

Background

Jeffrey Epstein was formally charged with Sex Trafficking Conspiracy in violation of 18 U.S.C. Section 371 and Sex Trafficking in violation of 18 U.S.C Section 1591(a), (b) (2), 2 on July 2, 2019. Specifically, he was accused of sexually exploiting and abusing minor females over the course of several years. Charging documents allege that Epstein enticed and recruited minor females to engage in sexual activity. The minor females were reportedly compensated with cash following the sexual encounters and some were encouraged to find other minor females to accompany them to Epstein's residences in New York and Florida.

Epstein's incarceration with the Federal Bureau of Prisons

The FBI arrested Jeffrey Epstein on the sex trafficking charges on Saturday, July 6, 2019. Epstein was arrested at Teterboro Airport in New Jersey upon his return from Paris, France. He was transported to the Federal Bureau of Prison (BOP) Metropolitan Correctional Center (MCC) located at 150 Park Row, New York, New York, and keyed into SENTRY at 9:24 p.m. that evening. The MCC, which housed approximately 750 inmates at any given time, assigned inmates to various housing units within the MCC. Epstein was initially assigned to a bed in the MCC's general population, but on July 7, 2019, at approximately 7:20 p.m., he was moved to the Special Housing Unit (SHU) pending reclassification due to the significant increase in media coverage and awareness of his notoriety among the inmate population. The SHU is a housing unit within the MCC where inmates are securely separated from the general population to ensure their own safety as well as the safety of staff and other inmates. The SHU is located on the ninth floor of the MCC, and access to that floor is controlled by a locked door that can be opened remotely only by an MCC staff member in the MCC's centralized control center, which is located on the first floor of the MCC. Access into the SHU is also controlled by a second locked door, to which only correctional officers assigned to the SHU have keys while on duty. Within the SHU, inmates are assigned to six separate tiers, each of which can be accessed only via a single locked door, to which the correctional officers assigned to the SHU have keys while on duty. Each tier has eight cells, each of which can house either one or two prisoners, and each individual cell, which is made of cement and metal, is accessed only through a single locked door, to which only correctional officers assigned to the SHU have keys while on duty. Epstein was assigned to the SHU due to, among other things, risk factors for suicidality and safety concerns relating to housing him with the MCC's general population.

According to former Warden [REDACTED], the MCC typically houses inmates in the SHU with a cellmate. Upon Epstein's transfer to the SHU, he was assigned a cell with Inmate Nicholas [REDACTED], Register Number 78514-054. He stated that he picked inmate Nicholas [REDACTED] to be Epstein's cellmate because [REDACTED] was a white male who could likely cope with Epstein.

On July 8, 2019, Epstein underwent a psychological intake screening at the MCC. Epstein reported that he did not have thoughts of suicide, never attempted suicide, and told the psychologist that he was not receiving treatment related to his mental health. The MCC's chief psychologist, [REDACTED] consulted with a psychiatrist from the BOP's Central Office, regarding Epstein. [REDACTED] notes state that risk factors for suicidality were present in Epstein's situation. [REDACTED] identified those risks as being: a high profile case with media attention, sex offense charges, pre-trial status, and a "court proceeding today which would potentially be giving him bad news regarding his legal situation." As a consequence, [REDACTED] directed that Epstein be placed in psychological observation upon his return from court pending a mental health evaluation. During Epstein's period under suicide watch and psychological observation, "inmate companions" stayed with and continuously observed him. The inmate companions kept a log

detailing Epstein's activities in 15-minute increments. The difference between suicide watch and psychological observation is the access to personal items while under observation and their clothing. During suicide watch, an inmate cannot have any clothing or personal items; whereas, during Psychological Observation, an inmate is permitted to have clothing and personal items that cannot be used to engage in self harm.

On July 9, 2019, ██████ conducted a suicide risk assessment of Epstein. Epstein denied any suicidality and had no mental health or suicide history. According to ██████ notes, Epstein was "future-oriented and expressed a commitment to life and safety, agreeing to contact staff immediately should he experience suicidal ideation." The notes also show that Epstein said "being alive is fun." ██████ determined that Epstein's overall suicide risk was "low" and a "suicide watch [was] not warranted at this time," but psychology observation is continued "pending suitable housing placement." In addition, Health Services completed a History & Physical for Epstein. This assessment was done in lieu of an Intake Screening, which should have been conducted within 24-hours of Epstein's arrival (PS6031.04).

A review of the BOP Electronic Medical Records (BEMR) indicate that Epstein was diagnosed with hyperlipidemia, sleep apnea, hypertension, constipation, prediabetes, neuralgia, and neuritis unspecified. He was prescribed the following medications: docusate sodium, milk of magnesia, omega 3, methylprednisone, and bisacodyl. Epstein was also prescribed insulin, and the prescription required him to go to the institution pharmacy for administration of this medication. However, the dates for which it was prescribed have a notation indicating "does not indicated," thus it does not appear insulin was routinely medically necessary. The rest of the medications prescribed were self-carry.

On July 10, 2019, ██████ met with Epstein again. According to ██████ notes, Epstein again denied suicidality. ██████ also wrote that Epstein appeared "psychologically stable at this time and can be released from the psychological observation area." Epstein was taken off of psychological observation and returned to the SHU with documented recommendations for a cellmate and next-day contact by psychology. Epstein was placed in cell Z05-124LAD, again with inmate ██████.

On July 11, 2019, Epstein again met with ██████ while conducting a legal visit, because Epstein was spending an inordinate amount of day time hours with his attorneys. To avoid missing the completion of the follow-up visit, ██████ briefly interrupted the attorney visit and met with Epstein privately. According to ██████ notes, Epstein denied any suicidality. This visit recommended additional follow-up the next week.

On July 16, 2019, Epstein is seen by psychology in the presence of his attorneys while conducting a legal visit. This visit recommended no follow-up. Per the BOP after action report, this visit was at the request of Epstein and was wholly inappropriate. Epstein's attempt to establish guidelines for communication and bring his attorneys into the fray regarding the mental health treatment being provided by the institution. It is not typical for the BOP to provide psychological intervention in the presence of others, nor is it appropriate for a BOP psychologist to meet with inmate attorneys.

On July 23, 2019, at approximately 1:27 a.m., while Epstein was housed in the SHU, MCC correctional officers assigned to the SHU responded to noises coming from Epstein's cell. When the two SHU correctional officers responded, Epstein's cellmate, ██████, told them that Epstein had attempted to hang himself. The correctional officers observed that Epstein had an "orange homemade rope" around his neck, which they removed. The correctional officers also observed that Epstein was breathing, but unresponsive. Epstein received medical treatment and, at approximately 1:40 am, was

placed on suicide watch by Operations Lieutenant [REDACTED]. Inmates placed on suicide watch are housed in a cell on the hospital wing floor of the MCC, and are watched twenty-four hours a day by a staff member or a specially trained inmate companion. During the incident, there were reports that Tartaglione had attempted to harm Epstein. However, multiple witnesses, including [REDACTED], told the OIG that Epstein was observed displaying behavior that was inconsistent with that allegation, and said that Epstein may have made the statement because he was attempting to be housed by himself. Special Investigative Services (SIS) staff opened an investigation to assess Epstein's safety and collect facts surrounding the episode. Despite this investigation, SIS investigators were unable to determine whether he was assaulted or engaged in self-directed violence.

On the morning of July 24, 2019, Staff Psychologist [REDACTED] [REDACTED], Ph.D., conducted a "Post Suicide Attempt" interview of Epstein and directed that he be taken off of suicide watch. According to the [REDACTED] notes, Epstein denied suicidality and stated, "I have no interest in killing myself" and that it "would be crazy" to take his life. He also said that he was "depressed" and "unhappy" about his current legal situation. The staff psychologist ended suicide watch and informed Epstein that he would remain in the same cell on psychological observation in the near term. Psychological observation is less restrictive than suicide watch, but inmates are still housed in the hospital wing of the MCC and watched twenty-four hours a day.

Every day between July 25, 2019 and July 29, 2019, either Chief Psychologist [REDACTED] or Staff Psychologist [REDACTED] [REDACTED] met with Epstein and conducted a clinical contact. In each instance, Epstein denied any suicidal ideation. According to [REDACTED] notes, she met with Epstein on July 29, and at that meeting, Epstein asked to remain in the hospital for one more week. [REDACTED] told Epstein that he would return to the SHU the next day. Daily psychology contact while on psychology observation indicated that Epstein would be moved to another cell due to toilet issues. This move is not shown by SENTRY to have occurred. A review of SENTRY indicates that he was transferred back to the SHU on July 29, 2019, whereas PDS-BEMR indicates that he was removed from Psychological Observation on July 30, 2019, at approximately 8:15 a.m.

On July 30, 2019, Psychology observation status was discontinued with a recommendation for a cellmate while assigned to the SHU.

Directive for Epstein to Have a Cellmate

As detailed in the Psychology section of this report, prior to Epstein's removal from Psychological Observation on July 30, 2019, a determination was made by the MCC New York Psychology Department that Epstein be housed with a cellmate. To ensure Epstein's cellmate requirement was disseminated to MCC New York staff, on July 30, 2019, at 12:30 p.m., Dr. [REDACTED] [REDACTED], Psychology Department, sent a mass email to MCC staff members which read, "Inmate Epstein #76318-054 is being taken off Psych Observation and needs to be housed within an appropriate cellmate." A review of the email recipients showed that the email was sent to, among others, Warden [REDACTED] [REDACTED], AW [REDACTED], Captain [REDACTED], SHU Lt. [REDACTED], SIS Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], and [REDACTED] [REDACTED], who were all interviewed by the OIG. As a result of the requirement, Epstein was assigned to SHU cell Z04-206LAD with inmate [REDACTED] [REDACTED], Register Number [REDACTED]. SENTRY is inaccurate regarding this move, as it shows to have occurred the previous day. A medical record note is completed stating that Epstein will be issued a Continuous Positive Air Pressure (CPAP) machine, which is typically used to treat sleep apnea. Per BEMR, Epstein was provided with his personal CPAP machine on July 30, 2019. Although

there is no SENTRY transaction, Epstein and [REDACTED] were moved to SHU cell Z06-220. This move was done to accommodate the electrical needs of Epstein's assigned the CPAP machine. Epstein was also assigned to the cell closest to the correctional officers' desk in the common area of the SHU, which was approximately fifteen feet from his assigned cell.

On July 30, 2019, the MCC psychologists determined that Epstein did not "appear to be an immediate danger to [himself]" and psychological observation was discontinued. Former MCC Warden [REDACTED] N' Diaye stated that [REDACTED] advised him that Epstein was not suicidal and was ready to return to the SHU. That same day, Staff Psychologist [REDACTED] completed a "Post-Watch Report" which stated that the "SHU Lt. was informed that Mr. Epstein needs to be housed with an appropriate cellmate." SHU Lieutenant [REDACTED] stated that a BOP psychologist said that Epstein must be housed with a cellmate when he returned to the SHU. [REDACTED] also sent a group email to the MCC's leadership, including the Warden, Associate Wardens, the Captain, and all lieutenants, stating that Epstein was "being taken off of Psych Observation and needs to be housed with an appropriate cellmate."

During interviews conducted by the OIG of AW [REDACTED], Captain [REDACTED], and SHU Lt. [REDACTED], they each said that they verbally informed the SHU Staff of Epstein's cellmate requirement, and were confident that each staff who worked in the SHU on August 9 and 10, 2019, knew of Epstein's cellmate requirement. AW [REDACTED] said that Captain [REDACTED] was in charge of correctional services, and LT [REDACTED] was the SHU LT. [REDACTED] said that [REDACTED] should have told [REDACTED], and [REDACTED] should have told the SHU staff. [REDACTED] would be responsible for ensuring that everything was in compliance within the SHU. They should have provided it in writing via email and verbally. [REDACTED] said the SHU staff did know that Epstein was required to have a cellmate, and said she personally heard it spoken about when she would visit the SHU on more than one occasion when doing rounds. Captain [REDACTED] said that after the directive was issued, he spoke with SHU LT [REDACTED] and directed him to ensure Epstein had a cellmate. LT [REDACTED] said that he passed the directive down to the SHU staff. Additionally, SHU OIC [REDACTED] [REDACTED] said that he was aware of Epstein's cellmate requirement, and said that all SHU staff were also aware of the requirement. MCC New York Psychology Department personnel told the OIG that MCC personnel knew of Epstein's cellmate requirement because it was discussed during staff meetings, department head meetings, SHU meetings, morning meetings, and during required staff training.

According to N' Diaye, when he spoke with [REDACTED] regarding Epstein, [REDACTED] said to get Epstein a cellmate. He added that typically the MCC will house an inmate who was previously on suicide watch with a cellmate. N' Diaye stated there was no BOP policy mandating that an inmate coming off of suicide watch have a cellmate, but that doing so was "sound correctional judgment." [REDACTED] similarly told the OIG that it was "common practice" in the BOP for prisoners coming off of suicide watch to be assigned a cellmate. However, there is no BOP policy addressing the necessity of assigning cellmates to individuals coming off of suicide watch.

Epstein's cellmate selection

Captain [REDACTED] told the OIG that on July 30, 2019, upon Epstein's removal from Psychological Observation, he was transferred to the SHU and inmate [REDACTED] [REDACTED], Register Number [REDACTED], was assigned as his cellmate. Captain [REDACTED] told the OIG that he compiled a list of potential cellmates for Epstein, but Epstein's ultimate cellmate selection was made by Warden [REDACTED] and Regional Director [REDACTED]. Warden [REDACTED] and Regional Director [REDACTED] confirmed that they selected inmate [REDACTED] was from a list of potential cellmates. Captain [REDACTED], Warden [REDACTED], and Regional Director [REDACTED] told the OIG that if [REDACTED] was removed as Epstein's cellmate, they would have to

review a new list of potential cellmate candidates to ensure that Epstein was housed with an appropriate selection. [REDACTED] and [REDACTED] told the OIG if [REDACTED] was removed from the MCC New York, SHU staff should have informed a Lieutenant on duty, who would in turn should have informed Captain [REDACTED], who would have ensured that the process of selecting a new cellmate would begin.

A review of financial transactions associated with Epstein's prison account revealed one of his attorneys was depositing funds into his [REDACTED] commissary account for unknown reasons.

Captain Jermain [REDACTED], who supervises all of the lieutenants and correctional officers working in the MCC, told the OIG that at [REDACTED] direction, he compiled a list of possible cellmates for Epstein, vetted those inmates, and provided the list of names to [REDACTED]. [REDACTED] stated that he identified three inmates to possibly house with Epstein and decided on [REDACTED] [REDACTED]. He further stated that he advised the BOP Director's Chief of Staff [REDACTED], Regional Director [REDACTED], and Associate Warden [REDACTED] that Epstein needed to have a cellmate and provided them with the names of the three possible inmates that could fill that role and his decision to use [REDACTED]. During [REDACTED] re-interview, he said that the Warden contacted the Regional Director and the two of them made that decision. [REDACTED] actually said that the Regional Director, [REDACTED], was the one who made the ultimate selection.

Typically, a lieutenant, in conjunction with the Officer in Charge and others can assign a cellmate to an inmate in the SHU. [REDACTED] said that in regard to Epstein, if [REDACTED] were to depart the MCC, the correctional officers were to notify the lieutenant of [REDACTED] departure; the lieutenant was then to advise [REDACTED]; and [REDACTED] would tell [REDACTED] that Epstein did not have a cellmate. [REDACTED] stated that he and his staff would then review the situation and determine which inmate would be Epstein's new cellmate. [REDACTED] also said that there were no inmates pre-vetted to replace [REDACTED] if he left the MCC. Aside from LT [REDACTED], the LTs on August 9, 2019, knew that Epstein was required to have a cellmate and were aware that Epstein's cellmate was selected at a higher level due to his high profile status.

[REDACTED] said that he was off from work on August 9, 2019, and was unaware of [REDACTED] transfer. [REDACTED] also said that in the event Epstein was without a cellmate, the plan was to review the situation and decide with whom to replace [REDACTED], but that no inmate in the SHU was preselected to replace [REDACTED] if this event occurred. [REDACTED] said that he directed [REDACTED] to ensure that Epstein had a cellmate

[REDACTED] confirmed that [REDACTED] directed him to ensure that Epstein had a cellmate. [REDACTED] said that he orally informed his lieutenants that Epstein needed a cellmate at all times, and repeatedly directed [REDACTED] to ensure Epstein had a cellmate. He said that he also visited the SHU on multiple occasions and directed his staff to be alert and attentive about Epstein's special needs.

[REDACTED] told the OIG that [REDACTED] told him that Epstein was required to have a cellmate. [REDACTED] also said that after the BOP staff psychologist directed that Epstein was to have a cellmate, he ensured that Epstein did so and advised his staff of the staff psychologist's directive. [REDACTED] said that he did not work on August 9, 2019, and was unaware that Epstein was without a cellmate.

Epstein's cellmate assignment

According to a BOP report obtained under this investigation titled Institution Response dated May 14, 2020, a SENTRY quarters roster generated on August 10, 2019, at 12:51 a.m., there were three inmates

assigned to Epstein's SHU cell, Z04-206LAD, including him, at the time of his death. However, his SHU cell was only a double occupancy cell. Inmate [REDACTED], Register Number [REDACTED], inmate [REDACTED], Register Number [REDACTED], and 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 inmates [REDACTED] and [REDACTED], respectively. Inmate [REDACTED] cell assignment was Z04-206LAD from August 5, 2019, until August 11, 2019, when he was moved to cell Z04-212UAD. Inmate [REDACTED] cell assignment was Z04-206UAD from August 1, 2019, until August 11, 2019, when he was moved to cell Z04-207LAD. A quarters history roster was generated for Epstein on August 13, 2019, at 9:07 a.m. His cell assignment was Z04-206LAD from July 29, 2019, until August 10, 2019.

The same BOP report indicates that on Monday, August 12, 2019, photographs of name tags on SHU cell doors and SHU locator forms were sent to the Correctional Service Department in the Northeast Region. The SHU locator form was dated August 9, 2019, and it shows inmate [REDACTED] in cell 207L (Sentry states he was moved to this cell on August 11, 2019), inmate [REDACTED] in cell 212U (SENTRY states he was moved to this cell on August 11, 2019), inmate Epstein in cell 220L (SENTRY never shows him in this cell) along with inmate [REDACTED], Register Number [REDACTED]. The locator shows inmate [REDACTED], Register Number [REDACTED], and inmate [REDACTED], Register Number [REDACTED], in cell 206. The photo sheets show the cell being 220 with inmates Epstein and [REDACTED] identification cards on the door. Inmate [REDACTED] was in cell Z06-220U from August 5, 2019, to August 9, 2019.

The OIG investigation has revealed that on July 30, 2019, at approximately XXXX, Epstein was placed into Special Housing Unit (SHU) cell number XXX with inmate [REDACTED]. MCC staff entered Epstein's cell number in SENTRY to reflect Epstein's assignment. Following the placement, Epstein's CPAP machine did not reach the power cord. Therefore, Epstein and [REDACTED] were physically moved to SHU cell number XXX. However, no one ever made the change in Sentry to reflect Epstein's move. (Check [REDACTED] Quarters History). XXX was responsible for making the change within Sentry at the time of the move. According to staff interviews, it does not appear that there were any checks and balances to ensure that inmates were physically located within the cells that they were assigned within Sentry. AW [REDACTED] told the OIG XXXX

July 31, 2019

Although neither SENTRY nor the Lieutenant's Log reflect this event, Epstein attended a court hearing on July 31, 2019, and, upon his return at an unspecified time, the United States Marshals Service (USMS) provided paperwork to the MCC New York Receiving and Discharge (R&D) staff that noted "suicidal tendencies."

August 1, 2019

Dr. [REDACTED], Psychology, was notified of the form received from the USMS the previous day stating that Epstein had reported suicidal tendencies. She consulted with Dr. [REDACTED] and then conducted a suicide risk assessment, noting watch was not indicated with a recommendation for follow-up in one week. According to the BOP After Action Review, the delay in conducting the assessment was not justified in the report.

August 2, 2019

An SIS Investigation into the July 23, 2019, incident was completed. The investigation stated there was insufficient evidence to support either Epstein harmed himself or was harmed by his cellmate.

August 8, 2019

On August 8, 2019, at 10:02 a.m., Psychology contact for suicide risk assessment follow-up was conducted. No concerns or follow-up noted.

At 10:33 a.m., the United States Marshals Service (USMS) sent an email to MCC personnel assigned to the MCC Receiving and Discharge Department with the Subject, "Transfers of Prisoners from NYM to GEO." GEO is a Detention Facility located in Queens, New York. Within the body of the document, the text reads, "The following prisoners are to be transferred:" followed by two names and register numbers. The second name was listed as "[REDACTED], [REDACTED], [REDACTED]." Immediately below inmate [REDACTED] name, it reads, "Please schedule the transfer for Friday 8/9/19. Please include 7 days mediation with the medical summary. Thank you."

At 3:36 p.m., the USMS sent a second email to a number of MCC personnel assigned to the MCC Custody Department, with the Subject, "Prisoner Production 08-09-2019," which included two attachments. One of the attachments was listed as "NYM 08-09-2019." That attachment was the Prisoner Schedule Report for the MCC New York on August 9, 2019. On the first page of the attachment, it shows that inmate [REDACTED] [REDACTED] was scheduled be transferred from the MCC to GEO, on August 9, 2019. The document reflects the acronym WAB within the Destination/Description portion of the document, which all MCC staff members told the OIG means "With All Belongings." The MCC staff members told the OIG that WAB meant that [REDACTED] was being permanently removed from the MCC on August 9, 2019. Among others, the email was sent to Captain [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. [REDACTED], Lt. SHU [REDACTED], Lt. [REDACTED] Stanley, SIS LT [REDACTED], and AW [REDACTED], who were all interviewed by the OIG.

August 9 and 10, 2019

According to a BOP Memorandum for [REDACTED] [REDACTED], Regional Director, Northeast Region, on August 9, 2019, a federal court unsealed approximately 2,00 pages of documents in the public domain. These included allegations against Epstein. Included was a book order receipt for titles such as SM 101: A Realistic Introduction; SlaveCraft: Roadmaps for Erotic Servitude; and Training with Miss Abernathy: A Workbook for Erotic Slaves and Their Owners. Additional high profile public figures were also named in the released documents. The documents were part of a defamation lawsuit filed by [REDACTED] [REDACTED] [REDACTED], a woman who alleged that Epstein had victimized her, against a British socialite, Ghislaine Maxwell, who was Epstein's ex-girlfriend, associate, and alleged to have assisted with his criminal activities.

Day Watch on August 9, 2019

According to the MCC Daily Log (BOP Form PP38) and the Lieutenant's Log from August 9, 2019, at approximately 8:38 a.m., Epstein's cellmate, [REDACTED] [REDACTED], was "Pre-Removed" and transferred out of the MCC in a routine, pre-arranged transfer. A BOP Form PP38 tracks the daily inmate movements throughout the MCC, while the Lieutenant's Log is utilized by the Lieutenant's to document the daily activities that took place within the MCC.

Supervisory Correctional Systems Specialist [REDACTED], who was the supervisor of the Receiving and Discharge (R&D) department on August 9, 2019, and responsible for overseeing all movements in and out of the MCC, verified that the R&D Department would have utilized the USMS emails sent on August 8, 2019, to coordinate [REDACTED] transfer from the MCC. [REDACTED] said that since [REDACTED] was listed as WAB on the USMS emails, that meant he was being transferred from the MCC and not coming back. [REDACTED] explained that if [REDACTED] was going to court, as many inmates at the MCC oftentimes do, the BOP Form PP38 entered by the R&D department would have been entered as court, rather than Pre-Remove. Since the BOP Form PP38 listed [REDACTED] as Pre-Remove, the R&D Department personnel who entered the information knew that [REDACTED] was being transferred from the MCC on the morning of August 9, 2019. [REDACTED] said that it was not acceptable for SHU Staff to say that they thought an inmate may return to the SHU if the inmate left the housing unit as a WAB. [REDACTED] said that if SHU staff have claimed that they did not know that [REDACTED] was not coming back to the SHU, they probably would have called R&D during the 4 p.m. count to check on his status. [REDACTED] said the R&D movement officer on August 9, 2019, was Corrections Systems Officer [REDACTED].

[REDACTED] confirmed that the BOP Form PP38 documentation meant that [REDACTED] was listed as Pre-Remove on August 9, 2019, at 08:38, because [REDACTED] "Was being officially removed out of the institution, going to another destination." [REDACTED] clarified by saying, "He was going to be transferred to another prison" and he was not going to return to the MCC. [REDACTED] said that she was likely the BOP employee who created the inmate call out list that was disseminated throughout the MCC on August 9, 2019, and utilized by the SHU staff when escorting [REDACTED] to the R&D for transfer. [REDACTED] explained that R & D would have entered the information with regard to [REDACTED] into Sentry, along with other inmates who would be leaving their housing units. R & D would then print out a call out lists, with all the inmate names and times they were to be moved, and the MCC internal officer would then take call out list to the various housing units within the MCC. The call out document created for August 9, 2019, would have listed WAB next to [REDACTED] name, which meant that [REDACTED] was departing from the MCC and not returning. [REDACTED] said that the MCC does not maintain the call out lists that are printed and hand delivered to the housing units, and said that the lists are not emailed. [REDACTED] also said that the inmate call out list is updated every 24 hours within an electronic document, so the call out lists are only maintained electronically for that 24-hour period, prior to it being update for the next day's list.

MCC SHU Lieutenant [REDACTED], who was the supervisor of the SHU, told the OIG that he worked at the MCC on August 8, 2019, from approximately 6 a.m. until approximately 2 p.m., and was off on August 9, 2019. [REDACTED] said that per Psychology, Epstein was required to have a cellmate. [REDACTED] said that the Warden and Captain both told him of the requirement, and [REDACTED] told the SHU Officer in Charge, [REDACTED], of the requirement. [REDACTED] said that everyone who regularly worked in the SHU also knew of the requirement. [REDACTED] also said that all staff knew that if an inmate came from suicide watch, the inmate needed to be assigned a cellmate. [REDACTED] explained that Psychology's policy says that if an inmate comes from suicide watch, they have to be assigned a cellmate. [REDACTED] said that he learned of the requirement during training, and knew of the requirement from the first day he joined the BOP, as should all MCC staff members. [REDACTED] said the requirement is clearly communicated during suicide watch training, posted throughout the SHU area, and is also institutional knowledge. [REDACTED] said that he was not aware that [REDACTED] was scheduled to be transferred from the MCC on August 9, 2019, and therefore did not make any notifications to his superior, Captain [REDACTED], that Epstein would require a new cellmate. [REDACTED] said that as soon as the SHU staff learned that [REDACTED] was going to be transferred, they should have notified a lieutenant. [REDACTED] said that if the SHU staff believed [REDACTED] was at court, it should have been recognized that he was not coming back during the 4 p.m. count, when Epstein was returned to his cell, or during any one of the 30-minute rounds conducted in the SHU after Epstein was returned to his cell.

████ said that it should have definitely been recognized by the 10 pm count. █████ said that the SHU staff should have notified either the Operations or Activities Lieutenant, and that Epstein should have then either been reassigned a new cellmate or have been placed in a "hard cell."

Captain █████ told the OIG that due to █████ absence, the Operations Lieutenant assigned to the various shifts throughout the day were responsible for overseeing the SHU. Operations Lieutenant █████ had responsibility for the SHU on August 9, 2019, from approximately 6:00 a.m. until 2:00 p.m. █████ told the OIG that he knew that Epstein was required to have a cellmate, but believed that █████ was removed from his cell on August 9, 2019, for a court appearance, and was then unexpectedly released during the appearance after █████ shift had ended. █████ said that he did not inform his supervisor, Captain █████, of █████ departure from the MCC, or that Epstein was without a cellmate, because he did not know that █████ was not going to return to the MCC. However, █████ said that he should have known that █████ was removed from the MCC based upon █████' scheduled transfer from the MCC and his WAB status that would have been listed on the August 9, 2019, MCC inmate production list that would have been generated by the MCC R&D. █████ said that no one informed him that █████ left the MCC as a WAB.

Captain █████ told the OIG that he was not notified of █████ departure, and did not know that Epstein was without a cellmate on August 9, 2019. █████ said that since █████ was transferred out of the MCC at approximately 8:38 a.m., it would likely have been the responsibility of █████ to have notified him of █████ departure. However, if █████ believed that █████ went to court and did not know that █████ was not returning to the MCC, then the responsibility would fall to the SHU Officer in Charge (OIC) █████ █████, who did know that █████ was leaving the MCC as a WAB. █████ said that █████ should have informed a Lieutenant during his shift. █████ claimed that no one informed him of █████ departure from the MCC, as they should have done, even though he worked until approximately 8 p.m. on August 9, 2019. █████ advised that if he was informed, he would have taken immediate action to ensure that Epstein was either assigned a new cellmate, or was monitored until he was assigned a new cellmate.

According to the Duty Roster from August 9, 2019, Activities Lieutenant █████ was the other Lieutenant on duty during █████ shift. █████ confirmed to the OIG that he was the Day Watch Activities Lieutenant on August 9, 2019, from approximately 6:00 a.m. until 2 p.m. The August 9, 2019, 30-Minute Round Sheet shows that █████ visited the SHU and conducted a Lieutenant Round at approximately 11:27 a.m.

████ told the OIG that on August 9, 2019, he and █████ were responsible for overseeing the SHU. █████ said that he knew Epstein was required to have a cellmate, and said that he received the email from █████ on July 30, 2019, documenting the requirement. He also said that all inmates in the SHU were required to have a cellmate, unless they had some special circumstance saying they should not have a cellmate. █████ believed that on August 9, 2019, Epstein went to court and never came back to the MCC later that day because he was either released or transferred. █████ said that he did not recall █████ departing the MCC as a WAB, did not recall having any conversations with anyone with regard to █████ being removed from the MCC, and did not know that Epstein was without a cellmate. █████ said that he did not have any conversation with █████ with regard to █████ departing the MCC or Epstein needing a new cellmate.

████ told the OIG that he was the MCC SHU OIC on August 9, 2019, from approximately 6 a.m. until 2 p.m. █████ said that he last saw Epstein on the morning of August 9, 2019, and said that Epstein was

in good spirits and they joked around. ██████ explained that at approximately 8:00 a.m., he escorted Epstein to the attorney conference room for Epstein's daily legal visit, along with MCC Internal Officer ██████ ██████, who escorted ██████ to the MCC Receiving and Discharge (R&D) Department. ██████ explained that the escorts occurred together. ██████ said that on the morning of August 9, 2019, the SHU staff received an inmate production document that listed ██████ as WAB. ██████ explained that WAB meant that ██████ was being discharged, or removed, from the MCC, and said that the document was utilized when escorting ██████ to the MCC R&D Department. ██████ and ██████ both told the OIG that ██████ was in fact escorted to R&D with all of his belongings, and both said that during the escort, ██████ informed Epstein that he (Epstein) would be assigned a new cellmate due to ██████ departure from the MCC, and Epstein's requirement to have a cellmate. According to the MCC PP38 Daily Log and the Daily Lieutenant's Log for August 9, 2019, ██████ was removed from the MCC at 8:38 a.m.

██████ told the OIG that he was aware that Epstein was required to have a cellmate, and said "We always practice, if somebody comes off suicide watch, they have to go with a cellmate until Psychology clears them to be alone." ██████ said that every inmate that is transferred from suicide watch and/or psychological observation to the SHU is placed with a cellmate, and also said the Lt. ██████ instructed him that Epstein was to be housed with a cellmate. ██████ said that between July 30, 2019, and August 9, 2019, he informed the other MCC staff members who worked in the SHU of the requirement, and added that everyone who worked in the SHU should have known that Epstein was required to have a cellmate due to their knowledge, training, and experience.

██████ said that he knew ██████ was WAB and expected him to depart from the MCC and not return to the SHU, but said there had been times that inmates had been escorted to R&D as an expected discharge, only to be returned to the SHU later that same day, due to unforeseen circumstances.

██████ said that ██████ should have been replaced as soon as it was confirmed that he left the MCC building, and said that he did not select a new cellmate for Epstein because although he assumed that ██████ was not going to return to the SHU, he was not certain that ██████ had been discharged from the MCC. Rather, ██████ claimed that at the end of his shift in the SHU, which ended at approximately 2 p.m., he informed SHU staff members ██████ ██████ and Senior Officer Shaadiq ██████ that Epstein would need a new cellmate upon Epstein's return from his attorney visit if ██████ did not return to the SHU.

██████ said that SHU staff should definitely have realized the ██████ was not returning to the SHU during the 4:00 p.m. SHU count, as well as when Epstein was returned to his cell from his attorney visit. ██████ said that Epstein was expected to be with his attorneys with an MCC attorney conference room until approximately 7 p.m., as was his daily routine, so the SHU staff had time to make a new cellmate assignment. ██████ believed that anyone assigned to the SHU could have replaced ██████, as long as the inmate did not have a separation order on them, and said that it was all SHU staff members shared responsibility to replace ██████. However, ██████ said that due to Epstein's high profile, the SHU staff members should have asked a Lieutenant to contact Psychology to see who should be placed with Epstein. ██████ said that it was likely that he informed ██████, the Operations Lieutenant assigned to his shift, at some point during his shift, but he could not specifically recall if he informed him. ██████ said that when he escorted Epstein to his attorney visit and ██████ to R&D, Ops LT ██████ and Activities Lieutenant ██████ were physically present, and should have seen ██████ depart the MCC.

██████ swore under oath, that he was very confident that he told ██████ that Epstein would need a new cellmate if ██████ did not return to the SHU. He said he specifically recalled the conversation, and recalled ██████ being present during the conversation. ██████ said that after ██████ walked into the SHU,

█████ said, "Make sure this guy gets a Bunkie.," to which █████ replied, "All right, █████." █████ said that a new cellmate could have been reassigned prior to the 4:00 p.m. SHU count if it was known that █████ was not coming back, but the SHU staff members had until Epstein returned from his Attorney visit to assign Epstein a new cellmate.

AW █████ said that on August 8, 9, and 10, 2019, she had oversight over MCC Correctional Services. AW █████ reviewed the aforementioned USMS emails sent to MCC staff on August 8, 2019. █████ said the "court list" was attached to the emails, and said the destination on the court list attached to the USMS email says WAB, which means with all belongings. █████ said that the USMS documents means that █████ was transferring, and not going to court. Therefore, the MCC knew as of August 8, 2019, that █████ was transferring. █████ said that the MCC Custody Department received the court production list from the USMS as a courtesy, and there really is not anyone in the Custody Department that is required to review the document to vet it. █████ was asked who should made the appropriate notification about █████ departure from the MCC due to his WAB status. █████ said that even though █████ was present, █████ should have contacted the Operations Lieutenant since he was the SHU OIC. Because as the OIC, he had oversight of the SHU. As the OIC, who knew that Epstein was required to have a cellmate, and who knew the █████ was listed as WAB, he would know that he should contact a supervisor and make them aware.

Warden █████ said that everyone who worked in the SHU at the time █████ left WAB would be partly responsible for not replacing Epstein's cellmate. █████ said that it was everyone's job to say that he needed a new cellmate, and anyone could have passed the information to a lieutenant. He said that holds true for every shift after █████ departure.

Regional Director █████ served as the regional director with oversight over the northeast region from Sept 2018 until his retirement in December 2019. Had oversight of the MCC in August 2019, and the warden reported directly to him. █████ said that the OIC of the SHU would be in charge of getting Epstein a new cellmate. "Whoever was in charge of the SHU at the time his cellmate was removed should be reviewing for, to find him a new cellmate." "Once he was removed from SHU, they knew he was removed and transferred, yeah, then someone should have started taking action at that point." If they knew that WAB meant that he wasn't going to return, then they should have started making plans for a new cellmate at that point. The OIC should have told the SHU LT. If the SHU LT was out, then he should have told the operations lieutenant, who would have been his direct supervisor. The activities lieutenant really would not be his direct supervisor. The Operations Lieutenant is responsible for the shift, and the Activities Lieutenant is responsible for going around and reviewing documents, and policy, and making sure everyone is doing their job. If █████ knew that █████ was WAB, and Epstein had not received a new cellmate by the end of his shift, than he should have passed the information onto his relief.

Night Watch on August 9, 2019

█████ told the OIG that he was the SHU OIC on August 9, 2019, from approximately 2 p.m. until approximately 10 p.m. He said that on August 9, 2019, he relieved █████ from his duties, and worked in the SHU with █████, █████, █████, █████, and Noel. █████ said that when he began his shift, Epstein was visiting with his attorneys in the Attorney Conference Visiting Room. █████ said he did not recall having a conversation with █████ about Epstein needing a cellmate. When advised that █████ was confident about their conversation, █████ stated, "I don't necessarily want to call anyone a liar, per se, but I don't remember him speaking to me about this. So, maybe he spoke to █████ (█████), and

maybe I was standing there, and he thought I heard him.” ██████ said if ██████ left WAB, then someone should have replaced ██████ when he departed, because Epstein was required to have a cellmate.

██████ told the OIG that on August 9, 2019, he worked in the SHU from approximately 8:45 a.m. until approximately 4 p.m. ██████ said that Epstein was already with his attorneys when he arrived to the SHU, and Epstein did not return by the time ██████ left the SHU. ██████ said that ██████ was also gone from the SHU by the time he arrived, and did not return prior to his departure. ██████ said that he did not know ██████ was discharged from the MCC, and said that no one told him that Epstein would need a new cellmate, including ██████, ██████, ██████, or anyone from the Psychology Department. ██████ elaborated that ██████ never told him that ██████ was released from the MCC, or that Epstein required a new cellmate.

No one else interviewed by the OIG had any knowledge of ██████ claim that he passed the information regarding Epstein’s cellmate departure onto ██████ or any else assigned to the next shift. However, the MCC staff members assigned to the SHU after ██████ shift did learn that Epstein was without a cellmate, as detailed later in this report.

Supervisors of the Night Watch

According to the Daily Roster from August 9, 2019, Lieutenant ██████ ██████ was the Operations Lieutenant, and Senior Officer Specialist (SOS) ██████ ██████ was the Activities Lieutenant.

██████ told the OIG that he was the Operations Lieutenant at the MCC on August 9, 2019, during the 2 p.m. to 10 p.m. shift, and was relieved between 9:50 and 9:55 p.m. ██████ said that he was aware that Epstein was required to have a cellmate due to a mass email that was sent to all of the MCC lieutenants. ██████ also said that Psychology generates a document called the “hot list” that was kept in the SHU, which identified all of the inmates that have psychological needs, and identifies the requirement to have a cellmate. ██████ believed that the SHU was the only place where the hot list was maintained, and said that it would have been located by the officers’ station, and the officers assigned to the SHU were required to review the hot list. ██████ said that everyone who regularly worked in the SHU should have known that Epstein was required to have a cellmate. ██████ reviewed the Roster for August 9, 2019, and said the following should have known: ██████, ██████, ██████ on the Day watch; and ██████ and Noel on the Night Shift. ██████ said that ██████ would have known because he was the SHU OIC during his shift, and Noel would have known because the SHU was her quarterly post and she was required to review the hot list, because all SHU staff were required to know who their psychological inmates were, and be aware of their high profile and dangerous inmates. ██████ said that Epstein was on the hot list, especially after his first suicide attempt. ██████ believed that everyone in the MCC, and especially those who worked in the SHU, should have been aware that Epstein was required to have a cellmate due to his high profile. ██████ said that he was not aware that Epstein did not have a cellmate on August 9, 2019, and did not know ██████ had left the MCC earlier that day. ██████ said that when an inmate is transferred, the PP38 is updated in Sentry, and that information gets transferred over to the LT log, to monitor the inmate movements for the day, and to make sure the inmate numbers are correct at the end of each shift. ██████ said that once ██████ was removed, Epstein should have been assigned a new cellmate “as soon as humanly possible.” ██████ said that WAB means that the inmate is not coming back. ██████ said there are occasions when they cancel the transport, and they do come back, but most of the time, when they go WAB, that means that they are gone from the MCC. ██████ said that if ██████ was transported to R&D as a WAB, and if the SHU LT was off, then an MCC supervisor should have been notified. If no one was notified, then no one would know. ██████ said

that the SHU staff on his shift should have notified him that Epstein was without a cellmate, and said that he was not informed. ██████ said that acting Activities Lieutenant ██████ conducted the Lieutenant round in the SHU on August 9, 2019. ██████ said that Activities LT ██████ would probably only have known that Epstein was without a cellmate if someone from the SHU told her, or if she went down range during the round she conducted in the SHU. The SHU staff should have told ██████ that Epstein was without a cellmate when she conducted her round. If they had, ██████ would have then notified ██████.

██████ told the OIG that she was the Activities Lieutenant at the MCC on August 9, 2019, from 4 p.m. until 10 p.m. ██████ explained that an Activities Lieutenant would normally have started their shift at 2 p.m., but she was working her regular time post in Attorney Conference during the earlier Day Watch shift, and did not get relieved until 4 p.m. ██████ said that ██████ was her supervisor on August 9, 2019. On August 9, Epstein was with two female attorneys and one male attorney. ██████ said that as an SOS, ██████ was not aware if Epstein had a cellmate or was required to have a cellmate. The requirement for an inmate to be mandated to have a cellmate would have been made in upper management meetings. The Captain would then tell the LTs, and the LTs would tell the line staff. If Epstein was required to have a cellmate, ██████ believed she should have absolutely been informed. ██████ recalled hearing that Epstein had been placed on suicide watch. She never received any specific instructions regarding Epstein. Claimed she didn't remember ever eventually hearing that Epstein's cellmate was removed. On August 9, everyone should have notified their respective supervisors of the cellmate requirement. If ██████ didn't inform ██████ about ██████ departure from the MCC, ██████ would have been the next person to have taken action on identifying that Epstein needed to be assigned a new cellmate. However, ██████ said that she did not know that Epstein was required to have a cellmate because she was only an acting LT, and was never provided the information regarding the requirement. ██████ said that the SHU staff didn't tell her about Epstein's requirement, but if they knew, they should have informed her during her shift. "If he required a cellmate, and it's a special case, then everyone knows that the phone should be ringing. But if it's just a regular inmate. Somebody got bailed out. It's not that big of a deal." If they did the 10 pm count and noticed that Epstein was without a cellmate, they should have called the Ops LT.

As detailed above, Captain ██████ told the OIG that he worked on August 9, 2019, until approximately 8:00 p.m. ██████ said that he was never told that ██████ departed from the MCC. ██████ said that since Epstein was in Attorney visiting all day, no one may have even thought about it, and may have only become aware when they put Epstein back in his cell after his attorney visit. ██████ said as soon as the SHU staff became aware that Epstein was without a cellmate, they should have notified the Operations Lieutenant, who was Lieutenant ██████ at the time.

Epstein's telephone call on August 9, 2019

The OIG found no evidence that Epstein signed an Acknowledgement of Inmate form (BP-408) necessary for him to use a non-ITC telephone. Nor did we find any notification to the MCC's SIS staff advising the telephone call had been made, the date and time of the telephone call, the name of the person being called, Epstein's name and register number, or a brief statement explaining the purpose of Epstein's telephone call.

██████ said that on August 9, 2019, he was getting ready to escort Epstein back to the SHU, but Until Manager ██████ was there, and said that he was going to escort him because he was going to provide Epstein with a legal call.

Captain ██████ said that he authorized Unit Manager ██████ to provide Epstein with a telephone call from the SHU on August 9, 2019. However, ██████ said he instructed ██████ to monitor and log the call because Epstein did not have the ability to place a telephone call. ██████ said that when Unit Manager Nathaniel ██████ was escorting Epstein from his attorney visit back to the SHU, he told ██████ in the elevator that Epstein could place a telephone call from the SHU, but it had to be monitored and logged. ██████ said that the conversation took place in front of Epstein.

According to a memorandum from ██████ dated August 10, 2019, Epstein terminated his legal visit early on August 9, 2019, in order to place a telephone call to his family. ██████, who was the Institutional Duty Officer that week, escorted Epstein to the 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 Epstein reportedly did not have his PAC and PIN number, which is required to use the inmate telephone system, ██████ placed the call, dialing a number that reportedly began with area code 347. Epstein told ██████ that he was calling his mother who, according to public records, had been deceased since 2004.

Regional Director ██████ explained that an institutional duty officer is a supervisor who monitors the facility on non-duty hours on behalf of the warden. He said that it is different from the Operations Lieutenant, in that they are the eyes and ears of the warden when the warden is not there. ██████ said that the position is filled by various department heads.

██████ told the OIG that he worked on August 9, 2019, from 11:00 a.m. to 7 p.m., confirmed the information documented within his memorandum, but advised that Epstein did have his PAC and PIN, it just had not been set up yet. ██████ explained that on August 9, 2019, Epstein requested to call his mother, but had not been able to set up his PAC and PIN for various reasons, including the fact that Epstein was with his attorneys during normal working hours, which was necessary to place telephone calls. ██████ said that he viewed ensuring inmates having family socialization as being part of his job, and would allow inmates to place telephone calls if they were unable to place calls under normal circumstances. ██████ said that later during the evening of August 9, 2019, at approximately 6:45 p.m., he and ██████ escorted Epstein from the attorney conference room to the SHU so that he could make the telephone call. ██████ put Epstein in the shower area to make the telephone call because guards were present in that area. ██████ said that he plugged the telephone line into the legal line, which was not recorded, and dialed the telephone number that Epstein provided to him. ██████ said the decision to have Epstein place the call was his, and his alone, because he was the duty officer, who was representing the warden who was not there. ██████ said that he did not recall having a conversation with Captain ██████, and would have provided the call even if ██████ did not want him to, because that was not a decision for the Captain to make. Rather, it is the responsibility of the Unit Team to make sure that inmates keep in contact with their family. ██████ said that after the telephone call was placed, a male answered, and ██████ handed the receiver to Epstein. ██████ said that he heard Epstein say "Hey, how are you doing? How's everything?" ██████ said that after he handed the telephone to Epstein, his shift ended, so he departed from the SHU and he left the MCC for the day. ██████ said that Correctional Officers ██████ ██████, Tova Noel, and Material Handler ██████ ██████ were in the SHU at the officers desk when he departed and while Epstein was still on the call. ██████ said that when he was departing, he told the officers, "Hey, make sure he get his 15-minutes, and after that, he's done." He did not provide them with instructions to monitor the call. He said that ██████ ██████ from Internal was also present. He said that after he departed, he contacted Noel via telephone, and asked her to make sure that Epstein's call had ended because his time was up. He said he may have called from within the MCC, he may have called from his vehicle, or he may have called on his way to the train.

██████████ said the proper to have an inmate place a telephone call on an unmonitored line would be to bring the inmate out, put him in a belly chain, because then he has to be cuffed in the front. Put him on the phone, with a counselor or unit team, and put him on speaker. ██████████ said that he did not stay and monitor the call as he should have.

Epstein did not, in fact, speak with his mother, who was dead; instead he spoke with ██████████ ██████████, who confirmed that she spoke with Epstein on August 9, 2019. A proffer was conducted with ██████████ ██████████, the Attorney for ██████████ ██████████, whom he spoke with on August 9, 2019. According to the proffer notes taken by the AUSA dated August 11, 2019, ██████████ was located in Belarus, and spoke with Epstein at approximately 7 p.m. on August 9, 2019, for approximately 20 minutes, via telephone number ██████████. Epstein told her that the press had gotten crazy, and they discussed personal things, such as books, music, and hygiene while incarcerated. Epstein said, "They are trying to keep me safe," and said his came would take a little longer that he originally thought. He told her he loved her, would not be able to call her again for another month, and to be strong. *****██████████ TO RESEARCH NUMBER CALLED DUE TO ██████████ CLAIM*****

Correctional Officer ██████████ ██████████ told the OIG that he was not a witness to the call, but said that he discussed this telephone matter with Epstein and physical saw Epstein's calling documentation that would have allowed him to place a call. ██████████ said that prior to August 9, 2019, he was on an elevator with Epstein and his attorney. ██████████ said that Epstein's Attorney asked ██████████ about getting Epstein his PAC and PIN to make calls. ██████████ then verified that Epstein had his PAC and PIN, and when he inquired with Epstein why he said he did not have it, Epstein responded, "but they monitor those phone calls." ██████████ said the Epstein's Attorney asked how Epstein could get an unmonitored call. ██████████ said that decision is made by a Lieutenant or Unit Team. ██████████ said that he asked Epstein at a later date if he was able to make his phone call. Epstein responded, "Yea, I got my phone call finally." ██████████ did not recall when the conversation took place. However, ██████████ said that Epstein was issued his PAC and PIN when he was still cellmates with ██████████.

██████████ advised the Epstein did have a "Pin Pack" which would have allowed him to place telephone calls, which he personal saw in Epstein's possession, but Epstein informed him that he did not want to utilize the Pin Pack because those call were monitored. The legal line was only to be used for attorney calls and it was allegedly known that Epstein was not placing a call to his attorney.

██████████ told us that he was present during the time of Epstein's telephone call, but did not overhear Epstein's conversation. He also said that while Epstein was having his telephone call, the correctional officers were distracted by the actions of another inmate.

██████████ said that Epstein came back to the SHU at approximately 8 p.m., and was put back into his cell on L Tier. ██████████ possible assisted ██████████ with Epstein. ██████████ did not recall seeing ██████████ and did not recall seeing Epstein in the shower area that night. He also did not recall anything regarding a phone call made by Epstein that night. He did help Noel feed Epstein, who was fed later than the rest of the inmate in the SHU because he came back late. Epstein was fed approximately 15-20 minutes after he was placed back in his cell. After Epstein received his food, ██████████ and Noel left the L Tier area. ██████████ said the Epstein was alone in his cell, and claimed that he was not aware that Epstein was required to have a cellmate. However, ██████████ was told the Epstein's cellmate was released earlier that day. The believed he may have heard from either Noel or ██████████ that Epstein's cellmate was released.

Noel confirmed that after Epstein's attorney conference, █████ placed Epstein in the shower to use the phone and █████ left. Noel said that she was present in the SHU, but no one monitored Epstein's call. █████ called her on phone later and told her to take the phone from Epstein because his time was up. Epstein's call possibly lasted for 20 minutes. Noel said that █████ and █████ were also present in the SHU during Epstein's phone call. Noel said that she left Epstein in the shower after the call, and then used the bathroom on 10 South. When she returned, Epstein was already placed back in his cell.

Noel said that █████ plugged a telephone line in the "legal line" which is not recorded and placed Epstein in a shower area within the SHU where he was afforded a telephone call. However, Noel said the call was not monitored or logged. Noel advised that after █████ set Epstein up with the call, █████ departed the SHU and did not instruct anyone to monitor the call. Approximately 15 to 20 minutes later, █████ called the SHU staff via telephone and informed them that Epstein's time was up and to retrieve the telephone from Epstein.

█████ said that if the call was authorized, then it should have been done on a speaker phone while being monitored by a staff member. The call should have been logged and a record of the call should have been created. █████ said that it is a big issue because we do not know what happened on the phone call. It could have potentially led to the incident, but we will never know.

Knowledge of Epstein's Cellmate Departure During the Night Shift

█████ said that on August 9, 2019, he did learn that █████ was released from the MCC, and that Epstein was without a cellmate. █████ said that following Epstein's telephone call, and when he escorted Epstein back to his cell during his shift, he asked Epstein where his cellmate was located. After learning that Epstein did not have a cellmate, he claimed that he called someone in the Lieutenant's Office and told a man that Epstein did not have a cellmate, but he could not recall who he informed. █████ learned that █████ was released from the MCC during his shift. █████ said that Noel and █████ also knew that Epstein was required to have a cellmate, because they were also working in the SHU during █████ shift. █████ said that he held a conversation with Noel and █████ on August 9, 2019, about Epstein needing a new cellmate after Epstein was brought back to his cell. █████ said that SHU staff could not just put anyone in the cell with Epstein. █████ swore under oath that he notified someone that Epstein needed a cellmate that night, but could not recall who he told.

As detailed above, on August 9, 2019, █████ was the Operations Lieutenant from 2:00 p.m. until 10:00 p.m., and █████ was the Activities Lieutenant from 4:00 p.m. until 10:00 p.m. █████ and █████ both said that they were not made aware that Epstein did not have a cellmate during their shift(s), although they should have been made aware.

█████ claimed that she did not know that █████ was removed from the MCC on August 9, 2019. However, she said that when she visited the SHU at approximately 4 a.m. on August 10, 2019, it is likely that she should have been made aware that Epstein required a new cellmate at that time.

█████ incident on August 9, 2019

According to the Lieutenants Log from August 9, 2019, Inmate █████ was removed from the MCC SHU at 3:15 p.m. and moved to the Receiving and Discharge dry cell. However, according to Morning Watch Operations LT █████, he was not keyed out of the SHU until after 12 a.m., and therefore remained on the August 9, 2019, 4 p.m. and 10 p.m. institutional counts. The 4 p.m., 10 p.m.,

and 12 a.m. SHU count slips incorrectly reflect that [REDACTED] was among the number of inmates present in the SHU during their "eyes on" count. This indicates that they did not conduct the counts and simply reported the number of inmates reflected on the institutional counts because if they had in fact counted the inmates present in the SHU, their numbers would be one less than what they reported on the respective count slips. This information also means that the number of inmates reflected as assigned to the SHU on the institutional counts were off during the 4 p.m. and 10 p.m. counts because [REDACTED] was not keyed out of the SHU. It is important to note that those in control would have been unable to know how many inmates were actually present in the SHU since they rely on what the BOP systems says for each housing unit by what is keyed into the system. This discrepancy was identified by Night Watch Operations Lieutenant [REDACTED] during the 12 a.m. institutional count. It is likely that it was identified because R & D sent in count slips identifying [REDACTED] as being present in their unit during the 10 p.m. and 12 a.m. institutional counts, although he was not identified as being present in R & D during the 10 p.m. institutional count sheet (the [REDACTED]-1). Capturing [REDACTED] "number" during the 12 a.m. total institutional count would have increased the total number of inmates by one (1), since he would have been counted twice (in the SHU and in R & D) on the count slips. There is reason to believe that the 10 p.m. institutional count and or count slips may have been modified after the count because all of the other 10 p.m. count slips have been crossed off and there is a plus one on both the SHU count slip and the Receiving and Discharge count slip, as well as the fact that the R & D count slip was not added to the [REDACTED]-1, which would have shown a discrepancy with the overall count, although it was added as an attachment. (It is also important to note that there was no R & D count slip for [REDACTED] during the 4 p.m. institutional count and his "number" was captured within the institutional SHU count.) Noel and Thomas admitted to not conducting the 12 a.m., 3 a.m., and 5 a.m. counts and falsifying the respective count slips. According to [REDACTED], COs get paid to count inmates. If a CO is not counting inmates, they should just stay home. Counts are the primary reason why we are Correctional Officers. It is to account for inmates. [REDACTED] said that rounds are absolutely equally important.

According to an email attachment sent from [REDACTED] to Ops Lt [REDACTED] [REDACTED] on August 9, 2019, on August 9, 2019, at approximately 1:40 p.m., [REDACTED] observed inmate Leonardo [REDACTED], Register Number [REDACTED], attempt to retrieve an unknow items from his visitor within the MCC SHU visiting room. In response, a visual search was conducted, the Operations LT was contacted, and inmate [REDACTED] was removed from the SHU. According to the LT Log from August 9, 2019, at 3:15 p.m., [REDACTED] was placed on dry cell with staff watch in R&D. However, according to [REDACTED] Inmate History Quarters, [REDACTED] was not keyed out of the SHU until August 10, 2019, at 12:35 a.m.

[REDACTED] said that the only reason to have removed [REDACTED] from the SHU Dry Cell and placed him in R&D Dry Cell would be because the SHU was short staffed and because a staff member had to watch [REDACTED]. [REDACTED] said that either the Control Center staff or the SHU OIC should have keyed [REDACTED] out of the SHU when he was moved to R&D. [REDACTED] said that the PP38 would only reflect when a movement was entered, and not necessarily when it occurred. [REDACTED] believed that the LT Log would be more accurate than the PP38. [REDACTED] said that [REDACTED] should have caught the mistake during the 4 p.m. count.

[REDACTED] said that the [REDACTED] incident occurred at 1:40 p.m., but [REDACTED] was moved to the R&D dry cell at 3:15 pm. [REDACTED] said that it is very important that the institutional count is accurate because that is how staff members know if all inmates are present, and if anyone escaped. [REDACTED] was present for the 4:00 p.m. count, but gone before the 10:00 p.m. count. [REDACTED] reviewed the 10:00 p.m. count slips for the SHU and R&D, and said that it appears the [REDACTED] was ghost counted. [REDACTED] said that this was the first time in his 21 years at the BOP that he saw a "+1" on a count slip.

█████ then reviewed the 10:00 p.m. █-1 institutional count, and said that █ took the count by himself, and that the inmates in the SHU should have said 72, rather than 73. █ believed that the SHU staff probably wrote 73 on their count slip because that is the number of inmates they believed were in the SHU at that time. █ also reviewed the 12:00 a.m. █-1 institutional count, which he said was prepared by █, but taken by █. █ said that █ keyed █ out of the SHU during the count, and keyed him into R&D. █ said that the count was then corrected.

LT █ told the OIG that she was the MCC Operations Lieutenant on August 9, 2019, from approximately 10 p.m., through August 10, 2019, at approximately 6 a.m. █ said that during the August 10, 2019, 12 a.m. count, she learned that █ was removed from the SHU and placed in the R&D dry cell earlier the previous day (August 9, 2019), but was mistakenly never keyed out of the SHU. █ said that after learning of the discrepancy, she keyed █ out of the SHU and into R&D.

Staff Counts in the SHU on August 9 and 10, 2019

The BOP required correctional officers assigned to guard inmates at the MCC to conduct institution-wide counts of inmates on regular scheduled intervals to ensure that each inmate is alive and accounted for within the MCC. On weekdays, the MCC conducts five institutional counts at 4 p.m., 10 p.m., 12 a.m., 3 a.m., and 5 a.m. Performing an institutional count is one of the most basic and essential aspects of a correctional officer's job, and the count is one of the most basic and essential functions of daily operation of the MCC. Two officers are required to perform the institutional count for each housing unit, including the SHU, and are further required to document their performance of the count on an official MCC form called a count slip. To perform the institution count in the SHU, two officers must walk from tier to tier to observe and count each individual inmate.

On the count slip, both correctional officers are required to fill in the date and time the count was performed, write the total number of inmates physically present in the unit counted, and then sign the count slip. Once the correctional officers have completed and signed the count slip, the count slips are then collected and delivered to the Control Center, where officers within the Control Center are responsible for comparing the count slips from each housing unit to the institution's inmate roster to ensure that each inmate is accounted for. Only after all the count slips are collected from each housing unit, and the numbers on the slips are matched to the institution's inmate roster, can the institutional count be deemed "cleared" or completed. If a housing unit's count slip is incorrect or incomplete, then the institution cannot "clear" the count. Instead, the count must be completely redone in that housing unit via a more intensive version of the institutional count, called a bed book count, in which officers must compare every individual inmate to the institution's inmate roster. Records of each institutional count, including the count slips, are provided to a supervising official and retained by the MCC.

4 p.m. SHU Count

During the time period from 4 p.m. on August 9, 2019, to 8 a.m. on August 10, 2019, the officers on duty in the SHU were responsible for conducting five institutional counts: 4 p.m. and 10 p.m. on August 9; and 12 a.m., 3 a.m., and 5 a.m. on August 10. The officers on duty were also responsible for completing paperwork attesting to each of those counts. While the count slips were completed for each institutional count, not a single one of the SHU counts were done. As video from the MCC's internal video surveillance system makes clear, the officers assigned to the SHU did not perform the 4 p.m.

count. Nonetheless, the officers completed and signed a count slip that falsely stated that the 4 p.m. SHU count had been performed. In reliance of that falsified count slip, at approximately 5:03 p.m., the Control Center cleared the 4 p.m. institutional count.

Captain ██████ said that counts are what correctional officers do. That is what they are paid for. That is their job. Their job is the accountability of the inmates.

The 4 p.m. count was signed by ██████ and Noel. ██████ said they probably didn't count and just wrote the numbers they thought should be entered. ██████ said, as the OIC, "It does tell me that the count was not done and they just assumed and went by the cheat sheet because the body wasn't even there."

██████ said that prior to his departure from the SHU at approximately 4 p.m., he told ██████ what the SHU count should be.

██████ reviewed ██████ movement and verified that the SHU count number was incorrect for 4 p.m. ██████ said that neither he nor any SHU staff member conducted the SHU count on August 9, 2019, at 4 p.m. He verified that it was his handwriting and signature on the 4 p.m. SHU count slip. He said that he pre-prepared the 4 p.m. count sheet. He said, "There was so much going on, everybody's leaving, some people coming in, and stuff like that. I'm, like, okay, count time or whatever you -. I wrote it out. I don't remember if I put a number in there or not yet, or whatever. And then, the count was supposed to take place. So, I pre-wrote it or whatever. And then, we just kept working. But there was a lot going on that day." ██████ said the other person whose name and signature appeared on the 4 p.m. count slip was Tova Noel.

Noel told the OIG that she worked in the SHU on August 9, 2019, from approximately 4:00 p.m. until August 10, 2019, at approximately 8:00 a.m. Noel said that the SHU was her regularly scheduled post that quarter. Noel said that counts are conducted to make sure every inmate was alive. Noel said that she and the SHU staff filled out the count sheets in advance before conducting the counts, including the number of inmates in the SHU, because they knew the number of inmates that they were supposed to report. Noel said that she signed the 4:00 pm count slip, but said that she did not recall conducting the 4:00 pm count. She said she did not conduct the count at 4 p.m., but claimed that she did conduct the 10 p.m. count.

10 p.m. SHU Count

By or before 10 p.m., all inmates in the MCC were locked in their cells for the night. At or around that time, two officers assigned to the SHU were responsible for conducting the 10 p.m. count in the SHU. However, video from the MCC's internal video surveillance system shows that no one performed the 10 p.m. count. Nonetheless, Noel and XXX completed and signed a count slip falsely stating that the 10 p.m. count of the SHU had been performed. In reliance of that falsified count slip, at approximately 10:36 p.m., the Control Center cleared the 10 p.m. institutional count.

The SHU count slip at 10 p.m. reads "73 + 1." ██████ said that if ██████ was not in the SHU, he should not have been counted on the SHU count. ██████ said he should have been taken off the count prior to the 4 p.m. count. He said you cannot ghost count. You have to count the actual bodies in the SHU. Two people have to count the actual bodies in the SHU. ██████ said the information surrounding ██████ being moved at 3:15 p.m. suggests that the SHU counts were not conducted correctly and were inaccurate.

Noel said that the 10:00 p.m. count was conducted by her and [REDACTED]. She said that she wrote the 73 on the count slip, but did not write the + 1. She said that she did not pre-populate the 10 pm slip. Noel said that she counted alone. Noel said that [REDACTED] signed the count slip even though he did not conduct the count. Noel said that [REDACTED] slept on the shift until it was time for him to go home.

Noel claimed that she went through each tier and conducted the 10 p.m. count. She said she went to Epstein cell for count, mattress was on floor, Epstein was laying on it and he put his hand up. It was typical for him to lay on the floor. She thinks he may have asked for his CPAP machine. She nodded and plugged it in for him. When she did 10pm count, she knew Epstein was in the cell by himself. Noel said that when an inmate is leaving as WAB, they are supposed to bring all their belongings with them. However, Noel claimed that she did not know that Epstein was required to have a cellmate.

Noel said she did not know the 10 p.m. count was inaccurate, and could not explain why the count slips at midnight showed 73 and the 3am and 5am shows 72. Said if inmate was moved from SHU to R&D, the inmate cannot include inmate on SHU count because they cannot see the inmate. Noel said that [REDACTED] would not know if she did count because he was sleeping.

Material Handler [REDACTED] [REDACTED] said that he worked in the SHU on August 9, 2019, from 4 p.m. until 12 a.m. [REDACTED] estimated that he had worked in the SHU between 10 and 20 times prior to that date. [REDACTED] said he worked with [REDACTED] and Noel during the shift. [REDACTED] said that [REDACTED] shift ended at 10 p.m., so he worked with Noel from 10 p.m. until 12 a.m. [REDACTED] recalled being very tired during the shift. [REDACTED] said that he was not present for the 4 p.m. count, but was present for the 10 p.m. count. [REDACTED] said that he did not conduct the 10 p.m. count in the SHU, and that the count was not conducted. No one said that they were not going to do the count, it was just mentioned that everyone was tired. [REDACTED] verified that he and Noel signed the 10 p.m. count slip. [REDACTED] believed that Noel called Control with their count numbers. [REDACTED] said since two people are required to conduct the count, the count was not conducted, and Noel could not have conducted it by herself. [REDACTED] did not know why the count slip said 73 + 1.

Senior Officer Specialist [REDACTED] [REDACTED] told the OIG that on August 9, 2019, he worked in Control from approximately 4:00 p.m. until 12 a.m., and then on August 10, 2019, as an Interview Officer from 12:00 a.m. until 8 a.m. [REDACTED] said that he would have been involved with counts during both shifts, and keying inmates in and out of different housing units. [REDACTED] said that he was one of two officers who worked in Control on August 9, 2019, until 10:00 p.m., and then he worked in Control by himself until approximately 12:00 a.m. on August 10, 2019. [REDACTED] said that on August 9, 2019, he took the 10:00 p.m. institutional count by himself in Control, and assisted with the 12 a.m., 3 a.m., and 5 a.m. counts on August 10, 2019, as an internal officer. [REDACTED] was the Control Officer on August 10, 2019, from 12:00 a.m. until 8:00 a.m. [REDACTED] said that from 10:00 p.m. until approximately 6:00 a.m., he reported to Operations Lieutenant [REDACTED].

[REDACTED] reviewed the MCC E1 institutional count taken at 10:00 p.m., which shows that R&D had zero inmates assigned to the unit, while the SHU said it had 73 inmates. [REDACTED] confirmed that he signed the E1 institutional count and provided a "good verbal" at 10:30 p.m. He then reviewed the 10:00 p.m. count slip from the SHU, which shows 73 + 1 inmates, which was signed by SHU staff members [REDACTED] and Noel. [REDACTED] believed that the + 1 on the count slip was his handwriting. [REDACTED] also reviewed the 10:00 p.m. R&D count slip that said one inmate was in R&D, that was signed by [REDACTED], and said that the 9S + 1 on the count slip was his handwriting. [REDACTED] said that the + 1 on the SHU count slip meant that they

were “ghost counting” the one inmate who was in R&D that had previously been assigned to the SHU. He said that is why the E1 showed zero inmates in R&D and 73 inmates in the SHU. [REDACTED] said that since there were only 72 inmates in the SHU during the 10:00 p.m. count, he should have written 73 – 1 on the SHU count slip, rather than 73 + 1, which he said was an error made by him. [REDACTED] said that [REDACTED], the Operations Lieutenant, authorized him to write on the count slips as he had done, although he could not recall when he wrote on the count slips, or why he wrote on the count slips. He said that the 10:00 p.m. SHU count slip was an inaccurate count conducted by SHU staff, and said they should have listed 72 inmates on the count slip. [REDACTED] did not recall if he wrote on the count slips during the 10:00 p.m. count, or during the 12:00 p.m. count, when the inmate who was in R&D was transferred in Sentry from the SHU to R&D. However, he believed he would have written on the count slips during the 10:00 p.m. count, and before it cleared at 10:36 p.m. He said that if he recognized the error during the count, he should have created a new E1 and should not have cleared the count. However, he again said that for him to have ghost counted, he would have received approval from the Operations Lieutenant, who was [REDACTED] at the time.

12 a.m., 3 a.m., and 5 a.m. SHU Counts

[REDACTED] said that [REDACTED] was the Operations Lieutenant on August 9, 2019, from approximately 10 p.m., until August 10, 2019, until approximately 6 a.m. [REDACTED] said that [REDACTED] was with him in the Control Center during the 12 a.m. count on August 10, 2019. [REDACTED] reviewed inmate [REDACTED] Inmate Quarter History, which shows that he was transferred from the SHU and entered into R&D within Sentry on August 10, 2019, at 12:35 a.m. [REDACTED] reviewed the E1 MCC Institutional Count that showed there were 72 inmates in the SHU, and 1 inmate in R&D. [REDACTED] also reviewed the 12:00 a.m. SHU Count slip that was signed by Noel and Thomas, which showed there were 73 inmates in the SHU, and the R&D Count slip signed by [REDACTED] and [REDACTED], that showed there was one inmate in R&D. [REDACTED] said that the 12:00 a.m. SHU Count slip on August 10, 2019, was inaccurate, and said that it should have listed 72 inmates in the SHU. [REDACTED] did not know what the 12:00 a.m. SHU count slip listed 73 inmates, if it was determined that their count slip should have listed 72 inmates during the 10:00 p.m. count. [REDACTED] said that he did not recall any conversation with the SHU staff, did not recall any conversation with [REDACTED], and did not recall any conversation between [REDACTED] and the SHU staff, with regard to inmate [REDACTED] and the count inaccuracies and discrepancies. [REDACTED] reviewed the E1’s and SHU count slips from 3 a.m. and 5 a.m., which list the SHU as having 72 inmates, and said that the E1’s and count slips were accurate as reported. [REDACTED] said that he was not aware that previous count slips did not match the respective E1’s until his interview with the OIG. However, [REDACTED] agreed that the SHU count slips on August 9, 2019, at 4:00 p.m. and 10:00 p.m. were inaccurate, as was the SHU count slip on August 10, 2019, at 12:00 a.m., but said the SHU count slips on August 10, 2019, at 3:00 a.m. and 5:00 a.m. were accurate.

[REDACTED] shift ended at approximately 10 p.m., and at approximately 12 a.m., Michael Thomas replaced [REDACTED], joining Noel as the only two correctional officers on duty in the SHU. Noel and Thomas were responsible for conducting the 12 a.m. count in the SHU. As confirmed by video from the MCC’s internal video surveillance system, Noel and Thomas did not perform the 12 a.m. count. Nonetheless, Noel and Thomas completed and signed a count slip for the 12 a.m. count that falsely stated that the SHU count had been performed. In reliance on that falsified count slip, at approximately 12:49 a.m., the Control Center cleared the 12 a.m. institutional count.

Noel and Thomas were additionally responsible for conducting the 3 a.m. and 5 a.m. counts in the SHU. As confirmed by video from the MCC’s internal video surveillance system, Noel and Thomas did not

perform either the 3 a.m. or the 5 a.m. counts. Noel and Thomas nonetheless completed and signed count slips for both counts that falsely stated that they performed the 3 a.m. and 5 a.m. counts in the SHU. In reliance of those falsified count slips, at approximately 3:24 a.m. and 5:30 a.m. the Control Center cleared the 3 a.m. and 5 a.m. institutional counts, respectively.

Noel said the Thomas prefilled the August 10, 2019, count slips for 12 am, 3 am, and 5 am, and she signed them. She said that she did not know why the 12 am count slip said there were 73 inmates in the SHU, while the 3 am and 5 am slips said there were only 72. Noel said that she recalled Thomas speaking with someone and they changed the count slips. Noel said that in an inmate was from the SHU to R&D, they could not be included on the SHU count, because the staff members could not physically see the inmate. She said the last time she recalled going down the tiers was during the 10 pm count. She said that was the last time she saw Epstein. Noel said that neither she nor Thomas conducted the 12 am, 3 am, or 5 pm count.

Noel said that she conducted the 3am and 5am counts in Unit 10 South with the CO [REDACTED]. When Noel came back to the SHU, CO [REDACTED], who was working in 10 South, called and said that per a Lieutenant, he was to be relieved so that he could go get his food, so Thomas went upstairs and relieved him. Only [REDACTED] and Lieutenant [REDACTED] visited the SHU overnight. [REDACTED] came in to conduct a round and was let in by Noel. No one else other than [REDACTED] and [REDACTED] came into the SHU. When she left to assist [REDACTED] with his counts, she took keys with her, so no one could have come into the SHU, because she had to physically open the door for anyone who came into the SHU that day.

[REDACTED] told the OIG that on August 10, 2019, from 12:00 a.m. until 8:00 a.m., he was as the only correctional officer in Unit 10 South, which is the single celled secure unit off of the SHU which had cameras in each cell. Unit 10 South is located next to the SHU Lieutenant's office, and can only be accessed by walking through the SHU. [REDACTED] said that Operations Lieutenant [REDACTED] assisted him with conducting the 12 a.m. count, and Officer Noel assisted him with conducting the 3 a.m. and 5 a.m. counts, because all counts required two people to conduct them. [REDACTED] said that Thomas relieved him at some point during his shift to give him a break, at which time he would have walked through the SHU. [REDACTED] said that he was in 10 South when Epstein's emergency call came over the radio, and said that he was shocked over the incident. [REDACTED] said that Epstein was supposed to be watched more closely than the other inmates, and that regular rounds should have been conducted on Epstein.

Thomas confirmed that he worked the midnight to 8 am shift on both August 9th and 10th, said that he worked in the SHU fairly regularly since he started with the BOP in 2007, and is familiar with how to work in the SHU and how the SHU is operated. Reviewed Overtime Schedule where he worked in the SHU from May through August 2019. (Shows he worked 21 shifts in the SHU and somewhat regularly when Epstein was there in July and August – particularly in July when he was first assigned to the SHU. All shifts were morning watch. Described responsibilities in the SHU. Stated, "Maintain the count of inmates. Make sure the inmates are fed. Depending on what shift you're referring to, take over a shift, make sure they get their showers. Um. Make sure they counted and that's basically it."

He replaced [REDACTED] in the SHU on August 10th. They did not speak about Epstein. Claimed he also didn't speak with Noel about Epstein during their shift. Thomas confirmed that he was told that if someone comes from suicide watch he should be assigned a cellmate. Said he knew because he was there for 14 years. Possibly heard during training or possibly from word of mouth. Assumed that Epstein was required to have a cellmate because he came from suicide watch, but didn't know of a

requirement. Claimed he didn't know anything about [REDACTED] being removed from the MCC on August 9th. Did not notify anyone on his August 10th shift that Epstein was without a cellmate.

Thomas stated that he did not conducted any rounds or counts during his shift on August 10, 2019. Thomas stated that Noel also didn't conduct any rounds or counts during their shift on August 10, 2019. Thomas stated that no one conducted any rounds or counts within the SHU on August 10, 2019, between 12 am and approximately 6:33 am. Said that the round sheets from August 10, 2019, were signed, but the rounds were not conducted. Noel's initials are on the round sheets. When asked why he didn't conduct the rounds, he said that he was tired that day. Said it takes 10 to 15 minutes to conduct a count. Said he didn't do them because he was "exhausted." Thomas said he recalled "dozing off from here and there" during his shift on August 10. Did not know if Noel slept. Said he was not authorized to sleep during his shift. Said he had probably fallen asleep during other shifts at the MCC. Said it is **not** understood that you can sleep during the morning shift.

Thomas verified that his signatures was on the 12 am count slip, which he filled out and signed along with Noel. Advised that the number on the count slip was 73 while the number on the [REDACTED]-1 institutional count was 72. Did not recall having a conversation with anyone with regard to the discrepancy. Said that the 3 am count slip said 72, he filled out, and he signed. Acknowledged that the 12 am and 3 am numbers were different. Didn't recall speaking with [REDACTED] about the 12 am count and said this was the first time he's seeing that the 12 am count slip was wrong. (He didn't know, but "believed" that it was "probably" corrected because the intuitional count shouldn't have cleared without a new slip.) Said it would have been a big deal that the wrong count number was called in so he believed it would have been corrected. But even though it would have been a big deal, it did not spark his memory regarding the matter.

Thomas said he has falsely documented count slips in the past that he did not conduct, but claimed that was not the norm. "Sometimes you have bad days. Sometimes you have good days." Thomas said that he was aware that he was falsely certifying the count slips when he signed them on August 10, 2019.

Count Discrepancies on August 9 and 10, 2019

**Per the Daily Activity Report dated August 10, and the LT Log from August 9, 2019, and inmate [REDACTED] Housing Quarters History*

The day began with 77 inmates assigned to ZA (SHU)

The 5 a.m. E-1 (Institutional count) and respective SHU count slip (eyes on count) show 77.

At 8:38 a.m., Inmate [REDACTED] is "Pre-Removed" from the SHU and taken off the institutional count. The accurate SHU count moves down to 76. [REDACTED] is removed from the Institution and does not, and should not, appear on any counts after this time.

Sometime between 1:40 p.m. and 3:15 p.m., Inmate [REDACTED], Register Number [REDACTED], was placed on R&D dry cell from the SHU, which moves the accurate SHU count down to 75.

The 4 p.m. [REDACTED]-1 institutional count shows a total of **76** inmates assigned to the SHU, with 1 in Attorney Conference (Epstein). This indicates that [REDACTED] was not keyed out of SHU and into R&D. The SHU count slip listed 75 inmates, which is inaccurate. The SHU count slip should have

listed 74 inmates, because although there were 75 inmates assigned to the SHU, Epstein was in Attorney Conference. There were no inmates assigned to R&D on the █-1 institutional count, and there was no count slip for R&D. *This is where the problem began.

At 6:34 p.m., Inmate █ was moved from the SHU to ES, bringing the accurate SHU count down to 74.

At 6:47 p.m., Inmate █ was moved from the SHU to ES, bringing the accurate SHU count down to 73.

At 8:21 p.m., Inmates █ and █ were moved from the SHU to Suicide watch, bringing the accurate SHU count down to 71.

At 8:28 p.m., Inmate █ was moved from KN to the SHU, bringing the accurate SHU count up to 72.

The 10 p.m. █-1 institutional count lists a total of 73 inmates assigned to the SHU, with 0 inmates assigned to R&D. However, the █-1 should have listed 72 inmates in the SHU, and 1 in R&D.

The 10 p.m. SHU count slip shows 73 + 1, which should have listed 72. There is an R&D count slip that shows there was 1 inmate assigned to R&D, which is accurate. However, the R&D count slips has "95 + 1" written on it.

The August 10, 2019, 12 a.m. █-1 institutional count lists a total of 72 inmates assigned to the SHU, with one inmate assigned to R&D. The SHU count slip lists 73 inmates, which is inaccurate. There is an R&D count slip that lists 1 inmate assigned to R&D

Per LT █, Inmate █ was never keyed out of the SHU and keyed into R&D on August 9, 2019, when he was transferred to R&D at approximately 3:15 p.m. Therefore, she keyed him out of the SHU and keyed him to R&D on August 10, 2019, at approximately 12:35 a.m.

Conclusion: The SHU staff did not conduct any counts between August 9, 2019, at 4 p.m. and August 10, 2019, at 5 a.m.

Lieutenant Counts on August 9 and 10, 2019

█ said that either the Operations Lieutenant or the Activities Lieutenant on duty was responsible for conducted the 4 p.m. institutional count. █ said that one of the two had to be present in the Control Center during the count. If fully staffed, there would be two officers and one lieutenant in the Control Center. █ reviewed the 4:00 p.m. count, and said that he did not participate in the count. Also, █ did not start her shift as Activities Lieutenant until 4:00 p.m., so she did not participate in the 4:00 p.m. count. █ did not know whose signature was on the 4:00 p.m. count, which was supposed to be signed by the Operations Lieutenant. █ said that he signed some of the pages on the 4:00 p.m. count, such as the Out Count, but said that he did not sign all of the pages, as he should have, and did not recognize a signature that was signed as the Operations Lieutenant. He also said that he did not take the count, and did not sign the first page of the █-1. █ said that he would typically be relieved by the oncoming Operations Lieutenant before the 10 p.m. count. █ said that he did not take a count during his shift on August 9, 2019.

█████ said she did not supervise any counts on August 9, 2019. █████ said an inmate is sometime “ghost counted” when the inmate is moved very close to a count (like what may have happened with █████ on August 9th at 4 pm). If a bad count is called in, the count must be reconducted. If you call in two bad counts, you have to do a bed book count. “That’s, we have like picture cards with like a long book with the inmate’s picture in it, reg number, his bed assignment. We now have to recount the inmates over again, but we’re physically making sure that like you’re Smith, you’re Jones, you’re where you’re supposed to be.” █████ believed that only the peoples whose names were on the counts slips were responsible if the counts were falsified, because the others aren’t babysitting and may not have known that the counts weren’t conducted. SHU staff counts take about 15 to 20 minutes if all is normal. Inmates are standing up for count and facing the staff member. But not at night. You just shine the flashlight in to see them move and make sure there is a live breathing body. I get paid to count inmates. If I’m not counting inmates, I should just stay home. Counts are the primary reason why we are correctional Officers. It is to account for inmates. Rounds are absolutely equally important.

█████ and █████ were relieved by Lieutenant █████ on August 9, 2019, at approximately 10:00 p.m., and she worked until 6:00 am. █████ said he is the supervisor of all lieutenants, at the MCC, and they report to him. █████ stated to the OIG that he did not specifically tell █████ that Epstein needed a cellmate. █████ stated that she did not know that Epstein was required to have a cellmate and that █████ never spoke with her about this issue. She stated further that she was unaware that the staff psychologist had required Epstein to have a cellmate.

█████ also stated that she did not know that Epstein was without a cellmate on August 9, 2019. However, evidence indicates that █████ reviewed the “Daily Log” that showed █████ was removed from the MCC.

█████ said that the Ops Lieutenant did not need to go to the SHU and witness the recount at midnight. █████ said that only happens if there is a double bad count.

█████ said that if █████, █████, and █████ conducted LT rounds as they should have, they would have recognized that Epstein was without a cellmate and needed a new one. And Attorney Visit is 10 steps away from the LT office.

Staff Rounds in the SHU on August 9 and 10, 2019

In addition to the institutional count, the BOP required correctional officers assigned to the SHU to walk each of the tiers of the SHU, which is called a round, every thirty minutes, called a 30-minute round. Like the institutional counts, correctional officers conduct 30-minute rounds to ensure that each inmate is alive and accounted for within his cell. Correctional officers working in the SHU are required to complete a form, which is reviewed and signed by their supervisor (lieutenant), documenting the date and time of each 30-minute round in each tier of the SHU.

█████ said that if rounds were not conducted SHU staff members, then every staff member in the unit was responsible/to blame.

SHU OIC █████ said that SHU staff spoke about conducting rounds on Epstein every day. █████ said that he always reiterated that information when he departed from his shift. He said that the Warden, Lt’s, and everyone always told the SHU staff to conduct rounds and to keep an eye on Epstein. In

addition, [REDACTED] created an orange sign that he hung on a computer in the SHU Officers area that said, "MANDATORY ROUNDS MUCH BE CONDUCTED EVERY 30 MINUTES ON EPSTEIN # 76318-054 AS PER GOD!!!!" The sign was hanging on the computer on August 9 and 10, 2019.

[REDACTED] said he checked on Epstein after this call and left after telling the other COs to "watch this guy."

[REDACTED] said that between 4 p.m. and 12 a.m., a good amount of rounds were probably conducted, but could not recall how many. [REDACTED] believed that the 4:01 p.m. to 7:36 p.m. timeframe on the round sheet was accurate, but was uncertain about the remaining rounds. [REDACTED] believed that Noel filled out the round sheet. [REDACTED] said that he had seen officers blow off 30-minute rounds in the past. [REDACTED] said he was relieved by Thomas at approximately 12 a.m.

As reflected on video obtained from the MCC's internal video surveillance system, at approximately 10:30 p.m., Noel briefly walked up to, and then walked back from, the door to the tier in which Epstein was housed. As confirmed by the video obtained from the MCC's internal video surveillance system, this was the last time anyone, including any correctional officer, walked up to, let alone entered, the only entrance to the tier in which Epstein was housed until August 10, 2019, at approximately 6:30 a.m.

Despite the requirement that officers on duty in the SHU conduct and document regular, 30-minute rounds, Noel and Thomas did not perform any of the required 30-minute rounds during their shift between approximately 12 a.m. and 6:30 a.m. Nonetheless, Noel completed and signed more than 75 separate 30-minute entries falsely affirmed that they had, in fact, conducted such rounds.

During the night, instead of completing the required counts and rounds, Noel and Thomas were seated at the correctional officer's desk in the SHU common area (as noted above, approximately 15 feet from Epstein's cell), used the computers, and moved around the SHU common area. For a period of approximately two hours, Noel and Thomas sat at their desk without moving, and appeared to have been asleep. Noel used the computer periodically throughout the night, including to search the internet for furniture sales and benefit websites. Thomas used the computer briefly around 1 a.m., 4 a.m., and 6 a.m. to search for motorcycle sales and sports news.

Tova Noel and Michael Thomas admitted that they did not conduct any rounds reflected on the SHU Round Sheet on August 10, 2019, from 12 a.m. until Epstein was found at approximately 6:30 a.m. Noel verified that her initials were on the round sheets for August 10, 2019. Noel said that she filled out both the round sheets and the count slips at the start of the 12 a.m. shift. She said she filled out the round sheets in advance. She advised that she took this action because she had observed other COs in the SHU take the same action on previous days, although denied ever being instructed to fill the forms out in that manner. Also, there has been some discrepancy on what a lieutenant round entails. Some lieutenants have said that a lieutenant round simply means that the LT must check in with the SHU staff members to ensure that there are no issues in the unit and claimed that rounds of the individual inmates were not required during each shift, while others have said that a lieutenant round consists of actually walking each tier to check on the individual inmates. On July 14, 2021, the current Acting MCC Warden provided the wording from the MCC Post Orders regarding LT rounds, which seems to be open for interpretation.

Noel said that when they go down the range to give out food or supplies, they counted that as a round. She has never worked in the SHU and actually done rounds every 30 minutes. When asked which rounds she conducted on August 9, Noel responded "that's hard for me to tell because I didn't conduct it every 30 minutes. It was to give out food, pick up trays, give out toilet paper. Those were the rounds I

conducted". August 9 & 10th are the only two days she has filled out the round sheets in the SHU. No one instructed her on how to do it. "I just followed what I seen. But I've worked with people before that was filling it out and that's how its been done".

Noel said that she did not conduct any rounds on August 10th. She pre-filled the round sheets. Noel verified those are her initials on the round sheets for August 10th. She filled out the rounds sheets in advance in hopes to conducting the rounds. She was aware they were supposed to conduct 2 rounds every hour. SA asked "So you knew that what you were writing in there wasn't true and accurate as you wrote it?" She responded, "Correct." Noel said that the rounds sheets were frequently filled out in the SHU, and they were not conducted.

Noel said that Epstein's cell was approximately 15 feet from the SHU officer's desk. No one went to Epstein's cell on August 10, 2019, during the night. No one else other than [REDACTED] and [REDACTED] came into the SHU.

Thomas said that it was the same thing for the rounds. He usually did at least some. "But I do get some done and like I said, this particular time I guess I didn't get anything done." Thomas said that in the past he certified on round sheets that his rounds were conducted when they were not conducted. He said he didn't know if it was a regular occurrence, just that it had happened in the past.

Lieutenant Rounds in the SHU on August 9 and 20, 2019

[REDACTED] said that the SHU LT and the Ops LT have to conduct rounds of all tiers and ranges within the SHU during their shift. Both have to do them regardless if one or the other is out. [REDACTED] said that he was certain that Lieutenant's had to conduct rounds of inmates in the SHU, not just check to make sure COs are doing their jobs. [REDACTED] said that ever LT knows that they have to conduct rounds in the SHU by walking around every tier and every range. [REDACTED] said that the LT's signature on the round sheets certifies that they walked the SHU tiers.

On August 9, 2019, Lt. [REDACTED] reportedly conducted a round in the SHU at 11:27 a.m. [REDACTED] said that he did not recall if he did or did not conduct a round in the SHU, but believed that he did conduct the round. [REDACTED] said that when conducting a round in the SHU, the lieutenant was responsible for checking in with the staff and going down each range and checking on the inmates. As detailed above, [REDACTED] said that he did not know that [REDACTED] was removed from the MCC or that Epstein was without a cellmate during his shift on August 9, 2019.

On August 9, 2019, Senior Officer Specialist (SOS) [REDACTED] [REDACTED] was the Acting Activities LT on August 9, 2019, from approximately 4:00 p.m. until approximately 10 p.m. Per Captain [REDACTED], he provided her with the temporary promotion. [REDACTED] told the OIG that she conducted a Lieutenant round in the SHU at 7:31 p.m., as reflected on the 30-Minute Round Sheet. [REDACTED] said that a Lieutenants Round consists of checking on both staff and inmates. [REDACTED] would log her rounds within the computer terminal located within each housing unit. [REDACTED] said as Activities Lieutenant, "I'm required to do rounds. Make sure that staff are alive and well. Rounds of them doing their duties, conducting their rounds, doing shakedown. You know making sure they're doing counts and things like that. So basically supervising staff." "So in Special Housing, inmates are locked down. So it's our (the lieutenants) responsibility to go up on the tier and go to every door and speak to every inmate because it's not general population." She said every shift an LT should be in the SHU conducting rounds of inmates (once per shift). She did conduct a round in the SHU on August 9, 2019, sometime between 5 pm and 8 pm, and recalled going to every tier.

Epstein was not in his cell when she conducted her round in the SHU because Epstein always did "open to close" in Attorney Conference, which would have placed him back in the SHU around 8 pm.

█████ claimed that she did not know █████ departed from the MCC, or that Epstein required a new cellmate, because she was an SOS, she did not attend SHU or department head meetings. "I do remember them putting a stickie note on the computer. You know everyone looks at the computer. Saying do rounds on Epstein. That's just something that as officers we do to say hey, reminder. Make sure you check on this inmate." █████ said that SHU staff rounds take about 12 to 15 minutes if it's a smooth round and inmates don't stop you to ask questions or make requests.

█████, the Ops LT on August 9, 2019 from 2:00 p.m. until 10 p.m., said that when a LT conducts a round in the SHU, they are making sure that the officers are doing their jobs, and conducting their 30-minute rounds. If time permits, the LT can do down range and conduct a round as an officer does, but that was not a requirement. █████ explained that the officers are the ones that have the grill keys, and they have to open the grills in the SHU so the Lieutenants can walk down the various ranges. He said that no one can just walk down range in the SHU. █████ reviewed the round sheets from August 9, 2019, and said that although his signature is on one of the forms, it was actually █████ who conducted the round. He said that he did not know why his signature was on the form, because he did not conduct any rounds within the SHU on August 9, 2019, and he did not recall signing the form. █████ assumed that █████ asked him to sign the forms after she conducted the round, but he could not recall, and noted that the round sheets would not have left the SHU on August 9, 2019. █████ believed that he may have signed them on August 10, 2019, after the forms were collected and sitting in the Lieutenant's Office.

At approximately 4 a.m., the overnight supervisor, █████, briefly visited Noel and Thomas in the SHU, and conferred with Noel and Thomas, who were seated at and around the officers' desk, before leaving. (█████ was relieved at 5:30 a.m. by Lieutenant █████.) At approximately 5:30 a.m., another correctional officer, █████, who was assigned to 10 South, briefly walked through the SHU common area. Aside from those two officers, as confirmed by video surveillance, no one else entered the SHU, no one conducted any counts or rounds throughout the night, and no one entered the tier in which Epstein was housed.

█████ said that when █████ visited the SHU at approximately 4:00 a.m., she should have conducted a round of the entire SHU, and checked on the status of every inmate within the SHU.

Noel said that no supervisors was present in SHU for count between 12 midnight and 5am. █████ visited the SHU, but did not walk down the tiers. Lt. █████ walks the tiers all the time, however, other LT's do not walk down the tiers.

Morning Watch Operations Lieutenant █████ said that she conducted her round in the SHU on August 10, 2019, at approximately 4 a.m. She said that she then went up to 10 South, and then back down to the SHU because she needed to sign the round sheets. █████ said "We are not required to go to each individual cell and look at the inmates. When we make rounds, we get with the officers." █████ said that she did not conduct a round with the inmates during her round in the SHU.

AW █████ said that a Lieutenant conducting a round in the SHU on August 9 and 10, 2019, should have learned that █████ was not in the SHU and Epstein was without a cellmate. █████ said that the SHU staff

should have removed ██████ name from the cell door, and a Lieutenant should have checked on Epstein's cell specifically, because he was of great concern. If they are not going to check on every inmate, they should at least check on the ones of concern. They should speak with them or at least physically see them. Anytime an LT went in the SHU during Epstein's stay, they should have checked on him, or looked in his cell if he was in atty conference. ██████ said that if a Lieutenant signed the round sheet, then they should have physically looked in all of the cells. In General Population, a Lieutenant checks on the staff and would not check in every cell. In the SHU, a Lieutenant is supposed to conduct their round on both the staff and the inmates. ██████ said that the inmates cannot come to you, so you have to go to them. ██████ said that if a Lieutenant did not check on every cell within the SHU during their round, they did not act responsibly. They may not have specifically violated policy due to the way it was written, but they did not make a responsible decision. However, ██████ **believed** their certification on the round sheet means that they visited the SHU **and** the inmates in the SHU.

Warden ██████ said that a lieutenant round in the SHU consists of checking in with the SHU staff, checking their documentation, and checking the 30-minute round log to see if the staff members are conducting their 30-minute rounds. ██████ said that if a lieutenant signed off on a round sheet that showed that all the rounds had not been conducted, as was done on August 8 and 9, 2019, then it is a problem, and the lieutenant should have listed a reason as to why the rounds were not conducted. A lieutenant can, and should, walk around the SHU and to see if there are any problems on the ranges. The expectation was that the lieutenant would conduct a round just as the SHU staff did, to conduct wellness checks on the inmates, but he did not believe the post orders required them to conduct the wellness checks. ██████ said it was something that a lieutenant should have been doing as "sound correctional judgement." ██████ said that if he found out a lieutenant was only checking in with the staff members, and not walking down the ranges to check on the inmates, he "would correct it." He said that a lieutenant needs to conduct rounds and check on the wellbeing of the inmates, so he would have the captain tell the lieutenants that they need to be walking down the ranges and conducting inmate rounds.

Regional Director ██████ said that he was not sure what the BOP policy said, but the expectation was that Lieutenants would be conducting rounds on every range when they conducted a Lieutenant round. ██████ said that he was not saying they should stop at every cell and talk with every inmate, but they should be walking down each range, and if an inmate stops them, they should address the inmate. Lieutenants who say otherwise are "pretty poor to average" Lieutenants. If they want to check on the officers, they can just call the officers and ask. The Lieutenant would not have to physically go to the SHU. The Lieutenant's signature, to ██████, meant that the Lieutenant actually conducted a round, going down each individual range in the SHU.

Emergency response on August 10, 2019

On August 10, 2019, shortly after 6 a.m., Thomas and Noel received a delivery of breakfast carts into the SHU, after which time they were again the only officers in the SHU. Shortly after 6:30 a.m., Noel and Thomas walked up to and entered the tier in which Epstein was housed to serve breakfast. At approximately 6:33 a.m., an alarm was active in the SHU. Epstein was alone in his cell and not responsive, with a noose around his neck.

Thomas told the OIG that he could see Epstein's cell door from the Officers Station, but he could not see inside the cell from the Officers Station. Thomas said that he was present in the SHU for his entire shift on August 10, 2019, from 12 a.m. until approximately 6:33 a.m., and did not see anyone go inside

Epstein's cell during his shift. Thomas said he would have known if someone went into Epstein's cell, because it was not possible for anyone to have visited the SHU without his knowledge because he and Noel would have had to let them in. Thomas was confident that no one entered Epstein's cell on August 10, 2019, between 12 a.m. and 6:33 a.m.

Thomas last saw Epstein the day prior, on August 9, 2019, around 6:30 a.m., when he fed him breakfast during his shift. Thomas said that on August 10, 2019, he was the one to discover Epstein when he was feeding the inmates breakfast. Thomas said that approximately 6:33 a.m., he knocked on Epstein's cell door, saw Epstein through the window, and said "come to the door, come to the door." Epstein did not move or respond, so Thomas entered the cell and saw Epstein hanging. They then immediately yelled for Noel to get help and call the medical emergency. Thomas believed that Noel called the medical emergency within 30 seconds from the time Thomas first saw Epstein hanging.

Thomas explained that when he first entered Epstein's cell, he found Epstein hanging from orange strings from a sheet or a shirt from the top portion of the bunkbed, with his butt approximately one inch to one inch and a half off the floor. Epstein did not look discolored or very different from when he was alive. Thomas immediately ripped the sheet or shirt from the bunkbed, and Epstein fell to his butt. Thomas then lowered Epstein's body to the floor and began chest compressions for approximately one minute, until responding MCC staff members arrived. Thomas did not provide rescue breaths, was unaware if Epstein was dead or alive, and never checked for a pulse prior to providing the chest compressions. He did not believe he was breathing so he started chest compressions. When the medical personnel arrived, they took over the medical response, took over chest compression, and put an AED on Epstein. Thomas estimated that it did not take more than one minute from the time the medical emergency was called for the responding staff to arrive at Epstein's cell. Thomas assisted with bringing Epstein down to the second floor. Thomas departed the MCC around 8 a.m.

Thomas believed that Epstein took his own life and died from hanging. Thomas said that neither he nor Noel took Epstein's life or took part in taking Epstein's life. Thomas said that he has received CPR training during MCC Annual Refresher training in the past, had responded to medical emergencies in the past, but this was the first time he was the very first responder. Thomas believed that he and Noel acted appropriately in their response to the medical emergency per BOP policy, but said that he did not know what the BOP policy states.

Noel told the OIG that the OIG told her that Epstein's cell was approximately 15 feet from the SHU officer's desk. Noel said that no one went to Epstein's cell on August 10, 2019, between 12 a.m. and 6:33 a.m. She never slept during her shift on August 9th and 10. She said when she is seen on the camera at the desk not moving, she was on the computer. She then stated that she worked 5 days of overtime and she would doze off, however, she caught herself and never slept.

Noel said on the morning on August 10, 2019, Thomas was doing the feeding, she opened the grill for the tier and was standing by it. Thomas knocked on Epstein's door and did not get a response. Thomas opened the door and went in. She heard Thomas call out get the cutter. She heard Thomas rip something, Thomas laid him down and began CPR. Within seconds of Thomas calling out for cutter, Noel hit the body alarm. She recalls Thomas saying "Breathe, Epstein, breathe" and "We're going to be in so much trouble." She stood at the grill and never went in. She stated she did not see anything that was going on in there. She believed Epstein hung himself. She never saw where Epstein was hanging. She was only a foot away from Epstein cell but she never looked in during the emergency. She did not get the cutter because Thomas didn't need it based upon the ripping sound she heard. She saw Thomas

lifting him from under his arms and dragging him back out of the corner and laying him down to perform CPR. Did not hear or see Epstein's body hit the floor. Thomas only performed chest compressions. Did not see Thomas checking for breath or pulse. Epstein did not have a shirt on. When she saw him, he did not have anything around his neck. He looked blue. Epstein's cell door was locked, she recalls Thomas using the key to open it. She does not recall which COs responded for the body alarm. She does not know what happened in the cell after the COs arrived because she was waiting at the bottom of the steps. She was alone in the SHU for 20 minutes, after they left with Epstein. She kept calling control to get status updates.

When shown a picture of the cell, she verified there were a lot of linen and extra clothing in there. Epstein always slept on the floor. Thomas was supposed to wait for somebody before going into Epstein's cell. She does not know why he is supposed to wait, just that it is the rule.

Noel said that she did not have any conversations with Thomas during the emergency response. Thomas stated that we are doing to be in so much trouble but she did not respond because by now all the inmates were at their cell doors watching. Lt. [REDACTED] asked her what happened and before she got the chance to answer, Thomas came off elevator and stated "Oh its not her fault, we fucked up." She does not recall making any comments or statements to Lt. [REDACTED].

[REDACTED], the Operations Lieutenant on duty, told the OIG that at approximately 6:33 a.m. he heard a call for a medical emergency in the SHU and immediately responded to the alarm. [REDACTED] said that when he arrived, Noel approached the door to the SHU to open the door for [REDACTED], and told [REDACTED] that "Epstein hung himself." [REDACTED] said he observed Correctional Officers Noel and Thomas near Epstein and that Thomas was performing CPR on Epstein. [REDACTED] stated that he asked, "where's his Bunkie at?" and that Noel responded, in substance, he doesn't have a Bunkie. Noel told [REDACTED] "we did not complete the 3 a.m. nor 5 a.m. rounds." Thomas stated, "we messed up," and "I messed up, she's not to blame, we didn't do any rounds." Epstein was transferred to a local hospital at approximately 7:10 a.m. Epstein was pronounced deceased at 7:36 a.m.

[REDACTED] said that he responds to Epstein's emergency call at 6:33 a.m., and believed he was in the elevator with Ms. [REDACTED], [REDACTED], and Officer [REDACTED], who were also responding to the call. [REDACTED] said that Lt [REDACTED], Thomas and Noel were on scene when he arrived. When he first arrived, he saw Thomas picking Epstein up and people were helping him put him on the stretcher. [REDACTED] said that he and [REDACTED] performed chest compressions on Epstein while he was on the stretcher on the way to the MCC's second floor. [REDACTED] said that he then went back to the SHU and worked there for approximately one hour along with Lieutenant [REDACTED] and Officer Noel. [REDACTED] said that he fed the inmates with [REDACTED]. When they were feeding the inmates, he inmates were saying, "You killed him. You weren't making rounds. You killed him." Danel explained that the inmates were saying that Thomas and Noel killed Epstein by not conducting rounds during their shift. The inmates said that Thomas and Noel just sat there at the officers station and never checked on the inmates. [REDACTED] said that he did not actually feeding the inmates with [REDACTED]. Rather, he was fed the inmates on one tier while she fed them on separate tiers, in contradiction to [REDACTED] statement. Noel was opening the grille on the outside of the tiers for both [REDACTED] and [REDACTED]. [REDACTED] believed he was in the SHU prior to 7 a.m. and until approximately 8 a.m., but was not positive. Said he was in there for a while. [REDACTED] believed that Epstein took his own life and said he had no reason to believe otherwise.

█████ said that he responded to Epstein's emergency call at 6:33 a.m. and when he arrived, staff members were already performing CPR on Epstein. █████ said that he assisted with bringing Epstein to the MCC Medical Unit, assisted with taking Epstein to the ambulance, followed the ambulance to the hospital in another secure vehicle, and stayed at the hospital until he was relieved from duty. █████ said that Epstein died by hanging, and said he was unaware of any suspicious activity that occurred on August 9 or 10, 2019, leading up to the discovery of Epstein in his cell. █████ believed that Epstein took his own life, and acted alone in taking his own life.

█████ said that she was relieved as the Operations Lieutenant prior to 6:00 a.m., but was still working on things like the Daily Activities Report and Lieutenant's Log that she did not get to finish during her shift, and at some point, heard that there was a medical emergency up in SHU. █████ said that she went up and helped after the medical emergency because she knew that "feeding and all that stuff still needed to be done." █████ estimated that she went to the SHU around 7:00 a.m. to help with the feeding, and believed █████ was also helping with the feeding. Noel was there, but she was not helping with feeding, and █████ had been feeding by himself. █████ said that she and █████ were on the same range feeding together, in contradiction to █████ statement. █████ believed that Noel left around the time they were finished with the feeding. █████ said that after the feeding, she finished that up and went home. █████ was provided an email that she sent on August 10, 2019, at 9:26. █████ said she was probably working on the Daily Activities Log and Lieutenant Report that were attached to the email. She said the reports are sent out whenever they are finished, and although she tries to have them done by the end of the shift, since they were short staffed, things took longer.

Cell searches

The photographs of Epstein's cell on August 10, 2019, appear to show an excess of blankets, linens, and clothing. We have been unable to identify an inventory of the blankets, linens, and clothing. However, when reviewing the requirement that SHU staff conduct cell searches during the day and evening watch, it was discovered that the SHU staff only logged one cell search in TruScope on August 9, 2019. The current MCC SIA advised that the SHU staff members were not conducting cell searches as required prior to Epstein's death. And although there is supposed to be an equal exchange of blankets, linens, and clothing, the lack of cell searches may have led to excess items being housed within the cells.

█████ said that at least five cell searches should be conducted on every shift. Cell searches are conducted on cells every time the inmate departs the cell. So when an inmate used the shower, their cell was searched. Inmates were showered on Monday, Wednesday, and Friday. At that time, every cell was searched. The SHU OIC is responsible for logging the cell searches in and making sure they're conducted. But anyone could have logged the cell searches into the BOP database. The SHU LT was responsible for making sure the SHU OIC did the cell searches. Although only one cell search was logged in on August 9, all of the cells should have been searched because it was a shower day. He believed the majority were conducted. Only one was entered because they are a pain in the butt to enter and he was busy. Epstein's cell should have been conducted because he and █████ both left on the morning of August 9. He didn't believe that it was a problem that only one cell search was logged on Aug 9 because they would have gone into every cell when the inmates took their showers. They should also conduct cell searches when inmates go to rec or atty visits. Even though they weren't keyed in, he believed they were conducted. In August, each inmate would have been authorized two sheets and one blanket. In the winter, it's two sheets and two blankets. Inmates may have medication in their cell if the medical dept says it's okay. Shown picture of cell from August 10. He believed the lines and blankets were for

Epstein and [REDACTED] with probably a couple of extra sheets. They should not have had extra sheets. [REDACTED] items should have been removed as soon as they knew he wasn't returning to the MCC. So either at 4 pm or 8 pm. Definitely by the time Epstein returned from Atty visit. They should have also noticed that [REDACTED] was not there and Epstein needed a cellmate. Any extra linens or blankets should be removed when the inmates take showers and their cells are searched. From the picture, it looks like Epstein may have had two extra blankets. On August 9, 2019, [REDACTED], [REDACTED], [REDACTED] and [REDACTED] would have been present during showers. Epstein should not have had two mattresses. The picture shows two mattresses. Although [REDACTED] belongings were likely not removed. [REDACTED] "believed" that [REDACTED] slept on the floor and Epstein slept on the bed. The purpose of limiting the items provided to the inmates is to ensure there is enough to go around. He believed it was more of an admin matter than a security matter.

[REDACTED] said that Epstein had too many linens, t-shirts, and blankets. The staff were responsible because they don't want to hear the inmates complain. It is a security issue because it "gives the inmates the materials to be able to make homemade fashioned and improvised nooses." "...or use it as escape paraphernalia, just like they did in Chicago. Tie that stuff together, they broke out the window, and the inmate had a rope. That's why we don't give inmates excess clothing."

The witnesses stated that this was an administrative error and that following Epstein's return from suicide watch, he was always housed within the cell where he was found on August 10, 2019. It seems that both SHU LT [REDACTED] and SHU OIC [REDACTED] were the primary employees responsible for the administrative error, since they were responsible for auditing the records to ensure inmates were in their assigned cells, although everyone who worked in the SHU could have exposure and share some blame.

Statement from staff with regard to Epstein's death

All MCC staff members who were interviewed by the OIG believed that Epstein took his own life, believed no one assisted Epstein with taking his own life, and did not know of any information suggesting that Epstein did not take his own life. The OIG did not receive any information from MCC staff members that lead the OIG believe that Epstein did not take his own life. All staff members said that if Epstein was assigned a new cellmate after [REDACTED] departure, and if rounds and counts were conducted in the SHU as they were supposed to be conducted, that would have helped prevent Epstein from taking his own life.

[REDACTED] said that Epstein's death was the result of a suicide and there was no outside influence or involvement. [REDACTED] believed that Epstein would still be alive if he was on suicide watch. He would have been alone on 10 S and G Tier. Inmates are usually on suicide watch for at least two weeks. The things that allowed Epstein to die: shortage of staff, staff working double shifts with no sleep, not enough equipment, staff not conducting counts and rounds, and having a cellmate. It only takes three minutes for a person to kill themselves. If Epstein wanted to kill himself, he would have found a way. A cellmate would have helped. "He definitely would not have tried." Everyone played a part in failing to re-assigned Epstein a cellmate. It started with his cellmate leaving. I told my relief. Maybe R&D should have called and said, "Hey, this is Epstein's.." Everyone (the whole building) knew that [REDACTED] was Epstein's cellmate. It's not acceptable for someone to say they didn't know. The LTs should have told Psychology. [REDACTED] should have said, "we got to get him a Bunkie" instead of "Epstein needs a Bunkie." He believed he spoke with LT [REDACTED] and [REDACTED] and told them, "[REDACTED] is leaving, Epstein is going to need a Bunkie." But their explanation that he could have come back is acceptable because there was always

the chance [REDACTED] could have returned. [REDACTED] and [REDACTED] should have notified the captain. If he wanted to kill himself, he would have. Even with a cellmate, the cellmate isn't always there. They could go to the law library, etc. But the cellmate would have helped.

[REDACTED] said that by 10 pm, the SHU staff would have definitely known the Epstein was without a cellmate. [REDACTED] said that Noel and Thomas should have also known that Epstein was without a cellmate and needed a new one during the 12 am count. [REDACTED] said that "Thomas has been working for the Bureau for a very long time, even before he did, so he's worked in the SHU in the past and he knew what to do in the SHU."

SHU Lieutenant [REDACTED] said that one of the main reasons why this happened was because the MCC was very understaffed. Due to Epstein's high profile, it may have made sense for him to have been placed in 10 South, because he would have been more closely monitored. He said that retrospectively, Epstein should have been in 10 South or on G Tier.

Operations Lieutenant [REDACTED] believed that Epstein should have been assigned to 10 South, because that is the Super Maximum-Security Unit, and every cell had a camera monitored by a staff member assigned to the unit.

Operations Lieutenant [REDACTED] believed that Epstein should have been assigned to 10 South during his entire stay with the MCC because he was a high profile inmate and there is no guarantee that any inmate will maintain a cellmate because the MCC is an administrative institution and inmates come and go all of the time. At any point in time the courts can release any of the inmates housed at the MCC. [REDACTED] said that if Epstein required an abnormal amount of supervision due to fear he was going to harm himself, then he should have remained on suicide watch/psychological observation.

Captain [REDACTED] said that 10 South was the MCC's highest level security unit that was reserved for Special Administrative Measures (SAMS) inmates, which were single celled and camera monitored. [REDACTED] said that he never discussed placing Epstein on 10 South with MCC Executive management, and believed that MCC Executive Staff would have had to obtain outside approval to place Epstein in 10 South, possibly from the Attorney General.

AW [REDACTED] would not say if Epstein should have been placed in a cell with a camera, because those cells were reserved for SAMS inmates, which is a different vetting process. [REDACTED] said that if Epstein wanted to take his own life, he could have, and would have. [REDACTED] said that rounds are only conducted every 30 minutes, so Epstein could have taken his own life in between rounds. [REDACTED] said that MCC staff did not do everything they should have, but she did not know if that would have changed the outcome. [REDACTED] said that a cellmate would have helped so they could have alerted staff if they saw it happening, but said that Epstein could have found a way even with a cellmate. [REDACTED] said, "I don't believe that the BOP is responsible for him committing suicide." [REDACTED] said, "I don't really believe the failure equals the contribution of the suicide." She added, "While I understand that this is something that no one wanted, there were things that were not done, that were in line with policy. That were required to be done, and had those things been done, maybe we would not be questioning the liability aspect." She continued, "I believe that staff should follow policy, to ensure with certainty that no inmate is able to hurt themselves, or that no other inmate is able to hurt them."

Warden [REDACTED] said that psychology took Epstein off of suicide watch, and said that Epstein was required to be housed with an inmate, so he had him assigned to the SHU. [REDACTED] said that the

Psychology Department were the subject matter experts, so who was he to question their judgement. ██████ said the 10 South single celled unit was the terrorist unit, and was reserved for SAMS inmates. ██████ said that assigning Epstein to 10 South would be problematic due to the amount of attorney's he had coming in and out of the MCC, and the amount of time he was spending with his attorneys, because of how restrictions placed on the unit. ██████ said that he could have placed Epstein on 10 South, but he had to have a justification for it. ██████ said that he did not believe 10 South was the appropriate unit for Epstein, and believed that Epstein's attorneys would have pushed back on that placement. ██████ said that past inmate suicides seem to indicate that having a cellmate is the best way to help prevent inmate suicides. ██████ said the basic failures of the BOP with regard to this incident were staff members not conducting their counts, not conducting their rounds, and not replacing Epstein's cellmate. ██████ said that if staff members were doing their job, 99 times out of 100 the incident would not have happened. However, ██████ said that even if staff members were doing their jobs and conducting their 30-minute rounds, if an inmate wanted to harm themselves, they would find a way to harm themselves.

Regional Director ██████ said that the cells in 10 South that had cameras in them should not have even existed, as they were left over from September 11, 2001, when terrorists were housed within the MCC. ██████ said there was actually a requirement not to have those areas recorded because it was a PREA violation. ██████ said that most BOP facilities will only have one or two cells that are recorded when inmates are in four-point restraints and for suicide watch. ██████ said that the MCC had the cells because they were never removed from the MCC after September 11, 2001. ██████ said that the cells were available, so they could have used one, but it was not required. However, ██████ did not believe that Epstein should have been housed within one of those cells. ██████ said that due to the amount of money Epstein had, he could have used it against the BOP for violating his rights. ██████ said that the BOP's stance is that an inmate is much less likely to commit suicide if they have a cellmate. ██████ said that the cellmate failure seems to be caused by the Lieutenants and OIC on multiple shifts who failed to follow up on the information they had regarding Epstein's cellmate departure. ██████ added that the SHU staff not conducted counts and rounds and Epstein not having a cellmate are the two things that lead to Epstein's death.

Documents used as sources of information

Noel and Thomas Indictment
Epstein's After Action Review
Recommendations from BOP
OIG's previously drafted ROI
All reference Interview reports