"A Message from the Inspector General: Inspection of the BOP's Federal Correctional Institution Sheridan," May 2024

Hello, I'm Michael Horowitz, Inspector General for the U.S. Department of Justice.

My office recently completed an unannounced inspection of the Federal Bureau of Prisons, or BOP's, facility in Sheridan, Oregon. As we detail in a report released today, we found several serious operational deficiencies, including alarming staffing shortages among Correctional Officers and healthcare workers, which substantially impact the health, welfare, and safety of employees and inmates.

In particular, we found that healthcare worker shortages acutely affected daily functions, such as drawing blood for laboratory tests and triaging patient requests for care. At the time of our inspection, the institution had a backlog of almost 1,000 medical laboratory and x-ray orders, which caused medical conditions to go undiagnosed and left providers unable to appropriately treat patients. An FCI Sheridan physician told us that the backlog of laboratory orders compromised his ability to treat patients and had prevented him from monitoring the effects of medication on his patients' kidney and liver function. We also found that due to a high Correctional Officer vacancy rate, FCI Sheridan did not always have Correctional Officers available to escort inmates to external medical providers, requiring a large number of outside medical appointments to be canceled.

Additionally, serious shortages among employees who facilitate FCI Sheridan's Residential Drug Abuse Program impacted its ability to offer this important rehabilitation program to eligible inmates. Many of these inmates had been transferred to FCI Sheridan from other BOP institutions specifically to participate in this program.

Staffing shortages also meant that institution management lacked the number of employees needed to safely supervise inmates, even with mandatory overtime. As a result, inmates were routinely confined to their cells during daytime hours and were often unable to participate in programs and recreational activities. As we have detailed in our prior work, including our recent report on BOP inmate deaths, when inmates are not appropriately monitored, the chance that they will engage in self-harm, violence, and other illicit activities increases.

We also found that Psychology Services Department and Education Department staffing shortages resulted in significant wait times for important mental health and rehabilitation programs, with waitlists often exceeding 500 names. For example, although BOP determined that more than 1,200 inmates needed programming to increase their ability to maintain employment upon release from prison, only 58 were enrolled in a vocational training program.

The body of our oversight work, including today's report, document serious issues at numerous Federal Bureau of Prisons institutions. These issues need to be addressed to ensure the safety and security of BOP employees, to provide humane living conditions for those in BOP's custody and care, and to provide inmates

the skills they need to successfully return to society. The OIG will continue to conduct aggressive oversight to make sure our recommendations are being implemented.

To read today's report and our prior BOP reports, and to see photographs of what we observed at the Sheridan prison, please visit our website, oig.justice.gov, or go to oversight.gov.

Thank you for joining me today.

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