



# Inspection of the Federal Bureau of Prisons' U.S. Penitentiary Canaan



EVALUATION & INSPECTIONS DIVISION

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## Executive Summary



### The DOJ OIG's Inspections Program

Between Monday, June 2, and Thursday, June 5, 2025, the U.S. Department of Justice (DOJ) Office of the Inspector General (OIG) conducted an unannounced, on-site inspection of U.S. Penitentiary (USP) Canaan in Waymart, Pennsylvania.<sup>1</sup> The institution houses male inmates in a high-security federal penitentiary and adjacent minimum-security satellite camp. This is the OIG's first inspection of a standalone USP.

The OIG has determined that it can enhance the effectiveness of its oversight, and its ability to alert the BOP to concerns, by conducting unannounced inspections of BOP institutions. Since 2023, the OIG has conducted inspections at 14 BOP institutions: 7 individual facility inspections, 6 inspections conducted as part of the OIG's Concurrent Inspections of BOP Food Service Operations, and the most recent ongoing inspection effort at Federal Correctional Institution (FCI) Berlin in New Hampshire. [Appendix 2](#) lists the published results of the completed inspections.

Our inspection work is consistent with the Federal Prison Oversight Act (FPOA), which requires the OIG to conduct periodic inspections of BOP facilities based on the OIG's assessment of risk. In accordance with the FPOA's requirements, we are reporting the findings from our inspection of USP Canaan, and our recommendations to the BOP that derived from this inspection, publicly and to the U.S. Congress.

Our unannounced inspection of USP Canaan identified serious issues with the application of restraints on inmates, the effects of restrictions on inmate movement, the provision of inmate healthcare, institutional safety and security, and employee professionalism. We were especially concerned with the application of four-point restraints that we observed on site, and we found evidence of instances in which USP Canaan employees applied restraints in a manner that caused inmates severe discomfort and posed a risk of serious and lasting injury.

We also found that USP Canaan frequently restricted the movement of general population inmates when its Special Housing Unit (SHU)—which houses inmates who need to be separated from the rest of the population for discipline or protection—was full. Delays in the discipline process due to staffing constraints contributed to the SHU capacity challenge. When inmates who would normally be assigned to the at-capacity SHU had to remain in general population housing units, USP Canaan significantly limited inmate movement in those units to maintain security. On about two-thirds of days in a 4-month period we examined, inmates housed in regular, non-SHU housing units were confined to their cells for all or most of the day. These frequent restrictions disrupted institution-wide functions and activities of general population inmates.

Additionally, we identified deficiencies with inmate healthcare, including the absence of an on-site physician; delays in treatment from outside providers for serious medical conditions; and the improper storage of sharp dental tools and other hazardous items, such as chloroform, in unlocked locations accessible to inmates. We also observed USP Canaan employees using inappropriate and demeaning language toward inmates and fellow employees and displaying imagery associated with designated criminal groups, white supremacy, and antisemitism. Lastly, we identified issues with employee searches, as well as contraband, including widespread sports gambling paraphernalia openly present in housing units. In this report, we make nine recommendations to the BOP to ensure effective operations at USP Canaan and safe conditions of confinement for the inmates housed there.

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<sup>1</sup> The lapse in appropriations that began on October 1, 2025, caused the completion and release of this inspection report to be delayed.

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# Introduction

This report details the results of the U.S. Department of Justice (DOJ) Office of the Inspector General’s (OIG) unannounced inspection of a Federal Bureau of Prisons (BOP) institution, U.S. Penitentiary (USP) Canaan, located in Waymart, Pennsylvania. USP Canaan is a male institution located in the BOP’s Northeast Region and is composed of a high-security USP and a minimum-security prison camp (Camp).

The OIG conducted its inspection of USP Canaan between Monday, June 2, and Thursday, June 5, 2025. While on site, we made physical observations; interviewed employees and inmates; reviewed security camera footage; and collected records related to inmate medical and mental healthcare, inmate programs and education, institution staffing levels, and conditions of confinement. We also made follow-up requests for additional data, interviews, and documents from the institution, its Regional Office, and the BOP’s Central Office, which we used to further inform our inspection (see [Appendix 1](#) for more details on the methodology).

### Federal Prison Oversight Act

The Federal Prison Oversight Act was signed into law on July 25, 2024; it requires the OIG to conduct periodic inspections of BOP facilities and operations based on the OIG’s assessment of risk factors at BOP facilities.

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



USP Canaan Main Entrance











**Source:** BOP, September 2025

## USP Canaan

As of June 3, 2025, USP Canaan’s high-security USP housed 1,357 male inmates, about 88 percent of its capacity of 1,536. The USP has 12 general population housing units and 1 Special Housing Unit (SHU). General population housing units contain double-occupancy cells with bunk beds, a sink, and a toilet. Individual shower stalls are located in housing unit communal areas. Under normal operating conditions, inmate cells remain open and inmates can move within the housing unit throughout the day. When authorized and under supervision, inmates can also move throughout the institution to access an array of institutional resources. The SHU houses inmates at the USP who need to be separated from the general population, and it contains double-occupancy cells with bunk beds and a shower, sink, and toilet. Unlike general population inmates who eat communally in a cafeteria, SHU inmates eat in their cells and generally remain locked inside except when they are escorted to single-use recreation areas. As necessary, SHU inmates may also be escorted to the infirmary for medical appointments, to visitation areas, or to a law library.

The Camp has one housing building with an open-concept living space for its minimum-security inmate population. At the time of our inspection, the Camp housed 86 inmates—about 90 percent of its physical capacity of 96. Camp inmates are afforded much more freedom of movement than the high-security USP inmates; inmates at the Camp can access indoor and outdoor areas with minimal supervision.

At the time of our inspection, 94 percent (414 of 442) of the institution’s employee positions were filled, which was a higher percentage than at most other institutions we have inspected in recent years. Of note, the Correctional Services Department, which is responsible for providing round-the-clock supervision of inmates, was staffed at 93 percent. The Health Services Department, which provides medical care to inmates, was staffed at 84 percent but had some key vacancies. We discuss these vacancies and their effects in greater detail in the [Inspection Results](#).

USP Canaan: Institution Profile	
 <b>Location</b> Waymart, PA	 <b>Medical Care Level</b> 2 of 4
 <b>Mental Health Care Level</b> 2 of 4	 <b>Employees</b> Total Positions: 442 On Board: 414 <i>28 Vacancies</i>
USP	Camp
<b>Population</b>  Physical Capacity: 1,536 Actual Headcount: 1,357 <i>~88% Capacity</i>	<b>Population</b>  Physical Capacity: 96 Actual Headcount: 86 <i>~90% Capacity</i>
<b>Security Level</b>  High	<b>Security Level</b>  Minimum
<b>Housing Units</b>  12 General Population Units and 1 SHU	<b>Housing Units</b>  1 Building with Open Concept Space
<b>Notes:</b> Employee totals are as of June 1, 2025. Inmate population totals are as of June 3, 2025.	
<b>Source:</b> USP Canaan documentation	

## Inspection Results

### Use of Restraints on Inmates

BOP policy authorizes employees to use force to gain control of an inmate, to protect inmates and employees, to prevent serious property damage, or to ensure institution security. The policy further authorizes employees to apply physical restraints to gain control of an inmate who appears to be dangerous because the inmate has assaulted another individual, destroyed BOP property, attempted suicide, inflicted injury upon self, or has become violent or displayed signs of imminent violence. Physical restraints include ambulatory restraints placed on an inmate's wrists, which allow the inmate to eat and drink without employee intervention, or more-restrictive, four-point restraints using four points of contact—both wrists and both ankles—to confine an inmate to a bed (see examples of BOP restraints below). The BOP's Use of Force Policy also requires employees to employ the least restrictive restraint method needed to control the inmate.<sup>2</sup> However, at USP Canaan, we identified unsafe application of four-point restraints that has contributed to serious inmate injury.



<sup>2</sup> See [Appendix 3](#) (Use of Force, Application of Restraints, and Firearms).

Multiple USP Canaan employees told us that they had seen four-point restraints applied too tightly, which they believed caused the hands of restrained inmates to swell and become discolored. A USP Canaan department head told us that they had seen an inmate's hands turn "purple," with marks on the inmate's wrists. Another employee told us that inmates are held in such tight restraints that "their hands will turn blue." A nonclinical supervisor in the Health Services Department told us that Correctional Officers often dismiss the health concerns expressed by nurses and paramedics who perform welfare checks on restrained inmates. The supervisor attributed this to USP Canaan having no medical doctor on site whose authority would lend credibility to the medical assessments of other clinical personnel.

During our inspection, we directly observed USP Canaan employees applying four-point restraints in a manner that risked physical injury to an inmate. Specifically, while on site, an OIG-contracted physician with significant experience in correctional healthcare observed that the restraints on an inmate in four-point restraints were so tight—due to the restraint chain pulling the wrist cuffs at a downward angle—that the cuffs exerted continuous pressure on the inmate's wrists and created an unnecessary strain on the inmate's arms and shoulders. The inmate told the OIG-contracted physician that there was a loss of feeling in one of his hands; he also arched his back and straightened his wrists in what appeared to be an attempt to lessen the pain. Out of concern for the inmate's safety, the OIG-contracted physician advised USP Canaan Correctional Officers that the amount of force applied on the inmate's wrists could be too tight and suggested that the restraints be slightly loosened to alleviate the pressure and reduce the risk of injury but still allow the inmate to be securely restrained. A Correctional Officer adjusted the chain securing the restraints to the four point anchors based on the OIG-contracted physician's suggestion, and the inmate verbalized immediate pain relief and was able to lie flat.

Due to USP Canaan employees' concerning comments and the OIG-contracted physician's observation, we reviewed available records of the 66 instances in which the BOP had used physical restraints on inmates at USP Canaan in the year preceding our inspection (July 2024 through June 2025). During that review, we found notable examples of inmate injury in conjunction with placement in restraints. Of most significant concern, one inmate, while in a combination of four-point and ambulatory restraints for a total of 106 hours over several days in May and June 2025, developed significant wounds on his wrists and ankles, as well as rhabdomyolysis, a potentially fatal medical condition in which damaged muscle tissue breaks down and releases harmful substances into the bloodstream. While the inmate recovered from the acute effects of rhabdomyolysis following a 9-day hospital stay, medical records noted that the inmate continued to experience significant nerve damage in one arm. In the months following the prolonged placement in restraints, the inmate had several consultations with outside medical specialists, who noted that the inmate had severely limited use of his arm and that the muscle was atrophying. About 6 months later, an outside neurologist noted that any recovery could take several years but that the inmate's arm was showing signs of improvement.

The BOP's Use of Force policy requires all incidents involving the use of force and the application of restraints to be carefully monitored and documented. The policy requires that inmates in four-point restraints be checked every 15 minutes by an employee and every 2 hours by a Lieutenant. Health Services employees are required to check inmates in four-point restraints twice every 8 hours and document in a Health Services Restraint Review Form information such as the inmate's circulation, vital signs, medication, injuries, hydration, intake and output, and any other significant findings that would show the deterioration of the inmate's health. In addition, Psychology Services personnel must check an inmate in four-point restraints at least once during every 24 hours that the inmate is restrained and complete a Psychology

Services Review Form. If an inmate engages in self-directed violence while in restraints, BOP policy requires a psychologist to evaluate the risk of suicide and, if warranted, complete a formal Suicide Risk Assessment in accordance with BOP's Suicide Prevention Program policy.

Based on our review of the 66 instances of physical restraint use in the year preceding our inspection, we found that USP Canaan generally could produce records showing that it had conducted required checks of restrained inmates and complied with requirements to document that these checks occurred. However, the institution did not consistently complete required fields in these records and, in a few notable instances, failed to adequately document crucial information about the progression of an inmate's injuries and food or water consumption during required checks. For example, we found that for the inmate who ultimately developed rhabdomyolysis, as described above, the required Health Services Restraint Review Form documented only that the inmate was becoming dehydrated but did not identify progression of the inmate's injuries. Below, we describe two other instances in which we found that documentation was lacking:

- An inmate restrained for 55 hours in a combination of ambulatory and four-point restraints experienced two medical emergencies while in restraints, as noted by the 15-minute checks from Correctional Officers. However, the Health Services Restraint Review Forms did not document or provide any additional details on the inmate's condition after the medical emergencies. The inmate also had no documented water consumption for over 47 hours. This inmate was sent to the hospital due to severe behavioral dysregulation at the end of his restraint incident. Weeks later, the inmate was sent to the hospital again, this time for possible restraint infection wounds on his wrists and ankles.
- Another inmate in restraints was documented as having swollen and discolored hands on a Psychology Services Suicide Risk Assessment Form. However, when we requested additional restraint documentation, such as the 15-minute checks and the Health Services Restraint Review Forms, the institution told us that it did not have any records related to this restraint incident.

While we acknowledge that USP Canaan employees may have communicated verbally during shift changes or through other informal interactions, the lack of documented information—such as inmate food consumption or progression of inmate injuries—in instances like those described above limits accountability and prevents verification that such communication had occurred. In response to a draft of this report, the BOP stated that food and water are typically offered by the Lieutenant during the 2-hour restraint checks and that records of the 15-minute checks will annotate the inmate's consumption of food or water. Nevertheless, in our review of the 66 instances of physical restraints use at USP Canaan, we found that employees did not consistently document inmate food or water consumption during the 15-minute restraint checks.

### Relevant Prior OIG Work and Related Recommendations: Inmate Restraints

Our findings at USP Canaan are consistent with concerns about restraints raised in two other recently released OIG products. In June 2025, the OIG issued a Management Advisory Memorandum advising the BOP of concerns involving use of four-point restraints on inmates for extended periods of time and an audit report that focused on the BOP's oversight of its use of restraints, both ambulatory and four-point, during use of force incidents. In these products, the OIG identified needed improvements in areas including guidelines for medical checks, quality and completeness of required documentation, and regional oversight. The OIG also found that BOP policy did not contain guidelines on how to address inmates pulling on or manipulating restraints, which can lead to or exacerbate restraint-related injuries; whether such behavior is sufficient to justify continued use of restraints; or when resulting injuries warrant removal from restraints or increased medical attention.

As a result of its findings in these two products, the OIG collectively made 16 recommendations to the BOP, including one that it reassess its policies, procedures, and training to identify ways to prevent prolonged placement in restraints, especially four-point restraints, that may result in serious injury. While the BOP has taken some action to address these recommendations, including drafting new policies and evaluating possible changes to other policies and training, all 16 remain open as of the date of this report on USP Canaan.

See [Appendix 2](#), Items IX and X, for more information about these reports.

We note that the BOP has begun taking actions (see above) that are responsive to the OIG's existing enterprise-wide recommendations regarding inmate restraints. However, the significance of the issues that we identified with the use of restraints specifically at USP Canaan requires separate and institution-specific attention. Therefore, we recommend that the BOP:

1. Ensure that USP Canaan makes improvements in its processes involving the application of inmate restraints, through actions including: (a) retraining USP Canaan employees as soon as possible on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates, and (b) implementing enhanced supervisory review to monitor and ensure compliance with BOP restraint application policies and document requirements.
2. Assess USP Canaan's use of restraints, including: the frequency of their use, the method by which they have been applied, and the duration of their use. Such an assessment should be performed by a medical doctor and other correctional experts not assigned to USP Canaan. The BOP should use the results of this assessment to inform the training and supervision provided to USP Canaan employees and determine whether any other operational changes are necessary.

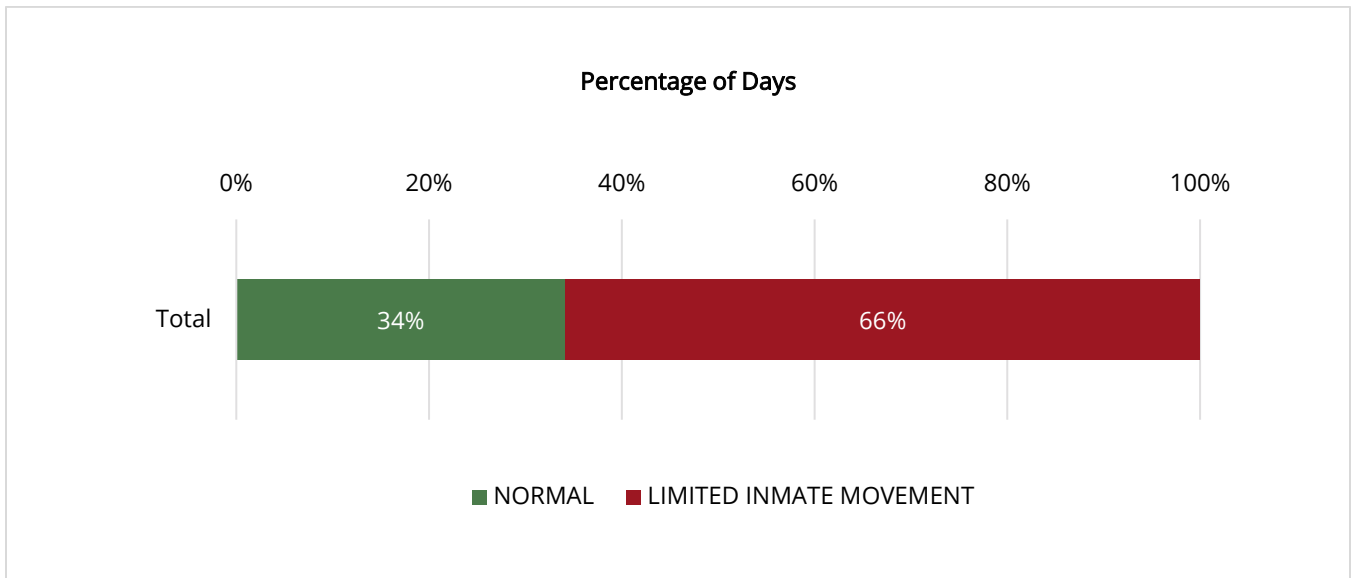
### Limitations on Inmate Movement

When USP Canaan is operating normally, inmates in general population can move around their housing unit and, under employee supervision, move throughout the institution to eat in the dining hall, work a prison job, attend a reentry program, go to the infirmary to receive medication or address a health issue, and receive visitors. We found, however, that between February and May 2025, USP Canaan management limited inmate movement in general population housing units on 79 of 120 days, meaning that, on about two-thirds of days in this 4-month time period, some or all inmates housed in general population housing units were confined to their cells for all or most of the day. See Figure 1 below for a visual breakdown of USP Canaan's operating status during this period. In addition to the obvious effects that prolonged confinement

to cells can have on an inmate’s emotional and mental well-being, it also limits the degree to which inmates can access institution resources.

Figure 1

USP Canaan Operating Status, February–May 2025



Source: OIG analysis of USP Canaan’s emails and memoranda sent to institution employees and the Regional Office regarding institution status

### Modified Operations and Lockdowns





At USP Canaan, Executive Leadership may need to limit inmate movement in the event of an institutional disruption, such as a medical emergency or inmate fight. The extent of the limitations varies depending on the circumstances at the institution.

- **Lockdown:** In the event of a serious disruption that affects the entire institution, the institution goes on *lockdown* status. When the institution is on lockdown status, all inmates are confined to their cells, except for three weekly opportunities to access communal showers.
- **Modified Operations:** During other situations in which Executive Leadership determines that inmate movement must be limited, but a full institution lockdown is not warranted (e.g., the institution is transitioning from lockdown status to normal operating status or an isolated inmate fight affects only one housing unit), the institution goes on *modified operations* status. Depending on the severity of the situation, these modified operations may be more or less restrictive. Under more restrictive modified operations, inmates in affected housing units are more strictly limited to their cells, similar to lockdown status. Under less restrictive modified operations, inmates in affected housing units are permitted to leave their cells for 1 to 3 hours per day to access communal resources, such as telephones, computers, and showers in their housing unit.

Table 1 below provides additional details about the conditions of confinement and access to resources for USP Canaan inmates depending on whether the institution is in a lockdown or modified operations status.

**Table 1**

**USP Canaan Operating Statuses and Conditions of Confinement for Inmates**

Status	Housing Units Affected	Inmates May:					
		Leave Cells	Eat Meals in Dining Hall	Pick up Medication at Pharmacy	Attend Routine Medical Appointments	Attend Programs	Access Email and Telephones
 Normal	All	Yes	Yes	Yes	Yes	Yes	Yes
 Modified Operations (Less Restrictive)	All or some	Yes, 1-3 hours daily	No, distributed in units	Yes	Yes*	Yes*	Yes
 Modified Operations (More Restrictive)	Some	No, except thrice a week to shower	No, distributed in units	No, distributed in units	No	No	No
 Lockdown	All	No, except thrice a week to shower	No, distributed in units	No, distributed in units	No	No	No

**Note:** "Yes\*" indicates that, while inmates are in theory able to attend programs and routine medical appointments, access in practice may be limited due to difficulty in arranging for them to be released from their cells and escorted in and out of units.

**Sources:** USP Canaan employee testimony and OIG analysis of USP Canaan internal communications

We found that USP Canaan goes on lockdown or modified operations status consistent with the situations, such as inmate fights, described above. We also found, however, that the institution was frequently placed in modified operations status in response to space limitations. Specifically, USP Canaan's Special Housing Unit (SHU), which houses inmates who need to be separated from the rest of the population for discipline or protection, is often at capacity; when this occurs, inmates who would normally be assigned to the SHU must remain locked in a cell in a general population housing unit until SHU bedspace becomes available. In the

text box below, we explain the reasons why USP Canaan's SHU, which can house up to 238 of the more than 1,500 inmates at USP Canaan, is often at capacity.

### Reasons Why USP Canaan's SHU Is Often at Capacity

According to USP Canaan officials, inmate misconduct is an inherent challenge in a high-security correctional environment. Among other reasons, inmates who are suspected of having committed a serious infraction are housed in the SHU pending an investigation into their misconduct and the outcome of a disciplinary hearing. If a Disciplinary Hearing Officer (DHO) determines the inmate to have committed misconduct, the DHO may impose a sanction, which can include an additional period of confinement in the SHU. USP Canaan officials told us that the institution's single DHO cannot manage the volume of misconduct cases at USP Canaan in a timely manner, which creates delays that result in inmates awaiting a hearing remaining in the SHU longer than they would have if their hearing had been more timely.

At the time of our inspection, USP Canaan officials told us that the institution needed an additional DHO and clerical support personnel to address the caseload and that they had previously made requests for a second DHO position but were not approved for it. We note that three of the BOP's four other standalone USPs, which are of a similar size to USP Canaan and have comparable inmate populations, are authorized two DHO positions. As of April 2026, the BOP informed us that a second DHO position had been authorized for USP Canaan and was awaiting selection by the Regional Director.

Because of the activity and violence inherent to a high-security correctional environment, USP Canaan's SHU also houses many inmates who either have been determined by the BOP to require, or personally believe they require, protective custody from other inmates. At the time of our inspection, 43 percent of inmates in the SHU were there for protective custody.

**Sources:** USP Canaan employee testimony and OIG analysis of USP Canaan and BOP documents

According to USP Canaan's Warden, along with the Captain (who supervises all Correctional Officers), when an overflow SHU inmate is locked in a general population unit cell, all inmate movement in that housing unit must be limited. One reason described to us for such restrictive movement is to mitigate risk to a protective custody inmate housed in a general population unit because the SHU is at capacity. Although the institution defines this scenario as a type of modified operations rather than a lockdown, the enhanced restrictions on the unit are similar to those that would be in place under a formal lockdown status (see Figure 1 above). When an inmate who is awaiting SHU placement for a reason other than protective custody (e.g., the inmate is suspected of committing a prohibited act) is assigned to a general population unit, the institution will also place that unit in modified operations status for safety and security reasons. However, in these situations, the modified operations applied will be less restrictive.



Overflow SHU Cells in General Population Housing Units

Source: OIG, June 2025

Prior to our June 2025 inspection, USP Canaan Executive Leadership had requested and received approval from BOP Central Office officials to convert a general population housing unit into an additional SHU unit. This arrangement, which lasted from August 2024 through January 2025, expanded USP Canaan's SHU capacity. This, in turn, allowed general population inmates to more frequently move about the institution, consistent with their housing assignment to general population, and, according to the Warden, allowed the institution to manage the rest of its general population units normally. Despite the persistently high volume of SHU inmates at USP Canaan, in early 2025, Central Office's Correctional Programs Division informed USP Canaan Executive Leadership that it could no longer operate the additional SHU unit. As a result, the unit transitioned back to serving as a general population unit in February 2025. In the months following this decision, the lack of additional SHU bedspace resulting from this decision once again caused employees to house overflow SHU inmates in general population housing units, potentially resulting in more periods of limited inmate movement in housing units with overflow SHU inmates.

When we asked the BOP's Assistant Director for the Correctional Programs Division why USP Canaan was no longer allowed to use a general population housing unit as an additional SHU unit, he explained that USP Canaan had been given time to address the issue and that the use of a general population unit as an additional SHU unit should not be a long-term solution. He also told us that the capacity of USP Canaan's existing SHU is relatively larger than SHUs in other institutions and that he did not believe that the institution had a significant number of inmates requesting protective custody.

Given the scope of this inspection, we did not fully assess the degree to which USP Canaan Executive Leadership and Central Office Correctional Programs Division officials substantively discussed their differing perspectives on the need for additional SHU space at the institution. Further, we did not fully assess whether USP Canaan was using appropriate inmate management techniques that could minimize its need to house inmates in the SHU. Nevertheless, our inspection revealed that space limitations have negatively affected the conditions of confinement for many general population inmates who have done nothing to justify restrictions on their movement and the accompanying effects on their access to activities, programs, and services. Further, USP Canaan Executive Leadership and BOP Central Office appear to be at an impasse in their efforts to address this issue. Therefore, we recommend that the BOP:

3. Ensure that USP Canaan Executive Leadership and relevant Central Office Correctional Programs Division officials discuss the scope of USP Canaan’s Special Housing Unit capacity issues and identify inmate management and space utilization techniques that can mitigate USP Canaan’s need to restrict inmate movement.

### Limitations on Movement Negatively Affect Inmate Access to Reentry Programs and Healthcare

Consistent with The First Step Act of 2018 (FSA), USP Canaan offers reentry programs, including substance abuse treatment, education classes, and employment training, to help prepare inmates for their return to the community.<sup>3</sup> However, since instruction often occurs in classrooms or other communal spaces outside of housing units, it becomes difficult for inmates to participate in these programs when movement is limited at the institution during lockdowns or modified operations. Under more restrictive modified operations, inmates cannot leave their housing units at all, including to attend programs. Under less restrictive modified operations, inmates can be scheduled to attend programs outside of their housing unit, such as group therapy sessions led by the Psychology Services Department; however, USP Canaan employees told us that it is challenging to arrange for individual inmates to be released from their cells and escorted in and out of units to participate in programming under these circumstances.

We also found that limitations on inmate movement negatively affected inmate access to medical care, including their ability to receive medication at consistent times and to attend medical appointments as originally scheduled. Under normal operations, inmates can visit the institution’s pharmacy to collect medication; however, when inmate movement is limited, Health Services Department employees have to deliver medication to inmates in their

#### Success Spotlight: Program Offerings at USP Canaan

In addition to traditional drug treatment, psychology, and education programs, USP Canaan offers programs including exercise and hobby-craft classes, as well as a personal trainer certification program. Camp inmates may also participate in horticulture and dog training vocational instruction.



A Dog Involved in the Training Program at the Camp

Source: OIG, June 2025

<sup>3</sup> The First Step Act of 2018 (Pub. L. No. 115-391).

cells, which is a time-consuming process that can cause delays in distribution. Although under normal operations inmates access their medication between 6 and 8 a.m., we noted that employees were still distributing medication after 11 a.m. on two of the three days in which the institution was in a modified operations status during our inspection. This delay is troubling because certain medications, such as insulin, should be administered at the same time every day. Health Services Department leadership also generally expressed concerns about medication distribution delays and the related effects on the medication efficacy.

In addition, although USP Canaan employees will facilitate the treatment of inmates experiencing medical emergencies regardless of the institution's operating status, we found that inmates frequently missed medical appointments when inmate movement was limited at the institution. According to the BOP's Bureau Electronic Medical Records System (BEMR), over the 6 months between January and June 2025, limitations on inmate movement contributed to inmates missing 1,271 medical appointments (which accounts for 83 percent of the 1,529 total medical appointments that inmates missed during that timeframe). While determining the nature of the underlying medical issues to be addressed and whether all of these appointments were ultimately rescheduled was beyond the scope of this inspection, a high volume of missed appointments interferes with the BOP's ability to ensure prompt and appropriate medical care for the inmates in its custody. We discuss additional findings regarding the provision of healthcare to USP Canaan inmates in the next section of this report.

#### **Related Prior and Ongoing Work: Limitations on Inmate Movement**

In our May 2024 inspection report for Federal Correctional Institution (FCI) Sheridan, we found that, due to Correctional Officer shortages, the institution could not always fill all Correctional Officer posts. To decrease the risks associated with limited supervision of inmates, institution management had to habitually confine inmates to their cells during daytime hours. This decision in turn prevented inmates from participating in institution programming and recreational activities.

Given the pervasiveness of inmate movement limitations we have observed at BOP institutions, we initiated an evaluation of the BOP's enterprise-wide use of lockdowns and modified operations, in order to assess their causes and their effects. Based on our findings, we will make recommendations to address issues related to the BOP's use of these inmate management techniques in the forthcoming report.

**Source:** See [Appendix 2](#), Item IV.

## **Inmate Healthcare**

We identified several additional concerns with the provision of inmate healthcare at USP Canaan. These included the lack of an on-site full-time physician since November 2022; problems with the timeliness of healthcare and laboratory testing; inconsistent and unsafe medication administration practices; and expired medical supplies. We also observed unsafe practices in Dental Services, specifically sharp dental surgical tools and chloroform stored in unlocked cabinets near inmates, and found that all of USP Canaan's medical transport vehicles were inoperable at the time of our inspection. These issues risk impeding the institution's ability to provide adequate and timely healthcare to inmates.

### **Lack of an On-site Physician**

Although at the time of our inspection USP Canaan's Health Services Department was staffed at 84 percent overall, which is higher than Health Services staffing levels at other institutions we have inspected, the

institution had been without an on-site full-time physician since November 2022. The Health Services staffing complement included three nurses and four mid-level providers (e.g., nurse practitioners or physician assistants) on board at the time of our inspection, but both of the on-site physician positions were vacant. Accordingly, no on-site physician was available to serve as the institution's Clinical Director, a position responsible for overseeing medical care provided at USP Canaan. As described below, the clinical decision-making, continuity of care, and timely clinical assessment for complex cases were constrained without a Clinical Director or a dedicated full-time physician on site.

Several Health Services Department employees told us that the lack of an on-site physician contributed to delays in conducting required examinations for inmates arriving at the institution. According to BOP policy, inmates with chronic conditions or mental health concerns should be seen by a mid-level provider or physician within 14 days of arrival. Delays in these appointments can cause medical conditions to go undiagnosed or unaddressed. Based on documentation provided by USP Canaan, 61 of these appointments were past the BOP's required timeframe for completion, as of January 2025. We found that delays with these medical intake appointments persisted and that USP Canaan was further backlogged by January 2026, when 94 of these appointments were overdue.

In addition to delayed care caused by a lack of on-site physicians, Health Services Department leadership told us that the absence of an on-site physician, particularly one serving as Clinical Director, makes it difficult to ensure that mid-level providers and other healthcare employees are exercising sound clinical judgment and are operating within their authorized scope of practice. In fact, an administrative employee in the Health Services Department told us that they had been instructed, during a telehealth visit, to measure and record inmate vital signs despite not being credentialed to do so.

In an effort to help cover the gap created by not having any dedicated, full-time physicians on site, at the time of our inspection the BOP's Northeast Regional Medical Director was remotely serving as USP Canaan's acting Clinical Director. However, because she was filling this role in addition to her regular regional duties and acting as Clinical Director at a different BOP institution, she could not focus her full attention on USP Canaan. In an environment without on-site physicians, the option for telehealth encounters with other physicians and providers has helped address some of the medical needs of USP Canaan inmates; however, telehealth physicians can see only a limited number of patients and their availability does not address full inmate healthcare needs, according to Health Services Department leadership at the institution.

### **Delays in Laboratory Testing**

USP Canaan had not had a full-time phlebotomist (a medical professional responsible for drawing blood samples and preparing the samples for testing) on staff for over 4 years—from 2020 until the phlebotomist position was filled in March 2025. This prolonged vacancy contributed to a backlog of 177 laboratory orders that were over 30 days past due as of June 2025. Prior OIG inspections have found that a backlog of laboratory tests can create difficulties for Health Services Department employees in appropriately monitoring inmates with chronic conditions, such as diabetes, or diagnosing new illnesses. To assess the effect of USP Canaan's laboratory backlog, we reviewed medical records for individuals with diabetes who require monitoring and management of blood sugar levels and completion of A1C tests, which are blood tests that measure the average amount of sugar in one's blood. Our review of records for 48 diabetic inmates found that only 65 percent (31) had A1C blood tests completed in the timeframes specified by the BOP's Management of Diabetes Clinical Guidance. Additionally, we found that an inmate who had arrived in

February 2025 was not identified as HIV positive until June 2025. Although the BOP provided evidence that the institution subsequently took appropriate steps—including ordering additional tests, providing counseling from clinical providers, and issuing a treatment plan—the several-month delay in virus identification created unnecessary risks for the individual, as well as other inmates and employees.

## Delays in the Outside Medical Appointment Process

As previous OIG oversight work, including our inspection at Federal Detention Center Sea Tac, has found, BOP inmates often experience delays receiving medical care when their needs require the involvement of outside medical providers. We found that this was also the case for inmates at USP Canaan, where some inmates experienced significant wait times to see an outside medical provider. Delays in medical care can place inmates at risk of adverse long-term health outcomes.

When inmates require nonemergency medical treatment in specialties such as rheumatology, oncology, and cardiology, they must be referred and scheduled for appointments with outside medical providers. To help schedule and manage medical treatment for inmates outside USP Canaan, the institution has a contract with a comprehensive medical services company. Once a medical visit is scheduled by the comprehensive medical services company, USP Canaan employees escort the inmate to and from the appointment and supervise the inmate during the appointment.

According to inmate medical records that we reviewed, inmates at USP Canaan attended a total of 891 medical appointments with outside medical providers between June 2024 and June 2025. Of these completed appointments, 72 percent (639) occurred within 3 months of the referral but 28 percent (252) occurred more than 3 months after the referral.

We also found that referrals had been made for another 368 pending outside medical appointments that were yet to be scheduled as of July 31, 2025. Of these 368 referrals yet to be scheduled, 86 percent (316) had not been scheduled within 14 days of the referral, which is the timeframe established in the BOP's contract with its comprehensive medical services company. Further, for 28 percent of the 368 referrals (102), the target date by which the referring provider had determined it medically necessary for the appointment to occur had already passed. On average, these 102 referrals remained unscheduled for 93 days.

### Inmate Case Study: Delays in Receiving Outside Medical Care for a Kidney Mass

One case file we reviewed involved an inmate whose MRI scan revealed a potentially cancerous mass on his right kidney in August 2024, approximately 2 months prior to his transfer to USP Canaan. We found that, over a year after identification of this mass, it had not been assessed for cancer. According to the inmate's medical history, USP Canaan employees ordered an urgent urology consultation but it was never scheduled and the inmate went without being seen by a urologist for the duration of his imprisonment at USP Canaan (October 2024–August 2025). The inmate was transferred to a different institution and had still not been seen by a urologist as of early September 2025.

We notified the BOP of our concerns on September 11, 2025, as soon as we learned of this matter. The BOP ordered an urgent urology consultation, and in November 2025 the inmate saw a urologist and began a course of follow-up care.

In response to OIG inquiries about this case, the BOP provided the OIG with a timeline of events that identified several failures across several different BOP institutions that led to the delay of care for this inmate. In addition, the BOP determined that the failure to place a medical hold on the inmate, lack of timely Clinical Director review of the initial urgent consultation order, and failure to order consultations with the appropriate urgency and target dates led to the delay in care.

**Source:** Documentation provided by the BOP

In the course of this analysis, we identified several instances of inmates experiencing delays that could negatively affect their long-term health, for example:

- an inmate with a potentially cancerous kidney mass who had not seen a medical provider to assess the mass for cancer in over a year (see the textbox above);
- an inmate referred for an urgent cardiac MRI in April 2025, with that referral still pending over 3 months later; and
- an inmate who fractured a bone in his hand in July 2025, whose referral to a hand specialist was still pending almost 2 months later.

Several USP Canaan employees told us that outside medical appointment delays were attributable to multiple factors, including contractor delays in scheduling appointments with providers; limitations on the number of medical escort trips that the institution could facilitate each day given its staff complement; and outside providers' apprehension to treat inmates due to a concern that their presence, along with that of armed BOP escorts, could intimidate other patients in the office.

#### **Relevant Prior OIG Work and Related Recommendations: Delayed Outside Medical Appointments**

Our March 2022 audit report on the BOP's use of comprehensive medical services contracts to facilitate outside medical care for inmates noted that outside medical appointments can be rescheduled for unanticipated reasons, including rescheduling initiated by the medical provider. This audit found that the BOP does not adequately track canceled or rescheduled inmate appointments, rendering it impossible to fully determine the effect these cancellations and rescheduling had on the timeliness of medical care provided to inmates. The OIG recommended that the BOP implement a reliable, consistent process throughout all BOP facilities to monitor and analyze wait times for inmates' external appointments and the causes for canceled or rescheduled appointments to ensure that inmates receive timely medical care. As of the publication of this report on USP Canaan, this recommendation remained open.

Our January 2026 review of the BOP's conditions of confinement and medical treatment of an inmate who died of metastatic cancer shortly after release identified serious deficiencies with the BOP's ability to schedule timely outside medical appointments. The review found that the inmate did not undergo an urgent colonoscopy until over 6 months after reporting blood in his stool, and 73 days after a CT scan showed that he likely had stage IV colon cancer and needed a colonoscopy. The OIG recommended that the BOP develop policies or formal procedures regarding timelines for scheduling medical appointments, based on the urgency with which an inmate's medical condition needs to be treated, and documenting and tracking the scheduling of such appointments. As of the publication of this report on USP Canaan, this recommendation also remained open.

See [Appendix 2](#), Items XX and XXII, for more information about these reports.

#### **Lack of Documentation for Sick Call Requests**

We found that USP Canaan did not always adequately document when inmates requested medical care and, as a result, we could not consistently determine whether inmates who requested care were seen within the timeframes required by BOP policy. Inmates generally may request medical care by submitting a paper or electronic form, known as a "sick call request." BOP policy requires that inmates who request sick call be seen by a medical provider ordinarily within 2 weeks for routine complaints, and it dictates that all sick call

requests be logged and tracked in BEMR. However, when we reviewed records for a sample of 42 USP Canaan clinical encounters initiated through sick call, we found that nearly half (19) of the requests were missing the inmate request date. As a result, we were unable to determine when those 19 sick call requests were submitted and the extent of compliance with the BOP's requirements for timeliness. Anecdotally, several inmates we spoke with told us that they had experienced significant delays in receiving medical treatment after submitting sick call requests. USP Canaan's incomplete documentation hinders its ability to adequately monitor the timeliness of responses to sick call requests and to identify instances in which inmates wait beyond BOP timeframes before receiving requested medical attention. Without reliable and complete records of the dates when inmates have made such requests, USP Canaan cannot demonstrate that all inmates in its custody received medical attention consistent with the BOP's timeliness guidelines, which could increase the risk that medical and mental health conditions worsen while inmates wait for care.

### Unsafe Practices in Dental Services

To promote the security of its institutions, BOP policy requires that potentially dangerous tools, such as surgical equipment and instruments, as well as poisonous and flammable liquids, be kept in a locked cabinet or secure storage area. However, we observed violations of these requirements at USP Canaan, where we found unlocked cabinets and storage areas that could create opportunities for inmates to acquire hazardous materials and use them to perpetrate violence or participate in other illicit activities. Specifically, while inspecting USP Canaan's dental examination room, we observed that the door to an adjacent and unattended storage room was unlocked; inside that storage room, we found an open tool cabinet with a lock that was not locked, which contained multiple sharp dental tools, including excavators, forceps, and other surgical instruments. At the time of our observation, in the dental examination room were two USP Canaan dental employees and a contractor performing the role of acting Dental Assistant attending to two inmates in examination chairs. A third inmate was sitting in an examination chair in the dental examination room unattended by any staff. When we raised concern over the accessibility of dangerous items in the storage room and tool cabinet, which were both unlocked and in close proximity to inmates, USP Canaan dental employees told us that the storage room had been left unlocked because the contractor serving as acting Dental Assistant needed to regularly retrieve tools but was not authorized to possess a key to the storage room.



*Left*, Unlocked Dental Tool Storage Cabinet Observed in the Unlocked Dental Storage Room, *Right*, Sharp Dental Tools inside the Unlocked Dental Tool Cabinet

Source: OIG, June 2025 (Brand Name Obscured)

When we returned to the dental examination room the following day, the door to the storage room was locked. However, after the storage room door was unlocked and opened for us, we identified additional safety and security concerns with storage practices inside this room. Specifically, we found that a nearly full bottle of chloroform, flammable wipes, and other materials were stored in an unlocked storage container and an unlocked flammable storage container. While chloroform can be used in dentistry to clean cement from teeth or equipment, it has toxic and carcinogenic potential and there are safer alternatives widely available. Further, the unsecured storage of chloroform in a correctional setting creates the risk of inmates misusing the substance for self-harm or to incapacitate others.

After we brought our concerns to the attention of BOP employees, additional locks were installed on the storage cabinets for corrosive and flammable items. Notwithstanding these measures, we believe that continued attention to the appropriate storage of dangerous medical equipment and supplies is necessary to help prevent security lapses in which inmates have the ability to acquire hazardous materials and use them to perpetrate violence or participate in other illicit activities. Therefore, we recommend that the BOP:

4. Implement controls to ensure that USP Canaan employees consistently follow BOP policy on securing potentially dangerous medical equipment and supplies.



*Left, Unlocked Corrosives and Flammable Storage Containers in the Dental Storage Room (Doors Opened by the OIG), Right, a Bottle of Chloroform Found in an Unlocked Storage Container in the Dental Storage Room*

**Source:** OIG, June 2025 (Brand Name Obscured)

## Inconsistent and Unsafe Medication Administration Practices

At USP Canaan, we identified several inconsistent and unsafe practices during medication administration (a process known as “pill line”) that violated the BOP’s Pharmacy Services policy and could result in medication administration errors, inmates diverting medication, or reduced medication efficacy. According to BOP policy, medications must be stored in appropriate packaging and clearly labeled until administration and the administration of medication must be documented promptly after completion. BOP policy also requires inmates to open their mouths after medication administration to show that the medication has been swallowed, and inmates must present two forms of identification before being administered any medication during pill line. Table 2 below shows examples of Health Services Department employees’ noncompliance, each of which carries associated risks.

Table 2

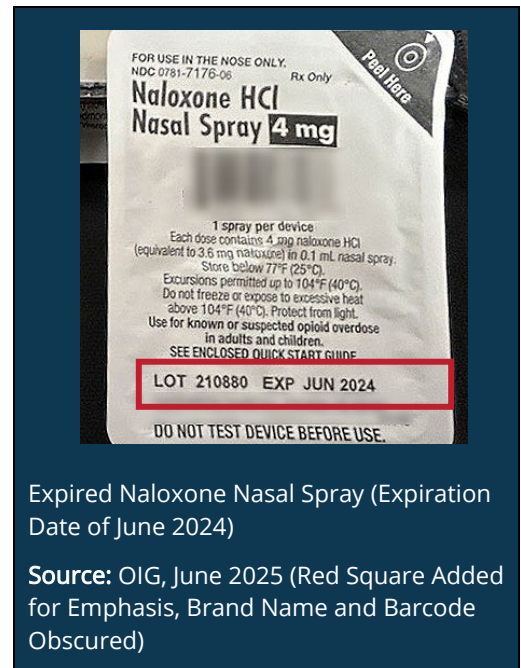
Unsafe Medication Administration Practices and Their Associated Risks

Unsafe Practices	Risks
Crushing medications ahead of administration time	Misidentification of medication during administration
Pouring crushed medication directly into an inmate patient’s hands	Reduced efficacy of medication if absorbed through the skin or inmate diversion of medication
Failing to document medication administration times and blood sugar levels (for diabetic inmates)	Increased risk of medication errors or inadequate management of the inmates’ diabetes
Allowing inmates to receive a lower dose of insulin than ordered, if requested by an inmate	Inadequate management of the inmate’s diabetes
Inconsistent adherence to the requirement that administrators ask inmates to open their mouths after medication administration	Inmate diversion of medications
Inconsistent adherence to the requirement that each inmate present two forms of identification before receiving medication	Administration of medication to an inmate for whom it was not prescribed

Source: OIG observations and analysis

Expired Naloxone

The BOP requires each of its institutions to keep naloxone—a lifesaving opioid overdose reversal drug—available 24 hours a day to ensure that, in the event of a suspected opioid overdose, it will be available for all employees to administer in a timely manner. This national policy, as well as local Health Services Department procedures at USP Canaan, also requires naloxone (sometimes called Narcan, a brand name) to be maintained within expiration dates. However, during our inspection of the Health Services Department at USP Canaan, we found that some of the naloxone nasal spray supply in the Health Services clinic at the minimum-security satellite Camp had expired. Despite the local Health Services Department’s procedures requiring pharmacy employees to inspect naloxone kits quarterly to identify expired supplies, we found that one naloxone nasal spray dose had expired in June 2024, approximately 1 year before our site visit. Once we notified Health Services leadership of the expired naloxone, it was promptly removed. However, we are concerned that this example indicates weaknesses in USP Canaan’s process to identify and replace expired medical supplies, which could result in delays to lifesaving care for inmates and employees in the event of an opioid overdose or other medical emergency.



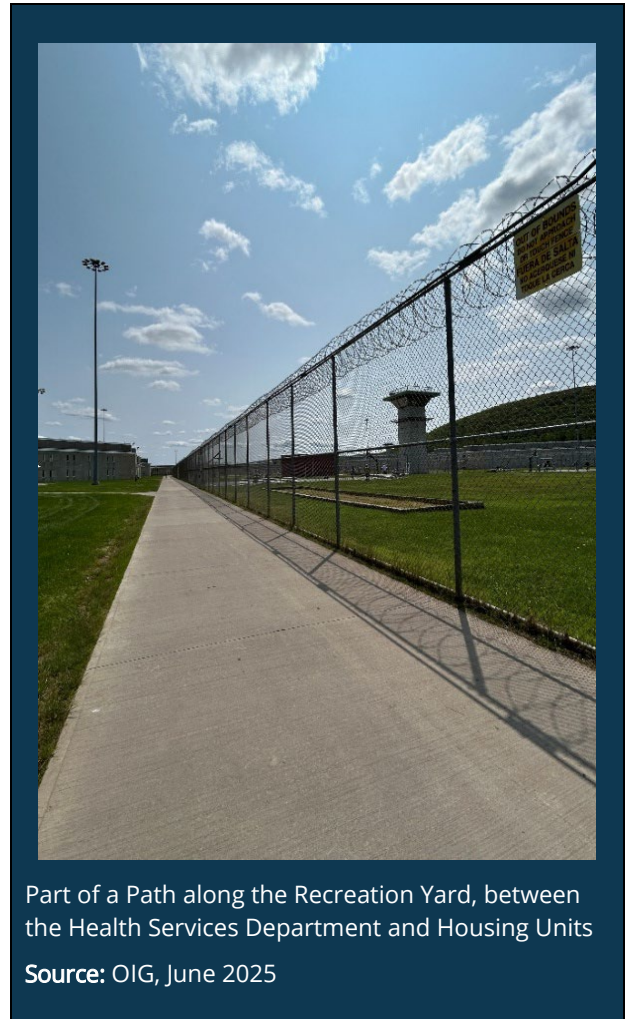
Expired Naloxone Nasal Spray (Expiration Date of June 2024)

Source: OIG, June 2025 (Red Square Added for Emphasis, Brand Name and Barcode Obscured)

## Nonfunctioning Medical Transport Vehicles

USP Canaan is a physically large institution, with about one-quarter mile between the Health Services Department and the most-distant housing unit, making a round trip on foot about one-half mile long. USP Canaan has four medical transport vehicles meant to aid in the rapid transport of sick or injured inmates or employees. However, at the time of our inspection none of these four medical transport vehicles was functional. The Associate Warden told us that the institution was aware of the nonfunctioning transport vehicles and was awaiting funding to replace them.

Health Services Department leadership told us that, in the absence of functional medical transport vehicles, BOP employees responding to an emergency must transport any sick or injured inmates on an emergency stretcher. Health Services employees expressed concern that, in the event of such an emergency, the need to carry inmates long distances would place additional stress and fatigue on the responding employees. Although Health Services leadership told us that they do not believe that the lack of functioning medical transport vehicles was resulting in any delays in care, we note that there can be considerable difference in timing between manual transportation and motorized transportation, and, in an emergency, timing is often critical. Further, medical emergencies at USP Canaan are not uncommon. For example, over the course of the 4 days we were at the institution, we observed two separate medical emergencies: one inmate seizure and one inmate with a fractured clavicle and stab wounds as a result of an altercation.





During our inspection, we voiced concerns to BOP officials about the non-functioning medical transport vehicles and the risk of delayed care that we believe this created for anyone experiencing a medical emergency. After our site visit, we followed up on the status of this issue. The BOP provided documentation showing that three of the institution’s medical transport vehicles had received the necessary repairs as of September 2025, and the Health Services Administrator confirmed that the vehicles were operational.

### Safety and Security

We identified several deficiencies affecting the safety and security of operations at USP Canaan. Chiefly, we found gaps in the institution’s practices for placement and monitoring of inmates that create risks for the inmate population, including self-harm and suicide. In particular, USP Canaan did not follow BOP requirements governing the decisions to initiate and continue placement of SHU inmates in single-cell confinement. Correctional Officers at USP Canaan also failed to complete frequent inmate monitoring rounds in general population housing units, including when the institution was in lockdown or modified operations status. In addition, we identified gaps in USP’s Canaan’s practices to search employees for potential contraband before they enter the institution.

## Gaps Found in Inmate Placement and Monitoring Practices Intended to Reduce Suicide Risks

BOP policy states that institutions should reduce single-celling in SHUs to the greatest extent possible. Single-celled inmates in the restrictive housing environment of a SHU have an increased opportunity to attempt suicide given the privacy they are afforded. However, we found that USP Canaan failed to adhere to BOP policy on single-cell procedures for its SHU. Additionally, we found that in general population housing units Correctional Officers failed to conduct rounds to verify inmate well-being for extended periods of time. This lack of frequent monitoring creates safety risks for all general population inmates, and these risks increase for general population inmates who also happen to be single-celled when the institution is in lockdown or modified operations status. This is because the conditions of confinement for these inmates can closely resemble the conditions for single-celled SHU inmates. Weaknesses in these areas have been a long-standing problem for the BOP and carry serious consequences. As discussed in our February 2024 OIG report on inmate deaths in custody, circumstances involving single-cell confinement, conditions of a restrictive housing setting, and insufficient inmate monitoring rounds were circumstances that often surrounded inmate suicides.<sup>4</sup>

Given the 19 suicide attempts at USP Canaan from January 2025 through May 2025—12 attempts by SHU inmates, 5 attempts by general population inmates, and 2 attempts by inmates on suicide watch—the gaps we identified in inmate placement and monitoring practices are particularly concerning. Further, as discussed in greater detail below, the BOP determined that failure to conduct rounds in a timely manner partially contributed to a USP Canaan inmate’s death by suicide in July 2025.

### Failure to Adhere to the BOP’s Single-Cell Procedures Policy for SHU Inmates

To minimize the likelihood of inmate suicide, the BOP’s SHU policy requires SHU inmates to have a cellmate unless there are unique circumstances that warrant single-cell placement. Further, March 2024 updates to the SHU policy prescribe two controls that institutions must implement to ensure that single-celling an inmate in the SHU is appropriate and to mitigate the risk of self-harm.

First, the policy requires documentation of the consultation and approval process that must occur contemporaneously with the initial decision to place an inmate in single-cell SHU confinement. If it appears necessary to single-cell an inmate in the SHU, the institution’s Captain and Chief Psychologist (or designee) must be contacted for their recommendations regarding the proposed placement. They must then receive the Warden’s final approval for the placement. It is then the responsibility of a Lieutenant (first-line Correctional Officer Supervisor) to prepare a Single-Cell Review form, which documents the recommendations and approvals, and collect signatures from the Captain, Chief Psychologist, and Warden. If the decision to single-cell an inmate occurs during regular working hours, the signatures must be collected immediately. If the decision occurs after hours or on a weekend, signatures must be collected no later than the next business day. During our inspection, we requested the Single-Cell Review forms for inmates who were single-celled on both the day of our request and 1 week prior: June 4 and May 28, 2025. The BOP did not produce those forms until June 30, 2025—after our site visit concluded—and further could not produce all forms for the 12 inmates who were single-celled as of June 4, 2025. Of the forms we received, we identified the following discrepancies, which raise concerns regarding the institution’s process to conduct required contemporaneous reviews for these placement decisions:

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<sup>4</sup> See [Appendix 2](#), Item XXVI.

- The Warden signed the forms but did not indicate the date and time of his signed approval on any of them. The date and time are necessary to confirm that the approval was documented contemporaneously with the inmate's placement alone in a cell.
- Recommendation signatures from the Captain and Chief Psychologist were all dated June 11, 2025, even though the inmates began their period of single-cell confinement in the SHU before June 2025.

The second control deriving from March 2024 updates to the BOP's SHU policy requires the attendees of a weekly multidisciplinary SHU meeting to review decisions to continue or discontinue an inmate's single-cell SHU confinement. Attendees typically include, among others, the Warden; the Captain; and heads of other departments, including the Chief Psychologist. During our inspection, we observed at USP Canaan one such meeting of the SHU multidisciplinary team. During the meeting we observed, an attendee read through the list of the more than 200 inmates housed in the SHU. There was no mention of inmates who were single-celled, and at no time during the meeting did participants discuss the continuation or discontinuation of single-confinement for SHU inmates.

When we discussed these issues with USP Canaan's Warden, he acknowledged that USP Canaan had not been complying with the new requirements from the March 2024 update to the BOP's SHU policy. Separately, we were also told that, as a matter of practice, the Chief Psychologist was not notified either in advance of or after an inmate was placed in SHU single-cell confinement and was not given the opportunity to provide a recommendation about the appropriateness of such placements. Following our inspection, in September 2025, we learned that some of the issues involving required notifications persisted. The report section below includes a recommendation to address concerns in this area.

### **Failure to Conduct Rounds**

For SHU housing units, BOP policy mandates that Correctional Officers conduct irregularly timed rounds twice within each hour. Based upon our review of surveillance camera footage of USP Canaan's SHU prior to our inspection, we found that Correctional Officers generally complied with this requirement in its dedicated SHU housing unit.

For general population housing units, requirements governing the frequency of rounds are typically established through institution-level post orders, and USP Canaan's post orders require its Correctional Officers to complete "frequent irregular rounds" while working a general population housing unit post. Although the post orders do not specify what "frequent irregular rounds" should consist of, we found, through a review of surveillance camera footage prior to our inspection, that Correctional Officers did not complete any rounds during a 24-hour period in five general population housing units with inmate movement limitations. Further, we found that, prior to our inspection, Correctional Officers did not complete any rounds in a sixth housing unit during a 48-hour period when there was no inmate movement. At the end of our on-site fieldwork on June 5, 2025, we informed USP Canaan Executive Leadership of Correctional Officer shortcomings in completing rounds in these general population housing units.

Failure to conduct rounds in general population housing units creates safety risks for all inmates, and these risks increase when inmate movement has been limited in the same or similar manner it would be in USP Canaan's SHU (where there is a more formal and frequent requirement for completion of monitoring rounds). Further, the risks of inmate death by suicide can become particularly acute for single-celled

inmates housed in general population housing units who meet criteria the BOP has determined place an inmate at high risk for suicide. Inmates who meet these criteria include those who are newly committed, seeking protective custody, or taking a medication for mental health reasons. If these inmates were to be housed in a SHU, the BOP would be required to closely assess the appropriateness of their single-cell placement in the manner described above and would also need to take additional steps to facilitate access to mental health treatment.

After our inspection, an inmate died at USP Canaan, and the circumstances surrounding his death exemplify how the outlined risks can materialize. In July 2025, a newly committed inmate who was single-celled in a general population housing unit died by suicide within 4 days of arriving to the institution. The BOP's suicide after-action report identified several factors that contributed to the inmate suicide, including deficiencies in conducting frequent, irregular rounds. Based on OIG analysis of camera footage, there was a 3-hour period from when the inmate was last observed alive to when employees found the inmate unresponsive. The inmate had also been identified by the BOP as having increased mental health needs and had been previously prescribed mental health medication, which BOP records identified was discontinued without clinical justification upon his arrival to USP Canaan. Although the inmate died in the evening, at a time when inmates are regularly confined to their cells, inmate movement had been limited in his housing unit in the days leading up to and including the day that he died.

Our separate ongoing evaluation of the BOP's use of lockdowns and modified operations will discuss at the enterprise level issues including the monitoring of inmates in general population housing units when inmate movement is limited. The report resulting from that evaluation will include enterprise-wide recommendations to address the BOP-wide issues we identify. Additionally, given the specific shortcomings that we identified at USP Canaan, which we believe warrant discrete remedial actions, we recommend that the BOP:

5. Ensure that USP Canaan's procedures and processes for single-cell Special Housing Unit inmate placements align with BOP policy, including all required coordination before, during, and after placement.
6. Review and update existing USP Canaan post orders to: (a) clarify expectations for Correctional Officers to conduct and document "frequent irregular rounds" in general population housing units, including when there are significant disruptions to normal operations, and (b) require supervisory review of round documentation to ensure rounds are being conducted.
7. When possible, place single-celled inmates who meet the BOP's increased suicide risk criteria with a cellmate if it is anticipated that inmate movement will be limited for an extended period in USP Canaan general population housing units. Further, facilitate for those inmates the same access to mental health treatment as would be available to similarly situated inmates housed in the Special Housing Unit.

### Relevant Prior OIG Work and Related Recommendations: Inmate Monitoring and Suicide Prevention

During prior OIG inspections of FCI Tallahassee, FCI Sheridan, Federal Medical Center Devens, and Federal Detention Center SeaTac, we identified shortcomings with inmate-monitoring rounds similar to those we identified at USP Canaan. Specifically, we found that these institutions had not conducted all inmate-monitoring rounds as required by BOP policy and their respective institution-level post orders, particularly when monitoring inmates housed in the general population.

For nearly a decade, the OIG has also identified single-cell confinement as a recurring and significant risk factor for inmates' mental health, including their risk of death by suicide. In 2017, the OIG found that the BOP did not track the confinement of inmates in single cells despite the recognized and adverse risks to mental health associated with that practice. A 2023 capstone review of the BOP's response to the coronavirus disease 2019 (COVID-19) pandemic also found that seven BOP inmates died by suicide during a 14-month period while housed in single-cell confinement in COVID-19 quarantine.

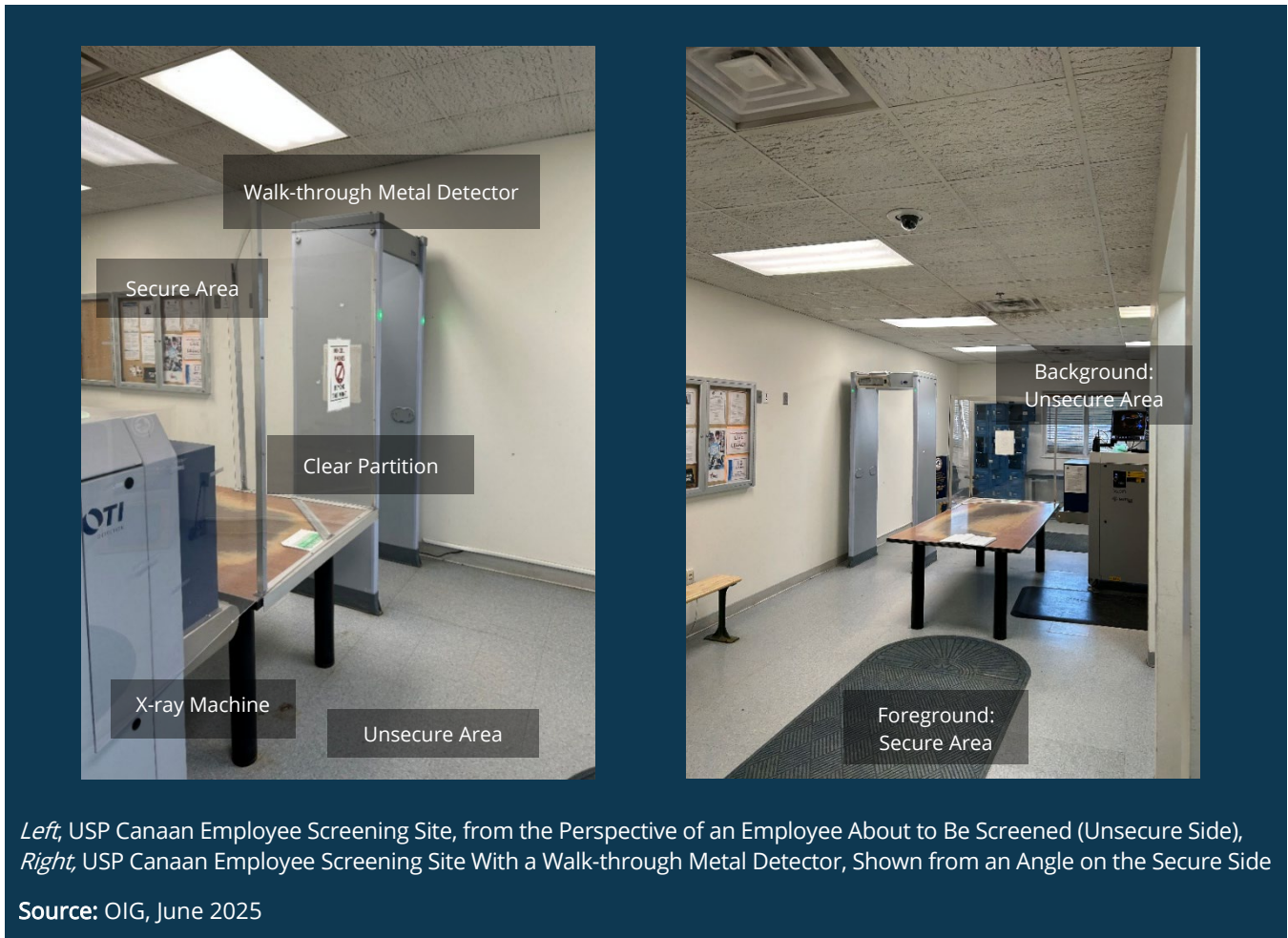
A February 2024 OIG report on issues surrounding inmate deaths in BOP institutions found that more than half (102 of 187) of the BOP inmates who died by suicide between fiscal years 2014 and 2021 were single-celled at the time of their deaths. The report found that suicide risk is further compounded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

See [Appendix 2](#), Items III, IV, VI, VIII, XIX, XVI, and XXVI, for more information about these reports.

### Gaps Found in Employee and Visitor Entrance and Search Procedures Intended to Reduce the Introduction of Contraband

Based on our direct, on-site observations and review of institutional documentation, we found that USP Canaan was not complying with BOP policies regarding entrance and search procedures. Specifically, we observed a Screening Site Officer allowing employees to enter the secure area of the institution without x-raying objects that had likely set off a metal detector alarm. We also found that USP Canaan had not been conducting monthly random employee pat searches as required. These security shortcomings are inconsistent with BOP policy and significantly increase the likelihood that an individual could introduce contraband into the institution. Further, we found that a Front Lobby Officer used their own judgment to select visitors to pat search, which is inconsistent with BOP policy requiring visitor pat searches to occur in accordance with a predetermined random selection method.

As described in previous OIG reports, contraband introduction is a long-standing safety and security challenge across BOP institutions. As part of the BOP's efforts to interdict contraband, BOP policy states that, when an employee sets off a walk-through metal detector before passing to the secure area of the institution, the screening employee (i.e., Screening Site Officer) should request that all metal items be removed and passed through an adjacent x-ray machine or secured without entering the institution (e.g., stored in a vehicle or available storage area). During our site visit, we observed that the metal detector alarmed when several employees passed through it to the secure area. While still in the secure area, these employees then removed from their person items that could have triggered the alarm, including shoes and jackets, and placed these items on a table or bench on the secure side. They then returned to the unsecure area, walked back through the metal detector without triggering the alarm, collected from the secure area the items that presumably had triggered the alarm, and proceeded into the institution. At no point were these items x-rayed or secured in accordance with BOP policy before the employees entered the institution.



An October 2024 update to the BOP’s Employee Entrance and Search Procedures policy requires institutions to conduct and document random pat searches (i.e., a search of a person that entails an employee pressing their hands on the person’s clothing and belongings to detect any prohibited items) of at least 30 employees across all shifts on a monthly basis.<sup>5</sup> To assess USP Canaan’s compliance with the policy, we requested documentation of employee pat searches from November 2024 through May 2025; but the institution was unable to produce any documentation that it conducted these searches before May 2025, when it conducted the monthly minimum of 30 pat searches. While we were on site, multiple employees responsible for screening told us that USP Canaan had not been conducting random employee pat searches in accordance with policy. Specifically, we learned that, when the institution began performing random employee pat searches in May 2025, female employees were not being selected for random searches because the employee conducting the searches did not have a female employee to help him search other female employees. BOP policy mandates that, absent emergency circumstances and Warden approval, pat searches be conducted by an employee of the same sex as the individual being searched.

In the months following the inspection, we discussed noncompliance with the employee search policy with the Warden, who acknowledged that the institution had not been in compliance with this policy, which he

<sup>5</sup> See [Appendix 3](#) (Employee Entrance and Search Procedures).

attributed in part to a vacancy in the Captain position. Through documentation provided to us following the inspection, including records the BOP provided in response to a draft of this report, USP Canaan ultimately was able to demonstrate that it began complying with the requirement to conduct monthly random pat searches of at least 30 employees in August 2025.

In addition to BOP employees, all visitors to a BOP institution may be subject to a random pat search, and BOP policy requires that such searches be impartial and not discriminate among visitors based on age, race, religion, or national origin. To ensure that random visitor pat searches are not discriminatory, they must be conducted in accordance with a random search method predetermined by the institution. We found at USP Canaan, however, that a Front Lobby Officer did not adhere to a random selection method and used their own judgment when selecting visitors to pat search. Given the significant deficiencies we identified at USP Canaan related to entry procedures, we recommend that the BOP:

8. Take corrective action, which should include retraining and increased supervision, to ensure that USP Canaan Front Lobby Officers, Screening Site Officers, and other relevant institution personnel consistently follow BOP policy to: (a) appropriately screen all items before they enter the institution, (b) conduct employee random pat searches, and (c) conduct visitor random pat searches.

## Physical Conditions and Infrastructure

At USP Canaan, we observed adequate conditions overall and found infrastructure across the institution to be generally sound and well-maintained; but we identified some issues with shower and sink temperature regulation. At the time of our inspection, the BOP had identified millions of dollars in infrastructure projects necessary to keep the institution in good repair, including upgrades to the toilets, showers, and sinks in inmate housing units and to the heating, ventilation, and air-conditioning system. As described in the text box, the BOP has recently received significant additional funding to support widespread infrastructure needs across its institutions; the OIG will continue to monitor developments in this area.

During the inspection, we found that many sinks and showers in inmate housing units produced water with temperatures outside the BOP's acceptable range of 100–120 degrees Fahrenheit. Specifically, we measured the water temperature in a sample of 40 showers and 40 sinks, with at least 3 showers and sinks sampled in all general population housing units. We found that the majority of sinks we tested in the housing units (22 of 40) produced water that was slightly above 120 degrees. We also found that 19 of the 40 showers we tested produced water that was too cold according to BOP policy. Notably, in one general population housing unit, two of the three showers we tested produced water that was below 60 degrees.

### Relevant Prior OIG Work and Related Recommendations: Infrastructure

In May 2023, the OIG reported that BOP institutions had a large and growing list of unfunded modernization and repair needs and that the BOP was unable to address these needs. We found that the BOP lacked a strategy to address this enterprise-wide problem and had historically failed to request funding to address its infrastructure needs. The OIG recommended that the BOP develop an infrastructure strategy to increase the overall effectiveness of facilities management and that the BOP develop and implement key performance indicators to track whether it is meeting its infrastructure goals. As of the publication of this report on USP Canaan, these recommendations remain open.

Public Law No. 119-21, signed into law on July 4, 2025, has made available to the BOP up to \$2 billion to address maintenance and repair needs at its institutions. The OIG is conducting oversight of how the BOP uses these funds.

See [Appendix 2](#), Item XXVII, for more information about the May 2023 report.

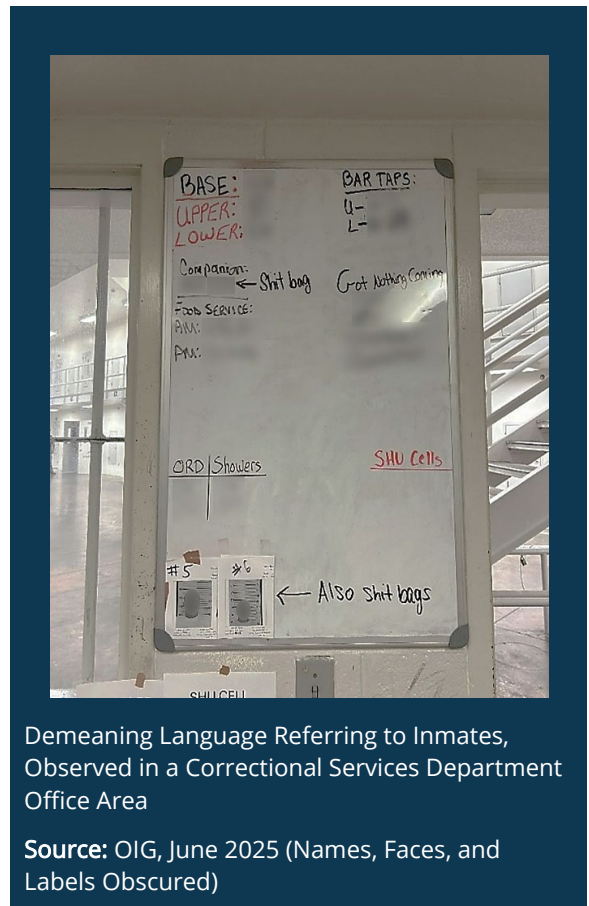
## Employee Professionalism

The BOP Standards of Employee Conduct policy states that employees must act professionally in all interactions and communications and may not use profane, obscene, or abusive language when communicating with inmates or fellow employees. The policy further requires that employees' conduct, both on and off duty, should not discredit the agency or create the appearance of association with any criminal entities. We found numerous instances, in various areas of the institution accessible only to USP Canaan employees, of employees using inappropriate and demeaning language toward both inmates and fellow employees and displaying imagery associated with designated criminal groups as well as white supremacy and antisemitic movements.

## Employees' Use of Profane and Demeaning Language

During our on-site observation of the control room, a centralized location where Correctional Officers monitor security cameras, electronic door controls, and facility-wide communication systems, we heard an employee use sexually explicit language toward another employee over the institution's official radio communications channel. Additionally, we witnessed employees using demeaning and derogatory language when referring to specific inmates and a religious services area used by inmates.

Multiple employees and inmates at USP Canaan told us that some institution employees routinely engage in unprofessional conduct when interacting with inmates. According to employees we interviewed, SHU inmates in particular have been subjected to intimidation or called racial slurs by some Correctional Officers. Similarly, several inmates we spoke with echoed these concerns about Correctional Officers' use of inappropriate language. For example, an inmate told us that Correctional Officers responded to his inquiry about the institution's lockdown status with profane and dismissive language. Further, while we were on site, we observed a whiteboard inside a Correctional Officers' office area in a general population housing unit that appeared to label inmates as "s—t bags."



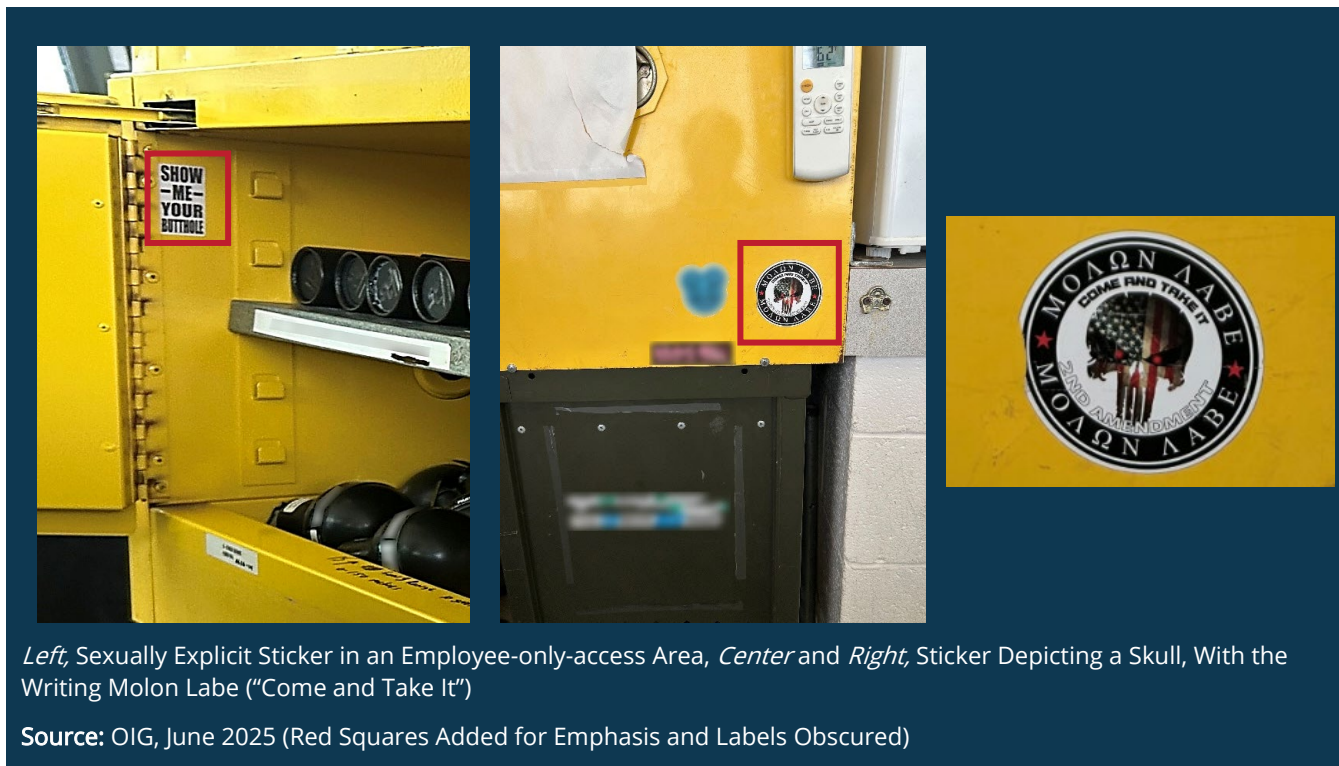
Demeaning Language Referring to Inmates, Observed in a Correctional Services Department Office Area

Source: OIG, June 2025 (Names, Faces, and Labels Obscured)

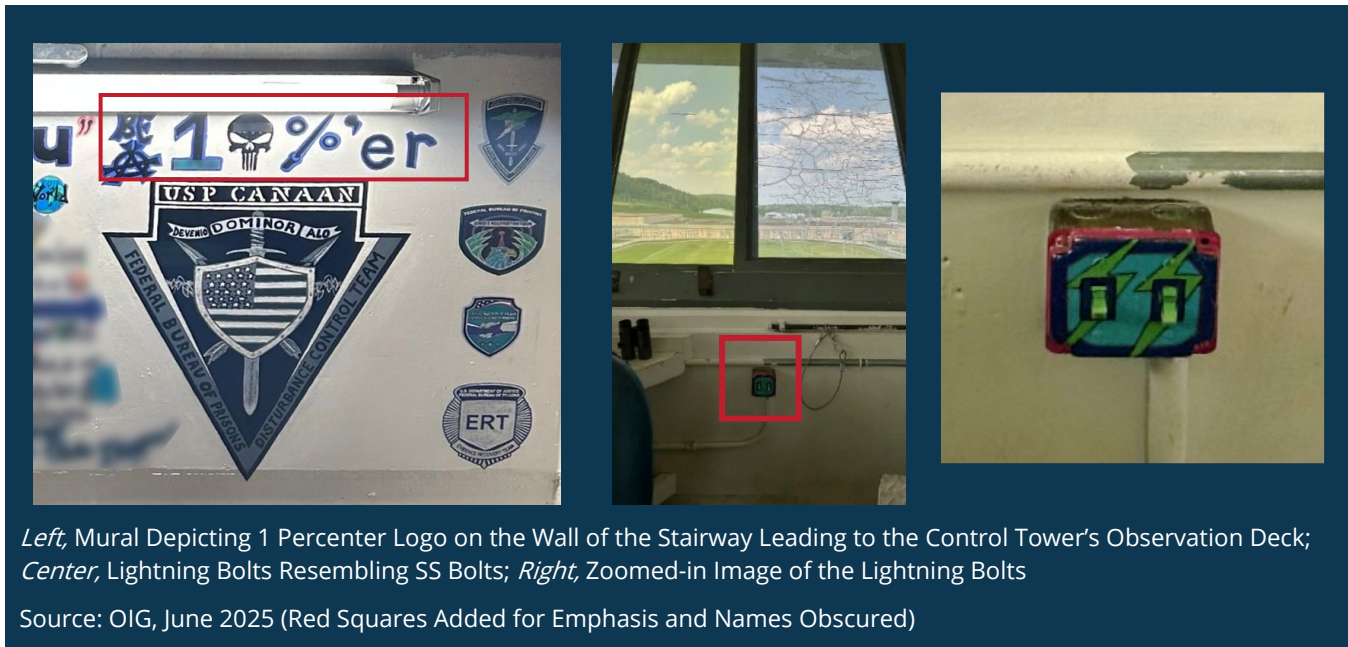
## Display of Concerning Imagery

We observed several instances of concerning imagery in employee-only areas of USP Canaan, including profane language and references to violent extremism, criminal groups, and white supremacy. Inside the institution's control tower, which is a secured and weapon-authorized post where Correctional Officers oversee the institution's perimeter and monitor inmates, we observed various stickers as well as a large mural with concerning content. Specifically, we found a sexually explicit sticker inside a control tower storage cabinet (see the photograph below). We also saw a sticker on the outside of this storage cabinet depicting a skull with the motto "Molon Labe" (translated from Greek as "Come and Take It"). The Federal

Bureau of Investigation (FBI) has identified Molon Labe imagery as a symbol adopted by militia violent extremists and other anti-authority violent extremists.



On the wall of a stairwell leading to the observation deck of the control tower, we observed a large and colorful mural that displayed the "1%er" ("1 percenter") logo adjacent to the logos of various BOP emergency response teams. According to the FBI's National Gang Intelligence Center, the term 1 percenter was adopted by outlaw motorcycle gangs who profess to be the 1 percent of bikers who have rejected societal norms. Lastly, we observed two lightning bolts at the institution's control tower that resemble "SS" bolts drawn on a light switch (see the photograph below). An FBI Law Enforcement Bulletin has identified the SS bolts as the historic insignia of the Schutzstaffel of Nazi Germany and documented that this imagery is commonly used by current white supremacists and neo-Nazi groups in the United States.



When we raised to the Warden and the Captain concerns over the imagery described above, they told us that they were not aware of these images, acknowledged that the conduct was unprofessional, and asserted that these depictions would be removed. The Warden told us that the 1 percenter logo (and perceptions associated with it) in particular is degrading to employees and should not be displayed. After our site visit, the OIG requested an update on whether corrective action, removal, or counseling had taken place in response to our concerns related to employee professionalism. As of February 2026, USP Canaan officials stated that “corrective action was completed,” through the removal of the stickers and the repainting of these areas, and provided photographic evidence to confirm these actions.

## Contraband

USP Canaan, like other institutions we have inspected, faces persistent challenges with contraband introduction. Contraband is material prohibited by law, regulation, or BOP policy that can reasonably be expected to cause physical injury or adversely affect the safety, security, or good order of the facility or protection of the public. The BOP's Correctional Services Manual additionally defines contraband as anything not authorized for retention upon admission to the institution, issued by authorized staff, purchased from the commissary, or purchased or received through approved channels. Employees we interviewed expressed concerns about the introduction of contraband at USP Canaan, and they cited drones and mail, as well as the lack of perimeter fencing and security at the Camp, as opportunities for the introduction of contraband items such as cell phones and narcotics. Institution employees also told us

### Risks Associated with Contraband Weapons

Two past incidents at USP Canaan illustrate the risks associated with undetected, handmade weapons in a prison.

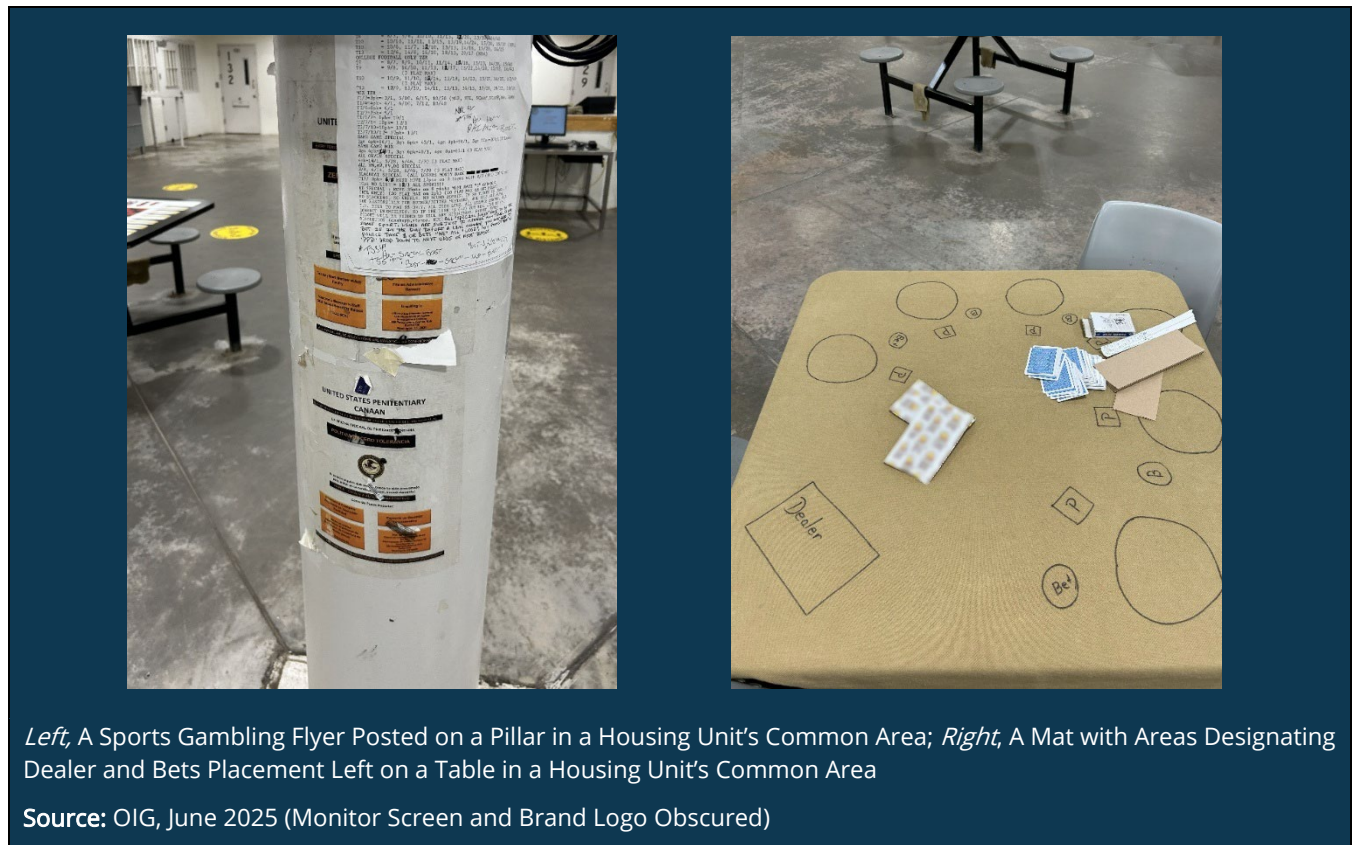
In February 2013, an inmate fatally stabbed a USP Canaan Correctional Officer, over 200 times, using a sharpened handmade weapon. Two years later, in August 2015, another inmate stabbed four USP Canaan Correctional Officers with a sharpened handmade weapon.

These incidents underscore the continued need for USP Canaan to consistently implement search procedures and proactively disrupt the manufacture and introduction of contraband.

that the extensive amount of contraband found at the Camp caused them to suspend visitation there for several months.

According to our review of BOP data on contraband recovery, during the 7-month period between December 2024 and June 2025 USP Canaan employees found 166 weapons throughout the institution. Moreover, during the single week of our on-site inspection, USP Canaan employees found three items sharpened into weapons. As noted in previous OIG work, rigorous contraband detection and interdiction are essential to maintaining the safety of both inmates and employees. During our walkthrough of USP Canaan, we identified several contraband items in housing units, including sports gambling paraphernalia and potential tattoo needles, described and pictured below.

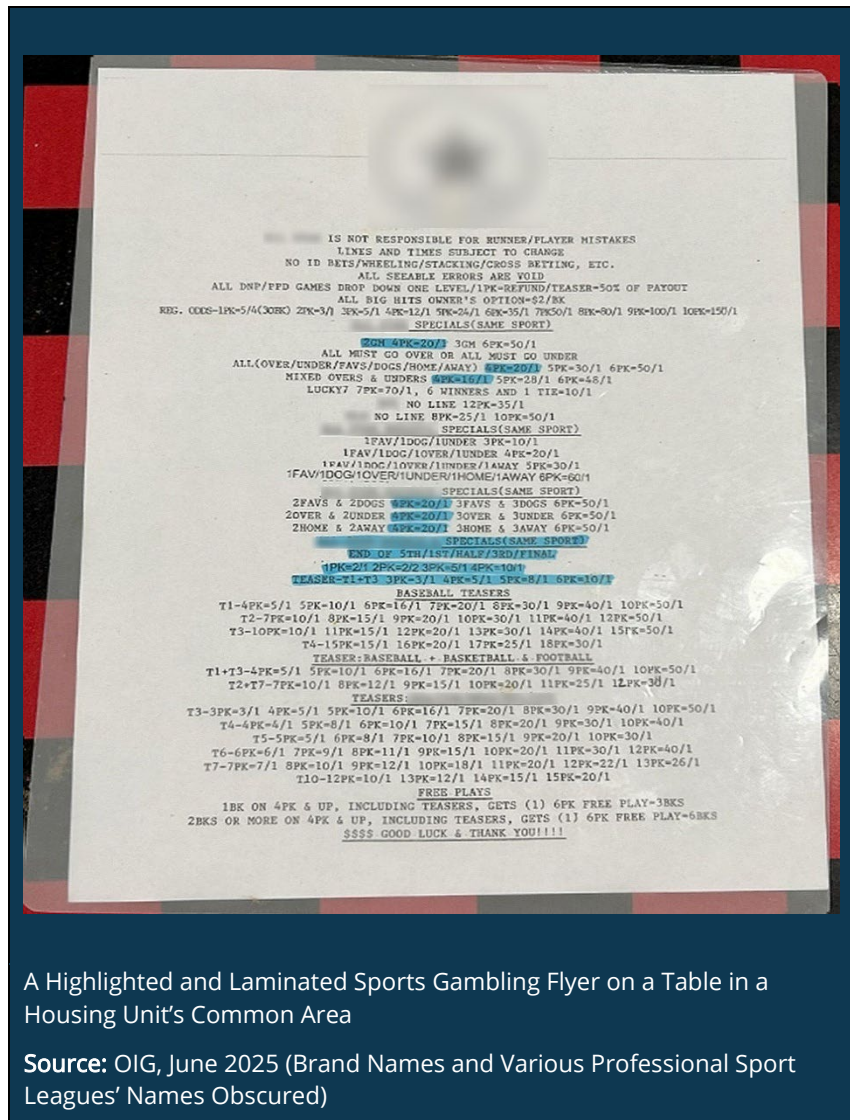
The BOP explicitly prohibits all forms of inmate gambling and inmate possession of gambling paraphernalia, which is considered contraband. Specifically, the BOP defines “preparing or conducting a gambling pool” and “possessing gambling paraphernalia” as prohibited acts of “moderate” severity, which carry disciplinary penalties for inmates such as the disallowance of up to 25 percent of available good conduct time credit for the year; disciplinary segregation up to 3 months; monetary fine or restitution; and removal from a program, job, or housing unit. Nevertheless, we found widespread and unconcealed evidence of gambling across five inmate housing units that we inspected. We observed numerous flyers, present or posted openly in common areas, that advertised sports gambling opportunities for inmates, and some even suggested using payment software applications commonly used on cell phones to facilitate paying and receiving funds from gambling. We also found a table mat, along with playing cards, spread across a table in the common area of one housing unit, with notations for a dealer and bets drawn onto it.



*Left, A Sports Gambling Flyer Posted on a Pillar in a Housing Unit’s Common Area; Right, A Mat with Areas Designating Dealer and Bets Placement Left on a Table in a Housing Unit’s Common Area*

**Source:** OIG, June 2025 (Monitor Screen and Brand Logo Obscured)

Notably, all of the gambling flyers we found were conspicuously posted in highly visible locations within the housing unit's common areas, where both inmates and BOP employees could easily view them. For example, some flyers were posted on pillars in common areas underneath televisions where inmates usually gather and congregate, with one flyer partially obscuring a poster that directed inmates how to report violations of the Prison Rape Elimination Act. We saw another flyer sitting openly on an inmate common area table. We also found gambling flyers on top of a control panel that Correctional Officers operate to monitor the housing unit. Of particular concern, at least one of the flyers was laminated and some of the flyers across different housing units were typewritten and appeared to be printed from the same file or direct photocopies of one another. We are concerned that these conditions indicate potential employee knowledge and acceptance of inmate gambling.

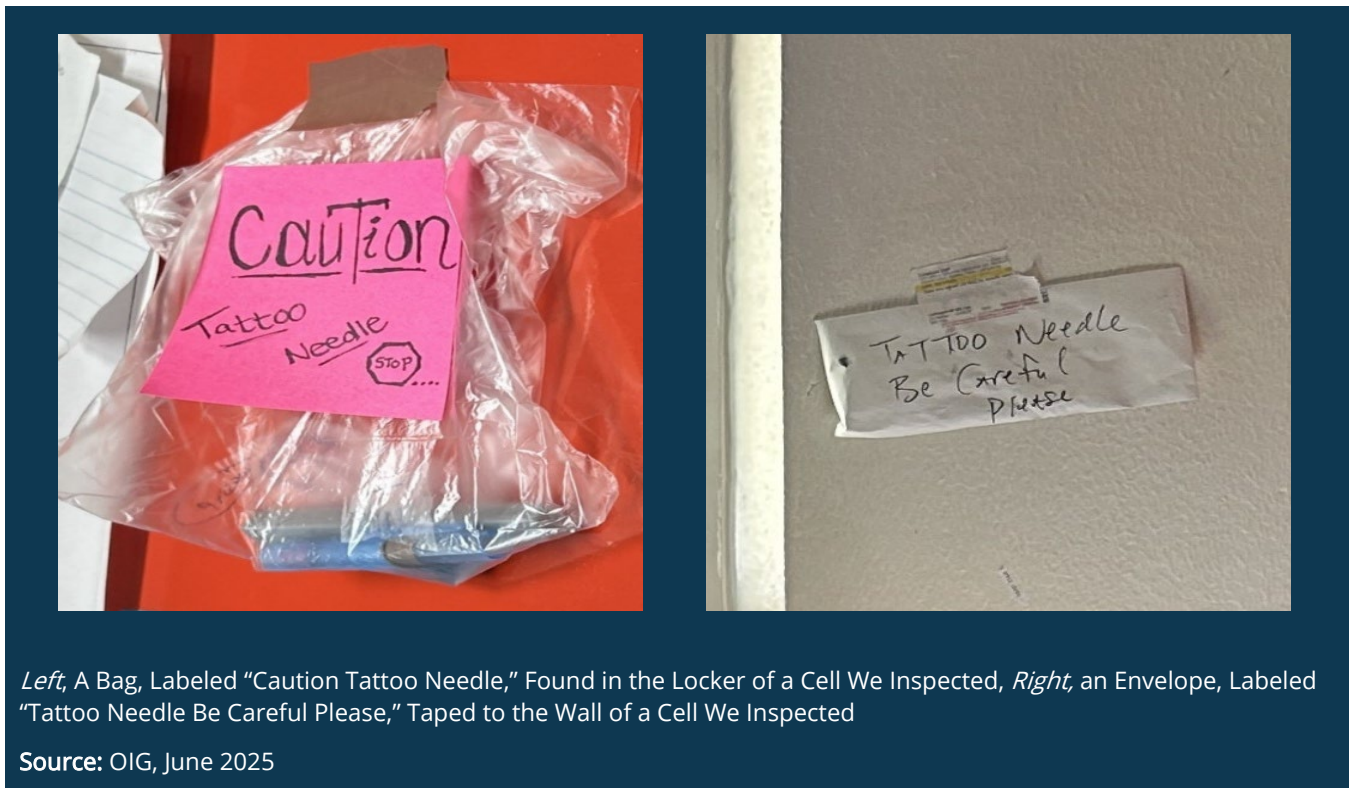


A Highlighted and Laminated Sports Gambling Flyer on a Table in a Housing Unit's Common Area

Source: OIG, June 2025 (Brand Names and Various Professional Sport Leagues' Names Obscured)

BOP policy also prohibits inmate tattooing in its institutions and defines the practice as a "high severity level prohibited act," which represents the second-most serious level of prohibited conduct (below "greatest severity"). Further, high severity level prohibited acts are subject to disciplinary penalties such as the disallowance of 25–50 percent of available conduct time credit for the year; disciplinary segregation for up

to 6 months, monetary fine or restitution; or removal from a program, job, or housing unit. Tattooing can present both security concerns stemming from gang affiliations and serious health risks including the transmission of hepatitis or other diseases. During our inspection, at two separate housing units, we found needles that were most likely used for tattoos inside inmates' cells. Specifically, we observed both a clear plastic bag and an envelope with handwritten notes cautioning that they contained a "tattoo needle"; one of these contained visible cylindrical objects that appeared to be consistent with use for tattooing. We shared these findings with local officials while on site for the inspection. However, when we later requested an update from USP Canaan on any actions taken with respect to the inmates possessing contraband in the units where we found the tattoo needles, the institution told us that it had no documentation pertaining to our request.



When we raised the issues involving contraband, including the gambling paraphernalia, to USP Canaan's leadership, these officials expressed concern about inmate gambling and agreed that such practices can jeopardize the safety of the institution. They told us that, to address this matter, they had developed a program that provided incentives to inmates to keep housing units clean, which would include removing the gambling flyers. In a February 2026 follow-up response to the OIG, USP Canaan provided a copy of a notice to inmates that announced the new program whereby employees would inspect units weekly, rank them based on sanitation, and promote inmate participation by providing inmates from the top-ranked unit with the opportunity to obtain an incentive item from the commissary. The notice also reminded inmates that any advertisements in housing units—including sports statistics, gambling information, and solicitations—were prohibited, and it emphasized that the only allowable common area postings were institution-approved notices. The notice further reminded inmates that personal property must be purchased from the commissary or approved by the BOP. This February 2026 response provided by USP Canaan included the

sanitation results rankings from September and October 2025 but did not provide evidence that the program had continued past October 2025.






To help ensure that the institution sustains over the long term its efforts to combat contraband and mitigate the risks associated with it, we recommend that the BOP:

9. Ensure that USP Canaan continues to improve the detection and removal of contraband in housing units and takes steps to ensure that employees remain vigilant to detect and deter the introduction of contraband.

## Conclusion and Recommendations

### Conclusion

We found various areas in which USP Canaan’s institutional practices and operational limitations pose risks to inmate safety and institutional security. We summarize our findings below:

 Restraints	<ul style="list-style-type: none"> <li>• We identified unsafe application of four-point restraints, which caused inmates severe discomfort and posed a risk of serious and lasting injury.</li> <li>• USP Canaan generally conducted required restraint checks but, in a few notable instances, failed to adequately document crucial information about the progression of an inmate’s injuries and food or water consumption while in restraints.</li> </ul>
 Modified Operations	<ul style="list-style-type: none"> <li>• USP Canaan frequently used modified operations to limit inmate movement due to a high Special Housing Unit (SHU) population and resultant need for inmates who would normally be assigned to the SHU to remain in general population housing units.</li> <li>• Inmates on units where an inmate assigned to SHU was housed were confined to their cells for most of the day.</li> <li>• Restrictions on inmate movement disrupted institution-wide functions and inmates’ access to programs, healthcare, and psychology services.</li> </ul>
 Inmate Healthcare	<ul style="list-style-type: none"> <li>• There was no Clinical Director or staff physician on site and, prior to March 2025, no full-time phlebotomist, leading to clinical challenges and delays in laboratory testing.</li> <li>• We identified issues that could delay treatment of inmates’ health conditions, including:                         <ul style="list-style-type: none"> <li>➢ delays in receiving outside medical care for serious health issues, and</li> <li>➢ lack of adequate documentation for sick call requests.</li> </ul> </li> <li>• Sharp tools, hazardous chemicals, and flammable materials were unsecured in Dental Services space.</li> <li>• Employees engaged in inconsistent and unsafe medication administration practices.</li> <li>• We discovered expired naloxone and found that the institution’s emergency vehicles were non-functioning.</li> </ul>
 Safety and Security	<ul style="list-style-type: none"> <li>• USP Canaan failed to follow BOP inmate-monitoring requirements, including:                         <ul style="list-style-type: none"> <li>➢ requirements for single-celling inmates in the SHU, and</li> <li>➢ completing rounds in general population housing units, including during lockdowns and modified operations.</li> </ul> </li> <li>• USP Canaan did not consistently search employees or visitors in accordance with BOP policy.</li> </ul>
 Other Issues	<ul style="list-style-type: none"> <li>• Several sinks and showers in housing units produced water temperatures outside the BOP’s acceptable range.</li> <li>• Iconography and symbols associated with criminal entities were displayed in employee-only areas, and we observed use of derogatory and sexually explicit language among employees.</li> <li>• Contraband, including sports gambling paraphernalia and tattoo needles, was present and highly visible in inmate housing units.</li> </ul>

## Recommendations

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

1. Ensure that USP Canaan makes improvements in its processes involving the application of inmate restraints, through actions including: (a) retraining USP Canaan employees as soon as possible on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates, and (b) implementing enhanced supervisory review to monitor and ensure compliance with BOP restraint application policies and document requirements.
2. Assess USP Canaan's use of restraints, including: the frequency of their use, the method by which they have been applied, and the duration of their use. Such an assessment should be performed by a medical doctor and other correctional experts not assigned to USP Canaan. The BOP should use the results of this assessment to inform the training and supervision provided to USP Canaan employees and determine whether any other operational changes are necessary.
3. Ensure that USP Canaan Executive Leadership and relevant Central Office Correctional Programs Division officials discuss the scope of USP Canaan's Special Housing Unit capacity issues and identify inmate management and space utilization techniques that can mitigate USP Canaan's need to restrict inmate movement.
4. Implement controls to ensure that USP Canaan employees consistently follow BOP policy on securing potentially dangerous medical equipment and supplies.
5. Ensure that USP Canaan's procedures and processes for single-cell Special Housing Unit inmate placements align with BOP policy, including all required coordination before, during, and after placement.
6. Review and update existing USP Canaan post orders to: (a) clarify expectations for Correctional Officers to conduct and document "frequent irregular rounds" in general population housing units, including when there are significant disruptions to normal operations, and (b) require supervisory review of round documentation to ensure rounds are being conducted.
7. When possible, place single-celled inmates who meet the BOP's increased suicide risk criteria with a cellmate if it is anticipated that inmate movement will be limited for an extended period in USP Canaan general population housing units. Further, facilitate for those inmates the same access to mental health treatment as would be available to similarly situated inmates housed in the Special Housing Unit.
8. Take corrective action, which should include retraining and increased supervision, to ensure that USP Canaan Front Lobby Officers, Screening Site Officers, and other relevant institution personnel consistently follow BOP policy to: (a) appropriately screen all items before they enter the institution, (b) conduct employee random pat searches, and (c) conduct visitor random pat searches.

9. Ensure that USP Canaan continues to improve the detection and removal of contraband in housing units and takes steps to ensure that employees remain vigilant to detect and deter the introduction of contraband.

# Appendix 1: Purpose, Scope, and Methodology

## Standards

The DOJ OIG conducted this inspection in accordance with the Council of the Inspectors General on Integrity and Efficiency's *Quality Standards for Inspection and Evaluation* (December 2020).<sup>6</sup>

## Purpose and Scope

The OIG has determined that it can enhance the effectiveness of its oversight, as well as its ability to alert the BOP of concerns, by conducting short-notice and unannounced inspections of BOP facilities, as appropriate. This was the thirteenth unannounced inspection the OIG has conducted of a BOP institution pursuant to its on-site inspections program and our first full inspection of a standalone USP. We selected USP Canaan as a site for inspection to better understand and assess the conditions of confinement for male inmates at a standalone federal penitentiary. USP Canaan is the only standalone USP in the BOP's Northeast Region.

Pursuant to the OIG's planned procedures for initiating an inspection, which we had previously shared with the BOP, the OIG notified USP Canaan at approximately 8 a.m. on June 2, 2025, that it would be initiating an inspection beginning at noon that day. The OIG team, which consisted of 10 OIG employees and 2 medical subject matter experts contracted by the OIG, conducted the on-site inspection Monday, June 2, through Thursday, June 5, 2025.

Our focus was the state of institution operations at the time of our inspection; although, for certain portions of our analysis, our scope included roughly the year that preceded our inspection, beginning around July 2024. The scope of this inspection did not include specialized testing to definitively determine, for example, the potential presence of mold or other hazardous substances.

## Inspection Methodology

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

## Observations

We toured the interior and exterior of the institution, including:

- general population inmate housing units, including those offering residential-based programming to inmates;

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<sup>6</sup> The lapse in appropriations that began on October 1, 2025, caused the completion and release of this inspection report to be delayed.

- the Special Housing Unit (SHU);
- Health Services Department areas;
- front lobby employee entrances and screening areas;
- programming areas used by the Psychology, Education, and Religious Services Departments;
- the mail room;
- the commissary;
- laundry areas;
- the evidence storage area;
- the visitation room;
- inmate intake and screening areas;
- food storage warehouses; and
- food preparation areas.

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

## **Interviews**

We interviewed USP Canaan inmates who were housed in the general population, programming, and SHU, as well as institution employees. Employees we interviewed included the Warden and the Associate Warden, who also serves as the institution's Prison Rape Elimination Act Coordinator; supervisory and nonsupervisory Correctional Officers; healthcare providers, managers, and employees; unit team employees; teachers; psychologists; food service employees; and employees responsible for institution safety, facilities management, human resources, and inmate discipline. Following our on-site work at USP Canaan, we conducted follow-up interviews with select USP Canaan employees and an employee at the BOP's Central Office.

## **General Document Review and Analysis**

We reviewed USP Canaan's records related to staffing levels, use of overtime, use of restraints, implementation of modified operations and lockdowns, inmate programming, provision of inmate

healthcare, use of restrictive housing, sexual abuse reporting and tracking, camera functions, completion of rounds, and facilities management.

To understand the institution's use of modified operations, we reviewed email records that were sent from USP Canaan leadership to employees regarding the operating status of the institution during the 6 months prior to our inspection. The emails included notifications about modified operations and lockdowns, as well as inmate movement schedules for units in modified operations. We constructed a dataset from the email records that contains the status of each housing unit for each day from February through May 2025. For each day in our scope, we considered a unit to be:

- in lockdown if email records used the words "lockdown" or "secured" to describe the unit, inmates on the unit, or the entire institution for the whole day;
- in modified operations if email records indicated deviation from the unit's normal status short of a lockdown or a lockdown that did not last the entire day; or
- in normal operations if email records explicitly stated that the unit or institution was on normal operations or if there were no email records indicating the operating status for that day.

USP Canaan leadership told us that the absence of emails for a given day did not necessarily imply normal operations and said that modified operations may be announced to employees in other ways, such as a conference call or posted sign in the control room. However, in the absence of more complete data, we erred on the side of assuming normalcy for days on which there was no email indicating the operating status.

### **Healthcare-related Review and Analysis**

We reviewed USP Canaan's operational documentation related to the provision, access, and quality of inmate medical and mental healthcare services provided. Specifically, our review included assessments of the following:

- implementation of the BOP's Clinical Guidelines for Preventive Health Care Screening in the areas of intake screening and tuberculosis screening;
- management of HIV;
- management of diabetes;
- medication administration;
- documentation of clinical encounters;
- management of inmate medical records and requests for care;

- instances in which USP Canaan inmates were sent to the hospital or emergency room;
- scheduling of specialty appointments for medical services offered on site and in the community;
- laboratory testing;
- healthcare employee credentials, including licensure requirements, privileges, and practice agreements; and
- case studies on inmate health and continuity of care concerns.

### **External Subject Matter Experts Assisting the OIG**

To assist the OIG in its efforts to assess the provision of healthcare to USP Canaan inmates, the OIG contracted the services of two healthcare subject matter experts, a registered nurse and a physician, who accompanied the OIG on site for the inspection and conducted analysis remotely after the on-site inspection.

## Appendix 2: DOJ OIG and Other Oversight Agency Related Work

### DOJ OIG Compendium of BOP Oversight Products

- I. [Compendium of Federal Bureau of Prisons Oversight Products](https://oig.justice.gov/news/compendium-federal-bureau-prisons-oversight-products) (February 2024), [oig.justice.gov/news/compendium-federal-bureau-prisons-oversight-products](https://oig.justice.gov/news/compendium-federal-bureau-prisons-oversight-products)

### DOJ OIG Inspection Reports of BOP Institutions

- II. [Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Waseca](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-waseca), Evaluation and Inspections (E&I) Report 23-068 (May 2023), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-waseca](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-waseca)
- III. [Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Tallahassee](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-tallahassee), E&I Report 24-005 (November 2023), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-tallahassee](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-tallahassee)
- IV. [Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Sheridan](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-sheridan), E&I Report 24-070 (May 2024), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-sheridan](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-sheridan)
- V. [Inspection of the Federal Bureau of Prisons' Federal Correctional Institution Lewisburg](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-lewisburg), E&I Report 24-113 (September 2024), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-lewisburg](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-correctional-institution-lewisburg)
- VI. [Inspection of the Federal Bureau of Prisons' Federal Medical Center Devens](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-medical-center-devens), E&I Report 25-009 (December 2024), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-medical-center-devens](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-medical-center-devens)
- VII. [Concurrent Inspections of BOP Food Service Operations](https://oig.justice.gov/reports/concurrent-inspections-bop-food-service-operations?utm_source=slider&utm_medium=web&utm_campaign=report), E&I Report 25-062 (June 2025), [oig.justice.gov/reports/concurrent-inspections-bop-food-service-operations?utm\\_source=slider&utm\\_medium=web&utm\\_campaign=report](https://oig.justice.gov/reports/concurrent-inspections-bop-food-service-operations?utm_source=slider&utm_medium=web&utm_campaign=report)
- VIII. [Inspection of the Federal Bureau of Prisons' Federal Detention Center SeaTac](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-detention-center-seatac), E&I Report 25-081 (September 2025), [oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-detention-center-seatac](https://oig.justice.gov/reports/inspection-federal-bureau-prisons-federal-detention-center-seatac)

### DOJ OIG Reports on Use of Restraints

- IX. [Notification of Concerns Regarding the Federal Bureau of Prisons' Policies Pertaining to the Use of Restraints on Inmates](https://oig.justice.gov/reports/notification-concerns-regarding-federal-bureau-prisons-policies-pertaining-use-restraints), Investigations Report 25-064 (July 2025), [oig.justice.gov/reports/notification-concerns-regarding-federal-bureau-prisons-policies-pertaining-use-restraints](https://oig.justice.gov/reports/notification-concerns-regarding-federal-bureau-prisons-policies-pertaining-use-restraints)

- X. [Audit of the Federal Bureau of Prisons' Oversight of the Use of Restraints](https://oig.justice.gov/reports/audit-federal-bureau-prisons-oversight-use-restraints), Audit Report 25-070 (July 2025), oig.justice.gov/reports/audit-federal-bureau-prisons-oversight-use-restraints

## DOJ OIG, Pandemic Response Accountability Committee, and U.S. Government Accountability Office Reports on BOP Staffing

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- XXV. [\*Management Advisory Memorandum: Notification of Needed Upgrades to the Federal Bureau of Prisons' Security Camera System\*](#), E&I Report 22-001 (October 2021), [oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security](https://oig.justice.gov/reports/management-advisory-memorandum-notification-needed-upgrades-federal-bureau-prisons-security)
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- XXVII. [\*The Federal Bureau of Prisons' Efforts to Maintain and Construct Institutions\*](#), Audit Report 23-064 (May 2023), [oig.justice.gov/reports/federal-bureau-prisons-efforts-maintain-and-construct-institutions](https://oig.justice.gov/reports/federal-bureau-prisons-efforts-maintain-and-construct-institutions)

## U.S. Government Accountability Office Report on BOP Employee Misconduct

- XXVIII. [\*Bureau of Prisons: Strategic Approach Needed to Prevent and Address Employee Misconduct\*](#), GAO-25-107339 (September 2025), [files.gao.gov/reports/GAO-25-107339/index.html](https://files.gao.gov/reports/GAO-25-107339/index.html)

## Appendix 3: BOP Policies and Clinical Guidance Cited

Topic Discussed in Report	Relevant Program Statement or Clinical Guidance	Link
Use of Restraints on Inmates	P5566.07 <a href="#">Use of Force, Application of Restraints, and Firearms</a> July 17, 2024	<a href="http://www.bop.gov/policy/progstat/5566.07.pdf">www.bop.gov/policy/progstat/5566.07.pdf</a> (accessed March 19, 2026)
Limitations on Inmate Movement	5270.12, CN-1 <a href="#">Special Housing Units</a> March 6, 2025	<a href="http://www.bop.gov/policy/progstat/5270_012_cn-1.pdf">www.bop.gov/policy/progstat/5270_012_cn-1.pdf</a> (accessed March 19, 2026)
Inmate Healthcare	6031.05, CN-2 <a href="#">Patient Care</a> March 14, 2025	<a href="http://www.bop.gov/policy/progstat/6031_005_cn-2.pdf">www.bop.gov/policy/progstat/6031_005_cn-2.pdf</a> (accessed March 19, 2026)
Delays in Laboratory Testing	<a href="#">Management of Diabetes</a> March 2017	<a href="http://www.bop.gov/resources/pdfs/201703_diabetes.pdf">www.bop.gov/resources/pdfs/201703_diabetes.pdf</a> (accessed March 19, 2026)
Delays in the Outside Medical Appointment Process	5538.08 <a href="#">Escorted Trips</a> April 8, 2024	<a href="http://www.bop.gov/policy/progstat/5538.08.pdf">www.bop.gov/policy/progstat/5538.08.pdf</a> (accessed March 19, 2026)
Medication Administration Practices	6360.02 <a href="#">Pharmacy Services</a> October 24, 2022	<a href="http://www.bop.gov/policy/progstat/6360_002.pdf">www.bop.gov/policy/progstat/6360_002.pdf</a> (accessed March 19, 2026)
Expired Naloxone	1610.02 <a href="#">Naloxone Procedures and Protocol for Reversal of Opioid Overdose</a> March 19, 2026	<a href="http://www.bop.gov/policy/progstat/1610_002-1.pdf">www.bop.gov/policy/progstat/1610_002-1.pdf</a> (accessed April 9, 2026)
Safety and Security	5500.14, CN-1 <a href="#">Correctional Services Procedures Manual</a> August 1, 2016	<a href="http://www.bop.gov/policy/progstat/5500_014_CN-1.pdf">www.bop.gov/policy/progstat/5500_014_CN-1.pdf</a> (accessed March 19, 2026)
Inmate Monitoring Practices Intended to Reduce Suicide Risks	5332.01 <a href="#">Suicide Prevention Program</a> March 19, 2026	<a href="http://www.bop.gov/policy/progstat/5332_001-1.pdf">www.bop.gov/policy/progstat/5332_001-1.pdf</a> (accessed April 9, 2026)
Employee Entrance and Search Procedures	3740.03, CN-1 <b>Employee Entrance and Search Procedures</b> March 6, 2025	Not applicable. The BOP does not make this policy publicly available.

Visitor Entrance and Search Procedures	5510.15 <a href="#">Searching, Detaining, or Arresting Visitors to Bureau Grounds and Facilities</a> July 17, 2013	<a href="http://www.bop.gov/policy/progstat/5510_015.pdf">www.bop.gov/policy/progstat/5510_015.pdf</a> (accessed March 19, 2026)
Physical Conditions and Infrastructure	4200.12, CN-2 <a href="#">Facilities Operations Manual</a> March 26, 2025	<a href="http://www.bop.gov/policy/progstat/4200_12_CN-2.pdf">www.bop.gov/policy/progstat/4200_12_CN-2.pdf</a> (accessed March 19, 2026)
Employee Professionalism	3420.14 <a href="#">Standards of Employee Conduct</a> May 15, 2026	<a href="http://www.bop.gov/policy/progstat/3420_014.pdf">www.bop.gov/policy/progstat/3420_014.pdf</a> (accessed May 20, 2026)
Contraband	5500.15, CN-1 <b>Correctional Services Manual</b> April 4, 2023	Not applicable. The BOP does not make this policy publicly available.
Contraband	5270.09, CN-1 <a href="#">Inmate Discipline Program</a> November 18, 2020	<a href="http://www.bop.gov/policy/progstat/5270_009_cn_1.pdf">www.bop.gov/policy/progstat/5270_009_cn_1.pdf</a> (accessed April 9, 2026)

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



U.S. Department of Justice

Federal Bureau of Prisons

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Office of the Director

Washington, DC 20534

May 18, 2026

MEMORANDUM FOR ALLISON RUSSO  
ASSISTANT INSPECTOR GENERAL  
EVALUATION AND INSPECTIONS

FROM:  5/18/2026  
William K. Marshall III, Director

SUBJECT: Response to the Office of Inspector General's Draft Report:  
Inspection of the Federal Bureau of Prisons' U.S. Penitentiary Canaan  
(A-2025-003)

The Federal Bureau of Prisons (BOP) appreciates the opportunity to formally respond to the Office of Inspector General's (OIG) draft report entitled Inspection of the Federal Bureau of Prisons' U.S. Penitentiary Canaan (the Report) and addresses the OIG's findings and recommendations.

The BOP understands the gravity and urgency of the OIG's findings from its inspection of U.S. Penitentiary (USP) Canaan and is committed to taking necessary steps to rectify the problems documented in the Report. The OIG identified issues with the application of restraints on inmates; the effects of restrictions on inmate movement; the provision of inmate healthcare; institutional safety and security; and employee professionalism. With the deployment of targeted resources and support from the Regional Office and BOP leadership, USP Canaan will be making concerted, immediate efforts to address the issues identified by the OIG.

To provide rapid and intensive support to USP Canaan, the BOP will deploy its National Resource Team to USP Canaan within the next few weeks. The National Resource Team is a new initiative that started in December 2025 to change the culture of BOP's high security institutions through collaborative engagement with staff and the inmate population. Its focus is on deliverables in staffing, accountability, performance, and competency-based leadership. Deputy Director Joshua J. Smith will lead the National Resource Team, which will be comprised of senior BOP leadership, during its visit to USP Canaan to provide on-site support and assessment to ensure meaningful and sustainable improvement. With this focused application of resources, USP Canaan will develop solutions to the challenges and implement corrective actions to promote a safe, professional, and accountable correctional environment.

As noted below, USP Canaan has already begun taking steps to address the issues identified in the Report and is fully committed to implementing all of the OIG's recommendations. The BOP offers the following responses:

**Recommendation 1: Ensure that USP Canaan makes improvements in its processes involving the application of inmate restraints, through actions including: (a) retraining USP Canaan employees as soon as possible on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates, and (b) implementing enhanced supervisory review to monitor and ensure compliance with BOP restraint application policies and document requirements.**

**BOP Response:** The BOP concurs with this recommendation. Application of restraints at USP Canaan is guided by the provisions of Program Statement 5566.07, Use of Force, Application of Restraints, and Firearms. Escort and application of restraint procedures are annual courses of instruction for all USP Canaan staff and are provided quarterly in person for all staff assigned to the Special Housing Unit (SHU). USP Canaan management selects and assigns the most qualified staff to work in SHU. Additionally, medical assessments are conducted throughout the inmate's duration in restraints and followed up with a post-restraint assessment.

To address the recommendation, the training materials will be updated based in part on the assessments discussed under Recommendation 2 and will be used to retrain all USP Canaan employees on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates.

Additionally, for enhanced supervisory review, the Warden or delegated Executive staff will regularly monitor the application of restraints and will ensure compliance with BOP restraint application policies and document requirements.

**Recommendation 2: Assess USP Canaan's use of restraints, including: the frequency of their use, the method by which they have been applied, and the duration of their use. Such an assessment should be performed by a medical doctor and other correctional experts not assigned to USP Canaan. The BOP should use the results of this assessment to inform the training and supervision provided to USP Canaan employees and determine whether any other operational changes are necessary.**

**BOP Response:** The BOP concurs with this recommendation. To implement this recommendation, Medical and Correctional Services staff from outside USP Canaan, identified by the Northeast Regional Office, will visit USP Canaan in the near future to assess USP Canaan's use of restraints, including the frequency of their use, the method by which they have been applied, and the duration of their use. The BOP will use the results of this assessment to update the training referenced under Recommendation 1.

**Recommendation 3: Ensure that USP Canaan Executive Leadership and relevant Central Office Correctional Programs Division officials discuss the scope of USP Canaan's Special Housing Unit capacity issues and identify inmate management and space utilization techniques that can mitigate USP Canaan's need to restrict inmate**

**movement.**

**BOP Response:** The BOP concurs with this recommendation. The leadership at the Northeast Regional Office and USP Canaan has worked towards mitigating USP Canaan's need to restrict inmate movement. On March 25, 2026, USP Canaan received approval to operate an external SHU; this is a temporary policy waiver valid for 60 days. During this time, USP Canaan is working to expedite the disciplinary process for inmates, which has been identified as the primary cause for the SHU reaching capacity.

While the Discipline Hearing Officer (DHO) position was vacant, expectations have been communicated to alternate DHOs at USP Canaan to assist as needed with monthly hearings. Additionally, DHOs from other locations have assisted in clearing the extensive backlog of inmates awaiting the disciplinary process. Those inmates, once the disciplinary process is completed, may be moved back to general population or transferred to other institutions, as appropriate. USP Canaan onboarded a new DHO in May 2026, restoring its capacity to hear discipline cases timely and to address the current backlog. While these processes take time to complete, clearing the disciplinary backlog is the first step, and it is underway.

Additionally, as of March 27, 2026, following receipt of approval to activate the external SHU, the institution resumed normal operations for all general population housing units. Only inmates in SHU and the external SHU remain secure pending resolution of the disciplinary process. Since this time, general population housing units have required modified operations occasionally due to exhausting all additional SHU bedspace. A population adjustment was requested and implemented to mitigate additional incoming inmates that result in an increase in incidents and protective custody requests. USP Canaan has strategically requested assistance in movement of inmates with new facility designations, as well as temporarily redesignating inmates with unverified protective custody cases that will result in transfers after a period of time. This additional movement helps to alleviate the backlog of inmates pending placement in the SHU.

**Recommendation 4: Implement controls to ensure that USP Canaan employees consistently follow BOP policy on securing potentially dangerous medical equipment and supplies.**

**BOP Response:** The BOP concurs with this recommendation. Additional locks were added to the appropriate storage cabinets, and responsible staff were counseled regarding safe handling and storage of equipment and supplies. When the Medical and Correctional Services staff from outside USP Canaan assess the restraint application procedures, as discussed under Recommendation 2, they will also check on proper securing of medical equipment and supplies. Lastly, to implement controls, USP Canaan's Institution Duty Officer will conduct and document weekly checks to ensure that potentially dangerous equipment and supplies are properly secured in the approved storage locations.

**Recommendation 5: Ensure that USP Canaan's procedures and processes for single-cell Special Housing Unit inmate placements align with BOP policy, including all required coordination before, during, and after placement.**

**BOP response:** The BOP concurs with this recommendation. USP Canaan is aware of and complies with the current BOP policies and procedures regarding single cell inmates in the SHU. Currently, the SHU Lieutenant is required to notify the Lieutenant, Captain, Unit Manager, Psychology staff, and Warden upon placement of an inmate in single cell status. Additionally, the SHU Lieutenant provides the Warden with a single cell report daily to ensure timely notification of all single cell placements. Single cell placements will be reviewed at weekly SHU multidisciplinary team meetings, and the meeting documentation will be maintained along with the single cell review to maintain consistency.

**Recommendation 6: Review and update existing USP Canaan post orders to: (a) clarify expectations for Correctional Officers to conduct and document “frequent irregular rounds” in general population housing units, including when there are significant disruptions to normal operations; and (b) require supervisory review of round documentation to ensure rounds are being conducted.**

**BOP Response:** The BOP concurs with this recommendation. USP Canaan has updated its post orders for housing unit officers since the OIG inspection on November 10, 2025, and it contains the following regarding conducting rounds:

“ROUNDS:

Conducting rounds within the unit is vital to the supervision of inmates, orderly running and security of the institution. Rounds will be conducted throughout each shift and documented in TRUSCOPE. Staff will conduct frequent irregular rounds throughout their shift and document the completion of these rounds in TRUSCOPE. Rounds are defined as leaving the office and roving around the unit on both upper and lower tiers. At the completion of each round staff will document the completion of rounds in TRUSCOPE.”

With respect to part (b) of the recommendation, since the OIG’s inspection, USP Canaan began implementing frequent supervisory reviews of TRUSCOPE to ensure rounds are being conducted in areas that house inmates. Additionally, USP Canaan will create an Institutional Supplement to address procedures for ensuring required rounds are conducted during periods of lockdown or modified operations pursuant to the new Program Statement 5525.01, Lockdown and Modified Operations.

**Recommendation 7: When possible, place single-celled inmates who meet the BOP’s increased suicide risk criteria with a cellmate if it is anticipated that inmate movement will be limited for an extended period in USP Canaan general population housing units. Further, facilitate for those inmates the same access to mental health treatment as would be available to similarly situated inmates housed in the Special Housing Unit.**

**BOP Response:** The BOP concurs with this recommendation. USP Canaan has worked to reduce single celled inmates throughout all general population housing units to ensure inmates are double celled wherever possible. To increase monitoring, USP Canaan’s Unit Management recently started sending daily notifications to Executive Staff with the total of single celled

inmates and a review of the single celled inmates' mental health care level. Additionally, single cells are reviewed weekly by Regional Correctional Programs staff.

Mental Health treatment needs and care plans are based on the specific inmate's individual care level assignments and are provided regardless of housing assignments. If limited inmate movement is anticipated, Correctional Services, Programs, and Psychology communicate to ensure adequate rounds are made and access to mental health treatment is readily available for the inmates based on their assignments.

The new Program Statement 5525.01, Lockdowns and Modified Operations, issued on May 7, 2026, requires institutions to maintain continued access to necessary and routine medical treatment to include mental health services. USP Canaan will comply with its provisions, including ensuring access to medical and mental health resources during periods of lockdown or modified operations.

**Recommendation 8: Take corrective action, which should include retraining and increased supervision, to ensure that USP Canaan Front Lobby Officers, Screening Site Officers, and other relevant institution personnel consistently follow BOP policy to: (a) appropriately screen all items before they enter the institution; (b) conduct employee random pat searches; and (c) conduct visitor random pat searches.**

**BOP Response:** The BOP concurs with this recommendation and has already taken the following corrective actions.

USP Canaan leadership has clearly communicated expectations to staff including the Front Lobby and Screening Site Officers. The Warden sent an email on July 14, 2025, to communicate expectations to all staff regarding employee screening procedures, which included the program statement on Employee Entrance and Search Procedures and reminders of key requirements of all staff entering the facility. USP Canaan's Correctional Services Department also sent an email to all staff regarding Front Entrance procedures and policy requirements on February 10, 2026. Additionally, USP Canaan provides quarterly in-person training to the Front Lobby and Screening Site Officers.

Regarding supervision, it is noted that USP Canaan was without a Captain from September 2024 to June 2025. Since the Captain position was filled, supervision of the Front Lobby and Screening Site posts increased. The issues that the OIG identified during their site inspection with employee pat searches have been remedied, and USP Canaan's practices are in compliance with BOP policy requirements. Supporting documentation demonstrating compliance has already been submitted to the OIG.

Relatedly, following termination of the Master Agreement with the BOP employee union, the Warden has been able to select appropriate staff with specific, relevant experience and knowledge to work in high visibility posts, such as the Front Lobby and Screening Site. This change has enhanced USP Canaan's ability to conduct proper screening.

**Recommendation 9: Ensure that USP Canaan continues to improve the detection and removal of contraband in housing units and takes steps to ensure that employees remain vigilant to detect and deter the introduction of contraband.**

**BOP Response:** The BOP concurs with this recommendation. USP Canaan continues to improve contraband detection and has activated crisis management teams to initiate searches throughout general population. During these searches over 130 weapons were located. Housing Unit Officers are required to conduct daily searches. USP Canaan's Correctional Services continues to conduct thorough random shakedowns throughout the facility to control contraband.

Additionally, since the OIG's inspection, USP Canaan staff have intercepted incoming contraband on 44 separate occasions; 41 of these were attempted introduction through the mail and 3 instances attempted in the visitation room. USP Canaan's SIS Department has also collaborated with local law enforcement K-9 units to assist in area searches in various areas of the facility in an effort to enhance contraband detection and control.

In January 2026, USP Canaan was selected to participate in a program to test out the Apex Drug Detection System and Foxhound Handheld Narcotics Analyzer (HNA). These systems are utilized to detect and prevent drugs from being introduced into the institution and support the improvement of USP Canaan's detection and removal of contraband drugs. Between January and March 2026, the systems detected narcotics on incoming mail and in the visiting room 19 times and helped prevent introduction of this contraband into the institution.

## Appendix 5: OIG Analysis of the BOP's Response

The OIG provided a draft of this report to the BOP for its comment. The BOP's response is included in [Appendix 4](#) to this report.

In its response, the BOP concurred with all our recommendations in this report and stated that it understands the gravity and urgency of our findings. The BOP reported that it will deploy its National Resource Team to USP Canaan within a few weeks of this report's issuance. The BOP added that the National Resource Team is a new initiative intended to change the culture of the BOP's high-security institutions through collaborative engagement with staff and the inmate population, with a focus on improving staffing, accountability, performance, and competency-based leadership. The BOP stated that its Deputy Director will lead the National Resource Team, which will consist of senior BOP leadership and will provide on-site support and assessment to ensure meaningful and sustainable improvement. In addition, the BOP also stated that USP Canaan will develop solutions and implement corrective actions to promote a safe, professional, and accountable correctional environment. Lastly, the BOP stated that USP Canaan has already begun taking steps to address the issues identified in the report.

We will monitor the BOP's efforts to remedy the issues identified at USP Canaan as part of our oversight of the BOP's corrective actions to address both the specific issues addressed in the recommendations and the systemic issues identified in our prior work. The OIG's analysis of the BOP's response and the actions necessary to close the recommendations are discussed below. Please respond to all recommendations by August 20, 2026.

### Recommendation 1

Ensure that USP Canaan makes improvements in its processes involving the application of inmate restraints, through actions including: (a) retraining USP Canaan employees as soon as possible on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates, and (b) implementing enhanced supervisory review to monitor and ensure compliance with BOP restraint application policies and document requirements.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that the application of restraints at USP Canaan is guided by the BOP's Use of Force policy, with training on escort and application of restraint procedures provided annually for all USP Canaan staff and quarterly in-person for SHU-assigned staff. The BOP further stated that USP Canaan management selects the most qualified staff to work in SHU and that medical assessments are conducted throughout the duration of an inmate's placement in restraints, followed by a post-restraint assessment. In addition, the BOP stated that the training materials will be updated, based in part on the assessments discussed under Recommendation 2, and will be used to retrain all USP Canaan employees on the safe application of restraints as well as the requirements for both conducting and documenting medical checks of restrained inmates. Furthermore, to enhance supervisory review, the Warden or delegated Executive Staff will regularly monitor the application of restraints to ensure compliance with BOP restraint application policies and document requirements.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide updated training materials that the BOP develops—on the safe application of restraints, as well as the requirements for both conducting and documenting medical checks of restrained inmates— informed by actions responsive to Recommendation 2. Please include in this update evidence demonstrating the extent to which this training is completed by USP Canaan employees. In addition, provide documentation demonstrating that the Warden, or delegated Executive Staff, regularly monitors the restraint applications to ensure compliance with BOP policies.

## Recommendation 2

Assess USP Canaan's use of restraints, including: the frequency of their use, the method by which they have been applied, and the duration of their use. Such an assessment should be performed by a medical doctor and other correctional experts not assigned to USP Canaan. The BOP should use the results of this assessment to inform the training and supervision provided to USP Canaan employees and determine whether any other operational changes are necessary.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that the Medical and Correctional Services staff from outside of USP Canaan, identified by the Northeast Regional Office, will soon visit the institution to assess its use of restraints, including the frequency of their use, the method by which they have been applied, and the duration of their use. The BOP further stated that it will use the results of this assessment to update the training referenced under Recommendation 1.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide documentation confirming that a medical doctor and other correctional experts, not assigned to USP Canaan, visited the institution and assessed its usage of restraints, including the frequency, method, and duration of their use. The BOP should provide the results of this assessment, as well as evidence demonstrating that any operational changes identified through these efforts have been implemented at USP Canaan, including through training referenced in Recommendation 1.

## Recommendation 3

Ensure that USP Canaan Executive Leadership and relevant Central Office Correctional Programs Division officials discuss the scope of USP Canaan's Special Housing Unit capacity issues and identify inmate management and space utilization techniques that can mitigate USP Canaan's need to restrict inmate movement.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that Northeast Regional Office leadership and USP Canaan have worked together toward mitigating the institution's need to restrict inmate movement. On March 25, 2026, USP Canaan received approval to temporarily operate an external Special Housing Unit (SHU) for 60 days. The BOP stated that, after receiving approval to operate an external SHU, the institution resumed normal operations for all general population housing units. The BOP acknowledged however, that general population housing units have sometimes had to operate on modified

operations when all SHU bedspace has been filled, and inmates who would otherwise be secured in the SHU while awaiting the completion of the disciplinary process must be secured in general population housing units.

The BOP also described actions it has been taking to decrease the demand for SHU space. Specifically, it stated that USP Canaan has been working to expedite the disciplinary process for inmates by onboarding a new Disciplinary Hearing Officer (DHO) in May 2026. Alternate DHOs at USP Canaan and other institutions have also been asked to hear USP Canaan disciplinary cases. The BOP also stated that a population adjustment was requested and implemented to control the number of new inmate admissions to USP Canaan and the protective custody requests those inmates may make. Further, USP Canaan has requested assistance in moving certain categories of inmates to other institutions.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide an update on the status of discussions between USP Canaan and relevant BOP leadership officials on the scope of USP Canaan's SHU capacity issues. Also provide any available documentation associated with the decisions and approaches that have been adopted to help mitigate USP Canaan's need to restrict inmate movement, along with information showing the results of those actions.

#### **Recommendation 4**

Implement controls to ensure that USP Canaan employees consistently follow BOP policy on securing potentially dangerous medical equipment and supplies.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that additional locks were added to the appropriate storage cabinets and that responsible staff were counseled regarding safe handling and storage of equipment and supplies. The BOP also reported that USP Canaan's Safety Department completed an assessment of chemical storage and advised staff on appropriate storage practices. Local leadership at USP Canaan also informed Department Heads that Institution Duty Officers are required to conduct and document weekly checks to ensure that potentially dangerous equipment and supplies are properly secured in the approved storage locations. The BOP further stated that when Medical and Correctional Services staff from outside USP Canaan assess the institution's practices as part of corrective actions associated with Recommendation 2, they will also check the storage of medical equipment and supplies.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide documentation, including photographic evidence, to show that additional locks were added to appropriate storage cabinets. Also, please clarify which personnel or job roles received the counseling described above regarding safe handling and storage of equipment and supplies, and provide a copy of this communication if conveyed in writing. In addition, provide copies of weekly check documents developed by the USP Canaan's Institution Duty Officer regarding the storage of potentially dangerous equipment and supplies, along with any documentation resulting from non-local personnel checks planned in this area, as well as any records to confirm that non-local personnel conducted the checks planned for this aspect of operations.

## Recommendation 5

Ensure that USP Canaan's procedures and processes for single-cell Special Housing Unit inmate placements align with BOP policy, including all required coordination before, during, and after placement.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that USP Canaan is aware of and complies with the current BOP policies and procedures regarding single-celled inmates in the SHU. The BOP also stated that the SHU Lieutenant is required to notify the Lieutenant, Captain, Unit Manager, Psychology staff, and Warden upon placement of an inmate in single-cell status. Additionally, the BOP reported that the SHU Lieutenant provides the Warden with a single-cell report daily to ensure timely notification of all single-cell placements. Accompanying its formal response to this report, the BOP also provided to the OIG examples of single-cell notifications to local leadership. Lastly, the BOP stated that single-cell placements will be reviewed at weekly SHU multidisciplinary team meetings and that the meeting documentation will be maintained along with the single-cell review to maintain consistency.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide available documentation that demonstrates proper compliance with SHU single-cell procedures, including all required coordination before, during, and after placement of an inmate in single cell status. As part of the next status update, provide documentation from the weekly SHU multidisciplinary team meetings, including any notes on discussions about inmates in single-cell status and the rationale for these placements. Also, provide copies of the accompanying single-cell forms for single-cell placements made between the issuance of this report and the BOP's next resolution status update.

## Recommendation 6

Review and update existing USP Canaan post orders to: (a) clarify expectations for Correctional Officers to conduct and document "frequent irregular rounds" in general population housing units, including when there are significant disruptions to normal operations, and (b) require supervisory review of round documentation to ensure rounds are being conducted.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that USP Canaan updated its post orders for housing unit officers in November 2025, after the OIG inspection; the BOP provided to the OIG a copy of these post orders. The post orders state that conducting rounds within housing units is vital, that staff will conduct "frequent irregular" rounds throughout each shift, and that staff will document the completion of these rounds in a BOP operational system. The post orders define rounds as leaving the office and roving around the unit on both upper and lower tiers. Regarding part (b) of the recommendation, the BOP stated that USP Canaan began implementing frequent supervisory reviews of round documentation in the operational system to ensure that rounds are being conducted in areas that house inmates.

As part of its response materials, the BOP also noted that the BOP published in May 2026 a new policy on Lockdowns and Modified Operations. USP Canaan officials reported that they notified all employees of the

new policy, including key requirements for conducting meaningful rounds throughout any lockdown periods. USP Canaan will create an Institutional Supplement to address procedures for ensuring that required rounds are conducted during periods of lockdown or modified operations pursuant to the new BOP policy regarding lockdown and modified operations.

**OIG Analysis:** The BOP's actions are partially responsive to this recommendation. The November 2025 post orders that the BOP provided include a definition of rounds and outline their importance; however, these orders do not clarify what is meant by "frequent irregular" rounds in general population housing units. Further, the orders do not detail how to document these rounds, beyond a general direction that their completion should be documented in the appropriate BOP operational system. Based on supplementary materials provided in response to Recommendation 7, USP Canaan appears to have provided, via email, additional guidance to all of its employees prescribing minimum frequency of rounds in general population units at least during periods of lockdown or modified operations. To close this recommendation, please provide updated USP Canaan post orders that formally define "frequent irregular" rounds and clarify expectations for Correctional Officers to conduct and document these rounds in general population housing units, including when there are significant disruptions to normal institution operations. Also, please provide support evincing the frequent supervisory reviews of round records that the BOP has described. Lastly, provide a copy of the Institutional Supplement that the BOP develops to address procedures for ensuring that required rounds are conducted and documented appropriately during periods of lockdown or modified operations.

## Recommendation 7

When possible, place single-celled inmates who meet the BOP's increased suicide risk criteria with a cellmate if it is anticipated that inmate movement will be limited for an extended period in USP Canaan general population housing units. Further, facilitate for those inmates the same access to mental health treatment as would be available to similarly situated inmates housed in the Special Housing Unit.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that USP Canaan has worked to reduce single-cell placements and ensure that inmates are double-celled wherever possible. The BOP reported that USP Canaan Unit Management recently started sending daily notifications to institution Executive Staff that include the total number of single-celled inmates and a review of the single-celled inmates' mental healthcare level(s); the BOP also provided examples of such communications. Additionally, the BOP reported that Regional Correctional Programs staff conduct weekly reviews of single-celling. The BOP stated that mental health treatment needs and care plans are based on each inmate's individual care level assignments and are provided regardless of housing assignments. Further, according to the BOP, if limited inmate movement is anticipated, the Correctional Services, Programs, and Psychology Departments will communicate to ensure that adequate rounds are made and that inmates have readily available access to mental health treatment that is based on the inmates' assignments. Lastly, the BOP stated that USP Canaan will comply with the May 2026 BOP policy on lockdowns and modified operations that requires institutions to maintain continued access to necessary and routine medical treatment, to include mental health services, during periods of lockdown or modified operations. In supplementary materials that accompanied the BOP's formal response to this report, the BOP included guidance recently provided to all

USP Canaan employees that defines expectations for the frequency of visits by mental health professionals, as well as personnel from other departments, to housing units affected by lockdowns.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide documentation demonstrating that the corrective actions described above have been sustained for the period between the issuance of this report and the BOP's next resolution status update. This response should include any available support demonstrating USP Canaan's efforts to provide access to mental health treatment to any single-celled inmates who meet the BOP's increased suicide risk criteria.

## Recommendation 8

Take corrective action, which should include retraining and increased supervision, to ensure that USP Canaan Front Lobby Officers, Screening Site Officers, and other relevant institution personnel consistently follow BOP policy to: (a) appropriately screen all items before they enter the institution, (b) conduct employee random pat searches, and (c) conduct visitor random pat searches.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that in July 2025 USP Canaan's Warden sent an email to all employees, including the Front Lobby and Screening Site Officers, to communicate expectations regarding employee screening procedures, which included the BOP policy on Employee Entrance and Search Procedures and reminders of key requirements of all staff entering the facility. USP Canaan's Correctional Services Department also sent a February 2026 email to all staff regarding Front Entrance procedures. Additionally, the BOP stated that USP Canaan now provides quarterly in-person training to the Front Lobby and Screening Site Officers, and the BOP provided records related to this training. Further, the BOP stated that the supervision of the Front Lobby and Screening Site posts has increased since the Captain position was filled, following a vacancy in this role from September 2024 to June 2025. Moreover, the BOP stated that the employee pat search issue we identified through this inspection had been remedied and that USP Canaan's practices comply with BOP policy requirements; the BOP provided supplementary records related to these searches as part of its response to a draft of this report. Lastly, the BOP stated that, following the termination of the Master Agreement with the BOP employee union, the Warden has been able to select staff with specific, relevant experience and knowledge to work in high visibility posts, such as the Front Lobby and Screening Site.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. We note that it was not until May 2026, in response to a draft of this report, that the BOP provided the OIG with complete documentation evincing that USP Canaan had begun consistently following BOP policy to conduct employee random pat searches. To close this recommendation, please provide documentation demonstrating that the corrective actions described above have been sustained for the period between the issuance of this report and the BOP's next resolution status update.

## Recommendation 9

Ensure that USP Canaan continues to improve the detection and removal of contraband in housing units and takes steps to ensure that employees remain vigilant to detect and deter the introduction of contraband.

**Status:** Resolved.

**BOP Response:** The BOP concurred with this recommendation. The BOP stated that USP Canaan continues to improve contraband detection and has activated crisis management teams to initiate searches throughout general population housing units. The BOP also said that USP Canaan required Correctional Services personnel to conduct daily searches of housing units and random shakedowns throughout the facility. The BOP detailed the results of these search efforts, which include over 130 weapons found by the crisis management team and the interception of incoming contraband on 44 separate occasions since our inspection. USP Canaan's Special Investigative Services Department also collaborated with local law enforcement K-9 units to search various areas of the facility to enhance contraband detection and control. The BOP further stated that in January 2026 USP Canaan was selected to test the Apex Drug Detection System and Foxhound Handheld Narcotics Analyzer, which resulted in the detection of narcotics in incoming mail and the visiting room.

**OIG Analysis:** The BOP's actions are responsive to this recommendation. To close this recommendation, please provide documentation demonstrating that the corrective actions described above have been sustained for the period between the issuance of this report and the BOP's next resolution status update. This response should include records of housing unit daily searches and random shakedowns. Please also provide additional detail on the coordination with local law enforcement K-9 units, as well as the results of the Apex Drug Detection System and Foxhound Handheld Narcotics Analyzer pilot program. Please also describe any additional efforts to communicate to USP Canaan employees regarding their obligation to remain vigilant in detecting and deterring contraband over the long term.