Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Lewisburg

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EVALUATION AND INSPECTIONS DIVISION

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SEPTEMBER 2024

Executive Summary

The DOJ OIG's Inspections Program

Between Monday, February 5, and Friday February 9, 2024, the Department of Justice (DOJ) Office of the Inspector General (OIG) conducted an unannounced, on-site inspection of Federal Correctional Institution (FCI) Lewisburg in Pennsylvania. The institution is composed of two sub-facilities: a medium-security prison and a minimum-security prison camp. Both facilities house male inmates.

This was the fourth unannounced inspection of a Federal Bureau of Prisons (BOP) institution under the OIG's on-site inspections program. The first two institutions we inspected, FCI Waseca and FCI Tallahassee, housed female inmates, and the third institution we inspected, FCI Sheridan, housed male inmates.

In this report, we make three recommendations to the BOP to ensure effective operations at FCI Lewisburg and safe conditions of confinement for the inmates housed there. Two of those recommendations are designed to address issues at FCI Lewisburg that we also identified in our prior oversight work of the BOP and for which we have made BOP-wide recommendations. The third recommendation is related to an FCI Lewisburg-specific inmate medical care issue that we identified.

Our unannounced inspection identified several serious issues at FCI Lewisburg related to staffing, inmate healthcare quality, infrastructure, single-celling of inmates in restrictive housing, suicide prevention practices, and employee professionalism. Additionally, we found that FCI Lewisburg's evolving correctional mission in recent years has created challenges for its Executive Leadership, who expressed pride in the institution's ability to manage the changing demands that have been placed on it.

We found that FCI Lewisburg's Correctional Services Department had only 191 of 245 authorized positions filled (78 percent) as of January 14, 2024. Further, we were told that this staffing shortage is likely to be exacerbated because of the institution's expanding mission functions—including serving as the regional transport hub for inmates transferring to and from institutions in the northeast. This mission includes absorbing inmates from other institutions and inheriting additional prisoner transportation responsibilities—which, based on Lewisburg Executive Leadership projections, will result in a 153 percent increase in the number of inmates the institution must process in 2024 compared to 2023.

Concerningly, we found that there are significant disparities in calculations on the number of employee positions appropriate for FCI Lewisburg. Institution leadership expressed the view that current authorized staffing levels are insufficient, particularly given the institution's increasing responsibilities and the dozens of vacancies they are experiencing in the Correctional Services Department, which they noted has created difficulty in managing the full scope of missions expected from FCI Lewisburg. However, calculations generated by an outside firm the BOP contracted to develop staffing models for its institutions nationwide yield significantly lower totals for the facility's appropriate staffing levels, particularly in Correctional Services. The OIG is concerned that, without alignment within the BOP on the number of authorized positions that FCI Lewisburg needs and the factors that should drive this determination, the BOP will not be positioned to ensure that it can reliably and effectively accomplish its missions and FCI Lewisburg could be impaired in the safety and efficacy of its recently expanded operations.

We also identified concerns related to the quality of healthcare provided to inmates, including delays in blood tests for diabetic inmates and delays in preventive colorectal cancer screening, as well as abrupt discontinuation of mental health medications for some inmates. Specifically, with regard to medication, during the week of our inspection 15 inmates had antidepressant

medication prescriptions discontinued abruptly upon their arrival because of FCI Lewisburg clinical personnel's concerns over the frequency with which these drugs are prescribed to BOP inmates and the potentially harmful effect they can have when interacting with other prescribed drugs. We found that discontinuation of these drugs was not tapered as recommended by BOP clinical guidance. Further, FCI Lewisburg clinical personnel who made the medication discontinuation decisions did not meet with any of the affected inmates and instead relied solely on medical records. Consequently, these decisions were not informed by direct interactions with inmates. One concern with this approach is that these inmates did not have the opportunity to be informed by clinical personnel of the early signs and symptoms of a major depression relapse, which can occur following the discontinuation of antidepressant medications.

We also found infrastructure issues at FCI Lewisburg that have the potential to affect its safety and security, including significant damage to the institution's food service area, as well as the need to replace much of the institution's fire alarm system. FCI Lewisburg officials estimated the cost to address infrastructure issues at the institution at over $28 million. We also measured temperatures inside the facility, which were well above BOP targets, including temperatures above 82° Fahrenheit (F) in an occupied inmate housing unit and an 89° F reading in a cell in a housing unit that was unoccupied at the time of our inspection (institution management planned to use the unoccupied unit to house incoming holdover inmates the week following our visit). According to FCI Lewisburg's Facilities Administrator, the institution's 1930s-era steam heat system is working as designed but it is difficult to ensure that temperatures remain at BOP targets during the winter heating season because the system only has only two settings—on or off.

Additionally, the number of inmates who were single-celled in restrictive housing at FCI Lewisburg was concerning. At the time of our inspection, 18 percent (13 of 71) of inmates in restrictive housing were single-celled despite BOP policy that strongly discourages single-celling. Given the privacy afforded to inmates when they are single-celled, inmates under those conditions have an increased opportunity to attempt suicide. As the OIG has noted in our prior oversight work, suicide risk is greatest when inmates are single-celled in restrictive housing, where they are confined to their cells for 23 hours a day. We also found prevalent violation of BOP guidance that all Correctional Officers assigned to a Special Housing Unit or housing unit custody post carry cut-down tools that would enable them to quickly cut ligatures used in inmate hanging attempts. This violation of recent BOP guidance directly compromises the institution's ability to effectively and timely respond to suicide attempts.

Lastly, multiple FCI Lewisburg employees told the OIG that a subset of institution employees engages in verbal abuse toward inmates and employees and that multiple alleged instances of harassment occurred at the institution in the past few years. In addition, we observed multiple examples of obscene and sexually graphic graffiti, degrading certain employees, in employee-only-access areas and we observed derogatory language and images. Separately, we found that FCI Lewisburg employees displayed inmate-drawn artwork that included Nazi and white-supremacist iconography, as well as symbols associated with street and prison gangs, in the hallway of the institution's Special Investigative Services (SIS) office. In response to a draft of this report, BOP Central Office Executive Staff and intelligence officials stated that images displayed in FCI Lewisburg's SIS office area showcase a diverse set of gang-related iconography and that SIS plays a vital role in managing gang-related activity and teaching employees to recognize, report, and monitor gang-related activity and membership. While we recognize the potential educational value of such displays for SIS employees, we are concerned that the prominent display of Nazi and white-supremacist iconography in the SIS hallway also could have a negative impact on employee morale, inmates' willingness to provide information to the BOP during their gang disassociation, and potentially contribute to a hostile work environment. We discuss these findings in the Inspection Results.

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Introduction

This report details the results of the U.S. Department of Justice (DOJ) Office of the Inspector General's (OIG) unannounced inspection of a Federal Bureau of Prisons (BOP) prison, Federal Correctional Institution (FCI) Lewisburg, which is approximately 60 miles north of Harrisburg, Pennsylvania. FCI Lewisburg is within the BOP's Northeast Region and is composed of two facilities, a medium-security prison, in which inmates have limited freedom of movement, and a minimum-security prison camp, in which inmates can move freely throughout camp buildings and surrounding areas. For the remainder of this report, we refer to the overall institution as FCI Lewisburg, the medium-security prison as the "Medium FCI," and the minimum-security prison camp as the "Camp." This is the fourth report of an unannounced inspection the OIG has conducted of a BOP institution pursuant to its on-site inspections program. We previously issued separate reports detailing our inspections of FCI Waseca and FCI Tallahassee, both of which housed female inmates. The former is located in the BOP's North Central Region; the latter is in the BOP's Southeast Region. Most recently, we issued our report on the inspection of FCI Sheridan, an institution housing male inmates, which is located in the BOP's Western Region. We selected FCI Lewisburg as the site of our fourth inspection because we wanted to better understand and assess the conditions of confinement for male inmates in a facility in the BOP's Northeast Region.

Federal Prison Oversight Act

On July 25, 2024, the Federal Prison Oversight Act (FPOA) was signed into law. The FPOA requires the OIG to conduct periodic inspections of BOP facilities based on the OIG's assessment of risk factors at BOP facilities. Prior to the FPOA's enactment, the OIG identified FCI Lewisburg for inspection based on our assessment of risk factors at the facility. Consistent with the FPOA's requirements, we are reporting the findings from our inspection of FCI Lewisburg, and our recommendations to the BOP, publicly and to the U.S. Congress.

Source: Federal Prison Oversight Act, Pub. L. No. 118-71, 138 Stat. 1492 (2024) (codified at 5 U.S.C. § 101 (note))

The OIG conducted its unannounced, on-site inspection of FCI Lewisburg between Monday, February 5, and Friday, February 9, 2024. While on site, we made physical observations; interviewed employees and inmates; reviewed security camera footage; and collected records related to inmate programming and education, institution staffing levels, conditions of confinement, inmate medical and mental healthcare, and allegations of employee and inmate misconduct, including sexual misconduct. We also made follow-up requests for additional data, interviews, and documents from the institution, the BOP's Northeast Regional Office, and the BOP's Central Office, which we used to further inform our inspection (see Appendix 1 for more details on the methodology).

FCI Lewisburg Main Entrance

Source: OIG, February 2024

FCI Lewisburg

As of February 5, 2024, the Medium FCI housed 575 inmates, about 45 percent of its physical capacity. It has 10 general population housing units and one Special Housing Unit (SHU). The general population housing units have three floors with double-occupancy cells. Cells generally contain bunk beds, a sink, a toilet, and a desk. Cells remain unlocked during the day so inmates can use common shower and recreation areas. The SHU houses inmates who need to be separated from the general population, and it generally contains double-occupancy cells with a shower, sink, and toilet. Inmates remain locked in SHU cells except when they are escorted to recreation areas.

At the time of our inspection, the Camp housed 348 inmates, approximately 69 percent of its physical capacity of 502. Camp inmates live in two housing buildings that have open concept living spaces. Each living space contains bays with inmate bunk beds, as well as communal areas for bathrooms, showers, and recreation.

FCI Lewisburg is a Medical Care Level 2 and a Mental Health Care Level 2 institution. According to BOP policy, Medical and Mental Health Care Level 2 institutions should have the capabilities and resources to provide care for stable outpatients whose medical and mental health conditions can be monitored and managed through routine appointments.

FCI Lewisburg: Institution Profile

Location
Lewisburg, PA

Medical Care Level
2 of 4

Mental Healthcare Level
2 of 4

Employees
Total Positions: 468
On Board: 392
67 Vacancies

	FCI	Camp
	Population	**Population**
	Physical Capacity: 1,284	Physical Capacity: 502
	Actual Headcount: 575	Actual Headcount: 348
	~45% capacity	*~69% capacity*
Security Level	Medium	Minimum
Housing Units	10 General Population and 1 SHU	2 Buildings with Open Concept Spaces

Employee totals as of January 14, 2024. Inmate totals as of February 5, 2024

Source: FCI Lewisburg documentation

Historical and Current Institution Missions

The Medium FCI opened in 1932, and the Camp opened in 1993. FCI Lewisburg historically operated as a high-security prison, and, to align with the BOP's naming conventions for high-security prisons, it was called U.S. Penitentiary (USP) Lewisburg for much of its history. Consistent with its designation, from 2009 to 2020 the institution operated a BOP Special Management Unit (SMU), which housed highly disruptive inmates who, the BOP determined, could not be managed at other BOP institutions. After the SMU mission ended,

in 2021 the institution was redesignated a medium-security prison.[1] In April 2024, USP Lewisburg's name was changed to FCI Lewisburg to align with the BOP's naming convention for medium- and low-security prisons.

After the SMU mission ended, FCI Lewisburg fulfilled a variety of missions for the BOP and inherited different inmate populations as ad hoc needs arose. For example:

- Between April 2020 and October 2020, it housed approximately 900 inmates who were displaced from FCI Estill, a BOP institution in South Carolina, after a tornado rendered much of that institution uninhabitable.

- Between February 2021 and September 2021, it accepted BOP inmates from a contract prison after the BOP ended its contracts with contract prison providers.

- In November 2021, it received approximately 200 inmates whom the U.S. Marshals Service (USMS) had been housing at District of Columbia jail facilities. The USMS transferred these inmates because it conducted an unannounced inspection of the District of Columbia jail facilities and found that conditions did not meet the USMS's minimum standards of confinement. Transferred inmates included defendants in pretrial custody related to alleged offenses stemming from events that took place on January 6, 2021, at the U.S. Capitol.

- In March 2022, it received all La Mara Salvatrucha (MS-13) gang inmates who had been housed at other BOP institutions. The BOP made the decision to transfer all MS-13 inmates to one institution to prevent system-wide gang violence after MS-13 members murdered two rival gang members at USP Beaumont in January 2022.

In addition to having addressed the housing needs discussed above, FCI Lewisburg has assumed new, permanent responsibilities in recent years. For example:

- In December 2019, it began accepting inmates from across the BOP who intend to drop out of gangs. These inmates stay at FCI Lewisburg until they complete the BOP's gang debrief process. During the gang debrief (disassociation) process, inmates are asked to provide intelligence to the BOP and outside law enforcement about gang operations.

- In April 2021, it activated a Reintegration Housing Unit (RHU) for inmates that have difficulty functioning in the prison environment and have fears of being around other inmates. Many of these

[1] The BOP established SMUs in 2008 as a program 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. In 2018, the BOP announced that it would relocate the SMU from FCI Lewisburg to USP Thomson. While the OIG was conducting this inspection, the BOP reported that it did not have any documentation or subject matter experts that could provide an explanation about the BOP's decision to move the SMU from FCI Lewisburg to USP Thomson. The BOP subsequently suspended the SMU program at USP Thomson in February 2023.

inmates have committed a sexual offense, cooperated with law enforcement, or owe debts to other inmates. Unlike other housing units at FCI Lewisburg, the RHU has dedicated psychologists to help inmates manage anxiety, develop relationships, and build self-confidence.

- In April 2021, it began serving as a regional transport hub for inmates being transferred to or from BOP institutions in Northeast and Mid-Atlantic states. These inmates are referred to as "holdover inmates." See the textbox below for a further description.

Holdover Inmates

A holdover inmate is defined as an inmate who is temporarily housed an institution while they are en route to the BOP institution at which they will serve their sentence. A holdover inmate is held at FCI Lewisburg for approximately 1 to 7 days before being transferred to another BOP institution. As part of its holdover inmate mission, FCI Lewisburg transports inmates, via bus, to and from other BOP institutions, local jails, and airports.

Source: BOP

Inspection Results

Staffing Challenges

As described extensively in previous OIG oversight products, staffing shortages and employee allocation are among the chief and longstanding operational challenges facing the BOP enterprise-wide. Our inspection of FCI Lewisburg found significant staffing shortages at the institution, as well as substantial disparities in BOP estimates of the staffing levels necessary for the institution to execute its mission successfully. FCI Lewisburg personnel noted that many of its existing authorized positions were vacant, which they believed hampered their ability to achieve effective operations. Further, while institution management expressed pride in their ability to manage the institution's evolving mission, they expressed concern with their ability to continue to do so given the institution's changing mission and increasing responsibilities, especially given the significant growth in the number of holdover inmates anticipated throughout 2024. FCI Lewisburg Executive Leadership told us that FCI Lewisburg should be allocated additional employee positions above the existing authorized total in view of its expanding mission requirements and inmate population. As described in greater detail below, FCI Lewisburg Executive Leadership's perspective about additional staffing needs is in contrast with estimates developed by an outside contractor hired by the BOP to calculate appropriate staffing levels for each institution through a recently deployed staffing projection tool.

Relevant Prior OIG Work and Related Recommendations: BOP Staffing Levels

A 2021 Government Accountability Office (GAO) report recommended that the BOP develop and implement a reliable method for calculating staffing levels at BOP institutions. The DOJ OIG made a similar recommendation in a 2023 report examining the BOP's strategies to identify, communicate, and remedy operational issues. In response to the GAO's recommendation, in 2021 the BOP hired an outside contractor to help it calculate staffing levels for each BOP institution using a staffing projection tool.

Both the GAO's and the OIG's recommendations remain open, but we note that the BOP has made progress in developing a staffing projection tool, which we discuss it in greater detail in this section.

See Appendix 2, Items IV and V, for more information about these reports.

At the time of our inspection, FCI Lewisburg had a total of 468 authorized positions in all departments, including 245 in its Correctional Services Department. The Correctional Services Department is composed primarily of Correctional Officers who are responsible for providing round-the-clock supervision of inmates. Of the 245 authorized positions for FCI Lewisburg's Correctional Services Department, only 191 positions (78 percent) were filled as of January 14, 2024. As a result of this shortage, according to the institution's payroll records, on-board employees work a significant amount of overtime to ensure that all Correctional Officer posts are filled. Specifically, we calculated that from January 1, 2023, to January 28, 2024, FCI Lewisburg employees worked approximately 52,000 hours of overtime for the Correctional Services Department, which is the equivalent of approximately 25 full-time positions based on the 2,080 total number of work and leave hours the U.S. Office of Management and Budget calculates that a full-time equivalent employee records

during a year.[2] We found that FCI Lewisburg is generally able to fill vacant Correctional Officer posts with Correctional Services Department employees willing to work *voluntary* overtime. At other BOP institutions, we have often found that leadership must resort to using *mandatory* overtime and reassignment of non-Correctional Officers from their regular duties in other departments to serve in Correctional Officer posts through a process called augmentation.[3]

When we discussed staffing levels with FCI Lewisburg's Executive Leadership, they expressed concern about their ability to meet operational needs with existing staffing levels, citing the amount of overtime needed to cover posts. They also explained that FCI Lewisburg is the only BOP institution with a freestanding concrete wall, which requires Correctional Officers to be posted in each of its eight watchtowers at all times. Additionally, given its age, the institution has housing units with unique layouts that require the posting of more Correctional Officers to supervise inmates than the number necessary to supervise inmates at more modern BOP institutions. Due to these three factors, they believed, the 245 in authorized positions for the Correctional Services Department was insufficient and told us that a more appropriate Correctional Services staffing number would be 265. However, both figures differ significantly from the calculation produced by the BOP outside contractor's staffing projection tool, which as of July 2024 projected that FCI Lewisburg needed only 197 authorized positions in its Correctional Services Department. Moreover, the staffing projection tool estimate of 197 employees is well below the number of Correctional Services employees currently on board combined with our OIG calculation of the amount of overtime FCI Lewisburg employees worked to cover Correctional Services needs, which totaled 216 full-time equivalent positions. Table 1 below depicts the significant discrepancies that exist between each estimate of the staffing totals appropriate to fulfill mission needs in the Correctional Services Department.

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[2] Because those 2,080 hours include annual, sick, and other leave that an employee can use during the year, our calculation understates the number of full-time employees that would be needed to cover those 52,000 hours of overtime. However, because annual leave granted to an employee each year is based on the employee's seniority and grade, it would be impracticable for us to calculate with precision the number of full-time equivalent employees that the 52,000 hours of overtime represents.

For past OIG work on the BOP's use of overtime, see Appendix 2, Item VI.

[3] The OIG described the BOP's use of mandatory overtime and augmentation in our inspection report of FCI Sheridan and in broader OIG work on BOP inmate deaths in custody. In the latter report, we found that all three BOP sites we visited (USP Thomson, Federal Transfer Center Oklahoma City, and Federal Correctional Complex Hazelton) used mandatory overtime to compensate for staffing shortages. See Appendix 2, Items III and XIII, for more information on these reports and Item VI for our 2020 Management Advisory Memorandum on the BOP's use of overtime in 2019.

Table 1

FCI Lewisburg Correctional Services Department Position Totals, as of February 2024, and Projected Needs

Filled Positions	Authorized Positions	Filled Positions Plus Positions Covered by Overtime	FCI Lewisburg Executive Leadership Estimate of Necessary Positions	Staffing Projection Tool Estimate of Necessary Positions
191	245	216 (191+25)	265	197

Note: As noted above, the OIG calculated positions filled via overtime for FCI Lewisburg's Correctional Services Department by dividing employee overtime hours worked in Correctional Services (approximately 52,000) by the total number of work and leave hours (2,080) the Office of Management and Budget calculates that a full-time equivalent employee records during a year. Positions filled via overtime numbers are rounded.

Sources: FCI Lewisburg staffing data, FCI Lewisburg Executive Leadership, and the BOP contractor's staffing projection tool

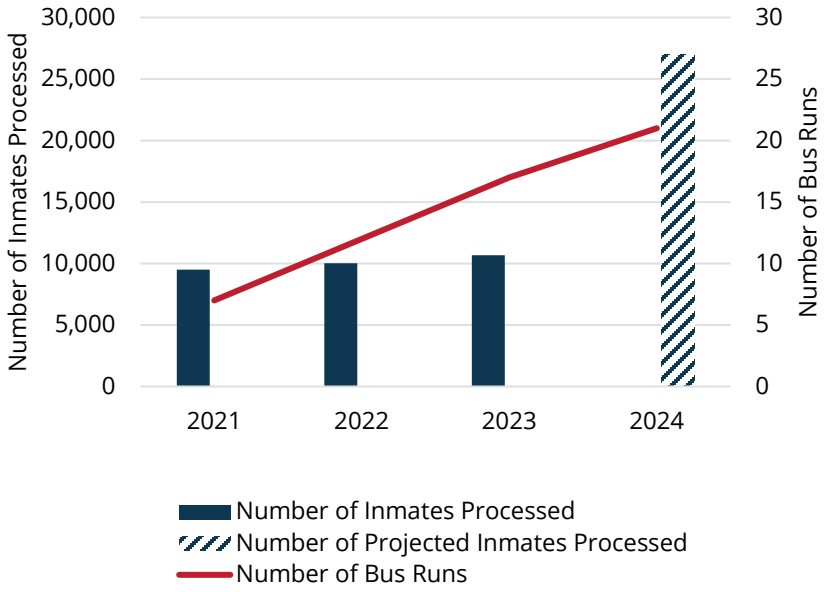
As noted above, during the past several years FCI Lewisburg began to serve as a regional transport hub for the Northeast and Mid-Atlantic regions. A regional transport hub is a central institution where the transfer, coordination, and management of inmate movements occur. In addition, according to FCI Lewisburg Executive Leadership, the institution will be expanding its holdover mission to absorb inmates who would have previously transited through Metropolitan Detention Center (MDC) Brooklyn. As a result of these changes, FCI Lewisburg Executive Leadership projected that the institution will process approximately 27,000 inmates in calendar year (CY) 2024, a 153 percent increase from the 10,674 inmates processed in CY 2023. During this same timeframe, FCI Lewisburg's bus transportation responsibilities will increase from 17 destinations in CY 2023 to 21 destinations in CY 2024.[4]

As seen in Figure 1 below, by the end of CY 2024, the number of bus runs and the number of inmates processed will have significantly increased from CY 2021, substantially increasing the operational burden on the institution.

[4] These numbers represent the distinct locations (such as other BOP institutions, local jails, and airports) that FCI Lewisburg transports inmates to and from.

Figure 1

FCI Lewisburg Inmates Processed and Bus Runs, CYs 2021–2024



Note: For January through June 2024, FCI Lewisburg provided data showing that 11,401 inmates were processed at FCI Lewisburg.

Source: FCI Lewisburg inmate intake and outtake data

Given these actual and anticipated increases, FCI Lewisburg officials expressed concern that their current staffing complement may not be able to effectively manage the institution's growing responsibilities. They also shared the perspective that the contractor staffing projection tool's projection was too low because, in part, it did not adequately take into account the institution's expanding mission requirements. Because even short-term holdover inmates processed at FCI Lewisburg must go through intake screening, which requires employees from multiple departments to support a variety of intake tasks, employees in a variety of positions outside the Correctional Services Department also expressed concern about the increased workload that would accompany a much higher volume of inmates passing through the institution. Illustrative of these concerns, the Associate Warden told us that the increase in bus transport responsibilities would require more employee support from the Correctional Systems Department and the Health Services Department. The Correctional Systems Department differs from the above-referenced Correctional Services Department. While Correctional Services employees are primarily Correctional Officers overseeing inmates in their housing units, Correctional Systems employees are responsible for receiving the buses, searching incoming and outgoing inmates, and fingerprinting and photographing incoming inmates.

Regarding Correctional Systems Department staffing, FCI Lewisburg has been able to hire and fill 13 of its authorized 14 positions. However, FCI Lewisburg Executive Leadership believes that the department needs at least 22 positions to address its current and anticipated responsibilities. The OIG's calculation of overtime hours worked from Pay Period 1 of 2023 through Pay Period 2 of 2024 found that FCI Lewisburg employees

worked approximately 20,000 hours on Correctional Systems Department duties such as supporting bus operations and processing incoming inmates, which equates to 10 full-time employee positions.

The Health Services Department was staffed at 87 percent (27 positions of 31 filled) at the time of our inspection. The four vacancies included one nurse practitioner position, one registered nurse position, one physician assistant position, and a paramedic position. FCI Lewisburg Executive Leadership believes that the institution needs at least 37 positions to address its current and anticipated responsibilities. In addition, Health Services Department employees told us that that they are burned out and that the department's current staffing levels are insufficient to manage the increased responsibilities associated with medical intake screenings for holdover inmates while at the same time providing adequate healthcare to the inmates designated to serve their sentence at FCI Lewisburg.[5] Unlike the paid overtime hours performed for the Correctional Services and Correctional Systems Departments, the institution's pay records reflect that few paid overtime hours are performed in the Health Services Department. We were told this is because not all clinical employees are eligible for overtime pay and instead receive compensatory time off for overtime worked. We did not request the number of compensatory hours Health Services Department employees earned from overtime and, as a result, we did not calculate the number of full-time employee positions Health Services Department employees worked. Table 2 below shows the differences in current and projected staffing needs for the Correctional Systems and Health Services Departments.

Table 2

FCI Lewisburg Correctional Systems and Health Services Department Position Totals, as of February 2024, and Projected Needs

Department	Filled Positions	Authorized Positions	Filled Positions and Positions Covered by Overtime	FCI Lewisburg Executive Leadership Estimate of Necessary Positions	Staffing Projection Tool Estimate of Necessary Positions
Correctional Systems	13	14	23 (13+10)	22	19
Health Services	27	31	N/A	38	33

Note: As noted above, the OIG calculated positions filled via overtime for FCI Lewisburg's Correctional Systems by dividing employee overtime hours worked in Correctional Systems (approximately 20,000) by the total number of work and leave hours (2,080) the Office of Management and Budget requires a full-time equivalent employee to record during a year. Positions filled via overtime numbers are rounded.

Sources: FCI Lewisburg staffing data, FCI Lewisburg Executive Leadership, and the BOP contractor's staffing projection tool

When we discussed discrepancies between FCI Lewisburg's and the staffing projection tool's estimates with the BOP's Assistant Director for the Human Resources Management Division (HRMD) and the contract

[5] See past OIG work on the BOP medical staffing challenges at Appendix 2, Items VII and VIII.

employees who developed the tool, they explained that the staffing projection tool includes a variety of factors in its algorithm to generate staffing estimates for institutions and that those estimates reflect the needs of an institution under ideal circumstances. However, the Assistant Director acknowledged that staffing circumstances at BOP institutions are not always ideal. For example, she explained that there is often a difference between the number of positions that are filled and the number of employees available to work. Specifically, multiple on-board employees may be on extended military, sick, or family leave at a given time, which can decrease the total availability of employees and can drive up overtime use. She also explained that multiple FCI Lewisburg employees had been temporarily detailed to MDC Brooklyn to help mitigate staffing shortages at that institution. This too decreased the number of on-board employees available to work their respective posts at FCI Lewisburg.

The Assistant Director for the HRMD also explained that the staffing projection tool assumes that FCI Lewisburg is a medium-security institution, as currently designated by the BOP. However, FCI Lewisburg Executive Leadership stated that, given the variety of missions the institution performs, it should be designated as an administrative facility. FCI Lewisburg Executive Leadership believes that, if Lewisburg was designated as such, the staffing projection tool would presumably generate higher staffing estimates.[6] Ultimately, the Assistant Director explained that the staffing projection tool is still in a developmental phase and will not "go live" until the start of fiscal year 2025. Even after implementation, she said, the staffing projection tool can be adjusted to reflect institution operational changes. Lastly, she said that it is important for institutions to provide the HRMD feedback about the staffing projections and that the HRMD welcomes institution feedback to ensure that staffing projections accurately reflect institution needs.

Given the longstanding challenges the BOP has experienced in determining appropriate staffing levels for institutions, and the efforts it has thus far taken to align staffing levels with mission needs, the OIG is concerned that FCI Lewisburg Executive Leadership's assessment of the institution's staffing needs differs significantly with preliminary staffing projection tool estimates. Therefore, we recommend that the BOP:

1. Ensure that FCI Lewisburg Executive Leadership and the Central Office's Human Resources Management Division discuss the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs to ensure greater alignment between stakeholder staffing projections.

Inmate Healthcare

In addition to the healthcare staffing concerns described above, the OIG identified three areas of concern related to the provision of healthcare to FCI Lewisburg inmates. First, we observed that antidepressant medications taken by some holdover inmates were discontinued abruptly instead of being tapered according to BOP clinical guidance. Second, fewer than half of the inmates who should have received a preventive screening for colon cancer had received an annual screening and, for those inmates requiring a colonoscopy, the time between when a colonoscopy was ordered and when the procedure was performed

[6] According to the BOP, administrative facilities are institutions with special missions, such as the detention of pretrial offenders; the treatment of inmates with serious or chronic medical problems; or the containment of extremely dangerous, violent, or escape-prone inmates.

was lengthy. Third, blood sugar testing for diabetic inmates was not being completed consistent with BOP clinical guidance. We discuss these non-staffing-related areas of concern in greater detail below.

Despite these issues, we also found that Health Services Department employees communicated well with one another and were aware of ongoing patient care responsibilities. One example of positive communication is a daily morning meeting wherein all Health Services Department employees who are on duty discuss, among other topics, inmates with special health issues, upcoming inmate medical appointments, inmate outside hospital admissions, and employee responsibilities and scheduling. We also found that, to mitigate clinical employee shortages, FCI Lewisburg regularly brings outside doctors into the institution to address the health problems of multiple inmates in a single day.

Inmate Medication Discontinuation

We reviewed medical records for the 121 holdover inmates who arrived at the institution during the week of our inspection and found that 24 had at least 1 of their prescribed medications discontinued. Of those 24 inmates, 15 had mental health medications discontinued. These included a wide spectrum of antidepressants, which are prescribed to address a variety of mental health conditions including anxiety disorder, obsessive-compulsive disorder, and major depressive disorder. FCI Lewisburg's Clinical Director (the physician who oversees clinical decisions at the institution) acknowledged that after reviewing inmate medical records he routinely discontinues antidepressant drugs for holdover inmates because he is concerned with the frequency with which those drugs are prescribed to BOP inmates and the potentially harmful effect they can have when interacting with other drugs an inmate is prescribed. Ultimately, he explained that, even if a holdover inmate is going to be housed at FCI Lewisburg for only a few days, "when they're here, they're under my care."

After speaking with the Clinical Director and reviewing inmate medical records to better understand his process for making medication discontinuation decisions for holdover inmates, the OIG identified three areas of concern. First, many of the discontinued antidepressant drugs were discontinued abruptly instead of being tapered for the 4 weeks recommended by BOP clinical guidance for management of major depressive order.[7] Such abrupt discontinuation can cause an inmate to experience antidepressant withdrawal (see the text box) and increase the risk of major depression relapse and suicide. Further, according to the OIG's medical subject matter experts, the risk of abruptly discontinuing these medications,

Antidepressant Withdrawal

Antidepressant withdrawal is usually mild, beginning within 1 week of stopping medication and attenuating over time (generally, 1 day to 3 weeks). However, stopping medications—especially short-acting antidepressants—abruptly can provoke an uncomfortable antidepressant discontinuation syndrome that can mimic a depressive episode.

Typical symptoms of the syndrome include flu-like symptoms, insomnia, nausea, imbalance, sensory disturbances, and hyperarousal.

Source: Appendix 3 (Antidepressant Discontinuation)

[7] Appendix 3 (Antidepressant Discontinuation).

especially medications that an inmate has taken for an extended period, may be greater than the drug interaction risks the Clinical Director is attempting to mitigate through discontinuation.

Second, the Clinical Director does not regularly meet with holdover inmates in advance of medication discontinuation decisions and as a result cannot consider the insight that could be gleaned by speaking directly to or examining an inmate before making a medication discontinuation decision. He told us that, given the volume of holdover inmates arriving at the institution, he does not have the time to meet with all of the inmates he believes should have their medication discontinued. We note that clinical employees subordinate to the Clinical Director, such as nurses and emergency medical technicians, conduct intake screenings of holdover inmates when the inmates arrive at FCI Lewisburg. However, the Clinical Director expressed concerns with the quality of intake screenings because employees must complete them quickly to have time to meet with all of the holdover inmates arriving at the institution. He also told us of situations in which subordinate employees did not accurately record an inmate's medications in the medical record generated during the screening. We also independently found errors in the FCI Lewisburg intake screening records generated for the 15 inmates who had their mental health prescriptions discontinued.[8] Specifically, all 15 of those screenings indicated that the inmate was not receiving a current mental health treatment, despite the fact they were all prescribed an antidepressant.

Third, without meeting with inmates before discontinuing a medication, the Clinical Director misses an opportunity to inform inmates of the early signs and symptoms of a major depression relapse, which can occur following the discontinuation of antidepressant medications. According to BOP clinical guidance, inmates should have a clear understanding of these signs and symptoms, as well as the importance of seeking help as soon as possible because early treatment may prevent unnecessary morbidity or suicide.[9]

Not only do discontinuation decisions made absent the Clinical Director's personal encounter with the inmate create a clinical risk for the inmate, but they also create safety risks for BOP employees. Health Services Department employees told us that inmates often become confrontational when their medication is not distributed to them because it is the first time the inmate learns that their medication has been discontinued. A Health Services Department employee expressed empathy with these inmates by telling us, "I'm not a physician, but I know I personally would be angry if I was on a medication and some random doctor took it away from me."

Following our on-site inspection, we asked the BOP's acting Northeast Regional Medical Director if she had any concerns with the Clinical Director's medication discontinuation practices. She said that she was aware that the Clinical Director tends to discontinue medications but that she had not reviewed specific details to determine whether those decisions were appropriate. She told us that she does perform peer reviews of Clinical Directors in her region, which includes a review of a sample of inmate medical charts and clinical decisions made by Clinical Directors. However, she explained that her role is generally to serve as a

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[8] In response to a draft of this report, the BOP stated that its Central Office Health Services Division conducted a preliminary review of documentation pertaining to the 15 cases of discontinued medications and has plans to do a more thorough assessment.

[9] Appendix 3 (Antidepressant Discontinuation).

consultant to institution employees and provide clinical assistance only when asked. Further, she said that, other than the peer review, regional medical employees "don't do much in the way of oversight."

The statements of the Regional Medical Director broadly describe the BOP's clinical practice and oversight functions. At a BOP institution, the clinical practice of medicine is ultimately at the discretion of an institution's Clinical Director, and, while the BOP publishes clinical guidance that informs clinicians of best practices, this guidance, unlike BOP policy, is nonbinding. Further, Clinical Directors at BOP institutions are not supervised by their respective Regional Medical Director; instead they are supervised by an institution Associate Warden, who in most instances has no medical or clinical experience.

The OIG acknowledges that the practice of medicine must be individualized to ensure the best possible outcomes and that the Clinical Director's decision to discontinue medications is informed by a desire to mitigate the potentially harmful effect certain medications can have when they interact with other drugs the inmate is prescribed. However, we are concerned that the Clinical Director is making such significant clinical decisions, at such a high frequency, without meeting with inmates to collect additional information about their condition and without informing them of the risks associated with antidepressant medication discontinuation. Therefore, we recommend that the BOP:

2. Ensure that the Health Services Division (Central and/or Regional Office) reviews medication discontinuation practices at FCI Lewisburg and other holdover facilities, including the discontinuation of antidepressants without a clinical encounter, to determine whether such practices are consistent with BOP clinical guidance. If the Health Services Division determines that such practices are inconsistent with BOP clinical guidance, it should work collaboratively with FCI Lewisburg clinicians to identify practical solutions to increase the frequency with which clinicians conduct a clinical encounter with holdover inmates in advance of such decisions so that clinicians can collect complete information about an inmate's condition and the inmate is informed of such decisions and aware of the potential risks associated with medication discontinuation.

Lack of Colorectal Cancer Screening for Designated Inmates

According to the BOP clinical guidance, inmates between the ages of 45 and 75 at average risk of colorectal cancer should receive an annual screening to detect potential signs of colon cancer.[10] If the results of that screening indicate potential signs of colon cancer, BOP clinical guidance states that the inmate should receive a colonoscopy.[11] Preventive colorectal cancer screenings are important because early disease detection can improve health outcomes and mitigate the need for more costly treatments.

At the time of our inspection, only 47 percent (78 of 165) of FCI Lewisburg-designated inmates who were between 45 and 75 years old, i.e., those with an average risk of colorectal cancer, had received an annual screening. According to FCI Lewisburg's internal meeting minutes, two factors contributed to the lack of

[10] Appendix 3 (Colorectal Cancer Screening).

[11] If an inmate is determined to be of increased risk for colorectal cancer, the BOP's clinical guidance (see Appendix 3 (Colorectal Cancer Screening)) refers providers to the *American Cancer Society Recommendations for Colorectal Cancer Early Detection.* Factors that increase an individual's risk of colon cancer include a history of polyps, past diagnosis of colorectal cancer, family history of and genetic predisposition to colon cancer, and inflammatory bowel disease.

screening at the institution. First, in July 2022 BOP clinical guidance was updated to lower the age of preventive screening for inmates at average risk of colorectal cancer from 50 to 45 years. As a result, more inmates became eligible for screening and FCI Lewisburg had not yet had an opportunity to offer screening to the larger population of eligible inmates. Second, FCI Lewisburg was without a laboratory technician from October to December 2023 and one of the duties of the laboratory technician is to distribute to and collect from inmates the fecal screening device.

We also found that, for inmates who were identified as having an increased risk of colorectal cancer or had tested positive on an annual screening test, the time between when a colonoscopy was ordered and when the procedure was performed was lengthy. For the 76 inmates for whom a colonoscopy was ordered, they waited an average 208 days (approximately 7 months) for the procedure and 9 of those inmates waited more than a year. Health Services Department leadership and employees at FCI Lewisburg told us that the long waits were caused by a lack of community providers who would perform the procedures for FCI Lewisburg inmates. In fact, at the time of our inspection only one community provider was accepting FCI Lewisburg inmates for the procedure and that provider could schedule only one or two colonoscopies for FCI Lewisburg inmates each week.

Given the importance of ensuring that inmates at risk of colon cancer have access to preventive screenings, in April 2024 we initiated a broader evaluation of inmate colorectal cancer screening practices and clinical follow-up on colorectal cancer screening results across the BOP.

Management of Diabetes

According to the BOP's clinical guidance, an A1C level (see the text box) should be obtained every 3 months for diabetic inmates with an A1C level above their individualized target, which is generally 7–7.5 percent, and every 6 months for diabetic inmates with an A1C level below 7 percent.[12] However, we found that, at FCI Lewisburg, 6 of the 19 diabetic inmates with A1C levels above 7 percent had not had an A1C test in the 3 months preceding our inspection and 6 of the 48 diabetic inmates with A1C levels below 7 percent had not had an A1C test within the 6 months preceding our inspection.

A1C Testing

An A1C level is obtained by testing an individual's blood to determine the average amount of sugar in their blood over the preceding 3 months.

A1C testing helps clinicians and patients manage diabetes effectively by providing clinicians information to make timely adjustments to patient treatment plans and recommend lifestyle modifications and prevention strategies to patients.

Source: Appendix 3 (Management of Diabetes)

[12] Appendix 3 (Management of Diabetes).

Infrastructure and Physical Conditions

As we have observed at other BOP institutions, we found that FCI Lewisburg has several unfunded major infrastructure repair projects that present safety and security issues for the facility. As of July 31, 2024, FCI Lewisburg management estimated that the total cost to complete those projects was approximately $28.1 million. We are concerned that, if these repairs are not made soon, equipment will fail, which would not only negatively affect the conditions of confinement for inmates but would also cause repair and replacement costs to exceed current estimated levels. In fact, FCI Lewisburg estimates that the costs of these $28.1 million repairs will increase 10 to 18 percent per year if they remain unaddressed. This issue is not unique to FCI Lewisburg. The BOP currently estimates that it has a $3 billion backlog of unfunded infrastructure repairs across all of its institutions (see the text box).

Relevant Prior OIG Work and Related Recommendations: Infrastructure

In May 2023, the OIG reported that BOP institutions had a large and growing list of unfunded modernization and repair needs and that the BOP was unable to address these needs because it lacked a strategy to do so. Further, we found that the BOP had historically failed to request funding to address its infrastructure needs.

To address this issue, the OIG recommended that the BOP develop an infrastructure strategy to increase the overall effectiveness of facilities management and to develop and implement key performance indicators to track whether the BOP is meeting its infrastructure goals. As of the publication of this report on FCI Lewisburg, these recommendations remain open.

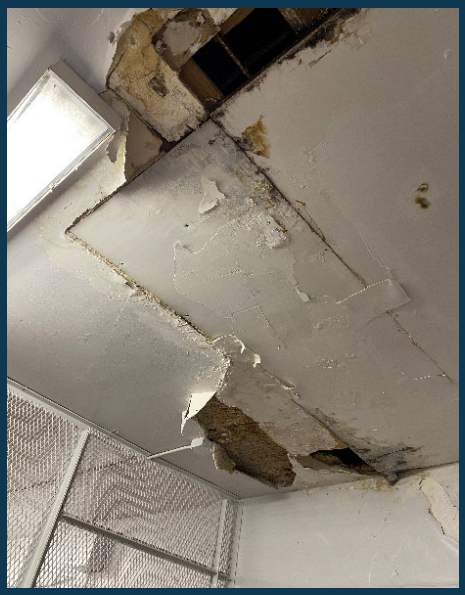
See Appendix 2, Item IX, for more information on this report.

The costliest of FCI Lewisburg's repair projects ($12.1 million) calls for the complete remodel of the institution's food service area. According to FCI Lewisburg project cost estimate documentation, due to the age of the building the area's finishes have deteriorated because of years of exposure to moisture, steam, food acids, chemicals, etc.: "Flooring is cracked allowing moisture to seep into areas below. Numerous roof leaks have permitted unchecked damage to walls and ceiling. The utility systems are old, undersized and unreliable. Plumbing lines break frequently and require total replacement. Most of the food preparation equipment is old, unreliable and demands constant maintenance."

We observed the effect of water intrusion into two separate rooms in the food service area. Water intrusion into the institution's butchering area has rendered the area unusable and has weakened the ceiling to the point that the institution had to install metal braces to support the weight of the ceiling. Additionally, water intrusion into a secure kitchen equipment area could cause water to flow into an adjacent food preparation room. Below, we provide images showing the effects of water intrusion into the two separate rooms in the food service area. Potential water intrusion into food preparation areas is not an issue unique to FCI Lewisburg; we observed this same issue when we inspected FCI Waseca in January 2023.

Evidence of Water Intrusion Damage and Braces Supporting the Deteriorating Ceiling in the Butchering Area

Source: OIG, February 2024



Evidence of Water Intrusion Damage in a Secure Kitchen Equipment Area That Could Cause Water to Flow into an Adjacent Food Preparation Room

Source: OIG, February 2024

In addition to the cost of remodeling the food service area, FCI Lewisburg needs to replace much of its fire alarm system. According to FCI Lewisburg project cost documentation, components of the fire alarm system have reached or are reaching the end of their useful life and require replacement estimated at approximately $3.3 million. Additionally, tanks that hold the water for the institution's potable water system have deteriorated to the point of non-repair in several areas and should be replaced. According to FCI Lewisburg project cost documentation, these new tanks would also supply water to the institution's fire suppression system. FCI Lewisburg estimates the cost of the tank replacement to be approximately $4.6 million.

Not only did we identify concerns with fire safety infrastructure, we also observed multiple obstructed fire escape routes in inmate housing units, which is inconsistent with BOP policy and an obvious safety risk.[13] See photos of obstructed fire escape routes below.

[13] Appendix 3 (Fire Protection).

Left and Right, Obstructed Fire Emergency Escape Routes in Inmate Housing Units

Source: OIG, February 2024

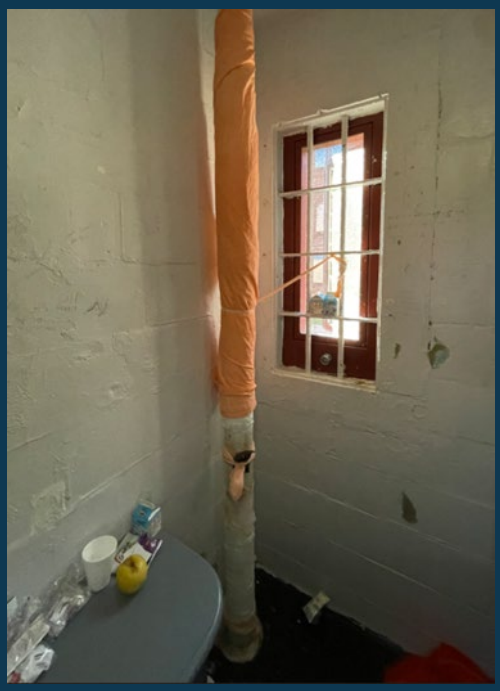
Although not identified by the BOP as a system in need of significant repair or replacement, we found that the institution's steam heating system struggles to maintain temperatures within BOP targets. While on site at FCI Lewisburg in February 2024, we measured temperatures above 82° F in an occupied inmate housing unit. We also measured a cell temperature of 89° F in a housing unit that was unoccupied at the time of our inspection but that institution management planned to use to house incoming holdover inmates the week following our visit.[14] Not only are these temperatures well above the BOP policy target of 68° F for winter months (i.e., heating season), but they are also likely uncomfortable and potentially unhealthy for inmates.[15] According to FCI Lewisburg's Facilities Administrator, it is difficult to ensure that institution temperatures remain at BOP targets during heating season because the 1930s-era steam heat system has only two settings—on or off. In the absence of the technology that would allow Facilities Department employees to more precisely regulate temperatures produced by the system, the Facilities Administrator explained, inmates can open their windows to regulate temperatures inside their cells. Temperature regulation issues are likely not limited to heating season because inmate cells in all but one of the institution's housing units are not air-conditioned. We note that all housing unit television viewing common areas are air-conditioned and there are multiple fans mounted on the walls. The OIG previously noted this issue in a in a July 2017 report that assessed in part the former SMU mission at FCI Lewisburg. Specifically, we noted that FCI

[14] In response to a draft of this report, FCI Lewisburg Executive Leadership told the OIG that the unoccupied unit's windows were all secured, which did not allow for ventilation of outside air to moderate the cell temperatures.

[15] Appendix 3 (Temperature Regulation).

Lewisburg's lack of air conditioning could make certain inmates more prone to heat stroke and heat-related illnesses.[16]

We identified one additional feature of the 1930s-era steam heat system that can make it difficult for inmates to regulate temperatures inside their cells. In some housing units, heat is transferred to inmate cells via heat-radiating steam pipes that enter through the floors of cells and exit through the ceilings. We saw that some inmates used bed linens to insulate the pipes to regulate temperatures inside their cell. The Facilities Administrator told us that previous efforts to insulate the pipes with heat-resistant paint proved ineffective. See pictures below of the radiating steam pipes running through cells.



Steam Pipes Insulated with Bed Linens in Inmate Cells

Source: OIG, February 2024

FCI Lewisburg also lacks an automatic way to measure and record temperatures throughout the institution, and institution employees do not take manual temperature readings. When we asked why institution employees do not take those readings, the Facilities Administrator told us that there is no way to actually control the temperature. As a result, neither FCI Lewisburg nor the OIG can state how many inmate housing areas experience temperatures that deviate from BOP target temperatures throughout the year.

[16] See Appendix 2, Item XI.

Relevant Prior OIG Work and Related Recommendations: Temperature Regulation and Monitoring

Temperature regulation and monitoring issues we identified at FCI Lewisburg are similar to issues we identified in a September 2019 report that detailed facilities heating, ventilation, and cooling (HVAC) equipment at the BOP's MDC Brooklyn. Specifically, we found that problems with HVAC equipment, as well as the absence of reliable temperature measuring methods, made it difficult for employees to regulate temperatures at the institution, which in turn negatively affected the conditions of confinement for inmates.

To address this issue, the OIG recommended that the BOP ensure that institutions use a consistent and sound method to measure and document temperatures and record all maintenance performed on HVAC equipment. To address this recommendation, the BOP reported to the OIG that it is modifying policy to address the measurement and documentation of temperatures. The OIG's recommendation is still open as of the publication of this inspection report of FCI Lewisburg.

See Appendix 2, Item X, for more information on the MDC Brooklyn report.

Safety and Security

In addition to our concerns about employee availability and the affect that low staffing can have on the safety of institution operations, we identified three other safety and security issues at FCI Lewisburg. First, we found that many inmates in restrictive housing were single-celled despite BOP guidance making clear that single-celling of inmates is disfavored. Moreover, as OIG reports have previously detailed, the privacy afforded to inmates when they are single-celled greatly increases their opportunity to attempt suicide. This risk is greatest when inmates are single-celled in restrictive housing, where they are restricted to their cells for 23 hours a day. Second, and relevant to the enhanced suicide risk from single-celling, the OIG identified that not all Correctional Officers carried a cut-down tool, which can be used to quickly cut a ligature used in a hanging attempt, despite recent BOP Central Office guidance requiring them to do so. This directly compromises the institution's ability to effectively and timely respond to inmate suicide attempts. Third, we found that 26 of the institution's existing 510 cameras were inoperable at the time of the inspection. The OIG has long stated that deficiencies within the BOP's security camera system have affected the OIG's ability to secure prosecutions of employees and inmates in BOP contraband introduction cases, and these same problems adversely affect the availability of critical evidence to support administrative or disciplinary action against employees or inmates. While we were on site, we noted that FCI Lewisburg was upgrading all of its older analog cameras to digital and was installing new cameras in areas that previously did not have them. We describe each of these safety and security issues in greater detail below.

Single-Cell Confinement in Restrictive Housing

BOP guidance states that institutions should reduce single-celling to the greatest extent possible because single-celled inmates have an increased opportunity to attempt suicide given the privacy they are afforded. The risk of inmate suicide is even greater when inmates are single-celled in a restrictive housing unit (i.e., a Special Housing Unit, or SHU) where they are restricted to their cells for 23 hours a day. From January 2022 through March 2024, FCI Lewisburg had 16 suicide attempts, of which 7 (44 percent) involved inmates who were single-celled at the time of their suicide attempt; 5 of these 7 attempts involved inmates who were in restrictive housing when they attempted suicide. At the time of our inspection, 18 percent (13 of 71) of FCI Lewisburg's restrictive housing inmates were in single-cell confinement. FCI Lewisburg's Captain told the OIG that, despite the risks associated single-celling inmates in restrictive housing, the management practice was "normal" at FCI Lewisburg because the variety of its missions creates a composition of inmates that

must be separated from one another. The Captain stated as an example that the prison cannot safely house an inmate with a history of sex offense in a cell with an MS-13 gang member.

The OIG has long identified that single-cell confinement may negatively affect an inmate's mental health and increase the risk of suicide. In a 2017 report that evaluated the BOP's use of restrictive housing for inmates with mental illness, we found that placement in restrictive housing, even for short periods of time, can be particularly harmful for inmates' mental health.[17] The report found that the BOP was not tracking inmates' single-cell confinement or assessing the cumulative time that inmates spent in restrictive housing and that its policy neither limited the length of time inmates spent in restrictive housing nor defined or addressed extended placement in restrictive housing. Among other things, we recommended that the BOP establish in policy the circumstances that warrant the placement of inmates in single-cell confinement (see the text box below).

More recent OIG work has shown that single-celling presents a significant risk of inmate suicide. A February 2024 OIG report on issues surrounding inmate deaths in BOP institutions found that more than half (102 of 187) of the BOP inmates who died by suicide between fiscal years 2014 and 2021 were single-celled at the time of their deaths.[18] The report found that suicide risk is further compounded when inmates are single-celled while in restrictive housing settings such as a SHU; 86 of the 187 suicides occurred in a restrictive housing setting, and over two-thirds (60 of 86 suicides) happened while the inmate was single-celled in a restrictive housing setting.

In March 2024, after our on-site inspection at FCI Lewisburg, the BOP updated its SHU policy to require BOP employees to place SHU inmates with a cellmate unless there are unique circumstances that warrant single-cell placement; the policy also implemented a Single-Cell Review Form that requires the Warden's written approval in all such circumstances when it is unfeasible for an inmate in the SHU to share a cell.[19] In light of this policy change, we requested completed forms from FCI Lewisburg so we could review the explanations provided for the seven inmates who were housed in single-cell confinement in the SHU during April 2024. FCI Lewisburg provided those forms, which indicated that at the time there were no compatible cellmates in the SHU to house these seven inmates safely with.

[17] See Appendix 2, Item XI.

[18] See Appendix 2, Item XIII.

[19] Appendix 3 (Special Housing Units).

Relevant Prior OIG Work and Related Recommendations: Single-Celling of Inmates in Restrictive Housing

In our 2017 report, we recommended that the BOP establish in policy the circumstances that warrant the placement of inmates in single-cell confinement, as well as tracking all inmates in single-cell confinement and monitoring the amount of time that inmates with mental illness spend in restrictive housing, including single-cell confinement. We also recommended that the BOP define and establish in policy extended placement in measurable terms, as well as evaluating and limiting as appropriate the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing. A 2023 capstone review of the BOP's response to the coronavirus disease 2019 (COVID-19) pandemic also found that seven BOP inmates died by suicide during a 14-month period while housed in single-cell confinement in quarantine units related to COVID-19. In that report, we recommended that the BOP thoroughly assess single-celling policies and processes (including those applicable to inmates housed in quarantine and medical isolation units and to inmates vulnerable to suicide) and 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.

As stated above, in March 2024 the BOP updated its SHU policy to require BOP employees to place SHU inmates with a cellmate unless there are unique circumstances that warrant single-cell placement; the policy requires the Warden's written approval in all such circumstances. The new policy includes requirements for monitoring SHU inmates, including those in single-cell confinement, as well as evaluating and limiting the consecutive amount of time that inmates with serious mental illness may spend in restrictive housing. The new policy also defines extended placement as occurring when an inmate is continuously housed in a SHU for 6 months or longer. Additionally, new policy provisions discourage the placement of inmates with serious mental illness in a SHU and require that Psychology Services Department employees conduct initial and 30-day psychological assessments of such inmates. As a result of the SHU policy revisions, in April 2024 we closed three of the six recommendations from the 2017 report. The two recommendations related to single-cell confinement from the 2023 capstone report remained open as of September 2024.

See Appendix 2, Items XI and XII, for more information about these reports.

Inmate Ligature Cut-down Tools

According to June and September 2023 BOP Central Office memoranda, employees working in inmate housing areas are required to carry a tool that will allow them to cut down a ligature in the event of an inmate hanging. These memoranda further state that "carrying cutdown tools improves response time and allows ligatures to be cut more quickly and life-saving measures to begin more promptly." These conclusions are consistent with the OIG's findings from our February 2024 report that evaluated BOP inmate deaths (see the text box below).[20]

[20] See Appendix 2, Item XIII.

Relevant Prior OIG Work and Related Recommendations: Cut-down Tools

In our February 2024 report that evaluated issues surrounding BOP inmate homicide, suicide, accidental, and unknown deaths, we found that suicide was the most prevalent form of inmate death in BOP institutions and that hanging was the most common method inmates used to facilitate suicide. Routine carrying of a cut-down tool would allow employees to quickly cut off these ligatures, thereby allowing potentially lifesaving measures to be administered promptly. However, BOP employees had difficulties using or lacked timely access to a properly functioning cut-down tool in nearly 40 percent (59 out of 159) of suicide hangings.

We recommended that the BOP ensure that cut-down tools in working order are accessible to employees in each housing unit at each institution, that employees are trained on proper use of the tool, and that the BOP determines whether employees should be issued and required to keep their own cut-down tool on their duty belt during their entire shift. The OIG's recommendation is still open as of the publication of this inspection report on FCI Lewisburg.

See Appendix 2, Item XIII, for more information about this report.

During our inspection, we observed that not all employees who should have been carrying this tool, including Correctional Officers assigned to both the SHU and housing unit custody posts, were doing so.[21] An FCI Lewisburg employee who worked in the SHU and should have been carrying a cut-down tool acknowledged that he was aware of the requirement but stated that, due to the unavailability of cut-down tools in a location within the SHU and within the institution's control center, he did not believe that it was necessary to personally carry the tool. We noted that the room where cut-down tools were stored in the SHU was not centrally located and that an employee would have to unlock at least two doors to access it. Further, the control room, which employees told us has additional cut-down tools, is outside the SHU and down a corridor. Given that mere seconds in response time can potentially mean life or death for an afflicted inmate, we are concerned that FCI Lewisburg employees' failure to comply with this important BOP requirement may limit their ability to respond to future emergencies. Therefore, we recommend that the BOP:

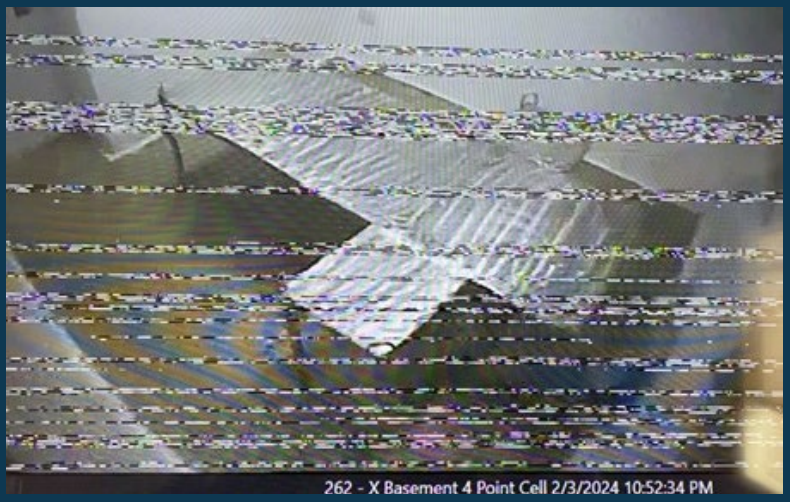
3. Ensure FCI Lewisburg's compliance with existing Central Office guidance for certain employees to carry a cut-down tool when on duty.

Security Cameras

Functional security cameras that produce clear footage are an important tool to help the BOP maintain institutional safety and security and provide evidence in criminal and disciplinary investigations. FCI Lewisburg investigative employees told us that they were satisfied with the overall quality and coverage of security cameras and the analog video footage the cameras produced. The quality of the video and the breadth of coverage it provides should improve in the future, as the institution's analog cameras are replaced with higher-resolution digital cameras. We were told that new cameras will also be installed in areas that did not previously have cameras.

[21] BOP memoranda from July 2023, September 2023, and June 2024 state that the following employees at all security levels are required to obtain a cut-down tool and carry it throughout their shift: Unit Team employees, employees who have an assigned office in a housing unit, employees assigned to a custody post on a housing unit, all employees assigned to a SHU, Compound Officers, and Lieutenants.

Despite these positive developments, we found that 26 of the institution's existing 510 cameras were inoperable at the time of the inspection. We were particularly concerned with a disruption in the video feed provided by the camera in a four-point restraint room. When reviewing the video feed from this camera, we observed that intermittently the feed was either disrupted entirely, producing a "no video" message in place of the feed, or had poor quality footage as the feed was overlaid with static bands. Below, see an image of the feed with the static bands.



Four-point Restraint Room Camera Feed Overlaid with Static Bands

Source: OIG, February 2024

Although no one was housed in the restraint room at the time of our inspection, and there is no BOP requirement to video record the pendency of an inmate's restraint period, we found the disruption troubling because BOP institutions have recently been accused of unnecessarily or inappropriately using four-point restraints to gain control of an inmate.[22] In such instances, the availability of camera footage could help investigations to either prove or disprove allegations of four-point restraint related misconduct.[23] The unavailability of that footage, when it should otherwise have been available, would only serve to further undermine public trust in the BOP's use of this restraint technique.

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[22] In response to a draft of this report, the BOP stated that its new Use of Force policy, which came into effect after our inspection, requires constant and direct supervision of inmates in four-point restraints. The BOP stated that FCI Lewisburg's inclusion of a camera in the restraint room exceeds policy requirements. See BOP, Program Statement 5566.07, Use of Force, Application of Restraints, and Firearms, July 17, 2024, www.bop.gov/policy/progstat/5566.07.pdf (accessed September 9, 2024).

[23] As of the publication of this report, the OIG is conducting an audit of the BOP's use of restraints. The preliminary objective is to examine the BOP's use of four-point restraints.

Relevant Prior OIG Work and Related Recommendations: Security Cameras

The OIG's June 2023 report on its investigation and review of the BOP's custody, care, and supervision of Jeffrey Epstein at Metropolitan Correctional Center (MCC) New York found longstanding deficiencies with MCC New York's security camera system. Specifically, a disk failure in the camera system recording device on July 29, 2019, caused nearly all of the cameras in and around the SHU where Epstein was housed to fail to record. It was not until August 8 that that institution employees identified the problem. Despite the lack of recording functionality, the necessary repair was not completed until after Epstein's death (Epstein died on August 10, 2019).

MCC New York's failure to ensure that its security camera system was fully functional and to make timely repairs is consistent with the OIG's previous observations regarding weaknesses in the BOP-wide security camera system. The OIG has repeatedly observed inadequacies in the BOP's camera system, including inoperable cameras, an insufficient number of cameras, poor video quality, and inadequate video storage. In a June 2016 report, we found that "deficiencies within the BOP's security camera system have affected the OIG's ability to secure prosecutions of employees and inmates in BOP contraband introduction cases. These same problems adversely affect the availability of critical evidence to support administrative or disciplinary action against employees and inmates." Following the issuance of our 2016 report, the BOP completed a multiyear update to cameras at 45 institutions; however, serious issues with the BOP's security camera systems remained. In October 2021, we issued a Management Advisory Memorandum finding that the BOP's camera systems continued to need significant infrastructure and equipment upgrades. In that memorandum, we also found that the BOP lacked a comprehensive strategic plan to address the significant deficiencies of its institution camera systems.

As a result of our finding from the 2021 Management Advisory Memorandum, we recommended that the BOP develop a comprehensive strategic plan for transitioning to a fully digital security camera system. As of the publication of this report on FCI Lewisburg, this recommendation remains open.

We also note that Congress passed, and the President signed the Prison Camera Reform Act of 2021, which requires the BOP Director to ensure that BOP facilities to have security camera coverage and capabilities necessary to ensure the documentation and accessibility of video evidence pertaining to misconduct, maltreatment, or criminal activity within correctional facilities.

See Appendix 2, Items XIV, XV, and XVI, for more information about these reports.

Inmate Programming and the Reintegration Housing Unit Program

As required by the FIRST STEP Act of 2018, BOP institutions must conduct a needs assessment on all sentenced inmates entering their custody to identify specific Evidence-Based Recidivism Reduction programs and Productive Activities that will best prepare the inmates for their reentry into society.[24] We found that FCI Lewisburg inmates were able to participate in vocational, educational, and drug abuse programs and that, generally, waitlists were not long:

- Drug abuse treatment programs include the BOP's residential and nonresidential drug treatment programs.
    - At the time of our inspection, 94 inmates were participating in the BOP's Residential Drug Abuse Treatment Program (RDAP), which is designed to help inmates address substance abuse disorder. The 94 inmates participating in the RDAP were spread among 4 cohorts of

[24] 18 U.S.C. § 3632(a).

approximately 24 inmates, and, at the time of our inspection, each cohort was at a different phase of program completion. Another 84 inmates were on a waitlist, and a new cohort of those inmates would begin as soon as a cohort of active participants had completed the program.

- At the time of our inspection, 29 inmates were participating in the non-Residential Drug Treatment Program. While also designed to help inmates address substance abuse disorder, the program is shorter and less clinically intensive than the RDAP. The non-Residential Drug Treatment Program also had a waitlist of 65 inmates.[25]

- Educational programs include English and Spanish General Educational Development and literacy classes and a variety of adult continuing education classes. Collectively, 552 inmates were participating in these classes and only 46 were on waitlists.

- Vocational programs include a personal training certification class, a general building and trades class, a barista training program, a plumbing apprenticeship, and a commercial driver's license training program. Collectively, 55 were participating in these programs and 38 were on waitlists.

- FCI Lewisburg inmates can also participate in a Pennsylvania state program that seeks to better align job training and skills development services to inmates preparing for reentry. Twelve inmates were participating in this program, and 16 were on the waitlist. Of note, this Pennsylvania state program is funded with federal FIRST STEP Act funding through the Partners for Reentry in Workforce Development grant initiative, which is a jointly administered by DOJ and the U.S. Department of Labor.

In addition to programs that are available to a wide spectrum of FCI Lewisburg inmates, the institution also operates a Reintegration Housing Unit (RHU) program for inmates who have difficulty functioning in the prison environment. Many of these inmates have committed a sexual offense, cooperated with law enforcement, or owe debts to other inmates; they have consistently refused to enter general population at multiple locations, requesting instead to live in restrictive housing to avoid conflict with other inmates. When transferred to the RHU at FCI Lewisburg, these inmates generally feel safer to live in a housing unit with a group of inmates who have experienced similar challenges functioning in general population housing units.

Unlike other housing units at FCI Lewisburg, the RHU has dedicated psychologists to help inmates manage anxiety, develop relationships, and build self-confidence. A BOP employee and an RHU inmate both told us that with the additional support RHU inmates are functioning more successfully in the prison environment and are better prepared for reentry.

[25] The non-Residential Drug Treatment Program waitlist had a total of 135 inmates; but 70 of these inmates were either currently enrolled in the RDAP, were enrolled in an upcoming RDAP class, or were holdover, debrief, or MS-13 inmates that would not stay at FCI Lewisburg long enough to complete the 4-month program.

An FCI Lewisburg Executive Leadership employee told us that it in certain situations it is appropriate and necessary to modify usual inmate management practices to supervise RHU inmates. For example, an RHU inmate with severe social anxiety may not as readily follow institutional rules and regulations if the inmate fears that doing so will expose him to potential danger. In such a scenario, FCI Lewisburg Executive Leadership told us, it is important for employees to recognize when these resistant behaviors are informed by fear or a mental health disorder and to manage them differently than they would if an inmate was simply challenging an employee's authority.

Employee Professionalism

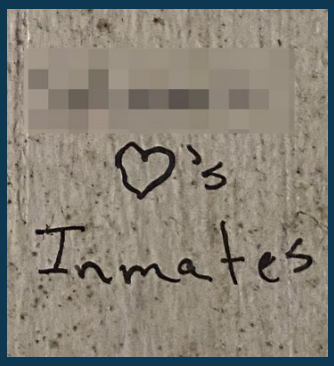
BOP policy dictates that employees will work in environment free from harassing conduct and intimidation from all employees.[26] However, multiple FCI Lewisburg employees told us that a subset of institution employees are verbally abusive toward their fellow employees, as well as inmates, and that a significant portion of the abuse is directed at inmates who have committed a sex offense and the employees who work with them in the RHU. According to a number of FCI Lewisburg employees, the verbally abusive employees resent the RHU program and the resources and support it offers to inmates who have committed a sex offense.

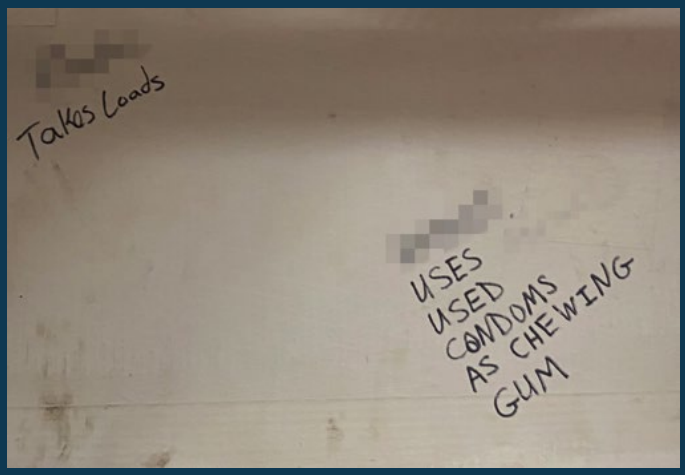
The Warden and the Captain acknowledged that some employees have had difficulty adjusting their inmate management approaches since the Special Management Unit (SMU) program ended at FCI Lewisburg. Specifically, they said that employees had become used to implementing restrictive inmate management practices given the high-security level of SMU inmates, whereas they now must modify those practices to more effectively manage RHU inmates.

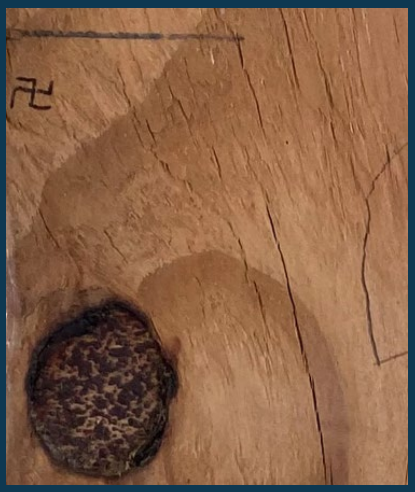
The Warden and Captain also told us that there had been multiple allegations of harassment when they assumed their current positions in February and January 2023, respectively, but that such allegations have decreased during their tenure. Further, the Warden said that she made clear at her first employee meeting that such abuse would not be tolerated. An Associate Warden told us that this message has been reiterated at employee meetings and that some employees have been counseled both verbally and in writing that their behavior toward other employees was unacceptable.

In addition to allegations of verbal abuse, we observed, in employee-only-access areas, multiple examples of obscene and sexually abusive graffiti degrading certain FCI Lewisburg employees. Additionally, we observed, on a piece of wood in an employee-only-access area, a swastika and derogatory language and images (an image of a rat labeled with an employee name, implying that the employee was cooperating with investigations into other employees). See images of this graffiti below.

[26] Appendix 3 (Employee Professionalism).







Inappropriate, Obscene, and Sexually Abusive Graffiti in Employee-Only-Access Areas

Source: OIG, February 2024 (Employee Names Blurred)

Regarding the swastika, the Warden told us that it would not be tolerated and would be dealt with. Regarding the sexually abusive graffiti, the Warden said that sexually suggestive graffiti had previously been drawn on walls and painted over but that she was not aware of any graffiti at the time of our inspection.[27] Lastly, she said that, although the graffiti is inappropriate, men have been drawing genitalia "since the man has learned how to draw on a cave wall with stick" and that corrections and law enforcement employees are known for their dark humor and can cross lines. She acknowledged that the culture needs to change. In response to a draft of this report, FCI Lewisburg Executive Leadership reported to the OIG that they had painted over any identified graffiti within the week of our inspection, raised the issue with employees during annual trainings, and implemented weekly random spot checks throughout the institution to verify that no new graffiti is present in employee-only-access areas.

The Warden told us that is often difficult to identify who is responsible for the graffiti, and we found that no FCI Lewisburg employee was under investigation for graffiti-related employee misconduct at the time of our inspection. We provide additional information about ongoing FCI Lewisburg employee misconduct cases in the text box below.

Employee Misconduct Investigations at FCI Lewisburg

As of February 2024, there were 17 open misconduct investigations involving FCI Lewisburg employees, for which the misconduct was alleged to have occurred after January 1, 2023. Of those 17 cases, 4 were still being investigated. For the remaining 13 cases, the underlying misconduct had been substantiated but the cases were pending a disciplinary sanction decision. Most of these investigations, such as unprofessional conduct, failure to follow instructions, and time and attendance irregularities, relate to allegations of misconduct that ordinarily have less effect on institutional operations; however, some allegations relate to more serious and potentially criminal misconduct, including physical abuse of inmates. We note that none of the open employee misconduct investigations related to sexual misconduct involving employees and inmates. We report this data for informational and transparency purposes and note that the volume of misconduct allegations, especially those for which the underlying investigation has yet to be concluded, should not be used, alone, to assess the pervasiveness of misconduct or absence thereof at an institution.

Source: FCI Lewisburg employee misconduct documentation

Separately, we found that inmate-drawn prison gang artwork was displayed in the hallway of FCI Lewisburg's Special Investigative Services (SIS) office. The artwork included Nazi iconography associated with white-supremacist gangs; MS-13 drawings; and an Aztec sunstone drawing, which in criminal and prison environments signifies affiliation with certain Latin American street and prison gangs. Other prison gang artwork not representing hatred, racism, or antisemitism was also displayed in the hallway. FCI Lewisburg SIS employees did not provide to the OIG an explanation of the purpose for displaying such artwork, but an SIS office employee told us that he believed that the artwork had been displayed for more than 10 years and that it had been given to the SIS office by inmates who were going through the gang disassociation process.

[27] We did not ask the Warden for her comment on the rat image.

Left and Top Right, Inmate-drawn Nazi Iconography in the SIS Office

Bottom Right, Inmate-drawn Aztec Sunstone in the SIS Office

Source: OIG, February 2024 (Artists' Names Obscured in Top Right and Bottom Right Images)

In response to a draft of this report, BOP Central Office Executive Staff and intelligence officials stated that the SIS plays a vital role in managing gang-related activity and teaching employees to recognize, report, and

monitor gang-related activity and membership. Those officials also stated that there are 14 images in the same hallway of FCI Lewisburg's SIS office area that support the SIS mission by showing a diversity of gang-related iconography. BOP officials stated that gang-related iconography is utilized throughout the BOP in conjunction with national task forces, such as the National Alliance of Gang Investigators Associations. They noted that such images are also displayed publicly in the same context on the Federal Bureau of Investigation's public website, as well as several anti-hate organizations' websites. While the OIG recognizes that such artwork can help BOP employees discern gang symbology, and that gang-related images may appear on law enforcement websites, we are concerned that the prominent display of the artwork in the SIS hallway, which is accessed by both employees and inmates going through the gang disassociation process, could have a negative effect on employee morale and inmates' willingness to provide information to the BOP during their gang disassociation, as well as potentially contributing to a hostile work environment. The BOP disagreed that the artwork displayed in the SIS hallway is problematic or contributes to a hostile work environment, citing its educational purpose.

Conclusion and Recommendations

Conclusion

Our unannounced inspection identified several serious issues at FCI Lewisburg related to staffing, inmate healthcare quality, infrastructure, single-celling of inmates in restrictive housing, suicide prevention practices, and employee professionalism. Additionally, we found that FCI Lewisburg's evolving correctional mission in recent years has created challenges for its Executive Leadership, who expressed pride in the institution's ability to manage the changing demands that have been placed on it.

We found that FCI Lewisburg's Correctional Services Department had only 191 of 245 authorized positions filled (78 percent) just prior to our inspection and that this staffing shortage is likely to be exacerbated because of the institution's expanding mission—including serving as the regional transport hub for inmates transferring to and from institutions in the northeast. This mission includes absorbing inmates from other institutions and inheriting additional prisoner transportation responsibilities—which, based on Lewisburg Executive Leadership projections, will result in a 153 percent increase in the number of inmates the institution must process in 2024 compared to 2023.

Additionally, we found that there are significant disparities in calculations of the number of employee positions appropriate for FCI Lewisburg. Institution leadership expressed the view that current authorized staffing levels are insufficient, particularly given the institution's increasing responsibilities and the dozens of vacancies they are experiencing in the Correctional Services Department, which they noted has created difficulty in managing the full scope of missions expected from FCI Lewisburg. However, calculations generated by an outside firm, which the BOP contracted to develop staffing models for its institutions nationwide, yield significantly lower totals for the facility's appropriate staffing levels, particularly in Correctional Services. The misalignment on the number of authorized positions needed at FCI Lewisburg is concerning as it limits the BOP's ability to ensure that it can reliably and effectively accomplish its missions and FCI Lewisburg could be impaired in the safety and efficacy of its recently expanded operations.

We also identified concerns related to the quality of healthcare provided to inmates, including delays in blood tests for diabetic inmates and delays in preventive colorectal cancer screening, as well as abrupt discontinuation of mental health medications for some inmates. Especially alarming was our finding that during the week of our inspection 15 inmates had antidepressant medication prescriptions discontinued abruptly upon their arrival because of FCI Lewisburg clinical personnel's concerns over the frequency with which these drugs are prescribed to BOP inmates and the potentially harmful effect they can have when interacting with other prescribed drugs. We found that discontinuation of these drugs was not tapered as recommended by BOP clinical guidance and that the Clinical Director who made the medication discontinuation decisions did not meet with any of the affected inmates, instead relying solely on medical records. A particular concern is that these inmates did not have the opportunity to be informed by clinical personnel of the early signs and symptoms of a major depression relapse, which can occur following the discontinuation of antidepressant medications.

The OIG also found at FCI Lewisburg infrastructure issues that have the potential to affect its safety and security, including significant damage to the institution's food service area, as well as the need to replace much of the institution's fire alarm system. FCI Lewisburg officials estimated the cost to address

infrastructure issues at the institution at over $28 million. We also measured temperatures inside the facility, which were well above BOP targets, including temperatures above 82° F in an occupied inmate housing unit and an 89° F reading in a cell in a housing unit that was unoccupied at the time of our inspection (institution management planned to use the unoccupied unit to house incoming holdover inmates the week following our visit).

Additionally, the number of inmates who were single-celled in restrictive housing at FCI Lewisburg was concerning. At the time of our inspection, 18 percent (13 of 71) of inmates in restrictive housing were single-celled despite BOP policy that strongly discourages single-celling. Given the privacy afforded to inmates when they are single-celled, inmates under those conditions have an increased opportunity to attempt suicide. As the OIG has noted in our prior oversight work, suicide risk is greatest when inmates are single-celled in restrictive housing, where they are confined to their cells for 23 hours a day. We also found prevalent violation of BOP guidance that all Correctional Officers assigned to the Special Housing Unit or a housing unit custody post carry a cut-down tool that would enable them to quickly cut ligatures used in inmate hanging attempts. This violation of recent BOP guidance directly compromises the institution's ability to effectively and timely respond to suicide attempts.

Separately, we also found that employees at FCI Lewisburg displayed in the hallway of the institution's Special Investigative Services (SIS) office inmate-drawn prison gang artwork that included Nazi and white-supremacist iconography, as well as symbols associated with Latin American street and prison gangs. The BOP cited the educational purpose of the artwork, noting that the SIS plays a vital role in managing gang-related activity and teaching employees to recognize, report, and monitor gang-related activity and membership. While we recognize the potential educational value of such material, we are concerned that the prominent display of the artwork in the SIS hallway, which is accessed by both employees and inmates going through the gang disassociation process, could have an unintentional negative effect on employee morale and potentially contribute to a hostile work environment.

Ultimately, many of the significant issues we identified at FCI Lewisburg were consistent with BOP-wide issues on which we have made recommendations in prior work. This report makes three additional recommendations to the BOP to ensure effective operations at FCI Lewisburg and safe conditions of confinement for the inmates housed there. Two of those recommendations are designed to address issues at FCI Lewisburg that we have also identified in our prior oversight work of the BOP and for which we have made BOP-wide recommendations. The third is an FCI Lewisburg-specific recommendation that ensures that the BOP will review the medication discontinuation practices at FCI Lewisburg and other holdover facilities.

Recommendations

To ensure effective operations at FCI Lewisburg and safe conditions of confinement for inmates housed there, we recommend that the BOP:

1. Ensure that FCI Lewisburg Executive Leadership and the Central Office's Human Resources Management Division discuss the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs to ensure greater alignment between stakeholder staffing projections.

2. Ensure that the Health Services Division (Central and/or Regional Office) reviews medication discontinuation practices at FCI Lewisburg and other holdover facilities, including the discontinuation of antidepressants without a clinical encounter, to determine whether such practices are consistent with BOP clinical guidance. If the Health Services Division determines that such practices are inconsistent with BOP clinical guidance, it should work collaboratively with FCI Lewisburg clinicians to identify practical solutions to increase the frequency with which clinicians conduct a clinical encounter with holdover inmates in advance of such decisions so that clinicians can collect complete information about an inmate's condition and the inmate is informed of such decisions and aware of the potential risks associated with medication discontinuation.

3. Ensure FCI Lewisburg's compliance with existing Central Office guidance for certain employees to carry a cut-down tool when on duty.

Appendix 1: Purpose, Scope, and Methodology

Standards

The DOJ OIG conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's Quality Standards for Inspection and Evaluation (December 2020).

Purpose and Scope

The OIG has determined that it can enhance the effectiveness of its oversight, as well as its ability to alert the BOP of concerns, by conducting short-notice and unannounced inspections of BOP facilities, as appropriate. Pursuant to the OIG's planned procedures for initiating an inspection, which we had previously shared with the BOP, the OIG notified FCI Lewisburg at approximately 8 a.m. on February 5, 2024, that the OIG would be initiating an inspection beginning at noon that day. The team of nine OIG employees conducted the on-site inspection Monday, February 5, through Friday, February 9, 2024. The OIG was assisted by two contract medical subject matter experts who reviewed FCI Lewisburg documentation following the on-site inspection. Our focus was the state of institution operations at the time of our inspection, although, for certain portions of our analysis, our scope included roughly the year that preceded our inspection, beginning in January 2023.

We selected FCI Lewisburg as the site of our fourth inspection because we wanted to better understand the conditions of confinement for male inmates at an FCI. The scope of this inspection did not include specialized testing to definitively determine, for example, the potential presence of mold and other hazardous substances. In addition, although this report includes information on allegations of employee misconduct, we report this data for informational and transparency purposes and note that the volume of employee misconduct investigations (especially those for which the underlying investigation has yet to be concluded) should not be used, alone, to assess the pervasiveness of employee misconduct or lack thereof at an institution.

Inspection Methodology

To better understand FCI Lewisburg's operations, we toured the institution, interviewed inmates and employees, and reviewed its operational records.

Observations

We toured the interior and exterior of the medium-security prison and the federal prison camp, including general population inmate housing units; the Special Housing Unit (SHU); watchtowers, Health Services Department spaces; front lobby employee entrances and screening areas; programming areas used by the Psychology, Education, and Recreation Departments; the mail room; the commissary; laundry areas; the evidence storage area; inmate intake and screening areas; Facilities Department areas; food storage warehouses; and food preparation and dining areas.

We also reviewed security camera footage, as well as the functionality of the security camera system. Further, we tested ambient temperatures throughout the institution, as well as the functionality of showers, sinks, and toilets in inmate housing areas.

Interviews

We conducted on-site interviews with FCI Lewisburg inmates who were housed in both the general population and the SHU, as well as on-site interviews with institution employees. Employees we interviewed included the Warden; Associate Wardens; Captain; supervisory and nonsupervisory Correctional Officers; healthcare providers; case managers; food service workers; and employees responsible for institution safety, facilities management, and human resources. Following our on-site work at FCI Lewisburg, we conducted virtual follow-up interviews with select employees from FCI Lewisburg, the BOP's Northeast Regional Office, and the BOP's Central Office.

Document Review and Analysis

We reviewed FCI Lewisburg records related to facilities management, staffing levels, use of overtime and augmentation, use of restrictive housing, provision of inmate healthcare, food service, inmate discipline, employee misconduct, sexual abuse reporting and tracking, inmate programming, and FIRST STEP Act implementation.

External Subject Matter Experts Assisting the OIG

To assist the OIG in its efforts to assess the provision of healthcare to FCI Lewisburg inmates and to review clinical documents and interviews with medical employees, the OIG contracted the services of two healthcare subject matter experts: one physician and one registered nurse.

Appendix 2: DOJ OIG and Other Oversight Agency Related Work

I. For the FCI Waseca **inspection report,** see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Waseca*, Evaluation and Inspections (E&I) Report 23-068 (May 2023), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-waseca.

II. For the FCI Tallahassee **inspection report**, see DOJ OIG, *Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Tallahassee*, E&I Report 24-005 (November 2023), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-tallahassee.

III. For the FCI Sheridan **inspection report**, see DOJ OIG, Inspection of the *Federal Bureau of Prisons' Federal Correctional Institution Sheridan*, E&I Report 24-070 (May 2024), oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-sheridan.

IV. For prior Government Accountability Office (GAO) reporting on **BOP staffing levels**, see GAO, *Bureau of Prisons: Opportunities Exist to Better Analyze Staffing Data and Improve Employee Wellness Programs*, GAO Report 21-123 (February 2021), gao.gov/products/gao-21-123.

V. For prior OIG reporting on **BOP staffing levels**, see DOJ OIG, *Limited-Scope Review of the Federal Bureau of Prisons' Strategies to Identify, Communicate, and Remedy Operational Issues*, E&I Report 23-065 (May 2023), oig.justice.gov/reports/limited-scope-reviewfederal-bureau-prisons-strategies-identify-communicate-and-remedy.

VI. For prior OIG reporting on the **BOP's use of overtime**, see DOJ OIG, *Management Advisory: Analysis of the Federal Bureau of Prisons' Fiscal Year 2019 Overtime Hours and Costs*, Audit Report 21-011 (December 2020), oig.justice.gov/reports/management-advisory-analysis-federal-bureau-prisons-fiscal-year-2019-overtime-hours-and.

VII. For prior OIG reporting on the **BOP's medical staffing challenges**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Medical Staffing Challenges*, E&I Report 16-02 (March 2016), oig.justice.gov/reports/review-federal-bureau-prisons-medical-staffing-challenges.

VIII. For additional prior OIG reporting on the **BOP's medical staffing challenges**, see Pandemic Response Accountability Committee, *Review of Personnel Shortages in Federal Health Care Programs During the COVID-19 Pandemic* (September 2023), oversight.gov/sites/default/files/oig-reports/PRAC/healthcare-staffing-shortages-report.pdf.

IX. For prior OIG reporting on the **BOP's infrastructure management challenges**, see DOJ OIG, *The Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions*, Audit Report 23-064 (May 2023), oig.justice.gov/reports/federal-bureau-prisons-efforts-maintain-and-construct-institutions.

X. For prior OIG reporting on **temperature regulation and monitoring**, see 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.

XI. For prior OIG reporting on the use of **restrictive housing for inmates with mental illness** and **single-celling**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness*, E&I Report 17-05 (July 2017), oig.justice.gov/reports/review-federal-bureau-prisonsuse-restrictive-housing-inmates-mental-illness.

XII. For additional prior OIG reporting on **single-celling**, see DOJ OIG, *Capstone Review of the Federal Bureau of Prisons' Response to the COVID-19 Pandemic*, E&I Report 23-054 (March 2023), oig.justice.gov/reports/capstonereview-federal-bureau-prisons-response-coronavirus-disease-2019-pandemic.

XIII. For prior OIG reporting on **inmate deaths in custody** and **cut-down tools**, see DOJ OIG, *Evaluation of Issues Surrounding Inmate Deaths in Federal Bureau of Prisons Institutions*, E&I Report 24-041 (February 2024), oig.justice.gov/reports/evaluation-issues-surrounding-inmate-deaths-federal-bureau-prisons-institutions.

XIV. For prior OIG reporting on the **insufficiency of the BOP's security camera systems at BOP institutions**, see DOJ OIG, *Investigation and Review of the Federal Bureau of Prisons' Custody, Care, and Supervision of Jeffrey Epstein at the Metropolitan Correctional Center in New York, New York*, Investigations Report 23-085 (June 2023), oig.justice.gov/reports/investigation-and-review-federal-bureau-prisons-custody-care-and-supervision-jeffrey.

XV. For additional prior OIG reporting on the **insufficiency of the BOP's security camera systems at BOP institutions**, see DOJ OIG, *Review of the Federal Bureau of Prisons' Contraband Interdiction Efforts*, E&I Report 16-05 (June 2016), oig.justice.gov/reports/review-federal-bureau-prisons-contraband-interdiction-efforts.

XVI. For additional prior OIG reporting on the **insufficiency of the BOP's security camera systems at BOP institutions**, see DOJ OIG, *Management Advisory Memorandum: Notification of Needed Upgrades to the Federal Bureau of Prisons' Security Camera System*, E&I Report 22-001 (October 2021), oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security.

Appendix 3: BOP Policies and Clinical Guidance Cited

Topic Discussed in Report	Relevant Program Statement or Clinical Guidance	Link
Antidepressant Discontinuation	Management of Major Depressive Disorder May 2014 (Reformatted October 2017)	www.bop.gov/resources/pdfs/depression.pdf (accessed July 17, 2024)
Colorectal Cancer Screening	Preventive Health Care Screening July 2022	www.bop.gov/resources/pdfs/preventative_healt_care_cg_2022.pdf (accessed April 25, 2024)
Management of Diabetes	Management of Diabetes March 2017	www.bop.gov/resources/pdfs/diabetes_guidance_march_2017.pdf (accessed July 17, 2024)
Fire Protection	1600.13 National Fire Protection Policy June 1, 2017	www.bop.gov/policy/progstat/1600.13.pdf (accessed July 17, 2024)
Temperature Regulation	4200.12 Facilities Operations Manual July 18, 2017	www.bop.gov/policy/progstat/4200.12.pdf (accessed March 22, 2024)
Special Housing Units	5270.12 Special Housing Units March 5, 2024	www.bop.gov/policy/progstat/5270.12.pdf (accessed July 17, 2024)
Use of Restraints	5566.07 Use of Force, Application of Restraints, and Firearms July 17, 2024	www.bop.gov/policy/progstat/5566.07.pdf (accessed September 9, 2024)
Employee Professionalism	3713.32 Bureau of Prisons Anti-Harassment Policy April 22, 2024	www.bop.gov/policy/progstat/3713.32.pdf (accessed July 17, 2024)

Appendix 4: The BOP's Response to the Draft Report

U. S. Department of Justice

Federal Bureau of Prisons

Central Office

Office of the Director — *Washington, DC 20534*

September 20, 2024

MEMORANDUM FOR JAN HAMM
CHIEF INSPECTOR, ACTING IN THE ROLE OF ASSISTANT INSPECTOR GENERAL, EVALUATIONS AND INSPECTIONS

FROM: Colette S. Peters, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Report: Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Lewisburg, Assignment Number A-2024-002

The Federal Bureau of Prisons (FBOP) appreciates the opportunity to formally respond to the Office of the Inspector General's (OIG) draft report: Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Lewisburg. Thank you for your thorough and thoughtful evaluation.

The FBOP appreciates the level of attention and detail that went into the site inspection Report, and notes that the Federal Correctional Institution (FCI) Lewisburg rectified several OIG findings that were brought to its attention at the time of the inspection and through the working draft Report. FCI Lewisburg has a zero-tolerance policy for the unacceptable graffiti and immediately repainted the areas in question within the week of OIG's inspection. Additionally, the FCI Lewisburg Executive Team has pursued all possible means to identify the transgressor. However, the graffiti was located in areas where there is no camera coverage and that have limited employee access. Therefore, the FCI Lewisburg Executive Team has not been able to identify the individual responsible for the abhorrent offense.

The FCI Lewisburg Executive Team, including the Warden, has emphasized this zero-tolerance policy with the employees during Annual Training and recalls and continue to do so. Further, the FCI Lewisburg Executive Team has required each FCI Lewisburg Department Head to likewise emphasize this zero-tolerance policy during their departmental meetings. Additionally, FCI Lewisburg is now requiring the Institutional Duty Officer to spot check random areas within the institution weekly, and FCI Lewisburg's Executive Team has conducted random checks of employee access-only areas to verify no presence of graffiti.

Additionally, once made aware that some employees were not in possession of the cutdown tool as required by current FBOP guidance[1], FCI Lewisburg's Executive Team reminded employees both in writing and verbally of their responsibilities pursuant to current FBOP guidance, which has been provided to OIG. Lieutenants are now completing random checks of employees to ensure that all relevant current guidance is followed. The FBOP addresses this concern in more detail in the response to recommendation 3, below.

Notably, FCI Lewisburg has participated in a variety of missions throughout the years, and the FCI Lewisburg Executive Team takes pride in the employees' ability to manage the changing and evolving missions of the institution. Additionally, FCI Lewisburg has been fortunate to employ multi-generational families from the surrounding area who play a critical role in helping to effectuate its mission. Both FBOP Central Office and FCI Lewisburg welcome the opportunity to address the OIG recommendations resulting from this site inspection.

The FBOP offers the following in response to the Report Recommendations.

Recommendation 1: Ensure that FCI Lewisburg Executive Leadership and the Central Office's Human Resources Management Division discuss the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs to ensure greater alignment between stakeholder staffing projections.

FBOP Response: FBOP concurs with this recommendation. Indeed, all institutions and regions have had multiple opportunities to discuss the staffing projections and methodology since June 2023, when the Correctional Services discipline was deployed in the Automated Staffing Tool (AST). Additionally, since the dates of OIG's site inspection of FCI Lewisburg, the FCI Lewisburg Executive Team and the contractor have discussed the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Team's understanding of its current and potential future mission needs.

FBOP has engaged in extensive and ongoing efforts to educate institutions and encourage feedback about the AST projections. Beginning in June 2023, with the rollout of each department, the institutions were given the opportunity to provide input and concerns regarding the position recommendations for their institution. Regarding the Correctional Services Department, regional calls were held with the contractor, and the FBOP's Human Resource Management Division (HRMD) participated, to discuss the overall methodology as well as to familiarize users with the AST. All wardens and institution Human Resource Managers have user access to the AST and have been encouraged to raise questions directly to the contractor. Further, at the Central Office level, each division designated subject matter experts to work directly with the contractor developing the AST to provide input into the appropriate criteria for

[1] FBOP previously provided OIG with the following memoranda containing cutdown tool guidance: "2024_CPD_HSD_RSD_Cutdown Tools" and "CEO Memo_Cutdown Tools 07102023"

departments under their area of responsibility. Each Assistant Director reviewed and confirmed the criteria prior to adopting it for use in the position calculations.

In August 2024, in order to provide another opportunity for input and to ensure a fulsome review of AST projections, HRMD asked all Wardens to complete a survey to provide specific input on the AST position recommendations. Specifically, the survey asked Wardens to confirm or provide concerns with the AST recommendations for their institutions. HRMD is compiling these survey results and sharing them with each respective Regional Directors to confirm any issues noted by institution leadership. Although the goal of the AST is to standardize the methodology for calculating recommended positions, there will inevitably be outliers to the global criteria that will require individualized solutions. FCI Lewisburg completed this survey on August 14, 2024.

FCI Lewisburg's Executive Team and the contractor have discussed the staffing projection tool methodology with the FCI Lewisburg Executive Team in several forums and using several methods as described above. HRMD and divisional SME's will engage with the institution and regional leadership within the next 30 days to ensure understanding of the criteria (e.g. only permanent program and mission changes can be considered in the AST) and seek to resolve any outlier issues that can be addressed for FCI Lewisburg.

Recommendation 2: Ensure that the Health Services Division (Central and/or Regional Office) reviews medication discontinuation practices at FCI Lewisburg and other holdover facilities, including the discontinuation of antidepressants without a clinical encounter, to determine whether such practices are consistent with BOP clinical guidance. If the Health Services Division determines that such practices are inconsistent with BOP clinical guidance, it should work collaboratively with FCI Lewisburg clinicians to identify practical solutions to increase the frequency with which clinicians conduct a clinical encounter with holdover inmates in advance of such decisions so that clinicians can collect complete information about an inmate's condition and the inmate is informed of such decisions and aware of the potential risks associated with medication discontinuation.

FBOP Response: The FBOP concurs with this recommendation and has already begun reviewing medication discontinuation practices at FCI Lewisburg and other holdover facilities according to the process described in its policy on Health Services Quality Improvement (Program Statement 6013.01, available at www.bop.gov). FBOP's Health Services Division (HSD) is in the process of investigating and substantiating OIG's findings through its Quality Management section. HSD's Mental Health Clinical Pharmacists, who are subject matter experts in the pharmacology of mental health pharmaceuticals, are assisting in an assessment of the 15 patients from FCI Lewisburg as well as a sampling of other AICs in other FBOP holdover institutions (for comparison). The FBOP will provide OIG with information regarding the results of this assessment, any findings, and corrective action plans, if needed, as they become available.

Recommendation 3: Ensure FCI Lewisburg's compliance with existing Central Office guidance for certain employees to carry a cut-down tool during when on duty.

FBOP Response: FBOP concurs with this recommendation and has already taken steps to ensure FCI Lewisburg's compliance with existing guidance for certain employees to carry a cut-down tool when on duty.

Specifically, for all employees who are required to wear cut-down tools, FCI Lewisburg has issued verbal and written reminders of the requirement to wear a cut-down tool during the duration of their shift. Additionally, lieutenants have begun random checks of correctional employees to ensure they are carrying a cut-down tool. Lastly, additional cut-down tools were added to each unit officer's tool cage on each floor of the Special Housing Unit and the location of the tools was changed to allow employees easier access.

FBOP provided OIG with the following documents:

"LEW Cut Down Memo": Assurance memo from the Captain at FCI Lewisburg attesting that guidance has been issued to all staff regarding the carrying of the cut down tools and that Lieutenants will spot check employees and conduct routine conference calls to ensure compliance with current cut-down tool guidance.

"07.25.2024 Captain's Email LEW (1035)": This email was sent by the Captain to all Lewisburg staff to remind them of the current cut-down tool guidance, including the list of staff that must carry a cut-down tool on their person while working in a housing unit, directions for obtaining cut-down tools.

"08.23.2024 Captain's Email LEW (1035)": This email was sent by the Captain to all Lieutenants at Lewisburg requiring them to ensure appropriate carrying of cut-down tools by required employees.

"LEW Cut Down Memo 2" : Assurance memo from the Associate Warden attesting that that an email was sent on 08/23/2024 reminding employees of the requirement to carry a cut down tool and listing the positions required to obtain a cut down toll at the beginning of their shift. This memorandum also attaches the most recent cut-down tool guidance from Central Office ("CEO_Memo_Cutdown Tools 07102023", also attached).

08.23.2024 AW Email LEW (1035)": This email was sent by the Associate Warden reminding employees that the following employees are required to carry a cutdown tool: Unit Team staff, staff who have an assigned office in a housing unit, staff assigned to a custody post on a housing unit, all staff assigned to a Special Housing Unit, Compound Officers and LTs.

At this time, FCI Lewisburg is in compliance with existing guidance regarding carrying of cut-down tools. Accordingly, the FBOP respectfully requests closure of this recommendation.

Appendix 5: 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 4 to this report.

In its formal response, the BOP acknowledged the issues identified in this report and described actions that FCI Lewisburg has already taken to rectify several of the findings, including one area for which we did not make a recommendation (described below). The BOP stated that both its Central Office and FCI Lewisburg welcome the opportunity to address the recommendations, noting that FCI Lewisburg has participated in a variety of missions throughout the year and that FCI Lewisburg's Executive Leadership takes pride in employees' ability to manage the challenging and evolving missions of the institution.

First, the BOP noted that FCI Lewisburg has a zero-tolerance policy for unacceptable graffiti and reported that the institution repainted the areas in question within the week of the OIG's inspection and pursued all possible means to identify the individual responsible. Additionally, FCI Lewisburg Executive Leadership, including the Warden, has emphasized the zero tolerance with employees and supervisors and FCI Lewisburg now conducts random spot checks of employee-only-access areas to verify that there is no graffiti. Second, the BOP described several steps that FCI Lewisburg has taken to ensure compliance with existing guidance for certain employees to carry a cut-down tool when on duty. Specifically, FCI Lewisburg's Executive Leadership reminded employees, both in writing and verbally, about their responsibility to be in possession of a cut-down tool pursuant to current BOP guidance; the BOP provided copies of written guidance sent to FCI Lewisburg employees, as described in Recommendation 3. The BOP also reported that Lieutenants now randomly check employees to ensure compliance.

The OIG's analysis of the BOP's response regarding specific recommendations and the actions necessary to close them are discussed below.

Recommendation 1

Ensure that FCI Lewisburg Executive Leadership and the Central Office's Human Resources Management Division discuss the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs to ensure greater alignment between stakeholder staffing projections.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that all institutions and regions have had multiple opportunities to discuss staffing projections and methodology since June 2023. The BOP noted that, since the OIG inspection, FCI Lewisburg Executive Leadership and Central Office's Human Resources Management Division (HRMD) met to discuss the staffing projection tool methodology and how it compares with FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs.

The BOP stated that it has engaged in extensive ongoing efforts to educate institutions and encourage feedback about the staffing projection tool. Since the staffing projection tool's deployment starting in June

2023, institutions were given an opportunity to provide input and concerns regarding the position recommendations for each department, the BOP reported. For the Correctional Services Department, the BOP noted that it held regional calls with the contractor, with Central Office's HRMD participation, to discuss the overall methodology and to familiarize users with the tool. The BOP stated that all Wardens and Human Resource Managers have user access to the staffing projection tool and have been encouraged to raise questions directly with the contractor. At the Central Office level, each division has designated subject matter experts to work directly with the contractor to provide input into the appropriate criteria, which each Assistant Director reviewed and confirmed prior to adopting it for position calculations.

The BOP further stated that in August 2024 the HRMD asked all Wardens to complete a survey to provide specific input on the staffing projection tool and the survey specifically asked Wardens to confirm or provide concerns about the staffing projections for their institutions. The BOP noted that the HRMD is compiling the results of the survey, which FCI Lewisburg completed on August 14, 2024, and is sharing the results with each respective Regional Director to confirm any issues identified by institution leadership. The BOP stated that, although the tool's goal is to standardize the methodology for calculating recommended positions, inevitably there will be outliers to the global criteria that require individualized solutions. Lastly, the BOP reported that the HRMD and division subject matter experts will engage with regional leadership within the next 30 days to ensure understanding of the criteria and seek to resolve any outlier issues that can be addressed for FCI Lewisburg.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. The OIG acknowledges the BOP's ongoing efforts, planned actions, and responsiveness to this recommendation. By January 6, 2025, please provide documentation evincing that the BOP has ensured that FCI Lewisburg Executive Leadership and Central Office HRMD have discussed the staffing projection tool methodology and how it compares to FCI Lewisburg Executive Leadership's understanding of its current and potential future mission needs to ensure greater alignment between stakeholder staffing projections. Please also provide any agreed upon adjustments to the staffing projection tool methodology.

Recommendation 2

Ensure that the Health Services Division (Central and/or Regional Office) reviews medication discontinuation practices at FCI Lewisburg and other holdover facilities, including the discontinuation of antidepressants without a clinical encounter, to determine whether such practices are consistent with BOP clinical guidance. If the Health Services Division determines that such practices are inconsistent with BOP clinical guidance, it should work collaboratively with FCI Lewisburg clinicians to identify practical solutions to increase the frequency with which clinicians conduct a clinical encounter with holdover inmates in advance of such decisions so that clinicians can collect complete information about an inmate's condition and the inmate is informed of such decisions and aware of the potential risks associated with medication discontinuation.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that it has already begun reviewing medication discontinuation practices at FCI Lewisburg and other holdover facilities according to the process described in its policy on Health Services Quality Improvement (Program Statement 6013.01). The BOP noted that its Health Services Division is in the process of investigating and substantiating the OIG's findings through its Quality Management section. Further, the BOP stated that Health Services Division

Mental Health Clinical Pharmacists, who are subject matter experts in the pharmacology of mental health pharmaceuticals, are assisting in an assessment of the 15 patients from FCI Lewisburg who had medication discontinued during the week of our inspection, as well as sampling other inmates at who are housed at other BOP holdover facilities. The BOP noted that it will provide the OIG information regarding the results of the assessment, including any findings and corrective actions, if needed, as they become available.

OIG Analysis: The BOP's planned actions are responsive to the recommendation. By January 6, 2025, please provide the results of the BOP's assessment or an update on its progress.

Recommendation 3

Ensure FCI Lewisburg's compliance with existing Central Office guidance for certain employees to carry a cut-down tool when on duty.

Status: Resolved.

BOP Response: The BOP concurred with this recommendation and stated that, for all employees who are required to wear a cut-down tool, FCI Lewisburg has issued verbal and written reminders of the requirement to wear a cut-down tool during their shift. The BOP provided copies of five memoranda and emails sent from FCI Lewisburg Executive Leadership to employees during July and August 2024. The BOP reported that FCI Lewisburg Lieutenants have begun random checks of Correctional employees to ensure that they are carrying a cut-down tool and the institution has added additional cut-down tools in each Unit Officer's tool cage on each floor of the Special Housing Unit to allow easier employee access. The BOP requested closure of this recommendation.

OIG Analysis: The BOP's planned actions are responsive to this recommendation. We recognize FCI Lewisburg Executive Leadership's written communications to employees to comply with Central Office's guidance for certain employees to possess a cut-down tool while on duty. To demonstrate FCI Lewisburg's compliance with the BOP's guidance, by January 6, 2025, please provide accountability and compliance measures such as random spot check reports and any Suicide Risk Assessments or Psychological Reconstruction Reports generated because of attempted or completed deaths by suicide.