

Cruel and Usual:

AN INVESTIGATION
INTO PRISON ABUSE
AT USP THOMSON



A Report By

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WASHINGTON LAWYERS' COMMITTEE
FOR CIVIL RIGHTS AND URBAN AFFAIRS

This report
is dedicated to
the brave individuals
who, despite facing retaliation,
physical danger, and psychological
trauma, spoke out about the conditions
in the Special Management Unit at
the United States Penitentiary
in Thomson, Illinois.

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CONTENT GUIDANCE: This report includes descriptions of torture, physical violence, sexual assault, and racist, homophobic, and transphobic language. Please read with care.



Executive Summary

Hundreds of people held in in the Federal Bureau of Prisons' (BOP) Special Management Unit (SMU) endured years of unconstitutional and abusive conditions. Those abuses were particularly extreme during the more than three years the program was located in the United States Penitentiary in Thomson, Illinois (Thomson).

Over the past 18 months, more than 40 lawyers and legal staff members from the Washington Lawyers' Committee for Civil Rights and Urban Affairs, Latham & Watkins LLP, Uptown People's Law Center, and Levy Firestone Muse LLP, investigated the conditions in the SMU at Thomson. During that investigation we collected accounts of extreme physical and psychological abuse from more than 120 people. We also witnessed firsthand abusive and obstructive staff behavior, and saw with our own eyes injuries inflicted by Thomson employees.

Guards regularly placed individuals in dangerous four-point restraints for hours, sometimes days, and often without food, water, or access to a toilet. Many individuals reported being beaten and sexually assaulted while in restraints. Guards fastened the restraints so tightly that they caused scars on individuals' wrists, ankles, and stomachs. This happened so frequently that the resulting scars became known as a "Thomson Tattoo."

In addition to physical abuse, guards subjected people in the SMU to psychological trauma through the use of extended solitary confinement, referred to by the BOP euphemistically as "restrictive housing."¹ In the SMU, solitary confinement involved locking two people in a cell for up to 23 hours a day, a practice known as double-cell solitary confinement. If Thomson officials wanted to punish someone, they would deliberately assign them a cellmate with whom they had known conflicts, or who posed a physical or sexual threat (forced celling). Refusing to move to a double-cell in such dangerous situations often led to further staff-initiated violence, including four-point restraints.

The physical and psychological trauma took its toll on everyone in the SMU, but was particularly harmful to those who were psychologically fragile. BOP policy generally prohibits people with severe mental health conditions from being placed in the SMU.² Yet we regularly interviewed people in the SMU with significant mental health diagnoses including bipolar disorder, schizophrenia, and posttraumatic stress disorder. Not only did staff at Thomson refuse to provide appropriate mental health care to these individuals, but they responded to suicidal ideations and self-harm attempts with brutal beatings, restraints, and extreme isolation.

Racism was also rampant. White SMU staff commonly targeted Black individuals in the SMU, hurling egregious racial slurs such as “boy,” “n****r,” or “Black bitch” while committing acts of violence against them, and even made threats to “make you the next George Floyd,” a reference to a Black man killed by police during an arrest.

When individuals held in the SMU would attempt to speak to an attorney about these and other abuses, Thomson staff actively interfered. Staff either refused to schedule, or cancelled, calls and visits, sometimes at the last minute, often under pretenses. Counsel often needed to involve senior BOP staff and the Office of the Deputy Attorney General just to arrange a single legal call or legal visit with a client. Following calls or visits, guards aggressively fished for information about the substance of legal conversations and, sometimes, brutally retaliated against individuals simply for having met with their lawyers.

Thomson staff also actively interfered with the administrative process that allows individuals who are imprisoned to complain about the conditions of their confinement—referred to colloquially as the “grievance process”—by refusing to provide, or otherwise destroying, the forms needed to file a grievance. By preventing people from completing the grievance process, staff knowingly increased the chance that any lawsuit filed would be barred for a failure to exhaust administrative remedies, no matter how unjustifiable the conduct or severe the constitutional violation. The individuals with whom we spoke described nothing less than a culture of torture far too pervasive to be the result of a few “bad apples.” More than 165 staff members participated in violence, abuse, or other inhumane treatment at Thomson. Indeed, more than 35 staff members were involved in 4 or more separate violent incidents. For many, this cycle of violence and abuse was inescapable. The BOP and Thomson officials regularly held people in the SMU for far longer than the expected 9-12 month duration of the program—in some cases, for close to 4 consecutive years.

This is also not a story of a rogue facility. After the BOP closed the Thomson SMU in February 2023, they transferred individuals held in Thomson to locations all over the country. Our clients report that similar issues are pervasive in the other facilities: 13 individuals reported the use of excessive restraints at their new facilities, 20 have experienced assault by staff or physical retaliation, 7 have reported being forced into cells with someone the guards knew was dangerous, 16 reported staff have failed to protect them from known dangers, 6 described encountering an inaccessible grievance process, and 30 reported a lack of access to mental health and medical care.

Comprehensive, system-wide reform is needed. At a minimum, the Department of Justice and BOP should take the following steps:

- 1.** The Department of Justice should immediately open a criminal investigation into the abuses in the SMU.
- 2.** The BOP must immediately end the SMU program and strictly limit the use of other restrictive housing.
- 3.** The BOP must strictly limit and monitor the use of restraints.
- 4.** The BOP must create a meaningful, accessible grievance process.
- 5.** The Department of Justice must impose external independent oversight.



History of the SMU

The BOP has a long history of abusing people in its care. One of many examples is the pervasive abuse of individuals in the SMU at Thomson.

More than 15 years ago, the BOP opened the first SMU at the United States Penitentiary in Lewisburg, Pennsylvania. Advocates filed multiple lawsuits challenging the unconstitutional conditions in the SMU at Lewisburg, including the Washington Lawyers' Committee for Civil Rights & Urban Affairs and Latham & Watkins. The BOP closed the SMU at Lewisburg in 2018, mooting the litigation. Rather than address the unconstitutional conditions that led to the lawsuits, or address the culture of brutality, the BOP simply transferred approximately 400 individuals—and many members of the staff—to a new SMU at Thomson, shifting the same venal culture from one SMU to the next. In the absence of any criminal accountability for staff offenses at the Lewisburg SMU, the culture at the Thomson SMU became even more medieval.

From the moment the SMU opened at Thomson, people held there reported unconstitutional conditions surpassing those at Lewisburg, and an increase in staff violence. Specifically, they reported excessive use of restraints, staff assaults, racial discrimination, being forced into cells with individuals who were known threats, interference with access to counsel and the grievance process, being forced by staff to fight other detained people, and wide-spread retaliation by guards.

In response we opened an investigation that would last more than 18 months. Yet again, before litigation could be filed, the BOP closed the SMU at Thomson. While we applaud its closure, the BOP and its staff have once again avoided any accountability. It is our understanding that none of the abuses described in detail below have resulted in either administrative consequences or criminal charges against the BOP staff involved. In fact, individuals at three different facilities have reported that multiple former Thomson guards are now working at their new institutions.

...the BOP and its staff have once again avoided any accountability.

The Investigation

During our investigation we received information from more than 120 people in the SMU, conducted at least 100 interviews and legal calls, and reviewed over a thousand pages of correspondence and institutional records.³

We uncovered a widespread culture of abuse involving officials up and down the chain of command. Thomson staff assaulted people in the SMU almost daily—for personal reasons, retaliation for grieving prior abuses, and sometimes for no reason at all. Five individuals imprisoned at USP Thomson died unnatural deaths between 2019 and 2022, the most of any BOP facility. Countless other individuals suffered serious injuries and unquantifiable psychological trauma, and many risked grave retaliations just to stand up for their rights.

Records and interviews with people in the SMU revealed:

241 acts of physical violence
by guards

178 uses of excessive restraint
by guards

136 separate incidents of retaliation
by guards against more than
50 people

These numbers reflect only the experiences of the people who contacted us. Understandably, many more were uncomfortable with disclosing, were otherwise unable to disclose their experiences, or had left the SMU by the time we began investigating. Since the BOP closed the SMU in February 2023, more than 25 additional people have provided their own first-hand accounts that are highly consistent with those reported to us during the investigation. Thus, the true extent of the abuse is likely far greater.

Below we describe the most common forms of abuse inflicted by Thomson staff on people in the SMU. This list is not exhaustive.

Abusive Use of Restraints

SMU staff regularly violated both federal regulations and BOP policies prohibiting the use of force, including restraints, as a form of punishment. Specifically, BOP staff repeatedly violated BOP Program Statements and federal regulations, which only allow for temporary and progressive use of restraints, only for the purpose of preventing an individual from hurting themselves, staff, or others, or causing serious property damage, and never in a way that causes unnecessary pain or extreme discomfort.⁴

SMU staff repeatedly and intentionally violated these prohibitions. Staff went so far as to dedicate a cell to be used as a restraint room, making it easier for guards (and their supervisors) to avoid accountability. Multiple people reported that staff denied them food, water, and access to a toilet while in restraints, contrary to federal regulations.⁵ As a result, they were forced to sit or lay in their own excrement.

Overall, we were able to uncover evidence of the following abuses:

82 people who guards assaulted or violently restrained

39 people who guards assaulted while in restraints

28 people who guards assaulted or restrained multiple times

13 people who guards left in 4-point restraints anywhere from 24 to 96 hours straight

178 individual incidents of guards using restraints as a form of punishment or torture

Four-Point Restraints. Four-point restraints severely limit a person’s movement by individually shackling all four limbs. At Thomson, guards would often add a belly chain and tighten the restraints so much that individuals were painfully stretched in four different directions and forced to lie prostrate on a concrete slab for hours or even days at a time. The restraints often caused temporary paralysis or numbness and left permanent scars, or “Thomson Tattoos.” Attorneys visiting people held at the Thomson SMU saw the scars on multiple individuals firsthand.

Restraint Chairs. Restraint chairs immobilize a person in a chair through straps applied across their chest, ankles, wrists, and arms—like a full body harness. In the SMU, the straps were intentionally applied to cut into people’s skin and to force their elbows and wrists into uncomfortable positions that cause shaking, numbness, and even temporary paralysis. Restraint chairs are banned in several states and have been linked to more than 36 deaths going back to the 1990s.⁶

Ambulatory Restraints. Ambulatory restraints limit a person’s ability to move their arms and legs while still allowing for some mobility. For example, a person who is handcuffed and wearing leg shackles can walk, but the length of their stride is restricted to exceedingly small steps. In the SMU, staff added a chain connecting the restraints on the ankles to the restraints on the wrists and tightened the chain to cut off circulation and pierce the skin during movement.

Date of Birth: [REDACTED] Sex: M Race: [REDACTED] [REDACTED]
 Encounter Date: 04/05/2022 10:58 Provider: [REDACTED]
 Was in hard restraints for four days. Concern regarding underlying bony injury to the ulna of [REDACTED]
 General Radiology-Wrist-2 View AP/Lat One Time
 [Bi] Specific reason(s) for request (Complaints and findings)

Survivor: A.S.

Officials abused A.S. in retaliation for writing letters to the American Civil Liberties Union and Department of Justice's Office of the Inspector General (OIG). Just after A.S. handed the letters to his counselor to mail, a group of guards dragged him from his cell and attacked him at the direction of a Lieutenant, who initiated the attack by simply saying "Now." The guards dug their nails into A.S.'s eyes, bent his fingers backwards, bashed his head into the ground, and struck him in the back, side, and legs. "We're going to teach your dumb n****r ass," one said.

Then, while wheeling A.S. to the restraint room on a gurney for further punishment, they choked him and dug into his eyes with gloves covered in pepper spray. Once in the restraint room, officials placed him in four-point restraints, sneaking in blows to his body while carefully avoiding the view of a handheld camera operated by a guard at the door.

Two hours later, six officials came back with a lieutenant to assault him again. One told him, "You're our bitch. We can do whatever we want to you. Now there's no cameras and nobody is going to stop us." Over the course of several hours, officials repeatedly tortured A.S., kneeling him in the groin and prying apart his lips so they could bang metal keys on his teeth. At one point a Lieutenant asked the other officials in the room, "Y'all haven't broken him yet? I would've had him at least three inches taller by now."

The officials immediately tightened the restraints in response, which gouged into

A.S.'s skin, and violently stretched his legs toward the table at the bottom of the concrete slab. The lieutenant exclaimed, "That Black bitch is going to be taller," laughed, and left the cell.

A.S.'s body convulsed as he screamed in pain and prayed for death. Hours later, during a restraint check, another lieutenant said, "I'm not going to help you. I don't give a fuck about you. Stop crying." Another hour passed before a nurse finally loosened the restraints. Thirteen hours after the assault began, a third lieutenant took A.S. back to his cell, but warned him, "Better not tell nobody what happened or next time will be worse. You see nobody can stop us, so keep your fucking mouth shut about this whole ordeal, boy."

Survivor: O.P.

Thomson staff frequently assaulted O.P. while he was restrained. Once, guards choked O.P. in restraints. As he struggled to breathe, he heard an official say, "Don't kill him right now because we're still under investigation for the last murder." Another official then held O.P.'s head against the concrete restraint slab, hitting him repeatedly. As O.P. lay there, battered, he heard an official ask if anyone would volunteer that O.P. attacked them first. O.P. was then held in four-point restraints for four days. To this day, O.P. suffers injuries including a "Thomson Tattoo," nerve damage, and scars from a rash that developed as he laid in his own waste.





Dangerous Cell Practices and Extreme Isolation

People confined to the SMU were subject to what the BOP euphemistically calls “restrictive housing.”⁷ In restrictive housing, people are locked in their cells more than twenty-two hours a day, often for months or years at a time. Some people are completely isolated without any other human contact, while others are forced to share a cell the size of a parking space⁸ with another person—a form of extreme confinement called double-cell solitary. Psychologists and those who have been subjected to double-cell solitary say it is often worse than single-cell solitary because it regularly leads to violent outbursts⁹ that cellmates cannot escape.

Forced Confinement with Dangerous Individuals

Staff at Thomson intentionally contrived dangerous cell assignments to incite violence (referred to here as “forced celling”). For instance, officials paired together cellmates with known conflicts or vulnerabilities; offered incentives, like reduced time in the SMU, to encourage fights; used those fights as a pretext to intervene with acts of violence; falsified subsequent incident reports; and beat up or restrained anyone who refused to play along. According to one person, this led to multiple “staged fights” every week. As another put it, “Cell consolidation days are when officers get geeked out or happy because they know 9 times out of 10 there’s going to be violence.”

The BOP was well aware of these problems. On March 2, 2020, SMU staff locked Matthew Phillips, a 31-year-old Jewish man, in a cage with two known white supremacist/anti-Semitic gang members.¹⁰ The gang members beat and kicked Matthew unconscious while the guards watched.¹¹ He died three days later.¹² All of this occurred before we began our investigation, yet violent forced celling arrangements continued.

41 individuals experienced at least one forced-celling arrangement against their consent.

Indefinite Solitary

People imprisoned in the SMU at Thomson were primarily held in double-cell isolation for more than 23 hours per day, every day. Being constantly locked in a space the size of a parking space with another person can be worse than being alone.¹³ Many people in the Thomson SMU endured double-cell solitary for years, despite the BOP's own program statement, which states the SMU is intended for periods not longer than 9-13 months at a time and 24 months in total.¹⁴ For many, the SMU became an indefinite form of isolation in violation of the BOP's own program statement.¹⁵

44 individuals spent more than 24 consecutive months in the SMU, in direct violation of the maximum time permitted

14 individuals spent more than 3 consecutive years in the SMU, with several approaching 4 years

54 individuals spent a combined 112 years in the SMU, an average of more than 2 years each

Survivor: Kareem Louis

Over repeated objections, officials forced Mr. Louis to cell with an individual they knew was dangerous. This cellmate eventually stabbed Mr. Louis in the hands, back, arms, and neck, then raped him while he was unconscious.

Survivor: E.C.

Guards tried to use E.C. to punish a different person, saying, "We're going to put you in his cell, and you have to beat his ass. He's coming off suicide watch; you're going to have to fuck him up or you got one coming." The last time

"...you're going to have to fuck him up or you got one coming."

he refused to fight a cellmate, guards beat him so badly they blinded him in one eye. However, E.C. still refused to cooperate. As a result, he was too terrified to leave his cell for eight months—even to shower.

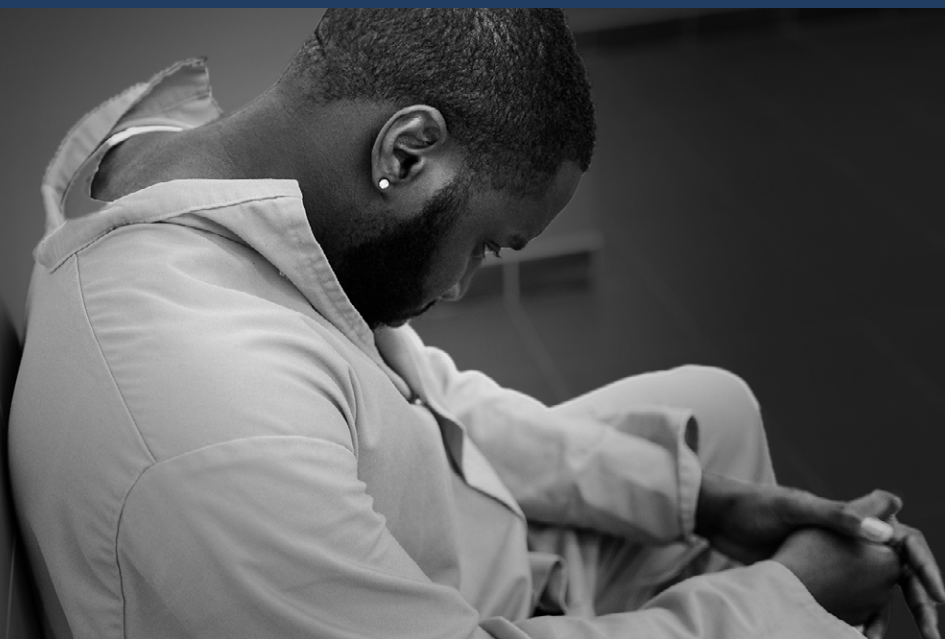
Survivor: E.M.

Officials forced E.M., a trans woman, to cell with an openly anti-LGBTQIA+ individual, who threatened to rape her and beat her until she died. When she reported this to an official and asked for a different cell assignment, he told her to "fight or fuck." E.M. then attempted suicide.

Survivor: Daryl Hickson

When Mr. Hickson objected to a cell assignment because of a conflict with his cellmate, a white guard told him, "You either kill or be killed." The guard then added, "You're going back in that cell to get killed, n****r." When Mr. Hickson continued to object, officials placed him in four-point restraints.





Mental Health – From Indifference to Violence

Individuals with serious mental health conditions are generally not supposed to be placed in the SMU.¹⁶ BOP psychologists are required to assess whether a person has a disqualifying mental health condition before they are transferred to the SMU, and if an individual develops a mental health condition that interferes with their ability to progress through the SMU program, staff are required to transfer that person out of the SMU.¹⁷ In reality, neither happened. We spoke with dozens of individuals in the SMU who had severe mental health conditions, including bipolar disorder, schizophrenia, and posttraumatic stress disorder. A number of them reported the BOP downgraded their mental health care level, either just prior to or after their transfer, so they would be eligible for the SMU—when they otherwise would not have been.

Our findings are well-known to the BOP, and they are consistent with a 2017 report by the OIG. In that report, the OIG found that mental health policies adopted in 2014 resulted in a significant decrease in the number of individuals identified as having mental illness.¹⁸ Principally damning was the OIG’s finding that “mental health staff may have reduced the number of inmates who needed regular mental health treatment because they did not have the necessary resources to meet the policy’s increased treatment standards.”¹⁹ The OIG found the problem “particularly pronounced among SMU inmates at USP Lewisburg” where all 27 individuals with mental illness had their care levels improperly reduced.²⁰

Solitary or restrictive housing, an ever-present condition of confinement in the SMU, can be especially harmful to individuals with mental health conditions. The OIG’s 2017 report was extremely critical of the BOP’s policies and practices relating to restrictive housing, finding they: did not adequately address the use of such housing for people with mental illness, did not sufficiently track or monitor the confinement of individuals with mental illness in such housing, and did not consistently document individuals’ mental illness, and therefore the BOP was unable to provide accurate or appropriate mental health care.²¹

Officials at Thomson exacerbated these problems by failing to provide even the most basic mental health care. Treatment instead consisted of one or two-minute psychology visits, approximately once a month. These “meetings” would be conducted with the psychologist on one side of the cell door and

the person in the SMU on the other. And in-between meetings, officials “treated” people by providing them books or puzzles.

The misclassification of serious mental health conditions combined with the complete lack of any meaningful mental health treatment led to highly foreseeable—and devastating—results. Many individuals held in the SMU in Thomson reported a significant deterioration of their mental health and increases in suicidal ideation and attempts. Yet, when an individual reported suicidal ideations to guards or engaged in self-harm, guards would often respond with violence rather than care. Officials would beat suicidal individuals and place them in restraints in a suicide watch room, where they were left completely isolated, wearing only paper clothes. Individuals would languish there, sometimes for a week or more, with no mental health services.

43 individuals in the SMU reported a serious mental health diagnosis, including severe depression and schizophrenia

15 individuals attempted suicide, in some cases as many as 9 times

Survivor: J.B.

J.B. attempted suicide nine times in the SMU. Once, after telling staff he had swallowed excess pills, guards restrained him to a chair for 24 hours. He was denied food, water, and access to a toilet the entire time. Another time, after telling the BOP’s Health Services Clinic he was hallucinating, and asking to speak with a psychologist, guards punished him by placing him in restraints for four days straight. When J.B. complained about the inadequate psychological care to Thomson’s doctors, one told him: “Get with the program or you’ll die.”

Survivor: D.L.

Prior to being placed in the SMU, D.L. had been diagnosed with schizophrenia and placed on mental health care level 3. His mental health care level was reduced, however, so he could be transferred to the SMU at Thomson. While waiting to be transferred, D.L. filed grievances disputing the reduction in his mental health care level. Despite these grievances and his known mental illness, D.L. was transferred to the SMU. For eight months D.L. repeatedly told staff at Thomson that he should not be

there and continued to file grievances. Just before shuttering the SMU, the BOP admitted he needed additional psychological services and transferred him to a different facility.

**“He’s playing games,
so beat his ass
and take him back
to his cell.”**

Survivor: O.P.

After O.P. told a doctor that he wanted to kill himself, the doctor replied, “Why did you wait until I’m supposed to leave work to bring me this crap?” The doctor asked O.P. how he planned to do kill himself and in response said, “Go do it then!” She subsequently told officials, “He’s playing games, so beat his ass and take him back to his cell.”



Sexual Assaults

Sex- and Gender-Based Violence

Staff routinely used sex- and gender-based violence against people in the SMU. Fifteen individuals reported 22 separate incidents of sexual assault by staff, sometimes while they were in restraints. People also reported being assaulted after guards intentionally double-celled them with someone known to be sexually violent. Additionally, multiple transgender individuals reported that staff forced them to cell with individuals who were openly anti-LGBTQIA+, resulting in several sexual assaults or rapes. Staff, in retaliation for meeting with lawyers, threatened sexual assault.

19 incidents were reported in which guards sexually assaulted a person in the SMU directly

8 of those assaults were committed while the individual was in restraints

3 individuals reported being sexually assaulted after being forced to double-cell with someone who Thomson staff knew was sexually violent

Survivor: J.H.

On at least two occasions, officials strapped J.H. to a gurney, wheeled him to the rotunda, stripped him naked, and filmed themselves assaulting his genitals, laughing when he begged them to stop.

Survivor: O.P.

Officials sexually assaulted O.P. multiple times, squeezing and twisting his testicles; attempting to insert a finger into his rectum;

and sawing a security shield into his penis, leaving cuts and abrasions.

Survivor: M.B.

Officials restrained M.B. in four-points as retaliation for a note he wrote alerting the Warden to threats against his life by guards. While in restraints, an official threatened to cut off M.B.'s penis but instead cut off three of his dreadlocks, waving them in the air while shouting, "I spared your dick!"

False Charges and Infractions

Staff frequently fabricated incident reports and filed false disciplinary infractions against individuals. The most common allegation was that individuals stuck their penises through a tiny flap in their cell doors and masturbated. Staff would then use these false disciplinary infractions to mislabel individuals as sex offenders and spread that information throughout the unit, placing them in grave danger.

Contrary to staff claims, the people we spoke with generally had no history of this behavior in their records and had not been identified as sex offenders before being transferred to the SMU.



Survivor: O.P.

Thomson staff placed O.P. in four-point restraints for four days, claiming he had harassed one of the nurses. Staff repeatedly insisted O.P. admit to this false charge during

torture sessions while restrained. O.P. never admitted to the infraction. Months after the fact, O.P. was exonerated and the infraction expunged from his record.



Rampant Racism

Much of the violence in the SMU resulted from blatant, unadulterated racism. White guards targeted Black individuals with derogatory racial terms—such as n****r, boy, monkey, and Black bitch—on a daily basis, often while committing assaults or placing individuals in restraints, but sometimes to simply assert their control.

Survivor: Darius Townsend

Following his return from suicide watch, an official told Mr. Townsend that he was going to “teach [Mr. Townsend] a lesson” not to harm himself. Several officials later rushed into Mr. Townsend’s cell, punched, kicked, and dragged him to the designated restraint room where they restrained him on a concrete slab. As he laid there, one of the officials put his knee on Mr. Townsend’s chest, choked him, and told him that if he “kept being disruptive”—which Mr. Townsend understood to mean raising grievances about prison conditions—“We’re going to make you the next George Floyd.”

Survivor: J.B.

Guards restrained J.B. 17 times while he was in the SMU at Thomson. Once, a guard came to his cell and said, “You n****s are going in chains. We’re gonna fuck y’all up.” During a different assault, an official shoved his genitals into J.B.’s face, calling him “my little n****r boy.” Another time, in response to J.B. filing a sexual assault grievance, an official

told him to “assume the position, snitch f**** n****r.” Another added, “You think you mean something, n****r? White men run the world.” When J.B. tried reporting this abuse to a lieutenant, he refused to accept the grievance saying, “I’m not taking that shit, n****r. It’s gonna keep happening to you.”

Other Survivors:

An Official told a restrained O.P. that he was his “master,” then lifted his shield high in the air and slammed it twice into O.P.’s face, bloodying his nose. After J.B. attempted to file a grievance about an assault, officials told him, “Stop filing on us, n****r.” When Wade Wilson complained about not having access to a shower for days at a time, one official called him a “dumb ass Black n****r,” a “bitch,” and a “dumb ass Black monkey” before destroying his belongings. A supervisor responded by saying, “Good, cause y’all n****rs need to pack shit, cause y’all are moving to G-3, and just to mention, G-3 is a disciplinary block.” And while J.T. was in four-point restraints, an official told him, “Lay the fuck back, you n****r monkey jacking fuck,” then choked him.



Re: Legal Calls Monitored, Mail Tampered With, and Grievance Process Unavailable at USP Thomson

Dear Regional Counsel Winter:

The Washington Lawyers' Committee for Civil Rights and Urban Affairs ("the Committee") represents several individuals incarcerated at USP Thomson. We have encountered significant problems relating to scheduling and conducting legal calls with our clients. Specifically, calls are delayed, legal calls are monitored, and incarcerated individuals are inappropriately charged for calls initiated by our office. In addition, multiple clients have reported that USP Thomson staff are tampering with their mail and interfering with their attempts to access the grievance process. This letter serves to provide you with notice of these illegal practices at USP Thomson in the hopes that you will instruct USP Thomson staff and administrators to immediately cease these practices and uphold incarcerated individuals' legal rights.

We have a right to speak confidentially with prisoners in this facility who wish to

Interference with Access to Counsel

Federal regulations,²² BOP policy,²³ and legal ethics²⁴ require attorneys to have unmonitored access to their clients. Thomson consistently failed to provide regular access to people in the SMU, let alone unmonitored access.

Confidential Legal Mail

Throughout our investigation, staff at Thomson unconstitutionally interfered with our clients' right to confidential legal mail.²⁵ Staff opened incoming legal mail outside the presence of the recipient, unreasonably delayed outgoing legal mail, and destroyed legal mail individuals kept in their cells, all in violation of BOP policies and federal regulations.²⁶ This interference with legal mail was routine and pervasive.

Survivor: D.S.



Staff never informed D.S. about a legal visit with our attorneys in September 2022. While we were able to meet with D.S., when he returned to his cell from that visit, he found

that staff had opened a confidential legal letter from us about the visit and placed it on his bed in an ominous and threatening manner.

Confidential Legal Calls

Likewise, staff at Thomson interfered with our ability to have confidential legal calls with clients. Our requests for unmonitored legal calls were repeatedly met with inappropriate inquiries into the nature of our relationship with the person we requested to speak with, and demands that we disclose the subject matter of the conversations. Calls would be scheduled and then cancelled with no explanation. Staff would trump up false charges against individuals scheduled to speak with us, then punish them in order to create a pretense for cancelling a legal call. Likewise, when individuals were on suicide watch, staff would not allow them to speak with us and would even conceal from them that we were trying to reach them, compounding their mental health crisis. Even when allowed, calls usually took weeks to schedule. One counselor simply refused to schedule any calls with the people on his case load.²⁷ When staff did schedule legal calls, they would frequently stagger them weeks apart and not inform individuals—including individuals on suicide watch—that the call was scheduled until just hours before the call was to take place, leaving the individuals with the false impression that counsel had forgotten about them. Keeping individuals unaware of their lawyers' efforts to reach out to them only compounded the individuals' poor mental health, distress, and suicidal ideation.

Staff would trump up false charges against individuals scheduled to speak with us, then punish them in order to create a pretense for cancelling a legal call.

Staff would also inappropriately monitor privileged calls in violation of BOP Program Statements,²⁸ often forcing individuals to conduct legal calls from a shower stall while staff remained in the room. Attorneys could sometimes hear staff (and others) in the background. In January 2022, the Warden at Thomson further interfered with attorney-client phone conversations by initiating a new policy charging 23 cents per minute for long-distance unmonitored legal calls, even if the call was requested and scheduled by counsel. The policy was ultimately withdrawn after our attorneys raised the issue with BOP regional counsel.²⁹

Confidential Legal Visits

Thomson staff also interfered with legal visits, often by retaliating against individuals who met with us. Staff (including Thomson's lawyers) also used pretenses to cancel attorney visits at the last minute, including on the day of the visit itself. This was done despite the visits being long-scheduled and staff knowing the lawyers had flown from Washington, D.C. to Illinois. Counsel had to contact senior BOP staff and the Office of the Deputy Attorney General to reverse Thomson staff's efforts to interfere with these legal visits.

Survivor: A.J.

When A.J. met with us in September 2022, he attempted to bring his legal files, grievance and medical records, and other documentation. Staff not only refused to

allow him to bring his records, but invasively strip-searched him before allowing him to meet with counsel.



Dear Regional Counsel Winter:

We have just learned that Thomson staff assaulted two of our clients immediately after they spoke with us via legal. Retaliatory assaults violate our clients' constitutional and civil rights. Our clients attempted to submit BP-8 grievance forms regarding the assaults in response to these incidents, but Thomson staff refuses to distribute BP forms. As a result, our clients wrote handwritten BP-8 grievances. Thomson staff intercepted those grievances and refused to accept them.

that Thomson staff assaulted two of our clients immediately after they spoke with us via legal (attached), Thomson staff violate our clients' constitutional and civil rights. Our clients attempted to submit BP-8 grievance forms regarding the assaults in response to these incidents, but Thomson staff refuses to distribute BP forms. As a result, our clients wrote handwritten BP-8 grievances. Thomson staff intercepted those grievances and refused to accept them. Thomson staff incarcerated at Thomson. We have communicated with our clients and public records shows that Thomson staff has refused to speak to our clients today.

attorney's futile efforts to schedule a legal call with his clients. Thomson staff refused to speak to the following individuals today:

[REDACTED]

Thank you,

Grievance and Accountability Failures

Under the Prison Litigation Reform Act, individuals usually cannot bring suit to address unconstitutional conditions—like the ones in the SMU—without first completing the prison facility's administrative remedy process, commonly referred to as the "grievance process." At Thomson, staff weaponized structural flaws in the grievance process to prevent individuals from ever being able to file lawsuits.

To start, SMU staff made obtaining grievance forms unnecessarily difficult. Guards and counselors at Thomson routinely refused to provide or process grievance forms. Because an individual is typically completely barred from bringing a lawsuit if they do not file their initial grievance within 20 days of an incident, staff could easily interfere with the grievance process by simply refusing to provide or process the forms. In other instances, staff ripped up the forms (completed and not) inside the cells of people incarcerated at the SMU.

Filing grievances could also be dangerous. Individuals in the BOP are often required to get grievance forms from, and file their initial grievances with, the very staff who abused them.³⁰ As a result, individuals are often left with an impossible choice: waive any right to legal redress or seek justice and risk severe retaliation. In the SMU, guards punished people for filing grievances by putting them in restraints, placing them in dangerous celling situations, threatening to rape them, destroying their property, and trumping up false sexual assault or masturbation infractions. Thomson staff created a culture of fear and intimidation that systematically suppressed the use of the grievance process, both shielding and emboldening the very people it is supposed to hold accountable.

Even if a person in the SMU can obtain and submit an initial grievance form, the process is virtually impossible to finish. It has four levels, each with its own form and strict deadlines. As the person moves through each level of the grievance process, they must attach the BOP's written response to the prior level of grievance. It is quite common, however, for BOP staff to simply fail to respond. If the person does not attach the BOP's written responses, even if they have not received it before the deadline to appeal, they are routinely found to have "failed" to comply with the grievance process. As a result, they are barred from bringing a lawsuit no matter how bad the violation of their constitutional or federal law rights.

All told, staff control the grievance process, they are incentivized to make it as difficult to complete as possible, and they routinely use it to thwart litigation.

h us via legal calls. These
BP-8 grievance forms
s. As a result, our clients
ept them.

refuses to schedule legal
ave not yet received a
s in writing unless the client
Thomson staff is refusing to
us report detailing an
ay. **Please ensure we are able**

Survivors

When D.L. attempted to grieve one of many forced celling arrangements, his counselor took over a month to provide forms. During that time, the counselor would ask why D.L. wanted a form and what he was going to say in it.

When A.S. attempted to grieve an issue concerning his legal mail his counselor told him, “I’m not giving you no more grievance forms.” When he attempted to file a grievance for more than one incident at a time, his counselor said, “You’re issued one [grievance form] per policy.” There is no such policy, and A.S. still does not know what happened

“You must have forgotten
what we do to n****rs
around here.

I’m gonna break
your fucking hands since
you like to write us up,
motherfucker.”

to his legal mail. Officials also confiscated and destroyed all A.S.’s stamps, legal papers, and family pictures. When he asked why, an official screamed in his face: “You must have forgotten what we do to n****rs around here.

I’m gonna break your fucking hands since you like to write us up, motherfucker.” He then told A.S., ominously, “Filing grievances will get you in a lot of trouble.”

Officials likewise took every piece of documentation **M.R.** kept in his cell pertaining to an excessive force grievance, including copies of appeals he had yet to mail to the Regional Office, causing him to miss his deadlines. No one has been held responsible for the underlying excessive force used against M.R.

When D.T. attempted to file a handwritten grievance for a violent assault after he was unable to obtain a prison-provided form for weeks, his counselor simply responded, “That’s not how this works.” No one has been held accountable for assaulting D.T.

When H.D. asked about the status of multiple grievances, the guards lied, telling him he never filed anything. He never received responses and was unable to complete the grievance process.

When M.S., who is transgender, filed a handwritten grievance after officials refused to give her a prison-provided form, officials placed her in a cell with an openly anti-LGBTQIA+ cellmate, who beat her up. No one has been held accountable for the forced celling or assault because M.S. could not access the grievance process and was afraid.



Necessary Reforms

The SMU at Thomson is closed, but many of the same constitutional and civil rights violations continue to occur throughout the BOP. The Washington Lawyers' Committee and Uptown People's Law Center receive intakes from individuals throughout the BOP that report assaults by staff, prolonged unnecessary use of restraints, intentional interference with the grievance process, lack of mental health services, and denial of access to counsel, among other things.

The BOP should not implement the SMU in some other location, as it did when it moved the SMU from Lewisburg, PA to Thomson, IL in 2018. Moreover, many of the staff responsible for abusing the individuals in the SMU remain employed by the BOP. We are aware of no disciplinary actions or criminal charges against any of them. Indeed, a May 2023 report by the OIG found the BOP was "unable to effectively investigate and adjudicate employee misconduct cases because [the BOP] is not sufficiently staffed."³¹ As of September 2022, the BOP had approximately 7,893 open employee misconduct cases and only 60 Special Investigative Officers to conduct investigations.³² Perhaps more concerning, the OIG found that the BOP had not imposed discipline in 2,279 other cases where the allegations of misconduct were sustained.³³

offending employees.

Due to this backlog of investigations and adjudications, the BOP is unable to effectively enforce its Standards of Employee Conduct. Further, it allows employees who may have engaged in misconduct, as well as those found to have engaged in misconduct, to remain employed by the BOP for extended periods of time.³⁴

The OIG found that, although the BOP's leadership at

employed by the BOP for extended periods of time.

The OIG found that, although the BOP's leadership at that time was aware that the employee discipline process was not operating effectively, few actionable steps were taken to improve it. As of March 2023, the BOP had plans to hire an additional 46 staff to investigate



The BOP's inaction, however, does not excuse the DOJ from its obligation to investigate and bring charges against SMU staff who have violated the law. The DOJ's failure to do so serves to reinforce the notion that staff are untouchable and are free to abuse individuals in their care. In the interest of justice and to protect the constitutional and civil rights of those in the BOP's care, the following reforms should be adopted immediately:

1 – The Department of Justice Should Immediately Open a Criminal Investigation into the Abuses in the SMU.

To our knowledge, the BOP staff involved in the abuses at the Thomson SMU remain employed by the BOP. A thorough independent criminal investigation is necessary to ensure that staff and their supervisors are held accountable for any criminal act or constitutional violation against the people imprisoned in the SMU at Thomson. The BOP culture needs reform far more than the law does. The Thomson SMU's staff, based on the credible allegations from the people with whom we spoke, are responsible for widespread violations of law and policy.

2 – Immediately End the SMU Program and Strictly Limit the Use of Other Restrictive Housing in the BOP.

The BOP should shutter the SMU permanently and retract Program Statement P5217.02. The BOP should also end the regular and systematic use of restrictive housing. As of the date of this report, there are 11,171 individuals held in either prolonged isolation with limited human contact (solitary confinement) or prolonged isolation in a cell with another individual (double-cell solitary confinement).³⁵ Instead, the BOP should design alternatives that are consistent with American Public Health Association Policy Statement 201310, American Bar Association Standard 23-2.8, American Medical Association House of Delegates Resolution 403 (A-23), United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), and H.R.176, as follows:

1. If used, restrictive housing should be limited to circumstances where there is reasonable cause to believe that substantial and immediate serious harm to another exists.³⁶
2. Mental health and medical examinations should be required prior to placing an individual in solitary confinement.³⁷ The BOP should ban the placement in restrictive housing of anyone with a history of a serious mental health conditions and those who are currently experiencing symptoms consistent with a serious mental health or medical condition.³⁸ Rather, the policy should mandate that such individuals be transferred to an appropriate medical facility as soon as possible. This policy change is critical.
3. Anyone placed in restrictive housing must have the right to a hearing within 72 hours of placement, with the assistance of counsel, and daily evaluations by a clinician.³⁹
4. BOP policy should limit solitary confinement to as short of a time as possible,⁴⁰ with a maximum of 15 consecutive days and no more than 20 days during a 60-day period.⁴¹
5. Even when placed in solitary confinement for these limited periods, the BOP should require individuals to receive a minimum of four hours a day of recreation or other activities outside of the cell during daylight hours.

3 – Strictly Limit & Monitor the Use of Restraints

The BOP should revise the current Use of Force and Application of Restraints Program Statement, BOP Program Statement 5566.06, to strictly limit the use of four-point, chair, and ambulatory restraints, and to increase oversight in any circumstance where such restraints are applied. The BOP should not permit any restraint for more than two hours under any circumstances.

If an individual is unable to self-regulate within that time, the program statement should require they be immediately moved to an appropriate mental health or medical facility.

Program Statement 5566.06 should also be amended to require all restraint be continuously recorded for the entirety of the restraint. The policy should further require the Warden at every facility, or their designee, to review all restraint recordings within four working days of the beginning of the restraint, unless requested sooner by the Regional Director, and to preserve all such recordings for no less than five years. Any videos wherein staff potentially violate BOP policy or an individual's constitutional rights should be immediately forwarded to the Regional Director. The Regional Director should be required to review the recordings and forward videotapes of potential policy or constitutional violations related to the Assistant Director, Correctional Programs Division, and Central Office, for review within five working days. Further, the BOP should amend the policy statement to require a written report any time restraints are used other than for the purpose of transportation.

4 – Create a Meaningful, Accessible Grievance Process

The BOP must rectify the problems with its Administrative Remedy Program by:

1. Updating Program Statement 1330.18 to limit the administrative grievance process to three steps: a formal grievance filed with the Warden, an appeal to the Regional Director, and a final appeal to the General Counsel;⁴²
2. Incorporating procedural safeguards identical to those contained in the Remedy Procedures under the Prison Rape Elimination Act (PREA), for individuals who submit a grievance alleging the use of force, forced celling, failure to intervene, or other forms of physical or emotional abuse by BOP staff, or physical or emotional abuse by third parties but with the knowledge of BOP staff;⁴³
3. Developing and implementing a process across all BOP facilities that allows people in prison to have unrestricted access to grievance forms without the need to engage BOP staff directly—such as an electronic grievance process or a grievance form library available in all housing areas. If paper rather than electronic grievances is provided, the facility should provide opaque sealable envelopes and access to a locked grievance box daily so that individuals can submit grievances without review or interference from staff;
4. Directing additional resources to conduct a comprehensive review of all grievance documents and to conduct unannounced regular audits of every facility to ensure grievances are responded to and returned with sufficient time for the person to include the response in the next step in the process.

5 – Create External Independent Oversight.

Office of the Inspector General. The Department of Justice Office of the Inspector General should establish a regular inspection regime of all BOP facilities to assess and report on the appropriateness of the use of single-cell solitary confinement, forced double-celling practices, administrative segregation, all other forms of restrictive housing, use of restraints, and the use of force against individuals held in BOP facilities consistent with its authority under 28 CFR Part 0 Subpart E-4, 5 U.S.C. 301; 28 U.S.C. 509, 510, 515–519. The Inspector General should be given

authority to conduct additional inspections or investigations to monitor the BOP's compliance with all corrective action plans. Such additional inspections or investigations can be either announced or unannounced at the discretion of the Inspector General.

Ombudsperson. Establish and fund an Ombudsman office in the Department of Justice who is authorized and directed to do the following:

1. Maintain a nationwide toll-free telephone number, a collect telephone number, a live caption or other phone system for deaf and hard of hearing individuals, an accessible website, and a mailing address for the receipt of complaints and inquiries regarding the BOP;
2. Promote awareness among BOP department employees, imprisoned people and their family members, and the public regarding the purpose of the office of the ombudsperson, services provided, and how the office can be contacted;
3. Receive complaints from individuals who are imprisoned, their family members, the representative of a person in prison, staff, contractors, or others with personal knowledge about the conditions in the relevant BOP facility;
4. Provide information, as appropriate, to individuals who are in prison, their family members and representatives, BOP employees, and others regarding the rights of imprisoned individuals;
5. Establish a nationwide uniform reporting system to collect and analyze data related to complaints received by the ombudsperson regarding the BOP;
6. Establish procedures to collect and resolve complaints;
7. Establish procedures to gather stakeholder input into the ombudsperson's activities and priorities, which shall include holding public meetings at least quarterly;
8. Aid people in prison or their family members whom the ombudsperson determines needs assistance, including advocating with an agency, provider, or other person in the best interests of the person who is imprisoned;
9. Make referrals, including to appropriate law enforcement authorities, when criminal complaints by people in prison are received by the office;
10. Notwithstanding any other provision of law to the contrary, review criminal investigations to ensure the investigations were accurate, unbiased, and thorough;
11. By a date certain each year, annually submit to the DOJ OIG and Office of Civil Rights, and make publicly available, a report that is both aggregated and disaggregated by each facility and includes, at a minimum, the number of complaints received, the number of complaints resolved by the ombudsperson, a description of systemic or individual investigations or outcomes achieved by the ombudsperson in the preceding year, any outstanding or unresolved concerns or recommendations of the ombudsperson, and input or comments from stakeholders regarding the ombudsperson's activities during the preceding year;
12. Adopt and comply with rules, policies, and procedures necessary to implement the above provisions.

Conclusion

The investigation of the SMU at Thomson has exposed systemic problems within the BOP that must be addressed immediately—including the excessive and violent use of restraints, insufficient treatment of individuals with mental health conditions, and pervasive use of restrictive housing. The administrative grievance process must also be revised to ensure that it provides actual, timely opportunities for individuals to seek remedies through the BOP, rather than simply shield staff from accountability. Finally, until such time as the BOP proves it is capable of investigating complaints about staff and enforcing its Standards of Employee Conduct in a timely manner, the DOJ must impose robust external oversight.

“[Thomson] was the
absolute worst experience
of my life... I’d rather be dead than
trapped in [that] dangerous place.”

~ Matthew Smith

Endnotes

1. The BOP claims that it does not practice solitary confinement. However, the Department of Justice Office of the Inspector General issued a report in 2017 finding a practice across several facilities of housing individuals, including those with mental illnesses, “in single-cell confinement for long periods of time, isolated from other inmates and with limited human contact.” *Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness*, Office of the Inspector General, U.S. Department of Justice, Evaluation and Inspections Division 17-05, Executive Summary (July 2017). Instead, the BOP euphemistically refers to its program of locking individuals in cells for 22 hours or more a day, “restrictive housing.” The BOP considers special housing units, housing at the Administrative Maximum Facility (ADX), and housing in SMUs to all be restrictive housing. As of June 30, 2023 there are 11,173 people being held in restrictive housing in the BOP: 10,846 in special housing units and 327 in ADX. With the closure of Thomson, there are no individuals currently being held in an SMU program. *Restricted Housing*, Statistics, Federal Bureau of Prisons, June 30, 2023, https://www.bop.gov/about/statistics/statistics_inmate_shu.jsp.

2. Federal Bureau of Prisons, Program Statement, P5310.16 (May 1, 2014).

3. We primarily reviewed documents collected from the individuals who contacted us, all of which corroborated their experiences. Obtaining files from the BOP directly was close to impossible. The BOP requires attorneys to file FOIA requests to get even basic records, but it can take years for the BOP to respond, if they ever do. During this investigation, we submitted more than 28 FOIA requests. To date, the BOP has responded to one. On May 10, 2023, Latham & Watkins LLP, and the Washington Lawyers’ Committee filed a lawsuit in the United States District Court for the District of Columbia to compel the BOP to provide the records from over 55 outstanding FOIA requests. *Washington Lawyers’ Comm. v. United States Department of Justice*, No. 1:23-cv-01328 (D.D.C. filed May 10, 2023).

4. Federal Bureau of Prisons, Program Statement, 5566.06, CN-1 (August 29, 2014); 28 CFR § 552.24 (1989).

5. 28 CFR § 552.24.

6. Maurice Chammah, *They Went to Jail. Then They Say They Were Strapped to a Chair for Days*, The Marshall Project (Feb. 7, 2020),

<https://www.themarshallproject.org/2020/02/07/they-went-to-jail-then-they-say-they-were-strapped-to-a-chair-for-days>.

7. *Restricted Housing*, Statistics, Federal Bureau of Prisons, June 30, 2023, https://www.bop.gov/about/statistics/statistics_inmate_shu.jsp.

8. The average cell size in the BOP is 7 x 12 feet, or a maximum of 84 square feet, while the average parking spot is 7.5 x 16 to 20 feet. Ryan J. Reilly and Saki Knafo, *America’s Top Prison Official Doesn’t Know How Big a Prison Cell Is*, Huffington Post, February 26, 2014, https://www.huffpost.com/entry/bop-director-prison-cell-size_n_4855865; Charles Montaldo, *Maximum Security Federal Prison: ADX Supermax*, ThoughtCo., updated January 29, 2020, <https://www.thoughtco.com/adx-supermax-overview-972970>.

9. Christie Thompson and Joseph Shapiro, *How the Newest Federal Prison Became One of the Deadliest*, The Marshall Project, May 31, 2022, <https://www.themarshallproject.org/2022/05/31/how-the-newest-federal-prison-became-one-of-the-deadliest>.

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

14. Federal Bureau of Prisons, Program Statement, P5217.02 (August 9, 2016).

15. *Id.*

16. *Id.*

17. *Id.*

18. *Review of the Federal Bureau of Prisons’ Use of Restrictive Housing for Inmates with Mental Illness*, Office of the Inspector General, U.S. Department of Justice, July 2017, <https://oig.justice.gov/reports/2017/e1705.pdf>.

19. *Id.*

20. *Id.*

21. *Id.*

22. 28 C.F.R. § 540.103.

23. Federal Bureau of Prisons, Program Statement, P5264.08 (corrected copy February 11, 2008).

24. *Rules of Professional Conduct*, Amended Rules 1.6 and 1.18, District of Columbia Bar.

25. Federal Bureau of Prisons, Program Statement 5265.14 (April 5, 2011); 28 C.F.R § 540.18 and 28 C.F.R § 540.19.

26. *Id.*

27. March 18, 2022 email to Rick Winter, Regional Counsel from the Washington Lawyers' Committee for Civil Rights & Urban Affairs; April 26, 2022 letter to Mary Noland from Washington Lawyers' Committee for Civil Rights & Urban Affairs (documenting no response to requests for legal calls for over a month).

28. Federal Bureau of Prisons, Program Statement P5264.08 (January 24, 2008).

29. March 11, 2022 letter to Rick Winter, Regional Counsel from the Washington Lawyers' Committee for Civil Rights & Urban Affairs, outlining staff interference with clients' access to counsel. The fee for calls with counsel were eliminated because of the letter to regional counsel.

30. Federal Bureau of Prisons, Program Statement, 1330.18 (January 6, 2014). There are two limited exceptions that exist within the program statements but are in practice unavailable. For grievances filed pursuant to the Prison Rape Elimination Act (PREA), individuals who allege sexual abuse may submit a grievance without submitting it to a staff member who is the subject or the complaint, and the grievances will not subsequently be referred to the staff member. *Id.*, 28 C.F.R. § 115. The same program statement theoretically allows imprisoned individuals to mail certain "sensitive" grievances directly to the Regional Office (avoiding the first two levels of review). However, if the regional coordinator does not consider the request sensitive, it will simply be returned to the person filing the grievance and they will be required to complete the regular administrative remedy process. *Id.* Not a single individual we spoke to in the SMU, however, reported successfully filing a sensitive grievance with the regional coordinator.

31. *Limited-Scope Review of the Federal Bureau of Prisons' Strategies to Identify, Communicate, and Remedy Operational Issues*, Department of Justice, Office of the Inspector General, Evaluation and Inspections Division, May 2023, <https://oig.justice.gov/sites/default/files/reports/23-065.pdf>.

32. *Id.*

33. *Id.*

34. *Id.*

35. *Restricted Housing*, Statistics, Federal Bureau of Prisons, June 30, 2023, https://www.bop.gov/about/statistics/statistics_inmate_shu.jsp.

36. H.R. 176 (2021); American Bar Association Standard 23-2.7(a).

37. United Nations General Assembly Resolution 70/175, Rule 45 (adopted 17 Dec. 2015); American Public Health Association, Policy 201310, Problem Statement (2013); American Bar Association Standard 23-2.8.

38. United Nations General Assembly Resolution 70/175, Rule 45 (adopted 17 Dec. 2015); American Public Health Association, Policy 201310, Problem Statement (2013); American Bar Association Standard 23-2.8.

39. *Id.*

40. American Public Health Association, Policy 201310, Action Steps; United Nations General Assembly Resolution 70/175, Rules 43 and 45 (adopted 17 Dec. 2015).

41. H.R. 176.

42. Currently, there is a four-step process. Individuals held in the BOP only have 20 days after an incident occurs to complete the first two steps in the grievance process. Federal Bureau of Prisons, Program Statement, 1330.18, (January 6, 2014); 28 U.S.C. §§ 542.13 and 542.14. Specifically, the individual must file a BP-8 form, also known as an "informal grievance," within 20 calendar days of the incident they are grieving. They are also required to file the second step using a BP-9 form, referred to as a "formal grievance," before the end of the same 20-day period. Given the overlap between the deadlines for the BP-8 (informal resolution) and BP-9 (grievance to Warden), the BP-8 should be eliminated.

43. Federal Bureau of Prisons, Program Statement 1330.18.

For More Information Contact:



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