FEDERAL BUREAU OF INVESTIGATION

Date of entry 08/15/2019

[redacted], Captain, FEDERAL BUREAU OF PRISONS (BOP), place of employment METROPOLITAN CORRECTIONAL CENTER (MCC), 150 Park Row, New York, NY 10007, was interviewed at the FBI New York Field Office, 290 Broadway, New York, NY 10278 by FBI Special Agent [redacted] and OIG Special Agent [redacted]. Agents reviewed a standard OIG interview waiver form; [redacted] signed the form and agreed to a voluntary interview. After the Agents introduced themselves and explained the purpose of the interview, [redacted] provided the following information:

[redacted] began his career with the BOP in Florence, CO in 2005. In 2014, he was transferred to the METROPOLITAN DETENTION CENTER (MDC) in Brooklyn, NY, where he was made Deputy Captain in 2015. In 2018, [redacted] was promoted to Captain at MCC, his current position, where he oversees security for the entire building. [redacted] directly supervises approximately 13 Lieutenants, and has approximately 125-134 line staff / Correctional Officers under his purview. [redacted] also sits on the institution's Executive staff, which also includes the Warden. [redacted] primary duty is to ensure that security protocols are met by his Lieutenants and sub-staff, and that policy guidelines are being followed as set forth by the BOP. Among others, [redacted] is responsible for the following: a Special Housing Unit (SHU) Lieutenant, Lieutenant [redacted]; an Administrative Lieutenant, responsible for maintaining paperwork, etc.; an SIS Lieutenant, responsible for paperwork; an Operations & Activities Lieutenant(s), responsible for day-to-day operations and maintaining order for three (3) shifts; and an Emergency Preparedness Lieutenant, a collateral duty responsible in the event of emergency incidents such as a fires, bomb threats, etc.

[redacted] advised that his staff provides special considerations for high profile inmates, if deemed appropriate and designated as such. In order to ensure an inmate is provided with proper care, the facility evaluates the inmate using several measures, including mental, physical, medical,

psychological, and sexual assault victim or predator assessments. Since different inmates are admitted with different criteria, appropriate housing varies.

[redacted] interacted with inmate JEFFREY EPSTEIN on approximately three occasions at MCC, all of which EPSTEIN maintained a pleasant demeanor. During the first instance, EPSTEIN asked [redacted] who he was, and [redacted] responded by introducing himself and explaining his position at the jail. During another instance, [redacted] explained to EPSTEIN the policy regarding meals during attorney sessions, and made certain EPSTEIN was accommodated with water, visits to the restroom, etc. EPSTEIN spent most of the day with his defense counsel, and was brought down as soon as attorney visiting opened.

[redacted] was made aware of the possibility that EPSTEIN would be housed at MCC in advance of EPSTEIN'S arrival. [redacted] was not present when inmate EPSTEIN was admitted to the facility. EPSTEIN was thoroughly vetted to determine if he was fit for General Population (GP) and was ultimately placed in the Special Housing Unit (SHU). MCC places inmates under three categories of close supervision: 1. "Dry Cell" for those at risk for smuggling contraband, 2. Psychological Observation, and 3. Suicide Watch.

[redacted] advised that EPSTEIN preferred not to have a cellmate and engaged in manipulative behavior to avoid having one, including requesting to see a psychologist. At EPSTEIN'S request, he was interviewed by a psychologist. Following this assessment, EPSTEIN was initially placed on Suicide Watch. He was later interviewed again and downgraded to Psychological Observation, because he was determined not to have suicidal tendencies. After some time, he was returned to the SHU. [redacted] began hearing talk that EPSTEIN was trying to get back on Suicide Watch. Information like this is usually generated from rounds, "kites", and monitoring of phone calls and letters.

On or about July 23, 2019, EPSTEIN was found unresponsive on the floor of his cell with a homemade piece of fabric on his chest. EPSTEIN'S cellmate had flagged the attention of a staff member, who handcuffed the cellmate and removed EPSTEIN to bring him to the medical unit. [redacted] heard from his staff that EPSTEIN may have been faking unconsciousness, because he was observed opening his eyes and making other suspicious movements not consistent with an unconscious state. EPSTEIN was medically assessed and

became coherent. EPSTEIN claimed that his cellmate, [redacted], tried to take his life. He was placed back on Suicide Watch for approximately one week. Unlike his first and previous placement on Suicide Watch, EPSTEIN now has definitive suicidal tendencies reported in his incarceration history. The staff was tasked with determining whether EPSTEIN was in fact suicidal, or using manipulative tactics to avoid assignment of a cellmate. After Suicide Watch, EPSTEIN was placed on Psychological Observation and eventually returned to the SHU.

At the direction of the Warden, [redacted] initiated the process of compiling possible cellmates for EPSTEIN, vetting them, and submitting candidates to the Warden for his review. [redacted] and his staff fully screened potential cellmates and reported their determinations up to the Warden. [redacted] was selected and housed in a cell with EPSTEIN. The Assistant Warden, Warden, and Regional Director were notified.

The Warden directed [redacted] on multiple occasions that EPSTEIN needed a cellmate at all times, and [redacted] verbally informed his Lieutenants the same. [redacted] repeatedly directed his SHU Lieutenant, Lieutenant [redacted], that EPSTEIN needed a cellmate at all times. Additionally, [redacted] visited the SHU on multiple occasions and directed staff to be very alert and attentive about EPSTEIN'S special accommodations.

On Friday, August 9, 2019, Lieutenant [redacted] was on leave and, thus, there was no dedicated Lieutenant assigned to the SHU. In this event, the Operation Lieutenant, Lieutenant [redacted], had oversight that day and took over the responsibilities of the SHU Lieutenant. Lieutenant [redacted] was aware that EPSTEIN was required to be housed with a cellmate, because approximately one week prior to EPSTEIN'S death, [redacted] informally advised his Lieutenants that EPSTEIN was not be housed alone, and emphasized the need to be vigilant about "30-minute checks" and unannounced rounds.

Inmates/cellmates are moved for various reasons, including but not limited to, an incident in the cell, visits to court, legal library, medical, and recreation. On Friday, August 9, 2019, EPSTEIN'S cellmate, [redacted], had court. It would not be uncommon for [redacted] to be out of his cell for an extended period. EPSTEIN had an attorney session that day. EPSTEIN'S attorney was processed into the facility in the morning and EPSTEIN was brought down to the attorney room. [redacted] was not notified that

[redacted] was released from court.

Typically, if an inmate is likely to be discharged or transferred following court, their property is retrieved from their cell, boxed, and secured with a property form by Receiving and Discharge staff. All items are normally accounted for and inventoried. In order to enter the SHU, all staff not assigned there must identify themselves and sign the logbook, then be physically escorted by a Correctional Officer. Alternatively, the staff can pick up inmate property at the Unit door. A Correctional Officer assigned to the SHU would have been aware that [redacted], or any inmate's, belongings were removed. At this time, the Correctional Officer should notify a Lieutenant, who would in turn brief [redacted]. [redacted] was not notified that [redacted]' belongings were removed. [redacted] advised that if he had known that EPSTEIN was without a cellmate, he would have likely put EPSTEIN on Psychological Observation. [redacted] is not aware of any Lieutenants knowing that [redacted]' property was moved.

On Saturday, August 10, 2019, [redacted] received a phone call from Lieutenant [redacted] around 7:00 AM, and was told that EPSTEIN was found unresponsive in his cell. [redacted] inquired about EPSTEIN'S cellmate and was surprised to hear [redacted] respond that EPSTEIN did not have a cellmate.

[redacted] worked a 4:00 PM - 10:00 PM shift on August 9, 2019. [redacted] was relieved by Lieutenant [redacted], who was assigned the 10 PM - 6 AM shift. [redacted] did not personally tell [redacted] that EPSTEIN required a cellmate at all times. He believed she was aware because he had informed his Lieutenants repeatedly, and instructed them to pass this message along and convey the information amongst themselves. [redacted] did not hold a formal all-Lieutenant meeting regarding EPSTEIN, or send a staff email with the Warden's directive. He verbally instructed his Lieutenants on an informal and individual basis, as many as possible with whom he had the opportunity. On Saturday morning, August 10, 2019, [redacted] was relieved early by [redacted].

In the SHU, 30-minute rounds need to be completed consistently at nonuniform intervals within a 40-minute time frame. The purpose of these rounds is to ensure that good order is being maintained, there is no suspicious activity, and all inmates are accounted for and responsive. 30-minute rounds are documented in TRUSCOPE, which serves as an electronic logbook. After a round is physically done, the Correctional Officer can log

in to TRUSCOPE and press a button certifying that the round was completed. Unfortunately, sometimes officers do not complete a 30-minute round, or exceed the 40-minute threshold. TRUSCOPE also documents from what location/terminal the rounds are logged. [redacted] is aware of at least two (2) terminals located in the SHU. The only way to determine if a 30-minute round was physically completed is to check the video surveillance footage.

There are two (2) Correctional Officers assigned to the SHU on morning watch at midnight, SHU1 and SHU2. SHU2 is responsible for completing rounds.

[redacted] was unaware that the camera system in the SHU was down. He left early on Thursday when the discussion about the camera system would have occurred. MR. [redacted], the camera technician, notified [redacted] that he was working on the system earlier that week, but [redacted] did not know specifics and was not informed that the cameras were not functioning. Since the building is in the middle of a camera project, [redacted] assumed the camera work may have been related. [redacted] was first notified that the cameras were down on Saturday morning, August 10, 2019, when he arrived at MCC and asked to see the video. Correctional Officers do not typically know when the cameras are down.

After receiving the phone call from [redacted] on the morning of Saturday, August 10, 2019, [redacted] notified Associate Warden [redacted], who informed the Warden. [redacted] also attempted to call Institution Duty Officer [redacted], the Chaplain, and the building, to get more information. He then went to MCC, arriving before 8:00 AM, approximately. Upon arrival, [redacted] screened in and retrieved his gear from the 3rd Floor. He went to the SHU and signed the logbook. He gathered any records pertaining to EPSTEIN, including the 30-minute rounds logbook, the attorney conference logbook, count slips, and E1's. He could not locate EPSTEIN'S inmate file. He also asked to view the camera footage. The Warden was already present at the facility when [redacted] arrived.

[redacted] expressed to [redacted] that the staff admitted to her they did not complete rounds, the 3:00 AM and 5:00 AM counts, and that Officer [redacted] entered EPSTEIN'S cell without supervision. EPSTEIN was placed on the floor to administer lifesaving efforts. [redacted] informed Associate Warden [redacted] about what Officers [redacted] admitted to [redacted].

[redacted] had concerns about the whereabouts of EPSTEIN'S cellmate. Some of his staff were under the impression that [redacted] was released from the SHU, which [redacted] later confirmed was not true.

The purpose of the 3:00 AM and 5:00 AM counts is to physically count and confirm each person in each cell. There were no entries of counts in TRUSCOPE the entire night. If technology is down, the Correctional Officers also have the option to document the count on a hardcopy form. Although there are no electronic records of counts, hardcopies may have been retained.

All inmate phone calls in the SHU are monitored and inmates have limited access to phone calls. All calls should be recorded. [redacted] was not aware of any issues or complaints with EPSTEIN related to phone calls. On Saturday, August 10, 2019, [redacted] was told that EPSTEIN made a phone call at approximately 7:00 PM on the evening of Friday, August 9, 2019. It is uncommon to make an unrecorded phone call in the SHU, and [redacted] would advise against it because calls should be surveilled. Inmates can make a recorded phone call in the Lieutenant's Office, where it is documented in a monitored logbook. In the SHU, Correctional Officers are not permitted to give inmates phone calls, but a Unit Team Member or the Chaplain can take the inmate to the Lieutenant's office to make a call. [redacted] is not briefed on phone calls in the SHU, generally.

[redacted] wholeheartedly emphasized that he and his staff at MCC did their best to supervise, safeguard and ensure the protection of EPSTEIN and all inmates effectively. His staff is aware of the seriousness of the investigation into EPSTEIN'S death.