

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA**

O.M.G. et al.,

Petitioners,

v.

CHAD WOLF, in his official capacity as the acting
Secretary of the U.S. Department of Homeland
Security, et al.,

Respondents.

NO. 1:20-cv-00786
J.E.B.

**BRIEF OF *AMICI CURIAE* PUBLIC HEALTH EXPERTS¹
AND AMERICAN ACADEMY OF PEDIATRICS IN SUPPORT OF
PETITIONERS' MOTION FOR A TEMPORARY RESTRAINING ORDER**

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CORPORATE DISCLOSURE STATEMENT

There are no parent corporations or publicly-held corporations that own 10% or more of the stock in any of the amici curiae.

INTERESTS OF AMICI CURIAE²

Amici public health experts are nine researchers and academics who are experts in the fields of public health. Among them, they have decades of cumulative experience creating models to improve responses to epidemic diseases, researching the effects of immigration policies on immigrants' health, and treating immigrants, including children, in clinical settings.

Amicus American Academy of Pediatrics (AAP) represents 67,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists who are committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. AAP believes that the future prosperity and well-being of the United States depends on the health and vitality of all of its children, without exception. Pediatricians know that even short periods of detention can have long-lasting consequences for children, including psychological trauma and mental health risks. There is no evidence that any amount of time in detention is safe for a child. All children—no matter where they or their parents were born—should have the right to access health care, remain united with their families, and pursue a high-quality education.

Amici seek to inform the court about the direct injuries to personal health that the Petitioners will suffer absent the requested relief, as well as the impact to the broader public if those injuries are not mitigated.

² No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting the brief. No person—other than the *amici*, its members, or its counsel—contributed money that was intended to fund preparing or submitting the brief.

INTRODUCTION

Society is rarely faced with circumstances so stark as in this case. The COVID-19 pandemic will inevitably impose substantial harms on families with children detained in U.S. Immigration and Customs Enforcement (ICE) “family residential centers,” or FRCs, and on the ICE personnel and contractors charged with Petitioners’ detention and care. Without an immediate change to the *status quo*, by the time the first cases are diagnosed, the FRCs will almost certainly already have become “hotspots,” causing untold numbers of children and their parents, as well as ICE personnel and contractors and their families, to eventually become sick. A significant number will then require hospitalization, facing the chance of permanent disability or death—with compounded accompanying harm to local hospital systems and communities.

The only viable public health intervention to address these negative outcomes and allow immigrant families, ICE personnel, contractors, and their families to practice appropriate prevention measures and prevent an outbreak is to release these families to their sponsors and immediately de-densify the detention centers. The urgency and clarity of the need for appropriate action cannot be overstated. Given the rapidity of transmission, to wait for a confirmed case is to wait far too long—placing countless lives in danger. Simply put, continued detention is a recipe for a public health disaster.

ARGUMENT

I. A DANGEROUS OUTBREAK OF THE HIGHLY CONTAGIOUS COVID-19 DISEASE INJURING PETITIONERS AND FRC STAFF IS INEVITABLE UNLESS PETITIONERS ARE IMMEDIATELY RELEASED FROM DETENTION.

A. COVID-19 is a Dangerous, Highly Contagious Disease, and Individual and Community Public Health Practices are Critical to Preventing its Transmission.

In any setting, including the FRCs where Petitioners are currently detained, COVID-19, caused by the SARS-CoV-2 virus, is a dangerous, highly contagious disease. One-fifth of all cases cause serious illness, including respiratory damage that requires hospitalization and mechanical ventilation, and can permanently harm those who survive.³ Currently, the U.S. mortality rate is 1.63%.⁴ By contrast, heart disease, which consistently ranks as the leading cause of death in the U.S., has a death rate over eight times smaller (0.2%).⁵

The World Health Organization (WHO) declared COVID-19 a pandemic, which it defines as the “worldwide spread of a new disease,” on March 11, 2020.⁶ The Centers for Disease Control and Prevention (CDC) has also classified COVID-19 as a pandemic.⁷

³ “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), available at http://www.euro.who.int/_data/assets/pdf_file/0019/434026/Preparedness-prevention-and-control-of-COVID-19-in-prisons.pdf?ua=1.

⁴ Jan Oke and Carl Heneghan, “Oxford COVID-19 Evidence Service” (Mar. 28, 2020), available at <https://www.cebm.net/covid-19/global-covid-19-case-fatality-rates/>.

⁵ Kenneth D. Kochanek et al., “Deaths: Final Data for 2017,” *National Vital Statistics Reports*, 6 Table B (June 24, 2019), available at https://www.cdc.gov/nchs/data/nvsr/nvsr68/nvsr68_09-508.pdf.

⁶ World Health Organization, “Director-General's opening remarks at the Mission briefing on COVID-19” (Mar. 12, 2020), available at <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---12-march-2020>; World Health Organization, “What is a pandemic?,” available at https://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/ (last accessed Mar. 29, 2020).

⁷ Centers for Disease Control and Prevention, “Coronavirus Disease 2019: Situation Summary” (Mar. 26, 2020), available at <https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/summary.html#covid19-pandemic> (“CDC Situation Summary”) (last accessed Mar. 29, 2020).

According to the CDC, pandemics “happen when new (novel) ... viruses emerge which are able to infect people easily and spread from person to person in an efficient and sustained way.”⁸

COVID-19 is highly transmissible: a recent meta-analysis of estimates of the reproductive number (R_0 , or “r-naught,” an estimate of how many people each infected person can spread the illness to) found that, on average in community settings, each infected person transmits the virus to an additional 2.79 people.⁹ This means that if each subsequent layer of infected individuals passes a COVID-19 infection on to 2.79 more people, after ten iterations of infection, a single infected person can be responsible for 28,579 infections. (By contrast, the seasonal flu has an R_0 of 1.3; after ten iterations of infection, a single infected person can be responsible for only fourteen infections.) This already high reproduction rate has been found to be exponentially higher in dense settings (such as a cruise ship) that are somewhat closer to the conditions found in detention. This is so for several reasons. *First*, even asymptomatic individuals can transmit the disease to others,¹⁰ 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 up to eighteen days,¹¹ allowing infected (and potentially asymptomatic) individuals to unwittingly infect others for weeks. *Third*, the virus can survive

⁸ Centers for Disease Control and Prevention, “Pandemic Basics,” *available at* <https://www.cdc.gov/flu/pandemic-resources/basics/index.html> (last accessed Mar. 29, 2020).

⁹ Yang Liu et al., “The reproductive number of COVID-19 is higher compared to SARS coronavirus,” 27 *Journal of Travel Medicine* 1, 1 (2020), *available at* <https://academic.oup.com/jtm/article/27/2/taaa021/5735319>.

¹⁰ Yan Bai et al., “Presumed Asymptomatic Carrier Transmission of COVID-19,” *JAMA* (Feb. 21, 2020), *available at* <https://jamanetwork.com/journals/jama/article-abstract/2762028>.

¹¹ Qun Li et al., “Early Transmission Dynamics in Wuhan, China, of Novel Coronavirus–Infected Pneumonia,” 382 *New England Journal of Medicine* 1199, 1203 (2020), *available at* <https://www.nejm.org/doi/10.1056/NEJMoa2001316>.

outside the body for prolonged periods of time—for example, it 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.¹² By contrast, influenza, itself a highly contagious virus responsible for tens of thousands of Americans’ deaths every year, has been shown to survive for 24-48 hours on hard, non-porous surfaces such as stainless steel and plastics, and 8-12 hours on paper products.¹³

The effects of COVID-19 are very serious, especially for people who are over the age of 65, and those of any age with underlying health problems such as—but not limited to— weakened immune systems, diabetes, lung, kidney, heart, and liver disease.¹⁴

Because of its high mortality rate and transmissibility, both the WHO and the CDC consider COVID-19 a public health emergency.¹⁵

¹² Neeltje van Doremalen, et al., “Aerosol and Surface Stability of SARS-CoV-2 as Compared with SARS-CoV-1,” *New England Journal of Medicine Correspondence* (Mar. 17, 2020), available at <https://www.nejm.org/doi/full/10.1056/NEJMc2004973>.

¹³ B. Bean et al., “Survival of influenza viruses on environmental surfaces,” 146 *Journal of Infectious Diseases* 47, Abstract (1982), available at <https://www.ncbi.nlm.nih.gov/pubmed/6282993>.

¹⁴ Centers for Disease Control and Prevention, “People who are at higher risk for severe illness,” available at <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-higher-risk.html> (last accessed Mar. 29, 2020).

¹⁵ 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), available at [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-\(2019-ncov\)](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, *supra*, Section entitled “Highlights of CDC’s Response.”

Because there is not yet any vaccine or herd immunity to COVID-19 (despite current research),¹⁶ containing the disease largely falls on individuals and communities implementing two fundamental public health practices.¹⁷ First, the CDC recommends “social distancing”—individuals staying at least six feet apart—to prevent transmission.¹⁸ Keeping distance from others is especially important with COVID-19 because asymptomatic individuals are often contagious without knowing it. Isolation—separating sick people from healthy ones—and quarantining—separating people who may have been exposed to see if they become sick—are also crucial strategies. When social distancing is not practical, the CDC recommends “cohorting,” the practice of isolating groups of lab-confirmed cases rather than isolating individuals.¹⁹ However, the CDC stresses that “[o]nly individuals who are laboratory confirmed COVID-19 cases should be placed under medical isolation as a cohort.”²⁰ In addition,

¹⁶ Carolyn Y. Johnson and Ben Guarino, “Blood from people who recover from coronavirus could provide a treatment,” *Washington Post* (Mar. 27, 2020), available at <https://www.washingtonpost.com/health/2020/03/27/coronavirus-serum-plasma-treatment/>

¹⁷ Centers for Disease Control and Prevention, “How to Protect Yourself,” available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fprepare%2Fprevention.html (last accessed Mar. 29, 2020); Eduardo Sanchez, “COVID-19 science: Understanding the basics of ‘herd immunity,’” *Heart.org* (Mar. 25, 2020), available at <https://www.heart.org/en/news/2020/03/25/covid-19-science-understanding-the-basics-of-herd-immunity>.

¹⁸ Centers for Disease Control and 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), available at https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html#social_distancing (“CDC Detention Guidance”) (last accessed Mar. 29, 2020).

¹⁹ *Id.*

²⁰ *Id.*, Section entitled “Medical Isolation of Confirmed or Suspected COVID-19 Cases.”

individuals who have been in close contact with a known COVID-19 case but who do not exhibit COVID-19 symptoms should be quarantined for two weeks.²¹

Second, proper hygiene practices are also vital to prevent COVID-19 transmission, particularly due to the virus's ability to survive inside and outside the body for long periods of time. These practices include 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.²²

At a basic level, then, the public health approach to containing the disease is to break people into the smallest feasible groups (individuals, families, cohorts), and to keep those smallest groups both physically distanced from each other and practicing good hygiene. Following these practices will not totally eliminate 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 prevent the system from being overburdened at any one instance. Outbreaks are anathema to this process because they cause large numbers of simultaneous infections and increase exponential hospitalization growth.

Implementing these practices has already led, in the United States and globally, to an unprecedented response akin to wartime mobilization. Public spaces have shuttered and individuals are self-quarantining at home, at significant economic cost (leading to the largest amount of aid from the federal government in history) in order to contain the virus. The drastic,

²¹ *Id.*, Section entitled “Quarantining Close Contacts of COVID-19 Cases.”

²² *Id.*, Section entitled “Hygiene.”

unprecedented measures are universal and are all in response to the need to contain the virus as quickly as possible.

B. ICE is not Adequately Following Practices to Mitigate the COVID-19 Pandemic in FRCs.

The highly infectious nature of COVID-19 poses unique challenges for any detainees, including Petitioners. Petitioners, groups of families with minor children, are trapped in settings with limited health care resources not designed to respond to an outbreak. They are housed in shared sleeping conditions, eat in communal cafeterias, use shared bathrooms, and both lack supplies and immediate and frequent access to soap and water. Recognizing at least some of these difficulties, the CDC recommends that detention centers maintain “sufficient stocks of hygiene supplies,” and “[p]rovide a no-cost supply of soap to incarcerated/detained persons, sufficient to allow frequent hand washing.”²³

But Petitioners’ already precarious relationship to the pandemic is made worse by ICE’s practices, which fall woefully short of the CDC’s recommendations. First, ICE’s practices do not adequately promote social distancing. According to ICE policies, only symptomatic detainees and those who meet “CDC criteria for epidemiologic risk” are isolated.²⁴ ICE does not define “epidemiologic risk,” but, whatever it means, distancing people who satisfy it from others is insufficient because, per the CDC, *everyone* should avoid contact with others.

²³ *Id.*, Section entitled “Operations & Supplies.”

²⁴ Immigration and Customs Enforcement, “ICE Guidance on COVID-19,” Section entitled “Detention,” available at <https://www.ice.gov/coronavirus> (“ICE Guidance”) (last accessed Mar. 29, 2020).

ICE's limited ability to use isolation is unsafe for detainees already in the facility, and is made even worse with the treatment of new detainees—even though new detainees might bring COVID-19 into the facility. ICE's practice is to isolate only those new detainees who *both* exhibit symptoms of COVID-19 *and* meet epidemiologic risk criteria²⁵: that is, a person showing symptoms of a COVID-19 infection but who does not meet CDC clinical criteria will remain in the general detention population, contravening the CDC's recommendation of a two-week quarantine for everyone who has had close contact with a known COVID-19 case. ICE's past actions regarding detainee health care, especially for children, strongly suggests that existing protocols will not prevent or slow the spread of COVID-19 in these facilities—nor safely address the needs of children.

Second, ICE does not adequately promote hygiene to either detainees or its staff. According to declarations accompany Petitioners' Complaint, the FRCs do not have adequate instructions on how to maintain hygiene,²⁶ detainees are not provided hand sanitizer,²⁷ detainees do not have consistent access to soap,²⁸ and are often required to purchase soap themselves,²⁹ and ICE staff do not practice social distancing, and even shake each other's hands.³⁰ ICE itself has conceded that at the Karnes and Dilley FRCs, they routinely permit gatherings of 10 individuals, including ICE personnel (though personnel have been instructed not to touch other

²⁵ *Id.* (“IHSC isolates detainees with fever and/or respiratory symptoms who meet these criteria.”)

²⁶ Complaint Exhibit 2: Decl. of Bridget Cambria, ¶ 27; Decl. of Tae D. Johnson, Dkt. 19-1 ¶ 21.

²⁷ *Id.*, ¶ 28.

²⁸ *Id.*

²⁹ Complaint Exhibit 7: Decl. of Andrea Meza, ¶ 24.

³⁰ Complaint Exhibit 8: Decl. of Julia Marcella Valero, ¶ 11.

staff members).³¹ Families lack frequent access to bathrooms³²—sink, water, and soap—for hand washing, lack access to cleaning supplies, and generally lack access to equipment that can promote good hygiene.³³ Even setting aside the apparent lack of masks for symptomatic detainees,³⁴ these basic failings contravene the CDC’s recommendations for detention centers.

C. The Three FRCs at Issue Inherently Cannot Follow Mitigation Practices.

Even if ICE were to suddenly conform its practices to minimal standards, an outbreak *still* would be highly probable. Detainees are in frequent contact with one another and therefore cannot practice social distancing. They share bedrooms and bathrooms, and frequently gather in communal spaces. Isolating known cases and cohorting would be impossible for the same reasons. The disease will then spread in the facility like wildfire.

It is uncontroversial in the public health literature that communicable diseases are far more prevalent in detention facilities. 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.³⁵ Another study found that,

³¹ Decl. of Tae D. Johnson, Dkt. 19-1 ¶ 21.

³² Caitlin Dickerson, “‘There Is a Stench’: Soiled Clothes and No Baths for Migrant Children at a Texas Center,” *N.Y. Times* (June 21, 2019), available at <https://www.nytimes.com/2019/06/21/us/migrant-children-border-soap.html>.

³³ ICE has stated that they have increased oversight of the maintenance of sanitizing stations, but that it has not added additional sanitation sites to, for example, the Karnes Facility. Decl. of Tae D. Johnson, Dkt. 19-1 ¶ 21.

³⁴ Complaint Exhibit 4: Decl. of Shalyn Fluharty, ¶ 21.

³⁵ Zulficar Gregory Restum, “Public Health Implications of Substandard Correctional Health Care,” 95 *American Journal of Public Health* 1689, 1689 (2005), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1449420/>.

during the H1N1-strain flu outbreak in 2009 (known as the “swine flu”), jails and prisons experienced a disproportionately high number of cases.³⁶

COVID-19 is no exception to this trend. Looking at other high-density environments is instructive. A recent study of COVID-19 on a densely populated cruise ship modeled its basic reproduction rate (R0) to be an astronomical 14.8 (rather than the already high 2.79 rate in the ordinary population—that is, four times higher than normal) absent countermeasures such as isolation and quarantine.³⁷ And even this rate is probably lower than in FRCs because cruise ship passengers would have been able to spend most of their time alone or in small family units, use private bathrooms, and have meals delivered. The recent spread of COVID-19 in New York City jails also illustrates the point. On March 20, there were nineteen confirmed cases. On March 21, there were thirty-eight.³⁸ On March 25, there were seventy-five; by March 29, there were 139.³⁹ Consistent with these examples, leading public health expertise, as documented in

³⁶ David M. Reutter, “Swine Flu Widespread in Prisons and Jails, but Deaths are Few,” *Prison Legal News* (Feb. 15, 2010), available at <https://www.prisonlegalnews.org/news/2010/feb/15/swine-flu-widespread-in-prisons-and-jails-but-deaths-are-few/>.

³⁷ J. Rocklöv et al., “COVID-19 outbreak on the Diamond Princess cruise ship: estimating the epidemic potential and effectiveness of public health countermeasures,” *Journal of Travel Medicine* (accepted manuscript published online Feb. 28, 2020), available at <https://academic.oup.com/jtm/advance-article/doi/10.1093/jtm/taaa030/5766334>.

³⁸ Associated Press, “Coronavirus: 38 test positive in New York City jails, including Rikers Island,” *The Guardian* (Mar. 22, 2020), available at <https://www.theguardian.com/us-news/2020/mar/22/coronavirus-outbreak-new-york-city-jails-rikers-island>.

³⁹ Andrew Denney, “New coronavirus cases in NYC jails outpacing rest of the city,” *New York Post* (Mar. 25, 2020), available at <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) available at <https://abcnews.go.com/Health/shampoo-watery-soap-disinfect-conditions-rikers-island-covid/story?id=69767859>.

recent reports by the WHO, has drawn attention to the special risks that detention poses in the context of the COVID-19 pandemic, both for the health and safety of detained individuals themselves and for the general population.

Further, FRCs are not built to handle the outbreaks that will inevitably occur (that is, unless Petitioners are released). For one, cohorting is practically impossible because families, staff, and ICE agents interact throughout the day. Even if they had adequate supplies to treat any COVID-19 patients at all, which they do not, they would still lack the resources to handle an outbreak. In the event of an outbreak, FRCs would need to rely on their local health care networks for help treating detainees and staff. ICE has already indicated that it is in fact relying on local health care communities to care for “individuals with moderate to severe symptoms, or those who require higher levels of care or monitoring.”⁴⁰ But staff who interact with infected detainees or take detainees to external facilities where COVID-19 patients are being treated are highly likely to become infected themselves, bring the infection back to the facility or out into the community, and exacerbate (or create) an outbreak. There is no clear indication of what ICE would do to care for a child whose parent required transfer for such treatment.

Moreover, these local communities are likely already overburdened themselves, especially because of the ease with which health care workers become infected with COVID-19. For example, one study of COVID-19 in Italy found that 20% of responding health care workers became infected,⁴¹ and another found that 21% of worldwide cases in the SARS outbreak—a

⁴⁰ Ice Guidance, *supra*, Section entitled “Detention.”

⁴¹ Editorial, “COVID-19: protecting health-care workers,” *The Lancet* (Mar. 21, 2020), available at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30644-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30644-9/fulltext) (“Protecting health-care workers”).

virus similar to COVID-19—were among health care workers.⁴² If community health care centers cannot treat the infected detainee or staff member, the detained parent or child presumably would have to remain in the detention center, essentially turning the detention facility into a COVID-19 hospital, and transforming all the staff into health care workers. In this scenario, an outbreak would be a public health disaster—speedy transmission, isolation and quarantining of staff, overwhelmed local health care facilities—without a clear endpoint such as with a cruise ship (when no new individuals were brought aboard and individuals ultimately were able to leave the ship).⁴³

II. DETAINED CHILDREN PRESENT UNIQUE RISKS THAT ONLY IMMEDIATE RELEASE CAN MITIGATE

A. Children are Uniquely Vulnerable to Acute Illness from COVID-19.

The generally non-compliant, high-risk conditions of the facilities in which these families with children are currently detained is sufficient to warrant release of all Petitioners in light of the COVID-19 pandemic. But several petitioners are infants and children, a uniquely vulnerable group that, absent release, could suffer serious harm.

⁴² David Koh, “Occupational health aspects of emerging infections – sars outbreak affecting healthcare workers,” 75 *Occupational & Environmental Medicine* Suppl 2, A14 (2018) available at https://oem.bmj.com/content/75/Suppl_2/A14.1.

⁴³ See Mirco Nacoti, MD, et al., “At the Epicenter of the Covid-19 Pandemic and Humanitarian Crisis in Italy: Changing Perspectives on Preparation and Mitigation,” *New England Journal of Medicine Catalyst* (Mar. 21, 2020) Mar. 21, 2020 available at <https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0080?fbclid=IwAR0wa6jzqtYYIZlYQtWiVmPhT8pjyGBCndLhJGSN34dBaeZJoGP0sfneo> (“... hospitals might be the main Covid-19 carriers, as they are rapidly populated by infected patients, facilitating transmission to uninfected patients.”).

It is well-documented that, for years before the current pandemic, detained non-citizen children have repeatedly suffered from various acute medical conditions that have gone unrecognized because of both insufficient medical staff and a lack of medical staff trained in pediatrics.⁴⁴ There is a high attrition rate for medical providers at detention centers, so the care that families do receive is fractured and inconsistent. As *amicus* American Academy of Pediatrics has described,

Children’s vital signs (breathing rate, heart rate, blood pressure) have different normal parameters than adults, and these parameters vary by age. When children begin to get sick, they present with subtle findings, and they tend to get sick more quickly. . . . A child can be happily playing, even running around, while her body systems begin to shut down.⁴⁵

The pattern of detention staff not understanding children’s medical needs, leading to poor outcomes for children, threatens to repeat itself with COVID-19—but at a far larger scale. While the CDC has stated that children are not at high risk for severe symptoms,⁴⁶ the virus is still

⁴⁴See, e.g., American Academy of Pediatrics, “Testimony on Assessing Adequacy of DHS Efforts to Prevent Child Deaths in Custody to the U.S. House of Representatives Committee on Homeland Security, Subcommittee on Border Security, Facilitation, and Operations” (Jan. 14, 2020), *available at* <https://downloads.aap.org/DOFA/Jan%202020%20Hearing%20Statement%20for%20the%20Record%20-%20AAP.pdf> (“AAP Testimony”); Scott Allen and Pamela McPherson, Letter to Senators Charles E. Grassley and Ron Wyden (Jul. 17, 2018), *available at* <https://www.wyden.senate.gov/imo/media/doc/Doctors%20Congressional%20Disclosure%20S WC.pdf>; Amir Vera, “Autopsy determines 7-year-old Guatemalan girl died from sepsis while in U.S. Custody,” *CNN* (Mar. 30, 2019), *available at* <https://www.cnn.com/2019/03/29/us/guatemala-jakelin-caal-maquin-autopsy/index.html>.

⁴⁵ AAP Testimony, *supra*.

⁴⁶ Centers for Disease Control and Prevention, “Coronavirus Disease 2019 (COVID-19): Caring for Children,” *available at* <https://www.cdc.gov/coronavirus/2019-ncov/prepare/children.html> (last accessed Mar. 29, 2020).

generally not well-understood, including as to the virus's effects on children.⁴⁷ There is no question that a significant number of children worldwide have contracted the virus, and at least one infant in the U.S. has died from COVID-19.⁴⁸ Children are certainly not immune.⁴⁹ And what little has been published about COVID-19 in children thus far describes cases of previously healthy children becoming sick with COVID-19 to the point of needing hospitalization.⁵⁰ The literature in particular points to possible higher risk of severe illness in infants,⁵¹ as well as in children with underlying medical disorders, including but not limited to immunodeficiencies and pulmonary pathology.⁵² Immigrant children in particular who may have already come from environments with sub-standard medical care and have gone through the trauma of international

⁴⁷ Didier Raoult et al., “Coronavirus infections: Epidemiological, clinical and immunological features and hypotheses,” *Cell Stress* (Mar. 2, 2020), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7064018/>.

⁴⁸ See Danielle Wallace, “Chicago infant dies after testing positive for coronavirus, governor says,” *Fox News* (Mar. 29, 2020), available at <https://www.foxnews.com/us/chicago-infant-dies-coronavirus-youngest-covid-19-death-illinois>.

⁴⁹ Yuanyuan Dong, et al., “Epidemiological Characteristics of 2143 Pediatric Patients With 2019 Coronavirus Disease in China,” *Pediatrics* (pre-publication release online Mar. 16, 2020), available at <https://pediatrics.aappublications.org/content/pediatrics/early/2020/03/16/peds.2020-0702.full.pdf> (“Dong, Epidemiological Characteristics”); Tyler Kingkade, “Coronavirus in juvenile detention is a 'nightmare scenario,' doctors and advocates say,” *NBC News* (Mar. 27, 2020), available at <https://www.nbcnews.com/news/us-news/coronavirus-juvenile-detention-nightmare-scenario-doctors-advocates-say-n1170256>.

⁵⁰ Weiyong Liu et al., “Detection of COVID-19 in Children in Early January 2020 in Wuhan, China” *New England Journal of Medicine*, Correspondence (Mar. 12, 2020) available at https://www.nejm.org/doi/full/10.1056/NEJMc2003717?url_ver=Z39.88-2003&rft_id=ori:rid:crossref.org&rft_dat=cr_pub%3dpubmed.

⁵¹ Dong, Epidemiological Characteristics, *supra*.

⁵² Andrea T. Cruz, and Steven L. Zeichner, “COVID-19 in Children: Initial Characterization of the Pediatric Disease,” *Pediatrics* (pre-publication release Mar. 16, 2020), available at <https://pediatrics.aappublications.org/content/pediatrics/early/2020/03/16/peds.2020-0834.full.pdf?rss=1>.

travel for days or weeks on foot are at further increased risk of health complications.⁵³

Moreover, many children, along with their families, have limited health literacy or speak indigenous languages that FRCs cannot adequately accommodate, increasing health risks when interpreters are not available.⁵⁴

This toxic combination of poorly staffed FRCs, an only partially understood virus, and facility medical personnel who lack training and resources to identify and treat acute medical conditions in children creates a substantial risk that detained children with known or undiagnosed medical conditions are at high risk of becoming seriously ill with COVID-19.

While children might still become ill when taken outside of a detention facility, nevertheless access to more robust resources outside of detention centers represents a significant improvement over the status quo. A child placed in a host family setting with access to medical resources (including pediatric care) in a local community and where they can maintain distance from others while awaiting care, is more likely to avoid poor outcomes. Continuing to keep vulnerable children in these FRCs, when the alternative is to release them and their parents to a host family, presents an unacceptable and unnecessary risk to their health.

⁵³ Krista M. Perreira and India Ornelas, “Painful Passages: Traumatic Experiences and Post-Traumatic Stress among Immigrant Latino Adolescents and their Primary Caregivers,” 47 *International Migration Review* 1, 10 (2013), available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3875301/pdf/nihms529682.pdf>.

⁵⁴ Jennifer Medina, “Anyone Speak K’iche’ or Mam? Immigration Courts Overwhelmed by Indigenous Languages,” *N.Y. Times* (Mar. 19, 2019), available at <https://www.nytimes.com/2019/03/19/us/translators-border-wall-immigration.html>.

B. The Presence of Children in the Dense Environment of a Detention Center Presents Serious Public Health Risks.

Children are not only a uniquely vulnerable population within immigration detention facilities; they also present a unique public health challenge to both the detained population and the general public. Because children do tend to have milder symptoms or appear asymptomatic when infected with COVID-19, they are more likely to be carriers not subject to isolation (if isolation were even possible in a detention facility). Children in detention facilities also frequently exhibit cold-like symptoms from other respiratory illnesses, which are hard to distinguish from COVID-19 symptoms. It would be irresponsible to leave them in the general population to await testing, but detention centers also lack the capacity to isolate detained families. Children are also children: they play, touch others and objects indiscriminately, move and run in available spaces, and have short attention spans that make following instructions (like washing hands) difficult. On a practical level, following CDC and other public health guidelines, including social distancing and increased efforts at hygiene, is impossible for children in a detention facility. While in a family setting, a sick child might get other family members sick, in a detention facility, the entire population (detainees and staff) is at risk.

The presence of asymptomatic or mildly symptomatic children within a larger detained population presents a “dangerous situation in community-acquired infections.”⁵⁵ Outside of the FRCs, numerous U.S. institutions have already recognized this danger and have closed schools, day care centers, parks, and playgrounds in an effort to de-densify, specifically reducing the

⁵⁵ See Haiyan Qiu et al., “Clinical and epidemiological features of 36 children with coronavirus disease 2019 (COVID-19) in Zhejiang, China: an observational cohort study,” *The Lancet* (Mar. 25, 2020), available at [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30198-5/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30198-5/fulltext).

likelihood that children will become ill with COVID-19 and helping to prevent them from infecting the larger community. School closings have proven particularly effective in preventing the spread of illness.⁵⁶ Analogously, taking families with children out of dense detention centers is likely to be effective in preventing the spread of illness to detainees and staff.

Importantly, de-densifying the detention population is a public health imperative not only for the detainee population, but also for the broader public. Children—including asymptomatic carriers—come into contact with detention staff, ICE employees, and others who travel between the general public to the FRC. Maintaining the status quo threatens not only the detainee population, which is already vulnerable to rapid spread of COVID-19, but also the general public when those in contact with detainees return to their homes or public places. Children in particular, because they may not present symptoms, pose a particular challenge in preventing broader spread of the virus. Releasing families with children will be an important step in improving public health outcomes.

III. PETITIONERS' REMEDY OF RELEASE IS SUBSTANTIALLY BETTER FOR PUBLIC HEALTH THAN THE STATUS QUO.

Without immediate de-densification, the physical conditions and current practices in ICE detention facilities make prevention and containment of COVID-19 within them impossible. Releasing families with children from detention is the only viable public health option currently available to reduce the risk that released individuals and families, any detainees remaining at the

⁵⁶ Joel Kelso et al., “Simulation suggests that rapid activation of social distancing can arrest epidemic development due to a novel strain of influenza,” *BMC Public Health* (Apr. 29, 2009), available at <https://link.springer.com/article/10.1186/1471-2458-9-117>.

facility during the release process, the personnel and contractors at these facilities, and public at large in surrounding communities will contract the disease.⁵⁷

Because epidemiologists, public health experts, and the CDC unanimously agree that avoiding congregative environments and practicing scrupulous social distancing is essential to preventing community transmission of COVID-19, government officials have instituted unprecedented, sweeping bans on gatherings of as few as ten people (in contrast to what ICE has allowed), have ordered individuals to shelter-in-place, and have mandated the closure of all but essential buildings—all to reduce the risk of COVID-19 transmission in congregative settings.⁵⁸ Government officials have taken these drastic measures *without* requiring a confirmed case of COVID-19, recognizing that given the rapidity of transmission, to wait for a confirmed case is to wait far too long—placing countless lives in danger.

For the same reason, officials overseeing detention settings across the nation and globe have ordered the release of inmates and detainees as a preventative measure. The vast majority of these have been individuals in the criminal justice system—not those, like the families here, merely civilly detained while their asylum applications are being processed. Correctly apprehending the extreme degree of risk posed by COVID-19, Los Angeles County has ordered

⁵⁷ This view is widely shared in the public health community. *See, e.g.*, Decl. of Marc Stern at 5-6, ¶ 12, 3:20-cv-02064, Dkt 4-20; Decl. of Robert B. Greifinger at 7-8, ¶¶ 29, 30, 3:20-cv-02064, Dkt. 4-22; Decl. of Nancy Yvonne Wang at 7, ¶ 27, 2:18-cv-05741-DMG-PLA, Dkt 227-7; Decl. of Carlos Franco-Paredes at 1, 4, 5:19-cv-01546-JGB-SHK, Dkt 812-12; Decl. of Jonathan Louis Golob at 3, ¶ 12, 20-cv-02064, Dkt 4-19. *See also* Amicus Letter Brief from Public Health Experts dated March 24, 2020 in Committee for Public Counsel Services et al. v. Chief Justice of the Trial Court, Massachusetts Supreme Judicial Court No. SJ-2020-0115.

⁵⁸ Centers for Disease Control and Prevention, “Resources for Large Community Events & Mass Gatherings,” *available at* <https://www.cdc.gov/coronavirus/2019-ncov/community/large-events/index.html> (last accessed Mar. 29, 2020).

the release of over 1,700 inmates as of March 24, 2020.⁵⁹ New Jersey officials have released over 1,000 inmates in response to the crisis.⁶⁰ Cleveland and Tulsa have appropriately followed suit.⁶¹ Even Iran has released more than 80,000 inmates from its prisons.⁶² These officials have recognized that a single case of COVID-19 will result in exponential growth of confirmed cases within their facilities. Confirmed cases of individuals in detention will need to be isolated in medical facilities, and some such cases require a negative pressure room.⁶³ Any individuals interacting with the confirmed individual need to be in personal protective equipment, and any individuals who were in contact with the confirmed individual need to be quarantined and monitored for symptoms. Detention settings are not prepared to take these necessary steps to prevent an outbreak.

Releasing families with children and other high-risk populations is the only way to limit the spread of COVID-19 in FRCs. Releasing individuals will not only reduce the risk of transmission to those that are permitted to follow CDC guidelines while living with sponsors, it

⁵⁹ Marissa Wenzke, “1,700 jail inmates in L.A. County released over coronavirus concerns, sheriff says,” *KTLA5* (Mar. 24, 2020), available at <https://ktla.com/news/local-news/1700-jail-inmates-in-l-a-county-released-over-coronavirus-concerns-sheriff-says/>.

⁶⁰ Tracy Tully, “1,000 Inmates Will Be Released From N.J. Jails to Curb Coronavirus Risk,” *N.Y. Times* (Mar. 23, 2020), available at <https://www.nytimes.com/2020/03/23/nyregion/coronavirus-nj-inmates-release.html>.

⁶¹ *Id.*

⁶² Adela Suliman, Andy Eckardt and Gabe Joselow, “Coronavirus prompts prisoner releases around the world,” *NBC News* (Mar. 26, 2020), available at <https://www.nbcnews.com/news/world/coronavirus-prompts-prisoner-releases-around-world-n1169426>.

⁶³ Centers for Disease Control and Prevention, “Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings,” available at <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html> (last accessed Mar. 29, 2020).

will reduce the risk of transmission to any who remain in the FRC during the release process, the guards and staff that work there, and the public at large in the surrounding communities.

A. Petitioners will be Significantly Less Likely to Become Sick if Released.

Releasing these families into a community setting will greatly reduce their individual risk of infection. The risk posed by infectious diseases in immigration detention facilities holding children is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected.⁶⁴ Releasing individual petitioners will take them out of dense communal spaces and reduce the number of people with whom these families and children interact, reducing their risk of exposure.

Children in particular who are no longer detained will have better access to general pediatricians, who can recognize the subtleties of a child who is mildly or moderately ill, but at risk of impending serious illness. A pediatrician will know how frequently a child should be re-evaluated and can accurately counsel the parent on when to bring the child for further medical attention. Non-detained children are also able to re-visit the same pediatrician and non-detained parents can bring their child to an emergency department for evaluation. There are numerous barriers to such resources for parents and children in detention.⁶⁵

B. Any Detention Population Remaining During the Release Process will be at Lower Risk as the Detention Population is Reduced.

⁶⁴ Peter Hotez, “The dangers of disease in migrant children detention centers” (June 28, 2018), *available at* <https://www.axios.com/detention-centers-pose-risk-of-epidemics-among-migrant-children-1529966221-c29a135c-83ca-45f5-8ad1-eeec8f72e5fe.html>.

⁶⁵ Kaelyn Forde, “Mother of toddler who died after being released from ICE custody files wrongful death claim,” *ABC News* (Aug. 29, 2018), *available at* <https://abcnews.go.com/US/mother-toddler-died-released-ice-custody-files-wrongful/story?id=57473060>.

Releasing families with children from detention centers will also decrease the risks of exposure for any individuals who remain during the release process. Congregate settings such as FRCs allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing, which can be exacerbated by the presence of children. An increasingly smaller population will also make it easier for family units who remain in ICE custody during the —presumably very short—release process to practice social distancing and follow the CDC guidelines for reducing the spread of the disease. Progressively fewer people would then be housed in each room, common spaces would be less crowded, and detainees would interact with fewer people. In particular, reducing the number of children in the detention centers will reduce the likelihood that asymptomatic children spread COVID-19 to more vulnerable adults.

A progressively smaller population will also permit FRCs to focus resources on maintaining the health and safety for any families that remain. As discussed above, detention centers lack the space and resources to handle an outbreak. By immediately de-densifying the population, ICE will be able to better focus resources on improving the safety of any detainees who remain as the agency moves to release all family detainees.

C. Immediately De-densifying the FRC Population and Releasing Immigrant Families is Better for Facility Staff and the General Public.

A COVID-19 outbreak at an FRC will create an immediate and significant risk for the facility staff and the general population of neighboring communities. Staff arrive and leave on a shift basis. Contractors and vendors also pass between communities and facilities. Detainees, especially asymptomatic children, may interact with many agents who then go back into the community. By the time ICE recognized that COVID-19 was spreading within the detainee

population, each of these staff members and other non-detained individuals will have been exposed to the virus. These staff, contractors, and vendors will have also risked exposing their families and communities. In this way, ICE staff themselves become vectors for COVID-19, moving the disease from FRCs to the multiple communities in which they live. Further, every quarantined ICE agent decreases the agency's capacity to maintain whatever hygienic practices may exist. Simply put, every staff member is important during a pandemic, and the rapid removal of ICE staff will only increase the chances of disease spread.⁶⁶

The risk of an outbreak spreading from an FRC to the neighboring community is enhanced by the susceptibility of the health care system, particularly in rural areas where many detention centers are located. The health care system, and rural systems in particular are already overtaxed.⁶⁷ Should a spread of coronavirus occur in an FRC, the rural medical facilities in those communities will face a significant strain on their resources. First, when a detention facility lacks the medical resources to deal with a significant outbreak of an infectious disease, they will turn to the local medical facilities for assistance, reducing the number of hospital beds available to the general public. Karnes County FRC, for example, has fewer than seventy hospital beds

⁶⁶ Sanya Mansoor, "About 700 New Jersey Police Officers Tested Positive for Coronavirus, State Police Head Says," *Time* (Mar. 29, 2020), available at <https://time.com/5812113/new-jersey-police-coronavirus/>; Blair Ledet, "St. Louis city police traffic division under quarantine, after officer test positive for COVID-19 virus," *Fox 2 Now* (Mar. 28, 2020), available at <https://fox2now.com/news/st-louis-city-police-traffic-division-under-quarantine-after-officer-test-positive-for-covid-19-virus/>.

⁶⁷ Brystana G. Kaufman et al., "The Rising Rate of Rural Hospital Closures," 32 *Journal of Rural Health* 35 (2016), available at <https://onlinelibrary.wiley.com/doi/abs/10.1111/jrh.12128>.

within a fifty-mile radius.⁶⁸ This influx of patients from the FRC will come at the same time the medical facility is seeing an increase in patients from the general public.

Second, as discussed above, COVID-19 is likely to infect a large number of health care workers. Thus, we can expect that these already overburdened community clinics and hospitals will be operating in a reduced staffing capacity.⁶⁹ A reduced health care work force will limit the ability of rural hospitals to treat both the general public who have been infected as well as the overflow from the FRC.

Releasing families and children currently in detention reduces the risk of creating a localized outbreak that puts increased strain on local resources. Families and children currently in detention will not be in contact with guards and other ICE staff if they are released, reducing the risk of exposure for guards and ICE staff. In fact, a reduction in the detainee population could allow the FRCs to decrease staffing, so that fewer staff are exposed to the virus, mitigating the likelihood of further community spread. Releasing families and children before an outbreak occurs will also leave fewer detainees who would need access to local medical facilities.

D. Petitioners will be Better Equipped for Social Distancing with Sponsors.

Releasing children and families into the custody of properly screened sponsors is the safest way to prevent the disease's spread and reduce the threat to this vulnerable population. This includes allowing families detained at FRCs to be released together. Living in the community with family sponsors, these children and families will be better equipped to practice

⁶⁸ Karnes County FRC is within fifty miles of Otto Kaiser Memorial Hospital (25 beds) and Connelly Memorial Medical Center (44 beds). *See* Centers for Medicare and Medicaid Services, "Mapping Medicare Disparities," (June 17, 2019), *available at* <https://data.cms.gov/mapping-medicare-disparities/hospital-view>.

⁶⁹ Protecting health-care workers, *supra*.

social distancing and safely self-isolate or quarantine and coordinate accessing needed health resources. In particular, these arrangements would far better address the needs of children and parents if they are required to self-isolate or quarantine in the future, ensuring that they will not be separated and have familiar sponsors available to ensure care for children.

Children and families currently in detention can best reduce their infection and transmission risk by following CDC guidance for the public in general: staying indoors, social distance, and washing hands, none of which can be done effectively in detention. At this point, there are no cases in the FRC, so releasing the detainees presents a lower risk to the public. By waiting and keeping these children and families in crowded detention facilities, ICE increases the risk of creating hot spots that would likely infect staff and spread to surrounding communities.

CONCLUSION

For the foregoing reasons, the court should grant Petitioners' motion for a temporary restraining order.

Respectfully submitted,

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