U. S. Department of Justice

Federal Bureau of Prisons

Central Office

Office of the Director *Washington, DC 20534*

June 16, 2023

MEMORANDUM FOR [redacted]
ASSISTANT INSPECTOR GENERAL
INVESTIGATIONS DIVISION

FROM: [redacted]

SUBJECT: Response to the Office of Inspector General's (OIG) Draft Report: 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

The Bureau of Prisons (BOP) appreciates the opportunity to formally respond to the Office of the Inspector General's above-referenced draft report. BOP values OIG's careful review of the facts and circumstances surrounding the death of Jeffrey Epstein and will utilize this report to apply lessons learned where applicable to the broader BOP correctional landscape. Under its current leadership, BOP is committed to improving the agency's ability to meet its mission. In fact, in April of this year, BOP announced its new mission as "corrections professionals who foster a humane and secure environment and ensure public safety by preparing individuals for successful reentry into our communities." BOP must treat the adults in its custody with dignity and respect and ensure they receive necessary medical and mental health care on an individualized basis, consistent with sound correctional judgment.

However, certain recommendations from this report appear to reflect an assumption that because a limited number of employees at MCC New York failed to adhere to BOP policies and practices, those policies and practices must themselves be flawed. As an agency with more than 35,000 employees across more than 120 facilities, BOP believes that employees who fail to adhere to the law, regulations, and BOP's own policies must be held accountable. However, the vast majority of BOP's employees work tirelessly under challenging conditions. We must be careful not to ascribe the facts specific to the Jeffrey Epstein incident at MCC New York to BOP's entire workforce. Using the Jeffrey Epstein incident as a basis for overhauling national policies and practices without evaluating whether similar trends exist at other locations or considering the role of employee accountability and training could be detrimental to sound correctional practices.

BOP previously provided OIG its technical assessment of these recommendations in an effort to resolve potential concerns prior to the publication of this report. BOP appreciates OIG's review of this

information and looks forward to working with OIG to address any remaining unresolved issues in the immediate future. BOP's specific comments regarding OIG's recommendations are as follows:

Recommendation One: The BOP should implement a process for assigning a cellmate following suicide watch or psychological observation.

BOP's Response: Although BOP cannot concur with this recommendation based on its current wording, BOP agrees to implement a process for assigning a cellmate following suicide watch or psychological observation whenever appropriate for the individual and when security concerns allow.

BOP's current process, updated in the years following Jeffrey Epstein's death, already takes an individualized approach to the care and custody of adults in custody in the context of suicide watch and psychological observation. Upon removal from suicide watch or psychological observation, psychologists make individualized care recommendations about clinical follow-up and other custodial concerns, including housing and cellmates. Mental health, custody, and unit team staff work collaboratively to ensure each individual removed from suicide watch has a cellmate whenever clinically and correctionally appropriate. In the event an individual is determined to have moderate to high baseline risk for suicide and no suitable cellmate can be identified, continued placement on suicide watch is to be considered. BOP provides guidance through national trainings each fiscal year for its psychologists about individualized care recommendations.

It is not sound correctional practice to apply a one size fits all approach regardless of a person's individual needs and without factoring the safety of others or the security concerns of the institution. For example, some persons may be extremely violent or pose a risk to other adults in custody at the conclusion of suicide watch. Additionally, some of these persons may require protective custody from others and placing them with a cellmate may create additional risk to their safety. An adult in custody's status post suicide watch or psychological observation cannot be the sole factor considered in cellmate placement; sound correctional judgement must be utilized and is vital to the safe and orderly operations of BOP's institutions. Therefore, at times, single celling may be the only sound correctional decision for an individual who has been removed from suicide watch or psychological observation. However, single-celling is routinely monitored by each region in the BOP.

Recommendation Two: The BOP should establish procedures to ensure inmates at high risk for suicide and for whom a cellmate is recommended will continue to have a cell mate until the recommendation is changed or rescinded, including establishing a contingency plan for cellmate re-assignment, ensuring that another cellmate can be assigned efficiently.

BOP's Response: BOP concurs with this recommendation insofar as BOP agrees to establish procedures to ensure adults in custody at high risk for suicide and for whom a cellmate is appropriate and recommended will continue to have a cellmate until the recommendation is changed or rescinded.

BOP's current process already takes an individualized approach to the care and custody of adults in custody in the context of suicide watch and psychological observation. Upon removal from suicide watch or psychological observation, individualized care recommendations are made by psychologists, custody, and unit team for each individual. BOP already makes each celling assignment on an individual basis for persons deemed to be at moderate to high risk for suicide. These considerations include both mental health and custodial concerns. Psychology Services, Correctional Services, and Unit Team work closely to monitor individuals identified to be at risk for suicide to determine placement considerations. BOP uses the Psychology Advisory List (PAL) and PSY ALERT status to monitor those individuals whom employees should have heightened awareness. These codes ensure employees are better able to monitor individuals at risk for suicide to ensure they have an appropriate cellmate.

Regarding contingency planning, BOP has serious concerns about "contingency-planning" for cellmates for adults in custody at high risk for suicide. The process of assessing this procedure is impossible given the number of individuals determined high risk, the frequency of movement, and the complexity of security concerns. Movement is frequent among BOP's mainline facilities and even more so at pre-trial facilities. It is not feasible to maintain accurate, individualized contingency plans listing several back-up individuals for each high-risk individual in its custody. Identifying appropriate cellmates is best done in real time with the most current information, resulting in the safest outcomes.

Recommendation Three: The BOP should implement a process that requires approval to be obtained and documented for social or legal visits while an inmate is on suicide watch or psychological observation.

BOP's Response: Although BOP cannot concur with this recommendation based on its current wording, BOP agrees to evaluate its processes and train its employees to ensure approval is obtained and documented for social or legal visits while an adult in custody is on suicide watch or psychological observation. Pre-trial institutions such as MCC New York have supplemental policy to address legal visits for persons on suicide watch. MCC New York had an appropriate institutional supplement to address this issue but did not adhere to that policy. As noted above, BOP will evaluate Program Statement 5324.08 and other relevant program statements to determine an effective method for integrating information from the local Suicide Prevention Coordinator regarding individuals' current stressors and protective factors into the Warden's decision-making process.

Recommendation Four: The BOP should improve its methods of accounting for inmate whereabouts and wellbeing by expanding institutional controls, training, and documentation.

BOP's Response: Although BOP cannot concur with this recommendation based on its current wording, BOP agrees to improve its methods for holding employees accountable for failing to account for adult in custody whereabouts and wellbeing as required through established institutional controls and documentation. BOP respectfully asserts that its current

policies already require personnel to account for adult in custody whereabouts and wellbeing. Program Statement 5500.14 outlines basic principles of accountability, such as count procedures, census checks, control center records, daily change/transfer sheet, adult in custody callouts. Policy also mandates institutions to develop a supplement which outlines adult in custody accountability, specifically census checks.

The OIG report's findings indicate a lack of employee accountability at MCC New York during the period when this incident occurred. BOP acknowledges the lack of accountability at MCC New York and is committed to ensuring its employees are appropriately trained and held accountable. This includes employees being held accountable for the completion of job duties involving controlling and documenting adult in custody movement, observation, and related activities.

Recommendation Five: BOP policy should clarify what is required of a lieutenant when conducting a round.

BOP's Response: BOP concurs with this recommendation and intends to clarify what is required of a lieutenant when conducting a round.

Recommendation Six: The BOP should develop and implement a plan to address staffing shortages at its prisons.

BOP's Response: BOP agrees that hiring and retaining qualified personnel is a key priority. BOP has already developed and implemented a multi-pronged approach that involves enhanced recruitment efforts and appropriate incentives. However, the scope of OIG's work in this product was limited to the investigation and review of Jeffrey Epstein's suicide at MCC New York and OIG did not request or give the BOP an opportunity to address the significant work that has already been undertaken regarding staffing.

Further, we disagree with the inference in this recommendation that a staffing shortage compounded the issues in this incident. While we recognize the statement by one employee that rounds were not conducted because they were tired, the incident did not result from lack of staffing. The Special Housing Unit was fully staffed on all three shifts prior to Jeffrey Epstein's suicide, with employees who chose not to conduct rounds.[1] OIG's position that employees failed to attend to their duties as a result of staffing challenges is tenuous and alleviates the responsibility of employees to perform duties during their scheduled shifts. This responsibility is carried out by the vast majority of BOP's employees every day and ensures the safety and security of those in our care and custody. The negligence of specific employees at MCC New York in their duties should not be excused by reinforcing BOP's staffing challenges as the basis for misconduct.

[1] OIG notes that these employees worked a 24-hour shift. Although these employees volunteered to work beyond 16 hours, BOP is examining options to ensure employees no longer work a consecutive 24-hour shift absent an institution emergency.

Recommendation Seven: The BOP should clarify and improve the cell search policy.

BOP's Response: BOP does not agree with this recommendation. BOP has established policy, Program Statement 5521.06, Searches of Housing Units, Inmates, and Inmate Work Areas, and Program Statement 5580.08, Inmate Personal Property, that outlines what an adult in custody is allowed to have in their possession and defines contraband, to include procedures for handling it. Program Statement 5270.11, Special Housing Units, outlines conditions of confinement, as well as personal property allowed, within the Special Housing Unit. Controlling excessive property and specifically linens is an employee performance and conduct issue rather than a policy issue. It is not realistic or sound correctional practice for BOP's policy to specifically list each piece of property an adult in custody may possess and the appropriate quantity for those items.

Additionally, institutions are required to supplement BOP cell search policy on a localized basis. To insist upon an across-the-board national cell search requirement detailing specific item restrictions fails to account for the wide variety of needs and diverse population of adults in custody throughout BOP's many facilities. We do, however, believe that employees should be held accountable when not following our policies.

Recommendation Eight: The BOP should enhance existing policies regarding institutional security camera systems to ensure they specifically state that such systems must have the capacity to record video and that BOP institutions must conduct regular security camera system functionality checks.

BOP's Response: BOP concurs with this recommendation and agrees to enhance policies that already exist to ensure institutional security camera systems have capacity to record video and are regularly checked for functionality. BOP notes that policies already exist concerning institutional security camera systems. Program Statement 5500.15, Correctional Services Manual, requires an Institutional Supplement for Security Inspections/Searches, and specifically states, "The Warden is to establish, by Institution Supplement, a security inspection system that involves all departments. The Institution Supplement will include posts and areas required to submit inspection forms, frequency of submission, guidelines for checking security features, and reporting of weaknesses and inconsistencies."

Additional Concerns: While the above is our formal response to the recommendations, BOP would also like to note our continued strong objections to some of the technical language/inconsistencies/security concerns still included in the version of the report provided to us on June 15th, 2023.

Specifically, BOP was unaware of any changes to Mr. Epstein's last will and testament prior to his death, yet it is consistently mentioned in the report, leading the reader to conclude differently (i.e., that BOP was aware prior to his death). Additionally, the report indicates that there were delays in completing the camera upgrade/repair; however, BOP would like to note that the upgrade/repair had been requested. Also, the BOP adamantly objects to the use of the

term "widespread" in relation to the failure of employees to follow policy. Finally, our concerns regarding the specific language in relation to Special Housing Unit keys was inconsistent in the report (i.e., differences in language were noted on pages iii, 23, and 96). We have attached all of our technical comments to this memorandum.

Thank you for the opportunity to comment on this report. We look forward to OIG closing the recommendations that the BOP has agreed to address.