☐ EXPEDITE
☒ No hearing set.
☐ Hearing set for:
Date: _____
Time: _____
Judge/Calendar: _____

SUPERIOR COURT OF WASHINGTON
FOR THURSTON COUNTY

CANDIS RUSH, JUSTIN AUTREY, GREGORY STEEN, THEODORE RHONE, and MICHAEL LINEAR, on behalf of themselves and all others similarly situated,

Plaintiffs/Petitioners,

vs.

WASHINGTON STATE DEPARTMENT OF CORRECTIONS, a state agency; STEPHEN SINCLAIR, Secretary of the Washington State Department of Corrections; WASHINGTON STATE DEPARTMENT OF HEALTH, a state agency; and DR. UMAIR SHAH, Secretary for the Washington State Department of Health,

Defendants/Respondents.

CLASS ACTION

No. 21-2-00491-34

FIRST AMENDED COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF AND PETITION FOR JUDICIAL REVIEW

I. PRELIMINARY STATEMENT

1. This case is about ensuring that our most vulnerable communities in Washington are not forgotten in the allocation of the new COVID-19 vaccines. Plaintiffs/Petitioners[1] and the class they seek to represent, are currently incarcerated in the custody of the Department of Corrections (DOC).

[1] Plaintiffs/Petitioners will be referred to as Plaintiffs to avoid confusion.

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2. As a group, people in DOC custody have suffered horribly over the last year. Thousands of them have fallen ill from COVID-19, some have died, and all have suffered horrendous conditions as Defendants/Respondents[2] have unsuccessfully managed the COVID pandemic in our prisons. To date almost 40% of the people in DOC custody have contracted COVID, a rate more than 8 times greater than the general public. There is likely no other large population cohort in Washington that has been infected at a greater rate than people in our prisons.

3. The very nature of Washington's prisons led to the introduction and rapid spread of COVID. Close living conditions, poor hygiene and sanitation, decrepit buildings and facilities, limited access to PPE, and the constant coming and going of people from the outside into prisons have all had predictable results—massive outbreaks. These are the results that Defendants were warned about by public health experts and community members at the outset of the pandemic.

4. However, since January 2021, Defendants have had the ability to protect people living in Washington's prisons and to end the terrible conditions that COVID has caused. Unfortunately, they made the conscious decision not to do so. To date, the State has given over 3,000,000 COVID vaccinations, but has refused to give the vast majority of the 14,300 people living in our prisons a single one.[3] As a result of Defendants' unwillingness to take this simple step, thousands of people remain at serious risk of contracting COVID.

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[2] DOH and Secretary Shah are the respondents in this case. DOC and Secretary Sinclair are the defendants. To avoid confusion, Defendants and Respondents will be referred to as Defendants. Plaintiffs/Petitioners will be referred to as Plaintiffs. DOC and DOH will include Secretary Sinclair and Secretary Shah.

[3] DOC's website does not currently disclose how many DOC staff or how many people in custody have been vaccinated. Staff and people in prison are lumped together. DOC's website says (and has said for weeks) that information as to how many staff and how many people in custody have been vaccinated is "Coming Soon." https://doc.wa.gov/corrections/covid-19/data-vaccines.htm (last viewed on April 4, 2021).

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5. While refusing to give most people in prison access to the vaccine, Defendants have also permitted correctional staff who have been offered but refused the vaccine to have continued direct face-to-face contact with people living in our prisons – the precise means by which COVID has entered Washington's prisons in the past.

6. Defendants' refusal to provide people living in Washington's prisons with the life-saving vaccines, refusal to protect those same people from staff who refuse the vaccine, and refusal to end the deplorable conditions imposed upon the people under their care all violate Defendants' duty to keep Plaintiffs and the proposed class free from cruel punishment in violation of Article I, §§ 12 and 14 of Washington's Constitution, their common law duty to protect their health, welfare and safety, and is arbitrary and capricious.

7. Accordingly, Plaintiffs ask this Court to certify the proposed class, to order Defendants to immediately administer the vaccine to all people in DOC custody who want to take the vaccine, and order DOC to prohibit staff who have refused to take the vaccine from having contact with anyone who lives in Washington's prisons.

II. PARTIES

1. Plaintiff Candis Rush is a person in prison at Washington Corrections Center for Women (WCCW) in Gig Harbor, Washington.

2. Plaintiff Justin Autrey is a person in prison at Monroe Corrections Center (MCC) in Monroe, Washington.

3. Plaintiff Gregory Steen is a person in prison at Clallam Bay Corrections Center (CBCC) in Clallam Bay, Washington.

4. Plaintiff Theodore Rhone is a person in prison at Stafford Creek Corrections Center (SCCC) in Aberdeen, Washington.

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5. Plaintiff Michael Linear is a person in prison at the Washington Corrections Center (WCC) in Shelton, Washington.

6. For purposes of this Petition the mailing address of all Plaintiffs and the Plaintiff Class shall be:

c/o Nicholas B. Straley
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7. Defendant Washington State Department of Corrections (DOC) is a state agency and operates Washington's state prisons.

8. Defendant Stephen Sinclair is the Secretary of the Washington State Department of Corrections.

9. Defendants DOC and Sinclair are responsible to supervise, train and manage DOC administrators, staff, and contractors.

10. Defendant Washington State Department of Health (DOH) is a state agency and is responsible for Washington State public health matters, including the State's COVID-19 response and vaccine allocation and distribution. DOH's mailing address is:

Washington State Department of Health
111 Israel Rd SE,
Tumwater, WA 98501

11. Defendant Dr. Umair Shah is the Secretary for the Washington State Department of Health.

12. The Defendants are all state actors and are responsible for implementing and enforcing the policies and practices described herein. Each of the acts described herein was done under color of law and constitute state action for all purposes.

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III. JURISDICTION AND VENUE

1. The events giving rise to this action occurred at DOC facilities that are all located in the State of Washington.

2. As to DOH and Dr. Shah, this case arises under the Administrative Procedure Act, RCW 34.05.001 *et seq*.

3. As to DOC and Secretary Sinclair, this case arises under RCW. RCW 2.08.010.[4]

4. Proper venue for this action is in Thurston County, pursuant to RCW 34.05.514 and RCW 4.12.020(2).

IV. DESCRIPTION OF AGENCY ACTION AND FACTUAL ALLEGATIONS

Facts related to COVID-19 and its impact in prisons:

1. COVID-19 is a novel coronavirus first identified in late 2019. It is easily spread from person to person by airborne particles/droplets, and in some cases by exposure to contaminated surfaces.

2. COVID-19 infections can range in severity, with the mildest cases showing few to no symptoms, the majority presenting as moderate to severe respiratory symptoms (e.g., cough, difficulty breathing, congestion, sore throat, loss of smell and/or taste, and fever), while the most serious cases can result in critical illness or death.

3. COVID-19 has been classified by the World Health Organization as a worldwide pandemic, and as of March 28, 2021, there have been 126,359,540 confirmed cases worldwide, as well as 2,769,473 deaths from this virus.[5]

[4] The APA does not apply to DOC. RCW 34.05.030(1)(c).

[5] WHO Coronavirus (COVID-19) Dashboard, World Health Organizations, https://covid19.who.int/ (last visited Mar. 28, 2021).

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4. On a national scale, over 30,500,000 people have contracted COVID in the United States and over 550,000 people have died since the outset of the pandemic.[6]

5. In Washington State alone, there have been a total of 367,115 cases and 5,278 deaths.[7] In short, COVID-19 has proven to be the most significant global health crisis in living memory.

6. For people in prisons, this public health crisis has been exponentially more severe. As of March 26, 2021, more than 396,000 people in prison and 96,000 correctional staff members throughout the United States have tested positive for COVID-19; 2,435 people in custody and 159 staff members have died.[8]

7. In Washington State, 6,191 individuals in DOC custody have tested positive for COVID-19, and 14 people in prison have died as a result of their infections.[9] Another 1,154 DOC staff members have also become ill, and two died.[10]

8. As of March 26, 2021, just over 39% of the people in DOC custody have tested positive for COVID-19.[11]

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[6] COVID Data Tracker, Centers for Disease Control and Prevention, https://covid.cdc.gov/covid-data-tracker/#datatracker-home (last visited April 2, 2021).

[7] COVID-19 Data Dashboard, Washington State Department of Health, https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard (last visited April 2, 2021). 367,115 cases includes 23,652 probable cases.

[8] National COVID-19 Statistics, COVID Prison Project, https://covidprisonproject.com/data/national-overview/ (last visited Mar. 28, 2021).

[9] Confirmed Cases, Washington Department of Corrections, https://www.doc.wa.gov/corrections/covid-19/data.htm#confirmed (last visited April 2, 2021).

[10] *Id.*

[11] COVID-19 Comparative Jurisdictions, Washington Department of Corrections, https://www.doc.wa.gov/corrections/covid-19/data-comparative-jurisdictions.htm (last visited Mar. 27, 2021).

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9. This is more than eight times the rate of infection compared to the rest of Washington State, where the infection rate equals just under 4.7% of the total state population.[12]

10. Residents and staff of correctional institutions are at a particular risk of harm from exposure and spread of COVID-19.

11. Prisons are crowded congregate environments where people live, eat, and sleep in close quarters. By structural design, people in correctional institutions cannot achieve the social distancing necessary to prevent the spread of COVID-19.

12. While the general public has been required by executive order to wear masks in public and, for several months last year, to stay at home except for essential activities, there have been other measures imposed to protect the public health, including prohibiting most gatherings, closing schools and state offices, and closing nonessential businesses.

13. People inside correctional facilities have not had nor do they currently have *any* of those protections.

14. Additionally, much like social distancing, effective masking cannot always take place. When people go to shower, eat, sleep, or simply forget to wear a mask, these individual gaps in mitigation efforts are not isolated incidents. Instead, they compound with every single person who may be doing the same activity at any given time inside the facility.

15. Like other congregate environments, such as nursing homes and cruise ships, diseases like COVID-19 that are transmissible by air or touch, can spread more rapidly in a carceral setting. This fact alone means that any person in DOC custody has a heightened risk.

[12] The total population for Washington State as of April 2020 is 7,656,200. *See,* Total Population and Percent Change, Washington State Office of Financial Management, https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/total-population-and-percent-change (last visited Mar. 27, 2021).

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16. Certain people are at heightened risk for a severe or even fatal outcome from COVID-19 because of their advanced age or because they suffer from some other health-related condition which may exacerbate COVID's symptoms.

17. However, COVID poses a serious risk of harm not only to people of advanced age or those with underlying medical conditions. In the United States, younger adults with COVID-19 have been severely affected by the disease as well. People between the ages of 18-64 make up 74% of positive cases and 19% of deaths.[13]

18. COVID-19 can also cause long-term health issues for people of all ages.[14] These conditions can include fatigue, shortness of breath, cough, joint pain, chest pain, difficulty thinking or concentrating, depression, muscle pain, intermittent fever, and heart palpitations.[15] These complications can cause long term or permanent damage to different systems in the body, including the cardiovascular, respiratory, renal, dermatologic, and neurologic systems.[16]

19. COVID's potential neurological impacts are particularly concerning. People who have contracted COVID have experienced long term issues like brain fog, memory loss, and other neurological problems.[17] Doctors are increasingly reporting "psychotic symptoms emerging weeks after coronavirus infection in some people with no previous mental illness."[18]

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[13] COVID Data Tracker, CDC, *supra*.

[14] Long Term Effects, Centers for Disease Control and Prevention, https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects.html (last visited Mar. 28, 2021).

[15] *Id.*

[16] *Id.*

[17] *Id.*

[18] Pam Belluck, "First Covid, Then Psychosis: 'The Most Terrifying Thing I've Ever Experienced," The New York Times (Mar. 22, 2021), available at: https://www.nytimes.com/2021/03/22/health/covid-psychosis.html.

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20. Large numbers of patients who have been infected with COVID-19 continue to experience an array of symptoms long past the time they have initially recovered from the initial stages of the illness.

21. Often referred to as "Long COVID," these symptoms, which can include fatigue, shortness of breath, "brain fog", sleep disorders, fevers, gastrointestinal symptoms, anxiety, and depression, can persist for months and can range from mild to incapacitating.[19]

22. In some cases, new symptoms arise well after the time of infection or evolve over time.[20]

23. As a result, it is imperative that health care providers implement measures post-infection to identify, monitor, and treat "long COVID" that may arise in patients.

24. One recommended standard is to require follow up encounters with patients in the 14 days following the end of medical isolation to talk with patients about any ongoing symptoms and provide treatment where necessary. For example, the identification of "Long COVID" following isolation may identify persisting respiratory problems that require occupational therapy or physical therapy to expand the lungs in the months following infection.

25. COVID-related behavioral health problems, particularly those related to mental health and substance abuse have also arisen since the start of the pandemic.

[19] *See* National Institute of Health Website, "NIH launches new initiative to study "Long COVID," (Feb. 21, 2021), available at: https://www.nih.gov/about-nih/who-we-are/nih-director/statements/nih-launches-new-initiative-study-long-covid.

[20] *Id.*

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26. The COVID pandemic has caused and exacerbated mental health conditions. Suicide and overdose rates have skyrocketed since the beginning of the pandemic.[21]

27. The COVID-19 virus has evolved since its initial discovery. Today, there are at least five different COVID-19 related variants of concern circulating in the United States. They are: B.1.17 first detected in the United Kingdom, B.1.351 originally detected in South Africa, P.1 first identified in travelers from Brazil, and B.1.427 and B.1.429 first identified in California.[22]

28. Cases involving all five variants have been identified in people in Washington within the last two months.[23]

29. Evidence suggests that some or all of the variants may be more transmissible and may cause more severe disease or be more lethal. Antibodies generated during a previous COVID-19 infection or through a vaccine may be less effective in fighting these variants and they may be more likely to elude diagnostic detection.[24]

30. For example, available information indicates that B.1.1.7 may be more infectious and potentially more lethal. The CDC indicates that B.1.1.7 may become the most dominant strain of COVID-19 in the United States.[25]

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[21] *See* CDC Newsroom, "Overdose Deaths Accelerating During COVID-19," (Dec. 17, 2020) (over 81,000 drug overdose deaths occurred in the U.S. in the 12 months ending in May 2020, the highest number of overdose deaths ever recorded in a 12-month period).

[22] *About the Variants*, Centers for Disease Control https://www.cdc.gov/coronavirus/2019-ncov/transmission/variant.html (last visited on April 2, 2021).

[23] https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/data-tables/420-316-SequencingAndVariantsReport.pdf (last visited on April 2, 2021); COVID-19 Variants, Washington State Department of Health, https://www.doh.wa.gov/Emergencies/COVID19/Variants (last visited Mar. 28, 2021).

[24] *Id.*

[25] *Id.*

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31. Plaintiffs and proposed class members are both more likely to contract COVID and are more likely to suffer long-term, adverse complications than are other groups of people who do not live in prisons.

32. They live in extremely close quarters with many other people where social distancing is impossible.

33. They often lack proper personal protective equipment and have no ability to stay away from others who do not take appropriate protective measures. They cannot avoid contact with correctional staff who may be infectious with COVID-19.

34. They live in decrepit facilities with poor ventilation and unhealthy sanitation systems.

35. Generally, health care provided in Washington's prisons is under-resourced and as a consequence has been inadequate to meet the needs of those infected with COVID.[26]

36. Moreover, it is also well-recognized that people incarcerated in prisons age at a much faster rate than people in the general public, because of the harsh realities of prison life, the prevalence of pre-existing conditions, the incidence of long-term, untreated substance abuse or mental health disorders, and the lack of necessary health care both while in prison and before entry.

37. Furthermore, people in prison are more likely to suffer from co-morbidities that can lead to serious illness and death from COVID-19. Those conditions include, hypertension,

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26 *See, e.g.* Jan. 14, 2021, Office of the Corrections Ombuds report: Delayed Cancer Diagnosis & Management. https://oco.wa.gov/sites/default/files/Delayed%20Cancer%20Diagnosis%20and%20Management%20Final%20with%20DOC%20Response.pdf (last visited on April 2, 2021). *See also* OCO 2019 and 2020 Annual Reports which indicate that inadequate medical care is the top complaint from people in prisons as well as OCO's largest area of concern. https://oco.wa.gov/sites/default/files/public/Annual%20Report%202019%20Final.pdf and https://oco.wa.gov/sites/default/files/public/Annual%20Report%202020%20Final.pdf.

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diabetes, chronic kidney disease, heart conditions, compromised immune systems, obesity, cardiovascular disease, sickle cell disease, and history of smoking.

38. As more becomes known about COVID, indications are that adults of any age with the following conditions *might* be at an increased risk for severe illness: Asthma, cystic fibrosis, auto-immune diseases, neurologic conditions such as dementia, liver disease, pulmonary fibrosis, thalassemia, and type 1 diabetes.[27] Many people in prisons suffer from these different maladies.

39. For these reasons, the risk associated with COVID-19 and its variants are much greater for Plaintiffs and the class they seek to represent than almost any other population cohort. Each person in DOC custody remains at grave risk of serious illness or death from this virus.

Facts regarding DOC's ineffective efforts to combat COVID-19 and the horrendous conditions that have resulted.

40. From the outset of the pandemic until the end of 2020, the only effective means of controlling the spread of this disease was through social distancing and use of personal protective equipment.

41. The past year has demonstrated that the nature of congregate settings (and correctional facilities in particular) makes the effective implementation of these measures exceedingly difficult, if not impossible. As a result, thousands of individuals in DOC custody have fallen ill over the past year.

42. Early on in the pandemic, Defendants created policies and protocols they claimed would avoid huge outbreaks in Washington's prisons.

[27] *Id.*

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43. They implemented a variety of practices and other measures in an attempt to keep COVID from entering the prisons and to reduce its spread once that occurred.

44. Unfortunately, as evidenced by the large number of people who have become infected, those efforts have proven to be disastrously ineffective.

45. DOC experienced a huge explosion of COVID-19 cases in a number of prisons beginning in November 2020 and continuing into January and February 2021.

46. On November 2, 2020, DOC had reported a total of 531 confirmed COVID cases amongst people in prison over the previous 10 months (with a total of 34 active cases). By November 30, 2020, those numbers had grown to 931 confirmed cases (including 378 active cases). On December 15, 2020, DOC had confirmed a total of 2,630 cases (1,727 active cases). By January 4, 2021, that number had nearly doubled again to 4,901 cases, with 1,792 active cases. There have been nearly 2,000 additional cases since the beginning of the year, with new cases reported each week.

47. To date, the facilities that have been hardest hit by COVID-19 outbreaks include: Airway Heights Corrections Center (1,671 cases); Coyote Ridge Corrections Center (400 cases); Larch Corrections Center (281 cases); Monroe Correctional Complex (551 cases); Stafford Creek Corrections Center (1,204 cases); Washington Corrections Center (976 cases); and the Washington State Penitentiary (985 cases).[28]

48. Though Defendants have failed to explain how COVID entered these facilities, it is extremely likely these massive outbreaks were caused by infectious correctional staff or contractors who infected the people who live there and other staff members.

[28] Confirmed Cases, DOC, *supra.*

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49. Once inside, the virus spread quickly and dangerously throughout the facilities because of the lack of social distancing, poor facility designs, failure by staff and others to follow safety protocols and other shortcomings.

50. Overwhelmed with the magnitude of the disaster and with limited options, DOC took to utilizing long-term, extreme isolation and quarantine and they have denied some people basic needs such as access to bathrooms, food, and the out-of-doors.[29]

51. People held in medical isolation have not been allowed to contact family for extended periods of time; have been denied access to personal hygiene or other personal items; and had only limited access to showers and clean clothes.

52. Similarly, people held in quarantine have experienced long periods of degrading and disgusting conditions.

53. Some prisons have experienced severe overcrowding in certain cell blocks with people forced to sleep on the floor in small cells as DOC staff attempts to manage the huge number of people under their care, many of whom have fallen seriously ill with COVID.

54. In attempting to control the spread of COVID-19 in the prisons, DOC staff have repeatedly shuffled people between units and cell blocks.

55. These movements have spread COVID as people with the virus come into contact with people who are not yet infected. The constant churn of people throughout the prisons and the lack of available locations to hold them has led to widespread contamination between units.

[29] *See, e.g.,* August 2020 OCO RECOMMENDATIONS RELATED TO THE DOC COVID-19 RESPONSE *https://oco.wa.gov/sites/default/files/COVID-19%20Workgroup%20Report%20Final.pdf*

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56. In addition, Plaintiffs and other proposed class members have, at times, lacked both basic hygiene products like bleach, Lysol, or other disinfectants, along with appropriate personal protective equipment such as masks.

57. DOC initially provided everyone with surgical masks that had a proven effectiveness against COVID, but those were replaced with cloth masks/bandannas made by correctional industries.

58. Early in the pandemic public health experts, community members and others pleaded with DOC and other state officials to reduce the number of people in DOC custody as the only potentially effective means of reducing the likelihood of mass infections.

59. Unfortunately, only a small number of people in custody were released which proved ineffective at controlling the spread of COVID in state correctional facilities.

60. The winter outbreaks are the utterly foreseeable result of those decisions.

61. In fact, history has proven that there is no policy or practice that DOC could have put in place to avoid these outbreaks that would have been effective, short of actually reducing the prison population.

62. As a result of the State's decisions, thousands of people in custody got sick and 14 people died.

63. Undoubtedly, due to the number of people exposed to COVID because of the DOC's actions, many people will likely suffer the health effects of these avoidable COVID infections. However, the State continues to refuse to provide information on how many people who contracted COVID continue to suffer from related long-term health effects.

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64. The poor state of health care in Washington's prisons before COVID is now going to be only more strained with the additional burden of caring for people with COVID related chronic health needs.

65. Defendants have not yet reckoned with this long-term obligation or received the resources necessary to meet it.

66. The State's efforts to date have not protected people in Washington's prisons from contracting COVID.

Facts regarding the COVID vaccines and Defendants' refusal to provide them to people in custody.

67. Now, with the introduction of three COVID-19 vaccines, the State has the means to more effectively protect people in prison from grave illness and death due to this virus. [30]

68. In fact, DOH prominently advertises on its website that the "COVID-19 vaccination is one of the most important tools to end the COVID-19 pandemic."[31]

69. Because of the conditions in prison facilities (overcrowding, limited access to cleaning supplies and sanitation, limited access to medical care), it is essential that people in prisons be offered the vaccine immediately.

70. Learning more about the variants and their response (or lack of response) to vaccines will be a critical, ongoing part of the global fight against COVID-19. It highlights the need for vaccinations to be offered immediately, however, particularly in high-risk congregate

[30] The cost of the vaccine itself is being borne by the federal government. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/faq.html?s_cid=10473:covid%20vaccine%20cost:sem.ga:p:RG:GM:gen:PTN:FY21 (last viewed on April 4, 2021).

[31] COVID-19 Vaccine, Washington State Department of Health, https://www.doh.wa.gov/Emergencies/COVID19/vaccine (last visited Mar. 28, 2021).

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settings like prisons and other correctional facilities, so as to reduce the risk of infection by the strains that are known to be responsive to the vaccines.

71. Given the nature of disease evolution, there is every reason to assume that other variants will continue to emerge as time passes, which means that COVID-19 is likely to represent an ongoing health risk, even once vaccines are fully distributed.

72. Just as the medical community does not yet fully understand how the vaccines will protect against the existing variants, they also do not know how emerging variants will respond to the existing vaccine protocols, nor if and/or how often recurring inoculation will be needed to protect against new infections.

73. It is critical that correctional facilities are prepared to address this issue as an ongoing need, and not a one-time vaccination undertaking. Otherwise, there may very well continue to be catastrophic rates of infection, severe illness, and death due to COVID in Washington's prisons, whether from existing strains or new, emerging variants.

74. As long as people in prisons do not have meaningful access to the vaccine, nor the information to make informed choices about whether or not to be vaccinated based on their individual health and circumstances, there remains a substantial risk of another mass outbreak at any one of DOC's facilities.

75. Unfortunately, Defendants have made the conscious and deliberate decision to not provide many people in DOC custody with immediate access to the vaccines.

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76. DOH has issued vaccine allocation instructions that dictate when certain discrete groups of people are "eligible" or will be "eligible" for the vaccine.[32]

77. These instructions allow DOH to control the allocation of vaccines to most people in Washington, which it then uses as the basis to send vaccines to different vaccine providers and sites, including the Department of Corrections.

78. Through these instructions, DOH has prioritized certain groups of people for "eligibility" for the vaccines.

79. These prioritizations are further broken down into different "Phases" and "Tiers."

80. DOH's December 2020, initial Phase 1a Tiers looked like this: [33]

Phase 1a Tiers (in order)	Groups
Tier 1	• High risk workers in health care settings, • High risk first responders, • Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision or assistance.
Tier 2	• All other workers at risk to COVID working in health care settings

81. In its initial vaccine allocation instruction, DOH also set out the people eligible in Phase 1b, Tiers 1 through 4.

82. DOH's initial Phase 1b Tiers looked like this:[34]

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[32] *See* e.g., *COVID-19 Vaccine Prioritization Guidance and Allocation Framework*, Washington State Department of Health, https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/820-112-InterimVaccineAllocationPrioritization.pdf.

[33] This Phase and Tiers can be found in *Guidance Summary WA-State COVID-19 Vaccine Prioritization Guidance and Interim Allocation Framework*, Washington State Department of Health, December 2020 at 2-4 (attached as Exhibit 1 to this Amended Complaint).

[34] *Id.* at 5.

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Phase 1b Tiers (in order)	Groups
Tier 1	• All people 70 years or older[35] • People 50 years and older in multigenerational households
Tier 2	• High-risk critical workers 50 years and older who work in certain congregate settings.
Tier 3	• People 16 years and older with 2 or more co-morbidities or underlying conditions
Tier 4	• High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2) • People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)

83. Attached as Exhibit 2 to this complaint is a one-page infographic which sets out these initial Phases and Tiers.

84. DOH refused to include people over 50 who live in prison in Tier 1, which includes people over 50 who live in "multigenerational households", though prisons are "multigenerational households".

85. DOH also refused to include people over 50 who live in prison in Tier 2, though correctional staff over 50 were included in Tier 2.

86. Phase 1b, Tier 1 which includes people over 50 in multigenerational households became eligible for the vaccine on January 18, 2021.[36]

87. In February and March, DOH changed these initial Tiers and again allowed other groups to move ahead of people in prisons.

[35] On January 18, 2021, DOH changed this eligibility standard to allow anyone 65 years and up to qualify for the vaccines. See

[36] *See COVID-19 Vaccine Prioritization Guidance and Allocation Framework*, Washington State Department of Health, at 2 (March 31, 2021) (attached as Exhibit 3 to this Complaint) (detailing dates of changes to DOH vaccine instructions and prioritization).

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88. DOH moved all teachers and day care workers irrespective of age or other risk factors ahead of people in prison and made them eligible for the vaccine on March 3.[37]

89. DOH moved all correctional officers and other "high-risk" critical workers irrespective of age or other risk factors ahead of people in prison and made them eligible for the vaccine on March 17.[38]

90. On March 31, 2021, DOH issued new instructions that included these changes, but also included new, additional groups in these Phases and Tiers.

91. Phase 1a remained substantially the same, however, by March 31, 2021, DOH had fundamentally changed Phase 1b to the detriment of people who live in DOC facilities.

92. The March 31, 2021, Phase 1b Tiers now are:[39]

Phase 1b Tiers (in order)	Groups (bold and italics indicate new groups of people that DOH added after its initial instructions to Tiers or expansions of existing groups to include people under 50)
Tier 1	• All people 65 years and older • People 50 years and older living in multigenerational households • ***Workers in childcare settings*** • ***Pre-K-12 educators and school staff***
Tier 2	• ***High-risk critical workers who work in certain congregate settings***: • Agriculture; food processing; grocery stores; corrections, prisons, jails, or detention facilities; public transit; fire, law, social workers and other first responders • ***People who are pregnant*** • ***People with a disability that puts them at high risk***
Tier 3	• People 16 years and older with 2 or more comorbidities or underlying conditions • ***All people 60 years and older***
Tier 4	• People, staff, and volunteers in congregate living settings; • Correctional facilities; group homes for people with disabilities; congregate settings for people experiencing homelessness that live in or access service in such settings

[37] *Id.*

[38] *Id.*

[39] *See COVID-19 Vaccine Prioritization Guidance and Allocation Framework*, Washington State Department of Health, (March 31, 2021)(attached as Exhibit 3 to this Complaint).

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	• ***Other critical workers in certain congregate settings; restaurants/food services; manufacturing; construction***

93. Attached as Exhibit 4 to this Complaint is a one-page infographic which sets out DOH's new Phases and Tiers.

94. As these tables and infographics demonstrate, DOH pushed people in prison farther and farther down the line while expanding eligibility for other people who do not face the same risks as people in prison do from COVID.

95. In addition to its earlier decisions to move all teachers and all correctional officers ahead of prisoners, on March 31, DOH reprioritized other large groups of people including people with disabilities that put them at high risk from COVID, people who are pregnant, all people over 60 irrespective of their individual circumstances, agricultural and food processing workers, grocery store workers, transportation workers, and "[o]ther critical workers in certain congregate settings; restaurants/food services; manufacturing; construction."[40]

96. By any measure, all people in prison have a greater chance of contracting COVID and experiencing bad outcomes than do the vast majority of people DOH has prioritized over Plaintiffs and the proposed class.

97. Because of the particular attributes and circumstances facing people in prison as detailed herein, the initial December DOH prioritization was incorrect.

98. DOH should have originally prioritized people in prisons within Phase 1a or at the very least Phase 1b, Tier 1 or Tier 2.

[40] *See* Ex. 3 (March 31, DOH vaccine instructions and prioritization) at 7-10.

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99. Prisons share all of the attributes of the settings that DOH prioritized for vaccines and have additional attributes that make people living within them more at risk and more in need of the vaccines than other groups of people or people living in other types of households or settings.

100. To the extent that DOH refused to include all people in prisons within Phase 1a or Phase 1b, Tier 1, DOH should have included anyone who is 50 or older in prison because prisons meet all of the criteria for "multigenerational households" that DOH used in creating Phase 1b, Tier 1.

101. Furthermore, it is unclear from a medical/vulnerability standpoint how corrections officers over the age of 50 were made eligible for vaccine as part of Tier 2, but people in prison who were over the age of 50 were not.

102. There exists no justification for vaccinating people who are employed by DOC, but not extending that same protection to people who are in DOC's custody and care.

103. DOH finally made all people in prison eligible to receive the vaccine on March 31, 2021.

104. Given DOH's significant reprioritization, people in prison are now being forced to compete against the more than 5 million Washingtonians currently eligible for a vaccine.

105. Making the vaccine even scarcer, every person over 16 becomes eligible on April 15, 2021, adding over a million more people eligible to receive the vaccine.

106. As detailed above, DOH's vaccine-allocation instructions have significantly changed and their prioritization of certain groups has also changed.

107. As discussed above, DOH failed to correctly prioritize people living in prisons from the beginning and the situation has only been made worse. DOH's decisions through the winter and spring of 2021 pushed people in prisons down the list of eligible people and deprived

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them of the opportunity to receive the vaccine. There is no good or legitimate reason that DOH has done this.

108. Instead, these changes were influenced by political and other pressures brought to bear upon DOH by powerful external players, like the Governor, the legislature, teachers, agricultural and hospitality interests, and unions.

109. Rather than rely on science and public health considerations to fairly analyze the actual risks associated with COVID-19, DOH buckled to these political pressures and changed its guidance to the detriment of Plaintiffs and the proposed class.

110. Plaintiffs and the proposed class as a group of people who have little to no political power and are not viewed as favorably by the public generally or policy makers saw their early prioritization fall away as DOH moved other groups of people ahead of them in DOH's vaccine "eligibility" prioritization.

111. In doing so, DOH violated legal duties it owes the Plaintiffs and the proposed class under the APA, the state constitution and common law.

112. Defendant DOC while offering the vaccine to all of its staff followed DOH's instructions and refused to vaccinate most people in prison.

113. DOC's refusal to vaccinate people in its prisons violate legal duties that it owes the Plaintiffs and the proposed class under the state constitution and common law.

114. The current distribution of the vaccine to "eligible" people has resulted in a wide variability of where vaccine is actually available, some amount of it has gone unused and "ineligible" people have jumped the line, often with the State's explicit or tacit consent.

115. People outside of prisons have the opportunity to find multiple vaccine providers in many different areas and travel to those locations to get a vaccination.

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116. Many locations across the state have excess vaccine to meet their current need and are vaccinating people who are not currently "eligible" for the vaccine.

117. For example, DOH Headquarters in Tumwater recently administered vaccines to an unknown number of people who were able to make same-day or next-day appointments without showing they were eligible under the Tier then in effect.

118. Similarly, people all over the state who are not currently "eligible" have been able to be vaccinated by waiting in lines or quickly traveling to sites that advertise having excess vaccine or open vaccine appointments.

119. Before March 31, 2021, DOC has had excess vaccine that it did not use to vaccinate people in prison.

120. In contrast to the general public, people in prison are utterly reliant on Defendants to provide them access to the vaccines. They cannot shop around or travel in order to find a location where a vaccine might be available.

121. In addition to allowing thousands of people to "jump the line," the State has also moved certain groups up in priority over the last several months.

122. Now, the State has announced that millions more Washingtonians are now or will soon become "eligible" for the vaccine even while refusing to vaccinate people in prisons or even provide a timeline by which DOC will vaccinate people in prison.

123. The history of vaccine distribution in Washington has shown that "eligibility" does not equate to actual access to the vaccine.

124. In fact, Defendants very recently admitted to Plaintiffs that they cannot guarantee access to the vaccine to people in Washington's prisons on any timeline.

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125. Expanding the numbers of people who will be "eligible" will only further dilute the chances that people in prison receive immediate access to the vaccine.

126. Defendants should have made the vaccine accessible to all interested people living in Washington's prisons long ago.

127. The State has received more than enough doses to have vaccinated every person in DOC custody without significantly limiting access to the vaccine for other high-risk populations.

128. DOH has received and allocated more than enough COVID vaccine over the last several months to have been able to vaccinate everyone in DOC facilities with millions of doses to spare for others.

129. As of March 31, 2021, DOH reports that more than 3,471,343 doses of vaccine have been administered in Washington.

130. As of March 31, 2021, DOH reports that the average number of COVID-19 doses administered each day (over the past 7 days) in Washington State is 57,321.[41] This is nearly four times the total population of DOC.

131. Effectively, DOH could allocate enough doses to vaccinate every person in DOC custody in a single day and there would still be roughly 42,000 doses remaining for distribution to other community sites.[42]

[41] COVID-19 Data Dashboard, DOH, *supra.*

[42] As of January 2021, the average total population of DOC prisons on any given day was 14,362 people. *See,* Average Daily Population of Incarcerated Individuals, Washington Department of Corrections, https://www.doc.wa.gov/docs/publications/reports/400-RE002.pdf (last visited Mar. 27, 2021).

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132. Vaccinating all people within DOC custody would not have significantly limited access of vaccine to any other eligible group.

133. It is imperative that there be no further delay in offering the vaccine to people in prison who are at an exponentially higher risk of infection than the general population of Washington State.

134. DOH reports that Washington is expected to receive the following vaccine allocations in the coming weeks:

> Week of April 4: 458,340 total doses (285,320 first doses, 173,020 second doses) This includes 201,240 doses of Pfizer, 148,100 doses of Moderna, and 109,000 doses of Johnson & Johnson
>
> Week of April 11: 412,570 total doses (217,320 first doses, 195,250 second doses) This includes 223,470 doses of Pfizer, 148,100 doses of Moderna, and 41,000 doses of Johnson & Johnson
>
> Week of April 18: 390,340 total doses (217,320 first doses, 173,020 second doses) This includes 201,240 doses of Pfizer, 148,100 doses of Moderna, and 41,000 doses of Johnson & Johnson

135. Immediate access to the vaccine is critical to protecting the people in DOC custody, but simply allocating the required number of doses will not be sufficient. It is also essential to utilize culturally responsive resources to provide ongoing outreach, education, and medical services in conjunction with immediate allocation of the vaccine doses for people in prison.

136. These services, information, and the vaccine itself must be provided to people in prison in a way that is factually accurate and designed to assuage the historic and ongoing distrust of DOC and the medical community at large.

137. Throughout our nation's history, BIPOC (Black/Indigenous/People of Color) communities have been the targets of unwanted, nonconsensual research, testing, and treatment

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by the medical community. This legacy has led to a deeply seated wariness by many BIPOC individuals of systems of medical research and care.

138. Furthermore, for many individuals in DOC custody, there is a pervasive distrust of the medical care provided to them by DOC. Thus, for BIPOC people in prison, these intersecting fears are often compounded.

139. Many people in prison may be reluctant to accept the vaccine when it is offered due to a lack of information being made available to them about the vaccine, its effectiveness, its risks/potential side effects, and who should or should not take the vaccine to protect against COVID.

140. A recent study published in the CDC Morbidity and Mortality Weekly Report entitled *Willingness to Receive a COVID-19 Vaccination Among Incarcerated or Detained Persons in Correctional and Detention Facilities — Four States, September–December 2020* reported the following most common reasons given by people in carceral settings for COVID-19 vaccine *hesitancy* were: waiting for more information (54.8%); efficacy or safety concerns (31.0%). The most common reason for COVID-19 vaccination *refusal* was distrust of health care, correctional, or government personnel or institutions (20.1%). The study concluded that public health interventions to improve vaccine confidence and trust are needed to increase vaccination acceptance by incarcerated or detained persons.[43]

141. In light of these realities, Defendants must implement a robust, culturally responsive outreach and education strategy in partnership with respected voices in the prison

[43] https://www.cdc.gov/mmwr/volumes/70/wr/mm7013a3.htm?s_cid=mm7013a3_w. The study surveyed people incarcerated in several Washington jails and two Washington prisons.

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community and general public to address issues of misinformation and to build trust around the COVID-19 vaccine.[44]

142. Unfortunately, Defendants have not taken these steps. Instead, little to no information about the vaccine has been provided to the general population of people in prisons.

143. In many cases, the most information that people have received, if any, is a consent form asking whether they wish to take the COVID-19 vaccine, but without any opportunity to consult with medical staff, or even written information about the vaccine, its benefits, and potential risks and side effects.

144. In addition, DOC staff have provided people with conflicting or plainly incorrect information. Some have encouraged people to not to accept the vaccine and have spread unsubstantiated conspiracy theories regarding COVID-19 and the vaccines. Others have boasted that they have refused to take the vaccine.

Facts related to Defendants' refusal to protect Plaintiff Class from staff members who refuse the vaccine.

145. The most prevalent and highest risk of initial COVID exposure in prisons is through corrections staff who come and go each day. These staff potentially expose the people in prison who do not have the ability to socially distance or refuse contact with DOC staff members.

146. As detailed above, infectious staff are the most likely cause of the outbreaks in our prisons.

[44] This report underscores the urgent need for interventions that are culturally relevant and appropriate for various health literacy levels to increase vaccine confidence among incarcerated or detained persons. *Id.*

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147. While denying the COVID vaccine to many people living in its facilities, DOC has offered the COVID vaccine to many of its staff members. However, many have refused to take it.

148. As many as 50% of DOC staff have refused or may refuse to take the vaccine when offered.

149. Nonetheless, DOC has continued to allow these staff refusers to have access to people in DOC facilities.

150. That decision puts everyone in DOC facilities at serious risk.

151. The danger posed by unvaccinated staff is particularly critical for individuals in DOC custody who may be unable to take the COVID-19 vaccine due to individual circumstances or risk factors. However, unvaccinated staff pose a danger to everyone who lives in DOC facilities even if they have received the vaccine.

152. While Defendants must give everyone in DOC custody immediate access to the vaccine, a certain as-yet unknown percentage of people in DOC custody will be unable or unwilling to accept the vaccine.

153. Defendants cannot force anyone, staff member or incarcerated person, to accept the vaccine.

154. Defendants have an obligation to protect people living in DOC facilities who are unvaccinated from staff who refuse to be vaccinated, an obligation that will continue for an unknown period of time going forward.

155. Staff refusal is particularly dangerous with the emergence of COVID variants that are more infectious and potentially more deadly – strains against which the current vaccine may have some but reduced efficacy. By refusing to take the vaccine, staff members are more likely

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to harbor these more virulent strains of the virus and more likely to transmit those strains to people in the prisons.

156. In addition, the emergence of new variants has increased the likelihood that the current vaccines will need to be supplemented in the near future by additional booster vaccinations. On-going staff refusal to accept the current vaccines or future boosters will continue to endanger an unknowable number of proposed class members.

157. Further, it is unknown how people who have already been vaccinated may react to new strains introduced by staff who have refused to receive even the first round of vaccines.

158. Current policies and procedures have not kept infectious staff members from infecting thousands of people in our prisons. The vaccines are a means to limit that danger. And yet, Defendants have refused to keep people safe by prohibiting staff who refuse the vaccine from contact with people inside.

159. As described herein, Defendants' actions and omissions constitute an unreasonable and unacceptable threat to the health and safety of Plaintiffs and the proposed class. They will continue to suffer irrevocable and serious physical and psychological injuries without relief from the Court.

Facts relating to communications with Defendants regarding subject matter and basis for judicial review.

160. Counsel for Plaintiffs sent the letter attached as Exhibit 5 to this Complaint to Secretaries Shah and Sinclair on March 9, 2021, asking Defendants to take immediate action to protect people living in Washington's prisons.

161. The March 9, 2021, letter was preceded by a virtual, face-to-face meetings with DOC and DOH representatives regarding the subject matter of the letter and the allegations herein.

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162. Plaintiffs' counsel received a response from DOC and DOH on March 19, 2021, which is attached as Exhibit 6.

163. In this letter, Defendants refused to commit to providing immediate access to all people in prison who would like the vaccine.

164. They also provided no date in the future by which they will commit to providing that access. Their response indicates that "eligibility" for the vaccine does not equate with actual access to the vaccine.

165. They also acknowledged in this letter that the State has been receiving roughly 350,000 doses per week for some time but has nonetheless refused to vaccinate people in prisons who want the vaccine.

166. Defendants also refused to create an education and distribution plan that meets the request made in the March 9 letter.

167. They also refuse to prohibit staff who refuse the vaccine from having contact with people living in DOC facilities.

168. As indicated in their March 19, 2021, letter, Defendants have refused to take action or cease on-going actions as described herein. Plaintiffs and the proposed class are aggrieved by these actions and inactions.

169. Defendants' refusal to take action or on-going actions has prejudiced and will continue to prejudice each of the Plaintiffs and each proposed class member.

170. Defendants were required to consider Plaintiffs' interests when they took the actions described herein.

171. A judgment in this case will substantially eliminate or redress the prejudice caused by Defendants' actions.

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Facts relating to individual Plaintiffs

Facts relating to Plaintiff Candis Rush

172. Candis Rush is currently incarcerated at the Washington Corrections Center for Women (WCCW).

173. Plaintiff Rush like all people incarcerated at WCCW and the other prisons is at serious risk from COVID-19.

174. Even in spite of new infections, DOC allows staff at WCCW to move around and potentially expose other people to the virus.

175. Staff members who have been working in the isolation and quarantine areas at WCCW are regularly transferred to other posts across the prison, thereby increasing the risk that they may expose people living in those units to the virus.

176. Even though DOC is testing WCCW staff for COVID, it can take up to three days for the test results to come back, so a staff member who is COVID-positive can potentially expose people in prison to the virus for days before they know they are sick.

177. People are being put in quarantine and placed in segregation at WCCW, which is a very disciplinary environment.

178. Residents who hold jobs that require them to go into quarantine and isolation units (e.g., janitors, porters, etc.) are not given extra PPE to wear. There is additional PPE available, but it is reserved for nurses and other DOC staff members.

179. Correctional officers do not follow social distancing requirements and have continued to come into people's rooms for searches and pat downs, take off their masks, and generally do not seem to take COVID precautions seriously.

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180. Cleaning and sanitation practices throughout WCCW are inconsistent and potentially leave people exposed.

181. People have had little to no access to programing, including educational programs, because of the limitations of pods and cohorting.

182. DOC has made arrangements to keep certain groups of people together (such as Correctional Industries employees), but similar arrangements have not been made to allow other groups to program.

183. People have had limited access to recreation and gym space because of COVID restrictions and DOC's staff retention issues, which has a negative impact on Ms. Rush and the people living at WCCW.

184. People at WCCW have received little information about the vaccine, except for people who have been deemed essential workers.

185. People have been given a consent form asking whether they want the vaccine, but they have not been given information about the vaccine itself or instructions on how to submit the consent form.

186. DOC staff have been offered the vaccine, but not everyone is taking it. Many staff members are refusing the vaccine because they are relying on other people to take it.

187. Some DOC staff members have been perpetuating conspiracy theories, telling people at WCCW that the vaccine contains mind-control technology and discouraging residents from taking the vaccine when it is offered to them.

188. Misinformation and conspiracy theories are a big issue for both staff and people at WCCW.

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189. People who want the vaccine but aren't yet "eligible" have not been given any information about when it will be offered to them.

190. DOC is not providing any information about what will happen if people in prison refuse the vaccine, but people are afraid of retaliation.

Facts relating to Plaintiff Justin Autrey

191. Mr. Autrey is currently incarcerated at the Monroe Correctional Complex. Mr. Autrey suffers from multiple medical conditions including asthma with an average lung capacity of 50%, bronchitis, early-stage COPD, and has elevated markers for lymphoma and cancer.

192. He also suffered a heart attack on February 7, 2021, while in custody at Monroe. He is now on multiple blood thinners and other heart medications.

193. Conditions at MCC make it impossible to abide by social distancing restrictions. For example, cell neighbors who have caught the virus were simply quarantined in their cell. They continue to snore, cough, and talk--breathing and exhaling the contagious virus throughout the facility.

194. Efforts to restrict movement and social interaction are only resulting in punishment instead of protection from the virus. Throughout MCC, programming, chow hall, and the yard are all shut down to promote social distancing and masking. However, entire units are let out at a time and no social distancing occurs when that happens.

195. People cannot wear a mask while showering, all the showers are next to each other, and overall, there are just mass groupings everywhere throughout the facility. Social distancing is impossible at MCC.

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196. The cleaning regime is also inadequate. With 200 people in a unit, in a small space, everyone touches everything at least once, and the phones for example get wiped down three times a day.

197. Correctional Officers walk around with their masks below their chins. This happens so often it is now called "chin diapers."

198. DOC has hung up memos about the vaccine, but they are vague and provide little information about the effects of the vaccine, especially for people in higher risk situations.

199. DOC has provided the vaccine to people who work inside the facilities, but not to people who are sick or who may have a compromised situation.

200. Before his heart attack, Mr. Autrey asked to get the vaccine. DOC refused to provide it to him and informed him that he was "ineligible".

201. He went to ask again after his heart attack and was told it may not be a good idea but was not provided any further information.

202. Staff at MCC are not helping Mr. Autrey because they tell him this is not their problem or they are not in a position to call anyone on that issue.

Facts relating to Plaintiff Gregory Steen

203. Mr. Steen is currently incarcerated at Clallam Bay Corrections Center (CBCC). COVID-19 has caused major disruptions in the lives of people at CBCC, even though there have not been any reported COVID cases there.

204. People in prison have had little or no programming, even when programing does not rely on volunteers.

205. People in CBCC have not been regularly tested for COVID, so it is unknown what the actual infection rate in that facility may have been.

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206. There was a major flu-like illness that went through CBCC in late 2019, early 2020, that people in prison suspect may have been related to COVID, but no one has addressed those concerns.

207. DOC has provided little to no information about the COVID vaccine to the general population at CBCC.

208. DOC provided staff with information about the vaccine well before any information was made available to people in prison, even those deemed essential workers.

209. DOC has announced that everyone will be "eligible" on March 31, 2021, but has not offered any information about when people in custody will get the vaccine if they want it.

210. Many people in prison do not trust vaccines, and without any information about the COVID vaccine, may not want to take it when it's offered to them.

211. Some people in prison are working with a lot of the same misinformation and conspiracy theories that are being circulated throughout the general public and amongst some staff members.

212. Some DOC staff have elected to take the vaccine, but others are refusing to be vaccinated.

213. People in prison are worried about what will happen if staff continue to expose them to the virus, and new variants that might develop.

214. People in prison want things to go back to normal: they want to see their families and loved ones, and to be able to go back to programing and other aspects of normal life.

215. DOC needs to put a plan in place to keep people in prison safe from COVID, both now and in the future.

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Facts Relating to Plaintiff Theodore Rhone

216. Mr. Rhone is currently incarcerated at the Stafford Creek Corrections Center (SCCC).

217. He is 63 years old and has multiple pre-existing medical conditions, which include being diabetic and insulin dependent, high blood pressure, anxiety, neuropathy, and an on-going heart condition that requires regular medical monitoring.

218. To date, Mr. Rhone had not yet caught COVID.

219. When the wave of infections hit DOC and SCCC in the late fall 2020, all people there went into lockdown for about three months. This meant people were not allowed to go outside and did not have access to fresh air. They were only allowed out of their cells for 45 minutes each day.

220. After the three months of lockdown, DOC has slowly begun to reopen the SCCC facilities.

221. However, one DOC employee who works in the kitchen has tested positive for COVID, just in the last few weeks. Other staff members have been sent home.

222. DOC has not provided people living in the facility with any update on the current state of COVID in the prison or related to the most recent staff outbreak. People have to rely on one another to pass along information to stay up to date on what is going on inside of the facility.

223. The kitchen did not shut down and people were still allowed to go in large groups to pick up their food.

224. There are still problems with masking and social distancing, and correctional officers themselves are not socially distancing or always appropriately wearing masks.

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225. There are no active efforts at education around the virus, the vaccine, or any of the variants.

226. Mr. Rhone has attempted to get the vaccine but was denied by DOC staff. Instead, he was told that DOC is only authorized to distribute it to certain categories of people: aged 65 or older and people working essential jobs.

227. Mr. Rhone has seen a questionnaire on whether people want to take the vaccine. This form lacks any information on the vaccine like its benefits, side effects, impacts on underlying conditions or current medications, or other information that may be useful.

228. People have different thoughts about the virus and the vaccine. Some believe in different conspiracy theories. Some are not comfortable with a vaccine produced so quickly, and others are concerned about long-term effects.

229. Roughly half of people at Stafford Creek may be hesitant to take the vaccine.

230. Many correctional staff have refused to take the vaccine and openly discuss this with people under their care.

231. Mr. Rhone continues to try to get the vaccine.

232. Mr. Rhone spoke to the Captain at SCCC. He said that SCCC had a number of vaccine doses that they could not use, because the state government had made specific categories on who was eligible to receive the vaccine, which did not include all prisoners at SCCC.

Facts Relating to Plaintiff Michael Linear

233. Mr. Linear is currently incarcerated at the Washington Correctional Center (WCC).

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234. He is 38 years old and recently served as his Tier's representative in meetings with DOC staff, until he resigned. He also works as a Porter and is housed in the Cedar living unit, which is one of two housing units for long term residents who hold jobs at WCC.

235. WCC is a known as a work facility because people can get transferred to WCC to get jobs with Correctional Industries and other jobs that are available.

236. Cedar and Evergreen are the long-term housing units for workers. Together, these two units provide the services for all eight units that house people at WCC.

237. DOC has not had proper measures to quarantine or isolate anyone. Around November 27, 2020, DOC called all kitchen workers back to the kitchen because one of the DOC staff working in the kitchen had tested positive for COVID. DOC ran tests on all staff and workers and, before receiving the test results, DOC allowed those workers to return to their respective living units, spread out among the different tiers —including his.

238. Mr. Linear did not work in the kitchen. He learned this information from one of the kitchen workers that returned to his unit. Those kitchen workers said that DOC had just tested them for COVID because a DOC kitchen staff member had tested positive. One of the men who was tested was immediately quarantined, but DOC allowed the rest of the workers who had been exposed to the staff member to return to their living units. Ultimately, ninety-five percent of his unit ended up sick with COVID.

239. DOC placed his unit on a cohort schedule and provided a notice on their cells explaining how cleaning would work. Cleaning would take place during fifteen-minute intervals between cells being let out, and people cleaning would be given proper PPE.

240. From November 29 to December 3, they were on a cohort schedule and Mr. Linear worked as a porter. DOC did not provide them with proper education on how to clean or

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proper PPE. Staff also often rushed the porters to stop cleaning. Porters had masks and gloves but no shield or gown.

241. Although Mr. Linear had asked for proper PPE, DOC told him that proper PPE was just for staff, and not for porters.

242. On December 3, DOC went to complete lockdown, restricting people to their cells. There are no toilets in their cells, so they had to wait for hours to use the bathroom.

243. People would send messages to their families, asking them to contact DOC to let them out to use the bathroom or have medical checks. Some people resorted to urinating out of their windows.

244. Mr. Linear and others were moved to the gym. There was no official word from DOC as to why, but some friendly staff members told them it was because they tested positive. Mr. Linear was kept in the gym for a number of days. He did not receive his test results until sometime in January 2021.

245. Mr. Linear experienced mild COVID symptoms early on, but still has breathing issues and periodically has severe headaches like never before in his life. His headaches are so painful that he needs to stop and rest. He also has periodic muscle aches. When he tries to exercise, he can feel his breathing is different and strained. Some days he is confined to his bed because his head is ringing from headaches. Prior to this, he had no preexisting medical conditions.

246. Around February 20, 2021, two counselors came into Mr. Linear's unit looking for CI employees and were calling out names. The counselors said they wanted to see how many people would sign up for the vaccine. One of the counselors said that they thought that most

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people did not want a vaccine because they already had COVID and were probably worried about getting sick from the vaccine.

247. DOC never provided any education around the vaccine.

248. Mr. Linear asked if he could be added to the list and other people asked to be added as well.

249. On February 26, staff returned to administer the first shots of the Moderna vaccine. They had a total of 60 doses, and all were seemingly assigned to CI employees.

250. Some of the CI employees had already gone to work in the kitchen, so the leftover doses were given to others in the unit that wanted it; for example, porters that worked in medical.

251. On March 12, Mr. Linear received his first vaccine shot. More CI workers got the shot, but so did porters who work in the living units, like Mr. Linear.

252. There are not enough vaccines. DOC is not making the vaccine available to the entire population. People have filed grievances asking to receive vaccines and asking why they do not qualify for the vaccines yet. Mr. Linear believes DOC prioritized vaccinating people who have jobs within the facility. DOC is not doing a good job of prioritizing who needs the vaccine.

253. All prisoners should be a priority, because if any one person gets sick, the disease will spread like wildfire, as it already has. Mr. Linear believes that if one person is at risk, then everyone is at risk because of the living conditions.

254. Currently, their facility is "cleared" meaning that they are not on outbreak status.

255. DOC restricts intermingling in the yard between people from different units. But if you work in Correctional Industries (CI), then DOC does not restrict intermingling between workers from different Tiers.

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256. Mr. Linear grieved this issue about CI in March, saying that DOC is still putting him at risk by allowing some workers to be exposed to people from other living units. DOC responded that the facility is taking proper precautions, and that this issue is not grievable.

257. Mr. Linear continues to work as a porter five nights a week sanitizing the unit.

258. DOC has a new policy requiring staff to report on each other when they do not wear their masks, but there's no accountability for this. Staff in Mr. Linear's unit will go to the duty station where the cameras cannot see them, and then take off their masks.

259. It is hard to keep safe in WCC when the staff do not care and do not believe that COVID is a problem. According to Mr. Linear, he was reprimanded for not wearing his mask correctly, but could see an officer not wearing a mask at all.

V. CLASS ACTION ALLEGATIONS

1. Plaintiffs seek to pursue this matter as a class action under CR 23(a) and CR 23(b)(2).

2. They ask the Court to define the class as all persons currently held in DOC custody and those who will be held in DOC custody in the future.

3. Each of the prerequisites to a class action enumerated in CR 23(a) is satisfied by the proposed class.

4. The class is so numerous that joinder of all members is impracticable. There are currently an estimated 14,300 individuals in DOC custody. Regardless of their vaccination status, all individuals at each facility are at risk of a COVID-19 outbreak due to the general lack of access to the vaccine, lack of protocols regarding unvaccinated staff, the increasing risk of possible reinfection and/or emergence of new variants that may be vaccine-resistant, and the on-

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going horrendous conditions under which all of them live. Moreover, the proposed class includes an unknown number of people who will enter DOC custody in the future.

5. There are questions of law and fact that are common to the class, including: (1) whether Defendants have violated the state constitution and legal duties owed Plaintiffs and the proposed class by refusing to provide them with access to COVID-19 vaccinations, (2) whether Defendants have violated the state constitution, state law, and legal duties owed Plaintiffs and the proposed class by allowing correctional staff or others who refuse to be vaccinated access to proposed class members, (3) whether Defendants have violated the state constitution, state law, and legal duties owed Plaintiffs by failing to take steps to protect the proposed class from future COVID-related outbreaks, and (4) whether DOH's actions or inactions have been and currently are arbitrary or capricious.

6. The claims of the named Plaintiffs are typical of the class which they seek to represent. Each Plaintiff is under the custody and care of DOC, each is at continued risk of exposure to the COVID-19 virus due to the inherent conditions inside of DOC, the general lack of access to the vaccine, continued exposure to unvaccinated staff, and the increasing risk of infection/reinfection/variants.

7. The named Plaintiffs will fairly and adequately protect the interests of the class. Plaintiffs are represented by counsel, Columbia Legal Services, who are experienced in representing persons and classes of people in disputes of this nature and who will vigorously prosecute this action. Plaintiffs are not aware of any conflict of interest among class members.

8. Defendants have acted or refused to act on grounds generally applicable to the proposed class, thereby making appropriate final declaratory and injunctive relief with respect to the class as a whole.

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VI. REASONS RELIEF SHOULD BE GRANTED AND CLAIMS FOR RELIEF

Violation of Art. I., § 14 of Washington Constitution– Cruel Punishment

1. Defendants have a constitutional duty to protect Plaintiffs and the class they represent from cruel punishment. Defendants have violated this duty by:

i. Failing to provide Plaintiffs and class members with vaccines that will protect them from COVID-19.

ii. Allowing state employees, contractors or agents who have refused to take the vaccine to have direct contact with Plaintiffs and members of the class.

iii. Refusing to create and implement a plan to vaccinate any class member who wants a vaccine to receive the vaccine.

Violation of Art. I, § 12 of Washington Constitution – Privileges and Immunities

2. Plaintiffs and proposed class members have a fundamental right rooted in the state constitution to be protected from harm when they are incarcerated in Washington's prisons. By authorizing the vaccination of certain groups and allocating vaccine to those groups, while refusing to authorize or actually vaccinate Plaintiffs or proposed class members, and by allowing people not in prison the means to protect themselves from other people who may be infectious or have refused the vaccine, while denying that privilege to Plaintiffs or class members, Defendants have created privileges and immunities that they have denied Plaintiffs or the proposed class without legitimate justification. Therefore, Defendants have violated Art. I, § 12 by:

i. Failing to provide Plaintiffs and members of the proposed class with vaccines that will protect them from COVID-19.

ii. Allowing state employees, contractors or agents who have refused to take the vaccine to have direct contact with Plaintiffs and members of the proposed class.

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iii. Refusing to create and implement a plan to vaccinate any proposed class member who wants a vaccine to receive the vaccine.

Violation of duty to keep Plaintiffs in health, welfare and safety

3. Defendants have an affirmative duty to provide for the health, welfare, and safety of Plaintiffs and members of the proposed class in DOC custody. Defendants violated this fundamental duty by:

i. Failing to provide the Plaintiffs and members of the proposed class with vaccines that will protect them from COVID-19.

ii. Allowing state employees, contractors or agents who have refused to take the vaccine to have direct contact with the Plaintiffs and members of the proposed class.

iii. Refusing to create and implement a plan to vaccinate any proposed class member who wants a vaccine to receive the vaccine.

Violation of RCW 34.05.570 (4)

4. DOH's refusal to provide vaccine access to Plaintiffs and members of the proposed class as DOH has provided access to other groups of people and refusal to require DOC to bar correctional staff who refuse the vaccine from having contact with people living in Washington's prisons are violations of DOH's duty required by law and are arbitrary or capricious and unconstitutional.

VII. RELIEF REQUESTED

WHEREFORE, Plaintiffs requests that the Court:

1. Certify this petition as a class action and approve the class proposed by Plaintiffs pursuant to CR 23(a) and (b)(2).

2. Designate Plaintiffs as class representatives pursuant to CR 23(a)(4).

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3. Appoint Columbia Legal Services as class counsel pursuant to CR 23(a)(4).

4. Declare that Defendants DOH and Secretary Shah have violated their constitutional duty to keep Plaintiffs and the class free from cruel punishment in violation of RCW 34.05.570(4)(c)(i), that Defendants DOC and Secretary Sinclair have violated their constitutional duty to keep Plaintiffs and the class free from cruel punishment, and that all Defendants and Respondents have violated their common law duty to protect the Plaintiffs' and the class's health, welfare and safety.

5. Enter a preliminary and permanent injunction requiring Defendants to immediately provide COVD-19 vaccinations to all people in DOC custody who want it.

6. Enter a permanent injunction requiring Defendants to provide any future COVID-related vaccines or boosters for everyone in DOC custody as soon as they become available to anyone in Washington.

7. Enter a preliminary and permanent injunction requiring Defendants to provide vaccine outreach and education to people in prisons that is comparable in content and quality to what is being deployed in communities outside of carceral settings. All outreach and education campaigns must (a) ascertain what medical information is needed, and (b) what outstanding questions need to be answered, and (c) what misinformation must be addressed to enable everyone in DOC custody to make an informed choice about whether they wish to take the COVID-19 vaccine.

8. Enter a preliminary and permanent injunction requiring DOC to prohibit contact between any DOC staff member, contractor or agent who has refused a vaccine and any class member.

9. Grant any further relief as just and appropriate.

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DATED this 5th day of April, 2021.

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EXHIBIT 1

GUIDANCE SUMMARY

WA STATE COVID-19 VACCINE PRIORITIZATION GUIDANCE AND INTERIM ALLOCATION FRAMEWORK

The Washington State Department of Health has developed this guidance for COVID-19 vaccine allocation and prioritization to facilitate harmonized planning for distribution across Washington State. This guidance is the result of several months of engagement with expert groups and community partners to gather input and ideas. Given current information and federal guidance, we are providing guidance on Phase 1a and 1b that incorporates this input while staying aligned with the principles and criteria noted below. We are offering tentative ideas of populations that may be considered in future phases. The guidance will be updated to provide details on these other phases based on:

- New information from clinical trials
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

In this guidance, population groups overlap and there are individuals who fit into multiple categories. When this is the case, the higher phase should take precedence. Also, the order of the populations does not suggest any type of prioritization or risk stratification. In all circumstances, although reinfection appears uncommon during the initial 90 days after symptom onset, prior confirmation of COVID-19 infection will not exclude any individual from eligibility for COVID-19 vaccine and serologic testing is not being recommended prior to vaccination. Vaccines should be administered according to age groups for which the specific vaccine is authorized (e.g., Pfizer for 16 and over and Moderna for 18 and over).

GOAL: To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2

ETHICAL PRINCIPLES
- Maximum benefit
- Equal concern
- Mitigation of health inequities

PROCEDURAL PRINCIPLES
- Fairness
- Transparency
- Evidence-based

CRITERIA
- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmitting infection to others

Washington State Department of Health

Currently, we are limiting Phase 1 of the allocation framework to **Phase 1a** and **Phase 1b**. Phase 1a is eligible for vaccine as of December 31, 2020. We anticipate Phase 1b will be eligible in mid to late January.

Phase 1a - Tier 1

Overarching Groups:

- **High-risk workers in health care settings** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **High-risk first responders** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance**

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders in order to protect our medical care response capacity and (b) residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance aiming to avoid hospitalizations, severe morbidity, and mortality. The table below identifies the desired objectives and guidance regarding what individuals would be prioritized for vaccine allocation in this phase. We provided recommendations that closely align with the Advisory Committee on Immunization Practices (ACIP) and initially include risk stratification given limited vaccine.

CDC provided initial COVID-19 vaccine supply projections for the first two months. Assuming Washington state receives approximately 2 percent of the total projections (Washington's approximate proportion of total U.S. population), our state was expected to receive between 150,000 to 350,000 doses in the first month and between 500,000 to 1 million doses in the second month (inclusive of second doses). Also note that many residents of long-term care facilities will be served via a federal pharmacy program that began in late December and draws down from the Washington state vaccine allotment. Given limited vaccine, sub-prioritization and sequencing of distribution to health care personnel was initially necessary. Furthermore, agencies have been encouraged to consider staggering vaccine schedules of teams to avoid potential clustering of worker absenteeism related to systemic reactions.

Beyond ACIP, this guidance was developed based on input and review by a number of experts including Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A-1 **OBJECTIVE**	PHASE 1A-1 **GUIDANCE**
To protect those at highest risk of exposure, to	*In the context of limited vaccine, this guidance includes the following sub-prioritization considerations:* • Personnel without known infection in prior 90 days

maintain a functioning health system, and to protect highly vulnerable populations	• Workers in sites where direct patient care is being frequently delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care
	  ○ Example setting: hospital sites managing suspected/confirmed COVID patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility
	  ○ Examples types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions
	• Workers frequently performing high-risk exposure procedures with suspected or confirmed COVID-19 patients
	  ○ Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g., nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax
	• Workers exposed to/handling potentially SARS-CoV-2 containing specimens
	• COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients
	• First responders at high risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures
	  ○ Licensed emergency medical service frontline staff regardless of agency (e.g., fire, ambulance, hospital)
	  ○ Emergency workers providing patient transport/ambulatory support regardless of agency
	  ○ Personnel working in the field to provide oversight of these emergency medical service positions
	• Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity
	  ○ Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g., healthcare, environmental facility management, counselors, dining staff, etc.)
	  ○ Home health aides, care aides, caregivers, companions, etc.
	  ○ Workers with patients undergoing chemotherapy, chronic renal disease, dialysis, etc.
	• Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a and 1b populations
	––
	
	Residents and staff of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:
	• Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness
	• Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings
	• Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters
	
	Where sub-prioritization is needed, consider:
	• Skilled nursing facilities caring for the most medically vulnerable residents and of congregate nature so they face the joint risk factors of severe disease/mortality and transmission due to their living settings
	• After skilled nursing facilities, consider broadening to other facilities, including:
	  ○ Assisted living facilities and adult family homes
	  ○ Residential care communities

	○ HUD 202 low-income senior housing ○ Intermediate care facilities for individuals with developmental disabilities ○ State Veterans Homes

Phase 1a (Tier 1) Additional Guidance

- We specifically use the terminology "workers in health care settings" and not "health care workers" because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services). ACIP provides similar guidance regarding defining healthcare personnel.[1]
- Special attention should be paid to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of PPE as well as those working in settings with inadequate environmental controls for recommended air exchange.

Phase 1a - Tier 2 (after completion of Tier 1)

Overarching Group:

- **All other workers at risk in health care settings**

PHASE 1A-2 **OBJECTIVE**	PHASE 1A-2 **GUIDANCE**
To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	**All other workers at risk to COVID working in health care settings** • Workers who are at risk of acquisition or transmission of COVID because they are interacting in close proximity (less than 6 feet) with patients, co-workers, or specimens and are unable to remain socially distant (i.e., not include remote workers)

Phase 1a (Tier 2) Additional Guidance

- We specifically use the terminology "workers in health care settings" and not "health care workers" because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).
- Across Washington, it is important that health care systems actively reach out to and provide access to COVID-19 vaccination for community-based health care workforce outside their systems and in their community. This includes other health care providers, school nurses, and behavioral health providers, etc., in order to compete this phase and ensure we have a protected healthcare system.

Phase 1b

Phase 1b phase generally includes people who are high to moderate risk against the four risk criteria:

- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact
- Risk of transmission to others

In addition, we have applied equity as a cross-cutting lens and considered situations when certain groups are disproportionately affected due to social factors and/or other systemic inequities to mitigate for these factors.

Summary:

Phase 1b Tiers (in order)	Groups
Tier 1	• All people 70 years and older • People 50 years and older in multigenerational households
Tier 2	• High-risk critical workers 50 years and older who work in certain congregate settings
Tier 3	• People 16 years and older with 2 or more co-morbidities or underlying conditions
Tier 4	• High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2) • People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)

Phase 1b - Tier 1

Overarching Groups:

- **All people 70 years and older**
- **People 50 years and older in multi-generational households**

The first tier focuses on protecting those who are driving hospitalization and face high rates of severe morbidity and mortality in order to reduce the burden on hospitals that keeps us in an emergency state. We also want to recognize that there are older adults and elders who may be vulnerable and unable to live independently similar to those in community-based, congregate care settings (Phase 1a) but their families care for them at home. In addition, we recognize that many families - especially those disproportionately affected by COVID - live in multi-generational homes that put the older

adults and elders in the household at significantly higher risk for acquiring infection. Because these individuals are among disproportionately affected groups, they are also at risk for higher rates of severe morbidity and mortality.

PHASE 1B-1 **OBJECTIVE**	PHASE 1B-1 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality	**All people 70 years and older** (about half of whom have co-morbidities that increase risk for severe outcomes if infected with COVID)
To prevent acquiring infection, hospitalization, and rates of severe morbidity and mortality	**People 50 years and older in a multigenerational (2 or more generations) household** These individuals would be at risk either due to: • Vulnerability (e.g., older adult or elder who cannot live independently and is being cared for by a relative or in-home caregiver) • Risk of exposure (e.g., older adult or elder who is living with someone who works outside the home, older adult or elder taking care of a grandchild) • Not include an older adult who is able to live independently and is taking care of the individual's children

Phase 1b - Tier 2

Overarching Groups:

- **High-risk critical workers 50 years and older who work in certain congregate settings**

Phase 1b – Tier 2 includes specific high-risk essential workers groups[1] age 50 and older who work in certain congregate settings. Occupational risk factors for COVID include setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to healthcare access. The course of the pandemic in Washington state indicates that specific groups of workers operating in congregate settings—such as, agricultural workers, food processing, incarceration facilities, and child care workers — have experienced significantly elevated rates of infection given the nature of their working and/or living conditions. In addition, the working and living conditions contribute to transmission at work and in the community. We have also selected an age range that represents about half of the workers in these groups whose age is associated with higher rates of hospitalization, morbidity and mortality.

Phase 1b – Tier 2 also includes workers in child care settings and K-12 educators and staff during in-person schooling or childcare. Child care includes programs that are permitted to operate under DOH guidance for child care/youth development/day camps. Not only do they face the risks noted above (note: there is growing evidence that older kids have higher risk of transmission) but remote care and education is also associated with very high risk of

[1] See Washington Essential Critical Infrastructure Workers for most up-to-date list of essential worker groups

negative societal impact. There is strong evidence regarding the negative impact remote schooling is having on K-12 students regarding educational advancement and access to meals and support services for children, which disproportionately affects low-income families.

PHASE 1B-2 **OBJECTIVE**	PHASE 1B-2 **GUIDANCE**
To protect those who are at *high risk* of exposure and transmission given the nature of working and living conditions, to prevent hospitalizations and rates of severe morbidity and mortality, and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers 50 years and older with significantly high risk of exposure and transmission in congregate settings** [note: congregate setting suggests an environment where individuals work and/or live in an enclosed space where they are interacting with a high volume of people over extended time and not able to consistently social distance] Specific groups and guidance are included below – although discretion is left to the employer to assess risk (note: workers who are able to socially distance, work remotely or work off-site not in a congregate setting should not be included): • *Congregate agriculture* – specifically those who work and/or live in a congregate setting interacting with a high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day). Relevant roles are more likely to include crop selection, production and packaging vs. equipment maintenance • *Congregate food processing* – specifically those who work and/or live in a congregate setting interacting with high volume of co-workers (vs. animals) over extended periods of time (i.e., >3 hours in 24 hour day) • *Congregate grocery store workers* - specifically those who work in a congregate setting interacting with high volume of co-workers over extended periods of time (i.e., >3 hours in 24 hour day). We encourage considering prioritizing retail stores of higher density/volume. • *Congregate staff in correction facilities, prisons, jails, and detention facilities* – specifically those who work in a congregate setting interacting with high volume of co-workers or residents over extended periods of time (i.e., >3 hours in 24 hour day). • *Congregate public transit* - specifically those who work in an enclosed (vs. outdoor) congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day) to facilitate the transport of people. Settings may include bus, train, ferry, airport, and other high density transportation settings – or lower density settings where individuals are tightly constricted over an extended time, specifically taxies, limos and private vehicles over 4 people). Not include those who can work remotely or in office where can practice being socially distant. • *Firefighters, law enforcement and social workers responding to public health and safety* - specifically those who work in a congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e., >3 hours in 24 hour day). Not including administrators or those who can work remotely.
Same as above and to reduce the negative societal impact on families and children (that disproportionately affects low-income families)	**Workers 50 years and older years of age in child care settings** **K-12 educators and staff 50 years and older who are working at the school (i.e., not remote workers)** • This category should consider the full spectrum of workers including administrators, environmental services staff, maintenance workers, school bus drivers, paraeducators, and all of who are essential to child care and education. • Specifically, this group includes those who face substantially high risk of exposure given work conditions because they are operating in a congregate setting interacting with co-workers or youth over extended periods of time.

	• Childcare includes early learning and child care programs that are permitted to operate under DOH guidance for child care, youth development, and day camps. • Attention should be given to the specific programs that reach children with special health care needs, individual educational plans, and technological gaps. • This group should not include those who are working remotely or in a role where they can practice being socially distant.

Phase 1b - Tier 3

Overarching Groups:

- **People 16 years and older with 2 or more co-morbidities or underlying conditions**

Phase 1b – Tier 3 includes people who have certain medical conditions that put them at increased risk for severe illness if infected with COVID leading to increased hospitalization, morbidity and mortality. The list of conditions is based upon research by CDC that is posted at the following site: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html. It is a living document that may be updated as science evolves.

PHASE 1B-3 **OBJECTIVE**	PHASE 1B-3 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality	**People 16 years and older with 2 or more co-morbidities or underlying conditions** (See CDC's list of the conditions that put people at increased risk of severe illness from COVID-19.)

Phase 1b - Tier 4

Overarching Groups:

- **High risk critical workers under age 50 in certain congregate settings (as noted above in Tier 2)**
- **People (residents, staff, volunteers) in congregate living settings (e.g., correction facilities, prisons, jails, detention centers; group homes for people with disabilities) and people experiencing homelessness that access services or live in congregate settings (e.g., shelters, temporary housing)**

Phase 1b – Tier 4 includes two other high risk groups: (1) essential workers from the same groups as Tier 2 but under age 50 and (2) people in congregate living settings where there is a high risk of exposure and transmission. Exposure risk is due to factors such as setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), barriers to healthcare access, etc.

PHASE 1B-4 **OBJECTIVE**	PHASE 1B-4 **GUIDANCE**
To prevent hospitalization and rates of severe morbidity and mortality, including in settings that increase potential exposure - and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Critical workers under age 50 with significantly high risk of exposure and transmission in congregate settings.** See Phase 1b – Tier 2 for description of congregate settings to be considered. **Residents and staff in group homes for individuals with disabilities, including serious mental illness, development and intellectual disabilities, and physical disabilities as well as residential substance use disorder facilities not already covered in Phase 1** **People in prisons, jails, detention centers, and similar congregate facilities who work in such settings not already covered in Phase 1** **People experiencing homelessness that access services or live in congregate settings (e.g., temporary housing, shelters)** **People living or residing in domestic violence shelters**

INTERIM COVID-19 Vaccine Allocation Phase Quick Reference

PHASE 1A

TIER 1

- High-risk workers in health care settings
- High-risk first responders
- Long-term care facility residents

TIER 2

- All other workers at risk in health care settings

PHASE 1B

TIER 1

- All people 70 years and older
- People 50 years and older living in multigenerational households

TIER 2

- High-risk critical workers 50 years and older who work in certain congregate settings:
  - Agriculture; food processing; grocery stores; K-12 educators and staff; childcare; corrections, prisons, jails, or detention facilities; public transit; fire; law enforcement

TIER 3

- People 16 years and older with 2 or more comorbidities or underlying conditions

TIER 4

- High-risk critical workers under 50 years who work in certain congregate settings (as noted above in Tier 2)
- People, staff, and volunteers in congregate living settings:
  - Correctional facilities; group homes for people with disabilities; people experiencing homelessness that live in or access services in congregate settings

PHASE 2*

- Critical workers in other settings who are in industries essential to the functioning of society and are at risk of exposure not already covered in Phase 1
- People 16 years and older with 1 comorbidity or underlying condition not already covered in Phase 1
- People with disabilities that prevent them from adopting protective measures
- All people 65 years and older who arenot already covered in Phase 1

PHASE 3*

- Workers in industries and occupations essential to the functioning of society and at increased risk of exposure not included in Phase 1 or 2
- Young adults/children under 16 years (if vaccine is authorized for children under 16 years)

PHASE 4*

- Everyone residing in Washington State who did not have access to vaccine in previous phases

*Future phases are still tentative and will be finalized based on clinical trial data, federal guidance, vaccine supply projections, and ongoing community input.

Certain population groups have been prioritized with an aim to mitigate health inequities recognizing that specific populations are disproportionately impacted by COVID-19 due to external social factors and systemic inequities. Examples of populations disproportionately affected due to such factors include:

- People of color
- People with limited English proficiency
- People in shared housing, crowded housing, and multi-generational homes
- People in poverty and low-wage earners
- People with disabilities that are connected to underlying health conditions that may put a person at higher risk for COVID-19
- People with access barriers to healthcare

Washington State has also developed a social vulnerability index which includes social determinants of health factors to identify highest vulnerability areas. This will be one of several inputs informing vaccine allocation decisions to ensure equitable allocation.

NOTE Immigration status and health insurance status do not impact an individual's eligibility.

EQUITY IS A CROSS-CUTTING FOCUS

Updated January 5, 2020

EXHIBIT 2

WASHINGTON'S COVID-19 VACCINE PHASES

Phase 1 Estimated Start Dates (Tiers A and B)

Find out if it's your turn at **FindYourPhaseWA.org**

WINTER | **SPRING / SUMMER** | **SUMMER / FALL**

1A TIER 1, 1A TIER 2

- High-risk healthcare workers in health care settings
- High-risk first responders
- Long-term care facility residents
- All other workers at risk in health care settings

1B TIER 1

- All people **65 years or older**
- All people **50 years or older** in multigenerational households (home where individuals from 2 or more generations reside such as an elder and a grandchild)

1B TIER 2

- High-risk critical workers **50 years or older** who work in certain congregate settings: Agriculture; food processing; grocery stores; K-12 (educators & staff); childcare; corrections; prisons, jails or detention centers; public transit; fire; law enforcement

1B TIER 3

- People **16 years or older** with 2 or more co-morbidities or underlying conditions

1B TIER 4

- High-risk critical workers **under 50 years** who work in certain congregate settings (as noted in B2)
- People, staff, and volunteers in congregate living settings: Correctional facilities; group homes for people with disabilities; people experiencing homelessness that live in or access services in congregate settings

FUTURE PHASES

- Information on who is eligible for Phases 2, 3 & 4 coming soon.

FOCUS ON EQUITY: This approach prioritizes population groups that have been disproportionately impacted by COVID-19 due to external social factors and systemic inequities.

The timelines represented here are estimates and subject to change.

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GLOSSARY OF TERMS

CO-MORBIDITIES

Morbidity is a medical term that means illness or disease. Co-morbidities means more than one illness or disease occurring in one person at the same time. Phase 1 – Tier 3 includes people with 2 more comorbidities or underlying conditions that put them at increased risk for severe illness if infected with COVID. This list of these conditions can be found on the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

CONGREGATE SETTING

An environment where individuals work and/or reside in an enclosed space and where they are interacting with a high volume of people over an extended period of time and not able to consistently maintain physical distance.

CRITICAL WORKERS

Individuals working in an industry that maintains critical infrastructure for social and economic systems in our state. (See reverse side for detailed list.)

HIGH-RISK WORKERS IN A HEALTHCARE SETTING

Workers who are at higher risk of COVID-19 infection because they meet one or more of the following criteria:

- Administer COVID-19 testing or handle COVID-19 specimens
- Administer COVID-19 vaccine or have patient contact in a COVID-19 vaccination site.
- Work at a community-based, congregate living facility (for example, long-term care facility, adult family home or residential care community) where people over 65 years old receive care, supervision or assistance.
- A professional care provider to someone who is a at higher risk of severe outcomes if infected with COVID-19 (for example, home health aide, dialysis provider, or cancer treatment provider).

HIGH-RISK WORKERS IN A HEALTHCARE SETTING (CON'T)

- Worker (for example, healthcare provider, security, environmental management) in a setting that provides direct care for suspected or confirmed COVID-19 patients.
- First responder (for example, EMS, police or firefighter) in settings where direct care is provided to suspected or confirmed COVID-19 patients.
- Worker at high risk of infection and transmission of COVID-19 because of exposure to the general public.

LONG-TERM CARE FACILITY

For the purposes of the vaccine allocation guidance, long-term care facilities are defined as community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community.

MULTIGENERATIONAL HOUSEHOLD

Household where individuals from 2 or more generations reside such as an elder and a grandchild. Does **not** include a parent or guardian caring for a child or teen.

WORKERS IN HEALTHCARE SETTINGS

Includes the full spectrum of workers at health agencies including all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).

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DOH 348-785 January 2021

EXHIBIT 3

GUIDANCE SUMMARY
WA STATE COVID-19 VACCINE PRIORITIZATION GUIDANCE AND ALLOCATION FRAMEWORK

The Washington State Department of Health has developed this guidance for COVID-19 vaccine allocation and prioritization to facilitate harmonized planning for distribution across Washington State. This guidance is the result of several months of engagement with expert groups and community partners to gather input and ideas. Given current information and federal guidance, we are providing guidance on Phases 1 through 4 that incorporates this input while staying aligned with the principles and criteria noted below. The guidance has and can continue to be updated based on:

- New information from clinical trials
- New federal guidance and vaccine recommendations
- Ongoing feedback from impacted communities, partners, sectors, and industries

In this guidance, population groups overlap and there are individuals who fit into multiple categories. When this is the case, the higher phase should take precedence. Also, the order of the populations does not suggest any type of prioritization or risk stratification. In all circumstances, although reinfection appears uncommon during the initial 90 days after symptom onset, prior confirmation of COVID-19 infection will not exclude any individual from eligibility for COVID-19 vaccine and serologic testing is not being recommended prior to vaccination. Vaccines should be administered according to age groups for which the specific vaccine is authorized (e.g., Pfizer for 16 and over and Moderna for 18 and over).

GOAL: To reduce severe morbidity and mortality and negative societal impact due to the transmission of SARS-CoV-2

ETHICAL PRINCIPLES	PROCEDURAL PRINCIPLES	CRITERIA
• Maximum benefit • Equal concern • Mitigation of health inequities	• Fairness • Transparency • Evidence-based	• Risk of acquiring infection • Risk of severe morbidity and mortality • Risk of negative societal impact • Risk of transmitting infection to others

Washington State Department of Health

Phase Eligibility Timing

The table below outlines groups who are currently eligible vs. projected timing for future eligible groups. These future plans are tentative and are subject to change depending upon vaccine supply and demand.

Phase	When it will open	Who is in it
1A	Currently open (Dec 14, 2020)	• See prioritization guidance
1B tier 1	Currently open (Jan. 18, 2021)	• See prioritization guidance • Pre-kindergarten through 12th grade educators and staff *(added March 2)* • Child care staff *(added March 2)*
1B tier 2	Currently open (March 17, 2021)	• High-risk critical workers in certain congregate settings • People age 16 or older who are pregnant • People age 16 or older who have a disability that puts them at higher risk
1B tier 3 & 4	Currently open (March 31, 2021)	• People 16 years or older with 2 or more comorbidities or underlying conditions • People 60 years and older • People, staff and volunteers in certain congregate living settings – specifically, correctional facilities, congregate settings where people experiencing homelessness live or access services, and group homes for people with disabilities • Other at-risk critical workers in certain congregate settings – specifically, restaurants/food services, manufacturing, and construction
2, 3	Opens April 15, 2021	• All people age 16 years and older not already covered

Phase 1a - Tier 1

Overarching Groups:

- **High-risk workers in health care settings** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **High-risk first responders** (clinical judgment should be applied to identify who is at greatest risk using the guidance below)
- **Residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance**

Phase 1a focuses on (a) high-risk workers in health care settings and high-risk first responders in order to protect our medical care response capacity and (b) residents and staff of nursing homes, assisted living facilities, and other community-based, congregate living settings where most individuals over 65

years of age are receiving care, supervision, or assistance aiming to avoid hospitalizations, severe morbidity, and mortality. The table below identifies the desired objectives and guidance regarding what individuals would be prioritized for vaccine allocation in this phase. We provided recommendations that closely align with the Advisory Committee on Immunization Practices (ACIP) and initially include risk stratification given limited vaccine.

CDC provided initial COVID-19 vaccine supply projections for the first two months. Assuming Washington state receives approximately 2 percent of the total projections (Washington's approximate proportion of total U.S. population), our state was expected to receive between 150,000 to 350,000 doses in the first month and between 500,000 to 1 million doses in the second month (inclusive of second doses). Also note that many residents of long-term care facilities will be served via a federal pharmacy program that began in late December and draws down from the Washington state vaccine allotment. Given limited vaccine, sub-prioritization and sequencing of distribution to health care personnel was initially necessary. Furthermore, agencies have been encouraged to consider staggering vaccine schedules of teams to avoid potential clustering of worker absenteeism related to systemic reactions.

Beyond ACIP, this guidance was developed based on input and review by a number of experts including Washington advisory groups (Vaccine Advisory Committee, Disaster Medical Advisory Committee, COVID-19 Science Advisory Working Group, Association for Professionals in Infection Control), health care providers, and local health jurisdictions (including health officers).

PHASE 1A-1 OBJECTIVE	PHASE 1A-1 GUIDANCE

To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	*In the context of limited vaccine, this guidance includes the following sub-prioritization considerations:*
	• Personnel without known infection in prior 90 days
	• Workers in sites where direct patient care is being frequently delivered to confirmed or suspected COVID-19 patients, including sites where suspected patients are directed for COVID testing and care
	  o Example setting: hospital sites managing suspected/confirmed COVID patients; emergency departments; urgent care; clinics (walk-in, respiratory); home; isolation and quarantine facility
	  o Examples types of workers: health care workers; technicians; security; environmental, janitorial, and facility staff; non-remote translators; counselors; home health aides, caregivers, and companions
	• Workers frequently performing high-risk exposure procedures with suspected or confirmed COVID-19 patients
	  o Example procedures: endotracheal or cough inducing intubation; cough induction or cough inducing procedure (e.g., nasogastric tube); bronchoscopy; suctioning; turning the patient to the prone position; disconnecting the patient from a ventilator; invasive dental procedures and exams; autopsies; respiratory specimen collection; cardiopulmonary resuscitation; upper endoscopy; laparoscopic surgery; placement of chest tubes for pneumothorax
	• Workers exposed to/handling potentially SARS-CoV-2 containing specimens
	• COVID-19 testing site staff at high risk of exposure to suspected COVID-19 patients
	• First responders at high risk of exposure to suspected or confirmed COVID-19 patients via high public exposure and procedures
	  o Licensed emergency medical service frontline staff regardless of agency (e.g., fire, ambulance, hospital)
	  o Emergency workers providing patient transport/ambulatory support regardless of agency
	  o Personnel working in the field to provide oversight of these emergency medical service positions
	• Workers with elevated risk of acquisition/transmission with populations at higher risk of mortality or severe morbidity

	- Workers at long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance (e.g., healthcare, environmental facility management, counselors, dining staff, etc.) - Home health aides, care aides, caregivers (paid or unpaid), companions, etc. - Workers with patients undergoing chemotherapy, chronic renal disease, dialysis, etc. • Workers (including pharmacists and occupational health staff) administering vaccines to Phase 1a and 1b populations - **Residents and staff of long-term care facilities and other community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community:** • Example: skilled nursing facilities – facility engaged primarily in providing skilled nursing care and rehabilitation services for residents who require care because of injury, disability, or illness • Example: assisted living facilities – facility providing help with activities of daily living; residents often live in their own room or apartment within building/group of buildings • Examples of possible settings: adult family homes; group homes for people with disabilities (physical, developmental, intellectual); mental/behavioral health institutions; residential homeless shelters *Where sub-prioritization is needed, consider*: • Skilled nursing facilities caring for the most medically vulnerable residents and of congregate nature so they face the joint risk factors of severe disease/mortality and transmission due to their living settings • After skilled nursing facilities, consider broadening to other facilities, including: - Assisted living facilities and adult family homes - Residential care communities - HUD 202 low-income senior housing - Intermediate care facilities for individuals with developmental disabilities - State Veterans Homes

Phase 1a (Tier 1) Additional Guidance

- We specifically use the terminology "workers in health care settings" and not "health care workers" because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services). ACIP provides similar guidance regarding defining healthcare personnel.[1]
- Specifically, for caregivers: eligible caregivers (licensed, unlicensed, paid, unpaid, formal, or informal) who support the daily, functional and health needs of another individual who is at high risk for COVID-19 illness due to advanced age, long-term physical condition, co-morbidities, or development or intellectual disability. For the caregiver to be eligible, the care recipient:
  - Must be someone who needs caregiving support for their daily, functioning, and health needs
  - Can be an adult or minor child. For dependent minor children, the caregiver is eligible if that child has an underlying health condition or disability that puts them at high risk for severe COVID-19 illness. For example: a caregiver of a minor child with Down syndrome.

- Special attention should be paid to workers in health care settings who are at high risk of exposure and may have inconsistent or limited use of PPE as well as those working in settings with inadequate environmental controls for recommended air exchange.

Phase 1a - Tier 2 (after completion of Tier 1)

Overarching Group:

- **All other workers at risk in health care settings**

The definition of health care settings as defined by the CDC refers to places where health care is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

PHASE 1A-2 OBJECTIVE	PHASE 1A-2 GUIDANCE
To protect those at highest risk of exposure, to maintain a functioning health system, and to protect highly vulnerable populations	**All other workers at risk to COVID working in health care settings** • Workers who are at risk of acquisition or transmission of COVID because they are interacting in close proximity (less than 6 feet) with patients, co-workers, or specimens and are unable to remain socially distant (i.e., not include remote workers)

Phase 1a (Tier 2) Additional Guidance

- We specifically use the terminology “workers in health care settings” and not “health care workers” because health agencies should consider the full spectrum of workers who might fit these conditions. Health care agencies should consider all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services).
- Across Washington, it is important that health care systems actively reach out to and provide access to COVID-19 vaccination for community-based health care workforce outside their systems and in their community. This includes other health care providers, school nurses, and behavioral health providers, etc., in order to compete this phase and ensure we have a protected healthcare system.

Phase 1b

Phase 1b phase includes people who are high to moderate risk against the four risk criteria listed below stratified in different tiers given limited vaccine supply:

- Risk of acquiring infection
- Risk of severe morbidity and mortality
- Risk of negative societal impact

- Risk of transmission to others

In addition, we have applied equity as a cross-cutting lens and considered situations when certain groups are disproportionately affected due to social factors and/or other systemic inequities to mitigate for these factors.

Phase 1b - Tier 1

Overarching Groups:

- **All people 65 years and older**
- **People 50 years and older in multi-generational households**
- **Workers in childcare settings**
- **Pre-kindergarten-12th grade educators and staff**

The first two objectives of this tier focus on protecting those who are driving hospitalization and face high rates of severe morbidity and mortality in order to reduce the burden on hospitals that keeps us in an emergency state. We also want to recognize that there are older adults and elders who may be vulnerable and unable to live independently similar to those in community-based, congregate care settings (Phase 1a) but their families care for them at home. In addition, we recognize that many families - especially those disproportionately affected by COVID - live in multi-generational homes that put the older adults and elders in the household at significantly higher risk for acquiring infection. Because these individuals are among disproportionately affected groups, they are also at risk for higher rates of severe morbidity and mortality.

PHASE 1B-1 OBJECTIVE	PHASE 1B-1 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality	**All people 65 years and older** (about half of whom have co-morbidities that increase risk for severe outcomes if infected with COVID)
To prevent acquiring infection, hospitalization, and rates of severe morbidity and mortality	**People 50 years and older in a multigenerational (2 or more generations) household** These individuals would be at risk either due to: • Vulnerability – specifically, an older adult or elder who cannot live independently *and* is being cared for by a relative or in-home caregiver or being cared for by someone who works outside the home • Risk of exposure – specifically, an older adult or elder who is living with and taking care of kinship (along the lines of a grandparent with a grandchild) • This group does not include an older adult who is able to live independently and is taking care of the individual's kinship/children

On March 2, 2021, Gov. Jay Inslee and the Washington State Department of Health in accordance with a federal directive added another group to this tier – specifically, workers in child care settings and pre-kindergarten through 12th grade educators and staff. This group was initially in Tier 2 with other workers at high risk in a congregate setting. However, not only do they face the risks of acquisition and transmission (note: there is growing evidence that

older kids have higher risk of transmission) but remote care and education is also associated with very high risk of negative societal impact. There is strong evidence regarding the negative impact remote schooling is having on students in pre-kindergarten through 12th grade regarding educational advancement and access to meals and support services for children, which disproportionately affects low-income families.

PHASE 1B-1 OBJECTIVE	PHASE 1B-1 GUIDANCE
To protect those who are at high risk of exposure given the nature of work, to reduce negative societal impact by maintaining critical infrastructure for social and economic systems, and to reduce the negative societal impact on families and children (that disproportionately affects low-income families)	**Workers in child care settings** **Pre-kindergarten through 12th grade educators and staff** • This category should consider the full spectrum of workers including administrators, environmental services staff, maintenance workers, school bus drivers, paraeducators, and all of who are essential to child care and education. • Specifically, this group includes those who face substantially high risk of exposure given work conditions because they are operating in a congregate setting interacting with co-workers or youth over extended periods of time. • Eligible child care includes: o Licensed family home child care providers, and the family members living in their home. o License-exempt family, friends, and neighbor providers that accept Working Connections Child Care subsidy. These in-home providers can serve up to 6 children. o ECEAP, Washington's state-funded preschool providers. This is similar to the national Head Start program, which is named in the directive. o License-exempt school-age and youth development providers who have been providing care to school-age children since the pandemic began and schools were closed. As schools moved to online and hybrid models, these programs have continued to provide child care for school-age children. • Attention should be given to the specific programs that reach children with special health care needs, individual educational plans, technological gaps, and migrant education programs.

Phase 1b - Tier 2

Overarching Groups:

- **High-risk critical workers who work in certain congregate settings**
- **People who are pregnant**
- **People with a disability that puts them at high risk**

Phase 1b Tier 2 includes a subset of high-risk critical worker groups[1] who work in certain congregate settings. Occupational risk factors for COVID include setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts,

[1] See Washington Essential Critical Infrastructure Workers for most up-to-date list of essential worker groups

capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), and barriers to healthcare access. The course of the pandemic in Washington state indicates that specific groups of workers operating in congregate settings—such as, agricultural workers, food processing, and incarceration facilities — have experienced significantly elevated rates of infection given the nature of their working and/or living conditions. In addition, the working and living conditions contribute to transmission at work and in the community. Other critical worker groups are included in future phases.

PHASE 1B-2 OBJECTIVE	PHASE 1B-2 GUIDANCE
To protect those who are at *high risk* of exposure and transmission given the nature of working and living conditions, to prevent hospitalizations and rates of severe morbidity and mortality, and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**Certain critical workers with significantly high risk of exposure and transmission in certain congregate settings** Congregate setting refers to an environment where individuals work and/or live in an enclosed space where they are interacting with a high volume of people (i.e., supermarket) over extended time and not able to consistently social distance (i.e., be more than 6 feet apart). This does not include all critical worker groups but just a subset outlined below. This subset is focused on workers who are working in a congregate/enclosed setting working within 6 feet of other workers over an extended time (3 or more hours in 24-hour day). **Therefore, workers who are able to socially distance, work remotely or work off-site not in a congregate setting would not be included.** Specific groups and guidance are outlined below: • *Congregate agriculture* – specifically those who work and/or live in a congregate setting interacting with a high volume of co-workers (vs. animals) over extended periods of time (i.e. 3 or more hours in a 24-hour day). Relevant roles are more likely to include crop selection, production and packaging vs. equipment maintenance • *Congregate food processing* – specifically those who work and/or live in a congregate setting interacting with high volume of co-workers (vs. animals) over extended periods of time (i.e. 3 or more hours in a 24-hour day). Also includes those working in fishing vessels. • *Workers in congregate grocery stores or food banks* - specifically those who work in a congregate setting interacting with high volume of co-workers over extended periods of time (i.e. 3 or more hours in a 24-hour day). We encourage considering prioritizing retail stores of higher density/volume (e.g., grocery stores, higher volume retail/convenience stores providing groceries) vs. where people are more able to be socially distant (e.g., wineries, coffee shops). • *Congregate staff in correction facilities, prisons, jails, detention facilities, and court facilities* – specifically those who are interacting with high volume of individuals in a congregate interior setting over extended periods of time (i.e. 3 or more hours in a 24-hour day). We encourage considering the spectrum of staff (e.g. facility management, security, counselors) who fit this exposure criteria. • *Congregate public transit* - specifically those who work in an enclosed (vs. outdoor) congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e. 3 or more hours in a 24-hour day) to facilitate the transport of people. Settings may include bus, train, ferry, airport, and other high density transportation settings – or lower density settings where individuals are tightly constricted over an extended time, specifically taxies, limos and ride-share private vehicles over 4 people. It does not include those who can work remotely or in an office where they can practice being socially distant.

	• *First responders not covered by an earlier phase or tier* - specifically those who work in a congregate setting interacting with high volume of co-workers or general public over extended periods of time (i.e. 3 or more hours in a 24-hour day). This first responders group includes firefighters, law enforcement, social workers, public health, and other people playing similar roles (e.g., tactical teams, some providers for homeless services) responding to public health and safety. It does not include administrators or those who can work remotely, except for public health and first responder functions critical for maintaining the COVID-19 pandemic response and continuity of operations. • *Early learning and child care program workers* that are permitted to operate under DOH guidance for child care, youth development, and day camps that were not covered in 1B-1.

Phase 1b Tier 2 also includes a subset of people with underlying conditions that put them at increased risk for severe illness if infected with COVID-19 leading to hospitalization, morbidity, and mortality that are anticipated to face challenges accessing care.

PHASE 1B-2 OBJECTIVE	PHASE 1B-2 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality	• **Pregnant people** • **People with a disability that puts them at high risk**. This includes individuals with Down syndrome, a developmental disability, or an intellectual disability, or who are deaf/hard of hearing, blind/low-vision, or deafblind, AND that disability or an underlying medical condition increases their risk for severe outcomes per the CDC's list of the conditions that put people at increased risk of severe illness from COVID-19 (note: this is a living document that may be updated as science evolves). This includes three types of groups - specifically: o People with a physical or intellectual disability where they cannot use protective measures (e.g., severe autism, epilepsy) o People with a physical or intellectual disability that is clinically associated with severe outcomes if infected with COVID (e.g., down syndrome, neurological condition) o People with a physical or intellectual disability AND at least one of the comorbidities or medical conditions that increases risk or may increase risk of severe illness from COVID-19 per the CDC's list of the conditions that put people at increased risk of severe illness from COVID-19

Phase 1b - Tier 3

Overarching Groups:

- **People 16 years and older with 2 or more co-morbidities or underlying conditions**
- **People 60 years and older**

Phase 1b – Tier 3 includes people who have certain medical conditions that put them at increased risk for severe illness if infected with COVID leading to increased hospitalization, morbidity and mortality. The list of conditions is based upon research by CDC posted at www.cdc.gov/coronavirus/2019-

ncov/need-extra-precautions/people-with-medical-conditions.html. It is a living document that may be updated as science evolves. This group also includes people over 60 years of age given high rates of hospitalization and severe morbidity and mortality associated with this older age bracket.

PHASE 1B-3 OBJECTIVE	PHASE 1B-3 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality	**People 16 years and older with 2 or more co-morbidities or underlying conditions** per the CDC's list of the conditions that put people at increased risk of severe illness from COVID-19. Conditions on the entire list are included for consideration. **People 60 years and older**

Phase 1b - Tier 4

Overarching Groups:

- **People (residents, staff, volunteers) in certain congregate living settings – specifically, correctional facilities, prisons, jails, and detention centers; group homes for people with disabilities; and congregate settings (e.g. shelters, temporary housing) where people experiencing homelessness live or access services**
- **An additional subset of at-risk critical workers in certain congregate settings – specifically, restaurants and food services, manufacturing and construction**

Phase 1b – Tier 4 includes an additional subset of people in certain congregate settings where there is a high to medium risk of exposure and transmission who have not been covered in earlier tiers. Exposure risk is due to factors such as setting (time inside vs. outside), proximity (to co-workers and/or customers), type of contact (physical, surface), duration, daily number of contacts, capability to assess possible infection (screening), consistent access to/ability to use protection, cleaning (frequency), barriers to healthcare access, etc. The first group in Tier 4 includes people in specific congregate living settings where there is local data indicating high rates of infection and transmission and people in these settings tend to have a high prevalence of underlying conditions and vulnerabilities that put them at higher risk for severe outcomes. We recognize there are other congregate living settings (e.g. communal residences) and these residents should evaluate their eligibility via other groups and phases. The second group in Tier 4 a subset of critical workers who are operating in congregate settings that have indicated high rates of infection and transmission. Other critical workers in congregate settings will be eligible in Phase 2.

PHASE 1B-4 OBJECTIVE	PHASE 1B-4 GUIDANCE
To prevent hospitalization and rates of severe morbidity and mortality, including in settings that increase potential exposure - and to reduce negative societal impact by maintaining critical infrastructure for social and economic systems	**People (residents, staff, volunteers) in certain congregate living settings** given high rates of infection and transmission and high prevalence of underlying conditions and vulnerabilities that put them at higher risk for hospitalization and severe outcomes. Thus, this does not include all people living in congregate living settings. Specific settings include: • Residents and staff in group homes for individuals with disabilities, including serious mental illness, development and intellectual disabilities, and physical disabilities as well as residential substance use disorder facilities not already covered in Phase 1 • People in prisons, jails, detention centers, and similar congregate facilities and staff who work in such settings not already covered in previous phases or tiers • Residents and staff working in congregate settings that serve people experiencing homelessness that access services or live in the congregate settings (e.g. temporary housing, shelters) who are not already covered above • People living or residing in domestic violence shelters and staff who work in such settings **Certain critical workers with high-medium risk of exposure and transmission in certain congregate settings** Congregate setting refers to an environment where individuals work in an enclosed space where they are interacting with a high volume of people over an extended time and are not able to consistently social distance (i.e., be more than 6 feet apart). **Workers in these settings who are able to socially distance, work remotely or work off-site not in a congregate setting would not be included.** This does not include all critical worker groups but just a subset outlined below based upon Washington State COVID-19 outbreak reports.. Specific groups and guidance are outlined below: • *Restaurants and food services* - specifically those who work in an enclosed congregate setting where they are in close proximity of a high volume of individuals over an extended period of time (i.e. >3 hours in 24 hour day). • *Manufacturing* - specifically those who work in an enclosed congregate setting interacting with high volume of individuals over an extended period of time (i.e., >3 hours in 24 hour day). • *Construction* - specifically those who work in a congregate setting (indoor or outdoor) where it is not possible to be socially distant and the individual is interacting with a high volume of individuals over an extended period of time (i.e., >3 hours in 24 hour day).

Phases 2 and 3

Overarching Groups:

- **All people not yet covered in Phase 1**

PHASE 2 and 3 OBJECTIVE	PHASE 2 and 3 GUIDANCE
To protect those who are at *substantially* high risk of exposure and have not yet been covered. To protect those who are at *moderately* high risk of exposure .	**All people 16 years and older who are not already covered**

We combined phases 2 and 3 after the Secretary of Health and Human Services directed that all persons eligible to receive COVID-19 vaccine will be included as of May 1, 2021.

EXHIBIT 4

WASHINGTON'S COVID-19 VACCINE PHASES

Go to **VaccineLocator.doh.wa.gov** to find and schedule an appointment

1A TIER 1
1A TIER 2

- High-risk health care workers in health care settings
- High-risk first responders
- Long-term care facility residents
- All other workers at risk in health care settings

1B TIER 1

- All people **65 years or older**
- All people **50 years or older** in multigenerational households (home where individuals from 2 or more generations reside such as an elder and a grandchild)
- Educators and staff for pre-K through 12th grade
- Child care providers

1B TIER 2

- High-risk critical workers who work in certain congregate settings: Agriculture; fishing vessel crews; food processing; grocery stores; corrections; prisons, jails or detention centers; public transit; remaining first responders
- People **16 years or older** who are pregnant or have a disability that puts them at high risk for severe COVID-19 illness.

1B TIER 3
1B TIER 4

- People **16 years or older** with 2 or more co-morbidities or underlying conditions
- All people **60 years and older**
- People, staff and volunteers in certain congregate living settings: Correctional facilities; groups homes for people with disabilities; settings where people experiencing homelessness live or access services
- High-risk critical workers in certain congregate settings: restaurants, food services, construction and manufacturing

DECEMBER 2020 – PRESENT 2021

FOCUS ON EQUITY: This approach prioritizes population groups who have been disproportionately impacted by COVID-19 due to external social factors and systemic inequities, including people of color; people with limited English proficiency; people in shared housing, crowded housing, and multigenerational homes; people in poverty and low-wage earners; people with disabilities that are connected to underlying health conditions that may put them at higher risk of COVID-19; and people with access barriers to healthcare. The social vulnerability index is one of several inputs informing equitable vaccine allocation.

NOTE: Immigration and health insurance status do not impact eligibility.

The timeline represented here is tentative and subject to change based on vaccine supply and demand.

Vaccinate WA

CovidVaccineWA.org

DOH 348-785 January 2021
Last updated 3/31/21

GLOSSARY OF TERMS

CO-MORBIDITIES

Morbidity is a medical term that means illness or disease. Co-morbidities means more than one illness or disease occurring in one person at the same time. Phase 1 – Tier 3 includes people with 2 more comorbidities or underlying conditions that put them at increased risk for severe illness if infected with COVID. This list of these conditions can be found on the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

CONGREGATE SETTING

An environment where individuals work and/or reside in an enclosed space and where they are interacting with a high volume of people over an extended period of time and not able to consistently maintain physical distance.

CRITICAL WORKERS

Individuals working in an industry that maintains critical infrastructure for social and economic systems in our state. (See reverse side for detailed list.)

HIGH-RISK WORKERS IN A HEALTH CARE SETTING

Workers who are at higher risk of COVID-19 infection because they meet one or more of the following criteria:

- Administer COVID-19 testing or handle COVID-19 specimens
- Administer COVID-19 vaccine or have patient contact in a COVID-19 vaccination site.
- Work at a community-based, congregate living facility (for example, long-term care facility, adult family home or residential care community) where people over 65 years old receive care, supervision or assistance.
- A professional care provider to someone who is a at higher risk of severe outcomes if infected with COVID-19 (for example, home health aide, dialysis provider, or cancer treatment provider).bv

HIGH-RISK WORKERS IN A HEALTH CARE SETTING (CON'T)

- Worker (for example, health care provider, security, environmental management) in a setting that provides direct care for suspected or confirmed COVID-19 patients.
- First responder (for example, EMS, police or firefighter) in settings where direct care is provided to suspected or confirmed COVID-19 patients.
- Worker at high risk of infection and transmission of COVID-19 because of exposure to the general public.

LONG-TERM CARE FACILITY

For the purposes of the vaccine allocation guidance, long-term care facilities are defined as community-based, congregate living settings where most individuals over 65 years of age are receiving care, supervision, or assistance and are unable to reside independently in the community.

MULTIGENERATIONAL HOUSEHOLD

Household where individuals from 2 or more generations reside such as an elder and a grandchild. Does **not** include a parent or guardian caring for a child or teen.

WORKERS IN HEALTH CARE SETTINGS

This includes the full spectrum of workers at health agencies including all types of staff (e.g., contracted, part-time, unpaid/volunteer) and the spectrum of staff who provide services (e.g., ambulatory, direct patient care, support services). It is inclusive of Community Health Workers, home care aides, health care interpreters, doulas, caregivers, and personal care providers.

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email **civil.rights@doh.wa.gov**.

Vaccinate WA

CovidVaccineWA.org

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EXHIBIT 5

Columbia Legal Services
Working for Justice Since 1967

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March 9, 2021

To: Washington State Governor Jay Inslee
Office of the Governor
PO Box 4002
Olympia, WA 98504

Secretary Umair A. Shah
Washington State Department of Health
111 Israel Road SE
Tumwater, WA 98501

Secretary Stephen Sinclair
Washington State Department of Corrections
PO BOX 41100, Mail Stop 41100
Olympia, WA 98504-1100

SENT BY ELECTRONIC MAIL

RE: Immediate action needed to protect individuals in Department of Corrections custody from ongoing COVID-19 pandemic.

Dear Governor Inslee, Secretary Shah, and Secretary Sinclair:

Since March 2020, nearly 6,200 individuals in DOC custody have tested positive for COVID-19, and 14 residents have died as a result of their infections.[1] Another 1,125 DOC staff members have also become ill, and two have passed away.[2] We are still in the midst of this global pandemic, which means that each person in DOC custody remains at grave risk of serious illness or death from this virus. The State of Washington has a constitutional obligation to protect the health and safety of the people in its custody against the ongoing threat posed by COVID-19.

For months, the only effective means of controlling the spread of this disease was through social distancing and use of personal protective equipment. As we have seen, the nature of congregate settings (and correctional facilities in particular) makes the effective implementation of these measures exceedingly difficult. As a result, thousands of individuals in

[1] The precise number is a total of 6,184 positive cases amongst DOC residents as of March 8, 2021. See https://www.doc.wa.gov/corrections/covid-19/data.htm#confirmed.
[2] https://www.doc.wa.gov/corrections/covid-19/data.htm#confirmed.

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DOC custody falling ill over the past year. However, with the introduction of several effective COVID-19 vaccines, there is now an opportunity to effectively mitigate the risk of grave illness and death from this deadly virus. In order for Washington State to curb the risk of another massive and deadly outbreak in DOC facilities, it is imperative to give every person in DOC custody the opportunity to receive the COVID-19 vaccination immediately and to protect residents from having contact with DOC staff members who refuse to be vaccinated.

The health and safety of the people in custody in DOC facilities is the responsibility of the State, and their lives should not be placed in further jeopardy by failing to make them immediately eligible for the vaccine. We are urging you to take the following steps to protect the more than 15,000 individuals in DOC custody:[3]

1. **All individuals in DOC custody must immediately be offered the COVID-19 vaccine.**

   Delaying the availability of the vaccine to all people residing in DOC correctional facilities is simply unacceptable. Governor Inslee, the Department of Health, and the Department of Corrections must immediately cooperate in adjusting the current phase designation of individuals in correctional custody so that all DOC residents who desire it can be vaccinated immediately.

   While we recognize that vaccine production has been insufficient to supply the number of doses needed to vaccinate everyone in Washington State at this time, people in DOC custody must be immediately prioritized due to the exponentially higher risk of infection, severe illness, and death from COVID-19. As of March 4, 2021, 39% of the residents in DOC custody had tested positive for COVID-19.[4] This is nearly ten times the rate of infection compared to the rest of Washington State, where there have been a total of 323,123 cases, equaling just over 4% of the total state population.[5] Furthermore, according to the Department of Health, as of March 1, 2021, the average number of COVID-19 doses administered each day (over the past 7 days) in Washington State is 43,765.[6] This is nearly three times the total population of DOC. That means that the Governor and the Department of Health could allocate enough doses to vaccinate every single person in DOC custody in a single day and there would still be nearly 30,000 doses remaining for distribution to other community sites.

   As of the date of this letter, Washington is currently in Phase 1B Tier 1 of the existing phases for vaccine eligibility established by the Washington State Department of Health. Under the current phase structure, individuals residing in correctional facilities do not become eligible for vaccination until Phase 1B Tier 4, though we understand that DOC may offer the vaccine sooner to incarcerated individuals who would otherwise be

[3] As of December 2020, the population of all DOC facilities was reported at 15,644. See https://www.doc.wa.gov/docs/publications/reports/400-RE002.pdf.

[4] https://www.doc.wa.gov/corrections/covid-19/data-comparative-jurisdictions.htm

[5] Office of Financial Management published the population of Washington State at 7,656,200 as of April 1, 2020. https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/total-population-and-percent-change

[6] DOH Dashboard as of March 4, 2021; https://www.doh.wa.gov/Emergencies/COVID19/DataDashboard

eligible in an earlier phase.[7] As of March 2, 2021, DOC had administered 5,448 doses of the vaccine (including 2,001 second doses).[8] However, this data does not distinguish between correctional staff and incarcerated individuals or how vaccine recipients' eligibility was established under the DOH phases. In addition, there is no data available on DOC's website that outlines their plan or timeline for how and when the vaccine will be made available to all individuals in its custody.

Given the availability of doses and the exponentially higher risk of infection for people incarcerated in DOC facilities, the Governor, the Department of Health, and the Department of Corrections must determine how to reallocate doses to protect these individuals immediately. Other important constituencies, such as teachers and childcare providers, and other critical workers have been recently reprioritized for vaccines, which moves more people ahead of people residing in correctional facilities, who are now not expected to have access to any doses until late April. The State must also immediately prioritize people who are living in Washington's prisons, who are at an even greater risk from COVID-19. [9]

2. **The Department of Health and Department of Corrections must immediately create a vaccine education and distribution plan that provides accurate information about the vaccine and is responsive to the environment of distrust and historical abuse of people who are incarcerated by both medical and carceral authorities.**

   In addition to the need to make the vaccine available to all individuals in DOC custody immediately, it is also essential to ensure that information about the vaccine – and the vaccine itself – are provided to DOC residents in a way that is both factually accurate and is designed to assuage the historic and ongoing distrust of DOC and the medical community at large.

   Immediate access to the vaccine is critical to protecting the people in DOC custody, but simply allocating the required number of doses will not be sufficient. Achieving herd immunity against the COVID-19 virus requires that a large enough percentage of the DOC population must accept the vaccine. In order to achieve this, it is essential to utilize culturally responsive resources to provide ongoing outreach, education, and medical services in conjunction with immediate allocation of the vaccine doses for DOC residents.

   Throughout our nation's history, BIPOC (Black/Indigenous/People of Color) communities have been the targets of unwanted, nonconsensual research, testing, and treatment by the medical community. This legacy has led to a deeply seated wariness by many BIPOC individuals of systems of medical research and care. Furthermore, for many individuals in DOC custody, there is a pervasive distrust of the medical care provided to them

[7] https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/VaccinationPhasesInfographic.pdf
[8] https://www.doc.wa.gov/corrections/covid-19/data-vaccines.htm.
[9] https://www.seattletimes.com/seattle-news/washington-state-teachers-childcare-workers-can-now-get-vaccinated-gov-inslee-says/.

through the department. Thus, for BIPOC residents of correctional facilities, these intersecting fears are often compounded.

CLS has received feedback from numerous individuals in a variety of DOC facilities, as well as concerned family members and loved ones, that many people are reluctant to accept the vaccine when it is offered because of fears that DOC is not providing accurate information about the vaccine, and concerns about whether they will be administering an approved vaccine to residents. The fact that the State is prioritizing correctional staff members over residents has in many cases exacerbated this distrust. It is imperative that the Governor, the Department of Health, and the Department of Corrections partner not only with each other, but also engage with authentic, respected voices in the community to help spread accurate information and build trust around the vaccine and DOC's ability to properly administer it. The State has made efforts to address distrust and misinformation in our communities outside of prisons, and it must also make similar efforts to engage and build trust with the individuals living in correctional facilities.

3. **DOC must create a plan to protect individuals in their custody from correctional staff who refuse to be vaccinated.**

As of the date of this letter, it is our understanding that the Department of Corrections does not currently have any plans in place to protect residents in its custody from correctional staff who refuse the COVID-19 vaccine – particularly those residents who are unable to be vaccinated due to contraindications. This is not acceptable, and DOC must immediately put together a response plan that ensures that all correctional staff who come into contact with DOC residents have been vaccinated to protect against another outbreak in one or more of its facilities.

Given the rapid rate of transmission of COVID-19 between individuals in DOC custody, DOC must limit the risk of COVID-19 being introduced to people who are incarcerated in its facilities. The most prevalent and highest risk of this exposure is through corrections staff who come and go each day and return to their families and communities outside of the prison, putting themselves at risk of exposure to COVID-19 via community transmission. These staff then return to work at DOC facilities and potentially expose the residents, who do not have the ability to socially distance or refuse contact with DOC staff members. CLS understands that a large number of DOC staff have refused to be vaccinated or have indicated they will refuse when it is available. The danger posed by unvaccinated staff is particularly critical for individuals in DOC custody who may be unable to take the COVID-19 vaccine due to individual circumstances or risk factors. Because DOC has a duty to protect the individuals who are incarcerated in its facilities, it should ensure that every staff member (regular or contract) who has direct contact with residents has been immunized against the COVID-19 virus.

Time is of the essence and the State must act immediately to protect people living in Department of Corrections' facilities.

Since the outset of the pandemic in early 2020, we have heard from hundreds of individuals residing in DOC custody with concerns about how the Department has responded to the virus. In addition to the over 6,100 residents who have contracted the virus, people in DOC custody have been subjected to abhorrent conditions as a result of the Department's COVID-19 response, ranging from facility-wide lockdowns, to the extensive use of solitary confinement, to limited access to toilets and showers, to restricted contact with family and loved ones, to placement of residents in decommissioned buildings without access to drinking water or ventilation.

Now with the introduction and availability of multiple effective vaccines, Governor Inslee, DOH, and DOC must take immediate steps to protect the vulnerable people who are living in our state correctional facilities. The people living in DOC custody are at an exponentially higher risk of contracting COVID-19 if and when another outbreak occurs, and prioritizing access to the vaccine for the over 15,000 people in these facilities should not be politicized – it is a matter of fulfilling the State's duty to protect people in its custody. We ask that the Governor, the Department of Health, and the Department of Corrections provide us with a detailed, comprehensive plan to address the concerns outlined in this letter no later than Friday, March 19, 2021, or we plan to file a lawsuit to effectuate these requests. We believe that these issues can be fully addressed with rapid action by your offices and hope that you are willing to take these immediate actions to protect every individual in DOC correctional facilities against the ongoing threat of this pandemic. Please contact us by email (addresses in signature, below) to provide us with details of the steps your offices intend to take.

Sincerely,

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