FCI Forrest City

Testimony from incarcerated individuals, families, and cooperating correctional officers highlights systemic corruption, medical neglect, and ongoing retaliation inside FCI Forrest City.

Reports describe staff negligence so severe that lives are being lost, with officers ignoring medical crises and case managers refusing to process release planning or program transfers. Families and incarcerated individuals describe a culture where staff indifference is normalized: “they will let someone die and turn away.”

Lockdowns are routinely imposed as mass punishment, often not tied to legitimate safety threats but used when staff do not want to work. These lockdowns cut off phone calls, programming, and education, reinforcing a cycle of stagnation and despair. Despite the Bureau of Prisons’ stated mission of rehabilitation, individuals have been held for four years without access to GED classes or meaningful programming.

Food and living conditions remain degrading, with spoiled meals and incorrect portions, leaving people hungry and malnourished. Medical neglect is widespread: individuals report no dental care for four years across multiple facilities, no access to yearly cleanings, and only bare-minimum medical attention. Prescription medications and routine checkups are routinely delayed or denied.

The MAT (Medication-Assisted Treatment) program is restricted to the final 90 days of incarceration, a policy that has directly contributed to preventable deaths. Families report that people with severe fentanyl addictions have died after being denied treatment.

Finally, reports confirm a pattern of staff retaliation and corruption. Officers allegedly issue “removal orders” targeting influential inmates who expose abuses, intentionally labeling them as threats so they can be transferred or physically removed from the yard. This practice functions as a silencing tool, punishing those who attempt to advocate or bring attention to misconduct.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Staff negligence & indifference to death	18 U.S.C. § 4042(a)(2); Eighth Amendment	Officers ignore medical crises; case managers fail to assist with release/programs.

Arbitrary lockdowns / mass punishment	28 C.F.R. § 541.23; P.S. 3420.12 (Inmate Discipline)	Lockdowns imposed as punishment or convenience, halting education and programs.
Spoiled food & inadequate nutrition	28 C.F.R. § 547.20; P.S. 4700.06 (Food Service Manual)	Wrong portions and spoiled food routinely served.
Denial of GED & education access	28 C.F.R. § 544.70; P.S. 5350.28 (Literacy Program)	No GED access despite years in custody.
Medical & dental neglect	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10	Four years without dental care, routine medical care denied or delayed.
MAT restrictions causing preventable deaths	18 U.S.C. § 3621(b); P.S. 5330.11 (Drug Abuse Treatment)	MAT only offered 90 days pre-release, excluding those with urgent addiction needs.
Retaliatory removal orders	P.S. 1210.25 (Employee Misconduct); First Amendment	Influential inmates silenced by false “threat” designations and forced transfers.

Direct Quote from Testimony

- “People don’t realize how corrupt the government and BOP are until they are inside. Staff negligence is real — they’ll let someone die and turn away. And when someone speaks up, staff send removal orders to silence them.”

Oversight Demands

- DOJ and OIG investigation into staff corruption, negligence, and retaliation at FCI Forrest City.
- Expansion of MAT access beyond the restrictive 90-day pre-release period.
- Mandatory audits of medical and dental care, with accountability for systemic denials.
- Independent review of lockdown practices and mass punishment policies.
- Congressional hearings on corruption and removal orders targeting incarcerated whistleblowers.

USP Lee

Testimony from incarcerated individuals, families, and cooperating correctional officers reveals severe allegations of excessive force, medical neglect, and retaliation at USP Lee.

Reports state that individuals experiencing seizures or other medical emergencies are being met with brutal use of force instead of medical assistance. Accounts describe officers restraining, beating, and dragging individuals while in medical crisis, leading to lasting injuries including fractured ribs, nerve damage, and head trauma.

Even after hospitalization, incarcerated people have been returned to the SHU without adequate medical care. Families report repeated denials of prescribed medication, delayed or ignored medical requests, and retaliation through fabricated incident reports.

These accounts reflect a pattern of constitutional violations, including cruel and unusual punishment, denial of medical treatment, and staff retaliation, requiring urgent external intervention.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details

Excessive force during medical emergencies	18 U.S.C. § 4042(a)(2); 28 C.F.R. § 552.20 (Use of Force)	Individuals beaten and restrained while seizing or unconscious.
Medical neglect and denial of treatment	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10	Failure to provide prescribed medications and follow-up care after hospitalization.
Cruel and unusual punishment	Eighth Amendment	Severe beatings, injuries, and unsafe housing placements despite medical needs.
Retaliation through fabricated reports	P.S. 1210.25 (Employee Misconduct)	Incident reports used as retaliation, later expunged.
Failure to accommodate disabilities	Rehabilitation Act of 1973, § 504	Lack of protections for individuals with epilepsy and other chronic medical conditions.

Direct Quote from Testimony

- “Instead of being given medical care, people in seizures are restrained, beaten, and left injured. Even after the hospital, they are sent back to SHU without medication or support.”

Oversight Demands

- Immediate DOJ/OIG investigation into excessive force and medical neglect at USP Lee.

- Independent review of medical practices, including access to prescribed medications.
- Congressional hearings into systemic retaliation and staff misconduct at USP Lee.
- Protection for whistleblowers and families reporting these abuses.

USP Beaumont

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms that USP Beaumont has been on near-continuous lockdown for over four weeks. Incarcerated individuals are only being let out every few days for 20–30 minutes, with no access to normal movement or programming. Reports describe repeated stabbings inside the same housing unit where prior assaults occurred, exposing a complete failure of staff to provide safety or protection.

Families and staff also report that the food being served is unfit for human consumption — raw chicken, spoiled salad mix, and eggs are being handed out during lockdown meals. Mail has stopped moving in or out of the facility, cutting families off from all communication. Testimonies reference “many deaths” during this lockdown, raising urgent concerns about systemic neglect and cover-ups at Beaumont.

Key Allegations & Violations

Allegation	**Policy / Statute Violated**	**Details**
Prolonged lockdown and denial of movement	18 U.S.C. § 4042(a)(2)	Four-week lockdown, out-of-cell time limited to 20–30 minutes every few days.
Repeated stabbings and staff failure to protect	18 U.S.C. § 4042(a)(3)	Violence continues in the same unit where prior assaults occurred.

Unsafe food and nutrition failures	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10	Raw chicken, spoiled salad mix, and eggs served to incarcerated individuals.
Mail obstruction and denial of communication	P.S. 5265.14 (Correspondence)	Mail not moving in or out, cutting families off.
Deaths under confinement	18 U.S.C. § 4042(a)(2)	Testimony references “many deaths” during lockdown with no transparency.

Direct Quotes from Testimony

- “Been locked down for the last 4 weeks pretty much a month. Out every few days for 20 mins. Feeding them raw chicken… Mail is not coming and going… many deaths.”
- “They finally let them out for 30 min today. … The stabbing happened in his old unit, the same one he got stabbed in.”

Oversight Demands

- Immediate federal investigation into stabbings and deaths at USP Beaumont.
- Independent inspection of food service and kitchen sanitation.
- Restoration of mail and outside communication in compliance with PS 5265.14.
- End to retaliatory and prolonged lockdown practices used as mass punishment.
- Congressional oversight hearings into systemic failures and accountability at USP Beaumont.

USP Victorville

Summary of Allegations

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms that USP Victorville has been on extended lockdown since August 30, 2025. Incarcerated individuals in Unit 6A have been denied showers for over two weeks, with families reporting no access since September 3rd. Loved ones are receiving desperate letters from inside, begging for help so that basic hygiene can be restored.

Reports further confirm that incarcerated individuals are being forced to paint over black mold in showers and cells, rather than repairs being made, raising serious health and safety concerns. Additional testimony states they are being pressured to conduct electrical and plumbing work without training or proper safety measures. Families describe Victorville as “always on lockdown,” with conditions worsening each cycle.

Key Allegation & Violation Table

Allegation	Policy / Statute Violated	Details
Prolonged lockdown	18 U.S.C. § 4042(a)(2)	Facility locked down since August 30, 2025, cutting off movement and programming.
Denial of showers & hygiene	28 C.F.R. § 551.100; P.S. 1600.11	Unit 6A denied showers since September 3, 2025.
Exposure to mold	18 U.S.C. § 4042(a)(2); OSHA Standards	Mold in showers and cells painted over rather than properly remediated.

Unsafe labor practices	P.S. 3420.12 (Employee Misconduct); Federal labor law	Incarcerated individuals pressured into electrical and plumbing work without safety training.
Retaliatory neglect & chronic mismanagement	18 U.S.C. § 4042(a)(2)	Families confirm Victorville is “always on lockdown,” with systemic denial of basic rights.

Direct Quotes from Testimony

- “They have been on lockdown since 8/30 and have not been allowed to have a shower since September 3rd.”
- “They’ve has been painting all the showers and cells… just painting over the mold.”
- “This place is a mess… they haven’t had showers since 9/3… that’s inhumane what they are doing.”

Oversight Demands

- Immediate restoration of showers and hygiene access at USP Victorville.
- Independent inspection for black mold and unsafe environmental conditions.
- End to the use of untrained incarcerated labor for electrical and plumbing work.
- Congressional oversight into Victorville’s chronic lockdown practices and systemic neglect.
- Formal accountability from BOP leadership regarding health and safety violations.

FCI Thomson

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms that serious abuse and retaliation are ongoing at FCI Thomson. Families report that mail is being deliberately withheld — individuals have not received letters for over two months despite their loved ones confirming multiple letters sent. This constitutes a direct violation of inmate correspondence policy and leaves families cut off from their only means of communication.

Further testimony alleges that Jon Zumkehr, head of the correctional officers' union at Thomson, physically assaulted a Hispanic incarcerated individual on September 10, 2025 in the rotunda of F Unit. The assault was carried out in an area with no cameras, raising grave concerns of premeditated abuse and cover-up. This individual is reported to still be housed in the SHU.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Mail obstruction and denial of communication	P.S. 5265.14 (Correspondence); 28 C.F.R. § 540.100	Families report no mail received for 2+ months; loved ones confirm letters sent.
Physical assault by staff	18 U.S.C. § 4042(a)(2); P.S. 3420.12 (Employee Misconduct)	Testimony that union head Jon Zumkehr assaulted a Hispanic inmate in F Unit rotunda on Sept 10, 2025.
Abuse in SHU	28 C.F.R. § 541.22; P.S. 5270.09	Incarcerated individual remains in SHU following staff assault, suggesting retaliatory confinement.

Failure of oversight	DOJ OIG standards; 18 U.S.C. § 4042	Use of no-camera area for assault indicates intentional avoidance of accountability.

Direct Quotes from Testimony

- “They holding my husband’s mail… haven’t heard from me in two months. I’m getting his letters, he not getting mine. I have sent multiple.”
- “Jon Zumkehr… assaulted a Hispanic inmate at approximately 8 pm on September 10th in the rotunda (no cameras) of F Unit at Thomson.”

Oversight Demands

- Immediate DOJ OIG investigation into the alleged staff assault by Jon Zumkehr.
- Full review of mailroom practices and accountability for deliberate withholding of correspondence.
- Independent audit of SHU confinement practices at Thomson.
- Installation of cameras in all rotunda/common areas to prevent cover-ups of abuse.
- Congressional oversight into the pattern of union-driven misconduct at FCI Thomson.

FCI Hazelton

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms severe medical neglect at FCI Hazelton. Families report that an incarcerated individual with a

tumor has been waiting 11 months for medical evaluation. This delay constitutes life-threatening neglect and is consistent with long-standing reports of inadequate health care at Hazelton.

The facility's failure to provide timely diagnostic care violates statutory and constitutional protections. Families describe Hazelton as "the worst," citing ongoing failures to meet even the most basic medical needs of their loved ones.

Key Allegations & Violations

Allegation	**Policy / Statute Violated**	**Details**
Medical neglect – failure to diagnose and treat	28 C.F.R. § 549.10 (Patient Care); P.S. 6031.04	Incarcerated individual has waited 11 months for tumor to be checked.
Failure to provide humane conditions	18 U.S.C. § 4042(a)(2)	Withholding timely medical evaluation poses serious risk of death or permanent injury.
Deliberate indifference to serious medical needs	Eighth Amendment; Estelle v. Gamble	Extended delay in treatment for tumor constitutes cruel and unusual punishment.

Oversight Demands

- Immediate outside medical evaluation for the incarcerated individual awaiting tumor care.
- Emergency audit of Hazelton's medical department for systemic neglect.
- Enforcement of 28 C.F.R. § 549.10 to ensure timely diagnosis and treatment of serious health conditions.

- Congressional and DOJ oversight hearings into the pattern of medical neglect at Hazelton.

FCI Yazoo City

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms ongoing food safety violations at FCI Yazoo City. Reports indicate that incarcerated individuals are being served expired and spoiled food items in the chow hall daily, including old chips and old ice cream. Nothing being served is fresh, raising serious concerns about nutrition, health, and compliance with federal standards.

These reports mirror similar food safety complaints across th FBOP, where rotten meals and unsafe portions are repeatedly documented. This suggests a broader, systemic breakdown in food procurement and quality oversight across the Bureau of Prisons.

Key Allegations & Violations

Allegation	**Policy / Statute Violated**	**Details**
Distribution of expired food	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10	Old chips, old ice cream, and expired products served at chow daily.
Unsafe food handling and nutrition	18 U.S.C. § 4042(a)(2); P.S. 6541.02 (Pharmacy/Food Services)	No fresh food, meals consistently unsafe for consumption.
Pattern of systemic neglect	DOJ OIG standards; 18 U.S.C. § 4042	Testimony aligns with similar reports from Beaumont, showing broader systemic failures.

Direct Quote from Testimony

- “ Yazoo City giving old food every day at chow… old chips, old ice cream… nothing is fresh, definitely not right.”

Oversight Demands

- Immediate inspection of food service and procurement practices at Yazoo City.
- Independent audit of BOP’s food supply chain to prevent expired food distribution.
- Enforcement of 28 C.F.R. § 549.10 and P.S. 6031.04 to guarantee safe, fresh, and adequate meals.
- Congressional investigation into systemic food service neglect across multiple BOP facilities.

FPC Duluth

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms a recent death inside FPC Duluth linked to medical neglect. According to reports, an incarcerated individual complained of chest pain and sought help from medical staff. Instead of providing emergency care or evaluation, staff instructed him to “take a shower” to feel better. He was later found unconscious in the shower and did not survive.

This incident demonstrates deliberate indifference to a medical emergency, a violation of statutory duties and constitutional protections. It raises urgent questions about the competence and accountability of medical staff at FPC Duluth.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Medical neglect in emergency	28 C.F.R. § 549.10 (Patient Care); P.S. 6031.04	Incarcerated individual with chest pain dismissed without evaluation or treatment.
Failure to protect life and safety	18 U.S.C. § 4042(a)(2)	Staff failed to provide humane care during a medical emergency.
Deliberate indifference	Eighth Amendment; Estelle v. Gamble	Individual died after being told to “take a shower” instead of receiving treatment.

Direct Quote from Testimony

- “Someone just died today in FPC Duluth. Inmate went to medical complaining of chest pain and they told him to take a shower… He was found unconscious in the shower.”

Oversight Demands

- Immediate independent investigation into the death at FPC Duluth.
- Full review of medical staff training, competency, and accountability.
- Emergency audit of medical response protocols to ensure compliance with 28 C.F.R. § 549.10.

- Public release of findings regarding this death and corrective action taken by the Bureau of Prisons.
- Congressional oversight hearings into systemic medical neglect across the BOP.

FCI Mendota

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms severe sanitation and food safety violations at FCI Mendota. Reports describe bread and hot dog buns chewed on by rats and contaminated with rat droppings. Incarcerated individuals reported being forced to sort through contaminated food themselves, a direct violation of federal safety and sanitation standards.

This incident highlights not only unsafe conditions but also exposure to disease, as rat droppings carry harmful pathogens. Forcing individuals to handle and eat contaminated food places them at extreme risk and reflects systemic neglect of food safety across the Bureau of Prisons.

Key Allegations & Violations

Allegation	**Policy / Statute Violated**	**Details**
Rodent infestation in food storage	18 U.S.C. § 4042(a)(2); P.S. 6541.02 (Food Service)	Bread and buns chewed by rats, contaminated with droppings.
Unsafe food distribution	P.S. 6031.04 (Patient Care); 28 C.F.R. § 549.10	Contaminated food still distributed to incarcerated individuals.

Exposure to disease and unsafe environment	OSHA standards; 18 U.S.C. § 4042	Handling rodent droppings places individuals at risk of serious illness.

Direct Quote from Testimony

- “At Mendota, the hot dog buns and the bread are chewed on by rats and rat dropping. We have to sort them out.”

Oversight Demands

- Immediate pest control inspection and remediation at FCI Mendota.
- Full audit of food storage, sanitation, and kitchen operations.
- Accountability for staff who knowingly distributed rodent-contaminated food.
- Congressional and DOJ oversight into systemic food safety failures across the BOP.

FCI Butner

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms life-threatening medical neglect at FCI Butner. An incarcerated individual housed in the SHU requires weekly medication and weekly blood draws to survive. Families report that he has not received his prescribed medication or blood work in 48 days. Without his meds, he is at risk of bleeding to death.

This represents deliberate indifference to urgent medical needs and a systemic violation of patient care standards. The ongoing denial of life-sustaining medication in SHU raises immediate human rights concerns and could result in preventable death.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Denial of prescribed medication	28 C.F.R. § 549.10 (Patient Care); P.S. 6031.04	Individual deprived of life-sustaining medication for 48 days.
Failure to provide blood monitoring	28 C.F.R. § 549.10; P.S. 6031.04	Weekly blood draws required for survival have not been conducted.
Deliberate indifference to serious medical needs	Eighth Amendment; Estelle v. Gamble	Failure to provide critical treatment places individual at risk of death.
SHU medical neglect	P.S. 5270.09 (Inmate Discipline); 18 U.S.C. § 4042	Isolation in SHU used to deny essential medical care.

Oversight Demands

- Immediate emergency medical intervention for the individual in SHU at FCI Butner.
- Independent investigation into SHU medical neglect at Butner.
- Accountability for staff responsible for withholding medication and treatment.
- DOJ and Congressional oversight into systemic medical neglect across the Butner complex.

FCI Phoenix

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms widespread abuse and dangerous living conditions at FCI Phoenix. Families report that the water supply is contaminated with parasites, placing incarcerated individuals at immediate risk of illness. Mail is being denied, leaving families cut off from communication.

Visitation rights are also being unlawfully restricted — officers are refusing visits under the pretense that “the warden is not on weekends.” Even after families requested a commander in charge, visits were still denied. These actions represent systemic violations of communication, sanitation, and visitation policies and confirm Phoenix as one of the most abusive facilities currently reported.

Key Allegations & Violations

Allegation	**Policy / Statute Violated**	**Details**
Contaminated water supply	18 U.S.C. § 4042(a)(2); EPA Safe Drinking Water Standards	Testimony confirms parasites in the water.
Denial of mail	P.S. 5265.14 (Correspondence); 28 C.F.R. § 540.100	Families report mail consistently denied.
Unlawful denial of visitation	P.S. 5267.09 (Visiting Regulations)	Officers refuse visits, claiming no warden present on weekends.
Abuse of authority	P.S. 3420.12 (Employee Misconduct)	Families report officers denying visitation even after escalation.

Direct Quote from Testimony

- “FCI Phoenix – parasites in water; denied mail; officers refuse visits saying warden not on weekends… horrible, worst one I’ve known thus far.”

Oversight Demands

- Immediate EPA and DOJ investigation into the water supply at FCI Phoenix.
- Enforcement of federal visitation policies and accountability for unlawful denials.
- Restoration of mail services in compliance with P.S. 5265.14.
- Congressional hearings into systemic neglect and abuse at FCI Phoenix.

FCI Greenville

Summary of Allegations

Testimony from incarcerated individuals, families, and cooperating correctional officers describes systemic neglect and degrading treatment at FCI Greenville. Incarcerated individuals are issued only four sets of clothing, leaving them without adequate clean clothes during their five-day work weeks. Laundry services return clothing still wet, and access to proper cleaning supplies is denied. Families further confirm black mold exposure, creating serious health risks.

Food is consistently reported as inedible, greasy, and nutritionally inadequate, even during holidays when “good” meals are promised. Commissary has been closed for weeks, and when briefly reopened, purchases were restricted to hygiene items only — preventing individuals from accessing food. Commissary restocks are delayed until the next quarter, leaving weeks without adequate food or supplies.

The facility also implemented a “green bag lockdown”, during which personal property, achievements, and paperwork — including program completion certificates — were confiscated and never returned. Families describe this as degrading and demoralizing. Staff reportedly responded with, “It happens,” when questioned about lost property, reflecting a culture of disregard and abuse.

Key Allegation & Violation Table

Allegation	Policy / Statute Violated	Details
Inadequate clothing and laundry	18 U.S.C. § 4042(a)(2); P.S. 4500.11 (Trust Fund/Clothing)	Only 4 sets of clothing; laundry returned wet; denial of basic hygiene.
Black mold exposure	18 U.S.C. § 4042; OSHA Standards	Testimony confirms exposure to toxic black mold.
Nutritionally inadequate meals	P.S. 6031.04 (Patient Care); Dietary Guidelines	Food described as greasy, inedible, failing to meet nutritional needs.
Commissary restrictions and denial of food	P.S. 4500.11; 28 C.F.R. § 540	Commissary shut down for weeks; only hygiene products allowed.
Confiscation of property (“green bag lockdown”)	P.S. 5580.08 (Inmate Personal Property)	Achievements, program paperwork, and belongings confiscated without return.
Degrading treatment	International human rights standards	Individuals stripped of dignity, treated worse than animals.

Direct Quotes from Testimony

- “They barely have enough clothes to cover 4 days of the week… laundry comes back wet and black mold exposure is constant.”
- “The green bag lockdown was a complete degrading of human rights… their response was ‘it happens.’”

Oversight Demands

- Immediate inspection of Greenville’s clothing, laundry, and commissary operations.
- Independent environmental testing and remediation for black mold.
- Full investigation into the “green bag lockdown” practice, with accountability for confiscated/destroyed property.
- Enforcement of food quality and nutritional standards across Greenville’s food service.
- Congressional and DOJ oversight into systemic neglect and abuse at FCI Greenville.

FCI McKean

Testimony from incarcerated individuals, families, and cooperating correctional officers confirms that FCI McKean remains in a cycle of prolonged lockdowns caused by the Special Housing Unit (SHU) being full. Because of overcrowding and lack of transfer scheduling, the facility resorts to weeks-long lockdowns that severely restrict programming, recreation, and communication.

Families report that when individuals are briefly allowed out, the phone lines are extremely long due to an inadequate number of phones or because phones are turned off by staff. Even after coming off a two-week lockdown, reports confirm the SHU is already near capacity again, signaling a systemic and ongoing failure to manage population levels without resorting to collective punishment.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Prolonged lockdowns due to SHU capacity	18 U.S.C. § 4042(a)(2); P.S. 5538.05 (Special Housing Units)	Individuals locked down for weeks at a time because SHU is full.
Denial of programming and recreation	28 C.F.R. § 544.10 (Education); 28 C.F.R. § 544.30 (Recreation)	No access to programming or recreation during prolonged lockdowns.
Restricted phone access	28 C.F.R. § 540.100; P.S. 5264.08 (Telephone Regulations)	Inadequate number of phones; staff reportedly turning phones off.
Overcrowding & mismanagement	18 U.S.C. § 4042; Eighth Amendment (conditions of confinement)	SHU consistently full; lack of transfers and population control leads to systemic lockdowns.

Direct Quote from Testimony

- “FCI McKean stays locked down for weeks at a time due to SHU being full. They came off of a 2-week lockdown today and are already saying the SHU is almost full again.”

Oversight Demands

- Immediate DOJ and BOP review of SHU population management at FCI McKean.
- Increased scheduling of transfers to reduce SHU overcrowding.

- Restoration of phone access in compliance with federal regulations.
- Congressional oversight into the use of lockdowns as a substitute for population management.

FCI Edgefield Camp

Summary of Allegations

Testimony from incarcerated individuals highlights extreme neglect of living conditions, prolonged denial of basic needs, and arbitrary punishment practices at Edgefield Camp. Reports describe weeks without hot water, limited working toilets for large units, and punitive restrictions on recreation that punish all residents for isolated incidents. Officers are documented as dismissive, leaving lights on through the night during counts and refusing to address urgent maintenance issues.

Key Allegation & Violation Table

Allegation	**Policy / Statute Violated**	**Details**
Extended lack of hot water (weeks at a time)	18 U.S.C. § 4042(a)(2) (Duty to provide for safekeeping, care, and subsistence of inmates); P.S. 1600.11 (Facilities Operations)	Testimony shows 502 men went 2+ weeks without hot water due to a failed boiler, forcing inmates to live without sanitation and showers.
Broken plumbing (4–5 working toilets for ~120 men)	18 U.S.C. § 4042; P.S. 1600.11	Units overcrowded with inmates had only a handful of working toilets, creating unsanitary and inhumane conditions.

Lights left on during night counts	P.S. 3420.12 (Standards of Employee Conduct)	Officers intentionally left lights on past 10 PM count, causing sleep deprivation and harassment.
Mass punishment lockdowns / recreation bans	28 C.F.R. § 541.22; P.S. 5270.09 (Inmate Discipline Program)	Entire camp placed on a 6-week “no rec” restriction because staff claimed contraband was found outside the fence, punishing the whole population.

Direct Quotes from Inside

- “We going on like day 4 or 5 with no hot water… now on week 2.”
- “In the unit I’m in, there’s 120 inmates with only 4 or 5 toilets that work.”
- “One officer said a screw in the light wasn’t like that yesterday, so instead of turning them off at 10 o’clock count, she’s leaving them on until the next count.”
- “They just put us back on no rec for 6 weeks now cause they said they found a couple bags by the fence with contraband in it.”

Oversight Demands

- Immediate inspection of plumbing, boilers, and sanitation facilities by neutral third-party.
- Documentation of officer conduct regarding sleep deprivation and arbitrary punishment.
- Policy compliance review to end mass punishment practices that violate due process.

- Assurance that recreation and program access cannot be stripped from entire populations without individualized findings.

FCI Schuylkill Camp

Summary of Allegations

Loved ones and incarcerated individuals report systemic failures at FCI Schuylkill Camp, including denial of meaningful visitation, arbitrary cancellation of family visits, and misconduct by case management staff. Testimony describes unprofessional and retaliatory practices that undermine reentry preparation, including denial of halfway house and home confinement placements.

Key Allegation & Violation Table

Allegation	**Policy / Statute Violated**	**Details**
Visitation denial and cancellations	28 C.F.R. § 540.40–63 (Visiting Regulations); Program Statement 5267.09	Families report visits canceled without notice due to “staffing,” no visits permitted on federal holidays, and visitation days changed last-minute from weekends (Saturday/Sunday) to weekdays (Tuesday/Wednesday), preventing children and families from visiting.
Case manager negligence and retaliation	Program Statement 5100.08 (Correctional Case Management); 18 U.S.C. § 4042(a)(1)-(2)	Reports state one case manager refuses to process release placements or program reviews, openly saying he “won’t do anything unless forced,” while another (Mr. Gipe) reportedly follows

		policy. Families allege retaliation in denying halfway house and home confinement placements.
Family hardship	First Step Act intent; BOP Mission Statement (Reentry Preparation)	Families describe traveling long distances (5+ hours) with children, only to be turned away upon arrival due to canceled visits. This causes financial and emotional strain.

Direct Quotes from Inside / Families

- “They never have visits on federal holidays. Then they changed visitation days from Saturday/Sunday to Tuesday/Wednesday. I drove five and a half hours with our children, only to be told visits were canceled due to staffing.”
- “The case manager over Camp 1 refuses to help anyone. He says he won’t do anything unless made to, and if the judge wanted a lesser sentence, he would’ve given it. Now everyone is being denied halfway house and home confinement.”

Oversight Demands

- Immediate restoration of weekend and holiday visitation access as required under BOP visiting regulations.
- Investigation into case management staff misconduct and retaliation, with specific review of Camp 1 practices versus Camp 2.
- Accountability for arbitrary cancellations and requirement that families receive proper notice of visit changes.
- Enforcement of FSA-mandated reentry placement, including fair processing of halfway house and home confinement referrals.

FCI Memphis

Summary of Allegations

Families report that CorrLinks, the primary communication system for incarcerated individuals, has been down for six consecutive days at FCI Memphis. Despite repeated complaints, staff allegedly refuse to repair or address the outage, leaving families and incarcerated individuals cut off from essential communication.

Key Allegation & Violation Table

Allegation	Policy / Statute Violated	Details
Denial of communication access	28 C.F.R. § 540.100; Program Statement 5265.14 (Correspondence)	CorrLinks has been down for 6 days, preventing incarcerated individuals from contacting family. Staff allegedly refuse to resolve the issue.
Family separation / hardship	First Step Act intent; BOP Mission Statement (Maintaining Family Ties)	Prolonged outages deny incarcerated people the ability to maintain family ties, directly undermining rehabilitation and reentry preparation.

Direct Quote from Families

- “Memphis CorrLinks is down for 6 days and they refuse to fix it.”

Oversight Demands

- Accountability for staff refusal to address outages that deprive families of communication.

- Implementation of backup communication measures (phone or extra visits) whenever electronic communication systems are down for more than 24 hours.

FMC Fort Worth

Summary of Allegations

Testimony and photographic evidence from incarcerated individuals, families, and cooperating staff confirm extreme environmental neglect and systemic health hazards at FMC Fort Worth. Cells, bathrooms, and common areas show pervasive black mold, collapsing ceilings, broken infrastructure, and filthy ventilation systems that circulate dust and contaminants throughout housing units.

Incarcerated individuals are forced to sleep inches from mold-covered walls, creating serious respiratory risks. Kitchen ceilings show advanced water damage and mold directly above food preparation areas, raising urgent food safety concerns. Reports also confirm that maintenance requests are ignored, and cosmetic cover-ups (painting over mold) are used instead of proper remediation.

Key Allegations & Violations

Allegation	Policy / Statute Violated	Details
Black mold exposure	18 U.S.C. § 4042(a)(2); OSHA Standards	Widespread toxic black mold in cells, bathrooms, and sleeping areas, including beds against moldy walls.

Collapsing ceilings and unsafe infrastructure	P.S. 6031.04 (Patient Care); 18 U.S.C. § 4042(a)(2)	Ceilings caving in above bunks and in kitchen areas; broken and unrepaired walls.
Unsanitary food preparation areas	Food Safety Standards; P.S. 6010.04 (Food Service)	Mold and water damage above food prep areas; unsafe for staff and incarcerated individuals.
Contaminated air ventilation	OSHA Standards; 18 U.S.C. § 4042	Ventilation systems clogged with dirt, dust, and mold, circulating contaminated air.
Medical neglect tied to environmental hazards	P.S. 6031.04; 28 C.F.R. § 549.10	No remediation despite evidence of health risks; respiratory issues ignored.

Direct Quotes from Testimony

- “They are forced to sleep with their heads against mold-covered walls.”
- “Ceilings are collapsing, and they just put plastic over it instead of fixing it.”
- “The kitchen has black mold above where the food is prepared.”
- “The vents are so caked with dirt and mold, you can’t even breathe.”

Oversight Demands

- Immediate independent environmental and health inspection of FMC Fort Worth, including air quality testing.
- Full remediation of black mold, collapsing ceilings, and broken infrastructure by certified contractors (not incarcerated labor).
- Food safety inspection of kitchens, with enforcement of federal food safety codes.
- Congressional oversight hearings on systemic neglect at FMC Fort Worth, including accountability for facility leadership.
- Medical reviews for incarcerated individuals exposed to mold and environmental toxins.