No. 98317-8

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

SHYANNE COLVIN, SHANELL DUNCAN, TERRY KILL, LEONDIS BERRY, and THEODORE ROOSEVELT RHONE,

Petitioners,

—v.—

JAY INSLEE, Governor of the State of Washington, and STEPHEN SINCLAIR, Secretary of the Washington State Department of Corrections,

Respondents.

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

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I. Introduction

Amici Curiae, public health officials and human rights experts familiar with the unique dangers associated with infectious diseases in jails and prisons, urge this Court to grant Petitioners request for a writ of mandamus as part of a necessary strategy to reduce the number of inmates in prisons operated by the Washington State Department of Corrections ("DOC"). Reducing the number of inmates at DOC facilities will minimize not only the public health risk to Petitioners, but also to other inmates, correctional facility 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, harm and kill anyone. But the risk is particularly acute for people with underlying health conditions that create a high risk for severe illness or death from COVID-19.

Managing the spread of COVID-19 within correctional 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 correctional setting, in which inmates are crowded together, sharing bathroom products, and where sanitizing products are frequently unavailable and infrequently used. Once an outbreak occurs, correctional 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 correctional 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 people with conditions like Petitioners' are at high risk of serious, life-threatening COVID-19 infection, and that their continued confinement in DOC facilities subjects them to a heightened risk of contracting and further spreading COVID-19.

Amici are committed to ensuring correctional facilities provide quality healthcare to inmates, and that correctional facilities do not exacerbate the health risks of their inmates, their staff or the public at large. 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 Respondents should work with state and local health officials to release individuals such as Petitioners, 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.

Maeve Bowen, M.D., is physician practicing in the Kirkland, Washington area. She has over 18 years' experience and currently practices and is board certified in internal medicine.

Donald J. Ross, M.D., is a Seattle, Washington psychiatrist with over 40 years of experience. He is a Fellow of the International Psychoanalytic Association and a Clinical Associate Professor. Dr. Ross also serves as a Trustee of the King County Medical Society.

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.

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

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.

Mark R. Levy, M.D., is a practicing physician in Issaquah, Washington, specializing in primary care, internal medicine and family medicine. He is also a

Clinical Assistant Professor and serves as a Trustee for the King County Medical Society.

Daniel H. Low, M.D., is a family medicine resident physician. He is a former NIH Fogarty Scholar, with experience studying the provision of health care in low resource settings, with an emphasis on East Africa. Dr. Low serves as a Trustee for the King County Medical Society.

Michelle Terry, M.D., is an attending physician and clinical professor in the Department of Pediatrics. She serves as a general medicine attending physician, and is also Vice President of King County Medical Society.

Carl Wigren, M.D., is a licensed physician and board-certified in Anatomic Pathology and Forensic Pathology by the American Board of Pathology. His practice often involves providing expert testimony in both criminal and civil proceedings. He served as the Associate Medical Examiner for Snohomish County in Everett, Washington.

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 Petitioners' Petition for a Writ of Mandamus.

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 14, 2020, there were 1,844,863 confirmed cases and 117,021 deaths in 213 countries, areas or territories worldwide.[2] Due to the apparent ease with which the virus spreads, these numbers have risen and will continue to rise exponentially without drastic government action.[3]

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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.

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 which the virus spreads, such social distancing measures may have to last as long as 18 months until a vaccine is successfully developed.[6] It is for precisely this reason that dozens of state governments, including Washington, have instituted mandatory social distancing policies; indeed, roughly three in four Americans is now under orders 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

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4 *See, e.g.*, Neil M. Ferguson et al., Imperial College 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.

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.

prescriptively.[8] The United States now has over 579,005 confirmed cases and over 22,252 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]

B. Jails and Prisons Are at a Heightened Risk for the Spread of COVID-19

Jails and prisons such as those operated by DOC are closed 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. It is common knowledge that outbreaks of contagious diseases are more common in correctional settings than in communities at large.[12] COVID-19 has proven to be no exception. Over the past

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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.

12 *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/; *see also* 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/

several weeks, hundreds of COVID-19 diagnoses have been confirmed at local, state and federal correctional facilities.[13] Given the dearth of testing, these numbers understate (and likely dramatically understate) the problem.[14] Indeed, in some areas, jails have seen infection rates *nine* times higher than the broader community.[15]

The enormity of the problem is exacerbated by the fact that staff, visitors, contractors and vendors all pass between communities and correctional facilities, and each group can bring infectious diseases into and out of 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, correctional facility populations are constantly turning over, with about 200,000 people nationwide flowing into and out of jails every week. Each entrant potentially carries COVID-19 and introduces it into the facility's population.[16]

PMC3116074/; Stephanie M. Lee, *Nearly 900 Immigrants Had The Mumps In Detention Centers In The Last Year*, Buzzfeed News (Aug. 29, 2019) https://www.buzzfeednews.com/article/stephaniemlee/mumps-ice-immigrant-detention-cdc.

13 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.

14 *Id.*

15 Anna Flagg & Joseph Neff, *Why Jails Are So Important in the Fight Against Coronavirus*, The Marshall Project (Mar. 31, 2020) https://www.themarshallproject.org/2020/03/31/why-jails-are-so-important-in-the-fight-against-coronavirus.

16 *Id.*

These factors, all of which make it effectively impossible for correctional 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, who may suffer from only mild symptoms or even be entirely asymptomatic, but still be carrying and spreading the disease. In fact, recent estimates suggest that as many as 1 in 4 cases of coronavirus will not present symptoms and yet remain contagious.[17] Unfortunately, correctional 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 correctional 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

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

transmission.[18] Additionally, spaces within correctional facilities often are poorly ventilated, which promotes the spread of diseases. Other hygiene-based prevention strategies are similarly ineffective in a correctional 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.

For DOC facilities, once an inmate or staff member becomes infected with COVID-19, it will be extremely difficult to properly treat those who have been infected or limit the spread of the virus. 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, such as intubation. Appropriate care for such cases almost always includes the use of highly specialized equipment like ventilators. The COVID-19 virus has put ventilators in high demand and short

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[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* Federal Bureau of Prisons Clinical Practice Guidelines, Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections, 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.").

supply around the world.[20] The virus even has led to shortages of less specialized equipment such as face masks, gloves and gowns.[21]

The necessary treatment for those infected with COVID-19, especially those in high-risk populations, is labor-intensive. It requires that nurses tend to a limited number of patients at a time, and often requires physicians with specialized backgrounds in respiratory care. Correctional facilities are unable to address these needs. Correctional 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. Correctional medical facilities, already underequipped, will be even more strained as staff members themselves become ill.[22] Thus, the problem will be dangerously exacerbated if jails and prisons do not act immediately to reduce their prison populations and contain the spread of the virus.[23]

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

[21] *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.

[22] *See, e.g.*, Jan Ransom & Alan Feuer, *'We're Left for Dead': Fears of Virus Catastrophe at Rikers Jail*, N.Y. Times (Mar. 30, 2020), https://www.nytimes.com/2020/03/30/nyregion/coronavirus-rikers-nyc-jail.html ("[T]he rate of infection in city jails has continued to climb, and by Monday, 167 inmates, 114 correctional staff and 23 health workers had test positive.").

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

C. DOC's Efforts to Combat COVID-19 Are Inadequate

Governor Inslee's recent announcement that he would release 950 inmates is an encouraging first step, but it is inadequate to protect prisons and jails from COVID-19. In a state with around 18,000 people incarcerated, the release of 950 simply cannot cure the tinderbox conditions of DOC facilities.[24]

Last month, the DOC suspended visitation for inmates, but that does not—and cannot—insulate its facilities to the outside world.[25] Indeed, since that time at least 14 corrections employees and eight inmates in Washington custody have tested positive for the virus.[26] The true outbreak may be far worse. According to the state's numbers, only 250 incarcerated people have been tested so far.[27] DOC's most recently released "COVID-19 Plan" indicates that "all individuals received at a [DOC] facility . . . always receive an initial health screening," but acknowledges that there are locations where resources are not available and only "passive screening" will take place, and does not explain what that screening entails.[28] Presumably, it does not include testing for coronavirus, as there is no mention of it.

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[24] Martha Bellisle, *Washington to Release Almost 1,000 Inmates Amid Outbreak*, USA Today (Apr. 13, 2020) https://www.usnews.com/news/best-states/washington/articles/2020-04-13/state-must-provide-details-on-protecting-inmates-from-virus.

[25] Department of Corrections, COVID-19 Information (accessed: Apr. 14, 2020) https://www.doc.wa.gov/news/covid-19.htm.

[26] *Id.*

[27] *Id.*

[28] Wash. State Dep't of Corrections, *Coronavirus / COVID-19 Plan*, https://doc.wa.gov/news/2020/docs/daily-situation-report.pdf (updated Apr. 13, 2020).

Such an insufficient screening procedure would allow for asymptomatic COVID-19 infections to enter the facility and spread. Consider the recent outbreak story from an Arkansas facility: a prisoner tested positive, so the facility tested others. 43 of the 46 other prisoners in the same housing unit tested positive. All were asymptomatic.[29]

Other correctional facilities have tried similar measures to mitigate against the introduction and spread of COVID-19, but they have been thwarted by the realities of correctional life. In the face of rising infection numbers, the top doctor at New York's Rikers Island was forced to conclude that mitigation efforts in such facilities cannot be successful unless paired with substantial inmate population reductions.[30] DOC must likewise embrace that conclusion before it is too late.

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[29] Samantha Michaels, *Want to Know How Fast Coronavirus Can Spread in Prison? Look at Arkansas.*, Mother Jones (Apr. 13, 2020) https://www.motherjones.com/coronavirus-updates/2020/04/cummins-unit-prison-arkansas-coronavirus-spread/.

[30] Meagan Flynn, *Top doctor at Rikers Island calls the jail a 'public health disaster unfolding before our eyes'*, Wash. Post (Mar. 31, 2020) https://www.washingtonpost.com/nation/2020/03/31/rikers-island-coronavirus-spread/.

V. Conclusion

For these reasons, Petitioners should be granted the requested writ of mandamus.

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CERTIFICATE OF SERVICE

I hereby certify that on April 16, 2020, the foregoing document was electronically filed with the Supreme Court of the State of Washington's CM/ECF system, which will send notification of such filing to all attorneys of record.

/s/ Heather L. Hattrup
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