U.S. Department of Justice
Federal Bureau of Prisons

Reentry Services Division

Washington, DC 20534

May 14, 2020

MEMORANDUM FOR [redacted], REGIONAL DIRECTOR
NORTHEAST REGION

FROM: [redacted] Assistant Director
Reentry Services Division

SUBJECT: Institution Response
Psychological Reconstruction
Inmate Epstein, Jeffrey (Reg. No. 76318-054)

I have reviewed your Institution Response, dated January 27, 2020, to the Psychological Reconstruction of an inmate suicide at MCC New York.

The corrective actions and plans for implementation in your response are appropriate. Please thank your staff for their efforts in addressing the recommendations outlined in the Psychological Reconstruction Report.

If you have questions or concerns, please feel free to contact me at [redacted].

cc: [redacted], MCC New York

PSYCHOLOGICAL RECONSTRUCTION OF INMATE DEATH

This is an interim report, due to an inability to gather all necessary data. Formal interviews were not conducted as a part of this reconstruction to avoid interference with pending investigations by other Department of Justice components. A copy of the video is normally made by Special Investigative Staff following a significant incident, but there was no such video in this case since the original video was confiscated by the Federal Bureau of Investigation (FBI) prior to the beginning of this reconstruction. The absence of these two sources of information severely limited the ability to establish accurate timelines, confirm subjective reports, establish converging and diverging lines of facts, or discover new areas of inquiry. As a result, information typically gathered, reviewed and consolidated during a reconstruction to support actionable findings and recommendations is limited.

Name:	Jeffrey Epstein
Register Number:	76318-054
Date of Death:	08-10-2019
Prepared by:	[redacted], National Suicide Prevention Coordinator, Psychology Services Branch, Central Office

BACKGROUND INFORMATION

Mr. Jeffrey Epstein was a 66-year-old, White male who died on August 10, 2019, while housed at the Metropolitan Correctional Complex (MCC), in New York, New York. [redacted], former Acting Assistant Director, Reentry Services Division, appointed a team to conduct a psychological reconstruction. The team consisted of [redacted]. This reconstruction was established in accordance with Bureau of Prisons' (BOP) Program Statement 5324.08, Suicide Prevention Program.

Social History: Mr. Epstein did not have a Pre-Sentence Report (PSR) available at the time of the reconstruction; therefore, no official information regarding social history was accessible. The following was gathered from publicly available documents. Mr. Epstein was born in 1953 and grew up in a middle-class family in the neighborhood of Sea Gate on Coney Island, Brooklyn, New York, with one brother. After early promotion in two grades, Mr. Epstein graduated from Lafayette High School in 1969, at the age of 16. He attended Cooper Union and New York University but did not graduate from either. Mr. Epstein taught at the Dalton School, a private school on the Upper East Side of Manhattan from September 1974 until he was

dismissed in June 1976 for inadequate development as a teacher. Following that, he held a number of positions in the financial industry to include a position as a limited partner at Bear Stearns until he was dismissed for unknown policy violations in 1981. He also worked as a financial consultant and founded at least two separate companies.

Mr. Epstein had two significant periods of employment. The first of these was his position as a consultant with Steven Jude Hoffenberg in the late 1980s. Mr. Hoffenberg was described as his first mentor. Mr. Hoffenberg was later convicted and incarcerated for running a large Ponzi scheme. He implicated Mr. Epstein in fraudulently diverting company funds for his own personal use. Years later, Leslie Wexner, Mr. Epstein's sole client at J. Epstein and Company, granted him power of attorney over his affairs. Despite also being identified as Mr. Wexner's mentee, Mr. Epstein was again accused of misappropriating funds-more than 46 million dollars. These large sums are believed to be the seed money Mr. Epstein used to establish his considerable fortune. These events are indicative of Mr. Epstein's highly-regarded intelligence and charismatic personality.

Legal History: Mr. Epstein had a history of adult criminal charges and convictions. In June 2008, he entered into a non-prosecution agreement and pleaded guilty to one count Solicitation of Prostitution and one count Procuring a Person Under the Age of 18 for Prostitution in the state of Florida. He was sentenced to 30 months: 18 months of incarceration and 12 months of probation. He was also mandated to register as a sex offender under the National Sex Offender Registration and Notification Act. Mr. Epstein served 13 of his 18-month incarceration and then successfully completed 12 months of probation. It is unclear whether he followed the sex offender registration guidelines in each place he owned a residence.

In regard to pending charges, Mr. Epstein was formally charged with Sex Trafficking Conspiracy in violation of 18 U.S.C. § 371 and Sex Trafficking in violation of 18 U.S.C. § 1591(a), (b) (2), 2 on July 2, 2019. Specifically, he was accused of sexually exploiting and abusing minor females over the course of several years. Charging documents allege Mr. Epstein enticed and recruited minor females to engage in sexual activity. The minor females were reportedly compensated with cash following the sexual encounters and some were encouraged to find other minor females to accompany them to Mr. Epstein's residences in New York or Florida. He pleaded not guilty to these charges and was in pretrial status at the time of his death.

In a 37-page Decision & Order Remanding the Defendant, signed by Judge Richard M. Berman on July 18, 2019, 18 pages were dedicated to detailing the danger Mr. Epstein posed to others and the community. The document also alleged he was a flight risk. As a result, Mr. Epstein's proposed bail package was determined to be inadequate. He was denied pretrial release and held on remand.

Institutional History: On July 6, 2019, Mr. Epstein was arrested at Teterboro Airport in New Jersey upon his return from Paris, France. It is unknown whether he was anticipating this arrest. He was transported to MCC New York and keyed into SENTRY at 9:24 p.m. that evening. Mr. Epstein was placed in a general population housing unit for approximately 22 hours. On July 7, 2019, at approximately 7:20 p.m. he was moved to the Special Housing Unit (SHU) pending reclassification due to the significant increase in media coverage and awareness of his notoriety among the inmate population.

With regard to his adjustment to a correctional setting, Mr. Epstein received one incident report while in BOP custody for Self-Mutilation on July 23, 2019. As of August 15, 2019, the incident report had been expunged though it is unclear why it had been expunged and whether Mr. Epstein knew this. Also, a review of financial transactions associated with Mr. Epstein's prison account revealed one of his attorneys was depositing funds into his cellmate's (inmate Reyes) commissary account for unknown reasons.

HEALTH CARE AND PERSONALITY DESCRIPTION

BOP Electronic Medical Records (BEMR) indicate Mr. Epstein was diagnosed with hyperlipidemia, sleep apnea, hypertension, constipation, prediabetes, neuralgia, and neuritis unspecified. He was prescribed the following mediations: docusate sodium, milk of magnesia, omega 3, methylprednisone, and bisacodyl. Mr. Epstein was also prescribed insulin, and the prescription required him to go to the institution pharmacy for administration of this medication. However, the dates for which it was prescribed have a notation indicating "dose not indicated," thus it does not appear insulin was routinely medically necessary. The rest of the medications prescribed were self-carry. He also had a continuous positive airway pressure (CPAP) machine which is typically used to treat sleep apnea. Mr. Epstein was provided with his personal CPAP machine on July 30, 2019, per BEMR.

In regard to mental health history and treatment, there are no known available records. Any records that may have been maintained relating to Mr. Epstein's incarceration in Florida were not available for review as of the date of this report. With regard to Psychology Data System records in BEMR (PDS-BEMR), [redacted], Forensic Psychologist at MCC New York completed a routine Intake Screening on July 8, 2019. During this screening, Mr. Epstein denied any history of mental health problems, substance abuse, and treatment. No symptoms of mental illness were observed. He was classified as Mental Health Care Level 1 and was not diagnosed with a mental illness.

Following a consultation with [redacted], National Suicide Prevention Coordinator on July 8, 2019, [redacted], Chief Psychologist at MCC New York determined Mr. Epstein should be pre-emptively evaluated for suicide risk upon his return from court. Primary consideration was given to his various risk factors for suicide such as his high profile case and media attention, pending sex offense charges, pre-trial status, and an ongoing court proceeding. Mr. Epstein returned from court on July 8, 2019, after normal business hours. He denied suicidal

thoughts at that time, but due to the potential for other risk factors listed above, the on-call psychologist placed Mr. Epstein on Psychological Observation in one of the suicide watch cells until he could be assessed in person by a BOP psychologist. Psychological Observation is a form of individual monitoring that is less restrictive than Suicide Watch. It is used for inmates who are stabilizing and not yet prepared for placement in general population or restrictive housing. It is often used to transition inmates off of Suicide Watch in order to monitor their transition and safety after an acute suicidal crisis. On July 9, 2019, Mr. Epstein underwent a formal, in-person suicide risk assessment with [redacted]. She determined that, while suicide watch was not warranted at that time, Mr. Epstein should remain on Psychological Observation status out of an abundance of caution. He was removed from Psychological Observation on July 10, 2019.

On July 23, 2019, [redacted], the on-call psychologist was notified Mr. Epstein had been found in his cell with a piece of orange cloth around his neck. Reportedly, he was observed lying in the fetal position on the floor with a noose around his neck. Medical staff evaluated Mr. Epstein and found friction marks and superficial reddening of the neck skin and one knee. He was placed on suicide watch by the Operations Lieutenant at approximately 1:40 a.m. pending a formal in-person suicide risk assessment. [redacted], Staff Psychologist at MCC New York, assessed Mr. Epstein for risk of suicide later in the morning of July 23, 2019, and determined he should remain on suicide watch. Mr. Epstein denied any knowledge of how he received marks on his neck and initially informed staff he believed his cellmate,Nicholas Tartaglione, had attempted to kill him. Special Investigative Services (SIS) staff opened an investigation to assess Mr. Epstein's safety and collect facts surrounding the episode. Despite this investigation, staff was unable to determine whether he was assaulted or engaged in self-directed violence. Mr. Epstein was removed from suicide watch on July 24, 2019, after 31 hours and 5 minutes. Thereafter, he remained in the suicide watch cell and was placed on Psychological Observation, where he remained housed until July 30, 2019, according to PDS-BEMR records. A discrepancy exists regarding when he was removed from Psychological Observation. His cell assignment, per SENTRY, indicates he was transferred back to the Special Housing Unit (SHU) on July 29, 2019, whereas PDS-BEMR indicates he was removed from Psychological Observation on July 30, 2019, at approximately 8:15 a.m.

Mr. Epstein attended a court hearing on July 31, 2019, and, upon his return, the United States Marshals Service (USMS) provided paperwork to Receiving and Discharge (R&D) staff that noted "suicidal tendencies." [redacted] was notified on August 1, 2019, about this paperwork. She consulted with [redacted] and then met with Mr. Epstein to conduct a suicide risk assessment. She determined suicide watch was not warranted at that time.

Mr. Epstein remained classified as a Mental Health Care Level 1 throughout his time at MCC New York. During his contacts with psychologists, Mr. Epstein routinely denied current mental health symptoms to include suicidal ideation, and he did not exhibit symptoms of a serious mental illness. However, there was evidence Mr. Epstein was experiencing challenges

adjusting to his environment and changes in his lifestyle. He reported frequent complaints of difficulty sleeping. He did not have access to his CPAP machine until it was reportedly provided to him on July 30, 2019. Mr. Epstein also reported he was bothered by noise in the SHU. At times, he noted concerns related to his safety in SHU or on a general population housing unit. On two occasions, July 26, 2019, and July 27, 2019, he described himself as a coward and as someone who does not like pain. On July 28, 2019, he told [redacted] the toilet in his cell would not stop flushing for an extended period of time, and he then took to sitting in the comer with his hands over his ears. Mr. Epstein indicated he was agitated following this incident and was unable to sleep that night.

ANTECEDENT CIRCUMSTANCES

Mr. Epstein entered BOP custody on July 6, 2019, with a history of convictions for sexual offenses and allegations comprised of more serious charges. The current indictment alleged sexual crimes against minors, and he was facing up to 45 years in prison. On July 18, 2019, Mr. Epstein's request for bail and pretrial release was denied.

On July 23, 2019, Mr. Epstein was found unresponsive in his cell. The motivation and context were never fully determined. After 31 hours and 5 minutes on Suicide Watch, he was then placed on Psychological Observation. On July 30, 2019, Mr. Epstein was removed from Psychological Observation. [redacted] sent an e-mail reporting Mr. Epstein had been removed from Psychological Observation and needed to be housed with an appropriate cellmate. This e-m ail was sent to 71 MCC New York staff and, as of August 13, 2019, only 27 staff members had opened the message.

On August 9, 2019, a federal court unsealed approximately 2,000 pages of documents into the public domain. These included graphic allegations against Mr. Epstein. Included was a book order receipt for titles such as *SM 101: A Realistic Introduction; SlaveCraft: Roadmaps for Erotic Servitude;* and *Training with Miss Abernathy: A Workbook for Erotic Slaves and Their Owners*. Additional high profile public figures were also named in the released documents. The documents were part of a defamation lawsuit filed by Virginia Roberts Giuffre, a woman who alleged Mr. Epstein had victimized her, against a British socialite, Ghislaine Maxwell, who was Mr. Epstein's ex-girlfriend, associate, and alleged to have assisted with his criminal activities. According to staff report, Mr. Epstein was afforded telephone calls on two different days although it is unknown whether they were legal or social calls. No recording of the calls exist and it is not known with whom he was speaking. One occurred on or around July 16, 2019, and the other on August 9, 2019. Legal calls are not monitored, and would not be recorded. A social call would be recorded; given the limited information known about Mr. Epstein, knowledge of the content of any social calls would have been crucial to helping staff work with him.

Following his final telephone call on the evening of August 9, 2019, Mr. Epstein was moved into his SHU cell. He was single-celled at that time because his cellmate (Efrain Reyes #85993-054)

did not return from court. The need for a cellmate was communicated between Day Watch (DW) and Evening Watch (EW) shifts in the SHU, but no cellmate was placed with him by the EW staff. According to a memorandum from Senior Officer Specialist [redacted], SHU staff were informed at approximately 1:50 p.m. that Mr. Epstein's cellmate would likely not return from court. Furthermore, Officer [redacted] noted Mr. Epstein would need a cellmate upon arrival from his attorney visit.

A review of the 30-minute rounds forms indicate unit rounds were completed for the entire MW shift on August 10, 2019. However, a memorandum from Lieutenant [redacted] indicates Officer Tova Noel and Material Handler Supervisor Michael [redacted] made a statement after Mr. Epstein's death that they did not complete proper 30-minute rounds at 3:00 a.m. or 5:00 a.m.

DESCRIPTION OF SCENE

A detailed description of the scene was unavailable because the officers who discovered Mr. Epstein did not write memorandums and could not be interviewed. According to the Report of lncident, on August 10, 2019, at approximately 6:33 a.m., while serving the breakfast meal in the SHU, Range 9 South, Mr. Epstein was found unresponsive in his cell. Staff reportedly called for medical assistance, activated the body alarm, and began life-saving measures. Arriving staff stated they brought an automated external defibrillator (AED) and stretcher. Cardiopulmonary resuscitation (CPR) reportedly continued while the AED was placed on Mr. Epstein. The AED reportedly indicated no shock advised and CPR was continued. Mr. Epstein was escorted to Health Services at approximately 6:39 a.m., and Emergency Medical Services (EMS) arrived at 6:43 a.m. He was transported to the local hospital at approximately 7:10 a.m. Mr. Epstein was pronounced deceased at 7:36 am. It was not possible to confirm this timeline without viewing video footage.

CONCLUSIONS/RECOMMENDATIONS

A general appreciation of risk factors for suicide specific to sex offenders is necessary when reviewing Mr. Epstein's death. These factors, as well as more general risk factors for suicide, were likely present. There are several common factors that increase risk for suicide in individuals with a history of a sexual offense. These include stigma due to the nature of sexually-based crimes (both within society and the prison system), a disruption of the ability to utilize sex as a coping mechanism (which can lead to increased levels of distress and negative affect), and grief about loss experienced in regards to arrest. This grief may be secondary to the loss of former lifestyle, loss of physical items or collections related to sexual offenses, and/or the loss of perceived relationships with victims. Other factors that may increase risk for suicide among individuals accused of a sex offense include safety concerns, potentially long sentences, and lack of skills necessary to navigate social relationships in prison.

Mr. Epstein was a high-profile, pretrial detainee awaiting trial on sex trafficking offenses. He had been a successful, wealthy businessman with a number of high-profile acquaintances that he accumulated through a combination of charisma, charm, and intelligence. Despite his many associates, he had limited significant or deep interpersonal ties. Although Mr. Epstein appeared

to cultivate a large social and professional network, he was estranged from his only brother. Indeed, his identity appeared to be based on his wealth, power, and association with other high- profile individuals. Approximately two-and-a-half weeks before his death, Mr. Epstein appeared to attempt suicide, but ultimately denied it was a suicide attempt. He was convincing in his denial. On that occasion, he was saved because his cellmate notified BOP staff. In the weeks before his death, he made statements that he was "a coward" and was having difficulty adapting to his diminished circumstances. He also frequently referenced poor sleep and an inability to tolerate the noise of prison. On the day before his death, a number of documents in his case were unsealed, further eroding his previously-enjoyed elevated status and potentially implicating some of his associates. The lack of significant interpersonal connections, a complete loss of his status in both the community and among associates, and the idea of potentially spending his life in prison were likely factors contributing to Mr. Epstein's suicide.

The following recommendations concern institution operations: **Corr Svc/ Psych**

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.

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 Lieutenant when inmates are removed from suicide watch and communicates to the Lieutenant that they will need to be placed with a cellmate (Providing direct communication and instructions). Cellmates are recommended not only for SHU inmates being removed from suicide watch, but also for inmates returning to the general population setting.

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.

Exec/IDO

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

Corr Svc / Legal

3. Cellmate Assignments: When Mr. Epstein was placed in SHU on July 7, 2019, Executive Staff decided Mr. Tartaglione 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. Tartaglione 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 [redacted], National Suicide Prevention Coordinator. In the e-mail, [redacted]

3. Cellmate Assignments: The psychological reconstruction 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. Tartaglione as both had high profile cases. Mr. Tartaglione is also a certified death penalty eligible inmate and, thus, based on correctional judgment, less likely to assault or otherwise try to extort Mr. Epstein. Indeed, Mr. Tartaglione 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. Tartaglione 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. Hoyt, was deemed dangerous to Mr. Epstein due to his threatening nature. Accordingly, MCC New York Executive Staff narrowed the possibilities to cooperators. Specifically, Efrain Reyes, reg. no. 85993-054, 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. Reyes 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.

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 discuss the inmate's needs. The Staff Attorney 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 that inmates at-risk for suicidality should celled with. Psychology Services takes into consideration the suicide risk factors involved with a particular inmate and share their knowledge with Executive Staff.

Legal

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.

Exec Staff

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.

Psyc Svc

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.

   [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 S9licitation 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. Brown.

4. Documentation Accuracy

Psychology 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.

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.

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 documents in the suicide watch log book. Log books are now being closely monitored on a daily basis by the Chief Psychologist.

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 or observation watch inmates as prescribed by the Captain. After-hours, the Unit 2 Officer will be responsible for making rounds, feeding 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.

[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.

4: Inmate Jeffery Epstein #76318-05, arrived in the 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 Health Services staff, Physician Assistant (PA) [redacted] on July 6, 2019, the same night he arrived 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]. According to P6031.04, 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 was conducted timely and in accordance to policy.

Psyc

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. [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 [redacted], Associate Warden to [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.

Corr Svc

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.

AW Edge

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. [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 [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.

   Section 5: There is no documentation to substantiate that a Lieutenant facilitated two telephone calls to Mr. Epstein. However, there is documented evidence that Unit Manager [redacted] 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.

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 [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

7. Follow Up

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

All Psychology Staff added a response to their incoming emails. This automatic replay states, "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 more immediately 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 more immediately prior to being released to a unit.

R&D staff have been reminded of the Marshall and Court alert notices. Psychology Staff are notified immediately if there are suicidal concerns noted by the Courts. If Psychology 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 is notified. These inmates receive a suicide risk assessment by a psychologist before being released to the general population.

Psyc Svc

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 [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 [redacted] at approximately 9:30 a.m.

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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).

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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., [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 [redacted] for a suicide risk assessment on August 1, 2019, at approximately 1:30 p.m.

Exec

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 Patrick Avila (#86710-054), inmate Gregory Ferrer (#79793-054), 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 Avila and Ferrer, respectively. Inmate Avila's cell assignment was Z04-206LAD from August 5, 2019, until August 11, 2019, when he was moved to cell Z04-212UAD. Inmate Ferrer's 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 ofnametags 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 Ferrer in cell 207L (SENTRY states he was moved to this cell on August 11, 2019), inmate Avila 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 Reyes (#85993-054). The locator shows inmate Copper (#92299-054) and inmate Dockery (#60685-050) in cell 206. The photo sheets show the cell being 220 with inmates Epstein and Reyes' identification cards on the door. Inmate Reyes, Efrain, Reg. No. 85993-054 was in cell Z06-220U from August 5, 2019 to August 9, 2019.

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   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.

Exec

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

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 the hospital 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.

Exec Staff

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.

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.

10: **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 perspective areas. The report was accurate and complete. New AEDs have been purchased and will be inspected Great Lakes Biomedical Services, upon their arrival. It must be noted that the list reviewed by the reconstruction team was an old and outdated list (January 8, 2018).

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].

11. Post Orders & SHU Training

The Suicide Watch Post Orders is located in the Lieutenant's Office with a quarterly sign-in sheet. All staff members assigned to a suicide watch post are responsible for signing the post orders prior to performing the staff suicide watch.

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, they see the Chief Psychologist and schedule a time to receive a make-up session for the SHU Suicide Prevention Training.

Psyc Svc

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.

12. Staffing

The current Drug Abuse Coordinator position is currently a shared position. The Warden is currently working on re-establishing 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 has been formally announced.

Psyc Svc

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.

13. **Sex Offense Risk Factors**

The Chief Psychologist or her representative 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 Institution Familiarization (IF) 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 & 295's