



Capstone Review of the Federal Bureau of
Prisons' Response to the Coronavirus
Disease 2019 Pandemic



EVALUATION AND INSPECTIONS DIVISION

23-054

MARCH 2023



EXECUTIVE SUMMARY

Capstone Review of the Federal Bureau of Prisons' Response to the Coronavirus Disease 2019 Pandemic

Introduction

The Federal Bureau of Prisons (BOP) is responsible for the care, safekeeping, and subsistence of federal inmates, as well as for reentry programming to help them return to the community. The BOP houses inmates in BOP-operated federal prisons and, if certain conditions are met, in contracted Residential Reentry Center (RRC) facilities, commonly known as halfway houses, or in home confinement.

The coronavirus disease 2019 (COVID-19) pandemic created significant safety and staffing challenges for the BOP due to the high risk of COVID-19 spread among staff and inmates once it is introduced into a correctional facility. Since April 2020, the U.S. Department of Justice (Department, DOJ) Office of the Inspector General (OIG) has conducted substantial oversight of the BOP's response to the COVID-19 pandemic. The resulting body of work, which the OIG previously publicly released, includes remote inspections of 16 facilities housing BOP inmates completed during the early months of the pandemic, multiple [surveys](#) of BOP staff conducted at different times, and a collection of [interactive data dashboards](#) containing up-to-date information about COVID-19 within BOP facilities. The OIG is also completing analysis of its first survey of BOP inmates.

This capstone review summarizes our overall findings regarding the BOP's response to the COVID-19 pandemic, the issues we identified through our pandemic oversight work, the topics that have emerged following that work, the challenges that the BOP will likely continue to face during and after the pandemic, and actions that the BOP should undertake to prepare for future potential healthcare emergencies.

Recommendations

We make 10 recommendations to assist the BOP in managing challenges during and after the COVID-19

pandemic and in mitigating the effects of future public health emergencies.

Results of the Review

The COVID-19 pandemic has required the BOP to prevent and manage the spread of COVID-19 and protect inmate and staff health and safety, while adhering to changing guidance and communicating essential information to stakeholders. As of June 21, 2022, the BOP reported that there had been over 60,000 inmate cases and 13,000 BOP staff cases of COVID-19 since the beginning of the pandemic, as well as 296 inmate deaths and 7 BOP staff deaths. We identified several areas in which the BOP should take action to address ongoing challenges, improve existing processes whose weaknesses were highlighted during the pandemic, and better prepare for future public health emergencies.

The BOP Should Improve and Retain Effective Practices for Protecting Staff and Inmate Health and Safety During Public Health Emergencies

We found that BOP facilities used a variety of strategies to try to implement social distancing, quarantine, and medical isolation guidance, but were often limited by facility infrastructure and population size. We also identified several areas in which the BOP should improve its processes and identify long-term changes to better protect staff and inmate health and safety during a public health emergency.

First, the BOP should review its policies and processes on placing inmates in single cells given the serious failures we identified in the BOP's use of single cells during COVID-19 modified operations. The BOP reported to the OIG that seven inmates died by suicide from March 2020 through April 2021 while housed in single-cell confinement in quarantine units related to COVID-19. We found that numerous facilities single-celled inmates during COVID-19 modified operations despite BOP guidance stating that facilities should

avoid doing so to the greatest extent possible. Additionally, although BOP guidance stated that psychology staff should be consulted for inmates proposed for single-celling, we found that this did not occur for at least five of the seven single-celled inmates who died by suicide. The BOP's postmortem documentation indicated that all seven inmates had factors that made them vulnerable to suicide. Second, the BOP should explore permanent facility modifications to help it more easily implement future infection control measures.

Third, the BOP needs to assess how it can more effectively use its home confinement authorities. For example, the BOP did not fully utilize its authorities to help address inmate population issues at prisons with COVID-19 outbreaks and social distancing, quarantine, and staffing challenges. While the BOP transferred a substantial number of inmates from prisons to home confinement during the first few months of the pandemic, the BOP actually transferred fewer inmates during the first year of the pandemic than it had during the year immediately preceding the pandemic. We note that, due to the decreasing inmate population overall, the percentage of inmates transferred to home confinement was similar for both years. Additionally, we found that the BOP did not meet its facility population reduction goals at some minimum and low security facilities. Of the inmates who were transferred to home confinement during the first year of the pandemic, less than 2 percent failed to comply with program rules.

The BOP Should Take Appropriate Steps to Address Staffing Shortages and Staff Morale

We found that the COVID-19 pandemic exacerbated the effects of preexisting BOP medical and nonmedical staffing shortages, increased staff workloads, and impeded facilities' ability to fully respond to the pandemic. The pandemic also strained BOP staff morale. Staff reported experiencing stress or anxiety at work due to the pandemic and identified a need to improve communication between BOP leadership and staff. Staff expressed concerns about inconsistent or changing guidance regarding leave and when to quarantine. The BOP can improve how it communicates the available staff support options.

The BOP Should Improve Its Communication of Essential Information to Stakeholders

We identified a significant deficiency in the BOP's communication with inmates' families regarding COVID-19 related serious illnesses. Despite BOP policy

requiring facilities to "promptly" notify inmate families of a serious illness, we found that, in almost one-third of the 49 cases of COVID-19 related inmate deaths we reviewed, facilities took more than 3 days to try to notify families of the inmates' serious illness.

We also received numerous complaints about the BOP's communications with inmates, the public, and attorneys, despite the BOP's attempts to communicate proactively during the pandemic. We identified issues with the BOP's notifications to crime victims and limitations with its website data.

The BOP Should Provide Clear Guidance on the Use of Healthcare Protective Equipment and Compliance with Healthcare Safety Guidance

Our remote inspections identified numerous personal protective equipment (PPE)-related issues, perceived PPE shortages, and staff concerns and confusion about guidance on PPE and face coverings. While PPE supply stabilized and staff concerns and confusion decreased during the pandemic, in OIG surveys staff and inmates identified an issue with the inconsistent use of face coverings when social distance could not be maintained. Additionally, our remote inspections found that the BOP encountered challenges managing COVID-19 testing delays early during the pandemic. Long turnaround times when the market for testing supplies was burdened meant that inmates sometimes had to wait several days for test results, and some facilities did not properly follow quarantine guidance to manage the risk of COVID-19 transmission between inmates awaiting test results.

The BOP Should Respond to Ongoing Pandemic Challenges and Prepare for Future Public Health Emergencies

We found that aspects of the BOP's COVID-19 pandemic response evolved over time and that the BOP should capture lessons learned from its COVID-19 response. First, the BOP should continue to explore ways to safely accommodate inmate access to mental healthcare, programming, counsel, recreation, commissary, and communication options during extended modified pandemic operations. Second, to protect inmates and staff, the BOP should continue COVID-19 vaccine educational campaigns for inmates and ensure that inmates and staff have access to the vaccine. Finally, to prepare for future public health emergencies, the BOP should document best practices and lessons learned from its ongoing COVID-19 challenges related to its continued use of modified operations and vaccines.

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Introduction

Background

Coronavirus disease 2019 (COVID-19) is an infectious respiratory disease caused by the SARS-CoV-2 virus. COVID-19 was first identified in December 2019 and spread quickly, reaching the level of global pandemic by March 2020. By June 2022, there had been over 85 million confirmed cases of COVID-19 in the United States. The COVID-19 pandemic created challenges for the Federal Bureau of Prisons (BOP) as it worked to prevent and manage the spread of COVID-19 among its staff and the inmates in its custody. The Centers for Disease Control and Prevention (CDC) has noted that the confined nature of correctional and detention facilities, combined with their congregate environments, “heighten[s] the potential for COVID-19 to spread once introduced” into a facility. Federal inmates typically eat, sleep, and participate in activities in close proximity to one another in these facilities, which can include custody, housing, healthcare, food service, education, recreation, and workplace components in a single physical setting. As of June 21, 2022, the BOP reported that there had been over 60,000 inmate cases and 13,000 BOP staff cases of COVID-19 since the beginning of the pandemic, as well as 296 inmate deaths and 7 BOP staff deaths attributed to COVID-19.

In response to the COVID-19 pandemic, beginning in April 2020, the U.S. Department of Justice (Department, DOJ) Office of the Inspector General (OIG) began conducting intensive oversight of the BOP, including 16 remote inspections of facilities housing inmates in BOP custody completed within the first several months of the pandemic, 5 surveys of BOP staff and inmates conducted at various times, and a collection of interactive data dashboards reflecting staff and inmate COVID-19 cases and deaths in each BOP facility over time. During the inspections, we examined how the pandemic affected those facilities and assessed the steps BOP officials took to prepare for, prevent, and manage COVID-19 transmission within the facilities, as well as whether each facility’s policies and practices complied with BOP directives implementing CDC guidance and DOJ policy and guidance. In this capstone report, we highlight the BOP’s response to the pandemic, including an overview of the themes we identified during the remote inspections, other topics that emerged after those inspections, and challenges that the BOP will likely continue to face during and after the pandemic. This report seeks to assist the BOP in managing those challenges and mitigating the effects of future public health emergencies.

The Federal Bureau of Prisons

The BOP is responsible for the care, safekeeping, and subsistence of federal inmates as they serve their sentences of imprisonment, as well as for providing reentry programming to help them return to the community. When we began this review, the BOP housed inmates in its custody in three main facility types: BOP-operated federal prisons, privately operated (contract) prisons, and contracted Residential Reentry Centers (RRC). In this report, we use the phrase “facilities housing BOP inmates” to encompass all three facility types. In addition, the BOP has inmates in its custody who are serving their sentence of imprisonment in home confinement. Below, see Figure 1 for the number of inmates in each facility type and in home confinement in March 2020, 2021, and 2022.

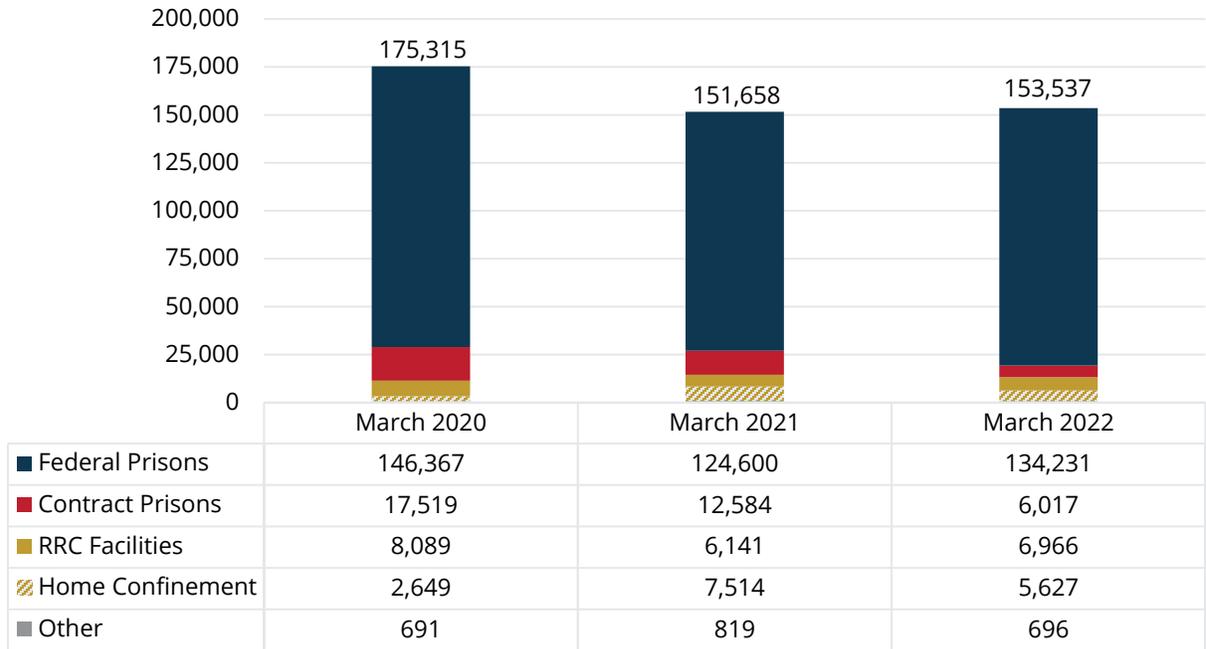
- **Federal Prisons:** The BOP currently operates 121 federal prisons (also called institutions) across the country.¹ The BOP designates its prisons at five security levels (minimum, low, medium, high, or administrative) based on a variety of infrastructure and security features. Thirty-nine of the prisons are located within 15 Federal Correctional Complexes, which encompass multiple facilities of different security levels in proximity. The BOP also assigns each prison a Care Level from 1 (Low) to 4 (High), based on the institution's level of medical or mental healthcare staffing and resources. BOP Health Services staff provide medical care for inmates in federal prisons.
- **Contract Prisons:** In March 2020, the BOP housed inmates at 12 contract prisons operated by 3 vendors. According to the BOP, the vast majority of federal inmates housed in contract prisons were criminal aliens or non-U.S. citizens subject to possible deportation. Contract prisons provided medical care to inmates inside the facilities. In January 2021, President Joseph R. Biden, Jr., signed Executive Order (E.O.) 14006 instructing the Attorney General not to renew DOJ contracts with private prisons.² The last contract ended on November 30, 2022. The BOP transferred inmates previously housed in contract prisons to federal prisons.
- **RRCs:** Commonly known as halfway houses, RRCs are contracted to supervise inmates who are generally nearing completion of their sentences and to help prepare them for their transition back into the community. RRCs supervise and provide reentry services for inmates assigned to both RRC facilities and home confinement. Inmates in both RRC facilities and home confinement are in BOP custody and are therefore included in the population totals in Figure 1 below. Between March 2020 and March 2022, the BOP maintained contracts for services at over 150 RRC facilities operated by over 75 different vendors nationwide. Unlike federal and contract prisons, RRC facilities do not offer in-house medical care; inmates receive care from community medical providers.

¹ This figure does not include Metropolitan Correctional Center (MCC) New York. In August 2021, the Department announced that it was closing MCC New York, at least temporarily, to assess steps to improve conditions at the facility.

² E.O. 14006 on [Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities](https://www.federalregister.gov/documents/2021/01/29/2021-02070/reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention-facilities), January 26, 2021, www.federalregister.gov/documents/2021/01/29/2021-02070/reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention (accessed November 10, 2022).

Figure 1

Annual Snapshots of the BOP's Inmate Population



Notes: Less than 1 percent of inmates in BOP custody are housed in other types of facilities, including contract juvenile facilities and jails or short-term detention facilities.

Source: OIG analysis of BOP public website data

As Figure 1 reflects, the overall BOP inmate population decreased substantially between March 2020 and March 2021. While we did not examine the specific causes, we note that there are likely several factors contributing to the decrease in BOP population. For example, the BOP's inmate population had already been decreasing each year since a peak in 2013 due to, among other things, various statutory and sentencing guidelines changes. There was also a substantial drop in the number of federal sentencings in fiscal year (FY) 2020 as the COVID-19 pandemic affected the work of the Department and the courts, resulting in far fewer arrests and convictions and therefore fewer people entering BOP custody.³ Additionally, there was an increase in compassionate release motions granted by the courts during FY 2020.⁴ The population decrease is unrelated to the increase in the number of inmates in home

³ U.S. Sentencing Commission, [2020 Annual Report and Sourcebook of Federal Sentencing Statistics](https://www.ussc.gov/sites/default/files/pdf/research-and-publications/annual-reports-and-sourcebooks/2020/2020-Annual-Report-and-Sourcebook.pdf), www.ussc.gov/sites/default/files/pdf/research-and-publications/annual-reports-and-sourcebooks/2020/2020-Annual-Report-and-Sourcebook.pdf (accessed November 16, 2022), 7, 48.

Bureau of Justice Statistics, [Federal Justice Statistics, 2020](https://bjs.ojp.gov/content/pub/pdf/fjs20.pdf), bjs.ojp.gov/content/pub/pdf/fjs20.pdf (accessed December 12, 2022), 4.

⁴ U.S. Sentencing Commission, [Compassionate Release: The Impact of the FIRST STEP Act and COVID-19 Pandemic](https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2022/20220310_compassionate-release.pdf) (March 2022), www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2022/20220310_compassionate-release.pdf (accessed November 16, 2022), 3.

confinement during that same period because, as mentioned above, an inmate transferred to home confinement remains in the BOP's custody.

The increase in the number of inmates in home confinement between March 2020 and March 2021 shown in Figure 1, as we discuss in greater detail in the [Results of the Review](#), was not due to an overall increase in the number of inmates transferred from BOP facilities to home confinement. Rather, our analysis showed that fewer inmates were transferred from BOP facilities to home confinement from April 2020 through March 2021 than were transferred during the prior year (April 2019 through March 2020). We found that, as described below, the increase was most likely attributable to the fact that inmates were spending longer amounts of time in home confinement as a result of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), passed by Congress in March 2020, which allowed the BOP to transfer inmates to home confinement with more time remaining on their sentences than allowed under its regular home confinement authorities, which we discuss below. The CARES Act also allowed prerelease inmates who had been placed in RRCs to be transferred from RRCs to home confinement earlier than under the BOP's standard prerelease process. Eligible inmates residing in RRC facilities whom the BOP transferred to home confinement increased the home confinement population while decreasing the number of inmates residing in RRC facilities.

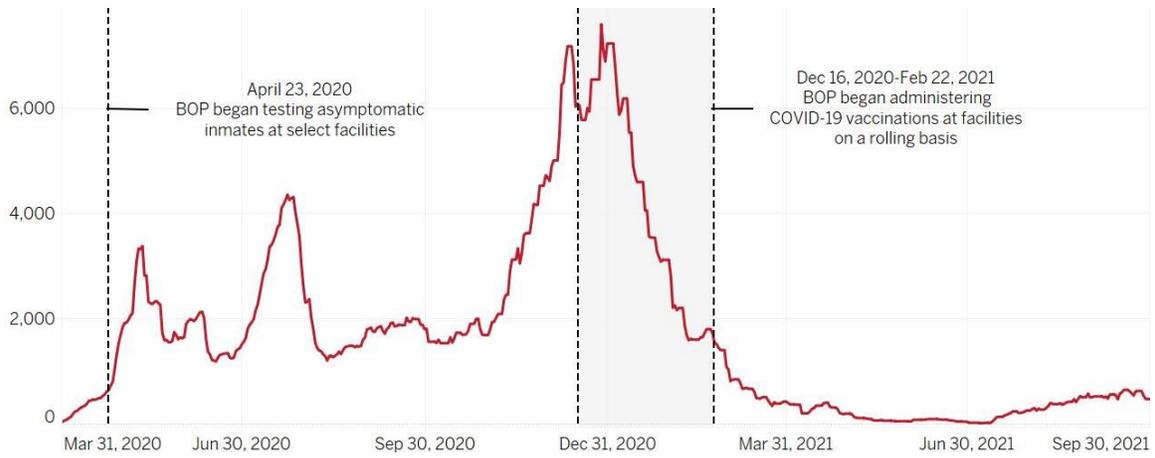
COVID-19 at Facilities Housing BOP Inmates

As mentioned above, the COVID-19 pandemic created significant challenges for the BOP in preventing and managing the spread of COVID-19 among its staff and the inmates in its custody. In its 2023 Congressional Budget Submission, the BOP reported that there had been over 60,000 inmate cases of COVID-19 since March of 2020. According to data presented on the BOP website, as of January 26, 2023, 131 federal inmates and 130 BOP staff at BOP-managed facilities and RRCs had confirmed positive test results (active cases); 46,559 inmates and 14,990 staff had recovered from the disease; and there had been 312 inmate and 7 staff deaths attributed to COVID-19.⁵ Also as of January 26, 2023, the BOP reported that 55,283 inmates in its custody at that time had received a positive COVID-19 test result at some point. Figures 2 and 3 below show the number of inmate and staff active COVID-19 cases at BOP facilities from March 31, 2020, through September 30, 2021.

⁵ "Active cases" includes open and lab-confirmed cases of COVID-19 contracted by inmates or staff in BOP custody or employment. Once someone has recovered or died, that individual is no longer considered an active case. "Recovered" reflects the number of inmates or staff in BOP custody or employment but does not include inmates who had been released or staff who had left BOP employment. Because of these definitions, the number of active and recovered cases is lower than the total cases reported by the BOP in its 2023 Congressional Budget Submission. We discuss limitations of the data posted on the BOP's website in the report section [The BOP's Transparency and Communication with the Public](#).

Figure 2

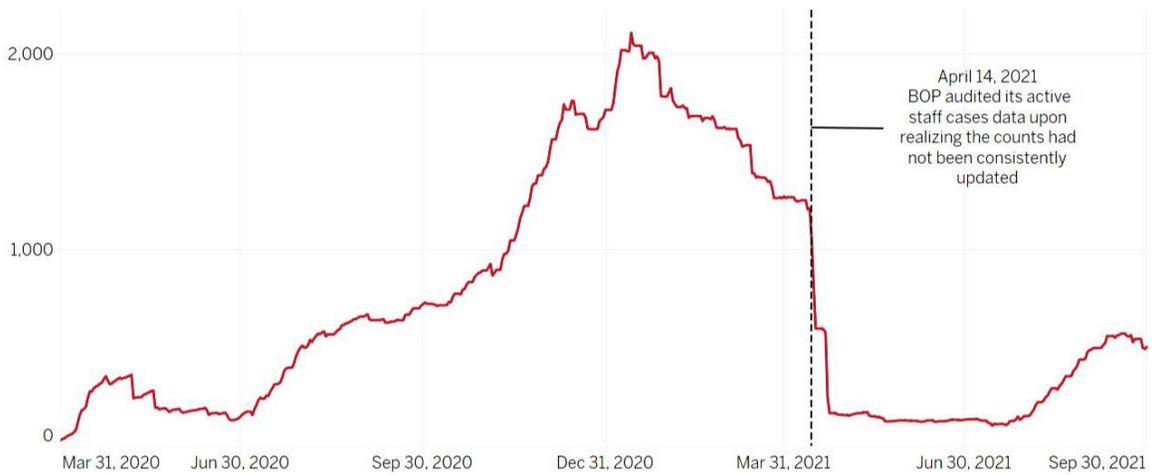
Number of Inmate Active Cases in BOP Facilities, March 31, 2020–September 30, 2021



Source: OIG Office of Data Analytics visualization of data collected from the BOP's public website

Figure 3

Number of Staff Active Cases in BOP Facilities, March 31, 2020–September 30, 2021



Source: OIG Office of Data Analytics visualization of data collected from the BOP's public website

The OIG's COVID-19 Oversight of the BOP

Between April and June 2020, the OIG conducted remote inspections of 16 facilities housing BOP inmates: 11 BOP-managed federal prisons, 3 privately managed contract prisons, and 2 contracted RRCs.⁶ The inspections examined how the pandemic affected each facility; the steps that the BOP took to prepare for, prevent, and manage COVID-19 transmission; and whether each facility's policies and practices complied with BOP directives implementing CDC guidance and DOJ policy and guidance.

Between April 2020 and April 2021, the OIG conducted five surveys to gauge staff and inmate experiences during the pandemic. In April and May 2020, we conducted three surveys (BOP federal staff, contract prison staff, and RRC staff) to collect information on staff concerns, effects, and immediate needs at the outset of the pandemic; we included facility-specific survey results in each of the 15 remote inspection reports. In February 2021, we conducted a follow-up survey of staff working at the BOP's federal prisons to collect staff perspectives on how their respective institutions were managing the pandemic; we presented those survey results in an [interactive web-based product](#).⁷ In March and April 2021, the OIG conducted a novel survey of federal inmates to understand their experiences during the pandemic. After receiving responses from 25,504 inmates, we applied statistical weighting techniques to generate results that represent 123,219 (or 97.5 percent) of the inmates held in BOP-operated facilities at the time of the survey launch.⁸ Table 1 below presents the number of responses and response rates to the five OIG surveys of BOP staff and inmates.

⁶ The OIG published 15 reports for the 16 remote inspections; the results of the inspections of two nearby institutions are in a single report.

⁷ See DOJ OIG, "[Staff Perceptions of the Federal Bureau of Prisons' Management of the Coronavirus Disease 2019 Pandemic: A Follow-up Survey of BOP Staff](#)," February 2021, experience.arcgis.com/experience/582f32f0127c4c86870b2e129c05b9bc.

⁸ Because we applied statistical weights, we refer to the *estimated percentage of inmates* rather than the percentage of respondents when referencing inmate survey analysis in this report. We plan to present additional results from the inmate survey in an interactive, web-based product.

Table 1

OIG Surveys Issued to BOP Staff and Inmates, April 2020–April 2021

	Invitations Sent	Open Period	Response Rate	Total Responses
Surveys Issued to Staff				
Federal Prison Staff (All Staff)	38,651	April 21–29, 2020	28%	10,735
Contract Prison Staff	2,689	May 1–11, 2020	29%	774
Contract RRC Staff	1,514	May 5–12, 2020	26%	395
Total Staff Responses to 2020 Surveys				11,904
Federal Prison Staff (institution only)	34,925	February 2–17, 2021	19%	6,578
Survey Issued to Inmates				
Federal Inmates in BOP-Operated Facilities	126,379	March 28–April 27, 2021	20%	25,504

Source: OIG surveys

The OIG also used multiple data sources to better understand trends across facilities housing and monitoring inmates. We collected data on BOP staff and inmate COVID-19 cases and deaths, inmate testing, vaccination efforts, home confinement, and modified operations that the BOP posted on its public website. The OIG published and maintains a collection of [interactive dashboards](#) of BOP staff and inmate COVID-19 cases and deaths and inmate testing over time, as well as estimated inmate vaccination percentages.⁹ (The text box below lists our COVID-19 oversight work for the BOP.)

Lastly, we received complaints sent to the [OIG Hotline](#) by individuals with concerns about the BOP’s handling of the pandemic, including inmates, their attorneys, friends and family, and BOP staff.¹⁰ We analyzed 3,190 complaints received from February through September 2020 to identify trends; we did not substantiate or assess the validity of each complaint.

⁹ DOJ OIG, “[Interactive Dashboards Relating to COVID-19 within the Federal Bureau of Prisons](#),” experience.arcgis.com/experience/ab22fb4c564e4f4b986e257c685190e8/page/page_0/.

¹⁰ If you know about waste, fraud, abuse, misconduct, or whistleblower retaliation within DOJ, you may report it to the [OIG Hotline](#), oig.justice.gov/hotline.

Scope and Methodology

In this capstone review, we highlight the BOP's response to the COVID-19 pandemic, present an overview of the themes we identified across the remote inspections and surveys described above, discuss topics that emerged following that work, and identify challenges that the BOP will likely continue to face during and after the COVID-19 pandemic. This report seeks to assist the BOP in managing those challenges and mitigating future effects of public health emergencies within its facilities. In addition to the remote inspections and surveys that we began in April 2020, from June 2020 through May 2022 we conducted additional fieldwork, which consisted of document reviews, data analysis, and additional interviews. We analyzed applicable policies and guidance in place through November 2021. Due to the summary nature of this product, the scope of the fieldwork for individual topics and sources varies but generally extends no later than the end of FY 2021. See [Appendix 1](#) for a more detailed description of the review methodology. See [Appendix 2](#) for a summary of previous OIG reviews of the BOP that relate to the topics discussed in this review.

The BOP's COVID-19 Response

In January 2020, the BOP began planning its response to reduce the transmission of COVID-19 in facilities housing BOP inmates. The BOP also established an Incident Command Center to centrally manage its COVID-19 response; published guidance for BOP facilities and other facilities housing BOP inmates; modified its inmate management system, SENTRY, to collect new COVID-19 data from each prison; and established a centralized process for collecting data to be published on the BOP's public website.

COVID-19 Guidance

CDC and BOP guidance on how to prevent and manage COVID-19 evolved over the pandemic in response to improved scientific understanding of the disease and the scale of the outbreak in the United States. BOP physicians and other officials consulted with the CDC early during the pandemic and continued working closely with the CDC throughout the pandemic, basing the BOP's COVID-19 guidance on CDC guidelines. BOP managers and medical officials emphasized to us that they based their COVID-19 management strategy on the CDC's evidence-based recommendations, which evolved quickly as the CDC and medical community learned more about the novel virus. As the CDC modified its guidelines for the general public, and subsequently for

Remote Inspections

Federal Institutions

1. [FCC Lompoc](#)
2. [FCC Tucson](#)
3. [MDC Brooklyn](#)
4. [FCC Oakdale](#)
5. [FCC Pollock](#)
6. [FMC Fort Worth](#)
7. [FCC Coleman](#)
8. [FCI Terminal Island](#)
9. [FCC Butner](#)
10. [FCI Milan](#)
11. [MCC Chicago](#)

Contract Prisons

12. [CI Dalby](#)
13. [CI McRae](#)
14. [CI Moshannon Valley](#)

Residential Reentry Centers

15. [Brooklyn House](#)
16. [Toler House](#)

Staff and Inmate Surveys

Staff Surveys

- April 2020 BOP Federal Staff Survey
- May 2020 Contract Prison Staff Survey
- May 2020 RRC Staff Survey
- [February 2021 BOP Staff Survey](#)

Inmate Survey

- April 2021 BOP Inmate Survey

Dashboards of BOP COVID-19 Data

The OIG maintains a public collection of [interactive dashboards](#) of BOP staff and inmate COVID-19 cases and deaths and inmate testing data over time.

Key: CI=Correctional Institution; FCC=Federal Correctional Complex; FCI=Federal Correctional Institution; FMC=Federal Medical Center; MCC=Metropolitan Correctional Center; MDC=Metropolitan Detention Center

correctional settings, the BOP progressively updated guidance to the facilities housing federal inmates. To ensure maximum consistency in virus control measures, BOP Central Office officials directed Wardens to follow CDC and BOP guidance. On March 23, 2020, the CDC issued interim guidance to provide guiding principles for healthcare and non-healthcare administrators of correctional and detention facilities, noting that modifications based on a facility's individual structure and resources may be needed.¹¹ The BOP worked with the CDC to develop the CDC's interim guidance, and the BOP's guidance to its federal and contract prisons mirrored this guidance.

In late August 2020, the BOP began issuing consolidated guidance in its COVID-19 Pandemic Response Plan, which includes 11 modules on topics such as infection prevention and control measures; screening and testing; inmate programming and services; and BOP employee, volunteer, and contract staff management. The BOP posted the COVID-19 Pandemic Response Plan on its intranet for staff to reference and continued to update it throughout 2020, 2021, and 2022 based on guidance from stakeholders, including the CDC and DOJ; the BOP intends to continue updating the plan as the CDC updates its COVID-19 guidance. See [Appendix 3](#) for more information on the BOP's guidance to federal prisons, contract prisons, and RRCs.

Modified Operations and Social Distancing

The BOP implemented modified operations intended to help mitigate the spread of COVID-19 and implement social distancing inside BOP facilities. In its March 13, 2020 Phase Two Action Plan, the BOP announced that it was suspending inmates' in-person social and legal visits, stopping nonmedical inmate transfers, canceling staff travel and training, restricting contractors' and volunteers' access to BOP facilities, and requiring Wardens to modify operations to maximize social distancing by staggering inmates' meal and recreation times. In its March 31, 2020 Phase Five Action Plan, the BOP began requiring inmates to remain in their cells or housing units for extended periods based on health concerns. Some facilities described this action as a "Shelter in Place" or a similar term to distinguish it from a punitive lockdown. These movement and gathering restrictions remained in place until the BOP's August 5, 2020 Phase Nine Action Plan instructed inmate programming, including residential programs and Evidence-based Recidivism Reduction Programs and Productive Activities, to resume with social distancing modifications; instructed the resumption of outdoor recreation time, not including group sports or use of gym equipment; and instructed Wardens to develop safety plans to restore UNICOR operations to 80 percent capacity by September 1, 2020, and to 100 percent by October 1, 2020.¹² The BOP's August 31, 2020 Modification of Phase Nine Action Plan provided guidance for the safe resumption of in-person social visits at facilities. The BOP's Phase Two Action Plan measures were initially scheduled to last 30 days, and the Phase Five Action Plan referenced the enactment of a 14-day nationwide action to minimize movement to decrease the spread of the virus. The BOP extended most of these measures multiple times until November 2020, when they were extended until further notice.

¹¹ CDC, "[Interim Guidance on Management of Coronavirus Disease 2019 \(COVID-19\) in Correctional and Detention Facilities](https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html)," March 23, 2020 (updated May 3, 2022), www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (accessed July 11, 2022).

¹² Federal Prison Industries, called UNICOR, is a government corporation within the BOP that offers work opportunities and job training for inmates at federal prisons throughout the United States.

In August 2021, the BOP moved to a Modified Operations Matrix Plan that provided guidance on how facilities should modify their operations based on the individual facilities' COVID-19 medical isolation rates, percentages of staff and inmates who had completed a COVID-19 vaccination series, and the local county transmission rates of COVID-19.¹³ The BOP's public website provided updates on facilities' operational levels on a scale of Level 1 to Level 3, with guidance for Level 1 facilities to generally follow normal operations and Level 3 facilities to implement more restrictive COVID-19 related modifications. Under this Modified Operations Matrix Plan, the BOP also provided guidance for general COVID-19 modifications to all facilities regardless of their operational levels. In November 2022, the BOP removed from its Modified Operations Matrix Plan the direction that facilities consider staff and inmate vaccination rates as indicators for modified operations; the BOP's Modified Operations Matrix Plan, as reflected in its November 30, 2022 COVID-19 Pandemic Response Plan, directed facilities to consider two primary factors in modifying operations: facility COVID-19 medical isolation rates and COVID-19 community risk.

Personal Protective Equipment and Cloth Face Coverings

The BOP issued its first consolidated guidance on the use of personal protective equipment (PPE) in specific COVID-19 scenarios on March 18, 2020, and updated it several times as the pandemic progressed.¹⁴ The BOP issued guidance on the use of cloth face coverings on April 6, 2020. The BOP disseminated its PPE instructions to staff via email and made them available on its employee intranet. Beginning in August 2020, the BOP also updated its PPE and face covering guidance in versions of its COVID-19 Pandemic Response Plan posted to its employee intranet. The BOP's PPE and cloth face covering instructions mirrored CDC recommendations on using PPE in correctional facilities and cloth face coverings where social distancing is difficult to maintain (see the text box). These instructions identified three types of protection for an individual's nose and mouth and described the situations in which each type of protection should be used:

CDC Definitions

PPE: a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with infectious agents. Depending on the situation, PPE may include gloves, surgical masks, N95 respirators, goggles, face shields, and gowns.

Cloth Face Coverings: items fashioned from common materials or household items that are intended to keep the wearer from spreading respiratory secretions when talking, sneezing, or coughing. The CDC does not consider cloth face coverings to be PPE.

Source: CDC

- **N95 Respirators:** Tight-fitting masks that filter out at least 95 percent of airborne particles and provide the wearer with respiratory protection. The BOP's instructions advised that N95 respirators were for use by staff working on units with inmates in medical isolation, staff present when inmates received certain medical procedures, and staff in close contact with an inmate suspected of or confirmed with COVID-19. The BOP's March and April 2020 guidance, which followed CDC guidance,

¹³ Isolation is used to separate people who have a confirmed or suspected case of COVID-19 from people who are not infected to prevent contact and reduce the risk of transmission. In a correctional setting, the CDC recommends using the term "medical isolation" to distinguish the isolation from punitive action. See CDC, "Interim Guidance."

¹⁴ Prior to March 18, the BOP's Action Plans recommended PPE for individuals in close contact with someone diagnosed with COVID-19 and for people performing temperature screenings. The guidance also recommended educating staff about how to correctly put on and take off PPE.

noted that N95 respirators were in short supply and permitted the use of surgical masks in certain situations if no N95s were available.

- **Surgical Masks:** Loose-fitting, fluid-resistant masks that protect the wearer against large droplets, splashes, or sprays of bodily or other hazardous fluids and protect others from the wearer's respiratory emissions but do not provide the wearer with respiratory protection. Surgical masks are for use by staff working in quarantine units, as well as inmates in medical isolation or quarantine. The BOP's October 2020 update to its COVID-19 Pandemic Response Plan states that staff should also wear surgical masks when providing routine health services to inmates and performing staff screening and temperature checks.
- **Cloth Face Coverings:** Reusable nose and mouth coverings made of cloth worn to help reduce the spread of COVID-19 by asymptomatic persons. Pursuant to CDC guidelines, the BOP does not consider cloth face coverings to be PPE. Rather, they are for use by staff and inmates in all areas of the facility other than medical isolation or quarantine units. The BOP's April 6, 2020 guidance advised that UNICOR was manufacturing cloth face coverings for all facilities and the BOP would issue all staff and inmates three cloth face coverings for personal use. In an email to all staff on April 15, 2020, the BOP mandated that "all BOP staff and inmates will wear face coverings provided by [the BOP]." On August 24, 2020, the BOP issued a memorandum stating that facility staff are required to wear facility-approved face coverings at work when social distancing is not possible and in common areas. When the BOP moved to its Modified Operations Matrix Plan in August 2021, staff and inmates were instructed to wear cloth face coverings according to the instructions for their facility's modified operations level.

Medical Isolation and Quarantine

Medical isolation and quarantine are measures that help prevent the spread of COVID-19 (see the text box). Throughout the pandemic, BOP facilities ideally had a variety of physically separate quarantine and medical isolation spaces: medical isolation for inmates with confirmed COVID-19, medical isolation for inmates with suspected COVID-19, quarantine for close contacts of those with confirmed or suspected COVID-19, quarantine for incoming inmates, and quarantine for outgoing inmates. For more detailed information on the BOP's early use of medical isolation and quarantine as part of its approach to COVID-19, see [Appendix 4](#).

CDC Definitions

Medical Isolation: confinement of an individual with a confirmed or suspected COVID-19 case to prevent contact with others and to reduce the risk of transmission.

Quarantine: confinement of an individual who has had close contact with a COVID-19 case to determine whether that individual develops symptoms of the disease.

Source: CDC

COVID-19 Testing

Viral COVID-19 testing is used to diagnose or screen individuals for current infection with SARS-CoV-2, the virus that causes COVID-19. The BOP's protocols surrounding COVID-19 testing evolved over the pandemic and with changes in CDC recommendations, availability of tests, and COVID-19 outbreaks in facilities housing BOP inmates. (See [Appendix 5](#) for more detailed information on factors that affected the BOP's testing protocols.) As a result, COVID-19 testing at facilities housing BOP inmates also evolved:

- **Testing at Federal Prisons:** The BOP's initial guidance on COVID-19 testing mirrored the CDC's guidance and limited testing to only *symptomatic* inmates consistent with local health authority protocols. In late April 2020, the BOP announced that it had acquired rapid test equipment and that it would begin to expand testing of *asymptomatic* inmates to "assist the slowing of transmission [by] isolating those individuals who test positive and quarantining contacts." However, due to equipment availability, it took several weeks for all BOP facilities to receive rapid test machines and test kits. On May 19, the BOP published guidance identifying high, intermediate, and low testing priorities for facilities that were limited in the number of tests they could conduct. As access to testing supplies stabilized over the following months, the BOP again expanded its testing strategies. On September 28, the BOP identified indications for testing both symptomatic and asymptomatic inmates and noted that facilities should consult with BOP medical officials to prioritize testing if a facility's ability to test was limited.
- **Testing at Contract Prisons:** Contract prisons received the same BOP guidance on testing as part of the BOP's Action Plans issued between March and October 2020. Like the federal prisons, all contract prisons housing BOP inmates acquired rapid testing equipment for COVID-19.
- **Testing at RRCs:** The RRC contractual model relies on community providers for inmate healthcare, including medical tests, so COVID-19 testing was not directly provided at these types of facilities. Instead, inmates at RRC facilities and in home confinement under RRC supervision relied on testing resources in the local community.

COVID-19 Vaccination

Both the CDC and the BOP have identified COVID-19 vaccination as an important tool for controlling the spread of the virus and reducing serious illness and death from COVID-19. According to the CDC, COVID-19 vaccines reduce the risk of COVID-19, including the risks of serious illness and death among people who are fully vaccinated, and can reduce the spread of disease, which helps protect those who get vaccinated and the people around them. As of January 2022, there were three COVID-19 vaccines authorized or approved for adults in the United States.

In November 2020, the BOP began planning for the distribution of COVID-19 vaccines for staff and inmates in federal prisons. The BOP developed a vaccine task force and worked in partnership with Operation Warp Speed, a government-led public-private partnership between various entities to facilitate and accelerate the development, manufacturing, and distribution of the vaccine across the United States. The BOP also worked with the CDC, developing a memorandum of agreement to receive and administer the vaccines at no cost to the BOP. The BOP first offered the COVID-19 vaccine to full-time staff due to the risk of possible introduction of the virus by staff traveling between BOP facilities and the community. The BOP distributed remaining doses of the vaccine to inmates based on priority levels determined by its COVID-19 Vaccine Guidance, which outlines four priority levels for vaccinating inmates in federal facilities. These levels prioritized inmates in certain jobs and housing situations, inmates 65 years and older, and inmates with underlying medical conditions as eligible to receive the vaccine first.

The BOP offered all staff and federal inmates the vaccine on a voluntary basis. In September 2021, an Executive Order required COVID-19 vaccination for all federal employees subject to exemptions as required

by law.¹⁵ Federal inmates are not required to receive the COVID-19 vaccine, and the BOP told us that historically inmate vaccinations are not required unless court ordered. Inmates and staff located at RRCs and contract prisons (when they were in operation) are referred to community resources, such as state and local health departments, to receive COVID-19 vaccinations. Inmates housed at RRCs and contract prisons were not part of the total CDC allotments of the vaccines distributed to the BOP under the current memorandum of agreement.

Home Confinement

BOP inmates with less than 12 months remaining on their sentences are typically eligible for transfer to an RRC, and some of these RRC-eligible inmates are permitted to complete the final portion of their sentences (10 percent or 6 months, whichever is shorter) in home confinement, under the supervision of an RRC or the U.S. Probation Office per 18 U.S.C. § 3624(c)(2).¹⁶ Additionally, under the FIRST STEP Act of 2018 (FSA), inmates age 60 or older are eligible for home confinement for the last third of their sentences and terminally ill inmates are eligible for longer periods of home confinement if they meet certain additional eligibility criteria.¹⁷ Inmates on home confinement are still in federal custody. They may work and participate in approved activities but must otherwise remain at home. Inmate compliance with these conditions is monitored through electronic monitoring equipment or regular contact with supervisory staff, in person or by telephone. An inmate's failure to remain at approved locations, return at required times, or otherwise follow the program rules may result in disciplinary action, including return to a BOP facility.

In a March 26, 2020 memorandum, then Attorney General William P. Barr directed the BOP to prioritize the use of its existing statutory authorities to grant home confinement, described above, and provided a non-exhaustive list of factors for the BOP to consider when assessing inmates for home confinement placement.

CARES Act Home Confinement

On March 27, 2020, one day after then Attorney General Barr's memorandum, the CARES Act was signed into law, authorizing the BOP Director to lengthen the maximum amount of time under 18 U.S.C. § 3624(c)(2) that an inmate may be placed in home confinement "if the Attorney General finds that emergency conditions will materially affect the functioning of the [BOP]."¹⁸ Barr made such a finding in an April 3, 2020 memorandum, in which he directed the BOP to "immediately maximize appropriate transfers to home confinement of all appropriate inmates" at those facilities "where COVID-19 is materially affecting

¹⁵ E.O. 14043 on [Requiring Coronavirus Disease 2019 Vaccination for Federal Employees](https://www.federalregister.gov/documents/2021/09/14/2021-19927/requiring-coronavirus-disease-2019-vaccination-for-federal-employees), September 9, 2021, www.federalregister.gov/documents/2021/09/14/2021-19927/requiring-coronavirus-disease-2019-vaccination-for-federal-employees (accessed November 10, 2022).

¹⁶ According to the BOP, the U.S. Probation Office monitors a small percentage of BOP inmates on home confinement through a program called Federal Location Monitoring. Participation is contingent on whether the U.S. Probation Office accepts the BOP's home confinement referral. Most inmates on home confinement are monitored by an RRC.

¹⁷ See 34 U.S.C. § 60541(g). The FSA reauthorized and modified a pilot program for eligible elderly and terminally ill offenders that was conducted under the Second Chance Act of 2007. Eligibility criteria ruled out inmates who had been convicted of crimes of violence, sex offense, terrorism, or espionage; had a history of escape or attempted escape; or posed a substantial risk to the public or of criminal conduct if granted home confinement.

¹⁸ Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136.

operations.”¹⁹ This finding expanded the pool of inmates who could be considered for home confinement by allowing the BOP to consider inmates for placement earlier than they would have been eligible otherwise.²⁰

The CARES Act did not specify what should happen to inmates on CARES Act home confinement after the pandemic ends. In January 2021, the DOJ Office of Legal Counsel published an initial opinion stating that the BOP would be required to recall inmates currently on home confinement to BOP facilities after the COVID-19 emergency period ends unless the inmates are otherwise eligible for home confinement under 18 U.S.C. § 3624(c)(2).²¹ That would have meant that only inmates with less than 6 months or 10 percent of their sentence remaining would have been allowed to remain in home confinement and the BOP would have had to return inmates who did not meet those eligibility requirements to BOP facilities at the end of the pandemic. The Office of Legal Counsel reversed this opinion on December 21, 2021, concluding that the CARES Act language and the BOP’s preexisting home confinement authorities give the BOP discretion to permit inmates in extended home confinement to remain there after the COVID-19 emergency period ends. In June 2022, the Department published a regulatory proposal consistent with the December 21, 2021 Office of Legal Counsel opinion.

Comparison of Home Confinement to Compassionate Release

Under the federal compassionate release statutes, 18 U.S.C. § 3582(c)(1)(A) or 18 U.S.C. § 4205(g), as applicable, the BOP or an inmate may request that a federal judge reduce the inmate’s sentence for “extraordinary and compelling reasons,” such as age, terminal illness, other physical or medical conditions, or family circumstances.²² Home confinement and compassionate release authorities have different eligibility criteria, approval processes, and decision makers, all of which we summarize in [Appendix 6](#). A primary difference is that, while home confinement allows an inmate to serve a portion of his or her sentence at home while still in BOP custody, compassionate release generally ends an inmate’s sentence early. Additionally, while home confinement authorities were expanded by the CARES Act and through the Attorney General’s memoranda, compassionate release authorities were not expanded. When responding to compassionate release motions filed by inmates with the courts, the Department’s position has been that the risk of contracting COVID-19 alone is not an “extraordinary and compelling circumstance” warranting

¹⁹ William P. Barr, Attorney General, memorandum for Director of Bureau of Prisons, [Increasing Use of Home Confinement at Institutions Most Affected by COVID-19](#), April 3, 2020, www.justice.gov/file/1266661/download (accessed July 11, 2022), 1.

²⁰ The OIG is conducting a separate review of the BOP’s use of home confinement as a response to the COVID-19 pandemic. That review is assessing the BOP’s processes for implementing its home confinement authorities under the CARES Act, considering the eligibility criteria outlined in the Attorney General’s memoranda, and evaluating Wardens’ recommendations for inmates who did not meet the Attorney General’s criteria to be placed in home confinement.

²¹ The then President declared the COVID-19 pandemic a national emergency on March 13, 2020. Under the CARES Act, the expanded home confinement authority will end “30 days after the date on which the national emergency declaration terminates.”

²² 18 U.S.C. § 3582(c)(1)(A) is applicable for inmates whose offenses occurred on or after November 1, 1987. 18 U.S.C. § 4205(g) was repealed effective November 1, 1987, but remains the controlling law for inmates whose offenses occurred prior to that date.

compassionate release.²³ Although 13 of our 15 remote inspection reports briefly discuss the compassionate release requests the respective facilities received during the first several weeks of the pandemic, we do not examine compassionate release requests and outcomes in this capstone report.

²³ See, for example, Response by the United States in Opposition to Defendant's Emergency Motion for Immediate Reduction of Sentence at 13-17, *United States of America v. Saad*, No. 16-cr-20197 (E.D. Mich. 2020), and Government's Response to Defendant's Motion for Compassionate Release at 9-11, *United States of America v. Franco*, No. 14-10205-01-EFM (D. Kan. 2020).

Results of the Review

The COVID-19 pandemic required the BOP to adapt to unique challenges in trying to prevent and manage the spread of COVID-19 and protect inmate and staff health and safety while adhering to changing guidance and communicating essential public health information to stakeholders. Our remote inspections, staff and inmate surveys, and review of other BOP information identified several areas in which the BOP should take action to better prepare for future public health emergencies and improve and address existing processes whose weaknesses, and in some cases failures, were highlighted during the pandemic. We identified particularly serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance on the single-celling of inmates during modified operations and their handling of inmates vulnerable to suicide while quarantined due to COVID-19. These findings, coupled with prior OIG findings regarding the mental health effects of the BOP's placement of inmates in single cells for extended periods of time, led us to conclude that the BOP should undertake a comprehensive review of its policies regarding the single-celling of inmates.

We also found that medical and nonmedical staffing shortages at a number of BOP facilities had predictable and significant ramifications on their ability to respond effectively to the pandemic. We determined that the BOP should take steps to address its staffing shortages, as well as staff morale issues that arose during the pandemic, and that it also needs to improve its processes for communicating essential information to stakeholders and correct a significant deficiency that we identified regarding its notification to families about inmates' COVID-19 related serious illnesses.

Further, we found that the BOP should improve certain processes to mitigate the risk of infection transmission inside facilities and protect the health of staff and inmates while also retaining best practices to prepare for future pandemics. Among the challenges that we found the BOP faced during the COVID-19 pandemic was the limitation on its ability to maintain social distancing in many of its prisons and to ensure that there was sufficient space to appropriately medically isolate inmates who had COVID-19 symptoms, quarantine those who had been exposed to inmates with symptoms, and quarantine incoming and outgoing inmates. Yet, despite these challenges, our remote inspections concluded that, at a number of facilities, the BOP did not fully leverage the home confinement authorities that it was given in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that could have permitted facilities to reduce their inmate population and thereby assist in mitigating COVID-19 transmission and improve inmate-to-staff ratios. Indeed, we found that, overall, the number of inmates whom the BOP transferred from facilities to home confinement was lower during the first year of the pandemic (April 2020 through March 2021) compared to the prior year, though we note that, due to the decreasing inmate population overall, the percentage of inmates transferred to home confinement was similar for both years. We determined that the BOP should assess how lessons learned related to the use of its home confinement authorities during the COVID-19 pandemic could apply to future public health emergencies and that it should monitor the challenges that can arise related to a significant increase in home confinement use.

Finally, we identified several other areas that the BOP should address, including inmate access to counsel and other essential services during emergency or modified operations, as well as taking additional actions to better prepare for potential future public health emergencies.

The BOP Should Improve and Retain Effective Practices for Protecting Staff and Inmate Health and Safety During Public Health Emergencies

Throughout the COVID-19 pandemic, to protect staff and inmate health and safety, the BOP needed to adapt to unique challenges in trying to prevent and manage the spread of COVID-19 in its facilities and in contract facilities housing BOP inmates. We found that some related BOP processes must be reassessed or require further improvements to better protect the health and safety of inmates and staff. For example, we identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance regarding the single-celling of inmates during modified operations and found that the BOP's existing practices were not sufficient to protect inmates vulnerable to suicide while quarantined due to COVID-19. The BOP should comprehensively review existing policies and processes on single-cell confinement, as well as those designed to protect inmates vulnerable to suicide. Additionally, we found that the BOP should ensure that it captures lessons learned during the pandemic. Identifying and retaining best practices for inmate social distancing, quarantine, and medical isolation, especially those that address space and infrastructure limitations, by incorporating them into standard operations and pandemic contingency plans will help the BOP respond effectively to future public health emergencies. Assessing how lessons learned in the BOP's use of home confinement during the pandemic could apply to other public health emergencies could also help the BOP respond more effectively in the future.

The BOP Should Ensure that Its Processes Prevent Inappropriate Single-Cell Assignments and Protect Inmates Vulnerable to Suicide When Quarantined

The BOP reported to the OIG that from March 2020 through April 2021 seven inmates died by suicide while housed in single-cell confinement in quarantine units related to COVID-19. Our review identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance regarding the single-celling of inmates during modified operations. One provision of the BOP guidance stated that facilities should limit single-celling of inmates (i.e., housing inmates alone in cells) to the greatest extent possible when inmates were confined to their cells during COVID-19 related modified operations. Contrary to this provision, we found that inmates in numerous BOP facilities were single-celled during periods when the facilities were in COVID-related modified operations.

An additional provision of the March 2020 guidance advised facilities that Psychology Services staff should be consulted regarding any inmates proposed for single-celling to assess whether they were vulnerable inmates. Yet, we found that psychology staff did not assess the suitability of single-cell assignments for at least five of the seven inmates who died by suicide prior to their single-cell placement. Further, postmortem documentation indicated that all seven inmates had factors that made them vulnerable to suicide. According to internal BOP documentation, a single-cell environment may afford an inmate greater privacy and increased opportunity to effectuate their death by suicide. We also noted that the BOP has had ongoing challenges with the use of single-cell confinement. Our 2017 report on the BOP's use of restrictive housing for inmates with mental illness noted that single-celling may present risks to inmate mental health,

and both of our recommendations from that report regarding the use and oversight of single-celling remained open as of February 2023.²⁴

Guidance on Single-Celling During the COVID-19 Pandemic

At the outset of the pandemic, BOP directives to limit single-celling of inmates warned about the risks of single-celling and inmate suicide. On March 13, 2020, the Assistant Director of the Reentry Services Division (RSD) issued to all Wardens a memorandum that stated, “If inmates are confined to their cells, single celling should be eliminated to the greatest extent possible to reduce the isolation and privacy that can facilitate suicide.” The memorandum further stated, “Psychology Services staff should be consulted regarding any inmates proposed for single celling to ensure they are not particularly vulnerable individuals and/or to make recommendations.” The BOP incorporated this memorandum language into its October 2020 COVID-19 Pandemic Response Plan and its subsequent versions.²⁵

On March 23, 2020, the CDC published guidance for correctional facilities that identified the housing of inmates in quarantine separately in single cells as the ideal practice from an infection control perspective.²⁶ However, contemporaneous BOP guidance issued by the RSD, described above, directed Wardens to limit single-celling to reduce the risk of inmate suicide and did not make exceptions for inmates housed in quarantine units. On February 1, 2021, almost 1 year later, the RSD issued to Wardens another memorandum, which stated, “Single celling must stop, particularly in restrictive housing and quarantine, except when approved by the Warden on a case by case basis.” The RSD memorandum noted that from October 1, 2020, through February 1, 2021, 15 total inmates had died by suicide, 12 of whom were single-celled at the time of their deaths. Four of those 12 inmates who died by suicide were in single cells related to COVID-19 quarantine, while the remaining 8 were in single cells for other reasons.²⁷ One additional inmate suicide occurred in a COVID-19 quarantine unit after the RSD issued this directive, in addition to two

²⁴ DOJ OIG, [Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness](#), Evaluation and Inspections (E&I) Report 17-05 (July 2017), oig.justice.gov/reports/review-federal-bureau-prisons-use-restrictive-housing-inmates-mental-illness.

In response to a draft of this report, the BOP stated that since May 2021 it has implemented two successive Restrictive Housing Work Groups to reduce the number of individuals in restrictive housing and to make restrictive housing safer for all individuals who are placed there. Because this occurred after the period of our review, we did not assess the efficacy of the work groups.

²⁵ For example, the BOP’s November 30, 2022 COVID-19 Pandemic Response Plan stated, “If medical isolation in single cells is necessary (inmates are not cohorted), Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.” The COVID-19 Pandemic Response Plan also stated, “If quarantining in single cells is necessary (inmates are not cohorted), consult Psychology Services staff for mental health suitability for placement in single cell.”

²⁶ As described in the [Introduction](#) to this report, “quarantine” refers to the confinement of an individual who has had close contact with a COVID-19 case to determine whether that individual develops symptoms of the disease. The BOP used quarantine for incoming inmates, inmates who were close contacts of those with confirmed or suspected COVID-19, and outgoing inmates. During our remote inspections, we learned that some facilities used vacant housing units for quarantine purposes.

²⁷ We made this determination based on the number of single-celled inmate suicides in quarantine units that the BOP reported to the OIG in April 2021. The OIG did not review the circumstances of all inmate suicides presented in the RSD memorandum or the reasons that the BOP single-celled the eight inmates who were not part of our review.

inmate suicides that occurred prior to October 1, 2020, for a total of seven inmate suicides in COVID-19 quarantine units between March 2020 and April 2021. In connection with this capstone report, we reviewed these seven inmate suicides.

The required internal BOP psychological reconstruction reports following the seven inmate suicides that occurred in COVID-19 quarantine units recommended that those facilities avoid single-celling inmates and also recommended that they document decisions about single-cell placement.²⁸ Although BOP policy did not require facilities to use a single-cell approval form, our review found that some BOP facilities had successfully implemented the use of such a form.²⁹ At facilities that used this form, single-celling inmates required the Warden's approval with input from correctional supervisors, the Unit Manager, and the Chief Psychologist prior to single-celling an inmate. However, we found no evidence that any of the facilities that housed the seven inmates whose cases we reviewed used such a form at the time of the inmates' single-cell assignments. A detention center where one of the inmate suicides occurred utilized such a form prior to the pandemic but did not use it in the case of the inmate who died by suicide during the pandemic. The BOP's psychological reconstruction documentation noted that the detention center did not consistently use the single-cell request form during the pandemic due to "competing quarantine and isolation needs."

We found that five of the BOP's psychological reconstruction reports recommended that facilities implement enhanced documentation or procedures to ensure that relevant staff receive notifications about who is single-celled and to minimize the amount of time any inmate is housed in a cell alone. One report recommended that a facility develop staff notification procedures to decrease the number of single-celled inmates, including inmates in quarantine.

We have the same concerns about the BOP's single-celling of inmates that we identified in our 2017 restrictive housing review, which found that single-cell confinement may present added risks to inmate mental health. Our 2017 review also found that the BOP did not track its housing of inmates in single-cell restrictive housing unit confinement and that policies addressing single-cell confinement were inadequate. As of February 2023, the BOP had yet to fully implement six of our 2017 recommendations, including five recommendations regarding the BOP's policies and tracking of single-cell confinement and restricted

²⁸ See BOP Program Statement 5324.08, [Suicide Prevention Program](http://www.bop.gov/policy/progstat/5324_008.pdf), April 5, 2007, www.bop.gov/policy/progstat/5324_008.pdf (accessed July 11, 2022). The policy provides guidance regarding the completion of an after-action review, or psychological reconstruction report, by a BOP psychologist in the event of an inmate suicide. The report includes background information about the inmate, the circumstances surrounding the inmate's death, a conclusion, and recommendations. The OIG did not conduct investigative analysis of the BOP's psychological reconstruction documentation or independently assess the BOP's psychological reconstruction findings and recommendations.

²⁹ In response to a draft of this report, the BOP stated that in May 2021 it established a Single Cell Task Force to review single-celling practices and inmate suicide and to provide recommendations to reduce single-celling and provide increased oversight for those housed alone. The BOP stated that it has since implemented several of the task force's recommendations and, based on the task force's work, has provided guidance to each region concerning regular review and oversight of those housed alone. The BOP further stated that each region has provided a single-cell review form to facilities and requires regular oversight and reporting of the use of single cells to the Regional Office. Because establishment of the task force and these practices occurred after the period of our review, we did not assess their efficacy. Finally, the BOP stated that vulnerable inmates may at times need to be single-celled due to their level of disruptive behavior, isolation, or quarantine.

housing, two of which specifically address single-celling.³⁰ In response to these recommendations, the BOP stated that as of September 2022 it had completed final steps for approval of its revised Special Management Unit (SMU) policy and that it had planned to conduct discussions with the national union regarding revisions to its Special Housing Unit (SHU) policy.³¹ The BOP also stated that as of September 2022 it had developed a SHU mental health dashboard extension to its SHU dashboard program that would generate rosters of inmates housed in a SHU and include inmate mental healthcare level assignments, the length of time they had spent in a SHU, the number of days they had been single-celled, and other information. Further, the BOP has struggled to enforce multiple directives to limit single-celling at facilities during the pandemic.³² The occurrence of inmate suicide in single-celled quarantine units at many facilities presents a significant risk for the BOP in ensuring inmate safety.

Use and Conditions of Single-Celling in Quarantine Units

All seven single-celled inmate suicides we reviewed occurred by hanging. One of the inmate suicides occurred after Health Services staff failed to conduct pill line in restrictive housing for 2 days, in violation of the BOP's Patient Care policy, resulting in the inmate missing two doses of antidepressant medication.³³ Staff failure to conduct pill line was reportedly due to staffing issues, which are more broadly discussed in [The BOP Should Take Appropriate Steps to Address Staffing Shortages and Staff Morale](#) section of this report, as well as staff error. Separately, initiation of lifesaving measures for one inmate who died by

³⁰ DOJ OIG, *Use of Restrictive Housing*. Five of the open recommendations regarding the BOP's policies and tracking of single-cell confinement and restricted housing are to: (1) establish in policy the circumstances that warrant the placement of inmates in single-cell confinement while maintaining institutional and inmate safety and security and ensuring appropriate, meaningful human contact and out-of-cell opportunities to mitigate mental health concerns; (2) define and establish in policy extended placement in measurable terms; (3) track all inmates in single-cell confinement and monitor, as appropriate, the cumulative amount of time that inmates with mental illness spend in restrictive housing, including single-cell confinement; (4) identify all forms of restrictive housing utilized throughout its institutions and ensure that all local policies are updated to reflect standards for all inmates in restrictive housing consistent with established nationwide policies; and (5) evaluate and limit as appropriate the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing. Recommendations 1 and 3 are related to single-cell confinement. A sixth open recommendation is specific to a restrictive housing unit at one BOP facility.

³¹ BOP Program Statements 5217.02, [Special Management Units](#), August 9, 2016, www.bop.gov/policy/progstat/5217_02.pdf, and 5270.11, [Special Housing Units](#), November 23, 2016, www.bop.gov/policy/progstat/5270.11.pdf (both accessed November 9, 2022). A SMU is a type of restrictive housing that the BOP established to house inmates who require greater management of their interactions with others to ensure the safety, security, or orderly operation of BOP institutions and to protect the public. The BOP defines SHUs as "housing units in Bureau institutions where inmates are securely separated from the general inmate population, and may be housed either alone or with other inmates."

³² In response to a draft of this report, the BOP stated that the Psychology Services Branch provides quarterly reviews of common recommendations and concerns detailed in psychological reconstruction reports and disseminates that information to Wardens for training purposes. Additionally, the BOP stated that facilities with increased rates of suicide (two suicides in 2 years) receive Risk Reduction Reviews from a multidisciplinary BOP team to examine adherence to psychological reconstruction recommendations, compliance with relevant policy, issues of facility culture, and training needs. The BOP stated that as of February 2023 it had completed these reviews at multiple facilities.

³³ BOP Program Statement 6031.01, [Patient Care](#), June 31, 2014, www.bop.gov/policy/progstat/6031_004.pdf (accessed July 11, 2022). "Pill line" refers to BOP medical staff's administration of prescribed medication to inmates, during which staff may directly observe inmates consuming their medication.

suicide were delayed for several minutes because officers did not have immediate access to keys to the inmate's cell door, which was inconsistent with the BOP's Patient Care policy.³⁴

BOP psychological reconstruction reports found that two inmates who had recently entered BOP custody and were recent arrivals to their facilities likely experienced opioid withdrawal symptoms prior to their suicides. The reconstruction teams recommended that both facilities update local procedures to improve opioid withdrawal monitoring. One report recommended that staff conceptualize opioid withdrawal as an acute risk for suicide and that the facility's Psychology Services Division staff complete additional Suicide Risk Assessment (SRA) training.³⁵

According to the BOP's psychological reconstruction reports, conditions of confinement in the quarantine unit may have contributed to inmate hopelessness and depression. In a description of quarantine unit conditions, one reconstruction report noted that "[staff] rounds and puzzles are not sufficient for occupying one's mind for what was likely 112 waking hours per week." Another report observed that inmates in the quarantine unit had only three 15-minute periods per week in which they were permitted out of their cells. According to one reconstruction report, quarantine and isolation conditions limited access to resources that can prevent suicide, such as peer support, psychology services, and telephones to call family or counsel. The BOP also found no evidence that one of the inmates was provided any educational or recreational activities or offered telephone calls, despite Regional Office direction that inmates be afforded programming and two 15-minute phone calls per month.

Additionally, we found that two of the inmates who died by suicide had both completed the BOP's required 14-day quarantine period for inmates newly admitted to a BOP facility and tested negative for COVID-19. As a result, under BOP guidance, they could have been removed from single-cell quarantine at the time of their deaths.³⁶ However, we found that two of the inmates who died by suicide remained in quarantine for 2 to 3 days after receiving their negative COVID-19 test results. In both cases, the reconstruction reports noted that the inmates would have been placed with cellmates had the BOP removed them from quarantine.

³⁴ The Patient Care policy says, "ACA standards require a four-minute response to life- or limb-threatening medical emergencies."

³⁵ We did not consider the totality of potential suicide risk factors in this review. In response to a draft of this report, the BOP stated that it already considers opioid withdrawal as an acute risk for suicide, that its SRA allows clinicians to provide substance use history as part of the clinical information gathered to conceptualize the inmate's risk of suicide, and that current intoxication is listed as a dynamic risk factor in the SRA. Further, the BOP issued clinical guidance in February 2020 that discusses the risk of suicide for inmates with substance abuse disorder and stated that frequent patient assessments are indicated during the withdrawal period, with particular attention to thoughts of self-harm. The guidance further stated that patients in active substance withdrawal are at increased risk of suicide and stated that extra care was warranted, including monitoring inmates for thoughts of self-harm. Additionally, the BOP stated that national training for BOP psychology staff included content connecting withdrawal and substance use, including opioid use, to suicide risk.

³⁶ BOP guidance states that inmates in quarantine should be retested for COVID-19 on or after 14 days of quarantine. Inmates may be discharged from quarantine if those test results are negative.

Conclusion

We identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance regarding the single-celling of inmates during modified operations. We were particularly troubled to find that the BOP did not address at the time these persistent deficiencies and violations of multiple BOP policies in single-celled quarantine suicide cases spanning many facilities.³⁷ Inmate suicide in single-cell units, including in COVID-19 quarantine units, remains a continued serious risk area for the BOP, and the BOP's internal oversight mechanisms have not been able to adequately address the scope of the problem. We recognize the inherent and conflicting challenges posed in a correctional environment during a pandemic, including the need to balance infection control measures, such as medically isolating or quarantining inmates to prevent the spread of the virus, with directives to stop single-celling inmates. However, quarantining inmates during the pandemic did not require them to be placed in single cells given the number of inmates who were being quarantined at the time. Further, the BOP failed to follow its own guidance that recognized that single-celling of inmates generally should not occur for quarantine purposes and that inmates should be assessed for possible vulnerability to suicide before being single-celled. That did not occur in at least five of the seven inmate suicide cases we reviewed, and in all seven of those cases the inmates had factors that made them vulnerable to suicide. To address these serious failures and limit the risk of single-celled suicide, including in quarantine and other pandemic-related housing, the BOP should conduct a thorough assessment of its policies, processes, and oversight surrounding the single-cell placement of inmates.

Recommendations

To ensure that BOP processes prevent inappropriate single-celling assignments and protect inmates vulnerable to suicide, including when they are quarantined, we recommend that the BOP:

1. Conduct a thorough assessment of single-celling policies and processes, including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide.
2. Ensure that actions, including any policy revisions, the BOP takes to close the two open recommendations from our 2017 restrictive housing report that reference single-celling also apply to single-celling during quarantine and medical isolation.

The BOP Should Ensure that Lessons Learned in Attempting to Address Space and Infrastructure Limitations at Its Facilities Are Captured for Future Public Health Emergencies

CDC guidance for correctional and detention facilities emphasized the importance of social distancing, quarantine, and medical isolation as tools to manage and help prevent the spread of COVID-19. The CDC also acknowledged that the guidance "may need to be adapted based on individual facilities' physical space, staffing, population, operations, and other resources and conditions." Over the course of the pandemic, BOP facilities relied on a variety of guidance and protocols when responding to the public health emergency, including those from the CDC, BOP Central Office, and individual facility plans.

³⁷ The OIG is currently conducting a review of BOP inmate deaths in custody to assess the circumstances surrounding nonnatural inmate deaths at BOP facilities.

We found that many BOP facilities, due to infrastructure limitations, faced challenges in maintaining social distancing and in quarantining inmates. While we found that BOP facilities took a variety of actions to achieve appropriate social distancing and quarantining of inmates, we also found, as discussed in the next section of this report, that at some facilities the BOP did not fully utilize its home confinement tools, including those provided for in the CARES Act, that could have allowed it to better manage social distancing, reduce exposure risks to staff and inmates, and help address staffing challenges at a number of those facilities. Separately, as described below, we found that, although the BOP developed a plan in the summer of 2020 to reduce the population in its minimum and low security facilities, as of December 2021 the BOP had not met its goals at many facilities. It is important for the BOP to capture lessons learned and best practices, at both individual facility and agency-wide levels, from the COVID-19 pandemic. Doing so will help the BOP ensure that its public health emergency response plans are as useful as possible for facilities that may need to implement them in the future.

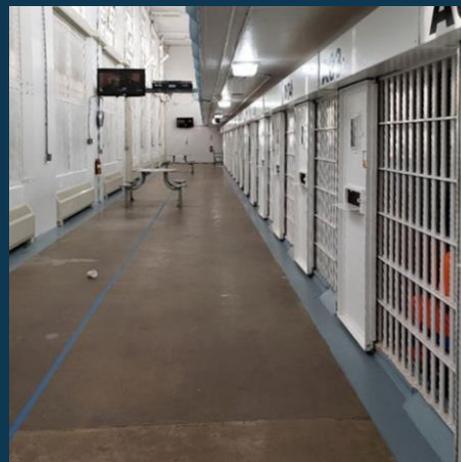
Social Distancing

The OIG's remote inspections, as well as the BOP's internal compliance reviews, found that facilities implemented a variety of social distancing measures in line with CDC guidance. However, because inmates live, eat, sleep, and work in communal environments, maintaining the recommended 6 feet of space between people was a challenge. Interviewees, complainants, and staff and inmate survey respondents all indicated that social distancing in BOP facilities could be improved. For example, between March and September 2020, the OIG received over 400 complaints regarding social distancing challenges. Additionally, the 2021 inmate survey results revealed that an estimated two-thirds (66 percent) of inmates were rarely or never able to maintain a distance of 6 feet between themselves and other inmates or BOP staff in common spaces during the pandemic. Thirty-four percent of [2021 BOP Staff Survey](#) respondents also believed that social distancing of inmates is a Top 5 area in which the BOP most needs to improve.

We found that the physical infrastructure of facilities contributed to social distancing challenges. The housing units in federal and contract prisons generally fall into two general categories: cell-type housing and open dormitory housing. The photographs below show examples of these types of housing units. In cell-type housing units, cells include beds, a toilet, and a sink and are generally occupied by one to four inmates. Cell doors lock, providing the option for controlled access to communal spaces, including showers, phones, and recreation areas. High and medium security facilities generally have cell-type housing. In open dormitory housing, there is generally a large room with rows of bunk beds. The room may be divided using partial-wall partitions between beds, in a configuration also called cubicle housing. Inmates in open dormitory housing are generally free to move between sleeping, restroom, and communal areas. Furniture, such as beds, is generally fixed and cannot be rearranged to increase distance among inmates. Low and minimum security facilities have mostly open dormitory or cubicle housing. However, housing unit layouts vary across facilities.³⁸ For example, most housing units at [Federal Medical Center \(FMC\) Fort Worth](#), an

³⁸ Administrative facilities have specialized missions, such as detaining pretrial offenders; treating inmates with serious or chronic medical conditions; or containing extremely dangerous, violent, or escape-prone inmates.

administrative facility, have cells without doors, meaning that, while there is more separation between inmates, they can still move freely within the unit.³⁹



Left, Solid-Door Cell-Type Housing Unit with Central Common Area at Federal Correctional Complex (FCC) Tucson, *Right*, Barred-Door Cell-Type Housing Unit at FCC Lompoc

Source: BOP, with OIG enhancement



Left, Open Dormitory Housing Unit at Metropolitan Detention Center Brooklyn, *Right*, Partitioned, Open Dormitory, or Cubicle Housing Unit at FCC Coleman

Source: BOP, with OIG enhancement

Interviewees, including the then BOP Medical Director, agreed that the inability to social distance in open dormitory housing units is likely one of the reasons why some BOP facilities experienced larger COVID-19 outbreaks than others. In contrast, staff at [Metropolitan Detention Center \(MDC\) Brooklyn](#), an administrative detention center that has mostly self-contained, tiered housing units with closed cells, told us that the physical layout of MDC Brooklyn helped the facility to limit contact between inmates and between

³⁹ DOJ OIG, [Remote Inspection of Federal Medical Center Fort Worth](#), E&I Report 21-012 (December 2020), oig.justice.gov/reports/remote-inspection-federal-medical-center-fort-worth.

housing units.⁴⁰ These observations are in line with a CDC study on mass testing initiatives in correctional settings suggesting that inmates in dormitory settings were at greater risk of COVID-19 infection.⁴¹

Through our remote inspections of BOP facilities, we found that BOP staff in facilities housing inmates employed a variety of strategies to increase social distancing in housing units and in some cases to overcome the limitations of the physical layout and infrastructure of the facilities. Below, the text box describes some examples of social distancing strategies and the photographs show two of the strategies:

⁴⁰ DOJ OIG, [Remote Inspection of Metropolitan Detention Center Brooklyn](#), E&I Report 21-002 (November 2020), oig.justice.gov/reports/remote-inspection-metropolitan-detention-center-brooklyn, 1.

MDC Brooklyn is an administrative facility with the mission to detain pretrial offenders. It houses inmates at all security levels, including unsentenced pretrial detainees and sentenced inmates.

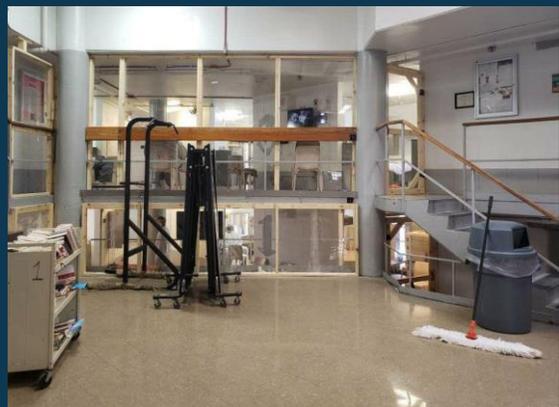
⁴¹ See Liesl M. Hagan et al., [“Mass Testing for SARS-CoV-2 in 16 Prisons and Jails—Six Jurisdictions, United States, April–May 2020,”](#) U.S. Department of Health and Human Services/CDC, *Morbidity and Mortality Weekly Report*, no. 33 (August 2020), www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6933a3-H.pdf (accessed July 11, 2022).

Social Distancing Strategies Identified Through OIG Remote Inspections of BOP Facilities

- Staggering inmates' access to common areas (FCC Tucson, CI Moshannon Valley, CI Dalby, CI McRae, FCC Oakdale, and FCC Pollock)
- Reducing the number of inmates participating in a program or activity or offering alternatives to in-person programs (FCC Tucson, CI Dalby, and CI McRae)
- Increasing space between computer stations (MDC Brooklyn)
- Instructing inmates in bunk beds to sleep "head-to-toe" (FCI Milan, FCC Oakdale, Toler House RRC)
- Moving inmates from open dormitory housing to cell-type housing (FCC Oakdale)
- Creating temporary housing units in other areas of the facility to increase space between inmate bunks (FCC Lompoc, FMC Fort Worth, FCI Terminal Island)
- Installing plexiglass barriers to create separations in open dormitory housing (MCC Chicago)
- Installing plastic sheeting to cover doorways of cells that do not have a solid door (FMC Fort Worth)

Key: CI=Correctional Institution; FCI=Federal Correctional Institution; FCC=Federal Correctional Complex; FMC=Federal Medical Center; MCC=Metropolitan Correctional Complex; MDC=Metropolitan Detention Center; RRC=Residential Reentry Center

Source: OIG remote inspections of BOP facilities



Top, Plastic Sheeting Covering Open Cell Doors at FMC Fort Worth

Bottom, Wooden Frames Holding Plexiglas Barriers Separating the Floors of an Open Dormitory Housing Unit at MCC Chicago

Source: BOP, with OIG enhancement

Another strategy that the BOP used to improve social distancing and reduce exposure risk was to reduce the number of inmates in its facilities. While the BOP developed a plan to reduce the inmate population levels at low and minimum security facilities during the pandemic and reduced the populations at some facilities, it did not uniformly meet its intended population targets at all facilities in 2020 and 2021. On June 19, 2020, the BOP issued to facility Wardens a memorandum that outlined a plan to reduce the inmate population levels at minimum and low security facilities due to COVID-19, setting temporary population targets intended to help with social distancing and to guide decision making regarding inmate movement. The plan included population targets for 144 minimum and low security facilities, satellite facilities, and cohorts at facilities of other security levels.

OIG analysis of population data, as of June 4, 2020, at the 108 minimum and low security facilities and satellite facilities we examined indicates that the BOP would have needed to reduce its overall minimum and low security population by over 2,700 inmates in order to meet the population targets set in its June 2020 memorandum.⁴² While over half of the facilities were already at or below their target populations in June 2020, 49 of the 108 facilities needed to decrease their populations to meet the targets. By December 2020, the overall population of minimum and low security inmates was below the total target population but 26 facilities still had populations that exceeded their targets. The number of facilities that did not meet the BOP’s population targets increased to 38 facilities by December 2021 (see Table 2 below).

Table 2

Minimum and Low Security Facilities and Satellite Facilities Meeting Population Targets, June 2020–December 2021

	June 2020	December 2020	June 2021	December 2021
Facilities Meeting Target Population	59	82	79	70
Facilities Not Meeting Target Population	49	26	29	38

Source: OIG analysis

In its 2022 performance budget, the BOP reported that there was extra space available at its low and minimum security facilities. Specifically, the BOP reported that, for the first time in many years, the system-wide population was below rated capacity at its low security facilities and that it had a 52 percent surplus capacity at its minimum security facilities as of March 25, 2021. Although these lower populations could help facilitate social distancing at low and minimum security facilities, the BOP’s higher than intended populations at some facilities could present barriers to improving social distancing.

⁴² We analyzed population data at 108 facilities, which include 37 minimum and low security facilities as well as 69 minimum and 2 low security satellite facilities that the BOP generally counts as part of its other facilities. For this analysis, we excluded the minimum and low security cohorts at medium and administrative security facilities because the population datasets for those facilities did not distinguish between the various security levels. See [Appendix 1](#) for additional discussion of our methodology.

Maintaining facility populations below a prison's rated capacity could help the BOP respond effectively to future public health emergencies that require social distancing, as well as address some of its staffing challenges. However, this could be a challenge given that the BOP's medium and high security facilities continue to experience overcrowding, according to the BOP's 2022 performance budget. A BOP Facilities Management official explained that BOP facilities were designed to house a specific number of inmates based on their classification and security requirements. If facilities are at or near capacity, there may not be enough space to leave beds empty in order to allow inmates to maintain social distance while sleeping.

Quarantine and Medical Isolation

We found that the amount of available space affected the facilities' abilities to create quarantine and medical isolation areas. The facilities we inspected that had vacant cell-type housing available had an easier time designating enough space for their needs, and some facilities created temporary housing units to increase the number of beds available. However, at some facilities, such as [Federal Correctional Complex \(FCC\) Butner](#), a large outbreak of COVID-19 overwhelmed the available space.⁴³ Having sufficient quarantine and medical isolation space appeared to be a widespread and ongoing concern during the pandemic. Thirty percent of respondents to the OIG's [2021 BOP Staff Survey](#) reported that there was "usually not enough space" or "never enough space" for inmates who needed to be placed in quarantine over the course of the pandemic. Thirty percent also reported that there was "usually not enough space" or "never enough space" for inmates who needed to be placed in medical isolation.

As described in the [Background](#) of this report, facilities needed to designate as many as five separate areas for quarantine and medical isolation purposes.⁴⁴ Interviewees at 7 of the 16 facilities we inspected, including 5 of the 11 federal facilities, specifically reported using vacant housing areas in their facilities for quarantine or medical isolation. For example, at [FCC Oakdale](#), staff initially established medical isolation and quarantine space in a vacant housing unit and used a second unit that had been empty while mold remediation work was completed to create additional space for inmates typically housed in the open dormitory camp.⁴⁵ Several facilities we inspected used temporary housing solutions, such as converted visitation rooms or tents outfitted with electricity and restrooms (see the photographs below), to supplement quarantine and medical isolation space.

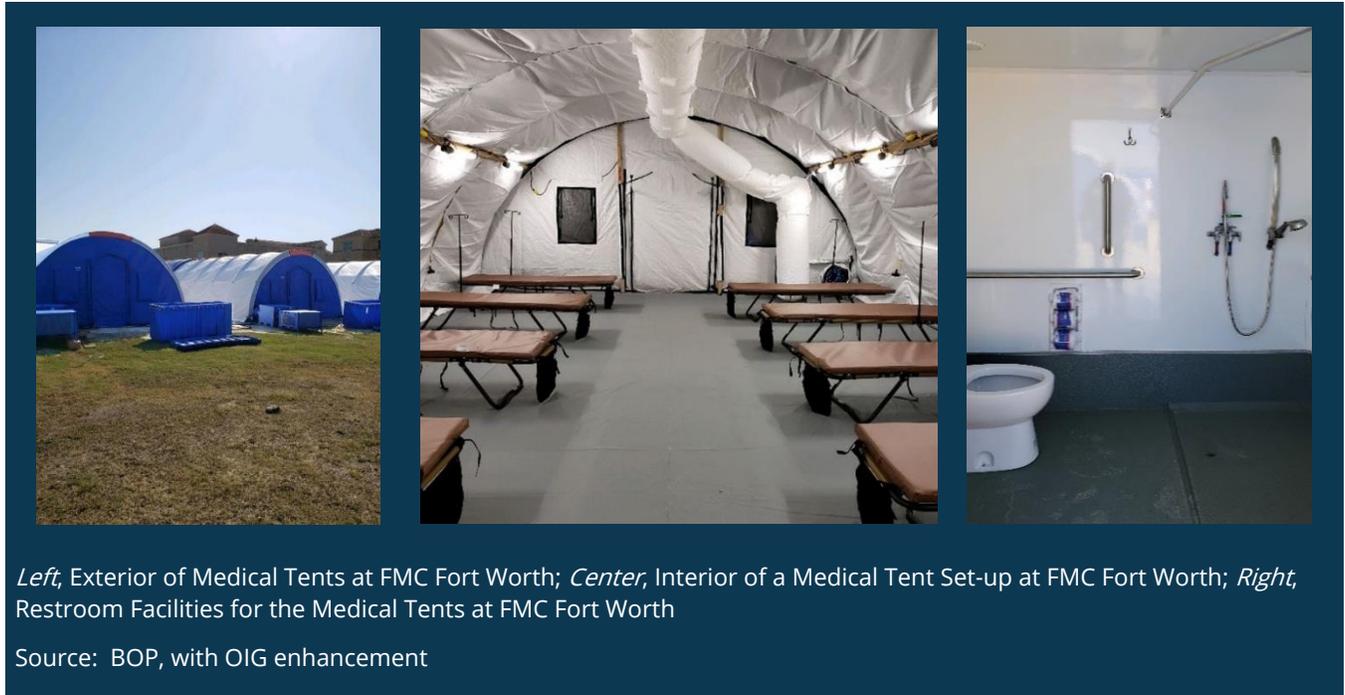
Finally, several of the facilities we inspected also used SHUs as quarantine or medical isolation areas. In particular, facilities with open dormitory style housing relied on the cell-type housing of SHUs to quarantine or medically isolate inmates. The BOP's COVID-19 Pandemic Response Plan specifies that, when facilities use restrictive housing for medical isolation, the conditions of confinement should be "operationally distinct"

⁴³ DOJ OIG, [Remote Inspection of Federal Correctional Complex Butner](#), E&I Report 21-031 (January 2021), oig.justice.gov/reports/remote-inspection-federal-correctional-complex-butner, 5.

⁴⁴ Per CDC, "Interim Guidance," medical isolation and quarantine locations should be separate and, if possible, incoming inmates should be quarantined separately from individuals quarantined due to contact with a COVID-19 case.

⁴⁵ DOJ OIG, [Remote Inspection of Federal Correctional Complexes Oakdale and Pollock](#), E&I Report 21-003 (November 2020), oig.justice.gov/reports/remote-inspection-federal-correctional-complexes-oakdale-and-pollock, 16.

from the use of restrictive housing for disciplinary or administrative reasons.⁴⁶ For example, facilities should try to provide similar access to radio, television, reading materials, personal property, and commissary as would be available in the inmate's regular housing unit and should consider allowing increased telephone privileges so inmates can maintain connection with others. In addition, the BOP stated that inmates in the SHU for medical quarantine or isolation purposes are categorized as being in administrative detention and are placed on a medical hold until cleared for COVID-19. However, we note that inmates in SHUs may be housed alone in their cells, and we identified concerns with the BOP's use of single-celling for quarantine purposes, as we discussed above. In May 2022, Executive Order (E.O.) 14074 directed the BOP to identify alternatives to the use of restrictive housing for quarantine and medical isolation.⁴⁷



Left, Exterior of Medical Tents at FMC Fort Worth; Center, Interior of a Medical Tent Set-up at FMC Fort Worth; Right, Restroom Facilities for the Medical Tents at FMC Fort Worth

Source: BOP, with OIG enhancement

Capturing Lessons Learned and Considering Facilities Modifications

In August 2020, the BOP issued the first version of its COVID-19 Pandemic Response Plan, which compiled COVID-19 guidance and “best practices” identified during the first months of the pandemic for limiting the spread of the disease in its facilities. The COVID-19 Pandemic Response Plan also instructs BOP facilities to periodically review agency and institution plans to “identify what has worked well (best practices), what has

⁴⁶ According to the BOP's SHU policy, inmates in disciplinary detention status have personal property impounded, may have limited commissary privileges, and may have their participation in programming activities suspended. Inmates in administrative detention status have access to a reasonable amount of personal property, reasonable access to commissary, and access to programming activities to the extent that such access does not jeopardize facility operations or public safety.

⁴⁷ E.O. 14074 on [Advancing Effective, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety](https://www.federalregister.gov/documents/2022/05/31/2022-11810/advancing-effective-accountable-policing-and-criminal-justice-practices-to-enhance-public-trust-and-public-safety), May 25, 2022, www.federalregister.gov/documents/2022/05/31/2022-11810/advancing-effective-accountable-policing-and-criminal-justice-practices-to-enhance-public-trust-and-public-safety (accessed September 26, 2022).

not, and deviations from established guidance (opportunities for improvement).” However, in a July 2021 report on the BOP’s COVID-19 response, the U.S. Government Accountability Office (GAO) recommended that the BOP take additional steps to ensure that lessons learned and best practices are captured, particularly those discussed among BOP officials during their regular information sharing teleconferences.⁴⁸ The GAO further recommended that the BOP develop and implement an approach for ensuring that its facilities are applying the best practices, as appropriate.

The BOP has reported that it considered potential permanent changes to facility infrastructure to help mitigate the risk of infection transmission inside its facilities. For example, [Federal Correctional Institution \(FCI\) Terminal Island](#) reported that it was considering placement of computers in the housing units instead of using a shared computer lab, which could help ensure access to the Trust Fund Limited Inmate Computer System (TRULINCS) inmate email system during extended modified operations while limiting cross-contamination among housing units.⁴⁹ The BOP should also look for opportunities to incorporate proactive infrastructure changes into its planned construction, modernization, and repair projects.⁵⁰ In its fiscal year 2022 budget submission, the BOP reported having 904 ongoing major and minor modernization and repair projects at its facilities. The BOP Facilities Management Branch Chief told us that the BOP plans to prioritize projects targeting the efficiency of heating, ventilation, and air conditioning systems, as these systems may affect the spread of COVID-19.⁵¹

Conclusion

Building on these steps already taken or in progress, we recommend that the BOP specifically look at the challenges related to the limitations of existing facility infrastructure and the methods that have been successful in mitigating those challenges. First, as described above, facilities have unique challenges based on their specific layouts, populations, and other circumstances. In addition to ensuring that best practices are shared such that similarly situated facilities can benefit from lessons learned during the pandemic, facility-specific measures and solutions should be captured and updated in individual facility pandemic plans. Updating these plans will ensure that future facility leadership will have access to information on what has worked well in their facility’s context if they need to respond to a public health emergency in the future. The BOP reported that it has already made several updates to its pandemic contingency plans based

⁴⁸ GAO, [BOP Could Further Enhance Its COVID-19 Response by Capturing and Incorporating Lessons Learned](#), GAO-21-502 (July 2021), www.gao.gov/products/gao-21-502 (accessed July 11, 2022), 58.

⁴⁹ TRULINCS enables electronic messaging (email) between inmates and approved contacts in a monitored and secure manner. DOJ, OIG, [Remote Inspection of Federal Correctional Institution Terminal Island](#), E&I Report 21-025 (January 2021), oig.justice.gov/reports/remote-inspection-federal-correctional-institution-terminal-island.

⁵⁰ Since 2017, the OIG has identified aging infrastructure at BOP facilities as an area of concern in its *Top Management and Performance Challenges* reports. The OIG is currently conducting an audit of the BOP’s efforts to construct and maintain its institutions. See DOJ OIG, [Audit of the Federal Bureau of Prisons’ Efforts to Maintain and Construct Institutions](#), oig.justice.gov/node/23304.

⁵¹ The CDC states that the risk of spreading the virus that causes COVID-19 through ventilation systems is not yet clear. However, the CDC does recommend improvements to building ventilation as tools to use in conjunction with other measures, such as social distancing, hand hygiene, and vaccination, to help reduce risk of exposure to the virus. See CDC, [“Ventilation in Buildings,”](#) updated June 2, 2021, www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html (accessed July 11, 2022).

on CDC guidance as detailed information was gathered on vaccinations, testing, and treatment of COVID-19 and that it intended to continue collaborating with the CDC as part of its pandemic response.

Second, the BOP should build on its lessons learned by exploring potential permanent changes to facility infrastructures that could help the BOP more easily implement infection prevention and control measures in the future. While these projects require sufficient funding, the BOP should take the opportunity to consider how it could incorporate modifications that would help with managing public health emergencies into other planned modernization and repair projects.

Recommendations

To ensure that lessons learned are captured for future public health emergencies, we recommend that the BOP:

3. Compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs.
4. Explore options for permanent changes to facility infrastructures that would allow for better implementation of social distancing and other infection control measures.

The BOP Should Assess How Lessons Learned Implementing CARES Act Home Confinement Could Apply to Future Public Health Emergencies While Monitoring How RRC Providers Manage a Larger Home Confinement Population

On April 3, 2020, the Attorney General gave the BOP the authority under the CARES Act to transfer to home confinement additional eligible inmates who would not have been eligible under the BOP's other existing authorities at the time of transfer (see the text box below). We concluded in five of our remote inspections that the BOP did not fully leverage its home confinement authorities under the CARES Act to transfer inmates within 6 months of release from the inspected facilities to home confinement. Greater use of these authorities could have allowed the BOP to better address the social distancing and quarantine challenges that many facilities faced, as well as assist with the staffing issues that it faced.

During this review, we found that the BOP's implementation of the Attorney General's memoranda on home confinement and related direction from the Department, as well as available resources, affected the extent to which the BOP transferred inmates to home confinement under the CARES Act. We also found that several factors led to delays in home confinement transfers, limiting the efficacy of home confinement as a tool to manage active COVID-19 outbreaks. Additionally, as described below, while the number of inmates transferred by the BOP to home confinement increased substantially in May and June 2020, shortly after the CARES Act was passed, the overall number of inmates transferred by the BOP to home confinement during the first year of the CARES Act—from April 2020 through March 2021—was actually less than the number of transfers that occurred from April 2019 through March 2020. However, we note that, due to the decreasing inmate population overall, the percentage of inmates transferred to home confinement was similar for both years. We also determined that, despite the lower number of facility-to-home-confinement transfers compared to the prior year, the BOP's home confinement population more than tripled during the first year of the CARES Act, generally due to (1) the longer period of time that inmates were remaining in home confinement because the CARES Act allowed the BOP to transfer inmates to home confinement with more

than 6 months remaining on their sentence and (2) the fact that the BOP also transferred inmates from Residential Reentry Center (RRC) facilities to home confinement in response to the pandemic, including under CARES Act authorities. Additionally, we determined that the home confinement failure rate for inmates transferred to home confinement during the first year of the CARES Act was less than 2 percent. Failure in the home confinement setting occurs when an inmate commits misconduct or fails to comply with program rules, such as by using illicit drugs, missing check-ins, or committing new criminal activity.

The BOP's Pre-Pandemic Home Confinement Authorities

Prerelease Inmates: Inmates nearing the end of their sentences are routinely considered for home confinement as part of their transition back into the community. Eligible inmates can spend up to 10 percent of their total sentence or 6 months, whichever is shorter, in home confinement under 18 U.S.C. § 3624(c)(2).

Elderly Inmates: Eligible inmates age 60 or older who have served at least two-thirds of their sentence may be placed in home confinement until the end of their sentence through a pilot program reauthorized under the FIRST STEP Act (FSA), codified at 34 U.S.C. § 60541(g).

Terminally Ill Inmates: Eligible inmates who are terminally ill may be placed in home confinement through a pilot program reauthorized under the FSA, codified at 34 U.S.C. § 60541(g).

Additional Home Confinement Authority During the COVID-19 Pandemic

Inmates Eligible Under the CARES Act: The CARES Act, Public Law No. 116-136, removed the 6 months or 10 percent of the total sentence time limit under 18 U.S.C. § 3624(c)(2) during the pandemic emergency period, allowing inmates to be considered for home confinement earlier in their sentences than usual. Memoranda from the Attorney General and the BOP defined additional eligibility criteria for home confinement placement under the CARES Act.

Sources: OIG summary of 18 U.S.C. § 3624(c)(2), 34 U.S.C. § 60541(g), and Public Law No. 116-136

In order to implement the Attorney General's April 3 memorandum and pre-CARES Act home confinement memorandum from March 26, the BOP issued its own memoranda to institutions on April 3, April 22, and May 8, 2020. Generally, under these BOP-issued memoranda, inmates were eligible for home confinement if they:

- were not serving a sentence for a crime of violence, a sexual offense, or terrorism;
- did not present a substantial risk of engaging in criminal conduct or endangering the community, as determined by the BOP;⁵²

⁵² To assess inmates' recidivism risk, the BOP uses the Prisoner Assessment Tool Targeting Estimated Risk and Needs (PATTERN) system, which the Department developed in response to the FSA. The FSA directed the Department to complete its initial risk and needs assessment for each federal inmate by January 15, 2020, which, among other things, calculated inmates' recidivism risk using a point system that classifies inmates into either minimum, low, medium, or high risk categories based on: (1) infraction convictions during current incarceration, (2) number of programs completed, (3) work programming, (4) drug treatment while incarcerated, (5) noncompliance with financial responsibility, (6) history of violence, (7) history of escape, (8) education score, (9) age at time of the assessment,

- did not have a history of serious misconduct, such as violence or gang activity, while incarcerated;
- did not have a current detainer requesting the inmate's custody after sentence completion;⁵³
- had a verifiable reentry plan, appropriate residence for home confinement, and ability to get any medical needs met appropriately in the community;
- had particular COVID-19 risk factors, as described in the CDC guidelines; and
- had served at least 50 percent of their sentence or had 18 months or less remaining on their sentence and had served at least 25 percent of their sentence (beginning with the April 22 memorandum).

The BOP's April 22, 2020 memorandum also granted Wardens additional authority to seek home confinement approval, for inmates who did not meet the criteria outlined in the memoranda, by sending to BOP Central Office the inmates' information for further consideration. A committee of Central Office officials reviewed these referrals and approved or denied the transfers to home confinement. However, a November 16, 2020 BOP memorandum, while reiterating the criteria for home confinement consideration and providing additional guidance, eliminated a Warden's ability to refer to the Central Office inmates who did not meet the home confinement criteria. This meant that Wardens would make the final decisions on which inmates to refer for home confinement but could not refer or seek approval for inmates who did not meet the memoranda criteria for CARES Act home confinement.⁵⁴ Five months later, in an April 13, 2021 memorandum, the BOP reverted to the practice outlined in the April 2020 memorandum allowing Wardens to seek approval from the Central Office for inmates with COVID-19 risk factors who did not meet all of the other eligibility requirements; the memorandum also emphasized the importance of continuing to review at-risk inmates for home confinement placement in accordance with the CARES Act and Attorney General guidance.

From the outset of the BOP's effort to review inmate eligibility for home confinement transfer, BOP Central Office and Regional Office officials sought to assist facilities in identifying eligible inmates by providing them with rosters of inmates who might meet the criteria listed in the guidance. According to a Correctional

(10) instant violent offense, (11) sex offense, and (12) criminal history score. For more information, see Office of the Attorney General, [The First Step Act of 2018: Risk and Needs Assessment System-Update](https://nij.ojp.gov/sites/g/files/xyckuh171/files/media/document/the-first-step-act-of-2018-risk-and-needs-assessment-system-updated.pdf) (January 2020), nij.ojp.gov/sites/g/files/xyckuh171/files/media/document/the-first-step-act-of-2018-risk-and-needs-assessment-system-updated.pdf (accessed July 13, 2022).

⁵³ A detainer may come from a federal, state, or local jurisdiction and may be related to criminal charges or noncriminal charges (e.g., material witnesses, deportation, probation/parole violator warrants, child support, etc.).

⁵⁴ BOP Central Office continued to review referrals in cases related to court orders, settlement agreements, or other legal matters. Documents we reviewed indicated that the Department was aware of this change and considered it to be an appropriate step.

Programs Division official, BOP facility staff were expected to review the inmates on the rosters and any other inmates they believed might be eligible.

OIG analysis of BOP data showed that the BOP transferred fewer inmates to home confinement during the first year it was given CARES Act authorities than the year prior. From April 2020 through March 2021, the BOP transferred 28,353 total inmates to home confinement, including 6,781 inmates who were specifically transferred under CARES Act authorities. By comparison, from April 2019 through March 2020, the BOP transferred 29,273 total inmates to home confinement. Although the number of transfers to home confinement was lower, the percentage of inmates transferred to home confinement was similar for both years due to the decrease in the inmate population overall. Additionally, the average number of inmates residing in home confinement during that same time period more than tripled. Two related factors contributed to the increased home confinement population. First, the CARES Act allowed the BOP to transfer inmates to home confinement regardless of the amount of time remaining on their sentence, as opposed to the standard prerelease home confinement statute that generally allowed transfers only for inmates with no more than 6 months remaining on their sentence; therefore, inmates were spending longer amounts of time in home confinement before their sentences ended.⁵⁵

Second, Attorney General directives to maximize the use of home confinement authorities during the pandemic, including the CARES Act, also applied to inmates at RRC facilities. Inmates could be transferred from RRC facilities to home confinement, reducing the in-house RRC population and increasing the home confinement population.⁵⁶ Additionally, on April 3, 2020, the BOP's Residential Reentry Management Branch issued a memorandum to all RRC contract providers to use home confinement "to the fullest extent practicable, as outlined in the Attorney General's [March 26] memorandum." While we did not examine BOP-wide data on the number of inmates transferred specifically from RRCs to home confinement, our remote inspections of [Brooklyn House RRC](#) and [Toler House RRC](#) found that those RRCs heeded this direction and moved many of their inmates into home custody settings as the pandemic worsened. Additionally, respondents to our 2020 survey of RRC contract staff generally indicated that their RRC facilities had increased the number of inmates on home confinement early during the pandemic. Specifically, 80 percent (247 of 307) of respondents who answered the survey question about measures their RRC facility was employing at the time of the survey stated that the number of residents placed on home confinement had increased.

As Figure 4 below shows, the vast majority of home confinement placements before April 2020 were part of the BOP's regular prerelease process, through which inmates generally spend a maximum of 6 months in home confinement prior to their release. The CARES Act resulted in an unprecedented increase in the number of inmates in home confinement for far more than 6 months. For example, as of December 2021,

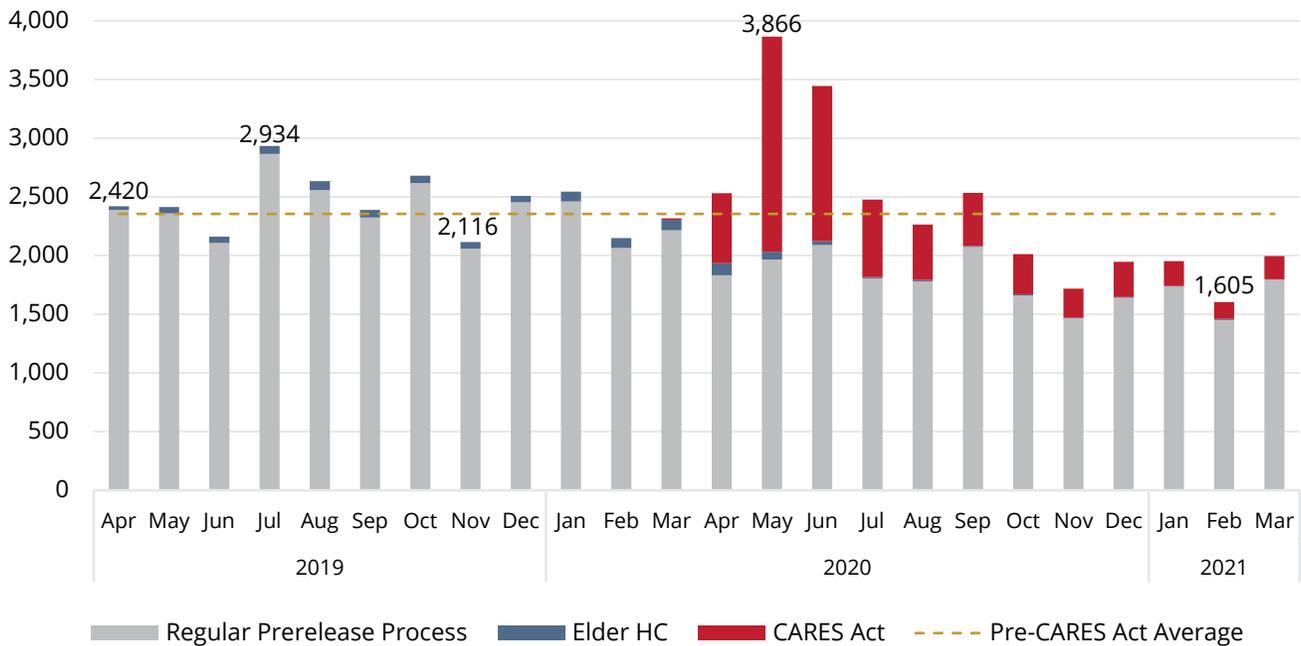
⁵⁵ As discussed in the [Introduction](#) to this report, inmates in home confinement are supervised by RRCs or the U.S. Probation Office but remain in BOP custody and are therefore included in the BOP's inmate population totals.

⁵⁶ The BOP's April 3 memorandum to RRC contract providers further noted that referrals must be made based on appropriateness for home confinement and that consideration should be given to whether inmates had a demonstrated verifiable reentry plan that would prevent recidivism and maximize public safety. A subsequent BOP memorandum to RRC contract providers on April 7, 2020, provided an update following the passage of the CARES Act and the Attorney General's April 3 memorandum and stated that the BOP was working to "ensure that all individuals who are appropriate for home confinement placement within our RRCs are placed on home confinement as soon as practical."

over 2,800 inmates in CARES Act home confinement had more than 1 year remaining on their sentences, including some inmates who had over a decade remaining. We discuss the effects of an increased home confinement population later in this section.

Figure 4

Number of Inmates Transferred Under Home Confinement Authorities, April 2019–March 2021



Notes: Data labels show total inmates transferred each month. “Elder HC” refers to transfers of elderly and terminally ill inmates to home confinement under 34 U.S.C. § 60541(g). The pre-CARES Act average is the average number of inmates transferred to home confinement each month from April 2018 through March 2020.

Source: OIG analysis of BOP data

Figure 4 also shows a large increase in the number of transfers to home confinement in May and June 2020, following the passage of the CARES Act.⁵⁷ While the majority of inmates whom the BOP transferred to home confinement during that time were part of the BOP’s regular prerelease process rather than under CARES Act authorities, a large number of additional inmates were released using the CARES Act authority. In the second half of 2020, the number of monthly transfers to home confinement dropped and remained below the pre-CARES Act average, with a small percentage of the releases being made using the CARES Act authority. According to a GAO report on the BOP’s COVID-19 response, BOP officials told the GAO that the BOP transferred fewer inmates from July through December 2020 because it had developed a list of inmates

⁵⁷ Although the CARES Act passed at the end of March 2020, it often took a few weeks for an inmate to be reviewed for home confinement and complete a mandatory quarantine period before being transferred to home confinement. The lower number of inmates transferred in April as compared to May and June reflects these delays. We discuss factors contributing to delays in home confinement transfers later in this section.

eligible for home confinement during the early stages of the pandemic.⁵⁸ The GAO report stated that, as a result, the transfer process was front loaded during the initial stages of the pandemic, from May through June 2020, resulting in a decrease in home confinement transfers after July 2020. As we discuss in the next section, the BOP's general practice of limiting eligibility for CARES Act consideration to inmates with COVID-19 risk factors also affected the number of inmates who were transferred to home confinement.

The Effect of the BOP's Implementation of the Attorney General's Memoranda and BOP Resource Limitations on Inmate Transfers Under Expanded Home Confinement Authorities

The OIG has previously reported that the BOP failed to broadly consider home confinement for inmates with a short amount of time remaining on their sentences during the pandemic, instead focusing its use of CARES Act and Attorney General authorities primarily on inmates with enhanced vulnerability to COVID-19.⁵⁹ In five of our remote inspections of BOP facilities during the pandemic, we concluded that the BOP did not fully leverage the available home confinement authorities because only small proportions of potentially eligible inmates were transferred from those facilities to home confinement. In particular, these inspections raised concerns about the number of inmates who were scheduled to be released within 6 months but who remained at BOP facilities instead of being transferred to home confinement. We noted in those reports that some inmates who were within 6 months of release could have been eligible for home confinement under the BOP's regular authorities and that they would have been releasing into the community shortly.⁶⁰ The conclusions in our remote inspection reports are in line with a 2016 OIG audit report on the BOP's management of inmate placements in RRCs and home confinement. In the 2016 report, we found that the BOP could more strategically identify inmates suitable for placement directly into home confinement and that the BOP had underutilized direct home confinement placement as an alternative to RRC placement for transitioning low risk, low need inmates back into society despite BOP policy and guidance stating that direct home confinement placement was preferred for such inmates.⁶¹

During this review, we found that the BOP's implementation of the Attorney General's memoranda on home confinement—based on the Department's direction to the BOP following both memoranda—affected the extent to which the BOP transferred inmates to home confinement under the CARES Act. DOJ officials in the Offices of the Attorney General and the Deputy Attorney General worked directly with BOP executives to convey specific direction on how to implement the Attorney General's March 26 and April 3, 2020 memoranda. For example, one document we reviewed described the Department's interest in making inmates with one or more COVID-19 risk factors who had 18 months or less remaining on their sentences and who had served at least 25 percent of their sentences a priority for home confinement. Other

⁵⁸ GAO, *BOP Could Further Enhance Its COVID-19 Response*, 46.

⁵⁹ See DOJ OIG, [Top Management and Performance Challenges Facing the Department of Justice-2021](https://oig.justice.gov/reports/top-management-and-performance-challenges-facing-department-justice-2021) (October 2021), oig.justice.gov/reports/top-management-and-performance-challenges-facing-department-justice-2021.

⁶⁰ BOP policy provides that inmates who fit certain categories, such as those who present certain public safety risks, should not ordinarily participate in RRC or home confinement. BOP Program Statement 7310.04, [Community Corrections Center Utilization and Transfer Procedures](https://www.bop.gov/policy/progstat/7310_004.pdf), December 16, 1998, www.bop.gov/policy/progstat/7310_004.pdf (accessed July 13, 2022).

⁶¹ DOJ OIG, [Audit of the Federal Bureau of Prisons' Management of Inmate Placements in Residential Reentry Centers and Home Confinement](https://oig.justice.gov/reports/audit-federal-bureau-prisons-management-inmate-placements-residential-reentry-centers-and-home-confinement), Audit Report 17-01 (November 2016), oig.justice.gov/reports/audit-federal-bureau-prisons-management-inmate-placements-residential-reentry-centers-and-home-confinement.

documents described the Department's evolving direction to the BOP about which of the home confinement criteria it considered "hard," meaning that the BOP should not approve any inmates who did not meet all such criteria, and other criteria the BOP could use to exercise its discretion when determining whether to transfer inmates to home confinement.

A Correctional Programs Division official told us that, in practice, at the facility level, inmates had to meet *all* of the factors listed in the BOP's home confinement memoranda to be considered eligible for home confinement. As discussed above, between April and November 2020, and again starting in April 2021, BOP memoranda allowed Wardens to refer to the Central Office review committee inmates who did not meet all the listed factors for case-by-case home confinement consideration. We reviewed documentation describing discussions between the BOP and the Department that indicate that, as least beginning in May 2020, the Department viewed certain criteria, including the presence of COVID-19 risk factors, as criteria that could be "waived" at the Central Office level when considering inmates whom Wardens referred to Central Office for home confinement consideration. However, the same Correctional Programs Division official and a Health Services Division official told us that they understood the Attorney General's memoranda to mean that *only* inmates with COVID-19 risk factors defined by the CDC could be transferred to home confinement under the CARES Act. They pointed to language in the Attorney General's April 3, 2020 memorandum directing the BOP to "immediately review all inmates who have COVID-19 risk factors, as established by the CDC."⁶² Additionally, the lack of COVID-19 risk factors was a reason that BOP staff gave for denying CARES Act home confinement at facilities we inspected, including at [MDC Brooklyn](#), where 139 of the 196 inmates who had been deemed ineligible for home confinement as of June 1, 2020, were denied due to lack of medical risk.

The OIG is conducting a separate review of the BOP's use of home confinement as a response to the COVID-19 pandemic; that review is assessing the BOP's processes for implementing its home confinement authorities under the CARES Act, considering the eligibility criteria outlined in the Attorney General's memoranda, and evaluating Wardens' recommendations that inmates who did not meet the Attorney General's criteria be placed in home confinement. That review will also select particular cases for examination to determine whether there were irregularities in the BOP's processes. Accordingly, while this report draws some conclusions about the BOP's use of home confinement, it does not draw specific conclusions regarding the BOP's processes related to implementing its home confinement authorities during the pandemic or make recommendations in this area.

A BOP Reentry Services Division official told us that available resources additionally affected the extent to which the BOP transferred inmates to home confinement. RRC contractors are retained by the BOP to monitor inmates in home confinement, and we were told that RRC and home confinement capacities are limited to what the RRC contractors can reasonably manage.⁶³ According to this official, the BOP wanted to focus its limited resources on (1) inmates with the greatest risk of contracting COVID-19 and (2) inmates who would be participating in the program as part of the traditional reentry philosophy in preparation for release from BOP custody. This same official pointed to the addition of the time-served criteria for home

⁶² Barr, memorandum for Director of Bureau of Prisons, April 3, 2020, 1.

⁶³ The U.S. Probation Office can also monitor BOP inmates on home confinement. However, according to the BOP, the Probation Office monitors a small percentage of BOP inmates on home confinement while RRCs monitor most inmates on home confinement.

confinement consideration in the BOP's April 22, 2020 memorandum, which prioritized for home confinement inmates who had served a certain portion of their sentences, or who had only a relatively short amount of time remaining on their sentences, as a way the BOP tried to prioritize its limited resources in the community.

The Department has recently indicated its support of the BOP's interpretation of the Attorney General's memoranda and the BOP's implementation of the expanded home confinement authorities. In response to the OIG's 2021 *Top Management and Performance Challenges* report, which discussed the OIG's findings from our remote inspection reports, the Department responded that it believes that the BOP properly executed the Attorney General's memoranda and that it was appropriate for the BOP to focus its efforts on medically vulnerable inmates. The Department further responded, "Although transferring healthy offenders with short sentences to home detention may have temporarily reduced the inmate population in some facilities, it would have drained available home detention resources from medically vulnerable offenders who were most at risk for contracting COVID-19 and subsequently developing serious illness or dying." While we appreciate the BOP's home confinement resource challenges, some BOP facilities also faced significant staffing and resource challenges, particularly those facilities where COVID-19 outbreaks occurred. Thus, deciding that inmates, particularly those who presented a low safety risk, could not be referred for transfer to home confinement at the facility level if they did not have any COVID-19 health risk factors, even if they met all of the other factors that the BOP and Department developed, meant that facility populations could have remained higher, including at facilities experiencing staffing shortages and space and infrastructure limitations.

We separately received OIG Hotline complaints about home confinement indicating that there was confusion among some inmates and other stakeholders about the eligibility criteria and the BOP's home confinement decisions. Home confinement was one of the most significant concerns for complainants; from March through September 2020 we received over 800 complaints related to home confinement, most of them from inmates. Complainants frequently requested inmate transfers to home confinement, and many complainants expressed interpretations of the home confinement eligibility criteria that differed from the BOP's interpretation.⁶⁴ According to some complainants, the BOP approved certain inmates for home confinement but subsequently reversed its decisions as guidance evolved.

We observed that the BOP's communication with the public regarding home confinement only restated the criteria in the Attorney General's memoranda without clarifying them in plainer language or describing how the BOP was interpreting or implementing the criteria. For example, while the BOP provided a Frequently Asked Questions section on home confinement on its public website during the pandemic, the section did not mention the additional time-served criteria the BOP was using to determine eligibility for home confinement. Clearly stating to the public how and why the BOP was implementing and prioritizing its

⁶⁴ We analyzed complaints to identify trends but did not substantiate or assess the validity of individual complaints or examine whether individual inmates were eligible for home confinement.

expanded home confinement authorities could have helped the BOP be more transparent with inmates and other stakeholders at a time of high stress and uncertainty.⁶⁵

The Home Confinement Review Process, COVID-19 Outbreaks, and Quarantine Protocols Potentially Contributed to Delays in Home Confinement Transfers

The Attorney General's April 3, 2020 memorandum instructed the BOP to "immediately maximize appropriate transfers to home confinement of all appropriate inmates" at those prisons "where COVID-19 is materially affecting operations."⁶⁶ We found, however, that the BOP's April 22 guidance, which implemented the April 3 memorandum, did not specifically address the Attorney General's instruction to "immediately maximize appropriate transfers to home confinement." A BOP Correctional Programs Division official stated that the Central Office sent additional rosters of potentially eligible inmates to facilities that were experiencing an increase in COVID-19 cases, following an initial roster of eligible inmates sent to all BOP facilities. This official further stated that the BOP authorized temporary duty (TDY) assignments at certain facilities to assist with reviewing inmates for potential transfer to home confinement. According to this official, the BOP expected institution staff to review inmates and complete referrals for home confinement as quickly as possible.

We found that the time it took to transfer inmates, coupled with the active COVID-19 outbreaks, potentially limited the effect that transfers to home confinement had on managing the outbreaks. The BOP facilities we inspected reported that it took at least 2–4 weeks between an inmate's identification for home confinement consideration and his or her transfer date. For example, our [FCC Lompoc](#) remote inspection found that the process for reviewing inmates for home confinement, coupled with the 14-day quarantine period the Attorney General memoranda required to ensure that inmates placed into the community did not have COVID-19, resulted in 3 or more weeks between the time the Central Office identified an inmate for transfer consideration to the date the inmate was actually transferred to home confinement. By May 13, 2020, over 900 inmates at FCC Lompoc had contracted COVID-19 and only 8 inmates had been transferred to home confinement under CARES Act authorities and BOP guidance. These delays are reflected in the relatively low number of CARES Act transfers BOP-wide in April 2020 as compared to May and June of 2020, as shown in Figure 4 above.

COVID-19 outbreaks may have also affected the ability of BOP facilities to promptly transfer inmates to home confinement. For example, at [FMC Fort Worth](#), officials told us that some of the inmates approved for home confinement had their transfers delayed because those inmates had tested positive for COVID-19. As we discuss in the [Introduction](#), facilities needed to designate several separate quarantine and medical isolation spaces for inmates, including separate spaces for isolation of inmates with COVID-19 and for quarantine for outgoing inmates, including those transferring to an RRC or home confinement. Outbreaks meant that there were sometimes competing quarantine and medical isolation needs. For example, an [FCC Butner](#) staff member reported that during a large outbreak the designated quarantine space was being used to quarantine outgoing inmates so it could not be used for exposure-related quarantine. While transferring inmates to home confinement allowed for improved social distancing, time and competing

⁶⁵ We discuss other topics related to the BOP's communication with stakeholders in the section titled [The BOP Should Improve its Communication of Essential Information to Stakeholders](#).

⁶⁶ Barr, memorandum for Director of Bureau of Prisons, April 3, 2020, 1.

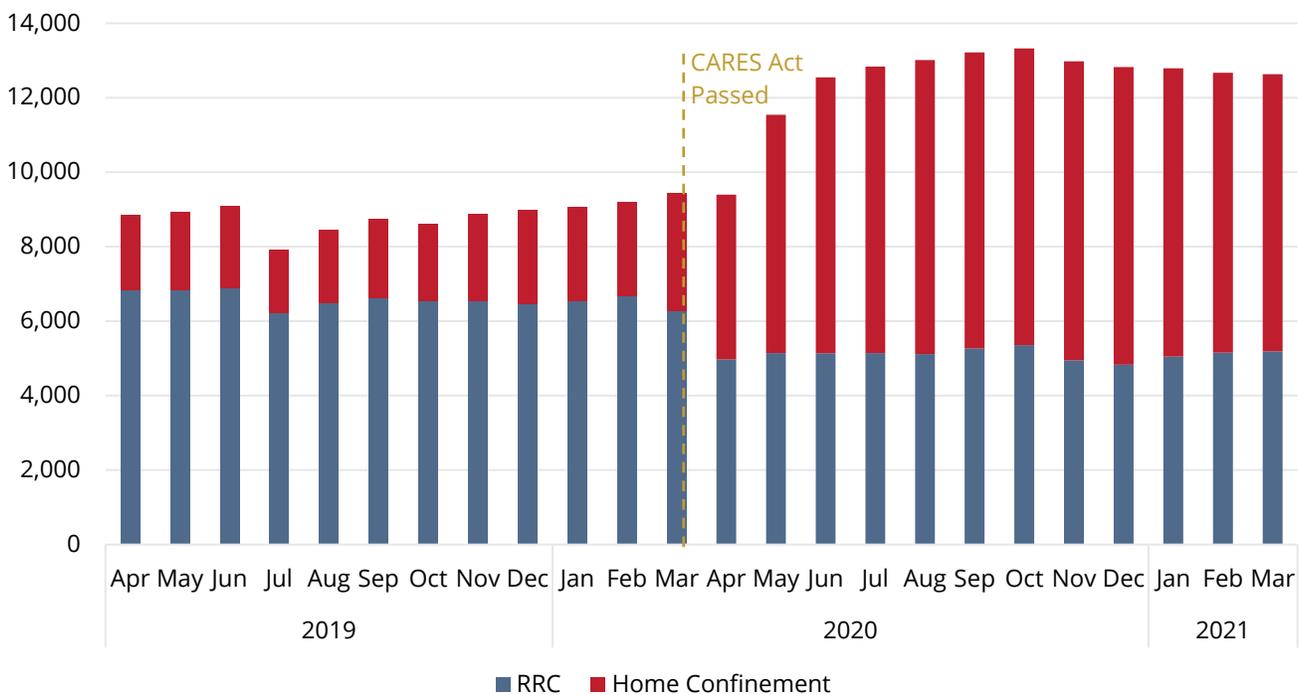
resources may have limited the effect that home confinement transfers had on the virus spread in affected facilities.

Potential Challenges for RRCs Due to the Increased Number of Inmates in Home Confinement

We found that in the year following the passage of the CARES Act, from April 2020 through March 2021, there was an average of 12,480 inmates under RRC supervision, either living in an RRC facility or in home confinement. This was a 41 percent increase in the average population under RRC supervision over a comparable period before the CARES Act. And, when we specifically examined inmates in home confinement, we found that the number of inmates in home confinement more than tripled, averaging 7,372 inmates in home confinement during the first year of the CARES Act as compared to 2,271 inmates in home confinement during the year before the CARES Act. Figure 5 below shows the number of inmates living in RRC facilities and in home confinement before and during the first year of the CARES Act.

Figure 5

Total Inmate Population in Community-Based Custody, April 2019–March 2021



Source: OIG analysis of BOP data

As we discussed above, one of the reasons for this increase was the CARES Act provision allowing inmates to be transferred to home confinement with more than 6 months remaining on their sentence; therefore, inmates were spending longer amounts of time in home confinement than would be permitted under standard prerelease authorities, resulting in an unprecedented increase in the number of inmates in extended home confinement. When using its CARES Act authority, the BOP transferred inmates directly

from prisons to home confinement.⁶⁷ The addition of the CARES Act authority also allowed prerelease inmates who had been placed in RRCs to transfer from RRCs to home confinement earlier than under the BOP's standard prerelease process. Eligible inmates residing in RRC facilities whom the BOP transferred to home confinement increased the home confinement population while decreasing the number of inmates residing in RRC facilities. Under the RRC contractual model, RRCs may typically place inmates in home confinement if (1) they met a home confinement eligibility date provided by the BOP and (2) the RRC could verify a suitable home address with mechanisms, such as a landline telephone, in place to maintain accountability.

Our remote inspections of [Brooklyn House RRC](#) and [Toler House RRC](#) found that the RRCs received direction from BOP officials that they could expand the use of home visit passes, which are traditionally used to allow for temporary, short-term home visits. Expanded home visit passes offered RRCs the flexibility to temporarily reduce the in-house RRC populations and increase social distancing at RRC facilities. Our inspections of Brooklyn House RRC and Toler House RRC found that, by using these flexibilities and home confinement, the only inmates who continued to reside in those RRCs at the time of our fieldwork were homeless or lacked a suitable home residence for placement. Between home confinement and the use of other flexibilities, RRCs needed to supervise a much larger population of inmates located outside of RRC facilities.

The increased home confinement population may pose challenges for RRCs and in the management of inmates in community-based custody. Changes in managing home confinement populations, RRC staffing and cost concerns, and addressing failures in the home confinement setting are all areas that the BOP will need to continue to monitor as the population in home confinement remains high during the COVID-19 pandemic and beyond. Below, we present the specific challenges in each area.

Monitoring a Larger Home Confinement Population

In response to the COVID-19 pandemic, the BOP allowed RRCs to reduce certain monitoring and accountability measures that it typically requires. For example, on March 24, 2020, the BOP allowed RRC staff to suspend routine breathalyzer and drug testing and replace in-person check-ins, employment site checks, and home site checks with virtual accountability measures such as telephone or video calls. On April 3, 2020, the BOP's Reentry Services Division (RSD) further modified guidance for interaction with and monitoring of inmates placed in a home setting. The April 3 guidance required that all inmates in home confinement be monitored via technology tools but allowed for virtual supervision and confirmation of electronic monitoring equipment functionality in certain circumstances, with the expectation that RRCs would physically verify inmate location via visual confirmation at least monthly.

An RSD official told us that the initial increase of inmates in home confinement was manageable due to the reduced RRC contractual requirements. However, as the pandemic continued, it became difficult to maintain contract compliance with increasing home confinement and RRC populations. Once all modified operations end, RRC contractors will need to meet all of the terms and conditions of their contracts, such as onsite monitoring, employment assistance, and drug and alcohol counseling, that were suspended during

⁶⁷ Under the BOP's prerelease process, inmates often spend a period of months in RRC facilities as a part of the transition back into the community before moving into home confinement.

the pandemic. The DOJ Office of Legal Counsel has determined that inmates placed in home confinement under the CARES Act can remain there after the pandemic ends, and in June 2022 the Department published a regulatory proposal consistent with the Office of Legal Counsel's opinion.⁶⁸ Therefore, the population of inmates in home confinement will likely continue to be higher than it was pre-pandemic. However, other factors may also affect the population of inmates in RRC custody, including those in home confinement. For example, on September 10, 2021, the BOP issued a memorandum to RRCs announcing that inmates on CARES Act home confinement who have underlying federal convictions for nonviolent drug offenses may be considered for clemency on an expedited basis by the Biden administration. The memorandum instructed RRCs to encourage inmates in home confinement and RRC facilities to apply for sentence commutation. Regardless of the effect that these external factors have on the number of inmates in home confinement, the BOP will need to ensure that RRCs are appropriately managing inmate populations in compliance with their contractual requirements during and after the pandemic.

Retaining Sufficient Services as RRCs Adjust to Staffing and Cost Changes

The shift in the RRC-managed population to predominately home confinement inmates required RRCs to adjust their operations and reallocate their resources. For example, RRCs have needed more field staff to conduct home visits and more global positioning system (GPS) equipment to monitor their larger home confinement populations. These changes may result in staffing and costs concerns for RRC providers as they experience additional costs driven by the pandemic. BOP RSD officials told us that some RRC contractors had reported reduced staffing and challenges hiring new staff and that some RRCs had needed to provide hazard pay in order to retain staff. Additionally, RRCs generally are paid based on a negotiated daily rate for each inmate housed at the RRC facility and are paid half the daily rate to monitor an inmate in home confinement. The BOP reported that it has already received funding adjustment requests from some RRC providers and that it expects to receive more. The BOP further observed that new contract solicitations have included higher prices. While the OIG did not independently conduct RRC cost assessments for this review, we note that the shift toward supervising more inmates in home confinement and fewer in RRC facilities may affect whether RRCs can afford their operational costs. The BOP may need to explore options to retain necessary services in an environment in which traditional RRC providers may be less able or willing to provide services to meet the demands of the larger home confinement population.

Handling Failure in the Home Confinement Setting

Although failures in the home confinement setting were rare during the first year of the CARES Act, RRCs and the BOP have fewer options for managing failures in CARES Act home confinement. Failure in the home confinement setting occurs when an inmate commits misconduct or fails to comply with program rules, such as by using illicit drugs, missing check-ins, or committing new criminal activity. Typically, if an inmate fails in home confinement or if the home setting is no longer an appropriate place for that inmate, the BOP can move the inmate into an RRC. However, RRC placements are generally limited to 12 months and the CARES Act did not authorize extended placement in RRCs when it authorized extended placement in home confinement. Therefore, if an inmate in home confinement under the CARES Act with more than 12 months remaining on his or her sentence breaks the rules, the BOP must decide between returning the inmate to a BOP facility or letting the inmate remain in home confinement. The BOP reported that this limitation makes

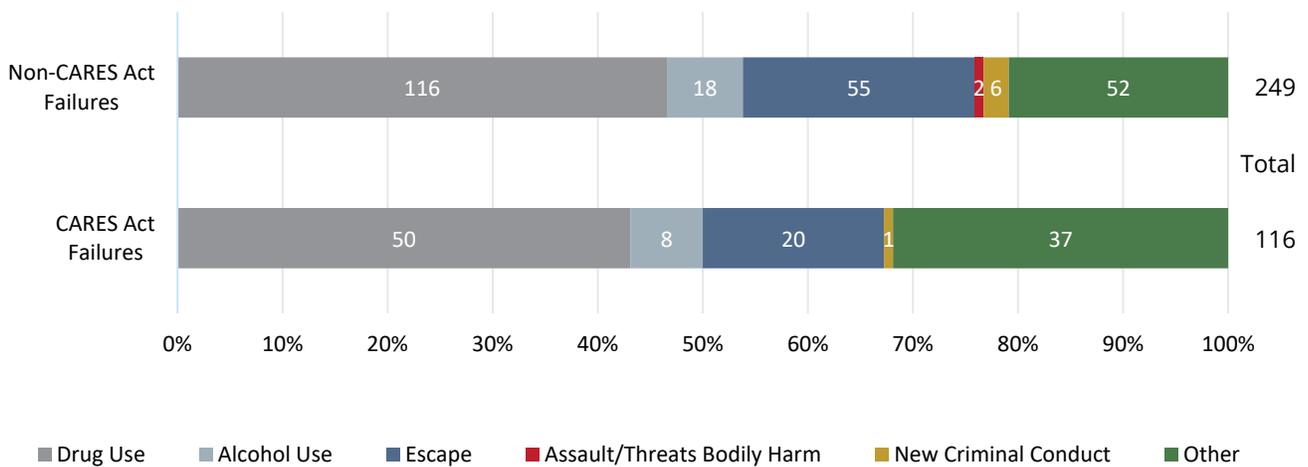
⁶⁸ See DOJ Office of Legal Counsel, Slip Opinion, "[Discretion to Continue the Home-Confinement Placements of Federal Prisoners After the COVID-19 Emergency](https://www.justice.gov/olc/file/1457926/download)," December 21, 2021, www.justice.gov/olc/file/1457926/download (accessed July 13, 2022).

it more challenging to address lower-level noncompliance because it does not have an intermediate sanction to impose before returning the inmate to a BOP facility.

RSD officials expressed concerns about long-term placements in home confinement and anticipated an increase in program failures. In particular, RSD officials anticipated that, when normal inmate monitoring, such as drug testing, resumed, failures would increase. OIG analysis of home confinement failure data through March 2021 indicates that the home confinement failure rate for inmates released under CARES Act authorities was low and only slightly higher than the failure rate for inmates released under preexisting authorities. Of the 6,781 inmates who were transferred to home confinement under the CARES Act from April 2020 through March 2021, 116 (1.7 percent) had failed in the home confinement setting as of the end of March 2021. By comparison, there were 21,572 inmates transferred to home confinement under other authorities during the same period and 249 (1.2 percent) had failed in the home confinement setting as of the end of March 2021. As shown in Figure 6 below, the majority of home confinement failures were related to drug or alcohol use. The most serious infraction, new criminal conduct, was infrequent for both inmates placed in home confinement under the CARES Act and inmates placed under other home confinement authorities.

Figure 6

Causes of Home Confinement Failures, April 2020–March 2021



Notes: In the home confinement setting, “Escape” refers to failing to remain at approved locations or failing to check in at required times. “Other” encompasses violations that do not fit into the categories listed. Some examples include no longer having an appropriate residence for home confinement and repeated noncompliance with the conditions of home confinement.

Source: OIG analysis of BOP data

Conclusion

During our remote inspections, and in our work on this capstone review, we found that the BOP limited its use of the CARES Act home confinement authorities by generally requiring that inmates have COVID-19

health risk factors in order to be eligible for transfer to home confinement. We also found that the BOP experienced challenges in timely transferring eligible inmates to home confinement at the outset of the pandemic. The OIG is taking a deeper look at some of these issues in its ongoing review of the BOP's use of home confinement as a response to the COVID-19 pandemic.

Ultimately, the BOP did transfer a substantial number of inmates to home confinement in May and June 2020; but we determined that the number of inmates transferred to home confinement during the first year of the pandemic was actually lower than the number of inmates transferred during the year immediately prior to the pandemic. We also found that the overall number of inmates monitored on home confinement increased and remained high because inmates were being transferred to home confinement with longer periods of time remaining in their sentences and therefore were spending more time in home confinement. Additionally, inmates who had been serving their sentences in RRC facilities were transferred to home confinement. In light of the increase in the number of inmates supervised by RRCs in the home confinement setting, we believe that the BOP should continue to assess the effects of the larger home confinement population on RRCs and their ability to monitor, manage, and provide services for inmates in home confinement. While we do not make specific recommendations on this topic in this report, we encourage the BOP to continue to assess how it can most effectively use its available authorities to appropriately place inmates in home confinement during and after the COVID-19 pandemic.

The BOP Should Take Appropriate Steps to Address Staffing Shortages and Staff Morale

During our remote inspections, we identified several facilities that faced COVID-19 challenges due to staffing shortages and found that the BOP used overtime, augmentation, and TDY assignments in an effort to alleviate them. The effects of insufficient staffing were also illustrated in our BOP staff surveys, indicating a need for more custody and medical staff in federal facilities, as well as a range of professional and personal impacts on staff due to the pandemic. Additionally, we found that staffing shortages at BOP facilities may have impeded some facilities' ability to respond to the COVID-19 pandemic in a timely and thorough manner. Finally, our remote inspections found that the pandemic strained staff morale and that facilities varied in their abilities to support staff.

COVID-19 Exacerbated the Effects of Staffing Shortages, Increased Staff Workloads, and Impeded Some Facilities' Ability to Fully Respond to the Pandemic

During our remote inspections, we found that the BOP has continued to struggle with staffing issues, including existing vacancies, staff absences, and increased workloads. The OIG has highlighted the BOP's staffing shortages as a long-standing issue in *Top Management and Performance Challenges* reports dating back to 2015.⁶⁹ The OIG discussed facilities' medical staffing shortages in particular in our 2016 *Review of the Federal Bureau of Prisons' Medical Staffing Challenges*.⁷⁰ As shown in Table 3 below, the BOP increased its total number of onboarded staff from FY 2018 through FY 2021. However, as of September 2022 the

⁶⁹ Each year, the OIG prepares a report on *Top Management and Performance Challenges Facing the Department of Justice*, which is required by statute to be included in the Department's Agency Financial Report. The OIG's 2021 report continued to highlight the BOP's staffing shortages. See DOJ OIG, *Top Management and Performance Challenges-2021*.

⁷⁰ DOJ OIG, [Review of the Bureau of Prisons' Medical Staffing Challenges](https://oig.justice.gov/reports/review-federal-bureau-prisons-medical-staffing-challenges), E&I Report 16-02 (March 2016), oig.justice.gov/reports/review-federal-bureau-prisons-medical-staffing-challenges.

BOP had over 2,500 staff vacancies, including 21 percent of its authorized Correctional Officer positions. The number of onboarded Correctional Officers declined from 17,114 at the end of September 2021 to 16,153 at the end of September 2022. As of September 2021, the BOP also reported that 14 percent of its Health Services positions were vacant, as shown in Table 4 below. A December 2020 OIG Management Advisory Memorandum on the BOP’s FY 2019 overtime hours and costs noted that the BOP uses overtime as a mechanism to supplement staffing and found that the BOP spent over \$300 million in overtime costs during FY 2019.⁷¹ As part of the OIG’s ongoing work with the Pandemic Response Accountability Committee, we are also assessing the BOP’s healthcare personnel shortages during the COVID-19 pandemic, the impact of healthcare personnel shortages, and strategies to attract and retain healthcare personnel.

Table 3

BOP Staff Vacancy Rates, September 2017–September 2022

As-of Date	All BOP Employees			Correctional Officers		
	Authorized Positions	Onboarded Positions	% Vacant	Authorized Positions	Onboarded Positions	% Vacant
End of September 2017	37,974	36,350	4%	20,921	18,170	13%
End of September 2018	38,557	34,414	11%	19,361	17,142	11%
End of September 2019	38,557	34,666	10%	20,446	17,031	17%
End of September 2020	38,680	35,869	7%	20,446	17,134	16%
End of September 2021	38,884	35,886	8%	20,446	17,114	16%
End of September 2022	38,995	34,094	13%	20,446	16,153	21%

Notes: “Authorized Positions” refers to the total possible staff positions, as reported in the BOP’s Enacted Spend Plans. This number does not necessarily reflect the number of staff positions for which the BOP received funding in the given year. In each year except FY 2018, the BOP received funding for fewer than the number of authorized positions. For this table, the OIG calculated the vacancy rates using onboarded and authorized positions. The BOP’s Administration Division told us that it calculated vacancy rates using funded positions instead of authorized positions, which is different from the manner that we present in this table. However, the Administration Division was not able to provide the OIG the number of funded Correctional Officer positions.

Source: BOP Congressional Budget Submissions and BOP Administration Division data

⁷¹ DOJ OIG, [Management Advisory: Analysis of the Federal Bureau of Prisons’ Fiscal Year 2019 Overtime Hours and Costs](https://www.oig.justice.gov/reports/management-advisory-analysis-federal-bureau-prisons-fiscal-year-2019-overtime-hours-and), Audit Report 21-011 (December 2020), [oig.justice.gov/reports/management-advisory-analysis-federal-bureau-prisons-fiscal-year-2019-overtime-hours-and](https://www.oig.justice.gov/reports/management-advisory-analysis-federal-bureau-prisons-fiscal-year-2019-overtime-hours-and).

Table 4

BOP Health Services Staff Vacancy Rates, September 2019–September 2021

As-of Date	Total Positions	Onboarded Positions	% Vacant
September 2019	3,746	3,052	19%
September 2020	3,878	3,246	16%
September 2021	3,806	3,255	14%

Notes: “Health Services Staff” includes civil service and U.S. Public Health Service (PHS) staff (described below) at the Central Office, six Regional Offices, and BOP facilities. There were between 95 and 103 onboarded Central and Regional Office Health Services staff each year. The BOP’s Administration Division does not track Health Services positions and they are not reported in BOP budget documentation, so the OIG requested this data from the BOP separately from the data in Table 3 above. Thus, the data is not directly comparable to the data we present in Table 3.

Source: BOP data

In our [2021 BOP Staff Survey](#), 78 percent of respondents said that their facility’s Correctional Officer staffing is insufficient and 53 percent said that their facility’s Health Services staffing is insufficient. BOP policy states that the vacancy rate of staff positions that work directly with inmates shall not exceed 10 percent during any 18-month period.⁷² Although our remote inspections did not assess individual facilities’ compliance with this policy, we identified examples of what we believe are insufficient staffing levels, especially for Health Services staff positions, at several facilities. For example, our remote inspection reports identified the following staffing issues:

- During our remote inspection of [FCC Lompoc](#), Lompoc’s Health Services Administrator indicated that prior to the COVID-19 outbreak the facility’s medical staff had a 38 percent vacancy rate.⁷³
- Our remote inspection of [MDC Brooklyn](#) found that the facility’s vacancy rates for Health Services positions were between 33 percent and 27 percent from March 15 through May 9, 2020. Additionally, MDC Brooklyn’s Custody Department was approximately 14 percent vacant from mid-March through mid-May 2020 and the facility received staff on TDY assignment to fill vacancies.⁷⁴

⁷² BOP Program Statement 3000.03, [Human Resource Management Manual](#), December 19, 2007, www.bop.gov/policy/progstat/3000_003.pdf (accessed July 11, 2022).

⁷³ The Lompoc Health Services Administrator told the OIG that prior to the COVID-19 outbreak the facility’s medical staffing was at only 62 percent. See DOJ OIG, [Remote Inspection of Federal Correctional Complex Lompoc](#), E&I Report 20-086 (July 2020), oig.justice.gov/reports/remote-inspection-federal-correctional-complex-lompoc.

⁷⁴ BOP staff on TDY assignments deploy to other BOP institutions or offices on a temporary basis to address staffing needs. Our remote inspection of [MDC Brooklyn](#) found that the facility staffed between 20 and 22 of its 30 authorized Health Services positions (between 67 and 73 percent) from March 15 to May 9, 2020. MDC Brooklyn’s Custody Department was approximately 86 percent filled from mid-March through mid-May 2020.

- During our remote inspection of [FCC Coleman](#), management and Health Services staff identified medical staffing shortages as the greatest challenge facing FCC Coleman in its efforts to combat COVID-19.⁷⁵ At the time of the remote inspection, Coleman’s Health Services Department had about a 20 percent vacancy rate.

BOP data, BOP staff survey results, and our remote inspections identified instances of COVID-19 related staff unavailability or absences:

- Based on our 2021 BOP Staff Survey results, 24 percent of BOP staff respondents reported that they contracted COVID-19 and believed it was due to work exposure, 23 percent reported taking leave due to demands at home, and 28 percent reported that they were required to work longer shifts. The effect that the pandemic had on BOP staff work assignments and schedules, based on our 2021 BOP Staff Survey, is further illustrated below in Figure 7.
- As of October 2021, BOP data indicated that over 7,800 current staff members had contracted and recovered from COVID-19.⁷⁶
- At [FCI Milan](#), three-quarters of the facility’s healthcare staff caught COVID-19 at some point, most of them during the first week of the facility’s outbreak in April 2020.⁷⁷
- At [FCC Oakdale](#), staff reported numerous absences due to illness, the need to quarantine, and fear of reporting to work, which forced some remaining staff to work longer shifts.

⁷⁵ At the time of our remote inspection, Coleman’s Health Services Department had only 66 of its 83 authorized medical personnel on hand. See DOJ OIG, [Remote Inspection of Federal Correctional Complex Coleman](#), E&I Report 21-026 (January 2021), oig.justice.gov/reports/remote-inspection-federal-correctional-complex-coleman.

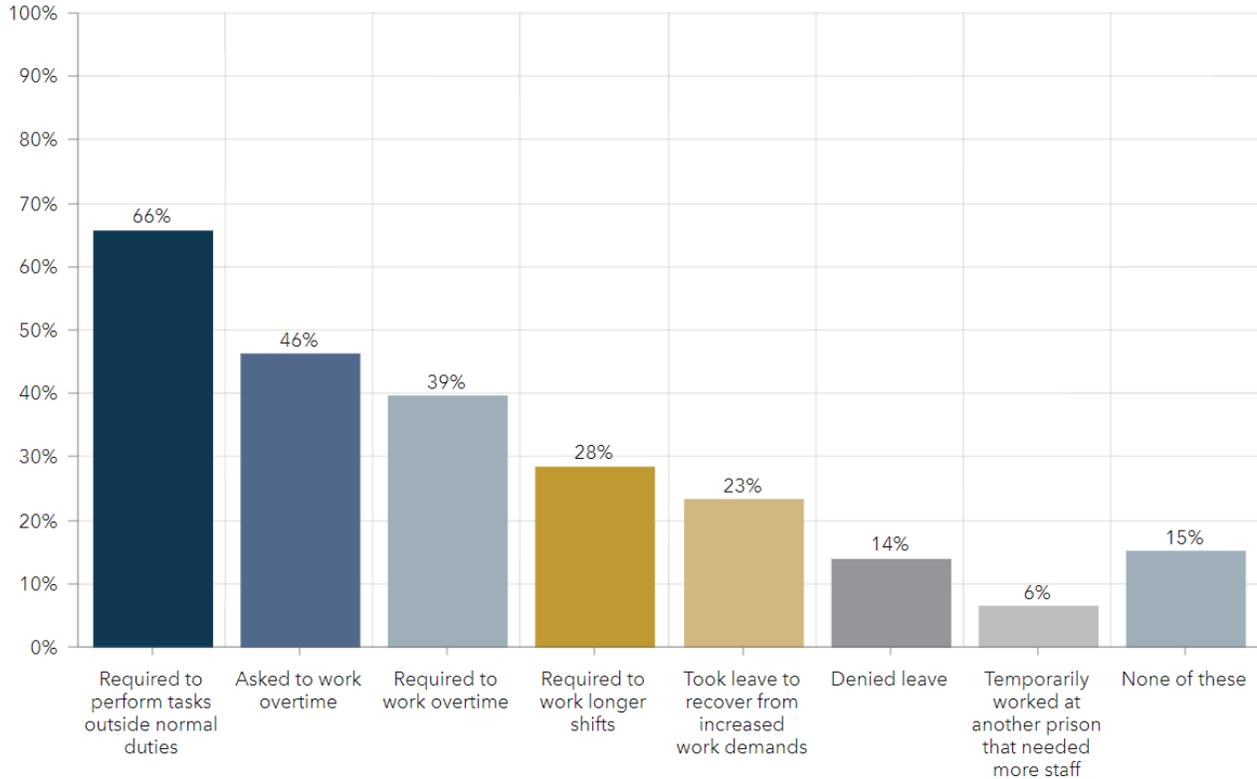
⁷⁶ This data does not account for individuals who may have contracted and recovered from COVID-19 while working at the BOP but who were no longer employed by the BOP.

⁷⁷ DOJ OIG, [Remote Inspection of Federal Correctional Institution Milan](#), E&I Report 21-032 (January 2021), oig.justice.gov/reports/remote-inspection-federal-correctional-institution-milan.

Figure 7

2021 BOP Staff Survey Results: Impact on Staff

How has the COVID-19 pandemic affected your work schedule/assignments? (Check all that apply.)



Source: [OIG dashboard of 2021 BOP Staff Survey data](#)

Additionally, BOP staff who continued to work during the COVID-19 pandemic requested a large number of temporary job modifications that we believe may have affected their ability to conduct their usual work.⁷⁸ OIG analysis of BOP data showed that, from March 2020 through May 2021, over 1,700 temporary job modifications related to the ongoing COVID-19 pandemic were approved. About 58 percent of the temporary job modifications involved duty modifications beyond the BOP’s social distancing and face covering requirements. These modifications included remaining separate from others or staying away from the facility, both of which severely limit the work that BOP facility staff can do, especially for staff whose jobs generally require in-person contact with inmates.

Staffing Shortages and Increased Workloads Due to COVID-19 Protective Measures

We found that modified operations and increased infection prevention and control measures due to the COVID-19 pandemic increased BOP facility staff workloads. Staff needed to take on additional responsibilities, including regularly screening inmates and staff for symptoms of COVID-19; managing quarantine and medical isolation units; and taking on tasks, such as food service, cleaning, and laundry, normally done by inmate work crews, in an effort to manage and reduce transmission of COVID-19 in

federal facilities. At some BOP facilities we inspected, so many inmates were simultaneously hospitalized for COVID-19 that dozens of Correctional Officers per shift were assigned to accompany and supervise them. For example, at [FMC Fort Worth](#), teams of two Correctional Officers are required to accompany each inmate receiving care at a hospital. Our inspection found that at one point in April 2020 as many as 81 Correctional Officers were assigned to the hospital and were not available to fill posts at the FMC due to the risk of further COVID-19 transmission.⁷⁹ Additionally, restrictions on inmate movement meant that staff had to bring services into the housing units rather than allowing inmates to gather in a common area to receive services. For example, our inspection of [FCC Pollock](#) found that Education Department staff performed rounds and made materials available to inmates for self-study when inmates could not visit classrooms.⁸⁰ Our inspection of [FCC Tucson](#) found that Health Services staff had to provide all medical services, such as sick calls and medication deliveries, inside housing units, which Tucson management described as “taxing.”⁸¹

We also found that facility staff were asked to work overtime to cover staffing shortages during the pandemic.⁸² For example, the remote inspection of [FCC Oakdale](#) noted an increased use of overtime to address COVID-19 related staffing issues. Collectively, Oakdale staff worked more than 18,700 overtime hours between March 29 and April 25, 2020, during the height of Oakdale’s COVID-19 crisis. This was a 487 percent increase from the 3,186 collective overtime hours that Oakdale staff worked between February 2 and 29, 2020. The BOP acknowledged that some Oakdale staff volunteered to work shifts as long as 40 hours straight but asserted that no staff member was mandated to work beyond a 16-hour shift. Nurses and Correctional Officer Lieutenants were mandated to work up to 12-hour shifts rather than their standard 8-hour shifts. The 2021 BOP Staff Survey results indicated that the use of overtime was widespread during the pandemic, with 46 percent of staff respondents reporting that they had been asked to work overtime and 39 percent of staff respondents reporting that they had been required to work overtime. These numbers were higher for Correctional Officers, with 64 percent of Custody staff (Correctional Officer) respondents reporting that they had been asked to work overtime and 72 percent reporting that they had been required to work overtime. In addition to overtime, staff workloads during the pandemic contributed to delayed family notifications of inmate serious illness. We discuss that issue below in [The BOP Should Improve Its Communication of Essential Information to Stakeholders](#) section of the report.

Finally, we found that BOP staff were often pulled from their normal duties to perform tasks in areas that were short staffed. In our [2021 BOP Staff Survey](#), 66 percent of respondents reported that they had been asked to perform tasks outside their normal duties. Further, at [FCC Oakdale](#), staff from the Recreation, Education, Religious Services, Facilities Management, and Human Resources Departments were reassigned

⁷⁸ Temporary job modifications allow the BOP to place staff members at work posts different from their normal job responsibilities.

⁷⁹ BOP Program Statement 5538.07, [Escorted Trips](#), December 10, 2015, www.bop.gov/policy/progstat/5538_07.pdf (accessed July 11, 2022).

⁸⁰ DOJ OIG, *Remote Inspection of Federal Correctional Complexes Oakdale and Pollock*.

⁸¹ DOJ OIG, [Remote Inspection of Federal Correctional Complex Tucson](#), E&I Report 20-087 (July 2020), oig.justice.gov/reports/remote-inspection-federal-correctional-complex-tucson.

⁸² Previous OIG work has examined the BOP’s use of overtime. In FY 2019, BOP employees worked 6.71 million overtime hours, the equivalent of 3,107 full-time positions. See DOJ OIG, *The Federal Bureau of Prisons’ Fiscal Year 2019 Overtime Hours and Costs*.

to cover general inmate supervision posts. A BOP Central Office official told us that, during the pandemic, facilities used education staff to augment correctional posts, which often resulted in insufficient staff to run education or recreation programming for inmates.⁸³ The OIG has previously raised concerns about augmentation because it often places program staff into critical security positions and interferes with the BOP's ability to ensure the safety of its staff and inmates, as well as its ability to provide inmate programs.⁸⁴ The GAO has also identified concerns in this area, specifically noting that the BOP has not assessed the risks associated with both overtime and augmentation, despite increased use of both practices between 2015 and 2019.⁸⁵

Staffing Shortages' Effect on Some Facilities' Ability to Fully Respond to the COVID-19 Pandemic

We found that medical staffing shortages affected the BOP's ability to provide routine medical care at certain facilities. The remote inspections of [FCC Lompoc](#) and [MDC Brooklyn](#) found that medical staffing shortages may have negatively affected the facilities' ability to screen inmates for COVID-19 symptoms in addition to providing routine medical care to inmates. MDC Brooklyn Health Services staff indicated that sick-call wait times increased significantly due to COVID-19, as the facility faced a much higher volume of sick calls compared to the prior year. Staff also reported that 160 inmate sick call requests, dating to early July 2020, had not been scheduled or completed as of late September 2020. MDC Brooklyn Health Services staff told us that, in addition to medical staffing shortages, the requirement for healthcare providers to visit inmates in housing units also lengthened the time it took for providers to evaluate and treat patients. In addition, as discussed previously, it was determined that, at another facility where an inmate had died by suicide, staff had failed to conduct pill line in restrictive housing, a failure that reportedly occurred due to staffing issues as well as staff error.

Shortages of staff also affected the implementation of COVID-19 control measures at certain facilities. At FCC Lompoc, an insufficient number of correctional staff members resulted in Lompoc officials delaying mandates on staff movement restrictions until 15 days after the BOP directed facilities with COVID-19 cases to maximize social distancing to help control the spread of the infection. Lompoc officials told us that they could not fully implement staff movement restrictions due to COVID-19 concerns until the arrival of adequate TDY staff because the facility did not have enough staff to fill all mandatory correctional posts, both at FCC Lompoc and at the local hospitals where some inmates were receiving care. Additionally, staffing shortages at [FCI Milan](#) due to a COVID-19 outbreak made it difficult for that facility to restrict staff movement to prevent the spread of the virus.

The BOP's Efforts to Address Staffing Shortages During the COVID-19 Pandemic

In addition to utilizing overtime and augmentation, as we described above, the BOP used a variety of methods to address the ongoing staffing shortages at its facilities. To address its immediate needs, the BOP

⁸³ Augmentation is the assignment of non-custody staff members to assume the duties of a Correctional Officer. The BOP practices augmentation to address custody staffing shortages. In response to augmentation practices described in a draft of this report, the BOP stated that it assigns necessary work to any staff member as all staff are correctional workers first and expected to complete work duties as a law enforcement professional first.

⁸⁴ DOJ OIG, [Top Management and Performance Challenges Facing the Department of Justice-2019](#) (October 2019), oig.justice.gov/reports/top-management-and-performance-challenges-facing-department-justice-2019, 3.

⁸⁵ See GAO, *BOP Could Further Enhance Its COVID-19 Response*, 57-59.

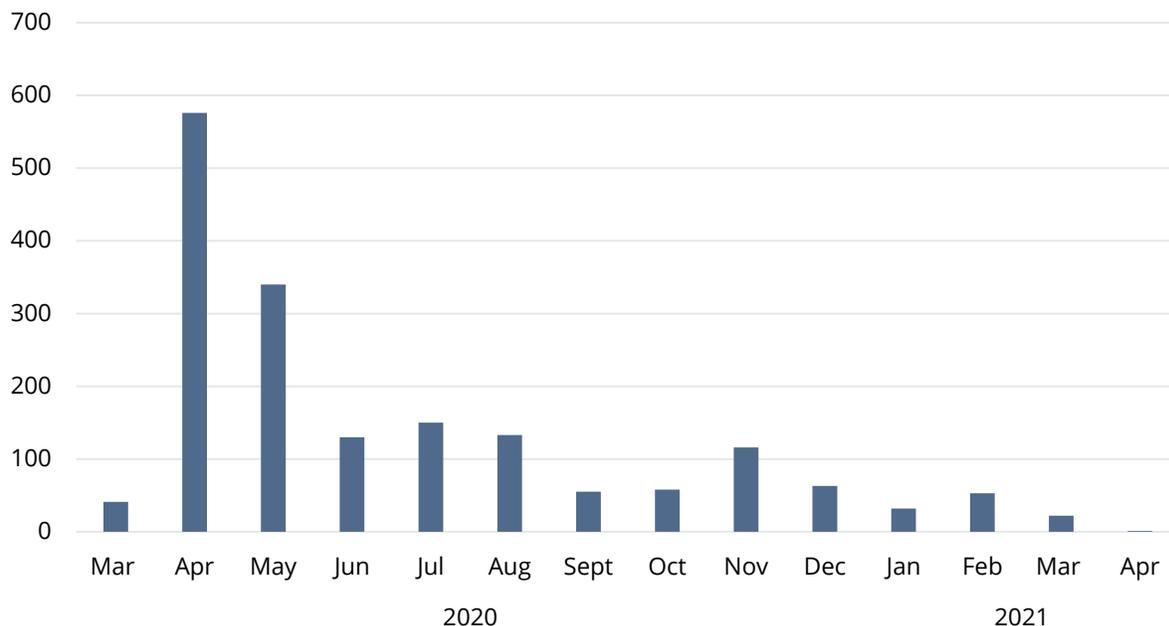
used short-term measures such as sending staff on TDY assignments and receiving additional support from the U.S. Public Health Service (PHS), a branch of deployable medical officers from the U.S. Department of Health and Human Services who serve in federal agencies. The BOP also continued efforts to increase employee retention and hire new staff during the pandemic. As shown in Table 3 above, the BOP increased its total staff from FY 2018 through FY 2021; however, in FY 2022, the number of total staff declined and 21 percent of the BOP's budgeted Correctional Officer positions remained vacant.

TDY staff are deployed from other BOP facilities or offices on a temporary basis to address a facility's immediate need for staff and ultimately return to their official duty post when the assignment is completed.⁸⁶ During our inspections, we found that the BOP deployed TDY staff to alleviate medical staffing shortages, decrease staff overtime hours, and assist staff with inmate supervision duties. Between March 2020 and April 2021, the BOP deployed 1,770 TDY staff for COVID-19 related assignments. As shown in Figure 8 below, the majority of the TDY assignments occurred during the beginning of the pandemic, in April and May 2020, though TDY surges occurred at various facilities throughout the first year of the pandemic. Overall, 59 BOP facilities and offices, including MDC Brooklyn, FCI Terminal Island, FMC Fort Worth, FCC Lompoc, and FCC Oakdale, received TDY staff to fill vacancies related to the COVID-19 pandemic. We found that, out of the 11 federal facilities we inspected, FCC Oakdale received the largest number of TDY staff, a total of 156 TDY staff placements between March 2020 and April 2021. Oakdale staff told the OIG that the additional help from TDY staff eased the burden on Oakdale's staff and made them better able to focus their efforts to contain the spread of COVID-19 at the facility.

⁸⁶ During our remote inspection of MDC Brooklyn, we conducted independent analysis of healthcare staffing levels and found that many positions were vacant. These vacancies were caused by extended absences from the institution due to a variety of reasons, including military leave, TDY assignments to other institutions, and extended sick leave. See DOJ OIG, *Remote Inspection of MDC Brooklyn*.

Figure 8

Number of BOP Staff Beginning a COVID-19 TDY Assignment, by Month, March 2020–April 2021



Source: OIG analysis of BOP data

The BOP employs both civil service employees and PHS officers to provide medical care to inmates in BOP facilities. A 1991 memorandum of understanding (MOU) between the BOP and PHS established conditions, responsibilities, and procedures governing the assignment of PHS officers to BOP facilities. As of May 2021, there were 670 PHS officers working at BOP facilities nationwide, according to a PHS Captain serving as a liaison on behalf of the BOP. PHS officers serve in various health service roles, including as nurses, physicians, pharmacists, and dentists. From April 28 through August 1, 2020, 28 additional PHS officers were deployed on a temporary basis to BOP facilities with the highest need nationwide in response to the COVID-19 pandemic.

The PHS Captain told us that the BOP and the PHS have been working on an updated MOU that would more clearly outline the staffing support that the PHS provides to the BOP. Current discussions related to updating the MOU include enhanced deployment plans, requirements of staff fitness for duty, and occupational and health safety plans for PHS staff deployed to BOP facilities. We believe that the BOP should continue its planned updates to the MOU with the PHS to clearly outline the medical staff support needed at BOP facilities that would help the BOP address medical staffing shortages beyond the pandemic.

To combat staffing shortages, the BOP has implemented programs aimed at hiring and retaining Correctional Officers and medical professionals. In recent years, the BOP has used recruitment incentives, relocation incentives, retention incentives, and other such programs in an effort to hire and retain staff. Beginning in September 2019, in an effort to retain staff, the BOP offered a 5 percent salary increase as part of a group retention incentive to approximately 3,000 employees who were eligible to retire as of the end of

calendar year 2019. This 5 percent group retention incentive was to be in effect until December 31, 2022. As of September 2019, 2,929 BOP staff had accepted the incentive, and, as of November 2022, 1,461 BOP staff continued to receive this incentive while remaining employed at the BOP despite their retirement eligibility.

In addition, according to a February 2021 GAO report, the BOP may repay federally insured student loans to attract job candidates or retain current staff. The GAO report further noted that, following U.S. Office of Personnel Management (OPM) approval, the BOP has established higher pay rates for some specialist positions, such as physicians and psychologists, as well as allowances for certain eligible physicians or dental professionals who enter into service agreements.⁸⁷ Additionally, all BOP facilities were instructed to hold at least one recruitment event per month to recruit more external staff and the BOP offered a \$1,000 recruitment incentive for staff who successfully recruited new hires.

For this report, we did not analyze the pay scales of BOP medical staff or potential challenges with staff recruitment. However, our 2016 report on the BOP's medical staffing challenges found that the BOP was required to classify positions according to the General Schedule pay scale, and, for physical therapists and pharmacists especially, the BOP struggled to offer competitive pay because the assigned grade of the positions limited the salaries they could offer.⁸⁸

To further understand the BOP's staffing shortages, we analyzed staffing data from 2018 through 2021. BOP staff retention remained largely the same over this 3-year period, with the BOP reporting total staff separation rates as 8.3 percent in 2018 and 7.4 percent in 2019. During the pandemic, in 2020, the separation rate for BOP employees was similar, at 7.6 percent. As shown in Figure 9 below, the number of separations month by month was fairly consistent throughout the 3-year period, despite the pressures of the ongoing pandemic.

⁸⁷ GAO, [Bureau of Prisons: Opportunities Exist to Better Analyze Staffing Data and Improve Employee Wellness Programs](https://www.gao.gov/products/gao-21-123), GAO-21-123 (February 2021), www.gao.gov/products/gao-21-123 (accessed December 21, 2021), 27.

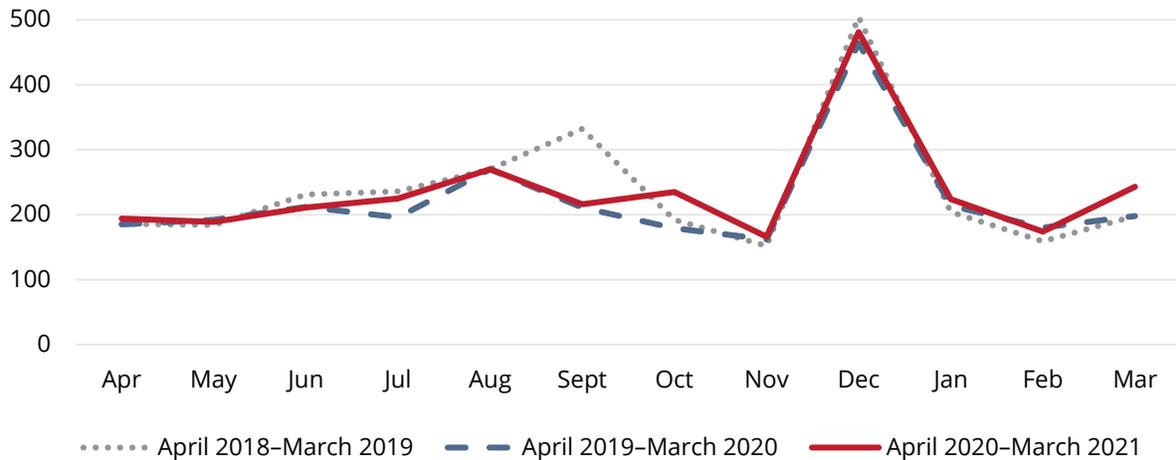
In January 2020, to improve healthcare recruiting and retention, the Department and OPM formally granted the BOP authority to pay physicians and dentists using the laws governing medical professional compensation in the U.S. Department of Veterans Affairs (Title 38 Pay Plan), which allows the BOP to offer staff in those positions higher pay than the BOP would otherwise be able to offer.

⁸⁸ DOJ OIG, *Review of the Bureau of Prisons' Medical Staffing Challenges*, 8–9. Our 2016 report also found that there was a large gap between the salaries the BOP pays its medical employees and those offered for similar positions in the local areas surrounding facilities.

In response to a draft of this report, the BOP stated that the pay scales of BOP medical staff, compared to those of medical staff in the general public, remain a major hurdle to the BOP's recruitment of medical staff. Separately, the OIG, in collaboration with the Pandemic Response Accountability Committee, is conducting a review of healthcare staffing in federal healthcare programs, including the BOP, to determine whether these programs experienced shortages in healthcare personnel during the pandemic, the impact of any shortages, and strategies used by agencies to reduce shortages of healthcare personnel for future pandemics.

Figure 9

Comparing BOP Staff Separations, by Month, April 2019–March 2021



Note: “Staff Separations” include retirements, transfers to other agencies, resignations, terminations, removals, and deaths.

Source: OIG analysis of BOP data

From April 2020 through January 2021, the BOP ran an advertising and marketing campaign to hire additional custody and Health Services staff through expanded recruitment efforts that reached an estimated 6.5 million viewers. This hiring campaign represented an attempt to rebrand and market the BOP for new recruits and included the use of online recruiting, social media, and web analytics to reach and engage new applicants. The BOP held live social media events geared toward the recruitment of nurses and Correctional Officers to reach wider audiences and drive applicants to the BOP application portal. However, new staff hiring levels appear to have remained largely the same despite the BOP’s increased focus on recruitment and retention. OIG analysis of BOP hiring data indicates that the number of new staff hired during the first year of the pandemic was similar to the number of staff hired during the year before the pandemic. The BOP hired 3,882 new staff from April 2019 through March 2020 and 3,823 new staff from April 2020 through March 2021. In March 2021, the then BOP Director told the House Appropriations Committee, Commerce, Justice, Science, and Related Agencies Subcommittee, that the BOP was able to hire new staff in 2020 but lost the same number of staff due to separations.

Conclusion

Overall, our inspections found that staffing shortages impeded the ability of some BOP facilities to provide routine medical care to inmates during the COVID-19 pandemic and implement effective infection mitigation strategies at various federal facilities, as well as straining already heavy staff workloads with additional responsibilities. In addition, as we discuss in the next section, the pandemic had a serious impact on staff morale. To alleviate staffing shortages, the BOP used overtime and augmentation and deployed TDY staff to requesting facilities most often related to COVID-19. The OIG has repeatedly highlighted the BOP’s staffing shortages issues, including its medical staffing shortages, in our *Top Management and Performance Challenges* reports. Additionally, a December 2021 GAO report found that the BOP lacks a plan for

identifying and addressing staffing challenges and has not leveraged available data to help identify and address the causes and potential impacts of staffing challenges.⁸⁹ Although we are not making any new recommendations on this topic given the GAO's open recommendations, we encourage the BOP to continue implementing additional proactive strategies to address staffing challenges and better prepare for public health emergencies in the future.

Staff Were Negatively Affected by the COVID-19 Pandemic, and the BOP Should Take Appropriate Steps to Support Staff Morale

Our remote inspections found that the pandemic strained staff morale and that facilities varied in their abilities to support staff. In addition to the negative effects of staffing shortages on facility staff that we described above, 70 percent of facility staff respondents from the [2021 BOP Staff Survey](#) reported having experienced stress or anxiety at work due to the pandemic. Further, BOP Central Office Psychology Services Branch officials we interviewed heard concerns from BOP staff related to facilities' implementation of COVID-19 related guidance, confusion regarding staff leave and quarantine, and fear of transmitting COVID-19 to family members. At [FCC Oakdale](#), management's failure to adequately communicate and engage with staff at the beginning of the complex's COVID-19 outbreak confused staff and created an environment in which staff felt that management did not appreciate them or lacked concern for their overall well-being. According to medical staff at FCC Milan, persistent staffing shortages took a toll on the health and well-being of medical staff. We also found that staff throughout the BOP expressed concerns regarding leave, including inconsistent and changing guidance about leave and quarantine due to COVID-19. Lastly, 2021 BOP Staff Survey respondents indicated that providing mental health resources for staff was one of the top five areas in which the BOP most needed to improve its pandemic response.

Staff's Mixed Perceptions of BOP Facility Leadership's Communication

We found in our remote inspections and staff survey responses that there were mixed reports about the BOP's communication with its staff during the pandemic. Respondents to the 2021 BOP Staff Survey identified facility leaders' communication with staff as the top area that the BOP most needed to improve in its handling of the pandemic. Further, our inspection reports found that facility leadership communication failures contributed to FCC Oakdale's delay in implementing the BOP's February 2020 staff screening guidance and FCC Lompoc staff's ignorance about a close contact who had tested positive for COVID-19, the latter of which potentially exposed others to the virus. In contrast, 2020 BOP Staff Survey respondents at eight BOP-managed facilities we inspected praised facility executive leadership for their proactive communication with staff members. Additionally, our inspections of the [Toler House Residential Reentry Center](#) (RRC) and three contract prisons found that contract facility leadership generally communicated information clearly to staff. The GAO's July 2021 report on the BOP's COVID-19 response recommended that the "BOP Director should routinely evaluate how the BOP communicates COVID-19 guidance to facility staff and that the BOP modify its approach, as needed, based on the results to ensure that BOP protocols are clearly communicated to staff."⁹⁰ The totality of staff perspectives that we received highlighted the

⁸⁹ GAO, *BOP: Opportunities Exist*, 41.

⁹⁰ GAO, *BOP Could Further Enhance Its COVID-19 Response*, 58.

importance of the BOP's communication with staff in maintaining facility safety and staff well-being during the pandemic.

Staff's Concerns About Inconsistent and Changing Guidance Regarding Leave

We found that BOP facility staff reported confusion about guidance on staff use of leave and quarantine due to COVID-19. To reduce the spread of COVID-19, the CDC advised the general public in 2020 to stay home if they were sick, had been in close contact with someone who had symptoms consistent with COVID-19, or had been in close contact with someone who tested positive for the disease.⁹¹ OPM and the CDC issued additional guidance to help federal employees whose ability to report to work may be affected by COVID-19, and the BOP subsequently issued its own guidance. Despite this guidance, we found that BOP staff were confused about their eligibility to use various types of leave and about the directions on whether to quarantine or continue reporting to work if they had been exposed to COVID-19.

BOP staff also expressed confusion about which types of leave they should use and their abilities to use leave during the pandemic. In March 2020, the BOP's Human Resources Management Division issued guidance advising that employees who were symptomatic or diagnosed with COVID-19 should use accrued or advance sick leave to cover the period of illness. The BOP's guidance further advised that asymptomatic employees who were told not to return to work by either a local health authority or the BOP's Health Services Division should either telework, if possible, or be placed on Weather and Safety leave. In April 2020 the BOP issued additional guidance explaining how the additional 80 hours of paid sick leave authorized by the Emergency Paid Sick Leave Act applied to BOP employees.⁹²

During our remote inspection fieldwork, BOP employees from 4 of the 11 federal facilities we inspected told us that they were unsure about aspects of the leave guidance, such as the types of leave afforded in various situations or how staff should determine when it was appropriate to return to work. Nationally, 45 percent (3,695 of 8,153) of 2020 BOP Staff Survey respondents who answered the survey question, "Which of the following are immediate needs for your institution during the COVID-19 pandemic," identified needing greater flexibilities for use of administrative leave due to COVID-19 related absences. Staff concerns about leave guidance and staff's ability to use leave were also expressed in complaints submitted to the OIG during the pandemic. Respondents to the 2021 BOP Staff Survey reported continued confusion about leave guidance, as less than half stated that guidance on using leave for COVID-19 reasons was easy to understand.

Staff's Reported Confusion About Whether to Quarantine or Report to Work

Another area of confusion for staff was whether they should quarantine or report to work following COVID-19 exposure. Early during the pandemic, CDC guidance on this topic applicable to BOP staff changed. Specifically, the CDC's March 23, 2020 interim guidance on management of COVID-19 in correctional facilities recommended that if a staff member was identified as a close contact of a COVID-19 case he or she should self-quarantine at home for 14 days before returning to work. However, the U.S. Cybersecurity

⁹¹ The CDC defines close contact as being within 6 feet for at least 15 minutes over a 24-hour period.

⁹² The Families First Coronavirus Response Act, enacted on March 18, 2020, made full-time federal employees generally eligible for expanded leave provisions if they were unable to work because of COVID-19. On April 1, 2020, the Emergency Paid Sick Leave Act went into effect as part of the Families First Coronavirus Response Act. Emergency Paid Sick Leave Act paid sick leave was available for use by federal employees from April 1, 2020, through December 31, 2020.

Infrastructure and Security Agency identified personnel in corrections as critical infrastructure workers and the CDC's April 9, 2020 guidance for critical infrastructure workers stated that asymptomatic workers exposed to COVID-19 could report to work following additional precautions.⁹³ For BOP correctional staff, this represented a significant change from the CDC's correctional facilities guidance that advised asymptomatic staff to quarantine for 14 days at home following COVID-19 exposure. A BOP Central Office Health Services official we interviewed described her own frustration about these inconsistencies and the resulting confusion and told us that representatives from the national union representing BOP Correctional Officers had expressed similar frustration.

On May 4, 2020, in a Families First Coronavirus Response Act Frequently Asked Questions document, the BOP's Human Resources Management Division wrote that asymptomatic employees should continue to report to work until advised otherwise. We did not find evidence that the BOP issued additional detailed guidance on this topic for non-TDY staff until September 2020, when the BOP issued the first version of its COVID-19 Pandemic Response Plan. This plan included an instructional flowchart for symptomatic facility and non-facility staff who had been potentially exposed to COVID-19, in addition to guidance for asymptomatic facility and non-facility staff who had been potentially exposed to COVID-19.

Respondents from our 2020 BOP Staff Survey also expressed confusion about whether to report to work if they had been exposed to COVID-19 and were asymptomatic. Some 2020 respondents reported instances in which they were advised by their physician to quarantine but told by the BOP to continue reporting to work. Similarly, a Central Office Health Services official we interviewed cited instances in which BOP staff had received mixed messages from healthcare providers. A 2020 BOP Staff Survey respondent observed that, by not offering administrative leave for the purposes of quarantining staff who had been exposed to COVID-19, the BOP's practices were inconsistent with those of local law enforcement or fire departments.⁹⁴

Prior to the BOP's issuance of its COVID-19 Pandemic Response Plan, facility staff working in different parts of the BOP reported receiving different instructions on what to do if they had been exposed to COVID-19. Federal staff working directly in facilities most commonly reported in our 2020 BOP Staff Survey that if they were exposed to COVID-19 they were expected to continue reporting to work unless they developed symptoms (45 percent, or 4,141 of 9,163). In contrast, federal staff working in the BOP's Central and Regional Offices most commonly reported in our 2020 BOP Staff Survey that if they were exposed to COVID-19 they were expected to quarantine for 14 days (47 percent, or 328 of 693).⁹⁵ Additionally, numerous 2020

⁹³ The CDC's suggested precautions included screening for elevated temperature and other symptoms, wearing a face mask or cloth face covering, social distancing, and regular cleaning and disinfecting workspaces.

⁹⁴ For example, news media reported in March 2020 that the New York City Fire Department initially quarantined Emergency Medical Services workers who had been exposed to COVID-19 before changing its policy to require exposed staff to continue working unless they developed symptoms. Ali Watkins, "[Last Week One Paramedic Was Infected. Now Over 150 Are in Quarantine.](https://www.nytimes.com/2020/03/20/nyregion/coronavirus-nyc-emergency-response.html)" *The New York Times*, March 20, 2020, www.nytimes.com/2020/03/20/nyregion/coronavirus-nyc-emergency-response.html (accessed July 13, 2022).

⁹⁵ Central and Regional Office respondents were also three times as likely as institution respondents to say that they were advised that they should use administrative leave or COVID-related leave if they were quarantined due to exposure to COVID-19. Specifically, 34 percent of Central and Regional Office respondents (235 of 693) said that they were advised that they should use administrative leave or COVID-related leave, compared to only 10 percent of institution respondents (955 of 9,163).

BOP Staff Survey respondents—nearly one in five facility respondents and one in seven Central and Regional Office respondents—reported that the guidance they had received on what to do if they had been exposed to COVID-19 was conflicting.⁹⁶

Uncertainty about whether to report to work or quarantine was of particular concern for staff returning from TDY assignments at other BOP facilities to their facilities of record. As we discussed above, the BOP utilized TDY staff to assist some facilities in their response to COVID-19, including at locations with high COVID-19 transmission. During our inspections, some staff reported concerns about the risk of COVID-19 transmission from TDY staff returning to their home facilities. Our inspection of [FCC Oakdale](#) found that staff returning from March 2020 TDY assignments in New York City, one of the areas hit hardest by COVID-19 at the time, were not initially given instructions about quarantine procedures and reported to work before being told to return home and quarantine for 14 days. Seven 2020 BOP Staff Survey respondents reported that TDY staff members returning from locations with high COVID-19 transmission were not required to quarantine. Similarly, in eight complaints submitted to the OIG in April and May 2020, complainants alleged that TDY staff returned to work without quarantining upon return to their primary work locations. Staff confusion about appropriate quarantine practices for returning TDY staff continued through 2021, as only 44 percent of [2021 BOP Staff Survey](#) respondents reported that guidance on quarantining staff following TDY assignments or official travel was easy to understand and that their facility followed communication and guidance on this issue.

The BOP's guidance for staff members returning to work from COVID-19 related TDY assignments evolved throughout the pandemic and likely contributed to staff's reported confusion. Between April and September 2020, the BOP issued three versions of guidance for staff returning from COVID-19 TDY assignments that included instructions on whether to report to work for both facility and non-facility staff in various scenarios (for a scenario example, see Table 5 below). For some staff members, the BOP's guidance on whether to report to work or take leave and quarantine at home changed each time the BOP updated its guidance. For example, we identified that an asymptomatic Correctional Officer returning from a TDY assignment working on a quarantine unit at a facility with active COVID-19 cases to his or her home facility with no active COVID-19 cases would have received the instructions presented in Table 5.

⁹⁶ Overall, 19 percent of federal institution respondents (1,750 of 9,163) and 14 percent of Central and Regional Office respondents (97 of 693) reported that they had received conflicting guidance.

Table 5

The BOP's TDY Guidance, May–September 2020

Scenario	Date	Applicable BOP TDY Guidance
An asymptomatic Correctional Officer returns from a TDY assignment working on a quarantine unit at a facility with active COVID-19 cases to their home facility with no active COVID-19 cases.	April 9, 2020	Report to work. ^a
	May 20, 2020	Stay at home and use 10 days of Weather and Safety Leave.
	September 11, 2020	Stay at home and use 14 days of Weather and Safety Leave. ^b

^a The April 9, 2020 guidance stated that Wardens could decide, contingent on staffing needs, to place an asymptomatic staff member returning from TDY on home quarantine for 14 days if he or she had been identified as a prolonged close contact of a COVID-19 positive case *and* did not have the appropriate PPE or had experienced a breach in PPE. The guidance further stated that staff who fit this category did not need to wear a face mask if a temporary job modification for a 14-day period could be provided to permit the staff member separation of greater than 6 feet from other individuals. On April 15, 2020, the BOP mandated that all staff and inmates would wear BOP-provided face coverings.

^b The September 11, 2020 guidance stated that an asymptomatic staff member who had been assigned to a quarantine unit, isolation unit, hospital duty, or inmate transport while on TDY “shall be placed on Weather & Safety Leave for 14 calendar days, unless otherwise determined by the [Warden] of their home institution (because of staffing needs).”

Source: OIG analysis of the BOP's 2020 TDY guidance

We found that during the pandemic there was uncertainty throughout the BOP about where to direct questions regarding leave and reporting to work. Concerns about use of leave and leave guidance were among the most common issues that staff raised in their calls to the BOP's COVID-19 staff support line, which we discuss below. At Central Office, the Human Resources Management Division was primarily responsible for the dissemination of guidance, which was largely derivative of OPM or DOJ guidance, about types of leave available to employees while the Health Services Division generally disseminated health guidance developed by the CDC. According to an official at the Occupational Health and Safety Branch within the Health Services Division, it was challenging for the branch to monitor updates to CDC guidance and the branch did not receive alerts when the CDC updated its guidance.

During interviews, BOP Occupational Health and Safety Branch staff told us that there had been constant challenges and areas of confusion regarding the use of leave for quarantine or isolation purposes and that it often referred those questions to the Human Resources Management Division. Despite these reported referrals, Human Resources Management Division staff advised us that they were unaware of staff members' confusion about leave during the pandemic and that facility staff concerns about leave were typically directed to the Regional Offices. Our analysis of call logs documenting calls made to the staff support line found that Central Office employees working on the staff support line often advised callers to consult their facilities regarding questions about leave and reporting to work. However, only 50 percent of [2021 BOP Staff Survey](#) respondents reported that their facility followed guidance on the use of leave for

COVID-19 reasons. Based on persistent BOP staff confusion about guidance on leave issues and differing directions about whom staff should consult, the BOP should clarify to staff where to direct leave inquiries.⁹⁷

The BOP Should Better Communicate Support Options to Staff

We found that the BOP could have better communicated the support options available to staff during the pandemic. The primary support options available to BOP staff during the pandemic include: (1) the Employee Assistance Program (EAP), which “provides employees and their family members with access to resources that help address work-related problems, traumatic incidents, substance abuse, mental illness, and other personal problems”; (2) a COVID-19 staff support line maintained by the BOP Central Office; and (3) Crisis Support Teams, which provide peer support to staff in response to critical incidents.⁹⁸ We found during our remote inspections that some facilities took actions to mitigate the effects of the pandemic on staff well-being. For example, management at contract prison [Correctional Institution \(CI\) Moshannon Valley](#) instituted morale and welfare teams composed of local staff to check on the well-being of staff and inmates during the pandemic.⁹⁹ Additionally, staff at three facilities we inspected told us that Crisis Support Teams were available to provide emotional support to staff. However, the BOP modified the support options available to staff during the pandemic, including changing EAP providers and creating and eventually discontinuing the COVID-19 specific 24-hour staff support line. Below, we discuss the support options available to staff during the pandemic:

- **EAP:** In December 2020, the BOP switched to a new EAP provider to provide enhanced resources to staff. BOP staff had expressed concerns about the effectiveness of the previous EAP provider the BOP utilized during the first 8 months of the pandemic. Although we did not assess the quality of EAP services as part of this review, a 2021 GAO report recommended that the BOP collect EAP participation and cost data in a more timely manner and routinely collect and evaluate feedback on its EAP.¹⁰⁰ The BOP Central Office announced the new EAP provider’s services using several methods, such as a video message from the then BOP Director, a written announcement posted to the BOP’s intranet, and virtual training. Of the 98 percent of 2021 BOP Staff Survey respondents who reported that they had heard of the EAP, approximately three-quarters stated that they had not used it.

⁹⁷ In response to a draft of this report, the BOP stated that, following the issuance of the GAO’s July 2021 report regarding the BOP’s COVID-19 response, the BOP adjusted its annual employee feedback survey to include two new questions related to staff perspectives on its COVID-19 guidance as of December 2021. The BOP stated that it has analyzed the results of this survey and is continuing its communication strategy for COVID-19 guidance based on those results. See GAO, *BOP Could Further Enhance Its COVID-19 Response*.

⁹⁸ In response to a draft of this report, the BOP stated that it changed the name “Crisis Support Team” to “Correctional Support Team” (CST). In this report, we refer to Crisis Support Teams to reflect the period of our review. The BOP stated that it has restructured CSTs to place more emphasis on regional involvement in oversight of and communication with facility CSTs.

⁹⁹ DOJ OIG, [Remote Inspection of Federal Bureau of Prisons Contract Correctional Institution Moshannon Valley, Operated by the Geo Group, Inc.](#), E&I Report 20-097 (August 2020), oig.justice.gov/reports/remote-inspection-federal-bureau-prisons-contract-correctional-institution-moshannon-valley.

¹⁰⁰ GAO, *BOP: Opportunities Exist*, 41.

- **COVID-19 Staff Support Line:** From April through December 2020, the BOP made a 24-hour COVID-19 staff support line available for facility staff to discuss their concerns with a BOP staff member. Central Office psychologists and chaplains took turns fielding staff support line calls in 24-hour shifts. Central Office staff told us that support line staff elevated some of the concerns that callers raised to BOP leadership, with caller consent. While the BOP updated its announcement about the activation of the COVID-19 staff support line on its internal employee website on April 3, 2020, 36 percent of facility staff respondents to our 2021 BOP Staff Survey had not heard of the staff support line.¹⁰¹ Further, our review of staff support line call logs indicated that some staff were unclear about how the support line worked. Moreover, the BOP's COVID-19 Pandemic Response Plan as of September 7, 2021, incorrectly listed the staff support line as an available resource for staff over 9 months after the line had ended. While the then BOP Director's April 2020 announcement stated that vocalizing concerns was a better way for staff to cope with pandemic stress than not speaking about them, his December 2020 message about the support line ending encouraged staff to contact an email box about their future COVID-19 concerns.

We found that the staff support line generally served as a useful source of support for staff who used it during the pandemic and that, overall, the number of staff calls to the support line decreased over time. Specifically, 74 percent of 2021 BOP Staff Survey respondents who called the staff support line reported that they found it to be helpful. Additionally, call log summaries indicated that callers expressed appreciation for the staff support line, which helped multiple callers resolve issues by sharing resources or providing guidance and support. However, the staff support line was available to staff for only about the first 8 months of the pandemic; a Central Office official told the OIG that the new EAP provider effectively replaced the support line.

- **Crisis Support Teams:** BOP data indicated that there were 289 Crisis Support Team activations in 2020, including 58 activations as a result of the pandemic. According to a psychologist at one BOP facility we inspected, a Crisis Support Team provided facility staff with resources related to mental health, childcare, and community services. A Central Office official explained that during the pandemic it was challenging to fully implement the Crisis Support Team peer support model, which entails peer support staff walking throughout facilities and talking to staff members, due to staff movement restrictions and limited face-to-face interactions. Lastly, 84 percent of [2021 BOP Staff Survey](#) respondents reported that they had heard of Crisis Support Teams but had not used them, while 9 percent reported they had used them and found them helpful.

¹⁰¹ In response to a draft of this report, the BOP stated that its current EAP provider offers in-the-moment crisis support for staff similar to what was provided through the COVID-19 staff support line. The BOP stated that its recently negotiated Staff Wellness and CST policies emphasize communication and training with staff regarding available support services to help staff develop skills to maintain wellness during a public health emergency. Additionally, the BOP stated that the Psychology Services Branch created materials to be used in person and virtually so that they may be available for staff during future public health emergencies. Finally, the BOP stated that it has built a page on its employee intranet site for all staff safety and support services and that it would be rolled out in conjunction with the official release of three staff safety and support policies. We did not assess the draft policies in this review.

Conclusion

Ongoing staffing shortages during the sustained COVID-19 pandemic had a significant and negative effect on staff morale. Staffing shortages have contributed to staff workload responsibilities and the BOP's use of overtime, staffing augmentation, and reliance on TDY staff during the pandemic. While this report does not make new recommendations for the BOP to address its ongoing staffing shortages, the GAO's February 2021 report recommendations to the BOP represent important next steps for the BOP to continue its efforts to address staffing challenges.¹⁰² In addition, BOP staff often expressed concerns and confusion regarding guidance about leave and quarantine procedures, highlighting the need for the BOP to provide clear guidance. Additionally, 2021 BOP Staff Survey respondents chose mental health resources as one of the top five areas that the BOP should seek to improve, which, when combined with reports of staff unawareness about the staff support line and incorrect BOP guidance about its availability, highlights the need for the BOP to better communicate support options available to facility staff. Clearly communicating staff support options, namely those the BOP described that it recently expanded, including the current EAP provider's crisis support services, the restructured CST, the intranet page for staff safety and support services, and the staff wellness materials, should help enable staff to take full advantage of all the resources available to them.

Recommendation

To improve staff support during public health emergencies, we recommend that the BOP:

5. Assess methods to engage with staff during public health emergencies to ensure that the BOP provides sufficient staff support and clearly communicates support options available to staff.

The BOP Should Improve Its Communication of Essential Information to Stakeholders

We identified a significant deficiency in the BOP's communication with inmates' families regarding COVID-19 related serious illness notifications. We also received numerous complaints about the BOP's communications with the public, inmates, and other stakeholders, including complaints from inmates' attorneys, about the BOP's lack of transparency regarding its management of COVID-19 inside facilities and the information it shared on its public website. Additionally, our remote inspections of particular facilities identified communication failures at some facilities that inhibited the ability of those facilities to fully respond to the COVID-19 pandemic, while other remote inspections found that facility leadership was proactive and clear in communicating with staff and inmates. The BOP should strengthen its overall communication as the pandemic continues and for future public health emergencies. In [The BOP Should Take Appropriate Steps to Address Staffing Shortages and Staff Morale](#) section above, we discussed the BOP's challenges and issues in communicating with BOP staff. In this section, we discuss the BOP's communications with inmates, families of inmates, contract facilities, crime victims, and the public. We discuss concerns regarding the BOP's communication with inmates' attorneys and further discuss inmate access to counsel in [The BOP Should Respond to Ongoing Pandemic Challenges and Prepare for Future Public Health Emergencies](#) section.

¹⁰² GAO, *BOP: Opportunities Exist*, 41.

The BOP Should Improve Its Procedures for Notifying Families About Inmate Serious Illness

During our remote inspections of BOP facilities, we found that facilities did not always comply with the BOP's policy to promptly notify families when an inmate develops a serious illness.¹⁰³ The BOP's Patient Care policy requires facilities to "promptly" notify the family of an inmate with any serious illness that it is of "immediate concern" to the family.¹⁰⁴ In the case of an inmate death, the BOP requires facilities to notify family of the deceased in the same manner as a serious illness notification; the Warden or designee must call the designated person listed in the deceased inmate's Acknowledgment of Inmate Form, BP-A0408, "immediately" to inform him or her of the circumstances surrounding the death and "as soon as practical" must also mail a condolence letter to the inmate's family advising them of the circumstances of the death.¹⁰⁵

We reviewed 49 cases of inmates who died of COVID-19 between April and July 2020 at 4 of the BOP-managed facilities we inspected: [FCC Butner](#), [FCC Coleman](#), [FMC Fort Worth](#), and [FCI Terminal Island](#). We found that, in just under a third of the inmate deaths we reviewed, facilities took more than 3 days to attempt to notify family of the inmate's serious illness, including complicating factors related to COVID-19 infection. Although the BOP's Patient Care policy does not specify a timeframe for prompt notification of serious illness, we believe that these instances of attempted family notification that took the BOP more than 3 days do not represent prompt notification as intended in the policy. For notifications of inmate deaths, in almost all of the cases we reviewed the inmates' family was notified within 1 day of the inmate's death.

BOP Guidance on Family Notification

The BOP's Patient Care policy outlines the effective delivery of medically necessary healthcare in order to preserve and extend the life of inmates in BOP custody.¹⁰⁶ Consistent with that goal for seriously ill or dying inmates, the policy states that an inmate's serious illness is of immediate concern to the inmate's family and requires the facility to notify the inmate's family "promptly." However, the policy does not include a standard definition for what constitutes a serious illness, a standardized procedure for how to determine whether and when a serious illness is deemed to be of immediate concern to an inmate's family, or a timeframe for prompt notification. The procedure for family notification of an inmate's serious illness begins with the Health Services Unit, which is responsible for notifying the Warden and Chaplain by phone or in person of the inmate's condition. Then the Warden or designee will arrange notification of the inmate's family. The Patient Care policy also directs facilities to develop supplemental guidance incorporating the specific information covered in the policy's Serious Illness and Death Procedures section. These supplements can include specific definitions, steps to take, timeframes, and assignment of responsibilities.

¹⁰³ In this report section, we use the term "family" to describe the next of kin or the individual listed in the BOP's Acknowledgment of Inmate form.

¹⁰⁴ BOP Program Statement 6031.04, [Patient Care](#), June 3, 2014, www.bop.gov/policy/progstat/6031_004.pdf (accessed July 12, 2022).

¹⁰⁵ BOP Program Statement 5553.08, [Escapes/Deaths Notifications](#), January 4, 2017, www.bop.gov/policy/progstat/5553.08.pdf (accessed July 12, 2022).

¹⁰⁶ BOP Program Statement 6031.04.

The BOP has an additional, more detailed policy on handling notification in the case of an inmate death. The BOP's Escapes/Deaths Notifications policy requires timely notifications to a variety of interested parties, including family members.¹⁰⁷ Upon an inmate's death, the Warden or official designee is responsible for contacting the deceased inmate's family, or person named on the inmate's BP-A0408 form, by telephone "immediately" to communicate the circumstances surrounding the inmate's death.¹⁰⁸ According to the Escapes/Deaths Notifications policy, if the inmate's file does not contain family or a designated person's contact information, Unit Management must attempt to locate and notify family members to determine the disposition of the deceased inmate's remains and property. The policy further states that the Warden, or designee, is responsible for mailing a letter of condolence "as soon as practical" to the inmate's family advising of the circumstances of the death.

Delays in Notifying Inmates' Families of Serious Illness Related to COVID-19

Among the cases of inmate deaths related to COVID-19 that we reviewed, we found that the BOP did not always timely notify the family of an inmate with serious illness before the inmate died. Based on available documentation provided by the BOP, we analyzed 49 cases of inmate death related to COVID-19 and determined that 40 of those inmates (82 percent) were determined to be seriously ill prior to their deaths.¹⁰⁹ Of the 40 serious illness cases we examined, the BOP attempted to notify 18 families (45 percent) within 0–3 days of the inmate's serious illness and 12 families (30 percent) more than 3 days after the inmate became seriously ill, including 8 families whom the BOP notified over 1 week after the inmate became seriously ill. In six cases, the BOP did not notify the inmate's family of the inmate's serious illness prior to his or her death.¹¹⁰ In contrast, when inmates died, the BOP typically notified their families within 1 day of their deaths. We found a variety of reasons for delays in the BOP's serious illness notification, including staff workload, limited staff access to emergency contact information, inability to contact family, and varying definitions of serious illness, as we discuss further below.

Staff Workload

FCC Butner, which had some of the longest delays in family notification of inmate serious illness, pointed to staff workloads during the pandemic as a reason for its delayed notifications. In one case at FCC Butner, an inmate had been in the hospital with respiratory failure for 18 days and on a ventilator for 5 days before the inmate's family was contacted. In a second case, an inmate had been on a ventilator for 16 days before the inmate's family was contacted. FCC Butner staff reported that delays in family notification were due to the unprecedented demands on BOP staff during the ongoing public health crisis. FCC Butner staff reported that they had to set aside their normal duties, including notifying next of kin in the case of inmate serious

¹⁰⁷ BOP Program Statement 5553.08.

¹⁰⁸ The BP-A0408 form also allows inmates to list additional emergency contacts whom the BOP may contact in the event of an inmate's serious illness or other emergency.

¹⁰⁹ For those 40 cases, we determined an inmate to be seriously ill if documentation showed that he or she was experiencing respiratory failure, moved to the intensive care unit in the hospital, placed on a ventilator, or determined to be seriously ill by a physician. For the remaining nine cases, we could not determine whether the inmate was determined to be seriously ill based on the information the BOP provided.

¹¹⁰ In an additional four cases of inmate serious illness, BOP documentation did not reflect the exact timeline of the serious illness determination and the family notification of serious illness.

illness or death, to support the emergency medical mission of providing care and security for a large population of at-risk and sick inmates during the pandemic.

Limited Access to Emergency Contact Information

We found that another cause of delayed serious illness notification was the availability of Unit Team staff with access to inmate emergency contact information found in Section 4 of an inmate's Form BP-A0408. For example, in one case we reviewed, FCI Coleman staff did not notify an inmate's emergency contact immediately after being notified of the inmate's quickly deteriorating illness. An Associate Warden at the facility told us that the Unit Team staff, who normally would have reached out to the inmate's emergency contact to offer the contact the opportunity to visit the inmate, had already departed on the Friday evening when the hospital called to report that the inmate's condition was declining.¹¹¹ He also told us that only Unit Team staff have access to the inmate's emergency contact information and that they handle notifications the next business day rather than after hours. This means that the family of an inmate who becomes seriously ill on a Friday night would not be notified until Monday. In the FCC Coleman case, the inmate died on Sunday, before the BOP could make a serious illness notification. An FCC Coleman official told us that, to make after-hours notifications possible, a policy change requiring a Unit Team member to report to the facility after hours would be necessary. An official at FMC Fort Worth also identified the lack of access to inmate emergency contact information as a problem, noting that delays in staff obtaining the form could result in delays notifying families.

Challenges Contacting Families

The BOP's Inmate Classification and Program Review policy specifies that a designated BOP staff member verify information in the Acknowledgment of Inmate Form, BP-A0408, which includes emergency contact and next of kin information, at the time of inmate program reviews, which occur at least every 180 days (or at least every 90 days if an inmate is within 12 months of release).¹¹² However, we found that BOP staff faced challenges identifying and contacting families, which contributed to delays in their serious illness notifications of inmates' families. In cases we reviewed, BOP staff described trying a variety of methods to identify and reach family members when they could not reach them using the inmate-provided emergency contact information. These methods included reviewing pre-sentencing materials, conducting internet searches, and requesting that the local police department attempt to contact the next of kin at the inmate's last known address. While the BOP's policy on inmate death notifications requires the BOP to attempt to locate next of kin if no one is listed on the inmate's emergency contact form, the BOP's policy on inmate serious illness notification does not require this. However, the case documents we reviewed indicated that BOP staff members attempted to identify inmates' next of kin for serious illness notifications as well. For example, at FCI Terminal Island, for 10 days BOP staff attempted to contact family about one inmate's serious illness but were unable to speak to the emergency contact or leave a voicemail at the phone number on file. Eventually, the FCI was able to contact another family member about the inmate's serious illness as a result of multiple attempts by BOP staff to find next-of-kin information.

¹¹¹ A BOP press release indicates that the inmate was placed on a ventilator that day.

¹¹² BOP Program Statement 5322.13, [Inmate Classification and Program Review](https://www.bop.gov/policy/progstat/5322_013.pdf), May 16, 2014, www.bop.gov/policy/progstat/5322_013.pdf (accessed February 13, 2023).

We also found cases in which challenges making contact with the listed emergency contact or family member meant that the inmate's family was unable to be involved in making time-sensitive end-of-life decisions. For example, in one case at FCC Butner, the hospital made end-of-life decisions for an inmate after FCC Butner was unable to reach the inmate's family members. FCC Butner finally reached the inmate's next of kin after the inmate's death. At FMC Fort Worth, one staff member told us that inmate emergency contact forms are updated only when an inmate enters the facility, which indicated that inmate emergency contact information could be outdated.

Varying BOP Definitions of Serious Illness

Finally, we found that the four facilities for which we reviewed inmate COVID-19 deaths had varying definitions for what constitutes a serious illness and at what time BOP staff should notify the family. For example, FCC Butner specifies that a serious illness is one with such severity that it threatens an inmate's life and that the attending physician will make that determination and notify the family. In contrast, FCI Terminal Island reported that it notifies families only of inmates who are critically ill, specifying that a critical illness is one in which death is considered imminent, as contrasted with a serious illness, which may persist for weeks or months. An FMC Fort Worth staff member told us that the acting Clinical Director established the threshold between seriously ill and critically ill designations to be when an inmate can no longer make decisions for himself or herself. Finally, FCC Coleman specifies that if an inmate is diagnosed with a terminal illness family should be notified within 72 hours but does not specify a timeframe for notification in the case of nonterminal illness. The other three facilities for which we reviewed inmate COVID-19 deaths do not specify timeframes for serious illness notification.

The lack of clear thresholds for serious illness caused delays in the BOP's time-sensitive family notifications. For example, during our remote inspection of FCI Terminal Island, we learned that the facility did not notify the family of an inmate that he had been hospitalized and intubated due to COVID-19 until after the inmate had died.¹¹³ At the time, Terminal Island staff told us that the facility was not required to notify family members when an inmate was intubated. However, a Western Regional Office official also told us that, as a result of FCI Terminal Island's failure to notify the inmate's family of his serious illness, the Western Regional Office issued verbal guidance shortly after the inmate's death, followed by written guidance on May 4, 2020, to all facilities in the region stating that they should notify the families of COVID-19 positive inmates who become hospitalized.

The issuance of E.O. 14074 in May 2022 requires the Attorney General to issue guidance to federal law enforcement agencies and other entities responsible for death notifications of persons in correctional or law enforcement agency custody on best practices for timely notification of family members and designated emergency contacts.¹¹⁴ Additionally, in May 2022, the Family Notification of Death, Injury, or Illness in Custody Act of 2022 was introduced in the U.S. Senate. If enacted, the legislation would require the Department to establish policies and procedures to promptly notify family members or emergency contacts

¹¹³ "Intubated" refers to endotracheal intubation, a type of medical procedure in which a tube is placed into a patient's windpipe to facilitate breathing.

¹¹⁴ E.O. 14074.

of the death, serious illness, or serious injury of persons in federal custody, including all inmates in BOP-managed facilities.

Conclusion

Overall, among the facilities we inspected there were several instances of delayed notification to families about inmate serious illness and some families did not receive notification of inmates' serious illnesses prior to their deaths. Although we recognize that the COVID-19 public health emergency put an unprecedented strain on BOP custody and medical staff, the stresses of the pandemic revealed weaknesses in the BOP's guidance and procedures for family notification that must be addressed. For example, having uniform guidance on what constitutes a serious illness and when staff should notify families in the case of an inmate's serious illness could help ensure that families receive these time-sensitive notifications regardless of the BOP facility in which the inmate is housed. Additionally, ensuring that family contact information is updated at least every 180 days, as required by policy, and is made readily available to the BOP staff who make family notifications could help the BOP contact inmates' families more quickly and reduce the need for the BOP to take additional steps to find alternate emergency contact or family contact information.

Recommendations

To improve its procedures for notifying inmates' families about serious illness related to COVID-19 and other serious illnesses, we recommend that the BOP:

6. Immediately update guidance regarding (1) when staff should notify the families of inmates who become seriously ill or die, including a specific timeframe, and (2) uniform criteria for what constitutes a serious illness.
7. Ensure that inmate family information, or the inmate emergency contact form, is updated according to policy and readily available for BOP staff who need to notify next of kin in cases of inmate serious illness or death.

The BOP Should Improve Its Communication with Other Key Stakeholder Groups

The BOP's Guidance for Contract Facilities

During our remote inspections, we found that COVID-19 related guidance that the BOP developed early during the pandemic was delayed in distribution to contract facilities despite being largely applicable to contract prison settings. Services provided by RRCs (and contract prisons, when in operation) are governed by contractual agreement and carried out by non-BOP personnel, so modified operations require approval from the BOP and new requirements must be formally implemented into contractual agreements. During the pandemic, contract operators had to determine how BOP guidance would fit within the existing arrangements for services and ensure that they consistently communicated the guidance to facility staff at the over 150 RRCs and 11 contract prisons nationwide.¹¹⁵

¹¹⁵ At the time of our remote inspections, the BOP had contracts with over 150 RRCs and 11 contract prisons. Following the January 2021 E.O. 14006, the BOP began transferring inmates out of contract prisons as the contracts expired. The

During our three contract prison remote inspections, we found that contract prison staff implemented strategies outlined in the BOP's technical directions and CDC guidance. However, between February and April 2020, the BOP's Privatization Management Branch, which provides guidance to and oversight of contract prison vendors, issued guidance, known as technical directions, to contract prisons later than the BOP issued guidance to BOP-managed facilities.¹¹⁶ Contract prisons received most of these guidance documents between 1 and 5 days after comparable guidance was issued to BOP-managed facilities, but some delays were more significant. During our remote inspections, a BOP official asserted that the BOP's underlying contracts with contract prison vendors required the vendors to comply with the CDC's COVID-19 guidance. Our remote inspections of contract prisons [CI Giles W. Dalby](#), [CI Moshannon Valley](#), and [CI McRae](#) found that in early April 2020 the BOP modified its contracts to require contract staff, in the event of an epidemic or pandemic, "to check with the CDC daily for updates and...implement those changes timely to prevent further spread of the disease."¹¹⁷ In two of our three contract prison remote inspections, the vendors did not wholly agree with the BOP's interpretation that they should have consulted and implemented CDC guidance before the BOP modified its contracts in early April 2020. After issuing our remote inspection reports, we found evidence that the BOP continued to issue technical directions to contract prisons regarding COVID-19. Our three reports concluded that the prompt issuance of guidance to contract prison vendors, even that which reiterates CDC guidance, was vital to the BOP's effective contract prison oversight and ensuring that inmates receive the same quality of care in contract prisons as in BOP-managed facilities.

Whereas contract prison staff generally implemented the protocols and modified operations stipulated in BOP guidance and the COVID-19 Action Plans, the BOP deferred to the RRC contractors in operational decisions on the handling of certain aspects of the pandemic. The BOP's March 13, 2020 guidance to facilities specifically mentioned sharing the guidance with contract prisons and RRCs "so that similar protocols can be implemented," and the BOP issued additional guidance specific to RRCs. However, BOP guidance to RRCs did not cover certain key decisions. For example, there was a lack of specific guidance from the BOP to RRCs to govern the use of personal protective equipment (PPE) and face coverings in RRC general population settings. Absent such guidance, [Toler House RRC](#) required the use of PPE only in certain cases and did not widely distribute masks to its resident inmates for 3 weeks after the CDC

BOP's last contract prison contract ended on November 30, 2022 and as of December 1, 2022 all inmates housed in contract prisons had been moved to BOP facilities. E.O. 14006 on [Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities](#), January 26, 2021, www.federalregister.gov/documents/2021/01/29/2021-02070/reforming-our-incarceration-system-to-eliminate-the-use-of-privately-operated-criminal-detention (accessed November 10, 2022).

¹¹⁶ The BOP's contracts with private prisons included a clause defining a technical direction as providing "technical direction on contract performance." Technical direction does not include "additional work that is outside the scope of the contract" or "action that would cause an increase or a decrease in contract pricing."

¹¹⁷ DOJ OIG, [Remote Inspection of Federal Bureau of Prisons Contract Correctional Institution Giles W. Dalby, Operated by Management & Training Corporation](#), E&I Report 20-096 (August 2020), oig.justice.gov/reports/remote-inspection-federal-bureau-prisons-contract-correctional-institution-giles-w-dalby; [Remote Inspection of Federal Bureau of Prisons Contract Correctional Institution Moshannon Valley, Operated by the Geo Group, Inc.](#), E&I Report 20-097 (August 2020), oig.justice.gov/reports/remote-inspection-federal-bureau-prisons-contract-correctional-institution-moshannon-valley; and [Remote Inspection of Federal Bureau of Prisons Contract Correctional Institution McRae, Operated by CoreCivic](#), E&I Report 20-098 (August 2020), oig.justice.gov/reports/remote-inspection-federal-bureau-prisons-contract-correctional-institution-mcrae-operated.

recommendation for individuals to wear cloth face coverings while [Brooklyn House RRC](#) did not enforce the use of PPE such as masks and gloves for staff and inmates until late April 2020.¹¹⁸

Additionally, despite the risk of inmates contracting COVID-19 while using public transportation to travel to and from an RRC, the BOP did not explicitly require RRCs to quarantine asymptomatic inmates either upon entry into custody or departure from the RRC for long-term home placement. Although there was no explicit requirement, the BOP expressed that its intent was to have inmates quarantine before arrival to the home setting. Absent any such formal requirement, Brooklyn House RRC did not formally quarantine individuals entering RRC custody or departing to a home placement. Challenges with the interpretation and implementation of relevant COVID-19 guidance at RRCs and contract prisons underscore the importance of the BOP's communication with these entities during the COVID-19 pandemic and other public health emergencies.

The BOP's Communication with Inmates

We found that, although the BOP took steps to communicate relevant COVID-19 information to inmates during the pandemic, the reports we received about the effectiveness of this communication varied. The BOP employed various mechanisms, such as town halls, inmate bulletins, and guidance posters (see an example below), to communicate pertinent COVID-19 information to inmates. According to interviewees at four BOP facilities we inspected, facility staff hosted weekly town halls to inform inmates about proper hygiene practices, share CDC guidance updates, and explain the status of modified operations. Inmate bulletins and COVID-19 guidance signs posted throughout BOP facilities and RRCs informed inmates about the prevalence of COVID-19 at the facilities and recommended best practices regarding sanitation and the proper use of PPE. Staff also provided these resources to inmates housed at BOP facilities via their TRULINCS email accounts, and interviewees at some facilities told us that staff responded to inmate questions sent by TRULINCS email.

¹¹⁸ DOJ OIG, [Remote Inspection of the GEO Group, Inc.'s Toler House Residential Reentry Center, Newark, New Jersey](#), E&I Report 21-007 (November 2020), oig.justice.gov/reports/remote-inspection-geo-group-incs-toler-house-residential-reentry-center-newark-new-jersey, and [Remote Inspection of the CORE Services Group, Inc.'s Brooklyn House Residential Reentry Center, Brooklyn, New York](#), E&I Report 21-006 (November 2020), oig.justice.gov/reports/remote-inspection-core-services-group-incs-brooklyn-house-residential-reentry-center.



During our remote inspection of [FCC Tucson](#), two facility interviewees told us that they thought that the FCC had clearly communicated information to inmates. Respondents to the 2020 BOP Staff Survey from two BOP-managed facilities reported that facility Wardens were proactive in sharing information with inmates. Additionally, our remote inspections of Toler House RRC and three contract prisons found that in general contract facility leadership clearly communicated information to inmates.

However, we received over 185 complaints about deficiencies in the BOP’s communication with inmates submitted by inmates, their friends and family, and other complainants.¹¹⁹ Further, our analysis of 2021 Inmate Survey results at BOP-managed facilities estimated that 47 percent of the inmates reported that the information they received from the BOP about how to protect themselves from COVID-19 infection was poor, and an estimated 7 percent said that they received no information. In comparison, an estimated 46 percent said that the information was good or fair, 15 and 31 percent, respectively.¹²⁰ The totality of responses we received from complainants and inmate survey respondents at BOP-managed facilities highlights the importance of

communication of information to the inmate population during public health emergencies.

The BOP’s Communication with Crime Victims

We found that the BOP did not always timely notify crime victims during the pandemic. The BOP issues notifications to victims of crime to provide them with information about specific inmate case events, including an inmate’s admission to or release from a BOP-managed or contract facility, transfer to an RRC or home confinement, escape, or death. The Department’s Victim Notification System generates notifications that BOP staff provide to victims via mail, email, or telephone based on victim contact preferences.¹²¹ We

¹¹⁹ As noted in the [Introduction](#), we analyzed complaints to identify trends. Although we did not substantiate or assess the validity of each complaint, we present the thematic issues that we identified in our complaint review to illustrate various stakeholder perspectives about the BOP’s response to the pandemic, including concerns about the BOP’s communication with inmates and other stakeholders.

¹²⁰ We present inmate survey responses in this report to illustrate the range of views expressed by inmate survey respondents about their experiences during the pandemic. The number of inmate survey respondents (25,504) represents a fraction of the number of inmates in BOP custody. Because we applied statistical weights, we refer to the *estimated percentage of inmates* rather than the percentage of respondents.

¹²¹ The Victim Notification System links the Federal Bureau of Investigation, all Assistant U.S. Attorney’s Offices, and the BOP through the DOJ intranet. The system maintains victim information and makes notification(s) during the arrest, arraignment, prosecutorial, and confinement phases to ensure that victims and witnesses are advised of the significant

found that during the pandemic the number of the BOP's missed or incomplete notifications issued to crime victims increased by 86 percent from April 1, 2020, through March 31, 2021, compared to the same time period of the previous year. There were also 121 delayed notifications that were not completed until after the inmate's release or transfer date from April 1, 2020, through March 31, 2021, a decrease compared to the same time period of the previous year. However, 40 percent of those delayed notifications occurred in the cases of inmates who transferred to an RRC or home confinement under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act).

The BOP reported that limitations to the Victim Notification System data may have contributed to delayed or missed crime victim notifications. While the system generates notifications automatically, it relies on inmate data updated from the BOP's SENTRY system every 24 hours. As a result, the Victim Notification System may not reflect immediate changes to an inmate's release or home confinement transfer date or be able to generate a notification in the event of an inmate's court-ordered immediate release until after the release has occurred. Late or unexpected changes to an inmate's transfer or release date, such as those that occurred during the pandemic due to accelerated home confinement placements and court-ordered releases, may have affected the BOP's ability to timely notify victims.

Additionally, once a victim is notified about the date of an inmate's forthcoming transfer to an RRC, the Victim Notification System does not generate another notification if the date changes. Unit Team staff at BOP facilities must therefore generate manual notifications for victims when there are changes to an inmate's RRC transfer date, in addition to when there are court orders for immediate release. BOP Central Office officials told us that, during accelerated home confinement placements due to the pandemic, mail notifications might not have reached victims before the inmates were transferred out of BOP facilities. In August 2021, the BOP reported that it was updating the Victim Notification System to reduce errors and limit the need for facility staff to generate manual notifications.

The BOP's Transparency and Communication with the Public

In an April 2021 written statement to Congress, the then BOP Director stated that the BOP had made an effort to be transparent about its COVID-19 operations, plans, and statistics and had published "one of the most detailed and thorough COVID pandemic resource areas across government on its public website." We found that, while the BOP shared and regularly updated relevant COVID-19 information on its public website throughout the pandemic, the information did not always provide a complete picture for stakeholders. Early during the pandemic, the BOP created a COVID-19 resource area on its public website to provide the public with the BOP's plans, operations, and COVID-19 related data. When [2021 BOP Staff Survey](#) respondents were asked to select up to 5 areas in which the BOP most needed to improve its handling of the COVID-19 pandemic, 906 respondents (16 percent) selected "BOP Central Office's communication with the public" as an area for improvement. Additionally, we received OIG Hotline complaints about information posted to the BOP's public website and the BOP's communication with stakeholders.

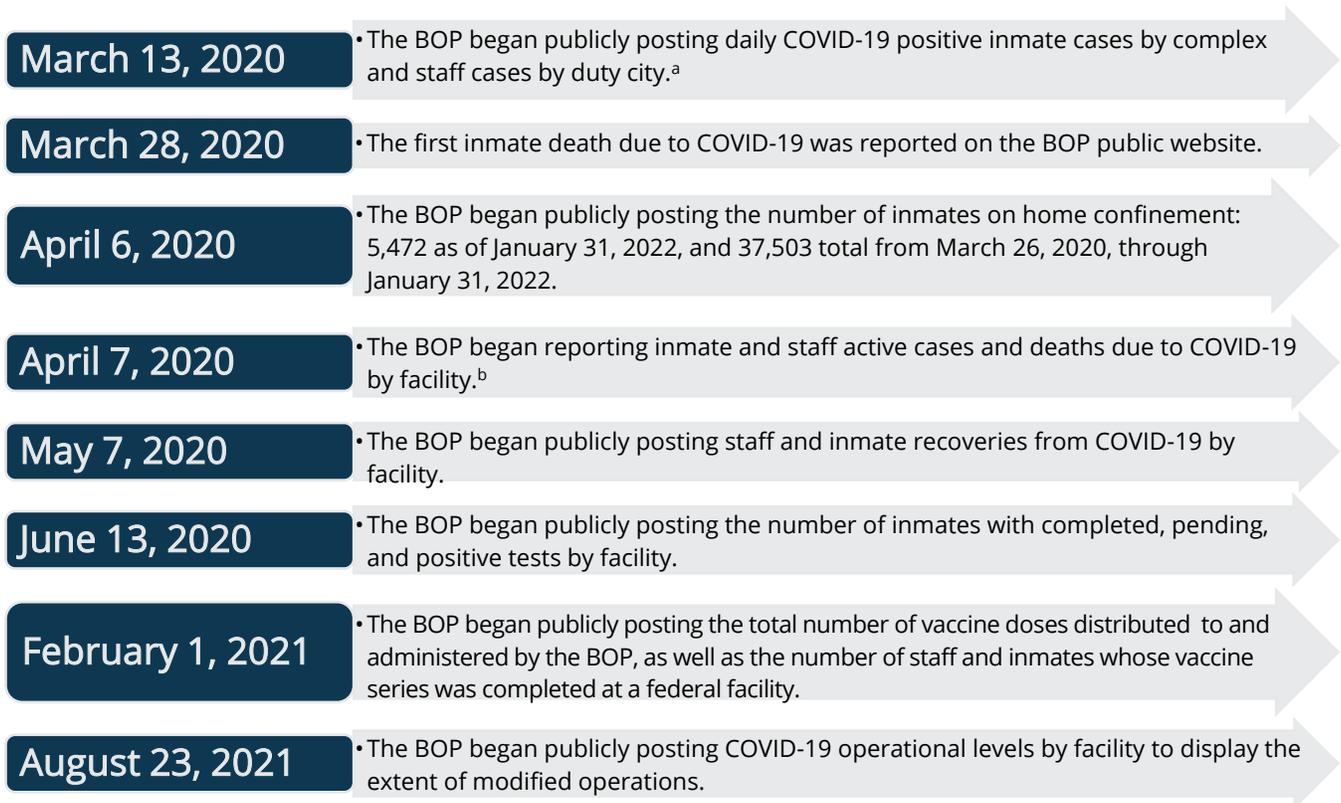
The BOP first posted COVID-19 related data to its public website at the beginning of the pandemic, and the types of COVID-19 related information that it shared on its public website evolved over time (see Figure 10

stages in the criminal justice process. For more information, see BOP Program Statement 1490.06, [Victim and Witness Notification Program](#), May 23, 2002, www.bop.gov/policy/progstat/1490_006.pdf (accessed July 12, 2022).

below). Press releases reported expanded inmate COVID-19 testing plans, various phases of the BOP’s COVID-19 Action Plan, and COVID-19 related inmate deaths at BOP facilities.

Figure 10

Timeline of the BOP’s Posting of COVID-19 Data to Its Public Website



^a “Complex” includes facilities with different security levels that are located in proximity.

^b The BOP began reporting BOP-wide recoveries from COVID-19 on April 8, 2022. “Active cases” refers to the number of individuals with lab-confirmed and open cases at a particular complex or facility on a particular day.

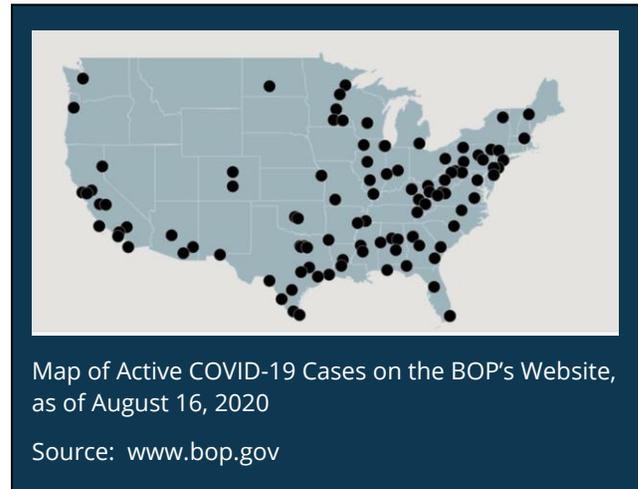
Notes: The BOP posted all of the above statistics for federal facilities. For RRCs, the BOP reported statistics regarding active and recovered cases, testing, and deaths due to COVID-19 but did not post vaccination statistics. For private prisons, the BOP reported statistics regarding active and recovered cases and deaths due to COVID-19 but did not post testing or vaccination statistics.

Source: OIG analysis of BOP data

We observed some limitations in the COVID-19 case, testing, and vaccination data posted on the BOP’s website. Below, we discuss examples of these limitations.

Case Data

Although the BOP publishes on its website counts of active and recovered COVID-19 cases among inmates currently in BOP custody and current BOP staff (see the example to the right), it does not publish a cumulative total of COVID-19 cases reported over the course of the pandemic. The active case counts do not include inmates or staff who recovered or died, and the recovered case counts do not include inmates or staff who die, inmates who have subsequently been released from BOP custody, or staff who have left BOP employment. These omissions mean that the BOP's publicly posted data does not represent the full extent of cumulative COVID-19 cases among inmates and staff over the course of the pandemic. Further, the BOP website does not mention that the staff and inmate recovery data presented excludes inmates who left BOP custody or staff who left BOP employment, which could lead stakeholders to draw incorrect conclusions about the BOP's data.



On October 1, 2020, the OIG released a collection of [interactive dashboards relating to COVID-19 in BOP facilities](#) that allow the public to view active and recovered COVID-19 cases and deaths over time for inmates and staff at individual federal facilities and aggregated across all federal facilities, among other data trends. While this presentation of the BOP's data allows stakeholders to see trends over time, it also highlights the limitations of the BOP's public data. For example, the OIG's presentation of BOP data on recovered cases shows a decreasing number of recovered inmates over time beginning in late March 2021 because some inmates who recovered from COVID-19 were subsequently released from BOP-managed facilities. Because of this, the BOP's recovered cases data cannot be used as a cumulative measure of the number of inmates who recovered from COVID-19.

Testing Data

Similar issues exist with the BOP's publicly posted data on testing, which also includes only inmates currently in BOP custody. The BOP publicly posts the following statistics for inmates in current BOP custody: the number of inmates who (1) have completed testing, (2) have pending tests and no previously completed test, and (3) have ever had a positive test. However, the published pending inmate test data is not a useful metric for the amount of testing conducted because it counts only the first time an inmate received a COVID-19 test even though inmates have been tested multiple times over the course of the pandemic. Additionally, the BOP website states that some inmate COVID-19 tests, such as tests performed in local hospitals, for example, are not reported to the BOP. Further, the BOP reported that it did not publicly post testing data for contract prisons when the BOP housed inmates in contract prisons due to the underlying data not being machine readable. This omission resulted in stakeholders lacking visibility into testing at BOP contract prisons. Finally, while in April 2022 the BOP added a note to the COVID-19 testing data section of its public website that it had conducted over 1 million COVID-19 tests for more than 200,000 inmates, the BOP does not publicly share the definitive number of COVID-19 tests that it has administered to inmates. These limitations result in a lack of complete public data about the BOP's testing effort over the course of the pandemic.

Vaccination Data

The BOP publishes data on the logistics of its vaccination progress at BOP-managed facilities, including the BOP-wide cumulative number of doses distributed and administered by the BOP and the number of staff and inmates whose vaccination series was completed by the BOP at each facility. However, the BOP does not publish data that allows stakeholders to see the proportion of vaccinated individuals at any of the facilities, as the published data displays only the cumulative number of BOP-administered vaccinations completed at each facility. Unlike the BOP's public testing and COVID-19 case data for inmates, which includes inmates in current BOP custody only, the public vaccination data includes both inmates in current BOP custody and those who have left BOP custody. Despite this key difference in the BOP's reporting of COVID-19 statistics, there is no explanation on the BOP website that the presented vaccination totals include inmates who have left BOP custody. The absence of this explanation could lead stakeholders to draw incorrect conclusions about the BOP's vaccination data.

In addition, the BOP's facility-specific vaccination data reflects only the number of staff and inmate vaccinations completed by the BOP at each facility and does not reflect the number of fully vaccinated inmates and staff currently at that facility. It also does not include vaccinations completed in the community; namely, the data does not include inmates who received full vaccinations prior to entering BOP custody or who received the vaccine through community resources at an RRC, contract prison, or while on home confinement. As new inmates may have received full vaccinations prior to entering BOP custody, the BOP's decision to publicly share vaccination data only for those whose vaccination series was completed by the BOP may make it increasingly difficult for stakeholders to glean useful, complete insights from the BOP's public vaccination data about individual facility vaccination levels. On May 25, 2022, President Biden signed E.O. 14074, which directed the Attorney General to undertake several actions, which include expanding the sharing and publication of BOP data on vaccination, testing, infections, and fatalities due to COVID-19 "in a manner that ensures the thoroughness and accuracy of the data; protects privacy; and disaggregates the data by race, ethnicity, age, sex, disability, and facility."¹²² Compliance with this Executive Order offers the BOP the opportunity to reassess the data that it publishes and to address the limitations we have identified here.

The OIG's collection of [interactive dashboards](#) includes OIG-estimated percentages of fully vaccinated inmates across BOP-managed institutions based on inmate vaccination data that the OIG receives from the BOP weekly. The dashboards also display the distribution of inmate vaccination percentages by BOP-managed facility.

Attorney and Judicial Concerns Regarding BOP Communication

We learned of reports from defense counsel representing inmates housed at BOP facilities that the BOP did not always provide them with transparent information during the pandemic. For example, defense counsel representing inmates at one BOP detention center that we inspected alleged that there was a lack of transparency about how the facility was managing its response to the COVID-19 crisis and that facility legal counsel did not answer questions about inmates. In a separate interview with representatives from the Federal Public and Community Defenders, attorneys alleged that the BOP was not transparent about some of the terminology used on its public website and that the BOP's information about its selection of inmates

¹²² E.O. 14074.

for home confinement and compassionate release had not been transparent. To ensure access to current and accurate information about two facilities' responses to the pandemic, a judge for the Eastern District of New York issued an April 2020 order that required the Wardens of MDC Brooklyn and Metropolitan Correctional Center (MCC) New York to provide biweekly status updates on their facilities' responses to COVID-19 to the court, the Executive Director of the Federal Defenders of New York, and the U.S. Marshals and U.S. Attorneys for the Eastern and Southern Districts of New York.¹²³ We discuss inmate access to counsel in detail in [The BOP Should Respond to Ongoing Pandemic Challenges and Prepare for Future Public Health Emergencies](#) section of this report.

Conclusion

Although we acknowledge that the BOP has taken steps to proactively and transparently communicate with stakeholders during the COVID-19 pandemic, we identified weaknesses in the BOP's communication with key stakeholders and believe that the BOP needs to continue to find ways to more effectively communicate with all of its stakeholders. The totality of information about the BOP's communication during the pandemic that we received highlights the need for the BOP to improve its communication of information to stakeholders during current and future public health emergencies. While the BOP should assess its communication with all stakeholders, we make one specific recommendation to the BOP regarding its communication with crime victims, in addition to the recommendation regarding family notification above.

Recommendation

To improve its procedures to notify crime victims, we recommend that the BOP:

8. Implement processes to ensure timely crime victim notifications, even under emergency conditions such as during a pandemic.

The BOP Should Provide Clear Guidance on the Use of Healthcare Protective Equipment and Compliance with Healthcare Safety Guidance

The BOP reported that, while it was initially affected by the same supply shortages as the rest of the nation, it has since amassed sufficient quantities of PPE. According to the former BOP Director's congressional testimony and Central Office officials we interviewed, the BOP has since made PPE available to its facilities. Staff concerns and confusion early during the pandemic about the BOP's PPE and face covering requirements appear to have decreased over time. However, the BOP faced persistent challenges ensuring staff and inmate compliance with face covering requirements. We found through our remote inspections and April 2020 BOP Staff Survey results that BOP staff reported multiple challenges regarding access to PPE and other PPE-related issues at the beginning of the pandemic. For example, 2020 BOP Staff Survey respondents at all 16 facilities we inspected identified more PPE for staff as a top five immediate need. Additionally, during FY 2020 we received over 130 OIG Hotline complaints concerning an inadequate supply of PPE and face coverings. However, in our [2021 BOP Staff Survey](#), facility staff respondents generally reported widespread availability of PPE and face coverings at facilities. Similar to the PPE supply challenges, the BOP and the nation were affected by limited COVID-19 testing capacity early during the pandemic. This

¹²³ As noted in the [Introduction](#), the Department announced in August 2021 that it was closing MCC New York, at least temporarily, to assess steps to improve conditions at the facility.

resulted in long turnaround times for test results, which meant that COVID-19 positive and negative inmates were sometimes housed together for several days, increasing the risk of transmission among them. Further, our remote inspections found that in 2020 some facilities did not properly follow the BOP's quarantine guidance to manage the risk of COVID-19 transmission between inmates awaiting test results. Since then, testing capacity has increased and the BOP added rapid testing options into its protocols, reducing the risk of long wait times for results.

The BOP Experienced PPE Supply Challenges at the Beginning of the Pandemic

We found numerous PPE-related issues and perceived PPE shortages for staff at the time of our remote inspections in 2020. For example, our remote inspection of [MDC Brooklyn](#) found that some Health Services staff were unable to obtain the necessary PPE to evaluate inmates with COVID-19 symptoms and treat them in medical isolation and Health Services staff told us that they believed the facility had sufficient PPE supplies but did not provide the necessary PPE to healthcare providers. At [FCC Oakdale](#), we found that some staff lacked the proper PPE when in close contact with COVID-19 infected inmates; according to interviews we conducted, staff concern about access to PPE was so dire after the first inmate tested positive in late March 2020 that PPE supplies were being taken from the complex's medical unit after hours and without permission. Further, our remote inspections of [FCI Milan](#) and FCC Oakdale identified incidents in which staff transported sick inmates to local hospitals without wearing the appropriate PPE. Additionally, our [FCI Terminal Island](#) remote inspection report found that temporary duty (TDY) staff were not fit tested for N95 respirators until days after they arrived at the facility. By the time we issued our [2021 BOP Staff Survey](#), however, approximately 95 percent of BOP-wide staff respondents reported that they had been fit tested for an N95 respirator. Results from our 2021 survey also generally found widespread availability of PPE and face coverings at facilities.

Our remote inspections of BOP contract facilities identified unique PPE-related challenges. Unlike at federal facilities, PPE supply levels at BOP contract prisons and Residential Reentry Centers (RRC), due to the privatized and decentralized nature of the BOP's contract model, depend on the ability of the dozens of contractors to acquire PPE independently. We found that for at least 2 weeks supply issues made two of the three contract prisons we inspected unable to comply with an April 3, 2020 CDC recommendation for individuals to wear cloth face coverings in public settings where social distancing measures are difficult to maintain. Further, our remote inspection of [Toler House RRC](#) found that the facility did not distribute face masks to all of its residents until nearly 3 weeks after the April 3 CDC recommendation. In addition, our [Brooklyn House RRC](#) remote inspection found that distribution of PPE at the RRC gradually expanded over the March–May 2020 timeframe and was shaped by both availability of supplies and a lack of PPE guidance.¹²⁴

At the beginning of the pandemic, the BOP maintained a central stockpile of PPE supplies for federal facilities at its Centralized Fill and Distribution Center in Pollock, Louisiana. By late April 2020, the BOP had created primary and secondary regional logistics sites for all six BOP regions to store PPE and provide PPE to BOP facilities. The BOP's Administration Division at its Central Office procured PPE and sent it to the regional logistics sites. Central Office officials told us that they purchased PPE for the regional logistics sites

¹²⁴ The BOP did not provide RRCs with specific guidance on PPE and face covering requirements. We discuss this limited guidance further in [The BOP Should Improve Its Communication of Essential Information to Stakeholders](#) section of this report.

in large quantities and never ran out of any PPE supplies. Internal BOP compliance inspection reports from July 2020 through March 2021 show that 94 percent of the inspected facilities ensured that sufficient PPE was available to all staff. At the time of our 2020 BOP Staff Survey, most facility respondents (64 percent, or 5,866 of 9,166) reported receiving a limited amount of PPE each week.¹²⁵

BOP facilities requested PPE through Central Office's Emergency Operations Center, which routed the requests to the regional logistics sites; BOP facilities also had the option to purchase their own PPE to bolster availability. The Central Office monitored PPE levels at the regional logistics sites and facilities daily via an electronic dashboard. Internal BOP compliance inspection reports found that 96 percent of inspected facilities uploaded PPE inventories to a Central Office dashboard on a weekly basis. According to Central Office officials we interviewed, the use of the Centralized Fill and Distribution Center and regional logistics sites were effective in the BOP's maintenance and distribution of PPE during the pandemic. Those officials explained that it would be worthwhile for the BOP to consider replicating in other areas the PPE model that it used during the COVID-19 pandemic.

Conclusion

PPE supply challenges affected the BOP early during the pandemic, and our remote inspections found numerous PPE-related issues at BOP facilities, contract prisons, and RRCs. While the BOP subsequently resolved supply issues to provide adequate PPE to facilities, the BOP should consider how its PPE supply model could support distribution efficiency beyond the current pandemic.

Recommendation

To mitigate future PPE supply and distribution challenges, we recommend that the BOP:

9. Determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic.

BOP Staff Expressed Concerns About PPE and Face Covering Guidance Early During the Pandemic

Though the confusion now appears to have waned, at the beginning of the pandemic BOP staff expressed concerns and confusion about PPE and face covering guidance. Our remote inspection reports identified instances of unclear BOP guidance and direction regarding the use of PPE. For instance, staff at [FCC Oakdale](#) who supervised COVID-19 positive inmates were not advised that they would be interacting with COVID-19 positive inmates and were not furnished proper PPE prior to inmates' isolation. By early April 2020, staff at [FCI Milan](#) had escorted at least one, and possibly more, inmates with COVID-19 symptoms to a

¹²⁵ On April 3, 2020, the CDC began recommending cloth face coverings for situations in which social distancing was difficult. CDC, "Recommendation Regarding the Use of Cloth Face Coverings, Especially in Areas of Significant Community-Based Transmission," April 3, 2020.

On April 6, the BOP began issuing two surgical masks per week to all staff and one per week to all inmates as an interim measure while the BOP's UNICOR factories manufactured cloth face coverings. Once a facility received its shipment of UNICOR-manufactured cloth face coverings, distribution of surgical masks was discontinued. At the time of our BOP Staff Survey in late April 2020, some staff reported that they were still receiving two surgical masks per week.

local hospital without wearing appropriate PPE, which potentially contributed to an increased risk of those staff contracting and spreading COVID-19.¹²⁶ In our [FMC Fort Worth](#) inspection, for example, we found that the Warden sent a memorandum in March 2020 requiring staff to utilize PPE in the isolation unit but did not specify what types of PPE were required. During FY 2020 we received over a dozen OIG Hotline complaints from BOP staff about the BOP's guidance on the use of PPE.

We found during our 2020 remote inspections that BOP staff were confused about the proper PPE requirements for specific situations. We received dozens of 2020 BOP Staff Survey responses from staff who believed that they should have received surgical masks or N95 respirators instead of cloth face coverings. We were also told that the BOP's national union had requested that the BOP provide N95 respirators to all staff at all federal facilities. The then BOP Medical Director stated that it would have been inappropriate for the BOP to distribute N95 respirators for general use, as the BOP followed CDC recommendations and required N95 respirators for staff only in certain situations, such as when transporting confirmed or suspected COVID-19 positive inmates. The BOP Occupational Safety and Health Branch Chief explained that, prior to the pandemic, N95 respirators were in plentiful supply and the BOP did not place any limits on when staff could wear them; the BOP's decision to control access to N95 respirators due to more limited supplies during the pandemic was a factor in staff frustration with the BOP's guidance.

According to the then BOP Medical Director, another source of confusion about PPE requirements was that some staff may not have understood the difference between medical isolation and quarantine and why there were different PPE requirements for those two types of units. Additionally, we believe that a visit to [FCC Oakdale](#) by CDC and Office of the Attorney General staff who wore N95 respirators while FCC Oakdale was experiencing a COVID-19 outbreak contributed to BOP staff's perception that the surgical masks provided by the BOP were insufficient.

Some feedback we received from BOP staff indicates that the BOP's guidance about whether staff could wear their own face coverings in lieu of those the BOP provided may have been unclear, particularly during the early phases of the pandemic. See the photographs below for examples of a BOP staff member wearing PPE, as well as the cloth face coverings manufactured by UNICOR and provided to BOP staff and inmates by the BOP. Neither the BOP's initial face covering guidance on April 6, 2020, nor the Department's face covering guidance on April 14, 2020, prohibited BOP staff from wearing their own personal face coverings. However, our [FCC Coleman](#) remote inspection found that the facility prohibited staff from wearing personal face coverings prior to the BOP's April 15, 2020 guidance mandating that BOP staff and inmates wear BOP-provided face coverings.¹²⁷ This caused confusion among some staff and led to staff concerns that their safety was not a management priority. Our [FCI Milan](#) remote inspection also found that management discouraged staff from wearing their own masks to avoid causing the inmates stress.

¹²⁶ The BOP identified inmate transport as a situation in which staff should wear an N95 respirator, eye protection, gloves, and a gown in its April 2, 2020 Vehicle Transport of Inmates Safety Check for COVID-19 guidance and in several versions of its Guidance for COVID-19 Personal Protective Equipment issued in late April 2020.

¹²⁷ As part of our FCC Coleman remote inspection, our review of 2020 BOP Staff Survey responses and OIG Hotline complaints found that some staff and inmates questioned the quality and effectiveness of the BOP-issued surgical masks and UNICOR-produced cloth face coverings, which resulted in some staff wearing personal face masks because they felt that they provided better protection. See DOJ OIG, *Remote Inspection of FCC Coleman*.

In our 2020 BOP Staff Survey, respondents reported in 34 open-ended comments that they were prohibited from wearing their own masks or face coverings and instead could wear only those that the BOP provided while other respondents reported in 20 comments that they were permitted to wear their own masks or face coverings. On August 24, 2020, the BOP issued a memorandum to all staff advising that facility staff were permitted to wear only face coverings provided by the BOP or purchased from a BOP Employee's Club with approval from the Warden. Despite this guidance, 66 percent of [2021 BOP Staff Survey](#) respondents reported that they were permitted to supply their own nose and mouth coverings.



Confusion among BOP staff about PPE and cloth face covering requirements appears to have waned over the course of the pandemic. For example, over 90 percent of 2021 BOP Staff Survey respondents said that COVID-19 communication and guidance on wearing cloth face coverings and PPE was easy to understand. Over the course of the pandemic, the BOP continued to update its PPE guidance to staff for specific situations. The BOP's October 8, 2020 update to its COVID-19 Pandemic Response Plan included a table that described the recommended use of PPE in various situations for both staff and inmates. Further, the Pandemic Response Plan provided detailed explanations for when staff and inmates should use N95 respirators, surgical masks, or cloth face coverings.

Conclusion

We recognize the inherent challenges that the BOP faced as CDC and DOJ guidance on this topic evolved during our remote inspections and over the course of the pandemic. Nonetheless, reports of staff confusion about PPE guidance early during the pandemic led us to conclude that the BOP should continue to update and clearly communicate guidance regarding PPE and face coverings as circumstances evolve. Because our [2021 BOP Staff Survey](#) results indicated that staff confusion in this area has declined, we do not make any recommendations in this report regarding PPE guidance to staff.

BOP Facilities Struggled to Ensure Compliance with Face Covering Requirements

We found that across the BOP there was inconsistent staff and inmate compliance with BOP guidance that required staff and inmates to wear face coverings inside facilities. As discussed in the [Introduction](#), staff

and inmates were first required to wear face coverings in April 2020.¹²⁸ On August 24, 2020, additional BOP guidance regarding the mandatory use of face coverings for BOP staff stated that employees who refused to wear face coverings and failed to follow a direct order to do so could be referred to the BOP's Office of Internal Affairs for misconduct. Nearly 95 percent of 2021 BOP Staff Survey respondents reported that they always or often covered their noses and mouths while working in the facilities, but only 82 percent of respondents reported that they observed other staff always or often doing so.¹²⁹ Even fewer respondents (68 percent) reported that inmates always or often covered their noses and mouths. Similarly, staff and inmate improper use or non-use of PPE and face coverings was a top concern for individuals who submitted OIG Hotline complaints: the OIG received over 530 complaints related to this issue between March and September 2020.

Our 2021 Inmate Survey also revealed face covering compliance issues. Results varied depending on reference group: inmates referring to themselves, to other inmates, or to staff. An estimated 84 percent of inmates self-reported always or often wearing cloth face coverings over their nose or mouth in common areas. In comparison, an estimated 53 percent of inmates indicated that other inmates always or often wore face coverings and an estimated 44 percent reported that staff did so always or often. BOP internal compliance inspections conducted between July 2020 and March 2021 found that only 66 of 90 inspected facilities (73 percent) had appropriate use of face coverings by BOP staff and inmates. Facilities at which lack of compliance with face covering guidance was observed took corrective actions, including distributing additional face coverings and making regular announcements to remind staff and inmates that face coverings were required. However, it is unclear whether those corrective actions were effective in increasing compliance.

Conclusion

To correct persistent face covering noncompliance at facilities, the BOP should assess ways to improve staff and inmate face covering compliance and regularly communicate the need to comply with healthcare protective equipment measures.

Recommendation

To ensure consistent staff and inmate compliance with face covering guidance, we recommend that the BOP:

10. Assess how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities and issue clear guidance to facilities about the importance of compliance.

¹²⁸ On April 6, 2020, the BOP issued initial guidance to Wardens referencing the issuance of face coverings to staff and inmates and directing facilities to issue surgical masks as an interim measure while advising that UNICOR would manufacture cloth masks. On April 13, the BOP issued its Phase Six Action Plan, which stated that all staff and inmates would be issued appropriate face coverings and strongly encouraged to wear them in public areas when social distancing could not be achieved. The BOP's April 15 guidance on the Mandatory Use of Face Coverings, sent to all staff via email, mandated that all staff and inmates wear BOP-provided face coverings.

¹²⁹ Seventy-five percent of respondents reported that they always covered their noses and mouths while working in facilities, and 20 percent reported often doing so.

Some BOP Facilities Did Not Take Required Preventive Measures When Waiting for Inmate COVID-19 Test Results Early During the Pandemic

Our remote inspections generally found that facilities housing BOP inmates complied with COVID-19 testing guidance and that, as testing capacity increased nationally, the BOP incorporated testing into quarantine strategies at its facilities. (See [Appendix 5](#) for more information on the factors affecting COVID-19 testing practices and availability.) While increased access to various rapid testing options has since decreased the turnaround time for test results, we found that long turnaround times for results early during the pandemic meant that COVID-19 positive inmates were sometimes housed with COVID-19 negative inmates for several days, especially during the first several months of the pandemic.

Federal COVID-19 Testing Report

In January 2021, the Pandemic Response Accountability Committee, of which the DOJ OIG is a member, published a report on COVID-19 testing efforts at six federal agencies, including the BOP. For more information about types of tests conducted, testing costs, and demographics of those who were tested, see the committee's [Federal COVID-19 Testing Report](#).

The BOP began to conduct COVID-19 tests through a contracted commercial laboratory, as well as through partnerships with public health laboratories, in March and April 2020. However, receiving test results from these laboratories could take several days. BOP medical officials told us that the turnaround time for commercial laboratory results was usually 2–4 days but that during late July into August 2020 it was as long as 10–14 days due to increased demand for testing nationwide. In some instances, the turnaround time limited facilities' abilities to timely separate inmates who had tested positive for COVID-19 from inmates who had tested negative. Our remote inspection reports on [FMC Fort Worth](#), [FCI Terminal Island](#), [FCC Oakdale](#), and [FCC Butner](#) all described situations in which inmates were housed together for up to 7 days before being separated into medical isolation and quarantine units. This resulted in an increased risk of COVID-19 transmission among inmates, as inmates whose test results were positive could have infected inmates whose test results were negative in the days before the results were received.

In some cases, this risk was exacerbated by the lack of preventive measures taken while awaiting test results. For example, at FCC Butner, our remote inspection found that, after COVID-19 positive and negative inmates in the Low Security Correctional Institution were separated into housing units based on their test results, the units housing negative inmates were not treated like quarantine units despite those inmates having had close contact with inmates who tested positive for COVID-19. At FCC Oakdale, inmates waiting for test results still left their housing units for meals instead of having meals delivered to the unit and staff working in the unit were not advised of inmates' positive results or instructed to wear appropriate PPE. The Regional Medical Director told the OIG that she was "disappointed" with how the situation was handled at FCC Oakdale and, in hindsight, believed that she and the Regional Medical Team should have more explicitly communicated to Oakdale officials their expectation about the protocols to follow during the wait period.

Conclusion

Compounding the delays due to test results turnaround time, facilities also took additional time to process the test results and develop a plan to appropriately place inmates into medical isolation or quarantine. Given the logistics involved in ensuring sufficient medical isolation and quarantine spaces, moving groups of inmates safely, and cleaning and sanitizing housing areas between occupants, we recognize that some delays may occur. However, given the risks associated with further spread of the virus in a communal living environment where staff move between units, ensuring that facilities are following quarantine guidance is

essential for minimizing transmission risk if there are delays. In response to a draft of this report, the BOP provided updated guidance from its December 2022 COVID-19 Pandemic Response Plan indicating that, because the virus has become endemic, broad-based testing in housing units was no longer required.¹³⁰ Additionally, in November 2022, the CDC updated its guidance for management of COVID-19 in correctional and detention facilities to state that facilities should base their quarantine policies on their risk tolerance instead of routinely recommending quarantine for people exposed to someone with COVID-19. Due to these guidance changes, we do not make any recommendations regarding testing and quarantine guidance in this report.

The BOP Should Respond to Ongoing Pandemic Challenges and Prepare for Future Public Health Emergencies

Aspects of the BOP's response to the COVID-19 pandemic—vaccination and modified operations at BOP facilities—have evolved over time along with various factors, including COVID-19 case counts and changes to federal guidance and legislation. For example, the BOP implemented programmatic and operational changes for inmates' daily activities and responded to evolving circumstances surrounding distribution of the COVID-19 vaccine to inmates and staff.

As circumstances evolve, the BOP should continue to ensure inmate access to essential services during modified operations, protect staff and inmate health and safety, and capture lessons learned to prepare for future public health emergencies. First, the BOP should continue to explore ways to safely accommodate inmate access to mental healthcare, programming, counsel, recreation, commissary, and communication options during extended COVID-19 related modified operations and restrictions at facilities. Second, to protect inmates and staff, the BOP should continue COVID-19 vaccine educational campaigns for inmates and ensure that inmates and staff have access to the vaccine. Finally, to prepare for future public health emergencies, the BOP should document best practices and lessons learned from ongoing COVID-19 challenges related to its continued use of modified operations and vaccines. Capturing lessons learned from these aspects of the BOP's COVID-19 response, which have evolved significantly during the pandemic, should assist the BOP in preparing for future public health emergencies and improve its ability to adapt to changing circumstances, prioritize the health of staff and inmates, and ensure continued inmate access to essential services.

The BOP Should Safely Accommodate Inmate Access to Services During COVID-19 Modified Operations and Future Public Health Emergencies

BOP facilities, contract prisons, and RRCs around the country modified their operations, tailoring them to the unique circumstances of the facility and the presence of COVID-19 in the surrounding area. As the period of modified operations continues, the BOP must continue to explore ways to balance COVID-19 prevention with inmate mental health and access to essential services. Our remote inspections and review of BOP documentation found that the BOP's modified operations resulted in reductions in, or suspension of, programming, recreation, social visitation, and commissary. In particular, we also identified significant

¹³⁰ The BOP also provided a January 2022 memorandum issued to Clinical Directors and Health Services Administrators at all BOP facilities stating that whenever mass testing was being considered at a facility it was important to communicate with the Regional Office to develop a plan based on the facility's specific epidemiological situation. Additionally, the BOP maintains an archive of previous COVID-19 guidance it has issued.

challenges related to inmate access to legal counsel during the pandemic. Following our remote inspections, modified operations continued to significantly affect most BOP facilities through 2022. Additionally, as we discuss throughout the following sections, the BOP should document best practices and lessons learned to ensure that it is prepared to accommodate inmate access to these services during future public health emergencies.

As described in the [Introduction](#) to this report, in August 2021 the BOP implemented a Modified Operations Matrix Plan that provides guidance on how individual BOP facilities should make modifications to their operations. The plan allowed for BOP facilities to intensify or relax current infection control mitigation strategies based on local COVID-19 risk factors. The plan also provided guidance on level-specific infection prevention procedural modifications and generally called for increased modifications at facilities with higher COVID-19 indicators such as medical isolation rates and facility vaccination rates. According to the BOP's public website, over 90 percent of listed BOP facilities remained under intense modifications, or "Level 3 Operations," as of June 2022. The BOP directed these facilities to follow its COVID-19 Pandemic Response Plan, which instructed facilities under Level 3 operations to modify congregate activities and advised that virtual methods for such activities were preferred to in-person meetings.

Inmate Mental Health

As discussed above, inmate suicide in single-cell confinement in quarantine units has been a significant issue during the pandemic and we found that psychology staff had not assessed the suitability of single-cell placement for at least five of the seven inmates who died by suicide in quarantine units. (Following these suicides, BOP psychological reconstruction reports recommended that psychology staff at one facility complete additional suicide risk assessment training and that two facilities improve opioid withdrawal monitoring.) The prevalence of inmate suicide in quarantine units underscores the importance of providing inmates with mental healthcare during modified operations when inmates are confined to their cells. In a March 13, 2020 memorandum issued to facility Wardens, the Reentry Services Division (RSD) Assistant Director stated that facilities must ensure that they prevent mental health emergencies and provide appropriate care to vulnerable inmates. The memorandum stated that facility psychologists must conduct daily rounds to inmate housing units to observe and communicate with inmates.

Our remote inspections and staff and inmate survey results found varied perceptions of inmate mental healthcare during the pandemic. Staff at several facilities we inspected told us that, under the Shelter in Place (or lockdown) early during the pandemic, when modified operations were most restrictive, Psychology Services staff generally visited housing units daily to evaluate inmates. Further, psychologists at several of the facilities we inspected told us that they maintained the provision of mental healthcare to inmates during modified operations. When we asked [2021 BOP Staff Survey](#) respondents to identify the areas that the BOP most needs to improve in its handling of the COVID-19 pandemic, providing mental healthcare to inmates was the second least selected response out of 15 possible responses, indicating that it was not among the top areas that institution staff felt needed improvement. However, inmate survey results show that, of the roughly three-quarters of inmates who responded that they had received mental healthcare, a higher proportion of inmates rated the quality of care during the pandemic as poor (an estimated 63 percent) compared to before the pandemic (an estimated 49 percent) and that during COVID-19 lockdowns an estimated 74 percent of respondents rated their mental healthcare as poor.

Although psychologists at two facilities we inspected reported that daily rounds to housing units enabled Psychology Services to have more opportunities to interact with inmates than normal, during our inspection fieldwork we received reports expressing concerns about inmate mental health and access to psychological care. Specifically, we found that approximately 40 complaints submitted to the OIG detailed concerns about inmate mental health during the pandemic. In addition, during our remote inspection of [FCI Terminal Island](#), staff told the OIG that the facility managed inmate mental health well, although a 2020 BOP Staff Survey respondent from FCI Terminal Island reported that inmates needed better and more frequent access to mental health services. As discussed above, BOP psychological reconstruction documentation noted that, at least one facility, quarantine and medical isolation conditions limited access to resources that can prevent suicide, such as peer support, psychology services, and telephones to call family or counsel.

According to Psychology Services staff at some facilities, lockdowns have been very stressful for inmates and could exacerbate some inmates' mental health issues. The Chief Psychologist at FCC Tucson told us in 2020 that mental health issues could increase among inmates due to the monotony of being in their cells for 22 hours a day. Moreover, previous OIG work has raised concerns about mental health for inmates housed in such conditions. Our 2017 report on the BOP's use of restrictive housing for inmates with mental illness noted that the Department defined restrictive housing as "placement in a locked room or cell and the inability to leave the room or cell for the vast majority of the day, typically 22 hours or more."¹³¹ Further, the report cited BOP policy as recognizing that "an inmate's mental health may deteriorate during restrictive housing placement."¹³² As of February 2023, 6 of the 15 recommendations from our 2017 restrictive housing report remained open, including a recommendation that the BOP evaluate and limit as appropriate the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing. In May 2022, E.O. 14074 directed the BOP to identify alternatives to the "use of facility-wide lockdowns to prevent the transmission of SARS-CoV-2, or to the use of restrictive housing for detainees and prisoners who have tested positive for SARS-CoV-2 or have known, suspected, or reported exposure."¹³³

In the absence of regular programming and group therapy sessions, some facilities provided inmates with mental health handouts, treatment journals, and therapeutic resources. For example, at [FCC Tucson](#), inmates dealing with mental health challenges were provided with secure audio devices programmed with cognitive behavioral therapy techniques to help inmates cope with anxiety. We learned following our remote inspections that the use of these devices was widespread at some facilities and that the BOP had awarded a contract to supply these devices at all facilities to complement the FIRST STEP Act (FSA) programming curriculum.

Since RRCs lack medical and psychology staff at their facilities, inmates at RRCs could be at even greater risk of mental health challenges. At the time of our remote inspections, [Brooklyn House RRC](#) and [Toler House RRC](#) had switched to remote interactions for mental healthcare.

¹³¹ DOJ OIG, *Use of Restrictive Housing*.

¹³² BOP Program Statement 5310.16, [Treatment and Care of Inmates with Mental Illness](#), May 1, 2014, www.bop.gov/policy/progstat/5310_16.pdf (accessed July 13, 2022), 16.

¹³³ E.O. 14074.

Inmate Programming

We found that COVID-19 has significantly affected the ability of BOP facilities to provide programming for inmates. In the BOP's March 13, 2020 Phase Two Action Plan, the Central Office directed facilities to implement modified operations and stated that programs should continue to be operated "when feasible." During our remote inspections, we learned that certain group programs and community meetings ceased during modified operations in order to maintain social distancing. Specifically, we were told that the Residential Drug Abuse Program (RDAP) and Mental Health Step Down Unit Program had been discontinued at [FCC Butner](#) and our remote inspection of [FCI Milan](#) found that Milan had suspended group programming.¹³⁴ Our remote inspections at contract facilities [CI Moshannon Valley](#) and [CI McRae](#) also identified reductions in programming during the pandemic. As of April 2021, the BOP reported that it was exploring the purchase of tablets for inmates as an alternative program delivery method and that it would issue a request for proposal for tablets once Congress approved the BOP's FSA spending plan.

We found that disruptions to inmate programming continued at BOP facilities beyond the period of our remote inspection fieldwork. In August 2020, the BOP issued its Phase Nine Action Plan and its modification, which directed facilities to resume programming, outdoor recreation, and in-person social visits. The Action Plan stated that "inmate programming is an essential function in our facilities, and delivery of [FSA] approved Evidence-Based Recidivism Reduction (EBRR) Programs and Productive Activities is required by law."¹³⁵ The FSA provides that an inmate who "successfully completes evidence based recidivism reduction programming or productive activities, shall earn time credits" toward prerelease custody (i.e., transfer to an RRC or home confinement) or supervised release (i.e., post-imprisonment supervision). The BOP's Phase Nine Action Plan stipulated that residential programs, such as the RDAP, would immediately resume full-time treatment, with social distancing modifications, and that delivery of non-residential EBRR Programs and Productive Activities would resume. However, the guidance also stated that facilities with active COVID-19 cases could make exceptions to programming requirements for the safety of staff and inmates and submit modification requests to the Regional Director. BOP data indicated that as of November 2020 at least 20 facilities had submitted waiver requests to suspend programming and inmate programming remained suspended at some facilities without waiver requests.¹³⁶ In response to some facilities' waiver requests, Central Office staff provided feedback or discussed the initial waiver

¹³⁴ The RDAP provides intensive drug treatment programming to inmates. The Mental Health Step Down Unit Program provides evidence-based treatment to seriously mentally ill inmates to maximize their ability to function and minimize relapse and the need for inpatient hospitalization. Inmates enrolled in either program are housed in a secured unit separate from general population housing units.

¹³⁵ The FSA defines an EBRR Program as a group or individual activity that: (1) has been shown by empirical evidence to reduce recidivism or is based on research indicating that it is likely to be effective in reducing recidivism; (2) is designed to help inmates succeed in their communities upon release from prison; and may include (3) social learning and communication, interpersonal, anti-bullying, rejection response, and other life skills. In addition, the FSA defines a Productive Activity as a group or individual activity that is designed to allow inmates determined to have a minimum or low risk of recidivating to remain productive and thereby maintain a minimum or low risk of recidivating.

Pursuant to 18 U.S.C. § 3621(h), "The Director of the Bureau of Prisons shall provide all prisoners with the opportunity to actively participate in evidence-based recidivism reduction programs or productive activities, according to their specific criminogenic needs, throughout their entire term of incarceration."

¹³⁶ The BOP indicated that there were potential errors in the dataset that it provided; the errors may have affected the accuracy of the figure presented in this sentence.

requests with facilities rather than approving them in an effort to encourage programming to continue. Central Office officials told us that, in practice, Wardens have some discretion during the pandemic regarding whether to deliver programming.

Due to the Phase Nine Action Plan's emphasis on the importance of FSA programming, we specifically reviewed available BOP FSA programming data during the pandemic. We found that FSA EBRR Programs and Productive Activities remained suspended at many facilities as of November 2020. In December 2020, a Central Office staff member sent a reminder email to facility program staff to prioritize EBRR Programs and Productive Activities led by BOP staff, contractors, or volunteers and to consider the use of alternative spaces for programming. Among the possible COVID-19 related factors that the BOP reported as contributing to programming disruptions were staff and inmate illness, precautions taken to prevent staff and inmate illness, and limited inmate transfers and movement within facilities. We also learned that staffing challenges affected program offerings; staff unavailability due to temporary job modifications and augmentation contributed to the BOP's inability to run programming at some facilities (we discuss temporary job modifications and staff augmentation in [The BOP Should Take Appropriate Steps to Address Staffing Shortages and Staff Morale](#) report section).

The BOP conducted an internal assessment of the COVID-19 pandemic's effect on FSA programming and determined that the pandemic had a high impact on "most programs" because they were "interrupted for a month or more or did not occur with any consistency across sites." The BOP reported that during the pandemic all FSA programming either fit this description or was moderately affected by COVID-19, meaning that it "may have stopped for a period of days or weeks but then quickly resumed." According to the BOP's internal assessment and our interview with a BOP official, while residential programming such as the RDAP was affected by the pandemic, it was generally less affected than nonresidential programs because services were provided in housing units and did not require inmates to interact across housing units. Historical data provided by the BOP showed an overall decline in inmate program participation through March 2021, compared to pre-pandemic participation. The data also showed marginal increases in program enrollment several times during the pandemic beginning in August 2020, when the BOP issued Phase Nine Action Plan directives to resume the program. Figure 11 below shows inmate program enrollment in the RDAP before and during the pandemic.

The significant disruption of FSA programming is concerning given the potential effects on the ability of inmates to earn time credits. According to a November 2021 OIG Management Advisory Memorandum, BOP data as of March 30, 2021, indicated that nearly half (60,146 out of 123,186) of all inmates in BOP custody were eligible to earn time credits if they had completed EBRR Programs or Productive Activities.¹³⁷

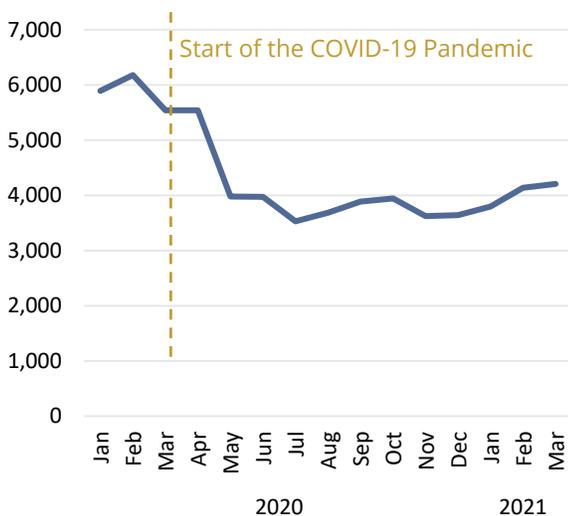
We found that the BOP has experienced challenges in systematically tracking inmate enrollment in other FSA programming, which has made it difficult to fully assess the effect of the pandemic on BOP-wide inmate program participation. According to the BOP, there is no mechanism to compare pre- and post-pandemic FSA program participation rates because the BOP changed how it tracks program participation following

¹³⁷ See DOJ OIG, [Management Advisory Memorandum: Impact of the Failure to Conduct Formal Policy Negotiations on the Federal Bureau of Prisons' Implementation of the FIRST STEP Act and Closure of Office of the Inspector General Recommendations](#), E&I Report 22-007 (November 2021), oig.justice.gov/reports/management-advisory-memorandum-impact-failure-conduct-formal-policy-negotiations-federal.

passage of the FSA.¹³⁸ Further, the BOP reported that, when it began to develop reports to track inmate program participation in and completion of EBRR Programs and Productive Activities during the pandemic, it took months to create and test the reports for data accuracy. The BOP was able to provide us with FSA programming participation totals beginning in November 2020, 8 months after the start of the pandemic. As shown in Figure 12 below, FSA program enrollment in FSA EBRR Programs and Productive Activities increased between November 2020 and October 2021.

Figure 11

BOP Inmate Participants in RDAP Programming, January 2020–March 2021



Source: OIG analysis of BOP data

Figure 12

BOP Inmate Participants in FSA EBRR Programs and Productive Activities, November 2020–October 2021



Note: This figure presents the total number of participating inmates as of the last day of each month.

Source: OIG analysis of BOP data

In addition, we found that some facilities housing female inmates did not have any inmates complete gender-specific programming for significant periods of time during the pandemic, based on our review of available EBRR Programs and Productive Activities programming completion data. We reviewed completion data from 10 Productive Activities that were intended to occur at all-female facilities from January 15 through September 30, 2020, and found that there were 0 inmate program completions for half (5 of 10) of those Productive Activities. During the subsequent 6-month period, program completion totals remained at 0 for 3 of the 10 Productive Activities for which the listed locations were all-female facilities. Although the data did not cite COVID-19 as the reason for the lack of completions, we are concerned that the BOP's female inmate population has not received essential programming in several areas during the pandemic. The programs with zero completions for female inmates included curricula to address cognition, trauma,

¹³⁸ The FSA, which was passed in December 2018, requires that, after 2 years of the FSA's enactment, the Department submit to Congress information on the types and effectiveness of recidivism reduction programs and productive activities provided by the BOP, including the capacity of each program and activity at each prison and any gaps or shortages in the capacity of such programs and activities.

mental health, and anger issues. We identify this lapse in programming completions for female inmates during the pandemic in light of concerns described in our 2017 review of the BOP's management of its female inmate population, which found that the BOP's programming and policy may not fully consider the needs of female inmates.¹³⁹ It is important for the BOP to ensure continued access to programming for female inmates during the pandemic.

Legal Visiting

Our remote inspections generally found that the BOP facilitated inmate access to legal calls with counsel at facilities we inspected but that it experienced some challenges providing inmate access to counsel visits during the pandemic. When the BOP directed facilities to suspend all in-person legal and social visits on March 13, 2020, facilities' Unit Teams arranged legal calls for inmates.¹⁴⁰ During our remote inspection of [FCI Terminal Island](#), facility staff reported that they facilitated inmates' legal communications to the extent possible but legal communication was limited during the pandemic; an attorney representing inmates alleged that the facility was unable to grant inmate legal call requests for a 3-week period. In August 2020, the BOP's Phase Nine Action Plan provided guidance for in-person legal visits at facilities able to safely conduct such visits, though inmates continued to have the option of visits by telephone or video teleconference (VTC).

According to our 2020 BOP Staff Survey results, 35 percent of BOP staff respondents (BOP-wide, as opposed to from a single institution) and 62 percent of RRC staff respondents (RRC-wide) reported that inmates had access to their counsel when requested, through facility phones, while 54 percent of BOP staff respondents did not know what strategies their facilities employed to facilitate inmate communication with legal counsel. Our analysis of complaints submitted to the OIG Hotline found over 100 complaints from April through September 2020 concerning inmate access to counsel or access to legal materials, including challenges reported by inmates' attorneys attempting to contact their clients. In addition, our analysis of the 2021 Inmate Survey shows that an estimated 84 percent of inmates who needed to contact their attorney during COVID-19 lockdowns reported that they were rarely or never allowed to do so. In comparison, an estimated 47 percent of inmate respondents said they were rarely or never allowed to contact their attorney before the pandemic and an estimated 59 percent of inmate respondents said that they were rarely or never allowed to contact their attorney during non-lockdown periods of the pandemic. These percentages represent approximately 60 percent of all inmates who responded to the survey question regarding access to attorneys; the other 40 percent either did not need to contact an attorney during the three reference periods or declined to answer the question.

Inmates' continued access to legal counsel is especially important at Federal Detention Centers (FDC), where pretrial inmates facing federal charges are typically housed. When we examined April 2020 BOP Staff Survey responses from the BOP's staff assigned to its detention centers, we found that only 59 percent of respondents (349 of 595) reported that inmates were able to communicate with their attorneys upon

¹³⁹ DOJ OIG, [Review of the Federal Bureau of Prisons' Management of Its Female Inmate Population](#), E&I Report 18-05 (September 2018), oig.justice.gov/reports/review-federal-bureau-prisons-management-its-female-inmate-population.

¹⁴⁰ On March 13, 2020, the BOP issued its COVID-19 Phase Two Action Plan, which permitted facilities to accommodate case-by-case requests for in-person legal visits.

request using facility telephones.¹⁴¹ Both FDCs that we inspected, MDC Brooklyn and MCC Chicago, received a large volume of legal call requests, and in response to the pandemic the BOP provided tablets or VTC units to facilitate inmate access to counsel and to the courts.¹⁴² At MDC Brooklyn, a Unit Manager described the accommodation of inmate legal calls as Unit Teams' greatest challenge during COVID-19, as Unit Team staff had to monitor emails multiple times per day to ensure that inmates had access to counsel. Following the BOP's issuance of its Phase Nine Action Plan, which provided guidance regarding in-person legal visits, our remote inspection of MDC Brooklyn found that the facility resumed in-person legal visits by appointment in September 2020 while continuing to conduct most visits by telephone or VTC. As mentioned above in the [Attorney and Judicial Concerns Regarding BOP Communication](#) section, an Eastern District of New York judge issued an April 2020 order that required the Wardens of MDC Brooklyn and MCC New York to provide biweekly status updates to the court and other organizations on their facilities' responses to COVID-19. During a 2019 inspection and review, the OIG found that MDC Brooklyn failed to provide timely and complete information to inmates' attorneys and the courts about its decision to cancel legal visits during a power outage and conditions inside the facility during the outage.¹⁴³

Although some BOP facilities effectively utilized VTC for virtual attorney-client visits, we found that the BOP did not provide VTC access for attorney-client video visits at all facilities during the pandemic. While the two detention centers we inspected had tablets or VTC units available for inmate legal calls and access to virtual court proceedings, not all BOP facilities utilized VTC capabilities for these purposes. Prior to the pandemic, all BOP facilities were equipped with VTC capabilities, though requests to use VTC for these purposes were reportedly rare because inmate-attorney visits generally occurred in person or over the phone while court appearances were generally held in person.¹⁴⁴ According to a Central Office official, there was a significant increase in requests for attorney-client video visits as a result of the pandemic. Although the BOP reported purchasing 175 VTC units during the pandemic, the BOP reportedly did not have enough units to support demand. In addition, the Central Office official told us that there was a need for more staff to help support the increased demand for VTC calls at facilities.

According to the Central Office official we interviewed, facility physical infrastructure challenges limited the BOP's ability to conduct attorney-client video visits at some facilities. For example, some older facilities needed to add internet ports in rooms intended for VTC use. Technological limitations at some facilities included insufficient bandwidth that led to poor audio and video quality. During the pandemic, the BOP initiated a pilot project that sent tablets or laptops for attorney-client video visits to six facilities, including four detention centers. However, the devices were reportedly unable to hold sufficiently strong mobile data connections at some of the facilities. Given these reported challenges and the importance of inmate access

¹⁴¹ For this analysis, we evaluated responses from MDC Brooklyn, MCC Chicago, MDC Guaynabo, FDC Honolulu, FDC Houston, MDC Los Angeles, FDC Miami, MCC New York, FDC Philadelphia, MCC San Diego, and FDC SeaTac.

¹⁴² DOJ OIG, [Remote Inspection of Metropolitan Correctional Center Chicago](#), E&I Report 21-053 (March 2021), oig.justice.gov/reports/remote-inspection-metropolitan-correctional-center-chicago.

¹⁴³ DOJ OIG, [Review and Inspection of Metropolitan Detention Center Brooklyn Facilities Issues and Related Impacts on Inmates](#), E&I Report 19-04 (September 2019), oig.justice.gov/reports/review-and-inspection-metropolitan-detention-center-brooklyn-facilities-issues-and-related.

¹⁴⁴ The BOP uses VTC also for telemedicine, Psychology Services programming, and religious services.

to counsel, the BOP should continue to explore ways to facilitate inmate access to counsel during modified operations at BOP facilities.

Recreation

Our remote inspections generally found that the facilities we inspected staggered inmate recreation times, following the BOP's March 13, 2020 Phase Two Action Plan, which required Wardens to implement modified operations at facilities to maximize social distancing. Inmate access to recreation varied at facilities we inspected and was especially limited during periods of high COVID-19 transmission at the facilities. For example, inmate access to recreation was suspended during COVID-19 outbreaks at [FCC Oakdale](#) and [FCC Coleman](#).

Our 2017 review of the BOP's use of restrictive housing for inmates with mental illness underscored the importance of inmate access to recreation, particularly when inmates are confined to their cells. As part of that review, the Chief Psychologist at FMC Carswell told us that it is "important for the mental and physical well-being of a person to get sun and fresh air and you cannot do that indoors."¹⁴⁵ During our COVID-19 remote inspections, Chief Psychologists at two facilities recommended beginning to allow inmates access to the outdoor recreation yard and one of the Chief Psychologists stated that such increased access could mitigate potential mental health issues. Additionally, 23 respondents to our 2020 BOP Staff Survey identified the ability to grant inmates access to recreation, especially outdoor recreation, as an immediate need. In June 2020, the then BOP Correctional Programs Division Assistant Director told us that he spoke to Regional Directors about allowing small groups of inmates at facilities with COVID-19 cases to rotate to the recreation yard. In August 2020, the BOP issued its Phase Nine Action Plan, which stated that recreation yard access would resume for inmates in the general population and for inmates in Special Housing Units consistent with standards outlined in policy.¹⁴⁶ However, as of November 2020, available BOP data indicated that at least 20 facilities were not holding outdoor recreation.¹⁴⁷ According to the BOP, outdoor recreation was available to inmates at all BOP facilities as of May 2022.

Commissary

Our remote inspections found that at federal facilities and contract prisons commissaries generally remained available to inmates who wished to make purchases during modified operations. Staff at several facilities we inspected delivered commissary items that inmates had purchased to housing units in order to limit the risk of COVID-19 transmission. While several of our remote inspections found that there were no disruptions to commissary, temporary commissary suspensions occurred at some facilities, including [MDC Brooklyn](#), [FCC Butner](#), [MCC Chicago](#), and [FCC Oakdale](#), for reasons such as staffing challenges or lockdown considerations. According to BOP staff we interviewed, some facilities reduced the inmate spending limit on

¹⁴⁵ DOJ OIG, *Use of Restrictive Housing*, 23.

¹⁴⁶ According to the BOP's Phase Nine Action Plan, general population inmates should have access to the recreation yard at least 3 times per week and inmates in groups of no more than 100 should be able to access the recreation yard for at least 1 hour at a time, provided they remain socially distant from one another. Phase Nine further stated that facilities with active COVID-19 cases could make exceptions to these programming requirements for the safety of staff and inmates.

¹⁴⁷ BOP-provided data contained inconsistencies in the number of facilities not holding outdoor recreation. We state "at least 20" because the BOP could not report the definitive number.

commissary purchases. We were told that spending restrictions at one facility were intended to reduce the burden on staff working in the commissary, many of whom had other duties. In addition, during FY 2020 there were over 65 complaints submitted to the OIG Hotline about inmate access to commissary during the pandemic. Inmates residing at RRCs, who normally would have had the opportunity to make purchases in the community, also had reduced opportunities to do so as these facilities restricted inmate movement because of the pandemic. For example, during our remote inspection fieldwork we noted that inmates at [Toler House RRC](#) were permitted to leave their facility only once per month to pick up medication and hygiene supplies.

Inmate Contact with Friends and Family

Inmates typically have contact with friends and family through in-person social visits, telephone calls, TRULINCS email, and regular mail. When the BOP suspended social visits on March 13, 2020, it took certain measures to accommodate inmates' ability to communicate with friends and family. The CARES Act required the BOP Director to "promulgate rules regarding the ability of inmates to conduct visitation through [VTC] and telephonically, free of charge to inmates, during the covered emergency period," if the Attorney General found that "emergency conditions [would] materially affect the functioning of the [BOP]."¹⁴⁸ In response to an inquiry from Senator Cory Booker regarding the cost of inmate telephone calls and video visits, the BOP reported that, as of March 13, 2020, it had increased each inmate's monthly telephone time from 300 minutes to 500 minutes to help compensate for the lack of visits.¹⁴⁹ The BOP further reported to Senator Booker that, as of April 9, 2020, telephone calls and video visits were made free of charge to inmates, although, as we explain below, social video visits were available only to certain facilities housing female inmates. According to a June 2021 BOP Operations Memorandum scheduled to expire in June 2022, the BOP may, on a case-by-case basis, continue to authorize inmates to have visitation through VTC and telephonically, free of charge to inmates.

Our remote inspections found that the availability of communication tools was limited for inmates under modified operations and the amount of time inmates had access to phones and TRULINCS email varied across facilities, from 10 minutes to 3 hours at a time and from 3 days per week to every day. We also found that temporary suspensions of inmate access to phones or TRULINCS email occurred during our inspections of [FCC Butner](#), [FCC Oakdale](#), and [FCI Terminal Island](#). Specifically, staff at FCC Butner and FCI Terminal Island told us that there were certain times when they temporarily suspended inmate access to TRULINCS computer terminals and phones in order to limit COVID-19 transmission. Additionally, a staff survey respondent at [FCI Milan](#) reported that having such limited time outside their cells meant that inmates had to choose between calling their loved ones and showering or cleaning the housing unit. Although only 9 percent of 2020 BOP Staff Survey respondents overall said that their facilities had decreased inmates' ability to communicate with loved ones by restricting access to telephones and

¹⁴⁸ On April 3, 2020, Attorney General Barr found that emergency conditions were materially affecting the functioning of the BOP. The "covered emergency period" refers to the period beginning on the date the President declares a national emergency under the National Emergencies Act (50 U.S.C. § 1601 et seq.) and ending 30 days after the date on which the national emergency declaration terminates. The emergency period was subsequently extended and remained in effect as of August 2022.

¹⁴⁹ Michael D. Carvajal, Director, BOP, letter to the Honorable Cory A. Booker, U.S. Senator, April 10, 2020.

computers, we found that this response was selected by nearly half of respondents at one facility that implemented a 14-day lockdown, which was in effect during our entire survey window.

Although the BOP made video visits free of charge to inmates during the pandemic beginning in April 2020, the use of VTC for social visits was available only to certain subsets of the inmate population throughout the pandemic. Pre-dating the pandemic, the use of TRULINCS video services for social visits at BOP facilities had been available only to the BOP's female inmate population. BOP officials told the OIG that, as of August 2021, video social visits were not available for all female inmates. According to BOP data as of May 2022, video social visits were available at 25 of the 27 BOP facilities that house female inmates. Additionally, we learned that in 2018 the BOP decided not to expand TRULINCS video services to other facilities. However, according to a Central Office official, the BOP has issued a request for information to explore the expansion of social video visiting at facilities. The BOP also initiated a pilot program to provide tablets for social video visits to inmates hospitalized with COVID-19 (see the text box).

Tablet Pilot Program for Hospitalized Inmates

During the pandemic, the BOP initiated a pilot program that provided tablets for social video visits to inmates hospitalized with COVID-19. These tablet video calls were conducted via a secure connection and allowed hospitalized inmates to virtually meet with family members and loved ones who would otherwise have been unable to visit them in the hospital during the pandemic. In November 2020, the BOP issued a technical bulletin to facilities providing instructions on how to request the purchase of approved tablets for hospitalized inmates. According to a Central Office official, the pilot program was successful and expanded over time. The BOP initially provided tablets to 5 BOP facilities, and 17 facilities had received tablets as of June 2021.

Source: BOP

The BOP's August 31, 2020 Modification of the Phase Nine Action Plan stated that non-contact social visits would restart at BOP facilities no later than October 3, 2020, and outlined COVID-19 mitigation measures such as scheduled visits, social distancing, and sanitation of visiting spaces. According to the BOP's August 31, 2020 COVID-19 Pandemic Response Plan, an agency-level decision to suspend or resume inmate social visits can be made based on agency- and pandemic-specific circumstances. The response plan further states that "visitation should not occur at [facilities] with a COVID-19 movement moratorium or when active facility transmission is occurring."

Conclusion

We identified disruptions to inmate access to programming, legal counsel, recreation, commissary, and communication options during the period of modified operations because of the pandemic. The pandemic also heightened the importance of continued inmate access to mental healthcare. While we do not make specific recommendations in this section, as the period of modified operations continues, we encourage the BOP to explore ways to accommodate inmate access to these essential services and prepare for a transition to normal operations. In addition, we encourage the BOP to document best practices and lessons learned to ensure that it is prepared to accommodate inmate access to these essential services in the event of future public health emergencies.

The BOP Should Continue to Ensure that All Inmates and Staff Have Access to the COVID-19 Vaccine

On December 16, 2020, the BOP began administering the COVID-19 vaccine to staff and inmates. The BOP received, distributed, and administered the vaccine to full-time BOP staff and inmates housed at BOP-managed facilities in collaboration with the CDC and the federal government's COVID-19 Vaccine/Therapeutics Operation, formerly known as Operation Warp Speed. The BOP received allotments of the COVID-19 vaccine directly from the CDC, at no cost to the BOP, as part of a memorandum of agreement between the BOP and the CDC. To distribute vaccines both fairly and efficiently, the BOP developed COVID-19 Vaccine Guidance, which provides direction on vaccine eligibility for inmates and staff. This guidance was intended to promote vaccine use as a means for controlling the spread of COVID-19 within federal facilities and to protect the health of inmates and staff, as well as outside community members at risk of exposure. The BOP's COVID-19 Vaccine Guidance identified vaccines as an important tool to stop the pandemic and followed criteria established by the Advisory Committee on Immunization Practices and the CDC.¹⁵⁰

The BOP offered the vaccine to full-time staff first due to the risk of staff contracting the virus because they travel between BOP facilities and the community. The BOP then distributed the remaining vaccine doses to inmates based on the priority levels determined by the BOP's COVID-19 Vaccine Guidance.¹⁵¹ To guide its decisions surrounding vaccine allocation orders sent to the CDC, the BOP established a vaccine allocation subcommittee that developed sub-allocation plans for facilities and relied on its COVID-19 Vaccine Guidance document. Ultimately, the CDC determined the quantity of vaccines allocated to the BOP in coordination with Operation Warp Speed. A Central Office Health Services Division official told us that starting in early December 2020 BOP facilities received the vaccine through the sub-allocation process based on priority. The vaccine supply was very limited at that time, and some facilities had to wait several weeks to

receive second doses after initial distributions were received at the facility, according to the Health Services Division official. The BOP told us that some vaccine shipments initially went to primary BOP facility locations

BOP Director Congressional Testimony on Vaccine Status

As of January 26, 2022, approximately 80 percent of Bureau staff are fully vaccinated, and 70 percent of inmates are fully vaccinated against COVID-19. The Bureau continues to offer and encourage both booster and primary vaccine doses to all inmates upon arrival at a Bureau facility and to all staff. We achieved a milestone in the distribution and administration of COVID-19 vaccines, exceeding 288,000 total doses administered, as of January 26, 2022, to staff and inmates.

Source: Michael Carvajal, Director, BOP, before the U.S. House of Representatives Committee on the Judiciary, "Oversight of the Bureau of Prisons," February 3, 2022

¹⁵⁰ The Advisory Committee on Immunization Practices includes 15 voting members who make vaccine recommendations. The Secretary of the U.S. Department of Health and Human Services selects members of the committee following an application and nomination process.

¹⁵¹ The BOP makes its COVID-19 Vaccine Guidance available to the public for information only, and the guidance may be adapted for the unique situations within federal facilities, according to the BOP's public website. See, for example, BOP, [COVID-19 Vaccine Guidance: Federal Bureau of Prisons Clinical Guidance](https://www.bop.gov/resources/pdfs/covid19_vaccine_guidance_20210311.pdf), Version 16, January 6, 2022, www.bop.gov/resources/pdfs/covid19_vaccine_guidance_20210311.pdf (accessed July 28, 2022).

in proximity to other BOP facilities and were subsequently transported to the other facilities. On January 28, 2021, the then BOP Director received a certificate of achievement recognizing the BOP for leading all jurisdictions and federal entities in the rate of vaccination utilization, having the highest percentage of vaccines administered per doses allocated nationally at that time. On February 3, 2022, the then BOP Director testified at a congressional hearing that, as of January 26, 2022, approximately 80 percent of BOP staff and 70 percent of inmates were fully vaccinated against COVID-19 (see the text box above). According to the OIG's collection of [interactive dashboards](#), an estimated 71 percent of inmates BOP-wide were fully vaccinated against COVID-19 as of August 2022.¹⁵²

Inmate Vaccination

The BOP's COVID-19 Vaccine Guidance initially outlined priority levels for inmate vaccination. These levels prioritized inmates based on factors such as job assignments, certain housing situations, age, and risk factors. [Appendix 7](#) contains the BOP's March 11, 2021 COVID-19 Vaccine Guidance priority levels for inmates at BOP facilities. Vaccine priority levels within the BOP's COVID-19 Vaccine Guidance have changed over time in response to the evolving pandemic and the availability of vaccines. For example, once vaccines became more readily available across the country, the BOP introduced into its guidance booster shots for both immunocompromised and non-immunocompromised inmates after their prospective vaccine series were completed. By January 6, 2022, the BOP had published Version 16 of its COVID-19 Vaccine Guidance, which eliminated priority levels for inmate vaccination and provided guidance for facilities to offer primary vaccination and a single booster shot to all inmates. We expect the BOP's COVID-19 Vaccine Guidance to continue to evolve in response to CDC guidance and the ongoing pandemic.

According to the BOP's Patient Care policy, medical treatment, including medication, is generally given only when an inmate consents.¹⁵³ However, certain diagnostic procedures for specific communicable diseases may be required for the protection of all inmates and staff. In addition, medical treatment, including prescribed medication, may also be required for an inmate if there is a court order in place for a specific treatment plan, if a physician determines that the inmate's life is in danger, or if it is determined that the inmate may pose a risk to others by refusing medical treatment. Accordingly, the BOP does not require inmates to receive the COVID-19 vaccine. A Health Services Division official told us that the BOP generally does not require vaccines or medical care for inmates unless court ordered. The BOP's COVID-19 Vaccine Guidance, Version 11.0, stated that the BOP must obtain documentation of vaccine consent or declination for all staff and inmates.

In the 2021 Inmate Survey, when asked what they would do when COVID-19 vaccinations were available, an estimated 62 percent of BOP inmates were either already vaccinated or planned to receive a COVID-19 vaccine. An estimated 24 percent of inmates had already declined or would decline to be vaccinated against COVID-19, and an estimated 14 percent were undecided.

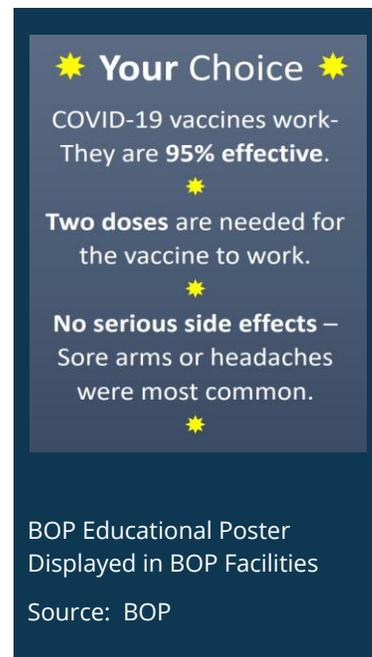
¹⁵² This OIG-estimated percentage represents fully vaccinated inmates currently in custody at any BOP-managed facility, regardless of the location of vaccine administration.

¹⁵³ BOP Program Statement 6031.01.

The BOP told us that it encouraged multiple strategies to educate inmates about the COVID-19 vaccine and to increase vaccine use among inmate populations. These strategies included conducting town halls with inmates to answer frequently asked questions, sending inmates vaccine information through TRULINCS, and ensuring that educational posters were prominently displayed throughout BOP-managed facilities. To the right is an example of an educational poster that the BOP displayed in BOP-managed facilities.

As of September 30, 2021, the BOP reported that it had administered full vaccinations to 101,806 inmates in BOP-managed facilities.¹⁵⁴ As discussed in [The BOP's Transparency and Communication with the Public](#) section of this report, although the BOP updates the number of total BOP-administered doses and full staff and inmate vaccinations completed, by federal facility, on its public website each weekday, the BOP website lacks information about the proportion of vaccinated individuals at individual facilities.

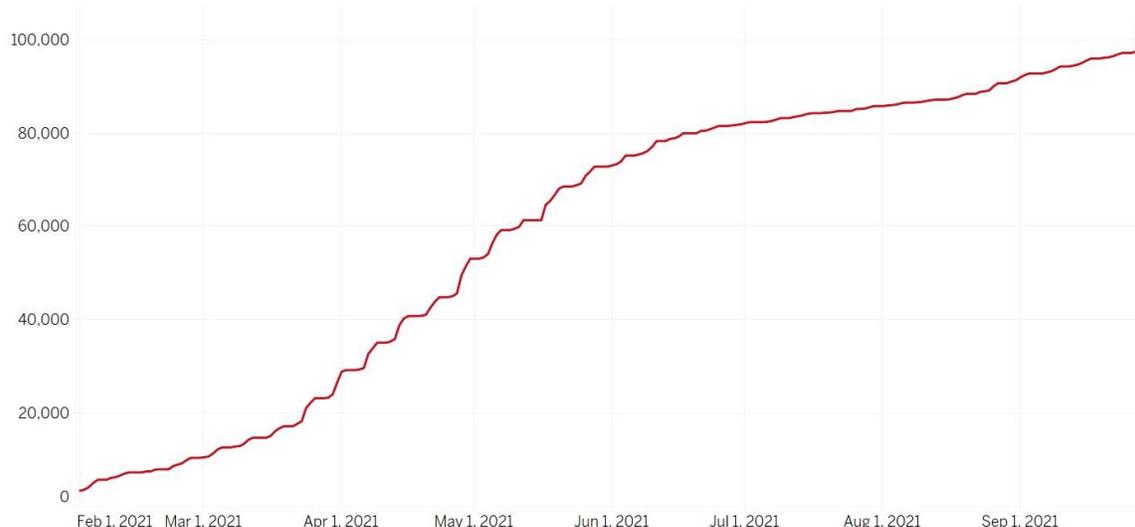
As discussed in the [Introduction](#), federal inmates and staff located at RRCs and contract prisons (when they were in operation) are referred to community resources, such as state and local health departments, to receive COVID-19 vaccinations. As of November 16, 2021, the BOP reported that all inmates in contract prisons had been offered the vaccine and that 5,554 inmates housed in those facilities were fully vaccinated. Figure 13 below shows the total number of inmates whose COVID-19 vaccination series was completed at a BOP facility between February and September 2021.



¹⁵⁴ This metric reflects inmates who either received both doses, or at least the final dose, of the complete vaccine series at a BOP-managed facility.

Figure 13

**Total Number of Inmates whose Vaccination Series Was Completed by the BOP,
February 2021–September 2021**



Notes: An inmate is counted as having received a full vaccination series completed by the BOP when he or she has received a complete vaccine series and both doses, or at least the final dose, of the vaccine series were administered at a BOP facility. Inmates who received all rounds of their vaccination series in the community rather than a BOP-managed facility are not reflected in the data.

Source: OIG Office of Data Analytics visualization of data collected from the BOP's public website

Staff Vaccination

Prior to initiating inmate vaccinations, the BOP first offered COVID-19 vaccines to BOP staff and U.S. Public Health Service officers assigned to the BOP to decrease the possible introduction of COVID-19 into federal facilities and protect the health of inmates, staff, and local communities. The BOP's COVID-19 Vaccine Guidance Version 11.0 stated that if vaccine supplies were low the BOP should prioritize staff to receive the vaccine based on job functions that pose a higher risk of transmission of infection. Table 6 below displays the BOP's employee sub-priorities for staff vaccination, based on the BOP's COVID-19 Vaccine Guidance Version 11.0.

Table 6

BOP COVID-19 Vaccine Guidance: Sub-Priorities for Employee Vaccination

First Sub-Priority	Staff with potential for close contact with sick persons (e.g., healthcare workers, workers in isolation or quarantine units, and those performing COVID-19 symptom screens and temperature checks)
Second Sub-Priority	Staff who are currently on COVID-19 related temporary job modifications
Third Sub-Priority	Staff in nursing care units and other residential healthcare units
Fourth Sub-Priority	Staff involved in receiving and discharge of inmates at facilities or performing inmate transfer or escort functions
Fifth Sub-Priority	Staff with other potential close contact with inmates (e.g., performing pat searches, supervising inmate work details)
Sixth Sub-Priority	All other staff

Source: BOP COVID-19 Vaccine Guidance Version 11.0, March 11, 2021

Beginning in December 2020, the BOP offered staff and federal inmates the COVID-19 vaccine on a voluntary basis. As of September 2021, E.O. 14043 required full COVID-19 vaccination for all federal employees, subject to exemptions as required by law, by November 22, 2021.¹⁵⁵ Additionally, all federal employees were required to upload proof of their vaccination status via an online application. The BOP had a similar online application for all BOP staff to upload proof of their vaccination status. The BOP continued to offer and encourage both booster and primary vaccine doses to all inmates upon arrival at a BOP facility and to all staff. In January 2022, a federal court in Texas issued an injunction against President Biden’s COVID-19 vaccine mandate for the federal workforce, pausing implementation of E.O. 14043. Additionally, a federal employee union filed a lawsuit challenging the vaccine mandate. The case aims to invalidate the Executive Order and subsequent guidance from the Safer Federal Workforce Task Force and OPM.

As of September 30, 2021, the BOP reported that it had administered full vaccinations to 20,226 BOP staff.¹⁵⁶ According to our [2021 BOP Staff Survey](#), 55 percent of staff respondents said that they had been vaccinated prior to the survey, 8 percent said that they would get vaccinated as soon possible, 10 percent said that they might vaccinate at a later date, 9 percent were undecided on their vaccination plans, and 18 percent said that they did not plan to get vaccinated. Custody staff respondents were more likely to say that they did not plan to get vaccinated (26 percent) compared to 11 percent of Health Services staff respondents who stated that they had no plans to get vaccinated. In addition to encouraging the display of educational posters in BOP facilities, the BOP reported that it has encouraged staff to ask questions about the vaccine. Figure 14

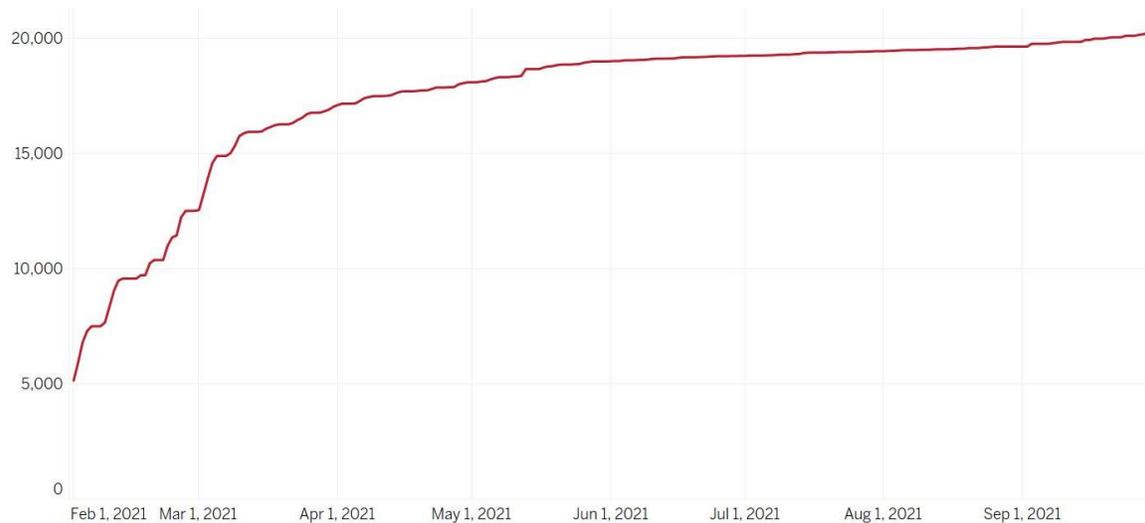
¹⁵⁵ E.O. 14043 on [Requiring Coronavirus Disease 2019 Vaccination for Federal Employees](#), September 9, 2021, www.federalregister.gov/documents/2021/09/14/2021-19927/requiring-coronavirus-disease-2019-vaccination-for-federal-employees (accessed November 10, 2022).

¹⁵⁶ This metric reflects staff who received both doses, or at least the final dose, of the complete vaccine series at a BOP-managed facility.

below displays the total number of BOP staff whose COVID-19 vaccination series was completed at a BOP facility between February 2021 and September 2021.

Figure 14

Total Number of BOP Staff Whose Vaccination Series Was Completed by the BOP, February 2021–September 2021



Note: A staff member is counted as having a full vaccination series completed by the BOP when he or she has received a complete vaccine series and both doses, or at least the final dose, of the vaccine series were administered at a BOP facility. Staff who received all rounds of their vaccination series in the community rather than at a BOP facility are not reflected in the data.

Source: OIG Office of Data Analytics visualization of data collected from the BOP's public website

Conclusion

The BOP has promoted the COVID-19 vaccine among inmates and staff and collaborated with the CDC regarding vaccine allotment and distribution. The BOP has reported that significant percentages of inmates and staff were fully vaccinated as of January 2022. Additionally, the BOP has updated its COVID-19 Vaccine Guidance based on contemporaneous public health advisements and the BOP began offering primary vaccination and booster shots to all inmates at federal facilities on January 6, 2022. Given the BOP's efforts to fully vaccinate inmates and staff and promote vaccination, and considering the status of E.O. 14043, we do not make recommendations in this report regarding vaccination. The BOP should continue to encourage COVID-19 vaccination and assess the effectiveness of its educational campaigns to encourage vaccination in federal facilities. To prepare for future public health emergencies, the BOP should document best practices and lessons learned from its COVID-19 vaccination campaign.

Conclusion and Recommendations

Conclusion

The COVID-19 pandemic tested the BOP's ability to respond to a widespread public health emergency and required the BOP to implement a variety of strategies to increase social distancing inside its facilities and to create spaces for quarantine and medical isolation. We concluded that the BOP should compile and regularly update best practices it has identified from its COVID-19 response to assist preparations for future public health emergencies. We also identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance on the single-celling of inmates during modified operations and found that the BOP should review existing practices regarding single-celling of inmates, including inmates vulnerable to suicide. Additionally, we identified several areas for improvement in the BOP's pandemic response regarding processes to protect the health and safety of inmates and staff. The BOP should address these issues by exploring permanent changes to facility infrastructures to help it more easily implement infection mitigation strategies.

Further, the number of inmates on home confinement increased during the pandemic and the BOP should continue to monitor the effects of this increase on Residential Reentry Center (RRC) providers. Our remote inspections concluded that, at a number of facilities, the BOP did not fully leverage the home confinement authorities that the BOP was given in the Coronavirus Aid, Relief, and Economic Security Act that could have permitted facilities experiencing COVID-19 outbreaks to reduce their inmate population and thereby assist in mitigating COVID-19 transmission and help with staffing issues. While we found that, overall, the BOP significantly increased the number of inmates in home confinement during the pandemic, we determined that the BOP should assess how it can most effectively use its home confinement authorities during and after the COVID-19 pandemic, as well as monitor the challenges that can arise related to a significant increase in home confinement use.

Staffing shortages during the pandemic impeded the BOP's ability to provide routine medical care at some facilities and to implement COVID-19 control measures at various facilities. Staffing shortages also contributed to increased staff workloads and negatively affected staff morale. We concluded that the BOP needs to better communicate support options to staff working at facilities, which we based on reports of staff confusion regarding the BOP's leave and quarantine guidance, reports of staff unawareness about a COVID-19 staff support line, and responses to our [2021 BOP Staff Survey](#) regarding the BOP's need to improve its provision of mental health resources to staff.

We found also that the BOP should improve its communication of essential information to stakeholders. First, the BOP must update its family notification processes and guidance to ensure that inmates' families can be appropriately involved in time-sensitive decisions if an inmate becomes seriously ill. Second, although the BOP took steps during the pandemic to communicate proactively with stakeholders, we received numerous complaints about the BOP's communications with inmates, the public, and other stakeholders, including complaints from inmates' attorneys. We also identified issues with the BOP's notifications to crime victims and limitations with its website data.

Personal protective equipment (PPE) supply challenges and COVID-19 testing challenges affected the BOP early during the pandemic, and our remote inspections found numerous PPE-related issues at BOP facilities,

contract prisons, and RRCs. While the BOP subsequently resolved supply issues to provide adequate PPE to facilities, the BOP should determine how its PPE supply model could support distribution efficiency beyond the current pandemic. We found that BOP staff were confused about PPE and face covering guidance, particularly early during the pandemic, though our [2021 BOP Staff Survey](#) results indicated that staff confusion in this area has declined. To correct persistent face covering noncompliance at facilities, the BOP should assess how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities and issue clear guidance to facilities about the importance of compliance. Additionally, we found that long turnaround times for test results when the market for testing supplies was burdened meant that inmates sometimes had to wait several days for test results and some facilities that we inspected did not properly follow quarantine guidance to manage the risk of COVID-19 transmission between inmates awaiting test results.

The BOP should also continue to monitor several ongoing challenges related to its COVID-19 response as circumstances evolve, as well as take additional actions to better prepare for potential future public health emergencies. We identified disruptions to inmate access to essential services, such as programming, legal counsel, recreation, commissary, and communication options during the period of modified operations. The BOP should explore ways to accommodate inmate access to these essential services and prepare for a transition to normal operations. In addition to continuing to ensure staff and inmate access to the COVID-19 vaccine, the BOP should continue to educate inmates about the vaccine and assess the effectiveness of ongoing vaccine educational campaigns. Finally, to prepare for future public health emergencies, the BOP should document best practices and lessons learned from ongoing COVID-19 challenges related to its continued use of modified operations and vaccines.

Recommendations

To assist the BOP in managing challenges during and after the COVID-19 pandemic and in mitigating the effects of public health emergencies in the future, we recommend that the BOP:

1. Conduct a thorough assessment of single-celling policies and processes, including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide.
2. Ensure that actions, including any policy revisions, the BOP takes to close the two open recommendations from our 2017 restrictive housing report that reference single-celling also apply to single-celling during quarantine and medical isolation.
3. Compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs.
4. Explore options for permanent changes to facility infrastructures that would allow for better implementation of social distancing and other infection control measures.
5. Assess methods to engage with staff during public health emergencies to ensure that the BOP provides sufficient staff support and clearly communicates support options available to staff.

6. Immediately update guidance regarding (1) when staff should notify the families of inmates who become seriously ill or die, including a specific timeframe, and (2) uniform criteria for what constitutes a serious illness.
7. Ensure that inmate family information, or the inmate emergency contact form, is updated according to policy and readily available for BOP staff who need to notify next of kin in cases of inmate serious illness or death.
8. Implement processes to ensure timely crime victim notifications, even under emergency conditions such as during a pandemic.
9. Determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic.
10. Assess how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities and issue clear guidance to facilities about the importance of compliance.

Appendix 1: Purpose, Scope, and Methodology

Standards

The OIG conducted this review in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* (January 2012).

Purpose and Scope

The OIG conducted this capstone review to assess the BOP's response to the COVID-19 pandemic and highlight themes we identified through our COVID-19 oversight work, including remote inspections of 16 facilities housing BOP inmates, 5 surveys of BOP staff and inmates, and a collection of interactive dashboards. This capstone review also examines COVID-19 topics that have emerged following that work. Finally, this review identifies challenges that the BOP will likely continue to face during and after the pandemic and actions that the BOP should undertake to prepare for potential public health emergencies in the future.

The COVID-19 oversight work we summarize in this report covers a variety of time periods. The remote inspections covered the period from April through June 2020. The first set of BOP staff surveys we conducted covered April and May 2020, and the follow-up survey of staff at the BOP's federal prisons covered February 2021. The survey of federal inmates covered March and April 2021. The interactive data dashboards reflecting staff and inmate COVID-19 cases and deaths in each BOP facility over time were launched on October 1, 2020, and present data starting from March 31, 2020. The OIG added data on inmate vaccination trends at BOP-managed facilities to the collection of the interactive dashboards in August 16, 2022, with data beginning August 4, 2021. Our additional fieldwork, conducted from June 2020 through May 2022, included data collection and analysis, interviews, and document reviews. To provide the most recent information on evolving BOP operations and practices, we reviewed supporting documentation provided by the BOP in January and February 2023 to a draft of this report and included applicable updates.

Methodology

Review and Summary of Previous COVID-19 Oversight Work

We reviewed our 15 remote inspection reports on 16 facilities and 5 surveys of staff and inmates to collect common themes and challenges identified in that body of work. We also reviewed the underlying support for the reports, including documents received during the remote inspections and records of interviews conducted for those projects. Additionally, we relied on data collected in support of the OIG's interactive dashboards to report on inmate and staff COVID-19 cases and vaccinations to inform our assessment of the BOP's public data reporting.

Data Collection and Analysis

The OIG used a variety of data provided by the BOP to assess and evaluate the BOP's response to the COVID-19 pandemic and the effects that the pandemic had on BOP operations, staff, and inmates. The scopes of individual data sets vary but generally extend no later than the end of FY 2021.

To examine changes in the BOP population over time, we analyzed snapshots of BOP population data that are regularly updated on the BOP's public website. To determine whether the BOP met its population targets for minimum and low security facilities during the pandemic, we compared population snapshots from the BOP's public website to the target populations set in the BOP's June 19, 2020 memorandum to facility Wardens. The memorandum lists population targets for minimum and low security facilities, including minimum and low security satellite facilities that are typically counted as part of other BOP facilities and minimum and low security cohorts at medium and administrative security facilities, by security level and gender, for a total of 141 individual minimum and low security groups. The population data we used did not have breakouts by gender, so we combined the population targets at facilities that housed both genders at the same security level. We excluded minimum and low security groups at medium and administrative security facilities because the population data we used did not break out population totals by security level at these facilities. Due to these limitations, we ultimately compared population snapshots to the set target populations at 108 minimum and low security locations: 7 minimum security facilities, 30 low security facilities, 69 minimum security satellite facilities, and 2 low security satellite facilities.

To assess the effects of the pandemic on BOP staffing, we compiled data on overall staffing between September 2017 and September 2021 from BOP budget documents and data received from the BOP, as well as data on Correctional Officer and Health Services staffing specifically. We also requested and analyzed data on temporary job modifications requested and offered between March 2020 and May 2021, temporary duty assignments made specifically to address needs related to COVID-19 between March 2020 and September 2021, and hiring and separations data before and during the pandemic.

To assess the use of staff support resources, we analyzed the call logs for the COVID-19 staff support line to examine call frequency and topic areas for questions and concerns. The call logs covered the period that the staff support line was active, April 3, 2020–December 1, 2020. We also reviewed data on Crisis Support Team activations in 2020, including those specifically related to the COVID-19 pandemic.

To assess the BOP's communication with various stakeholders, we analyzed data on family notification and victim notification. For family notification, we compiled a dataset of dates of inmate serious illnesses and deaths related to COVID-19 and dates that families were notified to assess the timeliness of those notifications. The scope of this data set encompassed inmate deaths related to COVID-19 that occurred at FCC Butner, FCC Coleman, FMC Fort Worth, and FCI Terminal Island between April and July 2020. We selected these locations because they had reported inmate COVID-19 deaths at the time of the OIG's remote inspections. For our analysis of the BOP's crime victim notification process, we requested data from the Victim Notification System to understand the frequency of delayed and missed notifications about inmate transfers to a Residential Reentry Center (RRC) or home confinement before and during the pandemic, as well as for notifications regarding inmates transferred to home confinement under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). We chose to use April 1, 2019–March 31, 2020, as the pre-pandemic period and April 1, 2020–March 31, 2021, as the during-pandemic period to roughly align the two periods before and after passage of the CARES Act on March 27, 2020.

We created a dataset of results from the BOP's internal COVID Compliance Review Checklists, which the BOP used to conduct oversight of its facilities' implementation of COVID-19 guidance, to understand the frequency of pandemic-response compliance issues across facilities reviewed by the BOP. The dataset comprised results from internal compliance reviews of 90 BOP institutions completed between August 2020

and April 2021. Because the BOP used several versions of the checklist over the course of its compliance reviews, we analyzed only topics that were consistent across the checklist versions.

We requested and analyzed a variety of BOP data related to home confinement and the population under RRC supervision. To examine the effect of expanded home confinement authorities under the CARES Act, we reviewed the number of transfers that occurred under each of the BOP's home confinement authorities. We also examined the population under RRC supervision, comprising both inmates in home confinement and inmates housed at RRC facilities. For both datasets, we chose to use April 2019–March 2020 as the pre-pandemic period and April 2020–March 2021 as the during-pandemic period to roughly align the two periods before and after passage of the CARES Act. To compare the percentage of inmates transferred to home confinement during these two periods, we used total population snapshots from within 6 weeks of April 1 each year and subtracted the home confinement population at that time from the total inmate population to better estimate the pool of inmates not already in home confinement that year.¹⁵⁷ We divided the total number of transfers for each yearlong period by the total number of inmates not already in home confinement to estimate the percentage of the inmate population transferred to home confinement each year. Finally, we analyzed failures in the home confinement setting to understand the types and frequency of failures between April 2020 and March 2021. We also used the failure data to compare the types and frequency of failures between inmates in home confinement under the CARES Act and under the BOP's other home confinement authorities.

To assess the effect that the COVID-19 pandemic had on inmate programming, we requested and analyzed available data from the BOP. The BOP provided data on Residential Drug Abuse Program participation from January 2020 through March 2021 and for Evidence Based Recidivism Reduction Program and Productive Activities participation between November 2020 and October 2021.

Interviews

In addition to reviewing the OIG interviews conducted to support the remote inspections, we conducted over 35 new interviews with BOP staff working in the Health Services Division; Reentry Services Division; Office of General Counsel; Program Review Division; Administration Division; Correctional Programs Division; Information, Policy, and Public Affairs Division; and Human Resource Management Division, including group interviews with other BOP Central Office and Regional Office staff. We also interviewed representatives of the Federal Public and Community Defenders Office and staff from the DOJ Office of the Deputy Attorney General.

The primary issues we assessed through our interviews were the BOP's response to the COVID-19 pandemic; preventive health measures put in place to minimize the spread of COVID-19; development and implementation of policy and directives for disease management; access to healthcare services, supplies, and treatment options; and communication practices with staff and outside stakeholders. We also assessed the BOP's implementation of the CARES Act and other relevant authorities. Through our interview with non-

¹⁵⁷ Although there are multiple potential methods to estimate the total BOP inmate population not already in home confinement, including using a different population snapshot or an average population over the year, we chose to use a snapshot from prior to each year as defined above because we believe it to be the best estimate of total inmates not already in home confinement given the data available.

BOP staff, we assessed the reported challenges encountered by inmate counsel during the pandemic. Our interview with Office of the Deputy Attorney General staff sought to understand the Department's involvement in the creation of, and the BOP's implementation of, the Attorney General's home confinement guidance.

Policy and Document Review

In addition to the documentation that we collected to support the remote inspections, we reviewed BOP program statements, BOP educational materials for disease prevention, and information on the BOP's public website relevant to the scope of our review. We also reviewed BOP guidance sent to BOP facilities, contract facilities, and RRCs during the COVID-19 pandemic. We reviewed various versions of the BOP's COVID-19 Pandemic Response Plan, COVID-19 Vaccine Guidance, and COVID-19 Action Plans. We also reviewed a memorandum of understanding between the BOP and the U.S. Public Health Service, a memorandum of agreement between the BOP and the CDC, Attorney General memoranda related to home confinement, and BOP memoranda related to suicide prevention. In addition, we reviewed the CARES Act and presidential Executive Orders, federal statutes, and CDC guidance. Lastly, we reviewed BOP budget documentation, BOP psychological reconstruction documentation, BOP communications with inmates' family members, FIRST STEP Act programming documentation, BOP Technical Directions, and BOP staff exit survey data.

Complaints Analysis

We reviewed over 3,300 complaints submitted to the OIG Hotline and directly to the OIG to assess COVID-19 related trends. The scope of complaints received by the OIG for the purposes of this analysis was February 27–September 30, 2020. Complaints came from several sources, including but not limited to BOP inmates, their attorneys, friends and family, and BOP staff. During our review, we determined that 3,190 complaints were COVID-19 related and directly relevant to our review scope. We then analyzed and categorized the complaints by primary topic categories to assess trends, but we did not substantiate or assess the validity of each complaint. The complaints sometimes detailed multiple issues or potential topic categories, and our analysis of complaints by topic category may not have captured each discrete issue detailed in each complaint. Examples of topic categories that we identified in the complaints include home confinement, improper or nonuse of personal protective equipment, and challenges of social distancing.

Appendix 2: Previous, Related OIG Work

As described in the [Introduction](#) to this report, the OIG conducted a variety of COVID-19 pandemic oversight work, including remote inspections, surveys, and interactive dashboards. (See the text box in the [Background](#) section for links to the published results of that work.) Over the past several years, the OIG has also conducted reviews and audits of topics that are relevant to the BOP's response to the COVID-19 pandemic. From contingency planning and staffing to inmate medical and mental healthcare, the COVID-19 pandemic has reemphasized the importance of these issues:

- [*Review of the Impact of an Aging Inmate Population on the Federal Bureau of Prisons*](#), May 2015. As of FY 2013, inmates age 50 and older were the fastest growing segment of the inmate population in BOP-managed institutions. The review found that the increasing population of aging inmates resulted in a need for increased trips outside of institutions for medical care but that institutions did not have enough Correctional Officers to staff such trips and had limited medical staff to meet older inmates' health needs within institutions, resulting in delays receiving medical care. The review also found that the physical infrastructure at BOP institutions could not adequately house aging inmates and that overcrowding throughout the BOP system limits access to lower bunks or handicapped-accessible cells that aging inmates often require. Additionally, the review found that insufficient support and access to medical care may limit the placement of aging inmates on home confinement. The OIG made eight recommendations to the BOP as a result of this review. As of September 2022, the OIG had closed seven of the recommendations and one remained open.
- [*Review of the Federal Bureau of Prisons' Medical Staffing Challenges*](#), March 2016. In September 2014, the BOP's institutions had 83 percent of its 3,871 Health Services positions filled and 12 of 97 institutions were medically staffed at or below 71 percent. The review found that multiple factors, including institution locations, pay, and the correctional setting, negatively affect the BOP's ability to recruit and retain medical staff. The review also found that the BOP did not identify or address these challenges in a strategic manner. In response to the OIG's two recommendations that the BOP use data to assess and prioritize medical vacancies and develop ways to address the vacancies, the BOP exempted 429 medical vacancies from a 2017–2018 hiring freeze and as of October 2018 had filled 303 of those positions. Considering the difficulty of filling these high-demand positions, the BOP continued to offer employment incentives and enacted several strategies, including expanding and examining its recruiting practices and identifying hiring obstacles. The BOP also implemented a pilot program allowing U.S. Department of Health and Human Services Public Health Service officers, who already make up a significant percentage of the BOP's medical staff, to fill temporary clinical assignments to satisfy professional licensing requirements. Both recommendations are closed.
- [*Audit of the Federal Bureau of Prisons' Management of Inmate Placements in Residential Reentry Centers and Home Confinement*](#), November 2016. Among other things, this audit found that the BOP underutilized direct home confinement placement as an alternative to Residential Reentry Center (RRC) placement for transitioning low-risk, low-need inmates back into society. Between October 2013 and March 2016, the home confinement population averaged nearly 159 percent of contracted monitoring capacity, despite the apparent underutilization. The OIG made five recommendations to the BOP as a result of this audit. In particular, the OIG recommended that the

BOP reevaluate the availability of alternatives to RRC placement, including consideration of increasing direct home confinement placement and home confinement monitoring capacity. All five recommendations are closed.

- [*Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness*](#), July 2017. This review identified significant issues with the adequacy of the BOP's policies and its implementation efforts surrounding the use of restrictive housing units for inmates with mental illness. In particular, the review found that inmates, including those with mental illness, were housed in single-cell confinement for long periods of time. The review also found that the BOP did not sufficiently track or monitor inmates with mental illness, including those in restrictive housing. The OIG made 15 recommendations to the BOP as a result of this review. As of February 2023, 6 of the 15 recommendations from this report remained open, including recommendations regarding the use and oversight of single-celling.
- [*Review of the Federal Bureau of Prisons' Management of Its Female Inmate Population*](#), September 2018. This review concluded that the BOP had not been strategic in its management of female inmates and that the BOP needed to take additional steps to ensure that the needs of female inmates are met at the institution level. In particular, the review identified instances in which the BOP's programming and policy had not fully considered the needs of female inmates, which made it difficult for inmates to access key programs and supplies. As a result of this review, the OIG made 10 recommendations, all of which are closed.
- [*Review and Inspection of Metropolitan Detention Center Brooklyn Facilities Issues and Related Impacts on Inmates*](#), September 2019. This review examined the BOP's response to an electrical fire in January 2019 that caused a 7-day power outage at MDC Brooklyn. The review found that MDC Brooklyn did not effectively communicate with stakeholders its decision to suspend legal and social visiting during the power outage and did not provide sufficient information to the public about the fire and the conditions of confinement during the power outage. The review also found that MDC Brooklyn's contingency plans did not address how and when staff should alert external stakeholders about significant disruptions that affect legal and social visits and conditions of confinement. The OIG made nine recommendations to the BOP as a result of this review. As of September 2022, seven of the recommendations remained open.
- [*Review of the Federal Bureau of Prisons' Pharmaceutical Drug Costs and Procurement*](#), February 2020. Among other things, the report recommended that the BOP assess the costs and benefits of a Central Fill and Distribution program for institutions that do not have in-house pharmacies to determine whether the program would be helpful to control long-term costs. As a result of this review, the OIG made nine recommendations, all of which are closed.
- [*Analysis of the Federal Bureau of Prisons' Fiscal Year 2019 Overtime Hours and Costs*](#), December 2020. This analysis found that 31,126 BOP employees worked 6.71 million overtime hours—the equivalent of 3,107 full-time positions, at a cost of \$300,874,769—during FY 2019. The vast majority of the overtime hours were worked by Correctional Officers. Health Services staff accounted for 4 percent of overtime hours, working almost 238,000 hours of overtime. The OIG did not make recommendations as part of this analysis.

- [*Management Advisory Memorandum: Impact of the Failure to Conduct Formal Policy Negotiations on the Federal Bureau of Prisons' Implementation of the FIRST STEP Act and Closure of Office of the Inspector General Recommendations*](#), November 2021. This Management Advisory Memorandum reported that there had been a 20-month period during the COVID-19 pandemic during which formal policy negotiations had not occurred between the BOP and its national union. The lack of formal negotiations disrupted aspects of the BOP's implementation of the FIRST STEP Act of 2018, as well as policy changes to address OIG recommendations on systemic correctional and safety issues. The OIG made two recommendations, both of which are closed.

Appendix 3: The BOP's COVID-19 Guidance

Guidance for Federal and Contract Prisons

On January 31, 2020, the BOP issued its first COVID-19 related memorandum to BOP medical staff, identifying the potential risk of exposure within BOP facilities, and informed recipients about risk factors, symptoms, and preventive measures. The memorandum also recommended screening new inmates for COVID-19 risk factors and symptoms and recommended the use of PPE for those in close contact with persons who may have COVID-19. Between January and October 2020, the BOP issued a series of memoranda to federal and contract prisons outlining phases of its overarching COVID-19 Action Plan and additional guidance addressing specific topics. The OIG published timelines of BOP guidance in its remote inspection reports, including the inspection of [Metropolitan Correctional Center \(MCC\) Chicago](#).

In late August 2020, the BOP began issuing consolidated guidance in its COVID-19 Pandemic Response Plan, which included modules on topics such as infection prevention and control measures; screening and testing; inmate programming and services; and BOP employee, volunteer, and contract staff management. The BOP posted the COVID-19 Pandemic Response Plan on its intranet for staff to reference and continued to update it throughout the period of our review, in 2020, 2021, and 2022, based on guidance from stakeholders, including the CDC and DOJ; the BOP intends to continue updating the plan as the CDC updates its COVID-19 guidance. As an additional step for contract prisons (which were in operation during our review period), on April 1, 2020, the BOP modified its underlying contracts with private prison vendors, emphasizing that in the event of an epidemic or pandemic the “contractor shall check with the CDC daily for updates and shall implement those changes timely to prevent further spread of the disease.”

Guidance for Residential Reentry Centers

There is no specialized CDC guidance for community correctional settings like Residential Reentry Centers (RRC), but the CDC stated that its correctional setting guidance can be adapted to the specific circumstances of other custodial settings as needed. The CDC stated that guidance topics “related to healthcare evaluation and clinical care of persons with confirmed and suspected COVID-19 infection and their close contacts may not apply directly to facilities with limited or no onsite healthcare services.” The CDC cautioned staff working in these types of facilities—which include RRCs—to coordinate closely with their state, local, tribal, and/or territorial health department when they identify inmates or staff with confirmed or suspected COVID-19.

In March 2020, the BOP called for modified operations at RRCs, including (1) discontinuing social movements, (2) restricting residents on home confinement and limiting trips beyond their approved residence locations, (3) discontinuing groups and nonessential facility services by external providers and vendors, (4) discontinuing access to outside religious services (with in-house alternative accommodations), and (5) removing the requirement of in-person visits for certain inmates deemed to be at high risk for illness. In May 2020, the BOP's Residential Reentry Management Branch provided guidance to RRCs regarding the gradual resumption of normal RRC operations, advising contract providers to follow local guidance where applicable and to tailor the application of local guidance based on local circumstances, staffing concerns, and individual population concerns. This phased-in approach to returning to regular operations called for vulnerable inmates to continue to shelter in place before eventually resuming public interactions while practicing social distancing, minimizing exposure to social settings where social distancing

is not practicable, observing all precautionary measures, and wearing appropriate personal protective equipment. In September 2021, the Residential Reentry Management Branch provided guidance to all RRCs, instructing case managers to help inmates apply for commutation of their sentences under a Biden-Harris administration clemency initiative. Inmates who had been convicted of nonviolent drug offenses or were on home confinement under Coronavirus Aid, Relief, and Economic Security Act authorities were potentially eligible.

Appendix 4: The BOP's Early Use of Medical Isolation and Quarantine

The use of medical isolation and quarantine was part of the BOP's approach to managing COVID-19 as early as its Phase One Action Plan issued on January 31, 2020. Below, we provide a timeline of the BOP's recommendations to facilities:

- **January 2020:** The BOP recommended that institutions screen incoming inmates for risk factors and COVID-19 symptoms, placing symptomatic inmates in medical isolation and asymptomatic inmates with risk factors in quarantine for 14 days. The BOP screened inmates for two risk factors:
 - recent travel from, or through, locations that the CDC identified as having increased epidemiological risk and
 - close contact with anyone diagnosed with COVID-19.

The BOP's choice to screen for these risk factors was in line with the CDC's guidance to healthcare providers in January and February 2020.

- **February–March 2020:** As the number of COVID-19 cases in the United States grew in February and March 2020, the BOP directed facilities to establish quarantine areas in case they were needed.
- **Mid-March 2020:** Following the first cases of COVID-19 in BOP facilities in mid-March 2020, the BOP's Phase Four Action Plan mandated that all facilities screen incoming inmates for COVID-19 symptoms, placing those who were asymptomatic in quarantine for at least 14 days and those who were symptomatic in medical isolation until they met CDC criteria for release from medical isolation. At the same time, the BOP mandated that facilities screen inmates for COVID-19 symptoms prior to leaving the facility for routine reasons and medically isolate inmates who were symptomatic.
- **Late March 2020:** In its Phase Five Action Plan on March 31, 2020, the BOP emphasized that institutions should quarantine close contacts of any suspected or confirmed COVID-19 cases.
- **April 2020:** In its April 13, 2020 Phase Six Action Plan, the BOP added a quarantine requirement for all inmates being released, including those releasing to Residential Reentry Centers or to home confinement. The BOP also emphasized specific medical isolation instructions, including a requirement that inmates in medical isolation be placed in a single cell if possible and the possible strategies for determining when an inmate could be safely released from medical isolation.

Appendix 5: Factors Affecting COVID-19 Testing Practices and Availability

Availability of COVID-19 Tests

During January and February 2020, diagnostic testing for COVID-19 in the United States was almost exclusively handled by CDC laboratories. In early February, the CDC received the first “emergency use authorization” from the U.S. Food and Drug Administration (FDA) to produce and distribute its laboratory-based COVID-19 test kit.¹⁵⁸ By February 6, the CDC had begun shipping the test kits to public health laboratories; but within days, laboratories began reporting that the test kits did not work properly. Over the next few weeks, the CDC identified a contaminated test component, determined that the test could be run without that component, and worked with the FDA to allow the tests to be run without it. It wasn’t until late February 2020 that healthcare providers began to have access to COVID-19 testing through public health laboratories in their areas. In March 2020, commercial laboratories began offering their own FDA-approved testing for COVID-19 and healthcare providers were able to obtain test kits from these vendors as well.

CDC Guidance on COVID-19 Testing

The CDC’s COVID-19 testing recommendations evolved over the course of the pandemic and as new information about the virus became available. When the CDC test kits first became available in February 2020, criteria for testing was limited to individuals who had both symptoms of lower respiratory infection and possible exposure to COVID-19 due to recent travel to China or recent close contact with someone diagnosed with COVID-19. As the virus spread in the United States, the CDC updated its recommendations for populations to be tested. On March 4, 2020, the CDC expanded its criteria, stating that clinicians should use their judgment about whether a patient should be tested based on the patient’s symptoms and how COVID-19 was affecting the local area.

From late March through mid-June 2020, the CDC’s testing guidance included priority categories, recognizing the potential for testing resources to be limited. Priority categories generally focused on symptomatic individuals and those at higher risk of severe illness if infected with COVID-19. For example, on April 27 the CDC identified symptomatic staff and residents in congregate living settings, including correctional facilities, as high priority for COVID-19 testing. In June 2020, the CDC broadened its testing guidance by removing prioritization categories, and, in September 2020, the CDC again updated its testing guidance to further emphasize testing asymptomatic individuals due to the potential for asymptomatic and pre-symptomatic transmission of COVID-19.

¹⁵⁸ Under § 564 of the Federal Food, Drug, and Cosmetic Act of 1938, the FDA may grant emergency use authorization for unapproved medical products or unapproved uses of approved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases when certain criteria are met, including that there are no adequate, approved, and available alternatives. See FDA, “[Emergency Use Authorization](https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization),” content current as of September 26, 2022, www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization (accessed September 27, 2022).

BOP Use of COVID-19 Rapid Tests

Testing capacity increased again through April and May 2020 with the introduction of COVID-19 rapid tests, which allowed tests to be analyzed quickly where the sample was collected rather than requiring it to be sent to a laboratory for analysis. The BOP began receiving rapid molecular RNA test machines (rapid test machines) and test kits from the Strategic National Stockpile in April 2020.¹⁵⁹ The BOP reported that all institutions had received at least one rapid test machine by mid-June 2020, and, as of September 2020, every BOP facility had at least two rapid test machines. In late 2020, the FDA began approving at-home COVID-19 test kits, and, in January 2021, the BOP added the use of these rapid antigen self-tests to its testing guidance as well.

¹⁵⁹ The Strategic National Stockpile, run by the U.S. Department of Health and Human Services, helps supplement state and local medical supplies and equipment during public health emergencies. U.S. Department of Health and Human Services, "[Strategic National Stockpile](https://www.phe.gov/about/sns/Pages/default.aspx)," last reviewed August 9, 2021, www.phe.gov/about/sns/Pages/default.aspx (accessed July 13, 2022).

Appendix 6: Home Confinement and Compassionate Release: Key Differences

	Home Confinement	Compassionate Release
Statutory Authority	18 U.S.C. § 3624(c)(2) and 34 U.S.C. § 60541(g) ^a	18 U.S.C. § 3582(c)(1)(A) or 18 U.S.C. § 4205(g) ^b
What It Does	Allows an inmate to serve the final portion of his or her sentence (generally, 10 percent or 6 months, whichever is shorter) at home rather than in a prison or a Residential Reentry Center (RRC). An inmate on home confinement is still in BOP custody and is subject to monitoring requirements.	Generally ends an inmate’s sentence early. Upon compassionate release, individuals are typically no longer in BOP custody. However, they may still be subject to probation or supervised release.
Who Is Eligible	Inmates nearing the end of their sentences who are referred for RRC placement. Candidates for home confinement under RRC supervision typically have an appropriate residence, low reentry support needs, and a low risk of reoffending.	Inmates with “extraordinary and compelling circumstances,” which may include advanced age, terminal illness, other physical or medical conditions, or family circumstances
How It Is Requested	BOP staff routinely consider inmates for home confinement near the end of their sentences as part of their transition back into the community.	An inmate, or another person on behalf of the inmate, may submit a compassionate release request to the Warden at the inmate’s institution. If the BOP approves the request, it is submitted to the U.S. Attorney’s Office for consideration by the court. An inmate may petition the court directly if the BOP denies the inmate’s request or if 30 days elapse after petitioning the Warden, whichever occurs first.
Who Makes the Decision	The BOP approves or denies home confinement placement.	Federal judges in the U.S. court system approve or deny compassionate release.
Changes During the COVID-19 Pandemic	The Coronavirus Aid, Relief, and Economic Security Act removed the time limit (6 months or 10 percent of the total sentence time) under 18 U.S.C. §§ 3624(c)(2), allowing inmates to be considered for home confinement earlier in their sentences than usual.	No change. The Department took the position that the risk of COVID-19 alone is not an “extraordinary and compelling circumstance” warranting compassionate release.

^a 18 U.S.C. § 3624(c)(2) is applicable for inmates who are approaching the end of their sentences. 34 U.S.C. § 60541(g) is applicable for elderly or terminally ill inmates.

^b 18 U.S.C. § 3582(c)(1)(A) is applicable for inmates whose offenses occurred on or after November 1, 1987. 18 U.S.C. § 4205(g) was repealed effective November 1, 1987, but remains the controlling law for inmates whose offense occurred prior to that date.

Source: OIG summary of federal statutes and BOP policy

Appendix 7: BOP COVID-19 Vaccine Guidance: Priority Levels for Inmate Vaccination (Eliminated in January 2022)

Priority Level 1	<ul style="list-style-type: none"> Inmates assigned to health service jobs Inmates in certain housing situations (e.g., nursing care centers or other residential healthcare units) Inmates in other job assignments considered high priority by the BOP
Priority Level 2	<ul style="list-style-type: none"> Inmates age 65 years and older Inmates of any age that meet one or more CDC criteria for being “at increased risk” for severe illness from COVID-19 (e.g., those with medical conditions such as cancer or chronic kidney disease) Inmates in job assignments considered a priority by the BOP
Priority Level 3	<ul style="list-style-type: none"> Inmates age 50 to 64 or inmates of any age with certain underlying medical conditions who might be at increased risk for severe illness from COVID-19
Priority Level 4	<ul style="list-style-type: none"> All other inmates upon completion of all preceding priority levels and following current CDC guidance

Source: BOP COVID-19 Vaccine Guidance, Version 11.0, March 11, 2021

Appendix 8: The BOP's Response to the Draft Report



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, DC 20534

March 9, 2023

MEMORANDUM FOR RENE L. ROCQUE
ASSISTANT INSPECTOR GENERAL
EVALUATION AND INSPECTIONS DIVISION

FROM:


Colette S. Peters, Director

SUBJECT:

Response to the Office of Inspector General's (OIG) Formal Draft Report: Capstone Review of the Federal Bureau of Prisons' Response to the Coronavirus Disease 2019 Pandemic, Assignment Number A-2020-011

The Bureau of Prisons (BOP) appreciates the opportunity to formally respond to the Office of the Inspector General's (OIG) above-referenced formal draft report. The BOP has completed our review and offer the following comments regarding the recommendations.

Recommendation 1: Conduct a thorough assessment of single-celling policies and processes, including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide.

BOP Response: BOP notes as an initial matter that single-celling in the context of medical isolation and quarantine is not restrictive housing. Guidance concerning this topic is separately addressed through relevant Health Services Division (HSD) materials previously provided to OIG including BOP's COVID-19 Pandemic Plan Module 4. As acknowledged in the draft formal report, BOP established a Single Cell Task Force ("Task Force") in May of 2021 that reviewed single-celling practices and provided recommendations. In response to this recommendation, BOP will assess the work of the Task Force to ensure that single-celling policies and processes, including those applicable to adults in custody housed in quarantine and medical isolation units and to adults in custody vulnerable to suicide, are addressed.

Recommendation 2: Ensure that actions, including any policy revisions, the BOP takes to close the two open recommendations from our 2017 restrictive housing report that reference single-celling also apply to single-celling during quarantine and medical isolation.

BOP Response: To the extent medical isolation or quarantine occurs in a restrictive housing environment, BOP will ensure the protections applicable to those settings are utilized.

However, single-celling in the context of medical isolation and quarantine is not restrictive housing. As a result, guidance concerning this topic is separately addressed through relevant HSD materials including BOP's COVID-19 Pandemic Plan Module 4, which states, "If medical isolation in single cells is necessary . . . Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations."

Additionally, BOP currently reviews all single cell placements in restrictive housing. When a BOP facility needs to place an adult in custody in a single cell, employees seek concurrence from Psychology, Medical, Unit Team, and the Captain prior to requesting the Warden's approval for placement.

Recommendation 3: Compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs.

BOP Response: The BOP concurs with this recommendation and will continue to compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs. Current best practices include but are not limited to the following: (1) separating those in medical isolation should always take priority; (2) when identifying spaces for isolation, quarantine, or movement observation, it is preferable to have these areas in separate units; (3) if it becomes necessary to house these types of adults in custody in different ranges or floors within the same unit, providing at least a 6-foot distance between the different groups is optimal (e.g., empty cell between cohorts with clear signage); (4) consider spaces not being utilized such as those used for education, religious services, visiting, recreation, or facilities; and (5) tents, shower stations, and mobile hand hygiene stations may need to be obtained to create separate spaces at some facilities.

Recommendation 4: Explore options for permanent changes to facility infrastructures that would allow for better implementation of social distancing and other infection control measures.

BOP Response: The BOP concurs with this recommendation and will continue to explore whether feasible options exist for permanent changes to facility infrastructure that would allow for better implementation of social distancing and other infection control measures within the confines of correctional safety and security requirements.

Recommendation 5: Assess methods to engage with staff during public health emergencies to ensure that the BOP provides sufficient staff support and clearly communicates support options available to staff.

BOP Response: The BOP concurs with this recommendation and will assess methods to engage with employees during public health emergencies to ensure that the BOP provides sufficient employee support and clearly communicates support options available to employees.

Recommendation 6: Immediately update guidance regarding (1) when staff should notify the families of inmates who become seriously ill or die, including a specific timeframe, and (2) uniform criteria for what constitutes a serious illness.

BOP Response: The BOP concurs with this recommendation and notes that to the extent OIG recommends policy be changed, BOP must abide by the terms of its policy development process. Additionally, BOP will need to assess whether and how to capture what constitutes a serious illness due to the variety of situations that can unfold. BOP also notes that it already provides clear expectations to employees regarding next of kin notifications following a death.

Recommendation 7: Ensure that inmate family information, or the inmate emergency contact form, is updated according to policy and readily available for BOP staff who need to notify next of kin in cases of inmate serious illness or death.

BOP Response: The BOP concurs with this recommendation and will address the need to ensure adult in custody emergency contact forms are updated according to policy. As part of its training, BOP will also address the need to ensure that such forms are readily available.

Recommendation 8: Implement processes to ensure timely crime victim notifications, even under emergency conditions such as during a pandemic.

BOP Response: The BOP concurs with this recommendation and as part of its training program, will address the need to ensure timely crime victim notifications even under emergency conditions such as a pandemic.

Recommendation 9: Determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic.

BOP Response: The BOP concurs with this recommendation and will determine how the Centralized Fill and Distribution (“CFAD”) Center and regional logistics sites model could support distribution efficiency beyond the current pandemic. The original CFAD model was developed and approved by BOP leadership in 2009. As a result of this approval, CFAD 1 was implemented on the grounds of the Federal Correctional Complex, Pollock and remains in operation today, pending funding approval for additional CFAD operations in the future. With the implementation of additional CFAD operations across the BOP, this would model the current CFAD operations along with the regional logistic sites. Funding for CFAD 2 operations was requested in the FY23 Budget Call and remains pending approval.

Recommendation 10: Assess how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities and issue clear guidance to facilities about the importance of compliance.

BOP Response: The BOP concurs with this recommendation and will conduct an assessment regarding how to improve employee and adult in custody compliance with

healthcare protective equipment measures at its facilities and issue guidance to facilities regarding the importance of compliance. BOP notes that its health services team has already issued guidance regarding appropriate healthcare protective equipment measures through multiple channels including via memoranda, email correspondence, and COVID-19 Pandemic modules that have been widely disseminated to all employees and made available on its intranet.

Appendix 9: OIG Analysis of the BOP's Response

The OIG provided a draft of this report to the BOP for its comment. The BOP's response is included in [Appendix 8](#) to this report. The OIG's analysis of the BOP's response and the actions necessary to close the recommendations are discussed below.

Recommendation 1

Conduct a thorough assessment of single-celling policies and processes, including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide.

Status: Resolved.

BOP Response: The BOP stated that single-celling in the context of medical isolation and quarantine is not restrictive housing and that guidance concerning this topic is separately addressed through relevant Health Services Division materials previously provided to the OIG, including the BOP's COVID-19 Pandemic Response Plan Module Four. The BOP stated that, as acknowledged in the OIG's formal draft report, in May 2021 the BOP established a Single Cell Task Force that reviewed single-celling practices and provided recommendations. In response to the OIG's recommendation, the BOP stated that it will assess the task force's work to ensure that single-celling policies and processes, including those applicable to adults in custody housed in quarantine and medical isolation units and to adults in custody vulnerable to suicide, are addressed.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. The OIG recognizes that the BOP does not consider single-celling in the context of medical isolation and quarantine to be restrictive housing. However, the guidance that the BOP referenced in its COVID-19 Pandemic Response Plan Module Four includes direction to consult Psychology Services staff for inmates proposed for single-celling, which is similar to guidance in the BOP's March 13, 2020 Reentry Services Division memorandum described in this OIG report. As explained in this report, we identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance and in their handling of inmates vulnerable to suicide while quarantined due to COVID-19. Further, this report notes that the BOP failed to follow its own guidance that recognized that single-celling of inmates generally should not occur for quarantine purposes. By June 23, 2023, please provide documentation evincing that the BOP, either through the work of the Single Cell Task Force or other mechanisms, has thoroughly assessed its single-cell policies and processes, including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide.

Recommendation 2

Ensure that actions, including any policy revisions, the BOP takes to close the two open recommendations from our 2017 restrictive housing report that reference single-celling also apply to single-celling during quarantine and medical isolation.

Status: Resolved.

BOP Response: The BOP stated that, to the extent medical isolation or quarantine occurs in a restrictive housing environment, it will ensure that the protections applicable to those settings are utilized. The BOP reiterated that single-celling in the context of medical isolation and quarantine is not restrictive housing and referenced its COVID-19 Pandemic Response Plan Module Four guidance, which states, “If medical isolation in single cells is necessary...Psychology Services staff should be consulted to ensure inmates proposed for single celling are not particularly vulnerable individuals and/or to make recommendations.” The BOP added that it currently reviews all single-cell placements in restrictive housing, stating that, when a BOP facility needs to place an adult in custody in a single cell, employees seek concurrence from Psychology, Medical, Unit Team, and the Captain prior to requesting the Warden's approval for placement.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. The OIG recognizes that the BOP does not consider single-celling in the context of medical isolation and quarantine to be restrictive housing and that the BOP's COVID-19 Pandemic Response Plan Module Four states that “medical isolation for COVID-19 should be distinct in name and practice from the use of restrictive housing for disciplinary or administrative reasons—even though limited housing availability may require the use of cells normally used for restrictive housing.” However, the guidance that the BOP referenced in its COVID-19 Pandemic Response Plan Module Four includes direction to consult Psychology Services staff for inmates proposed for single-celling, which is similar to guidance in the BOP's March 13, 2020 Reentry Services Division memorandum described in the OIG's report. As explained in this report, we identified serious failures by BOP facilities in their compliance with the BOP's March 2020 guidance and in their handling of inmates vulnerable to suicide while quarantined due to COVID-19. Further, this report notes that the BOP failed to follow its own guidance that recognized that single-celling of inmates generally should not occur for quarantine purposes and that inmates should be assessed for possible vulnerability to suicide before being single-celled. By June 23, 2023, please provide documentation evincing that any actions the BOP takes in response to the two open recommendations that reference single-celling from the OIG's 2017 restrictive housing report, including any policy revisions, would also apply to single-celling during quarantine and medical isolation that may occur in a restrictive housing environment.

Recommendation 3

Compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will continue to compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs. The BOP stated that current best practices include but are not limited to the following: (1) separating those in medical isolation should always take priority; (2) when identifying spaces for isolation, quarantine, or movement observation, it is preferable to have these areas in separate units; (3) if it becomes necessary to house these types of adults in custody in different ranges or floors within the same unit, providing at least a 6-foot distance between the different groups is optimal (e.g., empty cell between cohorts with clear signage); (4) consider spaces not being utilized such as those used for education, religious services, visiting, recreation, or facilities; and (5) tents, shower stations, and mobile hand hygiene stations may need to be obtained to create separate spaces at some facilities.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe the BOP's efforts to compile and regularly update best practices for addressing space limitations to meet social distancing, quarantine, and medical isolation needs. Please include supporting documentation that details any updates to these best practices.

Recommendation 4

Explore options for permanent changes to facility infrastructures that would allow for better implementation of social distancing and other infection control measures.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will continue to explore whether feasible options exist for permanent changes to facility infrastructure that would allow for better implementation of social distancing and other infection control measures within the confines of correctional safety and security requirements.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe how the BOP has explored options for permanent changes to facility infrastructures that would allow for better implementation of social distancing and other infection control measures. Please include supporting documentation or plans that describe the BOP's consideration of such options.

Recommendation 5

Assess methods to engage with staff during public health emergencies to ensure that the BOP provides sufficient staff support and clearly communicates support options available to staff.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will assess methods to engage with employees during public health emergencies to ensure that it provides sufficient employee support and clearly communicates support options available to employees.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please provide the OIG with information and documentation evincing that the BOP has assessed methods to engage with employees during public health emergencies to ensure that it provides sufficient employee support and clearly communicates support options available to employees.

Recommendation 6

Immediately update guidance regarding (1) when staff should notify the families of inmates who become seriously ill or die, including a specific timeframe, and (2) uniform criteria for what constitutes a serious illness.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that, to the extent the OIG recommends that policy be changed, the BOP must abide by the terms of its policy development process. The BOP stated that it will need to assess whether and how to capture what constitutes a serious illness due to the variety of situations that can unfold. The BOP stated that it already provides clear expectations to employees regarding next-of-kin notifications following a death.

OIG Analysis: The BOP's planned actions are sufficiently responsive to the recommendation. While the OIG recognizes that any policy changes must abide by the terms of the BOP's policy development process and that the BOP will need to assess how to capture what constitutes a serious illness, given the nature of the issue and the failures we identified, we believe the BOP must move expeditiously to address this issue. Similarly, in light of the examples in the OIG report of inconsistent staff notification to inmates' families regarding inmates' serious illnesses prior to their deaths, it is not apparent to us that BOP staff have clear expectations and understandings regarding next-of-kin notifications following an inmate death. To address the issues described in this report, the BOP should update its guidance in this area, either through policy changes or other guidance it provides to staff. By June 23, 2023, please provide copies of updated guidance regarding when staff should notify the families of inmates who become seriously ill or die, including a specific timeframe, and uniform criteria for what constitutes a serious illness. Also, please provide copies of guidance that the BOP has already provided to its staff that detail clear expectations regarding next-of-kin notifications following an inmate death.

Recommendation 7

Ensure that inmate family information, or the inmate emergency contact form, is updated according to policy and readily available for BOP staff who need to notify next of kin in cases of inmate serious illness or death.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will address the need to ensure that adult-in-custody emergency contact forms are updated according to policy. The BOP stated that, as part of its training, it will also address the need to ensure that such forms are readily available.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe actions the BOP has taken to ensure that inmate family information, or the inmate emergency contact form, is updated according to policy and readily available for BOP staff who need to notify next of kin in cases of serious illness or death and provide supporting documentation evincing these efforts.

Recommendation 8

Implement processes to ensure timely crime victim notifications, even under emergency conditions such as during a pandemic.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that, as part of its training program, it will address the need to ensure timely crime victim notifications even under emergency conditions such as a pandemic.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe how the BOP has implemented processes to ensure timely crime victim notifications, even under emergency conditions such as during a pandemic. Also, please provide supporting documentation evincing the implementation of processes to ensure timely crime victim notifications.

Recommendation 9

Determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic. The BOP stated that the original Centralized Fill and Distribution Center model was developed and proved by BOP leadership in 2009. The BOP stated that, as a result of this approval, Centralized Fill and Distribution Center 1 was implemented on the grounds of Federal Correctional Complex Pollock and remains in operation today, pending funding approval for additional Centralized Fill and Distribution Center operations in the future. The BOP stated that, with the implementation of additional Centralized Fill and Distribution Center operations across the BOP, this would model the current Centralized Fill and Distribution Center operations along with the regional logistics sites. The BOP stated that funding for Centralized Fill and Distribution Center 2 operations was requested in the fiscal year 2023 budget call and remains pending approval.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe the BOP's efforts to determine how the Centralized Fill and Distribution Center and regional logistics sites model could support distribution efficiency beyond the current pandemic. Please include supporting documentation evincing these efforts.

Recommendation 10

Assess how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities and issue clear guidance to facilities about the importance of compliance.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it will conduct an assessment regarding how to improve employee and adult in custody compliance with healthcare protective equipment measures at its facilities and issue guidance to facilities regarding the importance of compliance. The BOP noted that its Health Services team has already issued guidance regarding appropriate healthcare protective equipment measures through multiple channels including memoranda,

email correspondence, and COVID-19 Pandemic Response Plan modules that have been widely disseminated to all employees and made available on its intranet.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By June 23, 2023, please describe and provide supporting documentation evincing the BOP's assessment of how to improve staff and inmate compliance with healthcare protective equipment measures at its facilities. Also, please provide copies of guidance available to facilities about the importance of compliance with these measures.