DEPARTMENT OF JUSTICE | OFFICE OF THE INSPECTOR GENERAL

MANAGEMENT ADVISORY MEMORANDUM

25-064

JUNE 2025

Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates

INVESTIGATIONS DIVISION

June 30, 2025

Management Advisory Memorandum

To: William Marshall
Director
Federal Bureau of Prisons

From: William M. Blier
Acting Inspector General

WILLIAM BLIER Digitally signed by WILLIAM BLIER
Date: 2025.06.30 15:56:33 -04'00'

Subject: Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates

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The purpose of this memorandum is to advise the Director of the Federal Bureau of Prisons' (BOP) of the Department of Justice (DOJ or Department) Office of the Inspector General's (OIG) concerns regarding the BOP's policies and practices pertaining to the use of restraints on inmates. The OIG identified these concerns in connection with our investigators' reviews of allegations by multiple BOP inmates at multiple BOP institutions that they were placed in restraints while confined to a bed or chair for extended periods and were assaulted or otherwise mistreated while in restraints. Some of these inmates were placed in four-point restraints, which are restraints using four points of contact—both wrists and both ankles—to confine an inmate to a bed, and others were placed in restraints on both wrists and ankles while confined to a chair. Some inmates reportedly suffered long-term injuries after prolonged placement in restraints. For example, one inmate suffered injury requiring the amputation of part of the inmate's limb after being kept in restraints for over 2 days. We found that shortcomings in BOP's policies and practices contributed to the concerns we identified and limited the availability of evidence that could either corroborate or refute inmates' accounts of what happened while they were in restraints, thereby impairing the OIG's ability to investigate allegations of misconduct by BOP employees. Specifically, we identified the following shortcomings:

- Lack of clarity in BOP policy as to the meaning of four-point restraints and lack of clear guidance regarding restraint, medical, and psychology checks of inmates in restraints that are not considered four-point restraints;
- Policies and practices that allow inmates to be kept in restraints for prolonged periods, sometimes leading to long-term injuries, and that require only limited oversight by BOP regional offices while inmates are in restraints;
- Inadequate guidelines to memorialize what occurred during restraint checks, including the absence of a requirement that BOP staff video and audio record restraint checks; and
- Inadequate guidelines to document medical checks of inmates in restraints.

Clearer and more robust policies would assist the BOP in protecting inmates from abusive treatment, shielding staff from false allegations, deterring misconduct by staff, and holding staff who engage in

misconduct accountable. Since the OIG reviewed the allegations that formed the basis of this memorandum, the BOP has made updates to its policies regarding the use of force and application of restraints, including new training guidelines for confrontation avoidance and de-escalation tactics. While these updates are an improvement to the BOP's policies, additional policy revisions are needed to address the OIG's concerns. In this memorandum, the OIG makes six recommendations to address the concerns we identified. Separately, the OIG is continuing to conduct an audit related more broadly to the BOP's oversight of its use of restraints.

Relevant Authorities

The BOP's policies regarding the use of force and application of restraints are set forth in 28 C.F.R. Chapter V, Subchapter C, Part 552, Subpart C and BOP Program Statement 5566 (Use of Force Policy). The Use of Force Policy in place at the time of the allegations that formed the basis of this memorandum was dated August 29, 2014. The BOP published a revised Use of Force Policy on July 17, 2024.

Use of Force

According to the Use of Force Policy and 28 C.F.R. § 552.20, the BOP "authorizes staff to use force only as a last alternative after all other reasonable efforts to resolve a situation have failed." In addition, "[w]hen authorized, staff must use only that amount of force necessary to gain control of the inmate, to protect and ensure the safety of inmates, staff and others, to prevent serious property damage and to ensure institution security and good order." The Use of Force Policy further states, "Excessive force will not be tolerated. If substantiated it may constitute a prosecutable offense. Consistent with policy and regulations, an employee may not use brutality, physical violence, or intimidation toward inmates, or use any force beyond that which is reasonably necessary to subdue an inmate." In addition, "[f]orce may not be used to punish an inmate."

Application of Restraints

The Use of Force Policy and 28 C.F.R. § 552.20 state that "[s]taff are authorized to apply physical restraints necessary to gain control of an inmate who appears to be dangerous" because the inmate:

a. Assaults another individual;
b. Destroys government property;
c. Attempts suicide;
d. Inflicts injury upon self; or
e. Becomes violent or displays signs of imminent violence.

However, the BOP's policy states that restraints may not be used "as a method of punishing an inmate" or in "a manner that causes unnecessary physical pain or extreme discomfort."

According to the Use of Force Policy and 28 C.F.R. § 552.22, after placing an inmate in restraints, staff must notify the Warden immediately, and the Warden must decide whether the use of restraints should continue.

The Use of Force Policy states that BOP personnel must use "the least restrictive restraint method to control the inmate as deemed necessary for the situation." On the less restrictive side of this continuum are "ambulatory restraints," which are defined as "approved soft and hard restraint equipment which allow the inmate to eat, drink, and take care of basic human needs without staff intervention." More restrictive

restraints include "hard restraints with or without waist chain or waist belt, four-point soft restraints with hard restraints used for securing the inmate to the bed, or four-point hard restraints."[1]

Fifteen Minute and Two-Hour Checks of Inmates in Restraints

The Use of Force Policy states that if the Warden approves the use of restraints, restraints "should remain on the inmate until self-control is regained." The Use of Force Policy requires Fifteen Minute Restraints Check Forms and Two-Hour Lieutenant Check forms for inmates in both ambulatory and four-point restraints. With respect to four-point restraints, the policy states that the inmate must be checked by correctional staff at least every 15 minutes, "both to ensure that the restraints are not hampering circulation and for the general welfare of the inmate." The policy further states that every 2 hours the inmate's placement in four-point restraints must be reviewed by a Lieutenant "to determine if the use of restraints has had the required calming effect and so that the inmate may be released from these restraints (completely or to lesser restraints) as soon as possible." The policy states, with respect to four-point restraints, that "Staff should look for a pattern of non-disruptive behavior over a period of time indicating the inmate has regained self-control and is no longer a disruptive threat." The policy further states that at every 2-hour review of an inmate in four-point restraints, the inmate "will be afforded the opportunity to use the toilet, unless the inmate is continuing to actively resist or becomes violent while being released from the restraints for this purpose."

In July 2024, the BOP added to the Use of Force Policy a requirement that the 15-minute logs for both ambulatory and four-point restraints "include specific inmate actions during observations." The July 2024 update further added requirements that the 15-minute and 2-hour logs "support any decision concerning the continuation or progression of an inmate in restraints," and that when an inmate is placed in four-point restraints, "the supervising Lieutenant shall assign an employee to provide constant visual supervision until the restraints are removed or downgraded to less restrictive restraints such as ambulatory restraints."

According to the Use of Force Policy, both the 15-minute restraint checks and the 2-hour lieutenant checks must be documented. However, the policy does not require such checks to be video and audio recorded.

Medical and Mental Health Assessments of Inmates in Four-Point Restraints

The Use of Force Policy requires the BOP to conduct medical assessments of inmates in four-point restraints. Initially, the inmate must be assessed by qualified health personnel "to ensure appropriate breathing and response" and to ensure that the restraints "have not restricted or impaired the inmate's circulation." In addition, the policy states that when inmates are in four-point restraints, "qualified health personnel ordinarily are to visit the inmate at least twice during each 8-hour shift" and "Psychology Services staff will examine inmates in four-point restraints at least once during every 24-hour period that the inmate is restrained." The policy further states that "Mental health and qualified health personnel may be asked for

[1] The BOP also has used a restraint chair, which is a chair that restrains both legs and arms, as a method of progressive restraints. The BOP's Correctional Services Manual, Policy Statement 5500.15, allows the use of a restraint chair for transportation, involuntary feeding, and involuntary medical administration. The Correctional Services Manual states that the restraint chair is intended for short-term use and "is not to be used in lieu of progressive or four-point restraints." According to a January 10, 2022, memorandum from the BOP Assistant Director of the Correctional Programs Division to BOP Chief Executive Officers, in August 2020, BOP Executive Staff approved a pilot project which temporarily allowed the restraint chair as a method of progressive restraints. However, the January 10, 2022, memorandum halted the use of the restraint chair as a method of progressive restraints until further notice, due to "information [that had] been received which will require further examination." Although the BOP is reportedly no longer using the restraint chair as a method of progressive restraints, we included in this memorandum examples involving the restraint chair, because many of the concerns we identified, including serious injuries after an extended period in restraints and inadequate restraint check and medical check documentation, apply equally to four-point restraints and to situations in which an inmate was confined using a chair.

advice regarding the appropriate time for removal of the restraints." In July 2024, the BOP added to the Use of Force Policy a requirement that, "When individuals have engaged in self-directed violence, a psychologist will be notified to evaluate for the risk of suicide."

According to the Use of Force Policy, the initial medical examination of an inmate conducted after the application of restraints is required to be video recorded. However, the BOP's policy does not require subsequent medical checks of the inmate to be video recorded or documented with photographs.

Notification to Regional Office Staff

The Use of Force Policy states that the applicable BOP Regional Office must be notified if an inmate is restrained, in either ambulatory or four-point restraints, for longer than 8 hours. Specifically, the Use of Force Policy states that, "When it is necessary to restrain an inmate for longer than 8 hours, the Warden (or designee) or institution administrative officer shall notify the Regional Director or Regional Duty Officer by telephone." The policy states that such notification must be made "for each consecutive 8-hour period the inmate remains in restraints" and documentation detailing the reasons for the placement of the inmate in restraints must be provided. The policy does not state that the Regional Director or Regional Duty Officer must approve the use of restraints for longer than 8 hours or otherwise specify what the regional office should do with the notification.

Use of Restraints for Longer Than Twenty-Four Hours

The Use of Force Policy states that within 24 hours of placement in restraints, "a review of the inmate's status will be conducted, and a [behavior management plan] prepared." The BOP's policy requires such a review to occur at the 24-hour mark and every 48 hours thereafter. This review is conducted by the Warden, Associate Warden, Captain, Unit Manager, Health Services Administrator, and Chief Psychologist, or their designees. The Use of Force Policy requires this team to review "[a]ll relevant information, including the 15-minute, Lieutenant, medical staff, and psychology service checks logs."

According to the Use of Force Policy, to keep the inmate in restraints for longer than 24 hours, there must be a decision by the Warden supported by "evidence indicating the inmate's inability to be placed in lesser restraints or released from restraints." The policy further states that, "The Warden should look for a pattern of non-disruptive behavior over a period of time indicating the inmate has regained self-control and is no longer a disruptive threat. Additionally, the Warden's documentation must indicate specifically what considerations are being made for mental health treatment, including possible referral to an institution that provides the appropriate level of mental health treatment." The Use of Force Policy states that the Warden's review must be documented in a memorandum and provided to the Regional Director.

After-Action Reviews

BOP policy requires an institution to submit an After-Action Report to the Regional Director within 2 working days after the inmate has been released from restraints. The after-action review is conducted by the Warden, Associate Warden responsible for Correctional Services, Health Services Administrator, Captain, and Lieutenant supervising the use of force, when available. According to the Use of Force Policy, the after-action review is conducted "to assess the rationale of the actions taken (e.g., if the force was appropriate and in proportion to the inmate's actions)."

Use of Force and Restraints with Respect to the Mentally Ill

The BOP permits the use of restraints on inmates "due to mental illness (e.g. to prevent suicide or infliction of self-injury)," subject to the provisions of the Use of Force Policy and the BOP's Program Statement related to its Suicide Prevention Program. The 2014 Use of Force Policy stated that a mentally ill inmate "must be assessed carefully to determine whether the situation is grave enough to require the use of physical force,"

after consultation with the Clinical Director. In July 2024, the Use of Force Policy was modified to state that in the case of a mentally ill inmate, the Chief Psychologist or designee "must be consulted to determine if the proposed use of force . . . is clinically appropriate." After reviewing a draft of this memorandum, the BOP noted that placement in restraints does not preclude placement on suicide watch if determined clinically necessary by the evaluating psychologist, as outlined in the BOP's Suicide Prevention Program Statement.

Training

The Use of Force Policy requires staff to receive various types of training, including annual training in confrontation avoidance procedures. In July 2024, the BOP added new requirements and models related to training, including a requirement that employees be trained annually in "de-escalation tactics and techniques designed to gain voluntary compliance before using force." Employees are also required to receive training on the application of restraints. It is unclear from the policy whether employees receive regular training regarding conducting restraint checks.

The Issue

The OIG receives numerous allegations every year regarding abuse, mistreatment, or injury of inmates in connection with the use of restraints, including four-point restraints. For example, between August 2022 and August 2023, the OIG received dozens of complaints involving abuse, injury, or other mistreatment of inmates in connection with the use of four-point restraints.

BOP policy does not define the term "four-point restraints." However, the BOP has informed the OIG that four-point restraints are restraints using four points of contact—both wrists and both ankles—to confine an inmate to a bed. Four-point restraint equipment is depicted in the image below:

Left, Hard Steel Arm and Leg Restraints and Soft Vinyl Cuff
Middle, Restraints Applied to Bed with Soft Vinyl Cuffs
Right, Cell and Restraint Bed Used when Inmate Held in Restraints
Source: OIG, September 2024

In reviewing allegations by multiple BOP inmates at multiple BOP institutions that they were placed in four-point restraints for extended periods and were assaulted or otherwise mistreated while in restraints, in addition to assessing potential misconduct by BOP staff, we identified several shortcomings in BOP policy, including:

- Lack of clarity in BOP policy as to the meaning of four-point restraints and lack of clear guidance regarding restraint, medical, and psychological checks of inmates in restraints that are not considered four-point restraints;
- Policies and practices that allow inmates to be kept in restraints for prolonged periods, sometimes leading to long-term injuries, and that require only limited oversight by BOP regional offices while inmates are in restraints;
- Inadequate guidelines to memorialize what occurred during restraint checks, including the absence of a requirement that BOP staff video and audio record restraint checks; and
- Inadequate guidelines to document medical checks of inmates in restraints.

BOP Policy Does Not Define the Term "Four-Point Restraints" and Lacks Sufficient Guidance Regarding the Medical, Psychological, and Other Checks Required When Using Restraints Other than Four-Point Restraints

The Use of Force Policy does not define four-point restraints, which we found to be problematic given that the policy contains different requirements for four-point restraints versus other types of restraints. The BOP told us that four-point restraints are restraints using four points of contact—both wrists and both ankles—to confine an inmate to a bed, and cited the following language in the Use of Force Policy as support for that definition: "[E]mployees must determine the type of progressive restraints to be used (e.g., hard restraints with or without waist chain or belt, four-point soft restraints with hard restraints used for securing the inmate to the bed, or four-point hard restraints)." However, we found that this language could be read to mean that four-point soft restraints involve a bed, but four-point hard restraints do not. Further, in a section entitled "Use of four-point restraints," the Use of Force Policy states, "When an inmate is restrained to a bed, staff shall periodically rotate the inmate's position to avoid soreness or stiffness." The use of the clause, "When an inmate is restrained to a bed," in a section about four-point restraints implies that not all instances of four-point restraints involve confinement to a bed.

The Use of Force Policy specifically requires that inmates in four-point restraints be checked every 15 minutes by correctional staff, every 2 hours by a lieutenant, twice every 8 hours by Health Services staff, and every 24 hours by Psychology Services, and sets forth the purposes of each of these checks, including to assess whether restraints are hampering circulation and for the general welfare of the inmate. By contrast, with respect to other types of restraints, while the Use of Force Policy refers to the completion of forms for 15-minute restraint checks, 2-hour lieutenant checks, Health Services Restraints Review, and Psychology Services Review, it does not provide guidelines regarding such things as assessing circulation and the general welfare of the inmate, the specific purposes of Psychology checks or medical checks, or the expected frequency of medical checks.[2]

Inmates subject to restraints other than four-point restraints can suffer injuries similar to those suffered by inmates in four-point restraints, such as injuries resulting from restraints being too tight. In addition,

[2] While the restraint chair was not specifically mentioned in the Use of Force Policy, we found that the BOP seemed to treat inmates confined to a chair similarly to inmates subject to four-point restraints, at least with respect to conducting the relevant medical and psychology checks on such inmates.

inmates subject to restraints other than four-point restraints may similarly be at risk if not assessed for basic welfare and psychological concerns.[3]

Accordingly, the OIG recommends that the BOP revise its policies, procedures or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.

BOP Policy Does Not Limit the Amount of Time Inmates Can Remain in Restraints and Requires Only Limited Oversight by BOP Regional Offices

The BOP has no outer limit on the length of time an inmate may be kept in restraints, including four-point restraints. Instead, BOP policy imposes a timeline of actions that must be taken while an inmate is in restraints including:

- Warden approval when the inmate is first put in restraints;
- 15-minute restraint checks by correctional staff;
- 2-hour lieutenant checks;
- Notification by the Warden to the Regional Director or Regional Duty Officer after the inmate has been in restraints for 8 hours; and
- Review and creation of a behavior management plan by the Warden, Associate Warden, Captain, Unit Manager, Health Services Administrator, and Chief Psychologist after the inmate has been in restraints for 24 hours and every 48 hours thereafter.

Despite this timeline of actions, the OIG has reviewed complaints from multiple inmates alleging that they suffered nerve damage or other long-term injuries due to the prolonged use of restraints. For example, one inmate suffered long-term scarring and was provisionally diagnosed with carpal tunnel syndrome due to ongoing complaints of wrist numbness after being held in four-point restraints for over 3 days, and another inmate suffered severe injury requiring the amputation of part of the inmate's limb after being held in a combination of ambulatory restraints and a restraint chair for over 2 days.

Based on the OIG's analysis of data and records provided by the BOP, prolonged placement in restraints, including four-point restraints, is not unusual. While the OIG has determined that the BOP's data has certain accuracy issues which are addressed in the audit referenced above, the BOP recorded that between January 2018 and January 2024, there were thousands of incidents of inmates held in restraints for 16 hours or longer, hundreds of which were held in restraints for more than 24 hours and some for over a week or weeks.[4] Indeed, BOP records indicate that one inmate was held in ambulatory restraints for over 12 days, removed from restraints for approximately 4 hours, and then placed back into ambulatory restraints for over 30 days. The BOP placed this same inmate back into restraints just about a week later, and this time held him in a combination of ambulatory and four-point restraints for more than 29 additional days. Another inmate was placed in a combination of four-point and ambulatory restraints for more than 18 days, almost 9 days of which the inmate was in four-point restraints.

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[3] After reviewing a draft of this report, the BOP noted that the Use of Force Policy states: "The policies and procedures described in this Program Statement will be followed for inmates placed in ambulatory restraints including: conditions of confinement; scheduled checks; documentation; 24- and 48-hour reviews by the Warden and the Behavior Management Plan (BMP) team." However, we still believe that the policy needs additional clarity, because the specific criteria for the various restraint checks appear only in a section related to four-point restraints.

[4] Due to accuracy issues with the BOP's data, we were unable to determine how many of these incidents involved four-point restraints versus ambulatory restraints.

Such lengthy periods in restraints are especially concerning for inmates who were placed in restraints due to suicidal behavior or attempting self-harm. In one case reviewed by the OIG, an inmate was in a restraint chair with restraints on both wrists and both ankles for 18 hours after threatening to swallow a bottle of pain medication. The inmate was not assessed by a psychologist during that time. In July 2024, the BOP added a requirement that the Chief Psychologist or designee must be consulted prior to the calculated use of force on an inmate that is identified as mentally ill. However, once inmates are placed in four-point restraints, the Use of Force Policy requires Psychology Services staff to examine them only once during every 24-hour period.[5] In addition, the inmate referenced above who was held in restraints for over 18 days, including four-point restraints for almost 9 days, was placed in restraints due to engaging in self-harming behaviors. The BOP informed the OIG that this inmate's situation was extraordinary, because the inmate had engaged in multiple self-harming behaviors and psychological evaluations consistently noted an increased risk of lethality or permanent injury from additional self-harming behaviors. However, this inmate was not placed on suicide watch and was visited by Psychology Services just once per day during the 18-day period. While we understand that restraints may be needed to address inmates who attempt or threaten self-harm, the OIG finds it troubling that inmates experiencing serious psychological difficulties may be restrained for such extended periods without more frequent mental health intervention, especially given the potential added psychological impact of being in restraints.

Further, while the Use of Force Policy requires 15-minute restraint checks by correctional staff and 2-hour lieutenant checks, we found that the policy provides limited guidance on what behavior observed during such checks warrants the continuation of restraints. Specifically, the Use of Force Policy states that restraints "should remain on the inmate until self-control is regained," and that "Staff should look for a pattern of non-disruptive behavior over a period of time indicating the inmate has regained self-control and is no longer a disruptive threat." However, the policy does not provide specific guidance on how to make the determination that self-control has been regained or how long an inmate must demonstrate self-control for restraints to be removed.

During the course of reviewing numerous allegations of abuse or mistreatment of inmates while in restraints, we observed that the 15-minute and 2-hour restraint check forms often contained limited information regarding inmate behavior to justify the continued use of restraints. For example, in the case referenced above where an inmate was in a restraint chair with restraints on both wrists and both ankles for 18 hours, the only behaviors noted in the restraint check documentation during the final more than 5.5 hours were that the inmate was looking at the door or out the window, requesting to be released or asking when the inmate would be released from restraints, pulling on the shoulder straps, or refusing to respond. Another inmate was in four-point restraints for 16 hours, but during the final approximately 7.5 hours (nearly half the time the inmate was in restraints) the restraint check documentation indicated that the inmate did not respond to officers, appeared to be sleeping, expressed regret, cried, or said that the inmate wanted to be taken out of restraints or to return to his cell, and one lieutenant check during that time period indicated that the inmate was pulling on the restraints.[6] A third inmate was placed in a restraint chair with restraints on both wrists and both ankles for more than 2 days and then, less than 2 hours after being released from restraints, sprayed by BOP staff with Oleoresin Capsicum following an alleged altercation with a cellmate and placed back in the restraint chair for another approximately 5 hours until being discovered unresponsive. For the inmate's final hour in restraints before being discovered unresponsive, the 15-minute

[5] After reviewing a draft of this memorandum, the BOP noted that, in accordance with the Suicide Prevention Program Statement, inmates who are on suicide watch may receive more frequent intervention from Psychology Services.
[6] One of the lieutenant checks for this inmate during the final nearly eight hours in restraints stated that the inmate was not cooperating with staff during 15-minute checks. However, based on the OIG's review, the 15-minute checks around the same period did not indicate that the inmate was uncooperative.

and 2-hour restraint check forms indicated that the inmate was not responding to staff. According to the autopsy report for this inmate, the cause of death was "Vaso-Occlusive Crisis due to Sickle Cell Disease Complicating Oleoresin Capsicum Use and Prolonged Restraint Following Altercation." In addition, for the inmate described earlier in this memorandum that was in restraints for successive periods of approximately 12, 30, and 29 days, numerous 15-minute restraint checks stated only, "Restraints appear secure."

In most cases reviewed by the OIG, the 15-minute and 2-hour check forms listed manipulating or pulling on restraints as justifications for the continued use of restraints. In addition, BOP records sometimes indicated that the inmate's action of pulling on or manipulating restraints led to or exacerbated the inmate's injuries. However, the BOP's Use of Force Policy does not contain guidelines on how to address inmates pulling on or manipulating restraints or on whether such behavior is sufficient to justify continued use of restraints. The policy also does not provide guidelines on when injuries resulting from inmates pulling on or manipulating restraints warrant removal from restraints or increased medical attention. We found it unsurprising that a person who was restrained for hours or days, especially an inmate who may have mental health or anger management difficulties that contributed to the placement in restraints in the first place, would experience frustration leading to manipulating or pulling on the restraints. Given this, combined with how often we observed instances of inmates reportedly manipulating or pulling on restraints and the potential medical consequences of such behavior, we believe that this is a known risk that the BOP should address to meet its duty to provide for the safekeeping and protection of inmates. *See* 18 U.S.C. § 4042.

In July 2024, the BOP added to its Use of Force Policy new requirements and models related to training, including a requirement that employees be trained annually in "de-escalation tactics and techniques designed to gain voluntary compliance before using force." Employees are also required to receive training on the application of restraints. However, it is unclear from the policy whether employees receive adequate training regarding conducting restraint checks, such as training on the types of behaviors that amount to a lack of self-control and warrant the continuation of restraints, how long an inmate must demonstrate self-control for restraints to be removed, or the types of injuries or other issues to look for to assess an inmate's welfare and safety while in restraints.

In addition, we were troubled that BOP policy requires only notification to, and not specific action by, regional staff when an inmate is held in restraints for an extended period of time. Specifically, the policy requires the applicable regional office to be notified once the inmate is in restraints for 8 hours and for every 8 hours thereafter, but the policy does not specify what the regional staff are required to do with such notifications. We believe that regional staff could play an important role, especially given that regional staff are removed from the institution where the inmate engaged in behavior that led to the use of restraints and, thus, may be able to provide a more objective perspective than could be provided by institution staff on the need for continued restraints.

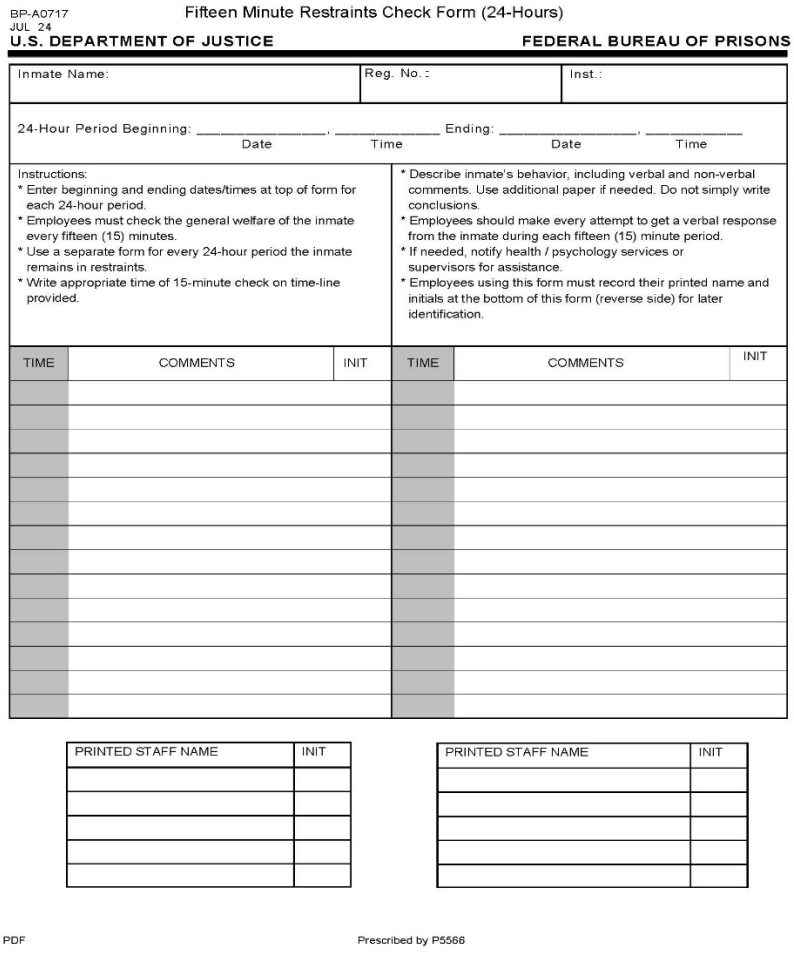
Accordingly, we recommend that the BOP reassess its policies, procedures, and training to identify ways to prevent prolonged placement of inmates in restraints, especially four-point restraints, that may result in serious injury. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:

- Additional training for BOP staff on conducting restraint checks;
- Guidelines and training on the specific types of behaviors that evidence self-control or warrant the continued use of restraints;
- Guidelines and training on the length of time an inmate must exhibit self-control to warrant removal from restraints;
- Guidelines and training on how to handle inmate's pulling on or manipulating restraints;

- Guidelines on how correctional officers are to assess whether restraints are hampering circulation;
- Enhanced guidelines and training for creating effective behavior management plans for inmates in restraints;
- More frequent checks by Psychology Services staff and alternatives to long-term restraints for certain inmates who were placed in restraints due to attempting, threatening, or engaging in self-harm or experiencing other mental health challenges;
- Greater involvement by BOP regional staff in determining whether inmates should be placed in or remain in restraints.

Inadequate Guidelines to Memorialize What Occurred During Restraint Checks, Including the Absence of a Requirement that BOP Staff Video and Audio Record Restraint Checks

BOP policy requires restraint checks to be documented. In cases reviewed by the OIG, we found that the 15-minute restraint check records frequently contained only a few words for each check, such as "inmate yelling," "inmate manipulating restraints," or "inmate ignoring staff." Following the OIG review of allegations that led to this memorandum, the BOP added to the Use of Force Policy a requirement that the 15-minute logs "include specific inmate actions during observations." However, the policy does not otherwise contain guidance on what information should be included in restraint check documentation. Moreover, as shown below, the 15-minute restraint check documentation forms contain limited space to even allow staff to incorporate detailed information about inmates' behavior during restraint checks:



BP-A0717
JUL 24

Fifteen Minute Restraints Check Form (24-Hours)

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Inmate Name:	Reg. No.:	Inst.:

24-Hour Period Beginning: _____ (Date), _____ (Time) Ending: _____ (Date), _____ (Time)

Instructions:
* Enter beginning and ending dates/times at top of form for each 24-hour period.
* Employees must check the general welfare of the inmate every fifteen (15) minutes.
* Use a separate form for every 24-hour period the inmate remains in restraints.
* Write appropriate time of 15-minute check on time-line provided.

* Describe inmate's behavior, including verbal and non-verbal comments. Use additional paper if needed. Do not simply write conclusions.
* Employees should make every attempt to get a verbal response from the inmate during each fifteen (15) minute period.
* If needed, notify health / psychology services or supervisors for assistance.
* Employees using this form must record their printed name and initials at the bottom of this form (reverse side) for later identification.

TIME	COMMENTS	INIT	TIME	COMMENTS	INIT

PRINTED STAFF NAME	INIT

PRINTED STAFF NAME	INIT

PDF Prescribed by P5566

The OIG has reviewed multiple cases in which inmates have claimed, contrary to BOP documentation or statements by BOP employees, that they were not disruptive during restraint checks and therefore should not have been kept in restraints for extended periods. In other cases, inmates have alleged that they were violently beaten while in restraints. However, the OIG's ability to assess the relative truthfulness of inmate accounts versus BOP employee accounts has been hampered by the lack of detailed information in restraint check forms and the absence of a requirement to video and audio record restraint checks. In addition, the absence of video recordings prevents the OIG from assessing whether correctional staff have actually conducted the checks they documented occurred.[7]

Two BOP Regional employees told the OIG that they believed restraint check documentation often does not contain sufficient detail and that additional detail would assist in assessing the inmate's behavior over time. Such details, as well as video footage, would inform the Warden's and Regional Office's 8-hour review, the 24-hour review by the Warden and other institution staff, and after-action reviews.

Requirements to video and audio record restraint checks as well as more detailed written documentation of restraint checks would similarly inform investigations of allegations by inmates that they were unjustifiably kept in restraints for prolonged periods or assaulted while in restraints. We also note that when video recording was required, such as during the initial use of force, we found that in some cases video recording did not occur as required or did not fully capture what occurred. Appropriate controls to ensure that video and audio recordings occur as required and adequately capture inmate and staff conduct during restraint checks would also support investigations. Ultimately, such requirements would better enable the BOP, OIG, and prosecutors to hold BOP staff who engage in misconduct criminally or administratively accountable, deter staff from engaging in such misconduct in the first place, and protect innocent staff from false allegations.[8]

Accordingly, the OIG recommends that the BOP require video and audio recording of all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15-minute restraint checks. The OIG further recommends that the BOP revise its policies, procedures, or training to provide greater clarity on the information that should be included in the restraint check documentation. In addition, the OIG recommends that the BOP revise its restraint check forms to provide adequate space for BOP staff to record detailed information about the inmate's condition and behavior during restraint checks and consider including check boxes to ensure that BOP staff make a record of key information.

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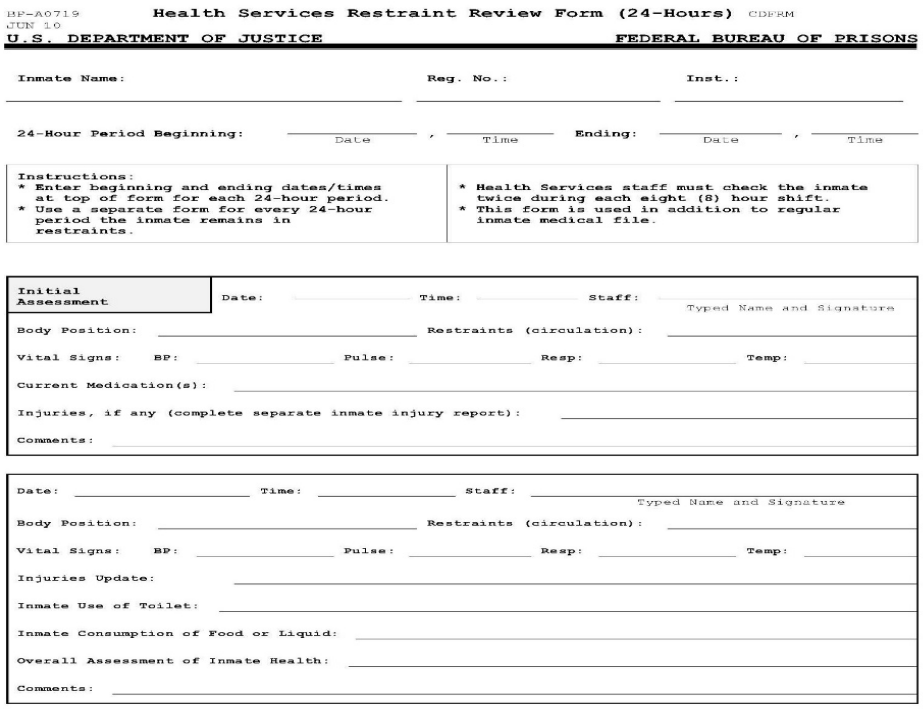
[7] The OIG has investigated multiple cases in other contexts in which correctional officers have attested that they completed inmate rounds that they did not in fact complete. Such allegations are often corroborated with video evidence. *See, e.g.,* Southern District of New York | Correctional Officers Charged With Falsifying Records On August 9th And 10th At The Metropolitan Correctional Center | United States Department of Justice.

[8] After reviewing a draft of this memorandum, the BOP informed the OIG that correctional officers are not expected to and typically do not enter the cells of restrained inmates for 15-minute restraint checks. We found this concerning given the Use of Force Policy states that the purposes of the 15-minute restraint checks are "to ensure that the restraints are not hampering circulation and for the general welfare of the inmate" and requires staff to "periodically rotate the inmate's position to avoid soreness or stiffness" when an inmate is restrained to a bed and wake inmates that are sleeping at the time of the 15-minute checks. The BOP informed us that correctional officers can assess whether restraints are hampering circulation by asking the inmate. However, we found that 15-minute restraint check paperwork frequently stated only that the inmate was not responding to staff or appeared to be sleeping, making it impossible for staff to assess whether restraints were hampering circulation based on the response to such a question. For example, the 15-minute restraint check paperwork for the inmate described above who died while in restraints indicated that the inmate was not responding to staff during the final hour before the inmate was discovered unresponsive.

Limited Guidelines Regarding Medical Checks of Restrained Inmates

The OIG has also found that the BOP has inadequate guidelines regarding documenting medical checks for restrained inmates and how to address injuries observed during such medical checks.

In the case referenced above where an inmate suffered severe injury requiring the amputation of part of the inmate's limb after being held in a combination of ambulatory restraints and a restraint chair for over 2 days, the inmate's injury worsened to the point of needing hospitalization and amputation despite medical checks occurring at time intervals that complied with policy. The medical checks were completed by different medical staff who did not discuss the progression of the inmate's injuries between shifts, and there were no photographs or video recordings to document that a medical check was actually performed and to show the progression of the inmate's injuries. While BOP policy requires that the first medical assessment after placement in restraints be video recorded, subsequent medical checks are not required to be recorded, even if the inmate has been held in restraints for an extended period of time, as occurred in this example. Further, if an inmate has injuries, there is no requirement to photograph the injuries, to provide a detailed description to document the progression of injuries, or to provide an explanation for allowing restraints to remain in place when injuries have been observed. Moreover, the Health Services Restraint Review Form contains minimal space to provide descriptions regarding the appearance or progression of an inmate's injuries. This form contains only small spaces for medical staff to record information about the inmate's vital signs, injuries, and other information, as shown in the images below:



BP-A0719 JUN 10 **Health Services Restraint Review Form (24-Hours)** CDFRM

U.S. DEPARTMENT OF JUSTICE **FEDERAL BUREAU OF PRISONS**

Inmate Name: _____ Reg. No.: _____ Inst.: _____

24-Hour Period Beginning: _____ Date , _____ Time Ending: _____ Date , _____ Time

Instructions:
* Enter beginning and ending dates/times at top of form for each 24-hour period.
* Use a separate form for every 24-hour period the inmate remains in restraints.
* Health Services staff must check the inmate twice during each eight (8) hour shift.
* This form is used in addition to regular inmate medical file.

Initial Assessment	Date:	Time:	Staff: Typed Name and Signature

Body Position: _____ Restraints (circulation): _____

Vital Signs: BP: _____ Pulse: _____ Resp: _____ Temp: _____

Current Medication(s): _____

Injuries, if any (complete separate inmate injury report): _____

Comments: _____

Date: _____ Time: _____ Staff: _____ Typed Name and Signature

Body Position: _____ Restraints (circulation): _____

Vital Signs: BP: _____ Pulse: _____ Resp: _____ Temp: _____

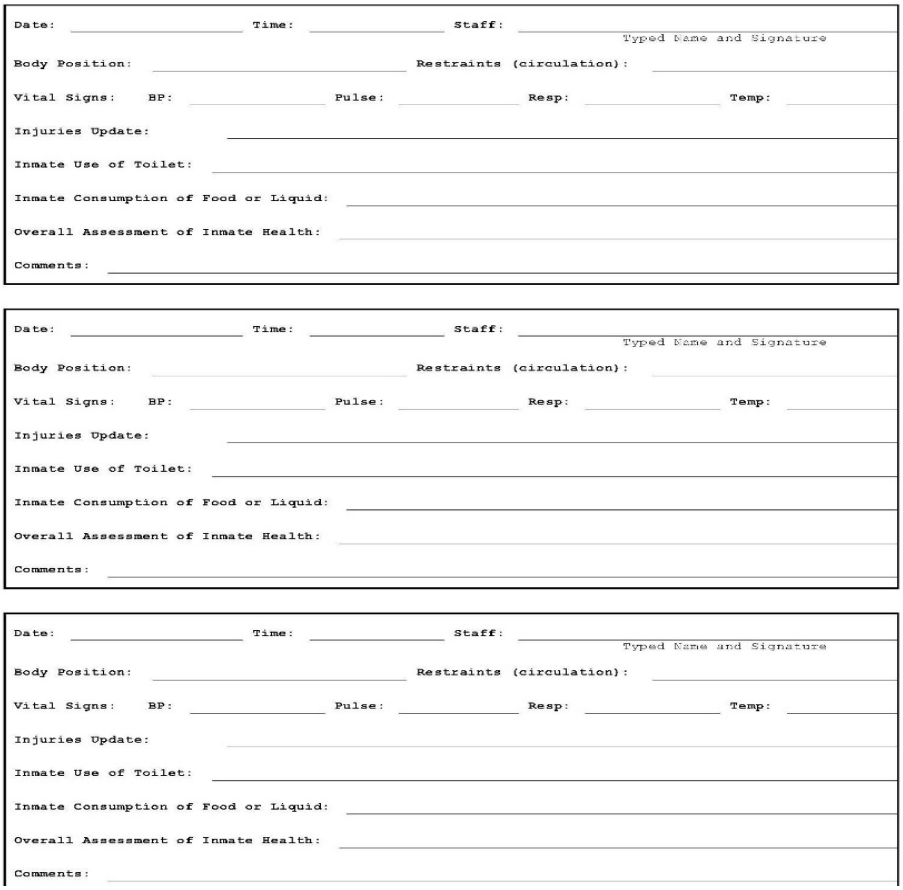
Injuries Update: _____

Inmate Use of Toilet: _____

Inmate Consumption of Food or Liquid: _____

Overall Assessment of Inmate Health: _____

Comments: _____



Video recordings of medical checks, photographs of injuries, and detailed descriptions of injuries in medical check documentation would better enable the BOP to assess the progression of an inmate's injuries and when to take further action before dire consequences, such as the amputation of a limb, occur. Video recordings would also help the BOP and OIG assess whether medical staff have actually conducted the checks they documented and whether inmates experienced health concerns that were not documented in the records.

Through our investigative work, we have also found that some medical personnel conducting medical checks on restrained inmates may not have been sufficiently familiar with the signs and symptoms of conditions that can lead to muscle and nerve damage. We believe that enhanced training is needed to address this concern.

In addition, we have found that Health Services Restraint Review Forms sometimes contained limited information regarding the inmate's toilet use and consumption of food or liquid. In some cases, instead of indicating in these blanks whether the inmate used the toilet or consumed food or liquid, the staff member wrote "offered." A BOP Regional Medical Director told the OIG that it is important for medical staff to not only know whether toilet, food, and liquid are offered, but also to know whether the inmate took advantage of these opportunities in order to assess the inmate's hydration and nutrition levels.

Accordingly, we recommend that the BOP reassess its policies, procedures, and training to provide better guidelines for medical staff conducting medical checks of inmates in restraints. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:

- A requirement to video record medical checks;
- A requirement to photograph injuries observed during medical checks;
- Requiring greater detail regarding inmate injuries, toilet usage, and food and liquid consumption in the Health Services Restraint Review Form, and revising the Health Services Restraint Review Form to include larger spaces to allow for such detail to be included;
- A requirement to provide a detailed explanation when concurring with the continued use of restraints despite evidence of injury;
- Enhanced guidelines and training to medical staff on recognizing the existence of injuries that can lead to nerve and muscle damage and on when injuries resulting from restraints warrant action, such as removing restraints or seeking a higher level of medical care;
- Enhanced guidelines or training to correctional staff to recognize signs of potential nerve or muscle damage that warrant seeking assistance from medical staff.

Conclusions

The purpose of this memorandum is to notify the BOP of the OIG's concerns identified during investigative activity regarding the BOP's use of restraints. Specifically, the OIG identified shortcomings in BOP's policies and practices regarding the use of restraints which have limited the availability of evidence to corroborate or contradict inmates' accounts of what happened while they were in restraints and impaired the OIG's ability to investigate allegations of misconduct by BOP employees. Clearer and more robust policies would assist the BOP in protecting inmates, protecting staff from false allegations, deterring misconduct by staff, and holding staff who engage in misconduct accountable. The OIG is also currently conducting an audit related more broadly to the BOP's oversight of the use restraints and, thus, may have additional recommendations on the topic of restraints in the future.

Recommendations

The OIG recommends the following:

1. The BOP should revise its policies, procedures or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.
2. The BOP should reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:
    - Additional training for BOP staff on conducting restraint checks;
    - Guidelines and training on the types of behaviors that evidence self-control or warrant the continued use of restraints;
    - Guidelines and training on the length of time an inmate must exhibit self-control to warrant removal from restraints;
    - Guidelines and training on how to handle inmate's pulling on or manipulating restraints;
    - Guidelines on how correctional officers are to assess whether restraints are hampering circulation;
    - Enhanced guidelines and training for creating effective behavior management plans for inmates in restraints;
    - More frequent checks by Psychology Services staff and alternatives to long-term restraints for certain inmates who were placed in restraints due to attempting, threatening, or engaging in self-harm or experiencing other mental health challenges;

- Greater involvement by BOP regional staff in determining whether inmates should be placed in or remain in restraints.

3. The BOP should require BOP staff to video and audio record all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15 minute restraint checks.
4. The BOP should revise its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.
5. The BOP should revise its restraint check forms to provide adequate space for BOP staff to record detailed information about the inmate's condition and behavior during restraint checks, and consider including check boxes to ensure that BOP staff make a record of key information.
6. The BOP should reassess its policies, procedures, and training to provide better guidelines for medical staff conducting medical checks of inmates in restraints. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:
    - A requirement to video record medical checks;
    - A requirement to photograph injuries observed during medical checks;
    - Requiring greater detail regarding inmate injuries, toilet usage, and food and liquid consumption in the Health Services Restraint Review Form, and revising the Health Services Restraint Review Form to include larger spaces to allow for such detail to be included;
    - A requirement to provide a detailed explanation when concurring with the continued use of restraints despite evidence of injury;
    - Enhanced guidelines and training to medical staff on recognizing the existence of injuries that can lead to nerve and muscle damage and on when injuries resulting from restraints warrant action, such as removing restraints or seeking a higher level of medical care; and
    - Enhanced guidelines or training to correctional staff to recognize signs of potential nerve or muscle damage that warrant seeking assistance from medical staff.

The OIG provided a draft of this memorandum to the BOP, and the BOP's response is incorporated as Appendix 1. The BOP indicated in its response that it concurs with the OIG's recommendations. Appendix 2 provides the OIG's analysis of the BOP's response and a summary of the actions necessary to close the recommendations. The OIG requests that the BOP provide an update on the status of its response to the recommendations within 90 days of the issuance of this memorandum. If you have any questions or would like to discuss the information in this memorandum, please contact me at (202) 514-3435 or Sarah E. Lake, Assistant Inspector General for Investigations, at (202) 616-4730.

cc: Kendra Wharton
Associate Deputy Attorney General
Department of Justice

Appendix 1: The BOP's Response

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director

Washington, DC 20534

June 23, 2025

MEMORANDUM FOR SARAH E. LAKE, ASSISTANT INSPECTOR GENERAL
INVESTIGATIONS DIVISION

FROM: William K. Marshall III, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Management Advisory Memorandum (MAM): Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates.

The Federal Bureau of Prisons (BOP) appreciates the opportunity to respond formally to the Office of the Inspector General's draft Management Advisory Memorandum (MAM) entitled, "Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates." The BOP values the insights provided by the Office of Inspector General (OIG) regarding policies and practices related to the use of restraints on inmates.

The challenges highlighted in this memorandum arise from OIG's identification of concerns related to the investigations of allegations made by specific BOP inmates. These individuals were held in BOP institutions and, during their confinement, were subjected to restraints for prolonged periods. Some inmates reported experiencing assaults or mistreatment during these times. Additionally, OIG has raised concerns about potential long-term injuries that inmates may face as a result of extended use of restraints.

The BOP is committed to addressing these issues and implementing meaningful improvements and views OIG's recommendations as a crucial opportunity to enhance agency practices and ensure the humane treatment of all inmates. As noted in OIG's MAM, BOP's statutory duty is to provide for the safekeeping and protection of inmates, and this duty is integral to the agency's mission.

Lastly, as stated in OIG's MAM, within 60 days, BOP is required to advise OIG as to what actions the BOP has taken or intends to take regarding the recommendations. Accordingly, the BOP will continue to evaluate appropriate action plans and values the opportunity to provide OIG with a more detailed response setting forth such plans in 60 days.

Recommendation One: **The BOP should revise its policies, procedures, or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.**

BOP Response: The BOP concurs with this recommendation and will revise its policies, procedures, or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.

Recommendation Two: **The BOP should reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:**

- **Additional training for BOP staff on conducting restraint checks;**
- **Guidelines and training on the types of behaviors that evidence self-control or warrant the continued use of restraints;**
- **Guidelines and training on the length of time an inmate must exhibit self-control to warrant removal from restraints;**
- **Guidelines and training on how to handle inmate's pulling on or manipulating restraints;**
- **Guidelines on how correctional officers are to assess whether restraints are hampering circulation;**
- **Enhanced guidelines and training for creating effective behavior management plans for inmates in restraints;**
- **More frequent checks by Psychology Services staff and alternatives to long-term restraints for certain inmates who were placed in restraints due to attempting, threatening, or engaging in self-harm or experiencing other mental health challenges;**
- **Greater involvement by BOP regional staff in determining whether inmates should be placed in or remain in restraints.**

BOP Response: The BOP concurs with this recommendation and will reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. The BOP will also consider whether to incorporate each of the items delineated in this recommendation into its policies, procedures or training.

Recommendation Three: **The BOP should require BOP staff to video and audio record all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15-minute restraint checks.**

BOP Response: The BOP concurs with this recommendation and will require BOP staff to video and audio record all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15-minute restraint checks.

Recommendation Four: **The BOP should revise its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.**

BOP Response: The BOP concurs with this recommendation and will revise its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.

Recommendation Five: **The BOP should revise its restraint check forms to provide adequate space for BOP staff to record detailed information about the inmate's condition and behavior during restraint checks and consider including check boxes to ensure that BOP staff make a record of key information.**

BOP Response: The BOP concurs with this recommendation and will revise restraint check forms to ensure that adequate space is provided for staff to record detailed information about the inmate's condition and behavior during restraint checks and will consider including check boxes to ensure that staff record key information.

Recommendation Six: **The BOP should reassess its policies, procedures, and training to provide better guidelines for medical staff conducting medical checks of inmates in restraints. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures or training.**

- **A requirement to video record medical checks;**
- **A requirement to photograph injuries observed during medical checks;**
- **Requiring greater detail regarding inmate injuries, toilet usage, and food and liquid consumption in the Health Services Restraint Review Form, and revising the Health Services Restraint Review Form to include larger spaces to allow for such detail to be included;**
- **A requirement to provide a detailed explanation when concurring with the continued use of restraints despite evidence of injury;**
- **Enhanced guidelines and training to medical staff on recognizing the existence of injuries that can lead to nerve and muscle damage and on when injuries resulting from restraints warrant action, such as removing restraints or seeking a higher level of medical care; and**
- **Enhanced guidelines or training to correctional staff to recognize signs of potential nerve or muscle damage that warrant seeking assistance from medical staff.**

BOP Response: The BOP concurs with this recommendation and will reassess its policies, procedures, and training to improve guidelines for medical staff conducting medical checks of inmates in restraints. The BOP will also consider each of the items delineated in this recommendation and whether to incorporate these items into its policies, procedures or training.

Appendix 2: Office of Inspector General Analysis of the BOP's Response

The OIG provided a draft of this memorandum to the BOP, and the BOP's response is incorporated as Appendix 1. The BOP indicated in its response that it concurs with the OIG's recommendations.

The following provides the OIG's analysis of the BOP's response and a summary of the actions necessary to close the recommendation. The OIG requests that the BOP provide an update on the status of its response to the recommendation within 90 days of the issuance of this memorandum.

Recommendation 1: The BOP should revise its policies, procedures or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will revise its policies, procedures, or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP revises its policies, procedures, or training to define the term "four-point restraints" and provide clearer guidance regarding 15-minute restraint checks, 2-hour lieutenant checks, medical checks, and psychological checks for inmates in restraints that are not considered four-point restraints.

Recommendation 2: The BOP should reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:

- Additional training for BOP staff on conducting restraint checks;
- Guidelines and training on the types of behaviors that evidence self-control or warrant the continued use of restraints;
- Guidelines and training on the length of time an inmate must exhibit self-control to warrant removal from restraints;
- Guidelines and training on how to handle inmate's pulling on or manipulating restraints;
- Guidelines on how correctional officers are to assess whether restraints are hampering circulation
- Enhanced guidelines and training for creating effective behavior management plans for inmates in restraints;
- More frequent checks by Psychology Services staff and alternatives to long-term restraints for certain inmates who were placed in restraints due to attempting, threatening, or engaging in self-harm or experiencing other mental health challenges;

- Greater involvement by BOP regional staff in determining whether inmates should be placed in or remain in restraints.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. The BOP will also consider whether to incorporate each of the items delineated in this recommendation into its policies, procedures or training.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP reassesses its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury and considers as part of this reassessment the bullets listed above.

Recommendation 3: The BOP should require BOP staff to video and audio record all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15 minute restraint checks.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will require BOP staff to video and audio record all 2-hour lieutenant checks; ensure adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assess the feasibility of video and audio recording 15-minute restraint checks.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP requires BOP staff to video and audio record all 2-hour lieutenant checks; ensures adequate fixed camera coverage outside of cells to capture whether staff are conducting 15-minute checks of restrained inmates as required; and assesses the feasibility of video and audio recording 15 minute restraint checks.

Recommendation 4: The BOP should revise its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will revise its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP revises its policies, procedures, or training to provide greater clarity on the information that should be included in restraint check documentation.

Recommendation 5: The BOP should revise its restraint check forms to provide adequate space for BOP staff to record detailed information about the inmate's condition and behavior during restraint checks, and consider including check boxes to ensure that BOP staff make a record of key information.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will revise restraint check forms to ensure that adequate space is provided for staff to record detailed information about the inmate's condition and behavior during restraint checks and will consider including check boxes to ensure that staff record key information.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP revises its restraint check forms to provide adequate space for BOP staff to record detailed information about the inmate's condition and behavior during restraint checks, and considers including check boxes to ensure that BOP staff make a record of key information.

Recommendation 6: The BOP should reassess its policies, procedures, and training to provide better guidelines for medical staff conducting medical checks of inmates in restraints. As part of this reassessment, the BOP should consider, among other things, incorporating the following into its policies, procedures, or training:

- A requirement to video record medical checks;
- A requirement to photograph injuries observed during medical checks;
- Requiring greater detail regarding inmate injuries, toilet usage, and food and liquid consumption in the Health Services Restraint Review Form, and revising the Health Services Restraint Review Form to include larger spaces to allow for such detail to be included;
- A requirement to provide a detailed explanation when concurring with the continued use of restraints despite evidence of injury;
- Enhanced guidelines and training to medical staff on recognizing the existence of injuries that can lead to nerve and muscle damage and on when injuries resulting from restraints warrant action, such as removing restraints or seeking a higher level of medical care; and
- Enhanced guidelines or training to correctional staff to recognize signs of potential nerve or muscle damage that warrant seeking assistance from medical staff.

Status: Resolved.

BOP Response: The BOP reported the following:

> The BOP concurs with this recommendation and will reassess its policies, procedures, and training to improve guidelines for medical staff conducting medical checks of inmates in restraints. The BOP will also consider each of the items delineated in this recommendation and whether to incorporate these items into its policies, procedures or training.

OIG Analysis: The BOP's response is responsive to the recommendation. The OIG will consider whether to close this recommendation after the BOP reassesses its policies, procedures, and training to provide better guidelines for medical staff conducting medical checks of inmates in restraints and considers as part of this reassessment the bullets listed above.