[NOT YET SCHEDULED FOR ORAL ARGUMENT]

No. 20-7055

IN THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

ENZO COSTA, et al.,

Appellees,

v.

BARBARA BAZRON, et al.,

Appellants.

On Appeal from the U.S. District Court for the District of Columbia (No. 1:19-cv-03185-RDM) (Hon. Randolph D. Moss, District Judge)

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CERTIFICATE AS TO PARTIES, RUILINGS, AND RELATED CASES

A. Parties and *Amici*

Pursuant to Circuit Rule 28(a)(1), Plaintiffs-Appellees Enzo Costa, Vinita Smith, and William Dunbar certify that the parties and *amici curiae* in this case are as follows:

Enzo Costa, Plaintiff-Appellee

Vinita Smith, Plaintiff-Appellee

William Dunbar, Plaintiff-Appellee

Barbara J. Bazron, Defendant-Appellant, in her individual capacity

Mark J. Chastang, Defendant-Appellant, in his individual and official capacity as Chief Executive Officer of Saint Elizabeths Hospital

District of Columbia, Defendant-Appellant

Ronald Waldman, *Amici*

Joan Hebden, *Amici*

Patrick Canavan, *Amici*

B. Rulings Under Review

The ruling under review is the district court order granting in part Plaintiffs'-Appellees' motion for preliminary injunction against Appellants. Judge Randolph D. Moss of the D.C. District Court issued the order and opinion on May 24, 2020. The order and opinion are entries 95 and 96 on the district court docket and are

available in the Joint Appendix at JA873-908 and JA909-911. The opinion granting in part Appellees motion for preliminary injunctions is published at *Costa v. Bazron*, 464 F. Supp. 3d 132 (D.D.C. 2020).

C. Related Cases

This case has not previously been before this Court or any other court. Undersigned counsel is unaware of any related cases pending in this Court or any other court.

/s/ John A. Freedman
John A. Freedman

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GLOSSARY

CDC	U.S. Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease
DBH	Department of Behavioral Health
HCP	Health Care Practitioners
Hospital	Saint Elizabeths Hospital
PPS	Point Prevalence Survey
TLC	Therapeutic Learning Center

STATEMENT OF THE ISSUES

Plaintiffs are three patients at Saint Elizabeths Hospital ("Hospital") who initially filed this suit on behalf of a class of all patients following discovery of Legionella bacteria in the water supply and a prolonged water shutoff, then amended to challenge Defendant's disastrous response to the COVID-19 pandemic.

COVID-19 spread at an exponential rate in the Hospital; the *mortality rate among patients was 40 times higher than in the community*. JA 301-302, 327. The number of patients with COVID-19 had grown from 1 on April 1 to 33 on April 16, when Plaintiffs moved to amend their complaint and for a temporary restraining order. By the time the Court entered the preliminary injunction on May 24, 79 patients were infected and 13 had died.

The Defendants' brief barely acknowledges the extent of illness and death at their Hospital. But this tragedy was not inevitable. The failure to contain the contagion and the ensuing deaths were the direct result of decisions by Defendants, who, as the district court found, delayed implementation of, or misapplied, Centers for Disease Control (CDC) guidance on infection control, testing, and quarantine, and departed from professional standards so significantly as to show a lack of professional judgment.

Notably, in the ten months that the Hospital has been complying with the measures required by the preliminary injunction, the rate of transmission within the

Hospital has plummeted; only a handful additional patients have contracted COVID-19. Meanwhile, Defendants have never complained to the district court that the preliminary injunction imposes any undue burden, or requested that the injunction be modified in any way.

The issues presented are, whether the district court made clearly erroneous findings of fact or abused its discretion:

1. in concluding that Plaintiffs showed a likelihood of success on the merits where the district court found Defendants so grossly departed from professional standards in responding to the pandemic as to demonstrate professional judgment was not exercised?

2. in concluding that suffering violations of their constitutional rights and unnecessary exposure to COVID-19 was an irreparable harm?

3. in concluding injunctive relief was in the public interest where the Defendants' gross departure from the standards of care led to 13 patient deaths?

COUNTER-STATEMENT OF FACTS

The Defendants' statement of facts is incomplete, highly selective, and fails to accurately portray conditions at the Hospital or Defendants' actions. Defendants misleadingly jumble together their actions at various points in the litigation, most notably by taking credit for subsequent remedial measures taken only in response the district court's orders. Because the chronology is important, Plaintiffs (after

providing a brief background) describe conditions at the Hospital during four critical periods: (1) prior to the entry of the temporary restraining order on April 25, 2020; (2) through expansion of the TRO on May 11, 2020, (3) through entry of preliminary injunction on May 24, 2020; and (4) following entry of the preliminary injunction.

1. Background

The Hospital is the District's only public psychiatric facility for individuals with serious and persistent mental illness who need intensive inpatient care to support their recovery. JA 504-505. Prior to the COVID-19 crisis, the Hospital had an average patient population of 275. JA 505. On April 14, 2020, the patient population was 237. JA 234 ¶32.

Hospital patients are typically housed in one of 11 units. JA 234 ¶33. The units consist of bedrooms (some double occupancy) and common spaces. JA 234 ¶33.

Plaintiffs are three patients involuntarily committed to the Hospital. Plaintiffs initially filed suit on October 23, 2019 on behalf of a class of all Hospital patients following the discovery of Legionella bacteria in the water supply and the resulting 28-day water shut-off, during which the facility failed to maintain basic patient hygiene and safety standards. JA 230 ¶6; 255-264 ¶¶131-188. When Defendants similarly failed to maintain safe conditions during the COVID-19 pandemic, Plaintiffs amended their claims accordingly.

Starting in early 2020, the U.S. Centers for Disease Control and Prevention (CDC) issued guidance for COVID-19 response in congregate facilities, including long-term care facilities, nursing homes, and correctional facilities. JA 242-247 ¶¶66-77; 38-39 ¶¶16(a)-(f); 372-398; 405-433. In congregate facilities, like the Hospital, residents live in close quarters. Most Hospital residents have been involuntarily committed to care and cannot freely leave. JA 234-235 ¶¶34-36.

Although the CDC refined its guidance over time, it consistently prescribed basic measures for congregate facilities to take to prevent the spread of COVID-19, including monitoring (such as testing and temperature screening, JA 408; 410; 420; 422; 720A), preventive measures (such as mask use, social distancing, population reduction, JA 411; 421), and containment measures (medical isolation, quarantine, and dedicated staffing) once persons in a facility reported symptoms or contracted COVID-19. JA 410-411; 424-428.

The CDC has also issued guidance for non-congregate facilities (i.e., those in which people do not reside for extended periods of time), including health care facilities such as hospitals, doctor's officers, and outpatient clinics. *See, e.g.,* JA 373-386. That guidance does not discuss containment measures; rather, it provides that persons with COVID-19 (staff, visitors, and patients) should be kept out of the facility unless they require hospitalization. *See, e.g.,* JA 381 ("[i]f hospitalization is not medically necessary, home care is preferable"). *See also* JA 383-384.

Defendants' inexplicable and inordinate focus on guidance for *non*-congregate healthcare settings, JA 439-442, had disastrous consequences.

2. Prior to the Entry of the Temporary Restraining Order on April 25, Defendants Endangered Patient Lives

Until the TRO was entered, Defendants' practices dramatically—and with deadly consequences—departed from the relevant CDC guidance in critical areas. Plaintiffs presented evidence and the district court found that the Hospital was substantially departing from professional standards in its: (1) efforts to quarantine and isolate COVID-positive and suspected patients; (2) COVID testing; and (3) mask use and social distancing. JA 516-519. In these areas, the Hospital adopted CDC prescribed measures either too little, too late, or not at all. Most problematically, the Defendants misunderstood basic principles of quarantining so badly that they grouped COVID-positive patients with the general population and they grouped patients awaiting COVID test results together—thus exposing uninfected patients to COVID-positive ones. JA 516-517; 883-887.

Plaintiffs' counsel wrote to Defendants twice in mid-March inquiring about precautions at the Hospital. JA 241 ¶58. Defendants responded that they had implemented an emergency-preparedness plan on March 12 and that as of March 18, no patients or staff were infected. JA 241 ¶62; 861-862. On April 1, 2020, one patient and five staff members were confirmed as COVID-positive. JA 241 ¶64. On April 2, Plaintiffs sent a follow-up letter reiterating that patient population should be

reduced and aggressive steps taken to protect patients. JA 241-242 ¶64. On April 9, Plaintiffs sent a further follow-up letter. JA 241 ¶64. Defendants did not substantively respond prior to the filing of the amended complaint on April 16. JA 241 ¶64.

By April 16, when Plaintiffs requested an emergency hearing, Plaintiffs' investigation (which resulted in eight fact declarations, discussing fourteen separate patients, and three expert declarations) disclosed that the Hospital had significantly departed from CDC guidance for congregate care settings. JA 35-40; 57-72; 242-253 ¶¶66-122. Defendants' opposition to the temporary restraining order (ECF 42) confirmed that the Hospital was not following CDC guidance for congregate facilities on key preventive, monitoring and containment measures. The reason was clear: Defendants were following CDC guidance for *non*-congregate healthcare settings, and did not believe certain CDC guidance for congregate settings was applicable to Saint Elizabeths. JA 361-367; 372; 435-446.

Medical Isolation and Quarantine: At the time Plaintiffs sought a TRO, the CDC guidance for congregate settings provided that:

- If there has been an outbreak of COVID-19 in the community surrounding the facility, residents with suspected COVID-19 should be isolated "in a private room with their own bathroom," and that if the "facility cannot fully implement all recommended precautions" residents with "known or suspected COVID-19 . . . should be transferred to another facility that is capable of implementation," and that "while awaiting transfer, symptomatic residents should . . . be separated from others." JA 243-244 ¶69; 410-411.

- When there are cases in a facility, ill residents should be housed in a dedicated space with dedicated health care professionals. JA 244 ¶70; 410; 425.

- When there are cases in a facility, "every possible effort should be made to place suspected and confirmed COVID-19 cases under medical isolation individually" and "cohorting [i.e., grouping] of COVID-19 positive or symptomatic patients should only occur if there are no other available options" because "cohorting multiple quarantined close contacts of a COVID-19 case could transmit COVID-19 from those who are infected to those who are uninfected." JA 222 ¶¶6-8; 244-246 ¶¶70-74; 410; 424-425.

- When there are cases in a facility, patients should be restricted to their rooms, and if they leave their rooms, they should wear a mask. JA 222 ¶6; 244 ¶70; 411; 424.

- Individuals in medical isolation should stay in isolation until free from fever for 72 hours with improvement in other symptoms and (i) they receive two negative tests, or (ii) seven days had passed since their first symptom or positive test. JA 222 ¶7; 425.

In seeking a TRO, Plaintiffs submitted first-hand accounts that the Hospital was not properly segregating COVID-positive individuals. At that time, Defendants had established one unit with 7 beds to quarantine COVID-positive patients, JA 250 ¶100; 64 ¶3a, but there were already 33 reported patient cases at the hospital, JA 229 ¶3, so the Defendants were not segregating all COVID-positive patients. Plaintiffs' declarations showed that patients who tested positive continued to be housed in the general patient population or with patients waiting for test results. JA 61 ¶¶5(a-b); 224 ¶5; 226 ¶4; 360 ¶4.

Similarly, the Hospital was not segregating *suspected* patients (*i.e.,* with symptoms, exposed to COVID-positive patients, or awaiting test results), who

continued to be housed in close quarters together with non-symptomatic individuals. JA 59 ¶6; 61 ¶¶5(a-b)-6; 71 ¶4, 224 ¶¶5-6, 226 ¶4; 360 ¶4; 249-251 ¶¶97-99, 104-107. Cohorting (grouping) individuals waiting for test results placed COVID-negative patients at greater risk by exposing them to potentially COVID-positive patients. JA 222 ¶¶5-8.

Defendants did not dispute this; they admitted that patients awaiting test results were cohorted together in their "Persons Under Investigation" unit. JA 129 ¶7; 310-311. *See also* JA 728 ¶4. In fact, the Hospital's Infection Control Coordinator would later admit that the Hospital only started to "isolate" patients in the PUI unit "two to three patients at a time," (JA 771 ¶8) when, at the time, the Hospital had well over 100 patients who were symptomatic or exposed. ECF 46 at 8.

Defendants did not explain why housing symptomatic patients together where they could expose each other was consistent with CDC guidance or professional judgment, nor did Defendants address their failure to isolate patients after they tested positive. One of the two COVID-positive units Defendants identified (Unit 2A) was Plaintiff William Dunbar's unit, and he averred that until April 15, he was housed with four patients who had tested positive and "interacted with us in the common areas." JA 61 ¶5(a-b). (Mr. Dunbar subsequently contracted COVID-19 while he was housed with patients from other units. JA 436-437.) Plaintiffs submitted

declarations discussing two other patients on Unit 2A who both reported that positive and symptomatic patients continued to be housed with asymptomatic patients as of April 22. JA 224 ¶¶5-6.

Although CDC prescribed that patients with COVID-19 should have "dedicated health care professionals," JA 410, the submission from Defendants' Chief Nurse and Medical Director did not address dedicated staffing at all. JA 73-76; 121-126.

Testing: When Plaintiffs sought the TRO, CDC Guidelines for congregate settings called for temperature screening and/or testing for both symptomatic and asymptomatic persons. JA 38-39 ¶16c; 246 ¶75; 410, and stated that "residents with suspected COVID-19 should be prioritized for testing," JA 410. On May 1 (while the TRO was in effect), the CDC issued further guidance that congregate facilities should conduct a "point prevalence survey (PPS) of all residents and all [staff] in the facility." JA 720A-720B.

In seeking the TRO, Plaintiffs submitted first-hand patient accounts that they did not observe testing at the hospital, and patients were not being tested even when they displayed characteristic symptoms or had been exposed to COVID-positive patients. JA 60 ¶13; 61 ¶¶5b, 6, 8; 63 ¶11; 64-65 ¶¶3b-c; 71 ¶3a; 249-251 ¶¶96, 103, 108. *See also* JA 728 ¶4. These accounts are consistent with what Court-appointed

amici later noted: although the Hospital had its first suspected case on March 20, testing was "delayed." JA 696.

Defendants did not dispute this. Defendants' evidence reflected that they did not begin testing patients until April 6, and tested just 31 patients by April 21, JA 130 ¶11. The Hospital only "began the process of testing entire patient units" on April 24. JA 451-452; 467-468; 569 ¶1.

The Defendants' declarations did not indicate that patients with suspected COVID-19 had been prioritized for testing in accordance with CDC guidance, and the reported number of patients tested was far fewer than the 144 patients publicly reported by the Hospital on April 12 as being "in quarantine or isolation due to exposure to or symptoms consistent with COVID-19." ECF 46 at 8.

Social Distancing and Mask Use: At the time Plaintiffs sought the TRO, the CDC guidance for congregate care facilities provided that if there is a community outbreak, the facility should cancel communal dining and all other group activities; ensure all staff wear facemasks at all times; and ensure "symptomatic residents" wear facemasks and "be separated from others." JA 243-244 ¶69; 408; 411. In addition, if there are COVID-19 cases in the facility (as there were at the Hospital), the universal use of facemasks should be implemented, including having residents wear a mask and stay six feet away from one another "whenever they leave their rooms." JA 244 ¶70; 411.

In response to the outbreak at the Hospital, Defendants did not cancel communal dining, close common facilities, or encourage social distancing. In conjunction with seeking the TRO, Plaintiffs submitted numerous first-hand accounts that patients were still using the same common spaces, and efforts to encourage social distancing were negligible. JA 59 ¶4; 61 ¶¶5, 5b; 63 ¶¶5-6; 64-65 ¶3b; 67-68 ¶5; 69 ¶¶4a-b; 247-249 ¶¶78, 82, 85, 89, 94. Defendants did not rebut these first-hand accounts. Rather, Defendants argued that staff did "as much as they" could to enforce social distancing, but supported this assertion with only a single declaration that vaguely represented staff had been "trained to practice and enforce social distancing," not that social distancing was actually being enforced. ECF 42 at 11 (citing JA 123-124 ¶9).

Nor did Defendants make masks available to patients or require mask use for staff or patients. Although Defendants reported the DC Department of Health promulgated rules requiring that all residents be provided with facemasks, ECF 42 at 11, there is no record evidence Defendants were meeting this requirement. Rather, Plaintiffs submitted numerous first-hand accounts that, contrary to guidance, Defendants failed to distribute masks to patients or staff, failed to provide masks to symptomatic patients, failed to require staff mask use, and failed to require patients to wear masks. JA 59 ¶7; 61 ¶5d; 63 ¶9; 64-66 ¶¶3b-c; 67-68 ¶5; 69 ¶4a; 225 ¶¶7-9; 226 ¶5; 247-249 ¶¶79, 83, 87, 91, 95. Defendants' declarations did not show the

contrary; instead, they stated that masks could be requested from the nurse's station. JA 202 ¶8; 125 ¶13. And rather than requiring residents wear a mask "whenever they leave their rooms"–as the CDC guidance required –Defendants merely stated that "[s]ome patients choose to wear masks, others do not." JA 125 ¶13.

During a phone call between the parties on April 23, Defendants acknowledged for the first time that their response to the pandemic was primarily based on the CDC's guidance for *non-congregate* healthcare settings (*i.e.,* doctors' offices, and outpatient clinics) rather than the guidance for congregate settings (like the Hospital). JA 439-442. The Defendants admitted that the "Persons Under Investigation" unit was only established after the Plaintiffs requested a TRO, that patients were being released from the "Persons Under Investigation" unit based on only one negative test, and that Defendants had just overhauled their practices the previous weekend (*i.e.,* April 19) following a site visit from the CDC. JA 129 ¶7; 363-364; 437-446.

When Plaintiffs sought a TRO on April 16, 2020, at least 33 Hospital patients, as well as at least 51 staff, had tested positive for COVID-19, and four patients had died. By the time briefing was completed six days later on April 22, there were 100 individuals (59 staff and 41 patients) who were COVID-19 positive—and six patients and one staff had died. By the time the TRO was entered on April 25, Plaintiff Dunbar had tested positive, JA 436-37, the Hospital reported there were

115 COVID-positive individuals (69 staff and 46 patients), and a seventh patient had died. JA 503.

3. *Amici* Find Defendants Failed to Comply with Professional Standards and Had Not Stopped COVID-19 Transmission

On April 25, 2020, the district court entered a TRO, requiring Defendants to implement two sets of essential changes to comply with CDC guidance, and to report on compliance efforts. JA 525-527. The relief was tailored to address the issues Plaintiffs had identified as the most critical life-saving measures – the failure to medically isolate exposed or symptomatic patients, and the Hospital's policy of releasing patients from quarantine based on a single negative test result. JA 525-526 ¶¶1-2. The district court found Defendants' quarantining practices and their standard for determining when to release individuals from isolation did not comply with CDC standards, "substantially departed from accepted professional standards," and the resulting risk to patients was "immediate and manifest." JA 516-520.

On May 1, 2020, the district court appointed as *amici curiae* three professional experts (mutually agreed upon by the Parties, JA 556-558) to investigate and report about conditions at the Hospital. JA 559-564. *Amici* comprehensively examined the Hospital's protocols, disease control and prevention measures, efforts to reduce population, and provision of mental health care (JA 554), and submitted their reports on May 11. JA 667-711.

Amici reported that as of "May 11, 2020, [the Hospital] continues to experience ongoing transmission of SARS-CoV-2." JA 695. Ongoing transmission was evident from the growing number of COVID-19 positive staff and patients: since the entry of the TRO, COVID-19 positive patients had increased from 46 to 79, COVID-positive staff had increased from 69 to 84, and Defendants reported that an additional 56 patients were in quarantine due to exposure or symptoms. The number of patients who had died had increased from 7 to 13. ECF 87 at 4, n. 4-6.

Amici explained that the increase in cases and deaths resulted from the Hospital's continued significant departures from professional standards in several critical areas, documenting numerous, critical deficiencies in the Hospital's response.

Regarding Defendants' implementation of quarantine and medical isolation procedures, *amici* documented Defendants' ongoing noncompliance with CDC standards. JA 578, 697. *Amici*'s observations were consistent with patient accounts. *See, e.g.,* JA 728 ¶4 (describing patient on May 5 watching TV and playing video games with other residents while awaiting test results, which turned out to be positive); JA 737 ¶6 (patient not moved to isolation while waiting test results); JA 739 ¶¶6-10 (positive patient describing four transfers since testing positive). *Amici*'s observations were also consistent with the Hospital's reports of ongoing spread after entry of the TRO, which included four separate incidents in which positive cases

emerged from units that had been considered COVID-negative. JA 554-555 (12 patients on TLC unit); 695 (2 patients on Unit 1D); 695 (4 patients on Unit 1G); 707-708 (patients released from the Persons Under Investigation unit infected other units).

Consistent with these observations, *amici* also found that Defendant failed to implement the CDC guidance regarding dedicated health care staff, which "should be assigned daily to only one unit." JA 708-709. *Amici* emphatically warned that the Hospital was not assigning dedicated staff: "in regard to traffic within the hospital itself . . . this has not been respected: there should be no mixing of staff between these units." JA 580-581. *Amici* also reported that COVID-19 had spread to two previously uninfected units (1D and 1G) likely because of cross-staffing contamination. JA 697; 574; 581.

Amici also observed that Defendants failed to follow CDC guidance on screening and testing strategies, particularly the failure to require a baseline "point prevalence" testing of staff. *Amici* advised the Court that the Defendants were "not testing internally at the facility of any staff," JA 591, that there needed to be a "much, much more aggressive testing strategy," JA 581-582, and later wrote "the greatest impediment" to stopping contagion was staff, and that "in full concordance with CDC guidelines, a point prevalence survey (PPS) of ALL [staff] should be

conducted as soon as possible in order to be able to determine whether any are currently COVID+" and weekly re-testing should be adopted. JA 709-710.

Amici also observed, that notwithstanding CDC guidance calling for "a point prevalence survey (PPS) of all residents," Defendants did not conduct widespread patient testing until May 4–5, JA 697; notably, the limited testing that had occurred was not a point prevalence survey, because it did not cover patients in the two non-quarantine "clear" units (2A and 2B). In light of this, *amici* recommended changes to the Hospital's patient testing protocols (that testing "be done on a weekly basis until no patients have positive test results. After all patients have tested negative ... a second test should be conducted 72 hours later"). JA 707.

Amici also noted that Defendants failed to comply with CDC guidance on mask use, JA 600; 604, the use of non-CDC compliant hand sanitizer, JA 699, and poor hand hygiene. JA 608; 699.

In light of the concerns expressed by *amici*, Plaintiffs requested the district court extend and expand the temporary restraining order to, among other things, require point prevalence testing and order measures to require staff to be dedicated to either COVID-positive or COVID-negative wards. JA 653-658.

On May 11, 2020, the district court extended the TRO based on *amici*'s findings. Given *amici*'s report that staff "likely contribute to the introduction and further spread" of COVID-19, JA 716-718, the court ordered Defendants to

complete a baseline point prevalence survey and to repeat testing of all patients and staff periodically. JA 722. And given the Hospital's failure "to abide by the CDC guidelines" requiring "dedicated [health care staff] to COVID positive or suspected units," JA 718-719, the court ordered that "to the extent medically and psychiatrically practicable, health care personnel and other staff shall be assigned daily to only one unit." JA 722.

4. Prior to the Entry of the Preliminary Injunction, Defendants Fail to Explain their Significant Departures from Professional Standards

On May 14, 2020, Plaintiffs moved the district court to convert the TRO to a preliminary injunction and, consistent with *amici*'s recommendations, to order measures to reduce the patient population and improve the provision of mental health care. ECF 87 at 37.

In opposing the preliminary injunction, Defendants failed to address numerous facets of their failure – past and current – to comply with minimum professional standards.

With respect to medical isolation and quarantine, the Defendants did not challenge that prior to entry of the TRO, they were housing symptomatic or exposed patients with non-symptomatic individuals. Rather, the Defendants' Infection Control Coordinator reported that the Hospital "isolated two to three patients" with potential COVID symptoms "at a time" in the Persons Under Investigation unit –

i.e., a small fraction of such patients. JA 771 ¶8. Defendants did not isolate these patients until after the TRO motion was filed, when the Defendants reported they had started a practice of "treating all units as quarantined." JA 516, 539 ¶5. Even then, as *amici* noted, implementation was poor. JA 578; 697. Multiple patients reported that patients awaiting test results or who had tested positive were kept with other patients, JA 728 ¶4; 737 ¶6.

Similarly, the Defendants did not dispute that, prior to the entry of the expanded TRO on May 14, they had failed to provide dedicated staff to COVID-positive or symptomatic patients. JA 580-581; 574; 697. Defendants also did not address the issue of mixing staff between different units at the Hospital, although the *amici* had been "emphatic in saying that . . . there should be no mixing of staff between these units," and that "staff is the most likely source of continued infection spread at Saint Elizabeths." JA 718.

With regard to testing, the Defendants did not dispute that prior to the entry of the expanded TRO on May 14, the Hospital was not timely or routinely testing patients or staff with COVID-19 symptoms, or individuals who had been exposed to COVID-19. JA 60 ¶13; 61 ¶8; 63 ¶¶8, 11; 130 ¶11; 331-333. Defendants were also not complying with CDC guidance to conduct point prevalence surveys of patients and staff. *Amici* explained that a point prevalence survey is one where "you test everyone at the same time" so that there is a full snapshot of viral spread. JA 587;

581-82. As the district court found, "Initial and recurring PPS testing is important because undetected, asymptomatic patients and health care practitioners often contribute to the further spread of the virus." JA 895. But, *amici* reported on May 7, the Hospital "was not [conducting] testing internally at the facility of *any* staff" and *amici* also reported that as of May 11, only 100 of the 786 staff had submitted proof of outside testing, JA 591; 696; 709-710. Moreover, Defendants did not comply with CDC guidance that the point prevalence survey should cover "all residents" ; rather, *amici* noted that the May 4 and 5 Hospital testing effort only involved 87 patients covering seven units, leaving out units that had previously been deemed "clear." JA 697; 709-710. In response, the Defendants acknowledged that the Hospital had only been testing patients "one unit at a time," and Defendants did not complete a point prevalence survey (*i.e.,* including staff) until May 15, JA 772-773 ¶¶13, 16, after the Hospital was directed to do so in the expanded TRO.

By the time preliminary injunction briefing was complete the number of individuals infected with COVID-19 at Saint Elizabeths had more than doubled since Plaintiffs had sought emergency relief, from 84 on April 16 (33 patients and 51 staff) to 187 on May 17 (79 patients and 108 staff). During that time, the number of people affiliated with the Hospital who died from COVID-19 had more than tripled, from 4 to 14 (13 patients and one staff).

5. Following Entry of the Preliminary Injunction, the Court-Directed Measures Stopped the Spread of COVID and Patient Deaths

On May 24, the district court converted certain aspects of the TRO into a preliminary injunction, but denied Plaintiffs' other requests for preliminary relief. JA 873-911. The district court specifically ordered Defendants "to the extent medically and psychiatrically practicable" to place patients exposed to COVID-19 in individual quarantine, to assign staff to only one unit, to complete the point prevalence study and re-test every two weeks, and to provide a report on implementation of other recommendations of *amici*. JA 909-910. In support of this order, the district court made numerous factual findings that Defendants substantially departed from accepted professional judgment in critical aspects of their response to the pandemic and that these departures needlessly placed patients at risk. JA 516-518; 717-718; 880; 887; 890-891; 896-897. In particular, the district court found:

- "Defendants' infectious disease control and prevention measures. . . substantially departed from accepted professional judgment." JA 880;

- "Defendants' implementation of the quarantine does not satisfy CDC standards." JA 886 (citing JA 516 and discussing "Defendants fail[ure] to explain what professional judgment would support housing individuals exposed to the virus in the same space, without isolating patients from one another within that space to prevent those who were positive from infecting those who were not") (emphasis omitted);

- "The Hospital's unexplained failure to implement appropriate restrictions on staff assignments constituted a substantial departure from professional

judgment." JA 889-890 (discussing *amici*'s findings (JA 718-719) on risk of "re-introduction of virus from the outside community" and "the Hospital must reduce staff movement between COVID positive and COVID negative units");

- "Defendants own actions following the Court's order support the conclusion that the exercise of acceptable professional judgment requires restricting cross-unit staff movement." JA 891-892 (discussing *amici*'s report that Hospital efforts on cross-unit movement are "a recent development" and the Hospital "needs to pay a lot more attention to it");

- "Defendants' delay in testing all staff and their lack of a plan to continue testing all patients and staff constitutes a substantial departure from professional judgment." JA 895-897 (discussing *amici*'s report that the "need for PPS testing – and, in particular, testing staff who have contact with the outside community – is essential to stemming the spread of the disease at the hospital" and that "when the Hospital tested its staff, it identified twenty-one COVID-19 positive employees").

In the ten months since the preliminary injunction was entered, the Defendants have filed status reports on patient and staff testing every two weeks. JA 912-914; 915-916; 939-940; 941; 942-943; 944-945; 946-947; 948-949; 950-951; 952-953; 954-955; 956-957. While Defendants report that staff members continue to contract COVID-19, this has been at a dramatically lower rate than previously – approximately 24 staff through October and several dozen since then). And from the time the preliminary injunction was entered on May 25, the Defendants reported no new COVID-positive patients until August 28 (1 case), JA 949, and then no new cases until the winter surge, when they reported one case on November 6 (SA1-2), five additional cases in December (SA3-4; SA5-7), 9 cases in January (SA8-10; SA11-13) and 2 cases in February (JA 957).

At the time the preliminary injunction was entered, the district court invited the Parties to meet and confer when Defendants believed further point prevalence testing was no longer warranted, JA 910, but Defendants have never done so. Since the entry of the preliminary injunction, the Defendants have not requested the district court modify any of the terms of the injunction. Nor have Defendants advised the district court that the injunction is burdensome in any respect.

STANDARD OF REVIEW

The district court's decision to grant a preliminary injunction is reviewed for abuse of discretion; the district court's legal conclusions are reviewed *de novo* and its factual findings are reviewed for clear error. *Davenport v. Int'l Brotherhood Of Teamsters*, 166 F.3d 356, 361 (D.C. Cir. 1999). Factual findings "will not be found clearly erroneous unless the court's account of the evidence is implausible in view of the entire record and it is apparent that its findings are clearly mistaken." *Collins v. Pension Benefit Guar. Corp.*, 881 F.3d 69, 72 (D.C. Cir. 2018).

SUMMARY OF ARGUMENT

The district court correctly concluded that Plaintiffs had shown a strong likelihood of success on the merits and faced irreparable harm, and the balance of equities and the public interest favored granting relief. The decision below should therefore be affirmed.

Faced with the exponential spread of COVID-19 among Hospital patients and staff, a mounting death toll, and a mountain of evidence that Defendants delayed or misapplied infection control and prevention standards, the district court properly applied the standard from *Youngberg v. Romeo*, 457 U.S. 307 (1982), under which civilly committed individuals' rights are violated if they are subjected to conditions that do not reflect professional judgment. The Defendants repeatedly acknowledged that the CDC guidelines for congregate living facilities reflected accepted professional standards for infection control and prevention. JA 336; 372; 393-398; 510; 881. The district court made factual findings that in critical components of its pandemic response, including quarantine, testing, and staff assignment, the Defendants substantially departed from the CDC guidelines and failed to justify those departures based on professional judgments. JA 711-719; 886-887; 890; 896-897. Specifically, the district court found:

- "Defendants fail[ed] to explain what 'professional judgment' would support housing individuals exposed to the virus in the same space, without isolating patients from one another *within that* space to prevent those who were positive from infecting those who were not" JA 886. The Defendants' evidence failed to "demonstrate[] that such an evidently perilous practice was a product of professional judgment." JA 887.

- "[T]he Hospital's unexplained failure to implement appropriate restrictions on staff assignments constituted a substantial departure from professional judgment." JA 890.

- "Defendants have offered no justification sounding in professional judgment for not periodically testing all patients . . . and all staff." JA 896-897.

Each of these findings was supported by ample evidence and the reports of three court-appointed *amici* experts who were jointly selected by the parties. The Defendants have not, and cannot, establish that any of the district court's findings was clearly erroneous.

Defendants' other arguments on the merits are similarly unavailing. Defendants have not come close to showing the district court clearly erred when it found that Defendant Bazron, a final policymaker within the meaning of *Monell*, was responsible for the Hospital's deadly response to the pandemic. Instead, Defendants turn to an inapplicable standard from a different theory of municipal liability on which the district court did not rely. And the district court properly exercised its discretion in setting the scope of the injunction, which was tailored to the ongoing constitutional violations it found.

The district court's findings on irreparable harm and public interest are equally unassailable. Defendants identify no clear error in the court's findings that the deprivation of Plaintiffs' constitutional rights and unnecessary exposure to a serious and deadly disease establish irreparable harm. Nor have Defendants provided any basis to disturb the court's finding that preventing patient deaths is in the public interest. Measured against spreading contagion and rising body counts, the hypothetical burdens cited by Defendants do not warrant reversal.

ARGUMENT

I. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN FINDING PLAINTIFFS ESTABLISHED A LIKELIHOOD OF SUCCESS ON THE MERITS

The district court applied the correct legal standard, which is the objective "professional judgment standard," and Defendants' claims that the district court applied the wrong standard are makeweights to obscure that Defendants are really objecting to the district court's factual findings. *See* Part I.A, below. The district court's factual findings, in turn, are abundantly supported in the record by reports from three *amici* experts, among other evidence, and Defendants' attempts to pick at these findings do not come close to demonstrating clear error, as they must to prevail. *See* Part I.B, below. The district court's findings regarding the responsibility of the Defendants' final policymaker are likewise not clearly erroneous, and Defendants' argument that deliberate indifference was required misunderstands the theory of municipal liability on which the district court relied. *See* Part I.C., below. The Defendants' argument that the court exceeded the scope of its authority is misguided, because it proceeds from the demonstrably wrong premise that unconstitutional conduct had ceased when the court issued its injunction. *See* Part I.D, below.

A. The District Court Properly Applied the *Youngberg* Standard

1. The *Youngberg* Professional Judgment Standard Is an Objective One

The district court held, and Defendants do not contest, that the operable legal standard governing Defendants' constitutional obligations to provide care for the patients in their custody at Saint Elizabeths is the "professional judgment" standard set forth in *Youngberg v. Romeo*, 457 U.S. 307 (1982). App Br. 31. *Youngberg* held that, under the Due Process Clause, "[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish." *Id.* at 321-22. Accordingly, this Court has explained that the government "has an affirmative duty to ensure the safety and general well-being of an involuntarily committed mental patient." *Harvey v. District of Columbia*, 798 F.3d 1042, 1050-51 (D.C. Cir. 2015). Under *Youngberg*, Defendants violate that duty when the conditions to which they subject patients are "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." 457 U.S. at 323. Professional judgment, in turn, is measured by the adherence to professional standards: "Although the State has considerable discretion in determining the nature and scope of its responsibilities, it is also charged with adhering to professional norms of conduct." *Terrance v. Northville Reg'l Psychiatric Hosp.*, 286 F.3d 834,

849-50 (6th Cir. 2002). *C.f. Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 943 (N.D. Cal. 2015) (finding that noncompliance with generally accepted guidelines can amount to a heightened deliberate indifference standard).

The district court properly assessed whether Defendants used "professional judgment," and determined that they did not. The court first identified the relevant professional standards that governed—in this case, as both parties agreed, CDC guidance designed to mitigate the spread of the virus in long-term care congregate settings. JA 336 (Defendants concede at oral argument the Hospital should follow CDC guidelines); JA 372, 393-398 (Defendants submit CDC Guidelines as authoritative guidance setting the relevant professional standard). Defendants point to no clear error in the district court's findings regarding the relevant professional standard, which are entitled to deference. *See, e.g., Doe 4 ex rel. Lopez v. Shenandoah Valley Juv. Ctr. Comm'n,* 985 F.3d 327 (4th Cir. 2021) (acknowledging part of district court's role in applying the professional judgment standard includes determining what professional guidance to look at in a "particular case").

The court then examined the Defendants' explanations as to why it was within professional judgment to depart from the standards that the Defendants had acknowledged were authoritative. *See* JA 882 ("Defendants at least bear the burden of coming forward with some identified reason based in professional judgment for failing to comply with CDC COVID-19 guidance.") (citing *Youngberg*, 457 U.S. at

321 (asking "whether [the state] has exercised professional judgment in choosing what action to undertake.").

The district court found that Defendants had not presented any evidence that justified their departures from CDC guidance as professional judgments:

- "Most importantly, Defendants fail to explain what "professional judgment" would support housing individuals exposed to the virus in the same space, without isolating patients from one another *within that space* to prevent those who were positive from infecting those who were not."; JA 886;

- "Defendants have offered no evidence that cross-staffing under these dire circumstances is a product of considered professional judgment."; JA 890;

- "Notably, Defendants have offered no justification sounding in professional judgment for not periodically testing all patients." JA 896.

As discussed in Part I.B, Defendants have not come close to establishing that any of these factual findings by the district court were clearly erroneous.

Defendants direct a substantial portion of their brief to arguing "good faith." App. Br. 2, 29, 39, 48. Good faith is no defense here. Defendants' intentions are not what matter; the question is whether Defendants acted unreasonably or outside the bounds of professional judgment. *Youngberg*, 457 U.S. at 312 n.11, 323.; a*ccord Shenandoah Valley Juv. Ctr.,* 985 F.3d 327 (2021) ("a court must do more than determine that some treatment has been provided – it must determine whether the treatment provided is adequate to address a person's needs under a relevant standard of professional judgment"); *Mays v. Dart*, 974 F.3d 810, 819 (7th Cir. 2020) ("we

must analyze Plaintiffs' claim under the objective reasonableness inquiry"). *See also Harvey v. District of Columbia*, 798 F.3d 1042, 1051-52 (2015) (contrasting the *Youngberg* professional judgment standard with the more stringent deliberate indifference standard). Unlike prisoners, who face the heavier burden under the Eighth Amendment of establishing *both* the objective unreasonableness of the conditions they face *and* their custodians' deliberate indifference to those unreasonable conditions, *see Farmer v. Brennan*, 511 U.S. 825, 834 (1994) (discussing Eighth Amendment standard), civilly committed persons need only show a substantial departure from professional judgment: "*Youngberg* does not require proof of subjective intent." *Shenandoah Valley Juv. Ctr.,* 985 F.3d 327 (2021). Because civilly committed individuals like Plaintiffs have the right to objectively reasonable conditions—as measured against professional standards—good faith and the sincerity of Defendants' efforts, whether recognized by *amici* or by the district court, is beside the point. The constitutionality of Defendants' conduct rises or falls based on their use of professional judgment; in this context, the due process clause does not recognize an "A for effort."

2. Defendants' Complaints That They Were Afforded Insufficient Deference Mischaracterize the District Court's Opinion and Fail to Demonstrate Clear Error

While Defendants characterize their complaints about the district court's analysis (the supposed lack of consideration of Defendants' "efforts," of "evolving

guidance" and of the need to balance among different considerations), as "legal errors," App. Br. 32, they are, in fact, challenging the district court's factual findings, which are reviewed for clear error. *See Davenport*, 166 F.3d at 361 ("underlying factual findings [supporting a preliminary injunction are reviewed] for clear error"). As Plaintiffs detail in the next section, the court's finding that Defendants' response substantially departed from the bounds of professional judgment was well-supported by an extensive record including declarations from patients and others who witnessed conditions at the Hospital, Hospital staff, and detailed reports of expert *amici*. Defendants do not, and cannot, point to any clear error in the court's factual findings.

Meanwhile, Defendants purported "legal" objections can be quickly dispatched. Defendants argue that it was legal error for the district court not to consider the "totality of the Hospital's efforts to address the pandemic." App. Br. 32-34. In fact, however, the district court explicitly "appl[ied] the [professional judgment standard] in light of all of the relevant circumstances." JA 879. Defendants had ample opportunity to present their case, and the court considered and analyzed the numerous declarations from Hospital staff. *See* JA 880-902 (reflecting consideration of the Hospital's efforts and declarations). Defendants' comparisons to *Mays v. Dart*, 974 F.3d 810 (7th Cir. 2020), and *Hope v. Warden*, 972 F.3d 310 (3d Cir. 2020), are way off of the mark. In *Mays*, the Seventh Circuit

mostly upheld a preliminary injunction ordering COVID protections at a county jail. 974 F.3d at 814. One aspect of the relief ordered by the *Mays* district court (social distancing) was overturned because the lower court focused on a single factual finding regarding group sleeping arrangements and did not consider other mitigation measures. *Id*. at 819-20. In *Hope*, a district court entered an *ex parte* TRO relying on factual findings from a previous case and did not address any of the evidence presented in the government's motion for reconsideration—including specifically how the facility was meeting CDC guidance. *See* 972 F.3d at 328-31. Unlike these cases, the district court here properly considered the panoply of Defendants' actions and inactions, as well as the impact on patients, in determining the specific failures driving the spread of COVID. JA 880-882.

Defendants' second "legal" objection is the district court's supposed failure to consider novel and changing circumstances. App. Br. 34-35. This argument also relies on a blinkered view of the district court's opinion, which expressly applied the constitutional standard "in light of . . . the rapidly evolving demands on the decisionmakers." JA 879. Indeed, to consider the evolving situation, the district court appointed three experts, jointly selected by both parties, to inspect the facility and report to the court. Citing another court's suggestion that CDC guidance does not provide a "workable standard for a preliminary injunction," Defendants argue the district court here "mechanically appl[ied] general CDC guidance." App. Br 35.

Again, on the contrary: the preliminary injunction order was tailored to the Hospital's unique needs, *explicitly* leaving room for the Hospital's discretion and judgment in accordance with *Youngberg's* guidance. JA 909 (ordering relief "to the extent medically and psychiatrically practicable" and "to the extent possible."). The district court did not "mechanically" apply CDC guidance without room for judgments based on circumstances at the Hospital; rather, it used the CDC guidance to assess whether Defendants had sound reasons based in professional judgment for their practices. JA 881-882 (acknowledging that "[i]n the abstract, Defendants are correct that the failure to follow CDC guidance does not mean that the Hospital failed to exercise professional judgment" but "that a failure to comply with significant CDC guidance raises the question why the guidance was not followed"). And where the Defendants expressed concerns, the district court took them into account in issuing narrow relief that did not go as far as Plaintiffs requested: where the Plaintiffs and *amici* requested broader changes to the operation of the Hospital, the district court credited Defendants' concerns regarding patient care and feasibility. JA 889 (deferring to Defendants that accelerating patient discharge was not feasible); 891 (deferring to practical considerations regarding staffing); 894 (deferring to Defendants that supply shortage excused failure to test patients in accordance with CDC guidance, and judgment in allocating the tests appropriate).

This careful approach was a far cry from "mechanical" and made ample allowance for the novel circumstances.

Defendants' assertion that the district court failed to account for the Hospital's need to "balance competing considerations," App. Br. 36, is a repackaging of its other arguments regarding the flexibility to respond to changing circumstances. As noted, the district court qualified its order to address Defendants' competing needs by limiting the relief ordered "to the extent medically and psychiatrically practicable." JA 909. At bottom, Defendants complain that rather than simply grant "deference to Hospital officials," the district court, after finding constitutional violations based on the record as a whole, "decided for itself where that balance should have been struck." App Br. 36. That is, of course, what courts must do when defendants fail to comply with the Constitution—a finding that the district court here made based on a fulsome record that amply supported its conclusions, as detailed in the next section. In sum, the court did not commit any of the supposed "legal errors" that Defendants charge.

B. Defendants' Repeated Failures Were Not Based on "Professional Judgments" and Resulted in Uncontrolled Spread and Death

The district court made factual findings that the Defendants substantially departed from accepted professional judgment in numerous critical aspects of their response to the pandemic and that these departures needlessly placed patients at risk. JA 516-18; 717-18; 880; 887; 890-891; 896-897. Defendants have not demonstrated

these findings were clearly erroneous: rather, they were well-supported by the evidence presented to the district court.

Indeed, Defendants persisted in failing to meet professional standards even after it was evident that Defendants' efforts were not stopping viral spread or patient deaths. Notably, between the time the TRO was entered on April 25 and Plaintiffs' motion for a preliminary injunction on May 14, the number of confirmed COVID-positive patients among patients continued to climb, from 46 to 79, and the number of patients and staff who died doubled, from 7 to 14. ECF 87-1 at 13 & n.12. This was not the product of "professional judgment," it was the product of incompetence to a degree that in other cases has established not just objective unreasonableness, but deliberate indifference. *See, e.g., Feliciano v. Gonzalez*, 13 F. Supp. 2d 151, 208-09 (D.P.R. 1998) (defendant's "inability . . . to properly isolate cases of active tuberculosis," the "insufficient medical dormitory beds," the failure to "fully screen incoming inmates," and the failure to "provide for a sick call system that ensures access to care and that is capable of effectively handling emergencies" constituted deliberate indifference); *Shimon v. Dep't of Corr. Servs.*, No. 93-cv-3144 (DC), 1996 WL 15688, at *1 (S.D.N.Y. Jan. 17, 1996) (defendant's inability to "adequately quarantine or remove inmates and support personnel known to have active tuberculosis" constitutes deliberate indifference); *Hernandez v. Cnty. of Monterey*, 110 F. Supp. 3d 929, 943 (N.D. Cal. 2015) ("known noncompliance with generally

accepted guidelines for inmate health strongly indicates deliberate indifference to a substantial risk of serious harm"); *Joy v. Healthcare C.M.S.*, 534 F. Supp. 2d 482, 485 (D. Del. 2008) (prison violated the Eighth Amendment where "inmates were not thoroughly screened for disease before going into general population"). *See also Youngberg*, 457 U.S. at 321-22 ("[p]ersons who have been involuntarily committed are entitled to more considerate treatment and conditions of confinement than criminals whose conditions of confinement are designed to punish.").

Defendants substantially departed from CDC guidance and accepted professional judgments in their response to COVID-19, and do not address the significance of the interplay among these failings, or the continued increase in COVID-19 positive cases and patient deaths at the Hospital prior to entry of the preliminary injunction.

1. Isolation and Quarantine

In support of their positions below, the Defendants represented at oral argument that the Hospital "should be doing what is consistent with the CDC guidance," JA 336, conceded that the Hospital should follow CDC guidelines, JA 510, 881, and submitted the CDC guidance *Long-term Care Facilities, Nursing Homes* as establishing the relevant professional standard. JA 372, 393-398. This guidance provides that when there are COVID-positive persons in a facility, they should be housed in a "dedicated space," JA 410, "residents with known or suspected

COVID-19 … should, ideally, be placed in a private room," facilities should "restrict residents (to the extent possible) to their rooms," and if residents leave their rooms, "they should wear a cloth face covering or facemask." JA 410-411.[1]

The district court found, and the Defendants do not dispute, that the Hospital was not complying with this guidance prior to the filing of the motion for and at the time of the entry of the TRO. As the district court noted, the Defendants' belated policy (adopted on April 19, after plaintiffs sought a TRO) of "treating all units as quarantined" did not reflect reality:

> Plaintiffs have offered compelling evidence . . . that the challenged practices substantially depart from accepted professional standards. . . . According to Defendants, the Hospital has already addressed the first pressing issue . . . by treating all units as "quarantined." The problem with that assertion is that Defendants' implementation of the quarantine does not satisfy CDC standards. . . . Plaintiffs have offered ample evidence that the Hospital has taken a less demanding approach to enforcing social distancing and mask use, that common spaces are open, and that patients are not remaining in their rooms to the extent practicable. . . . Much of Defendants' own evidence is consistent with Plaintiffs' narrative. . . . Defendants have offered no explanation why patients who have been exposed to the virus are not more closely monitored to ensure that they are isolated to the extent consistent with patient health and well-being.

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[1] Plaintiffs further submitted CDC congregate care guidance and expert testimony that cohorting of COVID-19 positive or symptomatic patients should only occur if there are no other available options. JA 424; 221-222 ¶¶4, 6, 8.

JA 516-517. As the district court found, the Hospital's failure to isolate and quarantine individuals exposed to or suspected of being COVID-positive demonstrated a likelihood of success on the merits. JA 887. *Cf. Helling v. McKinney,* 509 U.S. 25, 34 (1993) (exposing individuals to "infectious maladies" violates the Eighth Amendment). Indeed, it was through Defendants' practices of housing exposed and symptomatic individuals together that Plaintiff Dunbar, who had tested negative for COVID-19 on March 18, tested positive on April 24. JA 436-438; 61 ¶5(a); 739 ¶¶3-5.

Even after entry of the TRO, patients reported ongoing failure to properly segregate patients who were symptomatic, exposed, or waiting for test results. JA 728 ¶4; 737 ¶6; 739 ¶¶6-10. The Hospital and *amici* reported spread to units that had previously been considered uninfected. JA 554-555; 581; 695; 707-708. Noting this evidence, the district court further found that Defendants failed to comply with proper isolation and quarantine guidance following the entry of the TRO and could offer no reason based in professional judgment for their failure:

> Defendants fail to explain what "professional judgment" would support housing individuals exposed to the virus in the same space, without isolating patients from one another *within that space* to prevent those who were positive from infecting those who were not. . . . [Defendants' evidence] neither (1) refutes the premise that, before Plaintiffs moved for a TRO, the Hospital was not isolating exposed patients from other patients nor (2) demonstrates that such an evidently perilous practice was a product of professional judgment.

JA 886-887.

Defendants do not come close to establishing clear error in these findings. Instead, they cite a May 11, 2020 CDC document entitled *Healthcare Infection Prevention and Control FAQs for COVID-19*, and contend that this guidance allowed "psychiatric hospitals [to] tailor the CDC's healthcare infection prevention and control guidance to their particular settings," and retrospectively cures Defendants' failure to properly segregate exposed patients. App. Br. 37-38.

Defendants did not present this argument below, and it is waived. ECF 90 at 25-26. Notably, Defendants did not submit this document with the other guidance they provided to the Court. JA 372-404. And Defendants did not argue in the district court that the FAQ document excused their failure to properly isolate and quarantine suspected or exposed patients. *See* ECF 90 at 25-26.

And, in any event, the "FAQs" only addressed what should happen if cohorting of patients who were COVID-19 positive was impossible. JA 848 ("patients with COVID-19 [should] be transferred to a separate area of the facility . . . where cohorting is not possible, implement measures to maintain social distancing."). The FAQ document does not suggest that the CDC had rescinded its prior guidance on the need to isolate suspected and exposed patients. JA 848. As the district court found, the Hospital's practice of cohorting patients together who were exposed or were waiting for test results failed to comply with professional

standards, JA 516-517; 886, and unquestionably led to more infections, including that of Plaintiff Dunbar, JA 436-437; 739 ¶¶3-10.

2. Dedicated Staff

As noted above, the Defendants represented at oral argument that the Hospital "should be doing what is consistent with the CDC guidance," JA 336, conceded that the Hospital should follow CDC guidelines, JA 510, 881, and submitted the CDC guidance *Long-term Care Facilities, Nursing Homes* as establishing the relevant professional standard. JA 372, 393-398. That guidance provides that when there are COVID-positive persons in a facility, they should be housed in a "dedicated space" with "dedicated health care professionals." JA 410.

The district court found that the Defendants substantially and inexplicably departed from this standard. Noting that *amici* were "emphatic in saying that while in the past this has not been respected, there should be no mixing of staff between these units," the court found that the "failure to abide by the CDC guidance in this respect is not based on the exercise of professional judgment." JA 718-719. *See also* JA 890 ("the Hospital's unexplained failure to implement appropriate restrictions on staff assignments constituted a substantial departure from professional judgment."). As *amici* noted, this failure almost certainly led to spread of COVID-19 to two previously uninfected units (1D and 1G). JA 574; 580-81; 697; 708-709.

Defendants do not come close to showing clear error in these findings. Again, they emphasize the FAQ document, App. Br. 40-42, but the FAQs *reiterated* that COVID-19 positive patients "be cared for by dedicated" health care staff. JA 848. In this regard, it is entirely consistent with the *Long-Term Care* guidance that both Parties submitted to the Court, JA 372; 393-398; 405-412, and that the district court found to be authoritative. JA 718-719; 889-890. Thus, the "FAQs" are not the escape hatch Defendants claim: that document in no way suggested it was rescinding or even modifying the CDC's congregate facility guidance regarding staffing. The fact that the CDC recognized that its guidance needed to be adapted for the "particular settings" at each hospital did not diminish the import of the core standards or suggest that professional standards could be satisfied by anything less than providing "dedicated" health care staff that the FAQ expressly confirms are required.

Defendants also contend that "there is no genuine dispute that the Hospital's assignment of staff complied with CDC guidance, both before and after the TRO." App. Br. 40. This is directly contrary to the district court's findings, which among other things, were that "the Hospital's unexplained failure to implement appropriate restrictions on staff assignments constituted a substantial departure from professional judgment" and "[t]here is no evidence . . . that prior to this litigation a professional at Saint Elizabeths had exercised any considered judgment with respect to this issue." JA 889-892; 718-719. The district court's findings were supported

by observations from *amici* – trained public health officials who conducted contemporaneous on-site inspections – who told the district court "from what we've learned, it's really the staff that's the problem . . . we have reason to believe that the exposed individuals who tested positive yesterday may very well have been infected by staff …" JA 581. *See also* JA 708-709 ("[C]irculation of all patients and staff within the hospital must be curtailed. [Health care professionals] and other staff should be assigned daily to only one unit."); 580-581 ("there should be no mixing of staff between these units"); JA 697. The Defendants have not shown that any of these findings are clearly erroneous.

3. Incomplete Testing

Following the entry of the TRO, the CDC issued guidance calling for nursing homes to conduct "a point prevalence survey (PPS) of all residents and all HCP [Health Care Practitioners] in the facility." JA 720A-720B (May 1, 2020). Again, the Defendants represented at oral argument that the Hospital "should be doing what is consistent with CDC guidance," JA 336, and conceded that the Hospital should follow CDC guidelines, JA 510, 881. As the district court noted:

> The CDC guidance identified by *amici* explains the importance of including staff in the PPS. "When COVID-19 cases are identified in a long-term care facility, there are often Health Care Practitioners (HCP) with asymptomatic COVID-19 infection present as well," and, as a result, "HCP likely contribute to the introduction and further spread" of COVID 19.

JA 717 (quoting JA 720A-720B). The district court found the Defendants' "unexplained failure to abide by the CDC guidance in this respect is not based on the exercise of professional judgment" and that "Defendants have offered no justification sounding in professional judgment for not periodically testing all patients . . . and all staff." JA 717-719, 896-897.

Defendants argue that failure to conduct a point prevalence survey of all patients *and staff* was defensible under the CDC guidance, citing the novelty of the guidance and lack of testing capacity. App. Br. 42-44. It was not. Defendants were aware of the importance of testing all patients and repeatedly told the Court they had the capacity to do so. Specifically, in opposing Plaintiffs' request that the original TRO contain more systemic testing requirements, Defendants reported (on April 22 and 24) that the Hospital had obtained an onsite rapid testing machine, committed at those hearings that all patients would be tested, and subsequently reported that "all units [had] been tested." JA 303-304; 451-452; 467-468; 569 ¶1. The Defendants also submitted a declaration confirming they were aware as early as May 2, 2020, that the CDC guidance directed an all patient, all staff point prevalence survey. JA 779 ¶14.

But the Defendants did not conduct an all patient, all staff survey. Although Defendants had tested at least a portion of the patients over the course of over thirteen days, JA 569 ¶1; 697, a point prevalence survey as described by *amici* is

when "you test everybody at the same time, and then you know at a certain day at a certain time. You get a snapshot of what there is, who's positive, who's negative and where they need to be in the population." JA 587. *Amici* further found that no such survey had *ever* been given to the staff, noting that in total, only 100 of the 786 staff members had submitted proof of outside testing. JA 591; 696; 710. The district court thus was well justified in finding that the Hospital had "not included staff in its PPS as recommended for facilities with suspected or confirmed cases." JA 717. The district court also found that "Defendants have offered no justification sounding in professional judgment for not periodically testing all patients . . . and all staff. . ." JA 896. And the district court also found that despite the "tragic circumstances at Saint Elizabeths," Defendants did "not explain why the Hospital waited over a week – and until after *amici* had impressed on the Court the critical need for PPS testing for staff – before beginning to test staff." JA 896. The Defendants have not come close to establishing clear error for these findings.

The Defendants did not complete a CDC-compliant point prevalence survey until May 15 (JA 867) after being ordered to do so by the district court on May 11. JA 722. The Defendants' delay had real consequences: in the 13 days between when the Defendants admit they were aware of the requirement to conduct a point prevalence survey and when Defendants actually conducted a point prevalence survey, 11 additional patients and (as the district court found, JA 896) 21 additional

staff reported testing positive for COVID-19. ECF 87-1 at 9, 13 & n.12. And two more patients died. *Id.*

Defendants also argue that "it was not unreasonable for the Hospital to make future testing decisions based on the latest guidance and information" – App. Br. 44 – but in fact, the district court's order left room for Defendants to modify their testing practices when appropriate. JA 910 (PI Order inviting Defendants to revisit the PPS testing requirement when conditions improved). Defendants have never availed themselves of this option by going back to the district court to seek modification of the injunctive terms regarding testing.

C. The District of Columbia Was Responsible for the Hospital's Constitutional Violations

The District of Columbia is liable under 42 U.S.C. § 1983 if it had a policy or custom that served as the "moving force behind the constitutional violation[s]." *Baker v. District of Columbia*, 326 F.3d 1302, 1306 (D.C. Cir. 2001) (internal citations omitted). 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) (internal citations omitted).

The district court correctly found the Defendants liable under this theory of municipal liability. JA 903-904. As Plaintiffs argued below, Defendant Bazron is a final policymaker with respect to responding to crises at Saint Elizabeths and she

was responsible for the Hospital's constitutionally deficient handling of the pandemic. ECF 92 at 13–14.

In the district court proceedings, Defendants did not dispute Defendant Bazron's status as a final policymaker on the relevant issues, JA 903, and they do not dispute it here. *See* App. Br. 45 (describing the actions of "Director Bazron or another final policymaker").[2] Instead, Defendants challenge (at App. Br. 46) the district court's factual finding that "Plaintiffs have offered sufficient evidence to show . . . that a municipal policy was the moving force behind the constitutional violations at issue here" based on Defendant Bazron's role in Hospital's response to COVID-19. JA 903–904. Defendants do not come close to showing clear error in that factual finding. *Collins v. Pension Benefit Guar. Corp.*, 881 F.3d 69, 72 (D.C. Cir. 2018) (clear error requires demonstrating district court's account of the evidence was "implausible" and "clearly mistaken").

Defendants mischaracterize the district court's findings as to Defendant Bazron's responsibility as being "without elaboration," App. Br. 45; however,the

[2] This concession is well-taken. Defendant Bazron runs DBH, which oversees the Hospital. *See Banks v. District of Columbia*, 377 F. Supp. 2d 85, 87 (D.D.C. 2005); D.C. Code § 7-1141.04(1) (DBH director shall "[s]upervise and direct the Department"); *see also* § 7-1141.02(b). Defendant Bazrzon's position vests her with authority to "[e]xercise any other powers necessary and appropriate to implement the provisions of this chapter," D.C. Code § 7-1141.04(3), including the requirement that DBH "[d]irectly operate a hospital to provide inpatient mental health services." D.C. Code § 7-1141.06(6).. Accordingly, Defendant Bazron is a final policymaking authority.

district court pointed specifically to "the existing record," JA 904, which included Plaintiffs' "evidence that Director Bazron has been personally involved in the Hospital's response to COVID-19 crisis" JA 903. That evidence included the Hospital's Emergency Preparedness Plan, which requires the Director of DBH (i.e. Defendant Bazron), to be intimately involved in day-to-day decision-making about crisis response, JA 968, 991 (documents filed under seal providing specific details of DBH Director's role), and two letters written by Defendant Bazron which confirmed that the Hospital activated its Emergency Preparedness Plan on March 12, 2020 and detailed the decisions made to address the COVID-19 crisis at Saint Elizabeths. JA 861-865. Thus, it cannot be said the district court's conclusion was "implausible" or "clearly mistaken," so as to constitute "clear error." On the contrary, the district court's findings about Defendant Bazron's personal involvement in, and responsibility for, the Hospital's response to the crisis were amply supported by the record.

Defendants also argue that the District did not display deliberate indifference to the COVID-19 crisis or "adopt a policy of inaction," App. Br. 45–46, but this conflates distinct theories of municipal liability. While showing deliberate indifference based on municipal inaction (such as a failure to train its employees) is one way of establishing municipal liability, *see Baker*, 326 F.3d at 1306–07 (distinguishing these theories of municipal liability), it is not the theory on which

Plaintiffs or the district court relied. Plaintiffs relied on the final-policymaker rationale, ECF 92 at 13–15, and so did the district court, JA 903. *See also* JA 903–904 (discussing "final policymaker" theory of municipal liability and no others). As a result, Plaintiffs had no obligation to show that Defendants displayed deliberate indifference to the risk of constitutional violations.

This is not a case where the district court disregarded the municipal liability inquiry, as in *Swain v. Junior*, 961 F.3d 1276, 1291 (11th Cir. 2020), which Defendants cite. App. Br. 47. Rather, the court reviewed the record evidence and properly concluded that a final policymaker for the District bore responsibility for the Hospital's constitutional violations.

D. The District Court's Injunction Was Properly Tailored to Defendants' Violations

Defendants' invocation of cases limiting courts' authority to enjoin future misconduct proceeds from a demonstrably wrong premise that the district court "recogniz[ed] no current constitutional violation." App. Br. 47. In fact, the district court found ongoing constitutional violations that subjected patients to unnecessary risk of illness and death. JA 514, 879-897.

Specifically, the district court found:

- on testing, Defendants "lack[ed] a plan to continue testing all patients and staff" after the TRO expired, which "constitute[d] a substantial departure from professional judgment," JA 897.

- on quarantine, the district court had to issue a TRO to ensure that Defendants protected patients. JA 882–887. Even after the TRO, *amici's* review of cohorting practices—a critical aspect of infection control JA 886–887 & n.3—found these measures were implemented "obviously imperfectly." JA 578.
- on dedicated staffing, the district court found compliance was a "recent development," implemented only after *amici* raised "emphatic" concerns about staff transmission. JA 892. "Given this history," the district court properly found "a cognizable danger of recurrent violation sufficient to warrant further injunctive relief." JA 892 (cleaned up); *see also* JA 718–719.

On these findings, Defendants' discussion of the court's limited power to enjoin future misconduct is simply inapposite.

If Defendants intended to argue that the case was moot before the injunction was issued, that is obviously wrong: A case cannot be moot when defendants remain engaged in unlawful activity. *See Roane v. Leonhart*, 741 F.3d 147, 151 (D.C. Cir. 2014). Nor was the dispute moot as to any practices Defendants may have curbed before the injunction issued. Defendants did not make these changes voluntarily, but rather in response to the TRO. *See* JA 887; 892. Moreover, even if Defendants voluntarily ceased their violations, they could establish mootness only by carrying

the "heavy burden" of demonstrating that their past violations were not reasonably expected to recur, *Hardaway v. D.C. Hous. Auth.*, 843 F.3d 973, 979 (D.C. Cir. 2016), something Defendants failed to show, given that, at the time of the injunction, they were *still* violating professional standards in some respects.

Defendants fare no better if, instead of arguing mootness, they asserted that there was no "cognizable risk of recurrent violation" to contend that the court exceeded its equitable authority in issuing the injunction. *See* App. Br. 47. The limits Defendants discuss arise from *United States v. W.T. Grant Co.*, 345 U.S. 629 (1953), a case where the government sought to enjoin defendants from engaging in antitrust violations after the defendants had ceased anticompetitive behavior on their own. *See id.* at 630; *see also id.* at 633 (discussing "the court's power to grant injunctive relief [after] [the] discontinuance of the illegal conduct"). *W.T. Grant* does not address the district court's power to enjoin defendants who are engaged in *ongoing* unlawful acts or persisted in such acts until enjoined. The *W.T. Grant* factors Defendants analyze are thus inapposite to this context. Defendants' citation of *SEC v. Steadman*, 967 F.2d 636, 648 (D.C. Cir. 1992) is similarly misplaced because there, the defendant's violations were "corrected immediately."

Moreover, to establish that the district court exceeded its "equitable discretion," Defendants must show "abuse of discretion." *See Benisek v. Lamone*, 138 S. Ct. 1942, 1943 (2018). Defendants' reliance on *PETA v. U.S. Dep't of Agric.*,

918 F.3d 151 (D.C. Cir. 2019), to urge an "independent[] review" of the district court's analysis is therefore mistaken, App. Br. 48, as that case involved mootness, not the court's equitable powers, *see PETA*, 918 F.3d at 156–57; *see also W.T. Grant Co.*, 345 U.S. 633 (distinguishing the two concepts); *Halkin v. Helms*, 690 F.2d 977, 1006 (D.C. Cir. 1982) (same).

Here, the district court properly exercised its discretion. In responding to the pandemic, Defendants repeatedly failed to exercise professional judgment, altered their behavior only after the court ordered them to do so, and, at the time of the injunction, continued to fall short in their care of civilly committed individuals. *See* JA 887; 892; 897. Nor was the pandemic the first time Defendants displayed such poor judgment. JA 257–263 ¶¶148–183 (discussing Defendants' mismanagement of water crisis that resulted in inadequate mental health care and unhygienic conditions, with toilets overflowing with human waste, for a nearly month).

Indeed, on this record, even if the district court expressly found the Hospital in full compliance with the TRO (which it did not), it would have retained equitable authority to issue a preliminary injunction that kept its remedies in place. As the district court explained, "[i]f compliance with the terms of a TRO were sufficient to defeat entry of a preliminary injunction, few—if any—cases would make it past the TRO stage." JA 880; *see Banks v. Booth*, 468 F. Supp. 3d 101, 113 (D.D.C. 2020) (same), *Mays*, 974 F.3d at 823 (affirming aspects of preliminary injunction that

district court converted from TRO where court had made "detailed factual findings" about COVID-19 risks and jail policies); *see also DOJ v. Daniel Chapter One*, 89 F. Supp. 3d 132, 143 (D.D.C. 2015) (noting that past unlawful conduct is "highly suggestive of the likelihood of future violations") (internal citations and quotation marks omitted), *aff'd*, 650 F. App'x 20 (D.C. Cir. 2016). To the extent the TRO was working, releasing the Hospital from its mandates would be "like throwing away your umbrella in a rainstorm because you are not getting wet." *Shelby Cnty. v. Holder*, 570 U.S. 529, 590 (2013) (Ginsburg, J., dissenting).

As with their argument on *Youngberg*, Defendants' claim of good faith (App. Br. 48-49) is not an answer. The underlying constitutional standard is an objective one. *Youngberg*, 457 U.S. at 312 n.11, 323. Moreover, Defendants' good faith did not prevent contagion or deaths that continued after the TRO issued, JA 715, 717 (finding that increasing number of COVID-positive patients and fatalities justified extension of TRO), or even result in full TRO compliance, JA 578 (noting deficiencies in cohorting after original TRO).

Nor does the fact that this case arose during the "particularly challenging days of the early pandemic," App. Br. 50, preclude the district court from enjoining unlawful conduct. The district court expressly considered these challenges in crafting its remedy, JA 879, and its decision to issue an injunction to protect life, health, and constitutional rights appropriately recognized that the government cannot

abandon its constitutional obligations "in times of crisis." *Roman Catholic Diocese of Brooklyn v. Cuomo*, 141 S. Ct. 63, 69 (2020) (Gorsuch, J., concurring).

In sum, the district court was justified in concluding that a preliminary injunction was necessary.

II. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN FINDING PLAITIFFS ESTABLISHED IRREPARABLE HARM

As the district court found, Plaintiffs established a likelihood of success on the Fifth Amendment claims, and that the deprivation of constitutional rights, "for even minimal periods of time, unquestionably constitutes irreparable injury." JA 905–906 (citing *Mills v. District of Columbia*, 571 F.3d 1304, 1312 (D.C. Cir. 2009)). *See generally Brown v. Plata*, 563 U.S. 493, 511 (2011) ("Courts . . . must not shrink from their obligation to enforce the constitutional rights of . . . prisoners." (internal quotation marks and citation omitted)).

The district court also found that "the imminent risk to [Plaintiffs'] health . . . also constitutes an irreparable injury." JA 519-520; 906. COVID-19 is a serious disease and exposure can lead to permanent health effects and be irreparable. JA 53-56 ¶¶5, 8, 9, 14. And as proven by the thirteen patients who died, exposure to COVID-19 can be deadly. Death is certainly irreparable.

Given the circumstances – that the Plaintiffs are individuals involuntarily housed in a congregate setting, were unnecessarily exposed to COVID-19 without adequate means to protect themselves, and one of the Plaintiffs (Mr. Dunbar) tested

positive, the district court findings are unassailable, and not clearly erroneous. Court-appointed *amici* (jointly agreed to by the Parties) found that even after entry of the TRO, the Hospital "continues to experience ongoing transmission of SARS-CoV-2." JA 695.

COVID-19 continues to spread outside Saint Elizabeths' walls. Because the Defendants repeatedly failed to adhere to CDC standards even when ordered by the district court, injunctive relief to protect the patients from risks of COVID-19 exposure was not only warranted but unquestionably saved more patient lives. Indeed, following the entry of the injunction, transmission among patients plummeted.

III. THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN FINIDNG THAT ENTRY OF AN INJUNCTION WAS IN THE PUBLIC INTEREST

The district court properly concluded that entry of injunctive relief was in the public interest. JA 520-521, 907-908. The public interest is served when constitutional rights are protected because it "is always in the public interest to prevent the violation of a party's constitutional rights." *Simms v. District of Columbia*, 872 F. Supp. 2d 90, 105 (D.D.C. 2012) (citations omitted); *accord Lamprecht v. FCC*, 958 F.2d 382, 390 (D.C. Cir. 1992) ("a [government] policy that is unconstitutional would inherently conflict with the public interest").

In granting relief, the district court was deferential to the Defendants' management of the Hospital, ordering relief only "to the extent medically and psychiatrically practicable" and "to the extent [Defendants] have not already done so." JA 525-526, 721-723, 909-910. Although Defendants complain about burdens in staffing and quarantine of patients, these are posited as hypothetical rather than actual burdens. App. Br. 53-54. Defendants do not cite a single instance from their ten months of experience operating under the preliminary injunction where the injunction has negatively impacted patient care. Indeed, in the ten months since the injunction was entered, the Defendants have never once complained to the district court that the injunction was "rigid," casts "a shadow . . . over professional decisions," or is "facially ambiguous." App. Br. 52-54. Nor have Defendants ever asked the district court to lift the injunction or modify it in any way. In all of the compliance reports the Defendants have filed with the district court, they have never – not once – identified any actual burden, nor have they sought any relief from the Court.

Ultimately, the district court properly concluded that stopping patients from contracting a deadly disease *and from dying* is certainly in the public interest. These findings were not clearly erroneous.

CONCLUSION

For the reasons stated, the preliminary injunction order should be affirmed.

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rules of Appellate Procedure 32(a) and 32(g), the undersigned counsel for Appellees certifies that:

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because it contains 12,733 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and (6) because this brief has been prepared using Microsoft Office Word and is set in Times New Roman font in a size equivalent to 14 points or larger.

/s/ John A. Freedman
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was filed electronically on March 18, 2021, and will, therefore, be served electronically upon all counsel.

/s/ John A. Freedman
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