AFTER ACTION REVIEW

Inmate Suicide

Metropolitan Correctional Center
New York, NY
August 10, 2019

Submitted by
[redacted]
Regional Director
Southeast Region

LIMITED OFFICIAL USE

Table of Contents

INTRODUCTION

The Metropolitan Correctional Center (MCC) New York is an administrative level facility located in New York, New York. The primary mission of the facility is to house individuals in pre-trial status. On August 10, 2019, the facility had a base count of 758 inmates.

An After Action Review team was appointed by [redacted], Regional Director, Southeast Region, to review the inmate suicide which occurred at MCC New York on August 10, 2019. The review team members included:

[redacted]

The following analysis was compiled through a review of written documentation, electronic databases and limited staff conversations. Due to potential criminal investigations, care was taken to not conduct formal interviews with any staff and a specific exclusion on discussions with involved staff. Written documentation was taken at face value, with limited ability to verify times of events, staff perceptions, or stated practices at the institution. Discrepancies were noted with various documents and systems. Precise details such as times, should be considered approximations as many cannot be verified.

EXECUTIVE SUMMARY

On August 10, 2019, at approximately 6:33 AM, Inmate Jeffrey Epstein, Register Number 76318-054, was found unresponsive in his cell within the Special Housing Unit (SHU). Inmate Epstein was transported to the local hospital where he was later pronounced dead. The initial cause of death, although unofficial, would indicate suicide by hanging.

CHRONOLOGY OF EVENTS

July 6, 2019

9:24 PM - Inmate Epstein is entered into SENTRY as arriving at MCC New York as a pre-trial inmate.

9:36 PM - Inmate Epstein placed in general population cell E06-547U.

July 7, 2019

7:20 PM - Inmate Epstein was placed in SHU cell Z02-201LAD with Inmate Nicholas Tartaglione, Register Number 78514-054.

July 8, 2019

9:24 AM - Psychology intake screening conducted with a risk of sexual abusiveness documented. No mental health concerns reported by staff.

10:41 AM -The Chief Psychologist consulted with the Suicide Prevention Coordinator, Central Office. The decision was made to place Inmate Epstein on psychology observation upon his return from court pending a mental health evaluation.

5:49 PM - Inmate Epstein returns from court.

5:49 PM - SENTRY shows a cell change transaction from Z02-201LAD to the same cell. There is no documented explanation for this peculiar change.

6:03 PM - Inmate Epstein is placed on psychology observation in cell H01-001L.

July 9, 2019

7:30 AM - Psychology conducts a suicide risk assessment indicating suicide watch was not indicated, but psychology observation is continued "pending suitable housing placement."

10:13 AM -Psychology develops a diagnostic and care level formulation assigning "no diagnosis" and CARE 1 Mental Health.

12:35 PM -Health Services completes a History & Physical for Inmate Epstein. This assessment was done in lieu of an

Intake Screening, which should have been conducted within 24-hours of arrival (PS6031.04).

July 10, 2019

3:26 PM - Psychology conducts a Psychology Observation contact and ends observation. Inmate returned to SHU with documented recommendations for a cellmate and next-day contact by psychology. Inmate placed in cell Z05-124LAD, again with Inmate Tartaglione.

July 11, 2019

3:21 PM - Inmate Epstein is seen by psychology for follow-up in the presence of his attorneys while conducting a legal visit. This visit recommended follow-up the following week.

July 16, 2019

12:48 PM -Inmate Epstein is seen by psychology in the presence of his attorneys while conducting a legal visit. This visit was at the request of Inmate Epstein. This visit recommended no follow-up.

July 18, 2019

30-Day Psychology reviews are conducted for the entire SHU population. Inmate Epstein was not in SHU at the time due to an attorney visit. The review was never conducted.

July 23, 2019

1:27 AM - SHU staff heard noises coming cell Z05-124. Upon arrival staff observed Inmate Tartaglione, standing at the door of the cell stating Inmate Epstein attempted to hang himself. Staff observed Inmate Epstein lying on the floor near his bunk with what appeared to be a piece of homemade orange cloth around his neck. Inmate Epstein was removed from the cell and placed on suicide watch by the Operations Lieutenant and the on-call Psychologist was notified.

6:20 AM - Health Services conducted a medical assessment of Inmate Epstein. The following injuries were reported: "circular line of erythema at the base of neck reaching 2/3 of the

neck circumference, 2 inches wide, sparing the back of the neck. Has one section of this erythema in the front with marks of friction. Small erythema on left knee about 2cm in diameter (mild)." Medical record note states follow-up in 2-4 hours. This follow-up does not appear to have occurred.

7:56 AM - Psychology administrative note opened and later completed on July 24, 2019.

9:10 AM - Psychology began a suicide risk assessment note.

July 24, 2019

8:45 AM - Psychology ended suicide watch and began psychology observation for Inmate Epstein.

July 25, 2019 - July 27, 2019

Daily psychology contact while on psychology observation.

July 28, 2019

8:33 AM - Daily psychology contact while on psychology observation indicated Inmate Epstein would be moved to another cell due to toilet issues. This move is not shown by SENTRY to have occurred.

July 29, 2019

10:01 AM -Daily psychology contact while on psychology observation.

July 30, 2019

12:01 PM -Daily psychology contact while on psychology observation. Psychology observation status discontinued with a recommendation for a cellmate while in SHU.

12:30 PM -A Staff Psychologist distributed a mass email stating Inmate Epstein will require a cellmate upon return to SHU. Inmate Epstein was placed in Cell Z04-206LAD with Inmate Efrain Reyes, Register Number 85993-054. SENTRY is inaccurate regarding this transaction, as it shows to have occurred the previous day.

3:58 PM - A medical record note is completed stating Inmate Epstein will be issued a Continuous Positive Air Pressure (CPAP) machine. Although there is no SENTRY transaction, Inmate Epstein and Inmate Reyes are moved to cell Z06-220. This move was done to accommodate the electrical needs of the CPAP.

July 31, 2019

10:35 AM -Psychology contact completed for post removal from psychology observation.

Prisoner custody documentation shows Inmate Epstein left the institution with the USMS and returned at unspecified times. Neither SENTRY nor the Lieutenant's Log reflect this event.

August 1, 2019

8:30 AM - Psychology documented they were notified by Correctional Systems of a form received from the United States Marshals Service (USMS) the previous day stating Inmate Epstein had reported suicidal tendencies.

1:00 PM - Psychology conducts a suicide risk assessment noting watch is not indicated with a recommendation for follow-up in one week. The delay in conducting this assessment is not justified in the report.

August 2, 2019

11:34 AM -An SIS Investigation into the July 23, 2019 incident was completed. The investigation stated there is insufficient evidence to support either Inmate Epstein harmed himself or was harmed by his cellmate.

August 8, 2019

10:02 AM -Psychology contact for suicide risk assessment follow-up conducted. No concerns or follow-up noted.

INCIDENT

August 9, 2019

8:00 AM - Inmate Reyes (Cellmate) departs for court. Inmate Reyes does not return to the institution.

8:30 AM - Epstein arrives in attorney conference room to meet with several attorneys throughout the day.

6:45 PM - Epstein departs the attorney conference room and returns to SHU cell Z06-220LAD (SENTRY does not reflect this accurately). Inmate Epstein remains in the cell alone until the time of the incident.

7:00 PM - Epstein was provided a social call by the Institution Duty Officer (IDO). This call was done on an unmonitored line. It is extremely concerning why this call would have been placed and why it would be done on an unmonitored line. Without further interviews it is not possible to determine the reason for this call.

August 10, 2019

6:33 AM - A body alarm is activated in the Special Housing Unit (SHU). SHU staff reported Inmate Epstein was unresponsive in cell Z06-220LAD (SENTRY does not reflect this accurately). Staff entered the cell and attempted to wake Inmate Epstein. Control Center announced a medical emergency and Cardiopulmonary Resuscitation (CPR) was initiated.

6:35 AM - The on-duty Physician Assistant arrives in SHU and continues CPR and applies an Automated External Defibrillator (AED).

6:40 AM - Associate Warden notified.

6:45 AM - Emergency Medical Services (EMS) arrives and continues CPR. Inmate Epstein is intubated, given three rounds of Epinephrine, Intravenous (IV) access established, Intraosseous (IO) initiated. The AED indicated there was no pulse found and no shock advised. Inmate Epstein is prepared for medical transport.

7:10 AM - Inmate Epstein departs the institution for transport to Beekman Hospital.

7:20 AM - Special Investigative Supervisor (SIS) Lieutenant notified.

7:30 AM - Warden arrives at the intuition.

7:36 AM - Inmate Epstein pronounced dead by the emergency room physician.

8:10 AM - Associate Warden of Programs and Captain arrive at the institution.

8:10 AM - Case Management Coordinator (CMC) and Supervisory Correctional Systems Specialist (SCSS) notified.

8:34 AM - Federal Bureau of Investigation (FBI) notified.

9:00 AM - Assistant United States Attorney (AUSA) notified.

9:00 AM - Associate Warden of Operations and SIS Lieutenant arrive at the institution.

9:15 AM - CMC arrives at the institution.

9:30 AM - Acting Chief Psychologist arrives at the institution.

9:50 AM - SCSS arrives at the institution.

9:55 AM - CMC and IDO depart to Beekman Hospital.

10:00 AM -CMC and IDO arrive at Beekman Hospital. Inmate Epstein is fingerprinted, photographed, and his clothing is secured.

10:00 AM -Judge Richard M. Beerman is notified.

10:15 AM -CMC returns to the institution.

10:45 AM -Public Information Officer (PIO) arrives at the intuition.

11:00 AM -CMC notifies Inmate Epstein's brother as next of kin.

11:12 AM -Press release is issued to the media.

11:15 AM -Press release is provided to Judge Beerman.

11:15 AM -Crisis Support Team (CST) is activated.

12:15 PM -Inmate Epstein's body is released to the medical examiner for autopsy.

12:19 PM -FBI arrives at the institution.

1:40 PM - Office of the Inspector General (OIG) contacts the Warden and advises an agent is being dispatched to the institution.

3:10 PM - OIG arrives and escorted to SHU.

3:35 PM - A Referral for Alleged Misconduct is sent to Office of Internal Affairs (OIA), Regional Director (RD), and Office of General Counsel (OGC).

ANALYSIS OF EVENTS

Inmate Epstein arrived at MCC New York on July 6, 2019, as a pre-trial commit. It appears the staff receiving Inmate Epstein were not aware of his broad publicity and placed him within general population as a typical inmate. The following day he was placed in SHU, reportedly at the direction of the Warden. It is unclear how his cellmate was chosen or what method was used to determine appropriateness. A review of the assigned cellmate raises questions concerning the selection process.

From his initial placement in SHU, until the date of the incident, Inmate Epstein was outside the institution on four occasions to attend court appearances and spent a considerable amount of time in attorney visitation. His interactions with the various departments was considered ordinary, although Inmate Epstein had many interactions with the Psychology Department.

On July 23, 2019, Inmate Epstein was found in a state of unresponsiveness within his SHU cell. The investigation into this incident was inconclusive to determine if the cellmate was involved, if Inmate Epstein had made a suicide attempt or gesture, or if he was feigning the incident in an attempt to gain single cell status. The investigation was completed properly and appropriately without a definitive conclusion.

Following the July 23, 2019 incident, psychology staff maintained appropriate contact with Inmate Epstein to assess his condition and level of supervision. Psychology was clear in their recommendation for Inmate Epstein to be housed with another inmate

when returned to SHU. Although this information was distributed on several fronts, by email from a staff psychologist, through individual conversations by the Captain to his Lieutenants, and verbally between SHU Officers, there was ultimately a failure to place a cellmate with Inmate Epstein.

On August 10, 2019, the two assigned morning watch SHU Officers failed to make their designated rounds or count the SHU inmates for two counts. At 6:33 am, upon finding Inmate Epstein unresponsive in his cell, with a torn bedsheet around his neck, staff utilized a body alarm to initiate a call for assistance. The medical response to the incident was timely, efficient, and exhaustive. Staff utilized an AED, as well as continuous CPR until care was assumed by EMS personnel.

OTHER FACTORS

(Directly Related to the Incident)

Significant discrepancies exist within SENTRY regarding cell quarters assignments (QTR). Although it is well documented Inmate Epstein was housed with two other inmates during his assignment in SHU, SENTRY does not reflect this information accurately. Inmate Epstein was found within cell 220, yet SENTRY never reflects him being housed within that cell at any time.

Significant discrepancies exist within SENTRY regarding admission/release status (ARS). SENTRY does not reflect Inmate Epstein being escorted from the institution by the USMS on July 31, 2019, although a signed Prisoner Remand form is documented receiving him from the USMS.

SHU has multiple cells equipped with video recording capability. Inmate Epstein was not housed in one of these cells and there appears to be no set guidance on when to utilize these cells.

No notations concerning a requirement for a cellmate were entered into the SHU program, and subsequently available for SHU Officers to reference.

An outside person sent $200 each to Inmate Epstein and his cellmate Inmate Reyes. The outside person appears to be Inmate Epstein's attorney. The purpose of this transaction is undetermined at this point.

In an email to the Warden, dated post incident, the Supervisory Staff Attorney reported details of a conversation with Inmate

Epstein's attorneys. Inmate Epstein's attorneys requested he be housed in a single cell, the staff attorney stated Inmate Epstein could not be housed alone due to previous suicide attempt/gesture.

During the immediate response to the incident both SHU officers made reference to not completing required rounds and counts. This was documented by the responding Lieutenant.

In an email to the Warden, the Captain reported he had "informal training sessions" regarding SHU conditions and the housing of Inmate Epstein specifically. This meeting was held with Correctional Services supervisors and line staff during the week of July 31, 2019. Additionally, the Captain states he spoke with the SHU Lieutenant concerning the need to house Inmate Epstein with a cellmate.

The Psychology intake screening contains errors in identifying details. Inmate Epstein is referred to as a black inmate and a different inmate name is used within the report.

There are errors within the Risk of Sexual Abusiveness report, such as referencing an inaccurate program statement and noting a history of prior prison sexual predation.

Correctional Services and Health Services are not completing regular rounds of inmates housed under psychology observation.

On July 16, 2019, a psychologist met with Inmate Epstein in the presence of his attorneys. This was done at the request of Inmate Epstein and appears to have been for the purpose of airing grievances with conditions of confinement.

The Suicide Risk Assessment dated July 23, 2019, refers to the ligature as a "string" when in fact it was a sizable portion of torn bed sheet.

On August 1, 2019, Correctional Systems staff reported the USMS concerns from the previous day regarding Inmate Epstein's suicidal tendencies to Psychology staff. It is unknown why this issue was not reported to Psychology the previous day. There was a time delay between this report and Psychology conducting a suicide risk assessment.

On August 9, 2019, during a shift change in SHU, the SHU #3 6:00 am-2:00 pm officer briefed his 2:00 pm-10:00 pm relief and the other two 8:00 am-4:00 pm officers of the likelihood Inmate

Reyes, Register Number 85993-054 would not be returning and Inmate Epstein would require a cellmate upon returning from an attorney visit. Inmate Epstein was not placed with a cellmate upon his return to SHU.

SHU 30-minunte check documentation shows a trend of missing rounds and rounds which extend beyond the 40-minute limit.

Count documentation for August 9, 2019, could not be located.

Official count documentation shows all counts were conducted as scheduled, but based on the statements of the responsible officers, this appears to be inaccurate for at least the 3:00 am and 5:00 am counts.

The initial medical screening noted essential hypertension, but did not provide treatment. Upon further review it appears this diagnosis should not have been issued.

On July 6, 2019, Health Services notes Inmate Epstein has no known allergies. On July 30, 2019, a Modified Diet Request is issued by Health Services with no accompanying medical record note.

All psychologists at the institution are state licensed clinicians.

Psychology Observation procedures dictate a Physician's Assistant perform daily rounds. This is clearly not possible based on Health Services staffing.

It is not uncommon for staff working vital posts, which require effectuating SENTRY transactions, to not have the needed access.

A review of inmates housed within the suicide watch cells, during the period of this review, revealed the inmates were not properly assigned within SENTRY.

Institution Duty Officers (IDO) do not routinely visit SHU each day as required by the Institution Supplement (IS5502.11). Additionally, the IDO reports consistently documents the condition of SHU as "satisfactory", when observations have shown the SHU to be less than satisfactory.

The Correctional Services roster requires a complete review to best utilize staffing resources. Currently, the roster appears to have posts which could be reprioritized.

A review of discontinued suicide watches for the past 30-days shows a history of placing inmates returned to SHU with a cellmate on each occasion.

OTHER FACTORS
(Not Directly Related to the Incident)

Staffing

Staffing changes within the Correctional Services department have changed significantly over the past several years. In May of 2018, during pay period 5, the institution lost 21 positions as a result of phase 1 and 2 reductions. These positions consisted of 19 correctional officers, 1 lieutenant and 1 SIS technician.

The current complement for Correctional Services is 135 authorized, with 117 filled.

Staffing levels at pay period 26 for previous years

Year	Authorized	On Board
2015	153	150
2016	152	132
2017	152	143
2018 (No staffing report available. Numbers are based on December 23, 2017.)	153	128

Correctional Services staff in an unavailable status
(LWOP / Sick Leave / AWOL / COP / Suspension / Official Time)

August 2, 2019	27	July 26, 2019	22
August 1, 2019	23	July 25, 2019	23
July 31, 2019	26	July 24, 2019	22
July 30, 2019	28	July 23, 2019	25
July 29, 2019	26	July 22, 2019	25
July 28, 2019	12	July 21, 2019	13
July 27, 2019	10		

Overtime

The two morning watch SHU staff did not work an unusual amount of overtime leading up to the incident. The SHU #1 was assigned to SHU on mandatory overtime during the incident. This staff member does not typically work a large quantity of overtime. The SHU #2 was assigned to SHU on voluntary overtime. This staff member typically works a high volume of overtime on a volunteer basis.

Overtime hours for the August 10, 2019 morning watch SHU Officers

	SHU #1		SHU #2	
	Voluntary OT	Mandatory OT	Voluntary OT	Mandatory OT
August	24	8	32	0
July	24	0	152	0
June	8	0	150	0
May	0	0	184	0

Correctional Services overtime (8-Hour occurrences) by pay period based on the pay rate for a GL-8/5

PP 20	17.1	PP 2	23.1	PP 10	25.9
PP 21	20	PP 3	21.9	PP 11	23.6
PP 22	19.4	PP 4	22.9	PP 12	21.2
PP 23	23	PP 5	19	PP 13	22.3
PP 24	21	PP 6	22.7	PP 14	27.4
PP 25	19.5	PP 7	22.4	PP 15	23.1
PP 26	Incl. PP 1	PP 8	25		
PP 1	37.6	PP 9	25.3		

CONCLUSION

After a thorough review of all available evidence, the review team concluded there was a significant breakdown in basic correctional practices and communication within the institution. Inmate Epstein was an inmate who fell within multiple suicide risk groups. He was also an inmate who had risk factors for assault by other inmates and did require careful selection for appropriate cellmates. Although these issues were noted, well documented, and communicated, a failure still occurred by allowing Inmate Epstein to be placed in a cell alone. Although feasible for an inmate to effectuate suicide while housed with a cellmate, the odds of this occurring are significantly lowered when housed with another inmate. Without the use of compelled interviews, it is not possible to determine the true root of the communication breakdown.

Concerning deficiencies were noted in common functions within the institution. It appears a less than satisfactory state of condition within the Special Housing Unit has become acceptable to responsible staff. The review team observed significant failures in basic tasks such as SENTRY entries for quarters changes to the base count of the facility. Failure in the area of inmate accountability is a substantial finding which will require immediate attention.

Although inmate suicides do occur, the Bureau of Prisons has developed substantial training resources and processes to mitigate an environment leading to a suicide. While many correctional professionals completed their responsibilities within these processes, the failure to carry out all aspects of the suicide prevention process laid the groundwork for an environment vulnerable to suicide. At the core of this event was a direct dereliction of duty by the assigned correctional workers within the Special Housing Unit. Their failure to perform the most basic of correctional tasks should be viewed as the primary factor which exposed the institution to this event. Had they performed the basic task of counting and viewing inmates within their assigned area, it is possible this suicide could have been detected or a minimum, responded to the event quicker.

RECOMMENDATIONS

- A multi-disciplinary team assessment should be conducted throughout the institution to determine shortcomings and provide a corrective action plan.

- Regional Psychology Administrators should be considered for reinstatement to provide a direct contact to field staff.

- The Institution Supplement on Suicide Prevention is not required and occasionally not followed. It is recommended to review the need for having this supplement.

- Currently the Drug Abuse Prevention Coordinator (DAPC) has responsibilities between MCC New York and MDC Brooklyn. It is recommended this be reviewed to determine if the responsibilities are appropriately distributed or if they would be better served with an independent DAPC.

- A single post should be designated to document all movement within the facility. This should include internal, court, releases, etc.

- The Correctional Services roster should undergo a complete review to determine the best possible use of staff resources.

- A Deputy Captain should be considered to provide additional higher level supervision.

- Psychology Observation procedures should be reviewed to ensure consistency and accuracy in the expectations.

- Procedures should be established on when and how the video capable cells in SHU are utilized.

COST/IMPACT STATEMENT

Correctional Services Overtime (Estimate 16-Hrs)	$741.60
Health Services Overtime	$0.00
Medical Expenses (Historical Estimate)	$10000.00
Death Related Expenses (Not Yet Released)	$0.00

TOTAL: $10741.60

ATTACHMENTS

Attachment 1: Inmate Involvement Listing