



U. S. Department of Justice
Federal Bureau of Prisons
Metropolitan Correctional Center
New York, New York

For Immediate Release
August 10, 2019

Contact: Lee Plourde
Public Information Officer
(646) 836-6300

Inmate Death at the MCC New York

New York, NY: On Saturday, August 10, 2019, at approximately 6:30 a.m., inmate Jeffrey Edward Epstein was found unresponsive in his cell in the Special Housing Unit from an apparent suicide at the Metropolitan Correctional Center (MCC) in New York, New York. Life-saving measures were initiated immediately by responding staff. Staff requested emergency medical services (EMS) and life-saving efforts continued. Mr. Epstein was transported by EMS to a local hospital for treatment of life-threatening injuries, and subsequently pronounced dead by hospital staff. The FBI is investigating the incident.

Mr. Epstein was a 66-year-old male who arrived at MCC New York on July 6, 2019 under pretrial status after being indicted for sex trafficking of minors and conspiracy.

MCC New York is an Administrative security facility that currently houses 763 male offenders in New York, New York.

Additional information about the Federal Bureau of Prisons can be found at www.bop.gov.

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MCC NEW YORK UPDATES

Correctional Services

Inmate Accountability: SHU

- A whiteboard has been installed in the Special Housing Unit identifying the cell assignment of each inmate and pertinent information of each inmate which aids in accountability. This assists in correcting cell assignment discrepancies and aid in identifying programing needs (3 man hold, razor restriction, etc.).
- TDY Staff have been assisting Correctional Services with vacant positions; Correctional Officers, Lieutenant's and Deputy Captain.
- Addition to the Captains 2 hour SHU video review, IDO's are reviewing 6 hours of SHU video encompassing all three shift weekly.
- IDO's are conduction Bed book counts on weekends during the 10:00 am count.
- Single cell report emailed to the Warden each shift and receives approval memorandum for each.
- Morning Watch Lieutenant supervises one count in SHU and is documented in the LT's Log.

Psychology

- Running Hospital Rosters Every Morning to see if inmates on SW are in the proper cells according to their Sentry assignments. Inconsistencies are reported the Associate Warden of Programs. Further, C&A is contacted to make appropriate corrections on the roster.
- Court rosters are reviewed every day to see if any Psy Alerts are going out to court so that we can check in with them upon their return.
- PSY ALERT inmate assignments are considered for inmates with ongoing risk factors associated with suicidality (e.g., sex offender status, high profile) even regardless of whether they exhibit substantial acute mental health symptoms.
- The Chief Psychologist has written a new procedural Memorandum for Psy Alert inmates which is undergoing review in Central Office.
- Psychology has been routing Hot List via e-mail to Lieutenant's and Executive Staff each time new inmates are added to the hot list.

MCC NEW YORK UPDATES

- Psychology has been providing feedback at Executive Staff Meetings regarding inmates at-risk for suicidality and discussing cellmate placement (both GP and SHU) for inmates with significant mental health issues and suicide risk factors.
- When inmates are added and released from Suicide Watch, an email and a phone call is made to Warden and the Operations Lieutenant notifying them of the addition or termination of the watch as well as their need for cellmates. This recommendation is also placed in the Post Suicide Watch Report in PDS and the psychologist indicates exactly who they contacted about the inmate's need for a cellmate in the recommendation section of the report.
- Suicide Watch Books are reviewed daily by a psychologist and audited to see if the Unit Officer and Lieutenant make appropriate rounds and signed the log books each shift (MW, DW, and EW). Inconsistencies are sent to the Captain and Associate Warden of Programs.

Correctional Systems

- Since September 9, 2019, inmates have been tracked when released from court by utilizing the PP63 Sentry function as opposed to tracking by out count. There has been no issues to date utilizing this procedure.
- All releases are being reviewed by a higher authority other than the CSO/SCSS. Typically reviewed by the Case Management Coordinator.

Correctional Programs

Inmate Accountability:

- New bed books have been provided to each unit. A daily schedule of bed book counts has been established to ensure appropriate accountability of all inmates. Bed book counts are notated in the Daily Lieutenant Logs for Executive Staff review. Additionally, an Executive Staff member is present each evening to monitor this process and identify discrepancies. All discrepancies are typically corrected immediately.

MCC NEW YORK UPDATES

- Daily Camera status reports of the status of high priority areas; SHU, 10 South, Suicided Watch, Female unit and 3 Sally.

Facilities

Cameras:

- The FBI removed the previous camera system (DVR) and the new system (NVR) has been installed and is operational. 13 Additional cameras have been added in SHU which are digital. Within the next 6 months additional cameras will be added to the system with a target completion date of April 2020.
- MCC has a total of 142 cameras. Currently, 141 cameras are connected to the NICE DVR System and are operational and recording. The 1 camera is inoperable and in the process of being replaced (bad camera). The anticipated date of completion is within the next two weeks.
- The new NVR has the capability to monitor and record 350 cameras. The following locations have been identified as needing coverage: elevators, receiving and discharge, all inmate housing units, sallyports, and outside perimeter.

Summary

- To date all information requested by OIG and FBI has been provided.
- Health Services has received the autopsy results from the NY Medical Examiner's office on inmate Epstein and is secured
- TDY staff assigned to NYM have all been hard working and team players.
- Staff morale at MCC New York is average in light of the most recent event; however, they are resilient and working hard as a team to move forward. They have embraced the TDY staff that have arrived and have been extremely courteous and receptive to ensure everyone works together.

MCC NEW YORK UPDATES

Current Assessment:

Some of the issues identified are due to seriously reduced staffing levels, improper or lack of training, and follow up and oversight. Since January 1, 2019, MCC New York has hired 18 staff and lost 33 staff to retirement, and transfers within the BOP and other agencies.

To date approximately approximately 148 staff from multiple regions assisted NYM which we are very grateful for their assistance. All subject matter TDY staff are required to provide a report to the Warden prior to their departure. This report is similar to a Program Review report and includes areas of concern, tasks done well and recommendations. These reports will be shared with the Associate Wardens and Department Heads for guidance.

Further, to ensure the training and efforts that will occur is sustainable, there will need to be continuous oversight by leadership. Therefore, several positions will need to be added to the staff compliment, such as an Associate Warden over Correctional Services, a Deputy Captain, and an Assistant Case Management Coordinator, Assistant Food Services Administrator, to name a few.



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Warden

Metropolitan Correctional Center
150 Park Row
New York, New York 10007
(646) 836-6300, (646) 836-7551 (Fax)

August 10, 2019

Mark Epstein
301 E. 66 Street
New York, NY, 10065

Dear Mr. Epstein:

I am writing to express my condolences to you regarding the passing of your brother, Jeffrey Edward Epstein, who passed away Saturday, August 10, 2019.

On August 10, 2019, Jeffrey Edward Epstein was pronounced deceased at the New York Presbyterian-Lower Manhattan Hospital in New York, New York. At this time, although there are no preliminary reports identifying the exact cause of death, it appears to be the result of suicide.

Although I realize that words alone cannot lessen your sorrow, I hope that my thoughts and sincerest sympathy will be of some comfort to you.

Sincerely,


Warden
MCC New York

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U.S. Department of Justice

Federal Bureau of Prisons

Office of the Warden

Metropolitan Correctional Center
150 Park Row
New York, New York 10007
(646) 836-6300, (646) 836-7551 (Fax)

August 10, 2019

SENT VIA EMAIL

The Honorable Colleen McMahon, Chief Judge
The Honorable Richard M. Berman, District Judge
Daniel Patrick Moynihan United
States Courthouse
500 Pearl Street
New York, New York 10007-1312

Dear Mr. Epstein:

I am writing to express my condolences to you regarding the death of your brother, Jeffrey Edward Epstein, who passed away Saturday, August 10, 2019.

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Sincerely,


Warden
MCC New York

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**U.S. Department of Justice
Federal Bureau of Prisons**

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

January 27, 2020

**MEMORANDUM FOR HUGH J. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION**

FROM: M. Licon-Vitale, 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 December 27, 2019.

2. 30 Minute Rounds

The substance of the two hour Captain video review and six hour IDO video review is unclear. Please clarify the requirement for the Captain and IDO. Additionally, please identify the documentation used to maintain accountability of the reviews.

Institution Response:

Video review requirements have been instituted by NERO. Specifically, on Tuesday of each week, the institution is notified by NERO of the date, time, and SHU range in which to download video. The video is a two hour block. The video is to be reviewed by the Captain. During the reviews the Captain is looking for strict adherence to the requirements that rounds be conducted at least once during every 30-minute period, not to exceed 40 minutes between rounds and that all scheduled counts are being conducted in the SHU. The Captain will then submit an assurance memo to the institutional executive staff and Correctional Services Administrator (CSA) indicating the designated video footage was reviewed, and corrective actions which were taken for any deficiencies noted. This memorandum will be submitted to the Regional Office by COB on Friday of that same week. Institutional Duty Officers (IDOs) are required to review 6 hours of SHU video. The surveillance footage is downloaded by the institutional SIA and a compact disk is provided to the IDOs for review. The IDOs are reviewing the video for accuracy of the 30 minute rounds. All reviews are documented in the weekly IDO Report.

3. Cellmate Assignments

Documentation exists reflecting the role of the local Psychology Services department in communicating the importance of Mr. Epstein's status as a sex offender with specific needs to the Associate Warden. This includes consultation with the Psychology Services Branch in Central Office. The communication chain and decision making of Executive Staff lacks transparency as there is no documentation of the process or staff members present when decisions were made about the housing of Mr. Epstein. After the fact explanations may not accurately reflect what occurred.

Institution Response:

As was noted, there was no documentation indicating Psychology Services was present when housing decisions were made regarding Mr. Epstein. Psychology services is present at the weekly SHU meeting, Executive Staff meetings, and weekly Opening and Close-Out meetings. During these meetings, the Chief Psychologist or Acting Chief Psychologist are present to provide recommendations and feedback to the Executive Staff on housing concerns regarding inmates with mental health issues or risk factors for suicidality. When an inmate presents with unique risk factors associated with individuals who have been charged with and/or convicted of a sex offense, careful evaluation is made with regard to housing these inmates with appropriate cellmates. Moving forward, a plan has been established to have a sign-in sheet and checklist at these meetings where housing issues are addressed, indicating who was present and what the housing plan is for these inmates with psychological concerns. These checklists will be maintained in a binder by the Associate Warden of Programs. Please see the attached checklist.

4. Documentation Accuracy

Professional responsibility requires taking into account multiple descriptions of an incident as noted in your response. However, when discrepancies exist these should be compiled and noted in documentation to decrease the likelihood of conflicting conclusions.

As noted in the reconstruction report, an incident report must be written within 24 hours of having the information that an inmate likely violated BOP rules. An incident report was written for Mr. Epstein prior to a determination of whether he engaged in self-directed violence or was assaulted on July 23, 2019. Staff had ample time to wait for the outcome of the SIS investigation of this incident. The incident report presumed self-directed violence, although SIS was not able to determine whether this incident was self-directed violence or an assault. Generating the incident report for self-directed violence is evidence of a local bias about the July 23, 2019, incident that still exists amongst some staff at MCC New York. Preconceived notions challenge the ability to remain open about alternative explanations, and subsequent systemic changes may be needed.

Please develop and provide local training for all staff that at a minimum reviews the time frame for writing incident reports and offers guidance when there is not clear evidence of an infraction. Include an outline of the training and evidence of staff who attended the training.

Institution Response:

Additional information (slides) has been included in our Annual Training presentations for Report Writing. In addition to the established training, the slides further differentiate and provide guidance to staff regarding when it is appropriate to write an Incident Report and when, in cases of a lack of evidence, a memorandum is more appropriate. The additional information is being provided to all staff as a part of Annual Training. Annual Training began the week of January 6, 2020, and will continue through the week of March 8, 2020.

5. Telephone Calls

As noted in the response, there is a lack of documentation to substantiate that a lieutenant facilitated two telephone calls to Mr. Epstein. However, this does not address the report of two telephone calls being provided. This response implies that the reporting of two staff members is inaccurate.

The response neglects the documented telephone call to Mr. Epstein's deceased mother.

Institution Response:

On August 29, 2019, Warden [REDACTED] Petrucci, signed a referral related to [REDACTED] failure to follow policy in allowing Epstein to complete an unmonitored phone call. The referral was submitted to the Office of Internal Affairs on that same date and is pending further action at this time.

7. Follow-Up

Please provide documentation for the follow-up training provided to staff detailing the content of the training and to whom it was provided.

Institution Response:

As recommended by Central Office, the Chief Psychologist has conducted suicide prevention trainings during Department Head Meetings, e-mail correspondence, SHU Staff Trainings, and Lieutenant's Trainings. The follow-up training sign-in sheets, Department Head Meeting Minutes, and e-mails provided by psychology staff regarding PSY ALERT Inmates are attached for your review.

8. Inmate Accountability and Assignment Accuracy

Periodic and unannounced checks are now conducted in SHU to determine pp30 assignments and actual inmate placement match. Please provide an operational definition of periodic. Please do the same for routine, as it relates Executive Staff bed book counts in all units. Where will the periodic and routine reviews be documented and will they include the identity (e.g., name and title) of staff who complete them?

Institution Response:

An Executive Staff and Duty Officer schedule has been implemented to conduct daily 4 P.M. and 10 A.M. weekend bed book counts. Any discrepancies noted are documented and sent via email to Unit Managers and Captain at the conclusion of each count for corrective action. Please see the attached schedule.

9. Attorney Log Books

Please provide a copy of the log book audit.

Institution Response:

The audit revealed the **Random Visitor Log Book** did not reflect visitor pat searches after May 19, 2019. In addition, the log book does not offer a column to annotate a staff witness. The **Contractor/Volunteer Log Book** was not always filled in properly. The **Law Enforcement Log Book** was up to date; however, the time of departure was not always documented. The **Attorney Log** was missing inmate register numbers and more often than not was legible. There was no **Visitor Denial Log** created. The audit conducted on September 25, 2019, is attached for your review.

Additional corrective measures will now include the Activities Lieutenant checking all Front Lobby log books. The Captain will ensure these checks are included in the Lieutenant's Daily Log for Day Watch and Evening Watch. In addition, the Activities Lieutenant will address any discrepancies immediately through on the spot training and/or performance log entries.

13. Sex Offense Risk Factors

Psychologists are subject matter experts in sex offender risk factors and they play a crucial role in sharing this knowledge through traditional settings such as ICT, AT, and institutional meetings. However, Executive Staff play a pivotal role in establishing and addressing institutional culture and promoting and participating in training. A lack of a broad understanding of sex offender specific risk factors requires an intentional training approach led by Executive Staff. They must be out front talking about inmates with a sex offense, expressing an understanding of sex offender dynamics, modeling agency condoned expectations for the understanding and treatment of inmates with a sex offenses, and assisting with institutional trainings. These practices encourage a broader acceptance by line staff.

Institution Response:

The MCC New York Executive Staff are out front talking about inmates with sex offenses, and expressing an understanding of sex offender dynamics, modeling agency expectations for the understanding and treatment of inmates with sex offenses. This is done through departmental meetings, trainings, staff recalls and walking and talking throughout the institution.

ATTACHED DOCUMENTS:

Institution Duty Officer Report
Cellmate Review
Report Writing "Back to Basics Training"
SHU Suicide Prevention Training
Department Head Meeting minutes
PSY ALERT inmates
Bed Book Count Schedule (Exec Staff/IDO)
Bed Book Audit (emails)
Log Book Audit
Executive Staff List

Suicide Timeline:

RE: Epstein, Jeffrey Edward, Reg. No. 76318-054

Friday, August 9, 2019

8:00 am: inmate Reyes Efrain, Reg. No. 85993-054 departs for court (WAB-USMS-SDNY). Reyes is Epstein's cellmate.

8:30 am: inmate Epstein arrives in Attorney Conference. He is visited by several attorneys throughout the day.

6:45 pm: inmate Epstein departs attorney conference and returns to SHU.

7:00 pm: inmate Epstein provided a social call by IDO. IDO reports inmate Epstein was in good spirits, nothing unusual.

Saturday, August 10, 2019

6:33 am: Body alarm activated in SHU. Staff found inmate Epstein unresponsive in cell. Staff reported to bedside of inmate and attempted to wake him. Control announced medical emergency. CPR initiated

6:35 am: Medical staff (on duty PA) on site, CPR already in progress medical staff continues CPR and AED applied on inmate. Control called for ambulance

6:40 am: S. [REDACTED], AW notified

6:45 am: EMS arrives, paramedics continue CPR. Inmate Epstein remains unresponsive. Inmate Epstein is intubated, given three rounds of Epinephrine, IV access started, IO initiated. No pulse found, no shock advised, inmate prepared for transport to local hospital.

7:00 am: Institution placed on modified operations

7:10 am: EMS departs institution enroute to Beekman Hospital.

7:19 am: USMS notified of incident.

7:20 am: SIS Lt notified.

7:30 am: L. [REDACTED], Warden arrives at institution. [REDACTED], AW notified.

7:32 am: PIO notified of incident by the Warden.

7:36 am: Official time of death reported by ER physician.

7:40 am: Acting Chief Psychologist notified.

8:00 am: [REDACTED], AW and [REDACTED], Captain arrives at institution.

8:10 am: SIS Lt arrives at institution.

8:10 am: CMC and SCSS notified.

8:34 am: FBI notified.

9:00 am: AUSA notified.

9:00 am: C. [REDACTED] arrives at institution.

Cont. Saturday, August 10, 2019

9:00 am: SIS Lt. Reports to SHU. Interviews will be conducted with inmates assigned to tier.

9:15 am: CMC arrives at institution.

9:30 am: Acting Chief Psychologist arrived to the institution.

9:50 am: SCSS arrives at institution.

9:55 am: CMC and IDO depart institution enroute to Beekman Hospital.

10:00 am: CMC and IDO arrive at Beekman Hospital, fingerprints and photographs taken of inmate Epstein. Inmate clothing secured and brought back to institution.

10:00 am: Judge Berman notified.

10:15 am: CMC returns to institution.

Cont. Saturday, August 10, 2019

10:45 am: PIO arrived to the institution.

11:00 am: Next of kin (brother) notified by Case Management Coordinator.

11:12 am: Press Release released to media.

11:15 am: Press Release provided to Judge Berman.

11:15 am: Crisis Support Team activated.

12:15 pm: Body released to Medical Examiner (ME) for autopsy

12:19 pm: FBI arrives.

1:35 pm: FBI arrives in Special Housing Unit.

1:40 pm: OIG notified by the Warden and they will be sending an Agent to NYM.

2:15 pm: Crisis Support Team debrief conducted.

2:45 pm: OIG arrived in Special Housing Unit (SHU)

3:45 pm: OIG and FBI departed from SHU.

5:05 pm: OIG/FBI departed MCC New York.

5:30 pm: CST departed MCC New York.

10:15 pm: Computer Services Manager arrives at institution to remove hard drives (Computers) from SHU. And replaced with new ones.

Sunday, August 11, 2019

8:00 am: Resumed normal operations. Attorney conference visits and social visits (Unit 3) resume.

12:15 am: Computer Services Manager departs the institution.

Cont. Sunday, August 11, 2019

10:40 am: OIG Agent [REDACTED] and Agent [REDACTED] arrives at institution.

11:15 am: OIG Agent [REDACTED], departs institution with two computers FPS 021407270 and FPS 0214207268.

2:00 pm: OIG Agent [REDACTED] departs the institution.

Monday, August 12, 2019

1:00 pm: Staff recall conducted

3:14 pm: FBI arrives

7:56 pm: FBI departs

9:45 pm: FBI returns

10:30 pm: FBI departs

Tuesday August 13, 2019

7:15 am: Mr. [REDACTED], NER Correctional Services Administrator arrives to the institution

7:25 am: Dr. [REDACTED] National suicide prevention coordinator, and Dr. [REDACTED], National Sex offender program coordinator arrives to the institution.

8:40 am: Northeast Regional Director [REDACTED] arrives to the institution.

Wednesday August 14, 2019

11:30 am: FBI Agents arrive to work in communication room advised they will work through the night until next morning. NYM Facilities staff working in room also.

Thursday August 15, 2019

5:24 am: FBI agent departs communication room and secured the door with evidence tape.

8:30 am: NER Regional Director arrives to the institution.

9:30 am: ODAG arrives to the institution.

9:40 am: AUSA/FBI/OIG arrives to the institution.

11:30 am: FBI arrives to work in communication room.

12:00 am: AUSA/FBI/OIG departed the institution.

12:30 am: ODAG departs the institution.

4:52 pm: FBI Agents departs with all computer software from communication room new system running.

5:37 pm: Gave Facilities Manager receipt from FBI for computer system.



U.S. Department of Justice
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Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

January 14, 2020

MEMORANDUM FOR HUGH J. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION

FROM: M. Licon-Vitale, 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 December 27, 2019.

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.

The substance of the weekly video reviews by the Captain and IDO consists of a general review of randomly designated ranges and times, covering all three primary shifts, to ensure all SHU policies and procedures are being followed. Additionally, the reviews will ensure strict adherence to the requirements that rounds be conducted at least once during every 30-minute

period, not to exceed 40 minutes between rounds and that all scheduled counts are being conducted in the SHU. The Captain's reviews are documented in a memorandum that is submitted to institutional executive staff as well as the NERO Correctional Services Administrator. The IDO reviews are documented in their weekly report, with any misconduct being reported in a separate memorandum to the Warden and/or SIA.

The requirement is that the Captain will view two hours of Special Housing Unit archived video footage selected by the NERO. The surveillance footage is downloaded by the institutional SIA and a compact disk is provided to the Captain for review. The footage is reviewed for any discrepancies and/or egregious security violations, which will be immediately addressed.

On Tuesday of each week, institutions will be notified of the date, time, and range in which to download SHU video. The video is to be reviewed by the Captain. Each Captain will submit an assurance memo to the CSA indicating the designated video footage was reviewed, and corrective actions were taken for any deficiencies noted. This memorandum will be submitted to the Regional Office by COB on Friday of that same week. If an institution does not have inmates on the specified range, then video will be downloaded from the next highest/lowest range. References to highest/lowest and even/odd ranges are the SENTRY designations. (i.e. Z01, Z03, Z05, etc. are odd ranges and Z02, Z04, Z06, etc. are even)

Institutional Duty Officers (IDO's) are required to review 6 hours of SHU video to review the accuracy of SHU 30 Min Rounds. All reviews are documented in a memorandum to the Warden for review.

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 Dr. [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, Dr. [REDACTED] sent an e-mail to [REDACTED] [REDACTED], Associate Warden explaining a consultation between Dr. [REDACTED] and Dr. [REDACTED], National Suicide Prevention Coordinator. In the e-mail, Dr. [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 be 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. 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 harm 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, Register Number 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.

NYM Executive Staff conduct bed book audits Monday through Friday and the IDO conduct them on Weekends and Holidays. All discrepancies are noted and corrected ordinarily on the spot and or the next business day.

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, Dr. [REDACTED] documented information received from Operations Lieutenant [REDACTED] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer Wilson Silva, who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, [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. Brown.

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. [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 [REDACTED]'s 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 Dr. [REDACTED] with a carbon copy to Warden [REDACTED] on August 12, 2019. Of note, [REDACTED] did not make an entry explaining why she was making the log book changes. Additionally, [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 [REDACTED] nor was [REDACTED] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why [REDACTED] attempted to correct [REDACTED]'s 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.

Two slides (slide numbers 23-24) have been added to the Annual Training slide show for the Report Writing class. In addition to the established training, the slides further differentiate and provide guidance to staff regarding when it is appropriate to write an Incident Report and when, in cases of a lack of evidence, a memorandum is more appropriate. The additional information is being provided to all staff as a part of Annual Training that is already in progress.

5. Telephone Calls: In a PDS-BEMR note written by Dr. [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.

On August 29, 2019, Warden [REDACTED] Petrucci, signed a referral related to [REDACTED] failure to follow policy in allowing Epstein to complete an unmonitored phone call. The referral was submitted to the Office of Internal Affairs on that same date and is pending further action at this time.

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, ██████████, Facilities Assistant reported she observed Mr. Epstein in his cell. In an e-mail she sent to Drs. ██████████ and Imeri and Lieutenant ██████████ 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. ██████████ 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 Medina 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. ██████████ was concerned about suicide risk, P5324.08, Suicide Prevention Program, requires her to maintain direct, continuous observation of Mr. Epstein. When Dr. ██████████ opened the e-mail the following Monday morning, Mr. Epstein was evaluated by Dr. ██████████ 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., ██████████ sent Dr. ██████████ 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 ██████████ 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 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 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 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.

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 H01 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 H01-001L 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 H01-001L, 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 H01 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.

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

Suicide Timeline:

Re: Epstein, Jeffrey Edward, Reg. No. 76318-054

Friday, August 9, 2019

8:00 am inmate Reyes Efrain, Reg. No. 85993-054 departs for court (WAB-USMS-SDNY). Reyes is Epstein's cellmate.

8:30 am inmate Epstein arrives in Attorney Conference. He is visited by several attorneys throughout the day.

6:45 pm inmate Epstein departs attorney conference and returns to SHU

7:00 pm inmate Epstein provided a social call by IDO. IDO reports inmate Epstein was in good spirits, nothing unusual.

***Inmate Reyes is released from court and does not return to the institution.

Saturday, August 10, 2019

6:33 am body alarm activated in SHU. Staff found inmate Epstein unresponsive in cell. Staff reported to bedside of inmate and attempted to wake him. Control announced medical emergency. CPR initiated

6:35 am medical staff (on duty PA) on site, CPR already in progress medical staff continues CPR and AED applied on inmate. Control called for ambulance

6:40 am [REDACTED], AW notified

6:45 am EMS arrives, paramedics continue CPR. Inmate Epstein remains unresponsive. Inmate Epstein is intubated, given three rounds of Epinephrine, IV access started, IO initiated. No pulse found, no shock advised, inmate prepared for transport to local hospital.

7:10 am EMS departs institution enroute to Beekman Hospital.

7:19 am USMS notified of incident.

7:20 am SIS Lt notified.

7:30 am [REDACTED], Warden arrives at institution. [REDACTED], AW notified.

7:32 am PIO notified of incident by the Warden

7:36 am official time of death reported by ER physician.

7:40 am Acting Chief Psychologist notified.

8:00 am [REDACTED] and Captain arrive at institution.

8:10 am SIS Lt arrives at institution.
8:10 am CMC and SCSS notified.
8:34 am FBI notified.
9:00 am AUSA notified.
9:00 am C. [REDACTED] arrives at institution.

Cont. Saturday, August 10, 2019

9:00 am SIS Lt. reports to SHU. Interviews will be conducted with inmates assigned to tier.
9:15 am CMC arrives at institution.
9:30 am Acting Chief Psychologist arrived to the institution.
9:50 am SCSS arrives at institution.
9:55 am CMC and IDO depart institution enroute to Beekman Hospital.
10:00 am CMC and IDO arrive at Beekman Hospital, fingerprints and photographs taken of inmate Epstein. Inmate clothing secured and brought back to institution.
10:00 am Judge Berman notified.
10:15 am CMC return to institution.
10:45 am PIO arrived to the institution.
11:00 am next of kin (brother) notified by Case Management Coordinator.
11:12 am press release is released to media.
11:15 am press release provided to Judge Berman.
11:15 am CST activated.
12:15 pm body released to Medical Examiner (ME) for autopsy
12:19 pm FBI arrives.
1:35 pm FBI arrives in Special Housing Unit.
1:40 pm OIG notified by the Warden and they will be sending an Agent to NYM.
2:15 pm CST debrief conducted.
2:45 pm OIG arrived in Special Housing Unit (SHU).
3:45 pm OIG and FBI departed from SHU.
5:05 pm OIG/FBI departed MCC New York.
5:30 pm CST departed MCC New York.
10:15 pm Computer Services Manager arrives at institution to remove hard drives (Computers) from SHU. And replaced with new ones.

Sunday, August 11, 2019

12:15 am Computer Services Manager departs the institution.

10:40 am OIG Agent [REDACTED] and [REDACTED] arrives at institution.

11:15 am OIG Agent [REDACTED], departs institution with two computers FPS 021407270 and FPS 0214207268.

2:00 pm OIG Agent [REDACTED] departs the institution.

Monday, August 12, 2019

10:00 am Warden departed to AUSA office for questioning.

12:50 am Warden arrives back from AUSA office.

Tuesday August 13, 2019

7:15 am Mr. [REDACTED], NER Correctional Services Administrator arrives to the insitution

7:25 am Dr. [REDACTED] National suisice prevention coordinator, and Dr. Christen ***** arrives to the institution.

8:40 am Northeast Regional Director [REDACTED] arrives to the institution.



**U.S. Department of Justice
Federal Bureau of Prisons**

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

January 27, 2020

**MEMORANDUM FOR HUGH J. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION**

FROM: M. Licon-Vitale, 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 December 27, 2019.

2. 30 Minute Rounds

The substance of the two hour Captain video review and six hour IDO video review is unclear. Please clarify the requirement for the Captain and IDO. Additionally, please identify the documentation used to maintain accountability of the reviews.

Institution Response:

Video review requirements have been instituted by NERO. Specifically, on Tuesday of each week, the institution is notified by NERO of the date, time, and SHU range in which to download video. The video is a two hour block. The video is to be reviewed by the Captain. During the reviews the Captain is looking for strict adherence to the requirements that rounds be conducted at least once during every 30-minute period, not to exceed 40 minutes between rounds and that all scheduled counts are being conducted in the SHU. The Captain will then submit an assurance memo to the institutional executive staff and Correctional Services Administrator (CSA) indicating the designated video footage was reviewed, and corrective actions which were taken for any deficiencies noted. This memorandum will be submitted to the Regional Office by COB on Friday of that same week. Institutional Duty Officers (IDO's) are required to review 6 hours of SHU video. The surveillance footage is downloaded by the institutional SIA and a compact disk is provided to the IDO's for review. The IDOs are reviewing the video for accuracy of the 30 minute rounds. All reviews are documented in the weekly IDO Report.

3. Cellmate Assignments

Documentation exists reflecting the role of the local Psychology Services department in communicating the importance of Mr. Epstein's status as a sex offender with specific needs to the Associate Warden. This includes consultation with the Psychology Services Branch in Central Office. The communication chain and decision making of Executive Staff lacks transparency as there is no documentation of the process or staff members present when decisions were made about the housing of Mr. Epstein. After the fact explanations may not accurately reflect what occurred.

Institution Response:

As was noted, there was no documentation indicating Psychology Services, was present when housing decisions were made regarding Mr. Epstein. Psychology services is present at the weekly SHU meeting, Executive Staff meetings, and weekly Opening and Close-Out meetings. During these meetings, the Chief Psychologist and/or Acting Chief psychologist are present to provide feedback and or recommendations to the Executive Staff on housing concerns regarding inmates with mental health issues or risk factors for suicidality. When an inmate presents with unique risk factors associated with individuals who have been charged with and/or convicted of a sex offense, careful evaluation is made with regard to housing these inmates with appropriate cellmates. Moving forward, a plan has been established to have a sign-in sheet and checklist at these meetings where housing issues are addressed, indicating who was present and what the housing plan is for these inmates with psychological concerns. These checklists will be maintained in a binder by the Associate Warden of Programs.

4. Documentation Accuracy

Professional responsibility requires taking into account multiple descriptions of an incident as noted in your response. However, when discrepancies exist these should be compiled and noted in documentation to decrease the likelihood of conflicting conclusions.

As noted in the reconstruction report, an incident report must be written within 24 hours of having the information that an inmate likely violated BOP rules. An incident report was written for Mr. Epstein prior to a determination of whether he engaged in self-directed violence or was assaulted on July 23, 2019. Staff had ample time to wait for the outcome of the SIS investigation of this incident. The incident report presumed self-directed violence, although SIS was not able to determine whether this incident was self-directed violence or an assault. Generating the incident report for self-directed violence is evidence of a local bias about the July 23, 2019 incident that still exists amongst some staff at MCC New York. Preconceived notions challenge the ability to remain open about alternative explanations, and subsequent systemic changes may be needed.

Please develop and provide local training for all staff that at a minimum reviews the time frame for writing incident reports and offers guidance when there is not clear evidence of an infraction. Include an outline of the training and evidence of staff who attended the training.

Institution Response:

Two slides (slide numbers 23-24) have been added to the Annual Training slide show for the Report Writing class. In addition to the established training, the slides further differentiate and provide guidance to staff regarding when it is appropriate to write an Incident Report and when, in cases of a lack of evidence, a memorandum is more appropriate. The additional information is being provided to all staff as a part of Annual

Training that is already in progress.

5. Telephone Calls

As noted in the response, there is a lack of documentation to substantiate that a lieutenant facilitated two telephone calls to Mr. Epstein. However, this does not address the report of two telephone calls being provided. This response implies that the reporting of two staff members is inaccurate.

The response neglects the documented telephone call to Mr. Epstein's deceased mother.

Institution Response:

On August 29, 2019, Warden [REDACTED] Petrucci, signed a referral related to [REDACTED] failure to follow policy in allowing Epstein to complete an unmonitored phone call. The referral was submitted to the Office of Internal Affairs on that same date and is pending further action at this time.

7. Follow-Up

Please provide documentation for the follow up training provided to staff detailing the content of the training and to whom it was provided.

Institution Response:

Psychology Services: Attached please find the follow-up training sign-in sheets, Department Head Meeting Minutes, and e-mails provided by psychology staff regarding Psy Alert Inmates. As recommended by Central Office, the Chief Psychologist has conducted suicide prevention trainings during Department Head Meetings, through e-mail correspondence, during SHU Staff Trainings, and during Lieutenant's Trainings.

8: Inmate Accountability and Assignment Accuracy Periodic and unannounced checks are now conducted in SHU to determine pp30 assignments and actual inmate placement match.

Please provide an operational definition of periodic. Please do the same for routine, as it relates Executive Staff bed book counts in all units. Where will the periodic and routine reviews be documented and will they include the identity (e.g., name and title) of staff who complete them?

Institution Response:

9. Attorney Log Books

Please provide a copy of the log book audit.

Institution Response:

Please see the attached audit which was conducted on September 25, 2019.

13. Sex Offense Risk Factors

Psychologists are subject matter experts in sex offender risk factors and they play a crucial role in sharing this knowledge through traditional settings such as ICT, AT, and institutional meetings. However, Executive Staff play a pivotal role in establishing and addressing institutional culture and promoting and participating in training. A lack of a broad understanding of sex offender specific risk factors requires an intentional training approach led by

Executive Staff. They must be out front talking about inmates with a sex offense, expressing an understanding of sex offender dynamics, modeling agency condoned expectations for the understanding and treatment of inmates with a sex offenses, and assisting with institutional trainings. These practices encourage a broader acceptance by line staff.

Institution Response:

The PREA Compliance Manager whom is an Associate Warden has been delegated the instructor for Sex offender specific dynamics and addressing inmate sexual misconduct.

DOCUMENTS EXAMINED

Psy Alert inmates
Department Head meeting Minutes
SHU Suicide Prevention Training
Report Writing "Back to Basics training"
Bed book count Schedule
Bed Book audit Log Book Audit



**U.S. Department of Justice
Federal Bureau of Prisons**

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

January 20, 2020

**MEMORANDUM FOR HUGH [REDACTED] HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION**

FROM: M. Licon-Vitale, 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 December 27, 2019.

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

Institution Response:

Video review requirements have been instituted by NERO. Specifically, on Tuesday of each week, the institution is notified by NERO of the date, time, and SHU range in which to download video. The video is a two hour block. The video is to be reviewed by the Captain. During the reviews the Captain is looking for strict adherence to the requirements that rounds be conducted at least once during every 30-minute period, not to exceed 40 minutes between rounds and that all scheduled counts are being conducted in the SHU. The Captain will then submit an assurance memo to the institutional executive staff and Correctional Services Administrator (CSA) indicating the designated video footage was reviewed, and corrective actions which were taken for any deficiencies noted. This memorandum will be submitted to the Regional Office by COB on Friday of that same week.

Institutional Duty Officers (IDO's) are required to review 6 hours of SHU video to review. The surveillance footage is downloaded by the institutional SIA and a compact disk is provided to the IDO's for review. The IDOs are reviewing the video for accuracy of the 30 minute reviews. All reviews are documented in a memorandum to the Warden for review.

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 Dr. [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, Dr. [REDACTED] sent an e-mail to [REDACTED] [REDACTED], Associate Warden explaining a consultation between Dr. [REDACTED] and Dr. [REDACTED], National Suicide Prevention Coordinator. In the e-mail, Dr. [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:

Psychology Services: As was noted, there was no documentation indicating Psychology Services, was present when housing decisions were made regarding Mr. Epstein. Psychology services is present at the weekly SHU meeting, Executive Staff meetings, and weekly Opening and Close-Out meetings. During these meetings, the Chief Psychologist and/or Acting Chief psychologist are present to give feedback to the Executive Staff on housing concerns regarding inmates with mental health issues or risk factors for suicidality. When an inmate presents with unique risk factors associated with individuals who have been charged with and/or convicted of a sex offense, careful evaluation is made with regard to housing these inmates with appropriate cellmates. Moving forward, a plan has been established to have a sign-in sheet and checklist at these meetings where housing issues are addressed, indicating who was present and what the housing plan is for these inmates with psychological concerns. These checklists will be maintained in a binder by the Associate Warden of Programs.

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, Dr. [REDACTED] documented information received from Operations Lieutenant [REDACTED] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer Wilson Silva, who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, [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. Brown.

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. [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 [REDACTED]'s 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 Dr. [REDACTED] with a carbon copy to Warden [REDACTED] on August 12, 2019. Of note, [REDACTED] did not make an entry explaining why she was making the log book changes. Additionally, [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 [REDACTED] nor was [REDACTED] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why [REDACTED] attempted to correct [REDACTED]'s 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:

Two slides (slide numbers 23-24) have been added to the Annual Training slide show for the Report Writing class. In addition to the established training, the slides further differentiate and provide guidance to staff regarding when it is appropriate to write an Incident Report and when, in cases of a lack of evidence, a memorandum is more appropriate. The additional information is being provided to all staff as a part of Annual Training that is already in progress.

5. Telephone Calls: In a PDS-BEMR note written by Dr. [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:

On August 29, 2019, Warden [REDACTED] Petrucci, signed a referral related to [REDACTED] failure to follow policy in allowing Epstein to complete an unmonitored phone call. The referral was submitted to the Office of Internal Affairs on that same date and is pending further action at this time.

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 Imeri and Lieutenant [REDACTED] later that evening, she described Mr. Epstein as "distracted, 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 Medina 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 Dr. [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., [REDACTED] sent Dr. [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.

8. Inmate Accountability and Assignment Accuracy: According to a SENTRY quarter's 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 quarter's 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 quarter's 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 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.

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 HO1-001L 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 HO1-001L, one assigned to HO1-002L, and the fourth inmate assigned to a general population housing unit. Through physical observation of the dedicated suicide watch cells there were four

H01 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:

Psychology Services: Attached please find the follow-up training sign-in sheets, Department Head Meeting Minutes, and e-mails provided by psychology staff regarding Psy Alert Inmates. As recommended by Central Office, the Chief Psychologist has conducted suicide prevention trainings during Department Head Meetings, through e-mail correspondence, during SHU Staff Trainings, and during Lieutenant's Trainings.

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:

Please see the attached audit which was conducted on September 25, 2019.

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:

The PREA Compliance Manager whom is an Associate Warden has been delegated the instructor for Sex offender specific dynamics and addressing inmate sexual misconduct.

DOCUMENTS EXAMINED

Psy Alert inmates
Department Head meeting Minutes
SHU Suicide Prevention Training
Report Writing "Back to Basics training"
Bed book count Schedule
Bed Book audit Log Book Audit



**U.S. Department of Justice
Federal Bureau of Prisons**

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

January 27, 2020

**MEMORANDUM FOR HUGH I. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION**

FROM:  M. Licon-Vitale, 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 December 27, 2019.

2. 30 Minute Rounds

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Institution Response:

Video review requirements have been instituted by NERO. Specifically, on Tuesday of each week, the institution is notified by NERO of the date, time, and SHU range in which to download video. The video is a two hour block. The video is to be reviewed by the Captain. During the reviews the Captain is looking for strict adherence to the requirements that rounds be conducted at least once during every 30-minute period, not to exceed 40 minutes between rounds and that all scheduled counts are being conducted in the SHU. The Captain will then submit an assurance memo to the institutional executive staff and Correctional Services Administrator (CSA) indicating the designated video footage was reviewed, and corrective actions which were taken for any deficiencies noted. This memorandum will be submitted to the Regional Office by COB on Friday of that same week. Institutional Duty Officers (IDOs) are required to review 6 hours of SHU video. The surveillance footage is downloaded by the institutional SIA and a compact disk is provided to the IDOs for review. The IDOs are reviewing the video for accuracy of the 30 minute rounds. All reviews are documented in the weekly IDO Report.

3. Cellmate Assignments

Documentation exists reflecting the role of the local Psychology Services department in communicating the importance of Mr. Epstein's status as a sex offender with specific needs to the Associate Warden. This includes consultation with the Psychology Services Branch in Central Office. The communication chain and decision making of Executive Staff lacks transparency as there is no documentation of the process or staff members present when decisions were made about the housing of Mr. Epstein. After the fact explanations may not accurately reflect what occurred.

Institution Response:

As was noted, there was no documentation indicating Psychology Services was present when housing decisions were made regarding Mr. Epstein. Psychology services is present at the weekly SHU meeting, Executive Staff meetings, and weekly Opening and Close-Out meetings. During these meetings, the Chief Psychologist or Acting Chief Psychologist are present to provide recommendations and feedback to the Executive Staff on housing concerns regarding inmates with mental health issues or risk factors for suicidality. When an inmate presents with unique risk factors associated with individuals who have been charged with and/or convicted of a sex offense, careful evaluation is made with regard to housing these inmates with appropriate cellmates. Moving forward, a plan has been established to have a sign-in sheet and checklist at these meetings where housing issues are addressed, indicating who was present and what the housing plan is for these inmates with psychological concerns. These checklists will be maintained in a binder by the Associate Warden of Programs. Please see the attached checklist.

4. Documentation Accuracy

Professional responsibility requires taking into account multiple descriptions of an incident as noted in your response. However, when discrepancies exist these should be compiled and noted in documentation to decrease the likelihood of conflicting conclusions.

As noted in the reconstruction report, an incident report must be written within 24 hours of having the information that an inmate likely violated BOP rules. An incident report was written for Mr. Epstein prior to a determination of whether he engaged in self-directed violence or was assaulted on July 23, 2019. Staff had ample time to wait for the outcome of the SIS investigation of this incident. The incident report presumed self-directed violence, although SIS was not able to determine whether this incident was self-directed violence or an assault. Generating the incident report for self-directed violence is evidence of a local bias about the July 23, 2019, incident that still exists amongst some staff at MCC New York. Preconceived notions challenge the ability to remain open about alternative explanations, and subsequent systemic changes may be needed.

Please develop and provide local training for all staff that at a minimum reviews the time frame for writing incident reports and offers guidance when there is not clear evidence of an infraction. Include an outline of the training and evidence of staff who attended the training.

Institution Response:

Additional information (slides) has been included in our Annual Training presentations for Report Writing. In addition to the established training, the slides further differentiate and provide guidance to staff regarding when it is appropriate to write an Incident Report and when, in cases of a lack of evidence, a memorandum is more appropriate. The additional information is being provided to all staff as a part of Annual Training. Annual Training began the week of January 6, 2020, and will continue through the week of March 8, 2020.

5. Telephone Calls

As noted in the response, there is a lack of documentation to substantiate that a lieutenant facilitated two telephone calls to Mr. Epstein. However, this does not address the report of two telephone calls being provided. This response implies that the reporting of two staff members is inaccurate.

The response neglects the documented telephone call to Mr. Epstein's deceased mother.

Institution Response:

On August 29, 2019, Warden [REDACTED] Petrucci, signed a referral related to [REDACTED] failure to follow policy in allowing Epstein to complete an unmonitored phone call. The referral was submitted to the Office of Internal Affairs on that same date and is pending further action at this time.

7. Follow-Up

Please provide documentation for the follow-up training provided to staff detailing the content of the training and to whom it was provided.

Institution Response:

As recommended by Central Office, the Chief Psychologist has conducted suicide prevention trainings during Department Head Meetings, e-mail correspondence, SHU Staff Trainings, and Lieutenant's Trainings. The follow-up training sign-in sheets, Department Head Meeting Minutes, and e-mails provided by psychology staff regarding PSY ALERT Inmates are attached for your review.

8. Inmate Accountability and Assignment Accuracy

Periodic and unannounced checks are now conducted in SHU to determine pp30 assignments and actual inmate placement match. Please provide an operational definition of periodic. Please do the same for routine, as it relates Executive Staff bed book counts in all units. Where will the periodic and routine reviews be documented and will they include the identity (e.g., name and title) of staff who complete them?

Institution Response:

An Executive Staff and Duty Officer schedule has been implemented to conduct daily 4 P.M. and 10 A.M. weekend bed book counts. Any discrepancies noted are documented and sent via email to Unit Managers and Captain at the conclusion of each count for corrective action. Please see the attached schedule.

9. Attorney Log Books

Please provide a copy of the log book audit.

Institution Response:

The audit revealed the **Random Visitor Log Book** did not reflect visitor pat searches after May 19, 2019. In addition, the log book does not offer a column to annotate a staff witness. The **Contractor/Volunteer Log Book** was not always filled in properly. The **Law Enforcement Log Book** was up to date; however, the time of departure was not always documented. The **Attorney Log** was missing inmate register numbers and more often than not was legible. There was no **Visitor Denial Log** created. The audit conducted on September 25, 2019, is attached for your review.

Additional corrective measures will now include the Activities Lieutenant checking all Front Lobby log books. The Captain will ensure these checks are included in the Lieutenant's Daily Log for Day Watch and Evening Watch. In addition, the Activities Lieutenant will address any discrepancies immediately through on the spot training and/or performance log entries.

13. Sex Offense Risk Factors

Psychologists are subject matter experts in sex offender risk factors and they play a crucial role in sharing this knowledge through traditional settings such as ICT, AT, and institutional meetings. However, Executive Staff play a pivotal role in establishing and addressing institutional culture and promoting and participating in training. A lack of a broad understanding of sex offender specific risk factors requires an intentional training approach led by Executive Staff. They must be out front talking about inmates with a sex offense, expressing an understanding of sex offender dynamics, modeling agency condoned expectations for the understanding and treatment of inmates with a sex offenses, and assisting with institutional trainings. These practices encourage a broader acceptance by line staff.

Institution Response:

The MCC New York Executive Staff are out front talking about inmates with sex offenses, and expressing an understanding of sex offender dynamics, modeling agency expectations for the understanding and treatment of inmates with sex offenses. This is done through departmental meetings, trainings, staff recalls and walking and talking throughout the institution.

ATTACHED DOCUMENTS:

- Institution Duty Officer Report
- Cellmate Review
- Report Writing "Back to Basics Training"
- SHU Suicide Prevention Training
- Department Head Meeting minutes
- PSY ALERT inmates
- Bed Book Count Schedule (Exec Staff/IDO)
- Bed Book Audit (emails)
- Log Book Audit
- Executive Staff List



**U.S. Department of Justice
Federal Bureau of Prisons**

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

Office of the Warden

November 13, 2019

MEMORANDUM FOR HUGH [REDACTED] HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION

FROM: [REDACTED] Petrucci, 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. Tartaglione would be his cellmate. As explained by Dr. [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, Dr. [REDACTED] sent an e-mail to [REDACTED] [REDACTED], Associate Warden explaining a consultation between Dr. [REDACTED] and Dr. [REDACTED], National Suicide Prevention Coordinator. In the e-mail, Dr. [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. 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 harm 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, Register Number 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.

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, Dr. [REDACTED] documented information received from Operations Lieutenant [REDACTED] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer Wilson Silva, who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, [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. Brown.

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. [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 [REDACTED]'s 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 Dr. [REDACTED] with a carbon copy to Warden [REDACTED] on August 12, 2019. Of note, [REDACTED] did not make an entry explaining why she was making the log book changes. Additionally, [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 [REDACTED] nor was [REDACTED] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why [REDACTED] attempted to correct [REDACTED]'s 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 Dr. [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, ██████████, Facilities Assistant reported she observed Mr. Epstein in his cell. In an e-mail she sent to Drs. ██████████ and Imeri and Lieutenant ██████████ 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. Torres 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 Medina 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. Torres was concerned about suicide risk, P5324.08, Suicide Prevention Program, requires her to maintain direct, continuous observation of Mr. Epstein. When Dr. ██████████ opened the e-mail the following Monday morning, Mr. Epstein was evaluated by Dr. ██████████ 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., ██████████ sent Dr. ██████████ 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 ██████████ 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 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 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 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.

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 H01 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 H01-001L 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 H01-001L, 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 H01 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 L. Grey 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: [REDACTED], [REDACTED], and [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 position 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



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Warden

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

November 6, 2019

MEMORANDUM FOR HUGH J. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION

FROM: J. Petrucci, 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. Tartaglione would be his cellmate. As explained by Dr. [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, Dr. [REDACTED] sent an e-mail to [REDACTED] [REDACTED], Associate Warden explaining a consultation between Dr. [REDACTED] and Dr. [REDACTED], National Suicide Prevention Coordinator. In the e-mail, Dr. [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 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 be 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 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 harm 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.

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, Dr. [REDACTED] documented information received from Operations Lieutenant [REDACTED] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer Wilson Silva, who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, [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. Brown.

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. [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 [REDACTED]'s 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 Dr. [REDACTED] with a carbon copy to Warden [REDACTED] on August 12, 2019. Of note, [REDACTED] did not make an entry explaining why she was making the log book changes. Additionally, [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 [REDACTED] nor was [REDACTED] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why [REDACTED] attempted to correct [REDACTED]'s 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 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 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.

CORRECTIONAL SERVICES IN RE INCIDENT REPORT

The Reconstruction 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 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, 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.

5. Telephone Calls: In a PDS-BEMR note written by Dr. [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 Imeri 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. Torres 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 Medina 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 Dr. [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., [REDACTED] sent Dr. [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.

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 is not in the institution, an inmate is placed on suicide watch, and the on-call psychologist and Warden are notified.

As an automatic response to all incoming emails, all Psychology staff added the following auto-reply: "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 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.

An institutional procedural memorandum will be established by 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.

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 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 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.

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 H01 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 H01-001L 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 H01-001L, 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 H01 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.

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 are maintained by Correctional services in the Daily 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.

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:

THE BELOW IS NOT RESPONSIVE. WE NEED A STATEMENT AS TO WHEN THE 3 ATTORNEY LOG BOOKS AND THE INMATE SEARCH LOGBOOK FROM ATTORNEY CONFERENCE WERE SECURED AND A PLAN TO PULL THEM IN THE EVENT OF ANY FUTURE SUICIDE IF APPLICABLE. WE ALSO NEED TO ADDRESS HOW THE LOGBOOKS WERE FIXED TO ENSURE ACCURATE DOCUMENTATION.

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.

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 L. Grey 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: [REDACTED], [REDACTED], and [REDACTED].

Institution Response: 11. Post Orders & SHU Training:

The Suicide Watch Post Orders are 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.

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. Every shift a Lieutenant will make rounds 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 prescribe 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, MP-3 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 position 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 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.

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 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



U.S. Department of Justice

Federal Bureau of Prisons

Office of the Warden

Metropolitan Correctional Center
150 Park Row
New York, New York 10007

November 1, 2019

MEMORANDUM FOR HUGH J. HURWITZ, ASSISTANT DIRECTOR,
REENTRY SERVICES DIVISION

FROM: J. Petrucci, 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.

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. 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.

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) picture door tag to ensure staff are aware to take more security pre-cautions in dealing with this inmate. Two hour Captian 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. Tartaglione would be his cellmate. As explained by Dr. [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, Dr. [REDACTED] sent an e-mail to [REDACTED] [REDACTED], Associate Warden explaining a consultation between Dr. [REDACTED] and Dr. [REDACTED], National Suicide Prevention Coordinator. In the e-mail, Dr. [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 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 be celled with. Psychology Services takes into consideration the suicide risk factors involved with a particular inmate and share their knowledge with Executive Staff.

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.

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, Dr. [REDACTED] documented information received from Operations Lieutenant [REDACTED] that Mr. Epstein, "was found with a string loosely hanging around his neck." In contrast, Officer Wilson Silva, who responded to this emergency, wrote a memorandum dated July 23, 2019. In that memorandum, [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. Brown.

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.

Institution Response: 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 and Operations Lieutenants documents in the suicide watch log book. Log books are now being closely monitored on a daily basis by the Chief Psychologist.

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 292's on a daily basis, and provide the Captain with an assurance memorandum. 292's will be printed for the previous week every Sunday, and the SHU Lieutenant will acquire any needed signatures from the respective OIC in a handwritten manner.

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, 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.

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.

Officer [REDACTED] was responsible for observing Mr. Epstein and documenting his behavior while on suicide watch on July 23, 2019. [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 [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 Dr. [REDACTED] with a carbon copy to Warden [REDACTED] on August 12, 2019.

Of note, [REDACTED] did not make an entry explaining why she was making the log book changes. Additionally, M Coates 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 [REDACTED] nor was [REDACTED] assigned to work the Suicide Watch post. Due to the inability to interview staff at this time, it is unknown why [REDACTED] attempted to correct [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.

5. Telephone Calls: In a PDS-BEMR note written by Dr. [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. 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 Imeri and Lieutenant [REDACTED] later that evening, she described Mr. Epstein as "distracted, 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 Medina 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. Torres was concerned about suicide risk, P5324.08, Suicide Prevention Program, requires her to maintain direct, continuous observation of Mr. Epstein. When Dr. [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., [REDACTED] sent Dr. [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.

Institution Response: 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 immediately on classification/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 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.

Inmates who initially enter and/or transfer into the institution with a PSY ALERT assignment will be seen by a member from 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 more immediately and not just when an inmate is about to leave the institution.

An institutional procedural memorandum will be established by 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.

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 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 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.

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 H01 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 H01-001L 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 H01-001L, 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 H01 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 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.

To ensure inmates are assigned to the correct cell inside the Special Housing Unit. Periodic and un announced checks are conducted. Specifically, SENTRY Roster PP 30 Quarters assignments are audited daily by the assigned Lieutenant in the unit. Executive Staff conduct routine bed book counts in the unit. Procedures of how the count is conducted any discrepancies are identified and corrected. Results are maintained by Correctional services in Daily

Log.

In order to properly account for inmates in the unit, staff have informed not use the (Inmate Locator Form), due to forms inability as a reliable means for accounting for inmates and cell assignments. A Unit Accountability Board along with SENTRY PP 30 Quarters Roster has been placed in the unit to establish better oversight over inmate accountability.

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: 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. Every shift a Lieutenant will make rounds 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 prescribe 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, MP-3 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.

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: 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 L. Grey 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: [REDACTED], [REDACTED], and [REDACTED].

Institution Response: 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.

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 prescribe web-based training as identified on the agenda. Staff assigned to SHU and have not received the mandatory training before assuming post; will be roster adjusted to attend another training day as assigned by the Captain.

12. Staffing: The Drug Abuse Program Coordinator position 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 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.

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 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