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SUPREME COURT OF THE STATE OF WASHINGTON

IN RE THE PERSONAL RESTRAINT OF

Robert R. Williams,

Petitioner.

**ANSWER TO BRIEF OF *AMICI CURIAE* PUBLIC HEALTH AND
HUMAN RIGHTS EXPERTS**

WASHINGTON INNOCENCE PROJECT
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Barsky et al., *Vaccination Plus Decarceration — Stopping
Covid-19 in Jails and Prisons*, New Eng. J. Med. (Mar. 3,
2021) 1, 2

I. INTRODUCTION

Petitioner, Robert R. Williams, submits this Answer to Brief of *Amici Curiae* Public Health and Human Rights Experts to provide additional authority, published after the filing date for amicus briefs, in support of Amici’s conclusion that vaccination is insufficient to protect Mr. Williams from the dangers of COVID-19.

II. ARGUMENT

On March 3, 2021, the New England Journal of Medicine published Barsky et al., *Vaccination Plus Decarceration — Stopping Covid-19 in Jails and Prisons*, New Eng. J. Med. (Mar. 3, 2021). (Attached as Ex. 1). The article offers new support for Public Health and Human Rights Experts Amici’s conclusion that “releasing Mr. Williams will minimize the public health risk to Coyote Ridge’s staff, incarcerated people, visitors, and the public at large.” Public Health and Human Rights Experts Amici Br. at 1. The article warns that vaccines alone are not sufficient to protect incarcerated people from COVID-19.

The New England Journal of Medicine (NEJM) article discusses the factors suggesting that “vaccination alone will not be enough to stop carceral outbreaks.” Ex. 1 at 1. It highlights new data showing “even a highly efficacious vaccine will have suboptimal preventive effects in high-

spread, congregate settings.” *Id.* at 2. The article stresses that “[vaccines] must be coupled with large-scale decarceration to increase the real-world effectiveness of vaccination, disrupt wide ranging viral transmission chains, and turn off the epidemiologic pump.” *Id.* at 3. Based on “scientific evidence and [an] ethical responsibility to protect the vulnerable and the public at large,” the authors “demand that policymakers implement decarceration alongside priority vaccination in jails and prisons.” *Id.*

Moreover, the article underscores the Public Health and Human Rights Experts Amici’s conclusion that “the current status of vaccine development has not changed the need for social distancing measures to reduce transmission.” Public Health and Human Rights Experts Amici Br. at 6; *see* Ex. 1 at 2 (prisons need to combine vaccinations with “a sustained commitment to the public health practices and tools known to reduce the spread of Covid-19” including hygiene and social distancing).

In sum, the NEJM’s article offers new data to support and expand upon the Public Health and Human Rights Experts Amici’s conclusions that vaccination does not render Mr. Williams safe from COVID-19 in the Department of Correction’s prison.

III. CONCLUSION

The NEJM article, published after the filing date for amici briefs, further supports the Public Health and Human Rights Experts' opinion that "Mr. Williams faces heightened risk of further harm and death if he remains incarcerated at Coyote Ridge." Public Health and Human Rights Experts Amici Br. at 14.

DATED this 5th day of March, 2021.

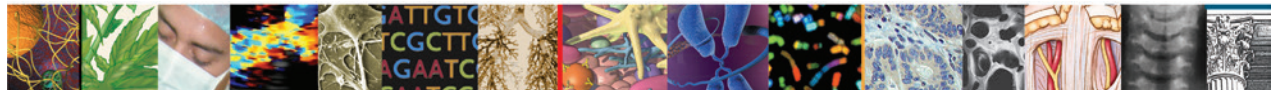
Respectfully submitted,

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EXHIBIT 1



Perspective

Vaccination plus Decarceration — Stopping Covid-19 in Jails and Prisons

Benjamin A. Barsky, J.D., M.B.E.,* Eric Reinhart, B.A.,* Paul Farmer, M.D., Ph.D., and Salmaan Keshavjee, M.D., Ph.D.

Covid-19 has exposed the inadequacy of the public health infrastructure in the United States and forced us to confront associated biosocial dynamics that are driving the pandemic,

including poverty, structural racism, distrust, unequal access to health care, and other social sources. But perhaps no collective preexisting condition has been more acute and preventable than that associated with the U.S. system of mass incarceration. U.S. jails and prisons house nearly 25% of the world's incarcerated population even though the United States accounts for only 4.2% of the global population. Because there is constant movement in and out of jails and prisons — where more than 620,000 Covid-19 cases have already been documented despite notable deficiencies in testing, transparency, and oversight — these facilities operate as epidemiologic pumps. Not only do carceral conditions lead to rapidly

multiplying Covid-19 cases among incarcerated persons and staff, these institutions also operate as high-pressure disease reservoirs that spread the virus into surrounding communities and exacerbate racial disparities in Covid-19 cases and deaths.¹

To protect the safety of incarcerated people, guards, and the general public, health experts have long called for large-scale decarceration. Decarceration measures that were used relatively early in the pandemic, though implemented in far too few jurisdictions to maximize public health benefit, have been shown to be safe — it is mass incarceration itself that threatens public safety — and have not been associated with increases in rearrest rates.² Now,

with the rollout of vaccines, public debate has increasingly shifted toward vaccination of incarcerated people. But several factors suggest that vaccination alone will not be enough to stop carceral outbreaks.

First, in many jurisdictions, it remains an open question whether incarcerated people — who are 5.5 times as likely to be infected with SARS-CoV-2 as the general population and face three times the risk of death from Covid-19 — will be among those prioritized for vaccination.¹ Although the National Academies of Sciences, Engineering, and Medicine and the American Medical Association have declared that refusing to prioritize incarcerated persons for vaccination is irrational and unethical, guidelines from the Centers for Disease Control and Prevention (CDC) omit plans for incarcerated people and prioritize only carceral staff for vaccination. Several states have neglected to

make any plans to vaccinate incarcerated people, let alone to prioritize them in allocation schedules. In Colorado, for example, health experts' plans for priority vaccination for incarcerated people were overturned by state politicians, who disregarded both epidemiologic reality and the likelihood of downstream harm to the general public.

Second, the real-world effectiveness of vaccination programs depends on the context in which they are implemented. The goal of widespread vaccination is to prevent disease and to enable broad swaths of the population to eventually achieve herd immunity to the virus. As more people are vaccinated, the virus will have fewer opportunities to replicate and spread, and it will cease being a population-level threat. Yet David Paltiel and colleagues have shown that even a highly efficacious vaccine will have suboptimal preventive effects in high-spread, congregate settings.³ A vaccine with low efficacy (e.g., 25%) can have a powerful preventive effect in areas where the effective reproduction number of the virus is low (e.g., $R_t=1.5$). By contrast, a vaccine with much higher efficacy (e.g., 75%) can nonetheless fail to prevent a large proportion of severe cases and deaths when deployed in areas where the effective reproduction number is high (e.g., $R_t=2.1$). Therefore, Paltiel et al. explain, "even a vaccine with seemingly adequate efficacy, pace, and coverage may be insufficient to alter the fundamental population dynamics that produce high disease prevalence." This warning points to the need to combine vaccination with "a sustained commitment to the public health practices and tools known to reduce the spread of Covid-19."³

When applied to the U.S. carceral context, with its approximately 2.3 million incarcerated people, 420,000 guards, and 11 million jail admissions and releases per year — churn that results in 55% turnover in the jail population each week, providing a constant supply of people who may not have been previously exposed to SARS-CoV-2 and ensuring that carceral and community health are intertwined — this warning is ominous.¹ In this setting, even a vaccine with 90% efficacy will leave many people at ongoing risk for Covid-19, given the extraordinarily high rate of transmission in jails and prisons attributable to rampant overcrowding, inadequate testing and health care, high-volume daily inflow and outflow of staff and detainees, lack of personal protective equipment, and normalized systematic neglect of the welfare of incarcerated people. In fact, Lisa Puglisi and colleagues found the SARS-CoV-2 basic reproduction number in a large urban U.S. jail to be 8.44 — the highest known basic reproduction number in any context in the world.⁴ From this and several other studies, it is clear that transmission dynamics in many jails and prisons exceed the threshold for what Paltiel and colleagues identify as high-severity environments, in which the effectiveness of vaccines is considerably diminished.¹

Finally, we should anticipate high rates of vaccine hesitancy among staff and especially among incarcerated people, who have been offered little to no educational material about Covid-19 vaccines and have abundant reasons for distrust, given U.S. carceral facilities' long-standing violations of basic human rights and histories of abuse. For example, a recent

survey in a Massachusetts jail that had already had more than 130 Covid-19 cases found that only 40% of detained persons would volunteer for vaccination — a finding that is more likely to be the norm than the exception. It will therefore be a considerable challenge to foster the especially high rate of vaccine uptake required in carceral facilities to reduce effective reproduction numbers to levels adequate to end epidemic transmission chains.

Reliance on vaccination alone thus seems unlikely to achieve necessary reductions in Covid-19 transmission in incarcerated populations. Fortunately, we already have strong evidence for a policy tool that can stop the spread of Covid-19 in jails and prisons: decarceration. Decarceration consists of large-scale releases of people who pose no public-safety risk, increased use of home confinement, ending of pretrial detention for persons held because they cannot afford cash bail, and non-carceral management of people arrested for alleged offenses that do not suggest ongoing threats to public safety.

Using data from a large urban jail, Giovanni Malloy and colleagues found that decarceration efforts, paired with basic CDC guideline compliance (e.g., testing, limited visitation), were strikingly effective in achieving reductions in viral transmission.⁵ A 9% reduction in the carceral population was associated with a 56% decrease in transmission. Further depopulation, ultimately reaching a population decrease of 25%, was associated with ongoing reductions in transmission. The investigators concluded that decarceration should be "a primary strategy for Covid-19 mitigation in jails" — a conclusion reinforced by a

subsequent study by Vest et al. (<https://link.springer.com/article/10.1007%2Fs11524-020-00504-z>) of transmission dynamics in Texas prisons.

Stopping the epidemic in jails and prisons is vital for protecting staff and incarcerated people; it is also critical for curbing the spread of Covid-19 into surrounding communities, especially Black and Latinx communities that are disproportionately affected by jail- and prison-linked coronavirus spread.¹ Furthermore, as we become aware of an increasing range of SARS-CoV-2 variants, we face greater urgency to disrupt the ideal environment that current carceral conditions provide for viral mutations that could undermine the efficacy of available vaccines and threaten health far beyond American borders.

Vaccination of incarcerated people is important for changing this dynamic, but it is not enough. We believe that it must be coupled with large-scale decarceration to increase the real-world effectiveness of vaccination, disrupt wide-ranging viral transmission chains, and turn off the epidemiologic

pump that puts the health of all at risk from mass incarceration.

Decarceration strategies can guide decisions made by a range of actors who wield power to change current conditions, including federal and state legislators, state and local law enforcement, prosecutors, judges, mayors, governors, the U.S. attorney general, and the president of the United States. We believe the medical community has a parallel responsibility to ensure that science is heard and applied. On the grounds of scientific evidence and our ethical responsibility to protect the vulnerable and the public at large, we can use our influence to demand that policymakers implement decarceration alongside priority vaccination in jails and prisons.

Disclosure forms provided by the authors are available at [NEJM.org](https://www.nejm.org).

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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing Petitioner's Answer to Amicus Curiae Brief with the Washington State's Appellate Court Portal, which will send notification of such filing to all attorneys of record.

Signed in Seattle, Washington, this 5th day of March, 2021.



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