Department of Justice

STATEMENT OF COLETTE S. PETERS

DIRECTOR, FEDERAL BUREAU OF PRISONS

BEFORE THE COMMITTEE ON THE JUDICIARY

UNITED STATES SENATE

AT A HEARING ENTITLED

“EXAMINING AND PREVENTING DEATHS OF INCARCERATED INDIVIDUALS IN FEDERAL PRISONS”

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Director, Federal Bureau of Prisons
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Good morning, Chairman Durbin, Ranking Member Graham, and Members of the Committee. I appreciate this opportunity to discuss how the Federal Bureau of Prisons (FBOP) is working to prevent deaths in custody and how we are committed to reviewing incidents in order to improve our work. I am humbled to represent the roughly 35,000 employees of the FBOP. As I have previously testified before this Committee, I believe in accountability, transparency, and the importance of oversight. As you are aware, there are inherent challenges to our work. But with proper planning, diligence, and resources, we will improve our efforts.

I am pleased to be here with Inspector General Horowitz from the Office of the Inspector General (OIG) to discuss his report's findings and respond to his team's thoughtful evaluation. At FBOP, any unexpected death of an adult in custody (AIC) is tragic. As noted in the OIG's report, we have already taken many steps to mitigate the risk of death and we welcome OIG's recommendations to further our efforts. In fact, we provided OIG a number of planned actions that address each of the recommendations in the report, which OIG has found are responsive.

FBOP prioritizes the physical and mental health needs of those in our care and custody. Individuals in our care are predisposed to acute and chronic illness, including higher cases of mental illness and substance use disorders. In fact, the rate of individuals who meet the clinical criteria for one or more substance use disorders is nearly double in the FBOP population, at 31.8 percent, compared to 16.5 percent in the general U.S. population.

Preventing suicide for those in our care is a top priority for us, and we provide our employees with regular training to identify indicators on increased suicide risk, on appropriate monitoring and care, on procedures to refer individuals to Psychology Services who are flagged as being at risk, and on responding during a medical emergency when an individual is attempting suicide.

As part of our efforts to prioritize suicide prevention, FBOP has recently undertaken several initiatives to prevent and reduce deaths by suicide, including issuing guidance for employees to carry cut-down tools on their person; reducing the incidence of placing individuals in custody in cells by themselves; and conducting specialized reviews at institutions that have higher incidence of suicide deaths. We also have doctoral-level psychologists at our institutions, who are working to continuously monitor, research and implement best practices as they relate to suicide prevention and mental health care for our AICs. Any time a risk of suicide is suspected, FBOP policy requires that psychologists swiftly conduct Suicide Risk Assessments. When we have identified an individual at possible risk for self-harm, they are immediately safeguarded, and the individual assessments then prompt short-term and long-term plans for the individual's treatment and care.

When tragedy strikes and a threat of suicide is realized, our employees rely on FBOP training to respond quickly. Specifically, we train employees on the appropriate use of cardiopulmonary resuscitation (CPR), automated external defibrillators (AEDs), the opioid reversal agents like naloxone, and cut-down tools and ensure employees have access to those tools in the workplace. Additionally, each institution has a clinical psychologist designated as a Suicide Prevention Program Coordinator. These coordinators monitor at-risk individuals and guarantee adherence to assessment and intervention protocols. When our

best efforts are not successful and death does occur, we conduct a rigorous review of the circumstances surrounding the death.

Substance use and overdoses also lead to death. Therefore, we employ a multidisciplinary approach to treating substance use disorders, including opioid use disorder (OUD), which affects approximately 2.7 million Americans, including 15-20 percent of those in our custody. To better educate and treat the needs of our AICs, we have incorporated evidence-based treatments, like medications for opioid use disorder (MOUD) and other substance use disorder treatment, into our programming. These programs tackle various facets of the issue, preparing individuals to reenter their communities successfully. MOUD is available across all FBOP facilities, and collaborations with agencies such as the Drug Enforcement Administration (DEA), Substance Abuse and Mental Health Services Administration (SAMHSA), Office of National Drug Control Policy (ONDCP), National Institute on Drug Abuse (NIDA), and the Justice Community Opioid Innovation Network (JCOIN), ensure consistent accessibility and success.

Dangerous substances like illicit fentanyl pose a health risk to those in our custody as well as our employees. To reduce the risk of death by overdose, we continuously work to combat contraband entering our institutions. We have implemented heightened screening of mail and publications and counter-drone initiatives, both of which have been used to surreptitiously introduce contraband into FBOP facilities. We continue exploring innovative methods to reduce physical correspondence which may have been adulterated with illicit substances.

To improve our capability to respond to the introduction of illicit substances, we have made naloxone, an opioid reversal medication, available in all our institutions. All FBOP employees within the facility are trained to administer life-saving doses of naloxone to anyone suspected of experiencing an opioid overdose. Our current tracking methods show that in the past 12 months, naloxone was administered by FBOP employees over 3,700 times to approximately 2,600 AICs at 91 institution complexes (out of 97). While it is important to note that FBOP employees are trained to provide naloxone whenever overdose cannot be ruled out and not all instances of naloxone usage are for confirmed overdose, please know that we will continue to improve our tracking mechanisms. Specifically, we have begun developing a dashboard to capture all use of naloxone and patient outcomes more effectively.

Beyond our efforts to prevent and respond to overdose emergencies, FBOP is committed to establishing and sustaining a culture of clinical excellence across all our facilities to prevent disease progression and death wherever possible. This is evident in our efforts to identify and treat hepatitis C, where FBOP cures more than 2,300 patients a year of this deadly yet treatable infection. We dedicate significant resources to our clinical teams to ensure they have access to continuous education and training focused on correctionally sound, evidence-based care.

Additionally, we use sound correctional practices throughout the country to prevent violence, including homicides, in our custody. We use our National Gang Unit, Counter Terrorism Unit, and Intelligence and Investigations Unit to forestall potential conflicts that could lead to homicide. Moreover, we work proactively with external partners to continually monitor and assess risks and vulnerabilities that can lead to violence.

We hold ourselves and our AICs to a high standard, and we are working diligently to comply with and improve the policies and procedures within our organization. As part of this work, we are in the process of creating a new executive position at the national level that will be charged with helping FBOP better use the information at its disposal–e.g., intelligence, misconduct, and after-action reports including death reviews–to recognize possible pressure points throughout the system. Our goal with this new

position is to identify and address concerns as early as possible. I believe our efforts over the last year and a half—and our efforts moving forward—have generated, and will continue to generate, change within our agency. We are grateful for OIG's thorough review and thoughtful recommendations in its report, and we welcome the opportunity to continue FBOP's ongoing efforts to improve in this area. I want to assure the Committee we will work with the appropriate officials and individuals to find creative solutions to our operational challenges and implement the recommendations given to us by OIG. We stand ready and eager to work with the Committee and Appropriators to provide more specificity on the funding recommendations in the OIG's report and recommendations.

Mental Health Care Level (MHCL) Assessments

When an individual enters our care, Health Services and Unit Management have 24 hours to conduct initial intake screenings to evaluate indicators for mental illness and adjustment issues. Within 14 days, Psychology Services employees must conduct a clinical interview of newly committed AICs after they arrive at an institution and assign an appropriate MHCL. Within 30 days, Psychology Services employees must conduct a transfer AIC screening and, if clinically needed, a clinical interview for transferred AICs after they arrive at an institution.

The report by OIG states that the majority of the AICs who died by suicide during the scope of their study were assigned MHCL 1.[1] According to the report, of the 187 who died by suicide, 22 did not have MHCL 1-4 assignments at the time of their deaths; 34 of 187 AICs did not have accurate documentation; and 118 of 187 AICs had an assigned level of MHCL 1. FBOP concurs with OIG that these rates, inaccuracies, or failures to follow policy are unacceptable, and we will continue working to ensure our employees assign accurate, consistent, and timely MHCLs to AICs.

It is important to note that we are already implementing several strategies to accomplish this goal. To start, while we conduct an initial intake screening within 24 hours of an AIC's arrival at an FBOP institution, we complete a full clinical interview within 14 days. Additional strategies include: assigning MHCLs to AICs within 14 days of arrival at their designated institution; using the guidelines from Program Statement 5310.16[2] to guide clinicians on how to determine the appropriate MHCL based on their clinical opinion and how to accurately document those MHCLs; confirming the Chief Psychologist at each institution is reviewing the documentation submitted by their subordinates;[3] ensuring a multidisciplinary and holistic team approach to treatment of AICs is upheld and that, during institution Care Coordination and Reentry Team meetings, professionals from multiple disciplines[4] discuss the numerous factors impacting the treatment of those AICs.

In addition to the strategies listed above, we also plan to continue our practices of having Psychology Services Branch (PSB) clinicians in Central Office review significant events from an AIC's previous institution locations, including incidents involving self-directed violence, suicide attempts, violence toward others, behavioral observations, and incident reports received. After reviewing such incidents and associated documentation, PSB clinicians may contact previous institutions, current supervisors, and Regional/Central Office psychologists to consult on these cases and associated clinical

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[1] Mental Health Care Level designations range from one to four where one indicates no significant mental healthcare; two indicates routine outpatient or crisis-oriented healthcare; three indicates enhanced outpatient or residential mental healthcare; and four indicates inpatient psychiatric care.

[2] "Treatment and Care of Inmates with Mental Illness"

[3] This is especially true for documentation related to changes in MHCLs.

[4] E.g., Psychology Services, Health Services, Unit Team, Correctional Services, Social Work, etc.

treatment needs as needed. When MHCL assignments appear inaccurate, clinicians will adjust care levels accordingly to reflect historical and current presentation and treatment needs.

Preparedness Drills and Training

Preparedness drills are set to take place three times per calendar year, once on each shift, to simulate a suicide attempt by an AIC. These drills are enacted to assess employees' response capabilities should an emergency arise and to identify any necessary areas of training. The goal of any type of mock exercise is to involve as many employees as possible without disrupting the safe, secure, and orderly operation of the facility. FBOP concurs with the OIG report recommendation calling for all institutions to conduct required mock suicide drills and to develop strategies to increase staff participation in those drills. To ensure institution compliance with Program Statement 5324.08,[5] FBOP has added a new program review requirement. Should an institution be found deficient in following our policy, we will require Corrective Actions Plans (CAPs) that we expect will improve compliance. CAPs will then be reviewed in the future to determine effectiveness.

When employees respond to these preparedness drills, they are to do so while simultaneously ensuring adequate monitoring of AICs such that safety, security, and orderly management of the institution are all maintained. To that end, the number of employees responding is directly influenced by many variables, including: the number of employees on shift, other operational needs of the institution, and if employees are needed for supervising AICs or contractors. Each institution maintains an emergency response plan with outlined expectations for employees who respond from each area of the institution to allow for a timely response while maintaining the safety and security of the facility.

To improve routine tracking and oversight of these preparedness drills, FBOP has incorporated these important drills into Operational Review assessments. If emergency response is a concern identified during a suicide reconstruction, the team conducting the reconstruction reviews these preparedness drills to ensure they included adequate employee participation and realistic mock experiences to allow employees the ability to practice using emergency response equipment.

Restrictive Housing[6]

As of February 2024, FBOP has approximately 11,000 AICs in restrictive housing, a number we are working to reduce. As the OIG report notes, 86 of the 187 suicides occurred in a restrictive housing setting, and over two-thirds (60 of 86 suicides) that occurred in a restrictive housing setting occurred while the AIC was single celled, that is assigned to a cell by themselves. Knowing these risk factors, FBOP provides additional specialized training to our employees who work in restrictive housing or other high-risk settings, and each institution has a dedicated program coordinator who oversees suicide prevention education and training.

FBOP strives to limit single-celling whenever possible, as there is evidence that single-celling is associated with a higher risk of suicide.[7] In May 2021, we established a task force to review single-celling practices and issued guidance and policy changes to identify limited circumstances when single-celling is deemed appropriate. We also enhanced training on the risks of single-celling individuals and introduced

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[5] "Suicide Prevention Program"

[6] "Restrictive housing," sometimes known as "administrative segregation," is the practice of housing some AICs separately from the general population of a correctional institution and imposing restrictions on their movement, behavior, and conditions of confinement.

[7] Seena Fazel, M.D., et al., Suicide in Prisoners: A Systematic Review of Risk Factors, J. of Clinical Psychiatry 69:11, Nov. 2008.

new internal controls to enhance our accountability such as regional oversight of single-celling in restrictive housing. Further, we now provide quarterly summaries of deaths by suicide to all wardens and regional directors and identify common recommendations found during suicide reconstructions and include talking points for wardens to discuss suicide prevention strategies with their employees.

Unfortunately, even with these procedures in place, including double-celling, suicides have occurred in restrictive housing. While restrictive housing can be an effective tool for maintaining safety and security and protecting lives, FBOP has both a short-term plan and a long-term plan to evaluate current practices and align with best correctional practices to reduce and limit use of restrictive housing overall. FBOP is partnering with the National Institute of Justice on a multi-year assessment of FBOP's use of restrictive housing, and this assessment is underway. The results of that assessment will include a final report and recommendations that will inform our future restrictive housing policies. In response to studies of FBOP's use of restrictive housing by DOJ and the Government Accountability Office, as well as our own studies, we have already taken steps to reduce the use of restrictive housing, including:

- Launching programs preventing and reducing the need for restrictive housing placements;
- Creating alternatives to restrictive housing;
- Creating baseline conditions of confinement;
- Developing and implementing Secure Mental Health units, which are designed to house and provide intensive treatment to incarcerated individuals with mental illness who would otherwise need to be placed in restrictive housing, and often solitary confinement;
- Amending the Disciplinary Program policy to limit the usage and duration of restrictive housing for disciplinary violations;
- Decreasing the number of individuals housed at the Administrative Maximum Facility in Florence, Colorado, by over 20 percent since 2017, demonstrating a reduction in at least one type of restrictive housing.

FBOP is committed to ensuring that any deficiencies in our use of restrictive housing are remedied, including deficiencies in how employee rounds are conducted that may contribute to suicides. Employees are trained annually on when and how to make rounds to observe AICs. Employees assigned to work in restrictive housing units receive this training quarterly. Departments such as Psychology Services, Religious Services, Recreation, Education, and Unit Teams conduct regular rounds and frequently provide programming to those in restrictive settings throughout our system. Internal oversight to ensure that rounds are being made as required is ongoing at the facility, regional, and national levels.

FBOP also is in the process of implementing an internal audit process to verify and document that facilities have implemented corrective actions to address restrictive housing deficiencies identified during internal audits conducted by its Program Review Division. This process will identify causes of common deficiencies that recur across multiple facilities. It will include an internal audit follow-up process involving all levels (local, regional, and divisional leadership) of the agency to establish internal controls to prevent deficiencies from reoccurring.

Automated External Defibrillators

The OIG report concludes that 22.7 percent (78 of 344) of AIC deaths involved issues related to AEDs. As a result, the OIG recommended that all appropriate employees be trained in AED use and that AEDs are strategically placed, readily available, and regularly checked to guarantee they are in working order at each FBOP institution. FBOP concurs with this recommendation, but it is important to note that all FBOP employees are trained on appropriate AED use annually. While local institutions determine the best available location for these tools, we will continue to ensure that all appropriate employees are

trained in AED use and that AEDs are strategically placed, readily available, and regularly checked to ensure they are in working order. Our Health Services Units purchase the AEDs, and we have tasked them with certifying these devices are, and will continue to be, inspected per the manufacturer recommendations.

Training and Tools to Prevent Suicide by Hanging

Hanging is the most common method AICs use to facilitate suicide. That is why FBOP guidance requires certain employees, including all those assigned to housing units, to carry specialized tools that cannot be used as weapons but are designed to help employees safely and quickly cut through materials to prevent hangings. FBOP distributed that guidance to the field in July 2023 and provided an update in September 2023. FBOP concurs with the OIG recommendations that these cut-down tools in working order be accessible to employees in each housing unit at each institution, that personnel be trained on proper use of the tools, and that FBOP determine whether employees should be issued and required to keep a cut-down tool on their duty belt during their entire shift. As we seek to add additional training on the use of cut-down tools agencywide, we will also continue to address the use of these tools generally and their use in emergency situations in our required Annual Training.

Gurneys

During a medical emergency, the Bureau initiates life-sustaining measures at the scene and then uses gurneys to transport AICs quickly and safely to a medical treatment area after. Because there are various factors in emergencies, such as the size of the affected AIC and the distance they must be transported, all employees must have access to reliable gurneys that are easy to maneuver. OIG recommended that each institution have a sufficient number of maneuverable gurneys in strategic locations to provide proper medical response during the transport of AICs.

FBOP concurs with this recommendation and will use Annual Training to continue educating our employees on the use of patient movers (maneuverable gurneys) at their site. As each site must have the ability to efficiently move a patient and determines the most appropriate type of patient movers based on their infrastructure, we plan to add language to our policy on Patient Care requiring the development of individualized institution guidance. We will ensure that a national standard is appropriately applied at the local level, taking the specific characteristics of each institution into account.

Radio Communication

The OIG report states that existing FBOP policies would, in some cases, mitigate certain risks associated with AIC suicide. However, the report states that FBOP employees did not consistently communicate with each other and coordinate efforts. FBOP recognizes radio communications are critical when responding to AIC medical emergencies. FBOP agrees with the OIG recommendation that we conduct standard, enterprise-wide training to employees on using the radio to communicate clear, descriptive information during AIC medical emergencies, and we have already begun this process. All new employees are trained on all emergency communication devices in Phase 1 of the “Introduction to Correctional Techniques” training; and additional communication training is provided in Phase 2 of the same exercise. Further, each year FBOP’s mandatory Annual Training covers radio etiquette and proper communication during emergencies. We will continue to monitor and examine the training provided to determine where we can make improvements for greater clarity and descriptiveness.

Naloxone

Naloxone is a life-saving medication that can reverse the effects of opioids and is available in strategic locations at all FBOP facilities. However, the report noted that despite being trained in administering naloxone, some employees have waited for medical staff to arrive and administer it. We will continue to ensure employees receive both the initial and the refresher naloxone training and are fully prepared to administer naloxone to an unresponsive AIC suspected of having experienced a drug overdose immediately.

A policy for naloxone was implemented in July 2018, and it declares that mandatory initial training, annual training, and inventory management will take place in our institutions. The current version of the policy, Program Statement 1610.01,[8] was issued in December 2020. Further, all employees are required to complete a course titled "Nasal Naloxone Administration." This course must be completed within 60 days of entry on duty and has an annual recertification requirement.[9] Health Services is responsible for curriculum development and will review current training to assess for opportunities to make improvements that address identified barriers to use. Our policy and training are crystal clear that when employees suspect an overdose, they are to immediately administer naloxone.

Evidence Recovery Teams

After an AIC dies, regardless of cause, FBOP mobilizes Evidence Recovery Teams (ERTs) to gather and collect evidence and to preserve and process crime scenes. The employees who respond to the scene must document the events and draft a memorandum, which is then attached to a Report of Incident form generated for each death. Ensuring all ERTs are properly trained across our agency is of utmost importance given the essential role the teams play in preserving and processing incident scenes, as well as in recovering evidence following attempted homicides, unexplained deaths, and suicides. We assessed our After-action Review reports and agree with OIG's recommendation to ensure all ERTs are properly trained on post-incident evidence recovery protocols. Currently, FBOP institutions are required by Program Statement 5510.14[10] to provide eight hours of training every quarter on post-incident evidence recovery protocols, complete one major mock scenario and a Prison Rape Elimination Act course annually, complete four Federal Emergency Management Agency courses, and be recertified every two years. We will continue to ensure all ERTs are properly trained on post-incident recovery protocols.

Death-related Records

OIG recommended FBOP develop procedures to ensure all required death-related records are completed and collected consistently and in accordance with established deadlines. The Health Services Division's (HSD) Population and Correctional Health Branch, Quality Improvement Section has already begun substantive improvements to its mortality review and record tracking systems, most of which were implemented between June 2023 and January 2024. These actions include: implementing a new resource email box to improve communication between institutions and Central Office concerning AIC deaths; updating the required multi-level mortality review (MLMR) to include additional data collection fields, expanded drop-down menu options, and electronic submission capabilities that will minimize transcription of data and input errors; updating the root cause analysis (RCA) form to provide more detail and more appropriate implementation of corrective actions; training quality improvement employees on the use of both forms; requiring follow-up from HSD Regional or Central Office at six and twelve months; establishing a multidisciplinary panel to evaluate overall appropriateness and comprehensiveness

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[8] "Naloxone Procedures and Protocol for Reversal of Opioid Overdoses"

[9] Employees recertify during Annual Training.

[10] "Crime Scene Management and Evidence Control"

of RCAs received from institutions; and providing HSD employees with clearer guidance on required forms, timelines, and submission routes to standardize messaging and processes.

After-action Reviews

After-action Reviews (AARs) are tools that help us understand how an incident arose and how we can apply corrective actions. FBOP agrees that the reports resulting from AARs provide more detailed information surrounding an AICs death than other required death documents such as MLMRs. Given that AARs compile information providing a more complete picture of the circumstances leading to a death and can help us identify factors and deficiencies that may help reduce the risk of future deaths, we are considering expanding our AAR policy to require AARs for non-suicide deaths.

All deaths in our facilities (except legal executions) undergo an MLMR process conducted by a multidisciplinary team of institution Health Services employees and executive leadership. This requirement is a quality improvement process that affords the institution the opportunity to identify clinical and administrative processes that can be improved through corrective actions or root cause analyses. Additionally, all AIC deaths—whether they occur by homicide, accidental, natural, or unknown factors—are investigated and reported through a Report of Incident by the institution; and current policy allows the Regional Director (RD) the discretion to appoint an After-action Review Team to further investigate the incident and prepare an AAR.

FBOP Program Statement 5500.14[11] addresses AARs in Chapter 6, and already includes "homicides" as a major incident requiring after-action review and reporting. Additionally, "other incidents as identified by the respective RD and Assistant Director, Correctional Programs Division" may also be considered major incidents requiring after-action review and reporting.

The program statement also indicates that, "[w]hen a major incident occurs at a Bureau or contract facility, the RD may, at his or her discretion, appoint an After-Action Review Team to investigate the incident and prepare an [AAR]." This provision allows RDs discretion to consider all aspects of an incident and use sound correctional judgement in determining when an After-Action Review Team should be assembled. Therefore, current policy already allows RDs, in their discretion, to designate deaths by accidental and unknown factors as major incidents requiring after-action review and reporting, on a case-by-case basis. However, notwithstanding the review processes that are currently in place, we will assess ways to enhance our review processes so they can reach the level of effectiveness of AARs.

Tracking Reports and Recommendations

FBOP has established numerous processes and mechanisms that have the potential to shed light on the circumstances surrounding AIC deaths, identify areas of improvement, and yield recommendations. OIG recommends we clarify responsibility for tracking, at an enterprise level, reports and recommendations required in the wake of an AIC death by suicide, homicide, accident, or unknown factors, and assess the information contained therein for broader trends, applicability, and implementation.

FBOP concurs with OIG's recommendation. HSD's Population and Correctional Health Branch, Quality Improvement Section already holds quarterly meetings with the Reentry Services Division, the Correctional Programs Division, and the Office of General Counsel—each of which has an intersection with mortalities—to review all deaths in the previous quarter. These meetings ensure accurate and coordinated data sharing between divisions and have already assisted in accurate reconciliation of death information. Going forward, we will explore processes to improve communication between divisions who are primarily responsible for the report types that may be indicated following an AIC death, ensuring each

[11] "Correctional Services Procedures Manual"

division is aware of work being conducted in other divisions, and has access to final reports and recommendations issued through those reports.

Electronic Devices and Inmate Security

Our employees use pat searches, visual searches, and electronic searches to ascertain whether an AIC has smuggled contraband within the facilities. It is important for correctional officers to thoroughly search AICs for items such as weapons, because it allows us to circumvent instances in which a weapon is used to commit suicide or harm a fellow AIC or FBOP personnel.

OIG recommends we evaluate existing electronic devices used for AIC screening to identify whether they are functioning as intended, and, if necessary, implement any needed adjustments or upgrades. We concur with this recommendation and will continue to evaluate, identify, and implement adjustments and/or upgrades. FBOP uses several devices for electronic screening, including well-established whole-body imaging metal detection technologies, and new security technologies like contraband cellphone identification and mitigation and Counter Unmanned Aircraft Systems (C-UAS) identification and mitigation. In FYs 2022 and 2023, our Office of Security Technology evaluated whole-body imaging devices that were deployed in 2012 and were end-of-life; then, they initiated replacement of these devices with newer technology that offers higher fidelity x-ray scans for contraband identification. We are already upgrading our technology and we are routinely evaluating existing equipment to determine if it needs to be upgraded. We will continue to review and invest in new technologies for AIC screening.

Further, we are pleased to report that even before the passage of the Prison Camera Reform Act, FBOP began conducting a nationwide review to assess its prison camera coverage and identify areas of limited or zero visibility. Following the review, during which institutions identified areas of limited or zero visibility, the number of additional cameras needed, and the associated costs to adequately address the identified blind spots, FBOP started installations and upgrades system-wide including blind spots assessments, supporting equipment, and camera installation.

Conclusion

Chairman Durbin, Ranking Member Graham, and Members of the Committee, thank you for this opportunity to speak on behalf of the Federal Bureau of Prisons and its dedicated employees throughout the country. I am grateful to have had the chance to discuss our plans to minimize the deaths of adults in custody within our institutions. I believe in the importance of transparency and oversight, and I look forward to continuing to work with the Committee. Our mission at the Bureau is challenging but critical to the safety and security of the public, our employees, and individuals housed within our facilities. Thank you again for the opportunity to speak with you today, for the support we have seen from Members of this Committee, and your continued support as we move forward.