UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MARIA ALEJANDRA CELIMEN SAVINO and JULIO CESAR MEDEIROS NEVES,	)	
Petitioners-Plaintiffs,	)	**20-cv-10617 WGY**
v.	)	
THOMAS HODGSON, et al.,	)	
Respondents-Defendants.	)	

DEFENDANTS' MEMORANDUM REGARDING
THE APPROPRIATE LEVEL OF DETAINEE POPULATION

A. General Concerns Regarding Setting a "Safe" Limit of Detainees

The Court has again invited the parties to suggest what is a safe level of detainee population at the Bristol County House of Corrections ("BCHOC"). Two months ago it first asked for input regarding the appropriate level of detainee population. *See* Docket # 55. In response to the Court's inquiry regarding whether there was a level of population reduction which would render the conditions relatively safe for the remaining detainees, Defendants submitted two declarations on Thursday, April 9, 2020. One was from Superintendent Steven Souza of BCHOC. *See* Docket Entry Nos. 67 & 69. That declaration went through the areas where detainees are held at BCHOC in painstaking detail, providing both dimensions and the current number of detainees housed in each. The second declaration was from Nelly Floriano, the Nursing Supervisor for ICE detainees at BCHOC, who reviewed the prevention and treatment practices at the facility and offered an opinion regarding the ability of ICE detainees to maintain social distance. *See also* Docket Entry No. 83 and exhibits thereto. Defendants also

submitted videos which showed the detention facilities at BCHOC. *See* email communication to Jennifer Gaudet, Courtroom Clerk, April 9, 2020 with links to two videos.

Defendants followed up the declarations with a brief on Tuesday, April 14, 2020. The brief addressed the (then-) current detainee population at BCHOC within each unit where immigration detainees are held. Attached to the brief were an updated declaration of Superintendent Souza and drawings of the current and social distancing-optimized layouts in the dormitories. Together, these submissions made the case that the reduction in population at that point, coupled with steps taken by BCHOC to reconfigure sleeping arrangements, meal taking, and other activities made social distancing much more feasible and compliant with all CDC recommendations (given the inherent limitations of a detention facility, which even the CDC recognizes). The detainee population at BCHOC had been diminished by thirty-eight percent (38%) from the level at the outset of the litigation at the time the Motion to Stay was filed; presently, the detainee population has been reduced by **66%** from the original level (from 148 to 66).

In response to Defendants' filings in early April, the Court entered a minute order on the docket that did not address the issue of population density as to which the Court had invited comment, nor was the issue discussed at the April 9, 2020 hearing or any subsequent hearing. *See* Dkt. # 86.

In the Preliminary Injunction decision, the Court did not make a finding that conditions at BCHOC did not allow for social distancing. Instead, the Court focused on Defendants' alleged resistance to the release of detainees, its claimed lack of contact tracing and testing of

asymptomatic individuals.[1] In light of this history, and given that the Court has held it against Defendants when they expressed their view that the safety of detainees did not require further reduction of the population (notwithstanding Defendants' clear acquiescence to more than half the total number of detainees released), Defendants, frankly, proceed with some measure of trepidation.

The current situation is that BCHOC has a virtually-perfect record of no confirmed positives among the detainee population. The extent to which this is due in part to the releases by the Court is anyone's guess. Given that there was no coronavirus among the detainees at the (below capacity) level of 148, nor at 125, or when the detainee population dropped below 100, it is speculative how much impact any one factor has had on the outcome. BCHOC has taken a number of steps to prevent the introduction of the virus into BCHOC and to limit its spread if it came into the facility. No one knows which steps, or what combination of measures, is responsible for the remarkable limit of COVID-19 among the ICE detainees.

But what we do know, with absolute certainty, is that in the three months of the pandemic, BCHOC has been successful in keeping the virus out of the immigration detainee population. As stated in previously submitted declarations to the Court, in the last ten weeks, there has been a single positive test of a detainee, and that person tested negative two days later.

---

[1] As argued in Defendants' Motion for Reconsideration, Defendants believe that the Court was incorrect as to the facts underlying this conclusion and that Defendants could be deliberately indifferent in failing to test asymptomatic individuals or to conduct contact tracing when neither the CDC nor the Massachusetts Department of Public Health recommended such steps. Even if the Court were correct regarding Defendants' opposition to releasing detainees, and it is not correct, that is insufficient to establish conduct which "shocks the conscience," particularly since Defendants have successfully implemented all recommended procedures and kept COVID-19 out of the detainee population.

All of his unit mates tested negative, suggesting that the initial positive was very likely a false positive. *See* Declaration of Judy Borges, submitted with the Motion for Reconsideration, dkt. # 185.

This is not a situation in which there was an outbreak and it was subsequently controlled by population reduction and quarantining. There never was an outbreak. The Court assumed that whatever the number of detainees was at the outset of the litigation, it was too many. The problem with this assumption is that the starting number could have been twice as high. Or it could have been half as much. And the Court would likely have assumed that the starting number was too high wherever it fell on that continuum, from 74 to 296. Put another way, there was no fact or science-driven determination that the initial number of detainees was too many. All the Court had was the general opinion of doctors, who either had never been to BCHOC or not been there recently, to the effect that the virus would likely spread quickly in a congregate setting such as BCHOC. While the danger of an outbreak was (and, to a lesser extent, still is) real, we now know it has not come to pass.[2]

The lack of a clarity regarding what constitutes a safe detainee population density has dogged this litigation throughout. Plaintiffs have refused to offer what they believe is a safe number or range.[3] It should not be for Defendants to pick the number, when Defendants had no

---

[2] None of the expert opinions submitted by Plaintiffs have suggested what a safe level of detainees would be. It is possible that the reduction in detainees achieved by the Court's bail orders (more than half of which Defendants agreed to) *and* the voluntary releases or transfers by ICE *plus* the release on bond by Immigration Judges has prevented an outbreak, no one can say for certain that is the case. All of the other steps taken by Defendants may have kept the virus out of the detainee population such that social distancing was not a factor.

[3] Nor have Plaintiffs agreed that a single class member should not be released regardless of how dangerous or likely to flee. Even now, Plaintiffs are blaming Defendants for their lack of compliance with the Court's bail order.

reason to think that the starting number was too high.[4] Nor, given the absence of evidence that the starting number was dangerous given the capacity of the facility, and in light of all of the other steps taken by BCHOC to comply with all available guidance on the coronavirus, can it be said that Defendants' view reflects deliberate indifference.

It is difficult to differentiate the degree of danger presented by various ranges of population. We can all agree that the risk of person-to-person transmission is reduced if there are only twenty detainees. But it will not be zero, because it only takes a single infected person having contact with another person for the infection to spread. And that infected person might not be a detainee. So even if there were two detainees left, one could be infected by an asymptomatic guard and then infect the other detainee.

This is unlikely, for many reasons. And, moreover, it must be remembered that release is no panacea. Just as a single infected guard could spread the virus to detainees, so could a released detainee's wife, brother, cousin, etc. who may not be socially isolated.

It is understandable that the Court has struggled with this issue and not made a determination to date. Given that the Court held it against Defendants when they did not pick a list of 50 detainees to be prioritized for bail review, and then distorted Defendants' position regarding the daily lists of ten detainees, Defendants are in an impossible situation. It is akin to

---

[4] Time and again, the Court and Defendants have disagreed on this fundamental point. The Court has been incredulous that Defendants did not embrace the concept of population density reduction, notwithstanding that there was no specific evidence that the starting level was unsafe. There was an *assumption that something had to be done* because the pandemic was, and remains, dangerous. While Defendants, Plaintiffs and the Court agree that the coronavirus presents risks to congregate living situations, surely the question of what to do in response depends in part on the relative crowdedness of a particular facility. If one institution is at half capacity, and another is at full capacity, it does not matter that they both have 148 detainees.

the Court asking a criminal defendant what the defendant thinks is the appropriate sentence when the defendant is still contesting his guilt. If Defendants suggest that 148 detainees is a safe level, they will earn the Court's opprobrium. The Court will say Defendants are refusing to "play ball." Even if Defendants were willing to suggest a number, whatever number they suggest will likely be cut down by the Court. Moreover, if Defendants pick a number or range below 148, Plaintiffs will use that as an admission that the starting level was dangerous. This would potentially prejudice Defendants on appeal.

Plaintiffs will argue that there is no safe level, ignoring the bedrock fact that the detainees have remained safe from the virus to date.[5] The coronavirus did not enter or spread the detainee population when there were 148 detainees; it did not enter or spread when there were 100 detainees, which is less than one-third of the capacity for immigration detainees at BCHOC as currently configured. In the end, the Court will have to use its best judgment and pick a number that is likely to be arbitrary.

In determining what a safe level of detainees is, it is worth noting that the CDC guidance for correctional facilities recognizes that social distancing is not easy in the correctional setting: "Although social distancing is challenging to practice in correctional and detention environments, it is a cornerstone of reducing transmission of respiratory diseases such as COVID-19." https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html (accessed 5/15/20). It is important to keep in mind, moreover, that social distancing does *not* mean, as Plaintiffs would have it, that two

[5] Plaintiffs are constrained by their desire to achieve class-wide relief, which is likely to be impossible. Although the case has been brought upon a claim that the risk of infection of COVID-19 violates the class members' Fifth Amendment rights, it has always been about getting all of the detainees released.

persons cannot *ever* be within six feet of each other even for a moment. As the CDC guidance on contact tracing cited by the Court states: "Based on our current knowledge, a close contact is someone who was within 6 feet of an infected person *for at least 15 minutes* starting from 48 hours before illness onset until the time the patient is isolated." CONTACT TRACING, Part of a Multipronged Approach to Fight the COVID-19 Pandemic available at https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/principles-contact-tracing-booklet.pdf (last accessed May 15, 2020)(emphasis supplied).

Because of the population reduction effected by transfers, voluntary releases and Court-ordered releases, and as a result of steps taken to prevent and limit the virus, adequate social distancing (within the CDC parameters) is now possible in all ICE detainee units. Moreover, because the current detainee population is decidedly below capacity, there is room for some re-population without significantly increasing the risk.

B. <u>Shared Goals</u>

What the parties, the Court and the Defendants are seeking is to minimize the risk of the detainees getting infected with COVID-19.[6] There are a number of ways in which that can be done. None of the possible steps is exclusive. There is no single right way to do this and there is no way to achieve absolute protection from the virus. *See, e.g.*, Declaration of Alysse Wurcel, M.D., attached hereto as Exhibit A.

Plaintiffs have painted an unrealistic, black and white picture in which the *only* effective

[6] The Defendants and the Court are also trying to ensure that the community into which the detainees are released is not endangered by their presence and that they will not flee. The danger to the community is of particular concern given that the majority of the released detainees have significant criminal records, typically involving violent crime, domestic abuse and/or drug trafficking. As has been previously stated, they were detained by ICE for good reasons and in good faith. And, as the Court is aware, some of the released detainees have violated their bail.

means of protection is the release of all detainees. This is flawed in both logic and pragmatics. First, there is no guarantee that the detainees won't encounter COVID-19 upon release. The Court, detainees' counsel and the government have very little means of knowing, much less controlling, the extent to which the detainees *and their families* practice appropriate precautions against the virus. While the Court has ordered house arrest, the Court neither has authority over, nor insight into, the behavior of those around the detainees. And not all detainees are complying with their conditions. Thus, the risk of the detainees contracting COVID-19 upon release is far from zero.

Conversely, the risk of detainees contracting COVID-19 if they remain at BCHOC is far from 100%. This is underscored by the fact that this litigation is now entering its eleventh week and there are still no cases of COVID-19 in the detainee population. In light of the daily increases in the number of confirmed cases in the Commonwealth of Massachusetts over that time, it is clear that the steps taken at BCHOC have been effective.

The detainees have all been quarantined together for months, and so the possibility of any one of them being infected is extremely low. This has been confirmed by the recent round of testing, in which not a single detainee tested positive. Therefore, social distancing is much less of an issue because the virus cannot be transmitted from an uninfected individual to any other person (with certain unlikely exceptions). This is not to say that social distancing should be ignored, as it remains an important defense against the spread of the virus *if* it gets introduced (through a staff member, for example). But now that we know that all the detainees are negative, and there are no recently introduced detainees, the risk of transmission from proximity is greatly reduced. It will happen only if an infected person, such as a guard, is not detected by the screening in place due to being asymptomatic *and* that person (and the detainees) fail to exercise

all of the other precautions in place – i.e., wearing masks, avoiding proximity for more than a moment, washing hands routinely, etc. This means that if a detainee passes by another detainee's bed briefly, the risk of transmitting the virus is extremely low because (a) none of the detainees are presently infected; and (b) the CDC's guidance indicates contacts for less than fifteen minutes are not significant enough to justify contact tracing if an infection is found.

On the other hand, it is by no means clear that release is a panacea. While it is true that individuals have the potential to exercise even greater control over who they come into contact with ***if*** they choose to isolate, it does not mean that they will in fact do so. We know that many detainees did not self-quarantine upon release even when they were ordered to do so. And now, with most businesses opening, there is a much smaller likelihood that released detainees will stay at home.

C. BCHOC Would Be Well Below Capacity with Additional Detainees

Presently, Bristol is significantly below capacity. The current detainee population versus the capacity is:

Location	Capacity	Current Population
ICE A	66	14
ICE B	66	CLOSED[7]
2 East	104	35
EE Unit	16	15 (originally from ICE B Unit)
EA Unit	1	1 (female)

[7] Owing to a riot by the detainees formerly housed in ICE B, that unit is uninhabitable presently. For the layout of the units, the Court is referred to the attachments to the Motion to Stay, dkt. # 83.

EC Unit	32	1 detainee (15 inmates)
EB Unit	38	0

Thus, the total capacity of these units is 323. The total occupancy, including the non-ICE inmates in Unit EC, is 81 (66 ICE detainees plus 15 non-ICE in Unit EC). This is twenty-five percent (25%) of capacity. Even if the arrangements return to the pre-pandemic setup, and without using units EE, EC and EB, the "normal" capacity at BCHOC for ICE detainees is 212.[8] The current detainee population is just over 30% of the normal capacity. Defendants believe that a 70% reduction from capacity is greater than necessary under any analysis.

D. Social Distancing Is Possible at BCHOC and Is Just One of the Precautions

BCHOC has been following all of the available recommendations from ICE, CDC and the Massachusetts Department of Public Health since before this litigation began. *See* Declarations of Superintendent Souza, Dr. Rencricca (attached to Defendants' Opposition to the TRO motion) and Director of Clinical Services Debra Jezard (same). It has updated its practices to conform to the guidance as it has evolved, by, for example, screening employees before every shift outside the facility and distributing and requiring the use of face masks.

While the CDC has updated its guidance regarding COVID-19 for correctional and detention facilities, it still does *not* recommend large-scale release of detainees, however. *See* CDC website https://www.cdc.gov/coronavirus/2019-ncov/community/correction-

[8] The current capacity if the isolation units are not used and 2 East is not fully dedicated to immigration detainees (neither restriction is presently in place) is at least 146. 75% of that temporarily low capacity would be 110 detainees. The Court has referenced the 75% figure, citing national ICE guidance. As previously indicated, that number is of total capacity, not the detainee population at the outset of the pandemic. It makes sense to tie any reduction to total capacity because some institutions, such as Bristol, were well below capacity (148 detainees with a capacity of 212) at the outset of the pandemic, while others had higher or lower percentages of capacity.

detention/index.html (*accessed* June 10, 2020).

E. A Special Master Is Unnecessary

The Court determined, correctly, that the conditions of the class members' confinement are not properly litigated pursuant to a habeas corpus petition.[9] A special master is not necessary or appropriate at this time. The essence of the petition and the complaint is that class members are subject to a risk of infection that violates their constitutional rights. They are not infected and have not become infected over the last three months. The conditions at BCHOC are not causing medical problems.

CONCLUSION

The track record at BCHOC speaks volumes. There have been no confirmed positive cases among the detainees. While the reduction in detainee population certainly may have been a factor in this, it is also possible that the virus was kept out of the detainee units entirely. In any event, some additional re-population is likely to be safe and further reduction is certainly not warranted. As stated in the attached declaration of Alysse Wurcel, M.D., infectious disease

[9] For an excellent discussion of this issue in a Bureau of Prisons case, *see Grinis, et al. v. Spaulding*, C.A. No. 20-10738-GAO, Order dated June 11, 2020 (dkt. # 60).

control is a matter of taking multiple steps to mitigate the risks. There is no single solution and it is impossible for a person to accurately determine an exact safe level for the detainees.

Respectfully submitted,

ANDREW E. LELLING,
United States Attorney

By: */s/ Thomas E. Kanwit*
Thomas E. Kanwit
Michael Sady
Assistant U.S. Attorneys
U.S. Attorney's Office
John J. Moakley U.S. Courthouse
1 Courthouse Way, Suite 9200
Boston, MA 02210
(617) 748-3100
thomas.kanwit@usdoj.gov
michael.sady@usdoj.gov

June 11, 2020

CERTIFICATE OF SERVICE

I hereby certify that this document filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF).

/s/ Thomas E. Kanwit
Dated: June 11, 2020 Thomas E. Kanwit

DECLARATION OF ALYSSE WURCEL, M.D.

Pursuant to the authority of 28 U.S.C. § 1746, I, Alysse Wurcel, M.D. declare as follows:

1. I am a medical doctor with a specialty in the area of Infectious Diseases. I attended Tufts University and graduated with a B.A. degree in 2000. I graduated from the University of Pennsylvania's Medical School in 2008. I completed a residency in internal medicine at the Massachusetts General Hospital in 2011. In 2012, I did the first of two fellowships in Infectious Diseases at Columbia University Medical Center in New York City. I did a second fellowship in Infectious Diseases at Tufts Medical Center in 2015. I completed a Masters degree in Clinical and Translational Research at Tufts University's School of Graduate Biomedical Sciences in 2014. I am a board-certified infectious disease specialist with a strong track record of successful infectious diseases-related research in vulnerable populations including people with HIV, people who use drugs, and people who are incarcerated. I have published over 40 manuscripts. I am a member of the Massachusetts Medical Society, the Infectious Diseases Society of America, the HIV Medicine Association, and the Infectious Diseases Society of America Opioid Task Force, among others. Since 2014, I have held dual academic positions as an Assistant Professor in both the Tufts Medical Center Department of Geographic Medicine and Infectious Diseases, as well as the Department of Public Health and Community Medicine, at Tufts University School of Medicine in Boston. For the 2015-2016 academic year, I was honored as the top lecturer. I have received a number of other awards, grants and recognition. Much of my work concerns underserved and underprivileged communities. I am currently leading an investigation involving hepatitis C virus ("HCV") testing in jails. In addition to my inpatient and outpatient responsibilities at Tufts Medical Center, I work as a clinician treating HIV and HCV in six jails in Eastern Massachusetts. I am a consultant to the Massachusetts

Sheriffs' Association for COVID-19 prevention and mitigation. I am not being directly paid for my time in preparing this declaration and my opinion stated herein is not affected, in any manner of which I am consciously aware, by such employment.

2. I have been asked to address safety issues at the Bristol County House of Corrections through the lens of what, if any, is a safe level of detainees in light of the coronavirus pandemic. As the Court is likely aware, this is not a simple question susceptible of arithmetic determination.

3. COVID-19, the disease caused by SARS COV2, is a new disease and we are learning more every day. It appears to be transmitted primarily through droplets. This is typically in a sneeze or exhalation from someone infected with the virus. Since COVID-19 is spread via droplets containing the virus coming out of the mouth or nose of an infected person primarily, the nose, mouth and eyes are the most susceptible area of a person exposed to the virus. This is the focus of the CDC in its recommendations for detention and prison facilities, and it is why social distancing is recommended in the first place, and why masks are now recommended for those who cannot self-isolate.[1] While it is certainly true that the virus can also be transmitted by touching a surface that an infected person has touched, this is not addressed by social distancing

[1] As stated on the CDC website:

> "The virus is thought to spread mainly from person-to-person.
> -- Between people who are in close contact with one another (within about 6 feet).
> -- Through respiratory droplets produced when an infected person coughs, sneezes or talks.
> -- These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs."

CDC website at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html (accessed June 9, 2020 at 12:19 p.m.).

so much as by proper hand washing, avoiding touching one's face, and disinfecting common areas.

4. There are several lines of defense for transmission of a droplet-spread virus from one person to another. The first is to keep people that are known or suspected of infection away from others. For a correctional facility, this means screening staff and any inmates or detainees prior to entry into the facility. A second step in this process is to quarantine anyone suspected of an infection if they are an inmate or detainee already within the facility.

5. Another means of defense against infection is to rigorously disinfect surfaces and areas within the facility. Hand washing has been identified by the CDC as a first line of defense against the spread of COVID-19, and I know from my training, experience, and expertise that this is a very important aspect of infection prevention and containment.

6. In addition to taking steps to keep the virus out of the facility and to kill the virus on surfaces, there are steps that can be taken to limit the likelihood of person-to-person transmission. These steps include requiring face masks to be worn, encouraging frequent hand washing (and avoiding touching one's face), and providing sufficient space so detainees and staff can maintain a distance of six feet or more.

7. Testing all people in jail, even asymptomatic people, can give you a sense if there is any COVID-19 in the jail. This is a snapshot in time, however, as the test can be done while the virus is still incubating. Jails that have the ability to test everyone, even asymptomatic people, are well positioned to identify and contain epidemics.

8. This spacing of individuals recommended by the CDC is widely referred to as "social distancing." Social distancing is challenging in jails. Social distancing is more possible in jails

that are under capacity. CDC does not anticipate that social distancing will be possible at all times within a correctional facility.

8. In the realm of infectious diseases, there are always trade-offs and practical considerations. I view prevention and mitigation in the jails through a harm reduction lens. Harm reduction is a framework for approaching drug use disorder. Someone may not be able to stop injecting heroin, but they can move from injecting to sniffing heroin. In the jails, it would be impossible to completely effectively socially distance and give people who are incarcerated time out of their cell. I have advised each of the jails on how to mitigate risk through masking, cleaning, and trying to encourage social distancing.

I declare under penalty of perjury that the foregoing is true and correct.

Signed on the 10 day of June, 2020