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DOJ OIG Releases Report on 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

Department of Justice (DOJ) Inspector General Michael E. Horowitz announced today the release of a report regarding the Federal Bureau of Prison's custody, care, and supervision of Jeffrey Epstein while detained at the Metropolitan Correctional Center in New York, New York (MCC New York). The DOJ Office of the Inspector General (OIG) initiated this investigation and review upon receipt of information from the BOP that inmate Jeffery Epstein was found hanged in his assigned cell. The Office of the Chief Medical Examiner, City of New York, determined that Epstein had died by suicide. The DOJ 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.

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, which 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.

The DOJ 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 of the custody, care, and supervision of Epstein, one of the BOP's most notorious inmates.

The OIG's findings included the following:

- **MCC New York Staff Failed to Ensure that Epstein Was Assigned a Cellmate.** Following a July 23, 2019 incident that resulted in Epstein being placed on suicide watch, the MCC New York Psychology Department determined that Epstein needed to be housed with an appropriate cellmate. On August 9, Epstein's cellmate was transferred out of MCC New York. MCC New York staff knew that Epstein did not have a cellmate as was required, but did not take steps to ensure that Epstein was assigned a new cellmate.

- **MCC New York Staff Failed to Undertake Required Measures Designed to Ensure that Epstein and Other Inmates Were Accounted for and Safe.** 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.

  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 4:00 p.m. on August 9.

- **MCC New York Falsified BOP Records Relating to Inmate Counts and Rounds.** MCC New York falsified count slips and round sheets to show that they had been performed when they were not, leaving Epstein unobserved for hours before his death.

- **The DOJ OIG Did Not Uncover Evidence Contradicting the FBI's Determination that there Was No Criminality Associated with Epstein's Death.** The OIG reviewed the available recorded video footage 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. 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. 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.

  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~~ linens 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, 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.

The DOJ OIG made nine recommendations to improve the BOP's management of its correctional institutions. The BOP agreed with all nine recommendations.

Report: Today's report can be found on the OIG's website at the following link:

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Tweet: Serious failures by MCC New York staff led to Epstein being unmonitored and alone in his cell before he died by suicide.