Donahoe, Kaitlyn N (SBOH)

From: Kirby, Kristin @ Bellevue <Kristin.Kirby@cbre.com>
Sent: Thursday, March 3, 2022 3:06 PM
To: DOH WSBOH LBOH Composition; DOH WSBOH
Subject: Public Comment - March 9 - Public Meeting
Attachments: 1152-S2.SL.pdf; Public Comments for WSBOH Members from March EH Committee Special Meeting; Public Comments for WSBOH Members from March EH Committee Special Meeting; WSBOH Criteria #6 Rebuttal - Lara Gabriel RN.pdf; WSBOH_ Criteria 5 Rebuttal - by Dr. Carver.pdf

Follow Up Flag: Follow up
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External Email

Good afternoon,

Regarding the Local Board of Health Composition – I only hope there is representation by people with varying views of issues and concerns. The whole Board cannot think the same way or the same thing. That's not diverse and doesn't represent the community nor is that fair or unbiased.
What is the cost to this update if the members have their expenses reimbursed?

WAC 246-100-070 – I don't believe community resources should be wasted on punishing community members of a misdemeanor for not following health office orders. This should be repealed.

WAC 246-100-040 – This should be repealed. After living through these crazy times, of government overreach and scare tactics, there should not be a law confirming a local health office at their "sole discretion" order a person into involuntary detention. Voluntary compliance to get a vaccine means it's voluntary. You cannot force a person to get a vaccine or medical examination. These rights are protected. This is insane to me. That we would forcible incarcerate people who some could deem a threat based off the reasons listed is insane.

Chapter 246-105 WAC – There is no way the Covid-19 shot should be included in ANY requirement for school. First of all, the very title states "certain vaccine-preventable diseases" – Covid shots do NOT fit this criteria. They do not provide full immunization. I have sent a few emails already to the BOH TAG regarding the issues. Further the TAG voted against this the other week.

Points to be made:

The Israeli Ministry of Health has found:

1. **Hospitalizations** - Six of the 2,049 (.29%) respondents were admitted to the hospital following the booster shot. That number, when extrapolated to the millions of booster doses that have been administered:
Israel: 4.5 million booster doses administered = 13,000 hospitalizations
U.S.: 92 million booster doses administered = 270,000 hospitalizations

2. **Exacerbation of pre-existing disease** - Six different categories of reported "chronic morbidities" (pre-existing diseases) were identified. These were the proportions of respondents in each category that reported a worsening of their disease after receiving a booster:

Heart disease = 5.4%.
Hypertension = 6.3%.
Lung disease = 7.0%.
Diabetes = 9.3%.
Anxiety disorder or depression = 26.4%.
Autoimmune disease = 24.2%.

3. **Neurological side effects** - A percentage of respondents (4.5%) reported a neurological adverse event. Ten different categories of neurological side effects were reported, including tingling sensations, Bell's Palsy, blurred vision, convulsions and involuntary movements. 3.9% of respondents reported an allergic reaction following the booster dose (rash, difficulty breathing, face/throat swelling), though no instances of anaphylaxis were reported.

4. **Menstrual cycle irregularities** - While the U.S. government-run Vaccine Adverse Event Reporting System (VAERS) does not track information specific to a woman's menstrual cycle, the volume of reported irregularities from the Israeli survey bears note. Of the 615 female respondents who were under the age of 54, 59 (9.6%) reported menstrual irregularities. These women were surveyed in a follow-up interview. Within this subgroup, according to the survey, more than 88% of women reported a regular menstrual cycle before the booster dose. However, after the booster dose:
31.1% sought medical treatment for menstrual irregularities.
9.1% received medication for the adverse reaction.
39.0% suffered similar side effects after previous COVID vaccinations. More than two-thirds of women reported that these initial conditions waned in the five-month interval between the primary dose series and booster dose, but the conditions returned after the booster was administered. About half the women reported their adverse event was ongoing during the seven- to 12-week window of the follow-up. Due to the overwhelming number of anecdotal reports of menstrual irregularities here in the U.S., the National Institutes of Health in September 2021 awarded Boston University a $1.67 million grant to study the effects of COVID vaccines on menstruation. The results are expected to be published in spring of 2022.There are some people out there who are naturally resistant to Covid – and scientists are trying to figure out why.

- A German health insurer BKK ProVita said an analysis of data collected from more than 10 million people suggests COVID vaccine side effects are "significantly" underreported. The company said its analysis revealed a "significant alarm signal" and said "a risk to human life cannot be ruled out."

- A study released recently showed the effectiveness of Pfizer's COVID-19 vaccine in 5- to 11-year-olds was only 12% after a seven-week period of observation. Federal health officials knew about the findings since early February.

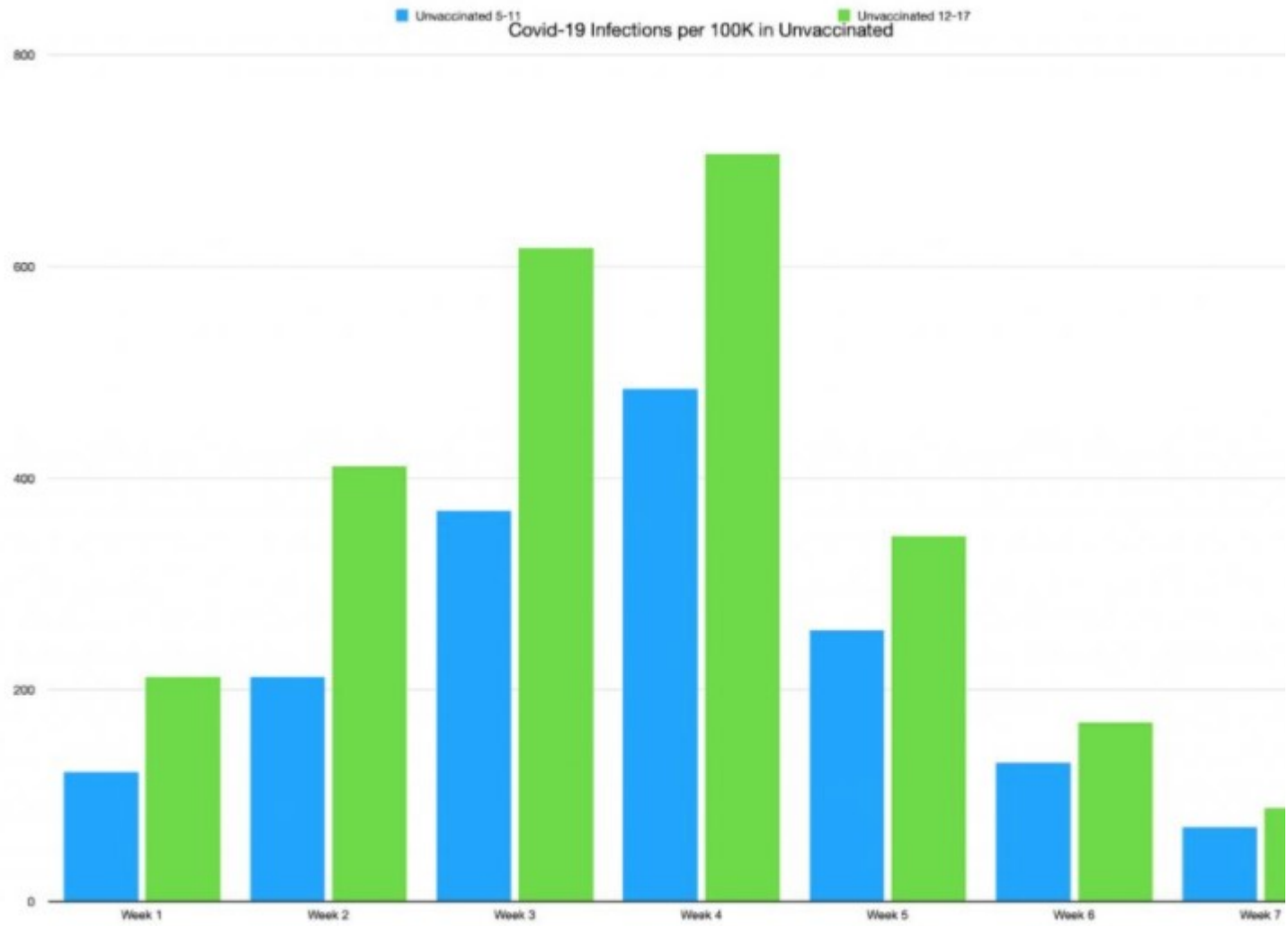
Table 1: New COVID-19 Cases and Hospitalizations by Vaccine Status, Children Ages 5-17 in New York State, November 29, 2021 – January 30, 2022

	Events		Rates per 100k		Incidence Rate Ratios, Vaccine Effectiveness				Full-vaccine Coverage
Week	*Vacci-nated*	*Unvacci-nated*	*Vacci-nated*	*Unvacci-nated*	*IRR*	*(95% CI)*	*VE*	*(95% CI)*	*%*
Cases									
5 -11 years [a]									
Dec. 13-19	204	10,062	39	122	3.1	(2.7, 3.6)	68%	(63, 72%)	4.7%
Dec. 20-26	1,051	16,915	91	212	2.3	(2.2, 2.5)	57%	(55, 60%)	10.6%
Dec. 27-Jan. 2	2,910	28,476	184	369	2.0	(1.9, 2.1)	50%	(48, 52%)	14.4%
Jan. 3-9	4,535	36,256	251	484	1.9	(1.9, 2.0)	48%	(47, 50%)	16.5%
Jan. 10-16	3,459	18,647	170	256	1.5	(1.5, 1.6)	34%	(31, 36%)	18.5%
Jan. 17-23	2,403	9,289	105	131	1.3	(1.2, 1.3)	20%	(16, 23%)	20.9%
Jan. 24-30	1,584	4,889	62	70	1.1	(1.1, 1.2)	12%	(6, 16%)	23.4%
12 – 17 years									
Nov. 29-Dec. 5	848	3,336	15	101	6.7	(6.2, 7.2)	85%	(84, 86%)	58.5%
Dec. 6-12	1,302	4,245	23	131	5.7	(5.3, 6.0)	82%	(81, 83%)	58.9%
Dec. 13-19	4,140	6,738	73	212	2.9	(2.8, 3.0)	66%	(64, 67%)	59.4%
Dec. 20-26	10,177	12,792	178	411	2.3	(2.3, 2.4)	57%	(56, 58%)	59.9%
Dec. 27-Jan. 2	15,934	18,905	276	617	2.2	(2.2, 2.3)	55%	(54, 56%)	60.5%
Jan. 3-9	19,219	21,333	331	706	2.1	(2.1, 2.2)	53%	(52, 54%)	60.9%
Jan. 10-16	10,185	10,264	174	345	2.0	(1.9, 2.0)	50%	(48, 51%)	61.4%
Jan. 17-23	5,010	4,971	85	169	2.0	(1.9, 2.1)	50%	(48, 52%)	62.0%
Jan. 24-30	2,581	2,575	43	88	2.0	(1.9, 2.2)	51%	(48, 54%)	62.5%
Hospitalizations									
5 -11 years [a]									
Dec. 13-19	0	18	0.00	0.22	+inf.	(0.3, +inf.)	100%	(-189, 100%)	4.7%
Dec. 20-26	2	50	0.17	0.63	3.6	(1.0, 30.9)	73%	(-7, 97%)	10.6%
Dec. 27-Jan. 2	3	80	0.19	1.04	5.5	(1.8, 27.1)	82%	(45, 96%)	14.5%
Jan. 3-9	5	78	0.28	1.04	3.8	(1.6, 12.0)	74%	(36, 96%)	16.6%
Jan. 10-16	6	68	0.29	0.94	3.2	(1.4, 8.9)	68%	(28, 91%)	18.6%
Jan. 17-23	8	46	0.35	0.65	1.9	(0.9, 4.6)	46%	(-15, 77%)	21.0%
Jan. 24-30	8	42	0.31	0.60	1.9	(0.9, 4.8)	48%	(-12, 75%)	23.4%
12 – 17 years									
Nov. 29-Dec. 5	2	20	0.04	0.61	16.9	(4.1, 148.8)	94%	(76, 99%)	58.4%
Dec. 6-12	1	11	0.02	0.34	19.0	(2.8, 818.3)	95%	(64, 100%)	58.8%
Dec. 13-19	6	23	0.11	0.72	6.8	(2.7, 20.4)	85%	(63, 95%)	59.3%
Dec. 20-26	18	45	0.31	1.44	4.6	(2.6, 8.4)	78%	(63, 88%)	59.9%
Dec. 27-Jan. 2	38	77	0.66	2.50	3.8	(2.5, 5.8)	74%	(61, 84%)	60.4%
Jan. 3-9	47	94	0.81	3.10	3.8	(2.7, 5.6)	74%	(63, 82%)	60.9%
Jan. 10-16	41	85	0.70	2.84	4.1	(2.8, 6.0)	75%	(64, 86%)	61.3%
Jan. 17-23	34	67	0.58	2.26	3.9	(2.6, 6.1)	75%	(61, 83%)	61.9%
Jan. 24-30	22	40	0.37	1.36	3.7	(2.1, 6.5)	73%	(53, 87%)	62.4%

[a] <1% of this age group fully vaccinated in previous weeks

Highlighted in red is the astoundingly low Vaccine Effectiveness (VE) in preventing COVID infection in the younger age group during the final week of observation. During the time period indicated in the chart, the VE was a mere 12%. The rate of new COVID cases in the unvaccinated group was 70 per 100,000 children per week compared to 62 per 100,000 per week. This means that 12,500 children would need to be vaccinated to prevent a single, non-severe COVID-19 infection. The same column of data also demonstrates a steep downward trend throughout the time window considered. Vaccine effectiveness is not only unimpressive, it's getting worse. It's being said that "vaccination of children 5-11 years will be protective against severe disease and is recommended," and yet the VE was still only 48% in preventing hospitalization from COVID. This corresponds to an Incidence Rate Ratio (IRR) of 1.9. An IRR of 1.9 indicates that an unvaccinated person has 1.9x the risk of being hospitalized compared to a fully vaccinated person. Note that a VE of 48% in preventing hospitalization and an abysmal 12% in preventing infection falls short of the stipulation for Emergency Use Authorization (EUA), which requires the authorized intervention to have a 50% effectiveness. VE is calculated by comparing the risk of disease in the unvaccinated to that in the vaccinated. A closer examination of rates of infection in the unvaccinated demonstrates a clear difference between the two age groups. Unvaccinated children in the 5-11 age group have substantially less risk of being infected than unvaccinated adolescents in each week of

observation. In other words, one reason why VE is so low in children is that they are more resistant to infection to begin with. They do not need this shot.



Data from this large group of children in New York demonstrate the COVID vaccine provides little, if any, protection from SARS-COV2 infection. This is not surprising given the rapid emergence of the Omicron variant and future variants. Each variant will be weaker but spread more quickly. At this time only one quarter of children 5 to 11 years old have been fully vaccinated in New York State. With such marginal and diminishing benefits, continuing to vaccinate cannot be justified. This is the same for WA State.

- Endless COVID-19 booster shots are being presented as the solution to the pandemic, as repeated injections increase the level of antibodies in your body. But artificially inflated antibodies signal to your body that you're always infected, and the resulting immune response could prove to be detrimental to your health. Repeated booster shots may lead to a "death zone," accelerating the development of autoimmune conditions such as Parkinson's, Kawasaki disease and multiple sclerosis. Molecular mimicry may be to blame for autoimmune conditions caused by COVID-19 shots — there are often significant similarities between elements in the vaccine and human proteins, which can lead to immune cross-reactivity. Case reports suggest that COVID-19 shots may trigger vaccine-induced immune-mediated and autoimmune hepatitis, and concern is growing that repeated booster shots will only worsen outcomes.

WHY WOULD WA STATE MANDATE THIS ON CHILDREN? We do not get the flu shot to protect another person. We should not be forcing injections on children to "protect" others – they are the ones that need protecting from these injections.

Thank you,

Kristin Kirby

WAC 246-203-130

Keeping of animals.

(1) Any person, firm or corporation is prohibited from keeping or sheltering animals in such a manner that a condition resulting from same shall constitute a nuisance.

(2) In populous districts, stable manure must be kept in a covered watertight pit or chamber and shall be removed at least once a week during the period from April 1st to October 1st and, during the other months, at intervals sufficiently frequent to maintain a sanitary condition satisfactory to the health officer. Manure on farms or isolated premises other than dairy farms need not be so protected and removed unless ordered by the health officer.

(3) Manure shall not be allowed to accumulate in any place where it can prejudicially affect any source of drinking water.

CR-103E Alert: Emergency Rule Adoption, Chapter 246-101 WAC – Notification and Reporting of COVID-19

The Washington State Board of Health has adopted a second emergency rulemaking order to continue the requirements established in WAC 246-101-017 – Novel Coronavirus (SARS-CoV-2), Coronavirus Disease 2019 (COVID-19) Reporting. The emergency rule is effective November 29, 2020 and will be in effect for 120 days upon filing. The CR-103E announces the emergency rulemaking order, filed as WSR 20-24-081.

This emergency rule:

- Continues the designation of Novel Coronavirus (SARS-CoV-2), also known as Coronavirus Disease 2019 (COVID-19), as a notifiable condition.
- Continues the requirement for health care providers, health care facilities, laboratories, and local health jurisdictions to report essential demographic and testing data with COVID-19 test results.
- Requires animal case reporting of COVID-19 by the Department of Agriculture to the Department of Health.

https://childrenshealthdefense.org/defender/chd-tv-rfk-jr-defender-vanden-bossche-vaccinating-omicron-pandemic/?utm_source=salsa&eType=EmailBlastContent&eId=cf7e950c-f8c5-4b6f-a297-3df709818651

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Rules Comment

Mar 14 2022 12:43PM

WAC 246-90-025, number 5 currently reads: “A local board of health shall also assess whether the applicant identifies with a historically underrepresented community when being considered as a non-elected member representing consumers of public health.” This should be stricken and replaced with the following or similar standard non-discrimination language: “A local board of health shall not discriminate potential applicants based on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status.” Thanks again for the opportunity to provide feedback!

Go Back

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Center for Public Affairs
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Last Update: 3/30/2022
Send inquires about DOH and its programs to the Health Consumer Assistance Office
Comments or questions regarding this web site? Send mail to the Subsite Developer.

Donahoe, Kaitlyn N (SBOH)

From: Heather Schleigh <fourshlys@hotmail.com>
Sent: Monday, March 14, 2022 5:33 PM
To: DOH WSBOH LBOH Composition
Subject: E2SHB 1152 Comment

Follow Up Flag: Follow up
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Hello,

I have greatly appreciated the transparency and proactive communication from our state BOH regarding the proposed changes in the rules regarding the appointment of representatives to our local boards of health. While the specifications within the WACs appear inarguably fair and diverse in the make-up of our local boards, the issue still at hand is that these representatives will be chosen by our County Commissioners. Therefore, all power and choice lie in the hands of a few individuals who do not necessarily represent all of the community members.

To be more specific, Spokane's County Commissioners represent mostly rural areas and are typically very conservative. They have already made choices that clearly demonstrate they are systematically dismantling our community's public health safety nets at Spokane Regional Health District. I am not referring to any specific details around all of the drama in the news about the previous Health officer or the current SRHD administrator. I am referring to the choices made and being made that may fall within the letter of the law in regard to choosing reps for the board, but do not fall within what I believe the intent of the new rules is all about.

I do not think appointment of local board members should be left to the majority vote of the county commissioners. I would like to see a more divers representation of elected officials on our board and assisting with these decisions.

Again, thank you for taking the time to address these issues and ensuring citizens have the opportunity to stay informed.

Best,
Heather Schleigh

March 23, 2022

Samantha Pskowski
P.O. Box 47990
Olympia, WA 98504-7990

Email: https://fortress.wa.gov/doh/policyreview

RE: CR 102- Rulemaking on WAC 346-90

Dear Ms. Pskowski;

The American Indian Health Commission for Washington State (AIHC) works on behalf of the Tribes and Urban Indian Health Organizations in Washington State. Per ESSB 1152, the AIHC is responsible for the selection process for each Tribe and/or Urban Indian Health Organizations (UIHO) represented on a local board of health. We are writing you with comments on the development of WAC 246-90-015 Local boards of health—Nonelected members, section (2).

Our recommend changes are in red below:

(2) If a federally recognized Indian tribe holds reservation, trust lands, or has ~~usual and accustomed areas~~ ceded lands within the county or health district, or if a 501(c)(3) organization registered in Washington that serves American Indian and Alaska Native people and provides services within the county or health district, the local board of health must include a tribal representative selected by the American Indian health commission according to the selection process prescribed by the commission. For those counties or health districts that have multiple Tribes and/or a 501(c)(3) organization, they must include a representative from each of the tribes and 501(c)(3) organization. 501(c)(3) shall have the same meaning as Urban Indian Organizations as defined under RCW 43.71B.010 (20). A tribal representative as described in this subsection may serve in any of the three of the categories as defined in this chapter if the representative meets the requirements of the category.

Comments:

1. "…usual and accustomed areas" refers to treaty fishing rights. We recommend changing this language to "ceded lands".
2. Add sentence in red above to define Urban Indian Organizations.
3. Clarify that each Tribe or Urban Indian Program represents itself.

In accordance with the Centennial Accord, "each sovereign tribe has an independent relationship with each other and the state." (Sect. II Parties). Counties derive their powers from the state, making them administrative units of the state. True tribal representation is each Tribe

representing itself. This has been done wrong for many years and this legislation gets it right. The process for the American Indian Health Commission to select tribal representation to local boards of health will honor the sovereignty of each Tribe to represent themselves. This needs to be clarified in the WAC language to ensure tribal representation to local boards of health is uniform across the state.

Thank you for the opportunity to provide comments. If you have any questions, please contact Vicki Lowe, AIHC Executive Director at vicki.lowe.aihc@outlook.com or (360)460-3580.

Thank you,

Stephen Kutz, BSN, MPH

Chair, AIHC

CCs: Tribal Leaders
AIHC Delegates