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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
EASTERN DIVISION – RIVERSIDE

FAOUR ABDALLAH FRAIHAT *et al.*,

Plaintiffs,

v.

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT *et al.*,

Defendants.

Case No. 5:19-cv-1546-JGB-SHK

BRIEF OF *AMICI CURIAE* PUBLIC HEALTH EXPERTS

Date: April 9, 2020

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INTEREST OF THE *AMICI CURIAE*

Amici curiae are experts in infectious diseases, healthcare policy, correctional healthcare, human rights, and other related fields who have decades of cumulative experience researching infectious diseases, crafting and evaluating public policy regarding the medical care of prisoners and detained persons, and treating patients in clinical settings, including in emergency departments. Based on their experience, and their review of the available information about the COVID-19 pandemic, it is their view that Plaintiffs in this action are at high risk of serious, life-threatening COVID-19 infection, and that their continued confinement puts them at a heightened risk of contracting and further spreading COVID-19.

Parveen Parmar, M.D., M.P.H., is the Chief of the Division of Global Emergency Medicine at the University of Southern California Keck School of Medicine, where she is an Associate Professor of Clinical Emergency Medicine, and the founder of Southern California Physicians for Health Equity, a group committed to protecting access to care for all patients, including undocumented immigrants. Dr. Parmar's research has focused on the study of health and human rights violations in refugees and internally displaced populations. Dr. Parmar has supported health care for refugees and other vulnerable persons globally in multiple settings – on issues such as emergency care delivery, maternal and child health, gender-based violence, and primary care provision. Currently Dr. Parmar is researching deaths in ICE detention centers nationally over the past decade, and she has extensive experience reviewing medical records of individuals currently in ICE detention.

Katherine P. Anderson, M.D., is an Assistant Professor of Family Medicine at the University of Colorado, Anschutz Medical Campus. Dr. Anderson has expertise in preventative medicine in underserved populations and has worked in federally qualified health centers in Colorado for twenty-three years. Dr. Anderson has worked extensively to assist training and coordination of clinician volunteers conducting forensic medical exams for detained persons at the Aurora, Colorado facility.

Lilia Cervantes, M.D., is an Associate Professor in the Department of Medicine at the University of Colorado, Anschutz Medical Campus. Dr. Cervantes has conducted extensive research and published on topics that highlight the worse outcomes faced by undocumented immigrants with poor access to care and has worked with key health policy and community stakeholders in the state of Colorado to change health policy and expand access to care for undocumented immigrants.

Annelies De Wulf, M.D., M.P.H., is an Emergency Medicine Physician at the University Medical Center of New Orleans. She is the Director in International Emergency Medicine and an Associate Program Director for the Spirit of Charity, Louisiana State University Emergency Medicine Residency in New Orleans. She is also the President-Elect of the American College of Academic International Medicine, a group focused on improving quality of medical care worldwide. She has researched and published on the topics of interpersonal violence and risk reduction, ethics of international medicine programs, and emergency care capacity building in resource-limited settings. Much of her teaching is focused on patient centered care, social determinants of health, and advocacy for vulnerable populations.

Carlos Franco-Paredes, M.D., M.P.H., is an Associate Professor of Medicine at the University of Colorado in the Department of Medicine, Division of Infectious Diseases. Dr. Franco-Paredes holds a public health degree with a concentration on the dynamics of global infectious disease epidemics and pandemics and from 2006 to 2009 participated in developing international guidelines for pandemic influenza preparedness and response as well as a global health action plan with the World Health Organization. He has written and published extensively on the topics of infectious diseases pandemics and epidemics, particularly in influenza. He also has experience providing care to individuals in civil detention centers in the United States (US) and has performed medical forensic examinations and medical second opinion evaluations for patients in ICE custody.

Dr. Mark Earnest is a Professor of Medicine at the University of Colorado School of Medicine where he serves as the Chief of General Internal Medicine. Dr. Earnest has taught Health Policy and published in areas related to Health Policy and health equity. He currently serves as the chairman of the Health Policy Committee of the Society of General Internal Medicine.

Matthew Gartland, M.D., is an Attending Physician in the Division of General Internal Medicine at Brigham and Women's Hospital in Boston, MA, the Department of Pediatrics at Newton Wellesley Hospital, Newton, MA, and the Department of Medicine at Harvard Medical School. He has participated in inpatient clinical care of adult and pediatric COVID-19 patients and is a contributor to the authorship of Brigham and Women's Hospital's clinical protocols for the care of patients with COVID-19, open access at covidprotocols.org. He is also the Director of the Massachusetts General Hospital Asylum Clinic, and in this capacity has conducted numerous medical and psychological evaluations of persons seeking asylum in the United States including individuals in ICE detention.

Marcia Glass, M.D., is an Associate Professor of Internal Medicine at Tulane University. Dr. Glass provides inpatient consultations as a member of the New Orleans VA Hospice and Palliative Medicine group and also provides care for hospitalized medical patients as part of the UMC hospitalist group, as well as teaching for medical students and residents. Dr. Glass has worked internationally with Doctors Without Borders, the Yale/Stanford Johnson and Johnson Global Health Program, Columbia University, UCSF, and Partners in Health. Dr. Glass also is the coauthor of the recently published Oxford Field Manual for Palliative Care in Humanitarian Crises.

Rohini J. Haar, M.D., M.P.H., is a Lecturer at the University of California at Berkeley School of Public Health in the Division of Epidemiology and Biostatistics, Berkeley CA and an emergency medicine physician at Physician, Kaiser Medical Center in Oakland, California. Dr. Haar is also a medical adviser to Physicians for Human Rights and has expertise in the fields of health and human rights. In addition to being a practicing physician

in Oakland, California, her research and advocacy work focuses on the protection of human rights in times of complex humanitarian crisis particularly for vulnerable populations. She teaches on global health ethics and health and human rights, with a focus on torture and the health impacts of human rights violations. She has specific expertise in documenting torture and has taught and written on the Istanbul Protocol, including working on the 2020 update to the Istanbul Protocol manual. She has conducted more than 100 evaluations of torture survivors and asylum seekers both in and out of detention.

Danielle Loeb, M.D., M.P.H, is an Associate Professor of Medicine at the University of Colorado School of Medicine, where she works as a primary care physician and healthcare services researcher. Dr. Loeb is a practicing physician and has researched and published on topics related to the delivery of care for patients with complex care needs, especially those with chronic medical and mental health conditions.

Jaime Moo-Young, M.D. is a primary care physician in Denver and an Assistant Professor of General Internal Medicine at the University of Colorado School of Medicine. She is the co-founder and co-medical director of Colorado's first Human Rights Clinic, which provides medical and mental health forensic evaluations for immigrants seeking asylum and other legal statuses in the United States. She also co-founded the Colorado Human Rights Consortium, a non-profit alliance of healthcare and legal professionals collaborating to address the intersecting medical and legal needs of immigrants across the state. She has extensive clinical experience working with refugee and immigrant populations, including detained immigrants in the GEO ICE Processing Center in Aurora, Colorado.

Todd Schneberk, M.D., is an assistant professor of clinical emergency medicine and an assistant program director of the LAC+USC Emergency Medicine Residency program. He completed his residency in emergency medicine at LAC+USC Medical Center and subsequently earned a fellowship in health policy and research at the University of California Los Angeles. His research and advocacy interests include social determinants of

health, immigration status as a health barrier, opioid use disorder and leveraging the emergency department to address upstream factors affecting the health and stability of vulnerable populations.

Sophie Terp, MD, MPH is an Assistant Professor of Clinical Emergency Medicine at the USC Keck School of Medicine. Dr. Terp is an emergency physician and health services researcher who studies access to emergency care for vulnerable populations. She works with incarcerated populations in the emergency department at LAC+USC Medical Center and is currently studying facility compliance with ICE Performance-Based National Detention as it pertains to deaths of persons in ICE custody.

Susi Vassallo, M.D., is a Clinical Professor at the Ronald O. Perelman Department of Emergency Medicine and NYU Langone Health. Dr. Vassallo is a nationally recognized expert in toxicology and emergency medicine.

Matthew Wynia, MD, MPH is a Professor of Medicine and of Public Health at the University of Colorado and the Director of the CU Center for Bioethics and Humanities. He has long-standing expertise in ethical issues in disasters and sits on the National Academies of Sciences, Engineering and Medicine's Forum on Medical and Public Health Preparedness for Disasters and Emergencies, and he has published widely on the ethics of triage and crisis standards of care.

Janine Young, M.D., FAAP, is an Associate Professor of Pediatrics at the University of Colorado School of Medicine and an expert in immigrant and refugee health. Dr. Young has continuously worked with immigrants and refugees over her twenty-year career and is a founding member of the Colorado Human Rights Consortium. In that capacity, she has provided her expertise, *pro bono*, for immigrants held in detention. She has spoken nationally, published articles, and presented webinars on healthcare for immigrant children and adults, including refugees, unaccompanied minors, and undocumented immigrants.

Amici seek to inform this Court about the direct injuries to personal health that Plaintiffs are likely to suffer absent the requested relief. Additionally, *Amici* seek to inform the Court about the impact to the broader public if those injuries are not mitigated.[1]

ARGUMENT

Rarely has this Nation faced so great a challenge. COVID-19 is an extremely infectious disease and its effects for many are serious enough to warrant hospitalization and all too often are fatal nonetheless. Given those basic realities, the rapid spread of COVID-19 across the globe has created an unprecedented international health crisis. In the United States, the epidemic has led to the adoption and implementation of unprecedented, but necessary, mitigation strategies, including the canceling of public events, the closing of schools and businesses, and stay-at-home orders to the general public. At present, there is no vaccine or cure for COVID-19.

It is imperative to the national interest that the spread of COVID-19 within detention facilities be managed aggressively. Such facilities, including those operated by Immigration and Customs Enforcement (ICE), are enclosed environments, which makes them, like cruise ships, highly susceptible to epidemics. That is because the now all too familiar tools for managing the spread of COVID-19—firm social distancing measures and aggressive hygiene protocols—are all but impossible in a detention facility setting, in which detained persons are crowded together, sharing bathroom products, and where sanitizing products are infrequently used. So without an immediate and substantial change to that *status quo*, it is a matter of time before the ICE detention facilities experience an outbreak of COVID-19 that will jeopardize the safety and well-being of those who are confined there, including Plaintiffs.

Amici believe that ICE has not—and cannot—take measures sufficient to blunt the spread of COVID-19 in ICE detention facilities. This is of grave concern not just to Plaintiffs and detention facility staff, but to the entire Nation. If, and when, an outbreak

[1] The opinions expressed in this brief are solely those of the *amici curiae* and should not be construed to represent the views of the various institutions with which they are affiliated.

occurs at these facilities, a significant number of the detained persons and staff alike will require hospitalizations that cannot be provided at the ICE facilities themselves. Instead, the burden to care for these individuals will fall to local hospital systems. This will create a significant risk of local hospitals being overrun, thereby preventing all those who need critical care from receiving it.

The only way to prevent a public health crisis in the communities located near ICE's detention facilities is to immediately reduce the density of the detention centers and significantly reform the prophylactic measures in place at such facilities for the detained persons who remain. The urgency for the Court to mandate these steps cannot be overstated. Given the speed with which COVID-19 is spreading, permitting ICE to delay these necessary reforms will place countless lives in danger. Allowing the *status quo* to endure is a recipe for a public health disaster.

I. Under Current Conditions, It Is Only A Matter Of Time Before There Will Be A Dangerous Outbreak Of The Highly Contagious COVID-19 Virus At ICE Detention Facilities.

A. COVID-19 Is A Dangerous Disease That Requires Aggressive And Proactive Measures To Curb Its Transmission.

The COVID-19 pandemic is an ongoing pandemic of coronavirus disease 2019 that is caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). As of April 8, 2020, there were 1,353,361 confirmed cases and 79,235 confirmed deaths worldwide.[2] In the United States, there were 395,011 confirmed cases and 12,754 confirmed deaths.[3] Due to the apparent ease with which COVID-19 spreads, it is expected that these numbers will continue to rise exponentially.[4]

COVID-19 is highly transmissible. Recent estimates suggest that, on average in community settings, each infected person transmits the virus to an additional 2.79 people

[2] *See* World Health Organization, *Coronavirus Disease (COVID-19) Pandemic* (2020), https://www.who.int/emergencies/diseases/novel-coronavirus-2019.
[3] *See* Centers for Disease Control & Prevention, *Coronavirus Disease 2019 (COVID-19): Cases & Latest Updates*, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.
[4] *See* Centers for Disease Control & Prevention, *Situation Summary* (2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html.

(*i.e.*, the reproductive number).[5] If that figure is correct, a single infected person can be responsible for 28,579 infections after just ten iterations of infection.

There are multiple reasons why COVID-19 has proven to be so communicable. *First*, even asymptomatic individuals can transmit the disease to others,[6] meaning that separating from others only those who exhibit symptoms will not stop the infection's spread. *Second*, the virus has been found to have an incubation period of fourteen days,[7] allowing infected (and potentially asymptomatic) individuals to unwittingly infect others for weeks. *Third*, the virus can survive outside the body for prolonged periods of time—for example, COVID-19 has been detected for up to seventy-two hours on plastic and stainless steel, twenty-four hours on cardboard, four hours on copper, and three hours as an aerosol.[8]

The effects of COVID-19 also are potentially life-threatening. One-fifth of all cases cause serious illness, including respiratory damage that requires hospitalization and mechanical ventilation, and can permanently harm those who survive.[9] As of April 6, the U.S. mortality rate was 3.13%.[10] By contrast, heart disease, which consistently ranks as the leading cause of death in the United States, has a death rate over eight times smaller (0.2%).[11] The risk is even greater for those who are over the age of 65, and those of any age

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[5] Ying Liu et al., *The Reproductive Number Of COVID-19 Is Higher Compared To SARS Coronavirus*, 27 J. Travel Med. 1, 1 (Feb. 13, 2020), https://academic.oup.com/jtm/article/27/2/taaa021/5735319.

[6] Yan Bai et al., *Presumed Asymptomatic Carrier Transmission Of COVID-19*, JAMA (Feb. 21, 2020), https://jamanetwork.com/journals/jama/article-abstract/2762028.

[7] Centers for Disease Control & Prevention, *Interim Clinical Guidance For Management Of Patients With Confirmed Coronavirus Disease (COVID-19)*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html.

[8] Neeltje van Doremalen et al., *Aerosol & Surface Stability Of SARS-CoV-2 As Compared With SARS-CoV-1*, (letter to editor) New Engl. J. Med. (Mar. 17, 2020), https://www.nejm.org/doi/full/10.1056/NEJMc2004973.

[9] "While about 80% of cases manifest as a mild illness (i.e. non-pneumonia or mild pneumonia), approximately 20% progress to a more severe illness, with 6% requiring specialist medical care, including mechanical ventilation." World Health Organization, *Preparedness, Prevention And Control Of COVID-19 In Prisons And Other Places Of Detention: Interim Guidance*, 10 (Mar. 15, 2020), http://www.euro.who.int/__data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1.

[10] Jason Oke & Carl Heneghan, CEBM, *Oxford COVID-19 Evidence Service* (updated Apr. 7, 2020), https://www.cebm.net/covid-19/global-covid-19-case-fatality-rates.

[11] Kenneth D. Kochanek et al., *Deaths: Final Data for 2017*, Nat'l Vital Stat. Rep., 6 tbl. B (June 24, 2019), https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf.

with underlying health problems such as—but not limited to—weakened immune systems, diabetes, and diseases of the lungs, kidneys, heart, and liver.[12]

Because of its high mortality rate and transmissibility, both the World Health Organization (WHO) and the Centers for Disease Control & Prevention (CDC) consider COVID-19 a public health emergency.[13] To contain the disease, public bodies across the globe have urged individuals and communities to implement two critical public health practices. *First*, proper hygiene practices, including regular hand washing with soap for at least twenty seconds, especially after coughing, sneezing, blowing one's nose, using the bathroom, eating, preparing food, taking medication, or touching garbage. Such practices are vital to prevent COVID-19 transmission due to the virus's ability to survive inside and outside the body for long periods of time. *Second*, as a leading and frequently cited report from the Imperial College London has suggested, "suppression will minimally require a combination of social distancing of the entire population, home isolation of cases and household quarantine of their family members."[14] Thus, the CDC has recommended that all individuals engage in such "social distancing" by staying at least six-feet apart throughout the duration of the pandemic.[15] Keeping distance from others is especially important with COVID-19 because asymptomatic individuals often are contagious without knowing it. And when social distancing is not practical, the CDC recommends "cohorting"—the

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[12] Centers for Disease Control & Prevention, *People Who Are At Higher Risk For Severe Illness*, https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html (last accessed Apr. 8, 2020).

[13] World Health Organization, *Statement On The Second Meeting Of The International Health Regulations (2005) Emergency Committee Regarding The Outbreak Of Novel Coronavirus (2019-nCoV)* (Jan. 30, 2020), https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov); CDC, *Situation Summary*, Section entitled "Highlights of CDC's Response," supra note 4.

[14] *See, e.g.*, Neil M. Ferguson et al., Imperial College London, *Impact Of Non-Pharmaceutical Interventions (NPIs) To Reduce COVID-19 Mortality And Healthcare Demand* 1 (2020), https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf.

[15] Centers for Disease Control & Prevention, *Interim Guidance On Management Of Coronavirus Disease 2019 (COVID-19) In Correctional And Detention Facilities*, Section entitled "Definitions of Commonly Used Terms" (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#social_distancing ("*CDC Detention Guidance*") (last accessed Apr. 8, 2020).

practice of isolating groups of lab-confirmed cases rather than isolating individuals[16]—although the CDC stresses that "[o]nly individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort."[17]

Of course, rigorous adherence to these practices will not foreclose the possibility of new infections. But it will help to achieve the vital public health goal of "flattening the curve"—that is, slowing the exponential growth of infectious diseases by preventing initial rapid onset. Flattening the curve allows the health care system to care for the same individuals over a longer period of time and prevents the system from being overburdened at any one instance.[18] Outbreaks are anathema to this process because they cause large numbers of simultaneous infections and trigger exponential hospitalization growth.

It is for precisely this reason that more than ninety percent of the U.S. population is now under order to stay home by state or local government officials.[19] This drastic, unprecedented response is necessary to contain the spread of the virus as quickly as possible. Without these measures, the worst-case scenario in the Imperial College London study cited above indicates that the United States could suffer up to 2.2 million deaths as a result of the COVID-19 crisis.[20]

B. There Is Good Reason To Believe That ICE Is Not Taking Adequate Measures To Prevent The Spread Of COVID-19 Among Detained Persons.

ICE has put forward only the most threadbare of descriptions for how it proposes to minimize the risk that COVID-19 will spread among detained persons. Notwithstanding

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[16] *Id.*
[17] *Id.*, Section entitled "Medical Isolation of Confirmed or Suspected COVID-19 Cases."
[18] *See* Kara Gavin, *Flattening The Curve For COVID-19: What Does It Mean And How Can You Help?*, Univ. Mich. Health (Mar. 11, 2020), https://healthblog.uofmhealth.org/wellness-prevention/flattening-curve-for-covid-19-what-does-it-mean-and-how-can-you-help; Brandon Specktor, *Coronavirus: What Is 'Flattening The Curve,' And Will It Work?*, Live Sci. (Mar. 16, 2020), https://www.livescience.com/coronavirus-flatten-the-curve.html.
[19] Nicole Chavez et al., *Nearly All Americans Are Under Stay At Home Orders But Fauci Says The US Needs More Coronavirus Restrictions*, CNN (Apr. 2, 2020), https://www.cnn.com/2020/04/02/health/us-coronavirus-thursday/index.html.
[20] Ferguson, *Impact Of Non-Pharmaceutical Interventions (NPIs) To Reduce COVID-19 Mortality And Healthcare Demand*, *supra* note 14, at 7.

that they are both vague and cursory, ICE's representations raise great concerns as to the adequacy of the protections in place at its various detention facilities.

ICE points to public guidance proposing that facilities manage the spread of COVID-19 through "cohorting."[21] Review of that guidance shows that ICE categorizes detained persons into three categories. First, "those who meet CDC's criteria for epidemiologic risk of exposure to COVID-19" and who present "with fever and/or respiratory symptoms" are "isolate[d]."[22] They are to be kept in "a single medical housing room, or in a medical airborne infection isolation room specifically designed to contain biological agents."[23] Second, those "who meet CDC's criteria for epidemiologic risk of exposure to COVID-19," but are asymptomatic, are to be "housed separately from the general population," either "in a single cell, or as a group, depending on available space."[24] Third, for those in the general population, the guidance states only that detention facilities should "increase social distancing," which may include "staggered meals and recreation times in order to limit the number of detainees gathered together."[25]

This cursory guidance raises concerns in multiple respects. Initially, it does not define the "criteria for epidemiologic risk" that drives this "cohorting," making it impossible to assess the degree to which these groups are over- or under-inclusive. Nor does it describe the methods by which individual detained persons are to be evaluated against those criteria, making it similarly impossible to evaluate the efficacy of ICE's evaluations. Indeed, this flaw in the ICE guidance is critical because detained persons often lack full knowledge of their medical condition to share with staff and often are reluctant to be transparent about their medical histories with ICE personnel, a concern that is all the greater given the growing social stigma surrounding COVID-19. Moreover, the ICE guidance does not propose any measures with respect to those who present with symptoms consistent with

[21] U.S. Immigration & Customs Enforcement, *ICE Guidance On COVID-19*, Section entitled "Detention," https://www.ice.gov/coronavirus (last accessed Apr. 8, 2020).
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*

COVID-19, but do not fit that unstated criteria. This creates a high risk that individuals with COVID-19 will be introduced into the general population. Lastly, vaguely providing that social distancing should be maximized is inadequate. Per the CDC, *everyone* should avoid contact with others—full stop.[26] If conditions at a detention facility do not permit adequate social distancing measures to be taken by all detained persons, regardless of their cohort, the facility should not house detained persons.

In short, ICE's guidance emphasizes testing of patients with known epidemiologic risk factors (travel, contact with known cases, etc.) as well as symptoms.[27] This strategy will not prevent outbreaks in ICE detention centers, as a significant proportion of COVID-19 carriers will not have known epidemiologic risk factors and may never have any symptoms, meaning that under ICE's guidance they may freely transmit the virus to dozens of other individuals while in detention. Indeed, there is now widespread transmission of COVID-19 in communities across the Nation, making ICE's continued reliance on epidemiologic risk factors particularly indefensible. Further, ICE's guidance still means those with epidemiologic risk factors and who exhibit symptoms must be properly tested. Because testing nationally is limited and slow at the present time, the ICE facility must wait for the result while isolating the individual, which depending on the location and lab involved, may take one hour to several days. Even then, COVID-19 tests are known to have a high rate of false negatives.[28] And even though an individual tests negative for COVID-19 once, but has a clinical presentation that is suspicious for COVID-19, expert consensus suggests that the patient should be retested and maintained in isolation until the test has been negative twice, the ICE guidance does not provide for any retesting.[29]

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[26] *See generally* Centers for Disease Control & Prevention, *How To Protect Yourself & Others*, https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.
[27] *ICE Guidance on COVID-19*, Section entitled "Detention," *supra* note 21.
[28] *See* Yicheng Fang et al., *Sensitivity Of Chest CT For COVID-19: Comparison To RT-PCR*, RSNA (Feb. 19, 2020), https://pubs.rsna.org/doi/full/10.1148/radiol.2020200432.
[29] Fact Sheet For Health Care Providers (updated Mar. 15, 2020), https://www.fda.gov/media/135662/download.

The April 4, 2020 supplemental guidance provided by ICE does nothing to cure these deficiencies. *See Angel Alejandro Heredia Mons et al. v. Kevin K. Mcaleenan*, No. 1:19-cv-1593-JEB, ECF No. 66-1 (D.D.C.). Although the supplemental guidance does direct detention facilities to identify detained persons at higher risk and to reassess whether those at-risk individuals should be released under the INA's discretionary custody provisions, that guidance does not provide a timeline for its implementation, it is preliminary and does not require any change in policy, and it excludes those who are in mandatory custody. *Id*. So even assuming *arguendo* that all those who are eligible for reassessment under this guidance are actually released, although there is no reason to make that assumption, the population in ICE detention facilities and the conditions therein still create a powder keg for the spread of infection.

The representations made by Defendants to the Court in this case also do not alleviate these concerns. With respect to screening detained persons for COVID-19, ICE's Action Plan submitted to all detention wardens and superintendents indicates only that "IHSC developed guidance for IHSC-staffed facilities to assist in the risk assessment and management of detained individuals with potential exposure to COVID-19, and guidance was disseminated to non IHSC-staffed ICE detention facilities for potential adoption of this guidance at their respective sites. This guidance addresses intake medical screenings, monitoring, encounters, laboratory testing, and public health actions." (Dkt. No. 95-2 at 5.) Notably, Defendants did not indicate whether any detention facilities had actually adopted and implemented that guidance. At most, the memorandum requires that "[f]acilities … have updated pandemic plans and policies as well as established quarantine and/or isolation areas within their facilities in the event they are needed." (*Id*. at 2.) The Declaration of Dr. Ada Rivera adds little. It simply describes the process of medical review during the detained person intake process and then summarizes ICE's cohorting plan. (Dkt. No. 95-3 at 3-4.)

The same is true of the Declaration of Captain Jennifer Moon. (Dkt. No. 95-11 at 3-4.) Indeed, Captain Moon's declaration simply rehashes the same description of the procedures used at Adelanto ICE processing center that Captain Moon provided to the court in another case. *See generally Pedro Bravo Castillo & Luis Vasquez Rueda v. Barr et al.*, No. 5:20-cv-00605-TJH-AFM (C.D. Cal.). But another member of this court already found that description wanting when granting a temporary restraining order compelling the release of certain ICE detained persons being held at Adelanto ICE processing center, the court gave little credit to Captain Moon's declaration. *Id*., TRO & Show Cause Order (Mar. 27, 2020), ECF No. 32. That likely is for the reason the plaintiffs' medical expert in that case, Dr. Ranit Mishori provided: "I am not aware of any epidemiologist or any public health expert who would consider these procedures to be sufficient preventative measures." *Id*., Reply (Mar. 27, 2020), ECF No. 28-1 ¶ 2.

As for the private prison companies that operate the majority of ICE's detention facilities, although they have issued statements regarding COVID-19, none of them sets forth clear protocols that would obviate the concerns regarding ICE's guidance. For instance, GEO released a press release acknowledging the risk, but without providing any specific details regarding quarantine policies, separation, or social distancing.[30] Similarly, another such company, CoreCivic issued a statement on their COVID-19 response that also does not identify any specific protocols aimed at curbing the risk presented by COVID-19.[31]

ICE does not deserve the benefit of the doubt. ICE health facilities are not routinely overseen or licensed by state departments of health and only some facilities are accredited, on a voluntary basis, by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), the National Commission on Correctional Healthcare (NCCHC)

[30] *See* Press Release, GEO Group Is Working To Address The Risk Of Coronavirus To Those In Our Care And Our Employees, https://www.geogroup.com/Portals/0/GEO_Coronavirus_Statement.pdf.

[31] *See* Press Release, An Update On CoreCivic's Response To COVID-19 From President & CEO Damon Hininger (Mar. 23, 2020), https://www.corecivic.com/news/an-update-on-corecivics-response-to-covid-19-from-president-and-ceo-damon-hininger. It appears that CoreCivic took down its initial tepid response, but it was archived by the Wayback Machine. *See How CoreCivic Is Managing COVID-19*, CoreCivic, https://web.archive.org/web/20200403002946/https://www.corecivic.com/hubfs/_files/CoreCivic%20Response%20to%20Covid-1.pdf.

or the American Correctional Association (ACA). But there is no consequence for any of the private companies that provide health care in these settings to lose that voluntary accreditation. Additionally, it has been documented by the Department of Homeland Security's Office of the Inspector General,[32] as well as in reports by the ACLU, Human Rights Watch, Human Rights First, and Disability Rights California,[33] that medical care provided in ICE facilities is commonly below community standards. For instance, last year, more than 5,200 detained persons were quarantined as ICE tried to contain outbreaks of chickenpox and mumps at its detention facilities, with the CDC ultimately concluding that most of those detained persons developed the illnesses while in federal custody, not before.[34] Further, a recent ProPublica review of seventy reports detailing deaths from medical conditions in ICE detention over the last decade also found that staff often break strict rules for testing contagious diseases, further exacerbating the limitations of the protocols in place at these facilities.[35] And there is evidence that detained persons frequently lack access to bathrooms, sinks, water, soap, cleaning supplies, and other equipment that can promote good hygiene.[36]

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[32] Dep't Homeland Sec. Office Inspector Gen., *ICE Does Not Fully Use Contracting Tools To Hold Detention Facility Contractors Accountable For Failing To Meet Performance Standards*, (Jan. 29, 2019), https://www.oig.dhs.gov/sites/default/files/assets/2019-02/OIG-19-18-Jan19.pdf.

[33] Human Rights Watch, *US: Poor Medical Care, Deaths, In Immigrant Detention* (June 20, 2018), https://www.hrw.org/news/2018/06/20/us-poor-medical-care-deaths-immigrant-detention; Disability Rights California, *There Is No Safety Here: The Dangers For People With Mental Illness & Other Disabilities In Immigration Detention At GEO Group's Adelanto ICE Processing Center* (Mar. 2019), https://www.disabilityrightsca.org/system/files/file-attachments/DRC_REPORT_ADELANTO-IMMIG_DETENTION_MARCH2019.pdf; Human Rights First, *New Report Documents Mental, Physical, Legal Impact Of Increased Detention In California* (Jan. 15, 2019), https://www.humanrightsfirst.org/press-release/new-report-documents-mental-physical-legal-impact-increased-detention-california.

[34] Centers for Disease Control & Prevention, *Notes From The Field: Mumps In Detention Facilities That House Detained Migrants-U.S., Sept. 2018-Aug. 2019* (Aug. 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6834a4.htm.

[35] ProPublica, *Ice Has Repeatedly Failed To Contain Contagious Diseases, Our Analysis Shows It's A Danger To The Public* (Mar. 20, 2020), https://www.propublica.org/article/ice-has-repeatedly-failed-to-contain-contagious-diseases-our-analysis-shows-its-a-danger-to-the-public.

[36] Caitlin Dickerson, *'There Is A Stench': Soiled Clothes And No Baths For Migrant Children At A Texas Center*, N.Y. Times (June 21, 2019), https://www.nytimes.com/2019/06/21/us/migrant-children-border-soap.html.

Lastly, the inadequacy of the preventative measures at detention centers is bolstered by the anecdotal evidence presented by Plaintiffs in this case. One detained person, a trained medical doctor, reports that his dormitory at an Aurora, Colorado facility operated by GEO is running at virtually full capacity, that new detained persons have been brought in without additional precautions during the outbreak, that facilities for handwashing are wholly inadequate, and that detained persons are not allowed hand sanitizer. (Decl. of Mikhail Solomonov, Dkt. 81-3, ¶¶ 6-9.) That detained person also reports that administrators are "doing nothing to ensure sanitation in our dorm," which is shared by eighty detained persons. (*Id.* ¶¶ 6, 9.) Detained persons held at other facilities report similar and related problems, including failures by administrators to explain basic precautions and safety protocols to detained persons, provide essentials like soap and hand sanitizer, prevent sick employees from coming to work, clean or sanitize high-traffic areas like bathrooms, or screen individuals transferred into and out of these facilities. (*See, e.g.*, Decl. of Keren Zwick, Dkt. 81-7, ¶¶ 9-13, 15-25, 28-30; Decl. of Francis L. Conlin, Dkt. 81-9, ¶¶ 5-14; Decl. of Elissa Steglich, Dkt. 81-10, ¶¶ 5-9; Decl. of Anne Rios, Dkt. 81-13, ¶¶ 7-9, 14-16, 22-23.) It appears, therefore, that these problems are widespread and that ICE's paltry efforts to curb the risk have been ineffective.

C. Regardless Of The Measures ICE Takes, The Detention Facilities Inherently Create A Heightened Risk Of COVID-19 Spread.

Detention centers are, by their very nature, enclosed environments. This makes it impossible to implement and enforce the sorts of social distancing protocols that are necessary to arrest the spread of COVID-19. So even if ICE mandated that all detention facilities optimized its policies, which it has not, an outbreak *still* would be highly probable.

Studies show that a significant portion of the current pandemic is driven by asymptomatic carriers passing the virus in close quarters.[37] Given that fact, it is impossible to implement the mitigation efforts inside immigration facilities that have become a

[37] U.S. Nat'l Library Med., Nat'l Inst. Health, *Estimating The Asymptomatic Proportion Of Coronavirus Disease 2019 (COVID-19) Cases On Board The Diamond Princess Cruise Ship, Yokohama, Japan, 2020* (Mar. 12, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7078829.

necessary safeguard of life outside those facilities. Detention facilities, by their very nature, require detained persons to share close quarters, such as dining halls, bathrooms, showers, and other common areas. Further, these spaces often are poorly ventilated, which further promotes the spread of diseases. Detained persons thus are stripped of the primary weapon in the war against COVID-19 by the enforced inability to practice meaningful social distancing.

Hygiene-based preventative measures also are frequently ineffective in detention facilities, as detained persons typically lack access to sufficient soap and alcohol-based sanitizers to engage in the kind of frequent hand washing encouraged throughout the rest of the country. Staff also often do not clean or sanitize high-touch surfaces with sufficient frequency, like door handles and light switches. Indeed, Plaintiffs in this case have provided evidence that detention facility staff often do not undertake cleaning tasks *at all*. (Decl. of Keren Zwick, Dkt. 81-7, ¶ 24 ("In Aurora, an NIJC client reports that immigrants in detention also continue to bear responsibility for daily cleaning the bathrooms and floors. They are not provided with masks or other safety supplies, and only sometimes get gloves.").) These issues are further exacerbated by the fact that staff, contractors and vendors all pass between communities and these shared spaces, with each group able to bring infectious diseases into those facilities. The populations of detention facilities experience constant turnover, as detained persons come and go, with each new detained person potentially carrying COVID-19 and introducing it into the facility's population. This problem is especially acute in the context of immigration detention facilities, where it is common to see detained persons transferred between facilities, which creates a risk of detention facilities spreading the virus throughout the system.[38]

These limitations are inherent with respect to all infectious diseases but are especially concerning in the context of COVID-19. As discussed above, it is difficult to identify and isolate those who are infected with COVID-19 because, while any given individual may

[38] *CDC Detention Guidance*, Section entitled "Quarantining Close Contacts of COVID-19 Cases," *supra* note 15 (last accessed Apr. 8, 2020).

suffer only from mild symptoms or be asymptomatic, that person may well be carrying and spreading the disease. Moreover, detention facilities lack the capacity to perform the kind of broad-based, systematic, and ongoing testing required to significantly lower the risk that COVID-19 will enter and spread throughout the facility.

These are not theoretical concerns. It is well documented that communicable diseases are far more prevalent in detention facilities than in the public as a whole.[39] For example, a 2005 study found that, nationwide, the prevalence of HIV among incarcerated populations is ten times that of the general population, and inmates are *2,500 times* more likely to suffer from tuberculosis.[40] Another study found that during the H1N1-strain flu outbreak in 2009 (known as the "swine flu"), jails and prisons experienced a disproportionately high number of cases.[41]

The evidence all but confirms that the same will be true of COVID-19. The recent spread of COVID-19 in New York City jails bears this out: On March 20, there were nineteen confirmed cases; on March 21, there were thirty-eight; on March 25, there were seventy-five; on March 29, there were 139; on April 3, there were 231—a more than 1,100% increase in confirmed cases in just two weeks.[42] Indeed, the chief doctor at Rikers Island has called the spread of COVID-19 at the prison a "public health disaster unfolding before our

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[39] E.g. Bianca Malcolm, *The Rise Of Methicillin-Resistant Staphylococcus Aureus In U.S. Correctional Populations*, J. Corr. Health Care (May 13, 2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116074; Stephanie M. Lee, *Nearly 900 Immigrants Had The Mumps In Detention Centers In The Last Year*, Buzzfeed News (Aug. 29, 2019), https://www.buzzfeednews.com/article/stephaniemlee/mumps-ice-immigrant-detention-cdc.

[40] Zulficar Gregory Restum, *Public Health Implications Of Substandard Correctional Health Care*, 95 Am. J. Pub. Health 1689, 1689 (Oct. 2005), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449420.

[41] 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.

[42] Michael Rezendes & Robin McDowell, *38 For Coronavirus At Rikers, NYC Jails*, Associated Press (Mar. 23, 2020), https://apnews.com/54dbc9d47f62cf0c0240314310cfe909; Andrew Denney, *New Coronavirus Cases In NYC Jails Outpacing Rest Of The City*, NY Post (Mar. 25, 2020), https://nypost.com/2020/03/25/new-coronavirus-cases-in-nyc-jails-outpacing-rest-of-the-city; Christina Carrega, *Shampoo, Watery Soap To Disinfect: Conditions On Rikers Island During COVID-19 Unsafe, Some Inmates Say*, ABC News (Mar. 29, 2020), https://abcnews.go.com/Health/shampoo-watery-soap-disinfect-conditions-rikers-island-covid/story?id=69767859; Julia Craven, *Coronavirus Cases Are Spreading Rapidly On Rikers Island*, Slate (Apr. 2, 2020), https://slate.com/news-and-politics/2020/04/rikers-coronavirus-cases-increase.html.

eyes."[43] Similarly, it was recently reported that the Cook County Jail in Chicago, Illinois has emerged as the nation's largest known source of COVID-19 infections.[44] Furthermore, data regarding the spread of COVID-19 in the analogous high-density living conditions of a cruise ship bolsters the risk detained persons face. A recent study of the spread of COVID-19 on the Diamond Princess cruise ship modeled the virus's basic reproduction rate to be 14.8 (rather than the already high 2.79 rate[45] in the ordinary population—that is, four times higher than normal), absent countermeasures such as isolation and quarantine.[46] And this already unfathomable rate is likely lower than what prisons and detention facilities will actually experience because the cruise ship passengers would have been able to spend most of their time alone or in small family units, use private bathrooms with access to soap, and have meals delivered.

II. Any Outbreak Of The COVID-19 Virus At A Detention Facility Will Overwhelm And Overburden Local Health Facilities.

It is imperative that all steps be taken to avoid an outbreak of COVID-19 at detention facilities, not just because of the impact on those being detained within those facilities and the staff, but because of the stress such an outbreak will place on the Nation's health infrastructure.

As discussed above, it is imperative that the Nation to the greatest extent possible adopt policies that will "flatten the curve." "The idea is to … slow the spread of the virus, so that you don't get a huge spike in the number of people getting sick all at once. If that were to happen, there wouldn't be enough hospital beds or mechanical ventilators for

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[43] Meagan Flynn, *Top Doctor At Rikers Island Calls The Jail A 'Public Health Disaster Unfolding Before Our Eyes,'* Wash. Post (Apr. 5, 2020), https://www.washingtonpost.com/nation/2020/03/31/rikers-island-coronavirus-spread.

[44] Timothy Williams & Danielle Ivory, *Chicago's Jail Is Top U.S. Hot Spot As Virus Spreads Behind Bars*, N.Y. Times (Apr. 8, 2020), https://www.nytimes.com/2020/04/08/us/coronavirus-cook-county-jail-chicago.html.

[45] Liu, *The Reproductive Number Of COVID-19 Is Higher Compared To SARS Coronavirus*, *supra* note 5.

[46] J. Rocklöv et al., *COVID-19 Outbreak On The Diamond Princess Cruise Ship: Estimating The Epidemic Potential And Effectiveness Of Public Health Countermeasures*, J. Travel Med., https://academic.oup.com/jtm/advance-article/doi/10.1093/jtm/taaa030/5766334.

everyone who needs them, and the U.S. hospital system would be overwhelmed."[47] An overwhelmed U.S. hospital system would force medical providers to make difficult decisions as to who will receive the suddenly scarce commodity of medical care.[48]

ICE detention facilities are not hospitals. ICE detention facilities generally do not have the ability to treat the one-fifth of COVID-19 patients whose symptoms are moderate to severe.[49] In Wuhan, China, for instance, 15-20 percent of COVID-19 patients required not just hospitalization but also admission to intensive care, and 3.2 percent required mechanical ventilation.[50] ICE knows that it does not have the capacity to provide this care. That is why ICE's own guidance provides that "ICE transports individuals with moderate to severe symptoms, or those who require higher levels of care or monitoring, to appropriate hospitals with expertise in high-risk care."[51]

As another federal district court recently recognized, this is not a panacea because it means an outbreak in an ICE detention facility has the potential to trigger an avalanche of cases that overwhelm local health systems. In an order granting a temporary restraining order compelling the release of detained persons, a judge in the Western District of New York observed that:

> a COVID-19 outbreak at a detention facility could result in multiple detainees—five, ten or more—being sent to the local

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[47] Maria Godoy, *Flattening A Pandemic's Curve: Why Staying Home Now Can Save Lives*, NPR (Mar. 13, 2020), https://www.npr.org/sections/health-shots/2020/03/13/815502262/flattening-a-pandemics-curve-why-staying-home-now-can-save-lives.

[48] Ezekial J. Emanuel et al., *How The Coronavirus May Force Doctors To Decide Who Can Live And Who Dies*, (Opinion) N.Y. Times (Mar. 12, 2020), https://www.nytimes.com/2020/03/12/opinion/coronavirus-hospital-shortage.html.

[49] "While about 80% of cases manifest as a mild illness (i.e. non-pneumonia or mild pneumonia), approximately 20% progress to a more severe illness, with 6% requiring specialist medical care, including mechanical ventilation." World Health Organization, *Preparedness, Prevention And Control Of COVID-19 In Prisons And Other Places Of Detention: Interim Guidance*, *supra* note 9.

[50] Lingzhong Meng et al., *Intubation And Ventilation Amid The COVID-19 Outbreak: Wuhan's Experience*, Anesthesiology (Mar. 26, 2020), https://anesthesiology.pubs.asahq.org/article.aspx?articleid=2763453.

[51] *ICE Guidance on COVID-19*, Section entitled "Detention," *supra* note 21.

> community hospital where there may only be six or eight ventilators over a very short period. As they fill up and overwhelm ventilator resources, those ventilators become unavailable for all the usual critical illnesses. And ventilators used to treat detainees cannot be used to treat others who contract the virus.

Jones v. Wolf, No. 20-CV-361, 2020 WL 1643857, at *13-14 (W.D.N.Y. Apr. 2, 2020) (internal quotation marks and record citations omitted).

This is the exact scenario described by Dr. Scott Allen and Dr. Josiah Rich, two medical subject matter experts for the Department of Homeland Security's Office of Civil Rights and Civil Liberties, in a March 19, 2020 letter to Congress. As Dr. Allen and Dr. Rich explained,

> social distancing is an oxymoron in congregate settings, which because of the concentration of people in a close area with limited options for creating distance between detainees, are at very high risk for an outbreak of infectious disease. This then creates an enormous public health risk, not only because disease can spread so quickly, but because those who contract COVID-19 with symptoms that require medical intervention will need to be treated at local hospitals, thus increasing the risk of infection to the public at large and overwhelming treatment facilities. As local hospital systems become overwhelmed by the patient flow from detention center outbreaks, precious health resources will be less available for people in the community.[52]

[52] Letter from Dr. Scott A. Allen & Dr. Josiah Rich to Congress (Mar. 19, 2020) at 4, https://whistleblower.org/wp-content/uploads/2020/03/Drs.-Allen-and-Rich-3.20.2020-Letter-to-Congress.pdf.

The risk of this "tinderbox" scenario at ICE detention facilities is all the more concerning because "dozens of immigration detention centers are in remote areas with limited access to health care facilities. Many facilities, because of the rural locations, have only one on-site medical provider. If that provider gets sick and requires being quarantined for at least fourteen days, the entire facility could be without any medical providers at all during a foreseeable outbreak of a rapidly infectious disease."[53] So in this scenario, "many people from the detention center *and the community* die unnecessarily for want of a ventilator."[54]

An example of this phenomenon is playing out in Illinois. Stateville Correctional Center, home to more than 4,100 inmates, has a rapidly growing outbreak of COVID-19. AMITA Health St. Joseph's Medical Center in Joliet is treating all forty-nine (as of April 3) inmates who have tested positive so far, eight of whom are on ventilators, limiting the availability of resources for all members of the community. "An emergency room physician described the hospital as a 'war zone,'" and there is now an acute shortage of nursing staff.[55] This pattern is expected to play out at prisons across the Nation.[56]

As Dr. Allen and Dr. Rich summarized, "[i]n the alternate scenario where detainees are released from high risk congregate settings, the tinderbox scenario of a large cohort of people getting sick all at once is less likely to occur, [ ] the peak volume of patients hitting the community hospital would level out," and "survival is maximized as the local mass outbreak scenario is averted."[57] Put another way, in this time of already strained resources, it is contrary to the national interest for there to be an outbreak at an ICE detention facility. Given that the status quo makes it all but certain that such an outcome will occur, it is imperative that Plaintiffs receive the injunctive relief they are seeking. To deny them that

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[53] *Id.*
[54] *Id.* (emphasis in original).
[55] Josh McGhee, *Stateville Prison Outbreak Signals COVID-19 Threat To Inmates, Surrounding Hospital Systems*, Chi. Reporter (Apr. 3, 2020), https://www.chicagoreporter.com/stateville-prison-outbreak-signals-covid-19-threat-to-inmates-surrounding-hospital-systems.
[56] Danielle Ivory, *'We Are Not a Hospital': A Prison Braces For The Coronavirus*, N.Y. Times (Mar. 17, 2020), https://www.nytimes.com/2020/03/17/us/coronavirus-prisons-jails.html (quoting prison staff members who explained that "if the prison had multiple cases, some would need to be sent to a nearby hospital for treatment.").
[57] Letter from Drs. Allen & Rich to Congress, *supra* note 52.

relief jeopardizes the lives and well-being of not just the detained persons, but of the tens of thousands of Americans living in close proximity to these facilities.

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request that this Court grant Plaintiffs' motion for preliminary injunction.

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CERTIFICATE OF SERVICE

I hereby certify that on April 9, 2020, I filed the foregoing document via the Court's CM/ECF system. The document will be served electronically on counsel of record for the parties.

/s/ *Christopher J. Rillo*
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