U.S. Department of Justice

Office of Legislative Affairs

Office of the Assistant Attorney General *Washington, D.C. 20530*

The Honorable Richard J. Durbin
Chairman
Committee on the Judiciary
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

Enclosed please find responses to questions for the record arising from the appearance of Michael D. Carvajal, Director of the Bureau of Prisons, before the Senate Committee on the Judiciary on April 15, 2021, at a hearing entitled "Oversight of the Federal Bureau of Prisons." We apologize for the delay in responding and hope that this information is of assistance to the Committee.

Please do not hesitate to contact this office if we can be of additional assistance regarding this or any other matter. The Office of Management and Budget has advised us that there is no objection to the submission of this letter from the perspective of the Administration's program.

Sincerely,

Peter S. Hyun
Acting Assistant Attorney General

Enclosure

cc: The Honorable Charles E. Grassley
Ranking Member
Committee on the Judiciary

United States Senate
Committee on the Judiciary
Hearing Titled
"Oversight of the Federal Bureau of Prisons"

April 15, 2021

Federal Bureau of Prisons' Responses to Questions for the Record

Ranking Member Grassley

1. The Independent Review Committee (IRC) is comprised of outside experts and assists in overseeing *First Step Act* implementation efforts. They issued a report in December of 2020, titled "Report of the Independent Review Committee Report Pursuant to the Requirements of Title I Section 107(g) of the First Step Act (FSA) of 2018 (P.L. 115-391).[2]" You noted your familiarity with the IRC and this Report in your testimony before the Judiciary Committee on April 15, 2021. In this report, the IRC outlined the following on *First Step Act* implementation:
   - Risk and Needs Assessment System, PATTERN:
     - "PATTERN itself is not a complete 'risk *and* needs assessment' tool; it primarily measures the likelihood of post-release recidivism."[3]
     - "At present, the information necessary to complete such truly careful needs assessments is inconsistently available to frontline BOP personnel, and much of that information is not recorded in or accessible through the Bureau's management information systems. Responsible BOP staff continue to rely heavily on individual inmates' pre-trial sentencing reports (which are of widely varying quality and detail), information self-reported by inmates, documentation in Bureau case-management reports, and results from facility-specific screenings to identify needs. ***And in many if not most instances, they have little means to determine the extent of an identified need, which is crucial for purposes of referral to appropriately tailored inmate programming***." [emphasis added][4]
   - Prison Programming:
     - "The IRC cannot overstate how strongly it believes that a much more robust evidentiary basis must be established for determinations about: a) which programs BOP should continue to offer, reform, replace, or add; b) which should be designated as ETC-qualifying EBRPs or PAs—and exactly why; c) which programs "work" to address inmate criminogenic needs while in custody; and d) what longer-term recidivism-reduction effects these programs have on participating inmates after they have been released to the community."[5]
     - "[E]ven a full return to pre-COVID BOP programming levels will not be sufficient to make available 'evidence-based recidivism reduction programs and productive

[2] *See* Report of the Independent Review Committee Report Pursuant to the Requirements of Title I Section 107(g) of the First Step Act (FSA) of 2018 (P.L. 115-391), Dec. 21, 2020, Available at: https://firststepact-irc.org/wp-content/uploads/2020/12/IRC-FSA-Title-I-Section-107g-Report-12-21-20.pdf.
[3] *Id*. at 4.
[4] *Id*.
[5] *Id*. at 5.

activities for all eligible prisoners,' in Bureau custody by January 2022, as . . . the text of the [First Step Act] Title I requires."[6]

- About 30.8% of earned time credit eligible prisoners and 18.8% of earned time credit ineligible prisoners participated in programming during 2020.[7]

a. Do you agree or disagree with the IRC's assessment on the above points?

Response: Regarding the 2020 report, we agree with the IRC that the December report and the areas it reviewed had a number of limitations due to the timing of when the data for the report was gathered and the significant impact of COVID. The Bureau uses PATTERN, a tool that is revalidated each year with the help of external subject matter experts, to assess the risk of recidivism. The Department's most recent revalidation report for PATTERN was published by consultants with the National Institute of Justice in December 2021. For the full report, *see* NIJ, *2021 Review and Revalidation of the First Step Act Risk Assessment Tool* (Dec. 2021), https://www.ojp.gov/pdffiles1/nij/303859.pdf. In April 2022, the Department also published additional detail regarding implementation of PATTERN at section II(A)(1) in its 2022 First Step Act Annual Report, which is available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

The Bureau uses different measurement tools and approaches to assess inmate needs, specifically thirteen need areas identified by scholars and experts. The Bureau uses the results of those assessments to refer inmates to specific programs designed to address those needs, such as GED curricula and adult literacy, vocational training, mental health, substance abuse, anger management, criminal cognitions, parenting, and faith-based programs. Some of these assessments cannot be automated. They require individual one-on-one assessments with inmates, often including review of available records, inmate interviews, and/or structured assessments like those for education/literacy. For example, assessments of need and eligibility for substance use disorder treatment occur with reviews by a drug treatment specialist, physician, advanced practice provider, social worker, or pharmacist and interview with a clinical psychologist. Although inmates receive programming recommendations and referrals to address identified needs, inmate participation in programs remains voluntary. Inmate progress toward addressing need areas through recommended programs is reassessed at least semi-annually by case management staff and recommendations for programs are adjusted as needed. Inmate recidivism risk is also assessed routinely as part of these inmate and case management staff meetings. In March 2022, BOP published a thorough report about its needs assessment system. *See* BOP, *First Step Act: Initial Review of the SPARC-13 Needs Assessment System* (March 2022), https://www.bop.gov/inmates/fsa/docs/bop_fsa_needs_validation_report_2021.pdf. Information on the implementation of the needs assessment is also included in the

[6] *Id*. at 2 – 3.
[7] *Id*. at 2.

Department's 2022 First Step Act Annual Report at section II(A)(2), which is available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

As part of the risk and need assessment process, Bureau staff rely on information in the inmate's Presentence Report (PSR) to help identify security risks and relevant need areas for each inmate. Some examples of common information found in PSRs and relevant to the needs assessment process are educational, social, substance use, criminal, and employment histories, as well as parental status. The PSR is the product of thorough investigation by U.S. Probation Officers and any dispute as to the information in these reports can be contested by the defendant and is subsequently rejected or approved by the sentencing court. Therefore, the PSR remains a valuable source of information about an inmate's history and circumstances prior to commencing their incarceration; it is that same information upon which the sentencing judge relies in order to impose a sentence. The Bureau's information systems capture relevant information about inmate need assessments. The Bureau's case management staff and staff in multiple disciplines, document key inmate information on need areas and progress toward addressing those needs in its information systems (e.g. education, mental health, criminal history). The inmate's overall needs assessments are captured, updated and tracked; as well, program recommendations are automatically mapped to identified needs to ensure appropriate programs are recommended.

The Bureau has long desired automated capture of information from the PSR to simplify and expedite the agency's risk and needs assessment process. The Bureau must, however, rely on the Administrative Office of the U.S. Courts (AOUSC) to provide a web service or application programming interface, to provide discrete data for ingestion into BOP's data systems. As well, this service would ensure data standardization across all 94 judicial districts. The Bureau has a robust partnership with AOUSC regarding information exchange.

The Bureau is working with the National Institute of Justice to engage external experts to validate the BOP's needs assessment system. The status of this engagement, and its intended scope, is described more fully in the BOP's March 2022 needs assessment report and the DOJ's April 2022 First Step Act Annual Report. In addition, pending budget issuance, the Bureau will engage an audit team to conduct a quality assurance review of the Bureau's use of the risk and needs assessment system in 2022.

Additionally, in order to develop an evidence base for the Bureau's programs, First Step Act (FSA) funds are being used to begin external evaluations of Evidence-Based Recidivism Reduction (EBRR) programs and Productive Activities (PA). The Bureau has more than 80 EBRR programs and PAs. Some of these programs have long-established research to show their effectiveness at reducing recidivism. For example, inmates who participate in educational programming are 43% less likely to recidivate. The Bureau worked with MITRE Corp. to develop an independent review process for

programs, which was published in July 2020. Programs accepted after review were placed into the Bureau's program guide. The Bureau continues working to fund partnerships with external research organizations to further evaluate the value and impact programs have on the lives of inmates and their communities.

Programming in the context of COVID-19 and the safety of inmates and staff is of primary importance. As health-safety measures indicate it is safe to do so, the Bureau will continue to expand programming. In fact, the Bureau recently issued guidance to Wardens to authorize the use of contractors and volunteers with those individuals who pose low risk (e.g. because they have been vaccinated themselves and the facility has few or no COVID-19 infections).

b. Please explain how the Bureau of Prisons (BOP) has acted on these assessments in efforts to implement the *First Step Act*.

Response: We refer you to our response to (a), which provides information on inmate assessments and prison programming discussed in the IRC assessment. We also refer you to the DOJ's April 2022 First Step Act Annual Report, which details First Step Act implementation efforts at the Department, available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

2. In the IRC's December 2020 Report, it noted that the BOP needs to lead *First Step Act* implementation efforts in a more comprehensive way, recommending that implementation teams be set up at each facility to lead and report on the status of implementation at the facility level.[8]

a. What are your thoughts on this suggestion?

Response: The Department considers full implementation of the First Step Act a priority and has made significant progress in its implementation since the IRC's December 2020 report.[9] Implementation efforts are led by Bureau experts across disciplines, who issue national guidance to all Bureau facilities as to the implementation of various aspects of the FSA. These experts interface with regional and local institution counterparts to ensure staff are properly trained to implement programs and do so consistently across the enterprise. The Bureau's Program Review Division is an entire division with responsibility for auditing, including quality assurance and compliance, at all Bureau facilities nationwide. The implementation of the FSA's requirements is part of the Bureau's daily operations and not a separate project. For example, all staff are trained to understand and required to implement the Act's prohibition against restraining pregnant offenders; this standard does not require a "special team" to lead or assure compliance. Likewise, all case managers are trained to understand the requirements of the Second

[8] *Id*. at 6.
[9] *See* The Attorney General's First Step Act Section 3634 Annual Report 10 (Apr. 2022). https://www.ojp.gov/first-step-act-annual-report-april-2022.

Chance Act's Elderly Home Confinement pilot and recommend inmates accordingly. The FSA's requirements, like other laws before it, currently are or will be captured in Bureau policy, which all staff are required to follow. Institutional progress in implementing FSA requirements are tracked at the institutional, regional, and Central Office levels, including audits by the Program Review Division and external entities such as the General Accounting Office. At the same time, the Bureau will be engaging with an outside auditor to audit and evaluate the BOP's implementation of the risk and needs assessment system in 2022, and it will work to implement any recommendations that are developed through that process.

3. The *First Step Act* requires the BOP to provide programming for prisoners that will reduce recidivism. COVID-19 has impacted inmate participation in programs, and has also hampered volunteer access to BOP facilities to hold programs.

    a. How will BOP ensure that it gives opportunities for faith-based groups to provide programming to prisoners, even during the pandemic, since BOP has yet to resume complete volunteering access to BOP facilities?

    Response: Throughout the COVID-19 pandemic, the agency has followed CDC guidance with respect to the delivery of programming, and the Bureau is working expeditiously to resume programming, including those from faith-based groups, to the fullest extent possible while complying with CDC guidance. Currently, programs are capable of being delivered with the use of masks and proper social distancing. Guidance was recently issued to allow volunteers and contractors, including those from faith-based groups, to resume entering facilities if it is deemed safe per the Bureau's medical, and CDC guidance. More information on this is available in the Department's 2022 First Step Act Annual Report at section III(E), which is available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

4. Please outline BOP's exact plans for implementing the *First Step Act* as if COVID-19 no longer impacted operations in BOP facilities, including – but not limited to – increasing prison programming and ensuring inmates' earned time credits.

    Response: The Bureau is working to resume normal operations as expeditiously as possible while continuing to protect inmates and staff. Once an end to the pandemic emergency has been declared, full programming will resume immediately. In the meantime, the Bureau has continued to offer EBRR programs and PAs to the extent possible given the restrictions necessitated by COVID-19. It is worth noting that more than 25,000 inmates completed a program in 2020 despite the pandemic and, in FY 2021 over 98,000 inmates completed EBRR programs and PAs. By February 2022, a total of 157,5567 inmates had completed EBRR programs and PAs and 78,098 inmates were enrolled in programs.

    To ensure the BOP can deliver programs and services safely in light of the pandemic, the BOP is using a tiered approach utilizing three indicators for each institution to determine a modified

operations level. These indicators, which are monitored daily by institution staff, are: medical isolation rate within the institution (active cases); facility vaccination rates (including staff and inmates); and hybrid community risks. Based on these indicators, each institution has an identified operating level and employs the required mitigation modifications: Level 1 (minimum modifications); Level 2 (moderate modifications); and Level 3 (intense modifications). A description of the operational modifications for each level is published on the Bureau's public website at https://bop-sallydvlp.bop.gov:7443/coronavirus/covid19_modified_operations_guide.jsp. The website also displays the number of facilities at each level: www.bop.gov/coronavirus. As indicators improve and mitigation measures are lifted, the BOP will continue to expand available programming delivery. The Bureau recently issued guidance to Wardens authorizing contractors and volunteers to reenter institutions and provide programming in contexts that pose a low risk of COVID-19 transmission (i.e., because the contractor or volunteer has been vaccinated themselves and the facility has few or no active COVID-19 infections).

With respect to earned time credits, beginning in January 2020, all inmates were notified of their initial risk and needs assessment findings and staff recommended programs specific to their needs. An inmate is eligible to earn FSA time credits (FTC) if the inmate is the sentenced to a term of imprisonment pursuant to a conviction for a Federal criminal offense, or is in the custody of the BOP, unless the in inmate is serving a term of imprisonment for a disqualifying offense specified in 18 U.S.C. § 3632(d)(4)(D). Any FSA program completed as a result of this process entitles eligible inmates to earn time credits, which may be applied towards pre-release custody or at the Director's discretion, early release to supervised release. The Bureau has been systematically tracking inmate participation in programming. A final rule regarding FSA Time Credits was published on January 19, 2022. In accordance with this rule, an eligible inmate begins to earn FTC as soon as they arrive at their designated BOP institution for service of their sentence, receive a PATTERN risk assessment score, and complete all needs assessments. As long as inmates are "successfully participating" in programming as defined by the regulation, they will continue to earn FTC; additionally, time credits are being applied retroactively back to December 21, 2018.

Additional information about the Bureau's implementation of the First Step Act is available on our website at www.bop.gov/inmates/fsa/index.jsp and in the Department's 2022 First Step Act Annual Report, available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

5. The *First Step Act* bars the shackling of female prisoners during pregnancy and childbirth.

   a. To what extent has the BOP implemented this requirement of the *First Step Act*?

      Response: The Bureau has fully implemented this requirement of the FSA. In fact, beginning in 2014, prior to the passage of the FSA, the Bureau ceased restraining pregnant women absent exigent circumstances. As a result of the FSA's passage, further

guidance and training were implemented for staff about specific FSA requirements (i.e. post-partum inmates and reporting requirements). Additionally, tracking assignments were created in the Bureau's information management system to ensure all staff have knowledge of an inmate's pregnant or post-partum status.

b. Have there been any challenges to its implementation?

Response: There have been no challenges to implementation of this requirement.

6. There are two exceptions to the *First Step Act*'s ban on shackling pregnant prisoners: prisoners may be restrained if they present an immediate flight risk or if they pose an immediate risk of harm, or if a healthcare professional finds the use of restraints to be appropriate.

a. In what percentage of cases has the BOP invoked either of these exceptions?

Response: While the Bureau does not typically restrain pregnant inmates—and did not do so even prior to the passage of the First Step Act— the Bureau did not previously track these incidents in a standardized manner. Since the passage of the First Step Act, there have been four cases in which pregnant or postpartum women have been restrained. In two of the cases, staff restraining women were not aware they were pregnant. In both cases, the inmates were restrained for under two minutes. In the other two cases, the inmates arrived from United States Marshals to Bureau custody restrained. Both were restrained upon receipt and transported while restrained. Staff were unaware of their postpartum status. Upon arrival at the institution, and after intake, it was determined they were in postpartum status and immediate action was taken. In all cases, as soon as it was determined by Bureau staff that they were pregnant or in post-partum status, appropriate action was taken, to include medical assessments following the use of restraints. It was determined that no adverse physical effects to the prisoner or fetus resulted. The incidents were appropriately reported.

b. Since the *First Step Act*'s passage, on how many occasions has a healthcare professional submitted a medical request, on a prisoner's behalf, that a correctional officer refrain from using restraints on a prisoner or remove restraints used on the prisoner in a BOP facility?

Response: As noted in the above response, it has not been necessary for a health care professional to submit a medical request, on a prisoner's behalf, that a correctional officer refrain from using restraints on a prisoner or remove restraints used on the prisoner.

7. Does BOP collect data and/or statistics on cost-saving metrics associated with releasing inmates from secured detention in a BOP facility? If so, please share these data and/or statistics.

Response: As noted in section VII of the annual FSA report 2022 (published on the Bureau's website here: https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.)

> "[t]he BOP bears the costs for inmates who have moved from an institution to home confinement or [a Residential Reentry Center], but at this time there is no cost savings data or information to report associated with such movement."

As inmates continue to earn time credits and the BOP applies them towards pre-release custody, the Bureau may be able to report out as to any identified savings.

8. When an individual is released on probation or supervised release, who is responsible for ensuring that the individual has access to adequate housing, mental health resources, medical care, and other needs?

   Response: Bureau staff work with inmates while they are in custody to ensure they have secure housing, mental health resources, medical care, and other needs upon release. The Bureau provides mental health and drug treatment for inmates while they are in Residential Reentry Centers. Once an inmate completes their sentence, the BOP no longer has jurisdiction over him or her. If the inmate is required to complete a period of supervised release after their time with the Bureau, that supervision is overseen either by U.S. Probation and Pretrial Services, an entity under the U.S. Courts if the inmate is a federal inmate, or overseen by the Court Services and Offender Supervision Agency (CSOSA), an independent federal agency responsible for supervising D.C. Superior Court offenders.

9. Does BOP provide U.S. Probation and Pretrial Services with information about an individual's housing, mental health counseling, substance abuse, and other needs prior to release on probation or supervised release?

   Response: Yes, the Bureau provides the relevant U.S. Probation Office (and CSOSA for D.C. inmates as noted above) with information about the inmate's release plans prior to the inmate's referral to a Residential Reentry Center or home confinement. The Bureau provides an automated feed of data regarding inmates nearing release to the Administrative Office of the U.S. Courts (AOUSC), which is then distributed to all U.S. Probation Offices to assist them in managing the inmates, including reviewing their confinement history, institutional adjustment, and any additional programming needs. (The Bureau separately provides a similar data feed to CSOSA for inmates releasing to the District of Columbia.)

<u>Senator Blackburn</u>

1. On January 26, 2021, President Biden issued *Executive Order on Reforming Our Incarceration System to Eliminate the Use of Privately Operated Criminal Detention Facilities*. Could there be

some federal Bureau of Prisons programs or treatments that would be interrupted if and when this executive order is put into place? For instance, if inmates have to be transferred to another facility, will there be interruptions with some inmate programs and medical treatments?

Response: The Bureau has taken and will continue to take these kinds of considerations about health care and programming into account when transferring inmates from any facility, including from private facilities whose contracts are not renewed. Upon arrival at an inmate's new destination, each inmate undergoes an intake screening. During this process, staff from various departments, including health services, education, psychology and the inmate's case management team, interview the inmate to ensure that vital issues are addressed to allow for appropriate continuity of care and that inmate's programming needs are met.

2. What will happen to the inmates in those privately run facilities if the contracts are not extended? Where will they go, and are the alternatives adequate to house an inmate population of the current size?

   Response: The Bureau's overall inmate population has experienced a downward trend over the past decade, including our noncitizen population, which are Low security offenders. The Bureau has already absorbed inmates from most privately run facilities and has sufficient bed space to safely accommodate the remaining inmates currently housed in privately run facilities. As part of the deactivation of a private facility, the Bureau transfers inmates in accordance with designation policies. Inmates are appropriately screened, and movement will occur in accordance with identified protocols to mitigate the spread of COVID-19.

3. How could the cancellation of private prison contracts lead to greater spread of COVID-19 transmission outside the prison population?

   Response: See response to Q.2 above. As noted, inmates are appropriately screened, and movement of inmates once contracts expire will occur in accordance with identified protocols to mitigate the spread of COVID-19.

4. What will happen to BOP inmates in privately run facilities who are sentenced criminal aliens if those facilities are closed? Will those criminal aliens be deported after the completion of their sentence, and if not, where are they being transferred?

   Response: Noncitizens housed at privately operated facilities will be transferred to Bureau facilities with available bed space. The Bureau coordinates with Immigration and Customs Enforcement as appropriate before the release of any person subject to a removal order or a detainer.

<u>Senator Blumenthal</u>

1. Please identify the Warden of FCI Danbury as of the date on which responses to these Questions for the Record are submitted. In addition—

   a. Please list the date on which the Warden was hired.

b. Please list the date on which the previous Warden of FCI Danbury, Diane Easter, vacated the position and please identify why Warden Easter vacated the position.

c. Please identify all the individuals who served as Acting Warden between when the position of Warden of FCI Danbury became available and the current Warden was hired, including their length of service as Acting Warden.

Response: Sheila D. Easter assumed duties as the Warden of FCI Danbury February 2, 2020. She was assigned to the Northeast Regional Office (NERO) on Temporary Duty Orders (TDY) February 1, 2021, where she worked until her retirement on July 31, 2021. The Regional Director, who has oversight over FCI Danbury, made the decision to detail Warden Easter to the Regional Office for work on a range of special projects. Specifics regarding individual personnel matters are not disclosed.

Upon Warden Easter's assignment to the NERO, Dr. Jessica Sage began acting in the capacity of Warden at FCI Danbury and remained in that capacity, with the exception of days she was on annual or sick leave, until October 28, 2021. In her absence, Dr. Steve Eckert was the Acting Warden the week of March 29, 2021, and Jamal Jamison was the Acting Warden the week of April 5, 2021. Associate Warden William Hess acted in the capacity of Warden from October 28, 2021 until the new Warden arrived on November 28, 2021.

A permanent selection for Warden at FCI Danbury was made November 21, 2021; namely, Timethea Pullen, who is currently occupying that position. Timethea Pullen arrived at FCI Danbury on November 28, 2021. Associate Warden Hess acted in the capacity of Warden at FCI Danbury from December 20, 2021, to January 2, 2022, while Warden Pullen was on annual leave.

2. For each of the following positions, please state the number of vacancies at FCI Danbury in three-month intervals starting on January 1, 2019 to the date on which responses to these Questions for the Record are submitted. For each individual vacancy listed in each three-month interval, please state how long the position has been vacant, the specific steps the Bureau of Prisons (BOP) took (or is taking) to fill it, and the expected hiring timeline.

   a. Doctors;

   b. Nurses, including Advanced Practice Registered Nurses, Nurse Practitioners, and Registered Nurses;

   c. Physician Assistants; and,

   d. Emergency Medical Technicians.

   Response: See included chart.

3. Please describe FCI Danbury's medical staffing and capacity (for the time periods listed below) to provide medical care or treatment to incarcerated individuals who have become ill due to COVID-19

or other underlying conditions, including how often medical staff monitors incarcerated individuals who have become ill, when medical staff intervenes to provide care or treatment to incarcerated individuals who have become ill, and what kind of care or treatment FCI Danbury medical staff is prepared to provide to incarcerated individuals who have become ill.

a. Prior to March 2020.

b. Between March 2020 and April 2021.

c. Between April 2021 and the date on which responses to these Questions for the Record are submitted.

Response: See chart below

Timeframe	Vacancies at End of Quarter	Length of Vacancies	Steps Taken To Fill Positions
January 2019 – March 2019	Doctors – 1 Clinical Director Nurses – 2 Mid-Level Provider (PA/APRN) 1 PA/1 APRN Paramedic - 0	Clinical Director – Vacant as of 02/02/2019 Nurse – 1 vacant as of 10/07/2018; 1 new position as of 11/11/2018 Mid-Level Providers – New positions as of 12/9/2018	• Quinnipiac University Career Fair – 2/27/2019 • Southern Connecticut State University Job Fair – 3/20/2019 • Pace University Career Fair – 3/27/2019 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
April 2019 – June 2019	Doctors – 1 Medical Officer Nurses – 2 + 3 P01A Mid-Level Provider (PA/APRN) – 1 PA/ 1 APRN Paramedic – 0	Medical Officer – Vacant as of 5/26/2019 – Projected In 09/29/2019 Nurses – 1 P01A Nurse filled 5/12/2019; 1 new position as of 11/11/2018; 3 new P01A Nurse positions as of 4/14/2019 Mid-Level Providers – New positions as of 12/9/2018	• University of New Haven Job Fair – 4/8/2019 • Housatonic Community College Job Fair – 4/10/2019 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
July 2019 – September 2019	Doctors – 0 Nurses – 1 + 3 P01A Mid-Level Provider (PA/APRN) – 1 PA/ 1 APRN Paramedic – 1	Nurses – 1 new position as of 11/11/2018; 3 new P01A Nurse positions as of 4/14/2019 Mid-Level Providers – New positions as of 12/9/2018 Paramedic – Abolish/Established from 1 Nurse Position (Vacant as of 10/07/2018) – Projected In 10/27/2019	• Camp Nett Niantic Military Career Fair – 8/25/2019 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport

October 2019 – December 2019	Doctors – 0 Nurses – 1 + 3 P01A Mid-Level Provider (PA/APRN) – 1 PA/ 1 APRN Paramedic – 0	Nurses – 1 new position as of 11/11/2018; 3 new P01A Nurse positions as of 4/14/2019 Mid-Level Providers – New positions as of 12/9/2018	• Southern Connecticut State University Career Fair – 10/16/2019 • Sacred Heart University Career Fair – 10/23/2019 • Hostos Community College Job Fair – 10/24/2019 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
January 2020 – March 2020	Doctors – 1 Nurses – 3 P01A Mid-Level Provider (PA/APRN) – 1 APRN Paramedic – 1	Medical Officer – New position as of 1/19/2020 Nurses –3 new P01A Nurse positions as of 4/14/2019 Mid-Level Providers – New positions as of 12/9/2018 Paramedic – Vacant as of 02/02/2020	• University of New Haven Job Fair – 2/6/2020 • Quinnipiac University Health Professions Career Fair – 2/26/2020 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
April 2020 – June 2020	Doctors – 1 Nurses – 2 P01A Mid-Level Provider (PA/APRN) – 1 APRN Paramedic – 0	Medical Officer – New position as of 1/19/2020 Nurses –2 new P01A Nurse positions as of 4/14/2019 Mid-Level Provider – New position as of 12/9/2018	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
July 2020 – September 2020	Doctors – 1 Nurses – 1 P01A Mid-Level Provider (PA/APRN) – 1 APRN Paramedic – 2 P01A	Medical Officer – New position as of 1/19/2020 Nurses – 1 New P01A Nurse position as of 4/14/2019 Mid-Level Provider – New position as of 12/9/2018 Paramedic – Abolish/Establish 2 P01A Nurse to Paramedic P01A 8/30/2020 – 1 Projected in 11/09/2020	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
October 2020 – December 2020	Doctors – 1 Nurses – 1 P01A Mid-Level Provider (PA/APRN) – 1 APRN Paramedic – 2 P01A	Medical Officer – New position as of 1/19/2020 Nurses – 1 New P01A Nurse position as of 4/14/2019 – Projected in 01/03/2021 Mid-Level Provider – New position as of 12/9/2018 Paramedic – 1 vacant P01A as of 8/30/2020; 1 vacant P01A as of 12/20/2020	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
January 2021 – March 2021	Doctors – 1	Medical Officer – New position as of 1/19/2020	• Quinnipiac University Health

	Nurses – 1 Mid-Level Provider (PA/APRN) - 0 Paramedic – 1	Nurses – 1 New P01A Nurse position as of 4/14/2019 – Projected in 05/23/2021 Paramedic – Vacant as of 12/20/2020 – Projected in 04/11/2021	Professions Career Fair – 3/18/2021 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport • Mass mailing of flyers and brochures to local colleges/universities
April 2021 – June 2021	Doctors – 0 Nurses – 0 Mid-Level Provider (PA/APRN) - 0 Paramedic – 0	No clinical Health Services positions vacant ending June 2021.	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport • Mass mailing of flyers and brochures to local colleges/universities
July 2021 – September 2021	Doctors – 0 Nurses – 0 Mid-Level Provider (PA/APRN) - 0 Paramedic – 1	Paramedic – Vacant as of 08/22/2021	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
October 2021 – December 2021	Doctors – 0 Nurses – 0 Mid-Level Provider (PA/APRN) - 0 Paramedic – 1	Paramedic – Vacant as of 08/22/2021	• Johnson and Wales University Career Fair – 11/4/2021 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport
January 2022 – March 2022	Doctors – 0 Nurses – 1 + 1 P01A Mid-Level Provider (PA/APRN) - 0 Paramedic – 1	Nurses – 1 vacant as of 03/19/2022; 1 vacant P01A as of 03/11/2022 Paramedic – Vacant as of 08/22/2021	• Quinnipiac University Health Professions Career Fair 2/22/2022 • Sacred Heart University Career Panel – 2/24/2022 • Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport

April 2022 - Present	Doctors – 0 Nurses – 1 + 1 P01A Mid-Level Provider (PA/APRN) - 0 Paramedic – 1	Nurses – 1 vacant as of 03/19/2022; 1 vacant P01A as of 03/11/2022 Paramedic – Vacant as of 08/22/2021	• Mass emailing to Public Health Service • Advertising positions actively recruiting to BOP staff on Sallyport • We are actively working to fill vacant Health Services positions. We are currently working a Nurse certificate.

d: Health Services staff at FCI Danbury provide care to the inmate population consistent with ambulatory healthcare settings, in general. FCI Danbury follows Bureau and CDC guidance to include temperature screening, quarantine units, and isolation for those with active COVID-19 symptoms. Although there has been one identified instance of this guidance not being followed, it was corrected the following day and an investigation for possible staff misconduct was initiated as a result. Health Services staff intervene when clinically appropriate and refer patients (inmates) to community hospitals if an inmate's needs exceed the available level of care at FCI Danbury.

Number of Consults for outside trips completed for FCI Danbury				
Sent Date (Year)	**Start Date of Quarter**	**# of Routine Consults**	**# of Urgent Consults**	**# of Emergent Consults**
2019	1/1/10	102	32	14
2019	4/1/19	139	76	11
2019	7/1/19	126	53	17
2019	10/1/19	130	56	15
2020	1/1/20	112	51	21
2020	4/1/20	2	4	13
2020	7/1/20	78	38	7
2020	10/1/20	40	28	4
2021	1/1/21	94	38	5
2021	4/1/21	19	11	1
2021	7/1/21	30	33	4
2021	10/1/21	51	17	2
2022	1/1/22 (thru 5/4/22)	117	24	51

4. Please describe the circumstances in which a Medical Asset Support Team (MAST) would be deployed to FCI Danbury. In addition, please state whether BOP has ever assessed the need to deploy a MAST to FCI Danbury.

   Response: MAST is designed to assist institutions with clinical, administrative, and technical support within Health Services. The Warden may request MAST deployments when situational needs at the institution create a need for any of these types of assistance.

MAST Support Deployments for FCI Danbury			
Staff	**Service**	**Date**	**Days of deployment**
NER - Regional Chief Pharmacist	Training	3/18/2019	5
NER - Regional Nurse Consultant	Training	1/21/2020	5
NER - Regional Physician	Training	1/21/2020	4
NER - Regional Physician	COVID-19	4/8/2020	4
NER - Regional Quality Improvement/ Infection Prevention Control	Training	1/21/2020	5

5. Please describe the current vaccination procedures at FCI Danbury for both incarcerated individuals and staff, including offers, prioritization, distribution, education, and what specific steps BOP is taking to encourage as close to 100% vaccine acceptance among incarcerated individuals and staff both at FCI Danbury, specifically, and across all federal correctional institutions.

   Response: The Bureau has an aggressive vaccination plan that includes FCI Danbury. FCI Danbury will continue to receive vaccines as they are delivered to the Bureau and distributed to our institutions. FCI Danbury, like all Bureau institutions, was given the Bureau's COVID-19 Vaccine Clinical Guidance for COVID-19 vaccines which is published on www.bop.gov. This guidance includes specifics for offering and prioritizing vaccines, as well as information regarding the distribution.

   The Bureau provided several flyers and a "Frequently Asked Questions" document to all institutions to be displayed on inmate bulletin boards. In addition, the flyers and FAQ document were also distributed to inmates via e-mail so that it can be reviewed at any time. Institutions have also been providing information in a variety of settings to inmates, including a video with Director Carvajal and advocacy via a Public Health Service officer encouraging inmates to receive the vaccine. The Bureau Director also issued several videos to all staff encouraging vaccination. One of these videos, titled "Get Vaccinated", featured information about the safety and efficacy of the vaccines and included Director Carvajal, a Public Health Service staff member, and Bureau staff from across the country discussing why they were vaccinated against COVID-19, the importance of doing so, and dispelling myths regarding the vaccines. The Bureau has vaccines available to all staff and inmates, with more than 322,746 doses administered. With regard to FCI Danbury, as of June 29, 2022, 232 (88%) staff and 701 (69%) inmates have been fully vaccinated. All staff and inmates who previously refused the vaccine may still request and receive the vaccine.

6. Has the CDC's *Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* has been updated since July 2020?

   a. If yes, please describe the updates that have been made. If no, please explain why no changes have been made.

      - **Response**: Yes, the CDC's *Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* was last updated on May 3, 2022. The CDC regularly updates this guidance. A list of updates can be found here:

https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

b. Please explain how the CDC's guidance for correctional and detention facilities differs from CDC guidance for the general public, with specific reference to: social distancing, isolation, and quarantine procedures, testing practices, and vaccination protocols.

Response: The Bureau respectfully defers to the CDC with respect to differences between the guidance the agency has developed for correctional and detention facilities and the guidance developed for the general public. The CDC's *Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* was last updated on May 3, 2022. The CDC regularly updates this guidance. A list of updates can be found here: https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

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7. Please describe what FCI Danbury is doing to ensure that incarcerated individuals have access to specialty consultations and outside medical procedures. In addition, please state the number of incarcerated individuals at FCI Danbury who have sought a specialty consultation or outside medical procedure in three-month intervals from January 1, 2019 to the date on which responses to these Questions for the Record are submitted. For each request per three-month interval, please describe—

a. The nature of the request, including whether it was identified or otherwise classified as urgent or emergent.

b. The date on which the request was first made and any subsequent related requests.

c. The status of the request as of the date on which responses to these Questions for the Record are submitted. If a request was granted, please list the date on which it was granted.

Response: Specialty consultations at all institutions to include FCI Danbury go through a rigorous Utilization Review (UR) process. Health Services clinicians at FCI Danbury evaluate the patient to determine the need for specialty services. If clinically appropriate, a consultation request is generated containing all pertinent information to the respective patient and is sent to the UR meeting for review and potential approval. Once approved, the patient is scheduled with the specialty provider and escorted to the specialist for further evaluation and treatment. The Clinical Director at FCI Danbury provides oversight of the process to include any recommended treatments prescribed by the specialist.

Number of Consults (including those with specialists) for Outside Trips Completed for FCI Danbury				
Sent Date (Year)	**Start Date of Quarter**	**# of Routine Consults**	**# of Urgent Consults**	**# of Emergent Consults**
2019	1/1/10	102	32	14
2019	4/1/19	139	76	11
2019	7/1/19	126	53	17

2019	10/1/19	130	56	15
2020	1/1/20	112	51	21
2020	4/1/20	2	4	13
2020	7/1/20	78	38	7
2020	10/1/20	40	28	4
2021	1/1/21	94	38	5
2021	4/1/21	19	11	1
2021	7/1/21	30	33	4
2021	10/1/21	51	17	2
2022	1/1/22 (thru 5/4/22)	117	24	51

8. Please state the number of incarcerated individuals from FCI Danbury since May 12, 2020 (and as of the date on which responses to these Questions for the Record are submitted), identified as medically vulnerable pursuant to the temporary restraining order (TRO) issued in *Martinez-Brooks v. Easter*, No. 3:20-cv-00569 (MPS), 2020 U.S. Dist. LEXIS 83300 (D. Conn. May 12, 2020).

   a. Of the number of incarcerated individuals identified as medically vulnerable pursuant to the TRO [Question 5], how many were assessed for eligibility for home confinement under the CARES Act?

      Response: With regard to the TRO, the Home Confinement Committee separately reviewed 1,992 cases. Between March 2020 and April 2022, the Home Confinement Committee, and/or local home confinement committee, has reviewed more than 1,900 individual cases to determine vulnerability and eligibility at FCI Danbury.

   b. Of the incarcerated individuals assessed for eligibility for home confinement under the CARES Act [Question 5(a)], how many were determined to be eligible for home confinement under the CARES Act? For those not determined, pleased explain why not.

      Response: Of the TRO cases reviewed by the Home Confinement Review Committee, 1,992 medically vulnerable inmates were determined to have a medical risk factor to date (May 4, 2022). Since March 2020, FCI Danbury has released over 271 inmates to HC.

      Inmates are also reviewed for home confinement placement under the CARES Act on a case-by case basis and by balancing public safety against inmate safety with substantial weight assigned to COVID-19 risk factors. Each case is reviewed based on the totality of circumstances, including but not limited to the PATTERN recidivism risk level, current offense, history of violence, history of escapes, recent discipline history, and history of supervision violations. Inmates who do not meet all the criteria under the CARES Act can still be elevated to the Central Office Home Confinement Committee for secondary review, and, by balancing public safety against inmate safety with substantial weight assigned to COVID-19 risk factors, may still be approved for home confinement or RRC. For more information on CARES Act home confinement, please see section III(F)(4) in the 2022 annual FSA report available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

c. Of the incarcerated individuals determined to be eligible for home confinement under the CARES Act [Question 5(b)], how many were approved for home confinement under the CARES Act? For those not approved, please explain why not.

   Response: Over 271 of the 1,992 cases reviewed have been approved for placement on Home Confinement.

   As noted in the response to Question 8.b above, inmates are approved for home confinement based on an individualized assessment of a variety of factors. Based on review of these factors, inmates who are identified as having COVID-19 risk factors but also present a heightened risk to the community are not be approved for home confinement to ensure safety of the public. Additionally, inmates may generally not be approved for home confinement if they do not have a viable release plan (e.g. the caregiver declines to or disagrees with placement, the community contractor expected to monitor the placement does not have capacity, etc.). See also Question 5.d for specific reasons inmates were not transferred.

d. Of the incarcerated individuals approved for home confinement under the CARES Act [Question 5(c)], how many were transferred to home confinement under the CARES Act? For those not transferred, please explain why not.

   Response: All 271 inmates indicated above have been transferred to Home Confinement. Between March 2020 and April 2022, FCI Danbury transferred more than 271 inmates to home confinement.

   For inmates not released to home confinement the reasons are as follows:
   - Releases via Compassionate Release prior to being placed on home confinement;
   - Completion of sentence prior to receiving home confinement date;
   - Approved and pending home confinement date; and
   - Placement denied further along the process (i.e. the Residential Reentry Manager determined placement may not be appropriate for the community).

e. Of the incarcerated individuals transferred to home confinement under the CARES Act [Question 5(d)], how many are expected to be recalled to FCI Danbury at the conclusion of the pandemic emergency pursuant to the Department of Justice's Office of Legal Counsel Memorandum Opinion for the General Counsel of the BOP dated January 15, 2021?[10]

   Response: There are no immediate plans to bring inmates back to FCI Danbury. The CARES Act temporarily expanded the Bureau's authority to place eligible inmates on home confinement in response to the COVID-19 pandemic. As is widely reported, the Department's Office of Legal Counsel recently issued an opinion indicating that the Bureau may use its preexisting authorities and discretion to permit prisoners granted CARES Act Home Confinement to

[10] Memorandum Opinion for the General Counsel Federal Bureau of Prisons. Home Confinement of Federal Prisoners After the COVID-19 Emergency. Dept. of Justice. Jan. 15, 2021. https://www.justice.gov/sites/default/files/opinions/attachments/2021/01/17/2021-01-15-home-confine.pdf

continue such placements after declaration of the end of the COVID-19 Emergency. The Department of Justice is preparing regulations to implement this decision.

9. On January 6, 2021, I sent a letter to former FCI Danbury Warden, Diane Easter, expressing serious concerns about conditions at FCI Danbury following reported gas leaks and failures to effectively respond to the COVID-19 pandemic.

   The Warden's response, dated January 26, 2021, did not acknowledge whether FCI Danbury had a working smoke alarm or detection system at the Camp, and stated that the facility was using a "30-minute fire watch program." The Warden did acknowledge that no carbon monoxide monitor existed in the Camp and stated that FCI Danbury relied on checks with a portable monitor. While the Warden also acknowledged that there is a sprinkler at the Camp, she did not indicate where those sprinklers are located—such as the dorms. The Warden also failed to provide any information about whether smoke alarms or detection systems, carbon monoxide monitors, or sprinkler systems are in place in other areas at FCI Danbury.

   a. Please state whether FCI Danbury has working smoke alarms or detection systems.

      i. If so, please identify the specific areas at FCI Danbury in which they are located.

      ii. If not, please explain why not and whether BOP is working to install them or fix existing ones. If BOP is not working to install smoke alarms or detection systems or fix existing ones, please explain why not.

   Response: FCI Danbury currently has working smoke alarms at the FCI, FSL, and SCP. Working alarms are located throughout the institution and in every housing unit that inmates occupy. The SCP has installed a new fire panel (smoke alarm system), which was completed on June 3, 2021.

   Please state whether FCI Danbury has working carbon monoxide monitors.

      i. If so, please identify the specific areas at FCI Danbury in which they are located.

      ii. If not, please explain why not and whether BOP is working to install them or fix existing ones. If BOP is not working to install carbon monoxide monitors or fix existing ones, please explain why not.

   Response: Carbon monoxide detectors are not required by building standards and are therefore not installed at FCI Danbury. However, in the event carbon monoxide measurement is necessary for a given area, the Facilities Department can utilize a portable instrument that provides carbon monoxide and gas levels.

   b. Please state whether FCI Danbury has working sprinkler systems.

      i. If so, please identify the specific areas at FCI Danbury in which they are located.

ii. If not, please explain why not and whether BOP is working to install them or fix existing ones. If BOP is not working to install sprinkler systems or fix existing ones, please explain why not.

Response: The sprinkler system is active and in working order at all three facilities: the FCI, FSL, and FPC.

c. Please provide the number of inspections or checks that were conducted at FCI Danbury in three-month intervals between January 1, 2019 and the date on which responses to these Questions for the Record are submitted. For each three-month interval, please list the date on which the inspection or check occurred, the nature of the inspection or check that occurred, and whether any remedial action was recommended following the inspection or check. If remedial action was recommended, please describe whether such action was taken. If remedial action was recommended but not taken, please explain why not.

Response: FCI Danbury has a gas line inspection completed by a third-party contractor annually as required per Bureau policy. Annual inspections were completed on August 29, 2019, September 10, 2020, and August 10, 2021. No deficiencies or leaks were detected at the facility. All pipes were in good condition. Additionally, institution Facilities staff perform routine maintenance checks and conduct repairs, as needed. These inspections would identify issues related to gas line concerns.

10. Please describe FCI Danbury's—

a. Current COVID-19 screening procedures, including the frequency of temperature checks and symptom monitoring.

Response: Current screening procedures at FCI Danbury are consistent with the BOP COVID-19 Pandemic Plan, which the Bureau developed in consultation with the CDC. All staff are screened for symptoms upon arrival to the institution prior to entering the facility as indicated by the operational level in the matrix. All inmates are screened for temperature and symptoms at intake. All inmates in medical isolation and in exposure quarantine are screened daily for symptoms and are temperature checked. Inmates that are in pre-release and pre-transfer observation are screened for symptoms and temperatures upon entrance and exit of their observation period, they are also tested for COVID-19 when they enter observation and prior to their departure. FCI Danbury screened the general inmate population daily in conjunction with the settlement agreement until April 29, 2021, when the Bureau achieved its goal of offering COVID-19 vaccines to the entire inmate population and administering the vaccine to all interested inmates. Thermometers remain available in each housing unit and inmates can request to have their temperature taken at any time. Thermometers are also available in food service. Inmates can also request to have their temperature taken during mealtimes. This is in addition to normal sick call procedures available at FCI Danbury.

FCI Danbury also has rapid testing capabilities on-site. Inmates with symptoms suspected of COVID-19 can be tested as part of their medical assessment. Rapid tests are analyzed in-house.

FCI Danbury also utilizes the Bureau National Lab Contract with Quest diagnostics to analyze all commercial PCR tests.

Any symptomatic inmate would be placed in medical isolation, regardless of a positive or negative rapid test result. In these cases, a confirmatory PCR commercial lab test would be performed.

b. Current COVID-19 testing practices, including—

  i. How long after reporting symptoms an incarcerated individual receives a test;

  Response: FCI Danbury has rapid testing capabilities on site. Inmates with symptoms suspected of COVID-19 can be tested as part of their medical assessment. Under BOP guidance, any inmate reporting symptoms of COVID-19 is immediately transferred to medical isolation.

  ii. What personnel or organization conducts and analyzes COVID-19 tests for FCI Danbury; and,

  Response: Inmate tests are collected by FCI Danbury staff. Rapid tests are analyzed in-house by trained medical staff. FCI Danbury also utilizes the BOP National Lab Contract with Quest diagnostics to analyze all commercial PCR tests.

  iii. Whether an incarcerated individual who has been tested for COVID-19 but who has not yet received their results is placed in isolation or quarantine during the intervening days.

  Response: In accordance with CDC guidance, as soon as an inmate develops symptoms of COVID-19, they are placed under medical isolation in a separate environment from other individuals and medically evaluated. Inmates with symptoms are placed in medical isolation regardless of a positive or negative rapid test result and a confirmatory PCR commercial lab test is performed. If negative, the inmate will be evaluated for other etiologies for symptoms and the healthcare provider will use their clinical judgment to determine if the inmate patient may be released from medical isolation.

11. Please list each date on which FCI Danbury conducted facility-wide testing for COVID-19.

Response: In order to mitigate the spread of COVID-19, mass testing was completed on all inmates at the facility on between May 26 and May 28, 2020 and again on December 2, 2020. Since that time, the facility continues to test all inmates as they arrive and utilizes numerous other mitigation efforts and strategies (i.e. testing, social distancing, face covering, and vaccination) to control the spread of the virus. Additionally, during another outbreak in December 2021, mass testing was performed at FPC Danbury on 12/21/2021. Individual testing for symptomatic inmates was also completed on 12/24/2021 and 12/26/2021. Mass testing was again completed at the FPC on 12/27/2021.

12. Please provide an assessment of FCI Danbury's current social distancing, isolation, and quarantine measures, including—

    a. Cleaning and sanitation procedures;

    b. An accounting of isolation and quarantine spaces; and,

    c. Contingency plans for handling an increase in the number of incarcerated individuals who are awaiting COVID-19 test results or who have tested positive for COVID-19.

    Response: FCI Danbury follows the BOP COVID-19 Pandemic Plan, which is aligned with the latest CDC guidance as it relates to social distancing, all medical isolation and quarantine measures, including cleaning and sanitation procedures. Specifically, Module 4 (Inmate Isolation and Quarantine) of the BOP COVID-19 Pandemic Plan addresses medical isolation and quarantine procedures, Module 1 (Infection Prevention and Control Measures) addresses environmental cleaning and disinfection procedures and social distancing measures. When necessary, housing units and quarantine/isolation space is adjusted accordingly to accommodate the number of medically isolated and/or quarantined inmates.

13. You last appeared before the Committee on June 2, 2020. I submitted Questions for the Record on June 9, 2020. You did not submit responses to those Questions for the Record until February 17, 2021.

    Response: We apologize for the delay. We are committed to timely responses and will continue to work with your office to answer all inquiries as expeditiously as possible.

Senator Booker

1. PATTERN is the risk assessment tool that was designed under the First Step Act for good time credits. It has been used for home confinement and compassionate release during the pandemic, but serious concerns exist around the design and development of the tool. Specifically, the First Step Act called for a risk and needs assessment tool to assess the risk that an incarcerated person will recidivate, but PATTERN instead predicts the risk of any arrest or return to BOP custody following release. Due to racial disparities in policing, including minor offenses and violations, PATTERN overestimates the risk of people of color, people with mental health or substance abuse challenges, and unhoused people.

   During your testimony to this Committee in April 2021, you stated that "PATTERN goes under review every year, and is being assessed right now," and that "our staff are involved in [that review]." You also testified that "there were some adjustments made [to PATTERN] in January 2020, there was a perceived or actual bias against people of color, so they removed two pieces of [the PATTERN tool]."

   a. Did BOP staff recommend the removal of the two pieces of the PATTERN tool in January 2020? If not, what was their role in the assessment of the tool and decision to remove the two pieces?

Response: As reported in *The First Step Act of 2018: Risk and Needs Assessment System – Update January 2020,* found on bop.gov at: https://www.bop.gov/inmates/fsa/docs/the-first-step-act-of-2018-risk-and-needs-assessment-system-updated.pdf, and following input from the IRC and stakeholders in 2019 about the version of the PATTERN tool proposed in July 2019, the Department removed two variables in furtherance of its commitment to ensuring that PATTERN is fair and accurate:

- Age of first arrest/conviction, and
- Voluntary surrender.

These changes reduced PATTERN's predictive accuracy by approximately one percent. Bureau staff worked collaboratively with National Institute of Justice (NIJ) staff, as well as their expert contractors to support development of the original PATTERN instrument and assisted the research staff in analyzing the recommendation to remove those two criteria, which was ultimately presented to the Department for final approval. The revised PATTERN tool was then finalized and published in January 2020, and the BOP assessed all inmates using the revised tool, known as "PATTERN 1.2."

Over the following months in 2020, as part of the annual PATTERN revalidation effort, the NIJ's research experts began conducting several analyses of the PATTERN 1.2 tool. The BOP's Office of Research and Evaluation (ORE) worked with the NIJ consultants and the BOP's Correctional Programs Division to develop a PATTERN simulation tool to enable ORE to assist NIJ consultants in validating PATTERN and comparing test results. By January 2021, the NIJ consultants had identified several coding, specification, and scoring discrepancies in PATTERN 1.2 and recommended immediate corrections to the BOP. The BOP adopted these recommendations, updating its field guidance and scoring sheets with the corrections made to the item and scoring typos, thereby refining the tool into version "PATTERN 1.2-Revised" (1.2-R). The BOP then began to reassess the risk scores for all inmates who were affected by the prior scoring errors. By June 2021, PATTERN 1.2-R was in full implementation.

In March 2021, the team of expert consultants contracting with NIJ throughout 2020 began their annual 2021 review and revalidation study for PATTERN 1.2-R. Upon review of that tool, they proposed a refined version of the tool, PATTERN 1.3, because although version 1.2-R had been revised to correct item and scoring errors that the NIJ consultants identified in 2020, version 1.2-R maintained the scoring scheme developed for version 1.2. The consultants' full revalidation report is accessible at NIJ, *2021 Review and Revalidation of the First Step Act Risk Assessment Tool* (Dec. 2021), https://www.ojp.gov/pdffiles1/nij/303859.pdf.

PATTERN 1.3 has been recently implemented and the Attorney General has directed the continued study of the tool to improve the equitability, efficiency, and predictive validity of the risk assessment system. For more information, please see section II of the 2022 annual

FSA report available at https://www.bop.gov/inmates/fsa/docs/First-Step-Act-Annual-Report-April-2022.pdf.

b. Are there further aspects of the PATTERN tool that you and your staff have identified as contributing factors to the ongoing racial bias in the PATTERN tool? If so, how have you expressed these contributing factors to the Department of Justice (DOJ) during its ongoing yearly review of the PATTERN tool?

Response: See the answer above, and the Department's 2022 annual FSA report for a thorough discussion of this issue.

c. PATTERN was created before COVID-19. Has it ever been adjusted to take medical vulnerability to COVID or other COVID-related factors into account?

Response: There have been no adjustments made to PATTERN to take medical vulnerability to COVID-19 or other COVID-19-related factors into account when determining risk of recidivism.

d. The inclusion of low-level arrests and technical violations of parole terms creates racial biases that are built into PATTERN. The BOP has said in the past that it lacks access to the case disposition data necessary to exclude acquittals or arrests not resulting in charges. What steps will you take to ensure PATTERN only uses data from adjudicated cases involving serious crimes?

Response: The Department is committed to making all necessary revisions and updates to the risk assessment system to ensure that it continues to show accuracy and predictive validity, while also ensuring that any racial disparities associated with the instrument are reduced to the greatest extent possible, as required by the FSA. 18 U.S.C. § 3631(b)(5). As part of future revalidation analyses, the Department will engage with the NIJ consultants, the Department's subject matter experts, BOP staff, and external stakeholders and experts, to consider further refinements to the tools' inputs and scoring scheme, as well as an evaluation of the definition of recidivism used by the instrument itself. For more information on this issue, please see the Department's 2022 annual FSA report.

2. During your testimony to this Committee in April 2021, you discussed some of the precautions that BOP has taken at FCI Fort Dix to follow CDC guidelines to reduce the number of incarcerated individuals and guards who test positive for COVID-19. I am particularly concerned about incarcerated individuals who have tested positive for COVID-19 being placed in solitary confinement to keep them isolated.

   a. What steps has the BOP taken to ensure it is following the CDC's guidance to place people in medical isolation—not solitary confinement or restrictive housing—when separation is necessary because of known or suspected COVID-19 infection?

Response: In accordance with CDC guidance, as soon as an inmate develops symptoms of COVID-19 or tests positive for SARS-CoV-2, they are placed under medical isolation in a separate environment from other individuals and medically evaluated. Medical isolation is distinct in both terminology and operational practice from restrictive housing.

Patients in medical isolation may be housed individually or as cohorted pairs or groups. If medical isolation in single cells is necessary, Psychology Services staff are consulted to ensure inmates proposed for single-celling are not particularly vulnerable individuals.

b. What steps has the BOP taken to ensure that proper medical care and other services are available, and that incarcerated people do not conceal possible COVID-19 symptoms because they fear being placed in solitary confinement?

Response: Medical isolation is operationally distinct from restrictive housing, with different conditions of confinement, even if the same cells are used for both. Medical isolation is a health-safety measure, whereas restrictive housing has increased and differing security procedures and modified access to personal property items, radios, commissary, etc., which is determined locally. The Bureau COVID-19 Pandemic Plan instructs institutions to:

- Ensure individuals under medical isolation, quarantine, and/or restrictive housing receive daily visits from medical staff.
- Ensure individuals under medical isolation, quarantine, and/or restrictive housing have access to both routine and urgent mental health services.
- Provide individuals in medical isolation or quarantine similar access to radio, TV, reading materials, personal property, and commissary as would be available in the individuals' regular housing units, to the extent possible.
- Allow increased telephone privileges, to the extent possible, without a cost barrier to maintain mental health and connection with others while isolated.

3. To date, more than 60 percent of incarcerated individuals at Fort Dix have tested positive for COVID-19. Additionally, as of April 20, 2021, there are 40 active COVID-19 cases among the Fort Dix staff, indicating a hesitance among the staff to receive the vaccine.

a. What is the timeframe and plan to offer the vaccine to all incarcerated persons?

Response: The Bureau has made the COVID-19 vaccine available to all incarcerated persons in BOP managed institutions. The BOP has completed a mass vaccination campaign and has transitioned to a micro-vaccination campaign to continue offering the vaccine to the inmates and those who have not accepted the vaccine, as well as new inmate intakes and new staff hires. Throughout the Bureau, more than 28,400 staff and more than 94,400 inmates have been fully vaccinated. As of June 30, 2022, 443 staff and 2469 inmates at FCI Fort Dix are fully vaccinated.

b. How many incarcerated persons have declined an offer of the vaccine to date?

Response: As of June 29, 2022, there are 37,058 incarcerated persons in the Bureau who have refused vaccination, including 551 at FCI Fort Dix who have signed a refusal of vaccination. The Bureau continues to encourage vaccination of all staff and inmates through a variety of methods. The BOP has also partnered with the CDC, resulting in the CDC presenting strategies to institution staff to overcome vaccine hesitancy within the Bureau. All staff and inmates who previously refused the vaccine may still request and receive the vaccine.

c. What educational materials regarding the vaccine have been distributed to incarcerated persons?

Response: The Bureau provided several flyers as well as a frequently asked questions document to institutions to be hung on inmate bulletin boards. Additionally, the same flyers and documents were posted to electronic message boards accessible to inmates. Institutions have also been providing information in a variety of in-person settings to inmates, including a video with Director Carvajal and a Public Health Service officer encouraging inmates to receive the vaccine.

d. What educational materials regarding the vaccine have been distributed to BOP staff?

Response: A variety of educational materials including frequently asked questions regarding the vaccines, which is accessible on the internal web site, have been provided to staff. The Bureau Director has addressed the issue in meetings with leadership and institution staff and issued several videos to all staff encouraging vaccination. One of these videos, titled "Get Vaccinated" featured information about the safety and efficacy of the vaccines and included Bureau Director Carvajal, a Public Health Service staff member and Bureau staff from across the country discussing why they were vaccinated against COVID-19, the importance of doing so, and dispelled myths regarding the vaccines.

<u>Senator Cruz</u>

1. At the hearing, I asked you whether the Bureau of Prisons and the Department of Homeland Security are deporting criminal aliens, once released from BOP custody. You assured me that BOP does indeed keep records about whether criminal aliens are, upon release, transferred to DHS for deportation, or released into the American public. Please provide:

a. Information on the current process undertaken in preparation for the release of criminal alien inmates, including coordination with DHS.

Response: The Bureau of Prisons receives information from Immigration and Customs Enforcement (ICE) to assist the Bureau in determining eligibility for inmates in the Institutional Hearing Program (IHP). Unit staff provide notification to the ICE designated Point of Contact (POC) regarding inmates arriving at a Bureau facility that requires an ICE

interview within 30 days (from the date of notification) and request a final disposition regarding IHP eligibility be provided. Inmates serving sentences of 60 months or less will be designated to an IHP site for a hearing before an Immigration Judge to determine deportation status. Inmates serving 18 months or less at an IHP site will normally remain at the hearing site for release processing. Sixty to ninety days prior to an inmate's release from federal custody, Bureau staff will contact ICE to verify ICE detainers and coordinate the transfer of inmates to ICE upon release from Bureau custody.

b. Bureau of Prison data reflecting the percentage of criminal alien inmates who, upon release, are released into the public, versus the percentage who are transferred to DHS for deportation.

Response: Noncitizen inmates with a deportation order are released to ICE upon completion of their sentences. The Bureau does not maintain data on inmates released into the public by ICE.

2. As I mentioned at the hearing, the Biden administration's political decisions are having serious consequences. We discussed what my colleagues and I saw at the border, observing the crisis. We also discussed how these decisions will be impacting BOP and our criminal enforcement agencies. To the point: the Biden administration has issued an executive order summarily banning and prohibiting private operators and contractors from Federal facilities into the future.

Your testimony, as I understand it, was that private contract facilities are safe, reliable, and consistently up to BOP needs and standards.

a. Has the Biden administration provided BOP with an explanation for its summary cancellation of private contractor operations? If so, please provide that explanation.

Response: Executive Order (E.O.) 14006 broadly directs that the Department of Justice not renew contracts with privately-operated criminal detention facilities, as consistent with applicable law. Consistent with this order, the Bureau will allow existing contracts with private detention facilities to expire in accordance with the terms of each contract. The Bureau's population has experienced a downward trend over the last decade and adequate bed space currently exists within Bureau's own inventory to accommodate private facility inmate populations.

In particular, many are concerned about the operations of the Marshals Service, which rely on private operators to fulfill unique mission needs, including in the big, wide State of Texas.

b. Has the Biden administration provided any instruction on how BOP is to address the looming logistical complications of the Executive Order; namely, concerns that BOP does not have the bed space, transportation infrastructure, or facilities with sufficient access to the courts and legal representation, to meet the needs of USMS' operations and mission? If so, please provide those instructions.

Response: The Bureau of Prisons has a current rated capacity of 135,704 beds. As of June 29, 2022, we have 140,332 inmates housed in Bureau managed facilities. The rated capacity does not include some beds in the design capacity of institutions, such as 14,871 secure Special Housing Units (SHU) beds, nor does it include community-based capacity (halfway house or home confinement).

The USMS have requested ongoing assistance from the BOP with absorbing prisoners housed at USMS contract jails in preparation for the expiration of many of those contracts. The BOP has also allocated beds at USP Lewisburg (350), USP Leavenworth (800), FCI Butner (200), and USP Victorville (512) to provide additional options for the USMS to house their pre-trial prisoners. These beds are in addition to the 1,200 beds allocated at 18 other facilities. The BOP, USMS, and JPATS have always worked closely together in coordinating inmate transportation between the BOP and the USMS. As a result of the Executive Order, increased efforts have been made to move more inmates from contract jails to BOP facilities. The BOP encourages the USMS to maximize the use of all beds that have been allocated to them.

Senator Feinstein

1. At the hearing, you described some of the extraordinary measures that had to be taken at Federal Correctional Institution (FCI) Terminal Island, where some seventy percent of the inmate population has tested positive for COVID-19. (OFFICE OF THE INSPECTOR GENERAL, U.S. DEPARTMENT OF JUSTICE, Pandemic Response Report No. 21-1025, *Remote Inspection of Federal Correctional Institution Terminal Island* at iii (Jan. 2021), *available at* https://oig.justice.gov/sites/default/files/reports/21-025.pdf) Among other things, you mentioned having to house inmates in tents within the facility's perimeter. As you put it, "COVID was new to everybody" last year, and you "wish[ed] [you] knew then what [you] know now about it."

    a. What policies, procedures, practices, and protocols does the BOP have in place now that it did not prior to the COVID-19 outbreak that would allow it to protect the health of its inmates if another pandemic with similar attributes (e.g., a new, more virulent strand of COVID-19) were to arise?

    Response: Although the Bureau had a pandemic emergency plan prior to the COVID-19 pandemic, it has been greatly expanded through development of the Bureau's COVID-19 Pandemic Plan and ongoing consultation with the CDC. The pandemic plan is a broad-sweeping plan that can be utilized in whole or part to provide guidance for facilities on procedures and practice for mitigating and containing widespread transmission of SARS-CoV-2 and non-COVID infectious disease threats. The pandemic plan is scalable and adaptable to a variety of disease/virus characteristics and will continue to be modified and developed as a general response plan for current and future threats and as updated CDC guidance becomes available.

b. Has the BOP documented in writing the lessons learned from the COVID-19 pandemic to inform future decision-making? If so, please provide this document. If not, why not?

Response: The Bureau continues to review its COVID-19 Pandemic Plan and has made updates based on CDC guidance. As the pandemic is not over and the Bureau is updating its response to include vaccine distribution, the BOP has not yet completed a post-response review, but has continuously adapted its operations in accordance with the latest CDC guidance and public health recommendations. The Bureau is also documenting best practices for institutions and conducting reviews to ensure facilities are adopting those measures and following required protocols.

2. I have received several complaints about the quality of the medical care provided at FCI Lompoc during the pandemic as well as its compliance with preventive measures designed to protect the inmate population from COVID-19. Among other things, I have heard that inmates at Lompoc with COVID-19 are denied palliative care and that social distancing is not maintained there.

   a. Do the medical personnel at FCI Lompoc, and at BOP facilities in general, provide palliative care to inmates with COVID-19? If so, what policies, procedures, practices, or protocols govern their provision of such care? If not, why not?

   Response: If an inmate meets the criteria for palliative care, regardless of COVID-19 status, they will be offered that care per the current Bureau procedures.

   b. What measures does the BOP have in place to measure compliance with its current policies, procedures, practices, and protocols concerning the pandemic, and how does it hold facilities and employees accountable for any failures in this regard?

   Response: The Bureau began using COVID-19 Compliance Review Teams (CCRT) to assess compliance, monitor response, and develop additional mitigation strategies to the COVID-19 pandemic to keep staff and inmates safe. Eighty-seven (87) initial site reviews were completed by October 2, 2020, and more than 30 follow-up reviews have also been completed. Recommendations and best practices for preventing and reducing transmission of COVID-19 were gathered and disseminated to all BOP facilities. All staff are required to follow Bureau policies and procedures. Staff not appropriately following policies or procedures would be corrected and could be subject to disciplinary action for continued noncompliance.

3. You testified that approximately 24,000 inmates have been transferred to home confinement and that the BOP has "reviewed everyone who is eligible" and has a COVID-19 risk factor. You further stated that, if you "had to make a guess," you would "say 50 to 75 percent" of eligible inmates "have been reviewed at this point." You also mentioned that many inmates were categorically disqualified from placement home confinement based on "four criteria."

a. As of today, how many inmates eligible for home confinement has the BOP reviewed for placement in home confinement? Please provide your response both in raw numbers and as a percentage of the overall inmate population.

   Response: All inmates eligible for home confinement placement under the CARES Act were reviewed according to criteria outlined by the Attorney General to include COVID-19 risk factors. Further, as COVID-19 risk factors changed or as inmates' individual circumstances changed, inmates were re-reviewed, referred, and placed as appropriate. With regard to the current population in Bureau custody within an institution, as of July 1, 2022, 116,173 (91%) of 127,524 inmates eligible for review have completed reviews, where a determination regarding eligibility has been made.

b. Of that total, how many inmates had at least one COVID-19 risk factor, and how many did not? Please provide your response both in raw numbers and as a percentage of the overall number of inmates eligible for home confinement.

   Response: The Bureau does not track aggregate data for how many inmates have at least one verified COVID-19 risk factor, as inmate reviews for CARES Act home confinement are an individualized process and COVID-19 risk factors include sensitive medical information. Additionally, some inmates may be excluded from placement eligibility prior to a medical assessment due to exclusionary factors including but not limited to pending charges, law enforcement or immigration detainers, no viable release plan, recent institution misconduct, violent/terrorism/sexual offenses, and/or the totality of the current offense to include victims, sentencing enhancements, and other community safety concerns.

c. Assuming less than 100 percent of inmates eligible for home confinement have not been reviewed for placement yet, when do you expect to have reviewed every eligible inmate for placement in home confinement (understanding that inmates will become newly-eligible for home confinement over time)?

   Response: All inmates identified as meeting criteria under the Attorney General's March 26, 2020 memorandum have been reviewed. The Bureau has since expanded review of inmates for eligibility for placement on home confinement under the CARES Act into an ongoing and dynamic process by staff at each institution, as inmates who do not currently meet the factors for automatic consideration may become eligible for such consideration in the future. Bureau staff continuously review the inmate population for those who may be newly eligible for review based on a COVID-19 risk factor, a change in PATTERN score, or other changes affecting eligibility. All inmates receive an initial review within 28 days of arrival at their designated facility and are subsequently reviewed a minimum of every 180 days thereafter. During these reviews, eligibility for home confinement is among the criteria reviewed by the assigned case manager.

d. What criteria did the BOP use to categorically disqualify certain inmates from home confinement? Please be specific.

Response: The following discretionary factors are to be assessed to ensure inmates are suitable for home confinement:

- Reviewing the inmate's institutional discipline history for the last twelve months (inmates who have received a 300 or 400 series incident report in the past 12 months may be referred for placement on home confinement, if in the Warden's judgement such placement does not create an undue risk to the community);
- Ensuring the inmate has a verifiable release plan;
- Verifying the inmate's current or a prior offense is not violent, a sex offense, or terrorism-related;
- Confirm the inmate does not have a current detainer;
- Ensuring the inmate is Low or Minimum security;
- Ensuring the inmate has a Low or Minimum PATTERN risk score;
- Ensuring the inmate has not engaged in violent or gang-related activity while incarcerated;
- Reviewing the COVID-19 vulnerability of the inmate, in accordance with CDC guidelines; and
- Confirming the inmate has served 50% or more of their sentence; or has 18 months or less remaining on their sentence and have served 25% or more of their sentence.
- If an inmate does not meet one or more of the above and the Warden determines if there is a need to refer an inmate for placement in the community due to COVID-19 risk factors, they may forward the referral to the Correctional Programs Division for further review.

4. In your written statement and at the hearing, you stated that "[a]t this point, all Bureau staff have been offered one of the COVID-19 vaccines" and that you expect all inmates to have been provided the opportunity to be vaccinated "by mid-May," but that you could not force employees or inmates to take one of the vaccines because they have received only an emergency use authorization from the U.S. Food and Drug Administration. At the hearing, you testified that at least "a little bit over 51 percent" of the BOP workforce have taken a COVID-19 vaccine and that the BOP has "done a campaign effort" in support of vaccination involving "video messages," but that the BOP does not track "staff . . . who received the vaccine on their own through their own care provider."

   a. Do you require or encourage BOP employees to report whether they have received a COVID-19 vaccine from their own health care provider? If not, why not?

   Response: Since my prior written statement and hearing testimony, President Biden signed Executive Orders mandating vaccinations for all DOJ employees and DOJ. In accordance with that Executive Order, all BOP employees are required to provide

proof of COVID-19 vaccination. BOP established a Staff COVID-19 Vaccine Verification Portal, whereby all staff that were not vaccinated through the BOP were required to attest to and submit proof of their vaccination status. By late March, BOP's workforce was at 80% vaccinated. In January 2022, a district court preliminarily enjoined Executive Order 14043 on *Requiring Coronavirus Disease 2019 Vaccination for Federal Employees*. While a panel of the U.S. Court of Appeals for the Fifth Circuit issued an opinion reinstating Executive Order 14043 in early April, on June 27, 2022, the Fifth Circuit granted rehearing en banc and vacated the panel decision. Therefore, BOP has halted enforcement but continues all efforts to encourage vaccination.

b. What, if any, additional protections beyond those generally offered to inmates have you provided for inmates who have not yet been offered the vaccine and are forced to interact with employees who have not been vaccinated on a regular basis?

Response: Consistent with CDC guidance for correctional and detention facilities, and without consideration of vaccination status, the Bureau continues to require masks and PPE where and when appropriate for all staff and inmates. In addition, the Bureau continues to employ other CDC measures to include cleaning and disinfecting, social distancing, and screening for symptoms and temperature checks including requiring every staff member and contractor to complete a temperature check and screening prior to entering any Bureau facility.

5. You explained in your written statement that "15 Federal Prison Industries . . . factories were converted to [personal protective equipment (PPE)] production for cloth face coverings, gowns, face shields, and hand sanitizer," which allowed the BOP "to be more self-sustaining in production areas rather than burdening the public supply chain."

a. How many BOP employees have been issued only cloth face coverings, and how many have been issued N95, KN95, or other types of face coverings providing equivalent protections? Please provide your response in both total numbers and as a percentage of the BOP workforce and specify the different types of face coverings received by BOP employees.

Response: Since April 2020, all Bureau managed institutions have been following CDC guidance requiring the wearing of face coverings. More recently, in light of updated CDC guidance, in addition to the double layered cloth face covering, KN-95 and/or surgical masks have been made available to all staff and inmates upon request. N-95 respirators are reserved to be utilized as part of the Personal Protective Equipment (PPE) based on exposure risk while maintaining the safety and security of the institution.

b. How many inmates in BOP custody have been issued only cloth face coverings, and how many have been issued N95 or KN95 face coverings? Please provide your response in both total numbers and as a percentage of the BOP inmate population and

specify the different types of face coverings received by inmates.

Response: The Bureau has continued to follow CDC guidance with respect to the wearing of face coverings, and KN-95 and/or surgical masks have been made available to all staff and inmates upon request. N-95 respirators are reserved to be utilized as part of the Personal Protective Equipment (PPE) based on exposure risk while maintaining the safety and security of the institution. The Bureau conducted hazard assessments to determine the type of masking appropriate for different environments and staff and inmates are provided N95 masks as well as other PPE as indicated by the assessment and associated guidance. The Bureau does not track the number of masks issued to inmates and staff.

6. As we have learned more about the COVID-19 pandemic, it has become increasingly clear that its effects on the health of those infected with the virus can be felt for weeks and even months after the first wave of symptoms abate. These health effects are no less serious, and require no lesser an amount of medical attention, than the immediate symptoms many people suffer.

    a. How many inmates in BOP custody have developed long-term medical effects from COVID-19? Please provide your response in both total numbers and as a percentage of the BOP inmate population.

    Response: It is challenging to quantify how many inmates in BOP custody have developed long-term medical effects from COVID-19, because most, if not all, of these medical effects are in fact the progression or worsening of other disease states. In August of 2021, the BOP's Medical Director issued a memo to the field introducing and urging medical providers to start using ICD-10 code U09.9 Post-Acute Sequelae of COVID-19 to identify patients suffering from post-COVID conditions. We currently have 290 patients who been diagnosed with a post-COVID condition (0.21% of BOP inmate population). The CDC has continued to recognize the evolving science of post-COVID conditions, which is an umbrella term for a wide range of health consequences. Inmates with post-COVID conditions are seen by a medical provider every 6-12 months (or more often as clinically indicated) and treatment is individualized to their unique disease states.

    b. What policies, plans, practices, procedures, or protocols do you have in place to treat inmates with lasting medical effects from COVID-19? Please be specific and provide any documentation in support of these policies, plans, practices, procedures, or protocols.

    Response: The clinical presentation for post-acute COVID-19 sequalae will vary from respiratory, neurologic, cardiovascular, renal, or gastrointestinal symptoms. Some individuals who suffered severe COVID-19 illness may develop complications such as

blood clotting, myocardial injury, liver injury, renal injury requiring long-term dialysis, and neurological injuries such as strokes, confusion, and anxiety.

The BOP's COVID-19 Pandemic Plan, developed in consultation with the CDC, addresses long-term consequences of COVID-19 in the Response Plan Overview. Patients will be treated according to their clinical presentation of post-acute COVID-19 complications-based community standards.

7. According to a recent Government Accountability Office report, in November of 2020, there were only 37,000 staff responsible for the 125,000 inmates in BOP custody. (GOVERNMENT ACCOUNTABILITY OFFICE, Report No. GAO-21-123, *Bureau of Prisons: Opportunities Exist to Better Analyze Staffing Data and Improve Employee Wellness Programs* at 1 (Feb. 2021), *available at* https://www.gao.gov/assets/gao-21-123.pdf). You said in your written statement and reiterated at the hearing that the BOP has "launched a new hiring initiative" to fill 100 percent of its "authorized positions at all [BOP] institutions nationwide."

   a. When do you expect to have filled all or nearly all of the vacant positions within BOP institutions nationwide?

      Response:
      The Department has made BOP hiring a priority. In 2020, BOP hired more than 3,800 new staff. For calendar year 2021, BOP hired just under 3,000 new staff members. During FY21 and while operating under the FY2022 Continuing Resolution, BOP worked to maintain staffing levels since its funding did not support increases in staffing. Now that BOP has an FY2022 appropriation, it can fund more staff and is developing a spend plan that includes an emphasis on increased hiring.

      As of March 29, 2022, BOP has 36,712 funded positions and has 36,090 onboarded staff. BOP estimates that the additional FY22 funding that it received will enable it to fill 93% of all authorized (38,884) positions. This is an increase from its FY2021 funding allowing it to fill 90% of authorized positions.

   b. In addition to offering a five percent retention incentive for employees eligible to retire in 2019 and expanding its use of its special pay authority under title 38 of the U.S. Code to include all employed physicians and dentists, what, if any, actions is the BOP taking in support of its hiring initiative?

      Response: BOP is conducting extensive outreach and targeted hiring campaigns. It hired a consultant to conduct innovative and targeted marketing and recruitment campaigns to attract new staff in all positions. The recruitment campaigns involve extensive use of social media, job fairs, and industry associations, and were a key to BOP's success in hiring in 2020 and 2021. In

addition, BOP has a 21-person national recruitment office that works exclusively on BOP recruitment.

c. What, if any, new authorities would be helpful to the BOP in pursuing its hiring initiative?

Response: One area that would be beneficial to assist with the Bureau's difficulty in filling mission critical positions would be waiving the payment limitation on the recruitment incentives of 25 percent of an employee's annual rate of basic pay multiplied by the number of years in the service period. With OPM approval, this cap may be increased to 50 percent based on a critical agency need, as long as the total incentive does not exceed 100 percent of the employee's annual rate of basic pay at the beginning of the service period. OPM may also waive the payment limit for retention incentives to allow payments of up to 50 percent. OPM recently approved a request to waive the normal payment limitation on retention incentives for six facilities that have been chronically difficult to staff. The Bureau is also exploring the possibility of requesting that OPM approve special rates of pay for mission critical occupations that are difficult to fill. The majority of our hard to fill prisons are geographically situated in remote locations. These prisons are faced with recruitment barriers such as high cost of living; competitive salaries; the public/private sector offering negotiable incentives and/or benefit packages. On the other end of the spectrum, some prisons are situated in communities offering less than desirable living conditions, poorly rated school systems, or lack of childcare, resulting in employees seeking residence in communities with suitable living opportunities.

8. The Department of Justice's Inspector General reported in 2018 that BOP facilities were ill-equipped to address the needs of female inmates—in particular, with respect to trauma treatment, pregnancy programming, and hygiene. (OFFICE OF THE INSPECTOR GENERAL,
U.S. DEPARTMENT OF JUSTICE, *Review of the Federal Bureau of Prisons' Management of Its Female Inmate Population*, at i (Sept. 2018), *available at* https://www.gao.gov/assets/gao-21-123.pdf)

a. Since the release of the Inspector General's report, what steps has the BOP taken to address these issues?

Response: The Bureau has made considerable progress in implementing both the First Step Act as it applies to female offenders and the recommendations of the OIG report on this population.

The Bureau has an entire office, the Women and Special Populations Branch, devoted to these issues. The office is fully staffed, and the Bureau has also created positions

located at institutions specifically to deliver gender-responsive services to female inmates. Pursuant the passage of FSA, 13 field positions have been established.

The Bureau requires facilities housing female offenders to deliver the Resolve Program, a gender-responsive, cognitive-behavioral intervention program for those who have experienced trauma. The Resolve Program is offered at all institutions housing designated female inmates.

The Bureau also hosts the Female Integrated Treatment (FIT) Program at FSL Danbury and SFF Hazelton, where women receive holistic trauma, vocational, drug, and mental health services.

Regarding pregnancy programming, in February 2019, the Director of the Bureau of Prisons issued a memorandum ordering the prohibition of the use of restraints on pregnant and post-partum female offenders unless under exigent circumstances. Also, within 48-hours after confirmation of an inmate's pregnancy, an inmate must be notified of restrictions on restraints. In 2019, the Bureau began entering medical identifiers into the SENTRY database to alert all staff once a female inmate was determined to be pregnant or post-partum and track information on pregnant inmates. The Bureau has also developed a National Parenting Program with modules designed specifically for mothers and expectant mothers and developed resource information for pregnant inmates regarding available services and programming. Staff training has been delivered focusing on addressing the unique needs of pregnant women, maximizing programming participation and increasing referrals to the MINT (Mothers and Infants Together) and RPP (Residential Parenting Program).

The provision of feminine hygiene products in the Bureau was initially addressed in annual Operations Memoranda entitled "Provision of Feminine Hygiene Products" which provided guidance on specific feminine hygiene products to be provided to female inmates. This requirement was then incorporated into the revised Program Statement 5200.02, Female Offender Manual which was issued May 12, 2021. This guidance applies to all facilities housing female inmates and makes clear that Wardens will ensure inmates are provided the following products (easily, readily, and at no cost to the inmates): tampons, regular and super-size; Maxi pads with wings, regular and super-size; and panty liners, regular.

b. Does trauma treatment (regardless of the gender of the recipient) improve inmate behavior overall? Does it reduce recidivism? Please explain the basis for your answers.

Response: The Bureau is currently in the initial stages of conducting a study to address the impact of trauma treatment on inmate behavior and recidivism.

The Bureau recognizes an individual's day-to-day ability to function, their mental and physical health as well as their interpersonal relationships, can be significantly impacted by their exposure to past, and present, violence and trauma. As a result, the individual's ability to develop functional and prosocial strategies for coping can be undermined. Often negative coping strategies such as substance use and aggression, have led to criminal justice involvement and a may result in the diagnosis of Posttraumatic Stress Disorder (PTSD), an anxiety disorder, which can raise the risk of recidivism among those who have been incarcerated.[1]

Seeking Safety, a component of the Bureau's Resolve Program, is considered an evidence-based program by the SAMHSA's National Registry of Evidence-based Programs and Practices. The California Evidence-Based Clearinghouse classifies the program as "supported by research evidence." A meta-analysis, or a statistical analysis of findings from 12 quantitative studies found that the Seeking Safety treatment model was more effective in decreasing PTSD symptoms than no treatment or alternative treatments.[2] Decreased drug use also is associated with participation in the Seeking Safety model.[3] A study of incarcerated women found that those who participated in Seeking Safety showed a significant decrease in PTSD symptoms from pre- to post-treatment and nine of 17 participants no longer met the diagnostic criteria for PTSD at the end of treatment.[4] Additional research can contribute to a stronger understanding of how effective trauma treatments being used within prisons might be adapted to meet the needs of those who are incarcerated. In addition to helping incarcerated individuals cope with and heal from trauma, research suggests that trauma-informed PTSD programs may reduce incarceration rates by helping to alleviate symptoms that can lead to criminality and recidivism.

9. Your written statement also references an effort to "develop[] and implement[] a reliable method for calculating staffing levels and . . . identify and address the causes and potential impacts of staffing challenges on staff and inmates."

    a. In the absence of a "reliable method for calculating staffing levels," how does the BOP do so today?

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[1]Ardino, V. (2012). Offending behaviour: The role of trauma and PTSD. European Journal of Psychotraumatology. 3.; Widom, C.S., & Maxfield. M.G. (2001). An update on the "cycle of violence". Washington, DC: U.S. Department of Justice, National Institute of Justice.

[2]Lenz, S., Henesy, R., & Callendar, K. (2016). Effectiveness of Seeking Safety for Co-Occurring posttraumatic Stress Disorder and Substance Use. Journal of Counseling & Development, 94(01), 51-61.

[3] Lenz, S., Henesy, R., & Callendar, K. (2016). Effectiveness of Seeking Safety for Co-Occurring posttraumatic Stress Disorder and Substance Use. Journal of Counseling & Development, 94(01), 51-61.

[4] Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M. (2003). A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study. Journal of Substance Abuse Treatment, 25, 99-105

Response: Staffing levels are determined by department subject matter experts and take into consideration several factors, which include institution security level, institution mission, required inmate programming, structural layout, custody posts, medical/psychological care levels, and inmate capacity. Specific staffing level calculations vary by department. We believe our current method is reliable but could be improved. The Bureau has hired a contractor to assess systemwide staffing levels and the methods by which they are determined. The Bureau is working closely with the vendor and expects that it will be able to start testing a new tool for making staffing projections this summer.

b. What is the projected or aspirational timeline for developing a method for calculating staffing levels?

Response: The Bureau is working closely with the contractor it hired to study staffing levels and the Bureau expects it will be able to begin testing a new tool for making staffing projections this summer.

c. What is the projected or aspirational timeline for developing a method to identify and address the causes and potential impacts of staffing challenges on staff and inmates?

Response: The contractor the Bureau hired to study staffing levels is assessing the quantifiable risks associated with Bureau's current staffing levels, including overtime use and staff schedule augmentation. The expected timeline for completion is two years.

Senator Hirono

1. How and to what extent has the Bureau of Prisons ("BOP") used residential reentry centers ("RRCs") curing the COVID-19 pandemic?

   Response: The CARES Act temporarily expanded the Bureau's authority to place eligible inmates on home confinement in response to the COVID-19 pandemic, but did not provide the Bureau any additional authority to place inmates into RRCs.

   The Bureau of Prisons has increased the home confinement population to approximately 220% of pre-COVID-19 levels – from a population of 2,800 prior to COVID-19 to population of 6,230 as of January 27, 2022.

   During the pandemic, RRCs faced the same challenges associated with communal living environments as federal prisons. Due to the enhanced risks associated with COVID-19 in communal living environments, individuals residing in RRCs were placed on home confinement as appropriate in an effort to reduce the RRC population.

2. In response to a Question of the Record I submitted following the Judiciary Committee's June 2, 2020 hearing, you projected that 57 federal inmates were scheduled to reenter the community in Hawaii between December 2, 2020 and December 1, 2021.

   a. Did these 57 individuals reenter the community in Hawaii as projected? If not, why not?

      Response: The Bureau's public webpage provides the data on inmates releasing geographically https://www.bop.gov/about/statistics/statistics_inmate_releases.jsp. The numbers of releases to Hawaii by month or year can be found on this page. For example, this information includes the number of releases each month from January 2021 to December 2021 (166 total).

   b. How did Hawaii's lack of a RRC impact the reentry of these individuals into the community?

      Response: Individuals returning to Hawaii without an approved release plan were provided Residential Reentry Services through other contract facilities in other states. Inmates with approved release plans were placed on Federal Location Monitoring through the United States Probation Office (USPO).

3. It has been nearly two years since my office first reached out to BOP to find a solution to the closure of Hawaii's only RRC. Throughout that time, BOP has provided minimal information—explaining only that it has extended the current solicitation but, otherwise, cannot share any additional information in an effort to protect the integrity of the process.

   The Mahoney Hale RRC closed on September 30, 2019 after its contract with the Bureau expired. It was operating in Hawaii for nearly three decades. The perception BOP has created for me and others in Hawaii is that it is washing its hands of any responsibility to reopen a RRC and is leaving it to third parties to come up with a solution. I and others in the community have been patient but it is apparent that BOP has no sense of urgency in this matter and I find this wholly unacceptable.

   Will you commit to personally looking into BOP's actions as it relates to the closure of the Mahoney Hale RRC and efforts to open a new RRC in Hawaii and informing me if you are satisfied with BOP's actions? If you are not satisfied, please provide an action plan on helping to reopen a RRC in Hawaii.

   Response: The Bureau has made repeated efforts to contract a Residential Reentry Center (RRC) in Hawaii. The previous contractor that operated the Mahoney Hale RRC notified the Bureau that it could no longer provide services to the Bureau due to a sale of the property that hosted the RRC. Three separate solicitations were posted and subsequently canceled after receiving no offers. The initial solicitation was posted on November 19, 2019, for services located within the boundaries of the Island of Oahu. The Bureau has extended the solicitation expiration date 11 times, with the most recent solicitation closed on July 31, 2021, with no offerors. Extensions of the solicitation period were issued per requests from potential vendors seeking additional time to find site locations or by the Bureau to encourage competition. The final solicitation allowed for the offeror to propose an RRC and home confinement services or a day reporting center. This solicitation for the day reporting center is expected to be awarded in summer 2022. The Bureau explored a Work Release Program utilizing FDC Honolulu as the site location utilizing contracted staff, but this was

determined to not be feasible. Bureau staff have facilitated community outreach and listening sessions with stakeholders, including the judiciary, as to our project plans and next steps. The Bureau is again attempting to obtain contract services for Hawaii in the boundaries of the Island of Oahu to include both in-house and home confinement beds. It is anticipated this solicitation will be announced during the summer of 2022.

Senator Kennedy

1. Some of my constituents back home in Louisiana are very concerned—so am I. Per the Joint Explanatory Statement to the 2021 Omnibus, the Federal Bureau of Prisons has been told "to hire additional full-time correctional officers to reduce the overreliance on augmentation and to improve staffing beyond mission-critical levels in custody and all other departments . . . ."

   In Oakdale alone, the administration at the Federal Correction Complex had to rely on augmentation twice so far in fiscal year 2021 to fill vacant positions in custody. Sixty-six positions at Oakdale, which are not only paying jobs for local residents but also critical for the operations and safety at the facility, must be filled to staff this correctional facility at its January 2016 level per the direction of Congress in the Joint Explanatory Statement.

   When will the staffing numbers at FCC Pollack and FCC Oakdale be adjusted to reflect the staffing positions of January 2016 as directed by Congress?

   Response: Through recent hiring initiatives to focus on hiring external applicants into the agency at entry level positions, the Bureau has hired or given conditional offers of employment to more than 2,000 individuals. While Congress did not direct specific staffing levels for individual institutions, the goal is to fill 100% of the Bureau's funded positions. We are also assessing our staffing guidelines and bed space to optimize efficient and effective operations at our facilities across the agency. Our review will modernize our staffing plans to maximize use of authorized positions with flexibility based on security level, number of staff, physical layout of facilities, and care level. We are maximizing the use of incentives, as appropriate, to recruit and more importantly, retain our staff. The Bureau remains in need of resources for additional FTEs beyond the current level. Funding for an additional 3,723 FTEs, to bridge the gap and match the number of authorized positions, would equate to approximately $500 million.

2. How much overtime has been used at FCC Pollack and FCC Oakdale between October 1, 2020, and April 1, 2021?

   Response: FCC Pollock - $2,769,082.59; FCC Oakdale - $1,340,114.01.

3. What is the current BOP policy for transferring and housing male inmates identifying as women into female facilities?

   Response: Bureau of Prisons Program Statement 5100.08 CN-1, *Inmate Security Designation and Custody Classification* outlines procedures for the transfer of all inmates. Additionally,

Program Statement 5200.08, *Transgender Offender Manual* addresses programming and housing issues specific to transgender inmates.

4. How many male inmates identifying as women have been transferred to BOP female facilities and where?

   Response: The Bureau of Prisons began tracking this information in February 2017. Since that time, 17 transgender inmates have been transferred from male to female facilities including FMC Carswell, FSL Danbury, FCI Dublin, FCI Aliceville, SPC Victorville, FCC Hazelton, and FCI Waseca.

5. How many male inmates identifying as women are currently housed in BOP women's facilities?

   Response: There are currently six inmates who identify as female who were assigned male sex at birth housed at female facilities.

Senator Klobuchar

1. Has the percentage of incarcerated people who have been tested for COVID-19 increased since August 2020?

   Response: As of August 31, 2020, 37.4% of inmates in BOP managed facilities had been tested. As of May 3, 2022, 95.7% of inmates currently in BOP managed facilities had been tested. When COVID-19 testing is warranted for an inmate who refuses testing (i.e. new arrivals or potential exposure), additional quarantine measures may be conducted as a health safety measure.

2. What percentage of those tests were administered to asymptomatic inmates?

   Response: 86%.

   Can you provide the demographic data for the inmates that have been transferred to home confinement since March 2020?

   Response: Number of Releases to RRC/HC March 26, 2020 - January 29, 2022:

Transfers by SEX			
	SEX		
Transfers	*Female*	*Male*	*Total*
Community Referral- CARES Act	2945	7408	10353
Elder HC	65	344	409
Other	4433	40329	44762
Total	7443	48081	55524

Transfers by RACE					
	RACE				
Transfers	*A*	*B*	*I*	*W*	*Total*
Community Referral- CARES Ac	309	3091	99	6854	10353
Elder HC	6	84	6	313	409
Other	568	19186	1307	23701	44762
Total	883	22361	1412	30868	55524

Transfer by AGE							
	AGE						
Transfers	*<=24*	*25 - 34*	*35 - 44*	*45 - 54*	*55 - 64*	*65+*	*Total*
Community Referral- CARES Act	82	1029	2401	3264	2422	1155	10353
Elder HC	0	0	0	2	165	242	409
Other	1454	12751	16361	9298	3952	946	44762
Total	1536	13780	18762	12564	6539	2343	55524

3. What percentage of home confinement transfers were denied because of an inmate's PATTERN (Prisoner Assessment Tool Targeting Estimated Risk and Needs) score?

   Response: Inmates are reviewed for home confinement placement under the CARES Act on a case-by-case basis balancing public safety with inmate safety. Under BOP policy, inmates are screened to confirm that their PATTERN risk score is Minimum or Low. If an inmate does not meet that criteria, and the warden determines that there is a need to refer an inmate for placement in the community due to COVID-19 risk factors, the warden may forward the referral to the Correctional Programs Division for further review based on a consideration of the totality of circumstances, to include but not limited to the PATTERN recidivism risk level, history of violence, history of escapes, recent discipline history, history of supervision violations, placement plans.

Senator Cornyn

1. One key goal of the bipartisan First Step Act was to facilitate greater BOP partnerships with outside third-party providers to provide evidence-based recidivism reduction programming and productive activities.

   a. Has the BOP made efforts to communicate or advertise the opportunity for third party providers to apply?

      Response: The Bureau has made a great deal of information available on its public website at https://www.bop.gov/inmates/fsa/programs.jsp. Under the section entitled "Have an idea for a program?" the Bureau has provided the criteria for submission, the criteria for reviewing submitted programs, and Frequently Asked Questions. The BOP also publicized this information via a press release and headline article when the submission process opened.

2. The BOP has published a list of approved evidence-based recidivism reduction programs ("EBRRs") and Productive Activities ("PAs") in the First Step Act's Approved Programs Guide (hereinafter "the Guide"). There is no indication that the BOP operated programs approved in the Guide have undergone the same review process and are held to the same standards as external applicants, to ensure a fair process of review for both external providers and BOP-operated programs.

   a. Does the BOP hold BOP-operated programs to the same standards as third party applicants?

      Response: The BOP has implemented protocols for internal and external review of the EBRR program and PA submissions using a third-party contractor. EBRR programs and PAs are reviewed for evidence of their effectiveness in achieving recidivism reduction and for their suitability in the federal correctional setting. The BOP engaged the MITRE Corporation, an external, not-for-profit organization without conflicts of interest, to support the development and execution of the review process. External programs are reviewed for evidence demonstrating effectiveness in reducing recidivism as well as

additional BOP-established criteria. The BOP decides which programs are included on the approved list using the information from the independent reviews. All approved Bureau and third-party programs must meet rigorous standards for approval as evidence-based programming.

b. Does a third-party reviewer – which has been referred to as MITRE – conduct the same independent review of BOP-related programs?

   Response: The Bureau worked with MITRE Corp. to develop the independent review process by which programs are evaluated, which was published in July 2020. Programs accepted after review were placed into the Bureau's program guide. Information about the review process, including what information is considered, is available on the public website at https://www.bop.gov/inmates/fsa/programs.jsp.

c. If BOP uses different criteria for its own programs, please provide the specific criteria and the reviewer information.

   Response: The Bureau has funded partnerships with external research organizations to conduct individual studies and further evaluate the value and impact its programs have on the lives of inmates and their communities. Many Bureau programs are cognitive-behavioral therapy interventions delivered by doctoral level psychologists, and this approach is well-supported in the scientific literature. The Bureau uses scientifically vetted protocols in accordance with professional standards.

d. Also, if BOP uses different criteria, what is BOP's rationale for holding third parties to a different standard than BOP-operated programs?

   Response: The evaluation of programs, whether by the Bureau or an external party, will follow accepted research design protocols.

3. The Life Connections Program ("LCP") is among the BOP's approved EBBR programs listed in the Guide. The First Step Act Independent Review Committee's 2019 report states that, "no evaluation of this federal program's impact on recidivism is publicly available." Please clarify what evidence, if any, qualifies the LCP as an EBRR.

   Response: The Life Connections Program (LCP) is an intensive residential, multi-faith-based reentry program and a strong example of a BOP partnership. LCP is open to inmates of all religious traditions as well as those with no faith affiliation. Partnerships with the community are an integral part of the program. Contract partners provide religious services while community volunteers serve as mentors, assisting inmate participants in addressing topics ranging from reestablishing family relationships to reconnecting with community resources and support. Determinations of EBRR programs or PAs are made after review of the literature, and in consultation with experts across the Department of Justice, including the National Institute of Justice.

4. How many external providers (those not run by BOP) have applied for approval as an EBBR?

   Response: Eleven externally proposed programs have been submitted.

   a. Of those applications, how many have been approved as an EBBR or PA?

      Response: Four externally proposed programs have been approved as an EBRR or PA. .

   b. If any such applicants have been approved, which ones have been approved?

      Response: The externally proposed programs which have been approved are: 7 Habits on the Inside, Resilience Support, Money Smart for Adults, and Aleph Institute.

   c. Has the BOP approved any applications from external faith-based groups to be EBBRs?

      Response: The Bureau continues our efforts to partner with outside providers for programming. With regard to faith-based programming, we received and approved an application from Aleph Institute.

5. Both the Threshold Program and the LCP are referred to as faith-based programs in the Guide. However, neither appear to be taught based on the worldview or teachings of a particular religious tradition. While many incarcerated people may welcome this Universalist approach, others may prefer to attend a faith-based program that reflects a specific religious tradition to which they follow.

   a. Please clarify whether the BOP is opposed to offering a faith-based program that is based on the worldview or teachings of a particular religious tradition. If so, please describe the BOP's rationale.

      Response: The agency fully supports faith-based programming that honors individual faith-specific practice. LCP and Threshold inmate participants bring their own belief systems, whether religious or secular, to their individual LCP and Threshold experience. LCP and Threshold programs foster personal and spiritual growth as well as social responsibility through the use of a standard curriculum, instruction from trained leadership, and the utilization of community mentors to assist inmates upon release.

6. How is the Bureau ensuring continued access to religious worship and services for prisoners that complies with CDC safety guidelines?

   Response: While religious accommodations were modified within agency and CDC COVID-19 guidelines, the Bureau has and will continue to respect and accommodate the religious rights and needs of federal offenders. Agency chaplains made rounds in the housing units with PPE equipment to offer pastoral care and deliver religious materials so the inmates could continue to observe their faith. When the inmates could not gather in

larger groups in centralized chapel areas for congregant worship and religious studies across faith lines, the chaplains went to them to further meet their spiritual needs. The agency also offered religious services in the housing units, outside, and in smaller chapel gatherings to adhere to the CDC guidelines. As COVID-19 numbers decreased and the vaccine distribution numbers increased, inmates have had more access to institutional chapels, worship within the chapels, and community chapel volunteers and religious contractors.

7. I asked whether individuals in BOP custody had access to support services if they are victims of sexual abuse, including hotline services. You testified that "we certainly encourage them to come forward, whether it's by staff or the use of the hotline, to report things of that nature." The Prison Rape Elimination Act, 42 U.S.C. § 15601 et seq., requires prisoners both to have access to an external reporting mechanism, as you described in your answer, and access to support services.

    a. What efforts has the BOP made to ensure those in custody have access to support services?

    b. How many prisoners have access to emotional support services? Additionally, how many facilities have emotional support services in place?

    c. How many prisoners have access to hotline support services? Additionally, how many facilities have hotline support services in place?

    d. How many prisoners have access to other kinds of support services, including accompaniment to forensic exams? Additionally, how many facilities have other kinds of support services in place, including accompaniment to forensic exams?

Response: Bureau of Prisons staff are committed to complying with all PREA standards. The Bureau aims to eliminate all sexually abusive behaviors in our facilities, and when these behaviors do occur, we ensure that victims receive the appropriate care and treatment.

All inmates have access to emotional support services. Every institution has qualified psychologists on staff who are available to provide support throughout the PREA process and beyond. Additionally, the vast majority of our facilities have agreements in place with local rape crisis centers, and these staff are available to support the victims through the forensic medical examination process and during the investigatory process and/or provide counseling following the allegation. The local hospitals which conduct the examinations also typically provide support staff throughout the evidence collection process. Approximately ten percent of our facilities do not have an agreement in place with a rape crisis center. The reasons for a lack of agreement typically are that the prison is located in a rural area with limited services nearby or the rape crisis center lacks sufficient staff or resources to enter into an agreement with the facility. In these rare instances in which an agreement is not in place, the qualified psychologists at the prison provide the necessary support and follow-up counseling with the victims.

Regarding the availability of hotline support services, there is currently no national PREA hotline in place. The Office on Violence Against Women (OVW) and the Bureau of Justice Assistance (BJA) are currently working to issue a solicitation for a planning grant to develop a national service hotline. In the meantime, inmates in facilities that have an agreement with a local rape crisis center are able to receive telephonic and/or in person support services via the local rape crisis center. In facilities where no local rape crisis center is available or an agreement is not in place, inmates are supported in contacting the national sexual assault hotline operated by the Rape, Abuse & Incest National Network (RAINN). Inmates do so with the assistance of the local Psychology Services and/or Chaplaincy staff. In addition, all BOP facilities have psychologists available to provide crisis counseling.

The Bureau is sensitive to the trauma victims of sexually abusive behavior experience, and it is BOP policy to ensure that these victims speak with a psychologist for crisis intervention within 24 hours of an allegation. The victims are treated with sensitivity and care by our psychologists, and they are offered support by rape crisis center staff, where those agreements are in place. Support services for all alleged victims of sexual abuse begin at the time of the allegation and continue until they are no longer needed. All support staff, whether they are Bureau or rape crisis center staff, take their role of providing emotional support seriously.

Senator Lee

1. Before the CJS Appropriations Subcommittee last month, you testified that the BOP has a good partnership with private contractors that operate facilities for the BOP. Your testimony, as I understood it, was that private contract facilities were safe; that the BOP relies on them; and those private contractors meet your agency standards. Can you elaborate on that partnership?

   Response: The Bureau's overall inmate population has experienced a downward trend over the past decade. The Bureau has sufficient bed space to safely accommodate these inmates currently housed in privately run facilities, and the Bureau does not plan to renew or resolicit expiring contracts with private detention facilities. In the meantime, Bureau contractors must comply with all applicable federal, state, and local laws and regulations. They are also required to achieve and maintain American Correctional Association (ACA) accreditation, Prison Rape Elimination Act (PREA) certification, and accreditation by an independent, not-for profit health care organization.

2. When President Biden announced the executive order on terminating the use of private contractors with the BOP, the Order stated that private contractors "consistently underperform." Is this statement accurate? Could you describe the nature of your firsthand experiences working with private contractors?

   Response: Private facilities typically do not provide the same degree of programming as Bureau facilities, especially given the population that typically have been housed within (deportable non-US citizens). In addition, a 2016 OIG report found that contract prisons had

more safety and security-related incidents per capita than Bureau institutions for most analyzed indicators.[11] Because the Bureau's overall inmate population has experienced a downward trend over the past decade, it has sufficient bed space to safely accommodate these inmates currently housed in privately run facilities. The Bureau does not plan to renew or resolicit expiring contracts with private detention facilities.

3. Do you believe BOP private contractors were responsive when managing COVID challenges in their facilities?

   Response: Bureau private contractors were, and continue to be, responsive in managing the various COVID-19 challenges in their facilities. The Bureau's private contractors are required to follow CDC guidelines. Bureau staff located at each facility provide oversight to help ensure adherence to contract requirements. Other external entities, to include OIG, have recently found that the Bureau's private contractors were responsive in managing COVID-19.

4. A recent OIG report states that contractors actually outperformed BOP in responding to COVID in their facilities. Do you agree with the OIG report's findings?

   Response: Oversight of the Bureau's private contracts, to include external audits, has identified a high level of effectiveness in contractor response to COVID mitigating efforts, including a report from one survey of a contract facility early on in the pandemic, which is referenced in the question. The Bureau sets standards for contract facilities in its contract Statements of Work and has staff on-site at all contract facilities to ensure requirements are met and to provide oversight, audits, and ensure adaptation to new guidance. Bureau of Prisons facilities and our contract facilities are held to very similar standards as it relates to COVID-19 mitigation strategies. The Bureau is in regular communication with the CDC on these issues, and developed a COVID-19 Pandemic Plan in consultation with the CDC. The Pandemic Plan is a broad-sweeping plan that can be utilized in whole or part to provide guidance for facilities on procedures and practice for mitigating and containing widespread transmission of SARS-CoV-2 and non-COVID infectious disease threats. We note that one distinction between BOP facilities and contract facilities is that contract facilities have the ability to limit the number of contracted persons housed in such sites whereas the BOP cannot prevent admissions to our facilities.

5. If the President's Executive Order applies to the USMS, would the BOP have the resources to take custody of an estimated 62,000 USMS detainees and provide the necessary bed space, transportation, access to the courts, and access to legal representation for these detainees?

   Response: In early 2021, the USMS contacted the Bureau to explore the possibility of absorbing approximately 4,300 USMS detainees prior to the end of the calendar year as USMS contracts expire. The Bureau did absorb all requested inmates, with additional beds

[11] https://oig.justice.gov/reports/2016/e1606.pdf

remaining as part of the agreement, and will continue to work with the USMS to ensure our missions are accomplished which includes ensuring transportation, access to the courts, and access to legal representation is provided to all USMS prisoners.

6. In your testimony, you referred to only one private contract that has been cancelled. Are the remaining BOP private contractors currently performing to contractual standards?

   Response: In accordance with the President's Executive Order on privately-operated detention facilities, the Bureau is allowing private facility contracts, performing to contract standards, to expire according to the terms of each contract. The Bureau has not canceled any private facility contract that has been performing to contractual standards but has only four sites remaining two of which will expire by the close of June 2022. At this time, the remaining Bureau private contractors are performing to contractual standards.

7. What is the current total capacity of the BOP system?

   Response: On May 3, 2022, the total rated capacity of all Bureau facilities was 135,162. Per BOP Program Statement 1060, Rated Capacities for Bureau Facilities, rated capacity is the baseline for the statistical measurement of prison crowding and is essential in managing the Bureau's inmate population to distribute the inmate population throughout the system reasonably and equitably. There are many factors taken into consideration in designating inmates to a specific facility. There is no maximum capacity limit in place, as the Bureau is required to accept pre-trial offenders, sentenced inmates, and USMS inmates. This requirement is addressed in the Bail Reform Act, 18 U.S.C (pre-trial) and § 3141 and 18 U.S.C. § 4042 (sentenced inmates). Per agreements between the BOP and USMS, the BOP allocates a set number of beds at certain BOP facilities for use by the USMS for district pretrial and JPATS in-transit inmates.

8. Is the BOP currently operating above capacity?

   Response: On May 3, 2022, the total population in all Bureau facilities was 137,923. Using the above stated rated capacity, Bureau facilities overall were 2 percent overcrowded on that date. On June 19, 2020, the BOP Assistant Director for the Correctional Programs Division (CPD) sent a memo to all BOP Chief Executive Officers (Wardens and Regional Directors) announcing a new set of population levels in low and minimum-security institutions to mitigate COVID-19 exposure risk. These new levels, called COVID-19 Target Populations, are a temporary measure implemented for the safety of inmates and staff. These targets did not include any medical, mental health or special housing beds or specialized designation facilities (nationally recognized programs, e.g., Residential Drug Abuse Program). CPD also reviewed requests from individual institutions to establish short term population caps or moratoriums restricting movement in and out of a specific facility to assist in COVID-19 mitigation.

9. Is the BOP currently operating with staffing shortages?

Response: Yes, however, in those locations with a critical staffing need, the Bureau has temporarily deployed staff from other locations to ensure all shifts are covered at all institutions nationwide. Additionally, we have instituted a robust hiring initiative focused on hiring external applicants into the agency at entry level positions. This initiative resulted in the Bureau hiring or issuing conditional offers of employment to more than 2,000 individuals. The Bureau remains in need of budgetary resources for additional FTEs beyond current funding levels. Funding for an additional 3,723 FTEs, to bridge the gap and match the number of authorized positions, would equate to approximately $500 million. We are also assessing our staffing guidelines and bed space to optimize efficient and effective operations at our facilities across the agency. Our review will modernize our staffing plans to maximize use of authorized positions with flexibility based on security level, number of staff, physical layout of facilities, and care level. We are maximizing the use of incentives, as appropriate, to recruit and more importantly, retain our staff.

10. Does the BOP currently house criminal non-citizen detainees? If yes, how many?

    Response: The Bureau houses non-citizen detainees. As of May 3, 2022, the Bureau houses a total of 4,540 non-US citizens in private contract facilities. Overall, as of May 5, 2022, the bureau houses approximately 22,296 non-US citizens confined in service of federal sentences in both Bureau facilities and private facilities under contract by the Bureau. Additionally, there are 19 ICE detainees in Bureau facilities.

11. In its explanatory statement for FY21 Commerce-Justice-Science appropriations bill, the Senate Appropriations Committee expressed the concern that the BOP's request for First Step Act (FSA) implementation "covers existing programming, including educational and counseling programming, which existed at BOP long before the FSA." Is this an accurate description of the Bureau of Prison's budget requests? How will the agency clearly distinguish between investments and programming that preceded and followed the First Step Act so that the public and lawmakers can clearly track the Bureau's progress?

    Response: The Bureau offers a range of successful inmate programming which existed prior to the enactment of FSA. However, with the implementation of FSA, the Bureau has expanded on those programs as well as added new initiatives, such as programming for inmate veterans, programs for persons living with disabilities, GED and adult literacy, mental health programs, anger management, substance abuse treatment, parenting programs, and many more. All programs that are funded with FSA resources are identified on a detailed spend plan and are reviewed by the Bureau, the Department, and the Office of Management and Budget (OMB). For more information on programs or information please see the Bureau's public webpage (https://www.bop.gov/inmates/fsa/).

12. A February 2021 BJS report using 2019 data identified an average vacancy rate of 16.1% for "medical and health-care positions" in the BOP. Today, in April 2021, by how much has that vacancy rate improved or declined? How is the Bureau meeting medical staff shortages during the pandemic?

Response: The Bureau's vacancy percentage for medical and health-care positions for April 3, 2022, is 15.91%. This reflects a .19% vacancy rate reduction.

The Bureau met medical staff shortages through a combination of avenues throughout the pandemic to include but not limited to the following: Health Services staff from administrative sites or institutions with little or no COVID-19 impact at that time providing temporary duty assistance to institutions with significant impacts, *locum tenems* (temporary contractor utilized on an as needed basis) contracts from FSS (Federal Supply Schedule, which is a list of federally approved vendors for contracting purposes) awarded at the local level, Public Health Service (PHS) deployments from other federal agencies, and expanding the number of contract providers through comprehensive medical contracts. The Bureau has also obtained some additional staffing resources to oversee quarantine and isolation units through assistance from the Ohio National Guard (FCI Elkton) for a limited time.

13. How will the BOP aim to accelerate constructive programming participation and completion given this period of prolonged disruption to programming and productive activities?

Response: In the early stages of the pandemic, programming in groups was suspended; however critical services associated with programming continued unabated. For example, mental health treatment and crisis intervention continued, as did religious services.

As information about virus mitigation strategies became available, the Bureau followed CDC guidance in resuming programming. Programs were held with decreased capacity to allow for social distancing and participants and staff wore masks. Additionally, some programs were held in unique spaces such as on housing units or outdoors.

The Bureau is working expeditiously to resume programming to fullest extent possible while complying with CDC guidance. Staff and inmates have been strongly encouraged to receive vaccinations to assist with the resumption of normal operations.

14. Under your leadership, what efforts has the BOP made to expand this programming?

Response: The initial guide issued in January 2020 was comprised of 70 Evidence-Based Recidivism Reduction (EBRR) programs and Productive Activities (PAs) focused on areas such as education, adult literacy, vocational training, mental health, substance abuse, anger management, criminal cognitions, parenting, and faith-based programs. Since January 2021, external stakeholders have submitted eleven proposed programs, of which the BOP approved four new programs: "7 Habits on the Inside"; "Resilience Support"; "Money Smart for Adults;" and "Aleph Institute." The Bureau has also added an internally proposed program, "Disabilities Education Program", as well as more Productive Activities. Altogether, the BOP now has more than 83 EBRR programs and PAs in the FSA Program Guide. The latest programs guide was published in January 2022 and is available on the BOP's website,

https://www.bop.gov/inmates/fsa/docs/fsa_program_guide_2201.pdf. All approved programs are designed to build upon individual successes and to address one or more of the BOP's thirteen defined needs. The passage of the Time Credits rule in January 2022 expanded the services which qualify as PAs. Only structured EBRR programs and PAs with a facilitator-led curriculum are listed in the FSA Programs Guide. Other activities (e.g., inmate work assignments) may also be recommended by staff to address individual inmate needs as well as qualify for time credits for eligible offenders.

Because there is such a wide range of programs addressing all thirteen identified criminogenic needs areas, the BOP has focused on building capacity in existing programs. The agency has achieved expansion in significant part through the addition of full-time program delivery staff (see *2022 First Step Act Annual Report* for more information on this staffing effort). Efforts to continue increasing programming opportunities for inmates in accordance with the FSA, even during the COVID-19 pandemic, remain a priority for the BOP.

While building capacity in existing programs, the BOP is also developing a number of new programs. To further complement those efforts, the BOP has initiated a new contract action to engage outside expertise to review and evaluate state correctional programs to determine their applicability to BOP. As of March 3, 2022, three contracts have been awarded for the study of specific EBRRs, specifically the BRAVE program, the Anger Management Program, and BOP's Drug Abuse Programs. These reviews are also detailed in the *2022 First Step Act Annual Report*, at pp. 35-36.

15. Can you point to specific programs and initiatives that been implemented since the First Step Act's passage along these lines?

Response: The Bureau has made a great deal of progress in implementing provisions of the First Step Act. As mentioned previously, the Bureau has undertaken an effort to increase program delivery staff and new programs, thereby increasing its program capacity. The Bureau has increased the number of programs offered from 70 EBRR and PA programs in January 2020 to 83 EBRR and PA programs as of January 2022. In addition to the expansion of the approved list of FSA programming, the Bureau has built technology infrastructure to track programming and results of risk assessments, recalculated inmate sentences to account for the new Good Conduct Time and Earned Time Credit regulations, automated the PATTERN risk instrument, developed an enhanced and automated needs assessment process, , developed updated training regarding pregnant and post-partum offenders, added pilot animal training and youth programs, implemented dyslexia evaluation and intervention, developed a new volunteer information and recruitment portal, and engaged external partners and consultants to conduct program evaluations. Comprehensive information on the Bureau's FSA

implementation activities can be found in the *2022 First Step Act Annual Report* published in April.

16. What is the Bureau's strategy for maintaining continuity of program access in the event of future public health emergencies and corresponding Bureau modified operations?

    Response: To assist with the pandemic and any future public health emergencies, institutions follow the COVID-19 Modified Operations Plan and Matrix. This matrix determines the operational level and mitigating procedures institutions need to follow to prevent the risk and spread of illness. To ensure the delivery of programs in a safe manner during these types of situations, the Bureau has learned to modify class size to support social distancing as well as utilizing other program delivery methods such as classes being held outdoors. Additionally, the Bureau solicited for a correctional tablet solution to enable inmates to supplement classroom-based learning with program and education curricula available on a tablet device. In this way, inmates will be able to continue program and treatment instruction even if institution operations are disrupted. As well, the BOP frequently uses residential unit based programs, which allows inmates to continue program treatment as they are co-horted together, living and programming in a residential housing unit. This allows programming to continue even in the event that a unit may need to be isolated.

17. Please describe the availability of religious worship and services for prisoners during the pandemic.

    Response: While religious accommodations were modified within agency and CDC COVID-19 guidelines, the Bureau has and will continue to respect and accommodate the religious rights and needs of federal offenders. While group programming was suspended during the early stages of the pandemic, aspects of religious services were deemed critical and continued unabated.

18. How is the Bureau ensuring continued access to religious worship and services for prisoners during the pandemic?

    Response: Agency chaplains made rounds in the housing units with PPE equipment to offer pastoral care and deliver religious materials so the inmates could continue to observe their faith. When the inmates could not gather in larger groups in centralized chapel areas for congregant worship and religious studies across faith lines, the chaplains went to them to further meet their spiritual needs. The agency also offered religious services in the housing units, outside, and in smaller chapel gatherings to adhere to the CDC guidelines. As COVID-19 cases decreased and the vaccine distribution numbers increased, the inmates have had more access to the institutional chapels, worship within the chapels, and community chapel volunteers and religious contractors.

19. Understanding that the pandemic has reduced some ability to expand and implement First

Step-related anti-recidivism programs, will you commit to ramp up access to these programs as soon as possible?

Response: Yes. The Bureau is resuming normal operations as it safe to do so, based on medical, CDC, and Bureau guidance. It is worth noting that more than 25,000 inmates completed a program in 2020 despite the pandemic and in FY 2021, there were over 98,000 completions, and as of April 30, 2022, over 85,000 inmates were enrolled in Evidence-Based Recidivism Reduction (EBRR) Programs and Productive Activities (PA). As for programming in the context of the pandemic, the safety of inmates and staff is of primary importance. To determine the appropriate level of infection prevention measures and programming and service modifications required at a given point in time, the Bureau has developed a matrix by which institutions can assess the risk and spread of COVID-19 within a particular facility. Institutions determine their operational level (Level 1, Level 2, or Level 3) based on the facilities' COVID-19 medical isolation rate, combined percentage of staff and inmate completed vaccinations series, and their respective community transmission rates. At each level, an infection prevention procedure or modification to operations (such as inmate programming and services) may be made to mitigate the risk and spread of COVID-19 in accordance with BOP pandemic guidance. You can find more information about the COVID-19 Modified Operations Plan and Matrix, as well as the current number of institutions at each level, at https://www.bop.gov/coronavirus/covid19_modified_operations_guide.jsp.

20. Please describe what steps you intend to take to expand access to First Step programs?

Response: The BOP's greatest resource in delivering programs is its staff and adding staff has been the primary factor in increasing program capacity. BOP is one of the largest civilian employers of doctoral level psychologists in the United States and also employs chaplains and teachers among its complement of service-delivery professionals. These positions have long provided treatment, training, and self-improvement services across BOP facilities. Since January 2021, the BOP allotted 109 new positions in program delivery disciplines to expand the capacity of its more than 80 EBRR programs and PAs. In addition to the aforementioned professions, the newly-added positions include the Special Populations Coordinator, who delivers gender-responsive programs, and a new vocational counselor position, which is currently pending position classification. Every new position adds capacity to the BOP's FSA programs.

Ordinarily, each BOP institution monitors the needs assessed within the local institution population to determine which programs to offer. Some large, residential programs, such as the Residential Drug Abuse Program, target a subset of the population for intensive services. For programs such as these, the Reentry Services Division monitors program completions and determines when and where more staffing is needed. For most programs, however the institutions have the ability to add cohorts and increase participant capacity as needed. Thus, if a facility is offering Anger Management but has a large group of inmates with needs remediated by this program that location could add an additional section of the

program to meet the population needs. Under COVID-19 pandemic mitigation strategies, the BOP has had to limit capacity in programs to promote social distancing.

21. Could you discuss any anti-recidivism programs that have been successful?

Response: The BOP has undertaken several major actions to study its programs to ensure their quality and validate their impact. Past studies have demonstrated the efficacy of Bureau programs such as the Residential Drug Abuse Program (RDAP) and Federal Prison Industries (UNICOR). More recently, the Bureau has procured independent evaluation services to explore outcomes of some of its largest and most robust reentry programs. Recidivism studies are lengthy endeavors; inmates must first complete programs, and then be released from prison for a period of time for analyses to be conducted. Additionally, while programs are designed to promote successful reentry, many of these programs have other priorities, such as symptom reduction or behavioral modification. Thus, the BOP has awarded funds to credentialed researchers capable of studying a variety of both short- and long-term measures of program efficacy. The Bureau has awarded contracts for multi-year studies of its Residential and Non-Residential Drug Treatment Programs, Medication Assisted Treatment programs, anger management programs, and its Bureau Rehabilitation and Values Enhancement (BRAVE) program. More information about the Bureau's efforts to evaluate the efficacy of its recidivism reduction programs can be found in the April 2022 *First Step Act Annual Report*, see pp. 35-36.

22. If a person born a biological male undergoes sex reassignment surgery while in BOP custody, would that individual ever be transferred to an all-female facility? What procedures or standards govern whether that individual is transferred?

Response: Bureau of Prisons Program Statement 5100.08 CN-1, *Inmate Security Designation and Custody Classification* outlines procedures for the transfer of all inmates. Additionally, Program Statement 5200.08, *Transgender Offender Manual* addresses programming and housing issues specific to transgender inmates. The Transgender Offender Manual is the Bureau's Program Statement that governs designation decisions for individuals who identify as transgender. All decisions are made by a multidisciplinary committee of senior agency staff. Policy allows for an individual to be placed at a facility that affirms his or her identified gender, regardless of surgery.

23. During the past year, there have been reports of what some call "an epidemic within the pandemic"—referring to the alarming rate of overdose deaths from substance abuse during the COVID crisis. As I am sure you are only too aware, the Centers for Disease Control and Prevention cited provisional figures last week citing a dramatic increase in overdose deaths during COVID. Of the inmates in your 112 prisons, how many are struggling with substance abuse problems? If possible, could you break this down by institution?

Response: It is estimated that 45% of inmates meet the diagnostic criteria for a substance use disorder at the time they enter Bureau custody.

24. What are your policies for the treatment of prisoners with substance abuse problems?

Response: The Bureau has a comprehensive policy that guides identification and treatment of inmates with substance use disorders. Inmates who enter Bureau custody with a history of substance misuse are required to complete Drug Education, which is designed to help inmates consider the impact drug use has had on their lives and motivate them to participate in treatment. Treatment options include:

a. the Non-Residential Drug Abuse Program (NRDAP) - a 16-week group treatment program in which participants meet in small groups to learn and practice skills designed to address criminality and substance use;
b. the Residential Drug Abuse Program (RDAP) - an intensive 9-month treatment program in which participants live on the same unit and engage in daily treatment;
c. the Medication-Assisted Treatment (MAT) Program - inmates who are prescribed medications for opioid use disorder are engaged in psychosocial treatment interventions guided by an individualized treatment plan;
d. the Challenge Program - an intensive residential treatment program for high security inmates with substance use and mental health problems; and
e. the Female Integrated Treatment (FIT) Program - an intensive residential treatment program that provides integrated substance use, mental health, and trauma treatment to female inmates.

25. Do substance abuse treatment policies extend to privately-run prisons as well?

Response: Privately-run prisons provide drug education and non-residential drug abuse programs. Inmates who are in need of residential drug treatment or Medication-Assisted Treatment (MAT) may be transferred to a Bureau facility.

26. Could you explain some of the challenges you face in identifying and treating inmates who overuse opioids or other drug substances?

Response: People with substance abuse problems often minimize the impact their substance abuse has had on their lives and are ambivalent about seeking treatment. Cravings and physical dependency can make the process of withdrawing from substances very painful, leading people to continue using substances in order to avoid withdrawal. Inmates who are actively using drugs while incarcerated are subject to the disciplinary process, and fear of negative consequences may prevent them from seeking treatment.

27. How has the problem of substance abuse in prisons changed during the COVID pandemic?

Response: Prior to the COVID-19 pandemic, jails and prisons have always faced problems with offender drug use and contraband drugs. The Bureau has developed interdiction (e.g., a pilot program involving scanning inmate mail) strategies to eliminate inmates' access to drugs as well as programs targeted to inmates who are

known to be actively using drugs (e.g., an awareness program about the harmful effects of synthetic cannabinoids). The Bureau has expanded the MAT Program to provide treatment options for inmates who are actively using opioids or who are at risk of relapse into opioid use.

28. Do you care to share any other observations that may be useful to the Committee in our study of substance abuse problems during the pandemic?

Response: The Bureau continues to expand substance use treatment programs and implement strategies to identify inmates who are in active use and encourage them to participate in treatment.

Senator Whitehouse

1. Effective prison programming can help prepare people for reentry and reduce recidivism. As you testified before the House Judiciary Committee in December 2020:

> [Residential Drug Abuse Program] participants were 16 percent less likely to recidivate and 15 percent less likely to have a relapse in their substance use disorder within three years after release. Inmates who participate in vocational or occupational training were 33 percent less likely to recidivate, and inmates who participate in education programs were 16 percent less likely to recidivate.

Congress recognized the power of prison programming to reduce recidivism when it passed the First Step Act, which requires the Bureau of Prisons (BOP) to make evidence-based recidivism reduction programs and productive activities available to all eligible people in custody by January 2022.

a. The Independent Review Committee (IRC) created by the First Step Act found that "during the first nine months of [2020], COVID-mitigation efforts undertaken by the Department of Justice (DOJ) and BOP seriously interrupted or curtailed rehabilitative programming in federal prisons. . . . 20 of 29 BOP-designated Evidence-Based Recidivism Reduction Programs . . . have been 'highly impacted' by the virus, including 'some that have been shut down entirely since the outbreak began.'"[12]

i. What, if any, steps did BOP take to mitigate the effects of COVID-19 on programming (for example, by allowing access to virtual education or treatment)?

Response: In the early stages of the pandemic, programming in groups was suspended; however critical services associated with programming continued unabated. For example, mental health treatment and crisis intervention continued, as did religious observances.

As information about virus mitigation strategies became available, the Bureau adhered to CDC guidance in resuming programming. Programs were held with decreased capacity to

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[12] Report of the Independent Review Committee Report Pursuant to the Requirements of Title I Section 107(g) of the First Step Act (FSA) of 2018 (P.L. 115-391), at 1 (Dec. 21, 2020), *available at* https://firststepact-irc.org/wp-content/uploads/2020/12/IRC-FSA-Title-I-Section-107g-Report-12-21-20.pdf.

allow for social distancing and participants and staff wore masks. Additionally, some programs were held in unique spaces such as on housing units or outdoors. It is worth noting that more than 25,000 inmates completed a program last year (2020) despite the pandemic, in FY 2021 over 98,000 inmates completed structured Evidence-Based Recidivism Reduction (EBRR) Programs and Productive Activities (PA) and as of April 30, 2022, 85,000 inmates were enrolled in EBRR programs and PAs.

As for programming in the context of the pandemic, clearly the safety of inmates and staff is of primary importance. However, as vaccination rates continue to increase, the Bureau will continue to expand programming. The Bureau recently issued guidance to Wardens authorizing the use of contractors and volunteers in those contexts and with those individuals who pose low risk (e.g. because they have been vaccinated themselves and the facility has few or no COVID-19 infections). As well, the BOP has developed residential unit-based programs which allows inmates to continue program treatment as they are co-horted together living and programming in a residential unit. This allows programming to continue even in the event that a unit may need to be isolated. The Bureau is also developing a correctional tablet solution that will enable inmates to supplement classroom-based training with programs and treatment materials accessible on a mobile device.

ii. What plans does BOP have to resume programming in the coming months?

Response: The Bureau is working expeditiously to resume programming to fullest extent possible while complying with CDC guidance. All staff and inmates are educated and encouraged to receive the vaccination for COVID-19. To date, all Bureau staff have been offered the vaccine and by June 1, 2021, all inmates had been offered the opportunity to be vaccinated. The Bureau continues to offer and encourage vaccines to new and existing inmates.

As health-safety measures indicate it is safe to do so, the Bureau will continue to expand programming. The Bureau has developed a system by which institutions can determine their operational level (Level 1, Level 2, or Level 3) based on each facility's COVID-19 medical isolation rate, combined percentage of staff and inmate completed vaccinations series, and their respective community transmission rates. At each level, an infection prevention procedure or modification to operations (such as inmate programming and services) may be made to mitigate the risk and spread of COVID-19 in accordance with Bureau pandemic guidance. More information about the Bureau's Operational Level Matrix and the number of institutions at each level can be found on our public website at https://www.bop.gov/coronavirus/covid19_modified_operations_guide.jsp.

iii. When does BOP anticipate programming will return to pre-COVID-19 levels?

Response: As for programming in the context of the pandemic, clearly the safety of inmates and staff is of primary importance. However, as vaccinations continue to increase, the

Bureau will continue to expand programming. The Bureau recently issued guidance to Wardens authorizing the use of contractors and volunteers in those contexts and with those individuals who pose low risk (e.g., because the contractors or volunteers have been vaccinated themselves and the facility has few or no COVID-19 infections). Although it is difficult to predict exactly when the restrictions imposed by COVID-19 will no longer be necessary, the Bureau regularly consults with the CDC on these issues and is committed to safely expanding access to programming. Institutions determine their operational level (Level 1, Level 2, or Level 3) based on the facilities' COVID-19 medical isolation rate, combined percentage of staff and inmate completed vaccinations series, and their respective hybrid community risk. At each level, an infection prevention procedure or modification to operations (such as inmate programming and services) may be made to mitigate the risk and spread of COVID-19 in accordance with Bureau pandemic guidance. More information about the Bureau's Operational Level Matrix can be found on our public website at https://www.bop.gov/coronavirus/covid19_modified_operations_guide.jsp.

b. The IRC found that even a full return to pre-COVID-19 BOP programming levels will not be sufficient to make evidence-based recidivism reduction programs and productive activities available to all eligible people in custody by January 2022, as the First Step Act requires. What steps is BOP taking to increase its program offerings and comply with the First Step Act?

Response: The Bureau has made programs available to all inmates. The agency offers over 80 FSA programs and more than 200 career technical education programs. The BOP's greatest resource in delivering programs is its staff and adding staff has been the primary factor in increasing program capacity. BOP is one of the largest civilian employers of doctoral level psychologists in the United States and also employs chaplains and teachers among its complement of service-delivery professionals. These positions have long provided treatment, training, and self-improvement services across BOP facilities. Since January 2021, the BOP allotted 109 new positions in program delivery disciplines to expand the capacity of its Evidence-Based Recidivism Reduction (EBRR) programs and Productive Activities (PAs). In addition to the aforementioned professions, the newly-added positions include the Special Populations Coordinator, who delivers gender-responsive programs, and a new vocational counselor position, which is currently pending position classification. Every new position adds capacity to the BOP's FSA programs.

Ordinarily, each BOP institution monitors the needs assessed within the local institution population to determine which programs to offer. Some large, residential programs, such as the Residential Drug Abuse Program, target a subset of the population for intensive services. For programs such as these, the Reentry Services Division monitors program completions and determines when and where more staffing is needed. For most programs, however the institutions have the ability to add cohorts and increase participant capacity as needed. Thus, if a facility is offering Anger Management but has a large group of inmates with needs remediated by this program that location could add an additional section of the program to meet the population needs.

2. The Department of Justice advised the IRC that it had discovered "technical issues" in the early administration and scoring of its risk assessment system, PATTERN, through the instrument's revalidation process.[13] The IRC encouraged DOJ to "release a detailed report on this matter—including any effect it may have had on inmate risk classifications, and steps taken to address misclassifications—as quickly as possible."[14]

    a. What "technical issues" did DOJ discover?

    Response: The PATTERN tool was finalized and published in January 2020, and the BOP assessed all inmates using the latest tool at that point, known as "PATTERN 1.2." In addition, the BOP's Office of Information Technology (OIT) began work to develop an automated PATTERN tool for integration into the BOP's inmate management systems. PATTERN contained four risk models: (1) male general recidivism, (2) male violent recidivism, (3) female general recidivism, and (4) female violent recidivism.

    Over the following months in 2020, as part of the annual PATTERN revalidation effort, the NIJ's research experts began conducting several analyses of the PATTERN 1.2 tool. The BOP's Office of Research and Evaluation (ORE) worked with the NIJ consultants and the BOP's Correctional Programs Division to develop a PATTERN simulation tool to enable ORE to assist NIJ consultants in validating PATTERN and comparing test results. By January 2021, the NIJ consultants had identified several coding, specification, and scoring discrepancies in PATTERN 1.2 and recommended immediate corrections to the BOP. The BOP adopted these recommendations, updating its field guidance and scoring sheets with the corrections made to the item and scoring errors, thereby refining the tool into version "PATTERN 1.2-Revised" (1.2-R). The BOP then began to reassess the risk scores for all inmates who were affected by the prior scoring errors.9 By June 2021, PATTERN 1.2-R was in full implementation. Currently, all inmates are assessed for their PATTERN risk score and level using the automated PATTERN 1.2-R tool. Once PATTERN is further refined, OIT will adjust PATTERN automation to update the calculation of BOP inmate risk scoring and levels.

    In March 2021, the team of expert consultants contracting with NIJ throughout 2020 began their annual 2021 review and revalidation study for PATTERN 1.2-R. Upon review of that tool, they proposed a refined version of the tool, PATTERN 1.3, because although version 1.2-R had been revised to correct item and scoring errors that the NIJ consultants identified in 2020, version 1.2-R maintained the scoring scheme developed for version 1.2. More information about the evaluation and adoption of PATTERN 1.3 and continued study and evaluation of the recidivism tool is available in the April 2022 *First Step Act Annual Report.*

    b. How many people did these "technical issues" affect? How did they affect them?

[13] *Id.* at 3.
[14] *Id.*

Response: The Bureau reassessed 1,745 inmates who were classified differently between the PATTERN 1.2 tool and the January 2020 corrected version of the PATTERN tool (PATTERN 1.2-R). As of early 2022, all inmates had been assessed for their PATTERN risk score and level using the automated PATTERN 1.2-R tool. BOP is now in the process of implementing the PATTERN 1.3 tool.

c. What steps have BOP and DOJ taken to correct these issues?

Response: BOP Information Technology (IT) staff and research staff worked to confirm concurrence between the research model and the software used to automate PATTERN scoring. The updated PATTERN 1.2-R instrument was fully automated and integrated with the BOP's case management application. In March 2021, the team of expert consultants contracting with NIJ throughout 2020 began their annual 2021 review and revalidation study for PATTERN 1.2-R. Upon review of that tool, they proposed a refined version of the tool, PATTERN 1.3, because although version 1.2-R had been revised to correct item and scoring errors that the NIJ consultants identified in 2020, version 1.2-R maintained the scoring scheme developed for version 1.2. PATTERN 1.3 has proven effective at distinguishing between recidivists and non-recidivists. Accordingly, and at the direction of the Attorney General, the Department will implement PATTERN 1.3 as it continues to consider all legally permissible options for reducing the differential prediction based on race and ethnicity to the greatest extent possible. More information on the evaluation and the adoption of the PATTERN 1.3 tool is available in the April 2022 *First Step Act Annual Report*.

d. Will DOJ commit to releasing a detailed report on these technical issues?

Response: A detailed accounting of the study, evaluation, and implementation of the PATTERN tool is available in the April 2022 *First Step Act Annual Report.*

3. In 2016, Rhode Island began offering all three medications approved by the FDA for opioid use disorder treatment to individuals who are incarcerated. The state subsequently saw a 61 percent reduction in overdose deaths among the targeted population. The First Step Act built on this success by requiring BOP to assess its capacity to treat opioid abuse through evidence-based programs, including medication-assisted treatment (MAT), and to develop a plan to expand access to treatment.

In the written testimony he submitted for this hearing, Dr. Homer Venters, a correctional health expert who audited several BOP facilities, states that there is still "an almost total lack of access to methadone and suboxone in BOP facilities…[d]espite public statements acknowledging the need to expand access to these lifesaving medications, a recent GAO report identified that almost none of the people who would qualify to have received them have."

a. In December 2020, you testified that BOP has one opioid treatment program at MCC Brooklyn and is working to start three more at FMC Butner, North Carolina; FMC Springfield, Illinois; and FMC Carswell, Texas.

i. Do these facilities have the capacity to serve everyone in the federal system with an opioid addiction?

   Response: All Bureau facilities have the ability to serve those with opioid addiction. In the Bureau's plan to roll out opioid treatment programs, FMC Butner, USMCFP Springfield, and FMC Carswell were selected as the first three institutions to apply for Opioid Treatment Program (OTP) certification As of June 30, 2022 FMC Lexington, FMC Forth Worth, FMC Devens, and FMC Rochester have also received OTP certification.

ii. Do all of those facilities offer MAT? If so, how many offer all three MAT drugs approved for opioid use disorder?

   Response: All Bureau facilities offer all three FDA-approved medications for opioid use disorder, either through internal or community resources. While the Bureau continues to expand its internal capacity to offer the medications, if an inmate requires a medication not offered internally at their facility, community resources are utilized.

iii. What plans does BOP have to expand the number of opioid treatment programs and the number of MAT drugs offered at those programs?

   Response: The Bureau requested and received approval as part of the FY2021 and FY2022 FSA Spend Plan by Congress to fill additional positions to support MAT Program expansion. The Bureau is also working on implementing a hub and spoke system that will allow all institutions to be certified as narcotic treatment programs working under the 7 certified opioid treatment programs. As of June 30, 2022 every BOP institution has been inspected by the DEA and has initiated the process to receive certification through Substance Abuse and Mental Health Services Administration (SAMHSA). Once certified, all facilities will be able to offer all FDA-approved medications for opioid use disorder within the confines of the institution.

b. As of September 2020, BOP had screened approximately 7,000 (of over 150,000) people in custody, but only 409 have enrolled in MAT.[15] How does BOP decide who to screen for MAT? Why more people were not screened?

   Response: The Bureau initially was screening those inmates releasing from Bureau custody for MAT services and those who were newly arriving for MAT services. The Bureau now screens all inmates for MAT services by utilizing several screening points to include self-referral for MAT services.

c. What percentage of people who are clinically eligible for receiving methadone or suboxone have been offered those drugs? How many are being treated with those drugs?

[15] The Attorney General's First Step Act Section 3634 Annual Report 10 (Dec. 2020), https://www.bop.gov/inmates/fsa/docs/20201221_fsa_section_3634_report.pdf.

Response: The Bureau does not currently assess the percentage of inmates who are clinically eligible for MAT services. At present, the Bureau has 43 patients receiving methadone and 305 receiving buprenorphine.

d. What steps does BOP take to connect people in custody to a provider who can continue their MAT once they leave prison?

Response: Inmates who transfer from prison to community placement (i.e., Residential Reentry Center or home confinement) are connected with providers in the community to continue counseling and medication services. Their clinical care is supervised by the Bureau's Community Treatment Services section.