SUPPLEMENTARY REPORT ON CORONAVIRUS AND IMMIGRATION DETENTION

Professor Richard Coker MB BS, MSc, MD, FRCP, FFPH

Introduction

I have been asked by Duncan Lewis Solicitors to provide my expert opinion on the risks posed by COVID-19 to immigration detainees in the United Kingdom in light of new Government guidance on prisons, and lessons learned from cruise ships' outbreaks.

My qualifications and experience

This it outlined in my earlier report.

My instructions

I have been instructed to address the following questions:

1. Does the Government's guidance in relation to COVID-19, published on 16 March 2020, alter your view that it is plausible and credible that 60% of detainees in IRCs will become infected? If not, please explain why not.
2. What, if any, success did the measures proposed in the Government's guidance have in controlling the outbreak of COVID-19 on cruise ships?
3. At para. 2 (pp14-15) of your report, you provided advice on the measures that should be taken to reduce the risk of exposure and contain the spread of COVID-19 in IRCs. To what extend do the proposals in the Government's guidance satisfy your recommendations?
4. In particular, do you still consider that unnecessary detention should be relaxed before the virus has spread (para. 2(e) at p15 of your first report) or is that unnecessary in light of the Government's guidance?

In addition, having regard to the 2001 study[i] on the link between PTSD immunosuppression:

5. To what extent do the results of this study accord with other medical literature and your experience?

6. To what extent, if any, do you consider do you consider those with PTSD to be at increased risk from COVID-19?

My instructions

I have been instructed to provide a supplementary report addressing the Government's guidance. In particular, to address the following:

Does the Government's guidance in relation to COVID-19 alter your view that it is plausible and credible that 60% of detainees in IRCs will become infected? If not, please explain why not.

The Government's guidance[ii] on the control of COVID-19 in prisons and places of detention does not alter the advice I provided in my earlier expert report. The estimate of 60% is based on epidemiological models of large populations. As the population size shrinks, then the margins of error around this estimate widen. The threshold at which herd immunity is achieved could, therefore, range, for example from 40% to 80%.

I have a number of concerns regarding the Government's new guidance. Critically, the guidance seems to assume that COVID-19 is containable through the identification of prisoners/detainees who are expressing signs and symptoms. This assumes that most transmission of the virus results from symptomatic individuals. In this they are assuming, I believe, that transmission dynamics are similar to influenza. Yet this is not the case. As I reflect in my previous report, transmission from infected individuals who are asymptomatic has been reported. Indeed, a recent publication (yet to be peer-reviewed) suggests that in the order of 50% (estimates of 48% and 62% are reported) or more of cases of COVID-19 acquire their infection from people who are asymptomatic or pre-symptomatic.[iii]

The implications that transmission from asymptomatic cases represents a substantial proportion of transmission has profound implications. It means that:

a) The identification of individuals who are infected through syndromic surveillance (fever, cough etc) and isolation of such cases, no matter how urgently this is implemented, will not halt transmission in a congregate setting.
b) The 'cohorting' of suspected cases is also unlikely to be effective in containing a detention centre outbreak or where many cases have been identified. Indeed, the guidance states 'the area used for cohorting should not be considered the only source of infection.' The reason given is that 'PPDs are at risk of new cases being imported from the community or other establishments.' Whilst this is correct, what is not made clear is that new clinically symptomatic cases may emerge, not through introduction 'from outside', but through asymptomatic/pre-symptomatic cases already present in the detention centre.

What, if any, success did the measures proposed in the Government's guidance have in controlling the outbreak of COVID-19 on cruise ships?

The cruise ships where outbreaks of COVID-19 have occurred offer useful insights into the control of the disease in closed congregate settings with somewhat similar conditions (as noted in my earlier report). Indeed, the Government recognised the threat to public health when it recommended that 'British nationals aged 70 and over, and those with underlying health conditions such as chronic diseases and diabetes, have been advised not to travel on cruise ships in response to the coronavirus outbreak.'[iv] Neither of the cruise ships with reported outbreaks was subject to UK guidance.

Briefly, the cruise ship "Diamond Princess," anchored in Yokohama, Japan. As of early March, 696 laboratory-confirmed cases on the Diamond Princess had been reported. The Japanese government quarantined the ship's 3,711 passengers and crew members for two weeks, from February 5, 2020 until February 19, effectively prohibiting the disembarkation of anyone. Three important concerns have been raised about this case that are relevant to detention centres (from which lessons can be drawn):

First, quarantine is an ineffective measure in preventing the transmission of the virus. It's estimated that each COVID-19 infected individual infected a further 2.2 people.[v]

Second, quarantine in the cruise ship accelerated the transmission because large numbers of people were in kept together in a semi-enclosed space, with limited sanitation, and poor ventilation. People who were infected could not be separated from those who were not infected. This was partly the result of inadequate diagnostic facilities, partly the result of cruise ship design, and likely, in my expert opinion, partly the result of transmission from pre-symptomatic cases.

Third, cruise ships in quarantine offer challenging circumstances to provide health care support that is needed during outbreaks in a timely manner. Passengers and crew suffered as a result.

These lessons were drawn upon, albeit slowly and in a somewhat 'lackadaisical' manner when another cruise ship, in North America, the Grand Princess reported an outbreak. Passengers were not quarantined on-board, they were transported to hospitals, hotels or military bases for 14 days of quarantine more quickly.[vi]

At para. 2 (pp14-15) of your report, you provided advice on the measures that should be taken to reduce the risk of exposure and contain the spread of COVID-19 in IRCs. To what extend do the proposals in the Government's guidance satisfy your recommendations?

The recommendations I made in my earlier report remain unchanged in light of the Government's new guidance on COVID-19 in prisons. As noted above, I remain concerned that guidelines around 'cohorting' are problematic.

I have other, more minor, concerns regarding the COVID-19 guidance. Specifically:

1. It is suggested that, on cases being transferred to an isolation room '[e]scorting staff do not require PPE but must clean their hands on leaving the prisoner or detainee.' The primary route of transmission of this virus is through the respiratory route. Respirators, or at a minimum, medical masks, for escorting staff would seem appropriate, in my opinion. This would be consistent with Government advice in health care settings.[vii]
2. The spread of COVID-19 through objects is acknowledged, and the recommendation to '[f]requently clean and disinfect objects and surfaces that are touched regularly'

made. Specific advice such as how often is not articulated and, it seems, is left to individual centres to determine.

In particular, do you still consider that unnecessary detention should be relaxed before the virus has spread (para. 2(e) at p15 of your report) or is that unnecessary in light of the Government's guidance?

My view that unnecessary detention should be relaxed remains unchanged in light of the Government's recently released guidance.

In addition, having regard to the 2001 study on the link between PTSD immunosuppression:

To what extent do the results of this study accord with other medical literature and your experience?

My knowledge of the literature and my experience in the field of PTSD is limited and I think I am unqualified to extend an expert opinion on this question.

To what extent, if any, do you consider do you consider those with PTSD to be at increased risk from COVID-19?

I am not qualified to answer this question.

Declaration

The contents of this report are true to the best of my knowledge and belief. I understand that in preparing this report I have an overriding duty to the Court, as defined in the *Ikarian Reefer* case and I confirm that I have complied with this duty. Although based in Bangkok, I would be prepared to attend the Court via videoconference to give evidence if required.

18th March 2020

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[i] https://ajp.psychiatryonline.org/doi/pdf/10.1176/appi.ajp.158.3.484

[ii] https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

[iii] https://www.medrxiv.org/content/10.1101/2020.03.05.20031815v1

[iv] https://www.gov.uk/government/news/over-70s-and-at-risk-brits-advised-against-travelling-on-cruise-ships

[v] https://academic.oup.com/qjmed/advance-article/doi/10.1093/qjmed/hcaa092/5805396

[vi] https://www.theguardian.com/world/2020/mar/13/from-paradise-to-coronavirus-the-grand-princess-and-the-cruise-from-hell

[vii] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872745/Infection_prevention_and_control_guidance_for_pandemic_coronavirus.pdf