UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

UNITED STATES OF AMERICA	:	CASE NUMBER 3:19 CR 0161 (VAB)
vs.	:	
PAUL GILENO	:	APRIL 13, 2020

EMERGENCY MOTION FOR COMPASSIONATE RELEASE UNDER FIRST STEP ACT

I. INTRODUCTION

On or about March 17, 2020 Paul Gileno filed a Motion For Modification of Sentence: To Substitute Remaining Sentence of Imprisonment with Home Confinement based upon extraordinary and compelling reasons that came to light after he began serving his sentence at FCI Schuylkill in Pennsylvania. [**Docket Entry #26**]. The Government filed a two-page memorandum objecting to Mr. Gileno's motions, claiming that "none of the grounds asserted by the defendant are a bass [sic] for a sentence modification and the government notes that the BOP has developed an extensive action plan---found at http:/www.bop.gov/resources/news/20200313_covid-19.jsp – to address the COVID-19 pandemic." See Government Memorandum at page 1. [**Docket Entry #27**].

The Court issued a written decision rejecting Mr. Gileno's arguments for home confinement. [**Docket Entry #28**]. The Court's ruling set forth that the defendant "had not satisfied the requirement under 18 U.S.C. §3582(c)(1)(A) to first request that the BOP file a motion on his behalf and then show that 30-days had passed without any BOP action. Moreover, the Court found that defendant's asserted reasons for home confinement were

not extraordinary or compelling. However, Mr. Gileno's motion was denied "without prejudice to renew upon a motion by the Bureau of Prisons on Defendant's behalf, or a showing that thirty days have passed since the Defendant submitted such request, and a showing that Defendant's circumstances meet the requirements for "extraordinary and compelling reasons".

In this emergency motion for compassionate release under 18 U.S.C. §3582 (c)(1)(A), Mr. Gileno supplements his prior submissions with additional medical documentation to establish that he falls in the high risk group under the circumstances surrounding the COVID-19 virus, and that the conditions within the BOP are becoming more dire by the day.

II. ELIGIBILITY FOR CONSIDERATION OF COMPASSIONATE RELEASE

In order to be entitled to relief under Section 3582(c)(1)(A), Mr. Gileno must both meet the exhaustion requirement and demonstrate that "extraordinary and compelling reasons" warrant a reduction of his sentence.

A. Extraordinary and Compelling Reasons

Section 3582(c)(1)(A) permits a sentence reduction only upon a showing of "extraordinary and compelling reasons," and only if "such a reduction is consistent with applicable policy statements issued by the Sentencing Commission." Congress never defined the term "extraordinary and compelling reasons," except to state that "[r]ehabilitation . . . alone" does not suffice. 18 U.S.C. § 944(t). Rather, Congress directed the Sentencing Commission to define the term. The Commission did so prior to the passage of the First Step Act, which amended section 3852(c)(1)(A) to allow prisoners to directly petition courts for

compassionate release and removed the BOP's exclusive 'gatekeeper' role. See United States v. Rodriguez, No. 2:03-cr-00271, 2020 WL 1627331, at *2 (E.D. Pa. Apr. 1, 2020).

Section 1B1.13 of the Sentencing Guidelines explains that a sentence reduction under section 3582(c)(1)(A) may be ordered where a court determines, "after considering the factors set forth in 18 U.S.C. § 3553(a)," that

(1)(A) Extraordinary and compelling reasons warrant the reduction; . . .

(2) The defendant is not a danger to the safety of any other person or to the community, as provided in 18 U.S.C. § 3142(g); and

(3) The reduction is consistent with this policy statement.

In subsections (A)-(C) of the Application Note to section 1B1.13, the Commission enumerated three specific "reasons" that qualify as "extraordinary and compelling": (A) terminal illness diagnoses or serious medical, physical or mental impairments from which a defendant is unlikely to recover, and which "substantially diminish" the defendant's capacity for self-care in prison; (B) aging-related health decline where a defendant is over 65 years old and has served at least ten years or 75% of his sentence; or (C) two family related circumstances.3 See id. cmt. n.1(A)-(C). The policy statement also added a catchall provision for "extraordinary and compelling reason[s] other than, or in combination with, the reasons described in subdivisions (A) through (C)."4 Id. cmt. n.1(D).

1.Documented Health Concerns Place Mr. Gileno at High Risk

Mr. Gileno is 47 years of age who has suffered from severe chronic asthma since childhood, and also has a history of chronic bronchitis. Moreover, he's had multiple bouts of pneumonia in his adult life, and this condition places him at high risk of death if he contracted the coronavirus and was not in a position to seek and/or obtain swift and proper

medical attention. His history is documented and supported by medical records which are attached to this motion. See **Exhibits A** and **B**. Prior to his incarceration, Mr. Gileno was treated for asthma and hyperactive airway disease by Marianne Mitchell, an advanced practice registered nurse (A.P.R.N.), who works at Pulmonary and Sleep Specialists in Danbury. He's been a patient of the practice since 2003 and is prescribed the following medications by A.P.R.N. Mitchell:

a. Albuterol-a bronchodilator that relaxes muscles in the airways and increases air flow to the lungs;

b. Alprazolam-treats anxiety disorders, panic disorders, and anxiety caused by depression;

c. Atorvastatin-helps to lower "bad" cholesterol and fats (such as LDL, triglycerides) and raise "good" cholesterol (HDL) in the blood;

d. Cetirizine-an antihistamine used to relieve allergy symptoms;

e. Fluticasone-salmeterol-used to treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by asthma;

f. Lisinopril-treats high blood pressure(hypertension);

g. Montelukast-used regularly to prevent wheezing and shortness of breath caused by asthma

According to A.P.R.N. Mitchell, "Mr. Gileno has a history of seasonal allergies and asthma which puts him at a higher risk of respiratory complications. Moreover, her professional medical opinion is that "Mr. Gileno needs to be monitored closely for any potential symptoms or complications surround [sp] the COVID-19 virus". **Exhibit A**.

Aside from these health concerns, Mr. Gileno also suffers from chronic remitting pain as well as anxiety and depression resulting from his back injury in 2003. His psychotherapist, Michelle Gargan, has also written a letter to the Court expressing her concern for Mr. Gileno during this health crisis and recommends compassionate release for her patient. See **Exhibit B**. Her concerns stem from the research she's gathered from the medical literature which shows that stress, anxiety and depression suppress immune system functioning. Thus, Mr. Gileno's physical and psychiatric condition place him at serious risk for a dangerous reaction to the COVID-19 virus. Dr. Gargan is concerned that under Mr. Gileno's current setting at the FCI facility, "the lack of social distance as well as the likely inability of the facility to maintain sterile conditions will not be able to prevent his exposure to the virus." If he were to contract the virus while he's incarcerated, Dr. Gargan believes Mr. Gileno may not survive. **Id**.

2. COVID-19 is Spreading in the Prison System

In recent months, COVID-19 has spread across the globe and throughout the United States. As of April 9, 2020, COVID-19 has sickened over 1.4 million people, leading to at least 89,162 deaths worldwide.[1] The United States has become the epicenter of the crisis, with 429,264 cases and 14,820 deaths thus far.[2] The numbers, which increase sharply every day, almost certainly underrepresent the true scope of the crisis in the United States considering the widespread unavailability of test kits to detect the virus.

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[1] *Coronavirus Map: Tracking the Global Outbreak*, N.Y. TIMES (updated daily), https://www.nytimes.com/interactive/2020/world/coronavirus-maps.html (last visited Apr. 9, 2020).

[2] *Coronavirus in the U.S.: Latest Map and Case Count*, N.Y. TIMES (updated daily), https://www.nytimes.com/interactive/2020/us/coronavirus-us-cases.html (last visited Apr. 9, 2020).

On March 11, 2020, the World Health Organization officially classified COVID-19 as a pandemic.[3] On March 13, 2020, the President of the United States declared the COVID-19 outbreak a national emergency under the National Emergencies Act, 50 U.S.C. §§ 1601 *et seq,*[4] and his administration states that even if all precautions are followed, there is an estimated death toll in the United States of 100,000 to 240,000 people.[5]

The CDC advises that the coronavirus is "spread mainly from person-to-person . . . [b]etween people who are in close contact with one another . . . [t]hrough respiratory droplets produced when an infected person coughs or sneezes."[6] The droplets can land in the mouths or noses, or can be inhaled into the lungs, of people who are within about six feet of the infected person.[7] The coronavirus is highly contagious and those who are infected can spread the virus even if they are asymptomatic.[8] Additionally, studies have shown that the

[3] Press Release, World Health Organization, WHO Director-General's opening remarks at the media briefing on COVD-19 – 11 March 2020, (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.

[4] 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/proclemation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

[5] White House Task Force Projects 100,000 to 240,000 Deaths Within U.S., Even with Mitigation, https://www.washingtonpost.com/world/2020/03/31/coronavirus-latest-news/.

[6] CDC, Coronavirus Disease 2019 (COVID-19), How It Spreads, March 4, 2020, https://www.cdc.gov/coronavirus/2019-ncov/prepare/transmission.html.

[7] *Id.*

[8] Marco Cascella, *et al.*, Features, Evaluation and Treatment Coronavirus (COVID-19), National Center for Biotechnology Information ("NCBI"), March 20, 2020, https://www.ncbi.nlm.nih.gov/books/NBK554776/#_ncbi_dlg_citbx_NBK554776.

coronavirus can survive from three hours to three days on various surfaces.[9] At this time, there is no known treatment, vaccine, or cure for COVID-19.[10]

COVID-19 cases have already been confirmed at multiple BOP facilities, and with every day that passes, BOP identifies additional cases at additional institutions.[11] As of April 9, 2020, BOP has identified 253 inmate cases and 85 staff cases.[12] As of April 9, 2020, eight inmates have died in BOP custody.[13] As the court noted in *United States v. Caddo*, "it is unknowable whether BOP detainees or inmates have Covid-19 until they are tested, and BOP has not conducted many or any such tests because, like the rest of the country, BOP has very few or no actual Covid-19 test packets." Order at 5, *United States v. Caddo*, No. 3:18-cr-08341-JJT, ECF No. 174 (D. Ariz. Mar. 23, 2020).

Because transmission may happen asymptomatically, BOP is quarantining inmates even in institutions where there are no positive cases. The Centers for Disease Control ("CDC") now warns that as many as 25 percent of people infected with the virus have no symptoms, would not be tested for the virus, and may be "unwitting spreaders."[14] Dr. Jeffrey

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[9] National Institute of Allergy and Infectious Diseases, New coronavirus stable for hours on surfaces, March 17, 2020, https://www.nih.gov/news-events/news-releases/new-coronavirus-stable-hours-surfaces ("[S]cientists [from the National Institutes of Health, CDC, UCLA and Princeton University] found that [coronavirus] was detectable in aerosols for up to three hours, up to four hours on copper, up to 24 hours on cardboard and up to two to three days on plastic and stainless steel.").

[10] CDC, Coronavirus Fact Sheet, March 20, 2020, https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf.

[11] U.S. Bureau of Prisons, COVID-19 Coronavirus (updated daily), https://www.bop.gov/coronavirus/ (last visited Apr. 9, 2020).

[12] *Id.*

[13] *Id.*

[14] Apoorva Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. TIMES (April 1, 2020), *available at* https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html?action=click&module=Top%20Stories&pgtype=Homepage.

Shaman, an infectious disease expert at Columbia University, explains: "The bottom line is that there are people out there shedding the virus who don't know that they're infected."[15]

Alarmingly, the Marshall Project recently reported that staff at the BOP facility at Oakdale were told to report to work, even if they had exposure to individuals who tested positive for COVID-19, as long as they were not symptomatic.[16] Prior to March 13, 2020, when the BOP suspended visits for 30 days, inmates regularly engaged in social, legal and medical visits with people in the community at a time when the novel coronavirus already began to spread.[17] To this day, inmates must share communal living spaces, such as cells, recreation rooms, dining halls, libraries, and exercise yards. To make matters worse, hand sanitizer, an effective disinfectant recommended by the CDC to reduce transmission, is deemed forbidden "contraband" in BOP facilities because of its alcohol content.[18]

Recognizing the unique risks that correctional facilities pose to both inmates and employees, members of Congress asked the BOP on March 19, 2020, to allow for the immediate release of elderly, non-violent inmates.[19] The following week, Attorney General

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[15] *Id.*

[16] Joseph Neff & Keri Blakinger, *Federal Prison Ageny "Put Staff in Harm's Way" of Coronavirus: Orders at Oakdale in Louisiana Help Explain COVID-19 Spread*, MARSHALL PROJECT, Apr. 3, 2020, 6:14 PM, https://www.themarshallproject.org/2020/04/03/federal-prisons-agency-put-staff-in-harm-s-way-of-coronavirus.

[17] U.S. Bureau of Prisons, Federal Bureau of Prisons Covid-19 Action Plan (Mar. 13, 2020, 3:09 PM), https://www.bop.gov/resources/news/20200313_covid-19.jsp.

[18] Keri Blakinger and Beth Schwarzapfel, *How Can Prisons Contain Coronavirus When Purell is Contraband?*, ABA J. (March 13, 2020), available at *https://www.abajournal.com/news/article/when-purell-is-contraband-how-can-prisons-contain-coronavirus.*

[19] Letter from Rep. Jerrold Nadler & Rep. Karen Bass to U.S. Attorney General William P. Barr (Mar. 19, 2020), *available at* https://judiciary.house.gov/uploadedfiles/2020-03-19_letter_to_ag_barr_re_covid19.pdf ("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.").

Barr urged the Director of the BOP to prioritize home confinement for such vulnerable individuals.[20] On March 27, 2020, more than 400 former DOJ leaders, attorneys, and federal judges sent an open letter to the President, asking that he take immediate action to reduce the population in correctional facilities to prevent the catastrophic spread of COVID-19, in particular by commuting the sentences of elderly and medically vulnerable inmates who have already served a majority of their sentence.[21] The same day, dozens of leading public health experts made a similar request, asking the President to commute the sentences of all elderly inmates, noting that these individuals are at the highest risk of dying from the disease and pose the smallest risks to public safety.[22] On March 30, 2020, Congress wrote Attorney General Barr again to implore him "to do the right thing" and "immediately move to release medically-compromised, elderly, and pregnant prisoners in the custody of the BOP."[23]

Jails and prisons are among the most dangerous places to be during an epidemic because they create the ideal environment for transmission of contagious diseases.[24] The attached expert declaration of Dr. Jaime Meyer explains the particular risks of contagious diseases in prison. **Exhibit C** (expert declaration of Dr. Jaime Meyer, Yale Law School Liman Center Affiliate, filed in numerous cases). Inmates are confined in close proximity

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[20] Memorandum from Attorney General William P. Barr to Director of Bureau of Prisons (Mar. 26, 2020), available at https://www.justice.gov/file/1262731/download.

[21] Letter from Julie Abbate, et al. to President Donald J. Trump (Mar. 27, 2020), *available at* https://fairandjustprosecution.org/wp-content/uploads/2020/03/Letter-to-Trump-from-DOJ-and-Judges-FINAL.pdf.

[22] Letter from Sandro Galea, et al. to President Donald J. Trump (Mar. 27, 2020), *available at https://thejusticecollaborative.com/wp-content/uploads/2020/03/Public-Health-Expert-Letter-to-Trump.pdf.*

[23] Letter from Rep. Jerrold Nadler & Rep. Karen Bass to U.S. Attorney General William P. Barr (Mar. 30, 2020), *available at* https://judiciary.house.gov/uploadedfiles/3.30.20_letter_to_ag_barr_re_covid19.pdf.

[24] Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 CLINICAL INFECTIOUS DISEASES 8, 1047–55 (Oct. 15, 2007), *available at* https://doi.org/10.1086/521910.

and the staff leave and return daily. 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," according to public health experts.[25] Jails and prisons are sites of disproportionate infectious disease rates.[26] Outbreaks of the flu regularly occur in jails, and during the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases. [27] It was reported on March 18 that a guard at Rikers Island in New York City had tested positive for COVID-19.[28] Three days later, at least 38 people at Rikers had tested positive.[29] Despite efforts to release hundreds of detainees to try to stem the tide of infection there,[30] the virus continues to spread rapidly; as of April 7, 2020, 287 inmates and 406 staffers had tested positive, and seven Department of Corrections staff members and one inmate have died.[31] Hundreds of detainees have been

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[25] "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://bit.ly/2W9V6oS.

[26] Leonard S. Rubenstein, *et al.*, *HIV, Prisoners, and Human Rights*, LANCET (July 14, 2016), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30663-8/fulltext.

[27] *Prisons and Jails are Vulnerable to COVID-19 Outbreaks*, THE VERGE (Mar. 7, 2020), https://bit.ly/2TNcNZY.

[28] *NYC Officials Call for Release of 'Most at Risk' on Rikers Island as More Test Positive for Virus*, NBC N.Y., ASSOCIATED PRESS (Mar. 18, 2020), https://www.nbcnewyork.com/news/local/nyc-officials-call-for-release-of-most-at-risk-on-rikers-prison-as-more-test-positive-for-virus/2333348.

[29] *38 Positive for Coronavirus at Rikers, NYC Jails*, N.Y. TIMES, ASSOCIATED PRESS (March 21, 2020), https://www.nytimes.com/aponline/2020/03/21/us/ap-us-virus-outbreak-inmates.html.

[30] Craig McCarthy, *NYC To Release 300 More Rikers Inmates Admit Coronavirus Pandemic*, N.Y. POST (Mar. 25, 2020 7:25 AM), https://nypost.com/2020/03/25/nyc-to-release-300-more-rikers-inmates-amid-coronavirus-pandemic/.

[31] *914 Dead in N.Y.C., and City's Virus Case Count Tops 38,000*, N.Y. TIMES (Mar. 31, 2020, 7:31 a.m. ET), https://www.nytimes.com/2020/03/30/nyregion/coronavirus-new-york-update.html.

released in other jurisdictions, including 600 in Los Angeles and 300 in San Francisco.[32]

The large-scale release of detainees reflects the growing recognition that "[i]t's like an approaching tsunami. Once it hits, it's too late. . . . We should release as many as it's safe to release in order to avoid a situation like the one at Rikers."[33] "The coronavirus is invading U.S. jails and prisons, prompting inmate releases, reduced bail requirements and other extraordinary measures as officials rush to avert a potentially disastrous spread of the virus among crowded inmate populations."[34] As a prominent group of Yale School of Medicine "medical professionals and experts in infectious disease and/or prison populations" recently wrote to Connecticut Supreme Court Associate Justice Andrew J. McDonald, the way to safeguard inmates is to reduce jail populations now.[35] "Once a case of COVID-19 [is] identified in a facility, it will likely be too late to prevent a widespread outbreak."[36] Two doctors who are contracted experts for the Department of Homeland Security's Office of Civil Rights and Civil Liberties said recently that COVID-19 presents an "imminent risk to the health and safety" of detainees in ICE detention centers, as well as the general public.[37]

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[32] Justin Carissimo, *First Rikers Island Inmate Dies After Testing Positive for Coronavirus*, CBS NEWS (Apr. 7, 2020 2:36 PM), https://www.cbsnews.com/news/coronavirus-michael-tyson-rikers-island-inmate-dies-covid-19/.

[33] *38 Positive for Coronavirus at Rikers*, *supra*.

[34] *Releasing Inmates, Screening Staff: U.S. Jails and Prisons Rush to Limit Virus Risks*, N.Y. TIMES, REUTERS (March 22, 2020), https://www.nytimes.com/reuters/2020/03/22/us/22reuters-health-coronavirus-usa-inmates.html (emphasis added).

[35] Letter from Dan Barrett to Justice Andrew McDonald (Mar. 26, 2020), *available at* https://www.acluct.org/sites/default/files/field_documents/2020-03-26_letter_to_committee_requesting_emergency_alteration_of_rules.pdf.

[36] *Id.*

[37] Catherine E. Shoichet, *Doctors Warn of 'Tinderbox Scenario' if Coronavirus Spreads in ICE Detention*, CNN (March 20, 2020, 8:21 PM ET), https://www.cnn.com/2020/03/20/health/doctors-ice-detention-coronavirus/index.html.

Judges both in the District of Connecticut and around the country are increasingly heeding the call from legal and medical experts by releasing old and vulnerable inmates from overcrowded facilities. On March 20, 2020, Judge Meyer granted an emergency motion for temporary release from Wyatt for a 62-year-old defendant with diabetes awaiting sentencing. *See United States v. Fellela*, No. 3:19-CR-79-JAM, 2020 WL 1457877 (D. Conn. Mar. 20, 2020) (Meyer, J.) In his order, Judge Meyer addressed the conditions of confinement at Wyatt:

> According to an inquiry through the U.S. Marshals Service of the Wyatt facility, there are more than 700 prisoners housed at Wyatt of which more than 500 prisoners are housed in two-person cells and more than 150 prisoners are housed in more-than-two-person cells. There are between 20 to 70 persons at one time in general dayroom areas, and up to 15 persons are allowed in the recreation area at one time. All levels of government nationwide have recently taken drastic measures in light of the COVID-19 pandemic to promote "social distancing" and to prohibit the congregation of large numbers of people with one another. But, as is true for most jails and prisons, the conditions of confinement at Wyatt are not compatible with these safeguards.

Id. at *1. *See also* Ruling and Order Granting Defendant's Motion for Release, *United States v. Forbes*, No. 3:19-CR-64-VLB, ECF No. 1063 (D. Conn. Apr. 6, 2020) (Bryant, J.) (granting motion to reopen bond hearing and ordering release from Wyatt pending trial for 45-year-old defendant with diabetes); Order, *United States v. Hawkins*, No. 3:19-CR-229-AWT, ECF No. 23 (D. Conn. Mar. 19, 2020) (Thompson, J.) (ordering release from Wyatt pending trial for 42-year old defendant with sarcoidosis who allegedly committed offense while on supervised release; release had been denied on February 24, 2020).

3. **Other Considerations**

Section 1B1.13 of the Guidelines further provides that a court may reduce a term of imprisonment only if the court determines that "[t]he defendant is not a danger to the safety of any other person or to the community[,]" U.S.S.G. § 1B1.13(3), and only after the court considers the factors set for in section 3553(a) of title 18 of the United States Code, id.

In the Statement of Reasons for issuing a variance from the recommended advisory guidelines, the Court considered the sentencing factors of 18 U.S.C. 3553(a), including that Mr. Gileno was a first-time offender, had a long-standing record of doing good, demonstrated remorse for his conduct, and that he had family responsibilities with a special needs child.

During Mr. Gileno's 3 ½ months of confinement at FCI-Schuylkill, he's been a model inmate with no reported disciplinary conduct. He works as a baker in the facilities kitchen, and he's also completed the reentry class, which is a requirement of the BOP for early release consideration. Counsel's rough calculations indicate that Mr. Gileno has approximately 6-months remaining on his prison sentence if his sentence were to run full term. According to Mr. Gileno's wife, federal probation has already conducted a home visit and approved the residence for his release.

4. Summary

Mr. Gileno is 47 years old and suffers from asthma, and other lung-related ailments which pose a health risk if he were to remain incarcerated during the corona virus pandemic. His medical conditions are documented and serious, and they substantially increase his risk of severe illness if he contracts COVID-19. See Groups at Higher Risk for Severe Illness, Center for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html (last visited Apr. 8, 2020).

The defendant respectfully submits his age and medical condition, taken in concert with the COVID-19 public health crisis, constitute extraordinary and compelling reasons to reduce his sentence to home confinment. See United States v. Gonzalez, No. 18-CR-1536155, 2020 WL 1536155, at *3 (approving compassionate release where defendant "is in

the most susceptible age category (over 60 years of age) and her COPD and emphysema make her particularly vulnerable"); United States v. Hernandez, No. 18-CR-834, 2020 WL 1684062, at *3 (S.D.N.Y. Apr. 2, 2020) (finding "extraordinary and compelling reasons" to reduce the defendant's sentence due to defendant's asthma and the "heightened medical risk presented to [the defendant] by the COVID-19 pandemic"); Rodriguez, 2020 WL 1627331, at *2 (granting compassionate release because for a diabetic inmate, "nothing could be more extraordinary and compelling than this pandemic"); United States v. Campagna, No. 16-CR-78-01, 2020 WL 1489829, at *3 (S.D.N.Y. Mar. 27, 2020) ("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 on the grounds that he is suffering from a serious medical condition that substantially diminishes his ability to provide self-care within the environment of the RCC."); Perez, 2020 WL 1546422, at *2 ("Perez meets th[e] requirement [of Application Note 1(D)] as well, because he has weeks left on his sentence, is in weakened health, and faces the threat of a potentially fatal virus. The benefits of keeping him in prison for the remainder of his sentence are minimal, and the potential consequences of doing so are extraordinarily grave."); see also United States v. Perez, No. 19-CR-297 (PAE), 2020 WL 1329225, at *1 (S.D.N.Y. Mar. 19, 2020) (granting bail application, pursuant to section 3142(i), of 65-year-old defendant with COPD, in light of "unique confluence of serious health issues and other risk factors facing this defendant, . . . which place him at a substantially heightened risk of dangerous complications should [he] contract COVID-19").

B. Exhaustion Requirement is Not Absolute

Section 3582(c)(1)(A) imposes "a statutory exhaustion requirement" that "must be strictly enforced." United States v. Monzon, No. 99-CR-157, 2020 WL 550220, at *2 (S.D.N.Y. Feb. 4, 2020) (citing Theodoropoulos v. I.N.S., 358 F.3d 162, 172 (2d Cir. 2004) (internal quotation marks and alterations omitted)). However, as courts in this Circuit have held, the requirement of completing the administrative process may be waived "if one of the recognized exceptions to exhaustion applies." United States v. Perez, No. 17-CR-513-3, 2020 WL 1546422, at *2 (S.D.N.Y. Apr. 1, 2020); see also United States v. Colvin, No. 19-CR-179, 2020 WL 1613943, at *2 (D. Conn. Apr. 2, 2020) ("[I]n light of the urgency of [d]efendant's request, the likelihood that she cannot exhaust her administrative appeals during her remaining eleven days of imprisonment, and the potential for serious health consequences, the [c]ourt waives the exhaustion requirement of Section 3582(c)(1)(A)."); United States v. Zukerman, No. 16-CR-194, 2020 WL 1659880, at *2 (S.D.N.Y. Apr. 3, 2020).

"Even where exhaustion is seemingly mandated by statute . . ., the requirement is not absolute." Washington v. Barr, 925 F.3d 109, 118 (2d Cir. 2019). There are generally three bases for waiver of an exhaustion requirement. See Perez, 2020 WL 1546422, at *2 (discussing exceptions to statutory exhaustion in context of motion for compassionate release during COVID-19 pandemic). "First, exhaustion may be unnecessary where it would be futile, either because agency decision-makers are biased or because the agency has already determined the issue." Washington, 925 F.3d at 118. "[U]ndue delay, if it in fact results in catastrophic health consequences, could make exhaustion futile." Id. at 120. Second, "exhaustion may be unnecessary where the administrative process would be incapable of

granting adequate relief," including situations where "the relief the agency might provide could, because of undue delay, become inadequate." Id. at 119-20. Third, "exhaustion may be unnecessary where pursuing agency review would subject plaintiffs to undue prejudice." Id. at 119.

All three exceptions apply here. First, exhaustion would be futile. "[U]ndue delay, if it in fact results in catastrophic health consequences, could make exhaustion futile." Washington, 925 F.3d at 120–21. Here, Mr. Gileno's age and underlying health issues, as described *supra*, when considered in light of the spread of COVID-19, demonstrate that further delay could likely result in such catastrophic health consequences, including death. See New York v. Sullivan, 906 F.2d 910, 918 (2d Cir. 1990) (holding that waiver was appropriate where "enforcement of the exhaustion requirement would cause the claimants irreparable injury" by risking "deteriorating health, and possibly even . . . death"). Even a few weeks' delay carries the risk of catastrophic health consequences for Mr. Gileno. Second, given the high volume of compassionate release applications being filed throughout the BOP, the prison system is unable to effectively evaluate an inmate's application in the same manner as a sentencing judge who's reviewed all of the defendant's pertinent sentencing submissions in addition to the presentence report. Thus, the exhaustion requirement likely renders the BOP incapable of granting adequate relief. Finally, and obviously, Mr. Gileno could be unduly prejudiced by such delay. Clearly, given his conditions, Mr. Gileno is at great risk of succumbing to COVID-19.

III. CONCLUSION

For the foregoing reasons, Mr. Gileno moves for compassionate release under 18 U.S.C. §3582(c)(1)(A), and that he be subject to a condition of home confinement for the remainder of his prison sentence.

The Defendant
Paul Gileno

/s/ William H. Paetzold
William H. Paetzold
Moriarty, Paetzold & Sherwood
2230 Main Street
Glastonbury, CT 06033
Tel. (860) 657-1010
Federal Bar No.: ct10074

CERTIFICATION

This is to certify that the foregoing was filed electronically on April 13, 2020 to all parties by operation of the court's electronic filing system or by mail to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing.

/s/ William H. Paetzold
William H. Paetzold

EXHIBIT A

HIGH RIDGE FAMILY PRACTICE

30 BUXTON FARM RD., STE 210 • STAMFORD, CT 06905
TELEPHONE: (203)322-7070 • FAX: (203)322-2389

Alan T. Falkoff, M.D., D.A.B.F.M., F.A.A.F.P. • David M. Berkun, M.D., D.A.B.P.
Melissa Montaruli, A.P.R.N. • Lindsay Meyer, A.P.R.N. • Alexandra R. Hagerman, A.P.R.N.
Lynda G. Royce, A.P.R.N. • Eileen Madsen, A.P.R.N. • Soohyun Nam, A.P.R.N.

March 18, 2020

To Whom It May Concern,

Paul Gileno has been a member of High Ridge Family Practice since 6/2003 and is under the care of Melissa G Montaruli, APRN.

Mr. Gileno has history of seasonal allergies and asthma which put him at a higher risk of respiratory complications. Mr. Gileno needs to be monitored closely for any potential symptoms or complications surround the Covid-19 virus.

Please call me at my office with any other questions or concerns.

Sincerely,

Melissa G Montaruli, APRN

BLUE BACKGROUND REFLECTIVE WATERMARK

MARIANNE MITCHELL, A.P.R.N.
PULMONARY AND SLEEP SPECIALISTS
WESTERN CONNECTICUT MEDICAL GROUP
33 Germantown Road, Danbury, CT 06810

203-739-8330 DEA No. MM0389230

Date 3/27/2020

Name Paul Gilens

Address dob 9/12/72

Please label name of drug and dosage with directions

℞ pt a pt of ours with asthma hx bronchitis + hyperactive airway disease.

Marianne Mitchell
MARIANNE MITCHELL, A.P.R.N.

Generic: Yes ____ No ____
REF:
0-1-2-3-4-6-12-Inf.

PU-07

THERMOCHROMIC INK & SECURITY FEATURES LISTED ON BACK

Nuvance Health

WCMG Pulmonary and Sleep Specialists Danbury
33 Germantown Road
Danbury, CT 06776-

Patient: GILENO, PAUL
DOB/Age/Sex: 9/12/1972 47 years Male Admit: 3/19/2020 Disch: 3/20/2020
MRN: 005524435

Letters

Document Type: Patient Letter
Service Date/Time: 3/19/2020 12:53 EDT
Result Status: Auth (Verified)
Document Subject:
Sign Information:

Western Connecticut Health Network

To Whom it May Concern:

Patient Gileno, Paul (DOB 9/12/1972) has a documented diagnosis of Asthma. Asthma is a chronic lung disease and therefore would be placed in the high risk group under the circumstances surrounding COVID-19.

If you have any further questions, please contact our office at 203-739-8330

Patient Name: GILENO, PAUL DOB: 9/12/1972 MRN: 005524435

Letters

Moore, Shawna, APRN

33 Germantown Rd
Danbury, CT 06810

GILENO, PAUL Admin Sex: **Male** DOB: **09/12/1972**

Ambulatory Summary Created: 03/27/2020

Summarization of Episode Note I 05/24/2018 to 05/24/2018

Source: WCMG Pulmonary and Sleep Specialists Danbury

Demographics

Contact Information:
13 BRADLEY COURTBrewster, NY 10509, US
Tel: (203)219-8751
Mail: jennifergileno@gmail.com

Marital Status: Married
Religion: --
Race: White, White
Previous Name(s): --

Ethnic Group: Not Hispanic or Latino
Language: English
ID: URN:CERNER:IDENTITY-FEDERATION:REALM:DB9C2801-7026-47B6-A85F-5D485070D969-CH:PRINCIPAL:A76GE3HM5MB6LR2C, 961098

Care Team

Type	Name	Represented Organization	Address	Phone
primary care physician	Falkoff, Alan T	--	Work:30 Buxton Farms RoadHigh Ridge Family PracticeStamford, CT 06905- , US	Work Tel: (203)322-7070

Relationships

No Data to Display

Document Details

Source Contact Info

21 Elm StreetNew Milford, CT 06776- , US
Tel: (203)739-8330

Author Contact Info

--

Recipient Contact Info

--

Healthcare Professionals

No Data to Display

IDs & Code Type Data

Document Type ID: 2.16.840.1.113883.1.3 : POCD_HD000040
Document Template ID: 2.16.840.1.113883.10.20.22.1.1 : --, 2.16.840.1.113883.10.20.22.1.2 : --
Document ID: 2.16.840.1.113883.3.5398.29.130.999362 : 1473684
Document Type Code: 2.16.840.1.113883.6.1, 34133-9
Document Language Code: en-US
Document Set ID: --
Document Version Number: --

Primary Encounter

Encounter Information

Registration Date: 05/24/2018

Discharge Date: 05/24/2018

Visit ID: --

Location Information

WCMG Pulmonary and Sleep Specialists Danbury

Work:33 Germantown RoadDanbury, CT 06776-

Providers

Type	Name	Address	Phone
Attending	Chronakos, John	Work:33 Germantown Road2nd FloorDanbury, CT 06810- , US	Work Tel: (203)739-8330
Referring	Falkoff, Alan T	Work:30 Buxton Farms RoadHigh Ridge Family PracticeStamford, CT 06905- , US	Work Tel: (203)322-7070

Encounter

FIN 1084074 **Date(s): 5/24/18 - 5/24/18**

WCMG Pulmonary and Sleep Specialists Danbury 33 Germantown Road Danbury, CT 06776- (203) 739-6586

Encounter Diagnosis

Hyperreactive airway disease (Discharge Diagnosis) - 5/24/18

Sleep apnea (Discharge Diagnosis) - 5/24/18

Discharge Disposition: DSCH Home or Self Care

Attending Physician: Chronakos, John, MD

Referring Physician: Falkoff, Alan T, MD

Vital Signs

Most recent to oldest [Reference Range]:	1
Peripheral Pulse Rate [60-100 bpm]	82 bpm (5/24/18 4:31 PM)
Respiratory Rate [14-20 br/min]	16 br/min (5/24/18 4:31 PM)
Blood Pressure [90-140/60-90 mmHg]	112/70 mmHg (5/24/18 4:31 PM)

Problem List

Condition	Effective Dates	Status	Health Status	Informant
Bronchitis(Confirmed) [1]		Active	Chronic ;	
Disease suspected(Confirmed) [2]		Active	Chronic ;	
Dyspnea(Confirmed) [3]		Active	Chronic ;	
Hyperlipidemia(Confirmed) [4]		Active	Chronic ;	
Hyperreactive airway disease(Confirmed) [5]		Active	Chronic ;	
Hypertensive disorder(Confirmed) [6]		Active	Chronic ;	

[1] Migrated from Touchworks. TouchWorks Dx: Bronchitis

[2] Migrated from Touchworks. TouchWorks Dx: Suspected sleep apnea

[3] Migrated from Touchworks. TouchWorks Dx: Shortness of breath

[4] Migrated from Touchworks. TouchWorks Dx: Hyperlipidemia

[5] Migrated from Touchworks. TouchWorks Dx: Asthma

[6] Migrated from Touchworks. TouchWorks Dx: Hypertension

Allergies, Adverse Reactions, Alerts

No Known Medication Allergies

Medications

albuterol (ProAir HFA 90 mcg/inh inhalation aerosol)

1 Puffs Inhale (breathe in) every 6 hours as needed as needed for wheezing.

ALPRAZolam (Xanax 0.25 mg oral tablet)

1 tab Oral (given by mouth) 2 times a day.

aspirin (Aspir 81 oral delayed release tablet)

1 tab Oral (given by mouth) every day.

atorvastatin (atorvastatin 10 mg oral tablet)

1 tab Oral (given by mouth) every day.

cetirizine (ZyrTEC)

every day.

DME RESP Auto Titrating CPAP (DME Auto Titrating CPAP)

auto PAP 5-20, pls send to HC, best fit mask. Refills: 0.

Ordering provider: Chronakos, John, MD

fluticasone-salmeterol (Advair Diskus 250 mcg-50 mcg dry powder inhaler)

1 Puffs Inhale (breathe in) 2 times a day.

lisinopril (lisinopril 10 mg oral tablet)

1 tab Oral (given by mouth) every day.

montelukast (montelukast 10 mg oral tablet)

1 tab Oral (given by mouth) every day. Refills: 2.

Ordering provider: Chronakos, John, MD

Results

No data available for this section

Immunizations

No data available for this section

Procedures

No data available for this section

Social History

Social History Type	Response
Smoking Status	Never smoker entered on: 5/24/18

Assessment and Plan

No data available for this section

EXHIBIT B

NEW CANAAN
PSYCHOTHERAPY
ASSOCIATES

51 Locust Avenue - Suite 304
New Canaan, CT 06840
Phone 203-966-6467
Fax 203-966-6807

March 27, 2020

Ms. Brill
FCI Schuylkill
P. O. Box 700
Minersville, PA 17954

Re: Paul Gileno 2638801Y

Dear Ms. Brill:

This letter is in support of the request for compassionate release for Paul Gileno. I have been Mr. Gileno's psychotherapist since 2007 when he was referred to me by David Levi, MD, his pain management physician. I am a clinical psychologist in private practice serving the pain population for over twenty years. Mr. Gileno suffers from chronic unremitting pain as well as from the anxiety and depression resulting from that pain condition, and I have worked with him on developing cognitive/behavioral strategies to manage his pain as well as his mood symptoms. Recent letters to me from Mr. Gileno indicate that his pain is significantly worse and his mood symptoms have increased since his admission to FCI Schuylkill.

I know from reviewing his medical records that he also suffers from asthma and related pulmonary difficulties. I also know from the medical research literature that stress, anxiety and depression suppress immune system functioning. Mr. Gileno's physical and psychiatric compromise places him at serious risk for a dangerous reaction to the Covid- 19 virus. In his current setting, I am concerned that the lack of social distance as well as the likely inability of the facility to maintain sterile conditions will not be able to prevent his exposure to the virus. I am concerned that should he contract the virus, he may not survive.

Therefore, I am hoping that FCI Schuylkill give serious consideration to my comments as well as to Mr. Gileno's medical history his request for compassionate release.

Thank you.

Respectfully,

Michele Gargan, PsyD

EXHIBIT C

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.

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[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

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[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.

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[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