U.S. Department of Justice
Federal Bureau of Prisons

Metropolitan Correctional Center
[redacted]
New York, New York 10007

Office of the Warden

November 13, 2019

MEMORANDUM FOR [redacted], ASSISISTANT DIRECTOR,
REENTRY SERVICES DIVISION

FROM: [redacted], Warden, MCC New York

SUBJECT: Institution Response to Psychological Reconstruction
Inmate Epstein, Jeffrey (76318-054)

This is the response to the psychological reconstruction of inmate Epstein, Jeffrey (76318-054) dated September 17, 2019.

1.Single Celling: It is recommended that all inmates be double-celled unless safety concerns or an odd number of inmates precludes this. Priority should be given to inmates with a history of mental illness, self-directed violence, recent stressors (e.g., losses, newly sentenced, etc.)

It is recommended that a system of control be implemented explaining who will be notified when a Suicide Watch or Psychological Observation ends and how that communication will take place. Because this is a life safety issue, the system of control, once approved by the warden, should be reviewed in formal meetings such as staff recalls, department head meetings, and lieutenants meetings.

Institution Response: 1. Single Cell Placement:

A system has been put in place to ensure inmates are not single celled. A single cell report is completed during each shift by the SHU Lieutenant during Day Watch and the Operations Lieutenant during the Morning Watch and Evening Watch. Notifications are made to the Institution Duty Officer (IDO) and Executive Staff.

Psychology discusses the status of inmates who are at-risk for suicidality, their housing needs, as well as their needs for cellmates during staff meetings, department head meetings, SHU meetings, morning meetings, and close out meetings.

When inmates are placed on and off suicide watch, the Warden is notified verbally, regardless of the time of day. The Warden then determines which suicide watch area a suicidal inmate will be housed and if they will be observed with an inmate companions or a staff member.

Psychology verbally notifies the Operations Lieutenant when inmates are removed from suicide watch and that they

will need to be placed with a cellmate. Cellmates are recommended not only for SHU inmates being removed from suicide watch, but also for inmates returning to the general population setting. The C&A officer is responsible for entering the proper assignment.

Once an inmate is removed from suicide watch, psychology staff sends an e-mail to the Executive Staff, IDO, and Lieutenants informing them the inmate is being removed from suicide watch and can return to a cell with a cellmate. The e-mail contains the name of the staff member whom psychology verbally spoke with. This recommendation for a cellmate and conversation with the Lieutenant is also documented in the Post Suicide Watch Report and placed in BEMR/PDS.

Psychology Services has eliminated the use of Psychological Observation to avoid any confusion as to the needs of inmates on a watch status.

2. Rounds: 30-minute rounds are required by P5500.14, Correctional Services Procedures Manual.

Institution Response: 2. Rounds:

SHU training is conducted quarterly in which emphasis will be placed on the importance of diligent rounds within the policy guided timeframes. In addition, the SHU Lieutenant will review documentation (SHU Round Sheets) on a daily basis and provide the Captain with an assurance memorandum of their completion weekly. SHU Rounds sheets will be maintained on the specified range to ensure officers are completing required rounds. A staff member must observe all inmates confined in continuous locked down status, such as administrative detention or disciplinary segregation, at least once in the first 30 minute period of the hour, followed by another round in the second 30 minute period of the same hour, thus ensuring an inmate is observed at least twice per hour. These rounds are to be conducted on an irregular schedule and no more than 40 minutes apart. All observations must be documented. Closer observation may be required for an inmate who is mentally ill, or who demonstrates unusual or bizarre behavior. These inmates have been identified with an orange photographic door tag to ensure staff are aware to take more security pre-cautions in dealing with this inmate. Two hour Captain video review and six hour IDO video review are being conducted.

3. Cellmate Assignments: When Mr. Epstein was placed in SHU on July 7, 2019, Executive Staff decided Mr. [redacted] would be his cellmate. As explained by [redacted], input was not sought from Psychology Services and it is not clear if or how sex offender-specific needs and associated risk were incorporated into the housing plan. Mr. [redacted] was also a high profile inmate-an ex-police officer charged in multiple murders. However, he and Mr. Epstein did not share the risk associated with being a sex offender and their pairing may have aggravated Mr. Epstein's risk for self-directed violence. In an effort to treat Mr. Epstein the same as other inmates, a statement repeated by multiple staff, Executive Staff may have inadvertently overlooked the need to consider unique risk factors associated with individuals who have been charged with and convicted of a sex offense. On July 25, 2019, [redacted] sent an e-mail to [redacted], Associate Warden explaining a consultation between [redacted] and Dr. Nagle, National Suicide Prevention Coordinator. In the e-mail, [redacted] Reviewed the consult and recommendation from the Psychology Services Branch, Central Office that Mr. Epstein be housed with another inmate who had also been accused of committing a sex offense. There is no evidence this information was considered beyond this e-mail, and Mr. Epstein was never housed with another inmate charged or convicted of a sexual offense.

It is recommended Executive Staff and Correctional Services staff include a psychologist in decisions about cellmates as a means of incorporating expertise about suicide risk, mental health needs, and interventions for psychological stability.

Institution Response: 3. Cellmate Assignments:

Inmates with serious mental illness and those at-risk for suicidality are discussed during staff meetings, department head meetings, SHU meetings, morning meetings, and close out meetings. The Captain, Associate Wardens, Warden and Psychology Services discuss the inmate's needs. The Legal Department also assists when the inmate's attorney or court are concerned about an inmate's mental health. Psychology Services are involved in making recommendations regarding the types of cellmates with whom inmates at-risk for suicidality should celled. Psychology Services takes into consideration the suicide risk factors involved with a particular inmate and shares their knowledge with Executive Staff.

The psychological reconstruction team suggests MCC New York Executive Staff did not take into account Mr. Epstein's sex offender-specific needs in assigning him a cellmate in SHU. However, that is not correct. MCC New York Executive Staff considered a variety of factors in determining the most appropriate cellmate for Mr. Epstein, including but not limited to history of sex offenses, nature of the inmate, cooperation status, etc.

MCC New York administrators initially housed Mr. Epstein with Mr. [redacted] as both had high profile cases. Mr. [redacted] is also a certified death penalty eligible inmate and, thus, based on correctional judgment, less likely to assault or otherwise try to harm Mr. Epstein. Indeed, Mr. [redacted] notified staff immediately when he realized Mr. Epstein first made a possible suicide attempt/gesture on July 23, 2019.

Prior to Mr. Epstein being taken off suicide watch, MCC New York Executive Staff, with input from Psychology staff, assessed all the inmates in SHU at that time and narrowed the list down to the most appropriate candidates. Mr. [redacted] was not chosen as the investigation at the time had not yet cleared him of any wrongdoing. Most of the other inmates in SHU at the time were there for disciplinary reasons and were otherwise not appropriate to be housed with Mr. Epstein. The other notable inmate in SHU with a history of sex offenses, Mr. [redacted], was deemed dangerous to Mr. Epstein due to his threatening nature. Accordingly, MCC New York Executive Staff narrowed the possibilities to cooperators. Specifically, [redacted], was placed in SHU for claims he was being threatened and extorted on his unit, and he was confirmed as proffering with the U.S. Attorney's Office. As both he and Mr. Epstein were in SHU for safety reasons, Mr. [redacted] was deemed an appropriate cellmate.

Based on the above, consideration was made for Mr. Epstein's sex-offender-specific needs in choosing his cellmate in SHU. His charged crime was just one of the factors reviewed in making the determination. MCC New York Executive Staff also considered high publicity inmates with ample reasons not to hurt Mr. Epstein, and cooperators who are not only vulnerable themselves, but also had a lot to lose should they harm Mr. Epstein.

4. Documentation Accuracy: On July 23, 2019, Mr. Epstein was found unresponsive in his cell. He had abrasions on his neck and knee. There are inconsistencies between documents describing the circumstances of the scene. In a General Administrative Note in PDS-BEMR, [redacted] documented information received from Operations Lieutenant [redacted] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer [redacted], who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, Officer [redacted] wrote he saw Mr. Epstein "laying down near his bunk with what appeared to be a piece of handmade orange cloth around his neck." It is critical that all descriptions of the incident accurately reflect objective evidence.

Officer [redacted] wrote Mr. Epstein an incident report for Self-Mutilation on July 23, 2019, after he was found unresponsive in his cell but prior to having the necessary facts to determine whether he likely engaged in a Bureau violation. BOP Policy expects staff to write an incident report within 24 hours of having the information that an inmate likely violated BOP rules but without making a presumptive decision about guilt. A Special Investigative Services Threat Assessment was completed August 2, 2019, but results were inconclusive as to whether Mr. Epstein engaged in self- directed violence, willingly fought with his cellmate, or was assaulted by his cellmate. It is

recommended that staff remain open to all reasonable explanations for a behavior and take the appropriate actions when a final determination is made. Although the incident report was later expunged, inmates frequently experience significant stress when they contemplate the potential consequences associated with findings of guilt.

Dr. [redacted] entered a Psychology Services Intake Screening into PDS-BEMR on July 8, 2010. The document has three typographical errors. She selected the No Sexual Offense Convictions check box when, in fact, Mr. Epstein was previously convicted of Solicitation of Prostitution and Procuring a Person Under the Age of 18 for Prostitution. Second, Mr. Epstein was erroneously identified as a Black male in this document. Finally, there is one instance where he was mistakenly referred to as Mr. [redacted].

Dr. [redacted] completed a Risk of Sexual Abusiveness document on July 8, 2019. She marked "History of prior prison sexual predation" in the affirmative. This is not accurate.

[redacted], Mid-Level Practitioner, completed a History and Physical on July 9, 2019. An Intake Screening should have been conducted within 24 hours of his entry into Bureau custody which was on July 6, 2019, according to P6031.04, Patient Care.

Officer [redacted] was responsible for observing Mr. Epstein and documenting his behavior while on suicide watch on July 23, 2019. Officer [redacted] mistakenly used a Suicide Watch Log Book intended for inmate companion documentation between 1:40 a.m. and 6:00 a.m. on July 23, 2019, when he should have been using the Staff Suicide Watch Log Book. Ms. [redacted], Drug Treatment Specialist, reportedly noticed this error and subsequently hand copied all of Officer [redacted]' entries from 1:40 a.m. to 6:00 a.m. into a Staff Suicide Watch Log Book. She then initialed these entries, and this makes it appear as if she was the one conducting the watch. This information was discovered and conveyed in an e-mail from Ms. [redacted], Associate Warden to Dr. [redacted] with a carbon copy to Warden [redacted] on August 12, 2019. Of note, Ms. [redacted] did not make an entry explaining why she was making the log book changes. Additionally, Ms. [redacted] then wrote entries for 6:15, 6:30, 6:45 and 7:00 a.m. in the Staff Suicide Watch Log Book. These were not a part of the original entries made by Officer [redacted] nor was Ms. [redacted] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why Ms. [redacted] attempted to correct Officer [redacted]' error, or made any of the subsequent log entries. It is recommended that if a staff member makes an entry error (e.g., writes in the incorrect suicide watch log book), the staff member should describe the error in the correct log book, to include indicating when they became aware of the error. The staff member should then notify the Chief Psychologist.

A review of Special Housing Unit Records (BP-A0292) revealed a number of incomplete entries. This document is used to monitor provision and receipt of basic services such as recreation, medical rounds, showers, meal consumption, etc. The Officer in Charge signature is missing on 10 occasions and a medical provider's signature is missing in seven instances. There are six instances in which it is not clear if Mr. Epstein ate his meal. There are nine instances in which it is not clear if Mr. Epstein took a shower. There are ten instances in which it is not clear if Mr. Epstein was offered recreation. P5500.15, Correctional Services Manual requires accurate and complete information on the BP-A0292.

A review of Psychology Observation Log Books revealed significant discrepancies from the approved Psychological Observation Procedural Memorandum, dated April 15, 2019. A Correctional Officer is required to complete hourly rounds and sign the log book.

179 out of 183 round signatures were missing. The lieutenant is required to sign the log book one time per shift and signatures were missing in 10 of 23 instances. A Physician Assistant is required to sign one time per shift and 16 of 16 instances were missing. It is recommended that a further review of Psychological Observation procedures be conducted.

Institution Response: 4. Documentation Accuracy:

The Reconstruction team indicates it is critical that all descriptions of the incident accurately reflect objective evidence, and references Psychology staff's reliance on differing statements from two different staff regarding the July 23, 2019 incident. Psychology staff considers the information from more than one source when making decisions about suicide watch placement. Clinical judgment is used to make determinations taking into consideration each person's self-report of a situation as they may be perceived differently.

In reference to typographical errors noted in PDS/BEMR notes, the Chief Psychologist has spoken to all psychology staff members concerning proof reading all documents entered to reduce typos and to improve information accuracy. Additionally, there is a second Staff Psychologist in the department which helps reduce the workload on current psychologists, allowing more time for documentation review.

Regarding the Reconstruction team's concerns in reference to Mr. Epstein's expunged incident report, Special Investigative Services staff will conduct all investigations in matters of attempted suicide and make a determination as to whether an incident report is warranted.

The Reconstruction team stated medical staff conducted Inmate Epstein's Intake Screening late. SENTRY records reflect Inmate Epstein arrived in MCC New York's Receiving and Discharge (R&D) area on July 6, 2019, at approximately 9:24 p.m. His medical Intake Screening was conducted at approximately 9:38 p.m., by Physician Assistant (PA) [redacted] on the same night and approximately 14 minutes after his arrival in R&D. On July 9, 2019, he was placed on Psychological Observation and at approximately 12:38 p.m., he was escorted from Psychological Observation to Health Services for a Medical Assessment and a History and Physical, which was performed by PA [redacted] within three (3) days of his arrival. According to Program Statement 6031.04, *Patient Care*, a provider must perform a History and Physical within 14 days of the inmate arriving at BOP facility. The History and Physical and Intake Screening were conducted timely and in accordance to policy.

Regarding use of the incorrect Suicide Watch Log and the re-creation thereof, the Chief Psychologist and Drug Abuse Coordinator counseled the Drug Treatment Specialist (DTS) concerning her documentation in the suicide watch log book. There was no ill-intent on the part of the DTS as all log books were maintained; the original log book written by the officer and the one documented by the DTS. The DTS indicated a desire to assist the officer as he had written in the wrong log book. Specifically, he wrote in the inmate companion log book rather than the staff log book. However, she was informed that this is not her role and she is not to document in a log book for anyone else observing an inmate on suicide watch. In the future, only the staff member watching the inmate on suicide watch and Operations Lieutenants document in the suicide watch log book. Log books are now being closely monitored on a daily basis by the Chief Psychologist.

Incomplete entries were noted in the BP-292s. SHU training is conducted quarterly, in which emphasis will be placed on the importance of proper 292 documentation. In addition, the SHU Lieutenant will review 292s on a daily basis and provide the Captain with an assurance memorandum. 292s will be printed for the previous week every Sunday, and the SHU Lieutenant will acquire any needed signatures from the respective OICs in a handwritten manner.

The Reconstruction team findings noted discrepancies in the procedures approved for Psychological Observation. The Psychology Department has eliminated Psychology Observation at MCC-NY. Both Staff and the Lieutenants received additional training on when they are required to complete rounds and sign Suicide Watch log books. With regard to suicide watch log books signatures, correctional staff are required to perform routine rounds every hour. The 2 Sally Officer on Monday- Friday during Day Watch is required to perform rounds on suicide watch inmates as prescribed by the Captain. After-hours, the Unit 2 Officer will be responsible for making rounds, serving meals, collecting trash in the area, and performing the count with the Internal 1 or Internal 2 assisting with duties as

assigned by the Captain. Additionally, Psychology staff check the suicide watch logs daily when they interview the inmates on suicide watch. If it is noted hourly rounds are not being conducted by the Unit Officer and/or the Lieutenants are not rounding and signing the books each shift, the Associate Warden over Programs and the Captain are notified immediately and enforce accountability.

5. Telephone Calls: In a PDS-BEMR note written by [redacted] on July 16, 2019, she was informed by an unnamed staff member that a lieutenant facilitated two telephone calls for Mr. Epstein. It is unknown when and to whom these calls were placed and no evidence that they took place on a monitored telephone.

According to a memorandum from Unit Manager [redacted] on August 10, 2019, Mr. Epstein terminated his legal visit early on August 9, 2019, in order to place a telephone call to his family. Mr. [redacted] (who was the Institutional Duty Officer that week) escorted Mr. Epstein to SHU around 7:00 p.m. that evening and he was placed in the shower area on G tier. While there, he was provided the telephone to make a call.

Since Mr. Epstein reportedly did not have his PAC or PIN number, which is required to use the inmate telephone system, the Unit Manager placed the call, dialing a number that reportedly began with area code 347. Mr. Epstein told Mr. [redacted] he was calling his mother who, according to public records, has been deceased since 2004.

It is recommended that all telephone calls, other than legal calls, be made on monitored lines to be available for post-call review or on a speaker phone so staff can monitor what is discussed.

Institution Response: 5. Telephone calls:

There is no documentation to substantiate that a Lieutenant facilitated two telephone calls to Mr. Epstein. However, there is documented evidence that Unit Manager Proto provided a call to Mr. Epstein on July 30, 2019, at 5:15 p.m., to a [redacted], friend, on a monitored telephone/speaker phone. The call was documented in a log that is maintained in the Correctional Systems Department. Mr. Epstein was provided a call because he had not been able to conduct voice recording on the inmate telephone. This is standard procedure by the Unit Team at MCC New York, to occasionally provide a call to new arrivals, when necessary.

6. Direct Observation: Mr. Epstein was on suicide watch from July 23, 2019, until July 24, 2019. While on suicide watch on July 23, 2019, Mr. Epstein attended an Attorney visit from approximately 12:40 p.m. until 7:15 p.m. During this time, he was without "direct, continuous observation" by a dedicated BOP staff member as required by P5324.08. While on Psychological Observation, he attended attorney visits on July 24, 2019, for 11.25 hours; on July 25, 2019, for 11.25 hours; on July 26, 2019, for 9.25 hours; on July 27, 2019, for 11.33 hours; on July 28, 2019, for 10.5 hours; and on July 29, 2019, for 8 hours. On July 30, 2019, Psychology Observation was terminated. During these visits, continuous observation by a dedicated BOP staff member was not maintained as required by MCC New York's Procedural Memorandum for Psychological Observation.

Institution Response: 6. Direct Observation:

The Psychology Department has eliminated Psychology Observation at MCC-NY. Inmates on Suicide Watch are only provided legal visits under special circumstances as deemed by the Court.

7. Follow-Up: Mr. Epstein arrived at MCC New York on Saturday, July 6, 2019. While conducting the 10:00 p.m. institution count that evening, [redacted], Facilities Assistant reported she observed Mr. Epstein in his cell. In an e-mail she sent to Drs. [redacted] and [redacted] and Lieutenant [redacted] later that evening, she described Mr. Epstein as "distraught, sad and a little confused." She said she then asked Mr. Epstein if he was okay, and he reportedly said he was. However, Ms. [redacted] noted in her e-mail she was not convinced of this, adding, "He seems dazed and withdrawn." She went on to say, "So just to be on the safe side and prevent any suicidal thoughts can someone from

Psychology come and talk with him." Despite the fact that Lieutenant [redacted] opened the e-mail there is no evidence that he contacted the on-call psychologist as is required by P5324.08, Suicide Prevention Program. Additionally, if Ms. [redacted] was concerned about suicide risk, P5324.08, Suicide Prevention Program, requires her to maintain direct, continuous observation of Mr. Epstein. When [redacted] opened the e-mail the following Monday morning, Mr. Epstein was evaluated by Dr. [redacted] at approximately 9:30 a.m.

Mr. Epstein was denied bail on Thursday, July 18, 2019. This was a significant disappointment for Mr. Epstein and likely challenged his ability and willingness to adapt to incarceration. Given the potential impact of the judge's decision, a psychologist should have assessed Mr. Epstein's mental status upon his return to the institution. The BOP developed a SENTRY assignment of PSY ALERT for purposes such as this.
Specifically PSY ALERT is used "to ensure, if movement occurs, that all staff consider the special psychological and management-related risks associated with the inmate." Furthermore, P5324.07, SENTRY Psychology Alert Function states, "When a decision to move [any PSY ALERT] inmate occurs, any special psychological needs of the inmate are reviewed and considered by Psychology Services staff [and] any safety and security concerns are highlighted for non-Psychology Services staff." Psychologists should use the PSY ALERT assignment more frequently with high profile cases and with inmates who have a history or charge of sex offense. Both of these groups of inmates are susceptible to exaggerated or unrealistic fears about correctional settings and experience stress associated during movement and periods of transition (e.g., cell/unit changes, movement to and from court, institutional movement, and release of information through the media).

Mr. Epstein was reportedly in court on July 31, 2019. It is unknown what time he departed or returned to MCC New York because this information was not entered in SENTRY. Regardless, upon his return, the United States Marshals Service (USMS) provided R&D staff with a Prisoner Custody Alert Notice regarding Mr. Epstein. The notice indicated Mr. Epstein had "MTL Mental Concerns Suicidal Tendencies." The USMS requested R&D staff sign the form, and they then departed with the signed copy. On August 1, 2019, at 8:46 a.m., Dr. [redacted] sent [redacted] an e-mail reporting she had just become aware of the above information. In the absence of additional information about this notation, this should have been considered a referral to Psychology Services about a potentially suicidal inmate and procedures should have been followed as outlined in P5324.08, Suicide Prevention Program. Specifically, when a staff member becomes aware an inmate may be thinking about suicide during normal working hours, that staff member must contact Psychology Services and maintain the inmate under direct,continuous observation until he is placed on Suicide Watch or seen by a psychologist. There is no evidence Mr. Epstein was monitored under these conditions from the time he returned from court until he was seen by Dr. [redacted] for a suicide risk assessment on August 1, 2019, at approximately 1:30 p.m.

Institution Response: 7. Follow Up:

Staff have been trained that it is required that they make verbal contact with either Psychology Staff or a Lieutenant when they have concerns for an inmate's mental health. If Psychology Staff is not in the institution, an inmate is placed on suicide watch, and the on-call psychologist and Warden are notified.

As part of their signature block, all Psychology staff have added the following: "If you are emailing about an inmate that may be at risk for suicide or self-harm, this is an emergency situation. Please make sure that you make contact (verbally) to Psychology Staff or the on-call psychologist. Please ensure to maintain constant visual observation of the inmate until formal steps can be taken to ensure his/her safety pending a formal assessment by a Psychologist."

The Psychology Department uses PSY ALERT codes more frequently with high profile cases and with inmates with a history or charge of a sex offense. The PSY ALERT code is applied immediately on classification and/or identification, and not just when an inmate is about to leave the institution. If an inmate is moved in and out of our institution for court, etc., the inmate is assessed immediately prior to being released to a unit.

R&D staff have been reminded of the U.S. Marshal and Court alert notices. Psychology Staff are notified immediately if there are suicidal concerns noted by the Courts. If Psychology Staff is not in the institution, an inmate that enters the institution with an alert notice is placed on suicide watch, and the on-call psychologist and Warden are notified. These inmates receive a suicide risk assessment by a psychologist before being released to the general population.

Inmates who initially enter and/or transfer into the institution with a PSY ALERT assignment will be seen by a member of the Psychology Services Department immediately and prior to being released to the general population. R&D will review the PP44 code and Intake Screeners will utilize the PP64 to determine if inmates entering the facility have a PSY ALERT assignment. If there is not a psychologist in the building when a PSY ALERT inmate is identified and/or if it is during non-duty hours, the Operations Lieutenant will immediately be notified and will then contact the on-call psychologist. The on-call psychologist will come in after hours to screen the inmate in R&D and determine their appropriateness for general population, as well as any other pertinent housing considerations, prior to the inmate's release to general population.

Inmates may also be assigned a PSY ALERT function code by a psychologist while housed at this institution. Psychologists will consider not only inmates with substantial mental health concerns for a PSY ALERT assignment, but will use PSY ALERT codes frequently with high profile cases and with inmates with a history or charge of a sex offense. The PSY ALERT code is applied immediately and not just when an inmate is about to leave the institution.

The attached institutional procedural memorandum has been reviewed by Central Office Psychology Services and implemented by MCC New York Psychology Services to outline the follow-up procedures when existing PSY ALERT inmates return from trips such as court proceedings and hospital trips. If any movement occurs with an existing PSY ALERT inmate, psychology must be verbally notified immediately when the inmate returns back to the institution. This would include movement from court, institutional movement, or hospital trips. The Psychology Department will also be notified of a PSY ALERT inmate's movement prior to the inmate leaving. The Psychology Department will be provided with the court lists as well as the Prisoner Schedule Report on a daily basis. These reports will be reviewed daily by a member of the psychology department to assess whether a PSY ALERT inmate is scheduled to go out to court the following day.

When an existing PSY ALERT inmate who has already been initially screened by the Psychology Department returns from court with a notice from the Judge or Marshal's Office indicating imminent mental health concerns or concerns related to suicidality, the PSY ALERT inmate will be seen by a psychologist immediately and prior to their return to general population. A psychologist will determine at that time if a PSY ALERT inmate is ready to return to general population, their psychological stability, and their treatment needs. If the inmate returns after hours and there is no psychologist in the institution, the PSY ALERT inmate will be placed on suicide watch pending a suicide risk assessment by a psychologist. The Operations Lieutenant, On-Call Psychologist and Warden will be notified.

When an existing PSY ALERT inmate who has already been initially screened by the Psychology Department returns from court routinely, and without a notice from the Judge or Marshal's Office, they will be screened by a member of the Psychology Department within 24 hours to assess if they are experiencing any significant distress regarding their court proceedings that may be exacerbating their mental health difficulties and/or risk factors.

Per guidance from Central Office Psychology Division, the Psychology Department will conduct a training with R&D staff to help train them about PSY ALERT inmates and to recognize signs of psychological distress and suicidality. Suicide Prevention and PSY ALERT Trainings have recently been conducted by the Psychology Services Department with Lieutenants and during a recent Department Head Meeting. Further, an e-mail regarding

PSY ALERT procedures was sent to all Lieutenants, Receiving and Discharge (R&D), Psychology and Health Services staff.

8. Inmate Accountability and Assignment Accuracy: According to a SENTRY quarters roster generated on August 10, 2019, at 12:51 a.m., there were three inmates assigned to Mr. Epstein's SHU cell, Z04-206LAD, including him, at the time of his death. However, his SHU cell was only a double occupancy cell. Inmate [redacted], inmate [redacted], and Mr. Epstein were all assigned to the same cell. On August 13, 2019, at 12:06 p.m. and 12:08 p.m., a quarters history roster was generated for inmate [redacted] and [redacted], respectively. Inmate [redacted] cell assignment was Z04-206LAD from August 5, 2019, until August 11, 2019, when he was moved to cell Z04-212UAD. Inmate [redacted] cell assignment was Z04-206UAD from August 1, 2019, until August 11, 2019, when he was moved to cell Z04-207LAD. A quarters history roster was generated for Mr. Epstein on August 13, 2019, at 9:07 a.m. His cell assignment was Z04-206LAD from July 29, 2019, until August 10, 2019.

On Monday, August 12, 2019, photographs of nametags on SHU cell doors and SHU locator forms were sent to the Correctional Service Department in the Northeast Region. The SHU locator form is dated August 9, 2019. It shows inmate [redacted] in cell 207L (SENTRY states he was moved to this cell on August 11, 2019), inmate [redacted] in cell 212U (SENTRY states he was moved to this cell on August 11, 2019), inmate Epstein in cell 220L (SENTRY never shows him in this cell) along with inmate [redacted] ([redacted]). The locator shows inmate [redacted]) and inmate [redacted]) in cell 206. The photo sheets show the cell being 220 with inmates Epstein and [redacted]' identification cards on the door. Inmate [redacted], [redacted] was in cell Z06-220U from August 5, 2019 to August 9, 2019.

MCC New York has four suicide watch cells and each is for single occupancy use. The suicide watch cells are located in Health Services. Each cell is abbreviated with the unit code HO1 in SENTRY followed by the four-digit cell number. The doors are identified by a painted number from one to four. Two reviews were conducted. The first revealed Mr. Epstein was in H0l-00lL according to SENTRY but the Suicide Watch Log Books indicate he was in cell 4. A second review was conducted on August 13, 2019, while there were four inmates on in these cells. SENTRY showed two inmates assigned to HOl-00lL, one assigned to H01-002L, and the fourth inmate assigned to a general population housing unit. Through physical observation of the dedicated suicide watch cells there were four H0l cells, however a review of the BOPWARE Inmate Housing Format, only shows three cells.

Inmate movement and assignments are not accurately reflected in SENTRY as required by P5500.14, Correctional Service Procedures Manual.

Institution Response: 8. Inmate Accountability and Assignment Accuracy:

With regard to the accuracy and accountability of inmates placed on suicide watch status in the hospital area, Psychology Services now runs a daily Sentry roster of all the inmates on suicide watch in that area. The roster is examined to ensure that the inmates placed on suicide watch in a suicide watch cell are keyed into SENTRY with the correct cell assignment noted. The Associate Warden, Programs, is notified if there are any inconsistencies. Moreover, the four suicide watch cells now all have SENTRY Assignments of H01-001L – H01-004L. Further, Psychology Services Department reviews suicide watch log books on a daily basis to assess whether the Lieutenants have conducted rounds during each shift and whether the Unit 2 Sallyport and Unit 2 Officer are conducting hourly rounds. Any inconsistencies noted in the logbooks by Psychology staff will be reported immediately to the Captain and the Associate Warden over Programs to address appropriately.

The Operations Lieutenant will physically check the PP30 Cell Assignment Roster when inmates are quartered on suicide watch. The Lieutenant will ensure the Counts and Assignments (C&A) Officer keys cell assignments correctly and annotate any errors in the daily log and contact the Captain immediately. Guidance was sent to the Lieutenants regarding keying of suicide watch bed assignments after hours. The Lieutenants were instructed that

upon placing an inmate on suicide watch, they are responsible for contacting C&A and providing the cell assignment. Additionally, the Lieutenant will run a PP30 with the selection category for suicide watch. The Operations Lieutenant will email the roster to the Captain, as he will be responsible for verifying that each inmate is in the appropriate cell. This verification process will ensure inmates placed on suicide watch are keyed into accurate bed assignments and will eliminate inmates being keyed into the same cell.

Additionally, the Lieutenants were instructed to contact the Captain and on-call Psychology staff by telephone when the need for suicide watch placement is determined after hours. Psychology staff have been instructed to contact the Warden upon receiving said notification. After consultation with the Warden, Psychology staff will designate whether a staff or inmate companion will be assigned. Psychology staff will in turn inform the Shift Lieutenant of this determination.

To ensure inmates are assigned to the correct cell inside the Special Housing Unit, periodic and unannounced checks are conducted. Specifically, SENTRY Roster PP30 Quarters assignments are audited daily by the SHU Lieutenant. Executive Staff also conduct routine bed book counts in all units. Any and all discrepancies identified are addressed. Results will be maintained by Correctional services in the Lieutenants Log. Morning Watch Lieutenant is responsible for observing one count during his or her shift in SHU which is documented daily in the Lieutenants Log.

In order to properly account for inmates in the unit, staff have been informed not use the Inmate Locator Form, due to the forms being unreliable in accounting for inmates and cell assignments. A Unit Accountability Board along with a SENTRY PP30 Quarters Roster have been placed in the unit to establish better oversight over inmate accountability.

Correctional Staff are required to perform routine rounds of the second floor suicide watch area every hour. On Day watch, Monday through Friday, the 2 Sally Officers are required to perform rounds on suicide watch inmates, as prescribed by the Captain. After hours, the Unit 2 Officer will be responsible for making rounds, serving meals, collecting trash in the area, and performing the count with the Internal 1 or Internal 2 Officer assisting with duties as assigned by the Captain. To ensure that staff are informed of the importance of Suicide Prevention and responsibilities when one occurs. Lieutenants will reinforce the message through conference calls with staff. Roll Call notes will be placed on TRU Scope to notify staff of which inmates are currently on suicide watch.

9. Attorney Log Books: Four log books were not secured following Mr. Epstein's death. Specifically, three Attorney Log Books located in the Attorney Visiting and Front Lobby areas and an Inmate Search Log Book located in the Attorney Visiting area were not secured. All four books were still in use at the outset of the reconstruction and after the reconstruction team advised staff to secure them. P5324.08 states, "In the event of a suicide, institution staff, particularly Correctional Services staff, and other law enforcement personnel, will handle the site with the same level of protection as any crime scene in which a death has occurred." This policy further states, "All possible evidence and documentation will be preserved to provide data and support for subsequent investigators doing a psychological reconstruction."

Further, a review of the attorney log books identified many errors and signify a systemic concern. For example, there were two concurrently open attorney log books in the Attorney Visiting area. Further, the different purposes of the two attorney log books, one in the Attorney Visit area and one in the Front Lobby, could not be explained. BOP staff were unable to articulate a system of control for the log books, and during the reconstruction, some of the log books could not be accounted for. Within the log books, entries were made out of chronological order, attorneys did not consistently sign in and out, significant information was illegible or missing, columns were not consistently labeled, log book opening and closing dates were inconsistent, and the cover had been tom off of several books. At the current time, these log books are not functioning as an adequate system of control and monitoring.

Institution Response: 9. Attorney Log Books:

On August 10, 2019, log books deemed relevant to the investigation were removed from various locations throughout the facility. The Reconstruction Team did identify pertinent logbooks that had not been secured. At this time, all relevant logbooks have been removed and replaced. In addition, a logbook audit was conducted to ensure accuracy of the documentation and compliance with policy. Measures are being taken to ensure in the future that all relevant logbooks are identified, secured immediately and replaced with new ones to ensure the institution can continue to run efficiently.

10. Automatic External Defibrillators: A review of available AEDs in the institution revealed that the list used for accountability and inspection purposes was inaccurate and incomplete.

Institution Response: 10: Automatic External Defibrillators:

A review of the Automatic External Defibrillators (AED) report presented by Great Lakes Biomedical Services dated July 22, 2019, revealed that all AEDS were accounted for and were placed in the correct respective areas. The report was accurate and complete. New AEDs have been purchased and will be inspected Great Lakes Biomedical Services upon their arrival. The list reviewed by the reconstruction team was an old and outdated list from January 8, 2018.

Medical staff have prepared and are awaiting approval of training and procedures to allow them to inspect institutional AEDs locally in between/in between outside inspections by Great Lakes Biomedical Services. A copy of the proposed procedures is attached hereto.

11. Post Orders & SHU Training: SHU Post Orders Sign-In Sheets were reviewed for the 3rd Quarter, spanning June 9, 2019, to September 7, 2019. Officer [redacted] failed to sign post orders for SHU #3 post.

Quarterly SHU Training Sign-In Sheets were reviewed. The 2019 3rd Quarter SHU Training was conducted on June 6, 2019. Three staff assigned to the 3rd Quarter SHU Roster in SHU did not attend or receive the SHU Training: Officer [redacted], Officer [redacted], and Officer [redacted].

Institution Response: 11. Post Orders & SHU Training:

The Suicide Watch Post Orders are located in the Lieutenant's Office and SHU with a quarterly sign-in sheet. A copy of the Suicide Watch Post Orders will also be placed in a secure container outside of the suicide watch cells on Tier H in SHU. This container will also hold signature sheets and additional Staff Suicide Watch Log Books. All staff members assigned to a suicide watch post are responsible for signing the post orders prior to performing the staff suicide watch. Attached please find a copy of the NERO Waiver permitting staff monitored suicide watches in SHU.

With regard to SHU Suicide Prevention training, this continues to be carried out on a quarterly basis. However, the sign-in sheets for this training are now be examined by the SHU Lieutenant for accuracy. If a staff member who is assigned to SHU misses the training, the sign-in sheet will be routed to the Captain, who will coordinate with the Chief Psychologist and schedule a time to receive a make-up session for the SHU Suicide Prevention Training.

SHU training is conducted quarterly two weeks from the beginning of the new quarter. A representative from Psychology will provide the required suicide prevention training. In addition, the SHU training on BOPLEARN will be completed by all staff assigned to SHU that day of training. SHU staff will be allotted time during that day to complete all prescribed web-based training as identified on the agenda. Staff who are assigned to SHU but have not received the mandatory training before assuming the post will be roster-adjusted to attend another training day as

assigned by the Captain.

Staff assigned to suicide watch shall maintain a chronological log of the inmate's behavior. Blank log books will be maintained in the Lieutenants office and on the 2nd Floor. A chronological record of events will commence immediately upon the initiation of watch. It is the responsibility of the staff member initiating the watch to obtain a blank log book prior to initiating the watch. Different log books will be used for each inmate on suicide watch; each log book will contain entries for one suicide watch only. The name and register number of the inmate on watch shall be clearly printed on the front cover of the log book and at the top of each page in the log book on which entries are made.

During some suicide watches, staff observers may cover some shifts and inmate companions may cover others. In this instance, two separate log books must be used: one for the shifts during which staff are maintaining constant visual observation (blue) and another for shifts during which inmate companions are providing constant visual observation (yellow). When separate inmate companion log books are used, staff must sign the inmate companion log book every 60 minutes.

Lights will remain on inside the cell 24 hours day to ensure the inmate on watch can be seen. A Lieutenant will make rounds every shift and remove the inmate from the cell and perform a cursory search. No food items, trays, eating utensils, milk cartons, toilet paper, plastic bags, reading materials, pens, pencils, or anything else not prescribed by Psychology staff should be in the cell.

The inmate will be outfitted in a suicide preventive smock, suicide preventive blanket, suicide preventive mattress and if necessary a suicide preventive helmet. Inmate Companions will be searched prior to assuming duties. Inmate Companions are not allowed to have radios, mp3 players, magazines, books or anything that would distract them from maintaining constant supervision. Inmate Companions will not have direct or physical contact with inmates on suicide watch.

12. Staffing: The Drug Abuse Program Coordinator positon at MCC New York was abolished during Phase I of the staff realignment during fiscal year 2018. Re-establishing
the Drug Abuse Program Coordinator position would provide the institution with an additional supervisory psychologist to provide critical clinical services.

Staffing in the Correctional Services department is relevant to the reconstruction. However, the details about this topic are provided in an After Action Review completed separately from this report.

Institution Response: 12. Staffing:

The Drug Abuse Coordinator position is currently a shared position. The Warden has re-established the Drug Abuse Coordinator position as a full-time position to provide the Psychology Department with an additional supervisory psychologist to perform critical clinical services. At the current time, the position is pending selection.

We are currently in the process of requesting to hire a Staff Psychologist position to provide additional psychological services to inmates in the SHU, including therapy sessions with PSY ALERT, CC2-MH and CC3-MH inmates who are currently housed there. An additional psychologist could also monitor Hot List inmates arriving to the SHU and ensure they are housed with appropriate cellmates. This psychologist could conduct daily rounds to look for signs of psychological distress and address the concerns of our Long Term SHU inmates. Finally, an additional Staff Psychologist could assist with our daily crisis interventions and suicide risk assessments.

13. Sex Offense Risk Factors: A broad understanding of risk factors associated with sex offenders, by staff at MCC

New York, did not appear to be present in all staff but was vital to his adjustment and safety in prison. A more focused management strategy is recommended, particularly in complex and high profile cases. Supplemental training on sex-offender specific risk factors is recommended for all staff and should be provided by Executive Staff and Psychology Services.

Institution Response: 13. Sex Offense Risk Factors:

The Chief Psychologist is a member of the Executive Staff. The Chief Psychologist or her designee continues to be present at all Executive Staff Meetings, Department Head Meetings, and SHU meetings. During these meetings, the Chief Psychologist offers feedback regarding the treatment and management of sex offender inmates. Additionally, the Chief Psychologist continues to educate all staff during Introduction to Correctional Techniques (ICT) and Annual Training (AT) about the sex offender specific risk factors and suicidality.

DOCUMENTS EXAMINED

TRU-INTEL Download Report of Incident (583), 586, & Global Report
TRUVIEW - Money Exchanged; Phone, Email, & Visitor Lists; Calls; Messages; Visits; Timeline
TRU-SCOPE - Logs, High Risk Inmates, Inmates Lists, etc. Staff Memorandums
Staff E-Mail
Photographs of Scene; Deceased, Autopsy Video Showing Scene and Staff Response Sentry Documentation
SIS Case File Index Psychology File PDS-BEMR
Psychological Observation Procedural Memorandum Post Orders
Lieutenant Logs Attorney Logs Staff Roster
Medical Information/Records (BEMR) BOP Twenty-Four Hour Death Report Pre-Sentence Report
Note(s) Left Behind by Deceased Time Line
Autopsy Request & Report Inmate Central File
Court Return Screening Form Prisoner Remand Form (If applicable)
USM 129 Individual Custody/Detention Report (If applicable) Prisoner Custody Alert Notice
Staff Sign-In Log 1 Week Prior to Suicide (If applicable) Detention Orders (If applicable)
30 minute SHU rounds BP 292's