OPENING STATEMENT

Chair Jon Ossoff
Permanent Subcommittee on Investigations (PSI)
Homeland Security and Governmental Affairs Committee (HSGAC)

Hearing titled, **"Corruption, Abuse, and Misconduct at U.S. Penitentiary Atlanta"**
Tuesday, July 26, 2022

In the course of conducting this ten-month bipartisan probe, the Subcommittee has secured and reviewed thousands of pages of internal documents from the Bureau of Prisons and interviewed nearly two dozen BOP whistleblowers and other witnesses, including current and former USPA staff, federal judges, defense attorneys, and former senior leaders at the Bureau of Prisons.

The totality of this evidence uncovered thus far paints a harrowing picture of a federal prison in crisis for many years. Internal BOP records reveal that, for years, some Correctional Services staff at USPA acted with impunity and even lacked regard for human life. The facility was extremely dangerous and insecure. Vast quantities of contraband, including weapons and narcotics, flowed through the prison, enabled by corrupt staff. Conditions for inmates were abusive and inhumane, and should concern all of us who believe in our country's constitutional traditions—that all people have an Eighth Amendment right to be free from cruel and unusual punishment and a Sixth Amendment right to counsel.

These were stunning failures of federal prison administration that likely contributed to the loss of life; jeopardized the health and safety of inmates and staff; and undermined public safety and civil rights in the State of Georgia and the Southeast Region of the United States.

Interviews and records reveal a facility where inmates, including presumptively innocent pretrial detainees, were denied proper nutrition, access to clean drinking water, and hygiene products; lacked access to medical care; endured months of lockdowns with limited or no access to the outdoors or basic services; and had rats and roaches in their food and cells. One federal judge described USPA an embarrassment to the judicial system and noted that incarceration at USPA is like adding another layer of punishment due to the appalling conditions.

Another federal judge wrote a letter to the USPA Warden in January 2022 of this year citing abusive conditions at the prison that were reported to him, including detainees subjected to "a month of twenty-four hour solitary confinement with only a Bible for entertainment or reading," "no change of clothes for several weeks," "lack of access to mail," "a week with only a paper jumpsuit and paper blankets for an inmate on suicide watch," and "blockage of written communications between attorney and client."

But records unearthed by the Subcommittee reveal that gross dysfunction and misconduct at this facility have persisted for at least nine years. And perhaps most striking about the internal BOP assessments and audits we have uncovered is that the most damning information was in the possession of BOP itself, hiding in plain sight. Its own audits of the Correctional Services

Department and the circumstances associated with the numerous inmate suicides at USP Atlanta, which identified the same repeated deficient practices year after year, staff misconduct, and security lapses.

For example,

- A July 2014 audit scored USPA's Correctional Services Department as "deficient," finding, among other things, the assignment of unqualified staff to armed posts, mishandled video footage of use of force incidents, failure to conduct rounds in the Special Housing Unit; failure to use spectrometers to detect contraband; deficient inmate disciplinary processes; and failures to implement suicide prevention policies.

- A December 2015 audit scored USPA's Correctional Services Department as "deficient," finding, among other things, the assignment of unqualified staff to armed posts, failures to conduct rounds in the SHU, failures to search for contraband, and failures to train staff in suicide prevention.

- A May 2017 audit scored USPA's Correctional Services Department as "at risk," finding, among other things, that USPA was improperly storing and failing to log large quantities of seized narcotics; improper prison weapons management; failure to conduct rounds in the SHU; and failure to maintain awareness of inmate whereabouts.

- An October 2017 suicide investigation found that "staff responded with no apparent sense of urgency" to the inmate hanging in his cell, staff logged no rounds on the inmate's SHU range that day, no evidence pertaining to the suicide was retained, and inmate orderlies in the SHU were "freely passing contraband items to inmates under their cell doors."

- A November 2018 suicide investigation found that "staff who initially responded to the medical emergency did not appear to have a sense of urgency" and officers did not conduct rounds before the suicide. Officers failed to supervise inmate orderlies working on the SHU who were caught on camera passing contraband to inmates under their cell doors.

- An August 2019 inspection reported missing weapons; significant failures to follow use of force, medical, and rape prevention policies; improper or non-use of metal detectors and spectrometers to detect contraband; failure to conduct rounds in the SHU; deficient inmate disciplinary processes; and fundamental failures in staff training, including weapons training and staff situational awareness.

- An October 2019 suicide investigation found that staff failed to perform SHU rounds on the day of the suicide during the period immediately before, during, and after the suicide; "a delay in the initiation of lifesaving measures;" and mishandling of evidence.

- An August 2020 suicide investigation noted that past investigations "have made many of the same recommendations noted in this report: the need for attention to detail, adherence to BOP policy, and regard for human life among Correctional Services staff . . . Once again, this reconstruction revealed complacency, indifference, inattentiveness, and lack of compliance with BOP policies and procedures. These lapses contribute to a dangerous and chaotic environment of hopelessness and helplessness, leaving inmates to their own means to improve their quality of life. Staff and inmate safety is not prioritized."

- An August 2020 Security Assessment found that USP Atlanta does not have strong internal controls to ensure institutional security. Staff were observed not in proper uniform and in some cases unaware or unconcerned of their immediate surroundings. . . . There appears to be a lack of oversight throughout the institution. . . In most cases staff indicated that they were not trained or were unsure of procedures vital to the overall operation. . . . USP Atlanta presents significant security concern for the Southeast Region. Both national and local policies are being violated on a regular basis. . . . USP Atlanta requires immediate corrective action.

- An October 2020 suicide investigation found that USP Atlanta has a serious problem with the availability of synthetic cannabis. Past reconstruction team members have noted they can smell synthetic cannabis in the air when visiting the Special Housing Unit (SHU) and the DCU [the jail at USPA]. Synthetic cannabis use has been linked to several BOP suicides. . . . USP Atlanta's failure to address this major problem at an institution level is contrary to policy and this agency's mission. . . . Of the four most recent suicides at USP Atlanta, including [the instant one], all four were actively using substances at USP Atlanta.

- A November 2020 suicide investigation found that between 2012 and 2020, 12 inmates have died by suicide at USP Atlanta, and four of those deaths occurred between October 2019 and November 2020. "Past reconstruction teams have made many of the same recommendations noted below in this report: the need for attention to detail, adherence to BOP policy, and regard for human life among Correctional Services staff, and, at times, other departments. Once again, this reconstruction revealed complacency, indifference, inattentiveness, and lack of compliance with BOP policies and procedures. These lapses contribute to a dangerous and chaotic environment of hopelessness and helplessness, leaving inmates to their own means to improve their quality of life."

In one instance, prison staff had to borrow a razor blade from a prisoner to cut the ligature suspending a prisoner who had hung himself in his cell. In another instance, officers intentionally disabled drug detection equipment used to identify trace amounts of narcotics coming into the prison at one of the entrances. As of last summer, USPA had over 170 delinquent internal investigations underway into staff at the facility.

Today, our witnesses include two individuals with more than 45 years of combined experience working within the Bureau of Prisons and several years working at the U.S.

Penitentiary Atlanta. Dr. Ramirez, who comes forward today as a whistleblower, previously served as the Chief Psychologist at USPA and remains employed by the BOP. Ms. Whitehead previously served as the Jail Administrator at USP Atlanta and recently retired after nearly 30 years of service.

Dr. Ramirez, Ms. Whitehead, I applaud your courage in coming forward to speak publicly about your personal experiences working at the U.S. Penitentiary Atlanta and at the Federal Bureau of Prisons. I know this was not an easy decision for you. And I know I speak for the Subcommittee when I say that we are grateful for your bravery today.

Our investigation is also about the impact of corruption and dysfunction at USP Atlanta on the criminal justice system and the rights of incarcerated people. Many of these individuals have not even gone to trial yet or been convicted of a crime. Today we will hear from Ms. Shepard, who will testify about her clients' experiences at USP Atlanta.

Later, we will hear from BOP Director Carvajal, who was the Assistant Director for Correctional Programs from 2018 until 2020, with oversight over Correctional Services nationwide, and who has served Director of the agency since 2020.