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DOJ OIG Releases Report on Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions

Department of Justice (DOJ) Inspector General Michael E. Horowitz announced today the release of a report on issues surrounding inmate deaths in Federal Bureau of Prisons (BOP) institutions. The DOJ Office of the Inspector General (OIG) evaluated 344 inmate deaths at BOP institutions from FY 2014 through FY 2021 in four categories: suicide, homicide, accident, and those resulting from unknown factors. Many of the deaths that occurred under accidental or otherwise unknown circumstances involved drug overdoses. Suicides comprised the majority of these deaths, with homicides the next most prevalent. The OIG identified several operational and managerial deficiencies that created unsafe conditions prior to and at the time of a number of these deaths.

The OIG's findings included the following:

- **Suicide Represents a Significant Risk Area for the BOP, Which the BOP Can Help Mitigate through Compliance with Existing Policies.** We found that a combination of recurring policy violations and operational failures contributed to inmate suicides, which accounted for just over half of the 344 inmate deaths we reviewed. Specifically, we identified deficiencies in staff completion of inmate assessments, which prevented some institutions from adequately addressing inmate suicide risks. We also found potentially inappropriate Mental Health Care Level assignments for some inmates who later died by suicide. More than half of the inmates who died by suicide were single-celled, or housed in a cell alone, which increases inmate suicide risk. We also found that some institution staff failed to coordinate efforts across departments to provide necessary treatment or follow-up with inmates in distress and that staff did not sufficiently conduct required rounds or counts in over a third of the inmate suicides in our scope. Finally, the BOP was unable to provide evidence that most of its facilities completed required mock suicide drills to prepare staff to respond to potential suicides.

- **The BOP's Response to Medical Emergencies Was Often Insufficient Due to Lack of Clear Communication, Urgency, or Proper Equipment.** We found significant shortcomings in BOP staff's emergency responses to nearly half of the inmate deaths we reviewed. These shortcomings ranged from a lack of urgency in responding, failure to bring or use appropriate emergency equipment, unclear radio communications, and issues with naloxone administration in opioid overdose cases.

- **A Lack of Available Information about Inmate Deaths Limits the BOP's Ability to Potentially Prevent Future Inmate Deaths.** We found that the BOP was unable to produce documents required by its own policies in the event of an inmate death for many of the inmate

deaths we reviewed. We also found that the BOP requires in-depth After Action Reviews only following inmate suicides but not for inmate homicides or deaths resulting from accidents and unknown factors. The BOP's ability to fully understand the circumstances that led to inmate deaths and to identify steps that may help prevent future deaths is therefore limited. Further, we found that, even when the BOP obtains insights on contributing factors and recommendations for improvement following an inmate's death, the impact of that information is curtailed by the decentralization of the BOP's processes.

- **Long-standing Operational Challenges, Such as Contraband Interdiction, Further Impair the BOP's Ability to Reduce the Risk of Inmate Deaths.** We found that contraband drugs or weapons contributed, or appeared to contribute, to nearly one-third of the inmate deaths in our scope, including 70 inmates who died from drug overdoses. In addition, one or more other long-standing operational challenges—staffing shortages; an outdated security camera system; staff failure to follow BOP policies and procedures; and an ineffective, untimely staff disciplinary process—were contributing factors in many of the inmate deaths in our scope. These challenges continue to present a significant and critical threat to the BOP's safe and humane management of the inmates in its care and custody.

The OIG made 12 recommendations to assist the BOP in addressing risk factors that contribute to inmate deaths. The BOP agreed with all the recommendations.

Report: Today's report is available on the OIG's website.

Video: To accompany today's report, the OIG has released a 2-minute video of the Inspector General discussing the report's findings. The video and a downloadable transcript are available on our website.

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