UNITED STATES DISTRICT COURT

WESTERN DISTRICT OF WASHINGTON

JOSE CASTAÑEDA JUAREZ; J[redacted] A[redacted]-M[redacted]; WILFREDO FAVELA AVENDAÑO; and NAEEM SOHAIL KHAN

Petitioners-Plaintiffs,

v.

NATHALIE ASHER, Director of the Seattle Field Office of U.S. Immigration and Customs Enforcement; MATTHEW T. ALBENCE, Deputy Director and Senior Official Performing the Duties of the Director of the U.S. Immigration and Customs Enforcement; U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT; STEVEN LANGFORD, Warden, Tacoma Northwest Detention Center,

Respondents-Defendants.

Case No. 2:20-cv-00700-RSM-MLP

BRIEF OF *AMICI CURIAE* PUBLIC HEALTH OFFICIALS

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I. Introduction

Amici Curiae, Robert L. Cohen, M.D., Joe Goldenson, M.D., Michael Puisis, D.O., and Brie Williams, M.D., M.S., a group of medical, public health and human rights experts who are familiar with the unique dangers associated with infectious diseases in detention facilities, urge this court to grant plaintiffs' petition for writ of habeas corpus and complaint for injunctive and declaratory relief. It is critical that Respondents-Appellants work with local health authorities to release detainees at the Tacoma Northwest Detention Center ("NWDC") whose continued detention puts them at high risk of contracting SAR-CoV-2, the 'novel' coronavirus, which causes COVID-19. Releasing at-risk detainees protects not only those detainees, but also detention facility staff, visitors and the public at large.

The novel coronavirus is an extremely infectious virus which causes potentially deadly COVID-19. It has created a global health crisis and led to the adoption and implementation of unprecedented mitigation strategies around the world, including the canceling of public events, the closing of schools and businesses, and stay-at-home orders to the general public. There is no vaccine or cure for COVID-19. The coronavirus can infect and seriously harm anyone. And yet it also is clear that some categories of people are at higher risk than others. In particular, the likelihood that a coronavirus infection will become serious or life-threatening is much higher if the infected person is advanced in age or has certain underlying medical conditions.

Managing the spread of coronavirus within detention facilities is critically important because they are enclosed environments, like cruise ships or nursing homes, where one infected person can unleash a rapidly spreading outbreak. The only way to mitigate the risk of serious infection is through hygienic measures such as frequent hand washing and physical distancing that limits exposure. However, these prevention methods are all but impossible to practice or implement in a detention facility setting, such as NWDC, where detainees are crowded together, sleep in dormitory-style rooms, share bathroom products, and rarely have access to sanitizing products. Moreover, once an outbreak occurs, detention facilities are rarely equipped to provide the care and support needed to treat patients suffering from coronavirus infection, or from severe COVID-19.

Acting quickly to mitigate the enormous risk associated with detention centers such as NWDC is not just necessary to protect detainees themselves, but also to protect staff and visitors. Because staff and visitors cycle in and out of detention facilities, if appropriate mitigation measures are not taken immediately, those individuals risk spreading the disease to the broader community. Accordingly, the time to act is now, before it is too late.

II. Statement of Interest of *Amici Curiae*

Amici curiae are experts in infectious diseases, healthcare policy, correctional healthcare, human rights, and other related fields who have spent decades studying the provision of healthcare in detention facilities. Based on their experience, and their review of the available information about the COVID-19 pandemic, it is their view that the plaintiffs in this action are at high risk of serious, life-threatening COVID-19 infection, and that their continued confinement in Tacoma's NWDC puts them at a heightened risk of contracting and further spreading COVID-19.

Amici are committed to ensuring detention facilities provide quality healthcare to detainees, and that detention facilities do not exacerbate the health risks of their detainees. They understand the COVID-19 pandemic has placed enormous strains on society, and are committed to doing their part to ensure that detention facilities take a prudent, science-based approach to addressing the virus. They respectfully submit this brief to offer their view that the NWDC should work with state and local health officials to release individuals to whom COVID-19 poses a high risk of serious infection.

Amici are the following:

Robert L. Cohen, M.D., has worked as a physician, administrator and expert in the care of prisoners for 40 years. Dr. Cohen was the Director of the Montefiore Rikers Island Health Services from 1981 through 1986. In 1986, he was appointed Vice President for Medical Operations of the New York City Health and Hospitals Corporation. Dr. Cohen represented the American Public Health Association on the Board of the National Commission for Correctional

Health Care for 17 years. He has served as a federal court-appointed monitor overseeing efforts to improve medical care for prisoners in Florida (*Costello* v. *Wainwright*), Ohio (*Austin* v. *Wilkinson*), New York (*Milburn* v. *Coughlin*) and Michigan (*Hadix* v. *Caruso*). He also has been appointed to oversee the care of all prisoners living with HIV in Connecticut (*Doe* v. *Meachum*). He currently serves on the nine member New York City Board of Correction, which regulates and oversees New York City's detention facilities.

Joe Goldenson, M.D., is a medical physician with 28 years of experience as the Director/Medical Director for Jail Health Services for the San Francisco Department of Public Health. He also has served as a member of the Board of Directors of the National Commission on Correctional Health Care, and was past President of the California chapter of the American Correctional Health Services Association. He has worked extensively as a correctional health medical expert and court monitor. He is currently one of the medical experts retained by the federal district court in *Plata* v. *Newsome*, Case No. 3:01-cv-01351 (N.D. Cal.), to evaluate medical care provided to inmate patients in the California Department of Correctional Rehabilitation. He also has been a medical expert/monitor for Cook County Jail in Chicago and Los Angeles County Jail, as well as in jails and prisons in Washington State, Texas, Florida, Ohio and Wisconsin.

Michael Puisis, M.D., is an internist who has worked in correctional medicine for 35 years. He began working at the Cook County Jail as a physician in 1985 and became the Medical Director of Cook County Jail from 1991 to 1996 and Chief Operating Officer for the medical program at the Cook County Jail from 2009 to 2012. He has worked in and managed correctional medical programs in multiple state prisons including in Illinois and New Mexico. He has worked as a monitor or expert for federal courts, and as a correctional medical expert for the Department of Justice, on multiple cases. He also has participated in revisions of national standards for medical care for the National Commission on Correctional Health Care and for the American Public Health Association. He also participated in revising tuberculosis standards for the Centers for Disease Control. Dr. Puisis has edited the only textbook on correctional medicine, Clinical Practice in Correctional Medicine.

Brie Williams, M.D., M.S., is a Professor of Medicine in the University of California San Francisco Division of Geriatrics, where she collaborates with colleagues from criminal justice, public safety and the law to integrate a healthcare perspective into criminal justice reform. She also co-directs the ARCH (Aging Research in Criminal Justice Health) Network, funded by the National Institute on Aging, which is a national group of researchers across multiple disciplines focused on developing evidence to better understand the health and healthcare needs of older adults and people with serious illness who reside in prisons and jails.

III. <u>Factual Background</u>

Amici adopt and incorporate by reference the factual background set forth in plaintiffs' complaint (Dkt. # 1).

IV. <u>Argument</u>

A. The COVID-19 Pandemic Requires Proactive Social Distancing Measures

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). The novel coronavirus that causes COVID-19 first emerged in the province of Hubei, China in December 2019.[1] As of May 10, 2020, there were 4,013,728 confirmed cases of COVID-19 and 278,993 deaths worldwide.[2] Due to the apparent ease with which the virus spreads, these numbers will continue to rise exponentially without drastic government action.[3]

The consensus of doctors and epidemiologists since the emergence of COVID-19 as a global pandemic has been that the only way to gird against spread of the virus is to take proactive and early action to "flatten the curve."[4] Accordingly, a leading and frequently cited

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[1] Kenji Mizumoto & Gerardo Chowell, *Estimating Risk of Death from 2019 Novel Coronavirus Disease, China, January–February 2020*, 26 Emerging Infectious Diseases, no. 6, June 2020, https://doi.org/10.3201/eid2606.200233.

[2] World Health Organization, Coronavirus Disease (Covid-19) Pandemic (2020), https://www.who.int/emergencies/diseases/novel-coronavirus-2019 (last updated May 10, 2020).

[3] *See* Centers for Disease Control and Prevention, Situation Summary (2020), cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html.

[4] *See, e.g.*, Neil M. Ferguson et al., Imperial College of London, Impact of Non-Pharmaceutical Interventions (NPIs) to Reduce COVID-19 Mortality and Healthcare Demand 7 (2020), https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf.

report from the Imperial College London has suggested that "suppression will minimally require a combination of social distancing of the entire population, home isolation of cases and household quarantine of their family members," in addition to school and university closures.[5] In other words, social distancing is necessary at every level, including the institutional level. Given the speed with which the virus spreads, such social distancing measures may have to last approximately 18 months until a vaccine is successfully developed.[6] It is for precisely this reason that dozens of state governments have instituted mandatory social distancing policies in recent days; indeed, one in five Americans is now under order to stay home.[7]

The coronavirus has wreaked havoc all over the United States, jeopardizing both the health and economic well-being of millions of Americans.[8] The United States now has over one *million* cases and over 70,000 fatalities.[9] It has been approximated that 3.4% of infected persons die.[10] Even patients who recover might suffer from permanent damage to their lungs and other vital organs.[11] Accordingly, social distancing should not only be practiced, but also mandated and enforced by all levels of government and their institutions.

B. The Danger Is Greatest for People Over 50 or with Underlying Illnesses

Emerging data suggests that 16% of people infected with COVID-19 will develop serious illness. About 1% of infected persons die.[12] Even those patients who ultimately recover

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5 *Id.* at 1.

6 *Id.* at 15.

7 Julie Bosman & Jesse McKinley, *One in Five Americans Ordered to Stay Home in Coronavirus Crackown*, N.Y. Times (Mar. 20, 2020), https://www.nytimes.com/2020/03/20/us/ny-ca-stay-home-order.html.

8 *See generally* Alexis C. Madrigal & Robinson Meyer, *How the Coronavirus Became an American Catastrophe*, The Atlantic (Mar. 21, 2020), https://www.theatlantic.com/health/archive/2020/03/how-many-americans-are-sick-lost-february/608521/.

9 Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Cases and Latest Updates, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (last updated May 10, 2020).

10 *See* ICE Enf't & Removal Operations, COVID-19 Pandemic Response Requirements 3 (2020), https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf.

11 Melissa Healy, *Coronavirus infection may cause lasting damage throughout the body, doctors fear*, L.A. Times (Apr. 10, 2020) https://www.latimes.com/science/story/2020-04-10/coronavirus-infection-can-do-lasting-damage-to-the-heart-liver.

12 Centers for Disease Control and Prevention, Coronavirus Disease 2019 (COVID-19): Situation Summary (2020), https://www.cdc.gov/coronavirus/2019-ncov/summary.html.

might suffer from permanent damage to their lungs and other vital organs.[13] Such serious cases of COVID-19 overwhelmingly afflict older individuals and individuals with underlying chronic health conditions, such as heart disease, lung disease, liver disease, kidney disease, diabetes and other immunodeficiency problems.[14] Early data from Italy, the site of one of the earliest and deadliest major outbreaks, is instructive: the average age of those who died from the virus there is 79.5; 99% of fatalities were in individuals who suffered from one or more prior illnesses; 75% had high blood pressure, about 35% had diabetes, and about 33% had heart disease.[15] Similar stories are now occurring in this country. According to a recent study about the virus' impact in New York City, the site of the worst outbreak in the United States, almost all hospitalized patients had at least one underlying health condition.[16] In short, COVID-19 presents a tremendous danger to older individuals and those suffering from underlying conditions.

C. Detention Centers Are at a Heightened Risk for the Spread of COVID-19

Detention centers like NWDC, which are enclosed, congregate environments in which it is impossible to implement and enforce social distancing, are at a heightened risk for the spread of coronavirus. Numerous public health officials have recognized that outbreaks of contagious diseases are more common in detention settings than in communities at large.[17] Indeed, over 780 confirmed cases of coronavirus have emerged in ICE facilities.[18] Given the dearth of

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[13] Pam Belluck, *What Does Coronavirus Do to the Body?*, N.Y. Times (Mar. 18, 2020), https://www.nytimes.com/article/coronavirus-body-symptoms.html.

[14] Fei Zhou et al., *Clinical Course and Risk Factors for Mortality of Adult Inpatients with COVID-19 in Wuhan, China: A Retrospective Cohort Study*, The Lancet (Mar. 9, 2020), https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30566-3/fulltext.

[15] Tommaso Ebhardt, *99% of Those Who Died From Virus Had Other Illness, Italy Says*, Bloomberg (Mar. 18, 2020), https://www.bloomberg.com/news/articles/2020-03-18/99-of-those-who-died-from-virus-had-other-illness-italy-says.

[16] Roni Caryn Rabin, *Nearly All Patients Hospitalized With Covid-19 Had Chronic Health Issues, Study Finds*, N.Y. Times (Apr. 23, 2020) https://www.nytimes.com/2020/04/23/health/coronavirus-patients-risk.html.

[17] *See* David Reuter, *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/; Bianca Malcolm, *The Rise of Methicillin-Resistant Staphylococcus aureus in U.S. Correctional Populations*, Journal of Correctional 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.

[18] *ICE Guidance on COVID-19 – Confirmed Cases*, https://www.ice.gov/coronavirus (last updated May 8, 2020).

testing, these numbers likely dramatically understate the problem.[19] One study using data from early March has found that under an optimistic scenario, 72% of individuals in ICE facilities would be expected to be infected within 90 days, while under a more pessimistic scenario, nearly 100% of detainees would be infected by day 90.[20]

The risk for widespread contagion is exacerbated by the fact that staff, visitors, contractors and vendors all pass between communities and detention facilities, and each group can bring infectious diseases into and out of those facilities. Moreover, the detainees themselves have to make court appearances and, each time they appear, they risk contracting infections and introducing them into the detention facility upon return. Additionally, detention facility populations are constantly turning over, as detainees cycle in and out of detention, with each new detainee potentially carrying coronavirus and introducing it into the facility's population. This problem is especially acute in the context of these immigration detention facilities, where it is common to see detainees transferred between facilities, exacerbating a risk of spread throughout the system.

These factors, all of which make it effectively impossible for detention facilities to protect themselves from outbreaks outside their walls, are made worse by the fact that it is difficult to identify and isolate individuals who are infected, who may suffer from only mild symptoms or even be entirely asymptomatic while still carrying and spreading the disease. Indeed, as many as 1 in 4 cases of coronavirus will not present symptoms and yet remain contagious.[21] Unfortunately, detention facilities typically do not have the ability to perform the kind of systematic screening and testing that would be required to ensure that the virus does not enter or circulate within these facilities.

The unique attributes of detention facilities also make it impossible to adopt and implement the mitigation efforts that have become a necessary safeguard of life outside these

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[19] *See id.*

[20] Michael Irvine, et al., *Modeling COVID-19 and impacts on U.S. Immigration and Enforcement (ICE) detention facilities*, J. Urban Health (2020), https://whistleblower.org/wp-content/uploads/2020/04/Irvine_JUH_ICE_COVID19_model.pdf.

[21] Apoora Mandavilli, *Infected but Feeling Fine: The Unwitting Coronavirus Spreaders*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/31/health/coronavirus-asymptomatic-transmission.html.

facilities. That is because immigration detention facilities are enclosed environments, much like the cruise ships, naval carriers or nursing homes that have proven susceptible to COVID-19 outbreaks. The social distancing that has been the hallmark of the United States' COVID-19 prevention efforts has not proven possible in such detention settings. Detainees share close quarters, including shared living quarters and bunk beds, dining halls, bathrooms, showers, telephones, law libraries and other common areas, each presenting dangerous opportunities for transmission.[22] Spaces within detention facilities are poorly ventilated, which promotes the spread of diseases. Other hygiene-based prevention strategies are similarly lacking in a detention setting. Detainees do not typically have access to sufficient soap and alcohol-based sanitizers to engage in the kind of frequent hand washing recommended throughout the rest of the country. At best, staff can only sporadically clean or sanitize high-touch surfaces like door handles, light switches or telephones. In fact, in these facilities detainees themselves have to clean the facility without adequate supplies or protective equipment, which further exposes them to infection.

Once an outbreak occurs, it is extremely difficult to properly treat those who become infected or limit the spread of the virus. COVID-19's most common symptoms are fever, cough and shortness of breath. Serious cases can require invasive measures to manage respiratory function, including the use of highly specialized equipment like ventilators. While serious infections have developed in all demographics, they are much more likely to occur in high-risk populations. The coronavirus epidemic has created a high demand for ventilators and resulted in short supply around the world.[23] The virus even has led to shortages of less specialized equipment such as dialysis machines, face masks and gloves.[24]

The necessary clinical management for those infected with coronavirus, especially those in high-risk populations, is labor-intensive. It requires that nurses tend to a limited number

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[22] Poor inmate hygiene has in previous years led to staph infection outbreaks, spread by, *inter alia*, the shared use of soap and towels and person-to-person contact via contaminated hands. *See* Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections, Federal Bureau of Prisons Clinical Practice Guidelines, 1-2 (April 2012), https://www.bop.gov/resources/pdfs/mrsa.pdf.

[23] Kulish et. al, *The U.S. Tried to Build a New Fleet of Ventilators. The Mission Failed.*, N.Y. Times (Mar. 29, 2020), https://www.nytimes.com/2020/03/29/business/coronavirus-us-ventilator-shortage.html.

[24] *See* Andrew Jacobs, et al., *'At War With No Ammo': Doctors Say Shortage of Protective Gear Is Dire*, N.Y. Times (Mar. 19, 2020) https://www.nytimes.com/2020/03/19/health/coronavirus-masks-shortage.html.

of patients at a time, and often requires physicians with specialized backgrounds in infectious diseases, respiratory, cardiac and kidney care. Immigration detention facilities are unable to address these needs. The novel coronavirus outbreak is already straining hospital capacity across the country. The problem will be dangerously exacerbated if ICE does not act immediately to reduce those detainees who are at the greatest risk of serious infection.[25]

D. IHSC's Recommendations to Combat COVID-19 Are Inadequate

ICE Health Service Corps ("IHSC") is the entity responsible for overseeing medical care in ICE detention facilities. On March 6, 2020, IHSC released interim guidelines to combat COVID-19.[26] Those guidelines, however, were woefully inadequate in light of the serious concerns outlined above. Among other things, the guidelines: 1) focused on questioning detainees about travel and potential contact with individuals with COVID-19, even though the disease is already widely spread in the U.S.; 2) failed to include simple measures recommended by the CDC to stop the spread of infections in institutional settings, such as access to hand sanitizer and use of masks; 3) failed to advise detention facility staff on planning for disease surges as illness spread, even though that spread would inevitably result in an increase in patients and a decrease in staff due to illness; 4) failed to advise detention facility staff on when to test for COVID-19; 5) failed to establish adequate protocols for isolating and monitoring detainees with coronavirus, instead treating the disease as a rare occurrence even though many new detainees may already have been infected with coronavirus; and 6) provided no guidance, training or protections for detainees when they enter detention.[27]

On April 10, 2020, ICE issued a new guidance document which "assists ICE detention facility operators to sustain detention operations, while mitigating risk to the safety and well-being of detainees, staff, contractors, visitors, and stakeholders due to COVID-19."[28] This

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[25] Matthew J. Akiyama, et al., *Flattening the Curve for Incarcerated Populations—Covid-19 in Jails and Prisons*, New England Journal of Medicine (April 2, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2005687.

[26] *See* Immigration and Customs Enforcement Health Service Corps, Interim Reference Sheet (Mar. 6, 2020), https://www.aila.org/File/DownloadEmbeddedFile/84066.

[27] Id.

[28] ICE Enf't & Removal Operations, COVID-19 Pandemic Response Requirements 3 (2020), https://www.ice.gov/doclib/coronavirus/eroCOVID19responseReqsCleanFacilities.pdf.

new document is still inadequate: much of the guidance is permissive or aspirational, rather than mandatory. For example, the guidance "encourage[s] staff to maintain a distance greater than six feet" from individuals appearing ill "[w]hen feasible and consistent with security priorities" and acknowledges that "strict social distancing may not be possible."[29] As recognized by a federal district judge in his April 20 order, the document also includes no mention of any enforcement mechanisms.[30] Moreover, the new ICE guidance came far too late. The guidance primarily serves to operationalize CDC's Interim Guidance for Correctional and Detention Facilities, which was released almost three weeks prior.[31] There are now at least 705 confirmed cases out of only 1,460 tested throughout the system among detainees in ICE custody, and 102 confirmed cases among ICE employees at detention centers.[32] This is in the context of very low testing levels: less than 5% of the total detained population has been tested.[33]

In short, these ICE guidelines fall far short of setting forth the sort of comprehensive and proactive social distancing measures that are necessary to prevent viral spread or to treat those who become infected. The current ICE approach will result in many preventable illnesses and deaths—in particular among people with high-risk characteristics, such as Plaintiffs in this case. Other governments appear to have recognized this risk and acted accordingly by releasing thousands from carceral settings.[34] ICE must also fully recognize this risk.

V. Conclusion

For these reasons, NWDC officials should work with local health departments to release detainees who are at a high risk of serious COVID-19 infection. *Amici* urge the Court to

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[29] *Id.* at 13.

[30] Order (1) GRANTING Motions to File Amicus Briefs (Dkt. Nos. 117, 119); (2) GRANTING Plaintiffs' Emergency Motion to Certify Subclass (Dkt. No. 83); (3) GRANTING Plaintiffs' Motion for Preliminary Injunction (Dkt. No. 81); and DENYING AS MOOT Plaintiffs' Ex Parte Application to File Supplement (Dkt. No. 127) (IN CHAMBERS) at 30, Fraihat v. ICE, No. 19-1546 (C.D. Cal. Apr. 20, 2020).

[31] *See Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities*, Ctrs. for Disease Control and Prevention (Mar. 23, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html.

[32] *ICE Guidance on COVID-19 – Confirmed Cases*, https://www.ice.gov/coronavirus (last updated May 8, 2020).

[33] *See id.*

[34] *See, e.g.*, Paige St. John, *California to release 3,500 inmates early as coronavirus spreads inside prisons*, L.A. Times (Mar. 31, 2020), https://www.latimes.com/california/story/2020-03-31/coronavirus-california-release-3500-inmates-prisons.

consider this information when assessing whether to grant plaintiffs' petition for habeas corpus, as well as plaintiffs requested injunctive and declaratory relief.

Dated: May 12, 2020

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