FEDERAL BUREAU OF INVESTIGATION

Date of entry 09/04/2019

DR. [redacted], date of birth (DOB) 08/17/1969, was interviewed at 1 Saint Andrews Plaza, New York, NY, 10007 (US Attorney's Office, Southern District of New York). Present at the interview was Office of the Inspector General (OIG) Special Agent (SA) [redacted], Assistant U.S. Attorney (AUSA) [redacted], and FBI SA [redacted]. After being advised of the identity of the interviewing Agents and the nature of the interview, DR. [redacted] provided the following statement:

DR. [redacted] is the Chief Psychologist at the Metropolitan Correctional Center (MCC). Her background includes: a Bachelor's degree in Criminology, a Master's in Mental Health Counseling, a Master's in Clinical Counseling, and a Doctorate. DR. [redacted] was the staff psychologist at East Jersey State Prison for two years, she completed a one year Post-Doctoral Fellowship, an internship working at an in / out patient mental health treatment center, and she did an externship at Federal Detention Center in Miami working with a battered women's program. DR. [redacted] worked as a staff psychologist at the Metropolitan Detention Center (MDC) Brooklyn from 2003-2006, and as a Forensic Psychologist from 2006-2008. DR. [redacted] has been the Chief Psychologist at MCC for the last 11 years.

DR. [redacted] oversees three forensic psychologists, one staff psychologist, a drug abuse coordinator, and a drug treatment specialist. Her duties include ensuring all patients are seen and the appropriate documentation is completed. She consults on individual cases as needed. She ensures the forensic reports are out on time. She reviews all the reports she signs off on. At this time, DR. [redacted] is seeing more patients then she normally does due to staffing. Her typical hours are 7a.m.-3:30p.m., Monday - Friday.

DR. [redacted] provided information on the intake process as it relates to Psychological Services at MCC. All inmates complete the Psychological Services Intake Questionnaire (PSIQ) themselves. It asks for the inmates

mental health history, as well as any symptoms they are feeling at that time. Based off the PSIQ, inmates are rated a 'Care Code' rating.

Code 1 means there are no concerns about the inmate's mental health status. They have no needs, and will not be followed up with unless requested to by either the inmate themselves, or staff.

Code 2 means there is some history of mental health issues, but the inmate has them under control. Psychological Services will follow up with these individuals monthly.

Code 3 are more severe cases and they are seen every week by Psychological Services to ensure the inmate is stable. If the inmate isn't stable in general population, they will be moved to observation. If they continue to deteriorate, they will go to the hospital.

Code 4 inmates are seen everyday by Psychological Services, and are under constant psychological observation.

DR. [redacted] pointed out that a Code 1 can be on Suicide Watch. Often times those cases involve manipulation techniques used by inmates to get what they want from staff. For example if an inmate is not getting along with a guard, or they want a new cellmate, they will claim to be suicidal to get out of their housing area. If an inmate does this two or three times, they will be bumped to a Code 2 so that a psychologist will meet with them monthly.

Suicide Watch means an inmate is imminently suicidal. If an inmate is placed on suicide watch they are under constant watch by staff, they have a special mattress, blanket, and smock to wear,and their cell lights are on 24/7.

Suicide Observation is a lower classification, and is not at all Bureau of Prison (BOP) facilities. Everything is the same with suicide observation inmates, except they are allowed to have their clothing, and some materials such as books. Suicide Watch can be detrimental if a person is left on it for too long, so Observation is used to see how an inmate is doing before releasing them back to general population.

Any psychologist at the jail can take an inmate off of Suicide Watch, but they do consult with DR. [redacted] on occasion. Many times the executive staff

at the jail meet, and inmates' psychological status and services are discussed. Meetings are held on Mondays, Thursdays, and Fridays. Generally present at those meetings are DR. [redacted], the Warden, two Associate Wardens, Captain, Supervisory Attorney, Duty Officer, and the Executive Assistant. Department Head Meetings are held on Wednesdays.

DR. [redacted] completed the PSIQ for JEFFREY EPSTEIN on July 8, 2019. EPSTEIN did not mark anything on his PSIQ, and had it not been EPSTEIN, he would have been sent to general population and rated a Care Code 1. DR. [redacted] consulted with DR. [redacted] about EPSTEIN's risk factors aside from his psychological health including the high profile case and sex offense charges. When EPSTEIN returned from court that day, DR. [redacted] ordered he be placed on watch status to allow psychology to complete a thorough suicide risk assessment. (See Reference #1, attached to this report in a 1A, for further details.)

DR. [redacted] completed the Suicide Risk Assessment the next day. EPSTEIN was angry he was placed on observation, but he continued to report no history of suicidally, no substance abuse, no major medical concerns,and no overt risk factors. EPSTEIN was polite but annoyed with DR. [redacted]. EPSTEIN was kept in observation pending a suitable housing placement given his risk factors of being an alleged sex offender, high profile crime, and having one living brother/relative. She quoted EPSTEIN as saying "being alive is fun." DR. [redacted] believed it was a genuine statement. (See Reference #2, attached to this report in a 1A, for further details).

DR. [redacted] provided the interviewing Agents with a copy of the Suicide Risk Assessment which was placed into this case as Reference #3, attached to this report in a 1A.

On July 10, 2019 DR. [redacted] met with EPSTEIN in Observation. EPSTEIN was still in Observation due to housing concerns. He continued to be psychologically stable at that time. EPSTEIN was aware even if he got bail, he would be at MCC for several more weeks. EPSTEIN made several demands and voiced many complaints to DR. [redacted], which she passed onto executive staff.

EPSTEIN's cellmate for the Special Housing Unit (SHU) was decided by the Warden and Associate Warden. DR. [redacted] was not included on that decision. Her thought was the decided upon cellmate, TARTAGLIONE, had a lot to lose

given his history and charges, which made him low risk to EPSTEIN.

On July 11, 2019, EPSTEIN was taken off observation and housed in the SHU. DR. [redacted] met with EPSTEIN in the attorney conference rooms that day because EPSTEIN was there all day. Both EPSTEIN and his attorney were mocking DR. [redacted] for thinking EPSTEIN was suicidal. EPSTEIN continued to make demands such as wanting to wear a brown uniform to his attorney meetings. DR. [redacted] continued to pass those concerns onto the SHU Lieutenant(LT)[redacted]

On July 16, 2019, after EPSTEIN's bail hearing, he called for DR. [redacted] to come to attorney conference. EPSTEIN didn't report any psychological concerns, but chastised her because his needs weren't being met. DR. [redacted] felt EPSTEIN thought of her as his personal assistant. EPSTEIN requested a Kosher diet, which she again passed on.

On July 18, 2019, a SHU review was attempted on EPSTEIN, but he was not seen because he was in attorney conference.

On July 23, 2019, DR. [redacted] received a phone call regarding EPSTEIN because he was found in his cell with a loose noose around his neck and had been placed on Suicide Watch. She ordered a suicide risk assessment be completed on him. DR. [redacted] completed the Suicide Risk Assessment later that morning. During the assessment EPSTEIN told DR. [redacted] he did not remember what happened. He denied suicidality, had future plans, he wanted to learn, he wanted to fight his case, and he was "acting like a big kid." DR. [redacted] learned that EPSTEIN had told staff that his cellmate, TARTAGLIONE, had tried to kill him. DR. [redacted] kept EPSTEIN on Suicide Watch.

DR. [redacted] had three hypotheses, in no particular order, regarding what this incident meant:

1.) It was gaming by either EPSTEIN, TARTAGLIONE, or both, meaning there was something they wanted that they weren't getting, so this was how they were going to play the system to their advantage.

2.) It was a rehearsal by EPSTEIN, who really was suicidal.

3.) It was an assault committed by TARTAGLIONE.

On July 24, 2019, DR. [redacted] met with EPSTEIN. EPSTEIN reported he was

fearful to return to his cell with TARTAGLIONE because TARTAGLIONE had called him a pedophile. EPSTEIN reported TARTAGLIONE had been playing with a bedsheet before EPSTEIN fell asleep, and then next thing EPSTEIN remembered was waking up snoring. EPSTEIN denied being suicidal and reported being unhappy with his legal situation. He had been eating, drinking, and sleeping. DR. [redacted] took EPSTEIN off Suicide Watch, and placed him on Psychological Observation.

At that time, DR. [redacted] was not any clearer on which of her hypotheses might have been true. EPSTEIN could have been using his charm to create doubt about what happened. Psychology had not been contacted by EPSTEIN's attorneys with any concerns regarding his mental health.

On July 25, 2019, DR. [redacted] met with EPSTEIN, who was in good spirits and greeted her by saying "welcome back." DR. [redacted] confronted EPSTEIN on the attempted suicide incident in an attempt to get answers. EPSTEIN said he was baffled over it, and told DR. [redacted] to give him some cues to help him remember. He continued with his requests and complaints, and did not want to go back to SHU. EPSTEIN told DR. [redacted] "I have a life and want to go back living my life." DR. [redacted] kept him on Observation because her questions had not been answered regarding the suicide attempt.

After a conversation with DR. [redacted], the National Suicide Prevention Coordinator from Central Office, DR. [redacted] got involved in EPSTEIN's housing. DR. [redacted] recommended housing EPSTEIN with a sex offender in SHU, which DR. [redacted] passed on via email to executive staff. (See email in Reference #6, attached to this report in a 1A.)

On July 26, 2019, DR. [redacted] met with EPSTEIN. EPSTEIN said he needed to establish trust with DR. [redacted]. He continued with complaints and jokes, making reference to DR. [redacted] being Jewish like him. It is against the Jewish religion to commit suicide. EPSTEIN said he did not like pain and didn't want to hurt himself. EPSTEIN had been interacting with the companions assigned to him regularly.

On July 27, 2019, DR. [redacted] met with EPSTEIN, who was anxious about going back to SHU due to the fact he did not know how he got the marks. EPSTEIN did not answer DR. [redacted] questions about that night. She had begun working more therapeutically with him, and provided him with handouts to cope with

housing. LT. DOCTOR's investigation into a possible assault regarding this incident still had not returned any answers. DR. [redacted] kept EPSTEIN on Psychological Observation.

On July 28, 2019, DR. [redacted] met with EPSTEIN, who appeared the same. His logbooks showed no signs of suicidality, and he was participating in his legal meetings. There had been no contact from EPSTEIN's legal team regarding any mental health concerns.

On July 29, 2019, DR. [redacted] visited EPSTEIN. EPSTEIN expressed that he would like to stay in Psychological Observation because it is "safe." EPSTEIN had been requesting his CPAP machine so that he could get a good night's sleep. Due to the machine having a cord, this could not be accommodated in Psychological Observation. EPSTEIN was given a choice to stay in Psychological Observation one more night without it, or go to SHU with it. He chose to stay in Psychological Observation one more night. DR. [redacted] consulted with executive staff prior to this decision.

On July 30, 2019, DR. [redacted] transitioned EPSTEIN back to the SHU. DR. [redacted] sent an email updating the appropriate staff of EPSTEIN's transition off Psychological Observation and the need for him to be housed with a cellmate. (See Reference #7, attached to this report in a 1A.)

DR. [redacted] discussed the importance of SHU inmates having a cellmate for the following reasons:

1.) decreases isolation

2.) decreases privacy

3.) provides a distraction

4.) provides a rescue opportunity

At risk settings for inmates include restrictive housing, single cells, and private spaces. SHU employees receive training on suicide prevention quarterly. All employees receive suicide prevention training once a year.

DR. [redacted] provided slides from MCC's suicide prevention training to the interviewing Agents, referred to as References #8 and #9, attached to this report in a 1A, which highlight the above information. She stated all

lieutenants should be aware of the cellmate policy both due to the training regularly provided, and Psychological Services constantly reminding them of the procedure and needs of specific inmates. DR. [redacted] noted after EPSTEIN's death, his old cellmate's label was still on his door. That is one of the things the psych department looks for in their daily rounds in the SHU - that there are two bodies in each cell.

DR. [redacted] was aware that DR. [redacted] attended the closeout meeting that week, and discussed EPSTEIN's desire to have a single cell, but his need for a cellmate.

DR. [redacted] was unaware regular rounds by the correctional officers were not being completed. She is considered executive staff, so officers would not tell her they were not being completed, and inmates wouldn't tell her because of fear of retaliation by the guards. DR. [redacted] noted LT. [redacted] is very regimented, and regularly does what she asks.

DR. [redacted] was not aware that EPSTEIN signed a new will on August 8. Had she known, it would have been considered a red flag, and EPSTEIN would have been placed on Psychological Observation. The attorneys did not tell anyone from Psychological Services that it had occurred.

On August 8, 2019, DR. [redacted] attended the SHU meeting. She couldn't recall all who was there, but it included unit team members, executive staff, and attorneys for MCC. Nothing significant was discussed about EPSTEIN at the meeting. She conducted SHU rounds to see EPSTEIN. He had a cellmate at that time, and EPSTEIN had the lower bunk. He didn't have any visible problems, appeared in good spirits, and reported getting along with his cellmate. He had received his PAC number which allows him to make phone calls, and he asked for his books from Psychological Observation.

DR. [redacted] never suggested a cell room with a camera for EPSTEIN because she wanted him to have a cellmate. Rooms with cameras aren't always perfect due to the guard having to maintain a constant eye on the camera screen. She noted she has never gone to attorney conference for any other patients / inmates. She believes MCC Psychological Services did all they could for EPSTEIN, and ultimately the lack of a cellmate and understaffing contributed to his death. Three suicide risk assessments were completed on EPSTEIN, which is unusual. One of those was completed due to a judge's order.