IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES OF AMERICA	:	Criminal Action
	:	
v.	:	No. 1:17-CR-237-ELR-1
	:	
BILLY WAYNE MCCLINTOCK	:	

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

The Defendant, Billy Wayne McClintock, through counsel and pursuant to 18 U.S.C. § 3582(c)(1)(A)(i), the compassionate release statute amended by the recent First Step Act, moves this Court for an order reducing his sentence to time served based upon both his terminal illness, myelodysplastic syndrome (known as MDS), and the looming COVID-19 pandemic.

Introduction

Mr. McClintock is 78 years old and has been in federal custody for fewer than two years.[1] He has a terminal illness: MDS, a blood cancer akin to leukemia. The disease swept over Mr. McClintock late last year, more than one year after this Court sentenced him.[2] While Mr. McClintock was an inmate at the federal

[1] On January 25, 2018, a jury convicted Mr. McClintock of seven counts resulting from a wire fraud conspiracy. (Doc. 38). On July 9, 2018, this Court sentenced Mr. McClintock to serve 120 months in prison. (Doc. 52). The Eleventh Circuit later affirmed the conviction. (Doc. 65).

[2] At the time of sentencing, Mr. McClintock suffered from several health problems, which the Court considered in imposing the sentence of 120 months in prison, but none was MDS. (PSR ¶ 65); Doc. 47, 47-1 (sentencing memorandum with attached letter from physician outlining medical maladies). This disease has come upon Mr. McClintock suddenly and ruthlessly.

prison camp in Pensacola, Florida, he began to show symptoms of a blood disease. In the late summer of 2019, the Bureau of Prisons ("BOP") sent him to at a hospital in Pensacola for in order to receive specialty treatment for symptoms that appeared to be leukemia. In November 2019, the BOP transferred Mr. McClintock to a federal medical center in Lexington, Kentucky. The physicians at FMC Lexington sent Mr. McClintock for specialized treatment at the Markey Cancer Center at the University of Kentucky Medical Center.[3] The next month, on December 6, 2019, one of those cancer specialists, Dr. Gregory P. Monohan, formally diagnosed Mr. McClintock with MDS:

> I discussed with Mr. McClintock the significance of his myelo-dysplastic syndrome (MDS). I explained that *MDS is a blood cancer, often thought of as a pre-leukemia. He is R-ISS stage: high risk with a predicted overall survival of 1.6 years* and a 25% risk of transformation to ADL at 17 months. Treatment in the form of chemotherapy can in some cases control the MDS, occasionally leading to complete remission, but in most cases it may decrease the transfusion requirements and improve blood counts. . . . I explained that the new normal would be consistent cytopenias with fatigue, increased risk for infections, increased risk for bleeding, and likely increased transfusion requirements for the rest of his life.[4]

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[3] For the sake of efficiency, Mr. McClintock has provided to the Court and to the government, under separate cover, a complete set of the 350-page medical records from the University of Kentucky, records which span the period of November 2019 through early February 2020. He has numbered those pages and will refer here to the record using those page numbers.

[4] (Attachment A at 166-67) (December 6-7, 2019, medical records from the University of Kentucky). A few definitions may help here. "AML," or acute myelogenous leukemia, is a cancer of the blood or bone marrow. MAYO CLINIC ONLINE, available at https://www.mayoclinic.org/diseases-conditions/acute-myelogenous-leukemia/symptoms-causes/syc-20369109 (last visited March 26, 2020). "Cytopenias" means a lower-than-normal amount of blood cells. NCI Dictionary of Cancer Terms, AMER. CANCER CENTER ONLINE, available at

Mr. McClintock began chemotherapy soon after the diagnosis, but the doctor's findings show this treatment is more likely to do no good at all, or to diminish the frequency of Mr. McClintock's visits to the cancer center, but will be unlikely to cure the disease. Instead, Dr. Monohan predicted that Mr. McClintock had approximately "1.6 years," or 19 months, to live. By now, four months later, that number is fast approaching one year. In spite of recent treatment at the Markey Cancer Center and FMC Lexington, including chemotherapy,[5] the disease endures.[6] One more note: Mr. McClintock's brother died of leukemia several years ago, so this may be a genetic condition.[7]

Although the BOP's physicians at FMC Lexington apparently did not learn of the diagnosis until recently, they know of it now. As of the filing of this motion, we do not yet know whether the BOP physicians have formally signed off on the terminal-illness diagnosis by signing a "Comprehensive Medical

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https://www.cancer.gov/publications/dictionaries/cancer-terms/def/cytopenia (last visited March 26, 2020).

[5] (Attachment A at 180, 188-89, 195, 263) (noting that Mr. McClintock agreed to chemotherapy, that the treatment's toxicity would cause serious side effects, and that the first round of treatment lasted ten days).

[6] (Attachment A at 263) (describing final diagnoses as MDS-EB2). This variant of MDS, known as "MDS with excess blasts," means that (1) "there are more blasts than normal in the bone marrow and/or blood and the person also has low numbers of at least one type of blood cell. There may or may not be severe dysplasia in the bone marrow" and (2) "this type accounts for about 1 in 4 cases of MDS. It is one of the types most likely to turn into AML, with the risk being higher for MDS-EB2 than for MDS-EB1." AMER. CANCER SOCIETY ONLINE, available at https://www.cancer.org/cancer/myelodysplastic-syndrome/about/mds-types.html (last visited March 26, 2020).

[7] (PSR ¶ 60).

Summary," but we expect they will do so soon. After all, the BOP physicians chose the UK doctors to provide Mr. McClintock to provide the specialized care they could not. But the fine doctors at the cancer center simply cannot cure Mr. McClintock of this disease. His projected release date, as things stand now, is March 14, 2027, nearly seven years away.[8] Unless this Court grants him compassionate release, Mr. McClintock will die in prison.

On January 14, 2020, Mr. McClintock filed at the prison—FMC Lexington—a formal, administrative request for reduction in sentence and compassionate release.[9] Several weeks later, his prison social worker, Tyson Baize, LCSW, reported that the prison did not yet have the records cited above from the University of Kentucky and, therefore, could not verify the terminal-illness diagnosis.[10] It was little surprise, then, that on February 6, 2020, the warden at the prison rejected Mr. McClintock's application through boilerplate language: "[A]t this time, you do not satisfy the medical components as specific in the program statement. Therefore, your request for RIS is denied."[11]

The terminal illness is not the only danger Mr. McClintock faces. The COVID-19 pandemic also poses a substantial, and immediate, threat. He is an elderly man with numerous medical conditions, in addition to his terminal

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[8] This date, listed on the BOP's "inmate locator" function on its public website (via Mr. McClintock's register number, 48742-018), is available at https://www.bop.gov/inmateloc/ (last visited March 26, 2020).

[9] (Attachment B at 2-3).

[10] (Attachment B at 4).

[11] (Attachment B at 5). Mr. McClintock then filed an internal appeal to the warden and that appeal, upon information and belief, is still pending.

illness. The Centers for Disease Control and Prevention ("CDC") tell us that Mr. McClintock is squarely within the group of people most vulnerable to the virus. Not only that, as an inmate living behind prison walls, he is even more imperiled. This constellation of risk factors—cancer, age, prison—mean that Mr. McClintock simply cannot wait any longer. Under the First Step Act, he now asks this Court to intervene.

Argument & Citation of Authority

Until recently, Mr. McClintock would have no choice but to wait for the grace of the BOP. But times have changed. Under the compassionate release statute, as originally written, the BOP was authorized to file in court a motion for reduction of sentence based on compassionate release. But if the BOP refused to file such a motion, a defendant had no right to file one on his own. He was at a dead-end. The recently-enacted First Step Act solved this problem. The statute now allows a defendant to file in the district court a motion on his own behalf, so long as he first exhausts, or tries to exhaust, administrative remedies. Once that motion is filed, a sentencing court is empowered to reduce a defendant's prison sentence if, after consideration of the factors set forth in 18 U.S.C. § 3553(a), it finds "extraordinary and compelling reasons warrant such a reduction." 18 U.S.C. § 3582(c)(1)(A)(i). Because Mr. McClintock's circumstances—the terminal illness, the elderly age, and the federal prison—constitute "extraordinary and compelling reasons" and the 18 U.S.C. § 3553(a) factors weigh in favor of release, he moves this Court to reduce his sentence to time served so that he may live out the short span of his remaining life at home.

1. Through the First Step Act, Congress penned a newly-renovated and expansive compassionate release statute.

Congress enacted the modern form of the compassionate release statute as part of the Comprehensive Crime Control Act of 1984, in which it created a mechanism for district courts to reduce a defendant's sentence for "extraordinary and compelling" reasons.[12] Any such request for relief, however, could only be filed by the Director of the BOP. Even if a defendant clearly qualified for a sentence reduction under the statute, a sentencing court only had authority to reduce a sentence upon motion of the Director.[13] The Director very rarely filed such motions.[14]

And then came the First Step Act. The express purpose of Section 603 of the First Step Act, which President Trump signed into law on December 21, 2018,

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[12] *See* Comprehensive Crime Control Act of 1984, Pub. L. No. 98–473, ch. II(D) § 3582(c)(1)(A), 98 Stat. 1837 (1984).

[13] *See, e.g.*, *Orlansky v. FCI Miami Warden*, 754 Fed. Appx. 862, 866 (11th Cir. 2018) ("Congress provided that a federal court may reduce an inmate's sentence only upon a motion by the Director of the BOP").

[14] *See generally* U.S. DEP'T OF JUSTICE OFFICE OF THE INSPECTOR GENERAL, THE FEDERAL BUREAU OF PRISONS' COMPASSIONATE RELEASE PROGRAM (2013) (criticizing the BOP's implementation of the Compassionate Release program and finding it rarely moved courts for compassionate release), *available at* https://oig.justice.gov/reports/2013/e1306.pdf (last visited January 24, 2020); *see also* Christie Thompson, *Frail, Old, and Dying, but Their Only Way Out of Prison Is a Coffin*, N.Y. TIMES (Mar. 7, 2018), available at https://www.nytimes.com/2018/03/07/us/prisons-compassionate-release-.html (last visited on January 24, 2020); Carrie Johnson, *Federal 'Compassionate' Prison Release Rarely Given*, NPR (Nov. 29, 2012), available at https://www.npr.org/2012/11/30/166178036/federal-compassionate-prison-release-rarely-given (last visited January 24, 2020).

is to "increas[e] the use and transparency of compassionate release."[15] In this statute, Congress, for the first time, enables a defendant (with or without BOP approval) to move for a sentence reduction based on "extraordinary and compelling reasons." A district court may now, with or without the BOP's blessing, resentence a defendant if she files a motion and establishes extraordinary and compelling reasons for a sentence reduction.

2. Under the new statute, this Court has jurisdiction to grant Mr. McClintock compassionate release.

A court may grant relief so long as the BOP fails to grant an inmate's administrative application within 30 days of its filing. Has Mr. McClintock satisfied the threshold requirement that he exhaust administrative remedies within the BOP so that the Court may entertain his motion? He has. The newly-revised statute reads in full:

> [T]he court, upon motion of the Director of the Bureau of Prisons, or upon motion of the defendant after the defendant has fully exhausted all administrative rights to appeal a failure of the Bureau of Prisons to bring a motion on the defendant's behalf or the lapse of 30 days from the receipt of such a request by the warden of the defendant's facility, whichever is earlier, may reduce the term of imprisonment . . . after considering the factors set forth in section 3553(a) to the extent that they are applicable, if it finds that—(i) extraordinary and compelling reasons warrant such a reduction . . . [16]

Mr. McClintock's motion is properly before this Court because in January, he submitted an administrative application for reduction and in February, the warden at FMC Lexington denied the request. By now, more than 30 days have elapsed "from the receipt of such a request by the warden of the defendant's

[15] First Step Act of 2018, Pub. L. No. 115-391, § 603, 132 Stat. 5194 (Dec. 21, 2018).

[16] 18 U.S.C. § 3582(c)(1)(A).

facility." Therefore, Mr. McClintock has exhausted his administrative remedies with the BOP. This motion is properly before this Court.

3. Mr. McClintock demonstrates "extraordinary and compelling reasons" for release pursuant to the compassionate release statute.

The specialists at the University of Kentucky Medical Center have diagnosed Mr. McClintock with a terminal illness. Not only that, the doctors have concluded that the disease is terminal; they predicted back in December that he had than "1.6 years" (or 19 months) to live. Nearly five months have passed since that diagnosis, so only 15 months remain. There is no evidence that Mr. McClintock's disease has ebbed or that the chemotherapy changed the diagnosis at all. Meanwhile, the COVID-19 virus is stalking the federal prison system and will soon imperil Mr. McClintock's health all the more. Time is running short.

A. Mr. McClintock's terminal illness is an "extraordinary and compelling reason" that warrants a reduction in sentence.

The compassionate release statute, 18 U.S.C. § 3582(c)(1)(A), provides that a court may reduce a defendant's term of imprisonment after consideration of the factors set forth in § 3553(a) if it finds "extraordinary and compelling reasons" and such a reduction is "consistent with the applicable policy statements issued by the Sentencing Commission." Congress never defined what constitutes extraordinary and compelling reasons and instead delegated this responsibility to the United States Sentencing Commission.[17] The Commission

[17] *See* 28 U.S.C. § 994(t) ("The Commission, in promulgating general policy statements regarding the sentencing modification provisions in section 3582(c)(1)(A) of title 18, shall describe what should be considered extraordinary and compelling reasons for sentence reduction . . . .").

authored United States Sentencing Guideline § 1B1.13 as the applicable policy statement and therein described what may constitute extraordinary and compelling reasons for a sentence reduction.[18]

The application notes to § 1B1.13 provide several specific categories of "extraordinary and compelling reasons."[19] Mr. McClintock's circumstances fit squarely within the very first category: "The defendant is suffering from a terminal illness (i.e., a serious and advanced illness with an end of life trajectory). A specific prognosis of life expectancy (i.e., a probability of death within a specific time period) is not required. Examples include metastatic solid-tumor cancer, . . . ALS, end-stage organ disease, and advanced dementia."[20] Mr. McClintock suffers from a terminal illness and merits compassionate release for that reason alone.

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[18] U.S.S.G. § 1B1.13.

[19] Congress initially delegated the responsibility for determining what constitutes "extraordinary and compelling reasons" to the United States Sentencing Commission. In light of the First Step Act, however, courts have recognized that while the Commission's policy statements provide helpful guidance, they no longer constrain the Court's independent assessment of whether "extraordinary and compelling reasons" exist to warrant a sentence reduction under § 3582(c)(1)(A)(i). *See, e.g.*, *Beck*, 2019 WL 2716505, at *6. This is so because the Commission's statutory authority is limited to explaining "the appropriate use of [§ 3582] under the current statute." *United States v. Cantu*, 2019 WL 2498923, at *3 (S.D. Tex. June 17, 2019). An amendment to § 3582, including to the compassionate release section, "may [therefore] cause some provisions of a policy statement to no longer fall under that authority." *Id.*

[20] U.S.S.G. § 1B1.13, comment. n.1(A)(i).

B. The COVID-19 pandemic, and the concentrated threat it poses to inmates in federal prisons, is an extraordinary and compelling reason that also merits compassionate release.

On March 11, 2020, the World Health Organization officially labeled the COVID-19 disease a pandemic.[21] As of March 26, 2020, the COVID-19 virus has infected at least 462,684 people worldwide, leading to at least 20,834 deaths.[22] As of the date of this motion, in the United States, at least 85,724 people have been infected with the virus, and at least 1,275 people have died because of the virus.[23]

On March 13, 2020, the White House declared a national emergency, under Section 319 of the Public Health Service Act (42 U.S.C. § 247(d)).[24] Three days later, the White House issued guidance recommending that, for the next eight

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[21] *WHO Characterizes COVID-19 as a Pandemic*, WORLD HEALTH ORGANIZATION (March 11, 2020), available at https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020 (last visited March 27, 2020).

[22] *Coronavirus disease 2019 (COVID-19) Situation Report – 66*, WORLD HEALTH ORGANIZATION (March 26, 2020), available at https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200326-sitrep-66-COVID-19.pdf?sfvrsn=9e5b8b48_2 (last visited March 27, 2020).

[23] *Coronavirus in the U.S.: Latest Map and Case Count*, NY TIMES ONLINE (March 27, 2020), available at https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited March 27, 2020).

[24] *The White House, Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak* (March 13, 2020), available at https://www.whitehouse.gov/presidential-actions/proclamation-declaring-national-emergencyconcerning-novel-coronavirus-disease-COVID-19-outbreak/ (last visited March 27, 2020).

weeks, no group of ten or more persons should congregate together.[25] The President's declaration followed a report by British researchers, in which they concluded that without drastic intervention to slow the spread of the deadly illness, 2.2 million Americans may die.[26] Our own governor, Brian Kemp, also declared a state of emergency here in Georgia for the same reason, and imposed his own strict measures, including a shelter-in-place edict for all "medically fragile" Georgians.[27]

The CDC issued its own expert guidelines on COVID-19. The people most at risk of contracting the disease—and of dying from the disease—are "older adults and people of any age who have serious underlying medical conditions;" this means adults over 65 years old and people with chronic medical conditions such as lung disease, heart disease, and diabetes, and "[p]eople who are immunocompromised, including cancer treatment."[28] Mr. McClintock's age (he

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[25] Sheri Fink, *White House Takes New Line After Dire Report on Death Toll*, NEW YORK TIMES ONLINE (March 17, 2020), available at https://www.nytimes.com/2020/03/16/us/coronavirus-fatality-rate-white-house.html (last visited March 27, 2020).

[26] *Id.*

[27] *Kemp Declares Public Health State of Emergency* (March 16, 2020), available at https://gov.georgia.gov/press-releases/2020-03-16/kemp-declares-public-health-state-emergency (last visited March 27, 2020); Greg Bluestein, ATLANTA JOURNAL-CONSTITUTION (March 23, 2020), available at https://www.ajc.com/blog/politics/breaking-kemp-bans-many-large-gatherings-orders-shelter-place-for-medically-fragile/LRp3MUBsORkUJjjaoBZZYK/ (last visited March 27, 2020).

[28] *People at Risk for Serious Illness for Severe Illness*, CDC ONLINE (March 12, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/people-at-higher-risk.html (last visited March 27, 2020).

is 78 years old), cancer treatment, and general poor health render him particularly susceptible to the disease. Mr. McClintock would be extremely vulnerable to the disease even if he lived in the safety of his own home and community. But what about people, like him, held in a federal prison?

The CDC, the White House, and the Governor have all urged vulnerable people to take immediate, preventive actions, including avoiding groups of people, washing hands frequently with soap, and staying home, separated from other people.[29] This is a hopeless set of guidelines for federal prisoners, who lack any ability to protect themselves in these urgent ways. People in prisons and jails are uniquely vulnerable to the COVID-19 virus. According to Dr. Jaimie Meyer, an infectious disease expert and professor at the Yale School of Medicine, inmates are particularly vulnerable because "[t]he risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected."[30] In her declaration, attached to this motion, Dr. Meyer describes the inadequate pandemic preparedness plans in many detention facilities and the difficulty of separating infected or symptomatic inmates from others. In short, the COVID-19 virus is highly transmissible, extraordinarily dangerous, and poses a severe threat to even healthy federal inmates.

The conditions of incarceration, through no fault of the BOP employees themselves, foster, rather than limit, the spread of the virus. Conditions of

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[29] *People at Risk for Serious Illness for Severe Illness*, CDC ONLINE, *supra* at 11 n.28.

[30] Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 CLINICAL INFECTIOUS DISEASES 1047, 1047 (Oct. 2007), available at https://doi.org/10.1086/521910 (last visited March 23, 2020).

confinement create an optimal environment for the transmission of contagious disease.[31] Inmates arrive at BOP facilities from all over the country, and people who work in the facilities leave and return daily. Public health experts believe that incarcerated individuals "are at special risk of infection, given their living situations," and "may also be less able to participate in proactive measures to keep themselves safe;" "infection control is challenging in these settings."[32] The social distancing that public health experts advocate as essential to limiting the spread of COVID-19 is simply impossible in jail and prison facilities. Crowding, inadequate ventilation, and security issues all contribute to the spread of infectious disease.[33] Hand sanitizer, an effective disinfectant recommended by the Centers for Disease Control to reduce transmission rates, is contraband in jails and prisons because of its alcohol content.[34] Correctional health experts

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[31] Attachment C (declaration of Dr. Jaimie Meyer).

[32] "Achieving A Fair And Effective COVID-19 Response: An Open Letter to Vice-President Mike Pence, and Other Federal, State, and Local Leaders from Public Health and Legal Experts in the United States" (March 2, 2020), available at https://law.yale.edu/sites/default/files/area/center/ghjp/documents/final_COVID-19_letter_from_public_health_and_legal_experts.pdf (last visited March 27, 2020).

[33] Michael Kaste, *Prisons and Jails Worry About Becoming Coronavirus 'Incubators'*, NPR (March 13, 2020), available at https://www.npr.org/2020/03/13/815002735/prisons-and-jails-worryabout-becoming-coronavirus-incubators (last visited March 27, 2020).

[34] Keri Blakinger & Beth Schwarzapfel, *How can prisons contain coronavirus when Purell is a contraband?*, ABA JOURNAL (March 13, 2020) https://www.abajournal.com/news/article/when-purell-is-contraband-how-can-prisons-contain-coronavirus (last visited March 27, 2020).

worry that, if jails and prisons are complacent about the coronavirus, these facilities may become incubators for the disease.[35]

The federal prison system simply may not be, in spite of its best efforts, capable of preventing a harrowing outbreak.[36] The BOP recently reported that guards have already tested positive and "[t]he agency is in chaos."[37] At FCI Tallahassee, for example, "officers charged with moving prisoners do not have access to protective gear. Employees said the facility has 60 masks to be shared among 200 employees, no soap in multiple staff restrooms, a lack of hand sanitizer and a supply of gloves that may only last through next week."[38]

Meanwhile, the COVID-19 virus has arrived at the BOP. As of the date of this motion, the BOP reports that 14 inmates (at six facilities) and 13 staff members (at 10 facilities) have tested positive for the COVID-19 virus.[39] And

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[35] Keri Blakinger & Beth Schwarzapfel, *supra* at 13 n.34.

[36] Walter Pavlo, *Can US Prisons React Fast Enough to COVID-19?*, FORBES ONLINE (March 21, 2020), available at https://www.forbes.com/sites/walterpavlo/2020/03/21/us-prisons-can-they-react-fast-enough-to-COVID-19/#10373e8f1033 (last visited March 23, 2020).

[37] Cassidy McDonald, *Federal prison workers say conflicting orders on coronavirus response is putting lives at risk*, CBS NEWS ONLINE (March 19, 2020), available at https://www.cbsnews.com/news/coronavirus-prison-federal-employees-say-conflicting-orders-putting-lives-at-risk-2020-03-19/ (last visited March 23, 2020).

[38] *Id.*

[39] *COVID-19 Tested Positive Cases*, BOP ONLINE (March 28, 2020), available at https://www.bop.gov/coronavirus/ (last visited March 28, 2020). The inmates are at MDC Brooklyn; FCC Oakdale (5); USP Atlanta (2); MCC New York (2); RRC Phoenix; RRC Brooklyn (3). The staff members work at these: Grand Prairie, TX; Leavenworth, KS (no inmate contact); Yazoo, MS (2); Atlanta, GA; Danbury,

now the first BOP inmate has died of COVID-19, an inmate whom the BOP's press release said also suffered from "long-term, pre-existing medical conditions which the CDC lists as risk factors for developing more severe COVID-19 disease."[40]

C. Federal courts, in all types of cases, including compassionate release motions, have granted immediate release to inmates imperiled by the COVID-19 epidemic.

Well before the COVID-19 outbreak, districts courts liberally exercised their novel authority to grant compassionate release to inmates with terminal illnesses and other debilitating medical conditions. In *United States v. Beck*, for example, the court granted compassionate release to a defendant who suffered from breast cancer, and for whom the BOP had provided "abysmal" treatment.[41] In *United States v. Spears*, a court ordered the release of a defendant who suffered from "high grade prostate cancer."[42] In *United States v. Johns*, the court granted an 81-year-old defendant's compassionate release motion and reduced his sentence from life without parole to time served based on his age and medical conditions that caused a "significant decline over time in daily living activities."[43] In *United*

CT; Butner, NC; Ray Brook, NY; New York, NY (2); Chicago, IL (2); Brooklyn, NY.

[40] *Inmate death at Oakdale I*, BOP Press Release (March 28, 2020), available at Ihttps://www.bop.gov/resources/news/pdfs/20200328_press_release_oak_death.pdf (last visited March 29, 2020).

[41] 2019 WL 2716505, at *7-*8 (M.D.N.C. June 28, 2019).

[42] 2019 WL 5190877, at *2-*6 (D. Or. Oct. 15, 2019).

[43] 2019 WL 2646663, at *4 (D. Ariz. June 27, 2019).

States v. McGraw, the court granted a motion for compassionate release filed by defendant who was dependent on oxygen and a wheelchair based on "chronic, serious conditions," despite the government's contention that the defendant's current medical needs were being met in prison.[44] These orders are not outliers in providing such equitable relief. Indeed, at least two judges in the Northern District of Georgia have granted immediate release to three defendants suffering from terminal illnesses.[45]

The COVID-19 pandemic has now increased the urgency—and frequency—of compassionate release motions. In recent weeks, district courts have begun to grant these motions based, at least in part, upon the virus's looming threat.[46] For example, in *United States v. Campagna*, a court held that

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[44] 2019 WL 2059488, at *5 (S.D. Ind. May 9, 2019).

[45] *United States v. Barmore*, No. 1:92-CR-11-ODE-1, Doc. 200 (N.D. Ga. Mar. 5, 2020) (Evans, J.) *United States v. Robinson*, No. 1:10-CR-129-ODE-1, Doc. 150 (N.D. Ga. Nov. 14, 2019) (Evans, J.) (granting motion for compassionate release for terminally-ill defendant who later died at home within several days of his release); *United States v. Bagwell*, No. 4:09-CR-8-HLM-1, Doc. 75 (N.D. Ga. Aug. 23, 2019) (Murphy, J.) (granting motion for compassionate release for terminally-ill defendant). A third judge in our district granted compassionate release for a defendant whose medical conditions, although not terminal, rendered her unable to care for herself in prison. *United States v. Culberson*, No. 4:97-CR-35-TCB-3, Doc. 397 (N.D. Ga. September 17, 2019) (Batten, J.)

[46] *United States v. Powell*, No. 1:94-CR-316-ESH, Doc. 98 at 1 (D.D.C. Mar. 28, 2020) (granting unopposed motion for compassionate release in light of COVID-19 and finding it "would be futile" to require defendant to first exhaust in light of open misdemeanor case); *United States v. Campagna*, 2020 WL 1489829, at *3 (S.D.N.Y. Mar. 27, 2020) (ordering that defendant served the remainder of his sentence in home confinement).

"Defendant's compromised immune system, taken in concert with the COVID-19 public health crisis, constitutes an extraordinary and compelling reason to modify to Defendant's sentence."[47] This Court should do the same here.

This crisis is not limited to compassionate-release cases, of course. Federal courts have begun, like forest firefighters, to snatch non-violent prisoners all of stripes—in immigration, bond, and pretrial cases, for example—from the pandemic's fiery path. In dozens of non-compassionate release cases, judges have met the dire threat that COVID-19 poses to individuals held in prisons and jails by moving them to safety. Courts have ordered the immediate release of prisoners in immigration detention sites.[48] Courts have released defendants from pre- and post-trial custody to divert them from federal detention centers.[49]

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[47] 2020 WL 1489829, at *3.

[48] *Basank v. Decker*, No. 1:20-CV-2518, Doc. 11 at 15 (S.D.N.Y. Mar. 26, 2020) (granting federal immigration detainees' TRO and ordering immediate release in light of the COVID-19 virus and the detainees' underlying health maladies); *Xochihua-James v. Barr*, No. 18-71460 (9th Cir. Mar. 23, 2020) (unpublished) (releasing detainee, on its own motion, from immigration detention "in light of the rapidly escalating public health crisis").

[49] *United States v. Grobman*, No. 1:18-CR-20989-RKA-2, Doc. 397 at 2 (S.D. Fla. Mar. 29, 2020) (ordering release of defendant post-trial in light of "extraordinary situation of a medically-compromised detainee being housed at a detention center where it is difficult, if not impossible, for [the defendant] and others to practice the social distancing measures which government, public health and medical officials all advocate"); *United States v. Kennedy*, No. 5:18-CR-20315-JEL-3, Doc. 77 at 2 (E.D. Mich. Mar. 27, 2020) (ordering presentence release of defendant because "the COVID-19 pandemic constitutes an independent compelling reason" for temporary release); *United States v. Mclean,* No. 1:19-CR-380-RDM, Doc. 21 at 1 (D.D.C. Mar. 28, 2020) ("As counsel for the Defendant candidly concedes, the facts and evidence that the Court previously weighed in concluding that Defendant posed a danger to the community have not

D. The Attorney General and Members of Congress have responded to the COVID-19 pandemic by urging the BOP to release more inmates from federal prisons.

In recent days, the Attorney General issued a memorandum to the Director of the BOP, outlining a new policy by the United States Department of Justice ("DOJ") to deal with confined inmates who are most vulnerable to the COVID-19

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changed—with one exception. That one exception—COVID-19—however, not only rebuts the statutory presumption of dangerousness, *see* 18 U.S.C. § 3142(e), but tilts the balance in favor of release."); *United States v. Michaels*, No. 8:16-CR-76-JVS-1, Minute Order, Doc. 1061 (C.D. Cal. Mar. 26, 2020) ("Michaels has demonstrated that the COVID-19 virus and its effects in California constitute 'another compelling reason'" justifying temporary release under § 3142(i)); *United States v. Harris*, No. 1:19-CR-356-RDM, Doc. 36 at 1 (D.D.C. Mar. 26, 2020) ("The Court is convinced that incarcerating Defendant while the current COVID-19 crisis continues to expand poses a far greater risk to community safety than the risk posed by Defendant's release to home confinement on . . . strict conditions."); *United States v. Garlock*, 2020 WL 1439980, at *1 (N.D. Cal. Mar. 25, 2020) ("The chaos has already begun inside federal prisons—inmates and prison employees are starting to test positive for the virus, quarantines are being instituted, visits from outsiders have been suspended, and inmate movement is being restricted even more than usual."); *United States v. Perez*, 2020 WL 1329225, at *1 (S.D.N.Y. Mar. 19, 2020) (releasing defendant due to the "heightened risk of dangerous complications should he contract COVID-19"); *United States v. Stephens*, 2020 WL 1295155, at *2 (S.D.N.Y. Mar. 19, 2020) (collecting authorities) (releasing defendant in light of "the unprecedented and extraordinarily dangerous nature of the COVID-19 pandemic"); *In re Manrigue*, 2020 WL 1307109, *1 (N.D. Cal. Mar. 19, 2020) ("The risk that this vulnerable person will contract COVID-19 while in jail is a special circumstance that warrants bail."); *United States v. Matthaei*, 2020 WL 1443227, at *1 (D. Idaho Mar. 16, 2020) (extending self-surrender date in light of COVID-19 threat); *United States v. Copeland*, No. 2:05-CR-135-DCN-2, Doc. 662 at 9 (D.S.C. Mar. 24, 2020) (granting First Step Act motion for defendant in part due to "Congress's desire for courts to release individuals the age defendant is, with the ailments that defendant has during this current pandemic").

virus.[50] This memorandum was issued "to ensure that [the BOP] utilize[s] home confinement, where appropriate, to protect the health and safety of BOP personnel and the people in our custody."[51] The Attorney General has "direct[ed the BOP] to prioritize the use of [its] various statutory authorities to grant home confinement for inmates seeking transfer in connection with the ongoing COVID-19 pandemic."[52] One of these statutes, of course, is the compassionate release statute, 18 U.S.C. § 3582(c)(1)(A), invoked in our motion on behalf of Mr. McClintock. The "list of discretionary factors" cited in the Attorney General's directive overwhelmingly support Mr. McClintock's immediate release.[53]

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[50] "Memorandum for Director of Bureau of Prisons: Prioritization of Home Confinement As Appropriate in Response to COVID-19 Pandemic," Office of Attorney General (March 26, 2020), available at https://www.justice.gov/file/1262731/download (last visited March 28, 2020).

[51] *Id.* at 1.

[52] *Id.*

[53] For the Court's benefit, here is a review of those factors: (1) *the age and vulnerability of the inmate to COVID-19*—Mr. McClintock, in light of his age, cancer, and chemotherapy treatments, is in the highest of the CDC's COVID-19 risk categories; (2) *the security level of the facility*—Mr. McClintock is held at the federal medical center in Lexington, Kentucky, and he has been admitted to local hospitals both in Kentucky and in Florida, so he poses no security risk whatsoever; (3) *the inmate's conduct in prison*—Counsel is not aware that Mr. McClintock has any history of disciplinary infractions while in custody. Under the Attorney General's factors, this fact merits priority treatment for home confinement; (4) the inmate's score under PATTERN—Counsel does not know Mr. McClintock's score based on the BOP's current calculation factors; (5) *the inmate's release plan*—We discuss this factor in detail below; (6) *the inmate's crime of conviction and assessment of danger posed to the community*—Mr. McClintock's fraud offenses began 13 years ago and ended with the SEC investigation eight years ago. Now, however, in light of his advanced age, his all-consuming cancer

Under the Attorney General's directive, then, Mr. McClintock ought to be among those inmates who receive priority treatment from the BOP for transfer to home confinement to complete his unserved portion of incarceration. However, we ask this Court not to wait for the BOP, but instead to take urgent action on our motion for compassionate release. We do not know how long the BOP will take to implement the new directive and, as we all well know, the COVID-19 virus will not wait to infect its victims.

The Attorney General is not alone in urging the BOP to act. In light of the sudden danger to federal prisoners, some Members of Congress have written to the BOP to urge it to accomplish the immediate release of non-violent, elderly inmates through compassionate release motions of its own.[54] And there is more.

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treatment, and his physical frailty, Mr. McClintock is an extremely low risk of committing any crime.

[54] Letter of Representatives Jerrold Nadler and Karen Bass (March 19, 2020) ("DOJ and BOP must also do all they can to release as many people as possible who are currently behind bars and at risk of getting sick. Pursuant to 18 U.S.C. 3582(c)(1)(A), the Director of the Bureau of Prisons may move the court to reduce an inmate's term of imprisonment for "extraordinary and compelling reasons."), available at https://judiciary.house.gov/uploadedfiles/2020-03-19_letter_to_ag_barr_re_Covid19.pdf (last visited March 30, 2020).

Senator Kamala Harris also sent a letter to the BOP urging it to release low-risk inmates and arguing that the close quarters prisoners live in—paired with the strict measures the BOP is taking distance inmates from the public—makes them particularly susceptible to the COVID-19 virus. Andrew O'Reilly, *Kamala Harris Wants Low Risk Inmates Released Ami Fears of COVID-19- Spreading in Prisons*, FOX NEWS ONLINE, available at https://www.foxnews.com/politics/kamala-harris-wants-low-risk-inmates-released-amid-fears-of-COVID-19-spreading-in-prisons (last visited March 23, 2020).

Four hundred former federal judges, prosecutors, and DOJ officials sent an open letter to the White House urging the President to commute sentences in response to the COVID-19 crisis.[55] These governmental voices urging a prompt response to the pandemic provide evidence that each of us, all of us, must use the tools available to us to accomplish the release of vulnerable inmates.

E. The § 3553(a) sentencing factors support a finding that a sentence of time served is sufficient but not greater than necessary to accomplish the goals of sentencing.

When Mr. McClintock committed these crimes one decade ago and when this Court sentenced him nearly two years ago, he did not suffer from this debilitating, terminal disease.[56] The passage of time—especially in these most recent six months—has broken him. Mr. McClintock's terminal illness fits squarely within the definition of "extraordinary and compelling reasons" set forth in Application Notes 1(A)(i) of U.S.S.G. § 1B1.13, and he merits compassionate release. That is not all. The dire nature of the COVID-19 pandemic, and its looming threat to the federal prison system, also qualifies as an "extraordinary and compelling" reason to grant Mr. McClintock compassionate release here, especially when coupled with his age and terminal illness. The BOP has not yet said so, but this Court should say so here and now.

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[55] *Hundreds of former DOJ officials and federal judges urge Prez Trump to commute sentences and create emergency advisory group to respond to COVID-19 challenges*, SENTENCING LAW AND POLICY BLOG (March 27, 2020), available at https://sentencing.typepad.com/sentencing_law_and_policy/2020/03/hundreds-of-former-doj-officials-and-federal-judges-urge-prez-trump-to-commute-sentences-and-create-.html (last visited March 30, 2020).

[56] (PSR ¶ 65) (outlining the following medical problems: a hernia, a heart condition (one which required bypass surgery), a compressed vertebrae, and high blood pressure).

How shall the Court measure its discretion? It must travel a familiar, but critical, path. Like any sentencing decision, the Court must consider the 18 U.S.C. § 3553(a) factors. These factors weigh in favor of reducing Mr. McClintock's sentence. The Court must consider, as always, the nature and circumstances of Mr. McClintock's offenses.[57] A jury convicted Mr. McClintock of seven crimes related to a wire-fraud scheme that he carried out between 2007 and 2012. This Court presided over the trial of the case and counsel did not, but, in short, the jury concluded that Mr. McClintock and others operated a Ponzi scheme and stole more than 15 million dollars from more than 200 victims.[58] The criminal conduct in this case was serious and unforgiveable. The crimes, committed over the course of a many years, caused true harm to the victims (some of whom lost their life savings or their children's college funds) and to the community. Mr. McClintock's original punishment (of 120 months in prison) fit those crimes. But compassionate release is available to everyone, no matter his crime. The statute provides no exceptions.

In *Pepper v. United States*, the Supreme Court held that as a district court carries out its § 3553(a) duties, it must measure a defendant's post-sentencing rehabilitation, as well as the twin aims of general and specific deterrence.[59] These factors, too, weigh toward compassionate release here. Mr. McClintock did not just lose his liberty in prison; he lost his vitality and health. He has a paid a deep price for his crimes. No person in community would ever choose to trade places

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[57] 18 U.S.C. § 3553(a)(1).

[58] (PSR ¶¶ 12-32).

[59] 562 U.S. 476, 491 (2011) (citing 18 U.S.C. § 3553(a)(2)(B), (C), and (D)).

with Mr. McClintock, or to risk suffering his fate. He will stand as a stark reminder of the immense penalties and consequences that can arise from violations of federal fraud laws. Mr. McClintock is not the same person who broke the law many years ago or even the same man whom this Court sentenced two years ago. He is no longer a danger to public safety. He has left behind the long-ago choices that led him to break the law.

Lest the Court ask whether Mr. McClintock will slide into neglect (and crime) outside the prison walls, he will not. He has a strong safety net. Christine Dafforn, a long-time friend, lives in Sarasota, Florida; she will permit Mr. McClintock to live with her.[60] She will help Mr. McClintock enroll in Medicare and then will make certain he receives medical care at the Sarasota Memorial Hospital.[61]

Meanwhile, the rising tide of COVID-19 news is surely just the beginning. Conditions in the BOP, across the entire system, are extraordinarily dangerous. The BOP's medical facilities, and its ability to take inmates to outside hospitals, are limited even in the best of times. But what will happen when the BOP inevitably becomes overwhelmed with COVID-19 cases? Many who require hospitalization and intensive treatment will not get it. Mr. McClintock is one of the most vulnerable victims to this deadly disease and is in the most vulnerable place to be infected: an overcrowded prison where he cannot take the self-care measures prescribed by the CDC. Yet, in light of hospitals' plans to ration care,

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[60] Attachment D (email from Ms. Dafforn to counsel, dated March 27, 2020).

[61] The website for the hospital is available at https://www.smh.com/ (last visited March 27, 2020).

he is one of least likely persons to receive comprehensive COVID-19 treatment.[62] We have no evidence, at least not yet, that the COVID-19 virus has struck Mr. McClintock's prison, but that is even more reason to grant him an early release.

Conclusion

A court's "duty is always to sentence the defendant as he stands before the court on the day of sentencing."[63] With his irreparable illness, Mr. McClintock's life may end within little more than one year. And that's without the COVID-19 virus stalking him. Mr. McClintock sits firmly in two CDC high-risk categories: old age and compromised immune system. Each category on its own would be harrowing, but both, in combination, must be lethal. If Mr. McClintock contracts the virus, he is almost certainly going to die. His terminal illness, combined with dangers of the COVID-19 pandemic, is an "extraordinary and compelling reason" that compels compassionate release under 18 U.S.C. § 3582(c)(1)(A). Mr.

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[62] Mr. McClintock might not receive proper treatment, even if the BOP refers to a hospital outside of the BOP. Hospitals have begun to ration their limited medical resources, including ventilators, and the young are often favored over the old. Sasha Pfeiffer, *U.S. Hospitals Prepare Guidelines For Who Gets Care Amid Coronavirus Surge*, NPR ONLINE (March 21, 2020), available at https://www.npr.org/2020/03/21/819645036/u-s-hospitals-prepare-guidelines-for-who-gets-care-amid-coronavirus-surge (last visited March 30, 2020) ("[The guidelines] vary from hospital to hospital, but their overall goal is usually to save the most lives. So hospitals consider a combination of factors: age, life expectancy, how severe a patient's illness is, how likely treatment is to help and whether a patient has additional illnesses that could shorten the person's life span, such as cancer or heart disease. Hospitals can then use those factors to develop scoring systems or clinical scores to prioritize care."). Mr. McClintock may be shut out of COVID-19 treatment. This is even more reason to take preventative action now, through this motion, and to ensure he does not contract the virus in the first place.

[63] *United States v. Bryson*, 229 F.3d 425, 426 (2d Cir. 2000).

McClintock respectfully requests that the Court grant a reduction in sentence to time served and leave in place the original 36 months of supervised release to follow.

/S/ W. MATTHEW DODGE
W. Matthew Dodge
Federal Defender Program, Inc.
101 Marietta Street, N.W., Suite 1500
Atlanta, Georgia 30303
(404) 688-7530 Fax (404) 688-0768
Matthew_Dodge@fd.org

Attorney for Billy Wayne McClintock

CERTIFICATE OF COMPLIANCE AND SERVICE

I hereby certify that the foregoing pleading was produced using Book Antiqua 13-point font in accordance with Local Rule 5.1C and that I electronically filed this pleading with the Clerk of Court using the CM/ECF system, which will simultaneously deliver a digital copy to opposing counsel: Alex R. Sistla and J. Elizabeth McBath, Assistant United States Attorneys, 6th Floor, United States Courthouse, Richard B. Russell Building, 75 Ted Turner Drive, SW, Atlanta, Georgia, 30303.

/S/ W. MATTHEW DODGE
W. Matthew Dodge
Federal Defender Program, Inc.

March 31, 2020

Attachment A

United States v. McClintock
No. 1:17-CR-237-ELR-1

Motion to Reduce Sentence
March 31, 2020

MR# 025733551

HealthCare

- University of Kentucky A.B. Chandler Hospital
- UK HealthCare Good Samaritan Hospital
- UK HealthCare Ambulatory Services
- UK Dental and Oral Health Clinics

RECEIVED MAR 09 2020 BY:

AUTHORIZATION FOR RELEASE OF INFORMATION (for Use and Disclosure)

Please fill out all sections or the form may be returned to you.

Patient Name: Billy Wayne McClintock
Address: FMC Lexington
City: Lexington State: KY Zip:
Social Security Number: [redacted]
Date of Birth:
Phone Number: None

Type of Release [X] ROI+ [X] CD [X] Paper [ ] Review records at UK (must make an appointment)
[X] Permission to discuss care [ ] Pick-up -- Phone number

Send Information from:
[X] UK HealthCare facilities
[ ] UK College of Dentistry
[ ] UK Student Health / Employee Health / Urgent Care Clinic
[ ] Other

Send to: email address (for ROI+ USE ONLY) or address (if name / address is different from above)
W. Matthew Dodge, Fed. Defender Prog.
101 Marietta St., NW, Ste 1500
Atlanta, GA 30303 Matthew_Dodge@FD.org

I would like records from the following dates: Jan. 1, 2019 through March 1, 2020
(This can be a very specific date or more general. Examples: July 15, 2007 or June 2006 - Feb 2007)

Please check the records you would like:
[X] Records related to (specify): All, including leukemia (examples: car accident or appendectomy)
[X] Discharge Summary [X] Pathology Report(s) [X] X-Ray Report(s)
[ ] TB Screening [X] Laboratory Report(s) [X] X-Ray Image(s)
[ ] Immunization Record [ ] Photo/Video/Other [X] All records
[X] ER Notes [ ] Outpatient Notes [X] Other: (specify) Incl. correspondence of doctors on at Markey Cancer Center (e.g., G.P. Monohan).
[X] Surgery Reports [ ] Psychological Test Report

Sharing of Special Protected Records: I authorize the sharing of information about:
a. The diagnosis or treatment of AIDS, including the results of HIV tests (the virus that causes AIDS) [ ] YES [X] NO / NA
b. The diagnosis or treatment of drug and/or alcohol abuse [ ] YES [X] NO / NA
c. The treatment and/or consultation for mental health or psychiatric disorders [ ] YES [X] NO / NA

Reason records are needed (check all that apply):
[ ] For another doctor or hospital [ ] Social Security/disability [X] Legal [ ] Personal use [ ] Other (specify)
This Authorization will expire on Feb. 25, 2021 **(date).**
If no date is included the Authorization will expire in 90 days.

- I understand that I may revoke this Authorization at any time, unless the Authorization was obtained as a condition of obtaining insurance coverage; that my revocation must be submitted in writing to the Registration Office at the Facility/location where I originally submitted/filed this authorization; and that the revocation shall be effective except to the extent that the Facility has already used or disclosed information in reliance on the Authorization.
- I further understand that treatment payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this Authorization, however, Facility may condition the provision of health care that is solely for the purpose of creating protected health information for disclosure to a third party on my signing this Authorization, and Facility may condition the provision of research-related treatment on my signing this Authorization.
- I understand that information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by applicable privacy law. I further understand that the facility, its employees, officers and agents are released from legal responsibility or liability for the use and disclosure of the above information to the extent indicated and authorized.

I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE OF THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

3/03/20
Date

Billy Wayne McClintock
Signature of Patient

If patient is unable to sign, secure consent of Legal Representative and indicate reason below:
[ ] Minor [ ] Incompetent [ ] Deceased
Proof of designation must be filed in the chart or sent with this request.

Signature of Legal Representative and Relationship to Patient

Signature of Witness for Psychiatric Records

CO - 0005 7/16/18

UKHealthCare

Documents Review Report

Patient:MCCLINTOCK, BILLY W	**MRN:** [redacted]	**DOB:** [redacted]	**Visit Status: DSC**
Provider: Kumar MD. Hanesh	**Admit Date: 11/26/2019**		**Age: 78**
Location: A11J-234-A	**Discharge Date: 12/20/2019**		**Gender: M**

Consult Follow Up Note *-HMC - Medicine / Hematology-Maligna

Last Updated: 12/6/2019 7:02:22 PM [Entered: 12/6/2019 6:52:00 PM]

Authored By: Nutalapati MD, Snigdha (Physician)

ATTENDING MD: A. Goldberg, MD Service: M14 Location: A11J OTHER MD(S): W. L. Fuller, M.D.
J.A. Troy, M.D. Client: UKCMC Reported: 12/4/2019 15:30
DIRECTOR/SUPERVISOR: John R. May, Jr.
Collected: 12/2/2019 15:57
IM, CELL MARKER - BONE MARROW
Interpretation
SLIGHTLY EXPANDED MONOCYTIC POPULATION AND 2-3% MYELOBLASTS, SEE COMMENT, BONE MARROW ASPIRATE, SEE COMMENT
Results-Comments
Specimen viability is 94%. Flow cytometric analysis shows slightly expanded monocytic population and normally placed marrow elements by forward/side scatter analysis. The monocytes comprise 10-12% of the total events and do not show any phenotypic aberrancy. Myeloblasts are 2-3% of the total events and show expression of CD34, CD 117, CD33 and variable CD 13. There is also a 2% population of CD19/CD10 positive cells with variable CD20 and CD34; the maturation pattern is consistent with hematogones. T lymphocytes are 4.5% of the total events and show CD4/CD8 ratio of 0.4. A minute population of polyclonal B lymphocytes and plasma cells is also noted. The remaining cells are left shifted myeloid precursors and monocytes.
In summary, this flow cytometric shows expanded population of monocytes and 2-3% myeloblasts. Correlation with bone marrow biopsy (B19-903) which shows focal increase in blasts/equivalents in a background of increased monocytes and left shifted myeloid precursors is recommended. Correlation with pending molecular and cytogenetic findings would also be prudent for final results.
The following antibodies were used in this analysis: CD45, CD5, CD10, CD19, CD20, CD38, kappa surface light chains, lambda surface light chains, CD2, CD3, CD4, CD5, CD7, CD8, CD56, HLA-DR, CD15, CD34, CD33, CD16, CD14, CD13 and CD117.

Assessment/Plans:

Mr. McClintock is a 77 yo M with CAD, CKD 3, GERD admitted with recurrent right MSSA iliopsoas abscess. Bone marrow biopsy consistent with MDS-EB2

1.MDS- EB2,mutilineage dysplasia
Pancytopenia
Patient pancytopenic since several months. Underwent Bone marrow biopsy 12.2.19 with **HYPERCELLULAR BONE MARROW WITH ATYPICAL MONOCYTOSIS, 16% BLASTS/BLAST EQUIVALENT POPULATION AND**

MULTILINEAGE DYSPLASIA , Only aspirate could be obtained, *Core sample couldn't be obtained after multiple efforts,*

- Hepatitis panel (including Hep B core) negative, HIV screen negative
- TTE with Ef of >55%, normal LV systolic function
- TLS labs normal today with normal LDH, low Uric acid
- Normal PT, aPTT, INR, fibrinogen
- CMV IgM -ve and IgG positive
- FU Cytogenetics

Plan:

- **He will need treatment with hypomethylating agent (Azacytidine/Decitabine). Given the presence of 16% blasts, we discussed with him today that it would be in his best interest to be initiated on chemotherapy to prevent the transformation to AML. We discussed in great detail the treatment options, prognosis of MDS. As he has been exhibiting no signs of infection, such as fevers and has been on antibiotics for a while we discussed with him regarding the urgent need of chemotherapy. He stated he would think about it and make a decision tomorrow.**
- Discussed in great detail with the patient regarding the diagnosis, bone marrow biopsy results, treatment options, need for transfusion and growth factor support in future, expectations and prognosis
- Continue IVF hydration
- Continue acyclovir and Posaconazole prophylaxis
- Allopurinol daily
- Lovenox if Plt>50k, if 25-50k, give 1/2 dose, if <25k hold
- Encourage ambulation

2. Right Iliopsoas abscess

- Last imaging from 11/26 shows soft tissue fullness right paraspinous with thickening of the right psoas muscle with a minimal residual right psoas abscess or collection measuring approximately 3.2 cm from superior to inferior approximately 2.4 cm from anterior to posterior, and at C4 5 mm in maximum thickness.

IR consulted, per them collection is too small for drainage

ID consulted: currently on Cefepime (11/26--> and Flagyl (11/29-->

3. Cold agglutinin disease:

Cold agglutinin titer 1:32

Received 2 units of warmed PRBC on 12/5 with improvement of Hb to 8.8

- No evidence of hemolysis so far with Low Abs retic count and normal LDH.

- avoid exposure to cold temperatures
- Transfuse PRBC if patient becomes symptomatic from anemia.

4. ?Hernia
Per patient he noted asymmetry of anterior abdominal wall since this admission.
CT abdomen and pelvis from 11/26 with no findings that could explain this such as ventral hernia.
No other symptoms such as abdominal pain or nausea or changes in BM. Normal BS+.

Snigdha Nutalapati MD
Hematology fellow,PgY4
1551

ATTESTATION STATEMENTS

:

Attending Attestation Statement:
I saw and evaluated the patient with the resident/fellow. I discussed the case with the resident/fellow and agree with the findings and plan as documented.

Attending Physician Comments:
I discussed with Mr McClintock the significance of his Myelodysplastic syndrome (MDS). I explained that MDS is a blood cancer, often thought of as a pre-leukemia. He is R-ISS stage: High risk with a predicted overall survival of 1.6 years and a 25% risk of transformation to AML at 17 months. Treatment in the form of chemotherapy can in some cases control the MDS, occasionally achieving a complete remission, but in most cases it may decrease the transfusion requirements and improve blood counts. The implications of his cold agglutinin disease is uncertain, but does make transfusion more complicated. If it is related to the MDS, it might improve with therapy, but this is unknown. I explained that his new normal would be consistent cytopenias with fatigue, increased risk for infections, increased risk for bleeding, and likely increased transfusion requirements for the rest of his life.

I briefly discussed the expectations of decitabine chemotherapy. I had discussed my concerns regarding his active, but controlled, infection and protracted duration of immunocompromised state from his MDS. Since he is at risk of progression to AML and will not recover a full immunity due to his underlying disease, my inclination is to initiate

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Documents Review Report

Patient:MCCLINTOCK, BILLY W	**MRN:** [redacted]	**DOB:** [redacted]	**Visit Status: DSC**
Provider: Kumar MD. Hanesh	**Admit Date: 11/26/2019**	**Age: 78**	
Location: A11J-234-A	**Discharge Date: 12/20/2019**	**Gender: M**	

Consult Follow Up Note *-HMC - Medicine / Hematology-Maligna

Last Updated: 12/6/2019 7:02:22 PM [Entered: 12/6/2019 6:52:00 PM]

Authored By: Nutalapati MD, Snigdha (Physician)

therapy. I also discussed that my understanding of his incarceration status is that he would only be considered for compassionate release if he was on palliative care alone without active chemotherapy and limited life expectancy. He wants to consider this information and will decide in the next few days about therapy.

Electronic Signatures:

Monohan MD, Gregory P (Attending) (Signed 07-Dec-19 07:42)

Authored: *ATTESTATION STATEMENTS*

Co-Signer: *DOCUMENT TOPIC, EVALUATION*

Nutalapati MD, Snigdha (Resident) (Signed 06-Dec-19 19:02)

Authored: *DOCUMENT TOPIC, EVALUATION*

Last Updated: *07-Dec-19 07:42 by Monohan MD, Gregory P (Attending)*

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Documents Review Report

Patient:MCCLINTOCK, BILLY W	**MRN:** [redacted]	**DOB:** [redacted]	**Visit Status: DSC**
Provider: Kumar MD. Hanesh	**Admit Date: 11/26/2019**		**Age: 78**
Location: A11J-234-A	**Discharge Date: 12/20/2019**		**Gender: M**

Consult Follow Up Note *-HMC - Medicine / Hematology-Maligna

Last Updated: 12/9/2019 3:49:10 PM [Entered: 12/9/2019 3:38:00 PM]

Authored By: Nutalapati MD, Snigdha (Physician)

Consultation Service:
Service/ Team: HMC - Medicine / Hematology-Malignancy.

Consult Follow Up:
-

Subjective:
No new complaints today. Discussed about the initiation of chemotherapy, he states he is willing to start the treatment.
He asks if we can discuss the diagnosis and treatment with family members. We discussed with him that per policy we are not allowed to reveal any of the information.
Guard at bedside.

ROS:
Gen: Denies fever, weight change, fatigue
HEENT: Denies vision changes, hearing loss, sore throat, rhinorrhea
CV: Denies chest pain, palpitations, LE edema, orthopnea
Pulm: Denies cough, shortness of breath
GI: Denies abdominal pain, nausea, vomiting, diarrhea, constipation, melena, hematochezia
GU: Denies dysuria, polyuria, hematuria, flank pain
MSK: Denies myalgias, joint swelling
Skin: Denies easy bruising or bleeding, rash, ulcers
Neuro: Denies headache, dizziness, focal weakness, seizure, tremor
Lymph: Denies lymphadenopathy, edema
Psych: Denies anxiety, depression

Vital Signs:
VITALS (last 24h) [retrieved for MCCLINTOCK, BILLY WAYNE at 09 Dec 2019 15:41]:
Tc: 36.7 Tmax: 36.8 @ 08 Dec 23:31
Tf: 98.0 Tmax: 98.3 @ 08 Dec 20:51
HR: 69 (69 - 79)
BP: 121/65 (105/46 - 139/69)
RR: 16 (14 - 16) | SpO2: 97% (93% - 98%)

I & O Summary [retrieved for MCCLINTOCK, BILLY WAYNE at 09 Dec 2019 15:41]:

UKHealthCare

Documents Review Report

Patient:MCCLINTOCK, BILLY W	**MRN:** [redacted]	**DOB:** [redacted]	**Visit Status: DSC**
Provider: Kumar MD. Hanesh	**Admit Date: 11/26/2019**		**Age: 78**
Location: A11J-234-A	**Discharge Date: 12/20/2019**		**Gender: M**

Consult Follow Up Note *-HMC - Medicine / Hematology-Maligna

Last Updated: 12/9/2019 3:49:10 PM [Entered: 12/9/2019 3:38:00 PM]

Authored By: Nutalapati MD, Snigdha (Physician)

Snigdha Nutalapati MD
Hematology fellow,PgY4
1551

ATTESTATION STATEMENTS

:

Attending Attestation Statement:

I saw and evaluated the patient with the resident/fellow. I discussed the case with the resident/fellow and agree with the findings and plan as documented.

Attending Physician Comments:

I discussed with Mr McClintock the significance of his MDS-RAEB. We discussed his treatment options. We discussed the side effects and expected toxicities of Decitabine therapy. None the least being the increased the risk of infection, especially with the current iliopsoas abscess. I answered all of his questions.

Electronic Signatures:

Monohan MD, Gregory P (Attending) (Signed 10-Dec-19 15:14)
Authored: *ATTESTATION STATEMENTS*
Co-Signer: *DOCUMENT TOPIC, EVALUATION*
Nutalapati MD, Snigdha (Resident) (Signed 09-Dec-19 15:49)
Authored: *DOCUMENT TOPIC, EVALUATION*

Last Updated: *10-Dec-19 15:14 by Monohan MD, Gregory P (Attending)*

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Attending Progress Note *-M14 - Medicine / Internal Medicine

Last Updated: 12/9/2019 3:49:58 PM [Entered: 12/9/2019 3:43:00 PM]

Authored By: Kumar MD, Hanesh (Physician)

Document Topic:
Service/ Team: M14 - Medicine / Internal Medicine Team 14.

Progress Note:
-
09 December 2019

Subjective:
he has made the decision to do chemo. will be started on it tomorrow. No other new complains.

ros;
no soa, chest pain, nausea/vomiting, fever, diarrhea/constipation, cough or headaches.

Exam:
VITALS (last 24h) [retrieved for MCCLINTOCK, BILLY WAYNE at 09 Dec 2019 15:49]:
Tc: 36.7 Tmax: 36.8 @ 08 Dec 23:31
Tf: 98.0 Tmax: 98.3 @ 08 Dec 20:51
HR: 69 (69 - 79)
BP: 121/65 (105/46 - 139/69)
RR: 16 (14 - 16) | SpO2: 97% (93% - 98%)
General: comfortably lying in bed; watching TV
Head: Normocephalic and atraumatic
Eyes: Anicteric
Heart: RRR, normal S1 and S2
Lungs: Lung fields clear bilaterally, with no rales or wheezes
Abdomen: Soft, non-tender, non-distended, mass in right lower abdomen; likely hernia without signs of strangulation or infection
Extremities: No edema, distal pulses intact; RUE PICC
Skin: No visible rashes or lesions
Neuro: AOx3; able to move all extremities.
Psychiatric: Calm and cooperative.

Medications:
CONTINUOUS MEDS [retrieved for MCCLINTOCK, BILLY WAYNE at 09 Dec 2019 15:49]:
NS (no additives) (ONC) FLOORSTOCK

SCHEDULED MEDS [retrieved for MCCLINTOCK, BILLY WAYNE at 09 Dec 2019 15:49]:
(Pharmacy) 1 EACH <see task> GivenOnce
(Pharmacy) 1 EACH <see task> GivenOnce
Acyclovir 400 MG Oral 3 times a day
Allopurinol 300 MG Oral once a day
Aspirin 81 MG Oral once a day

(polyclonal) hypergammaglobulinemia, consistent with chronic inflammation, infection, and/or antigenic stimulation.

ASSESSMENT AND PLAN:

77 years old male with PMH of cold agglutinin disease, right MSSA iliopsoas abscess, CAD with bypass and CKD is admitted with a persistent right psoas abscess. Pt is noted to have MDS-EB2 and is initiated on Decitabine on 12/10/2019. Pt needs warm blood for transfusion and needs to avoid cold.

Updates for today:

D1/10 of Decitabine

ACTIVE ISSUES:

MDS-EB2

- He previously had BMBX in Pensacola, FL on 10/7 (by Dr. Yallappa Nadiminti, 941-748-2217, or at West Florida Regional Medical Center in Pensacola?), which raised concern for AML-M5, secondary to MDS
- Repeat BMBx done at UK on 12/2. HYPERCELLULAR BONE MARROW WITH ATYPICAL MONOCYTOSIS, 16% BLASTS/BLAST EQUIVALENT POPULATION AND MULTILINEAGE DYSPLASIA , Only aspirate could be obtained, Core sample couldn't be obtained after multiple efforts,
- Hematology reviwed the results. Opined its MDS-EB2 and plan for treatment with hypomethylating agent (azacytidine) once he completes the course of antibiotics
- HIV and hepatitis negative

CMV IgG+; IgM-

TTE 12/2 showed LVEF >55%

PLAN:

- Decitabine D1/10 on 12/10/2019

Right psoas abscess, due to MSSA (POA)

Previously s/p drainage (reportedly weeks before coming to UK)

IR consulted, but remaining collection is too small for drainage

ID following; plan as below

PLAN:

- Continue with cefepime and flagyl.
- Plan for 4 weeks, anticipate end of treatment 12/24/2019.
- please Arrange for a CT of the abdomen and pelvis to be done on weeks 3-4 of treatment (will schedule for 12/20 or later)
- Weekly CBC, CMP while on IV abx,
- Routine PICC line care
- Pt already has a follow up with Dr. El Haddad on 12/19/201 at the ID telemedicine clinic with FMC

Asymptomatic Ventral abdominal wall hernia

- he has had the mass since admission per patient

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Provider: Kumar MD. Hanesh	**Admit Date: 11/26/2019**	**Age: 78**	
Location: A11J-234-A	**Discharge Date: 12/20/2019**	**Gender: M**	

Discharge Summary Final

Last Updated: 12/20/2019 12:50:55 PM [Entered: 12/20/2019 12:00:00 PM]

Authored By: Kumar MD, Hanesh (Physician)

HOSPITALIZATION:

Admit Date:	26-Nov-2019
Discharge Date:	20-Dec-2019
Discharge Atttending Physician	Kumar MD, Hanesh
Admitting Diagnosis	Pancytopenia

DISCHARGE DIAGNOSIS:

Psoas abscess:
Cold agglutinin disease:
Myelodysplastic syndrome:
Pancytopenia:

Reason for Hospitalization

77y male with PMH of cryoglobulinemia, cold agglutinins and possible new diagnosis of AML who presents with right psoas abscess that has failed to clear on IV antibiotic

HOSPITAL COURSE:

Hospital Course

77 years old male with PMH of cold agglutinin disease, right MSSA iliopsoas abscess, CAD with bypass and CKD wass admitted with a persistent right psoas abscess despite antibiotics for MSSA. He had imaging done; abscess foundt to be too small IR to drain. ID gave recs to do cefepime flagyl and cefepime. He had a repeat CT abdomen done on 12/18 which showed resolution of abscess. Antibiotics stopped on 12/19. On admission he was diagnosed with MDS-EB2. He was started on decitabine 12/10 and he finished 10 days of chemotherapy. During the hospitalization he required transfusion 3 times and blood had to be warmed. He is doing very well now without any more side effects. He will be discharged to FMC. Checkout given to Berry Williams at FMC. Please see below for more details.

MDS-EB2
- He previously had BMBX in Pensacola, FL on 10/7 (by Dr. Yallappa Nadiminti, 941-748-2217, or at West Florida Regional Medical Center in Pensacola?), which raised concern for AML-M5, secondary to MDS
- Repeat BMBx done at UK on 12/2. HYPERCELLULAR BONE MARROW WITH ATYPICAL MONOCYTOSIS, 16% BLASTS/BLAST EQUIVALENT POPULATION AND MULTILINEAGE DYSPLASIA , Only aspirate could be obtained, Core sample couldn't be obtained after multiple efforts,
- Hematology reviwed the results. Opined its MDS-EB2
- HIV and hepatitis negative
- CMV IgG+; IgM-
- TTE 12/2 showed LVEF >55%
- Started on decitabine on 12/10; got total of 10 days course
- Tolerated chemo very well.
- He will follow with hematology in clinic with Dr. Fleischman on 12/26/2019
- He needs CBC, CMP three times a week and results faxed to hematology clinic.

Attachment B

United States v. McClintock
No. 1:17-CR-237-ELR-1

Motion to Reduce Sentence
March 31, 2020

BP-A0148
JUNE 10

INMATE REQUEST TO STAFF CDFRM

U.S. DEPARTMENT OF FEDERAL BUREAU OF PRISONS

TO: (Name and Title of Staff Member) MR. FRANCISCO QUINTANA – WARDEN	DATE: 01-14-2020
FROM: BILLY WAYNE McCLINTOCK	REGISTER NO.: 48742-018
WORK ASSIGNMENT: NONE	UNIT: F-4 – Room 201

SUBJECT: (Briefly state your question or concern and the solution you are requesting. Continue on back, if necessary. Your failure to be specific may result in no action being taken. If necessary, you will be interviewed in order to successfully respond to your request.

WARDEN - I AM SENDING YOU THIS FORM FOR YOUR CONSIDERATION FOR A REDUCTION IN SENTENCE KNOWN AS A COMPASSIONATE RELEASE. MY REASON'S ARE AS FOLLOWS: I JUST TURNED 78 YEARS OF AGE. I WAS IN A CAMP IN PENSACOLA, FLORIDA, WHEN I STARTED FEELING SICK. SINCE THEN I HAVE BEEN IN AND OUT OF HOSPITALS FOR SEVERAL MONTHS. IN NOVEMBER, 2019 I WAS DIAGNOSE WITH AML A TYPE OF LEUKEMIA AND WAS GIVEN ONE YEAR TO LIVE. THERE IS A LETTER THAT WAS SENT TO FMC MEDICAL FILES BY THE U.K. MEDICAL DOCTORS THAT WILL CONFIRM THIS. I HAVE HAD THE FIRST ROUND OF CHEMO THERAPY AND WILL BE DOING - FOLLOW-UPS WITH UK DOCTORS. I RECEIVE BLOOD & BLOOD PLATELETS

OVER

(Do not write below this line)

DISPOSITION:

Signature Staff Member	Date

Record Copy - File; Copy - Inmate

PDF

Prescribed by P5511

This form replaces BP-148.070 dated Oct 86 and BP-3148.070 APR 94

FILE IN SECTION 6 UNLESS APPROPRIATE FOR FAMILIAL: OLDER

SECTION 6

AS NEEDED. THERE ARE GREAT MEDICAL FACTILITIES IN FLORIDA WERE I LIVE, THAT CAN TAKE OVER MY CARE SHOULD I BE RELEASED. I HAVE A PLACE TO LIVE IN FLORIDA AND A WONDERFUL FAMILY AND FRIENDS THAT WILL LOVE AND SUPPORT ME THROUGH THESE TRYING TIMES. I TALK TO MY FAMILY OFTEN, BUT HAVEN'T SEEN THEM IN OVER 20 MONTHS, BECAUSE OF BEING WELL OVER 500 MILES FROM HOME. THANK YOU FOR YOUR CONSIDERATION ON THIS MATTER.

Brian McClinton #48742-018

Bureau of Prisons
Health Services
Clinical Encounter - Administrative Note

Inmate Name:	MCCLINTOCK, BILLY WAYNE			Reg #:	48742-018
Date of Birth:	01/10/1942	Sex:	M Race:WHITE	Facility:	LEX
Note Date:	02/04/2020 14:25	Provider:	Baize, Tyson LCSW	Unit:	F02

Social Work - Reduction in Sentence encounter performed at Other.

Administrative Notes:

ADMINISTRATIVE NOTE 1 **Provider:** Baize, Tyson LCSW

As RIS Coordinator- received I/M McClintock's request for Medical: Terminal RIS/Compassionate Release.

Began screening the request and forwarding to Medical Staff for review. I/M reports that his UK physician indicates he has less than 1 year to live.

At the same time of screening the request, I/M McClintock is asking multiple staff for copies of the note from the UK Doctor.

I was asked to speak to the inmate about his request.

I met with I/M McClintock today to discuss his request. He reports that his physician stated that he had less than a year survival, with treatment. I/M does NOT know the name of the physician, but claims he was shown a note/letter/document that utilized this specific language. I/M reports this conversation with his treating provider took place around December 8/9, 2019.

At this time multiple staff have reviewed his BEMR record and do NOT find any notations from his treating staff that have this statement included.

Will continue to have his request reviewed and then it will be routed to the Warden for his 1st review.

Copay Required: No **Cosign Required:** No

Telephone/Verbal Order: No

Completed by Baize, Tyson LCSW on 02/04/2020 14:42

REC 2/18/2020

RESPONSE TO INMATE CORRESPONDENCE

Name: McClintock, Billy
Reg. No.: 48742-018
Unit: Health Care Unit

This is in response to your correspondence dated January 14, 2020, in which you request to be considered for a Compassionate Release or Reduction in Sentence (RIS) based on medical circumstances: terminal.

Per Program Statement 5050.50 Compassionate Release/Reduction in Sentence: Procedures for Implementation of 18 U.S.C. §§ 3582(c)(1)(A) and 4205(g), there are certain criteria which you must meet in order to be considered for an RIS. Your request was reviewed, at this time you do not satisfy the medical components as specified in the program statement. Therefore, your request for RIS is denied.

If you are not satisfied with this decision, you may appeal utilizing the Administrative Remedy Process within 20 days of receiving this notice. Your counselor or case manager will assist you with directions and appropriate forms if you request them.

Francisco J. Quintana, Warden

2/6/2020
Date

Attachment C

United States v. McClintock
No. 1:17-CR-237-ELR-1

Motion to Reduce Sentence
March 31, 2020

Declaration of Dr. Jaimie Meyer

Pursuant to 28 U.S.C.§ 1746, I hereby declare as follows:

I. Background and Qualifications

1. I am Dr. Jaimie Meyer, an Assistant Professor of Medicine at Yale School of Medicine and Assistant Clinical Professor of Nursing at Yale School of Nursing in New Haven, Connecticut. I am board certified in Internal Medicine, Infectious Diseases and Addiction Medicine. I completed my residency in Internal Medicine at NY Presbyterian Hospital at Columbia, New York, in 2008. I completed a fellowship in clinical Infectious Diseases at Yale School of Medicine in 2011 and a fellowship in Interdisciplinary HIV Prevention at the Center for Interdisciplinary Research on AIDS in 2012. I hold a Master of Science in Biostatistics and Epidemiology from Yale School of Public Health.

2. I have worked for over a decade on infectious diseases in the context of jails and prisons. From 2008-2016, I served as the Infectious Disease physician for York Correctional Institution in Niantic, Connecticut, which is the only state jail and prison for women in Connecticut. In that capacity, I was responsible for the management of HIV, Hepatitis C, tuberculosis, and other infectious diseases in the facility. Since then, I have maintained a dedicated HIV clinic in the community for patients returning home from prison and jail. For over a decade, I have been continuously funded by the NIH, industry, and foundations for clinical research on HIV prevention and treatment for people involved in the criminal justice system, including those incarcerated in closed settings (jails and prisons) and in the community under supervision (probation and parole). I have served as an expert consultant on infectious diseases and women's health in jails and prisons for the UN Office on Drugs and Crimes, the Federal Bureau of Prisons, and others. I also served as an expert health witness for the US Commission on Civil Rights Special Briefing on Women in Prison.

3. I have written and published extensively on the topics of infectious diseases among people involved in the criminal justice system including book chapters and articles in leading peer-reviewed journals (including Lancet HIV, JAMA Internal Medicine, American Journal of Public Health, International Journal of Drug Policy) on issues of prevention, diagnosis, and management of HIV, Hepatitis C, and other infectious diseases among people involved in the criminal justice system.

4. My C.V. includes a full list of my honors, experience, and publications, and it is attached as Exhibit A.

5. I am being paid $1,000 for my time reviewing materials and preparing this report.

6. I have not testified as an expert at trial or by deposition in the past four years.

II. Heightened Risk of Epidemics in Jails and Prisons

7. The risk posed by infectious diseases in jails and prisons is significantly higher than in the community, both in terms of risk of transmission, exposure, and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.

8. Globally, outbreaks of contagious diseases are all too common in closed detention settings and are more common than in the community at large. Prisons and jails are not isolated from communities. Staff, visitors, contractors, and vendors pass between communities and facilities and can bring infectious diseases into facilities. Moreover, rapid turnover of jail and prison populations means that people often cycle between facilities and communities. People often need to be transported to and from facilities to attend court and move between facilities. Prison health is public health.

9. Reduced prevention opportunities: Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. When infectious diseases are transmitted from person to person by droplets, the best initial strategy is to practice social distancing. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Placing someone in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

10. Disciplinary segregation or solitary confinement is not an effective disease containment strategy. Beyond the known detrimental mental health effects of solitary confinement, isolation of people who are ill in solitary confinement results in decreased medical attention and increased risk of death. Isolation of people who are ill using solitary confinement also is an ineffective way to prevent transmission of the virus through droplets to others because, except in specialized negative pressure rooms (rarely in medical units if available at all), air continues to flow outward from rooms to the rest of the facility. Risk of exposure is thus increased to other people in prison and staff.

11. Reduced prevention opportunities: During an infectious disease outbreak, people can protect themselves by washing hands. Jails and prisons do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in and working in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons because of a lack of cleaning supplies and lack of people available to perform necessary cleaning procedures.

12. Reduced prevention opportunities: During an infectious disease outbreak, a containment strategy requires people who are ill with symptoms to be isolated and that caregivers have

access to personal protective equipment, including gloves, masks, gowns, and eye shields. Jails and prisons are often under-resourced and ill-equipped to provide sufficient personal protective equipment for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

13. Increased susceptibility: People incarcerated in jails and prisons are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.[1] This is because people in jails and prisons are more likely than people in the community to have chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and lower immune systems from HIV.

14. Jails and prisons are often poorly equipped to diagnose and manage infectious disease outbreaks. Some jails and prisons lack onsite medical facilities or 24-hour medical care. The medical facilities at jails and prisons are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and ill need to be isolated in specialized airborne negative pressure rooms. Most jails and prisons have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). Resources will become exhausted rapidly and any beds available will soon be at capacity. This makes both containing the illness and caring for those who have become infected much more difficult.

15. Jails and prisons lack access to vital community resources to diagnose and manage infectious diseases. Jails and prisons do not have access to community health resources that can be crucial in identifying and managing widespread outbreaks of infectious diseases. This includes access to testing equipment, laboratories, and medications.

16. Jails and prisons often need to rely on outside facilities (hospitals, emergency departments) to provide intensive medical care given that the level of care they can provide in the facility itself is typically relatively limited. During an epidemic, this will not be possible, as those outside facilities will likely be at or over capacity themselves.

17. Health safety: As an outbreak spreads through jails, prisons, and communities, medical personnel become sick and do not show up to work. Absenteeism means that facilities can become dangerously understaffed with healthcare providers. This increases a number of risks and can dramatically reduce the level of care provided. As health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions. As supply chains become disrupted during a global pandemic, the availability of medicines and food may be limited.

18. Safety and security: As an outbreak spreads through jails, prisons, and communities, correctional officers and other security personnel become sick and do not show up to

[1] *Active case finding for communicable diseases in prisons*, 391 The Lancet 2186 (2018), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext.

work. Absenteeism poses substantial safety and security risk to both the people inside the facilities and the public.

19. These risks have all been borne out during past epidemics of influenza in jails and prisons. For example, in 2012, the CDC reported an outbreak of influenza in 2 facilities in Maine, resulting in two inmate deaths.[2] Subsequent CDC investigation of 995 inmates and 235 staff members across the 2 facilities discovered insufficient supplies of influenza vaccine and antiviral drugs for treatment of people who were ill and prophylaxis for people who were exposed. During the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[3] Even facilities on "quarantine" continued to accept new intakes, rendering the quarantine incomplete. These scenarios occurred in the "best case" of influenza, a viral infection for which there was an effective and available vaccine and antiviral medications, unlike COVID-19, for which there is currently neither.

III. Profile of COVID-19 as an Infectious Disease[4]

20. The novel coronavirus, officially known as SARS-CoV-2, causes a disease known as COVID-19. The virus is thought to pass from person to person primarily through respiratory droplets (by coughing or sneezing) but may also survive on inanimate surfaces. People seem to be most able to transmit the virus to others when they are sickest but it is possible that people can transmit the virus before they start to show symptoms or for weeks after their symptoms resolve. In China, where COVID-19 originated, the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. A vaccine is currently in development but will likely not be able for another year to the general public. Antiviral medications are currently in testing but not yet FDA-approved, so only available for compassionate use from the manufacturer. People in prison and jail will likely have even less access to these novel health strategies as they become available.

[2] *Influenza Outbreaks at Two Correctional Facilities — Maine, March 2011*, Centers for Disease Control and Prevention (2012), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6113a3.htm.

[3] David M. Reutter, *Swine Flu Widespread in Prisons and Jails, but Deaths are Few*, Prison Legal News (Feb. 15, 2010), https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/.

[4] This whole section draws from Brooks J. Global Epidemiology and Prevention of COVID19, COVID-19 Symposium, Conference on Retroviruses and Opportunistic Infections (CROI), virtual (March 10, 2020); *Coronavirus (COVID-19)*, Centers for Disease Control, https://www.cdc.gov/coronavirus/2019-ncov/index.html; Brent Gibson, *COVID-19 (Coronavirus): What You Need to Know in Corrections*, National Commission on Correctional Health Care (February 28, 2020), https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections.

21. Most people (80%) who become infected with COVID-19 will develop a mild upper respiratory infection but emerging data from China suggests serious illness occurs in up to 16% of cases, including death.[5] Serious illness and death is most common among people with underlying chronic health conditions, like heart disease, lung disease, liver disease, and diabetes, and older age.[6] Death in COVID-19 infection is usually due to pneumonia and sepsis. The emergence of COVID-19 during influenza season means that people are also at risk from serious illness and death due to influenza, especially when they have not received the influenza vaccine or the pneumonia vaccine.

22. The care of people who are infected with COVID-19 depends on how seriously they are ill.[7] People with mild symptoms may not require hospitalization but may continue to be closely monitored at home. People with moderate symptoms may require hospitalization for supportive care, including intravenous fluids and supplemental oxygen. People with severe symptoms may require ventilation and intravenous antibiotics. Public health officials anticipate that hospital settings will likely be overwhelmed and beyond capacity to provide this type of intensive care as COVID-19 becomes more widespread in communities.

23. COVID-19 prevention strategies include containment and mitigation. Containment requires intensive hand washing practices, decontamination and aggressive cleaning of surfaces, and identifying and isolating people who are ill or who have had contact with people who are ill, including the use of personal protective equipment. Jails and prisons are totally under-resourced to meet the demand for any of these strategies. As infectious diseases spread in the community, public health demands mitigation strategies, which involves social distancing and closing other communal spaces (schools, workplaces, etc.) to protect those most vulnerable to disease. Jails and prisons are unable to adequately provide social distancing or meet mitigation recommendations as described above.

24. The time to act is now. Data from other settings demonstrate what happens when jails and prisons are unprepared for COVID-19. News outlets reported that Iran temporarily released 70,000 prisoners when COVID-19 started to sweep its facilities.[8] To date, few state or federal prison systems have adequate (or any) pandemic preparedness plans in

[5] *Coronavirus Disease 2019 (COVID-19): Situation Summary*, Centers for Disease Control and Prevention (March 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.
[6] *Clinical course and risk factors for mortality of adult inpatients with COVID-19 in Wuhan, China: a retrospective cohort study.* The Lancet (published online March 11, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext
[7] *Coronavirus Disease 2019 (COVID-19): Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease*, Centers for Disease Control and Prevention (March 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.
[8] *Iran temporarily releases 70,000 prisoners as coronavirus cases surge*, Reuters (March 9, 2020), https://www.reuters.com/article/us-health-coronavirus-iran/iran-temporarily-releases-70000-prisoners-as-coronavirus-cases-surge-idUSKBN20W1E5.

place.[9] Systems are just beginning to screen and isolate people on entry and perhaps place visitor restrictions, but this is wholly inadequate when staff and vendors can still come to work sick and potentially transmit the virus to others.

IV. Risk of COVID-19 in ICE's NYC-Area Detention Facilities

25. I have reviewed the following materials in making my assessment of the danger of COVID-19 in the Bergen, Essex, Hudson, and Orange County jails ("ICE's NYC-area jails"): (1) a declaration by Marinda van Dalen, a Senior Attorney in the Health Justice Program at New York Lawyers for the Public Interest (NYLPI); (2) the report *Detained and Denied: Healthcare Access in Immigration Detention*, released by NYLPI in 2017; and (3) the report *Ailing Justice*: *New Jersey*, *Inadequate Healthcare, Indifference, and Indefinite Confinement in Immigration Detention*, released by Human Rights First in 2018.

26. Based on my review of these materials, my experience working on public health in jails and prisons, and my review of the relevant literature, it is my professional judgment that these facilities are dangerously under-equipped and ill-prepared to prevent and manage a COVID-19 outbreak, which would result in severe harm to detained individuals, jail and prison staff, and the broader community. The reasons for this conclusion are detailed as follows.

27. The delays in access to care that already exist in normal circumstances will only become worse during an outbreak, making it especially difficult for the facilities to contain any infections and to treat those who are infected.

28. Failure to provide individuals with continuation of the treatment they were receiving in the community, or even just interruption of treatment, for chronic underlying health conditions will result in increased risk of morbidity and mortality related to these chronic conditions.

29. Failure to provide individuals adequate medical care for their underlying chronic health conditions results in increased risk of COVID-19 infection and increased risk of infection-related morbidity and mortality if they do become infected.

30. People with underlying chronic mental health conditions need adequate access to treatment for these conditions throughout their period of detention. Failure to provide adequate mental health care, as may happen when health systems in jails and prisons are taxed by COVID-19 outbreaks, may result in poor health outcomes. Moreover, mental health conditions may be exacerbated by the stress of incarceration during the COVID-19 pandemic, including isolation and lack of visitation.

[9] Luke Barr & Christina Carrega, *State prisons prepare for coronavirus but federal prisons not providing significant guidance, sources say*, ABC News (March 11, 2020), https://abcnews.go.com/US/state-prisons-prepare-coronavirus-federal-prisons-providing-significant/story?id=69433690.

31. Failure to keep accurate and sufficient medical records will make it more difficult for the facilities to identify vulnerable individuals in order to both monitor their health and protect them from infection. Inadequate screening and testing procedures in facilities increase the widespread COVID-19 transmission.

32. Language barriers will similarly prevent the effective identification of individuals who are particularly vulnerable or may have symptoms of COVID-19. Similarly, the failure to provide necessary aids to individuals who have auditory or visual disabilities could also limit the ability to identify and monitor symptoms of COVID-19.

33. The commonplace neglect of individuals with acute pain and serious health needs under ordinary circumstances is also strongly indicative that the facilities will be ill-equipped to identify, monitor, and treat a COVID-19 epidemic.

34. The failure of these facilities to adequately manage single individuals in need of emergency care is a strong sign that they will be seriously ill-equipped and under-prepared when a number of people will need urgent care simultaneously, as would occur during a COVID-19 epidemic.

35. For individuals in these facilities, the experience of an epidemic and the lack of care while effectively trapped can itself be traumatizing, compounding the trauma of incarceration.

V. Conclusion and Recommendations

36. For the reasons above, it is my professional judgment that individuals placed in ICE's NYC-area jails are at a significantly higher risk of infection with COVID-19 as compared to the population in the community and that they are at a significantly higher risk of harm if they do become infected. These harms include serious illness (pneumonia and sepsis) and even death.

37. Reducing the size of the population in jails and prisons can be crucially important to reducing the level of risk both for those within those facilities and for the community at large.

38. As such, from a public health perspective, it is my strong opinion that individuals who can safely and appropriately remain in the community not be placed in ICE's NYC-area jails at this time. I am also strongly of the opinion that individuals who are already in those facilities should be evaluated for release.

39. This is more important still for individuals with preexisting conditions (e.g., heart disease, chronic lung disease, chronic liver disease, suppressed immune system, diabetes) or who are over the age of 60. They are in even greater danger in these facilities, including a meaningfully higher risk of death.

40. It is my professional opinion that these steps are both necessary and urgent. The horizon of risk for COVID-19 in these facilities is a matter of days, not weeks. Once a case of

COVID-19 identified in a facility, it will likely be too late to prevent a widespread outbreak.

41. Health in jails and prisons is community health. Protecting the health of individuals who are detained in and work in these facilities is vital to protecting the health of the wider community.

I declare under penalty of perjury that the foregoing is true and correct.

March 15, 2020
New Haven, Connecticut

Dr. Jaimie Meyer

Attachment D

United States v. McClintock
No. 1:17-CR-237-ELR-1

Motion to Reduce Sentence
March 31, 2020

From: Christine Dafforn
To: Matthew Dodge
Subject: Re: Another question
Date: Friday, March 27, 2020 11:27:21 AM

Good morning again Mr. Dodge: To answer your questions

1. Yes I agree to allow him to live with me.

2. Yes you have my current address as 3904 Maravic Place, Sarasota, FL 34231

3. He will receive medical care at The Sarasota Memorial Hospital, which is very close to my home, and he should be back on Medicare as soon as we can get him reinstated

4. Once we reinstate his Medicare coverage, I am hopeful that will help with covering the payments.

Gosh! I hope this helps. - Christine

-----Original Message-----
From: Matthew Dodge <Matthew_Dodge@fd.org>
To: Christine Dafforn <spookycat1@verizon.net>
Sent: Fri, Mar 27, 2020 10:10 am
Subject: Another question

Christine,

So sorry to flood you with emails. I want to tell the judge of Billy's game plan if he is released from prison.

1. Do you agree to allow him to live with you?

2. If so, is your address still 3904 Maravic Place, Sarasota, FL, 34231?

3. Where (which hospital, etc.) will Billy receive medical care?

4. How will he pay for it? Will he be on Medicare, e.g.?

These are questions that judge will have when she decides whether or not to release Billy. Can you help me?

Thanks,

Matthew

W. Matthew Dodge
Appellate Attorney
Federal Defender Program, Inc.