

June 8, 2020

**Dear Colleagues:**

We are writing this in response to your request that we provide our opinion on the risks of novel coronavirus transmission and resulting COVID-19 disease on prison populations. We have extensively studied these issues and are glad to assist. We also understand that this is of particular concern in Brazil generally and Rio de Janeiro state particularly. We are, therefore, glad to present the following to you and hope that it may be helpful to the court in evaluating the case of *Ministério Público e Defensoria Pública do Estado do Rio de Janeiro, Petitioners-Plaintiffs, v. Estado do Rio de Janeiro, Município do Rio de Janeiro e Associação Filantrópica Nova Esperança (Pronto Socorro Geral Hamilton Agostinho), Respondents-Defendants. Matter of Ação Civil Pública #0087229-92.2020.8.19.0001.*

**I. I. Professional Experience**

1. I am Dr. Ranit Mishori. I am a senior medical advisor at Physicians for Human Rights (PHR), and Professor of family medicine at the Georgetown University School of Medicine, where I am the director of the department's Global Health Initiatives, Health Policy fellowship and our practice-based research network. A fellow of the American Academy of Family Physicians and Diplomate of the American Board of Family Medicine, I did my residency training at the Georgetown University/Providence Hospital Family Medicine Residency program. I received my medical degree from Georgetown University School of Medicine and a master's degree in International Health from the Johns Hopkins Bloomberg School of Public Health, in the Disease Control and Prevention Track (focusing on the science of how to halt the spread of infectious disease).
2. I am the faculty leader for Georgetown University School of Medicine's Correctional Health Interest group, where I supervise medical students placed at various area jails, prisons and detention centers. In addition, I am the director of Georgetown University's Asylum program which focuses on the care and medico-legal issues of asylum seekers, including immigration detention. I have written extensively and given talks and lectures about such issues nationally and internationally. In my role as senior medical advisor at PHR (and prior to that, as a consultant for PHR), I have reviewed and analyzed dozens of cases related to health outcomes of individuals in correctional facilities, and advised the organization and other partners (civil society, legal aid organizations and the media) about issues related to incarceration, including hunger strikes, medical care quality, communicable disease management, violence, and care of pregnant women in such settings.<sup>1</sup>

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<sup>1</sup> See, e.g., Ranit Mishori, *Risk Behind Bars: Coronavirus and Immigration Detention*, The Hill (Mar. 17, 2020), <https://thehill.com/opinion/immigration/487986-risk-behind-bars-coronavirus-and-immigration-detention>; Amanda Holpuch, *Coronavirus Inevitable in Prison-Like US Immigration Centers, Doctors Say*, The Guardian (Mar. 11, 2020), <https://www.theguardian.com/world/2020/mar/11/coronavirus-outbreak-us-immigration-centers>; Abigail Hauslohner, et al., *Coronavirus Could Pose Serious Concern in ICE Jails, Immigration Courts*, The Washington Post (Mar. 12, 2020), <https://www.washingtonpost.com/immigration/coronavirus-immigration-jails/2020/03/12/44b5e56a->

3. As an attending physician at the Georgetown University/Washington Hospital Center Family Medicine Residency Program, I work with urban underserved populations, including the homeless, formerly incarcerated individuals, immigrants and refugees. I routinely come in contact with victims of abuse, trauma and poverty where I regularly assess their medical as well as psycho-social needs in the context of their social-determinants of health (such as housing and incarceration).
4. For four years I was an elected member of the American Academy of Family Physicians' Commission on the Health of the Public and Science, where I chaired the Public Health Issues sub-committee. During that time, I was a lead-author of the Academy's comprehensive position paper on Incarceration and Health.
5. I am Dr. Michele Heisler. I am a physician licensed in the State of Michigan and a diplomate of the American Board of Internal Medicine. I am Medical Director of Physicians for Human Rights (PHR) and Professor of Internal Medicine and Public Health at the University of Michigan Health System (Michigan Medicine) and provide clinical care at the University of Michigan Health System and the Veteran's Affairs Health System in Ann Arbor, MI. I have been on the faculty and practicing medicine at the above health systems since 2002.
6. I am a graduate of Harvard Medical School. I have a master's degree in Public Policy from Princeton University's Woodrow Wilson School. My clinical training (residency and fellowship) was at the University of Michigan Health System in Internal Medicine. I then completed additional fellowship research training as a Robert Wood Johnson Clinical Scholar at the University of Michigan. In my clinical work caring for low-income Veterans, many of my patients have multiple chronic diseases and behavioral disorders, with a high percentage of formerly incarcerated individuals. I am well trained in caring for complex patients at high risk from severe illness if infected with COVID-19.
7. I have twenty years of experience leading large-scale epidemiological, longitudinal studies examining clinical, social, and behavioral risk factors for morbidity and death from noncommunicable chronic diseases such as type 2 diabetes and cardiovascular diseases, the very conditions that increase severe illness and death from COVID-19. I have authored over 200 peer-reviewed studies published in medical and public health journals including Lancet, BMJ, The New England Journal of Medicine, JAMA, and the American Journal of Public Health. Since 2018, I have been an elected member of the Association of American Physicians, an honorary medical society for outstanding researchers in biomedical science and/or translational biomedical research

## **II. II. The Novel Coronavirus**

8. The novel coronavirus, officially known as SARS-CoV-2 (Coronavirus), causes a disease known as COVID-19. The novel coronavirus is thought to pass from person to

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[646a-11ea-845d-e35b0234b136\\_story.html](https://www.expressnews.com/news/us-world/border-mexico/article/Whether-in-detention-or-in-Mexico-U-S-15129447.php); Silvia Foster-Frau, *Coronavirus Cases in Migrant Detention Facilities Called 'Inevitable'*, Express News (Mar. 15, 2020) <https://www.expressnews.com/news/us-world/border-mexico/article/Whether-in-detention-or-in-Mexico-U-S-15129447.php>.

person primarily through respiratory droplets (by coughing or sneezing) but it also survives on surfaces for up to a few days. Some evidence suggests that it can be aerosolized (spread by small particles able to stay suspended in the air for several hours where an infected person coughed or sneezed). It is possible that people can transmit the virus before they start to show symptoms or even when they are asymptomatic.<sup>2</sup>

9. Studies have shown that the average infected person passed the virus on to 2-3 other people; transmission occurred at a distance of 3-6 feet. The “contagiousness” of this novel coronavirus—its  $R_0$ , or replication number (the number of people who can get infected from a single infected person)—is twice that of the flu.<sup>3</sup> It is estimated that in congregate environments such as prisons and other places of detention, the ‘replication number’ can be much higher, with some models showing and  $R_0$  between 5-10.<sup>4</sup>
10. Not only is the virus very efficient at being transmitted through droplets, everyone is at risk of infection because our immune systems have never been exposed to or developed protective responses against this virus. There is no vaccine to prevent novel coronavirus infection.

### III. COVID-19

11. The disease caused by the novel coronavirus is called COVID-19. As of June 5, 2020, according to the WHO, more than 6.5 million people have been confirmed as having COVID-19 around the world, and of those, over 387,000 have died. In Brazil, over 584,000 cases have been confirmed, which makes the country 2<sup>nd</sup> only to the US in the number of cases.<sup>5</sup> These numbers are most likely undercounts of the true number of cases due to access issues and pervasive testing challenges noted throughout the world.
12. Once somebody becomes sick with COVID-19, the harm can be long lasting. The disease is known to affect multiple body system including the lungs, heart, kidneys and blood vessels, requiring rehabilitation.
13. While individuals of any age any be infected with the novel coronavirus, recent data suggest that those with chronic medical conditions, such as diabetes, heart or lung disease, or other chronic conditions, are at a higher risk of developing severe cases, facing complications and dying from COVID-19.<sup>6</sup>

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<sup>2</sup> *Clinical Guidelines about COVID-19: Questions and Answers*, Centers for Disease Control and Prevention (Updated June 4, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Transmission>.

<sup>3</sup> James Gallagher, *Coronavirus: What is the R Number and how is it Calculated?* BBC News (May 18, 2020), <https://www.bbc.com/news/health-52473523>.

<sup>4</sup> Michael Irvine et al., *Modeling COVID-19 and its Impacts on U.S. Immigration and Customs Enforcement (ICE) Detention Facilities*, 2020, *Journal of Urban Health* (May 15, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7228433/>.

<sup>5</sup> World Health Organization, *WHO Coronavirus Disease (COVID-19) Dashboard*, (accessed June 5, 2020), <https://covid19.who.int/>.

<sup>6</sup> Centers for Disease Control and Prevention, *Groups at Higher Risk for Severe Illness*, (accessed June 5, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html>.

14. Older adults (>65) are also at a higher risk of developing severe disease and dying. According to the US CDC, the following underlying medical conditions may increase the risk of serious COVID-19 for individuals of any age: high blood pressure, blood disorders, chronic kidney or liver disease, immunosuppression, metabolic disorders (including diabetes), heart and lung disease, among others.
15. Research suggests that of those infected, 80% will have mild/moderate disease, 15% will have severe disease requiring hospitalization, and ~5% will have to be treated in the intensive care unit.<sup>7</sup>
16. Those in high-risk categories and those who develop severe disease and are hospitalized require intensive and expensive hospital care, including mechanical ventilation, which is already in short supply in several parts of the country.
17. The care of those with severe COVID-19 requires an entire team of clinicians, including 1:1 or 1:2 nurse to patient ratios, respiratory therapists, and intensive care physicians.
18. Patients who do not die from serious cases of COVID-19 may also face prolonged recovery periods, including extensive rehabilitation from cardiac damage and loss of respiratory capacity.
19. At this time, there is no known cure or effective antiviral treatment for the virus or for COVID-19
20. Because the lack of treatment or an effective vaccine, prevention strategies are crucial. Prevention strategies require population-based and public health interventions focusing on containment and mitigation. Containment requires testing, tracing and isolating people who are ill or who have had contact with people who are ill. This strategy, however, requires mass testing, which is not was not widely available due to delayed action.<sup>8</sup>
21. Mitigation in this situation involves widespread adoption of meticulous hand hygiene practices, as well as social distancing. For that reason, public health officials have recommended extraordinary measures to combat the rapid spread of coronavirus. Schools, courts, collegiate and professional sports, theater and other congregate settings have been closed as part of this risk mitigation strategy.

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<sup>7</sup> Centers for Disease Control and Prevention, *Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease (COVID-19)*, (updated June 2, 2020), <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html>.

<sup>8</sup> Ernesto Londoño, Manuela Andreoni, Leticia Casado, *Brazil, Once a Leader, Struggles to Contain Virus Amid Political Turmoil*, New York Times (May 16, 2020), <https://www.nytimes.com/2020/05/16/world/americas/virus-brazil-deaths.html>.

#### **IV. IV. Prison Conditions in the State of Rio de Janeiro**

##### **V.**

22. Between March and April, 2020 there were already four deaths in the prison system in the state of Rio de Janeiro that were officially confirmed to be COVID-related. That indicates that SARS-CoV-2 has already been introduced into prison facilities.
23. According to official state numbers, as of April 2020, there were 52,100 incarcerated persons across the state's 46 prisons, while the overall capacity of the system is designed for 29,241 people. These conditions of over-crowding further make social distancing impossible and create conditions ideal for the rapid spread of SARS-CoV-2 infection. Under these conditions it is imperative to have adequate screening, testing, identification and appropriate medical management of individuals with COVID-19, presence of well-trained health care teams to provide medical care and adequate hospital beds and transfer processes as necessary to public hospitals and medical centers.

#### **VI. V. COVID-10 in Prisons and Places of Detention**

24. The risk posed by infectious diseases in prisons and detention facilities is significantly higher than in the community, both in terms of risk of exposure and transmission and harm to individuals who become infected. There are several reasons this is the case, as delineated further below.<sup>9</sup>

25. Globally, outbreaks of contagious diseases are all too common in confined prisons and detention settings and are more common than in the community at large. Though they contain a captive population, these settings are not isolated from exposure. Staff arrive and leave on a shift basis; Contractors and vendors also pass between communities and facilities and can bring infectious diseases into facilities. People are often transported to, from, and between facilities.

26. Jails, prisons and detention centers often do not have access to vital community health resources that can be crucial in identifying infectious diseases, including sufficient testing equipment and laboratories. This is especially true when, as now, there is a shortage in available test kits.

27. During an infectious disease outbreak, such as with COVID-19, a containment strategy requires people who are ill to be isolated and that caregivers have adequate personal protective equipment (PPE). Jails and prisons are often under-resourced and ill-equipped

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<sup>9</sup> Ank E. Nijhawan, *Infectious Diseases and the Criminal Justice System: A Public Health Perspective*, American Journal of Medical Science (May 27, 2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5119815/#:~:text=Hammett%20estimated%20the%20burden%20of%20present%20in%20the%20releasee%20population>.

to provide sufficient PPE for people who are incarcerated and caregiving staff, increasing the risk for everyone in the facility of a widespread outbreak.

28. When jailed or imprisoned, people have much less of an opportunity to protect themselves by social distancing than they would in the community. Congregate settings such as jails and prisons allow for rapid spread of infectious diseases that are transmitted person to person, especially those passed by droplets through coughing and sneezing. When people live in close, crowded quarters and must share dining halls, bathrooms, showers, and other common areas, the opportunities for transmission are greater. Toilets, sinks, and showers are shared, without disinfection between use.

29. Spaces within jails and prisons are often also poorly ventilated, which promotes highly efficient spread of diseases through droplets. Detainees often have a small number of telephones that they share, and which form their only contact with the outside world—including their family and lawyers. People in such a setting therefore dramatically reduces their ability to protect themselves from being exposed to and acquiring infectious diseases.

30. Additionally, jails and prisons are often unable to adequately provide the mitigation recommendations recommended by medical and public health experts. During an infectious disease outbreak, people can protect themselves by washing hands. Many detention facilities do not provide adequate opportunities to exercise necessary hygiene measures, such as frequent handwashing or use of alcohol-based sanitizers when handwashing is unavailable. Jails and prisons are often under-resourced and ill-equipped with sufficient hand soap and alcohol-based sanitizers for people detained in these settings. High-touch surfaces (doorknobs, light switches, etc.) should also be cleaned and disinfected regularly with bleach to prevent virus spread, but this is often not done in jails and prisons.

31. People incarcerated are more susceptible to acquiring and experiencing complications from infectious diseases than the population in the community.<sup>10</sup> This is because people who are incarcerated, for a variety of reasons, have higher rates of chronic underlying health conditions, including diabetes, heart disease, chronic lung disease, chronic liver disease, and suppressed immune systems from HIV or other conditions, than people in the community.

32. Places of detention are often poorly equipped to manage infectious disease outbreaks. Some places lack onsite medical facilities or 24-hour medical care. The medical facilities are almost never sufficiently equipped to handle large outbreaks of infectious diseases. To prevent transmission of droplet-borne infectious diseases, people who are infected and symptomatic need to be isolated in specialized negative pressure rooms. Most places of detention have few negative pressure rooms if any, and these may be already in use by people with other conditions (including tuberculosis or influenza). In the course of an

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<sup>10</sup> *Active Case Finding For Communicable Diseases in Prisons*, 391 *The Lancet* 2186 (2018), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(18\)31251-0/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)31251-0/fulltext).

infectious disease outbreak, resources will become exhausted rapidly and any beds available will soon be at capacity.

33. A coronavirus brought into prison can quickly spread among the dense detainee cohort. Many may become sick—including high-risk groups such as those with chronic conditions—quickly overwhelming the already strained health infrastructure within the facility. This can also lead to a strain on the surrounding hospitals to which these individuals may have to be transferred.

34. Reports from around the world of overcrowding, poor hygiene measures, medical negligence, and poor access to resources and medical care have led to outbreaks of infectious diseases in jails and prisons globally.<sup>11</sup>

35. Additionally, as health systems inside facilities are taxed, people with chronic underlying physical and mental health conditions and serious medical needs may not be able to receive the care they need for these conditions.

36. We have ample basis to conclude that places of detention are unprepared for the rapid spread of coronavirus. Not surprisingly, Chinese prison officials reported that over 500 COVID-19 cases in the current outbreak stemmed from the Hubei province prisons.<sup>12</sup> In Israel, an entire prison was quarantined.<sup>13</sup> In the US, over 40,000 cases were reported in prison settings, with more than 495 deaths.<sup>14</sup> Recognizing that the release of those incarcerated is the only solution, jails in at least a dozen states in the United States have released inmates. In Iran, over 80,000 prisoners were released as a means of preventing death in government prisons.<sup>15</sup> In the United Kingdom, the government released 300 immigrants from detention centers as a result of coronavirus. Major human rights organizations such as Human Rights Watch, Physicians for Human Rights and Amnesty International have issued calls to release those detained in prisons, jails and immigration facilities to prevent the spread of coronavirus.

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<sup>11</sup> Justin Carissimo, *CDC report details extent of coronavirus outbreaks in U.S. jails and prisons*, CBS News (May 6, 2020), <https://www.cbsnews.com/news/coronavirus-outbreaks-jails-prisons-cdc-report-covid-19/>; Talha Burki, *Prisons are “in no way equipped” to deal with COVID-19*, The Lancet (May 2, 2020), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)30984-3/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30984-3/fulltext).

<sup>12</sup> Zi Yang, *Cracks in the System: COVID-19 in Chinese Prisons*, The Diplomat (March 9, 2020) <https://thediplomat.com/2020/03/cracks-in-the-system-covid-19-in-chinese-prisons/>.

<sup>13</sup> TOI Staff, *Palestinian in Israeli jail diagnosed with virus; detainee and staff quarantined*, The Times of Israel (April 24, 2020), <https://www.timesofisrael.com/palestinian-held-in-israeli-jail-diagnosed-with-virus-he-and-staff-quarantined/>.

<sup>14</sup> The Marshall Project, *A State-by-State Look at Coronavirus in Prisons*, (updated June 4, 2020), <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons>.

<sup>15</sup> Adam Payne, *Iran has released 85,000 prisoners in an emergency bid to stop the spread of the coronavirus*, Business Insider (Mar 17, 2020), <https://www.businessinsider.com/coronavirus-covid-19-iran-releases-eighty-five-thousand-prisoners-2020-3>.

37. In a joint statement from May 13 2020, the main public health and human rights organizations of the UN –WHO, UNODC, UNAIDS and OHCHR– also highlighted the heightened vulnerability of persons in prison to the COVID-19 pandemic. The organizations outlined appropriate measures to mitigate the risks, with recommendations covering measures to reduce overpopulation, including through releases of persons in prison who would not be a risk to public safety. The organizations called for measures to improve sanitation and hygiene and to guarantee access to adequate health services as well as high quality preventive, supportive and curative care. The statement called for the immediate implementation of measures to prevent infection and provide COVID-19 treatment in prisons and other closed facilities. The organizations declared those measures as an urgent priority in public health in the framework of global and national efforts to contain and combat the pandemic.

## **I. Conclusion and Recommendations**

38. For the reasons above, it is our professional judgment that individuals placed in prisons or jails are at a significantly higher risk of infection with coronavirus as compared to the population in the community, and that they are at a significantly higher risk of complications and poor outcomes if they do become infected. These outcomes include severe illness (including respiratory, cardiac and kidney failure) and even death.

39. Given that the only viable public health strategy available in Brazil currently is risk mitigation, reducing the size of the population in detention centers, jails and prisons is crucially important to reducing the level of risk both for those within those facilities and for the community at large. Not doing so is not only inadvisable but also reckless given the public health realities facing Brazil at the moment.

40. Even with the best-laid plans to address the spread of coronavirus in prisons and jails, the release of high-risk individuals is a key part of a risk mitigation strategy. In our professional opinion, the optimal public health recommendation is to release people from congregate detention centers, jails, and prisons, with highest priority to those at the highest risk, especially given the lack of an effective vaccine for prevention or effective treatment for the disease at this stage. Our professional opinion is consistent with the view of the global public health and medical profession as a whole that there are no conditions of confinement in carceral settings that can adequately manage the serious risk of harm for high-risk individuals during the COVID-19 pandemic.

41 So long as carceral settings include congregate living spaces, shared bathrooms, and shared and confined spaces for eating and recreating, there is no way to minimize the risks to an acceptable level in these spaces.

42. Immediate release is crucial for individuals who are older, and those with chronic illnesses or other preexisting conditions (heart disease, diabetes, server obesity, etc.)

43. Releasing people from incarceration is the best and safest way to prevent the spread of disease and reduce the threat to the most vulnerable people who are detained, as well as for



vulnerable people in the community and for the public health. It is our professional opinion that this step is both necessary and urgent. The window of opportunity is rapidly narrowing for mitigation of COVID-19 in these facilities. Once a case of coronavirus is identified in a facility, it will likely be too late to prevent a widespread outbreak.

44. It is our professional judgment that for those remaining in these congregate settings in the prison system, it is imperative to carry out the ten measures requested by the Defensoria Publica and Ministerio Publico in the current case to prevent the spread of the virus in the prison system. As most of these have not been put into practice, emergency measures are necessary to prevent further loss of life and further harm to the health of persons deprived of liberty.

45. We recommend implementation of the recommendation to ensure there are health care teams to carry out basic medical assistance at prison units, through the necessary procurement of professionals to ensure attention especially in units with elderly and at-risk population.

46. We recommend implementing a robust mass testing program that includes regular and frequent testing of symptomatic and asymptomatic inmates and staff, followed by contact tracing and appropriate medical management of those who test positive (that does not include solitary confinement), especially those in the high risk groups.

47. We recommend implementation of the recommendation to procure and install hospital beds at infirmaries and intensive care units (at the Gericinó prison complex).

48. We recommend implementation of fast-track transfer of suspected cases to public hospitals, with the designation of reference hospitals for each prison.

49. We recommend the opening of spaces at public and private facilities to isolate suspected and confirmed cases that do not require further medical attention.

50. We recommend the replacement of medical staff in prisons who are themselves suspected of being infected, with the necessary procurement of additional staff to ensure medical care is unaffected by staff shortages.

51. We recommend the promotion and provision of vaccination against seasonal influenza and measles at all prison units and for the entire staff.

52. We recommend the implementation of designating certain prison units as additional diagnosis and testing units (*unidades sentinela*) to complement the already existing ones.

53. We recommend the adoption of criteria under the contingency plans of the Secretary of State for Health for healthcare staff in prisons to notify health authorities and the Health Coordination of the Penitentiary Administration Secretariat when inmates or staff members present with symptoms of the common cold and flu (cough, sneezing, fever, shortness of breath), or/and other symptoms associated with COVID-19 such as loss of smell and taste, headache, diarrhea, body aches, and skin changes, especially among those belonging to risk groups. Inmates who present with such symptoms should be tested, isolated (not in solitary confinement), and monitored every 48 hours for 14 days. Staff who present with such symptoms should be given sick leave, tested and not return to work until 72 hours after the resolution of their symptoms.

54. We recommend maintenance of routine health care not related to COVID-19, for the management of acute and chronic conditions through referrals to medical centers assigned to prison units or outside this system.

Executed this 5<sup>th</sup> day of June, 2020 in Washington, D.C/Ann Arbor, Michigan.

Ranit Mishori, M.D, MHS, FAAFP

Michele Heisler, MD, MPA