Audit of the Federal Bureau of Prisons' Oversight of the Use of Restraints

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AUDIT DIVISION

25-070

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EXECUTIVE SUMMARY

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Objective

The U.S. Department of Justice Office of the Inspector General (OIG) conducted an audit of the Federal Bureau of Prisons' (BOP) oversight of the use of restraints. Our audit objective was to examine the BOP's oversight of the use of restraints.

Background

BOP staff are authorized to use force to gain control of an inmate, to protect and ensure the safety of other inmates and staff, to prevent serious property damage, and to ensure institution security and good order. BOP policy further authorizes staff to apply physical restraints to gain control of an inmate who appears to be dangerous because the inmate assaults another inmate, destroys BOP property, attempts suicide, inflicts injury upon self, or becomes violent or displays signs of imminent violence. Physical restraints include ambulatory restraints, where restraints are placed on an inmate's wrists and allow the inmate to eat and drink without staff intervention; or more restrictive four-point restraints using four points of contact—both wrists and both ankles—to confine an inmate to a bed. BOP is required to employ the least restrictive restraint method to control the inmate.

Between January 2018 and January 2024, the BOP recorded 14,772 use of force incidents that involved the use of ambulatory, four-point, or both types of restraints. The data further indicated that inmates have been held in restraints for lengthy periods of time, including one instance where the data showed an inmate was in ambulatory restraints for over 30 days, and another incident where the data captured that an inmate was held in a combination of ambulatory and four-point restraints for over 29 days.

Recommendations

Our audit makes 10 recommendations for the BOP to improve its oversight of the use of restraints. The BOP's official response is in Appendix 5. Our analysis of the BOP's response is in Appendix 6.

Audit Results

In July 2025, the OIG issued a memorandum advising the BOP of concerns involving use of four-point restraints on inmates for extended periods of time. This audit focuses on the BOP's oversight of its use of restraints, both ambulatory and four-point, during use of force incidents.

We identified significant deficiencies with BOP oversight of its use of restraints. For example, while BOP policy requires real-time Regional Director notification when inmates are restrained for extended periods of time, it does not state what Regional Directors are expected to do in response. Similarly, although BOP policy requires reviews by regional offices following the use of restraints, it does not provide guidance for how reviews should be conducted, a timeframe or method for the reviews, or how identified policy violations or systemic issues should be addressed. Moreover, we identified concerns with the accuracy of BOP data that is relied upon in reviews conducted after an inmate is removed from restraints. Additionally, we found that the BOP did not have reliable or consistent processes to conduct, track, and document regional office reviews.

The BOP Should Clarify the Purpose of Required Real-Time Notifications to Regional Directors

BOP policy requires Wardens to verbally notify Regional Directors in real-time when restraints are used on inmates for lengthy periods of time. In addition, institutions must provide Regional Directors with a Behavioral Management Plan when restraints are used for more than 24 hours. These notifications could be valuable if regional offices used them to provide guidance and to ensure that institutions are using them appropriately. However, BOP policy does not identify a defined purpose of these notifications or what Regional Directors are expected to do in response to them.

The BOP Needs Accurate Incident Data in Order to Conduct Effective After-Action Reviews

The BOP utilizes an application called TRUINTEL to document information related to the use of restraints during use of force incidents. Our review of TRUINTEL case file data found instances where its data did not reconcile to supporting documentation concerning the total length of time in restraints or the length of time in each type of restraint. For example, TRUINTEL data in one incident reflected that an inmate had been held in four-point restraints for over 18 days. After receiving a draft of this report citing this TRUINTEL data, the BOP questioned the data's accuracy but subsequently told us it was correct. We then decided to review the underlying BOP documentation and determined the TRUINTEL data actually was inaccurate—the inmate actually had been in four-point restraints for 8 days and ambulatory restraints for 10 days. We reviewed additional case files and found further TRUINTEL data errors. In order to conduct effective After-Action reviews, the BOP needs to ensure it has accurate incident data.

The BOP Should Have Standard Procedures for Regional Office Reviews of After-Action Reports

BOP policy requires that the Regional Director receive an After-Action Report within 2 working days of an inmate's release from restraints. It further provides that these reports and video of the incident be "reviewed, audited, and monitored" by regional offices. While we found that regional offices were reviewing After-Action Reports, the reviews varied substantially in terms of substance, documentation, and timeliness. We concluded this is likely due to BOP policy lacking guidance on how regional offices should conduct and document reviews, or when they are expected to complete them.

For example, we found that regional offices varied in the scope of their reviews, including what video evidence they reviewed and how they documented their findings. Additionally, only two of six regional offices tracked the timeliness of their reviews. For the two regional offices with a tracking process, their timeliness rates varied widely, with one region completing 82 percent of their reviews within 90 days but with the other region finishing only 31 percent of their reviews within 90 days. Given the important role that these reviews can have in ensuring compliance with BOP protocols, the safety and security of an institution, and accountability for any staff misconduct, the BOP should provide additional guidance and to its regional offices regarding the conduct of these reviews.

The BOP Should Develop a Reliable Notification and Tracking Process for Regional Office Reviews

While BOP policy requires Regional Directors to review, audit, and monitor After-Action Reports, the BOP lacks a mechanism for notifying regional offices that After-Action Reports are ready for review. Further, the BOP lacks a mechanism for tracking regional office review completion. A reliable notification process and tracking mechanism process is critical to ensuring that regional office reviews are completed in a timely fashion and that critical issues identified in those reviews are addressed promptly.

The BOP Should Ensure Video Recordings are Being Timely Provided to Regional Offices

BOP policy requires institutions to use a handheld video camera to record application of restraints incidents as soon as feasible. The recording is to be provided to the regional office within 4 working days. However, we found the BOP did not have a reliable method for providing the videos to regional offices, the BOP lacked controls to track compliance with the 4-day requirement, and institutions frequently did not comply with the 4-day requirement.

The BOP Should Put in Place a Process to Address Systemic Issues and Violations Identified During Reviews

The BOP does not have a process for tracking, addressing, or mitigating systemic issues or violations identified during incident reviews. For example, we found there was no process in place to track issues identified during After-Action and regional office reviews and reviews that resulted in referrals to the BOP's Office of Internal Affairs. We believe the lack of a process impairs the BOP's ability to identify and address systemic issues.

The Program Review Division Should Ensure Its Oversight Process Can Identify and Address Systemic Issues

The BOP's Program Review Division (PRD), located within BOP's Central Office headquarters, provides oversight of program performance and compliance. We found that PRD's program and operational reviews of institutions and regional offices prior to its March 2024 implementation of a new internal auditing process were not sufficient to ensure compliance with the use of force and application of restraints requirements in BOP policy, or to determine the significance of any issues identified. We were unable to assess PRD's new auditing process because it was not fully implemented at the time of our fieldwork. PRD needs to ensure, in connection with the use of restraints, that it can identify common issues across institutions and take action to address and mitigate those findings.

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Introduction

The Federal Bureau of Prisons (BOP) authorizes its staff to use force over an inmate only as a last alternative after all other efforts to gain control of a situation have been unsuccessful. When force is necessary, staff must use only the amount of force necessary to gain control of an inmate, protect and ensure the safety of other inmates and staff, prevent serious property damage, and ensure institution security and good order. In addition, staff may apply physical restraints to gain control of an inmate who appears to be dangerous.[1] The use of force and application of restraints may not be used to punish an inmate.

On August 29, 2014, the BOP issued Program Statement 5566.06, CN-1, entitled "Use of Force and Application of Restraints," which outlined the policies and procedures on the appropriate use of force, as well as the use of restraints. In July 2024, after our fieldwork for this audit was completed, the BOP issued new guidance, entitled "Use of Force, Application of Restraints, and Firearms," updating its policies and procedures from August 2014.[2] While the new policy made some changes to the BOP's requirements related to the use of force and application of restraints, it does not address the concerns identified in this report. Therefore, unless otherwise stated or a change in policy requirements discussed, we are referring to the original 2014 policy in this report.

BOP policy describes two types of use of force situations: calculated and immediate. A calculated use of force occurs when an inmate is in an area that can be isolated and there is no immediate threat to the inmate or others. In such instances, staff have time to assess the situation, including information about the inmate's history, and will attempt to obtain the inmate's voluntary cooperation using confrontation avoidance procedures. If unsuccessful, staff will move forward with a team to carry out a calculated use of force. An immediate use of force occurs when there is an immediate, serious threat to an inmate, staff, or the institution's security and good order. Due to the need to respond immediately, staff do not have time to fully assess the situation and coordinate with management, Health Services, or Psychology Services prior to the use of force.

In some use of force situations, the application of restraints is necessary to gain control of an inmate and prevent the inmate from hurting themselves, staff, or others or to prevent serious property damage. According to BOP policy, restraints should only be used when an inmate continues to resist after other effective means of control have failed. Ambulatory or four-point restraints may be used, and the least restrictive restraint method should be used in such situations to control the inmate. Ambulatory restraints, placed only on an inmate's wrists, are the least restrictive and allow an inmate to eat, drink, and manage most human needs without staff assistance. Four-point restraints are more restrictive as an inmate is restrained using four points of contact—both wrists and both ankles—and the inmate is confined to a bed. When using either ambulatory or four-point restraints, inmates are placed in either soft vinyl cuffs or hard steel handcuffs. Hard handcuffs are only to be used after soft cuffs have proven ineffective or an inmate has a history of defeating or being able to remove soft cuffs. Pictures of the different types of restraints are shown below. Given the restrictive nature of restraints, the BOP requires specific oversight of their use,

[1] An inmate may appear dangerous because the inmate assaults another individual, destroys government property, attempts suicide, inflicts injury upon self, or becomes violent or displays signs of imminent violence.

[2] The new policy added guidance specific to the use of firearms within an institution, which is not relevant to the scope of this audit.

which is discussed later in this report. While an inmate is restrained, staff are to look for a pattern of non-disruptive behavior over a period of time to support a decision to move an inmate to either a less restrictive form of restraints or removal from restraints entirely.

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 July 2025, the Department of Justice Office of the Inspector General (OIG) issued a memorandum to advise the BOP of concerns regarding its policies and practices pertaining to the use of restraints on inmates.[3] The memorandum focused on concerns identified in connection with reviews of allegations by multiple BOP inmates who were placed in restraints for extended periods. The OIG made six recommendations for the BOP to enhance its policies and practices to assist in protecting inmates, protecting staff from false allegations, deterring misconduct by staff, and holding staff who engage in misconduct accountable. While the memorandum focused on concerns regarding BOP procedures during the period an inmate was held in restraints (such as concerns related to documentation and recording of restraint checks and medical checks of inmates by staff), this report focused on the BOP's oversight of its use of force and application of restraints incidents.

[3] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Management Advisory Memorandum Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates,* Investigations Report 25-064 (July 2025), oig.justice.gov/reports/notification-concerns-regarding-federal-bureau-prisons-policies-pertaining-use-restraints.

BOP Policies Regarding Application of Restraints Following Use of Force Incidents

Depending on the circumstances of a calculated or immediate use of force situation, either ambulatory or four-point restraints may be used. BOP policy establishes requirements for both types of restraints. These requirements are communicated to new employees during introductory training prior to assignment and again within the first 12 months of employment. According to the BOP, the use of force and application of restraints requirements are also included in the BOP's annual training materials as well as within training materials for staff promoted to the rank of Lieutenant.

BOP policy requires all use of force incidents to be video recorded using a handheld video camera, including any application of restraints. However, BOP policy does not require video recording for subsequent inmate interactions mandated by BOP policy in those instances when restraints are kept in place for an extended period of time.

When a calculated use of force is planned and performed, the entire interaction must be documented in writing and video recorded beginning with the confrontation avoidance process. This documentation, written and video, is to include statements from all staff members who participated and responded to the incident, and that documentation is to be submitted for an After-Action review. The After-Action review is described later in this section. When an immediate use of force occurs, the Warden is to be notified immediately, and staff must begin filming the incident with a handheld video camera as soon as feasible, unless it is determined that a delay in resolving the situation would endanger a person, cause a major disturbance, or damage property. Institution staff must provide the video recording to the Regional Director within 4 working days of the incident. Immediate and calculated use of force video recordings are required to include the performance of an initial medical assessment, the decontamination if chemical agents (such as oleoresin capsicum aerosol spray) were used, and the debriefing of the incident.[4]

When any use of force incident includes the application of restraints, BOP policy requires the completion of several actions and associated documentation, as summarized below in Table 2, to ensure the use of restraints was appropriate.[5] As reflected in Table 2, the level of review mandated increases with the amount of time an inmate is kept in restraints.

[4] Staff are required to video record the application of restraints during a calculated use of force; however, this may not be feasible during an immediate use of force due to a delay in obtaining a camera because of safety issues.

[5] If restraints are not applied during a use of force situation, the restraint check forms, Health Services Restraint Review, Psychology Services Review, and a Behavior Management Plan would not be required. Only a Report of Incident and Use of Force After-Action Report are required.

Table 1

Actions and Associated Documentation Required for Use of Force and Application of Restraints Incidents

Form/Documentation	Description	Submission Process
Report of Incident (BP-E583)	• Standard BOP incident form documenting the use of force, including any application of restraints, which includes: identity of all involved (inmates, staff, and others), date and time of incident, type and location of incident, injuries, type of and reason for use of force, whether restraints were used, date and time placed in restraints, confrontation avoidance usage, and detailed incident description	• Completed by institution staff and submitted to Warden or designee **no later than the end of the tour of duty** • Copy submitted to Assistant Director, Correctional Programs Division; Assistant Director, Health Services Divisions; Central Office Correctional Services Administrator; Regional Director; and Regional Correctional Services Administrator **within 2 workdays**
Fifteen Minute Restraints Check (BP-A0717)	• Standard BOP form documenting inmate's behavior, including verbal and non-verbal comments, which includes: inmate's name, registration number, 24-hour period beginning and ending date and time, restraint check time, comments, and staff initials	• Completed by institution staff conducting check **every 15 minutes** • Reviewed by Lieutenant **during 2-hour checks**
Two-Hour Lieutenant Restraints Check (BP-A0718)	• Standard BOP form documenting inmate's behavior, including verbal and non-verbal comments, which includes: inmate's name, registration number, 24-hour beginning and ending date and time, Lieutenant name, restraint check time, description of inmate's behavior, action taken, whether desired calming effect reached, and whether toilet was used • Documents a detailed description of inmate's behavior to warrant continuation of restraints	• Completed by Lieutenant **every 2 hours**
Health Services Restraints Review (BP-A0719)	• Standard BOP form documenting medical assessment of inmate, which includes: inmate's name, register number, 24-hour beginning and ending date and time, staff name, body position, restraints (circulation), vital signs, current medication, injuries, and comments	• Completed by Health Services staff **twice during each 8-hour shift**

Eight Hour Notice to Regional Director	• Warden must notify the appropriate Regional Director when an inmate is held in restraints for longer than 8 hours, with additional notifications every consecutive 8 hours the inmate remains in those restraints; No standard BOP form or documentation required.	• Completed by Warden **every 8 hours**
Psychology Services Review (BP-A0720)	• Standard BOP form documenting psychology assessment of inmate, which includes: inmate's name, register number, 24-hour beginning and ending date and time, staff name, date, and time • Documents a summary of the inmate's psychology history, description and synopsis of the inmate interview, description of current mental health status, recommendations for care, and referral to mental health facility	• Completed by Psychology Services staff **at least once during every 24-hour period**
Behavior Management Plan (BMP)	• Documentation of an institution's review of the inmate's status; No standard BOP form or format; institutions prepare memorandum using various formats. • Summary of all relevant information reviewed (15-minute check logs, Lieutenant check logs, Health Service reviews, and Psychology reviews) • Documents specifically what considerations are being made for mental health treatment, including possible referral to a mental health institution	• Completed when an inmate is in restraints for **24 hours** • Prepared by the Warden, Associate Warden, Captain, Unit Manager, Health Services Administrator, and Chief Psychologist • Submitted to the Regional Director
Use of Force After-Action Report (BP-E586)	• Standard BOP form documenting the After-Action Review Committee review of whether policy was adhered to and any findings, which includes: inmate's name, register number, date and time of incident, type of use of force, whether restraints were used, date and time placed in and released from restraints, participants of After-Action team, items reviewed, location of video recordings, any extraordinary actions taken to prevent serious injury or property damage, and recommendations and results of review	• Completed by After-Action Review Committee made up of Warden, Associate Warden responsible for Correctional Services, Captain, and Health Services Administrator • Submitted by the Warden to the Regional Director **as soon as possible but not later than 2 working days** after inmate released from restraints

Source: OIG analysis of BOP policies and records

Once an inmate is removed from restraints, institution staff, including the Warden, the Associate Warden responsible for Correctional Services, the Health Services Administrator, and the responsible Captain, must meet to review the incident to ensure the use of force and application of restraints was appropriate and in compliance with BOP policy. The group considers whether sound correctional judgment was used and identifies matters that require further investigation. The policy states that, if deemed necessary, the Warden will refer the matter to the OIG, BOP Office of Internal Affairs, or Federal Bureau of Investigation depending on the circumstances involved. At the conclusion of the review, a Use of Force After-Action Report is generated detailing any instances where sound judgment was not used, or staff did not utilize force or implement restraints according to requirements, as well as recommendations to remedy those issues.

The After-Action Report is then submitted to the appropriate Regional Director, and the Regional Office Correctional Services staff are responsible to review all use of force incidents. According to the regional staff we interviewed, their review is similar to that conducted by the After-Action Review Committee with the intention of ensuring all issues were appropriately addressed by the After-Action Review Committee at the institution, with any referrals appropriately being made by the Warden for further investigation. If the regional office staff identify any additional issues that had not been referred appropriately, they are responsible to submit those for further investigation.

Tracking of Use of Force and Application of Restraints Incidents

The BOP has an administrative staff network infrastructure called the Trust Fund Network (TRUNET), which has several applications including TRUINTEL. TRUINTEL is used to manage institution investigations and cases and to document all use of force incidents, including those that involve the application of restraints. BOP staff enter information required to complete the Report of Incident (referred to as the 583) and Use of Force After-Action Report (referred to as the 586) into TRUINTEL, as discussed in Table 2. In addition, all required documentation for use of force incidents is to be uploaded and maintained in TRUINTEL, including regional office memoranda that detail any issues identified during their review of incidents.

During our audit, we requested a listing of all use of force incidents that included the application of restraints, both ambulatory and four-point, and the BOP provided a list with the data for the period from January 2018 through mid-January 2024.[6] The list included an incident number (which identifies the institution), inmate last name and register number, and recorded data for the type of restraints used and the start and end date and times of each incident. During our discussions with the BOP, we were told that this summary information was not normally accessed or analyzed by the institutions, regional offices, or at headquarters (referred to by the BOP as Central Office). In addition, we were told that the information provided was not easily traced to corroborating information outside of TRUINTEL, and no other form of readily available documentation could be used to verify the information. Within the context of this audit, as well as the OIG's memorandum noted in footnote 3, we did not pursue the verification and validation of the data contained within TRUINTEL, and as discussed later in this report, found concerns with the data contained within the system. As a result, we only used the data provided for informational purposes in

[6] We refer to January 2018 through September 2018 as fiscal year (FY) 2018, and October 2023 through mid-January 2024 as FY 2024.

understanding the extent to which restraints were used within BOP institutions and did not rely on the TRUINTEL data for our analysis of BOP's oversight of the use of restraints for this audit.

In utilizing the BOP TRUINTEL data as informative, the data indicated that ambulatory restraints were used more than 12,600 times and four-point restraints were used more than 2,600 times between January 2018 and January 2024. Using the BOP's provided data, we calculated the recorded number of incidents for each type of restraints by year as shown in Table 2 below. The recorded total number of incidents in Table 2 does not match the figures in later tables because some incidents involved the application of more than one type of restraints.

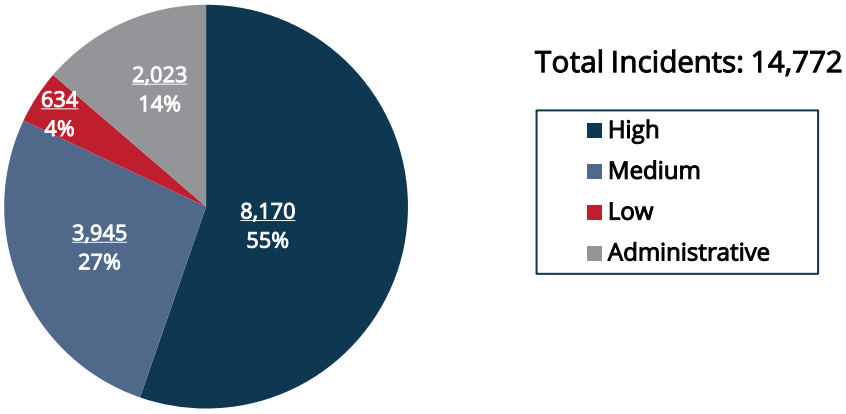
Table 2
Application of Restraints Incidents Recorded in TRUINTEL
January 1, 2018, through January 16, 2024

Fiscal Year	Ambulatory Restraints	Four-Point Restraints
2018	1,170	280
2019	1,851	394
2020	2,810	463
2021	2,289	423
2022	2,074	397
2023	1,866	492
2024	574	179
Total Incidents	**12,634**	**2,628**

Source: BOP data from TRUINTEL

In addition, we further isolated the recorded data provided and as shown below, BOP's data indicates that most of the incidents occurred in high security institutions.

Figure 1
Application of Restraints Incidents Recorded in TRUINTEL by Institution Security Level



Note: Several institutions had security level changes which resulted in name changes to match their mission and security level.
The affected institutions are detailed in Appendix 2. The Administrative category includes Metropolitan Correctional Centers, Metropolitan Detention Centers, Federal Detention Centers, Federal Medical Centers, the Federal Transfer Center, the Medical Center for Federal Prisoners, and the Administrative-Maximum Security Penitentiary.

Source: BOP data from TRUINTEL

We also broke down the BOP data by institution and prepared the following table showing the BOP institutions with over 300 recorded incidents of the application of restraints.

Table 3
Institutions with Over 300 Reported Applications of Restraints Incidents

Institution	Security Level	Number of Incidents
USP Thomson	High	1,448
USP Big Sandy	High	712
USP McCreary	High	632
USP Florence	High	605
USP Lee	High	523
USP Victorville	High	480
USP Coleman I	High	477
USP Hazelton	High	432
USP Beaumont	High	405
USP Canaan	High	400
USP Tucson	High	386
USP Pollock	High	381
USP Allenwood	High	373
FMC Butner	Administrative	317
FCI Hazelton	Medium	311
USP Lewisburg	Medium	301

Note: For USP Thomson and USP Lewisburg we used the security level that was in effect that covered a significant time period of the incidents. See additional information related to the security level changes in Appendix 2.

Source: BOP data from TRUINTEL

OIG Audit Approach

Our audit objective was to examine the BOP's oversight of the use of restraints. The scope of our audit covered BOP activities related to the application of restraints during use of force incidents from January 2018 through September 2024. To accomplish our objective, we reviewed BOP policies and training materials related to the use of force and application of restraints. We visited Federal Detention Center Philadelphia to gain an understanding of the use of force and application of restraints process and requirements at an institution. We conducted interviews of BOP officials at Central Office headquarters, as well as officials from BOP's six regional offices (Mid-Atlantic, North Central, Northeast, South Central, Southeast, and Western). We also reviewed a sample of BOP documentation related to use of force and application of restraints incidents. Finally, we reviewed BOP Correctional Services program and operational reviews conducted for its institutions and regional offices. Appendix 1 contains further details on our audit objective, scope, and methodology.

Audit Results

Overall, we found that the BOP did not effectively utilize its TRUINTEL system for documenting the use of restraints within its institutions. While we did not rely on the data contained within TRUINTEL for this report beyond its use for informational purposes, our review of supporting documentation for the data from that system indicated that there were inaccuracies within the system. We also determined that the BOP's policy that prescribed procedures for regional offices within the BOP to oversee the use of force and application of restraints was lacking and that the BOP did not have methods to ensure that violations and systemic issues identified in use of force and application of restraints incidents were addressed. We found that while the BOP's policy required regional offices to review use of force and application of restraints incidents after the use of force was completed and the inmate was removed from restraints, the BOP's policy did not provide guidance for how regional office staff should conduct the required regional office reviews, including the timeframe or methods to be used. As a result, there was no consistency in the review process and each office had different methods for performing, tracking, and documenting its reviews; therefore, the reviews may not be accomplishing their intended purpose.

We further found that the policy required institutions to notify regional offices when an inmate is restrained in restraints for longer than 8 hours, with additional notifications every consecutive 8 hours the inmate remains in those restraints; however, we were unable to identify within BOP policy or practice a defined purpose for these real-time restraint use notifications, despite the potential usefulness of increased regional office involvement. In addition, we found that the BOP did not have a reliable process in place to track and document regional office reviews of use of force incidents, including its review of video recordings, and that TRUINTEL did not include the capability to track and monitor use of force and application of restraints incidents that required review. Also, we found that while the BOP required use of force incidents be video recorded, it did not have a reliable method for institutions to provide recordings to regional offices or to ensure institutions complied with the requirement to provide such recordings within 4 working days of an incident. While the BOP recently updated its policy related to the use of force and application of restraints and is revising its internal auditing process, additional improvements are needed to ensure that appropriate measures are being taken to oversee and monitor the use of force and application of restraints within BOP institutions.

Based on BOP data, ambulatory restraints were used more than 12,600 times and four-point restraints were used more than 2,600 times between January 1, 2018, and January 16, 2024. Given the importance of ensuring the safety and security of BOP's institutions, staff, and inmates as well as identifying staff misconduct, we find it concerning that the BOP's oversight of its use of force incidents and application of restraints is not guided by internal controls for ensuring that the oversight is performed or that reviews performed are done consistently and adequately.

Accuracy of Data Recorded in TRUINTEL

As discussed in the background section of this report, BOP utilized its TRUINTEL system to document all use of force incidents, including those that involved the application of restraints. However, and as discussed later in this report, BOP was not utilizing the information contained within TRUINTEL to make policy or management decisions in overseeing the use of restraints. In performing this audit, we requested and were provided a list of incidents from TRUINTEL where restraints were used within the time period of January 1,

2018, through January 16, 2024. Table 4 below displays incidents with prolonged time in restraints, as recorded in TRUINTEL.

In discussing the details of the data BOP provided, BOP officials stated that it did not review or perform analysis of the data included in TRUINTEL and that TRUINTEL was not readily usable for such review and analysis. In addition, we found that the BOP did not take steps to ensure the accuracy of the data entered into TRUINTEL. When asked about supporting documentation for data entered into the system, a BOP official indicated that such documentation could be obtained, but that the information was not readily available or maintained in support of the system. After reading a draft of this report, the BOP questioned the accuracy of what the recorded data represented for Incident Number 3 from Table 4 below. Subsequently, the BOP confirmed the recorded data in TRUINTEL was correct. However, based on our review of supporting documentation provided by the BOP, we found that the recorded data in TRUINTEL was inaccurate. Due to this inaccuracy, we requested documentation for the additional 12 incidents where the recorded data from TRUINTEL indicated an inmate was held in restraints for a prolonged period of time, as shown below in Table 4.

Table 4
Incidents with Prolonged Time in Restraints as Recorded in TRUINTEL

Incident Number	Time in Restraints	Four-Point	Ambulatory
1	30 days, 22 hours, 17 minutes	No	Yes
2	29 days, 6 hours, 5 minutes	Yes	Yes
3	18 days, 20 hours, 45 minutes	Yes	No
4	13 days, 20 hours, 45 minutes	Yes	No
5	13 days, 13 hours, 40 minutes	No	Yes
6	12 days, 19 hours, 30 minutes	No	Yes
7	11 days, 2 hours, 0 minutes	No	Yes
8	11 days, 2 hours, 0 minutes	No	Yes
9	10 days, 1 hours, 10 minutes	Yes	No
10	9 days, 16 hours, 12 minutes	No	Yes
11	8 days, 21 hours, 30 minutes	No	Yes
12	8 days, 17 hours, 0 minutes	No	Yes
13	7 days, 13 hours, 55 minutes	No	Yes

Source: BOP data from TRUINTEL

In reviewing the data, as entered in TRUINTEL and recorded in the documentation we were provided, we found additional instances where the data within TRUINTEL did not reconcile to supporting documentation. We determined that in some instances the BOP inaccurately reported the type of restraints used throughout the incident. For example, Incident Numbers 3, 4, and 9 indicated that each of the inmates were held only in four-point restraints throughout the incident. Our review of the documentation indicated the inmates were actually held in both ambulatory and four-point restraints. For example, for Incident Number 3, the TRUINTEL data indicated, and the BOP confirmed after reviewing a draft of this report, that the inmate was

held in four-point restraints for over 18 days. However, the supporting documentation provided indicated that the inmate was in four-point restraints for almost 9 days and was held in ambulatory restraints for the remaining 10 days.

Further, we found that inmate transfers between ambulatory and four-point restraints throughout an incident were sometimes categorized in TRUINTEL as separate incidents. Specifically, we found that Incident Numbers 5, 9, 10, and 13 were all related to the same initial incident but changes in restraint type and alleged assaults by the inmate on BOP staff during restraint checks resulted in the incident being entered into TRUINTEL as multiple, separate incidents.[7] In comparing the TRUINTEL data to supporting documentation, it appeared that the BOP inaccurately reported the end time of each incident in TRUINTEL because it used the date and time that the inmate was permanently released from restraints for each of its recorded incidents rather than the time it changed restraint type or resolved the alleged assault on staff. This caused inaccuracies in the recorded length of time in restraints for each type of restraint as well as the total length of time in restraints.

The BOP should maintain accurate data to effectively monitor the use of restraints within its institutions, including the appropriate use of restraints and any negative impact associated with the use of restraints, as well as ensuring compliance with relevant policies and procedures. Accurate data is also necessary to enable the BOP to respond to concerns or complaints from inmates, staff, and others regarding the use of restraints. As a result, we recommend that BOP take steps and implement controls to ensure that it maintains appropriate and accurate records and data on the use of restraints. Those steps should include providing appropriate training to staff when documenting incidents, as well as appropriate review procedures ensuring that, once entered, the data is correct and supported with appropriate supporting documentation.

Effectiveness of the BOP's Policies and Procedures Concerning the Regional Office Role in Application of Restraints Incidents

The BOP's six regional offices provide oversight and technical assistance to its 122 institutions. As shown in Appendix 3, the regional offices are located throughout the country, and each is responsible for approximately 20 institutions of varying security levels and missions. The main function of regional offices is to provide operational oversight to its assigned institutions.

Regional staff assigned to Correctional Services, consisting of a team of about five people in each regional office, are responsible for oversight of the use of force and application of restraints.[8] They are also responsible for other operational areas such as lock shop and armory operations, physical security,

[7] Our review of BOP's documentation for Incident Number 10 indicated that during a required medical assessment the inmate was able to remove their hand from one of the restraints and strike a staff member, which required staff to use force to reapply the inmate's restraints. The 583 for this incident indicated it was a use of force and staff assault. Additionally, our review of documentation for Incident Number 13 indicated that during a required 2-hour Lieutenant check, the inmate swung and struck a BOP staff member with part of the restraint chain. Again, the 583 for this incident noted it was a use of force and staff assault.

[8] For the remainder of this report, we refer to the Regional Correctional Services staff as regional staff or staff.

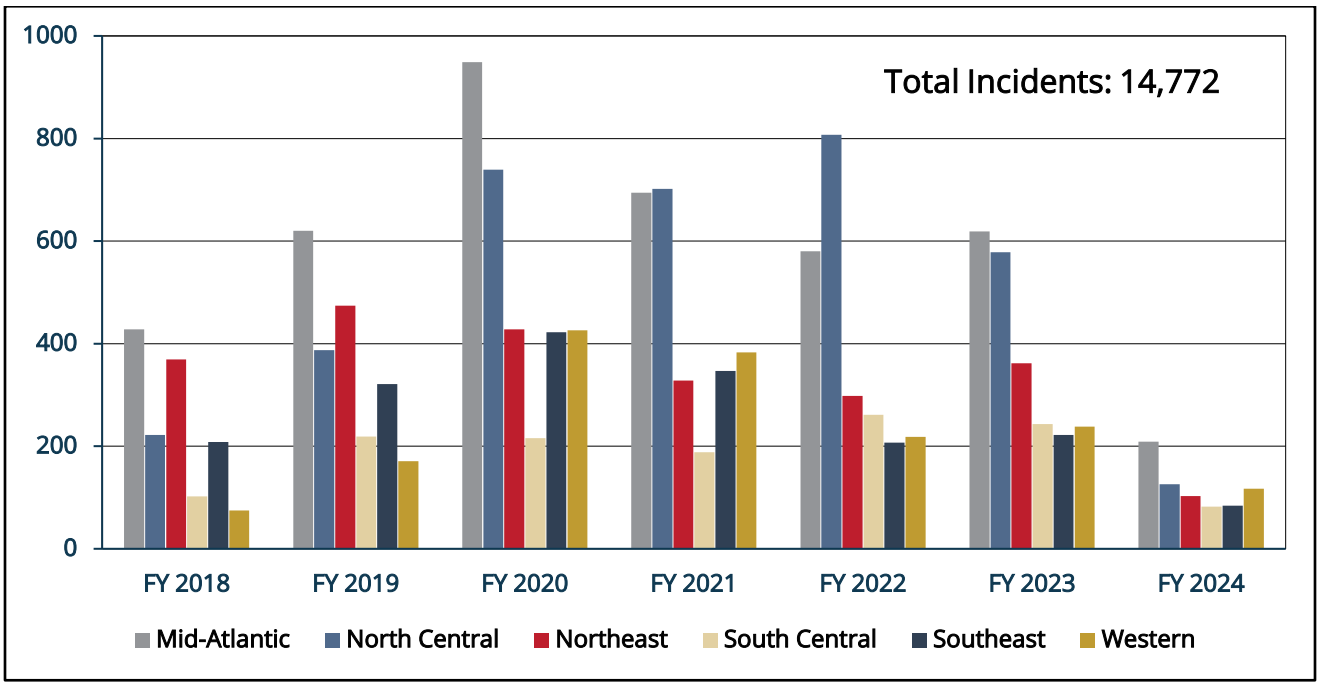
emergency preparedness, inmate discipline, and intelligence gathering and sharing. Additionally, regional staff assist with providing correctional services training and administrative operations.

As stated earlier in this report, management staff of BOP institutions are required to provide various reports to their respective regional office for the review of use of force and application of restraints incidents. When any use of force incident occurs, institution staff must submit in TRUINTEL the Report of Incident (referred to as the "583") within 2 workdays. If an incident involves the application of restraints, Wardens must notify the responsible Regional Director when an inmate remains in restraints for longer than 8 hours and then after every consecutive 8 hours the inmate remains in restraints. BOP policy does not require that the Warden or Regional Director document what information was provided to the Regional Director and what direction, if any, was given by the Regional Director to the Warden. When an inmate remains in restraints for 24 hours, the institution must submit to the Regional Director a Behavior Management Plan (BMP), described in Table 1. Use of Force After-Action Reports (referred to as a "586"), including all required documentation, must then be prepared by institution staff and submitted in TRUINTEL to the Regional Director within 2 workdays after an inmate is released from restraints. These reports must then be accessed in TRUINTEL and reviewed by regional staff for all use of force incidents, including those with the application of restraints.

In describing the regional reviews of incidents, regional staff we met with stated that after a 586 is submitted they review the video recordings for each incident, review all required documentation described in Table 1, and prepare a memorandum indicating whether any instances of non-compliance with BOP policy were identified during the incident. In addition, if necessary, staff refer incidents to the BOP's Office of Internal Affairs (OIA). OIA will then refer matters, as appropriate, to the OIG, for allegations of criminal or administrative misconduct by BOP officials, or the FBI, for allegations of criminal conduct by inmates. The OIG will either open an investigation or send the matter back to the BOP for handling.

As shown in Figure 2 below, between January 1, 2018, and January 16, 2024, there were a total of 14,772 use of force incidents recorded in TRUINTEL that involved the application of restraints. Each of the regions had anywhere from as few as 75 to as high as 949 incidents that required review.

Figure 2
Application of Restraints Incidents as Recorded in TRUINTEL by Regional Office



Source: BOP data from TRUINTEL

We interviewed staff at each of the six regional offices to gain an understanding of their roles and responsibilities related to reviewing and monitoring use of force and application of restraints incidents as well as how TRUINTEL was utilized throughout the process. Throughout our audit we identified improvements needed to the BOP's oversight of the use of force and application of restraints incident process. Specifically, we found that the BOP should have standard procedures for the timing and substance of regional office reviews. These procedures should include a timeframe for when the regional office reviews should be completed as well as how the reviews should be conducted, and the results reported. In addition, we determined that the BOP needs a consistent and reliable process to notify regional offices that use of force and application of restraints incidents are ready to be reviewed and to track and monitor regional office reviews. Last, we found that the BOP needs a reliable method to ensure video recordings are timely provided to and tracked by regional offices. Effective oversight of use of force and application of restraints incidents within BOP institutions is of utmost importance to ensure that the BOP is protecting its institutions, staff, and inmates and identifying as well as addressing staff misconduct timely. These improvements are discussed in more detail in the following sections.

The BOP Should Have Standard Procedures for Regional Office Reviews of After-Action Reports

BOP policy states: "Reports and video tapes of the incident must be reviewed and audited by Regional and Central Office."[9] It continues, "All use of force incidents must be reported and investigated to protect staff from unfounded allegations and eliminate the unwarranted use of force." In addition, the policy states that the institution must submit an After-Action Report to the Regional Director within 2 working days after the inmate has been released from restraints. However, BOP policy does not detail the specific requirements for how regional offices are expected to conduct their reviews, when such reviews should be completed, or what the regional offices were expected to do in response to notifications that occur prior to the submission of the After-Action Report.

The BOP Should Implement Standard Procedures for How Regional Offices Conduct and Report on Their Reviews, Including What Types of Video Recordings They Must Review

We conducted interviews with regional staff responsible for reviewing use of force and application of restraints incidents, and many told us that their review included watching video recordings (noting any BOP policy violations) as well as reviewing the 583 and 586. Staff told us that once their reviews were completed, they composed a memorandum asserting their review and noting any violations not already identified in the 586. According to staff, if any actions were identified that warranted referral to OIA they would refer the incident. Staff told us that if the institution has already referred the incident to OIA, they would not review further.

We were told that the main purpose of regional office incident reviews was to determine whether the use of force was appropriate and compliant with BOP policy. However, during our interviews, we found that BOP policy did not include specific procedures for completing reviews of the use of force incidents, including instances that resulted in the application of restraints. Instead, we found each of the regional offices performed reviews differently, and some staff told us that during their reviews, though not required, they utilized a checklist from the BOP's internal website as a tool to assist in determining whether any misconduct or violations of BOP policy had occurred. While we were not able to determine where the checklist originated, we reviewed the checklist and found that it included procedures and requirements taken directly from the BOP's use of force policy, as well as other BOP standard correctional practices.[10]

As discussed in the *Accuracy of Data Recorded in TRUINTEL* section, during our review, we identified issues with some of the recorded data in TRUINTEL. Specifically, in three instances, we found that over the course of being held in restraints, the inmate was held in both four-point and ambulatory restraints. However, the data recorded in TRUINTEL only indicated one type of restraint for each incident. Additionally, we identified four recorded incidents that were all related to the same incident in which the BOP inaccurately recorded the end time of each incident by using the date and time that the inmate was permanently released from restraints. Even though there were inaccuracies with the data recorded in TRUINTEL, neither the After-Action review nor the regional office review noted the discrepancies that we identified.

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[9] The Program Review Division within BOP's Central Office headquarters has responsibility for this requirement, which is discussed later in this report.

[10] The checklist is titled "Use of Force & Video Review – Worksheet." We include the checklist in Appendix 4.

During our audit, we also found that the BOP policy did not include a requirement for regional offices to receive or review video footage of the events leading up to a use of force incident, but instead only included a requirement to review handheld video recordings of the incidents. For immediate use of force situations, BOP employees may not begin using a handheld video camera until after the use of force is initiated. Institutions also have multiple fixed cameras monitoring inmates, which could be used to view what transpired before the use of force was initiated and help assess whether using force to contain an inmate was warranted. We interviewed regional staff and determined there was not a consistent process across the regional offices regarding this fixed camera footage. Two regional offices told us that it required its institutions to provide the additional footage—along with handheld camera recordings—for use when reviewing use of force incidents, while the remaining offices informed us that they did not make such a request. Further, staff at one of the regional offices agreed that reviewing the security and corridor footage from the institutions fixed cameras was beneficial as it aided in protection of the institution.

At the close of a region's review of an institution's use of force and application of restraints incident, the regional staff drafts a memorandum to the institution documenting any findings resulting from the review and uploads the memorandum to TRUINTEL. To assess the consistency of regional office reviews of use of force and application of restraints incidents, we reviewed a sample of two memoranda from each regional office and found that memoranda from two regional offices had significant inconsistencies from the other four offices. Specifically, for four regions, staff told us and we confirmed that they reported any violations identified during their review that were not previously identified by the institution, explaining that common violations noted during their review of recordings included correctional officers' improper handling of the inmate, excessive noise in the background (this hinders the ability to hear whether conversations were appropriate and necessary between BOP staff and inmates), improper uniform being worn by BOP staff, and missing information on the video recording during the medical assessment statement. At a fifth region, staff told us that they similarly reported any violations identified during their reviews that were not previously identified by the institution, but during our review of the memoranda, we found that this region actually did not report any violations in its memoranda. Instead, this region noted in its memoranda only that any violations were brought to the attention of the Captain at the institution. At the sixth regional office, one official told us that their office only reported violations that were related to the actual use of force and not other violations, such as improper uniform and excessive background noise. The official further explained that they reduced the violations documented to only use of force policy deviations in order to make the process more efficient.

Regarding the management of fixed camera video footage, the OIG issued a memorandum in October 2021 outlining concerns regarding the BOP's security camera systems, particularly with regard to the systems not being fully upgraded and reliable.[11] One of the findings in the memorandum was that some BOP institutions utilized an outdated analog system with a 14-day duration for storing camera footage, while some have transitioned to the new digital system with a longer storage duration of 30 days. However, we are concerned that even the 30-day storage duration would not ensure that video footage from use of force incidents would be accessible when needed, due to the lack of specific timeframes for regional staff to complete incident reviews as discussed in the next section. Specifically, as shown in Figure 3 below, there were some

[11] U.S. Department of Justice (DOJ) Office of the Inspector General (OIG), *Management Advisory Memorandum Notification of Needed Upgrades to the Federal Bureau of Prisons' Security Camera System*, Evaluation and Inspections Report 22-001 (October 2021), oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security.

regional reviews that occurred more than 300 days after the use of force incident. Given that the purpose of the review is to identify any misconduct or noncompliance with BOP policy, we are concerned that reviewers may not have all the information necessary to make such determinations.

Overall, we found that in the absence of requirements, regional staff conducted reviews inconsistently and may not be accomplishing the intended purpose of regional office reviews as required by the BOP's policy. Thus, we recommend that the BOP establish Bureau-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews, including how the results should be transmitted, communicated, documented, and reported. We also recommend that the BOP require institutions timely submit and regional offices review relevant fixed camera footage, in addition to handheld camera video, during use of force and application of restraints incident reviews.

The BOP Policy Should Include a Timeframe for Completion of the Regional Office Review

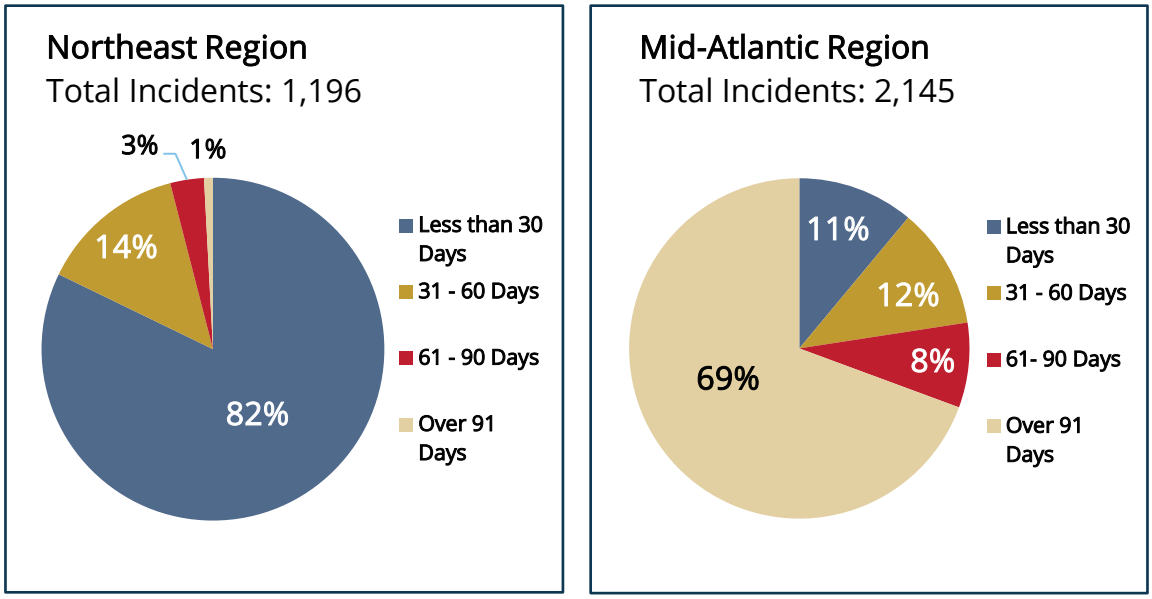
While BOP policy required regional offices to review all incidents involving the use of force and application of restraints, it did not provide a required timeframe in which reviews must be completed. As discussed later in this report, we found that two of the six regional offices (the Northeast and Mid-Atlantic Regional Offices) had a process in place to track use of force incidents and had the ability to provide us the dates on which its reviews were completed. Consequently, we were unable to determine the length of time it took the remaining four regional offices to complete reviews because that information was not readily available.

During our site visits, we discussed the performance of reviews and staff expressed that completing a review can take a significant amount of time. Staff members stated that reviews included viewing video recordings that could take an hour or more, noting that the video should contain the application of restraints, if necessary; decontamination of the inmate, if chemical agents were used; the initial medical assessment; and the staff debriefing. Staff also told us they must review all required documentation submitted for each incident. Further, staff told us that because of their heavy workload and their understanding that incidents were already reviewed by each institution's Executive staff, their review of use of force incidents was a lower priority.

Using the spreadsheets provided by the Northeast and Mid-Atlantic Regional Offices, we calculated the number of days it took those offices to complete reviews of use of force incidents once an institution submitted a 586, as shown below in Figure 3.[12]

[12] The spreadsheets include incidents from October 1, 2022, through March 18, 2024, for the Northeast Regional Office, and October 1, 2022, through April 15, 2024, for the Mid-Atlantic Regional Office.

Figure 3
Length of Time for Completion for Northeast and Mid-Atlantic Regional Offices' Reviews of Use of Force Incidents



Note: The total number of incidents included all use of force incidents, including those that did not include the application of restraints.

Source: OIG Analysis of BOP information

As shown above, there was a significant difference in the timeframes in which the two regional offices completed their reviews of use of force incidents. Between October 2022 and March 2024, the Northeast Regional Office reviewed 82 percent (983 of 1,196 incidents) in less than 30 days while the Mid-Atlantic Regional Office only reviewed 11 percent (237 of 2,145 incidents) of its incidents occurring between October 2022 and April 2024. Moreover, 69 percent (1,488 of 2,145 incidents) of the Mid-Atlantic Regional Office reviews were completed more than 90 days after the submission of the 586, including 621 incidents that had not been reviewed at the time of our analysis, with some incidents occurring over 300 days before our analysis.[13]

We reviewed a sample of two required regional office memoranda from each office to gain a better understanding of the reviews performed. We noted that for the South Central and Western regions, the reviews we were provided were completed between 9 and 11 months after the incidents, which occurred between October 2023 and December 2023, and the reports appeared to be prepared in response to our request. In addition, one of the incidents we requested included an incident where an inmate had been in ambulatory restraints for almost 6 days, and the 586 identified several violations of BOP policies and practices, including that several 2-hour Lieutenant restraint checks indicated that the inmate was asleep at the time of the check and never awakened to reassess their behavior. However, the region did not review the incident until 308 days after the 586 was submitted.

[13] The Mid-Atlantic Regional Office provided us all use of force incidents for FY 2024 up to April 15, 2024. We used the date of our analysis (August 15, 2024) to determine the days elapsed since the 586 was submitted.

Given the importance of ensuring compliance with policies and procedures, as well as ensuring no staff misconduct occurred in a use of force incident, we find it concerning that the BOP's policy did not include timeframes for regional offices to complete reviews and did not include a mechanism to monitor the completion of the regional office reviews. Without a required timeframe to complete the regional review, issues of misconduct or noncompliance with BOP requirements have the potential of being unaddressed for extended periods of time. Therefore, we recommend that the BOP develop, formalize, and disseminate guidance to ensure effective regional office reviews of institution After-Actions involving use of force and application of restraints incidents, including timelines for when such reviews are to be completed.

The BOP Should Clarify the Purpose of Required Real-Time Notifications to Regional Directors

During a use of restraint incident, BOP policy requires Regional Directors to be verbally notified by Wardens in those instances when inmates have remained in restraints for longer than 8 hours, and additional Regional Director notification is required every consecutive 8 hours thereafter. Further, when inmates have been held in restraints for 24 hours, the institution must submit a Behavior Management Plan (BMP) to the Regional Director. We reviewed BOP's policy and were unable to identify within BOP policy or practice the intended purpose of such real-time 8-hour notifications of Regional Directors or what the Regional Directors were expected to do in response to them or receipt of a BMP.

During our interviews of regional staff, we were told that the 8-hour notifications were typically provided through email or phone calls meant to make the region aware of the continued use of restraints. We were told that the time and date of each notification were recorded in TRUINTEL after the fact. However, no other data was documented in TRUINTEL related to the notification, including what information was provided to the Regional Director, how the notification was made, and what direction, if any, was given by the Regional Director to the Warden in response. Further, they told us that with respect to the BMP, that regional staff reviewed the institution's assessment and plan to remove an inmate from restraints but did not do anything with this information other than take in the information for awareness of the situation.

Based on data provided by the BOP, prolonged placement in four-point restraints is not unusual. That BOP data indicates that between January 1, 2018, and January 16, 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.[14] We believe that, given the Regional Director notification mechanism that the BOP has put it place when an inmate is held in restraints for a prolonged period of time, this oversight mechanism could be more effectively used by the BOP to ensure that the need for and continued use of restraints is warranted. As a result, we recommend that the BOP develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks and what regional personnel are expected to do in response to receiving the BMPs. In our July 2025 MAM, we recommended that the BOP reassess its policies, practices, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury, and as part of that recommendation we stated that the BOP should consider greater involvement of regional staff in determining whether inmates should be placed in

[14] We determined that the BOP's data contained some inaccuracies concerning the nature of restraints that were used during a use of force incident (but not as to the length of time the inmate was held in restraints). Due to these issues, we were unable to determine how many of these incidents involved four-point restraints versus ambulatory restraints.

or remain in restraints. We are not replicating this recommendation here but note that the BOP should ensure its corrective action for the MAM is coordinated with the recommendation made here.

The BOP Should Develop a Reliable Notification and Tracking Process for Regional Office Reviews

As described in the *Tracking of Use of Force and Application of Restraints* section of this report, all BOP use of force incident reports and After-Action Reports are to be created in TRUINTEL. However, according to BOP officials, there was no mechanism in TRUINTEL to indicate or notify users when incidents were ready for review, and regional staff were required to manually search TRUINTEL by institution to determine whether there were incidents for review. During our interviews, we found that different methods in the six regional offices were used to identify use of force incidents ready for review in TRUINTEL. At four of the regional offices, individual staff members were each assigned a group of institutions and were responsible for identifying and reviewing all associated use of force and application of restraints incidents at their assigned institutions in TRUINTEL. Staff from another office stated that periodically, throughout the year, incidents were assigned to the staff to conduct reviews. At the last office, we were told use of force incidents were assigned to the staff on a weekly basis.

We also asked regional staff how reviews of use of force incidents were tracked, including their review of the video recordings. For two regional offices, we were told that reviews were tracked utilizing a spreadsheet that was manually maintained. We reviewed the spreadsheets and found that they contained a variety of information, including when regional staff completed a review of the use of force incident. Further, we were told by staff from all six regional offices that, aside from uploading the memorandum attesting that their review was completed, staff did not use TRUINTEL to record any other information related to reviews of incidents, including when a review was completed or the results of the review. Most staff that we spoke to told us that there was no easy way to ensure all incidents were reviewed other than manually keeping track of the last incident reviewed for each institution. Some staff told us they kept notes on their desk to notate the last incident number reviewed for their assigned institutions.

While BOP policy required use of force incident reviews by regional offices, without a reliable tracking mechanism, it is unable to ensure its regional office reviews, including reviewing video recordings, were conducted as required. As a result, we recommend that the BOP implement a process to ensure responsible regional office reviewers are notified as soon as Use of Force After-Action Reports are submitted and to track and monitor the completion of the regional office use of force incident reviews, including reviewing video recordings.

The BOP Should Ensure Video Recordings are Being Timely Provided to Regional Offices

BOP policy requires Wardens to provide handheld camera video recordings of use of force incidents to Regional Office Directors within 4 working days of an incident. These video recordings are required to include the application of restraints, the initial medical assessment, decontamination if chemical agents were used, and the debriefing of the incident. Regional staff are then required to review such video recordings for all use of force incidents. We were told that TRUINTEL does not allow for video recordings to be uploaded and TRUINTEL does not have fields to record the date a recording was provided to a regional office. Instead, institutions upload video recordings to a shared network drive without regional staff being alerted when video recordings were uploaded. Regional staff told us that video recordings were often not provided within the 4-day timeframe, and they had to request video recordings be uploaded by institution staff. Staff acknowledged some institutions frequently required reminders to provide video recordings; however, they were unable to provide us the number of times this occurred and how long it took for institutions to provide the recording.

Instances Where Video was Provided More than 85 Days after Incident in FY 2023

FCI Schuylkill – 105 days

MDC Brooklyn – 98 days

FCI Danbury – 95 days

MDC Brooklyn – 90 days

FCI Fort Dix – 89 days

MDC Brooklyn – 89 days

MDC Brooklyn – 86 days

Source: OIG Analysis of BOP records

During our review of the Northeast Regional Office's spreadsheets, we found that the spreadsheet also included a date identifying when an institution within that region provided video recordings for review.[15] Using the dates provided, we determined that for FY 2023, the average amount of time it took institutions to provide video recordings to the Northeast Regional Office was about 8 days after the incident occurred. Further, as shown in the text box to the left, we identified 7 instances where it took an institution more than 85 days from the incident to provide the video recording to the regional office, with the longest recording taking 105 days from the date of the incident. For the data we were provided for the period of October 1, 2023, through March 18, 2024, we found that it took institutions in the Northeast Region about 5 days for videos to be provided to the regional office, with the longest taking 35 days. While this may appear to be an improvement, during the same timeframe there were 30 incidents in which the video recording upload date was not included in the spreadsheet. Additionally, in FY 2023, we found that in 280 of 823 incidents, video recordings were provided after the Use of Force After-Action Report was submitted to the regional office, and in the first 6 months of FY 2024 this occurred for 144 of 379 incidents.[16] We also identified a total of 366 incidents between October 1, 2022, and March 18, 2024, in which the video submission was not provided within 4 working days of the incident and, thus, did not meet the BOP policy requirement.

We believe timely reviews help contribute to the safety and security of the BOP's institutions, inmates, and staff by holding people accountable and offering opportunities for the BOP to correct deficiencies and identify training and development needs or lapses. Thus, timely submission of video recordings are integral to ensuring regional offices are able to complete its reviews in a timely manner. Therefore, we recommend that the BOP develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability and ensure it includes

[15] We did not verify the dates in the spreadsheets. We used the information provided for informational purposes only.

[16] In some instances, this still met the four working days requirement, per BOP policy.

controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident.

BOP's Tracking and Monitoring of Issues Identified During Reviews of Application of Restraints Incidents

BOP policy requires use of force incident reports and videotapes be reviewed, audited, and monitored by regional offices and Central Office headquarters, and referred as appropriate to the OIG, BOP OIA, or the Federal Bureau of Investigation. However, we were told by regional staff that there was no process in place to track and monitor referrals made to OIA by either the institution or the regional offices. Additionally, we were unable to determine how many referrals were made during the time of our audit and found no indication that the regional offices or Central Office tracked, reviewed, or addressed violations reported in the Use of Force After-Action Reports or regional office review memoranda. We believe effective monitoring is crucial because it allows for accountability, helps identify patterns of problematic behavior, and can deter future misconduct.

The BOP Should Have a Process to Track and Monitor Referrals to the Office of Internal Affairs

In accordance with the BOP's Standards of Employee Conduct, staff who become aware of any violation or alleged violation of the Standards of Employee Conduct must report such allegations or violations to OIA, including those associated with the use of force and application of restraints. Throughout our audit, regional staff told us that referrals to OIA related to the use of force and application of restraints usually occurred at the institution as a result of institution-level After-Action reviews. The staff also indicated that there were instances in which regional staff refer incidents to OIA during their review of use force and application of restraints incidents.

During our interviews, we found that regional staff were not able, with certainty, to provide the total number of incidents referred to OIA, and we were told that the regional offices did not have any mechanisms in place to track and monitor such referrals. Most staff told us that, based on their recollection, they either had not made any referrals or could only recall referring one or two incidents. Further, we were told that the regional staff were not notified and did not track referrals made by its institutions based on the After-Action review. Consequently, regional staff did not appear to be aware of OIA referrals made by institution staff.

Referrals to OIA are important because they may lead to OIG, FBI, or BOP investigations of criminal or administrative misconduct by BOP employees. By not tracking OIA referrals it hinders BOP's ability to hold staff accountable for misconduct as well as its ability to identify and address specific institutions and regional offices that are not making referrals when appropriate, potential systemic misconduct issues at institutions, and systemic problems with the After-Action and regional office review process. As a result, we recommend that the BOP implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to OIA, as required and implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referrals originated.

The BOP Should Put in Place a Process to Address Systemic Issues and Violations Identified During Reviews

Staff told us that common violations identified during regional office reviews included improper handling of an inmate, video recordings that had excessive background noise, and BOP staff not wearing the appropriate uniform. While After-Action and regional office reviews are performed, we found that the BOP did not take further action to analyze the violations identified in the Use of Force After-Action Reports and regional office memoranda.

Specifically, we were told by regional staff and Central Office management that violations reported during regional reviews were not tracked. In our interviews, regional staff were unable to tell us how the violations identified during reviews were handled at the institution or regional office once reported. Additionally, staff were unable to describe to us any process in place to track, monitor, or otherwise address such issues, including any determination as to whether issues identified during the reviews reoccurred and indicated a systemic concern. Further, staff were unaware of any processes at the institutions in their regions to address repetitive issues identified during the After-Action review and regional office review, such as by putting in place additional policies, procedures, or staff training.

We selected and reviewed a sample of 12 Use of Force After-Action Reports (586) and the related regional office memoranda. In nine of the After-Action Reports, institution staff documented excessive background noise and in seven staff identified improper uniform as an issue. Excessive background noise can be a significant concern, especially if it impairs the ability of reviewers to assess whether staff are behaving appropriately or have proper justification for their actions during use of force and application of restraints incidents. We also noted other issues documented by institution staff in the reports included a variety of issues related to the video recording, improper control of the inmate, and medical assessment issues. In our review of regional office memoranda, which staff told us included any issues identified by the regional staff during its review that were not noted in the 586, we identified that in at least 6 of 12 memoranda staff documented issues related to the video recording, improper control of the inmate, medical assessment issues, and issues with required documentation. For one regional office, staff did not document any issues and instead noted that "any discrepancies found have been forwarded to the Captain," which we were told meant that the issues were referred back to institution staff.

We believe that tracking and performing analysis of the deficiencies identified during reviews would help the BOP address potentially systemic issues throughout its institutions and mitigate vulnerabilities that exist within its use of force and application of restraints process. Conducting this type of analysis may also facilitate the identification of root causes and allow for the implementation of best practices to improve the process. Therefore, we recommend that the BOP evaluate and enhance the After-Action review process to ensure identified issues are appropriately tracked and systemic matters are addressed.

Effectiveness of BOP's Program Review Division Oversight Process

BOP's Program Review Division (PRD), located within BOP's Central Office headquarters, was created to establish a self-monitoring system that provides oversight of program performance and compliance. This oversight includes conducting reviews to examine BOP's compliance with laws, rules, regulations, and policy including those related to the use of force and application of restraints. These reviews are to examine the adequacy of controls, efficiency of operations, and effectiveness in achieving program results. However, as

discussed throughout this report, we identified deficiencies in several areas of the BOP's regional offices oversight of use of force and application of restraints incidents, including a lack of standard procedures for the timing and substance of regional office reviews, as well as a lack of consistent and reliable processes for completing such reviews. We believe that the aforementioned deficiencies may hinder BOP's ability to effectively mitigate risk and provide adequate governance of the use of force and application of restraints process carried out within its institutions.

In March 2024, in response to recommendations made by the OIG in a May 2023 report that identified limitations in the BOP's program review process, the BOP discontinued its program and operational review process and transitioned to a risk-based approach that includes compliance audits, process audits, area audits, and perpetual audits.[17] According to the BOP, to address the OIG's concerns, the new internal auditing process intends to identify causes of common findings that recur across multiple facilities, and to implement a follow-up process that involves all levels of the BOP to establish internal controls to mitigate the recurrence of findings. In addition, PRD is to conduct annual risk analyses using a variety of data sources with a focus on high-risk areas and when common findings rise to the top of the analysis, PRD will conduct audits to provide a more in-depth analysis of the process and validate existing internal controls.

During the scope of our audit, PRD relied on its prior internal auditing process in which it conducted program reviews of each operation or program within an institution or regional office using Program Review Guidelines (PRG). The BOP also conducted operational reviews, which were self-evaluations conducted by staff within an institution or regional office, using the same PRGs and process as a program review. To gain an understanding of how use of force and application of restraints incidents were addressed during the BOP's prior process, we examined the PRGs and identified the steps conducted to review use of force and application of restraints incidents, as shown below in Figure 4.

[17] DOJ OIG, *Limited-Scope Review of the Federal Bureau of Prisons' Strategies to Identify, Communicate, and Remedy Operational Issues*, Evaluation and Inspections Report 23-065 (May 2023), oig.justice.gov/reports/limited-scope-review-federal-bureau-prisons-strategies-identify-communicate-and-remedy.

Figure 4
Program and Operational Reviews - PRG Review Steps

Institution
1. Randomly selecting and reviewing 25 percent (not to exceed 5 at each institution) use of force files over the past 12 months to determine if: o Reviews were conducted by administrative staff o After-Action reviews were submitted within 2 working days after the last inmate was released from restraints o Use of force video recordings are stored as evidence in SIS
2. Randomly selecting and reviewing 25 percent (not to exceed 5 at each institution) use of force files over the past 12 months in which four-point restraints were applied to determine if policy and procedures were followed
3. At each institution, inspect use of force equipment to determine if it is operational, controlled, and secured per policy
Regional Office
1. Randomly select 10 use of force incidents within the past 12 months to determine if regional reviews were conducted

Source: OIG Analysis of BOP policies

We also reviewed program review reports completed during the scope of our audit and noted that the program reviews identified issues with the use of force incident files. Despite issues being identified during the reviews, we found that neither the reviewers nor Central Office personnel took any additional steps to determine whether the issues identified could be systemic. Specifically, if multiple issues were identified during the performance of the PRG review steps, there was no guidance or additional actions for further testing to allow a reviewer the ability to determine the significance and context of any issues identified, such as whether there was a systemic issue requiring managerial action to correct.

We met with BOP officials to gain an understanding of the status of implementation of the new process and how the BOP intends to provide oversight of its operations and programs going forward, including the use of force and application of restraints. Officials told us that PRD is still working through development of the new process, specifically the risk assessment analysis, and as of September 2024, conducted about five limited focus compliance audits. BOP officials also told us that although draft reports had been issued to the responsible parties, the audits had not been finalized.

According to the BOP, its new internal audit process will help to mitigate the reoccurrence of findings. Yet, because the BOP had not yet fully implemented this policy and finalized any audits, we were unable to determine whether the process will be sufficient to identify deficiencies in its use of force and application of restraints process and the regional offices' oversight of incidents. We believe that a robust internal control process should include an analysis of the deficiencies that are occurring to include a determination as to

whether patterns of deficiencies exist. As a result, we recommend that the BOP finalize and implement its new internal audit process and consider including steps that will sufficiently identify systemic issues pertaining to adherence to the BOP's policies and procedures related to use of force and application of restraints.

Conclusion and Recommendations

BOP staff are authorized to use physical restraints to gain control of an inmate who appears to be dangerous, but BOP staff are to use only the force necessary to gain control of an inmate, protect and ensure the safety of other inmates and staff, prevent serious property damage, and ensure institution security and good order. Overall, we found that the BOP did not effectively utilize TRUINTEL for documenting the use of restraints within its institutions, and while we did not fully verify the data within the system, we did identify inaccuracies regarding case files we reviewed. While the BOP has policies and procedures in place requiring the review of use of force incidents, which may include the application of restraints, we found that the BOP needs to improve its oversight of the use of force and application of restraints incident process. Specifically, BOP policy did not establish standard procedures for the regional office reviews, including the timing and substance of the reviews. We also found that there is no mechanism within BOP's TRUINTEL to indicate or notify users when incidents were ready to review, and it did not allow its users the capabilities to track and monitor regional office reviews of use of force and application of restraints incidents. Further, BOP policy required institutions to provide handheld video recordings of use of force incidents to regional offices; however, the BOP did not have a reliable method to ensure video recordings were timely provided to and tracked by regional offices. Given the importance of ensuring compliance with policies and procedures, we believe timely reviews help contribute to the safety and security of BOP's institutions, inmates, and staff by holding people accountable and offering opportunities for the BOP to correct deficiencies and identify training and developments needs or lapses.

In addition, we found that the BOP did not have a process in place to track and monitor referrals made to OIA by either the institution or regional offices. Moreover, we found no indication that the regional offices or Central Office tracked, reviewed, or addressed violations reported in After-Action Reports and regional office memoranda. The BOP is in the process of finalizing its internal audit guidance and the new process is not yet fully implemented; however, we were unable to determine whether the process will be sufficient to identify deficiencies in its use of force and application of restraints process and the regional offices' oversight of incidents. We believe that tracking and performing an analysis of deficiencies identified during reviews would benefit the BOP in their efforts to identify systemic issues, as well as whether there are gaps in its existing control activities. Effective oversight of use of force and application of restraints incidents within BOP institutions is of utmost importance to ensure that the BOP is protecting its institutions, staff, and inmates and identifying as well as addressing staff misconduct timely.

We recommend that the BOP:

1. Take steps and implement controls to ensure that it maintains appropriate and accurate records and data on the use of restraints. Those steps should include providing appropriate training to staff when documenting incidents, as well as appropriate review procedures ensuring that, once entered, the data is correct and supported with appropriate documentation.

2. Establish Bureau-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews, including how the results should be transmitted, communicated, documented, and reported.

3. Require institutions timely submit and regional offices review relevant fixed camera footage, in addition to handheld camera video, during use of force and application of restraints incident reviews.

4. Develop, formalize, and disseminate guidance to ensure effective regional office reviews of institution After-Actions involving use of force and application of restraints, including timelines for when such reviews are to be completed.

5. Develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks and what regional personnel are expected to do in response to receiving the BMPs.

6. Implement a process to ensure responsible regional office reviewers are notified as soon as Use of Force After-Action Reports are submitted and to track and monitor the completion of the regional office use of force incident reviews including reviewing video recordings.

7. Develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability and ensure it includes controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident.

8. Implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to OIA, as required and implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referral originated.

9. Evaluate and enhance the After-Action review process to ensure identified issues are appropriately tracked and systemic matters are addressed.

10. Finalize and implement its new internal audit process and consider including steps that will sufficiently identify systemic issues pertaining to adherence to the BOP's policies and procedures related to use of force and application of restraints.

APPENDIX 1: Objectives, Scope, and Methodology

Objectives

The objective of this audit was to examine the Federal Bureau of Prisons' (BOP) oversight of the use of restraints.

Scope and Methodology

The scope of our audit covered the BOP activities related to use of force and application of restraints incidents from January 2018 through September 2024. To accomplish our objective, we reviewed BOP policies and training materials related to the use of force and application of restraints. This included (but was not limited to) BOP's Program Review Guidelines for Correctional Services, BOP's Correctional Services Procedures Manual, BOP's Program Statement on Use of Force and Application of Restraints, BOP's Program Statement on Use of Force, Application of Restraints, and Firearms, and interim guidance on BOP's Internal Audit Process. We visited Federal Detention Center Philadelphia to gain an understanding of the use of force and application of restraints process and requirements at an institution. Additionally, we visited BOP facilities in Annapolis Junction, Maryland; Philadelphia, Pennsylvania; Leavenworth, Kansas; Dublin, California; Grand Prairie, Texas; and Atlanta, Georgia. We conducted interviews of officials from the BOP's Central Office headquarters, as well as officials from BOP's six regional offices (Mid-Atlantic, North Central, Northeast, South Central, Southeast, and Western). We reviewed a sample of BOP documentation related to use of force and application of restraints incidents. We obtained a listing of 14,772 use of force incidents recorded in TRUINTEL between January 1, 2018, and January 16, 2024. We also obtained a list of use of force incidents which occurred within BOP's Northeast Regional Office between October 1, 2023, and March 18, 2024, totaling 1,196, as well as a list of use of force incidents which occurred within BOP's Mid-Atlantic Regional Office between October 1, 2023, and April 15, 2024, totaling 2,145. Finally, we reviewed BOP Correctional Services program and operational reviews it conducted for its institutions and regional offices during the scope of our audit.

Statement on Compliance with Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Internal Controls

In this audit, we performed testing of internal controls significant within the context of our audit objectives. We did not evaluate the internal controls of the BOP to provide assurance on its internal control structure as a whole. BOP management is responsible for the establishment and maintenance of internal controls in accordance with OMB Circular A-123. Because we do not express an opinion on the BOP's internal control structure as a whole, we offer this statement solely for the information and use of the BOP.[18] To accomplish

[18] This restriction is not intended to limit the distribution of this report, which is a matter of public record.

our objective, we reviewed the BOP processes related to the oversight of the use of force and application of restraints. Further, we evaluated the BOP's policies, procedures, information provided, and monitoring activities.

The internal control deficiencies we found are discussed in the Audit Results section of this report. However, because our review was limited to those internal control components and underlying principles that we found significant to the objectives of this audit, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

Sample-Based Testing

To accomplish our audit objective, we performed sample-based testing for the BOP's After-Action Reports, regional office memoranda, program review reports, and operational review reports. The entire universe of use of force and application of restraints incidents included 14,772 incidents recorded in TRUINTEL between October 1, 2018, and January 16, 2024. In examining the BOP's recorded data in TRUINTEL, we selected a judgmental sample of 13 incidents to review documentation within the incident file. Based on our analysis of the data, we identified high-risk areas associated with the BOP's oversight of use of force and application of restraints process. In this effort, we employed a judgmental sampling design to obtain broad exposure to numerous facets of the areas we reviewed. This non-statistical sample design did not allow projection of the test results to the universe from which the samples were selected. To review the BOP's incident review process, we selected a judgmental sample of 2 incidents per regional office occurring between October 1, 2023, and January 16, 2024, and reviewed the institutions' After-Action Report and corresponding regional office memorandum. In addition, we reviewed all program reviews completed for institutions during our audit scope, which totaled 19 program review reports. Additionally, we reviewed the most recent program and operational review report for each regional office.

Computer-Processed Data

During our audit, we obtained information from the BOP's TRUINTEL application within its administrative staff network infrastructure called the Trust Fund Network (TRUNET). We did not test the reliability of those systems as a whole, therefore any findings and conclusions involving data from those systems were verified with documentation from other sources. We did not validate the data provided and during our discussions with the BOP, we were told that this data was not normally accessed or analyzed by the institutions, regional offices, or Central Office. In addition, we were told that the data was not easily traced to corroborating information outside of TRUINTEL, and no other form of readily available documentation could be used to verify the data. As a result, we used the data provided for informational purposes in understanding the extent to which restraints are used within BOP institutions.

Appendix 2: BOP Institution Security Level and Name Changes

During our audit scope, several BOP institutions had security level and mission changes. In February 2024, the BOP Executive Team approved name changes for seven institutions to match the security level and mission changes. These changes became official in April 2024. The BOP provided the information in the table below detailing the changes.

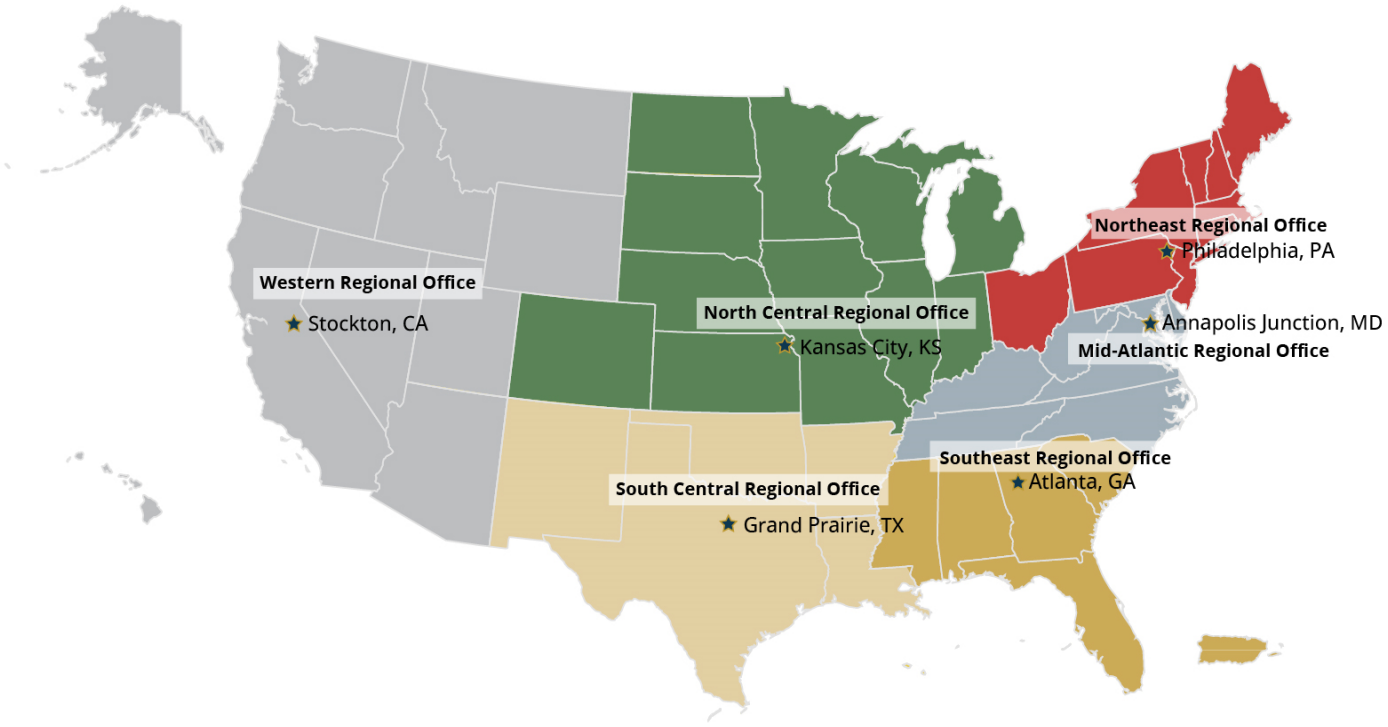
Institution	Name Change			Security Level Change		
	From	To	Date of Change	From	To	Date of Change
Thomson	USP	FCI	4/4/2024	High	Low	4/17/2023
Lewisburg	USP	FCI	4/4/2024	High	Medium	8/17/2018
Atlanta	USP	FCI	4/4/2024	Medium	Low	6/24/2022
Yazoo City	USP	FCI	4/4/2024	High	Medium	4/22/2022
Yazoo City	FCI	FCI	N/A	Medium	Low	4/22/2022
Morgantown	FCI	FPC	4/4/2024	N/A	N/A	N/A
Lompoc	USP	FCI	4/4/2024	Medium	Low	3/23/2023

USP – United States Penitentiary
FCI – Federal Correctional Institution
FPC – Federal Prison Camp

Notes: FPC Morgantown was always designated as a FPC but was named an FCI. For naming consistency, the BOP approved the name change to match its mission. Yazoo City is a Federal Correctional Complex that includes three separate institutions, and with the changes detailed above, there is a medium security level institution and two low security level institutions.

Source: BOP

Appendix 3: BOP Regional Offices



Western Regional Office – Stockton, CA

- Alaska
- Arizona
- California
- Idaho
- Hawaii
- Montana
- Nevada
- Oregon
- Utah
- Washington
- Wyoming

North Central Regional Office – Kansas City, KS

- Colorado
- Illinois
- Indiana
- Iowa
- Kansas
- Michigan
- Minnesota
- Missouri
- Nebraska
- North Dakota
- South Dakota
- Wisconsin

South Central Regional Office – Grand Prairie, TX

- Arkansas
- Louisiana
- New Mexico
- Oklahoma
- Texas

Southeast Regional Office – Atlanta, GA

- Alabama
- Florida
- Puerto Rico
- Mississippi
- South Carolina

Mid-Atlantic Regional Office – Annapolis Junction, MD

- Delaware
- District of Columbia
- Kentucky
- Maryland
- North Carolina
- Tennessee
- Virgina
- West Virginia

Northeast Regional Office – Philadelphia, PA

- Connecticut
- New Hampshire
- New Jersey
- New York
- Maine
- Ohio
- Pennsylvania
- Rhode Island
- Vermont

Source: OIG and BOP

Appendix 4: BOP Use of Force & Video Review – Worksheet

USE OF FORCE & VIDEO REVIEW – WORKSHEET

DATE & TIME OF INCIDENT: _____ **IMMEDIATE** _____ **CALCULATED** _____ **DATE REVIEWED:** _____

TRUINTEL 583/586 INCIDENT NUMBER: _____

TRUINTEL 586 AFTER ACTION REVIEW REPORT: (Reviewed by Warden, AW Over Custody, Captain, and HSA) **Yes / No**

USE OF FORCE VIDEO: (Sent to the Regional Office within four working days of Incident) **Yes / No**

USE OF RESTRAINTS: (√) Escort Only _____ **Ambulatory** _____ **Soft** _____ **Hard** _____ **Four Point** _____ **Warden Approved:** _____
(NOTE: If inmate was secured in restraints during the UOF ensure both Type and Method of restraints used is marked Yes)

CONFRONTATION AVOIDANCE:

Confrontation Avoidance - procedures used were sufficient	Y N N/A
Confrontation Avoidance Measures – videotaped and sequential	Y N N/A
Inmate provided opportunity to voluntarily submit to restraints prior to team entry	Y N N/A

MANDATORY PROCEDURES:

Camera Operator Identified	Y	N	N/A	Decontamination conducted on video (OC)	Y	N	N/A
Start Date, Time & Location on Video (Stated)	Y	N	N/A	Injury Assessment on Video	Y	N	N/A
LT in proper Uniform	Y	N	N/A	I/M identified by Name and Reg. No.	Y	N	N/A
Lt. and staff displayed Professionalism	Y	N	N/A	Medical Checked Restraints on video	Y	N	N/A
Scenario Adequately Described	Y	N	N/A	Staff maintain control of the Inmate	Y	N	N/A
Lt state justification on video for placement in 4-point/ambulatory restraints	Y	N	N/A	Appropriately clothed	Y	N	N/A
Staff willing and able to participate	Y	N	N/A	Placed on Back (4 pt only)	Y	N	N/A
Medical Staff Present	Y	N	N/A	Blanket / Sheet Provided (4 Pt)	Y	N	N/A
Staff Correctly Stated Responsibilities	Y	N	N/A	Mattress on Bed	Y	N	N/A
Protective Equipment Worn	Y	N	N/A	Debrief by Supervisor Videotaped	Y	N	N/A
No unauthorized items used	Y	N	N/A	All staff participating identified on video	Y	N	N/A
No unnecessary pressure applied	Y	N	N/A	Incident Sequentially Taped	Y	N	N/A
Lt Supervised and no Physical Involvement	Y	N	N/A	Justification for Video Breaks	Y	N	N/A
Inmate Searched / Scanned with Metal Det	Y	N	N/A	End Date and Time on Video (Stated)	Y	N	N/A

583/586 REPORT:

Submitted within 2 days of incident or released from restraints	Y N N/A	Type and Method of restraints used	Y N N/A
Proper Classification indicated	Y N N/A	Video Tape of incident saved	Y N N/A
8 hour Notifications to RD noted and accurate if placed in ambul or 4-point	Y N N/A	Video indicated as being stored in evidence safe or locker	Y N N/A

DOCUMENTATION REVIEWED: (SIS should review to ensure all proper documents were entered by the Lieutenant)

583 Report of Incident	Y N N/A	Incident Report(s)	Y N N/A
586 After-Action Report	Y N N/A	Photo Sheet(s)	Y N N/A
Supervisor's Memorandum	Y N N/A	Staff Assignment Roster	Y N N/A
ALL Staff Memorandum(s)	Y N N/A	Detention Order(s)	Y N N/A
Injury Assessments	Y N N/A	Medical Restraint Review Sheet	Y N N/A
15 Minute Checks	Y N N/A	Psychology Review Sheet	Y N N/A
2 Hour Checks	Y N N/A	Behavior Management Plan (24 Hour)	Y N N/A
Chain of Custody Form	Y N N/A	Behavior Management Plan (48 Hour)	Y N N/A

Notes:

APPENDIX 5: The Federal Bureau of Prisons Response to the Draft Audit Report

U.S. Department of Justice

Federal Bureau of Prisons

Office of the Director *Washington, DC 20534*

July 18, 2025

MEMORANDUM FOR JASON R. MALMSTROM
ASSISTANT INSPECTOR GENERAL
AUDIT DIVISION

FROM: William K. Marshall III, Director

SUBJECT: Response to the Office of Inspector General's (OIG) Audit of the Federal Bureau of Prisons' Oversight of the Use of Restraints

The Federal Bureau of Prisons (BOP) appreciates the opportunity to formally respond to the Office of the Inspector General's report entitled, "Audit of the Federal Bureau of Prisons' Oversight of the Use of Restraints (the Report)." The BOP values the OIG's assessment regarding the agency's policies and practices pertaining to the oversight of the use of restraints.

The OIG identified deficiencies with BOP's oversight of the use of restraints and made several recommendations calling for more detail regarding the role of regional personnel upon notification of an institution's use of restraints and during reviews by regional offices following the use of restraints. Specifically, OIG found the BOP does not provide guidance for how reviews should be conducted, a timeframe or method for the reviews, and a process to track and address identified issues and systemic matters. Additionally, OIG identified concerns with the accuracy of BOP data.

The BOP has six regional offices which are tasked with providing operational oversight and technical assistance to the facilities within their regions. Accordingly, BOP strives to ensure leadership in each of its regional offices have the correctional expertise necessary to make appropriate and necessary decisions regarding the oversight of the use of force and application of restraints at each institution in their respective regions.

The BOP is committed to improving its oversight of the use of force and application of restraints process and as such, offers OIG the following comments regarding the Report's recommendations:

Recommendation One: **Take steps and implement controls to ensure that it maintains appropriate and accurate records and data on the use of restraints. Those steps should include providing appropriate training to staff when documenting incidents, as well as appropriate review procedures ensuring that, once entered, the data is correct and supported with appropriate documentation.**

BOP Response: The BOP concurs with this recommendation and will implement controls to ensure it maintains appropriate and accurate records and data on the use of restraints. The BOP will ensure it provides necessary training to staff regarding documenting incidents and appropriate review procedures ensuring, once entered, the data is correct and supported with appropriate documentation.

Recommendation Two: **Establish Bureau-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews, including how the results should be transmitted, communicated, documented, and reported.**

BOP Response: The BOP concurs with this recommendation and will establish BOP-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews. This will include how the results should be transmitted, communicated, documented, and reported. The BOP will consider multiple avenues to determine the proper method to set specific criteria and procedures for the region to follow.

Recommendation Three: **Require institutions timely submit and regional offices review relevant fixed camera footage, in addition to handheld camera video, during use of force and application of restraints incident reviews.**

BOP Response: The BOP concurs with this recommendation and will assess how to best reinforce the requirements in existing policy, which outline expectations for the timely submission and review of all relevant CCTV and handheld camera footage during use of force and application of restraint incident reviews.

Recommendation Four: **Develop, formalize, and disseminate guidance to ensure effective regional office reviews of institution After-Actions involving use of force and application of restraints incidents, including timelines for when such reviews are to be completed.**

BOP Response: The BOP concurs with this recommendation and will develop, formalize, and disseminate guidance to ensure effective regional office reviews of institution After-Actions involving use of force and application of restraints, including timelines for when such reviews are to be completed.

Recommendation Five: **Develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force**

notifications at the 8-hour marks and what regional personnel are expected to do in response to receiving the BMPs.

BOP Response: The BOP concurs with this recommendation and will develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks. This guidance will include what regional personnel are expected to do in response to receiving the BMPs.

Recommendation Six: Implement a process to ensure responsible regional office reviewers are notified as soon as Use of Force After-Action Reports are submitted and to track and monitor the completion of the regional office use of force incident reviews including reviewing video recordings.

BOP Response: The BOP concurs with this recommendation and during its review of recommendation two, will establish a method for regional office use of force and application of restraints After-Action notification. This will include tracking and monitoring the completion of the regional office use of force incident reviews. The BOP will consider multiple avenues to determine the proper method to establish this notification, tracking and review process.

Recommendation Seven: Develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability and ensure it includes controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident.

BOP Response: The BOP concurs with this recommendation and will develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability and ensure it includes controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident as currently specified in policy.

Recommendation Eight: Implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to OIA, as required and implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referral originated.

BOP Response: The BOP concurs with this recommendation and will evaluate its systems to determine the best way to implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to OIA as required. The BOP will implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referral originated.

Recommendation Nine: Evaluate and enhance the After-Action review process to ensure identified issues are appropriately tracked, and systemic matters are addressed.

BOP Response: The BOP concurs with this recommendation and will evaluate and enhance the current After-Action review process to ensure identified issues are appropriately tracked, and systemic matters are addressed.

Recommendation Ten: Finalize and implement its new internal audit process and consider including steps that will sufficiently identify systemic issues pertaining to adherence to the BOP policies and procedures related to use of force and application of restraints.

BOP Response: The BOP concurs with this recommendation. In 2023, the Program Review Division (PRD) began modifying its internal audit process in response to external audit recommendations. Previously, PRD conducted "program reviews," which were based on a written set of guidelines available to all sites being reviewed. The previous review process used employees from across the agency to conduct the review at a specific location to evaluate compliance with Program Review Guidelines. A final rating was issued at the completion of the review, which determined when the site would be reviewed next.

The PRD has made key changes to the review process bringing new accountability, expanded communication and transparency to the internal audit process. The PRD now conducts internal audits of the BOP consisting of risk-based compliance and process audits utilizing only PRD employees to ensure independence in accordance with the Generally Accepted Government Auditing Standards (GAGAS). Compliance audits are conducted to assess internal controls and compliance with current policy, rules and regulations. Compliance audits are typically conducted at one location. Process audits are agency-level audits that assess a process or part of a process across the entire BOP to determine internal controls and compliance agency-wide. Process audits may involve site visits to multiple locations to assess agency-wide controls.

The new internal audit process includes a robust follow-up process involving all levels of leadership at the local institution, regional office and division. Specifically, the process ensures subject matter experts (SMEs) at all levels (individual site/facility, regions, and division level) are aware of the audit reports under their program areas. The SMEs at the Regional Office and Central Office Divisions monitor the audit reports and are responsible for identifying common findings in their program areas and determining the appropriate application of corrective action within the region or agency-wide. If the region/division intends to implement any regional/agency wide internal control(s) within their purview, in response to common findings they have identified in internal audit reports, a separate memorandum must be provided to PRD identifying the internal control(s) and time frame of enactment.

The PRD will continue to assess resources, including funding, so PRD can continue to implement, and ultimately finalize, its new internal audit process, which will include steps that will assist with identifying systemic issues pertaining to adherence to BOP's policies and procedures related to use of force and application of restraints.

APPENDIX 6: Office of the Inspector General Analysis and Summary of Actions Necessary to Close the Audit Report

The Office of the Inspector General (OIG) provided a draft of this audit report to the Federal Bureau of Prisons (BOP). The BOP's response is incorporated in Appendix 5 of this final report. In response to our audit report, the BOP concurred with our recommendations and discussed the actions it will implement in response to our findings. As a result, the status of the audit report is resolved. The following provides the OIG analysis of the response and summary of actions necessary to close the report.

Recommendations for BOP:

1. **Take steps and implement controls to ensure that it maintains appropriate and accurate records and data on the use of restraints. Those steps should include providing appropriate training to staff when documenting incidents, as well as appropriate review procedures ensuring that, once entered, the data is correct and supported with appropriate documentation.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will implement controls to ensure it maintains appropriate and accurate records and data on the use of restraints. In addition, the BOP stated that it will ensure it provides necessary training to staff regarding documenting incidents and appropriate review procedures ensuring, once entered, the data is correct and supported with appropriate documentation. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has taken steps and implemented controls to ensure it maintains appropriate and accurate records and data on the use of restraints.

2. **Establish Bureau-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews, including how the results should be transmitted, communicated, documented, and reported.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will establish BOP-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews, including how the results should be transmitted, communicated, documented, and reported. In addition, the BOP stated it will consider multiple avenues to determine the proper method to set specific criteria and procedures for the region to follow. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive documentation that the BOP has established Bureau-wide criteria and standard procedures for regional office use of force and application of restraints incident reviews that includes how the results should be transmitted, communicated, documented, reported.

3. **Require institutions timely submit and regional offices review relevant fixed camera footage, in addition to handheld camera video, during use of force and application of restraints incident reviews.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will assess how to best reinforce the requirements in existing policy, which outlines expectations for the timely submission and review of all relevant fixed camera footage and handheld camera footage during use of force and application of restraint incident reviews. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive documentation that the BOP requires its institutions to timely submit, and regional offices review, relevant fixed camera and handheld camera video footage in a timely manner.

4. **Develop, formalize, and disseminate guidance to ensure effective regional office reviews of institution After-Actions involving use of force and application of restraints, including timelines for when such reviews are to be completed**.

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will develop, formalize, and disseminate guidance to ensure effective regional office reviews of After-Actions involving use of force and application of restraints, including timelines for when such reviews are to be completed. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has developed, formalized, and disseminated guidance to ensure effective regional office reviews of After-Actions involving use of force and application of restraints, including timelines for when such reviews are to be completed.

5. **Develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks and what regional personnel are expected to do in response to receiving the Behavior Management Plan (BMP).**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will develop, formalize, and disseminate guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks. Additionally, the BOP stated that guidance will include what regional personnel are expected to do in response to receiving the BMP. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has developed, formalized, and disseminated guidance that clarifies how regional personnel are expected to utilize and/or respond to real-time use of force notifications at the 8-hour marks and what regional personnel are expected to do in response to receiving the BMP.

6. **Implement a process to ensure responsible regional office reviewers are notified as soon as Use of Force After-Action Reports are submitted and to track and monitor the completion of the regional office use of force incident reviews including reviewing video recordings.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that during its review of recommendation two, it will establish a method for regional office use of force and application of restraint After-Action notification. Further, the BOP stated that this will include tracking and monitoring the completion of the regional office use of force incident reviews and will consider multiple avenues to determine the proper method to establish this notification, tracking, and review process. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has implemented a process to ensure regional office reviewers are notified as soon as Use of Force After-Action Reports are submitted and to track and monitor the completion of the regional office use of force incident reviews including reviewing video recordings.

7. **Develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability and ensure it includes controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will develop and implement a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability. The BOP further stated that it will ensure the method includes controls to track and monitor compliance with the requirement to submit video recordings within 4 working days of an incident as currently stated in policy. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has developed and implemented a reliable method for institutions to submit and notify regional offices of use of force and application of restraints incident video recording availability, and that it includes controls to track and monitor compliance with the policy requirement to submit recordings within 4 working days.

8. **Implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to the Office of Internal Affairs (OIA), as required and implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referral originated.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will evaluate its systems to determine the best way to implement controls to ensure all violations or alleged violations of the Standards of Employee Conduct are reported to OIA as required. The BOP further stated that it will implement a reliable process to track and monitor referrals made to OIA based on After-Action and regional office reviews of use of force incidents, including where the referral originated. As a result, this recommendation is resolved.

This recommendation can be closed when we receive documentation that the BOP has implemented controls to ensure all violations or alleged violations of the Standard of Employee Conduct are reported to OIA and has implemented a reliable process to track and monitor referrals made to OIA.

9. **Evaluate and enhance the After-Action review process to ensure identified issues are appropriately tracked and systemic matters are addressed.**

   Resolved. The BOP concurred with our recommendation. The BOP stated in its response that it will evaluate and enhance the current After-Action review process to ensure identified issues are appropriately tracked and systemic matters are addressed. As a result, this recommendation is resolved.

   This recommendation can be closed when we receive evidence that the BOP has evaluated and enhanced the current After-Action review process to ensure identified issues are appropriately tracked and systemic matters are addressed.

10. **Finalize and implement its new internal audit process and consider including steps that will sufficiently identify systemic issues pertaining to adherence to the BOP's policies and procedures related to use of force and application of restraints.**

    Resolved. The BOP concurred with our recommendation. The BOP included in its response a discussion on changes taking place within its Program Review Division, particularly in regard to its internal review process. In addition, the BOP stated in its response that it will continue to assess resources, including funding, so that the Program Review Division can continue to implement and ultimately finalize its new internal audit process, which will include steps that will assist with identifying systemic issues pertaining to adherence to BOP's policies and procedures related to use of force and application of restraints. As a result, this recommendation is resolved.

    This recommendation can be closed when we receive documentation that the BOP finalized and implemented its new internal auditing process and considered including steps that will sufficiently identify systemic issues pertaining to adherence of the BOP's policies and procedures related to use of force and application of restraints.