

July 2, 2025
For Immediate Release

*[Content warning: this press release mentions SA, r*pe]*

**Monitor Issues First Report Evaluating Compliance with the Dublin Consent Decree;
Finds Widespread Issues Across Federal Prison System**

Report finds BOP has not fully complied with most provisions of the decree, including significant deficiencies in medical care, mental health care, discipline, and retaliation

Oakland, Calif. -- Senior Monitor Wendy Still issued her [first monthly report](#) monitoring compliance of the Consent Decree in California Coalition for Women Prisoners et al. v. United States Bureau of Prisons et al., (*CCWP v. BOP*), finding that the BOP has failed to fully comply with most requirements. The BOP entered into the Consent Decree in order to resolve litigation brought on behalf of all people who were incarcerated at FCI Dublin before its closure, due to serious harms from decades of systemic staff sexual abuse, retaliation, medical neglect, and other institutional failures.

The April 2025 report is the first of its kind, enforcing an unprecedented Consent Decree. The Consent Decree went into effect on March 31, 2025 and extends to any BOP facility where class members are housed, currently spanning sixteen BOP facilities. Under the Consent Decree, the Monitor is tasked with investigating and reporting on the treatment and conditions of class members who have since transferred to other BOP prisons. Senior Monitor Still was provided access to staff, facilities, records, and class members while preparing this historic report.

“The report finds significant deficiencies and affirms much of what survivors of BOP already know,” said Kara Janssen, Senior Counsel at RBGG, “that the problems that came to light at FCI Dublin were symptoms of larger, systemic problems throughout BOP.”

“This report shines a light on what has been clear for years—the conditions in the Bureau of Prisons are extremely dangerous, and the agency does not have the tools nor the will to adequately care for people in their custody,” said Amaris Montes, Director of West Coast Litigation and Advocacy at Rights Behind Bars. “But BOP does have one solution at their disposal and that is to release people immediately.”

The Monitor’s first monthly Report found that BOP were non-compliant or only partially compliant with the vast majority of the Consent Decrees requirements. The Report found that:

- **Class members continued to report experiences of staff sexual abuse and physical assault.** The report highlighted that 13 complaints of sexual abuse and 3 complaints of physical abuse were received in the month of April alone. Class members shared that in some instances they reported abuse to BOP staff, with “no follow up action taken by BOP.” Despite being required to by policy and Consent Decree requirements, BOP does not consistently report to class members the status of investigations arising from their allegations of sexual abuse. The report also found that staff were not properly trained on

what constitutes sexually abusive behavior, and that staff are not equipped to provide trauma-informed care to sexual abuse survivors.

- **Class members continued to report widespread staff retaliation**, including 17 complaints of retaliation in the month of April alone. The report found a “noticeable trend of class member complaints regarding staff member retaliation and subsequent receipt of disciplinary incident reports, followed by extremely harsh penalties,” and included numerous examples of class members who faced harsh disciplinary consequences after reporting staff misconduct or mistreatment.
- **Class members continue to face barriers to receiving adequate and timely medical care, and face serious and systemic issues with medical and mental health care across the BOP system.** Class members experienced significant delays in accessing care, in part due to systemic understaffing. BOP also has no system currently for recording, tracking, and auditing the requests for medical care, or for monitoring the provision and quality of care, leaving class members extremely vulnerable.

Class members also faced unprofessional and retaliatory behavior by medical providers across facilities. Class members report that providers have told them they “should feel lucky they are getting care since they are illegal aliens or criminals,” and “they should not expect special care because they are from Dublin, and no amount of ‘whining to lawyers’ will get them care.” The Monitor found that it is “not clear that front line providers have retained professional independence, and there appear to be instances when facility protocols or directives outweigh clinical professional judgment.”

Regarding medical care, the report specifically found:

- inadequate accountability systems, including “no systemside processes for accurately recording, tracking, and auditing requests for medical care,” and “no systemwide processes for measuring provider productivity, workload, and other clinical operational metrics”
- failure to follow up on testing and treatment plans, meaning that “all responsibility falls on the Class Member to seek care”
- long delays in medical care, including for chronic medical conditions
- failure to provide appropriate medications, and failure to follow up after changes to doses or medications are made to monitor effectiveness and side effects
- “overreliance on commissary medications and unwillingness to utilize prescription medications,” coupled with inadequate access to over-the-counter medications for indigent individuals
- inadequate access to interpretation and translation during medical encounters
- lack of communication with class members regarding test results and care plans
- inconsistent and inequitable access to specialty care across facilities, and failure to utilize telehealth services that “could offer appropriate and timely access to care”
- “widespread, long wait times for essential medical devices, including, but not limited to prescription glasses and dentures,” including an average wait time of nine to ten months for glasses, “which is both unacceptable and does not meet community standards”

Regarding mental health care, the report found:

- “limited” access to psychiatric care across facilities, exacerbated by understaffing and “high” vacancy rates for mental health providers; “recently as many as 20 mental health care providers have left BOP employment”
 - class members in need of one-on-one therapy “are not receiving this care and instead are in group programming even when clinically indicated,” which can be “threatening and re-traumatizing” for people with serious mental health needs
 - mental healthcare is “not consistently performed in the patient’s primary language” and translation services “are not routinely utilized”
 - failure to follow up after changes to psychiatric medications to monitor effectiveness and side effects; and providers are not using standardized tools commonly used in community settings to measure response to medications, which “increases the risk of a patient having clinical decompensation”
 - long delays in obtaining Medication Assisted Treatment (MAT) for class members with opioid use disorder, and no timely access to providers to evaluate side effects for such treatments, creating a “highly risky” situation
 - BOP uses incarcerated people to monitor other incarcerated individuals on suicide watch, which is “problematic due to the lack of confidentiality”
- **BOP failed to fully comply with requirements related to solitary confinement, and class members continue to be placed in isolation, without appropriate process and protections.** Ten class members were placed in isolation during the month of April alone; six of these class members were released from SHU after their cases were reviewed and expunged or reduced. Class members in isolation did not consistently receive medication and medical devices, and did not receive medical and mental healthcare in confidential settings. The Monitor found BOP in non-compliance, or was unable to fully evaluate compliance, for multiple provisions related to SHU because BOP failed to provide adequate, timely information and documentation as required under the Consent Decree.
 - **Class members received false incident reports and, even in error-free incident reports, extremely harsh penalties throughout their time at FCI Dublin.** BOP and the monitoring team reviewed disciplinary incident reports issued at FCI Dublin between January 2020 and May 2024. Out of 965 incident reports reviewed, *571 (59%) had errors so significant they had to be expunged.* As a result of these errors, “class members were subjected to disciplinary segregation, credit losses, and loss of privileges,” which impacted their security levels and eligibility for release. The Report found that there “appears to be a systemic failure, by BOP, to ensure that imposed discipline is applied consistent with BOP policy and within constitutional mandates.”

As one advocate from CCWP shared: “In addition to unwarranted punishments and solitary confinements, these expunged charges represent weeks and months of improperly extended incarceration for each affected person. In the aggregate this adds up to more than 10 years of freedom stolen from the class members by prison staff. CCWP monitors release dates for class members independently, and we demand a full accounting of earned credits.”

- **BOP failed to fully comply with requirements related to designations and release of class members.** Many class members remain incarcerated far from their families. During the reporting period, one class member was held at a temporary transfer center for over a month. Despite clear requirements under federal statute and the Consent Decree, BOP staff “inappropriately den[ied]” community placements for noncitizen class members with immigration detainers. Many class members reported that they lost early release credits due to transfer from FCI Dublin, and BOP still had not corrected these issues, despite a previous court order and a provision of the Consent Decree that required them to do so.

Senior Monitor Wendy Still will be issuing monthly and quarterly reports for the duration of the Consent Decree. You can read the full report [here](#).

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Formed in 2021, the [Dublin Prison Solidarity Coalition](#) is a partnership of people currently and formerly at FCI Dublin and their supporters, anchored by the [California Coalition for Women Prisoners](#). Counsel on CCWP v. BOP also includes [Rights Behind Bars](#), [Rosen Bien Galvan & Grunfeld LLP](#), the [California Collaborative for Immigrant Justice](#), and [Arnold & Porter LLP](#).