June 27, 2023

DOJ OIG Releases Report on the BOP's 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 of investigation regarding the Federal Bureau of Prison's (BOP) custody, care, and supervision of Jeffrey Epstein while detained at the Metropolitan Correctional Center in New York, New York (MCC New York). Epstein died by suicide on August 10, 2019 while in BOP custody. The focus of DOJ Office of the Inspector General's (OIG) investigation was the conduct of BOP personnel.

The DOJ OIG investigation and review identified:

- **Numerous and Serious Failures by MCC New York Staff.** The DOJ OIG found numerous and serious failures by MCC New York staff constituting misconduct and dereliction of their duties. Among other things, these failures resulted in Epstein being unmonitored and alone in his cell with an excessive amount of bed linens, from approximately 10:40 p.m. on August 9 until he was discovered hanged in his locked cell on August 10 at approximately 6:30 a.m.

    - ***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 but did not take steps to ensure that he 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 Special Housing Unit (SHU) staff to observe all inmates, conduct rounds, conduct inmate counts, search inmate cells, and ensure adequate supervision of the SHU. BOP staff in the SHU in the hours before Epstein's death failed to carry out these responsibilities. Specifically, 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. Had Epstein's cell been searched as required, the search would have revealed that Epstein had excess prison blankets, linens, and clothing in his cell. 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 staff 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. Following a DOJ OIG investigation, two MCC New York employees were charged criminally with falsifying BOP records. The charges were dismissed upon compliance by the employees with the terms of deferred prosecution agreements they entered into with the U.S. Attorney's Office for the Southern District of New York. That office declined prosecution for

other MCC New York employees who the OIG found created false documentation on earlier dates and times not proximate to the Epstein's death.

- ***MCC New York Staff Failed to Ensure that the Institution's Security Camera System was Fully Functional Resulting in Limited Recorded Video Evidence.*** BOP policy also requires SHU staff to ensure the functionality of the video camera surveillance system. This investigation and review revealed longstanding deficiencies with MCC New York's security camera system. Although video cameras in the SHU provided live video feeds to monitoring stations, system deficiencies resulted in nearly all of the cameras in and around the SHU where Epstein was being housed to not record video starting in late July 2019 and continuing through the date of Epstein's death.

- **Long-standing Operational Challenges.** 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, maintaining functional security camera systems, 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 high profile inmates.

- **No Evidence Contradicting the FBI's Determination that there Was No Criminality Associated with Epstein's Death.** Separate from the OIG's investigation, which focused on the conduct of BOP personnel, the FBI concurrently investigated whether Epstein's death was the result of criminal conduct by any non-BOP actors. Among other things, the FBI investigated the cause of Epstein's death and determined it was not the result of a criminal act. The Office of the Chief Medical Examiner, City of New York, determined that Epstein died by suicide. While the OIG determined MCC New York staff engaged in significant misconduct and dereliction of their duties, we did not uncover evidence contradicting the FBI's determination regarding the absence of criminality in connection with Epstein's death.

The combination of negligence, misconduct, and outright job performance failures documented in the report all contributed to an environment in which arguably one of the most notorious inmates in BOP's custody was provided with the opportunity to take his own life. The BOP's failures are troubling not only because the BOP did not adequately safeguard an individual in its custody, but also because they led to questions about the circumstances surrounding Epstein's death and effectively deprived Epstein's numerous victims of the opportunity 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 problems plaguing the BOP.

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

Report: Today's report and an interactive timeline of events can be found on the OIG's website at the following link: https://oig.justice.gov/reports/investigation-and-review-federal-bureau-prisons-custody-care-and-supervision-jeffrey

Video: To accompany today's report, the OIG has released a 3-minute video of the Inspector General discussing the report's findings. The video and a downloadable transcript are available at the following link: https://oig.justice.gov/news/multimedia/video/message-inspector-general-investigation-and-review-bops-custody-care-and

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