UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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UNITED STATES OF AMERICA,

– against – No.14-cr-810 (CM)

Moshe Mirilashvili,

Defendant.

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MEMORANDUM OF LAW IN SUPPORT OF MOSHE MIRILASHVILI'S MOTION FOR COMPASSIONATE RELEASE UNDER 18 U.S.C. § 3582(c)(1)(A)

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MOSHE MIRILASHVILI'S MOTION FOR COMPASSIONATE RELEASE UNDER 18 U.S.C. § 3582(c)(1)(A)

Movant, Moshe Mirilashvili, through undersigned counsel, respectfully moves this Court to grant his motion for compassionate release under 18 U.S.C. § 3582(c)(1)(A), and order the remainder of his sentence to be served on home confinement. This motion should be granted due to the "extraordinary and compelling reasons" confronting the federal prison system by the pandemic of COVID-19 and the fact that Mr. Mirilashvili, at age 71, is not a danger to the community; is no longer a licensed medical doctor; suffers from serious medical issues; and further because respect for the law and general deterrence, other notable Section 3553(a) factors, would not be undermined by converting the remainder of his sentence to home confinement given the cataclysmic events of the current pandemic. We respectfully ask the Court to consider this motion on an expedited basis as each day in custody brings renewed and unthinkable risk to Mr. Mirilashvili's life.

BACKGROUND

Mr. Mirilashvili was convicted after a jury trial of three counts of violations of the federal narcotics trafficking statutes, 21 U.S.C. §§ 841(b)(1)(C) and 846. These offenses arose out of evidence that Moshe Mirilashvili, who at the time was a licensed medical doctor, unlawfully prescribed opioid medication for distribution. The Court remanded Mr. Mirilashvili upon the return of the guilty verdicts on March 17, 2016. It later sentenced Mr. Mirilashvili, on September 14, 2016, to 160 months (or 13.3 years) of imprisonment. Mr. Mirilashvili appealed his conviction and sentence, and the U.S. Court of Appeals for the Second Circuit affirmed. *See United States v. Mirilashvili,* 738 F. App'x 7 (2d Cir. 2018).

Mr. Mirilashvili has been in continuous custody since the time of the trial verdicts in March 2016. He initially was designated to the federal Bureau of Prisons ("BOP") facility at FCI Danville

(Connecticut), and in or about July 2018 was transferred to FSC Otisville (New York). He has now served just over four years of imprisonment. His expected date of release, as calculated by the BOP, is October 27, 2027.

Simultaneously with this motion, Mr. Mirilashvili filed an administrative relief request with FCI Otisville likewise seeking compassionate release on the same grounds as submitted herein. Because of the urgency of the spread of COVID-19 in New York State (which now has more than 7 percent of the recorded COVID-19 cases worldwide), we respectfully ask the Court to waive the 30-day waiting period for any response by the warden. Waiting for a response could cost Mr. Mirilashvili his life.

ARGUMENT

This Court never intended to sentence Mr. Mirilashvili to a death sentence. Indeed, this Court specifically rejected the Probation Department's recommendation of a sentence at the low-end of the federal Sentencing Guidelines of 292 months because it wanted Mr. Mirilashvili to survive his sentence. Indeed, based on the calculation of federal good-time credit, the Court's sentence of 160 months would cause Mr. Mirilashvili to come home from prison before he turned 80. Now, however, because of the unthinkable spread of a global pandemic that is killing the elderly who have pre-existing medical conditions like Mr. Mirilashvili at alarming rates of approximately 11% percent, he is faces a serious risk of dying in prison if infected. *See* "Severe Outcomes Among Patients with Coronavirus Disease 2019 (COVID-19) — United States, February 12–March 16, 2020," Centers for Disease Control and Prevention Report (March 18, 2020), available at https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e2.htm.

Mr. Mirilashvili is just shy of his 72nd birthday. His health is extremely fragile. He suffers from Type-II diabetes, coronary-artery disease, high blood pressure, and is a prolific former

smoker (having smoked up until the day he was remanded to BOP custody). Given his age and these medical conditions, we are extremely concerned that when (and not if) the COVID-19 virus spreads through the facility at FSC Otisville, it will be a death sentence for Mr. Mirilashvili. *See id.* ("a majority of coronavirus disease 2019 (COVID-19) deaths have occurred among adults aged ≥60 years and among persons with serious underlying health conditions.").

This unparalleled health crisis in our country and its deadly expected arrival in our prisons present "extraordinary and compelling reasons" to grant Mr. Mirilashvili's motion. As explained below, FSC Otisville is already overcrowded—beyond recommended capacity—and the conditions there make it impossible for Mr. Mirilashvili to self-care and prevent his infection if the virus is found at the facility. "Social distancing" is not an option for most of our federal inmates. The New York Times recently explained why jails are a much more dangerous place to be than even a cruise ship. *See* "An Epicenter of the Pandemic Will Be Jails and Prisons, If Inaction Continues," *The New York Times* (March 16, 2020), available at https://www.nytimes.com/2020/03/16/opinion/coronavirus-in-jails.html. Mr. Mirilashvili relates to counsel that there is no hand sanitizer available to the inmates and air circulation is very poor. Soap is only available if one can purchase it from the prison's commissary.

As to the Section 3553(a) factors, Mr. Mirilashvili, at 71, is not a danger to the community. His crime was based on privileges he had as a licensed medical doctor. He was correctly stripped of that license by New York State after his conviction. He is aged, infirm, and unlikely to be able to return to the workforce. He simply wishes to live out his final years—under continued confinement—at the home of his beloved wife. He poses no harm to others and can continue to be confined safely there until the end of his original term of imprisonment in 2027.

The humane and compassionate thing to do is to convert Mr. Mirilashvili's sentence to home confinement for the remainder of its term. At his current age and medical condition, when COVID-19 infects FSC Otisville, he will not have much of a chance to survive.

I. THIS COURT HAS AUTHORITY TO RESENTENCE MR. MIRILASHVILI UNDER 18 U.S.C. § 3582(c)(1)(A)(i) FOR THE "EXTRAORDINARY AND COMPELLING REASONS" CREATED BY THE COVID-19 PANDEMIC AND THE PRISON CONDITIONS WHICH PREVENT SELF-CARE FOR A HIGH-RISK PATIENT

With the changes made to the compassionate release statute by the First Step Act, courts need not await a motion from the Director of BOP to resentence prisoners under 18 U.S.C. § 3582(c)(1)(A)(i) for "extraordinary and compelling reasons." Importantly, the reasons that can justify resentencing need not involve only terminal illness or urgent dependent care for minor children.

Congress first enacted the modern form of the compassionate release statute, codified at 18 U.S.C. § 3582, as part of the Comprehensive Crime Control Act of 1984. Section 3582(c) states that a sentencing court can reduce a sentence whenever "extraordinary and compelling reasons warrant such a reduction." 18 U.S.C. § 3582(c)(1)(A)(i). In 1984, Congress conditioned the reduction of sentences on the BOP Director's filing of an initial motion to the sentencing court. Absent such a motion, sentencing courts had no authority to modify a prisoner's sentence for compassionate release. *Id.*

Congress never defined what constitutes an "extraordinary and compelling reason" for resentencing under Section 3582(c). But the legislative history to the statute gives an indication of how Congress thought the statute should be employed by the federal courts. The Senate Committee stressed how some individual cases, even after the abolishment of federal parole, still may warrant a second look at resentencing:

> The Committee believes that there may be unusual cases in which an eventual reduction in the length of a term of imprisonment is justified by changed circumstances. These would include cases of severe illness*, cases in which other extraordinary and compelling circumstances* justify a reduction of an unusually long sentence, and some cases in which the sentencing guidelines for the offense of which the defendant was convicted have been later amended to provide a shorter term of imprisonment.

S. Rep. No. 98-225, at 55-56 (1983) (emphasis added). Congress intended that the circumstances listed in § 3582(c) would act as "safety valves for modification of sentences," *id.* at 121, enabling judges to provide second looks for possible sentence reductions when justified by various factors that previously could have been addressed through the abolished parole system. This safety valve statute would "assure the availability of specific review and reduction of a term of imprisonment for 'extraordinary and compelling reasons' and [would allow courts] to respond to changes in the guidelines." *Id.* Noting that this approach would keep "the sentencing power in the judiciary where it belongs," rather than with a federal parole board, the statute permitted "later review of sentences in particularly *compelling situations*." *Id.* (emphasis added).

Congress initially delegated the responsibility for outlining what could qualify as "extraordinary and compelling reasons" to the U.S. Sentencing Commission ("Commission"). *See* 28 U.S.C. § 994(t) ("The Commission . . . shall describe what should be considered extraordinary and compelling reasons for sentence reduction, including the criteria to be applied and a list of specific examples."). The Commission took considerable time to promulgate its policy in response to Congress's directive. It finally acted in 2007, almost a generation later, with the very general guidance that "extraordinary and compelling reasons" may include medical conditions, age, family circumstances, and "other reasons." U.S.S.G. § 1B1.13, app. n.1(A). However, this guidance did little to spur the BOP to file on behalf of prisoners who might have met these general standards. After a negative Department of Justice Inspector General report found that the BOP rarely invoked

its authority under the statute to move for reduced sentences, the Commission felt compelled to act again. *See* U.S. Dep't of Justice, Office of the Inspector General, *The Federal Bureau of Prisons' Compassionate Release Program,* I-2023-006 (Apr. 2013). The Commission amended its policy statement on "compassionate release" in November 2016. *See* U.S.S.G. § 1B1.13 Amend. (11/1/2016). In addition to broadening the eligibility guidelines for sentencing courts, the new policy statement admonished the BOP for its past failures to file motions on behalf of inmates who had met the general criteria identified in U.S.S.G. § 1B1.13. *See* U.S.S.G. § 1B1.13, n.4; *see also United States v. Dimasi*, 220 F. Supp. 3d 173, 175 (D. Mass. 2016) (discussing the history of the BOP, DOJ and Commission's interplay in developing guidance for "compassionate release" motions). Notably, the Commission concluded that reasons beyond medical illness, age, and family circumstances could qualify as "extraordinary and compelling reasons" for resentencing. *Id.,* n.1(A) (including a category for "Other Reasons," when there is "an extraordinary and compelling reason other than, or in combination with, the reasons described in subdivisions (A) through (C).").[1]

[1] *But see United States v. Cantu*, No. 1:05-CR-458-1, 2019 WL 2498923, at *4 (S.D. Tex. June 17, 2019) (holding that, given the changes to the compassionate release statute by the First Step Act, U.S.S.G. § 1B1.13, application note 1(D) "no longer fits with the statute and thus does not comply with the congressional mandate that the policy statement must provide guidance on the appropriate use of sentence-modification provisions under § 3582."); *United States v. Fox*, No. 2:14-CR-03-DBH, 2019 WL 3046086, at *3 (D. Me. July 11, 2019) ("I treat the previous BOP discretion to identify other extraordinary and compelling reasons as assigned now to the courts."); *United States v. Cantu-Rivera*, No. CR H-89-204, 2019 WL 2578272, at *2 n.1 (S.D. Tex. June 24, 2019) ("Because the current version of the Guideline policy statement conflicts with the First Step Act, the newly-enacted statutory provisions must be given effect."); *United States v. Beck*, No. 1:13-CR-186-6, 2019 WL 2716505, at *6 (M.D.N.C. June 28, 2019) (holding that application note 1(D) is "inconsistent with the First Step Act, which was enacted to further increase the use of compassionate release and which explicitly allows courts to grant such motions even when BoP finds they are not appropriate," and courts thus may "consider whether a sentence reduction is warranted for extraordinary and compelling reasons other than those specifically identified in the application notes to the old policy statement"); *but see United States v. Lynn*, No. CR 89-0072-WS, 2019 WL 3805349, at *4 (S.D. Ala. Aug. 13, 2019) (holding that application note 1(D)

The Commission's actions, however, did little to change the dearth of filings by the BOP on behalf of inmates who satisfied the Commission's general guidance. During the more than three decades during which the BOP was the exclusive gatekeeper for "compassionate release" motions, very little effort was made to implement Congress's intention to provide a safety valve to correct injustices or allow relief under extraordinary and compelling circumstances.

Finally, this changed with the passage of the First Step Act in 2018. *See* P.L. 115-391, 132 Stat. 5194, at § 603 (Dec. 21, 2018). Section 603 of the First Step Act changed the process by which § 3582(c)(1)(A) compassionate release occurs: instead of depending upon the BOP Director to determine an extraordinary circumstance and move for release, a court can now resentence "upon motion of the defendant," after the inmate exhausted administrative remedies with the BOP, or after 30 days from the receipt of the inmate's request for compassionate release with the warden of the defendant's facility, whichever comes earlier. 18 U.S.C. § 3582(c)(1)(A). Thus, under the First Step Act, a court may now consider the defendant's own motion to be resentenced, without waiting for it to be made by the BOP.

Courts are now authorized to consider a defendant's motion, even one which the BOP opposes, and order resentencing if a resentencing court finds that "extraordinary and compelling reasons" warrant a reduction and such a reduction is consistent with the Section 3553(a) factors. *Id.* Resentencing courts are also advised that any decision to reduce a previously ordered sentence be "consistent with applicable policy statements issued by the Sentencing Commission." *Id.*

Here, while the 30-day period since the warden's receipt of Mr. Mirilashvili's request for compassionate release due to the threat of coronavirus infection has not yet passed, this Court can

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governs compassionate release reductions of sentence and federal judges have no authority to create their own criteria for what constitutes an "extraordinary and compelling" reason for resentencing).

construe the exhaustion requirement as futile given the urgency of this national emergency and rapid spread of the pandemic.

II. THE COURT CAN WAIVE THE 30-DAY REQUIREMENT FOR EXHAUSTION OF ADMINISTRATIVE REMEDIES UNDER 18 U.S.C. § 3582(c)(1)(A) BECAUSE OF THE URGENT RISK OF FATAL INFECTION

Mr. Mirilashvili filed his petition with the warden simultaneously with this motion to the Court. Under section 3582(c)(1)(A), Mr. Mirilashvili would ordinarily be required to either wait 30 days following the warden's receipt of his compassionate release request, or exhaust all administrative remedies prior to approaching the Court, whichever happens earlier. *See* 18 U.S.C. § 3582(c)(1)(A). However, the Court may waive these administrative exhaustion requirements, and should do so here.

Under clear Second Circuit precedent preceding the First Step Act, although a prisoner seeking to alter his conditions of imprisonment generally must exhaust administrative remedies before resorting to judicial intervention, the Court may waive that prerequisite. *See, e.g., Hemphill v. New York*, 380 F.3d 680, 686 (2d Cir. 2004) (under Prison Litigation Reform Act,[2] where the prisoner "did not exhaust available remedies, the court should consider whether special circumstances have been plausibly alleged that justify the prisoner's failure to comply with administrative procedural requirements," permitting the court to waive the failure to exhaust (quotation marks and citations omitted));[3] *Carmona v. U.S. Bur. of Prisons*, 243 F.3d 629, 634 (2d Cir. 2001) (while prior to filing a habeas corpus petition under § 2241 "federal prisoners must

[2] Prison Litigation Reform Act, 42 U.S.C. § 1997e, referred to herein as "PLRA."

[3] *Accord Vogelfang v. Riverhead Cnty. Jail Officers*, No. 07-1268-CV, 2009 WL 230132, at *2 (2d Cir. Feb. 2, 2009) (reviewing dismissal of under Prison Litigation Reform Act action for failure to exhaust finding "[i]t was error for the district court not to consider Vogelfang's arguments . . . that her failures to exhaust should be excused.");

exhaust their administrative remedies . . . [w]hen, however, legitimate circumstances beyond the prisoner's control preclude him from fully pursuing his administrative remedies, the standard we adopt excuses this failure to exhaust"). Thus, courts in this Circuit have "excuse[d] exhaustion if it appears that an administrative appeal would be futile, or because the appeals process is shown to be inadequate to prevent irreparable harm to the defendant." *United States v. Basciano*, 369 F. Supp. 2d 344, 348 (E.D.N.Y. 2005) (addressing § 2241 habeas claim regarding circumstances of confinement despite defendant's failure to exhaust administrative remedies); *accord United States v. Khan*, 540 F. Supp. 2d 344, 350 (E.D.N.Y. 2007) (under PLRA, "[a] court may, however, excuse the exhaustion requirement if a petitioner demonstrates that pursuing appeals through the administrative process would be futile or that the appeals process is inadequate to prevent irreparable harm to the petitioner").[4]

The First Step Act did not alter this longstanding precedent—both the administrative exhaustion procedure and the circumstances meriting its waiver remain unchanged. *See, e.g., United States v. Bolino*, No. 06-CR-0806 (BMC), 2020 WL 32461, at *1 (E.D.N.Y. Jan. 2, 2020) (under the First Step Act, "the same exhaustion procedure for routine administrative grievances . . . applies to requests for compassionate release."). Indeed, courts throughout the country have

[4] *Accord Charboneau v. Menifee*, No. 05 CIV. 1900 (MBM), 2005 WL 2385862, at *2 n.3 (S.D.N.Y. Sept. 28, 2005) (in addressing petition for determining eligibility for placement in a halfway house, the court excused the defendant's failure to exhaust administrative remedies "on the grounds of futility, and the likelihood of irreparable injury before further appeals could be exhausted"); *Drew v. Menifee*, No. 04 CIV. 9944HBP, 2005 WL 525449, at *3 n.1 (S.D.N.Y. Mar. 4, 2005] (granting, in part, motion "to release petitioner to community confinement in a halfway house when petitioner has six months remaining on his sentence after deduction of good time credits," explaining that any failure to exhaust administrative remedies "should be excused on the ground of futility."); *Terry v. Menifee*, No. 04 CIV. 4505 (MBM), 2004 WL 2434978, at *2 (S.D.N.Y. Nov. 1, 2004) (excusing failure to exhaust administrative remedies "on the grounds of futility and irreparable injury" in 2241 habeas corpus petition requesting determination of eligibility for transfer to a halfway house).

continued to waive the administrative exhaustion requirements under the First Step Act, where circumstances warrant. *See Washington v. Bur. of Prisons*, No. 1:19-CV-01066, 2019 WL 6255786, at *2 (N.D. Ohio July 3, 2019) (in addressing motion for recalculation of good time credit under the First Step Act, the court explained that "[t]he failure to exhaust administrative remedies may be excused if seeking administrative remedies would be futile."); *United States v. Walker*, No. 3:10-cr-00298-RRB-1, [Dkt. 110] (D. Or. Feb. 7, 2019) (finding that, although the defendant failed to exhaust administrative remedies, the Court had jurisdiction to order recalculation of defendant's good time credit under the First Step Act and to order defendant's release if his term of imprisonment had expired); *see also Gurzi v. Marques*, No. 18-CV-3104-NEB-KMM, 2019 WL 6481212, at *2 (D. Minn. Oct. 10, 2019) (despite prisoner's failure to exhaust administrative remedies, addressing the merits of prisoner's objections to his designation, in part under the First Step Act, as "the Court observes that it has the authority to proceed to the merits of the case rather than rely on a failure to exhaust when appropriate.").[5]

The futility and potentially irreparable harm of requiring Mr. Mirilashvili to wait a minimum of 30 days to exhaust his administrative remedies are manifest. Mr. Mirilashvili seeks this emergency relief to avoid contracting COVID-19 at FSC Otisville where he has a high risk of infection: "social distancing" is impossible in the crowded facility, and soap, hand sanitizer and disinfectant products are scarce. Waiting for Mr. Mirilashvili to exhaust his administrative

[5] Nor is there a colorable argument that the exhaustion requirement under the First Step Act is jurisdictional. Like the administrative exhaustion requirements applicable to § 2241 petitions, and under the PLRA, § 3582(c)(1)(A) "lacks the sweeping and direct language that would indicate a jurisdictional bar rather than a mere codification of administrative exhaustion requirements." *Richardson v. Goord*, 347 F.3d 431, 434 (2d Cir. 2003) (quotation marks and citations omitted); s*ee also Atkinson v. Linaweaver*, No. 13 CIV. 2790 JMF, 2013 WL 5477576, at *1 (S.D.N.Y. Oct. 2, 2013) ("In a case brought pursuant to Section 2241, exhaustion . . . does not go to the Court's jurisdiction to adjudicate the dispute").

remedies would only compound his risk of exposure to COVID-19. Should he contract the virus while waiting for an administrative response any remedy will come too late—Mr. Mirilashvili will be in mortal danger, causing him potentially irreparable physical harm, and rendering this compassionate release request utterly moot. *See, e.g., Sorbello v. Laird*, No. 06 CV 948 (JG), 2007 WL 675798, at *3 n.8 (E.D.N.Y. Feb. 28, 2007) (refusing to dismiss petition requesting designation to halfway house "for failure to exhaust administrative remedies" where delay in processing administrative remedies would "result in the irreparable harm of late designation to community confinement"); *Pimentel v. Gonzales*, 367 F. Supp. 2d 365, 371 (E.D.N.Y. 2005) (addressing merits of request for designation to halfway house, where "not only would an administrative appeal be futile, but without immediate relief by this court, Pimentel could suffer irreparable harm," as "[w]ere Pimentel required to pursue administrative remedies prior to bringing this action, he would likely be done serving much, if not all of his entire sentence such that his request would become moot.").[6]

The Bureau of Prisons has known for months of the impending COVID-19 crisis, creating a further reason to excuse Mr. Mirilashvili's failure to exhaust all administrative remedies. The BOP has had ample opportunity to adequately prepare FSC Otisville for this emerging health crisis, which would have obviated the need for Mr. Mirilashvili's emergency compassionate release petition. Because the BOP was on notice of the potential dangers to inmates like him, Mr. Mirilashvili should not be required to wait while the BOP takes additional time addressing his

[6] The factual questions at issue—the rapid spread of COVID-19, the serious danger to certain high-risk individuals, and Mr. Mirilashvili's health conditions placing him squarely in the highest fatal risk group—are well-developed in the record before this Court, thus rendering administrative exhaustion all but pointless. *See Gurzi*, No. 18-CV-3104-NEB-KMM, 2019 WL 6481212, at *2 ("given the clear circumstances here, a principal purpose of administrative exhaustion, the development and crystallization of the factual record, is not implicated in this case." (quotation marks and citations omitted)).

administrative request. *See Basciano*, 369 F. Supp. 2d at 349 (despite failure to exhaust administrative remedies, because "the BOP ha[d] not addressed [his] request for relief in a timely fashion," despite "ample opportunity" to do so, the court found that "[t]he administrative appeals process would thus, in the circumstances of this case, be an empty formality that would risk exposing Basciano to irreparable harm"). Mr. Mirilashvili should not be forced to bear the brunt of the facility's failure to adequately prepare for COVID-19. In these extraordinary circumstances, the Court should waive the administrative exhaustion requirement in § 3582.

III. THE COVID-19 OUTBREAK PRESENTS A COMPELLING AND EXTRAORDINARY CIRCUMSTANCE THAT WARRANTS COMPASSIONATE RELEASE FOR MR. MIRILASHVILI, WHO IS A HIGH-RISK FATALITY PATIENT

On March 11, 2020, the World Health Organization ("WHO") officially classified the new strain of coronavirus, COVID-19, as a pandemic.[7] As of March 24, 2020, COVID-19 has infected at least 438,000 worldwide, leading to at least 19,641 deaths.[8] In the United States, approximately 60,000 have been infected, leading to 804 deaths.[9] These numbers almost certainly underrepresent the true scope of the crisis; test kits in the United States have been inadequate to meet demand.

[7] "WHO Characterizes COVID-19 as a Pandemic," World Health Organization (March 11, 2020), available at https://bit.ly/2W8dwpS.

[8] "Coronavirus Map: Tracking the Global Outbreak," *New York Times* (March 25, 2020), available at https://www.nytimes.com/interactive/2020/world/coronavirus-maps.html?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu?action=click&pgtype=Article&state=default&module=styln-coronavirus&variant=show&region=TOP_BANNER&context=storyline_menu.

[9] *Id.*

New York has been labeled the new "epicenter" of the pandemic worldwide.[10] As of March 25, 2020, there were more than 30,000 cases in New York, and at least 280 deaths.[11] New York health officials estimate that the number of hospitalizations in New York State will double every two days over the course of the next two to three weeks.[12] New York's cases of COVID-19 now represent 7 percent of the cases worldwide.[13]

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)).[14] On March 16, 2020, the White House issued guidance recommending that, for the next eight weeks, gatherings of ten persons or more be canceled or postponed.[15] On March 20, 2020, Governor Andrew Cuomo ordered 100 percent of all non-essential workers to remain home, effectively shuttering New York state's entire economy.[16] These drastic measures followed the issuance of a report by British epidemiologists,

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[10] New York Becomes 'Epicenter' of Coronavirus Pandemic, *Politico New York Health Care* (March 25, 2020), at https://www.politico.com/states/new-york/newsletters/politico-new-york-health-care/2020/03/25/new-york-becomes-epicenter-of-coronavirus-pandemic-333669.

[11] "Coronavirus Map: Tracking the Global Outbreak," *New York Times* (March 25, 2020).

[12] *Id.*

[13] *Id.*

[14] 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/.

[15] Sheri Fink, "White House Takes New Line After Dire Report on Death Toll," *New York Times* (March 17, 2020), available at https://www.nytimes.com/2020/03/17/us/coronavirus-fatality-rate-white-house.html?action=click&module=Spotlight&pgtype=Homepage.

[16] Keshia Clukey and Henry Goldman, "Cuomo Orders 100% of Nonessential N.Y. Workforce to Stay Home," *Bloomberg News* (March 20, 2020), available at https://www.bloomberg.com/news/articles/2020-03-20/n-y-gov-cuomo-100-percent-of-workforce-must-stay-home.

concluding from emerging data that 2.2 million Americans could die without drastic intervention to slow the global spread of the deadly disease.[17]

The Centers for Disease Control and Prevention ("CDC") have also issued guidance related to the deadly effects of COVID-19 on certain high-risk patients of the population. The CDC identified the population most at risk of death from the disease to include adults over 60 years old with chronic medical conditions, such as lung disease, heart disease, and diabetes.[18] For these individuals, the CDC warned to take immediate preventative actions, including avoiding crowded areas and staying at home as much as possible. *Id.*

IV. THE CONDITIONS OF BOP INCARCERATION FOSTER THE SPREAD OF COVID-19, AND MR. MIRILASHVILI'S AGE AND PREEXISTING MEDICAL CONDITIONS RENDER HIM PARTICULARLY SUSCEPTIBLE TO AN UNREASONABLE RISK OF DEATH AND AN INABILITY TO TAKE PREVENTATIVE MEASURES OR SELF-CARE RECOMMENDED BY THE CDC

With New York at the "epicenter" of the COVID-19 pandemic, it is only a matter of time before COVID-19 finds its way into FSC Otisville, where Mr. Mirilashvili is housed. Indeed, the disease already has spread widely in Orange County, New York, where Otisville is located with recent daily increases of cases of over 25 percent from March 22-25, 2020, and total reported cases of 663 as of March 25.[19]

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[17] Fink, "White House Takes New Line After Dire Report on Death Toll," *New York Times*.

[18] "People At Risk for Serious Illness from COVID-19," CDC (March 12, 2020), available at https://bit.y/2vgUt1P.

[19] Orange County Health Department, Orange County Government, at https://www.orangecountygov.com/1936/Coronavirus (indicating total reported cases of COVID-19 in-county of 663 as of March 25, 2020; the increase in cases is rising at alarming rates: 311 (3/22), 411 (3/23), 539 (3/24), and 663 (3/25)).

Conditions of confinement at FSC Otisville create an optimal environment for the transmission of contagious disease.[20] People who work in the facility leave and return daily; people deliver supplies to the facility daily; inmates were having social, legal and medical visits regularly after the initial spread of the virus prior to the BOP's decision to stop visits for 30 days on March 13, 2020.[21] Public health experts are unanimous in their opinion 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," and "infection control is challenging in these settings."[22]

Mr. Mirilashvili is powerless to take the preventative self-care measures directed by the CDC for his high-risk group to remain safe from COVID-19 infection. He cannot self-quarantine or partake in "social distancing" in his prison facility. He is housed in a community dormitory environment that beds about 124 inmates with "quad"-style cubicles, each housing two to four persons on either side of a central hallway with one common washroom on each floor. There are also community spaces where inmates and prison staff gather, including a common room, laundry facilities, barber shop, medical areas, dining hall, small library and gym. These high-density areas are precisely the kind of spaces that have caused the alarmingly high-spread rates of COVID-19

[20] Joseph A. Bick, "Infection Control in Jails and Prisons," *Clinical Infectious Diseases* 45(8): 1047-1055 (2007), available at https://doi.org/10.1086/521910.

[21] "Federal Bureau of Prisons Covid-19 Action Plan," available at https://www.bop.gov/resources/news/20200313_covid-19.jsp.

[22] "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), at https://bit.ly/2W9V6oS.

in New York City.[23] Hand sanitizer, an effective disinfectant recommended by the CDC to reduce transmission rates, is contraband in jails and prisons because of its alcohol content.[24] Correctional health experts worry that no matter what precautions are taken by crowded prisons, these facilities may become incubators for the COVID-19 disease.[25]

During the H1N1 epidemic in 2009, many jails and prisons dealt with high numbers of cases because they could not maintain the level of separation and sanitation necessary to prevent widespread infection.[26] The Prison Policy Initiative has called on American jails and prisons to release medically fragile and older adults, noting that these persons are at high risk for serious complications and even death from COVID-19.[27] Similarly, members of Congress have written to the BOP to urge that efforts be made to allow immediate release of non-violent, elderly inmates.[28]

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[23] "White House Tells Travelers from New York to Isolate as City Cases Soar," *New York Times* (March 24, 2020), available at https://www.nytimes.com/2020/03/24/nyregion/coronavirus-new-york-update.html.

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

[25] 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-worry-about-becoming-coronavirus-incubators.

[26] "Prisons and Jails are Vulnerable to COVID-19 Outbreaks," *The Verge* (Mar. 7, 2020), available at https://bit.ly/2TNcNZY.

[27] Peter Wagner & Emily Widra, "No Need to Wait For Pandemics: The Public Health Case for Criminal Justice Reform," *Prison Policy Initiative* (March 6, 2020), available at https://www.prisonpolicy.org/blog/2020/03/06/pandemic.

[28] 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.").

Given that Mr. Mirilashvili is 71 years old (turning 72 in June) and suffers from significant underlying health issues that make him exceptionally vulnerable to COVID-19, compelling and extraordinary circumstances exist to support compassionate release at this unique time in our country's history. There is an urgent need to act now, before the virus spreads within the prison and Mr. Mirilashvili becomes infected. As described in the attached declaration of Dr. Jamie Meyer, an infectious disease specialist and Assistant Professor of Medicine at Yale School of Medicine, inmates are uniquely vulnerable:

> [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.

Exhibit A (Decl. of Dr. Meyer). Dr. Meyer describes the inadequate pandemic preparedness plans in many detention facilities and the difficulty of separating infected or symptomatic inmates from others. *Id.*

In summary, the COVID-19 virus is highly transmissible, extraordinarily dangerous, and poses a severe threat of death to the high-risk medical profile of Mr. Mirilashvili. The conditions at FSC Otisville do not allow Mr. Mirilashvili to take the self-care measures required by the CDC to protect his safety.

V. THE RELEVANT § 3553(a) FACTORS, INCLUDING MR. MIRILASHVILI'S RELEASE PLAN, FAVOR RESENTENCING

When extraordinary and compelling reasons are established, the Court must consider the relevant sentencing factors in §3553(a) to determine whether a sentencing reduction is warranted. 18 U.S.C. § 3582(c)(1)(A)(i).

In this case, a review of the Section 3553(a) factors, and his release plan of home confinement under electronic G.P.S. monitoring for the remainder of his unserved original term of imprisonment, favor granting Mr. Mirilashivili's compassionate release.

First, Mr. Mirilashvili's offense conduct, while concededly serious, did not involve personal violence. He used his privilege as a licensed medical doctor to perpetrate the crime. He no longer holds that license as a result of his conviction, and at the age of almost 72, he will never hold another license. Indeed, as part of this motion, he is willing to consent to a condition of supervised release that he never re-apply for any medical license.

Mr. Mirilashvili's advancing age and medical conditions, as first outlined in his PSR and which have only worsened over the last four years, leave him in a frail physical state. *See* PSR, ¶ 87 ("Starting at the age of 55, the defendant was diagnosed with type II diabetes, elevated cholesterol, hypertension, coronary heart disease, and rheumatoid arthritis. He still suffers from these conditions. Up until the time of his incarceration, the defendant was also a heavy smoker. The defendant was prescribed the following medications: Glyberide (5 mg-once daily); Lipazol (10 mg-once daily); aspirin (325 mg-once daily); and Advil once daily.") Since his incarceration at FSC Otisville, Mr. Mirilashvili has been hospitalized twice. The first time, in November 2018, he was experiencing continuous high fever. He had fainted while at the facility. He was never conclusively diagnosed for that illness, but it was deemed to be an infection of some kind, which also resulted in sepsis at the hospital. Mr. Mirilashvili was told he would receive follow-up testing, but never received testing or any post-recovery care. Then, in March 2019, Mr. Mirilashvili asked a prison advisor to write the Otisville warden to seek care for sudden and severe lower back pain, which he self-diagnosed as sciatica. (*See* Exhibit B, Letter of Joel Sickler: "Sciatica is a symptom and not a condition, and is the term given to pain caused by irritation of the sciatic nerve. It is usually caused by a compressed nerve in the lower back, and the most common cause is a herniated disc in the back. Other causes of sciatica include lumbar spinal stenosis (narrowing of the spinal cord), spondylolisthesis (slippage of the disc over the disc below), tumors of the spine, infections

and others.") Despite this request, little testing was performed to attempt to find the source of the sciatica. Mr. Mirilashvili continues to experience chronic pain in this area.

Mr. Mirilashvili's advanced age and frail health present reasons combined with the COVID-19 crisis for the Court to conclude that his current personal history and characteristics favor resentencing under the Section 3553(a) factors. Also, these conditions indicate that Mr. Mirilashvili no longer poses a credible threat to the safety of the public if he were now released to home confinement.

Indeed, the only Section 3553(a) factors that might give pause to this Court as disfavoring resentencing (*i.e.,* deference to the seriousness of the offense conduct and due respect for the law) are largely overcome by the unreasonable threat of death in Mr. Mirilashvili's current conditions of confinement, and that there are conditions of home detention which can still provide a "sufficient but not greater than necessary" sanction of punishment. 18 U.S.C. § 3553(a). Mr. Mirilashvili has served four years in prison at an advanced age, from years 67-71, and under poor health conditions, resulting from Type-II diabetes, coronary-artery disease, a history of chronic smoking, and high blood pressure. As the court noted in *McGraw, infra,* "his sentence has been significantly more laborious than that served by most inmates." *McGraw,* 2019 WL 2059488, at *5.

While conceding that Mr. Mirilashvili's offense conduct was serious and that he still has approximately seven years unserved from his original sentence, the circumstances—since this sentence was initially imposed by this Court—have certainly changed. The government cannot dispute the serious physical danger created by the current pandemic to someone with Mr. Mirilashvili's medical profile. It also cannot guarantee or provide any sense of confidence that this widespread virus will not make its way inside the doors of the federal facility in Otisville. If

the virus spreads inside that prison, and this is not alarmist hyperbole, it likely will kill Mr. Mirilashvili. This Court never intended to impose such a risk at the time of Mr. Mirilashvili's original sentencing.

We propose here that as part of Mr. Mirilashvili's continued punishment in this case that the Court convert the remaining years of his expected term of imprisonment, through October 2027, to strict home detention as a condition of supervised release. In this way, Mr. Mirilashvili continues to face confinement as a measure of due punishment, but without the serious risk to his physical health. The recently amended compassionate release statute, at § 3582(c)(1)(A), authorizes the Court to extend supervised release in this way. *See* 18 U.S.C. § 3582(c)(1)(A) (the court "may impose a term of probation or supervised release with or without conditions that does not exceed the unserved portion of the original term of imprisonment"). Such a prolonged period of home confinement will meet Section 3553(a)'s purpose to give due respect for the law and to acknowledge the seriousness of the offense.

Congress's expansion of the compassionate release statute by § 603(b) of the First Step Act reflects congressional intent for courts to have greater flexibility to reduce sentences when compelling circumstances justify a later review. The title of the amendment, "Increasing the Use and Transparency of Compassionate Release," accentuates that intent. The evolving case law also demonstrates that courts have construed their discretion generously to effectuate Congressional desire to increase the use of the compassionate release statute encouraged by this amendment. Significantly, courts weighing § 3553(a) factors have granted release to defendants with convictions for serious crimes and with histories of violence, finding that changed health circumstances, aging defendants, post-offense rehabilitation, and carefully crafted conditions of supervised release ameliorate public safety concerns.

In *United States v. Bailey,* for example, the defendant was sentenced to 30 years for "an extensive racketeering scheme," including a specific finding that the defendant committed offenses relating to a murder. *Bailey,* No. 94-cr-481 (N.D. Ill. July 24, 2019) (slip op. at 1). The parties agreed that the defendant, who was almost 90 years old and suffered from multiple health issues, had satisfied the statutory requirements for compassionate release. However, the government opposed release under the Section 3553(a) factors due to the "reprehensible nature of the offense." The court acknowledged that the defendant's criminal history and serious offense conduct supported a denial of the requested reduced sentence. But the court weighed the more recent factors in the defendant's favor, including his institutional adjustment, lack of disciplinary infractions, his advanced age, and his release plan, and concluded that they "point in the opposite direction[ ]." *Id.* In weighing these more recent favorable factors over the defendant's past criminal history, the court granted the reduced sentencing request, concluding that release at this stage of the defendant's life would not minimize the severity of the offense and the defendant no longer posed any credible threat to the public. *Id.* at 2.

In a District of Oregon case, the court likewise granted compassionate release to a defendant, who also was serving a 30-year sentence for leading a "major drug conspiracy." *United States v. Spears*, No. 3:98-Cr.-208-SI-22, 2019 WL 5190877, at *4 (D. Or. Oct. 15, 2019). As explained in the court's opinion granting release, the defendant's history included crimes of violence, his performance on supervised release had been poor, and he committed the last serious offense for which he was serving imprisonment when he was in his fifties. *Id.* at *4. Despite these findings, the district court found that the defendant was now 76 years old and suffered from "multiple chronic serious medical conditions and limited life expectancy." *Id.* at *1. Although the government persisted that the defendant remained dangerous, the Court disagreed. The Court

concluded that, in light of the defendant's strong family support, the age of his prior convictions, and his diminished physical condition, "appropriate supervision conditions can mitigate any limited risk" to public safety and provide sufficient specific deterrence. *Id.* at *5.

Similarly, in *United States v. McGraw,* No. 02 Cr. 18 (LJM-CMM), 2019 WL 2059488 (S.D. Ind. May 9, 2019), the court granted compassionate release from the defendant's life sentence for a drug trafficking conspiracy based on the defendant's serious health concerns and diminished ability to provide self-care under commentary note 1(A)(ii) of U.S.S.G. § 1B1.13. The defendant, who was approximately 55 years old at the time of the offense, was 72 years old at the time of the court's release opinion and suffered from limited mobility, diabetes, and chronic kidney disease. *Id.* at *2. The government argued that the defendant remained a danger to the community because of his leadership in a notorious motorcycle gang, noting that he could continue his criminal activity with simple access to a telephone. *Id.* at *4. The court, however, concluded that given the defendant's frail health, his positive record at the institution, and the ability of the court to impose conditions that would reasonable assure the safety of the community upon release, the more flexible compassionate release statute, as amended by the First Step Act, favored granting the defendant's motion. *Id.* With respect to the Section 3553(a) factors, the court concluded that the "significant sanction" the defendant had already served was sufficient:

> But further incarceration is not needed to deter Mr. McGraw from further offenses; nor for reasons described above, is it necessary to protect the public from future crimes. Finally, Mr. McGraw has served much of his sentence while seriously ill and in physical discomfort. This means that his sentence has been significantly more laborious than that served by most inmates. It also means that further incarceration in his condition would be greater than necessary to serve the purposes of punishment set forth in § 3553(a)(2).

Id. at *5. The court imposed lifetime supervision to "continue to serve as a sanction and general deterrent, appropriately recognizing the seriousness of Mr. McGraw's conduct." *Id.* at *4.

As amplified in the cited cases above, release of an aged and infirm Mr. Mirilashvili under the current extraordinary and compelling circumstances of the threat of a novel contagion contaminating the prison would not serve to diminish the seriousness of the offense of conviction, but would fulfill Congress's intent in offering courts greater flexibility to reduce sentences when changed circumstances justify a later review. Mr. Mirilashvili's pre-existing health conditions, his age, and the rapidly advancing COVID-19 outbreak, together with the prison's inflexibility to give Mr. Mirilashvili the ability to take self-care measures directed by the CDC to remain safe during the outbreak, warrant a reduced sentence in his case.

CONCLUSION

For the foregoing reasons, Mr. Mirilashvili respectfully requests that the Court grant a reduction in his sentence to time served with an extended period of supervised release of seven years (to cover the unserved portion of his prison term), with a condition of home confinement.

Dated: March 26, 2020
New York, New York

Respectfully submitted,

/S/

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EXHIBIT A

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

EXHIBIT A

CURRICULUM VITAE

Date of Revision:	November 20, 2019
Name:	Jaimie Meyer, MD, MS, FACP
School:	Yale School of Medicine

Education:

BA, Dartmouth College Anthropology 2000
MD, University of Connecticut School of Medicine 2005
MS, Yale School of Public Health Biostatistics and Epidemiology 2014

Career/Academic Appointments:

2005 - 2008	Residency, Internal Medicine, NY Presbyterian Hospital at Columbia, New York, NY
2008 - 2011	Fellowship, Infectious Diseases, Yale University School of Medicine, New Haven, CT
2008 - 2012	Clinical Fellow, Infectious Diseases, Yale School of Medicine, New Haven, CT
2010 - 2012	Fellowship, Interdisciplinary HIV Prevention, Center for Interdisciplinary Research on AIDS, New Haven, CT
2012 - 2014	Instructor, AIDS, Yale School of Medicine, New Haven, CT
2014 - present	Assistant Professor, AIDS, Yale School of Medicine, New Haven, CT
2015 - 2018	Assistant Clinical Professor, Nursing, Yale School of Medicine, New Haven, CT

Board Certification:

AB of Internal Medicine, Internal Medicine, 08-2008, 01-2019
AB of Internal Medicine, Infectious Disease, 10-2010
AB of Preventive Medicine, Addiction Medicine, 01-2018

Professional Honors & Recognition:

International/National/Regional

2018	NIH Center for Scientific Review, Selected as Early Career Reviewer
2017	Doris Duke Charitable Foundation, Doris Duke Charitable Foundation Scholar
2016	American College of Physicians, Fellow
2016	NIH Health Disparities, Loan Repayment Award Competitive Renewal
2016	AAMC, Early Career Women Faculty Professional Development Seminar
2014	NIH Health Disparities, Loan Repayment Program Award
2014	NIDA, Women & Sex/Gender Differences Junior Investigator Travel Award
2014	International Women's/Children's Health & Gender Working Group, Travel Award
2014	Patterson Trust, Awards Program in Clinical Research
2013	Connecticut Infectious Disease Society, Thornton Award for Clinical Research
2011	Bristol Myers-Squibb, Virology Fellows Award

2006	NY Columbia Presbyterian, John N. Loeb Intern Award
2005	American Medical Women's Association, Medical Student Citation
2005	Connecticut State Medical Society, Medical Student Award
2000	Dartmouth College, Hannah Croasdale Senior Award
2000	Dartmouth College, Palaeopitus Senior Leadership Society Inductee

Yale University

2014	Women's Faculty Forum, Public Voices Thought Leadership Program Fellow

Grants/Clinical Trials History:

Current Grants

Agency:	Center for Interdisciplinary Research on AIDS (CIRA)
I.D.#:	2019-20 Pilot Project Awards
Title:	Optimizing PrEP's Potential in Non-Clinical Settings: Development and Evaluation of a PrEP Decision Aid for Women Seeking Domestic Violence Services
P.I.:	Tiara Willie
Role:	Principal Investigator
Percent effort:	2%
Direct costs per year:	$29,993.00
Total costs for project period:	$29,993.00
Project period:	7/11/2019 - 7/10/2020

Agency:	SAMHSA
I.D.#:	H79 TI080561
Title:	CHANGE: Comprehensive Housing and Addiction Management Network for Greater New Haven
Role:	Principal Investigator
Percent effort:	20%
Direct costs per year:	$389,054.00
Total costs for project period:	$1,933,368.00
Project period:	11/30/2018 - 11/29/2023

Agency:	Gilead Sciences, Inc.
I.D.#:	Investigator Sponsored Award, CO-US-276-D136
Title:	Delivering HIV Pre-Exposure Prophylaxis to Networks of Justice-Involved Women
Role:	Principal Investigator
Percent effort:	8%
Direct costs per year:	$81,151.00
Total costs for project	

period:	$306,199.00
Project period:	6/19/2018 - 1/31/2020
Agency:	NIDA
I.D.#:	R21 DA042702
Title:	Prisons, Drug Injection and the HIV Risk Environment
Role:	Principal Investigator
Percent effort:	22%
Direct costs per year:	$129,673.00
Total costs for project period:	$358,276.00
Project period:	8/1/2017 - 7/31/2020
Agency:	Doris Duke Charitable Foundation
I.D.#:	Clinical Scientist Development Award
Title:	Developing and Testing the Effect of a Patient-Centered HIV Prevention Decision Aid on PrEP uptake for Women with Substance Use in Treatment Settings
Role:	Principal Investigator
Percent effort:	27%
Direct costs per year:	$149,959.00
Total costs for project period:	$493,965.00
Project period:	7/1/2017 - 6/30/2020

Past Grants

Agency:	NIDA
I.D.#:	K23 DA033858
Title:	Evaluating and Improving HIV Outcomes in Community-based Women who Interface with the Criminal Justice System
Role:	Principal Investigator
Percent effort:	75%
Direct costs per year:	$149,509.00
Total costs for project period:	$821,147.00
Project period:	7/1/2012 - 11/30/2017
Agency:	Robert Leet & Clara Guthrie Patterson Trust
I.D.#:	R12225, Award in Clinical Research
Title:	Disentangling the Effect of Gender on HIV Treatment and Criminal Justice Outcomes
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$75,000.00

Total costs for project period:	$75,000.00
Project period:	1/31/2014 - 10/31/2015
Agency:	Bristol-Myers Squibb
I.D.#:	HIV Virology Fellowship Award
Title:	Effect of newer antiretroviral regimens on HIV biological outcomes in HIV-infected prisoners: a 13 year retrospective evaluation
Role:	Principal Investigator
Percent effort:	10%
Direct costs per year:	$34,390.00
Total costs for project period:	$34,390.00
Project period:	12/1/2011 - 11/30/2012

Pending Grants

Agency:	NIMH
I.D.#:	R01 MH121991
Title:	Identifying Modifiable Risk and Protective Processes at the Day-Level that Predict HIV Care Outcomes among Women Exposed to Partner Violence
P.I.:	Sullivan, Tami
Role:	Principal Investigator
Percent effort:	30%
Direct costs per year:	$499,755.00
Total costs for project period:	$4,148,823.00
Project period:	1/1/2020 - 12/31/2024

Invited Speaking Engagements, Presentations, Symposia & Workshops Not Affiliated With Yale:

International/National

2019: CME Outfitters, Washington, DC. "A Grassroots Approach to Weed out HIV and HCV in Special OUD Populations"

2019: US Commission on Civil Rights, Washington, DC. "An Analysis of Women's Health, Personal Dignity and Sexual Abuse in the US Prison System"

2018: College of Problems on Drug Dependence, College of Problems on Drug Dependence, San Diego, CA. "Research on Women who Use Drugs: Knowledge and Implementation Gaps and A Proposed Research Agenda"

2018: Clinical Care Options, Washington, DC. "Intersection of the HIV and Opioid Epidemics"

2016: Dartmouth Geisel School of Medicine, Hanover, NH. "Incarceration as Opportunity: Prisoner Health and Health Interventions"

2010: Rhode Island Chapter of the Association of Nurses in AIDS Care, Providence, RI. "HIV and Addiction"

Regional

2018: Clinical Directors Network, New York, NY. "PrEP Awareness among Special Populations of Women and People who Use Drugs"

2018: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "HIV prevention for justice-involved women"

2017: Clinical Directors Network, New York, NY. "Optimizing the HIV Care Continuum for People who use Drugs"

2016: Frank H. Netter School of Medicine, Quinnipiac University, Hamden, CT. "Topics in Infectious Diseases"

2016: Connecticut Advanced Practice Registered Nurse Society, Wethersfield, CT. "Trends in HIV Prevention: Integration of Biomedical and Behavioral Approaches"

Peer-Reviewed Presentations & Symposia Given at Meetings Not Affiliated With Yale:

International/National

2019: CPDD 81st Annual Scientific Meeting, CPDD, San Antonio, TX. "Punitive approaches to pregnant women with opioid use disorder: Impact on health care utilization, outcomes and ethical implications"

2019: 14th International Conference on HIV Treatment and Prevention Adherence, IAPAC Adherence, Miami, FL. "Decision-Making about HIV Prevention among Women in Drug Treatment: Is PrEP Contextually Relevant?"

2019: 2019 NIDA International Forum, NIDA, San Antonio, TX. "Diphenhydramine Injection in Kyrgyz Prisons: A Qualitative Study Of A High-Risk Behavior With Implications For Harm Reduction"

2019: 11th International Women's and Children's Health and Gender (InWomen's) Group, InWomen's Group, San Antonio, TX. "Uniquely successful implementation of methadone treatment in a women's prison in Kyrgyzstan"

2019: Harm Reduction International, Porto, Porto District, Portugal. "How does methadone treatment travel? On the 'becoming-methadone-body' of Kyrgyzstan prisons"

2019: APA Collaborative Perspectives on Addiction Annual Meeting, APA Collaborative Perspectives on Addiction Annual Meeting, Providence, RI. "Impact of Trauma and Substance Abuse on HIV PrEP Outcomes among Women in Criminal Justice Systems. Symposium: "Partner Violence: Intersected with or Predictive of Substance Use and Health Problems among Women.""

2019: Society for Academic Emergency Medicine (SAEM), Worcester, MA. "Effects of a Multisite Medical Home Intervention on Emergency Department Use among Unstably Housed People with Human Immunodeficiency Virus"

2019: Conference on Retroviruses and Opportunistic Infections (CROI), IAS, Seattle, WA. "Released to Die: Elevated Mortality in People with HIV after Incarceration"

2019: 12th Academic and Health Policy on Conference on Correctional Health, 12th Academic and Health Policy on Conference on Correctional Health, Las Vegas, NV. "PrEP Eligibility and HIV Risk Perception for Women across the Criminal Justice Continuum in Connecticut"

2019: Association for Justice-Involved Female Organizations (AJFO), Atlanta, GA. "Treatment of Women's Substance Use Disorders and HIV Prevention During and Following Incarceration"

2018: American Public Health Association (APHA) Annual Meeting, American Public Health Association (APHA) Annual Meeting, San Diego, CA. "New Haven Syringe Service Program: A model of integrated harm reduction and health care services"

2018: 12th National Harm Reduction Conference, 12th National Harm Reduction Conference, New Orleans, LA. "Service needs and access to care among participants in the New Haven Syringe Services Program"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "HIV risk perceptions and risk reduction strategies among prisoners in Kyrgyzstan: a qualitative study"

2018: 22nd International AIDS Conference, 22nd International AIDS Conference, Amsterdam, NH, Netherlands. "Methadone Maintenance Therapy Uptake, Retention, and Linkage for People who Inject Drugs Transitioning From Prison to the Community in Kyrgyzstan: Evaluation of a National Program"

2018: NIDA International Forum, NIDA, San Diego, CA. "HIV and Drug Use among Women in Prison in Azerbaijan, Kyrgyzstan and Ukraine"

2018: 2018 Conference on Retroviruses and Opportunistic Infections (CROI), CROI, Boston, MA. "From prison's gate to death's door: Survival analysis of released prisoners with HIV"

2018: 11th Academic and Health Policy on Conference on Correctional Health, Academic Consortium on Criminal Justice Health, Houston, TX. "Assessing Concurrent Validity of Criminogenic and Health Risk Instruments among Women on Probation in Connecticut"

2017: IDWeek: Annual Meeting of Infectious Diseases Society of America, Infectious Diseases Society of America, San Diego, CA. "Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons (Oral presentation)"

2017: International AIDS Society (IAS) Meeting, International AIDS Society, Paris, Île-de-France, France. "Late breaker: Predictors of Linkage to and Retention in HIV Care Following Release from Connecticut, USA Jails and Prisons"

2017: NIDA International Forum, NIDA, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "Assessing Receptiveness to and Eligibility for PrEP in Criminal Justice-Involved Women"

2017: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Montreal, QC, Canada. "A Mixed Methods Evaluation of HIV Risk among Women with Opioid Dependence in Ukraine"

2017: Annual Meeting of the Society for Applied Anthropology, Society for Applied Anthropology, Santa Fe, NM. "Where rubbers meet the road: HIV risk reduction for women on probation (Oral presentation)"

2016: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Palm Springs, CA. "An Event-level Examination of Successful Condom Negotiation Strategies among College Women"

2015: CDC National HIV Prevention Conference, CDC, Atlanta, GA. "Beyond the Syndemic: Condom Negotiation and Use among Women Experiencing Partner Violence (Oral presentation)"

2015: International Harm Reduction Conference, International Harm Reduction, Kuala Lumpur, Federal Territory of Kuala Lumpur, Malaysia. "Evidence-Based Interventions to Enhance Assessment, Treatment, and Adherence in the Chronic Hepatitis C Care Continuum"

2015: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, Phoenix, AZ. "Violence, Substance Use, and Sexual Risk among College Women"

2014: International Women's and Children's Health and Gender Working Group, International Women's and Children's Health and Gender Working Group, San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: College on Problems in Drug Dependence (CPDD), College on Problems in Drug Dependence (CPDD), San Juan, San Juan, Puerto Rico. "Gender Differences in HIV and Criminal Justice Outcomes"

2014: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Boston, MA. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: HIV Intervention and Implementation Science Meeting, HIV Intervention and Implementation Science Meeting, Bethesda, MD. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2013: Conference on Retroviruses and Opportunistic Infections (CROI), Conference on Retroviruses and Opportunistic Infections (CROI), Atlanta, GA. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Correlates of Retention in HIV Care after Release from Jail: Results from a Multi-site Study"

2012: IDWeek: Infectious Diseases Society of America Annual Meeting, Infectious Diseases Society of America, San Diego, CA. "Frequent Emergency Department Use among Released Prisoners with HIV: Characterization Including a Novel Multimorbidity Index"

2012: 5th Academic and Health Policy Conference on Correctional Health, 5th Academic and Health Policy Conference on Correctional Health, Atlanta, GA. "Effects of Intimate Partner Violence on HIV and Substance Abuse in Released Jail Detainees"

2011: IAPAC HIV Treatment and Adherence Conference, IAPAC, Miami, FL. "Adherence to HIV treatment and care among previously homeless jail detainees"

Regional

2019: Connecticut Infectious Disease Society, New Haven, CT. "Preliminary Findings from a Novel PrEP Demonstration Project for Women Involved in Criminal Justice Systems and Members of their Risk Networks"

2017: Connecticut Public Health Association Annual Conference, Connecticut Public Health Association, Farmington, CT. "The New Haven syringe services program"

2014: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Longitudinal Treatment Outcomes in HIV-Infected Prisoners and Influence of Re-Incarceration"

2013: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Women Released from Jail Experience Suboptimal HIV Treatment Outcomes Compared to Men: Results from a Multi-Center Study"

2011: Connecticut Infectious Disease Society Annual Meeting, Connecticut Infectious Disease Society, Orange, CT. "Emergency Department Use by Released Prisoners with HIV"

Professional Service:

Peer Review Groups/Grant Study Sections

2019 - present Reviewer, NIDA, NIH Reviewer: RFA-DA-19-025: HEAL Initiative: Justice Community Opioid Innovation Network (JCOIN) Clinical Research Centers

2019 - present Reviewer, Yale DCFAR Pilot Projects

2018 - present Reviewer, Center for Interdisciplinary Research on AIDS (CIRA)

2015 - present Reviewer, University of Wisconsin-Milwaukee Research Growth Initiative

Advisory Boards

2017 Advisor, HIV Prevention and Treatment in Cis-Gendered Women, Gilead Sciences, Inc.

Journal Service

Editor/Associate Editor

2019 - present Associate Editor, Journal of the International Association of Providers of AIDS Care (JIAPAC), Section Editor: Sex and Gender Issues

Reviewer

2019 - present Reviewer, JAIDS

2012 - present Reviewer, Addiction Sci and Clin Pract

2012 - present Reviewer, Addictive Behav Reports

2012 - present Reviewer, AIDS Care

2012 - present Reviewer, Social Science and Medicine

2012 - present Reviewer, SpringerPlus

2012 - present Reviewer, Substance Abuse Treatment Prevention and Policy

2012 - present Reviewer, Women's Health Issues

2012 - present Reviewer, Yale Journal of Biology and Medicine

2012 - present Reviewer, AIMS Public Health

2012 - present Reviewer, American Journal on Addictions

2012 - present Reviewer, American Journal of Epidemiology

2012 - present Reviewer, American Journal of Public Health

2012 - present Reviewer, Annals Internal Medicine

2012 - present Reviewer, BMC Emergency Medicine

2012 - present Reviewer, BMC Infectious Diseases

2012 - present Reviewer, BMC Public Health

2012 - present Reviewer, BMC Women's Health

2012 - present	Reviewer, Clinical Infectious Diseases
2012 - present	Reviewer, Critical Public Health
2012 - present	Reviewer, Drug and Alcohol Dependence
2012 - present	Reviewer, Drug and Alcohol Review
2012 - present	Reviewer, Epidemiologic Reviews
2012 - present	Reviewer, Eurosurveillance
2012 - present	Reviewer, Health and Justice (Springer Open)
2012 - present	Reviewer, International Journal of Drug Policy
2012 - present	Reviewer, International Journal of Prisoner Health
2012 - present	Reviewer, International Journal of STDs and AIDS
2012 - present	Reviewer, International Journal of Women's Health
2012 - present	Reviewer, JAMA Internal Medicine
2012 - present	Reviewer, Journal of Family Violence
2012 - present	Reviewer, Journal of General Internal Medicine
2012 - present	Reviewer, Journal of Immigrant and Minority Health
2012 - present	Reviewer, Journal of International AIDS Society
2012 - present	Reviewer, Journal of Psychoactive Drugs
2012 - present	Reviewer, Journal of Urban Health
2012 - present	Reviewer, Journal of Women's Health
2012 - present	Reviewer, Open Forum Infectious Diseases
2012 - present	Reviewer, PLoS ONE
2012 - present	Reviewer, Public Health Reports

Professional Service for Professional Organizations

AAMC Group on Women in Medicine and Science (GWIMS)

2016 - present	Member, AAMC Group on Women in Medicine and Science (GWIMS)

American College of Physicians

2016 - present	Fellow, American College of Physicians
2013 - 2016	Member, American College of Physicians

American Medical Association

2005 - present	Member, American Medical Association

American Medical Women's Association

2011 - present	Member, American Medical Women's Association

American Society of Addiction Medicine

2009 - present	Member, American Society of Addiction Medicine

Connecticut Infectious Disease Society

2011 - present Member, Connecticut Infectious Disease Society

Infectious Disease Society of America

2008 - present Member, Infectious Disease Society of America

InWomen's Network, NIDA International Program

2013 - present Member, InWomen's Network, NIDA International Program

New York State Medical Society

2005 - 2008 Member, New York State Medical Society

Yale University Service

University Committees

2016 - 2018 Council Member, Leadership Council, Women's Faculty Forum

Medical School Committees

2015 - 2016 Committee Member, US Health and Justice Course, Yale School of Medicine

2014 - present Committee Member, Yale Internal Medicine Traditional Residency Intern Selection Committee

Public Service

2019 - present Faculty Member, Yale University Program in Addiction Medicine

2017 - present Faculty Member, Arthur Liman Center for Public Interest Law, Yale Law School

2013 - present Mentor, Women in Medicine at Yale Mentoring Program

2012 - present Faculty Member, Yale Center for Interdisciplinary Research on AIDS

2009 - 2011 Instructor, Preclinical Clerkship Tutor, Yale School of Medicine

2002 Fellow, Soros Open Society Institute

1998 - 1999 Fellow, Costa Rican Humanitarian Foundation

Bibliography:

Peer-Reviewed Original Research

1. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Emergency department use by released prisoners with HIV: an observational longitudinal study. PloS One 2012, 7:e42416.
2. Chen NE, **Meyer JP**, Bollinger R, Page KR. HIV testing behaviors among Latinos in Baltimore City. Journal Of Immigrant And Minority Health / Center For Minority Public Health 2012, 14:540-51.
3. Chitsaz E, **Meyer JP**, Krishnan A, Springer SA, Marcus R, Zaller N, Jordan AO, Lincoln T, Flanigan TP, Porterfield J, Altice FL. Contribution of substance use disorders on HIV treatment outcomes and antiretroviral medication adherence among HIV-infected persons entering jail. AIDS And Behavior 2013, 17 Suppl 2:S118-27.

4. Chen NE, **Meyer JP**, Avery AK, Draine J, Flanigan TP, Lincoln T, Spaulding AC, Springer SA, Altice FL. Adherence to HIV treatment and care among previously homeless jail detainees. AIDS And Behavior 2013, 17:2654-66.
5. Althoff AL, Zelenev A, **Meyer JP**, Fu J, Brown SE, Vagenas P, Avery AK, Cruzado-Quiñones J, Spaulding AC, Altice FL. Correlates of retention in HIV care after release from jail: results from a multi-site study. AIDS And Behavior 2013, 17 Suppl 2:S156-70.
6. Williams CT, Kim S, **Meyer J**, Spaulding A, Teixeira P, Avery A, Moore K, Altice F, Murphy-Swallow D, Simon D, Wickersham J, Ouellet LJ. Gender differences in baseline health, needs at release, and predictors of care engagement among HIV-positive clients leaving jail. AIDS And Behavior 2013, 17 Suppl 2:S195-202.
7. **Meyer JP**, Wickersham JA, Fu JJ, Brown SE, Sullivan TP, Springer SA, Altice FL. Partner violence and health among HIV-infected jail detainees. International Journal Of Prisoner Health 2013, 9:124-41.
8. **Meyer JP**, Qiu J, Chen NE, Larkin GL, Altice FL. Frequent emergency department use among released prisoners with human immunodeficiency virus: characterization including a novel multimorbidity index. Academic Emergency Medicine : Official Journal Of The Society For Academic Emergency Medicine 2013, 20:79-88.
9. **Meyer JP**, Cepeda J, Springer SA, Wu J, Trestman RL, Altice FL. HIV in people reincarcerated in Connecticut prisons and jails: an observational cohort study. The Lancet. HIV 2014, 1:e77-e84.
10. **Meyer JP**, Zelenev A, Wickersham JA, Williams CT, Teixeira PA, Altice FL. Gender disparities in HIV treatment outcomes following release from jail: results from a multicenter study. American Journal Of Public Health 2014, 104:434-41.
11. **Meyer JP**, Cepeda J, Wu J, Trestman RL, Altice FL, Springer SA. Optimization of human immunodeficiency virus treatment during incarceration: viral suppression at the prison gate. JAMA Internal Medicine 2014, 174:721-9.
12. **Meyer JP**, Cepeda J, Taxman FS, Altice FL. Sex-Related Disparities in Criminal Justice and HIV Treatment Outcomes: A Retrospective Cohort Study of HIV-Infected Inmates. American Journal Of Public Health 2015, 105:1901-10.
13. Boyd AT, Song DL, **Meyer JP**, Altice FL. Emergency department use among HIV-infected released jail detainees. Journal Of Urban Health : Bulletin Of The New York Academy Of Medicine 2015, 92:108-35.
14. Shrestha R, Karki P, Altice FL, Huedo-Medina TB, **Meyer JP**, Madden L, Copenhaver M. Correlates of willingness to initiate pre-exposure prophylaxis and anticipation of practicing safer drug- and sex-related behaviors among high-risk drug users on methadone treatment. Drug And Alcohol Dependence 2017, 173:107-116.
15. Peasant C, Sullivan TP, Weiss NH, Martinez I, **Meyer JP**. Beyond the syndemic: condom negotiation and use among women experiencing partner violence. AIDS Care 2017, 29:516-523.
16. Wickersham JA, Gibson BA, Bazazi AR, Pillai V, Pedersen CJ, **Meyer JP**, El-Bassel N, Mayer KH, Kamarulzaman A, Altice FL. Prevalence of Human Immunodeficiency Virus and Sexually Transmitted Infections Among Cisgender and Transgender Women Sex Workers in Greater Kuala Lumpur, Malaysia: Results From a Respondent-Driven Sampling Study. Sexually Transmitted Diseases 2017, 44:663-670.
17. Hoff E, Marcus R, Bojko MJ, Makarenko I, Mazhnaya A, Altice FL, **Meyer JP**. The effects of opioid-agonist treatments on HIV risk and social stability: A mixed methods study of women with opioid use disorder in Ukraine. Journal Of Substance Abuse Treatment 2017, 83:36-44.

18. Rutledge R, Madden L, Ogbuagu O, **Meyer JP**. HIV Risk perception and eligibility for pre-exposure prophylaxis in women involved in the criminal justice system. AIDS Care 2018, 30:1282-1289.
19. Peasant C, Sullivan TP, Ritchwood TD, Parra GR, Weiss NH, **Meyer JP**, Murphy JG. Words can hurt: The effects of physical and psychological partner violence on condom negotiation and condom use among young women. Women & Health 2018, 58:483-497.
20. Loeliger KB, Altice FL, Desai MM, Ciarleglio MM, Gallagher C, **Meyer JP**. Predictors of linkage to HIV care and viral suppression after release from jails and prisons: a retrospective cohort study. The Lancet. HIV 2018, 5:e96-e106.
21. Odio CD, Carroll M, Glass S, Bauman A, Taxman FS, **Meyer JP**. Evaluating concurrent validity of criminal justice and clinical assessments among women on probation. Health & Justice 2018, 6:7.
22. Loeliger KB, Altice FL, Ciarleglio MM, Rich KM, Chandra DK, Gallagher C, Desai MM, **Meyer JP**. All-cause mortality among people with HIV released from an integrated system of jails and prisons in Connecticut, USA, 2007-14: a retrospective observational cohort study. The Lancet. HIV 2018, 5:e617-e628.
23. Loeliger KB, **Meyer JP**, Desai MM, Ciarleglio MM, Gallagher C, Altice FL. Retention in HIV care during the 3 years following release from incarceration: A cohort study. PLoS Medicine 2018, 15:e1002667.
24. Azbel L, Wegman MP, Polonsky M, Bachireddy C, **Meyer J**, Shumskaya N, Kurmanalieva A, Dvoryak S, Altice FL. Drug injection within prison in Kyrgyzstan: elevated HIV risk and implications for scaling up opioid agonist treatments. International Journal Of Prisoner Health 2018, 14:175-187.
25. Peasant C, Montanaro EA, Kershaw TS, Parra GR, Weiss NH, **Meyer JP**, Murphy JG, Ritchwood TD, Sullivan TP. An event-level examination of successful condom negotiation strategies among young women. Journal Of Health Psychology 2019, 24:898-908.
26. Ranjit YS, Azbel L, Krishnan A, Altice FL, **Meyer JP**. Evaluation of HIV risk and outcomes in a nationally representative sample of incarcerated women in Azerbaijan, Kyrgyzstan, and Ukraine. AIDS Care 2019, 31:793-797.
27. Rhodes T, Azbel L, Lancaster K, **Meyer J**. The becoming-methadone-body: on the onto-politics of health intervention translations. Sociology Of Health & Illness 2019, 41:1618-1636.
28. Olson B, Vincent W, **Meyer JP**, Kershaw T, Sikkema KJ, Heckman TG, Hansen NB. Depressive symptoms, physical symptoms, and health-related quality of life among older adults with HIV. Quality Of Life Research : An International Journal Of Quality Of Life Aspects Of Treatment, Care And Rehabilitation 2019.

Chapters, Books, and Reviews

29. Azar MM, Springer SA, **Meyer JP**, Altice FL. A systematic review of the impact of alcohol use disorders on HIV treatment outcomes, adherence to antiretroviral therapy and health care utilization. Drug And Alcohol Dependence 2010, 112:178-93.
30. **Meyer JP**, Springer SA, Altice FL. Substance abuse, violence, and HIV in women: a literature review of the syndemic. Journal Of Women's Health (2002) 2011, 20:991-1006.
31. **Meyer JP**, Chen NE, Springer SA. HIV Treatment in the Criminal Justice System: Critical Knowledge and Intervention Gaps. AIDS Research And Treatment 2011, 2011:680617.
32. Springer SA, Spaulding AC, **Meyer JP**, Altice FL. Public health implications for adequate transitional care for HIV-infected prisoners: five essential components. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2011, 53:469-79.

33. Chen NE, **Meyer JP**, Springer SA. Advances in the prevention of heterosexual transmission of HIV/AIDS among women in the United States. Infectious Disease Reports 2011, 3.
34. **Meyer J**, Altice F. HIV in Injection and Other Drug Users. Somesh Gupta, Bhushan Kumar, eds. Sexually Transmitted Infections 2nd ed. New Delhi, India: Elsevier, 2012: 1061-80. ISBN 978-81-312-2809-8.
35. **Meyer JP**, Althoff AL, Altice FL. Optimizing care for HIV-infected people who use drugs: evidence-based approaches to overcoming healthcare disparities. Clinical Infectious Diseases : An Official Publication Of The Infectious Diseases Society Of America 2013, 57:1309-17.
36. **Meyer J**, Altice F. Chapter 47, Treatment of Addictions: Transition to the Community. Robert L. Trestman, Kenneth L. Appelbaum, Jeffrey L. Metzner, eds. Oxford Textbook of Correctional Psychiatry (Winner of the 2016 Guttmacher Award). Oxford University Press 2015. ISBN 9780199360574.
37. **Meyer JP**, Moghimi Y, Marcus R, Lim JK, Litwin AH, Altice FL. Evidence-based interventions to enhance assessment, treatment, and adherence in the chronic Hepatitis C care continuum. The International Journal On Drug Policy 2015, 26:922-35.
38. Mohareb A, Tiberio P, Mandimika C, Muthulingam D, **Meyer J**. Infectious Diseases in Underserved Populations. Onyema Ogbuagu, Gerald Friedland, Merceditas Villanueva, Marjorie Golden, eds. Current Diagnosis and Treatment- Infectious Diseases. McGraw-Hill Medical 2016.
39. **Meyer JP**, Womack JA, Gibson B. Beyond the Pap Smear: Gender-responsive HIV Care for Women. The Yale Journal Of Biology And Medicine 2016, 89:193-203.
40. **Meyer JP**, Muthulingam D, El-Bassel N, Altice FL. Leveraging the U.S. Criminal Justice System to Access Women for HIV Interventions. AIDS And Behavior 2017, 21:3527-3548.
41. Shrestha R, McCoy-Redd B, **Meyer J**. Pre-Exposure Prophylaxis (PrEP) for People Who Inject Drugs (PWID). Brianna Norton, Ed. The Opioid Epidemic and Infectious Diseases. Elsevier 2019.
42. **Meyer JP**, Isaacs K, El-Shahawy O, Burlew AK, Wechsberg W. Research on women with substance use disorders: Reviewing progress and developing a research and implementation roadmap. Drug And Alcohol Dependence 2019, 197:158-163.

Peer-Reviewed Educational Materials

43. The Fortune Society Reentry Education Project Detailing Kit. New York City Department of Health and Mental Hygiene. October 2014
44. United Nations Office on Drugs and Crime. Vienna, Austria

Invited Editorials and Commentaries

45. **Meyer JP**. Capsule Commentary on Pyra et al., sexual minority status and violence among HIV infected and at-risk women. Journal Of General Internal Medicine 2014, 29:1164.
46. Brinkley-Rubinstein L, Dauria E, Tolou-Shams M, Christopoulos K, Chan PA, Beckwith CG, Parker S, **Meyer J**. The Path to Implementation of HIV Pre-exposure Prophylaxis for People Involved in Criminal Justice Systems. Current HIV/AIDS Reports 2018, 15:93-95.
47. **Meyer JP**. The Sustained Harmful Health Effects of Incarceration for Women Living with HIV. Journal Of Women's Health (2002) 2019, 28:1017-1018.

Case Reports, Technical Notes, Letters

48. **Paul J.** Bullous pemphigoid in a patient with psoriasis and possible drug reaction: a case report. Connecticut Medicine 2004, 68:611-5.
49. How J, Azar MM, **Meyer JP**. Are Nectarines to Blame? A Case Report and Literature Review of Spontaneous Bacterial Peritonitis Due to Listeria monocytogenes. Connecticut Medicine 2015, 79:31-6.
50. Vazquez Guillamet LJ, Malinis MF, **Meyer JP**. Emerging role of Actinomyces meyeri in brain abscesses: A case report and literature review. IDCases 2017, 10:26-29.
51. Harada K, Heaton H, Chen J, Vazquez M, **Meyer J**. Zoster vaccine-associated primary varicella infection in an immunocompetent host. BMJ Case Reports 2017, 2017.
52. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Answer to December 2017 Photo Quiz. Journal Of Clinical Microbiology 2017, 55:3568.
53. Bernardo R, Streiter S, Tiberio P, Rodwin BA, Mohareb A, Ogbuagu O, Emu B, **Meyer JP**. Photo Quiz: Peripheral Blood Smear in a Ugandan Refugee. Journal Of Clinical Microbiology 2017, 55:3313-3314.

Scholarship In Press

54. Hoff E, Adams Z, Dasgupta A, Goddard D, Sheth S, **Meyer J.** Reproductive Health Justice and Autonomy: A systematic review of pregnancy planning intentions, needs, and interventions among women involved in US criminal justice systems. J Women's Health

EXHIBIT B

Justice Advocacy Group LLC

Joel A. Sickler
Founder

March 15, 2019

Warden J. Petrucci
FCI Otisville
2 Mile Drive
Otisville, New York 10963

RE: Moshe Mirilashvili; Reg. No. 71770-054

Warden Petrucci:

My name is Joel Silver and I am a criminologist and founder of the Justice Advocacy Group. Due to the medical nature of this letter, I have asked our medical consultant to opine.

Moshe Mirilashvili is a 71-year old inmate with a history of Diabetes Mellitus II, Hypercholesterolemia, Hypertension, Coronary Artery Disease, and Rheumatoid Arthritis. He is currently taking Glyburide, Metformin, Hydrochlorthiazide, and Lipazol.

We were notified by family that Dr. Mirilashvili has been suffering from apparent sciatica for the past several weeks. The pain has been unsuccessfully treated with over-the-counter medications and on March 13th, he was given "some type of injection which made it worse."

Sciatica is a symptom and not a condition, and is the term given to pain caused by irritation of the sciatic nerve. It is usually caused by a compressed nerve in the lower back, and the most common cause is a herniated disc in the back. Other causes of sciatica include lumbar spinal stenosis (narrowing of the spinal cord), spondylolisthesis (slippage of the disc over the disc below), tumors of the spine, infections and others.

Due to the nature of the function of the various nerves that comprise the sciatic nerve, including bowel and bladder function and the ability to walk, it is often necessary to attempt to diagnosis the cause of the pain. This is usually done by obtaining plain x-rays, followed by a specialized x-ray called an MRI. In addition, neurologists often include nerve conduction studies such as an Electomyogram (EMG).

Once diagnosed, treatment can be addressed to the cause of the condition. Various therapies include pain medication (ranging from an NSAID like Advil, codeine preparation, steroids, or antidepressants such as Duloxetine), physical therapy, steroid injections into the affected disc, or perhaps surgery. As stated above, he has unsuccessfully tried OTC medications such as Ibuprofen.

We appreciate the care you give the men at your institution and would request the medical staff to further assess Inmate Mirilashvili's status and give him the therapy he needs based upon their evaluation.

Sincerely,

Joel A. Sickler

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Joel A. Sickler

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