Federal Bureau of Prisons Oversight Hearing
Subcommittee on Crime, Terrorism, and Homeland Security
House of Representatives, Committee on the Judiciary
July 21, 2009

Testimony of
Philip Fornaci
Director, D.C. Prisoners' Project
Washington Lawyers' Committee for Civil Rights & Urban Affairs
11 Dupont Circle, N.W., Suite 400
Washington, D.C. 20036 (202)319-1000; Philip_fornaci@washlaw.org

Thank you for this opportunity to provide testimony for this hearing on oversight of the Federal Bureau of Prisons. In particular, I would like to thank Congressman Scott for his leadership on important issues affecting incarcerated and formerly incarcerated people.

My name is Philip Fornaci. I serve as Director of the D.C. Prisoners' Project, a section of the Washington Lawyers' Committee for Civil Rights & Urban Affairs. Our organization advocates for D.C. prisoners held both locally in D.C. jail facilities as well as those held in the federal Bureau of Prisons (BOP), where those convicted of felonies in D.C. are sent. We advocate for appropriate medical care, protection from violence, and access to basic constitutional rights. We also provide representation to DC prisoners at parole grant hearings.

Our organization was created in 1989, focused on the needs of DC prisoners held locally in the Lorton Prison Complex in Lorton, Virginia. With the enactment of the DC Revitalization Act in 1997, and the subsequent (2001) closing of Lorton and transfer of sentenced DC prisoners to the custody of the federal BOP, the focus of our work shifted to the BOP. Although D.C. prisoners are a relatively small percentage of the overall BOP population (approximately six percent), nearly 8,000 D.C. prisoners are spread throughout 90 separate BOP institutions. Our organization receives calls and correspondence from individuals living in as many as 70 different facilities every year. Our vantage point for assessing the performance of the BOP is unique among advocates nationally, a result of the closure of the District of Columbia's "state" prison facility and the federalizing of DC Code offenders. In advocating for DC's "state" prison population, by extension we also become involved with the needs of people held in the BOP not from DC. No other private or public organization is as closely involved with addressing problems with conditions of incarceration for BOP prisoners.

My testimony today will focus primarily on medical care issues in the BOP, as well as certain other issues about the BOP of general concern to this Subcommittee. In addition, I have included comments about problems specific to DC prisoners in the BOP and have included with my testimony a document prepared by our office, *DC Prisoners: Issues for the Obama* Administration, a series of policy recommendations for the current Administration. (See attachment 1.) My testimony places this information in the context

of our work with the BOP, both in litigation and, more commonly, in non-litigation advocacy with various BOP institutions and with the BOP's central office.

Medical Care in the Bureau of Prisons: A Study in Contrasts

In April 2009, the *American Journal of Public Health* published the first national survey of the prevalence of chronic health conditions and analysis of access for health care for US prisoners.[1] The authors noted that, although prisoners have a constitutional right to health care, prisoners' access to health care is often deficient[2], due at least in part to the political unpopularity of treating this population. As the report notes: "Indeed, former Surgeon General Richard Carmona stated that he Bush Administration had blocked the release of the Surgeon General's report, *Call to Action on Corrections in Community Health*, for fear that the report would increase government spending on inmates."[3]

And there is clearly a need for addressing problems in health care delivery for the federally incarcerated population, but the problems are not simply related to funding shortfalls (although increased spending on prisoner health services would be welcomed). Even with additional funding, there are significant problems with health care delivery in the BOP that require broader changes. For example, in our experience, we have found that certain BOP facilities provide extremely high levels of medical care, while others – primarily (but not exclusively) private contract facilities – provide abysmal care. We have worked with clients at three Federal Medical Centers (FMCs), FMC Rochester, FMC Butner, and FMC Carswell, who have received excellent medical care, sometimes for extremely complex medical needs. These facilities are clearly the "gold standard" in terms of what BOP facilities can achieve in providing medical care, but each is a specialized medical facility. We would certainly not expect this high level of quality to be matched by any BOP facility that is not a Federal Medical Center, but the drop-off in quality of care from the FMCs is significant.

At the other extreme, we have had extensive experience with certain privately-owned prisons, particularly the Rivers Correctional Institution in Winton, North Carolina, a prison owned and operated by the GEO Group under contract to the BOP. This facility holds approximately 800-900 DC prisoners, as well as 400-500 foreign nationals serving federal prison sentences. In contrast to treatment provided at FMCs, or even at comparably-sized BOP-run prisons, medical care at Rivers is abysmal.

---

[1] Wilper, Andrew, MD, MPH, Boyd, Wesley J., MD, PhD, Lasser, Karen E., MD, MPH, McCormick, Danny, MD, MPH, Bor, David H, MD, and Himmelstein, David U, MD, "The Health and Health Care of US Prisoners: Results of a Nationwide Survey," *American Journal of Public Health*, Vol. 99, No. 4, April 2009.

[2] Some important findings of the *American Journal of Public Health* article are (1) that 13.9% of federal prisoners with a "persistent medical problem" had received no medical examination since incarceration (in contrast to 20% of state inmates) and (2) nearly eight percent of federal prisoners received no medical care after a serious injury. Ibid at 669.

[3] Ibid, p. 671.

Rivers opened in early 2002, immediately after the closing of the Lorton Prison Complex, and began housing primarily DC prisoners at that time. From the moment of its opening, our organization has received a steady stream of complaints from prisoners housed there, from the failure to provide basic primary medical care to an unwillingness to send prisoners off-site for specialty care to abrupt changes in medication regimens in the interests of saving money. Rivers employs a single physician (working fewer than 40 hours/week) for its 1300+ prisoners, in contrast to similarly-sized BOP facilities that tend to employ at least two full time physicians and provide for an on-site physician on weekends. (Rivers does not provide such coverage.)

In 2006, the Washington Lawyers' Committee (in collaboration with the law firm of Covington & Burling), filed a class action lawsuit aimed at improving medical care at Rivers (*Collins et al. v. GEO Group et al,* Civ. No. 08-CV-00021-H, ED North Carolina). I have attached excerpts from this complaint with my testimony, which details some of the horrible injuries and mistreatment suffered by prisoners at Rivers, and the failures of the BOP to provide effective oversight. (See Attachment 2.) The complaint notes: "[t]he deficiencies and deprivations ...detailed in this Complaint are the result both of Defendant GEO's aggressive efforts to cut costs and boost profits and of Defendant BOP's persistent failure to ensure that GEO fulfills the federal duty it has undertaken to provide."

It is important to note that, in its motions to dismiss our complaint, the GEO Group has argued that, as a private contractor, it is bound only to deliver on its contract to the BOP. If the BOP has problems with its performance of its contract, the BOP must raise them, according to GEO. Conversely, the BOP claims that any problems with medical care at Rivers are the responsibility of its contractor, GEO, and not the BOP. Both defendants argue that the other is responsible. As the BOP noted in its Motion to Dismiss our complaint:

> In any case, plaintiffs' implicit suggestion that GEO Group is somehow not an independent contractor because the BOP allegedly exerts "supervision and control" over Rivers operations is insupportable. A review of the BOP-GEO contract is sufficient to demonstrate that, while the BOP reserves the right to engage in limited monitoring of GEO decisions, and requires that GEO hire only those who pass drug and background checks unless the BOP approves a waiver, the BOP does not exercise control over day-to-day operations at Rivers.

Although arguing against the federal government's liability in this case (which seeks only injunctive relief, not monetary damages), it is striking that the BOP asserts that the BOP exerts "limited monitoring" authority over Rivers operations. It is not the responsibility of the Federal Bureau of Prisons to ensure that prisoners assigned to its care receive constitutionally adequate medical treatment because it has contracted out

those responsibilities. Although the Court has not ruled on the BOP's argument, as a matter of public policy it is simply reprehensible. So long as GEO hires people who pass drug and background checks (unless BOP issues a waiver), the BOP – and by extension the Department of Justice and the Executive branch itself -- absolves itself of all other responsibility. The outright refusal of the BOP to effectively monitor its own contractors has led to untold suffering, illness, disability, and early death for hundreds of prisoners. Rather than resolve the issues in *Collins*, the BOP and GEO have aggressively fought the case for two years and have refused to make any significant improvements in medical services at this facility.

Assessing Medical Care in the BOP

The *Collins* case is the most significant litigation involving the BOP and delivery of medical care with which our organization is involved, but it is not the only one. We have been involved with extended litigation since 2006 in another medical case, involving an action for damages suffered by a prisoner at USP Lewisburg whose surgery for an extremely painful (and obvious) gastrointestinal problem was delayed for several months due to the indifference of medical staff (*Boling v. Bussanich et al*, Civil No. 3:Cv-07-1133, M.D. PA).

In the course of discovery in *Boling*, it has become apparent that the quality of medical care at BOP facilities varies with each institution. Certain problems identified in other BOP facilities are not present in this case, while different problems may be specific to Lewisburg. For example, Lewisburg (at the time this case was filed) employed two full time physicians for approximately 1500 prisoners, a far superior physician/patient ratio than at Rivers. However, we also discovered in the course of litigation that facility staff routinely discard sick call requests (requests for medical attention), failing to keep a record of ongoing and chronic complaints. While primarily an administrative/organizational error, the failure to keep track of prisoners' medical complaints allowed staff to ignore developing problems and even to punish prisoners who complain "too often" by remaining indifferent to their medical needs.

Similarly, diagnosis and treatment of such diverse conditions as diabetes, hepatitis C, MRSA (staph) infections, and HIV varies by facility. The BOP has created a system of assigning "CARE Levels" 1 to 4 for its facilities, with FMCs rated CARE Level 4 and 16 facilities rated CARE Level 1. Those at CARE Level 1 are considered inappropriate for prisoners with chronic medical needs (e.g., HIV, hepatitis, etc.). The majority of BOP facilities are rated at CARE Level 2.

Yet even within this system of CARE Levels, significant variations exist among similarly-sized and similarly-rated facilities. However, the BOP makes designation decisions (about which facilities to place individuals) with only the most general considerations – or knowledge of – the capacities of its facilities. This decision-making process is completely closed; judges, attorneys, and advocates cannot challenge placement of a prisoner to a particular facility, nor effectively advocate for designation to a particular prison. For example, we have encountered several seriously ill prisoners sent

to the privately-owned Rivers Correctional Institution, despite instructions from their sentencing judges that they be sent to a facility where they will receive specialized medical care. The BOP has sent prisoners in desperate need of psychiatric treatment, monitoring of life-threatening cardiac conditions, kidney disease and even amyotrophic lateral sclerosis (ALS, or "Lou Gehrig's disease") to Rivers, a facility that cannot possibly provide appropriate treatment for any of these conditions.

In recognition of this problem and in an attempt to secure meaningful information about access to medical care at BOP facilities, our organization developed a system for interviewing clients in facilities holding large numbers of DC prisoners and where we received large numbers of complaints about medical care. We developed a survey instrument to aggregate information gleaned from our interviews, pinpointing problems with delivery of medical services in these facilities. We planned to summarize the data and present it to Public Health Service staff (who oversee medical care in the BOP). We had received informal indications from the Medical Director of the BOP, Dr. Newton Kendig, that information on medical problems at specific facilities would be welcomed by the BOP.

Rather than simply sending uninvited letters to Dr. Kendig, our organization sought a series of twice annual or quarterly meetings with BOP medical staff to report on our investigations at BOP institutions. I attempted to contact Dr. Kendig directly, but was diverted to his assistant, Elizabeth Nagy. In an email to Ms. Nagy on December 12, 2007, I made the following request:

> [B]ecause DC prisoners are housed in 99 different BOP facilities, and because our organization is the only non-governmental body that monitors conditions in BOP facilities on a systemic basis, we are uniquely situated to provide feedback to the BOP. In particular, we are interested in working with BOP medical staff to improve medical and mental health care delivery. Although our organization is involved in several lawsuits with the BOP as a defendant, our goal is not to pursue litigation for its own sake but to encourage improvements in the conditions under which our clients are held.

Subsequently, Ms. Nagy and I had an extended conversation during which I described our work in some detail, including our development of a survey instrument to facilitate our discussions with the BOP. I had also requested the BOP's cooperation in our efforts to interview our clients, asking that we be permitted to arrange group meetings of clients in these facilities. Ms. Nagy listened attentively and indicated she would get back to me with some answers.

Three months later, in March 2008, I received a letter from Kathleen Kenney, Assistant Director/General Counsel for the BOP. (See Attachment 3 for the full letter.)

> This is in response to your communications with Elizabeth Nagy. You raised several issues related to health care received by D.C. Code felony offenders in Bureau facilities. In the future, please direct all such inquiries to the U.S. Attorney's Office representative handling such case(s), as you represent inmates currently in litigation with the Bureau regarding health care issues.

The BOP's response to our careful attempts to identify medical problems without litigation our efforts was a resounding rejection. BOP attorneys barred us from speaking to medical staff, instead directed to our staff to local US Attorneys, who could certainly not be expected to have any knowledge of medical issues in the BOP, and little particular interest in resolving problems. In the same letter, Ms. Kenney went on to refer me to the District's Corrections Information Council (CIC) as a more appropriate conduit for the medical information we were gathering, a volunteer entity created under the DC Revitalization Act that had *never visited a BOP facility*, has had no members since mid-2006, and which DC Mayor Fenty has now vowed to dissolve entirely. Finally, Ms. Kenney included a thinly-veiled threat that our very access to BOP facilities might be threatened if we persisted in trying to investigate our client's problems with medical care in the BOP.

This unexpectedly hostile response closed the door on our efforts to address medical care issues with medical staff at the BOP Central office, although we continue to collect information and visit our clients in BOP facilities to address medical issues. We also continue to communicate directly with medical staff in individual facilities to help resolve issues for our clients. It is apparent that the BOP is uninterested in receiving input from advocates and prefers that our concerns take the form of litigation, a wasteful and destructive approach.

Administrative Remedies and Medical Care

One point Ms. Kenney did not make in her letter is that prisoners should have a way to improve their medical care through the Administrative Remedy Request process. This is the internal grievance system of the BOP through which prisoners can file informal complaints to staff, and appeal denials or unsatisfactory responses to the Warden, Regional BOP, and BOP Central offices. This process takes a minimum of three months to fully exhaust to the national level.

The Administrative Remedy Request system is in fact the only avenue that prisoners have available to them to address deficiencies in medical care, and serves as the necessary precursor to litigation (as exhaustion of this system is required prior to filing a federal lawsuit). It is also an avenue that cannot possibly bring results. If a prisoner has a severe medical problem for which he disagrees with the facility's treatment, or if he believes they are being indifferent to his needs, he can only complain. The staff and Warden will invariably deny the problem, and the BOP Regional and Washington offices will concur with the facility. End of problem, the prisoner is simply mistaken. The obvious result is litigation, if the prisoner is clever enough or if he has an attorney.

For prisoners held in transit facilities (FTC Oklahoma City, etc.), their access to the grievance process is even more limited. They are rarely held in these facilities for more than a few weeks or sometimes months. This is not enough time for a grievance to reach the Regional or Central Office levels, even if a BOP official were inclined to act upon it. We recently had a client held in the FTC Oklahoma City for nearly two months, during which time he did not get his HIV medications nor other medications he had been receiving in a USP. The indifference displayed by staff was striking. Calls to the BOP Central Office simply resulted in calls to management of the FTC, with predictable denials of the existence of any problems. Again, there is no way to bring these issues to the attention of BOP medical officials – and secure some kind of remedies -- short of litigation.

If the prisoner is in a private contract facility, the situation is particularly difficult. In response to their grievances, the BOP Central office refers complaints from contract facilities to its Privatization Management Branch. In response to requests for medical care, staff at this office simply inform the prisoner that medical care in a contract facility is not a grievable issue, even to the BOP office set up to monitor private prisons. Further, several courts have held that prisoners in privately-owned BOP facilities have no right to bring their claims of Eighth Amendment (deliberate indifference to serious medical needs) to federal court.[4] These prisoners have no available remedy except hostile local state courts, with their complex pre-filing requirements[5] and anti-prisoner biases. Their health care – and their lives – are dependent on whatever inclinations the for-profit management company may happen to have to provide constitutionally-adequate levels of care. Obviously, profit considerations will almost always override medical needs in this context.

The BOP has effectively closed off any non-litigation avenues for people outside its own staff to identify problems and secure improvements in medical care at BOP facilities. As noted, there is no way for the BOP Central Office to get useful information about problems in the more than 130 BOP prisons (and probably thousands of contract halfway house facilities) through the grievance process. This is the only mechanism prisoners have to communicate with the BOP directly. Obviously Wardens are extremely unlikely to bring concerns about their own facility's medical services to Washington. Finally, as I have described, the BOP refuses to accept input from advocates, referring these issues to local Attorneys General, inviting only protracted litigation.

The BOP has fought all monitoring of its medical care by outsiders, and it has no effective internal mechanism for effectively addressing problems as they arise. We are asked to simply accept their assurances of adequate care, even when presented with

---

[4] See *Holly v. Scott*, 434 F.3d 287 (4th. Cir. 2006), cert. denied – U.S. – 126 S.Ct. 2333 (2006). The Fourth Circuit affirmed the dismissal of a Rivers prisoner's claim that his Eighth Amendment rights were violated when he was denied medical care at a private contract facility.

[5] Most states now require that complaints for medical malpractice include an affidavit by a medical expert vouching for the validity of the claims *before it is filed.* This requirement is virtually impossible for prisoners to meet.

evidence to the contrary. Prisoners are unable to effectively raise concerns without litigation, and individual staff within facilities are unlikely to complain. This leaves only the courage of individual whistleblowers or protracted litigation to address problems that we all know exist.

Non-medical Issues at the Bureau of Prisons

Although medical care is a priority focus of our advocacy work, we have also struggled with the BOP over a myriad of other issues, which I will highlight here.

Use of Restraints

We are in litigation on behalf of a prisoner held in USP Lewisburg in 2006. He wrote to us with an incredible story of being placed in four-point restraints *while in his cell* for a period of 28 days, causing extreme psychological anguish and permanent nerve damage. This treatment can accurately be described as torture. We requested his medical records, which verified the accuracy of his story in all details. We subsequently contacted the Warden of the facility at that time, who did not deny what had happened but instead cited our client's alleged destruction of a sink in his cell and his obstinacy in accepting a cellmate. We filed *Womack v. Smith et al* (1:06-cv-2346; MD PA) in December 2006. (See Attachment 4.)

In this case, it is important to recognize that the BOP staff at this facility maintains that such treatment is consistent with BOP policy, a point we dispute. However, even if true, this would mean the BOP policy permits the use of restraints for nearly a month as a punishment, not to protect staff, other inmates, or the prisoner himself. Indeed, the brazen attempts of the Warden to justify his handling of the situation verified that he kept the man in restraints weeks beyond any necessity for controlling his behavior (if that were ever a goal) but utilized brutal restraints *as punishment.*

Unfortunately, this is not an isolated incident. The use of restraints as punishment in BOP facilities is common. We recently learned that prisoners in USP McCreary (Kentucky) held in the Special Housing (disciplinary) Unit are routinely subjected to restraint as punishment. They are strapped to the four corners of a bed, with lights on 24 hours/day, for periods of three or four days, in retaliation for breaking rules of the Special Housing Unit. There have been numerous deaths in restraints in prisons across the country, and the dangers of such practices are well-known.[6] That the BOP tolerates such practices, and arguably encourages their use, is both foolish and unconscionable.

Government informants

We have attempted to assist several individuals who have provided information to the government in criminal cases, in investigations of BOP staff, or in other matters

[6] See, for example, this award-winning 1998 newspaper series that identified 142 deaths during or shortly after restraint or seclusion in the previous decade. Weiss EM, et al. "Deadly restraint: A Hartford Courant Investigative Report," *Hartford Courant* 1998; October 11 – 15.

where prisoners have information considered useful to prosecutors or investigatory agencies. These individuals are promised various considerations for their cooperation – reduced prison sentences, better treatment while incarcerated, and protection – which rarely materialize.

The position of so-called "snitches" in the BOP, and in most prisons and jails, is precarious. Any prisoner who provides information to staff or to government officials is immediately suspect, and vulnerable to assault and even murder. Although the BOP has several mechanisms to protect these individuals, and indeed has a constitutional duty to protect their safety, it is rare when the BOP recognizes its responsibilities. The BOP has its own Witness Protection Program, it can transfer vulnerable prisoners to state facilities (where their identities may not be known), or it can place them in a different custody level. Unfortunately, these mechanisms are all too infrequently utilized.

One case with which we are involved is illustrative of this problem. We have been involved in a case for nearly four years involving a prisoner who provided information to the FBI about a corrupt BOP corrections officer, even wearing a recording device at the FBI's prompting. After the BOP employee was fired, the FBI and the BOP disavowed any knowledge of our client's role. When he filed grievances seeking protection, the content of his grievances was made available to staff and prisoners in the high security prison where he was being held, putting him at even greater risk for the multiple attacks that followed. He has been beaten on numerous occasions (including once by a co-worker of the BOP official who had been fired) and raped by a known sexual predator, in one of several incidents apparently facilitated by BOP staff. He has been moved to six different high security prisons, where he has been either threatened or assaulted after each move. Two Wardens of BOP facilities have requested his transfer to a medium security facility or to a state facility for the man's protection, but the BOP has repeatedly refused. We had repeatedly requested assistance from all levels of the BOP in an effort to avoid time-consuming litigation, but were unsuccessful. One BOP official even denied that it had a Witness Protection Program and that there was nothing that could be done.

We filed *Doe v. Wooten et al* (1:07-cv-2764; ND GA) in November 2007, naming among others Harley Lapin, Director of the BOP. (See Attachment 5.) We are seeking simple remedies: removal to a medium security facility, a state facility, or the Witness Protection Program. The BOP first vigorously denied our client's story of cooperation with the FBI. When the facts were irrefutably presented, the BOP argued that the Court had no authority to instruct it where to place inmates in its custody, an argument the Court accepted. The matter is currently in appeal.

We have also contacted the BOP Central Office of Designations to remedy the situation, again to no avail. We were told to write a letter to Director Lappin. Even during the course of litigation, our client was twice transferred to other high security facilities, where he was brutally assaulted. The BOP has again refused to take virtually any step to protect our client, despite ample knowledge of the underlying facts of his situation, the ensuing threats and assaults he has endured, and the warnings of BOP

Wardens that the man's life is in danger in these high security facilities. It is difficult to ignore that our client is being punished for cooperating with the FBI against a BOP staffer, and that personnel at all levels of the BOP have shown an unwillingness to protect the life and safety of a "snitch." Our client was recently told he has again been designated to another high security prison, where his chances for survival are grim.

"John Doe's" story is extreme, but not unusual. The pressure applied to prisoners to provide testimony can be intense, and the potential rewards tantalizing to the prisoner. Yet government officials continue to use these individuals for their purposes, then abandon them to the brutal retaliation of other prisoners. In its own way, the BOP tacitly accepts certain prevailing cultural views against "snitches" by refusing to identify and protect prisoners who provides state's evidence, in stark contrast to the promises other DOJ officials make to encourage such snitching.

DC Prisoners in the Federal Bureau of Prisons

Unlike "state" prisoners in other jurisdictions, DC Code offenders have a unique relationship with the federal government. DC prisoners are, for most purposes, treated as federal prisoners. The location and conditions of their incarceration, and the terms of their parole (or supervised release), are under the exclusive control of the federal government. Unfortunately, DC residents have no effective mechanism for influencing these decisions beyond litigation.

Our organization has prepared the attached document, *DC Prisoners: Issues for the Obama Administration*, for distribution to various federal officials and agencies, including the BOP. Issues around the handling of DC prisoners within the BOP system have not been addressed since the DC Revitalization Act in 1997. There are three areas where the BOP could improve the treatment of DC prisoners and facilitate their successful reentry into the community.

First, the BOP should house all DC prisoners in only a few BOP facilities in Maryland, Virginia, and Pennsylvania within 250 miles of the District, with concerted efforts to house DC prisoners as close as possible to DC. Except in the most extraordinary circumstances, no DC prisoner should be held more than 250 miles away from home. In these facilities housing DC prisoners, case management staff should be trained in appropriate discharge planning issues for the DC population, facilitating engagement by DC employers and social services agencies. With a more significant population of DC prisoners in these facilities, it would be worthwhile for potential employers and service providers to set up training and job placement programs to facilitate their successful reintegration into the DC community.

One of the most difficult problems facing formerly incarcerated people in DC is overcoming the loss of community ties during their absence. When they return to DC, most typically lack employment prospects, housing, and substance abuse treatment. Because they are released from dozens of different facilities, assisted by staff with no knowledge of DC, they have virtually no preparation for reintegration. An overwhelming

number of formerly incarcerated people are homeless in DC, with few opportunities for employment or housing, and a near-certain likelihood of re-arrest on a parole revocation or violation of supervised release as a result.

Second, to the extent feasible, DC prisoners should have access to halfway house placement a full year prior to their release, particularly those who have served lengthy sentences. Such placements are mandated under the Second Chance Act, but have yet to be implemented by the BOP. Further, the BOP must insure that the halfway houses with which it contracts do not discriminate on the basis of disability or other grounds.[7] Further, it must monitor its contracts with local halfway houses to insure that these halfway houses actually provide the housing, employment, and public benefits assistance they are contracted to provide. Most currently do not.

In 2008, the DC District Court issued a landmark decision in *Sellmon v. Reilly* (Civ. No. 06-01650, 2008 WL 1933759 (D.D.C. 2008)), ruling that, in many cases, the US Parole Commission has applied the wrong standards in making parole decisions for DC prisoners, resulting in inappropriately long sentences. This will result in the release of 500-1000 additional people from the BOP to DC in the coming 18 months, all of whom have been incarcerated for at least a decade. The BOP must quickly develop contractual relationships with other halfway house service providers to accommodate this jump in parolees, and maximize their halfway house time. There is no indication that the BOP is even aware of the general implications of *Sellmon.*

Third, the BOP should reconsider its use of private contract prisons, in particular the Rivers Correctional Institution that houses primarily DC prisoners. If it chooses to continue its contractual relationship with these facilities, the BOP must take responsibility for insuring that (1) it monitors and improves the provision of medical care and mental health services, (2) provides a mechanism for receiving and responding to complaints and grievances, and (3) takes seriously its role as contract monitor to protect the health, safety, and due process concerns of people held in those facilities.

I urge the Subcommittee to review the full text of the *DC Prisoners: Issues for the Obama Administration* document. We look forward to working with the Subcommittee, the BOP, and other federal agencies to improve conditions of incarceration and reentry preparation for DC prisoners and for all federal prisoners.

---

[7] Our organization has filed a lawsuit against the largest halfway house in the District, Hope Village, which explicitly rejects applications from blind prisoners. We have had similar problems with BOP placing people in halfway houses that are not wheelchair accessible, despite numerous local and federal laws requiring accessibility.