those individuals where we actually have step-down programs and units that help people get out of restrictive housing. And we need to do better there, as well.

Chair DURBIN. Thank you. Senator Blackburn.

Senator BLACKBURN. Thank you, Mr. Chairman, and good to see you again. Always appreciate our conversations with you. I know our hearing today is focused on deaths of the incarcerated.

But I want to change the topic just a little bit and look at the treatment of our BOP officers and focus on what is happening with some of the assaults against our staff—BOP staff. And not only the physical, but the PTSD and some of those issues that occur.

And yesterday I introduced the Safer Prisons Act, which would double the maximum term of imprisonment for assaulting a BOP correctional officer.

And Director Peters, for you, I know you'd agree that these assaults present a real danger for the Bureau of Prisons. So I'd like to have your support on the Safer Prisons Act and have you support doubling that maximum term.

Director PETERS. Thank you, Senator. Well, you know, there are processes with the Department of Justice in terms of component heads being able to support legislation.

But I will tell you that the safety and security of our employees are the—are essential, they are our everything. If they don't feel safe—

Senator BLACKBURN. Yes.

Director PETERS [continuing]. In our institutions then we have lost the core of our mission.

Senator BLACKBURN. Let me ask you this, you mentioned hiring and retention as an issue. Do you think the safety or the lack of safety and protection plays into that difficulty in hiring and retention?

Director PETERS. I think that we do our best through augmentation and overtime in order to ensure that the posts that need to be filled are filled.

But you and I have talked before, augmentation is a great resource in the short-term and we've been using it in the long-term to solve a long-term recruitment and retention problem.

And it is making our people exhausted. They are riveted with overtime augmentation impacts, FSA programming and operations visiting is sometimes canceled because we don't have the people to support those posts. So we have a lot of work to do in this area and we've thrown every incentive and direct hire authority and everything that we can. But we need to go further.

Senator BLACKBURN. You and I have previously discussed Jeffrey Epstein, and the Chairman knows I've been trying to subpoena his flight logs in Ghislaine Maxwell's little black book.

I think it's essential as we look to break apart the sex trafficking rings that not only are here in the U.S. but have grown to be global entities—\$150 billion-a-year business, globally trafficking human beings—primarily women and girls.

So while Epstein was in BOP's custody, did you ever have access to his unredacted flight logs or to Ghislaine Maxwell's little black book?

Director PETERS. So as a former victim's advocate, I know that you and I share values around combating sex trafficking.

The Epstein situation happened before my tenure—

Senator BLACKBURN. Yes.

Director PETERS [continuing]. At the Federal Bureau of Prisons. So I was not a part of any of that evaluation and would turn to the Inspector General for any of those questions.

Senator BLACKBURN. Okay.

Inspector General HOROWITZ. Senator, I don't—I don't know the answer as I sit here. We can certainly make an inquiry.

Senator BLACKBURN. I would like to have that answer in writing, if you will?

Inspector General HOROWITZ. Yes—I mean, we'll ask the BOP—

Senator BLACKBURN. I—

Inspector General HOROWITZ [continuing]. Obviously, we don't have—

Senator BLACKBURN. Right—

Inspector General HOROWITZ [continuing]. The information you're looking for—

Senator BLACKBURN. Absolutely.

Inspector General HOROWITZ [continuing]. For we'd have to ask the BOP.

Senator BLACKBURN. I appreciate that. But I would like a response in writing.

I also, Director Peters, there is—we have heard that BOP is helping to transport migrants from the Southern Border into the country. And the Bureau has confirmed that it has provided transportation for migrants since CBP has been inundated with the surge at the Southern Border.

And we've talked before about the extensive staffing challenges at BOP and the negative consequences that come with that. So are you comfortable with having to dedicate your resources that are already stressed to alleviate President Biden's Border surge?

Director PETERS. So as a fellow law enforcement agency inside the Departments, we, of course, support supporting other components in helping with crises. It's one of the things that we do well. But—

Senator BLACKBURN. Let me ask you this. My time's about to run out. Have you ever transported an individual who was on the Terrorist Watch List?

Director PETERS. Senator, I don't know the answer to that question.

Senator BLACKBURN. Could you look into that and respond in writing?

Director PETERS. I will have my team look into it and we'll get back to you with information that's available.

Senator BLACKBURN. Excellent. And my time is up, but as always, I'm going to mention the Memphis facility and you and I have such an ongoing conversation around that and I do look forward to getting an update on that from you.

Director PETERS. Thank you, Senator.

Senator BLACKBURN. Thank you.

Director PETERS. I did check this morning, and it looks like the timelines that we have provided the last time we checked are on target.

Senator BLACKBURN. Excellent. Thank you, Mr. Chairman.

Chair DURBIN. Thank you, Senator. Senator Blumenthal.

Senator BLUMENTHAL. Thanks Mr. Chairman. Thanks for having this hearing.

You know, correctional officers, as I know from having been United States Attorney and then Attorney General of our State in

Connecticut, are among the hardest working and least appreciated, whether at the State level or Federal level. They have to deal with dangerous situations every day. Their work is out of public sight for good reason, because obviously they're in confinement situations.

And so I am very, very sympathetic to the points that you made, Director Peters, about the need for retention, recruitment, and appreciation of the working conditions and the compensation that they deserve.

And I wonder, short of additional compensation, whether there are working condition issues that could be addressed? Mandated overtime, other kinds of demands placed on them, that maybe can be mitigated through better scheduling, better accommodations for them in their leisure moments during the job. Maybe you can comment.

Director PETERS. Thank you, Senator. Well, I appreciate those comments greatly. I think you're right. They are unsung heroes. They're people that don't get lifted up.

And I will say to any other law enforcement agency, I think correctional officers have the toughest beat in public safety and the wear and tear, you know, the data—one in three have PTSD. Many are exhausted with overtime and augmentation.

And so yes, we have to change the cultures inside our institutions. We're working on creating more normalized and humanized environments so that they feel less institutional.

Our maintenance and repair backlog is about \$3 billion. So when I visit our institutions, our wardens are just as excited to show me the new FSA programming and treatment as they are the walls that are crumbling and the stairwells that are crumbling.

And so that type of an environment is no place for anyone to live or work. And so we have a lot to do to change the environment for our correctional officers.

The Fed survey says that the Federal Bureau of Prisons is the worst place to work in Federal Government. So we have a lot of work to do to help support our correctional officers who are exhausted.

Senator BLUMENTHAL. Correctional officers work behind bars.

Director PETERS. That's right.

Senator BLUMENTHAL. They work 8 hours a day, sometimes more, with people—let's be very blunt—who have often committed very violent acts that put them behind bars. And so the more we can do to improve those institutional settings, the more we can change the environment for them, and perhaps the way they react to the challenges they face. Would you agree?

Director PETERS. Thank you, Senator. I agree wholeheartedly.

And while we have issued every authority in our power, like we've increased the base salary for COs by \$2000, we have recruitment and retention incentives across the country, we have direct hire authority.

The bottom line, as I said in my opening comments is, we need to pay them more. That base, the retention incentive and recruitment incentives, are band aids. We have to figure out how to increase that base salary so that we can hire the best and the brightest and keep them.

Senator BLUMENTHAL. Mr. Horowitz, in 2014 I led an effort called the Death in Custody Reporting Act.

Congress passed it. The President signed it.

It included, among other things, a requirement for a study. We are here 10 years after the passage of that measure. There has been no study of the data with respect to arrest-related and in-custody deaths.

I agree wholeheartedly with the Chairman that the time for studies is over. We need action. But studies sometimes can be informative and can guide action in the right direction. Would you agree that study should be done?

Inspector General HOROWITZ. Absolutely, Senator.

In fact, one of the reasons we undertook this work was because there wasn't a set of data out there. And we shouldn't have to be the—the first line of defense on these issues. Right? It should be the Department itself. It should be the component itself that does that. It's not happening as it should.

Senator BLUMENTHAL. And you point out, I think, and I think Director Peters you make the point, as well, that half of the 344 deaths by suicide have occurred with respect to prisoners who are in single-cell housing or in solitary confinement.

Now, I recognize that there are significant mental health components to the reasons for the suicide, but the correlation between that fact—isolation in a single cell and death by suicide—maybe ought to give us reason to change some of those policies. Would you agree?

Inspector General HOROWITZ. Absolutely, Senator. I think there are several figures that jump out here.

One is the fact that half of the folks are—roughly half were in single cells, roughly half, little less, were in restricted housing.

And the one I mentioned in my opening, which is that over 60 percent of the suicides—of the individuals who died by suicide were in the lowest mental health category.

Of the four categories, they were deemed to not need mental health treatment. That's over 60 percent of people. And that's very concerning. That's something that needs to be addressed, and something frankly we've highlighted before as a problem and an issue.

Senator BLUMENTHAL. Thank you. I want to thank the Chairman for having this hearing. I want to thank you both for your public service. Correctional policy isn't the most glamorous, but it is among the most important of what we do in criminal justice. And thank you both for your work. Thank you.

Chair DURBIN. Thank you, Senator. Senator Coons.

Senator COONS. Thank you, Mr. Chairman, and thank you to both of our witnesses for your testimony.

Director Peters, you have inherited leadership of a deeply troubled institution, and I suspect you some days feel like your job is more akin to trying to change the direction of an aircraft carrier than lead an agile and well-resourced organization, because BOP is frankly neither. And I appreciate the determination, openness, and vigor with which you've approached this task.

And to Inspector General Horowitz, it was very encouraging to hear that the two of you are working together, responsibly, that in-

stead of viewing the IG as a hostile party, you, as a BOP Director, are engaging around these issues.

Nonetheless, as the Chairman pointed out—and I want to thank you Chairman Durbin for your engagement and determination on this issue over many years—there are lots of recommendations that have not yet been fully implemented. There’s lots of important policy work to do here.

As Senator Blumenthal just said, Federal corrections is a really important part of our criminal justice system. It doesn’t get the attention that it needs and deserves.

I’ve long been concerned with the overuse of solitary confinement, and have appreciated the chance to work with Chairman Durbin in support of his Federal Solitary Confinement Reform Act now for several congresses.

Director Peters, I just want to say I appreciate your leadership in establishing an internal task force and partnering with the National Institute of Justice to develop further recommendations on this issue. But we’ve got lots of recommendations over many years of work.

Inspector General, let’s put aside, just for the moment, the issue of policy implementation and first—focus first on the need to have policies to implement. Can you just briefly elaborate on what is lacking at an overall policy level now in terms of addressing restrictive housing in single-celling?

Inspector General HOROWITZ. Thank you, Senator. So that is one of the significant recommendations we’ve made in the past many years ago, 2017 report, about the lack of an overall policy guidance for when people should be put in restrictive housing and when they should be single-celled. And we weren’t alone in that, actually.

The BOP itself put together a 2021 task force and asked what should they do. They listed 11 recommendations, I believe it was. And one of them was implement the OIG’s earlier recommendation and put in place this policy. And that is still an open recommendation.

So there needs to be an understanding among all the wardens in all 121 institutions that what, when, and how should single-celling be used.

Let me just, if I could, Senator, just give you a sense during COVID.

A directive went out from BOP leadership to not use single-celling as a quarantine method unless there was an extraordinary reason to do so.

Well, seven of the suicides were quarantined individuals during COVID, not because they were acting up, but because of COVID quarantine. By the way, five of the seven hadn’t had the review done before they were single-celled to see if they had indicia of mental health illness or potential, and after-action reviews indicated that maybe all seven did.

Senator COONS. Striking. Director Peters, can you just respond to that particular question about having a policy in order to be able to implement it?

Director PETERS. Absolutely. And so here’s what we’ve done.

First, I want to say thank you for your comments about the partnership with the Inspector General. I'd love to say publicly that the partnership has been exceptional.

I am the former Inspector General of the State of Oregon, so I know very much to respect his very hard job. And we are working on implementing all of the recommendations. Here's what we've done as it relates to the fine point of the question that you've asked.

We have a policy, a restrictive housing policy that has been under review and negotiation with the National Union for a very long time. We are so close to finalizing that policy, which will implement a lot of the Inspector General and GAO's recommendations.

Furthermore, we have an exceptional relationship with the National Union and the incoming President is working with us directly, and we're going to come up with a plan to streamline policy adoption so that we don't have significant delays and have this be a barrier to implementation of the Inspector General and GAO's recommendations.

So we also have a future state and plan on how these policy negotiations will happen going forward.

Senator COONS. Good. That's encouraging.

I would hate to see the clock run out on your opportunity to resolve these long-standing issues and to have the union at the table and BOP leadership at the table and be implementing some of the IG's recommendations on this critical area. It's encouraging to me.

I'll be following this and I know the Chairman will be legislating. Could I briefly ask one more question, Mr. Chairman, with the forbearance of my colleague down the dais?

When a Federal defendant is found mentally incompetent to stand trial, my understanding is if they're released on bail, they're then required to be returned to custody to see if their competency can be restored in a BOP facility.

But there's few facilities with this capacity. They have very long wait times, and that means that mentally ill, but presumed innocent people can end up in terminable incarceration before they get the help they need and before the criminal justice process can proceed.

This has led to charges being dropped in some cases due to speedy trial issues. Director Peters, can you speak about what BOP has been doing about this? And will you work with me on helping identify ways that Congress can help specifically on this issue?

Director PETERS. Yes. Thank you, Senator.

So this is another issue—a long-standing issue that the Department has had around lack of resources that are resulting in this backlog of these reviews. And here's what we've done in the last year.

We have added additional beds at our—40 additional beds at our facility in Chicago to help us peel back this backlog.

We are looking at adding additional beds this year at another facility that we've yet to determine, but are working on a plan.

We have also worked to create a psychology review team—that's a traveling team that's going to travel across the country now to help work on this backlog.

And then further, we're working on a program where we can hire individuals who have their Ph.D., but yet haven't completed their dissertation, that would be able to come and help with these reviews, as well.

So this is a long-standing issue that we're trying to fix. It's a conversation that I've had with the U.S. attorneys on many, many occasions. But it is certainly in our sights.

Senator COONS. Thank you. Thank you both, and thank you, Mr. Chairman, for your leadership.

Chair DURBIN. Thanks, Senator Coons.

As we mentioned earlier, Senator Booker's Subcommittee on Crime is having a hearing this afternoon on staffing in the Federal prisons, which has come up in this morning's meeting many, many times. So let me recognize Senator Booker.

Senator BOOKER. First of all, thank you very much for this hearing and I'm grateful for the two witnesses being here.

Before I get to just a question on staffing in general, I just want to talk about mental health and the well-being of both people that are incarcerated, as well as the mental health of a lot of our incredible correctional officers.

Suicide rates for both groups are alarming to me. Nationally, according to this society for suicide prevention, it's about 14 out of every 100,000 Americans die of suicide annually.

That number alone should cause concern for all Americans that it's so high. But people in custody die at rates that are much higher.

According to the Bureau of Justice Statistics, in 2019 it was up to 20 out of every 100,000 persons. So I'm wondering, first, maybe perhaps Director, for the people that are incarcerated, what steps is the BOP taking to curb this extraordinary rate of individuals committing suicide in custody?

Director PETERS. Thank you, Senator. So we've done a variety of things and while one suicide on our watch is one suicide, too many, I think the things that we have implemented at the Bureau are represented in the data in that our suicide rate is less than the general population and less than State corrections. And I think it has to do a lot with the psychology resources that we do have.

While I am going to argue for more and better pay for those doctoral level psychologists, they do do incredible work in terms of finding those individuals that need resources, and then we wrap those resources around them, and we have more work to do.

We have—are looking at our after-action reports, looking to see if those need to be more substantive. Are we sharing the data across the country when we find issues that need to be resolved, resolved? I personally, Senator, read every reconstruction report and then meet with a multidisciplinary team to talk about what we've learned and how we're going to implement changes going forward.

Senator BOOKER. And then just sticking with inmates, in an OIG report, there was a discussion of the inmate companion program in which institutions may utilize individuals who are in BOP custody in lieu of BOP staff. And it seemed to have some really promising success.

The report indicates that both detained individuals and staff found several benefits from the program. Staff explained that program participants were more effective than BOP staff at suicide watches because they took better notes and interacted more frequently than staff.

And so I'm just wondering, can you provide the Committee with additional information on this program? And is it promising, and something that you may want to expand?

Director PETERS. Yes. Thank you, Senator. So, as I've traveled to more than 40 of our institutions in the last year. I've had the privilege of meeting some of these companions. And not only does the data bear that it is a productive program, but just hearing the anecdotal stories about their ability to connect better with a peer, if you will, than maybe a corrections professional would be able to do, has been quite profound.

And they take their job so seriously. So we train them. We just don't select random adults in custody. We have a really clear selection process, and then we train them like we train our staff on looking for those predictive characteristics that we're looking for. And then that—

Senator BOOKER. And just to jump in, so far as interrupting, because I want to try to get two more questions in, and respect Senator Ossoff's time.

Just law enforcement in general has real challenges with mental health, and the suicide rates of law enforcement in general are difficult. Can you just talk about the—the BOP personnel really quick, and then I'll get my other question out on the staffing issues for correctional officers?

Can you just provide the Committee with an update on some of the financial incentives that you've talked about before?

I just still find it astonishing that correctional officers are at the very bottom of all Federal law enforcement. That the amount of money they make to me is, why would you—better to go be a TSA agent or jobs like that than it is for—in terms of the compensation.

So can you address both the mental health and wellness steps you're taking for correctional officers? And then just those financial incentives, which seem to be urgently needed? And frankly, I think these incredibly hard workers need to be paid more.

Director PETERS. Thank you, Senator. Well, I certainly appreciate your passion around the mental health of our corrections professionals who are often unsung heroes in the toughest law enforcement beat.

And the data is startling. One in three have symptoms of PTSD. That means more anxiety, more depression. That means more reliance on substance abuse and higher levels of divorce. Over 90 percent are obese or in the overweight category. Over 90 percent have hypertension or pre-hypertension, which means they're on the track for cardiac disease.

And so the data is staggering. And what we're finding across the country, in some places, they can leave the Federal Bureau of Prisons and work for State corrections and make two to three times more, let alone the bonuses that we're battling against at fast food organizations.

So it is incredibly difficult. We have thrown every incentive that we can at this problem—every recruitment incentive, every retention incentive. We've increased the base salary by \$2000 for correctional officers. That's the amount of authority that I have.

But the bottom line, as I said in my opening comments, is like you are referring, we need to increase that base salary. We need to pay more. And when we compare to other law enforcements, I also want to remind the Committee that the average onboarding for law enforcement in this country is 21 weeks. And our officers receive about six.

Senator BOOKER. It's truly unfortunate. And I'm hoping you can answer for the record, my second part of that question about some more detailing of the financial incentives. But I appreciate the indulgence, Mr. Chairman.

Chair DURBIN. Thanks, Senator Booker. Senator Cotton, you would be next, but if you'd like a minute, Senator Ossoff.

Senator OSSOFF. Thank you, Mr. Chairman. Thank you, Senator Cotton, and thank you both for being here. It's a pleasure to see you both again.

Director Peters, following up on Senator Booker's question about retention incentives, at USP Atlanta, as at so many facilities, there are severe staffing issues, a real difficulty recruiting and retaining staff. I had sent you a letter asking that BOP undertake what efforts it could to add retention incentives, take steps to ensure that those correctional officers are well paid and can be retained.

And you've replied, which I appreciate, just like your commitment to continue working with my office to make sure that we are treating those correctional officers well, paying them properly, and retaining their services.

Director PETERS. Thank you, Senator. I'm certainly committed to that. We have thrown every incentive that we can that's in our authority at recruitment incentives, retention incentives.

And at the core of many of the issues that the Inspector General reveals, is a lack of staffing. And so this is incredibly important to us. As I said in my opening comments, while the incentives have proven a band aid effect, we need to increase the base salary for these correctional officers so we can hire the best and the brightest and then keep them.

Senator OSSOFF. Well, I'm hoping we can work together to identify some additional tools that may be available for the team at USP Atlanta. Let's remain on the subject of staffing.

In 2021, BOP hired a contractor to develop a tool that was intended to help the Bureau to determine necessary staffing levels for safety at BOP facilities. Correct?

Director PETERS. That's correct.

Senator OSSOFF. And in March 2023, so a year ago approximately, BOP reported that the tool was still being tested in three of BOP's six regions and said it would be rolled out to all six BOP regions by June of 2023. Did that happen?

Director PETERS. Senator, I'm not sure exactly when it was rolled out, but we have completed the initial data analysis as it relates to those employees who are in the correctional services program division, and they're recommending an additional 3,500 positions in that category going forward.

Senator OSSOFF. And how many regions is that tool currently being used, and is it being used for USP Atlanta, for example?

Director PETERS. So I think it's important to understand that that tool is to help us plan for future budget planning and request. It won't—that tool won't help me with the crisis today because I already cannot fill the positions that you've paid for today. And so—

Senator OSSOFF. But in how many regions is that tool currently being used?

Director PETERS. All six. That 3,500 is all six. And then Senator, the next category that they're working on right now is health services, which we have difficulty maintaining and recruiting staff in that category, as well.

Senator OSSOFF. My office—several offices on this Committee have asked for a demonstration of this tool and been told that BOP won't provide it because the tool is still being refined. Can you make sure that we are able to view and observe and participate in a demonstration of that tool within the next several weeks?

Director PETERS. Senator, I will work with my team and see the availability and where we're at with the tool and our ability to share it with you.

Senator OSSOFF. We don't—we can't understand why we can't see. It doesn't make any sense. We should be able to come and see the tool.

Director PETERS. Thank you, Senator. I'll work with my team and see what we can do.

Senator OSSOFF. Well, I hope that we can come and see it in short order.

I understand BOP conducted an inspection of FPC Alderson earlier this year. My team has requested a copy of that inspection report. Sounds like BOP is working on it. Do I have your commitment to get that to us promptly?

Director PETERS. Thank you, Senator. You have my commitment to work with your team to get it to you as quickly as we can.

Senator OSSOFF. Thank you very much.

Inspector General, your report has detailed how BOP staff were in some cases not carrying out key duties, including required inmate mental health assessments, counts and rounds and trainings among others. It found that these operational failures contributed to deaths in custody. How significant a role did under staffing play in those failures?

Inspector General HOROWITZ. I think it's a very significant problem here. It's been a challenge that we've seen not only in deaths, but as we've gone to prisons to inspect them, and the problems that go both for correctional officers who are substantially understaffed ultimately being asked to work sometimes voluntarily, sometimes mandatory overtime.

Then we have augmentation, which is pulling healthcare, potentially educational staff, potentially facility staff, potentially to cover the duties of the correctional officers, which has a cascading effect. Meaning, there are long waits for First Step Act training, healthcare staffing can be shortages are exacerbated and things like that. So it's a big challenge.

Senator OSSOFF. Thank you, Inspector General.

With my remaining time Director Peters, I want to follow up on an issue at USP Atlanta. As you know, a PSI investigation that I led several years ago found very substantial flow of contraband into the facility, including weapons and narcotics. IG's recent report found that contraband drugs or weapons contributed to nearly one third of deaths in custody at BOP.

What steps, Director, have you taken to address the flow of contraband and the threat that poses to public safety at BOP facilities and in particular at USP Atlanta, please?

Director PETERS. At USP Atlanta, the issues that were uncovered still fall into these two categories: lack of staffing, and our maintenance and repair backlog.

As we were able to show you during your visit at USP Atlanta, that facility structure was crumbling and it allowed for hiding contraband inside our institutions.

So we're working to maintain our facilities in a way where they are safe and secure. But we're also working every day to interdict contraband in our institutions through the use of detecting and stopping drone activity, looking at the mail, and looking at ways to stop drugs from coming in via the mail.

We work diligently to ensure that anyone entering our institution has a background check and is physically screened before they come inside.

So this is something that is absolutely top of mind as you well know and pointed out. Contraband is a significant issue and can lead to lost lives or even impact the safety and security of our employees.

Inspector General HOROWITZ. Can I just speak to the contraband issue because it's such a significant issue. It's connected to, we found, one third of the deaths in our review and in the report.

We've been on inspections and we were at FCI Tallahassee, for example, an inspection, and our team went. And what you saw there in terms of challenges on contraband with inmates potentially smuggling contraband, inmates who were working near the fence lines could easily have something thrown over a fence to them.

Inmates who went out to collect garbage were not being checked as they brought bags back into the facility. Some basic stuff that you would think it's not sophisticated to figure out how to try and interdict those kinds—that kind of contraband.

And not surprisingly, by the way, the prison with the highest number of deaths in our report was USP Atlanta, which had been closed in 2021 precisely because of the hundreds—of the dozens of cell phones and drugs found in the prison.

And so this is a major problem. We've had a staff search policy recommendation open for years that has not been implemented—a basic search policy for staff coming in to the facility, that hasn't happened either.

So there are a lot of challenges on the contraband issue that are very significant, that we are concerned is contributing to inmate deaths, both from homemade weapons and from drugs being brought into the facility.

Senator OSSOFF. Thank you both.

Director PETERS. Thank you.

Chair DURBIN. Senator Cotton.

Senator COTTON. Director Peters, the Inspector General noted in his statement for today's hearing that solving the Bureau's staffing shortages is, quote, "One of the building blocks to begin to address the chronic challenges facing the BOP." He also said that significant staffing shortages have had a, quote, "cascading effect" on your Bureau's facilities.

When you testified six months ago, I asked you how many correctional officer positions were filled. You didn't have an answer at the time.

Last month you did an interview with "60 Minutes." You also didn't have an answer. Do you have an answer today for how many correctional officers you currently have on payroll?

Director PETERS. Yes, Senator. We have almost 40,000 authorized positions across the organization, and 14,899 of those are correctional officers. We are going to 100 percent fund those positions. They are only 82 percent filled at this time.

Senator COTTON. 14,899 are correctional officers?

Director PETERS. Yes, correctional officers. The individuals that you would think, in your mind, are on the units safeguarding are custodians.

Senator COTTON. And you said 40,000, that's your total personnel. Right?

Director PETERS. That's our total personnel.

Senator COTTON. What are you authorized and funded for by Congress for correctional officers?

Director PETERS. For correctional officers, we are authorized at that 14,899 number. And it's 100 percent funded.

Senator COTTON. Are you sure you're not authorized about 20,000?

Director PETERS. 20,000 is the correctional officers series position, that's 20,466. That includes correctional officers, lieutenant, correctional services officers, which are in our receiving and discharging unit, and also that number includes correctional counselors.

Senator COTTON. Okay—14,899 is what you have today. Do you know what you had six months ago?

Director PETERS. No, Senator. I don't have that number.

Senator COTTON. Do you know how many new officers have been hired over the last six months? New correctional officers?

Director PETERS. I know that we've made progress in the last year. We have moved our overall recruitment and retention from 87 percent last year to 90 percent. We moved our correctional officer fill from 70s into about 82 percent now.

Senator COTTON. Right. In 2022, the Congress passed the law requiring that your employees spend 90 percent of their time on their primary responsibility. So a correctional officer spends 90 percent of his time being a correctional officer. An HVAC technician spends 90 percent of his time doing HVAC work.

The Bureau hasn't complied with that law, to my knowledge. Six months ago when you were here, I asked how much time your employees are spending on average on their primary responsibility. You didn't have an answer. Do you have an answer for that today?

Director PETERS. I do, Senator, and it's different in every institution. In some of our institutions—we'll take USP Thompson right now. Because we've been able to lower the number of—lower the mission, we needed fewer employees. And so we're not relying on augmentation and overtime. When you look at Brooklyn, we are relying on it substantially because of the lack of staffing.

Many of my officers are working 16 hours regularly and we're having to engage in augmentation on a daily basis at that institution, which as you well know, while those psychologists or teachers, whomever is being augmented, is fully trained and prepared to do that work, it also means that they're not able to do their current job as you're alluding to.

Senator COTTON. Yes. So I take your point that you could average across all of your facilities, but that average is not particularly meaningful, because each facility is its own world and a facility that is well balanced is going to have everyone doing 90 percent of their job, whether it's HVAC or teacher or counselor, correctional officer, another facility might be unbalanced and rely heavily on augmentation and overtime. Is that right?

Director PETERS. That's correct, Senator. And in those facilities where we are fully staffed or more full staffed, we've just given clear direction to those wardens to begin over-hiring so that if they're in an economy where we're actually able to bring in correctional officers, we'll hire them and then we'll TDY them to some of these other institutions that are in more dire straits.

Senator COTTON. Okay. But based on your answer, I assume you know the answer on a facility-by-facility basis, you have that data available to you?

Director PETERS. That's correct, Senator.

Senator COTTON. Is that data public in any of your published reports?

Director PETERS. I will have to check on that and see.

Senator COTTON. If it's not—if it is, please send us the link. If it's not, could we get those—that data——

Director PETERS. We will work——

Senator COTTON [continuing]. For the Committee?

Director PETERS [continuing]. With your staff——

Senator COTTON. Thank you.

Director PETERS [continuing]. To see what we can share. Yes, Senator.

Senator COTTON. I want to talk briefly about challenges staffing up. Your correctional officers start out at the GS-5 salary level, making \$48,000 a year.

My understanding is, they can top out at \$74,000 a year. By contrast, Border Patrol officers can start as high as \$68,000, and they can top out at \$113,000—even without becoming a supervisor.

Does the Bureau have trouble competing with the pay of other Federal law enforcement agencies?

Director PETERS. It's great trouble competing with other law enforcement agencies.

I'll pick on Brooklyn again. As we look at State corrections in New York, individuals can make two or three times more working for the New York City Corrections Department than the Federal Bureau of Prisons.

So even after we issued a 35 percent retention bonus at Brooklyn, that allows someone after a few years to be making \$90,000 a year for State corrections in the same time period to be making about \$130,000 a year.

Senator COTTON. Okay. In the last major Appropriations Bill that Congress passed in December 2022, Congress asked the Bureau to consider increasing pay to match those other agencies and asked for a review to be submitted no later than last June. Has that review been submitted yet?

Director PETERS. Senator, I don't know. I can check. I will tell you that this year I was able to the—increase the base salary of correctional officers by \$2000. I didn't have the authority to go beyond that.

Senator COTTON. Okay. Please do get back to us.

One final point, since you and Mr. Horowitz both raised about contraband in prisons. I think, like, maybe the most dangerous kind of contraband in prisons is cell phones. Cell phones aren't going to kill anyone themselves, but they enable the commission of many other heinous crimes in prison.

That's one reason why I've introduced the Cellphone Jamming Reform Act, which would make it clear to State prisons that they can use targeted jamming to block cell phone signals in prison housing units.

We've had some resistance from the telecom industry. I wish they would come to their senses on this issue. But Ms. Peters, have you conducted pilot programs in your facilities on micro-jamming and managed access systems?

Director PETERS. We have, Senator, at a variety of our institutions, both in terms of detection and jamming. Both prove very successful.

What my employees are telling me is the detection versus the jamming is the most helpful because then we can investigate, figure out who actually has it, who brought it in, and solve the greater flow of the contraband problem.

Senator COTTON. Okay. And Mr. Horowitz, since you addressed the issue, would you like to make any comment on cell phones in prisons based on your work?

Inspector General HOROWITZ. Yes, Senator. Couldn't agree more.

I often say, a cell phone in a prison is a deadly weapon. We investigated a murder for hire carried out on a Federal correctional officer in Guaynabo, Puerto Rico, where the hit was put on by someone in the prison.

And one of the things I've asked for, and I'd be happy to work with you, Senator, on this—smuggling a cell phone into a prison is a Federal misdemeanor. It's not a felony. And that—I was surprised by that, frankly.

I, having been an AUSA for many years. I assumed, of course, it had to be a felony. It isn't.

And what we've found, by the way, I'm going to tie contraband to sexual assault. As you know, we have a major problem with sexual assaults in prison. Not just on female inmates—obviously on female inmates, but also on male inmates.

And one of the things we found is that contraband is used to groom inmates. It's the way to gain favor by a correctional officer

or BOP employee—it's not just correctional officer, BOP employee—to gain favor.

We prosecuted a chaplain in a Federal facility in New Hampshire for bringing in contraband cell phones and other items. So that is something—we shouldn't have to make the bribery case, which is what we have to do to bring the felony charge, as you know. As a former prosecutor, that's what we strive to do.

But finding the person with the contraband, it's a lot easier to make those cases. We get a lot more prosecuted, and get a lot of the very small fraction of BOP staff who are engaged in misconduct, out.

Because the other thing I know, I met with President White the other day, I know this from my time as a prosecutor in New York where I prosecuted some corrupt police officers.

There is not a single BOP employee who wants to work next to a corrupt employee or a dangerous inmate, right, who's engaging in crimes. So we all have to focus on that.

Senator COTTON. All right. Thank you, both.

Director PETERS. Thank you.

Chair DURBIN. Thank you, Senator Cotton.

I think there's some valuable suggestions for legislation, and I'm happy to work on a bipartisan basis to see if we can move some of those forward.

I'd like to ask—be more specific. We've talked about staffing in so many different respects, and I'm sure Senator Booker will address many of them this afternoon. But I'd like to zero in on the health staff because it appears that this is one of the real deficiencies.

And what we've identified as we go forward through the reports, is that identifying potentially suicidal individuals, which takes some expertise in mental health, managing medication, mental health treatment, is going to call for certain specialty training or education.

Let me ask Director Peters, what has been your luck in recruiting people in those categories?

Director PETERS. It's been a challenge. And as you and I have discussed before, we have to consider ourselves a healthcare organization.

So many of our people come to us with severe mental health issues, and they are 10 years older biologically than their chronological age based on the lack of preventative healthcare and lifestyle choices. So we have a sick population and recruiting and retaining medical professionals is incredibly difficult.

I visited some of our institutions where health services was half filled and we're having to TDY people across the country. So we're doing a variety of things.

We're leaning into telehealth in order to ensure more quality care. Our recruitment for medical professionals, we just approved a 25 percent recruitment incentives. We have individual incentives across the country for doctors that said they were going to leave, psychologists that said they were going to leave.

And so we're doing everything in our authority. But I will tell you that doctors in our care can leave and make almost double what they're making for us in the community. And so this is some-

thing that we're working on. This is something that is very troubling.

But we have to figure out, again, like I said with correctional officers, how to increase the base pay for our medical professionals so that we can provide the quality care we need to provide.

Chair DURBIN. Are you familiar with the National Health Service Corps?

Director PETERS. Yes.

Chair DURBIN. Are there applicants for jobs in Bureau of Prisons who are going to have an opportunity for loan forgiveness if they take those jobs?

Director PETERS. Senator, I don't know the answer to that, but I'm happy to look into it and get back to you.

Chair DURBIN. I want to look into it, as well. I think we have to.

General Horowitz, do you have any thoughts on that?

Inspector General HOROWITZ. I don't know the answer, but I think it is something that's important to look into. We've also noted the importance of public health service professionals and considering how to bring more of those individuals—

Chair DURBIN. I think if we're looking for incentives to bring in healthcare professionals—and they're certainly needed, they're needed so many different places.

But they're needed in the Bureau of Prisons. The incentive of loan forgiveness may make a difference. At least we ought to try it.

I also want to want to say that, I'd go out on a limb and believe that at the Federal level, we have so many areas where we need healthcare professionals, that we ought to think more seriously about some type of program that is federally inspired, that results in a workforce that is absolutely needed at this point.

Senator Welch, do you need a minute more to adjust to the circumstances, or are you ready?

Senator WELCH. I thank you for keeping—

Chair DURBIN. I'm recognizing you.

Senator WELCH. Well, I appreciate that. Thank you very much.

And Director Peters, it's good to see you. We talked about the situation in Vermont where we don't have a residential reentry facility. It's a really serious issue.

As you know, individuals with 12 months or less on their sentence are eligible to transfer to that residential facility. It really makes a big difference. They can receive assistance with housing, treatment, unemployment. And it's been proven, as you know, to reduce recidivism.

In Vermont, this is really pretty shocking to me and to Senator Sanders and to Congresswoman Balint.

Vermont is one of only two States that does not have the benefit of that facility. Hawaii being the other one. And they had one, and I think they're looking to get another—to get a replacement.

And I know when we spoke about this, you had indicated that we were going to get one. But you clarified that you misspoke and it was going to be a reporting facility instead.

Reporting facility is not worth it.

[Poster is displayed.]

Senator WELCH. Reporting would mean that people have to go to Providence, Rhode Island. It's a long way from Burlington. Or they'd have to go to Manchester, New Hampshire. Very, very long way. Or maybe Boston.

So it just doesn't do the job. And I think after you clarified that, you indicated that if the Vermont delegation researched the matter and determined that a residential facility was necessary, you might change course.

And we did our research. And most prominently among them we checked with the attorneys, and most importantly, with our Federal judges.

And Chairman Durbin, I ask unanimous consent to be able to submit a letter to Director Peters into the record.

Chair DURBIN. Without objection.

[The information appears as a submission for the record.]

Senator WELCH. So we were surprised, this is the delegation, when we got a letter from the Bureau of Prisons on Friday, indicated that you planned to proceed against our consensus and not provide this residential treatment facility.

As I mentioned, our office did speak to the stakeholders, including the Chief Judge Crawford. And he wrote to you in December expressing his strong belief that Vermont absolutely, absolutely needs a reentry center.

And Chairman Durbin, I request permission to submit his letter into the record.

Chair DURBIN. Without objection.

[The information appears as a submission for the record.]

Senator WELCH. And in his letter, he wrote—the Chief Judge, that, “The lack of a facility in Vermont interferes with every prosocial activity necessary to return to normal life, including the long-term employment, connecting with family, and locating housing.”

And Chief Justice Crawford added, “Our judges all believe—our judges all believe that opening a residential reentry center in Vermont is a significant step toward the improvement of public safety and rehabilitation.”

And the Chief Judge attached a report from the chief probation officer further outlining the need for a center. And we've heard this from our attorneys, both in the defense and the prosecution side. And I understand you've received this letter.

So what's the deal? How do we get our residential reentry program in Vermont so that we're not essentially the only State in the country that doesn't have the opportunity to provide the benefit of these services to people who really need them?

Director PETERS. Well, thank you, Senator. Well, first off, thank you for the conversations we've had around this table and individually one-on-one around this issue. I am always happy to take in new information—

Senator WELCH. No, let's get to the point.

Director PETERS [continuing]. That we haven't received.

And I will get to the point, Senator.

So our market analysis determined that since there are so few individuals releasing back to Vermont, that it's not financially feasible for a residential reentry center.

And we're actually really optimistic about the day reporting center. The day reporting center will provide all of the wraparound services——

Senator WELCH. So——

Director PETERS [continuing]. That a residential reentry center will.

Senator WELCH [continuing]. So I don't think you've provided the market study to us, to take a look at.

Director PETERS. Senator, I can work with your team and mine to see what we can share with you around that study.

Senator WELCH. Well, you know, I don't understand about the market study.

We've got the probation officers, we've got the judges in the district saying, "Hey, we need this."

And, why is it that Vermont would be the only one State in the entire Nation—along with Hawaii, temporarily—that doesn't have it? I mean, why do we need a market study? We've got defendants. We've got judges. We've got the need.

Director PETERS. Senator, again, it's all around resources and trying to balance those resources we have.

Senator WELCH. Well, that's a different question. That's a different question.

If you're saying the market study says we don't need it as much as New York City, maybe that's right. But we need it in Vermont. That's what I'm saying. And every other State has it basically. And we don't.

Director PETERS. Senator, again, I'm happy to take any new information that you have and look at it, of course.

But we do feel confident in our decision around the day reporting center that it's going to be able to——

Senator WELCH. All right——

Director PETERS [continuing]. To help more people——

Senator WELCH [continuing]. We've got to work on this more.

I mean, they're two totally different things. A reentry center provides resources to people when they're coming back in to society.

The reporting center, they're going down, you know, it's a long way. There's no follow through. You don't get the resources.

And it is just astonishing to Senator Sanders, to Congresswoman Balint, and to me, that somehow this market study says Vermont is unique in that we don't need, or deserve, or should have the benefit of the same services that are provided in every other State in this great country of ours.

Director PETERS. Senator, again, happy to have further conversation. We are optimistic about the day reporting center——

Senator WELCH. Just to be clear, I'll talk to you.

But what we want is a reentry center. And that's what our Chief Judge is saying we need. Thank you.

Director PETERS. Thank you.

Chair DURBIN. Thank you, Senator Welch. Senator Grassley.

Senator GRASSLEY. Ms. Peters, would the Bureau of Prisons let correctional officers supervise adult inmates if the officer hadn't successfully cleared an FBI National Crime Information Center background and fingerprint check?

Director PETERS. Senator, it's my understanding that our policies and practices require that background check prior to employment.

Senator GRASSLEY. Well, if that's the case, I'd like to say something not just for you, but for my colleagues.

If folks who haven't passed an FBI background check aren't allowed to supervise adults, we shouldn't give them custody of unaccompanied alien children.

However, the Office of Refugee Resettlement doesn't require FBI background checks for all sponsors, and it refuses to give law enforcement information on the sponsors even if the child's well-being is in question.

It seems to me this would have to stop. And I hope this Committee brings in more witnesses on this subject and takes up meaningful legislation to protect our kids.

Mr. Horowitz, I'm going to take advantage of you being here to ask a follow-up question. I wrote you on November the 2nd last year about your review of the Justice Department obtaining phone records of Members of Congress and staff.

In response, you said your report will likely cover most, if not all of the eight categories of information that I asked for.

It's been said that the Justice Department obtained these records to investigate alleged leaks related to the discredited Crossfire Hurricane investigation.

But I'm concerned that the Justice Department used this as an excuse to keep tabs on Congress as we conducted oversight of the Department relating to the Crossfire Hurricane. Can you provide an update on the scope of your review? And when you expect to issue your findings?

And a second question related to this is, did the Justice Department apply the same investigative standards to its agents and staff or other officials in the executive branch who may have leaked the information, as did Members of Congress and our staff?

Inspector General HOROWITZ. Thank you, Senator.

And I'll give you an update on timing and where we are. We are planning to cover, as I said in my letter to you, the issues that you referenced in the categories we spoke about there. We are actually in the process of drafting the report. So we will hopefully be able to get out in a reasonable amount of time.

I will just add, because so much of these issues cover highly classified information, as you know from our prior reviews, we have to go through the Department and the various Intelligence Community processes to get it to the point where we can issue it.

So I always put that caveat on any reports we have that involve classified information. But we are working to get it done. We've made good progress.

And the second question you raised, the issue you addressed is one that we're also assessing.

Senator GRASSLEY. They do exactly the same thing for their own staffers.

Inspector General HOROWITZ. We're—that's one of the issues we're assessing. And we will report on that, Senator.

Senator GRASSLEY. Director Peters, in February 2024, Justice Department's Inspector General report on deaths in the Bureau of

Prisons facilities found the FCC Hazelton had 14 deaths from 2014 to 2021.

Last year, September 12th, 2023, I, along with Chairman Durbin, Senators Manchin and Capito, wrote to you about additional allegations of serious misconduct occurring at FCC Hazelton. Some of the allegations include prison staff falsifying records involving releasing the wrong inmate, prison escapes, inmate medical assessment time, attendance sheets, and staff's physical assaulting inmates.

So you've yet to respond to our letter. Why not? And what are you doing to straighten out the significant problems at Hazelton that we brought to your attention?

Director PETERS. Thank you, Senator. Well, we take all of those allegations very seriously and when we learn that someone has not done the job that we've required of them, we investigate it and hold them accountable.

Hazelton, like many of our institutions, is suffering from a lack of staffing. We are having difficulty recruiting and retaining there. One of the things that we have done recently is we've actually closed down a unit in order to deploy staff to the rest of the institution.

And so, like I said earlier, recruitment and retention is crisis at the Federal Bureau of Prisons, and Hazelton is not alone in that problem.

Senator GRASSLEY. Is the problem that I brought to your attention entirely related to the number of people you have on staff and nothing else?

Director PETERS. Senator, I think it's a variety of things. We talked about contraband and having to tackle the very serious issues of contraband inside our institutions.

As you look at the older facility of Hazelton and the maintenance repair backlog, I think that can add to it.

I think we also have to talk a lot about the work that the Inspector General and I have been working on to clear up our backlogged investigations. The number of staff that we've added to our Office of Internal Affairs.

When I started, there were less than 30 employees in that Office. And now we're looking at almost 150 with direct oversight directly to central office in order to not only shore up that backlog, but to hold people accountable in a swift and sure fashion.

Senator GRASSLEY. Thanks to both of you for answering my questions.

Chair DURBIN. Thanks, Senator Grassley.

I believe Senator Kennedy is still—has a first-round opportunity, and I understand Senators Booker and Ossoff would like a second-round opportunity. Senator Kennedy.

Senator KENNEDY. Thank you, Mr. Chairman. General, how are you?

Inspector General HOROWITZ. I'm doing well. Good to see you again, Senator.

Senator KENNEDY. I'm a big fan.

Director Peters, you're the Director of the Bureau of Prisons. Is that right?

Director PETERS. That's correct, sir.

Senator KENNEDY. You came from—you used to run the corrections system in Oregon. Right?

Director PETERS. That's correct.

Senator KENNEDY. Yes. Oregon legalized drugs. Is that right?

Director PETERS. That's correct.

Senator KENNEDY. Oregon's about to reverse that. Is that correct?

Director PETERS. Senator, I'm not familiar with the policy proposed to reverse that.

Senator KENNEDY. Oh, you just ignored Oregon.

Director PETERS. Oregon still has a very special place in my heart, sir.

Senator KENNEDY. Okay. You haven't read any of the articles about the reversal?

Director PETERS. I haven't, Senator.

Senator KENNEDY. You don't know anything about it?

Director PETERS. Correct, sir.

Senator KENNEDY. Okay. Wow. You're in charge of implementing the First Step Act, Director?

Director PETERS. That's correct.

Senator KENNEDY. How many criminals have you released into the First Step Act?

Director PETERS. So First Step Act for the overall release since the initiation of the First Step Act is—I have that exact number in front of me.

Senator KENNEDY. You don't know off the top of your head?

Director PETERS. Sorry, Senator. So 70 percent of those that were released, we have about 30,000 individuals that have been released since the passage of the First Step Act.

Senator KENNEDY. So you've released 30,000 criminals onto the First Step Act.

Okay. And how many of them when you—before you released them, did you contact any of their victims to say, "We're about to let this guy out"?

Director PETERS. Senator, it's my understanding that that notification happens through the U.S. Attorney's Office. But I will check into that and get back to you.

Senator KENNEDY. You don't know?

Director PETERS. Senator, I don't.

Senator KENNEDY. Have you followed up with the U.S. Attorneys to say, "Do you have a system to say, 'Hey, we're about to let this guy out. Would you, you know, we want to be sure the victim's contacted.'"?

Director PETERS. As a former victim's advocate, I share that value, that victim notification should happen. I'll check on the process and I'll get back to you.

Senator KENNEDY. But you don't know if it's happening?

Director PETERS. That's correct, Senator.

Senator KENNEDY. Wow. Okay. Of the 30,000 criminals you let free, how many of them have come back? Have committed a crime again or hurt somebody else?

Director PETERS. So that number is one that we're still looking at as it relates to the recidivism rate for those that were released on the First Step Act.

Senator KENNEDY. You don't have any idea?

Director PETERS. No, Senator.

Senator KENNEDY. You don't have anybody at the Bureau that can count?

Director PETERS. I do not have that number in front of me today, sir.

Senator KENNEDY. So let me get this straight. The First Step Act was passed in 2018. This is 2024. Am I right so far?

Director PETERS. That's correct.

Senator KENNEDY. That's six years. And in six years you've let 30,000 criminals go. Right?

Director PETERS. That's correct.

Senator KENNEDY. And you don't have the slightest idea how many of them committed another crime and came back?

Director PETERS. I don't have that number in front of me today, sir.

Senator KENNEDY. And you run the Bureau of Prisons?

Director PETERS. That's correct.

Senator KENNEDY. And how many employees do you have?

Director PETERS. About 40,000 employees.

Senator KENNEDY. Oh my God. Oh my God.

General, I know you got a lot to do, but could you give us a hand here and let's find out whether the First Step Act worked and how many—if we've released 30,000 criminals after six years, our Director here doesn't know how many have—have committed another crime and come back. Can you help us?

Inspector General HOROWITZ. Senator, I can certainly follow up on that issue.

I will just say, in terms of work we've done in the past, for example, on compassionate release, and going to the Bureau of Prisons—this is before Director Peters was there—and asking them for data on compassionate release because that was one of the issues that has come up. How—

Senator KENNEDY. Excuse me for interrupting, but I'm not talking about compassionate release.

Inspector General HOROWITZ. No, I understand. I'm just saying—

Senator KENNEDY. You know, my colleagues said, we were told that—that it would save money and it would be in the interest of public safety to release criminals from prison.

I didn't vote for it, but the majority rules, and so Congress did.

And Director Peters at the Bureau of Prisons, and her colleagues, released 30,000 criminals, all of whom were there for a reason. Okay? They didn't just go to prison for a free toaster. They were there for a reason.

And so her Department let them go.

And after six years, we don't have the slightest idea—not a single one of the 40,000 of her employees know how many have committed a second crime and come back.

So how the hell are we supposed to figure out whether it worked?

Inspector General HOROWITZ. Senator—

Senator KENNEDY. Your people ought to hide their head in a bag, Director, that you can't come here in front of this Congress and answer that question. I'm sorry, I interrupted you with my speech.

Inspector General HOROWITZ. No, that's okay.

I was just going to—my bottom-line point on it was, I've often looked to those questions on things like compassionate release and other programs. And one of the challenges we found is the Department just doesn't have good data—halfway houses.

Congress is spending about a half a billion dollars a year on halfway houses. There's really not great recidivism data on that, either.

Senator KENNEDY. Well—

Inspector General HOROWITZ. Are they working—

Senator KENNEDY [continuing]. Well, before we do this, we need to find out.

Look, I believe in justice. I believe in treating everybody fairly.

But there are people out there—I don't know why, if I make it to heaven, I'm going to ask. They're not mixed up. They're not confused. They're not sick. It's not that their mama or daddy didn't love them—or, not enough.

They just hurt other people. And they take other people's stuff. And we have to separate them from society. And the Director let 30,000 of these folks go and can't tell me today how many have come back.

I just—I just find it takes my breath away with 40,000 people. How many of your 40,000 people actually coming to work or are still working from home, Director?

Director PETERS. The super majority of our employees come to work every day, because we're running 24/7 institutions.

Senator KENNEDY. What percentage are coming to work every day?

Director PETERS. The percentage is quite high. I don't have the exact number.

Senator KENNEDY. You don't know?

Director PETERS. But the super—

Senator KENNEDY. Well, maybe there's your problem.

Director PETERS [continuing]. The super majority of our individuals—

Senator KENNEDY. If they're not coming to work—

Director PETERS [continuing]. Come to work at our institutions—

Senator KENNEDY [continuing]. They can't give us the answer.

I've gone over, I'm sorry Mr. Chairman. This is—this is why people—this is why people hate government and don't trust government.

Chair DURBIN. So I'd like to respond concerning the Grassley-Durbin First Step Act, signed into law by President Donald Trump—

Senator KENNEDY. I thought you might have a response.

Chair DURBIN [continuing]. By President Donald Trump.

I almost want to repeat that because this notion that it's soft on crime—I don't consider Chuck Grassley soft on crime. I don't consider Donald Trump soft on crime.

Let me tell you the numbers. The numbers that we have. Some 30,000 released, the recidivism rate for people released under the First Step Act is 12.4 percent. Seven out of every eight individuals

released under the law have not been rearrested, or charged with a new crime.

By comparison, DOJ estimates that in the decade before the First Step Act was passed, 43 percent of the people formerly incarcerated in BOP were rearrested within three years of their release. Is the First Step Act working? I would submit it is.

Senator KENNEDY. Would you give her a question, Mr. Chair?

Chair DURBIN. When I finish.

Senator KENNEDY. I'm sorry. Excuse me for interrupting.

Chair DURBIN. The point I'm making is, we decided with the Trump administration and Senator Grassley's leadership that we were going to take a different approach to releasing people from prison.

We would give them an opportunity to be trained, educated, skilled, in many ways, more prepared for release. Because 80 percent, I believe, in the system are going to be released someday—who don't want them to commit another crime or create another victim.

I would submit this is a success. Don't put your head in a bag—or whatever Senator suggested. Stand up tall and try to make it better. And I'm ready to do that.

But the First Step Act was a constructive reform of the penal system. And I think it was a good idea and I stand by it. I'll submit to your question.

Senator KENNEDY. Thank you. And I appreciate as usual, Dick, you made good points.

Here's my point. I didn't vote for the First Step Act because I was afraid this was going to happen. And what I hear you saying is that of the 30,000 that the Director released, over 3,000 committed another crime and are back. Here's my question. How come you know that and she doesn't—

Chair DURBIN. Because she's probably looking for—

Senator KENNEDY [continuing]. And the 40,000 people at Bureau of Prisons, who are supposed to give us this information, don't know.

Chair DURBIN. Well, I'd like to say, in all fairness, she's under oath.

And I think when you ask for numbers, she wants to make sure she tells you a number she can live with. I have this information. I think it's probably close to being a hundred percent accurate. But I wouldn't say under oath it is.

So I think, give her a fair opportunity to respond. I mean, it just might not be the type of thing—

Senator KENNEDY. But—

Chair DURBIN [continuing]. That comes—

Senator KENNEDY [continuing]. But—

Chair DURBIN [continuing]. Rolling off the tongue.

Senator KENNEDY [continuing]. But it is not your job. And I appreciate the information and I'd like to see the study that shows that. I just don't understand why the Director has no idea.

Chair DURBIN. Well—

Senator KENNEDY. She didn't say, she was uncertain and she wanted to go back and check. She said, "I don't know." And I just find that extraordinary.

Chair DURBIN. I'm assuming since she's under oath, it's an honest answer.

We have two other individuals who are seeking a second round. I believe Senator Booker is first.

Senator BOOKER. I hate to distract from my questions. But I just want to defend the bipartisan work that we all did—86 Senators voted for it, and the dramatic drop in recidivism rates—that is not the Bureau of Prison's job to track, it's the Justice Department's job to track it—is stunning.

I mean, this has literally saved the United States of America hundreds of millions of dollars. It has lowered crime. The data shows we max people out in prison don't prepare them. You can't keep them by law.

So when people max out and don't have halfway houses, don't have the kind of resources that people that were released during this have, their recidivism rates are through the charts.

So we have to be smart on crime. And one of the biggest growths of bureaucracy I've seen in my life is a prison industrial complex in the United States of America. And it's not making us safer. So I understand that.

And then the second thing in your defense, the mission of the BOP is not to necessarily track folks after they're gone. From what I understand, having done a lot of reading and prep for the later hearing, that's not your mission.

Your mission is to hold them securely, prepare them, programs, hold—so forth. So that, if we want to get, Senator Kennedy, if we want to get the head of the Justice Department, I'm all for grilling them.

But you're—you're one of these folks that we're giving you too little resources to do too much work. And that's what I'd like to jump into. And I have a lot of frustrations, obviously, with what's going on.

But I've watched you now, as a professional, struggle mightily to meet the demands that have put on you in a moment where Congress is not giving you the resources necessary to do your job, even. In facilities that are outrageously decrepit.

I mean, your Fiscal Year 2022 is estimated that the BOP needs \$2 billion in funding to repair facilities. But the BOP—this is my challenge to you, has requested \$200 million for infrastructure repairs. Congress allocated \$59 million. But is it not true that people are dying in your facilities because there's no air conditioning?

Director PETERS. Senator, your data points around the maintenance and repair backlog are absolutely spot on.

And that number has grown since we last reported that \$2 billion. It is now closer to \$3 billion because we continue to have roofs that are crumbling. We continue to have HVACs that have stopped working.

And if you look at the amount of money that we typically get from Congress, it's about a hundred thousand dollars a year to solve that \$3 billion problem. And the cost of one roof replacement alone is a million dollars.

Senator BOOKER. Yes. And I just point this out to say again, this is a, a pattern here. Your employees could literally leave your job

and not make 10 percent more, 20 percent more, but a hundred percent more and not have to work hour—and you know this.

And I'm going to bring this out in the hearing later on today. When you have to hold somebody over on a shift, what does that do to a family suddenly, where they can't pick up their kids for school?

Director PETERS. Senator, I hear it all the time when I'm walking the halls of our institutions. It isn't just the physical wear and tear, and mental wear and tear of that overtime and augmentation. It is what impacts their family.

Senator BOOKER. Yes. I talked to the Capitol Police when we had them working, held over on shifts. They just weren't allowed to leave. And now suddenly their whole family is in crisis.

Director PETERS. That's right. We hear all the time. They had their week planned out on who was picking the kids up from daycare, who was cooking. And the Federal Bureau of Prisons messes with that schedule, day in and day out, for our families.

Senator BOOKER. Yes, and we preach how much we support law enforcement. This is utterly shameful.

A February 2024 GAO report found that by October 2023, the BOP housed approximately 8 percent of its prison population in solitary confinement.

One of the things I—I'd like for you to address is the report noted significant racial disparities with Black individuals comprising less than half, 38 percent of the total Federal prison population, but represented over half, 59 percent of those in solitary. Can you address that for me?

Director PETERS. Yes, Senator.

And this is an issue that's been studied across the country, both in Federal corrections and in State corrections. And often what we find is the level of gang activity that happens inside our institutions often drives that number. That's still unacceptable to me.

I think we have so much work to do in restrictive housing reform, and we have to ask those hard questions about the disproportionate number of individuals of minority status who are in restrictive housing.

Senator BOOKER. Yes, and I'm hoping that's something that my staff can work with you on, as well.

And then the final thing I just want to say is, the Chairman said it. I think there's room for a lot of bipartisan work here to try to address these issues.

The shamefulness of what's happening as a result of the lack of funding for facilities, for personnel, and for certain position line items is outrageous implications of the United States of America and its support of law enforcement officers, and creating inhumane conditions in prisons.

The one thing, the very small point to the Inspector General that was brought out and I want to talk to Senator Cotton, who I'm going to be sitting with chairing, and is the Ranking on this Committee, is this idea of the inability to jam cell phone signals.

And the fact that it's a misdemeanor to bring in something that you said under oath is a—tantamount to a deadly weapon.

And I'm wondering—number one, on the jamming issue, the only pushback my staff could say that they get is the need for Federal

public defenders when meeting with their client to be able to access the internet. Is there a workaround that you see to that concern?

And then, number two is the—do you think it would be enough of a deterrent if it was suddenly not a misdemeanor, but a felony?

Inspector General HOROWITZ. Yes, Senator. I think on both those issues, there's certainly a workaround.

I think one of the issues—I think Senator Cotton had it right, the FCC and the technology companies have opposed it or raised concerns about it in part because of the inability, I think, and Director Peters can speak to this, as well, to limit the jamming or limit the interference to the grounds itself of the facility as opposed to some of the perimeter areas, particularly where there are homes nearby.

And so I think there are—those are some of the issues that have been at issue here.

But many State prisons have been doing this for years. California has been involved in jamming technology. We've done work in this space, our office over the years, and have seen other States successfully do it. So it's clearly doable. We're glad to see the BOP moving forward. But there are some areas they have to be careful about. And—

Senator BOOKER. But the misdemeanor to the felony.

I mean, if somebody is caught sneaking a cell phone in, they're fired. Right? They lose their job. Is that not enough of a deterrent?

Inspector General HOROWITZ. Well, here's the issue.

From a union standpoint, if they're a union member, there is an ability to litigate that question on a misdemeanor. A felony charge—if someone's convicted of a felony charge, my understanding is they're out. My understanding is, if it's a misdemeanor or it never prosecuted and is, you know, if it's only a misdemeanor, Federal prosecutors are not taking these cases.

So no one's getting prosecuted for a misdemeanor. Right? There's lots of felonies to be prosecuted. So the problem is, they're not being prosecuted and that leaves it to the BOP's administrative process only to deal with the problem.

Senator BOOKER. Yes.

Inspector General HOROWITZ. And that sometimes does not, as I understand it, result in removal of individuals.

And I have multiple examples, I'm happy to come speak to your staff about them and to you, as well, where we have had cases involving sexual assaults that were the result of some grooming food—bringing in food is a misdemeanor. Well, think about how that's an enticement to female inmates, potentially, and a grooming tool. It just shouldn't happen.

Senator BOOKER. No, I agree with you. And not to be a little lighthearted on this, but I want you to clarify for the record when you say that nobody is prosecuted for Federal misdemeanors. That's not an invitation to anybody on this dais to commit misdemeanors.

Inspector General HOROWITZ. I am—you are correct. And there are rare occasions where there are misdemeanor charges brought. But almost every U.S. attorney's office in the country has lots of felony cases.

Senator BOOKER. Because Senator Durbin's staff, I just want to make sure they heard that they should not do Federal misdemeanors. Thank you, sir.

[Laughter.]

Chair DURBIN. Thanks for the help, Senator. Senator Ossoff.

Senator OSSOFF. Thank you, Mr. Chairman. Thank you for the second opportunity.

On this point about disciplinary procedures, it's the Office of Internal Affairs at BOP that handles investigations—internal investigations of staff misconduct. Correct, Director?

Director PETERS. That's correct. As soon as we refer all allegations to the Office of the Inspector General, once they review and determine that there's nothing criminal in nature, then they kick it back to us and we engage in the administrative investigation.

Senator OSSOFF. So let's update on the OIA backlog.

PSI investigation a couple years ago into the sexual assault of female inmates in BOP facilities found that there was about 8,000 backlogged cases at OIA. And at that time, about 2 years ago, BOP told us that it would take about 2 years to clear the backlog.

BOP just provided to my office an update that there are still over 7,300 pending cases before OIA. So that's about a 7 percent reduction.

You said publicly, I think in a CBS interview last month, that it would take about 2 years to clear the OIA backlog. So 2 years ago, BOP said 2 years to clear the backlog. This year, BOP says 2 years to clear the backlog. Why? And when will it be cleared?

Director PETERS. Thank you, Senator.

So I, too, share your frustration in the time it's taking to clear the backlog. But it hasn't been for lack of a plan.

So, as I shared with you, we had just under 30 employees in the Office of Internal Affairs. And since you and I last spoke, it simply took us until last fall to get those positions filled.

And so now we're at about 150 individuals who are in the Office of Internal Affairs who report directly to headquarters so that there's that centralized oversight that you wanted.

We now have them fully trained and we're just starting to see a chip down of that backlog. But we're not just looking at the backlog, we're looking at other ways to clear the backlog by looking at, as an example, how many of these investigations could actually be handled at a lower level, at the warden level. If you have an employee that comes in and is 5 minutes late, you're considered AWOL.

That AWOL gets kicked to the Office of Internal Affairs. We're asking the question, does that really need to be investigated by a special investigative agent at headquarters? Or is that something the warden can handle, and then would it be more swift and sure action?

Senator OSSOFF. So I'm glad to hear you've added capacity in personnel and you're looking at changing procedure. So when will it be cleared?

Director PETERS. So I asked for that exact update before this hearing because I knew you would ask. And the answer is, we are hoping to have it cleared within the next 2 years.

Senator OSSOFF. Two years. Well, I hope this is the last time that it'll be, again, "2 years." But I do appreciate the effort that you've clearly invested into trying to rectify this.

Director PETERS. Thank you.

Senator OSSOFF. Getting back to some of the staffing issues and staff compensation and retention incentives. And again, I hope that we can work together to find additional tools for retention and recruitment at USP Atlanta, in particular.

But we've been talking about how BOP personnel are underpaid and they can't—you can't compete in this labor market against other law enforcement agencies. We talked about health staff. So how much more do they need to be paid?

Director PETERS. Thank you, Senator. So right now, we have about 45 percent of our employees receiving some form of incentive. And what we're finding in communities like New York, the New York Department of Corrections, you can get paid two or three times more for working for them. So the answer varies depending on where our facilities are and what issues we're faced with.

In rural areas, we are faced with just having saturated the market, and we've hired everybody that lives in those areas. In the urban areas, we're competing, as I said earlier, with fast food chains and grocery stores.

Senator OSSOFF. So, I understand that these labor markets are regional.

Let's try it this way. How much more in the next Fiscal Year does BOP need to be appropriated in order to resolve the fact that you can't currently offer competitive salaries? What's the number?

Director PETERS. Thank you, Senator. I don't have that number today. But we're looking at proposing a new salary rate—salary rate table. And so my H.R. team is working on that data right now. So we will have that during our next budget ask.

Senator OSSOFF. And what concerns me is, you know, you've got to go to DOJ, and then DOJ has to go to OMB, and justify your annual budget request. And OMB's going to come back and say, "Well, why do you need this many more hundreds of millions or billions of dollars for personnel?" And if you can't justify that through some rigorous demonstration, some rigorous analysis, then your request for the PBR is going to get denied.

So for the next Presidential budget cycle, are you going to have a specific number, a specific appropriation that you need from the Congress that's backed up by rigorous analysis in order to resolve this competitive salaries issue?

Director PETERS. We hope to have that number, not just in the recruitment and retention category, but the other main crisis issue around maintenance and repair backlog.

Senator OSSOFF. Okay. I'm just out of—my last point was just, you know, I mentioned earlier my team's trying to look at this, this staffing tool.

I can't—you know, the Senate Judiciary Committee accesses a lot of sensitive information. We conduct a lot of rigorous oversight. We're asking to come and review a tool that you use to determine staffing levels.

Racking my brain sitting here, I can't think of any reason why your Office of Legislative Affairs would deny my staff and Members

of this Committee the opportunity to view how that tool functions. I can't think of any reason at all. So we need to get our teams together, get in the room, look at the tool, see how it works. Okay?

Director PETERS. Thank you, Senator. I've said again and again, we want to be as transparent as possible. I suspect the reason is that it's still a work in progress—

Senator OSSOFF. Well, we can look at the—we can look at works in progress.

Director PETERS. I'm happy to have this conversation with you. We've even talked around the executive team, if we would be able to, once the product is completed, have it be an outward facing product so that the public could even see it. That's still being deliberated by individuals inside our organization. But I'm happy to work with you Senator.

Senator OSSOFF. Yes, please just let my team have a look.

Director PETERS. Thank you.

Senator OSSOFF. Thank you.

Chair DURBIN. Thank you, Senator Ossoff. And I want to thank all the Members who participated in this hearing today.

I've made this a special item in the agenda of the Committee to focus on corrections because I felt for a long time that we're fast and loose when it comes to sentencing and criminal procedure and the like. And we ought to see what happens next for those who are, in fact, convicted, and are incarcerated as a result of it.

Historically, I know some great people have had things to say about corrections.

One of them I quoted before was Nelson Mandela, who himself spent 18 years in prison on Robben Island in South Africa, and then went on to be elected president of his country. But he said, "No one truly knows a nation until one has been inside its jails. A nation should not be judged on how it treats its highest citizens, but its lowest ones."

The purpose of this hearing was to make it clear that a Federal prison sentence should never be a death sentence. Never. And in too many circumstances it has been. We're lucky to have you, Director Peters. I'm glad you took this job. It's a tough one.

Director PETERS. Thank you, Senator.

Chair DURBIN. It's a challenge and I think you're handling it well. We don't agree on everything, but that's never going to happen. But I do respect you very much for all the work that you're putting into this effort.

General Horowitz, you are a treasure to this Government and to this country. You keep us honest, and that's your job, and you do it well. We're lucky to have you.

And I want to say for all of the workers in the Bureau of Prisons, but especially those who are at risk in the discharge of their duties, thank you. We could not keep this country safe without you. And I appreciate all of those at every level of the Bureau of Prisons who make that possible.

There'll be some questions for the record. You've seen them before. You better respond or General—Senator Grassley will remind you that you didn't. And others will, too.

I don't want to pick on Chuck, but he loves to get his letters answered.

So thanks for being here today. And this hearing stands adjourned.

[Whereupon, at 11:48 a.m., the hearing was adjourned.]

[Additional material submitted for the record follows.]



Office of the Inspector General
United States Department of Justice

Statement of Michael E. Horowitz
Inspector General, U.S. Department of Justice

before the

U.S. Senate Committee on the Judiciary

concerning

Examining and Preventing Deaths of Incarcerated Individuals in Federal Prisons

February 28, 2024

Chairman Durbin, Ranking Member Graham, and Members of the Subcommittee:

Thank you for inviting me to testify at today's important hearing about preventing inmate deaths in federal prisons, and to discuss the Office of the Inspector General's (OIG)'s "[Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons \(BOP\) Institutions](#)" (Deaths in Custody report), which we released earlier this month.

Before turning to the Deaths in Custody report, it is important to put its findings into a broader context, and to emphasize the recurring, chronic nature of many of the issues we identified. I have been the Inspector General at the Justice Department for almost 12 years, and every year I have included the BOP in my annual report of the top management and performance challenges facing the Department. Yet, with some notable exceptions, the problems at the BOP have generally increased over the years. Indeed, last year, the Comptroller General for the first time added the BOP to the Government Accountability Office's (GAO) high-risk list due to its "long-standing challenges with managing staff and resources, and planning and evaluating programs that help incarcerated people successfully return to the community."

To be clear, these are not new problems, but rather problems that are over a decade in the making. In that vein, yesterday the OIG released a [compendium of 117 primarily non-investigative reports and other OIG products](#) that we have publicly issued since 2002 detailing the OIG's extensive oversight of the BOP's programs and operations, and reflecting the systemic challenges at the BOP that have significantly increased over the past two decades. The compendium organizes these oversight products into four themes: (1) the Safety and Security of BOP Institutions, (2) the Health and Welfare of Inmates, (3) Staffing and Inmate Management Programs, and (4) Cost Management. These oversight products have identified recurring issues that impede the BOP's efforts to consistently ensure the health, safety, and security of all staff and inmates within its custody. The OIG's Deaths in Custody report is a continuation of the OIG's extensive BOP oversight work.

In the OIG's 2023 [Limited-Scope Review of the Federal Bureau of Prison's Strategies to Identify Communicate and Remedy Operational Issues](#) (Limited Scope review), we provided a high-level overview of some of the foundational challenges currently facing the BOP. We highlighted long-standing failures in four areas, with recommendations to address: (1) staffing challenges, (2) a crumbling infrastructure, (3) deficiencies in the BOP's internal audit function, and (4) an ineffective staff disciplinary process. Many of the homicides, suicides, and overdoses we reviewed in the Deaths in Custody report have a direct connection to one or more of these long-standing, systemic challenges.

As our continuing BOP oversight and investigative work demonstrates, these issues are interrelated. We have consistently seen how understaffed prisons with overburdened employees create security and safety issues. And the recruitment and retention of competent staff becomes increasingly difficult when the facilities where they work are, in many instances, literally falling apart. Yet, as we have noted in multiple reports, including the OIG's 2023 [Audit of the Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions \(BOP Infrastructure Report\)](#), the BOP has not had a comprehensive plan to fix, or even maintain, its aging institutions, which also has limited its ability to sufficiently identify and request funding through the budget process. And, as our Limited Scope review confirmed, the BOP's various internal audit and inspection functions often do not identify institutional failures, compounding problems that could potentially be remedied with less cost if identified sooner.

Additionally, holding staff accountable for criminal and administrative misconduct is a critical part of improving the safety and security of BOP institutions for both inmates and the overwhelming majority of BOP employees who do their jobs every day with honesty and integrity. Yet we have found that an ineffective staff disciplinary process can create safety and security issues and exacerbate staffing challenges by failing to hold individuals accountable for egregious misconduct.

The sexual assault of inmates by BOP personnel continues to be a top challenge for the Department and the BOP, and the OIG continues to dedicate significant investigative resources to these cases. That is why I was pleased when the Deputy Attorney General convened an important working group to review the BOP's and DOJ's response to sexual misconduct by DOJ personnel; in November 2022, the Working Group issued a Report that contained numerous recommendations and reforms, which the OIG supports. The need for these reforms is exemplified by our ongoing investigative efforts at Federal Correctional Institution (FCI) Dublin, where the Warden, Chaplain, and other staff have been convicted on sex abuse charges. Our FCI Dublin investigation has shown what happens when misconduct is not timely identified and addressed, and instead spirals and poisons the culture at an institution.

Indeed, the failure to address the rampant proliferation of contraband into USP Atlanta, including dozens of cell phones and large amounts of drugs, prompted the BOP to partially close that institution in 2021, shortly after an inmate died by suicide while under the influence of methamphetamine. As our Deaths in Custody report notes, USP Atlanta had the highest number of deaths during the time period of our evaluation. And, as we noted in our BOP Infrastructure Report, the failure to effectively maintain Metropolitan Correctional Center (MCC) New York resulted in BOP having to close it because the substantial building deficiencies jeopardized the safety and security of the staff and inmates.

Relatedly, we are conducting an audit of the BOP's use of restraints that was prompted in large part by allegations that inmates in the Special Management Unit (SMU), a type of restrictive housing, at U.S. Penitentiary (USP) Thomson were routinely placed in four-point restraints for extended periods of time, sometimes even days, and otherwise mistreated while restrained. In 2023, in response to these and other allegations of misconduct, as well as a series of deaths at the facility, several of which we reference in our Deaths in Custody report, Director Peters closed the SMU at USP Thomson. The BOP acknowledged significant concerns with the institutional culture at USP Thomson and a lack of compliance with its own policies. The OIG had previously identified concerns in the BOP's administration of the SMU at USP Lewisburg and recommended in our 2017 report on the [BOP's Use of Restrictive Housing for Inmates with Mental Illness](#) that the BOP "conduct a comprehensive review of [USP] Lewisburg's [SMU] that addresses the staffing, treatment, conditions of confinement, and performance metrics of the program." That OIG recommendation was open when the BOP began transitioning the SMU from USP Lewisburg to USP Thomson in 2018, and it remains open today, nearly 7 years after our report's publication, underscoring the range of serious issues that can arise with the BOP's use of this type of restrictive housing. As is clear from our oversight work, these problems – from understaffing and aging infrastructure to safety, security, and contraband threats – will continue to surface and re-surface if left unaddressed.

While the BOP has generally been responsive to our findings and recommendations, numerous important recommendations remain open, including the SMU-related recommendation from our 2017 Restrictive Housing report and five other recommendations from that same 2017 report, including two concerning the BOP's use of single-cell confinement. Further, high-priority recommendations addressing issues that we

identified 8 years ago regarding the BOP's searching of staff entering BOP facilities to preempt contraband introduction and the BOP's security camera system upgrades remain open. We will continue to push the BOP to finalize changes to address these important areas. Full implementation of the OIG's recommendations, in addition to the GAO's staffing-related and other open recommendations, are the building blocks to begin to address the chronic challenges facing the BOP.

To further enhance our oversight of the BOP, last year we launched our unannounced inspections of BOP facilities, as well as creating a BOP interdisciplinary oversight team at the OIG, which was made possible because of the support our office received from the Judiciary and Appropriations Committees. Under our unannounced inspection protocol, we typically provide an institution's warden 4-hour notice of our plan to begin a multiday inspection of the institution. We have already completed four inspection site visits – three last year at FCI Waseca, FCI Tallahassee, and FCI Sheridan, and one earlier this month at USP Lewisburg. Our reports on FCI Waseca and FCI Tallahassee – including an extensive collection of photographs documenting our findings – can be found on our website and in the compendium that I mentioned earlier. We anticipate publicly releasing reports of our findings at FCI Sheridan and USP Lewisburg in the coming months.

As we noted in our [FCI Waseca](#) and [FCI Tallahassee](#) reports, the problems we identified were glaring and disturbing. For example, at FCI Waseca, we found serious infrastructure issues that significantly impact staff and the conditions of inmate confinement. We observed roofs in serious disrepair, that routinely leaked, had caused damage to facilities, and needed immediate repair. Notwithstanding the evident nature of these problems, we found that these repairs remain unaddressed due to the BOP's lack of a well-defined infrastructure and budgeting strategy to address what the BOP currently estimates to be a more than \$3 billion backlog in major repair projects across institutions. We also observed inmates living in basements, with some inmate bunk beds positioned in very close proximity to pipes that occasionally leaked and were covered in plastic to control the leaking. Following our inspection, the BOP took action to relocate inmates from top bunks in close proximity to pipes to other areas of the institution. We also found at FCI Waseca that significant Correctional Officer and healthcare staffing shortages have had a cascading effect on institution operations, and that, because of Correctional Officer shortages, FCI Waseca routinely uses overtime, which can negatively affect staff morale and attentiveness and, therefore, institution safety and security. Further, these staffing shortages have required the institution to temporarily reassign non-Correctional Officer staff to work in Correctional Officer posts (a practice known as augmentation), negatively affecting the ability of these non-Correctional Officers to conduct their routine duties, which include performing maintenance and teaching inmate programs, including First Step Act programs. And, as we know from our past work, augmentation is a long-standing and widespread problem for the BOP. We also observed the challenges the institution has had in preventing contraband from entering the facility.

At FCI Tallahassee, our inspection also identified, among other things, serious staffing shortages, substantial infrastructure problems, and contraband issues. Once again, we saw a facility with significant Correctional Officer shortages resulting in large amounts of overtime and augmentation. Additionally, we observed Health Services Department staff shortages that are negatively affecting inmate healthcare treatment. We found that these staff shortages have caused staff to modify the time of day it distributes insulin and drugs to female inmates, which may limit the therapeutic benefit of these drugs for certain inmates. Separately, we observed a healthcare provider failing to ask required questions during inmate intake screenings and omitting guidance on how to access healthcare services. Further, like at FCI Waseca, we observed buildings that were in serious disrepair, with damaged roofs and leaking windows, causing female inmates to use feminine hygiene products

to try to control the leaks. We also saw how damaged infrastructure can be exploited by inmates to hide contraband or create dangerous weapons. Additionally, we identified extraordinarily serious issues with the Food Service Department; this included moldy bread being served to inmates as well as discolored and rotting vegetables in a food preparation refrigerator at the female prison. In the food storage warehouses, we found what appeared to be rodent droppings, as well as bags of cereal with insects in them and warped food containers.

The glaring, serious issues identified in these unannounced inspections reinforce the need for the BOP to act quickly to address the weaknesses in its internal audit and review functions, and to implement the 10 recommendations from the OIG's 2023 [Audit of the Federal Bureau of Prisons' Contract Awarded to the American Correctional Association](#) (ACA). In that audit, we found that, although the BOP contracts with the ACA to accredit and reaccredit its institutions, the ACA process was reliant on the BOP's own problematic internal reviews and therefore raised concerns regarding ACA's third-party independence, and that because of this the process did not valuably enhance BOP's operations and programs.

National attention to the BOP's operation and management challenges followed from the high-profile deaths of BOP inmates James "Whitey" Bulger in 2018 and of Jeffrey Epstein in 2019. In June 2023, the OIG issued an [investigative report](#) on the custody, care, and supervision of Epstein, which identified numerous and serious failures by Metropolitan Correctional Center New York staff, including that staff did not assign Epstein a cellmate as directed by the institution's Psychology Services Department. The report also found that staff failed to undertake required measures designed to ensure that Epstein and other inmates in restrictive housing were accounted for and safe, such as conducting inmate counts and 30-minute rounds; searching inmate cells; and ensuring adequate supervision of the housing unit, as well as the security camera system functionality.

In December 2022, the OIG issued an [investigative report](#) on the circumstances surrounding the transfer and subsequent homicide of Bulger, finding serious job performance and management failures at multiple levels within the BOP. Those failures included prolonged single-cell confinement in restrictive housing, the transfer of Bulger to a facility with a lower level of medical care (USP Hazelton) than his prior facility without adequate consideration of his medical records, and shortcomings in communication among BOP personnel regarding the transfer process. The OIG concluded that staff and management performance failures; bureaucratic incompetence; and flawed, confusing, and insufficient policies and procedures pose risks not just to notorious offenders like Bulger but to all inmates in the midst of a facility transfer.

In addition to concerns over these high-profile incidents, Members of Congress, including the Chairman, and prisoner advocacy groups have expressed concern about the BOP's efforts to prevent inmates' deaths. Based on these and other concerns, the OIG initiated its Deaths in Custody review. The results of that review are summarized below.

The OIG's Deaths in BOP Custody Report

As the committee is aware, the OIG released our Deaths in Custody report on February 15, 2024. The OIG initiated this evaluation to assess the circumstances surrounding deaths among inmates at BOP institutions that occurred from FY 2014 through FY 2021 and to evaluate how the BOP seeks to prevent future deaths. We analyzed the frequency and pattern of deaths among the BOP inmates in four categories: (1) suicide, (2) homicide, (3) accident, and (4) those resulting from unknown factors. We also identified potential

management deficiencies and systemic issues related to those deaths, including the prevalence of long-standing operational challenges highlighted in prior OIG work.

Factual Findings

Our review of records provided by the BOP identified a total of 344 inmate deaths at BOP institutions from FY 2014 through FY 2021 in the four categories I just mentioned: suicide, homicide, accident, or unknown factors. Suicides comprised the majority of these deaths, with homicides the next most prevalent. Many of the deaths that occurred under accidental or otherwise unknown circumstances involved drug overdoses. We identified several operational and managerial deficiencies, which created unsafe conditions prior to and at the time of these deaths, that the BOP must address. We also identified recurring conditions following an inmate's death that limited the BOP's ability to identify measures that would help minimize future risks to inmates in its custody.

Results of the Evaluation

Suicide Represents a Significant Risk Area for BOP, Which the BOP Can Help Mitigate through Compliance with Existing Policies

Suicide accounted for just over half of the 344 inmate deaths that we reviewed, and more than half of those who died by suicide were in single-cell confinement, or housed alone in a cell. Multiple BOP policies – in areas such as identifying potentially suicidal inmates, managing inmate medication, and making inmate housing decisions -- may help staff mitigate certain risks associated with inmate suicide. However, we found that a combination of recurring policy violations and operational failures contributed to inmate suicides. Specifically, deficiencies in staff completion of inmate assessments have prevented some institutions from adequately identifying and proactively addressing inmate suicide risks. We also found numerous instances of potentially inappropriate Mental Health Care Level assignments for some inmates who later died by suicide. In addition, almost half of the suicides occurred in a restrictive housing setting, where about 8 percent of inmates across the BOP were housed as of August 2018. The BOP has recommended against single-celling, noting that it increases the risks of inmate suicide, and OIG reports have raised concerns with the BOP's single-celling of inmates, including those in restrictive housing.

Further, while existing BOP policies direct institutions to train staff on identifying signs of suicide, make appropriate referrals when staff identify suicidal inmates, and provide appropriate counseling and treatment, we found that some institution staff failed to communicate with each other and coordinate efforts across departments to provide necessary treatment or follow-up with inmates in distress. We also found that staff did not sufficiently conduct required inmate rounds or counts in over a third of the inmate suicides during our scope. Finally, while the BOP requires institutions to conduct mock drills to prepare staff to respond to a potential suicide, we found that the BOP was unable to provide evidence that most of its facilities met this requirement. These deficiencies helped foster conditions in which inmates were able to advance their suicidal ideations and created increased opportunities for them to die by suicide.

The BOP's Response to Medical Emergencies Was Often Insufficient Due to Lack of Clear Communication, Urgency, or Proper Equipment

To properly respond to high-stress, extraordinary inmate emergency situations such as inmate hanging, attempted homicide, or drug overdose, BOP staff must be prepared to follow correct protocols and use proper, easily accessible, functioning equipment. Mere seconds in response time can potentially mean life or death for an afflicted inmate. While multiple staff we interviewed generally believed that staff responded quickly to emergencies, we found significant shortcomings in BOP staff's emergency responses to nearly half of the inmate deaths that we reviewed, ranging from a lack of urgency in responding, failure to bring or use appropriate emergency equipment, unclear radio communications, and issues with naloxone administration in opioid overdose cases. Improvements in these areas would help prepare BOP personnel to address future inmate emergency scenarios.

A Lack of Available Information About Inmate Deaths Limit the BOP's Ability to Potentially Prevent Future Inmate Deaths

BOP policies and procedures require certain actions and reports in the event of an inmate death. However, for many of the inmate deaths we reviewed, we found that the BOP was unable to produce documents required by its own policies. Moreover, the BOP requires in-depth After Action Reviews only following inmate suicides; it does not require them for inmate homicides or deaths resulting from accidents and unknown factors. Together, these factors limit the BOP's ability to fully understand the circumstances that led to inmate deaths and to identify steps that may help prevent future deaths. To better enable it to identify and address issues surrounding inmate deaths in these circumstances, the BOP must improve its completion and organization of the mandatory records currently required by policy for all inmate deaths. Further, we believe the BOP should conduct After Action Reviews not only for suicides, but also for inmate deaths due to homicide and accident or unknown factors to help it better understand the circumstances surrounding these deaths and potentially prevent future inmate deaths.

In addition, we found that, even when the BOP obtains insights on contributing factors and recommendations for improvement following an inmate's death, the impact of that information is curtailed by the decentralization of the BOP's processes. We believe that the BOP should assess this information more broadly and consistently to help identify, track, and address recurring factors and challenges that may contribute to deaths among inmates in its custody.

Long-standing Operational Challenges, Such as Contraband Interdiction, Further Impair the BOP's Ability to Reduce the Risk of Inmate Deaths

As I noted in the first half of this statement, the OIG has repeatedly identified long-standing operational challenges, including contraband interdiction, that negatively affect the BOP's ability to operate its institutions safely and securely, some of which may increase the risk of inmate deaths. We found that, in nearly one-third of the inmate deaths in our scope, contraband drugs or weapons contributed, or appeared to contribute, to the death, including 70 inmates who died from drug overdoses. Other operational challenges include staffing shortages, including for both physical and mental healthcare; an outdated security camera system; staff failure to follow BOP policies and procedures; and an ineffective, untimely staff disciplinary process. One or more of these challenges was a contributing factor in many of the inmate deaths in our scope, and these long-standing challenges continue to present a significant and critical threat to the BOP's safe and humane management of inmates in its care and custody.

We made 12 recommendations to assist the BOP in addressing risk factors that contribute to inmate deaths.

1. Develop strategies to ensure that staff assign accurate, consistent, and timely Mental Health Care Level designations to inmates.
2. Ensure that all institutions conduct required mock suicide drills and develop strategies to increase staff participation in those drills.
3. Ensure that all appropriate staff are trained in automated external defibrillator use and that automated external defibrillators are strategically placed, readily available, and regularly checked to ensure that they are in working order at each BOP institution.
4. Ensure that cut-down tools in working order are accessible to staff in each housing unit at each institution, that staff are trained on proper use of the tool, and that the BOP determines whether staff should be issued and required to keep their own cut-down tool on their duty belts during their entire shift.
5. Ensure that each institution has a sufficient number of maneuverable gurneys in strategic locations to provide proper medical response during inmate transport.
6. Issue standard, enterprise-wide guidance and training to staff on using the radio to communicate clear, descriptive information during inmate medical emergencies.
7. Ensure that staff receive both the initial and refresher naloxone training and are fully prepared to administer naloxone to an unresponsive inmate suspected of having experienced a drug overdose.
8. Ensure that all Evidence Recovery Teams are properly trained on post-incident evidence recovery protocols.
9. Develop procedures to ensure that all required death-related records are completed and collected consistently and in accordance with established deadlines.
10. Assess the benefit and feasibility of expanding its policy requiring After Action Reviews to include reviews of all inmate homicides and deaths by accidental and unknown factors, not just for inmate suicides.
11. Clarify responsibility for tracking at an enterprise level the reports and recommendations required in the wake of an inmate death by suicide, homicide, accident, or unknown factors, and assess the information contained therein for broader trends, applicability, and implementation.
12. Evaluate existing electronic devices used for inmate screening to identify whether they are functioning as intended, and, if necessary, implement any needed adjustments or upgrades.

The BOP concurred with each of our recommendations. Consistent with our oversight responsibilities, we intend to carefully monitor the BOP's implementation of the recommendations to ensure the BOP fully addresses the issues we identified.

Conclusion

Effectively addressing these widespread, systemic issues at the BOP that the OIG has identified through our oversight work over the past two decades requires a long-term vision and strategy from BOP and Department leadership, with support from the Office of Management and Budget, Congress, and other important stakeholders. To be clear, the problems that we have identified in our oversight work over the past 20 years, as detailed in the compendium we released yesterday, will not be solved overnight, but they must be addressed with urgency to protect the health, safety, and security of BOP staff and inmates, and to enable inmates to successfully return to our communities upon their release from prison. Toward that end, Director Peters and I meet quarterly to discuss the wide variety of issues and challenges that the OIG's oversight work is identifying, as well as our open recommendations, the first time in my almost 12 years as Inspector General that a BOP Director has committed to regular oversight-focused meetings with me. The OIG will continue to conduct our oversight, as well as to closely monitor the BOP's implementation of our recommendations, to ensure that reforms are taking place at the BOP. I also look forward to continuing to work with this Committee and other Congressional stakeholders as you perform your critical oversight and legislative efforts.

I want to thank the Committee for its support for our mission and for the opportunity to testify on this important topic. I would be pleased to answer any questions you may have.

The Honorable Thom Tillis
Senate Judiciary Committee
Questions for the Record
“Examining and Preventing Deaths of Incarcerated Individuals in Federal Prisons”

Responses from Michael E. Horowitz, Inspector General, Department of Justice

Question 1: Inspector General Horowitz, over the past year, you’ve conducted multiple reports regarding the federal prison system. In three of the reports, your office provided BOP with various recommendations to improve safety and conditions.

- *Evaluation of the Federal Bureau of Prisons’ Efforts to Address Sexual Harassment and Sexual Assault Committed by Inmates Toward Staff (2.23.2023)*
- *Report on the Federal Bureau of Prisons’ Efforts to Maintain and Construct Institutions (5.3.2023)*
- *Limited-Scope Review of the Federal Bureau of Prisons’ Strategies to Identify, Communicate, and Remedy Operational Issues (5.4.2023)*

Are you aware of BOP implementing any of the recommendations provided by the OIG in the three reports? If yes, what changes have been made?

Response: In its latest response to the recommendations in the OIG’s [Evaluation of the Federal Bureau of Prisons’ Efforts to Address Sexual Harassment and Sexual Assault Committed by Inmates Toward Staff](#), the BOP reported that, consistent with one of our report’s nine recommendations, it has taken actions to ensure that inmate-on-staff sexual harassment training continues to include content related to reporting, preventing, and mitigating inmate-on-staff sexual harassment, as well as information on resources available to employees who witness or experience this harassment. To address the concerns outlined in the report, the BOP told us that it updated its annual employee training on sexual misconduct, report writing, and the Employee Assistance Program. The updates include enhanced content related to reporting, preventing, and mitigating inmate-on-staff sexual harassment and resources and guidance for employees who experience or witness this type of harassment. The BOP provided copies of the training to the OIG, and we closed this recommendation. With respect to the remaining eight recommendations, the BOP has taken actions that are responsive to them, but because the BOP has yet to make sufficient progress to address the underlying issues, the other eight recommendations remain open.

The OIG received the BOP’s most recent response to our [Efforts to Maintain and Construct Institutions](#) report on February 28, 2024. That report contained two recommendations, both of which remain open. The BOP has told us that work is ongoing to respond to them. BOP stated that, in August 2023, it awarded a contract to assist with developing a strategic framework to increase the effectiveness of facility management. According to the BOP, the contractor is currently developing the strategic framework.

In its latest response to the five recommendations in the OIG’s [Limited-Scope Review of the Federal Bureau of Prisons’ Strategies to Identify, Communicate, and Remedy Operational Issues](#),

the BOP reported that, consistent with one of the five recommendations, it has taken actions to ensure its program review process is sufficiently independent. One of the issues the OIG identified in the report was that BOP audit teams consisted of not only Program Review Division (PRD) employees, but also employees from BOP's Central Office, Regional Office, and institutions. We were told that program review team members who worked at BOP institutions may have been hesitant to criticize fellow BOP employees, fearing that if they issued negative findings to an institution under review, that institution's leadership might withhold future promotions for the team member. To address these concerns, the BOP told us that audit teams now consist only of PRD employees. Additionally, the BOP explained that all PRD audit team members now sign a statement of independence prior to each audit to help limit any potential issues or concerns. Based on the BOP's actions, we closed this recommendation. The BOP has taken actions that are responsive to the report's other four recommendations, but because the BOP has not yet made sufficient progress to address the underlying issues, the other four recommendations remain open.

Question 2: I understand that the recent BOP report you released focused on (1) suicides, (2) homicides, (3) accidents, (4) unknown factor deaths for fiscal years 2014-2021.

Ten of those deaths took place at the Federal Medical Center Butner. Do you have a detailed breakdown of those deaths? If so, can you provide the information.

Response: The ten deaths at Federal Medical Center Butner during the evaluation period of our [Deaths in Custody](#) report included the following:

- 4 Homicides (1 in FY 2017, 1 in FY 2019, and 2 in FY 2020)
- 3 Suicides (1 in FY 2016, 1 in FY 2017, and 1 in FY 2020)
- 3 Accidents (1 in FY 2018, 1 in FY 2019, and 1 in FY 2020)

Question 3: During your oversight investigation, did you notice any specific areas at the Butner Prison that need immediate action? For example, staff training, resources, or medical equipment?

Response: A number of the issues identified in our [Deaths in Custody](#) report were a factor in one or more of the deaths at the Federal Correctional Complex (FCC) Butner institutions (i.e., Federal Medical Center Butner, Federal Correctional Center [FCI] Butner Low, FCI Butner Medium I, and/or FCI Butner Medium II). Some of the most important issues contributing to these deaths include: insufficient staff training, potentially inappropriate Mental Health Care Level (MHCL) assignments, single-celling and restrictive housing of suicidal inmates, failure to sufficiently complete rounds or counts, interdepartmental and radio communication issues, emergency first response and AED issues, documentation issues, contraband drugs or weapons, overdose deaths, security camera issues, and insufficient staffing. These issues at FCC Butner and other BOP institutions need attention, which is why we issued twelve BOP-wide recommendations in our report, all of which remain open.

Question 4: It's not a secret that BOP is facing a staffing challenge. Do you believe giving direct hire authority to local institutions will alleviate some of the difficulties that BOP is facing?

Response: In her testimony before the Committee on February 28, 2024, BOP Director Colette Peters referred to the importance of direct hire authority several times. For example, in response to a question from Sen. Richard Blumenthal, Director Peters testified as follows: “[W]hile we have issued every authority in our power—like, we’ve increased the base salary for COs by \$2000, we have recruitment and retention incentives across the country, we have direct hire authority—the bottom line, as I said in my opening comments, is we need to pay them more. [] The retention incentives and recruitment incentives are band-aids. We have to figure out how to increase that base salary so that we can hire the best and the brightest and keep them.”

The OIG has identified the need for BOP to address staffing shortages since at least 2015. For example, in the June 2023 report [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](#), the OIG recommended that BOP continue to develop and implement plans to address staffing shortages at its prisons. While direct hire authority should be an aspect of a comprehensive approach to staffing, direct hire authority is not sufficient on its own to address the shortages. A comprehensive staffing plan is needed, and the OIG is continuing to monitor the BOP’s progress regarding staffing shortages at its prisons as part of its ongoing work as well as in the resolution process for several recent OIG recommendations in this area.

Question 5: In August 2023, BOP and National Institute of Justice (NIJ) announced that a study will be conducted on the use and impact of restrictive housing in federal correctional facilities. Do you believe that by eliminating restrictive housing that it will create a safer working environment for staff?

Response: Because the BOP has not proposed or implemented a plan to eliminate restrictive housing, the OIG has not conducted oversight work on that issue, and I would defer to the BOP to respond to that question. However, prior OIG reports have identified safety and security issues in the BOP’s current use of restrictive housing and the BOP recently took action to address the OIG’s concerns about BOP’s use of restrictive housing and single-cell confinement and the risk of inmate suicide. In particular, on March 5, 2024, seven years after the OIG published its 2017 report on the [BOP’s Use of Restrictive Housing for Inmates with Mental Illness](#), the BOP published its revised [Special Housing Unit \(SHU\) policy](#). This revised policy will satisfy several of the remaining open recommendations from our 2017 report and provides new guidance in the areas detailed below. We will continue to monitor the BOP’s corrective actions on other open OIG recommendations related to the use of restrictive housing and on the BOP’s own recommendations from its 2021 *BOP Task Force Report on Single Celling and Inmate Suicide: Preventing Suicide Through Improved Housing Decisions*.

Key elements of the revised SHU policy include:

- **Single-cell confinement:** The policy provides, for the first time, guidance specifically addressing single-cell confinement and discouraging its use, stating: “Employees must place inmates in SHU with a cellmate, unless there are unique circumstances that warrant single cell placement.” There are also new required approvals up to the Warden when an inmate must be single-celled, and the approval must be documented on a new Single-Cell Review Form.

- **SHU placement, review, and monitoring:** A multidisciplinary team must now be convened to determine housing options and the appropriateness of extended SHU placement (6 months). Additionally, a new SHU Multidisciplinary Team Review form is to be used to document weekly SHU review meetings. The revised policy defines restrictive housing and extended restrictive housing duration. Health Services must now be notified of all new arrivals to the SHU, mental health and education employees must visit all inmates in the SHU at least weekly, and there must be “meaningful contact” with SHU inmates.
- **Pregnant and transgender inmates:** The policy provides expanded guidance on the placement of pregnant inmates in the SHU and on the use of restraints on those inmates, in accordance with the First Step Act. The policy also provides new guidance on conditions of confinement for transgender inmates in the SHU.
- **SHU staffing and training:** The policy directs that all SHUs with an inmate population of more than 50 must now be staffed with a second officer on the morning watch shift. The policy also calls for the completion of required quarterly training for staff assigned to the SHU and for the documentation of this training.

Question 6: If restrictive housing is terminated, what recommendation would you provide to BOP on housing arduous and disruptive inmates?

Response: *See response to Question 5.*

Question 7: Do you believe that the elimination of restrictive housing will lead to new challenges for staff?

Response: *See response to Question 5.*

Question 8: As you have highlighted in your report—overdose deaths are a major trend across the BOP system. Do you believe that BOP should transition to scanning and providing digital mail to help decrease contraband and narcotics from entering the prison?

Response: Contraband drugs are a significant problem facing the BOP, as a number of prior OIG reports have demonstrated, and the BOP needs to take action to address this issue. In a January 2024 statement to the OIG in response to a draft of the [Deaths in Custody](#) report, BOP stated that digital scanning of both general and legal mail across the BOP would have a positive impact on contraband interdiction, and pointed to an apparently successful result from its digital mail scanning pilots at two institutions, which are also discussed in [HR 5266 Interdiction of Fentanyl in Postal Mail at Federal Prisons Act](#). In its statement to the OIG, BOP also observed that the development, implementation, and use of digital scanning technology could risk burdening employee resources and require significant budget resources that have not yet been

allocated. However, the BOP stated that digital scanning is more effective than photocopying mail, another method the BOP previously piloted and assessed. The OIG has not independently verified the effectiveness of digital mail scanning as a contraband drug interdiction tool, but, as stated in our [Deaths in Custody](#) report, we encourage the BOP to explore all strategies for interdicting contraband drugs and other prohibited items in its institutions, given the significant safety risks and threats to inmate livelihood posed by contraband's presence in BOP institutions.



Department of Justice

STATEMENT OF COLETTE S. PETERS
DIRECTOR, FEDERAL BUREAU OF PRISONS
BEFORE THE COMMITTEE ON THE JUDICIARY
UNITED STATES SENATE

AT A HEARING ENTITLED
“EXAMINING AND PREVENTING DEATHS OF INCARCERATED
INDIVIDUALS IN FEDERAL PRISONS”

PRESENTED
FEBRUARY 28, 2024

**Statement of Colette S. Peters
Director, Federal Bureau of Prisons
Before the Committee on the Judiciary
United States Senate
February 28, 2024**

Good morning, Chairman Durbin, Ranking Member Graham, and Members of the Committee. I appreciate this opportunity to discuss how the Federal Bureau of Prisons (FBOP) is working to prevent deaths in custody and how we are committed to reviewing incidents in order to improve our work. I am humbled to represent the roughly 35,000 employees of the FBOP. As I have previously testified before this Committee, I believe in accountability, transparency, and the importance of oversight. As you are aware, there are inherent challenges to our work. But with proper planning, diligence, and resources, we will improve our efforts.

I am pleased to be here with Inspector General Horowitz from the Office of the Inspector General (OIG) to discuss his report's findings and respond to his team's thoughtful evaluation. At FBOP, any unexpected death of an adult in custody (AIC) is tragic. As noted in the OIG's report, we have already taken many steps to mitigate the risk of death and we welcome OIG's recommendations to further our efforts. In fact, we provided OIG a number of planned actions that address each of the recommendations in the report, which OIG has found are responsive.

FBOP prioritizes the physical and mental health needs of those in our care and custody. Individuals in our care are predisposed to acute and chronic illness, including higher cases of mental illness and substance use disorders. In fact, the rate of individuals who meet the clinical criteria for one or more substance use disorders is nearly double in the FBOP population, at 31.8 percent, compared to 16.5 percent in the general U.S. population.

Preventing suicide for those in our care is a top priority for us, and we provide our employees with regular training to identify indicators on increased suicide risk, on appropriate monitoring and care, on procedures to refer individuals to Psychology Services who are flagged as being at risk, and on responding during a medical emergency when an individual is attempting suicide.

As part of our efforts to prioritize suicide prevention, FBOP has recently undertaken several initiatives to prevent and reduce deaths by suicide, including issuing guidance for employees to carry cut-down tools on their person; reducing the incidence of placing individuals in custody in cells by themselves; and conducting specialized reviews at institutions that have higher incidence of suicide deaths. We also have doctoral-level psychologists at our institutions, who are working to continuously monitor, research and implement best practices as they relate to suicide prevention and mental health care for our AICs. Any time a risk of suicide is suspected, FBOP policy requires that psychologists swiftly conduct Suicide Risk Assessments. When we have identified an individual at possible risk for self-harm, they are immediately safeguarded, and the individual assessments then prompt short-term and long-term plans for the individual's treatment and care.

When tragedy strikes and a threat of suicide is realized, our employees rely on FBOP training to respond quickly. Specifically, we train employees on the appropriate use of cardiopulmonary resuscitation (CPR), automated external defibrillators (AEDs), the opioid reversal agents like naloxone, and cut-down tools and ensure employees have access to those tools in the workplace. Additionally, each institution has a clinical psychologist designated as a Suicide Prevention Program Coordinator. These coordinators monitor at-risk individuals and guarantee adherence to assessment and intervention protocols. When our

best efforts are not successful and death does occur, we conduct a rigorous review of the circumstances surrounding the death.

Substance use and overdoses also lead to death. Therefore, we employ a multidisciplinary approach to treating substance use disorders, including opioid use disorder (OUD), which affects approximately 2.7 million Americans, including 15-20 percent of those in our custody. To better educate and treat the needs of our AICs, we have incorporated evidence-based treatments, like medications for opioid use disorder (MOUD) and other substance use disorder treatment, into our programming. These programs tackle various facets of the issue, preparing individuals to reenter their communities successfully. MOUD is available across all FBOP facilities, and collaborations with agencies such as the Drug Enforcement Administration (DEA), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of National Drug Control Policy (ONDCP), National Institute on Drug Abuse (NIDA), and the Justice Community Opioid Innovation Network (JCOIN), ensure consistent accessibility and success.

Dangerous substances like illicit fentanyl pose a health risk to those in our custody as well as our employees. To reduce the risk of death by overdose, we continuously work to combat contraband entering our institutions. We have implemented heightened screening of mail and publications and counter-drone initiatives, both of which have been used to surreptitiously introduce contraband into FBOP facilities. We continue exploring innovative methods to reduce physical correspondence which may have been adulterated with illicit substances.

To improve our capability to respond to the introduction of illicit substances, we have made naloxone, an opioid reversal medication, available in all our institutions. All FBOP employees within the facility are trained to administer life-saving doses of naloxone to anyone suspected of experiencing an opioid overdose. Our current tracking methods show that in the past 12 months, naloxone was administered by FBOP employees over 3,700 times to approximately 2,600 AICs at 91 institution complexes (out of 97). While it is important to note that FBOP employees are trained to provide naloxone whenever overdose cannot be ruled out and not all instances of naloxone usage are for confirmed overdose, please know that we will continue to improve our tracking mechanisms. Specifically, we have begun developing a dashboard to capture all use of naloxone and patient outcomes more effectively.

Beyond our efforts to prevent and respond to overdose emergencies, FBOP is committed to establishing and sustaining a culture of clinical excellence across all our facilities to prevent disease progression and death wherever possible. This is evident in our efforts to identify and treat hepatitis C, where FBOP cures more than 2,300 patients a year of this deadly yet treatable infection. We dedicate significant resources to our clinical teams to ensure they have access to continuous education and training focused on correctionally sound, evidence-based care.

Additionally, we use sound correctional practices throughout the country to prevent violence, including homicides, in our custody. We use our National Gang Unit, Counter Terrorism Unit, and Intelligence and Investigations Unit to forestall potential conflicts that could lead to homicide. Moreover, we work proactively with external partners to continually monitor and assess risks and vulnerabilities that can lead to violence.

We hold ourselves and our AICs to a high standard, and we are working diligently to comply with and improve the policies and procedures within our organization. As part of this work, we are in the process of creating a new executive position at the national level that will be charged with helping FBOP better use the information at its disposal—e.g., intelligence, misconduct, and after-action reports including death reviews—to recognize possible pressure points throughout the system. Our goal with this new

position is to identify and address concerns as early as possible. I believe our efforts over the last year and a half—and our efforts moving forward—have generated, and will continue to generate, change within our agency. We are grateful for OIG’s thorough review and thoughtful recommendations in its report, and we welcome the opportunity to continue FBOP’s ongoing efforts to improve in this area. I want to assure the Committee we will work with the appropriate officials and individuals to find creative solutions to our operational challenges and implement the recommendations given to us by OIG. We stand ready and eager to work with the Committee and Appropriators to provide more specificity on the funding recommendations in the OIG’s report and recommendations.

Mental Health Care Level (MHCL) Assessments

When an individual enters our care, Health Services and Unit Management have 24 hours to conduct initial intake screenings to evaluate indicators for mental illness and adjustment issues. Within 14 days, Psychology Services employees must conduct a clinical interview of newly committed AICs after they arrive at an institution and assign an appropriate MHCL. Within 30 days, Psychology Services employees must conduct a transfer AIC screening and, if clinically needed, a clinical interview for transferred AICs after they arrive at an institution.

The report by OIG states that the majority of the AICs who died by suicide during the scope of their study were assigned MHCL 1.¹ According to the report, of the 187 who died by suicide, 22 did not have MHCL 1-4 assignments at the time of their deaths; 34 of 187 AICs did not have accurate documentation; and 118 of 187 AICs had an assigned level of MHCL 1. FBOP concurs with OIG that these rates, inaccuracies, or failures to follow policy are unacceptable, and we will continue working to ensure our employees assign accurate, consistent, and timely MHCLs to AICs.

It is important to note that we are already implementing several strategies to accomplish this goal. To start, while we conduct an initial intake screening within 24 hours of an AIC’s arrival at an FBOP institution, we complete a full clinical interview within 14 days. Additional strategies include: assigning MHCLs to AICs within 14 days of arrival at their designated institution; using the guidelines from Program Statement 5310.16² to guide clinicians on how to determine the appropriate MHCL based on their clinical opinion and how to accurately document those MHCLs; confirming the Chief Psychologist at each institution is reviewing the documentation submitted by their subordinates;³ ensuring a multidisciplinary and holistic team approach to treatment of AICs is upheld and that, during institution Care Coordination and Reentry Team meetings, professionals from multiple disciplines⁴ discuss the numerous factors impacting the treatment of those AICs.

In addition to the strategies listed above, we also plan to continue our practices of having Psychology Services Branch (PSB) clinicians in Central Office review significant events from an AIC’s previous institution locations, including incidents involving self-directed violence, suicide attempts, violence toward others, behavioral observations, and incident reports received. After reviewing such incidents and associated documentation, PSB clinicians may contact previous institutions, current supervisors, and Regional/Central Office psychologists to consult on these cases and associated clinical

¹ Mental Health Care Level designations range from one to four where one indicates no significant mental healthcare; two indicates routine outpatient or crisis-oriented healthcare; three indicates enhanced outpatient or residential mental healthcare; and four indicates inpatient psychiatric care.

² “Treatment and Care of Inmates with Mental Illness”

³ This is especially true for documentation related to changes in MHCLs.

⁴ E.g., Psychology Services, Health Services, Unit Team, Correctional Services, Social Work, etc.

treatment needs as needed. When MHCL assignments appear inaccurate, clinicians will adjust care levels accordingly to reflect historical and current presentation and treatment needs.

Preparedness Drills and Training

Preparedness drills are set to take place three times per calendar year, once on each shift, to simulate a suicide attempt by an AIC. These drills are enacted to assess employees' response capabilities should an emergency arise and to identify any necessary areas of training. The goal of any type of mock exercise is to involve as many employees as possible without disrupting the safe, secure, and orderly operation of the facility. FBOP concurs with the OIG report recommendation calling for all institutions to conduct required mock suicide drills and to develop strategies to increase staff participation in those drills. To ensure institution compliance with Program Statement 5324.08,⁵ FBOP has added a new program review requirement. Should an institution be found deficient in following our policy, we will require Corrective Actions Plans (CAPs) that we expect will improve compliance. CAPs will then be reviewed in the future to determine effectiveness.

When employees respond to these preparedness drills, they are to do so while simultaneously ensuring adequate monitoring of AICs such that safety, security, and orderly management of the institution are all maintained. To that end, the number of employees responding is directly influenced by many variables, including: the number of employees on shift, other operational needs of the institution, and if employees are needed for supervising AICs or contractors. Each institution maintains an emergency response plan with outlined expectations for employees who respond from each area of the institution to allow for a timely response while maintaining the safety and security of the facility.

To improve routine tracking and oversight of these preparedness drills, FBOP has incorporated these important drills into Operational Review assessments. If emergency response is a concern identified during a suicide reconstruction, the team conducting the reconstruction reviews these preparedness drills to ensure they included adequate employee participation and realistic mock experiences to allow employees the ability to practice using emergency response equipment.

Restrictive Housing⁶

As of February 2024, FBOP has approximately 11,000 AICs in restrictive housing, a number we are working to reduce. As the OIG report notes, 86 of the 187 suicides occurred in a restrictive housing setting, and over two-thirds (60 of 86 suicides) that occurred in a restrictive housing setting occurred while the AIC was single celled, that is assigned to a cell by themselves. Knowing these risk factors, FBOP provides additional specialized training to our employees who work in restrictive housing or other high-risk settings, and each institution has a dedicated program coordinator who oversees suicide prevention education and training.

FBOP strives to limit single-celling whenever possible, as there is evidence that single-celling is associated with a higher risk of suicide.⁷ In May 2021, we established a task force to review single-celling practices and issued guidance and policy changes to identify limited circumstances when single-celling is deemed appropriate. We also enhanced training on the risks of single-celling individuals and introduced

⁵ "Suicide Prevention Program"

⁶ "Restrictive housing," sometimes known as "administrative segregation," is the practice of housing some AICs separately from the general population of a correctional institution and imposing restrictions on their movement, behavior, and conditions of confinement.

⁷ Seena Fazel, M.D., et al., Suicide in Prisoners: A Systematic Review of Risk Factors, *J. of Clinical Psychiatry* 69:11, Nov. 2008.

new internal controls to enhance our accountability such as regional oversight of single-celling in restrictive housing. Further, we now provide quarterly summaries of deaths by suicide to all wardens and regional directors and identify common recommendations found during suicide reconstructions and include talking points for wardens to discuss suicide prevention strategies with their employees.

Unfortunately, even with these procedures in place, including double-celling, suicides have occurred in restrictive housing. While restrictive housing can be an effective tool for maintaining safety and security and protecting lives, FBOP has both a short-term plan and a long-term plan to evaluate current practices and align with best correctional practices to reduce and limit use of restrictive housing overall. FBOP is partnering with the National Institute of Justice on a multi-year assessment of FBOP's use of restrictive housing, and this assessment is underway. The results of that assessment will include a final report and recommendations that will inform our future restrictive housing policies. In response to studies of FBOP's use of restrictive housing by DOJ and the Government Accountability Office, as well as our own studies, we have already taken steps to reduce the use of restrictive housing, including:

- Launching programs preventing and reducing the need for restrictive housing placements;
- Creating alternatives to restrictive housing;
- Creating baseline conditions of confinement;
- Developing and implementing Secure Mental Health units, which are designed to house and provide intensive treatment to incarcerated individuals with mental illness who would otherwise need to be placed in restrictive housing, and often solitary confinement;
- Amending the Disciplinary Program policy to limit the usage and duration of restrictive housing for disciplinary violations;
- Decreasing the number of individuals housed at the Administrative Maximum Facility in Florence, Colorado, by over 20 percent since 2017, demonstrating a reduction in at least one type of restrictive housing.

FBOP is committed to ensuring that any deficiencies in our use of restrictive housing are remedied, including deficiencies in how employee rounds are conducted that may contribute to suicides. Employees are trained annually on when and how to make rounds to observe AICs. Employees assigned to work in restrictive housing units receive this training quarterly. Departments such as Psychology Services, Religious Services, Recreation, Education, and Unit Teams conduct regular rounds and frequently provide programming to those in restrictive settings throughout our system. Internal oversight to ensure that rounds are being made as required is ongoing at the facility, regional, and national levels.

FBOP also is in the process of implementing an internal audit process to verify and document that facilities have implemented corrective actions to address restrictive housing deficiencies identified during internal audits conducted by its Program Review Division. This process will identify causes of common deficiencies that recur across multiple facilities. It will include an internal audit follow-up process involving all levels (local, regional, and divisional leadership) of the agency to establish internal controls to prevent deficiencies from reoccurring.

Automated External Defibrillators

The OIG report concludes that 22.7 percent (78 of 344) of AIC deaths involved issues related to AEDs. As a result, the OIG recommended that all appropriate employees be trained in AED use and that AEDs are strategically placed, readily available, and regularly checked to guarantee they are in working order at each FBOP institution. FBOP concurs with this recommendation, but it is important to note that all FBOP employees are trained on appropriate AED use annually. While local institutions determine the best available location for these tools, we will continue to ensure that all appropriate employees are

trained in AED use and that AEDs are strategically placed, readily available, and regularly checked to ensure they are in working order. Our Health Services Units purchase the AEDs, and we have tasked them with certifying these devices are, and will continue to be, inspected per the manufacturer recommendations.

Training and Tools to Prevent Suicide by Hanging

Hanging is the most common method AICs use to facilitate suicide. That is why FBOP guidance requires certain employees, including all those assigned to housing units, to carry specialized tools that cannot be used as weapons but are designed to help employees safely and quickly cut through materials to prevent hangings. FBOP distributed that guidance to the field in July 2023 and provided an update in September 2023. FBOP concurs with the OIG recommendations that these cut-down tools in working order be accessible to employees in each housing unit at each institution, that personnel be trained on proper use of the tools, and that FBOP determine whether employees should be issued and required to keep a cut-down tool on their duty belt during their entire shift. As we seek to add additional training on the use of cut-down tools agencywide, we will also continue to address the use of these tools generally and their use in emergency situations in our required Annual Training.

Gurneys

During a medical emergency, the Bureau initiates life-sustaining measures at the scene and then uses gurneys to transport AICs quickly and safely to a medical treatment area after. Because there are various factors in emergencies, such as the size of the affected AIC and the distance they must be transported, all employees must have access to reliable gurneys that are easy to maneuver. OIG recommended that each institution have a sufficient number of maneuverable gurneys in strategic locations to provide proper medical response during the transport of AICs.

FBOP concurs with this recommendation and will use Annual Training to continue educating our employees on the use of patient movers (maneuverable gurneys) at their site. As each site must have the ability to efficiently move a patient and determines the most appropriate type of patient movers based on their infrastructure, we plan to add language to our policy on Patient Care requiring the development of individualized institution guidance. We will ensure that a national standard is appropriately applied at the local level, taking the specific characteristics of each institution into account.

Radio Communication

The OIG report states that existing FBOP policies would, in some cases, mitigate certain risks associated with AIC suicide. However, the report states that FBOP employees did not consistently communicate with each other and coordinate efforts. FBOP recognizes radio communications are critical when responding to AIC medical emergencies. FBOP agrees with the OIG recommendation that we conduct standard, enterprise-wide training to employees on using the radio to communicate clear, descriptive information during AIC medical emergencies, and we have already begun this process. All new employees are trained on all emergency communication devices in Phase 1 of the "Introduction to Correctional Techniques" training; and additional communication training is provided in Phase 2 of the same exercise. Further, each year FBOP's mandatory Annual Training covers radio etiquette and proper communication during emergencies. We will continue to monitor and examine the training provided to determine where we can make improvements for greater clarity and descriptiveness.

Naloxone

Naloxone is a life-saving medication that can reverse the effects of opioids and is available in strategic locations at all FBOP facilities. However, the report noted that despite being trained in administering naloxone, some employees have waited for medical staff to arrive and administer it. We will continue to ensure employees receive both the initial and the refresher naloxone training and are fully prepared to administer naloxone to an unresponsive AIC suspected of having experienced a drug overdose immediately.

A policy for naloxone was implemented in July 2018, and it declares that mandatory initial training, annual training, and inventory management will take place in our institutions. The current version of the policy, Program Statement 1610.01,⁸ was issued in December 2020. Further, all employees are required to complete a course titled “Nasal Naloxone Administration.” This course must be completed within 60 days of entry on duty and has an annual recertification requirement.⁹ Health Services is responsible for curriculum development and will review current training to assess for opportunities to make improvements that address identified barriers to use. Our policy and training are crystal clear that when employees suspect an overdose, they are to immediately administer naloxone.

Evidence Recovery Teams

After an AIC dies, regardless of cause, FBOP mobilizes Evidence Recovery Teams (ERTs) to gather and collect evidence and to preserve and process crime scenes. The employees who respond to the scene must document the events and draft a memorandum, which is then attached to a Report of Incident form generated for each death. Ensuring all ERTs are properly trained across our agency is of utmost importance given the essential role the teams play in preserving and processing incident scenes, as well as in recovering evidence following attempted homicides, unexplained deaths, and suicides. We assessed our After-action Review reports and agree with OIG’s recommendation to ensure all ERTs are properly trained on post-incident evidence recovery protocols. Currently, FBOP institutions are required by Program Statement 5510.14¹⁰ to provide eight hours of training every quarter on post-incident evidence recovery protocols, complete one major mock scenario and a Prison Rape Elimination Act course annually, complete four Federal Emergency Management Agency courses, and be recertified every two years. We will continue to ensure all ERTs are properly trained on post-incident recovery protocols.

Death-related Records

OIG recommended FBOP develop procedures to ensure all required death-related records are completed and collected consistently and in accordance with established deadlines. The Health Services Division’s (HSD) Population and Correctional Health Branch, Quality Improvement Section has already begun substantive improvements to its mortality review and record tracking systems, most of which were implemented between June 2023 and January 2024. These actions include: implementing a new resource email box to improve communication between institutions and Central Office concerning AIC deaths; updating the required multi-level mortality review (MLMR) to include additional data collection fields, expanded drop-down menu options, and electronic submission capabilities that will minimize transcription of data and input errors; updating the root cause analysis (RCA) form to provide more detail and more appropriate implementation of corrective actions; training quality improvement employees on the use of both forms; requiring follow-up from HSD Regional or Central Office at six and twelve months; establishing a multidisciplinary panel to evaluate overall appropriateness and comprehensiveness

⁸ “Naloxone Procedures and Protocol for Reversal of Opioid Overdoses”

⁹ Employees recertify during Annual Training.

¹⁰ “Crime Scene Management and Evidence Control”

of RCAs received from institutions; and providing HSD employees with clearer guidance on required forms, timelines, and submission routes to standardize messaging and processes.

After-action Reviews

After-action Reviews (AARs) are tools that help us understand how an incident arose and how we can apply corrective actions. FBOP agrees that the reports resulting from AARs provide more detailed information surrounding an AIC's death than other required death documents such as MLMRs. Given that AARs compile information providing a more complete picture of the circumstances leading to a death and can help us identify factors and deficiencies that may help reduce the risk of future deaths, we are considering expanding our AAR policy to require AARs for non-suicide deaths.

All deaths in our facilities (except legal executions) undergo an MLMR process conducted by a multidisciplinary team of institution Health Services employees and executive leadership. This requirement is a quality improvement process that affords the institution the opportunity to identify clinical and administrative processes that can be improved through corrective actions or root cause analyses. Additionally, all AIC deaths—whether they occur by homicide, accidental, natural, or unknown factors—are investigated and reported through a Report of Incident by the institution; and current policy allows the Regional Director (RD) the discretion to appoint an After-action Review Team to further investigate the incident and prepare an AAR.

FBOP Program Statement 5500.14¹¹ addresses AARs in Chapter 6, and already includes “homicides” as a major incident requiring after-action review and reporting. Additionally, “other incidents as identified by the respective RD and Assistant Director, Correctional Programs Division” may also be considered major incidents requiring after-action review and reporting.

The program statement also indicates that, “[w]hen a major incident occurs at a Bureau or contract facility, the RD may, at his or her discretion, appoint an After-Action Review Team to investigate the incident and prepare an [AAR].” This provision allows RDs discretion to consider all aspects of an incident and use sound correctional judgement in determining when an After-Action Review Team should be assembled. Therefore, current policy already allows RDs, in their discretion, to designate deaths by accidental and unknown factors as major incidents requiring after-action review and reporting, on a case-by-case basis. However, notwithstanding the review processes that are currently in place, we will assess ways to enhance our review processes so they can reach the level of effectiveness of AARs.

Tracking Reports and Recommendations

FBOP has established numerous processes and mechanisms that have the potential to shed light on the circumstances surrounding AIC deaths, identify areas of improvement, and yield recommendations. OIG recommends we clarify responsibility for tracking, at an enterprise level, reports and recommendations required in the wake of an AIC death by suicide, homicide, accident, or unknown factors, and assess the information contained therein for broader trends, applicability, and implementation.

FBOP concurs with OIG’s recommendation. HSD’s Population and Correctional Health Branch, Quality Improvement Section already holds quarterly meetings with the Reentry Services Division, the Correctional Programs Division, and the Office of General Counsel—each of which has an intersection with mortalities—to review all deaths in the previous quarter. These meetings ensure accurate and coordinated data sharing between divisions and have already assisted in accurate reconciliation of death information. Going forward, we will explore processes to improve communication between divisions who are primarily responsible for the report types that may be indicated following an AIC death, ensuring each

¹¹ “Correctional Services Procedures Manual”

division is aware of work being conducted in other divisions, and has access to final reports and recommendations issued through those reports.

Electronic Devices and Inmate Security

Our employees use pat searches, visual searches, and electronic searches to ascertain whether an AIC has smuggled contraband within the facilities. It is important for correctional officers to thoroughly search AICs for items such as weapons, because it allows us to circumvent instances in which a weapon is used to commit suicide or harm a fellow AIC or FBOP personnel.

OIG recommends we evaluate existing electronic devices used for AIC screening to identify whether they are functioning as intended, and, if necessary, implement any needed adjustments or upgrades. We concur with this recommendation and will continue to evaluate, identify, and implement adjustments and/or upgrades. FBOP uses several devices for electronic screening, including well-established whole-body imaging metal detection technologies, and new security technologies like contraband cellphone identification and mitigation and Counter Unmanned Aircraft Systems (C-UAS) identification and mitigation. In FYs 2022 and 2023, our Office of Security Technology evaluated whole-body imaging devices that were deployed in 2012 and were end-of-life; then, they initiated replacement of these devices with newer technology that offers higher fidelity x-ray scans for contraband identification. We are already upgrading our technology and we are routinely evaluating existing equipment to determine if it needs to be upgraded. We will continue to review and invest in new technologies for AIC screening.

Further, we are pleased to report that even before the passage of the Prison Camera Reform Act, FBOP began conducting a nationwide review to assess its prison camera coverage and identify areas of limited or zero visibility. Following the review, during which institutions identified areas of limited or zero visibility, the number of additional cameras needed, and the associated costs to adequately address the identified blind spots, FBOP started installations and upgrades system-wide including blind spots assessments, supporting equipment, and camera installation.

Conclusion

Chairman Durbin, Ranking Member Graham, and Members of the Committee, thank you for this opportunity to speak on behalf of the Federal Bureau of Prisons and its dedicated employees throughout the country. I am grateful to have had the chance to discuss our plans to minimize the deaths of adults in custody within our institutions. I believe in the importance of transparency and oversight, and I look forward to continuing to work with the Committee. Our mission at the Bureau is challenging but critical to the safety and security of the public, our employees, and individuals housed within our facilities. Thank you again for the opportunity to speak with you today, for the support we have seen from Members of this Committee, and your continued support as we move forward.

**Questions for the Record from Senator Lindsey O. Graham for
Colette S. Peters, Director of the Federal Bureau of Prisons
“Examining and Preventing Deaths of Incarcerated Individuals in Federal Prisons”
February 28, 2024**

1. How many biological men have been placed in federal women’s prisons under the Biden administration?
2. What is the Biden administration doing to track instances of biological male violence against women inside women’s prisons as a result of this policy?

Senate Judiciary Committee
Hearing on “Examining and Preventing
Deaths of Incarcerated Individuals in Federal Prisons”
February 28, 2024
Questions for the Record
Senator Amy Klobuchar

For Ms. Colette S. Peters, Director of the Federal Bureau of Prisons

In 2022, I co-led the *Justice and Mental Health Collaboration Reauthorization Act* with Senator Cornyn, which President Biden signed into law later that year. The Act helps ensure that we have the training and resources to address mental health issues at all stages of the justice system. The Inspector General’s report notes that many inmates’ Mental Health Care Levels were not adjusted even after those inmates attempted suicide.

- Why are these adjustments not being made, and does the Bureau need additional support from Congress to continue improving access to care for incarcerated people experiencing mental health challenges?

**Bureau of Prisons Director Colette S. Peters – “Examining and Preventing Deaths of
Incarcerated Individuals in Federal Prisons”
Questions for the Record
Submitted March 6, 2024**

QUESTIONS FROM SENATOR COONS

1. I appreciate your efforts to address BOP’s staffing challenges.
 - a. What is the total staffing BOP has determined it needs?
 - b. Your testimony indicates that pay needs to be higher for BOP to compete and retain employees. Has BOP assessed what pay increases will be needed? If so, please provide information. If not, why not?
 - c. What obstacles or bottlenecks would prevent BOP from quickly hiring new staff once additional resources for such staff are located?
 - d. What authorities could Congress provide to help BOP hire and retain staff?

2. In a recent court declaration,¹ BOP indicated that as of January 2024 there were approximately 99 individuals ordered committed to the Attorney General for competency restoration and who have been waiting 60 or more days to be transferred to a suitable medical facility for restoration.
 - a. Please provide updated information about this figure as of the time of your response.
 - b. How many of these individuals were on pretrial release prior to being ordered committed to the custody of the Attorney General upon the finding of incompetence?
 - c. Please provide information about where individuals are held while awaiting placement in a restoration facility. Is it a BOP facility, some other federal facility, or on some form of release? What are the policies and procedures by which such placement determinations prior to entering restoration treatment are made?
 - d. What costs have been incurred housing and transporting individuals who have been found incompetent who otherwise would have been on pretrial release?

3. The court declaration highlights the significant resource limitations that are causing a backlog for such restoration services.
 - a. Has BOP estimated what resources would be needed to fully eliminate the backlog? If so, please provide information. If not, why not?
 - b. What additional authorities apart from resources would be helpful to ensure mentally incompetent defendants are not waiting in pretrial detention for restoration services?

4. I appreciate your efforts to address the backlog in competency restoration services through the new program at MCC Chicago. Please provide additional information about the capabilities and limitations of jail-based restoration programs such as that at MCC Chicago versus the capabilities of the other facilities that offer restoration services.

5. The court declaration describes how BOP has been “severely impacted” by the Ninth Circuit’s decision in *United States v. Donnelly*. Please elaborate on the nature of this impact.

¹ Declaration of Dia B. Boutwell, Ph.D, *United States v. Sisk*, 21-cr-114, Dkt. 146-1 (S.D. Ind. January 3, 2024).

6. The court declaration indicates that BOP has been unable to locate a private or state-run facility that BOP could contract with to provide restoration services under 18 U.S.C. 4247(i) that would meet the statutory requirements of Section 4241(d).
 - a. Please provide additional information about BOP's efforts to identify such a facility.
 - b. Which statutory factors has BOP determined cannot be met in private or state-run facilities?

Senator Jon Ossoff
Questions for the Record for Colette Peters
Director, Federal Bureau of Prisons
February 28, 2024

Staffing Shortages

1. During the Judiciary Committee's February 28 hearing, you testified that BOP was developing a new salary rate table to identify the competitive salaries needed to help address the Bureau's ongoing staffing shortage.
 - a. Please describe what the new salary rate table will entail, including whether it will evaluate competitive pay rates for each of BOP's 122 facilities and/or BOP's 6 regions.
 - b. Which type of BOP employees will be included in the salary rate table? Which ones will not be included?
 - c. When does BOP anticipate completing the salary rate table?
 - d. Will BOP provide my office with a copy of the table when it is complete?

Prison Cameras

2. The Prison Camera Reform Act, signed into law in December 2022, aimed to strengthen and upgrade security systems at Bureau of Prisons (BOP) facilities across the country. Consistent with the Act, the BOP reportedly completed a bureau-wide review to assess its prison camera coverage and identify "blind spots," or areas that are not captured by cameras, during summer 2023.
 - a. Please explain what this review entailed and provide my office with a copy of the review.
 - b. When does BOP anticipate addressing the blind spots identified in the review by installing and upgrading camera systems, as necessary?

Deaths in Custody

3. How many individuals, in total, died while in BOP custody in 2023?
 - a. Of this total, how many were reported to have died of natural causes?
 - b. How many deaths classified as natural were of individuals aged 65 or younger?
 - c. Does BOP examine death data by BOP facility or region?
 - i. If so, how does your examination of death data inform any changes in policy and practice?
 - ii. If not, why? What changes would be necessary to begin doing so?
4. What rubric does BOP use to categorize different causes of death?
 - a. Is there Department of Justice (DOJ) guidance on how to categorize causes of death?
 - i. If not, what guides BOP's classifications?
 - b. How does BOP define "natural deaths"?

5. When examining natural death cases, how, if at all, does BOP determine whether any medical neglect, poor facility conditions, and/or lack of resources were factors relating to cause of death?
 - a. If you are not addressing these factors as potentially related, why not?
 - b. What changes would be necessary for you to begin doing so?
6. What, if any, justification does a facility warden need to provide when deciding whether an autopsy is needed following an inmate's death?
 - a. If no justification is needed, why not and what changes would allow for this?
 - b. Does an appeal process exist for families if a warden decides against an autopsy?
 - i. If so, please describe the process and how often a warden's decision has been overturned.
 - ii. If not, why? What changes would be necessary to allow for this?
 - c. Please explain how BOP ensures that deaths in BOP custody are properly investigated and classified.
7. What procedures are in place to ensure transparency about the circumstances surrounding an incarcerated person's death with their family members?
 - a. How long after an individual's death in BOP custody is a call made to a family member listed as the primary contact for the decedent?
 - b. What information does BOP routinely share with families about the cause and circumstances related to the death?
 - i. When is it shared?
 - ii. With whom is it shared?
 - iii. How is it shared—orally during a call, by email, by mail?
8. As laid out in the IG report on deaths in custody, After Action Reports are required in the case of a suicide in BOP custody. Do these reports include details of grievances filed by the deceased prior to their deaths?
 - a. If not—why?
 - b. Please explain any BOP efforts to track, review, and address grievances filed by inmates who have died by suicide in BOP custody.

Senator Peter Welch
Senate Judiciary Committee
Written Questions for BOP Director Collette Peters
Hearing on “Examining and Preventing Deaths of
Incarcerated Individuals in Federal Prison”
February 28, 2024

At a Senate Judiciary Committee hearing on September 13, 2023, you announced a Request for Proposal (RFP) for a residential reentry center (RRC) in Vermont. After the hearing, you stated you misspoke, and you planned to place a day reporting center (DRC) in Vermont instead. When we spoke on September 19, 2023, you committed that if the Vermont delegation researched the matter and determined that an RRC was necessary, you would reissue the RFP for an RRC instead. In response, the Vermont delegation sent a letter on December 12, 2023, expressing the delegation’s strong preference for an RRC in Vermont. On the same date, Chief Judge Geoffrey W. Crawford sent you a letter conveying the same preference on behalf of the federal judges in Vermont. On February 22, 2024, in a letter to the Vermont delegation, the Bureau of Prisons (BOP) reiterated plans to move forward with a DRC and not an RRC.

1. What is the basis of BOP’s conclusion that Vermont does not need an RRC?
2. Please identify the number and location of all Vermont residents housed in RRCs as of February 28, 2024.
3. What steps have you personally taken to assess the need for reentry services in Vermont?
4. What steps has BOP taken to assess the need for reentry services in Vermont?
5. Have you reviewed the Vermont delegation’s letter, dated December 12, 2023, regarding Vermont’s preference for an RRC in our state?
6. Have you reviewed the letter from Chief Judge Crawford, dated December 12, 2023, regarding the federal judiciary’s preference for an RRC in Vermont?
7. What are the estimated 10-year costs for BOP to open an RRC in Vermont?
8. What has BOP currently budgeted for the RFP issued for a DRC in Vermont?
9. How many individuals per year do you expect a DRC would serve in Vermont?
 - a. What reentry services would they receive at a DRC?
 - b. What on-site programming is available at a DRC?
 - c. How many employees would BOP have at a DRC?
10. How many individuals per year would you expect an RRC to serve in Vermont?
 - a. What reentry services would they receive at an RRC?
 - b. What on-site programming is available at an RRC?
 - c. How many employees would BOP have at an RRC?
11. Please attach a copy of the market study conducted by BOP on placing an RRC in Vermont to the responses to these questions.

Senator Charles E. Grassley Questions for the Record
Federal Bureau of Prisons Director Collette Peters
Senate Judiciary Committee
Examining and Preventing Deaths of Incarcerated Individuals in Federal Prisons
February 28, 2024

1. In May 2023, former BOP Director Michael Carvajal acknowledged that BOP's internal auditing process, known as Program Review, failed to reveal significant deficiencies within BOP and was unable to take corrective action. Director Peters, you have now been the BOP Director for over 19 months.
 - a. What specific improvements have you made to ensure that Program Review is effective in improving the operation of the 122 institutions you oversee and their programs?
 - b. The Inspector General made several recommendations to address the weakness in the BOP internal auditing program. Which, if any, of these recommendations have not been adopted and why?
2. In 2023, the Inspector General stated that BOP continues to bypass the contract solicitation process through the issuance of sole-source contract actions, potentially creating significant risk for the BOP due to lack of competition. As of August 31, 2023, 22 recommendations remain open related to medical services contracts, with one recommendation dating as far back as 2016.
 - a. Does BOP still engage in these sole-source contracts? If so, why?
 - b. Why have these recommendations not been closed and adopted?
3. In September 2023, the Inspector General stated that BOP employed 12,484 Correctional Officers (COs) across 122 institutions and had 2393 vacancies for the same position, a 16 percent vacancy rate. You have now been BOP Director for 19 months. What is the current vacancy rate for COs, and how many of these 2393 vacancies have you been able to fill?
4. On May 3, 2023, The Department of Justice Office of The Inspector General released a report entitled, "*The Federal Bureau of Prison's Efforts to Maintain and Construct Institutions.*" This report identified a Congressional set aside of \$1 billion for BOP to construct two new institutions in Letcher County, Kentucky, and Leavenworth, Kansas. The report noted that the funds remain unspent, as the projects have been in the planning stages for over a decade.
 - a. What is the status of the \$1 billion set aside?
 - b. How do these projects contribute or not contribute to BOP's ability to meet its infrastructure and mission goals?
5. A spokesperson for the Federal Bureau of Prisons told Fox News that BOP "is providing limited transportation resources to assist Border Patrol on the southwest border."

- a. How many BOP correctional officers have provided assistance to Border Patrol?
 - b. How many hours, broken down by year over the last three years, have BOP employees spent providing assistance to Border Patrol?
6. The BOP estimates it needs \$2 billion to address modernization and repair needs. Please provide a breakdown of the repairs and modernization projects behind the \$2 billion request.
 7. Please provide the percentage of BOP's net operating costs that have been dedicated to BOP payroll costs for the past three years. Please further identify what percentage of BOP's payroll cost is spent on overtime and employees other than correctional officers.

Questions 8 through 16 relate to employee misconduct at FCC Hazelton. On September 12, 2023 I, along with Chairman Durbin, and Senators Capito and Manchin wrote you about whistleblower allegations of serious misconduct occurring at FCC Hazelton, located in Bruceton Mills, West Virginia. Whistleblowers have alleged that staff had sought to cover up their release of a wrong inmate and a group of inmates escaping, staff abusing inmates, supervisory staff falsifying documents and encouraging staff to abuse inmates, and other serious claims of wrongdoing. Some of the claims made by these whistleblowers have also been substantiated through public reports.¹ Since the release of the letter, news reports have released video footage of allegedly two escaped inmates from FCC Hazelton being held in custody by a homeowner until law enforcement authorities could arrive.² If these allegations are true and accurate, they reflect a rampant culture of abuse and misconduct at FCC Hazelton.

The February 2024 Justice Department Inspector General report on deaths in Bureau of Prisons facilities found that FCC Hazelton had 14 deaths from Fiscal Year 2014 to Fiscal Year 2021.³ Since the beginning of this year, it's been reported at least three inmates have died while in custody at FCC Hazelton.⁴ Two of these deaths reportedly occurred March 2, 2024, on the same day.⁵

¹ Pam Bailey, *FCI Hazelton: Called 'Misery Mountain' for a Reason, More Than Our Crimes* (Sep. 5, 2022) <https://morethanourcrimes.org/voices/fci-hazelton-cauldron-of-misery/>; Pam Bailey, *Staffing Shortage or Toxic Culture? Prisoners say Hazelton has Both*, *More Than Our Crimes* (Feb.25, 2023) <https://morethanourcrimes.org/voices/staffing-shortage-or-toxic-culture-prisoners-say-hazelton-has-both/>.

² 5 WDTV News, *Security camera footage shows two escaped inmates from FCC Hazelton being held at gunpoint*, (Sep. 13, 2023) <https://www.wdtv.com/video/2023/09/13/security-camera-footage-shows-two-escaped-inmates-fcc-hazelton-being-held-gunpoint/>.

³ DOJ-OIG, *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, (Feb. 15, 2024) https://oig.justice.gov/reports/evaluation-issues-surrounding-inmate-deaths-federal-bureau-prisons-institutions?utm_source=pressrelease&utm_medium=web&utm_campaign=report%2C24-041.

⁴ Mike Nolting, *Hazelton inmate death now investigated as homicide*, *MetroNews* (Jan. 25, 2024) <https://wvmetronews.com/2024/01/25/hazelton-inmate-death-now-investigated-as-homicide/>; MetroNews Staff, *Two deaths reported at Hazelton prison*, *MetroNews* (Mar. 3, 2024) <https://wvmetronews.com/2024/03/03/two-deaths-reported-at-hazelton-prison/>.

⁵ *Id.*

On September 20, 2023, I transmitted to you Questions for the Record 8-14 for the September 13, 2023 Senate Judiciary Committee oversight hearing of the Federal Bureau of Prisons. To-date, you have failed to respond. Accordingly, I am resending them in addition to questions 15 and 16.

8. Will you conduct a full and independent investigation into the alleged misconduct occurring at FCC Hazelton? If not, why not?
9. Do you commit that no taxpayer money will be used to identify, expose the identity of, or retaliate against any whistleblowers and that the anonymity of all individuals interviewed is maintained, regardless of whether or not they corroborate any allegations of misconduct? If not, why not?
10. Provide copies of all charging documents, plea agreements, staff transfer orders, and judgment and commitment orders for any current or former BOP employee charged with a crime that occurred at FCC Hazelton.
11. How many misconduct investigations involving current or former FCC Hazelton employees are pending? In your answer include the type of misconduct that is being investigated.
12. How many FCC Hazelton employees who, while under investigation for abuse of inmates, continued to perform employment duties requiring contact with or supervision of inmates from 2013 to present?
13. How many FCC Hazelton staff members who, while under a pending investigation for abuse of inmates, have been promoted or transferred to another institution? Please list the highest-ranking title or grade the staff member held in the case of a promotion or the receiving institution in the case of a transfer.
14. Provide list of all sustained allegations of abuse of inmates at FCC Hazelton that have occurred since 2013 and the corrective actions taken to address each incident.
15. What are the circumstances of the 14 deaths in custody at FCC Hazelton identified in the Inspector General's report?
16. Will BOP investigate the circumstances of the deaths that occurred at FCC Hazelton this year? Will you release the findings from these investigations? If not, why not?

Senator Mike Lee
Questions for the Record
Colette S. Peters, Federal Bureau of Prisons

1. The BOP maintains statistics on its prison population, including the number of male and female inmates. Will the BOP commit to publish statistics on the number of transgender inmates housed in units that do not reflect the biological sex of the inmates?
2. Does the BOP record instances of transgender inmates assaulting prisoners after they have been moved to units for the opposite sex? Where are those statistics published?
3. What are you doing to ensure that BOP facilities are capable of accommodating persons apprehended by Immigration and Customs Enforcement? How many total beds are available for this purpose in BOP facilities and how many more beds are necessary to satisfy ICE's needs?

**Questions from Senator Thom Tillis
for Director Collette Peters**

1. On December 14th, 2023 the Occupational Safety and Health Administration (OSHA) issued a denial of FCC Butner’s third Petition for Modification of Abatement extension request with regards to a Notice of Unsafe or Unhealthful Working Conditions issued on April 8, 2022.
 - a. Are you aware that this decision was based on “minimal progression towards final abatement,” continued reports from employees of “deviations from previously agreed upon interim abatement controls” and exposure “to serious hazards including: structural degradation, electrical and fire hazards, falling materials including water saturated ceiling tiles, slips and falls, and Indoor Air Quality issues to include airborne mold and increased humidity?”

b. What is your response to these specific concerns highlighted by OSHA?

2. In your February 26, 2024 response to my office, you stated that FCC Butner received six OSHA complaints in 2021, eight in 2022, and seven in 2023. How many OSHA Complaints has FCC Butner received in 2024? What is the status of those OSHA complaints?
3. In your agency's response to the 2022 oversight questions for the record, you acknowledged "several maintenance issues at FCC Butner" but indicated that projects must be prioritized for consideration due to the backlog of maintenance issues throughout the BOP. Where do the identified maintenance issues at FCC Butner currently fall within the BOP's project prioritization framework?
4. How does your agency balance your own prioritizations alongside OSHA Notices of Unsafe or Unhealthful Working Conditions?

5. Director Peters— in September 2023, you committed to providing an update to my constituents/your Butner staff on the complaints I submitted in the questions for the record. Has your team resolved any of those issues? If so, which ones?

6. Last year, the Office of Inspector General (OIG) conducted various reports that provided recommendations for BOP to improve work conditions and operations. Has BOP implemented any of the recommendations?

7. In the February 2024 report, IG Horowitz provided twelve recommendations. Does BOP plan to implement any of the recommendations? If so, which ones are being prioritized?

COMPLAINT	# RECEIVED
OSHA #1981721 – roof leaks and food	9
Duplication of responsibilities	4
OSHA #2011562 – kitchen flooring	1
RDAP participants as informants	3
Broken Body Alarms/Radios	7
Paid Parental Leave Overtime Policy	1
Complaint to OSHA – water in light fixtures	1
Timeliness of Evaluation Forms	6
Letter request Congress investigate (Jackson)	1
Failure to Notify the Union of Major Incidents	1
Failure to follow Protocol for MHU Assaults	1
Cleanliness of Protective Vests	7
Unsatisfactory Evaluations	2
Loss of Power/Water at Butner for 31 Hours	5
Roster changes	4
Staffing challenges	4
EMS Chase Vehicles	1
Failure to transfer assets in TRUFACS	1
EAP Participation Disclosure	1
Incentive pay disparities	1
9pm-5am medical coverage	2
Overtime Denials	1
Overflow Unit	1
Medical Accommodations for Staff	1
Inmates Using Illegal Substances	2
Needed medical equipment	1
Arbitration Award Delays	1
Denial of Official Time	2
Water accumulation due to Hurricane Idalia	1
TOTAL	73

A P P E N D I X

The following submissions are available at:

<https://www.govinfo.gov/content/pkg/CHRG-118shrg63048/pdf/CHRG-118shrg63048-add1.pdf>

Submitted by Senator Welch:

Crawford, Hon. Geoffrey W., letter and attachment to Director Colette Peters, Federal Bureau of Prisons, December 12, 2023	2
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