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Attorney for Defendant

IN THE
UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

UNITED STATES OF AMERICA	:	
v.	:	NO. 07-258
LLOYD WASHINGTON	:	

DEFENDANT LLOYD WASHINGTON'S SUPPLEMENTAL MOTION FOR COMPASSIONATE RELEASE UNDER 18 U.S.C.§3582(c)(1)(A)

Defendant, Lloyd Washington, by and through his attorney, Hope C. Lefeber, respectfully moves this Honorable Court to grant this motion for compassionate release pursuant to 18 U.S.C. §3582(c)(1)(A) and to provide that the remaining months of incarceration be either vacated, modified to time served or servable as home confinement.

1. Since the filing of Mr. Washington's initial Motion and Memorandum on Monday, April 20, 2020, the number of inmates in BOP custody that are infected with COVID-19 has more than DOUBLED and the inmate deaths have increased by 25%. On April 20, 2020, there were 495 infected inmates, 309 infected staff and 22 inmate deaths. As of April 27, 2020 there are 1,046 infected inmates, 330 infected staff and 28 inmate deaths. https://www.bop.gov/coronavirus/

BACKGROUND

2. Defendant Washington is currently in the Satellite Camp at FCI Beckley, Beaver, West Virginia. He is 50 years old and suffers from Type II Diabetes, severe obesity, hypertension, cardiovascular disease (hyperlipidemia), Type II diabetes related neuropathy and sinus disease (allergic rhinitis). (Medical records are attached hereto and marked Exhibit "A")[1]. All of these medical conditions are recognized risk factors for severe illness from COVID-19 by the CDC.[2] As a result of his multiple risk factors, as recognized by the CDC, he is at heightened risk of severe illness and possible death from COVID-19.

3. On July 30, 2009, Mr. Washington was found guilty, by a jury, of conspiracy to distribute cocaine and attempted possession with intent to distribute cocaine. He was sentenced to 192 months (16 years) of imprisonment. His projected release date is November, 2022, but he was advised by his counselor that he would be released to home confinement in May, 2022. Therefore, he has approximately two years' imprisonment remaining on his sentence.

4. On or about April 10, 2020, Mr. Washington placed two (2) formal requests in the prison mailbox wherein he formally requested that he be transferred to home confinement in light of his serious medical conditions and the COVID-19 pandemic. The formal requests were based upon 1) the BOP Furlough Policy under the CARES Act; and 2) Compassionate Release. He further emailed the Warden to advise that he had made written submissions.

5. On April 15, 2020, the undersigned sent a letter to the Warden of FCI Beckley, requesting that Mr. Washington be released pursuant to the CARES Act and Barr Memorandum. A copy of the letter to the Warden is attached hereto and marked "Exhibit "B."

6. On April 24, 2020, the undersigned supplemented the above letter to the Warden of FCI Beckley, requesting that Mr. Washington be released pursuant to the compassionate release provisions of 18 U.S.C. §3582(c)(1)(A). A copy of the letter to the Warden is attached hereto and marked "Exhibit "C."

7. As of this date, no response has been received to either Mr. Washington's requests nor to those of the undersigned.

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[1] More detailed medical records that confirm the findings in Exhibit "A" were obtained by the government and can be provided to the Court under seal.

[2]Center for Disease Control and Prevention, *Coronavirus Disease 2019 (COVID-19): At Risk for Sever Illness* (April 28, 2020) *available at* https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html

THE LEGAL STANDARD

8. Under Section 3582, as amended by the First Step Act, Pub. L. No. 115-391, 132 Stat. 5194 (Dec. 21, 2018), a court may modify a defendant's sentence "upon motion of the defendant after the defendant has fully exhausted all administrative rights to appeal a failure of the [BOP] to bring a motion on the defendant's behalf or the lapse of 30 days from the receipt of such a request by the warden of the defendant's facility, whichever is earlier." 18 U.S.C. § 3582(c)(1)(A). Upon such a motion, a court may modify a defendant's sentence "after considering the factors set forth in §3553(a) to the extent applicable" if it finds "extraordinary and compelling reasons warrant such a reduction" and "such a reduction is consistent with applicable policy statements issued by the Sentencing Commission." *Id.* § 3582(c)(1)(A)(i).

9. Upon such a motion, a court may modify a defendant's sentence "after considering the factors set forth in §3553(a) to the extent applicable" if it finds "extraordinary and compelling reasons warrant such a reduction" and "such a reduction is consistent with applicable policy statements issued by the Sentencing Commission." *Id.* § 3582(c)(1)(A)(i).

10. The relevant Sentencing Commission policy statement sets forth several "extraordinary and compelling reasons." U.S. Sentencing Guidelines, § 1B1.13(1)(A) & cmt. 1. One of these reasons is whether the defendant is "suffering from a serious physical or medical condition…that substantially diminishes the ability of the defendant to provide self-care within the environment of a correctional facility and from which he or she is not expected to recover." *Id.* § 1B1.13 cmt. 1(A)(ii). The Commission also requires that the defendant not pose a danger to the safety of the community. *Id.* § 1B1.13(2).9.

EXTRAORDINARY AND COMPELLING REASONS UNDER 18 U.S.C. § 3582(c)(1)(A)(i)

11. As stated above, Mr. Washington is 50 years old and suffers from Type II Diabetes, severe obesity hypertension, cardiovascular disease (hyperlipidemia), Type II diabetes related neuropathy and sinus disease (allergic rhinitis).

12. The CDC has defined Severe Obesity to be a BMI of 40 or higher. Mr. Washington's BMI is 45.9. The CDC guidance states that "COVID-19: Severe Obesity (a BMI of 40 or Higher) may raise risk of severe illness. https://www.cdc.gov/obesity/adult/defining.html *See also* https://www.physiciansweekly.com/largest-us-study-of-covid-19-obesity-biggest-chronic-factor/ Obesity Single Largest Chronic Factor, NYU Grossman School of Medicine.

13. Dr. Steven Edelman, Professor of Medicine, Department of Endocrinology and Diabetes, has opined [3] that "people with Type II diabetes are "especially vulnerable to both contracting COVID-19 and suffering the severe consequences of COVID-19 if they are infected, with rare exception." *See* Affidavit of Dr. Steven Edelman, April 19, 2020, ¶18, attached hereto as Exhibit "D." Dr. Edelman further states that people with Type 2 diabetes are more vulnerable to contracting COVID-19 as a result of reduced immunity derived from their type 2 diabetes, and because such persons are more likely to suffer serious and deadly consequences of COVID-19 as a result of particular co-morbidities seen in this population. *Id.*. at ¶11. *See also: "*Diabetes is a risk factor for the progression and prognosis of COVID-19." https://www.ncbi.nlm.nih.gov/pubmed/32233013 and https://www.diabetes.org/sites/default/files/2020-03/COVID-19%20Letter%20to%20Detention%20Centers.pdf

14. Dr. Chris Beyrer, Professor of Epidemiology, Int'l Health and Medicine at the Johns Hopkins Bloomberg School of Public Health, has opined [4] that comorbidities, including, but not limited to diabetes and cardio-vascular disease, individuals over 50 years old put them at a higher risk to contract and suffer acute disease and a higher case fatality rate if infected with COVID-19. Declaration of Dr. Beyrer, attached hereto, and marked Exhibit "E").

15. Similarly, Dr. Marc Stern[5], a board-specialized internal medicine physician, specializing in correctional health care and former Assistant Secretary for Health Care at the Washington State System, has opined[5] that people over age 50 with hypertension, diabetes, blood, lung, and heart disease are especially vulnerable and can experience severe respiratory illness, as well as damage to other major organs if they are infected with COVID-19. Declaration of Dr. Stern, attached hereto, and marked Exhibit "F").

16. Dr. Edelman, *supra*., has opined that "Death due to COVID-19 infection is more likely for those with diabetes because viral infection makes them more susceptible to pneumonia, kidney failure and diabetic ketoacidosis. Exhibit "D" at ¶14.

17. Prisoners are particularly vulnerable to infection. Center for Disease Control, Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities (Mar. 23, 2020. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

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[3] The Affidavit of Dr. Steven Edelman was submitted to the Court in *United States v. Perez Felix,* No. 18-cr-10468 (D.C. Mass)(April 20, 2020)(DE #402).

[5] [4]The Declaration of Dr. Chris Beyrer was submitted to the Court in *United States v. Joling*, No. 15-cr-113 (D.C. Oregon)(April 17, 2020).

[5] The Declaration of Dr. Marc Stern was submitted to the Court in *United States v. Hammond*, No. 02-294 (D.C.D.C.)(April 16, 2020)(DE #44-5).

18. As of Monday, April 28, 2020, 1,046 inmates are infected with COVID-19, 330 staff are infected and 28 inmates have died. There are COVID-19 infections in approximately half of the BOP facilities. https://www.bop.gov/coronavirus/

19. It is likely that the above-cited numbers significantly underrepresent the true level of contagion and disease in the federal prisons, as there is no testing going on in many BOP facilities; there is none at FCI Beckley, where Mr. Washington is. The BOP has frankly acknowledged that it is not testing every suspected infection. Walter Pavlo, Bureau Of Prisons Underreporting COVID-19 Outbreaks In Prison, FORBES(Apr. 1, 2020), https://www.forbes.com/sites/walterpavlo/ 2020/04/01/bureau-of-prisons-underreporting-outbreaks-in-prison/#7c9d4637ba32

20. In sum, the exponential infection rate of COVID-19 and high mortality rate for those with Mr. Washington's conditions, coupled with the likely inability of the BOP to address a surge in cases, and prevent widespread infection due to the inability of inmates to practice "social distancing" and proper hygiene to prevent the spread of COVI-19, make it clear that these factors constitute an extraordinary and compelling reason to modify his sentence from his remaining term of incarceration to home detention.

21. Other courts have also found that an extraordinary and compelling reason exists under similar situations:

- United States v. Rodriguez, No. 2:03-cr- 00271, 2020 WL 1627331, at *2 (E.D. Pa. Apr. 1, 2020) (granting compassionate release because for a diabetic inmate, "nothing could be more extraordinary and compelling than this pandemic")

- United States v. Park, No. 16-cr-473, 2020 WL 1970603 (S.D. N.Y. April 24, 2020) (Opinion and Order granting compassionate release based upon COVID-19)

- Samy v. United States, No. 2:16-cr-20610-1, 2020 WL 1888842 (E.D. Mich Apr. 16, 2020) (Order granting petitioner's motion for reconsideration of order denying compassionate release based in part on COVID-19) Dkt 88
- United States v. Hammond, No. 1:02-cr-00294-BAH-1, 2020 WL 1891980 (D.D.C. Apr. 16, 2020) (Memorandum and Indicative Ruling, granting compassionate release based in part on COVID-19, if Court of Appeals remands), Dkt. 51

- United States v. Coker, No. 3:14-CR-085-RLJ-DCP-20, 2020 WL 1877800 (E.D. Tenn. Apr. 15, 2020) (Memorandum Opinion, granting compassionate release based in part on COVID-19), Dkt. 868

- United States v. Cosgrove, No. 2:15-cr-00230-RSM-1, 2020 WL 1875509 (W.D. Wash. Apr. 15, 2020) (Order Granting Defendant's Motion for Reconsideration, granting compassionate release in part based on COVID-19), Dkt. 95

- United States v. Kataev, No. 1:16-cr-00763-LGS-5 (S.D.N.Y. Apr. 14, 2020) (Amended Order, granting compassionate release in part based on COVID-19), Dkt. 779

- United States v. Wen, No. 6:17-CR-06173, 2020 WL 1845104 (W.D.N.Y. Apr. 13, 2020) (Decision and Order, granting compassionate release in part based on COVID-19), Dkt. 106

- United States v. Smith, No. 1:12-cr-00133-JFK-1, 2020 WL 1849748 (S.D.N.Y. Apr. 13, 2020) (Opinion and Order, granting compassionate release based in part on COVID-19), Dkt. 197

- United States v Ben-Yhwh, No. 11:15-cr-00830-LEK-1, 2020 WL 1874125 (D. Hawaii Apr. 13, 2020) (Amended Order, granting in part and denying in part defendant's emergency motion to modify sentence for compassionate release based in part on COVID-19), Dkt. 206

- United States v. Tran, No. 8:08-cr-00197-DOC, 2020 WL 1820520 (C.D. Cal. Apr. 10, 2020) (Order re: Motion Emergency Motion to Reduce Sentence, granting compassionate release in part based on COVID-19), Dkt. 405

- United States v. Burrill, No. 17-cr-00491-RS-2, 2020 WL 1846788 (N.D. Cal. Apr. 10, 2020) (Order Granting Emergency Motion for [Compassionate] Release, based in part on COVID-19), Dkt. 308

- United States v. Hernandez, No. 18-CR-834, 2020 WL 1684062, at *3 (S.D.N.Y. Apr. 2, 2020) (finding "extraordinary and compelling reasons" to reduce the defendant's sentence due to defendant's asthma and the "heightened medical risk presented to [the defendant] by theCOVID-19 pandemic")

- United States v. Gonzalez, No. 18- CR-1536155, 2020 WL 1536155, at *3 [(E.D. Wash. Mar. 31, 2020)] (approving compassionate release where defendant "is in the most susceptible age category (over 60 years of age) and her COPD and emphysema make her particularly vulnerable")

- US v. Copeland, No. 2:05-cr-00135-DCN (D.SC Mar 24, 2020)
  Order, granting compassionate release for 73-year-old with severe health conditions under the First Step Act, as "[g]iven defendant's tenuous health condition and age, remaining incarcerated during the current global pandemic puts him at even higher risk for severe illness and possible death, and Congress has expressed its desire for courts to release individuals the age defendant is, with the ailments that defendant has during this current pandemic"), Dkt. 662

- US v. Mace, No. 4:17-cr-00618-DJB (SD TX April 1, 2020)
  Order for Reduced Sentence and Release to Home Confinement), Dkt. 56

- US v. Perez, No. 1:17-cr-513-3-AT (S.D.N.Y. Apr 1, 2020)
  Order Granting Sentence Reduction CR Sentence reduced to time served with supervised release beginning immediately; "The Court holds . . . that Perez's exhaustion of the administrative process can be waived in light of the extraordinary threat posed--in his unique circumstances--by the COVID-19 pandemic.")

- US v. Muniz, No. 4:09-cr-199-DJB (S.D.Tex. Mar 30, 2020)
  Order Granting CR, Dkt. 578 releasing defendant serving 188-month sentence for drug conspiracy in light of vulnerability to COVID-19)

- US v. Jepsen, No. 3:19-cr-00073(VLB), 2020 WL 1640232 (D. Conn. Apr. 1, 2020)
  ("Mr. Jepsen is in the unique position of having less than eight weeks left to serve on his sentence, he is immunocompromised and suffers from multiple chronic conditions that are in flux and predispose him to potentially lethal complications if he contracts COVID-19, and the Government consents to his release. The Court finds that the totality of the circumstances specific to Mr. Jepsen constitute 'extraordinary and compelling reasons to grant compassionate release.")

- US v. Williams, No. 3:04-cr-95-MCR (N.D. Fla. Apr. 1, 2020)
  ("Williams' cardiovascular and renal conditions compromise his immune system, which, taken with his advanced age, put him at significant risk for even more severe and life threatening illness should he be exposed to COVID-19 while incarcerated.... Based on these facts, the Court finds that Williams' deterioration in physical health is sufficiently serious to satisfy the medical criteria for a reduction in sentence.")

- US v. Resknik, No. 1:12-cr-00152-CM (S.D.N.Y. Apr. 2, 2020)
  ("Releasing a prisoner who is for all practical purposes deserving of

compassionate release during normal times is all but mandated in the age of COVID-19")

- US v. Brannan, No. 4:15-CR-80-01 (S.D. Tx. Apr. 2, 2020)
  (though not reflected in order, emergency motion was granted on same day of filing for prisoner who had served only 9 months of a 36-month sentence for fraud at FCI Oakdale and had not exhausted BOP remedies)

- US v. Colvin, No. 3:19cr179 (JBA), 2020 WL 1613943 (D. Conn. Apr. 2, 2020)
  ("She has **diabetes**, a 'serious ... medical condition,' which substantially increases her risk of severe illness if she contracts COVID-19.... Defendant is 'unable to provide self-care within the environment of' FDC Philadelphia in light of the ongoing and growing COVID-19 pandemic because she is unable to practice effective social distancing and hygiene to minimize her risk of exposure, and if she did develop complications, she would be unable to access her team of doctors at Bridgeport Hospital. In light of the expectation that the COVID-19 pandemic will continue to grow and spread over the next several weeks, the Court concludes that the risks faced by Defendant will be minimized by her immediate release to home, where she will quarantine herself.")

- US v. Foster, No. 1:14-cr-324-02 (M.D. Pa. Apr. 3, 2020)
  ("The circumstances faced by our prison system during this highly contagious, potentially fatal global pandemic are unprecedented. It is no stretch to call this environment 'extraordinary and compelling,' and we well believe that, should we not reduce Defendant's sentence, Defendant has a high likelihood of contracting COVID-19 from which he would "not be expected to recover." USSG SS 1B1.13. No rationale is more compelling or extraordinary.

22. The prison conditions where Mr. Washington is housed are dormitory like with approximately 50 people sleeping in the same rooms, using the toilets and showers together, living together and eating together. They share common computers, televisions and telephones which are not sanitized after each use. Hand sanitizer is not available to Mr. Washington, nor is any other available means of preventing infection by cleaning any commonly used surface – toilets, knobs, handles, telephones, computers, etc. There is no personal protection equipment available at FCI Beckley. *See* CDC, *Get Ready for COVID-19* (Mar. 17, 2020), https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/get-ready.html (recommending that people who are at high risk for severe illness avoid crowds and "stay home as much as possible to further reduce your risk of being exposed"); *see also* CDC, *Steps to Prevent Getting Sick* (Mar. 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/get-ready.html (instructing people to avoid crowds and "avoid touching high-touch surfaces" and explaining that the risk of exposure

to COVID-19 increases in "crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.").

23. Dr. Edelman has opined that "it is especially critical that persons with type 2 diabetes …. observe strict social distancing and maintain cleanliness, including frequent hand-washing, use of sanitizer, and the use of personal protection equipment such as masks when held in settings where they are exposed to other individuals. Wearing plastic gloves at times of potential contact with surfaces exposed to the virus is also critical. Exhibit "D" at ¶13.

24. Should Mr. Washington contract COVID-19, the results may be devastating. Vulnerable people at high risk, such as Mr. Washington, who contract COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. https://www.hopkinsmedicine.org/health/conditions-and-diseases/coronavirus/coronavirus-and-covid19-who-is-at-higher-risk diseases/coronavirus/coronavirus-and-covid19-who-is-at-higher-risk

25. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support." *Id.* Ventilators are currently in short supply in the United States; if Mr. Washington falls ill, there is no guarantee and it is unlikely that he will have access to one in prison. https://www.nytimes.com/2020/03/18/business/coronavirus-ventilator-shortage.html

26. As such, Mr. Washington is suffering from a "serious physical and medical condition that substantially diminishes the ability of the defendant to provide self-care within the environment of a correctional facility..." Due to his multiple high risk factors, he is more vulnerable to contracting COVID-19. See Exhibits "C," "D," "E" and "F." Were he to become infected with COVID-19, it is likely that he will suffer severe respiratory illness, and organ failure from which he will would not be "expected to recover." USSG § 1B1.13.

OTHER CONSIDERATIONS

27. Mr. Washington is not a danger to the safety of any other person or to the community. He has served almost eleven years in custody and has had an excellent record of good conduct while in prison.[4] Although he was recently written up for a petty infraction, that

[4] The Disciplinary Records of the BOP are attached as Exhibit "G." While the records do not reflect any disciplinary infractions since 2012, when he received low level infractions for illegal possession of food, the undersigned believes that he recently received one for improper possession of food. This infraction, like the ones he received in 2012, is believed to be a 300 level infraction, the lowest level.

infraction involved Mr. Washington being in possession of food that he should not have had. Given his problem with obesity, this infraction is not an indication of any concern as to his ability to abide by rules.

28. A balancing of the factors set forth in 18 U.SC.§3553(a) weigh in favor of release at this time. They are:

> (1) The nature and circumstances of the offense and the history and characteristics of the defendant;
>
> (2) the need for the sentence imposed—
> (A) to reflect the seriousness of the offense, to promote respect for the law, and to provide just punishment for the offense;
> (B) to afford adequate deterrence to criminal conduct;
> (C) to protect the public from further crimes of the defendant; and
> (D) to provide the defendant with needed educational or vocational training, medical care, or other correctional treatment in the most effective manner;
>
> . . . [and]
>
> (6) the need to avoid unwarranted sentence disparities among defendants with similar records who have been found guilty of similar conduct[.]
> 18 U.S.C. § 3553(a).

29. The circumstances of Mr. Washington's offense were serious. Drug distribution is a serious threat to our society which requires deference to the seriousness of the offense and due respect for the law. However, he has already served more than his ten-year mandatory minimum and he would be eligible for release to home confinement in May, 2022, given his good time credits as calculated by the BOP. Therefore, he has served over 85% of his sentence.

30. The second factor, the need for the sentence imposed, must be viewed with an eye to "impose a sentence sufficient, but not greater than necessary…" 18 U.S.C. § 3553(a). Given the amount of time that Mr. Washington has served (85% of his sentence), there are conditions of home detention than can adequately provide the sanction of continued punishment.

EXHAUSTION UNDER §3582(c)(1)(A)

31. For all of the reasons set forth in the *Amicus Brief* of the National Association of Criminal Defense Lawyers, attached as Exhibit "A" to Defendant's Reply Brief (DE #524) and in Defendant's Notion and Memorandum (DE #522), the 30 day exhaustion requirement can be excused by this Court.

32. In addition, requiring Mr. Washington to exhaust his administrative remedies would be both futile and risk his health and life. There are "well-established exceptions to exhaustion," *Granberry v. Greer*, 481 U.S. 129, 134 (1987); *see also Association of Flight Attendants-CWA v. Chao*, 493 F.3d 155, (D.C. Cir. 2007) (listing exceptions for "irreparable injury," agency incompetence, and futility). The COVID-19 pandemic is an "exceptional circumstance of peculiar urgency."

33. The risk increases each day that Mr. Washington will experience "irreparable injury" if his motion is not ruled upon soon. As above, Mr. Washington's health conditions are exactly those factors that put an individual at most risk of death and serious injury from COVID-19. He is living alongside other inmates, in close and tight quarters, with no access to hygiene essentials to protect himself from infection and spread of disease from others. It is impossible for him to practice "social distancing" as mandated by the CDC. The numbers reported by the BOP are undoubtedly an undercount because in prison, just as in the rest of the United States, there are not enough tests.

34. There is no testing for COVID-19 at FCI Beckley. Therefore, there are no reported cases. *See* BOP Expands COVID-19 Testing (April 28, 2020) available at: https://www.bop.gov/resources/news/20200424_expanded_testing.jsp (BOP received 10 Abbott testing instruments on April 10, 2020, 264 test kits were deployed to institutions with known COVID-19 cases. An additional 10 Abbott instruments are expected next week, but will go to institutions with known COVID-19 cases

35. In the one week since the filing of Defendant's Motion on Monday, April 20, 2020, the number of COVID-19 infections of inmates has more than DOUBLED. As of Monday, April 27, 2020, there are 1,046 inmates who are infected, 330 staff and 28 inmates have died. There are coronavirus infections in approximately one-half of all federal prison facilities. https://www.bop.gov/coronavirus/

36. The conditions at FCI Beckley are even more dangerous for individuals like Mr. Washington, given his severe risk factors, because staff are still entering and leaving daily, deliveries of food

and other supplies occur daily, and thus Mr. Washington is confined in close quarters in an institution that statistically is likely to have at least one asymptomatic case. https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html

37. Mr. Washington has no other administrative remedies available to him as the food infraction, described in ¶18 *supra*., bars him from release under the Furlough and Home Confinement Guidance of the BOP under the CARES Act. The BOP Memo on Furlough and Home Confinement Guidance is attached hereto and marked Exhibit "H."

CONCLUSION

38. In sum, the exponential infection rate of COVID-19 at the BOP, the vulnerability of Mr. Washington to infection and high mortality rate for those with Mr. Washington's conditions, coupled with the likely inability of the BOP to address a surge in cases, make clear that these are just the kind of "exceptional circumstances of peculiar urgency" requiring an exception to the exhaustion requirement.

39. In light of Mr. Washington's underlying chronic health conditions, which expose him to a very high risk of both becoming infected and experiencing serious health complications or death if he were to contract COVID-19, it is respectfully requested that the Court find extraordinary and compelling circumstances under 18 U.S.C. § 3582(c) and grant Mr. Washington's compassionate release from prison, to home confinement.

Respectfully,

HOPE C. LEFEBER, LLC

By:

HOPE C. LEFEBER, ESQUIRE

CERTIFICATE OF SERVICE

I certify that on April 28, 2020, a copy of the within Supplemental Motion for Compassionate Release and Exhibits were served on the Government via ECF.

s/Hope C. Lefeber, Esq.

Hope C. Lefeber

EXHIBIT "A"

LLOYD H. WASHINGTON (61246066)
FCI BECKLEY
FEDERAL CORRECTIONAL INSTITUTION
SATELLITE CAMP
P.O. BOX 350
BEAVER, WV 25813

Bureau of Prisons
Health Services
Inmate Report Only (formerly labeled ISDS)

Reg #: 61246-066 **Inmate Name:** WASHINGTON, LLOYD JR

SENSITIVE BUT UNCLASSIFIED – This information is confidential and must be appropriately safeguarded.

TB Clearance: Yes

Last PPD Date: 12/11/2019 Induration: 0mm
Last Chest X-Ray Date: Results:
TB Treatment: Sx free for 30 days: Yes
TB Follow-up Recommended: No

Transfer To: Transfer Date: 04/08/2020

Health Problems

Health Problem	Status
Diabetes mellitus, type II (adult-onset)	Current
Other and unspecified hyperlipidemia 10 year CVD risk - 20.6%	Current
Obesity, unspecified	Current
Allergic rhinitis, cause unspecified	Current
Dental caries extending into dentine this Dx. for #2	Current
Other dental caries	Current
Tinea pedis	Current
Essential (primary) hypertension	Current
Unspecified diseases of pulp and periapical tissues	Current
Chronic periodontitis, localized #4	Current
Unspecified renal colic left renal calculi	Current
Body Mass Index 45.0 - 49.9, adult BMI - 45.9	Current
Carpal tunnel syndrome right more than the left.	Remission

Medications: All medications to be continued until evaluated by a physician unless otherwise indicated. Bolded drugs required for transport.

Aspirin 81 MG Tab Chewable Exp: 01/14/2021 SIG: Take one tablet (81 MG) by mouth each day
Atorvastatin 40 MG TAB Exp: 01/14/2021 SIG: Take one tablet (40 MG) by mouth at bedtime
glipiZIDE 5 MG TAB Exp: 07/13/2020 SIG: Take one tablet (5 MG) by mouth twice daily
Lisinopril 10 MG Tab Exp: 01/14/2021 SIG: Take three tablets (30 MG) by mouth each day
metFORMIN HCl 850 MG Tab Exp: 01/14/2021 SIG: Take one tablet (850 MG) by mouth twice daily

OTCs: Listing of all known OTCs this inmate is currently taking.
None

Pending Appointments:

Date	Time	Activity	Provider
07/13/2020	00:00	Chronic Care Visit	MLP 03
10/12/2020	00:00	Diabetic Foot Screen	MLP 04
12/11/2020	00:00	PPD Administration	Nurse

Non-Medecation Orders:
No Data Found

Active Alerts:
No Data Found

Reg #: 61246-066 **Inmate Name:** WASHINGTON, LLOYD JR

SENSITIVE BUT UNCLASSIFIED – This information is confidential and must be appropriately safeguarded.

Consultations:

Pending Institutional Clinical Director Action
No Data Found

Pending UR Committee Action
No Data Found

Pending Regional Review Action
No Data Found

Pending Scheduling
No Data Found

Pending Consultation
No Data Found

Pending Results
No Data Found

Sickle Cell:
Sickle Cell Trait/Disease: No

Limitations/Restrictions/Diets:
Cell: lower bunk --- 11/02/2020
Cleared for Food Service: Yes
MDS Comments: bilateral carpal tunnel, decrease grip

BMI 45.4 06/08/18

Comments:

Allergies
No Known Allergies

Devices / Equipment
Brace - wrist
Alternate Institutional Shoes
Shoe inserts
Brace - wrist

Travel:
Direct Travel: No
Travel Restrictions: None

UNIVERSAL PRECAUTIONS OBSERVED WHEN TRANSPORTING ANY INMATE:

Transfer From Institution: BECKLEY FCI Phone Number: 3042529758
Address 1: 1600 INDUSTRIAL ROAD
Address 2:
City/State/Zip: BEAVER, West Virginia 25813

Name/Title of Person Completing Form: Walker, Jeff RN IOP/ICO Date: 04/08/2020

Inmate Name: WASHINGTON, LLOYD JR Reg #: 61246-066 DOB: 01/04/1970 Sex: M

EXHIBIT “B”

HOPE C. LEFEBER LLC
LAW OFFICES

TWO PENN CENTER
SUITE 1205
1500 JFK BOULEVARD
PHILADELPHIA, PENNSYLVANIA 19102

Telephone: 610-668-7927 Facsimile: 610-668-7929
Web: www.hopelefeber.com Email: hope@hopelefeber.com

April 15, 2020

Warden, FCI Beckley
Unit Team
1600 Industrial Road
Beaver, WV 25813

Via Email to: *bec/execassistant@bop.gov*

Re: Lloyd Washington # 61246-066

Dear Warden:

I write to urge you to release my client, Lloyd Washington, Register #61246-066, to home confinement immediately, pursuant to the directive issued on April 3, 2020 by Attorney General William Barr. Mr. Washington suffers from diabetes, obesity, heart disease and hypertension. He is treated and receives medication, in prison, for all of these conditions. Thus, he is extremely vulnerable to severe illness and death from COVID-19. Each of these conditions are high risk factors for COVID-19, as per the CDC website. Given the number of risk factors that Mr. Washington has, he is at an extraordinary risk of death should he contract COVID-19. As explained below, he will be able to fully self-quarantine at home for 14 days without exposing any other vulnerable person to a risk of infection.

Mr. Washington does not pose a risk of reoffending if released, nor is he otherwise a danger to the community. This was his first offense. He has been incarcerated for almost 11 years for a non-violent drug offense and was due to be released to home confinement in May, 2022. If released to home confinement, Mr. Washington would go immediately his father, Lloyd Washington, Sr.'s house at 2690 Irish Hill Road, Magnolia, Delaware 19962. There he would be able to follow CDC Guidelines for self-quarantine where he would be able to self-quarantine as people who have actually had COVID-19 are directed to by the CDC, which guidelines are even

more stringent that the guidelines for those who may have been exposed[1]. He would be able to self-quarantine in his own bedroom and bathroom, separate and apart from the rest of the family. The house has four bedrooms and two and a half bathrooms. Therefore, he would be isolated from the rest of the family and would pose no danger to them. His sister, Lynette Washington would pick him up at your facility if he is released.

For all of these reasons, Mr. Washington is critically in need of release to home confinement pursuant to Attorney General Barr's April 3, 2020 directive. Please let me know if you need additional information.

Thank you.

Very truly yours,

HOPE C. LEFEBER, LLC

By:

HOPE C. LEFEBER, ESQUIRE

Cc: Adam Johnson, Deputy Regional Counsel, BOP

[1] *See* https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html.

EXHIBIT “C”

HOPE C. LEFEBER LLC
LAW OFFICES

TWO PENN CENTER
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Telephone: 610-668-7927 Facsimile: 610-668-7929
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April 24, 2020

Warden, FCI Beckley
Unit Team
1600 Industrial Road
Beaver, WV 25813

Via Email to: bec/execassistant@bop.gov

Re: Lloyd Washington # 61246-066

Dear Warden:

I represent inmate Lloyd Washington # 61246-066. I previously emailed you on April 10, 2020 requesting release for Mr. Washington pursuant to Attorney General Barr's Memorandum. I wish to supplement that correspondence to request **Compassionate Release pursuant to 18 U.S.C. §3582(c)(1)(A).** It is my understanding that Mr. Washington placed two formal requests for release under 1) the CARES Act and Barr Memorandum; and 2) Compassionate Release, in the prison mailbox on April 10, 2020.

Mr. Washington suffers from Type II diabetes, obesity, heart disease, hypertension, hyperlipidemia and type II diabetes related neuropathy.. He is treated and receives medication, in prison, for all of these conditions. Thus, he is extremely vulnerable to severe illness and death from COVID-19. Each of these conditions are high risk factors for COVID-19, as per the CDC website. Given the number of risk factors that Mr. Washington has, he is at an extraordinary risk of death should he contract COVID-19. As explained below, he will be able to fully self-quarantine at home for 14 days without exposing any other vulnerable person to a risk of infection.

Mr. Washington does not pose a risk of reoffending if released, nor is he otherwise a danger to the community. This was his first offense. He has been incarcerated for almost 11 years for a non-violent drug offense, has a low PATTERN score and was due to be released to home confinement in May, 2022. If released to home confinement now, Mr. Washington would go immediately his father, Lloyd Washington, Sr.'s house at 2690 Irish Hill Road, Magnolia,

Delaware 19962. There he would be able to follow CDC Guidelines for self-quarantine where he would be able to self-quarantine as people who have actually had COVID-19 are directed to by the CDC, which guidelines are even more stringent that the guidelines for those who may have been exposed[1]. He would be able to self-quarantine in his own bedroom and bathroom, separate and apart from the rest of the family. The house has four bedrooms and two and a half bathrooms. Therefore, he would be isolated from the rest of the family and would pose no danger to them. His sister, Lynette Washington would pick him up at your facility if he is released.

For all of these reasons, Mr. Washington is critically in need of release to home confinement pursuant to the compassionate release provisions of 18 U.S.C. §3582(c)(1)(A). Please let me know if you need additional information. I would respectfully request that you act upon Mr. Washington's case immediately so that we can seek relief in the courts should you deny same. Delay in this matter can be a matter of life or death for Mr. Washington.

Thank you.

Very truly yours,

HOPE C. LEFEBER, LLC

By:

HOPE C. LEFEBER, ESQUIRE

Cc: Adam Johnson, Deputy Regional Counsel, BOP

[1] *See* https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html.

EXHIBIT “D”

AFFIDAVIT OF STEVEN EDELMAN, M.D.

I, Steven Edelman, M.D., attest:

1. My name is Steven Edelman. I am a physician, Board Certified in Diabetes and in Internal Medicine.

2. I am a Professor of Medicine in the Division of Endocrinology, Diabetes and Metabolism, at the University of California San Diego, since 2001, teaching, conduction research and practicing diabetes patient care within the university and the Veterans Affairs (VA) Healthcare Systems, San Diego, CA.

3. I am Director of the Clinical Clerkship Program, University of California, San Diego and the Veterans Affairs (VA) Medical Center.

4. I am the Founder, Director, and Chairman of the Board, of-Taking Control of Your Diabetes (TCOYD) www.tcoyd.org, a not-for-profit 501(c)(3) organization promoting patient education, motivation and self-advocacy via a number of informa-

tion portals (national conferences, publications, social media, television, and community programs), since 1995.

5. Attached hereto at Ex. A is a true and correct copy of my most recent CV, which accurately states my employment background in medicine, my education and training in medicine, a list of appointments and community service, academic honors and awards, professional associations, teaching experience, publications, and other related information regarding my medical background.

6. Because TCOYD is engaged in ongoing conferences around the United States, and I give many presentations each year to people with type 1 and type 2 diabetes as well as health care professionals.

7. I am providing this affidavit about the risk of SARS-CoV-2 infection, also known as COVID-19, or the novel coronavirus, to persons with type 2 diabetes, because such persons held

within correctional settings are particularly vulnerable as a result of their incarceration.

8. Attached hereto at Ex. B is a true and correct copy of a form letter prepared and published by the American Diabetes Association ("ADA"), which addresses concerns regarding facilities that detain people with diabetes under criminal or civil law during the COVID-19 pandemic.

9. The American Diabetes Association is recognized as a global authority on diabetes, and is the author of the Standards of Care for Diabetes.

10. Consistent with the position of the ADA reflected in the form letter attached at Ex. B, I would add specifically that having Type 2 diabetes is a significant risk factor for serious complications from COVID-19, including death.

11. Vulnerability of persons with type 2 diabetes exists both because such persons are more vulnerable to contracting

COVID-19 as a result of reduced immunity derived from their type 2 diabetes, and because such persons are more likely to suffer serious and deadly consequences of COVID-19 as a result of particular co-morbidities seen in this population.

12. Although COVID-19 is novel, the medical community has been collecting and analyzing information with regard to all patients which support the conclusion of increased risks for persons with diabetes. For example, the CDC, which publishes peer reviewed studies, and advises the government on matters of public health, reported that the risk of death for those with diabetes is 7%, a number much higher than the general popu-laton. (https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html).

13. These risks make it especially critical that persons with type 2 diabetes to have access to the best resources to keep the glucose levels close to normal, observe strict social distancing

and maintain cleanliness, including frequent hand-washing, use of sanitizer, and the use of personal protection equipment such as masks when held in settings where they are exposed to other individuals. Wearing plastic gloves at times of potential contact with surfaces exposed to the virus is also critical.

14. The risk of complications from COVID-19 is substantially increased for those with a history of poor blood glucose control, regardless of the type of diabetes, because the immune system is compromised and individuals will not be able to fight off any type of infection, including VOVID 19. Patients with poor control are also more likely to have already developed complications from their diabetes such as eye, kidney, heart and nerve disease. Having these underlying medical conditions make them more vulnerable to the serious consequences from COVID-19, including death. Death due to COVID-19 infection is more likely for those with diabetes be-

cause viral infection makes them more susceptible to pneumonia, kidney failure and diabetic ketoacidosis.

15. Persons at risk for type 2 diabetes, especially those not receiving annual blood tests from a physician, commonly go undiagnosed for years. During this time, their blood glucose management is poor because no effort is made to manage a disease that can be asymptomatic in the early stages, and has not been diagnosed, let alone treated. Many such persons are only diagnosed once they've had dangerous blood glucose levels for so long that they are already suffering consequences and complications from poor blood glucose management. It is not uncommon that a patient may have type 2 diabetes for 5 to 10 years without knowing it if not tested properly.

16. Persons entering the correctional system who already have a history of poor blood glucose management, meaning he-

moglobin a1c levels in excess of 8% over time, enter the system with increased vulnerability to Covid-19.

17. There are very few persons with type 2 diabetes who have no additional underlying medical conditions. The vast majority are overweight, which is inherent for individuals with type 2 diabetes, have high blood pressure, abnormal cholesterol levels, and underlying heart disease, or overt heart disease. Also the vast majority of persons with type 2 diabetes are older, another important risk factor for bad COVID-19 outcomes.

18. In summary, virtually all persons with type 2 diabetes, regardless of the date of diagnosis, are especially vulnerable to both contracting COVID-19, and suffering the severe consequences of COVID-19 if they are infected, with rare exception.

Signed and sworn to under the pains and penalties of perjury this 19th day of April 2020.

/s/ Steven Edelman, M.D.

151dc3994b
Apr 19, 2020

American Diabetes Association®
Connected for Life

Dear Detention Center:

The American Diabetes Association, in its position as a global authority on diabetes and author of the *Standards of Care for Diabetes*, writes to share information that is important for facilities that detain people under criminal or civil law during the COVID-19 pandemic.

Medical Information Concerning Diabetes and COVID-19

During the COVID-19 pandemic, the American Diabetes Association recommends that people with diabetes avoid crowds, especially in poorly ventilated spaces. This is because the risk of exposure to COVID-19 increases in crowded, closed-in settings with little air circulation if there are people in the crowd who are sick.

People with diabetes face a higher chance of experiencing serious complications from COVID-19.

In general, people with diabetes are more likely to experience severe symptoms and complications when infected with a virus.

When people with diabetes experience fluctuating blood sugars, they are generally at risk for a number of diabetes-related complications. Having heart disease or other complications in addition to diabetes could worsen the chance of getting seriously ill from COVID-19, like other viral infections, because the body's ability to fight off an infection is compromised.

Viral infections can also increase inflammation, or internal swelling, in people with diabetes. This is also caused by above-target blood sugars, and both could contribute to more severe complications.

When sick with a viral infection, people with diabetes face an increased risk of DKA (diabetic ketoacidosis), commonly experienced by people with type 1 diabetes. DKA can make it challenging to manage fluid intake and electrolyte levels—which is important in managing sepsis. Sepsis and septic shock are some of the more serious complications that people with COVID-19 have experienced.

In general, we don't know of any reason to think COVID-19 will pose a difference in risk between type 1 and type 2 diabetes.

2451 Crystal Drive
Suite 900
Arlington, VA 22202

1-800-DIABETES (342-2383)

diabetes.org
@AmDiabetesAssn

American Diabetes Association®
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Information Pertaining to the Detention Setting

People detained in crowded locked facilities *are* at significantly elevated risk of contracting infectious diseases like COVID-19 because of the close confines in which they live. The scientific evidence available demonstrates that COVID-19 is highly contagious.

Based on medical expert guidance, governments are taking aggressive steps to minimize people congregating in crowded spaces, in an effort to reduce transmission of this dangerous virus. Some jurisdictions have issued "shelter in place" orders for residents, directing them to limit their contact with others except for the most essential of purposes.

Detention facilities frequently lack the health care resources, space, and staffing to care for people who are acutely ill. This is of heightened concern during these times of a dangerous pandemic. When a high number of detained people take ill, the number of people requiring acute care can quickly overwhelm on-site medical resources, with outside facilities increasingly pressed to their limits.

Because people with diabetes face a significant and higher-than-average risk of getting *seriously* ill if infected with the COVID-19 virus, up to and including the risk of death, criminal and civil detention facilities (prisons, jails, juvenile facilities, immigration detention centers, psychiatric institutions, etc.) should take aggressive steps to protect both the health of these individuals and larger public health interests in our communities.

Local officials should explore all possible strategies to release people with diabetes and other serious risk factors related to COVID-19, and to reduce the level of crowding in detention facilities. Medical furloughs, compassionate release, and pretrial or early release for those most vulnerable to the virus are among options to be considered.

People in detention also need to be provided with ready access to warm or hot water, soap and sanitizer, and adequate hygiene and cleaning supplies both for handwashing and for cleaning their living area.

People in detention should also be educated on the importance of proper handwashing, coughing into their elbows, and social distancing to the extent practicable. Information about the spread of the virus, the risks associated with it, and prevention and treatment measures must be based on the best available science. Education should be reiterated upon release to best inform individuals on how to prepare for a healthy return to the public.

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Conclusion

Thank you for considering this information as you work to ensure that detainees with diabetes are safe during a difficult time for all. For more information on this topic, the ADA has additional resources here: https://www.diabetes.org/diabetes/treatment-care/planning-sick-days/coronavirus and here: https://care.diabetesjournals.org/content/37/Supplement_1/S104.

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CURRICULUM VITAE

Steven V. Edelman, M.D.

VA Address: Veterans Affairs Medical Center
Department of Endocrinology and Metabolism
3350 La Jolla Village Drive (111G)
San Diego, California 92161
Email: sedelman@ucsd.edu

Mailing Address: Taking Control Of Your Diabetes (501c3)
990 Highland Drive Suite 312
Solana Beach, Ca 92075
Email: steve@tcoyd.org

Phone:
Mobile: (619) 339-3112
Office: (858) 755-5683
Fax: (858) 755-6854

Board Certifications: Diabetes, Endocrinology and Metabolism (1991, 2002)
Internal Medicine (1986)

EMPLOYMENT

2001 - present	**Professor of Medicine** Division of Endocrinology, Diabetes and Metabolism, University of California San Diego Veterans Affairs Healthcare System, San Diego
1995-2001	**Associate Professor of Medicine** Division of Endocrinology and Metabolism, University of California San Diego Veterans Affairs Healthcare System, San Diego
1991-1995	**Assistant Professor of Medicine** Division of Endocrinology and Metabolism, University of California San Diego
1989-1990	**Visiting Physician** Department of Medicine, Division of Endocrinology and Diabetes, Chaim Sheba Medical Center, Tel Hashomer, Israel
1989-1990	**Staff Physician** Portland Diabetes and Endocrinology Center, Portland, Oregon
1989-1990	**Clinical Assistant Professor** Department of Medicine, Division of Endocrinology and Metabolism, University of Oregon Center for Health Sciences, Portland, Oregon

EDUCATION

1987-1989	**Research Fellowship in Diabetes and Metabolism** University of California, San Diego San Diego, California
1986-1987	**Fellowship in Endocrinology and Metabolism** The Lahey Clinic Burlington, Massachusetts
1985-1986	**Clinical Fellowship in Diabetes and Metabolism** The Joslin Clinic Boston, Massachusetts
1982-1985	**Resident in Internal Medicine** University of California, Los Angeles Los Angeles, California
1978-1982	**Doctor of Medicine and Valedictorian** University of California, Davis Davis, California
1977-1978	**Master of Science, Biology** University of Southern California Los Angeles, California
1973-1977	**Bachelor of Science, Biology** University of California, Los Angeles Los Angeles, California

APPOINTMENTS & COMMUNITY SERVICE

Founder, Director, and Chairman of the Board
Taking Control of Your Diabetes (TCOYD) www.tcoyd.org
A not-for-profit organization promoting patient education, motivation and self-advocacy via a number of information portals (national conferences, publications, social media, television, and community programs) (1995-Present)

Director, Clinical Clerkship Program
University of California, San Diego and the Veterans Affairs (VA) Medical Center (1995-Present)

Director, Diabetes Care Clinic
VA Medical Center, San Diego, CA (1995-Present)

Research and Independent Student Project Advisor for UCSD graduate and medical students (1995-Present)

Therapeutic expert/speaker - FDA meetings and panels (1998-Present)

Journal Reviewer - current:

Annals of Internal Medicine
Diabetes Monitor, Journal of Clinical Investigation
Journal of Clinical Endocrinology and Metabolism
Diabetes Interviews
Diabetes Care
Diabetes
Diabetologia
Endocrine Practice
New England Journal of Medicine
Journal of Diabetes and Complications

Grant Reviewer, Austrian Diabetes Association (2008-2010)

Editor-in-Chief, Insulin (2004-2010)

Editor-in-Chief, Diabetes, Metabolic Syndrome & Obesity (2002-2010)

Director, Endocrine Fellowship Training Program
University of California, San Diego and the VA Medical Center (1998-2005)

Editorial Advisory Board, *Endocrine Today* (past)

Certification and Recertification Programs for the American Board to Internal Medicine (past)

Professional Education Committee, American Diabetes Association
(past)

ACADEMIC HONORS AND AWARDS

2015 Recipient of the Josiah Kirby Lilly, Sr. Distinguished Service Award

2013 US World Report: Top 1% of US Endocrinologists

2012 *San Diego Magazine* Top Doctors in San Diego award

2011 UC Davis School of Medicine Transformational Leadership award

2011 *AACE* Distinction in Clinical Endocrinology award

2011 *San Diego Magazine* Physicians of Exceptional Excellence award

2010 *San Diego Magazine* Physicians of Exceptional Excellence award

2009 *San Diego Magazine* Physicians of Exceptional Excellence award

2009 *ADA* Diabetes Educator of the Year

2008 *PharmaVoice* 100 of the Most Inspiring People award

2008 *San Diego Magazine* Top Doctors in San Diego County award

2007 *San Diego Magazine* Top Doctors in San Diego County award

2007 UCSD Student-Run Free Clinic Project's Community Leader award

2006 Combined Health Agencies San Diego Chapter "Health Hero" award

2006 *San Diego Magazine* Top Doctors in San Diego County award

2005 *San Diego Magazine* Top Doctors in San Diego County award

2004 *San Diego Magazine* Top Doctors in San Diego County award

2003 *San Diego Magazine* Top Doctors in San Diego County award

2002 House staff Teaching Award for Excellence Award University of California San Diego

2002 Chief Resident's Teacher of the Year Award, University of California San Diego

2001 Chief Resident's Teacher of the Year Award, University of California San Diego

2001 Healthcare Foundation of New Jersey's Humanism in Medicine Award

2001 Whittier Institutes Persistence Award for Public Service

2001 House staff Teaching Award for Excellence Honorable Mention, University of California San Diego

2000 House staff Teaching Award for Excellence Award, University of California San Diego

1999. Chief Resident's Teacher of the Year Award, University of California San Diego

1996. House staff Teaching Award for Excellence: Honorable Mention University of California, San Diego

1995 Chief Resident's Teacher of the Year Award, University of California San Diego

1995 Citation of Excellence, Cal Aggi Alumni, Association

1994. Chief Resident's Teacher of the Year Award, University of California San Diego

1994 Distinguished Alumnus Award, University of California Davis, Medical School

1985 National Commanders Award of the Disabled American Veterans, Sepulveda Veterans Affairs Medical Center, Los Angeles, CA

1982 Ad Hoc Judicial, Honors and Awards, and Admissions Committee, University of California, Davis Medical School

1982 Valedictorian, University of California, Davis Medical School

1978 Regents Scholar, University of California

1977 Deans Honor List, University of California, Los Angeles

1977 Graduate cum Laude, University of California, Los Angeles

PROFESSIONAL ASSOCIATIONS

Active Member:

The Endocrine Society

Association of Academic Professors

Juvenile Diabetes Research Foundation

American Diabetes Association

American Association of Diabetic Educators

American Physicians Fellowship

Association of Clinical Endocrinologists

American Society of Clinical Investigation

International Diabetes Federation

TEACHING EXPERIENCE

1995-Present	Director, Diabetes Care Teaching Clinic VA Medical Center, San Diego, CA
1998-2005	Director, Endocrine Fellowship Training Program, UCSD and VA Medical Center, San Diego, CA
1998.	Co-Director, Endocrine Fellowship Training Program, UCSD and VA Medical Center, San Diego, CA
1989-1991	Residency Education Staff Good Samaritan Hospital, Portland, OR
1989.	Teaching Assistant University of California, San Diego Department of Medicine, Division of Endocrinology

and Metabolism, San Diego, CA

1987. Teaching Assistant, Harvard Medical School, Department of Medicine, Boston, MA

1978. Teaching Assistant, Department of Human Physiology, University of Southern California, Los Angeles, CA

PUBLICATIONS

1. Tuck ML, **Edelman SV**. Drug therapy: special concerns in the hypertensive diabetic. *Mod Med.* 11:48-54, 1985.

2. **Edelman SV**, Kosofsky E, Paul R, Kozak GP. Neuro-osteoarthropathyb (charcot's joint) in diabetes mellitus following revascularization surgery. *Arc Intern Med.* 147:1504-1508, 1987.

3. Vignati L, **Edelman SV**. Replacement of pancreatic function through the use of mechanical or electronic devices. In: *Organ Transplantation and Replacement*. G.J. Cerilli, editor. J.B. Lippincott, Philadelphia, PA. 680-688,1988 (book chapter).

4. Baron AD, Brechtel G, Wallace P, **Edelman SV**. Fasting decreases rates of non-insulin-mediated glucose uptake in man. *J Clin Endocrinol Metab.* 67:532-540, 1988.

5. Baron AD, Brechtel G, Wallace P, **Edelman SV**. Rates and tissue sites of non-insulin and insulin-mediated glucose uptake in humans. *Am J Physiol.* 255:E769-E774, 1988.

6. Baron AD, Brechtel G, **Edelman SV**. Effects of free fatty acids on ketone bodies on in vivo non-insulin-mediated glucose utilization and production in humans. *Metabolism.* 38:1056-1061, 1989.

7. **Edelman SV**, Witztum J. Hyperkalemia during treatment with HMG- CoA reductase inhibitor. *New Engl J Med.* 320:1219-1220, 1989.

8. Molina JM, Baron AD, **Edelman SV**, Brechtel G, Wallace P, Olefsky JM. Use of a variable tracer infusion method to determine glucose turnover in humans. *Am J Physiol.* 25(8):E16-E23, 1990.

9. Baron AD, Laakso M, Brechtel G, Hoit B, Watt C, **Edelman SV**. Reduced postprandial skeletal muscle blood flow contributes to glucose intolerance inhuman obesity. *J Clin Endocrinol Metab.* 70:1525-1533, 1990.

10. Laakso M, **Edelman SV**, Brechtel G, Baron AD. Decreased effect of insulin to stimulate skeletal muscle blood flow in obese man: a novel mechanism for insulin resistance. *J Clin Invest.* 85:1844-52, 1990.

11. **Edelman SV**, Laakso M, Brechtel G, Wallace P, Olefsky JM, Baron AD. Kinetics of insulin-mediated and non-insulin-mediated glucose uptake in humans. *Diabetes.* 39(8):955-964, 1990.

12. Laakso M, **Edelman SV**, Olefsky JM, Brechtel G, Wallace P, Baron AD. Kinetics of in vivo muscle insulin-mediated glucose uptake in human obesity. *Diabetes.* 39(8):965-974, 1990.

13. **Edelman SV**. Intensive insulin therapy. *Diabetes Forecast* 44:40-43, 1991.

14. Baron AD, Laakso M, Brechtel G, **Edelman SV**. Reduced capacity and affinity of skeletal muscle for insulin-mediated glucose uptake in non-insulin dependent diabetic subjects: effects of insulin therapy. *J Clin Invest.* 87:1186 1194, 1991.

15. Baron AD, Laakso M, Brechtel G, **Edelman SV**. Mechanism of insulin resistance in insulin-dependent diabetes mellitus: a major role for reduced skeletal muscle blood flow. *J Clin Endocrinol Metab.* 73:637-643, 1991.

16. Henry RR, **Edelman SV**. Advances in treatment of type II diabetes mellitus in the elderly. *Geriatrics.* 47:24-30, 1992.

17. Saudek CD, Duckworth WC, Veterans Affairs Study Group, **Edelman SV**. The Department of Veterans Affairs implanted insulin pump study. *Diabetes Care.* 15:567-570, 1992.

18. Laakso M, **Edelman SV**, Brechtel G, Baron AD. Impaired insulin-mediated skeletal muscle blood flow in patients with NIDDM. *Diabetes.* 41:1076-1083, 1992.

19. Duckworth WC, Saudek CD, Henry RR, The Veterans Affairs Study Group, **Edelman SV**. Why intraperitoneal delivery of insulin with implantable pumps in NIDDM? *Diabetes.* 41:657-661, 1992.

20. Laakso M, **Edelman SV**, Brechtel G, Baron AD. Effects of epinephrine on insulin-mediated glucose uptake in whole body and leg muscle in humans: role of blood flow. *Am J Physiol.* 263:E199-E209, 1992.

21. **Edelman SV**. Diabetes mellitus: recent developments and clinical implications. In: *Manual of Endocrinology and Metabolism.* Norman Lavin, editor. Little, Brown and Company, Boston, MA. 581-586, 1994 (book chapter).

22. **Edelman SV**. The diabetes epidemic. *Medical Section Proceedings of the American Council of Life Insurance.* JG Pallas, editor. 1994.

23. **Edelman SV**, White D, Henry RR. Intensive insulin therapy for patients with type II diabetes. *International Diabetes Monitor.* 7(2):1-9, 1994.

24. **Edelman SV**, Henry RR. Insulin therapy for normalizing glycosylated hemoglobin in type II diabetes: application, benefits and risks. *Diabetes Review.* 3:308-334, 1995.

25. **Edelman SV**. Impaired glucose tolerance: a precursor of NIDDM or a disease entity in itself? *Diabetes News.* 26:1-5, 1995.

26. **Edelman SV**, White D, Henry RR. Intensive insulin therapy for patients with type II diabetes. *Current Opinion in Endocrinology and Diabetes.* 2:333-340, 1995.

27. Reaven P, Herold DA, Barrett JE, **Edelman SV**. Effects of vitamin E on susceptibility of LDL and LDL subfractions to oxidation and on protein glycation in NIDDM. *Diabetes Care.* 18(6):807-816, 1995.

28. Henry RR, **Edelman SV**. Diabetes mellitus in adults. In: *Conn's Current Therapy*. Conn HF et al, editors. 28:522-530, 1995 (book chapter).

29. DPT-1 Study Group. The Diabetes Prevention Trial-Type 1 Diabetes (DPT-1), **Edelman SV**. Implementation of screening and staging of relatives. *Transplantation Proceedings.* 27(6):3377, 1995.

30. **Edelman SV**, Henry RR. Intensive insulin treatment for patients with type II diabetes: a fundamental and clinical text. *Diabetes Mellitus.* D LeRoith, SI Taylor, JM Olefsky, editors. Lippincott -Raven JB, Philadelphia, PA. p. 647, 1996 (book chapter).

31. **Edelman SV**. Glycemic control and complications in type II diabetes: design of a feasibility trial: summary and commentary. *Diabetes Spectrum.* 9(1):47-50, 1996.

32. **Edelman SV**. New orally administered antihyperglycemic agents for the management of patients with type II diabetes and the syndrome of insulin resistance. *Endocrine Practice.* 2(4):271-275, 1996.

33. **Edelman SV**. Management of patients with diabetes by nurses with support subspecialists: summary and commentary. *Diabetes Spectrum.* 9(3):178-180,1996.

34. **Edelman SV**. New oral antidiabetic agents for the prevention and management of NIDDM. *International Diabetes Monitor.* 8(4):1-8, 1996.

35. Saudek CD, Duckworth WC, Giobbie-Hurder A, Henderson WG, Henry RR, Kelley DE, **Edelman SV**, Zieve F, Adler RA, Anderson JW, Anderson RJ, Hamilton BP, Donner TW, Kirkman MS, Morgan NA, Department of Veterans Affairs. Implantable insulin pump vs. multiple dose insulin in the treatment of non-insulin-dependent

diabetes mellitus: a randomized clinical trial. *JAMA*. 276:1322-1327, 1996.

36. Kelley DE, Henry RR, **Edelman SV**, Veterans Affairs Implantable Insulin Pump Study Group. Acute effects of intraperitoneal versus subcutaneous insulin delivery on glucose homeostasis in patients with NIDDM. *Diabetes Care*. 19(11):1237-1242, 1996.

37. **Edelman SV**, Kartun K, Nadeau DA, Prince MJ. Clinical case studies in diabetes: pearls and pitfalls. A focus on NIDDM. Volume 1. Alain D. Baron, editor. Clinical Communications Inc., Greenwich, CT. pages 1-29, 1996.

38. **Edelman SV**, Kartun K, Prince MJ, Zimmerman BR. Clinical case studies in diabetes: pearls and pitfalls. A focus on NIDDM. Volume 2. Alain D. Baron, editor. Clinical Communications Inc., Greenwich, CT. pages 1-33, 1996.

39. **Edelman SV**. Troglitazone: a new and unique oral anti-diabetic agent for the treatment of type II diabetes and the insulin resistant syndrome. *Clinical Diabetes*. 15(2):60-65, 1997.

40. **Edelman SV**, Henry RR. Non-insulin-dependent diabetes mellitus. In: *Current Therapy in Endocrinology and Metabolism*. Sixth Edition. CW Bardin, editor. Mosby-Year Book Inc. pages 430-438, 1997 (book chapter).

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EXHIBIT “E”

Declaration for Persons in Detention and Detention Staff
COVID-19

Chris Beyrer, MD, MPH
Professor of Epidemiology
Johns Hopkins Bloomberg School of Public Health
Baltimore, MD

I, Chris Beyrer, declare as follows:

1. I am a professor of Epidemiology, International Health, and Medicine at the Johns Hopkins Bloomberg School of Public Health, where I regularly teach courses in the epidemiology of infectious diseases. This coming semester, I am teaching a course on emerging infections. I am a member of the National Academy of Medicine, a former President of the International AIDS Society, and a past winner of the Lowell E. Bellin Award for Excellence in Preventive Medicine and Community Health. I have been active in infectious diseases Epidemiology since completing my training in Preventive Medicine and Public Health at Johns Hopkins in 1992.
2. I am currently actively at work on the COVID-19 pandemic in the United States. Among other activities I am the Director of the Center for Public Health and Human Rights at Johns Hopkins, which is active in disease prevention and health promotion among vulnerable populations, including prisoners and detainees, in the US, Africa, Asia, and Latin America.

The nature of COVID-19

3. The SARS-nCoV-2 virus, and the human infection it causes, COVID-19 disease, is a global pandemic and has been termed a global health emergency by the WHO. Cases first began appearing sometime between December 1, 2019 and December 31, 2019 in Hubei Province, China. Most of these cases were associated with a wet seafood market in Wuhan City.
4. On January 7, 2020, the virus was isolated. The virus was analyzed and discovered to be a coronavirus closely related to the SARS coronavirus which caused the 2002-2003 SARS epidemic.
5. COVID-19 is a serious disease. The overall case fatality rate has been estimated to range from 0.3 to 3.5%, which is 5-35 times the fatality associated with influenza infection. COVID-19 is characterized by a flu-like illness. While more than 80% of cases are self-limited and generally mild, overall some 20% of cases will have more severe disease requiring medical intervention and support.
6. The case fatality rate varies significantly depending on the presence of certain demographic and health factors. The case fatality rate is higher in men, and varies significantly with advancing age, rising after age 50, and above 5% (1 in 20 cases) for those with pre-existing medical conditions including cardio-vascular disease, respiratory disease, diabetes, and immune compromise.
7. Among patients who have more serious disease, some 30% will progress to Acute Respiratory Distress Syndrome (ARDS) which has a 30% mortality rate overall, higher in those with other health conditions. Some 13% of these patients will require mechanical

ventilation, which is why intensive care beds and ventilators have been in insufficient supply in Italy, Iran, and parts of China.

8. COVID-19 is widespread. Since it first appeared in Hubei Province, China, in late 2019, outbreaks have subsequently occurred in more than 100 countries and all continents, heavily affected countries include Italy, Spain, Iran, South Korea, and increasingly, the US. As of today, March 16th, 2020, there have been 178,508 confirmed human cases globally, 7,055 known deaths, and some 78,000 persons have recovered from the infection. The pandemic has been termed a global health emergency by the WHO. It is not contained and cases are growing exponentially.

9. SARS-nCoV-2 is now known to be fully adapted to human to human spread. This is almost certainly a new human infection, which also means that there is no pre-existing or "herd" immunity, allowing for very rapid chains of transmission once the virus is circulating in communities.

10. The U.S. CDC estimates that the reproduction rate of the virus, the R_0, is 2.4-3.8, meaning that each newly infected person is estimated to infect on average 3 additional persons. This is highly infectious and only the great influenza pandemic of 1918 (the Spanish Flu as it was then known) is thought to have higher infectivity. This again, is likely a function of all human populations currently being highly susceptible. The attack rate given an exposure is also high, estimated at 20-30% depending on community conditions, but may be as high as 80% in some settings and populations. The incubation period is thought to be 2-14 days, which is why isolation is generally limited to 14 days.

The risks of COVID-19 in detention facilities

11. COVID-19 poses a serious risk to inmates and workers in detention facilities. Detention Facilities, including jails, prisons, and other closed settings, have long been known to be associated with high transmission probabilities for infectious diseases, including tuberculosis, multi-drug resistant tuberculosis, MRSA (methicillin resistant staph aureus), and viral hepatitis.

12. The severe epidemic of Tuberculosis in prisons in Central Asia and Eastern Europe was demonstrated to increase community rates of Tuberculosis in multiple states in that region, underscoring the risks prison outbreaks can lead to for the communities from which inmates derive.

13. Infections that are transmitted through droplets, like influenza and SARS-nCoV-2 virus, are particularly difficult to control in detention facilities, as 6-foot distancing and proper decontamination of surfaces is virtually impossible. For example, several deaths were reported in the US in immigration detention facilities associated with ARDS following influenza A, including a 16-year old male immigrant child who died of untreated ARDS in custody in May, 2019.

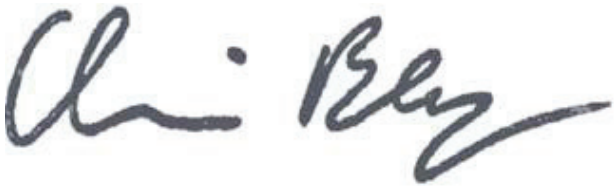
14. A number of features of these facilities can heighten risks for exposure, acquisition, transmission, and clinical complications of these infectious diseases. These include physical/mechanical risks such as overcrowding, population density in close confinement, insufficient ventilation, shared toilet, shower, and eating environments and limits on hygiene and personal protective equipment such as masks and gloves in some facilities.

15. Additionally, the high rate of turnover and population mixing of staff and detainees increases likelihoods of exposure. This has led to prison outbreaks of COVID-19 in multiple detention facilities in China, associated with introduction into facilities by staff.

16. In addition to the nature of the prison environment, prison and jail populations are also at additional risk, due to high rates of chronic health conditions, substance use, mental health issues, and, particularly in prisons, aging and chronically ill populations who may be vulnerable to more severe illnesses after infection, and to death.
17. While every effort should be made to reduce exposure in detention facilities, this may be extremely difficult to achieve and sustain. It is therefore an urgent priority in this time of national public health emergency to reduce the number of persons in detention as quickly as possible.
18. Pre-trial detention should be considered only in genuine cases of security concerns. Persons held for non-payment of fees and fines, or because of insufficient funds to pay bail, should be prioritized for release. Immigrants awaiting decisions on their removal cases who are not a flight risk can be monitored in the community and should be released from immigration detention centers. Older inmates and those with chronic conditions predisposing to severe COVID-19 disease (heart disease, lung disease, diabetes, immune-compromise) should be considered for release.
19. Given the experience in China as well as the literature on infectious diseases in jail, an outbreak of COVID-19 among the U.S. jail and prison population is likely. Releasing as many inmates as possible is important to protect the health of inmates, the health of correctional facility staff, the health of health care workers at jails and other detention facilities, and the health of the community as a whole.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 16th day of March, 2020.



Professor Chris Beyrer[1]

[1] These views are mine alone; I do not speak for Johns Hopkins University or any department therein.

EXHIBIT “F”

Declaration of Dr. Marc Stern

I, Marc Stern, declare as follows:

1. I am a physician, board-specialized in internal medicine, specializing in correctional health care. I most recently served as the Assistant Secretary for Health Care at the Washington State Department of Corrections. I also have considerable familiarity with the immigration detention system. I served for four years as a medical subject matter expert for the Officer of Civil Rights and Civil Liberties, U.S. Department of Homeland Security, and as a medical subject matter expert for one year for the California Attorney General's division responsible for monitoring the conditions of confinement in Immigration and Customs Enforcement (ICE) detention facilities. I have also served as a consultant to Human Rights Watch in their preparation of two reports on health-related conditions of confinement in ICE detention facilities. In those capacities, I have visited and examined more than 20 ICE detention facilities and reviewed hundreds of records, including medical records and detention death reviews of individuals in ICE detention. Attached as Exhibit A is a copy of my curriculum vitae.

2. COVID-19 is a serious disease and has reached pandemic status. At least 132,758 people around the world have received confirmed diagnoses of COVID 19 as of March 13, 2020, including 1,629 people in the United States. At least 4,955 people have died globally as a result of COVID-19 as of March 13, 2020, including 41 in the United States. These numbers will increase, perhaps exponentially.

3. COVID-19 is a novel virus. There is no vaccine for COVID-19, and there is no cure for COVID-19. No one has immunity. The only way to control the virus is to use preventive strategies, including social distancing.

4. The time course of the disease can be very rapid. Individuals can show the first symptoms of infection in as little as two days after exposure and their condition can seriously deteriorate in as little as five days (perhaps sooner) after that.

5. The effects of COVID-19 are very serious, especially for people who are most vulnerable. Vulnerable people include people over the age of 50, and those of any age with underlying health problems such as – but not limited to – weakened immune systems, hypertension, diabetes, blood, lung, kidney, heart, and liver disease, and possibly pregnancy.

6. Vulnerable people who are infected by the COVID-19 virus can experience severe respiratory illness, as well as damage to other major organs. Treatment for serious cases of COVID-19 requires significant advanced support, including ventilator assistance for respiration and intensive care support. An outbreak of COVID-19 could put significant pressure on or exceed the capacity of local health infrastructure.

7. Detention facilities are congregate environments, i.e. places where people live and sleep in close proximity. In such environments, infectious diseases that are transmitted via the air or touch are more likely to spread. This therefore presents an increased danger for the spread of COVID-

19 if and when it is introduced into the facility. To the extent that detainees are housed in close quarters, unable to maintain a six-foot distance from others, and sharing or touching objects used by others, the risks of spread are greatly, if not exponentially, increased as already evidenced by spread of COVID-19 in another congregate environment: nursing homes and cruise ships.

8. Social distancing in ways that are recommended by public health officials can be difficult, if not impossible in detention facilities, placing people at risk, especially when the number of detainees is high.

9. For detainees who are at high risk of serious illness or death should they contract the COVID-19 virus, release from detention is a critically important way to meaningfully mitigate that risk. Additionally, the release of detainees who present a low risk of harm to the community is also an important mitigation strategy as it reduces the total number of detainees in a facility. Combined, this has a number of valuable effects on public health and public safety: it allows for greater social distancing, which reduces the chance of spread if virus is introduced; it allows easier provision of preventive measures such as soap for handwashing, cleaning supplies for surfaces, frequent laundering and showers, etc.; and it helps prevent overloading the work of detention staff such that they can continue to ensure the safety of detainees.

10. The release of detainees, especially those with increased health-related vulnerability, also supports the broader community because carceral and detention settings, regardless of the level of government authorities that oversee them, are integral parts of the community's public health infrastructure. Reducing the spread and severity of infection in a Federal immigration detention center slows, if not reduces, the number of people who will become ill enough to require hospitalization, which in turn reduces the health and economic burden to the local community at large.

11. As a correctional public health expert, I recommend release of eligible individuals from detention, with priority given to the elderly and those with underlying medical conditions most vulnerable to serious illness or death if infected with COVID-19.

12. Conditions related to COVID-19 are changing rapidly and may change between the time I execute this Declaration and when this matter appears before the Court. One of the most worrisome changes would be confirmation of a case of COVID-19 within the detention center, either among staff or detainees. In the event of this occurring, and eligible detainees being quarantined or isolated due to possible exposure to the virus, I recommend that the detainee(s) be tested for the virus if testing is available. Armed with the results of that test if it is available, or in the absence of other instructions from the health authority of the municipality to which they will be returning or the Washington State public health authority, those who can easily return to a home without exposure to the public, should be released to that home for continued quarantine or isolation for the appropriate time period. All others can be released to appropriate housing as directed or arranged in coordination with the relevant health authority.

13. I have reviewed Plaintiffs' complaint and on the basis of the claims presented, conclude that Plaintiffs have underlying medical conditions that increase the risk of serious illness or death if exposed to COVID-19. Due to the risks caused by the congregate environment in immigration

detention, compounded by the marked increase in risk conferred by their underlying medical conditions, I recommend their release.

Pursuant to 28 U.S.C. 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this __15th___ day in March, 2020 in Tumwater, Washington.

Dr. Marc Stern

EXHIBIT “G”

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  NERBE          *           INMATE DISCIPLINE DATA           *     04-23-2020
PAGE 001 OF 001 *     CHRONOLOGICAL DISCIPLINARY RECORD      *     14:52:19

REGISTER NO: 61246-066 NAME..: WASHINGTON, LLOYD JR
FUNCTION...: PRT       FORMAT: CHRONO    LIMIT TO ___ MOS PRIOR TO 04-23-2020

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REPORT NUMBER/STATUS.: 2284955 - SANCTIONED INCIDENT DATE/TIME: 03-27-2012 1845
UDC HEARING DATE/TIME: 04-04-2012 0900
FACL/UDC/CHAIRPERSON.: PHL/4 NORTH/REED
REPORT REMARKS.......: INMATE STATED, "I DIDN'T KNOW I COULDN'T HAVE THAT"
   305  POSSESSING UNAUTHORIZED ITEM - FREQ: 1
        LP COMM    / 30 DAYS / CS
        COMP:    LAW:    EFFECTIVE 05-01-2012 THRU 05-30-2012 UPON COMPLETI
                         ON OF PRIOR COMM SANCTION.
--------------------------------------------------------------------------------
REPORT NUMBER/STATUS.: 2257635 - SANCTIONED INCIDENT DATE/TIME: 01-03-2012 1300
DHO HEARING DATE/TIME: 02-01-2012 0812
FACL/CHAIRPERSON.....: PHL/POTTER, J
REPORT REMARKS.......: INMATE ADMITS
   305  POSSESSING UNAUTHORIZED ITEM - FREQ: 1
        LP COMM    / 90 DAYS / CS
        COMP:    LAW:    IMPOSED TO DEMONSTRATE SERIOUSNESS OF OFFENSE
        LP VISIT   / 90 DAYS / CS
        COMP:    LAW:    IMPOSED TO DETER FUTURE MISBEHAVIOR




G0005       TRANSACTION SUCCESSFULLY COMPLETED - CONTINUE PROCESSING IF DESIRED
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EXHIBIT “H”

U.S. Department of Justice
Memorandum
Federal Bureau of Prisons

Correctional Programs Branch

Central Office
320 First Street, N.W.
Washington, DC 20534

MEMORANDUM FOR CORRECTIONAL PROGRAM ADMINISTRATORS

FROM: David Brewer, Acting Senior Deputy Assistant Director

SUBJECT: Furlough and Home Confinement Additional Guidance

The following guidance is provided from information contained in the CARES Act, memoranda from Attorney General Barr, and the Bureau of Prisons. This memorandum rescinds guidance previously provided.

Furlough

The current pandemic is considered an urgent situation that may warrant an emergency furlough under 570.32(b)(1) and 570.33(b). These regulations authorize a non-transfer emergency furlough if the inmate is otherwise deemed appropriate, even if he/she has been submitted for Home Confinement (HC). Effective April 16, 2020, all inmates referred for an emergency furlough due to the Covid-19 pandemic should be submitted and keyed as FURL CRI.

Inmates who have been referred for a release planning furlough based on guidance issued prior to April 16, 2020, do not require a new application. These inmates should be keyed out of the facility as FURL REL. Furlough applications completed on or after April 16, 2020, should follow the updated guidance. Inmates within 12 months of his/her Projected Release Date (PRD), or those who have received Home Confinement placement and have a PRD exceeding one year, should be reviewed for furlough.

Home Confinement

In an effort to alleviate concerns and questions, the following criteria should be met when reviewing and referring inmates for HC:

- Primary or prior offense is not violent

- Primary or prior offense is not a sex offense
- Primary or prior offense is not terrorism
- No detainer
- Mental Health Care Level is less than CARE-MH 4
- PATTERN risk score is Minimum (R-MIN)
- No incident reports in the past 12 months (regardless of severity level)
- U.S. Citizen
- Viable Release Plan

If the inmate meets the criteria above, the following factors should be noted, but are not a reason for denial:

- Age
- Projected Release Date
- Percentage of time served
- Medical Care Level
- Victim Witness Program
- Arrival dated (ARSD)

Any concerns regarding an inmate's suitability for HC placement should be noted in Section 11 of the BP-210, *Institutional Referral for CCC Placement.* It is strongly encouraged to refer inmates currently housed in a facility with active Covid-19 cases.

For inmates requesting relocation, a release plan must be submitted to the USPO prior to HC referral submission. The USPO approval letter must be forwarded to the RRM, once received. Institution staff should contact the Health Service Specialist in the RRM's office with questions regarding HC placement for inmates with medical concerns.

If you have any questions, please contact David Brewer, Acting Senior Deputy Assistant Director, Correctional Programs Division, at (202)353-3638.