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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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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 improvidet064.03 T2(Cerv)2.2(a)-1.7(ti)4(Pres)3.5(Pe)12932(e)-1 oOn wid-3.4(n)Phe Shh-1.9(v)-3

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

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, 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.

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

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

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

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 …

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

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]

[32] Dep't Homeland Sec. Office Inspector Gen., *ICE Does Not Fully Use Contracting Tools To Hold*

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

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

[39] E.g. Bianca Malcolm,

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 .9(o)3c(v)-5.2(a)8.4(t)-4.9(e)1.8(b-3.8(e64It)3.2(i)-4.1(p)-3.9t( )1.1.8

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 Cont* */F1 6.1(*

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> community hospital where there may only be six or eight ventilators over a very short period. As they fill up and the [illegible] 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. Jos[illegible]

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 aati-1.9(n29.3(g)83.9( )-41.5(a)8l2(i)-4

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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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Respectfully Submitted,

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