IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF ARKANSAS

CENTRAL DIVISION

JASON MATTHEW LYNCH, Reg. No. 07405-510
Plaintiff,

v.

DOES, et al.,
Defendants.

Case No. 4:24-cv-00740-LPR-BBM

PLAINTIFF'S MOTION FOR RE-REVIEW AND FULL CONSIDERATION OF DOCKET ENTRIES 31 AND 57, AND REQUEST TO DEFER DISMISSAL OR ALTERNATIVELY TO ALLOW POST-DISCOVERY AMENDMENT

Plaintiff Jason Matthew Lynch, proceeding pro se and in forma pauperis, respectfully moves this Honorable Court to re-review and give full consideration to Docket Entries 31 and 57, which were timely submitted in support of Plaintiff's Third Amended Complaint ("TAC"). Plaintiff brings this motion pursuant to Federal Rules of Civil Procedure 1, 8, 10, 12(b)(6), 15(a)(2), 15(d), 16, 26, 52, 54(b), 59(e), and 60(b), 28 U.S.C. §§ 1915(e)(2) and 636(b)(1), and the Court's inherent authority to ensure justice and a complete record.

Plaintiff files this motion in good faith out of serious concern that the Court may not have had the opportunity to fully consider the substance and evidentiary relevance of Docket Entries 31 and 57 before recommending or entering dismissal of any claims. These filings are not redundant or immaterial; rather, they are integral supporting briefs and evidentiary proffers directly tied to the factual allegations, constitutional claims, and statutory causes of action pleaded in the TAC.

I. IDENTIFICATION AND IMPORTANCE OF DOCKET ENTRIES 31 AND 57

Docket Entries 31 and 57 collectively include, inter alia:

1. A Memorandum of Law supporting the Third Amended Complaint;

2. A Confidential Medical Legal Report detailing Plaintiff's HIV diagnosis, prescribed antiretroviral therapy (Biktarvy), the prolonged denial and mishandling of that medication, and the resulting medical harm;

3. A Supplemental Brief synthesizing federal constitutional law, § 1983 jurisprudence, and analogous case summaries;

4. A Memorandum of Harm and Damages, explaining physical injury, immunological risk, emotional distress, and long-term medical consequences;

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A Confidential Medical-l egal Report documenting prolonged interruption of prescribed HIV antiretroviral therapy (Biktarvy);

A Supplemental Brief consolidating constitutional and statutory claims;

A Memorandum of Harm and Damages; and

Detailed chronological timelines linking Defendants' acts and omissions to specific injuries.

Plaintiff reasonably fears these materials critical to the Court's understanding of deliberate indifference, discriminatory intent, causation, supervisory liability, municipal policy, and damages may not have been fully considered during screening or in connection with any partial disposition.

Given the egregious, repeated, and medically dangerous nature of the conduct alleged, Plaintiff respectfully prays that the Court re-review these entries before dismissing any claim, defer dismissal until discovery, or, in the alternative, permit amendment after discovery.

II. GOVERNING STANDARDS AND COURT AUTHORITY

A. Authority to Re-Review the Record

Federal courts possess inherent authority to reconsider the record to prevent manifest injustice.
Dietz v. Bouldin, 579 U.S. 40, 45 46 (2016); United States v. Healy, 376 U.S. 75, 80 (1964).

Where a litigant reasonably fears that material submissions may not have been fully evaluated, reconsideration is appropriate.
Arnold v. Wood, 238 F.3d 992, 998 (8th Cir. 2001).

B. Liberal Construction and Screening Obligations

At the §1915(e)(2) and §1915A screening stage, the Court must:

Accept factual allegations as true;

Draw reasonable inferences in the plaintiff's favor; and

Construe pro se pleadings liberally.

Haines v. Kerner, 404 U.S. 519, 520 21 (1972); Stone v. Harry, 364 F.3d 912, 914 (8th Cir. 2004).

III. DOCKET ENTRIES 31 AND 57 ARE MATERIAL TO PLAUSIBILITY

Dismissal under Twombly and Iqbal is improper where supplemental filings supply factual detail supporting plausibility.
Bell Atl. Corp. v. Twombly, 550 U.S. 544 (2007);
Ashcroft v. Iqbal, 556 U.S. 662 (2009).

Here, Docket Entries 31 and 57:

Establish subjective knowledge and reckless disregard (Farmer v. Brennan, 511 U.S. 825 (1994));

Demonstrate medical causation and worsening injury;

Support religious discrimination and retaliation claims;

Identify policy-level failures and customs under Monell v. Dep't of Soc. Servs., 436 U.S. 658 (1978); and

Demonstrate continuity and coordination supporting conspiracy claims under 42 U.S.C. § 1985.

These materials materially supplement the TAC and are integral to a fair screening determination.

IV. HIV ANTIRETROVIRAL THERAPY (ART) INTERRUPTION CASE LAW

Courts uniformly recognize that interruption of HIV antiretroviral therapy constitutes a serious medical risk capable of satisfying the objective and subjective components of deliberate indifference:

Smith v. Carpenter, 316 F.3d 178, 186 87 (2d Cir. 2003);

Brock v. Wright, 315 F.3d 158, 164 (2d Cir. 2003);

De'Lonta v. Johnson, 708 F.3d 520, 525 26 (4th Cir. 2013);

Johnson v. Wright, 412 F.3d 398, 404 (2d Cir. 2005);

Greeno v. Daley, 414 F.3d 645, 654 55 (7th Cir. 2005).

Plaintiff alleges approximately 100 days without prescribed ART, a duration far exceeding periods courts have deemed constitutionally actionable.

V. DISMISSAL PRIOR TO DISCOVERY IS PREMATURE

Where intent, policy, training, or medical decision-making are at issue, dismissal before discovery is disfavored. White v. Smith, 696 F.3d 740, 753 (8th Cir. 2012).

Critical evidence medical policies, medication procurement records, grievance responses, staff communications, and evidence of similar incidents remains exclusively within Defendants' control.

Premature dismissal would frustrate the remedial purpose of 42 U.S.C. § 1983. Gomez v. Toledo, 446 U.S. 635, 641 (1980).

VI. RULE 59(e) AND RULE 60(b) ALTERNATIVE RELIEF

To the extent any dismissal or partial disposition has issued or may issue, Plaintiff alternatively seeks relief under:

Rule 59(e), to correct clear error or prevent manifest injustice; and/or

Rule 60(b)(1) and (6), for mistake, oversight, or extraordinary circumstances.

Failure to consider material docketed submissions constitutes grounds for such relief.

United States v. Metro. St. Louis Sewer Dist., 440 F.3d 930, 933 (8th Cir. 2006).

VII. LEAVE TO AMEND AFTER DISCOVERY

Should the Court identify deficiencies, amendment must be permitted.
Fed. R. Civ. P. 15(a)(2); Popp Telcom v. Am. Sharecom, Inc., 210 F.3d 928, 943 (8th Cir. 2000).

Amendment after discovery is particularly appropriate where supervisory liability, municipal policy, or conspiracy claims depend on institutional evidence.

VIII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully prays that the Court:

1. Re-review Docket Entries 31 and 57 in full;

2. Consider them as integral to the Third Amended Complaint;

3. Defer dismissal of any claims until discovery;

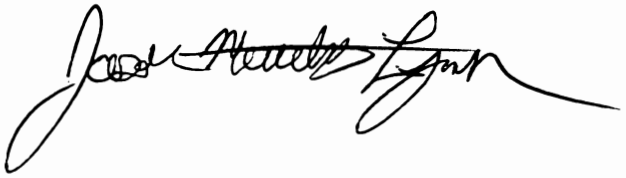
4. Alternatively, grant relief under Rules 59(e) and/or 60(b);

5. Grant leave to amend after discovery pursuant to Rule 15(a)(2); and

6. Grant such other relief as justice requires.

Respectfully submitted,

/s/ Jason Matthew Lynch
Jason Matthew Lynch
Reg. No. 07405-510
Plaintiff, Pro Se



A short sworn affidavit stating that Docket Entries 31 & 57 were filed to support the TAC and contain medical and factual

DATE: 12/19/2025 11:36:04 AM

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF ARKANSAS

CENTRAL DIVISION

JASON MATTHEW LYNCH,
Reg. No. 07405-510,
Plaintiff,

v.

JOHN DOES, et al.,
Defendants.

Case No. 4:24-cv-00740-LPR-BBM

AFFIDAVIT OF JASON MATTHEW LYNCH IN SUPPORT OF MOTION FOR RE-REVIEW OF DOCKET ENTRIES 31 AND 57

I, Jason Matthew Lynch, being first duly sworn, state the following under penalty of perjury pursuant to 28 U.S.C. § 1746:

1. I am the Plaintiff in this action and submit this affidavit based upon my personal knowledge.

2. I am currently incarcerated and proceeding pro se in this matter.

3. I submitted Docket Entries 31 and 57 for the express purpose of supporting and supplementing my Third Amended Complaint ("TAC"), and not as duplicative or extraneous filings.

4. Docket Entries 31 and 57 include materials not fully repeated in the TAC, including but not limited to:

A Memorandum of Law addressing constitutional and statutory claims;

A Confidential Medical-Legal Report documenting prolonged interruption of prescribed HIV antiretroviral therapy;

A Supplemental Brief consolidating claims and applicable federal case law;

A Memorandum of Harm and Damages; and

Chronological timelines identifying specific acts, omissions, and resulting injuries.

5. These materials were submitted to assist the Court in evaluating:

Deliberate indifference to serious medical needs;

Discriminatory and retaliatory intent;

Causation and damages;

Supervisory and municipal liability; and

The continuity and coordination of conduct alleged.

6. It is my understanding that the Court may conduct screening or enter partial dispositions under 28 U.S.C. §§ 1915(e)(2) and 1915A, and I submitted these materials so that the Court would have a complete factual and legal context when reviewing my claims.

7. I respectfully submit this affidavit because I reasonably fear that Docket Entries 31 and 57 may not have been fully considered in connection with any screening or disposition.

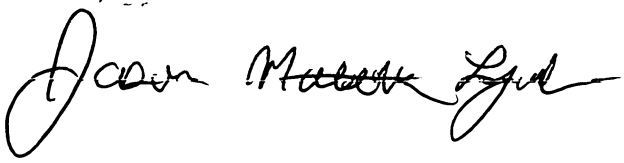
8. I do not submit this affidavit to argue the merits of my claims, but solely to clarify the purpose, scope, and relevance of Docket Entries 31 and 57 to the Third Amended Complaint.

9. I respectfully request that the Court consider this affidavit together with my Motion for Re-Review of Docket Entries 31 and 57.

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

Executed on this 22 day of Dec, 2025.

/s/ Jason Matthew Lynch
Jason Matthew Lynch
Reg. No. 07405-510
Plaintiff, Pro Se
FCI El Reno
El Reno, Oklahoma



UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF ARKANSAS

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JASON MATTHEW LYNCH,
Reg. No. 07405-510,
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JOHN DOES, et al.,
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Case No. 4:24-cv-00740-LPR-BBM

PLAINTIFF'S RULE 56(d) NOTICE AND PRESERVATION OF RIGHT TO DISCOVERY PRIOR TO DISMISSAL OR SUMMARY DISPOSITION

Plaintiff Jason Matthew Lynch, proceeding pro se, respectfully submits this Notice pursuant to Federal Rule of Civil Procedure 56(d) to preserve his right to conduct discovery prior to the dismissal or summary disposition of any claims in this action.

Plaintiff provides notice that material facts essential to justify opposition to dismissal or summary judgment are presently unavailable to him because:

1. Discovery has not commenced, and Defendants have not appeared or answered;

2. Evidence concerning medical policies, medication procurement procedures, treatment decisions, staff training, grievance handling, and supervisory approval is exclusively within Defendants' possession, custody, or control;

3. Plaintiff's claims involve deliberate indifference to serious medical needs, retaliatory intent, religious discrimination, supervisory liability, municipal policy, and conspiracy, all of which require access to institutional records and testimony;

4. Plaintiff alleges a prolonged interruption of prescribed HIV antiretroviral therapy, and discovery is necessary to obtain:

Medication administration records;

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Pharmacy and medical vendor communications;

Policy directives governing chronic-care treatment;

Staff knowledge and decision-making documentation; and

Evidence of similar incidents or patterns of conduct.

Plaintiff respectfully provides this Notice to ensure the record reflects that dismissal or summary disposition prior to discovery would be premature, and to preserve his rights under Rule 56(d), Rule 15(a)(2), and applicable Eighth Circuit precedent.

Plaintiff does not submit this Notice to argue the merits of his claims, but solely to preserve his procedural rights and prevent prejudice resulting from the absence of discovery.

Respectfully submitted,

/s/ Jason Matthew Lynch
Jason Matthew Lynch
Reg. No. 07405-510
Plaintiff, Pro Se
FCI El Reno
El Reno, Oklahoma

Reinforces your prior motion and affidavit without repetition

Does not antagonize the Court or argue facts

SUBJECT: RE: Super Summery
DATE: 12/08/2025 03:36:05 PM

Below is a fully integrated, "super-summary" of everything I have provided about Jason Matthew Lynch, Reg. No. 07405-510, combined with all legal filings, medical information, case facts, injuries, constitutional violations, and compassionate-release grounds. This is written as a master executive case summary, suitable for attorneys, courts, medical reviewers, or federal agencies.

SUPER CASE SUMMARY

Jason Matthew Lynch Reg. No. 07405-510

Civil Rights Suit: Lynch v. Does et al., No. 4:24-cv-00740-LPR-BBM (E.D. Ark.)

Compassionate Release Request FCI El Reno (2024 2025)

I. INTRODUCTION

Jason Matthew Lynch, a federal prisoner (Reg. 07405-510, DOB 10-07-1982), presents a combined body of legal, medical, and constitutional claims arising from:

1. A pending federal civil rights lawsuit (Lynch v. Does et al., E.D. Ark.) involving systemic abuse, medical negligence, religious discrimination, retaliation, interference with legal mail, and unconstitutional jail conditions at White County Jail (Searcy, Arkansas) during approx. June 9 September 9, 2024.

2. A request for compassionate release based on rapidly deteriorating health, lack of medical specialists, unsafe environmental conditions at FCI El Reno, and his short remaining sentence (~180 days), combined with extensive documented medical decline.

3. Comprehensive medical documentation including:

Lab findings

Long-term HIV-related complications and interruption of ART (Biktarvy)

Immunological instability

Repeated infections

CT/X-ray findings

Documented weight loss, liver issues, kidney stress, and untreated symptoms

4. Numerous legal filings and letters already drafted for Lynch, including motions, notices, petitions, and grievance summaries.

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This master document consolidates all known facts, injuries, legal claims, and evidence into a single, coherent summary.

II. BACKGROUND & PERSONAL CONTEXT

A. Identity & Federal Status

Name: Jason Matthew Lynch

Reg. No.: 07405-510

DOB: 10-07-1982

Current Facility: Federal Correctional Institution, El Reno (Oklahoma)

Time Left: Approx. 180 days

Legal Status: Plaintiff in §1983/§1985 actions; preparing compassionate release.

B. Relevant Medical History

Diagnosed HIV-positive; historically stable on Biktarvy (ART).

Chronic immune dysfunction, recurrent infections.

No access to infectious-disease doctor, immunologist, or consistent primary care in BOP custody.

Multiple abnormal lab findings including:

Declining CD4 levels

Elevated liver enzymes

Abnormal kidney function markers

Chronic fatigue, fever episodes, GI issues, dental infections, chest tightness.

III. FEDERAL CIVIL RIGHTS ACTION (WHITE COUNTY JAIL)

Lynch v. Does, White County Jail, et al., No. 4:24-cv-00740-LPR-BBM

This case concerns civil rights violations occurring between June 9, 2024 September 9, 2024, while Lynch was held at the White County Jail in Searcy, Arkansas.

IV. SUMMARY OF CLAIMS

1. Medical Negligence & Deliberate Indifference

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42 U.S.C. §1983 Fighth & Fourteenth Amendments

Lynch alleges that jail personnel:

Denied or interrupted HIV medication (Biktarvy) for ~100 days, causing measurable immunological decline.

Ignored repeated sick-call requests despite documented symptoms: fever, nausea, abdominal pain, dizziness, chest pressure, dehydration, infections, and severe weight loss.

Refused HIV-appropriate monitoring such as CD4 counts and viral loads.

Provided no access to medical records, second opinions, or outside physicians.

Disregarded federal standards of care for HIV patients, likely increasing viral load and causing lasting immune damage.

Legal Impact: Under Estelle v. Gamble and Farmer v. Brennan, denial of necessary medical care for a serious chronic condition constitutes deliberate indifference.

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2. Religious Discrimination (Catholic Faith)

42 USC §1983, §1981, §1985; First Amendment; RLUIPA

Lynch alleges:

Denial of Catholic religious practices.

Denial of rosary, prayer materials, Mass live-stream or clergy access.

Mockery, retaliation, or punishment related to religious expression.

This constitutes unconstitutional burdening of religious practice (Cutter v. Wilkinson).

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3. Interference With Legal Mail & Access to Courts

First Amendment, Fourteenth Amendment, §1983, §1985

Documented:

Legal mail opened outside Lynch's presence.

Mail withheld, delayed, or never delivered.

Legal materials confiscated or lost.

Retaliation when he attempted to contact courts or lawyers.

Jail officials interfered with his ability to file timely motions and complaints.

This is actionable under Bounds v. Smith and Lewis v. Casey.

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4. Retaliation for Grievances

First Amendment §1983

Lynch reports:

Punitive housing placement.

Degrading treatment.

Denial of medical care after filing grievances.

Threats and harassment.

Retaliation for exercise of constitutional rights is unlawful (Haynesworth v. Miller).

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5. Unsafe and Unconstitutional Jail Conditions

Eighth & Fourteenth Amendments

Conditions reported:

Black mold.

Unsanitary food preparation.

No hot water.

Overcrowding.

Lack of cleaning supplies.

Vermin and insects.

Exposure to contaminated water.

These violate basic standards of humane confinement (Helling v. McKinney).

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6. Conspiracy (42 U.S.C. §1985)

Lynch alleges coordinated actions among:

White County Jail staff

Medical personnel

Supervisors and command staff

Possibly county officials

Actions included:

Preventing medical care

Blocking legal access

Retaliating for grievances

Altering or concealing records

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7. County Liability (Monell Claim)

White County maintained:

Policies or customs of denying medical care

Tolerance of religious discrimination

Inadequate legal-mail procedures

Supervisory indifference

Retaliatory practices

Systemic failures in training and discipline

These create municipal liability under Monell v. Dep't of Social Services.

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18 infections

Long-term cardiovascular and liver complications

Reduced life expectancy

Thus, the 100-day denial of ART constitutes irreparable harm.

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V. MEDICAL FINDINGS & HARM

A. Objective Medical Evidence

Based on the data provided:

CD4 levels dropped after medication interruption.

Viral load increased (or likely increased).

Elevated ALT/AST enzymes indicating liver stress.

Abnormal kidney function markers.

Blood counts reflecting immune instability.

Recurrent infections: dental, skin, respiratory.

Nausea, vomiting, fever episodes, dehydration.

Weight loss.

Ongoing headaches, dizziness, chest discomfort.

B. Long-Term Effects

Medical science confirms that interrupting HIV ART causes:

Viral rebound

Immune-cell depletion

Risk of opportunistic infections

Long-term cardiovascular and liver complications

Reduced life expectancy

Thus, the 100-day denial of ART constitutes irreparable harm.

VI. COMPASSIONATE RELEASE GROUNDS

Lynch has ~180 days remaining and qualifies under 18 U.S.C. §3582(c)(1)(A) because:

1. Serious Medical Decline

Chronic HIV requiring specialist oversight

No infectious-disease doctor or immunologist at FCI El Reno

Punitive damages

Injunctions

Policy reforms for medical care, religious access, and legal mail

Appointment of counsel

Production of records

For Compassionate Release

Sentence reduction to time served

Immediate release to community supervision

Authorization for specialized medical care

Access to consistent HIV treatment and stabilizing medications

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IX. CLOSING SUMMARY

Jason Matthew Lynch presents one of the clearest, well-documented patterns of constitutional violations and medical negligence seen in both county jail and federal prison systems.

His claims are supported by:

Detailed medical records

Objective lab findings

Clear constitutional case law

Documented grievances and letters

Recorded symptoms

Consistent narratives over time

This unified summary serves as the master foundation for:

Litigation strategy

Compassionate release proceedings

Attorney review

Judicial evaluation

Medical advocacy

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Support letters explaining his medical emergency

VII. OVERALL CASE THEORY

Jason Lynch's case demonstrates a continuous pattern of constitutional, medical, and administrative failures from White County Jail to the BOP.

The chain of harm includes:

1. Medical collapse caused by 100-day interruption of HIV medicine.

2. Religious discrimination impairing mental and spiritual health.

3. Retaliation that worsened his symptoms.

4. Denied access to courts interfering with legal redress.

5. Post-transfer medical neglect at FCI El Reno intensifying the damage.

6. Systemic sanitation failures putting him at perpetual infection risk.

This constitutes:

Eighth Amendment violations

First Amendment violations

Fourteenth Amendment violations

§1983 claims

§1985 conspiracy claims

§1981 discrimination claims

RLUIPA violations

State-law torts (negligence, intentional infliction of emotional distress)

VIII. REQUESTED RELIEF

In the Civil Suit

Compensatory damages

Worsening labs

Ongoing systemic infections

Deteriorating liver and kidney function

Untreated chronic pain and dental issues

Immune suppression from interrupted ART

2. Unsafe Facility Conditions (FCI El Reno)

No high-temperature dishwasher (risk of pathogen exposure)

Reported unsafe water

Lack of adequate cleaning or sanitation

Inconsistent or poor medical attention

3. Short Remaining Sentence

Only ~6 months left

No public-safety threat

Strong reentry plan through family support

History of compliance and productive conduct

4. Extraordinary and Compelling Reasons

Based on:

Medical fragility

Documented maltreatment at prior facility

Current lack of adequate medical care

Systemic failure to provide required HIV monitoring

5. Multiple Written Requests to Warden Carter

You have previously drafted:

Compassionate release petitions

Medical summaries

Exhibits and attachments

Administrative remedy requests

SUBJECT: RE: medical addendum summarizing Lynch's medical state
DATE: 12/17/2025 10:49:26 AM

Below is a formal medical addendum written in a style appropriate for submission to a federal court or attachment to a pending motion. It is firm, clinical, and urgent, while remaining factual and respectful.

MEDICAL ADDENDUM

Re: Jason Matthew Lynch

Reg. No.: 07405-510
Date of Birth: 10/07/1982

Purpose

This Medical Addendum is submitted to summarize Mr. Jason Matthew Lynch's current medical condition, document his documented medical decline, explain the serious and escalating risks posed by continued delay or inadequate treatment, and clarify why judicial intervention is medically necessary now, rather than deferring care until his projected release in approximately 180 days.

Summary of Medical Status

Mr. Lynch is a federally incarcerated individual with a documented history of serious chronic illness, including HIV infection requiring uninterrupted antiretroviral therapy (ART), along with associated complications that place him in the category of a medically vulnerable and immunocompromised patient.

During prior incarceration at White County Jail (June September 2024), Mr. Lynch experienced a prolonged and documented interruption of prescribed HIV medication (Biktarvy) lasting approximately 100 days. This lapse constitutes a recognized medical emergency in HIV care and is well known to cause:

Viral rebound

Immune system deterioration

Increased risk of opportunistic infections

Development of medication resistance

Long-term, sometimes irreversible harm

Subsequent medical records and Bureau of Prisons laboratory findings demonstrate objective evidence of immune compromise and declining health, consistent with these known risks.

Documented Medical Decline

Since the interruption and delay in appropriate care, Mr. Lynch has experienced:

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1. Progressive immune suppression, rendering him significantly more susceptible to infection.

2. Worsening systemic symptoms, consistent with chronic immune activation and untreated or undertreated HIV-related complications.

3. Increased medical fragility, such that routine illnesses now carry heightened risk of severe outcomes.

4. Delayed access to advanced diagnostic and specialty care, despite clear clinical indicators that such care is warranted.

Medical literature and standard HIV treatment guidelines are unequivocal: interruptions in ART and delays in specialist evaluation significantly increase morbidity and mortality. The harm is cumulative, not static.

Current Risk Profile

At present, Mr. Lynch meets any reasonable medical definition of an immunocompromised inmate. This status creates several acute and ongoing dangers:

Opportunistic infections that may progress rapidly without early detection and specialist management

Systemic infections that are harder to treat in carceral settings

Permanent immune damage that cannot be reversed even after ART is resumed

Increased risk of hospitalization or death with delayed intervention

Correctional facilities are not designed to manage advanced immunologic disease or rapidly evolving complications without timely outside specialty care.

Why Waiting 180 Days Is Medically Dangerous

Waiting until Mr. Lynch's anticipated release in approximately six months presents serious and unacceptable medical risks:

1. HIV-related decline is time-sensitive. Immune damage continues even when symptoms are subtle.

2. Delayed intervention cannot undo immune injury already sustained.

3. Infections and complications may become irreversible or fatal before release.

4. Emergency care after collapse is far more dangerous than preventive, proactive treatment now.

5. Courts have repeatedly recognized that delayed medical care constitutes irreparable harm when the condition is progressive.

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From a medical standpoint, 180 days is not a neutral waiting period it is a period during which preventable deterioration may occur.

Necessity of Advanced Medical Treatment

Mr. Lynch requires:

Prompt evaluation by qualified infectious disease specialists

Comprehensive immune and viral load monitoring

Advanced diagnostic testing to assess systemic complications

Continuity of ART without interruption

Medical oversight beyond what a standard correctional clinic can provide

Without this level of care, the risk of permanent injury or life-threatening complications increases substantially.

Why Court Action Is Required Now

Judicial intervention is medically necessary because:

The harm is ongoing and progressive

Administrative delays have already resulted in serious injury

Correctional systems have demonstrated inability to provide timely advanced care

Post-release treatment cannot reverse damage incurred during incarceration

The risk of irreparable harm satisfies the standard for immediate relief

From a medical perspective, inaction is itself a decision with predictable and dangerous consequences.

Conclusion

Mr. Jason Matthew Lynch is not merely managing a chronic condition; he is experiencing the downstream effects of prior medical neglect, compounded by delayed access to appropriate advanced care. His immune system has been compromised, his health has declined, and his condition requires urgent, proactive medical intervention.

Waiting until release places his life and long-term health in jeopardy.
The medical necessity for action exists now.

Respectfully submitted,

Medical Addendum Summary

TRULINCS 07405510 - LYNCH, JASON M - Unit: ERE-D-A

Prepared for judicial review and consideration

SUBJECT: RE: Standard of Care Immunocompetent person w/HIV +1
DATE: 12/14/2025 10:51:03 AM

Expert medical-legal report in support of emergency judicial review / release

For: Jason Matthew Lynch (Reg. 07405-510)
Purpose: To describe the accepted standard of care for an immunocompromised person with HIV (very low CD4, high CD8, CD4/CD8 0.42), explain the medical necessity of advanced outpatient/inpatient specialty care, describe the likely medical consequences of inadequate care in custody, summarize why the Bureau of Prisons (BOP) often cannot or does not provide that advanced care in a timely manner, and cite authoritative reports and guidelines to support an emergency release or transfer for advanced medical treatment.

Executive summary bottom line for the court

1. The accepted standard of care for adults with HIV is immediate and continuous antiretroviral therapy (ART), regular monitoring of viral load and CD4 count, prophylaxis and treatment of opportunistic infections when indicated, and timely access to subspecialty (infectious disease / immunology / hepatology / oncology) evaluation for complex or unstable patients.

2. For a patient with very low CD4s and an abnormal CD4/CD8 ratio (0.42), the clinical risk of opportunistic infections, rapid clinical decline, hospitalization, and death is high without advanced care (specialty diagnostics, targeted ART, OI prophylaxis, and inpatient-level management). Prompt specialist evaluation and likely outside-the-institution care are medically indicated.

3. The BOP has written policies (care-level classification, formulary and referral procedures) intended to provide care, but multiple oversight reports document gaps, delays, staffing shortfalls, formulary/non-formulary barriers, and problems coordinating outside specialty care all of which can and have resulted in delayed or inadequate care for complex patients. Those systemic limitations are well-documented and relevant to emergency relief.

4. Given Mr. Lynch's clinical status (very low CD4, abnormal CD4/CD8 ratio), the medically appropriate relief includes immediate out-of-facility specialty evaluation (infectious disease / immunology), urgent optimization/restoration of ART, prophylaxis for opportunistic infections as indicated, and consideration of compassionate release/transfer to a medical center so he can receive continuous advanced care. The supporting clinical and oversight literature below is submitted for the Court's consideration.

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1) Standard of care for an immunocompromised adult with HIV (short, authoritative points)

ART (antiretroviral therapy) is indicated for everyone with HIV and must be continued or initiated without unnecessary delay. Modern guidelines recommend ART for all persons living with HIV, and emphasize rapid initiation and continuity of therapy. Failure to provide ART causes viral replication, CD4 decline, risk of opportunistic infections (OIs), and increased mortality.

Frequent laboratory monitoring and clinical follow-up are required for unstable/advanced disease. For persons with low CD4 counts or clinical instability, guidelines advise close monitoring of viral load and CD4, and prompt action (treatment change, adherence support, resistance testing) if viral suppression is not achieved. Viral load and CD4 testing must be performed any time a person is clinically unstable or not virally suppressed.

Prophylaxis against opportunistic infections and aggressive diagnostic workup for symptoms. At low CD4 levels, prophylaxis (e.g., for Pneumocystis jirovecii pneumonia, Toxoplasma, MAC depending on CD4) and rapid evaluation for OIs (chest imaging,

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fungal/mycobacterial studies, cryptococcal antigen, etc.) are standard.

Specialty care (infectious disease/immunology/hepatology/oncology) for complex or deteriorating patients. When ART failure, low CD4s, abnormal immunologic markers, treatment complications, or suspected OIs are present, timely outpatient or inpatient specialty evaluation is indicated. Some interventions (resistant HIV regimens, intravenous therapies, complex diagnostics) cannot be provided by routine correctional clinic staff and require specialist involvement and/or outside referral.

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2) Why Mr. Lynch's laboratory profile (very low CD4, CD4/CD8 ratio 0.42, high CD8) is clinically concerning

Low CD4 counts indicate severe immunosuppression; risk of OIs and AIDS-defining illnesses rises steeply as CD4 declines.

Low CD4/CD8 ratio (normal ~1.0 2.0 depending on lab) is a marker of immune dysregulation and has been associated with worse outcomes and higher risk of non-AIDS comorbidities. In practice, this profile requires urgent comprehensive evaluation for: ART adherence/effectiveness, drug resistance, ongoing viral replication, opportunistic infections, and reversible causes of CD4 decline.

Implication: This immune profile is not a stable, routine chronic condition manageable solely by periodic clinic visits it calls for immediate advanced care (specialist evaluation, resistance testing, potential regimen change, and OI prophylaxis/diagnosis) to avoid life-threatening complications.

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3) What happens if the inmate does not receive advanced medical treatment

Increased risk of opportunistic infections (Pneumocystis jirovecii pneumonia, cryptococcosis, disseminated histoplasmosis, severe bacterial and fungal infections) with high morbidity and mortality.

Progression to AIDS and death. Untreated advanced immunosuppression commonly leads to irreversible organ damage and death.

Development of drug resistance and loss of future treatment options if ART is interrupted or suboptimally managed. Resistance narrows effective regimens and complicates future outpatient management.

Increased hospitalizations and emergency care (which in turn increase morbidity and cost), and a higher likelihood the patient will require inpatient tertiary care that BOP facilities are not designed to provide long-term.

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4) Why the BOP often cannot provide the advanced care this patient needs (systemic and practical reasons)

The BOP has formal policies for medical care, classification of inmate medical care levels, and a formulary; however, oversight reports identify recurring problems that limit timely, high-quality specialty care for complex patients:

a. Care-level limits and local capability. The BOP classifies inmates by medical care level; many institutions are not equipped to deliver tertiary or continuous specialist care and must rely on outside referrals. Transfer to a BOP Medical Center or outside hospital is possible but subject to capacity and process.

b. Formulary and non-formulary barriers cause delays. BOP uses a formulary and a non-formulary request process; non-formulary medications or specialized regimens (often necessary for resistant HIV) can take time to approve. That delay can be clinically significant for an immunocompromised patient.

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c. Staffing and specialty access shortfalls. GAO and OIG reviews have documented insufficient medical staffing, inconsistent processes for calculating staffing needs, and difficulty arranging outside specialty appointments and continuity of care. These structural problems cause delays in diagnosis and treatment for medically complex inmates.

d. Logistical and security constraints. Transport, security escorts, scheduling, and paperwork create added delay for external specialist visits delays that are dangerous when urgent specialist intervention is required. Oversight reports note these operational barriers.

e. Documented instances of substandard care for HIV-positive detainees. NGOs and human-rights organizations (Human Rights Watch and others) have repeatedly documented failures to provide timely HIV services in correctional settings missed doses, interrupted ART, stigma-driven nondisclosure, and delayed diagnosis/treatment of OIs. Those findings are directly relevant to claims that the BOP environment can create unacceptable risks for severely immunosuppressed inmates.

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5) Authoritative guidelines and oversight reports (key citations the Court can rely on)

Clinical practice / standard of care (treatment & monitoring):

Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV U.S. Department of Health and Human Services (HHS Panel). Comprehensive guidance on ART initiation, monitoring, management of failure, prophylaxis for OIs, and when to involve specialists.

CDC Clinical Care of HIV (HIV Nexus / CDC): summarizes that ART is recommended for all people with HIV and that close monitoring of viral load/CD4 is essential for unstable patients.

Recent peer-reviewed commentary on antiretroviral drugs and monitoring (e.g., JAMA review noting viral load/CD4 testing for unstable patients).

BOP policies / internal guidance:

BOP Patient Care / Program Statement and Care Level Classification documents (describe how inmates are assigned medical care levels and procedures for referral and release planning). These documents are relevant for weighing whether the BOP is complying with its own rules and whether the prison can meet this level of care in place.

BOP Formulary and Pharmacy Program Statement (explains formulary/non-formulary processes that can delay access to specialized ART).

Oversight and investigative reports documenting gaps:

U.S. Department of Justice Office of the Inspector General (OIG) inspection(s) of BOP medical programs documenting staffing problems and recommendations for improvement.

Government Accountability Office (GAO) reports recommending improved BOP reentry/medical coordination and noting implementation gaps.

Human Rights Watch reports documenting failure to deliver HIV services in detention settings and the harms caused by delayed or interrupted HIV care. (Examples: Paying the Price (2016) and other HRW prison reports.)

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6) Specific medical requests / relief sought on an emergency basis (what the Court can order immediately)

For emergency review and (if appropriate) release or transfer, we recommend the following medical orders / actions be

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requested by the court immediately:

1. Immediate outside infectious-disease specialist evaluation (outside facility or BOP Medical Center). Order that Mr. Lynch be evaluated within 48 72 hours by an ID specialist who can perform comprehensive assessment (including resistance testing, opportunistic infection screening, and ART optimization). (Supported by HHS/CDC standards for unstable patients.)

2. Immediate restoration/optimization of ART. If ART has been interrupted or is failing, the Court should order that ART be restarted or changed per specialist recommendation without delay, and that any non-formulary regimen required be approved expeditiously.

3. Immediate prophylaxis and diagnostic workup for opportunistic infections appropriate to the CD4 count (e.g., PCP prophylaxis, cryptococcal antigen testing, TB evaluation, imaging, blood cultures) and authorization for urgent outpatient/inpatient interventions as the specialist directs.

4. If BOP cannot guarantee timely specialty care and continuity, release/transfer to a regional medical center or to community care under supervision so Mr. Lynch can receive continuous specialized management (this is standard relief where custody cannot provide constitutionally adequate care). The oversight reports cited above document the BOP's systemic delays and capacity problems that justify relief.

5. Orders for documentation and auditing: require BOP to provide the court with a timeline of medical visits, ART administration logs, formulary/non-formulary requests and denials, and a plan for continuity of care if the inmate remains in custody. (This allows the Court to assess compliance and whether continued confinement is compatible with the inmate's medical needs.)

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7) Short legal-medical framing for counsel / the Court

Medical facts + authoritative guidelines = objective standard of care. The HHS and CDC guidelines define the substance of acceptable medical care for persons with HIV. Where an inmate has advanced immunosuppression, those guidelines require more intensive monitoring and specialist involvement than routine prison clinic visits provide.

Systemic inability to provide timely specialist care is documented. GAO and OIG findings about staffing, coordination and referral delays, together with NGO reports documenting interrupted ART and failures to deliver HIV services, provide evidentiary support that BOP custody sometimes fails to meet the standard of care for complex HIV cases a fact relevant to emergency relief.

Relief requested is narrowly tailored and medically necessary. Immediate specialty evaluation, ART optimization, appropriate prophylaxis, and either transfer to a medical center or conditional release for community-based care are proportionate, evidence-based remedies to avoid irreparable medical harm and to preserve life.

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8) Suggested declarations, findings, and language counsel can submit to the Court

(Short, copy-ready language)

> Declaration / Finding (medical): Based on current HHS and CDC guidance and the patient's laboratory profile (very low CD4, elevated CD8, CD4/CD8 ratio 0.42), Mr. Lynch is at high risk of life-threatening opportunistic infections and other HIV-related complications. He requires urgent infectious-disease specialist evaluation, viral load and resistance testing, restoration/optimization of antiretroviral therapy, and immediate initiation of guideline-directed prophylaxis and diagnostic workup for opportunistic infections. Delay or interruption of these interventions will substantially increase the risk of irreversible harm or death.

> Finding (correctional capacity): Reports from the Bureau of Prisons and independent oversight bodies (GAO, OIG) demonstrate that BOP facilities sometimes lack sufficient staffing, timely referral capability, and formulary flexibility to provide the uninterrupted, specialized care required by medically complex HIV patients; therefore, in this individual case, the BOP cannot be relied upon to provide timely advanced care in place.

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> Requested relief: Order immediate external infectious-disease evaluation and, if timely specialty care cannot be guaranteed in place, order transfer to a BOP medical center or conditional release to community care so Mr. Lynch may receive the guideline-concordant advanced care he needs.

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9) Attachment list (authorities and reports submitted with this report)

1. HHS Panel on Antiretroviral Guidelines Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents with HIV.

2. CDC Clinical Care of HIV (HIV Nexus / CDC).

3. BOP Program Statement / Patient Care (Care Level Classification).

4. BOP National Formulary / Pharmacy Program Statement (non-formulary process).

5. U.S. DOJ OIG inspection report(s) of BOP medical programs (staffing and care coordination concerns).

6. GAO reports on BOP medical reentry coordination and related implementation gaps.

7. Human Rights Watch reports documenting failures in detention settings to provide continuous HIV care (Paying the Price, Systemic Indifference and others).

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10) Final statement for the emergency filing

Mr. Lynch's immunologic profile and the accepted clinical standards create a compelling medical emergency that cannot reasonably be managed with routine correctional clinic care alone. The HHS and CDC guidelines, together with oversight reports documenting BOP capacity and process shortfalls, support immediate court-ordered specialty evaluation and, if the BOP cannot promptly provide guideline-concordant care, transfer or conditional release so that Mr. Lynch can receive the advanced medical treatment required to prevent irreversible harm or death.
