



1 foodborne disease epidemiologist, influenza surveillance coordinator, and medical consultant to  
2 the Offices of Communicable Disease Epidemiology and Infectious Disease.

3 3. On January 8, 2020, I received an advisory from the CDC regarding an outbreak  
4 of pneumonia of unknown etiology in Wuhan, China. This cluster of pneumonia was  
5 subsequently determined to be the start of the COVID-19 pandemic. Since early January, in  
6 collaboration with state and local public health experts, I have helped lead Washington State’s  
7 response to the COVID-19 pandemic by developing, implementing, and advising the Secretary  
8 of Health and Governor on public health interventions to limit the spread of COVID-19 in  
9 Washington and maintain capacity and supplies in our healthcare system to adequately provide  
10 care to people with COVID-19.

11 4. On January 21, 2020, the CDC and DOH announced what was then believed to  
12 be the first confirmed case of COVID-19 in the United States in Snohomish County,  
13 Washington. By late February/early March, public health officials recognized the spread of  
14 COVID-19 in Washington, including an individual with COVID-19 from Snohomish County  
15 who had not traveled and an outbreak in the Life Care Center, a skilled nursing facility in  
16 Kirkland, associated with at least 167 cases and 35 deaths. On February 29, 2020, DOH  
17 announced that a patient had died in the EvergreenHealth Medical Center in Kirkland, which  
18 was then believed to be the first COVID-19 death in the United States. (In April, it was  
19 determined that the first known COVID-19 death had occurred in early February in California.)  
20 Since then, public health officials have worked to determine the extent of COVID-19 in  
21 Washington and worked with the Office of the Governor and others to coordinate a response.

22 5. On January 30, 2020, the World Health Organization declared the COVID-19  
23 outbreak a “public health emergency of international concern.” On January 31, 2020, the United  
24 States Health and Human Services Secretary, Alex M. Azar II, declared a public health  
25 emergency.  
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1           6.       COVID-19, a disease that can result in serious illness or death, is caused by the  
2 SARS-CoV-2 virus, which is a coronavirus not identified in humans prior to December 2019  
3 that spreads easily from person to person. It spreads mainly from person to person through  
4 respiratory droplets produced when an infected person coughs, sneezes, or talks. A person may  
5 also get COVID-19 by touching a surface or object that has the virus on it and then touching  
6 their own mouth, nose, or possibly their eyes. People can spread the virus before their symptoms  
7 begin (pre-symptomatic transmission) and during an asymptomatic infection which results in  
8 people unknowingly spreading the virus to others. The CDC has reported two situations in  
9 Singapore where pre-symptomatic transmission likely occurred in a religious setting (CDC.  
10 *Morbidity and Mortality Weekly Report* 2020; 69[14]:411–415). Various studies have found that  
11 the risk of transmission of SARS-CoV-2 is significantly greater in indoor settings compared to  
12 outdoor settings.

13           7.       Although many patients experience mild to moderate, or no symptoms, some  
14 patients experience severe or critical illness requiring hospitalization and intensive care  
15 treatment, such as the use of ventilators (intubation). A subset of those with severe disease will  
16 die. Older adults and people of any age with certain underlying medical conditions are at higher  
17 risk for severe COVID-19 illness. *See CDC, People who are at Increased Risk for Severe Illness,*  
18 [https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html)  
19 [risk.html](https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-at-increased-risk.html).

20           8.       Because of the speed with which COVID-19 spreads in a community and the  
21 portion of COVID-19 patients who require hospitalization, intensive care, and mechanical  
22 ventilation, outbreaks threaten to overwhelm the healthcare system.

23           9.       There are currently no drugs or therapeutics presently approved by the U.S. Food  
24 and Drug Administration (FDA) or vaccines to treat or prevent COVID-19. On May 1, 2020, the  
25 FDA issued an Emergency Use Authorization for emergency use of remdesivir for the treatment  
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1 of hospitalized COVID-19 patients with severe disease. An Emergency Use Authorization does  
2 not constitute formal FDA approval.

3 10. On February 29, 2020, Governor Inslee proclaimed that “a State of Emergency  
4 exists in all counties in the state of Washington,” and directed that emergency plans be  
5 implemented. At the same time, the Governor ordered into active state service the National  
6 Guard and the State Guard. In a series of proclamations issued over the following month, the  
7 Governor took multiple actions to slow the spread of COVID-19, including: prohibiting  
8 gatherings of 250 people or more (and, later, 50 or more); permitting gatherings of fewer than  
9 50 people only if individuals complied with CDC and DOH social distancing and sanitation  
10 guidelines; closing schools, colleges, and universities; prohibiting gatherings of any size in  
11 “public venues,” including restaurants, gyms, private clubs, faith-based organizations, and any  
12 “other similar venues.”

13 11. These actions were essential to mitigating the spread of COVID-19 and easing  
14 the strain on our healthcare system. Because COVID-19 spreads from person to person through  
15 close contact, maintaining distance between people and avoiding large gatherings, particularly  
16 indoors, is critical. If people consistently retain a distance of at least six feet from each other, the  
17 risk of the virus spreading from an infected person to an uninfected person is low. That reduces  
18 the overall spread and number of persons infected within a geographic area and persons requiring  
19 hospitalization, which in turn reduces the number of intensive-care beds and ventilators needed  
20 to treat patients.

21 12. Without efforts to stop person-to-person transmission, modeling studies have  
22 shown that unmitigated spread of COVID-19 would lead to an explosion of cases, many more  
23 hospitalizations and fatalities, and an untenable burden on the healthcare system. This potentially  
24 includes deaths of patients who could potentially recover but for the unavailability of ventilators  
25 and other medical care due to the strain on the healthcare system.  
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1           13. For that reason, significant preventative steps were medically and scientifically  
 2 necessary in order to stem the outbreak in Washington. The Governor has issued numerous  
 3 proclamations since his initial emergency proclamation on February 29, 2020. Throughout this  
 4 process, I have worked in tandem with the Governor’s Office, other DOH officials, and public  
 5 health experts to ensure the state’s mitigation strategies are based on the latest and most accurate  
 6 data and accepted scientific practice. Despite the state’s early and aggressive mitigation efforts,  
 7 the virus continued to spread rapidly in the first month of the outbreak: In mid-March,  
 8 Washington had the highest absolute number and had among the highest number per capita of  
 9 COVID-19 cases of any state in the country. The effective reproductive rate ( $R_e$ ) during the first  
 10 half of March—that is, the number of new infections estimated to stem from a single case—was  
 11 estimated in the 2 to 3.5 range. By late March, 400 to 500 new COVID-19 cases were being  
 12 reported each day. From a public health standpoint, that transmission rate was unsustainable.

13           14. Thus, DOH and the Governor’s Office determined that it was necessary  
 14 to escalate Washington’s mitigation strategies. Most prominently, this included  
 15 Proclamation 20-25, the Governor’s “Stay Home, Stay Safe” proclamation on March 23, 2020,  
 16 as well as subsequent modifications to that Proclamation, which generally required  
 17 Washingtonians not to leave their homes except for certain essential activities and essential  
 18 employment, and generally prohibited social, spiritual, and recreational gatherings other than  
 19 those attended by household members in the home. My office continues to work with the  
 20 Governor, Secretary of Health, and others to modify proclamations.

21           15. Without a vaccine or treatment for COVID-19, reducing person-to-person  
 22 transmission through community mitigation measures is the most effective way of mitigating the  
 23 outbreak and ensuring that the healthcare system is not overwhelmed. The “Stay Home, Stay  
 24 Healthy” order served this mitigation objective by imposing a clear, categorical prohibition on  
 25 all gatherings, private or public, for any purpose. If exceptions were made to this prohibition  
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1 based on the subjective purpose of the gathering, mitigation efforts would be less successful and  
2 it would be difficult, if not impossible, for officials to enforce the proclamation.

3 16. The state's Essential Critical Infrastructure Workers list (Essential Workers list)  
4 referenced in Proclamation 20-25 established exceptions to the stay-home order based on  
5 objective criteria, including the epidemiological risk inherent in and the necessity of continued  
6 operations in light of public health, economic, national security, and other governmental  
7 objectives. The essential activities and essential business services allowed under the  
8 Proclamation did not present comparable health risks to the "public and private gatherings and  
9 multi-person activities for social, spiritual, and recreational purposes, regardless of the number  
10 of people involved" that the Proclamation prohibits. They did not present a comparable health  
11 risk because face-to-face interactions—those most likely to result in transmission—with a  
12 worker at a grocery store or pharmacy are generally much shorter in duration than face-to-face  
13 interactions during social, spiritual or recreational events.

14 17. Throughout the outbreak, DOH has collected, and updated daily, statistical  
15 information concerning the outbreak. Data are available online at: [https://www.doh.wa.gov/  
16 Emergencies/Coronavirus](https://www.doh.wa.gov/Emergencies/Coronavirus). Six weeks after the Stay Home, Stay Healthy order was announced,  
17 the data indicated that Washington had made progress in slowing the spread of COVID-19.  
18 COVID-19 activity, as measured by the number of new COVID-19 hospitalizations, peaked in  
19 late March then declined steadily throughout April. Although the daily number of COVID-19  
20 confirmed hospitalizations declined while the Stay Home – Stay Healthy Order was in effect, as  
21 of May 3, 2020, data demonstrated that about 200 new confirmed cases continue to arise daily.  
22 In addition, for every confirmed case detected, there are an estimated 11 infected people that are  
23 not detected. For those reasons, the Governor extended the stay-home order on May 4, 2020 until  
24 May 31, 2020.

25 18. In my professional opinion, the steps taken to date to control COVID-19 have  
26 successfully mitigated morbidity and mortality from COVID-19 in Washington State and

1 prevented our healthcare system from becoming overwhelmed. Although the stay-home order is  
2 unprecedented, based on the epidemiological and public health data I have reviewed, I do not  
3 believe less stringent measures would have slowed the rate of transmission as effectively as the  
4 stay-home order. Restricting gatherings, including small gatherings with people outside one’s  
5 household, was an important part of the stay-home order because people tend to talk face-to-face  
6 for prolonged periods of time when they gather.

7 19. In early May, Governor Inslee announced the *Safe Start Washington* phased  
8 reopening plan—a process for careful, gradual, and science-based relaxation of mitigation  
9 measures across the state. The plan sets forth four phases across which mitigation measures are  
10 successively eased and is guided by a range of important public health metrics, including  
11 COVID-19 cases and hospitalizations; disease modeling; testing capacity and availability; case  
12 and contact investigation capacity; and health care system readiness. This approach reduces the  
13 risk of COVID-19 to Washington’s most vulnerable populations and preserves capacity in our  
14 health care system, while safely opening up businesses and resuming gatherings, travel, shopping  
15 and recreation. The plan allows counties and DOH to holistically review COVID-19 activity and  
16 the ability for the county to respond when determining if a county is ready to move into a new  
17 phase. During the month of May, only counties with populations below 75,000 people and  
18 without a new reported COVID-19 case in the prior three consecutive weeks were eligible to  
19 apply to DOH for a variance to move to Phase 2. Starting May 19, 2020, counties with a rate of  
20 <10 newly diagnosed cases per 100,000 population during the prior two weeks were eligible to  
21 apply for a variance. Between May 4 and June 1, DOH approved 27 counties’ applications to  
22 move to Phase 2: Adams, Asotin, Clallam, Columbia, Cowlitz, Ferry, Garfield, Grant, Grays  
23 Harbor, Island, Jefferson, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Pacific, Pend  
24 Orielle, San Juan, Skamania, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, and  
25 Whitman.  
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1           20.     Effective June 1, 2020, any county became eligible to apply for Phase 2,  
2 regardless of size, provided its local health officer, board of health, and county executive or  
3 county commission supports the application. Each application is assessed in a holistic fashion  
4 by the Secretary of Health and a team of public health experts at the Department of Health, based  
5 on a variety of key metrics reflecting the disease transmission risk of the county’s advancement  
6 to the next phase. Those metrics include the following:

- 7           a.     COVID-19 activity: The ideal target for new cases will be 25 or fewer per  
8                 100,000 residents over a 14-day period. Hospitalizations for COVID must  
9                 be flat or decreasing.
- 10          b.     Healthcare system readiness: The percentage of licensed beds with patients  
11                 in a given jurisdiction would preferably be less than 80% and the percentage  
12                 of licensed beds with confirmed or suspected COVID-19 patients would  
13                 preferably be less than 10%.
- 14          c.     Testing: Counties need to show they have adequate testing capacity, 50 times  
15                 as many people tested per day as they have confirmed new cases per day –  
16                 which equates to positive test results under 2%. They also need to show rapid  
17                 testing of patients, ensuring that we can work effectively to contain the virus.
- 18          d.     Case and contact investigations: The goal is to contact 90% of cases by  
19                 phone or in person within 24 hours of receipt of a positive lab test result.  
20                 There is also a goal of reaching all that person’s contacts within 48 hours of  
21                 a positive test result.
- 22          e.     Protecting high-risk populations: The ideal number of outbreaks reported by  
23                 week (defined as two or more non-household cases where transmission  
24                 occurred at work, in congregate living, or in an institutional setting) is zero  
25                 for counties under 75,000, and no higher than three for our largest counties.  
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1           21. As of July 3, 2020, 6 additional counties were approved for Phase 2: Clark, King,  
 2 Okanogan, Pierce, Skagit, Snohomish, and Whatcom. Also as of July 3, 2020, 17 counties have  
 3 been approved for Phase 3: Asotin, Columbia, Ferry, Garfield, Grays Harbor, Island, Kittitas,  
 4 Lewis, Lincoln, Mason, Pacific, Pend Oreille, Skamania, Stevens, Thurston, Wahkiakum, and  
 5 Whitman. Five counties have been approved for a modified version of Phase 1 (sometimes  
 6 referred to as “Phase 1.5” or “Phase 1.75”): Franklin, Benton, Yakima, Chelan, and Douglas.  
 7 Franklin, Benton, and Yakima Counties were approved to move to the modified Phase 1 on  
 8 July 3, 2020. No counties remain in the unmodified Phase 1.

9           22. As of July 1, 2020, the key metrics in Benton and Franklin Counties lagged  
 10 behind statewide goals. For COVID-19 activity, the ideal target for new cases is 25 or fewer per  
 11 100,000 residents over a 14-day period; Benton County is currently at 265.1 new cases and  
 12 Franklin County is at 629.5 new cases. For testing capacity, Benton County is testing an average  
 13 of 6 individuals for each new case per day and Franklin County is testing an average of 3.4  
 14 (compared to a goal of 50); 16.7% of individuals are testing positive in Benton County and  
 15 29.6% are testing positive in Franklin County (compared to a goal of less than 2%). The  
 16 percentage of licensed beds with COVID-19 patients is 18% in Benton County (compared to a  
 17 goal of less than 10%). Notwithstanding the progress we have made in mitigating the spread of  
 18 COVID-19 in Washington, an emergency continues to exist for the entire state. As described  
 19 above, COVID-19 can be (1) difficult to detect, (2) easily transmitted, and (3) lethal. More than  
 20 33,000 Washington residents have contracted COVID-19 and over 1,300 Washington residents  
 21 have died since the pandemic began a few short months ago. In some parts of Eastern  
 22 Washington, COVID-19 activity is increasing rather than decreasing, including in the counties  
 23 of Benton, Franklin, and Spokane. While Washington has passed an initial peak of COVID-19  
 24 hospitalizations, our progress is mostly attributable to the extensive, statewide mitigation  
 25 measures—above all, the Governor’s Stay Home – Stay Healthy order—the state implemented.  
 26 As more and more counties progress to Phase 2 and Phase 3, however, social distancing will

1 decline and mobility across the state will increase, and neither geographic nor political  
2 boundaries prevent the spread of COVID-19. Recall that at the beginning of the COVID-19  
3 outbreak in February, transmission was concentrated primarily in King and Snohomish Counties.  
4 Within just a matter of weeks, the virus had moved across the whole state and, by April, all but  
5 one county in the state had confirmed at least one case. While mitigation efforts in Washington  
6 State have helped reduce the spread of COVID-19, cases will rebound and hospitals could  
7 become overwhelmed with COVID-19 patients if we do not continue to practice social  
8 distancing, so a statewide public health emergency still exists.

9         23. I believe that the efficacy of Washington's mitigation efforts thus far has been  
10 achieved through the coordinated, statewide public health emergency response directed by the  
11 Governor and the Secretary of Health. This illustrates that widespread public health emergencies  
12 are best managed through the current process of centralized decision-making guided by close  
13 cooperation and consultation with local public health authorities. This current process allows a  
14 bird's eye view of statewide data to drive decisions; consistent and science-based mitigation  
15 measures and public messaging; coordinated and efficient distribution of health care resources  
16 (including personal protective equipment (PPE) that is centrally purchased by the state from  
17 private vendors and resources received by the federal government); and a clear hierarchy to  
18 resolve competing interests. Importantly, the current process also takes into account county-  
19 specific concerns and provides for re-opening plans and processes tailored to local conditions  
20 and constraints. For example, after Yakima, Benton and Franklin counties remained in Phase 1  
21 for several weeks, the Governor and the Secretary of Health visited the region and met with local  
22 leaders to hear their concerns. These visits subsequently resulted in the creation of a specific  
23 recovery plan for these counties and the decision to move the counties to a modified Phase 1.  
24 Decentralizing management of the public health emergency would sacrifice the advantages just  
25 described. Washington has 35 local health jurisdictions. Throughout the pandemic, nearly all  
26 local health jurisdiction administrators have fully supported a centralized response effort. Each

1 of the counties and their local elected leaders could have their own unique concerns, interests,  
2 and approach. Yet, because these local jurisdictions are not hermetically sealed from one  
3 another—for example, COVID-19 patients can expose people or get hospitalized in counties  
4 outside their counties of residence—each county’s response will likely have an impact beyond  
5 its borders. And, to the extent one county’s interests conflict with another’s interests,  
6 decentralized decision-making leaves no efficient or clear mechanism for resolving those  
7 conflicts. For those reasons (and others), I would not advocate for devolving policy authority to  
8 local jurisdictions during any widespread public health crisis, let alone during the worst  
9 pandemic in a century.

10 24. Finally, I will address the statements made in certain media and by various public  
11 officials to the effect that COVID-19 is equivalent to influenza. While they both cause  
12 respiratory illness and an influenza pandemic could be similar to the COVID-19 pandemic,  
13 SARS-CoV-2 is a coronavirus and biologically distinct from an influenza virus. The viruses bind  
14 to different receptors in the human body and result in different pathophysiologic processes. The  
15 human population appears to have little to no preexisting immunity to SARS-CoV-2—unlike  
16 some past influenza pandemics such as the 2009 H1N1 flu pandemic when prior immunity likely  
17 protected a segment of the population. The incubation period for SARS-CoV-2 is longer  
18 (average of 5 days, with a range of 2 to 14 days) than for most influenza viruses (average of 2  
19 days, with a range of 1 to 5 days). The infectious period for COVID-19 starts at least 2 days prior  
20 to symptom onset (compared to one day for influenza) resulting in at least 1 additional day of  
21 infectiousness before a person knows they are sick. One study found that, for SARS-CoV-2,  
22 viral load was highest at the time of symptom onset, suggesting that viral shedding may peak on  
23 or before symptom onset—and thus making pre-symptomatic transmission more likely. By  
24 comparison, for the H1N1 pandemic influenza A virus, viral shedding peaks the first 1 to 2 days  
25 after symptom onset. Lastly, we know much less about novel coronaviruses than novel influenza  
26 viruses, which have infected humans several times over the past couple decades.



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**DECLARATION OF SERVICE**

I hereby declare that on this day I caused the foregoing document to be electronically filed with the Clerk of the Court using the Court’s CM/ECF System which will send notification of such filing to all counsel of record.

DATED this 6th day of July, 2020, at Seattle, Washington.

/s/ Emma Grunberg  
EMMA GRUNBERG, WSBA #54659  
Deputy Solicitor General