MICHAEL P. STONE, SBN 91142
MUNA BUSAILAH, SBN 166328,
ROBERT RABE, SBN 72312, members of
STONE BUSAILAH, LLP
A Partnership of Professional Law Corporations
1055 East Colorado Boulevard, Suite 320
Pasadena, California 91106

Telephone: (626) 683-5600
Facsimile: (626) 683-5656
Email: m.busailah@police-defense.com

Attorneys for Defendant, SCOTT CRAIG

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, Plaintiff, v. SCOTT CRAIG, Defendant.	NO. CR 13-00819-PA NO. 2:18-CV-3479 **DECLARATION OF ROBERT RABE IN SUPPORT OF MOTION TO REDUCE SENTENCE OR PROVIDE OTHER EQUITABLE RELIEF PURSUANT TO 28 U.S.C. § 2255; REQUEST FOR IMMEDIATE HOME CONFINEMENT** *Expedited Consideration Requested* (Assigned for all Purposes to Honorable Percy Anderson, United States District Judge)

DECLARATION OF ROBERT RABE

I Robert Rabe declare as follows:

1. I am an Associate Attorney in the law firm of Stone Busailah, LLP, attorneys for Scott Craig, the defendant in the above entitled matter.

2. On March 6, 2018, Annette Craig sent an electronic mail to the Courtroom Deputy Clerk for the Honorable Percy Anderson, requesting assistance from the Court to obtain medical treatment for her husband, Scott Craig, a copy of which is attached as Exhibit A. The Courtroom Deputy Clerk forwarded that email to Muna Busailah, a partner in the firm of Stone Busailah, LLP. The Courtroom Deputy Clerk also spoke with Ms. Busailah, and explained to her that it was inappropriate for Annette Craig to email the court directly, and suggested that a written request be submitted to this Court with a proposed Order.

3. On March 9, 2018, the Courtroom Deputy Clerk forwarded to Muna Busailah the medical records of Scott Craig that had been submitted by Annette Craig to this Court with her request. A copy of the email sent by the Courtroom Deputy Clerk is attached as Exhibit B. The relevant medical records of Scott Craig are Attached as Exhibits B1 through B5.

4. Annette Craig has written a letter to this Court, dated April 10, 2018, in support of the Motion to Reduce Sentence or Provide Other Equitable Relief ("the Motion"), a copy of which is attached as Exhibit C.

5. Scott Craig has written a letter to this Court, dated April 7, 2018, in support of the motion, a copy of which is attached as Exhibit D.

6. Annette Craig has written a letter to this Court, dated March 6, 2018, in support of the motion, a copy of which is attached as Exhibit E.

7. Annette Craig sent an email, dated March 9, 2018, in support of the motion, a copy of which is attached as Exhibit F.

8. Annette Craig sent an email, dated April 6, 2018, in support of the motion, a copy of which is attached as Exhibit G.

9. Annette Craig sent an email, dated April 11, 2018, in support of the motion, a copy of which is attached as Exhibit H.

10. Annette Craig sent an email, dated April 20, 2018, in support of the motion, a copy of which is attached as Exhibit I.

11. A copy of the Kaiser Permanente card issued the Scott Craig is attached as Exhibit J.

12. An article on the Treatment of Colon Cancer, by Stage, issued by the American Cancer Society, is attached as Exhibit K.

13. An article on the Survival Rates for Colorectal Cancer, by Stage, issued by the American Cancer Society, is attached as Exhibit L.

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

Executed on this 24th day of April, 2018

Robert Rabe

Robert Rabe

EXHIBIT A

Muna Busailah

From: Kamilla_Sali-Suleyman@cacd.uscourts.gov
Sent: Friday, March 09, 2018 9:55 AM
To: Muna Busailah
Subject: Fw: Scott Craig Case # CR 13-819-PA

KAMILLA SALI-SULEYMAN KOGOSOV
COURTROOM DEPUTY CLERK TO
THE HONORABLE PERCY ANDERSON

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
350 West 1st Street STE 4311, Room 4176
Los Angeles, California 90012
Office: (213) 894-8810 Fax:(213) 894-4422
Email: kamilla_sali-suleyman@cacd.uscourts.gov

----- Forwarded by Kamilla Sali-Suleyman/CACD/09/USCOURTS on 03/09/2018 09:55 AM -----

From: Annette Craig
To: kamilla_sali-suleyman@cacd.uscourts.gov
Date: 03/06/2018 03:54 PM
Subject: Scott Craig Case # CR 13-819-PA

Good Afternoon,

My name is Annette Craig, my husband, Scott Craig (case# CR 13-819-PA) appeared before the Honorable Percy Anderson and was sentenced on September 23, 2014. He self-surrendered to Florence, CO on April 24, 2017. On December 28, 2017 he was diagnosed in prison with colon cancer. To date he has not received treatment to remove the malignant tumor that was found in December. I am trying to find the best and quickest way possible to reach Judge Anderson to see if there is anything that can be done to get my husband the medical treatment that he is desperate need of. We have our own insurance and could pay for his immediate treatment. I have letters from both my husband and myself, and medical records for his review and consideration.

I am unsure how I can go about getting information to him The Honorable Percy Anderson. I would be greatly appreciative of any help and direction that you could provide.
Sincerely,
Annette Craig
[redacted]

EXHIBIT B

Muna Busailah

From: Kamilla_Sali-Suleyman@cacd.uscourts.gov
Sent: Friday, March 09, 2018 9:54 AM
To: Muna Busailah
Subject: Fw: Scott Craig's Medical Records & Request
Attachments: AC's Letter to Hon. Percy Anderson.docx; Colonoscopy Results & Pathology Report.pdf; CT Scan & blood work results.pdf

KAMILLA SALI-SULEYMAN KOGOSOV
COURTROOM DEPUTY CLERK TO
THE HONORABLE PERCY ANDERSON

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
350 West 1st Street STE 4311, Room 4176
Los Angeles, California 90012
Office: (213) 894-8610 Fax:(213) 894-4422
Email: kamilla_sali-suleyman@cacd.uscourts.gov

----- Forwarded by Kamilla Sali-Suleyman/CACD/09/USCOURTS on 03/09/2018 09:53 AM -----

From: Annette Craig
To: kamilla_sali-suleyman@cacd.uscourts.gov
Date: 03/09/2018 09:45 AM
Subject: Scott Craig's Medical Records & Request

EXHIBIT B-1

Arkansas Valley Surgery Center
933 Sell Ave., Suite B
Canon City, Colorado 81212
Tel: (719)275-6433 Fax: (719)275-7009

HISTORY AND PHYSICAL EXAMINATION

#67178-112
PATIENT: Craig, Scott
PHONE #: [redacted]
PHYSICIAN: James F. Reppert, M.D.

DOB: [redacted]1964
DATE: 12/28/2017

FPC FLORENCE, CO

ATTENDING SURGEON:
James F. Reppert, M.D.

HISTORY OF PRESENT ILLNESS:
This federal inmate comes in for a screening colonoscopy. He denies any GI complaints.

MEDICATIONS:
Noted.

DRUG ALLERGIES:
Noted.

PHYSICAL EXAMINATION:
VITAL SIGNS: Blood pressure 130/70, pulse 70.
HEAD AND NECK: Fine.
HEART: Fine.
LUNGS: Fine.
ABDOMEN: Fine.

IMPRESSION:
Colonoscopic screen.

James F. Reppert, M.D.

JFR/km
DD: 12/28/2017 DT: 12/28/2017 TID: 163146483

DOS: 12/28/17 Chart: 109788
PT Name: CRAIG, SCOTT
DOB: [redacted]64 Sex: M Age: 53 yrs.
Surgeon: REPPERT MD, JAMES

EXHIBIT B-2

Arkansas Valley Surgery Center
933 Sell Ave., Suite B
Canon City, Colorado 81212
Tel: (719)275-6433 Fax: (719)275-7009

FPC FLORENCE, CO

REPORT OF OPERATION/PROCEDURE

#67178-112

PATIENT: Craig, Scott
PHONE #: [redacted]
PHYSICIAN: James F. Reppert, M.D.

DOB: [redacted]1964
DATE OF PROCEDURE: 12/28/2017

PREPROCEDURE DIAGNOSIS:
Screening colonoscopy.

POSTPROCEDURE DIAGNOSIS:

1. Apple core lesion 20-25 cm from the anus, biopsied.
2. Some nodularity distal to the tumor, biopsied.
3. Tattoos placed. The first tattoo, the more proximal tattoo, was actually distal to the rim of the apple core lesion and then the distal tattoo was below the level of the nodularity just at the outlet of the rectum.

PROCEDURE:
Colonoscopy.

ATTENDING SURGEON:
James F. Reppert, M.D.

DESCRIPTION OF PROCEDURE:
The patient comes in for evaluation. He has an IV running and is given propofol anesthesia. Anal exam was normal to visual and digital check. Prostate normal to digital check. U-maneuver in the rectal vault, mild hemorrhoidal disease. Colonoscope was advanced about 20-25 cm. There was a friable apple core lesion. We were able to traverse such and advance to the cecum. Patient had quite a good prep. Cecum, ileocecal valve normal. Appendiceal orifice normal. On withdrawal back to the level of the tumor, we went ahead and biopsied it. It was several centimeters in length and we biopsied the distal rim of such and

DOS: 12/28/17 Chart: 109788
PT Name: CRAIG, SCOTT
DOB: [redacted]64 Sex: M Age: 53 yrs.
Surgeon: REPPERT MD, JAMES

Arkansas Valley Surgery Center
933 Sell Ave., Suite B
Canon City, Colorado 81212
Tel: (719)275-6433 Fax: (719)275-7009

FPC FLORENCE, CO

REPORT OF OPERATION/PROCEDURE

#67178-112

PATIENT: Craig, Scott
PHONE #: [redacted]
PHYSICIAN: James F. Reppert, M.D.

MEDICAL RECORD #:
DOB: [redacted]1964
DATE OF PROCEDURE: 12/28/2017

---

placed in container A. We then put a tattoo down distal to the distal end of the tumor to mark the distal mucosa that was clear below the tumor. We then noted that there also was some nodularity between the rectum and up to the level of the initial tattoo so we biopsied this and then placed a tattoo distal to the nodularity right at the rectosigmoid junction.

I will confer with Dr. Oba or one of the physicians at the prison in regard to these findings.

James F. Reppert, M.D.

JFR/km
DD: 12/28/2017 DT: 12/28/2017 TID: 163146920

DOS: 12/28/17 Chart: 109788
PT Name: CRAIG, SCOTT
DOB: [redacted]64 Sex: M Age: 63 yrs.
Surgeon: REPPERT MD, JAMES

EXHIBIT B-3

#L7178-112

Centura Laboratory Services

Patient: Craig, Scott
MRN:

Craig, Scott
M, 53 yrs, [redacted]1964

FPC FLORENCE, CO

PAML Outreach
110 West Cliff Drive
Spokane Washington 99204

Authorizing Provider
James Fred Reppert, MD F: 719-275-3743

SURGICAL (Final result) MS17-002636

Authorizing Provider	James Fred Reppert, MD	Ordering Provider	James Fred Reppert, MD
Pathologist.	Blair Christian Presti, MD	Collected	12/28/2017 1100
		Received.	12/29/2017 1054

Specimens
A 20-25cm colon bx
B Rectosigmoid colon bx

Final Diagnosis
Colon biopsy, 20–25 centimeters
- Invasive adenocarcinoma, low-grade

Rectosigmoid colon biopsy
- No pathologic abnormality
- No microscopic features of polyp identified
- Negative for malignancy

Comment: Lynch syndrome screening by immunchistochemistry and KRAS mutation analysis are pending and will be reported in a subsequent addendum. Dr. Webster has reviewed this case and concurs.

Electronically signed by Blair Christian Presti, MD on 1/2/2018 at 1440

Clinical Information
Screening colonoscopy (per PAML requisition)

Gross Description
The specimens are received in two formalin-filled containers unless otherwise noted, each labeled with the patient's name " Scott Craig".

A. "Tumor 20–25 centimeters"- five fragments tan tissue up to 2 mm submitted as (A1).

B. "Rectosigmoid"- three fragments tan tissue up to 2 mm submitted as (B1).

Blair Christian Presti, MD, 12/29/17 3:05 PM

Microscopic Description
Section(s) examined.

This report is distributed to Dr. Reppert, Arkansas Valley Surgery Center, and FBOP/Dr Oba.

#67178-112
Patient: Craig, Scott
MRN:

Centura Laboratory Services

CPT Codes
88305/2 88342 88341/3

FPC FLORENCE, CO

Resulting Labs
SMCLab SMC LABORATORY, 1008 MINNEQUA, PUEBLO CO 81004 719-557-5011

CC Recipients
Florence Federal Bureau of Prisons (Fax: 719-784-6065), PAML Outreach, PAML Pathology (Fax: 509-209-6921)

have reviewed the results and have/will review the results with the patient or their authorized representative
signature _____
date _____

EXHIBIT B-4

#67178-112

FPC FLORENCE, CO

CT Abdomen Pelvis with and without Contrast

Status: Final result

Study Result

EXAM: CT ABDOMEN PELVIS W WO CONTRAST

HISTORY: Colon mass

COMPARISON: None

TECHNIQUE: Routine multidetector acquisitions obtained through the abdomen and pelvis before and after IV contrast

FINDINGS: Normal liver, gallbladder, spleen, pancreas, adrenal glands, and kidneys. Small 1.5 cm right renal cyst. No hydronephrosis. Normal appendix. There is a sigmoid colon constricting mass measuring 6.8 x 3.8 cm. There are few if any diverticula seen in the colon. Moderately prominent prostate gland. 2.4 cm periportal lymph node. No other pathologic adenopathy. Lung bases are clear. Bony structures appear unremarkable.

IMPRESSION:
Sigmoid colon mass. Most probably cancer. Enlarged periportal lymph node. Metastatic disease to periportal lymph node is a consideration.

This exam was performed using automated exposure control, adjustment of mA or kV according to patient size, and/or use of iterative reconstruction technique

Transcribed by: NTS

WS: CECANSTM-RAD460
DICTATED BY: Harlow, Curtis Date: 01/24/2018 10:48:09 MT
TRANSCRIBED DATE: 01/24/2018 11:02:35 MT

Signed by

Signed	Date/Time	Phone	Pager
HARLOW, CURTIS LEE	1/24/2018 11:18	719-584-7415	

Exam Information

Status	Exam Begun	Exam Ended
Final [99]	1/24/2018 09:11	1/24/2018 09:36

Collection Information

Specimen ID: CT201801241224
Collected: 1/24/2018 10:48 AM
Resulting Agency: POWERSCRIBE

Risk Scores

No risk assessment data

FPC FLORENCE, CO

External Results Report
Open External Results Report

Encounter
View Encounter

Orders Requiring a Screening Form

Procedure	Order Status	Form Status
CT Abdomen Pelvis with and without Contrast	Completed	Created

IR Procedure Log
IR Procedure Documentation

Order Report
CT Abdomen Pelvis with and without Contrast (Order #169571975) on 1/24/18

Reprint Order Requisition
CT Abdomen Pelvis with and without Contrast (Order #169571975) on 1/24/18

Screening Form Questions
No questions have been answered for this form.

Medication Detail

	Disp	Refills	Start	End
CT Abdomen Pelvis with and without Contrast			1/24/2018	1/24/2018

Sig: Once.
Class: Ancillary Performed

Order Diagnosis: Mass of colon [K63.9 (ICD-10-CM)]
CPT: 74178 (1)

EXHIBIT B-5

Surgery Specialists of Fremont County, LLC 933A Sell Canon City, CO 81212 (719) 275-4061 FAX275-4058
Timothy R. Brown, M.D.

HISTORY AND PHYSICAL

Craig Scott #67178-112 Date of Birth: [redacted]1964

Referring Physician: Federal Bureau of Prisons (FPC)
Date of Service: 02/02/2018

FPC FLORENCE, CO

CHIEF COMPLAINT: Sigmoid Colon Tumor

HISTORY OF PRESENT ILLNESS: 53-year-old white male with a newly diagnosed sigmoid colon cancer is seen in the FPC clinic for evaluation. The tumor is low grade and the patient's CEA is normal. His CBC indicates a mild anemia. The tumor is located 20-25 centimeters from the anal verge on colonoscopy and is an apple core configuration with near obstruction. A CT scan showed one enlarged periportal lymph node but no liver disease. The patient describes no altered bowel habits, weight loss, or rectal bleeding at this time. He is very interested in pursuing sigmoid colectomy given the presence and nature of the lesion.

MEDICATIONS: Sertraline

ALLERGIES: no known medical allergies

PAST SURGICAL HISTORY: no previous abdominal surgery

REVIEW OF SYSTEMS: negative for recent heart attack, pneumonia, stroke, or blood clots; patient has had no acute illnesses requiring hospitalization

PAST MEDICAL HISTORY: depression

SOCIAL HISTORY: non-smoker, nondrinker, denies recreational drug use

PHYSICAL EXAMINATION: patient in no distress
Vital Signs – temperature 97, weight 225 pounds, pulse 84, height 70 inches
Cardiovascular - heart regular rate and rhythm without murmurs, rubs, or gallops; femoral pulses palpable
Lungs - clear to auscultation without wheezes or rales, no egophony
Abdomen – soft, flat, non-tender, both testicles descended without masses, bowel sounds normal, no evidence of organ enlargement – abdominal masses – hernias
Psychiatric - normal judgment and insight, alert and oriented times three; no evidence of depression – anxiety – suicidality – psychosis – personality disorder upon interview

IMPRESSION: 53-year-old white male with a sigmoid colon cancer

PLAN: Appropriate instructions and precautions were given to the patient. All of his questions were answered. I explained the risks, benefits, complications, and alternatives of open sigmoid colectomy to the patient who understands and agrees to proceed. All appropriate preoperative orders will be written on the day of surgery and the consent form signed. Surgery as an inpatient at a local hospital would be appropriate to remove the mass. A morning bowel preparation with Miralax or Colyte the day before surgery would be appropriate along with Neomycin 1 gram and Erythromycin 1 gram given at 1 o'clock, 3 o'clock, and 8 o'clock the afternoon after the bowel preparation. The patient can remain on a clear liquid diet the day before surgery and be NPO after midnight.

Timothy R. Brown, M.D.
General Surgeon

EXHIBIT C

April 10, 2018

Honorable Percy Anderson,

I am writing you regarding my husband of 32 years, Scott Craig (#67178-112), who is currently serving a 33 month prison sentence in Florence, CO where he self-surrendered on April 24, 2017.

On December 28, 2017 during a routine colonoscopy doctors found a malignant tumor and he was diagnosed with colon cancer. To date he has had surgery (March 14, 2018) to remove the tumor and has been diagnosed with Stage 3 Cancer and is need of further treatment consisting of chemotherapy. He currently is being treated for a staph infection and the BOP has approved a consultation with an oncologist, but to date he has not been scheduled for an appointment.

I am writing to you, pleading for your help and requesting home confinement as an alternative to imprisonment for the remainder of his sentence so my husband can seek the best cancer treatment available. I currently reside in Colorado Springs, CO, our home has been inspected and approved by Robert Haberman, US Probation Officer, assigned to Scott's case. We have private medical insurance that would cover the cost of his treatment, would lessen the financial burden to an already overtaxed BOP system and allow him the best possible opportunity for a full recovery.

Thank you for considering my request regarding his current imprisonment, immediate health crisis, and life-saving cancer treatment needed.

Respectfully,

Annette Craig

Annette Craig

[redacted]

EXHIBIT D

April 7, 2018

Honorable Percy Anderson,

On December 28, 2017 Doctors discovered a malignant tumor in my colon through a routine colonoscopy.

On March 14, 2018, I underwent surgery to remove the tumor and 11 inches of my colon. During the surgery several of my lymph nodes were collected and biopsied confirming that the cancer had spread from my colon to my lymph nodes. As a result, I have been diagnosed with Stage 3 cancer. My surgeon has told me the treatment needed for this type of cancer is chemotherapy.

To date, the Bureau of Prison has only approved a consultation with an oncologist but I have yet to be seen by one. My best chance for surviving this cancer is receiving the best treatment possible and in a timely manner.

I am pleading with you to consider a modification to my sentence allowing me to be confined to my home where I could receive my chemotherapy treatment. A sentence modification would allow me to recover between treatments, afford me a more humane and suitable environment to manage the side effects of chemotherapy.

I have medical insurance, which would cover my expected medical expenses. I am willing to assume all responsibility associated with my medical treatment.

I make this plea to you, for your compassionate consideration, on behalf of myself and my family.

Respectfully,

Scott A. Craig
#67178-112

EXHIBIT E

Honorable Percy Anderson, U.S. District Judge
Courtroom No. 9A 9th Floor
350 W. 1st Street
Los Angeles, CA 90012

March 6, 2018

Honorable Percy Anderson,

My name is Annette Craig and I am writing you on behalf of my husband of 32 years, Scott Craig (case# CR 13-819-PA), who appeared before you and was subsequently convicted and sentenced on September 23, 2014 (Reg. # 67178-112). He is currently serving his 33 month prison sentence in Florence, CO where he self-surrendered on April 24, 2017.

On December 28, 2017 during a colonoscopy they found a malignant tumor and he was diagnosed with colon cancer. To date he has not received surgery to remove the malignant tumor that was found over 2 months ago. I am writing to you, pleading for your help and requesting home confinement as an alternative to imprisonment for the remainder of his sentence so my husband can seek the best cancer treatment available. We have private medical insurance that would cover his treatment and would lessen the financial burden to an already overtaxed BOP system. I have enclosed copies of his medical records that we have to date for your review and consideration.

Thank you for considering my request regarding his current imprisonment, immediate health crisis, and life-saving cancer treatment needed.

Respectfully,
Annette Craig
[redacted]

EXHIBIT F

Robert Rabe

From: Annette Craig [redacted]
Sent: Friday, March 09, 2018 1:07 PM
To: Robert Rabe
Subject: Petitioning the BOP

Good Afternoon Robert,

Muna sent me your contact info and said that you would be the person to contact regarding petitioning the BOP.

My husband, Scott Craig, is currently serving his 33 month sentence in Florence, CO where he self-surrendered on April 24, 2017. On December 28, 2017 during a colonoscopy they found a malignant tumor and he was diagnosed with colon cancer. To date he has not had surgery so that the cancer can be surgically staged. We have the medical reports, pathology, blood work, CT Scan results which show that Metastatic disease to periportal lymph node is a consideration. We have been patiently waiting for Scott to have surgery. % weeks ago he was told by the surgeon he would see him "real soon" and yet to date we are still waiting. How long must we continue to wait while the cancer grows and the BOP continues to drag their feet??

Is this something that qualifies for petitioning the BOP? If so what kind of timeline are we looking at and what is the fee for you filing?

I appreciate any help and direction that you can provide.

--
Thank you for making a difference in the lives of our teens,

Annette Craig

[redacted]

EXHIBIT G

Robert Rabe

From: Annette Craig [redacted]
Sent: Friday, April 06, 2018 10:49 AM
To: Muna Busailah; Robert Rabe
Subject: Update on Scott

Good Morning Robert & Muna,
I will be sending you the information requested by Robert this weekend, I should be getting Scott's letter tonight or tomorrow requesting chemo at home. I just got this email from Scott:

I went to medical today because my staples were bugging me. As luck would have it my surgeon (Dr Brown) was there. He was pleased with the healing. They lanced part of my incision and drained it. Antibiotics to be extended for another week. Dr Brown informed me the "tumor board" met yesterday and my case was discussed. My cancer has been classified as stage 3. He told the medical staff here they need to get my chemotherapy started. He said if they start treating it soon they can reduce a chance of reoccurence by half. I will request any paperwork documenting that. The records lady is not working today.

Not sure if this info helps at all... just wanting to give you everything possible to persuade Judge Anderson to find in our favor.

--
Thank you for making a difference in the lives of our teens,

Annette Craig

[redacted]

EXHIBIT H

Robert Rabe

From: Annette Craig [redacted]
Sent: Wednesday, April 11, 2018 2:41 PM
To: Robert Rabe; Muna Busailah
Subject: Information Requested to Submit To Judge Anderson
Attachments: Honorable Percy Anderson Letter_SAC.docx; AC's Letter to Hon. Percy Anderson_ 4-10-18docx.docx; Scott Kaiser Ins. Card.pdf

Hi Robert,

I have attached copies of letters from Scott and myself requesting home confinement for chemotherapy and a copy of his insurance card per your request.

On Thursday, April 4, 2018 he saw Dr Brown, his surgeon, just by happenstance when he went to have his incision rechecked for staph infection. Dr. Brown said that he needed the incision lanced and drained and prescribed another week of antibiotics. He told Scott that the tumor board had met and discussed his case. He was diagnosed with Stage 3 cancer. Dr. Brown told the medical staff that they needed to get is chemotherapy started. He told them that if they start treating him soon they could reduce the risk of recurrence by half.

He has yet to be seen by the oncologist and he has no treatment plan. I understand that you wanted to have a treatment plan to send with our request, but we need him to be seen as soon as possible and that's not happening. Can we submit the request to Judge Anderson based on that fact that if he was on home confinement he could have already been seen by an oncologist and treatment could have been started?

As you can imagine we are both anxious to get treatment started so that he doesn't have to run the risk of recurrence...please let me know your thoughts.

Thank you.

--

Thank you for making a difference in the lives of our teens,

Annette Craig

[redacted]

EXHIBIT I

Robert Rabe

From: Annette Craig [redacted]
Sent: Friday, April 20, 2018 12:04 PM
To: Robert Rabe; Muna Busailah
Subject: Request Status

Hi Robert & Muna,

I just wanted tto check in and see if you had an idea on when we would be submitting the request to Percy? It has been another week (5 weeks total since he had surgery), he still hasn't met with an oncologist and we have no treatment plan for chemo until after he meets with the oncologist. Once we have a plan then the BOP has to approve it...at this rate we will be lucky if he starts chemo by June.

Time is crucial, according to his surgeon, and if he starts chemo he reduce recurrence by half. I will see him tonight and would like to have a timeline on the request to share with him if you have one.

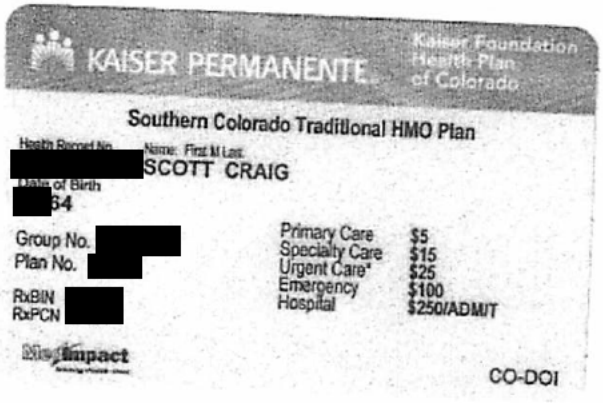
We appreciate you and your help.

--
Thank you for making a difference in the lives of our teens,

Annette Craig

[redacted]

EXHIBIT J


KAISER PERMANENTE
Kaiser Foundation Health Plan of Colorado
Southern Colorado Traditional HMO Plan
Health Record No. [redacted]
Name: First M Last
SCOTT CRAIG
Date of Birth
[redacted]54
Group No. [redacted]
Plan No. [redacted]
RxBIN [redacted]
RxPCN
MedImpact
Primary Care $5
Specialty Care $15
Urgent Care* $25
Emergency $100
Hospital $250/ADM/T
CO-DOI

Emergency:	911	
Medical Advice and Urgent Care*:	1-800-218-1059	711 TTY
Member Services:	1-888-681-7878	711 TTY
Claims Information:	1-888-681-7878	
MedImpact Customer Service:	1-800-788-2949	
Mail Order Pharmacy:	1-866-523-6059	

Notify Member Services at **1-888-681-7878** if you receive emergency hospital services in a non-plan facility.

Submit Claims to: **Kaiser Permanente Claims Department**
PO Box 373150, Denver, CO 80237-3150

This card is for identification only. Possession of this card confers no right to services or other benefits unless the holder is a member complying with all provisions of an applicable agreement. * See Evidence of Coverage for benefit details.

kp.org Card Issued: 03-10-2018

EXHIBIT K

Treatment of Colon Cancer, by Stage

Treatment for colon cancer (/cancer/colon-rectal-cancer/about/what-is-colorectal-cancer.html) is based largely on the stage (/cancer/colon-rectal-cancer/detection-diagnosis-staging/staged.html) (extent) of the cancer, but other factors can also be important.

People with colon cancers that have not spread to distant sites usually have surgery (/cancer/colon-rectal-cancer/treating/colon-surgery.html) as the main or first treatment. Chemotherapy (/cancer/colon-rectal-cancer/treating/chemotherapy.html) may also be used after surgery (called adjuvant treatment). Most adjuvant treatment is given for about 6 months.

Treating stage 0 colon cancer

Since stage 0 colon cancers have not grown beyond the inner lining of the colon, surgery (/cancer/colon-rectal-cancer/treating/colon-surgery.html) to take out the cancer is often the only treatment needed. In most cases this can be done by removing the polyp or taking out the area with cancer through a colonoscope (local excision). Removing part of the colon (partial colectomy) may be needed if a tumor is too big to be removed by local excision.

Treating stage I colon cancer

Stage I colon cancers have grown deeper into the layers of the colon wall, but they have not spread outside the colon wall itself or into the nearby lymph nodes (/cancer/cancer-basics/lymph-nodes-and-cancer.html).

Stage I includes cancers that were part of a polyp. If the polyp is removed completely during colonoscopy, with no cancer cells at the edges (margins) of the removed piece, no other treatment may be needed.

If the cancer in the polyp is high grade (see Colorectal Cancer Stages (/cancer/colon-rectal-cancer/detection-diagnosis-staging/staged.html) for more on this), or there are cancer cells at the edges of the polyp, more surgery might be recommended. You might also be advised to have more surgery if the polyp couldn't be removed completely or if it had to be removed in many pieces, making it hard to see if cancer cells were at the edges.

For cancers not in a polyp, partial colectomy — surgery to remove the section of colon that has cancer and nearby lymph nodes — is the standard treatment. You typically won't need any more treatment.

Treating stage II colon cancer

Many stage II colon cancers have grown through the wall of the colon, and maybe into nearby tissue, but they have not spread to the lymph nodes (/cancer/cancer-basics/lymph-nodes-and-cancer.html).

Surgery to remove the section of the colon containing the cancer (partial colectomy) along with nearby lymph nodes may be the only treatment needed. But your doctor may recommend adjuvant chemotherapy (/cancer/colon-rectal-cancer/treating/chemotherapy.html) (chemo after surgery) if your cancer has a higher risk of coming back (recurring) because of certain factors, such as:

- The cancer looks very abnormal (is high grade) when viewed under a microscope.
- The cancer has grown into nearby blood or lymph vessels.
- The surgeon did not remove at least 12 lymph nodes.
- Cancer was found in or near the margin (edge) of the removed tissue, meaning that some cancer may have been left behind.
- The cancer had blocked off (obstructed) the colon.
- The cancer caused a perforation (hole) in the wall of the colon.

Not all doctors agree on when chemo should be used for stage II colon cancers. It's important for you to discuss the pros and cons of chemo with your doctor, including how much it might reduce your risk of recurrence and what the likely side effects will be.

If chemo is used, the main options include 5-FU and leucovorin, oxaliplatin, or capecitabine, but other combinations may also be used.

Treating stage III colon cancer

Stage III colon cancers have spread to nearby lymph nodes (/cancer/cancer-basics/lymph-nodes-and-cancer.html), but they have not yet spread to other parts of the body.

Surgery to remove the section of the colon with the cancer (partial colectomy) along with nearby lymph nodes, followed by adjuvant chemo is the standard treatment for this stage.

For chemo, either the **FOLFOX** (5-FU, leucovorin, and oxaliplatin) or **CapeOx** (capecitabine and oxaliplatin) regimens are used most often, but some patients may get 5-FU with leucovorin or capecitabine alone based on their age and health needs.

Radiation therapy and/or chemo may be options for people who aren't healthy enough for surgery.

Treating stage IV colon cancer

Stage IV colon cancers have spread from the colon to distant organs and tissues. Colon cancer most often spreads to the liver, but it can also spread to other places like the lungs, brain, peritoneum (the lining of the abdominal cavity), or to distant lymph nodes (/cancer/cancer-basics/lymph-nodes-and-cancer.html).

In most cases surgery (/cancer/colon-rectal-cancer/treating/colon-surgery.html) is unlikely to cure these cancers. But if there are only a few small areas of cancer spread (metastases) in the liver or lungs and they can be removed along with the colon cancer, surgery may help you live longer and may even cure you. This would mean having surgery to remove the section of the colon containing the cancer along with nearby lymph nodes, plus surgery to remove the areas of cancer spread. Chemo (/cancer/colon-rectal-cancer/treating/chemotherapy.html) is typically given as well, before and/or after surgery. In some cases, hepatic artery infusion (/cancer/colon-rectal-cancer/treating/chemotherapy.html) may be used if the cancer has spread to the liver.

If the metastases cannot be removed because they're too big or there are too many of them, chemo may be given before any surgery (neoadjuvant chemo). Then, if the tumors shrink, surgery to remove them may be tried. Chemo would then be given again after surgery. For tumors in the liver, another option may be to destroy them with ablation or embolization (/cancer/colon-rectal-cancer/treating/ablation-embolization.html).

If the cancer has spread too much to try to cure it with surgery, chemo is the main treatment. Surgery might still be needed if the cancer is blocking the colon or is likely to do so. Sometimes, such surgery can be avoided by putting a stent (/cancer/colon-rectal-cancer/treating/colon-surgery.html) (a hollow metal or plastic tube) into the colon during a colonoscopy to keep it

open. Otherwise, operations such as a colectomy or diverting colostomy (/cancer/colon-rectal-cancer/treating/colon-surgery.html) (cutting the colon above the level of the cancer and attaching the end to an opening in the skin on the belly to allow waste out) may be used.

If you have stage IV cancer and your doctor recommends surgery, it's very important to understand the goal of the surgery — whether it's to try to cure the cancer or to prevent or relieve symptoms of the disease.

Most people with stage IV cancer will get chemo and/or targeted therapies (/cancer/colon-rectal-cancer/treating/targeted-therapy.html) to control the cancer. Some of the most commonly used regimens include:

- FOLFOX: leucovorin, 5-FU, and oxaliplatin (Eloxatin)
- FOLFIRI: leucovorin, 5-FU, and irinotecan (Camptosar)
- CAPEOX or CAPOX : capecitabine (Xeloda) and oxaliplatin
- FOLFOXIRI: leucovorin, 5-FU, oxaliplatin, and irinotecan
- One of the above combinations plus either a drug that targets VEGF, (bevacizumab [Avastin], ziv-aflibercept [Zaltrap], or ramucirumab [Cyramza]), or a drug that targets EGFR (cetuximab [Erbitux] or panitumumab [Vectibix])
- 5-FU and leucovorin, with or without a targeted drug
- Capecitabine, with or without a targeted drug
- Irinotecan, with or without a targeted drug
- Cetuximab alone
- Panitumumab alone
- Regorafenib (Stivarga) alone
- Trifluridine and tipiracil (Lonsurf)

The choice of regimens depends on several factors, including any previous treatments you've had and your overall health.

If one of these regimens is no longer working, another may be tried. For people with certain gene changes in their cancer cells, another option after initial chemotherapy might be treatment with an immunotherapy drug (/cancer/colon-rectal-cancer/treating/immunotherapy.html)such as pembrolizumab (Keytruda).

For advanced cancers, radiation therapy (/cancer/colon-rectal-cancer/treating/radiation-therapy.html) can also be used to help prevent or relieve symptoms such as pain (/treatment/treatments-and-side-effects/physical-side-effects/pain.html). It may shrink tumors for a time, but it's not likely to cure the cancer. If your doctor recommends radiation therapy, it's important that you understand the goal of treatment.

Treating recurrent colon cancer

Recurrent cancer (/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html) means that the cancer has come back after treatment. The recurrence may be local (near the area of the initial tumor), or it may be in distant organs.

Local recurrence

If the cancer comes back locally, surgery (/cancer/colon-rectal-cancer/treating/colon-surgery.html) (often followed by chemo (/cancer/colon-rectal-cancer/treating/chemotherapy.html)) can sometimes help you live longer and may even cure you. If the cancer can't be removed surgically, chemo might be tried first. If it shrinks the tumor enough, surgery might be an option. This would again be followed by more chemo.

Distant recurrence

If the cancer comes back in a distant site, it's most likely to appear in the liver first. Surgery might be an option for some people. If not, chemo may be tried to shrink the tumor(s), which may then be followed by surgery to remove them. Ablation or embolization (/cancer/colon-rectal-cancer/treating/ablation-embolization.html) techniques might also be an option to treat some liver tumors.

If the cancer has spread too much to be treated with surgery, chemo and/or targeted therapies (/cancer/colon-rectal-cancer/treating/targeted-therapy.html) may be used. Possible regimens are the same as for stage IV disease.

For people whose cancers are found to have certain traits on lab tests, another option might be treatment with immunotherapy (/cancer/colon-rectal-cancer/treating/immunotherapy.html).

Your options depend on which, if any, drugs you had before the cancer came back and how long ago you got them, as well as your overall health. You may still need surgery at some point to relieve or prevent blockage of the colon or other local problems. Radiation therapy (/cancer/colon-rectal-cancer/treating/radiation-therapy.html) may be an option to relieve symptoms as well.

Recurrent cancers can often be hard to treat, so you might also want to ask your doctor if clinical trials (/treatment/treatments-and-side-effects/clinical-trials.html) of newer treatments are available.

For more on recurrence, see Understanding Recurrence (/treatment/survivorship-during-and-after-treatment/understanding-recurrence.html).

The treatment information given here is not official policy of the American Cancer Society and is not intended as medical advice to replace the expertise and judgment of your cancer care team. It is intended to help you and your family make informed decisions, together with your doctor. Your doctor may have reasons for suggesting a treatment plan different from these general treatment options. Don't hesitate to ask him or her questions about your treatment options.

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Libutti SK, Salz LB, Willett CG, Levine RA. Chapter 57: Cancer of the colon. In: DeVita VT, Lawrence TS, Rosenberg SA, eds. DeVita, Hellman, and Rosenberg's Cancer: Principles and Practice of Oncology. 10th ed. Philadelphia, Pa: Lippincott Williams & Wilkins; 2015.

National Cancer Institute. Colon Cancer Treatment (PDQ®)–Patient Version. December 7, 2017. Accessed at www.cancer.gov/types/colorectal/patient/colon-treatment-pdq on February 14, 2018.

National Comprehensive Cancer Network, Clinical Practice Guidelines in Oncology (NCCN Guidelines®), Colon Cancer, Version I.2018 -- January 18, 2018. Accessed at www.nccn.org/professionals/physician_gls/pdf/colon.pdf on February 14, 2018.

Van Schaeybroeck S, Lawler M, Johnston B, et al. Colorectal cancer. In: Neiderhuber JE, Armitage JO, Doroshow JH, Kastan MB, Tepper JE, eds. Abeloff's Clinical Oncology. 5th ed. Philadelphia, Pa: Elsevier; 2014: 1278-1335.

EXHIBIT L

Survival Rates for Colorectal Cancer, by Stage

Survival rates tell you what portion of people with the same type and stage of cancer are still alive a certain amount of time (usually 5 years) after they were diagnosed. They can't tell you how long you will live, but they may help give you a better understanding about how likely it is that your treatment will be successful. Some people will want to know the survival rates for their cancer type and stage, and some people won't. If you don't want to know, you don't have to.

What is a 5-year survival rate?

Statistics on the outlook for a certain type and stage of cancer are often given as 5-year survival rates, but many people live longer – often much longer – than 5 years. The 5-year survival rate is the percentage of people who live at least 5 years after being diagnosed with cancer. For example, a 5-year survival rate of 90% means that an estimated 90 out of 100 people who have that cancer are still alive 5 years after being diagnosed. Keep in mind, however, that many of these people live much longer than 5 years after diagnosis.

Relative survival rates are a more accurate way to estimate the effect of cancer on survival. These rates compare people with colorectal cancer to people in the overall population. For example, if the 5-year relative survival rate for a specific type and stage of cancer is 90%, it means that people who have that cancer are, on average, about 90% as likely as people who don't have that cancer to live for at least 5 years after being diagnosed.

But remember, the 5-year relative survival rates are estimates – your outlook can vary based on a number of factors specific to you.

Cancer survival rates don't tell the whole story

Survival rates are often based on previous outcomes of large numbers of people who had the disease, but they can't predict what will happen in any particular person's case. There are a number of limitations to remember:

- The numbers below are among the most current available. But to get 5-year survival rates, doctors have to look at people who were treated at least 5 years ago. As treatments are improving over time, people who are now being diagnosed with colorectal cancer may have a better outlook than these statistics show.
- These statistics are based on the stage of the cancer when it was first diagnosed. They do not apply to cancers that later come back or spread, for example.
- The outlook for people with colorectal cancer varies by the stage (/cancer/colon-rectal-cancer/detection-diagnosis-staging/staged.html) (extent) of the cancer – in general, the survival rates are better for people with earlier stage cancers. But many other factors can affect a person's outlook, such as age and overall health, and how well the cancer responds to treatment. The outlook for each person is specific to his or her circumstances.

Your doctor can tell you how these numbers may apply to you, as he or she is familiar with your particular situation.

Colon cancer survival rates, by stage

The numbers below come from the National Cancer Institute's SEER database, looking at people diagnosed with colon cancer between 2004 and 2010.

- The 5-year relative survival rate for people with **stage I** colon cancer is about 92%.
- For people with **stage IIA** colon cancer, the 5-year relative survival rate is about 87%. For **stage IIB** cancer, the survival rate is about 63%.
- The 5-year relative survival rate for **stage IIIA** colon cancers is about 89%. For **stage IIIB** cancers the survival rate is about 69%, and for stage **IIIC** cancers the survival rate is about 53%.
- Colon cancers that have spread to other parts of the body are often harder to treat and tend to have a poorer outlook. Metastatic, or **stage IV** colon cancers, have a 5-year relative survival rate of about 11%. Still, there are often many treatment options available for people with this stage of cancer.

These statistics are based on a previous version of the TNM staging system. In that version, there was no stage IIC (those cancers were considered stage IIB). Also, some cancers that are now considered stage IIIC were classified as stage IIIB, while some other cancers that are now considered stage IIIB were classified as stage IIIC.

Remember, these survival rates are only estimates – they can't predict what will happen to any individual person. We understand that these statistics can be confusing and may lead you to have more questions. Talk to your doctor to better understand your specific situation.

Rectal cancer survival rates, by stage

The numbers below come from the National Cancer Institute's SEER database, looking at people diagnosed with rectal cancer between 2004 and 2010.

- The 5-year relative survival rate for people with **stage I** rectal cancer is about 87%.
- For people with **stage IIA** rectal cancer, the 5-year relative survival rate is about 80%. For stage IIB cancer, the survival rate is about 49%.
- The 5-year relative survival rate for **stage IIIA** rectal cancers is about 84%. For **stage IIIB** cancers the survival rate is about 71%, and for **stage IIIC** cancers the survival rate is about 58%.
- Rectal cancers that have spread to other parts of the body are often harder to treat and tend to have a poorer outlook. Metastatic, or **stage IV** rectal cancers, have a 5-year relative survival rate of about 12%. Still, there are often many treatment options available for people with this stage of cancer.

These statistics are based on a previous version of the TNM staging system. In that version, there was no stage IIC (those cancers were considered stage IIB). Also, some cancers that are now considered stage IIIC were classified as stage IIIB, while some other cancers that are now considered stage IIIB were classified as stage IIIC.

Remember, these survival rates are only estimates – they can't predict what will happen to any individual person. We understand that these statistics can be confusing and may lead you to have more questions. Talk to your doctor to better understand your specific situation.

Written by References