IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*,

Plaintiffs,

v.

DISTRICT OF COLUMBIA, *et al.*,

Defendants.

No. 1:19-cv-3185 (RDM)

PLAINTIFFS' REPLY IN SUPPORT OF THEIR MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Since Plaintiffs first sought injunctive relief, the number of individuals infected with COVID-19 at Saint Elizabeths has more than doubled, from 84 on April 16 (33 patients and 51 staff) to 187 on May 17 (79 patients and 108 staff). In that time, the number of people affiliated with the Hospital who have died from COVID-19 has more than tripled, from 4 to 14. Defendants' opposition brief ("Opp.") (ECF 90) fails to acknowledge or address the stark fact that the measures taken by Defendants since the beginning of this crisis have failed. The extent of illness and death at the Hospital was not inevitable. It was the direct result of policies and decisions by Defendants that delayed implementation of, or misapplied, CDC guidance on infection control, testing, quarantine, and reduction in census.

Defendants attempt to escape liability by describing every decision to act or to delay in acting as "professional judgment." But when hospital authorities fail to consider, ignore, misinterpret, or misapply CDC guidance to protect the patient population, that departs substantially from the "accepted professional judgment" to which Plaintiffs were entitled under the Constitution. Similarly, when the Hospital radically curtailed its provision of mental health services without providing anything close to an alternative, that is not an "accepted professional judgment"; indeed, Defendants' medical professionals do not even suggest it was.

As they have at prior stages of the litigation, Defendants also argue that because of measures they took before and in response to this litigation, there is no "irreparable harm that is likely and imminent absent court-ordered relief." Opp. 40. This claim ignores *amici*'s warning that "as of the date of the filing of this report on May 11, 2020, [the Hospital] continues to experience ongoing transmission of SARS-CoV-2," ECF 81 at 2, as well as other evidence of further COVID-19 spread within the facility. ECF 89 at 13-14, 19. Moreover, "injunctive relief is

appropriate when there is a 'cognizable danger of recurrent violation,'" and "all that need to be shown is that 'there is some reasonable likelihood of future violations,' and past unlawful conduct is 'highly suggestive of the likelihood of future violations.'" *U.S. Dep't of Justice v. Daniel Chapter One*, 89 F. Supp. 3d 132, 143 (D.D.C. 2015) (quoting *United States v. W.T. Grant Co.*, 345 U.S. 629, 633 (1953), and *Commodity Futures Trading Comm'n v. Hunt*, 591 F.2d 1211, 1220 (7th Cir 1979)), *aff'd*, 650 F. App'x 20 (D.C. Cir. 2016).

A preliminary injunction should be granted.

ARGUMENT

1. Plaintiffs Are Likely to Succeed on the Merits. Defendants' discussion of the applicable legal standard mischaracterizes Plaintiffs' arguments and recycles legal errors from their TRO briefing that this Court has already rejected. Defendants persist in arguing that Plaintiffs seek to impose liability based on negligence, Opp. 19-20, 23. Defendants are wrong.

The fact that due process requires Defendants not to depart substantially from "accepted professional judgment," *Youngberg v. Romeo*, 457 U.S. 307, 323 (1982) and to treat noncriminal detainees in accordance with an "objective" standard of reasonableness, *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2473 (2015), does not reduce the inquiry to one of negligence. Indeed, in *Kingsley*, the Court explicitly differentiated the objective standard for measuring the treatment of detainees from the question whether the defendant acted intentionally or negligently "with respect to the bringing about of certain physical consequences in the world." *Id.* at 2472–73. Plaintiffs do not argue that Defendants *accidentally* failed to set up an appropriate system of precautionary measures against COVID-19. Instead, Plaintiffs argue that the set of measures that Defendants *intentionally* chose were objectively unreasonable (*i.e.*, in their failure to comport or their departure from CDC guidance), and that in so doing, Defendants subjected Plaintiffs to an

"excessive risk to their health." *Banks v. Booth*, No. CV 20-849 (CKK), 2020 WL 1914896, at *6 (D.D.C. Apr. 19, 2020). By failing to behave reasonably, Defendants did not meet their "affirmative duty to ensure the safety and general well-being of an involuntarily committed mental patient;" they did not satisfy the professional judgment standard. ECF 59 at 10 (citing *Harvey v. District of Columbia*, 798 F.3d 1042, 1050-51 (D.C. Cir. 2015)).[1]

This Court previously recognized the correct standard: "Liability exists 'when the decision by the professional is such a *substantial departure from accepted professional judgment, practice, or standards* as to demonstrate that the person responsible actually did not base the decision on such a judgment.'" Pls.' Mem. 11 (emphasis added) (quoting this Court's decision on the TRO, ECF 59 at 11, which in turn quotes *LaShawn A. v Dixon*, 762 F. Supp. 959, 994 (D.D.C. 1991), which in turn quoted *Youngberg*, 457 U.S. at 323). The Defendants themselves rely on the same standard. Opp. 20-21, as do their main authorities. *See Patten v. Nichols*, 274 F.3d 829, 843 (4th Cir. 2001); *Jordan v. District of Columbia*, 161 F. Supp. 3d 45, 58 (D.D.C. 2016). This Court applied this standard both in issuing the TRO and in extending it. *See* ECF 59 at 11; ECF 82 at 7-8 ("[T]he hospital's unexplained failure to abide by the CDC guidance in this respect is not based on the exercise of professional judgment."). Defendants offer no reason to deviate from it.

a. Defendants' Failures To Protect Their Patients from Risk of Infection Were Substantial Departures from Accepted Professional Judgment or Reflected No Professional

[1] Defendants suggest *Kingsley* is inapposite because it involved the due process rights of pretrial detainee in the context of an excessive force claim. Opp. 17 n.7. They cite no authority for this limitation, which this Court has rejected in reliance on the decisions of several appellate courts. *See Banks*, 2020 WL 1914896, at *6 (citing *Hardeman v. Curran*, 933 F.3d 816, 823 (7th Cir. 2019), *Darnell v. Pineiro*, 849 F.3d 17, 35 (2d Cir. 2017), and *Castro v. County of Los Angeles*, 833 F.3d 1060, 1070 (9th Cir. 2016)); *accord United States v. Moore*, No. CR 18-198 (JEB), 2019 WL 2569659, at *2 (D.D.C. June 21, 2019) (applying *Kingsley* to due process claim by pretrial detainee outside excessive force context).

Judgment At All. Throughout the opening brief, Plaintiffs cited specific accepted professional standards (most prominently from the CDC) from which Defendants' actions deviated to demonstrate that Defendants' choices were not based on an exercise of professional judgment. The deviations chosen by Defendants were neither small nor on peripheral issues; they widely missed the mark on the core measures necessary to be taken to protect patients and had catastrophic results. In their opposition, Defendants do not even attempt to explain how their decisions to deviate from CDC guidance comports with professional judgment other than by reference to the credentials of the decision maker. For example, with regard to Defendants' quarantine and isolation practices:

- The CDC recommends medically isolating patients who are exhibiting COVID-19 symptoms.[2] Prior to entry of the TRO, the Hospital was housing individuals with COVID-19 symptoms together with non-symptomatic individuals. ECF 39-6 (Costa Decl.) ¶ 6; ECF 39-7 (Dunbar Decl.) ¶¶ 5(a-b), 6; 4/20 Tr. 30; ECF 87-2 (Murphy Decl.) ¶ 4. In her declaration, Ms. Tu states that starting on March 30, the Hospital "isolated two to three patients" with potential COVID symptoms "at a time" in the PUI unit. Tu Decl. (ECF 90-1) ¶ 8. During this period, however, the Hospital reported having well over 100 patients who were symptomatic or exposed.[3]

- When there are COVID-19 cases in a congregate facility, the CDC recommends medically isolating patients who may have been exposed.[4] Defendants did not isolate these individuals until after the TRO motion was filed, when they started a practice of "treating all units as quarantined." ECF 59 at 13. Rather, Dr. Candalis says nothing about exposed patients, only that there was an effort to "cohort COVID-positive patients together and to isolate symptomatic patients who may have COVID-19." Candalis Decl. (ECF 90-5) ¶ 7.

[2] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, ECF 55-2.
[3] Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data (last accessed May 19, 2020).
[4] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, ECF 55-1; CTRS. DISEASE CONTROL & PREVENTION, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (Mar. 23, 2020), ECF 55-2.

- When there are COVID-19 cases in a congregate facility, the CDC guidelines provide that ill residents should have dedicated health care professionals. ECF 81-1 at 4-5.[5] *Amici* specifically noted this was not happening and hypothesized that the recent COVID-19 patient infections on Units 1D and 1G were spread by Staff. ECF 81 at 4; May 7 Tr. 4, 11. In her declaration, Chief Nurse Pontes does not address the CDC's guidance on this topic – rather she states that she exercises her "professional judgment" in staffing and "there may be a need to reassign a staff member to another unit" and "the Nursing Department may approve overtime for a staff member working on a non-COVID-positive unit to work on a . .. COVID-positive unit." Pontes Decl. (ECF 90-7) ¶¶ 5-6.

Defendants departures from CDC guidance on each of these points exposed patients to COVID-19 infection. This is clear from Plaintiff Dunbar (who tested negative on March 18, only to be infected when he came back to the Hospital) as well as the ongoing infections since the TRO was entered. None of these departures from standard can be defended as "professional judgment."

Similarly, with regard to Defendants' testing practices:

- The CDC guidance for nursing homes states that "the first step of a test-based prevention strategy should ideally be a point prevalence survey (PPS) of all residents and all HCP [health care professionals] in the facility."[6] *See* ECF 82 at 6-7. Defendants attempt to excuse their failure to conduct testing by raising a question about the date the CDC recommended PPS. ECF 90 at 25. Defendants do not, however, address why they delayed conducting such a survey until they were ordered to do so by the Court. Defendants also do not explain their failure to test staff. May 7 Tr. 21-22. As *amici* noted, prior to the Court's order extending the TRO, only 100 of the 786 staff had been tested. ECF 81-1 at 3, 6.

- The CDC guidance for nursing homes says "residents with suspected COVID-19 should be prioritized for testing."[7] When Plaintiffs moved for a TRO, patients were not being tested for COVID-19, even when they displayed characteristic symptoms of the virus. Costa Decl. (ECF 39-6) ¶ 13; Dunbar Decl. (ECF 39-7) ¶ 8; Smith Decl. (ECF 39-8) ¶¶ 8, 11; Murphy Decl, (ECF 87-2) ¶ 4. Rather, at the time they opposed the TRO on April 21, Defendants reported having conducted only 31 tests. Tu Decl. (ECF 42-5) ¶ 11. In her supplemental declaration, Ms. Tu acknowledges that the Hospital did not receive any test kits from the Defendant District until April 9, when

[5] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, ECF 55-2.
[6] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019, Testing for Coronavirus in Nursing Homes*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
[7] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019 Nursing Homes & Long-Term Care Facilities*, ECF 55-2

it received 20. ECF 90-1 ¶ 7. On that day, the Hospital reported 142 patients who were symptomatic or exposed.[8]

Defendants' failures to test their symptomatic patients or staff in accordance with CDC guidance hindered their ability to properly quarantine or isolate patients, and exposed patients to COVID-19. This is clear from the rapid spread of COVID-19 among the patient population, as well as the recent transmission from staff to patients. The lack of testing contrary to CDC guidance cannot be defended as anything close to "accepted professional judgment."

Defendants similarly failed to address the relevant standards for hygienic practices:

- When there are cases in a facility, the CDC recommends that the facility should implement universal use of facemasks for health care professionals, encourage patients to remain in their rooms, and encourage patients to wear face masks and perform social distancing when they leave their rooms.[9] As the Court recognized in granting the TRO, at the time Plaintiffs filed for the TRO, Defendants had not provided masks to all patients or instructed or required patients to wear masks in a manner consistent with public health guidelines. ECF 59 at 13-14.

- The CDC guidance provides that when masks are reused there should be "a minimum of five days between each [mask] use."[10] *Amici* noted that the staff's reuse of masks was not in accordance with CDC guidance and presented a "contamination risk." May 7 Tr. 30, 34. Although Defendants discuss their need to reuse masks, they do not address the CDC practice for mask rotation. ECF 90-1 (Tu Decl.) ¶ 20.

- CDC guidelines provide that health care personnel should "perform hand hygiene before and after all patient contact, . . . and before putting on and removing PPE."[11] *Amici* noted that the "hand hygiene audit data provided to *amici* revealed compliance to be <80%." ECF 81 at 6. Although Defendants note that they began training staff on proper hand-hygiene in February, ECF 90-1 (Tu. Decl.) ¶ 4.

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[8] Dist. of Columbia Dep't of Human Servs., *Human Services Agency COVID-19 Case Data*, https://coronavirus.dc.gov/page/human-services-agency-covid-19-case-data (last accessed May 19, 2020).

[9] *Id.*

[10] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019, Decontamination and Reuse of Filtering Facepiece Respirators*, https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html.

[11] CTRS. DISEASE CONTROL & PREVENTION, *Coronavirus Disease 2019, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease in Healthcare Settings*, ECF 54-1.

When Defendants claim that Plaintiffs' "standards of care" are "undefined," Opp. 22, they ignore that Plaintiffs' repeatedly identified the specific standards throughout their brief. *See* ECF 87-1 at 1, 4, 5, 6, 7, 9, 15, 16, 18, 20, 22, 24, 35 (relying explicitly on CDC guidance).

CDC guidance is the same standard that has guided this Court's analysis throughout the case thus far, and Defendants provide no reason to select a different standard. And as the reports of *amici*, Plaintiffs' opening brief, and the following arguments show, Defendants' actions are such a departure from professional standards as to be unmoored from professional judgment and have been ineffective at preventing the spread of the virus.

Citing guidance issued by the CDC on May 11 (which they characterize as "CDC Psychiatric Guidance"),[12] the Defendants also suggest that CDC guidance is not mandatory and is "designed to be flexible." Opp. 27. The fact that the CDC recognizes that its guidance must be adapted for the specific conditions at each hospital does not diminish the import of the core standards nor effect that the guidance reflects professional standards. To the contrary, it leaves the decisions of how – not whether – to implement the guidance to Hospital administrators. Thus, if the question is whether Defendants have exercised their professional judgment in implementing infection control practices, their consideration (or failure to consider) the CDC's expertise on these topics is relevant, if not dispositive.[13] Here, the Defendants failed to address multiple, critical

[12] This document is an excerpt from a set of "Frequently Asked Questions" posted by the CDC covering various topics as what type of PPE or face masks to wear when interacting with known, suspected, and exposed COVID-19 patients, and how a facility should communicate when it has a known or suspected COVID-19 case. ECF 90-8. With regard to psychiatric hospitals, this guidance is consistent with other CDC guidance on these topics. For example, the guidance says patients with COVID-19 should be "cared for by dedicated HCP" and emphasizes the need for mask use.

[13] It is significant that the Centers for Medicare and Medical Services embrace the CDC guidance as the standards for Hospitals seeking reimbursement for services: "Hospitals, psychiatric hospitals, and CAHs should monitor the Centers for Disease Control and Prevention's (CDC)

components of CDC guidance; the failure to consider preventive measures deemed important by the CDC were substantial departures from accepted professional judgment.

b. Defendants' Failure to Provide Adequate Mental Health Care Was a Substantial Departure from Accepted Professional Judgment: Defendants do not defend their extraordinary curtailment of mental health care or their continued confinement of more than 50 individuals "ready for discharge" as consistent with professional judgment. Notably, Defendants do not dispute Dr. Canavan's observations that:

- "there has been a dramatic decrease in the provision of mental health services at the hospital," ECF 78 at 17;
- notwithstanding a plan to offer alternate on-unit therapy, "that plan was not approved by the Hospital administrative leaders and, as a result, no group therapies have been provided by Rehabilitation or TLC staff since mid-March," ECF 78 at 12;
- the plan to provide a "telehealth program on each unit to allow for remote group therapy" was "delayed" and had not been implemented, ECF 78 at 17;
- 90 percent of the treatment plans reviewed contained treatment components "that are no longer operating," ECF 78 at 16; and
- Defendants substantially reduced their efforts at discharge planning and execution, and there "were 56 individuals in care on the 'ready to discharge' list," ECF 78 at 7-9.

Notably, neither Dr. Candalis (the Medical Director) nor Dr. Gontang (the Chief Clinical Officer) state or otherwise suggest that any of these facts—the radically reduced amount of mental health care provided, the failure to provide a substitute, the stale treatment plans, or the continued

website (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html) for up-to-date information and resources for the mitigation of transmission of COVID-19 for both inpatient and outpatient facilities." CTRS. FOR MEDICARE AND MEDICAID SERVICES, *Guidance for Infection Control and Prevention of Coronavirus Disease (COVID-19) in Hospitals, Psychiatric Hospitals, and Critical Access Hospitals (CAHs): FAQs, Considerations for Patient Triage, Placement, Limits to Visitation and Availability of 1135 Waivers*, https://www.cms.gov/files/document/qso-20-13-hospitals-cahs-revised.pdf. While the Hospital does not receive reimbursement from the Medicaid or Medicare programs, it underscores that the CDC guidance reflects professional judgment and is not optional.

detention of over 50 "ready to discharge" patients at the facility – is the product or result their professional judgment. While Dr. Candalis attests that the "Hospital has continued to provide psychiatric care to all of our patients," he conspicuously fails to state whether the level of care provided meets professional standards. *See* Candalis Decl. (ECF 90-5) ¶¶ 4-5. Similarly, while Dr. Gontang's declaration discusses the Hospital's efforts in March to plan for alternative therapy and telemedicine, Gontang Decl. (ECF 90-4) ¶¶ 5-7, he confirms these plans were delayed and have not implemented, *Id.* ¶ 16. He also conspicuously fails to state whether the level of mental health care being provided meets professional standards.

Rather, Dr. Gontang, states that he and "his team" designed a plan to provide mental health care—that was presumably his professional judgment as to what was needed, Gontang Decl. (ECF 90-4) ¶¶ 5-6. But this plan has not yet been implemented. *Id*. ¶¶ 8. 10. Leaving aside the question of whether the plan is adequate, the fact that no plan was implemented is certainly a departure from Defendants' own doctors' clinical judgment. Thus, while Defendants dispute there has been a 98 percent drop in the hours of mental health services provided measured against February, Opp. 32, they do not contest (i) Dr. Canavan's observation that there were "fewer than 100 hours of treatment scheduled" in April, ECF 78 at 15, and (ii) Defendants did not come close to replacing this therapy with alternatives.

As Ms. Jones concluded, these "circumstances violate professional standards of care and treatment." ECF 87-8 ¶ 4. Guidance from various federal authorities advise mental health facilities to implement alternative strategies to provide therapy. For example, the federal Substance Abuse and Mental Health Services Administration ("SAMSHA") recommends that mental health facilities "preserve healthcare system functioning [by] engag[ing] patients in more one to one activities." ECF 87-3 at Recommendation 4. As an alternative to group therapy, the

CDC recommends "use virtual methods, or decrease group size so social distancing can be maintained." ECF 90-8. Even the Hospital's own emergency plan provides that care should be continued as much as possible during a public health emergency. ECF 44 Ex. A at 9-10. The failure to follow all of this guidance—not least the Hospital's own plan—reflects a substantial departure from accepted professional judgment.

Finally, Defendants dispute the propriety of Plaintiffs' proposed remedy for the curtailment of mental health services during the COVID-19 crisis. Although Defendants do not dispute that Plaintiffs have standing to seek an injunction that orders the Hospital to develop a COVID-19 appropriate method of mental health service delivery or that requires the procurement of appropriate technology to implement such a plan, *see* ECF 87-1 at 44-45, they argue that Plaintiffs lack standing to seek mental health services for other patients at the Hospital. Opp. 31. Defendants are incorrect for two reasons.

First, as Plaintiffs have discussed (and Defendants do not dispute), the Court's power to provide appropriate injunctive is broad and flexible once a constitutional violation has been shown. *See* ECF 87-1, at 36-37. That includes the power to ensure that relief is "complete." *U.S. Dep't of Justice v. Daniel Chapter One*, 89 F. Supp. 3d 132, 147 (D.D.C. 2015) (citing *Porter v. Warner Holding Co.*, 328 U.S. 395, 399 (1946)). As Chief Judge Howell recently observed, "Fashioning equitable relief is not and has never been an exercise in formalistic matching, of formulaically ordering relief scoped precisely to the injury the plaintiff has asserted and proven. As the Supreme Court recently said in allowing an equitable remedy affecting non-parties, '[c]rafting a preliminary injunction,' indeed any equitable relief, 'is an exercise of discretion and judgment, often dependent as much on the equities of a given case as the substance of the legal issues it presents.'" *District of Columbia v. U.S. Dep't of Agric.*, No. CV 20-119 (BAH), 2020 WL 1236657, at *38 (D.D.C.

Mar. 13, 2020) (quoting *Trump v. Int'l Refugee Assistance Project*, 137 S. Ct. 2080, 2087 (2017). Exercising this authority, it is entirely appropriate for the Court to consider—as it has throughout this litigation—the collateral effects that its orders, including isolation requirements, will have on a vulnerable population. That these requirements may well be life-saving and indispensable does not prevent them from taking a toll on all Hospital residents' mental health, ECF 78 at 27, particularly where Defendants have not provided appropriate mental health care. Accordingly, the Court may order facility-wide relief regarding mental health to mitigate the effects of isolation on the population, in order to provide "complete relief" from not just the grave threat to patients' physical health but also to the unaddressed ancillary effects of isolation on their mental health. To be clear, Plaintiffs' request is modest: not that the Court should determine what each individual patient should receive or order a change to patients' mental health treatment, but merely a requirement that Defendants evaluate each patient, determine an appropriate treatment plan, and implement that treatment plan. *See* ECF 87-1 at 44-45.

Second, and in the alternative, Plaintiffs have brought this case as a class action, and Defendants do not dispute that the requested remedy would be appropriate for class-wide relief. If the Court finds that Plaintiffs do not have standing to seek an injunction requiring the evaluation of each patient from appropriate mental health care, the Court should provisionally certify the class. The Court has broad discretion to certify the class provisionally to provide preliminary injunction relief, subject to later reconsideration or amendment. Courts in this district have done so many times. *See, e.g.*, *Kirwa v. U.S Dep't of Defense*, 285 F. Supp. 3d 21, 44 (D.D.C. 2017) (granting provisional class certification in context of granting preliminary injunction); *R.I.L-R v. Johnson*, 80 F. Supp. 3d 164, 181 (D.D.C. 2015) (same); *Chang v. United States*, 217 F.R.D. 262, 274 (D.D.C. 2003) (granting provisional class certification before defendants had filed their

opposition to certification); *Bame v. Dillard*, No. 05-cv-1833, 2008 WL 2168393 at *9 (D.D.C. May 22, 2008) (provisionally certifying class "without prejudice to Defendant's renewed objections after the close of discovery"); *Kifafi v. Hilton Hotels Retirement Plan*, 189 F.R.D. 174, 176 (D.D.C. 1999) (granting provisional class certification and noting that Rule 23 "provid[es] that class certification may be granted provisionally and subsequently altered or amended").

The putative class is "all current Saint Elizabeths Hospital patients and all patients who will be admitted in the future while the hospital operates without a sufficient emergency preparedness plan that protects patients from an unreasonable risk of harm." ECF 50 ¶ 212 (First Amended Complaint). Plaintiffs submitted their Motion for Class Certification under Rule 23(b)(2) prior to amending the complaint. *See* ECF 30.[14] Although the First Amended Complaint incorporated new facts, the fundamental arguments for class certification remain the same: Plaintiffs' claims that Defendants' actions and/or inactions have deprived class members of safe conditions and adequate mental health care in violation of the Fifth Amendment's Due Process Clause and the ADA raise common, class-wide questions which can be resolved through common evidence and common answers. *See* ECF 30. Certification under Rule 23(b)(2) is appropriate where, as here, "(1) the defendant's action or refusal to act [is] generally applicable to the class; and (2) plaintiffs . . . seek final injunctive relief or corresponding declaratory relief on behalf of the class." *Taylor v. D.C. Water & Sewer Auth.*, 241 F.R.D. 33, 47 (D.D.C. 2007). *See also DL v. District of Columbia*, 860 F.3d 713, 723 (D.C. Cir. 2017) (same).

The COVID-19 pandemic affected patient care and safety throughout the facility, and affected all of Saint Elizabeths' patients. All patients were exposed to conditions that deprived

[14] This Court held Defendant's obligation to respond to this Motion in abeyance pending a decision on Defendant's Motion to Dismiss. January 22, 2020 Minute Order.

them of, among other things, reasonable safety and adequate psychiatric care. These injuries stemmed from Defendants' adherence (or non-adherence) to a set of policies, procedures, and protocols. Thus, Defendants' actions or inactions were generally applicable to the class for purposes of Rule 23(b)(2). Rule 23(b)(2) certification is allowed when "a single injunction or declaratory judgment would provide relief to each member of the class." *Dukes*, 564 U.S. at 360. The declaratory and injunctive relief sought here is class-wide in nature, and would provide relief to each class member.

Plaintiffs do not request a different injunction, or, as Defendants allege, particularized services, for each individual member of the class. Rather, "they ask the Court to determine whether [Defendant's] systematic actions, or failures to act, in response to COVID-19 amount to violations of the class members' constitutional or statutory rights." *Faour Abdallah Fraihat v. United States Immigration & Customs Enf't*, No. EDCV 19-1546 JGB (SHKx), 2020 U.S. Dist. LEXIS 72015, at *64 (C.D. Cal. Apr. 20, 2020) (concluding that Rule 23(b)(2)'s requirements are satisfied). Plaintiffs further demonstrate that the proposed class satisfies each of the four requirements in Rule 23(a): for numerosity, commonality, typicality, and adequacy. ECF 50; ECF 30 at 8-13. Accordingly, Plaintiffs' proposed mental-health care relief is appropriate either as a component of complete relief or based on provisional class certification.

c. Plaintiffs are Entitled to Injunctive Relief Against Both the District and Individual Defendant Chastang. Plaintiffs can demonstrate their entitlement to a preliminary injunction by showing either that the District as an entity, or one of the named defendants as an individual bears responsibility for the constitutional violations at Saint Elizabeths. Here, Plaintiffs have done both.

First, the District itself is liable under § 1983 because its "policy caused the claimed violations of [the plaintiffs'] constitutional rights." *Jones v. Horne*, 634 F.3d 588, 601 (D.C. Cir. 2011). Of relevance here, a "single action can represent municipal policy where the acting official has final policymaking authority over the 'particular area, or . . . particular issue.'" *Thompson v. District of Columbia*, 832 F.3d 339, 347–48 (D.C. Cir. 2016) (quoting *McMillian v. Monroe Cty.*, 520 U.S. 781, 785 (1997)). The acting official here is Defendant Bazron, Director of the Department of Behavioral Health (DBH). DBH oversees the Hosptial, *see Banks v. District of Columbia*, 377 F. Supp. 2d 85, 87 (D.D.C. 2005), and Defendant Bazron oversees DBH. *See* D.C. Code § 7-1141.04(1) (DBH director shall "supervise and direct the Department").

Director Bazron possesses authority to "[e]xercise any other powers necessary and appropriate to implement the provisions of this chapter." D.C. Code § 7-1141.04(3). One such provision establishes that DBH "shall . . . [d]irectly operate a hospital to provide inpatient mental health services." D.C. Code § 7-1141.06(6). The only inpatient facility maintained by the District of Columbia is Saint Elizabeths, D.C. Olmstead Plan 2017–2020 at 8,[15] and "operating" it entails formulating a response to an emergency that severely affects the facility's conditions. Moreover, Defendant Bazron's responsibility to exercise "necessary and appropriate" powers confers the authority to issue regulations. Indeed, when DBH promulgates regulations, it does so in the director's name. *See, e.g.*, 63 D.C. Register 006936 (May 6, 2016) ("The Director of The Department of Behavioral Health . . . hereby gives notice of the adoption of a new [chapter of the DCMRs governing] . . . reimbursement rates . . . ."). Combined with her duty to "supervise" the agency that operates St. Elizabeths, D.C. Code § 7-1141.04(1), Defendant Bazron's authority to

[15]Dist of Columbia, *Olmstead Plan: 2017-2020*, available eat https://odr.dc.gov/sites/default/files/dc/sites/odr/page_content/attachments/2017%20Olmstead%20Plan%20Draft%20CLEAN%20APPROVED%206-2017.pdf

"promulgat[e] [the] rules to run the[] . . . [D]epartment" establish her as a final policymaker for responding to emergencies at Saint Elizabeths, *Banks*, 377 F. Supp. 2d at 91–92 (concluding that power to issue rules qualified director as "a final-policy-maker" for the agency in general); *see also Triplett v. District of Columbia*, 108 F.3d 1450, 1453 (D.C. Cir. 1997) (relying on same reasoning to identify Director of Department of Corrections as final policymaker for that department).

The record reflects Director Bazron's personal involvement in the Hospital's response to the COVID crisis. The Hospital's emergency response plan, directs that the Director of DBH be intimately involved in day-to-day decision-making about crises response. ECF 44 Ex. A-1 at 11 and Ex. A-2 at 34 (documents filed under seal provide specific details of DBH Director's role). Director Bazron directly confirmed to Plaintiffs that the Hospital activated this plan on March 12, 2020. See Ex. 1 at 1 (Letter from Defendant Bazron to Maggie Hart and Kaitlin Banner, dated March 18, 2020). Further, in response to the concerns expressed by Plaintiffs' counsel about Hospital patients in the early days and weeks in which the District was affected by the COVID crisis, Defendant Bazron offered detailed descriptions of Saint Elizabeths' response to the crisis, demonstrating her awareness of the Hospital's operations. *See generally* Exs. 1 & 2 (Letter from Defendant Bazron to Maggie Hart and Kaitlin Banner, dated April 16, 2020). Defendant Bazron also made clear that she would remain directly involved in Saint Elizabeths' efforts to address the pandemic. *See* Ex. 1 at 2 ("[W]e are preparing contingency plans in the event of an outbreak at the Hospital. . . ."); Ex. 2 at 3 ("[W]e look forward to continue working together to ensure the safety of all those in care at Saint Elizabeths Hospital."). These facts establish that the Hospital's inadequate response to the crisis is attributable to Defendant Bazron and, therefore, the District. Thus, unlike the Plaintiffs in the *Swain v. Junior*, No. 20-11622-C, 2020 WL 2161317, at *6 (11th

Cir. May 5, 2020), on which Defendant's rely, Opp. at 35, Plaintiffs here have shown that they are likely to establish municipal liability.

Second, Defendant Chastang bears responsibility for the constitutional violations at issue and this Court can enjoin him personally to make Saint Elizabeths comply with the law. Supervisors are personally liable for the constitutional torts when they "know about the conduct and facilitate it, approve it, condone it, or turn a blind eye for fear of what they might see." *Barham v. Ramsey*, 434 F.3d 565, 578 (D.C. Cir. 2006) (quoting *Jones v. City of Chicago*, 856 F.2d 985, 992 (7th Cir.1988)). Defendant Chastang, whom Plaintiffs "sued in his individual and official capacity," ECF 36-1 at 28, is the chief executive officer of Saint Elizabeths. Defendant Chastang, whom Plaintiffs "sued in his individual and official capacity," ECF 36-1 at 28, is the chief executive officer of Saint Elizabeths. The Hospital's 2020–2021 Emergency Management Plan vests the CEO of Saint Elizabeths with responsibility to work with the DBH Director to lead operational decision-making about the crisis at the Hospital. ECF 44 Ex. A-1 at 11 (providing additional details about Chastang's authority in document filed under seal).

Defendant Chastang has exercised this authority in ways that have made him "personally involved" in the Hospital's infirm response to the crisis. *Avila v. Dailey*, 404 F. Supp. 3d 15, 25 (D.D.C. 2019) (internal citation and quotation marks omitted). For example, he signed the Hospital's Administrative Issuance regarding the "Prevention and Management of COVID-19," a guidance document that, as of April 3, among other flaws, envisioned keeping common areas open. *See* 42-3 at 4, 5 (noting that certain protective equipment not required "when maintaining more than a 6 foot distance in the milieu or common areas"); *see also* ECF 59 at 13 (TRO opinion noting that Hospital has taken a less demanding approach [than the CDC recommends] to enforce social distancing [partly as demonstrated by fact] that common areas are open"). He personally reviews

admissions decisions, Candillas Decl. (ECF 90-5) ¶ 17, met with *amici* to assist them in their review of the conditions at the facility, ECF 78 at 2; ECF 81-3, and appears to have directly participated in decisions that have deprived patients of mental health care, *see* ECF 78 at 13 (noting that "there has not been coordinated treatment delivery due to the administrative leadership decision" not to approve a proposed plan for programming during the pandemic).

This level of involvement establishes the necessary link between Defendant Chastang and the challenged actions and authorizes this Court to order him to improve the facility's response. This conclusion follows directly from *Ex parte Young*, which described its exception to sovereign immunity by stating that the official is subject to suit "in his person," 209 U.S. 123, 160 (1908). The modern Court has reiterated *Ex parte Young* to recognize an "exception . . . for certain suits seeking declaratory and injunctive relief against state officers *in their individual capacities.*" *Idaho v. Coeur d'Alene Tribe*, 521 U.S. 261, 269 (1997) (emphasis added). Circuit courts opining on this issue after *Coeur d'Alene*'s clarification agree. *See Redondo- Borges v. U.S. Dep't of Hous. & Urban Dev.*, 421 F.3d 1, 7 (1st Cir. 2005); *MCI Telecomm. Corp. v. Bell Atl. Pa.*, 271 F.3d 491, 506 (3d Cir. 2001).[16]

[16] A decision in this district reached a contrary conclusion, *see Hatfill v. Gonzales*, 519 F. Supp. 2d 13, 19- 24 (D.D.C. 2007), but it was, respectfully, in error. The rationale of that decision was that a government official can be sued in an official capacity for an injunction because that is the capacity in which the official injures the plaintiff. That reasoning conflicts not only with *Ex parte Young* itself but also with *Hafer v. Melo*, 502 U.S. 21 (1991). In that case, the Supreme Court held that an individual-capacity defendant is susceptible to liability for conduct taken as a government official because the actions at issue were taken "under color" of law within the meaning of § 1983, regardless of the capacity in which the defendant is named. The Court explained that "[t]he requirement of action under color of state law means that Hafer may be liable for discharging respondents precisely because of her authority as auditor general. We cannot accept the novel proposition that this same official authority insulates Hafer from suit." *Id.* at 27. Although *Hafer* was a case about damages, nothing in *Hafer*'s discussion or logic suggests that its invocation of the "under color" principle holds only for damages suits. Indeed, in light of *Ex parte Young* and *Coeur d'Alene*, the opposite assumption is far more justified. Moreover, the alternative

In sum, this Court can attribute the constitutional violations at issue to all three defendants in this action. Whether it enjoins the District or Defendant Chastang personally, the Court will be justified in ordering the relief Plaintiffs seek.

d. Plaintiffs Are Likely to Succeed on Their ADA Claim of Unjustified Isolation. Defendants' argument that Plaintiffs lack standing to assert a claim of unlawful segregation and the failure to accommodate disability under the ADA because they themselves are not currently on Defendants' "ready for discharge" list, Opp. 36-37, is thrice flawed. First, Plaintiffs are not just asking that Defendants take reasonable steps to discharge patients on the list, but are requesting that the Court order evaluation and discharge planning for *all* patients, including Plaintiffs. The fact that Plaintiffs are not yet on the "ready" list cannot be dispositive. While Defendants may rely on the assessments of their own professionals in determining whether an individual "meets the essential eligibility requirements" for habilitation in a community-based program, those assessments must be reasonable and the government's treating professional is not the sole gatekeeper on whether a person is in the most integrated setting. *Olmstead v. L.V. by Zimring*, 527 U.S. 581, 602 and *M.J. v. District of Columbia*, 401 F. Supp. 3d 1, 12 (D.D.C. 2019) (Because *Olmstead* "did not state that a determination by a State's own professionals is the only way that a plaintiff may establish" community placement is warranted) (citing *Steimel v. Wernert*, 823 F.3d 902, 915-16 (7th Cir. 2016) (whether community based treatment was appropriate could be demonstrated by allegations that the state had previously allowed plaintiffs more community

rule would leave plaintiffs entirely without a remedy when individual municipal officers threaten to violate a person's rights. Concretely, a Saint Elizabeths nurse in charge of a single patient unit could decide to segregate all the patients by race for no medical reason, and no one could seek an injunction against this presumptive equal protection violation because it was not a matter of policy or a pervasive custom. That cannot be the law.

interaction). Defendants "cannot deny the [integration] right simply by refusing to acknowledge that the individual could receive appropriate care in the community. Otherwise the right would, or at least could, become wholly illusory." *Long v. Benson*, No. 08-0026, 2008 U.S. Dist. LEXIS 109917, 2008 WL 4571904, at *2 (N.D. Fla. 2008) (refusing to limit class to individuals whom state professionals deemed could be treated in the community). Accordingly, Defendants may not defeat an unjustified isolation claim simply because their employees have not yet determined that the named Plaintiffs in this matter could receive appropriate care in the community at this time.

Second, expedited and periodic evaluation for community placement of all patients in the Hospital would facilitate one of the *amici's* chief recommendations to address the pandemic—reducing the patient population—and thereby dramatically decrease the risk of exposure to COVID-19 for the Plaintiffs. *See* ECF 81-1 at 1-2. Indeed, the Supreme Court has recognized that detained persons' health does not exist in a vacuum but instead can be dramatically affected by the size of the institution's population. Specifically, in *Brown v. Plata*, 563 U.S. 493 (2011), the Supreme Court considered whether a district court had erred in ordering the release of tens of thousands of inmates in California prisons that were so overcrowded they could not provide the minimum medical or mental health services required by the Eighth Amendment. The Court observed that "[e]ven prisoners with no present physical or mental illness may become afflicted, and all prisoners in California are at risk so long as the State continues to provide inadequate care. . . . Prisoners who are not sick or mentally ill . . . are that system's next potential victims." *Id.* at 531-32.

Third, in the alternative and as discussed above, Plaintiffs have brought this case as a class action. If the Court finds that Plaintiffs as individuals do not have standing to seek an injunction

requiring the evaluation of each patient for appropriate mental health care, the Court should provisionally certify the class. *See* ECF 30.

On the merits, it is Defendants' burden to show that community placement would "fundamentally alter" its programs and services such that it would be unreasonable. *Brown*, 928 F.3d 1070 (D.C. Cir. 2019); 28 C.F.R. § 35.130(b)(7) (2019). Defendants cannot meet that burden. Defendants can only establish a fundamental alteration if they can show that the accommodation would be inequitable to other persons with disabilities or if they can "demonstrate that [they have] a comprehensive, effectively working plan for placing qualified persons with disabilities in less restrictive settings, and a waiting list that move[s] at a reasonable pace not controlled by the State's endeavors to keep its institutions fully populated," i.e., an "*Olmstead* Plan." *Brown*, 928 F.3d at 1077-78 (quoting *Olmstead*, 527 U.S. at 604).

The waiting list cannot be moving at a reasonable pace where more than 50 patients are in the Hospital at the risk of COVID-19 infection and there are housing resources available for them in the community. Defendants' filings demonstrate that there are appropriate community placements available for at least some patients and that there are further steps Defendants can take to reduce barriers to community placement. Defendants have identified several patients who could be appropriately housed and treated in Mental Health Community Residential Facilities (MHCRFs), single room occupancy apartments, or housing provided by the Department on Disability Services. ECF 90 n. 16. Defendants provide multiple housing resources, including a rent voucher for individual apartments, placement in MHCRFs, and placement in DDS housing. Gotang Decl. ¶ 26; ECF 90 at 38 (citing Canavan report, ECF 78 at 9). Moreover, to the extent that available housing is a barrier, *amici* has identified modest measure the Defendants can

immediately take to increase available housing for those determined to be ready for community placement. ECF 78 at 10.

Defendants' reliance on *Seth v. District of Columbia* to assert that Plaintiffs must show that the discrimination was solely based on the plaintiff's disability, Opp. 39, continues to be misplaced. *See* ECF 46 at 15-16. *Seth* addressed an entirely different issue – whether the District had an obligation to accommodate a prisoner in federal custody for whom the District had no obligation to assume custody. *Seth v. District of Columbia*, No. 18-cv-1034 (BAH), 2018 WL 4682023, at *10 (D.D.C. Sept. 28, 2018) There can be no dispute that the Plaintiffs are confined to the hospital because of their disability and for no other reason;"[u]njustified isolation of persons with disabilities is a form of discrimination." *Brown*, 928 F.3d at 1077. Indeed, Plaintiffs are only subject to discriminatory isolation by Defendants because Defendants have determined that they require inpatient psychiatric treatment because of their disabilities. ECF 39-6 (Costa Decl.) ¶ 1; ECF 39-7 (Dunbar Decl.) ¶ 1; Smith Decl. (ECF 39-8) ¶ 1 (Plaintiffs are each indefinitely, involuntarily civilly committed to Saint Elizabeths Hospital for psychiatric care).

2. Defendants Have Caused Irreparable Harm to Plaintiffs. Defendants do not dispute that the violation of Plaintiffs' constitutional and statutory rights is, as a matter of law, sufficient to establish irreparable harm. *See* Mot. 33; Opp. 40-43. Instead, they argue that because they took certain measures "well before plaintiffs amended their complaint," "voluntarily implemented several recommendations proposed by the Court-appointed *amici*," and are complying with the "measures the Court has ordered," there is no "irreparable harm that is likely and imminent absent court-ordered relief." Opp. 40. Nowhere in this recitation do Defendants acknowledge or otherwise address that (i) the number of COVID-19 cases at the facility continues to mount, (ii) *amici* concluded that "as of the date of the filing of this report on May 11, 2020, [the

Hospital] continues to experience ongoing transmission of SARS-CoV-2," ECF 81 at 2, (iii) Plaintiffs and other patients at the facility continue to be exposed to risk of contracting COVID-19, and (iv) one of the Plaintiffs has contracted COVID-19. As the Court has recognized, "the imminent risk to [Plaintiffs] health . . . also constitutes an irreparable injury." ECF 59 at 16-17.

Defendants also do not address that even if Plaintiffs faced no future risk of contracting COVID-19—which Defendants have not established—the "'court's power to grant injunctive relief survives discontinuance of the illegal conduct,' and because the 'purpose . . . is to prevent future violations,' injunctive relief is appropriate when there is a 'cognizable danger of recurrent violation.'" *U.S. Dep't of Justice v. Daniel Chapter One*, 89 F. Supp. 3d 132, 143 (D.D.C. 2015) (citations omitted).

Defendants also oppose the appointment of a monitor. Opp. 42. Plaintiffs request a monitor whose charge would be "to conduct such factual investigations as are necessary to measure the Defendants' efforts at compliance with the preliminary injunction and Defendants' efforts to implement *amici* recommendations," and to file reports with the Court. ECF 87-1 at 39-40. Defendants claim that such an appointment is proper "only in the most 'unusual circumstances,'" Opp. at 42 (quoting *Women Prisoners of District of Columbia Dep't of Corr. v. District of Columbia*, 93 F.3d 910, 930 (D.C. Cir. 1996)), and when it "is really the only remedy left for the Court." *Id.* at 42 (quoting *Dixon v. Barry*, 967 F. Supp. 535, 550 (D.D.C. 1997)). But the cases Defendants cite have nothing to do with the appointment of a monitor. *Women Prisoners* involved the appointment of a "Special Officer" who "perform[ed] the functions of local authorities," and had power (among other things) to order the warden to impose discipline on employees. As the Court of Appeals pointed out, the Special Officer and his staff were "monitors in name only." 93

F.3d 910 at 930. *Dixon* involved the appointment of a *receiver* to operate the Commission on Mental Health Services and to "restructure" the agency. *Dixon*, 967 F. Supp. at 555.

The Court's authority to appoint a *monitor*, by contrast, is well established and appropriate here: "'Monitors are appropriate if the remedy is complex, if compliance is difficult to measure, or if observation of the defendant's conduct is restricted.'" *Cobell v. Norton*, 392 F.3d 461, 477 (D.C. Cir. 2004) (quoting Special Project, *The Remedial Process in Institutional Reform Litigation,* 78 Colum. L. Rev. 784, 828 (1978)). In particular, "When the defendant is a closed institution, such as a prison or mental hospital, observing compliance may be difficult, and then monitors will be appropriate." Special Project, 78 Colum. L. Rev. at 828 (citing *N.Y. State Ass'n for Retarded Children, Inc. v. Carey*, 393 F. Supp. 715 (E.D.N.Y. 1975) (mental hospital) and *Hamilton v. Landrieu*, 351 F. Supp. 549, 550 (E.D. La. 1972) (prison)). Thus, for example, in a case involving a state's failure to provide proper treatment to individuals with intellectual and developmental disabilities in nursing facilities, the court appointed "a monitor who can oversee compliance in a much more timely manner than the court itself," *Rolland v. Patrick*, 483 F. Supp. 2d 107, 118 (D. Mass. 2007). And in a case involving discriminatory hiring and promotion tests in a fire department, the court appointed a monitor "who will be responsible for apprising the court on a monthly basis of the defendants' compliance with the terms of [the court's] order." *United States v. City & Cty. of San Francisco*, 656 F. Supp. 276, 29293 (N.D. Cal. 1987). Here, too, a monitor would enable the Plaintiffs and the Court to remain informed, in a timely manner, regarding Defendants' compliance with a preliminary injunction and regarding conditions at the Hospital.

3. The Remaining Factors Favor Plaintiffs. Finally, Defendants' arguments regarding the public interest and the balance of harms all rely on the premise that Defendants are responding appropriately to the crisis and indeed that they are "already doing most of what

plaintiffs seek." Opp. 43-44. Because this premise is incorrect, as demonstrated above, these factors favor Plaintiffs, not Defendants.

Moreover, the proposed order is well-crafted to permit "the government to carry out its authorized functions." Opp. 44. The proposed injunctive relief balances the need for court intervention to remedy the constitutional and statutory violations of Plaintiffs' rights with deference to the judgment of treating professionals, for example by requiring evaluations of all patients so that the treatment teams can craft appropriate treatment plans and prepare patients for discharge and by developing a plan to deliver mental health services during COVID-19.

CONCLUSION

The evidence before the Court from *amici*, Plaintiffs, and other witnesses, combined with the ongoing spread of COVID-19 cases at the Hospital, shows overwhelmingly that Defendants' practices and failures are continuing to expose Saint Elizabeths patients to grave risk and are badly out of step with appropriate medical guidance. The preliminary injunction should be granted.

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Respectfully submitted,

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