U.S. Department of Justice

Office of the Deputy Attorney General

Associate Deputy Attorney General

Washington, D.C. 20530

May 11, 2021

The Honorable Henry J. Kerner
Special Counsel
Office of the Special Counsel
1730 M. Street, N.W., Suite 300
Washington, D.C. 20036-4505

Re: OSC File No. DI-20-0698; Investigation Regarding Whistleblower Complaint Concerning Metropolitan Correction Center New York

Dear Mr. Kerner:

I am responding to your June 5, 2020 letter in which you conclude that allegations raised by an employee of the United States Department of Justice, Federal Bureau of Prisons (BOP) constitute a substantial likelihood that a violation of law, rule, or regulation has occurred. Specifically, a federal employee at the Metropolitan Correction Center (MCC) New York alleged that BOP staff may have mishandled prisoners and their property when in late February and early March 2020, the MCC temporarily limited inmate movement and conducted mass searches of all areas in the facility as BOP staff sought to locate a contraband firearm. Staff members from other institutions were temporarily assigned to the MCC to provide resources for the extensive search operation, and a firearm ultimately was recovered as a result of these efforts. Authority has been delegated to me to review and sign the Department's response, in accordance with 5 U.S.C. 1213(d).

As reflected in the attached report, the BOP Office of Internal Affairs initiated an investigation upon receiving the referral from your office. That investigation concluded that while some allegations were supported, others were not. In particular, the investigation revealed sufficient evidence that: (1) proper dry cell procedures (procedures used to determine if an inmate is hiding on their person contraband) were not always conducted in accordance with policy; and (2) there were issues with inputting accurately data into an inmate tracking system. The investigation revealed that due to the exigent circumstances of having to quickly but thoroughly search the entire facility to determine whether a contraband firearm had been introduced into the facility, these administrative policy requirements were not completely followed.

The investigation established, however, that during the lockdown and search for the firearm, staff took measures to ensure operations continued in an appropriate and reasonable manner, and when MCC leadership became aware of problematic issues, they took what the believed to be the best corrective action that could be implemented under the conditions in which the MCC was operating. The investigation concluded that these actions were reasonable under the exigent circumstances. No

long-term problems resulted from the measures used during the search for the weapon, and as a result of the search, the firearm was located.

The Department of Justice Office of Inspector General is currently investigating the introduction of the firearm into the facility. Due to the unusual and unprecedented nature of the search operation, the investigation resulted in no long-term recommendations to agency policies and practices used in daily operations. However, the investigation recommended that BOP review contingency plans with respect to certain policies for emergency situations, and BOP will undertake that review.

Sincerely,

Bradley Weinsheimer

Bradley Weinsheimer
Associate Deputy Attorney General

United States Department of Justice
Federal Bureau of Prisons

Office of Internal Affairs

Report of Investigation

OSC File Number DI-20-0698

Subject: INVESTIGATION REGARDING A WHISTLEBLOWER ALLEGATION OF VIOLATION OF LAW, RULE, OR REGULATION; GROSS MISMANAGMENT; AN ABUSE OF AUTHORITY AT THE METROPOLITAN CORRECTIONAL CENTER (MCC) NEW YORK.

SYNOPSIS

This investigation was initiated based upon a whistleblower disclosure alleging that employees of the United States Department of Justice (DOJ), Federal Bureau of Prisons (BOP), assigned to the Metropolitan Correctional Center (MCC) New York may have engaged in conduct that constitutes a violation of law, rule, or regulation, gross mismanagement, and an abuse of authority. The Office of Special Counsel (OSC) received these allegations from Associate Warden [redacted], at MCC New York, who consented to the release of her name.

MCC New York received reliable intelligence in February 2020 that an inmate may have had a contraband firearm inside of the facility. Unprecedented modifications to institution operations were implemented from February 27, 2020, through March 13, 2020 to temporarily limit inmate movement and to conduct mass searches of all areas to find or eliminate the possibility of there being a contraband firearm inside the facility. Staff members from other institutions were temporarily assigned to the MCC to provide resources for the search operation. Further, outside staff were used as at that time it was unknown if a MCC staff member was involved in the introduction of the weapon.

As an Associate Warden at MCC New York, Ms. [redacted] was part of the facility's leadership team, reporting as a second in command to the Warden. Ms. [redacted] was an Associate Warden at the facility from July 2019 to present. Associate Warden [redacted] made numerous allegations of staff misconduct by temporarily assigned staff that she alleged occurred during the search for the weapon, to include:

- Dry cell procedures were not followed during the mass shakedown;
- The location and identities of inmates were not properly tracked;
- Inmates were not provided proper clothing and linen after visual search process;
- Personal property, legal paperwork, and other documentation were not returned to inmates promptly or at all;

- Inmates were not assigned safe housing, in consideration of gang affiliations and other potentially problematic groups;
- Inmate witnesses in court procedures were not transported separately from general inmates; and
- Two of the response units - the Special Operations Response Team (SORT) and the Disturbance Control Team (DCT) - did not go through proper screening protocols to ensure that contraband or other inappropriate items did not enter the facility.

On June 5, 2020, OSC referred this matter to the Attorney General for investigation. On July 22, 2020, the Bureau of Prisons (BOP), Office of Internal Affairs (OIA), received notice of the need for an investigation.

Between October 5, 2020, and October 9, 2020, the OIA conducted an on-site investigation at MCC New York. The OIA conducted interviews and gathered and reviewed additional documentary information. During the investigation, eleven staff members were interviewed.

No witnesses were offered confidentiality for their responses, and no witnesses requested or were granted confidentiality for their responses. Notice for the on-site investigation was provided to the MCC Warden. The witnesses were not provided notice of the investigation prior to the interview.

No other investigations or reports from other investigations were relied upon as substitutes for the OIA investigation of this case.

In summary, while some allegations were supported, others were not. In particular, the investigation revealed sufficient evidence that: (1) proper dry cell procedures were not always conducted in accordance with policy; and (2) there were issues with inputting accurate SENTRY data showing the locations of inmates during the lockdown. The investigation revealed that due to the exigent circumstances, these administrative policy requirements were not followed. During the lockdown and search for the firearm, staff took measures to ensure operations continued in an appropriate and reasonable manner, and when EX2 became aware of problematic issues, she attempted to take the best corrective action that could be implemented under the conditions in which the MCC was operating. No long term issues resulted from the measures used during the search for the weapon, and as a result the firearm was located on March 5, 2020. The Office of Inspector General of the Department of Justice is currently managing the investigation into the weapon introduction. Due to the unusual and unprecedented nature of the search operation, there are no long-term recommendations to agency policies and practices used in daily operations. However, a review of contingency plans for emergency situations is recommended.

INVESTIGATION

Background:

MCC New York is located in the Federal judicial district of the Southern District of New York. The MCC is a 12 story Administrative facility, with a total of ten single housing units of multiple occupancy cells and one open bay/dormitory type unit. The MCC houses all security levels from

inmates facing minimal federal charges to international terrorists facing trial. The facility houses approximately 800 pretrial and holdover, male and female inmates, who are going through the judicial process. The MCC has a complicated operation, to include housing inmates that have been identified by the U.S. Attorney's Office or other law enforcement agencies that need to be separated from other inmates at the facility while pending trial. There are nearly 500 separation cases, with approximately 300 of these having at least one inmate separation also at the MCC. A lockdown[1] was implemented February 27, 2020, through March 13, 2020 at MCC New York. This lockdown was initiated due to intelligence that was deemed reliable from an inmate source that a firearm was introduced into the MCC. The purpose of the lockdown was to temporarily limit inmate movement and to conduct mass searches of the entirety of the MCC, to either find the weapon, or eliminate the possibility of a firearm being inside the facility.

Warden EX2 said the MCC was locked down from approximately February 27, 2020, through March 13, 2020, due to the report of a weapon introduction. EX2 stated she notified the Regional Director and they made arrangements for Disturbance Control Teams (DCT)[2] and Special Operations Response Teams (SORT)[3] from other institutions to deploy to the MCC to search the institution. The extraordinary response and deployment of staff was due to the serious nature of the circumstances, the significant threat to staff and inmate safety, and the security of the institution. Staff were deployed to the MCC to provide resources for the search operation, and because at that time it was unknown if an MCC staff member was involved in the introduction of the weapon. The deployed DCT and SORT employees are referenced herein as Temporary Duty[4] (TDY) staff.

Allegation 1. ***Dry cell procedures were not followed during the mass shakedown.***

Policy Requirements:

Federal Bureau of Prisons (BOP), Program Statement 5521.06, Searches of Housing Units, Inmates, and Inmate Work Areas, outlines the dry cell procedures for inmates incarcerated within the BOP. Dry cell status is often appropriate when staff believe an inmate has ingested contraband. When there is reasonable belief that an inmate has ingested contraband or concealed contraband in a body cavity, the Warden or designee may authorize the placement of an inmate in a room or cell for the purpose of staff closely observing the inmate until the inmate has voided the contraband or sufficient time has elapsed to preclude the possibility that the inmate is concealing contraband.

[1] A lockdown at a BOP facility is typically initiated due to an institutional emergency resulting from a security concern, disturbance within the inmate population, or other situation that poses a risk to the facility if it continues to operate under normal procedures. During a lockdown, inmate movement is significantly reduced, or even eliminated. A lockdown may result in alternative feeding procedures, cancellation of visitation and recreation, limited inmate to inmate interaction, and other actions deemed necessary to eliminate the immediate security concern, disturbance, or risk to the facility.
[2] DCT is used during emergency situations, often used to disperse crowds, move participants, and gain control of a crisis situation. Specialized training is required for team members.
[3] SORT is used during emergency situations, specifically designed to have a flexible and effective response to unconventional and high-risk situations. Specialized training is required for team members.
[4] TDY references staff not permanently assigned to that facility, but temporarily assigned.

Allegations:

[redacted] stated dry cell procedures were not properly followed during the lockdown. Specifically, [redacted] stated that inmates were placed in dry cells together, that appropriate log book information was not maintained, and that inmates did not go to district court proceedings as a result.

According to [redacted], she did not know if inmates were placed together in Special Housing Unit[5] (SHU) recreation areas or in the housing units. [redacted] stated there was no proper documentation to show justification of the inmates placed on this status. Lieutenant CS1 and Lieutenant CS2 were the staff who told her ([redacted]) about inmates being placed on dry cell status. CS1 is on extended sick leave and could not be interviewed. CS2 resigned from the BOP and could not be interviewed.

In addition, according to [redacted] inmates missed court appearances due to being on dry cell status According to [redacted], she contacted Correctional Services Specialist TDY1, who was Acting Captain at the time. [redacted] said TDY1 did not provide any information. [redacted] stated she informed EX2 verbally and sent her a follow up e-mail. [redacted] said she also emailed EX2 in an attempt to get information on inmates who could not go to court because of dry cell status.

Investigation:

According to Associate Warden EX3, she did not have any knowledge of any inmates on dry cell status until she reported to duty during the lockdown. EX3 initially stated she did not observe any inmates on dry cell status, then clarified that she remembered on one occasion, while conducting rounds, seeing inmates in the SHU recreation area who she believed were on dry cell status.

Staff members TDY1, TDY2, TDY3, and TDY5 all described substantially similar operations. According to these staff, inmates were escorted from their cells to Receiving and Discharge[6] (R&D) to be run through the RapidScan and Cellsense[7] to check for contraband. If the electronic screening detected contraband, and staff could not retrieve the contraband, the inmate was placed on dry cell status. Ordinarily, there should only be one inmate assigned to one cell during dry cell status; however, due to the number of inmates on dry cell status and limited cell space, they made the decision to have more than one inmate in an area. TDY staff were assigned to monitor these inmates, as there was more than one inmate in the area. If an inmate had to provide a sample, the inmate was removed from the area and taken to a place to provide the sample away from other inmates. The TDY staff retrieved drugs and cell phones from the inmates placed in dry cell status.

[5] SHUs are housing units in Bureau institutions where inmates are securely separated from the general inmate population, and may be housed either alone or with other inmates. SHUs help ensure the safety, security, and orderly operation of correctional facilities, and protect the public, by providing alternative housing assignments for inmates removed from the general population.
[6] R&D is an area inside BOP facilities in which all inmates entering or exiting the facility are taken for search, screening and processing when exiting or entering the facility. This area contains specialized screening equipment.
[7] Cellsense is an advanced screening system that detects ferrous metal contraband, including all cell phones when on or off, and anywhere on the person or internalized.

According to Associate Warden TDY4, he was assigned as the Operations Section Chief[8] and worked 7:00 a.m., to 7:00 p.m. TDY4 stated he does not recall any inmates ever being held back from court because of dry cell status. TDY4 stated recreation rooms in the general housing units and in the SHU were used as dry cells.

According to EX2, inmates were taken to R&D to go through the RapidScan and Cellsense machines. EX2 stated there should have been a log book for inmates who are visually searched and processed through the RapidScan; however, she does not know if there were times when the documentation was not being maintained. According to EX2, when she recognized problems, she immediately addressed the issues with staff.

According to EX2, inmates should have been placed on dry cell status in the SHU after being scanned. EX2 said she was not aware of any inmates being placed in recreation rooms together for the purpose of dry cell status. EX2 stated there was a time she recalled one inmate being placed on dry cell status in R&D, but he was in the cell alone. According to EX2, at times procedures were not being followed by the MCC staff or lieutenants when dealing with dry cell status, and once they were made aware of these discrepancies, they corrected the issue. EX2 stated one of the issues was inmates were being taken off of dry cell status too soon and another issue was a log book was not being utilized. EX2 said the lieutenants were informed and instructed not to take an inmate off of dry cell status without first notifying the captain.

EX2 said she had to rely on TDY staff for this function, and reassign multiple MCC staff due to allegations of staff misconduct involving contraband throughout the facility. EX2 stated approximately six staff were reassigned.[9]

EX2 stated she does not recall any inmates not being able to go to court because of dry cell status. EX2 said if an inmate was on dry cell status they would not go to court.

According to EX2, she met personally with the Honorable District Judge NBS1, Executive Director and Attorney-in-Chief NBS2 of Federal Public Defender Service, Attorney-in-Charge of the Federal Public Defender Service NBS3, and BOP Consolidated Legal Center Attorney EX4 to notify them of the lockdown. EX2 stated they were fully aware that inmates may not be going to court, receive legal visits, or receive legal phone calls during that time.

Conclusions:

During the investigation there was evidence to suggest that the usual procedure of placing inmates in a dry cell alone was not adhered to during this emergency. Several staff admitted that due to the number of inmates on dry cell status, there were not enough spaces to secure the inmates and observe them properly while on dry cell status. Therefore, staff did allow inmates on dry cell status to come into contact with other inmates which is contrary to Program Statement 5521.06, Searches of Housing Units, Inmates, and Inmate Work Areas. However, as TDY staff were assigned to

[8] Operations Section Chief is an assignment position in an Incident Command Structure, NIMS, ICS, in charge of the Operations Section, and is not a permanent BOP position. The Operations Section is responsible for managing tactical operations at the incident site to reduce immediate hazards, save lives and property, establish situation control, and restore normal operations.

[9] Currently these matters are with the Office of the Inspector General and are being investigated independently.

monitor the inmates, inmate privacy was maintained, and the procedures resulted in significant amount of contraband recovered, there was no specific harm resulting from these actions.

To ensure such violations are not repeated in the future, it is recommended that staff at MCC New York receive additional training on dry cell procedures and the policy provisions that apply.

Allegation 2. ***The location and identities of inmates were not properly tracked.***

Policy Requirements:

Federal Bureau of Prisons Program Statement 5500.15, Correctional Services Manual, provides that housing locations of inmates should be documented in SENTRY, the computer-based records management system that keeps track of inmates incarcerated within the Federal Bureau of Prisons. Federal Bureau of Prisons Program Statement 5500.14, Correctional Services Procedures Manual, states a bed book[10] may be utilized in the event that an institutional count does not initially clear and each inmate will be counted, identifying the inmate using the bed book picture card.

Allegations:

[redacted] stated SENTRY was not updated to reflect inmates' exact locations while on dry cell status, causing delay for court appearances. [redacted] stated inmates were not able to go to court when they were on dry cell status.

[redacted] stated on March 12, 2020, she was informed by Correctional Systems Officer CS3, there were several inmates that could not be located for the morning court line. [redacted] stated in an effort to locate the inmates, she personally went to the housing unit in question to locate and retrieve an inmate to bring him down to court. According to [redacted], she had to ask inmates in the housing unit to identify themselves. [redacted] stated it was difficult due to some of the inmates' identification cards being confiscated, which made it impossible to properly identify inmates.

Investigation:

According to CS3, it was Unit Team's[11] responsibility to key inmate movements internally during the lockdown. CS3 recalled one incident when [redacted] came to R&D and asked why they did not have an inmate produced for court. CS3 does not remember the inmate's name. CS3 informed [redacted] that no one could locate him. CS3 states she, along with [redacted], went into the facility and found him on an unknown unit. CS3 states there were several times when they could not locate inmates. When this would happen, they would notify the lieutenant and the institution would do a lockdown count. CS3 states inmates were not keyed properly because the search teams were moving inmates and not notifying the proper person who was keying inmates into SENTRY. On one occasion, CS3 recalls being told by TDY5 all decisions were on a need-to-know basis and they did not know who they could trust at MCC New York.

[10] A bed book is a book that is maintained by unit and contains a picture card of every inmate assigned to that unit. Currently bed books are digital. A proper bed book count is conducted comparing inmates against a picture card. The picture cards will be used to determine exactly which inmates are missing or present without authorization.
[11] Unit team are staff assigned to Unit Management, which has the responsibility to determine inmate program needs.

According to Case Management Coordinator CS4, typically keying of inmates into SENTRY for bed moves is Unit Team's responsibility. CS4 stated if there was a reason to move an inmate other than for a unit team issue, generally the Counts and Accountability (CNA) Officer would key the inmate into SENTRY. CS4 said during the lockdown, he was unaware who had the responsibility of keying inmates into SENTRY. CS4 stated he does not remember the specifics of the incident, but he recalled where one inmate was not keyed into SENTRY correctly during the lockdown. CS4 said this caused delays finding an inmate for movement. According to CS4, the issue was resolved and he does not recall any other incident of this nature during the lockdown.

According to Associate Warden TDY4, some of the team members which consisted of TDY staff were keying inmates when they were moved and placed on dry cell status. TDY4 said he does recall having a conversation with an R&D supervisor, but could not remember her name. TDY4 stated the R&D supervisor said she needed to be involved with knowing the movement of the inmates and keying them into SENTRY. According to TDY4, he advised her that as MCC staff may be involved in the introduction of contraband, she would not be involved in inmate movement, and she respectfully advised him that was a fair response.

According to TDY1, he recalled a couple of instances in which inmates were not transported to court because of the emergency lockdown. However, inmates were generally transported to court; there were only a couple of instances in which they were not. TDY1 stated he was present in R&D to assist in the process of releasing inmates to the U.S. Marshals Service, so he had firsthand knowledge that they were getting inmates to court. TDY1 said EX2 spoke with the courts and notified them of the emergency at MCC New York. According to TDY1, deployed staff had to take over keying the inmates into SENTRY due to MCC staff refusing to or making numerous mistakes. TDY1 had other experienced TDY staff take over those duties.

TDY2 stated they had a TDY staff member on site in the units while the inmates were escorted from one unit to another. TDY2 said he could not recall the staff member's name who was documenting the moves, but they recorded inmate movements and handed it to local R&D staff so they could enter the movements into SENTRY. TDY2 stated the local staff were making numerous errors and they informed the MCC Executive Staff. According to TDY2, someone from the Western Region took over entering movements. TDY2 said this was approved by the MCC Executive Staff.

EX2 said the MCC historically had systemic issues with SENTRY in the past for inmates' cell assignments, primarily staff not keying inmates into SENTRY when they changed cell assignments, or unauthorized inmates moving to another cell and staff not holding them accountable. EX2 said when she initially arrived at the MCC, the units did not have bed books. According to EX2, she had them ordered and took corrective action to address this issue. EX2 stated two bed book counts are conducted every day, one in the SHU and in one additional unit. According to EX2, once the counts are conducted, the lieutenant sends an email to executive staff to provide assurance that bed book cards are accurate.

Conclusions:

Evidence suggests that during the lockdown, some inmates were moved to other housing units and not keyed into SENTRY appropriately. During this period, it was unknown if staff normally assigned to the MCC were involved in the introduction of the firearm into the facility, which caused communication issues with the TDY staff sent to assist with institution operations and the search procedures. Therefore, there is insufficient evidence to determine who specifically was responsible to key the moved inmates appropriately during to the emergency, due to the number of different MCC and TDY staff involved.

Corrective measures have been implemented. Bed book counts are not required by policy on a daily basis or for every count. However, EX2 determined under the circumstances to make use of this tool as a backup to identify and rectify SENTRY errors. As noted by EX2, two bed book counts are conducted daily, and a lieutenant confirms the counts with an email to executive staff. Also, additional training will be provided to supervisors and staff at MCC New York tasked with SENTRY keying.

Allegation 3. ***Inmates were not provided proper clothing and linen after visual search process.***

Policy Requirements:

Pursuant to Program Statement 4500.12, Trust Fund/Deposit Fund Manual, inmates are to be provided proper clothing and linens.

Allegations:

According to [redacted], she did not witness the visual search process of the inmates during the lockdown. However, she does not believe the inmates received proper linens because on one day, she had to get a cart of linens to provide to inmates who did not have any linens. [redacted] stated she and Correctional Officer CS5 worked together on March 6, 2020, to distribute linens to the entire unit of 7 North. According to [redacted], while passing out linens, she observed several inmates not in possession of linens or blankets in their cells, nor were they in possession of jumpsuits, all of which they should have possessed overnight, or from when they were placed in their cell. [redacted] said they were wearing shorts and t-shirts. [redacted] stated no inmates expressed to her that they did not have linens.

Investigation:

According to CS5, he recalled being assigned to unit 7 North on March 6, 2020. CS5 stated he assisted [redacted] with handing out linens to the inmates. According to CS5, these inmates transferred from another unit, but does not know how long they were in the unit. CS5 stated some of the inmates did have bedrolls and some did not. CS5 said he does not know how long the inmates had no bedrolls because he and [redacted] had just arrived in the unit. CS5 stated at no time did an inmate express to him that they did not have linens overnight.

According to TDY1, TDY2, and TDY3, inmates received proper clothing and linens when they were escorted to clean units. TDY1 said TDY staff took over the laundry procedures at night so the inmates could have clean clothing and laundry. TDY1 stated they conducted searches after normal business hours, as they were running a 24-hour operation. TDY1 stated they usually searched two units during the day and two units at night. At night, the inmates received proper linens and clothing.

EX2 said she was not aware of inmates not receiving linens and clothing in a timely manner when they were removed from a housing unit and placed into another. EX2 stated she recalled borrowing linens from another institution to ensure a sufficient supply for all the moves due to the lockdown and mass shakedown. According to EX2, staff were assigned to continually launder linens to ensure inmates received clean clothing and linens. EX2 said if an inmate had not received new clothing or linens, it was rectified as soon as possible.

Conclusions:

The investigation revealed insufficient evidence to support any misconduct findings regarding the allegation that inmates were not provided clothing or linens. While [redacted] reported that inmates in one unit did not have linens or proper clothing, the investigation did not reveal inmates were without linens for an unacceptable time or that inmates complained of not having proper linens. The investigation otherwise revealed that staff took steps to ensure inmates had proper linens, and that EX2 made certain that linens were obtained from other institutions while linens and clothing otherwise were being laundered. This was a reasonable response to an emergency situation.

Allegation 4. Personal property, legal paperwork, and other documentation were not returned to inmates promptly or at all.

Policy Requirements:

According to Federal Bureau of Prisons Program Statement 5580.08, Inmate Personal Property, when inmates are transferred to new housing units for segregation, transferred to another institution, depart the institution without an expected return, or there is a need to store an inmates property; their personal property should be packed and documented by staff members, and the inmate provided a property form.

Policy does not require inmate property to be packed, inventories, and documented when inmates are moved from one unit to another unit within the same facility unless they are being sent to segregation.

Allegations:

According to [redacted], when the search teams conducted cell searches, they confiscated and threw property in trash bags and in blankets. [redacted] said this included identification cards and legal work. [redacted] stated over the time of the lockdown, she observed bags of property left unsecured everywhere, without an inmate personal property form attached. [redacted] said the process was disorganized and inmates complained about property and legal work missing. According to [redacted],

when the property was returned, the inmates complained that legal work and other personal effects were missing, and other inmates complained they have yet to receive any property back.

Investigation:

According to TDY3, TDY4, and TDY5, teams began by searching the housing unit from where the inmates were removed. TDY5 stated during the searches, property was x-rayed and bagged inside the cell. These staff did not recall or witness property inventory forms being completed, but the bags were labeled with the inmates' names housed in that cell. The bags were then transported to the inmates in the new housing unit and given to the owner of that property. Contraband that was found in the cells was processed by MCC Special Investigative Services (SIS) staff and the TDY Evidence Recovery Team[12] (ERT).

According to EX2, the inmate's property from each housing unit being searched would be bagged in plastic bags with either handwritten identification of the inmate for which the property belonged, or an ID card was placed in the bag and transported to R&D to be scanned. EX2 said once the property was scanned, it was placed in a large wheeled bin with identification for which unit from which the property had been removed. EX2 stated she did not witness property placed in blankets. EX2 said property was not inventoried because they were looking for a weapon and time was of the essence, but the property was identified with handwritten identification or an ID card.

Conclusions:

The movement of inmate personal property from one unit to another was conducted consistent with policy. Typically, when an inmate is moved from one cell or unit to another, the inmates transport their own property. Different procedures were used in this situation due to the need to scan the property for contraband. Given the exigent circumstances, staff made every attempt to ensure all inmate property was secured and labeled with the inmate's name. Personal property was secured with the identification or name of the inmate possessing the personal property.

Allegation 5. Inmates were not assigned safe housing, in consideration of gang affiliations and other potentially problematic groups.

Policy Requirements:

Federal Bureau of Prisons Program Statement 5180.05, Central Inmate Monitoring System, provides that inmates placed on separation status[13] should not be housed in units with certain inmates due to gang affiliation, cooperating witness status, etc.

[12] ERT are a group of staff that work in an integrated fashion to gather and collect evidence and manage scenes. Specialized training is required for team members.

[13] Inmates who may not be housed together who are presently in federal custody or who may come into federal custody in the future.

Allegations:

According to [redacted], she was not directly aware of any inmates being placed in housing units with separation status from another inmate, or problematic inmates being housed together. However, [redacted] stated due to the numerous issues of inmates not being properly keyed into SENTRY, it would be impossible to determine with certainty that inmates were not housed with a separatee or problematic inmates.

Investigation:

TDY1, TDY2, and TDY5 stated they are unaware of any separatees being placed in the same unit. The inmates that were already housed in the same unit, moved together to the new unit.

EX2 was not aware of any separate being placed in the same unit.

Conclusions:

The investigation revealed insufficient evidence to support any misconduct findings regarding the allegation that inmates were not assigned to safe housing. Inmates were properly screened, cleared of separation concerns, and were currently being housed together were moved together to another unit. Because inmates were moved with other inmates already in their unit, there is no reason to believe separation orders were violated.

Allegation 6. Inmate witnesses in court procedures were not transported separately from general inmates.

Policy Requirements:

Federal Bureau of Prisons Program Statement 5540.08, Prisoner Transportation Manual, provides that inmates with separation status should not be transferred to other facilities together.

Allegations:

According to [redacted], there was a group of six inmates that were all involved in three different cases and were assigned separation. [redacted] stated they were scheduled to be transported to FCI Otisville due to the lockdown at the MCC. [redacted] stated she discovered the mistake of the six inmates being scheduled to be transported together when she reviewed the bus list. [redacted] stated CS4 confirmed the inmates should not have been scheduled to be transported together, and [redacted] confirmed that ultimately the inmates did not travel on the same bus.

Investigation:

EX2 stated she was not involved in the planning process of inmates being transported to FCI Otisville, but she was not aware of any separatee inmates being transported to FCI Otisville on the same bus.

Conclusions:

The investigation revealed insufficient evidence to support any misconduct findings regarding the allegation that inmate witnesses in court proceedings were not transported separately from general inmates. [redacted] is part of a systematic, multilayered review process to prevent inmates assigned separation from being transported together. As such, the inmates were not transported together and no violation occurred. [redacted] confirmed inmates assigned separation status from each other were not transported together.

Allegation 7. ***Two of the TDY SORT and DCT teams did not go through proper screening protocols to ensure that contraband or other inappropriate items did not enter the facility.***

Policy Requirements:

According to Program Statement 3740.02, Staff Entrance and Search Procedures, all staff members entering a correctional facility will undergo screening procedures, to include clearing a metal detector. X-ray screening may be used routinely, or in addition to, visual searching of personal containers and belongings.

Allegations:

[redacted] stated she observed on two occasions, both TDY SORT and DCT teams entered the institution through the rear dock without being properly screened through the walk-through metal detector or the use of a hand held metal detector, nor were their personal belongings subject to search via the x-ray machine. [redacted] said there is a walk-through metal detector in the warehouse area, but it is not operational.

According to [redacted], there was no staff checking the teams' bags prior to coming into the institution. [redacted] stated both teams were from other institutions throughout the BOP. [redacted] stated on one occasion, she was in the Command Center and observed via camera, teams enter the institution through the rear dock without being properly screened. [redacted] stated on another occasion, she observed and was present when TDY2 allowed the teams to enter the institution through the rear dock without being screened. [redacted] did not provide dates or times at which the alleged violations occurred.

Investigation:

EX3 did not observe team members enter the institution at the rear dock and also did not observe if team members were screened or not screened, prior to entering the facility. EX3 stated she does not know if they were utilizing the staff screening site located in the front entrance on a regular basis.

According to Special Investigative Agent CS6, when the first DCT and SORT teams arrived, they placed their equipment at the rear dock. CS6 said he then escorted them around to the front entrance screening site. CS6 stated he is unaware if after that night those teams utilized the

screening site. CS6 said the teams staged their equipment at the rear dock during the time they were there and there was an operable metal detector at the rear dock.

According to TDY3 and TDY5, during the lockdown the rear dock served as a staging area for equipment utilized by the teams. TDY3 and TDY5 reported that the team members would enter the institution either through the door from the rear dock into the institution, or the front staff entrance. According to TDY3 and TDY5, all team members, prior to entering the facility, were identified and screened either through a walkthrough metal detector or a handheld metal detector.

According to EX2, she was unaware of the entrance and screening procedures utilized by the DCT and SORT teams that entered the facility. EX2 did not report receiving a complaint from [redacted] that screening procedures were being disregarded.

Conclusions:

The investigation revealed insufficient evidence to support any misconduct findings regarding the allegation that SORT and DCT entered the facility without being screened. Even though staff stated SORT and DCT did not utilize the front entrance staff screening area at all times, there was an operational metal detector at the rear dock where SORT and DCT entered the facility and team leaders TDY3 and TDY5 stated all SORT and DCT staff were screened. The operable metal detector at the rear dock was also confirmed by CS6.

Investigative Findings Summary:

The investigation revealed sufficient evidence that: (1) proper dry cell procedures were not always conducted in accordance with policy; and (2) there were issues with inputting accurate SENTRY data showing the locations of inmates during the lockdown.

During the time of the lockdown, however, there was a search for a contraband weapon that posed a life safety concern for all staff and inmates, and ultimately the weapon was found and recovered. Deviations from policy occurred during this time due to the grave nature of the mission assigned and the enormous tasks undertaken by MCC staff and TDY staff during the lockdown. However, it does appear as though staff took measures to ensure operations continued in an appropriate manner, and when EX2 became aware of problematic issues, she attempted to take the best corrective action that could be implemented under the conditions in which the MCC was operating.

To avoid these types of challenges in the future, it is recommended that contingency plans used in emergency situations be reviewed to ensure they are comprehensive enough to accommodate situations like that at MCC New York.

Violation of Laws, Rules, or Regulations:

This investigation did not substantiate a violation of law or regulation at the MCC. While the investigation did find some evidence of administrative policy violations, it appears when such violations were discovered, the best corrective action that could be taken under the conditions were implemented. In particular, the investigation concludes that while numerous allegations

were submitted, staff responded appropriately to address staff and inmate safety, search procedures, and inmate accountability.

Action taken or planned as a result of the investigation

(A) Changes in agency rules, regulations, or practices.

1. All staff assigned to MCC New York will receive additional training on proper dry cell procedures.
2. To improve inmate accountability, daily bed book counts were implemented and are now used. There are two bed book counts per day. Although this action was immediately implemented and should be continued until such time as SENTRY is up to date and accurate, this does not address the issue of inaccuracies in SENTRY. Additional training will be provided to supervisors and staff at MCC New York tasked with this function.
3. There will be a review of emergency contingency plans to determine if a specific plan containing more specific procedures for similar emergencies is warranted.

(B) Restoration of any aggrieved employee.

Not applicable.

(C) Disciplinary action against any employee.

Not applicable

(D) Referral to the Attorney General of any evidence of criminal violation.

Not applicable

United States Department of Justice
Federal Bureau of Prisons

Office of Internal Affairs

Supplemental Report of Investigation

OSC File Number DI-20-0698

Subject: INVESTIGATION REGARDING A WHISTLEBLOWER ALLEGATION OF VIOLATION OF LAW, RULE, OR REGULATION; GROSS MISMANAGMENT; AN ABUSE OF AUTHORITY AT THE METROPOLITAN CORRECTIONAL CENTER (MCC) NEW YORK.

SYNOPSIS

The investigation was initiated based upon a whistleblower disclosure alleging that employees of the United States Department of Justice (DOJ), Federal Bureau of Prisons (BOP), assigned to the Metropolitan Correctional Center (MCC) New York may have engaged in conduct that constitutes a violation of law, rule, or regulation, gross mismanagement, and an abuse of authority. The Office of Special Counsel (OSC) received these allegations from Associate Warden [redacted], at MCC New York, who consented to the release of her name. After review of the initial investigation, OSC posed the following questions:

- What actions will MCC take to ensure that such lockdowns or similar emergency situations are handled properly in the future?

  - Specifically, the report states that there will be a review of emergency contingency plans. When will the review be conducted and completed? *See pages 13-14 of Agency Report.*

  - How will the agency ensure that proper dry cell procedures are followed during emergency situations?

  - How will the agency ensure that proper inmate tracking occurs during emergency situations?

  - What actions will the agency take to ensure that the roles of temporary duty (TDY) staff and permanent staff are clear during emergency situations?

  - Please list any other planned actions.

- Please clarify the roles of the permanent staff during the MCC February/March 2020 lockdown, and how those roles differed from the TDY staff.

    - For instance, the report states that it was the Unit Team's responsibility to key the movements into Sentry, but it appears that TDY staff moved inmates without notifying the Unit Team. *See bottom of page 6 of Agency Report.*

    - How will such issues be avoided for future emergency situations?

    - Please provide any other relevant information.

FOLLOW-UP RESPONSES

Inquiry 1. What actions will MCC take to ensure that such lockdowns or similar emergency situations are handled properly in the future?

- Specifically, the report states that there will be a review of emergency contingency plans. When will the review be conducted and completed? *See pages 13-14 of Agency Report.*

- How will the agency ensure that proper dry cell procedures are followed during emergency situations?

- How will the agency ensure that proper inmate tracking occurs during emergency situations?

- What actions will the agency take to ensure that the roles of temporary duty (TDY) staff and permanent staff are clear during emergency situations?

- Please list any other planned actions.

The agency will initiate a review of emergency contingency plans within sixty calendar days. At each institution, there are a number of contingency plans that have been developed to address situations like natural disasters and other major emergencies. The events examined herein suggest that there may be a need to expand existing contingency plans to provide more effective communication and record-keeping when emergencies arise. Among other issues, the review will consider how dry cell procedures should be handled in this type of emergency, or whether modified procedures would best balance the interests at stake. The review likewise will consider documenting the need for policy waivers where, as here, the expectations of policy cannot be met under the circumstances of the emergency. The review will also consider whether, if the requirements of a policy are being waived in an emergency situation, there should be a record of what policy requirement is being waived, how the waiver may impact operations, what alternative procedures should be adopted under the circumstances, and under whose authority the policy

waiver was approved. Finally, the review will examine methods by which documentation could be maintained to demonstrate how the waiver was communicated to staff and stakeholders, as appropriate.

In addition, the agency review of contingency plans will examine if identifying specific roles and duties of TDY staff is possible, while continuing to provide the flexibility that is required in an emergency response. Typically during emergency situations, permanent staff continue to perform their normal duties. However, contingency plans may need to contemplate situations that require widespread reallocation of those duties. In such circumstances, effective lines of communication need to be reestablished as quickly as possible to ensure successful resolution of the emergency.

In addition, the agency will ensure staff at MCC New York receive additional training on dry cell and inmate tracking procedures and the policy provisions that apply.

As previously noted, corrective measures have already been implemented to ensure proper inmate tracking during normal daily operations, as well as during emergency situations. Bed book counts are not required by policy on a daily basis or for every count. However, this tool is utilized during normal operations to immediately identify and rectify SENTRY errors. Until such time as SENTRY errors are minimized, the bed book counts are a reliable, although labor-intensive, backup system.

Inquiry 2. Please clarify the roles of the permanent staff during the MCC February/March 2020 lockdown, and how those roles differed from the TDY staff.

- For instance, the report states that it was the Unit Team's responsibility to key the movements into Sentry, but it appears that TDY staff moved inmates without notifying the Unit Team. *See bottom of page 6 of Agency Report*.

- How will such issues be avoided for future emergency situations?

- Please provide any other relevant information.

Typically, during emergency situations, permanent staff continue to perform their normal duties. However, during this unusual emergency, there was concern that some permanent staff assigned to the MCC could have been involved in the introduction and continued movement of contraband, to include a firearm, making it necessary to reallocate some duties to visiting staff. As noted in the Agency Report, the Office of Inspector General is investigating the introduction of the contraband firearm into the facility and any role that may have been played by permanent staff. As also noted in the Agency Report, under most circumstances, Unit Team is responsible for keying inmate locations into SENTRY. However, they are not the only staff permitted to perform this function. During the mass search, visiting staff moved inmates from unsearched areas of the institution to cleared areas. Because of concerns surrounding possible compromised staff, there were communication failures related to inmate tracking. As part of the agency's review of contingency plans, there will be consideration of situations that require widespread reallocation of duties to visiting staff. In such circumstances, effective lines of communication need to be reestablished as quickly as possible to ensure successful resolution of the emergency.

United States Department of Justice
Federal Bureau of Prisons

Office of Internal Affairs

Second Supplemental Report of Investigation

OSC File Number DI-20-0698

Subject: INVESTIGATION REGARDING A WHISTLEBLOWER ALLEGATION OF VIOLATION OF LAW, RULE, OR REGULATION; GROSS MISMANAGMENT; AN ABUSE OF AUTHORITY AT THE METROPOLITAN CORRECTIONAL CENTER (MCC) NEW YORK.

SYNOPSIS

This initial investigation was initiated based upon a whistleblower disclosure alleging that employees of the United States Department of Justice (DOJ), Federal Bureau of Prisons (BOP), assigned to the Metropolitan Correctional Center (MCC) New York may have engaged in conduct that constitutes a violation of law, rule, or regulation, gross mismanagement, and an abuse of authority. The Office of Special Counsel (OSC) received these allegations from Associate Warden [redacted], at MCC New York, who consented to the release of her name. After review of the initial investigation and subsequent follow-up, OSC posed the following questions:

- Please indicate whether it is proper procedure to include an inmate's identification card among the property that needs to be removed and scanned in an emergency. In addition, please indicate whether the agency is also considering addressing the potential concerns surrounding this action in its review of its emergency contingency plans.

- Please indicate the agency's reason for not interviewing TDY2. In addition, please indicate whether any employee, who worked during the whistleblower's shift during the lockdown, was questioned about the allegation. If not, please indicate the agency's reasons for not interviewing other staff (either TDY or permanent), who worked during the whistleblower's shift.

FOLLOW-UP INQUIRY

Background:

MCC New York is located in the Federal judicial district of the Southern District of New York. As described in the initial report, a lockdown was implemented February 27, 2020, through March 13, 2020 due to intelligence that was deemed reliable from an inmate source that a firearm was introduced into the facility. The purpose of the lockdown was to temporarily limit inmate

movement and to conduct mass searches of the entirety of the MCC, to either find the weapon, or eliminate the possibility of a firearm being inside the facility. Staff from other BOP facilities were deployed to the MCC due to the serious nature of the circumstances, the significant threat to staff and inmate safety, and the security of the institution. In addition, staff were deployed to the MCC because at that time it was unknown if an MCC staff member was involved in the introduction of the weapon. The deployed staff are referenced herein as Temporary Duty (TDY) staff.

Inquiry 1. *Please indicate whether it is proper procedure to include an inmate's identification card among the property that needs to be removed and scanned in an emergency. In addition, please indicate whether the agency is also considering addressing the potential concerns surrounding this action in its review of its emergency contingency plans.*

Normally, inmates are required to carry their identification card on their person. However, there are times when it is more efficient to keep identification cards with inmate property, in order to facilitate returning the property to the correct inmate. If an inmate identification card is among property being scanned and moved to a new location, regardless of the cause, it is appropriate for the card to remain with the property until that property is returned to the inmate.

Issues surrounding the handling of inmate property will be further considered in the review of emergency contingency plans.

Inquiry 2. *Please indicate the agency's reason for not interviewing TDY2. In addition, please indicate whether any employee, who worked during the whistleblower's shift during the lockdown, was questioned about the allegation. If not, please indicate the agency's reasons for not interviewing other staff (either TDY or permanent), who worked during the whistleblower's shift*.

TDY2 was interviewed. TDY2 specifically denied escorting DCT, SORT, or any other staff into the facility without going through the appropriate screening procedures, or entering without going through the appropriate screening procedures. Multiple other staff, specifically including TDY1, CS6, EX2, EX3, and TDY3, all of whom worked various and overlapping shifts, were also interviewed regarding the whistleblower's allegation that she observed TDY2 escort DCT and SORT teams into the facility's rear gate without going through the appropriate screening process. None of the staff interviewed supported this allegation.

United States Department of Justice
Federal Bureau of Prisons

Office of Internal Affairs

Third Supplemental Report of Investigation

OSC File Number DI-20-0698

Subject: INVESTIGATION REGARDING A WHISTLEBLOWER ALLEGATION OF VIOLATION OF LAW, RULE, OR REGULATION; GROSS MISMANAGMENT; AN ABUSE OF AUTHORITY AT THE METROPOLITAN CORRECTIONAL CENTER (MCC) NEW YORK.

SYNOPSIS

The investigation was initiated based upon a whistleblower disclosure alleging that employees of the United States Department of Justice (DOJ), Federal Bureau of Prisons (BOP), assigned to the Metropolitan Correctional Center (MCC) New York may have engaged in conduct that constitutes a violation of law, rule, or regulation, gross mismanagement, and an abuse of authority. After review of the initial investigation dated May 11, 2021, and subsequent responses from the BOP dated May 25, 2021, OSC requested the several issues be specifically addressed. A second supplemental report was submitted on July 14, 2021, with information regarding a review of emergency procedures pending. A review of current internal security procedures by staff from multiple disciplines has now been completed. This third supplemental report is provided to address the following issues brought forth by OSC:

- Whether there is a need to expand emergency plans to provide more effective communication and record-keeping when emergencies arise;

- Whether modified dry cell procedures would best balance the interests at stake under a similar emergency;

- Whether there is a need to document that policy may be waived when the expectations of policy cannot be met in an emergency and, if so, whether there should be a record of what policy requirement is being waived, how the waiver may impact operations, what alternative procedures should be adopted, under whose authority the policy waiver was approved, and the methods by which documentation could be maintained to demonstrate how the waiver was communicated to staff and stakeholders, as appropriate;

- Whether it is possible to identify the specific roles and duties that TDY staff would have during an emergency response, while continuing to provide the flexibility that is required; and

- Whether there is a need to contemplate situations that require widespread reallocation to TDY staff of duties normally performed by permanent staff.

Furthermore, based on the second supplemental response submitted on July 14, 2021, the review also examined:

- Whether issues surrounding the handling of inmate property should be included in the review.

FOLLOW-UP INQUIRY

Background:

MCC New York is located in the Federal judicial district of the Southern District of New York. As described in the initial report, a lockdown was implemented February 27, 2020, through March 13, 2020 due to intelligence that was deemed reliable from an inmate source that a firearm was introduced into the facility. The purpose of the lockdown was to temporarily limit inmate movement and to conduct mass searches of the entirety of the MCC, to either find the weapon, or eliminate the possibility of a firearm being inside the facility. Staff from other BOP facilities were deployed to the MCC due to the serious nature of the circumstances, and the significant threat to staff and inmate safety and the security of the institution. In addition, staff were deployed to the MCC because at that time it was unknown if an MCC staff member was involved in the introduction of the weapon. The deployed staff are referenced herein as Temporary Duty (TDY) staff.

Inquiry 1. *Whether there is a need to expand emergency plans to provide more effective communication and record-keeping when emergencies arise.*

After review of current emergency procedures, written guidelines meant to assist facility and regional administrators in the event that credible evidence is gleaned to suggest a firearm could have been introduced to a secure institution were adopted. These written guidelines provide general information to administrators as a tool to guide the process of searching for a firearm inside a secure institution. Topics in the written guidelines range from assigning staff responsibilities during the search and specific search procedures, to the movement of inmates throughout the secure environment.

These written guidelines were distributed to the Regional Directors of all six of the BOP's geographic regions on November 9, 2021, and address the remaining inquiries from OSC. As these guidelines provide insights into law enforcement and security procedures, we have not attached the document to this report, but have summarized responses below. If further information is needed, please let us know.

Inquiry 2. *Whether modified dry cell procedures would best balance the interests at stake under a similar emergency.*

Dry cell procedures were addressed in the review. Specifically, the guidelines discuss need for alternate observation locations and related dry cell measures. The inclusion of this issue in the written guidelines allows administrators to review their local procedures and establish designated alternative dry cell observation cells should the need arise. As the incident at MCC was the first of its kind, the need for such a large number of dry cells was unique to that incident. Allowing administrators to plan for and address any projected inadequacy in the number of available dry cells will help to avoid the issue in the future.

Inquiry 3. *Whether there is a need to document that policy may be waived when the expectations of policy cannot be met in an emergency and, if so, whether there should be a record of what policy requirement is being waived, how the waiver may impact operations, what alternative procedures should be adopted, under whose authority the policy waiver was approved, and the methods by which documentation could be maintained to demonstrate how the waiver was communicated to staff and stakeholders, as appropriate.*

It is recognized that unique policy waivers will arise during large emergency situations that involve the entire inmate population in a given facility. The written guidelines that were established address when and how such emergency policy waivers will be requested and documented. Additionally, the guidelines provide that these emergency waivers will be posted for staff to see in all areas affected by the waiver. The guidelines also limit the application of any waiver to the pendency of the incident for which it was established. Finally, the guidelines call for modifications to normal procedures to be documented and the records maintained.

Inquiries 4 & 5. *Whether it is possible to identify the specific roles and duties that TDY staff would have during an emergency response, while continuing to provide the flexibility that is required; and whether there is a need to contemplate situations that require widespread reallocation to TDY staff of duties normally performed by permanent staff.*

The written guidelines that were developed during this review make clear the need to establish specific duties for permanent institution staff and TDY staff during such an emergency. The success of the mission depends on each staff member understanding their specific duties each day. Based on specific intelligence, duties will be assigned and staff briefings will be held to ensure all parties understand their duties. When duties change, those directions will be clear and will flow from the staff commanding the incident. It is recognized that directives must be intelligible to both sides when TDY staff are being assigned duties normally undertaken by permanent staff members.

Inquiry 6. *Whether issues surrounding the handling of inmate property should be included in the review.*

The team conducting the review of emergency procedures contemplated the impact of a wide-ranging and time sensitive search on the handling of inmate property. As a result, guidance was provided to address ensuring the accountability of both inmates and property during such an event. In particular, procedures were provided to address how and when property will be inventoried, and what documentation will be provided to the inmate upon completion of the inventory. The guidelines also provide both a timeline for this process, and an alternate storage location for property that is rerouted due to the unavailability of the inmate.