UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ENZO COSTA, *et al.*, Plaintiffs, v. BARBARA BAZRON, *et al.*, Defendants.	Civil Action No. 19-3185 (RDM)

DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

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INTRODUCTION

Plaintiffs seek a preliminary injunction (PI) against the District of Columbia, Department of Behavioral Health Director Barbara Bazron and Saint Elizabeths Hospital CEO Mark Chastang (collectively, the District), that would require a breadth of specific measures to be immediately implemented at Saint Elizabeths Hospital in response to the COVID-19 pandemic. Plaintiffs are unlikely to succeed on the merits of their claims under the Due Process Clause or the Americans with Disabilities Act (ADA), and have not shown a likelihood of irreparable harm absent a court order, or that the balance of the equities and the public interest weigh in their favor.

Since well before recording its first case of COVID-19—and well before plaintiffs raised any claims—Saint Elizabeths has been implementing infection control measures consistent with sound public health guidance and has taken extraordinary steps to continue providing mental health care to its patients amid a public health emergency. The reports submitted by the Court-appointed *amici curiae*—which applaud the Hospital's "remarkable job" responding to the pandemic—now confirm these facts. Plaintiffs fall far short of establishing constitutional or statutory liability and do not seek any relief necessary to prevent irreparable harm that is both likely and imminent. The balance of the equities, far from supporting the plaintiffs, weighs against the extensive and intrusive equitable relief that plaintiffs request. Their requests, which include burdensome monitoring and reporting requirements, would divert the time and resources of Hospital staff responding to this

pandemic, and would intrude on the judgments of healthcare professionals entrusted with patient care. Plaintiffs' motion should be denied.

BACKGROUND

I. Saint Elizabeths Hospital

Saint Elizabeths Hospital (Saint Elizabeths, or the Hospital), overseen by the District of Columbia Department of Behavioral Health (DBH), is the District's only public psychiatric facility for individuals with serious and persistent mental illness requiring intensive inpatient care to support their recovery. Decl. of Philip Candilis (Candilis Decl.) [42-1] ¶ 2. The Hospital is licensed to house 292 patients, although before March of 2020, its average daily patient census was approximately 275. Decl. of Richard Gontang (Gontang Decl.) [42-2] ¶ 6. Each unit at the Hospital generally houses no more than 27 patients, and has bedrooms, common living areas, bathrooms and showering facilities, and dining areas. *Id.*

A designated treatment team is assigned to each unit consisting of a variety of professionals devoted to the care of each patient in that unit. *Id.* ¶ 11. Each treatment team consists of a clinical administrator that is responsible for coordinating all care, a psychiatrist responsible for psychiatric treatment and medication, a social worker responsible for discharge planning, and a registered nurse responsible for daily nursing care. *Id.* Each unit also has a general medical officer or nurse practitioner to assist with medical issues, and a psychologist. *Id.* Other specialists such as neurologists are available throughout the Hospital as needed. *Id.*

II. COVID-19 and the Hospital's Response

On January 21, 2020, the United States recorded its first confirmed case of COVID-19, a previously unknown illness caused by the novel coronavirus. *See* Erin Schumaker, *Timeline: How Coronavirus Got Started*, ABC News (Apr. 23, 2020), available at https://abcnews.go.com/Health/timeline-coronavirus-started/story?id=69435165. The District of Columbia recorded its first case on March 7, 2020, and a declaration of emergency and declaration of public health emergency from Mayor Muriel Bowser followed on March 11, 2020. *See* Mayor's Order 2020-046, March 11, 2020, available at https://mayor.dc.gov/sites/default/files/dc/sites/mayormb/release_content/attachments/MO.DeclarationofPublicHealthEmergency03.11.20.pdf.

On January 29, 2020, more than one month earlier, and just eight days after the first recorded case in the United States, Saint Elizabeths began providing guidance to its staff on the prevention and management of COVID-19, including requirements for the screening of patients suspected of COVID-19 and the use of personal protective equipment by staff. *See* DBH Admin. Issuance 2020-01, Attach. 1 to Decl. of Elaine Tu (Tu Decl.) [42-5]. In February, the Hospital's Infection Control Coordinator began training staff on COVID-19 prevention measures based on then-current guidance from the Centers for Disease Control and Prevention (CDC) and the D.C. Department of Health (DOH). Supp. Decl. of Elaine Tu (Tu Supp. Decl.) Ex. A ¶ 4. Before having any confirmed cases, the Hospital implemented requirements for staff screening upon entry and suspended social visitation. *See* DBH Admin. Issuance 2020-01, Attach. 3 to Tu Decl. [42-5]; Report of Joan Hebden, RN and Dr. Ronald

Waldman (Hebden and Waldman Report) [81] at 5 (visitation suspended on March 16, 2020).

It was not until April 1, 2020 that the Hospital confirmed its first case of COVID-19. *See* Tu Decl. ¶ 6; Hebden and Waldman Report at 3. Since that time, the Hospital has continued to implement aggressive infection control measures to ensure the continuity of appropriate care to its patient population and protect the safety of its patients and staff.

A. Cohorting and Quarantine

On March 30, 2020, based on advice from DOH, the Hospital established its first dedicated housing unit for patients under investigation (PUI) with private bedrooms and bathrooms away from all other patients, and then began "cohorting" COVID-positive patients together on the same unit. Tu Supp. Decl. ¶ 8. On April 17, 2020, the CDC and DOH visited the Hospital, observed its quarantine and cohorting practices, and confirmed the practices were in compliance with CDC and DOH standards. *See* Tu Decl. ¶¶ 9-10; Decl. of Joel Selanikio (Selanikio Decl.) Ex. B ¶¶ 10-11. Patients continue to be cohorted, isolated and quarantined according to their COVID-19 status, symptoms and exposure in accordance with CDC and DOH guidelines. *See* Hebden and Waldman Report at 4 (commending the Hospital's "remarkable effort" to cohort patients) Tr. of *Amici Curiae* Oral Report (*Amici* Oral Report Tr.), Ex. C, at 42 (finding "appropriate cohorting of ... patients"). Patients who test positive are placed into dedicated COVID-positive units. Hebden and Waldman Report at 4; Gontang Supp. Decl. ¶ 4. Patients exhibiting symptoms consistent with

COVID-19 who have not yet tested positive are designated as PUI and moved to isolated, individual spaces while they await test results. Gontang Supp. Decl. ¶ 11. When a patient or staff member tests positive for COVID-19, any unit to which he or she had exposure is considered "exposed" and placed under quarantine for 14 days. Hebden and Waldman Report, App'x A [81-1] at 3 (explaining that Hospital's current quarantine practices should be maintained).

Saint Elizabeths also continues to follow CDC guidance for removing patients from COVID-positive and PUI units. Supp. Decl. of Philip Candilis (Candilis Supp. Decl.), Ex. D ¶¶ 8, 18. The Hospital only transfers patients out of COVID-positive units after any symptoms improve, the patient receives negative results from two tests administered at least 24 hours apart, and medical staff approve. *Id.* ¶ 18. A PUI patient will only be discharged after receiving negative results from two tests administered at least 24 hours apart, and with the approval of medical staff. *Id.*

B. Testing

Since its first suspected case of COVID-19, Saint Elizabeths has followed the CDC and DOH guidance regarding the testing of patients with symptoms consistent with COVID-19 and regularly updates its internal policies accordingly. *See* Tu Decl. ¶ 11; Tu Supp. Decl. ¶ 7. *See also* DBH Admin. Issuance 2020-01 (Jan. 20, 2020), Attach. 1 to Tu Decl; DBH Admin. Issuance 2020-01 (Mar. 4, 2020), Attach. 2 to Tu Decl.; DBH Admin. Issuance 2020-0 (Mar. 30, 2020), Attach. 3 to Tu Decl. The Hospital, however, was constrained at first by the limited availability of testing kits, and limits of local laboratories to analyze test results. Tu Supp. Decl. ¶ 7; Selanikio

Decl. ¶ 8. This was a nationwide problem. *See* Dan Goldberg, *et al.*, States Still Waiting on Coronavirus Tests as Trump Tells Them To Do More, POLITICO (Mar. 20, 2020), available at https://tinyurl.com/r7ooyoj.

As testing capacity in the District and at the Hospital improved, Saint Elizabeths expanded testing beyond the recommendations of the CDC and DOH to better protect patient health. Tu Supp. Decl. ¶¶ 13, 14; *see* Hebden and Waldman Report, App'x A at 5 (noting "it is perfectly understandable that the lack of available tests, reagents, nasopharyngeal swabs and other equipment has delayed a regular, routine testing schedule for all patients and staff"). The Hospital completed its first two point prevalence surveys of patients.[1] *See* Tu Supp. Decl. ¶ 15.

C. Reduction in Patient Census

Since the pandemic began, Saint Elizabeths has worked to reduce its patient census to the extent possible through the reduction of patient admissions and the discharge of patients to the community where safe and appropriate. *See* Candilis Decl. ¶ 7; Gontang Decl. ¶¶ 7-9. This was an important early step in combatting the virus. *See Amici* Oral Report Tr. at 18; Report of Dr. Patrick Canavan (Canavan Report) [78] at 4. The current patient population stands at 196, down from 221 on April 21, 2020 and 277 on February 1, 2020. Tu Supp. Decl. ¶ 15; Decl. of Martha Pontes (Pontes Decl.) [44-2] ¶ 4.

[1] On April 30, 2020, CDC issued new guidance recommending for the first time that nursing homes consider facility-wide testing of all patients and staff. *See* CDC, Testing for Coronavirus (COVID-19) in Nursing Homes (April 30, 2020), available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html.

Saint Elizabeths's patients fall into two main categories: forensic patients committed by court order, and patients admitted through the civil commitment process. Supp. Decl. of Richard Gontang (Gontang Supp. Decl.), Ex. E ¶ 20. Forensic patients include patients committed for pre-trial competency evaluations and post-trial patients adjudicated not guilty by reason of insanity in criminal proceedings. *Id.* Saint Elizabeths lacks the authority to discharge forensic patients absent court approval. *Id.*

Saint Elizabeths continues to regularly assess civilly committed patients for discharge to the community. *See* Gontang Decl. ¶ 9; Gontang Supp. Decl. ¶ 29; Canavan Report at 6. The Hospital keeps a "ready-for-discharge" list tracking patients in care who "ha[ve] progressed sufficiently such that the treatment team could identify the level of care and housing needs for the individual when discharged." Canavan Report at 7. The Hospital regularly updates this list and implements discharge plans for patients when appropriate and possible. *See* Gontang Supp. Decl. ¶¶ 24, 26-29. None of the plaintiffs in this case are on the ready-for-discharge list. *See* Gontang Supp. Decl. ¶ 25.

Discharges have continued throughout the COVID-19 emergency. Gontang Supp. Decl. ¶¶ 22, 27-29; Canavan Report at 9. A number of barriers beyond the control of DBH or Saint Elizabeths have hindered additional discharges. *See* Canavan Report at 8-9 (observing barriers outside of the District's control such as a lack of affordable housing, fear over COVID-19, fear of conducting in-person interviews, and outside providers no longer visiting the Hospital in person). DBH has

nonetheless taken proactive steps to address these barriers, such as directly contacting providers who refuse to admit new residents, and issuing a bulletin reminding providers of their obligations to safely accommodate new residents. *See* Declaration of Atiya Jackson (Jackson Decl.), Ex. F ¶¶ 5-6.

In addition to discharging patients, Saint Elizabeths has limited new patient admissions to the greatest extent possible since mid-March 2020. *See* Candilis Decl. ¶ 7 (only three civilly committed patients admitted between March 11, 2020, and April 21, 2020, compared to a pre-COVID-19 average of six to seven per month); Gontang Supp. Decl. ¶ 17-18. The Hospital continues to limit new admissions to court-ordered pretrial patients—whom the Hospital does not have authority to deny—and to civil patients who need longer term hospitalization and cannot be treated in community hospitals. Gontang Supp. Decl. ¶ 18; Candilis Decl. ¶ 7. The last civil commitment was admitted to the Hospital on March 25, 2020, and only three pretrial forensic patients have been admitted since April 24, 2020. Gontang Supp. Decl. ¶¶ 12, 18.

The Hospital continues to take precautions to prevent the introduction of COVID-19 into the facility by new admissions. Gontang Supp. Decl. ¶¶ 17-18. *See Amici* Oral Report Tr. at 24-26. All newly admitted patients are examined upon their arrival to the Hospital. Gontang Supp. Decl. ¶¶17-18. The patient will be quarantined and isolated away from other patients for at least 14 days for observation. *Id.* The patient will not be transferred to a general housing unit until the quarantine period

expires, and until he or she tests negative on two tests administered at least 24 hours apart. *Id.*

D. Staff Movement

Since the Hospital began designating COVID-positive units, dedicated staff have been assigned to care for patients on those units, and movement between units, and in particular between COVID-positive units and other units, has been limited to the extent possible. *See* Tu Decl. ¶ 7; Supp. Decl. of Martha Pontes (Pontes Supp. Decl.), Ex. G ¶¶ 5-7. Each nursing staff member is assigned to a base unit where they provide care to patients. Pontes Supp. Decl. ¶ 4. In limited circumstances, staff may be reassigned to another unit prior to beginning a shift, if necessary to ensure patients receive adequate care and treatment. *Id.* ¶ 5. Although rare, the Hospital's Chief Nurse has made the determination that medical and safety considerations may require nursing staff to move to another unit during a shift; this may occur when, for instance, a patient has a medical emergency requiring immediate attention, or when a patient must be transported to an area hospital with a staff member accompanying them, requiring another staff member to fill in. *Id.* ¶ 5. During the COVID-19 emergency, staff movement across units is not permitted except when necessary. *Id.* ¶ 7; *see* Hebden and Waldman Report at 8 ("Nursing staff are not being moved to another unit within the same shift unless testing results on their assigned patients require movement to another unit.").

When necessary to provide adequate care and ensure patient safety, the Chief Nurse must approve and assign staff for overtime where needed. Pontes Supp. Decl.

¶¶ 5-6. Whenever possible, staff will be assigned for overtime on the same unit as their daily shift. *Id.* However, when the availability of staffing does not allow for such an assignment, the Chief Nurse must balance the medical and psychiatric needs of the patients, security concerns, and the unit's COVID-19 status, among other considerations. *Id.* ¶ 5. When necessary to provide appropriate care and ensure patient safety, nursing staff may be approved for overtime on a different unit than their daily assignment, if the unit has the same COVID-19 status. *Id.* However, the Hospital will not approve any staff member assigned to a COVID-positive unit to then work an overtime shift on any unit with a different COVID-19 status. *Id.* Rarely, and only when management determines it is necessary, will a staff member previously assigned to a COVID-positive unit be re-assigned to a non-COVID-positive unit, and the staff member must take off at least one shift before reassignment. *Id.*

E. Masking and Social Distancing

Since early April 2020, staff have been instructing residents to keep six feet apart and to wear face masks when outside of their rooms. *See* Pontes Decl. ¶ 10; Pontes Supp. Decl. ¶ 13. Universal masking was implemented on April 15, 2020, *see* Hebden and Waldman Report at 5, and masks were and continue to be provided to patients, *see* Pontes Decl. ¶ 13; Pontes Supp. Decl. ¶ 12. Staff have been instructed to enforce these policies to the extent possible, while also considering the unique mental health needs and capacities of individual patients. *See* Pontes Supp. Decl. ¶ 13. Enforcement has been and continues to be effective. *See Amici* Oral Report Tr. at 36, 43.

F. Provision of Mental Health Care

Patients' mental health treatment at Saint Elizabeths consists of many components, the majority of which have remained unchanged during the COVID-19 emergency. Gontang Decl. ¶ 11. Patients continue to receive appropriate and individualized psychiatric treatment, including medications, psychological support, nursing and social work services, as well as other specialty services they may require. *Id.* ¶ 11; Canavan Report at 13. Individual therapy, though now happening remotely, has continued at largely the same frequency as pre-COVID-19. *See* Canavan Report at 16.[2]

Nevertheless, necessary infection control measures have required some components of care to be temporarily altered or suspended. In early March 2020, to protect patients from COVID-19, the Hospital's Chief Clinical Officer decided to temporarily suspend group therapies and activities in the Therapeutic Learning Center (TLC), a large communal gathering space in each of the Hospital's two buildings. Gontang Supp. Decl. ¶ 4; CDC Healthcare Guidance. The movement of patients through the Hospital and the congregate nature of TLC treatment presented too great a risk of infection transmission. *Id.* Under the leadership of its Chief Clinical Officer, the Hospital developed a telehealth plan, which was approved by Hospital

[2] Plaintiffs Costa, Smith and Dunbar each report receiving individual therapy remotely on a weekly basis. *See* Supp. Decl. of Vinita Smith (Smith Supp. Decl.) [87-4] ¶ 6; Supp. Decl. of Enzo Costa (Costa Supp. Decl.) [87-5] ¶ 11; Supp. Decl. of William Dunbar (Dunbar Supp. Decl.) [87-6] ¶ 15.

management, and ordered the necessary technological equipment. *Id.* ¶ 5-6; Attach. 1 to Gontang Supp. Decl.

This plan could not be immediately implemented, however, so that the Hospital could focus its efforts on preventing the spread of the virus. Gontang Supp. Decl. ¶¶ 8-9. The Hospital has now obtained and deployed the necessary technology and will begin to implement the telehealth plan. *Id.* ¶¶ 13, 15 Canavan Report at 17. This will enable some modified group treatment consistent with necessary infection control practices. *Id.* ¶ 13.

III. Plaintiffs' Allegations and Procedural History

Plaintiffs Enzo Costa, Vinita Smith, and William Dunbar filed this putative class action on October 23, 2019.[3] They originally asserted two counts based solely on allegations pertaining to a temporary water outage that occurred at Saint Elizabeths in the fall of 2019. Initial Compl. ¶¶ 1-4. They raised a substantive due process claim under 42 U.S.C. § 1983 and a disability discrimination claim under the ADA, 42 U.S.C. § 12131, *et seq.*, *id.* ¶¶ 97-110, and sought declaratory and injunctive relief, *id.* ¶¶ 111-17. The District later moved to dismiss the case. *See* Mot. to Dismiss [21].

On April 16, 2020, plaintiffs moved to amend their complaint, adding allegations that the District has not been taking proper measures at Saint Elizabeths to mitigate the risks of COVID-19 to patients.[4] *See* Pls.' Mot. For Emergency Hr'g

[3] On April 22, 2020, the Court dismissed plaintiff Stefon Kirkpatrick based on the Parties' joint stipulation of voluntary dismissal. *See* April 22, 2020 Minute Order.

[4] The Court interpreted plaintiffs' motion to be a motion to supplement their complaint under Federal Rule of Civil Procedure 15(d). *See* Mem. Op. and Order [48].

[36]; Proposed Am. Compl. [36-1] ¶¶ 37-122. Over the District's objection, the Court granted the motion. *See* Mem. Op. and Order [48].

Plaintiffs also moved for a TRO, which this Court granted in part on April 25, 2020. *See* Mem. Op. on Mot. for TRO [59]; TRO [60]. The Court ordered that Saint Elizabeths implement specific measures involving the quarantining of patients exposed to COVID-19 and testing of previously symptomatic patients, and that the District file semi-weekly reports detailing its compliance. *See* TRO ¶¶ 1-3. The TRO was initially set to expire on May 8, 2020. *Id.* ¶ 4.

On May 1, 2020, the Court appointed three *amici curiae* proposed by the Parties to inspect Saint Elizabeths and provide findings on disputed issues of fact surrounding infection control measures and the provision of mental health care. *See* May 1, 2020 Minute Order. *Amici* provided a preliminary oral report on May 7, 2020. *See Amici* Oral Report Tr. The Parties agreed to extend the TRO through May 11, 2020. *See* May 7, 2020 Minute Order.[5] *Amici* then submitted written reports on May 11, 2020. *See* Canavan Report; Hebden and Waldman Report.

That same day, the Court extended the TRO through May 22, 2020, and added two additional requirements on the unit assignments of Hospital staff and the completion of "point prevalence surveys" to test all Hospital patients and staff for

[5] As the District noted in the Parties' May 8, 2020 Joint Status Report, the District agreed to extend the TRO through May 11, 2020 "only to allow the *amici* to complete their written report before any further proceedings—not because there is any need for oversight of the Hospital's work." *See* May 8, 2020 Joint Status Report [74] at 11.

COVID-19. Modified TRO [83]. The Court also recommended, but did not require, that DOH assign an individual to oversee and analyze the Hospital's infection control data. *Id.*

LEGAL STANDARD

A preliminary injunction "is 'an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.'" *Sherley v. Sebelius*, 644 F.3d 388, 393 (D.C. Cir. 2011) (quoting *Winter v. Nat'l Res. Def. Council, Inc.*, 555 U.S. 7, 22 (2008)). "The primary purpose of a preliminary injunction is to preserve the object of the controversy in its then existing condition—to preserve the status quo." *Aamer v. Obama*, 742 F.3d 1023, 1043 (D.C. Cir. 2014) (internal quotation marks omitted); *see Chaplaincy of Full Gospel Churches v. England* (*CFGC*), 454 F.3d 290, 297 (D.C. Cir. 2006).

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, *and* that an injunction is in the public interest." *Winter*, 555 U.S. at 20 (emphasis added). The plaintiff must prove all four prongs of the standard before relief can be granted. *See Davis v. Pension Benefit Guar. Corp.*, 571 F.3d 1288, 1296 (D.C. Cir. 2009) (Kavanaugh, J., concurring) ("It appears [post-*Winter*] that a party moving for a preliminary injunction must meet four independent requirements."); *In re Navy Chaplaincy*, 738 F.3d 425, 428 (D.C. Cir 2013). The plaintiff bears the burden of doing so. *Davis*, 571 F.3d at 1292.

ARGUMENT

I. Plaintiffs Cannot Show a Likelihood of Success on the Merits.

Since plaintiffs moved for a TRO, the Parties have developed the record on the Hospital's response to the COVID-19 pandemic. The current record, including the reports issued by the Court-appointed *amici*, makes clear that plaintiffs cannot establish a likelihood of success on the merits.

Demonstrating a likelihood of success on the merits is "the first and most important factor" in the preliminary injunction analysis. *Aamer*, 742 F.3d at 1038. Where the moving party "can show no likelihood of success on the merits, then preliminary relief is obviously improper." *Kiyemba v. Obama*, 561 F.3d 509, 513 (D.C. Cir. 2009); *see also Sherley*, 644 F.3d at 393 (reading the Supreme Court's decision in *Winter* "at least to suggest if not hold 'that a likelihood of success is an independent, free-standing requirement for a preliminary injunction'"); *Davis*, 571 F.3d at 1296 (Kavanaugh, J., concurring) (under *Winter* "a likelihood of success is an independent, free-standing requirement for a preliminary injunction"). The Court need not conclude that plaintiffs will definitely lose on the merits, only that they have not met the demanding burden of showing a clear entitlement to immediate, extraordinary relief. *Sweis v. U.S. Foreign Claims Settlement Comm'n*, 950 F. Supp. 2d 44, 48 (D.D.C. 2013). To overcome this burden, it must be shown not merely that

success is a "possibility" but that it is "likely." *Winter*, 555 U.S. at 20-22. Plaintiffs cannot show a likelihood of success on the merits for either claim they have raised.[6]

A. Plaintiffs' Due Process Claim Is Not Likely To Succeed.

1. Plaintiffs Have Not Shown the Hospital Is Failing to Provide Adequate Care and Safety, or that Anyone Failed To Exhibit Professional Judgment.

Plaintiffs cannot succeed on their first claim for relief under the Fifth Amendment's Due Process Clause. *See* Am. Compl. ¶¶ 218-24. The Fifth Amendment's guarantee of "substantive" due process protects individuals from "unjustified intrusions on personal security." *Ingraham v. Wright*, 430 U.S. 651, 673 (1977). The Supreme Court "has 'emphasized time and again that the touchstone of due process is protection of the individual against arbitrary action of government,' and that the Constitution does not, of its own accord, 'guarantee due care on the part of state officials.'" *Jordan v. District of Columbia*, 161 F. Supp. 3d 45, 54 (D.D.C. 2016) (alteration adopted) (quoting *Cnty. of Sacramento v. Lewis*, 523 U.S. 833, 845, 848-49 (1998)).

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[6] As noted above, the legal claims laid out in plaintiffs' Complaint allege actions from two separate events: the COVID-19 pandemic, and a temporary water outage that occurred in the Fall of 2019. *See* Am. Compl. In their motion for a PI, however, plaintiffs argue they are likely to succeed on the merits only based on the events of the pandemic. *See generally* Pls.' Mem. They do not include any arguments or factual proffers about the water outage. Without raising any arguments about these events, plaintiffs cannot show they are likely to succeed on the merits based on any facts relating to the water outage.

The legal standard applicable to this case comes from *Youngberg v. Romeo*, 457 U.S. 307 (1982).[7] *See* TRO Mem. Op. [59] at 10. In *Youngberg*, the Supreme Court recognized that due process imposes on the government a "duty to provide certain services and care" to "a person [who] is institutionalized—and wholly dependent on the State." *Id.* at 317. These include duties "to provide adequate food, shelter, clothing, and medical care," and "reasonable safety for all residents and personnel within the institution." *Id.* at 324. But plaintiffs' challenge here cannot succeed for two reasons.

First, plaintiffs cannot show that they have at any point been denied "adequate" care or "reasonable safety." *See Youngberg*, 457 U.S. at 324. The record shows that as far back as January 2020, Saint Elizabeths's leadership began taking measures to guard against the spread of COVID-19, in accordance with public health guidelines. *See* Tu Decl. ¶¶ 4, 12; App'x 1 to Tu Decl. Visitation to the facility was suspended in March 2020, before the Hospital's first case of COVID-19, and the Hospital expanded from offering all patients masks to a policy of universal masking on April 15, 2020. *See* Hebden and Waldman Report at 5. Patients and staff were educated and trained on proper hand-hygiene and social distancing, *see* Tu Decl. ¶¶ 4-5, Pontes Decl. ¶ 9, and staff received instruction on the proper use of personal protective equipment, Pontes Decl. ¶ 11, Pontes Supp. Decl. ¶ 11. Plaintiffs' own

[7] Plaintiffs again incorrectly attempt to apply the legal standards applicable to cases involving excessive force. *See* Pls.' Mem. at 10 (citing *Kingsley v. Hendrickson*, 135 S. Ct. 2466, 2475 (2015)). Plaintiffs here, however, do not allege excessive force, nor do they raise claims based on any affirmative acts taken by government officials.

evidence from the middle of April makes clear that even then, the Hospital was providing patients with the things they needed to stay as safe as possible during the pandemic. *See* Guzman Decl. [39-9] ¶ 3 (residents receiving face masks, hand sanitizer, room cleaning and sanitation from staff); Rose Decl. [39-10] ¶ 5 (anonymous patient reported adequate cleaning and availability of soap and hand sanitizer in early April).

The Hospital has been properly cohorting patients based on their COVID status since early April. *See* Selanikio Decl. ¶ 11; Pontes Decl. ¶ 14; Tu Decl. ¶¶ 7-8. Treatment teams have continuously provided patients with individualized care throughout the emergency, including psychiatric and medical care. Gontang Decl. ¶ 11; Candilis Supp. Decl. ¶¶ 4-7; *Amici* Oral Report Tr. at 59; Canavan Report at 13-14. Although most group therapy services have been suspended based on CDC guidance to minimize in-person gatherings, some services have continued with modifications to ensure patient safety. *Amici* Oral Report Tr. at 61 (Dr. Canavan describing staff's "Herculean efforts" to continue competency restoration simulations "on a one-to-one basis"); Costa Supp. Decl. ¶ 13 (participating in music group therapy "every day in my unit"). And, as plaintiffs' own declarations show, Hospital staff deployed digital technology to facilitate virtual individualized therapy sessions weeks before the Amended Complaint was filed, which has allowed individual therapy to continue at the same rate. Gontang Decl. ¶¶ 12-13; *Amici* Oral Report Tr. at 62; Smith

Decl. [38-9] ¶ 10.[8] Plaintiffs cannot show that they are being subjected to inadequate care, an unreasonable risk to their health and safety, or a deficiency of any other rights to which they are entitled when their own evidence shows just the opposite.

Second, plaintiffs are incorrect that a deficiency in care alone would establish a violation of their due process rights. The Fifth Amendment does not establish a negligence regime by which any "objectively unreasonable" action gives rise to a due process claim. *See* Mem. in Support of Pls.' Mot. for PI (Pls.' Mem.) at 18-19. In numerous cases (including *Kingsley*, the key authority on which plaintiffs rely), the Supreme Court has emphasized just the opposite: that constitutional due process violations require more than mere negligence by government actors. *See Kingsley*, 135 S. Ct. at 2472 ("[L]iability for *negligently* inflected harm is categorically beneath the threshold of constitutional due process" (Court's emphasis)); *Davidson v. Cannon*, 474 U.S. 344, 347 (1986) ("[T]he Due Process Clause of the Fourteenth Amendment is not implicated by the lack of due care of an official causing unintended injury to life, liberty or property."); *accord Hargett v. Adams*, Civil Action No. 02-1456, 2005 WL 399300, at *17 (N.D. Ill. Jan. 14, 2005) (observing due process action under

[8] Consistent with plaintiff Vinita Smith's declaration from the middle of April, all three plaintiffs now attest they are receiving individual therapy once per week. *See* Smith Supp. Decl. ¶ 6; Costa Supp. Decl. ¶ 11; Dunbar Supp. Decl. ¶ 15. Dr. Canavan noted that even before the pandemic, those patients who received individual therapy did so "generally once per week." *See* Canavan Report at 11.

Youngberg "not a negligence case where any deviation from the standard of care could impose liability").[9]

The Court in *Youngberg* made explicit that while states have "a duty to provide certain services and care" to those who are institutionalized, "even then a State necessarily has considerable discretion in determining the nature and scope of its responsibilities." 457 U.S. at 317. The Constitution does not force the government to "choose between attacking every aspect of a problem or not attacking the problem at all." *Id.* That is why, when applying Fifth Amendment due process to involuntarily committed medical or psychiatric patients, the Court "must show deference to the judgment exercised by a qualified professional." *Id.* at 322. "By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized." *Id.*

To establish a due process violation, plaintiffs must show that the professionals entrusted with their care made a decision that was "such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that

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[9] Were excessive force at issue here, the Court in *Kingsley* held that an official may be held liable under the Due Process Clause only where "the use of force [was] deliberate—*i.e.*, purposeful or knowing." 135 S. Ct. at 2472. The official's affirmative, physical action must have been carried out deliberately, but the official need not have intended the force itself be excessive as long as the level of force was "objectively unreasonable." *Id.* at 2473. At most, *Kingsley* stands for the proposition that excessive force can rise to a due process violation even absent any intent to inflict punishment.

the person responsible actually did not base the decision on such judgment." *Youngberg*, 457 U.S. at 323.[10]

Under this rubric, in cases involving those involuntarily committed to the state's care, due process "only requires that the courts make certain that professional judgment in fact was exercised" by appropriate staff, without mandating that any specific judgment should have been made. *Youngberg*, 457 U.S. at 321. "[E]vidence establishing mere departures from the applicable standard of care is insufficient to show a constitutional violation." *Patten v. Nichols*, 274 F.3d 829, 845 (4th Cir. 2001). Rather, any given decision, "if made by a professional, is presumptively valid." *Youngberg*, 457 U.S. at 323. The inquiry "is whether the decision was so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one." *Patten*, 274 F.3d at 845 (citation and internal quotation marks omitted).

Professional judgments must also be considered "in light of the constraints under which most state institutions necessarily operate." *Youngberg*, 457 U.S. at 324. Administrative officials, too, "are responsible to the state and to the public for making professional judgments of their own, encompassing institutional concerns as well as

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[10] Although this standard is "potentially less-demanding" than the familiar "deliberate indifference" standard, *see Jordan*, 161 F. Supp. 3d at 58, it is so only in terms of the evidentiary burden it imposes; deliberate indifference requires showing that the official in question subjectively knew of a heightened risk to the plaintiff and disregarded that risk. *See Harvey v. District of Columbia*, 798 F.3d 1042 1052 (D.C. Cir. 2015). Were it the applicable standard, plaintiffs could not establish a due process violation under the deliberate indifference standard, either. The record is clear that the District did not recklessly disregard any known risk to plaintiffs.

individual welfare." *Cameron v. Tomes*, 990 F.2d 14, 20 (1st Cir. 1993); *see also LaShawn A. v. Dixon*, 762 F. Supp. 959, 994 (D.D.C. 1991) (courts must consider "any relevant state interests, including fiscal constraints and administrative burdens."). The practical constraints imposed by an unprecedented public health emergency surely qualify.

Plaintiffs disregard this standard and instead question whether Saint Elizabeths's numerous actions in responding to COVID-19 comport with undefined "standards of care." *See* Pls.' Mem. at 13. But that is not the legal standard for a due process claim, a point vividly illustrated by the Fourth Circuit's decision in *Patten.* There, a patient at a state psychiatric hospital died from congestive heart failure after exhibiting shortness of breath. *Patten*, 274 F.3d at 833. Four days before her death, an attending social worker was alerted that the patient, Patten, had complained of difficulty breathing, displeasure with her anti-psychotic medication, and the fear that she was dying. *Id.* at 832. Both the social worker and a physician at the hospital promptly spoke with Patten, who stated other grievances but did not complain of any physical ailments. *Id.* Her physician neither took her vital signs nor instructed staff to observe her more closely. *Id.* Experts proffered by Patten's estate later testified that her physician's actions amounted to "a significant and gross deviation from the standard of care," observing that he paid her situation insufficient attention and "didn't even arrive at first base to make a diagnosis." *Id.* at 833.

Despite all of those circumstances, the Fourth Circuit held that the hospital and its staff had not failed to exercise professional judgment. Rather, the court

observed "that the defendants in fact took immediate action" upon learning Patten had complained about her health, which included "talking to [Patten] and observing and evaluating her." *Id.* at 844. Although her providers' conclusions about her condition "might have turned out to be wrong, their actions nonetheless exhibited professional concern and judgment and therefore were sufficient to satisfy the requirements of *Youngberg*." *Id.* As the court observed:

> We have no doubt that the defendants could have done more than just talk to [Patten] from across a hallway, and we suspect that the … evidence would be sufficient to withstand a motion for summary judgment if this were simply a medical malpractice case. But, as discussed above, evidence establishing mere departures from the applicable standard of care is insufficient to show a constitutional violation….

Id. at 845. *See Jordan*, 161 F. Supp. 3d at 59-60 (no due process violation under *Youngberg* where defendants provided detailed records reflecting treatment decisions countered only by opinion of plaintiff's expert's "mere disagreement about the scope of treatment or the proper diagnosis"); *P.C. v. McLaughlin*, 913 F.2d 1033, 1043 (2d Cir. 1990) (*Youngberg*'s "requirement that professional judgment be exercised is not an invitation to a court reviewing it to ascertain whether in fact the best course of action was taken").

Plaintiffs rely on a theory of liability amounting to little more than negligence. *See, e.g.*, Pls.' Mem. at 11 (any finding of "objectively unreasonable" conditions amounts to Fifth Amendment violation "regardless of Defendants' subjective intent"). But a constitutional violation cannot be inferred from undesirable circumstances alone. *See Hanson v. Madison Cnty. Det. Ctr.*, 736 F. App'x 521, 539 (6th Cir. 2018) ("There is no *res ipsa loquitur* principle for constitutional torts."); *Kent v. Sziebert*,

Civil Action No. 15-05553, 2016 WL 3248077, at *4 n.3 (W.D. Wash. Apr. 19. 2016) ("*Res ipsa loquitur*, if applicable, allows only for an inference of negligence, which cannot constitute a violation of the stricter standards of deliberate indifference or *Youngberg*'s professional judgment standard."). Plaintiffs must point to a specific decision and show that the decision itself—regardless of the result—was "so completely out of professional bounds as to make it explicable only as an arbitrary, nonprofessional one." *Patten*, 274 F.3d at 845. They have not done this for the Hospital's infection control measures or for the provision of mental health care.

a. The Hospital Has Imposed Infection Control Measures Based on Sound Judgments by Professionals.

Plaintiffs misstate the facts underlying many of the infection control policies and practices they criticize as deficient. In any case, they fail to identify any decision falling outside the bounds of professional judgment. Plaintiffs cannot show any constitutional deficiency in any of the following decisions.

Testing the Patient Population. Plaintiffs assert that at the time they moved for a TRO, the District was not testing patients "even when they displayed … symptoms." Pls.' Mem. at 5. As described in the very declaration plaintiffs cite, the Hospital was evaluating and testing symptomatic patients where appropriate based on applicable guidance at the time—which did not recommend testing every symptomatic patient. *See* Tu Decl. ¶ 11 ("Hospital staff evaluate patients exhibiting possible COVID-19 symptoms, and when appropriate, collect a nasal swab sample for testing."); DBH Admin. Issuance #2020-001 [42-3] at 17 (showing DOH guidance advising that symptomatic patients be tested under limited circumstances). To the

extent plaintiffs fault Saint Elizabeths for not conducting a point prevalence survey until the beginning of May, Pls.' Mem. at 5-6, the very CDC guidance document plaintiffs cite, from April 24, 2020, says nothing about point prevalence testing. *See* Pls.' Mem. at 5 (citing CDC, Preparing for COVID-19: Long-term Care Facilities, Nursing Homes (CDC LTCF Guidance) (April 24, 2020) [55-1]). The CDC did not even recommend point prevalence testing until May 2, 2020. *See* Selanikio Decl. ¶ 14.

Isolation and Quarantine. Plaintiffs incorrectly assert that *amici* found the Hospital's isolation and quarantine measures "have not complied with critical aspects of professional standards of care." Pls.' Mem. at 13 (citing Hebden and Waldman Report at 4). *Amici* found no such thing. *Amici* observed—in the very portion of their report to which plaintiffs cite—that Saint Elizabeths "has made a remarkable effort" to isolate and quarantine patients, but that "[d]ue to delays in determining the viral status of all patients and [providers], along with the unavoidable mobility of [providers] into the community, maintaining the integrity of these units has proven to be challenging." Hebden and Waldman Report at 4. As Ms. Hebden clarified in her oral report to the Court, those "delays in determining the viral status of all patients" resulted from the Hospital being "very limited in the ability to acquire testing early on." *Amici* Oral Report Tr. At 19.

Plaintiffs also wrongly assert that before they amended their Complaint, Saint Elizabeths "was housing individuals with COVID-19 symptoms together with non-symptomatic individuals." Pls.' Mem. at 15. This, too, is incorrect—and again undercut by the very declaration they cite. *See* Tu Decl. ¶ 7 (stating that "all of the

Hospital's known positive COVID-19 cases are cohorted in two specific units," and the Hospital "has a dedicated PUI unit" for "[p]atients who exhibit symptoms of COVID-19"); *see also* Pontes Decl. ¶ 14 ("Any patient that exhibits COVID-19 symptoms will be immediately transferred to the PUI unit and tested … [and] will remain in the PUI [unit] until the DC Forensic Laboratory provides the test results ….").

Patient Census Reduction. Plaintiffs fault the Hospital for "the failure to continue to take measures to reduce head count." Pls.' Mem. at 13-14. This is baseless and contradicted throughout the record. Far from criticizing the Hospital's efforts on census reduction, *amici* approved of them and noted the substantial reductions that have been made. *See* Hebden and Waldman Report at 9 (Hospital "currently has reduced census by 33%"); *Amici* Oral Report Tr. at 6 ("I think the facility has [reduced the census] to a reasonable extent."); *id.* at 8 (census reduction "accomplished very, very well"); *id.* at 47 ("I believe the hospital is effectively reducing the census as the COVID virus became known."); Canavan Report at 4 (observing patient census at "historic lows"); *id.* at 9 ("In an effort to reduce the census at the time the outbreak started, DBH and the Hospital worked with the courts to discharge as many misdemeanant pre-trial individuals as possible."). To the extent the patient census has not been reduced further, it is because the Hospital's Treatment Teams have determined through ongoing individualized evaluations that discharge of each remaining patient is not currently appropriate in light of the patient's mental health

or available community placement options. *See* Gontang Supp. Decl. ¶ 29; Canavan Report at 8.

Staff Movement. Plaintiffs assert that any movement of staff across units runs afoul of CDC guidance. Pls.' Mem. at 18. That is incorrect. Plaintiffs have not identified any CDC guidance that prohibits or even discourages staff movement between non-COVID-positive units in a hospital or long-term care facility. CDC guidelines specify—and have specified since the start of this phase of the lawsuit—that among the things long-term care facilities "*should* do" is to create designated units for COVID-positive residents with dedicated staff.[11] CDC LTCF Guidance at 2, 5 (emphasis added). The same guidance document says that after dedicating units specifically for COVID-positive patients, facilities should merely "*consider* creating a staffing plan for that specific location." *Id.* at 1 (emphasis added). As the CDC recently made clear in new guidance issued for psychiatric and behavioral health facilities, its recommendations are designed to be flexible, giving a facility like Saint Elizabeths the room to account for its unique patient population. CDC, Healthcare Infection Prevention and Control FAQs for COVID-19 (May 11, 2020) (CDC Psychiatric Guidance), Ex. H, at 1 ("[A]s with any guidance, facilities can tailor certain recommendations to their setting."). Nevertheless, staff movement between units has

[11] Similarly, CDC guidance for healthcare facilities, upon which *amici* based their recommendations, *see* Hebden and Waldman Report at 10, advises that "facilities *could consider*" creating designated COVID-positive units with healthcare personnel "assigned to care only for these patients during their shift." *See* CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings [54-1] at 10 (emphasis added).

occurred only where necessary for adequate patient care, and only with changing of PPE and hand washing or sanitization in between. *See* Pontes Supp. Decl. ¶¶ 5-6; Tu Decl. ¶ 7. The Hospital's Chief Nurse decided to permit rare cases of necessary cross-unit movement, including to COVID-positive units, to ensure adequate staff would be available to respond to emergencies. Pontes Supp. Decl. ¶ 5.

Hand Hygiene. Plaintiffs take issue with the Hospital's previous use of preventive hygienic measures, such as non-alcohol based hand sanitizer (which has since been replaced with alcohol-based hand sanitizer). *See* Pls.' Mem. at 14; Hebden and Waldman Report at 6. But *amici* themselves observe that the Hospital "has historically used non-alcohol sanitizing product for patients and around patients due to the risk that alcohol products might be ingested."[12] Hebden and Waldman Report at 6-7. They further observed that "the procurement of alcohol-based sanitizer in larger quantities has been difficult." *Id.* at 7. Although *amici* offered some recommendations, they at no point concluded that any of the Hospital's hand hygiene practices fell outside the bounds of acceptable professional judgment.

TLC Housing. For a short period of time, the Hospital temporarily moved 17 patients from a non-COVID-positive housing unit into the Transitional Side TLC because the unit from which they were moved, 2B, was needed as a COVID-positive isolation unit. *See* Tu Supp. Decl. ¶ 12. The Hospital's Infection Control Coordinator

[12] The Hospital's infection control coordinator had previously determined that the use of non-alcohol-based hand sanitizer was the best way to balance infection control measures with patient safety, given the risks of patients ingesting alcohol-based products. *See* Hebden and Waldman Report at 6-7. CDC guidance acknowledges this difficulty. *See* CDC Psychiatric Guidance at 2.

determined this was the best way to achieve proper cohorting of COVID-positive patients under then-current guidance. *See id.* The Hospital consulted with DOH, which approved of the use of the TLC for housing in this manner. Selanikio Decl. ¶ 9; Tu Supp. Decl. ¶ 12.

Discontinuing PUI Isolation. Prior to the Court's TRO on April 25, 2020, two patients were released from PUI back to their units. *See* Candilis Supp. Decl. ¶ 8. The decision to remove each patient from PUI was made based on the individual receiving negative results on one COVID-19 test, and a medical evaluation and assessment to rule out COVID-19 suspicion. *Id.*[13] The Hospital's current policy is to require two negative results on tests administered at least 24 hours apart before a patient is discharged from isolation back to a non-COVID-positive unit. *Id.* ¶ 18.

Patient Mask Use and Social Distancing. Based on the Court's TRO, plaintiffs contend they have established a due process violation because patient mask use and social distancing were previously not enforced rigidly enough. Pls.' Mem. at 22. But the Court noted that "the (fast evolving record) [was] not developed on" the potentially "sound medical reasons why [facemask use and social distancing] should not be stringently enforced in the context of a psychiatric hospital." TRO Mem. Op. at 14. The record is now clear that the Hospital's Chief Nurse, in consultation with the Chief

[13] More current guidelines specify that a "test-based strategy [for ending isolation] is **NOT REQUIRED** and might not be possible due to limitations on availability of testing." CDC Psychiatric Guidance at 3 (emphasis in the original); *see also Roman v. Wolf*, No. 20-55436, 2020 WL 2188048, at *1 (9th Cir. May 5, 2020) (Collins, J., concurring in part and dissenting in part) (CDC's COVID-19 guidelines are "a poor candidate for incorporation into an injunction").

Clinical Officer and the Infection Control Coordinator, made the judgment that enforcing the Hospital's patient masking and social distancing policies too harshly could be detrimental to the mental health of patients. Pontes Supp. Decl. ¶ 13; *see also* Hebden and Waldman Report at 40-41 (patient refusal to engage in infection control measures a unique limitation in psychiatric settings). In any case, the *amici*'s inspection settled any previous factual disputes: the Hospital's implementation of universal masking and social distancing has been effective and adequate. *See Amici* Oral Report Tr. at 26 (Hospital staff "do have the strategy for universal masking in place throughout the facility"); 40 (masking compliance "very good"); 43 (no concerns with social distancing).

N95 Mask Use Among Staff. The Hospital's Infection Control Coordinator made the judgment that to preserve a limited supply of N95 masks, staff should reuse N95s that were not torn or soiled. Staff were instructed to store their N95s in paper bag overnight between shifts, up to a maximum five times as permitted by CDC guidance. *See* Tu. Supp. Decl. ¶ 20. This decision was based on CDC guidance recommending that staff working directly with COVID-positive or COVID-suspected patients should wear N95s, and concerns about the patient population's inability to comply with masking requirements creating an increased risk to staff. *Id.* This decision was a reasonable medical judgment, *see Youngberg*, 457 U.S. at 322, and a reasonable administrative judgment amid resource constraints, *see LaShawn*, 762 F. Supp. at 994. Currently, the Hospital is providing one N95 each day to all staff members working on COVID-positive and PUI units. Tu Supp. Decl. ¶ 21.

Plaintiffs have thus shown no decision pertaining to infection control outside the bounds of any professional judgment.

b. Mental Health Care Has Continued, and the Decision To Suspend Group Therapy Was Based on Sound Professional Judgment.

Plaintiffs also argue that the District has violated their Fifth Amendment rights by failing to provide adequate mental health services during the COVID-19 emergency. *See* Pls.' Mem. at 25. The record makes clear this is not so, especially in light of a public health emergency. In any case, plaintiffs cannot show that the Hospital has failed to exercise professional judgment.

As a threshold matter, plaintiffs lack standing to seek mental health services for other patients who are not a party to this case. Plaintiffs have not argued that the mental health care of others could cause any injury to them in particular, and the relief they request would require the Hospital to alter the individual treatment plans of nearly 200 patients who are not parties to this case. The cases plaintiffs cite to support this expansive notion of standing involved relief to individual plaintiffs with only "collateral effects" on non-parties. *See Brown v. Plata*, 563 U.S. 493, 531 (2011). But the relief they seek on behalf of nearly 200 patients, such as rewriting every patient's individual treatment plan with "an individual assessment of each patient," *see* Pls.' Proposed Order [87-10] ¶ 8, goes far beyond mere "collateral effects."

Standing aside, plaintiffs cannot establish that the District's provision of mental health services was outside the bounds of professional judgment. The Hospital's Chief Clinical Officer decided to suspend group therapy based on his judgment that it was necessary to protect patients and staff from COVID-19—not, as

plaintiffs contend, based on a judgment that Saint Elizabeths patients "all of a sudden needed almost no services." *See* Gontang Supp. Decl. ¶ 4; Pls.' Mem. at 29.

Far from falling outside the realm of professionally acceptable judgment, this decision comported with then-current CDC guidance on infection control, which recommended that long-term care facilities suspend group activities to prevent the spread of COVID-19. *See* CDC LTCF Guidance at 6.[14] Plaintiffs point only to Dr. Canavan's data compilation comparing the number of treatment hours patients received in February 2020 with treatment hours from April 2020. *See* Canavan Report at 15. There is no dispute that the Hospital suspended group therapies in March in response to COVID-19; it is unsurprising that group therapy tracking for April would not exist. But as Dr. Canavan points out, individual treatment has continued in the form of "frequent 'check-ins'" by nursing and clinical staff, individualized competency restoration, and individual therapy. Canavan Report at 13. He also noted that "[e]ach unit continues to have psychiatry, nursing, social work and clinical administrator services available to the individual in care." *Id.*; *see* Candilis Supp. Decl. ¶ 5. Individual therapy sessions are "continuing either through in-person, phone or through video/teleconferencing," and some activities that are typically conducted through group therapy, such as competency restoration, are still

[14] Plaintiffs themselves cite to guidance from the Substance Abuse and Mental Health Services Administration (SAMHSA), specifying that "group treatment sessions *may have to be suspended* if these sessions cannot be safely modified with fewer individuals reliably practicing social distancing or with video technology available." SAMHSA Guidance [87-3] at 2 (emphasis added).

occurring "on a one-to-one basis with psychology staff." *Id.* He found only a "slight decline" in individual therapy since the outbreak, concluding that "[t]he creative use of alternatives to in-person therapy has allowed most therapy individuals in care uninterrupted treatment."[15] *Id.* at 16. The Hospital is indeed moving forward with its plan to expand teletherapy and resume some groups remotely. *See* Gontang Supp. Decl. ¶¶ 12-13.

Plaintiffs have failed to point to any decision made during the pandemic that was "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." *Youngberg*, 457 U.S. at 323. On the contrary, the record shows that the various procedures and protocols Saint Elizabeths officials have implemented in light of the pandemic have in fact been based on sound professional judgments, balancing the need to provide appropriate care with the need to protect patients from the risks of COVID-19 against the backdrop of external resource limitations. *See LaShawn*, 762 F. Supp. at 994; *Cameron*, 990 F.2d at 20. Plaintiffs cannot succeed on the merits of their substantive due process claim.

2. Plaintiffs Cannot Establish Municipal or Supervisory Liability.

In addition, plaintiffs cannot show a likelihood of success on the merits against the District, or against defendants Bazron and Chastang, neither of whom may be

[15] Dr. Canavan also notes that, based on his interviews, the hours of individual treatment he cited in April were likely underreported. Canavan Report at 15 n.26. This is true. Although the Hospital tracks group treatment hours in a centralized data management system, individual treatment is recorded and tracked in individual patient's medical files and not aggregated. *See* Gontang Supp. Decl. ¶ 14.

liable under a theory of *respondeat superior*. *See Monell v. Dep't of Soc. Servs. of New York*, 436 U.S. 658, 690–91 (1978). "Plaintiffs who seek to impose liability on local governments under § 1983 must prove that 'action pursuant to official municipal policy' caused their injury." *Connick v. Thompson*, 563 U.S. 51, 60 (2011) (quoting *Monell*, 436 U.S. at 691).

There are four ways an official municipal policy can be demonstrated: (1) "the explicit setting of a policy by the government that violates the Constitution;" (2) "the action of a policy maker within the government"; (3) "the adoption through a knowing failure to act by a policy maker of actions by his subordinates that are so consistent that they have become 'custom,'"; and (4) "the failure of the government to respond to a need (for example, training of employees) in such a manner as to show 'deliberate indifference' to the risk that not addressing the need will result in constitutional violations." *Baker v. District of Columbia*, 326 F.3d 1302, 1306-07 (D.C. Cir. 2003) (citations omitted). It is the plaintiff's burden to show the elements of any theory alleged. *Blue v. District of Columbia*, 811 F.3d 14, 20 (D.C. Cir. 2015).

Supervisory liability is likewise "limited." *Elkins v. District of Columbia*, 690 F.3d 554, 565 (D.C. Cir. 2012). For officials sued in their individual capacities, a plaintiff must produce evidence "that each [one], through the official's own individual actions, has violated the Constitution." *Id.* at 564. In this regard, it is not enough to show "mere negligence," by an individual supervisor, but an "affirmative link" between the supervisor's conduct and the constitutional injury that is "strong enough that, from [the supervisor's] perspective, the possibility of a constitutional violation

occurring [by a subordinate] would have been highly likely, not simply foreseeable." *Id.* at 566.

Plaintiffs' motion presents no factual basis or legal theory for municipal or supervisory liability. Without any facts or arguments, plaintiffs cannot establish a likelihood of success on the merits of their *Monell* claim. Accordingly, no preliminary injunction can be issued. *See Swain v. Junior*, — F.3d —, 2020 WL 2161317, at *6 (11th Cir. May 5, 2020) ("Because a district court cannot award prospective relief against a municipality unless the requirements of *Monell* are satisfied …, plaintiffs must establish that they are likely to satisfy the requirements of *Monell* to obtain a preliminary injunction against a municipality.").

B. Plaintiffs Are Not Likely To Succeed on Their ADA Claim.

Plaintiffs also cannot show a likelihood of success on their ADA claim. *See* Am. Compl. ¶¶ 225-31 (citing 42 U.S.C. § 12131). Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

The ADA calls for institutionalized individuals to be placed in community settings "when (1) the State's treatment professionals have determined that community placement is appropriate, (2) the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and (3) the placement can be reasonably accommodated, taking into account the resources available to the State

and the needs of others with mental disabilities." *Brown v. District of Columbia*, 928 F.3d 1070, 1077 (D.C. Cir. 2019) (quoting *Olmstead v. Zimring*, 527 U.S. 581, 587 (1999)). Plaintiffs, however, have failed to raise an ADA claim that they have standing to pursue.

1. Plaintiffs Cannot Succeed on an Unjustified Isolation Claim.

In their motion, plaintiffs argue that the District has "failed to meet [its] obligations under the ADA to facilitate community placement for" a list of specified patients. Pls.' Mem. at 32. As Dr. Canavan observed, Saint Elizabeths maintains a "ready for discharge" list tracking patients in care who "ha[ve] progressed sufficiently such that the treatment team could identify the level of care and housing needs for the individual when discharged." Canavan Report at 7. As of May 6, 2020, 56 patients were on the ready-for-discharge list, each one identified as requiring a certain type of housing in the community.[16] *Id.* at 8.

Plaintiffs cannot succeed on their argument for two reasons. First, they have no standing to raise it. To meet the "case or controversy" requirement of Article III, a plaintiff must demonstrate, among other things, that she has suffered an "injury in fact." *Spokeo v. Robins*, 136 S. Ct. 1540, 1547 (2016). Plaintiffs Costa, Smith and Dunbar have no standing to assert a claim that patients are not being moved off of the ready-for-discharge list quickly enough because they are not themselves on that

[16] Fourteen of those patients would require nursing home care, ten a supporting rehabilitation residence, three an intensive residence, eighteen a supported residence, three a single-room occupancy, two Department on Disability Services (DDS) housing, and one apartment housing. Canavan Report at 8 n.13. Planning for one patient is on hold for clinical reasons. *Id.*

list. *See* Gontang Supp. Decl. ¶ 25. They thus cannot show an injury-in-fact. *See Spokeo*, 136 S. Ct. at 1547. Moreover, plaintiffs cannot seek to vindicate the ADA rights of third parties, and to the extent they are alleging their own interests in the reduction of the Hospital's patient population, those interests are not within the zone protected by the ADA. *See Am. Immigration Lawyers Ass'n v. Reno*, 199 F.3d 1352, 1357 (D.C. Cir. 2000).

Second, even if they did have standing, plaintiffs do not account for the numerous limitations to placing patients into the community. Plaintiffs simply assert that community placement is warranted anytime treatment professionals have determined it is appropriate and the affected individual does not oppose it. Pls.' Mem. at 31. But they omit the third prong of *Olmstead*'s legal standard: that "the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." 527 U.S. at 587. The D.C. Circuit has held that this requires state-run institutions to have a working community transition plan, including a waiting list "that moves at a reasonable pace." *Brown*, 928 F.3d at 1078. Although a state must make certain "modification[s] to its policies and procedures" to facilitate this, it need not do so where "the modification would be so costly as to require an unreasonable transfer of the State's limited resources away from other disabled individuals." *Id.*

The manifest difficulties of placing patients in the community during a pandemic are well documented on the record. As noted by Dr. Canavan, many housing providers have not been willing to take on new residents because of this COVID-19

emergency. *Amici* Oral Report Tr. at 50. Moreover, there is a general shortage in the community of appropriate housing for the needs of the hospital population. Canavan Report at 8. Even when appropriate housing is identified, there is frequently a lack of available bed space. *Id.*

Placement is further complicated by pandemic restrictions on travel and face-to-face interactions, which prevent individuals from being taken to see housing options and to be interviewed in person by housing providers, although the Hospital arranges for phone interviews whenever possible. *Amici* Oral Report Tr. at 50. Some housing providers such as group homes and apartment landlords have expressed hesitation to accept placements Saint Elizabeths patients, *id.* at 9, despite DBH's best efforts to ensure housing providers comply with applicable laws and regulations requiring them to consider housing patients, *see* Jackson Decl. ¶ 5.

All of these barriers aside, the Hospital has still managed to place individuals into the community where possible. *See* Canavan Report at 9 n.16 (noting numerous discharges, including one "extremely difficult" DDS placement). The presence of patients on the ready-to-discharge list is not the product of ADA discrimination or the District's failure to make appropriate efforts towards placement. Despite the obstacles to placement amid COVID-19, between March 15, 2020, and May 2, 2020, Saint Elizabeths discharged 57 patients into the community. Canavan Report at 9. This includes the discharge of four patients to group homes in March 2020, and three patients to group homes in April 2020. That is consistent with the Hospital's average of three discharges to group homes per month since March 2019. *See* Gontang Supp.

Decl. ¶ 27. Even if plaintiffs had standing, they could not show a likelihood of success on the merits as to their claim that the District does not have a transition plan in place that is moving at a reasonable pace. Plaintiffs cite no authority supporting their contention that the list is not moving at a reasonable rate under the circumstances of a public health emergency.

2. Even if Their Claims Are Otherwise Cognizable, Plaintiffs Have Not Shown a Deprivation "By Reason Of" Their Disabilities.

An ADA plaintiff must show "sufficient facts to establish that the complained-of discrimination was due to his disability." *Seth v. District of Columbia*, Civil Action No. 18-1034, 2018 WL 4682023, at *11 (D.D.C. Sept. 28, 2018) (internal quotation marks omitted) (quoting *Howell v. Gray*, 843 F. Supp. 2d 49, 59 (D.D.C. 2012)). It is plaintiffs' burden to allege "that the disability actually played a role in the decision making process and had a determinative influence on the outcome." *Id.* (internal quotation marks omitted). Simply put, plaintiffs must "show that the complained-of discrimination was based on, or based solely on, [plaintiffs'] disability." *Id.*

Plaintiffs cannot show that the District deprived them of anything "by reason of" their disabilities. Saint Elizabeths has been discharging patients at an acceptable rate, and to the extent more patients are not being discharged, the reasons for this have nothing to do with disability discrimination. In fact, the District has been working to ensure community housing providers cannot discriminate against Saint Elizabeths patients by denying them access to housing. *See* Jackson Decl. ¶¶ 5-6. Plaintiffs do not have a cognizable ADA claim.

II. Plaintiffs Fail To Show They Will Suffer Likely and Imminent Irreparable Harm Absent Court-Ordered Relief.

Since January 2020, Saint Elizabeths staff have worked diligently to update infection control protocols and mental health treatment services to keep pace with applicable public health guidance. Those measures were taken well before plaintiffs amended their Complaint and have continued through this litigation. In addition, the Hospital has voluntarily implemented several recommendations proposed by the Court-appointed *amici*. *See, e.g.*, *Amici* Oral Report Tr. at 33-34 (implemented *amici*'s recommendation to switch to surgical masks with face shields for staff); Hebden and Waldman Report at 6 (non-alcohol-based hand sanitizers replaced with alcohol-based hand sanitizers); *id.* at 7 (recommendation to assign one gown per week to staff was adopted by management). And the District's reports to the Court confirm the Hospital's continued compliance with the measures the Court has ordered. *See* Notices of Compliance [64, 70, 73, 76, 85].

In light of these measures, and plaintiffs' failure to show any constitutional or statutory violation, they cannot point to any irreparable harm that is likely and imminent absent court-ordered relief. "The failure to demonstrate irreparable harm is 'grounds for refusing to issue a preliminary injunction, even if the other three factors … merit such relief.'" *Nat'l Mining Ass'n v. Jackson*, 768 F. Supp. 2d 34, 50 (D.D.C. 2011) (quoting *CFGC*, 454 F.3d at 297). "[P]roving irreparable injury is a considerable burden, requiring proof that the movant's injury is certain, great and actual—not theoretical—and imminent, creating a clear and present need for extraordinary equitable relief to prevent harm." *Power Mobility Coal. v. Leavitt*, 404

F. Supp. 2d 190, 204 (D.D.C. 2005) (citations and internal quotation marks omitted).

Plaintiffs ask this Court to order actions that are already occurring or will not address any likelihood of harm that would otherwise occur. Saint Elizabeths has been and intends to continue doing the first three items in plaintiffs' proposed order with or without Court-ordered relief. *See* Pls.' Proposed Order [87-10] ¶¶ 1-3. The Hospital was undertaking mass testing of patients before the Court's Modified TRO. *See id.* ¶ 4. The Hospital also already has Individual Recovery Plans for all patients and updates them regularly.[17] *See* Pls.' Proposed Order ¶ 8; Gontang Supp. Decl. ¶ 15. Patients are already assessed for discharge regularly, Gontang Supp. Decl. ¶ 29, and ordering this to occur every ten days would place an enormous administrative burden on the Hospital's Social Work staff, *id.* ¶ 16. As *amici* repeatedly observed, the Hospital is already reducing the census to the best of its ability. *See* Section I.A.1.a, above; Pls.' Proposed Order ¶ 10. And, as discussed, the Hospital has already implemented many of *amici*'s additional recommendations.

The District has also assigned a DOH liaison to assist Saint Elizabeths, *see* Tu Supp. Decl. ¶ 18, and plaintiffs will not suffer likely and imminent harm if the Court declines to order their requested relief. *See* Pls.' Proposed Order ¶ 5. The same is true of a plan to restore group treatments. *Id.* ¶ 6. The Hospital already has such a plan and is implementing it. *See* Gontang Supp. Decl. ¶ 13. Nevertheless, plaintiffs cannot

[17] Dr. Canavan's observation of some record-keeping inconsistencies, *see* Canavan Report at 16-17, does not undermine this fact, and it certainly does not suggest that plaintiffs are likely to suffer imminent harm unless the Court orders these inconsistencies immediately resolved.

explain how the mere existence or non-existence of a plan would likely stand to imminently injure them if they are in fact receiving appropriate care.

In light of this, plaintiffs' call for an independent monitor is unwarranted and would amount to significant overreach. *See* Pls.' Proposed Order ¶ 12. It is only in the most "unusual circumstances" that the appointment of an independent monitor is necessary to secure compliance with a court order. *Women Prisoners of District of Columbia Dep't of Corr. v. District of Columbia (Women Prisoners)*, 93 F.3d 910, 930 (D.C. Cir. 1996) (citing Fed. R. Civ. P. 53(b)). The question is whether an independent monitor "is really the only remedy left for the Court." *Dixon v. Barry*, 967 F. Supp. 535, 550 (D.D.C. 1997).

In so evaluating, "the court should consider whether there were repeated failures to comply with the Court's orders, whether continued insistence that [the defendant's] compliance with the Court's orders would lead only to confrontation and delay, if there is a lack of sufficient leadership to turn the tide within a reasonable time period, whether there was bad faith, … whether resources are being wasted, … [and] whether a receiver can provide a quick and efficient remedy." *Id.* (citation and internal quotation marks omitted). In the rare cases in which courts appoint monitors, they are appointed (1) when final judgment has been issued against the defendant, and (2) where there are good grounds to question whether the defendant will comply with court-ordered injunctions, *i.e.*, a history of uneven (or no) compliance. *See, e.g.*, *Women Prisoners*, 93 F.3d at 930. An independent monitor here cannot be justified given that this case remains in its preliminary stages, the District

has complied fully and in good faith with all relief this Court has ordered so far, and an independent monitor would do little more than impose additional burdens on Hospital staff. *Amici* have already conducted independent oversight and provided recommendations that the Hospital is now implementing.

Plaintiffs fail to show harm, let alone irreparable harm that is likely and imminent, absent a PI. This alone suffices to deny plaintiffs' motion in full. *See Nat'l Mining Ass'n*, 768 F. Supp. 2d at 50.

III. The Balance of Equities and Public Interest Counsel Against a Preliminary Injunction.

Even if plaintiffs could show a likelihood of success on the merits and that irreparable harm would result without a PI, they must additionally show both that "the balance of equities tips in their favor," and that "an injunction is in the public interest." *Winter*, 555 U.S. at 20. These two factors "merge when the Government is the opposing party" and are thus analyzed together. *Guedes v. Bureau of Alcohol, Tobacco, Firearms & Explosives*, 920 F.3d 1, 10 (D.C. Cir. 2019) (citation and internal quotation marks omitted).

The record demonstrates that since January 2020—more than two months before the Hospital's first confirmed case of COVID-19—Saint Elizabeths staff have worked tirelessly to implement infection control measures and continue the provision of patient care under enormously difficult circumstances. Plaintiffs have not shown a constitutional or statutory violation. On the contrary, *amici* observed that Hospital staff were "very proactive" from the start, *Amici* Oral Report Tr. at 22, have done "a remarkable job" of implementing pandemic response measures, *id.* at 15-16, were

observed putting forward "Herculean efforts," *id.* at 61, and continue to care for patients in ways "that show[] kindness, deep respect and real respect for their dignity," *id.* at 69. To grant an injunction in light of these conclusions would merely show that "no good deed goes unpunished." *Winter*, 555 U.S. at 31.

The burden imposed by the TRO has already been significant. To order the time- and work-intensive relief plaintiffs now seek would strain the Hospital's staff and threaten to jeopardize the provision of adequate care to patients. *See* Gontang Supp. Decl. ¶ 16. The balance of the equities strongly favors avoiding that result. *See Roudachevski v. All-American Care Ctrs., Inc.*, 648 F.3d 701, 707 (8th Cir. 2011) (balance of harms weighed against enjoining nursing home in light of "risk of further disruption to the treatment of residents"); *Subacz v. Sellars*, Civil Action No. 96-6411, 1998 WL 720822, at *3 (E.D. Pa. Sept. 21, 1998) (balance of the equities weighed "against interfering with the delivery of [plaintiff psychiatric patient's] current adequate level of care").

Similarly, there is a well-established public interest in permitting the government to carry out its authorized functions where doing otherwise would needlessly upend its operations. *See, e.g.*, *Benisek v. Lamone*, 138 S. Ct. 1942, 1945 (2018). This is especially true for a public hospital attempting to adjust its patient care to fluid public health guidance amid an ongoing pandemic. *See Youngberg*, 457 U.S. at 322 ("By so limiting judicial review of challenges to conditions in state institutions, interference by the federal judiciary with the internal operations of these institutions should be minimized.").

The balance of the equities and the public interest weigh in the District's favor and counsel against granting injunctive relief.

CONCLUSION

For the foregoing reasons, the Court should deny plaintiffs' motion for a preliminary injunction.

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Respectfully submitted,

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