UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

Janet Malam, et al.

Petitioner-Plaintiff,

Civil No. 20-10829

v.

Honorable Judith E. Levy
Mag. Judge Anthony P. Patti

Rebecca Adducci,

Respondent-Defendant.

_____/

RESPONDENTS SUPPLEMENTAL BRIEF IN OPPOSITION TO PETITIONERS' MOTION FOR TEMPORARY RESTRAINING ORDER

Pursuant to the Court's order, Respondents submit supplemental briefing regarding Petitioners Salabarria and Borboa's medical conditions, and the proper constitutional standard to be applied to this case. (Order, ECF No. 68).

A. Salabarria is not at an increased risk of harm from COVID-19.

At the outset, inasmuch as the Court found the evidence on whether non-pulmonary hypertension increases the risk of serious complications from COVID-19 "unclear," Salabarria has not met her burden to obtain the extraordinary relief of a preliminary injunction and the Court should deny her motion in favor of litigation on the merits. (Order, ECF No. 68, PageID.1922-23).

The scientific community has not found that primary hypertension alone (as opposed to pulmonary hypertension) places an individual at an increased risk of harm from COVID-19. As noted by the Court, CDC data shows that primary hypertension is a frequent comorbidity of those hospitalized for COVID-19. (Order, ECF No. 68, PageID.1924). But, importantly, the CDC, on whose data and findings every expert in this case relies, has not found primary hypertension alone to be a high-risk factor. (Resp., ECF No. 52-10). A May 2020 publication in the American Journal of Hypertension concluded that "there is as yet no evidence that hypertension is related to outcomes of COVID-19." (Hypertension and COVID-19, Ex. 1). The authors noted that a conclusion could not be drawn from the fact that hypertension is such a common comorbidity because hypertension is "exceedingly

frequent" in older people. *Id*.

Dr. Venters does not offer any evidence, which has eluded the scientific community, to support his conclusion that hypertension alone is a risk factor. He recognizes that the CDC does not identify primary hypertension as a high-risk factor, but nonetheless claims that it is an "additional risk factor" by citing the CDC data identifying hypertension as a common comorbidity among those hospitalized with complications from COVID-19. (Mot., ECF No. 44-4, ¶ 23). He does not explain how that fact means hypertension increases the risk of harm from COVID-19. As explained in the article above, correlation is not a basis in and of itself to presume that hypertension causes increased hospitalization. A physician who actually treats COVID-19 patients recently stated in a similar case that CDC guidelines are the "gold standard" for managing COVID-19 and "are in keeping with global expert consensus." (Scissors Dec., Ex. 2). As he points out, there is no research, either in the United States or abroad, that supports a causal connection between primary hypertension and an increased risk of harm from COVID-19. *Id*.

Salabarria has established only that she has primary hypertension, which is stable with medication. (Mitchell, ECF No. 52-4, ¶ 15). Absent any evidence that primary hypertension alone puts her at an increased risk of harm from COVID-19, she fails to establish a likelihood of success on her due process claim or that she is likely to suffer irreparable harm absent an injunction.

B. Borboa does not establish that his asthma is moderate or severe.

To the extent the Court found Borboa did not present evidence that his asthma is moderate or severe, like Salabarria, he did not meet his burden to obtain extraordinary relief. Respondent does not take a position on whether Borboa's asthma is moderate or severe, only that the evidence presented in this record does not establish that it is. The only evidence presented to the Court is Borboa's statement to his lawyer that ten years ago he was diagnosed with asthma, prescribed the steroid Prednisone, and prescribed an Albuterol inhaler, which he claims he has used multiple times per week ever since. (Mot., ECF No. 44-11, ¶ 9). He does not state whether he used Prednisone beyond his hospital stay. *Id*. Medical records show that during his over two months of detention, he has not required an inhaler, nor has he made a single sick call to request evaluation or treatment for shortness of breath or asthma. (Quinn, ECF No. 52-5, ¶ 12).

According to the National Asthma Education and Prevention Program, which publishes asthma guidelines, the levels of asthma severity are intermittent, mild, moderate, and severe. (Asthma, Ex. 3). Level of severity is assigned based on different features including the frequency of symptoms and the amount of medication needed to control exacerbations. *Id*. Importantly, the guidelines also state that, "[f]requency and severity may fluctuate over time for patients in any severity category." Dr. Venters did not examine Borboa, and reviewed only the

declaration from Borboa's attorney and medical records from ICE,[1] which show no exacerbations or treatment for asthma over the last two months. (Mot, ECF No. 44-4, ¶¶ 39-40; Reply, ECF No. 57-2, ¶ 12). Dr. Venters noted that Borboa had a "recent need for oral steroids" from which he concluded that "his asthma is not well controlled." (Reply, ECF No. 57-2, ¶ 14(a)). There is no evidence that Borboa had a recent need for oral steroids. Nor is there any evidence that his asthma is not well controlled, or that poorly controlled asthma is necessarily moderate to severe asthma. Borboa fails to present any evidence to support his claim that at present, he has moderate to severe asthma. Thus, he fails to establish a likelihood of success or that he is likely to suffer irreparable harm absent an injunction.

C. The deliberate indifference standard applies to this case.

The Court asked the parties to address to what extent the due process freedom from punishment standard articulated in *Bell v. Wolfish* applies independently of the deliberate indifference standard articulated in *Farmer v Brennan*. The constitutional standard that should be applied to prove a due process violation will vary with the "differences in the kind of conduct" alleged to be a violation. *See Whitley v. Albers*, 475 U.S. 312, 320 (1986); *accord. J.H. v. Williamson Cty.*, 951 F.3d 709 (6th Cir. 2020) (applying different standards to pretrial detainee based on conduct); *Butler v. Fletcher*, 465 F.3d 340, 344 (8th Cir.

[1] Based on discovery responses, Borboa has not obtained any medical records from his treating physicians.

2006) (applying deliberate indifference to pretrial detainees for certain conduct). Because the only "conduct" at issue in this case alleged to have violated the Fifth Amendment is the purported failure to provide for detainees' reasonable safety from COVID-19, only one standard, the deliberate indifference standard, applies.

The deliberate indifference standard developed under the Eighth Amendment. The Eighth Amendment "applies to conditions of confinement that are not formally imposed as a sentence for a crime." *Helling v. McKinney*, 509 U.S. 25, 29–30 (1993) (citation omitted). "[S]uch claims require proof of a subjective component," and "where the claim alleges inhumane conditions of confinement or failure to attend to a prisoner's medical needs, the standard for that state of mind is the 'deliberate indifference' standard." *Id*. at 30 (citation omitted). *See also Wilson v. Seiter*, 501 U.S. 294, 302–04 (1991) ("Whether one characterizes the treatment received by the prisoner as inhumane conditions of confinement, failure to attend to his medical needs, or a combination of both, it is appropriate to apply the 'deliberate indifference' standard."). "[P]retrial detainees, who have not been convicted of any crimes, retain at least those constitutional rights that we have held are enjoyed by convicted prisoners." *Bell v. Wolfish*, 441 U.S. 520, 545 (1979). Thus, due process allows pretrial detainees to raise traditional Eighth Amendment claims, including for failure to provide medical care or adequately protect those in its custody. *See Estelle v. Gamble*, 429 U.S. 97, 102-

03 (1976). While civil detainee claims "sound in the Due Process Clause of the Fourteenth Amendment rather than the Eighth Amendment," the deliberate indifference standard remains the same. *Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563, 568 (6th Cir. 2013). *See also Roberts v. City of Troy*, 773 F.2d 720, 723 (6th Cir. 1985) ("[T]he eighth amendment rights of prisoners are analogized to those of detainees under the fourteenth amendment, to avoid the anomaly of extending greater constitutional protection to a convict than to one awaiting trial.").

In *Bell*, the Court recognized an additional due process protection for pretrial detainees. There, the Court did not address the propriety of confinement itself, but "the detainee's right to be free from punishment" during pretrial confinement. *Bell*, 441 U.S. at 534. The Court held "[i]n evaluating the constitutionality of conditions or restrictions of pretrial detention that implicate only the protection against deprivation of liberty without due process of law, we think that the proper inquiry is whether those conditions amount to punishment of the detainee." *Id*. at 535.

The *Bell* Court identified two manners in which pretrial detainees could show that prison officials intended the conditions of their confinement to be punitive, rather than "an incident of some other legitimate governmental purpose." *Bell*, 441 U.S. at 538. First, the detainee can point to "an expressed intent to punish on the part of detention facility officials." *Id*. Second, in the absence of an expressed intent, "a court may permissibly infer that the purpose of the

governmental action is punishment" "if [the] restriction or condition is not reasonably related to a legitimate goal—if it is *arbitrary or purposeless*." *Id.* at 539. While *Bell* explained that a court should also look to whether the condition "appears excessive in relation to the alternative purpose assigned [to it]," it cautioned that "these inquiries spring from constitutional requirements and that judicial answers to them must reflect that fact rather than a court's idea of how best to operate a detention facility." *Id.* at 538-39.

Since *Bell*, the Sixth Circuit has drawn a distinction among pretrial detainee claims challenging the government's failure to protect those in its custody, which are evaluated under a deliberate indifference standard, and challenges to affirmative acts of prison officials, which are evaluated under *Bell*'s punishment standard. In *Roberts*, the family of a pretrial detainee who committed suicide alleged that the defendant's failure "to promulgate and enforce procedures to identify potential suicides and prevent their occurrence" violated his due process right to "reasonably necessary medical care while incarcerated." 773 F.2d at 722. The plaintiff argued, among other things, that the district court failed to "submit to the jury the question whether the defendants intended to punish the deceased" in addition to the question of deliberate indifference. *Id.* at 725. The court drew a distinction between failure to act claims and those where a specific action was challenged. The court noted that *Bell* "deals with actions rather than the failure to

act," but even if it "transpose[d] the *Bell v. Wolfish* standard to failures to act, [it] would also arrive at a deliberate indifference requirement." *Id.* at 724-25. The court concluded because the jury was instructed on deliberate indifferent, the district court did not err in failing to provide an additional instruction on *Bell*'s punitive intent standard. *Id.*

The reason for the distinction is that where it concerns reasonable safety, prisoners and pretrial detainees are entitled to the same level of protection under the constitution, thus the same standard applies. *See Villegas*, 709 F.3d at 568 (internal citations omitted) ("Pretrial detainee claims, though they sound in the Due Process Clause of the Fourteenth Amendment rather than the Eighth Amendment, are analyzed under the same rubric as Eighth Amendment claims brought by prisoners" because "the concept underlying the Eighth Amendment is nothing less than the dignity of humankind."). In the context of protection and medical care, courts have held *Bell* is satisfied by a finding of deliberate indifference. "*Bell* establishes that jail officials violate the due process rights of their detainees if they exhibit a deliberate indifference to the medical needs of the detainees that is tantamount to an intent to punish." *Danese v. Asman*, 875 F.2d 1239, 1243 (6th Cir. 1989). "Properly understood, the *Bell* test is functionally equivalent to a deliberate indifference inquiry." *Hare v. City of Corinth, Miss.*, 74 F.3d 633, 646 (5th Cir. 1996).

The distinction between failure to act to protect and challenges to overt actions of prison officials is reflected in Sixth Circuit case law following *Roberts* and *Bell*. *See, e.g.*, *Richko v. Wayne Cty.*, Mich., 819 F.3d 907, 913 (6th Cir. 2016) (applying deliberate indifference for failure to protect pretrial detainee "from violent attacks by inmates"); *Villegas*, 709 F.3d at 568 (failure to provide for immigration detainees' medical needs); *Blackmore v. Kalamazoo County*, 390 F.3d 890 (6th Cir. 2004) (applying deliberate indifference standard to claim alleging failure to provide prompt medical care);. *Compare with Turner v. Stumbo*, 701 F.2d 567 (6th Cir. 1983) (applying *Bell* standard to assess decision to close one facility for pretrial detainees and transfer them to another).

In *J.H. v. Williamson Cty.*, 951 F.3d 709 (6th Cir. 2020), the court applied both the deliberate indifference standard and the *Bell* punishment standard based on the conduct at issue. In *J.H.*, the plaintiff, a minor in pretrial detention, raised a number of due process claims challenging the prison's decision to place him in solitary confinement, *id.* at 716-17, its failure to "provide adequate medical and mental health care," *id.* at 722, and the municipality's failure to adequately train its employees, *id.* at 720. The court applied the *Bell* standard to the prison's affirmative act of placing the minor in solitary confinement, *id.* at 717, but evaluated defendants' failure to provide adequate training and provide adequate medical and mental health care under a deliberate indifference standard, *id.* at 720,

722. *See also Leary v. Livingston Cty.*, 528 F.3d 438, 442 (6th Cir. 2008) (applying both standards based on conduct at issue).

In *Butler*, the Eighth Circuit directly addressed whether deliberate indifference or the *Bell* punishment standard applied to a claim alleging a failure by the government to protect those in its care from a communicable disease. 465 F.3d at. 344. The court emphasized that "the infliction of punishment is a deliberate act" and the *Bell* standard was meant to determine whether a governmental *act* is punitive in nature." *Id.* Conversely, the government's "duty to protect . . . is not based on a pretrial detainee's right to be from punishment but is grounded in principles of safety and general well-being: 'when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e.g.*, food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.'" *Id.* at 344-45 (quoting *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989)). Because pretrial detainees and convicted inmates "have the same right to these basic human needs," the Eighth Amendment deliberate indifference standard must apply. *Id.* at 345.

In this case, Petitioners assert that the conditions at Calhoun fail to protect them from exposure to COVID-19. The only conduct at issue is an alleged failure

to act to adequately protect the Petitioners' reasonable safety – not whether Respondent failed to act as a means of punishment. Thus, as set forth above, the deliberate indifference standard applies to determine whether Petitioners can establish a Fifth Amendment due process violation based on this conduct.

Petitioners attempt to get a second bite at the apple by asserting that apart from conditions of confinement, an independent claim exists under *Bell* because they also assert a "fact of confinement" claim. *Bell* did not address the fact of confinement. *Bell*, 441 U.S. at 526. Nonetheless, Petitioners allege that because there are no conditions that would ensure their safety from COVID-19 based on the nature of congregate settings, the very fact of their detention has become punitive under *Bell*. This "distinction" does not give rise to an independent claim. The right to relief still arises from the same obligation to provide reasonable safety, and the same conduct is at issue. The distinction between whether there are, or are not, conditions that the Court could impose to make the confinement constitutional is only relevant to the relief that may be ordered. If the Court finds that there are no possible conditions that ensure reasonable safety, the Court may be able to enter habeas relief. *See Bell*, 441 U.S. at 527, n.6 ("[W]e leave to another day the question of the propriety of using a writ of habeas corpus to obtain review of the conditions of confinement, as distinct from the fact or length of the confinement itself."). Otherwise, if the Court finds deliberate indifference, the remedy for a

conditions of confinement claim is injunctive relief to address the conditions. *See Califano v. Yamasaki*, 442 U.S. 682, 702 (1979) (affirming general principle that injunctive relief should be no more burdensome to the defendant than necessary to provide complete relief to plaintiffs); *Ziglar v. Abbasi*, 137 S. Ct. 1843, 1862 (2017) ("Respondents instead challenge large-scale policy decisions concerning the conditions of confinement imposed on hundreds of prisoners…[t]o address those kinds of decisions, detainees may seek injunctive relief.").

Typically, when courts address a "fact of confinement" claim, it is the fact that the person is detained at all, i.e. the validity of detention, not whether conditions of confinement have become unbearable (that is why *Bell* left the question for another day). *See Lutz v. Hemingway*, 476 F.Supp.2d 715, 718 (E.D. Mich. 2007) (citing *Preiser v. Rodriguez*, 411 U.S. 475, 500 (1973)) ("Complaints that involve only conditions of confinement do not relate to the legality of the petitioner's confinement…"); and *Muhammad v. Close*, 540 U.S. 749, 750 (2004) (challenges to "circumstances of confinement" do not go to validity of confinement) (internal citation omitted).

Petitioners present only a challenge to the conditions of confinement at Calhoun. Because they allege the conditions violate the due process requirement that Respondent provide for detainees' reasonable safety, the only applicable constitutional standard is deliberate indifference.

D. Petitioners are not entitled to relief under the *Bell* standard.

Even if the Court found a separate claim can be stated under *Bell*, Petitioners fail to establish that an intent to punish can be inferred from their lawful immigration detention. Petitioners do not allege an express intent to punish. Instead, they ask the Court to find their otherwise lawful detention punitive based solely on the emergence of COVID-19. "Under *Bell*, a pretrial detainee can demonstrate conditions of confinement amount to unconstitutional punishment: (1) by showing "an expressed intent to punish on the part of the detention facility officials," or (2) by showing that a restriction or condition is not rationally related to a legitimate government objective or is excessive in relation to that purpose." *J.H.*, 951 F.3d at 717.

The Supreme Court has for over a century recognized the government's legitimate interest in protecting the community and ensuring that noncitizens appear for their immigration proceedings. *See Jennings v. Rodriguez*, 138 S. Ct. 830, 836 (2018); *Demore v. Kim*, 538 U.S. 510, 523 (2003) ("[D]etention during deportation proceedings [is] a constitutionally valid aspect of the deportation process. As we said more than a century ago, deportation proceedings would be vain if those accused could not be held in custody pending the inquiry into their true character.") (citations and internal quotation marks omitted). Further, detention for Petitioners is not merely authorized, it is required. An immigration

judge found Borboa to be a danger and *ordered* him to remain detained pending his removal proceedings. (Quinn, ECF No. 52-5, ¶ 10). The Board of Immigration Appeals affirmed Salabarria's removal order on April 3, 2020, and her detention is mandated for at least the 90-day period following entry of the removal order. (Mitchell, ECF No. 52-4, ¶ 12); 8 U.S.C. § 1231(a)(2). Thus, Borboa and Salabarria's detention is rationally related to a legitimate government purpose.

To the extent *Bell* applies to confinement itself, neither Salabarria nor Borboa's detention is excessive in relation to the government's legitimate purpose. Petitioners have a "heavy burden" to establish that Respondent "exaggerated [her] response" to the government's legitimate purpose when she "actuated these restrictions and practices." *Bell*, 441 U.S. 561-62. Petitioners cannot show that Respondent exaggerated her response to the legitimate purpose served by immigration detention in order to punish them. The decision to detain Borboa and Salabarria was made independent of the pandemic, and is the same response applied to immigration detainees across the country. Further, their detention is mandatory. Nor is detention excessive merely because other less restrictive means exist. *See Bell*, 441 U.S. at 540 ("If the government could confine or otherwise infringe the liberty of detainees only to the extent necessary to ensure their presence at trial, house arrest would in the end be the only constitutionally justified form of detention.").

Other courts who have considered the issue have been unwilling to find that detention, in and of itself, violates *Bell*'s prohibition on punitive detention and conditions of confinement. *See Dawson v. Asher*, No. 20-0409, 2020 WL 1304557, at *2 (W.D. Wash. Mar. 19, 2020) ("Plaintiffs do not cite to authority, and the court is aware of none, under which the fact of detention itself becomes an 'excessive' condition solely due to the risk of a communicable disease outbreak—even one as serious as COVID-19."). "To adopt [Plaintiffs'] position would be to hold that the detention of any [civil] detainee during the pandemic is necessarily unconstitutional." *Toure v. Hott*, --- F. Supp. 3d ----, 2020 WL 2092639, at *10 (E.D. Va. Apr. 29, 2020). Like other courts in this district, this Court should decline to find a claim under *Bell*. *See Murai v. Adducci, et al*., Case No. 20-10816, ECF No. 15 (Cleland, R.) (not addressing which standard should apply but finding immigration detention at Calhoun is not punitive); and *Marqus v. Adducci, et al.*, Case No. 20-11121, ECF No. 7 (Hood, D.) (not addressing which standard should apply but finding that immigration detention is not punitive).

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Dated: May 18, 2020

CERTIFICATE OF SERVICE

I hereby certify that on May 18, 2020, the foregoing paper was filed with the Clerk of the Court using the ECF System which will give notice to all counsel of record.

/s/ Jennifer L. Newby

Hypertension and COVID-19

Ernesto L. Schiffrin,[1] John M. Flack,[2] Sadayoshi Ito,[3] Paul Muntner,[4] and R. Clinton Webb[5]

The world is currently suffering from the outbreak of a pandemic caused by the severe acute respiratory syndrome coronavirus SARS-CoV-2 that causes the disease called COVID-19, first reported in Wuhan, Hubei Province, China on 31 December 2019.[1] As of 29 March 2020, there have been 732,153 confirmed cases of COVID-19 reported worldwide, with 34,686 deaths.[2] The clinical and epidemiological features of COVID-19 have been repeatedly published in the last few weeks. Interestingly, specific comorbidities associated with increased risk of infection and worse outcomes with development of increased severity of lung injury and mortality have been reported. The most common comorbidities in one report were hypertension (30%), diabetes (19%), and coronary heart disease (8%).[3] Another report showed that the most frequent comorbidities in patients with COVID-19 who developed the acute respiratory distress syndrome were hypertension (27%), diabetes (19%), and cardiovascular disease (6%).[4] The frequency with which COVID-19 patients are hypertensive is not entirely surprising nor does it necessarily imply a causal relationship between hypertension and COVID-19 or its severity, since hypertension is exceedingly frequent in the elderly, and older people appear to be at particular risk of being infected with SARS-CoV-2 virus and of experiencing severe forms and complications of COVID-19.

It is unclear whether uncontrolled blood pressure is a risk factor for acquiring COVID-19, or whether controlled blood pressure among patients with hypertension is or is not less of a risk factor. However, several organizations have already stressed the fact that blood pressure control remains an important consideration in order to reduce disease burden, even if it has no effect on susceptibility to the SARS-CoV-2 viral infection.[5] Nevertheless, the fact that hypertension, and other forms of cardiovascular disease also found frequently in COVID-19 patients, are often treated with angiotensin-converting enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs), and that SARS-CoV-2, the virus causing COVID-19, binds to ACE2 in the lung to enter cells,[6,7] has raised questions regarding the possibility that these agents could either be beneficial or actually nefarious in patients treated with them with respect to susceptibility to acquire COVID-19 or in relation to its outcome. It has been shown that ACE inhibitors and ARBs increase ACE2,[8,9] which could theoretically increase the binding of SARS-Cov-2 to the lung and its pathophysiological effects leading to greater lung injury. However, ACE2 has actually been hown to protect from lung injury in experimental studies.[10] ACE2 forms angiotensin 1–7 from angiotensin II, and thus reduces the inflammatory action of angiotensin II, and increases the potential for the anti-inflammatory effects of angiotensin 1–7. Accordingly, by reducing either formation of angiotensin II in the case of ACE inhibitors, or by antagonizing the action of angiotensin II by blocking angiotensin AT_1 receptors in the case of ARBs,[11,12] these agents could actually contribute to reduce inflammation systemically and particularly in the lung, heart, and kidney. Thus, ACE inhibitors and ARBs could diminish the potential for development of either acute respiratory distress syndrome, myocarditis or acute kidney injury, which can occur in COVID-19 patients. In fact, ARBs have been suggested as a treatment for COVID-19 and its complications.[13] Increased soluble ACE2 in the circulation could bind SARS-CoV-2, reducing its ability to injure the lungs and other ACE2 bearing organs.[14] Using recombinant ACE2 could be a therapeutic approach in COVID-19 to reducing viral load by binding circulating SARS-CoV-2 viral particles and reducing their potential attachment to tissue ACE2. None of these possibilities have however been demonstrated in patients yet.

In conclusion, there is as yet no evidence that hypertension is related to outcomes of COVID-19, or that ACE inhibitor or ARB use is harmful, or for that matter beneficial, during the COVID-19 pandemic. Use of these agents should be maintained for the control of blood pressure, and they should not be discontinued, at least on the basis of current evidence at this time.

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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 20-cv-00825-DDD

[redacted]

Petitioner,

v.

JOHN MARTINEZ, Acting Denver Field Office Director for Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement,
TIMOTHY S. ROBBINS, Acting Executive Associate Director for Enforcement and Removal Operations, U.S. Immigration and Customs Enforcement,
MATTHEW T. ALBENCE, Acting Director of U.S. Immigration and Customs Enforcement,
CHAD F. WOLF, Acting Secretary of the U.S. Department of Homeland Security,
WILLIAM P. BARR, Attorney General of the United States,
JOHNNY CHOATE, Warden, Denver Contract Detention Facility,

Respondents.

DECLARATION OF KENNETH SCISSORS, M.D.

I, Kenneth Scissors, M.D., do hereby declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746.

Expert Qualifications

1. I have been continuously board certified in Internal Medicine since 1987. I have worked as an internal medicine and/or emergency room physician continuously since that time. I am currently a part-time hospitalist at St. Mary's Medical Center in Grand Junction, Co. I have treated patients with hypertension throughout my career. I have actively followed the medical literature and

guidelines for the SARS CoV-2 virus and COVID-19 disease since early 2020 and I am a member of a team of physicians treating COVID-19 patients. My C.V. is attached.

Analysis and Opinion

2. My opinions are based on my knowledge, training, and experience related to the issues at hand. The materials I relied upon are listed below. My opinions could be modified if additional factual information comes to light. All of my opinions are stated within a reasonable degree of medical certainty.

a. The CDC has published guidance specific to correctional and detention facilities for risk factors related to COVID-19: "Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities", originally posted March 23, 2020 and still current as of today, May 6, 2020. https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-correctional-detention.html

b. The declaration of Dr. Carlos Franco-Peredes erroneously contends that the [redacted] diagnosis of hypertension is considered by the CDC as one that would qualify as increasing his risk of severe disease from COVID-19 as a detainee.

c. In fact, the CDC guidelines for detainees does not include hypertension as a risk factor. The only risk factors listed are: age over 65 years; chronic lung disease, moderate to severe asthma; serious heart conditions; immunocompromise; severe obesity; diabetes, kidney disease requiring

dialysis; and liver disease. As a point of clarification, "pulmonary hypertension", which is listed as a sub-category of "serious heart disease" is not the same disease as essential hypertension such as [redacted] had, they are completely different.

d. It should further be noted that [redacted] was diagnosed by his Provo, Utah physician with "hypertension—essential, benign" (also known as primary or systemic hypertension) in 2013. This indicates that there was no evidence of uncontrolled or a more complicated form of hypertension that involved critical organs such as the heart or kidneys. The medical records from Aurora Processing Center are consistent with the diagnosis of benign essential hypertension. There is no evidence in any of the records or declarations that [redacted] suffered at any time from a serious heart condition or any of the other CDC's listed conditions that would increase his risk of severe disease from COVID-19. Hypertension must not be conflated with "serious heart condition", as they are somewhat related but distinct diagnoses.

e. The CDC's guidelines are the "gold-standard" for managing COVID-19 in the U.S. and are in keeping with global expert consensus.

f. Five internationally respected authors (including three Americans) concluded in their editorial titled "Hypertension and COVID-19" in the May, 2020 issue of the American Journal of Hypertension: "there is as yet no evidence that hypertension is related to outcomes of COVID-19".

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7184512/

g. Recent publications from China, Italy, and New York have demonstrated a correlation of the baseline characteristic of hypertension with severe cases of COVID-19. The authors of these studies explicitly explained that their studies are methodologically limited to only report baseline characteristics within the population they studied, and as such were inadequate to conclude that these baseline characteristics conferred specific risk for individual patients throughout the world. Although it is tempting to jump from a correlating baseline characteristic to a cause and effect relationship, to do so is speculative, not evidence-based, and commonly proves to be unfounded when subsequent studies designed to determine cause and effect are performed. Determining baseline characteristics provides important clues as to what factors may, with additional study and analysis, eventually result in conclusions--but cannot be taken as evidence prior to that further research.

h. Dr. Franco-Peredes in his declaration misrepresented the findings in the study by Grasselli, et al, titled "Baseline Characteristics and Outcomes of 1591 Patients Infected With SARS-CoV-2 Admitted to ICUs of the Lombardy Region, Italy" published April 6, 2020 online by the Journal of the American Medical Association (https://jamanetwork.com/journals/jama/fullarticle/2764365) . Dr. Franco-Peredes writes: "those with hypertension were 23 times more likely to die from COVID-19 compared to those without hypertension". The authors made

no such claim, and in fact made no claim related to an increased likelihood of dying related to hypertension at all. The authors merely stated that "The prevalence of hypertension was higher among patients who died in the ICU (63%, 195 of 309 patients) compared with those discharged from the ICU (40%, 84 of 212 patients)". They also determined that patients with hypertension were significantly older than those without hypertension. The baseline characteristic of hypertension represents only a correlation, which without further study cannot be taken as a definitive risk factor.

Conclusions

There is no evidence that [redacted] has a medical condition that increases his risk of severe disease from COVID-19. The current medical science and CDC guidelines do not support his underlying condition of hypertension as posing an increased risk of severe disease from COVID-19., and [redacted] does not have any of the accepted risk factors that do increase that risk. Therefore, it is my opinion to a high degree of medical certainty, that [redacted] does not have any medical condition that confers a higher risk of severe COVID-19.

Materials Relied Upon

1. Declarations of [redacted], Dr. Carlos Franco-Peredes, [redacted], and [redacted].
2. Office records from [redacted] Provo, Utah physicians.
3. Aurora ICE Processing Center medical records

4. Documents referenced with direct links in my report.

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

Executed on this 7th day of May, 2020 in Grand Junction, Colorado.

Kenneth Scissors, M.D.

National Asthma Education and Prevention Program Expert Panel Report 3

Guidelines for the Diagnosis and Management of Asthma

U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

FIGURE 14. CLASSIFYING ASTHMA SEVERITY AND INITIATING TREATMENT IN YOUTHS 12 YEARS OF AGE AND ADULTS

Assessing severity and initiating treatment for patients who are not currently taking long-term control medications

Components of Severity		Classification of Asthma Severity ≥12 years of age			
			Persistent		
		Intermittent	Mild	Moderate	Severe
Impairment Normal FEV_1/FVC: 8–19 yr 85% 20 –39 yr 80% 40 –59 yr 75% 60 –80 yr 70%	Symptoms	≤2 days/week	>2 days/week but not daily	Daily	Throughout the day
	Nighttime awakenings	≤2x/month	3–4x/month	>1x/week but not nightly	Often 7x/week
	Short-acting $beta_2$-agonist use for symptom control (not prevention of EIB)	≤2 days/week	>2 days/week but not daily, and not more than 1x on any day	Daily	Several times per day
	Interference with normal activity	None	Minor limitation	Some limitation	Extremely limited
	Lung function	• Normal FEV_1 between exacerbations • FEV_1 >80% predicted • FEV_1/FVC normal	• FEV_1 >80% predicted • FEV_1/FVC normal	• FEV_1 >60% but <80% predicted • FEV_1/FVC reduced 5%	• FEV_1 <60% predicted • FEV_1/FVC reduced >5%
Risk	Exacerbations requiring oral systemic corticosteroids	0–1/year (see note)	≥2/year (see note)		
		← Consider severity and interval since last exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. →			
		Relative annual risk of exacerbations may be related to FEV_1.			
Recommended Step for Initiating Treatment (See "Stepwise Approach for Managing Asthma" for treatment steps.)		Step 1	Step 2	Step 3 and consider short course of oral systemic corticosteroids	Step 4 or 5
		In 2–6 weeks, evaluate level of asthma control that is achieved and adjust therapy accordingly.			

Key: EIB, exercise-induced bronchospasm, FEV1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICU, intensive care unit

Notes:

- The stepwise approach is meant to assist, not replace, the clinical decisionmaking required to meet individual patient needs.
- Level of severity is determined by assessment of both impairment and risk. Assess impairment domain by patient's/caregiver's recall of previous 2–4 weeks and spirometry. Assign severity to the most severe category in which any feature occurs.
- At present, there are inadequate data to correspond frequencies of exacerbations with different levels of asthma severity. In general, more frequent and intense exacerbations (e.g., requiring urgent, unscheduled care, hospitalization, or ICU admission) indicate greater underlying disease severity. For treatment purposes, patients who had ≥2 exacerbations requiring oral systemic corticosteroids in the past year may be considered the same as patients who have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.