UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA, PLAINTIFF	§	
V.	§	CASE NO. 18-CR-00115
RODOLFO "RUDY" DELGADO, DEFENDANT	§	

EMERGENCY MOTION FOR COMPASSIONATE RELEASE PURSUANT TO 18 U.S.C. § 3582(c)(1)(A)(i)

TO THE HONORABLE JUDGE OF THE SOUTHERN DISTRICT OF TEXAS:

NOW COMES, Defendant Rodolfo Delgado, by and through his undersigned attorney, and, pursuant to 18 U.S.C. § 3582(c)(1)(A)(i) as amended by the First Step Act of 2018, § 603(b)(1), Pub. L. 115-391, 132 Stat. 5194, 5239 (2018) and United States Sentencing Guidelines § 1B1.13, requests that this Court grant him immediate compassionate release from FMC Fort Worth, and reform his judgment to a time-served sentence or home detention for a specified time period.

I. Procedural History.

On October 1, 2019, judgment was entered reflecting that Mr. Delgado was sentenced to serve a sentence of imprisonment of 60 months.[1] Because of his fragile medical condition, the Bureau of Prisons designated Mr. Delgado to the Bureau of Prisons' Federal Medical Center prison facility in Fort Worth, Texas. Mr. Delgado reported to FMC Fort Worth on November 19, 2019, as instructed. He has been fully compliant with all restrictions and conditions imposed upon him by prison officials.

II. Mr. Delgado's Personal Situation.

As this Court was made aware prior to sentencing, Mr. Delgado suffers from the following:

- He is a diabetic, having been diagnosed as suffering from hyperglycemia. PSR ¶ 67.
- He is immunocompromised and is prescribed Sirolimus (an immunosuppressant).

[1] He was sentenced to 48 months on several counts, and 60 months on others, all to run concurrently.

- He is diagnosed as suffering from hypertension . PSR ¶ 67.
- He is diagnosed as suffering from hypercholesteremia, a heart condition. PSR ¶ 67.
- He underwent a liver transplant in 2010 and takes daily and b-weekly medication. PSR ¶ 66.

Prior to his conviction, Mr. Delgado was licensed to practice law in the State of Texas and was elected numerous times to serve as a judge. As a result of his conviction, Mr. Delgado voluntarily agreed that his license to practice law would be suspended and resigned from his elected position as judge.

III. The Current Coronavirus Situation in Prison.

A. The General Population of Prisoners.

The COVID-19 virus has not been sympathetic to those whose life in prison does not lend itself to social distancing. We have learned that the coronavirus is a particular threat to prison populations because of the circumstances of confinement and the inmates' close proximity to each other. *See* U.S. Congressional Research Service, Federal Prisoners and COVID-19: Background and Authorities to Grant Release, Rpt. No. R46297, April 2, 2020, https://crsreports.congress.gov; https://www.businessinsider.com/trump-consider-coronavirus-executive-order-federal-prisons2020-3. On March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act"), which addressed many issues including incarceration. Under the CARES Act, the U.S. Attorney General and the Director of the Bureau of Prisons were given broader authority to release inmates to home confinement. The Bureau of Prisons has announced that two dozen federal inmates have died of COVID-19 since March 2020, and more than 600 inmates and 350 staffers have tested positive for the virus. On March 26, 2020, the AG issued a memorandum to the BOP Director calling on BOP to grant home confinement to inmates who (a) are at-risk because of health problems, (b) were convicted of non-violent offenses, and (c) pose minimal likelihood of recidivism. He followed that up a week later by issuing a memorandum on April

3, directing the BOP to prioritize those prisoners who reside in facilities that are most affected by COVID-19. In essence, AG Barr recognized that some inmates may be safer at home than in BOP facilities. More than 1,500 prisoners have been sent home early.

B. Prisoners with Health Issues are a Higher Risk to Suffer More Severe Consequences.

Masks and social distancing efforts address the issue of whether someone will contract the virus. But this is not the only issue. Those prisoners who suffer from different diseases are particularly susceptible ***suffering more severe consequences*** of the virus. The Centers for Disease Control and Prevention ("CDC") recognized that "older adults and people of any age who have serious underlying medical conditions might be at higher risk for severe illness from COVID-19." *See* Centers for Disease Control and Prevention, People Who Are at Higher Risk for Severe Illness, April 25, 2020, attached hereto as Exhibit A. The CDC designated nine factors, any one of which would pose a "high-risk for severe illness from COVID-19":

1. People 65 years and older;
2. People living in a nursing home or long-term care facility;
3. People with chronic lung disease or moderate to severe asthma;
4. People who have serious heart conditions;
5. People who are immunocompromised, including those who are receiving or have received cancer treatment, organ transplantation, or possess immune deficiencies;
6. People with severe obesity;
7. People with diabetes;
8. People with chronic kidney disease undergoing dialysis; and,
9. People with liver disease.

See Exhibit A.

Several of these are worthy of examination, as they directly relate to Mr. Delgado's situation.

1. Diabetes & Hypertension.

Persons who are elderly, and who also suffer from hyperglycemia and hypertension are more vulnerable than the average person. *See* International Diabetes Federation, Diabetes Research and

Clinical Practice, Timely Blood Glucose Management for the Outbreak of 2019 Novel Coronavirus Disease is Urgently Needed, Vol. 162, # 108118, April 1, 2020, attached hereto as Exhibit B.

> Due to compromised innate immune response, diabetic patients exist increased susceptibility and enhanced disease severity following SARS-CoV-2 infection. In addition, COVID-19 with diabetes ***has much more potential to progress rapidly*** with acute respiratory distress syndrome and septic shock, which may be eventually followed by multiple organ failure.

Id. (emphasis added)*; see also* Centers for Disease Control and Prevention, Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 - United States, February 12 - March 28, 2020, April 3, 2020, attached hereto as Exhibit C ("Based on preliminary U.S. data, persons with underlying health conditions such as diabetes mellitus, chronic lung disease, and cardiovascular disease, appear to be at ***higher risk for severe COVID-19-associated disease*** than persons without these conditions.").

2. Long-Term Liver Transplant Patients.

Due to the recency of the COVID-19 pandemic, there is not yet substantial data relative to those persons who are long-term liver transplant patients. However, there does appear to be an indication that these persons are particularly susceptible to suffering rapid and severe degeneration of their health at the onset of the virus. *See* The Lancet, Gastroenterology & Hepatology, COVID-19 in Long-Term Liver Transplant Patients: Preliminary Experience from an Italian Transplant Centre in Lombardy, April 9, 2020, DOI: https://doi.org/10.1016/S2468-1253(20)30116-3, attached hereto as Exhibit D. An analysis was conducted of three long-term liver transplant patients, each of which were older than 65 years, receiving antihypertensive drugs, and suffering also from diabetes. *Id.* All three died very soon after being admitted to a hospital, rapidly developing severe respiratory distress syndrome.

Just days ago, the British Liver Trust in England published a notice on the internet that persons who received a liver transplant are at "a very high risk of severe illness from COVID-19" and are

instructed to remain no closer than 6 feet from any other person and to not go outside for any reason. *See* British Liver Trust, Coronavirus - Health Advice for People with Liver Disease and Liver Transplant Patients, April 21, 2020, attached hereto as Exhibit E.

3. Hypercholesterolemia.

The CDC published that "[b]ased on currently available information and clinical expertise, people who have serious heart disease are among those ***more likely to have severe illness from COVID-19***." *See* Centers for Disease Control and Prevention, Familial Hypercholesterolemia, March 20, 2020 (emphasis added), attached hereto as Exhibit F. On its website, the CDC recommends that persons with this diagnosis remain 6 feet away from others, "keep away from people who are sick," and "stay home if possible." *See* Centers for Disease Control and Prevention, What You Can Do, April 3, 2020, attached hereto as Exhibit G (this article was accessed via a link incorporated into the page "Familial Hypercholesterolemia", attached as Exhibit F, where it states "Click here to learn steps you can take to help protect yourself, especially if you are at higher risk of severe illness from COVID-19.").

IV. Mr. Delgado's Situation.

A. BOP's Treatment of Mr. Delgado's Health Problems.

As noted above, Mr. Delgado suffers from hyperglycemia, hypertension, hypercholesteremia, and needs ongoing treatment for issues associated with his liver transplant. He reported to FMC Fort Worth in November 2019, over five months ago. In the FCM Fort Worth facility, prison personnel schedules all medical appointments and procedures; a prisoner literally has no control over whether he is examined by a physician or other medical personnel. Mr. Delgado has had three visits with a physician:

1. Mr. Delgado visited with a general practice physician only once since he arrived in November. The prison has not scheduled Mr. Delgado for another visit with the physician.

2. On one occasion, Mr. Delgado was seen by a gastroenterologist to monitor Mr. Delgado's liver situation. Although the gastroenterologist ordered an endoscopy and colonoscopy months ago, Mr. Delgado has yet to be taken to the hospital for the procedures. He learned that the procedures carry substantial risks given his medical history. He has not been told when, or if, he will be taken to the hospital, and no follow-up examination has been scheduled by the gastroenterologist or other prison official. He has not seen this doctor again.

3. Mr. Delgado was also seen by a cardiologist as a result of his hypercholesteremia and other issues. The doctor did not adjust any medications, and no follow-up meetings have been scheduled by the doctor.

Mr. Delgado was told by physicians prior to entering prison that it is very important that he receive a full checkup of his liver condition every 10 years. His checkup is now due, as he underwent the liver transplant ten years ago. Mr. Delgado sought three (possibly four) times to provide prison medical personnel his Transplant Clinic Orders, which document his transplant physician's orders that Mr. Delgado should receive a lab test (AFP Tumor Marker) and an ultrasound of the liver as soon as possible. Each of these three times, no action was taken by the prison employee personnel (non-physicians), as they each indicated they did not know what action they were supposed to take. Finally, on April 2, 2020, Mr. Delgado was able to convince one non-physician employee to take the Orders and make a copy. Almost four weeks have gone by, and Mr. Delgado still has not been provided the opportunity to discuss these Orders or the required tests with his general physician or any other physician. Nor will anyone tell him when he can see these doctors or whether they are going to give him these needed examinations. He receives a daily temperature check for fever, but there are no other COVID-19 examinations or testing being conducted on him (or others insofar as he knows).

B. Mr. Delgado Suffers Almost All of the High-Risk Factors.

Mr. Delgado is burdened with suffering not only one or two of the high-risk factors identified by the CDC and other medical professionals, but virtually all of them:

High-Risk COVID-19 Factors identified by CDC and Diabetes and Liver Disease Experts	**Mr. Delgado**
1. People 65 years or older	67 years old
2. People living in a nursing home or long-term care facility	He is living in a long-term medical care facility
3. People who are immunocompromised, including those who have received an organ transplant	He received an organ transplant in January 2010 and is taking immunosuppressed medication (PSR ¶ 66)
4. People with diabetes & hypertension	He is diagnosed with hyperglycemia & hypertension (PSR ¶ 67)
5. Long-term liver transplant patient	He received a liver transplant in 2010.
6. People with hypercholesterolemia, a severe heart disease	He is diagnosed with hypercholesterolemia (PSR ¶ 67)

C. Mr. Delgado's Current Living Conditions.

Burdened with so many high-risk factors, one would think that special attention would have to be paid to Mr. Delgado to protect him from contracting COVID-19. Unfortunately, not so. He was assigned to a 2-man cell with a 79-year-old cellmate who suffers from leukemia. Due to the small size of the cell, Mr. Delgado's bunk has to touch his cellmate's bunk. All inmates on the first floor of his area have disabilities and illnesses; some require wheelchairs, walkers or otherwise are unable to climb stairs. As noted above, Mr. Delgado lives in a long-term medical care facility. The second floor of the unit where Mr. Delgado's cell is situated has one large room where over 100 inmates gather. Inmates are free to go to/from the first and second floor. There are approximately 250 inmates in the unit. Social distancing in this close-confined area as well as inside his individual cell is impossible. There is only one entrance/exit to the one large room where inmates are allowed to access. This doorway leads to a central hallway which is the only way to access Mr. Delgado and others' cells.

All inmates, including those on wheelchairs and walkers, line up on both sides of the narrow hallway each day to receive their mail. They are instructed to squeeze in next to each other in order to have room for everyone to line up. They then are called to walk one-by-one to the end of the hallway between the two lines of men when their name is called in order to retrieve their mail. They walk back to their place in line between the lines of men and wait to walk up again as many times as their name is called (the pile of mail is not segregated by name when being called out). This procedure takes some time given the number of prisoners.

When it is time to eat, the inmates are again instructed to line up on both sides of the hallway, each one closely behind the man in front of him, and close to the men on the other side of the narrow hallway. The men walk slowly in line downstairs to receive their meal. Once the meal is given to an inmate, the inmate turns and climbs back up the stairs in between the lines of men walking slowly downstairs on each side of the hallway. Again, no social distancing is possible.

Their sinks are immediately next to each other in the group restroom. The urinals are close enough so that one's face is 18 inches from the other man's face next to him. In the computer room, computers are situated next to each other, less than 2 feet apart, and are continuously used by prisoners to access email, communicate with staff counselors and case managers, receive bulletins issued by the BOP, and access the commissary account. Computer keyboards are never cleaned, though used by all. There are no sanitizers in the rooms nor gloves.

Telephones are located on the floor of the unit, and also are continuously used by inmates to contact family, lawyers and others. Visitation to all BOP facilities was terminated upon the onset of COVID-19 and policy was changed to allow up to 500 minutes of free calls per month. Because of this, telephone use increased dramatically. Again, the phones are never cleaned, inmates are not using masks when talking on the phones, there are no sanitizers close by, and there is no washing of hands prior to each prisoner's use of the phone.

Once each week, inmates again are told to line up on both sides of the hallway and to bring their towels, washcloths, bed linen and pillowcase. The men in the two lines in the hallway are told to walk in a line downstairs, and then place his soiled items in large bins, one-by-one. The bins accommodate several hundred articles of items. Each inmate is then given a laundered exchange of whatever item was placed in the bins. The line keeps moving, each man close to the man in front of him, until they return to their cells upstairs. Again, there is no social distancing, and coughing and sneezing by anyone so afflicted must be borne by others during all walks of this nature. The inmates are not allowed to know the procedure for washing and stacking the clean items, other than they are washed in a large machine to accommodate everyone's items.

This procedure is repeated for clothing, but on another day. When an inmate receives a new pillowcase or towel, it is undoubtedly that of a different prisoner's dirty laundry from days before. Thus, the inmates are forced to rely on those who wash the items to ensure that any potential virus is eliminated from the cleaning process.

Given that this is a medical facility, coughing and sneezing and other bodily functions are common. Masks have been issued to each prisoner, but most often are not worn by many of the prisoners, particularly the younger ones, and prison officials do not mandate that they be worn, except for certain isolated instances. Men walk around in close proximity to each other without masks. Masks are washed as well, but an inmate is not returned the mask that he has been wearing; he is given a mask that was worn by another prisoner and told that it was washed. Inmates were told that they are not allowed to wash their own masks.

But again, the issue is not only whether Mr. Delgado will contract the virus, but the extent to which he will experience a rapid, severe reaction which could lead to death given his medical condition.

D. COVID-19 Infections in the FMC Fort Worth Prison Facility.

Several days ago, a prisoner housed in the same prison facility as Mr. Delgado died. Arnoldo Almeida, 61 years old, tested positive for COVID-19 on April 13, 2020, and was placed in isolation. Although he was placed on a ventilator this past Saturday, he died less than 10 days after the prison realized he was infected. *See* NBCDFW News, Inmate Dies of Coronavirus Amid Outbreak at Fort Worth Federal Prison Where "Tiger King" is Held, April 22, 2020, attached hereto as Exhibit H. There is no indication from whom inside Mr. Delgado's unit Mr. Almeida contracted the virus.

In the past two days, Mr. Delgado and others in his unit saw three inmates taken away by gurney to an ambulance. The crew taking them all were wearing protective gear and the patients looked in severe distress.

The BOP's website indicates that ***two hundred seventeen (217) inmates*** at FMC Fort Worth have tested positive for COVID-19. *See* Federal Bureau of Prisons, COVID-19 Coronavirus, printed April 26, 2020, attached hereto as Exhibit I. In fact, FMC Fort Worth is the ***highest ranked prison facility in the country*** for the number of inmates affected. Remarkably, BOP indicates that the prisoners at FMC Fort Worth have experienced ***three times as many positive infections as any other prison facility*** in the United States. *Id.,* p. 2; *see also* USA Today, Federal Prison System Expands Virus Testing to Find Hidden Asymptomatic Infections, Kevin Johnson, April 23, 2020, attached hereto as Exhibit J (FMC Fort Worth ranks among the highest in number of infections).

One staff member at FMC Fort Worth has tested positive, and two inmates have died at this facility. *Id.* Employees at this particular prison facility realize the risk is very real: The leader of the prison employees' union said employees are taking off their work clothes outside their homes and disinfecting them to avoid contaminating their families. The union leader expressed that the "big concern right now is I don't believe we've peaked yet. We have a lot of elderly inmates with underlying health issues." *See* Exhibit H.

Perhaps the most glaring example of the precarious and dangerous situation that Mr. Delgado faces is the photograph depicted in the NBCDFW article, attached as Exhibit H.

Federal prison correctional officer Gregory Watts shows the protective gear employees at Federal Medical Center Fort Worth are wearing.

The situation at FMC Fort Worth is so dire that prison officials wear protective gear, protecting their hands and body. Unfortunately, the same benefit is not given to the inmates in FMC Fort Worth who have to stand next to each other, and sleep and eat and breathe and cough within two feet of each other on a 24-hour basis.

E. Mr. Delgado's Administrative Request.

Upon realizing that his age and physical maladies place him in the upper level of risk for severe consequences of COVID-19, plus the fact that his proximity to other sick prisoners without adequate protection leave him in an extremely vulnerable place, Mr. Delgado presented an administrative request for compassionate release. On April 1, Mr. Delgado met with his case manager, Mr. Brown, and requested a release to home confinement. Mr. Brown asked that Mr. Delgado return to see him on April 3. On April 3rd, Mr. Delgado hand delivered a completed form (Form FTW 1330.13,

commonly referred to as "BP 8") requesting transfer to home confinement, with attachments, to his case manager Mr. Brown and his Unit Manager Mr. Gutierrez. He had obtained the administrative form from his counselor, Mr. Cruz. Mr. Delgado spoke to three prison officials about his unique vulnerability, even among others who are sick, and his request for transfer to home confinement.

Seven days went by and he received no response. On April 10, he wrote an email to his case manager Mr. Brown, detailing again his request for transfer to home confinement. In the email, he provided more information to demonstrate about his medical history that matched closely the criteria set out by Attorney General Barr in his directive. On April 11, Mr. Delgado's unit officer gave him BOP's written response which indicated on its face that it had been signed on April 6 by the Unit Manager Mr. Gutierrez. The response stated that Mr. Delgado's request was under consideration.

On April 13, however, he received another written response to his request. This appeared to be the same response, also signed by the same Unit Manager Mr. Gutierrez, but with a date of signature of April 10. Again, the response stated that the request was under consideration. The fact that Unit Manager Mr. Gutierrez signed one response dated April 6 and then again the same exact typed response on April 10 suggests that Mr. Gutierrez may not be reviewing these requests intently. Otherwise, why would he sign a response on April 10 that reads and appears exactly the same as the response that he had signed four days earlier, unless he had not read Mr. Delgado's request?

On April 16, Mr. Delgado went again to see Mr. Brown, his case manager. Mr. Brown had Mr. Delgado's request on his desk and indicated to Mr. Delgado that they had submitted his request. Mr. Brown related to Mr. Delgado appeared to be a good candidate for release as he did not pose a risk for recidivism. Nevertheless, the request was still pending consideration. Although Mr. Brown asked for Mr. Delgado's wife's name and address (a common procedure if BOP is truly investigating a transfer to home confinement), neither Mr. Delgado nor his wife have been contacted by BOP relative to release.

Clearly, current BOP policy dictates that Mr. Delgado would have to undergo a 14-day quarantine if he was chosen for transfer to home confinement. This has not happened, nor has he been given any indication that his request will be granted. Meanwhile, the virus was spreading rapidly at FMC Fort Worth with one death and three other persons carted away in the last five days. Mr. Delgado was holding out hope until he and other prisoners received a shock on April 23rd.

F. Arbitrariness of BOP Release Policy.

On April 23, Warden Wilson of FMC Fort Worth released a bulletin to the prisoners. It announced that BOP policy changed on all home confinement requests; such requests would be prioritized according to whether the prisoner has served at least 50% of their sentence or served at least 25% and have 18 months or less to serve. Obviously, Mr. Delgado does not fit within this criterion.

Initially, the policy for transferring prisoners to home confinement in response to the COVID-19 pandemic was to allow transfer for those prisoners who pose a particularly high risk of severe illness and death, were convicted of a non-violent offense, and posed minimal likelihood of recidivism. The policy was not intended to be driven by how much of one's sentence a prisoner has served. As noted above, the Attorney General and Director of Bureau of Prisons were given authority to relax the criteria to qualify for compassionate release. On March 26, the AG released a memorandum authorizing BOP to begin releasing prisoners. *See* Memorandum for Director of Bureau of Prisons, Attorney General William Barr, March 26, 2020, attached hereto as Exhibit K. Attorney General Barr placed emphasis on the reason for change in policy:

TRANSFER OF INMATES TO HOME CONFINEMENT
WHERE APPROPRIATE TO DECREASE THE RISKS TO THEIR HEALTH

Ex. K, p. 1.

AG Barr's March 26 memo included criteria, ***none of which*** related to the percentage of time served. He mandated that an assessment be made "of the inmate's risk factors for severe COVID-19 illness,

risks of COVID-19 at the inmate's prison facility, as well as the risks of COVID-19 at the location in which the inmate seeks home confinement." Attorney General Barr's second memorandum on April 3rd emphasized that focus should be made at those BOP facilities which are most affected. *See* Memorandum for Director of Bureau of Prisons, Attorney General William Barr, April 3, 2020, attached hereto as Exhibit L. The subject line of Attorney General Barr's second memo was: Increasing Use of Home Confinement at Institutions Most Affected by COVID-19. *See* Exhibit L, p. 2. Over three weeks have passed since the release of that memo. People have died and been infected within FMC Fort Worth since the release of that memo. There is an emergency situation within this facility.

Yet, for no apparent reason, the prioritization of criteria changed this past week. Undersigned counsel could not find anything published to indicate the reason for this sudden and unexpected change in policy. Indeed, neither directive issued by Attorney General Barr makes mention of an arbitrary percentage of sentence being served. Unfortunately, the BOP has been less than consistent in its application of AG Barr's direction. Many prisoners (not Mr. Delgado) were placed into quarantine in the last two weeks and their families were notified that prisoners were being prepared for release. Suddenly, without warning, BOP altered its strategy on April 23rd, pulled prisoners out of quarantine back into general population, and issued a new directive driven by percentage of time served. The change in strategy did not go unnoticed. *See* Politico, Trump Administration Reverses Prisoner Coronavirus Release Policy, Advocates Say, April 26, 2020, attached hereto as Exhibit M; Washington Post, Amid Coronavirus Pandemic, Federal Inmates Get Mixed Signals About Home-Confinement Release, April 24, 2020, attached hereto as Exhibit N; *see also United States v. Lewis Stahl,* No. 18-cr-694 (RA) (S.D. N.Y. Apr. 24, 2020) (U.S. District Judge Ronnie Abrams orders government to explain switch in policy).

G. Exhaustion of Administrative Remedy.

Although Mr. Delgado's administrative request has not been formally denied, it certainly has been effectively denied. The urgency of his medical condition coupled with what has occurred in recent weeks at FMC Fort Worth indicate that further efforts at obtaining administrative relief are futile. If BOP followed its initial policy that focused on the health of the prisoner, it would have to recognize that Mr. Delgado is burdened with having six of the nine "risk factors for severe COVID-19 illness" identified by the CDC. *See* Exhibit A (analysis of factors discussed above). He is imprisoned at a prison facility which ranks ***the highest in the nation*** for persons who have contracted the COVID-19 disease, more than ***three times*** the next highest number. *See* Federal Bureau of Prisons, COVID-19 Coronavirus, printed April 26, 2020, attached hereto as Exhibit I. Mr. Delgado has requested transfer to home confinement with his wife and no others, a place where there is minimal risk of infection, if at all. In short, he is a poster prisoner under the initial criteria described by Attorney General Barr and the CDC.

The President of the United States has declared a state of emergency because of the threat of the coronavirus to the lives of those in federal. Courts have recognized that the judicial branch may act without waiting for a final decision by the BOP. *See FDIC v. Scott*, 125 F.3d 254, 258 (5th Cir. 1997)(when administrative exhaustion step is futile, court may waive requirement); *United States v. Perez*, No. 17-cr-513-3 (S.D. N.Y. Apr. 4, 2020). Further, under this Court's supervisory powers the Court may formulate procedural rules not specifically required by the Constitution to implement a remedy for recognized rights. *United States v. Santana,* 6 F.3d 1, 10 (1st Cir. 1993). As the court found in *United States v. Perez*, even where exhaustion is mandated by statute the requirement is not absolute and may be waived by the district court. *United States v. Perez, supra* at 3-4, citing *McCarthy v. Madigan*, 503 U.S. 140, 146-147 (1992) & *Washington v. Barr*, 925 F.3d 109, 1118 (2d Cir. 2019). The court recognized three circumstances where failure to exhaust may be excused. "First, exhaustion may be

unnecessary where it would be futile, either because agency decisionmakers are biased or because the agency has already determined the issue." *Id.* Second, "exhaustion may be unnecessary where the administrative process would be incapable of granting adequate relief." *Id.* Third, "exhaustion may be unnecessary where pursuing agency review would subject plaintiffs to undue prejudice." *Id.* The Court found that "undue delay, if it in fact results in catastrophic health consequences, could make exhaustion futile. Moreover, the relief the agency might provide could, because of undue delay, become inadequate. Finally, and obviously, [Perez] could be unduly prejudiced by such delay." *Id.* citing *Washington v. Barr, supra* & *Bowen v. City of New York,* 476 U.S. 467, 483 (1986) (irreparable injury justifies waiver of exhaustion requirements where severe medical setback may be triggered by administrative process). As noted by the *Perez* court, "even a few weeks' delay carries the risk of catastrophic health consequences" and found that "requiring him to exhaust administrative remedies, given his unique circumstances and the exigency of a rapidly advancing pandemic, would result in undue prejudice and render exhaustion of the full BOP administrative process both futile and inadequate." *United States v. Perez, supra* at 4-5; *see also Miller v. United States,* No. 16-20222-1, 2020 U.S. Dist. LEXIS 62421 (E.D. Mich. Apr. 9, 2020) (court may waive exhaustion requirement if recognized exception applies); *United States v. Rodriguez,* No. 03-cr-00271-01 (E.D. Penn. Mar. 26, 2020) (initial denial of request by BOP render "almost certainty" that further administrative appeals would be "both futile and perilously time consuming; time Mr. Rodriguez does not have"); *United States v. Latrice Colvin,* No. 3:19-cr-179 (JBA) (D. Conn. Apr. 2, 2020) (compassionate release motion granted).

The District Court in the District of Connecticut found that waiver of exhaustion of administrative remedy was warranted ***even though the defendant had not yet received a response from BOP on her administrative request.*** *United States v. Latrice Colvin,* No. 3:19-cr-179 (JBA), p. 2 (D. Conn. Apr. 2, 2020). The Government objected to the defendant's motion, arguing that the BOP had not yet ruled upon her administrative request for transfer to home confinement, and thus the

defendant had not exhausted her administrative remedies. *Id.* The rejected the Government's objection, finding all three exceptions: (1) undue delay could result in catastrophic health consequences, making exhaustion futile, (2) exhaustion is unnecessary where the administrative process is incapable of granting adequate relief, and (3) exhaustion is unnecessary where pursuing agency review would subject the defendant to undue prejudice. *Id.* at 3.

Similarly, all three exceptions apply in the instant case. BOP officials received Mr. Delgado's first verbal request on April 1st; his first written request was submitted April 3rd. He has met with his case manager and unit manager several times since then and was told the request is being considered.

It is now 26 days after his request has been made, and BOP continues to delay giving him notice. Even more telling of the prospects of ultimately receiving a rejection is the posting of a bulletin that prisoners will be released to home confinement only if 50% of their sentence has been served (or 25% if they only have 18 months or less to serve). Waiting for a definitive, written rejection is using up time that Mr. Delgado does not have. Such a delay paints a picture of a dire emergency situation, given (a) his 6-level severe risk factors relative to COVID-19, (b) his prison facility is the highest ranked facility for COVID-19 infections, and (c) his fellow inmates are dying or contracting the virus at an alarming rate in the last few days, with no indication from whom each of them contracted the virus within the facility. Who in the FMC Fort Worth unit is carrying the disease? Just yesterday, it was published that "ninety-six percent of inmates in four state prisons who tested positive for coronavirus were asymptomatic." *See* The Hill, Ninety Six Percent of Inmates in Four State Prisons Who Tested Positive for Coronavirus were Asymptomatic, Marty Johnson, April 25, 2020, attached hereto as Exhibit O.

This added to the fact that there is no testing going on within FMC Fort Worth makes this an emergency situation. BOP's delay within the FMC Fort Worth facility could bring catastrophic health consequences, making exhaustion futile. We know that the coronavirus spreads exponentially. Because

of the delay visited by exhaustion, the relief the agency could possibly provide would likely be inadequate by the time it is provided. Mr. Delgado would be unduly and possibly irreparably prejudiced if he gets infected.

The provision allowing defendants to bring motions for compassionate release under § 3582(c) was added by the First Step Act "to increase the use and transparency of compassionate release." *Id.* at 5. Multiple courts across the country are taking the initiative to address this severe health concern where the BOP is demonstrating that it is ill-equipped to do so, including several courts within the Houston Division of the Southern District of Texas. A defendant is eligible for compassionate release if the Court finds "extraordinary or compelling reasons" to warrant a sentence reduction. 18 U.S.C. § 3582(c)(1)(A). The First Step Act did not define what "extraordinary or compelling reasons" warrant a sentence reduction, but the compassionate release statute directs the Court to consider the Sentencing Commission's policy statements when deciding compassionate release motions. *United States v. Gonzalez, supra* at 4, citing 18 U.S.C. § 3582(c)(1)(A). The Sentencing Commission's policy statement has not yet been updated to reflect the procedural change brought about by the First Step Act, however "[w]hile that particular policy statement has not yet been updated to reflect that defendants (and not just the [Bureau of Prisons ("BOP")]) may move for compassionate release, courts have universally turned to U.S.S.G. § 1B1.13 to provide guidance on the 'extraordinary and compelling reasons' that may warrant a sentence reduction." *Id.* at 5, citing *United States v. McGraw,* No. 2:02-cr-00018-LJM-CMM, 2019 WL 2059488, at *2 (S.D. Ind. May 9, 2019) (gathering cases). The Sentencing Commission policy statement on reductions of sentences under 18 U.S.C. § 3582(c)(1)(A) lists four specific categories of "extraordinary and compelling reasons" but expressly does not restrict what combination of factors can warrant release. U.S.S.G. § 1B1.13 (p.s.), comment. (n.1(A)-(D)). One category recognizes that there may "other reasons" not specifically identified in the application note but which recognize that an extraordinary situation may compel release. *See* Category D of note 1,

U.S.S.G. § 1B1.13; *see, e.g., United States v. Gonzalez, supra* at 6 (COVID-19 situation coupled with defendant's physical situation were sufficient "other reasons" to compel release).

Our country is experiencing an unprecedented change to our way of life. Persons and offices across the country, indeed the globe, have been forced to change our thinking and way of living. Courts and offices associated with the business of running the criminal justice system are no exception. Indeed, because this system includes the management of large groups of people at a time, extraordinary measures have been undertaken to protect those managing the system as well as the persons we are called to serve. Almost daily, orders are being issued by governing courts in the federal and state systems of justices. With the benefit of our internet, we can see at a glance what others are doing in different jurisdictions to respond to the current situation.

Evident from published reports, jails across the United States have taken unusual yet necessary steps to protect all involved. Mayor Bill de Blasio of New York City declared that "vulnerable" prisoners were to be released from jails. This announcement came days after the same action had been taken by the cities of Los Angeles and Cleveland. Los Angeles Sheriff Alex Villanueva stated the obvious: "Our population within our jails is a vulnerable population just by who they are, where they are located, so we're protecting that population from potential exposure." Santa Clara County Assistant Public Defender Charlie Hendrickson commented on the banding together of courts, attorneys and law enforcement officials: "This is a humanitarian crisis confronting all of us, and one of the most important ones is the jail. This is a time of urgent need and creativity. We're going to responsibly reduce the jail population." Mayor de Blasio stated that city officials would seek to identify those prisoners who were most vulnerable to infection due to underlying health problems. Other countries have taken the same approach with respect to their prisoners. One need only to type *"jails releasing prisoners to stem covid 19 coronavirus"* onto an internet search engine to find a wealth of publications on the topic.

Mr. Delgado's situation is not a close case. The sheer number of six at-risk factors that plague him in the midst of a particularly vulnerable location make this the exact type of extraordinary and compelling case that warrants an immediate response. This Court never intended its sentence of imprisonment to practically result in a death sentence. It is not hyperbole to consider that Mr. Delgado is serving a sentence in a situation in which there is a significant likelihood of severe illness and death. He has tried to make the best of his time there. He has a job as a "compound worker," walking the compound with a broom and dustpan to pick up trash throughout the compound. He initially applied for a job at the chapel or library but was not called for an interview; he did not sit on his hands and do nothing, but rather decided then to apply as a compound worker. Mr. Delgado was selected to work in the psychology department as a mental health "companion," helping other inmates who are experiencing trouble adjusting to prison life, but the "lockdown" of the prison facility on April 1 negated his opportunity. Mr. Delgado attends Narcotics Anonymous to address issues of alcohol use, and participates in the church choir, services and rehearsals. He also enrolled in a 12-month educational and spiritual program called "Threshold," which is a program for positive change, emotional and mental health, and personal responsibility, and also enrolled in a 13-week educational program called "A Sense of Self," designed with a life behavior curriculum. FMC Fort Worth notified Mr. Delgado that he was eligible to participate in RDAP based on his past alcohol abuse and was scheduled to begin the program in July 2020, but that was before COVID-19 hit. Participation in RDAP would have reduced his sentence by 9 months. This reduction, together with a 15% reduction for good time and early release to a halfway house or home detention pursuant to the First Step Act of 2018, would mean that Mr. Delgado would likely have been released from imprisonment after 36 months of time served. A modification of sentence to time served with a condition of home confinement is not as stark given the reductions of time Mr. Delgado would likely receive. This type of modification is a remedy available to this Court. *See United States v. Kirk Lawrence Brannan,* No. 4:15-cr-00080-1 (S.D. Tex. Apr. 2, 2020) (Chief Judge Lee H. Rosenthal grants emergency

motion for compassionate release, reduces sentence from 36 months [issued on April 1, 2019] to time served, followed by 3-year term of supervised release, requiring at least 12 months home incarceration).

While Mr. Delgado appreciates that he has served 5 months of a "60-month" sentence, he never contemplated the extreme medical danger that he now faces. The Court may also consider that a reduction to time served (coupled with a condition of home confinement) can be based on the reasoning behind the "shock probation" sentencing concept utilized in Texas and other states. Under that methodology, a limited time in prison is deemed sufficient to advance the goals of sentencing under certain circumstances. Clearly, Mr. Delgado has worked hard in these past five months to address the factors that brought him to be investigated and prosecuted and is demonstrating a contrite and humble spirit. In other words, this motion is not being filed by a person who is moaning and complaining about being in prison, sitting around waiting for the day to be released. Mr. Delgado not only is burdened with a grave and serious health risk, but has demonstrated to a large degree, and will continue to demonstrate, that he is prepared to make amends for his sins and contribute to his community in a healthy and productive way. This assume, of course, that he is alive to do so.

WHEREFORE, Mr. Delgado humbly requests that this Court grant this motion and re-sentence him to a sentence of time-served or, alternatively, a sentence of time-served followed by a term of supervised release that requires home confinement for a period of time.

Respectfully submitted,

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Telephone: (210) 225-2285
ATTORNEY FOR DEFENDANT

CERTIFICATE OF SERVICE

I hereby certify that on April 27, 2020, I electronically filed the foregoing with the Clerk of Court using the ECF system, which sent notification of such filing to all counsel of record.

By: */s/ Michael McCrum*
Michael McCrum

CERTIFICATE OF CONFERENCE

I hereby certify that I communicated with DOJ Trial Attorney Peter Nothstein about the instant motion. He indicated to me today, April 27, that he has sought to contact BOP officials at FMC Fort Worth but cannot reach anyone, and that he left a message but has not received a return call. Mr. Nothstein indicated that he cannot tell me the Government's position on the instant motion until he speaks with someone at FMC Fort Worth. Given the emergency nature of this motion, plus the fact that BOP officials are not responding to Mr. Delgado about his request either, the instant motion is being filed without knowing the Government's position.

By: */s/ Michael McCrum*
Michael McCrum

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

UNITED STATES OF AMERICA, PLAINTIFF	§	
V.	§	CASE NO. 18-CR-00115
RODOLFO "RUDY" DELGADO, DEFENDANT	§	

ORDER

Came on to be considered Defendant's Emergency Motion for Compassionate Release. The Court finds that the motion should be granted. Accordingly,

IT IS HEREBY ORDERED that Defendant's Emergency Motion for Compassionate Release is granted.

SIGNED this _____ day of _____, 2020.

_____
Alfred Bennett
United States District Judge

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Exhibit A

People Who Are at Higher Risk for Severe Illness

COVID-19 is a new disease and there is limited information regarding risk factors for severe disease. Based on currently available information and clinical expertise, **older adults and people of any age who have serious underlying medical conditions** might be at higher risk for severe illness from COVID-19.

Based on what we know now, those at high-risk for severe illness from COVID-19 are:

- People 65 years and older
- People who live in a nursing home or long-term care facility

People of all ages with underlying medical conditions, particularly if not well controlled, including:

- People with chronic lung disease or moderate to severe asthma
- People who have serious heart conditions
- People who are immunocompromised
  - Many conditions can cause a person to be immunocompromised, including cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

Older Adults

People with Asthma

At Risk For Severe Illness

People with HIV

COVID-19: Are You at Higher Risk for Severe Illness?

Resources

- ASL Video Series: COVID-19: Are You at Higher Risk for Severe Illness?
- Learn how you can help protect yourself if you are at higher risk of severe illness from COVID-19

Page last reviewed: April 15, 2020

Exhibit B

FULL LENGTH ARTICLE | VOLUME 162, 108118, APRIL 01, 2020

Timely blood glucose management for the outbreak of 2019 novel coronavirus disease (COVID-19) is urgently needed

Aihong Wang • Weibo Zhao • Zhangrong Xu • Jianwen Gu

Published: March 13, 2020 • DOI: https://doi.org/10.1016/j.diabres.2020.108118 •

Since December 2019, a novel coronavirus disease (COVID-19) caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was emerged in Wuhan, China. Due to sustained human-to-human transmission, the rapid spread of SARS-CoV-2 results in a formidable outbreak in many cities in China and expanding internationally, including Japan, South Korea and the United States. As of 24 February 2020, this new emerging virus had caused a total of 79,331 confirmed cases with 2618 deaths globally. The population is generally susceptible to this coronavirus, and the elderly and those with certain underlying diseases are more vulnerable to SARS-CoV-2, including hypertension and diabetes [1, 2]. It was reported that the overall proportion of diabetes in COVID-19 was from 5.3% to 20% [1, 2, 3, 4, 5, 6]. Due to compromised innate immune response, diabetic patients exist increased susceptibility and enhanced disease severity following SARS-CoV-2 infection. In addition, COVID-19 with diabetes has much more potential to progress rapidly with acute respiratory distress syndrome and septic shock, which may be eventually followed by multiple organ failure. Comorbid diabetes was associated with much more intensive care unit (ICU) admission. Compared with patients who did not receive ICU care, ICU patients with virus infection were more likely to have underlying diabetes (22.2% vs 5.9%) [1]. Clinical data shown that the mortality of COVID-19 patients

of COVID-19 with diabetes up to 7.3% (80/1102), which is dramatically higher than that of the patients without any comorbidities (0.9%, 133/15,536) [6]. Infection of SARS-CoV-2 with diabetes might trigger stress condition and increased secretion of hyperglycemic hormones, such as glucocorticoid and catecholamines, which results in elevated blood glucose, abnormal glucose

lity and diabetic complications. Moreover, in order to raise admission capacity of local

als, huge amount of Chinese medical personnels went to Wuhan, the epicenter

outbreak, to battle against this epidemic. However, compared with professional endocrinologists, most of front-line respirologists and critical care specialists in Wuhan may be lack of the concern of blood glucose and insufficient of clinical experience of diabetes therapy, which may lead to blood glucose fluctuation for patients with diabetes. Therefore, timely and standardized blood glucose management for diabetic patients with COVID-19 is urgently needed.

For the COVID-19 patients with diabetes, tailored therapeutic strategy and optimal goal of glucose control should be formulated based on clinical classification, coexisting comorbidities, age and other risk factors. Blood glucose should be controlled for all patients during hospitalization to monitor the progress of illness and avoid aggravation. For critical cases, early identification and timely reduction adverse drug reaction (for instance, glucocorticoid-induced hyperglycemia) could prevent worse symptoms. During the 4-week follow-up period after discharge, blood glucose homeostasis should be maintained continuously and patients need to avoid infectious diseases due to a lower immune response. Long-term follow-up is still essential for diabetic patients to reduce diabetes-related complications and mortality.

With the aim of preventing person-to-person transmission, a variety of online services of glucose management have been implemented widely for diabetic patients and general population during the outbreak of COVID-19 in China. The popularization of Internet and smartphones, as well as emerging fifth generation networks, have ensured endocrinologists to provide remote medical consultation for the patients who are not advised to go to the hospital during the COVID-19 outbreak. Furthermore, free educational videos and e-books on diabetes self-management and COVID-19 prevention have been provided for the public via WeChat mobile app. To date, these online services and resources have played remarkable roles in the nationwide COVID-19 control in China.

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Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships uld have appeared to influence the work reported in this paper.

Appendix A. Supplementary data

The following are the Supplementary data to this article:

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Help with xml files

Supplementary data 1

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Centers for Disease Control and Prevention

Morbidity and Mortality Weekly Report (*MMWR*)

Weekly / April 3, 2020 / 69(13);382–386

Exhibit C

On March 31, 2020, this report was posted online as an MMWR *Early Release.*

CDC COVID-19 Response Team (View author affiliations)

View suggested citation

Summary

What is already known about this topic?

Published reports from China and Italy suggest that risk factors for severe COVID-19 disease include underlying health conditions, but data describing underlying health conditions among U.S. COVID-19 patients have not yet been reported.

What is added by this report?

Based on preliminary U.S. data, persons with underlying health conditions such as diabetes mellitus, chronic lung disease, and cardiovascular disease, appear to be at higher risk for severe COVID-19–associated disease than persons without these conditions.

What are the implications for public health practice?

Strategies to protect all persons and especially those with underlying health conditions, including social distancing and handwashing, should be implemented by all communities and all persons to help slow the spread of COVID-19.

On March 11, 2020, the World Health Organization declared Coronavirus Disease 2019 (COVID-19) a pandemic (*1*). As of March 28, 2020, a total of 571,678 confirmed COVID-19 cases and 26,494 deaths have been reported worldwide (*2*). Reports from China and Italy suggest that risk factors for severe disease include older age and the presence of at least one of several underlying health conditions (*3*,*4*). U.S. older adults, including those aged ≥65 years and particularly those aged ≥85 years, also appear to be at higher risk for severe COVID-19–associated outcomes; however, data describing underlying health conditions among U.S. COVID-19 patients have not yet been reported (*5*). As of March 28, 2020, U.S. states and territories have reported 122,653 U.S. COVID-19 cases to CDC, including 7,162 (5.8%) for whom data on underlying health conditions and other known risk factors for severe outcomes from respiratory infections were reported. Among these 7,162 cases, 2,692 (37.6%) patients had one or more underlying health condition or risk factor, and 4,470 (62.4%) had none of these conditions reported. The percentage of COVID-19 patients with at least one underlying health condition or risk factor was higher among

those requiring intensive care unit (ICU) admission (358 of 457, 78%) and those requiring hospitalization without ICU admission (732 of 1,037, 71%) than that among those who were not hospitalized (1,388 of 5,143, 27%). The most commonly reported conditions were diabetes mellitus, chronic lung disease, and cardiovascular disease. These preliminary findings suggest that in the United States, persons with underlying health conditions or other recognized risk factors for severe outcomes from respiratory infections appear to be at a higher risk for severe disease from COVID-19 than are persons without these conditions.

Data from laboratory-confirmed COVID-19 cases reported to CDC from 50 states, four U.S. territories and affiliated islands, the District of Columbia, and New York City with February 12–March 28, 2020 onset dates were analyzed. Cases among persons repatriated to the United States from Wuhan, China, and the Diamond Princess cruise ship were excluded. For cases with missing onset dates, date of onset was estimated by subtracting 4 days (median interval from symptom onset to specimen collection date among cases with known dates in these data) from the earliest specimen collection. Public health departments reported cases to CDC using a standardized case report form that captures information (yes, no, or unknown) on the following conditions and potential risk factors: chronic lung disease (inclusive of asthma, chronic obstructive pulmonary disease [COPD], and emphysema); diabetes mellitus; cardiovascular disease; chronic renal disease; chronic liver disease; immunocompromised condition; neurologic disorder, neurodevelopmental, or intellectual disability; pregnancy; current smoking status; former smoking status; or other chronic disease (*6*). Data reported to CDC are preliminary and can be updated by health departments over time; critical data elements might be missing at the time of initial report; thus, this analysis is descriptive, and no statistical comparisons could be made.

The percentages of patients of all ages with underlying health conditions who were not hospitalized, hospitalized without ICU admission, and hospitalized with ICU admission were calculated. Percentages of hospitalizations with and without ICU admission were estimated for persons aged ≥19 years with and without underlying health conditions. This part of the analysis was limited to persons aged ≥19 years because of the small sample size of cases in children with reported underlying health conditions (N = 32). To account for missing data among these preliminary reports, ranges were estimated with a lower bound including cases with both known and unknown status for hospitalization with and without ICU admission as the denominator and an upper bound using only cases with known outcome status as the denominator. Because of small sample size and missing data on underlying health conditions among COVID-19 patients who died, case-fatality rates for persons with and without underlying conditions were not estimated.

As of March 28, 2020, a total of 122,653 laboratory-confirmed COVID-19 cases (Figure) and 2,112 deaths were reported to CDC. Case report forms were submitted to CDC for 74,439 (60.7%) cases. Data on presence or absence of underlying health conditions and other recognized risk factors for severe outcomes from respiratory infections (i.e., smoking and pregnancy) were available for 7,162 (5.8%) patients (Table 1). Approximately one third of these patients (2,692, 37.6%), had at least one underlying condition or risk factor. Diabetes mellitus (784, 10.9%), chronic lung disease (656, 9.2%), and cardiovascular disease (647, 9.0%) were the most frequently reported conditions among all cases. Among 457 ICU admissions and 1,037 non-ICU hospitalizations, 358 (78%) and 732 (71%), respectively occurred among persons with one or more reported underlying health condition. In contrast, 1,388 of 5,143 (27%) COVID-19 patients who were not hospitalized were reported to have at least one underlying health condition.

Among patients aged ≥19 years, the percentage of non-ICU hospitalizations was higher among those with underlying health conditions (27.3%–29.8%) than among those without underlying health conditions (7.2%–7.8%); the percentage of cases that resulted in an ICU admission was also higher for those with underlying health conditions (13.3%–14.5%) than those without these conditions (2.2%–2.4%) (Table 2). Small numbers of COVID-19 patients aged <19 years were reported to be hospitalized (48) or admitted to an ICU (eight). In contrast, 335 patients aged <19 years were not hospitalized and 1,342 had missing data on hospitalization. Among all COVID-19 patients with complete information on underlying conditions or risk factors, 184 deaths occurred (all among patients aged ≥19 years); 173 deaths (94%) were reported among patients with at least one underlying condition.

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Discussion

Among 122,653 U.S. COVID-19 cases reported to CDC as of March 28, 2020, 7,162 (5.8%) patients had data available pertaining to underlying health conditions or potential risk factors; among these patients, higher percentages of patients with underlying conditions were admitted to the hospital and to an ICU than patients without reported underlying conditions. These results are consistent with findings from China and Italy, which suggest that patients with underlying health conditions and risk factors, including, but not limited to, diabetes mellitus, hypertension, COPD, coronary artery disease, cerebrovascular disease, chronic renal disease, and smoking, might be at higher risk for severe disease or death from COVID-19 (*3*,*4*). This analysis was limited by small numbers and missing data because of the burden placed on reporting health departments with rapidly rising case counts, and these findings might change as additional data become available.

case counts, and these findings might change as additional data become available.

It is not yet known whether the severity or level of control of underlying health conditions affects the risk for severe disease associated with COVID-19. Many of these underlying health conditions are common in the United States: based on self-reported 2018 data, the prevalence of diagnosed diabetes among U.S. adults was 10.1% (*7*), and the U.S. age-adjusted prevalence of all types of heart disease (excluding hypertension without other heart disease) was 10.6% in 2017 (*8*). The age-adjusted prevalence of COPD among U.S. adults is 5.9% (*9*), and in 2018, the U.S. estimated prevalence of current asthma among persons of all ages was 7.9% (*7*). CDC continues to develop and update resources for persons with underlying health conditions to reduce the risk of acquiring COVID-19 (*10*). The estimated higher prevalence of these conditions among those in this early group of U.S. COVID-19 patients and the potentially higher risk for more severe disease from COVID-19 associated with the presence of underlying conditions highlight the importance of COVID-19 prevention in persons with underlying conditions.

The findings in this report are subject to at least six limitations. First, these data are preliminary, and the analysis was limited by missing data related to the health department reporting burden associated with rapidly rising case counts and delays in completion of information requiring medical chart review; these findings might change as additional data become available. Information on underlying conditions was only available for 7,162 (5.8%) of 122,653 cases reported to CDC. It cannot be assumed that those with missing information are similar to those with data on either hospitalizations or underlying health conditions. Second, these data are subject to bias in outcome ascertainment because of short follow-up time. Some outcomes might be underestimated, and long-term outcomes cannot be assessed in this analysis. Third, because of the limited availability of testing in many jurisdictions during this period, this analysis is likely biased toward more severe cases, and findings might change as testing becomes more widespread. Fourth, because of the descriptive nature of these data, attack rates among persons with and without underlying health conditions could not be compared, and thus the risk difference of severe disease with COVID-19 between these groups could not be estimated. Fifth, no conclusions could be drawn about underlying conditions that were not included in the case report form or about different conditions that were reported in a single, umbrella category. For example, asthma and COPD were included in a chronic lung disease category. Finally, for some underlying health conditions and risk factors, including neurologic disorders, chronic liver disease, being a current smoker, and pregnancy, few severe outcomes were reported; therefore, conclusions cannot be drawn about the risk for severe COVID-19 among persons in these groups.

Persons in the United States with underlying health conditions appear to be at higher risk for more severe COVID-19, consistent with findings from other countries. Persons with underlying health conditions who have symptoms of COVID-19, including fever, cough, or shortness of breath, should immediately contact their health care provider. These persons should take steps to protect themselves from COVID-19, through washing their hands; cleaning and disinfecting high-touch surfaces; and social distancing, including staying at home, avoiding crowds, gatherings, and travel, and avoiding contact with persons who are ill. Maintaining at least a 30-day supply of medication, a 2-week supply of food and other necessities, and knowledge of COVID-19 symptoms are recommended for those with underlying health conditions (*10*). All persons should take steps to protect themselves from COVID-19 and to protect others. All persons who are ill should stay home, except to get medical care; should not go to work; and should stay away from others. This is especially important for those who work with persons with underlying conditions or who otherwise are at high risk for severe outcomes from COVID-19. Community mitigation strategies, which aim to slow the spread of COVID-19, are important to protect all persons from COVID-19, especially persons with underlying health conditions and other persons at risk for severe COVID-19–associated disease (https://www.cdc.gov/coronavirus/2019-ncov/downloads/community-mitigation-strategy.pdf).

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CDC COVID-19 Response Team

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All authors have completed and submitted the International Committee of Medical Journal Editors form for disclosure of potential conflicts of interest. No potential conflicts of interest were disclosed.

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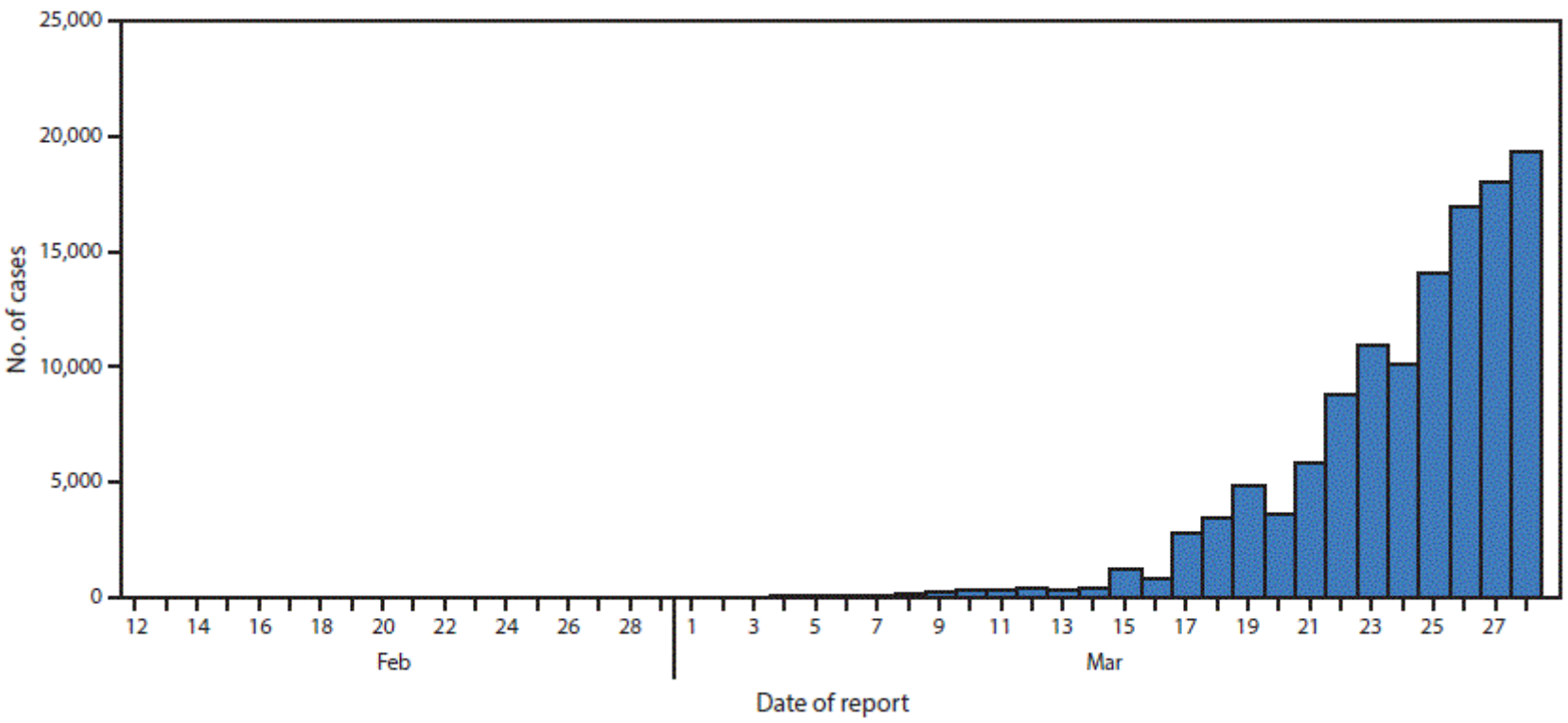
FIGURE. Daily number of reported COVID-19 cases* — United States, February 12–March 28, 2020†

Return



* Cases among persons repatriated to the United States from Wuhan, China, and the Diamond Princess cruise ship are excluded.

† Cumulative number of COVID-19 cases reported daily by jurisdictions to CDC using aggregate case count was 122,653 through March 28, 2020.

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TABLE 1. Reported outcomes among COVID-19 patients of all ages, by hospitalization status, underlying health condition, and risk factor for severe outcome from respiratory infection — United States, February 12–March 28, 2020

Return

Underlying health condition/Risk factor for severe outcomes from respiratory infection (no., % with condition)	No. (%) Not hospitalized	No. (%) Hospitalized, non-ICU	ICU admission	Hospitalization status unknown
Total with case report form (N = 74,439)	12,217	5,285	1,069	55,868
Missing or unknown status for all conditions (67,277)	7,074	4,248	612	55,343
Total with completed information (7,162)	5,143	1,037	457	525
One or more conditions (2,692, 37.6%)	1,388 (27)	732 (71)	358 (78)	214 (41)
Diabetes mellitus (784, 10.9%)	331 (6)	251 (24)	148 (32)	54 (10)
Chronic lung disease* (656, 9.2%)	363 (7)	152 (15)	94 (21)	47 (9)
Cardiovascular disease (647, 9.0%)	239 (5)	242 (23)	132 (29)	34 (6)
Immunocompromised condition (264, 3.7%)	141 (3)	63 (6)	41 (9)	19 (4)
Chronic renal disease (213, 3.0%)	51 (1)	95 (9)	56 (12)	11 (2)
Pregnancy (143, 2.0%)	72 (1)	31 (3)	4 (1)	36 (7)
Neurologic disorder, neurodevelopmental, intellectual disability (52, 0.7%)†	17 (0.3)	25 (2)	7 (2)	3 (1)
Chronic liver disease (41, 0.6%)	24 (1)	9 (1)	7 (2)	1 (0.2)
Other chronic disease (1,182, 16.5%)§	583 (11)	359 (35)	170 (37)	70 (13)
Former smoker (165, 2.3%)	80 (2)	45 (4)	33 (7)	7 (1)
Current smoker (96, 1.3%)	61 (1)	22 (2)	5 (1)	8 (2)
None of the above conditions¶ (4,470, 62.4%)	3,755 (73)	305 (29)	99 (22)	311 (59)

Abbreviation: ICU = intensive care unit.

* Includes any of the following: asthma, chronic obstructive pulmonary disease, and emphysema.

† For neurologic disorder, neurodevelopmental, and intellectual disability, the following information was specified: dementia, memory loss, or Alzheimer's disease (17); seizure disorder (5); Parkinson's disease (4); migraine/headache (4); stroke (3); autism (2); aneurysm (2); multiple sclerosis (2); neuropathy (2); hereditary spastic paraplegia (1); myasthenia gravis (1); intracranial hemorrhage (1); and altered mental status (1).

§ For other chronic disease, the following information was specified: hypertension (113); thyroid disease (37); gastrointestinal disorder (32); hyperlipidemia (29); cancer or history of cancer (29); rheumatologic disorder (19); hematologic disorder (17); obesity (17); arthritis, nonrheumatoid, including not otherwise specified (16); musculoskeletal disorder other than arthritis (10); mental health condition (9); urologic disorder (7); cerebrovascular disease (7); obstructive sleep apnea (7); fibromyalgia (7); gynecologic disorder (6); embolism, pulmonary or venous (5); ophthalmic disorder (2); hypertriglyceridemia (1); endocrine (1); substance abuse disorder (1); dermatologic disorder (1); genetic disorder (1).

¶ All listed chronic conditions, including other chronic disease, were marked as not present.

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TABLE 2. Hospitalization with and without intensive care unit (ICU) admission, by age group among COVID-19 patients aged ≥19 years with and without reported underlying health conditions — United States, February 12–March 28, 2020*

Return

Age group (yrs) Age group (yrs)	Hospitalized without ICU admission, No. (% range†) Hospitalized without ICU admission, No. (% range†)		ICU admission, No. (% range†) ICU admission, No. (% range†)	
	Underlying condition present/reported§ Underlying condition present/reported§		Underlying condition present/reported§ Underlying condition present/reported§	
	Yes Yes	No No	Yes Yes	No No
19–64	285 (18.1–19.9)	197 (6.2–6.7)	134 (8.5–9.4)	58 (1.8–2.0)
≥65	425 (41.7–44.5)	58 (16.8–18.3)	212 (20.8–22.2)	20 (5.8–6.3)
Total ≥19	**710 (27.3–29.8)**	**255 (7.2–7.8)**	**346 (13.3–14.5)**	**78 (2.2–2.4)**

* Includes COVID-19 patients aged ≥19 years with known status on underlying conditions.

† Lower bound of range = number of persons hospitalized or admitted to an ICU among total in row stratum; upper bound of range = number of persons hospitalized or admitted to an ICU among total in row stratum with known outcome status: hospitalization or ICU admission status.

§ Includes any of following underlying health conditions or risk factors: chronic lung disease (including asthma, chronic obstructive pulmonary disease, and emphysema); diabetes mellitus; cardiovascular disease; chronic renal disease; chronic liver disease; immunocompromised condition; neurologic disorder, neurodevelopmental, or intellectual disability; pregnancy; current smoker; former smoker; or other chronic disease.

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Suggested citation for this article: . Preliminary Estimates of the Prevalence of Selected Underlying Health Conditions Among Patients with Coronavirus Disease 2019 — United States, February 12–March 28, 2020. MMWR Morb Mortal Wkly Rep 2020;69:382–386. DOI: http://dx.doi.org/10.15585/mmwr.mm6913e2 .

Page last reviewed: April 2, 2020

THE LANCET
Gastroenterology & Hepatology

Exhibit D

CORRESPONDENCE | ONLINE FIRST

COVID-19 in long-term liver transplant patients: preliminary experience from an Italian transplant centre in Lombardy

Sherrie Bhoori • Roberta Elisa Rossi • Davide Citterio • Vincenzo Mazzaferro

Published: April 09, 2020 • DOI: https://doi.org/10.1016/S2468-1253(20)30116-3

Coronavirus disease 2019 (COVID-19) is a public health emergency and a pandemic of international concern.[1] Italy has witnessed, in the past month, an unexpectedly high rate of infection, with more than 100 000 patients testing positive for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and a case-fatality rate close to 10% (as of March 31, 2020)[2] and therefore faces a worse scenario than in China, where the disease was first reported.

Data on COVID-19 in liver transplant patients are scarce. We report the experience in our transplant centre, in the midst of the current outbreak in Lombardy, Italy (10 million inhabitants; 25 124 ascertained infections, and 7199 virus-related deaths as of March 31, 2020).[2] Three of our 111 long-term liver transplant survivors (transplanted more than 10 years ago) have died in the past 3 weeks (between March 5 and March 18) following severe COVID-19 disease. All three were male, older than 65 years, receiving antihypertensive drugs, overweight (BMI >28 kg/m^2), with hyperlipidaemia, and diabetes (median HbA_{1c} of 6·9%). The post-transplant course had been uneventful for all three patients, and their immunosuppressive regimen had been gradually tapered off, with very low trough concentrations of calcineurin inhibitors (two patients receiving ciclosporin [28 and 35 ng/mL, respectively] and one receiving tacrolimus [2·1 ng/mL]). All three patients died after admission to hospital for community-acquired pneumonia, and were in need of supplementary oxygen at admission but rapidly developed severe respiratory distress syndrome that required mechanical ventilation. The patients died between 3 and 12 days after the onset of pneumonia; all three patients had tested positive for SARS-CoV-2 by nasopharyngeal swabs. By contrast, three of our 40 recently transplanted (ie, within the past 2 years) patients have tested SARS-CoV-2 positive, and although quarantined, are all experiencing an uneventful course of disease.

- View related content for this article

Available data regarding COVID-19 suggest that tissue damage might be mediated by a direct virus-induced cytopathogenic effect or could be due to an immunomediated inflammatory response to the virus.[3] Whether liver transplant recipients are more susceptible to SARS-CoV-2 infection is a matter of concern, but so far there have been no specific recommendations from major societies. A case series from Italy showed that children who had received liver transplants, despite being immunosuppressed, were not at increased risk of severe pulmonary disease compared with the general population.[4]

All three COVID-19-related deaths observed in our centre were long-term patients on minimal immunosuppressive regimens, rather than recently transplanted, fully immunosuppressed patients. We examined clinical and demographic data of our patients (table). In keeping with the paediatric data,[4] immunosuppression did not seem to increase the risk of severe COVID-19 disease. Given that a reactive innate immune response might be responsible for severe clinical manifestations, immunosuppression might be protective, although this needs further clarification. Conversely, the presence of metabolic-related comorbidities, which are known to increase with time since transplant,[5] might be associated with an increased risk of severe COVID-19 disease. However, the number of COVID-19-related deaths in our series is small, and these observations can only be considered preliminary.

Table Characteristics of liver transplant recipients in Istituto Nazionale Tumori, Milan

	Long-term liver transplant recipient (>10 years, n=111)	Short-term liver transplant recipient (<2 years, n=40)	p value
Age older than 65 years	55 (50%)	12 (30%)	0·04
Overweight or obesity (body mass index >25 kg/m^2)	89 (80%)	24 (60%)	0·02
Diabetes	67 (60%)	9 (23%)	0·0001
Hyperlipidaemia	50 (45%)	7 (18%)	0·002
Arterial hypertension	111 (100%)	27 (68%)	0·0001
History of cardiovascular event	39 (35%)	2 (5%)	0·0015
Chronic kidney disease	44 (40%)	8 (20%)	0·03
Full immunosuppression*	11 (10%)	28 (70%)	0·0001

COVID-19=coronavirus disease 2019.

*** Ciclosporin concentration more than 150 ng/mL or tacrolimus concentration more than 5 ng/mL.**

Open table in a new tab

Post-transplant metabolic complications (eg, arterial hypertension, chronic renal insufficiency, diabetes, hyperlipidaemia, and weight gain) might outweigh immuno-suppression as a risk factor for development of severe COVID-19 disease in patients who have received liver transplants, in line with data from China, which suggest that comorbidities are associated with a worse prognosis.[6] Of these metabolic cations, diabetes might be of particular concern, given its high prevalence (20–40%) in patients oing solid organ transplantation.[7]

Notably, a comparison of the 3% COVID-19-associated mortality observed in our long-term transplant recipients with the 10% case-fatality rate noted in Italy at present is difficult, since the case-fatality rate is known to be biased because nasopharyngeal swabbing is only done in highly symptomatic patients.[8] This limitation also applies to our population of liver transplant recipients—the total number who could be SARS-CoV-2 positive (but who remain asymptomatic or who have only mild symptoms, and who have thus not been tested), is not known. Nonetheless, given the short observation period (3 weeks) which we report here, the observed death rate is of concern.

We recognise the intrinsic limitations of this case series (ie, the small sample size, the unavailability of the exact number of COVID-19 positive patients, and the associated difficulty in accurately calculating the case-fatality rate) and the consequent urgent need of collecting data for further studies to draw more solid conclusions. However, according to this initial observation, we suggest that great attention is paid to long-term liver transplant recipients with metabolic comorbidities. In keeping with clinical insights from the American Association for the Study of Liver Diseases we suggest that immunosuppression should not be reduced or stopped in asymptomatic liver transplant recipients.[9]

We declare no competing interests.

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Tables

Table: Characteristics of liver transplant recipients in Istituto Nazionale Tumori, Milan

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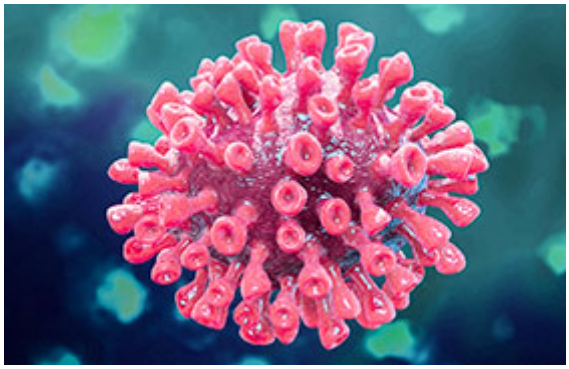

COVID-19 Resource Centre

Access the latest 2019 novel coronavirus disease (COVID-19) content from across *The Lancet* journals as it is published.

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ıl Burden of Disease

BRITISH LIVER TRUST

Exhibit E

Coronavirus (COVID-19) – health advice for people with liver disease and liver transplant patients

Posted on: 21st April 2020

If you or a loved one has a liver condition, or you've had a liver transplant, you might be wondering what the coronavirus outbreak means for you.

High-risk groups

The government has now published advice for people who are at a very high risk of severe illness from COVID-19.

Some people with certain liver conditions who fall into this high-risk category are now advised to rigorously follow shielding measures to keep themselves safe.

We've had guidance from medical experts and the British Society of Gastroenterology as to which liver patients fall into this vulnerable group and what it means to them.

› Who is in this vulnerable group?

Liver patients who fall into the 'shielding group' category are those on immunosuppression for a liver transplant or for autoimmune hepatitis (AIH). People with liver cancer who are undergoing active chemotherapy or having immunotherapy or other continuing antibody treatments should also follow the shielding advice.

Patients who fall into this category should have received a letter either from a governmental organisation or by the clinician in charge of your care.

If you believe that you are in this group and have not received a letter, please still follow the 'shielding' advice. If you need a letter, for example, for employment reasons or to access social care support, check with your doctor or nurse specialist.

We are aware that some physicians are also advising patients who have **decompensated liver disease** to practice shielding although this is not part of the formal guidance from Public Health England. The government approach also varies with Scotland, recommending shielding for those with decompensated liver disease as well. If you are concerned about your own situation, please contact your own liver specialist to obtain specific advice from them.

All patients with liver disease are at risk of adverse outcomes from the virus. We are therefore advising that **all** liver patients (who are not identified as extremely vulnerable) should attempt to adhere to **strict** social distancing measures as much as they can to minimise their chance of exposure to COVID-19.

You can self-register for shielding on the gov.uk website.

If I'm in a vulnerable group, what are the shielding measures I need to adhere to?

What if I live with someone who falls into a vulnerable group?

I have decompensated cirrhosis, does that put me at increased risk of Covid 19?

What if I don't fall into a high-risk category but have a liver condition?

What should you do if I'm in a vulnerable group and I live with other people?

Common questions about COVID-19

If you or a family member has a liver condition, you are bound to have a lot of questions. Below you will find more information about the disease, its symptoms and preventative measures. We have also answered some of the most common questions that callers have asked our helpline nurses.

You can also take a look at NHS information on COVID-19.

- What is the coronavirus and COVID-19?
- What are the symptoms?
- What can I do to protect myself and others?
- What are the risks to liver patients?
- What is social distancing?
- What is social shielding?
- Can I get tested for coronavirus?
- I am on steroid treatment. What should I do?
- Should I call my transplant co-ordinator?
- I am waiting for a transplant. Will the virus affect the transplantation programme?

I am really scared – there is so much different information out there and many of it seems to conflict? What should I do?

USEFUL LINKS

COVID-19 FAQs

Social distancing, self-isolating and shielding: what are they and how do they differ

Sourcing food and essential supplies while you're shielding

Managing anxiety during the COVID-19 crisis

Lockdown: shops and retail advice

Welfare and benefits during the pandemic

Government COVID-19 advice

Scotland COVID-19 advice

Wales COVID-19 advice

Northern Ireland COVID-19 Advice

How to help safely

Support us today

Our help and advice is only possible thanks to your donations, a donation of any amount will help.

Our helpline nurses are receiving huge numbers of calls and emails about the pandemic - please help us to be here for everyone who needs us.

Recent Posts

Celebrating a centenary: Pioneer of treatment for Wilson's Disease turns 100

People shouldn't turn to alcohol as a means of coping with coronavirus, says the British Liver Trust

Coronavirus (COVID-19) – health advice for people with liver disease and liver transplant patients

Get involved in the 2.6 challenge 'together at home'

Coronavirus and mental health: government guidance and support for coping with the Covid-19 outbreak

Tweets by @LiverTrust

British Liver Trust
@LiverTrust

We're sad not be in #Edinburgh today on our #LoveYourLiver roadshow, but we'll be reorganising our trip to the Scottish capital as soon as we can. Stay safe everyone!

4h

British Liver Trust
@LiverTrust

Are you missing your regular gym fix? Get back into the exercise habit and support people with liver disease by taking on the #TwoPointSixChallenge.

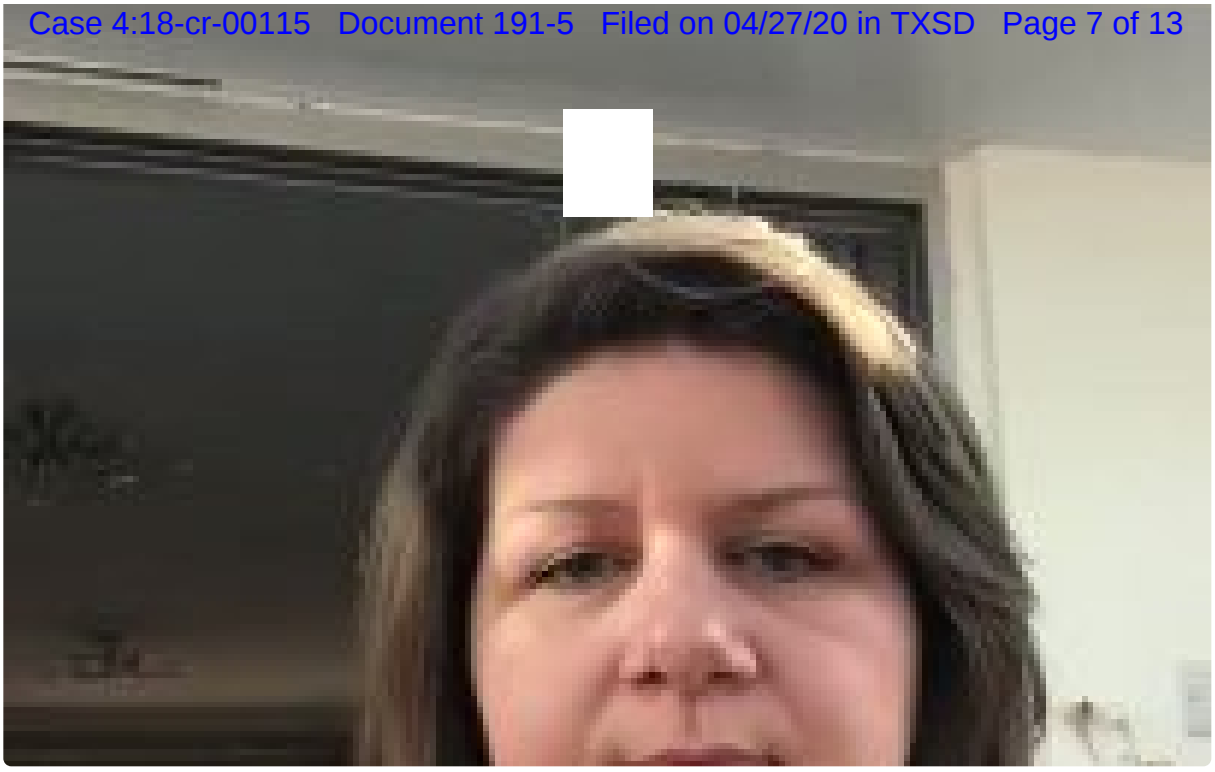
Not a gym bunny? No problem. You can set your own personal challenge - anything goes!

Find out more at: buff.ly/2XSnVad

11h

British Liver Trust
@LiverTrust

Emma from the British Liver Trust explains why the charity's work means so much to her: "I speak from personal experience, having helped my dad through his five year #LiverCancer battle. I was so lucky to have at my fingertips all the support anyone could possibly need."#Thanks



11h

British Liver Trust
@LiverTrust

We're sorry we can't be in #Stirling today for our #LoveYourLiver roadshow, but we're looking forward to being there in the future as soon as we safely can.

Apr 24, 2020

British Liver Trust

Just two days to go until the #TwoPointSixChallenge begins! There's plenty of time to prepare for your personal challenge to support the nation's charities during the Covid19 outbreak.

What's the big deal? buff.ly/3cGvhC1

Apr 24, 2020

British Liver Trust
@LiverTrust

New guidance from NICE https://twitter.com/NICEGetInvolved/status/1253630773376225281

Apr 24, 2020

British Liver Trust
@LiverTrust

Today is the 100th birthday of Dr John Walshe, the Cambridge hepatologist who revolutionised the treatment of #WilsonsDisease. Follow the link to read his story.

Celebrating a centenary
britishlivertrust.org.uk

Apr 24, 2020

British Liver Trust
@LiverTrust

Wishing our followers a happy and peaceful #Ramadan2020.

Apr 23, 2020

British Liver Trust
@LiverTrust

Here's to all of our wonderful key workers and, of course, our fabulous supporters. Thank you from everyone at the British Liver Trust! #ClapForOurCarers

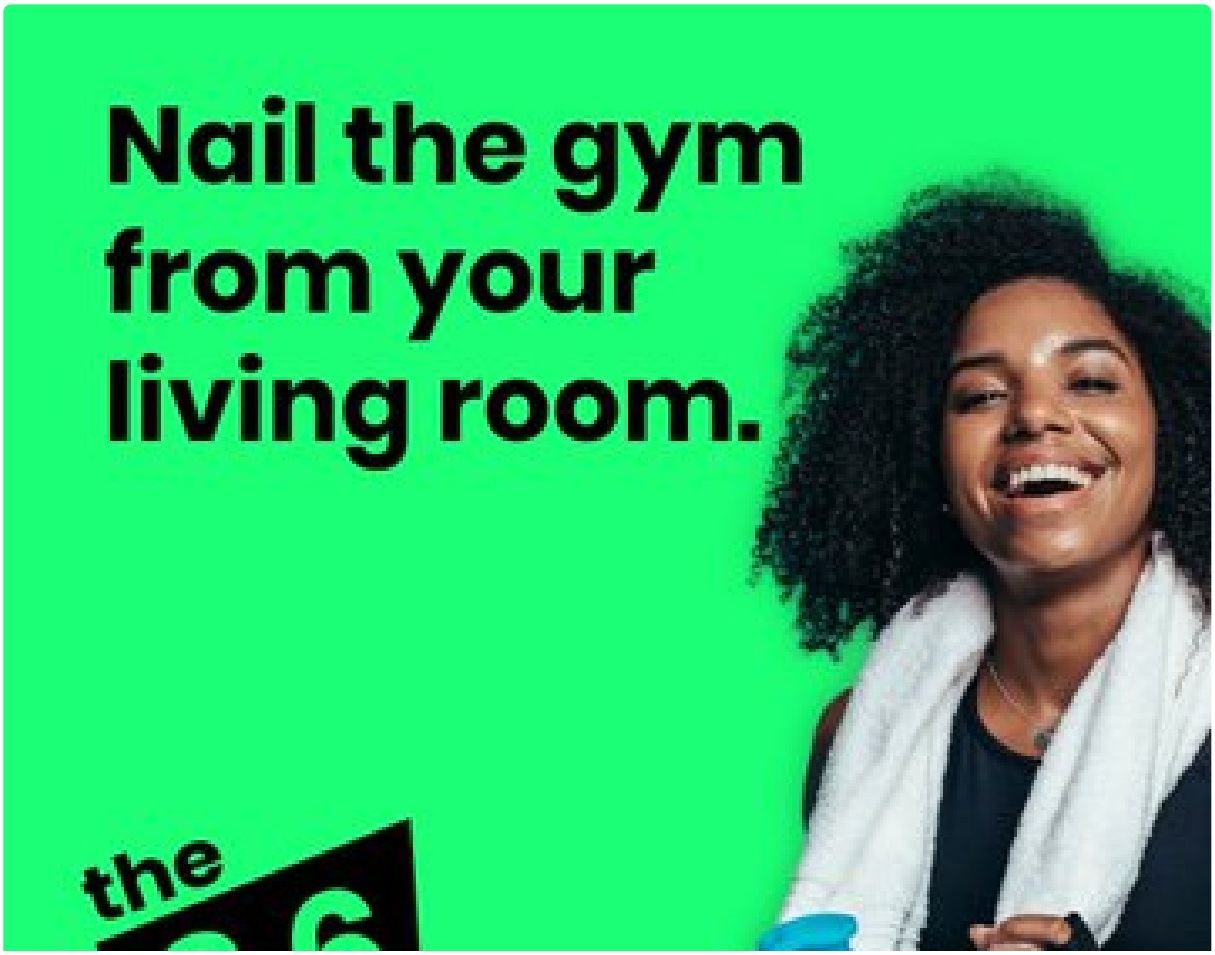
Apr 23, 2020

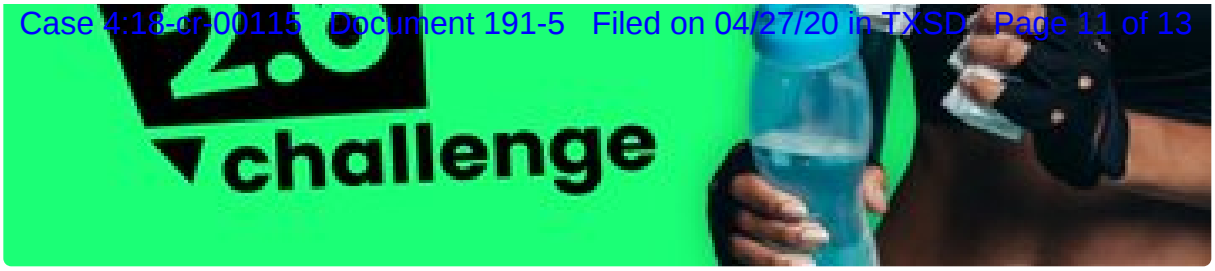
British Liver Trust
@LiverTrust

Are you missing your regular gym fix? Get back into the exercise habit and support people with liver disease by taking on the #TwoPointSixChallenge.

Not a gym bunny? No problem. You can set your own personal challenge - anything goes!

Find out more at: buff.ly/3eNatdZ





Apr 23, 2020

British Liver Trust
@LiverTrust

Vanessa Hebditch, Director of Policy and Communications at the British Liver Trust, says: “We know this is an extremely stressful time for many of us in the UK but drinking too much #alcohol is not the answer."

People shouldn’t turn to alcohol as a means of coping with coronavirus
britishlivertrust.org.uk

Apr 23, 2020

British Liver Trust
@LiverTrust

Not sure how we didn’t know about this day but sending a belated massive thank you to all the nurses who work in liver transplantation. We know the difference you make 💕@livernursing #organdonation https://twitter.com/share_wishes/status/1250306274413051908

Apr 23, 2020

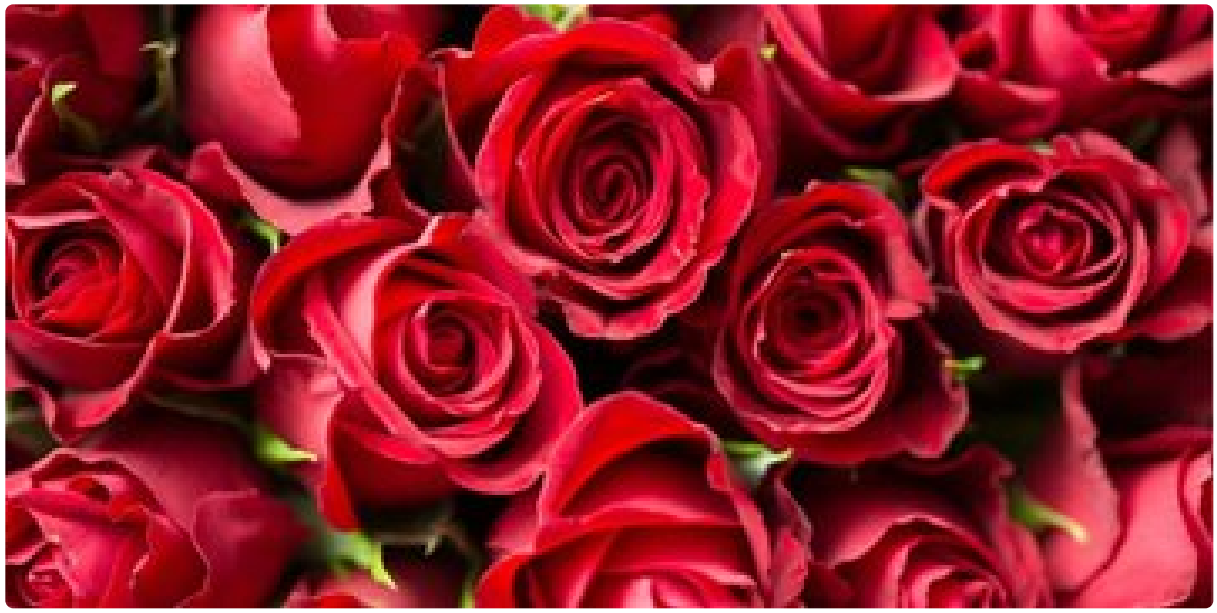
British Liver Trust
@LiverTrust

Happy birthday from all of us @LiverTrust strange times to be celebrating a big birthday but we hope you still manage to have an amazing day #organdonation https://twitter.com/Tabitha_Jenks/status/1253221866812080128

Apr 23, 2020

British Liver Trust
@LiverTrust

Happy #SaintGeorgesDay.



Apr 23, 2020

British Liver Trust
@LiverTrust

Hello #Ayr - we were meant to be with you today on our #LoveYourLiver roadshow, but sadly we've had to rearrange our plans due to the Covid 19 oubreak. We'll be there in the future as soon as we can. Stay safe everyone!

Apr 22, 2020

British Liver Trust
@LiverTrust

At the British Liver Trust, we're going to be running, cartwheeling and somersaulting ourselves silly on 26th April for the #TwoPointSixChallenge.

Don't miss out on this national effort to support the UK's charities. Sign up today!buff.ly/3cGvhC1

Centers for Disease Control and Prevention

Heart Disease, Family Health History, and Familial Hypercholesterolemia

Exhibit F

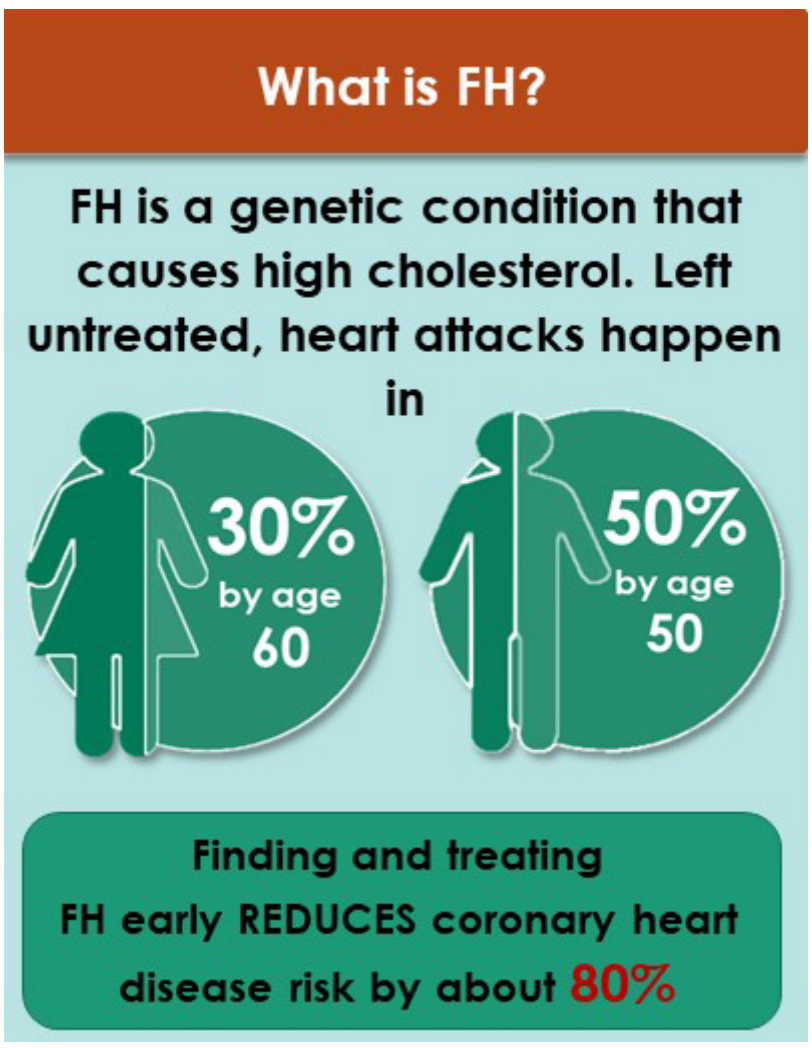
Familial Hypercholesterolemia

Coronavirus Disease 2019 (COVID-19) and Familial Hypercholesterolemia (FH)

COVID-19 is a new disease and information on risk factors for severe disease is limited. Based on currently available information and clinical expertise, people who have serious heart disease are among those more likely to have severe illness from COVID-19. If untreated, people with FH are up to 22 times more likely to have coronary heart disease than those without FH. Although not everyone with FH has heart disease, many do. Everyone is encouraged to take certain steps to protect themselves from getting sick with COVID-19. It is especially important that those with increased risks, such as serious heart disease, take these steps.

Click here to learn steps you can take to help protect yourself, especially if you are at higher risk of severe illness from COVID-19. Be sure to keep taking prescribed FH medications including statins and PCSK9 inhibitors as directed by your healthcare provider. Contact your healthcare provider to ask about obtaining extra FH medications. Consider telemedicine appointments if you need to see your healthcare provider.

Familial hypercholesterolemia (FH) is a genetic disorder that affects about 1 in 250 people and increases the likelihood of having coronary heart disease at a younger age.



People with FH have increased blood levels of low-density lipoprotein (LDL) cholesterol, sometimes called “bad cholesterol.” Having too much LDL cholesterol in your blood increases your risk for developing coronary artery disease or having a heart attack. For people with FH, exercising and healthy eating habits are important, but often not enough to lower their cholesterol to a healthy level. Medicines, such as statins, are needed to help control cholesterol levels. If you have FH, finding the disorder early and treating it can reduce your risk of heart disease by about 80%. If your child is diagnosed with FH, statin therapy in childhood may be required, often starting by age 8-10.

How do I know if I have familial hypercholesterolemia?

One of the main signs of FH is LDL cholesterol levels over 190 mg/dL in adults (and over 160 mg/dL in children). In addition, most people with FH have a family health history of early heart disease or heart attacks. In some cases, elevated LDL levels are found through routine blood cholesterol screening. If you have a family health history of heart disease or FH and have not had your cholesterol screened, your doctor may order a lipid screening, which measures the amount of cholesterol and lipids in your blood.

Your doctor may be able to detect physical signs of FH during a clinical exam, although not everyone with FH has these signs. These physical signs of FH occur when extra cholesterol builds up in different parts of the body:

- Bumps or lumps around your knees, knuckles, or elbows
- Swollen or painful Achilles tendon
- Yellowish areas around your eyes
- A whitish gray color in the shape of a half-moon on the outside of your cornea

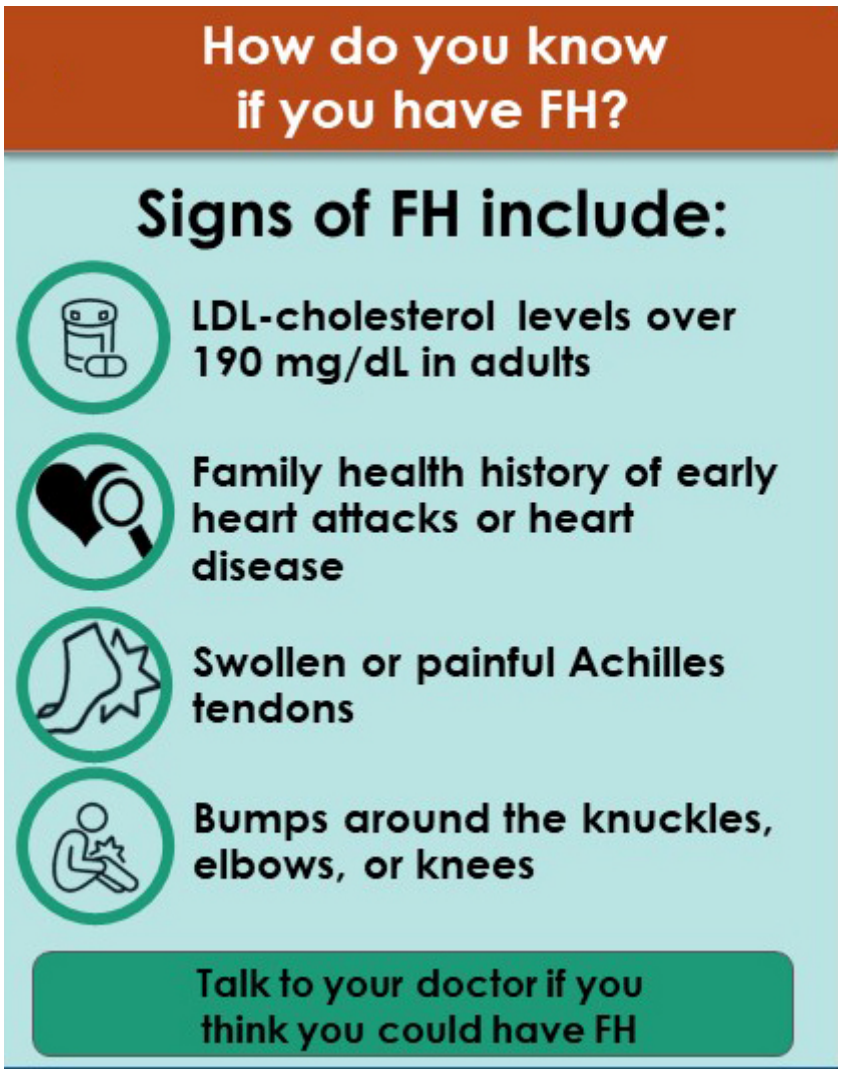
If your doctor suspects you have FH, he or she may refer you for genetic counseling and testing for FH.

Genetics of Familial Hypercholesterolemia

Familial hypercholesterolemia (FH) can be caused by inherited changes (mutations) in the *LDLR*, *APOB*, and *PCSK9* genes, which affect how your body regulates and removes cholesterol from your blood. About 60-80% of people with FH have a mutation found in one of these three genes. Genetic testing is available to check for mutations in these genes. However, there are likely more genes involved in FH that remain unknown.

You have two copies of each of the genes involved in FH, one from your mother and one from your father. A mutation in only one copy of one of the genes is enough to cause FH. If either your mother or father has a mutation that causes FH, they have a 50% chance of passing it on to you.

Most people with FH only have one FH-causing mutation. In very rare cases, a person can have two FH-causing mutations in both copies of the same gene, which results in a much more serious , rare form of FH called homozygous FH. People with homozygous FH have extremely high levels of cholesterol and can have heart attacks in childhood. People with homozygous FH need to find a doctor knowledgeable about FH and start treatment right away.



Family Health History is Important

If you are concerned that you could have familial hypercholesterolemia or hereditary heart disease, the first step is to collect your family health history of heart disease and share this information with your doctor.

Page last reviewed: March 20, 2020

Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Exhibit G

What You Can Do

Stay home and avoid close contact, especially if you are at higher risk of severe illness or if you may have issues getting assistance if you get sick.

Steps you can take

If you are at higher risk for serious illness from COVID-19 because of your age or because you have a serious long-term health problem, it is extra important for you to take actions to reduce your risk of getting sick with the disease.

- **Stay home if possible.**
- **Wash your hands** often.
- **Take everyday precautions to keep space between yourself and others** (stay 6 feet away, which is about two arm lengths).
- **Keep away from** people who are sick.
- **Stock up on supplies**.
- **Clean and disinfect** frequently touched services.
- **Avoid all cruise travel** and non-essential air travel.
- **Call your healthcare professional if you have concerns** about COVID-19 and your underlying condition or if you are sick.
- Steps You Can Take (Printer Friendly version)

Related: How to Protect Yourself

Coping with stress

Older people and **people of any age who have serious underlying health conditions** are at higher risk for severe illness from COVID-19. **People who may have issues getting assistance** if they become ill, like those experiencing homelessness or people with disabilities are also at increased risk from COVID-19.

These conditions and situations may result in **increased stress** during this pandemic. Fear and anxiety can be overwhelming and cause strong emotions.

Things you can do to support yourself:

- **Take breaks from watching, reading, or listening to news** stories and social media. Hearing about the pandemic repeatedly can be upsetting.
- **Take care of your body**. Take deep breaths, stretch, or meditate. Try to eat healthy, well-balanced meals, exercise regularly, get plenty of sleep, and avoid alcohol and drugs.
- **Make time to unwind**. Try to do some other activities you enjoy.
- **Connect with others**. Talk with people you trust about your concerns and how you are feeling.
- **Call your healthcare provider if stress gets in the way** of your daily activities for several days in a row.

- **If you, or someone you care about, are feeling overwhelmed** with emotions like sadness, depression, or anxiety, or feel like you want to harm yourself or others call
  - 911
  - Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Distress Helpline: 1-800-985-5990 or text TalkWithUs to 66746. (TTY 1-800-846-8517)

> **Related:** Stress and Coping

Have a plan for if you get sick

- **Know how to stay in touch with others by phone or email.** You may need to ask for help from friends, family, neighbors, and community health workers if you become sick.
- **Determine who can care for you** if your caregiver gets sick.
- **Contact your healthcare provider to ask about obtaining extra necessary medications** to have on hand in case there is an outbreak of COVID-19 in your community and you need to stay home for a prolonged period of time.
- If you cannot get extra medications, consider using **mail-order for medications**.
- **Be sure you have over-the-counter medicines and medical supplies** (tissues, etc.) to treat fever and other symptoms. Most people will be able to recover from COVID-19 at home.
- **Have enough household items and groceries** on hand so that you will be prepared to stay at home.
- **Consider ways of getting medications and food brought to your house** through family, social, or commercial networks.
- **Have a plan for someone to care for your pets** during your illness.

> **Related:** Cleaning and Disinfecting Your Home

Check with your local public health officials

Depending on how severe the outbreak is, **your local public health officials may recommend community actions** to reduce people's risk of being exposed to COVID-19. These actions can slow the spread and reduce the impact of disease.

Stay home as much as possible. Take extra measures to put distance between yourself and other people to further reduce your risk of being exposed to this new virus.

> **Related:** List of Local Health Departments

What to do if you have symptoms

Watch for symptoms and emergency warning signs.

- **Pay attention for potential COVID-19 symptoms** including, fever, cough, and shortness of breath.
- If you feel like you are developing symptoms, **stay home and call your doctor**. Tell them that you have or may have COVID-19. This will help them take care of you and keep other people from getting infected or exposed.
- **If you are not sick enough to be hospitalized**, you can recover at home.

- **If you develop emergency warning signs for COVID-19 get medical attention immediately.** In adults, emergency warning signs* are:
  - Difficulty breathing or shortness of breath
  - Persistent pain or pressure in the chest
  - New confusion or inability to arouse
  - Bluish lips or face

*This list is not all inclusive. Please consult your medical provider for any other symptoms that are severe or concerning.

> **Related:** Symptoms and Testing | What to do if You Are Sick

What others can do

Community support

Community preparedness planning for COVID-19 should include **older adults and people with disabilities**, and the organizations that support them in their communities, to ensure their needs are taken into consideration. Many of these individuals live in the community, and many depend on services and supports provided in their homes or in the community to maintain their health and independence.

Long-term care facilities should be vigilant to prevent the introduction and spread of COVID-19. See guidance for long-term care facilities.

> **Related:** Schools, Workplaces, and Community Locations

Family and caregiver support

- **Know what medications your loved one is taking** and see if you can help them have extra on hand.
- **Monitor food and other medical supplies** (oxygen, incontinence, dialysis, wound care) needed and create a back-up plan.
- **Stock up on non-perishable food** to have on hand in your home to minimize trips to stores.
- **If you care for a loved one living in a care facility**, monitor the situation, ask about the health of the other residents frequently and know the protocol if there is an outbreak.

> **Related:** If you are Sick or Caring for Someone

More information

More information

How to Protect Yourself

List of Local Health Departments

Stress and Coping

Symptoms & Testing

Cleaning and Disinfecting Your Home

What to Do If You Are Sick

Long-term Care Facilities

If You Are Sick or Caring for Someone

Schools, Workplaces, and Community Locations

Page last reviewed: April 3, 2020

Exhibit H

CORONAVIRUS

Inmate Dies of Coronavirus Amid Outbreak at Fort Worth Federal Prison Where "Tiger King" is Held

56 inmates and one employee at Federal Medical Center Fort Worth test positive

By **Scott Gordon** • Published April 22, 2020 • Updated on April 23, 2020 at 10:20 am

An inmate at the Federal Medical Center Fort Worth where the "Tiger... **Read more**

An inmate at the Federal Medical Center Fort Worth where the "Tiger King" known as "Joe Exotic" is being held died Wednesday of coronavirus, the Bureau of Prisons announced.

Arnoldo Almeida, 61, tested positive for COVID-19 on April 13 and was placed in isolation, the BOP said in a news release. His condition worsened and he was placed on a ventilator Saturday.

Almeida, from Crystal City, Texas, was sentenced in the Western District of Texas to more than 15 years in prison after he pleaded guilty to trafficking cocaine. He had been in custody in Fort Worth since September 2018, the BOP said.

"My thoughts and prayers go out to his family," his former attorney Jaime Aldape of San Antonio said. "Every loss to this deadly virus is tragic."

"Joe Exotic," whose real name is Joe Maldonado-Passage, became a celebrity with the popular Netflix documentary. He is being housed at the same facility.

Some 56 inmates and one staff member have tested positive at the Fort Worth prison, which houses inmates with medical issues, according to the Bureau of Priso

The leader of the union representing correctional officers at the facility said he is worried the number will continue to rise.

"Our big concern right now is I don't believe we've peaked yet," said American Federal of Government Employees Local 1298 president Gregory Watts. "We have a lot of elderly inmates with underlying health issues.

Federal prison correctional officer Gregory Watts shows the protective gear employees at Federal Medical Center Fort Worth are wearing.

Watts said guards are working 16 to 20 hours a day in protective gear and fear bringing the virus home.

He said employees are taking off their work clothes outside their homes and disinfecting them to avoid contaminating their families.

Inmates are wearing masks and are isolated to their units as much as possible, he said.

FMC Fort Worth houses 1,528 federal inmates.

This article tagged under:

CORONAVIRUS • FORT WORTH • PRISON

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COVID-19
Coronavirus

Exhibit I

The Bureau of Prisons (BOP) is carefully monitoring the spread of the COVID-19 virus. As with any type of emergency situation, we carefully assess how to best ensure the safety of staff, inmates and the public.

BOP COVID-19 Modified Operations Plan

BOP's Emergency Response

Every institution is like a small city and to cope with major emergencies or other significant interruptions of normal operations, they each have continuity of operations (COOP) plans that provide guidance to staff.

Learn More

BOP's COVID-19 Response

In February 2020, the BOP's Public Health Service (PHS) staff were placed in operational dress uniforms to be ready to respond to COVID-19 incidents by the Assistant Secretary for Health.

Learn More

BOP's COVID-19 Collaboration Efforts

BOP PHS Officers have been deployed for national travel-related screening at airports and NIC has been asked to share BOP-related guidance with state and local corrections.

Learn More

Coronavirus.gov

The primary lane of information for the public regarding Coronavirus (COVID-19) is a portal for public information published by the Coronavirus (COVID-19) Task Force at the White House, working in conjunction with CDC, HHS and other agency stakeholders.

Go to coronavirus.gov

CDC.gov

The Centers for Disease Control and Prevention (CDC) has established a resource portal on CDC.gov with the latest information from CDC and the overarching medical community on COVID-19.

Go to cdc.gov

USA.gov

To learn about international travel restrictions, how you can prepare for coronavirus, and what the U.S. government is doing in response to the virus, visit https://www.usa.gov/coronavirus

Go to usa.gov/coronavirus

COVID-19 Cases

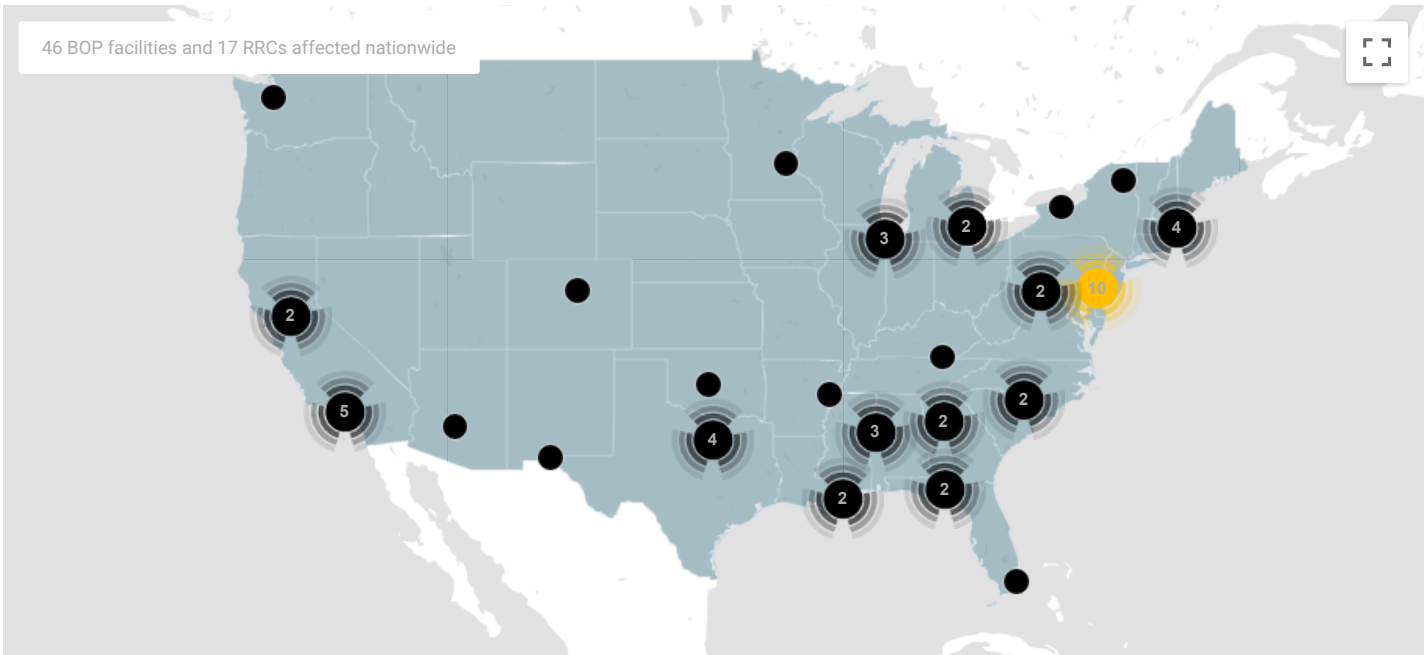
The BOP has **142,663** federal inmates in BOP-managed institutions and **10,442** in community-based facilities. The BOP staff complement is approximately **36,000**. As of 04/25/2020, there are **730 federal inmates** and **317 BOP staff** who have confirmed positive test results for COVID-19 nationwide. Currently, **383** inmates and **124** staff have recovered. There have been **26** federal inmate deaths and **0** BOP staff member deaths attributed to COVID-19 disease.

Due to the rapidly evolving nature of this public health crisis, the BOP will update the open COVID-19 confirmed positive test numbers and the number of COVID-19 related deaths daily at 3:00 p.m. The positive test numbers are based on the most recently available **confirmed lab results** involving open cases from across the agency as reported by the BOP's Office of Occupational Health and Safety. BOP field sites may report additional updates throughout the day. Data is subject to change based on additional reporting.

The inmate totals listed do not include inmates participating in the Federal Location Monitoring program.

Please note: The reference to the FCI Butner Low below refers to an isolation unit that is physically separated from the rest of the LSCI.

Inmates Positive	Staff Positive	Inmate Deaths	Staff Deaths	Facility	City	State
217	1	2	0	Fort Worth FMC	Fort Worth	TX
73	8	2	0	Terminal Island FCI	San Pedro	CA
69	11	1	0	Lompoc USP	Lompoc	CA
60	9	5	0	Butner Medium I FCI	Butner	NC
51	48	6	0	Elkton FCI	Lisbon	OH
39	0	0	0	Forrest City Low FCI	Forrest City	AR
35	2	0	0	Yazoo City Low FCI	Yazoo City	MS
34	34	1	0	Milan FCI	Milan	MI
					Joint Base	



[Mouseover facility markers for more information. Zoom in to densely clustered marker areas to see additional locations.]

COVID-19 Home Confinement Information

Given the surge in positive cases at select sites and in response to the Attorney General Barr's directives, the BOP began immediately reviewing all inmates who have COVID-19 risk factors, as described by the CDC, to determine which inmates are suitable for home confinement. Since the release of the Attorney General's original memo to the Bureau of Prisons on March 26, 2020 instructing us to prioritize home confinement as an appropriate response to the COVID-19 pandemic, the BOP has placed an additional **1,576** inmates on home confinement; an increase of **55.2** percent.

COVID-19 Home Confinement Information Frequently Asked Questions

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Resources

- **Correcting Myths and Misinformation About the BOP and COVID-19**
- **COVID-19 Visitor/Volunteer/Contractor Screening Tool**
- **COVID-19 Inmate Screening Tool**
- **COVID-19 Staff Screening Tool**
- **Coronavirus (COVID-19) Precautions/Modified Operations for Residential Reentry Centers.**
- **Coronavirus (COVID-19) Religious Accommodations**

USA TODAY

Exhibit J

POLITICS

Federal prison system expands virus testing to find hidden asymptomatic infections

Kevin Johnson USA TODAY

Published 5:58 p.m. ET Apr. 23, 2020 | **Updated 5:58 p.m. ET Apr. 23, 2020**

WASHINGTON – The federal prison system, confronted with mounting infections and deaths attributed to the coronavirus, is expanding testing to seek out previously hidden asymptomatic inmates in an attempt to control the spread.

The Bureau of Prisons, the largest detention system in the country, now joins a small number of states that have adopted a testing regimen to include suspected carriers of the virus beyond those who display common symptoms of infection.

"Expanding the testing ... on asymptomatic inmates will assist the slowing of transmission with isolating those individuals who test positive and quarantining contacts," the agency said Thursday. "The deployment of these additional resources will be based on facility need to contain widespread transmission and the need for early, aggressive interventions required to slow transmission at facilities with a high number of at-risk inmates such as medical referral centers."

At the time of the announcement, the BOP reported that 620 inmates and 357 staffers had been infected, while 24 prisoner deaths have been attributed to COVID-19's spread.

Virus sparks prison inquiry: DOJ team reviewing conditions at virus-plagued federal prisons; IG leading separate probe

Lawsuit targets troubled prison: Prisoners sue for release from troubled federal prison where coronavirus has killed 5 inmates

Officials said that the agency had obtained additional testing capacity that would be deployed at especially hard-hit facilities across its 122-prison system.

The largest numbers of infections were reported at bureau prisons in Fort Worth, Texas; Lompoc, California; and Terminal Island, California. Seven inmates, meanwhile, have died at the prison in Oakdale, Louisiana; six deaths were reported at the Elkton, Ohio facility.

"Asymptomatic inmates who test positive for COVID-19 can transmit the virus to other inmates," the agency said. "The testing of asymptomatic inmates will assist in slowing transmissions within a correctional setting along with increasing the number of COVID-19 positive tests..."

State prison systems in Ohio and North Carolina have already expanded testing in search of asymptomatic inmates, resulting in a surge of new infections.

In Ohio, authorities have tested the entire inmate population at three separate prisons, revealing startling numbers of new infections. The expanded testing has pushed the number of infections at one prison, the Marion Correctional Institution, to more than 2,000 – the largest outbreak in the country.

Asymptomatic inmates accounted for more than 90% of those infections, officials said.

Officials in North Carolina recently completed mass testing at a prison near Raleigh where more than 90% of the 458 infected inmates displayed no common symptoms.

"Expanding COVID-19 testing for asymptomatic inmates ... with public health entities will improve the BOP's ability to manage COVID-19 at facilities experiencing widespread transmission," the bureau said.

For more than a week, a Justice Department team has been reviewing conditions at coronavirus-plagued federal prisons.

A group of senior advisers to Attorney General William Barr have conducted in-person inspections of the hardest hit units in Louisiana, Ohio and North Carolina. A virtual inspection was scheduled at the facility in Lompoc.

Justice's inspector general, Michael Horowitz, also is conducting a separate inquiry into conditions at the agency.

Exhibit K

Office of the Attorney General
Washington, D. C. 20530

March 26, 2020

MEMORANDUM FOR DIRECTOR OF BUREAU PRISONS

FROM: THE ATTORNEY GENERAL

SUBJECT: Prioritization of Home Confinement As Appropriate in Response to COVID-19 Pandemic

Thank you for your tremendous service to our nation during the present crisis. The current situation is challenging for us all, but I have great confidence in the ability of the Bureau of Prisons (BOP) to perform its critical mission during these difficult times. We have some of the best-run prisons in the world and I am confident in our ability to keep inmates in our prisons as safe as possible from the pandemic currently sweeping across the globe. At the same time, there are some at-risk inmates who are non-violent and pose minimal likelihood of recidivism and who might be safer serving their sentences in home confinement rather than in BOP facilities. I am issuing this Memorandum to ensure that we utilize home confinement, where appropriate, to protect the health and safety of BOP personnel and the people in our custody.

I. TRANSFER OF INMATES TO HOME CONFINEMENT WHERE APPROPRIATE TO DECREASE THE RISKS TO THEIR HEALTH

One of BOP's tools to manage the prison population and keep inmates safe is the ability to grant certain eligible prisoners home confinement in certain circumstances. I am hereby directing you to prioritize the use of your various statutory authorities to grant home confinement for inmates seeking transfer in connection with the ongoing COVID-19 pandemic. Many inmates will be safer in BOP facilities where the population is controlled and there is ready access to doctors and medical care. But for some eligible inmates, home confinement might be more effective in protecting their health.

In assessing which inmates should be granted home confinement pursuant to this Memorandum, you are to consider the totality of circumstances for each individual inmate, the statutory requirements for home confinement, and the following non-exhaustive list of discretionary factors:

- The age and vulnerability of the inmate to COVID-19, in accordance with the Centers for Disease Control and Prevention (CDC) guidelines;

- The security level of the facility currently holding the inmate, with priority given to inmates residing in low and minimum security facilities;

- The inmate's conduct in prison, with inmates who have engaged in violent or gang-related activity in prison or who have incurred a BOP violation within the last year not receiving priority treatment under this Memorandum;

- The inmate's score under PATTERN, with inmates who have anything above a minimum score not receiving priority treatment under this Memorandum;

- Whether the inmate has a demonstrated and verifiable re-entry plan that will prevent recidivism and maximize public safety, including verification that the conditions under which the inmate would be confined upon release would present a lower risk of contracting COVID-19 than the inmate would face in his or her BOP facility;

- The inmate's crime of conviction, and assessment of the danger posed by the inmate to the community. Some offenses, such as sex offenses, will render an inmate ineligible for home detention. Other serious offenses should weigh more heavily against consideration for home detention.

In addition to considering these factors, before granting any inmate discretionary release, the BOP Medical Director, or someone he designates, will, based on CDC guidance, make an assessment of the inmate's risk factors for severe COVID-19 illness, risks of COVID-19 at the inmate's prison facility, as well as the risks of COVID-19 at the location in which the inmate seeks home confinement. We should not grant home confinement to inmates when doing so is likely to increase their risk of contracting COVID-19. You should grant home confinement only when BOP has determined—based on the totality of the circumstances for each individual inmate—that transfer to home confinement is likely not to increase the inmate's risk of contracting COVID-19.

II. PROTECTING THE PUBLIC

While we have an obligation to protect BOP personnel and the people in BOP custody, we also have an obligation to protect the public. That means we cannot take any risk of transferring inmates to home confinement that will contribute to the spread of COVID-19, or put the public at risk in other ways. I am therefore directing you to place any inmate to whom you grant home confinement in a mandatory 14-day quarantine period before that inmate is discharged from a BOP facility to home confinement. Inmates transferred to home confinement under this prioritized process should also be subject to location monitoring services and, where a court order is entered, be subject to supervised release.

We must do the best we can to minimize the risk of COVID-19 to those in our custody, while also minimizing the risk to the public. I thank you for your service to the country and assistance in implementing this Memorandum.

Exhibit L

Office of the Attorney General
Washington, D. C. 20530

April 3, 2020

MEMORANDUM FOR DIRECTOR OF BUREAU OF PRISONS

FROM: THE ATTORNEY GENERAL

SUBJECT: Increasing Use of Home Confinement at Institutions Most Affected by COVID-19

The mission of BOP is to administer the lawful punishments that our justice system imposes. Executing that mission imposes on us a profound obligation to protect the health and safety of all inmates.

Last week, I directed the Bureau of Prisons to prioritize the use of home confinement as a tool for combatting the dangers that COVID-19 poses to our vulnerable inmates, while ensuring we successfully discharge our duty to protect the public. I applaud the substantial steps you have already taken on that front with respect to the vulnerable inmates who qualified for home confinement under the pre-CARES Act standards.

As you know, we are experiencing significant levels of infection at several of our facilities, including FCI Oakdale, FCI Danbury, and FCI Elkton. We have to move with dispatch in using home confinement, where appropriate, to move vulnerable inmates out of these institutions. I would like you to give priority to these institutions, and others similarly affected, as you continue to process the remaining inmates who are eligible for home confinement under pre-CARES Act standards. In addition, the CARES Act now authorizes me to expand the cohort of inmates who can be considered for home release upon my finding that emergency conditions are materially affecting the functioning of the Bureau of Prisons. I hereby make that finding and direct that, as detailed below, you give priority in implementing these new standards to the most vulnerable inmates at the most affected facilities, consistent with the guidance below.

I. IMMEDIATELY MAXIMIZE APPROPRIATE TRANSFERS TO HOME CONFINEMENT OF ALL APPROPRIATE INMATES HELD AT FCI OAKDALE, FCI DANBURY, FCI ELKTON, AND AT OTHER SIMILARLY SITUATED BOP FACILITIES WHERE COVID-19 IS MATERIALLY AFFECTING OPERATIONS

While BOP has taken extensive precautions to prevent COVID-19 from entering its facilities and infecting our inmates, those precautions, like any precautions, have not been perfectly successful at all institutions. I am therefore directing you to immediately review all inmates who have COVID-19 risk factors, as established by the CDC, starting with the inmates incarcerated at FCI Oakdale, FCI Danbury, FCI Elkton, and similarly situated facilities where you determine that COVID-19 is materially affecting operations. You should begin implementing this directive immediately at the facilities I have specifically identified and any other facilities facing similarly serious problems. And now that I have exercised my authority under the CARES Act, your review should include all at-risk inmates—not only those who were previously eligible for transfer.

For all inmates whom you deem suitable candidates for home confinement, you are directed to immediately process them for transfer and then immediately transfer them following a 14-day quarantine at an appropriate BOP facility, or, in appropriate cases subject to your case-by-case discretion, in the residence to which the inmate is being transferred. It is vital that we not inadvertently contribute to the spread of COVID-19 by transferring inmates from our facilities. Your assessment of these inmates should thus be guided by the factors in my March 26 Memorandum, understanding, though, that inmates with a suitable confinement plan will generally be appropriate candidates for home confinement rather than continued detention at institutions in which COVID-19 is materially affecting their operations.

I also recognize that BOP has limited resources to monitor inmates on home confinement and that the U.S. Probation Office is unable to monitor large numbers of inmates in the community. I therefore authorize BOP to transfer inmates to home confinement even if electronic monitoring is not available, so long as BOP determines in every such instance that doing so is appropriate and consistent with our obligation to protect public safety.

Given the speed with which this disease has spread through the general public, it is clear that time is of the essence. Please implement this Memorandum as quickly as possible and keep me closely apprised of your progress.

II. PROTECTING THE PUBLIC

While we have a solemn obligation to protect the people in BOP custody, we also have an obligation to protect the public. That means we cannot simply release prison populations en masse onto the streets. Doing so would pose profound risks to the public from released prisoners engaging in additional criminal activity, potentially including violence or heinous sex offenses.

That risk is particularly acute as we combat the current pandemic. Police forces are facing the same daunting challenges in protecting the public that we face in protecting our inmates. It is impossible to engage in social distancing, hand washing, and other recommend steps in the middle of arresting a violent criminal. It is thus no surprise that many of our police officers have fallen ill with COVID-19, with some even dying in the line of duty from the disease. This pandemic has dramatically increased the already substantial risks facing the men and women who keep us safe, at the same time that it has winnowed their ranks while officers recover from getting sick, or self-quarantine to avoid possibly spreading the disease.

The last thing our massively over-burdened police forces need right now is the indiscriminate release of thousands of prisoners onto the streets without any verification that those prisoners will follow the laws when they are released, that they have a safe place to go where they will not be mingling with their old criminal associates, and that they will not return to their old ways as soon as they walk through the prison gates. Thus, while I am directing you to maximize the use of home confinement at affected institutions, it is essential that you continue making the careful, individualized determinations BOP makes in the typical case. Each inmate is unique and each requires the same individualized determinations we have always made in this context.

I believe strongly that we should do everything we can to protect the inmates in our care, but that we must do so in a careful and individualized way that remains faithful to our duty to protect the public and the law enforcement officers who protect us all.

POLITICO

Exhibit M

CORONAVIRUS

Trump administration reverses prisoner coronavirus release policy, advocates say

On Monday, some prisoners were told that officials were no longer considering early releases for inmates who have served less than half their sentence.

Federal prison in North Carolina. | Sara D. Davis/Getty Images

By JOSH GERSTEIN
04/21/2020 02:49 PM EDT
Updated: 04/21/2020 10:01 PM EDT

A coronavirus-related policy shift that could have cleared the way for thousands of federal prisoners to be sent home early was abruptly reversed this

POLITICO

Prison officials indicated earlier this month that inmates who had served less than half their sentences could still be considered for early release to limit the spread of infection behind bars. However, inmates in various prisons who had been put into prerelease quarantine almost two weeks ago were advised Monday by authorities that the policy had changed, lawyers and associates said. Officials would not waive a requirement that prisoners must have completed 50 percent their sentence to be eligible for early release during the pandemic, the inmates were told.

A federal prosecutor in New York also confirmed the shift to a court Tuesday, drawing the ire of a judge for contradicting the position the government took

However, shortly after this article was published Tuesday, a Justice Department spokesman suggested yet another course correction and indicated that officials at the Bureau of Prisons were confused or given inaccurate guidance about previous directives from Attorney General William Barr.

"The Department confirmed to BOP this afternoon that the BOP has discretion under the Attorney General's Memoranda on March 26 and April 3 regarding which home confinement cases are appropriate for review in order to fight the spread of the pandemic," the Justice Department statement said. "BOP will proceed expeditiously consistent with that confirmation."

from federal custody, including former Trump campaign chairman Paul Manafort and former Trump personal lawyer Michael Cohen. Neither man has served half his sentence.

LEGAL

Judge rips feds over prison quarantine policies

BY JOSH GERSTEIN

According to Manafort's lawyer, Manafort was put into prerelease quarantine at a prison in Loretto, Pa., on March 30. Such quarantines typically last two weeks, but Manafort has not yet been released. He has served about 22 months of a 7½-year sentence.

Cohen's lawyer told reporters last week that Cohen had been approved for home confinement, but needed to go through a quarantine. Cohen has served about 11 months of a three-year sentence.

Bureau of Prisons spokespeople did not respond to requests for comment for this report.

Barr ordered federal prisons to increase their use of home confinement on March 26 to lower risks associated with the virus. Some of the worst outbreaks in the country have occurred in close-quarters prisons, which cannot easily adhere to social-distancing guidelines.

On April 3, Barr used authority under the newly passed CARES Act to declare an emergency at prisons seriously impacted by Covid-19, the disease that develops from the novel coronavirus. The move waived the usual cap limiting home confinement to no more than six months at the end of an inmate's sentence.

While the initial set of criteria for home confinement included a requirement that inmates had completed half of their sentences, prison officials were told by their superiors on April 9 that rule was expected to be dropped. The decision

in Oakdale, La., that has suffered a serious outbreak of the virus.

That guidance led prisoners at a number of federal facilities nationwide to be put into prerelease quarantine around that date, according to family members of inmates. Some family and friends were making plans to pick up their loved ones this week. Others had purchased air tickets to return home, only to be told Monday that the expected releases had been scuttled.

"They just posted a new BOP Bulletin a few minutes ago, reversing the Barr decision and requiring that those released to home confinement must have served 50% of their sentence," Stephen Donaldson, son of an inmate at a prison in Georgia, wrote in an email to POLITICO. "I was hoping to have my father home. He tells me a number of other inmates had started the quarantine pre release and then were told of the reversal."

"I got a call from my wife today in tears because they put her back into the general population and last week they moved her into a quarantine room to

your sentence."

One advocate for inmates complained Tuesday that inconsistent information and a lack of transparency from the Bureau of Prisons were creating an emotional roller coaster for inmates and their families already on edge about the perils posed by the virus.

"I find myself baffled at the ineptness, if not the downright cruelty displayed by the BOP," Kevin Ring of sentencing reform group FAMM, formerly known as Families Against Mandatory Minimums, wrote in a letter to Barr and BOP Director Michael Carvajal. "To have the promise of early release snatched away under these circumstances is simply inexcusable. ... Transparency would go a long way to allaying confusion and fear."

In the case that riled up a judge in New York, Assistant U.S. Attorney Olga Zverovich wrote to the court Tuesday to reverse the government's confirmation just three days earlier that Lewis Stahl — who pleaded guilty in 2018 to tax evasion — was eligible for home confinement.

"The Bureau of Prisons ... advised the Government this afternoon that the Department of Justice ("DOJ") has just issued new guidance to the BOP requiring that an inmate serve at least fifty percent of his or her sentence in order to be eligible for placement on home confinement," Zverovich wrote, adding that Stahl not longer met the criteria for the program. Her letter was first reported by Forbes.

The confusion appeared to anger U.S. District Court Judge Ronnie Abrams, who demanded answers.

"The Government is hereby directed to provide the Court with an explanation from the BOP, including by way of affidavit from the appropriate representative, as to how the new DOJ guidance can affect these prior decisions," wrote Abrams, an appointee of President Barack Obama. The judge

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Despite the apparent flip-flops on eligibility, federal officials have significantly ramped up the use of home confinement in the past few weeks as the coronavirus pandemic intensified in the U.S. After Barr's first directive on the subject last month, 1,362 inmates were moved to house arrest, according to an update Tuesday on the BOP website.

It was not immediately clear how the latest clarification to Justice Department policy would be implemented, including the question of whether inmates already put into and out of quarantine would now be released without undergoing another 14-day period of isolation.

Some prisoners whose requests for home confinement have been rejected by the Bureau of Prisons can seek release from officials or a judge under separate "compassionate release" program, but the numbers released under that mechanism have been smaller.

As of Tuesday evening, there was no indication that government lawyers had advised the federal court in Georgia that the early release criteria have changed from those described in the declaration filed on April 10.

Official statistics issued Tuesday show 540 federal inmates and 323 staff with confirmed cases of the virus, with 23 prisoners having died after contracting Covid-19. The prison complex in Yazoo City, Miss., has the most reported inmate infections at 76, but the prison in Lisbon, Ohio, has the highest number of overall cases: 98 among prisoners and staff.

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Exhibit N

The Washington Post
Democracy Dies in Darkness

Amid coronavirus pandemic, federal inmates get mixed signals about home-confinement releases

By **Neena Satija** and **Matt Zapotosky**

April 24, 2020 at 2:02 p.m. CDT

The early release of about 200 federal inmates to home confinement amid the coronavirus pandemic abruptly stalled earlier this week as the Bureau of Prisons and the Justice Department issued shifting, contradictory guidelines, interviews and documents show.

Some inmates already in prerelease quarantine were returned to cells as a result, surprising families who had been contacted about the steps needed for their return. The Justice Department now says the inmates will indeed be released, though others like them might face a harder time going forward.

Attorney General William P. Barr in late March ordered the Bureau of Prisons to allow more inmates to finish their sentences at home as a way to help address coronavirus challenges in close quarters. But weeks after his statement, the department reset, then reset again, the bar prisoners must reach to be considered for release to home detention.

“Some families had already showed up to pick up their loved ones. Others were days away from doing it,” said Kevin Ring, executive director of the advocacy group Families Against Mandatory Minimums. “To have that taken away, obviously, is devastating. Every day, they go at 3 o’clock, they look at the Bureau of Prisons website for the update to see how many more cases there are at their loved ones’ facilities. The sense of urgency is through the roof.”

The flip-flopping at the federal level since early April stems from the question of whether prisoners must have served at least half of their sentences to be considered for early release to home detention: First they needed to have met that mark, then they didn’t, then the requirement was apparently reinstated, inmates were told earlier this week.

Then, on Wednesday, a new Bureau of Prisons memo indicated that prisoners who had not hit the halfway point were still eligible. In addition, a Justice Department spokesman said the agency now would try to expedite the cases of the inmates who had been caught in limbo amid the back-and-forth changes, moving them to the front of the line for home confinement.

The handling of early federal releases contrasts sharply with some local and state actions that have released thousands of inmates deemed to be the most vulnerable or the least dangerous amid escalating outbreaks of the coronavirus.

Two dozen federal inmates have died of covid-19 since March and more than 600 inmates and 350 staffers have tested positive for the coronavirus, according to the Bureau of Prisons, which houses about 174,000 inmates across the federal prison system.

The bureau's website says it has sent more than 1,500 inmates home early since March 26 at Barr's direction, adding that "this is a tremendous lift that was accomplished through the marshaling of all of BOP's resources."

It is not clear where those inmates were transferred from, how they were

determined to be eligible or whether some already might have been scheduled for home confinement anyway. The agency declined to provide more details.

It is unclear how widespread testing is at bureau facilities. The bureau said 11 institutions now have rapid test instruments from medical-device maker Abbott, and three also are working with local health departments or the Centers for Disease Control and Prevention to test inmates, including those who are asymptomatic.

The bureau did not respond to questions on the shifting guidance, and the Justice Department declined to elaborate beyond its public statements.

The department's response to the spread of coronavirus at Bureau of Prisons facilities has moved in fits and starts. Initially, the department seemed reluctant to use early release as a mechanism to prevent outbreaks, instead restricting visitors and inmate movements. That was in keeping with Barr's conservative approach on criminal justice issues.

But as confirmed exposures climbed, Barr relented.

In his original March 26 directive, Barr urged making home-confinement releases

more accessible. He followed up on April 3 to significantly expand the pool of those who would be eligible, using a provision of the coronavirus relief legislation that allowed him to declare an emergency and waive the normal requirements about who can finish out their prison sentences at home. He cited three in particular as a priority for evaluating early releases — low-security federal prisons in Oakdale, La., and Danbury, Conn., and the Elkton prison in Lisbon, Ohio.

Since then, the criteria for weighing an inmate's time-served factor has fluctuated.

In the immediate wake of Barr's announcement, the Bureau of Prisons decided inmates needed to have passed the halfway mark on their sentences to be considered, prosecutors wrote in response to a lawsuit over conditions in the Oakdale prison, where seven inmates have died of covid-19. But soon after, on April 9, that factor was removed from the list of eligibility criteria, the prosecutors wrote.

The bureau turned toward the more demanding direction Monday, as stated in a court filing in the case of Lewis Stahl, 64, formerly the owner of a medical technology company in New York. He has served less than a quarter of a 30-month sentence for tax evasion at a low-security prison in Miami.

U.S. District Judge Ronnie Abrams had urged the bureau to consider releasing Stahl, noting that his heart condition and high blood pressure "very well may put him at a heightened risk of suffering serious complications from the virus if contracted."

But new guidelines got in the way.

"The Bureau of Prisons ('BOP') advised the Government this afternoon that the Department of Justice ('DOJ') has just issued new guidance to the BOP requiring that an inmate serve at least fifty percent of his or her sentence in order to be eligible for placement on home confinement," Assistant U.S. Attorney Olga I. Zverovich wrote in her Monday filing.

In the new memo dated Wednesday, the bureau said that the amount of time served would merely count as a "priority factor" in decisions. Prosecutors added late Thursday that Stahl was now approved to go home Friday.

Justice Department spokesman Matt Lloyd said the Bureau of Prisons "intends to expeditiously transfer all inmates to home confinement who were previously referred for home confinement provided that such transfers are not forbidden by statute or the criteria expressly adopted in the Attorney General's Memoranda." A Justice Department official said the directive affects about 200 inmates across the system.

Exactly who is in that pool was not immediately clear. In one high-profile instance, prosecutors told a federal court that Dean Skelos, the Republican former New York State Senate majority leader who had been serving a four-year-and-three-month prison term, would be furloughed from prison — only to reverse that this week because he had not served 50 percent of his sentence. On Thursday — after the Justice Department had said those cleared for release would be transferred to home confinement — prosecutors wrote that the Bureau of Prisons had "not yet resolved" whether Skelos would be let out.

The 50 percent rule also would seem to apply to Michael Cohen, President Trump's former lawyer. Cohen's attorney said this week that he was cleared to be released to home confinement. Cohen had reported to prison on May 6 to begin serving a three-year sentence for financial crimes and lying to Congress; he had previously expected release in November 2021. As of early Friday, though, Cohen's attorney said, he had not been told of any change in his client's status.

Inmates in at least six prisons were affected by the change in guidance, according to court records and interviews with lawyers, family members, advocates and prisoners.

At the low-security prison in Oakdale that Barr had mentioned because of its "significant levels of infection" and multiple deaths in recent weeks, 51-year-old Donald Cain is serving a five-year sentence for "causing substantial emotional distress" in phone conversations with his wife, according to court records. His daughter recently sent by overnight mail a request for final approval to pick up her father in the coming days, at the instruction of his prison caseworker.

Everything changed earlier this week, Cain wrote in a federal court affidavit filed Wednesday, when the same caseworker told him "the guidelines had changed and that I have served only 39% of my sentence."

"He's literally three months from qualifying, and now he has to stay," said Somil Trivedi, an attorney with the American Civil Liberties Union who has filed a class-action lawsuit against the Oakdale prison seeking the release of more inmates amid the coronavirus pandemic.

At a minimum-security dormitory-style prison in New Mexico, 67-year-old Thomas Balsiger said he was told last week that he would soon be sent to home confinement. Balsiger remembers signing release papers, and his wife received a call from a prison caseworker to verify that the home she lived in had a landline phone.

On Monday, he wrote to his daughter, Angela Caldwell, that "we were each called in

and told that new guidelines . . . now requires 50% of the sentence served for anyone to be released."

Balsiger, who was sentenced to 10 years in prison for a widespread grocery-store coupon fraud scheme, is $3^1/_2$ years in and has advanced coronary artery disease. Balsiger was recently placed in solitary confinement for reasons that are unclear, his daughter said, and so he is unreachable.

At the Oakdale and Elkton prisons, where a total of 13 inmates have died, about a dozen inmates have been approved for home confinement out of the thousands there, the Justice Department told a judge in federal court filings last week.

Six of those approvals are for inmates at Elkton. That is a small dent in a facility where about 2,000 live in dormitory-style units, said David Carey, an attorney with the ACLU in Ohio who has filed a class-action lawsuit on behalf of inmates there. "Six is equivalent to the number of people who have died of coronavirus at Elkton," Carey pointed out.

The Bureau of Prisons website says 51 inmates and 49 staff members at Elkton have tested positive for the virus, but in an April 18 court filing, prosecutors said the number of "suspected" cases at the facility was about twice that.

On Wednesday, U.S. District Judge James Gwin wrote that the Elkton staff was fighting "a losing battle." He noted that the prison's dormitory-style design makes social distancing among inmates impossible and that less than 100 tests had been provided to the prison as of late last week.

He ordered the Bureau of Prisons to quickly provide a list of inmates who fit the CDC guidelines as being at "higher risk" for complications from the virus, including those older than 65 and those with underlying medical conditions such as heart disease or diabetes.

Those prisoners must be transferred out of Elkton "through any means," including

home confinement, Gwin said. If any were deemed ineligible to go home, they would have to go to another facility "where appropriate measures, such as testing and single-cell placement, or social distancing, may be accomplished."

Joseph Mayle, a Bureau of Prisons union official who works at Elkton, told The Washington Post on Thursday that 25 people from the facility are hospitalized and 10 are on a ventilator. The bureau did not respond to a request for comment on those figures.

Exhibit O

Ninety-six percent of inmates i state prisons who tested positi coronavirus were asymptomat report

BY **MARTY JOHNSON** - 04/25/20 04:48 PM EDT

An overwhelmingly majority of inmates from four states' prison systems that tested positive for COVID-19 have been asymptomatic, according to Reuters.

Between Arkansas, North Carolina, Ohio and Virginia, 3,277 inmates tested positive for the virus. Of that number, 96 percent of the inmates were asymptomatic, meaning they showed no symptoms associated with the disease.

Asymptomatic patients can transmit COVID-19 unknowingly, putting at-risk populations in danger of contracting a virus that could be fatal. This fact has alarmed health experts since the onset of the pandemic and forced state government officials to instate social distancing measures.

Asymptomatic carriers pose a particular challenge in the country's state prison system where often, inmates come in close contact with one another.

"It adds to the understanding that we have a severe undercount of cases in the U.S.," Leana Wen, adjunct associate professor of emergency medicine at George Washington University, told the wire service. "The case count is likely much, much higher than we currently know because of the lack of testing and surveillance."

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The U.S. has more incarcerated persons than any other country in the world – over 2.3 million were reported in 2017. Michigan, Tennessee and California have all started mass testing in their respective prisons.

The results in those state prisons were similar; Tennessee reported a majority of its positive cases didn't show symptoms, while Michigan reported that "a good number" of the 620 positive cases showed no symptoms of the virus.

Some states, like Florida, New York and Texas are only testing inmates who exhibit symptoms.

"Prison agencies are almost certainly vastly undercounting the number of COVID cases among incarcerated persons," Michele Deitch, a corrections specialist and senior lecturer at the University of Texas, told Reuters.

"Just as the experts are telling us in our free-world communities, the only way to get ahead of this outbreak is through mass testing."

Overall in the U.S., COVID-19 has infected over 925,500 people, killing more than 53,000, according to data compiled by Johns Hopkins University.

TAGS **CORONAVIRUS** **ASYMPTOMATIC**