



EXECUTIVE SUMMARY

Investigation and Review of the Federal Bureau of Prisons' Custody, Care, and Supervision of Jeffrey Epstein at the Metropolitan Correctional Center in New York, New York

Introduction and Background

According to its website, the Federal Bureau of Prisons (BOP)'s current mission statement is "Corrections professionals who foster a humane and secure environment and ensure public safety by preparing individuals for successful reentry into our communities." However, the Department of Justice (DOJ) Office of the Inspector General (OIG) has repeatedly identified long-standing operational challenges that negatively affect the BOP's ability to operate its institutions safely and securely. Many of those same operational challenges, including staffing shortages, managing inmates at risk for suicide, functional security camera systems, and management failures and widespread disregard of BOP policies and procedures, were again identified by the OIG during this investigation and review into the custody, care, and supervision of one of the BOP's most notorious inmates, Jeffrey Epstein.

The OIG initiated this investigation upon receipt of information from the BOP that on August 10, 2019, in the Metropolitan Correctional Center in New York, New York (MCC New York), Epstein was found hanged in his assigned cell within the Special Housing Unit (SHU). The Office of the Chief Medical Examiner, City of New York, determined that Epstein had died by suicide.

The OIG conducted this investigation jointly with the Federal Bureau of Investigation (FBI), with the OIG's investigative focus being the conduct of BOP personnel. Among other things, the FBI investigated the cause of Epstein's death and determined there was no criminality pertaining to how Epstein had died.

This report concerns the OIG's findings regarding MCC New York personnel's custody, care, and supervision of Epstein while detained at the facility from his arrest on federal sex trafficking charges on July 6, 2019, until his death on August 10.

Epstein is Assigned to the SHU on July 7

Epstein was assigned to a cell in the SHU on July 7 due to media coverage of his case and inmate awareness of his notoriety. SHU inmates are securely separated from general population inmates and kept locked in their cells for approximately 23 hours a day.

BOP policy requires SHU staff to observe all inmates at least twice an hour and that Lieutenants conduct at least one round in the SHU each shift. BOP policy also requires multiple inmate counts during every 24-hour period. Among other things, inmate counts and rounds enable BOP staff to observe inmates and ensure they are secure in their cells and in good health. Further, to eliminate safety hazards, MCC New York requires SHU staff to search SHU common areas and at least five cells daily, and to search the entire SHU every week.

On July 18, the court refused to set bail for Epstein and ordered him detained pending trial on the criminal charges.

Incident Involving Epstein on July 23

While in MCC New York, Epstein was screened on numerous occasions by psychological staff, including a formal suicide assessment on July 9. In the evaluations he denied having thoughts or a history of attempted suicide. Psychological staff determined Epstein did not meet the criteria for a psychological diagnosis.

On July 23, at 1:27 a.m., correctional officers (CO) responded to Epstein's SHU cell where they found Epstein with an orange cloth around his neck. Epstein's cellmate told officers Epstein tried to hang himself. Medical staff examined Epstein, observed friction marks and superficial reddening around his neck and on his knee, and placed him on suicide watch. BOP policy requires that inmates identified as suicide risks be placed on suicide watch until no longer at imminent risk. The BOP uses a less restrictive monitoring form,

psychological observation, for inmates who are stabilizing but not yet ready to return to a housing unit. Epstein was removed from suicide watch on July 24 but remained under psychological observation until July 30.

Epstein first told MCC New York staff he thought his cellmate had tried to kill him, but later said he did not know what occurred and did not want to talk about how he had sustained his injuries. Epstein also later asked if he could be housed with the same cellmate. Another inmate housed on the same SHU tier told the OIG that he heard Epstein's cellmate call for assistance, and that Epstein's cellmate told him that Epstein tried to hang himself from the bunkbed ladder. Disciplinary charges against Epstein for alleged self-mutilation were not sustained due to insufficient evidence.

Following the July 23 incident, the Psychology Department determined Epstein needed to be housed with an appropriate cellmate, and on July 30 it sent an email to over 70 MCC New York employees informing them of this requirement. The Warden at the time told the OIG that he selected a new cellmate for Epstein in consultation with BOP executive leadership. That inmate remained Epstein's cellmate until August 9.

Events of August 8–10, 2019, and Epstein's Death

On August 8, the U.S. Marshals Service sent two emails notifying numerous MCC New York staff that Epstein's cellmate was being transferred to another facility on August 9. However, no action was taken to ensure Epstein was assigned another cellmate.

Also on August 8, Epstein met with his attorneys at the prison, as he had on prior occasions, and signed a new Last Will and Testament. MCC New York officials did not learn about the new Will until after Epstein's death.

The following day, August 9, Epstein's cellmate was transferred to another facility and he was not assigned a new cellmate. Additionally, on that date, the U.S. Court of Appeals for the Second Circuit unsealed approximately 2,000 pages of documents in civil litigation involving Ghislaine Maxwell, who was later convicted in December 2021 of conspiring with Epstein to sexually abuse minors over the course of a decade. The documents contain substantial derogatory information about Epstein and there is extensive media coverage of information in the unsealed documents.

Also on August 9, after meeting at the prison with his lawyers, MCC New York staff allowed Epstein to make, in violation of BOP policy, an unrecorded, unmonitored telephone call before he was returned to his SHU cell. Although Epstein said he was calling his mother, in actuality he called someone with whom he allegedly had a personal relationship.

At approximately 8 p.m. on August 9, SHU inmates were locked in their cells for the night, including Epstein who was without a cellmate. A search of Epstein's cell following his death revealed Epstein had excess prison blankets, linens, and clothing in his cell, and that some had been ripped to create nooses. Only one SHU cell search was documented on August 9, and it was not of Epstein's cell. BOP records did not indicate when Epstein's cell was last searched. The OIG also found that SHU staff did not conduct any 30-minute rounds after about 10:40 p.m. on August 9 and that none of the required SHU inmate counts were conducted after 4 p.m. on August 9. Count slips and round sheets were falsified to show that they had been performed.

On August 10, at approximately 6:30 a.m., the two SHU staff on duty, CO Tova Noel and Material Handler Michael Thomas, began delivering breakfast to SHU inmates. Noel unlocked the door to Epstein's SHU tier. When Thomas attempted to deliver breakfast to Epstein through the food slot in his locked cell door, Epstein did not respond to Thomas's verbal commands. Thomas unlocked the cell door and saw Epstein hanged. Thomas immediately yelled for Noel to get help and call for a medical emergency.

Thomas told the OIG that when he entered Epstein's cell, Epstein had an orange string, presumably from a sheet or a shirt, around his neck that was tied to the top portion of the bunkbed. Epstein was suspended from the top bunk in a near-seated position, with his buttocks approximately 1 inch to 1 inch and a half off the floor. Thomas said he immediately ripped the orange string from the bunkbed, and Epstein's buttocks dropped to the ground. Thomas then lowered Epstein's body to the floor and began chest compressions until responding MCC New York staff members arrived approximately 1 minute later. Shortly thereafter, outside medical personnel arrived and took over the emergency response, eventually removing Epstein to a local hospital where he was pronounced dead.

On August 11, 2019, the Office of the Chief Medical Examiner performed an autopsy and determined the

cause of death was hanging and the manner of death was suicide. Blood toxicology tests did not reveal any medications or illegal substances in Epstein's system. The Medical Examiner who performed the autopsy told the OIG that Epstein's injuries were consistent with suicide by hanging and that there was no evidence of defensive wounds that would be expected if his death had been a homicide. Epstein did not have marks on his hands, broken fingernails or debris under them, contusions to his knuckles that would have evidenced a fight, or, other than an abrasion on his arm likely due to convulsing from hanging, bruising on his body.

The Limited Available Video Evidence

Recorded video evidence for August 9 and 10 for the SHU area where Epstein was housed was only available from one prison security camera due to a malfunction of MCC New York's Digital Video Recorder system that occurred on July 29, 2019. While the prison's cameras continued to provide live video feeds, recordings were made for only about half the cameras. MCC New York personnel discovered this failure on August 8, 2019, but it was not repaired until after Epstein's death. As detailed in this report, like many other BOP facilities, MCC New York had a history of security camera problems.

The available recorded video footage from the one SHU camera captured a large part of the common area of the SHU and portions of the stairways leading to the different SHU tiers, including Epstein's cell tier. Thus, anyone entering or attempting to enter Epstein's SHU tier from the SHU common area would have been picked up by that video camera. Epstein's cell door, however, was not in the camera's field of view. The OIG reviewed the video and found that, between approximately 10:40 p.m. on August 9 and about 6:30 a.m. on August 10, no one was seen entering Epstein's cell tier from the SHU common area. The OIG determined that movements captured on video before and after those times were generally consistent with employee actions as described by witnesses and documented in BOP records.

Results of the OIG's Investigation and Review

The OIG's investigation and review identified numerous and serious failures by MCC New York staff, including multiple violations of MCC New York and BOP policies and procedures. The OIG found that MCC New York staff failed on August 9 to carry out the Psychology Department's directive that Epstein be assigned a cellmate, and that an MCC New York supervisor allowed

Epstein to make an unmonitored telephone call the evening before his death. Additionally, we found that staff failed to undertake required measures designed to make sure that Epstein and other SHU inmates were accounted for and safe, such as conducting inmate counts and 30-minute rounds, searching inmate cells, and ensuring adequate supervision of the SHU and the functionality of the video camera surveillance system.

The OIG also found that several staff falsified BOP records relating to inmate counts and rounds and lacked candor during their OIG interviews. Two MCC New York employees, Noel and Thomas, were charged criminally with falsifying BOP records. The charges were later dismissed after they successfully fulfilled deferred prosecution agreements. The U.S. Attorney's Office for the Southern District of New York declined prosecution for other MCC New York employees who the OIG found created false documentation.

The combination of these and other failures led to Epstein being unmonitored and alone in his cell, which contained an excessive amount of bed linens, from approximately 10:40 p.m. on August 9 until he was discovered hanged in his locked cell the following day.

While the OIG determined MCC New York staff engaged in significant misconduct, we did not uncover evidence contradicting the FBI's determination regarding the absence of criminality in connection with how Epstein died. We did not find, for example, evidence that anyone was present in the SHU area where Epstein was housed during the relevant timeframe other than the inmates who were locked in their assigned cells. The SHU housing unit was securely separated from the general inmate population and inmates were kept locked in their cells for approximately 23 hours a day. Access to the SHU was controlled by multiple locked doors. Within the SHU, the entrance to each tier could be accessed only via a single locked door at the top or bottom of the staircase leading to the individual tier. Keys to open the locked tier doors were available to a limited number of COs while on duty. Each tier had eight cells and each individual cell, which was made of cement and metal, could be accessed only through a single locked door, to which a limited number of COs had keys while on duty. The SHU cell doors were made of solid metal with a small glass window and small locked slots that correctional staff used to handcuff inmates and provide food and toiletries to inmates. As a further security measure, during each shift a limited number of the COs had keys while on duty.

SHU staff told the OIG that at approximately 8 p.m. on August 9, all SHU inmates, including Epstein, were locked in their cells for the evening and we found no evidence to the contrary. The prison's recorded video did not identify any staff or other individuals approaching Epstein's SHU tier from the SHU common area between approximately 10:40 p.m. on August 9 and about 6:30 a.m. on August 10. Additionally, the OIG did not observe on the recorded video that Noel and Thomas, who were seated at the desk at the SHU Officers' Station immediately outside the area where Epstein was housed, at any time during the time period rose from their seats or approached the cell block. We additionally found that Thomas's and Noel's reaction on the morning of August 10 upon finding Epstein hanging in his cell, as described to us by Thomas, Noel, the responding Lieutenant, and inmates, was consistent with their being unaware of any potential harm to Epstein prior to Thomas entering Epstein's cell at about 6:30 a.m. on August 10.

None of the MCC New York staff members we interviewed were aware of any information suggesting Epstein's cause of death was something other than suicide. Additionally, none of the inmates we interviewed had any credible information suggesting Epstein's cause of death was something other than suicide. Further, the SHU staff and three interviewed inmates with a direct line of sight to Epstein's cell door on the night of his death stated that no one entered or exited Epstein's cell after the SHU staff returned Epstein to his cell on August 9.

As noted, the surveillance camera in the SHU area where Epstein was housed was live streaming movement in the hallway outside of Epstein's cell. Although the camera was not recording the captured video, the camera was in plain view of the inmates and therefore inmates would have been aware that any hallway movements, including into or out of Epstein's cell, could be monitored by BOP staff, even if, unbeknownst to them, the DVR system was not recording the live stream at that time. As the OIG has noted in numerous prior reports, BOP staff and inmates are aware of where prison cameras are located and often engage in wrongdoing in locations where they know cameras are not located.

We noted as well that Epstein had previously been placed on suicide watch and psychological observation due to the events of July 23, 2019; that numerous nooses made from the excess prison sheets were

found in his cell on the morning of August 10; that no weapons were recovered from his cell after his death; and that he signed a new Last Will and Testament on August 8, 2 days before he died. We found that the staff's failure to assign Epstein a cellmate on August 9; failure to conduct rounds and counts that evening; and to allow him to have excess linens in his cell, left Epstein unmonitored and locked alone in his cell for hours, which provided him an opportunity to commit suicide.

Finally, the Medical Examiner who performed the autopsy detailed for the OIG why Epstein's injuries were more consistent with, and indicative of, a suicide by hanging rather than a homicide by strangulation. The Medical Examiner also cited the absence of debris under Epstein's fingernails, marks on his hands, contusions to his knuckles, or bruises on his body evidencing a struggle, which would be expected if Epstein's death had been a homicide by strangulation.

Conclusion and Recommendations

This is not the first time the OIG has found significant job performance and management failures on the part of BOP personnel and widespread disregard of BOP policies that are designed to ensure that inmates are safe, secure, and in good health. The combination of negligence, misconduct, and outright job performance failures documented in this report all contributed to an environment in which arguably one of the BOP's most notorious inmates was provided with the opportunity to take his own life, resulting in significant questions being asked about the circumstances of his death, how it could have been allowed to happen, and most importantly, depriving his numerous victims, many of whom were underage girls at the time of the alleged crimes, of their ability to seek justice through the criminal justice process. The fact that these failures have been recurring ones at the BOP does not excuse them and gives additional urgency to the need for DOJ and BOP leadership to address the chronic staffing, surveillance, safety and security, and related problems plaguing the BOP.

The OIG made eight recommendations to the BOP to address the numerous issues identified during our investigation and review. Finally, we recommended that the BOP review the conduct and performance of the BOP personnel as described in this report and determine whether discipline or other administrative action with regard to each of them is appropriate.