UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

ADHAM AMIN HASSOUN, Petitioner, - vs - JEFFREY SEARLS, in his official capacity as Acting Assistant Field Office Director and Administrator, Buffalo Federal Detention Center, Respondent.	W.D.N.Y. Civil Action No. 19-cv-370-EAW

BRIEF OF *AMICI CURIAE* PUBLIC HEALTH AND HUMAN RIGHT EXPERTS

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I. Introduction

Amici curiae, a group of public health officials and human rights experts who are familiar with the unique dangers associated with infectious diseases in jails, prisons and detention facilities, strongly urge this Court to grant Adham Amin Hassoun's Emergency Motion for Transfer to Home Incarceration as part of a necessary strategy to reduce the number of inmates in facilities like the Buffalo Federal Detention Facility. Reducing the number of inmates at these facilities will minimize not only the public health risk to Mr. Hassoun, but also to other inmates, staff, visitors and the public at large.

COVID-19 is an extremely infectious disease. It has created an unprecedented global health crisis and led to the adoption and implementation of novel but necessary 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 virus has proven that it can infect and seriously harm anyone. But it is particularly problematic for individuals with high risk underlying conditions, like Mr. Hassoun.

Managing the spread of COVID-19 within detention facilities is critically important because they are enclosed environments, like cruise ships, that are highly susceptible to epidemics. In the case of COVID-19 specifically, the only way to mitigate the risk of serious infection is through hygienic measures like frequent hand washing and social distancing to limit exposure. But those prevention methods are all but impossible in a detention setting, in which detainees are crowded together, sharing bathroom products, and where sanitizing products are infrequently used. And once an outbreak occurs, detention facilities are rarely equipped to provide the intensive care and support needed to treat patients suffering from a severe COVID-19 infection.

Acting quickly to mitigate the enormous risk associated with detention facilities is not just necessary to protect those who are incarcerated, but also to protect staff and visitors. Moreover, because staff and visitors cycle in and out of these 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 correctional facilities. Based on their experience, and their review of the available information about the COVID-19 pandemic, it is their view that the petitioner in this action is at high risk of serious, life-threatening COVID-19 infection, and that his continued confinement puts him at a heightened risk of contracting and further spreading COVID-19.

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

Amici are the following:

Joseph Bick, M.D., is an infectious diseases specialist and medical administrator with over 25 years' experience in correctional health care, most recently as Chief Medical Executive of the California Medical Facility in the California Department of Corrections and Rehabilitation. Dr. Bick has served as an International Technical Expert on Prisons for the United

Nations Office for Project Services in Myanmar, and an Infectious Diseases consultant for the Malaysian prison system. Dr. Bick served as a federal court-appointed medical monitor to oversee health care in Alabama (*Leatherwood* v. *Campbell*), and has published extensively on issues related to infectious diseases in correctional settings.

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 correctional facilities.

Kathryn Hampton is Senior Officer of the Asylum Program at Physicians for Human Rights. In that capacity, she coordinates Physicians for Human Rights' Asylum Network Program, an initiative that recruits, trains and supports a network of clinicians to provide forensic evaluations for asylum seekers and to advocate for human rights-based immigration policies. She has over 10 years of experience in human rights monitoring, analysis, and reporting.

Ranit Mishori, M.D., is senior medical advisor at Physicians for Human Rights (PHR), and Professor of family medicine at the Georgetown University School of Medicine, where she directs the department's Global Health Initiatives and Health Policy fellowship. She

has over 20 years of public and primary care experience working with immigrants, asylum seekers, incarcerated and formerly incarcerated individuals. At Georgetown, she leads the School of Medicine's Correctional Health Interest group, where she supervises medical students placed at jails, prisons and detention centers. In addition, she is the director of Georgetown University's Asylum program which focuses on both the care and medico-legal issues of asylum seekers, including immigration detention. She has written extensively and given talks and lectures about these issues nationally and internationally. She has reviewed and analyzed dozens of legal cases related to health outcomes of individuals in correctional facilities, and advised multiple organizations (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and the care of pregnant women.

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. Factual Background

Amici adopt and incorporate by reference the factual background set forth in Petitioner's Response to Respondent's Motion for an Adjournment and Memorandum in Support of Petitioner's Emergency Motion for an Order Transferring Him to Home Incarceration.

IV. Argument

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 April 6, 2020, there were 1,174,855 confirmed cases and 64,471 deaths in 209 countries, areas or territories 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 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

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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.

3 *See* Centers for Disease Control and Prevention, Situation Summary (2020), cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fsummary.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.

5 *Id.* at 1.

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, nearly three in four Americans is now under order to stay home.[7]

Although these measures are welcomed and necessary, they would have been more effective if governments had acted proactively, rather than merely prescriptively.[8] The United States now has over 304,826 confirmed cases and over 7,616 fatalities.[9] Indeed, the COVID-19 virus has wreaked havoc all over the United States, jeopardizing both the health and economic wellbeing of millions of Americans.[10] The worst-case scenario in the Imperial College study above suggests that the United States could suffer up to 2.2 million deaths as a result of the COVID-19 crisis.[11] Accordingly, extreme social distancing should not only be practiced, but also mandated and enforced by all levels of government and their institutions.

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6 *Id.* at 15.

7 Sarah Mervosh et al., *See Which States and Cities Have Told Residents to Stay Home*, N.Y. Times (Mar. 31, 2020), https://www.nytimes.com/2020/03/20/us/ny-ca-stay-home-order.html.

8 *See* Impact of Non-Pharmaceutical Interventions (NPIs) to Reduce COVID-19 Mortality at 3 ("Cities in which these interventions were implemented early in the epidemic were successful at reducing case numbers while the interventions remained in place and experienced lower mortality overall.").

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.

10 *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/.

11 Impact of Non-Pharmaceutical Interventions (NPIs) to Reduce COVID-19 Mortality at 7.

B. The Danger is Greatest for Individuals Over Fifty and with Underlying Conditions

Emerging data suggests that 16% of people infected with COVID-19 will develop serious illness. About 1% of infected persons die. Even those patients who ultimately recover might suffer from permanent damage to their lungs and other vital organs. 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. The experience of Italy, which is suffering one of the world's worst outbreaks of COVID-19 and has seen more deaths than any other country, is instructive: recent reporting indicates that the average age of those who have 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.[12] 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 are unusual environments in which it is impossible to implement and enforce social distancing guidelines, and are thus at a heightened risk for the spread of COVID-19. Indeed, numerous public health officials have recognized that outbreaks of contagious diseases are more common in jail settings than in communities at large.[13] COVID-19 almost certainly will

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[12] Tommaso Ebhardt et al., *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.

[13] *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*

be no exception. Over the past two weeks, hundreds of COVID-19 diagnoses have been confirmed at local, state and federal correctional facilities.[14] Those numbers are almost certainly an undercount given the dearth of testing.[15]

The enormity of the problem 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 those facilities. Moreover, inmates themselves often have to make court appearances and, each time they appear, they risk contracting infections and introducing them into the 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 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 detainees transferred between facilities, which creates a risk of detention facilities spreading the virus throughout the system.[16]

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 those individuals who are infected with COVID-19. Those who are infected

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Detention Centers In The Last Year, Buzzfeed News (Aug. 29, 2019) https://www.buzzfeednews.com/article/stephaniemlee/mumps-ice-immigrant-detention-cdc.

[14] Timothy Williams, et al., *As Coronavirus Spreads Behind Bars, Should Inmates Get Out?*, N.Y. Times (Mar. 30, 2020) https://www.nytimes.com/2020/03/30/us/coronavirus-prisons-jails.html.

[15] *Id.*

[16] *See* Hamed Aleaziz, *A Local Sheriff Said No To More Immigrant Detainees Because of Coronavirus Fears. So ICE Transferred Them All To New Facilities*, BuzzFeed News (Mar. 18, 2020) (ICE recently transferred 170 immigrant detainees from Wisconsin to facilities in Texas and Illinois. "'In order to accommodate various operational demands, ICE routinely transfers detainees within its detention network based on available resources and the needs of the agency…' an ICE official said in a statement."), https://www.buzzfeednews.com/article/hamedaleaziz/wisconsin-sheriff-ice-detainees-coronavirus.

with COVID-19 may suffer from only mild symptoms or even be entirely asymptomatic, but still be carrying and spreading the disease[17]. And, unfortunately, detention facilities typically do not have the ability to perform the kind of systematic testing that would be required to ensure that the virus does not enter the facility.

The unique attributes of detention facilities also make it impossible for those facilities to adopt and implement the mitigation efforts that have become a necessary safeguard of life outside those facilities. That is because these facilities are enclosed environments, much like the cruise lines that have proven susceptible to COVID-19 outbreaks. The social distancing that has been the hallmark of the United States' COVID-19 prevention efforts is simply not possible in such a setting. Incarcerated people share close quarters, including dining halls, bathrooms, showers and other common areas, each presenting dangerous opportunities for transmission.[18] Additionally, spaces within detention facilities often are poorly ventilated, which promotes the spread of diseases. Other hygiene-based prevention strategies are similarly ineffective in a jail setting. Inmates will not typically have access to sufficient soap and alcohol-based sanitizers to engage in the kind of frequent hand washing encouraged throughout the rest of the country.[19] And staff often do not clean or sanitize high-touch surfaces like door handles or light switches.

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[17] Apoorva 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.

[18] 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.

[19] *See* Timothy Williams, et al., *As Coronavirus Spreads Behind Bars, Should Inmates Get Out?*, N.Y. Times (Mar. 30, 2020) https://www.nytimes.com/2020/03/30/us/coronavirus-prisons-jails.html (explaining that in some correctional facilities "Even as a visitor . . . if you want to wash your hands, you've got to walk out and go into another building to do it.").

Once an outbreak starts, it will be extremely difficult to contain the spread of the infection or properly treat those who have been infected. COVID-19's most common symptoms are fever, cough and shortness of breath. Serious cases can develop that require invasive measures to improve respiratory function, including the use of highly specialized equipment like ventilators. The COVID-19 virus has put ventilators in high demand and short supply around the world, and the virus even has led to shortages of less specialized equipment such as face masks and gloves.[20]

The necessary treatment for those infected with COVID-19, especially those in high-risk populations, is labor-intensive. It would only allow nurses to tend to one or two patients at a time, and may require physicians with specialized backgrounds in respiratory care. Detention facilities are unable to address these needs. In fact, such facilities often employ nurses who practice beyond the scope of their licenses, and part-time physicians who have limited availability to be on-site. The novel coronavirus outbreak is already straining hospital capacity across the country. That problem will be dangerously exacerbated if detention centers, jails and prisons do not act immediately to reduce their inmate populations and contain the spread of the virus.

D. IHSC's COVID-19 Mitigation Efforts 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.[21] Those guidelines, however, are inadequate in light of the serious concerns outlined above. Among other things, the guidelines: focus on questioning detainees about travel and potential contact with individuals with COVID-19, even though the disease is already widely

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[20] *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

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

spread; fail 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 for those with coughs; fail to advise detention facility staff on planning for surges as illness spreads, even though that spread will inevitably result in an increase in patients and a decrease in staff due to illness; fail to advise detention facility staff on when to test for COVID-19; establish protocols for isolating and monitoring detainees with COVID-19 as if it will be a rare occurrence, even though many or most new detainees likely already have been exposed to the virus; provide no guidance or special protections for high-risk patients when they enter detention; and provide no guidelines for identifying high-risk patients who are already in detention.

In short, the IHSC guidelines fall far short of setting forth the sort of comprehensive and proactive social distancing measures, described above, that are necessary to prevent viral spread. And, indeed, viral spread already appears to be happening. Because of the particular risks facing detention facilities, the current IHSC approach will result in many preventable illnesses and deaths—in particular among older individuals and individuals with preexisting illnesses. Other governments appear to have recognized this risk and acted accordingly. ICE must do the same in order to stop the spread of COVID-19 in its detention facilities and protect those who are most vulnerable to the illness.

V. Conclusion

For these reasons, *amici* urge the Court to grant Emergency Motion for an Order Transferring Him to Home Incarceration.

Dated: April 6, 2020

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CERTIFICATE OF SERVICE

I hereby certify that, on April 6, 2020, I caused to be electronically filed a copy of the foregoing Brief of *Amici Curiae* Public Health and Human Rights Experts using the Court's CM/ECF system, and service was effected electronically pursuant to all counsel of record.

Dated: April 6, 2020

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