"A Message from the Inspector General: Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions," February 2024

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

Recent high-profile inmate deaths at federal prisons have raised concerns about operational and management challenges at the Federal Bureau of Prisons, or BOP. Today my office released a report on inmate deaths in federal prisons over an 8-year period in four categories: suicides, homicides, accidental deaths, including drug overdoses, and deaths resulting from unknown factors. Of the 344 deaths in our scope, suicides accounted for over half.

Today's report identifies numerous operational and managerial deficiencies, which created unsafe conditions prior to and at the time of a number of these deaths.

For example, the BOP has recommended against housing inmates alone in a cell because of the increased risk of inmate suicide. Yet we found that more than half of the inmates who died by suicide were in single-cell confinement, and more than half of those single-cell suicides occurred in a restrictive housing setting.

We also found instances of potentially inappropriate Mental Health Care Level assignments for some inmates who died by suicide, as well as deficiencies in staff completion of required mental health assessments.

Additionally, we found that contraband drugs and weapons contributed to many of the inmate deaths in our scope, including for the 70 inmates who died of drug overdoses. Other long-standing operational challenges also contributed to many inmate deaths, such as staffing shortages, an outdated security camera system, and an ineffective, untimely staff disciplinary process.

We further found that in nearly half of the inmate deaths, there were shortcomings in BOP staff's emergency responses, ranging from a lack of urgency in responding, failure to bring or use appropriate emergency equipment, to unclear radio communications, and issues with naloxone administration in opioid overdose cases. Improvements in these areas would help prepare BOP personnel to address future inmate emergency scenarios.

Finally, we found that the BOP only requires in-depth after-action reviews following suicides and that, even when such reviews are done, the BOP's current decentralized system limits its ability to effectively implement recommendations for improvement.

It is critical that the BOP address these challenges so it can operate safe and humane facilities and protect inmates in its custody and care.

To read our report and our 12 recommendations, please visit our website oig.justice.gov, or go to oversight.gov.

Thank you for joining me today.

(Stock media provided by composer William Pearson and publisher Prolific Two Publishing/Pond5.com, www.pond5.com.)