DOCKET NO. A-001525-21T2

SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION

NEW JERSEY STATE POLICEMEN'S BENEVOLENT ASS'N, INC., ET AL.,
Appellants,

v.

PHILIP D. MURPHY, GOVERNOR,
Respondent.

On Grant of Application for Emergent Motion for Stay of Governor Murphy's Executive Order No. 283

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF CORRECTIONAL PHYSICIANS, AND MEDICAL SOCIETY OF NEW JERSEY IN OPPOSITION TO EMERGENT MOTION TO STAY EXECUTIVE ORDER NO. 283

John Zen Jackson
GREENBAUM, ROWE, SMITH & DAVIS LLP
P.O. Box 5600
Woodbridge, NJ 07095
Telephone: (732) 476-3336
jjackson@greenbaumlaw.com
Atty ID 011041975

Rachel L. Fried (pro hac vice pending)
JoAnn Kintz (pro hac vice pending)
DEMOCRACY FORWARD FOUNDATION
P.O. Box 34553
Washington, DC 20043
Telephone: (202) 448-9090
rfried@democracyforward.org

Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*[1]

The American Medical Association is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state. The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

[1] *Amici* certifies that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund this brief, and no person other than *Amici*, their members, and their counsel contributed money intended to fund this brief.

The American College of Correctional Physicians, formerly known as The Society of Correctional Physicians, was founded in 1993. Its purpose is to support the interests of the providers who care for those incarcerated in correctional facilities of all types. This includes jails, juvenile facilities, and state and federal prisons. ACCP's members have dedicated their medical careers to ensuring those incarcerated receive the quality of medical, mental, and dental care mandated by the United States Constitution. ACCP members are united through the goal of improving public health by examining issues specific to the incarcerated and identifying solutions for medical professionals. ACCP meets those goals through education, advocacy, networking, and avenues of communication. ACCP therefore has a strong interest in promoting public health and reducing the spread of COVID-19, particularly in correctional facilities, where surges in COVID-19 infection affect both ACCP members and their patients.

The Medical Society of New Jersey was founded in 1766 and is the oldest professional society in the United States. It is composed of physician members across all specialties and practice areas, from every corner of the state, and is led by an all-physician board of trustees elected

annually by membership. In its own capacity and as a state medical society member of the AMA, MSNJ advances its mission—promoting the betterment of public health, fostering public awareness of medical issues, and advocating for physicians—in various ways, including serving as *Amici* in litigation affecting public welfare and the medical community. MSNJ members, and the New Jersey physician community that MSNJ represents, have spent the last twenty-two months on the frontlines of the battle against COVID-19. Like the patients they serve, and often as patients themselves, these physicians have been aided immeasurably in the fight by widespread administration of FDA-authorized and approved vaccines. This matter will have profound effects on MSNJ and its members, and MSNJ therefore has a significant interest in the outcome of this litigation.

INTRODUCTION

The United States is in an unprecedented and ongoing public health crisis as it battles COVID-19—a battle that can be won only with widespread vaccination. SARS-CoV-2, the causative agent of COVID-19, has wreaked havoc in communities across the country, taxed hospitals to the point of rationing care, upended the lives of countless families, and

killed over 892,000 Americans, including more than 28,000 New Jerseyans.

The dangers and upheaval caused by COVID-19 are particularly acute in correctional facilities: as of January 30, 2022, there have been over 10,000 confirmed positive cases of COVID-19 and fifty-eight deaths among individuals incarcerated within New Jersey Department of Corrections facilities and nearly 7,000 confirmed cases among New Jersey Department of Corrections staff. *COVID-19*, State of New Jersey Department of Corrections ("NJDOC"), https://bit.ly/3Hj0yKQ (last visited Feb. 4, 2022). ACCP's extensive review of the medical literature demonstrates that COVID-19 vaccines authorized or approved by the U.S. Food and Drug Administration are safe and effective, and that the widespread use of those vaccines is the best way to keep COVID-19 from spreading within carceral settings. This Court should therefore deny the emergent motion for stay of Executive Order No. 283, and permit the implementation of the Order, requiring vaccination among workers in high-risk congregate settings, including New Jersey's correctional facilities.

PROCEDURAL HISTORY

On January 19, 2022, Governor Murphy issued Executive Order 283, which requires covered staff who work in certain health care and high-risk congregate settings, including carceral settings, to become vaccinated against COVID-19. [PBA Aa008–18; NJSOAa 000005–15.][2] On January 24, 2022, the New Jersey State Policemen's Benevolent Association, Inc., along with several of its local chapters, and on January 25, 2022, the New Jersey Superior Officers Law Enforcement Association, each moved the Court for permission to file emergent motions to stay EO 283. [PBA Aa037; NJSOAa 000088.] On January 25, 2022, this Court granted the applications and set a briefing schedule. [PBA Aa058; NJSOAa 000001.]

[2] Citations to the NJSOA Brief or Appendix refer to the Brief or Appendix of New Jersey Superior Officers Law Enforcement Association in *New Jersey Superior Officers Law Enforcement Association v. Philip D. Murphy*, Docket No. A-001548-21 (App. Div.). Citations to the PBA Brief or Appendix refer to the Brief or Appendix of New Jersey State Policemen's Benevolent Association, Inc. in *New Jersey State Policemen's Benevolent Association v. Philip D. Murphy*, Docket No. A-001525-21T2 (App. Div.).

STATEMENT OF THE FACTS

On January 19, 2022, Governor Murphy issued Executive Order 283, which requires covered staff who work in certain health care and high-risk congregate settings, including carceral settings, to become vaccinated against COVID-19. [PBA Aa008–18; NJSOAa 000005–15.] EO 283 set forth numerous findings, including the COVID-19 vaccines' role in mitigating the effects of the pandemic, [PBA Aa008, NJSOAa 000005], and the effectiveness of booster doses against infection by the Omicron variant, [PBA Aa010–11, NJSOAa 000007–8.] EO 283 directs covered health care settings to maintain a policy that requires covered workers to provide proof that they are vaccinated against COVID-19, including booster doses, according to a specified schedule. [PBA Aa013–14; NJSOAa 000010–11.] EO 283 directs that the policies provide medical and religious accommodations to the extent required by law. [PBA Aa017; NJSOAa 000014.] EO 283's vaccination requirement "can help prevent outbreaks and reduce transmission [of COVID-19] to vulnerable individuals who may be at a higher risk of severe disease." [PBA Aa013; NJSOAa 000010.]

ARGUMENT

I. COVID-19 Poses a Grave Danger to the Health of People Who Are Incarcerated.

COVID-19 presents a severe risk to public health. Although most people infected with the virus will experience mild to moderate symptoms, individuals with COVID-19 can become seriously ill or die at any age. As of January 20, 2022, there have been more than seventy-five million confirmed cases of COVID-19 in the United States,[3] leading to more than 4,203,000 hospitalizations[4] and more than 892,000 deaths—more than twelve times the number of people in the United States who die from influenza in the average two-year span.[5]

New Jerseyans account for more than 1,835,000 of those COVID-19 cases, and over 28,000 New Jerseyans have died from COVID-19.[6] And incarcerated New Jerseyans account for more than 10,000 cases; fifty-

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[3] *COVID Data Tracker*, CDC, https://bit.ly/3Du7Glz (last visited Feb. 4, 2022).

[4] *COVID Data Tracker Weekly Review*, CDC (Jan. 28, 2022), https://bit.ly/3EYAdAb.

[5] *See Disease Burden of Flu*, CDC (Oct. 4, 2021), https://bit.ly/3ocAuZA.

[6] *See New Jersey COVID-19 Dashboard*, State of New Jersey Department of Health (last updated Feb. 3, 2022), https://bit.ly/3G840qp.

eight incarcerated New Jerseyans have died.[7] To put these numbers in perspective, nearly 20% of New Jerseyans overall have contracted COVID-19 over the course of the pandemic,[8] while the number of incarcerated New Jerseyans who have contracted COVID-19 is more than 54% of the number of people incarcerated in New Jersey as of 2020.[9] Although Appellants claim that the existing option to test, rather than vaccinate, "has been proven to work as it brought these CPOs through the Delta variant," [PBA Br. at 15], the numbers show otherwise. Indeed,

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[7] *COVID-19*, State of New Jersey Department of Corrections ("NJDOC"), https://bit.ly/3Hj0yKQ (last visited Feb. 4, 2022).

[8] *Compare New Jersey COVID-19 Dashboard*, *supra* note 7 (listing 1,835,533 cases in New Jersey), *with QuickFacts: New Jersey*, U.S. Census Bureau, https://bit.ly/3GcGhFy (last visited Feb. 4, 2022) (listing New Jersey population as 9,267,130).

[9] *Compare COVID-19*, *supra* note 7 (listing 10,139 positive COVID-19 cases among incarcerated populations in NJDOC facilities), *with Offender Characteristics Report on January 1, 2021*, NJDOC, https://bit.ly/3L88jpt (in most recent publicly available data, listing total incarcerated individuals in NJDOC facilities as 12,808) *and Total Inmates in New Jersey State Correctional Institutions and Satellite Units*, State of New Jersey Department of Corrections (2020), https://bit.ly/3ukd4pJ (listing total incarcerated individuals in NJDOC facilities as 18,477 in 2020).

although the Department of Corrections employs approximately 8,000 people,[10] it has recorded 6,941 positive COVID-19 tests.[11]

As these numbers indicate, SARS-CoV-2 is highly transmissible. The original strain was more contagious than the flu, and the Delta variant of SARS-CoV-2, the leading strain until recent weeks, is more than twice as contagious as previous variants.[12] The surging Omicron variant—which now accounts for more than 99.9% of new cases in the United States—appears to be more contagious still.[13] Crucially, more than 50% of the spread of the virus may be from individuals who have no symptoms at the time of transmission.[14]

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[10] State of New Jersey Department of Corrections, *About Us* (last visited Feb. 4, 2022), https://www.nj.gov/corrections/pages/aboutUs.html.

[11] *COVID-19*, *supra* note 7.

[12] *Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), https://bit.ly/3plAmcy; Apoorva Mandavilli, *C.D.C. Internal Report Calls Delta Variant as Contagious as Chickenpox*, N.Y. Times (July 30, 2021), https://nyti.ms/3EtJXTb.

[13] *Omicron Variant: What You Need to Know*, CDC (last updated Dec. 20, 2021), https://bit.ly/327xwyr; *COVID Data Tracker: Variant Proportions*, CDC (last visited Feb. 4, 2022), https://bit.ly/3udcJoI.

[14] *Science Brief: Community Use of Masks to Control the Spread of SARS-CoV-2*, CDC (last updated Dec. 6, 2021), https://bit.ly/30inWYx.

The disproportionate rate of COVID-19 among incarcerated persons is unsurprising, because "[r]esidential institutions have long been associated with an increased risk of infectious diseases."[15] Correctional institutions, like cruise ships and nursing homes, "can be considered high risk for amplifying infectious diseases such as COVID-19, because the conditions that prevent disease dissemination are nearly impossible to achieve."[16] Indeed, correctional institutions present even higher risks than cruise ships, the original COVID-19 hot spots, because correctional staff function as "a vector of disease transmission between the community and incarcerated individuals because they are in the community for a large percentage of their time, [but] pierc[e] the membrane of the prison daily as they go to and from work."[17] Correctional

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[15] Mary Devereaux Hutton et al., *Tuberculosis in Nursing Homes and Correctional Facilities: Results of a 29-State Survey*, CDC, at 2 (Nov. 1990), https://bit.ly/3I51ySJ; *see also, e.g.*, Joseph A. Bick, *Infection Control in Jails and Prisons*, 45 Clinical Infectious Diseases 1047 (2007), https://bit.ly/3qrND34.

[16] Philip D. Sloane, *Cruise Ships, Nursing Homes, and Prisons as COVID-19 Epicenters: A 'Wicked Problem' With Breakthrough Solutions?*, 21 J. Am. Med. Dirs. Ass'n 958, 958 (July 2020), https://bit.ly/3KfJBmC.

[17] Danielle Wallace et al., *Is There a Temporal Relationship Between COVID-19 Infections among Prison Staff, Incarcerated Persons and the Larger Community in the United States?*, 18 Int'l J. Env't. Rsch. Pub. Health 6873 (June 26, 2021), https://bit.ly/3I2ttmk.

staff are thus "an avenue for COVID-19 to enter the prison, whether at the beginning of a pandemic or during successive waves."[18]

As a result, "staff members' COVID-19 prevalence . . . ha[s] a direct relationship on the prevalence of COVID-19 among incarcerated individuals."[19] Transmission among staff in correctional facilities has been a major factor in the spread of COVID-19 to people incarcerated.[20] Indeed, one comprehensive analysis of federal prisons concluded that "rising case rates inside federal prisons have been driven increasingly by infections among staff, rather than among incarcerated people."[21] In New Jersey, about "1,600 of the 7,300 staffers with the state [New Jersey] Department of Corrections were out because of COVID-19 in

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[18] *Id.*

[19] *Id.*

[20] Laura Hawks et al., *COVID-19 in Prisons and Jails in the United States*, 180 JAMA Internal Med. 1041, 1041 (Apr. 28, 2020), https://bit.ly/3fqrpZb ("[P]eople who are incarcerated will be at higher risk of exposure, as correctional officers and other staff frequently leave the facility and then return.").

[21] Alix M.B. Lacoste et al., *Fast, frequent, and widespread: COVID-19 outbreaks inside federal prisons*, UCLA Law COVID Behind Bars Data Project, at 2 (Nov. 2021), https://bit.ly/34DQY6L.

December [2021], and another 450 tested positive the first week of the year."[22]

Even those who recover from COVID-19 may experience debilitating symptoms lasting for several months or more after the acute phase of infection. A systematic review of forty-five studies found that 73% of infected individuals experienced at least one long-term symptom.[23] Another, more recent systematic review of fifty-seven studies found that more than half of COVID-19 survivors experienced post-acute sequelae (that is, chronic complications of an acute condition) six months after recovery, including difficulty concentrating, generalized anxiety disorder, general functional impairments, and fatigue or muscle

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[22]**Error! Hyperlink reference not valid.** Dana Difilippo, *N.J. prisons grapple with staff shortages, inmate restrictions as COVID-19 spreads anew*, New Jersey Monitor (Jan. 10, 2022), https://bit.ly/3g8CaiW.

[23] Tahmina Nasserie et al., *Assessment of the Frequency and Variety of Persistent Symptoms Among Patients With COVID-19: A Systematic Review*, JAMA Network Open (May 26, 2021), https://bit.ly/3qocFkk; *see also* Karen B. Jacobson et al., *Patients With Uncomplicated Coronavirus Disease 2019 (COVID-19) Have Long-Term Persistent Symptoms and Functional Impairment Similar to Patients with Severe COVID-19: A Cautionary Tale During a Global Pandemic*, 73 Clinical Infectious Diseases e826 (Feb. 6, 2021), https://bit.ly/3FD32Ch ("'Long COVID' has been reported in 87% of hospitalized patients two months post-infection and in 53% of non-hospitalized patients 125 days after diagnosis.").

weakness.[24] Studies also indicate that COVID-19 is associated with increased risk of adverse neurological and psychiatric outcomes.[25] Although Appellants correctly note that, on average, Omicron infections are less severe than Delta infections, [*see* PBA Br. at 29], they fail to grapple with these potential long-term effects. And because Omicron is so much more contagious than Delta, the raw number of people who will experience severe illness remains of critical concern, as illustrated by the record rate of hospitalizations at the peak of the January 2022 Omicron surge—more than 30% higher than the January 2021 peak nationwide, and fully twice as high in New Jersey specifically.[26]

Moreover, incarcerated people are more likely than the rest of the population to have comorbidities that put them at higher risk for severe

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[24] Destin Groff et al., *Short-term and Long-term Rates of Postacute Sequelae of SARS-CoV-2 Infection: A Systematic Review*, 4(10) JAMA Network Open e2128568 (Oct. 13, 2021), https://bit.ly/3qskBjR.

[25] Maxime Taquet et al., *6-month neurological and psychiatric outcomes in 236379 survivors of COVID-19: a retrospective cohort study using electronic health records*, 8 The Lancet Psychiatry 416 (Apr. 6, 2021), https://bit.ly/3DXTbGo.

[26] *See COVID Data Tracker, New Admissions of Patients with Confirmed COVID-19 per 100,000 Population by Age Group, United States*, CDC (last visited Feb. 1, 2022), https://bit.ly/3GhYjGb. To see statistics for New Jersey, use the "Select a Jurisdiction" drop-down menu.

outcomes.[27] In fact, during the early months of the pandemic, New Jersey's prisons had a higher COVID-19 death rate than any other prison system in the country.[28] What's more, transmission in carceral settings carries additional consequences beyond the risk of infection: when prisons are facing outbreaks, they are likely to cancel visitation and order lockdown of facilities, leading to significant isolation and detrimental psychological effects.[29] COVID-19 therefore poses a grave danger to the health and safety of people who are incarcerated above and beyond the already significant risk faced by the general public.

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[27] Elizabeth M. Viglianti et al., *Mass Incarceration and Pulmonary Health: Guidance for Clinicians*, 15 Annals Am. Thoracic Soc'y 409, 409–12 (Jan, 30, 2018), https://bit.ly/3rvWosf (identifying lung-related conditions that disproportionately affect incarcerated persons).

[28] Blake Nelson, *N.J. Prisons have highest coronavirus death rate in the nation, new study shows*, NJ.com (May 3, 2020), https://bit.ly/3HiHvQX.

[29] *See* Steven Rodas, *N.J. prisons, halfway houses suspend visits due to COVID omicron wave*, New Jersey Advance Media (Jan. 7, 2022), https://bit.ly/3IKlPNG; *see also* Lucy Wainwright & Donna Gipson, *The Impact of Lockdown to Mental Health: A Summary of Patient Views*, EP:IC, https://bit.ly/3zYt2Xt (finding that 84% of patients in closed prisons in the United Kingdom reported deteriorating mental health during COVID-19 lockdown); ACCP, *Restricted Housing of Mentally Ill Inmates*, https://bit.ly/3noyePc ("Many patients with mental illness, such as depression, can be expected to worsen as a result of isolation imposed by restricted housing.").

II. Vaccines Provide a Safe and Effective Way to Help Reduce Transmission of COVID-19 in Carceral Settings.

COVID-19 vaccines are safe. Before FDA authorized/approved, and the Centers for Disease Control and Prevention recommended use of, the COVID-19 vaccines in the population, scientists conducted extensive clinical trials. FDA, CDC, and their advisory committees then conducted rigorous reviews of the data, and they continue to monitor the vaccines' safety.[30] A study of more than six million people who received the Pfizer or Moderna vaccines found that serious side effects are very rare.[31] Further, a study concluded that there is no increased risk for mortality among recipients of any of the COVID-19 vaccines, and that vaccine recipients had lower non-COVID-19 mortality risks than did unvaccinated people.[32]

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[30] *Benefits of Getting a COVID-19 Vaccine*, CDC (last updated Jan. 11, 2022), https://bit.ly/3H6BsiF; Nicola P. Klein et al., *Surveillance for Adverse Events After COVID-19 mRNA Vaccination*, 326 JAMA 1390 (Sept. 3, 2021), https://bit.ly/3F1XQYM; *COVID-19 vaccine safety surveillance*, FDA (Dec. 7, 2021), https://bit.ly/3y1dDET.

[31] Klein et al., *supra* note 30.

[32] Stanley Xu et al., *COVID-19 Vaccination and Non–COVID-19 Mortality Risk — Seven Integrated Health Care Organizations, United States, December 14, 2020–July 31, 2021*, 70 Morbidity & Mortality Weekly Rep. 1520, 1520–24 (Oct. 29, 2021), https://bit.ly/3D1ZRn4. Although the CDC recently recommended the Pfizer or Moderna vaccines

COVID-19 vaccines are also effective. First, each of the three vaccines greatly reduces the likelihood of contracting SARS-CoV-2. The Pfizer, Moderna, and J&J/Janssen vaccines have been found to be 91.3%, 90%, and 72% effective against infection by prior variants, respectively.[33] And, contrary to Appellants' assertions,[34] studies uniformly demonstrate that COVID-19 vaccine regimens that include a booster are effective even against the novel Omicron variant, which has a higher immune evasion than its predecessors.[35] (For comparison, the flu vaccination reduces the

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over the J&J/Janssen vaccine, the CDC's advisory committee made clear that "receiving any vaccine is better than being unvaccinated." Press Release, CDC, *CDC Endorses ACIP's Updated COVID-19 Vaccine Recommendations* (Dec. 16, 2021), https://bit.ly/3yzUTfJ.

[33] Kathy Katella, *Comparing the COVID-19 Vaccines: How Are They Different?*, Yale Med. (updated Jan. 31, 2022), https://bit.ly/307jEU5. Scientists are still learning about how effective the vaccine is against the Omicron variant.

[34] PBA Br. at 2 (asserting that "vaccination/booster shots" are "largely ineffective against the Omicron variant"); NJSOLEA Br. at 14 (asserting "a booster shot . . . does not prevent vaccinated individuals from becoming infected").

[35] *See, e.g.*, Amelia G. Johnson et al., *COVID-19 Incidence and Death Rates Among Unvaccinated and Fully Vaccinated Adults with and Without Booster Doses During Periods of Delta and Omicron Variant Emergence — 25 U.S. Jurisdictions, April 4–December 25, 2021*, 71 Morbidity & Mortality Weekly Rep. 132, 135 (Jan. 28, 2022), https://bit.ly/3Hie01C; Mark G. Thompson et al., *Associated Emergency Department and Urgent Care Encounters and Hospitalizations Among*

risk of flu illness by between 40% and 60%.[36]) In December 2021, when the Omicron variant became prominent, people who were unvaccinated were nearly five times more likely to contract COVID-19 than people who were fully vaccinated with booster doses.[37]

Second, each of the three vaccines is even more effective against serious illness and death. Studies conducted earlier in the pandemic have estimated the Pfizer, Moderna, and J&J/Janssen vaccines as 95.3%–97%, 95%, and 86% effective against severe disease, respectively.[38] The vaccines were likewise highly effective against hospital admissions, "even in the face of widespread dissemination of the delta variant."[39] As of

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Adults During Periods of Delta and Omicron Variant Predominance — VISION Network, 10 States, August 2021–January 2022, 71 Morbidity & Mortality Weekly Rep. 139 (Jan. 28, 2022), https://bit.ly/35F0OpB; Emma K. Accorsi, *Association Between 3 Doses of mRNA COVID-19 Vaccine and Symptomatic Infection Caused by the SARS-CoV-2 Omicron and Delta Variants*, JAMA (Jan. 21, 2022), https://bit.ly/3gct6d5. The uncontrolled spread of the virus in areas with low immunization rates, however, certainly raises the risk that a fully vaccine-resistant strain will one day emerge.

[36] *Vaccine Effectiveness: How Well Do Flu Vaccines Work?*, CDC (last visited Feb. 4, 2022), https://bit.ly/3HifLMP.

[37] *See* Johnson et al., *supra* note 35, at 133.

[38] Katella, *supra* note 33.

[39] Sara Y. Tartof et al., *Effectiveness of mRNA BNT162b2 COVID-19 Vaccine Up to 6 Months in a Large Integrated Health System in the USA:*

December 25, 2021, the age-adjusted rate of COVID-19-associated hospitalizations in unvaccinated adults was more than 16 times that of fully vaccinated adults.[40] And although research into the effect of Omicron is ongoing, preliminary results suggest that the Pfizer vaccine remains 70% effective against hospitalization, even before a booster dose.[41] Recent research also shows that receipt of a third mRNA COVID-19 vaccine dose is 82% effective against urgent care encounters and 90% effective against hospitalization due to the Omicron variant.[42] A survey of New Jersey hospitals on December 31, 2021 showed that fully vaccinated COVID-19 patients with a booster shot accounted for only 5.8% of total COVID-19 hospitalizations.[43]

A Retrospective Cohort Study, 398 Lancet 1407, 1407 (Oct. 4, 2021), https://bit.ly/3ouPvqS.

[40] *See Rates of laboratory-confirmed COVID-19 hospitalizations by vaccination status*, CDC (last updated Feb. 3, 2022), https://bit.ly/3oIwsZ4.

[41] Shirley Collie et al., *Effectiveness of BNT162b2 Vaccine against Omicron Variant in South Africa*, New Eng. J. Med., Correspondence (Dec. 29, 2021), https://bit.ly/3qrESpW.

[42] Thompson et al., *supra* note 35, at 144.

[43] Scott Fallon, *COVID hospitalizations surpass 5,100 in New Jersey, stressing health care facilities*, NorthJersey.com (Jan. 4, 2022), https://njersy.co/3odXDeX.

Even vaccinated people who are hospitalized for COVID-19 have a significantly lower risk of death than do unvaccinated people. A study found that, among patients hospitalized with the Delta variant, "[t]he crude risk for COVID-19-related death in fully vaccinated persons was sevenfold lower than that among unvaccinated COVID-19 patients."[44] Although research regarding vaccine efficacy against the Omicron variant is still developing, initial reports suggest that vaccination, including a booster, remains efficacious against severe disease, and lowers a person's risk of dying from COVID-19 at every step.[45]

Third, although still developing, evidence suggests that those who are fully vaccinated are contagious for shorter periods than unvaccinated people. A study found that viral loads of the Delta variant declined more rapidly in infected people who had been vaccinated, indicating that

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[44] Allison L. Naleway et al., *Incidence of SARS-CoV-2 Infection, Emergency Department Visits, and Hospitalizations Because of COVID-19 Among Persons Aged ≥12 Years, by COVID-19 Vaccination Status — Oregon and Washington*, *July 4–September 25, 2021*, 70 Morbidity & Mortality Weekly Rpt. 1608, 1609 (Nov. 19, 2021), https://bit.ly/3F05RwX.

[45] *See* Carl Zimmer & Sheryl Stolberg, *New Studies Raise Hopes That Vaccines Prevent Severe Disease From Omicron*, N.Y. Times (Dec. 15, 2021), https://nyti.ms/3H3uCd4.

vaccinated people are contagious for shorter periods of time than unvaccinated people.[46] Moreover, the fact that unvaccinated people are more likely to contract COVID-19 in the first place means that they pose a higher risk of transmission than do those who are vaccinated. Thus, vaccination protects not only people who are vaccinated, but also those they encounter.

III. The More Staff Who Get Vaccinated, The Safer Carceral Settings Become.

The more carceral workers who get vaccinated, the closer we are to slowing the spread of the virus and creating a safer environment. As the American Medical Association has explained, "[t]he only way to truly end this pandemic is to ensure *widespread* vaccination."[47] "By limiting viral spread, vaccination also minimizes opportunities for the introduction of

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[46] Po Ying Chia et al., *Virological and serological kinetics of SARS-CoV-2 Delta variant vaccine breakthrough infections: a multicentre cohort study*, Clinical Microbiology & Infection (Nov. 22, 2021), https://bit.ly/3ENkd4a.

[47] Press Release, American Medical Ass'n, *AMA, AHA, ANA urge vaccinations as U.S. reaches 750,000 COVID-19 deaths* (Nov. 4, 2021) (emphasis added), https://bit.ly/3C07CIS.

more infectious variants through random mutation."[48] Widespread vaccination is the only practical way to push the effective reproduction rate of the SARS-CoV-2 virus below one, the rate at which endemic transmission begins to die out.

Widespread vaccination reduces the likelihood of infections among both vaccinated and unvaccinated people. During the wave of Delta infections, "states with high vaccination rates (>70% of the population) . . . report[ed] lower numbers of vaccine breakthrough cases as well as hospitalizations and deaths from COVID-19."[49] An analysis found that "[i]n the presence of high community prevalence of Covid-19, nursing homes with low staff vaccination coverage had higher numbers of cases and deaths than those with high staff vaccination coverage."[50] Widespread vaccination is particularly important for people who cannot

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[48] *Vaccination to Prevent COVID-19 Outbreaks with Current and Emergent Variants — United States, 2021*, CDC (July 27, 2021), https://bit.ly/3oFcakp.

[49] Carlos del Rio et al., *Confronting the Delta Variant of SARS-CoV-2, Summer 2021*, 326 JAMA 1001, 1002 (Aug. 18, 2021), https://bit.ly/3bVL5Cj.

[50] Brian E. McGarry et al., *Nursing Home Staff Vaccination and Covid-19 Outcomes*, New Eng. J. Med., Correspondence (Dec. 8, 2021), https://bit.ly/3pQ7O9H.

get vaccinated due to age or medical condition, as well as immunocompromised people, who remain particularly susceptible to infection even after vaccination.[51] This is particularly critical in carceral settings, where people who are at high risk—or for whom vaccination may not be effective—are unable to choose to socially distance themselves from unvaccinated corrections officers and other prison workers, with whom they come into close contact. Thus, requiring those incarcerated to be vaccinated, as Appellants suggest, [*see* NJSOA Br. at 15], would not solve the problem the Governor seeks to address.

Like other infectious diseases, COVID-19 spreads in communities with fewer vaccinated individuals, even if they are within or adjacent to communities with a higher proportion of vaccinated individuals. The more staff in high risk congregate settings who are vaccinated, the better protected all staff and all people who are incarcerated—vaccinated and unvaccinated alike—will be.

Appellants suggest that a vaccine requirement will lead corrections officers to simply quit en masse, resulting in staffing shortages. [PBA Br.

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[51] Katherine Lontok, *How Effective Are COVID-19 Vaccines in Immunocompromised People?*, Am. Soc'y for Microbiology (Aug. 12, 2021), https://bit.ly/3F24HBh.

at 46–47.] But that has not occurred in the institutions already covered by vaccination requirements.[52] Appellants also miss the broader point. The high number of COVID-19 infections among corrections officers is *itself* causing a staffing shortage,[53] one that will not abate until the vaccination rate is sufficiently high. It is the unchecked spread of COVID-19, rather than vaccination requirements, that poses the major risk to staffing levels at carceral facilities and the safety of those residing there.

IV. Widespread Vaccination Is the Most Effective Way to Protect People Who Live and Work in Carceral Settings from COVID-19.

The statistics on COVID-19 vaccine efficacy speak for themselves. No other measure has been shown to reduce the risk of infection, hospitalization, and death to the degree that vaccination does. The science is clear: no arguments against the need for vaccination are medically valid, other than to accommodate a medical contraindication.

Natural immunity—the immunity against SARS-CoV-2 that develops following recovery from infection—is not an adequate substitute for

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[52] Jack J. Barry et al., *Unvaccinated Workers Say They'd Rather Quit Than Get a Shot, but Data Suggest Otherwise*, Scientific American (Sept. 24, 2021), https://bit.ly/3kUYKOT.

[53] Difilippo, *supra* note 22.

vaccination.[54] Infection, unlike vaccination, carries a significant risk of death or serious illness. Moreover, vaccination better protects previously infected people against reinfection. Although research into Omicron is still developing, studies of prior variants have shown that unvaccinated people are at least twice as likely to become reinfected as are vaccinated people.[55] And, contrary to Appellants' assertions, [*see* PBA Br. at 12–13], studies show that the COVID-19 vaccines "can be given safely to people with evidence of a prior SARS-CoV-2 infection."[56] Although Appellants suggest that vaccination "may actually compromise [people's] ability to fend off infection," [PBA Br. at 16, *see also id.* at 13], that proposition is unsupported. Appellants rely on a certification, [*see* Aa133–47], that, in

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[54] *See* Catherine H. Bozio et al., *Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19-Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021*, 70 Morbidity & Mortality Weekly Rep. 1539 (Nov. 5, 2021), https://bit.ly/3kvoBwR (finding 5.49 times higher odds of laboratory-confirmed COVID-19 among previously infected, unvaccinated patients than among fully vaccinated patients).

[55] Alyson M. Cavanaugh et al., *Reduced Risk of Reinfection with SARS-CoV-2 After COVID-19 Vaccination — Kentucky, May–June 2021*, 70 Morbidity & Mortality Weekly Rep. 1081 (Aug. 13, 2021), https://bit.ly/306e4Bg.

[56] *Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States*, CDC (last updated Jan. 6, 2022), https://bit.ly/3rwXkNf.

turn, cites to a single study—which states, in bold letters, that the raw data it cites "**should not be used to estimate vaccine effectiveness**."[57] Indeed, the study on which Appellants indirectly rely notes that rates of positive COVID-19 tests among vaccinated people "is likely to be due to a variety of reasons, including differences in the population of vaccinated and unvaccinated people as well as differences in testing patterns."[58]

Other mitigation measures, such as mask wearing and social distancing, remain important. They do not, however, provide the same level of protection against COVID-19 as vaccination. Although masks can be highly effective at limiting the transmission of SARS-CoV-2 in non-carceral settings, mask mandates appear to be "associated with only a small decline in infections among incarcerated persons."[59] The other elements of a layered prevention strategy are often impossible in carceral settings, where "[a] lack of space in prison inhibits social distancing, cohorting prisoners (i.e., limiting movement in prison to smaller groups

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[57] UK Health Security Agency, *COVID-19 vaccine surveillance report: Week 3*, at 30 (Jan. 20, 2022), https://bit.ly/3AOz2m1 (emphasis in original).

[58] *Id.* at 31.

[59] Wallace, *supra* note 17.

of prisoners at a time), creating areas for hand washing or sanitization, and medical isolation."[60] And although testing protects workers better than no requirement at all, it does not rise to the level of protection that widespread uptake of vaccinations would provide. "[I]n short, even with strong infection control policies in place, correctional staff are associated with infection spread within prisons."[61] Appellants are therefore incorrect in their position that weekly testing—absent vaccination—is sufficient. [*See* PBA Br. at 31; NJSOLEA Br. at 14–15.]

People who are incarcerated—particularly those who are immunocompromised or otherwise at high risk for severe complications from infection—do not have the luxury of choosing to self-isolate and curtail their social interactions. They should not be forced to encounter unvaccinated individuals in cramped settings that have already been proven to lead to outsized infection rates. Immediate, widespread vaccination of prison workers against COVID-19 is the surest way to protect people who are incarcerated.

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60 *Id.*

61 *Id.*

CONCLUSION

For the reasons stated above and in Respondent's filings, the *amici* American Medical Association, American College of Correctional Physicians, and Medical Society of New Jersey urge this Court to deny Appellant's emergent motion to stay EO 283.

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Respectfully Submitted,
/s/ John Zen Jackson

John Zen Jackson
Greenbaum, Rowe, Smith & Davis LLP
P.O. Box 5600
Woodbridge, NJ 07095
Telephone: (732) 476-3336
jjackson@greenbaumlaw.com
Atty ID 011041975

Rachel L. Fried (pro hac vice pending)
JoAnn Kintz* (pro hac vice pending)
DEMOCRACY FORWARD FOUNDATION
P.O. Box 34553
Washington, D.C. 20043
Telephone: (202) 448-9090
rfried@democracyforward.org
jkintz@democracyforward.org
Counsel for *Amici Curiae*

*Not admitted in the District of Columbia; practicing under the supervision of Democracy Forward lawyers