

**Quarantine and Police Powers:
The Role of Law Enforcement in a
Biomedical Crisis**

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I. Introduction

A bioterrorism attack will create unprecedented challenges for law enforcement commanders. Experts believe that an outbreak of smallpox, for example, could result in the deaths of thousands—or even millions—of citizens.

In the event of such an attack, delays resulting from police legal uncertainty will compromise efforts to immediately protect the public from the spread and transmission of virulent agents. Commanders confronting such scenarios without the benefit of advance planning, or without access to a workable set of graduated tactical options, will face severe difficulties.¹

What is the extent of police powers during crisis-level outbreaks of communicable disease? And what is the legal authority of the federal and state governments to contain such outbreaks? Over the years, those questions have led to legal battles weighing the risks to public health against the rights of the individual.

The key to effective and legal disease control is matching the restrictions to the threat. Tens of millions of people catch colds each year, but law enforcement stays uninvolved because the severity is low. By contrast, other diseases, such as smallpox, may justify severe restrictions, including quarantine and even, possibly, the use of deadly force.²

In the last two centuries, such diseases as cholera and smallpox have provided the impetus for numerous quarantines by the federal and state governments.³ In nearly every instance, however, the quarantine proved too blunt an instrument, inadequately safeguarding those quarantined and provoking widespread civil unrest within the affected communities.

The threat of biological terrorism and the recent SARS outbreak have once again brought quarantine to the forefront of issues facing the health care, public health, and first responder communities. This document examines the issue of exactly who has the legal authority to implement a quarantine. It also discusses the extent of police powers in enforcing a quarantine and some of the difficulties police can expect during a quarantine.

¹ Kevin Smith, “Enforcement of a Temporary Protective ‘Quarantine’ by Local Police in the Event of Biological Terrorism,” paper published by Smith, Rodgers & Strickland, PLLC, May 2003.

² For more information on factors influencing quarantine decisions, see this paper’s Appendix A: Epidemiologic Factors for Implementation of Quarantine.

³ Other diseases that may lead to quarantine are listed in Appendix D: Executive Order 13295: Revised List of Quarantinable Communicable Diseases.

II. Definitions

“Quarantine” is often used to describe many different measures to control threats to public health. The term has been used in bioterrorism exercises to describe a range of containment actions, including travel restrictions and isolation of individuals. The result can be widespread confusion among various elements of the public health command and control structure.

An article in the *Journal of the American Medical Association (JAMA)* notes that “it is most appropriate to use ‘quarantine’ to refer to compulsory physical separation, including restriction of movement, of populations or groups of healthy people who have been potentially exposed to a contagious disease, or to efforts to segregate these persons within specified geographic areas.”⁴ Sometimes the term “large-scale quarantine” is used to differentiate community restrictions from individual restrictions.

“Isolation” refers to the confinement of a person carrying a communicable disease in a controlled environment, usually a hospital, to prevent that person from coming into contact with other persons unless they are taking specific precautions to prevent the spread of disease.

In its “Fact Sheet on Legal Authorities for Isolation/Quarantine,” the Centers for Disease Control and Prevention (CDC) offers these definitions:⁵

Isolation and quarantine are two common public health strategies, which aim to protect the public by preventing exposure to infected or potentially infected individuals.

In general, isolation refers to the separation of people who have a specific infectious illness from healthy people and the restriction of their movement to stop the spread of that illness. Isolation is a standard procedure used in hospitals today for patients with tuberculosis and certain other infectious diseases.

Quarantine, in contrast, generally refers to the separation and restriction of movement of people who are not yet ill, but who have been exposed to an infectious agent and are therefore potentially infectious.

When managing a crisis, it is crucial that each element of the public health response, including law enforcement, use the same terminology. For example, restriction levels should be divided into two classes: individual restrictions and community restrictions. Individual restrictions are based on specific information about the individual, such as whether he or she shows signs of the disease or has been exposed to the disease agent. Individual restrictions can range from instructing people to contact their doctor if they get sick to, in the extreme case, isolation. Community restrictions are those applied to a group of people or an entire community based on community-wide factors. For example,

⁴ Joseph Barbera, M.D., and Anthony Macintyre, M.D., “Large-Scale Quarantine Following Biological Terrorism in the United States: Scientific Examination, Logistic and Legal Limits, and Possible Consequences,” *Journal of the American Medical Association (JAMA)*, Vol. 286, No. 21., p. 2712.

⁵ Centers for Disease Control and Prevention (CDC), “Fact Sheet on Legal Authorities for Isolation/Quarantine,” April 23, 2003, www.cdc.gov/ncidod/sars/factsheetlegal.htm.

after a suspected bioterrorism attack using an agent such as smallpox, everyone in the geographic area of the attack might be prevented from leaving the area and persons outside the area might be prevented from entering.

III. Quarantine Authority

More complicated than the subtleties of terminology are the legal issues regarding who has the authority to declare a quarantine and under what conditions. From the perspective of law enforcement, those issues are not a paramount concern. The decision to declare a quarantine will never be left to the law enforcement community but will be made instead by elected officials or public health officials. Still, law enforcement officials should understand the issues involved, for ultimately they may be required to expand or adjust a quarantine in a time frame that does not permit consultation with public health officials.

In theory, the role of the police during a quarantine will be to carry out public health orders given by the responsible city, county, or state health authority. In practice, the police will frequently have to assess threats to public health and develop appropriate strategies without clear guidance from public health officials. This will happen for three reasons. First, unanticipated situations will develop that must be managed before it is possible to get guidance from the public health authority. Second, in many areas public health resources and expertise are stretched so thin that any widespread outbreak will overwhelm the local personnel. Third, in some areas there is no local health authority with the appropriate expertise. For these reasons, it is useful for police authorities to understand the basics of restrictive measures to control communicable diseases so that they can apply them appropriately.

Local and State

In the event of a local outbreak (one confined to an individual jurisdiction within an individual state), the authority to declare a quarantine usually rests with local public health officials and local elected officials. However, the provisions of public health statutes vary by state. Some states have the authority to intercede in a highly localized outbreak and will likely exercise that authority under such conditions.⁶

If an outbreak spreads beyond a single jurisdiction within a state, the authority to declare a quarantine will be reserved for state public health officials in conjunction with the governor. Still, few states or local jurisdictions have policies or procedures that could help officials decide whether to implement a quarantine.⁷

⁶ “There is great variation among State and local laws and regulations regarding the issues of compelled isolation and quarantine. Historically some states have codified extensive procedural provisions relating to the enforcement of these public health measures, while other states rely on older statutory provisions which can be very broad. In some jurisdictions, local health departments are governed by the provisions of state law; in other settings local health authorities may be responsible for enforcing state or more stringent local measures. In many states, violation of a quarantine order constitutes a criminal misdemeanor.” From “Fact Sheet on Legal Authorities for Isolation/Quarantine” at www.cdc.gov.

⁷ In 2001, the State of Kansas issued a report reviewing the statutory authority of public health, fire, and law enforcement in the event of a terrorist attack or other emergency. The report specifically questioned public health, fire, and law enforcement powers to enforce quarantine. This document, “Kansas Review of Authorities to Address Terrorism Weapons of Mass Destruction,” includes recommendations for modi-

One recent analysis of North Carolina law found that local law enforcement had little explicit quarantine enforcement authority. The analysis was performed by a law firm specializing in tactical legal counsel to police departments.⁸ In March 2002, to guide law enforcement commanders in responding to a suspected chemical or biological attack, the firm published a working draft titled “Enforcement of a Temporary Protective ‘Quarantine’ Under Existing North Carolina Law in the Event of Chemical or Biological Terrorism.” That report is included in Appendix B of this paper.

Federal

The commerce clause of the U.S. Constitution (Article I, Section 8) gives Congress the power to “regulate Commerce...among the several States.” The federal government may therefore impose a quarantine in the event that a communicable disease is spread across state lines or impairs interstate commerce. The Secretary of Health and Human Services has “statutory responsibility for preventing the introduction, transmission, and spread of communicable diseases from foreign countries into the United States, e.g., at international ports of arrival, and from one state or possession into another.”⁹ By executive order of the president, that authority applies to cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, and (added recently) Severe Acute Respiratory Syndrome (SARS). Federal quarantine authority includes the authority to conditionally release individuals from quarantine (for example, on the condition that they comply with medical monitoring and surveillance).

General

In the event of a major outbreak, there will likely be considerable jurisdictional overlap. It is possible for federal, state, and local health authorities to have separate, concurrent legal quarantine power in a particular situation, such as the arrival of an aircraft at a large city airport. Such situations require close cooperation among local, state, and federal officials. However, because the decision to declare a quarantine is ultimately not the responsibility of law enforcement, the rest of this paper will focus on the extent of police powers in maintaining a sanctioned quarantine, as well as the associated moral, legal, and criminal problems law enforcement agencies may face.

fication to state law and additional state and local agency policies needed to prepare for these events.

This document is available at http://nemaweb.org/docs/NEMA_Kansas_Report.pdf.

⁸ Smith, Rodgers & Strickland, PLLC, www.policehelp.net. See appendix.

⁹ CDC “Fact Sheet.”

IV. Underlying Issues for Law Enforcement

Special, underlying issues affect police when they are called on to carry out disease control orders and maintain quarantines. These include chain of command, surety and use of discretion, and officers' personal risk of exposure. Additional issues are raised in Appendix C: Key Considerations for Developing Local Policy for Enforcement of Containment Measures.

Chain of Command

For an individual officer, the chain of command does not change during quarantines and other disease-control actions. However, scene managers need to understand who is directing the operation, when to accept orders, and from whom. Generally, the person in charge will be not a law enforcement officer but an emergency operations manager or health officer. In these scenarios, police must understand that their role is crowd control and restriction of individual activities, not routine law enforcement. This is a major shift that may be difficult for some officers.

Surety and Use of Discretion

How a quarantine is enforced is also very different from other law enforcement, especially in regard to surety requirements and police use of discretion. When serving a warrant or arresting a suspect, an officer tries to be as certain as possible that he or she has the right person before acting. In a criminal matter, that is appropriate. In disease control, the opposite is true. Subjects should be detained or isolated until medical experts are sure it is safe to let them go. Further, the history of quarantine is the history of individuals begging, buying, or forcing their way through quarantine lines, thereby spreading the disease. Police officers should understand that they may not have the usual discretion to make individual judgments in quarantine enforcement. That is, people under restriction may not be allowed out, no matter how urgent their appeals.

Personal Risk of Exposure

Police should also appreciate their own risk and the extent to which they too must be in quarantine. Personal protective equipment may be effective for short periods in limited areas, but during a large disease outbreak or quarantine it will be almost impossible for those enforcing the quarantine to avoid some level of exposure themselves. It may be necessary for officers to be quarantined while they enforce the quarantine on others. At the least, officers should not go home at the end of their shift and become another source of infection in their home or community. With highly infectious diseases, officers should be quarantined with the others who have been exposed or should be provided housing close to the quarantine area and should limit their activities.

If there is a vaccine for the disease or if having the disease gives immunity, everything possible should be done to use officers who are immune. Officers should be screened for conditions that increase the danger of the disease (like pregnancy) or raise susceptibility to the disease. Officers with those conditions should not be used to enforce disease control measures.

V. Special Measures and Powers

As one observer has noted, “A quarantine that cannot be enforced is not a quarantine at all.”¹⁰ In disaster management and disease control, the legal authority to act expands with the threat. Judges will not stop the enforcement of a quarantine or the detention of individuals if they believe it is necessary for public safety. Even if the police are sued later, the courts will be forgiving if the basis for police action was documented and is consistent with good public health practices.

The U.S. Supreme Court has steadfastly upheld the broad powers of the state to protect its citizens from threats to public health. Further, the Court has never questioned police authority to enforce quarantines and other public health measures. Nevertheless, many states have amended their traditional public health laws to provide citizens with additional due process protections.

In a quarantine, the police may be required to enforce temporary measures that, under normal conditions, would not be politically acceptable and might raise constitutional questions. The police must never violate the Constitution (for example, by imprisoning someone for punishment without a trial), but the general scope of police power increases as the threat to the community increases. The exact responsibilities of the police in maintaining a quarantine will vary widely, depending on the specific federal, state, or local laws under which the quarantine was authorized. However, it is almost certain that the right to free assembly will be suspended, as will certain prohibitions on the warrantless search and seizure of property.¹¹ Ultimately, the most important issue is protecting public health. Any mass event would quickly overwhelm official responders. The public will follow the directions or suggestions of the police only if the public trusts the police, and trust cannot be commanded. Ideally, police departments and local organizations (such as faith-based organizations, schools, and businesses) should work together to make plans and lay out their understandings in advance.

Recognizing this need to provide guidance for states on the authority needed by public health to enforce protective measures, the CDC, the Center for Law and the Public’s Health at Georgetown and Johns Hopkins Universities, and representatives from various national organizations collaborated to develop a “Model State Emergency Health Powers Act” (MSEHPA). The goal of the Model Act is to assist state governments in reviewing emergency public health powers to ensure they are adequate to respond to modern disease and bioterrorism concerns. The Model Act helps to define elements of an emergency and the types of measures that can be enforced, but specific guidance on how to

¹⁰ Smith.

¹¹ “[U]nder the Police Power [in contrast to the “takings power”], public health officials 1) may search and seize without probable-cause warrants; 2) may take enforcement actions without prior court hearings; 3) are entitled to have courts defer to their discretion; 4) have great flexibility in crafting enforcement strategies; and 5) must only prove their cases by a “more probable than not” standard if the actions are challenged in court.” From Edward P. Richards, “Collaboration between Public Health and Law Enforcement: The Constitutional Challenge,” *Emerging Infectious Diseases*, Vol. 8. No. 10.

enforce these measures and the role and authority of police agencies in enforcement is not included.¹²

The following sections (“Powers to Control People” and “Powers to Control Property”) contain charts from a commentary¹³ on the MSEHPA, enumerating the emergency powers that, under the Model Act, may be taken toward persons and property when a public health emergency is declared. While the charts do not explicitly define the conditions and manner in which those powers may be exercised, they provide general information on the extent of police powers to control communicable diseases.

Regardless of whether states have formally adopted the provisions of the MSEHPA, police have the power to act under existing laws, even if no public health emergency has been declared. This is a critical point because states are not likely to declare a public health emergency except in the most extreme circumstances.

Powers to Control People

Powers to control people are intrinsic in the state’s police power. Most such powers are used on a day-to-day basis as part of routine disease control, sometimes with the assistance of the police. For example, vaccinations are mandatory for school attendance; medical examinations and quarantine are used for persons suspected of carrying tuberculosis; protected health information is provided to the health department for more than 50 reportable diseases and conditions; and laboratory tests are required on both living and dead persons to detect communicable diseases. The use of those powers in emergencies is just an extension of their day-to-day use.

The following table lists some of the provisions of the MSEHPA relating to control over people and personal information. (Note: PHA means “public health authority.”)

¹² The Model State Emergency Health Powers Act can be viewed at www.hss.state.ak.us/dph/deu/turningpoint/PDF%27s/phsm_EMPA.pdf. The following states have passed the MSEHPA in some form: AZ, FL, GA, HI, MD, ME, MN, MO, NH, NM, SD, TN, UT, and VA.

¹³ “Model State Emergency Health Powers Act Commentary,” Public Health Statute Modernization National Excellence Collaborative, October 2002.

| Sec. | Title and Brief Description |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| § 601 | Protection of persons - generally authorizes PHA to use every available means to control a threat to the public health during an emergency. |
| § 602 | Medical examination and testing - allows PHA to perform physical examinations and tests as necessary for the diagnosis or treatment of individuals during an emergency. Persons who refuse may be isolated or quarantined. |
| § 603 | Vaccination and treatment - PHA may require the vaccination of persons to prevent the spread of an infectious condition. Persons who refuse may be isolated or quarantined. |
| § 604 | Isolation and quarantine - empowers PHA to implement mandatory isolation (for infected persons) or quarantine (for exposed persons) measures for a limited period of time and consistent with a series of conditions and principles. |
| § 605 | Procedures for isolation and quarantine - outlines provisions for temporary isolation and quarantine measures, including notice, relief, recorded proceedings, appointment of counsel, and consolidation of claims, if and when possible. |
| § 606 | Collection of laboratory specimens; performance of tests - authorizes collection of lab specimens and performance of tests on living or deceased animals or persons and permits sharing information with public safety authorities to facilitate criminal investigations related to the public health emergency. |
| § 607 | Access to and disclosure of protected health information - allows access to records of persons under care of the PHA to persons with a need to know, but prohibits many disclosures of identifiable data outside the public health or safety setting without written, specific informed consent. |
| § 608 | Licensing and appointment of health personnel - requires in-state health care providers to assist with emergency treatment and preventative measures authorized by the Act, lifts licensing requirements to encourage out-of-state health care workers to participate in a public health emergency, and authorizes qualified individuals to assist with duties of state medical examiner and coroners. |

Additional information on controlling people during a disease outbreak can be found in Appendix E: Community Containment Measures, Including Non-Hospital Isolation and Quarantine.

A North Carolina-centered analysis of quarantine-related police powers to control people (referenced earlier) found that “curfew law provides the most immediately effective means for local law enforcement to ‘quarantine’—and protect internally—an affected area, if only to await the arrival of health directors, state and federal resources, etc.”¹⁴ That analysis continues:

Because existing quarantine statutes set forth no separate body of use-of-force law..., our model by default cites to *Tennessee v. Garner* and G.S. § 15A-401 (“...or who by his conduct or any other means indicates that he presents an imminent threat of death or serious physical injury to others unless apprehended without delay”). When considering the phrase “imminent threat of death” one cannot hope to make a tidy legal comparison between the average bank robber fleeing with a revolver to many dozens of potentially smallpox- or plague-infected citizens bent on flight from a quarantine zone....

¹⁴ Smith.

Indeed, even a routine bank robber scenario can pose difficult use-of-force dilemmas for experienced officers. ...[W]ith respect to the smallpox scenario, ... officers may find themselves legally, tactically—and even emotionally—unprepared in every respect.

As difficult as conventional use-of-force decisions may be for officers (“what degree of threat is posed by this suspect that justifies a use of force?”), it is axiomatic that no bank robber ever posed a threat to national security, or to the world’s entire population. Further, many officers encounter emotional difficulty and even hesitation when using force against a known dangerous felon wielding a deadly weapon against them.... Which brings us to this question: how will officers respond to innocent men, women, and children seeking panicked egress from a quarantine zone where the consequences of such breach are (or may be) a threat to national security and the world’s entire population? These are very difficult questions indeed!¹⁵

If an individual is forcibly isolated, he or she has a right to seek judicial review of the isolation through a writ of habeas corpus. (Of course, it may be difficult for a person in isolation to arrange for an attorney to file it.) Some states require judicial review before confinement. By contrast, individuals have very limited rights to contest community-wide restrictions and have no due process right to an individual hearing in such cases.

A person who violates a public health order and as a result endangers or infects others can be prosecuted. Arrests and prosecutions are not a primary disease control strategy, but they may be necessary to ensure that the public takes the restrictions seriously.

The police and the government have the moral authority to limit civil rights and liberties in order to prevent a significant risk to other persons. When they do so, each person gains the benefits of living in a healthier and safer society.¹⁶ But significant social costs are incurred whenever the police act in such a manner. Therefore, police departments should work to find ways to avoid such actions.

Powers to Control Property

The state has broad powers to control and even destroy property to protect the public health. Those powers have been enumerated in the MSEHPA (see the following table) but are also part of the state’s fundamental police power. Thus, the police may use those powers as directed by public health or emergency preparedness authorities in states that have not enacted the Model Act and in situations where a public health emergency has not been declared.

¹⁵ Smith.

¹⁶ Barbera and Macintyre, p. 2712.

| Sec. | Title and Brief Description |
|-------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| § 501 | Emergency measures concerning facilities and materials - allows PHA to close, evacuate, or decontaminate any facility or material that poses a danger to the public health without compensation to the owner. |
| § 502 | Access to and control of facilities and property - allows PHA broad access and use of private facilities or materials during a public health emergency with compensation to private owners in the event of a taking. |
| § 503 | Safe disposal of infectious waste - sets rules for the safe disposal of infectious waste to prevent the spread of an illness or health condition. |
| § 504 | Safe disposal of human remains - provides guidelines for the safe disposal of human remains that may pose a public health threat, including use of private facilities as needed. |
| § 505 | Control of health care supplies - authorizes PHA to procure, obtain, and ration needed health supplies (e.g., anti-toxins, serums, vaccines, antibiotics, and other medicines), as well as control their distribution during a public health emergency. |
| § 506 | Compensation - provides compensation for private owners whose property is taken during a public health emergency. Compensation does not occur if the public health agency is exercising police powers (e.g., a nuisance abatement), but only if there is a taking of property. |
| § 507 | Destruction of property - requires some civil procedures prior to the destruction of property where possible. |

VI. Quarantine Maintenance

In addition to the legal battles that can be expected after the declaration of a public health emergency and the accompanying exercise of police powers, law enforcement will have to contend with other issues critical to the maintenance of an effective quarantine. Will the police face widespread civil unrest as they attempt to implement a quarantine? It is hard to say. Some historical examples suggest that a portion of the population will resist the quarantine and that vigilantism may occur as citizens seek to enforce the quarantine themselves. On the other hand, one can find many examples of public cooperation with significant curtailment of liberties by the government. During the Second World War, Japanese-Americans were sent to internment camps without widespread unrest. The public cooperated with the smallpox vaccination program in New York City in 1948. During the Vietnam War, many citizens who opposed the war allowed themselves to be drafted. In a number of ways, civil liberties have been curtailed since the September 11, 2001, terrorist attacks, and no widespread unrest has occurred. Further, in any given riot most people obey authorities.

Police may need to be prepared for problems, yet assuming that the public will refuse to cooperate could be a self-fulfilling prophecy. Unnecessarily heavy-handed law enforcement actions could produce the very responses they are intended to prevent. Because unrest is likely only under certain conditions—not all conditions—it is important to understand what conditions lead to problems so that the police can avoid or mitigate those conditions in a quarantine situation.

One person or a small number of persons can be restricted by force. As the number of affected persons increases, the efficacy of force diminishes because it is impossible to force a large number of persons, spread over a large area, to comply with restrictive orders. People must be convinced that the restrictions are for the public good and that they should comply with them voluntarily. The vast majority of the population will behave responsibly if they have confidence in public authorities and are properly informed. The role of the police then becomes one of facilitation of proper behavior and the management of non-complying individuals.

In quarantines that do meet significant resistance and vigilantism, police must strive to maintain law and order if they wish to maintain the quarantine. A breakdown in law and order may provoke widespread fear, leading to an attempted mass exodus from the quarantined area.

Another historical problem in the implementation of quarantine is the tendency for bias in the drawing of quarantine perimeters and in the application of police powers. While decisions as to which areas should be quarantined will almost certainly be made by public health officials rather than law enforcement, it is important that law enforcement remain vigilant of the deleterious effect their actions may have if they are perceived as biased.

VII. Conclusion

The legal authority to declare a quarantine may reside with local, state, or federal officials, or conceivably with all three. This jurisdictional overlap requires that officials from all levels of government collaborate. Bioterrorism preparedness exercises have demonstrated the confusion that can arise when terminology is used inconsistently. Police executives should ensure that their officers understand exactly what is meant by the buzzwords of a public health emergency, like “quarantine” and “isolation.”

Law enforcement agencies will not be charged with deciding where and when to implement a quarantine. However, their power to enforce the quarantine will be greater than what is allowed by the Constitution under normal circumstances. The goal of a quarantine is to prevent the spread of communicable disease, and the expansion of police powers is provided to further that goal. In the event of a public health emergency, individual rights may have to be subordinated to the rights and health of the community as a whole. Finally, law and order must be maintained. Practices that may help on that front include avoiding bias in quarantine decision making, developing a reputation for trustworthiness with the community and local organizations, convincing the public of the need for the quarantine, and, if necessary, suppressing civil unrest through the use of force.

Appendix A: Epidemiologic Factors for Implementation of Quarantine

The information in this appendix was provided by Professor Edward Richards.

When restrictions are needed to control the spread of a disease, several factors determine the nature of the restrictions, the legal authority to use them, and public support for them. The determining factors are as follows:

Severity of the disease. This is the most important criterion. Tens of millions of people catch colds each year. The result is discomfort and loss of income but few deaths or complications. No quarantines are declared to control the spread of colds because the severity of the disease is low. Flu also afflicts millions, killing some 38,000 elderly and infirm people in an average year, but for otherwise healthy people its severity is limited. Public health authorities recommend immunization shots but do not attempt to keep people who are sick with the flu from moving about in public. By contrast, the 2003 SARS outbreak had a high death rate, so in some locations quarantine was declared.

Number and geographic distribution of persons initially exposed. The smaller the number of persons initially exposed, the more effective the restrictions. When the number of exposed is small, it is more likely that everyone who has been exposed will be found, and resistance to the restrictions is likely to be limited. Restrictions are also more effective when the exposed persons are concentrated in a small area, as was the case with SARS in Canada. When AIDS was recognized in 1981, it had been spreading for several years and as many as 500,000 persons were already infected. It would have been impossible to quarantine such a large group. If the number of persons is large and widely distributed, measures such as quarantine are of little value because they are impossible to carry out. A bioterrorism attack with smallpox that infected a small number of persons would be managed with quarantine, other restrictions, and targeted vaccinations. An attack that infected a large number of persons could not be managed with quarantine, and all resources would be diverted to mass community vaccination programs.

Whether the disease is treatable or preventable. SARS is frightening because it is not treatable and cannot be prevented by vaccination. Smallpox can be prevented by vaccination, but the vaccine is too dangerous to use unless the risk of the disease is high. Anthrax is easily treated if caught early. SARS justifies early and significant restrictions because it can only be controlled by limiting contact between infected and uninfected persons. The risk of smallpox could be greatly reduced or eliminated through resumption of the routine vaccination that was done until 1971. In an outbreak, persons might have to be vaccinated against their will, posing difficult issues for the police because the vaccine is dangerous. If the vaccine were safe, these issues would be much less important.

How the infection is spread. Measles is spread by respiratory contact and is so contagious that an infected person will spread the disease to almost every other non-immune person he or she contacts. Few diseases spread that easily. Even respiratory diseases,

such as SARS, generally require some significant contact time or exposure to concentrated virus, as is suspected in the big apartment house outbreak in Hong Kong where residents may have been exposed to contaminated sewage. The harder the disease is to spread, the less justification there is for restrictions. Hanson's disease (leprosy) was once managed by isolating infected persons until they died. Now it is known that the disease is difficult to spread, so there are few restrictions on infected persons. If SARS were as easy to catch as measles, persons would need to be much more carefully isolated and face masks and hand washing would do little good. Such a disease would require the police to wear protective gear whenever enforcing restrictions.

Timeframe of the illness. The faster the exposed person becomes sick, and the faster the illness progresses, the more the public is frightened of the disease and the more restrictions are called for. SARS sickens people within 10 days and can kill them within another week, while HIV may not cause symptoms for many years. Where onset of illness comes quickly, people are more likely to cooperate with restrictions. Asking someone exposed to SARS to stay home for 10 days is very different from asking someone with drug-resistant tuberculosis to stay home for months or years.

Level of public fear and political reaction to that fear. This is a product of the other factors. The faster a disease develops, the easier it is to catch, the more dangerous it is, and the harder it is to prevent or treat, the more the public and politicians will be frightened and demand restrictions. This public fear can be useful if it increases cooperation with restrictions. It can be disruptive if it causes exposed persons to flee the community or otherwise evade restrictions.

Appendix B: Working Policy Model

The paper on the following pages is a working draft created by Smith, Rodgers & Strickland, PLLC, a law firm specializing in legal counsel to police commanders. The model was presented at the Tier I Anti-Terrorism Training sponsored by the U.S. Attorney's Office and North Carolina's Governor's Crime Commission. The electronic form of the model can be found at the firm's Web site, www.policehelp.net, under "Homeland Security."

WORKING POLICY MODEL

AN INTERIM LEGAL CONSTRUCT FOR NORTH CAROLINA LAW ENFORCEMENT COMMANDERS

ENFORCEMENT OF A TEMPORARY PROTECTIVE “QUARANTINE” UNDER EXISTING NORTH CAROLINA LAW IN THE EVENT OF CHEMICAL OR BIOLOGICAL TERRORISM



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INTRODUCTION

This policy model has been prepared by SR&S for North Carolina Police Commanders who may be in need of an immediate set of “quarantine” enforcement legal guidelines based on existing North Carolina criminal law and procedure.

This draft is properly a work in progress. Commanders may find these guidelines useful to generate discussions, evaluate readiness, and formulate individual department response models within the legal framework of the SR&S five-level paradigm. It is hoped that this draft policy model may lead to the development of a more refined legal construct, or be superseded by more specific governmental directives or even legislative provisions. SR&S welcomes input from law enforcement commanders, emergency management officials, legislative interests, members of the medical community, and others knowledgeable of the issues.

PRECEPTS

- A chemical or bioterrorism attack will create unprecedented challenges for law enforcement commanders. Experts in bioterrorism believe that an outbreak of smallpox, for example, could result in the illness or death of thousands—or even millions—of citizens.
- In the event of a chemical or bioterrorism attack, delays resulting from police legal uncertainty will compromise efforts to immediately protect the public from the spread and transmission of virulent agents.
- North Carolina statutes pertaining to the enforcement of public health quarantines were not enacted in contemplation of chemical or biological attack, or in consideration of the demands of maintaining large-scale quarantines.
- Express statutory authority for the exercise and enforcement of quarantines is vested in local and state health directors. Local health directors are presumably not equipped to immediately enforce large-scale quarantines. And whereas a terrorist attack could occur at any time of the day or week and require instantaneous “on the scene” decision-making, the offices of health directors are generally not manned around the clock.
- Law enforcement commanders are not granted express quarantine authority by the General Assembly. In the absence of other legislative provisions, the police “quarantine” measures set forth in the SR&S model are by resort to the existing statutory mechanisms of curfew, police “urgent necessity,” as well as familiar “use of force” provisions found at G.S. § 15A- 401(d).
- In the event of a terrorist attack, various governmental agencies and officials (including the Governor, the National Guard, the SBI, the State Highway Patrol, the Office of Emergency Management, the Department of Crime Control and Public Safety, the Department of Agriculture, Local and State Health Directors, the FBI, the CDC, and others) will play a vital role in directing local response, rescue, and control measures. Even under optimum circumstances, state and federal intervention may be attended by some period of delay. More adverse circumstances (such as those presented by multiple or multi-faceted attacks, loss of power or communications, catastrophic property damage or loss of life) can be expected to produce significant delays in state and federal intervention. Under any scenario, effective local law enforcement decision-making during the crucial first minutes (to perhaps include the first hours or even days) may be of paramount importance to national security and preservation of life.
- Discussion scenarios on pp. 6-7 of this booklet raise decidedly grim law enforcement possibilities. A police commander confronting such scenarios without the benefit of advance planning, or without access to a workable set of graduated tactical options, will face severe difficulties.

Five Level Response Model

| Response Level | Police Guidelines for Enforcement of Quarantine | Legal Authority |
|----------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
| <p>response level</p> <p style="font-size: 48pt; font-weight: bold;">1</p> | <p>PREPARATION FOR POSSIBLE QUARANTINE –</p> <p>Commanders will mobilize personnel at appropriate locations and remain in a readiness or “stand-by” mode pending corroboration or confirmation of the presence of a chemical or biological agent, information about its identity, inherent risks to public health, method(s) of transmission or contagion, specific directives from State Health and other officials, etc. The Office of Emergency Management will be notified by police commanders in accordance with standard protocols. No action to enforce a quarantine is taken at this response level.†</p> | n/a |
| <p>response level</p> <p style="font-size: 48pt; font-weight: bold;">2</p> | <p>ADVISORY WARNING –</p> <p>Persons seeking entry into the prospective “quarantine zone” are stopped and advised by officers of the possible presence of a chemical or biological warfare agent (including the risk of being prevented from leaving the quarantine zone in the event of an upgrade in the response level); persons wishing to exit the quarantine zone are urged to limit contacts with other persons pending further developments (such as the pronouncement of specific medical directives, more onerous control measures, an “all clear” from State Health officials, etc.). The quarantine and control measures at this response level are voluntary.††</p> | <p>G.S. § 15A-285 (police “urgent necessity”)</p> <p>Indianapolis v. Edmond (dicta)</p> <p>South Dakota v. Opperman</p> |

| | | |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| <p>response level</p> <p style="font-size: 48pt; text-align: center;">3</p> | <p>CURFEW –</p> <p>An immediate curfew* is enacted in the quarantine zone and surrounding area. A properly enacted curfew may restrict the movement of people in public places, prohibit the operation of business establishments, and restrict or prohibit other activities or conditions the control of which may be reasonably necessary to maintain order and protect lives. At this response level, enforcement of the curfew (and hence the quarantine) is by verbal warning and criminal citation** whenever possible, and by custodial arrest where necessary. In the event of custodial arrests, arrestees are specially “classified” and thus isolated from the general jail population to the extent possible.</p> | <p>G.S. §§ 14-288.12 through 14-288.15 (municipal and county curfew authority)</p> <p>See also G.S. § 15A-285 (police “urgent necessity”)</p> |
| <p>response level</p> <p style="font-size: 48pt; text-align: center;">4</p> | <p>CUSTODIAL ARRESTS OF CURFEW VIOLATORS –</p> <p>At this response level, enforcement of the curfew/quarantine is by means of custodial arrest by officers attired in protective clothing and equipment. Persons resisting arrest, fleeing from officers, or otherwise seeking to egress the quarantine zone in defiance of the curfew may be evaluated by officers under the “deadly physical force” standard of G.S. § 15A-401(d)(2)b, to wit: “...or who by his conduct or any other means indicates that he presents an imminent threat of death or serious physical injury to others unless apprehended without delay.”</p> | <p>G.S. § 15A-401(d)(2)b</p> <p>G.S. § 15A-285</p> <p>Tennessee v. Garner</p> <p>Indianapolis v. Edmond (dicta)</p> |
| <p>response level</p> <p style="font-size: 48pt; text-align: center;">5</p> | <p>“MARTIAL LAW” –</p> <p>At this response level representing a worst-case scenario, persons for whom officers have probable cause to believe are seeking to egress the quarantine zone in defiance of the curfew shall be presumed to present an imminent threat of death or serious physical injury to others unless apprehended without delay.</p> | <p>G.S. § 15A-401(d)(2)b</p> <p>G.S. § 15A-285</p> <p>Tennessee v. Garner</p> <p>Indianapolis v. Edmond (dicta)</p> |

SUGGESTED FACTORS TO BE CONSIDERED BY POLICE COMMANDERS IN DETERMINING AN APPROPRIATE “QUARANTINE” RESPONSE LEVEL

- Whether alternative quarantine procedures or directives have been received from state or federal officials, properly superseding local law enforcement control.

Pending timely notification of alternative quarantine procedures (and the arrival of specialized state or federal resources necessary to implement alternative procedures), police commanders contemplating “quarantine” measures under these guidelines should consider the following factors:

- The nation’s terrorism alert level as determined by the Office of Homeland Security, together with any OHS bulletins specifically identifying chemical or biological terrorist threats or conditions.
- Confirmed or suspected chemical or biological attacks elsewhere in the nation, with special consideration to whether those attacks or outbreaks have been attended by illness and loss of life, and in what magnitude.
- The police commander’s degree of certainty that a chemical or biological warfare agent has been identified within the jurisdiction. To facilitate effective and precise communication, commanders “conferencing” the incident may wish to quickly evaluate and categorize available information in terms of such uniformly understood standards as “proof beyond a reasonable doubt,” “probable cause,” and “reasonable suspicion.”
- The police commander’s knowledge of the probable identity of the suspected agent, its potency, the availability of effective vaccines or medications, and the manner and probabilities of contagion unique to the identified agent.
- The availability of personnel resources to establish and enforce a quarantine (including whether the demands of the quarantine might require that officers be pulled from other Homeland Security assignments). [Query: What might be the effect on the delivery of emergency services elsewhere in the jurisdiction, for example, should a major traffic artery be blocked as part of the quarantine? How many off-duty doctors, nurses, police and fire fighters, vital supplies, etc., might be “sealed off” in the quarantine zone? Will a schedule of curfew “exemptions” be enacted? What other tactical and logistical factors might bear consideration?]
- How else might a curfew or quarantine response prove to be counterproductive? For example, might a public declaration of a curfew/quarantine fuel public hysteria, lead to civil disorder (such as a rush on hospitals or drugstores), or otherwise enhance the risks of spreading the contagion, or compromise efforts to contain it?
- What might be the likely effect, elsewhere in the jurisdiction, in the event a quarantine is not enacted and enforced? [Suppose, for example, there is very limited evidence of an attack or outbreak. Might a “preemptive” quarantine of several dozen persons in one location nevertheless be justified as a means of minimizing panic and hysteria among several thousand elsewhere?]

- What is the police commander’s degree of certainty that the chemical or biological agent is indeed confined to a specific and “containable” area within the jurisdiction? [Consider: Fifty confirmed cases of smallpox within a two-block area versus fifty confirmed cases from all over the city. And what effect where the Chief elects to impose a limited or “spot” quarantine, whereupon the Sheriff deems it prudent to quarantine the entire city?—in effect, a larger quarantine overtaking a smaller one? See G.S. § 14-288.15(b)(3) (authority of Governor where state of emergency has spread across local jurisdictional boundaries).]
- Commanders considering quarantine response levels 4 and 5 should evaluate, among a myriad of very difficult factors, the availability of hazmat-equipped medical teams to enter quarantine zones for provision of basic medical care; the availability of food, water and other supplies; the timely arrival of specialized state and federal assistance, medical teams, vaccines, etc.; and other legal, ethical, and moral issues having a direct bearing on basic human rights and preservation of life.

DISCUSSION SCENARIOS:

1. In City A, a 911 operator receives a call from an excited citizen who believes he is exhibiting signs of smallpox. (In October this same citizen phoned 911 on multiple occasions to report that he was likely infected with anthrax.)
2. In County B, a postal customer has received a suspicious letter in the mail. The letter, penned in Arabic-appearing script, appears tainted with a mysterious white dust. A rumor is spreading through the neighborhood that the white dust contains the smallpox virus. Calls from concerned citizens are beginning to flood the 911 communications center.
3. Same facts as #2 above, but the nation is in a “Red” (Severe) Condition for risk of terrorist attack. Homeland Security Director Tom Ridge has disclosed that the specific risk identified by his agency involves an imminent biological attack
4. In City C, local hospital officials and EMS report that dozens of persons—all from the same neighborhood—have suddenly fallen ill. Explanations are speculative, and range from food poisoning to a possible smallpox outbreak.
5. Same facts as 4 above, but bioterrorist attacks are already occurring in three other States (casualty tolls: California – 600 dead; New York – 2,000 dead; Florida – 70,000 dead).
6. Same facts as 5 above, but smallpox outbreaks have just been confirmed in Raleigh and Statesville.
7. Same facts as 6 above. The ranking law enforcement commander has declared Quarantine Level 5. Several hours later, a minivan driven by a mother and containing small children attempts to circumvent a police roadblock in an attempt to egress the quarantine zone. The woman is panicked and seeking emergency medical care.

8. City E and Town F are fifteen miles apart, joined by highway U.S. 421. A smallpox outbreak has just been confirmed in City E. The Commander in Town F wishes to impose a “reverse quarantine” by blocking traffic inbound from U.S. 421.

† At this response level commanders may consider the advisability of issuing a public service announcement via local media outlets requesting that persons and traffic use alternate routes of travel.

†† At this response level commanders will consider the appropriateness of broadcasting the “advisory warning” through local media outlets, including the possibility of activating the emergency broadcast system via local emergency management and civil defense authorities.

*Law enforcement officials should consult G.S. §§ 14-288.12 (“municipal curfews”), 14-288.13 (“county curfews”), and 14-288.17 (“when curfews effective”) very carefully. In order for a curfew to become immediately effective (that is, without the delay attendant to convening local governing bodies for proclamation of a state of emergency), a jurisdiction’s ordinance must delegate to the mayor (or chairman) the unilateral authority to quickly determine and proclaim a state of emergency. [NOTE: If your town (county) curfew ordinance does not delegate this authority to the mayor (chairman), SR&S strongly recommends that the ordinance be redrafted. Secondary to that effort, SR&S recommends that the mayor (chairman) delegate the authority to proclaim a state of emergency directly to the Police Chief or Sheriff (or on-duty designee). These steps will expedite the curfew process, and could be pivotal in helping law enforcement commanders quickly utilize existing curfew law as an effective bioterrorism quarantine tool.]

**Sample charging language for a misdemeanor citation may read as follows: “...did knowingly and unlawfully violate the restrictions imposed by a [city][county] ordinance properly in effect pursuant to G.S. § 14-288.12(13), to wit: [describe violation]”.

Appendix C: Key Considerations for Developing Local Policy for Enforcement of Containment Measures

In September 2003, as a result of the rapid spread of Severe Acute Respiratory Syndrome (SARS) and the very real threat of bioterrorism, the Police Executive Research Forum (PERF) convened a discussion group of professionals to identify issues that would face police officers and other enforcement personnel during the implementation of a large-scale quarantine.

Officials from PERF, the Center for Strategic and International Studies (CSIS), and the Charlotte-Mecklenburg Police Department identified the following key considerations to address when developing policy to enforce public health declaratives and containment measures:

1. Type of Outbreak: The type of outbreak will largely determine the necessary law enforcement response, amount and types of resources needed, and length of the quarantine. A local policy needs to consider the types of outbreaks that are possible and the range of procedures needed to effectively contain each outbreak situation.
2. Quarantine Perimeter: Model policy must consider quarantines with both very large and very small perimeters, along with associated factors, such as the numbers of persons contained. Policy considerations for quarantines that cross jurisdictional boundaries must address information- and resource-sharing issues, such as who is responsible for communication among departments and what type of information is shared. Policy will need to accommodate varying levels of containment measures implemented in adjoining counties and varying types of enforcement policies and procedures. Law enforcement agencies will need policies and directives on when and how to increase or decrease the perimeter of the quarantine. Other policy considerations may include when to seek additional resources and where those resources will come from.
3. “Levels” of Quarantine: There is no guide or manual for the implementation of a quarantine, only considerations for developing protocols based on public health decisions. (See Appendix E.) Should a policy define levels of quarantine, including what enforcement measures are appropriate and the type and amount of resources required for each quarantine level? Should this policy be developed in conjunction with public health, so that all first responders are clear on the activities and guidelines that will be in place? What can be done to encourage voluntary compliance at each quarantine level?
4. Law Enforcement Training: Police must have some training in public health issues and threats, considerations and reasons for implementing quarantine, and vaccines and other medications—as part of the information base to implement an

- effective quarantine effort. Average departments (both police and fire) need basic education and training, the necessity of which should be outlined in policy. Further, knowledge of probabilistic information on various risks and how they are mitigated or prevented will be needed for law enforcement to act effectively and to work collaboratively with community members faced with a quarantine.
5. Public Health-Law Enforcement Coordination: During a public health emergency, police will need to work with hospital administrators, public health officials, legal advisors, EMS, and others from different disciplines. Although law enforcement personnel work with these individuals routinely on criminal matters, participating in managing a public health threat and enforcing public health directives is not a usual activity for police. Does the policy need to outline hospital–law enforcement interaction and police responsibilities? What law enforcement agencies expect from public health needs to be identified, clarified, and prioritized so police have the information needed to do their job prior to an actual emergency. Policy instruments, such as mutual aid compacts, are key here and will require public health to either take the lead in developing new compacts or work collaboratively with law enforcement agencies to come to a mutual understanding of roles and responsibilities. Communication, information-sharing, and terminology issues will also need to be addressed so public health, law enforcement, and other first responders are all working from a common frame of reference.
 6. Multijurisdictional (State-to-State) Law Enforcement Coordination: A key quarantine issue that must be addressed arises when two or more states that share borders need to contain an outbreak. Considerations include differences in public health enabling law, law enforcement training, experience and resources, resource sharing, and access to timely, coordinated information about new outbreaks, quarantined populations, and individual and community containment measures.
 7. Enforcement Procedures and Functions: Enforcement functions and procedures for handling a public health emergency are very different from routine police functions. For example, one reality of a quarantine situation is that exposed or infected persons must first be located, and locating them is not an easy matter, as they may be spread out widely. Who is responsible, and what level of force should be used to contain individuals or move them to contained areas? Will policy need to include considerations for altering enforcement procedures based on the specific risk? How will law enforcement manage and integrate functions such as quarantine enforcement, criminal investigations of suspected terrorist involvement, public fear, crowd control, and mass casualty and death scenes, to name a few? What other roles and responsibilities will law enforcement be required to take on?
 8. Information Sharing and Release of Information to the Public: Releasing timely and accurate information to the public is of utmost importance in a quarantine situation to maintain public order and achieve maximum voluntary compliance with quarantine measures. The key will be determining beforehand—well before a quarantine needs to be imposed—what must be communicated to the public.

Special attention should also be paid to anticipating public concerns and questions, including challenges regarding authority to impose the quarantine.

Community education on what the problem is, how disease is spread, and what the role of the individual citizen is in cooperating with public health measures must be addressed. Policy needs to address who is responsible for community education, the channels through which the information is provided, and how and when the media will be convened. Ensuring media understanding of the rationale for public health directives, and what police will be doing to enforce the directives, will be key to accurate reports to the community.

While formal release of information will primarily be the responsibility of public health agencies, policy should also include special considerations for public health to provide timely information to law enforcement, including the reasoning behind quarantine measures. Law enforcement will likely be a direct channel of informal information to the public during daily enforcement activities. Police officers will need to know the types of information to provide and how the information should be presented.

9. Resources: Quarantine will likely exhaust unimaginable community resources, both public and private, including volunteers. Sufficient resources must be researched and identified early on, especially if the quarantine will be in place a long time. Policy should outline procedures for procuring additional local, state, and federal resources and for reserving and deploying these resources in the event of a large-scale public health emergency.
10. Technology/Technological Resources: Policy should also provide some directive on the types of technology that may be needed in the event of a quarantine and on ways in which technology can be used to help police determine their information and resource needs and enforcement responses. How can technology, especially analytical and mapping programs, help law enforcement manage resources and identify or track threats or noncompliance in a quarantine?
11. Reductions in Containment Measures/Demobilization: Consideration for scaling back containment measures and for recovery after a public health emergency may also be included in policy. For example, when does the community resume normal function? What are the protective measures first to be relinquished, how are they “repealed,” and when should this be done? What is the enforcement role in this process? What does the community need in order to resume normal function?

Appendix D: Executive Order 13295: Revised List of Quarantinable Communicable Diseases

Office of the Press Secretary

For Immediate Release

April 4, 2003

EXECUTIVE ORDER

REVISED LIST OF QUARANTINABLE COMMUNICABLE DISEASES

By the authority vested in me as President by the Constitution and the laws of the United States of America, including section 361(b) of the Public Health Service Act (42 U.S.C. 264(b)), it is hereby ordered as follows:

Section 1. Based upon the recommendation of the Secretary of Health and Human Services (the "Secretary"), in consultation with the Surgeon General, and for the purpose of specifying certain communicable diseases for regulations providing for the apprehension, detention, or conditional release of individuals to prevent the introduction, transmission, or spread of suspected communicable diseases, the following communicable diseases are hereby specified pursuant to section 361(b) of the Public Health Service Act:

(a) Cholera; Diphtheria; infectious Tuberculosis; Plague; Smallpox; Yellow Fever; and Viral Hemorrhagic Fevers (Lassa, Marburg, Ebola, Crimean-Congo, South American, and others not yet isolated or named).

(b) Severe Acute Respiratory Syndrome (SARS), which is a disease associated with fever and signs and symptoms of pneumonia or other respiratory illness, is transmitted from person to person predominantly by the aerosolized or droplet route, and, if spread in the population, would have severe public health consequences.

Sec. 2. The Secretary, in the Secretary's discretion, shall determine whether a particular condition constitutes a communicable disease of the type specified in section 1 of this order.

Sec. 3. The functions of the President under sections 362 and 364(a) of the Public Health Service Act (42 U.S.C. 265 and 267(a)) are assigned to the Secretary.

Sec. 4. This order is not intended to, and does not, create any right or benefit enforceable at law or equity by any party against the United States, its departments, agencies, entities, officers, employees or agents, or any other person.

Sec. 5. Executive Order 12452 of December 22, 1983, is hereby revoked.

GEORGE W. BUSH

THE WHITE HOUSE,

April 4, 2003.

Appendix E: Community Containment Measures, Including Non-Hospital Isolation and Quarantine

The following is a supplement to the Centers for Disease Control (CDC) document “Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) Version 2.” Currently, there is little information for law enforcement on containment measures and law enforcement activities to enforce the measures. This supplement to the CDC guide to SARS response provides an overview of the range of community containment measures and considerations for increasing or decreasing the levels of containment. This overview can be generalized to other types of threats. Section VI outlines activities for developing protocols for enforcing community containment measures.

Public Health Guidance for Community-Level Preparedness and Response to Severe Acute Respiratory Syndrome (SARS) Version 2

Supplement D: Community Containment Measures, Including Non-Hospital Isolation and Quarantine

V. Community-Based Control Measures

Whereas decisions on use of containment measures in individual situations depend primarily on the characteristics of the exposure and the affected contact, the decision to institute broader use of community measures is more complex. The different options—e.g., active monitoring with voluntary activity restrictions, legally mandated quarantine, institution of snow days—will vary in their effectiveness in controlling the outbreak and their impact on personal liberties. Other measures that might prevent inadvertent SARS-CoV exposures (e.g., temperature monitoring in public places; use of masks) should also be considered. Decisions should be based primarily on the epidemiologic characteristics of the outbreak. Other considerations will include the healthcare and public health resources available and the level of community cooperation (see Appendix D4).

Local officials will face enormous logistic, economic, ethical, and psychological challenges in implementing community-level containment measures. Preparedness planning should include development of essential partnerships to address: 1) provision of essential services and support (e.g., food, household and medical supplies, medical attention, care-taking, continuation of work/school via telecommuting or home-based curricula, financial support), 2) mental health (e.g., stigma management and prevention, psychological support), and 3) enforcement (e.g., controlling entry into and exit from narrowly defined geographic areas; border surveillance/monitoring; travel permits and credentials).

Even with the most comprehensive planning, however, officials must be prepared to make decisions on the basis of incomplete or inadequate information and to modify strategies as the situation unfolds. Although control measures should never be used in-

discriminately or in a manner out of proportion to the situation, undue caution should not inhibit the bold and swift implementation of the interventions upon which effective control depends.

Objective 1: *Reduce the risk of transmission of SARS-CoV at the community level by implementing large-scale measures that limit social interactions and prevent inadvertent exposures.*

Activities

- Implement community containment measures based on the epidemiologic characteristics of the outbreak, according to the graded response outlined in the box below.
- In the absence of SARS-CoV transmission in the world, activities should focus on preparedness, planning, and surveillance for the first case(s). Public health and healthcare officials should provide community members with information about SARS and promote hand hygiene and respiratory hygiene/cough etiquette (See Supplement C).

| Graded Implementation of Community Containment Measures | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Level of SARS Activity | Response |
| No SARS-CoV transmission globally | Preparedness planning |
| SARS-CoV transmission in the world, but all cases locally either are imported or have an identifiable epidemiologic link to other cases at the time of initial evaluation | Passive or active surveillance/monitoring of contacts |
| SARS activity in the area, with either a small number of cases in persons without an identifiable epidemiologic link at the time of initial evaluation or increased occurrence of SARS among known contacts | Quarantine of close contacts |
| SARS activity in the area, with a large number of cases in persons without an identifiable epidemiologic link at the time of initial evaluation; control measures are believed to be effective to increase social distance | Focused measures to increase social distance; consider community-level measures |
| SARS activity in the area, with a large number of cases in persons without an identifiable epidemiologic link at the time of initial evaluation; control measures are believed to be ineffective | Community-level measures to increase social distance; consider community-wide quarantine |
| Decreases in the number of new cases, unlinked (or “unexpected”) cases, and generations of transmission | Quarantine of contacts |
| Transmission has been controlled/eliminated; no new cases reported | Active monitoring in high-risk populations; continue for 2-3 incubation periods after control or elimination of transmission. |

If SARS-CoV transmission is occurring in the world, but the United States is reporting only a few imported cases and no or limited local transmission from those cases, then officials in areas with SARS cases should consider passive (at minimum) or active monitor-

ing of close contacts. Although active monitoring promotes early identification of non-specific or insidious symptoms and reliable assessment of fever and symptoms, it also requires substantial resources. Local conditions therefore may dictate at least initial use of passive monitoring, particularly in the management of contacts with lower-risk exposures. For persons with high-risk exposures (e.g., healthcare workers with unprotected exposure to a SARS case, especially during a high-risk procedure), home quarantine with either passive or active monitoring may be considered.

Jurisdictions should consider more restrictive measures for any of the following situations:

- Identification of cases without known epidemiologic links (i.e., cases occurring in persons who, at the time of diagnosis, are not known to have had contact with a known SARS case or exposure to a known transmission setting)
- Increasing number of cases among contacts of SARS patients
- Significant interval between the onset of symptoms and the isolation of cases
- Inadequate resources for continued isolation of cases and tracing and monitoring of contacts

Measures to be considered include quarantine of close contacts, such as family members or healthcare workers who provided care to SARS patients. This approach has the advantage of limiting the use of quarantine to those at greatest risk, but implementation requires time, effort, and availability of skilled interviewers.

Whenever possible, contacts should be quarantined at home. Home quarantine requires the fewest additional resources, although arrangements must still be made for monitoring patients, reporting symptoms, transporting patients for medical evaluation, and providing essential supplies and services.

In some cases, affected persons may not have access to an appropriate home environment for quarantine. Examples include travelers; persons living in dormitories, homeless shelters, or other group facilities; and persons whose homes do not meet the minimum requirements for quarantine. In other instances, contacts may have an appropriate home environment but may not wish to put family members at risk. In these situations, health officials should identify a facility with the appropriate characteristics for quarantine of contacts. Monitoring may be either passive or active, although active monitoring may more appropriate in a facility setting.

Jurisdictions with large numbers of cases without known epidemiologic linkages should consider instituting *measures to increase social distance*. Identification of an unlinked case can mean either that transmission is occurring from undetected cases or that contact tracing efforts are not identifying all potential contacts. Increasing social distance can reduce the likelihood that unexposed community members will be exposed to SARS-CoV and that persons who have already been exposed will unknowingly transmit to others if

they become symptomatic. Interventions to increase social distance are usually applied to groups of persons in settings where there might have been exposure to SARS-CoV (e.g., a school in which several cases of SARS have been diagnosed). In a community with ongoing transmission, these measures may be applied to settings without known exposure (e.g., cancellation of concerts or sporting events; restricted use of public transportation).

The “snow day” approach may be an effective way to increase social distance and reduce transmission because it is a concept with which most Americans are familiar. This intervention would likely be instituted for an initial 10-day period, with final decisions on duration based on assessment of current epidemiologic information. Other community-level measures, such as community-wide temperature monitoring, temperature screening before entering public buildings, or recommended or mandatory mask use, may also be considered. Although the effectiveness of these interventions has not been quantified, they might enhance public awareness and facilitate early detection of cases.

In extreme circumstances, when control measures do not appear to be effective or resources are overwhelmed, more restrictive measures such as *widespread or community-wide quarantine* may be considered.

Objective 2: *Scale back community containment measures as soon as appropriate.*

Communities may scale back community containment measures as the outbreak comes under control. For example, with significant declines in the number of new cases, unlinked cases, and generations of transmission, the community measures can be halted and efforts can be refocused on quarantine of known contacts.

The process by which community containment measures are lifted requires as much thought and planning as their implementation. When applied to individuals, movement restrictions such as quarantine can be removed as soon as the exposed contact has remained without signs or symptoms of disease for a complete incubation period for SARS-CoV disease (i.e., 10 days).

A decision to discontinue the broader use of community-level measures is more complex. A decision on the optimal time to remove these measures must balance the need to restore personal liberties against community safety. Premature removal of containment strategies can increase the risk of additional transmission and recurrent outbreaks. Decisions should be based on evidence of improving local/regional control, such as 1) consistent decrease in the number of confirmed cases, 2) reduction in the number of probable and known cases, and 3) confirmation that all cases either were imported or have a known source or well-defined epidemiologic link.

Activities

- When there is reasonable evidence of improved control of the outbreak, discontinue quarantine of contacts of persons meeting the criteria for SARS RUI (see Supplement B, Appendix B1). Continue quarantine of contacts of persons with

probable or confirmed SARS-CoV disease, particularly those with known exposures or well-defined epidemiologic links.

- When three incubation periods have elapsed since the last reported confirmed case of SARS-CoV disease, discontinue quarantine of contacts. Also discontinue maintenance of designated facilities for quarantine.
- As soon as appropriate, discontinue use of community-level containment measures. Withdraw the most stringent measures (e.g., geographic or population-based movement restrictions, mass transit interruptions, travel restrictions) first. Begin scaling back community-level measures when three incubation periods have elapsed after identification of the last unlinked or probable case of SARS-CoV disease (i.e., all cases are imported or have known exposures or well-defined epidemiologic links).

VI. Enforcement of Community Containment Measures

Data from modeling studies suggest that community containment measures such as quarantine are effective for controlling an outbreak even if compliance is less than perfect. Optimally, quarantine applied on a voluntary basis will afford sufficient compliance to attain the necessary effect. Nevertheless, protocols must be established for enforcement of both individual and community measures when higher levels of compliance are required.

Objective 1: Enforce individual quarantine restrictions as necessary.

Activities

- Develop protocols for follow-up of persons who cannot be reached by telephone. Protocols might include a threshold period for non-responsiveness that should trigger a home visit or other means to locate the person. Partnerships with law enforcement and other community-based resources will be helpful in tracing the whereabouts of persons who have violated restrictions.
- Consider and plan for the use of alternative arrangements for persons who cannot or will not comply with voluntary home quarantine. These might include:
 - Issuing official, legally binding quarantine orders
 - Posting a guard outside the home
 - Using electronic forms of monitoring
 - Using guarded facilities

Objective 2: Enforce community-level containment measures as necessary.

Activities

Enforcement of community-wide containment measures is necessarily more complex given the larger number of persons involved. Although some measures, such as cancellation of public events or scaling back of mass transit services, are self-enforcing, others (e.g., restrictions on travel between areas) may require use of physical measures such as checkpoints. Implementation will require close partnerships and cooperation with law enforcement at the local and state levels. Federal law enforcement resources may also be available in some situations.

For more information, visit www.cdc.gov/ncidod/sars or call the CDC public response hotline at (888) 246-2675 (English), (888) 246-2857 (Español), or (866) 874-2646 (TTY).