REPORT OF INVESTIGATION

SUBJECT	CASE NUMBER
[redacted] Warden [redacted]	2019-004379

OFFICE CONDUCTING INVESTIGATION	DOJ COMPONENT
Los Angeles Field Office	Federal Bureau of Prisons

DISTRIBUTION		STATUS		
☒ Field Office	LAFO	☐ OPEN	☐ OPEN PENDING PROSECUTION	☒ CLOSED
☒ AIGINV		PREVIOUS REPORT SUBMITTED:	☐ YES	☒ NO
☒ Component	BOP	Date of Previous Report:		
☐ USA				
☐ Other				

SYNOPSIS

The Department of Justice Office of the Inspector General (OIG) initiated this investigation upon the receipt of information from the Federal Bureau of Prisons (BOP) Office of Internal Affairs alleging [redacted] Warden [redacted] subjected inmates to inhumane conditions by forcing them to live in housing units with inadequate heat for an extended period of time. [redacted]

Subsequent to the onset of the investigation, the OIG found indications that [redacted] knowingly failed to maintain a fully functioning camera system throughout the facility for more than a year and failed to report the issue to BOP's regional management for remedy. Additionally, the OIG found indications that [redacted] lacked candor in sworn statements to the OIG. [redacted]

The OIG investigation substantiated the allegation that [redacted] violated the BOP Standards of Employee Conduct when [redacted] was inattentive to [redacted] duties as warden and risked the safety and security of inmates and staff by knowingly failing to address a lack of heat in housing units during a period of exceptionally cold weather. The investigation also substantiated that [redacted] violated the BOP Standards of Employee Conduct when [redacted] was inattentive to [redacted] duties as warden and risked the safety and security of inmates and staff by knowingly failing

DATE	SIGNATURE	[redacted]
[redacted] PREPARED BY SPECIAL AGENT		
DATE	SIGNATURE	Digitally signed by ZACHARY SHROYER Date: 2021.07.28 14:46:27 -07'00'
Zachary Shroyer APPROVED BY SPECIAL AGENT IN CHARGE		

to maintain a functioning camera system throughout the facility. Finally, the OIG investigation substantiated that [redacted] violated the BOP Standards of Employee Conduct when [redacted] lacked candor under oath in [redacted] two voluntary OIG interviews.

[redacted]

On [redacted], a damaged pipe at [redacted] resulted in a lack of heat in the [redacted] housing units. Four BOP staff witnesses told the OIG they were aware of a damaged steam pipe at [redacted] in [redacted], and one witness told the OIG that [redacted] informed [redacted] of the damaged pipe on [redacted] Three of the witnesses told the OIG that the damaged pipe and corresponding lack of heat was significant enough that extra blankets were issued to inmates as early as [redacted], and space heaters were procured for staff members as early as [redacted]. One witness stated that [redacted] was well informed of issues related to the damaged pipe and lack of heat. Further, the [redacted] told the OIG that when [redacted] called [redacted] on [redacted], and ordered [redacted] to transfer the inmates, [redacted] indicated [redacted] was aware of the lack of heating in the housing units.

An OIG review of minutes associated with [redacted] department head meeting attended by [redacted] on [redacted] indicated that [redacted] and the department heads were briefed by the [redacted] that repair work on the broken pipe was ongoing and the damage had affected heating in the [redacted] housing units.

Three BOP inmate witnesses told the OIG that there was a lack of heat in the [redacted] housing units at the facility during a period of unusually cold weather. [redacted]

[redacted]

Three BOP staff witnesses reported knowledge of the facility's malfunctioning camera system, albeit with varying degrees of depth related to the extent of the malfunction. One of the witnesses reported [redacted] was aware that [redacted] had knowledge of the malfunctioning cameras as early as [redacted]. The other two witness were unable to state with certainty as to [redacted] knowledge related to the cameras.

In two voluntary OIG interviews, [redacted] stated that on or about [redacted], [redacted] was made aware of a broken steam pipe and that repair work began shortly after. Further, [redacted] acknowledged [redacted] was aware that inmates in the [redacted] units had requested and received extra blankets and that staff had requested and received space heaters. Despite these acknowledgements, [redacted] told the OIG [redacted] was unaware that the broken steam pipe had caused a lack of heat in the housing units unti [redacted] was contacted by [redacted] on [redacted]. [redacted]

[redacted]. Regarding the malfunctioning camera system [redacted] admitted that [redacted] was aware elements of the facility's camera system were not functioning, but further stated [redacted] was unaware as to the extent of the problem until the OIG requested camera footage pursuant to this investigation. [redacted] further admitted that [redacted] should have done a better job monitoring logs that document the functionality of cameras, which were routinely submitted for [redacted] review.

The DOJ Public Integrity Section declined to pursue a criminal prosecution of [redacted]

The OIG has completed its investigation and is providing this report to the BOP for appropriate action.

Unless otherwise noted, the OIG applies the preponderance of the evidence standard in determining whether DOJ personnel have committed misconduct. The Merit Systems Protection Board applies this same standard when reviewing a federal agency's decision to take adverse action against an employee based on such misconduct. See 5 U.S.C. § 7701(c)(1)(B); 5 C.F.R. § 1201.56(b)(1)(ii).

[redacted]

ADDITIONAL SUBJECTS

DETAILS OF INVESTIGATION

Predication

The Department of Justice Office of the Inspector General (OIG) initiated this investigation upon the receipt of information from the Federal Bureau of Prisons (BOP) Office of Internal Affairs alleging [redacted] Warden [redacted] subjected inmates to inhumane conditions by forcing them to live in housing units with inadequate heat for an extended period of time. [redacted]

Subsequent to the onset of the investigation, the OIG found indications that [redacted] knowingly failed to maintain a fully functioning camera system throughout the facility for more than a year and failed to report the issue to BOP's regional management for remedy. Additionally, the OIG found indications that [redacted] lacked candor in sworn statements to the OIG. [redacted]

Investigative Process

The OIG's investigative efforts consisted of the following:

Interviews of the following BOP personnel:

- [redacted], Warden

[redacted]

Interviews of the following [redacted]:

[redacted]

Review of the following:

- [redacted] BOP emails from [redacted]
- [redacted]
- [redacted] log from [redacted]
- Weather records for [redacted]

[redacted] Alleged Inhumane Treatment of Inmates Related to Housing and Lack of Candor

The information provided to the OIG alleged that [redacted] subjected inmates to inhumane housing conditions by forcing inmates to live in housing units with inadequate heat for an extended period prior to [redacted].

BOP Program Statement 3420.11, dated December 6, 2013, Standards of Employee Conduct, Offense Number 7, prohibits inattention to duty, involving the potential danger to safety of persons.

BOP Program Statement 3420.11, dated December 6, 2013, Standards of Employee Conduct, Offense Number 34 addresses "falsification, misstatement, exaggeration, or concealment of material fact in connection with employment, promotion, travel voucher, any record, investigation, or other proper proceeding."

[redacted] told the OIG that in [redacted], a steam pipe collapsed causing a loss of heat to the [redacted] housing units. [redacted] stated it was [redacted] understanding that [redacted] subsequently sent an email to the executive staff of the institution notifying them of the collapse and loss of heat.

[redacted] told the OIG [redacted] learned of the steam leak on [redacted]. According to [redacted] notified [redacted] and [redacted] the same day and, at [redacted] request, [redacted] provided daily updates to [redacted] regarding the progress of repairs. [redacted] added that [redacted] received complaints from staff members about the lack of heat and that [redacted] purchased space heaters as a temporary fix for staff. [redacted] also stated [redacted] was aware that because of the heat loss, the [redacted] department issued additional blankets to inmates.

[redacted] told the OIG he learned from [redacted] on [redacted], that there was a steam leak issue. [redacted] stated that between [redacted], and [redacted] began receiving estimates through the facilities staff regarding replacing the heating system, which was turned off on [redacted]. [redacted] further stated that on [redacted] learned inmates were being issued extra blankets. [redacted] also stated that on [redacted] space heaters were ordered and delivered for staff shortly thereafter. [redacted] noted that heaters were ordered for the inmates on [redacted], but were delivered to the facility after the inmates transferred [redacted] [redacted] stated that [redacted] informally told [redacted] about the steam issues between [redacted], and [redacted]. [redacted] recalled having multiple conversations with [redacted] on the topic, especially when they were both present in the dining facility during meal service with the inmates. [redacted] said [redacted] was also aware that [redacted] and [redacted] notified [redacted] about the steam issues, but [redacted] was unaware of the specific dates. Regarding management's reaction to the loss of heat, [redacted] acknowledged that "we dropped the ball, it wasn't malicious."

[redacted] told the OIG that he had minimal knowledge related to the loss of heating in the housing units [redacted] further stated that [redacted] attended a meeting in which they discussed the issue of cold conditions in the housing units during which the heating issue was brought to the attention of the warden and a decision was made to obtain heaters until the broader issue was resolved.

[redacted]. [redacted] recalled that in [redacted] became aware there was a heating outage in some of the housing units at [redacted] and that [redacted] called [redacted] the same day to discuss the issue. According to [redacted], [redacted] told [redacted] was aware of the heating issue, but anticipated [redacted] would be able to resolve it internally and therefore chose not to inform [redacted] [redacted] noted that [redacted] had visited [redacted] and met with [redacted] 7 to 10 days prior to their call and [redacted] did not inform [redacted] of the heating issue at that time. [redacted] added that the same

day of [redacted] call to [redacted] to discuss the heating issue, [redacted] ordered the affected inmates be transferred [redacted] until the heating outage could be resolved.

[redacted] told the OIG that the heat in [redacted] housing unit had been out for 5 weeks prior to [redacted] move [redacted] on [redacted] added that at one point [redacted] estimated that it was 39 degrees in his cell.

[redacted] told the OIG that prior to being transported [redacted] on [redacted] [redacted] estimated that [redacted] and the other inmates in [redacted] housing unit had been without heat for over 45 days.

[redacted] told the OIG that that [redacted] and approximately 100 other inmates were removed from their cells on [redacted] and transferred [redacted]. [redacted] noted that the heat in [redacted] housing unit had not been working for some time prior to the move.

An OIG review of weather records from Accuweather.com revealed that average low temperatures at [redacted] from [redacted] ranged between 46 to 49 degrees Fahrenheit. The lowest temperature recorded during the period was 37 degrees on [redacted]

An OIG review of minutes of an [redacted] department head meeting attended by [redacted] on [redacted] indicated [redacted] and the department heads were briefed by the [redacted] that "[redacted] is working on repairing the broken pipe in the ground by [redacted] Units which has been effecting [sic] heating."

Over two voluntary interviews, [redacted] stated that on or about [redacted] advised [redacted] of a broken steam pipe and that repair work began shortly after. Further, [redacted] acknowledged [redacted] was aware that inmates in the [redacted] units had requested and received extra blankets and that staff had requested and received space heaters. Despite these acknowledgements, [redacted] told the OIG [redacted] was unaware that the broken steam pipe had caused a lack of heat in the housing units until [redacted] was contacted by [redacted] on [redacted]

The Department of Justice Public Integrity Section declined to open a criminal investigation [redacted]

OIG's Conclusion

The OIG investigation concluded that [redacted] violated BOP Program Statement 3420.11, Standards of Employee Conduct, Offense Number 7, when [redacted] was inattentive to [redacted] duties as warden and risked the safety and security of inmates and staff by failing to address the lack of adequate heating in [redacted] facility. The OIG investigation also concluded that [redacted] violated BOP Program Statement 3420.11, Standards of Employee Conduct, Offense Number 34, when [redacted] lacked candor in [redacted] two voluntary OIG interviews under oath. The OIG found that [redacted] was fully aware of inadequate heating in housing units [redacted] no later than on or about [redacted], which was the date [redacted] told the OIG that [redacted] learned about the broken steam pipe and the issuance of extra blankets. The OIG credited the testimony of both [redacted] and [redacted], who told the OIG that they informed [redacted] on multiple occasions in [redacted] about the broken steam pipe issue. Based on the evidence, the OIG found [redacted] statement that [redacted] was unaware until [redacted] that the broken steam pipe had caused a lack of heat in the housing units implausible. The OIG further found that [redacted] took no corrective action to mitigate inmates' exposure to cold conditions until ordered to do so by the [redacted] on [redacted].

[redacted]

[redacted]

[redacted]

[redacted] Alleged Failure to Maintain Institution Camera System

During the investigation, the OIG found that numerous cameras were non-functioning throughout [redacted]. Further, the OIG learned that [redacted] had knowledge of the non-functioning cameras for months and took no corrective action.

BOP Program Statement 3420.11 dated December 6, 2013, Standards of Employee Conduct, Offense Number 7, prohibits inattention to duty, involving the potential danger to safety of persons.

[redacted] told the OIG that [redacted] had been aware of some non-functioning cameras at [redacted] since [redacted] arrival in [redacted] but that [redacted] did not understand the extent of the camera malfunctions until video footage was requested subsequent to the inmate transfer [redacted] on [redacted]. [redacted] acknowledged that [redacted] was inconsistent in [redacted] reporting related to non-functioning cameras, but that [redacted] did forward multiple reports to [redacted] related to malfunctioning cameras. [redacted] noted that camera coverage could be monitored from [redacted] office, [redacted]

[redacted] told the OIG that when [redacted] arrived at [redacted] in [redacted], [redacted] was advised by [redacted] that cameras throughout the institution were not working and that the malfunctioning cameras would be one of the issues [redacted] needed to address. [redacted] stated that based on conversations [redacted] had with [redacted], it was [redacted] understanding that [redacted] was also aware of the malfunctioning cameras since at least [redacted]

[redacted] told the OIG that [redacted] was aware of [redacted] non-functioning cameras within the institution prior to the [redacted] inmate transfer and that subsequent to that event, [redacted] learned there were [redacted] non-functioning cameras [redacted] further stated that after the [redacted] transfer, [redacted] sent manpower and resources to [redacted] in order to repair the camera system. [redacted] stated [redacted] was unaware of the extent of [redacted] knowledge related to the non-functioning cameras.

During [redacted] first voluntary OIG interview, [redacted] stated [redacted] had no video recordings of the night of [redacted], [redacted] because the cameras that covered the areas where the inmates walked were not working. [redacted] acknowledged that [redacted] submit a log each night with a list of non-functioning cameras, and [redacted] admitted that [redacted] often did not review it. [redacted] further acknowledged that [redacted] should have devoted more time and attention to the camera system and said many incidents were not documented due to the camera failures. During [redacted] second voluntary interview, [redacted] admitted that [redacted] knew for "a while" that the cameras around the institution had been down but never reported it to [redacted] or anyone else in [redacted]. [redacted] also admitted [redacted] knowing that the camera outage was a safety issue.

OIG's Conclusion

The OIG investigation concluded that [redacted] violated BOP Program Statement 3420.11, Standards of Employee Conduct, Offense Number 7, when [redacted] was not attentive to [redacted] duties as warden and risked the safety and security of inmates and staff by failing to monitor the upkeep of the institution's camera system and ensure its operability.

[redacted]

[redacted]