
FMC Fort Worth

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes severe medical neglect, unsafe environmental conditions, and gross mismanagement at FMC Fort Worth. Accounts highlight broken air conditioning across multiple units during extreme heat, improper handling of serious medical conditions (pressure ulcers), expired medical supplies, and administrative negligence.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|---|---|
| Extreme temperature mismanagement | 18 U.S.C. § 4042(a)(2); P.S. 6031.04 (Patient Care) | Abilene Unit A/C is malfunctioning to the point that incarcerated people are forced to wear winter coats indoors, while Dallas Unit has no A/C despite outside temps in the 100s. |
| Medical neglect – pressure ulcer misdiagnosis | 28 C.F.R. § 549.10; P.S. 6031.04 | A diabetic patient with a pressure ulcer was told by a nurse it was “just a blister.” He had to self-treat, despite heightened risk of severe infection and limb loss. |
| Expired medical supplies | P.S. 6541.02 (Pharmacy Services) | Antibiotic ointment available in commissary/clinic dated 2007 — 18 years expired. |
| Administrative negligence – case manager | P.S. 1210.25 (Employee Misconduct Reporting) | A deceased case manager remains on the roster, and incarcerated individuals are still being reassigned under his name, reflecting systemic HR and oversight failures. |

3. Direct Quotes from Inside

- “Abilene unit the AC is so jacked up ppl are wearing winter coats meantime Dallas unit has no AC still and it’s been in the low 100’s here.”
- “He also got a pressure ulcer that he treated himself because the nurse said it was a blister. Um no ma’am not at all.”
- “Went to buy antibiotic ointment and it was from 2007!!!!!!!!!!!!”

- “The dead case manager has yet to raise from the dead but was added another person on his roster.”

4. Oversight Demands

- Immediate independent inspection of all HVAC systems at FMC Fort Worth with written repair timelines.
- OIG investigation into medical staff who misdiagnosed a pressure ulcer in a diabetic patient.
- FDA and health safety audit of all medical/commissary supplies for expiration and compliance.
- Formal review of administrative staffing practices, with removal of deceased staff from active rosters and accountability for negligent recordkeeping.

FCI Beckley

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes chronic staff shortages, inhumane living conditions, denial of medical care, and food deprivation at FCI Beckley.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|---|--|
| Extreme heat and lack of basic relief | 18 U.S.C. § 4042(a)(2); P.S. 6031.04 | No A/C and no access to ice for days at a time, leaving individuals in unsafe heat conditions. |
| Chronic lockdowns due to staffing shortages | P.S. 5500.14 (Correctional Services Procedures) | Continuous lockdowns are imposed not for safety, but because of not enough staff. |
| Denial of family access | P.S. 5267.09 (Visiting Regulations) | No vending machines or food access available during visits, denying families basic needs. |
| Medical neglect | 28 C.F.R. § 549.10; P.S. 6031.04 | Individual reports severe arm and shoulder pain for months; hand going numb; dropping items. Despite ongoing pain, he is repeatedly given the runaround. |

Nutritional deprivation

18 U.S.C. § 4042(a)(2); P.S.
6031.04

Meals served are described as so inadequate they would barely feed a preschooler.

3. Direct Quotes from Inside

- “FCI Beckley is awful. No AC and/or ice for days at a time. Continuous lockdown because of not enough staff.”
- “Medical attention is terrible. My guy has been having bad issues with his shoulder and arm for months... but they keep giving him the run around.”
- “Don’t get me started on what they get served as a ‘meal.’ Would barely feed a preschooler.”

4. Oversight Demands

- Emergency inspection of HVAC and cooling systems.
- Federal review of staffing levels and policies leading to punitive lockdowns.
- OIG inquiry into medical neglect cases, including untreated neurological issues.
- USDA/FDA inspection into nutritional adequacy of meals served at Beckley.

USP Canaan

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes retaliation by correctional officers, destruction of personal and religious property, and unexplained communication blackouts at USP Canaan. These actions have caused heightened family distress during critical legal proceedings.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|----------------------------------|---|
| Retaliatory searches and destruction of property | 28 C.F.R. § 541.10; P.S. 3420.12 | After a joking exchange over a photo in his room, a guard allegedly retaliated the next day by flipping the cell, tearing down pictures, and interfering with his belongings. |

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| Religious rights violations | 28 C.F.R. § 548.10; Religious Freedom Restoration Act (RFRA) | Family testimony reports that staff tampered with or destroyed a prayer space, violating protections for religious practice. |
| Unexplained communication blackout | P.S. 5265.14 (Correspondence); P.S. 4500.12 (Trust Fund/Email) | Family reported no contact for over 24 hours, which is unusual even during lockdowns. This occurred during a critical legal deadline. |
| Emotional distress tied to legal access | 18 U.S.C. § 4042(a)(2) | Missed communication coincided with the filing of a response to the U.S. Attorney, leaving the family anxious and uncertain about safety and due process. |

3. Direct Quotes from Inside

- “Last week there was a guard that went into my lo’s cell and tore apart all of his stuff... and they also did something to his prayer space.”
- “I have not heard from him all day yesterday or today, which is unusual because even though they are locked down a lot of times, he’s still able to send a text to my phone.”
- “It is so stressful because yesterday was going to be the day that his response to the US attorney was filed and I know he was very anxious and excited about it.”

4. Oversight Demands

- Immediate investigation into retaliation by staff and review of officer conduct at USP Canaan.
- DOJ and OIG inquiry into the destruction of religious property and RFRA violations.
- Audit of communication access and reliability during lockdowns to ensure families can confirm safety.
- Congressional oversight hearings into retaliation patterns at USP Canaan and their impact on incarcerated individuals with pending legal matters.

FCI El Reno

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated raises urgent concerns about asbestos exposure in UNICOR work areas, coerced waivers of liability, and systemic endangerment of health and safety at FCI El Reno. Incarcerated workers were allegedly ordered to stop work only after an asbestos removal company was brought in, confirming they had been laboring in contaminated conditions for years without safeguards.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|---|---|
| Asbestos exposure without protection | OSHA 29 C.F.R. § 1910.1001; 18 U.S.C. § 4042(a)(2) | Incarcerated workers in UNICOR were exposed to asbestos-contaminated conditions for years without protective equipment, monitoring, or training. |
| Coerced waivers of liability | U.S. Const. 8th Amendment; Helling v. McKinney, 509 U.S. 25 (1993) | Inmates were allegedly told they would need to sign waivers giving up the right to sue if they later developed asbestos-related illness, despite deliberate exposure. |
| Violation of environmental safety standards | Clean Air Act; Toxic Substances Control Act; EPA asbestos regulations | Federal law mandates strict containment and safety measures during asbestos handling and removal, which were not followed at El Reno. |
| Constitutional violation – deliberate indifference | 8th Amendment (Eighth Amendment protections) | Forcing incarcerated people to work in hazardous environments and then coercing waivers shows deliberate indifference to known risks. |

3. Direct Quotes from Inside

- “Inmates were recently ordered to stop work while an asbestos removal company was brought in... this indicates that inmates have been working in asbestos-contaminated conditions for years, with no apparent safeguards in place.”
- “Inmates have been told they will be required to sign documents upon returning to work, allegedly waiving their right to pursue legal action if they later develop asbestos-related illness.”
- “This appears to be a coercive attempt to absolve UNICOR and the Bureau of Prisons from liability, despite knowingly exposing inmates to hazardous conditions.”

4. Oversight Demands

- Immediate OSHA and EPA inspection of UNICOR workspaces at FCI EI Reno.
 - Halt to all UNICOR work until independent testing and air quality certification confirm safety.
 - Federal inquiry into forced waiver practices and accountability for staff who attempted coercion.
 - Medical monitoring and long-term care access for all incarcerated individuals exposed to asbestos.
 - Congressional oversight hearings into systemic safety violations in UNICOR nationwide.
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FPC Talladega Camp

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes unsanitary living conditions, recurring fungal infections, and unsafe infrastructure at FPC Talladega Camp. Photos submitted confirm widespread mold growth in showers, cracked and water-damaged ceilings, and standing water in housing areas.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|--|---|
| Recurring fungal infections | 28 C.F.R. § 549.10; P.S. 6031.04 (Patient Care) | Incarcerated individuals report weekly fungal infections, linked to unsanitary water and living conditions. |
| Mold and mildew contamination | 18 U.S.C. § 4042(a)(2); P.S. 6031.04; EPA Indoor Air Quality Standards | Photos show heavy black mold growth in shower areas and on walls, presenting a direct respiratory hazard. |
| Unsafe infrastructure | P.S. 6400.03 (Facility Sanitation); OSHA standards | Testimony and evidence confirm cracked ceilings, leaking pipes, and standing water in common areas, contributing to contamination and health risks. |
| Failure to provide safe and sanitary housing | 8th Amendment (deliberate indifference); 18 U.S.C. § 4042(a)(2) | Ongoing exposure to mold and repeated infections show |

failure to meet constitutional standards of care.

3. Direct Quotes from Inside

- “I’ve been getting fungal infections every week almost.”
- [Photo evidence: cracked ceilings, standing water, black mold in showers and housing areas.]

4. Oversight Demands

- Immediate EPA and OSHA inspection of housing and shower facilities at Talladega.
- Emergency remediation of black mold and water damage.
- Access to adequate medical treatment for those experiencing fungal infections.
- Congressional oversight into sanitation standards across BOP camps, with public reporting of compliance measures.

FCI Fairton (New Jersey)

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes unexplained SHU placement, denial of visitation, restricted visitation schedules, staff-issued death threats, destruction/theft of property, racial targeting, medical neglect, lack of transparency, and mail interference at FCI Fairton. Families report sudden loss of communication, inconsistent explanations from staff, arbitrary visitation denials, abusive handling of medical emergencies, and intimidation against those who speak out.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|--|--|
| Unexplained SHU/special unit placement | 28 C.F.R. § 541.22; P.S. 5270.09 (Inmate Discipline Program) | Incarcerated individual placed in SHU immediately after a family visit, without incident report or due process. |
| Denial and restriction of visitation | P.S. 5267.09 (Visiting Regulations); 18 U.S.C. § 4042(a)(2) | Families report visitation is limited to the 1st and 3rd Saturdays only, without explanation. One family member was told visits required warden approval, later denied “for her safety.” |

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| Staff death threats & retaliation | 18 U.S.C. § 242; P.S. 3420.12 | Guard threatened to “fold him up like laundry and send him home” if he exposed staff misconduct. |
| Theft/destruction of inmate property | 28 C.F.R. § 553.10–553.17 | Guards failed to secure property, allowed others to steal items, and withheld family photographs and personal effects. |
| Racially discriminatory treatment | 14th Amendment Equal Protection; DOJ Civil Rights obligations | Testimony indicates Black inmates are disproportionately stripped of belongings and targeted for harsher treatment. |
| Medical neglect & abusive handling | 18 U.S.C. § 4042(a)(2); P.S. 6031.04 (Patient Care) | Multiple reports of stomach issues ignored. One man collapsed in his cell and was dragged out nearly naked, accused of hooch/drug use despite negative tests. Later bloodwork confirmed H. Pylori infection, a condition common in unsanitary facilities. |
| Lack of transparency from staff | P.S. 1210.25 | Officers refused to confirm SHU placement, citing “special unit” without documentation. |
| Mail interference & communication blackout | P.S. 5265.14; 28 C.F.R. § 540.100 | Families report daily letters written are not being received, indicating communication tampering. |

3. Direct Quotes from Inside

- “I went to visit... then suddenly when I got home one of his friends tells me he is in the hole. I waited a day, no call, no message — unlike him.”
- “The unit manager told me, ‘It’s a special unit, I can’t give you that information.’”
- “I was told visitation was denied due to my safety, which makes no sense.”
- “His letters he is writing me are not getting to me but I continue to write every day.”

- “If word gets out about this incident, the guard said he’ll make sure he is folded up like laundry and sent home.”
- “They withheld most of his clothing, his shoes, and wouldn’t give back my pictures. He said this place is horrible to the Black inmates and strips them of anything tied to their family.”
- “There is zero explanation why visits are only the 1st and 3rd Saturdays.”
- “He was incoherent from illness, not combative. They dragged him in his boxers across the unit accusing him of drinking hooch, but his bloodwork showed H. Pylori infection.”

4. Oversight Demands

- Immediate OIG and DOJ Civil Rights Division investigation into retaliation, racial targeting, and SHU misuse.
- Urgent investigation into staff death threats, with potential criminal referral under 18 U.S.C. § 242.
- Audit of inmate property handling, including accountability for theft and destruction.
- Audit of medical neglect cases, including review of H. Pylori and infection control conditions at FCI Fairton.
- Audit of mail handling practices and staff obstruction of communication.
- Enforcement of visitation rights under P.S. 5267.09 and removal of arbitrary visitation restrictions.
- Congressional inquiry into transparency failures and racially discriminatory treatment at FCI Fairton.

FPC Schuylkill Camp

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes toxic heating practices, mold exposure, lack of hot water, visitation cancellations, and staff retaliation at FPC Schuylkill Camp. Families and incarcerated individuals report ongoing endangerment due to diesel fumes and black mold, combined with deliberate interference in visitation and case management.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|---|---|
| Toxic heating practices | OSHA 29 C.F.R. § 1910; EPA Clean Air Act | Facility used industrial diesel heaters indoors, causing dangerous carbon monoxide and diesel fume exposure. Incarcerated individuals report nearly passing out from fumes. |
| Failure to repair HVAC / no hot water | 18 U.S.C. § 4042(a)(2); P.S. 6400.03 (Facility Sanitation) | Heat and hot water have been broken since last winter. Incarcerated individuals forced to take cold showers or use coffee water in buckets to bathe. |
| Mold contamination and collapsing ceilings | P.S. 6031.04; EPA Indoor Air Quality Standards | Testimony and photos confirm mold-infested ceilings and walls, creating respiratory health risks. |
| Visitation interference | P.S. 5267.09 (Visiting Regulations) | Weekend visits eliminated and restricted to Tuesdays/Wednesdays. Families who flew in were turned away same-day when a sign was posted saying visits were canceled "until further notice." |
| Case management neglect and retaliation | P.S. 1210.25 (Employee Accountability); 8th Amendment deliberate indifference | Case manager accused of cursing at inmates, refusing to provide services, and threatening to influence sentence length. Only one-hour "open house" per week for 160 inmates, leaving grievances unresolved. |

3. Direct Quotes from Inside

- "The diesel fumes about killed us for real... carbon monoxide is a silent killer but these people don't give a shit."
- "The ceiling is falling in, mold everywhere, but no one ever comes to check."
- "We had no hot water last winter, had to shower with cold water or use coffee water out of a bucket."

- “The case manager cuss you out, tell you to get out of his office, says he will make sure you do as much of your sentence as the judge gave you.”
- “They took our weekend visits away, gave us Tuesday and Wednesday, then canceled visits same-day while families were already there.”

4. Oversight Demands

- Immediate OSHA and EPA inspections for diesel fume exposure, mold, and unsafe housing.
- Repair of heating and hot water systems with written compliance deadlines.
- OIG investigation into arbitrary visitation cancellations and accountability for staff misconduct.
- Congressional hearings into retaliation by case managers, denial of family contact, and staff dereliction of duty at Schuylkill.

FCI Butner

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes denial of medical care, commissary access, phone communication, and family contact for an incarcerated individual with a life-threatening medical condition at FCI Butner. Despite being classified as Level 3 medical and diagnosed with ITP (immune thrombocytopenia) — a disease that destroys platelets and creates a high risk of fatal internal bleeding — the individual has been held in SHU since early August with no access to essential services.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|---|--|
| Denial of medical care to a critical patient | 28 C.F.R. § 549.10; P.S. 6031.04; Estelle v. Gamble, 429 U.S. 97 (1976) | A Level 3 medical inmate with ITP is being held without access to medical care. Family fears that any fall, push, or injury could lead to internal bleeding and death. |
| Communication blackout | P.S. 5265.14 (Correspondence); P.S. 4500.12 (Trust Fund/Email) | Individual has no access to the phone or commissary, and family reports no calls received since SHU placement. |

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|--|--|---|
| SHU placement without transparency | 28 C.F.R. § 541.22; P.S. 5270.09 | Neither Butner staff nor the Regional Office provided any explanation for SHU placement, violating due process. |
| Deliberate indifference to serious medical needs | 8th Amendment; Helling v. McKinney, 509 U.S. 25 (1993) | Withholding medical care for a patient known to be at high risk of fatal bleeding constitutes deliberate indifference and a constitutional violation. |

3. Direct Quotes from Inside

- “My son has been in the SHU at Butner since the first week of August. Neither Butner nor the Regional Office will tell me anything.”
- “His girlfriend received a letter... he is being denied access to his commissary account. He has no access to the phone either. No one in the family has received a call.”
- “He is on a Level 3 medical and has ITP — a disease that destroys the platelets in his blood. If he has no platelets and he falls, is pushed, or hit, there is a good chance he will bleed internally and die without medical care.”

4. Oversight Demands

- Immediate independent medical review of the individual with ITP currently in SHU at FCI Butner.
- Urgent intervention to restore phone and commissary access for SHU inmates, especially those with critical medical needs.
- OIG investigation into misuse of SHU for medically vulnerable individuals.
- Congressional oversight to ensure Butner’s medical classification system is honored in practice, not ignored.

FCI Petersburg

1. Summary of Allegations

Testimony from incarcerated individuals, cooperating staff, and families of the incarcerated describes denial of hot meals and inadequate nutrition at FCI Petersburg. Reports indicate that incarcerated individuals are only being served cold, minimal items such as cereal, powdered milk, muffins, and pears — a diet grossly insufficient to meet federal caloric and nutritional standards.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|-------------------------------|---|--|
| Denial of hot meals | P.S. 4700.06 (Food Service Manual); 18 U.S.C. § 4042(a)(2) | Testimony confirms incarcerated individuals are being denied hot meals altogether. |
| Nutritionally inadequate diet | National Research Council Dietary Standards; 8th Amendment | Meals consist only of cereal, powdered milk, a muffin, and a pear, failing to provide adequate protein, calories, or balanced nutrition. |
| Cruel and unusual punishment | 8th Amendment deliberate indifference; <i>Hutto v. Finney</i> , 437 U.S. 678 (1978) | The deprivation of sufficient and hot meals constitutes inhumane treatment in violation of constitutional protections. |

3. Direct Quotes from Inside

- “Y’all they are not getting hot meals.”
- “Cereal, powder milk, muffin, pear — that’s it.”

4. Oversight Demands

- Immediate inspection of food services at FCI Petersburg by the DOJ and OIG.
- Restoration of hot meals meeting minimum caloric and nutritional standards.
- Accountability for staff responsible for depriving incarcerated individuals of adequate meals.
- Congressional inquiry into systemic food deprivation across BOP facilities.

USP Terre Haute

1. Summary of Allegations

Testimony from families of the incarcerated describes systemic neglect and abuse of a disabled adult at USP Terre Haute. The individual, who has an IQ of 71 and cannot read or write beyond a 2nd–3rd grade level, is under adult legal guardianship. Despite documented psychiatric needs, including federal evaluations confirming the necessity of a specific injectable medication, he has been denied the correct treatment for over two years. Instead, he is forced onto alternative medications with adverse effects, leading to deterioration, suicidal thoughts, and repeated SHU placements.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|--|--|
| Denial of appropriate psychiatric medication | 28 C.F.R. § 549.40; P.S. 6031.04 (Patient Care); Estelle v. Gamble, 429 U.S. 97 (1976) | Despite a federal psychiatric evaluation recommending his injectable medication, staff refuse to provide it, substituting harmful alternatives. |
| Punitive SHU placement for medical behaviors | 28 C.F.R. § 541.22; P.S. 5270.09 | Inmate is sent to SHU when he exhibits behaviors or suicidal ideation tied directly to untreated medical needs. |
| Violation of disability rights | Rehabilitation Act of 1973 § 504; ADA Title II | Inmate has a recognized intellectual disability (71 IQ) and requires accommodations. Instead, he is punished for inability to read/write and cut off from communication. |
| Family/legal guardian interference | P.S. 5265.14 (Correspondence); 28 C.F.R. § 540.100 | His legal guardian reports mail being held, blocking family contact and undermining guardianship rights. |

3. Direct Quotes from Inside

- “He can’t read or write, has a 71 IQ... someone always has to read or write for him and he has been punished for that.”
- “Denied correct meds this whole time — the federal psych eval clearly stated he must be placed back on his injectable or he will face severe mental deterioration.”
- “And when he has a behavior or attempts suicide or suicidal thoughts from medical neglect, then he spends months in the SHU.”
- “Cut off from family and they hold his mail.”

4. Oversight Demands

- Immediate independent psychiatric review of this disabled individual at Terre Haute.
- Restoration of his federally recommended injectable medication with full documentation of medical compliance.

- OIG investigation into SHU misuse against disabled inmates and denial of guardianship communication.
 - DOJ Civil Rights Division enforcement for ADA and Rehabilitation Act violations.
 - Congressional oversight hearings into the systemic neglect of mentally ill and disabled individuals at USP Terre Haute.
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FCI Terminal Island (California)

1. Summary of Allegations

Reports from families describe a death at Terminal Island linked to medical neglect and improper emergency response. The deceased had a history of open-heart surgery, was not monitored appropriately, and was allegedly given Narcan instead of receiving life-saving intervention consistent with his medical history.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|--|---|
| Failure to provide adequate medical care | 18 U.S.C. § 4042(a)(2); P.S. 6031.04 (Patient Care) | Individual with a known heart condition was left without proper monitoring despite recent open-heart surgery. |
| Improper emergency response | P.S. 3420.12 (Standards of Employee Conduct); 28 C.F.R. § 549.10 | When medical crisis occurred, staff administered Narcan (intended for overdose) instead of proper cardiac emergency care. |
| Neglect leading to death | Eighth Amendment – deliberate indifference to serious medical needs (Estelle v. Gamble, 429 U.S. 97) | Reported failure to revive the individual and provide necessary intervention constitutes deliberate indifference. |

3. Direct Quotes from Families

- “It was reported they never tried to revive him and then started to give him Narcan when he had known heart problems.”
- “He had open heart surgery and was not checked on or monitored by medical until very recent and he’s been in since January.”

4. Oversight Demands

- Immediate OIG and DOJ Civil Rights Division investigation into this death and the role of medical neglect.
- Mandatory audit of Terminal Island medical practices and emergency response protocols.
- Independent autopsy and release of medical records to the family.
- Congressional oversight hearing on BOP’s pattern of wrongful deaths tied to medical neglect.

FCI Florence (Colorado)

1. Summary of Allegations

Testimony from families and incarcerated individuals indicates systemic noncompliance with the First Step Act (FSA) and Second Chance Act (SCA) at FCI Florence. Staff are accused of refusing to apply earned time credits, blocking early release placements, and ignoring federal recalculation directives. Families also describe serious facility conditions, including black mold exposure, which poses ongoing health risks. The failures are leaving families in financial crisis and incarcerated individuals unlawfully confined.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--------------------------------------|---|---|
| Failure to apply FSA/SCA credits | First Step Act (18 U.S.C. §§ 3632, 3624); BOP June 17, 2025 Directive | Family reports staff are openly refusing to apply earned time credits, preventing eligible release and halfway house placement. |
| Insubordination to federal directive | P.S. 1210.25 (Employee Accountability) | Staff behavior constitutes direct insubordination to BOP leadership’s written directive requiring recalculations and placements. |
| Unsafe facility conditions (mold) | 18 U.S.C. § 4042(a)(2); OSHA standards | Family reports widespread mold in the housing units, with no remediation efforts or inspection follow-up. Mold exposure is linked to respiratory illness and violates the duty of care. |

3. Direct Quotes from Inside

- “The staff aren’t applying the FSA and SCA credits to any of the inmates... if they would apply the credits he could probably get out soon and help me so I don’t lose everything we’ve worked our whole lives for.”
- “Who do you email or contact about a mold issue with the facility?”

4. Oversight Demands

- Immediate DOJ OIG investigation into Florence staff’s refusal to implement federally mandated recalculations.
- Congressional review of BOP noncompliance with the June 17 directive, with Florence cited as a case study.
- Full environmental health inspection at FCI Florence, including independent mold testing and remediation plan.
- Enforcement of accountability measures against staff engaged in policy defiance and insubordination.

FCI Leavenworth (Kansas)

1. Summary of Allegations

Testimony from incarcerated individuals and families describes severe food contamination, systemic mold exposure, diabetic neglect, and retaliation through fabricated disciplinary actions. Reports also highlight obstruction of the BOP grievance system (BP-8/BP-9), widespread lockdowns, and staff misconduct tied to falsified evidence and coerced “shot” (disciplinary) outcomes.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|--|--|
| Contaminated food & sanitation violations | 18 U.S.C. § 4042(a)(2); 28 C.F.R. § 549.10; PS 3420.12 | Families report food with feces, roaches, and moldy bread still being served. Inmates forced to eat spoiled meals. |
| Black mold exposure | OSHA Standards; 18 U.S.C. § 4042(a)(2) | Large amounts of black mold reported, with fans installed that blow contaminated air directly into inmate cells. |

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| Diabetic neglect | BOP Program Statement 6031.04 (Patient Care); 28 C.F.R. § 549.10 | Diabetics denied required nighttime snacks, forced to go from 4:30 p.m. dinner until 7–9 a.m. without food, in violation of medical care standards. |
| Retaliatory/fabricated disciplinary actions | 28 C.F.R. § 541.22; P.S. 5270.09; P.S. 1210.25 (Employee Accountability) | Multiple testimonies detail COs planting or misattributing contraband, falsifying reports, coercing inmates into accepting guilt, and retaliating against those who resist. |
| Obstruction of grievance process | 28 C.F.R. § 542.10–542.19 (Administrative Remedy Program) | Inmates report BP-8 forms thrown away and BP-9s ignored without attachments, effectively blocking due process. |
| Evidence tampering & cover-ups | 18 U.S.C. § 1519 (Destruction/alteration of records); P.S. 1210.25 | Requests for camera footage, DNA, and fingerprints deliberately denied. Video evidence “gone” despite timely requests. Testimonies suggest a long history of staff lying in official reports. |

3. Direct Quotes from Inside

- “My husband said the feces and roaches in the food is worse. Still serving moldy bread, spoiled food.”
- “They put fans on the wall under black mold. It just blows air directly at the cells.”
- “Diabetics are supposed to get snacks with dinner, but never once in 10 years did I see it. We had to spend outrageous money just to survive the night.”
- “I filed many BP-8s, but they throw them away. Without BP-8s attached, the BP-9s go nowhere. That’s how they stop your process.”
- “The CO told me if I didn’t get the other inmate to confess, he’d put the case on me. When I refused, he buried me with a false write-up... the DHO admitted evidence was gone, witnesses silenced, and still tried to find me guilty.”
- “This CO has written more false shots than anyone, even after being caught lying in reports and to a grand jury. How is he promoted to unit team?”

4. Oversight Demands

- Immediate DOJ OIG investigation into food contamination and mold exposure at Leavenworth.
 - Independent environmental and food safety inspections, with photographic documentation from family sources to be included.
 - Federal review of retaliatory disciplinary practices, including reopening of all “shots” written by the named officer(s) with independent audits.
 - Congressional inquiry into obstruction of grievance rights and destruction of evidence at Leavenworth.
 - Emergency policy enforcement to ensure diabetics receive medically required nighttime nutrition.
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USP Lee (Virginia)

1. Summary of Allegations

Family testimony highlights classification manipulation, score miscalculations, and lack of accountability for correctional staff assurances. Incarcerated individuals are being mis-scored, resulting in higher custody levels and harsher placements. Staff who claim they will correct errors fail to follow through, leaving families without recourse.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|---|--|
| Custody point miscalculation & improper housing | P.S. 5100.08 (Inmate Security Designation and Custody Classification) | Husband’s points were incorrectly increased, moving him from a camp to low security. This recalculation was not corrected despite officer assurances. |
| Lack of transparency & follow-through by staff | P.S. 1210.25 (Employee Accountability); 18 U.S.C. § 4042(a)(2) | Lt. Graham allegedly told the incarcerated individual he would fix the issue, but the miscalculation remains unresolved, directly harming placement and proximity to family. |
| Family left without recourse | 28 C.F.R. § 542.10–542.19 (Administrative Remedy Program) | Family reports difficulty accessing accountability or support to ensure |

recalculation is performed correctly.

3. Direct Quotes from Families

- “This issue has caused my husband’s points to be increased which rehoused him from a camp to low security.”
- “That officer assured him he was working on righting that wrong... I just need support with getting this recalculation done so he can get back into a camp and hopefully closer to home.”

4. Oversight Demands

- Independent audit of custody point calculations at USP Lee.
- OIG review of staff accountability where promises to correct scores are not followed.
- Directive to ensure recalculations are corrected promptly, with oversight from the regional office.
- Congressional inquiry into misuse of classification as a retaliatory or negligent tool preventing low-security eligible individuals from being placed appropriately.

USP Beaumont (Texas)

1. Summary of Allegations

Loved ones report that USP Beaumont has been on extended lockdown for weeks, allegedly connected to multiple deaths under investigation. Testimonies describe total deprivation of basic human needs, including food, showers, outside recreation, and movement. The FBI has reportedly entered the facility, but families and incarcerated individuals remain in the dark about the reasons or timeline.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|--|---|
| Extended lockdown with no access to basic needs | 18 U.S.C. § 4042(a)(2); P.S. 5538.05 (Lockdowns, Disturbances, and Controlled Movements) | Reports indicate “no showers, no food, no outside time, no movement” for weeks, violating federal duty of care. |
| Deprivation of food & sanitation | 28 C.F.R. § 541.31; Eighth Amendment (deliberate indifference) | Incarcerated individuals allegedly denied meals and hygiene access during prolonged lockdown. |

Lack of transparency on deaths & FBI investigation

P.S. 1210.25 (Employee Accountability); FOIA compliance

Families report no communication on the circumstances of deaths or investigative oversight.

3. Direct Quotes from Families

- “Lock down @ USP Beaumont for weeks now.”
- “Word was FBI was in there for all the deaths.”
- “No showers, no food, no outside time, no movement, no nothing for weeks.”

4. Oversight Demands

- Immediate OIG and DOJ Civil Rights Division investigation into conditions during lockdowns.
- Congressional inquiry into why FBI involvement has not been publicly disclosed to families.
- Emergency order requiring USP Beaumont to restore access to food, showers, outdoor time, and medical care during lockdowns.
- Accountability for staff who allow indefinite lockdowns that constitute cruel and unusual punishment.

FMC Carswell (Texas)

1. Summary of Allegations

Testimony and visual evidence from family members and incarcerated women at FMC Carswell detail a catastrophic infrastructure failure — including a collapsed ceiling, widespread black mold, flooding with suspected sewage water, and malfunctioning emergency medical response. These conditions place medically vulnerable women at extreme risk and demonstrate systemic neglect of health and safety.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|---|---|---|
| Collapsed ceiling and black mold exposure | 18 U.S.C. § 4042(a)(2) (Duty to provide safe conditions), OSHA mold standards, EPA indoor air quality standards | A ceiling collapse in Unit 1N exposed incarcerated women to black mold. The ceiling was replaced superficially, but the root leak was ignored, resulting in water damage across three floors. |

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| Contaminated water and sewage leaks | EPA Safe Drinking Water Act, 18 U.S.C. § 4042(a)(2) | Water, possibly sewage, continues to leak across three floors, including into prison computer systems. Family testimony links poor water quality to widespread kidney stones among incarcerated individuals. |
| Failed emergency medical response | 28 C.F.R. § 549.10 (Medical services), P.S. 6031.04 (Patient care) | During a dialysis emergency, staff could not locate a crash cart, retrieved a non-functional cart from another department, and delayed resuscitation. Described as “Carswell 911 instead of Reno 911.” |
| Inhumane conditions for medically vulnerable population | Americans with Disabilities Act (ADA), Eighth Amendment (cruel and unusual punishment) | FMC Carswell is designated for medical care, yet individuals with chronic conditions are exposed to mold, contaminated water, and life-threatening lapses in emergency care. |

3. Direct Quotes from Inside

- “Ceiling fell down in 1N today... full of black mold. Inmates cleaned up as best they could. Now it’s leaking down three floors.”
- “They call it ‘Carswell Falls.’ If you don’t hear from loved ones, it’s because the water ruined the computers.”
- “Someone on dialysis stopped breathing and staff couldn’t find the crash cart. The first one they brought wouldn’t work. It’s like Carswell 911 instead of Reno 911.”
- “Every dude at MGM last year got kidney stones from the water. I tested it and it came back contaminated. I’m getting a scrap of the ceiling at Carswell tested too.”

4. Oversight Demands

- Emergency inspection of FMC Carswell’s infrastructure and mold contamination by EPA, OSHA, and independent health authorities.
- Independent water testing and full disclosure of results to families and Congress.
- Immediate corrective action to replace contaminated water systems, repair structural damage, and ensure safe air and water.

- Review of emergency medical protocols and disciplinary action for staff who failed to provide timely resuscitation.
- Congressional hearing into BOP's failure to protect medically vulnerable women housed at Carswell.

USP Coleman I (Florida)

1. Summary of Allegations

Loved ones and testimony report systemic abuse, medical neglect, and mental health rights violations at USP Coleman I. Incarcerated individuals with severe conditions (epilepsy, bipolar disorder, PTSD, TBI) have been placed in the SHU without treatment, subjected to guard assaults, denied psych/seizure medication, and retaliated against after suicide attempts. Inmates are being housed over 1,000 miles away from family despite judicial recommendations for medical placement. Reports indicate deliberate indifference, falsified disciplinary actions, and retaliatory transfers.

2. Key Allegation & Violation Table

| Allegation | Policy / Statute Violated | Details |
|--|--|---|
| Medical neglect of seizures/psych conditions | 18 U.S.C. § 4042(a)(2); PS 6031.04 (Patient Care); 28 C.F.R. § 549.10 | Inmate repeatedly denied psych & seizure medications while in SHU, untreated for months. |
| Excessive SHU placement & retaliation | PS 5270.09 (Inmate Discipline Program); 28 C.F.R. § 541.22 | Inmate placed directly into SHU upon designation and kept there for months without due process. |
| Guard assaults & retaliation | 18 U.S.C. § 242 (Deprivation of Rights); PS 3420.12 (Employee Conduct) | Reports of multiple physical assaults by guards, including during seizures; guard allegedly told inmate to "kill yourself" when he requested mental health. |
| Mishandling of suicide attempt | PS 5324.12 (Suicide Prevention Program); 28 C.F.R. § 541.40 | After suicide attempt (50 pills ingested), inmate returned to SHU and placed in PC without proper psychiatric evaluation. |
| Misuse of disciplinary action | PS 5270.09 | Inmate "shot" for assault despite seizure-related |

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| | | behavior, raising due process and medical defense concerns. |
| Unsafe pill distribution practices | PS 6360.01 (Controlled Substances); PS 6031.04 | Inmate issued 180-day supply of psych meds to keep in-cell, despite suicide risk and presence of addicted population. |
| Denial of recommended medical transfer | PS 5100.08 (Inmate Security Designation & Custody) | Judge recommended medical facility placement; BOP failed to comply. |
| Communication & retaliation | PS 5265.14 (Correspondence) | Phone privileges revoked until 2026, furthering isolation and separation anxiety. |

3. Direct Quotes from Inside / Family

- “He was not put on any of his psych meds or seizure meds — basically untreated.”
- “The guard told him, ‘kill yourself and then I’ll get mental health.’”
- “Every time he’s transferred, it’s always 1000 miles away from me... he has severe separation anxiety and seizures from the stress.”
- “He took 50 Rimron pills in front of a guard. They took him to the hospital, then right back to the SHU.”
- “Why would you give an inmate a 180-day supply of psych meds knowing he is a suicide risk?”

4. Oversight Demands

- Immediate OIG investigation into systemic medical neglect, SHU misuse, and staff misconduct at USP Coleman I.
- Review of all suicide prevention failures, including issuance of excessive pill supplies and staff verbal incitement.
- Accountability for guards involved in physical assaults and retaliatory actions; referral for possible 18 U.S.C. § 242 violations.
- Enforcement of judicial recommendation for medical facility placement, with immediate transfer to an FMC.

- Restoration of communication rights consistent with PS 5265.14 and monitoring of retaliation through mail/phone restrictions.
- Congressional and DOJ inquiry into why Coleman I continues to house mentally ill inmates in SHU conditions rather than medical units.

FCC Victorville

1. Summary of Allegations

Multiple accounts from loved ones and internal testimony document severe abuse, neglect, and systemic misconduct at FCC Victorville. Allegations include untreated medical and mental health needs, excessive SHU placement, staff assaults, retaliation, falsified records, and direct whistleblower testimony naming HR Manager Sherry Franco as a central figure in silencing accountability. Conditions at Victorville are described as dangerous, coercive, and retaliatory — with violations of BOP program statements, federal regulations, and constitutional protections.

2. Key Allegation & Violation Table

| Allegation | Details | Violations |
|----------------------------------|---|--|
| Excessive SHU Placement | Husband placed directly in SHU at initial designation (Gilmer WV), later transferred to Victorville, where SHU confinement continued unnecessarily. | 28 C.F.R. § 541.22; PS 5270.11 (SHU policies) |
| Medical & Mental Health Neglect | Failure to provide seizure medication or psych meds; untreated conditions for months. | 18 U.S.C. § 4042(a)(2); 28 C.F.R. § 549.10; PS 6031.04 (Patient Care) |
| Staff Assaults | Repeated assaults by guards, documented with witnesses. | 18 U.S.C. § 242 (Deprivation of Rights); PS 3420.12 (Employee Conduct) |
| Retaliation & Encouraged Suicide | Guard told inmate “kill yourself” instead of providing mental health referral. Attempted suicide followed (50 Rimron pills). | Eighth Amendment; PS 3420.12; PS 5310.16 (Suicide Prevention) |
| Improper Disciplinary Charges | Assault shot given during seizure episode; inmate pled | PS 5270.11; Due Process protections |

| | | |
|-------------------------------|--|--|
| | not guilty but was still sanctioned. | |
| Dangerous Transfers | Each transfer >1,000 miles from family, worsening separation anxiety and medical risk. | First Step Act family proximity provisions |
| HR Corruption & Retaliation | Whistleblower testimony naming Sherry Franco, HR Manager, as obstructing tort claims, falsifying records, retaliating against staff, and enabling systemic misconduct. | PS 1210.25 (Internal Affairs); Whistleblower Protection Act |
| Malpractice in Medications | Inmate provided 180-day supply of psych meds despite being high-risk suicide case and housed with drug users. | PS 6031.04; 28 C.F.R. § 549.10; Eighth Amendment deliberate indifference |
| Weight Loss / Medical Decline | Inmate lost 84 lbs in 10 months (330 → 246 lbs); no medical transfer despite judge's recommendation. | Eighth Amendment; PS 6031.04 |

3. Direct Quotes from Inside

- “He was not put on any of his seizure meds or psych meds. He was basically untreated.”
- “On July 8th he asked a guard for mental health... the guard told him ‘kill yourself and then I’ll get mental health.’”
- “He took over 50 Rimron pills in front of the guard.”
- “Every time he is transferred it’s always over 1000 miles away from me which makes it worse on him.”
- “He has gone from 330 lbs to 246 lbs in 10 months.”
- “Since Franco’s arrival... Victorville has become a dangerous place for staff, inmates, and the public. Integrity is no longer rewarded. Collaboration has been replaced with coercion.”

4. Oversight Demands

1. Immediate investigation into FCC Victorville’s HR Department, specifically the role of Sherry Franco in silencing whistleblowers and obstructing accountability.
 2. Independent medical review of all inmates denied seizure, psychiatric, and prescribed medications.
 3. Audit of SHU placements to determine misuse and excessive confinement at Victorville.
 4. Accountability for staff misconduct, including the guard who encouraged suicide.
 5. Review of medication distribution practices, especially long-term psych meds handed to suicide-risk inmates.
 6. Enforcement of family proximity provisions under the First Step Act to prevent punitive long-distance transfers.
 7. Referral to DOJ OIG for investigation into systemic cover-ups, falsified records, and obstruction of tort claims.
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FCC Hazelton

1. Summary of Allegations

Loved ones of individuals incarcerated at FCC Hazelton report serious medical neglect, mail interference, sanitation failures, and unlawful lockdown practices. Testimony documents untreated MRSA infections, denial of access to showers due to prolonged lockdowns, and interference with privileged legal correspondence. These violations represent systemic failures to uphold constitutional rights and federal regulatory standards.

2. Key Allegation & Violation Table

| Allegation | Violation of Law / Policy |
|--|---|
| Inmate’s legal mail from an attorney was copied and left unsecured on his bed. | 28 C.F.R. § 540.18 (Special Mail handling), BOP PS 5800.16 – requires attorney-client correspondence be opened only in the inmate’s presence, never read or copied. |
| Prolonged lockdowns with no showers (Aug 29 – Sept 1, incl. Labor Day weekend) and restricted movement under false pretense of “modified” schedules. | Eighth Amendment – Cruel and Unusual Punishment, 18 U.S.C. § 4042(a)(2) (duty to provide humane conditions), BOP PS 5538.07 (sanitation standards). |
| No hot water for days; water so cold inmates could not shower. | 28 C.F.R. § 541.21 (minimum living conditions), BOP sanitation/health policy – |

requires access to functional hygiene facilities.

Inmate developed a severe MRSA infection (cut became swollen, infected, non-responsive to oral antibiotics). He reported extreme fatigue, worsening condition, and medical neglect despite repeated medical visits.

28 C.F.R. § 549.10 (health services), Eighth Amendment deliberate indifference standard (*Estelle v. Gamble*, 429 U.S. 97), BOP PS 6031.04 (patient care).

3. Direct Quotes from Inside

- “My guy got something from an attorney, and it was thrown on his bed when he wasn’t even in there and was copied as well. Smh.”
- “Well they told them they would be on modified this weekend however it doesn’t seem like it. The week of Labor Day weekend they were locked in from the 29–1 with no shower.”
- “No hot water for couple day the cold water is so cold they can’t take showers.”
- “He got a cut on his legs and now it is super infected and swollen... They told him it was MRSA. They gave him oral antibiotics on Monday. They still aren’t working... He is saying that it is hard for him to stay awake and that he is just tired all the time. Definitely is not normal for him.”

4. Oversight Demands

1. Immediate medical intervention for individuals with untreated MRSA infections, including transfer to outside hospitals if BOP medical staff cannot provide adequate care.
 2. Independent review of medical unit practices at Hazelton to determine systemic failures in diagnosing and treating infectious diseases.
 3. Investigation into legal mail interference at Hazelton, with staff accountability for violating privileged attorney-client communications.
 4. Inspection of sanitation and water systems, including verification of hot water access and shower availability during lockdowns.
 5. Congressional and OIG oversight hearings to investigate misuse of lockdowns as punishment, denial of basic hygiene, and systemic medical neglect at FCC Hazelton.
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Conditions & Evidence

Photographic and firsthand evidence collected by the Loved Ones Coalition demonstrates systemic failures across federal prisons that violate BOP's own policies and minimum standards of care. These are not isolated incidents but patterns of abuse and neglect that are leaving people sick, malnourished, and living in inhumane environments.

Environmental & Structural Failures

- Black mold and fungal contamination are widespread in housing units, bathrooms, and kitchens. Incarcerated people report chronic respiratory issues, skin infections, and ongoing illness directly tied to these conditions.
- Collapsing infrastructure: roofs leaking and ceilings caving in, creating unsafe living and working conditions for both staff and incarcerated individuals.
- Sanitation neglect: units remain unclean and unventilated, contributing to the spread of infections and disease.

Medical Consequences

- Individuals are reporting fungal infections and other illnesses directly linked to mold, contaminated water, and unsanitary conditions.
- Infected wounds (including MRSA) are being left untreated or inadequately treated, with antibiotics provided that do not work against resistant infections.
- These failures amount to deliberate indifference to serious medical needs and violate constitutional protections under the Eighth Amendment.

Food Service Failures (Photographic Evidence Attached)

- Meals being served do not meet BOP or ACA nutritional standards:
 - Portions are well below caloric requirements, leaving people hungry and undernourished.

- Spoiled, moldy, or inedible food has been documented, including undercooked items and rotten produce.
- The food service system is functioning in clear violation of BOP Program Statement 4700.06 (Food Service Manual) and USDA/FDA safety guidelines.
- Families and incarcerated individuals report that malnutrition is widespread, with weight loss and health issues directly tied to food quality and quantity.

Oversight Demands

1. Immediate independent inspection of federal prison infrastructure and food service programs, with photographs reviewed by DOJ/OIG.
2. Full compliance with BOP food service standards, including caloric and nutritional minimums.
3. Emergency environmental remediation, including removal of black mold, repair of collapsed or collapsing infrastructure, and sanitation protocols.

4. Accountability for leadership allowing systemic violations to persist in plain view.











