

Final Agenda

Time	Agenda Item	Speaker
8:30 a.m.	Call to Order & Introductions	Patty Hayes, Board Chair
8:40 a.m.	1. Approval of Agenda – Possible Action	Patty Hayes, Board Chair
8:45 a.m.	2. Approval of March 12, 2025, Minutes – Possible Action	Patty Hayes, Board Chair
8:50 a.m.	3. Public Comment	Please note: Verbal public comment may be limited so that the Board can consider all agenda items. The Chair may limit each speaker's time based on the number people signed up to comment.
9:20 a.m.	4. Announcements and Board Business	Michelle Davis, Board Executive Director
9:50 a.m.	5. Department of Health Update	Tao Kwan-Gett, Department of Health, Secretary's Designee
10:10 a.m.	Break	
10:25 a.m.	6. Newborn Screening (NBS) Technical Advisory Committee (TAC) Draft Reports and Recommendations for Congenital Cytomegalovirus (cCMV) – Possible Action	Kelly Oshiro, Board Vice Chair Kelly Kramer, Board Staff John Thompson, Department Staff Karin Neidt, Department Staff
11:40 a.m.	7. Rules Briefing, Auditory Screening Rulemaking, <u>Chapter 246-760 WAC</u>	Kelly Oshiro, Board Vice Chair Molly Dinardo, Board Staff Annie Hetzel, Office of the Superintendent of Public Instruction
12:00 p.m.	8. Review and Approval of the Draft Report on Branched Chain Ketoacid Dehydrogenase Kinase (BCKDK) – Possible Action	Kelly Oshiro, Board Vice Chair Kelly Kramer, Board Staff

Notice of Public Meeting

Wednesday, April 9, 2025, 8:30 a.m. – 4:45 p.m.

Physical meeting location:

Cedarbrook Lodge (Cedar I and II Rooms)
18525 36th Avenue South | SeaTac, WA 98188

Virtual meeting: ZOOM Webinar
(hyperlink provided below)

Language interpretation available

Time	Agenda Item	Speaker
12:15 p.m.	9. 2025 Board Meeting Schedule Update – Possible Action	Michelle Davis, Board Executive Director
12:20 p.m.	Lunch	
1:10 p.m.	10. Joint Meeting School Rule Project (SRP) Technical Advisory Committee (TAC) and Board	Patty Hayes, Board Chair Andrew Kamali, Project Manager Karen Langehough, Facilitator
4:15 p.m.	11. Consideration of School Environmental Health and Safety Rule TAC Recommendations – Possible Action	Patty Hayes, Board Chair Andrew Kamali, Project Manager
4:25 p.m.	12. Board Member and SRP TAC Member Comments and Updates	
4:45 p.m.	Adjournment	

- **To access the meeting online and to register:**
https://us02web.zoom.us/webinar/register/WN_4-Q-Qo-XQf2OSvcxKh7xkQ
- **You can also dial-in using your phone for listen-only mode:**
Call in: +1 (253) 215-8782 (not toll-free)
Webinar ID: 829 4960 2827
Passcode: 682856

Important Meeting Information to Know:

- Times are estimates only. We reserve the right to alter the order of the agenda.
- Every effort will be made to provide Spanish interpretation, American Sign Language (ASL), and/or Communication Access Real-time Transcription (CART) services. Should you need confirmation of these services, please email wsboh@sboh.wa.gov in advance of the meeting date.
- If you would like meeting materials in an alternate format or a different language, or if you are a person living with a disability and need [reasonable modification](#), please contact the State Board of Health at (360) 236-4110 or by email

PO Box 47990, Olympia, WA 98504-7990
(360) 236-4110 • wsboh@sboh.wa.gov • www.sboh.wa.gov

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Information About Giving Verbal Public Comment at Hybrid Meetings:

- Individuals may give verbal public comments at the meeting, in-person or virtually, during the public comment period.
- The amount of time allotted to each person will depend on the number of speakers present (typically 1 to 3 minutes per person). We will first call on those who have signed up in advance.
- Sign up **by 12:00 Noon the day before a meeting** to participate in the public comment period:
 - [Email the Board](#) or
 - Register through the **Zoom webinar link**. **The Zoom webinar link is in the meeting agenda located on the [Meeting Information webpage](#).**
 - If you are **attending the meeting in person** and did not sign up in advance, you may write your name on the sign-in sheet to provide comments if time allows.

Information About Giving Written Public Comment:

- Please visit the Board's [Public Comment webpage](#) for details.

WASHINGTON STATE BOARD OF HEALTH

Draft Minutes of the State Board of Health

March 12, 2025

Hybrid Meeting

ASL (or CART) and Spanish interpretation available

Washington State Department of Health

111 Israel Road S.E.

Tumwater, WA 98501

Building: Town Center Two (TC2, Rooms 166 & 167)

Virtual meeting: ZOOM Webinar

State Board of Health Members present:

Patty Hayes, RN, MSN, Chair

Kelly Oshiro, JD, Vice Chair

Socia Love, MD

Tao Sheng Kwan-Gett, MD, MPH, Secretary's Designee

Jessica Todorovich, Interim Secretary of Health

Mindy Flores, MHCM

Paj Nandi, MPH

Peter Browning, MA

State Board of Health Members absent:

Stephen Kutz, BSN, MPH

State Board of Health staff present:

Michelle Davis, Executive Director

Lilia Lopez, Assistant Attorney General

Ashley Bell, Deputy Director

Melanie Hisaw, Executive Assistant

Michelle Larson, Communications

Manager

Anna Burns, Communications Consultant

Marcus DeHart, Communications

Consultant

Ash Noble, Health Policy Advisor

Kelly Kramer, Newborn Screening Project

Policy Advisor

Molly Dinardo, Health Policy Advisor

Hannah Haag, Community Engagement
Coordinator

Andrew Kamali, School Rules Project
Manager

Nina Helpling, School Rules Project Policy
Advisor

Mary Baechler, School Rules Project
Community Engagement Coordinator

Guests and other participants:

Kseniya Efremova, Department of Health

Amy Ferris, Department of Health

Kseniya Efremova, Department of Health

John Thompson, Department of Health

Megan McCrillis, Department of Health

Cindan Gizzi, Deputy Director of Public

Health Tacoma-Pierce Health Department

Lauren Jenks, Department of Health

Chantell Harmon Reed, Director of Public

Health Tacoma-Pierce Health Department

Michael Ellsworth, JD, MPA, Secretary's
Designee

Patty Hayes, Board Chair, called the public meeting to order at 9:33 a.m. and read from a prepared statement (on file).

Michelle Davis, Board Executive Director, gave a land acknowledgement.

1. APPROVAL OF AGENDA

Motion: Approve March 12, 2025 agenda

Motion/Second: Vice Chair Oshiro/Member Browning. Approved unanimously

2. ADOPTION OF JANUARY 8, 2025 MEETING MINUTES

Motion: Approve the January 8, 2025 minutes

Motion/Second: Vice Chair Oshiro/Member Browning. Approved unanimously, Member Kwan-Gett abstained.

3. PUBLIC COMMENT

Patty Hayes, Board Chair, opened the meeting for public comment and read from a prepared statement (on file).

Bill Osmunson requested four hours to present on the fluoridation panel, saying some panel members lack the background to weigh the science. B. Osmunson talked about fluoride concentration levels and said research shows evidence of lower IQ and harm.

Gerald Braude discussed Benton County's resolution to promote gene therapy for infectious disease. G. Braude highlighted the adverse effects of the synthetic mRNA shots. G. Braude also mentioned physician licenses being stripped when speaking out about the shots.

Lisa Templeton talked about a global vaccine study supporting independent research on neurological disorders and other issues. L. Templeton said science is clear, the risk is real and asked if this catastrophic approach will be repeated.

Sue Coffman emphasized the importance of understanding residents' concerns about consent and right to review. S. Coffman said RFK Jr.'s position would contribute to the discussion and help uncover corruption. S. Coffman asked the Board to conduct their own due diligence, uncover the reality, and stop spouting the lies of lobbyists and special interest groups.

Anni-Michele Jean-Pierre talked about placing children at the heart of their work so that every child can thrive. A. Jean-Pierre advocated for health equity and oral health, highlighting the importance and benefits of community water fluoridation.

Dewey Gibson discussed the need for a Do-It-Yourself (DIY) septic inspection program and mentioned submitting written comments to the Board. D. Gibson discussed the misleading information from the Department of Health and said that every county should have a DIY inspection program.

Natalie Chavez discussed events in Southwest Idaho, explaining that House Bill 1531 was introduced to address communicable diseases and that the bill is not needed since it is already law. N. Chavez said that paid lobbyists from the Washington Vaccine

Association passed the legislation in the early morning hours, contributing to a loss of trust with Washingtonians.

Bob Runnells discussed a study from the Centers for Disease Control and Prevention regarding 13 adverse effects from the shots but not acknowledging other injuries.

Chair Hayes asked staff to follow up on the DIY septic inspection.

4. ANNOUNCEMENTS AND BOARD BUSINESS

Michelle Davis, Board Executive Director, provided updates on staff and Board Member activities. The Health Impact Review (HIR) Team has completed five HIRs this legislative session and will present at two upcoming national events. Executive Director Davis also gave updates on rulemaking petitions received by the Board, described recent subcommittee meetings, directed Board Members to the finalized Pro-Equity Anti-Racism plan, and highlighted upcoming events.

Kelly Oshiro, Vice Chair, asked for more information about legislative actions.

Executive Director Davis described some of the budgetary impacts and possible legislative impacts of bills the team has been tracking.

5. DEPARTMENT OF HEALTH UPDATE

Jessica Todorovich, Interim Secretary of Health, described the State budget deficit and shared updates on recruitment for the Secretary of Health.

Tao Kwan-Gett, Secretary's Designee, provided an overview of federal impacts the Department is experiencing, which include changes in funding, data integrity impacts on employees, and impacts from executive orders. Data integrity and availability is a major concern. For example, the Pregnancy Risk Assessment Monitoring System (PRAMS) has been impacted and is currently unavailable. This is a major interruption with large impacts on child and maternal health. The Behavioral Risk Factor Surveillance System (BRFSS) system has also been impacted with some data points being altered or deleted. Disease response activities have been resumed. The Department is following key federal health appointments, and closely following the federal budget and grants.

Amy Ferris, Chief Financial Officer, Department of Health (Department), gave updates on the state level budget and reviewed various proposed reductions which are currently under consideration in the House and Senate. The revenue forecast is coming out on March 18, and we expect budget proposals to come out after the revenue forecast comes out. We are also watching how federal actions will impact our state revenue, such as tariffs.

Peter Browning, Board Member, wondered how much Washington Association of Local Public Health Officials (WSALPHO) is involved in budget conversations and how Foundational Public Health Services (FPHS) is impacted.

Secretary Todorovich confirmed that WSALPHO has been involved and that we don't have decisions on FPHS yet. We are talking with the government public health systems for our next biennium.

Michelle Davis, Board Executive Director, noted that FPHS dollars are unique and how those funds are allocated are decided by the steering committee.

Paj Nandi, Board Member, asked Member Kwan-Gett about PRAMS and BRFSS and gender identification questions being removed. Is there advocacy happening on a state level to mitigate harm caused by this change at the federal level?

Member Kwan-Gett confirmed that they are monitoring this. There is also concern that the data we collect on a state level be secure and that we know how that data is being used.

Socia Love, Board Member, thanked the Department staff for their hard work and asked about measles deaths and vaccination. Do you have any information about vaccine availability and about data that might shed light on this situation?

Member Kwan-Gett noted that they monitor this closely and have talked with local health about how to make the data more useful to them. There is currently a dashboard, and local health jurisdictions have asked for more details. The immunization team has put together a guide for Tribal and local health partners about responding to measles incidents.

Patty Hayes, Board Chair, thanked the Department presenters.

6. SHELLFISH RULES BRIEFING

Patty Hayes, Board Chair, said this agenda item was for informational purposes only to inform Board Members of the rulemaking project and next steps.

Ash Noble, Board staff, introduced themselves and their co-presenter, Kseniya Efremova, who would provide updates on the sanitary control of the shellfish rulemaking project.

Kseniya Efremova, Department staff, provided background on the project. The rulemaking was initiated after a 2021 heatwave that led to a surge in Vibriosis (Vibrio) cases, prompting a reevaluation of existing rules and protections. Kseniya then presented a timeline of the work completed to date, including the Board's delegation of authority to the Department, Code Reviser filing dates, interested party engagement, an informal comment period on draft proposed rules, and recent Board briefings. Responses from the informal comment period indicated the need for more engagement before proceeding which led to the organization of workshops with shellfish growers and Tribal partners. These workshops resulted in revisions. The next step is a second informal comment period for the shellfish industry, followed by further rule revisions, CR-102 preparation, and additional learning opportunities for the Board and Department (see presentation on file).

Chair Hayes complimented the Department and Board collaboration, emphasizing the shellfish industry's importance for the economy and public health. Chair Hayes expressed appreciation for the work done so far and stressed the need for continued

engagement with all levels of the industry to ensure solutions work for everyone. Chair Hayes then opened the floor for questions.

Peter Browning, Board Member, asked for more information about Vibrio, specifically whether it is always present in water and how it proliferates in the heat.

Ksenyia briefly explained that Vibrio is a bacteria found in the water but noted that they would need to ask subject matter experts from the Department to follow up with Board Members to provide more detailed information.

Paj Nandi, Board Member, asked staff to share more about small business economic impact statements (SBEIS).

Ksenyia provided an overview of Significant Analyses (SAs), which are cost-benefit analyses required for many rulemaking projects under state law. Ksenyia explained that during the SA process, staff assess proposed rule changes and evaluate their potential impact on the industry. If small businesses (defined as those with 50 or fewer employees) are affected, further analysis of costs is required. This may involve gathering information from the industry through surveys or focus groups, depending on the project. The SBEIS provides a detailed analysis of the impact on small businesses.

Member Nandi inquired if the SBEIS considers additional impacts on certain small businesses, such as minority or women-owned businesses, or if the SBEIS focuses on general impacts on small businesses.

Ksenyia responded that as staff work through the SA and SBEIS, these are important impacts to consider.

Kelly Oshiro, Board Vice Chair, asked for clarification on the definition of small businesses in the SBEIS, specifically whether small businesses are defined based on their normal operations and if seasonal workers are included in that definition.

Ksenyia responded that the statutory definition of small businesses does not account for such specific details, but the team should explore them further. Ksenyia added that during the SA and SBEIS process, staff work with the Department's economist, Anna Hidle, and staff can raise these nuances with Anna.

Vice Chair Oshiro inquired about when the Board could expect another project update and whether data from the 2024 shellfish season would be available to share with Board Members.

Ash responded that an additional update is expected at the June Board meeting.

Ksenyia added that they would consult with the Shellfish program to determine if data from the 2024 season can be included in the next update.

Vice Chair Oshiro also asked to hear more about what staff learned from Tribes during the Tribal shellfish grower workshops.

Ksenyia emphasized the value of organizing workshops by operation size and providing separate spaces for Tribal growers to offer feedback. Ksenyia noted that Tribal partners raised unique topics, including the impact of regulations and tagging recommendations on Tribal treaty rights, and the importance of including harvest site certifications on the application. Ksenyia concluded by sharing how insightful the feedback from Tribal partners was for staff.

Vice Chair Oshiro said they were pleased to hear the feedback from Tribes.

Chair Hayes thanked staff and said the Board would look forward to future updates on this work and data from 2024.

The Board took a break at 11:20 a.m. and reconvened at 11:35 a.m.

7. LOCAL PUBLIC HEALTH FOCUS—TACOMA PIERCE PUBLIC HEALTH DEPARTMENT

Chantell Harmon Reed, Director of Public Health Tacoma-Pierce County Health Department (TPHD), and Cindan Gizzi, Deputy Director of Public Health County Tacoma-Pierce Health Department, introduced themselves. Director Harmon Reed shared that they began at TPHD in 2024, bringing a background in public health, healthcare administration, and compliance. Director Harmon Reed shared their passion and focus for improving public health, community connections, and organizational efficiencies.

Director Harmon Reed then provided an overview of the local health jurisdiction's (LHJ's) structure and key demographics of Pierce County. Director Harmon Reed also provided information about TPCHD's 2025-2029 Strategic Plan and current TPCHD program highlights (see presentation on file).

Paj Nandi, Board Member, inquired further about TPCHD's Street Medicine program and whether long-term funding exists for this work.

Director Harmon Reed confirmed that the Street Medicine program is funded through one-time funding, but TPCHD aims to build the infrastructure for its long-term sustainability. Director Harmon Reed added that TPCHD is working to establish a system that allows billing through a "clinic without walls" model, which will generate revenue to support the program. Efforts are underway to integrate the program into the county's overall homelessness response, ensuring it becomes a permanent part of their clinic services.

Member Nandi asked if Elevate Health, the Accountable Community of Health (ACH) in the area, is involved in the Street Medicine program. Member Nandi noted their efforts to open community care hubs and wondered if there is any connection between these programs.

Director Harmon Reed explained that although the Street Medicine program and Elevate Health's community care hubs are separate initiatives, TPCHD has reached out to nearly all Federally Qualified Health Centers (FQHCs) in Pierce County to explore collaboration and integration. One FQHC raised questions about how their street

medicine program aligns with TPCHD's efforts. Director Harmon Reed concluded that while the current Street Medicine grant is focused on the City of Tacoma, TPCHD is working to expand the program countywide through partnerships.

Mindy Flores, Board Member, inquired about TPCHD's Do-It-Yourself (DIY) septic program and asked why it is not yet available.

Director Harmon Reed provided some background context on the topic of septic systems in Pierce County and shared some of their program's challenges, including staffing and inspection workloads. Director Harmon Reed explained that TPCHD had to prioritize other program projects, leading to the difficult decision to delay the DIY program until 2026. The delay was necessary to ensure the program is well-planned and considered all impacts. Director Harmon Reed cited the Minter Bay Protection District as an example of a failed septic system, and if that happened across several systems, could the TPCHD septic program contain the spill as well as they were able to with Minter Bay? Director Harmon Reed emphasized the importance of being thoughtful and intentional when rolling out a new program like the DIY septic program and stressed that TPCHD wants to avoid rushing the program and having to reverse it later.

Tao Sheng Kwan-Gett, Secretary's Designee, thanked Director Harmon Reed and Deputy Director Gizzi for their presentation and leadership in the Washington State public health system. Member Kwan-Gett asked if Director Harmon Reed had any general comments on their approach to strategic planning and setting measurable goals for TPHD.

Director Harmon Reed shared that upon joining TPCHD, they focused on establishing clear metrics to measure success and demonstrate impact. With a background in healthcare, Director Harmon Reed has always prioritized data and quantifiable outcomes. Director Harmon Reed expressed appreciation for the TPCHD team's willingness to transition to data-driven practices, which are now central to decision-making. Director Harmon Reed noted that TPCHD is working on dashboards to track progress and evaluate effectiveness. While this evolution has been challenging, it is crucial for adapting the department's approach, ensuring funding stability, and making necessary adjustments if goals are not met.

Kelly Oshiro, Board Vice Chair, asked about TPCHD's engagement with diverse communities across the county, including refugee populations.

Director Harmon Reed responded that they conducted numerous meet-and-greet visits throughout all districts to connect with the community directly. Director Harmon Reed noted that Pierce County has a large refugee population, and based on feedback from these visits, TPCHD has made some adjustments to better serve these communities. They also emphasized the ongoing need to secure funding to support language access efforts in the county.

Patty Hayes, Board Chair, thanked the presenters and added that TPCHD's stories about Foundational Public Health Service (FPHS) dollars have been impactful, and they hope elected officials can hear more about the great work they are doing in Pierce County.

**8. NEWBORN SCREENING TECHNICAL ADVISORY COMMITTEE (TAC)
RECOMMENDATIONS: BRANCHED-CHAIN KETOACID DEHYDROGENASE
KINASE (BCKDK) DEFICIENCY, AND PROCESS AND CRITERIA UPDATES**

Kelly Oshiro, Vice Chair, shared that the Newborn Screening Technical Advisory Committee (TAC) has two recommendations for the Board to consider. The first concerns a candidate condition for universal newborn screening and the second is about updating the newborn screening process and criteria. Vice Chair Oshiro noted that the TAC used the existing criteria when evaluating Branched-Chain Ketoacid Dehydrogenase Kinase (BCKDK) Deficiency. If the Board updates the criteria today, the TAC will apply the new criteria to all future reviews. Vice Chair Oshiro then introduced Kelly Kramer, State Board of Health Policy Advisor for the Newborn Screening Program.

Kelly Kramer, Board staff, introduced Megan McCrillis, Policy Advisor for Newborn Screening, and John Thompson, Office Director for Newborn Screening at the Department of Health (Department). Kelly reviewed BCKDK, a rare genetic amino acid disorder with 21 cases known worldwide. Kelly reviewed the limited data, its characteristics, testing methods, and treatment (see presentation on file).

Megan McCrillis, Department staff, explained the challenges of conducting a cost-benefit analysis for BCKDK due to its rarity, no pilot studies, no experts, and no current screening. Due to limited data, Megan consulted with Anna Hidle, a Public Health Economist, who recommended not to run the cost-benefit analysis. Megan created a cost-benefit model for future use if more data becomes available.

Kelly summarized the TAC discussed on BCKDK and their recommendation to not add it to the newborn screening panel. Kelly opened it up for discussion.

Paj Nandi, Board Member, agreed with the TAC's conclusion and asked how BCKDK was brought to the Board's attention.

Kelly answered that Senator Linda Wilson, now retired, sponsored the legislation due to their interest in addressing the rising cases of Autism Spectrum Disorder in Washington State.

Motion: The Board determines that branch-chain ketoacid dehydrogenase kinase (BCKDK) deficiency should not be considered for addition to the newborn screening panel at this time.

Motion/Second: Member Browning/Member Nandi. Approved unanimously.

Kelly reviewed the proposed updates to the newborn screening criteria from the TAC (see presentation on file). The updates to Criterion 1 focused on ensuring screening test has at least 95% sensitivity, acceptable specificity, and timely results for early intervention.

Vice Chair Oshiro asked Kelly to explain if all points in Criterion 1 need to be met for a condition to pass.

Kelly responded that not all points in Criterion 1 need to be met, but it helps future TACs consider all factors when making a recommendation.

Kelly then reviewed the proposed edits to Criterion 2 and Criterion 3. The proposed changes in Criterion 2 include accurately identifying the need for treatment and ensuring that treatment is readily available. The proposed changes in Criterion 3 define infancy.

Vice Chair Oshiro noted that the TAC aimed to rephrase the language to be more positive than negative.

Socia Love, Board Member, asked if the proposed criteria would generally apply to current conditions.

John Thompson, Department staff, answered that there are currently 32 conditions being screened and three more that are being developed. John believes the proposed criteria would generally apply to these conditions.

Kelly moved to Criterion 4. The TAC proposed adding that risk-based screening tools are inferior to universal screening and that there is sufficient evidence of acceptable quality to evaluate the criterion.

Patty Hayes, Board Chair, asked for clarification of the term's "inferior" and "acceptable quality."

Tao Sheng Kwan-Gett, Secretary's Designee, said in their interpretation, quality would refer to evidence.

Megan said that they were not sure there is a stated benchmark for the term inferior. The TAC had a robust discussion about keeping terms somewhat vague to allow for further discussion.

Kelly moved on to Criterion 5. The proposed updates included adding an economic analysis, comparing screening versus no screening, and considering impacts like ambiguous results and adverse effects. The analysis must show benefits outweigh costs with sufficient evidence.

Member Nandi said that a lot of the dot points are highly subjective and asked if this was by design.

John thanked Member Nandi for that observation and confirmed that the subjectiveness was intentional. John explained that the TAC believed future committees would consider all relevant points when evaluating conditions.

Peter Browning, Board Member, asked to confirm that this wouldn't prevent a provider from ordering a test due to other risk factors, like family history.

Kelly confirmed that providers are welcome to use discretion in ordering testing as they see fit.

Kelly moved to Criterion 6. This new criterion would assess the Newborn Screening Program's capacity to implement screening on time, including staffing, follow-up, resources, and treatment accessibility for all newborns who screen positive.

Vice Chair Oshiro added that this new criterion is important to ensure the Newborn Screening Program's input is included in evaluating conditions for screening.

Mindy Flores, Board Member, was confused by the third dot point, "accessibility," and wanted clarification.

John explained that the third dot point refers to the medical community's readiness to treat identified babies and the ability for families to access treatment. John gave the example of congenital hypothyroidism, which is common and easily treated at local hospitals and pharmacies. In contrast, Pompe Disease, an enzyme deficiency, has only two treatment centers in Western Washington. This poses a challenge for families in Eastern Washington who may need to relocate for regular treatment. This dot point gets the TAC thinking and considering that it may not be easy to access treatment.

Member Flores wondered if this dot point would better fall under Criterion 5.

Vice Chair Oshiro suggested renaming Criterion 6 as "Public Health Infrastructure Readiness." That way, it's thought of more as a public health system, which would include the Newborn Screening Program, because Criterion 5 is considering the economics of the criteria.

Member Kwan-Gett asked about discussions on health insurance coverage and accessibility. Testing and treatment may not be accessible without insurance coverage.

Vice Chair Oshiro commented that the Health Care Authority has had representation at TAC meetings.

Kelly added that the TAC includes representation from private and public insurance, and they have been part of the planning and proposal discussions. However, insurance coverage is not specifically mentioned in the criteria.

Vice Chair Oshiro suggested that the Board break for lunch and vote when they return from lunch.

Lilia Lopez, Assistant Attorney General, reminded Board Members that they should not discuss Board business during lunch.

The Board recessed for lunch at 12:45 p.m. and reconvened at 1:47 p.m.

Chair Hayes welcomed Board Members back from lunch and returned to agenda item 8.

Vice Chair Oshiro asked Board Members if there were any questions before they moved to a vote.

Chair Hayes complimented the TAC's work and Vice Chair Oshiro's leadership. Chair Hayes expressed interest in hearing back after the TAC applies the new criteria and looked forward to collaborating with the TAC to improve the process.

Vice Chair Oshiro explained that if the Board adopted the new criteria, the next condition to be investigated by the TAC is congenital Cytomegalovirus (cCMV). It was previously reviewed in 2023 but lacked sufficient evidence. The TAC would report back their experience applying the new criteria.

Member Browning expressed their appreciation for understanding the process and criteria.

Member Nandi inquired about the suggested language change in Criterion 6. Would the Board consider that change today, or would that suggestion go back to the TAC for consideration?

Vice Chair Oshiro explained that the Board would decide on any amendments and asked if the Department and Board staff had any thoughts on the change.

John expressed support for the amendment of the title change to Criterion 6.

Michelle Davis, Board Executive Director, added that the changes make sense, and they are glad that the Board recommended them.

Member Kwan-Gett shared that they believe the proposed criteria allows for flexibility and provides the committee the opportunity to think and discuss individual conditions.

Motion: The Board accepts the Newborn Screening Technical Advisory Committee recommendations for Process and Criteria Updates with a minor, clarifying edit, changing criteria 6 to read Public Health Infrastructure Readiness.

Motion/Second: Member Kwan-Gett/Member Browning. Approved unanimously.

9. SCHOOL RULE PROJECT UPDATE

Patty Hayes, Board Chair, explained that the staff will provide an overview of the work done in preparation for the April meeting with the School Rule Technical Advisory Committee (TAC). Chair Hayes reminded Board Members that the Legislature requires a report outlining the rule, issues identified, and recommendations for implementation. Chair Hayes explained that the expectation is to recommend a phased implementation approach. Chair Hayes praised staff for navigating this challenge and highlighted the TAC's role in fostering relationships between local public health and schools. Chair Hayes thanked the Department of Health (Department) for their guidance.

Andrew Kamali, Project Manager, thanked Chair Hayes for the introduction and introduced staff that will present today. Andrew explained that staff will provide a refresher on the proviso, review the process, community engagement, and a summary of the changes. Andrew noted the draft rule in the Board packet is 98% complete, with further changes expected. Andrew then reviewed the proviso that directed the Board to update the school environmental health and safety rules, including a fiscal analysis and

an environmental justice assessment. Andrew reviewed the TAC membership and the final report due by June 30, 2025. Andrew then asked Lauren Jenks to speak about their experience as a TAC member.

Lauren Jenks, Assistant Secretary of Environmental Public Health, explained that the current School Environmental Health and Safety rules are outdated and were last revised in 2009. This has been an ongoing project for the Board. Lauren shared how the TAC worked together to balance ensuring safety and managing school resources. Lauren provided examples of compromise and collaboration.

Paj Nandi, Board Member, asked about students and youth input.

Lauren explained that the community engagement portion of the presentation will speak to that.

Marcus DeHart, Board staff, reviewed the TAC timeline and meeting process.

Andrew explained the TAC meetings were initially held across the state to accommodate geographic diversity and in-person attendance. Due to Governor Inslee's travel guidance, most meetings shifted to virtual settings.

Mary Baechler, Board staff, discussed community outreach efforts, including a Tribal Listening Session and several in-person and online sessions across Washington. Notices of these listening sessions were sent to nine districts, reaching over 198,000 students. Feedback received from these sessions focused on air quality, implementation costs, and bathrooms. The feedback will be included in the report.

Andrew highlighted that the Tri-Cities listening session had the highest attendance and credited the partnership with the local health jurisdiction for its success.

Kelly Oshiro, Vice Chair, thanked Mary for sharing the community engagement plan and asked what the most surprising thing that they learned.

Mary was surprised to learn that vaping in bathrooms is a big issue for students. Students raised concerns about air quality and exposure to vaping. Some schools are locking bathrooms during class time to control vaping, which has led to complaints about limited bathroom access.

Nina Helpling, Board staff, then summarized the changes and explained that the financial analysis is challenging due to varying impacts on schools. Nina thanked Lauren Jenks and the Department team for their help, especially in creating and providing guidance documents, resources, and templates for schools. The rule focuses on providing flexibility for schools and local health jurisdictions to adapt as needed.

Member Nandi asked if there was any pushback from school officials regarding bathrooms and handwashing facilities.

Chair Hayes answered that some of the conversation is still occurring and explained that there will be a TAC meeting on March 19 to discuss this further.

Socia Love, Board Member, asked if water fountain access and safety locks on doors for active shooters were discussed.

Andrew explained that the current building code has requirements for water fountains. For active shooter safety, that's captured under the Office of Superintendent and Public Instruction and the State Board of Education.

Chair Hayes thanked the School Rule Team for their work on the project and hoped the Board found the overview helpful.

The Board took a break at 3:00 p.m. and reconvened at 3:15 p.m.

10. REQUEST FOR THE BOARD TO DELEGATE RULEMAKING FOR [246-290 WAC](#): GROUP A PUBLIC WATER SUPPLIES, AND FOR [246-390 WAC](#): DRINKING WATER LABORATORY CERTIFICATION AND DATA REPORTING TO THE DEPARTMENT OF HEALTH

Paj Nandi, Board Member, referred Board Members to the materials on file and introduced Board and Department of Health (Department) staff regarding the request for delegation. Member Nandi said this expedited process allows for quick action without affecting the Board's permanent rulemaking.

Ash Noble, Board staff, began the discussion and facilitated the presentation.

Mike Means, Department staff, presented background information on the emergency rule (see presentation on file). Mike noted that the scope of the rulemaking will focus on incorporating the federal per- and polyfluoroalkyl substances (PFAS) requirements and adding federal PFAS levels to the appropriate contaminant tables.

Member Nandi asked for Board staff details regarding the next steps.

Ash said if the motion carries, the Board would receive an update at the June 2025 meeting.

Motion: The Board moves to delegate rulemaking authority to the Department of Health to adopt by reference new, federal National Primary Drinking Water Regulations related to PFAS into chapter 246-290 WAC and chapter 246-390 WAC.

Motion/Second: Vice Chair Oshiro/Member Flores. Approved unanimously.

11. 2026 STATE HEALTH REPORT UPDATE

Hannah Haag and Molly Dinardo, Board staff, discussed the upcoming State Health Report (SHR) and proposed updates to the report development process. Molly emphasized that the SHR presents an opportunity to integrate the goals and objectives of the Board's recently adopted Pro-Equity Anti-Racism (PEAR) Plan into practice. Molly highlighted the intention to build upon the 2024 process and, for the 2026 report, implement a core team model structure for planning and scoping the development of the report. Molly also mentioned that staff are seeking sponsorship from several Board Members to support this project.

Hannah provided an update on proposed plans for community engagement related to the report development, emphasizing the importance of initiating engagement early and incorporating community voices at the outset. Hannah added that staff want to focus recommendations on topics and areas where there is an overlap between community needs and Board work. Hannah concluded by sharing that the community engagement process is still being planned, and staff will keep the Board updated as it develops.

Paj Nandi, Board Member, commented that the State Health Improvement Plan (SHIP) is starting and will involve extensive community engagement. Member Nandi asked how the Board can align with that work and noted that the SHIP may address similar issues and engage the same communities.

Hannah responded that Member Nandi's questions are part of ongoing conversations around how to integrate resources like the SHIP into the State Health Report. Hannah added that staff hope to address this through a landscape analysis and aim to incorporate as many relevant resources as possible.

Patty Hayes, Board Chair, suggested that having the Department provide a brief update on the vision for the SHIP and its evolution could help the Board understand their role and enable meaningful input.

Chair Hayes added that this is a unique opportunity, as the report will be sent to the Governor and policymakers. Chair Hayes suggested that, given the current federal actions and budget challenges, there may be an opportunity to utilize community input to discuss potential consequences if the Federal Public Health Services (FPHS) budget is decreased.

Tao Kwan-Gett, Secretary's Designee, offered to have the SHIP team brief the Board and expressed appreciation for the thoughtful approach. Member Kwan-Gett explained that the State Health Assessment illustrates the state of Washington's health, while the SHIP enables the state to prioritize health issues for focus. Member Kwan-Gett also noted that the Public Health Advisory Board (PHAB) focuses on creating recommendations and raised the question of how to improve the system to address these priorities better. Member Kwan-Gett added that within this framework, there is a unique role for the State Health Report.

Member Nandi appreciated the suggestion for a briefing and commented that while state agencies and boards produce many reports, they often lack evaluation of effectiveness. Member Nandi emphasized the significant resources invested into these reports, and the challenge of aligning budgets with priorities. Member Nandi noted that funding is often inflexible, and the community may perceive a disconnect between state and community priorities. Member Nandi inquired if it's possible to meet community needs, given these funding limitations.

Chair Hayes appreciated Member Nandi's comment and pointed out the unique opportunity the report offers to highlight these issues. Chair Hayes explained that while the SHIP focuses on assessment, the SHR presents recommendations and can provide an account of policies and priorities. However, the report does not necessarily explore

the implications of those outcomes. Chair Hayes noted that past actions driven by the report have led to changes, such as revising rules.

Kelly Oshiro, Vice Chair, noted that this report will be submitted to the Governor and that Washington hasn't had a new governor in over ten years, presenting an opportunity for a fresh start. Vice Chair Oshiro suggested taking a fundamental approach, such as creating a paragraph to explain the Board's purpose and authority to help the Governor and legislators better understand their role. Vice Chair Oshiro inquired whether the Legislature would read the report and what key takeaways they would derive from it.

Molly shared that Board staff have received some feedback on past SHR reports and will apply the lessons learned to improve the upcoming report. Molly acknowledged the uncertainty related to evaluating the impact of the report and its recommendations. Molly emphasized that staff would continue discussions on how to assess the report's impact better and welcomed Board Members to join in these conversations. Hannah added that staff also plan to be more intentional about bringing updates to the Board for discussion.

Chair Hayes noted follow-ups and next steps, including outlining the time commitment for Board Members interested in participating in this work. Chair Hayes stated that Member Flores led the development of the last SHR and could potentially serve as an advisor or co-chair.

Mindy Flores, Board Member, volunteered to sponsor the project again and commended Molly and Hannah for their work. Member Flores acknowledged the short timeline and high expectations of the previous report but emphasized that helpful information was still gathered, and communities appreciated the outreach. Member Flores raised concerns about the potential for redundant data and noted that, although similar questions had been raised previously, limited capacity had prevented thorough inclusion. Member Flores expressed optimism about the core team model and the potential for collaboration with the Department of Health. Member Flores added that this report is a potential opportunity to connect with other reports and partners.

Chair Hayes expressed hope that one more person will join Member Flores on this project.

12. RECOGNIZING BOARD MEMBER CONTRIBUTIONS

Patty Hayes, Board Chair, read the resolution for Dimyana Abdelmalek that recognized their appointment to the Board, service to others, commitment to improving health, and leadership during the pandemic (on file). Chair Hayes described Dimyana's many contributions to the Board.

Motion: The Board formally recognizes and expresses deep gratitude to Member Abdelmalek for her exceptional leadership, dedication to public health, tireless service to communities worldwide, and outstanding contributions to the people of Washington State as a member of the Board.

Motion/Second: Member Kwan-Gett/ Member Browning. Approved unanimously.

13. BOARD MEMBER COMMENTS

Patty Hayes, Board Chair, explained that they will present the work of the Board to Northeast Tri-County Public Health on March 20. Chair Hayes asked about the Public Health Law conference mentioned earlier in the meeting and if Board Members can attend.

Michelle Davis, Executive Director, will keep Board Members updated on registration opportunities and noted that there is uncertainty about the budget and reimbursement for Board Members who attend.

Executive Director Davis asked Member Kwan-Gett about the ongoing state health assessment and noted that the Department had previously reported on morbidity and mortality to the Board. Executive Director Davis suggested it would be a valuable presentation for both the Board and the State Health Improvement Plan.

Tao Sheng Kwan-Gett, Secretary's Designee, will consult with the team on the timeline and will try to get them on a future agenda item.

ADJOURNMENT

Patty Hayes, Board Chair, adjourned the meeting at 3:55 p.m.

WASHINGTON STATE BOARD OF HEALTH

Patty Hayes, Chair

To request this document in an alternate format or a different language, please contact the Washington State Board of Health at 360-236-4110 or by email at wsboh@sboh.wa.gov
TTY users can dial 711.

PO Box 47990 • Olympia, Washington • 98504-7990
360-236-4110 • wsboh@sboh.wa.gov • sboh.wa.gov



Public Comment

*Accepted until noon three business days prior to meeting.
The following 120 pages are the emails and attachments sent by
12:00 p.m. on Friday, April 4, 2025*

From: Derek Kemppainen
Sent: 4/1/2025 10:18:39 PM
To: Foust, Chelsea S (DOH),DOH WSB0H,DOH EPH DW Info
Cc:
Subject: Cities Defer to WA DOH on Fluoridation – Need for Clearer Direction

External Email

Dear Ms. Foust and Members of the Washington State Board of Health & Department of Health,

I'm writing to share a recent response I received from the City of Vancouver regarding community water fluoridation that could be a relevant discussion point for the upcoming April 9th meeting. I believe this response helps illustrate a key dynamic: cities across Washington are relying on Department of Health guidance and see themselves as unable to act independently, even when residents request change.

The City wrote:

"We will continue as always to follow the guidance on recommended levels of usage from the Washington State Department of Health. If those recommendations change, the City will act accordingly."

Vancouver also cited its municipal code as a legal obligation to fluoridate according to DOH policy:

"The city council of the city of Vancouver hereby authorizes and directs that a source of fluoridation approved by the State Department of Health be added to the city of Vancouver water supply, under the rules and regulations of the Washington State Department of Public Health, such addition to be administered in a manner approved by the State Director of Public Health, and in accordance with the laws of the state of Washington."

This highlights a broader issue: local governments are effectively locked into fluoridation as long as the state continues to support it. The Department's guidance is not simply advisory in practice - it's interpreted as binding.

While the Department's current review on fluoridation is a welcome and necessary step, many cities and their residents are still left in a holding pattern. Local governments are eager to respond to community input, but feel constrained by current DOH recommendations. A revised stance from the Department would provide them with the clarity and authority they need to move forward.

Thank you for taking this issue seriously and for the work already underway.

Sincerely,

Derek Kemppainen
Vice President, Washington Action for Safe Water
360-975-2011

<https://dxwIKZ04.na2.hs-salescrm-engage.com/Cto/GJ+23284/dxwIKZ04/R5R8b40T1N7psDMX2fJj7W1Vp_6D23f2bHW1Qs7mB1XnZrGW1Gd3>

From: Drew Frank
Sent: 4/3/2025 9:33:12 PM
To: DOH WSBOH
Cc:
Subject: My Public Comments

External Email

Board Members,

I had the opportunity to listen in on parts of the 2/26 meeting with the Board and the TAC. I'm especially interested in ventilation and indoor air quality, and it was great to hear the detailed discussion of these topics informed by technical experts. Thank you for your work on this.

Prior to the meeting, I did not appreciate the constraints the Board operates under here. One common theme I heard come up again and again is that the rules must not be burdensome, and that there is a very strong desire to define requirements such that all existing schools are already in compliance. Additionally, equity came up as a concern – if a policy would be beneficial but would be more burdensome for a subset of schools, due to a difference in either impact or available resources, that is considered a strong mark against the policy.

I certainly understand the rationale, especially in the current fiscal climate. At the same time, it results in a tragic loss of potential impact from this group's work. It takes significant scientific and engineering expertise to weigh the costs and benefits associated with different ventilation & filtration strategies. This group has done that work, and many school districts could benefit from a full understanding of it! However, by focusing on (1) minimum standards that are (2) already met and (3) are equally comfortable for all schools to adhere to, much of that accumulated knowledge never makes it onto the page.

My ask is this: look for ways to communicate best practices above and beyond the required minimums. For example, if evidence suggests a higher rate of outdoor airflow would be beneficial, that should be written somewhere even if it would be expensive to meet in the depths of winter in the colder parts of the state. Similarly, I still don't see any mention of effective clean air flow rate as discussed in ASHRAE 241 – I know this group is familiar with the literature, but district administrators are not and they need a group like this to make it simple and actionable. The last example I'll mention has to do with monitoring these systems. I recall there was discussion about the frequency of test and balance procedures and it came up that there are other ways of telling if the air in a building is safe, which can mitigate the risk of less frequent TABs. I don't see anything about those other mechanisms (CO2 and PM2.5 monitors?) in the guidance – is that a best practice you can help define?

The goal of this is to empower school districts that are able and inclined to do more than meet the minimum requirements. This will leverage your hard work and expertise to gradually move more schools to create healthier environments, even while fiscal realities prevent you from simply mandating them into existence.

Thank you,
Drew Frank


From: Michelle Anderson
Sent: 3/31/2025 7:48:36 PM
To: DOH WSBOH
Cc:
Subject: COVID rules.

External Email

Can we please just repeal the original rule??
Can we please put common sense back into the rules??
Enough already!

From: Derek Kemppainen
Sent: 4/2/2025 1:12:55 PM
To: Foust, Chelsea S (DOH),DOH WSB0H,DOH EPH DW Info
Cc:
Subject: Follow-Up: Background Information on City of Vancouver Response

 *attachments\D3CCB10AE0984237_Complaint - Citizens of Vancouver_PRDTool_NAMETOOLONG.docx*

 *attachments\BAB0C26776E2485B_Cease and Desist Order and Notice_PRDTool_NAMETOOLONG.docx*

 *attachments\BCFC819AD3F141AC_City of Vancouver Public Records Request 8.19.24.docx*

External Email

Dear Ms. Foust and Members of the Washington State Board of Health & Department of Health,

I'm writing to provide additional background on the City of Vancouver's response to my concerns about community water fluoridation, which I shared previously. I believe this context is important for your ongoing review and could be relevant to the upcoming April 9th meeting.

After months of communication with the City, they ultimately responded:

"We will continue as always to follow the guidance on recommended levels of usage from the Washington State Department of Health. If those recommendations change, the City will act accordingly."

Leading up to this response:

- * On August 19, 2024, I submitted the attached public records request, asking the City to demonstrate compliance with state and federal laws, as well as ethical guidelines regarding medical experimentation. The City was unable to produce any documentation confirming such compliance.
- * On October 1, 2024, I sent the attached Cease and Desist Order and Notice of Legal Liability Regarding Water Fluoridation, requesting an immediate end to fluoridation and outlining legal violations tied to the program as well as the September 24, 2024 court ruling that fluoridation at current levels presents an unreasonable risk of reduced IQ in children.
- * On December 9, 2024, I submitted a draft lawsuit outlining in detail how the City is in violation of state and federal law by continuing its fluoridation program. These legal arguments extend far beyond Vancouver - they apply to any municipality following current Department guidance. By continuing to endorse and promote water fluoridation, the Department is not only enabling these violations, but shares direct responsibility for them. I strongly urge the Department to review this document carefully and evaluate how its recommendations may be encouraging municipalities across Washington to violate the law - whether knowingly or not. This is an opportunity to course-correct before further harm is done.

**Derek Kemppainen
31404 NE 142nd Ave
Battle Ground, WA 98604**

December 10, 2024

**Clerk of the Court
Clark County Superior Court
1200 Franklin Street
Vancouver, WA 98660**

**RE: Public Interest Litigation Against the City of Vancouver for Violations Related to
Water Fluoridation**

COMPLAINT FOR INJUNCTIVE RELIEF AND DECLARATORY JUDGMENT

Plaintiff:

**Citizens of Vancouver, represented by Derek Kemppainen
31404 NE 142nd Ave
Battle Ground, WA 98604**

Defendant:

**City of Vancouver
415 W. 6th St.
Vancouver, WA 98660**

I. INTRODUCTION

1. This action seeks injunctive relief and declaratory judgment to prevent the City of Vancouver (hereafter "Defendant") from continuing the addition of fluoride to the public water supply. The Defendant's fluoridation practice violates both state and federal laws regarding public health, safety, and proper drug administration, posing significant and unreasonable risks to the citizens of Vancouver.
2. Fluoride added to drinking water in Vancouver has been identified as a hazardous and potentially harmful substance, constituting a violation of Washington State law (RCW 69.38.010), federal regulations governing the distribution of drugs, and laws prohibiting the introduction of toxins into public consumables.

Cease and Desist Order and Notice of Legal Liability Regarding Water Fluoridation

October 1, 2024

City Manager

City of Vancouver

415 W. 6th St.

Vancouver, WA 98660

Courtesy Copies to: Mayor, City Council Members, Public Works Director, City Attorney, Public Health Director, City Clerk, Water Department Manager, Risk Management Officer, Communications Director, Planning and Development Director, Public Records Officer

To the City Council,

I am writing on behalf of the Citizens of Vancouver to formally issue a Cease and Desist Order and Notice of Legal Liability to the City of Vancouver (the City) regarding the addition of fluoride to the public water supply. On August 19, 2024, I submitted a public records request to the City seeking documentation to justify the continuation of the fluoridation program. To date, the City has not provided any evidence demonstrating that the program is safe or legally compliant, raising serious concerns about its defensibility. Recent legal developments highlight the immediate need for action, as continuing the fluoridation program not only poses serious health risks to the community but is also illegal and unethical under both federal and state law. There is no longer any doubt about whether adding fluoride at the current levels is safe—it is not. Both scientific evidence and legal rulings have made this clear, compelling the City to act without delay.

In a landmark decision on September 24, 2024, the U.S. District Court for the Northern District of California ruled that water fluoridation at 0.7mg/L presents an “unreasonable risk” to children’s health by reducing IQ, a judgment that places a legal obligation on public agencies to reconsider fluoridation policies. Judge Edward Chen, presiding over the case, emphasized that the level of fluoride in drinking water across the U.S. is far too close to hazardous dosages, stating, “*there is substantial and scientifically credible evidence establishing that fluoride poses a risk to human health.*” He further noted that the risk is “unreasonable” under the Toxic Substances Control Act (TSCA), highlighting that even a slight reduction in IQ can result in “*reduced educational attainment, employment status, productivity, and earned wages.*” This decision signals that fluoridation practices nationwide, including those in Vancouver, are no longer justifiable.

Further corroborating this decision is the National Toxicology Program (NTP) report, published on August 21, 2024, which concluded that fluoride exposure presents a developmental neurotoxicity risk with no safe threshold for consumption. This finding draws a striking parallel to the NTP’s groundbreaking report on lead toxicity, which had a profound impact on public health policy and regulatory reform by revealing that even low levels of lead exposure are harmful, particularly to children.

Request for Public Records

August 19th, 2024

Public Records Officer
City of Vancouver
415 W. 6th St.
Vancouver, WA 98660

Courtesy Copies to: City Mayor, City Manager, City Council Members, City Ethics Committee, Public Works Department, City Attorney

Dear Public Records Officer,

I am writing to request access to certain public records under the Freedom of Information Act (5 U.S.C. § 552) and the Washington State Public Records Act (RCW 42.56) related to the water fluoridation practices in the City of Vancouver (the City.)

1 - Additives and Drugs Added to Water Supply

1. List of Additives added to treat Water Supply

- a. Please provide a comprehensive list of all additives currently added by the City to the water supply for the purpose of treating the water and making it safe for human consumption. This list should include the name of each additive and its purpose.

2. List of Drugs added to Water Supply

- a. A list of all drugs added by the City to the water supply intended to treat the recipients of the water according to the FDA definition (The FDA defines a drug as "A substance intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease OR A substance (other than food) intended to affect the structure or any function of the body.")

3. List of Drugs added to Water Supply that are FDA Approved

- a. Please provide a list of all drugs added to the water supply that are FDA-approved. This should include documentation verifying that these drugs have undergone clinical trials, have been deemed safe for human use, and have received FDA approval for their specific use in public water systems.
- b. Please include any drug fact pamphlets for each of the FDA-approved drugs added to the water supply.

4. List of Drugs added to Water Supply that are not FDA Approved

- a. Please provide a list of all drugs added to the water supply that are not FDA Approved (See [Citizen Petition - Fluoride Supplements are Unapproved New Drugs](#))

5. Process for Adding New Drugs to the Water Supply

- a. Please provide all documentation regarding the standard process the City follows when deciding to add new drugs to the water supply. This should include procedures, decision-making criteria, and any required approvals or reviews, and opportunities for public input.

6. Review Process for drugs in water supply

- a. Please provide documentation detailing the review process for all drugs currently or previously added to the water supply. This should include how the effectiveness, safety, and necessity of these drugs are evaluated over time, as well as the criteria required for continuing, altering, or discontinuing their use, the frequency at which these reviews take place, and the names and titles of those on the review committee.

7. Safety Requirements for Drugs Added to the Water Supply

- a. Please provide all safety standards and requirements that the City adheres to when adding drugs to the water supply. This should include any federal, state, or local regulations, as well as any internal policies aimed at ensuring the safety and well-being of the public.

8. List of Drugs or substances that have been evaluated for addition to Water Supply

- a. Please provide a comprehensive list of all other drugs or substances that have been evaluated for potential addition to the water supply, along with the criteria used for their evaluation and the reasons for their approval or rejection.

9. Evaluation of Essential Nutrients for Addition to water

- a. It is well established that fluoride is not a nutrient, and there are no cellular processes in the body which use fluoride. However, there are numerous essential substances that the human body requires for proper functioning of cellular processes, many of which could potentially be added to the water supply to address deficiencies in the population. Such substances include, but are not limited to, Vitamin C, Vitamin D, Iodine, Calcium, Iron, Magnesium, Potassium, and Zinc. I am requesting documentation on whether any of these or similar essential substances have been evaluated for addition to the water supply, including the criteria used for their evaluation and the reasons for their inclusion or exclusion.

2 - Medical Experimentation on Human Subjects

According to the U.S. Food and Drug Administration (FDA), the administration of an unapproved drug outside of a clinical setting and without proper oversight constitutes a medical experiment, as defined by federal regulations governing human experimentation. Such activities require compliance with stringent rules to protect the rights and welfare of human subjects, including obtaining informed consent, securing Institutional Review Board (IRB) approval, and adhering to Investigational New Drug (IND) regulations (21 CFR Part 312)

Please provide all records, documents, and communications related to the administration of any unapproved drug by the City of Vancouver to its citizens. Specifically, I am seeking documents

that demonstrate the City's compliance with the following federal regulations and ethical guidelines:

1. Informed Consent Regulations (21 CFR Part 50)

- **Requirement:** Federal regulations mandate that informed consent must be obtained from all individuals before administering any drug, particularly in clinical investigations. This consent must be voluntary, informed, and documented.
- **Request:** Please provide documentation showing that informed consent was obtained from every individual who was administered the unapproved drug, including consent forms, communication records, and any related materials.

2. Protection of Human Subjects (21 CFR Part 50)

- **Requirement:** These regulations protect the rights and welfare of individuals involved in clinical investigations. The regulations require that subjects are treated ethically, with considerations for their safety, privacy, and well-being.
- **Request:** Please provide records that demonstrate how the City ensured the protection of human subjects, including any protocols, procedures, or assessments that were implemented.

3. Investigational New Drug (IND) Regulations (21 CFR Part 312)

- **Requirement:** An unapproved drug can only be administered under an Investigational New Drug (IND) application, which must be submitted to and approved by the FDA. The IND process includes detailed requirements for the safe and ethical administration of the drug, including monitoring and reporting adverse events.
- **Request:** Please provide copies of any approved IND applications, FDA correspondence, or other documentation that authorizes the City to administer the unapproved drug.

4. Institutional Review Board (IRB) Approval (21 CFR Part 56)

- **Requirement:** Any clinical investigation involving human subjects must be reviewed and approved by an Institutional Review Board (IRB). The IRB is responsible for ensuring that the study is ethical and that participants' rights are protected.
- **Request:** Please provide evidence of IRB review and approval for the administration of the unapproved drug, including IRB meeting minutes, approval letters, and any related communications.

5. Compliance with the Food, Drug, and Cosmetic Act (FD&C Act)

- **Requirement:** The FD&C Act prohibits the distribution and administration of unapproved new drugs. Compliance with this law requires that any drug administered to the public must be either FDA-approved or administered under an approved IND.
- **Request:** Please provide documentation confirming compliance with the FD&C Act, including any FDA approvals, authorizations, or other relevant legal documents that permit the administration of the unapproved drug.

Please include any internal communications, external communications with regulatory bodies, meeting minutes, legal opinions, or any other relevant documents that pertain to the above-listed regulations and guidelines.

3 - Adherence to Ethical Guidelines (Nuremberg Code and Belmont Report)

Requirement: The Nuremberg Code is a foundational document in medical ethics, establishing strict guidelines for conducting experiments involving human subjects. The first and most critical principle of the Nuremberg Code is the absolute necessity of voluntary consent. This means that any individual subjected to an experiment must be fully informed of the nature, purpose, duration, and potential risks involved. Consent must be given freely, without any form of coercion, pressure, or undue influence. Additionally, individuals must be allowed to withdraw from the experiment at any time, without penalty or loss of benefits to which they are otherwise entitled.

“The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.”

The last principle of the Nuremberg Code emphasizes the experimenter's responsibility to terminate the experiment if it becomes apparent that continuing could result in injury, disability, or death. This underscores the obligation to prioritize the safety and well-being of participants above all else.

The Belmont Report complements the Nuremberg Code by outlining additional ethical guidelines, particularly the principles of Respect for Persons and Beneficence. These principles reinforce the need for voluntary consent and the requirement to maximize benefits while minimizing harm to participants.

Request: Please provide comprehensive records demonstrating that the City of Vancouver has adhered to these critical ethical principles in the administration of the unapproved drug. Specifically, I am requesting:

1. Documentation of how citizens were fully informed about the drug, including its purpose, potential risks, and the option to freely opt out of participation at any time without any consequences.
2. Copies of internal policies or guidelines that ensure compliance with the first and last principles of the Nuremberg Code, particularly the safeguarding of voluntary consent and the procedures for terminating the administration if it poses any risks.
3. Evidence of any ethical reviews conducted before the drug's administration, as well as records of how the city ensured that all participants could freely withdraw from the process.
4. Any communications or protocols that outline how the well-being and safety of the citizens were prioritized throughout the process.

4 - Violation of Ethical Guidelines (Nuremberg Code and Belmont Report) and Regulatory Compliance

Requirement: The adherence to ethical guidelines and federal regulations is crucial in the administration of any drug, especially an unapproved one. Violations of these principles and regulations can lead to serious consequences, including:

1. Legal Liability:

- Violating the Nuremberg Code: Legal action could be taken against individuals and institutions, potentially leading to civil and criminal penalties if voluntary consent was not obtained or if the drug was administered without necessary safeguards.
- FDA Regulations: Non-compliance with informed consent, IND, and IRB requirements can result in significant legal penalties, including fines and sanctions. There could also be legal repercussions if the FDA's regulations under the Food, Drug, and Cosmetic Act are not followed.

2. Harm to Participants:

- Informed Consent Violations: If participants were not adequately informed or did not have the option to freely opt out, it could result in physical and psychological harm, which may have long-term effects on their health and well-being.
- Non-FDA Approved Drugs: Administration of drugs that are not FDA-approved can pose risks to participants, leading to adverse health outcomes and legal action against the entity administering the drug.

3. Regulatory and Compliance Issues:

- FDA and IND Regulations: Violating these regulations can lead to FDA enforcement actions, including fines, penalties, or restrictions on the ability to conduct future research or administer drugs.
- Documentation and Record-Keeping: Inadequate documentation or failure to follow required processes can result in non-compliance findings during audits or inspections, leading to further legal and regulatory repercussions.

Request: Please provide comprehensive documentation related to how the City of Vancouver is prepared to address these potential consequences, including:

1. **Contingency Plans:** Any documented plans or procedures for managing legal, ethical, and financial repercussions in the event of violations of the Nuremberg Code, FDA regulations, or other ethical guidelines.
2. **Risk Mitigation Strategies:** Records of measures implemented to prevent violations of ethical and regulatory standards, including procedures for promptly addressing and correcting any issues that arise.
3. **Training and Oversight:** Documentation of training programs for City staff and officials regarding ethical standards and regulatory compliance, as well as records of oversight mechanisms in place to ensure adherence to these principles and regulations.

5 - Voluntary Participation and Right to Discontinue

Requirement: According to the Code of Federal Regulations (21 CFR 50.25), participation in any medical experiment, including the administration of an unapproved drug, must be completely voluntary. This regulation mandates that individuals must be informed that they have the right to refuse participation without any penalty or loss of benefits to which they are otherwise entitled. Additionally, participants must be allowed to discontinue their involvement at any time without suffering any penalty or loss of benefits. Given that the drug is being administered through the public water supply—a resource that is inherently difficult to avoid—it is crucial that the City of Vancouver ensures that citizens are fully aware of these rights. Furthermore, the City must provide a clear and accessible means for citizens to opt out, which may include offering alternative sources of water that are fluoride-free.

Request: Please provide detailed documentation demonstrating how the City of Vancouver has complied with the requirement to inform citizens that participation in the administration of this unapproved drug is voluntary. Specifically, I am requesting:

1. Documentation on how the City has communicated to citizens their right to refuse participation without penalty or loss of benefits, including any public notices, informational campaigns, or other outreach efforts.
2. Records of any procedures or policies that allow citizens to discontinue participation in the drug administration, particularly considering the drug is distributed through the public water supply.
3. Documentation on the availability and provision of alternative water sources that are fluoride-free, including the locations of such sources, the criteria for accessing them, and any steps taken to ensure these alternatives are readily accessible to those who wish to opt out.
4. Any measures or protocols that have been implemented to ensure that citizens who choose to opt out can do so effectively and without undue burden, despite the communal nature of the water supply.

6 - Requests to End or Opt Out of the Medical Experiment

Requirement: In accordance with ethical guidelines and federal regulations, individuals participating in a medical experiment have the right to request to end their participation or to opt out at any time, without facing any penalties or loss of benefits. This is especially pertinent when the experiment involves the administration of an unapproved drug through a public resource like the water supply.

Request: Please provide detailed records and documentation related to all requests made by citizens to either end the medical experiment or to opt out of the drug administration through the water supply. Specifically, I am requesting:

1. **Logs of Requests:** A complete log or record of all requests made by citizens to discontinue their participation in the experiment or to opt out of the drug administration. This should include the date and nature of each request, the method by which the request was submitted (e.g., written, verbal, online), and any corresponding documentation.
2. **Response to Requests:** Documentation detailing how each of these requests was handled, including any correspondence or communication between the City and the individual making the request, and the outcome of the request (e.g., whether and how the individual was able to opt out).
3. **Actions Taken:** Records of any actions taken by the City to accommodate those who wished to opt out, such as the provision of alternative water sources or other measures to ensure that the individual's right to opt out was respected and facilitated.
4. **Policies and Procedures:** Copies of any policies, procedures, or guidelines followed by the City in responding to these requests, including how the City ensured compliance with ethical and regulatory requirements in handling such requests.

7 - Request for Public Engagement Records:

I request a comprehensive list of all forums, meetings, surveys, or other opportunities where the public has been invited to share their views and provide input on the City's water fluoridation program. This includes any public hearings, town hall meetings, community discussions, online surveys, or other avenues that have been made available for citizen engagement. Since the fluoridation program is intended solely for the public's benefit and as a service to the taxpayers, it is important to understand how the opinion of the taxpayers funding the program has been solicited and considered in this matter.

8 - Process for Discontinuing Fluoridation:

Please provide comprehensive documentation detailing the legal and procedural steps required to terminate the fluoridation of City water and end any associated involuntary medical experimentation and compulsory medication related to the fluoridation program.

This should include:

1. **Legal Requirements:** All statutes, regulations, and legal requirements that govern the cessation of water fluoridation in the City.
2. **Procedural Steps:** A detailed description of the procedural steps involved in ending fluoridation, including any necessary approvals, notifications, or public hearings.
3. **Documentation:** Any forms, petitions, or official documents required to formally initiate and complete the discontinuation process.
4. **Notifications:** Information on required notifications to regulatory bodies, health departments, and the public regarding the decision to stop fluoridation and related activities.
5. **Implementation Plan:** Guidelines for implementing the cessation of fluoridation, including timelines and responsible parties.

9 - Request for Decision-Maker Information:

1. Please provide a detailed list of all positions within the City that hold the authority to make decisions regarding the continuation or discontinuation of the drug's addition to the water supply. This should include any roles within relevant committees, boards, or governing bodies, as well as any specific City officials or employees with the power to influence or finalize these decisions. Additionally, I request the names of the individuals currently occupying these positions to ensure transparency in the decision-making process.

10 - Ethics Committee Information and Documentation:

I am requesting the following information regarding the City's Ethics Committee:

1. **Committee Members:** Please provide the names, titles, and roles of all current members of the City's Ethics Committee.
2. **Ethical Review Documentation:** I request all memos, reports, meeting minutes, and any other correspondence or documentation produced by the Ethics Committee related to the ethical implications of mass medication through the water supply without obtaining informed consent from the population. This includes any discussions, evaluations, or decisions made concerning the ethicality of such practices.

11 - Potential Conflicts of Interest Among Decision-Makers

1. **Requirement:** Ethical standards and federal regulations require that all decisions related to public health, especially those involving the administration of unapproved drugs, be made without any undue influence or conflicts of interest. Decision-makers involved in these processes must be free from personal, financial, or professional conflicts that could compromise their objectivity and the integrity of their decisions.
2. **Request:** Please provide detailed information and documentation related to any potential conflicts of interest among the decision-makers responsible for the decision to continue adding the drug to the water supply. Specifically, I am requesting:

3. **Conflict of Interest Disclosures:** Copies of all conflict of interest disclosure forms or statements submitted by the decision-makers involved in the process. This should include any financial, personal, or professional interests that could influence their decisions.
4. **Financial Interests:** Documentation of any financial interests, investments, or affiliations that decision-makers may have with companies, organizations, or entities that could benefit from the continued administration of the drug.
5. **Professional Affiliations:** Records of any professional affiliations or relationships that decision-makers have with organizations or individuals who advocate for the use of the drug in the water supply.
6. **Decision-Making Processes:** Documentation outlining the processes and criteria used to ensure that decisions regarding the addition of the drug to the water supply are made impartially and without conflict of interest. This should include any reviews, audits, or oversight mechanisms in place to identify and address potential conflicts.
7. **Actions Taken to Mitigate Conflicts:** Records of any actions taken by the City to mitigate or eliminate identified conflicts of interest, including recusal of decision-makers, reassignment of decision-making responsibilities, or implementation of additional oversight measures.

12 - Request for Public Notifications Regarding Fluoride Exposure Effects

I am requesting copies of all notifications, advisories, public health bulletins, or any other form of communication provided to the public regarding the potential effects of fluoride exposure and advising the public that drinking City water could exacerbate their symptoms and to avoid fluoride to prevent worsening their symptoms of fluoride poisoning / exposure. Specifically, I am interested in information related to the following symptoms and conditions associated with both acute and chronic fluoride exposure:

Acute Fluoride Exposure:

- **Nausea and vomiting:** Common gastrointestinal symptoms that may indicate excessive ingestion of fluoride.
- **Abdominal pain or cramping:** Sharp or persistent pain in the abdomen, often accompanying other digestive disturbances.
- **Diarrhea:** Frequent, loose, or watery stools that can result from ingesting high levels of fluoride.
- **Excessive saliva production:** An increase in saliva flow, which may be a bodily response to fluoride toxicity.
- **Headache:** Fluoride exposure can trigger headaches due to its effects on the nervous system.
- **Sweating:** Profuse sweating as the body tries to expel toxins.
- **General weakness:** A feeling of fatigue or lack of energy, which may accompany other acute symptoms.

- **Tingling or numbness in the face, hands, or feet:** Fluoride toxicity can cause peripheral neuropathy, leading to these sensations.
- **Muscle spasms or tremors:** Involuntary muscle contractions that may result from nervous system involvement.
- **Seizures:** Severe fluoride poisoning can lead to convulsions or seizures.
- **Respiratory issues, such as difficulty breathing:** Shortness of breath or labored breathing due to fluoride's impact on respiratory muscles.
- **Heart issues, such as irregular heartbeat or chest pain:** Potential disturbances in heart rhythm or sharp chest pains.
- **Coma (in severe cases):** In extreme cases, severe fluoride poisoning can lead to loss of consciousness.

Chronic Fluoride Exposure:

- **Dental fluorosis:** White spots, streaks, or pitting on the teeth, particularly in children whose teeth are still developing.
- **Skeletal fluorosis:** Progressive condition characterized by joint stiffness, chronic pain, and calcification of ligaments, potentially leading to immobility.
- **Arthritis:** symptoms include joint pain, swelling, stiffness, and decreased range of motion. May include systemic symptoms like fatigue and fever, and affect joints that bear weight, like knees and hips.
- **Increased risk of bone fractures:** Prolonged fluoride exposure can weaken bones, increasing susceptibility to fractures, especially in older adults.
- **Kidney dysfunction:** Long-term fluoride exposure can impair kidney function, leading to reduced ability to filter waste from the blood.
- **Neurological effects:** Cognitive impairments, including difficulties with concentration, memory loss, and potential impacts on mental processing.
- **Gastrointestinal problems:** Persistent stomach discomfort, pain, and chronic irritation of the gastrointestinal tract.
- **Skin conditions:** Chronic exposure can cause skin rashes, itchiness, and other dermatological reactions.
- **Muscle weakness and fatigue:** Persistent muscle weakness and overall fatigue that could impair daily activities.
- **Endocrine disruption:** Potential impact on thyroid function, possibly leading to hypothyroidism or other thyroid-related conditions.
- **Reproductive issues:** Possible effects on fertility and reproductive health, including impacts on pregnancy outcomes.
- **Developmental effects in children:** Delayed cognitive development, lower IQ, and other developmental challenges in children exposed to high levels of fluoride.
- **Immune system suppression:** Reduced immune function, potentially increasing susceptibility to infections and illnesses.
- **Cardiovascular issues:** Long-term exposure may contribute to high blood pressure, increased risk of heart disease, and other cardiovascular concerns.

- **Increased oxidative stress:** Elevated levels of free radicals in the body, which can lead to cellular damage and chronic health issues.
- **Gastrointestinal inflammation:** Ongoing irritation or inflammation of the stomach lining and intestines, which could lead to chronic digestive issues.
- **Hypercalcemia:** Elevated calcium levels in the blood, leading to symptoms such as kidney stones, bone pain, and abdominal pain.
- **Metabolic bone disease:** Conditions like osteomalacia (softening of the bones) due to disrupted calcium metabolism linked to fluoride exposure.
- **Cognitive and behavioral changes:** Potential for mood disorders, including anxiety and depression, as a result of long-term fluoride exposure.

Please include any documentation that outlines the potential health risks, symptoms to watch for, and any instructions or guidance provided to the public on what actions to take if they suspect fluoride poisoning, the dates these notifications were issued, the means by which they were issued, and the distribution list for these notices.

13 - City Awareness of Fluoride's Health Effects and Mechanisms

I am requesting all documentation, internal communications, studies, and public health bulletins that indicate whether the city has discussed and is aware of the mechanisms by which fluoride exposure can cause cellular and systemic harm. Specifically, I seek information on whether the following health effects and their underlying mechanisms have been addressed by the city:

1. Enzyme Inhibition and Disruption

Fluoride can inhibit and alter the activity of various enzymes in the body. Enzymes are critical for numerous biological processes, and when fluoride interferes with them, it can disrupt normal cellular function. This disruption can lead to several issues:

- **Neurological effects:** Fluoride's ability to cross the blood-brain barrier and inhibit enzymes in the brain can impair cognitive function and lead to neurological symptoms.
- **Immune system suppression:** Fluoride's interference with immune-related enzymes can weaken the immune system, making the body more susceptible to infections.
- **Gastrointestinal problems:** Enzyme disruption in the digestive tract can lead to gastrointestinal inflammation and other digestive issues.

2. Oxidative Stress

Fluoride can induce oxidative stress by generating free radicals, which are highly reactive molecules that can damage cells, proteins, and DNA. Oxidative stress is linked to:

- **Increased oxidative stress:** Chronic fluoride exposure can lead to an imbalance between free radicals and antioxidants, contributing to chronic diseases and cellular damage.

- **Cardiovascular issues:** Oxidative stress is a known factor in the development of cardiovascular diseases, including hypertension and atherosclerosis.

3. Calcium Metabolism Disruption

Fluoride can interfere with calcium metabolism, which is crucial for bone health and many other physiological processes. This disruption can lead to:

- **Skeletal fluorosis:** Excess fluoride can deposit in bones, replacing calcium, which leads to abnormal bone growth, joint stiffness, and pain.
- **Metabolic bone disease:** Disruption of calcium metabolism can result in conditions like osteomalacia, where bones become soft and weak.
- **Hypercalcemia:** Elevated fluoride levels can lead to an imbalance in calcium, causing increased levels in the blood, which can lead to kidney stones, bone pain, and other symptoms.

4. Thyroid Function Impairment

Fluoride can affect the thyroid gland, particularly by interfering with the production and regulation of thyroid hormones. This can result in:

- **Endocrine disruption:** Fluoride can inhibit the synthesis of thyroid hormones, leading to hypothyroidism or other thyroid-related conditions, which can affect metabolism, energy levels, and overall health.

5. Direct Toxicity to Cells

At high levels, fluoride can be directly toxic to cells, leading to:

- **Kidney dysfunction:** The kidneys filter fluoride from the blood, and over time, high fluoride levels can damage kidney tissue, impairing their ability to function properly.
- **Reproductive issues:** High fluoride exposure can negatively affect reproductive cells and tissues, potentially leading to fertility issues and adverse pregnancy outcomes.

6. Interference with Bone and Tooth Formation

Fluoride has a high affinity for calcium and can incorporate into bones and teeth. Fluoride can cause:

- **Dental fluorosis:** Overexposure during tooth development can lead to enamel defects, resulting in white spots or streaks on the teeth.
- **Increased risk of bone fractures:** Fluoride can make bones more brittle, increasing the risk of fractures, especially with chronic exposure.

7. Alteration of Neurotransmitter Function

Fluoride can affect the central nervous system by altering neurotransmitter function, leading to:

- **Cognitive and behavioral changes:** Changes in neurotransmitter levels can contribute to mood disorders, such as anxiety and depression, as well as cognitive impairments, especially in developing children.

Please provide all documentation that shows the city's awareness and discussion of these mechanisms by which fluoride causes cellular and systemic harm. This includes internal communications, health bulletins, studies, and any other relevant information.

Iatrogenic Disease

I am particularly concerned about the potential for iatrogenic diseases—conditions that are inadvertently caused by medical treatment or public health interventions, including water fluoridation. Given that fluoride exposure has been linked to various adverse health effects, I am requesting any documentation, studies, or internal discussions that address the risk of iatrogenic disease resulting from fluoride in the city's water supply. Specifically, I am interested in whether the city has evaluated the possibility that the introduction of fluoride, intended as a preventive health measure, could contribute to the development of conditions such as skeletal fluorosis, thyroid dysfunction, or other chronic illnesses. Please provide all relevant materials that reflect the city's awareness and consideration of these risks in the context of public health.

14 - Additional Program Information

1. Safety

- a. All scientific studies and documents the City is relying on to show that fluoride has been proven safe for pregnant women and infants to consume
- b. All scientific studies and documents the City possesses regarding the impact of fluoride on the IQ of developing children and the neurotoxicity of fluoride
- c. All scientific studies the City is relying on to show that fluoride has been proven safe for ingestion

2. Health & Safety Notices

- a. Please provide all notices, documents, disclosures, photos, literature, or other materials provided to the public related to the following:
- b. Public notifications about fluoride in City water and advice on preventing fluoride overconsumption.
- c. Warnings about the CDC's recommendation not to reconstitute infant formula with fluoridated tap water.
- d. Notices indicating that City water contains fluoride and is not recommended for pregnant women, infants drinking baby formula, and individuals with thyroid or kidney disease.
- e. Notices regarding the presence of lead in City water, including the risk of lead leaching from pipes, solder, and fittings, especially in older buildings.
- f. Disclosures about the potential psychological impact of dental fluorosis on children's development, self-esteem, job performance, and social skills.

3. Drug Prescription / Doctor's orders:

- a. Please provide all written orders or prescriptions in the City's possession, or available to the City, from medical or other professionals related to the addition of fluoridation materials to City water, including:
- b. Orders or prescriptions authorizing the addition of fluoridation materials, specifying the amount and type of chemicals to be used.
- c. Written assurances that the fluoridation of water is safe for the general population and for special groups, such as babies, those with thyroid or kidney disease, diabetes, arthritis, Crohn's disease, and those recovering from cancer.
- d. Advice on contraindications and potential interactions with other medications for those drinking fluoridated water.
- e. Recommendations on the maximum safe quantity of fluoridated water for:
 - i. Individuals with kidney problems.
 - ii. Pregnant women and infants.
 - iii. People with diabetes.
 - iv. Individuals with arthritis.
 - v. Those with Crohn's disease.
 - vi. Athletes who consume more water than average.
 - vii. Laborers who sweat more and drink more water.
- f. Guidance for parents regarding lead levels in drinking water and its safety for children.

4. Source and Supplier Information:

- a. Documents identifying the commercial source or sources from which the City purchases or has purchased fluoridation materials in the last five years
- b. The names of companies providing said materials, their addresses, their telephone numbers, their email addresses, and the names of contact persons who represent said companies.
- c. Any certifications or quality assurances provided by the supplier.
- d. Country of Origin
- e. Name of Supplier
- f. Address and name of Factor(ies) where the fluoride is sourced from
- g. Primary product produced at the address where the fluoride is sourced (ie Phosphate fertilizer production, aluminum production, steel production, glass manufacturing, ceramic manufacturing, petroleum refining, brick manufacturing, tile manufacturing etc.)

5. Fluoride Purification Process:

- a. Documentation of the purification methods used by the supplier for the fluoridation chemical, including details on filtration, chemical treatment, and quality control measures to ensure the fluoride does not contain contaminants

6. Fluoridation Chemicals Used:

- a. Documentation identifying the specific chemicals used and which specific minerals, compounds, and trace elements are contained in the fluoridation materials used in the water fluoridation process in the City.
- b. Material Safety Data Sheets

7. Insurance & Liability Coverage

- a. Provide documents, reports, or correspondence produced, received, or sent which relate to insurance which would cover the City in case of an individual or class action suit for damages based on harm caused by water fluoridation or lead levels caused by fluoridation, including correspondence with insurance organizations or cooperatives including the current dollar limits of insurance coverage.

8. Assays of fluoridation products prior to dilution:

- a. Documents which show the presence of all elements and compounds in raw fluoridation materials, that is assays made of raw fluoridation materials, before they are added to drinking water and are diluted.
- b. Documents which would indicate whether there are any trace amounts of aluminum, arsenic, antimony, asbestos, cadmium, lead, mercury, radium, radon, polonium, barium, beryllium, thallium, or uranium included in the fluoridation materials and the quantities and concentrations of them.

9. Assays immediately after fluoridation:

- a. Documents which show the presence of all elements and chemicals in fluoridation materials, that is assays made of drinking water immediately after fluoridation materials have been added to drinking water.

10. Testing Protocols:

- a. Information on the testing protocols and frequency used to monitor fluoride levels in the water supply, as well as testing for potential contaminants such as heavy metals, radionuclides, organic impurities, and particulate matter.
- b. Provide documents listing the specific contaminants, elements, and compounds for which the City or its subcontractors currently test and have tested for over the last five years.

11. Test Results:

- a. Provide documents identifying the levels of various contaminants, elements, and compounds for which the City tests and has tested over the last five years (the levels below which elements or compounds, even if present are not reported as being present, and which are typically marked “u” on assays) along with the maximum level which the City considers and has considered acceptable.

12. Fluoride’s Caustic Properties on Water System Infrastructure:

- a. It is well-documented that fluoride is a highly reactive and caustic substance capable of dissolving various durable materials. Fluoride can corrode and dissolve metals, including lead, aluminum, steel, and even glass. Additionally, it can break down ceramic materials and react with silicates. These corrosive properties may lead to increased maintenance and replacement costs for infrastructure, as well as higher insurance premiums due to the potential for damage. Given these concerns, I request any documentation or studies in the City’s possession that discuss the potential effects of fluoride on infrastructure and materials, particularly within the water distribution system, and any related increases in maintenance, replacement, or insurance costs.

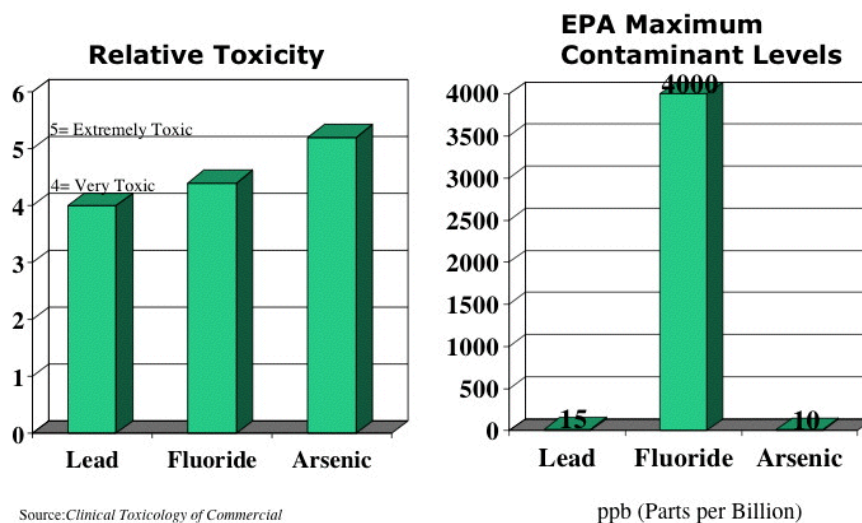
13. Impact of Fluoride and Chloramines on Lead Leaching in Water Systems:

- a. It is well-known that fluoride can interact with lead in water systems through chemical processes that increase the amount of lead dissolved in the water. When fluoride combines with other chemicals such as chloramines, which are commonly used as disinfectants in water treatment, it can create conditions that are more corrosive to lead pipes and fittings. These reactions can dissolve the protective passivation layers—composed of lead(II) oxide or lead carbonate—that naturally form on the interior surfaces of lead pipes, leading to higher levels of lead leaching into the water supply, especially in areas with older infrastructure.
- b. Given these concerns, please provide any available studies, reports, or data on how the presence of fluoride and chloramines in the water supply has been tested for their impact on lead leaching, particularly after contact with lead-containing fittings. Additionally, I seek information on how lead levels have been monitored at the point of consumption in locations known to have lead pipes, including the methods and frequency of testing conducted.

14. Fluoride Toxicity and Regulatory Discrepancies:

- a. It is widely recognized that fluoride is more toxic than lead and only marginally less toxic than arsenic. Despite this, the Environmental Protection Agency (EPA) sets the maximum contaminant level (MCL) for lead at 15 parts per billion (ppb) and arsenic at 10 ppb, while allowing fluoride levels to reach up to 4,000 parts per billion (4 parts per million), which is over 250 times higher than the MCL for lead, which is less toxic, and 400 times higher than arsenic, which is only slightly less toxic.

How Toxic is Fluoride compared to Lead & Arsenic.



- b. Given fluoride's high toxicity, logic suggests that its maximum contaminant level should be at least as strict as that for lead, if not lower. Additionally, it is notable

that fluoride byproducts from the phosphate fertilizer industry, captured through scrubbers to prevent environmental harm because of their toxicity, are often repurposed for water fluoridation.

- c. I request documentation on the City's awareness of these toxicity levels, any evaluations conducted regarding the appropriateness of the EPA's current MCL for fluoride in relation to its toxicity, and any discussions or decisions related to reducing fluoride levels or discontinuing fluoridation in the water supply in light of these concerns.

15. Fluoride Safety and Neurotoxicity:

- a. In its [2022 study](#), the National Toxicology Program (NTP) was unable to determine any safe threshold for fluoride consumption, which was also the case with the NTP analysis on lead toxicity. The NTP concluded with "moderate confidence" that fluoride exposure poses a risk of developmental neurotoxicity based on human studies. When applying the NTP's Office of Health Assessment and Translation (OHAT) methodology, this conclusion supports a "presumed hazard" classification for fluoride's impact on developing brains.
- b. In light of these findings, I request any documents, studies, or communications in the City's possession that refute or challenge the NTP's conclusions, specifically those that argue there is a safe threshold for fluoride consumption and that fluoride is not a developmental neurotoxin.

16. Removal of PFAS and Fluoride Addition:

- a. According to the [City's website](#), the City is actively working to eliminate per- and polyfluoroalkyl substances (PFAS) from the water supply due to their harmful health effects. It is important to note that PFAS are fluoride-containing substances. However, at the same time, the City is adding fluoride to the water in another chemical form. This approach appears contradictory, as both PFAS and the form of fluoride added to the water have been associated with health risks. To better understand the rationale behind these actions, I request any documents, studies, or communications in the City's possession that explain or justify the simultaneous removal of PFAS and the addition of fluoride to the water supply. Specifically, I am interested in any information that addresses the inconsistency in these efforts and any data that could clarify why one fluoride-containing substance is being removed for health reasons while another is being added.

17. Financial Records - Budget & Expenditures:

- a. Please provide records detailing the annual budget allocated to and expenditures on water fluoridation over the past five years. This should include the costs for purchasing fluoridation chemicals and any other related expenses.

18. Delivery Method and spills:

- a. Provide documents identifying the means by which fluoridation materials have been delivered to the City over the past five years, including documents relating to spill prevention and cleanup.
- b. Documents discussing any spills or malfunctions which have occurred in the handling of fluoridation materials since fluoridation began.

19. Fluoridation Protocol:

- a. Documents identifying the protocol for sourcing and procuring fluoridation materials, adding fluoridation materials to drinking water, including but not limited to mixing and dispensing fluoridation materials into drinking water and keeping the fluoridation materials uniformly mixed over time and distance.
- b. Diagrams showing the design and function of the fluoridation equipment.
- c. Documents discussing any instances where fluoride content has not been consistent throughout the water system.

20. Fluoride Insertion Points:

- a. Provide documents identifying the locations where the City inserts fluoridation materials into water.

21. Facility Tour:

- a. Please provide me with a tour of the facilities where fluoridation takes place so that I can observe the fluoridation process and take photographs. The law says that “public records shall be available for inspection,” and the fluoridation facilities themselves are “public records” by definition. Contact me at 360-975-2011 to schedule a tour.

22. Facility Plans:

- a. Documentation regarding any plans to modify, upgrade or install fluoridation facilities

23. Information Sources:

- a. Many information sources exist regarding fluoridation and ongoing research and experimentation is taking place regularly on fluoridation safety, which is relevant to the status of the ongoing fluoridation experiment in the City. See [Information about Fluoride & Water Fluoridation](#)
- b. Provide documents identifying websites, agencies, laboratories, or other organizations and individuals from which the City obtains on an ongoing basis or has obtained in the past or which the City can now obtain information pertaining to the requests and questions posed in this document.
- c. Provide evidence that the City has been reviewing and discussing the latest fluoride research performed since 1956 and evaluating how it pertains to the ongoing water fluoridation program in the City.

24. Decision Background:

- a. Please provide all documents related to the decision to fluoridate the City's water supply. This includes records of those who supported and opposed the fluoridation.
- b. Include historical documents such as newspaper clippings and correspondence related to the discussion and debate over fluoridation from the initial proposal to the present. This should cover each instance when fluoridation was put to a vote, whether by the city council or through public referendum.
- c. Provide a list of individuals who campaigned for or voted in favor of fluoridation who are still alive today.

25. Initiation of Fluoridation:

- a. Please provide all documents prepared or received during the initiation of water fluoridation. This includes, but is not limited to, the following:
- b. Requests and Bids:**
 - i. Requests for construction and maintenance bids.
 - ii. Actual bids and contracts for construction and maintenance.
 - iii. Documents and advice received in response to these requests, including input—both for and against—from bidders, consultants, or other advisers concerning the fluoridation decision.
- c. Fluoridation Facilities Documentation:**
 - i. All documents related to the design, construction, and contracting for the construction of fluoridation facilities maintained by the City, both current and past.
 - ii. Records detailing the cost of construction, financing, and any financial assistance received from entities other than the City for these facilities.
 - iii. Any agreements made with external groups, such as dental associations, regarding the funding or financial support for the construction of fluoridation facilities.

26. Fluoride Communication:

- a. Please provide all written communications related to water fluoridation, including internal communications among City employees and communications with outside parties, dating back to five years before fluoridation was first implemented (1956.) Specifically, I am requesting the following:
- b. Public Correspondence:** All written communications from members of the public expressing support for or opposition to water fluoridation.
- c. Citizen Identifications:** A list of names of all citizens who have expressed either support for or opposition to water fluoridation, noting their stance on the subject.
- d. Internal Communications:** All internal written communications between City employees concerning water fluoridation, including emails, memos, meeting notes, and reports.

27. Additional Correspondence:

- a. Please provide documents and correspondence, dating back to five years before fluoridation was first implemented (1956), received from or sent to the following agencies and organizations:
- b. Federal Agencies:** U.S. Centers for Disease Control and Prevention (CDC), U.S. Environmental Protection Agency (EPA), U.S. Food and Drug Administration (FDA), U.S. Public Health Service (PHS), National Institutes of Health (NIH), Surgeon General.
- c. State Agencies:** Washington State Department of Health (DOH), Washington State Board of Health, or any other agency or official of the state of Washington.
- d. Private and Non-Profit Organizations:** National Sanitation Foundation, American Dental Association (ADA), American Medical Association (AMA), American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), World Health Organization (WHO), National Institute of Dental and Craniofacial Research (NIDCR), Washington Dental Service

Foundation, Washington State Dental Association (WSDA), and any other related private or non-profit group.

I request that all of the information be provided in electronic format if possible. If there are any fees for searching or copying these records, please inform me if the cost exceeds \$50.00.

I request a waiver of all fees for this request because the disclosure of the requested information is in the public interest and in alignment with all of the city's five core values identified in 2021: livability, equity and inclusion, innovation, sustainability and resiliency, and community trust and relationships.

If there are any documents or records that are responsive to this request but are not directly within the City's possession—yet the City has constructive ownership, control, or the legal right to obtain them—I respectfully request that the City take the necessary steps to access these documents. Please include any such documents in the response to this request, ensuring that all relevant information is made available.

In addition to providing the requested documents, please return a copy of this request along with a summary of the response to each request under the respective request. This summary should include:

- A list of all responsive documents that were provided.
- A brief description of the content or nature of these documents.
- An explanation for any portions of the request that were not fulfilled, including the reasons why certain documents were not available, exempt from disclosure, or withheld.

Given that the fluoridation program impacts all citizens of the city, I respectfully request that the results of this FOIA request be made publicly available. Please ensure that the documents and information provided in response to this request are posted on a publicly accessible website such as the City's public records portal. Making this information available to the public will help ensure that all citizens are informed and can engage in the conversation about water fluoridation. Please provide the direct link to the webpage here in the response.

It is not necessary to send all documents if they are repetitive and virtually identical to other records provided. It is acceptable to send a representative sample, provided that the sample does in fact include samples from all types or kinds of sources.

If any part of this request is denied, please provide a detailed explanation for the denial, including the specific legal basis for withholding the information.

I acknowledge that the number of public records requested is significant and will take time to fulfill. I respectfully request a detailed schedule, including:

1. The estimated date when the first set of responsive documents will be provided.

2. The anticipated intervals at which successive documents will be made available.
3. The expected date by which the request will be fully completed.

If you need any clarification regarding this request, please contact me at 360-975-2011 or derekkempp@gmail.com.

Thank you for your assistance in this matter. I look forward to your timely response as required by law.

Sincerely,

Derek Kemppainen
Safe Water Clark County
31404 NE 142nd Ave
Battle Ground, WA 98604
360-975-2011
derekkempp@gmail.com

The NTP report revealed that elevated levels of fluoride in drinking water are linked to lower IQ scores in children, classified fluoride as a "presumed hazard" and found with "moderate confidence" that fluoride exposure leads to developmental neurotoxicity, particularly in children whose developing brains are especially vulnerable. A similar ruling preceded the high-profile policy shifts that followed the NTP's report on lead toxicity, which reshaped regulations on lead in drinking water and led to increased litigation against cities and industries that failed to protect their communities from lead.

Given these findings, it is crucial for the City to carefully consider the long-term neurological health risks posed by continued fluoridation, particularly for vulnerable populations like children. As evidence continues to mount—just as it did with lead—being proactive in protecting public health is not only a legal duty but also the wisest course of action to avoid further unnecessary harm.

I urge the City Council to carefully review these new legal precedents and consider the significant benefits of taking immediate steps to discontinue the fluoridation of our water supply. Under Washington Code 70A.125.210, the cessation of fluoridation requires proper public notice and a legally established process. Therefore, I respectfully recommend that the City initiate the legally required procedure by issuing the attached public notice, which will start a 90-day period before any formal decision to discontinue fluoridation can be made.

Additionally, I respectfully request that the City provide any and all public records showing that it is not in violation of the international, federal, and state laws and regulations as detailed below.

Failure to comply with this cease and desist order, or failure to provide the requested records, may unnecessarily expose the City to legal challenges. Based on the concerns detailed above and in the letter below, I encourage the City to act promptly in the interest of public health and to reduce potential legal risks. Please provide written confirmation of your compliance, along with the requested public records, within 30 days of the date of this letter.

Sincerely,

Derek Kemppainen
Fluoride Action Network
Safe Water Clark County
Washington Action for Safe Water
31404 NE 142nd Ave
Battle Ground, WA 98604
360-975-2011
derekkempp@gmail.com

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FLUORIDE AS A POISON

Fluoride is a Poison According to Washington Law

[RCW 69.38.010](#) defines "poison" to include substances such as arsenic, cyanide, and strychnine, as well as any other substance designated by the Pharmacy Quality Assurance Commission that, when introduced into the human body in quantities of sixty grains (3.9 grams) or less, can cause violent sickness or death.

Sodium fluoride, which is currently being added to the City's water supply, meets the Washington State definition of a poison. The lethal dose (LD50) of sodium fluoride is approximately 52 mg/kg. For an average adult human weighing 154 pounds (70 kg), this lethal dose equates to around 3.64 grams, which is below the 3.9-gram threshold. This amount corresponds to roughly 0.73 teaspoons, or 73 drops, which, when dissolved in water, is less than 100 drops or 1.4 ml.

For children, the lethal dose of sodium fluoride is even more concerning. For an average 1-year-old child weighing about 22 pounds, it is approximately 1.1 grams, and for a 3-year-old child weighing about 33 pounds, it is around 1.7 grams. Washington State Law does not specify the size of the individual, but 3.9 grams of sodium fluoride can cause death in an adult or up to 3.5 1-year-olds or 2.3 3-year-olds. This quantity of fluoride unequivocally meets the definition of a poison under RCW 69.38.010.

A 50-pound (22.68 kg) bag of sodium fluoride contains enough to kill approximately 56,181 average 1-year-old children, 31,145 average 3-year-old children, and provides about 6,226 lethal doses for an average adult. Historically, sodium fluoride has been used as a rat poison due to its high toxicity, with a lethal dose for a rat weighing 300 grams being only 15.6 mg—equivalent to 0.0012 teaspoons or about 1/3 of a drop of liquid.

The intentional introduction of this toxic substance into the public water supply poses a serious threat to public safety and necessitates immediate action to halt such practices.

Intentional Addition of Poison to the Water Supply

[RCW 69.40.030](#) states: "Every person who willfully mingles poison or places any harmful object or substance... in any food, drink, medicine, or other edible substance intended or prepared for the use of a human being... and every person who willfully poisons any spring, well, or reservoir of water, is guilty of a class B felony and shall be punished by imprisonment in a state correctional facility for not less than five years or by a fine of not less than one thousand dollars."

The City's ongoing addition of fluoride to the public water supply is a clear violation of RCW 69.40.030. This statute classifies such actions as a class B felony, carrying severe penalties including imprisonment and substantial fines. Therefore, we formally demand that the City immediately cease the addition of fluoride to the water supply. This notice also serves to inform you of the potential legal liability and personal accountability that may arise if corrective measures are not taken. Failure to comply with this order not only jeopardizes public health but also exposes the City and its officials to significant legal consequences, including prosecution under this law.

FLUORIDE AS AN UNAPPROVED NEW DRUG

Fluoride Classification as a Drug and Lack of FDA Approval

Fluoride, when added to the public water supply, is intended to prevent dental cavities and, as such, falls under the legal definition of a drug. According to 21 U.S.C. § 321(g)(1), a drug is defined as "articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Since the primary purpose of water fluoridation is to prevent tooth decay, fluoride clearly meets this definition.

Despite its classification as a drug, the fluoride compounds used for water fluoridation—such as sodium fluoride and fluorosilicic acid (FSA)—have never been approved by the U.S. Food and Drug Administration (FDA) as safe and effective for this purpose. The FDA requires that all drugs distributed in the United States undergo a rigorous process of evaluation to ensure they meet standards for safety, efficacy, and manufacturing quality. Fluoride compounds added to drinking water have not gone through the FDA's New Drug Application (NDA) process, meaning that they lack the necessary approval to be legally marketed or administered as a drug. This makes fluoride an unapproved new drug under the Food, Drug, and Cosmetic Act, which prohibits the introduction of unapproved drugs into interstate commerce (21 U.S.C. § 355(a)).

Unauthorized Distribution and Administration of a Legend Drug

Fluoride, when added to the public water supply for the purpose of ingestion to prevent dental cavities, fits the legal definition of a legend drug. Under federal law, a legend drug is defined as any medication that requires a prescription from a licensed healthcare professional because it is intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease (21 U.S.C. § 321(g)(1)). Legend drugs carry specific labeling, such as "Rx only" or "Caution: Federal law prohibits dispensing without a prescription," indicating they cannot be legally dispensed without proper authorization.

In 2001, the U.S. Food and Drug Administration (FDA) testified before Congress that fluoride, when used for the prevention of dental disease, is classified as a drug under the Federal Food, Drug, and Cosmetic Act. This statement reinforces the fact that fluoride is considered a drug when used for medical purposes, such as cavity prevention, rather than a mere water additive.

Since fluoride is intended to treat or prevent tooth decay, its addition to the water supply is essentially administering a drug for therapeutic purposes. According to RCW 69.41.030, it is unlawful to sell, deliver, or possess any legend drug without the order or prescription of a

licensed physician, dentist, or other authorized healthcare professional. Given that fluoride in water is distributed without individual prescriptions, it bypasses the regulatory safeguards in place to ensure the responsible and informed use of therapeutic substances.

This lack of individualized medical oversight, along with the FDA's classification of fluoride as a drug, strengthens the argument that the city's fluoridation of the public water supply constitutes unauthorized distribution of a legend drug.

Analysis of the City's Violations of RCW 69.41.030

RCW 69.41.030 clearly outlines the legal framework for the sale, delivery, possession, and use of legend drugs. Fluoride intended for ingestion, as used by the City in its water supply, falls under the definition of a legend drug. Here's how the City's actions violate this statute:

1. Unlawful Delivery Without Prescription

RCW 69.41.030(1) states: "It shall be unlawful for any person to sell or deliver any legend drug... except upon the order or prescription of a physician... or other licensed professionals as outlined in this section." Fluoride is being delivered to all citizens through the public water supply without any individual prescriptions from licensed healthcare providers. This widespread, unregulated distribution of a legend drug directly contravenes the statute, which requires that legend drugs be prescribed or ordered by a licensed medical professional for individual use.

To demonstrate compliance with this law, please provide all written orders or prescriptions in the City's possession, or available to the City, from medical or other professionals related to the addition of fluoridation materials to City water, including Doctor's orders or prescriptions authorizing the addition of fluoridation materials, specifying the amount and type of chemicals to be used.

2. Unlawful Possession of a Legend Drug

Under RCW 69.41.030(1), it is also "unlawful for any person to... knowingly possess any legend drug, except upon the order or prescription of a physician." The City is providing fluoride to the entire population, resulting in citizens unknowingly possessing a legend drug without a prescription. Since the law requires possession to be tied to a licensed provider's order, this practice puts the City in clear violation of the statute.

3. Unlawful Use of a Legend Drug

RCW 69.41.030(1) makes it "unlawful for any person to... knowingly use any legend drug in a public place" without a prescription. Fluoride is being ingested by citizens daily through the public water supply, which is a form of use. The law specifically defines "use any legend drug" as introducing the drug into the body "by injection, inhalation, ingestion, or any other means"

under RCW 69.41.030(4). Since the fluoride is ingested without individual prescriptions, the City is effectively facilitating the unlawful use of a legend drug by its residents.

4. Circumvention of Authorized Distribution Channels

The statute provides limited exceptions for the sale, delivery, and possession of legend drugs, such as when handled by licensed professionals or in cases of specific programs like drug take-back initiatives (RCW 69.41.030(1)). The City's broad fluoridation practice does not fall under any of these exceptions. It is not being handled by licensed pharmacists, physicians, or drug wholesalers, nor is it part of any authorized public health program for individual prescriptions. Therefore, this unauthorized distribution and use further breaches the legal distribution framework established by RCW 69.41.030.

5. Lack of Medical Oversight

RCW 69.41.030 emphasizes that legend drugs can only be distributed with "the order or prescription" of a healthcare professional licensed under various chapters of Washington law (such as physicians, dentists, and osteopathic surgeons). The City's method of adding fluoride to the water bypasses these medical professionals entirely, meaning there is no oversight, diagnosis, or consideration of individual medical needs. This constitutes a violation of the statute's requirement for healthcare provider involvement in legend drug distribution and use.

6. Class B Felony for Unlawful Sale or Delivery

According to RCW 69.41.030(2)(a), "A violation of this section involving the sale, delivery, or possession with intent to sell or deliver is a class B felony punishable according to chapter 9A.20 RCW." Since the City is effectively delivering fluoride—classified as a legend drug—without prescriptions or orders, this illegal delivery could be prosecuted as a class B felony. The ongoing distribution through the water system subjects the City to severe legal penalties, including potential imprisonment and fines.

7. Potential for Legal Diversion or Misdemeanor Charges for Possession and Use

While the City's distribution practices raise felony concerns, the ingestion or possession of fluoride without proper medical oversight also poses misdemeanor risks for individuals under RCW 69.41.030(2)(b) and (c). Although RCW encourages prosecutors to divert cases involving knowing possession or use of legend drugs in public places to treatment programs, the violation by the City may escalate the severity of the legal response, considering the widespread impact.

Conclusion

The City's actions surrounding the fluoridation of the public water supply involve several violations of RCW 69.41.030. These include the unlawful delivery, possession, and use of fluoride—classified as a legend drug—without proper prescriptions or medical oversight. Furthermore, these actions may constitute a class B felony, with serious legal implications. Immediate cessation of the City's water fluoridation program is necessary to comply with state law and avoid further legal repercussions.

UNLAWFUL MARKETING OF FLUORIDE

Violation of Prescription Drug Advertising Regulations in City Water Fluoridation Statements

The City's water quality report contains statements that promote fluoride as a dental health additive, such as "Fluoride is added to promote dental health," "Fluoride is an additive for strong teeth," or "Fluoride is added to the water to maintain good dental hygiene." These statements, in the context of water fluoridation, function as advertisements for fluoride's systemic use through public drinking water. However, these claims violate several federal advertising regulations under CFR Title 21 regarding the truthful promotion of prescription drugs. Here's an analysis of how these specific statements from the City violate federal standards:

1. Failure to Disclose Side Effects, Contraindications, and Effectiveness (CFR Title 21, § 202.1(e))

CFR Title 21, § 202.1(e) requires that any promotion of a prescription drug include truthful statements about its side effects, contraindications, and effectiveness. This includes:

- A summary of the major side effects and contraindications for the drug.
- Full disclosure of the drug's potential risks.

Violation:

The City's statement, "Fluoride is added to promote dental health," implies that fluoride, as added to drinking water, is universally beneficial. However, the City fails to include essential information regarding fluoride's potential side effects, particularly when ingested. There is scientific evidence linking excessive fluoride intake to conditions such as **dental fluorosis**, **skeletal fluorosis**, and concerns about potential neurotoxic effects, particularly in young children.

By not including a comprehensive disclosure about these possible side effects in their water quality reports, the City is omitting critical health information from the public. This failure to inform residents of the risks involved in consuming fluoridated water violates the requirement for a true and complete statement regarding side effects and contraindications.

The statement oversimplifies fluoride's benefits without addressing the real, scientifically supported risks of long-term exposure, which are necessary for informed public understanding.

2. Inadequate "True Statement" of Information (CFR Title 21, § 202.1(e)(3))

CFR Title 21, § 202.1(e)(3) mandates that any advertisement or promotion must provide truthful and non-misleading information, ensuring that no essential details or qualifications are omitted.

Violation:

Statements such as “Fluoride is an additive for strong teeth” present an incomplete and overly simplified view of fluoride’s role in dental health. While topical fluoride applications (such as toothpaste) have been shown to benefit tooth enamel, systemic ingestion through water fluoridation is more controversial. The City does not clarify that the benefits of fluoride in drinking water may not apply equally to all residents. Certain populations, such as **infants** and **those with compromised kidney function**, are at greater risk for harm from fluoride ingestion.

Furthermore, the City’s statement provides no qualifications or warnings regarding the variability in fluoride’s effectiveness or its potential risks, particularly for those who may already receive fluoride from other sources (like toothpaste or food). This lack of critical detail makes the City’s statement misleading, as it does not present a full picture of the potential health outcomes of fluoridated water.

By omitting this essential information, the City’s report violates the requirement to provide a true and balanced statement, misleading the public into believing that fluoride ingestion is universally safe and effective.

3. Off-Label or Unsupported Claims (CFR Title 21, § 202.1(e)(4))

CFR Title 21, § 202.1(e)(4) prohibits advertisements from recommending or suggesting uses that are not included in the approved labeling of a prescription drug or supported by substantial clinical evidence.

Violation:

The City’s statements suggest that fluoride, when consumed through drinking water, is an effective method for strengthening teeth and preventing dental disease. However, fluoride’s primary approved use is topical, as in toothpaste or mouth rinses, not systemic via ingestion.

The FDA has never approved fluoride for ingestion as a cavity-prevention drug.

Furthermore, evidence supporting the effectiveness of systemic fluoride in preventing cavities is inconsistent, particularly in populations where topical fluoride products are widely used.

By suggesting that fluoride ingestion through water consumption is a proven method for improving dental health, the City is promoting an off-label use that is not adequately backed by the necessary clinical evidence. This constitutes a violation of the regulations prohibiting unsupported claims.

The City’s endorsement of systemic fluoride for preventing dental disease misrepresents the scientific consensus and violates advertising regulations by promoting an unapproved use of the drug.

4. False or Misleading Effectiveness Claims (CFR Title 21, § 202.1(e)(3)(ii))

CFR Title 21, § 202.1(e)(3)(ii) specifies that all claims about the effectiveness of a prescription drug must be both truthful and specific. Broad, unspecific claims about a drug's general benefits are prohibited.

Violation:

Statements like “Fluoridation: Fluoride is added to promote dental health” and “Fluoride is an additive for strong teeth” imply that fluoridation provides a universal solution to dental health problems. This broad claim is not only overly simplistic but also misleading. Research has shown that the effectiveness of fluoridation can vary significantly based on regional factors, individual health, and age. For example, infants who consume formula mixed with fluoridated water are at higher risk of developing dental fluorosis. Additionally, communities with widespread use of topical fluoride products may receive little to no added benefit from fluoridated water.

The City's broad claims about fluoride's effectiveness in promoting dental health fail to account for these nuances, violating the regulatory requirement for truthful and specific claims. By presenting fluoridation as universally effective without acknowledging its limitations or potential harms, the City is misleading the public and engaging in false advertising.

Conclusion

The City's annual water quality report statements about fluoride—“Fluoride is added to promote dental health” and “Fluoride is an additive for strong teeth”—violate several advertising regulations under CFR Title 21. These violations include the failure to disclose potential side effects, the omission of critical qualifications, the promotion of off-label uses unsupported by clinical evidence, and the use of misleading claims about fluoride's effectiveness. The City must revise its communication regarding fluoridation to provide the public with truthful, complete, and non-misleading information that aligns with federal advertising standards for prescription drugs.

Violation of 21 CFR 202.1(e)(6) Regarding Fluoridation Claims

The City's statement, “Fluoride is added to promote dental health,” **is in clear violation** of 21 CFR 202.1(e)(6). When examined in light of the specific criteria regarding prescription drug advertising, it is evident that the City's representation of fluoride is misleading and non-compliant with federal law.

1. **Misleading Claims and Lack of Substantiated Evidence:** Under 21 CFR 202.1(e)(6)(i), an advertisement is unlawful if it implies that a drug is “better, more effective, [or] useful in a broader range of conditions or patients” without substantial evidence. The City's broad claim that fluoridation universally benefits dental health is demonstrably false and unsupported by the required clinical evidence. Chronic exposure to fluoride poses significant risks, including dental and skeletal fluorosis, directly contradicting the City's claim of general benefit.

2. **Unsubstantiated Comparison with Other Treatments:** In direct violation of 21 CFR 202.1(e)(6)(ii), the City's promotion of fluoride as a dental health strategy implies superiority over alternative measures such as diet-based cavity prevention or topical fluoride use. The City fails to provide the substantial evidence necessary to support the claim that fluoridation is safer or more effective than these alternatives, rendering the claim legally untenable.
3. **Failure to Address Contradictory Information:** The City also violates 21 CFR 202.1(e)(6)(iii) by continuing to promote fluoride's dental benefits while ignoring credible, more recent studies that highlight fluoride's long-term health risks. The disregard for evolving scientific evidence, including neurological and thyroid concerns, further solidifies the City's non-compliance with this regulation.
4. **Selective Presentation of Information:** Under 21 CFR 202.1(e)(6)(iv), the City is prohibited from selectively presenting favorable data while concealing adverse information. The City's omission of fluoride's significant risks, including fluorosis and potential neurotoxicity, constitutes a direct violation of the regulation by misleading the public about the safety of fluoride.
5. **Overstated Generalized Effectiveness:** The City's claim that fluoride "promotes dental health" overstates its effectiveness, in direct violation of 21 CFR 202.1(e)(6)(v). The statement implies a universal benefit, which is patently false and unsupported by substantial evidence, especially considering fluoride's widely documented risks to various vulnerable populations.
6. **Misrepresentation of Supporting Studies:** The City violates 21 CFR 202.1(e)(6)(x) by misrepresenting or failing to disclose that fluoride's benefits are primarily established through topical application, not systemic ingestion through water. By failing to clarify this, the City's statement misleads residents into believing that water fluoridation is effective for dental health, which is not supported by the appropriate evidence.
7. **Failure to Present Unfavorable Data:** The City's representation of fluoride violates 21 CFR 202.1(e)(6)(viii) by presenting only favorable information while ignoring substantial unfavorable data, including growing evidence of harmful long-term effects from fluoride ingestion. This selective reporting misleads the public and fails to meet the standards required by federal law.

Conclusion:

The City's statement that "fluoride is added to promote dental health" is in violation of 21 CFR 202.1(e)(6). The City's failure to provide a fair balance of information, present accurate evidence, and disclose the substantial risks associated with fluoride use constitutes a clear breach of federal law. The City's misleading claims not only disregard the regulation but actively misrepresent the safety and effectiveness of fluoride, putting public health at risk.

UNAUTHORIZED PRACTICE OF MEDICINE

Unauthorized Practice of Medicine Through Water Fluoridation

The City's ongoing addition of fluoride to the public water supply without proper medical licensing, FDA approval, and informed consent constitutes the unauthorized practice of medicine under Washington law. Washington State's RCW 18.71.011 clearly defines the practice of medicine as including administering, prescribing, or advising for any human condition, directly or indirectly. By introducing fluoride into the water supply for the purpose of preventing dental cavities, the City is administering a treatment to all residents without appropriate medical oversight.

Key Points of Violation:

1. Lack of Medical Licensing:

- a. Under RCW 18.71.021, no person or entity may practice medicine without a valid license. The administration of fluoride for the purpose of preventing cavities falls squarely under the scope of medical practice as defined by RCW 18.71.011, which includes "administering or prescribing drugs or medicinal preparations." The City is not a licensed medical provider and, therefore, lacks the authority to prescribe or administer treatments like fluoride. Engaging in such activities without proper licensure is a clear violation of state law.
- b. RCW 18.71.011(2): "A person is practicing medicine if he or she... administers or prescribes drugs or medicinal preparations to be used by any other person."
- c. RCW 18.71.021: "No person may practice or represent himself or herself as practicing medicine without first having a valid license to do so."

2. Absence of Informed Consent:

- a. A fundamental principle of medical practice is obtaining informed consent before administering any treatment. Informed consent requires that individuals are fully informed about the potential benefits, risks, and alternatives of a medical intervention and are given the opportunity to consent or refuse. By adding fluoride to the water supply, the City is administering a treatment without the ability of individuals to provide informed consent, thus infringing on their rights to make autonomous health care decisions.

3. No Individualized Medical Oversight:

- a. Medical treatments should be administered under the guidance of a licensed healthcare professional who can monitor patient outcomes, adjust dosages, and address potential side effects. The blanket administration of fluoride through the water supply eliminates any possibility of individualized care, ignoring the variability in individual health needs and susceptibility to potential adverse effects.

4. Risk of Harm:

- a. The practice of medicine involves careful consideration of the risks and benefits of any treatment. Without proper medical oversight, the risks associated with fluoride ingestion, such as dental fluorosis, potential neurological effects, and other health concerns, are not adequately monitored or managed. This lack of oversight could result in harm to the population, contrary to the ethical obligations of medical practitioners.

Legal and Ethical Implications

The City's unauthorized practice of medicine through water fluoridation violates several key legal and ethical safeguards designed to protect public health. By bypassing licensing requirements, failing to obtain informed consent, and ignoring the need for individualized medical oversight, the City is exposing residents to potential harm without adhering to the standards set by **RCW 18.71.011** and **RCW 18.71.021**. This disregard for medical licensing laws necessitates cessation of fluoridation to comply with state law and protect the public's health and autonomy.

The City is not only violating state laws, but it is also acting in opposition to established ethical standards in medicine that require proper licensing, informed consent, and individualized care. The gravity of these violations warrants swift action to cease the unlawful addition of fluoride to the water supply.

FLUORIDATION AS ILLEGAL MEDICAL EXPERIMENTATION

Illegal Medical Experimentation on Human Subjects

The U.S. Food and Drug Administration (FDA) defines the administration of an unapproved drug, such as fluoride, outside of a controlled clinical setting and without the appropriate oversight, as a form of medical experimentation. According to 21 CFR § 312.3(b), "a clinical investigation" is defined as "any experiment in which a drug is administered or dispensed to, or used involving, one or more human subjects." Fluoridation of public water supplies clearly meets this definition, as it involves the use of a drug (fluoride) on human subjects without individual consent.

Federal regulations outline strict requirements for such experimentation, including obtaining "legally effective informed consent" (21 CFR § 50.20), approval from an Institutional Review Board (IRB) (21 CFR Part 56), and compliance with Investigational New Drug (IND) regulations (21 CFR Part 312). The administration of fluoride in public water fails to meet these regulatory safeguards, constituting an illegal medical experiment on human subjects without their knowledge or consent.

Violation of Informed Consent Regulations

Citation: 21 CFR Part 50

Regulation: "Except as provided in §§ 50.23 and 50.24, no investigator may involve a human being as a subject in research covered by these regulations unless the investigator has obtained the legally effective informed consent of the subject or the subject's legally authorized representative" (21 CFR § 50.20).

Violation: The City has failed to obtain "legally effective informed consent" from individuals

before administering fluoride through the public water system. Fluoride, an unapproved drug, is being distributed without any form of voluntary, informed, or documented consent, in direct violation of the informed consent requirement under federal regulations.

Failure to Protect Human Subjects

Citation: 21 CFR Part 50

Regulation: "In seeking informed consent, the following information shall be provided to each subject: (1) A statement that the study involves research, an explanation of the purposes of the research and the expected duration of the subject's participation, a description of the procedures to be followed, and identification of any procedures which are experimental" (21 CFR § 50.25(a)(1)).

Violation: No such information was provided to the public regarding the nature of fluoride administration as an experimental procedure. Without any disclosure or explanation of the risks, purpose, or procedure, the City failed to protect the human subjects involved, violating the basic tenets of ethical treatment under the federal human subject protection regulations.

Non-Compliance with Investigational New Drug (IND) Regulations

Citation: 21 CFR Part 312

Regulation: "A sponsor shall not begin a clinical investigation subject to § 312.2(a) until the IND is in effect" (21 CFR § 312.40).

Violation: Fluoride is being administered without an approved Investigational New Drug (IND) application, and no such application has been filed or granted by the FDA. The City has not followed the required procedures for the safe and ethical administration of an investigational drug, including "monitoring the progress of the investigation and reporting adverse events" (21 CFR § 312.50). This non-compliance constitutes a clear breach of the IND regulations.

Lack of Institutional Review Board (IRB) Approval

Citation: 21 CFR Part 56

Regulation: "An IRB shall review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by this part" (21 CFR § 56.109(a)).

Violation: There has been no review or approval from an Institutional Review Board (IRB) regarding the administration of fluoride. The City failed to seek IRB approval, which is necessary for the protection of human subjects involved in any clinical investigation. No records of IRB involvement, such as meeting minutes or approval letters, exist, making the City's actions non-compliant with 21 CFR Part 56.

Violation of the Food, Drug, and Cosmetic Act (FD&C Act)

Citation: FD&C Act, 21 U.S.C. § 355

Regulation: "No person shall introduce or deliver for introduction into interstate commerce any new drug, unless an approval of an application... is effective with respect to such drug" (21 U.S.C. § 355(a)).

Violation: The City is introducing fluoride, an unapproved drug, into the public water supply

without an approved New Drug Application (NDA) or IND. Under the FD&C Act, any new drug must have FDA approval before distribution. By bypassing these requirements, the City is in direct violation of federal law, as there is no evidence of FDA approval or authorization for the mass administration of fluoride.

Violation of Nuremberg Code and Belmont Report Ethical Guidelines

Requirement: The Nuremberg Code serves as a cornerstone in medical ethics, establishing standards for conducting experiments involving human subjects. Foremost among these is the unequivocal necessity of voluntary consent. It is imperative that individuals subjected to any experimental procedure, such as the fluoridation of drinking water, are fully informed of the experiment's nature, purpose, duration, and potential risks involved. Consent must be obtained freely, without coercion, pressure, or undue influence. Moreover, individuals must retain the right to withdraw from the experiment at any time without penalty or loss of benefits.

Legal Text:

"The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment. The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity."

The final principle of the Nuremberg Code mandates that the experimenter bears the responsibility to terminate any procedure that poses a risk of injury, disability, or death to the participant, emphasizing the paramount importance of prioritizing the safety and well-being of the public.

The Belmont Report further supports the Nuremberg Code by outlining essential ethical principles, specifically those of Respect for Persons and Beneficence. These principles reaffirm the necessity of voluntary consent and the obligation to maximize benefits while minimizing harm to individuals.

Status: The City has failed to adhere to these critical ethical standards in its fluoridation program. Citizens were not adequately informed about the nature, purpose, and potential risks of fluoride addition to their drinking water, nor were they made aware of their right to freely opt out. There exists a conspicuous absence of documentation and internal policies that ensure the attainment of voluntary consent or procedures for terminating the fluoridation process in light of emerging risks. Moreover, there is no evidence of ethical reviews conducted prior to the

initiation of fluoridation, nor are there records indicating that residents were afforded the opportunity to withdraw from participation in this process. The lack of communication or protocols to prioritize the health and safety of the citizens during this program is similarly alarming.

Violation of Ethical Guidelines (Nuremberg Code and Belmont Report) and Regulatory Compliance

Requirement: Strict adherence to ethical guidelines and federal regulations is imperative in the administration of any drug, especially one that is unapproved. Breaches of these principles can lead to severe consequences, including:

- **Legal Liability:**
 - Violations of the Nuremberg Code could result in legal actions against individuals and institutions, exposing them to civil and criminal penalties for failing to secure voluntary consent or for administering the drug without appropriate safeguards.
 - Non-compliance with FDA regulations regarding informed consent, Investigational New Drug (IND) applications, and Institutional Review Board (IRB) requirements may lead to substantial legal repercussions, including fines and sanctions. There could also be ramifications for failure to adhere to the FDA's regulations under the Food, Drug, and Cosmetic Act.
- **Harm to Participants:**
 - If participants were not adequately informed or denied the opportunity to opt out freely, this could result in significant physical and psychological harm, potentially leading to long-term adverse effects on their health and well-being.
 - The administration of unapproved drugs presents inherent risks, which may culminate in detrimental health outcomes for individuals exposed to such substances.
- **Regulatory and Compliance Issues:**
 - Violations of FDA and IND regulations may result in enforcement actions by the FDA, including fines, penalties, or restrictions on the ability to conduct future research or administer drugs.
 - Inadequate documentation or failure to adhere to required protocols can result in findings of non-compliance during audits or inspections, exposing the city to further legal and regulatory consequences.

Status: The City has notably failed to address these potential repercussions. There are no documented contingency plans or procedures to manage the legal, ethical, and financial ramifications associated with violations of the Nuremberg Code, FDA regulations, or other ethical guidelines. Risk mitigation strategies to prevent violations of these standards are absent, and there are no records indicating measures to promptly address and rectify issues as they arise. Additionally, there exists a lack of documentation regarding training programs for City staff and officials concerning ethical standards and regulatory compliance, as well as an absence of oversight mechanisms to ensure adherence to these crucial principles and regulations.

Voluntary Participation and Right to Discontinue

1. **Requirement:** Under the Code of Federal Regulations (21 CFR 50.25), participation in any medical experiment, including the administration of unapproved drugs, must be entirely voluntary. This regulation mandates that individuals be informed of their right to refuse participation without incurring penalties or losing benefits. Furthermore, participants must retain the right to discontinue their involvement at any time without facing adverse consequences. Given that fluoride is administered through the public water supply—a resource that is inherently difficult to avoid—it is crucial for the City to ensure that citizens are fully aware of these rights and provide clear, accessible options for opting out, which may include offering alternative sources of fluoride-free water. Additionally, individuals participating in such medical experiments have the right to request to end their participation or opt out at any time without facing penalties or loss of benefits.
2. **Status:** The City has not adequately informed citizens about their rights to refuse participation or discontinue their involvement in the fluoridation program. There is a noticeable lack of evidence showing that the City has provided alternative fluoride-free water sources or that citizens have been given clear and accessible means to opt out. Moreover, the City has not demonstrated sufficient procedures for handling requests from citizens who wish to end their participation. There are no records indicating how these requests were managed, nor is there evidence of how the City accommodated those who wished to opt out. The absence of policies or procedures for responding to such requests further undermines citizens' ability to exercise their rights, raising concerns about the voluntary nature of their participation in the fluoridation program.

Legal Precedent on Government-Mandated Medication

In the landmark case *Doe v. Rumsfeld*, the court established a crucial precedent regarding government authority to mandate medication. The ruling emphasized that even under emergency conditions such as wartime, the government cannot compel individuals to receive medication with substances that have not been specifically approved for their intended purpose and manner of use. This legal principle underscores that any compulsory medical intervention must be based on substances that have been rigorously evaluated and officially sanctioned for their specific use.

Applying this precedent to the practice of water fluoridation, it is evident that fluoride, as used in public water systems, has not received specific approval for the manner in which it is administered. Fluoride's use in water fluoridation has not undergone the rigorous approval process required for pharmaceuticals or medical treatments. Therefore, compelling individuals to consume fluoride through their drinking water, without its specific approval for this purpose, violates the fundamental legal protections established in *Doe v. Rumsfeld*. This infringement underscores the need for immediate cessation of fluoride addition to ensure that government practices comply with established legal standards for medical interventions.

Violation of the Common Law Right of Self-Determination of One's Body

The City is required to uphold the common law right of self-determination over one's body, a fundamental principle that grants individuals autonomy to make decisions about their own health, including the substances they consume. This right is rooted in case law, such as *Schloendorff v. Society of New York Hospital (1914)*, where Justice Cardozo stated, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body." This principle was further affirmed in *Cruzan v. Director, Missouri Department of Health (1990)*, where the U.S. Supreme Court recognized the right of competent individuals to refuse medical treatment. By adding fluoride to the public water supply without individual consent, the City is effectively mandating a form of medical treatment and infringing upon this fundamental right. Fluoridation does not allow individuals to make an informed choice about ingesting this substance, thereby violating their bodily autonomy and the right to refuse treatment. Despite public health interests, such a measure directly contradicts the established common law right of self-determination, which the City is obligated to protect. Thus, the City's actions disregard these legal precedents and violate individuals' autonomy over their own bodies.

CONSTITUTIONAL RIGHTS INFRINGED

Violation of Constitutional Rights by Water Fluoridation

The practice of adding fluoride to the public water supply represents a flagrant violation of several fundamental constitutional rights. These violations occur on both state and federal levels, infringing upon the principles of personal autonomy, bodily integrity, and the right to make informed medical decisions. Below are the primary constitutional rights that are breached by this practice:

1. Right to Bodily Integrity and Informed Consent

- **Fourteenth Amendment:** The Fourteenth Amendment to the U.S. Constitution protects the right to personal liberty and the right to refuse unwanted medical treatment. The Supreme Court has upheld that individuals have the right to make decisions about their own bodies, including the right to refuse medical treatment. By introducing fluoride into the public water supply without informed consent, the city is effectively imposing a medical intervention on the population without their individual consent, violating this constitutional protection.
- **State Constitutional Rights:** Washington State's constitution, under Article I, Section 7, affirms the right to privacy, stating that "No person shall be disturbed in his private affairs, or his home invaded, without authority of law." Fluoridation of public water supplies infringes upon this right, as it forces individuals to consume a substance without their explicit consent or the opportunity to refuse.

2. Violation of the Right to Privacy

- The right to privacy extends to medical decisions and the right to be free from governmental intrusion in one's personal health choices. Water fluoridation constitutes a mass medical intervention imposed by the government, interfering with individuals' private health decisions. By administering fluoride indiscriminately through the water supply, the city is encroaching upon the private right of individuals to decide whether or not they wish to consume a particular substance for health purposes.
- The concept of medical privacy, including the right to make autonomous health decisions, is a fundamental aspect of the right to privacy. The blanket application of fluoride without regard for individual health needs or preferences ignores the principle that medical treatments should be personalized and voluntarily accepted.

3. Denial of Due Process

- **Substantive Due Process:** The substantive component of the Due Process Clause of the Fourteenth Amendment protects fundamental rights from governmental interference unless there is a compelling state interest. The government must prove that the benefits of water fluoridation outweigh the intrusion on individual rights and that no less intrusive means are available to achieve the same public health goals. However, water fluoridation bypasses less intrusive alternatives such as providing fluoride in other forms (e.g., toothpaste, supplements), directly violating the substantive due process rights of individuals.
- **Procedural Due Process:** The procedural aspect of the Due Process Clause requires that individuals be given notice and an opportunity to be heard before being deprived of a fundamental right. The implementation of water fluoridation fails to provide individuals with adequate notice or the opportunity to opt out of this public health intervention, thus violating procedural due process.

4. Freedom of Choice in Medical Treatments and Religious Beliefs

- The First Amendment protects individual freedom of conscience, including the right to refuse medical treatment based on personal beliefs or religious convictions. Forcing fluoride consumption through the public water supply infringes upon individuals' First Amendment rights if they object to fluoride on moral, ethical, or religious grounds. By not allowing individuals the choice to accept or decline this treatment, the city disregards the diversity of beliefs and values within its population.
- The right to reject medical intervention is a fundamental aspect of personal autonomy. There is an expectation that individuals have the right to consult with medical professionals, weigh the benefits and risks, and make informed choices about their health care. The city's mass administration of fluoride eliminates this choice, assuming a one-size-fits-all approach that ignores individual autonomy and consent. This practice effectively denies citizens the right to make personal decisions regarding their medical care, including the freedom to reject a treatment they do not agree with.
- Furthermore, the right to religious freedom is a cornerstone of individual liberty. Many people hold specific religious or spiritual beliefs that directly conflict with the forced ingestion of fluoride. These beliefs are often deeply rooted in the conviction that the body is sacred and that individuals should have the autonomy to decide what substances they consume.

- **Sanctity of the Body:**
 - For many Christians, the body is considered a temple of the Holy Spirit (1 Corinthians 6:19-20), which should be kept pure and untainted. They may believe that introducing any foreign substances, especially those that are chemically altered or industrial byproducts like fluoride, goes against the biblical mandate to honor and care for their bodies. Forcing individuals to consume fluoride through the public water supply can be seen as a direct violation of this religious duty to maintain bodily sanctity.
- **Adherence to Natural Living:**
 - Various religious and spiritual groups, such as certain denominations within Hinduism, Buddhism, or New Age spiritualities, emphasize a lifestyle in harmony with nature. They advocate for consuming only what is naturally available and avoiding synthetic chemicals or additives. For these individuals, fluoride, especially in its industrial form, is considered an unnatural and potentially harmful substance. Compelling them to ingest it through the water supply infringes upon their religious practice of living naturally and could be seen as an imposition on their spiritual beliefs.
- **Dietary Laws and Purity:**
 - In religions that follow strict dietary laws, such as Judaism and Islam, there are clear guidelines on what substances are permissible for consumption. While fluoride is not explicitly mentioned in these religious texts, its classification as an industrial byproduct or chemical additive lead some adherents to view it as impure or unfit for ingestion. For example, some might argue that fluoride does not meet the standards of "halal" (permissible) or "kosher" (fit) because it is not a natural substance and has not been prepared in accordance with religious dietary laws. Thus, mandatory fluoridation could be perceived as forcing individuals to violate their dietary practices and purity laws.
- **Informed Consent and Moral Autonomy:**
 - Certain religious beliefs, including those of Jehovah's Witnesses and Christian Scientists, emphasize the importance of personal autonomy and informed consent in medical decisions. Jehovah's Witnesses, for instance, are known for their refusal of blood transfusions based on biblical interpretation. Similarly, some may view fluoridation as a form of medical treatment or intervention that requires informed consent, as it is introduced into the body to affect health outcomes (preventing dental cavities). Being forced to consume fluoride without explicit consent infringes upon their religious right to make autonomous decisions about their health and violates their moral conviction that medical treatments should be a matter of personal choice.
- **Alternative Healing Practices:**
 - Some individuals adhere to religious or spiritual traditions that advocate for natural healing and alternative medicine, such as certain sects within Hinduism, naturopathy, or indigenous spiritualities. They may believe in the power of natural remedies and oppose conventional medical practices, including the use of chemicals like fluoride. For them, fluoridation represents an unwelcome intrusion of a medical practice they do not consent to and is incompatible with their religious beliefs in natural health and healing.
- **Summary:**

- Forcing individuals to consume fluoride through the public water system disregards the diversity of religious beliefs that emphasize bodily sanctity, natural living, dietary restrictions, informed consent, and alternative healing. By imposing this practice, the city violates the religious freedom of those who see fluoride consumption as conflicting with their spiritual or moral values. In a society that values freedom of religion, individuals should have the right to decide what they consume based on their beliefs without government interference.

5. Equal Protection Clause Violations

- **Equal Protection Under the Law:** The Fourteenth Amendment guarantees equal protection under the law. The fluoridation of water does not take into account the varying health needs and conditions of different individuals, including those who may be more susceptible to adverse effects from fluoride exposure (such as individuals with certain medical conditions, infants, or the elderly). By mandating a uniform dosage of fluoride for the entire population, the city fails to provide equal protection to those who may suffer disproportionate harm, thus violating the principle that laws and policies should not unfairly discriminate against certain groups.

6. Right to Self-Determination and Autonomy

- **International Human Rights Principles:** Although not directly enforceable in U.S. courts, international human rights norms, such as those outlined in the Universal Declaration of Human Rights, emphasize the right to self-determination and autonomy in health-related decisions. Water fluoridation disregards these principles by removing the individual's ability to make an autonomous decision about fluoride consumption.

Conclusion

The city's practice of adding fluoride to the water supply without individual consent constitutes a serious violation of constitutional rights. It infringes upon the rights to bodily integrity, privacy, due process, and freedom of choice in medical treatments. By mandating fluoride consumption, the city unlawfully overrides individual autonomy and disregards the diverse needs and beliefs of its residents. Immediate cessation of this practice is required to uphold these fundamental rights and protect the public from unauthorized medical intervention. Failure to comply with this notice could result in legal action to rectify these constitutional violations.

Violation of the City's Obligation to Be "Of the People, For the People, and By the People"

The City has a fundamental duty to serve as a government "of the people, for the people, and by the people." This principle, rooted in democratic governance, mandates that city officials act in the best interests of the community, ensuring transparency, public participation, and respect for individual rights. However, the City's decision to fluoridate the public water supply without comprehensive public consent or full disclosure of the associated risks and benefits represents a significant departure from this obligation.

1. **Lack of Informed Consent:** In medical practice, informed consent is a foundational ethical requirement, ensuring that individuals are fully aware of and agree to any treatment they receive. By adding fluoride to the water supply, the City effectively administers a substance to all residents without their explicit consent. This action disregards individuals' right to make informed choices about what substances they consume, particularly when those substances have potential health implications. The universal and compulsory nature of water fluoridation denies residents the autonomy and ability to opt out, thus violating the principle of individual choice in matters of personal health.
2. **Disregard for Public Input:** The City has an obligation to involve the community in decisions that directly affect public health. Fluoridation is a contentious issue, with significant public concern about its safety and efficacy. By implementing water fluoridation without adequate public consultation or a referendum, the City has sidestepped the democratic process. This failure to actively engage with the concerns of its constituents undermines the trust between the government and the people it serves. It suggests a top-down approach that is more reflective of paternalistic governance rather than a government that is responsive and accountable to the will of the people.
3. **Failure to Uphold Public Health Obligations:** A government "for the people" must prioritize public health measures that are safe, effective, and equitable. The City's addition of fluoride to the water supply, without addressing the potential risks and controversies surrounding its use, fails to meet this standard. There are segments of the population, including infants, pregnant women, and individuals with certain medical conditions, for whom fluoride consumption may pose increased health risks. By implementing a one-size-fits-all approach to public health, the City has neglected the nuanced needs of its community, potentially placing vulnerable populations at risk.
4. **Transparency and Accountability:** Being a government "by the people" entails a commitment to transparency and accountability. The City has a duty to provide clear, accessible information regarding its decision-making processes, especially when those decisions impact public health. If the City has not disclosed all relevant information about the source, safety, and efficacy of the fluoride being added to the water supply, it has failed in its duty to maintain an open and honest dialogue with its residents. This lack of transparency not only erodes public trust but also impedes the community's ability to hold the City accountable for its actions.
5. **Ethical and Legal Responsibilities:** The City's actions in fluoridating the water supply must be guided by both ethical principles and legal requirements. By mandating the consumption of fluoridated water without public consent, the City may be infringing on individual rights protected under the Constitution and various legal statutes. This disregard for personal autonomy, public input, and informed consent challenges the ethical and legal foundation upon which a government "of the people" is built.
6. **Conclusion:** In its pursuit of water fluoridation, the City has not acted in a manner that is "of the people, for the people, and by the people." It has imposed a measure that lacks informed consent, disregarded public input, failed to protect vulnerable populations, and neglected its ethical and legal obligations. These actions undermine the very principles of democratic governance and public trust. The City is urged to immediately cease the fluoridation of the public water supply and engage in a transparent, democratic process that respects the rights and concerns of all its residents.

LEGAL PROCESS TO DISCONTINUE FLUORIDATION

Legal Process for Discontinuing Fluoridation Under Washington Code 70A.125.210

Under Washington Code 70A.125.210, the City is required to follow a legally mandated process when making any changes to the fluoridation of the public water supply. This code ensures transparency, public involvement, and proper administrative procedures before the discontinuation of fluoridation can occur.

The process must include the following steps:

1. Issuance of Public Notice:

As the first requirement, the City must notify the public of the intent to discontinue the addition of fluoride to the water supply. This notification must be issued at least 90 days before any formal decision to cease fluoridation is made. The notice should be distributed through official channels, including the City's website, local newspapers, and other media outlets to ensure that all residents are informed.

2. Public Comment Period:

After the public notice is issued, a public comment period must be initiated. This allows residents, health officials, and other stakeholders to provide their input and express concerns or support for discontinuing fluoridation. Public hearings may also be scheduled to provide a platform for direct community engagement.

3. Formal Review and Decision:

Following the 90-day public notice and comment period, the City Council is obligated to review the feedback, assess the available scientific evidence, and make a formal decision regarding fluoridation. This decision should be based on legal, health, and ethical considerations, including the latest scientific findings regarding the risks of fluoride exposure.

4. Compliance with State and Federal Regulations:

Throughout this process, the City must ensure that it complies with both state and federal health regulations, including those set by the Environmental Protection Agency (EPA) and Washington State Department of Health. Any changes to the water treatment process must be documented, and the City must work closely with regulatory bodies to ensure a safe transition away from fluoridation.

The City is legally obligated to initiate this process immediately to begin the orderly and lawful discontinuation of fluoridation in response to the serious health risks that have been identified, as outlined in recent scientific and legal findings. Failure to follow these steps may result in legal challenges and additional liabilities.

CONFLICTS OF INTEREST

Potential Conflicts of Interest Among Decision-Makers and Legal Requirements

Legal Obligation to Avoid Conflicts of Interest:

Federal and state laws, including the Code of Federal Regulations (CFR) Title 21, Part 50 (Protection of Human Subjects), and Washington State's Ethics in Public Service Act (RCW 42.52), mandate that decisions impacting public health, particularly those involving the administration of substances like fluoride—an unapproved drug under the Federal Food, Drug, and Cosmetic Act (FDCA)—must be free from undue influence and conflicts of interest. All decision-makers are required to disclose any personal, financial, or professional conflicts that could compromise the integrity of their decisions, ensuring that public health decisions are made impartially, transparently, and in the best interest of the public.

Concerns Regarding Lack of Transparency:

Currently, there is no available documentation indicating that potential conflicts of interest among decision-makers involved in the decision to fluoridate the public water supply have been addressed or disclosed. While this does not confirm the existence of conflicts, the absence of publicly available records on conflict disclosures, financial interest statements, or professional affiliations raises concerns about the transparency and integrity of the decision-making process.

Call for Disclosure and Compliance:

To uphold public trust and comply with federal and state laws, it is crucial that the City takes proactive steps to ensure that all decision-makers involved in this process are free from any personal or financial interests that could influence their objectivity. The Washington State Ethics in Public Service Act (RCW 42.52.020) specifically prohibits public officers from acting where their personal interests conflict with their public duties. Failure to provide the necessary disclosures could lead to the perception of bias, undermining the legitimacy of the decisions made.

Request for Immediate Action:

I strongly urge the City to ensure that all relevant conflict of interest disclosures are made publicly available and that any potential conflicts are addressed in compliance with the law. This will help protect the integrity of the process and prevent any actions that may later be challenged for ethical breaches. If these steps are not taken, the City may be exposed to legal scrutiny and penalties, including possible civil action under RCW 42.52.480.

FLUORIDE AS HAZARDOUS INDUSTRIAL WASTE

Sources of Fluoride as Industrial Hazardous Waste

Industries that produce fluoride as a byproduct of their manufacturing processes often frame the substance as a "naturally occurring mineral" to downplay its hazardous nature. However, the reality is that fluoride, in various chemical forms such as sodium fluoride (NaF) and fluorosilicic acid (H_2SiF_6), is produced as a toxic industrial waste. Below, we will explore how several major

industries generate fluoride waste, and why these byproducts are neither suitable for reuse in the industries that create them nor in public health initiatives such as water fluoridation.

1. Aluminum Production

Key Inputs:

- **Alumina (Aluminum Oxide, Al_2O_3):** The primary raw material for aluminum production.
- **Cryolite (Sodium Aluminum Fluoride, Na_3AlF_6):** Used as a flux to dissolve alumina and lower its melting point, facilitating the extraction of aluminum.
- **Carbon (C):** Used in the form of carbon anodes to conduct electricity and reduce alumina to aluminum.

Desired Output:

- **Aluminum (Al):** The final product, extracted via an electrolytic process from alumina in molten cryolite.

Waste Products:

- **Sodium Fluoride (NaF):** A toxic byproduct produced during the electrolytic reduction of alumina. It is captured in scrubbers to prevent atmospheric release.
- **Fluoride Gases (e.g., Hydrogen Fluoride, HF):** Released during the process and must be treated due to their hazardous nature.

Why Sodium Fluoride is Not Reusable:

Aluminum production relies on cryolite, which has specific properties that enable the dissolution of alumina at high temperatures. Sodium fluoride, while chemically related to cryolite, lacks the necessary structure and melting properties for aluminum extraction. Furthermore, the fluoride waste produced in aluminum smelting is contaminated with various impurities, rendering it unsuitable for recycling back into the process. This waste must be safely disposed of as it has no value in aluminum production.

2. Phosphate Fertilizer Production

Key Inputs:

- **Phosphate Rock (Calcium Phosphate):** The primary mineral used to create phosphoric acid for fertilizer production.
- **Sulfuric Acid (H_2SO_4):** Reacts with phosphate rock to release phosphoric acid, the essential ingredient for fertilizers.

Desired Output:

- **Phosphoric Acid (H_3PO_4):** Used to produce various phosphate-based fertilizers such as diammonium phosphate (DAP) and monoammonium phosphate (MAP).

Waste Products:

- **Fluorosilicic Acid (Hexafluorosilicic Acid, H_2SiF_6):** A toxic byproduct formed when fluoride is released during the chemical reaction between phosphate rock and sulfuric acid.
- **Calcium Sulfate (Gypsum):** Also a byproduct but less hazardous and often stored in large stacks.

Why Fluoride Byproducts Are Not Reusable:

Fluorosilicic acid is produced during the "wet process" of fertilizer manufacturing, where phosphate rock is treated with sulfuric acid. This fluoride compound is extremely toxic and contaminated with other residues from the fertilizer production process. It has no value for reuse in fertilizer manufacturing or other industrial processes. Instead of being properly disposed of, industries often sell this byproduct for water fluoridation, where it is used despite the risks to public health.

3. Chemical Manufacturing

Key Inputs:

- **Fluorine (F_2):** Used in the production of various fluorine-containing chemicals such as Teflon, refrigerants, and pesticides.
- **Organic and Inorganic Compounds:** Various chemicals that react with fluorine to create products like hydrofluorocarbons (HFCs), fluoropolymers, and other specialty chemicals.

Desired Output:

- **Fluorochemicals:** Products that include refrigerants, non-stick coatings (e.g., Teflon), and other industrial fluorinated products.

Waste Products:

- **Hydrofluoric Acid (HF):** A byproduct of many chemical reactions involving fluorine, used but eventually released as waste.
- **Fluoride Salts (e.g., Sodium Fluoride, NaF):** Produced as waste when fluorine reacts with other elements.

Why Fluoride Byproducts Are Not Reusable:

Fluoride wastes from chemical manufacturing, including hydrofluoric acid and fluoride salts, are produced during the synthesis of fluorinated chemicals. These waste products are heavily contaminated with byproducts of the manufacturing process, including solvents, hydrocarbons, and residual reactants. Once contaminated, the fluoride byproducts cannot be reused in chemical production and must be treated as hazardous waste.

Disposal Cost of Fluoride as Hazardous Waste

Across several industries, including aluminum smelting, fertilizer production, and chemical manufacturing, sodium fluoride and other fluoride compounds are consistently produced as hazardous byproducts rather than useful materials. These fluoride wastes result from industrial processes that require specific inputs—such as alumina, sulfuric acid, and fluorine—for the creation of products like aluminum, fertilizers, and chemicals. Fluoride, once captured, is contaminated with industrial residues and impurities, making it unsuitable for reuse in any productive capacity.

Importantly, sodium fluoride and other fluoride compounds are never produced specifically for public health uses such as water fluoridation or dental treatments. They are always byproducts of larger industrial activities. The industries that produce these fluoride wastes have no financial or technical incentive to recycle them back into their processes. Instead, disposing of fluoride waste as a hazardous material involves significant costs. Proper hazardous waste disposal can range from \$1,000 to \$3,000 per ton, depending on contamination levels and regulatory requirements.

To avoid these costs, many industries sell their fluoride byproducts for use in water fluoridation, effectively repackaging toxic waste as a supplement for drinking water. This practice shifts the burden of managing hazardous waste away from industry and onto municipalities and the public, despite the substantial health risks involved. The use of industrial fluoride byproducts for water fluoridation not only raises serious public health concerns but also circumvents the ethical and legal obligations surrounding proper hazardous waste management.

This practice brings into question the city's responsibility for public safety, as the use of fluoride in public water systems is neither based on medical necessity nor on rigorous safety evaluations but rather on the convenient repurposing of industrial waste.

Contaminants in Fluoride as Raw Hazardous Waste

The fluoride compounds used in water fluoridation, primarily fluorosilicic acid, sodium fluoride, and sodium fluorosilicate, are derived from industrial processes, particularly the production of phosphate fertilizers. These compounds are not purified to the same standards as substances intended for direct human consumption. Instead, they are often captured as byproducts during manufacturing, and their introduction into public water supplies occurs with minimal treatment.

As a result, the fluoride that is added to our drinking water is, in essence, still a form of raw hazardous waste. It retains impurities and contaminants that are inherent to its industrial origins. While regulatory agencies may set acceptable limits for fluoride concentrations in drinking water, the lack of rigorous purification means that these compounds can still contain toxic byproducts from the manufacturing process.

Contaminants commonly found in these fluoride compounds can include:

- **Heavy Metals:** Lead, arsenic, cadmium, mercury, and chromium, which can leach from industrial equipment or during the production process.
- **Radioactive Elements:** Uranium and radium, which can be present in phosphate rock and may remain in the fluoride byproducts.
- **Pesticides and Herbicides:** Residues from agricultural chemicals used in phosphate mining or processing.
- **Solvents:** Organic solvents that may be used in the manufacturing process and could contaminate the fluoride compounds.
- **Acids:** Byproducts like sulfuric acid or phosphoric acid that may remain as contaminants in the final fluoride product.
- **Fluorinated Organic Compounds:** These compounds, including perfluorinated substances, which are known for their persistence in the environment and potential health impacts.

This practice raises significant concerns about public health. By allowing unrefined fluoride to be used in water fluoridation, the City is effectively introducing a hazardous material into the water supply without ensuring it meets the stringent safety and purity standards expected of substances that are consumed by the public. The ethical implications of this practice, particularly regarding informed consent and the potential health risks posed by impurities, must be addressed. The continuation of this practice not only undermines the safety of our drinking water but also contradicts the City's responsibility to protect the health and well-being of its residents.

Fluoride Universally Recognized as Industrial Hazardous Waste

Fluoride is a recognized hazardous byproduct in several major industries, including:

- **Phosphate Fertilizer Production:** Fluorosilicic acid (H_2SiF_6) is captured from the scrubbers in phosphate fertilizer plants as an industrial byproduct.
- **Aluminum Smelting:** Sodium fluoride and other fluoride compounds are generated during the smelting process.
- **Chemical Manufacturing:** Hydrofluoric acid (HF) and fluoride salts (NaF) are produced as waste in the creation of fluorinated chemicals such as refrigerants and non-stick coatings.
- **Glass and Cement Production:** Fluoride emissions are produced during the manufacture of glass and cement.
- **Steel Manufacturing:** Fluoride is a byproduct in steel production through the use of fluxes and other fluoride-bearing materials.
- **Ceramics Industry:** Fluoride emissions are released during high-temperature firing processes when fluorides are used as fluxes.
- **Coal-Fired Power Plants:** Fluoride compounds are captured in flue gas desulfurization systems as a byproduct of coal combustion.
- **Petroleum Refining:** Fluoride-containing waste is generated during catalytic processes used to refine crude oil.
- **Semiconductor Manufacturing:** Hydrofluoric acid (HF) is a waste product from etching silicon wafers during chip production.
- **Brick and Tile Manufacturing:** Fluoride emissions are produced during the firing process when fluorides are used to enhance material melting.
- **Nuclear Industry:** Fluoride waste is generated during the uranium enrichment process, particularly in the form of uranium hexafluoride (UF_6).

Under federal law, these industries are required to capture and dispose of fluoride waste properly due to its classification as a hazardous waste. For example, under 40 CFR §261.24, any waste that contains fluoride concentrations above 4.0 mg/L is classified as toxic waste under the Resource Conservation and Recovery Act (RCRA). In the phosphate fertilizer industry, scrubbers are used to prevent fluoride emissions from polluting the environment, as fluoride is known to harm human health, corrode equipment, and damage ecosystems.

The Clean Air Act (42 U.S.C. §7401) also mandates that industries prevent the release of fluoride emissions into the atmosphere, given the risk of environmental contamination and harm to both human and animal health. Once captured, fluoride must be handled as a hazardous waste due to its toxicity.

The capture of fluoride from industrial processes does not alter its chemical properties—it remains a hazardous waste. Fluoride does not "magically transform" into a harmless substance upon capture; it retains its toxic characteristics. Under the RCRA, the EPA defines hazardous waste as any waste that "may cause, or significantly contribute to an increase in mortality or an increase in serious irreversible, or incapacitating reversible illness" or pose "a substantial

present or potential hazard to human health or the environment when improperly treated, stored, transported, or disposed of" (42 U.S.C. §6903(5)).

Fluoride in Water: Still Hazardous Waste

Despite being captured and processed, fluoride—whether as sodium fluoride or fluorosilicic acid—remains a hazardous substance. The addition of fluoride to the public water supply does not exempt it from these classifications. Under several regulatory frameworks, fluoride added to water still qualifies as hazardous waste:

1. Resource Conservation and Recovery Act (RCRA)

- As per 40 CFR §261.24, any waste that exceeds a concentration of 4.0 mg/L of fluoride, when tested under the Toxicity Characteristic Leaching Procedure (TCLP), is classified as hazardous. The City's addition of sodium fluoride to water risks exceeding this threshold, particularly when considering the accumulation of fluoride over time. This concentration is directly tied to fluoride's potential to cause irreversible health effects such as skeletal and dental fluorosis.

2. Washington State Regulations (WAC 173-303-100 and WAC 173-303-040)

- The Washington State Department of Ecology, under WAC 173-303-100, defines hazardous waste as any substance that exhibits "toxicity, persistence in the environment, or potential for bioaccumulation." Fluoride, due to its high toxicity at elevated concentrations, its persistence in water systems—where it does not naturally degrade—and its bioaccumulation in the human body, clearly meets these criteria, making it classified as hazardous under Washington State law. Fluoride accumulates in bones and tissues over time, leading to adverse health effects such as skeletal and dental fluorosis. Additionally, WAC 173-303-040 prohibits the addition of any substance to the environment that poses a "threat to human health or the environment," which explicitly applies to toxic chemicals like fluoride. The City's addition of fluoride to drinking water falls squarely within this definition of hazardous waste, given its toxic, persistent, and bioaccumulative properties.

3. Safe Drinking Water Act (SDWA)

- The Safe Drinking Water Act (42 U.S.C. §300g-1) sets a maximum contaminant level for fluoride at 4.0 mg/L. While this limit is set for "safe" drinking water, it also acknowledges that fluoride, beyond this concentration, becomes hazardous. The City's addition of fluoride, even in doses intended to remain below this threshold, disregards the fact that fluoride's toxic effects accumulate over time, especially for vulnerable populations such as children, the elderly, and those with compromised health.

4. Toxic Substances Control Act (TSCA)

- The Toxic Substances Control Act (15 U.S.C. §2605) prohibits the distribution of chemicals that pose an unreasonable risk to health or the environment. Fluoride's potential to cause long-term harm, including skeletal fluorosis, thyroid dysfunction, and neurological damage, presents such a risk when added to the water supply. Under TSCA, the City's use of sodium fluoride constitutes

distribution of a hazardous substance without proper risk mitigation, violating federal law.

5. Occupational Safety and Health Administration (OSHA)

- Under 29 CFR §1910.1200, OSHA classifies substances that are toxic or corrosive as hazardous chemicals. Fluoride compounds used in water fluoridation are both toxic and corrosive, requiring strict handling guidelines in the workplace. This same fluoride, when added to drinking water, still retains its hazardous nature, putting not only workers but also the general public at risk of exposure to a chemical deemed hazardous by OSHA.

The City's practice of adding fluoride to the public water system is a clear violation of hazardous waste regulations. Fluoride captured from industries is classified as hazardous due to its toxicity, and this classification does not change once it is introduced into the water supply. By adding sodium fluoride, the City is effectively distributing hazardous waste under federal and state law, in violation of the Resource Conservation and Recovery Act (RCRA), the Safe Drinking Water Act (SDWA), the Toxic Substances Control Act (TSCA), and Washington State hazardous waste regulations. These laws are designed to protect public health and the environment from precisely the kind of risks that fluoride poses. The City must cease this practice or face legal liability for non-compliance with hazardous waste management laws.

Violation of Hazardous Waste Laws: Handling of Fluoride

The City's fluoridation program is not just a public health issue—it is a direct violation of Washington State hazardous waste management laws. Fluoride, which is purchased and added to the public water supply, clearly meets the state's definition of hazardous waste under both the Revised Code of Washington (RCW) and the Washington Administrative Code (WAC). The City's ongoing failure to properly classify, handle, store, and dispose of fluoride demonstrates a disregard for state regulations, endangering both public health and the environment.

Failure to Classify Fluoride as a Hazardous Waste

The Washington State Department of Ecology, under WAC 173-303-100, explicitly defines hazardous waste as any substance that demonstrates "toxicity, persistence in the environment, or potential for bioaccumulation." Fluoride is toxic at concentrations added to water, persistent in water systems where it does not naturally degrade, and bioaccumulates in the human body, particularly in bones and tissues. Despite this, the City has failed to classify fluoride as hazardous waste, as required by WAC 173-303-070(1b):

"Any person who generates or discovers a solid waste on their site must make an accurate determination if that waste is a dangerous waste in order to ensure wastes are properly managed according to applicable dangerous waste regulations."

The City's failure to make an accurate determination of fluoride's hazardous properties constitutes a clear violation of this code.

Violation of Proper Handling and Storage Requirements

In addition to failing to classify fluoride as hazardous waste, the City has also violated requirements for the safe handling and storage of hazardous materials. WAC 173-303-200 mandates that dangerous waste must be managed in a way that "prevents releases to the environment, minimizes exposure to humans, and complies with standards for safe handling and storage."

The City's practice of introducing fluoride directly into the water supply—without any safeguards to prevent exposure or environmental contamination—directly contradicts this legal mandate. There is no evidence that the City has taken any steps to contain fluoride as required by law.

Moreover, WAC 173-303-201 sets strict limits on how long dangerous wastes may be stored. Dangerous wastes cannot be stored for longer than 90 days without specific authorization, and any accumulation of fluoride in storage tanks or containers must adhere to stringent containment guidelines. The City has offered no proof of compliance with these laws, further solidifying its noncompliance.

Improper Disposal of Hazardous Fluoride Waste

State hazardous waste regulations are designed to prevent hazardous substances from entering the environment, which includes air, land, water, and groundwater, as explicitly defined in WAC 173-303-040:

"Environment" means any air, land, water, or groundwater.

WAC 173-303-610 further mandates that hazardous wastes must be disposed of at facilities specifically permitted for such disposal:

"Hazardous waste must be treated, stored, or disposed of at a permitted hazardous waste facility."

Despite this clear requirement, the City is bypassing proper hazardous waste protocols by adding fluoride—a substance that exhibits toxicity, persistence, and bioaccumulation—directly into the public water supply. This is not just a failure in proper waste disposal; it is a direct violation of state law aimed at preventing hazardous waste from entering the environment. The City cannot legally bypass these regulations by introducing hazardous materials like fluoride into the water supply under the guise of fluoridation.

Fluoride's hazardous nature does not change once it is added to water. As a persistent and toxic chemical, it continues to present risks to both human health and the environment. The very purpose of RCW 70.95.010 is to protect public health and the environment through the proper management of hazardous wastes, ensuring that substances like fluoride do not enter the environment—including water supplies—without stringent controls. By failing to adhere to these required disposal protocols, the City has breached its legal duty and is in clear violation of the state's hazardous waste management laws.

Failure to Use Certified Transporters and Maintain Records

Hazardous waste transportation and documentation requirements under WAC 173-303-240 and WAC 173-303-300 further underscore the City's failures.

WAC 173-303-240 requires that hazardous waste be transported by certified hazardous waste transporters. The City's supply of fluoride, however, is likely transported and distributed without the use of certified transporters or following manifest procedures.

"A generator who transports dangerous waste must use a transporter with a valid EPA identification number."

Additionally, WAC 173-303-300 requires a manifest to accompany all shipments of dangerous waste, ensuring proper tracking and compliance with disposal regulations. There is no evidence the City has followed any of these required protocols.

Violations of RCW 70.95.010 – Hazardous Waste Management

The City's fluoridation program is also a direct violation of RCW 70.95.010, which makes clear that hazardous wastes must be managed in a way that protects public health and the environment:

"The legislature finds that the protection of the public health and environment is a matter of public concern and that the management of hazardous wastes is necessary to protect these interests."

The law requires that hazardous wastes like fluoride be carefully controlled, handled, stored, and disposed of to prevent environmental contamination and human exposure. By failing to adhere to these legal standards, the City has endangered its citizens.

Penalties and Corrective Actions

The City's violations of Washington State hazardous waste laws expose it to significant legal and financial consequences. Under RCW 70.95.010, penalties for violations of hazardous waste management laws include fines of up to \$10,000 per violation, per day. Each day that fluoride is improperly handled and introduced into the water supply represents a separate violation.

Immediate corrective actions must be taken to bring the City into compliance with state and federal hazardous waste regulations, including:

- **Proper Classification of Fluoride:** The City must classify fluoride as a hazardous waste under WAC 173-303-070(3) and comply with all associated hazardous waste regulations.
- **Safe Handling and Storage:** Fluoride must be stored in containment facilities designed to prevent environmental release and protect public health, as required by WAC 173-303-200.
- **Permitted Disposal:** Fluoride must be disposed of in a facility permitted to handle hazardous waste, in compliance with WAC 173-303-610.
- **Certified Transport:** The City must use a certified hazardous waste transporter with an EPA identification number for any movement of fluoride, in accordance with WAC 173-303-240.
- **Transparent Recordkeeping:** The City must maintain a manifest for all fluoride-related activities, as required by WAC 173-303-300, to ensure proper tracking and compliance with hazardous waste management laws.

By continuing its current practices, the City is not only violating multiple state regulations, but it is also risking substantial penalties and putting its residents in harm's way. It is imperative that the City cease and desist from adding hazardous waste fluoride to the public water supply and take immediate steps to comply with all applicable hazardous waste management laws.

DUTY TO ENSURE SAFE DRINKING WATER

Violation of Duty to Ensure Safe Drinking Water under RCW 70A.125.060

Under RCW 70A.125.060, the City has a legal obligation to provide a safe and reliable public water system to protect public health. The statute clearly outlines the City's duties to maintain and operate water systems in compliance with all federal, state, and local rules. However, by introducing fluoride—a recognized hazardous substance—into the public drinking water supply, the City is failing to meet the requirements established by law.

Specifically, RCW 70A.125.060(1b)(i-vi) states that Group A public water systems must:

- (i) Protect the water sources used for drinking water.
- (ii) Provide treatment adequate to assure that the public health is protected.
- (iii) Provide and effectively operate and maintain public water system facilities.
- (iv) Plan for future growth and assure the availability of safe and reliable drinking water.
- (vi) Take whatever investigative or corrective action is necessary to assure that a safe and reliable drinking water supply is continuously available to users.

In introducing hazardous fluoride into the water system, the City has breached its duty under these subsections in multiple ways:

1. Failure to protect water sources (as required by (i)): By adding fluoride—a substance that is toxic, persistent, and bioaccumulative—the City has endangered the water source rather than protecting it. Fluoride's persistence in water means that it does not degrade, continuing to pose risks to public health.
2. Inadequate treatment (as required by (ii)): The addition of fluoride does not constitute a protective treatment; instead, it introduces a hazardous chemical into the water supply that remains toxic after treatment. This compromises the safety of the drinking water rather than ensuring it.
3. Ineffective operation and maintenance (as required by (iii)): The City's failure to classify fluoride as hazardous waste, as mandated by WAC and RCW codes, and to properly manage its disposal demonstrates a neglect of effective system operation and maintenance.
4. Jeopardizing future availability of safe drinking water (as required by (iv)): By introducing harmful chemicals into the water system, the City is jeopardizing the long-term safety and reliability of its water sources, violating its obligation to plan for future growth and ensure continued access to clean water.
5. Failure to take corrective action (as required by (vi)): Despite clear evidence of fluoride's hazardous nature, the City has failed to take the necessary investigative or corrective measures to ensure the continuous availability of a safe water supply to users.

The introduction of fluoride into the public water supply without following proper procedures and safeguards directly violates the legal duties set forth under RCW 70A.125.060. The City is required by law to assure that public health is protected through proper treatment and management of the water supply. Instead, the City's actions are introducing a toxic and persistent substance into the drinking water, compromising the very health and safety that these statutes aim to protect.

Violation of WAC 246-290-220: Non-Compliance with ANSI/NSF Standard 61

WAC 246-290-220 mandates that any materials or additives used in drinking water systems that come into substantial contact with the water must conform to ANSI/NSF Standard 61. This standard is essential for ensuring that materials do not release harmful contaminants into the water that could pose public health risks.

ANSI/NSF Standard 61 applies to materials that come into direct contact with potable water, such as pipes, treatment chemicals, and storage tanks. It sets strict limits on the amount of contaminants that these materials can leach into the water, ensuring that levels remain safe for human consumption. The standard defines "substantial contact" as:

"A material in contact with water that has the potential to leach contaminants into the water such that the levels of these contaminants may pose a risk to public health."

In the case of fluoridation, the fluoride additives used are in direct and continuous contact with the water supply, creating an environment where toxic byproducts such as arsenic, lead, and other harmful substances can leach into the water. According to ANSI/NSF Standard 61:

"Materials or additives that have substantial water contact must not release contaminants at levels that would pose a public health concern."

It is well-documented that fluoride is a highly reactive and caustic substance capable of dissolving various durable materials. Fluoride can corrode and dissolve metals, including lead, aluminum, steel, and even glass. Additionally, it can break down ceramic materials and react with silicates.

The fluoride additives used in the city's water system have been shown to release harmful contaminants, including heavy metals, which exceed the public health safety limits outlined in ANSI/NSF Standard 61. This non-compliance constitutes a violation of WAC 246-290-220, as the City has failed to demonstrate that the fluoride it uses does not leach dangerous substances into the water at unsafe levels.

Non-Compliance with WAC 246-290-220

By failing to ensure that the fluoride additives used in the water system meet ANSI/NSF Standard 61, the City is in direct violation of WAC 246-290-220. This lack of compliance is a significant threat to public health, as fluoride additives are introducing harmful contaminants into

the drinking water, which can cause long-term health issues, including cancer, kidney disease, and developmental disorders in children.

PUBLIC HEALTH NOTICES REGARDING FLUORIDE POISONING AND MECHANISMS OF HARM

Failure to Uphold Legal Duty of Public Notification Regarding Fluoride Exposure

Requirement:

The City has a legal obligation to provide timely and accurate notifications to the public regarding the potential effects of fluoride exposure, including guidance on symptoms of fluoride poisoning and recommended actions to take. This obligation is grounded in several statutes designed to ensure the public's right to information about health hazards.

Relevant Laws:

1. **RCW 70.05.050 – Health Officer's Duties** This statute mandates that health officers must "advise the public as to the proper measures to take to protect themselves from health hazards." The continuous administration of fluoride through the public water supply constitutes a health hazard, yet the City has failed to adequately inform residents about its potential risks.
2. **RCW 43.70.510 – Department of Health's Powers** This law grants the Department of Health the authority to implement public health programs and disseminate information about health risks. The lack of comprehensive communication regarding the health implications of fluoride exposure indicates a failure to comply with this legal requirement.
3. **RCW 70.24.022 – Public Health Information** According to this statute, health departments are required to provide public information on health-related issues, including potential effects of exposure to harmful substances. The absence of clear communication about fluoride's health risks signifies a breach of this obligation.
4. **RCW 70.95.060 – Solid Waste Management** This law emphasizes the importance of public notification regarding health risks associated with hazardous substances. Fluoride, when considered a potential health hazard, falls under this requirement, and the City's failure to notify residents breaches this legal duty.

Status:

Despite these legal mandates, the City has not provided adequate notifications or advisories regarding the potential effects of fluoride exposure. There is no evidence of communication to the public about symptoms associated with both acute and chronic fluoride exposure as listed below or guidance on avoiding fluoride to prevent worsening symptoms. This oversight not only undermines the community's right to be informed but also poses significant risks to public health.

Symptoms of Fluoride Poisoning

Acute Fluoride Exposure:

- **Nausea and vomiting:** Common gastrointestinal symptoms that may indicate excessive ingestion of fluoride.
- **Abdominal pain or cramping:** Sharp or persistent pain in the abdomen, often accompanying other digestive disturbances.
- **Diarrhea:** Frequent, loose, or watery stools that can result from ingesting high levels of fluoride.
- **Excessive saliva production:** An increase in saliva flow, which may be a bodily response to fluoride toxicity.
- **Headache:** Fluoride exposure can trigger headaches due to its effects on the nervous system.
- **Sweating:** Profuse sweating as the body tries to expel toxins.
- **General weakness:** A feeling of fatigue or lack of energy, which may accompany other acute symptoms.
- **Tingling or numbness in the face, hands, or feet:** Fluoride toxicity can cause peripheral neuropathy, leading to these sensations.
- **Muscle spasms or tremors:** Involuntary muscle contractions that may result from nervous system involvement.
- **Seizures:** Severe fluoride poisoning can lead to convulsions or seizures.
- **Respiratory issues, such as difficulty breathing:** Shortness of breath or labored breathing due to fluoride's impact on respiratory muscles.
- **Heart issues, such as irregular heartbeat or chest pain:** Potential disturbances in heart rhythm or sharp chest pains.
- **Coma (in severe cases):** In extreme cases, severe fluoride poisoning can lead to loss of consciousness.

Chronic Fluoride Exposure:

- **Dental fluorosis:** White spots, streaks, or pitting on the teeth, particularly in children whose teeth are still developing.
- **Skeletal fluorosis:** Progressive condition characterized by joint stiffness, chronic pain, and calcification of ligaments, potentially leading to immobility.
- **Arthritis:** symptoms include joint pain, swelling, stiffness, and decreased range of motion. May include systemic symptoms like fatigue and fever, and affect joints that bear weight, like knees and hips.
- **Increased risk of bone fractures:** Prolonged fluoride exposure can weaken bones, increasing susceptibility to fractures, especially in older adults.
- **Kidney dysfunction:** Long-term fluoride exposure can impair kidney function, leading to reduced ability to filter waste from the blood.
- **Neurological effects:** Cognitive impairments, including difficulties with concentration, memory loss, and potential impacts on mental processing and reduction in IQ.
- **Gastrointestinal problems:** Persistent stomach discomfort, pain, and chronic irritation of the gastrointestinal tract, also known as irritable bowel syndrome (IBS)

- **Skin conditions:** Chronic exposure can cause skin rashes, itchiness, and other dermatological reactions.
- **Muscle weakness and fatigue:** Persistent muscle weakness and overall fatigue that could impair daily activities.
- **Endocrine disruption:** Potential impact on thyroid function, possibly leading to hypothyroidism or other thyroid-related conditions.
- **Reproductive issues:** Possible effects on fertility and reproductive health, including impacts on pregnancy outcomes.
- **Developmental effects in children:** Delayed cognitive development, lower IQ, and other developmental challenges in children exposed to high levels of fluoride.
- **Immune system suppression and cancer:** Reduced immune function, increasing susceptibility to infections and illnesses, including cancer
- **Cardiovascular issues:** Long-term exposure may contribute to high blood pressure, increased risk of heart disease, heart attacks, and other cardiovascular concerns.
- **Increased oxidative stress:** Elevated levels of free radicals in the body, which can lead to cellular damage and chronic health issues.
- **Gastrointestinal inflammation:** Ongoing irritation or inflammation of the stomach lining and intestines, which could lead to chronic digestive issues.
- **Hypercalcemia:** Elevated calcium levels in the blood, leading to symptoms such as kidney stones, bone pain, and abdominal pain.
- **Metabolic bone disease:** Conditions like osteomalacia (softening of the bones) due to disrupted calcium metabolism linked to fluoride exposure.
- **Cognitive and behavioral changes:** Potential for mood disorders, including anxiety and depression, as a result of long-term fluoride exposure.

FLUORIDE - MECHANISMS OF ACTION FOR HARM

Fluoride's Health Effects and Mechanisms For Harm

Fluoride exposure is associated with numerous negative health effects, including enzyme inhibition, oxidative stress, disruption of calcium metabolism, and impairment of thyroid function. These mechanisms can cause both cellular and systemic harm, affecting critical biological processes.

Given these well-documented health risks, it is crucial that the City demonstrates an awareness and thorough understanding of how fluoride affects public health. Currently, there is no documentation or internal communication showing that the City has adequately addressed or discussed these harmful mechanisms. This lack of acknowledgment reflects an oversight in assessing the full impact of fluoride exposure on residents. It is essential that the City review and assess these risks to ensure it is not compromising public health by continuing its fluoridation practices.

In light of these concerns, I request that the City provide documentation confirming its awareness of fluoride's potential harms, along with any discussions or considerations regarding the associated health effects. If such documentation does not exist, it reflects a critical failure to

understand the far-reaching implications of fluoride exposure. Therefore, the City is urged to cease water fluoridation until these risks are thoroughly evaluated and addressed.

1. Enzyme Inhibition and Disruption

Fluoride inhibits over 100 enzymes throughout the body, affecting a wide range of biological processes critical for maintaining health. Some of the key enzymes disrupted by fluoride include enolase, adenylate cyclase, pyrophosphatase, alkaline phosphatase, glucose-6-phosphatase, phosphoglucomutase, acetylcholinesterase, and catalase. This broad enzymatic inhibition has serious implications for various body systems:

- **Neurological Effects:** Fluoride can cross the blood-brain barrier and inhibit enzymes like enolase and acetylcholinesterase, which are vital for brain function and neurotransmitter regulation. This disruption may result in impaired cognitive function, developmental delays, memory loss, reduced IQ, and increased risk of neurodegenerative diseases such as Alzheimer's and Parkinson's.
- **Immune System Suppression:** Fluoride inhibits superoxide dismutase and catalase, which are essential enzymes in the body's defense against oxidative stress. Inhibition of these enzymes weakens the immune system, reduces the body's ability to neutralize harmful free radicals, and increases susceptibility to infections, inflammation, and chronic illnesses like cancer.
- **Gastrointestinal Problems:** Enzyme disruption in the digestive system, such as the inhibition of amylase, sucrase, and protease, can interfere with the digestion and absorption of nutrients. This may lead to gastrointestinal inflammation, acid reflux, indigestion, diarrhea, and impaired nutrient uptake, which can contribute to malnutrition and other long-term health complications.
- **Skeletal Effects:** Fluoride's inhibition of alkaline phosphatase, an enzyme crucial for bone mineralization, can negatively impact bone health. This disruption may result in weakened bones, increased risk of fractures, and conditions like skeletal fluorosis, where excessive fluoride accumulates in the bones, leading to pain, stiffness, and joint problems.
- **Endocrine Disruption:** Fluoride can interfere with enzymes involved in hormone regulation, such as thyroid peroxidase. Inhibiting this enzyme affects thyroid hormone production, which can lead to hypothyroidism, weight gain, fatigue, and developmental issues, particularly in infants and children.
- **Cardiovascular Impact:** Fluoride also affects enzymes like cytochrome P450, which play a role in metabolizing various substances, including drugs and toxins, within the liver. Inhibition of these enzymes can lead to abnormal cholesterol levels, high blood pressure, and an increased risk of heart disease. Additionally, fluoride may impact enzymes involved in calcium metabolism, contributing to cardiovascular calcification, a factor in atherosclerosis and heart attacks.
- **Reproductive Health:** Enzymes involved in reproductive function, such as aromatase, are also affected by fluoride. Disruption of these enzymes may contribute to fertility issues, hormonal imbalances, and developmental problems in offspring. Research

suggests that fluoride exposure is linked to decreased sperm quality and reproductive toxicity.

- **Respiratory Effects:** Fluoride exposure can inhibit enzymes involved in maintaining healthy lung function, such as elastase, contributing to respiratory issues, chronic bronchitis, and exacerbating conditions like asthma. This is particularly concerning for individuals exposed to fluoride through industrial pollution or occupational hazards.

By disrupting enzymes across multiple organ systems—neurological, immune, digestive, skeletal, endocrine, cardiovascular, reproductive, and respiratory—fluoride poses a far-reaching risk to human health. The cumulative effects of inhibiting these enzymes can lead to a wide array of health problems, both acute and chronic, and raise serious concerns about the safety of fluoride exposure.

2. Oxidative Stress

Fluoride can induce oxidative stress by generating free radicals, which are highly reactive molecules that can damage cells, proteins, and DNA. Oxidative stress is linked to:

- **Increased oxidative stress:** Chronic fluoride exposure can lead to an imbalance between free radicals and antioxidants, contributing to chronic diseases and cellular damage.
- **Cardiovascular issues:** Oxidative stress is a known factor in the development of cardiovascular diseases, including hypertension and atherosclerosis.

3. Calcium Metabolism Disruption

Fluoride can interfere with calcium metabolism, which is crucial for bone health and many other physiological processes. This disruption can lead to:

- **Skeletal fluorosis:** Excess fluoride can deposit in bones, replacing calcium, which leads to abnormal bone growth, joint stiffness, and pain.
- **Metabolic bone disease:** Disruption of calcium metabolism can result in conditions like osteomalacia, where bones become soft and weak.
- **Hypercalcemia:** Elevated fluoride levels can lead to an imbalance in calcium, causing increased levels in the blood, which can lead to kidney stones, bone pain, and other symptoms.

4. Thyroid Function Impairment

Fluoride can affect the thyroid gland, particularly by interfering with the production and regulation of thyroid hormones. This can result in:

- **Endocrine disruption:** Fluoride can inhibit the synthesis of thyroid hormones, leading to hypothyroidism or other thyroid-related conditions, which can affect metabolism, energy levels, and overall health.

5. Direct Toxicity to Cells

At high levels, fluoride can be directly toxic to cells, leading to:

- **Kidney dysfunction:** The kidneys filter fluoride from the blood, and over time, high fluoride levels can damage kidney tissue, impairing their ability to function properly.
- **Reproductive issues:** High fluoride exposure can negatively affect reproductive cells and tissues, potentially leading to fertility issues and adverse pregnancy outcomes.

6. Interference with Bone and Tooth Formation

Fluoride has a high affinity for calcium and can incorporate into bones and teeth. Fluoride can cause:

- **Dental fluorosis:** Overexposure during tooth development can lead to enamel defects, resulting in white spots or streaks on the teeth.
- **Increased risk of bone fractures:** Fluoride can make bones more brittle, increasing the risk of fractures, especially with chronic exposure.

7. Alteration of Neurotransmitter Function

Fluoride can affect the central nervous system by altering neurotransmitter function, leading to:

- **Cognitive and behavioral changes:** Changes in neurotransmitter levels can contribute to mood disorders, such as anxiety and depression, as well as cognitive impairments, especially in developing children.

FLUORIDE AND THE BRAIN

Evidence of Fluoride's Impact on Mental Retardation & Cognitive Development

- Research conducted over the past two decades has raised significant concerns about the impact of fluoride exposure on cognitive development. A notable study published in *Fluoride* in 2000 found that increased fluoride exposure is associated with a marked increase in mental retardation rates. Specifically, the study reported a 21.6% prevalence of mental retardation at fluoride concentrations of 3.14 ppm, compared to only 3.4% at 0.37 ppm (Tianjin, *Fluoride* Vol. 33 No. 2, 2000). Additional research corroborates these findings, indicating that high fluoride levels can adversely affect intelligence in children. For instance, studies by Lu et al. (2000) and Li et al. (1995) observed detrimental effects on intelligence associated with fluoride exposure. Furthermore, the National Research Council (2006) also noted concerns regarding fluoride's potential to lower IQ levels. The growing body of evidence suggesting adverse cognitive effects from fluoride exposure raises serious questions about the safety of its widespread use in water fluoridation programs. These findings underscore the need for a reevaluation of fluoride's safety profile, given its potential impact on public health and cognitive development.

Impact of Fluoride-Induced IQ Loss on Society

- The serious implications of fluoride-induced IQ loss extend beyond individual health, affecting broader societal outcomes. Research has illustrated that even modest reductions in IQ can lead to significant societal challenges. For instance, a decrease in IQ of just 5 points is linked to higher dropout rates in education, increased unemployment, and higher incarceration rates. This drop in cognitive ability also correlates with a rise in divorce rates and an increased need for special education services. Furthermore, societies experiencing reduced average IQ levels often see declines in innovation, with fewer inventors and critical thinkers emerging. This can also impact the arts, resulting in fewer artists and decreased overall excellence in various fields. These negative outcomes highlight the far-reaching consequences of fluoride exposure on cognitive development, emphasizing the importance of reconsidering the use of fluoride in public water supplies to mitigate these broader societal impacts.

INCREASED INFANT MORTALITY AND MISCARRIAGE

Potential Developmental Harm from Fluoride Exposure

- Preliminary studies suggest that fluoride may pose developmental risks beyond merely lowering IQ levels. Emerging evidence indicates that fluoride exposure could be linked to serious health concerns such as miscarriage, premature birth, and increased infant mortality rates. Data comparing fluoridated and unfluoridated countries reveal alarming trends: fluoridated countries experience approximately 6.5 deaths per 1,000 live births, whereas unfluoridated countries have a significantly lower rate of 4.5 deaths per 1,000 live births. These statistics underscore the urgent need for further research to comprehensively assess the developmental and reproductive risks associated with fluoride. The existing preliminary data raise substantial concerns about fluoride's potential impact on public health, emphasizing the necessity for more rigorous investigations before continuing its widespread use in water supplies.

FLUORIDE AND LEAD LEACHING

Concern Over Lead Levels and Fluoride's Potential Role

The City's water supply currently has a lead level of 0.025 mg/L, surpassing the EPA's action level of 0.015 mg/L. This exceedance is concerning as it suggests potential health risks, particularly to vulnerable populations such as children and pregnant women. Studies have demonstrated that fluoride, specifically when combined with water disinfection chemicals, can exacerbate lead leaching from plumbing materials, increasing lead levels in drinking water. For instance, research indicates that the introduction of silicofluorides, a common form of fluoride used in water fluoridation, can significantly elevate lead concentrations by causing lead to leach from plumbing fixtures. This increased risk is highlighted by the findings of the 2007 study by Coplan et al., which reported that communities with fluoridated water show elevated blood lead levels compared to non-fluoridated communities. Given this context, the elevated lead levels in our city's water may be linked to the fluoride additive, raising serious concerns about both its contribution to lead contamination and its impact on public health. Immediate investigation and

action are necessary to address this potential source of contamination and ensure the safety of our water supply.

Elevated Blood Lead Levels Associated with Water Fluoridation

The addition of fluoride to public water supplies has been associated with increased blood lead levels, especially among children in fluoridated areas. Studies have shown that children living in communities with water fluoridation chemicals have significantly higher rates of elevated blood lead levels compared to those in non-fluoridated areas. One study by Coplan et al. (2007) found that the prevalence of children with elevated blood lead levels (PbB > 10 µg/dL) is approximately double in fluoridated communities. This suggests a disturbing link between fluoridation practices and lead exposure in children, raising serious public health concerns.

Furthermore, research has indicated that when FSA is added to water supplies, lead concentrations can spike dramatically. Maas et al. (2007) reported instances where lead levels surged to over 900 parts per billion (ppb) following the addition of FSA. The leaching of lead from plumbing materials is exacerbated by the interaction between fluorosilicates used in water treatment and the lead in pipes and fittings, resulting in increased lead contamination of drinking water.

Additional studies have reinforced this connection between water fluoridation and elevated blood lead levels. Masters and Coplan (1999, 2000) demonstrated that silicofluoride-treated water is associated with increased lead uptake in children, with particularly adverse effects on those living in older homes. The combination of fluoridation and disinfection agents can enhance the corrosion of lead in plumbing materials, leading to greater lead exposure.

While other sources of lead, such as leaded gasoline and canned foods, have decreased over time, the association between water fluoridation and elevated blood lead levels persists, posing a continued risk to public health. Given these findings, the City's practice of adding fluoride to the water supply is not only harmful but may also disproportionately impact vulnerable populations, including children and communities of color, who already face higher risks of lead exposure. This raises ethical and legal concerns, as the City is obligated to protect the health and well-being of all its residents, not to expose them to additional environmental hazards. Immediate action is necessary to cease the addition of fluoride to the water supply to prevent further public health harm and potential legal liability.

ADDITIONAL CONCERNS / SUMMARY VERSION

Quick Overview of Fluoride Concerns (some of which are mentioned elsewhere in this letter)

1. **Topical Benefits vs. Systemic Risks:** The Centers for Disease Control and Prevention (CDC) has acknowledged that fluoride's benefits are primarily topical, meaning there is

no need to ingest fluoride to protect teeth. Delivering fluoride directly to teeth through toothpaste is a safer and more effective method than forced ingestion through water.

2. **Doubtful Impact on Tooth Decay:** The largest survey conducted in the U.S. (over 39,000 children from 84 communities) found negligible differences in tooth decay between fluoridated and non-fluoridated areas.
3. **Fluoride Accumulates in the Body:** Healthy adult kidneys excrete only 50-60% of ingested fluoride daily, with the remainder accumulating in tissues like bones and the pineal gland. Infants and children excrete even less, with up to 80% of ingested fluoride being absorbed into their bones, leading to increased fluoride concentration over a lifetime.
4. **Non-Essential Nutrient:** Fluoride is not an essential nutrient; no diseases, including tooth decay, are caused by a fluoride deficiency. Extensive evidence shows that fluoride can interfere with important biological processes and enzymes, negatively impacting human health.
5. **Health Risks:** Chronic fluoride exposure has been associated with dental and skeletal fluorosis, increased fracture risk, kidney dysfunction, neurological impairments, gastrointestinal issues, skin reactions, muscle weakness, endocrine disruption, reproductive problems, developmental challenges in children, immune suppression, cardiovascular concerns, gastrointestinal inflammation, hypercalcemia, metabolic bone disease, and cognitive and behavioral changes.
6. **No Margin of Safety with Fluoride:** Research indicates that fluoride exposure causes IQ damage at concentrations as low as 1.5 ppm. Considering a standard safety factor of 10, the acceptable fluoridation dose should be no more than 0.015 ppm to ensure safety. This highlights the lack of a sufficient safety margin at the level of .7ppm.
7. **Lack of Individual Monitoring:** Without individual monitoring, some people may unknowingly consume harmful levels of fluoride.
8. **Violation of Informed Consent:** Fluoridating the public water supply violates individuals' right to informed consent, as citizens are not given the option to avoid fluoride ingestion. Adding it to the water supply forces mass medication without individual consent.
9. **Only Medicine added to Water:** Fluoride is the only chemical added to water specifically for medical treatment purposes. All other water treatment chemicals are used solely to enhance the quality or safety of the water.
10. **Fluoride as Industrial Hazardous Waste:** Fluoride used in water fluoridation originates as a toxic industrial byproduct, not as a naturally occurring mineral as commonly portrayed.
11. **EPA Scientists Oppose Fluoridation:** Over 1,500 scientists, engineers, and professionals at the Environmental Protection Agency (EPA) have expressed opposition to water fluoridation, citing significant health risks such as cancer, bone fractures, and neurological damage.
12. **Fluoride as an Unapproved Drug:** Fluoride, intended to prevent tooth decay, is classified as a drug but lacks FDA approval as safe and effective for this use in public water supplies, violating the Food, Drug, and Cosmetic Act.
13. **Lack of Randomized Controlled Trials:** There has not been a single randomized controlled trial demonstrating the effectiveness or safety of water fluoridation. Randomized trials are the standard for assessing the safety and efficacy of any medical treatment. No long-term studies on the safety of ingesting fluoride over a lifetime exist.

14. **Ethical and Legal Concerns:** Adding fluoride to public water raises ethical and legal issues that could increase the risk of legal liability for the City.
15. **Unauthorized Distribution of a Legend Drug:** Fluoride is classified as a legend drug, which requires a prescription, but it is being distributed in public water without individual prescriptions, violating RCW 69.41.030.
16. **Unauthorized Practice of Medicine:** By adding fluoride to the water supply, the City is administering a medical treatment without proper licensing, violating Washington State RCW 18.71.021, which prohibits practicing medicine without a valid license.
17. **Fluoride Classified as a Poison:** Sodium fluoride meets the Washington State definition of poison under RCW 69.38.010, with lethal doses far below the legal threshold for poisons, posing a serious threat, especially to children.
18. **Violations of RCW 69.40.030:** The addition of fluoride to the public water supply may constitute a violation of state law that prohibits the willful mingling of poison in food, drink, or water, which is a Class B felony.
19. **Increased Risk of Lead Exposure:** Fluoride combined with chlorinating agents like chloramine can increase lead leaching from plumbing materials such as brass fittings and soldered joints. Even low levels of lead exposure are known to lower IQ in children, posing a significant health risk.
20. **Local, National & International Rejection:** Many nearby cities, states, and other countries have discontinued or never adopted water fluoridation, citing health, ethical, and environmental concerns.
21. **Fluoride Safety and Neurotoxicity:** Emerging research suggests a possible link between fluoride exposure and neurodevelopmental issues, including reduced IQ in children.
22. **Lack of Public Notice:** The addition of fluoride to the water supply may have been conducted without adequate public notice or the opportunity for citizen input, violating Washington State regulations (RCW 69.40.030).
23. **Questionable Efficacy:** Recent research indicates that the topical application of fluoride is more effective for dental health than ingestion through drinking water, making water fluoridation unnecessary.
24. **Dosage Control Issues:** It is impossible to control the dosage of fluoride individuals receive through water fluoridation, as consumption varies widely among people.
25. **Impact on Vulnerable Populations:** Fluoridation does not account for the varied susceptibility of different population groups, including infants, the elderly, and those with certain medical conditions, to the adverse effects of fluoride.
26. **Environmental Concerns:** The process of fluoridating water has potential environmental implications, including the contamination of ecosystems with industrial-grade fluoride compounds.
27. **Availability of Alternatives:** Fluoride is readily available in toothpaste and other dental products, providing individuals with the choice to use fluoride without mandating its consumption through public water.
28. **Dental Fluorosis Prevalence:** The increase in cases of dental fluorosis in children suggests an overexposure to fluoride, indicating that current levels of water fluoridation are excessive.
29. **Industrial By-product:** The fluoride compounds used in water fluoridation are often by-products of industrial processes, raising concerns about the safety and purity of the substances added to the water.

30. **No Individual Monitoring:** The lack of monitoring of individual fluoride intake means that certain individuals may be exposed to harmful levels of fluoride without their knowledge.
31. **Conflict of Interest:** The promotion of water fluoridation has been influenced by industries that benefit financially from selling fluoride waste products, raising concerns about potential conflicts of interest.
32. **Right to Pure Water:** Citizens have the right to access pure, uncontaminated water. Fluoridation compromises this right by introducing a chemical additive into the water supply.
33. **Financial Burden:** The cost of water fluoridation, including the purchase of fluoride, maintenance, and equipment, places an unnecessary financial burden on the city and its residents.
34. **Fluoride Disposal as Hazardous Waste:** The same fluoride used in water treatment would be considered hazardous waste if disposed of in the environment, raising questions about its safety for human consumption.

APPENDIX:

Additional information regarding fluoride not directly related to violation of state, federal, and international laws and regulations:

Tobacco and Fluoride - A Comparison:

The parallels between the historical promotion of tobacco and the current advocacy for water fluoridation are striking, reflecting a pattern where industries influence public policy and research to downplay potential risks.

1. Industry Influence on Research and Public Policy

- **Tobacco:** The tobacco industry invested heavily in funding research to obscure and downplay the risks of smoking. They sponsored studies that either minimized the link between smoking and health issues like lung cancer or suggested that the evidence was inconclusive. By creating doubt, they aimed to delay regulatory actions and maintain their market.
- **Fluoride:** Similar to the tobacco industry, fluoride proponents, including manufacturers of fluoride products and dental associations, have funded research to support the safety and efficacy of fluoridation. Critics argue that many studies supporting fluoridation fail to address potential risks comprehensively or have conflicts of interest.

2. Manipulation of Public Perception

- **Tobacco:** In the mid-20th century, tobacco companies aggressively marketed cigarettes as safe, with endorsements from respected figures and institutions lending credibility to their claims. Despite mounting evidence of health risks, these endorsements created a facade of safety that delayed public recognition of tobacco's dangers. For decades, the tobacco industry ran advertising campaigns that featured doctors endorsing cigarettes, creating a false sense of safety. They emphasized smoking as a socially acceptable and even health-promoting activity.
- **Fluoride:** Fluoride has been promoted as a vital public health measure, with endorsements from major health organizations like the CDC and the ADA. Public campaigns often present fluoridation as a necessary and completely safe intervention, downplaying or ignoring emerging concerns about its potential risks. The promotion of fluoride in water supplies has been framed as a simple and essential measure to prevent tooth decay, without sufficient discussion of possible side effects, which have contributed to its widespread acceptance despite ongoing concerns about potential risks.
- Both industries have used similar tactics to shape public perception, including the promotion of misleading information and attacks on dissenting voices. The tobacco industry's efforts to portray smoking as a harmless pleasure echo how fluoride proponents often dismiss concerns as unfounded or exaggerated. The result in both cases is a prolonged period where public and regulatory responses lag behind the emerging evidence of harm.

3. Delay in Regulatory Actions

- **Tobacco:** Despite mounting evidence of the dangers of smoking, it took decades for significant regulatory action to be implemented. The tobacco industry lobbied against regulations, delaying warning labels, advertising bans, and public smoking restrictions. The tobacco industry's influence led to a slow regulatory response, allowing the harmful effects of smoking to become more apparent only after decades of widespread use.
- **Fluoride:** Current debates over fluoride show a similar pattern, where despite emerging evidence of potential harm, regulatory bodies and public health agencies continue to support fluoridation based on incomplete or biased data. Regulatory bodies, such as the EPA and FDA, have been slow to re-evaluate the safety of water fluoridation in light of new research suggesting potential health risks, including dental fluorosis and neurological effects. The widespread endorsement of fluoridation by influential organizations has contributed to resistance against revisiting or modifying current policies. Just as the tobacco industry's tactics delayed action on smoking risks, fluoridation advocates are utilizing similar strategies to maintain public endorsement despite growing evidence of adverse effects.

4. Conflicts of Interest and Financial Influence

- **Tobacco:** The tobacco industry had a financial incentive to promote smoking and downplay its risks. They invested in research and public relations to maintain cigarette sales, despite knowing the health consequences.
- **Fluoride:** There are concerns about financial conflicts of interest within organizations that promote fluoride. Dental product manufacturers benefit from the sale of fluoride-containing products, and some health organizations receive funding from these industries. Additionally, water fluoridation reduces the disposal costs for industries producing fluoride as a by-product, creating a financial incentive to endorse its use in public water supplies.

5. Questionable Health Claims

- **Tobacco:** Tobacco companies used to claim that certain cigarette brands were less harmful than others or even beneficial, such as "low-tar" or "light" cigarettes. This was a misleading tactic to maintain consumer confidence and delay the decline in smoking rates.
- **Fluoride:** While fluoride is widely claimed to be essential for dental health, the CDC itself has acknowledged that fluoride's predominant effect is topical rather than systemic. Despite this, systemic water fluoridation continues to be promoted as an effective public health measure. The potential adverse effects, such as dental fluorosis and neurological risks, are often downplayed or ignored in public messaging.

6. Public Health Consequences

- **Tobacco:** The delay in recognizing the dangers of smoking led to millions of preventable illnesses and deaths worldwide. Tobacco-related diseases, such as lung cancer, heart disease, and respiratory illnesses, have had a massive impact on public health.

- **Fluoride:** The potential long-term health consequences of water fluoridation are still being studied. Concerns have been raised about possible links to dental fluorosis, reduced IQ in children, and other health issues. If these risks are substantiated, the failure to critically assess and address them could have significant public health implications.

7. Endorsements and Legitimacy

- **Tobacco:** Endorsements from doctors and health organizations in the past were used to legitimize smoking. This tactic created a false sense of security and delayed public awareness of the health risks.
- **Fluoride:** Endorsements from prominent health agencies like the CDC, ADA, and WHO are used to legitimize fluoridation. Critics argue that these endorsements do not necessarily reflect the latest scientific evidence and may be influenced by historical precedent, financial interests, or institutional inertia.

Conclusion

Both the tobacco and fluoride industries have utilized similar tactics to influence public perception, delay regulatory actions, and maintain their products' status quo. These include funding favorable research, manipulating public messaging, exploiting endorsements from trusted organizations, and minimizing potential health risks. The comparison underscores the importance of critically evaluating public health policies, especially when they involve widespread exposure to substances with potential risks. Historical examples like tobacco serve as a cautionary tale about the need for ongoing scrutiny, transparency, and the willingness to revisit established practices in light of new evidence.

Misrepresentation of Fluoride as a Naturally Occurring Substance and the "Optimal" Level of Supplementation

It is often claimed that the addition of fluoride to public water supplies is merely a means of supplementing what is described as a “naturally occurring mineral” to an “optimal” level. However, this representation is both scientifically misleading and legally concerning.

1. Distinction Between Naturally Occurring Fluoride and Synthetic Fluoride Compounds

While **calcium fluoride (CaF₂)** occurs naturally in some groundwater sources, it is chemically and biologically distinct from the **sodium fluoride (NaF)** and **fluorosilicic acid (H₂SiF₆)** that are commonly used in water fluoridation.

- **Calcium fluoride**, found in natural environments, is much less soluble and significantly less toxic than synthetic fluoride compounds. Its **LD50** is approximately **5,250 mg/kg**, making it about **100 times less toxic** than **sodium fluoride** (LD50 of 52 mg/kg) and **12 times less toxic** than **fluorosilicic acid** (LD50 of 430 mg/kg).
- **Sodium fluoride** and **fluorosilicic acid**, which are the forms added to public water systems, are industrial byproducts and do not occur naturally in water supplies. These chemicals are not benign minerals but are instead classified as hazardous waste under federal regulations due to their toxicity.

2. Fluorosilicic Acid: A Hazardous Byproduct, Not a Mineral

The primary chemical used in water fluoridation, **fluorosilicic acid**, is derived from the scrubbing systems of the phosphate fertilizer industry, where it is captured as a hazardous byproduct of industrial processes. It is not found naturally in any significant amounts and does not occur in a form that can be considered part of a healthy, natural water supply.

By labeling this compound as a "supplement" to achieve an "optimal" level, it conceals its true nature as a hazardous material that is being repurposed into public drinking water. The National Sanitation Foundation (NSF) and the Environmental Protection Agency (EPA) have recognized that fluorosilicic acid contains contaminants, including arsenic, lead, and other heavy metals, which present additional health risks.

3. Misleading Use of "Optimal" Levels

The claim that water fluoridation merely adjusts fluoride to an "optimal" level is based on outdated and non-peer-reviewed assumptions. The concentration of **0.7 mg/L**—the level currently recommended for fluoridation by U.S. authorities—does not take into account modern research highlighting fluoride's cumulative toxicity and the risk to vulnerable populations, including infants, pregnant women, and those with pre-existing health conditions.

Moreover, studies have shown that fluoride, even at so-called "optimal" levels, can have harmful effects on the human body, particularly on brain development in children. A recent ruling in federal court highlighted this risk, stating:

"There is substantial and scientifically credible evidence establishing that fluoride poses a risk to human health; it is associated with a reduction in the IQ of children and is hazardous at dosages that are far too close to fluoride levels in the drinking water of the United States... this risk is unreasonable." (U.S. District Court, NRDC v. EPA)

4. Legal Implications of Misrepresenting Fluoride as a Nutritional Supplement

Under federal law, substances added to the water supply are regulated based on their intended use. The **Food, Drug, and Cosmetic Act** (FDCA) and the **Safe Drinking Water Act** (SDWA) mandate that chemicals added to drinking water for health purposes must be proven both safe and effective. However, fluoride, in the forms used in water fluoridation programs, has never been approved by the Food and Drug Administration (FDA) as a supplement or a drug. The continued use of fluoride under the guise of a supplementing "naturally occurring" substance violates ethical and regulatory standards.

By framing the practice of water fluoridation as a harmless supplementation of natural fluoride, decision-makers may be engaging in deceptive conduct that misrepresents the nature of the substances being added to the water supply. This could lead to **legal liability** for the dissemination of misleading information and for the failure to properly inform the public of the risks associated with fluoride consumption.

Conclusion and Warning

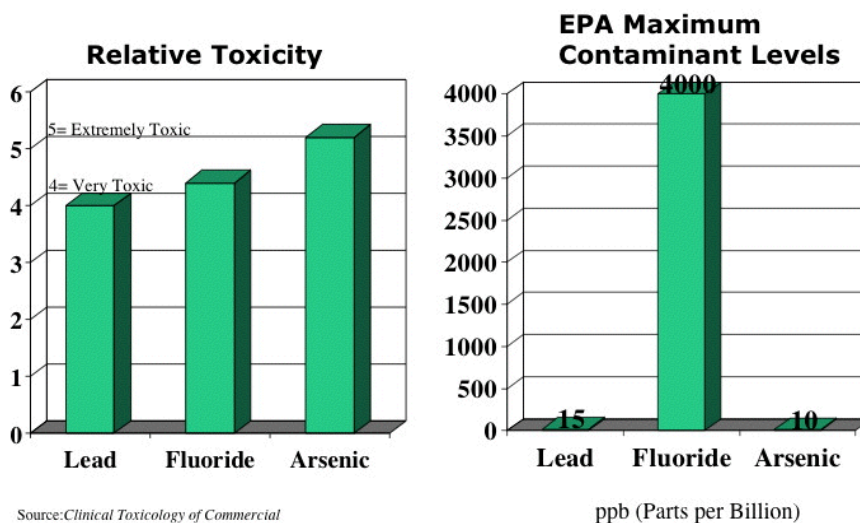
The introduction of industrial fluoride chemicals like **sodium fluoride** and **fluorosilicic acid** into the public water system cannot be justified as merely supplementing a "naturally occurring mineral." These chemicals are far more toxic and present significant health risks, which have been confirmed by credible scientific studies and court rulings. Any attempt to continue promoting this practice without addressing these concerns may result in legal action due to the violation of public health standards, regulatory laws, and the public's right to be informed.

Action Required: The city is advised to immediately cease any claims that fluoridation is merely the supplementation of naturally occurring fluoride to an optimal level. Failure to accurately represent the true nature and risks of water fluoridation chemicals could lead to further liability and legal consequences.

Fluoride Toxicity and Regulatory Discrepancies:

It is widely recognized that fluoride is more toxic than lead and only marginally less toxic than arsenic. Despite this, the Environmental Protection Agency (EPA) sets the maximum contaminant level (MCL) for lead at 15 parts per billion (ppb) and arsenic at 10 ppb, while allowing fluoride levels to reach up to 4,000 parts per billion (4 parts per million), which is over 250 times higher than the MCL for lead, which is less toxic, and 400 times higher than arsenic, which is only slightly less toxic.

How Toxic is Fluoride compared to Lead & Arsenic.



Given fluoride's high toxicity, logic suggests that its maximum contaminant level should be at least as strict as that for lead, if not lower. Additionally, it is notable that fluoride byproducts from the phosphate fertilizer industry, captured through scrubbers to prevent environmental harm because of their toxicity, are often repurposed for water fluoridation.

1. Fluoride Safety and Neurotoxicity:

- a. In its [2022 study](#), the National Toxicology Program (NTP) was unable to determine any safe threshold for fluoride consumption, which was also the case with the NTP analysis on lead toxicity. The NTP concluded with "moderate confidence" that fluoride exposure poses a risk of developmental neurotoxicity based on human studies. When applying the NTP's Office of Health Assessment and Translation (OHAT) methodology, this conclusion supports a "presumed hazard" classification for fluoride's impact on developing brains.
- b. In light of these findings, I request any documents, studies, or communications in the City's possession that refute or challenge the NTP's conclusions, specifically those that argue there is a safe threshold for fluoride consumption and that fluoride is not a developmental neurotoxin.

REJECTION OF FLUORIDATION

Developed Nations worldwide rejecting Fluoridated Water

- In light of growing concerns and emerging evidence, many leading European dental associations and countries have revised or abandoned their recommendations regarding fluoride supplementation. For instance, Austria, Belgium, and Denmark have outright rejected the use of fluoride in public water supplies, citing concerns about toxicity and advocating for personal choice in fluoride consumption. Finland, Germany, and Hungary have stopped recommending or using fluoridation, with recent studies indicating no significant trend in dental caries and questioning the benefits of fluoride. Norway, Sweden, and the Netherlands have also moved to ban or reject fluoride in drinking water, often citing a lack of safety data or legal battles against the practice. Japan has restricted fluoride use to safer calcium-fluoride forms and suspended the addition of industrial by-product fluoride due to potential health risks. Israel has suspended mandatory fluoridation pending further review, and China has implemented a ban on fluoridation. These actions reflect a significant shift in the global perspective on fluoride, underscoring increasing skepticism about its safety and efficacy and highlighting a broader trend away from its use in public health policies.

EFFICACY OF FLUORIDATION

Cost Effectiveness of Fluoridation in Question

- Fluoridation of drinking water has been increasingly questioned for its cost-effectiveness, particularly when the full range of associated costs is considered. According to the CDC, "Ingestion of fluoride is not likely to reduce tooth decay" (MMWR, 1999), suggesting that the anticipated benefits may not be realized. A systematic review conducted by Källestål et al. (2003) found that "the reviewed original studies on economic evaluation of caries prevention do not provide support for the economic value of caries prevention," further questioning the financial justification for fluoridation. When factoring in the economic impact of dental fluorosis and cognitive impairment, the cost-effectiveness of fluoridation

is further undermined. The cost to treat dental fluorosis is approximately \$126 per person per year (PPPY), while the estimated economic loss due to a 3-point reduction in IQ is around \$438 PPPY. In contrast, the anticipated benefit of caries prevention from fluoridation is only about \$8 PPPY. Additionally, the EPA's analysis reveals that the cost of restoring dental function due to fluorosis often outweighs the cosmetic costs, highlighting significant overlooked expenses in fluoridation programs (EPA, 2022). This evidence collectively underscores that fluoridation may not be cost-effective when all relevant costs and benefits are considered.

Efficacy of Fluoride and Incomplete Research

The efficacy of fluoride as a preventive measure for dental decay has been questioned by various health authorities and scientific experts. Notably, the FDA has characterized research on the effectiveness of fluoride ingestion as "incomplete," highlighting significant gaps in the evidence base. The absence of rigorous, prospective randomized controlled trials further complicates the validation of fluoride's benefits.

Key limitations in existing studies include:

- **Inadequate Study Design:** None of the studies have corrected for unknown confounding factors, and there are no prospective randomized controlled trials, which are considered the gold standard in research.
- **Socioeconomic Status:** Many studies fail to adequately control for socioeconomic factors, which can significantly influence dental health outcomes.
- **Study Size and Diagnosis Challenges:** The sample sizes in many studies are often insufficient, and there are difficulties in consistently diagnosing early stages of tooth decay.
- **Control Variables:** Important factors such as vitamin D, calcium, strontium, dietary habits, and total fluoride exposure are frequently not controlled. Additionally, the delay in tooth eruption and variations in oral hygiene practices are not consistently addressed.
- **Lack of Comprehensive Evaluation:** Studies do not adequately evaluate lifetime benefits of fluoride, or consider the impact of fluoride on dental fluorosis treatment expenses. Moreover, factors such as maternal fluoride exposure, breastfeeding, and infant formula are often excluded from consideration.

Furthermore, estimates of fluoride consumption assume that individuals actually drink the water, without accounting for variations in consumption patterns. There are also concerns about potential fraud, gross errors, and bias in some research, and genetic factors influencing dental health are not considered.

Given these substantial limitations and the lack of a robust evidence base, the efficacy of fluoride as a public health intervention remains uncertain. The City's decision to add fluoride to the water supply is based on incomplete and potentially flawed research, raising questions about the justification and safety of this practice. Immediate reevaluation and cessation of fluoride addition are necessary to ensure that public health measures are based on reliable and comprehensive evidence.

Tooth Decay Rates declining in Fluoridated & Unfluoridated Countries

- Recent data from the World Health Organization reveals that tooth decay trends among 12-year-olds show similar patterns in both fluoridated and unfluoridated countries. The graph demonstrates that the rate of tooth decay has been decreasing in both types of communities, indicating that fluoridation does not provide a distinct advantage over non-fluoridated water supplies in terms of reducing dental caries. This trend suggests that other factors, beyond water fluoridation, may be contributing to the decline in tooth decay rates. The lack of a significant difference in dental health outcomes between fluoridated and unfluoridated regions challenges the notion that fluoride is essential for preventing tooth decay, raising questions about the necessity and efficacy of widespread water fluoridation programs.

Fluoridation and Unexpected Dental Health Outcomes

- The situation surrounding fluoride use in dental health reveals a striking irony. In 2003, the American Dental Association (ADA) awarded Kentucky with a “50 Year Award” for achieving 100% fluoridation in its water supply. Despite this accolade, the state faced a significant dental health crisis, with 42% of its population edentulous (having no teeth)—ranking it as number one in the USA for tooth loss according to the 2002 Mortality Weekly Report. Historical data also indicates a troubling trend: a 1944 study published in the Journal of the American Dental Association (JADA) noted that with fluoride concentrations ranging from 1.6 to 4 ppm in water, over 50% of individuals past the age of 24 suffered from fluoride damage that led to the need for false teeth. Furthermore, cities with high levels of water fluoridation such as Connecticut, Detroit, and Boston are also reporting significant dental decay crises. These cities, despite their extensive use of fluoride, face ongoing challenges with dental health, highlighting a paradox where increased fluoride exposure correlates with rising dental issues rather than solving them. This irony underscores the need to critically evaluate the effectiveness and safety of water fluoridation practices.

Benefits of Fluoride are Topical & Not Systemic

- According to the CDC's August 17, 2001 MMWR Report (Vol. 50/No. RR-14), fluoride's anticaries effects are primarily topical rather than systemic. The report highlights that laboratory and epidemiological research indicate fluoride's predominant effect occurs after teeth have erupted, through direct contact with the tooth surface rather than through systemic ingestion. Specifically, the concentration of fluoride in ductal saliva is 0.016 ppm in fluoridated areas compared to 0.006 ppm in non-fluoridated areas, suggesting that fluoride ingestion is unlikely to significantly affect cariogenic activity. This finding supports the notion that fluoride's primary benefits in preventing tooth decay are realized through topical application, not systemic consumption. Consequently, the argument for widespread fluoridation based on systemic benefits is undermined, emphasizing the need to reassess the practice of adding fluoride to drinking water for its purported systemic health benefits.

ENDORSEMENTS

Weight of Fluoridation Endorsements

Many substances and practices that were once widely endorsed by reputable agencies and professionals were later found to be harmful, demonstrating that official endorsements do not always equate to safety or legality. Asbestos, for instance, was widely used in construction and industrial applications due to its fire-resistant properties and was endorsed by many experts and organizations. It wasn't until much later that its severe health risks, such as lung cancer and mesothelioma, were acknowledged, revealing that regulatory bodies were slow to act despite mounting evidence of harm.

Similarly, lead was added to gasoline and paint for decades, with endorsements touting its effectiveness. This persisted even as scientific evidence eventually linked lead exposure to significant health problems, particularly in children, such as reduced IQ and behavioral issues. Regulatory agencies were slow to respond, allowing widespread lead poisoning to occur before decisive action was taken. Another example is thalidomide, a drug prescribed in the late 1950s and early 1960s to pregnant women for morning sickness. Despite being widely recommended by medical professionals and considered safe, it was later discovered to cause severe birth defects, leading to a tragic medical crisis and a re-evaluation of drug safety regulations.

These historical instances show that endorsements from respected agencies and experts, such as those currently supporting water fluoridation, do not inherently prove safety or legality. Just as asbestos, lead, and thalidomide were once promoted before their dangers were fully understood, fluoride's widespread acceptance should not exempt it from rigorous scrutiny.

Many federal, state, and private organizations endorse water fluoridation, including the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Environmental Protection Agency (EPA), the U.S. Food and Drug Administration (FDA), the U.S. Public Health Service (PHS), and the National Institutes of Health (NIH). State agencies like the Washington State Department of Health (DOH) and various private and non-profit groups like the American Dental Association (ADA) and the World Health Organization (WHO) also support this practice. However, these endorsements do not make fluoridation any more legal or inherently safe. These agencies often have potential conflicts of interest. For instance, some organizations benefit financially from promoting fluoride products, research funding, or maintaining professional reputations that have long supported fluoridation. Endorsements may reflect established practices rather than an unbiased assessment of current evidence, and they don't override legal considerations like informed consent, individual rights, or the principle of safe medication practices. The legality and safety of adding fluoride to public water supplies must be evaluated independently of these endorsements, with a focus on current scientific evidence, ethical standards, and public consent.

EPA Endorsement of Fluoride holds no Weight

- In 2000, the Union of Scientists at the Environmental Protection Agency (EPA), representing over 1,500 scientists, engineers, and other professionals, voiced strong opposition to the use of fluoride in public water supplies. Despite the EPA's official

endorsement of water fluoridation, this group of experts highlighted significant concerns about the potential health risks associated with fluoride exposure. They pointed to studies suggesting links between fluoride and adverse health effects, such as cancer, bone fractures, and neurological damage. Notably, Dr. J. William Hirzy, Senior Vice-President of the Headquarters Union at the EPA, has publicly criticized the practice of fluoridation. On March 26, 2001, Dr. Hirzy stated, *“In summary, we hold that fluoridation is an unreasonable risk. That is, the toxicity of fluoride is so great and the purported benefits associated with it are so small - if there are any at all – that requiring every man, woman and child in America to ingest it borders on criminal behavior on the part of governments.”* This statement underscores the serious concerns raised by EPA scientists about the safety and justification of adding fluoride to the public water supply. The union's stance illustrates a critical distinction between the EPA's policy position and the views of many of its own scientists, indicating that the agency's endorsement does not necessarily reflect a unanimous scientific consensus. This internal protest underscores the need for a more thorough and unbiased evaluation of fluoride's safety and efficacy, challenging the assumption that fluoridation is unequivocally supported by the scientific community.

Department of Health Endorsement and Its Legal Implications

Department of Health Endorsement:

The Department of Health (DOH), at both state and federal levels, often endorses water fluoridation as a public health measure to reduce the incidence of dental caries. This endorsement typically includes several key points:

1. **Public Health Benefit:** The DOH cites studies suggesting that community water fluoridation reduces tooth decay in children and adults.
2. **Safety and Efficacy:** The DOH claims that water fluoridation is a safe and effective method to improve oral health, based on decades of research and practice.
3. **Cost-Effectiveness:** They argue that fluoridating public water supplies is a cost-effective way to deliver fluoride to large populations, reducing dental care costs.
4. **Endorsement from Health Organizations:** The DOH often refers to endorsements from reputable organizations like the Centers for Disease Control and Prevention (CDC) and the American Dental Association (ADA) to support their stance.

Why DOH Endorsement Does Not Make Fluoridation Lawful

While the DOH's endorsement may carry significant weight in public health discussions, it does not equate to a lawful mandate for several reasons:

1. **Lack of Legislative Authority:**
 - **Recommendations vs. Legislation:** The DOH's endorsement is a recommendation rather than a law. While the DOH can recommend fluoridation as a public health measure, it does not have the legislative power to mandate it. Public health policies must be enacted through legislation passed by elected representatives, not merely through administrative endorsement.

- **No Explicit Mandate:** Most state and federal laws do not explicitly require fluoridation of water supplies. In Washington State, for instance, while the Department of Health supports fluoridation, there is no statewide law mandating it. Fluoridation decisions are typically made at the municipal level, which means they are subject to local government ordinances and public consent.
2. **Informed Consent and Medical Ethics:**
- **Violation of Informed Consent:** The DOH's endorsement of fluoridation as a public health measure overlooks the principle of informed consent. Fluoride, when used to prevent dental caries, is acting as a medication. Administering a medication without an individual's informed consent violates medical ethics and individual rights.
 - **No Individualized Dosage:** Public water fluoridation does not account for individualized dosages based on a person's age, weight, health condition, or existing fluoride exposure. This one-size-fits-all approach fails to meet the standard for safe medication practices.
3. **Regulatory Limitations:**
- **FDA Approval:** The Food and Drug Administration (FDA) classifies fluoride as a drug when used to prevent or treat disease. However, it has never approved fluoride for ingestion to prevent tooth decay. The Department of Health's endorsement does not override the FDA's jurisdiction or compensate for the absence of randomized controlled trials (RCTs) demonstrating fluoride's safety and efficacy when ingested.
 - **EPA Standards:** The Environmental Protection Agency (EPA) sets maximum contaminant levels (MCL) for substances in drinking water, including fluoride, to protect against adverse health effects. However, these standards are primarily concerned with limiting exposure to prevent toxicity, not endorsing fluoride as a health supplement. The EPA's role is environmental safety, not medication regulation.
4. **Public Safety and Legal Protections:**
- **Washington State Laws:** In Washington, **RCW 69.41.030** states that it is unlawful for any person to sell, deliver, or possess any legend drug except upon the order or prescription of a physician or other authorized prescriber. Fluoride, when used for its therapeutic effect, should fall under this regulation, and adding it to public water supplies without individual prescriptions could be considered unlawful.
 - **RCW 69.40.030:** This law prohibits the introduction of any poison or deleterious substance into food, drink, medicine, or water supplies with the intent to harm or without regard to the potential harm. Since fluoride is recognized as a potentially toxic substance, adding it to the water supply without addressing potential risks may violate this statute.
5. **Scientific and Ethical Controversy:**
- **Lack of Consensus:** Despite the DOH endorsement, there remains significant scientific and ethical controversy surrounding water fluoridation. Research points to potential health risks, including dental fluorosis, lower IQ in children, and possible developmental harm. The scientific debate raises questions about the propriety of mandating fluoridation without clearer evidence of its safety.

- **Risk vs. Benefit Analysis:** The DOH's endorsement often emphasizes the benefits of fluoridation while downplaying or ignoring potential risks. A proper risk vs. benefit analysis should consider the latest research findings, including potential negative health outcomes associated with fluoride exposure, and should inform policy decisions.
6. **Public Autonomy and Local Decision-Making:**
- **Local Control:** Fluoridation decisions are typically made by local governments or water authorities, reflecting the principle that public health measures should be tailored to the needs and preferences of individual communities. Even if the DOH endorses fluoridation, municipalities have the authority to accept or reject these recommendations based on local input and evidence.
 - **Right to Refuse:** Citizens have the right to refuse medication or interventions they do not consent to, and this extends to water fluoridation. The DOH endorsement does not nullify this right or make fluoridation a legally enforceable mandate.

Conclusion:

The Department of Health's endorsement of water fluoridation does not make the practice lawful or obligatory. Endorsements serve as recommendations based on public health perspectives but lack the force of law. They do not override the need for informed consent, FDA approval, compliance with state statutes, or consideration of individual rights. Municipalities and citizens retain the right to scrutinize and challenge water fluoridation practices, especially when there are concerns about health risks and legal compliance.

ADDITIONAL INFORMATION SOURCES / LINKS

Information about Fluoride & Water Fluoridation:

Videos

- [Professional Perspectives: Fluoride in Tap Water: Dr. Bill Osmunson -a general and cosmetic dentist](#) (5 min 19 sec)
- [10 Facts About Fluoride: By Attorney Michael Connett](#) (19 min 54 sec)
- [Dr. Vyvyan Howard on Fluoride in Drinking Water](#) (3 min 53 sec)
- [Video - CDC Oral Health Director: We Have No Safety Data on Fluoride and the Brain](#) (1 min)
- [The Great Culling - Our Water Documentary Film](#) (1hr 32min)
- [An Inconvenient Tooth - Fluoride Documentary](#) (2hr 49min)
- [Portland voters overwhelmingly say no to fluoride](#) (1 min 59 sec)
- [Portland Water Fluoridation Testimony](#) (4 min 10 sec)
- [More Fluoride Alert Videos](#)

TSCA Lawsuit against the EPA on Fluoride

- [Breaking: Fluoride in Water Poses 'Unreasonable Risk' to Children, Federal Judge Rules](#)
- [Court Ruling Against EPA by Judge Edward Chen](#) (80 page decision)

- The plaintiff won against the EPA in the TSCA Fluoride trial, being exposed for not having evidence of fluoride safety at the currently recommended levels, and attempting to obfuscate the science and postpone the ruling as long as possible. [The TSCA Fluoride Trial, 2016 – present](#)
- [United States of America lawsuit on community water fluoridation under the Toxic Substances Control Act \(TSCA\) - Update by Bruce Spittle](#)
- [Fluoride on Trial: CDC's 'Greatest Public Health Achievement' Exposed - The HighWire](#)

National Toxicology Program (NTP) Report

- [2022 NTP Report Summary of Findings.pdf](#)
- [NTP Monograph on Fluoride Toxicity 2022 - draft.pdf](#)
- [NTP Monograph on Fluoride Toxicity 2019 - draft.pdf](#)
- <https://fluoridealert.org/researchers/the-national-toxicology-program/>

Articles

- [50 Quotes by Doctors Against Fluoride](#)
- [4800 Professionals Call for an End to Water Fluoridation Worldwide](#)
- [Why I am now officially opposed to adding fluoride to drinking water](#) (Article & Video By Dr. Hardy Limeback, BSc, PhD, DDS | Former President, Canadian Association for Dental Research)
- [Testimony In For HB-5350 -An Act Concerning the Department of Public Health's Recommendations on Fluoridation of the Public Water Supply: Stuart Cooper, National Campaign Director, Fluoride Action Network](#)
- [SCBWA Board: Decision to Remove Fluoride Came After 'Significant Study' by Members | State College, PA](#)
 - Summary of the reasons why the SCBWA Board voted to remove fluoride
- [State College Borough Water Authority Board Votes to Stop Fluoridation](#)
 - Additional information on the discussion surrounding the decision to stop fluoridating
- [Portland Uses Science & Integrity to Defeat Fluoridation](#)
- Fluoride is a potent neurotoxin, shown in 76 studies to reduce the IQ of unborn and developing children: [Fluoride & IQ: 76 Studies](#)
- The FDA has never approved any fluoride supplement as either safe or effective [Not Approved by FDA - Fluoride Action Network](#)
- Fluoride is not a nutrient to the body - As with teeth, no other tissue or cellular process requires fluoride. [Fluoride Is Not an Essential Nutrient](#)
- Many children now exceed the recommended daily fluoride intake from toothpaste alone [Dental Products - Fluoride Action Network](#)
- Since 2010, 240+ communities have rejected water fluoridation - [See the list here](#)
- Portland rejected water fluoridation in 2013 - [Portland voters reject water fluoridation for fourth time since 1956](#)
- 97% of Western Europe does not drink fluoridated water. What do they know that we don't? [Statements From European Health, Water, & Environment Authorities On Water Fluoridation](#)
- [Email Exchange with FDA re: Fluoride Supplements - No studies done since use as Rat Poison](#)
- [Meanwhile, an Update From the Great Big Fluoride Debate - Portland Mercury](#)
- [Legislature Moves Forward With Bill Banning Fluoridation](#)

- [Toxic Treatment: Fluoride's Transformation from Industrial Waste to Public Health Miracle | Origins](#)
- [CDC Website - Recommends limiting fluoride for bottle fed babies](#)

PDF Handouts / Printouts

- [3 Reasons to End Water Fluoridation.pdf](#)
- [10 Facts About Fluoride Brochure.pdf](#)
- [10 Facts about Fluoride with Detail.pdf](#)
- [50 Reasons to Oppose Fluoridation.pdf](#)
- [A response to Pro Fluoride Claims.pdf](#)
- [Fluoridation's Neurotoxicity 1pg.pdf](#)
- [Who Opposes Fluoridation.pdf](#)
- [Worldwide Movement against Fluoridation.pdf](#)

Books

- [The Fluoride Deception - By Christopher Bryson](#) (PDF of 398 page book)
- [Rebuttal to Proponent Claims - Excerpt from book The Case Against Fluoride How Hazardous Waste Ended Up in Our Drinking Water and the Bad Science and Powerful Politics That Keep It There](#)

Scientific Studies

- [Association of water fluoride and urinary fluoride concentrations with attention deficit hyperactivity disorder in Canadian youth - ScienceDirect](#) (2.8x increase in ADHD in fluoridated cities vs non-fluoridated)
- 76 studies have reported that elevated fluoride exposure is associated with reduced IQ in humans [Fluoride & Iq: 76 Studies](#)
- 2022 - [US Government Releases Censored Documents Detailing Fluoride's Impact On Childhood IQ](#)

Opinion Pieces

- [CUSHMAN: NH Needs to Stop Adding Fluoride to Water Sources](#)

Lawsuits

- [Fluoride Class Action, has alerted the Seattle City Council and Mayor McGinn that Seattle drinking water contains dangerous levels of lead as a result of the type of fluoridation materials used to fluoridate city water](#)
- [Results from 2008 Freedom of Information Act Request to City of Seattle WA](#)

II. JURISDICTION AND VENUE

3. This Court has jurisdiction over this matter pursuant to RCW 2.08.010, granting the superior court authority in all cases involving state law violations impacting public health and safety.
4. Venue is proper in this Court because the City of Vancouver is within this jurisdiction, and the acts giving rise to this complaint occurred within Clark County.

III. PARTIES

5. **Plaintiff:** Derek Kemppainen represents the interests of the citizens affected by the City's actions in adding fluoride to the water supply without adequate oversight or lawful authorization.
6. **Defendant:** The City of Vancouver, a municipal corporation in Washington State, is responsible for the administration and regulation of public utilities, including the municipal water supply.

IV. FACTUAL ALLEGATIONS

A. Fluoride as a Poison in Violation of RCW 69.38.010

7. Sodium fluoride, the substance added to Vancouver's water supply, meets the legal definition of a "poison" under Washington State law (RCW 69.38.010). According to the statute, any substance that can cause violent sickness or death when introduced into the human body in small quantities qualifies as a poison.
8. Scientific studies indicate that fluoride, even in relatively low doses, poses risks such as developmental neurotoxicity, skeletal and dental fluorosis, and other adverse health effects. This toxicity is especially concerning for vulnerable populations, including children, pregnant women, and individuals with compromised health.
9. Despite clear evidence of fluoride's potential toxicity, the Defendant continues to introduce fluoride into the public water supply, thereby knowingly exposing residents to a substance classified as a poison under state law.
10. The City's willful addition of fluoride to drinking water, without adequate safety measures or individual medical oversight, constitutes a violation of RCW 69.40.030, which prohibits the willful poisoning of any water supply intended for human consumption.

B. Fluoride as an Unapproved New Drug under Federal Law

11. Under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 321(g)(1)), any substance used to diagnose, cure, mitigate, treat, or prevent disease is classified as a drug. The Defendant's stated purpose for adding fluoride is to prevent dental cavities, which falls under the definition of a drug.
12. However, the FDA has not approved fluoride for ingestion as a safe or effective treatment for cavity prevention. Fluoride compounds added to drinking water, such as

sodium fluoride, have not undergone the FDA's New Drug Application (NDA) process to ensure safety, efficacy, and quality standards are met.

13. The Defendant's addition of fluoride to the public water supply without FDA approval constitutes the unauthorized distribution of an unapproved drug, violating federal laws prohibiting the sale and distribution of drugs not cleared by the FDA.

C. Violations of RCW 69.41.030 for Unlawful Distribution and Use of a Legend Drug

14. In Washington, fluoride added to water for the purpose of treating or preventing cavities meets the definition of a "legend drug," a category that includes drugs requiring a prescription from a licensed healthcare provider (RCW 69.41.030).
15. The Defendant's addition of fluoride to the public water supply results in the distribution of a legend drug without any individualized medical prescription, oversight, or diagnosis. This practice circumvents the safeguards set by RCW 69.41.030, which prohibit the delivery, possession, and use of legend drugs without proper authorization.
16. The Defendant's action constitutes the unlawful distribution of a legend drug to all citizens of Vancouver, including those who may not consent to or benefit from such a medical intervention. This blanket distribution of fluoride violates the following provisions under RCW 69.41.030:
 - **Unlawful Delivery Without Prescription:** RCW 69.41.030(1) mandates that legend drugs may only be delivered upon order or prescription from a licensed healthcare provider.
 - **Unlawful Use of a Legend Drug:** The Defendant's unprescribed fluoridation program results in the daily ingestion of fluoride by residents, effectively using the drug in violation of state law.
17. The Defendant's actions disregard Washington State's requirements for drug administration, medical oversight, and individualized consent, placing the population at risk of unwarranted and unapproved medical treatment.

V. CAUSES OF ACTION

Count I: Violation of Washington State Law for Poisoning the Water Supply (RCW 69.38.010 and RCW 69.40.030)

1. **Sodium Fluoride Classified as a Poison under RCW 69.38.010**

Washington State law (RCW 69.38.010) defines "poison" as including substances like arsenic, cyanide, strychnine, and any other substance that, when introduced into the human body in quantities of sixty grains (3.9 grams) or less, can cause violent sickness or death. The Pharmacy Quality Assurance Commission is responsible for designating substances under this category.
2. **Toxicity of Sodium Fluoride**

Sodium fluoride, currently added to the City of Vancouver's water supply, meets this definition due to its lethal dose (LD50) of approximately 52 mg/kg. For an average adult human weighing 154 pounds (70 kg), the lethal dose equates to around 3.64 grams—

well below the 3.9-gram threshold defined by Washington law. This dosage is approximately 0.73 teaspoons, or 73 drops, an amount that can dissolve into less than 100 drops or about 1.4 ml of water.

3. Increased Toxicity Risk for Children

For children, the lethal dose of sodium fluoride is significantly lower. For example:

- A 1-year-old child weighing approximately 22 pounds (10 kg) has a lethal dose of around 1.1 grams.
- A 3-year-old child weighing approximately 33 pounds (15 kg) has a lethal dose of around 1.7 grams.

4. Washington State law does not differentiate by age or body weight, yet 3.9 grams of sodium fluoride could be lethal to an adult, 3.5 one-year-old children, or 2.3 three-year-old children. Thus, sodium fluoride unequivocally meets the statutory definition of a poison.

5. Quantitative Risk in Public Water Supply

A standard 50-pound (22.68 kg) bag of sodium fluoride contains enough of the substance to provide approximately:

- 56,181 lethal doses for an average 1-year-old child,
- 31,145 lethal doses for an average 3-year-old child, and
- 6,226 lethal doses for an average adult.

6. Historically, sodium fluoride has been used as a rat poison due to its high toxicity, with a lethal dose for a 300-gram rat being only 15.6 mg (equivalent to 0.0012 teaspoons or about one-third of a drop of liquid).

7. Intentional Addition of Poison to the Water Supply in Violation of RCW 69.40.030

Under RCW 69.40.030, “Every person who willfully mingles poison or places any harmful object or substance... in any food, drink, medicine, or other edible substance intended or prepared for the use of a human being... and every person who willfully poisons any spring, well, or reservoir of water, is guilty of a class B felony...” The City of Vancouver’s ongoing practice of adding sodium fluoride to the public water supply constitutes a clear violation of this statute. The law classifies such actions as a class B felony, subject to penalties including imprisonment and substantial fines.

8. Demand for Immediate Cessation and Legal Notice

In light of the above, the City is formally notified to cease the addition of fluoride to the public water supply immediately. Failure to comply will expose the City and its officials to significant legal consequences, including potential prosecution under RCW 69.40.030.

This notice serves to inform the City of both its legal liability and the personal accountability of its officials in ensuring public safety.

18.

Count II: Violation of Federal and State Drug Regulations for Unauthorized Distribution of an Unapproved and Legend Drug

1. Fluoride Classification as a Drug Under 21 U.S.C. § 321(g)(1)

The primary purpose of adding fluoride to the public water supply is to prevent dental cavities, a function that meets the legal definition of a “drug” under federal law.

According to 21 U.S.C. § 321(g)(1), a drug is defined as “articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease.” By aiming to prevent tooth decay, fluoride clearly falls under this definition when added to drinking water, as it is intended to perform a therapeutic and preventive medical function.

2. Lack of FDA Approval as a New Drug

Despite fluoride’s intended medical purpose, the fluoride compounds used in water fluoridation, such as sodium fluoride and fluorosilicic acid (FSA), have never been evaluated or approved by the U.S. Food and Drug Administration (FDA) as safe and effective for ingestion. Under the Food, Drug, and Cosmetic Act, all drugs distributed in the United States must go through the FDA’s New Drug Application (NDA) process to ensure they meet rigorous safety, efficacy, and manufacturing quality standards.

3. Unapproved Drug Status

Because sodium fluoride and fluorosilicic acid have not undergone the NDA process, they lack FDA approval and are classified as unapproved new drugs. The Food, Drug, and Cosmetic Act prohibits the distribution of unapproved drugs in interstate commerce under 21 U.S.C. § 355(a). Therefore, fluoride’s addition to the public water supply without FDA approval constitutes the unauthorized distribution of an unapproved drug, in direct violation of federal law.

4. Fluoride as a Legend Drug Requiring a Prescription

Under federal law, legend drugs are those requiring a prescription from a licensed healthcare provider, as they are intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease. Legend drugs are labeled with “Rx only” or “Caution: Federal law prohibits dispensing without a prescription.” Fluoride, when added to the public water supply for ingestion and cavity prevention, meets the federal definition of a legend drug, as its primary purpose is a therapeutic intervention intended to prevent dental disease.

5. FDA’s Testimony on Fluoride as a Drug

In 2001, the FDA affirmed fluoride’s classification as a drug when used to prevent dental disease. During Congressional testimony, the FDA stated that fluoride, when used for cavity prevention, is a drug under the Federal Food, Drug, and Cosmetic Act, reinforcing its status as a therapeutic agent rather than a standard water additive. This classification underscores that fluoride, when added to water for dental health purposes, should be subject to the same regulatory standards as any drug.

6. Unauthorized Distribution and Administration of a Legend Drug Under RCW 69.41.030

RCW 69.41.030 prohibits the sale, delivery, or possession of legend drugs without the order or prescription of a licensed physician, dentist, or authorized healthcare professional. By adding fluoride to the public water supply without obtaining individual prescriptions, the City of Vancouver is distributing a legend drug in a manner that circumvents regulatory safeguards designed to ensure responsible, informed, and individualized medical use of therapeutic substances.

7. Lack of Individualized Medical Oversight and Informed Consent

The fluoridation of Vancouver’s public water supply involves distributing a drug to all residents without individualized medical assessment, oversight, or consent. By

distributing fluoride in this manner, the City bypasses the necessary regulatory and ethical safeguards that apply to legend drugs. The absence of individual prescriptions violates both federal and state drug regulations, undermining the responsible and controlled use of substances intended to prevent disease.

8. Conclusion and Demand for Immediate Cessation

Given that fluoride is unapproved by the FDA for ingestion and classified as a legend drug when used for therapeutic purposes, the City's practice of adding fluoride to the water supply constitutes an unauthorized distribution of both an unapproved and legend drug. This practice violates 21 U.S.C. § 355(a) and RCW 69.41.030, exposing the City to liability and warranting immediate cessation of water fluoridation to comply with federal and state drug laws.

21.

Count III: Violation of RCW 69.41.030 for Unlawful Distribution and Use of a Legend Drug

24. The Plaintiff incorporates by reference all preceding paragraphs.

25. The Defendant's addition of fluoride, classified as a legend drug, to the public water supply without prescriptions for individual citizens violates RCW 69.41.030, which mandates that legend drugs may only be distributed upon prescription or medical order from licensed healthcare professionals.

26. This unauthorized distribution of fluoride constitutes a failure to comply with Washington State's laws governing prescription medications, which require individualized medical oversight, informed consent, and prescription for legend drugs.

Count IV: Unauthorized Practice of Medicine

27. The Plaintiff incorporates by reference all preceding paragraphs.

28. Under Washington State law (RCW 18.71.021), the practice of medicine without a license is strictly prohibited. The Defendant's addition of fluoride to the public water supply constitutes a form of medical intervention with the intent to prevent dental disease.

29. By administering fluoride without the oversight of licensed healthcare professionals, individualized patient diagnosis, or informed consent, the Defendant is effectively practicing medicine without proper licensure, violating RCW 18.71.021.

30. This practice of administering fluoride without medical licensing or individualized assessments fails to account for differing health needs, preexisting conditions, and specific susceptibilities among the population of Vancouver, further placing vulnerable individuals at risk.

Count V: Violation of Informed Consent Requirements

31. The Plaintiff incorporates by reference all preceding paragraphs.

32. Informed consent is a fundamental legal and ethical requirement in medical treatment. By introducing fluoride into the public water supply, the Defendant is administering a substance intended to impact health without obtaining consent from the residents of Vancouver.
33. The Defendant's failure to seek or obtain individual consent for the ingestion of fluoride infringes upon the rights of the citizens of Vancouver to make autonomous health decisions, violating principles of informed consent required for any public health intervention.
34. As the Defendant has neither provided individualized health assessments nor obtained explicit consent from the public, it continues to infringe upon the constitutional right to bodily integrity and informed consent.

Count VI: Violation of Federal Prescription Drug Advertising and Labeling Standards (CFR Title 21)

35. The Plaintiff incorporates by reference all preceding paragraphs.
36. The Defendant's annual water quality reports and public statements regarding fluoride's health benefits, such as "Fluoride is added to promote dental health," qualify as promotional claims under the federal standards of prescription drug advertising, per CFR Title 21, § 202.1(e).
37. Under CFR Title 21, § 202.1(e)(3) and (4), it is unlawful to advertise or promote a prescription drug without including information on side effects, contraindications, and effectiveness. The Defendant's promotional claims regarding fluoride fail to disclose scientifically supported risks, including developmental neurotoxicity and dental and skeletal fluorosis, which have been documented as potential side effects.
38. Additionally, the Defendant's statements promote an "off-label" use of fluoride as an ingested treatment for dental health, which is not approved by the FDA and lacks sufficient clinical evidence, violating the standards for prescription drug advertising outlined in CFR Title 21, § 202.1(e)(6).
39. The Defendant's actions therefore constitute false advertising and misrepresentation of fluoride's effectiveness and safety, in direct violation of CFR Title 21 and related federal drug regulations.

Count VII: Constitutional Violations – Infringement on Right to Bodily Integrity

40. The Plaintiff incorporates by reference all preceding paragraphs.
41. The Fourteenth Amendment to the United States Constitution protects an individual's right to bodily integrity, including the right to refuse unwanted medical treatment or intervention.
42. By introducing fluoride into the public water supply with the intent to treat dental disease, the Defendant imposes a medical intervention upon residents of Vancouver without their consent, violating their right to bodily integrity as guaranteed by the Fourteenth Amendment.

43. The Defendant's actions force individuals to ingest a substance that alters bodily health without any opportunity to refuse or opt-out, constituting an infringement on personal autonomy and bodily rights under the Constitution.

Count VIII: Violation of Washington State Public Health Law (RCW 70A.125.060) – Duty to Ensure Safe Drinking Water

44. The Plaintiff incorporates by reference all preceding paragraphs.
45. Under RCW 70A.125.060, the Defendant has a duty to ensure the safety and quality of public drinking water for all residents of Vancouver.
46. The continued fluoridation of public water supplies, particularly with fluoride substances that may contain contaminants or impurities from industrial byproducts, raises concerns over the safety and compliance of the Defendant's water supply practices.
47. Failure to adequately assess and disclose the risks associated with fluoridation, including contaminants and potential side effects, violates the Defendant's duty to provide safe drinking water under RCW 70A.125.060, putting the public health of Vancouver's residents at risk.

Count IX: Violation of the Common Law Right to Self-Determination

48. The Plaintiff incorporates by reference all preceding paragraphs.
49. Under common law, individuals possess the right to make informed decisions regarding their own bodies, including the substances they consume, in alignment with the principle of self-determination.
50. By mandating the ingestion of fluoride through public water without providing alternatives or individual consent, the Defendant disregards residents' right to self-determination, coercing them into a medical intervention they may not want.
51. This practice contradicts the fundamental principle of self-determination, violating citizens' autonomy over their health and personal choices in public health matters.

Count X: Illegal Medical Experimentation on Human Subjects

52. The Plaintiff incorporates by reference all preceding paragraphs.
53. Under federal regulations (21 CFR § 50.20 and 21 CFR Part 56), any experimentation involving human subjects must obtain legally effective informed consent and Institutional Review Board (IRB) approval, ensuring ethical standards for protecting human health.
54. The Defendant's introduction of fluoride to the public water supply constitutes an experimental use of an unapproved drug on human subjects without obtaining legally effective informed consent or IRB approval, violating federal protections.
55. As an unapproved drug intended to prevent cavities, fluoride's addition to public water effectively subjects residents to a form of medical experimentation without consent or oversight, breaching the rights of Vancouver's citizens as human subjects under federal regulations.

Count XI: Violation of Informed Consent and IRB Approval Requirements (21 CFR Part 50)

56. The Plaintiff incorporates by reference all preceding paragraphs.
57. 21 CFR Part 50 mandates that individuals be informed and must consent before participating in any form of medical experiment involving unapproved drugs. This requirement includes full disclosure of risks, purpose, and duration of the intervention.
58. The Defendant's fluoridation program fails to obtain legally effective informed consent or disclose fluoride's risks, including its developmental neurotoxicity, particularly for young children.
59. Further, the Defendant has not obtained IRB approval for the addition of fluoride to the water supply, which is required by 21 CFR Part 56 to ensure the protection of human subjects involved in any medical or clinical research.
60. By circumventing these informed consent and IRB requirements, the Defendant violates essential federal protections for the public and exposes residents to unnecessary health risks.

Count XII: Non-Compliance with Investigational New Drug (IND) Regulations

61. The Plaintiff incorporates by reference all preceding paragraphs.
62. Under 21 CFR Part 312, the FDA requires that any investigational drug, including unapproved uses of drugs like fluoride, be subject to an Investigational New Drug (IND) application to assess risks and benefits before public administration.
63. The Defendant has not obtained an IND approval for adding fluoride to the drinking water, failing to meet federal standards required to assess and monitor its safety and efficacy.
64. This lack of regulatory compliance constitutes a violation of 21 CFR Part 312, placing the population at risk of adverse health outcomes without proper FDA assessment, oversight, or approval for investigational drugs.

Count XIII: Violation of the Nuremberg Code and Belmont Report Ethical Standards

65. The Plaintiff incorporates by reference all preceding paragraphs.
66. The Nuremberg Code and the Belmont Report establish ethical guidelines for human subject research, mandating that informed consent be obtained and that individuals have the right to choose freely regarding their participation in medical interventions.
67. The Defendant's fluoridation program introduces fluoride into the drinking water without any public consent or comprehensive disclosure, disregarding the Nuremberg Code's mandate that participation in medical interventions be voluntary and fully informed.
68. Additionally, the Belmont Report emphasizes respect for persons and beneficence, which the Defendant has ignored by imposing fluoride on all residents, many of whom may have specific medical conditions or personal beliefs against such treatment.
69. By failing to adhere to these internationally recognized ethical standards, the Defendant engages in non-consensual, unethical experimentation on the citizens of Vancouver.

Count XIV: Violation of the Food, Drug, and Cosmetic Act (FD&C Act), 21 U.S.C. § 355

- 70. The Plaintiff incorporates by reference all preceding paragraphs.
- 71. Under 21 U.S.C. § 355 of the Food, Drug, and Cosmetic Act, no new drug may be introduced or delivered for introduction into interstate commerce without an approved New Drug Application (NDA).
- 72. Fluoride compounds used in public water for the purpose of treating dental health issues are considered “new drugs” and require an NDA to ensure compliance with safety, efficacy, and quality standards for ingestion.
- 73. The Defendant has failed to obtain an NDA for the use of fluoride in the drinking water supply, directly violating the FD&C Act and placing the citizens of Vancouver at risk of unapproved drug exposure.

Count XV: Violation of Washington State Hazardous Waste Management Laws (RCW 70.105)

- 74. The Plaintiff incorporates by reference all preceding paragraphs.
- 75. Under RCW 70.105, Washington State mandates strict handling and disposal of hazardous waste materials, including toxic substances like fluoride compounds derived from industrial sources.
- 76. Fluoride used in water fluoridation often contains industrial byproducts, including heavy metals and other contaminants. Despite this, the Defendant has not taken measures to comply with state hazardous waste handling and disposal standards for such materials.
- 77. By introducing fluoridated water to residents without managing the inherent hazards, the Defendant disregards RCW 70.105's requirements for responsible handling, exposing Vancouver residents to potential toxic contaminants in the public water supply.

Count XVI: Violation of Constitutional Right to Privacy and Bodily Integrity

- 78. The Plaintiff incorporates by reference all preceding paragraphs.
- 79. The U.S. Constitution and Washington State Constitution protect individuals' right to privacy and bodily integrity, which includes the right to make autonomous health decisions without undue government interference.
- 80. By mandating fluoride ingestion through the public water supply, the Defendant infringes upon the personal and bodily autonomy of the citizens of Vancouver. This forced ingestion prevents residents from exercising their right to decide which substances they consume and introduces a medical intervention without their consent.
- 81. Additionally, Washington State's constitution, under Article I, Section 7, guarantees the right of individuals to be free from governmental interference in their private affairs, which includes making personal medical choices. The Defendant's water fluoridation practices infringe upon this fundamental state right, compelling individuals to ingest fluoride regardless of personal health, religious beliefs, or informed consent.
- 82. This infringement on privacy and bodily integrity by a government entity violates the substantive due process rights under the Fourteenth Amendment of the U.S.

Constitution and the equivalent protections under Washington State's constitution, infringing on citizens' personal autonomy and right to refuse medical treatment.

Count XVII: Violation of the Right to Equal Protection under the Fourteenth Amendment

83. The Plaintiff incorporates by reference all preceding paragraphs.
84. The Equal Protection Clause of the Fourteenth Amendment guarantees that all individuals shall be treated equally under the law. The Defendant's fluoridation practice imposes a uniform medical treatment on all residents, regardless of differing health conditions, ages, or susceptibilities, which results in disproportionate harm to vulnerable groups such as young children, the elderly, and individuals with medical conditions.
85. This uniform administration of fluoride fails to consider individual health needs, unique susceptibilities, or the potential increased health risks faced by certain populations, such as individuals with compromised kidney function, infants, and those who rely on high volumes of municipal water.
86. By enforcing fluoride ingestion equally across the population without addressing these differential impacts or providing alternatives, the Defendant's actions violate the Equal Protection rights of Vancouver residents, failing to consider the unique needs of each individual as required by law.

Count XVIII: Violation of Industrial Hazardous Waste Standards and Misclassification of Fluoride

87. The Plaintiff incorporates by reference all preceding paragraphs.
88. Fluoride compounds used in the Defendant's water supply are often derived from industrial byproducts, including those produced by the phosphate fertilizer industry. These fluoride compounds—such as fluorosilicic acid—contain contaminants that are classified as hazardous waste under federal law.
89. Under the Resource Conservation and Recovery Act (RCRA) and Washington State's RCW 70.105, hazardous waste materials must be handled, disposed of, or processed according to stringent standards to ensure public health and environmental safety.
90. Despite this, the Defendant administers fluorosilicic acid in the public water supply without adequately addressing its hazardous waste status. This fluoride contains potential contaminants, including heavy metals like lead and arsenic, which pose significant health risks and must be managed as hazardous substances under federal and state law.
91. By misclassifying and distributing this fluoride waste in drinking water, the Defendant bypasses necessary hazardous waste handling regulations. This lack of proper classification and handling of fluoride not only violates RCW 70.105 but also places the public at risk of exposure to toxic industrial contaminants.

Count XIX: Failure to Ensure Safe Drinking Water in Compliance with RCW 70A.125.060

92. The Plaintiff incorporates by reference all preceding paragraphs.

93. Washington State law (RCW 70A.125.060) requires public water systems to maintain safe drinking water standards that protect consumers from harmful contaminants and adhere to recognized safety protocols, including compliance with ANSI/NSF Standard 61, which governs the safety of materials added to drinking water.
94. Sodium Fluoride, the fluoride compound added to the Vancouver water supply, contains industrial byproducts that do not meet ANSI/NSF Standard 61 requirements for safe drinking water additives. The Defendant has not adequately tested or certified this fluoride to ensure compliance with these safety standards, resulting in an increased health risk for residents consuming this water.
95. By failing to ensure that the fluoride used in water fluoridation meets Washington State's safe drinking water standards, the Defendant is in violation of RCW 70A.125.060. This oversight directly endangers the health of Vancouver's citizens, exposing them to potential contaminants and other health risks associated with improper water treatment practices.

Count XX: Misclassification and Mishandling of Sodium Fluoride as a Drinking Water Additive

96. The Plaintiff incorporates by reference all preceding paragraphs.
97. Sodium fluoride, as used in the Vancouver water supply, is often sourced from industrial byproducts and is classified under hazardous waste regulations when used outside of water fluoridation.
98. The City's administration of sodium fluoride in the public water supply bypasses proper regulatory classification and fails to address its status as an industrial-grade chemical. This sodium fluoride often contains contaminants such as heavy metals, including lead and arsenic, which require strict handling as hazardous materials outside of water treatment contexts.
99. The Defendant has not sufficiently tested the sodium fluoride it uses to ensure purity and safety, disregarding established federal and state standards for handling and managing such chemicals in public health contexts.
100. By failing to properly classify and handle sodium fluoride in line with its industrial chemical status, the Defendant endangers Vancouver's residents, who may be exposed to contaminants that are otherwise regulated as hazardous waste, in direct violation of both Washington State's hazardous materials standards (RCW 70.105) and federal environmental guidelines.

Count XXI: Violation of ANSI/NSF Standard 60 Certification Requirements for Chemical Additives

101. The Plaintiff incorporates by reference all preceding paragraphs.
102. ANSI/NSF Standard 60 establishes health effects requirements for chemicals, including sodium fluoride, added to drinking water. Certification to Standard 60 is a requirement to ensure that all additives used in public drinking water are tested and deemed safe for human consumption.

103. The Defendant has failed to certify that the sodium fluoride used in Vancouver's water supply meets ANSI/NSF Standard 60 requirements, particularly in regard to purity, contaminant levels, and safety for ingestion. Sodium fluoride without ANSI/NSF certification may contain impurities and contaminants that pose significant health risks.
104. The Defendant's failure to ensure ANSI/NSF certification for sodium fluoride violates Washington State laws mandating safe water additives and places citizens at risk of exposure to unverified and potentially harmful contaminants.
105. By neglecting this certification, the Defendant violates both the regulatory standards set forth under RCW 70A.125.060 and ANSI/NSF Standard 60, failing to provide safe drinking water and risking public health.

Count XXII: Health Risks Associated with Chronic Sodium Fluoride Exposure

106. The Plaintiff incorporates by reference all preceding paragraphs.
107. Research has indicated that chronic exposure to sodium fluoride, even in low doses, can have serious health consequences, particularly for vulnerable populations. Documented risks include neurotoxic effects, skeletal fluorosis, and potential endocrine disruption.
108. Sodium fluoride ingestion has been shown to increase risks of developmental issues in children, as well as exacerbate conditions such as kidney disease and thyroid dysfunction, which can be impacted negatively by chronic fluoride exposure.
109. By continuing to administer sodium fluoride without individualized medical oversight or dosage adjustments, the Defendant fails to protect the health of at-risk populations, including children, the elderly, and those with preexisting health conditions.
110. The Defendant's ongoing fluoridation practices, despite known health risks associated with sodium fluoride, demonstrate a disregard for the well-being of the public and violate Washington State's duty of care in administering public health interventions.

Count XXIII: Violation of State Environmental Policy Act (SEPA) for Public Health and Environmental Impact Review

111. The Plaintiff incorporates by reference all preceding paragraphs.
112. The Washington State Environmental Policy Act (SEPA) requires that government actions, especially those involving chemical use in public resources like water, undergo an environmental and public health impact assessment.
113. The Defendant has failed to conduct a comprehensive SEPA review assessing the environmental and public health impacts of adding sodium fluoride to Vancouver's water supply. This review should address cumulative health risks, long-term effects on the environment, and potential contamination of natural water sources.
114. By neglecting to carry out a SEPA review for sodium fluoride's impacts on Vancouver's public health and environment, the Defendant is in direct violation of state environmental protection laws.
115. The failure to conduct this necessary environmental review disregards the rights of Vancouver's citizens to safe, unpolluted water and a healthy environment, as safeguarded under SEPA regulations.

Count XXIV: Failure to Meet Washington State's Duty of Care in Public Health Administration

116. The Plaintiff incorporates by reference all preceding paragraphs.
117. Washington State requires all government entities to exercise a reasonable duty of care in managing public health resources, ensuring that no actions taken result in undue harm or unnecessary risk to the public.
118. By adding sodium fluoride to the public water supply without comprehensive testing, proper certification, and an adequate assessment of potential health impacts, the Defendant has breached its duty of care to Vancouver residents.
119. This breach of duty is exacerbated by the failure to seek expert consultation on sodium fluoride's safety, purity, and impact on vulnerable populations, thus neglecting necessary precautions that would have safeguarded public health.
120. The Defendant's disregard for state-mandated duty of care constitutes a violation of Washington State's public health administration standards, increasing residents' exposure to potential health hazards without due diligence or oversight.

VI. PRAYER FOR RELIEF

WHEREFORE, the Plaintiff requests that the Court grant the following relief:

1. An injunction preventing the City of Vancouver from continuing its fluoridation program until it complies with all relevant state and federal laws regarding the safe distribution of drugs and substances in the public water supply.
2. A declaratory judgment stating that the City's current fluoridation practices violate Washington State laws regarding public health and safety, as well as federal drug regulations.
3. An award of costs and reasonable attorney's fees incurred in bringing this action.
4. Any other relief that the Court deems just and proper.

VII. JURY DEMAND

The Plaintiff demands a trial by jury on all issues so triable.

Dated this 10th day of December, 2024.

Respectfully submitted,

**Derek Kemppainen
31404 NE 142nd Ave
Battle Ground, WA 98604**

* On December 31, 2024, I received the City's final response, which deferred entirely to the Department's guidance, with no indication they had engaged with any of the evidence or legal points provided.

The City made it clear they are not willing or able to independently evaluate the health, legal, or ethical implications of fluoridation, as they view the matter as entirely under DOH authority.

It brings up a tough but necessary question: when the Department says fluoridation is safe, cities take that as the final word. They stop digging deeper. But what if the state takes too long to catch up with the science? We've seen it before - tobacco, lead, asbestos, even arsenic - all widely used and defended long after their harms were known. Now that the September 24, 2024 court ruling has found that fluoridation at current levels poses an unreasonable risk of harm to children by lowering IQ, does the Department truly want to keep putting its name behind it?

Derek Kemppainen
Vice President, Washington Action for Safe Water
360-975-2011

On Tue, Apr 1, 2025 at 10:18 PM Derek Kemppainen <derekkempp@gmail.com
<mailto:derekkempp@gmail.com> > wrote:

Dear Ms. Foust and Members of the Washington State Board of Health & Department of Health,

I'm writing to share a recent response I received from the City of Vancouver regarding community water fluoridation that could be a relevant discussion point for the upcoming April 9th meeting. I believe this response helps illustrate a key dynamic: cities across Washington are relying on Department of Health guidance and see themselves as unable to act independently, even when residents request change.

The City wrote:

"We will continue as always to follow the guidance on recommended levels of usage from the Washington State Department of Health. If those recommendations change, the City will act accordingly."

Vancouver also cited its municipal code as a legal obligation to fluoridate according to DOH policy:

"The city council of the city of Vancouver hereby authorizes and directs that a source of fluoridation approved by the State Department of Health be added to the city of Vancouver water supply, under the rules and regulations of the Washington State Department of Public Health, such addition to be administered in a manner approved by the State Director of Public Health, and in accordance with the laws of the state of Washington."

This highlights a broader issue: local governments are effectively locked into fluoridation as long as the state continues to support it. The Department's guidance is not simply advisory in practice - it's interpreted as binding.

While the Department's current review on fluoridation is a welcome and necessary step, many cities and their residents are still left in a holding pattern. Local governments

are eager to respond to community input, but feel constrained by current DOH recommendations. A revised stance from the Department would provide them with the clarity and authority they need to move forward.

Thank you for taking this issue seriously and for the work already underway.

Sincerely,

Derek Kemppainen
Vice President, Washington Action for Safe Water
360-975-2011

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From: Derek Kemppainen
Sent: 3/31/2025 4:32:28 PM
To: Foust, Chelsea S (DOH),DOH WSB0H
Cc:
Subject: Proposed April 2025 Update to DOH Community Water Fluoridation Advisory



*attachments\4B44A4C424B245C7_April 2025 Update to DOH
Communit_PRDTOOL_NAMETOOLONG.docx*



attachments\730D33740D8A4AF2_2023 DOH Fluoride Support Statement.pdf

External Email

Dear WA DOH,

I hope this message finds you well.

Attached is a proposed April 2025 update to the Department of Health's advisory on community water fluoridation, intended to reflect the growing body of scientific research, legal developments, and ethical considerations that have emerged since the Department's August 2023 statement (also attached for reference).

Can you please include this in the agenda packet for the upcoming April 9th DOH meeting, and also add me to the speaker list for public comment via Zoom?

Let me know if you have any questions or would like to discuss the proposed revisions further.

Thank you,

Derek Kemppainen
Vice President, Washington Action for Safe Water
360-975-2011

<https://dxwIKZ04.na2.hs-salescrm-engage.com/Cto/GJ+23284/dxwIKZ04/R5R8b40T1N7psDMX2fDmMW3z8JPG1S1mXQW3yPnXL1W_KVzW1GW1SrS_t22YtTRW24WVtp22YpXzn1Q3fSs4W1>

**STATE OF WASHINGTON
DEPARTMENT OF HEALTH**

PO Box 47890 • Olympia, Washington 98504-7890
Tel: 360-236-4030 • 711 Washington Relay Service

April 2025

UPDATED POLICY STATEMENT ON COMMUNITY WATER FLUORIDATION

The Washington State Department of Health is committed to protecting the health and well-being of all Washington residents through science-based public health guidance. As part of this commitment, the Department continuously reviews emerging research and evaluates long-standing practices in light of new evidence.

Based on recent scientific findings and legal developments, the Department now advises against the continued use of fluoride in public water systems. Communities are encouraged to reconsider their fluoridation programs and explore alternative strategies for promoting oral health.

In *Food & Water Watch v. Environmental Protection Agency* (2024), a federal court found that fluoride in drinking water at the recommended level of 0.7 milligrams per liter poses an unreasonable risk of reduced IQ in children and does not provide an adequate margin of safety.

Additional studies have raised concerns about fluoride's potential effects on neurodevelopment, endocrine function, and bone health. Infants who consume formula prepared with fluoridated tap water may be exposed to fluoride at levels significantly higher than those found in breast milk, raising concerns about early developmental risk.

Evidence increasingly supports that fluoride's primary benefit in preventing tooth decay is topical rather than systemic. Fluoridated toothpaste, mouth rinses, and professional dental treatments are effective tools for reducing cavities and are widely accessible.

Recent large-scale reviews, including the 2024 Cochrane Review and the UK-based LOTUS study, have found limited or no statistically significant benefit from systemic fluoride exposure in reducing dental caries, even among populations considered at higher risk.

Fluoride delivered through the public water supply is consumed by all residents regardless of age, health status, or personal preference. Because it is added to address a non-contagious condition, this approach does not allow for individualized dosing or informed consent, which are standard features of most medical or preventive treatments.

In terms of oversight, the Environmental Protection Agency (EPA) regulates additives used to treat water itself, while the FDA oversees therapeutic substances intended to treat people. This division has created a regulatory gap, leaving fluoride's use as a systemic agent in public drinking water without clear, coordinated federal oversight.



STATE OF WASHINGTON

DEPARTMENT OF HEALTH

PO Box 47890 • Olympia, Washington 98504-7890

Tel: 360-236-4030 • 711 Washington Relay Service

August 2023

STATEMENT OF COMMUNITY WATER FLUORIDATION

The Department of Health supports community water fluoridation as a sound, population-based public health measure. The decision to add fluoride to a public water system is made by the local community. The department encourages communities to begin and maintain optimal fluoride levels for health benefits in drinking water systems.

Community water fluoridation began in the United States over 75 years ago. Today, fluoridated water systems serve nearly 75 percent of the U.S. population. Water fluoridation is cost-effective, practical, and safe. People who live in communities with fluoridated water are more likely to have healthier teeth than those living in communities without fluoridated water.

Tooth decay is the result of a preventable bacterial disease process that occurs throughout life. Exposure to optimally fluoridated water improves dental health. Fluoride is a naturally occurring mineral that strengthens the enamel surface of teeth. When in contact with teeth, it helps to repair early signs of tooth decay, hardens the tooth's surface, and slows decay-causing bacteria.

Community water fluoridation is a proven public health prevention measure that benefits both children and adults, regardless of age, race, gender, or income. It is the most effective way to deliver the benefits of fluoride to all community members served. Providing fluoridated water to 77.1% percent of Americans is a goal of the Healthy People 2030 initiative.

The Surgeon General of the United States and over one hundred national and international organizations endorse water fluoridation. The U.S. Centers for Disease Control and Prevention recognized fluoridation of drinking water as one of ten great public health achievements of the twentieth century.

A handwritten signature in blue ink, reading "Tao Sheng Kwan-Gett MD".

Tao Sheng Kwan-Gett, MD MPH
Chief Science Officer
Office of Health and Science

Unlike fluoride products intended for topical use, ingested fluoride used for cavity prevention has not been approved by the U.S. Food and Drug Administration (FDA) as a drug. As a result, it is not subject to the same regulatory requirements that typically apply to substances intended to treat or prevent disease, such as prescription guidance, labeling, and pharmaceutical-grade manufacturing.

Given the range of scientific, medical, and regulatory concerns, the Department recommends that public health agencies and water systems pursue oral health strategies that do not rely on artificial water fluoridation. These alternatives provide effective protection against tooth decay while minimizing potential risks and allowing individuals to make informed decisions about their own health.

Tao Sheng Kwan-Gett, MD, MPH

Chief Science Officer

Office of Health and Science

From: Derek Kemppainen
Sent: 4/1/2025 1:42:48 PM
To: Foust, Chelsea S (DOH),DOH WSOH
Cc:
Subject: Public Comment – Request for Updated Guidance on Fluoridation



attachments\19F15BAEBBE64D18_Public Comment – Request for Upda_PRDPOOL_NAMEPOOLONG.pdf

External Email

Dear Ms. Foust and Members of the Washington State Board of Health & Department of Health,

Please find below and attached a letter undersigned by 15 individuals urging the Department to take action by issuing updated guidance that no longer promotes community water fluoridation. Recent federal court findings, expert testimony, and peer-reviewed research have fundamentally undermined the scientific, legal, and ethical foundation for this practice.

The continued promotion of fluoridation despite a federal court ruling and peer-reviewed data confirming neurodevelopmental risks exposes the Department to both legal and ethical scrutiny. We urge you to update your guidance to reflect the clear shift in scientific and legal consensus.

Please include this as a public comment for the April 9th meeting.

Thank you for your time and attention to this matter.

Derek Kemppainen
Vice President, Washington Action for Safe Water
360-975-2011

April 1, 2025

Chelsea S. Foust

Washington State Board of Health & Department of Health

Dear Ms. Foust and Members of the Washington Board of Health & Department of Health,

We, the undersigned, oppose the continued fluoridation of public water supplies in Washington and urge the Department to issue updated guidance that no longer supports this practice. Recent scientific findings, expert testimony, and a federal court ruling have fundamentally undermined the rationale for fluoridation. The evidence now points to clear

risks, particularly to developing children, that cannot be ignored. We submit the following points in support of this policy change::

- * **Neurodevelopmental Risks Confirmed by Science:** The National Toxicology Program's (NTP) August 2024 Monograph concluded with "moderate confidence" that fluoride exposure above 1.5 mg/L—only twice the recommended 0.7 mg/L—consistently lowers IQ in children. The 2023 Lotus Study (NIH-funded) further found that prenatal fluoride exposure significantly impairs cognitive outcomes, even at levels near current standards.
- * **Federal Court Ruling on Unreasonable Risk:** In September 2024, U.S. District Court Judge Edward Chen ruled in *Food & Water Watch et al. v. EPA* that fluoridation at 0.7 mg/L poses an "unreasonable risk of reduced IQ in children" under the Toxic Substances Control Act. The court cited "substantial and scientifically credible evidence" and rejected the EPA's claims of insufficient data.
- * **Expert Testimony on Neurotoxicity:** Witnesses in the TSCA trial, such as Dr. Philippe Grandjean, a globally recognized neurotoxicity expert, established fluoride as a developmental neurotoxin, with cognitive deficits linked to U.S. exposure levels. Judge Chen noted an "insufficient margin" between hazard and exposure.
- * **Inadequate Risk Assessment:** Dr. Kathleen Thiessen, another TSCA trial witness, critiqued the EPA's failure to apply proper risk assessment protocols, a concern Judge Chen echoed in his ruling. This suggests a broader need for health agencies, including at the state level, to reassess fluoridation with rigorous, updated standards.
- * **Historical Suppression of Evidence:** Christopher Bryson's *The Fluoride Deception* reveals how early studies linking fluoride to skeletal damage and neurological harm were buried by government and industry in the 1940s and 1950s. This legacy of concealment calls for transparency and a reexamination of long-held assumptions.
- * **Industry-Driven Origins:** Fluoridation began as a means to dispose of hazardous fluoride containing waste from aluminum and phosphate industries. Today, the practice continues using hydrofluorosilicic acid and sodium fluoride. Communities, especially low-income and minority populations, now bear the burden of this industrial waste being added to their drinking water as an industrial dumping ground.
- * **Collusion and Conflicts of Interest:** *The Fluoride Deception* exposes how the Public Health Service, influenced by corporations like ALCOA, endorsed fluoridation despite internal dissent. This historical pattern suggests a need to scrutinize whether current policy reflects science or vested interests.
- * **Health Risks Beyond Dental Claims:** Bryson highlights fluoride's toll on industrial workers—bone deformities, respiratory issues—ignored to shield liability. Modern evidence, like the Lotus Study, extends this to community-wide neurotoxic risks, particularly for vulnerable populations such as children and pregnant women.
- * **Questionable Efficacy in Today's Context:** The 2024 Cochrane Review, a gold-standard analysis, found fluoridation's impact on tooth decay to be minimal and poorly evidenced. TSCA witness Dr. Howard Hu testified that topical fluoride alternatives suffice, diminishing the need for systemic ingestion in an era of widespread dental products.
- * **Ethical Violation of Consent:** Adding fluoride to drinking water amounts to mass medication without individual consent. It lacks the informed choice, dosing controls, and regulatory oversight required for substances intended to treat human health—especially

concerning since the FDA classifies fluoride as an unapproved drug for ingestion. Unlike voluntary health measures, it offers no practical opt-out, conflicting with principles like the Nuremberg Code.

- * **Statewide Pressure on Communities:** Every community in Washington faces significant pressure to conform to the Department of Health's fluoridation recommendation, widely assumed to be supported by a group of scientists who fully understand its risks and benefits. Yet, these communities—lacking the resources or expertise to challenge this perceived authority—are reluctant to oppose it, even as new evidence and Judge Chen's ruling undermine its foundation.
- * **Lack of State Mandate and Local Burden:** Fluoridation is not required by Washington State law, leaving it as a local choice, yet the Department of Health's recommendation places undue pressure on communities to adopt a practice increasingly unsupported by science and public will, diverting resources from other health priorities.
- * **Regulatory Ambiguity and FDA Concerns:** Fluoride, classified as a drug by the FDA but unapproved for ingestion, lacks the medical oversight, individualized dosing, and pharmaceutical standards required for substances intended to treat humans, raising questions about its unregulated use in public water as a systemic therapeutic agent.
- * **Heightened Risk to Infants:** Scientific research highlights the disproportionate fluoride exposure infants face when formula is prepared with fluoridated tap water—far exceeding levels in breast milk—posing a potential neurodevelopmental risk not adequately addressed by current safety standards.
- * **Primarily Topical Benefit:** The CDC and National Research Council affirm that fluoride's dental benefits are primarily topical, not systemic, undermining the justification for adding it to drinking water when widely available alternatives like toothpaste and dental treatments suffice.
- * **Environmental and Industrial Concerns:** Fluoride, a hazardous waste before being repurposed for water treatment, allows industries to offload disposal costs onto public systems, impacting local waterways and ecosystems as it enters wastewater and stormwater untreated.

The combination of Judge Chen's ruling, expert scientific testimony, recent peer-reviewed research, and historical context presents a strong case against continued fluoridation. We urge the Department of Health to reevaluate its stance, prioritize the safety of Washington residents, and support a move toward safer, evidence-based dental health strategies that respect individual rights and public well-being.

Sincerely,

Derek Kemppainen, Battle Ground, WA

Bill Osmunson, DDS, MPH, Issaquah, WA

Griffin Cole, DDS, NMD, Conference Chairman - IAOMT, President and COO - Center for Advanced Dental Disciplines, Austin, TX

Geri Rubano, Camas, WA

Kristine Alonzo, Camas, WA

Pamela Pollock, Buckley, WA

Manuel Lozano, Camas WA

Margaret Tweet, Camas, WA

Glenda Martin, La Center, WA

Michael Martin, La Center, WA

Helena Green, Yacolt, WA

Scott Shock, Seattle, WA

Audrey Adams, Renton, WA

Olemara Peters, Redmond, WA

Julie Simms, Seattle, WA

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April 1, 2025

Chelsea S. Foust

Washington State Board of Health & Department of Health

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Sincerely,

Derek Kemppainen, Battle Ground, WA

Bill Osmunson, DDS, MPH, Issaquah, WA

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Glenda Martin, La Center, WA

Michael Martin, La Center, WA

Helena Green, Yacolt, WA

Scott Shock, Seattle, WA

Audrey Adams, Renton, WA

Olemara Peters, Redmond, WA

Julie Simms, Seattle, WA

From: lisa@informedchoicewa.org
Sent: 4/4/2025 11:18:54 AM
To: DOH WSBOH
Cc:
Subject: please include this comment in the BOH's materials for its April 9 meeting



attachments\2A42A46F57614CDE_image003.jpg

External Email

Good morning, BOH Members,

On behalf of Informed Choice Washington, I am writing to express my strong opposition to the continued fluoridation of public water systems in our state.

Water fluoridation is an outdated practice that persists despite mounting evidence of harm, and it fails to meet the ethical and scientific standards we expect of public health policy.

Any purported benefit of fluoride pertains only to topical application, not ingestion. Consumption of fluoride through drinking water has not been shown to provide meaningful dental protection; instead, it contributes to cumulative toxic exposure.

Water fluoridation is not necessary. According to data from the World Health Organization and other public health sources, developed nations that have rejected water fluoridation—such as most of Western Europe—have experienced the same overall declines in tooth decay over many decades as countries that continue the practice. Multiple comparative studies have found no significant difference in dental caries rates between fluoridated and non-fluoridated populations when factors like diet and access to dental care are taken into account. Notably, in communities where fluoridation has been discontinued—such as in Canada, the former East Germany, Cuba, and Finland—rates of tooth decay have not increased but have often continued to decline.

Fluoridation is not only unnecessary, but its use has never been supported by randomized controlled trials. No such trial has ever demonstrated that fluoridated water reduces tooth decay, which raises serious concerns about the scientific rigor behind current policy.

There is a growing and credible body of scientific literature documenting a wide range of harms associated with systemic fluoride exposure, particularly in children, the elderly, and those with morbidities. These harms include damage to multiple tissues of the body, such as the following:

- * Endocrine system
- * Skeletal system
- * Reproductive system
- * Gastrointestinal tract
- * Kidneys
- * Liver
- * Thyroid
- * Pineal gland
- * Teeth (dental fluorosis)
- * Bones (skeletal fluorosis)

In addition, neurodevelopmental effects are well documented. A 2019 study by Green et al., published in JAMA Pediatrics, reported a significant association between higher prenatal fluoride exposure and reduced IQ scores in children—especially boys. This is not an isolated finding but part of a larger trend in neurotoxicity research that demands urgent attention.

In September 2024, U.S. District Court Judge Edward Chen ruled that fluoridation of water at 0.7 milligrams per liter—the level currently considered 'optimal' in the United States—poses an unreasonable risk of reduced IQ in children.

Furthermore, water fluoridation is inherently unethical. It removes the right to informed consent and fails to account for personal variables such as age, health conditions, and daily water intake. Fluoride, as added to drinking water, is not a nutrient. It is a medical intervention applied indiscriminately, with no control over dosage and no ability for individuals to opt out. For example, infants consuming formula made with fluoridated water experience the highest fluoride exposure per body weight in the population.

Fortunately for the Board, it has no duty to promote the claimed benefits of additives. Rather, it is the Board's responsibility to ensure that public water supplies are safe. On that basis alone, fluoridation fails to meet the statutory standard.

I also respectfully urge the Board to invite Dr. Bill Osmunson to present to the fluoridation panel. As you know, Dr. Osmunson is a seasoned dentist and public health advocate who has provided the Board a vast body of evidence for over a decade regarding the risks of fluoridation. His voice is critical to any fair and balanced evaluation of this issue.

Thank you for your time and dedication to the health and well-being of all Washington residents. I am happy to provide citations upon request.

Sincerely,

Lisa Templeton

Director

<<https://gcc02.safelinks.protection.outlook.com/?url=http%3A%2F%2Finformedchoicewa.org%2F&data=0>

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From: bill teachingsmiles.com
Sent: 3/26/2025 1:55:05 PM
To: DOH WSBOH
Cc:
Subject: April 9 Board Meeting

External Email

I am registering to provide public comment at the April 9, 2025 Board of Health Meeting.
I will send my comments later.

Thank you,

Bill Osmunson DDS MPH
425.466.0100

From: Rick North
Sent: 4/2/2025 1:08:09 PM
To: DOH WSBOH
Cc:
Subject: RE: Request to testify at your April 9 meeting

External Email

Thank you for your response. I'll be commenting on Zoom and will most likely submit written comments beforehand.

Thank you for the opportunity to make a statement.

Rick North
503-706-0352

From: DOH WSBOH <WSBOH@SBOH.WA.GOV>
Sent: Wednesday, April 2, 2025 3:25 PM
To: hrnorth@hevanet.com
Subject: RE: Request to testify at your April 9 meeting

Mr. North,
We have received your request to provide public comment during:
Item 3 – Public Comment (scheduled for 8:50 a.m.) – This is for any topic covered by the State Board of Health.

Your name has been added to the list. Will you be in person or providing comments via Zoom?

The Board Chair determines the length of time for testimony for each public commenter based on how many sign-up for that meeting. Generally, the times range between one – three minutes. We also encourage people to submit their written public comments to the Board at this email address.

More information about submitting public comments can be found on our website. Public Comments | SBOH

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or put into your browser: <https://sboh.wa.gov/public-comments>
<<https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsboh.wa.gov%2Fpublic-comments&data=05%7C02%7CWSBOH%40SBOH.WA.GOV%7C87bbad0a1a304a69f2c408dd722214ec%7C>>

Thank you,
WSBOH staff

From: Rick North <hrnorth@hevanet.com <mailto:hrnorth@hevanet.com> >
Sent: Tuesday, April 1, 2025 3:43 PM
To: DOH WSBOH <WSBOH@SBOH.WA.GOV <mailto:WSBOH@SBOH.WA.GOV> >
Subject: Request to testify at your April 9 meeting

External Email

To whom it may concern: Please sign me up to testify at the April 9 Board of Health meeting by Zoom.

Could you confirm that you've received this e-mail?

Thank you,

Rick North

503-706-0352



PREPROPOSAL STATEMENT OF INQUIRY

CR-101 (October 2017)
(Implements RCW 34.05.310)

Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: March 25, 2025

TIME: 3:14 PM

WSR 25-08-026

Agency: Washington State Board of Health

Subject of possible rule making: Chapter 246-101 WAC, Notifiable Conditions; Adjustment of COVID-19 reporting requirements. The Washington State Board of Health (Board) is considering amending the reporting requirements for COVID-19 in response to feedback from local health jurisdictions and changes in the national notifiable condition designation by the Council for State and Territorial Epidemiologists (CSTE). The Board will not consider other changes to these rules at this time.

Statutes authorizing the agency to adopt rules on this subject: RCW 43.20.050

Reasons why rules on this subject may be needed and what they might accomplish: Chapter 246-101 WAC provides public health authorities in Washington with essential information to prevent and control both infectious and non-infectious conditions, ultimately safeguarding public health. It establishes reporting requirements for healthcare providers, facilities, laboratories, and other entities to help public health officials track communicable diseases and other conditions, in accordance with RCW 43.20.050, 70.104.055, and 43.70.545.

The Board will consider amending the rules to ease COVID-19 reporting requirements while retaining key data needed to protect the public's health and for ongoing disease surveillance.

Currently, healthcare providers, facilities, and labs must report all COVID-19 cases to local health jurisdictions immediately. Local health jurisdictions must then notify the Department within three business days. The Board and Department have received feedback from local health officers and regulated entities that these reporting requirements are burdensome and do not align with the shift from pandemic emergency response to regular monitoring of endemic respiratory viruses. Updating the reporting in rule will help alleviate this burden.

Each year, the Council for State and Territorial Epidemiologists (CSTE), with input from the U.S. Centers for Disease Control (CDC), reviews the list of nationally notifiable conditions. In 2024, CSTE updated its position statement on COVID-19 ([24-ID-11](#)), changing the case definition and removing COVID-19 from the nationally notifiable condition list. National case-based data no longer reflect overall infection trends and the CDC only tracks severe illness due to COVID-19 in select sites across the U.S.

CSTE's position statement calls for ongoing routine surveillance of COVID-19 alongside other respiratory viruses. The Board proposes adjusting the COVID-19 reporting requirements in chapter 246-101 WAC to align with CSTE's recommendations and updated CDC respiratory virus monitoring practices.

Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies: The Board has broad authority to establish rules for notifiable conditions. To develop the proposed rules, the Board will work closely with the Department of Health, as they are the agency responsible for implementing chapter 246-101 WAC. The Department of Agriculture also has authority to create notification requirements for veterinarians. Board staff will consult with the Washington Department of Agriculture to ensure the veterinary notification requirements for COVID-19 in the state are aligned.

Process for developing new rule (check all that apply):

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe)

The Board will work with the Department of Health to develop the proposed rules. They will consult with members from the regulated community, associations, local health jurisdictions, and other impacted parties throughout the course of this rulemaking. After drafting the rules, they will gather more feedback through an informal review process before formally proposing the rules and holding a public hearing.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting:

Name: Molly Dinardo

Address: PO Box 47990, Olympia, WA 98504-7790

Phone: 564-669-3455

Fax: 360-236-4088

TTY: 711

Email: molly.dinardo@sboh.wa.gov

Web site:

Other:

(If necessary)

Name: Samantha Fuller

Address: 101 Israel Rd. S.E. Tumwater, WA 98501

Phone: 564-669-1964

Fax:

TTY: 711

Email: Samantha.Fuller@doh.wa.gov

Web site:

Other:

Additional comments: The Board will work with partner agencies and may convene listening sessions for additional input. The Board will keep interested parties informed of the rulemaking through email, the Board's listserv and rulemaking website, and notices in the Washington State Register. Interested parties, including those who are subject to the requirements of chapter 246-101 WAC, will have opportunities to provide comments through the rulemaking process, including informal review of the draft rule, formal review and comment on the proposed rule, and at the Board's public hearing.

Date: March 25, 2025

Name: Michelle A. Davis

Title: State Board of Health Executive Director

Signature:





Date: April 9, 2025

To: Washington State Board of Health Members

From: Kelly Oshiro, Board Member

Subject: Recommendations of the Congenital Cytomegalovirus Newborn Screening Technical Advisory Committee

Background and Summary:

The Washington State Board of Health (Board) has the authority under RCW 70.83.050 to adopt rules for screening Washington-born infants for hereditary conditions. WAC 246-650-010 defines the conditions, and WAC 246-650-020 lists the conditions on the state's required newborn screening panel.

During the 2024 legislative session, the Legislature passed and the Governor signed Senate Bill 5829, which directed the Board to review congenital cytomegalovirus (cCMV) for Washington's mandatory newborn screening panel. Congenital cytomegalovirus (cCMV) occurs when a pregnant person is infected with cytomegalovirus (CMV) and subsequently passes the infection to their unborn child. cCMV can result in decreases in hearing and is the leading cause of nonhereditary, sensorineural hearing change. cCMV can lead to other significant impacts, including developmental delay, changes in vision, seizures, or death.

cCMV may be detected through screening via three different biological specimen types: dried blood spot, saliva swab, and dried urine filter paper. Each biological specimen type has unique testing, cost, and infrastructural considerations. Chapter 70.83 RCW specifies that the Department of Health must conduct newborn screening tests on blood specimens.

Infants suspected of having cCMV can have a diagnostic DNA test for CMV infection using a saliva or urine sample. Diagnostic testing must be completed within 21 days of life to confirm a congenital infection. Babies with cCMV who are symptomatic or experiencing isolated decreases in hearing may be treated with antivirals. Antivirals may increase hearing but may also have side effects.

On February 11 and March 26, 2025, a technical advisory committee (TAC) convened to consider this condition against the Board's newborn screening criteria. During the committee meeting, TAC Members heard presentations on the natural history of the condition, diagnostic testing and treatment, available screening technology, and cost-benefit analysis for adding this condition to the state's screening panel. The TAC then voted on individual criteria for cCMV as well as an overall recommendation to the Board.

I have invited John Thompson, Director of the Department of Health's Newborn Screening Program, and Kelly Kramer, Policy Advisor, to present information from the cCMV TAC for Board Member consideration.

(Continued on the next page)

Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motions:

The Board directs staff to file a CR-101 to initiate rulemaking for chapter 246-650 WAC to consider adding cCMV to the Washington state newborn screening panel using dried blood spot, and further directs staff to draft a cCMV legislative report, consistent with Senate Bill 5829, based on the findings and recommendations provided, for review by the Board prior to the due date of December 31, 2025.

OR

The Board directs staff to work with the Department of Health to assess further the feasibility and implications of including dried urine filter screening testing as part of the current newborn screening infrastructure and present this information back to the Board in time to develop final recommendations and next steps for the cCMV legislative report required by Senate Bill 5829 and due December 31, 2025.

OR

The Board determines that cCMV should not be considered for addition to the newborn screening panel at this time for the reasons stated by the Board, and directs staff to draft a cCMV legislative report, consistent with Senate Bill 5829, based on the findings and recommendations provided, for review by the Board prior to the due date of December 31, 2025.

Staff

Kelly Kramer, Policy Advisor

To request this document in an alternate format or a different language, please contact the Washington State Board of Health, at 360-236-4110 or by email at wsboh@sboh.wa.gov
TTY users can dial 711.

PO Box 47990 • Olympia, WA 98504-7990
360-236-4110 • wsboh@sboh.wa.gov • sboh.wa.gov

Washington State Board of Health

PROCESS TO EVALUATE CONDITIONS FOR INCLUSION IN THE REQUIRED NEWBORN SCREENING PANEL

Updated March 14, 2025

Amended Section The Washington State Board of Health (Board) has the duty under [RCW 70.83.050](#) to define and adopt rules for screening Washington-born infants for heritable conditions. [Chapter 246-650-020 WAC](#) lists conditions for which all newborns must be screened. Members of the public, staff at Department of Health (Department), and/or Board members can request that the Board review a particular condition for possible inclusion in the newborn screening (NBS) panel.

To determine which conditions to include in the NBS panel the Board convenes a newborn screening technical advisory committee (TAC) to evaluate candidate conditions using guiding principles and an established set of criteria.

This document describes the Qualifying Assumption, Guiding Principles, and Criteria the Board has approved to evaluate conditions for possible inclusion in the newborn screening panel. The Board and Department apply the qualifying assumption. The Board-appointed Newborn Screening TAC applies the following three guiding principles and evaluates the criteria to make recommendations to the Board on which condition(s) to include in the state's required NBS panel.

QUALIFYING ASSUMPTION

Amended Section

Before the Board convenes a TAC to review a candidate condition against the newborn screening criteria, staff should complete a preliminary review to determine whether sufficient scientific evidence is available to apply the criteria for inclusion, which is the qualifying assumption. If the candidate condition is on the Health Resources and Services Administration (HRSA) [Recommended Uniform Screening Panel \(RUSP\)](#), the Board and Department will consider the qualifying assumption met and convene a TAC.

New Section

A note on the RUSP: The RUSP is a list of conditions that the Secretary of the Department of Health and Human Services (HHS) recommends states screen for as part of their newborn screening programs. Once the HHS Secretary recommends a new condition, the Board and Department will review it for possible inclusion in the Washington NBS panel within two years of the recommendation.

New Section Conditions pending RUSP Review or Previously Denied for the RUSP: [RCW 34.05.330](#) of the Administrative Procedures Act (APA) allows any person to petition a state agency to adopt, repeal, or amend any rule within its authority. Agencies must respond to the petitioner within 60 days. If the agency accepts the petition, it must initiate rulemaking. An agency can deny the request for rulemaking, and in doing so, it must explain its reasons and, if appropriate, describe alternative steps it is prepared to take.

If the Board receives a petition for rulemaking regarding a candidate condition currently under review for the RUSP, the Board will wait until the federal committee finishes its review and the HHS Secretary makes a final decision before convening a TAC. For petitions involving conditions that have already been reviewed and denied inclusion on the RUSP, the Board will instruct staff to work with the petitioner to determine if concerns raised during the federal review have been addressed before recommending the Board convene a TAC to review the condition.

THREE GUIDING PRINCIPLES

Three guiding principles govern all aspects of the evaluation of a candidate condition for possible inclusion in the NBS panel.

- Decision to add a screening test should be driven by evidence. For example, test reliability and available treatment have been scientifically evaluated, and those treatments can improve health outcomes for affected children.
- All children who screen positive should have reasonable access to diagnostic and treatment services.
- Benefits of screening for the disease/condition should outweigh harm to families, children and society.

CRITERIA

1. Available Screening Technology: Sensitive, specific and timely tests are available that can be adapted to mass screening.

- The sensitivity of the screening test is estimated to be $\geq 95\%$.

- The specificity of the screening test is considered acceptable based on the estimated number of false positive results and their potential impact on the families, healthcare system, and newborn screening program.
- A timely test is one that enables intervention before irreversible harm develops, within the current standard timeframes for specimen collection, receipt, testing, and reporting.
- There is adequate peer reviewed evidence to evaluate this criterion.

2. Diagnostic Testing and Treatment Available: Accurate diagnostic tests, medical expertise, and effective treatment are available for evaluation and care of all infants identified with the condition.

- A diagnostic test accurately identifies who needs treatment and is readily available to all newborns screened.
- The available treatment is effective in reducing morbidity or mortality and outweighs any risks or harms of the treatment.
- The medical expertise needed to diagnose and care for those with a positive newborn screen is reasonably available to all newborns screened.
- The appropriate consultants and treatment centers have been identified and have capacity for the expected increase in diagnostic testing and/or referrals.

3. Prevention Potential and Medical Rationale: The newborn identification of the condition allows early diagnosis and intervention.

- There is sufficient time between birth and onset of irreversible harm to allow for diagnosis and intervention.
- The condition must have an onset form that occurs in infancy (within the first year of life); newborn screening is not appropriate for conditions that only present after the first year of life.
- The benefits of detecting and treating infantile-onset forms of the condition (within one year of life) balance the impact of detecting later onset forms of the condition.
- There is adequate evidence of acceptable quality to evaluate this criterion.

4. Public Health Rationale: Nature of the condition justifies population-based screening rather than risk based screening or other approaches.

- All available risk-based screening tools for the condition have been considered and are found to be inferior to universal newborn screening.
- There is adequate evidence of acceptable quality to evaluate this criterion.

5. Cost-benefit/Cost-effectiveness: The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis.

- The economic analysis considers:
 - The prevalence of the condition among newborns.
 - The positive and negative predictive values of the screening and diagnostic tests.
 - Variability of clinical presentation by those who have the condition.
 - Dollar values for costs and benefits of screening vs. no screening.
- The impact of ambiguous results, adverse effects, or unintended consequences of screening, such as psychosocial or economic impacts on the family and medical system, must also be considered.
- The results of the economic analysis shows that the outcomes, financial or otherwise, outweigh the costs of screening.
- There is adequate evidence of acceptable quality to evaluate this criterion.

6. Public Health Infrastructure Readiness: The Newborn Screening Program's capacity to implement screening within a reasonable timeframe has been considered.

- The systems and staffing necessary to perform the test and report screening results have been identified.
- Resources needed to implement short/long term follow up protocols by the newborn screening program have been identified.
- Accessibility to treatment for anyone diagnosed with the condition is considered acceptable based on the frequency of treatment needed.

Criterion	Opinion			Comments
	Meets	Does not meet	More info needed	
1. Available Screening Technology				
Sensitive, specific and timely tests are available that can be adapted to mass screening.				

The sensitivity of the screening test is estimated to be $\geq 95\%$				
The specificity of the screening test is considered acceptable based on the estimated number of false positive results and their potential impact on families, the healthcare system, newborn screening program.				
A timely test is one that enables intervention before irreversible harm develops, within the current standard timeframes for specimen collection, receipt, testing, and reporting				
There is adequate evidence of acceptable quality to evaluate this criterion				
Overall impression of criterion 1:				
2. Diagnostic Testing and Treatment Available Accurate diagnostic tests, medical expertise, and effective treatment are available for evaluation and care of all infants identified with the condition.				
A diagnostic test accurately identifies who needs treatment, and is readily available to all newborns screened.				
The available treatment is effective in reducing morbidity or mortality, and outweighs any risks or harms of the treatment.				

The medical expertise needed to diagnose and care for those with a positive newborn screen is reasonably available to everyone screened				
The availability and proximity to treatment for anyone diagnosed with the condition is considered acceptable based on the frequency of treatment needed				
The appropriate consultants and treatment centers have been identified and have capacity for the expected increase in diagnostic testing and/or referrals				
There is adequate evidence of acceptable quality to evaluate this criterion				
Overall impression of criterion 2:				
3. Prevention Potential and Medical Rationale The newborn identification of the condition allows early diagnosis and intervention.				
There is sufficient time between birth and onset of irreversible harm to allow for diagnosis and intervention				

The condition must have an onset form that occurs in infancy (within the first year of life); newborn screening is not appropriate for conditions that only present after the first year of life.				
The benefits of detecting and treating infantile-onset forms of the condition balance the impact of detecting later onset forms of the condition				
There is adequate evidence of acceptable quality to evaluate this criterion				
Overall impression of criterion 3:				
4. Public Health Rationale Nature of the condition justifies population-based screening rather than risk based screening or other approaches.				
Any available risk-based screening tools for the condition have been considered and are inferior to universal newborn screening				
There is adequate evidence of acceptable quality to evaluate this criterion				
Overall impression of criterion 4:				
5. Cost-benefit/Cost-effectiveness The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis.				

<p>The economic analysis considers:</p> <ul style="list-style-type: none"> • The prevalence of the condition among newborns. • The positive and negative predictive values of the screening and diagnostic tests. • Variability of clinical presentation by those who have the condition. • Dollar values for costs and benefits of screening vs. no screening 				
<p>The impact of ambiguous results, adverse effects, or unintended consequences of screening, such as emotional or economic impacts on the family and medical system, must also be considered.</p>				
<p>The results of the economic analysis shows that the outcomes, financial or otherwise, outweigh the costs of screening</p>				
<p>There is adequate evidence of acceptable quality to evaluate this criterion.</p>				
<p>Overall impression of criterion 5:</p>				

6. Public Health Infrastructure Readiness

The Newborn Screening Program's capacity to implement screening within a reasonable timeframe has been considered.

The systems and staffing necessary to perform the test and report screening results have been identified				
Resources needed to implement short/long term follow up protocols by the newborn screening program have been identified				
Accessibility to treatment for anyone diagnosed with the condition is considered acceptable based on the frequency of treatment needed				
Overall impression of criterion 6:				
Overall impression of the condition:				
Recommendation:				

RCW 70.83.020

Screening tests of newborn infants.

(1) It shall be the duty of the department of health to require screening tests of all newborn infants born in any setting. Each hospital or health care provider attending a birth outside of a hospital shall collect and submit a sample blood specimen for all newborns no more than forty-eight hours following birth. The department of health shall conduct screening tests of samples for the detection of phenylketonuria and other heritable or metabolic disorders leading to intellectual disabilities or physical defects as defined by the state board of health: PROVIDED, That no such tests shall be given to any newborn infant whose parents or guardian object thereto on the grounds that such tests conflict with their religious tenets and practices.

(2) The sample required in subsection (1) of this section must be received by the department [of health] within seventy-two hours of the collection of the sample, excluding any day that the Washington state public health laboratory is closed.

[2014 c 18 § 1; 2010 c 94 § 18; 1991 c 3 § 348; 1975-'76 2nd ex.s. c 27 § 1; 1967 c 82 § 2.]

RCW 70.83.030

Report of positive test to department of health.

Laboratories, attending physicians, hospital administrators, or other persons performing or requesting the performance of tests for phenylketonuria shall report to the department of health all positive tests. The state board of health by rule shall, when it deems appropriate, require that positive tests for other heritable and metabolic disorders covered by this chapter be reported to the state department of health by such persons or agencies requesting or performing such tests.

[1991 c 3 § 349; 1979 c 141 § 113; 1967 c 82 § 3.]

RCW 70.83.050

Rules and regulations to be adopted by state board of health.

The state board of health shall adopt rules and regulations necessary to carry out the intent of this chapter.

[1967 c 82 § 5.]



Washington State Board of Health

Overview of Congenital Cytomegalovirus

Kelly Kramer, Policy Advisor – April 09, 2025

WASHINGTON STATE 
BOARD OF HEALTH

Background: Congenital Cytomegalovirus (cCMV)

- Senate Bill 5829 (2024 legislative session)
 - Directed the Board of Health to conduct a review of cCMV to determine if this condition should be added to our mandatory newborn screening panel
- Previously reviewed by TAC in 2022
 - Recommendation to re-review in 3 years



Overview of cCMV

- Congenital cytomegalovirus (cCMV) is a viral infection that occurs when a pregnant person passes a CMV infection to their unborn child.
- 1 out of 200 babies are born with cCMV.
- cCMV is the leading cause of non-genetic decreases in hearing.
- Other significant impacts include developmental delay, changes in vision, or death.
- Most babies with cCMV are asymptomatic.
 - But may still experience decreases in hearing.

CDC. "About Cytomegalovirus." *Cytomegalovirus (CMV) and Congenital CMV Infection*, 10 May 2024, www.cdc.gov/cytomegalovirus/about/index.html.

Akpan US, Pillarisetty LS. Congenital Cytomegalovirus Infection. [Updated 2023 Aug 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK541003/>



Available Screening Technology

- Real-time polymerase chain reaction (RT-PCR) to detect CMV in newborn screening specimens.
- Screening results available within 1–2 days of specimen receipt.
 - Would allow for a diagnosis to occur within 21 days of life
- Three options for biological specimen type
 - Dried blood spot
 - Saliva swab
 - Dried urine filter paper



Available Screening Technology

Specimen type	Sensitivity	Specificity
Dried blood spot	76.8%	>99%
Saliva Swab	92.9%	>91%
Dried urine filter paper	98.8-100%	>99%

Diagnostic Testing and Available Treatment

- Must be diagnosed within 3 weeks of birth to determine if congenital.
- The virus may be detected through urine, blood, saliva, or cerebral spinal fluid via diagnostic DNA testing.
- Infants with cCMV who are symptomatic or experiencing isolated decreases in hearing may receive antivirals.
- Antivirals may reduce changes in hearing and improve development.
 - They do not reduce mortality or serious morbidity.
- Antivirals may lead to serious side effects.
- All infants with cCMV must have regular hearing, vision, and developmental assessments.



Cost Benefit, Cost Effectiveness Analysis

Megan McCrillis, MPH

Policy Analyst, Department of Health's Newborn Screening Program

John Thompson, PhD, MPA, MPH

Director, Department of Health's Newborn Screening Program



Public Health Infrastructure Readiness

Megan McCrillis, MPH

Policy Analyst, Department of Health's Newborn Screening Program

John Thompson, PhD, MPA, MPH

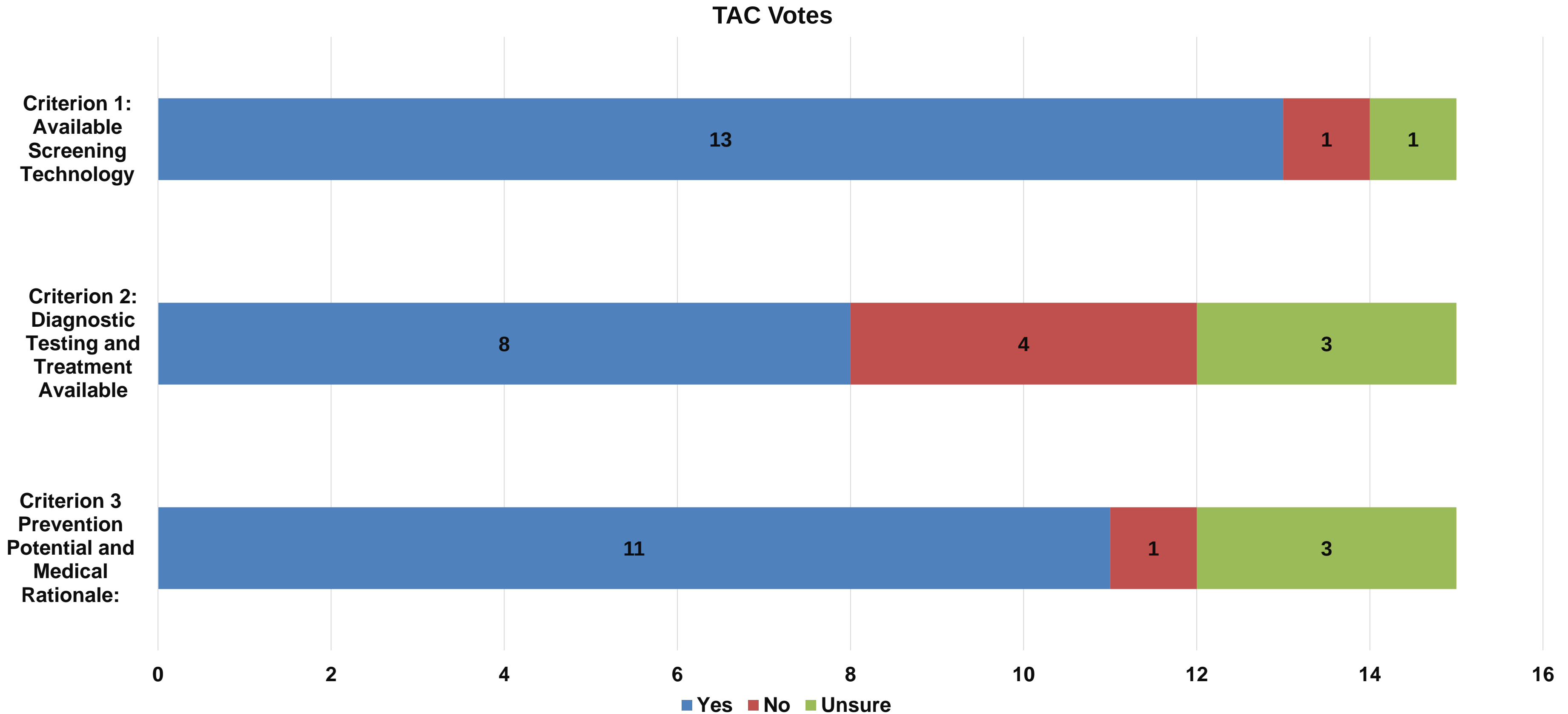
Director, Department of Health's Newborn Screening Program

Julie Walker, CHES, MPH

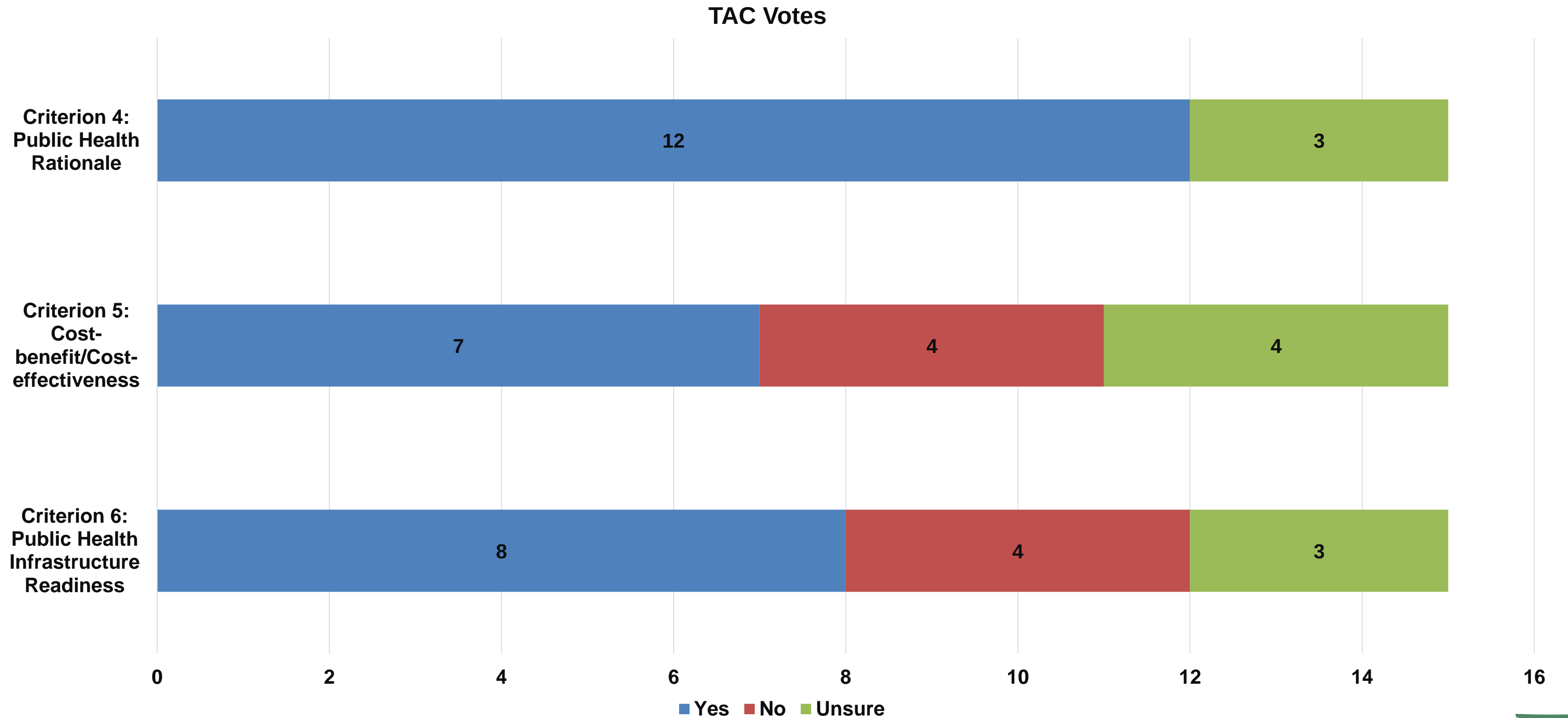
EHDDI Program Manager, Early Hearing Detection, Diagnosis and Intervention (EHDDI) Program



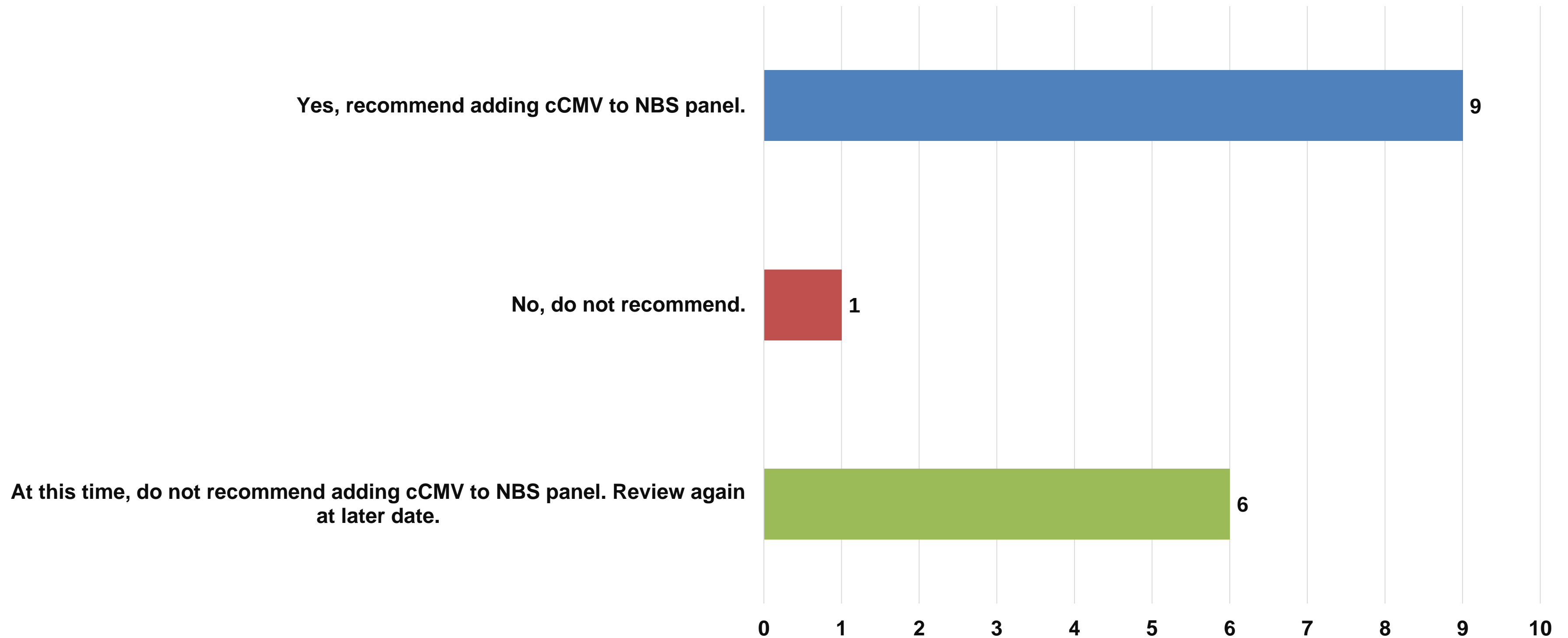
Criteria Review of cCMV



Criteria Review of cCMV



Overall Recommendation for cCMV



Board Member Discussion

- RCW 70.83 specifies testing of dried blood spot specimens.
- Several biological specimen types to screen for cCMV, including saliva, blood, and urine.
- TAC evaluation and recommendation focused on dried urine filter paper.



THANK YOU

To request this document in an alternate format, please contact the Washington State Board of Health at 360-236-4110, or by email at wsboh@sboh.wa.gov | TTY users can dial 711

ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
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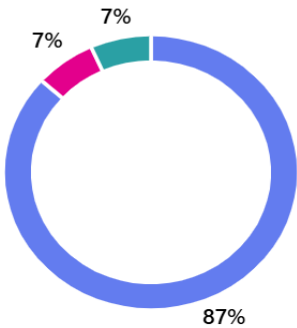


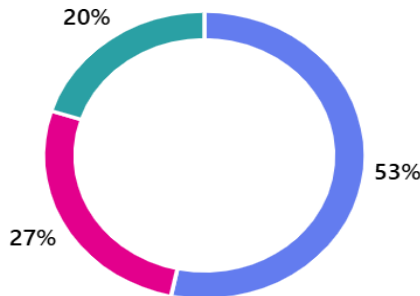
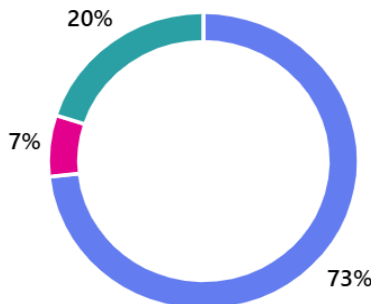
Newborn Screening Technical Advisory Committee (TAC)

Meeting to Review Congenital Cytomegalovirus (cCMV) for the Newborn Screening Panel

TAC Member Voting Summaries and Comments

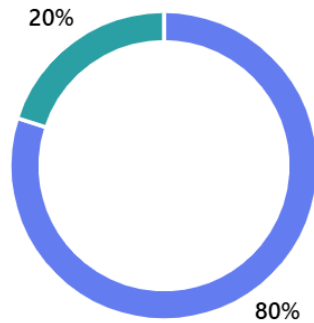
The following is a compilation of comments from TAC members provided when voting on each individual criteria, and an overall recommendation. Comments have been summarized and are organized by each criterion and then overall comments provided.

Criteria	Major themes
<p>1. Available Screening Technology</p> <ul style="list-style-type: none"> ● Yes, meets criterion. 13 ● No, does not meet criterion. 1 ● Unsure or more information needed. 1 	<ul style="list-style-type: none"> • Urine PCR is the gold standard screening test for cCMV due to sensitivity and specificity. • Universal screening may not prevent irreversible harm, but allows for prevention of progression of hearing loss and developmental delays .

<div>2. Diagnostic Testing and Treatment Available</div> <div><div><div>●</div>Yes, meets criterion.</div><div>8</div></div> <div><div>●</div>No, does not meet criterion.</div> <div>4</div> <div><div>●</div>Unsure or more information needed.</div> <div>3</div> <div><table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>Yes, meets criterion.</td><td>8</td><td>53%</td></tr><tr><td>No, does not meet criterion.</td><td>4</td><td>27%</td></tr><tr><td>Unsure or more information needed.</td><td>3</td><td>20%</td></tr></table></div>	Response	Count	Percentage	Yes, meets criterion.	8	53%	No, does not meet criterion.	4	27%	Unsure or more information needed.	3	20%	<div><ul style="list-style-type: none">Concern that medical expertise is not reasonably available to all newborns screened and for the capacity of treatment centers.</div>
Response	Count	Percentage											
Yes, meets criterion.	8	53%											
No, does not meet criterion.	4	27%											
Unsure or more information needed.	3	20%											
<div>3. Prevention Potential and Medical Rationale</div> <div><div><div>●</div>Yes, meets criterion.</div><div>11</div></div> <div><div>●</div>No, does not meet criterion.</div> <div>1</div> <div><div>●</div>Unsure or more information needed.</div> <div>3</div> <div><table><tr><th>Response</th><th>Count</th><th>Percentage</th></tr><tr><td>Yes, meets criterion.</td><td>11</td><td>73%</td></tr><tr><td>No, does not meet criterion.</td><td>1</td><td>7%</td></tr><tr><td>Unsure or more information needed.</td><td>3</td><td>20%</td></tr></table></div>	Response	Count	Percentage	Yes, meets criterion.	11	73%	No, does not meet criterion.	1	7%	Unsure or more information needed.	3	20%	<div><ul style="list-style-type: none">Screening for cCMV will not eliminate harm but can ameliorate consequences of infection.</div>
Response	Count	Percentage											
Yes, meets criterion.	11	73%											
No, does not meet criterion.	1	7%											
Unsure or more information needed.	3	20%											

4. Public Health Rationale

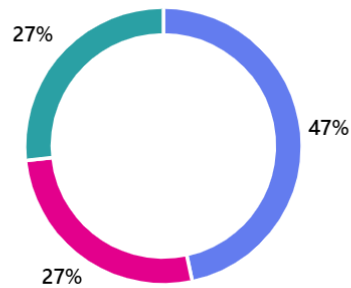
● Yes, meets criterion.	12
● No, does not meet criterion.	0
● Unsure or more information needed.	3



- Risk-based screening not an option as most babies with cCMV are asymptomatic at birth.
- Targeted hearing screening misses a majority of cases.

5. Cost Benefit / Cost Effectiveness

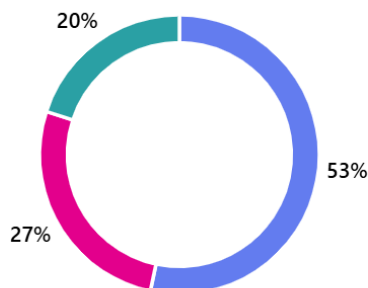
● Yes, meets criterion.	7
● No, does not meet criterion.	4
● Unsure or more information needed.	4



- Intangible benefits may be received from cCMV screening such as limiting family turmoil from a late diagnosis and connection to early intervention.
- Cost benefit is negative.

6. Public Health Infrastructure Readiness

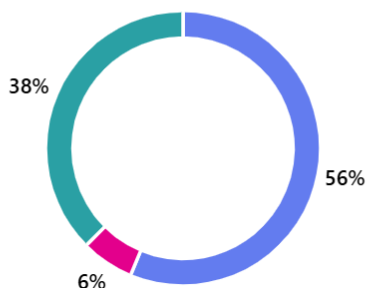
- Yes, meets criterion. 8
- No, does not meet criterion. 4
- Unsure or more information needed. 3



- Lack of infrastructure in Washington, especially in rural areas.
- Demand for infrastructure will be stronger if universal screening is implemented.
- State and community partners to re-evaluate needs after cCMV screening is implemented.

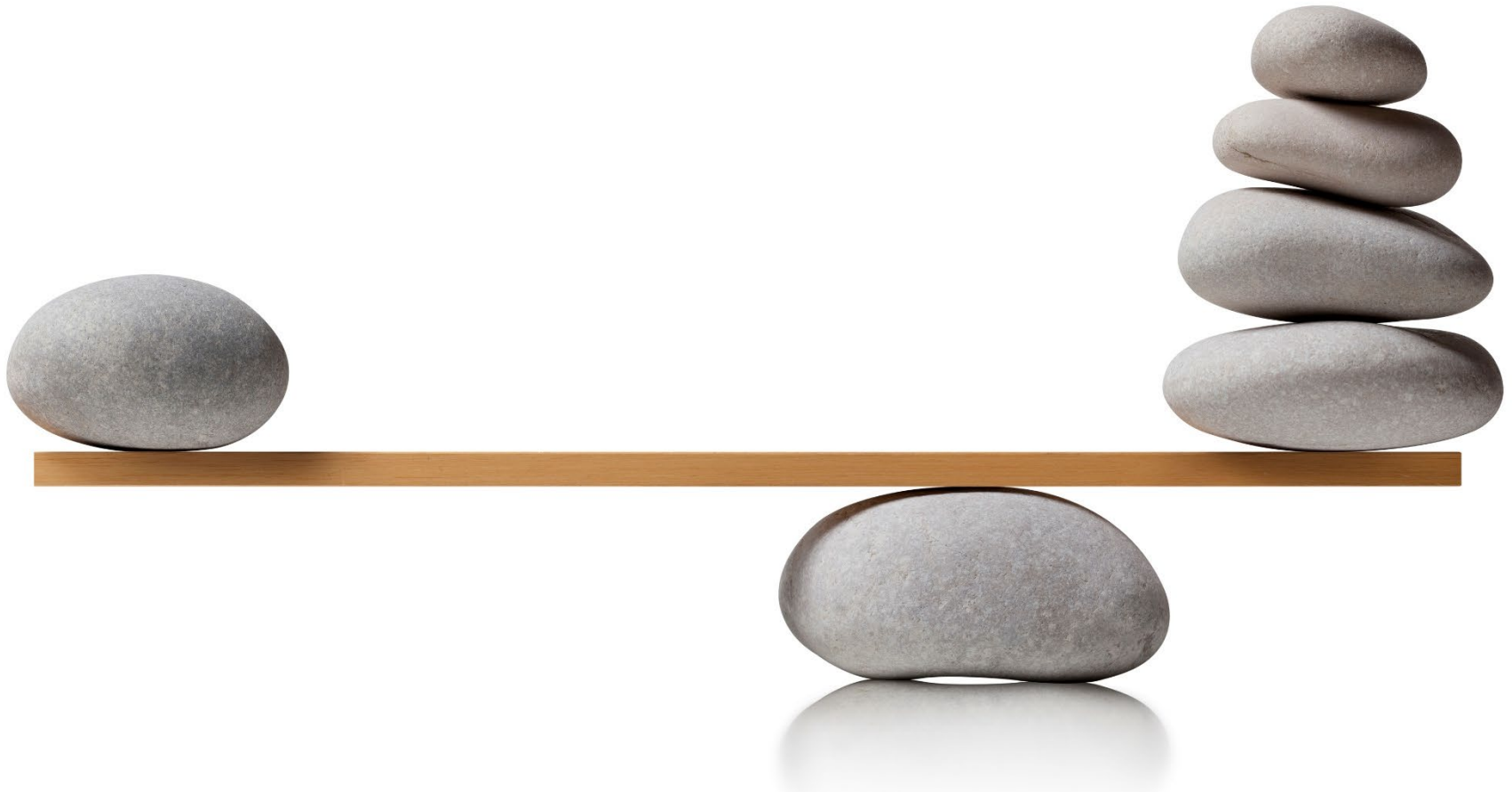
Overall Recommendation to add cCMV to the mandatory newborn screening panel

- I recommend the Board add universal screening of cCMV to the list of conditions for which all... 9
- I do not recommend the Board add cCMV to the list of conditions for which all Washington-born... 1
- At this time, I do not recommend the Board add cCMV to the list of conditions for which all... 6



- cCMV prevention and education should be prioritized for people who are pregnant.
- Concerns for lack of infrastructure, especially for audiological follow-up.
- Rural Washington populations have limited accessibility to healthcare services.
- More data on long-term health outcomes for asymptomatic infants is needed and may lead to an improvement in the cost-benefit of cCMV screening over time.

To request this document in an alternate format or a different language, please contact the State Board of Health at 360-236-4110 or by email at wsboh@sboh.wa.gov.



COST-BENEFIT ANALYSIS OF NEWBORN SCREENING FOR CONGENITAL CYTOMEGALOVIRUS (cCMV)

Megan McCrillis, MPH

Policy Analyst, WA State Newborn Screening Program

John D. Thompson, PhD, MPA, MPH

Director, Newborn Screening Program



Acknowledgement

- We would like to recognize Caitlin Maloney, who completed much of the cost-benefit work in 2022 during the original review of cCMV as a graduate student in the Institute for Public Health Genetics at the University of Washington.
- This is an updated model using the framework of Caitlin's 2022 analysis.

Washington State NBS Criteria

5. Cost-benefit/Cost-effectiveness: The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis.

- The economic analysis considers:
 - The prevalence of the condition among newborns.
 - The positive and negative predictive values of the screening and diagnostic tests.
 - Variability of clinical presentation by those who have the condition.
 - Dollar values for costs and benefits of screening vs. no screening.
- The impact of ambiguous results, adverse effects, or unintended consequences of screening, such as psycho-social or economic impacts on the family and medical system, must also be considered.
- The results of the economic analysis shows that the outcomes, financial or otherwise, outweigh the costs of screening.
- There is adequate evidence of acceptable quality to evaluate this criterion.

CMV and the RUSP

In 2022, the Advisory Committee on Heritable Disorders in Newborns and Children declined to move the CMV nomination forward to the evidence review step, due to the lack of a prospective population-based pilot study.

Strategy

Decision Tree

- Compares status quo v. screening model
- Data from primary literature, states currently screening or pilot studies, expert opinion

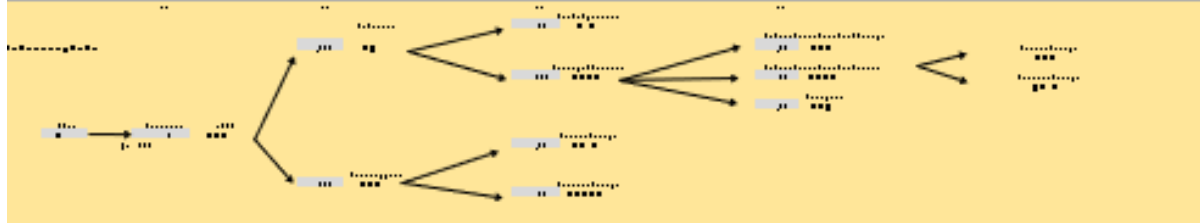
Sensitivity analysis – vary assumptions

- High and low estimates for parameters

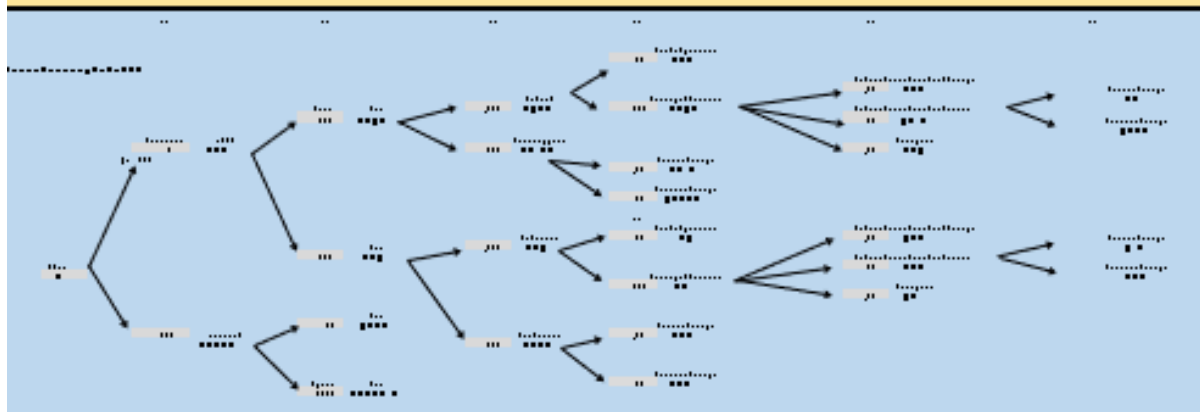
cCMV does not fit typical newborn screening rationale

- No quantifiable difference in mortality/neurodevelopmental outcomes at this time
- Potential benefit: early identification and intervention of hearing loss for infants with clinically inapparent cCMV infection

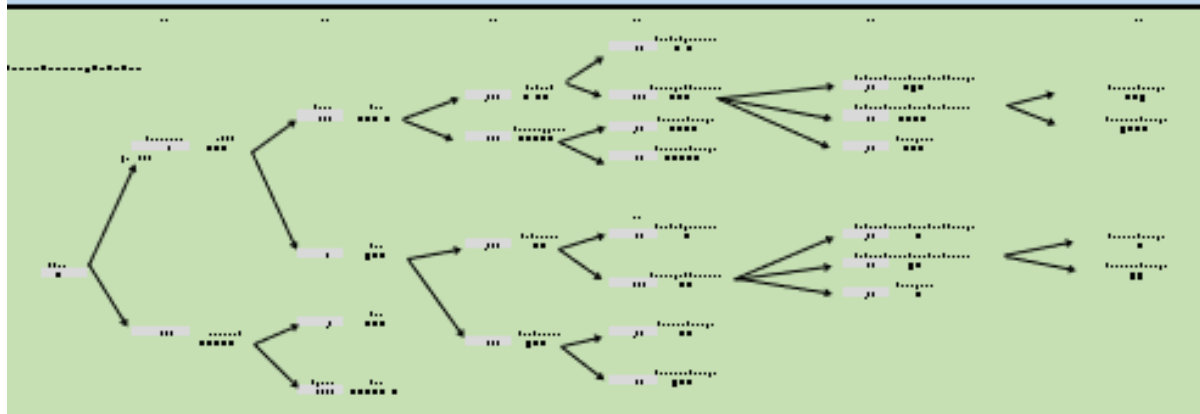
No Screening



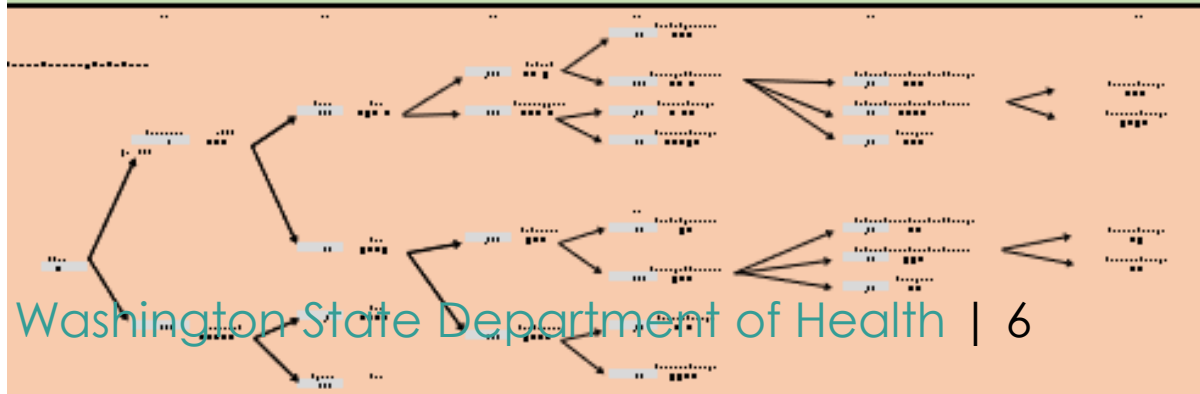
Universal
Screening:
Dried blood
spot



Universal
Screening:
Dried Urine
Filter Paper



Universal
Screening:
Dried Saliva
Swab



Benefits vs. Costs: All Specimen Types

	Total Benefits	Total Costs	Start-up Cost (one-time)	Net Benefit	Benefit/Cost Ratio
Dried Urine Filter Paper	\$2,424,044	\$3,383,327	\$203,442	-\$959,282	0.58-0.72
Dried Blood Spot	\$1,872,903	\$3,043,740	\$94,765	-\$1,170,836	0.49-0.62
Dried Saliva Swab	\$2,320,401	\$3,540,158	\$203,442	-\$1,219,756	0.53-0.66

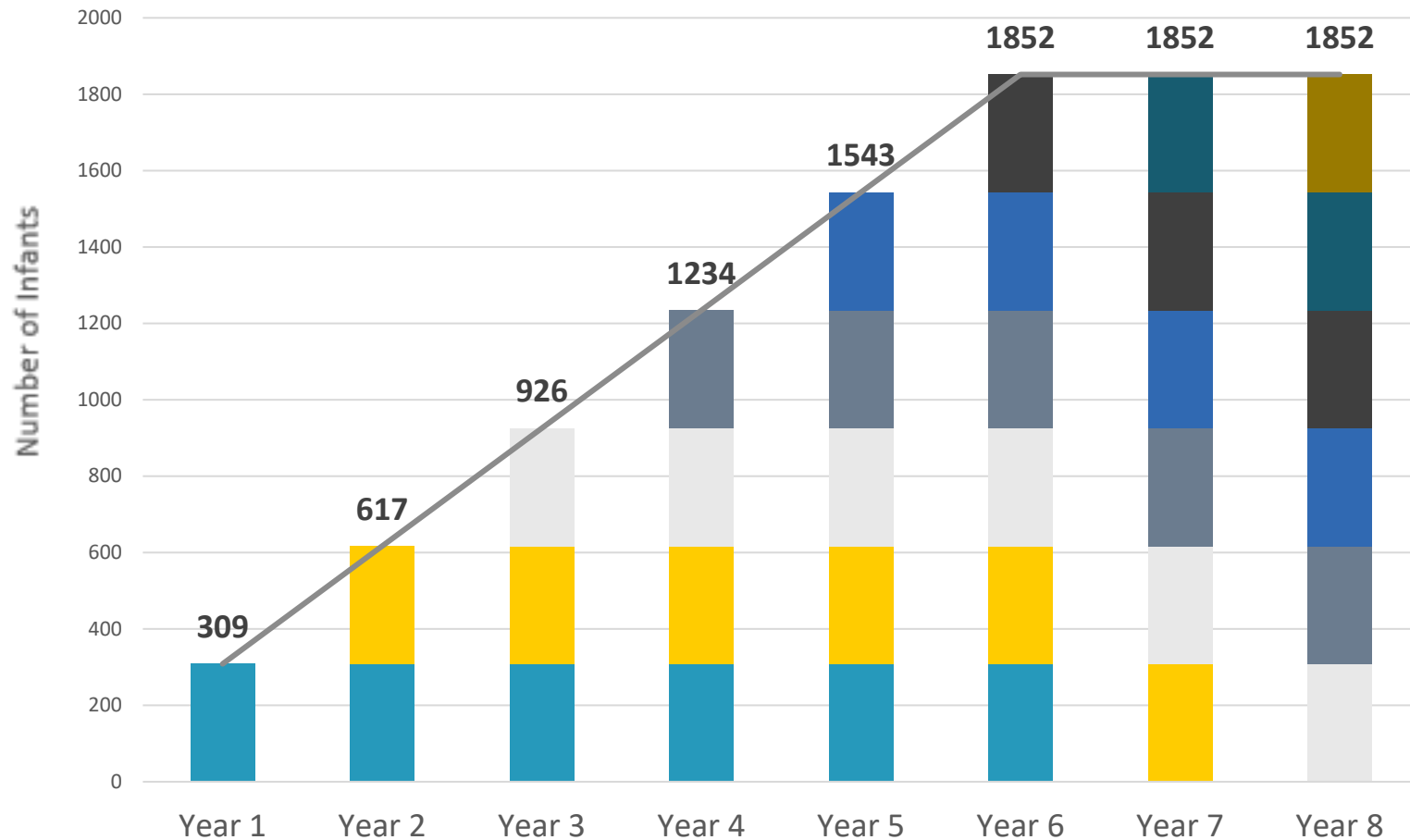
Minnesota CMV experience

- Minnesota became the first state to universally screen all newborns for cCMV by PCR on dried bloodspots
- They published findings after the first year of screening (2023-2024), which included 60,115 newborns
- Of note, they reported 75% of confirmed cases completed comprehensive initial evaluations and linkage to care
- Our cost – benefit model assumed all confirmed cases would complete the surveillance schedule, but that component may be more challenging in practice and may limit the amount of benefit a screening program could provide
- If we adjusted our model to reflect a 75% participation in hearing surveillance, the benefit cost ratio for urine screening would be reduced from 0.72 to 0.58

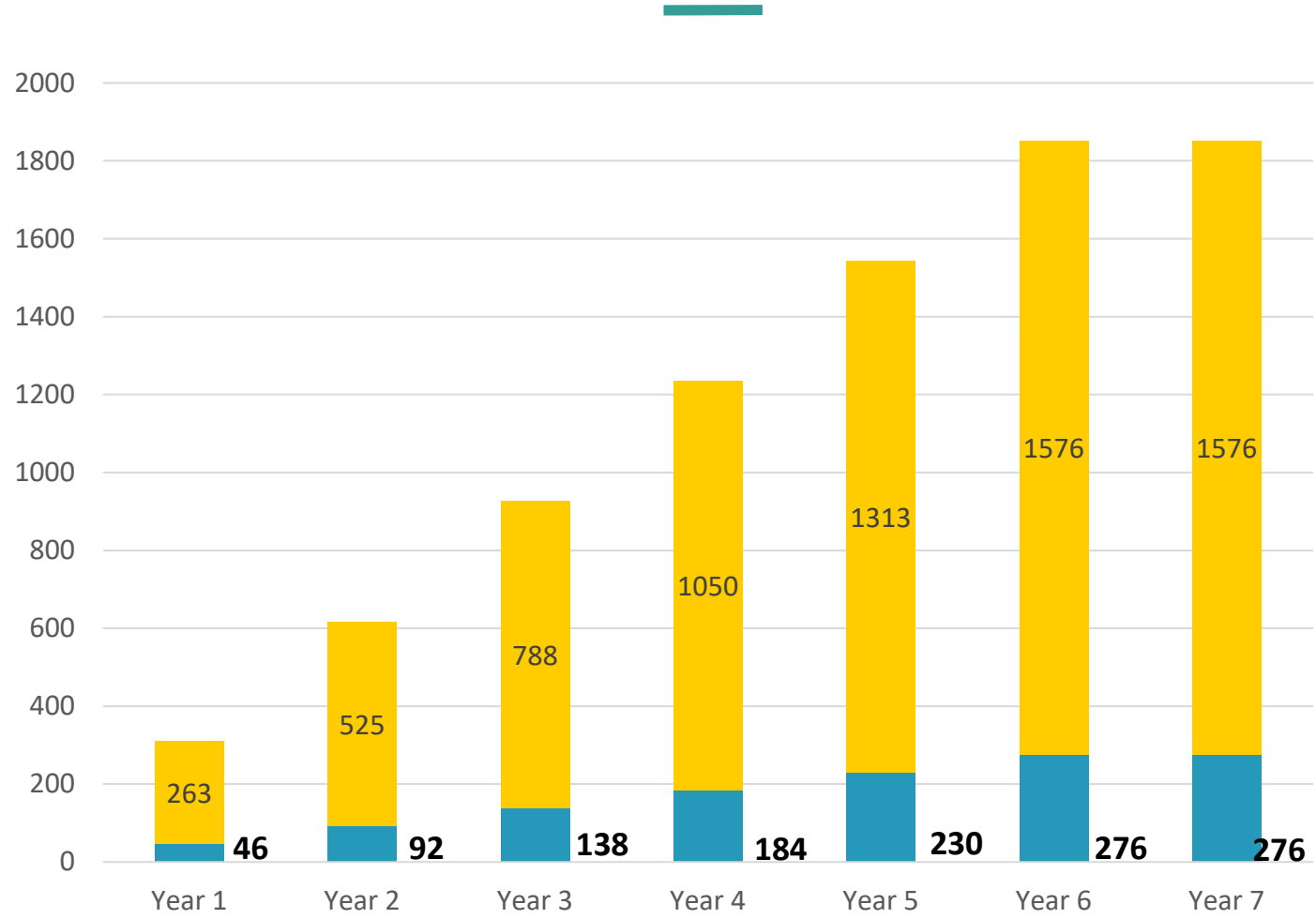
Intangible Benefits and Costs

- Emotional impact on individuals and families
 - 43 additional infants benefit from surveillance and early identification
 - 242 additional infants will go through surveillance and not receive benefits from early identification

Surveilling cCMV Positive Infants for Hearing Loss



cCMV Positive Infants Who Develop Late Onset Hearing Loss



Intangible Benefits and Costs

- Emotional impact on individuals and families
 - 43 additional infants benefit from surveillance and early identification
 - 242 additional infants will go through surveillance and not receive benefits from early identification
- Wages lost for parents and families
- CMV infections prevented from prenatal education and outreach
 - State prenatal CMV education bill, SB 5829, which required DOH to develop educational materials for pregnant people to inform about CMV and strategies to reduce transmission

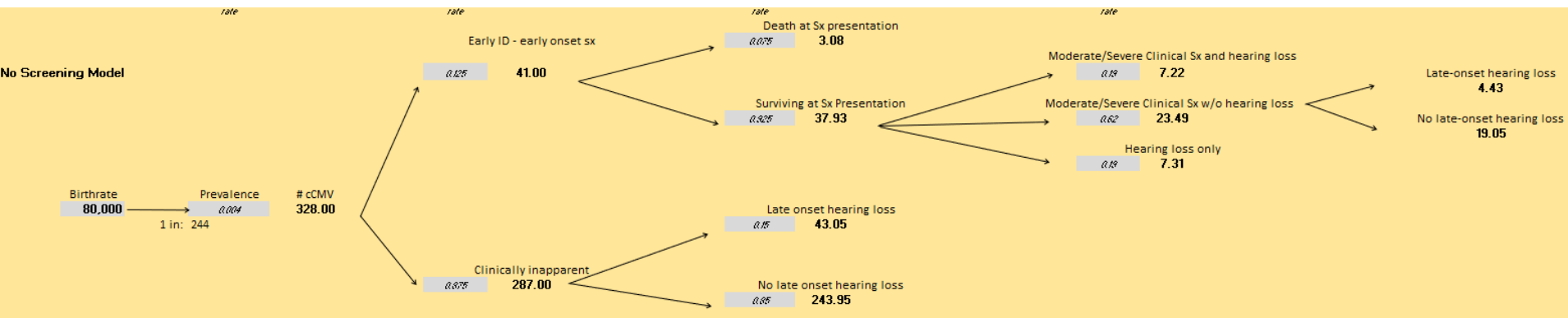
Questions?



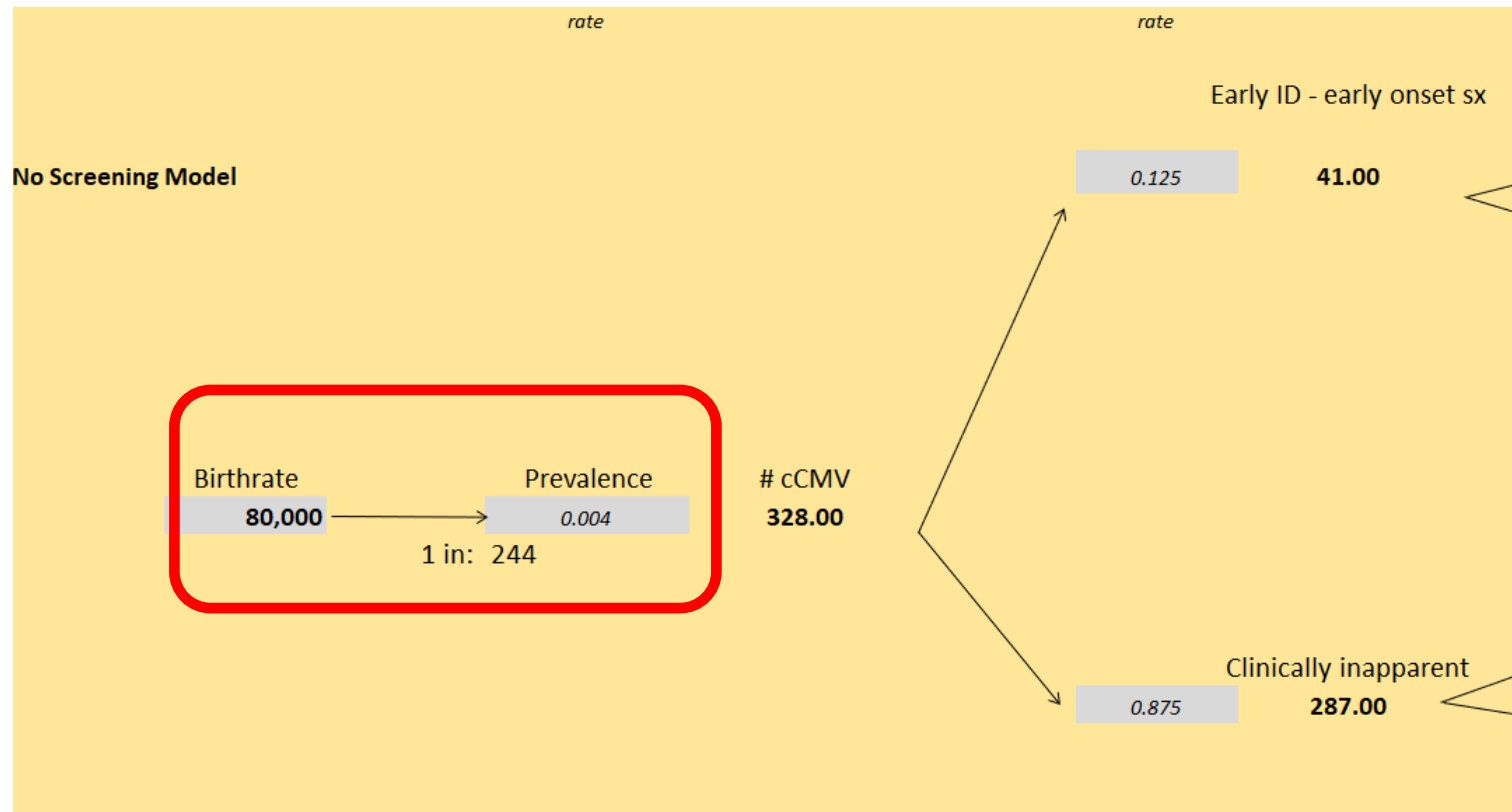
Materials on the following slides are for
reference



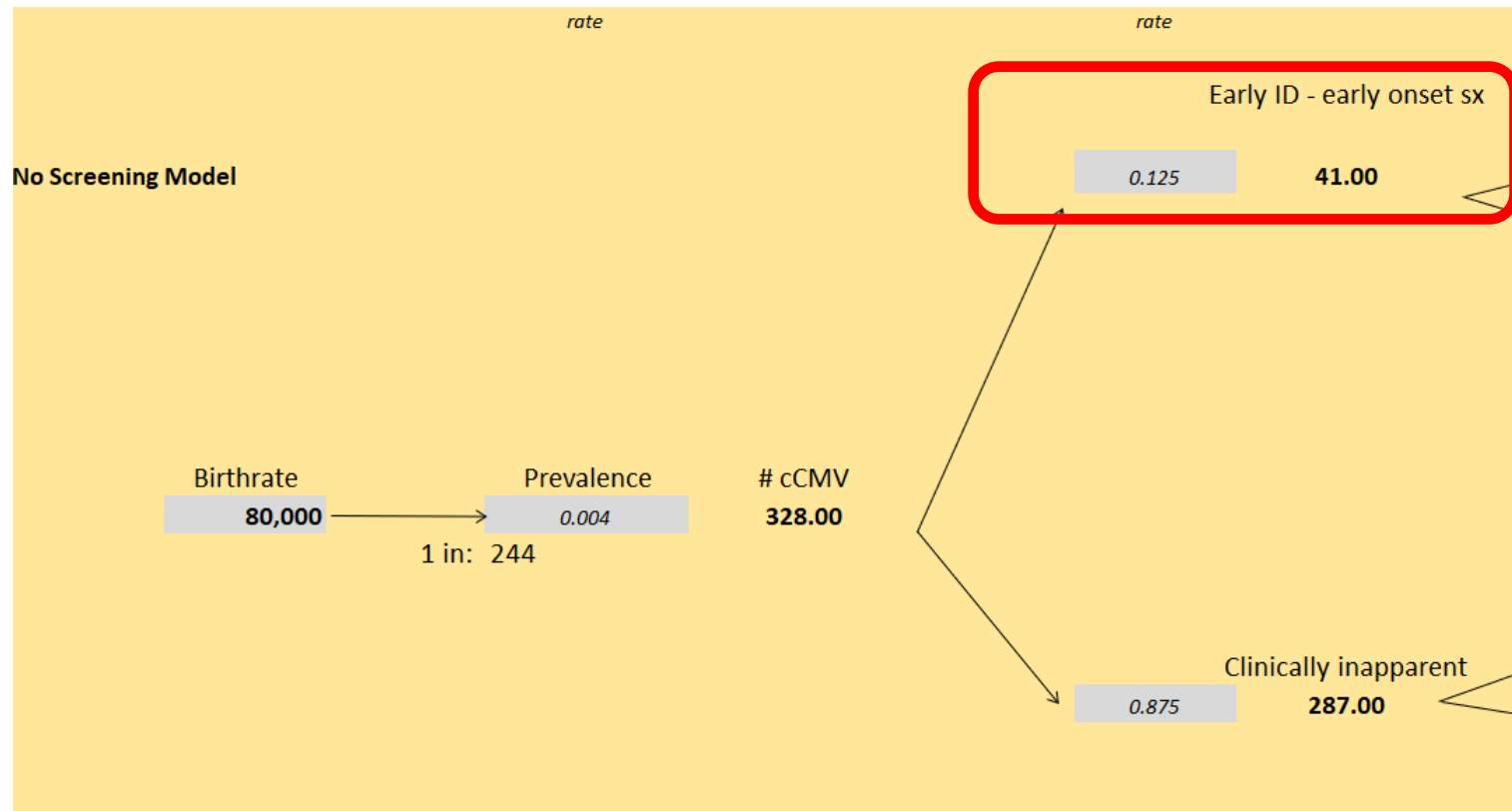
No Screening Model



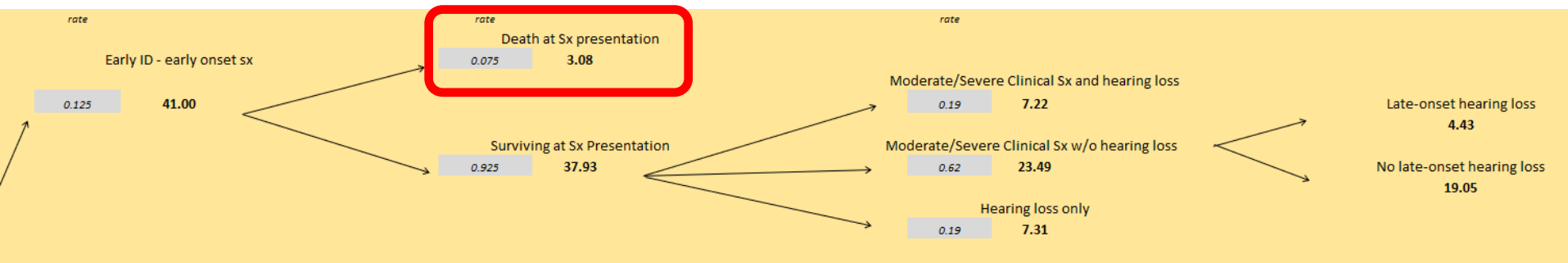
No Screening Model



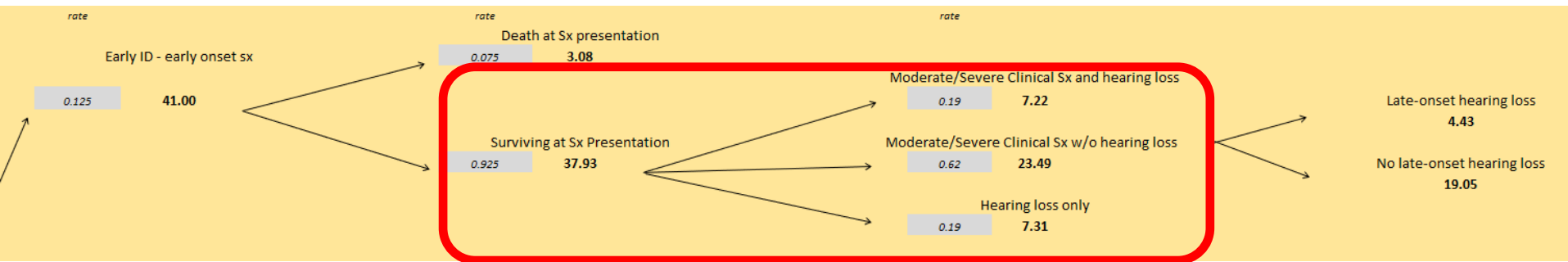
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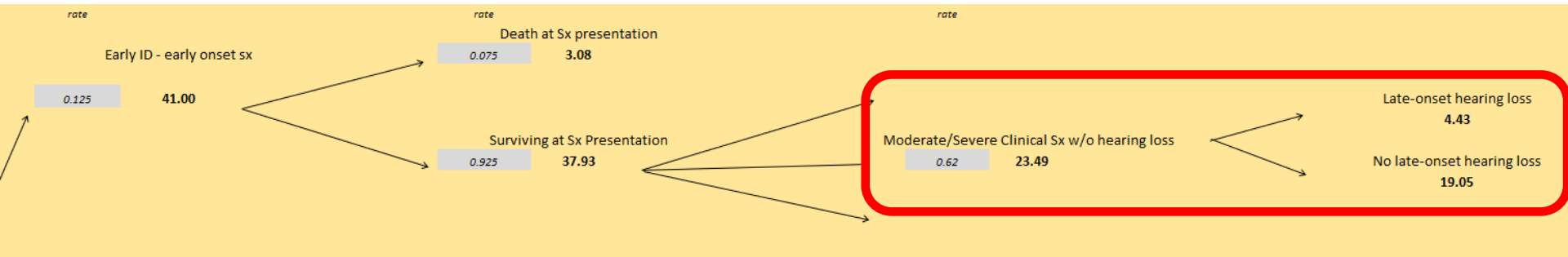
No Screening Model



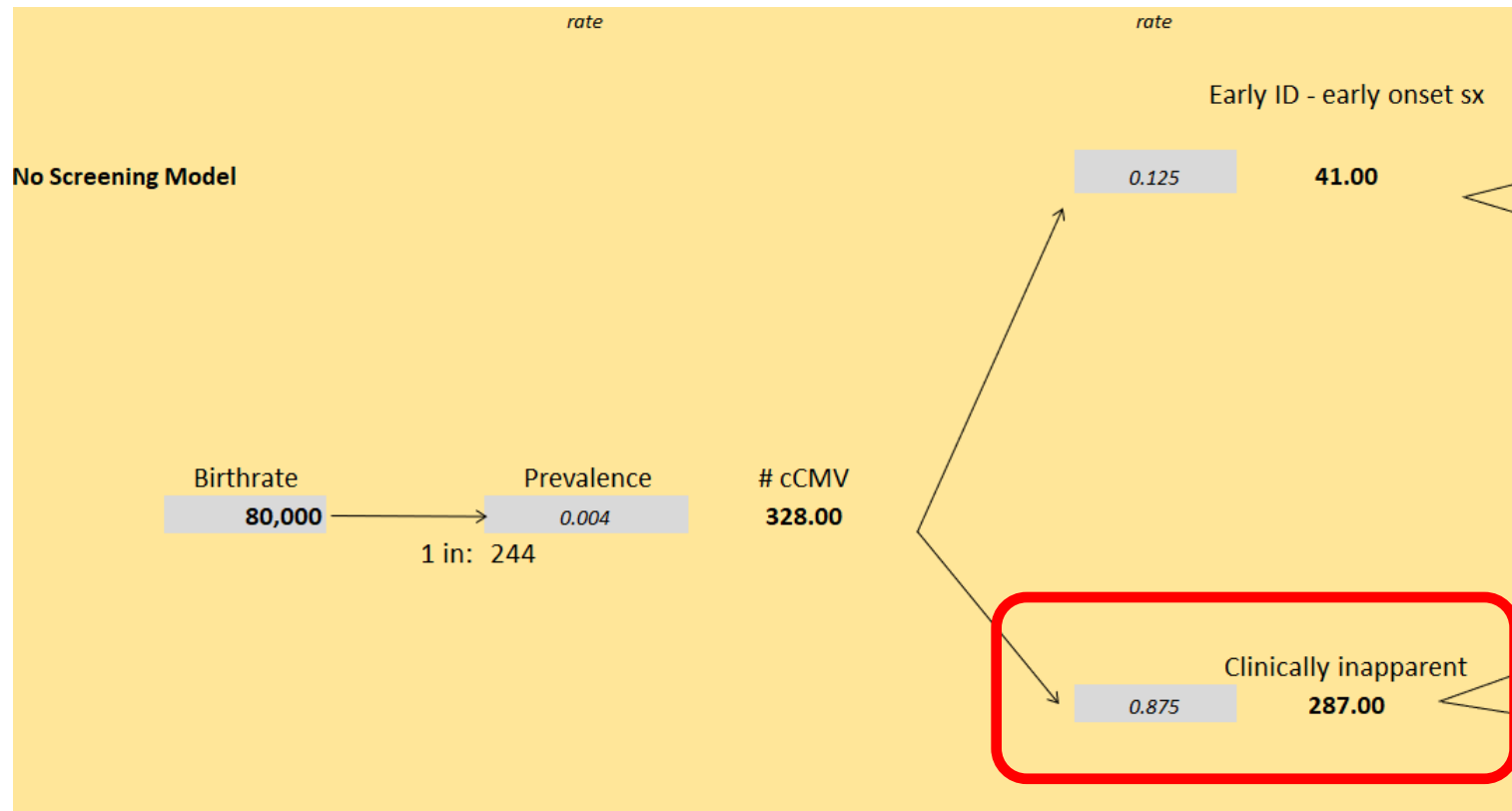
No Screening Model



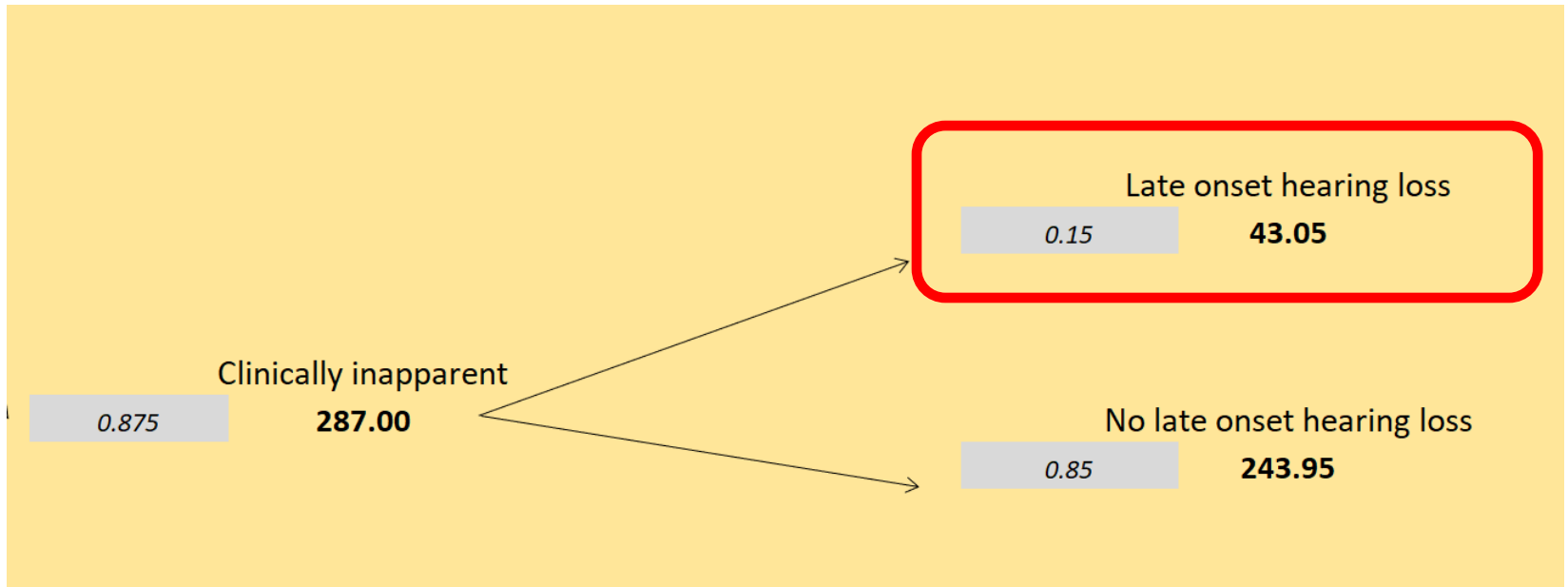
No Screening Model



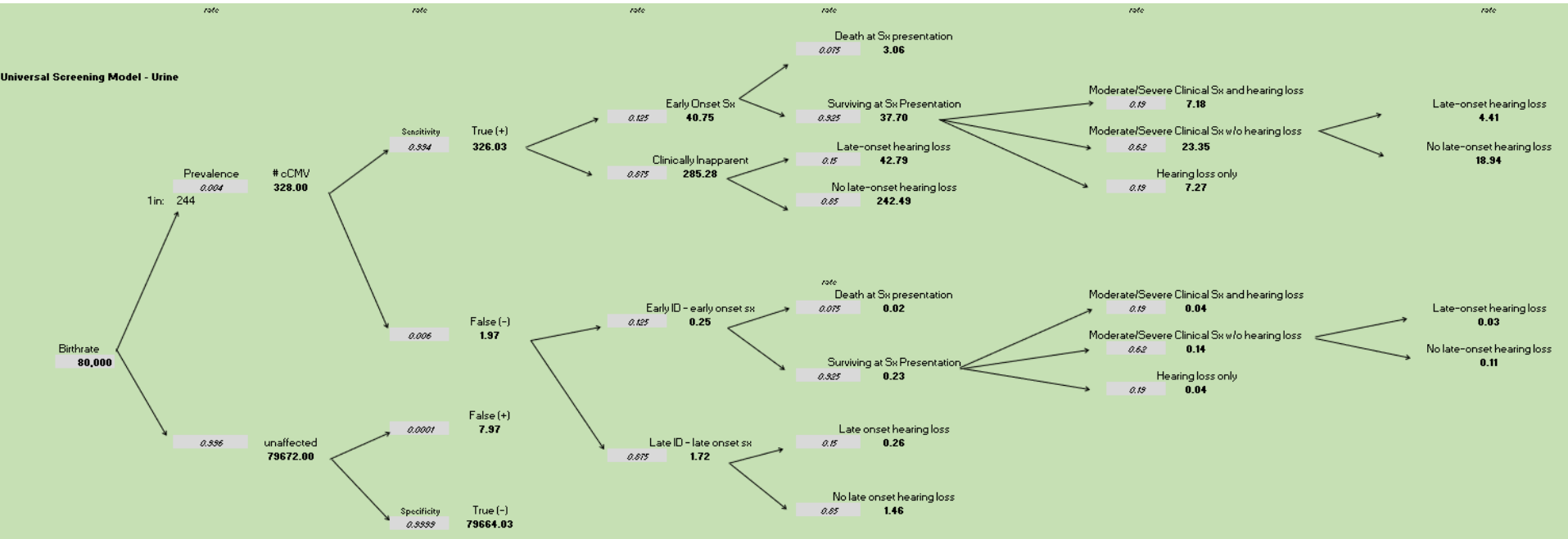
No Screening Model



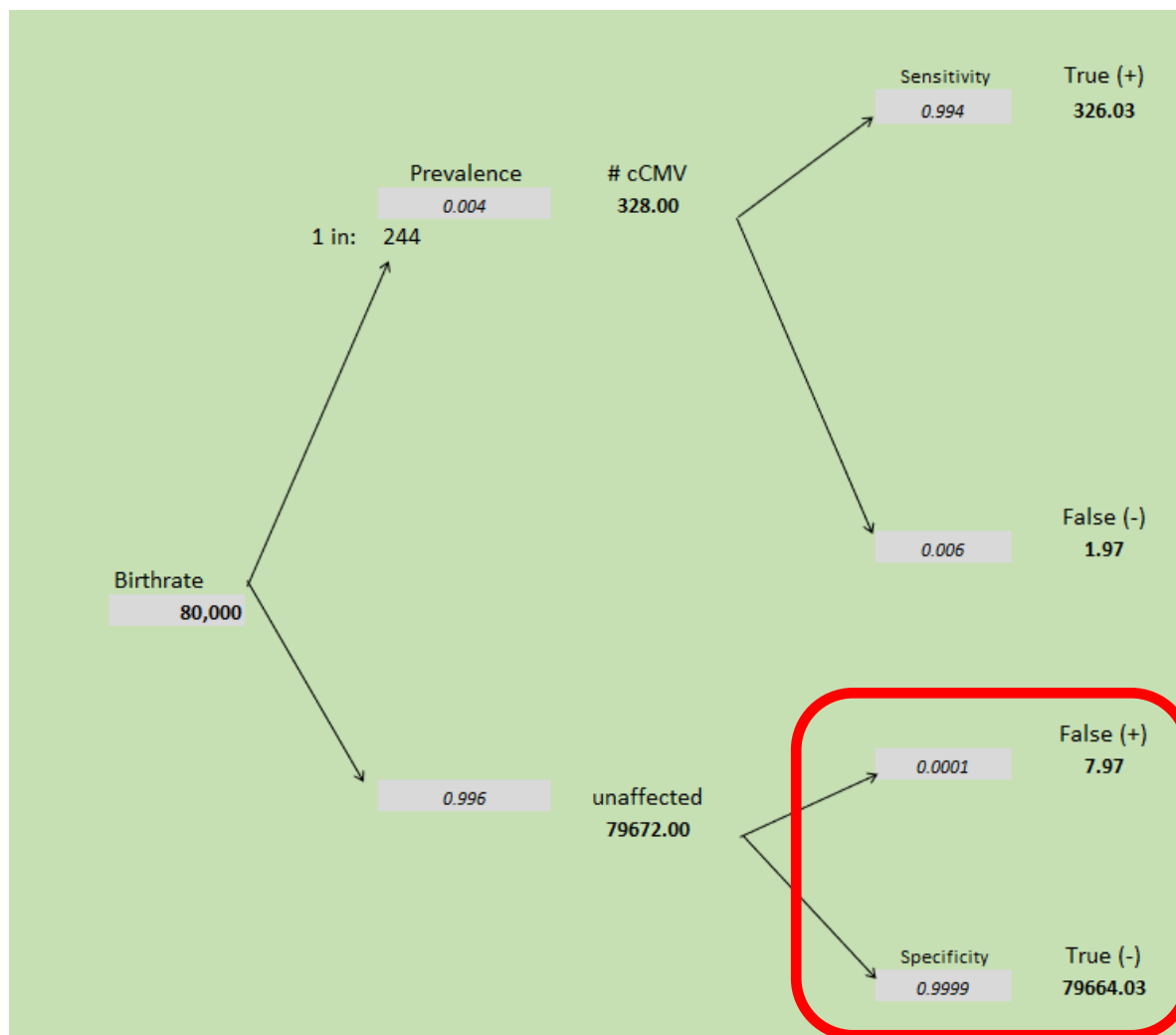
No Screening Model



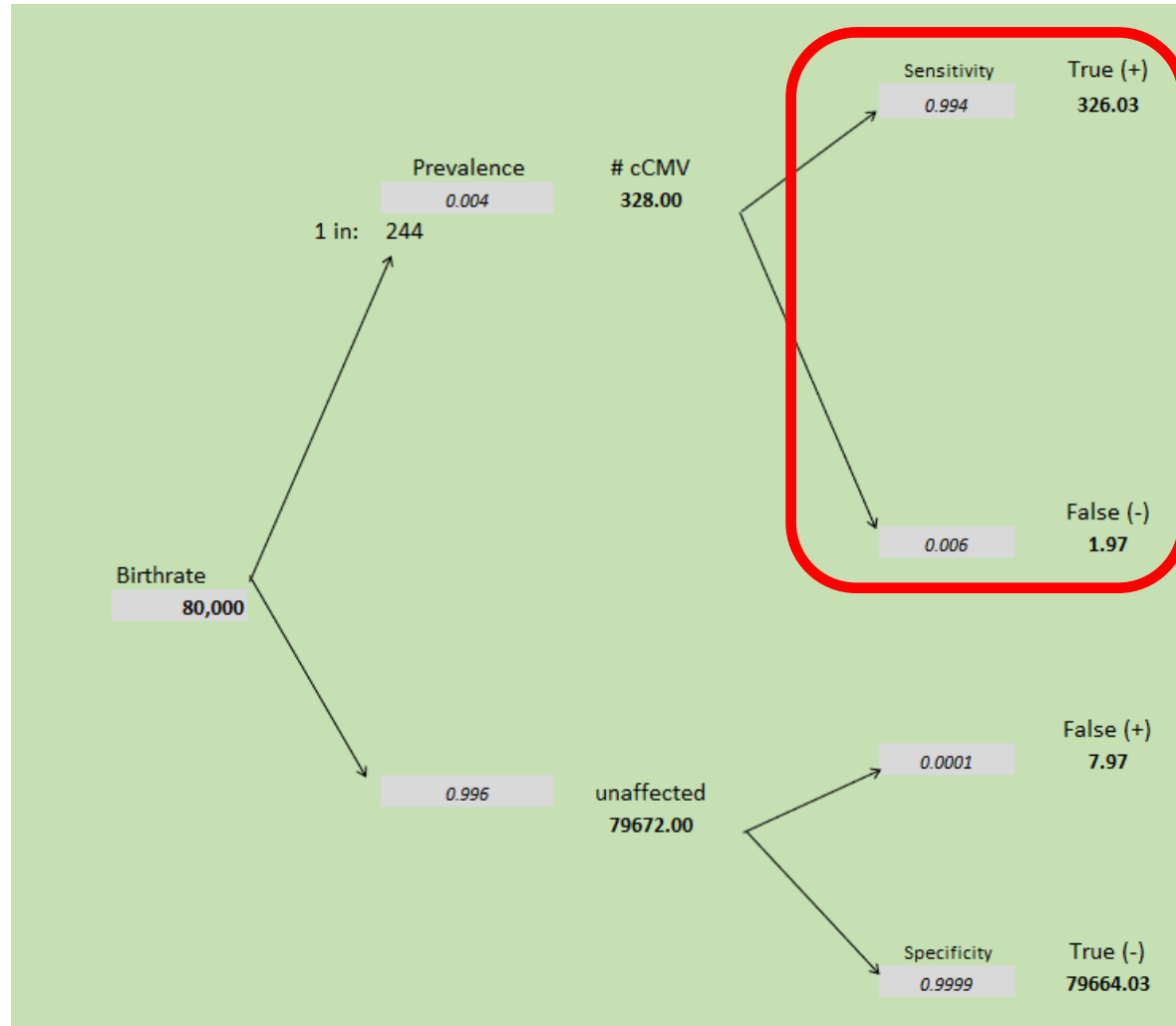
Universal Screening Model: Dried Urine Filter Paper



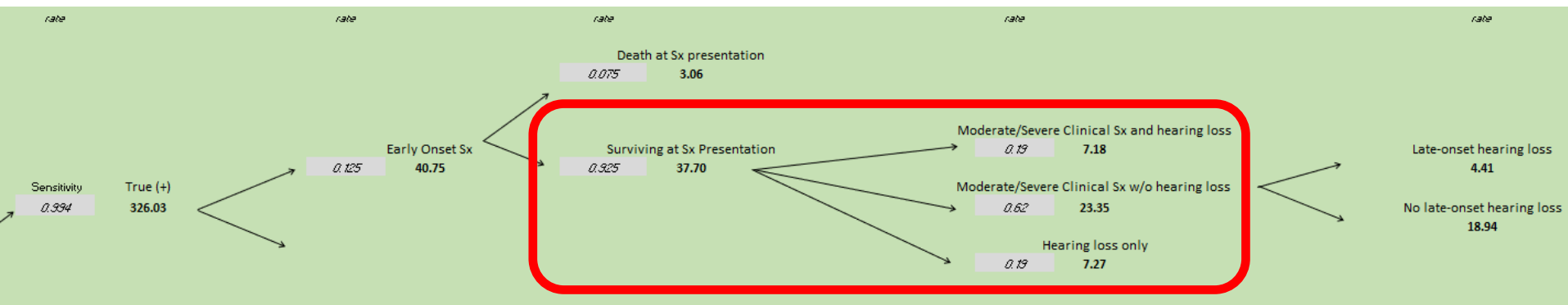
Universal Screening Model : Dried Urine Filter Paper



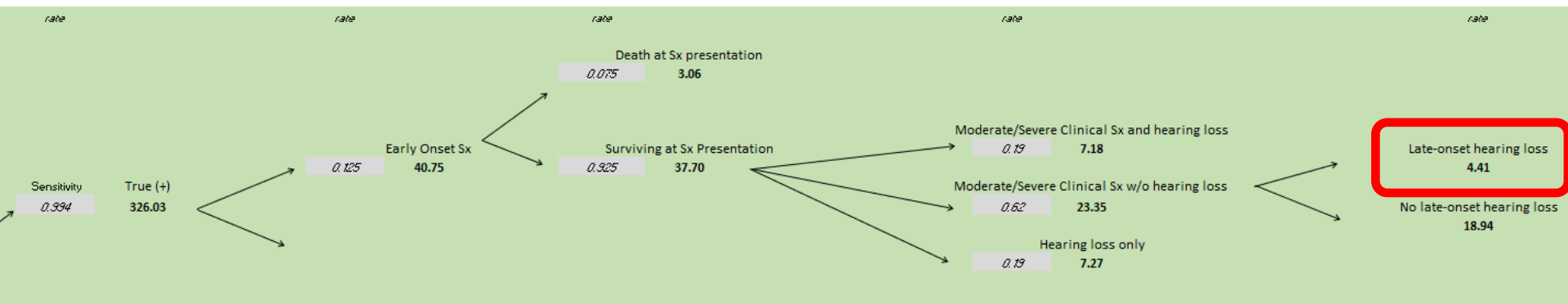
Universal Screening Model : Dried Urine Filter Paper



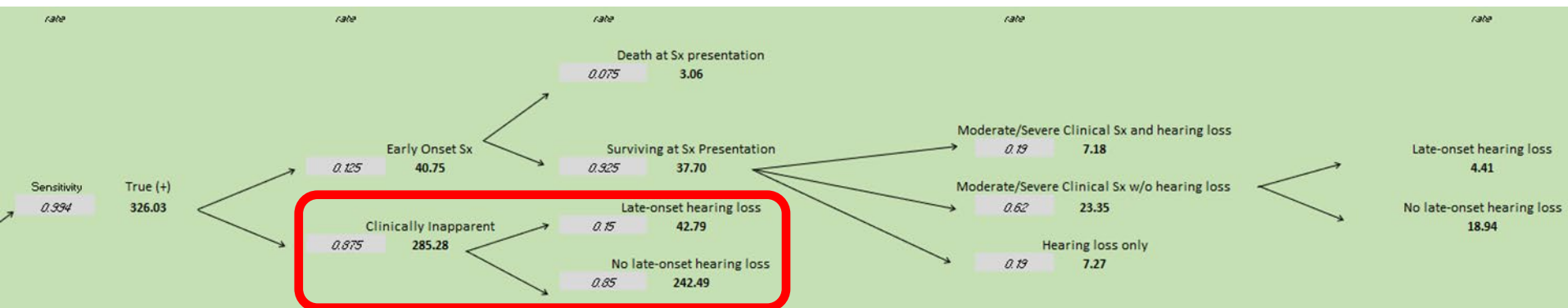
Universal Screening Model : Dried Urine Filter Paper



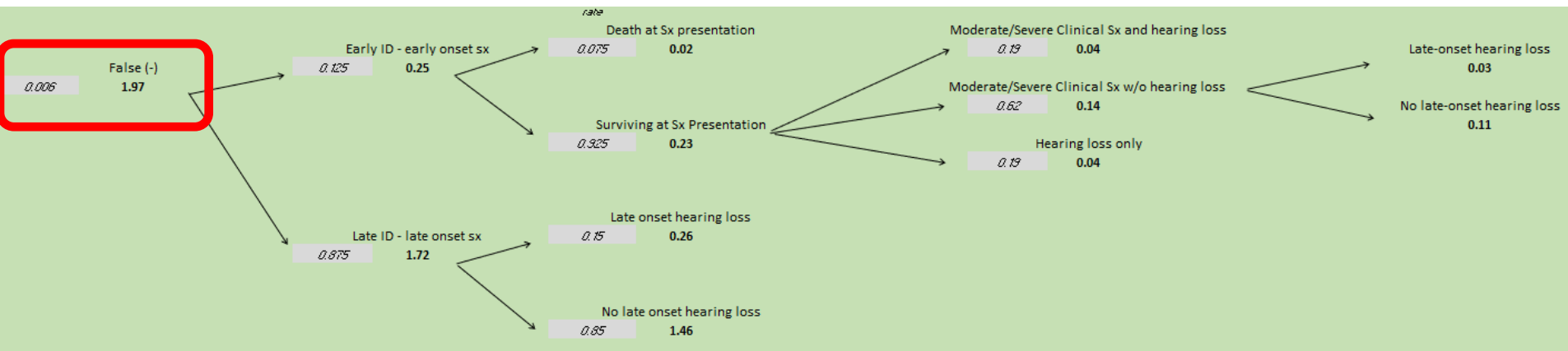
Universal Screening Model : Dried Urine Filter Paper



Universal Screening Model : Dried Urine Filter Paper



Universal Screening Model : Dried Urine Filter Paper



No Screening vs. Universal Urine Screening

	No Screening	Universal Screening (Urine)
Deaths	3.08	3.08
# of babies with diagnostic testing	41.00	334.25
# of babies w/ late onset hearing loss and early intervention	4.43	47.22
# of babies w/o hearing loss but 6 years surveillance	19.05	261.55

No Screening vs. Universal Urine Screening

	No Screening	Universal Screening (Urine)	Shift
Deaths	3.08	3.08	0.00
# of babies with diagnostic testing	41.00	334.25	+293.25
# of babies w/ late onset hearing loss and early intervention	4.43	47.22	+42.79
# of babies w/o hearing loss but 6 years surveillance	19.05	261.55	+242.50



PUBLIC HEALTH INFRASTRUCTURE READINESS FOR CONGENITAL CYTOMEGALOVIRUS (cCMV)

John D. Thompson, PhD, MPA, MPH
Director, Newborn Screening Program

Washington State NBS Criteria

6. Public Health Infrastructure Readiness: The Newborn Screening Program's capacity to implement screening within a reasonable timeframe has been considered.

- The systems and staffing necessary to perform the test and report screening results have been identified.
- Resources needed to implement short/long term follow up protocols by the newborn screening program have been identified.
- Accessibility to treatment for anyone diagnosed with the condition is considered acceptable based on the frequency of treatment needed.

Public Health Infrastructure Readiness

Systems and staffing needed to test and report test results:

Systems:

Additional laboratory equipment needed:

- 2 punch indexers to punch urine filter paper
- 3 new DNA testing machines
- Sample prep equipment such as liquid handlers/thermomixers

Staffing:

Ongoing:

- 1.7 full time equivalent in laboratory staff

Start-up:

- Approximately 1360 staff hours to validate lab methodology, develop follow up procedures and develop infrastructure for new specimen type

All of these needs were included in the cost-benefit analysis

Public Health Infrastructure Readiness

Resources needed to implement short/long term follow up protocols by the newborn screening program have been identified:

Ongoing:

- 1 full time equivalent for short term follow up
- 1 full time equivalent for long term follow up

Start-up:

- At least 80 hours of staff time to develop long term follow up program and follow up procedures and infrastructure

All of these needs were included in the cost-benefit analysis

Questions?





BOH MEETING – cCMV
APRIL 9, 2025



EHDDI Program

EHDDI Program

Early Hearing Detection Diagnosis and Intervention



EHDDI Program Goals

National 1-3-6 Goals for all state EHDDI Programs

- 1** All infants receive a hearing screen before they are **1** month old.
- 3** Infants who do not pass two hearing screens have a diagnostic evaluation before they are **3** months old.
- 6** Infants who have been identified as deaf or hard of hearing (DHH) start early support (early intervention) services before they are **6** months old.



What Does EHDDI Do?

- Monitors that EHDDI 1-3-6 goals are met by collecting and reviewing data:
 - Hearing screening results
 - Diagnostic hearing evaluation results
 - Early support enrollment data
- Recommends follow-up through primary care providers (PCPs) when an infant needs additional testing or services.
- Works with audiologists, Family Resources Coordinators (FRCs), and PCPs to ensure audiology and early support referrals are placed and received.
- Provides families with resources when a child is referred for diagnostic testing and identified as deaf or hard of hearing.



Newborn Hearing Screening in Washington

- Newborn hearing screening is **optional** in Washington State.
 - All birth hospitals provide hearing screenings.
 - 99% of infants receive a hearing screening.
 - 63 midwives have hearing screening equipment.
 - Provide hearing screenings to out-of-hospital births.
 - ◆ 65% of out-of-hospital births received a hearing screening.
- 1-3 infants per 1,000 births are deaf or hard of hearing.
- Each year, ~170 infants born in Washington are identified as deaf or hard of hearing.



Risk Factors for Hearing Differences (Hearing Loss)

1. Extended stay in NICU
2. Syndromes
 - Trisomy 21
 - Waardenburg
 - Branchio-Oto-Renal
 - CHARGE
 - Usher
 - Pendred
3. Family History
4. Craniofacial Anomalies
 - Cleft Lip/Palate
 - Atresia/Microtia
 - Ear Tags/Ear Pits
5. In-Utero Infections
 - Toxoplasmosis
 - Syphilis
 - **CMV**
 - Rubella
 - Herpes

DO NOT USE THIS AREA		NEWBORN SCREENING (EHDDI) WASHINGTON STATE DEPT. OF HEALTH P.O. BOX 55729 (1610 NE 150TH ST) SHORELINE, WA 98155-0729 Phone: 206-418-5410 Toll Free: 1-866-660-9050			
MOTHER'S INFORMATION		CHILD'S INFORMATION			
LAST NAME		Mo Day Yr Hr : Mn am pm			
FIRST NAME		Birth: ____/____/____ : ____ : ____			
MISCELLANEOUS INFORMATION		Collection: ____/____/____ : ____ : ____			
		Name: First Last			
		Med Rec #: _____			
		Sex: M <input type="radio"/> F <input type="radio"/> Gestational Age: _____ weeks			
		Birth Order: single <input type="radio"/> if multiple A <input type="radio"/> B <input type="radio"/>			
HEARING SCREENING					
Date of Screen ____/____/____		Follow-Up Clinic: _____		Screener Initials: (please print)	
Refused <input type="radio"/>		Left Ear		Right Ear	
Test Method		Pass <input type="radio"/>		Pass <input type="radio"/>	
<input type="radio"/> TEOAE		Refer <input type="radio"/>		Refer <input type="radio"/>	
<input type="radio"/> ABR					
<input type="radio"/> DPOAE					
		Risk Factors Present (See Definitions on Back of Card) 1 2 3 4 5 <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> 0 - No Risk Factors			
EHDDI				5398601X	

cCMV and Hearing Differences

- cCMV is the leading non-genetic cause of sensorineural hearing loss (SNHL) in children.
 - Accounts for 25% of hearing differences in children by age 4.
- cCMV related SNHL can occur:
 - At birth or later in childhood.
 - In 30%-70% of symptomatic cases.
 - In 10%-15% of asymptomatic cases



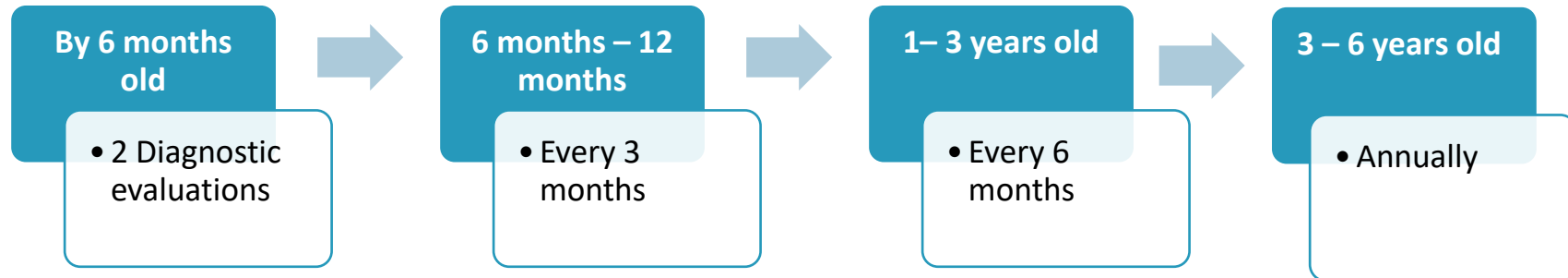


Current Process: Risk Factor Follow-Up

- For infants who pass their hearing screening, but have a risk factor, we provide follow-up recommendations to the PCP through fax.
 - [Joint Committee on Infant Hearing \(JCIH\) 2019 Position Statement](#)
 - First evaluation by 3 months of age
 - Then every 12 months to age 3 or shorter intervals based on parent/caregiver concern
- We send a maximum of two faxes then our follow-up process ends unless we receive a diagnostic evaluation showing the child needs more follow-up.

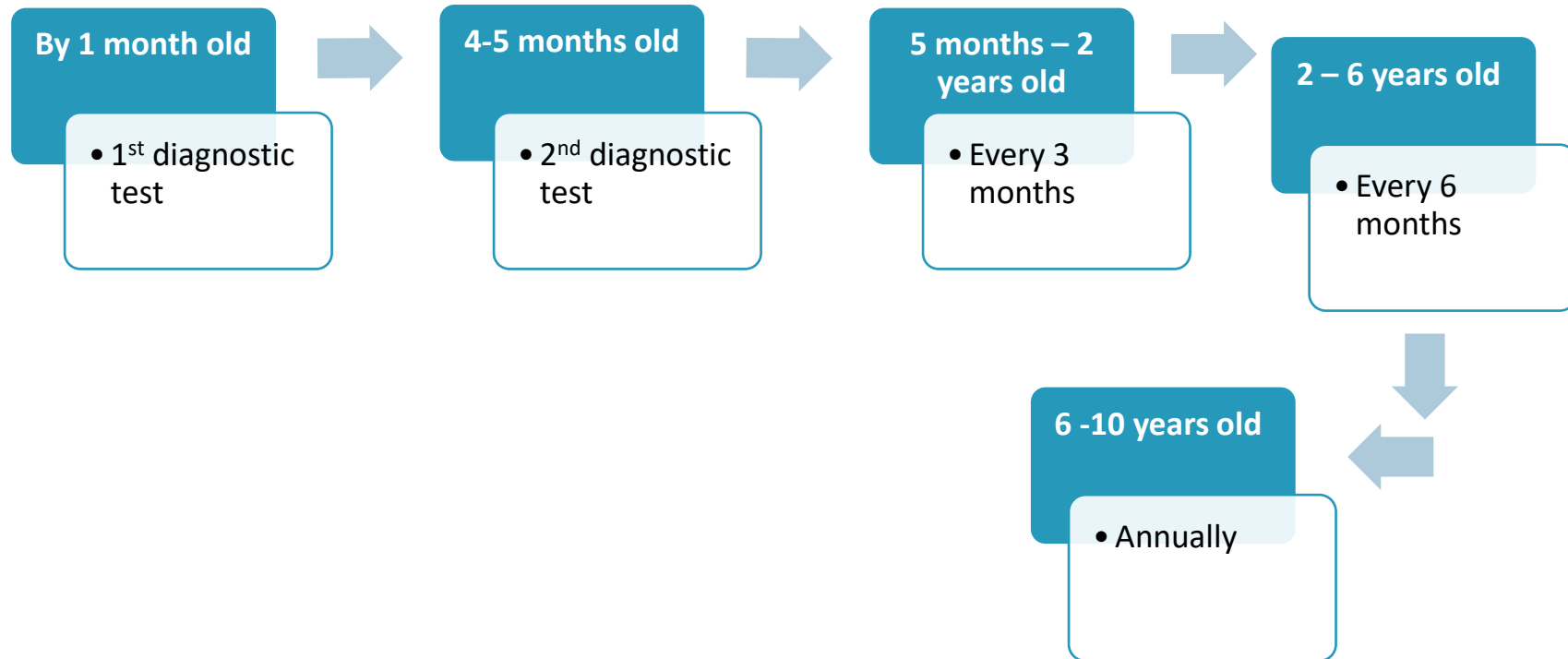
Recommended Audiological Monitoring - cCMV Infants that Passed their Hearing Screen

- Seattle Children's Audiology – Based on [American Academy of Audiology](#) recommendations.



Recommended Audiological Monitoring

● Minnesota



Pediatric Audiology Clinics in Washington

- Pediatric audiology clinics have specialized equipment needed to test children from birth to 6-9 months of age.
 - [30 clinics in Washington](#)
 - 8 in Central/Eastern Washington
 - 22 in Western Washington
 - 5 clinics in Oregon near the Washington border
 - 2 clinics frequently see Washington patients.
- 9 audiology clinics only see pediatric patients
 - Mary Bridge Audiology (5 clinics)
 - Seattle Children's Audiology (3 clinics)
 - UW Pediatric Audiology (1 clinic)

Current Challenges

- Longer wait times (2-3 months) at larger audiology clinics.
 - Seattle Children's
 - Mary Bridge
- Lack of pediatric audiology clinics in Central/Eastern Washington.
- The clinics in Central/Eastern Washington are smaller.
 - Do not have as many audiologists
 - Less capacity for patients



Summary

- The EHDDI program conducts follow-up when notified that a child has cCMV.
- There are no universally accepted guidelines for the long-term audiological follow-up of children with cCMV.
- Infants with late onset hearing differences will be identified through universal screening and monitoring.
- Increase in children requiring audiological follow-up may strain capacity at audiology clinics.



Questions?



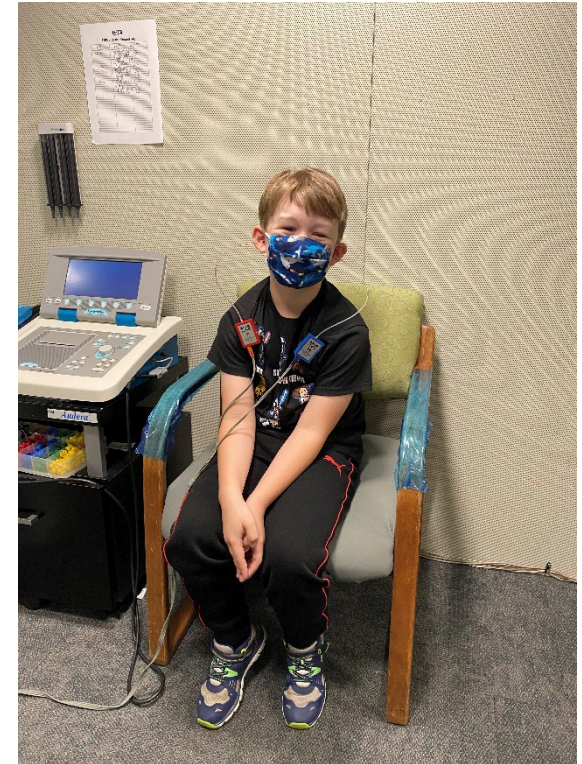
EHDDI Program

1610 NE 150th St
Shoreline, WA 98155
Toll-free: 1-888-WAEHDDI
Fax: 206-364-0074
Email: ehddi2@doh.wa.gov
Website: www.doh.wa.gov/earlyhearing

Julie Walker
Phone: 206-418-5556
Julie.Walker@doh.wa.gov

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Kelsey.Davis@doh.wa.gov

Anna Dodd
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Anna.Dodd@doh.wa.gov





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WASHINGTON STATE BOARD OF HEALTH

Date: April 9, 2025

To: Washington State Board of Health Members

From: Kelly Oshiro, Board Member

Subject: Rules Briefing, Chapter 246-650 WAC, Auditory Screening Standards – School Districts

Background and Summary:

Under state law (RCW 28A.210.020), the Washington State Board of Health (Board) sets the rules for yearly hearing screenings in schools. These rules are in chapter 246-760 WAC. The rules ensure that schools can identify students with diminished hearing and refer them for follow-up care.

In August 2023, the Lake Chelan Lion's Club requested that the Board update its hearing screening rules. They suggested adding another screening technology called otoacoustic emission screening (OAE). The Board accepted the request and filed a CR-101, Preproposal Statement of Inquiry, in October 2023 to consider this update and other minor changes.

Since then, Board staff have worked with hearing experts, reviewed potential rule changes, and gathered feedback from interested parties and affected communities through school site visits, informational sessions, and a survey for school screening staff. Board staff used this feedback to draft proposed rules for informal comment and supporting analyses.

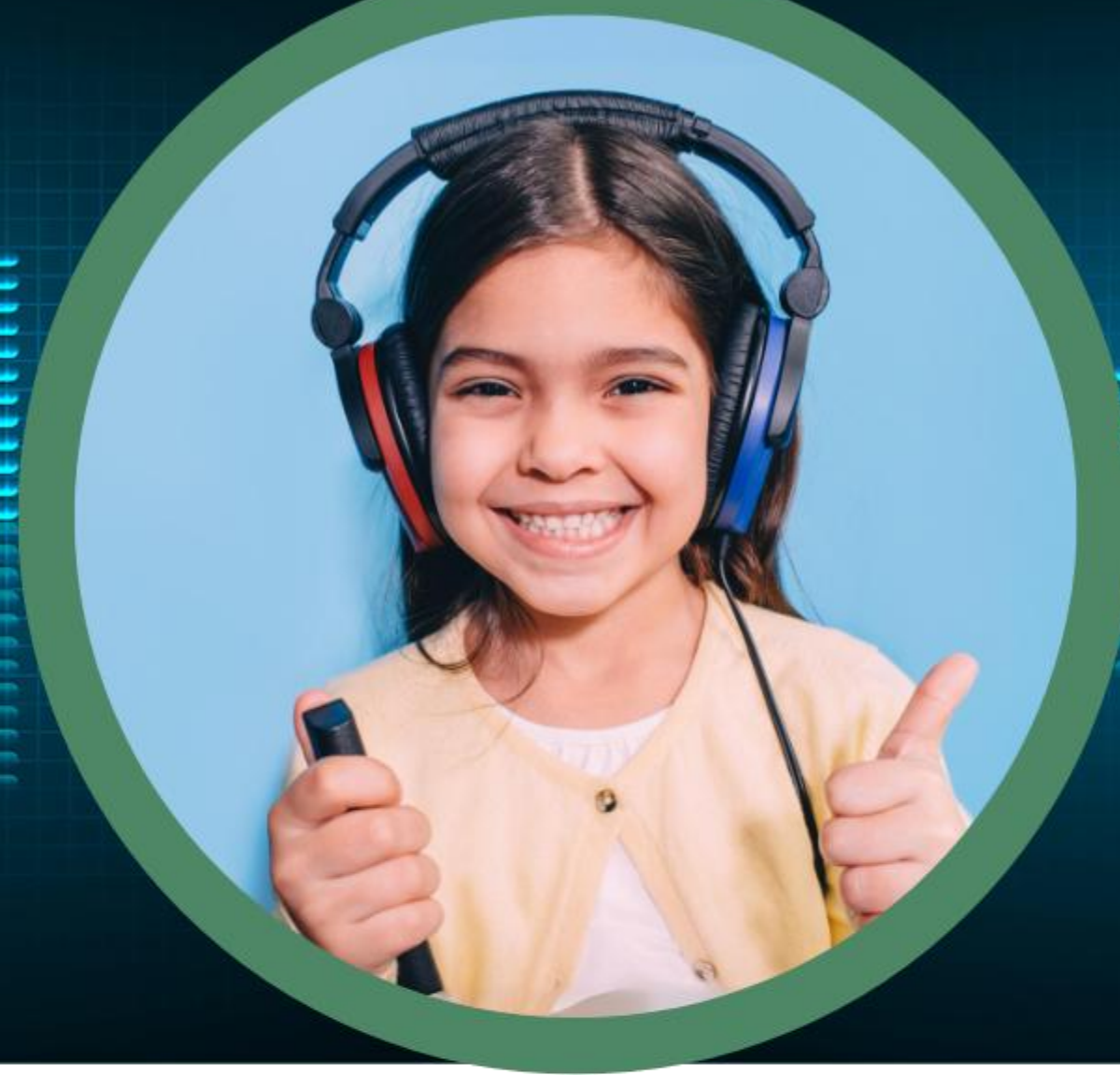
I have invited Molly Dinardo, Board staff, to brief the Board on progress to date and the next steps in the rulemaking process. This is an informational briefing, and no Board action is required. Staff plan to file the CR-102, Proposed Rulemaking, at the end of April for public review and comment. The official public hearing for the proposed rules is tentatively scheduled for the Board's June meeting.

Staff

Molly Dinardo

To request this document in an alternate format or a different language, please contact the Washington State Board of Health at 360-236-4110 or by email at wsboh@sboh.wa.gov. TTY users can dial 711.

PO Box 47990 • Olympia, WA 98504-7990
360-236-4110 • wsboh@sboh.wa.gov • sboh.wa.gov



Auditory Screening Rules Briefing - Chapter 246-760

WAC

Molly Dinardo, State Board of Health, Health Policy Advisor
Annie Hetzel, Office of Superintendent of Public Instruction,
School Health Services Consultant

April 9, 2025

Overview

- Background
- Engagement and Rule Development
- Proposed Rule Changes
- Summary of Feedback
- Timeline and Next Steps



Overview of Washington Auditory Screening Rules

- Washington law requires that the Board make rules for the yearly hearing screenings done in Washington schools (RCW 28A.210.020).
- Chapter 246-760 WAC outlines the requirements for these screenings.
- Screenings are required for students in kindergarten, grades 1-3, and grades 5 and 7.
- Schools may expand these screenings to other grade levels if resources permit.
- The Board last updated the hearing sections of the rule in 2002 (vision screening sections were updated in 2017).

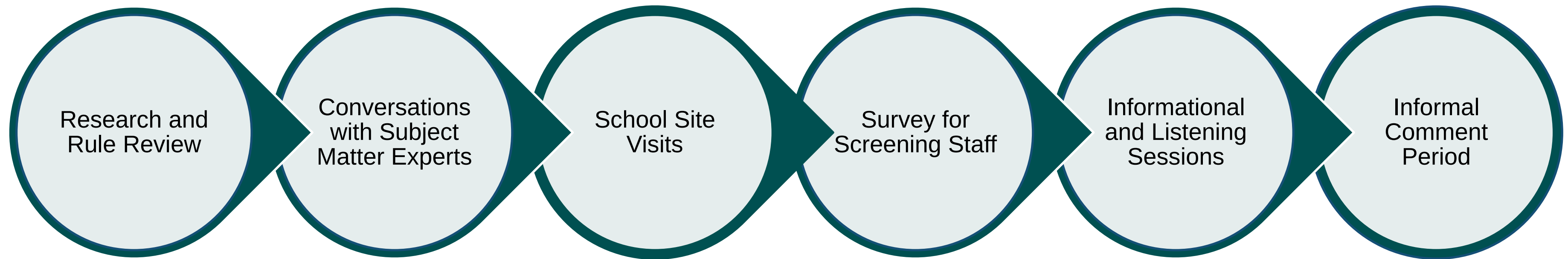


Rulemaking Background

- The Board received a petition for rulemaking from the Lake Chelan Lion's Club asking to add otoacoustic emission (OAE) screening technology to chapter 246-760 WAC.
- The Board accepted this request and directed staff to start the rulemaking process to explore options for possibly including OAE technology in the rule, and to make other technical or editorial changes.



Engagement and Rule Development



Proposed Rule Changes

Revisions to chapter 246-760 WAC include:

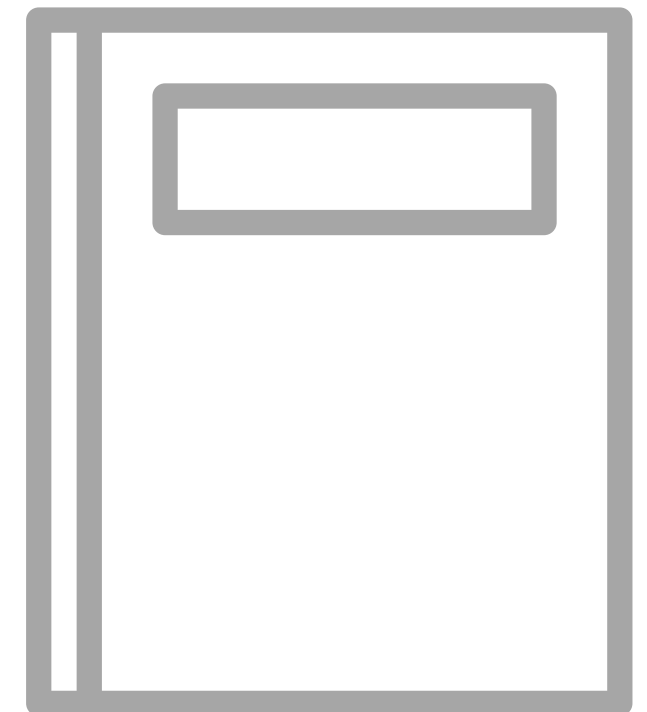
Updating hearing section titles and content to align with vision sections

Adding a new section, “Auditory Screening,” to align with WAC 246-760-070

Including definitions/abbreviations for auditory screening

Removing deficit-based terminology and updating language for clarity

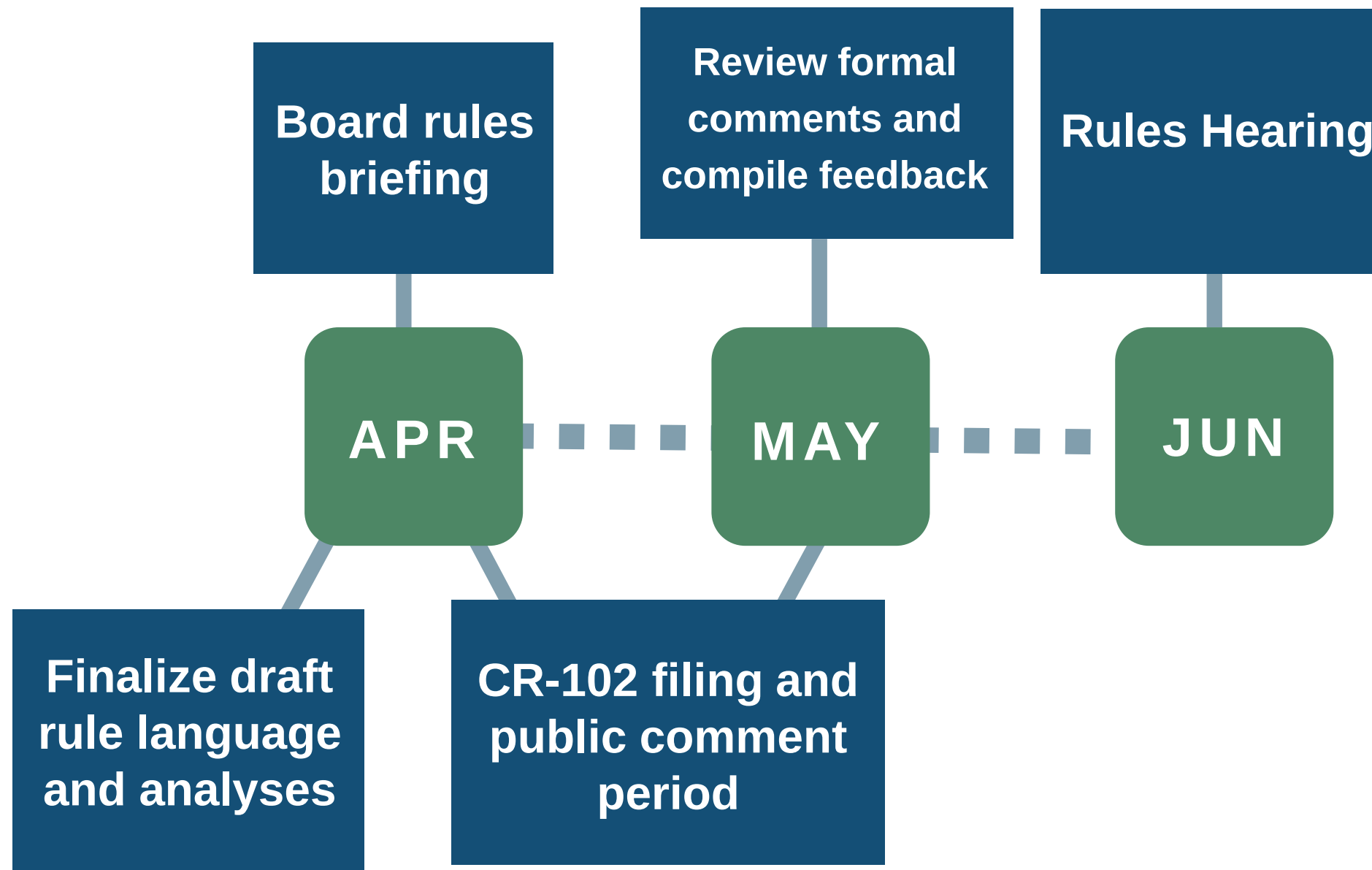
Updating ANSI standards for audiometers, and including OAE devices as an optional screening technology



Summary of Feedback

- Comments included:
 - Appreciation for OAE as an optional tool, not a requirement.
 - Disagreement with limiting OAE use to students who can't participate in pure-tone audiometry.
 - Suggestion to allow parents to defer screening for several years, provided they have documented specialist care, without requiring annual submission of paperwork.
 - Recommend adding a requirement for audiological evaluation reports to include hearing acuity measures for both ears.
 - Update the "decibel (dB)" definition in WAC 246-760-010 to include "hearing level (HL)" instead of "sound pressure level (SPL)."
 - Request to clarify language in WAC 246-760-030 and 040.
 - Recommend a minimum of 3 weeks between the initial and rescreen for resolution of middle ear dysfunction.
 - Suggest that referral letters include a checkbox to indicate the screening tool used.
 - Request to include the option of expanding hearing screening frequencies to 3000 Hz and 6000 Hz.

Timeline and Next Steps



THANK YOU

To learn more about this project, email Molly Dinardo at molly.dinardo@sboh.wa.gov

OR

**SCAN
ME!**



To request this document in an alternate format, please contact the Washington State Board of Health by email at wsboh@sboh.wa.gov or by phone at 360-236-4110
TTY users can dial 711

ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
 - The nature of the accessibility needs
 - The URL (web address) of the content you would like to access
 - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.



PREPROPOSAL STATEMENT OF INQUIRY

CR-101 (October 2017)
(Implements RCW 34.05.310)

Do **NOT** use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 18, 2023

TIME: 4:26 PM

WSR 23-22-004

Agency: Washington State Board of Health

Subject of possible rule making: Auditory screening of school-age children. The Washington State Board of Health (Board) is considering amending the auditory screening sections of chapter 246-760 WAC, Auditory and Visual Standards – School Districts, to align with current national evidence-based practices and assess potential options regarding whether to include otoacoustic emission (OAE) screening technology in the Board's rules. The Board may also consider other technical or editorial changes as needed.

Statutes authorizing the agency to adopt rules on this subject: RCW 28A.210.020

Reasons why rules on this subject may be needed and what they might accomplish: The Board sets standards in chapter 246-760 WAC for the auditory and visual screening of children attending schools in Washington under the authority provided in RCW 28A.210.020. The purpose of these standards is to screen and identify students in Washington who may be experiencing hearing or vision impairments and refer them for diagnostic evaluation and care by an appropriate healthcare provider. Hearing screenings provide the opportunity to help detect a student's hearing loss or previously unrecognized hearing loss and intervene to limit further loss or otherwise address the loss and improve learning.

In response to a petition for rulemaking, the Board, in consultation with the Office of Superintendent of Public Instruction (OSPI), will consider revisions to the auditory screening sections of the chapter, specifically, regarding the potential inclusion of otoacoustic emission (OAE) screening technology. The auditory screening sections of the rule haven't been updated since 2002. As such, other possible revisions may include aligning Washington standards with national school childhood hearing screening guidelines; for example, the American Academy of Audiology (AAA) Clinical Practice Guidelines and the American Speech-Language-Hearing Association (ASHA) Childhood Hearing Screening Guidelines, and making other technical or editorial changes as needed.

Identify other federal and state agencies that regulate this subject and the process coordinating the rule with these agencies: Per RCW 28A.210.020, the Board must seek the recommendations of the Superintendent of Public Instruction (OSPI) regarding the administration of school auditory screening before revising the rules. The Board will conduct this rulemaking in consultation with OSPI. In addition, the Department of Children, Youth, and Families (DCYF) has authority over screenings in early learning facilities. The Board will invite DCYF to participate in this rulemaking to ensure coordination, as applicable.

Process for developing new rule (check all that apply):

- ☐ Negotiated rule making
- ☐ Pilot rule making
- ☐ Agency study
- ☒ Other (describe) The Board will use a collaborative rulemaking approach in developing the proposed rules.

Interested parties can participate in the decision to adopt the new rule and formulation of the proposed rule before publication by contacting:

Name: Molly Dinardo

Address: PO Box 47990, Olympia, WA 98504-7790

Phone: 564-669-3455

(If necessary)

Name:

Address:

Phone:

Fax: 360-236-4088
TTY: 711
Email: molly.dinardo@sboh.wa.gov
Web site: sboh.wa.gov
Other:

Fax:
TTY:
Email:
Web site:
Other:

Additional comments: The Board will work with partner agencies and may convene listening sessions or an advisory group for additional input. The Board will keep interested parties informed of the rulemaking through email, the Board's listserv and rulemaking website, and notices in the Washington State Register. Interested parties, including those who implement Chapter 246-760 WAC, will have opportunities to provide comments through the rulemaking process, including informal review of the draft rule, formal review and comment on the proposed rule, and at the Board's public hearing.

Date: October 18, 2023

Name: Michelle A. Davis

Title: State Board of Health Executive Director

Signature:

A handwritten signature in black ink that reads "Michelle A. Davis". The signature is written in a cursive style with a large, stylized "M" and "D".

From: [Craig Boothe](#)
To: [Dinardo, Molly \(SBOH\)](#)
Subject: RE: Otoacoustic emission screening (OAE) - Change in Rule WAC 246-760-030
Date: Wednesday, July 26, 2023 8:49:55 AM

External Email

Hi Molly, Thanks again for taking my call this morning, I learn a lot from our chat. Please consider this email back to you is a formal request for petition for rule change for WAC-246-760-030.

Have a great day and thanks again for your help.

Craig

Craig Boothe
President Lake Chelan Lions Club
Sight and Hearing Chairman
www.lakechelanlions.org
www.lakechelanlionsclubfoundation.org
craigb47@hotmail.com
425-241-1401

From: [Dinardo, Molly \(SBOH\)](#)
Sent: Wednesday, July 26, 2023 8:27 AM
To: [Craig Boothe](#)
Subject: RE: Otoacoustic emission screening (OAE) - Change in Rule WAC 246-760-030

Hi Craig,

Thanks for sending this information along. Are you still available to connect around 8:30 am this morning? If yes I can give you a call then.

Best,

[Molly Dinardo, MPH](#) (she/her)
Health Policy Advisor
Washington State Board of Health

Molly.Dinardo@sboh.wa.gov
564-669-3455
[Website](#), [Facebook](#), [Twitter](#)

From: Craig Boothe <craigb47@hotmail.com>
Sent: Wednesday, July 26, 2023 8:20 AM
To: Dinardo, Molly (SBOH) <Molly.Dinardo@sboh.wa.gov>
Subject: Otoacoustic emission screening (OAE) - Change in Rule WAC 246-760-030

External Email

Molly here is what was sent to Bill Lundin by Ric Giles to review with suggested new language for the OAE screening in schools, the language in *italic underline* are not yet approved by the department of Health.

Craig

The full ASHA text can be found here https://www.asha.org/Practice-Portal/Professional-Issues/Childhood-Hearing-Screening/#collapse_1

WAC 246-760-030

What are the auditory acuity screening standards for screening equipment and procedures?

(1) Schools shall use auditory screening equipment providing tonal stimuli at frequencies at one thousand, two thousand, and four thousand hertz (Hz) at hearing levels of twenty decibels (dB), as measured at the earphones, in reference to American National Standards Institute (ANSI) 1996 standards.

(2) Qualified persons will check the calibration of frequencies and intensity at least every twelve months, at the earphones, using equipment designed for audiometer calibration.

(3) *Or Otoacoustic emission screening (OAE) equipment may be used for initial screening with auditory screening equipment for any student that has a "Fail/Refer" result.*

WAC 246-760-040

What are the procedures for auditory acuity screening?

(1) Schools shall screen all children referenced in WAC [246-760-020](#) on an individual basis by using

(a) Otoacoustic emission (OAE) screening and, or

(b) Auditory screening equipment at one thousand, two thousand, and four thousand Hz.

(2) The screener shall:

(a) Follow manufacturer guidelines for OAE screening. Children who receive "Fail/Refer" results with OAE shall be screened

using auditory screening equipment. Present each of the tonal stimuli at a hearing level of twenty dB based on the ANSI 1996 standards;

(b) Conduct screenings in an environment free of extraneous noise;

(c) If at all possible, complete screening within the first semester of each school year;

(d) Place the results of screenings, any referrals, and referral results in each student's health and/or school record; and

(e) Forward the results to the student's new school if the student transfers.

Reason for OAE screening be included in any rule change;

- OAE's can screen school age children much more rapidly than using pure tones, saving more time for class room instruction and allowing screeners to complete the auditory screening requirements much quicker.
- OAE requires no active participation from the students.
- Instructions on how to respond to a faint sound are not needed or misunderstood.
- Students who respond or don't respond to pure tones because they watch others doing so is avoided, reducing false positive or false negative screening results.
- Parents notified that their child failed a hearing screening due to false "fail" pure tone screening are reduced.
- Incidence of false "fail/refer" screening results are still possible due to ear canal blockage or transient middle ear issue.
- Incidence of false "pass" are not, only normal hearing can produce a "pass" screening result.
- Any child who receive a "fail/refer" screening should then be screened using traditional pure tone screening.
- OAE screening is required to quickly screen newborn infants before release from the hospital it just makes sense to use them to screen school age children as well.

Edited Recommendations taken from the ASHA website, for background information only;

Otoacoustic Emissions (OAE)

Otoacoustic emissions (OAEs)—either transient-evoked OAEs (TEOAEs) or distortion product OAEs (DPOAEs)—are measured using a sensitive probe microphone inserted into the ear canal. OAEs are a direct measure of outer hair cell and cochlear function in response to acoustic stimulation and yield an indirect estimate of peripheral hearing sensitivity. OAEs do not technically test an individual's hearing, but rather OAE results reflect the performance of the inner ear mechanics.

Factors to Consider

- With OAE protocols taking less time than pure tone protocols, more children may be screened on a given day (Kreisman, Bevilacqua, Day, Kreisman, & Hall, 2013).
- Personnel may include an audiologist, SLP, nurse, or other trained volunteer screener. Equipment can be automatic with no decision making required regarding equipment parameters or pass/fail criteria.
- Screening in quiet environments typically reduces the amount of time needed to complete an OAE hearing screening. A reasonable amount of noise may be present without interrupting the OAE screening process. OAE equipment may indicate when the screening environment is too noisy.
- OAEs will usually be absent when there is outer or middle ear dysfunction.
- OAEs may miss some cases of educationally significant mild and mild-moderate hearing loss or ANSD (AAA, 2011).
- The use of OAE technology may be appropriate for screening children who are difficult to test using pure-tone audiometry (those who cannot respond to traditional pure tone or conditioned play techniques; Stephenson, 2007)

OAE Screening Procedure

- Place small probe in the ear canal to deliver the sound stimuli.
- Read results. Automated OAE screening units will analyze the emission and provide a result of either "pass" or "fail/refer." Screeners other than audiologists should not independently change the parameters of the test equipment or provide interpretation of findings.

TEOAEs: Clicks or tone bursts are used as the stimuli at one level—for example, 80 dB SPL. Normal distributions for this condition for normal hearing are documented in the literature (Hussain, Gorga, Neely, Keefe, & Peters, 1998).

DPOAEs: Pure tones are used as the stimuli. Normal distributions for this condition for normal hearing are documented in the literature (Gorga et al., 1997).

OAE Screening Results

Screening programs that use OAE equipment often use the manufacturer's pre-set stimulus and pass/fail parameters, which will vary. This allows for participation by screeners who do not have the background or knowledge to adjust or interpret result parameters. When automated equipment is used, findings will be recorded as either "pass" or "fail/refer." For children who could not complete screening due to lack of cooperation, internal or external noise, or other

reasons, the findings are recorded as "could not scree

Craig Boothe

President Lake Chelan Lions Club

Sight and Hearing Chairman

www.lakechelanlions.org

www.lakechelanlionsclubfoundation.org

craigb47@hotmail.com

425-241-1401

From: [Dinardo, Molly \(SBOH\)](#)
To: craigb47@hotmail.com; [Davis, Michelle \(SBOH\)](#)
Bcc: [Steele, Mike \(LEG\)](#); [Steele, Mike \(LEG\)](#)
Subject: RE: WAC on hearing tests in Schools
Date: Tuesday, July 25, 2023 12:15:00 PM
Importance: High

Hi Brenda,

Thanks so much for connecting us. Moving you to bcc to avoid further cluttering your inbox.

Hi Craig,

It's nice to meet you virtually.

Please let me know if you would like to submit your inquiry to Rep Steele's office below as a petition for rulemaking, or if you would like to submit a separate request and any additional supporting information directly to the Board for consideration. I spoke with someone from the NW Lion's Foundation back in March regarding a similar inquiry, but never heard back. Below is the information that I provided them with (note the dates were based on the timeframe we received their voicemail). If you have any questions about the information below or about your request, do let me know.

Best,

Molly Dinardo, MPH (she/her)
Health Policy Advisor
Washington State Board of Health
Molly.Dinardo@sboh.wa.gov
564-669-3455
[Website](#), [Facebook](#), [Twitter](#)

Hello,

Thanks for reaching out to our team at the State Board of Health and for expressing your interest in updating the school hearing tests listed in [Chapter 246-760 WAC](#).

As I mentioned, our next regularly scheduled [Board meeting](#) will be **Wednesday April 12th**. This will be a hybrid meeting, with both virtual and in-person options for attendance. Our next Board meeting after April is scheduled for June 14th and will also be hybrid.

If you'd like to file a formal petition to the Board requesting to amend Chapter 246-760 WAC, you can do so by following the process outlined on the Board's website [here](#). Note that any member of the public may petition a state agency to adopt, repeal, or amend a rule within its authority. Once

you send your petition to the Board, the Board has 60 days to respond to the petition, and may take one of the following actions at its meeting where the petition is on the agenda:

- Deny the request and explain why the request was denied
- Describe alternative steps the Board will take
- Initiate rulemaking

I encourage you to review [the Board's petition policy](#) to learn more about the petitioning, response, and appeal process. You can also find information on the Board's rulemaking process under the [Agency Overview](#) section of our website.

To submit a petition for rulemaking, [please download and complete the petition form](#) from the Office of Financial Management's (OFM) website. Please let me know if you have any questions about completing the form. Once you complete the form, you can either email your petition to wsboh@sboh.wa.gov or you may email it to me directly. You may also include any supplemental materials that you'd like to include with the petition form for the Board's review. Any materials you submit will be included in the Board meeting packet materials and posted to the Board's website.

The deadline for the Board to post its draft meeting agenda is next week, Wednesday March 29th.

You may also [sign up for public comment](#) at our upcoming Board meeting to share more about your request. Note that the Board does not take testimony on petitions, but you can speak to your petition during the public comment section of the meeting. The information to register for virtual participation will become available on Wednesday March 29th with the draft meeting agenda.

From: Glenn, Brenda <Brenda.Glenn@leg.wa.gov> **On Behalf Of** Steele, Rep. Mike
Sent: Tuesday, July 25, 2023 12:04 PM
To: craigb47@hotmail.com; Dinardo, Molly (SBOH) <Molly.Dinardo@sboh.wa.gov>
Cc: Steele, Mike (LEG) <mike.steele@leg.wa.gov>
Subject: FW: WAC on hearing tests in Schools
Importance: High

External Email

Molly and Craig,

This email serves as a way to introduce you to each other.

Craig Boothe
President Lake Chelan Lions Club

Sight and Hearing Chairman

www.lakechelanlions.org

www.lakechelanlionsclubfoundation.org

craigb47@hotmail.com

425-241-1401

Molly Dinardo, MPH (she/her)

Health Policy Advisor

Washington State Board of Health

Molly.Dinardo@sboh.wa.gov

564-669-3455

[Website](#), [Facebook](#), [Twitter](#)

Craig will work with you Molly on this or let you know who will be contacting you from the Lions to work with you on this issue.

Molly, Rep. Steele and I really appreciate your follow through on this issue!

Brenda Glenn, Sr. Executive Legislative Assistant

For Deputy Minority Leader Rep. Mike Steele

360-786-7832

Visit Rep. Steele's website: <https://mikesteele.houserepublicans.wa.gov/>

Sign up for Rep. Steele's enewsletters: <https://mikesteele.houserepublicans.wa.gov/email-updates/>

NOTICE OF PUBLIC DISCLOSURE: Please note, this email and any documents you send this office, may be subject to disclosure requirements under the state Public Records Act, RCW 42.56.

From: Dinardo, Molly (SBOH) <Molly.Dinardo@sboh.wa.gov>

Sent: Tuesday, July 25, 2023 11:33 AM

To: Glenn, Brenda <Brenda.Glenn@leg.wa.gov>

Cc: Davis, Michelle (SBOH) <Michelle.Davis@sboh.wa.gov>; Steele, Rep. Mike <Mike.Steele@leg.wa.gov>

Subject: RE: WAC on hearing tests in Schools

Importance: High

CAUTION: External email.

Good Afternoon Brenda,

I hope that you are well.

My name is Molly Dinardo, and I'm a Health Policy Advisor for the Washington State Board of Health. In my role, I support the Board's policy and rulemaking work related to vision and hearing screening in schools. I'm writing to follow up on the email correspondence below. Has Rep Steele's office received a response or additional follow-up from the constituent regarding interest in using otoacoustic emission screening (OAE) equipment for hearing screenings in schools?

I ask because the Board has its next full [meeting scheduled](#) for Wednesday, August 9th. Our team is currently in the process of finalizing our draft meeting agenda for posting and distribution. I'm curious if our team should expect to hear from the constituent/if it's a topic that might be brought to the Board at the August meeting. Any additional information that you might be willing to share would be greatly appreciated.

Thank you in advance for your time and consideration, and I look forward to hearing from you.

Best,

Molly Dinardo, MPH (she/her)
Health Policy Advisor
Washington State Board of Health
Molly.Dinardo@sboh.wa.gov
564-669-3455
[Website](#), [Facebook](#), [Twitter](#)

From: Davis, Michelle (SBOH) <Michelle.Davis@sboh.wa.gov>
Sent: Tuesday, July 18, 2023 9:13 PM
To: Steele, Mike (LEG) <mike.steele@leg.wa.gov>
Cc: Dinardo, Molly (SBOH) <Molly.Dinardo@sboh.wa.gov>
Subject: RE: WAC on hearing tests in Schools

Hi Brenda and Representative Steele,

Thank you for your email. I was out of the office last week, please excuse the delay in my response.

The rulemaking for Chapter 246-760 WAC, auditory and visual standards for school districts, falls under the State Board of Health's (Board) authority ([RCW 28A.210.020](#)). Each board of school directors then has the authority to establish procedures to implement the Board's rules.

While the hearing sections of Chapter 246-760 WAC allow for some flexibility in which

screening technologies are used, the rule generally describes behavioral pure tone screening for auditory screening standards and procedures in schools. The constituent's proposed changes to WAC 246-760-030 below wouldn't necessarily require legislation, this proposal could be presented to the Board through a [petition for rulemaking](#) per the Administrative Procedures Act ([RCW 34.05.330](#)). The Board would review the petition within 60 days and determine whether to deny the petition in writing or accept the petition and initiate rulemaking.

In March, the Board received a voicemail from a Northwest Lion's Foundation representative regarding their interest in supplying schools with otoacoustic emission screening (OAE) equipment for hearing screenings. One of our policy advisors followed up with the representative by phone and shared information regarding the Board's petition for rulemaking process, but our team hasn't heard anything since the initial inquiry. If your constituent wants to propose their amendment to the rule, Board staff can process the below request as a petition for rulemaking and bring the proposed changes to the next full Board meeting. Please let us know if you would like to us to submit the inquiry as a petition for rulemaking, or if your constituent would like to submit their request and any additional supporting information directly to the Board.

Warm regards,

From: Glenn, Brenda <Brenda.Glenn@leg.wa.gov> **On Behalf Of** Steele, Rep. Mike

Sent: Tuesday, July 11, 2023 7:54 AM

To: Davis, Michelle (SBOH) <Michelle.Davis@sboh.wa.gov>

Subject: FW: WAC on hearing tests in Schools

External Email

Good morning Michelle,

I sent a constituent's email to the State Board of Education, but going through the WAC I am wondering if this is an area that the State Board of Health handles, (please see email chain below).

The constituent is proposing a Rule change because there is more up to date, better hearing testing equipment available then what is in the WAC. So my questions are: does the rule making for this [WAC \(246-760-030\)](#) fall under the State Board of Health or Education, and can the proposed change be made through rule or would it require legislation?

Thank you,

Brenda Glenn, Sr. Executive Legislative Assistant
For Deputy Minority Leader Rep. Mike Steele
360-786-7832

Visit Rep. Steele's website: <https://mikesteele.houserepublicans.wa.gov/>

Sign up for Rep. Steele's enewsletters: <https://mikesteele.houserepublicans.wa.gov/email-updates/>

NOTICE OF PUBLIC DISCLOSURE: Please note, this email and any documents you send this office, may be subject to disclosure requirements under the state Public Records Act, RCW 42.56.

From: Glenn, Brenda **On Behalf Of** Steele, Rep. Mike
Sent: Monday, July 10, 2023 1:53 PM
To: randy.spaulding@k12.wa.us
Subject: WAC on hearing tests in Schools

Good afternoon Randy,

I received J. Lee's out of office response with the suggestion to contact you. I know the Lions probably would like to be ready to give hearing tests to students once school starts, so this seems pretty time sensitive to m.

Rep. Steele received the email below from a constituent and he is wondering if the Rule needs to be changed or if a bill needs to be passed so the Lions can use more updated equipment to do hearing tests in the schools?

Brenda Glenn, Sr. Executive Legislative Assistant
For Deputy Minority Leader Rep. Mike Steele
360-786-7832

Visit Rep. Steele's website: <https://mikesteele.houserepublicans.wa.gov/>

Sign up for Rep. Steele's enewsletters: <https://mikesteele.houserepublicans.wa.gov/email-updates/>

NOTICE OF PUBLIC DISCLOSURE: Please note, this email and any documents you send this office, may be subject to disclosure requirements under the state Public Records Act, RCW 42.56.

CAUTION:External email.

Mike,

It is mandated by the state of WA that the schools on a yearly basis, screen all children K-5 and 7 for sight and hearing anomalies. The Lake Chelan Lions in conjunction with the school districts, have been screening children for sight and hearing problems for more than 25 years and have screened over 16,000 students here in the Lake Chelan Valley.

Last fall, the equipment we were using became unavailable to us for further use. Since then we have raised over \$30,000 to replace the equipment. We are now in the process of buying new screening equipment and would like to buy OAE hearing screeners, which are more advanced than the PT screeners now used. Using the more advanced OAE screeners, would be a step forward in screening the +10000 students we need to test this year.

We are temporarily blocked from using the new type of equipment because WAC 246-760-030 which was written in 2007 prevents us from using it. The suggested language is before the board of education, but may not even be looked at.

Here is the suggested new language for the OAE screening in schools, the language in italics have not yet been approved by the department of education, but has been submitted to them for consideration and acceptance.

We would like your help in getting the new language in the rules changed.

Thanks for your help

WAC 246-760-030

What are the auditory acuity screening standards for screening equipment and procedures?

(1) Schools shall use auditory screening equipment providing tonal stimuli at frequencies at one thousand, two thousand, and four thousand hertz (Hz) at hearing levels of twenty decibels (dB), as measured at the earphones, in reference to American National Standards Institute (ANSI) 1996 standards.

(2) Qualified persons will check the calibration of frequencies and intensity at least every twelve months, at the earphones, using equipment designed for audiometer calibration.

(3) *Or Otoacoustic emission screening (OAE) equipment may be used for initial screening with auditory screening equipment for any student that has a "Fail/Refer" result.*

WAC 246-760-040

What are the procedures for auditory acuity screening?

(1) Schools shall screen all children referenced in WAC [246-760-020](#) on an individual basis *by using*

(a) *Otoacoustic emission (OAE) screening and, or*

(b) *Auditory screening equipment* at one thousand, two thousand, and four thousand Hz.

(2) The screener shall:

(a) *Follow manufacturer guidelines for OAE screening. Children who receive "Fail/Refer" results with OAE shall be screened*

using auditory screening equipment. Present each of the tonal stimuli at a hearing level of twenty dB based on the ANSI 1996 standards;

(b) Conduct screenings in an environment free of extraneous noise;

(c) If at all possible, complete screening within the first semester of each school year;

(d) Place the results of screenings, any referrals, and referral results in each student's health and/or school record; and

(e) Forward the results to the student's new school if the student transfers.

Reason for OAE screening, not to be included in any rule change;

1. OAE's can screen school age children much more rapidly than using pure tones, saving more time for class room instruction and allowing screeners to complete the auditory screening requirements much quicker.
2. OAE requires no active participation from the students.
3. Instructions on how to respond to a faint sound are not needed or misunderstood.
4. Students who respond or don't respond to pure tones because they watch others doing so is avoided, reducing false positive or false negative screening results.
5. Parents notified that their child failed a hearing screening due to false "fail" pure tone screening are reduced.
6. Incidence of false "fail/refer" screening results are still possible due to ear canal blockage or transient middle ear issue.
7. Incidence of false "pass" are not, only normal hearing can produce a "pass" screening result.
8. Any child who receive a "fail/refer" screening should

then be screened using traditional pure tone screening.

9. OAE screening is required to quickly screen newborn infants before release from the hospital it just makes sense to use them to screen school age children as well.

Edited Recommendations taken from the ASHA website, for background information only;

Otoacoustic Emissions (OAE)

Otoacoustic emissions (OAEs)—either transient-evoked OAEs (TEOAEs) or distortion product OAEs (DPOAEs)—are measured using a sensitive probe microphone inserted into the ear canal. OAEs are a direct measure of outer hair cell and cochlear function in response to acoustic stimulation and yield an indirect estimate of peripheral hearing sensitivity. OAEs do not technically test an individual's hearing, but rather OAE results reflect the performance of the inner ear mechanics.

Factors to Consider

1. With OAE protocols taking less time than pure tone protocols, more children may be screened on a given day (Kreisman, Bevilacqua, Day, Kreisman, & Hall, 2013).
2. Personnel may include an audiologist, SLP, nurse, or other trained volunteer screener. Equipment can be automatic with no decision making required regarding equipment parameters or pass/fail criteria.
3. Screening in quiet environments typically reduces the amount of time needed to complete an OAE hearing screening. A reasonable amount of noise may be present without interrupting the OAE screening process. OAE equipment may indicate when the screening environment is too noisy.
4. OAEs will usually be absent when there is outer or middle ear dysfunction.
5. OAEs may miss some cases of educationally significant mild and mild-moderate hearing loss or ANSD (AAA, 2011).
6. The use of OAE technology may be appropriate for screening children who are difficult to test using pure-tone audiometry (those who cannot respond to traditional pure tone or conditioned play techniques; Stephenson, 2007)

OAE Screening Procedure

1. Place small probe in the ear canal to deliver the sound stimuli.
2. Read results. Automated OAE screening units will analyze the emission and provide a result of either "pass" or "fail/refer." Screeners other than audiologists should not independently change the parameters of the test equipment or provide interpretation of findings.

TEOAEs: Clicks or tone bursts are used as the stimuli at one level—for example, 80 dB SPL. Normal distributions for this condition for normal hearing are documented in the literature (Hussain, Gorga, Neely, Keefe, & Peters, 1998).

DPOAEs: Pure tones are used as the stimuli. Normal distributions for this condition for normal hearing are documented in the literature (Gorga et al., 1997).

OAE Screening Results

Screening programs that use OAE equipment often use the manufacturer's pre-set stimulus and pass/fail parameters, which will vary. This allows for participation by screeners who do not have the background or knowledge to adjust or interpret result parameters. When automated equipment is used, findings will be recorded as either "pass" or "fail/refer." For children who could not complete screening due to lack of cooperation, internal or external noise, or other reasons, the findings are recorded as "could not screen"

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Brenda Glenn, Sr. Executive Legislative Assistant
For Deputy Minority Leader Rep. Mike Steele
360-786-7832

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STATE OF WASHINGTON
WASHINGTON STATE BOARD OF HEALTH

PO Box 47990 • Olympia, Washington 98504-7990

August 14th, 2023

Craig Boothe
President, Sight and Hearing Chairperson
Lake Chelan Lion's Club
PO Box 1521
Chelan, WA 98816

Sent Via Email

Dear Mr. Boothe,

Thank you for the rulemaking petition you submitted to the State Board of Health (Board) on July 26th, 2023, requesting to amend chapter 246-760 WAC to include otoacoustic emission (OAE) as a screening technology in the Board's school auditory screening standards.

The Board met on August 9th, 2023, and after reviewing and discussing your petition, voted to accept your petition and explore options to revise relevant sections of chapter 246-760 WAC. The Board directed staff to file a CR-101, Preproposal Statement of Inquiry, to initiate rulemaking, further evaluate your request, and assess potential options regarding whether to include OAE screening technology in the Board's rules.

We will soon file the CR-101 and begin work. As noted during the meeting deliberations, Board Members have requested that staff conduct additional research and bring more information to the Board regarding the use of otoacoustic emission as an auditory screening technology for further consideration and scoping of the rulemaking. If you have additional materials that you'd like to send along for staff to review as part of this process, please let Board staff know.

We thank you for your interest and work on this topic. If you require further assistance, please don't hesitate to contact Molly Dinardo, Health Policy Advisor in our office, at 564-669-3455 or at Molly.Dinardo@sboh.wa.gov.

Sincerely,

Keith Grellner, Chair, State Board of Health

cc: Bill Lundin, Chair, Northwest Lion's Foundation

Chapter 246-760 WAC
Auditory and Visual Standards –
School Districts

Navigating this Document:

Introduction:

The Washington State Board of Health (Board) wants your feedback on possible updates to school hearing screening rules ([chapter 246-760 WAC](#)). This is your chance to suggest changes, ask questions, or share ideas. Your feedback will help shape the final rule before it's opened for formal public comment and the Board holds a hearing to decide on the final changes.

How to Use this Document:

This document includes a summary of possible changes to the Board's hearing screening rules in chapter 246-760 WAC and two versions of the rule language. One version shows the changes proposed in red line edits; the other is a "clean" version (no line edits) of the updated rules. If you need any of these documents in a more accessible format, please contact wsboh@sboh.wa.gov.

Document Contents:

- State Board of Health Accessibility Statement (pg. 3)
- Summary of changes (pg. 4)
- Draft proposed changes to current rule language, tracked changes (pg. 7)
- Draft proposed changes to current rule language, no tracked changes (pg. 21)

Accessibility and the Americans with Disabilities Act (ADA)

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Summary of Proposed Rule Changes

Overall Chapter Edits:

- **Addition of a new section, “Auditory Screening,”** under “Auditory Acuity Standards” or “Hearing Screening Standards” to align with WAC 246-760-070, which addresses “Vision Screening”.
- **Inclusion of otoacoustic emission (OAE) devices** as an optional screening tool for students who cannot participate in pure-tone audiometry.
- **Removal of deficit-based terminology** such as hearing “loss,” hearing “problems,” and terms like “pass/fail.”
- **Replacement of the term “auditory” with “hearing”** throughout the chapter where appropriate.
- **Revision of language** throughout the chapter to improve clarity, readability, and plain language use and be more consistent with the vision screening sections.

Section Specific Edits

WAC 246-760-020 through 060:

- **Revisions to section titles** to mirror the format used in vision screening sections (e.g., removal of questions from section titles and conversion to statements).

WAC 246-760-001 – Purpose and Application:

- **Replaces** “auditory or visual problems” with “reduced auditory or visual acuity” that may negatively impact a student’s learning.

WAC 246-760-010 – Definitions, Abbreviations, and Acronyms:

- **Addition of new terms** and definitions, including “ASA/ANSI” (American Acoustical Society of America/American National Standards Institute), “audiometer,” “audiological evaluation,” “auditory acuity,” “calibrate,” “decibels” (dB), “frequencies,” “hearing screening,” “hertz” (Hz), “Otoacoustic emission screening technology” (OAEs), and “tonal stimuli.”

WAC 246-760-020 – Frequency for Schools to Screen Children:

- **Relocation** of this section from the “Auditory Acuity Standards” or “Hearing Screening Standards” to a more appropriate place in the chapter.
- **Title revision** to “Screening Requirements for Schools” to better reflect the broader content of this section.
- **Clarification** in subsection (1) that screenings must be conducted annually.

- **Replacement of the term “loss”** in subsection (1)(b) with “reductions in auditory or visual acuity that may negatively impact their learning.”
- **Update 2(a)-(c)** to clarify that schools may expand screenings (vision or hearing) to other grades if resources allow.
- **Removal of subsection (3)** and references to hearing screenings in subsections (2)(a) and (c).

New Section – Auditory Screening:

- **Addition of a new section** under “Hearing Screening Standards” to align with the existing vision screening standards.
- **Introduction of rule language** similar to WAC 246-760-070, specifying that hearing screenings must use tools and procedures that are linguistically, developmentally, and age-appropriate, with clarification on student exemptions from screening requirements.

WAC 246-760-030 – Auditory Acuity Screening Standards for Equipment and Procedures:

- **Title revision** to “Required and Alternative Hearing Screening Tools.”
- **Update of references** to the most current version of American Acoustical Society of America/American National Standards Institute standards for audiometers.
- **Addition of a new subsection (3)** allowing Otoacoustic Emissions (OAEs) as an optional screening tool for students who cannot participate in pure-tone or behavioral audiometry.
- **Clarification** of when OAEs may be used, as outlined in subsections (3)(a) through (d).
- **Specification** that OAEs cannot replace auditory screening equipment for students who can participate in pure-tone audiometry.
- **Addition of procedures and standards** in subsections (5) and (6) for schools opting to use OAE devices.

WAC 246-760-040 – Auditory Acuity Screening Procedures:

- **Title revision** to “Hearing Screening Procedures.”
- **Incorporation of additional steps** (subsections (2)(a) through (g)) for screeners to follow during hearing screenings.
- **Introduction of subsection (3)** to include OAE-related language, specifying when OAEs may be used and outlining requirements for screeners using OAEs.

WAC 246-760-050 – Auditory Acuity Screening Referral Procedures:

- **Title revision** to “Hearing Screening Referral Procedures.”
- **Inclusion of language** to address students receiving a “refer” result from OAEs.

- **Revised language** throughout the section to improve readability and use of plain language.

WAC 246-760-060 – Auditory Acuity Screening Qualifications for Personnel:

- **Title revision** to “Hearing Screening Personnel Qualifications.”
- **Expansion to include additional staff** typically leading and implementing school screening programs.
- **Revised language** throughout the section to enhance clarity and readability.

Chapter 246-760 WAC

AUDITORY HEARING AND VISUAL SCREENING STANDARDS— **SCHOOL DISTRICTS**

Washington Administrative Code (WAC) Sections

246-760-001 Purpose and application of auditory hearing and visual screening standards for school districts.

246-760-010 Definitions, abbreviations, and acronyms.

246-760-020 Frequency Screening requirements for schools to screen children.

AUDITORY HEARING ACUITY SCREENING STANDARDS

NEW SECTION Hearing screening.

246-760-030 What are the Required and alternative hearingauditory acuity screening standards for screening equipment and procedurestools?

246-760-040 Hearing screening What are the proceduress for auditory acuity screening?

246-760-050 What are the auditory acuityHearing screening referral procedures?

246-760-060 Qualifications for What are the auditory acuityhearing screening qualifications for personnel?

VISION SCREENINGUAL ACUITY STANDARDS

246-760-070 Vision screening.

246-760-071 Required and alternative vision screening tools and referral criteria.

246-760-080 Vision screening procedures.

246-760-100 Qualifications for thevisual acuity screening personnel.

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WAC 246-760-001 Purpose and application of auditory-hearing and visionual screening standards for school districts. Each board of school directors in the state shall provide for and require screening of the auditory and visual acuity of children attending schools in their districts to determine if any child demonstrates reduced auditory or visual acuityproblems that may negatively impact their learning. Each board of school directors shall establish procedures to implement these rules.

WAC 246-760-010 Definitions, abbreviations, and acronyms. The definitions, abbreviations, and acronyms in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "AAPOS" or "American Association for Pediatric Ophthalmology and Strabismus" means the national organization that advances the quality of children's eye care, supports the training of pediatric ophthalmologists, supports research activities in pediatric ophthalmology, and advances the care of adults with strabismus.

(2) "ASA/ANSI" or "American Acoustical Society of America/American National Standards Institute" means the national organization responsible for publishing standards and technical reports that standardize acoustical terminology and measurements, as well as for developing consensus-driven industry standards.

(3) "Audiometer" means an instrument used to measure hearing acuity. It is commonly used in hearing tests, typically by presenting pure tones, speech signals, or other auditory stimuli to assess changes in a person's hearing ability.

(4) "Audiological evaluation" means a comprehensive diagnostic exam used to determine the type, degree, and configuration of reduction in hearing. This evaluation is performed by a licensed professional or specialist to diagnose and characterize hearing reductions and create an individualized treatment plan to address hearing needs.

(5) "Auditory acuity" or "hearing acuity", refers to how sharp or sensitive someone's hearing is. It can mean the ability to hear faint sounds, distinguish between

different sounds (like pitch or loudness), and identify the direction from which a sound is coming from.

(6) "Calibrate" means to adjust and/or verify the accuracy of screening equipment to ensure it meets established standards. This process involves checking and fine-tuning the equipment to ensure it provides reliable and consistent results in assessing auditory or visual acuity.

(72) "Crowding bars" means four individual lines surrounding a single optotype.

(83) "Crowding box" or "surround box" means crowding bars on all four sides extended to form a crowding rectangle surrounding a single line of optotypes.

(9) "dB" or "Decibel" means a measurement that expresses the relative intensity or sound pressure level (SPL) of sound. It is used to describe the level of hearing sensitivity.

(104) "Distance vision" means the ability of the eye to see images clearly at a calibrated distance.

(11) "Frequencies" refer to the different pitches of sounds, from low (deep) to high (sharp). Hearing is screened across a range of frequencies with the goal of identifying reduced hearing at one or more frequencies.

(12) "Hearing screening" means a non-diagnostic test to identify if the person being screened needs to be referred for an audiological evaluation.

(13) "Hz" or "Hertz" is the standard unit of measurement used for measuring frequency.

(145) "HOTV letters" means a test using the letters H, O, T, and V calibrated of a certain size used to assess visual acuity.

(156) "Instrument-based vision screening device" means a U.S. Food and Drug Administration approved instrument for vision screening that uses automated technology to provide information about amblyopia and reduced-vision risk factors such as estimates of refractive error and eye misalignment.

(167) "Lay person" means any individual who is conducting school-based vision screening other than a school nurse, a school principal or his or her designee, a licensed vision care professional, or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-

retest protocol for vision screening. This includes, but is not limited to, retired nurses, nursing students, parents, and school staff.

(178) "LEA vision test(s)" means a test used to measure visual acuity using specific symbols or numbers, designed for those who do not know how to read the letters of the alphabet.

(189) "Licensed vision care professional" means a licensed ophthalmologist or licensed optometrist.

(199) "Near vision acuity" means the ability of the human eye to see objects with clarity at close range, also termed near point acuity or near acuity.

(204) "Optotype" means figures, numbers or letters of different sizes used in testing visual acuity.

(21) "OAEs" or "Otoacoustic emission screening technology or devices" refers to a test that measures the function of the inner ear (cochlea). This technology is commonly used for screening infants and other special populations, particularly when behavioral hearing tests, such as pure tone audiometry, are not appropriate.

(242) "Principal's designee" means a public health nurse, special educator, teacher or administrator designated by the school principal and responsible for supervision, training, reporting and referral of vision screening in instances where the school nurse or school principal is not filling this role.

(243) "School nurse" means a registered nurse acting as the health professional in a school whose specialized practice and attendant tasks and activities advance student health, well-being and achievement; and conforms to Washington state educational and nursing laws according to chapters 18.79 RCW and 246-840 WAC, and WAC 181-79A-223.

(244) "Sloan letters" means a test using ten specially formed letters which include C, D, H, K, N, O, R, S, V and Z to assess visual acuity.

(245) "Test-retest protocol" means a method of screening where a screener conducts two or more screenings for any student who meets the referral criteria in order to ensure the reliability of the initial screening.

(26) "Tonal stimuli" refer to sounds with a clear pitch or tone, like a musical note or a beep. These sounds are used in hearing tests to check how well someone can hear.

(2746) "Visual acuity" refers to the ability of the visual system to discern fine distinctions in the environment as measured with printed or projected visual stimuli.

WAC 246-760-020 ~~FrequencyS for schools to screening requirements for schools-children.~~

(1) ~~SA schools~~ shall conduct ~~annual screening for hearing~~auditory and ~~distance~~ vision ~~(both near and distance)-near vision acuity screening of for students:children:~~

(a) In kindergarten and in grades one, two, three, five, and seven; and

(b) Showing ~~symptoms~~signs of possible ~~reductions~~less in auditory or visual acuity ~~that may negatively impact their learning, or those and who are~~ referred to the district by parents, guardians, school staff, ~~etc~~or student self report.

(2) If resources are available, a school may:

(a) Expand ~~vision~~ screenings to ~~any~~ other grades;

(b) Conduct ~~other~~additional optional vision screenings at any grade using evidence-based screening tools and techniques; or

(c) ~~Both e~~Expand ~~vision~~ screenings to other grades and conduct optional vision screenings as outlined in (a) and (b) of this subsection.

~~(3) If resources permit, schools shall annually conduct auditory screening for children at other grade levels.~~

AUDITORY HEARING SCREENINGACUITY STANDARDS

NEW SECTION – Hearing screening.

(1) A school shall conduct all hearing screenings using tools and procedures that are linguistically, developmentally, and age-appropriate, and shall use screening tools identified in WAC 246-760-030.

(2) A school shall conduct hearing screening according to the tool's instructions and screening protocol.

(3) A school is not required to screen a student who has already had a comprehensive audiological evaluation by a licensed professional within the last twelve months. To waive the screening, schools need to have a report or form signed by a licensed professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who has been reported by the school district as having reduced hearing levels, as required under RCW 72.40.060.

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WAC 246-760-030 ~~What are the~~Required and alternative auditory acuityhearing screening standards for screening equipment and procedures?tools.

~~(1) Schools shall use auditory-hearing screening equipment providing-that delivers~~ tonal stimuli at frequencies ~~ofat~~ one thousand, two thousand, and four thousand hertz (Hz) at ~~hearing-a sound~~ levels of twenty decibels (dB), ~~as~~ measured at the earphones, ~~consistent with Acoustical Society ofin reference to America (ASA)/~~ American National Standards Institute (ANSI) ~~1996-S3.6-2018 (R 2023)~~ standards.

(2) Qualified persons will check the calibration of frequencies and intensity at the earphones at least ~~every twelve months~~once a year, ~~at the earphones~~, using equipment designed for audiometer calibration.

(3) Otoacoustic emission (OAE) screening devices may be used to screen students who cannot participate in pure tone hearing screening, including but not limited to:

(a) Students with special healthcare needs.

(b) Students with developmental delays or disabilities.

(c) Students who speak a language other than English.

(d) Students who are not old enough or have difficulty understanding the screener's instructions.

(4) OAE screening devices shall not replace screening using pure tone hearing screening equipment except as described in subsection (3).

(5) If schools use OAE devices for students who cannot participate in pure tone hearing screening, they shall use calibrated equipment that delivers appropriate stimuli and pass/refer criteria.

(a) The tonal stimuli used during the test must be:

(i) Sixty-five/fifty-five dB for distortion product otoacoustic emissions (DPOAEs);

or

(ii) Eighty dB for transitory evoked otoacoustic emissions (TEOAEs).

(b) For a pass result, the screening device must show a response at least three dB louder than the background noise at a minimum of three different frequencies, ranging from two thousand Hz to eight thousand Hz.

WAC 246-760-040 ~~What are the~~Hearing screening procedures.

~~for auditory acuity screening?~~ (1) Schools shall screen all ~~children students~~ referenced in WAC 246-760-020 ~~on an individual basis at using hearing screening equipment that delivers tonal stimuli at~~ one thousand, two thousand, and four thousand Hz.

(2) The screener shall:

(a) Conduct screenings in an environment free of extraneous noise;

(b) Position the student so they cannot see the front of the hearing screening equipment or are not facing it;

(c) Present each ~~of the tonal stimuli~~tone at a hearing level of twenty dB, following based on the ASA/ANSI 20231996 standards;

~~(b) Conduct screenings in an environment free of extraneous noise;~~

(de) Reinstruct the student or reposition the earphones if they appear confused or do not respond to the tonal stimuli;

(e) If at all possible, complete screening within the first semester of each school year;

(fd) Place the results of screenings, any referrals, and referral results in each student's health and/or school record; and

(ge) Forward the results to the student's new school if the student transfers.

(3) If a student cannot participate in pure tone hearing screening, an OAE device may be used. For screeners using OAE devices, they shall:

(a) Examine the student's ear to select an appropriately sized probe tip that fits comfortably and securely in the ear canal. If the ear canal is blocked with wax, the OAE screening cannot be performed.

(b) Insert the probe into the student's ear canal and begin the screening. Make sure the equipment shows that the probe is securely in place and that the student is calm and still. For the best results, the screener should help the student stay quiet and keep the probe steady during the test.

(c) Continue measuring the OAE response until the equipment shows either a "PASS" or "REFER" result.

WAC 246-760-050 ~~What are the auditory acuity~~Hearing screening referral procedures? (1) If a ~~child-student~~ does not respond to one or more frequencies in either ear during a hearing screening or gets a "refer" result from an OAE:

(a) The school must rescreen the ~~child-student~~ within six weeks, allowing a minimum of 1-2 weeks, if possible, between screenings; and

(b) The school must notify the ~~student's~~ teachers ~~of/about~~ the need for preferential ~~seat~~positioning in class ~~because due to of~~ the possibility of decreased hearing; and

(c) If the student's results suggest the need for additional assessment or follow-up, the school shall notify the parents or legal guardian that a full audiological assessment is necessary~~of the need for audiological evaluation if the student fails the second screening.~~

(2) ~~The s~~Schools shall notify parents or legal guardians if a ~~of the need for~~ medical evaluation is needed iff:

(a) ~~Indicated by audiological evaluation~~The results of a hearing screening suggest it; or

(b) An audiological evaluation is ~~not un~~available.

WAC 246-760-060 ~~What are the auditory acuity~~Hearing screening

~~qualifications for personnel qualifications. ?~~ Each school district shall designate a district audiologist, school nurse, speech language pathologist, health assistant or other district staff member to be responsible for the hearing screening program. This person must have:

- (1) ~~Oversee Responsibility for administering the auditory hearing~~ screening program; and
- (2) ~~Have the t~~Training and experience to:
 - (a) ~~Develop Create~~ an administrative plan for conducting ~~auditory annual hearing~~ screenings and work with ~~in cooperation with the~~ appropriate school ~~staff personnel~~ to ensure the program is carried out efficiently and effectively;
 - (b) Obtain and maintain the necessary ~~screening equipment~~ instrumentation for carrying out the screening program, and ensuring it the equipment is calibrated correctly and in good proper working order and calibration; and
 - (c) ~~Recruit Secure~~ appropriate personnel for carrying out the screening program, if assistance is necessary, and ~~for assuring~~ these personnel are sufficiently trained to:
 - (i) Understand the purposes and regulations ~~of involved in the hearing auditory~~ screening programs; and
 - (ii) ~~Utilize~~ the screening equipment properly to get accurate results to ensure maximum accuracy;
 - (d) Ensure screening records are created made and distributed as appropriate; and
 - (e) Disseminate information to other school ~~personnel staff to~~ familiarize ing them with aspects of a ~~child's student's~~ behavior that may indicate ing the need for referral for ~~hearing auditory~~ screening.
 - (f) The person designated as responsible for the hearing screening program must be sufficiently trained to meet the provisions in subsection (c) if they are involved in carrying out the screening program.

VISION SCREENING ~~QUAL~~ ACUITY STANDARDS

WAC 246-760-070 Vision screening. (1) A school shall conduct all vision screening using tools and procedures that are linguistically, developmentally and age-appropriate. For distance vision and near vision acuity screening schools shall use screening tools identified in WAC 246-760-071.

(2) A school shall conduct vision screening according to the tool's instructions and screening protocol and consistent with AAPOS and National Association of School Nurses guidance.

(3) A school is not required to screen a student who has already had a comprehensive vision examination by a licensed vision care professional within the previous twelve months. In order to waive the screening, schools need to have a report or form signed by a licensed vision care professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who the school district has reported as having a visual impairment as required under RCW 72.40.060.

WAC 246-760-071 Required and alternative vision screening tools and referral criteria. (1) A school must use the standardized optotype-based distance vision and near vision acuity screening tools approved for each grade as well as the rescreening and referral criteria by grade outlined in Table 1 of this section. When using a screening tool with a single isolated optotype or a single line of optotypes, the tool must include the use of crowding bars or crowding boxes.

(2) A school may use an instrument-based vision screening device in lieu of the optotype-based tools outlined in this section. Referral using instrument-based vision screening devices is determined through the manufacturer's criteria. If the instrument-based screening device does not generate a result for a student, a school must screen that student using the optotype-based tools outlined in this section.

Table 1

Purpose of Screening	Grade	Screening Tools	Rescreening and Referral Criteria
Distance Vision	Kindergarten	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/40 in either eye
Distance Vision	Grade one	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/32 in either eye
Distance Vision	Grades two and above	LEA vision tests: LEA symbols or numbers, or HOTV letters, or Sloan letters	Visual acuity worse than 20/32 in either eye
Near Vision Acuity	Kindergarten	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/40 in either eye
Near Vision Acuity	Grade one and above	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/32 in either eye

WAC 246-760-080 Vision screening procedures. (1) A school shall:

- (a) Screen children with their corrective lenses on;
- (b) Place the results of screening, any referrals, and referral results in each student's health record; and
- (c) Forward the results to the student's new school if the student transfers.

(2) If a student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening and the screening was conducted by a lay person, then the school nurse, or the school principal or his or her designee as qualified under WAC 246-760-100(4) shall rescreen the student within two weeks or as soon as possible after the original screening before referring the child to a licensed vision care professional for an assessment.

(3) If the student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening, and the screening was conducted by the school nurse; the school principal or his or her designee; a volunteer who is a licensed vision care professional; or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening, a school may either refer the student after the first screening or rescreen the student at the discretion of the school nurse, or the school principal or his or her designee.

(4) A school shall notify a child's parent or guardian with a written referral if a child meets the referral criteria set forth in WAC 246-760-071 during:

(a) The first screening if a rescreening is not required; or

(b) The second screening if a rescreening is required or is conducted at the discretion of the school nurse, or the school principal or his or designee.

(5) This written referral shall indicate that school-based vision screening is not a substitute for a comprehensive eye examination, include the screening results, and include language recommending that:

(a) The parent or guardian take the child to a licensed vision care professional to receive a comprehensive eye examination; and

(b) An appropriate remedy, such as corrective lenses, be obtained if indicated.

(6) Only the school nurse, or the school principal or his or her designee may notify a child's parent or guardian in order to refer the student for professional care. A school nurse, or school principal or his or her designee shall notify parents or guardians in writing that their child should be evaluated by a licensed vision care professional when:

(a) The student meets the referral criteria for vision screening tests conducted under WAC 246-760-071; or

(b) The school nurse, or school principal or his or her designee observes other signs or symptoms related to eye problems that negatively impact the student's learning; or

(c) The student is unable to complete vision screening for any reason.

WAC 246-760-100 Qualifications for the visual acuity screening personnel.

(1) Persons performing visual screening may include, but are not limited to, school nurses, school principals, other school personnel, or lay persons who have completed training in vision screening; and ophthalmologists, optometrists, or opticians who donate their professional services to schools or school districts. If an ophthalmologist, optometrist, or optician who donates his or her services identifies a visual problem that may impact a student's learning, the vision professional shall notify the school nurse, or the school principal or his or her designee of the results of the screening in writing but may not contact the student's parents or guardians directly per RCW 28A.210.020.

(2) Screening must be performed in a manner consistent with this chapter and RCW 28A.210.020. Any person conducting vision screening must be competent to administer screening procedures as a function of their professional training and background or special training and demonstrated competence under supervision by the school nurse, or the school principal or his or her designee.

(3) A lay person shall demonstrate his or her competence at administering the screening tools including controlling for lighting or distractions that could affect the screening results.

(4) Supervision, training, reporting and referral of vision screening shall be the responsibility of the school nurse, or the school principal or his or her designee. The principal or his or her designee must demonstrate his or her competence in vision screening through supervised training by a competent school or public health nurse or licensed vision care professional, have supervisory ability and experience, and have the ability to work well with school staff and lay persons. Ideally, the person should demonstrate the ability to teach vision screening techniques and operations to others.

|

(5) Students in grades kindergarten through twelve may not assist with or conduct vision screening of other students in their school district, unless students are supervised and conducting screening within the scope of an advanced vocational health-related curriculum such as nursing.

DRAFT

Chapter 246-760 WAC
HEARING AND VISION SCREENING STANDARDS—SCHOOL DISTRICTS

Washington Administrative Code (WAC) Sections

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HEARING SCREENING STANDARDS

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WAC 246-760-001 Purpose and application of hearing and vision screening standards for school districts. Each board of school directors in the state shall provide for and require screening of the auditory and visual acuity of children attending schools in their districts to determine if any child demonstrates reduced auditory or visual acuity that may negatively impact their learning. Each board of school directors shall establish procedures to implement these rules.

WAC 246-760-010 Definitions, abbreviations, and acronyms. The definitions, abbreviations, and acronyms in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "AAPOS" or "American Association for Pediatric Ophthalmology and Strabismus" means the national organization that advances the quality of children's eye care, supports the training of pediatric ophthalmologists, supports research activities in pediatric ophthalmology, and advances the care of adults with strabismus.

(2) "ASA/ANSI" or "American Acoustical Society of America/American National Standards Institute" means the national organization responsible for publishing standards and technical reports that standardize acoustical terminology and measurements, as well as for developing consensus-driven industry standards.

(3) "Audiometer" means an instrument used to measure hearing acuity. It is commonly used in hearing tests, typically by presenting pure tones, speech signals, or other auditory stimuli to assess changes in a person's hearing ability.

(4) "Audiological evaluation" means a comprehensive diagnostic exam used to determine the type, degree, and configuration of reduction in hearing. This evaluation is performed by a licensed professional or specialist to diagnose and characterize hearing reductions and create an individualized treatment plan to address hearing needs.

(5) "Auditory acuity" or "hearing acuity", refers to how sharp or sensitive someone's hearing is. It can mean the ability to hear faint sounds, distinguish between different sounds (like pitch or loudness), and identify the direction from which a sound is coming from.

(6) "Calibrate" means to adjust and/or verify the accuracy of screening equipment to ensure it meets established standards. This process involves checking and fine-

tuning the equipment to ensure it provides reliable and consistent results in assessing auditory or visual acuity.

(7) "Crowding bars" means four individual lines surrounding a single optotype.

(8) "Crowding box" or "surround box" means crowding bars on all four sides extended to form a crowding rectangle surrounding a single line of optotypes.

(9) "dB" or "Decibel" means a measurement that expresses the relative intensity or sound pressure level (SPL) of sound. It is used to describe the level of hearing sensitivity.

(10) "Distance vision" means the ability of the eye to see images clearly at a calibrated distance.

(11) "Frequencies" refer to the different pitches of sounds, from low (deep) to high (sharp). Hearing is screened across a range of frequencies with the goal of identifying reduced hearing at one or more frequencies.

(12) "Hearing screening" means a non-diagnostic test to identify if the person being screened needs to be referred for an audiological evaluation.

(13) "Hz" or "Hertz" is the standard unit of measurement used for measuring frequency.

(14) "HOTV letters" means a test using the letters H, O, T, and V calibrated of a certain size used to assess visual acuity.

(15) "Instrument-based vision screening device" means a U.S. Food and Drug Administration approved instrument for vision screening that uses automated technology to provide information about amblyopia and reduced-vision risk factors such as estimates of refractive error and eye misalignment.

(16) "Lay person" means any individual who is conducting school-based vision screening other than a school nurse, a school principal or his or her designee, a licensed vision care professional, or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening. This includes, but is not limited to, retired nurses, nursing students, parents, and school staff.

(17) "LEA vision test(s)" means a test used to measure visual acuity using specific symbols or numbers, designed for those who do not know how to read the letters of the alphabet.

(18) "Licensed vision care professional" means a licensed ophthalmologist or licensed optometrist.

(19) "Near vision acuity" means the ability of the human eye to see objects with clarity at close range, also termed near point acuity or near acuity.

(20) "Optotype" means figures, numbers or letters of different sizes used in testing visual acuity.

(21) "OAEs" or "Otoacoustic emission screening technology or devices" refers to a test that measures the function of the inner ear (cochlea). This technology is commonly used for screening infants and other special populations, particularly when behavioral hearing tests, such as pure tone audiometry, are not appropriate.

(22) "Principal's designee" means a public health nurse, special educator, teacher or administrator designated by the school principal and responsible for supervision, training, reporting and referral of vision screening in instances where the school nurse or school principal is not filling this role.

(23) "School nurse" means a registered nurse acting as the health professional in a school whose specialized practice and attendant tasks and activities advance student health, well-being and achievement; and conforms to Washington state educational and nursing laws according to chapters 18.79 RCW and 246-840 WAC, and WAC 181-79A-223.

(24) "Sloan letters" means a test using ten specially formed letters which include C, D, H, K, N, O, R, S, V and Z to assess visual acuity.

(25) "Test-retest protocol" means a method of screening where a screener conducts two or more screenings for any student who meets the referral criteria in order to ensure the reliability of the initial screening.

(26) "Tonal stimuli" refer to sounds with a clear pitch or tone, like a musical note or a beep. These sounds are used in hearing tests to check how well someone can hear.

(27) "Visual acuity" refers to the ability of the visual system to discern fine distinctions in the environment as measured with printed or projected visual stimuli.

WAC 246-760-020 Screening requirements for schools.

(1) Schools shall conduct annual screening for hearing and vision (both near and distance) for students:

- (a) In kindergarten and in grades one, two, three, five, and seven; and
- (b) Showing signs of possible reductions in auditory or visual acuity that may negatively impact their learning, or those referred to the district by parents, guardians, school staff, etc.

(2) If resources are available, a school may:

- (a) Expand screenings to other grades;
- (b) Conduct additional optional vision screenings at any grade using evidence-based screening tools and techniques; or

(c) Both expand screenings to other grades and conduct optional vision screenings as outlined in (a) and (b) of this subsection.

HEARING SCREENING STANDARDS

NEW SECTION – Hearing screening. (1) A school shall conduct all hearing screenings using tools and procedures that are linguistically, developmentally, and age-appropriate, and shall use screening tools identified in WAC 246-760-030.

(2) A school shall conduct hearing screening according to the tool's instructions and screening protocol.

(3) A school is not required to screen a student who has already had a comprehensive audiological evaluation by a licensed professional within the last twelve months. To waive the screening, schools need to have a report or form signed by a licensed professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who has been reported by the school district as having reduced hearing levels, as required under RCW 72.40.060.

WAC 246-760-030 Required and alternative hearing screening tools.

(1) Schools shall use hearing screening equipment that delivers tonal stimuli at frequencies of one thousand, two thousand, and four thousand hertz (Hz) at a sound level of twenty decibels (dB), measured at the earphones, consistent with Acoustical Society of America (ASA)/ American National Standards Institute (ANSI) S3.6-2018 (R 2023) standards.

(2) Qualified persons will check the calibration of frequencies and intensity at the earphones at least once a year using equipment designed for audiometer calibration.

(3) Otoacoustic emission (OAE) screening devices may be used to screen students who cannot participate in pure tone hearing screening, including but not limited to:

- (a) Students with special healthcare needs.
- (b) Students with developmental delays or disabilities.
- (c) Students who speak a language other than English.
- (d) Students who are not old enough or have difficulty understanding the screener's instructions.

(4) OAE screening devices shall not replace screening using pure tone hearing screening equipment except as described in subsection (3).

(5) If schools use OAE devices for students who cannot participate in pure tone hearing screening, they shall use calibrated equipment that delivers appropriate stimuli and pass/refer criteria.

- (a) The tonal stimuli used during the test must be:
 - (i) Sixty-five/fifty-five dB for distortion product otoacoustic emissions (DPOAEs);or
 - (ii) Eighty dB for transitory evoked otoacoustic emissions (TEOAEs).

(b) For a pass result, the screening device must show a response at least three dB louder than the background noise at a minimum of three different frequencies, ranging from two thousand Hz to eight thousand Hz.

WAC 246-760-040 Hearing screening procedures. (1) Schools shall screen all students referenced in WAC 246-760-020 using hearing screening equipment that delivers tonal stimuli at one thousand, two thousand, and four thousand Hz.

(2) The screener shall:

(a) Conduct screenings in an environment free of extraneous noise;

(b) Position the student so they cannot see the front of the hearing screening equipment or are not facing it;

(c) Present each tone at a hearing level of twenty dB, following ASA/ANSI 2023 standards;

(d) Reinstruct the student or reposition the earphones if they appear confused or do not respond to the tonal stimuli;

(e) If at all possible, complete screening within the first semester of each school year;

(f) Place the results of screenings, any referrals, and referral results in each student's health and/or school record; and

(g) Forward the results to the student's new school if the student transfers.

(3) If a student cannot participate in pure tone hearing screening, an OAE device may be used. For screeners using OAE devices, they shall:

(a) Examine the student's ear to select an appropriately sized probe tip that fits comfortably and securely in the ear canal. If the ear canal is blocked with wax, the OAE screening cannot be performed.

(b) Insert the probe into the student's ear canal and begin the screening. Make sure the equipment shows that the probe is securely in place and that the student is calm and still. For the best results, the screener should help the student stay quiet and keep the probe steady during the test.

(c) Continue measuring the OAE response until the equipment shows either a "PASS" or "REFER" result.

WAC 246-760-050 Hearing screening referral procedures. (1) If a student does not respond to one or more frequencies in either ear during a hearing screening or gets a "refer" result from an OAE:

(a) The school must rescreen the student within six weeks, allowing a minimum of 1-2 weeks, if possible, between screenings; and

(b) The school must notify the student's teachers about the need for preferential seating in class due to the possibility of decreased hearing; and

(c) If the student's results suggest the need for additional assessment or follow-up, the school shall notify the parents or legal guardian that a full audiological assessment is necessary.

(2) The school shall notify parents or legal guardians if a medical evaluation is needed if:

(a) The results of a hearing screening suggest it; or

(b) An audiological evaluation is unavailable.

WAC 246-760-060 Hearing screening personnel qualifications. Each school district shall designate a district audiologist, school nurse, speech language pathologist, health assistant or other staff member to be responsible for the hearing screening program. This person must:

(1) Oversee the hearing screening program; and

(2) Have the training and experience to:

(a) Create an administrative plan for conducting annual hearing screenings and work with appropriate school staff to ensure the program is carried out efficiently and effectively;

(b) Obtain and maintain the necessary screening equipment, ensuring it is calibrated correctly and in good working order; and

(c) Recruit appropriate personnel for carrying out the screening program, if assistance is necessary, and assure these personnel are sufficiently trained to:

(i) Understand the purpose and regulations of the hearing screening program; and

(ii) Use the screening equipment properly to get accurate results;

(d) Ensure screening records are created and distributed as appropriate; and

(e) Disseminate information to other school staff to familiarize them with aspects of a student's behavior that may indicate the need for referral for hearing screening.

(f) The person designated as responsible for the hearing screening program must be sufficiently trained to meet the provisions in subsection (c) if they are involved in carrying out the screening program.

VISION SCREENING STANDARDS

WAC 246-760-070 Vision screening. (1) A school shall conduct all vision screening using tools and procedures that are linguistically, developmentally and age-appropriate. For distance vision and near vision acuity screening schools shall use screening tools identified in WAC 246-760-071.

(2) A school shall conduct vision screening according to the tool's instructions and screening protocol and consistent with AAPOS and National Association of School Nurses guidance.

(3) A school is not required to screen a student who has already had a comprehensive vision examination by a licensed vision care professional within the previous twelve months. In order to waive the screening, schools need to have a report or form signed by a licensed vision care professional indicating that an examination has been administered. A school must place this report or form in the student's health record.

(4) A school is not required to screen a student who the school district has reported as having a visual impairment as required under RCW 72.40.060.

WAC 246-760-071 Required and alternative vision screening tools and referral criteria. (1) A school must use the standardized optotype-based distance vision and near vision acuity screening tools approved for each grade as well as the rescreening and referral criteria by grade outlined in Table 1 of this section. When using a screening tool with a single isolated optotype or a single line of optotypes, the tool must include the use of crowding bars or crowding boxes.

(2) A school may use an instrument-based vision screening device in lieu of the optotype-based tools outlined in this section. Referral using instrument-based vision

screening devices is determined through the manufacturer's criteria. If the instrument-based screening device does not generate a result for a student, a school must screen that student using the optotype-based tools outlined in this section.

Table 1

Purpose of Screening	Grade	Screening Tools	Rescreening and Referral Criteria
Distance Vision	Kindergarten	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/40 in either eye
Distance Vision	Grade one	LEA vision test: Single LEA symbol (at 5 feet), or HOTV letter	Visual acuity worse than 20/32 in either eye
Distance Vision	Grades two and above	LEA vision tests: LEA symbols or numbers, or HOTV letters, or Sloan letters	Visual acuity worse than 20/32 in either eye
Near Vision Acuity	Kindergarten	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/40 in either eye
Near Vision Acuity	Grade one and above	LEA vision tests: LEA symbols near vision, HOTV, or Sloan letters	Visual acuity worse than 20/32 in either eye

WAC 246-760-080 Vision screening procedures. (1) A school shall:

(a) Screen children with their corrective lenses on;

(b) Place the results of screening, any referrals, and referral results in each student's health record; and

(c) Forward the results to the student's new school if the student transfers.

(2) If a student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening and the screening was conducted by a lay person, then the school nurse, or the school principal or his or her designee as qualified under WAC 246-760-100(4) shall rescreen the student within two weeks or as soon as possible after the original screening before referring the child to a licensed vision care professional for an assessment.

(3) If the student meets the referral criteria set forth in WAC 246-760-071 during the first vision screening, and the screening was conducted by the school nurse; the school principal or his or her designee; a volunteer who is a licensed vision care professional; or an individual trained by and conducting vision screening on behalf of a nationally recognized service organization that utilizes a test-retest protocol for vision screening, a school may either refer the student after the first screening or rescreen the student at the discretion of the school nurse, or the school principal or his or her designee.

(4) A school shall notify a child's parent or guardian with a written referral if a child meets the referral criteria set forth in WAC 246-760-071 during:

(a) The first screening if a rescreening is not required; or

(b) The second screening if a rescreening is required or is conducted at the discretion of the school nurse, or the school principal or his or designee.

(5) This written referral shall indicate that school-based vision screening is not a substitute for a comprehensive eye examination, include the screening results, and include language recommending that:

(a) The parent or guardian take the child to a licensed vision care professional to receive a comprehensive eye examination; and

(b) An appropriate remedy, such as corrective lenses, be obtained if indicated.

(6) Only the school nurse, or the school principal or his or her designee may notify a child's parent or guardian in order to refer the student for professional care. A school nurse, or school principal or his or her designee shall notify parents or guardians

in writing that their child should be evaluated by a licensed vision care professional when:

(a) The student meets the referral criteria for vision screening tests conducted under WAC 246-760-071; or

(b) The school nurse, or school principal or his or her designee observes other signs or symptoms related to eye problems that negatively impact the student's learning; or

(c) The student is unable to complete vision screening for any reason.

WAC 246-760-100 Qualifications for the visual acuity screening personnel.

(1) Persons performing visual screening may include, but are not limited to, school nurses, school principals, other school personnel, or lay persons who have completed training in vision screening; and ophthalmologists, optometrists, or opticians who donate their professional services to schools or school districts. If an ophthalmologist, optometrist, or optician who donates his or her services identifies a visual problem that may impact a student's learning, the vision professional shall notify the school nurse, or the school principal or his or her designee of the results of the screening in writing but may not contact the student's parents or guardians directly per RCW 28A.210.020.

(2) Screening must be performed in a manner consistent with this chapter and RCW 28A.210.020. Any person conducting vision screening must be competent to administer screening procedures as a function of their professional training and background or special training and demonstrated competence under supervision by the school nurse, or the school principal or his or her designee.

(3) A lay person shall demonstrate his or her competence at administering the screening tools including controlling for lighting or distractions that could affect the screening results.

(4) Supervision, training, reporting and referral of vision screening shall be the responsibility of the school nurse, or the school principal or his or her designee. The principal or his or her designee must demonstrate his or her competence in vision screening through supervised training by a competent school or public health nurse or licensed vision care professional, have supervisory ability and experience, and have the

ability to work well with school staff and lay persons. Ideally, the person should demonstrate the ability to teach vision screening techniques and operations to others.

(5) Students in grades kindergarten through twelve may not assist with or conduct vision screening of other students in their school district, unless students are supervised and conducting screening within the scope of an advanced vocational health-related curriculum such as nursing.

DRAFT



Chapter 246-760 WAC, Hearing Standards, School Districts – Summary of Informal Comments

WAC 246-760-001: Purpose and application of hearing and vision screening standards for school districts

- I wish that if parents provide documentation of known issues with vision and/or hearing and are following up with the appropriate specialist, and they request that we defer screening, there would be a better allowance for this. I have some families that are following up but don't want to submit the paperwork every year, although they have also requested that we continue to screen the child. The parent should be able to sign a document and defer screening for at least several years.
- I appreciate the suggested replacement of "reduced acuity" with "reduced visual acuity," as this language is more inclusive, as not all people view their deficits as "problems."

WAC 246-760-010: Definitions, abbreviations, and acronyms.

- Agree with additional terms and definitions to increase understanding.
- #9 "dB" or decibel - HL (Hearing Level) is the term used rather than SPL (Sound Pressure Level) when referring to hearing level thresholds. Those terms are not interchangeable as they are different measurements. Ex- 25 dB HL.
- These new terms and definitions are critical to include, as individuals who are not audiologists rarely know what these terms mean. This addition will also create a clear black-and-white picture of what is required of audiologists so standards are consistent and well-regulated.

WAC 246-760-020 Screening requirements for schools.

- As an educational audiologist, I like the title change so it is clear what schools need to follow. I also like the replacement of "auditory" with "hearing" to be clearer in layman's terms.

NEW SECTION – Hearing screening.

- I like adding that screening is not necessary if evidence of a full evaluation within the year. I do wish it allowed for contact with the parent and if they verify follow-up within the year vs requiring the documentation. Just something more we will end up chasing - or have to screen a student with known issues.
- I really like the addition of the new section that outlines when/when not a school must complete screenings. This provides greater clarity and is easy to read and understand.
- Recommend - The audiologic evaluation report must show hearing acuity measures for both ears.
- Agree to clarify expectations and requirements.

WAC 246-760-030: Required and alternative hearing screening tools.

- Agree with the approval of OAEs. Disagree that OAEs can't be used for students who can participate in auditory screening equipment. There is no medical reason that they are inferior screening tools, as far as I am aware, and could potentially solve many issues with the hearing screening process. School nurses should be able to select the appropriate screening tool for their specific needs and obtain the most accurate results from their students. For example, when rescreening a child who failed the initial screening using pure tone equipment the same day. We are not always aware of behavioral or intellectual concerns that may make traditional screening unreliable.
- I'm very glad they are not requiring additional equipment - I'm not sure that optional equipment will be very useful unless districts have more extensive resources.
- This portion of the WAC will need clarity: "(3) Otoacoustic emission (OAE) screening devices may be used to screen students who cannot participate in pure tone hearing screening, including but not limited to." This is followed by sections A-D along with "(4) OAE screening devices shall not replace screening using pure tone hearing screening equipment except as described in subsection (3)". The clarity needs to revolve around language "except as described in subsection (3)" as subsection (3) reads "including but not limited to." Do sections A-D provide the only reasons to use OAEs, or are there other allowable reasons (i.e., "including but not limited to") that might allow for OAE screening?
- I appreciate documentation stating OAEs are sufficient to provide families with pass/refer results for the student populations outlined. In our district, we have consistently utilized OAEs for students who are difficult to test, but we have been hesitant to provide that documentation to families because it was not outlined in the WAC. This is an incredible addition and fully supported by our district. The details utilized in the update are spot on, and I would not change a thing about it.
- Recommend - Define what a pass on an OAE screen means in terms of hearing acuity. It does not indicate typical hearing.
- Adding OAEs is an important addition. Having this option for students who cannot participate in the tone test would make it possible to screen more of our most vulnerable students.

WAC 246-760-040: Hearing screening procedures.

- Need more information to understand this section.
- This portion of the WAC conflicts with 246-760-030. " (c) Continue measuring the OAE response until the equipment shows either a "PASS" or "REFER" result." The previous section reads "(b) For a pass result, the screening device must show a response at least three dB louder than the background noise at a minimum of three different frequencies, ranging from two thousand Hz to eight thousand Hz." Is the screener looking for a "pass or refer" result or is the device supposed to show " a response at least three dB louder than the background noise at a minimum of three different frequencies, ranging from two thousand Hz to eight thousand Hz"?

- I disagree with the point in 3a, stating that "If the ear canal is blocked with wax, the OAE screening cannot be performed." While the statement is accurate, audiologists and/or staff trained in performing otoscopy are not often the individuals performing the screening, so individuals may not know if wax is an issue. I would like this statement removed from the WAC, as I would prefer an OAE to be completed and a referral letter sent home to the family, allowing them to follow up with the doctor to determine the cause of the referral. At that point, the family is at least being notified that there is a referral, which would lead them to follow up, rather than listing their student as a "could not test" and no follow-up occurring.
- Recommend - 20 dB or twenty decibels in place of "twenty dB"
- I would not know if wax were the cause of an OAE referral.

WAC 246-760-050: Hearing screening referral procedures.

- Referral letters should have a box to check in order to inform parents, guardians, and health care providers what type of screening tool was used.
- I love that it says "refer" and not fail. Thank you.
- Recommend minimum of 3 weeks between initial and rescreen. One week is not enough time for middle ear dysfunction resolution.

WAC 246-760-060: Hearing screening personnel qualifications.

- N/A

Is there anything else that you'd like the Board to know regarding these proposed rule updates, or do you have questions?

- I wonder if there are screening standards for preschool students.
- Please include the option to expand hearing screening frequencies to 3000 & 6000 Hz. These are often where noise induced hearing loss occurs first. Please screen at 9th grade. Please encourage hearing screening for all children. Audiologists do not always measure the hearing of the historically better ear in cases of unilateral hearing loss. I have seen the results where they note, "Did not test, WNL." Children with unilateral hearing loss are at a higher risk for progression in the better-hearing ear.

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RCW 28A.210.020

Visual and auditory screening of pupils—Rules.

Every board of school directors shall have the power, and it shall be its duty to provide for and require screening for the visual and auditory acuity of all children attending schools in their districts to ascertain which if any of such children have defects sufficient to retard them in their studies. Visual screening shall include both distance and near vision screening. Auditory and visual screening shall be made in accordance with procedures and standards adopted by rule of the state board of health. Prior to the adoption or revision of such rules the state board of health shall seek the recommendations of the superintendent of public instruction regarding the administration of visual and auditory screening and the qualifications of persons competent to administer such screening. Persons performing visual screening may include, but are not limited to, ophthalmologists, optometrists, or opticians who donate their professional services to schools or school districts. If a vision professional who donates his or her services identifies a vision defect sufficient to affect a student's learning, the vision professional must notify the school nurse and/or the school principal in writing and may not contact the student's parents or guardians directly. A school official shall inform parents or guardians of students in writing that a visual examination was recommended, but may not communicate the name or contact information of the vision professional conducting the screening.

[2016 c 219 § 1; 2009 c 556 § 18; 1971 c 32 § 2; 1969 ex.s. c 223 § 28A.31.030.

Prior: 1941 c 202 § 1; Rem. Supp. 1941 § 4689-1. Formerly

RCW 28A.31.030, 28.31.030.]



Date: April 09, 2025

To: Washington State Board of Health Members

From: Kelly Oshiro, Board Member

Subject: Legislative Report of the Technical Advisory Committee Review of Branch-Chain Ketoacid Dehydrogenase Kinase Deficiency Newborn Screening

Background and Summary:

The Washington State Board of Health (Board) has the authority under RCW 70.83.050 to adopt rules for screening Washington-born infants for hereditary conditions. WAC 246-650-010 defines the conditions, and WAC 246-650-020 lists the conditions on the state's required newborn screening panel.

During the 2023-2024 legislative session, Senate Bill 6234 passed, which directed the Board to conduct a review of branch-chain ketoacid dehydrogenase kinase (BCKDK) deficiency for Washington's mandatory newborn screening panel.

On January 14, 2025, a technical advisory committee (TAC) convened to consider this condition against the Board's five newborn screening criteria. During the committee meeting, TAC Members evaluated BCKDK deficiency against established criteria: Available Screening Technology, Diagnostic Testing and Treatment Available, Prevention Potential and Medical Rationale, Public Health Rationale, and Cost-benefit/Cost-effectiveness. The TAC also voted to make an overall recommendation to the Board whether to adopt BCKDK deficiency to the newborn screening panel.

At the March 12, 2025, Board of Health meeting, the Board reviewed the TAC's votes and recommendations. They voted unanimously to accept the TAC's recommendation to not include BCKDK deficiency to the newborn screening panel.

Recommended Board Actions:

The Board may wish to consider and amend, if necessary, the following motion:

The Board directs staff to finalize the draft BCKDK deficiency legislative report based on the Board's input today, in consultation with the NBS TAC Co-Chairs and Department of Health's Newborn Screening program and send the report to the Governor in advance of the final report due date June 30, 2025. Once the Governor's Office receives the report, staff are directed to send a copy to TAC Members who contributed to it, and appropriate legislative committees.

Staff

Kelly Kramer, Policy Advisor

To request this document in an alternate format or a different language, please contact the Washington State Board of Health, at 360-236-4110 or by email at wsboh@sboh.wa.gov
TTY users can dial 711.

BCKDK Deficiency Legislative Report- DRAFT

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Kelly Oshiro, Board Sponsor Letter-- TBD

Executive Summary

Newborn screening helps detect treatable conditions early in life through blood tests. The State Board of Health (Board), with the support of the Department of Health (Department), evaluates potential new conditions through a defined process and criteria involving evidence, ethics, equity, and cost-effectiveness.

During the 2024 legislative session, the Legislature passed, and Governor Inslee signed Senate Bill (SB) 6234, screening newborn infants for branched-chain ketoacid dehydrogenase kinase deficiency. SB 6234 directed the Board to consider adding Branch-Chain Ketoacid Dehydrogenase Kinase (BCKDK) deficiency to Washington's mandatory newborn screening panel and submit a report to the Governor and the appropriate committees of the Legislature by June 30, 2025.

BCKDK deficiency is a rare genetic disorder that impairs the metabolism of branched-chain amino acids, potentially causing neurodevelopmental issues such as autism spectrum disorder, seizures, and developmental delays. It may be detectable via newborn bloodspot testing using tandem mass spectrometry, which is part of the state's existing newborn screening technology. BCKDK is not included on any universal screening panel in the United States or abroad.

The Board convened a multi-disciplinary Technical Advisory Committee (TAC) to evaluate whether BCKDK deficiency should be added to the state's newborn screening panel. The TAC considered key factors such as the availability of screening technology, diagnostic tests, treatment options, prevention potential, public health rationale, and cost-effectiveness. The TAC noted that while screening technology exists, there is currently insufficient evidence regarding the condition's

prevalence, treatment outcomes, and cost-effectiveness. As a result, most TAC members voted against adding BCKDK deficiency to the panel, due to limited data and the lack of available information to complete a cost-benefit analysis.

On March 12, 2025, the Board reviewed the TAC's findings and unanimously accepted the recommendation. The Board does not recommend including BCKDK deficiency on the newborn screening panel at this time. Both the Board and TAC agreed to not re-review the condition until more data and research are available to complete a comprehensive evaluation.

Background

RCW 70.83.050 authorizes the State Board of Health (Board) to adopt rules for screening Washington-born babies for hereditary conditions, including the list of conditions on the mandatory newborn screening panel. Chapter 246-650 WAC is the Board's rules for newborn screening and WAC 246-650-020 lists conditions for which all newborns must be screened.

Newborn screening is a public health system that universally tests newborn babies to identify serious, but treatable, conditions. The Department of Health (Department) houses the state's Newborn Screening Program. Shortly after birth, the attending health care provider collects a newborn screening specimen by obtaining drops of blood from a baby's heel on a filter paper card. Each newborn screening specimen is submitted to the Public Health Laboratories where it is tested for 32 conditions that are currently on the mandatory newborn screening panel.

To add new conditions to the panel, the Board and the Department have developed a process and criteria for evaluation that focuses on evidence, ethics, equity, and the balance between cost-benefit and cost-effectiveness. To determine whether a condition should be added to the panel, the Board convenes a technical advisory committee (TAC) to evaluate candidate conditions using guiding principles and established criteria [Appendix A]. The multi-disciplinary TAC includes representatives with expertise and experience related to the candidate conditions including clinicians, academia, insurers, public health, and families of those with rare conditions.

During the 2024 legislative session, the Legislature passed, and the Governor signed SB 6234 (Chapter 105, 2024 Laws), which directed the Board to consider adding branch-chain ketoacid dehydrogenase kinase (BCKDK) deficiency to the mandatory newborn screening panel.

The Board convened a TAC to evaluate BCKDK deficiency in January 2025. The TAC consisted of seventeen multi-disciplinary members, representing public health, public and private insurance organizations, healthcare providers and facilities, state ethnic commissions, specialty care clinics, and parent advocates [Appendix B].

Branch-Chain Ketoacid Dehydrogenase Kinase Deficiency

BCKDK deficiency is a rare inherited genetic disorder that leads to a deficiency of branched-chain amino acids. There are approximately 21 cases of BCKDK deficiency identified worldwide, with no

reported cases in the United States. BCKDK deficiency is caused by changes in the BCKDK gene, which produces the BCKDK enzyme. The BCKDK enzyme regulates the metabolism of branched-chain amino acids. Mutations with the BCKDK enzyme cause an overactive breakdown of branched-chain amino acids. As a result, proteins can't form properly, which impairs neurodevelopmental growth and development.[1,2]

Signs and symptoms for BCKDK deficiency can vary but may include autism spectrum disorder (ASD), language impairment, seizures, and microcephaly. Low levels of branched-chain amino acids can be detected via newborn screening of a dried bloodspot using tandem mass spectrometry. Newborns that have an out-of-range screening result for BCKDK deficiency should have DNA testing to rule out or confirm the diagnosis. BCKDK deficiency can be treated with a high protein diet and supplementation of branch-chain amino acids.[2]

[1] Novarino, G., et al. Mutations in BCKD-kinase lead to a potentially treatable form of autism with epilepsy. *Science* 338: 394-397, 2012. [PubMed: [22956686](#)]

[2] Tangeraas, T., et al. BCKDK deficiency: a treatable neurodevelopmental disease amenable to newborn screening. *Brain* 146: 3003-3013, 2023. [PubMed: [36729635](#)]

Technical Advisory Committee Review

The TAC convened on January 14, 2025, to evaluate BCKDK deficiency. against an established set of criteria: Available Screening Technology, Diagnostic Testing and Treatment Available, Prevention Potential and Medical Rationale, Public Health Rationale, and Cost-benefit/Cost-effectiveness. To help inform this criteria review, the TAC heard from Michelle Whitlow, Executive Director of the Lewis County Autism Coalition. While BCKDK deficiency does not cause all cases of autism spectrum disorder (ASD), it is associated with epilepsy and certain forms of ASD. M. Whitlow provided insights on the broader connection between ASD and branched-chain amino acid disorders [Appendix D].

Philip White from Duke University and Beth Ogata from the University of Washington Medical Center (UWMC) provided subject matter expertise regarding the natural history, diagnostic testing, and treatment for BCKDK deficiency. P. White explained how the BCKDK enzyme is involved in the breakdown of branched-chain amino acids (BCAA), and how a deficiency of this enzyme limits protein synthesis and growth. P. White noted that in the limited number of studies, all BCKDK deficiency cases showed global developmental delay at diagnosis. In these studies, clinical outcomes were shown to be improved in patients when BCAAs are supplemented, with a greater improvement of developmental delay if treatment was initiated before two years of age.

Beth Ogata, a registered dietitian at UWMC Metabolic Clinic, reviewed what a potential treatment plan would be for any patients that might be identified with BCKDK deficiency. Treatment recommendations for patients could include: increased dietary protein intake, BCAA supplements of an oral powder or tablets taken 4-7 times per day, plasma BCAA monitoring, developmental surveillance and referral, and regular clinic visits for monitoring, education, and adjustment of plan. B. Ogata explained that branch-chain amino acid supplements are not always reimbursed by

insurance or readily accessible. B. Ogata advised some patients may experience treatment fatigue and may not adhere to their treatment plan over time, due to the high burden of the lifelong treatment.

The Department's Newborn Screening Program shared the available screening technology and provided a cost-benefit analysis for Washington if BCKDK deficiency was to be added to the mandatory newborn screening panel. A cost benefit analysis is a part of the newborn screening evaluation process because adding a condition to the newborn screening panel would be considered a significant legislative rule change under the Administrative Procedures Act Chapter 34.05 RCW. BCKDK deficiency may be detected from a dried bloodspot by testing for low branch-chain amino acids using tandem mass spectrometry; the Newborn Screening Laboratory currently analyzes specimens for the inverse by detecting abnormally elevated branch-chain amino acids to screen for another condition on the panel. The cost-benefit analysis compares the status quo (no universal screening of a condition) versus a screening model. This analysis includes data from primary literature, states conducting screening for a condition, and expert opinion. Newborn Screening Program staff consulted with the Department's health economist who recommended against generating a benefit/cost ratio or cost-effectiveness estimate because of the lack of robust data to inform the economic model.

After the presentations from subject matter experts and the Department, TAC members were given the opportunity to vote anonymously via Microsoft Forms. Members voted on each criterion and provided an overall recommendation on whether BCKDK deficiency should be added to the mandatory newborn screening panel. For each criterion, TAC members could vote 'Yes, this condition meets the criterion,' 'No, this condition does not meet the criterion,' or 'Unsure.' Additionally, TAC members had the option to leave anonymous comments for each criterion and the overall recommendation.

Criterion 1: Available Screening Technology

The TAC evaluated BCKDK deficiency against Criterion 1: Available Screening Technology, in which sensitive, specific, and timely tests are available that can be adapted to mass screening. BCKDK deficiency can be detected from a dried bloodspot using tandem mass spectrometry, which is technology that has been utilized by the Newborn Screening laboratory since 2008. BCKDK deficiency would be screened for by looking for low branch-chain amino acid levels in a baby's blood.

Out of seventeen total TAC members, 6 voted 'Yes, meets criterion', 7 voted 'No, does not meet criterion', and 4 voted 'Unsure'.

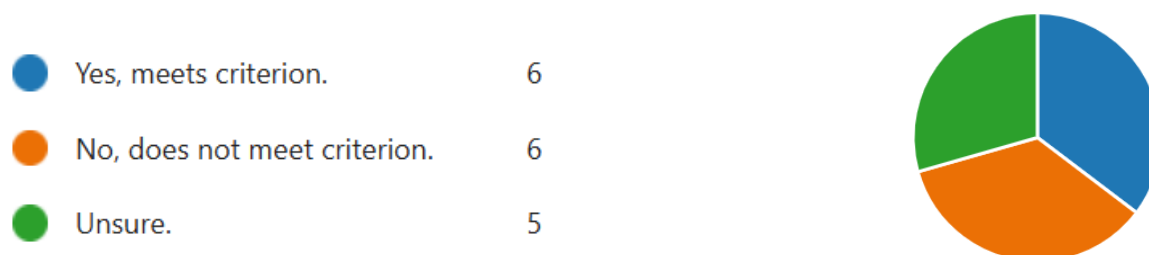


TAC members commented that screening technology is available to detect low branch-chain amino acids, but the actual test performance, such as the sensitivity and specificity, is unclear. Establishing a cutoff to determine a 'low' value for branch-chain amino acids for a newborn would need to be estimated from a population study as no other newborn screening program in the United States is currently screening for BCKDK deficiency.

Criterion 2: Diagnostic Testing and Treatment Available

Criterion 2: Available Diagnostic Testing and Treatment Available considers the availability of accurate diagnostic tests, medical expertise, and effective treatment for evaluation and care of all infants identified with the condition.

Out of seventeen total TAC members, 6 voted 'Yes, meets criterion', 6 voted 'No, does not meet criterion', and 5 voted 'Unsure'.



TAC members commented that there is very limited evidence available for this disorder, making it unclear whether the diagnostic criteria are met. Additional comments included the data on prevalence, long-term outcomes, false positives/negatives, and treatment effectiveness is insufficient, and the small sample size makes it difficult to verify the disorder's validity.

Criterion 3: Prevention Potential and Medical Rationale

Criterion 3, Prevention Potential and Medical Rationale: The newborn identification of the condition allows early diagnosis and intervention. Includes considerations: there is sufficient time between birth and onset of irreversible harm to allow for diagnosis and intervention; the benefits of detecting and treating early onset forms of the condition (within one year of life) balance the impact of detecting late onset forms of the condition; newborn screening is not appropriate for conditions that only present in adulthood.

Out of seventeen total TAC members, 7 voted 'Yes, meets criterion', 3 voted 'No, does not meet criterion', and 7 voted 'Unsure'.

● Yes, meets criterion.	7
● No, does not meet criterion.	3
● Unsure.	7



TAC member comments cited a lack of sufficient data on the prevalence, long-term outcomes with early treatment, and few number of patients in the literature. These limitations make it difficult to assess the relevant criteria.

Criterion 4: Public Health Rationale

Criterion 4, Public Health Rationale: Nature of the condition justifies population-based screening rather than risk-based screening or other approaches.

Out of seventeen total TAC members, 2 voted 'Yes, meets criterion', 12 voted 'No, does not meet criterion', and 3 voted 'Unsure'.

● Yes, meets criterion.	2
● No, does not meet criterion.	12
● Unsure.	3



TAC members who commented again cited the limited data, making it difficult to properly assess whether the criterion has been met.

Criterion 5: Cost-benefit/Cost-effectiveness

Criterion 5, Cost-benefit/Cost-effectiveness: The outcomes outweigh the costs of screening. All outcomes, both positive and negative, need to be considered in the analysis. Important considerations to be included in economic analyses include: the prevalence of the condition among newborns; the positive and negative predictive values of the screening and diagnostic tests; variability of clinical presentation by those who have the condition; the impact of ambiguous results such as the emotional and economic impact on the family and medical system; and adverse effects or unintended consequences of screening

Out of seventeen total TAC members, 0 voted 'Yes, meets criterion', 13 voted 'No, does not meet criterion', and 4 voted 'Unsure'.

● Yes, meets criterion.	0
● No, does not meet criterion.	13
● Unsure.	4



TAC members commented that due to the limited data on BCKDK deficiency, the Department was unable to generate a benefit-cost ratio or cost-effectiveness estimate from the existing cost benefit analysis model.

Overall TAC Recommendation

Out of seventeen TAC members, all but one member voted to recommend that the Board not include BCKDK deficiency on the newborn screening panel. One member voted in favor of recommending the inclusion of this condition to the panel. Comments from TAC members further emphasized concerns about the lack of evidence for BCKDK deficiency to make an informed decision. Many TAC members noted that the Board may want to consider re-evaluating BCKDK deficiency for the newborn screening panel if more evidence becomes available.

Board of Health Review

At its March 12, 2025 meeting, the Board reviewed the TAC recommendation regarding BCKDK deficiency and unanimously accepted the TAC's recommendation to not include BCKDK deficiency at this time. The Board could, as more evidence becomes available, review the condition at a later date.

Appendices

- A. WSBOH Newborn Screening Process and Criteria 2015-2024
- B. TAC Membership
- C. BCKDK One-Pager
- D. Lewis County Autism Coalition, letter
- E. Duke University- Natural History, Diagnostic Testing and Treatment of BCKDK Deficiency
- F. University of Washington Medical Center- Treatment of BCKDK Deficiency
- G. Department of Health- Cost Benefit Analysis
- H. TAC Voting and Comments Summary



Washington State Board of Health

Legislative Report:

Branched-Chain Ketoacid Dehydrogenase Kinase Deficiency (BCKDK)

BCKDK Deficiency Legislative Report

- Senate Bill 6234 (2024 legislative session)
 - Directed the Board of Health to conduct a review of BCKDK deficiency for the Newborn Screening (NBS) panel and to submit a report by June 30, 2025
- BCKDK deficiency was reviewed by TAC in January 2025
 - Recommended not to add BCKDK deficiency to NBS panel
- The Board accepted TAC recommendations at the March 2025 Board of Health meeting
- Seeking Board approval for draft legislative report



THANK YOU

To request this document in an alternate format, please contact the Washington State Board of Health at 360-236-4110, or by email at wsboh@sboh.wa.gov | TTY users can dial 711

ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
 - The nature of the accessibility needs
 - The URL (web address) of the content you would like to access
 - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.

WASHINGTON STATE BOARD OF HEALTH

2025 Meeting Schedule

Approved by the Board November 13, 2024

Updates approved by the Board January 8, 2025

Update proposed to the Board April 9, 2025

Note: Precise location and meeting time will be posted to the Board's website at least two weeks in advance of the meeting.

	Meeting Date	Location
Board	Wednesday January 8, 2025	Hybrid: <ul style="list-style-type: none"> Physical Location; Washington State Department of Labor & Industries, 7273 Linderson Way SW Tumwater, WA 98501-5414, (LNI Auditorium) Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.
Board	Wednesday March 12, 2025	Hybrid: <ul style="list-style-type: none"> Physical Location; Washington State Department of Health, 111 Israel Road S.E., Tumwater, WA 98501, Building: Town Center 2 (Rooms 166 & 167) Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.
Board	Wednesday April 9, 2025	Hybrid: <ul style="list-style-type: none"> Physical Location; Cedarbrook Lodge (Cedars I & II), 18525 36th Avenue South, SeaTac, WA 98188 Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.
Board	Wednesday June 11, 2025 UPDATE PROPOSED: Wednesday, June 4, 2025	Hybrid: <ul style="list-style-type: none"> Physical Location; Washington State Department of Health, 111 Israel Road S.E., Tumwater, WA 98501, Building: Town Center 2 (Rooms 166 & 167) Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online. <p><i>(note: WA State Association of Local Public Health Officials (WSALPHO) Annual meeting is at Semiahmoo Resort in Blaine, WA, June 3-5, 2025, June 10-12, 2025)</i></p>
Board	Wednesday July 9, 2025	Hold date – meet only if necessary

Board	Wednesday August 20, 2025 (3 rd Week)	Hybrid: <ul style="list-style-type: none"> Physical Location; To Be Determined (TBD). Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.
Board	Wednesday October 8, 2025	Hybrid: <ul style="list-style-type: none"> Physical Location; To Be Determined (TBD). Virtual Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online. <p><i>(note: WA State Public Health Association (WSPHA) Annual conference is in Yakima, October 21-23, 2025. The WSALPHO Environmental Public Health Directors meeting is Sept 30-Oct 3 in Leavenworth)</i></p>
Board	Wednesday November 19, 2025 (3 rd week)	Hybrid: <ul style="list-style-type: none"> Physical Location; To Be Determined (TBD), likely in Tumwater, WA at LNI or DOH Meeting via ZOOM Webinar; hyperlink provided on website and agenda. Public Attendees can pre-register and access the meeting online.

Start time is 9:30 a.m. unless otherwise specified. Time and locations subject to change as needed. See the [Board of Health Web site](#) and the [Health Disparities Council Web site](#) for the most current information.

Last updated 1/8/2025

WASHINGTON STATE BOARD OF HEALTH

Date: April 9, 2025

To: Washington State Board of Health Members

From: Patty Hayes, Board Chair

Subject: School Environmental Health and Safety Rule Project Technical Advisory Committee – Final Recommendations

Background and Summary:

During the 2024 legislative session, the Legislature passed a proviso included in the [2024 supplemental operating budget](#) (Section 222, subsection 159, page 491 – 492) that directed the State Board of Health (Board) to review and draft new proposed rules to set minimum health and safety standards for K-12 schools.

The proviso tasks the Board with developing a report in collaboration with the Office of Superintendent of Public Instruction (OSPI), the Department of Health, a multi-disciplinary technical advisory committee, and local health jurisdictions. This report must identify the sections or subject areas that offer the greatest health and safety benefits to students and include any related implementation recommendations. In addition, the Board must complete an environmental justice assessment. The Board must submit a final report to the Legislature and the Governor's Office by June 30, 2025.

Since August 2024, the Board's School Environmental Health and Safety committee convened 15 full meetings and three subcommittee meetings to develop the draft rule. An informal comment period gathered public feedback that the committee carefully reviewed and incorporated when refining the proposed rule. The Board also produced a fiscal analysis in partnership with the committee, OSPI, and industry partners.

Board staff conducted extensive community outreach, including in-person and online listening sessions throughout the state. Feedback from parents, students, teachers, and support staff proved vital in shaping practical aspects of the proposed rule, and the committee gave thorough consideration to this input.

The committee has finalized the draft language for the proposed rule, Chapter 246-370 WAC. Today, committee members will share with the Board how they developed the rule. They will also discuss the proposal's content, its fiscal analysis, and the key themes they will highlight in the forthcoming report to the Legislature. Following discussion with the committee today, the Board will take action on the next steps relating to the draft proposed rule, Chapter 246-370 WAC.

Recommended Board Actions:

The Board accepts the technical advisory committee's recommendations regarding the proposed rule, Chapter 246-370 WAC, and directs staff to begin the process of repealing Chapter 246-366A WAC and any other items articulated in conversation today.

Or

The Board directs staff to continue refining the proposed rule, Chapter 246-370 WAC, in collaboration with the members of the technical advisory committee.

Staff

Andrew Kamali

School Environmental Health and Safety Rule Project – 2024-2025

2024 Supplemental Operating Budget

Section 222, Subsection 159, Page 492¹

Proviso Language:

- (a) \$750,000 of the general fund—state appropriation for fiscal year 2025 is provided solely to review and update the rules for school environmental health and safety. The state board of health and the department shall conduct the review in collaboration with a multi-disciplinary technical advisory committee. The proposed new rules shall establish the minimum statewide health and safety standards for schools. The state board of health shall consider the size of school districts, regional cost differences, the age of the schools, the feasibility of implementing the proposed rules by section or subject area, and any other variables that may affect the implementation of the rules. In developing proposed rules, the state board of health shall:
 - (i) Convene and consult with an advisory committee consisting of, at minimum, representatives from:
 - (A) The office of the superintendent of public instruction;
 - (B) Small and large school districts;
 - (C) The Washington association of school administrators;
 - (D) The Washington state school directors' association;
 - (E) The Washington association of maintenance and operations administrators;
 - and
 - (F) The Washington association of school business officials;
 - (ii) After the development of the draft rules, the state board of health shall meet at least one time with the advisory committee and provide the opportunity for the advisory committee to comment on the draft rules;
 - (iii) Collaborate with the office of the superintendent of public instruction and develop a fiscal analysis regarding proposed rules that considers the size of school districts, regional cost differences, the age of the schools, range of costs for implementing the proposed rules by section or subject area, and any other variables that may affect costs as identified by the advisory committee; and
 - (iv) Assist the department in completing environmental justice assessments on any proposed rules.
- (b) The office of the superintendent of public instruction, the department, the state board of health, the advisory committee, and local health jurisdictions shall work collaboratively to develop and provide a report to the office of the governor and appropriate committees of the legislature by June 30, 2025, detailing prioritized sections or subject areas of the proposed rules that will provide the greatest health and safety benefits for students, the order in which they should be implemented, and any additional recommendations for implementation.

¹ <https://fiscal.wa.gov/statebudgets/2024proposals/Documents/co/5950-S.SL.pdf>

School Environmental Health and Safety Rule Project 2024 - 2025

TAC Membership

MEMBER	ALTERNATE	REPRESENTING
Patty Hayes WSBOH Chair		Washington State Board of Health
Tyler Muench Director of Advocacy & External Affairs	Randy Newman Director of School Facilities & Organization	Washington State Office of Superintendent of Public Instruction
Steve Main Division Director, School Safety Lead	Sandy Phillips School Health and Safety Program Technical Advisor	Spokane Regional Health District
Gina Yonts Associate Director	Roz Thompson Director of Government Relations	Association of Washington School Principals
Geoff Lawson Operations Coordinator	Jeff Rogers Manager of Environmental Health & Safety	Washington Association of Maintenance and Operation Administrators & Tacoma School District
Tammy Allison Board Director – Region 121	Nicole Roel WASBO Board of Directors, Olympia ESD 114	Washington Association of School Business Officials
David Hammond School Construction Committee Chair	Dan Steele Assistant Executive Director, Government Relations	Washington Association of School Administrators
Suzie Hanson Executive Director	Sharon Ricci Community Relations	Washington Federation of Independent Schools
Kate Espy Board Member and Legislative Representative		South Kitsap School District
Erin Hockaday Senior Manager, Surveillance & Investigation	Bailey Stanger	Benton-Franklin Health District

School Environmental Health and Safety Rule Project 2024 - 2025

TAC Membership

MEMBER	ALTERNATE	REPRESENTING
Laurette Rasmussen School EH Specialist	Jamie Bodden WSALPHO Managing Director	Whatcom County Health & Community Services
Lauren Jenks Assistant Secretary, Environmental Public Health	Kelly Cooper Director, Policy and Legislative Relations	Washington State Department of Health
Kevin Jacka Executive Director	Richard Conley Consultant	The Rural Alliance
Samantha Fogg Co-President Seattle Council PTSA		Seattle Council PTSA
Devon Kellogg Volunteer WSPTA, Advocacy Committee	Susan Baird-Joshi Volunteer WSPTA	Washington State PTA
Laura Peterson Volunteer/Appointed Role WSPTA		Washington State PTA
Brook Wilkerson Director of Operational Supports	Anders Lindgren President	School Ops
Preet Singh Director of Health Services	Jessica Sankey Chief Operations Officer	Bellingham Public Schools
Brian Buck Executive Director of Support Services	Kenny Johnson Director of Maintenance & Operations	Lake Washington School District
Kellie Lacey Assistant Director of Human Resource	Kelsey Greenough Records Specialist	Richland School District
Nicole Daltoso Senior Director of Capital Facilities	Theodore (Ted) Dehnke Assistant Director of Maintenance	Evergreen Public Schools

School Environmental Health and Safety Rule Project 2024 - 2025

TAC Membership

MEMBER	ALTERNATE	REPRESENTING
Brian Freeman Superintendent		Inchelium School District
Becky Doughty Executive Director of School Support Services (Operations)	Sandra Jarrad Chief Communications Officer	Spokane Public Schools
Jared Mason-Gere Government Relations Staff	Julie Salvi Lobbyist/Government Relations	Washington Education Association
Pam Schwartz Assistant Superintendent	Doug Rich Superintendent	Washington State Catholic Conference
Jake Cook Public Advocate		Public

School Rule Project Staff

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Marcus DeHart

Communications Consultant

Crystal Ogle

Administrative Assistant

School Environmental Health and Safety Rule Project 2024 - 2025

Technical Advisory Committee (TAC) Charter

Start Date: August 1, 2024

End Date: June 30, 2025

Members: See TAC Membership Addendum A

Objective

To review and update the rule for school environmental health and safety. The State Board of Health (Board) and the Department of Health (Department) shall conduct the review with a multi-disciplinary technical advisory committee (TAC). The proposed new rule shall establish the minimum statewide health and safety standards for schools. The TAC will help the Board consider the size of school districts, regional cost differences, the age of the schools, the feasibility of implementing the proposed rule by section or subject area, and any other variables that may affect the implementation of the rule.

Team Expectations

We will:

- Be respectful of all perspectives and opinions.
- Communicate openly and respectfully, disagree without being disagreeable.
- Assume positive intent and ask for clarification.
- Share the air—allow everyone to share insights, one person speaking at a time.
- Ask questions and seek to understand.
- Be on time for meetings and calls.
- Be present and actively participate (no multitasking during meetings).
- Be efficient with our meeting time.
- Meet deadlines and commitments.
- Support the final decisions of the TAC.
- Stay focused on the goals and objectives of the committee.

Decision Making

- The committee will use Fist to Five and Ranked Choice Voting to make decisions.
- Primary or Alternate member voting: Both may attend, but the Primary speaks and votes. The alternate only speaks and votes when Primary is not in attendance.

Information Sharing

Board Project Team will:

- Email meeting materials 72 hours before the scheduled meeting
- Email updates and notices to TAC members and designated alternates
- Post information on [2024-2025 School Rule Review Project | SBOH \(wa.gov\)](https://sboh.wa.gov/rulemaking/agency-rules-and-activity/2024-2025-school-rule-review-project)^[1] to keep the public informed.

[1] <https://sboh.wa.gov/rulemaking/agency-rules-and-activity/2024-2025-school-rule-review-project>

School Environmental Health and Safety Rule 2024-2025

Phased Implementation of Rule

WAC 246-370-001 Purpose

The purpose of this chapter is to set minimum environmental health and safety standards for school facilities operated for the primary purpose of providing education.

1

WAC 246-370-005 Definitions

(1) "Air contaminant" means pollutants in the air that could, depending on dose and circumstances, cause adverse health impacts.	3
(2) "Decibel (dB)" means a standard unit of measurement of sound pressure.	1
(3) "Decibel, A-weighted (dBA)" means a decibel measure that has been weighted in accordance with the A-weighting scale. The A-weighting adjusts sound level as a function of frequency to correspond approximately to the sensitivity of human hearing.	1
(4) "Department" refers to the Washington State Department of Health.	1
(5) "Emergency washing facilities" means equipment such as emergency showers, eyewashes, eye/face washes, hand-held drench hoses, or other similar units.	3
(6) "Emissions" mean substances released into the air, including gases and particles, from various sources.	3
(7) "Equivalent Continuous Sound Level" or "Leq" means the sound pressure level of a noise fluctuating over a period of time, expressed as the amount of average energy.	1
(8) "Foot candle" means a unit of measure of the intensity of light falling on a surface, equal to one lumen per square foot.	1
(9) "Imminent health hazard" means a significant threat or significant danger to health or safety that requires immediate action to prevent serious illness, injury, or death.	1
(10) "Integrated pest management" means a program that reduces sources of food, water, and shelter for pests by using the least toxic pest controls when necessary.	1
(11) "Local board of health" means the county or district board of health as defined in RCW 70.05.010(3).	1
(12) "Local health officer" means a legally qualified physician who has been appointed as the health officer for the county or district public health department as defined in RCW 70.05.010(2) or their authorized representative.	1
(13) "New construction" means new buildings or structures, including construction of additions to existing school facilities and reconstruction or retrofitting of an existing building not originally intended for use as a school facility. New construction does not include reconstruction of an existing school facility.	1

1 Develop plans, no change from 366, or basic WAC structures

2 Collaborative tasks and events

3 Meet compliance

School Environmental Health and Safety Rule 2024-2025

(14) "Noise abatement" means measures taken to reduce unacceptable sounds or vibrations.	1
(15) "Noise criterion" means a single number for rating the sound quality of a room by comparing actual or calculated sound level spectra with a series of established octave band spectra.	1
(16) "Noise criterion 35 (NC35)" means the curve for specifying the maximum permissible sound pressure level for each frequency band.	1
(17) "OSPI" refers to the Washington Office of Superintendent of Public Instruction.	1
(18) "Portable" means any school building with a prefabricated structure that can be transported and installed on-site to provide additional educational space.	1
(19) "Preschool" means an educational establishment or learning space offering early childhood education to children not old enough to attend kindergarten.	1
(20) "Readiness Plan" means a written guide to ensure the health and safety of the occupants of a school facility in the event of a particular hazard, such as extreme heat or wildfire smoke.	1
(21) "School" means any public institution of learning where the primary purpose is educational instruction for children in any grade from kindergarten through grade twelve, including transition programs, programs where students will advance to grade one the following year, and related activities by the public school as defined in RCW 28A.150.010 and any private school or private institution regulated by chapter 28A.195 RCW.	1
(22) "School facility" means all buildings and land intended primarily for student use including, but not limited to portables, sports fields, playgrounds, classrooms, and common areas.	1
(23) "School official" means a member of the school district or school staff who has the authority to make decisions on behalf of the district or school to maintain and improve environmental health and safety within the limitations of this rule.	1
(24) "Site assessment" means an evaluation of any historical or other readily available information on site conditions and surroundings to evaluate whether the site poses a potential hazard to human health and determine if further investigation is needed.	2
(25) "Source capture system" means a mechanical exhaust system designed and constructed to capture air contaminants at their source and release air contaminants to the outdoor atmosphere.	3
(26) "Specialized room" means a space or room that has a specific function that uses equipment, furniture, or supplies not found in a standard room that are a potential health and safety risk. This may include but is not limited to a career and technical education room, laboratory, art room, or health room.	1

School Environmental Health and Safety Rule 2024-2025

- | | |
|---|---|
| (27) "Stationary machinery" means equipment that is designed to be installed in a fixed location and does not require intermittent movement to service different needs. | 3 |
| (28) "Transition services" means a coordinated set of activities as defined in WAC 392-172A-01190. | 1 |

WAC 246-370-010 Applicability

- | | |
|---|---|
| <p>(1) This chapter applies to all school facilities operated for the primary purpose of providing education, including those primary and secondary school facilities that offer preschool education or transition services. This chapter does not apply to:</p> <ul style="list-style-type: none"> (a) Any facility or part of a facility that is licensed by the department of children, youth, and families under Title 110 WAC; (b) Private residences used for home-based instruction as defined by RCW 28A.225.010(4); (c) Facilities hosting educational programs where educational instruction is not a primary purpose, including, but not limited to, detention centers, jails, hospitals, mental health units, or long-term care facilities; (d) Private facilities where tutoring is the primary purpose; (e) Public or private postsecondary education facilities providing instruction to students enrolled in secondary school; and (f) State-tribal education compact schools established under chapter 28A.715 RCW. <p>(2) Additional environmental health and safety rules that apply to school facilities include, but are not limited to:</p> <ul style="list-style-type: none"> (a) Chapter 246-215 WAC regarding facility and equipment sanitation, food preparation, food storage, and food temperature control ; (b) Chapter 246-217 WAC regarding food service workers, including contracted staff and volunteers, who must maintain a current food worker card as set forth in chapter 246-217 WAC; and (c) Chapters 246-260 and 246-262, as applicable, regarding water Recreation Facilities or aquatic venues ; (d) WAC 51-54A-0915 regarding the installation and maintenance of carbon monoxide detection and alarms in mechanical rooms and occupied zones; and (e) RCW 43.70.830 through 43.70.845 regarding lead in drinking water if the facility was built or all plumbing was replaced before 2016. <p>(3) Schools must use sewer and liquid waste disposal that is connected to a municipal sewage disposal system or an on-site sewage disposal system designed, constructed and maintained under chapter 246-272A or 246-272B.</p> <p>(4) Schools must provide drinking water from public water supplies regulated under WAC 246-290 or 246-291.</p> | 1 |
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- 1 Develop plans, no change from 366, or basic WAC structures
- 2 Collaborative tasks and events
- 3 Meet compliance

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- (5) These rules are not intended to replace or supersede the department of labor and industries' authority and jurisdiction under Title 296 WAC over employee safety and health.
- (6) These rules are not intended to replace building code council requirements under Title 51 WAC. In the event this chapter is more stringent to protect health and safety it may supersede Title 51 WAC.
- (7) If the local permitting jurisdiction received a complete building permit application for school construction before the effective date of this chapter, the construction-related requirements of chapter 246-366 WAC apply.

WAC 246-370-015 Good Safety Practice and Guidance

- (1) Except where more specific requirements apply, school facilities must apply good safety practices to conditions which present a potential hazard to occupants of the school.
- (2) The department in cooperation with OSPI shall review potentially hazardous conditions in schools which are not aligned with good safety practice, especially in specialized rooms.
- (3) The department and OSPI shall jointly prepare a guide for use during routine school inspections to identify issues relating to good safety practices. The guide should include recommendations for safe facilities and safety practices.
- (4) The guide shall be reviewed and updated at least every five years.

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WAC 246-370-020 Site Assessment

- (1) A local health officer shall conduct or require that a site assessment be conducted when a school district is planning:
 - (a) To construct a new school facility on a site that was previously undeveloped or developed for other purposes; or
 - (b) To convert an existing structure for primary use as a school facility.
- (2) A local health officer may conduct or require that a site assessment be conducted when a school district is planning to construct:
 - (a) A new school facility on an existing school site; or
 - (b) An addition to an existing school facility.
- (3) A site assessment must include:
 - (a) A Phase 1 Environmental Site Assessment (ESA) that meets the requirements of the American Society for Testing and Materials (ASTM) Standard #1527-21 (published December 2021);
 - (b) Sampling and analysis of potential contaminants if the Phase 1 ESA indicates that hazardous materials may be present. Sampling and analysis must comply with the applicable rules of the department of ecology, WAC 173-303-110 ; and

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- (c) A noise assessment that measures noise from all sources during the hours that school is normally in session.
 - (i) The noise must not exceed:
 - (A) An hourly average of 55 dBA or the mean sound energy level for a specified time in Leq 60 minutes; and
 - (B) A maximum sound level, recorded during a specified time, measured as Lmax, of 75 dBA during the time of day the school is in session.
- (4) A school official shall ensure:
 - (a) The local health officer receives notification within 90 days of starting:
 - (i) The preliminary planning for school construction that requires a review and approval of a site assessment by a local health officer under subsection (1) of this section; or
 - (ii) The preliminary planning for school construction under subsection (2) of this section to determine if a site assessment is required;
 - (b) Consultation with the local health officer throughout the plan development phase regarding the scope of the site assessment when one is required and the timeline for completion of the site assessment;
 - (c) The submission of a written report to the local health officer for a required site assessment that assesses the potential impact on health and safety presented by the proposed site and includes, but is not limited to, the following:
 - (i) The findings and results obtained under subsection (3) of this section;
 - (ii) An analysis of the findings;
 - (iii) If a site exceeds sound levels under subsection (3)(c)(i), the school official must include a plan for noise reduction in the new construction proposal under WAC 246-370-030;
 - (iv) Identified health and safety risks present at the site;
 - (v) A description of any mitigation proposed to address identified health and safety risks present at the site; and
 - (vi) Any site assessment-related information requested by the local health officer to complete the site assessment review and approval process; and
 - (d) The acquisition of a site review and written site approval from the local health officer when required under subsection (1) or (2) of this section.
- (5) When notified by a school official of preliminary planning for school construction, the local health officer shall:
 - (a) Conduct an inspection of the proposed site;
 - (b) Determine whether a site assessment is required when notice is provided under subsection (4)(a)(ii) of this section and notify the school official of the determination;

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- (c) Review the inspection findings, written report provided under subsection (4)(c), and any other site assessment-related information for environmental health and safety risk;
 - (d) For site assessments conducted under subsection (1) of this section, provide written approval or describe site deficiencies needing mitigation to obtain approval or deny use of the proposed school facility site if mitigation is not possible within 60 days of receiving a complete request unless a school official and the local health officer agree to a different timeline; and
 - (e) For site assessments conducted under subsection (2) of this section, provide written approval or describe site deficiencies needing mitigation to obtain approval of the proposed school facility site within 60 days of receiving a complete request unless the school officials and the local health officer agree to a different timeline.
- (6) If a written site assessment request from a school official is received by the local health officer before the effective date of this section, the site assessment requirements of chapter 246-366 WAC apply unless otherwise specified in this chapter.

WAC 246-370-030 Construction Plan Review New, Alterations, and Portables

- (1) The following school construction projects must be reviewed and approved by the local health officer:
 - (a) Construction of a new school facility, playground, bathroom, shower, or specialized room;
 - (b) Establishment of a school in all or part of any existing structure previously used for another purpose;
 - (c) Additions or alterations consisting of more than 5,000 square feet of floor area or more than 20 percent of the total square feet of an existing school facility, whichever is less;
 - (d) Alteration of a playground, bathroom, shower, or specialized room; and
 - (e) Installation or construction of a portable classroom.
- (2) A school official shall ensure:
 - (a) Consultation with the local health officer takes place at the 50 percent design development stage of school construction project plans to determine if the project requires construction review;
 - (b) The provision of additional documents, beyond the construction project plans, if requested by the local health officer, which may include, but are not limited to, written statements signed by the project's professional engineer or licensed architect verifying that design elements comply with requirements specified by this chapter;
 - (c) Consultation with the local health officer to determine whether additional construction project review is required to ensure that the project meets the requirements of this chapter;

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- (d) The submission of the design at the 100 percent development stage for the construction design plans.
 - (e) The acquisition of a written approval from the local health officer for the construction project before starting construction;
 - (i) If the school official meets the requirements of subsection (2)(a) but the local health officer does not meet the requirements of subsection (3), the school official may proceed with their scheduled construction timeline;
 - (f) The submission of a request for a preoccupancy inspection to the local health officer to correct any imminent health hazards before allowing occupancy at the school facilities; and
 - (g) The local health officer receives notification at least five business days before a desired preoccupancy inspection.
- (3) The local health officer shall:
- (a) Respond to a request to consult with a school official within 15 business days of receipt;
 - (b) Consult with a school official to determine the necessary documentation for plan review and approval of the particular project;
 - (c) Review construction project plans at the 50 percent design development stage to confirm the need for a construction review and approval to meet the health and safety requirements of this chapter;
 - (d) Consult with a school official when requiring additional construction plan reviews between the 50 and 100 percent construction plan design development stages;
 - (e) Identify and request any additional documents needed to determine compliance with the requirements outlined in this chapter;
 - (f) Provide written approval within 60 days of receiving the 100 percent design development for the construction design plans or provide a written statement describing construction project plan deficiencies that need to change to obtain approval. The school official and the local health officer may alter this timeline if mutually agreed upon; and
 - (g) Conduct an inspection:
 - (i) Before occupancy of a completed construction project and within five business days after receiving a request from a school official;
 - (ii) At any point during the construction period to verify compliance with the requirements of this chapter;
 - (iii) In a coordinated effort with the on-site project manager or other appropriate person identified by a school official; or
 - (iv) To confirm satisfactory correction of the items identified under (h) or (i) of this subsection;

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- (h) If an imminent health hazard is identified during an inspection, work with the school official and local building official to identify and agree upon a solution that the school officials will implement before occupation of the affected portion; and
- (i) If other conditions of noncompliance with this chapter are identified during an inspection, provide the school official with a written list of items and consultation in developing a correction schedule based on the level of risk to health and safety.

WAC 246-370-040 Routine Inspection

- 2
- (1) The local health officer shall:
 - (a) Conduct an environmental health and safety inspection of each school facility within their jurisdiction every three years, prioritizing areas for emphasis based on risk;
 - (b) Notify school officials at the time of discovery, or immediately following the inspection, if conditions that pose an imminent health hazard are identified and follow the imminent health hazard requirements set forth in WAC 246-370-120;
 - (c) Consult with school officials upon completion of the inspection about findings and recommended follow-up actions and, if necessary, collaborate with school officials to develop a remediation schedule;
 - (d) Issue a final inspection report within 60 days following an inspection. The local health officer may establish an alternate timeline for issuing the final inspection report when agreed upon in consultation with school officials. The report must include inspection findings related to this chapter and any required remediation; and
 - (e) Confirm, as needed, that corrections are made.
 - (2) The local health officer may:
 - (a) Adjust the inspection interval of the schools within their jurisdiction by developing a written risk-based inspection schedule that is uniformly applied throughout the jurisdiction based on credible data or local risk factors. The time between routine inspections may not:
 - (i) Exceed five years; and
 - (ii) Be more frequent than one year; or
 - (b) Allow a school official or qualified designee to conduct the required additional inspections under a program approved by the local health officer if the program includes provisions for:
 - (i) Assuring that the school official or designee conducting the inspection has attended training in the standards, techniques, and methods used to conduct an environmental health and safety inspection;
 - (ii) Completing a standardized checklist at each inspection; and
 - (iii) Providing a written report to the local health officer detailing the findings of the inspection, within 60 days of completing the inspection.

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WAC 246-370-050 General Building Requirements

A school official shall ensure that school facilities:

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- (1) Are clean and in good repair;
- (2) Do not attract, shelter, or promote the propagation of insects, rodents, bats, birds, or other pests of public health significance;
- (3) Have floors that suit the intended use, allow easy cleaning, and dry easily to inhibit mold growth and mitigate fall risks;
- (4) Have no projections from the finished ceiling that are less than seven clear vertical feet from the finished floor;
- (5) Have vacuum breakers or backflow prevention devices installed on hose bibs, sinks, and supply nozzles where hoses or tubing can be connected;
- (6) Provide proper storage for student jackets or backpacks, play equipment, and instructional equipment to mitigate trip, pest, or other public health hazards;
- (7) Contain toilet and handwashing facilities that are accessible for use during school hours and scheduled events;
- (8) Provide handwashing stations equipped with:
 - (a) Soap;
 - (b) Single-use towels, disposable towels, blower, or equivalent hand-drying device;
 - (c) Fixtures with water temperatures that do not exceed 120-degrees Fahrenheit; and
 - (d) Fixtures that deliver at least 10 seconds of running water if they are self-closing, metering faucets.
- (9) Provide toilet paper in restrooms;

- (10) Provide handwashing sinks that are accessible where activities present a potential risk of microbiological or chemical contamination of the hands in any student spaces, which may include, but are not limited to:
 - (a) Restrooms;
 - (b) Specialized rooms; or
 - (c) Health rooms; and
- (11) Provide accessible drinking fountains that are constructed with a nozzle that directs an arc of water to flow away from the nozzle and is located above water-impervious flooring. The drinking fountains must be deactivated when attached to a handwashing sink in a specialized room or located in a restroom.

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WAC 246-370-060 Showers and Restrooms

- (1) For new construction or alterations of an existing shower facility for grades nine and above with classes in physical education or team sports, at least one shower must:
 - (a) Meet the Federal Americans with Disabilities Act (ADA);

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- 1 Develop plans, no change from 366, or basic WAC structures
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- (b) Meet the requirements of the uniform plumbing code set forth in chapter 51-56 WAC;
- (c) Be accessible to any student for use during school hours and scheduled events; and
- (d) Contain floors that are slip resistant.
- (2) For new construction or alterations of an existing shower facility for grades nine and above with classes in physical education or team sports, if a locker or dressing room is provided, it must have easy-to-clean walls and floor surfaces that are slip resistant.
- (3) For new construction or alterations of an existing restroom facility, restrooms must:
 - (a) Contain handwashing fixtures that do not have water temperatures that exceed 120 degrees Fahrenheit;
 - (b) Meet the requirements of the uniform plumbing code set forth in chapter 51-56 WAC;
 - (c) Contain floor surfaces impervious to water, slip-resistant, and sloped to floor drains;
 - (d) Contain walls, floors, and ceilings that are easy to clean; and
 - (e) Contain soap and single-use or disposable towels. Blower or equivalent hand-drying devices are prohibited.

WAC 246-370-070 Indoor Air Quality and Ventilation

A school official shall ensure:	
(1) The implementation of a written indoor air quality plan within five years of the effective date of this section that includes: <ul style="list-style-type: none"> (a) Identified areas of indoor air quality concerns and development of preventive measures to address the concerns; (b) A schedule to perform routine inspections of heating, ventilation, and cooling systems; (c) An integrated pest management plan; (d) A plan for monitoring and mitigating carbon dioxide levels if required by subsection (7)(b)(iii) of this section; and (e) A plan with identified actions for ensuring health and safety for periods of increased health risk or poor outdoor air quality; 	1
(2) The control of air contaminant sources by: <ul style="list-style-type: none"> (a) Excluding sources of potential air contaminants from a school facility; or (b) Providing a space with appropriately used and maintained ventilation to minimize student exposure to potential air contaminants; 	3
(3) The development and implementation of a plan to test for radon every five years in regularly occupied areas on or below ground level;	1
(4) The prohibition of air fresheners, candles, or other products that contain fragrances;	3

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- (5) The minimization of student exposure to construction activities that generate emissions by physically containing the activities or conducting activities when students are not present;
- (6) The prompt control of identified moisture sources and remediation of mold using measures to minimize occupant exposure to mold and chemicals used during the remediation process;
- (7) Adequate ventilation by:
 - (a) Ensuring direct mechanical exhaust for specialized rooms as set forth in WAC 246-370-140; and
 - (b) Ensuring all student-occupied instruction and gathering spaces during hours of occupation provide outdoor air ventilation flow rates as set forth in chapter 51-52 WAC at the time the ventilation system was permitted;
 - (i) If outdoor air ventilation flow rates were not established at the time of the original building construction, ventilation airflow rates must be operated to meet chapter 51-52 WAC or maximum outdoor air ventilation flow rates achievable within existing system capacity;
 - (ii) Compliance is determined based on variables including but not limited to:
 - (A) The type and area of the space;
 - (B) The planned number of occupants; and
 - (C) The type of ventilation system; and
 - (iii) If the school facility does not have a mechanical outdoor air ventilation system or the outdoor air flow rate cannot be determined, provide ongoing carbon dioxide concentration monitoring;
- (8) Adequate filtration by:
 - (a) Ensuring particulate matter filtration as set forth in chapter 51-52 WAC at the time the heating, ventilation, and air conditioning systems were permitted, including facilities that have small, ducted air handlers and ventilation systems;
 - (i) If particulate matter filtration requirements were not established at the time of the original installation of the system, the system must meet chapter 51-52 WAC or the maximum particulate matter filtration achievable within existing system capacity; and
- (9) For schools with mechanical heating, ventilation, or cooling systems, the performance of routine maintenance that includes:
 - (a) Testing and balancing for existing heating, ventilation, and air conditioning systems every fifteen years;
 - (b) Performing routine inspections of existing heating, ventilation, and cooling systems to ensure systems are operating within intended parameters of this rule;
 - (c) Replacing filters as needed to achieve required filtration and air flow rates; and

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- (d) Maintaining records of these activities for review upon request by the local health officer.

WAC 246-370-080 Temperature

(1) A school official shall ensure the development of an extreme temperature readiness plan and implement the plan when a school facility is occupied by students and either of the following conditions apply:	1
(a) Classroom temperatures are outside of the range of 65 degrees to 79 degrees Fahrenheit; or	3
(b) Hallways, gymnasiums, and common area temperatures are outside of the range of 60 degrees to 79 degrees Fahrenheit.	
(2) A school official may consult with a local health officer to develop an extreme temperature readiness plan.	1

WAC 246-370-090 Noise

A school official shall ensure:	1
(1) For new construction:	
(a) Ventilation equipment or other equipment that will contribute to mechanical noise sources in a classroom must include designs that ensure that the background sounds conform to a noise criterion curve or equivalent not to exceed NC-35. The school official shall certify that equipment and features are installed according to the approved plans;	
(b) The actual background noise at any student location within a newly constructed classroom must not exceed 45 dBA (Leqx) and 70 dB(Leqx) (unweighted scale) where x is thirty seconds or more. The health officer shall determine compliance with this section when the ventilation system and the ventilation system's noise generating components, such as the condenser, heat pump, and other similar components are in operation; and	
(c) The maximum ambient noise level in specialized rooms shall not exceed 65 dBA when all fume and dust exhaust systems are operating;	
(2) Portable classrooms constructed before January 1, 1990, moved within the same school property or the same school district, are excluded from the requirements of this section if the portable classrooms:	
(a) Do not alter the noise abatement features;	
(b) Do not increase noise-generating features;	
(c) Were previously used for classroom instruction;	
(d) Do not change ownership; and	

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- (e) Are located on a site that meets the noise assessment requirements set forth in WAC 246-370-020(3)(c);
- (3) The maximum noise exposure for students in classrooms shall not exceed the levels specified in Table 1;
- (4) Activities that expose students to sound levels equal to or greater than 115 dBA are prohibited; and
- (5) Students are provided with and required to use personal protective equipment where noise levels exceed those specified in Table 1. Personal protective equipment must reduce student noise exposure to comply with the levels specified in Table 1.

Table 1	
Maximum noise exposures permissible	
Duration per day (hours)	Sound Level (dBA)
8	85
6	87
4	90
3	92
2	95
1-1/2	97
1	100
1/2	105
1/4	110

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WAC 246-370-100 Lighting

A school official shall ensure that:

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- (1) Light intensities that meet or exceed those specified in Table 2 are provided. Natural lighting, energy-efficient lighting systems, lighting fixtures, or bulbs may be used to maintain the minimum lighting intensities;

Table 2	
Lighting intensities measured 30 inches above the floor or on working or teaching surfaces. Some lighting fixtures may require a start-up period before reaching maximum light output.	
Task	Min. Foot Candle Intensity
Specialized rooms where safety is of prime consideration or fine detail work is done, for example, family and consumer science laboratories, science laboratories (including chemical storage areas), shops, drafting rooms, and art and craft rooms.	50
Kitchen and food preparation areas.	50
General instructional areas, for example, study halls, lecture rooms, and libraries.	30
Gymnasiums: main and auxiliary spaces, shower rooms and locker rooms.	20
Non-instructional areas including auditoriums, lunchrooms, food storage rooms, assembly rooms, corridors, stairs, storerooms, and restrooms.	10

- (2) Excessive brightness and glare in all instructional areas is controlled. Surface contrasts and direct or indirect glare must not cause excessive eye accommodation or eye strain problems;
- (3) Sun control to exclude direct sunlight from window areas and skylights of instructional areas, assembly rooms, and meeting rooms during at least 80 percent of the normal school hours is provided. Sun control is not required for sun angles less than 42 degrees up from the horizontal. Sun control is not required if air conditioning is provided, or special glass is installed having a total solar energy transmission factor of less than 60 percent;
- (4) Lighting in a manner that minimizes shadows and other lighting deficiencies on work and teaching surfaces is provided; and
- (5) Windows in sufficient number, size, and location to enable students to see outside at least 50 percent of the school day are provided. Windows are optional in specialized rooms.

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WAC 246-370-110 Injury Prevention

A school official shall ensure:

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- (1) The mitigation of potential slip and fall hazards by, but not limited to:
 - (a) Providing stairwells and ramps with handrails and stairs with surfaces that reduce the risk of injury;
 - (b) Providing protection or barriers for areas that have fall risks such as balconies and orchestra pits;
 - (c) Storing unsecured equipment in a manner that prevents unauthorized use or injury;
- (2) The storage of chemicals and cleaning supplies includes:
 - (a) Manufacturer use instructions, warning labels, and safety data sheets for proper storage of the supplies;
 - (b) Labels on supplies that are diluted from bulk chemical or cleaning agents with the accurate agent name and dilution rates;
 - (c) The original bulk or concentrated containers of cleaning and disinfectant agents for reference to labels and instructions until diluted contents are exhausted;
 - (d) Separation of incompatible substances; and
 - (e) Access limited to authorized users;
- (3) The use of fragrance-free and low-hazard cleaning and sanitation supplies when available or ensure cleaning at a time and manner that would limit exposure to students; and
- (4) Documentation of a policy to mitigate injury and the spread of diseases if the school allows animals other than service animals in a school facility.

WAC 246-370-120 Imminent Health Hazard Procedure

- (1) If a school official identifies a condition that could pose an imminent health hazard, a school official shall ensure:
 - (a) The immediate mitigation of hazards and prevention of exposure if an imminent health hazard is confirmed;
 - (b) The immediate consultation with the local health officer to investigate the suspected hazard; and
 - (c) Consultation with the local health officer in developing appropriate health and safety messages for school staff, students, and parents.

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- (2) If a local health officer identifies a condition that is an imminent health hazard at a school, the local health officer shall:
- (a) Immediately inform school officials of the imminent health hazard;
 - (b) Consult with school officials to mitigate hazards and prevent exposure; and
 - (c) If requested, assist school officials in developing health and safety messages for school staff, students, and parents.

WAC 246-370-130 Playgrounds

- (1) A school official shall ensure:
- (a) Consultation with the local health officer regarding playground review and approval requirements takes place prior to:
 - (i) Installing new playground equipment or fall protection surfaces;
 - (ii) Adding new playground features or equipment to an existing playground; or
 - (iii) Modifying existing playground equipment, features, or fall protection surfaces;
 - (b) The proper installation, maintenance, and operation of playground equipment, including used equipment, and fall protection surfaces:
 - (i) In a manner consistent with the ASTM F 1487-21: Standard Consumer Safety Performance Specification for Playground Equipment for Public Use; and
 - (ii) In a manner consistent with the manufacturer's instructions and *Consumer Product Safety Commission Handbook for Public Playground Safety*, 2010;
 - (a) The local health officer receives requested information including playground plans, equipment specifications, and any additional information; and
 - (b) Acquisition of a plan review and written approval from the local health officer before installing, adding, or modifying playground equipment or fall protection surfaces.
- (2) The local health officer shall:
- (a) Consult with a school official to determine necessary documentation for playground plan review and approval consistent with the scope of the particular project;
 - (b) Review playground plans and equipment specifications to confirm that the requirements of these rules are addressed;
 - (c) Identify and request any additional documents required to complete the review;
 - (d) Provide written approval or denial of the playground plans and equipment specifications within 60 days of receiving all documents needed to complete the review unless the school officials and the local health officer agree to a different timeline;
 - (e) Verify that playground installation complies with the requirements of this section; and
 - (f) Coordinate all playground-related inspections with the school official.

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- (3) The use of chromated copper arsenate or creosote-treated wood to construct or install playground equipment, landscape structures, or other structures on which students may play is prohibited.

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WAC 246-370-140 Specialized Rooms

- (1) A school official shall ensure specialized rooms that are part of a school facility include, if applicable:
- (a) Single-use soap and single-use towels at handwashing sinks;
 - (b) Emergency washing facilities that contain an emergency shower or emergency eyewash fountain or both:
 - (i) An emergency shower must:
 - (A) Be provided when there is potential for major portions of a person's body to contact corrosives, strong irritants, or toxic chemicals; and
 - (B) Deliver water that cascades over the user's entire body at a minimum rate of 20 gallons (75 liters) per minute for fifteen minutes or more;
 - (ii) An emergency eyewash fountain must:
 - (A) Be provided when there is potential for a person's eyes to be exposed to corrosives, strong irritants, or toxic chemicals;
 - (B) Irrigate and flush both eyes simultaneously while the user holds their eyes open;
 - (C) Contain an on-off valve that activates in one second or less and remains on without user assistance until intentionally turned off; and
 - (D) Deliver at least 0.4 gallons (1.5 liters) of water per minute for fifteen minutes or more;
 - (iii) Emergency washing facilities must:
 - (A) Be located so that it takes no more than 10 seconds to reach and the travel distance should be no more than 50 feet;
 - (B) Be kept free of obstacles blocking their use;
 - (C) Function correctly;
 - (D) Provide the quality and quantity of water that is satisfactory for emergency washing purposes; and
 - (E) Be designed, installed, and maintained in accordance with the American National Standards Institute (ANSI) publication Z358.1 - 2014, American National Standard for *Emergency Eyewash and Shower Equipment*;

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- (c) A prohibition of use and storage of compounds that are:
 - (i) Considered shock-sensitive explosives, for example, picric acid, dinitro-organics, isopropyl ether, ethyl ether, tetrahydrofuran, dioxane; or
 - (ii) Lethal at low concentrations when inhaled or in contact with skin, for example, pure cyanides, hydrofluoric acid, toxic compressed gases, mercury liquid and mercury compounds, and chemicals identified as the P-list under WAC 173-303-9903. This excludes prescribed medications such as epinephrine pens;
- (d) Safety procedures and processes for instructing students regarding the proper use of hazardous materials or equipment;
- (e) Appropriate personal protective equipment when exposure to potential hazards might occur;
- (f) Appropriate situation-specific emergency equipment is available when exposure to potential hazards might occur;
- (g) Appropriate ventilation, source capture system, or other equipment approved by the local health officer to prevent the recirculation of air into the room or transfer of airflow into other parts of the school facility and to prevent contaminants from entering the students breathing zone; and
- (h) Emergency shut-off valves or switches for gas and electricity connected to stationary machinery are installed during new construction. Valves or switches must:
 - (i) Be located close to the exit door;
 - (ii) Have unobstructed access; and
 - (iii) Have signage posted adjacent to the valve that room occupants can easily read and understand from the opposite side of the room during an emergency.
- (2) If a school facility has a designated health room, a school official shall ensure that it includes:
 - (a) The means to visually supervise and provide privacy for room occupants;
 - (b) Surfaces that staff can easily clean and sanitize;
 - (c) A handwashing sink in the room;
 - (d) An adjoining restroom; and
 - (e) Mechanical exhaust ventilation that prevents air from flowing from the health room to other parts of the school facility.

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WAC 246-370-150 Variances and Emergency Waivers

- (1) A school official may:
 - (a) Submit a written variance request to the local health officer if there is an alternative that meets the intent of this chapter. The variance request must include:
 - (i) The specific rule section or sections that the variance would replace;
 - (ii) The alternative proposed to replace the rule section or sections;
 - (iii) A description of how the variance will provide a comparable level of protection as the rule section or sections that it will replace; and
 - (iv) Any clarifying documentation needed to support the request, including but not limited to, engineering reports, scientific data, or photos; and
 - (b) Implement a variance only after obtaining approval from the local health officer.
- (2) The local health officer shall provide written approval or denial of a request for a variance to the school applicant and the department within 60 days of receiving a complete written variance request, unless the school official and the local health officer agree to a different timeline.
- (3) The local health officer may grant a school official an emergency waiver from some or all the requirements in this chapter for the use of a temporary facility, if the facility normally used by the school is not safe to be occupied.

2

WAC 246-370-160 Appeals

- (1) A school official may appeal any environmental health and safety decisions or actions of the local health officer to the local board of health.
- (2) The local board of health will conduct environmental health and safety appeals in a manner consistent with the written procedure within each office.

2

WAC 246-370-170 Severability

If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected.

1

Fiscal Analysis

April 9, 2025

School Environmental Health and Safety Rule 2024 – 2025

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Cost Assumptions

- **General:** All cost assumptions represent both the school and local health jurisdiction costs to comply with the proposed requirements in chapter 246-370 WAC beyond those currently incurred by 246-366 WAC.

For example, 246-366-040 (current regulation) and 246-370-030 (proposed regulation) WAC are both subsections for construction plan review. This fiscal analysis will address any new costs or savings that will occur based on the change in requirements from the existing rule to the proposed rule.

- **Labor:** Calculated labor costs assume that the new or additional requirements in chapter 246-370 WAC may require additional labor hours than what are currently required under chapter 246-366. The Board staff surveyed local health officials (LHOs), the Department of Health (department) staff, and school officials to estimate how many additional hours would be required to comply with the new rule requirements. Additionally, they identified staff members who would be mostly likely to perform the additional labor hours. Data from the Office of Financial Management¹, Office of Superintendent of Public Instruction² (OSPI), and local health official surveys were used to calculate hourly wages. Benefits and indirect cost are included in the hourly wage estimates. Benefits and indirect costs can vary year by year and are only an approximate percentage of the hourly wage.

Some, but not all, local boards of health require cost recovery. These boards will assess additional fees to the schools.

Labor cost categories:

- **LHO Hours:** LHOs that don't require fees for cost recovery will incur a cost for hourly services.
 - **Hourly LHO Fees:** Schools will incur a cost when their LHOs require fees for cost recovery.
 - **School Official Hours:** School officials provided a range of hours and hourly wages.
- **Construction Costs:** Professional engineers that specialize in school construction supported construction cost calculations.
- **Trade Service Costs:** Board staff conducted phone surveys of industry professionals that perform the work in Washington state, searched the internet, and consulted with professional engineers that specialize in school construction to calculate trade service costs.
- **Consumable Goods:** Board staff priced goods through online retail searches, phone surveys, consulted with professional engineers, and consultation with department staff to calculate consumable goods.
- **Costs Per Square Foot:** OSPI has an Information and Condition of Schools (ICOS) database, which serves as a web-based inventory tracking system for sites and facilities, where they store information and conditions of buildings for each school district.³

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Schools can enter data that pertains to their school in ICOS. Since there are some costs that are calculated as costs per square foot, we used the self-reported data for 2,058 schools. The smallest school has 929 square feet, an average school has 77,391 square feet, and the largest school has 367,301 square feet.

- All costs above \$1.00 are rounded up to whole numbers.

Sections Not Analyzed

WAC Section and Title	Section Purpose	Why is section exempt from analysis?
WAC 246-370-001 Purpose Formerly 246-366-005 ⁴	Introduces the topic of the rule and why the rule is adopted	Clarifies who the rule intends to govern
WAC 246-370-005 Definitions Formerly 246-366-010 ⁵	Add clarity to rule language and do not impose requirements for schools to conform to	Brings clarity to rule language only
WAC 246-370-010 Applicability Formerly 246-366-060 ⁶ , -070 ⁷ , and -130 ⁸	Outlines what type of school this WAC applies to and refers to other regulations that schools must conform to	Clarifies the entities that are governed by this rule and other environmental health and safety regulations that those entities are also governed by
WAC 246-370-060 Showers and Restrooms Formerly WAC 246-366-090 ⁹ and 100 ¹⁰	Stipulates shower and restroom requirements for new construction and alteration projects	No changes from WAC 246-366 other than clarifying language and removal of duplicative building code requirements
WAC 246-370-090 Noise Formerly WAC 246-366-110 ¹¹	Stipulates permissible levels of noise within a school facility	No changes from WAC 246-366 other than non-substantive changes clarifying language
WAC 246-370-100 Lighting Formerly WAC 246-366-120 ¹²	Stipulates required lighting levels based on tasks performed within a school facility	No changes from WAC 246-366 other than non-substantive changes clarifying language
WAC 246-370-160 Severability Formerly WAC 246-366-160 ¹³	Outlines how individual provisions of the rule are independent from each other and if one provision is found to be invalid the other provisions are not affected	Non-substantive changes clarifying language
WAC 246-370-170 Appeals New WAC Topic	Explains how an entity can appeal a decision made by the local health officer	Explains a process for appeals

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Fiscal Analysis by Section

WAC 246-370-015 Guidance

Formerly 246-366-140¹⁴

WAC 246-366-140 requires the department and OSPI to jointly prepare a guide used by staff during routine inspections. WAC 246-366-140 requires the creation of the guide but does not require updates to the guide at any frequency. The department published the first *Health and Safety Guide for K-12 Schools in Washington State* (K-12 Guide) in June 2000. The department and OSPI published two subsequent updates of the guide. Once in January 2003 and a second in September 2024.

New Requirements of WAC 246-370-015:

- The department must review and update the guide at least every five years.

Costs

Labor: One Time Update Costs

Agency	Position	Hourly Total Compensation	Total Number Hours	Position Total	Total
OSPI	Administrative Program Specialist 2	\$ 69	120	\$ 8,222	\$68,243
Department	Environmental Planner 4	\$ 72	350	\$ 25,373	
Department	Environmental Planner 3	\$ 67	200	\$ 13,349	
Department	Environmental Planner 3	\$ 67	200	\$ 13,349	
LHO	Environmental Health Specialist 3	\$106	75	\$7,950	

Labor: Once Every Five Years Costs

Agency	Position	Hourly Total Compensation	Total Number Hours	Position Total	Total
OSPI	Administrative Program Specialist 2	\$ 69	40	\$ 2,741	\$ 43,138
Department	Environmental Planner 4	\$ 72	300	\$ 21,749	
Department	Environmental Planner 3	\$ 67	100	\$ 6,674	
Department	Environmental Planner 3	\$ 67	100	\$ 6,674	
LHO	Environmental Health Specialist 3	\$106	50	\$5,300	

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WAC 246-370-020 Site Assessment

Formerly 246-366-030¹⁵

Site assessments are historical reviews of properties that consider commonly known and reasonably ascertainable information to identify recognized environmental conditions in connection with the subject property and the surrounding area.¹⁶

WAC 246-366-030 currently requires “the board of education to obtain written approval from the health officer that the proposed development site presents no health problems.” WAC 246-366-030 also requires the completion of a noise assessment at the site before beginning construction.

New requirements of WAC 246-370-020

- Adds an American Society for Testing and Materials (ASTM) Phase 1 Environmental Site Assessment.¹⁶
- Requires a school official to notify the LHO 90 days before construction planning and throughout the plan development stage of the construction project.
- Requires a school official to submit a written report on the health and safety impacts of the construction project.
- Adds a 60-day deadline for LHOs to approve or deny completed site assessments.
- Gives LHOs flexibility to decide if a new school facility on an existing school site or if an addition to an existing school facility requires a site assessment.

Costs

A basic ASTM Phase 1 Site Assessment is a historical research and evaluation project of the site conditions and the surrounding areas. This includes historical land use to determine if there are known soil contamination issues or other environmental factors of interest. If a site assessment is for a renovation of an existing building, then additional research will be required to assess the building use and potential building contamination. If there is a concern about contamination of a site, a Phase 2 Site Assessment might be required. During a Phase 2 site assessment, physical testing of the ground or building materials might be required to confirm contamination and make recommendations for remediation if needed.

Site assessment costs were an estimate from phone surveys of companies that perform site assessments in Washington state.

Trade Service Cost: Site Assessment

Task	Estimated Low Cost	Estimate High Cost
ASTM Phase 1 Site Assessment ¹⁶	\$1,400	\$5,000
ASTM Phase 2 Site Assessment ¹⁶	\$10,000	\$30,000

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Schools surveyed indicated that smaller schools without dedicated staff or larger schools would take longer to complete the site assessment than those schools with dedicated staff.

Labor: Site Assessment Additional Costs

Labor Category	Hourly Wage			Number Hours			Total Costs Per Site Assessment		
	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max
LHO Hours	\$40	\$71	\$105	3	7	12	\$120	\$497	\$1,260
Hourly LHO Fee	\$100	\$162	\$250	3	7	12	\$300	\$1,134	\$3,000
School Official	\$48	\$107	\$133	2	61	200	\$96	\$6,527	\$26,600

Total Labor Costs

Labor Description	Min	Avg.	Max
Total Costs to LHO without fee recovery	\$120	\$497	\$1,260
Total Costs to LHO with fee recovery	\$0	\$0	\$0
Total costs to schools if charged LHO Fee	\$396	\$7,661	\$29,600
Total costs to schools if not charged LHO Fee	\$96	\$6,527	\$26,600

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WAC 246-370-030 Construction Plan Review New, Alterations, and Portables

Formerly 246-366-040(1)&(2)(a)¹⁷

Before the start of construction, a school official must submit construction plans for review and approval. The LHO must review the plans and discuss possible changes to construction based on current health and safety regulations. Once construction is complete, the LHO will inspect the newly constructed building to ensure there are no imminent health hazards present and that the building is in compliance with the current regulations.

New requirements of WAC 246-370-030

- Added additional parameters requiring a construction plan review:
 - New or altered playgrounds
 - New or altered specialized rooms
 - New or altered bathrooms or showers
 - Remodeling an existing building that was not used as a school facility
 - Altering more than 5,000 square feet or 20% of the total square feet of the school
 - Installation of a portable classroom
- Added a specific timeline for the construction plan review:
 - A school official will consult with LHO at 50% design development.
 - A school official will request a preoccupancy inspection at least five days in advance.
 - LHO has 15 days from receipt of a request to consult with a school official.
 - LHO provides construction review results within 60 days of receiving the completed 100% design development paperwork.
- Added flexibility for school officials and LHOs:
 - After the initial construction review at 50% design development, the LHO determines if additional review is needed.
 - If at any time the LHO cannot meet the required timeline requirement of 246-370-030 WAC, the school official may choose to proceed with construction.

Costs

Findings from LHO surveys concluded that the local health staff already performed these tasks and no additional labor hours would be required.* Most schools surveyed indicated that it would take up to four additional hours to complete the construction plan review, while two smaller schools without dedicated staff indicated that it would take 40 to 100 additional hours to complete the construction plan review process in the proposed rule.

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Labor: Construction Plan Review

Labor Category	Increase in Hours			Hourly Wage			Total		
	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max
*LHO Hours	0	0	0	\$0	\$0	\$0	\$0	\$0	\$0
School Official Hours	0	13	100	\$46	\$106	\$134	\$0	\$1,378	\$13,400

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WAC 246-370-040 Routine Inspection

Formerly [WAC 246-366-040\(2\)\(b\)](#)¹⁸

Routine inspections of school facilities by an LHO ensure that the environmental health and safety of the school complies with the regulations. WAC 246-360-040(2)(b) requires an LHOs to inspect school facilities on a routine basis.

NEW requirements of WAC 246-370-040

- LHOs must inspect school facilities once every three years.
- LHOs have the flexibility to increase the frequency of inspections up to once every year or decrease the frequency of inspections to once every five years based on local risk factors or credible data.
- An LHO may have a qualified designee complete additional inspections.
- LHOs have 60 days to issue a final report to school officials

Cost

Labor Additional Costs Per Routine Inspection

Labor Category /Task	Hourly Wage		Number of Hours		Per routine inspection	
	Min	Max	Min	Max	Min	Max
LHO Hours	\$40	\$105	1	2	\$40	\$210
School Official Hours	\$42	\$133	0	6	\$0	\$798
Total					\$40	\$1,008

Labor Additional Costs for Routine Inspection Per Year

Labor Category /Task	Hourly Wage		Number of Hours		Per year	
	Min	Max	Min	Max	Min	Max
LHO Hours: Training	\$40	\$105	0	40	\$0	\$4,200
School Official Hours: Training	\$42	\$133	4	6	\$168	\$798
Total					\$168	\$4,998

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WAC 246-370-050 General Building Requirements

Formerly WAC 246-366-050¹⁹

This section of the rule describes the basic requirements that all school facilities should comply with such as:

- Clean and in good repair
- Free of pests
- Appropriate floors for intended use
- Adequate storage for loose items to prevent injuries
- Toilet and handwashing facilities available during school and school events

New requirements from WAC 246-370-050

- Add vacuum breakers or backflow devices on all faucets that can connect a hose or tube to the fixture and be used for activities like filling a mop bucket or diluting chemicals.

Cost

Any sink that can connect a hose or tube to faucets requires a vacuum breaker or back-flow prevention device installed to prevent potential backflow of unsafe water into the potable water pipes of the school facility. These can be purchased at a local hardware store or purchased online and shipped directly to the school. The plumbing code requires backflow prevention devices; however, we are unable to determine how many schools currently have backflow devices or how many sinks can connect a hose or tube, therefore the total cost to schools is indeterminant.

Consumable Goods: One Time Cost

Goods	Cost (Per Device)	
	Min	Max
Self-Draining Vacuum Breaker ²⁰	\$9	\$25
Faucet with inline Vacuum Breaker ^{21, 22}	\$96	\$130

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WAC 246-370-070 Indoor Air Quality and Ventilation

Formerly [WAC 246-366-080](#)²³

NEW WAC Chapter

This new chapter of WAC includes specific requirements to improve and maintain indoor air quality. Indoor air quality standards help to control airborne pollutants and introduce and distribute adequate outdoor airflow. This contributes to a favorable environment for students, better performance of teachers and staff, and a sense of comfort, health, and well-being. Comparative risk studies performed by the Environmental Protection Agency (EPA) and its Science Advisory Board (SAB) have consistently ranked indoor air pollution among the top five environmental risks to public health. Improper indoor air quality can increase health issues such as cough, eye irritation, headache, and asthma. Nearly one in 13 children of school-age have asthma, the leading cause of school absenteeism due to chronic illness. Substantial evidence shows that indoor environmental exposure to allergens, such as dust mites, pests, and molds, can trigger asthma symptoms. These allergens are common in schools.²⁴

NEW requirements from WAC 246-370-070

- Develop an indoor air quality plan.
- Remove and exclude potential sources of air contaminants.
- Develop an integrated pest management plan.
- Monitor carbon dioxide concentrations.
- Test for radon.
- Prohibit fragrances.
- Contain emissions from construction.
- Control mold growth and exposure.
- Provide appropriate ventilation.
- Provide appropriate air filtration.
- Inspect and maintain ventilation systems.
- Test and balance mechanical ventilation systems every 15 years.

Costs: Indoor Air Quality

Labor Indoor Air Quality: One Time Cost

Some schools surveyed stated that they already developed radon testing plans and integrated pest management plans so this would not be a new cost for all schools, just those that would need to develop the plans.

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Task	Hourly Wage		Number of Hours		One Time Costs	
	Min	Max	Min	Max	Min	Max
Develop radon plan	\$43	\$134	0	10	\$0	\$1,340
Develop indoor air quality plan	\$43	\$134	8	32	\$344	\$4,288
Develop integrated pest management plan	\$43	\$134	0	10	\$0	\$1,340
Total Costs					\$344	\$6,968

Labor Indoor Air Quality: Annual Cost

Some schools surveyed indicated that they already implement the requirements of the proposed indoor air quality section of this rule in their schools and therefore they would not incur any new costs. Only schools that have not implemented these requirements would incur costs. The total cost to all schools is indeterminant.

The rule requires “routine” ventilation inspections. Depending on the type of system, the school could complete this task several times a year. The total annual cost to schools is indeterminant, however listed below is the cost to perform one inspection a year.

Task	Hourly Wage		Number of Hours		Annual Costs	
	Min	Max	Min	Max	Min	Max
Routine ventilation Inspection	\$43	\$134	2	8	\$86	\$1,072
Implement radon plan	\$43	\$134	1	50	\$43	\$6,700
Implement indoor air quality plan	\$43	\$134	17	68	\$731	\$9,112

Consumable Costs: Radon Testing Every Five Years

The proposed rule requires radon testing once every five years. Schools test radon on all ground-floor or sub-ground classrooms in a school. Using data from ICOS, we can estimate the number of classrooms that would need to be tested, but we cannot determine the total. Data shows that schools range from one floor up to seven floors and have anywhere from one classroom to 120 classrooms. The data shows at least one school with a single floor and 87 classrooms.

Task	Test Cost		Number of Tests		One time costs	
	Min ²⁵	Max ²⁶	Min	Max	Min	Max
Radon test	\$12	\$16	1	87	\$12	\$1,392

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Labor Integrated Pest Management Plan: Annual Costs

Schools surveyed said that if they did not have dedicated staff members to implement a pest management plan or have never implemented a pest management plan, it would take an additional 200 to 600 hours annually to implement a pest management plan.

Task	Hourly Wage			Number of Hours			Annual Costs		
	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max
Implement integrated pest management plan	\$43	\$80	\$114	200	440	600	\$8,600	\$35,200	\$68,400

Schools with dedicated staff or schools that already have a pest management plan said they would need the following additional hours to implement an integrated pest management plan.

Task	Hourly Wage			Number of Hours			Annual Costs		
	Min	Avg.	Max	Min	Avg.	Max	Min	Avg.	Max
Implement integrated pest management plan	\$43	\$80	\$114	5	12	18	\$215	\$960	\$2,052

Costs: Ventilation

The ventilation and filtration subsections of WAC 246-370-070 allow schools the flexibility to maximize outdoor airflow rates and increase filtration where possible within the capabilities of the systems that already exist within the school facility. This means that schools will only incur costs based on where their current ventilation needs require them to make changes.

Included in this report are all potential costs for schools to conform with WAC 246-370-070(7)(b) of the proposed rule. Many of these costs in this section will depend on the size of the school to determine the total cost to comply with the proposed rule. Since school sizes vary from school to school some of the total costs to schools will be indeterminant. If the total costs to a school are indeterminant, a costs per square foot or the total cost of one consumable good was determined.

For ventilation specifically, schools are given three options to comply with the ventilation requirements in the proposed rule.

1. WAC 246-370-070(7)(b) "Ensuring all student-occupied instruction and gathering spaces during hours of occupation provide outdoor air ventilation flow rates as set forth in chapter 51-52 WAC at the time the ventilation system was permitted."

If a school's ventilation system complies with this subsection of the rule the school does not need to take any further action and therefore will not incur a cost.

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2. If the school cannot comply with WAC 246-370-070(7)(b), then WAC 246-370-070(7)(b)(i) states “If outdoor air ventilation flow rates were not established at the time of the original building construction, ventilation airflow rates must be operated to meet chapter 51-52 WAC or maximum outdoor air ventilation flow rates achievable within existing system capacity.”

To conform with this subsection of the proposed rule, a school must hire a professional to test and balance (TAB) the ventilation system.

Trade Services: One Time Cost

Task	Cost (per sq ft)	Small School	Average School	Large School
Test and Balance	0.81	929	77,391	367,301
Total		\$753	\$62,687	\$297,514

3. If the school cannot comply with WAC 246-370-070(7)(b) or WAC 246-370-070(7)(b)(i), then the school must conform with WAC 246-370-070(7)(b)(iii) which states “*If the school facility does not have a mechanical outdoor air ventilation system or the outdoor air flow rate cannot be determined, provide ongoing carbon dioxide concentration monitoring.*”

To conform with this subsection of the rule a school must develop a carbon dioxide monitoring plan and purchase carbon dioxide sensor to monitor carbon dioxide in at least one room.

Consumable Goods Ventilation: One Time Cost

Goods	Cost (per room)	
	Min	Max
Portable carbon dioxide sensor	\$170	\$3,425
Fixed carbon dioxide sensor and installation	\$2,000	\$2,500

Labor Ventilation: One Time Cost

Task	Hourly Wage		Number of Hours		One Time Costs	
	Min	Max	Min	Max	Min	Max
Develop carbon dioxide monitoring plan	\$43	\$134	5	10	\$215	\$1,340

Labor Ventilation: Initial Cost

Task	Hourly Wage		Number of Hours		Annual Costs	
	Min	Max	Min	Max	Min	Max
Implement carbon dioxide monitoring plan	\$43	\$134	25	200	\$1,075	\$26,800

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Labor Ventilation: Reoccurring Annual Cost

Task	Hourly Wage		Number of Hours		Annual Costs	
	Min	Max	Min	Max	Min	Max
Implement carbon dioxide monitoring plan	\$43	\$134	20	175	\$860	\$23,450

Costs: Filtration

Included in this report are all potential costs for schools to conform with WAC 246-370-070(8) of the proposed rule. The costs in this section will depend on the size of the school to determine the total cost to comply with the proposed rule. Since school sizes vary from school to school, the total costs for schools will be indeterminant. Since the total costs to a school are indeterminant, we used a cost per square foot to comply with this rule.

Consumable Goods Ventilation: Annual Cost

Schools are given two options to comply with the filtration requirements WAC 246-370-080(8) of the proposed rule.

1. WAC 246-370-070 (8)(a) *“Provide adequate filtration by ensuring particulate matter filtration as set forth in chapter 51-52 WAC at the time the heating, ventilation, and air conditioning systems were permitted, including in facilities that have small, ducted air handlers and ventilation systems.”*

If a school's filtration system complies with this subsection of the rule the school does not need to take any further action and therefore will not incur a cost.

2. If the school cannot comply with WAC 246-370-070(8)(a) then WAC 246-370-070(8)(a)(i) states *“If particulate matter filtration requirements were not established at the time of the original installation of the system, the system must meet chapter 51-52 WAC or the maximum particulate matter filtration achievable within existing system capacity.”*

Goods	Cost (per sq ft)		Square Feet		Total	
	Min	Max	Min	Max	Min	Max
Increase filter size from MERV 8 to MERV 13	\$0.07	\$0.10	929	367,301	\$66	\$36,731
Increased utility rates depending on fuel source	\$0.01	\$0.02	929	367,301	\$10	\$7,347

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Trade Services: Once every 15 years

TAB involves testing and adjusting the air and water flow, pressure, temperature, and humidity of heating, ventilation, and air conditioning (HVAC) systems. Certified professionals typically test the system, which requires specialized equipment to measure and adjust the HVAC systems. Visual inspection, functional testing, measuring airflow rates, adjusting system components, and documenting the results are all part of the TAB process.²⁷ The total cost to schools to perform a TAB will vary from school to school depending on school size and therefore is indeterminant.

Task	Cost (per sq ft)	Small School	Average School	Large School
Test and Balance	0.81	929	77,391	367,301
Total		\$753	\$62,687	\$297,514

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WAC 246-370-080 Temperature

Formerly

This section of the rule stipulates the permissible indoor temperature range of school facilities. WAC 246-366-090 and WAC 246-370-090 require that classrooms maintain a minimum temperature of 65° Fahrenheit and that gymnasiums and other “common” areas maintain a minimum temperature of 60° Fahrenheit.

New requirements from WAC 246-370-080

- Sets a maximum indoor temperature of 79° Fahrenheit for the school facility.
- Requires school officials to develop an extreme temperature readiness plan.

Costs

Each school facility will prepare a customized plan to implement when the facility or parts of the facility are consistently above or below the minimum or maximum temperatures required in WAC 246-370-090 for extended periods of time. Since weather conditions vary from year to year and the readiness plan is uniquely tailored to each school, the total annual cost to implement the plan is indeterminant.

Labor Extreme Temperature Readiness Plan

Task	Hourly Wage		Number of Hours		Total	
	Min	Max	Min	Max	Min	Max
Develop Extreme Temperature Readiness Plan	\$65	\$133	1	10	\$65	\$1,330

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WAC 246-370-110 Injury Prevention

Formerly [WAC 246-366-050](#)²⁸

This section of the rule requires general overall facility injury prevention.

NEW requirements from WAC 246-370-110

- Provide fall protection for balconies and orchestra pits
- Store unsecured equipment when not in use
- Update chemical and cleaning supply storage
- Provide fragrance-free and low-hazard cleaning and sanitation supplies
- Develop an animal safety plan

Cost

Consumable Goods: One Time Cost

Adequate fall guards are required when two adjacent occupied areas have a height distance of 30 inches or more per chapter 1015.2 of the 2024 International Building Code.²⁹ Most schools would already have the required protection in place. The size of an area that would require a fall guard varies from school to school, therefore the total cost to install fall guards is indeterminate.

Goods	Cost (per linear foot)
Fall protection guards	\$350

Labor Chemical and Cleaning Supply Storage: One Time

Proper storage and use of cleaning and chemical supplies requires a school to do an initial walkthrough of the school and inventory the supplies. Some schools, especially small elementary schools, may already be complying. Larger high schools with multiple specialized classrooms or older schools with large amounts of outdated or unlabeled supplies will take longer to inventory and properly store all supplies. Schools already in compliance will only have recurring annual maintenance costs.

Task	Hourly Wage		Number of Hours		One Time Costs	
	Min	Max	Min	Max	Min	Max
Initial inventory	\$43	\$134	0	32	\$0	\$4,288

Labor Chemical and Cleaning Supply Storage: Annual Cost

Task	Hourly Wage		Number of Hours		One Time Costs	
	Min	Max	Min	Max	Min	Max
Yearly Maintenance	\$43	\$134	1	10	\$43	\$1,340

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Fragrance-Free and Low-Hazard Cleaning Supplies

Fragrance-free and low-hazard cleaning supplies are comparable in price to equivalent supplies with fragrances or those that pose a higher health hazard. Schools won't incur an additional cost to comply with this requirement of the proposed rule.

Labor Animal Safety Plan: One Time Cost

Not all schools allow animals on the premises and would not require an animal safety plan.

Task	Hourly Wage		Number of Hours		One Time Costs	
	Min	Max	Min	Max	Min	Max
Develop animal safety plan	\$43	\$134	0	120	\$0	\$16,080

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WAC 246-370-120 Imminent Health Hazard Procedure

NEW WAC Chapter

This section of the rule requires that a school official takes action when an imminent health hazard is identified in a school facility. An imminent health hazard could be a sewage leak, prolonged utility interruption, fires, floods, etc.

NEW requirements from WAC 246-370-120

- Identify and mitigate exposure to an imminent health hazard
- Collaborate between school officials and LHOs to investigate the potential hazard

Costs

School officials currently identify and mitigate potential health hazards in schools. There will be no additional costs to schools to conform to this requirement.

Labor Imminent Health Hazard Annual Cost

LHOs expect that there will be additional labor hours associated with this requirement now that school officials are required to report potential health hazards to their local health department.

Labor Category /Task	Hourly Wage		Number of Hours		Annual Costs	
	Min	Max	Min	Max	Min	Max
LHO Hours: consulting	\$40	\$105	1	100	\$40	\$10,500

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WAC 246-370-130 Playgrounds

NEW WAC Chapter

This section of the rule sets minimum installation and maintenance requirements for new and updated playgrounds.

NEW requirements from WAC 246-370-130

- A school official must submit plans and consult with their LHO before installing, updating, or modifying playground structures or fall protection surfaces.
- The LHO has 60 days to approve or deny the school official's plans for playground construction.
- School officials must maintain equipment consistent with ASTM F 1487 Standard Consumer Safety Performance Specification for Playground Equipment for Public Use and Consumer Product Safety Commission Handbook for Public Playground Safety, 2010.
- School officials cannot use chromated copper arsenate or creosote-treated wood to construct or install playground equipment, landscape structures, or other structures.

Costs

Playground inspections are performed when replacing existing equipment or constructing a new playground on an existing school facility site. Depending on the size and the nature of the equipment, the time to conduct these inspections would vary. When surveyed, LHOs explained that they already perform these inspections, but it might take additional time now that there are requirements in the proposed rule language. School officials indicated zero additional labor hours incurred by these proposed rules.

Labor: Playground Inspections Additional Costs

Labor Category	Hourly Wage		Number Hours		Total Costs Per Site Assessment	
	Min	Max	Min	Max	Min	Max
LHO Hours	\$40	\$105	0	3	\$0	\$315
Hourly LHO Fee	\$100	\$250	0	3	\$0	\$750

Total Labor Costs

Labor Description	Min	Max
Total Costs to LHO without fee recovery	\$0	\$315
Total Costs to LHO with fee recovery	\$0	\$0
Total costs to schools if charged LHO Fee	\$0	\$750
Total costs to schools if not charged LHO Fee	\$0	\$0

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WAC 246-370-140 Specialized Rooms

Formerly WAC 246-366-140³⁰

WAC 246-366-140 mentions minimum health and safety standards for chemical laboratories. WAC 246-370-150 created the definition of a “specialized room” to include more than just chemistry laboratories. Specialized rooms are classrooms that have a specific function that uses equipment, furniture, or supplies not found in a standard classroom that are a potential health and safety risk. This may include, but is not limited to, a career and technical education room, a laboratory, an art room, or a health room. These types of rooms could require special ventilation and permit temperatures outside of a normal classroom range.

NEW requirements from 246-370-140

- Requires emergency eye wash and showers in specialized rooms, not just installing them at the time of new construction
- Requires single-use soap and towels in hand-washing facilities
- Adds the Washington State Labor and Industry requirements for emergency eye wash and shower installation and fixture requirements
- Prohibits shock-sensitive and lethal at low-concentration compounds
- Requires safety procedures for students
- Provides personal protective equipment
- Requires installation of appropriate ventilation equipment for specialized room activities that produce air contaminants
- Adds specific requirements for school facilities that have health rooms such as showers and bathrooms
- Includes emergency shut off for gas and electricity in new construction

Costs

Construction costs are minimum estimates based on basic expected costs with assumptions that there could be at minimum ceiling work and floor work for all these installations. Some assumptions were made about electrical, plumbing, and parts costs as well. Not all schools will need to incur these costs so a total school cost is indeterminant.

Construction: One Time Cost

Goods	Construction Cost	City Capacity Fee	Total
Emergency Eye Wash Install	\$4,000	\$0	\$4,000
Emergency Shower Install	\$6,000	\$0	\$6,000
Source Capture Ventilation	\$20,000	\$0	\$20,000
Handwashing Sink	\$3,000	\$1,370	\$4,370
Bathroom - Toilet	\$5,000	\$4,100	\$9,100
Bathroom - Urinal	\$5,000	\$3,420	\$8,420
Emergency Shut Off Valves: Gas	\$5,000	\$0	\$5,000
Emergency Shut Off Valves: Electric	\$2,500	\$0	\$2,500

School Environmental Health and Safety Rule 2024 – 2025

WAC 246-370-150 Variances and Emergency Waivers

Formerly WAC 246-366-150³¹

This section of the rule outlines how a school official can request an exception to the rule requirements. The request must show how the alternative to the rule still meets the intent.

NEW requirements from WAC 246-370-150

- Requires an LHO to approve or deny a variance within 60 days of receiving a complete variance packet
- Allows an LHO to issue an emergency waiver in an instance where a school might have to temporarily use a facility that is not regularly used as a school
- Allows an LHO to permit a school to remain in operation during an imminent health hazard event if it is safe to do so

Costs

Labor Variances Additional Costs

Labor Category	Hourly Wage		Number Hours	Total Costs Annually	
	Min	Max	Total	Min	Max
LHO Hours	\$40	\$105	10	\$400	\$1,050
Hourly LHO Fee	\$100	\$250	10	\$1,000	\$2,500

Total Additional Labor Costs

Labor Description	Min	Max
Total Costs to LHO without fee recovery	\$400	\$1,050
Total Costs to LHO with fee recovery	\$0	\$0
Total costs to schools if charged LHO Fee	\$1,000	\$2,500
Total costs to schools if not charged LHO Fee	\$0	\$0

¹ <https://ofm.wa.gov/state-human-resources/compensation-job-classes/job-classes-and-salaries>
² <https://ospi.k12.wa.us/sites/default/files/2024-02/allpersonnelsummaryreport2023-24.pdf>
³ <https://ospi.k12.wa.us/policy-funding/school-buildings-facilities/information-and-condition-schools-icos>
⁴ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-005&pdf=true>
⁵ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-010&pdf=true>
⁶ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-060&pdf=true>
⁷ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-070&pdf=true>
⁸ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-130&pdf=true>

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- ⁹ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-090&pdf=true>
- ¹⁰ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-100&pdf=true>
- ¹¹ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-110&pdf=true>
- ¹² <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-120&pdf=true>
- ¹³ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-160&pdf=true>
- ¹⁴ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-140&pdf=true>
- ¹⁵ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-030&pdf=true>
- ¹⁶ <https://www.astm.org/e1527-21.html>
- ¹⁷ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-040&pdf=true>
- ¹⁸ <https://app.leg.wa.gov/wac/default.aspx?cite=246-366-040>
- ¹⁹ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-050&pdf=true>
- ²⁰ https://www.homedepot.com/pep/Arrowhead-Brass-Chrome-Fine-Thread-Self-Draining-Vacuum-Breaker-PK1390/202579291?clickid=yybU9B2fAxyKR-R0QhVQ3UGOUks1guWC0XEUVUM0&irgwc=1&cm_mmc=afl-ir-2003851-1420157-EdgeBingFlow
- ²¹ https://www.amazon.com/American-Standard-8344212-0039999997-Service-Breaker/dp/B00CH4RW44/ref=asc_df_B00CH4RW44?tag=bingshoppinga-20&linkCode=df0&hvadid=79920803409762&hvnetw=o&hvqmt=e&hvbmt=be&hvdev=c&hvlocint=&hvl-ocphy=&hvtargid=pla-4583520382335840&psc=1
- ²² https://www.amazon.com/Zurn-Z843M1-RC-Chrome-Plated-Breaker-Handles/dp/B001UOZVDQ/ref=asc_df_B001UOZVDQ?tag=bingshoppinga-20&linkCode=df0&hvadid=80058242473023&hvnetw=o&hvqmt=e&hvbmt=be&hvdev=c&hvlocint=&hvl-ocphy=&hvtargid=pla-4583657821965601&psc=1
- ²³ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-080&pdf=true>
- ²⁴ https://www.epa.gov/iaq-schools/reference-guide-indoor-air-quality-schools#IAQRG_Section1
- ²⁵ https://www.homedepot.com/pep/PRO-LAB-Radon-Gas-Test-Kit-RA100/100141467?mtc=SEM-BF-CDP-BNG-D26P-026_005_PUMPS-NA-NA-NA-DSA-NA-NA-NA-NBR-NA-NA-NEW-NA-N2025_LBT&cm_mmc=SEM-BF-CDP-BNG-D26P-026_005_PUMPS-NA-NA-NA-DSA-NA-NA-NA-NBR-NA-NA-NEW-NA-N2025_LBT-21692166716-167614481895-1738649489211&gclid=ccedf711c6ad124e499990fdde1850a1&gclsrc=3p.ds&msclkid=ccedf711c6ad124e499990fdde1850a1
- ²⁶ <https://www.bing.com/shop/productpage?q=radon+test+kits&filters=scenario%3a%2217%22+gType%3a%2212%22+gld%3a%22302571249599%22+gldHash%3a%220%22+gGlobalOfferIds%3a%22302571249599%22+AucContextGuid%3a%220%22+GroupEntityId%3a%22302571249599%22+NonSponsoredOffer%3a%22True%22&productpage=true&FORM=SHPPDP&browse=true>
- ²⁷ <https://bluerithm.com/test-and-balance-tab-of-an-hvac-system-what-it-is-and-why-its-important/>
- ²⁸ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-050&pdf=true>
- ²⁹ https://codes.iccsafe.org/content/IBC2021P1/chapter-10-means-of-egress#IBC2021P1_Ch10_Sec1015
- ³⁰ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-140&pdf=true>
- ³¹ <https://app.leg.wa.gov/WAC/default.aspx?cite=246-366-150&pdf=true>

School Environmental Health and Safety Rule 2024-2025

WASHINGTON STATE DEPARTMENT OF HEALTH WASHINGTON STATE BOARD OF HEALTH

Environmental Justice Assessment Summary

Chapter 246-370 WAC

Board of Health, April 2025

School Environmental Health and Safety Rule 2024-2025

Overview

Purpose

An environmental justice assessment is an evaluation of a significant agency action, including the impact on and meaningful involvement of Washington state residents to provide solutions for communities that face environmental health inequities.

Background Information

The assessment provides a summary of the State Board of Health (Board) proposed rule that establishes minimum health and safety standards for public and private K-12 schools. The summary includes background, history, proposed chapter 246-370 WAC, issues for implementation, and impacts on overburdened communities and vulnerable populations.

Section One: Analyze Environmental Benefits and Harms

The assessment describes the likely environmental benefits, environmental harms, positive health impacts, and negative health impacts for overburdened communities, vulnerable populations, and tribes associated with this action.

Section Two: Identify Overburdened Communities and Vulnerable Populations

The assessment identifies the geographic areas where there may be environmental and health impacts because of the agency's action. The proposed rulemaking will directly affect over one million K-12 students in Washington state served by public, charter, and private schools. The assessment includes maps with geographic information system tracking to show statewide locations and concentrations of unhealthy air days, extreme heat days, asthma hospitalization rate by age, overburdened communities, and free or reduced lunch.

Section Three: Tribal Engagement and Consultation

This section summarizes Tribal engagements and invitations for Tribal consultation. It addresses potential impacts on Tribal rights, discusses resources associated with this action, and explains how information received from Tribes and Tribal organizations informed decision-making about this action. It sets an agency plan for ongoing and future Tribal consultation after the rule is implemented. Staff reached out to the 29 federally recognized Washington Tribes and hosted two Tribal listening sessions and completed outreach to 12 Tribal educational or community-based organizations.

Section Four: Community Engagement Summary

This section summarizes engagement with people from overburdened communities and vulnerable populations. Between October 2024 through February 2025, we held three online listening sessions and six in-person listening sessions in Yakima, Lacey, Spokane, Vancouver, Pasco, and Auburn. We connected with nine educational service districts, 24 school districts, 364 schools, and 198,232 student families. We engaged with people who identify as Latino, Black, Indigenous, and People of Color (BIPOC), LGBTQ+, and various community-based organizations representing people with disabilities. The Board is committed to ongoing community engagement and will continue outreach to underserved communities throughout the rulemaking process.

We accepted feedback through an informal public comment period from December 2024 through February 9, 2025. We notified 7,873 contacts and encouraged them to submit their informal remarks. We received 79 unique informal comments and presented them to the technical advisory committee for review and consideration.

We had 53 participants in a total of six in-person listening sessions and 171 participants in the virtual listening sessions. Concerns raised by participants included air quality, vaping, wildfire smoke, illness in schools, cost of implementation, wildfires, extreme temperatures, safe drinking water, and pest management. The technical advisory committee reviewed a summary of informal public comments, as well as having access to the verbatim remarks.

Section Five: Strategies to Address Environmental Harms and Equitably Distribute Environmental Benefits

The agency will pursue the following strategies to eliminate, reduce, or mitigate environmental harms and equitably distribute environmental benefits:

Provide equitable participation and meaningful engagement of vulnerable populations and overburdened communities in the development of the significant agency action. Staff included a wide range of participants in both the technical advisory committee and in the public listening sessions who are from diverse, vulnerable, and overburdened communities to ensure meaningful engagement during development of the rule.

Prioritize equitable distribution of resources and benefits to overburdened communities. Staff brought resources, benefits, and outreach efforts to underserved communities throughout the state.

Modify substantive regulatory or policy requirements. The technical advisory committee acknowledged the financial impact of substantive regulatory or policy requirements on overburdened communities and sought solutions that would provide flexibility to address environmental health and safety issues while maintaining minimum standards.



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WAC 246-370

School Environmental Health and Safety

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WAC 246-370-001

Purpose

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Summary of changes: 001 Purpose

- **Combined:** Introduction statement with Purpose statement

Language Comparison: 001 Purpose

246-370-001 Draft	246-366-001 & 005	246-366A-001
	These rules and regulations are established as minimum environmental standards for educational facilities and do not necessarily reflect optimum standards for facility planning and operation.	(2) Implementation of this chapter is subject to the state legislature providing funding to public schools in accordance with section 222 of the 2009-11 biennial operating budget, chapter 564, laws of 2009, and may be subject to future legislative requirements. Unless and until legislative action allows for full or partial implementation of this chapter, chapter 246-366 WAC shall take precedent and this chapter shall not be implemented or enforced in any manner. (3) It is the intent of the Washington state board of health to work with the legislature to develop a strategy and timeline for funding and implementation of this chapter.
The purpose of this chapter is to set minimum environmental health and safety standards for school facilities operated for the primary purpose of providing education.	The purpose of this chapter is to maintain minimum environmental health and safety standards for school facilities until legislative action allows for full or partial implementation of chapter 246-366A WAC. To the extent the legislature funds or otherwise allows for its implementation, chapter 246-366A WAC is intended to replace or supersede this chapter.	(1) The purpose of this chapter is to replace chapter 246-366 WAC with a more modern set of minimum environmental health and safety standards for school facilities to promote healthy and safe school environments.

WAC 246-370-005

Definitions

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Summary of changes: 005 Definitions

- **Added:** 24 New definitions
- **Removed:** 5 Obsolete definitions
- **Modernized:** 3 Existing definitions
- **No Change:** 2 Existing definitions

Language Comparison: 005 Definitions

246-370-005 Draft	246-366-010	246-366A-010
		(1) "Addition" means an extension or increase in floor area or height of a building or structure.
(1) "Air contaminant" means pollutants in the air that could, depending on dose and circumstances, cause adverse health impacts.		(2) "Air contaminants of public health importance" means pollutants in the indoor air that could, depending on dose and circumstances, have health impacts, including but not limited to: (a) Volatile organic compounds, for example, formaldehyde and benzene; (b) Combustion by-products, for example, carbon monoxide and nitrogen oxides; (c) Vapors and gases, for example, chlorine, mercury, and ozone; (d) Heavy metal dusts and fumes, for example, chromium and lead; and (e) Particulates, for example, wood and ceramic dust.
		(3) "Alteration" means any construction or renovation to an existing structure other than repair or addition.
		(5) "Construction documents" means written, graphic, and pictorial documents prepared or assembled for describing the design, location, and physical characteristics of the elements of a project necessary for obtaining a building permit.
		(6) "Contaminant" means any hazardous material that occurs at greater than natural background levels.

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(2) "Decibel (dB)" means a standard unit of measurement of sound pressure.		(7) "Decibel (dB)" means a standard unit of measurement of sound pressure.
(3) "Decibel, A-weighted (dBA)" means a decibel measure that has been weighted in accordance with the A-weighting scale. The A-weighting adjusts sound level as a function of frequency to correspond approximately to the sensitivity of human hearing.		(8) "Decibel, A-weighted (dBA)" means a decibel measure that has been weighted in accordance with the A-weighting scale. The A-weighting adjusts sound level as a function of frequency to correspond approximately to the sensitivity of human hearing.
(4) "Department" refers to the Washington State Department of Health.	(10) "Department" - Means Washington state department of health.	(9) "Department" means the Washington state department of health.
		(10) "Drinking fountain" means the type of plumbing fixture that delivers a stream of water for drinking without actively cooling the water.
(5) "Emergency washing facilities" means equipment such as emergency showers, eyewashes, eye/face washes, hand-held drench hoses, or other similar units.		(11) "Emergency eye wash" means a hands-free device that: (a) Irrigates and flushes both eyes simultaneously with tepid potable water; (b) Activates an on-off valve in one second or less and remains on without user assistance until intentionally turned off; and (c) Delivers at least 0.4 gallons (1.5 liters) of water per minute for at least fifteen minutes
		(12) "Emergency shower" means a hand-activated shower that delivers tepid potable water to cascade over the user's entire body at a minimum rate of 20 gallons (75 liters) per minute for at least fifteen minutes.
(6) "Emissions" mean substances released into the air, including gases and particles, from various sources.		
(7) "Equivalent Continuous Sound Level" or "Leq" means the sound pressure level of a noise fluctuating over a period of time, expressed as the amount of average energy.		(13) "Equivalent sound level (Leq)" means the level of a constant sound that, over a given time period, contains the same amount of sound energy as the measured fluctuating sound.
		(14) "Faucet" means a type of plumbing fixture that is a valved outlet device attached to a pipe that normally serves a sink or tub and can discharge hot water, cold water, or both.

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		(15) "First draw sample" means a water sample collected immediately upon opening a plumbing fixture that has not been used for at least eight hours prior to collection.
		(16) "Flush sample" means a water sample collected after allowing cold water to run for at least thirty seconds from a plumbing fixture that has not been used for at least eight hours prior to collection.
(8) "Foot candle" means a unit of measure of the intensity of light falling on a surface, equal to one lumen per square foot.		(17) "Foot-candle" means a unit of measure of the intensity of light falling on a surface, equal to one lumen per square foot.
		(18) "Hazardous materials" means toxic, corrosive, flammable, explosive, persistent, or chemically reactive substances that, depending on dose and circumstances, pose a threat to human health.
(9) "Imminent health hazard" means a significant threat or significant danger to health or safety that requires immediate action to prevent serious illness, injury, or death.		(19) "Imminent health hazard" means a significant threat or significant danger to health or safety that requires immediate action to prevent serious illness, injury, or death
		(20) "Implementation" or "implemented" means being given or having the force of law, requiring compliance, and being subject to enforcement.
	(3) "Instructional areas" - Space intended or used for instructional purposes	
(10) "Integrated pest management" means a program that reduces sources of food, water, and shelter for pests by using the least toxic pest controls when necessary.		
		(21) "Laboratory" means instructional areas of the school facility where students might be exposed to greater potential health and safety hazards than typically exist in general academic classrooms. Such laboratories may include, but are not limited to, chemistry, physics, material science, and biology laboratories or art studios (for example: Darkrooms, ceramic studios, and print making studios).

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(11) "Local board of health" means the county or district board of health as defined in RCW 70.05.010(3).		(22) "Local board of health" means the county or district board of health as defined in RCW 70.05.010(3).
(12) "Local health officer" means a legally qualified physician who has been appointed as the health officer for the county or district public health department as defined in RCW 70.05.010(2) or their authorized representative.	(8) "Health officer" - Legally qualified physician who has been appointed as the health officer for the city, town, county or district public health department as defined in RCW 70.05.010(2), or his authorized representative.	(23) "Local health officer" means the legally qualified physician who has been appointed as the health officer for the county or district public health department as defined in RCW 70.05.010, or his or her authorized representative, including, but not limited to, the environmental health director.
		(24) "Mechanical exhaust ventilation" means the removal of indoor air to the outside of the building by mechanical means.
(13) "New construction" means new buildings or structures, including construction of additions to existing school facilities and reconstruction or retrofitting of an existing building not originally intended for use as a school facility. New construction does not include reconstruction of an existing school facility.	(4) "New construction" - Shall include the following: (a) New school building. (b) Additions to existing schools. (c) Renovation, other than minor repair, of existing schools. (d) Schools established in all or part of any existing structures, previously designed or utilized for other purposes. (e) Installation or alteration of any equipment or systems, subject to these regulations, in schools. (f) Portables constructed after the effective date of these regulations.	(4) "Construction" or "construction project" means any activity subject to state or local building codes.
(14) "Noise abatement" means measures taken to reduce unacceptable sounds or vibrations.		
(15) "Noise criterion" means a single number for rating the sound quality of a room by comparing actual or calculated sound level spectra with a series of established octave band spectra.		(25) "Noise criterion (NC)" means a system for rating the noise level in an occupied area by comparing actual or calculated sound level spectra with a series of established octave band spectra.
(16) "Noise criterion 35 (NC35)" means the curve for specifying the maximum permissible sound pressure level for each frequency band.		(26) "Noise criterion 35 (NC35)" means the curve for specifying the maximum permissible sound pressure level for each frequency band.
(17) "OSPI" refers to the Washington Office of Superintendent of Public Instruction.		
	(5) "Occupied zone" - Is that volume of space from the floor to 6 feet above the floor when determining temperature and air movement, exclusive of the 3 foot perimeter on the outside wall.	

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(18) "Portable" means any school building with a prefabricated structure that can be transported and installed on-site to provide additional educational space.	(7) "Portables" - Any structure that is transported to a school site where it is placed or assembled for use as part of a school facility.	(28) "Portable" means any relocatable structure that is transported to a school site and is placed or assembled there for use by students as part of a school facility.
(19) "Preschool" means an educational establishment or learning space offering early childhood education to children not old enough to attend kindergarten.		(27) "Preschool" means an instructional curriculum and portion of a school facility designed to instruct children not old enough to attend kindergarten.
(20) "Readiness Plan" means a written guide to ensure the health and safety of the occupants of a school facility in the event of a particular hazard, such as extreme heat or wildfire smoke.		
		(29) "Repair" means the reconstruction or renewal of any part of an existing school facility for the purpose of its maintenance
(21) "School" means any public institution of learning where the primary purpose is educational instruction for children in any grade from kindergarten through grade twelve, including transition programs, programs where students will advance to grade one the following year, and related activities by the public school as defined in RCW 28A.150.010 and any private school or private institution regulated by chapter 28A.195 RCW.	(1) "School" - Shall mean any publicly financed or private or parochial school or facility used for the purpose of school instruction, from the kindergarten through twelfth grade. This definition does not include a private residence in which parents teach their own natural or legally adopted children.	(30) "School" means any public, religious-affiliated, or private institution for instructing students in any grade from kindergarten through twelfth grade
(22) "School facility" means all buildings and land intended primarily for student use including, but not limited to portables, sports fields, playgrounds, classrooms, and common areas.		(32) "School facility" means buildings or grounds owned or leased by the school or donated to the school for the primary purpose of student use including, but not limited to, portables, playgrounds and sports fields.
(23) "School official" means a member of the school district or school staff who has the authority to make decisions on behalf of the district or school to maintain and improve environmental health and safety within the limitations of this rule.		(33) "School officials" means those persons designated by the school board as responsible for planning, policy development, budgeting, management, or other administrative functions.

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	(2) "Board of education" - An appointive or elective board whose primary responsibility is to operate public or private or parochial schools or to contract for school services	(31) "School board" means an appointed or elected board whose primary responsibility is to operate schools or to contract for school services and includes the governing body or owner of a private school.
	(9) "Secretary" - Means secretary of the Washington state department of health or the secretary's designee.	
		(34) "Shop" means instructional areas of the school facility where students are exposed to greater health and safety hazards than typically exist in general academic classrooms. Shops include, but are not limited to, industrial and agricultural shops, including career and technical education (for example: Metal-working, wood-working, construction, automotive, and horticulture).
	(6) "Site" - Shall include the areas used for buildings, playgrounds and other school functions.	(35) "Site" means any real property used or proposed to be used as a location for a school facility
(24) "Site assessment" means an evaluation of any historical or other readily available information on site conditions and surroundings to evaluate whether the site poses a potential hazard to human health and determine if further investigation is needed.		
(25) "Source capture system" means a mechanical exhaust system designed and constructed to capture air contaminants at their source and release air contaminants to the outdoor atmosphere.		(36) "Source capture system" means a mechanical exhaust system designed and constructed to capture air contaminants at their source and release air contaminants to the outdoor atmosphere.
(26) "Specialized room" means a space or room that has a specific function that uses equipment, furniture, or supplies not found in a standard room that are a potential health and safety risk. This may include but is not limited to a career and technical education room, laboratory, art room, or health room.		

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(27) "Stationary machinery" means equipment that is designed to be installed in a fixed location and does not require intermittent movement to service different needs.		
		(37) "Tempered water" means water having a temperature range between eighty-five degrees Fahrenheit and one hundred ten degrees Fahrenheit.
		(38) "Tepid water" means water having a temperature range between sixty degrees Fahrenheit and ninety-five degrees Fahrenheit.
(28) "Transition services" means a coordinated set of activities as defined in WAC 392-172A-01190.		
		(39) "Toxic" means having the properties to cause or significantly contribute to death, injury, or illness.
		(40) "Variance" means an alternative to a specific requirement in these rules, approved by the local health officer, that provides a comparable level of protection.
		(41) "Very low lead plumbing fixture" means plumbing fittings or fixtures used in the installation or repair of any plumbing providing water for human consumption that contain less than 0.3% lead by weight.
		(42) "Water cooler" means a type of mechanical plumbing fixture that actively cools the water.

WAC 246-370-010

Applicability

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Summary of changes: 010 Applicability

- **Referenced:** Exceptions to chapter 246-370 WAC including:
 - Facilities licensed under Title 110 WAC – Department of Children, Youth, and Families
 - Home-based instruction
 - Locations that provide education services, but education is not the primary function of the facility
 - Private tutoring
 - Post secondary schools
 - State-tribal education compact schools
- **Referenced:** Existing regulations that contain legal requirements for schools to follow for environmental health and safety on:
 - Food handling and preparation
 - Water recreation
 - Sewer and liquid waste disposal
 - Carbon monoxide detection
 - Drinking water

Language Comparison: 010 Applicability

246-370-010 Draft	246-366-060, -070, & -130	246-366A-005
(1) This chapter applies to all school facilities operated for the primary purpose of providing education, including those primary and secondary school facilities that offer preschool education or transition services. This chapter does not apply to: (a) Any facility or part of a facility that is licensed by the department of children, youth, and families under Title 110 WAC;		(1) To the extent implemented in accordance with legislative action, this chapter, or such portions thereof funded or approved as part of a phase-in or partial implementation, shall apply to all school facilities operated for the primary purpose of providing education at the kindergarten through twelfth grade (K-12) levels, and preschools that are part of such facilities except:
(b) Private residences used for home-based instruction as defined by RCW 28A.225.010(4);		(a) Private residences used for home-based instruction as defined by RCW 28A.225.010(4);
(c) Facilities hosting educational programs where educational instruction is not a primary purpose, including, but not limited to, detention centers, jails, hospitals, mental health units, or long-term care facilities;		(b) Facilities hosting educational programs where educational instruction is not a primary purpose, including, but not limited to, detention centers, jails, hospitals, mental health units, or long-term care facilities;
(d) Private facilities where tutoring is the primary purpose;		(c) Private facilities where tutoring is the primary purpose; and

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246-370-010 Draft	246-366-060, -070, & -130	246-366A-005
(e) Public or private postsecondary education facilities providing instruction to students enrolled in secondary school; and		(d) Public or private postsecondary education facilities providing instruction to students primarily enrolled in secondary school.
(f) State-tribal education compact schools established under chapter 28A.715 RCW.		
(2) Additional environmental health and safety rules that apply to school facilities include, but are not limited to: (a) Chapter 246-215 WAC regarding facility and equipment sanitation, food preparation, food storage, and food temperature control; (b) Chapter 246-217 WAC regarding food service workers, including contracted staff and volunteers, who must maintain a current food worker card as set forth in chapter 246-217 WAC; and	-130(1) Food storage, preparation, and service facilities shall be constructed and maintained and operated in accordance with chapters 246-215 and 246-217 WAC. -130(2) When central kitchens are used, food shall be transported in tightly covered containers. Only closed vehicles shall be used in transporting foods from central kitchens to other schools.	(2) These rules are in addition to all other requirements that apply to schools and, except as specified, do not affect the applicability of those requirements. (3) Additional environmental health and safety rules that apply to school facilities include, but are not limited to: (a) Chapter 246-215 WAC Food services; (b) Chapter 246-217 WAC Food worker cards;
(c) Chapters 246-260 and 246-262, as applicable, regarding water Recreation Facilities or aquatic venues;		(c) Chapter 246-260 WAC Water recreation facilities; (d) Chapter 246-262 WAC Recreational water contact facilities;
(c) Chapters 246-260 and 246-262, as applicable, regarding water Recreation Facilities or aquatic venues; (d) WAC 51-54A-0915 regarding the installation and maintenance of carbon monoxide detection and alarms in mechanical rooms and occupied zones; and (e) RCW 43.70.830 through 43.70.845 regarding lead in drinking water if the facility was built or all plumbing was replaced before 2016.		
(3) Schools must use sewer and liquid waste disposal that is connected to a municipal sewage disposal system or an on-site sewage disposal system designed, constructed and maintained under chapter 246-272A or 246-272B.	-070 All sewage and wastewater from a school shall be drained to a sewerage disposal system which is approved by the jurisdictional agency. On-site sewage disposal systems shall be designed, constructed and maintained in accordance with chapters 246-272 and 173-240 WAC.	(e) Chapter 246-272A WAC On-site sewage systems; (f) Chapter 246-272B WAC Large on-site sewage system regulations;

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246-370-010 Draft	246-366-060, -070, & -130	246-366A-005
	-060(1) Plumbing: Plumbing shall be sized, installed, and maintained in accordance with the state building code. However, local code requirements shall prevail, when these requirements are more stringent or in excess of the state building code.	
(4) Schools must provide drinking water from public water supplies regulated under WAC 246-290 or 246-291.	-060(2) Water supply: The water supply system for a school shall be designed, constructed, maintained and operated in accordance with chapter 246-290 WAC.	(g) Chapter 246-290 WAC Public water supplies; and (h) Chapter 246-291 WAC Group B public water systems.
(5) These rules are not intended to replace or supersede the department of labor and industries' authority and jurisdiction under Title 296 WAC over employee safety and health. (6) These rules are not intended to replace building code council requirements under Title 51 WAC. In the event this chapter is more stringent to protect health and safety it may supersede Title 51 WAC.		(4) This chapter, or portions thereof, are intended to replace or supersede chapter 246-366 WAC, or corresponding portions thereof as identified by the state board of health, once the legislature has provided funding for implementation by public schools or taken other action to authorize implementation. (5) These rules are not intended to replace or supersede the department of labor and industries' authority and jurisdiction over employee safety and health. (6) These rules are not intended to replace requirements of the building code council under Title 51 WAC, but may be more stringent to protect health and safety.
(7) If the local permitting jurisdiction received a complete building permit application for school construction before the effective date of this chapter, the construction-related requirements of chapter 246-366 WAC apply.		

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246-370-010 Draft	246-366-060, -070, & -130	246-366A-005
		<p>(7) For a school undergoing an alteration or addition, WAC 246-366A-040, 246-366A-060, 246-366A-090, 246-366A-100, 246-366A-110, 246-366A-120, 246-366A-150, and 246-366A-160 apply only to:</p> <ul style="list-style-type: none">(a) Areas that are part of the addition;(b) Areas undergoing alteration; and(c) Changes to existing building systems, such as heating and ventilation systems, when those changes are included in construction documents or a building permit application describing the alteration or addition. <p>(8) If the local permitting jurisdiction received a complete building permit application for school construction prior to the effective date of any construction-related requirements of this chapter, the construction-related requirements of chapter 246-366 WAC and this chapter in effect at the time of application apply.</p>



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WAC 246-370-015

Good Safety Practice and Guidance

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 015 Good Safety Practice and Guidance

- **Updated:** Language without making substantive changes.

Language Comparison: 015 Good Safety Practice and Guidance

246-370-015 Draft	246-366-140	246-366A-015
<p>(1) Except where more specific requirements apply, school facilities must apply good safety practices to conditions which present a potential hazard to occupants of the school.</p> <p>(2) The department in cooperation with OSPI shall review potentially hazardous conditions in schools which are not aligned with good safety practice, especially in specialized rooms.</p> <p>(3) The department and OSPI shall jointly prepare a guide for use during routine school inspections to identify issues relating to good safety practices. The guide should include recommendations for safe facilities and safety practices.</p> <p>(4) The guide shall be reviewed and updated at least every five years.</p>	<p>(1) The existence of unsafe conditions which present a potential hazard to occupants of the school are in violation of these regulations. The secretary in cooperation with the state superintendent of public instruction shall review potentially hazardous conditions in schools which are in violation of good safety practice, especially in laboratories, industrial arts and vocational instructional areas. They shall jointly prepare a guide for use by department personnel during routine school inspections in identifying violations of good safety practices. The guide should also include recommendations for safe facilities and safety practices.</p>	<p>(1) The department, in cooperation with the office of superintendent of public instruction, shall:</p> <p>(a) Update the Health and Safety Guide for K-12 Schools in Washington (the guide) at least every four years; and</p> <p>(b) Make the guide available on the department's website.</p> <p>(2) The guide is the primary source of guidance for local health officers and school officials implementing these rules.</p>

WAC 246-370-020

Site Assessment

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 020 Site Assessment

- **Added:** Local Health Officer (LHO) may require a site assessment for construction projects on existing school facilities.
- **Added:** School officials must:
 - Have a Phase 1 Site Assessment
 - Notify LHO at least 90 days prior to planning new construction
 - Submit site assessments to LHOs
- **Added:** LHOs must:
 - Review site assessments
 - Provide written approval to a school official within 60 days of receiving a completed site assessment

Language Comparison: 020 Site Assessment

246-370-020 Draft	246-366-030	246-366A-030
(1) A local health officer shall conduct or require that a site assessment be conducted when a school district is planning: (a) To construct a new school facility on a site that was previously undeveloped or developed for other purposes; or (b) To convert an existing structure for primary use as a school facility.	(1) Before a new school facility is constructed, an addition is made to an existing school facility, or an existing school facility is remodeled, the board of education shall obtain written approval from the health officer that the proposed development site presents no health problems. The board of education may request the health officer make a survey and submit a written health appraisal of any proposed school site.	(1) A full site assessment and local health officer review and approval to determine environmental health and safety risk, is required for: (a) Constructing a new school facility on a site that was previously undeveloped or developed for other purposes; or (b) Converting an existing structure for primary use as a school facility.
	(2) School sites shall be of a size sufficient to provide for the health and safety of the school enrollment.	
(2) A local health officer may conduct or require that a site assessment be conducted when a school district is planning to construct: (a) A new school facility on an existing school site; or (b) An addition to an existing school facility.		(2) The local health officer shall determine, in consultation with school officials, the need for and scope of the site assessment, review, and approval process for: (a) Constructing a new school facility on an existing school site; (b) Constructing an addition to an existing school facility; or (c) Converting part of an existing structure primarily used for other purposes into a school facility.

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(3) A site assessment must include: (a) A Phase 1 Environmental Site Assessment (ESA) that meets the requirements of the American Society for Testing and Materials (ASTM) Standard #1527-21 (published December 2021);		(3) A full site assessment must include: (a) A Phase 1 Environmental Site Assessment (ESA) that meets the requirements of the American Society for Testing and Materials (ASTM) Standard #1527-05 (published November 2005);
(b) Sampling and analysis of potential contaminants if the Phase 1 ESA indicates that hazardous materials may be present. Sampling and analysis must comply with the applicable rules of the department of ecology, WAC 173-303-110 ; and		(b) Sampling and analysis of potential contaminants if the Phase 1 ESA indicates that hazardous materials may be present. Sampling and analysis must comply with applicable rules of the Washington state department of ecology;
(c) A noise assessment that measures noise from all sources during the hours that school is normally in session. (i) The noise must not exceed: (A) An hourly average of 55 dBA or the mean sound energy level for a specified time in Leq 60 minutes; and (B) A maximum sound level, recorded during a specified time, measured as Lmax, of 75 dBA during the time of day the school is in session.	(3) Noise from any source at a proposed site for a new school, an addition to an existing school, or a portable classroom shall not exceed an hourly average of 55 dBA (Leq 60 minutes) and shall not exceed an hourly maximum (Lmax) of 75 dBA during the time of day the school is in session; except sites exceeding these sound levels are acceptable if a plan for sound reduction is included in the new construction proposal and the plan for sound reduction is approved by the health office.	(c) A noise assessment. Noise from any source must not exceed an hourly average of 55 dBA (the mean sound energy level for a specified time (Leq60 minutes)) and must not exceed an hourly maximum (the maximum sound level recorded during a specified time period (Lmax)) of 75 dBA during the time of day the school is in session. Sites exceeding these sound levels are acceptable if a plan for noise reduction is included in the new construction proposal and the plan for noise reduction is approved by the local health officer.
(4) A school official shall ensure: (a) The local health officer receives notification within 90 days of starting: (i) The preliminary planning for school construction that requires a review and approval of a site assessment by a local health officer under subsection (1) of this section; or (ii) The preliminary planning for school construction under subsection (2) of this section to determine if a site assessment is required;		(4) School officials shall: (a) Notify the local health officer within ninety days of starting preliminary planning for school construction that may require a site assessment with local health officer review and approval.
(b) Consultation with the local health officer throughout the plan development phase regarding the scope of the site assessment when one is required and the timeline for completion of the site assessment;		(b) Consult with the local health officer throughout the plan development phase regarding the scope of the site assessment and the timeline for completion of the site assessment.
		(c) Have a site assessment completed when required under this section.

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(c) The submission of a written report to the local health officer for a required site assessment that assesses the potential impact on health and safety presented by the proposed site and includes, but is not limited to, the following:		(d) Submit a written report to the local health officer assessing the potential impact of health and safety risks presented by the proposed site, including, but not limited to the following: (i) The findings and results obtained under subsection (3) of this section;
(i) The findings and results obtained under subsection (3) of this section; (ii) An analysis of the findings;		(ii) Analysis of the findings;
(iii) If a site exceeds sound levels under subsection (3)(c)(i), the school official must include a plan for noise reduction in the new construction proposal under WAC 246-370-030; (iv) Identified health and safety risks present at the site; (v) A description of any mitigation proposed to address identified health and safety risks present at the site; and		(iii) Description of any mitigation proposed to address identified health and safety risks present at the site; and
(vi) Any site assessment-related information requested by the local health officer to complete the site assessment review and approval process; and		(iv) Any site assessment-related information requested by the local health officer to complete the site assessment review and approval process.
(d) Obtain the site review and written site approval from the local health officer when required under subsection (1) or (2) of this section.		(e) Obtain site review and written site approval from the local health officer when required under subsection (1) or (2) of this section.
		-020(1)(d) Retain for at least six years, unless otherwise required by other state or federal laws, records pertaining to: (iii) Site assessment, review, and approval as required under WAC 246-366A-030;
(5) When notified by a school official of preliminary planning for school construction, the local health officer shall: (a) Conduct an inspection of the proposed site;		(5) The local health officer shall: (a) Conduct an inspection of the proposed site;

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<p>(b) Determine whether a site assessment is required when notice is provided under subsection (4)(a)(ii) of this section and notify the school official of the determination;</p> <p>(c) Review the inspection findings, written report provided under subsection (4)(c), and any other site assessment-related information for environmental health and safety risk;</p>		<p>(b) Review the site assessment for environmental health and safety risk;</p>
<p>(d) For site assessments conducted under subsection (1) of this section, provide written approval or describe site deficiencies needing mitigation to obtain approval or deny use of the proposed school facility site if mitigation is not possible within 60 days of receiving a complete request unless a school official and the local health officer agree to a different timeline; and</p>		<p>(c) For site assessments according to subsection (1) of this section, provide written approval, describe site deficiencies needing mitigation to obtain approval, or deny use of the proposed school facility site within sixty days of receiving a complete request unless the school officials and the local health officer agree to a different timeline; and</p>
<p>(e) For site assessments conducted under subsection (2) of this section, provide written approval or describe site deficiencies needing mitigation to obtain approval of the proposed school facility site within 60 days of receiving a complete request unless the school officials and the local health officer agree to a different timeline.</p>		<p>(d) For site assessments according to subsection (2) of this section, provide written approval or describe site deficiencies needing mitigation to obtain approval of the proposed school facility site within sixty days of receiving a complete request unless the school officials and the local health officer agree to a different timeline.</p>
<p>(6) If a written site assessment request from a school official is received by the local health officer before the effective date of this section, the site assessment requirements of chapter 246-366 WAC apply unless otherwise specified in this chapter.</p>		<p>(6) If school officials notified the local health officer in writing prior to the effective date of this section that construction is planned for a particular site, the site review requirements in effect at the time of notification apply, provided that school officials comply with all agreed on timelines for completion.</p>

WAC 246-370-030
Construction Plan Review –
New, Alterations, and Portables

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Summary of changes: 030 Construction Plan Review – New, Alterations, and Portable

- **Added:** Specifications for types of construction that might require plan review
- **Added:** Set timelines for school officials and LHOs to review construction plans

Language Comparison: 030 Construction Plan Review – New, Alterations, and Portables

246-370-030 Draft	246-366-040	246-366A-020, -040, & -050
<p>(1) The following school construction projects must be reviewed and approved by the local health officer:</p> <p>(a) Construction of a new school facility, playground, bathroom, shower, or specialized room;</p> <p>(b) Establishment of a school in all or part of any existing structure previously used for another purpose;</p> <p>(c) Additions or alterations consisting of more than 5,000 square feet of floor area or more than 20 percent of the total square feet of an existing school facility, whichever is less;</p> <p>(d) Alteration of a playground, bathroom, shower, or specialized room; and</p> <p>(e) Installation or construction of a portable classroom.</p>	<p>(1) Any board of education, before constructing a new facility, or making any addition to or major alteration of an existing facility or any of the utilities connected with the facility, shall:</p> <p>(a) First submit final plans and specifications of such buildings or changes to the jurisdictional health officer;</p>	<p>-040(1) The following school facility construction projects must be reviewed by the local health officer:</p> <p>(a) Construction of a new school facility;</p> <p>(b) Schools established in all or part of any existing structures previously used for other purposes;</p> <p>(c) Additions or alterations consisting of more than five thousand square feet of floor area or having a value of more than ten percent of the total replacement value of an existing school facility;</p> <p>(d) Any construction of a shop or laboratory for use by students; and</p> <p>(e) Installation of a portable.</p> <p>(2) Review and approval requirements for installation of a playground are established in WAC 246-366A-150.</p>
<p>(2) A school official shall ensure:</p> <p>(a) Consultation with the local health officer takes place at the 50 percent design development stage of school construction project plans to determine if the project requires construction review;</p>	<p>(b) Shall obtain the health officer's recommendations and any required changes, in writing;</p>	<p>-040(3) School officials shall:</p> <p>(a) Consult with the local health officer during preliminary planning for school construction projects that are subject to the requirements of this section;</p> <p>(b) Invite the local health officer to a predevelopment conference with school officials and project design professionals to participate in the discussion about the preliminary design to highlight health and safety matters and requirements of these rules;</p>

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246-370-030 Draft	246-366-040	246-366A-020, -040, & -050
<p>(b) The provision of additional documents, beyond the construction project plans, if requested by the local health officer, which may include, but are not limited to, written statements signed by the project's professional engineer or licensed architect verifying that design elements comply with requirements specified by this chapter;</p> <p>(c) Consultation with the local health officer to determine whether additional construction project review is required to ensure that the project meets the requirements of this chapter;</p> <p>(d) The submission of the design at the 100 percent development stage for the construction design plans.</p>		
<p>(e) The acquisition of a written approval from the local health officer for the construction project before starting construction;</p> <p>(i) If the school official meets the requirements of subsection (2)(a) but the local health officer does not meet the requirements of subsection (3), the school official may proceed with their scheduled construction timeline;</p>	<p>(c) Shall obtain written approval from the health officer, to the effect that such plans and specifications comply with these rules and regulations.</p>	<p>-040(c) Obtain construction project review and written approval from the local health officer regarding environmental health and safety requirements in these rules before starting construction;</p> <p>(d) Provide construction documents to the local health officer at the same time as the local building official to facilitate a concurrent and timely review; and</p> <p>(e) Provide additional documents requested by the local health officer, which may include, but are not limited to, written statements signed by the project's licensed professional engineer verifying that design elements comply with requirements specified by these rules.</p>
<p>(f) The submission of a request for a preoccupancy inspection to the local health officer to correct any imminent health hazards before allowing occupancy at the school facilities; and</p> <p>(g) The local health officer receives notification at least five business days before a desired preoccupancy inspection.</p>		<p>-050(1) School officials shall:</p> <p>(a) Obtain a preoccupancy inspection by the local health officer of construction projects subject to WAC 246-366A-040(1), conducted in coordination with a final inspection by the local building official, in order to ensure imminent health hazards are corrected before allowing school facilities to be occupied; and</p> <p>(b) Notify the local health officer at least five business days before a desired preoccupancy inspection.</p>

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246-370-030 Draft	246-366-040	246-366A-020, -040, & -050
		-020(1)(d) Retain for at least six years, unless otherwise required by other state or federal laws, records pertaining to:(iv) Construction project plan review and approval as required under WAC 246-366A-040;
<p>(3) The local health officer shall:</p> <p>(a) Respond to a request to consult with a school official within 15 business days of receipt;</p> <p>(b) Consult with a school official to determine the necessary documentation for plan review and approval of the particular project;</p> <p>(c) Review construction project plans at the 50 percent design development stage to confirm the need for a construction review and approval to meet the health and safety requirements of this chapter;</p> <p>(d) Consult with a school official when requiring additional construction plan reviews between the 50 and 100 percent construction plan design development stages;</p> <p>(e) Identify and request any additional documents needed to determine compliance with the requirements outlined in this chapter;</p> <p>(f) Provide written approval within 60 days of receiving the 100 percent design development for the construction design plans or provide a written statement describing construction project plan deficiencies that need to change to obtain approval. The school official and the local health officer may alter this timeline if mutually agreed upon; and</p>		<p>-040(4) The local health officer shall:</p> <p>(a) Consult with school officials and determine what is required for plan review and approval;</p> <p>(b) Review construction documents to confirm that the health and safety requirements of these rules are met;</p> <p>(c) Identify and request any additional documents required to determine compliance with requirements specified by these rules; and</p> <p>(d) Provide written approval, or describe plan deficiencies needing change to obtain approval, of the construction project within sixty days of receiving all documents needed to complete the review, unless the school officials and the local health officer agree to a different timeline.</p>

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246-370-030 Draft	246-366-040	246-366A-020, -040, & -050
<p>(g) Conduct an inspection:</p> <p>(i) Before occupancy of a completed construction project and within five business days after receiving a request from a school official;</p> <p>(ii) At any point during the construction period to verify compliance with the requirements of this chapter;</p> <p>(iii) In a coordinated effort with the on-site project manager or other appropriate person identified by a school official; or</p> <p>(iv) To confirm satisfactory correction of the items identified under (h) or (i) of this subsection;</p> <p>(h) If an imminent health hazard is identified during an inspection, work with the school official and local building official to identify and agree upon a solution that the school officials will implement before occupation of the affected portion; and</p> <p>(i) If other conditions of noncompliance with this chapter are identified during an inspection, provide the school official with a written list of items and consultation in developing a correction schedule based on the level of risk to health and safety.</p>	<p>(2) The health officer shall:</p> <p>(a) Conduct a preoccupancy inspection of new construction to determine its conformity with the approved plans and specifications.</p>	<p>-050(2) The local health officer:</p> <p>(a) Shall coordinate all construction-related inspections with the on-site project manager or other appropriate person identified by school officials.</p> <p>(b) May inspect for compliance with these rules during the construction phase.</p> <p>(c) Shall conduct a preoccupancy inspection for construction projects subject to WAC 246-366A-040(1) to verify compliance with these rules before the building is occupied and not more than five business days after the date requested by school officials or as otherwise agreed to by the school officials and the local health officer.</p> <p>(i) If an imminent health hazard is identified, a solution must be identified and agreed to by school officials, the local health officer, and the local building official and implemented by school officials before the affected portion of the building is occupied.</p> <p>(ii) If other conditions of noncompliance with these rules are identified, school officials shall be provided with a written list of items and consulted in developing a correction schedule, based on the level of risk to health and safety.</p> <p>(d) May reinspect to confirm satisfactory correction of the items identified under (c) of this subsection.</p>

WAC 246-370-040

Routine Inspection

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 040 Routine Inspection

- **Added:** Routine inspection frequency
- **Added:** Allow a trained LHO designee to perform additional inspections

Language Comparison: 040 Routine Inspection

246-370-040 Draft	246-366-040	246-366A-120
(1) The local health officer shall: (a) Conduct an environmental health and safety inspection of each school facility within their jurisdiction every three years, prioritizing areas for emphasis based on risk;	b) Make periodic inspections of each existing school within his jurisdiction, and forward to the board of education and the administrator of the inspected school a copy of his findings together with any required changes and recommendations.	(2) Responsibilities of the local health officer. (a) Except as provided in (b) of this subsection, the local health officer shall: (i) Periodically conduct an environmental health and safety inspection of each school facility within his or her jurisdiction. Beginning one year after the effective date of this section, those inspections must be conducted at least once each year.
(b) Notify school officials at the time of discovery, or immediately following the inspection, if conditions that pose an imminent health hazard are identified and follow the imminent health hazard requirements set forth in WAC 246-370-120;		(ii) Notify school officials at the time of discovery or immediately following the inspection if conditions that pose an imminent health hazard are identified and recommend actions to mitigate the hazards and prevent exposure.
(c) Consult with school officials upon completion of the inspection about findings and recommended follow-up actions and, if necessary, collaborate with school officials to develop a remediation schedule;		(iii) Consult with school officials upon completion of the inspection about findings and recommended follow-up actions and, if necessary, develop a correction schedule. Approaches and timelines used to address noncompliant conditions will depend on the level of risk to health and safety presented by the condition and may include consideration of low-cost alternatives.
(d) Issue a final inspection report within 60 days following an inspection. The local health officer may establish an alternate timeline for issuing the final inspection report when agreed upon in consultation with school officials. The report must include inspection findings related to this chapter and any required remediation; and		(iv) Develop draft and final inspection reports, in consultation with school officials, within sixty days after conducting an inspection. The report must include inspection findings related to this rule and any required correction schedule.
(e) Confirm, as needed, that corrections are made.		(v) Confirm, as needed, that corrections are accomplished.

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246-370-040 Draft	246-366-040	246-366A-120
		(vi) Retain for at least six years, unless otherwise required by other state or federal laws, records pertaining to: (A) Health and safety inspections of the school facilities performed by the local health officer, including, but not limited to, the final inspection report and correction schedules; and
		(B) Imminent health hazards identified under this section and WAC 246-366A-190, and local health officer actions taken in response.
		(vii) Have the records described in this subsection available to the public, except where otherwise provided by applicable public disclosure law.
(2) The local health officer may: (a) Adjust the inspection interval of the schools within their jurisdiction by developing a written risk-based inspection schedule that is uniformly applied throughout the jurisdiction based on credible data or local risk factors. The time between routine inspections may not: (i) Exceed five years; and (ii) Be more frequent than one year; or		
(b) Allow a school official or qualified designee to conduct the required additional inspections under a program approved by the local health officer if the program includes provisions for: (i) Assuring that the school official or designee conducting the inspection has attended training in the standards, techniques, and methods used to conduct an environmental health and safety inspection;		(b) The local health officer may allow a school official or qualified designee to conduct a required inspection under a program approved by the local health officer not more than two out of every three years. The program must include provisions for: (i) Assuring that the school official or designee conducting the inspection has attended training in the standards, techniques, and methods used to conduct an environmental health and safety inspection;
(ii) Completing a standardized checklist at each inspection; and		(ii) Completing a standardized checklist at each inspection;
(iii) Providing a written report to the local health officer detailing the findings of the inspection, within 60 days of completing the inspection.		(iii) Providing a written report to the local health officer about the findings of the inspection;



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WAC 246-370-050

General Building Requirements

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Summary of changes: 050 General Building Requirements

- **Added:** Backflow devices on housekeeping sinks
- **Added:** Bathrooms and handwashing facilities are available during school hours and scheduled events

Language Comparison: 050 General Building Requirements

246-370-050 Draft	246-366-050	246-366A-060, -065
A school official shall ensure that school facilities: (1) Are clean and in good repair;	(1) Buildings shall be kept clean and in good repair.	-065 (1) Keep school facilities clean and in good condition.
(2) Do not attract, shelter, or promote the propagation of insects, rodents, bats, birds, or other pests of public health significance;	(5) The premises and all buildings shall be free of insects and rodents of public health significance and conditions which attract, provide harborage and promote propagation of vermin.	-060 (1) Design school facilities to minimize conditions that attract, shelter, and promote the propagation of insects, rodents, bats, birds, and other pests of public health significance. This subsection does not mandate the installation of window screens nor does it prohibit the installation of retention ponds or rain gardens.
(3) Have floors that suit the intended use, allow easy cleaning, and dry easily to inhibit mold growth and mitigate fall risks;	(4) The floors shall have an easily cleanable surface.	-060(5) Provide floors throughout the school facility that are appropriate for the intended use, easily cleanable and can be dried effectively to inhibit mold growth. These floor materials include, but are not limited to, wood, vinyl, linoleum, and tightly woven carpets with water impervious backing.
(4) Have no projections from the finished ceiling that are less than seven clear vertical feet from the finished floor;	(2) Instructional areas shall have a minimum average ceiling height of 8 feet. Ceiling height shall be the clear vertical distance from the finished floor to the finished ceiling. No projections from the finished ceiling shall be less than 7 feet vertical distance from the finished floor, e.g., beams, lighting fixtures, sprinklers, pipe work.	
(5) Have vacuum breakers or backflow prevention devices installed on hose bibs, sinks, and supply nozzles where hoses or tubing can be connected;		
(6) Provide proper storage for student jackets or backpacks, play equipment, and instructional equipment to mitigate trip, pest, or other public health hazards;	(7) There shall be sufficient space provided for the storage of outdoor clothing, play equipment and instructional equipment. The space shall be easily accessible, well lighted, heated and ventilated.	-060 (6) Provide reasonably sufficient space for the storage of play equipment, instructional equipment, and outdoor clothing. The space must be reasonably accessible, lighted, and ventilated.

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246-370-050 Draft	246-366-050	246-366A-060, -065
		-065 (8) Use products that comply with American National Standards Institute/National Sanitation Foundation (ANSI/NSF) Standard 61 (2007) to coat, line, seal, or patch drinking water contact surfaces, if the interior of water piping or plumbing fixtures is coated or lined.
<p>(7) Contain toilet and handwashing facilities that are accessible for use during school hours and scheduled events;</p> <p>(8) Provide handwashing stations equipped with:</p> <ul style="list-style-type: none"> (a) Soap; (b) Single-use towels, disposable towels, blower, or equivalent hand-drying device; (c) Fixtures with water temperatures that do not exceed 120-degrees Fahrenheit; and (d) Fixtures that deliver at least 10 seconds of running water if they are self-closing, metering faucets. <p>(9) Provide toilet paper in restrooms;</p>	<p>(3) Toilet and handwashing facilities.</p> <p>(a) Adequate, conveniently located toilet and handwashing facilities shall be provided for students and employees. At handwashing facilities soap and single-service towels shall be provided. Common use towels are prohibited. Warm air dryers may be used in place of single-service towels. Toilet paper shall be available, conveniently located adjacent to each toilet fixture.</p> <p>(c) Toilet and handwashing facilities must be accessible for use during school hours and scheduled events.</p> <p>(d) Handwashing facilities shall be provided with hot water at a maximum temperature of 120 degrees Fahrenheit. If hand operated self-closing faucets are used, they must be of a metering type capable of providing at least ten seconds of running water.</p>	
<p>(10) Provide handwashing sinks that are accessible where activities present a potential risk of microbiological or chemical contamination of the hands in any student spaces, which may include, but are not limited to:</p> <ul style="list-style-type: none"> (a) Restrooms; (b) Specialized rooms; or (c) Health rooms; and <p>(11) Provide accessible drinking fountains that are constructed with a nozzle that directs an arc of water to flow away from the nozzle and is located above water-impervious flooring. The drinking fountains must be deactivated when attached to a handwashing sink in a specialized room or located in a restroom.</p>		

WAC 246-370-060

Showers and Restrooms

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 060 Showers and Restrooms

- **Added:** At new construction or renovation
 - Must have 1 shower per 15 individuals per each gender participating in physical education or sports teams.
 - Must have 1 toilet per 15 individuals with up to 10% of the fixtures being urinals.

Language Comparison: 060 Showers and Restrooms

246-370-060 Draft	246-366-050 & -060	246-366A-120 & -125
(1) For new construction or alterations of an existing shower facility for grades nine and above with classes in physical education or team sports, at least one shower must: (a) Meet the Federal Americans with Disabilities Act (ADA); (b) Meet the requirements of the uniform plumbing code set forth in chapter 51-56 WAC; (c) Be accessible to any student for use during school hours and scheduled events; and (d) Contain floors that are slip resistant.	-060(4) Showers: (a) Showers shall be provided for classes in physical education, at grades 9 and above. An automatically controlled hot water supply of 100 to 120 degrees Fahrenheit shall be provided. Showers with cold water only shall not be permitted.	-120 School officials shall: (1) Provide shower facilities for grades nine and above for classes in physical education and for team sports. Showers must supply hot water between one hundred and one hundred twenty degrees Fahrenheit.
	-060(b) Drying areas, if provided, shall be adjacent to the showers and adjacent to locker rooms. Shower and drying areas shall have water impervious nonskid floors. Walls shall be water impervious up to showerhead heights. Upper walls and ceiling shall be of smooth, easily washable construction.	-120(3) Locate drying areas, if provided, adjacent to showers and locker or dressing rooms. Walls and ceilings must have an easily cleanable surface and floor surfaces must be water impervious, slip-resistant, and sloped to floor drains.
(2) For new construction or alterations of an existing shower facility for grades nine and above with classes in physical education or team sports, if a locker or dressing room is provided, it must have easy-to-clean walls and floor surfaces that are slip resistant.	-060(c) Locker and/or dressing room floors shall have a water impervious surface. Walls shall have a washable surface. In new construction, floor drains shall be provided in locker and dressing areas.	(4) Provide locker or dressing rooms adjacent to showers or drying rooms. Walls and ceilings must have an easily cleanable surface. When drying areas are provided, floor surfaces in locker or dressing rooms must be appropriate for the intended use, easily cleanable and dryable to effectively inhibit mold growth. When drying areas are not provided, locker or dressing room floor surfaces must be water impervious, slip-resistant, and sloped to floor drains.

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246-370-060 Draft	246-366-050 & -060	246-366A-120 & -125
		-120(2) Provide floor surfaces in shower areas that are water impervious, slip-resistant, and sloped to floor drains. Walls must be water impervious up to showerhead height. Upper walls and ceilings must have an easily cleanable surface.
	-060(d) If towels are supplied by the school, they shall be for individual use only and shall be laundered after each use.	-125(7) When cloth towels are supplied by the school, provide them for individual use and launder them after each use.
(3) For new construction or alterations of an existing restroom facility, restrooms must: (a) Contain handwashing fixtures that do not have water temperatures that exceed 120° F;	-050(3) Toilet and handwashing facilities. (a) Adequate, conveniently located toilet and handwashing facilities shall be provided for students and employees. At handwashing facilities soap and single-service towels shall be provided. Common use towels are prohibited. Warm air dryers may be used in place of single-service towels. Toilet paper shall be available, conveniently located adjacent to each toilet fixture.	-125 School officials shall: (2) Provide hot water to all handwashing plumbing fixtures at a maximum temperature of one hundred twenty degrees Fahrenheit. (3) Provide tempered water for those handwashing plumbing fixtures that do not allow the user to select water temperature. (4) Provide any hand operated, self-closing handwashing plumbing fixtures with the capability of providing at least ten seconds of running water.
(b) Meet the requirements of the uniform plumbing code set forth in chapter 51-56 WAC;	-050(b) The number of toilet and handwashing fixtures in schools established in existing structures, previously designed or utilized for other purposes shall be in accordance with the state building code. However, local code requirements shall prevail, when these requirements are more stringent or in excess of the state building code.	
(c) That contain water-impervious floor surfaces that are slip-resistant and sloped to floor drains;		
(d) Contain walls, floors, and ceilings that are easy to clean; and		
(e) Contain soap and single-use or disposable towels. Blower or equivalent hand-drying devices are prohibited.		-125(1) Provide in each restroom: (a) Toilet paper in each toilet stall; (b) Single service handwashing soap near each handwashing sink; and (c) Single-service towels or an adequate number of warm-air dryers. Common use towels are not allowed.

WAC 246-370-070

Indoor Air Quality and Ventilation

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 070 Indoor Air Quality and Ventilation

- **New Section:** Sets prescribed indoor air quality requirements like radon testing, pest management plan, carbon dioxide monitoring plan, and ventilation requirements.

Language Comparison: 070 Indoor Air Quality and Ventilation

246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
A school official shall ensure: (1) The implementation of a written indoor air quality plan within five years of the effective date of this section that includes: (a) Identified areas of indoor air quality concerns and development of preventive measures to address the concerns;		
(b) A schedule to perform routine inspections of heating, ventilation, and cooling systems;		-095(3) Use and maintain mechanical exhaust ventilation installed for equipment or activities that produce air contaminants of public health importance or moisture.
(c) An integrated pest management plan; (d) A plan for monitoring and mitigating carbon dioxide levels if required by subsection (7)(b)(iii) of this section; and (e) A plan with identified actions for ensuring health and safety for periods of increased health risk or poor outdoor air quality;		
(2) The control of air contaminant sources by: (a) Excluding sources of potential air contaminants from a school facility; or (b) Providing a space with appropriately used and maintained ventilation to minimize student exposure to potential air contaminants;		-095(4) Limit student exposure to air contaminants of public health importance produced by heat laminators, laser printers, photocopiers, and other office equipment by placing such equipment in appropriately ventilated spaces and providing instruction to users on how to operate and maintain equipment as recommended by the manufacturer. (5) Take preventive or corrective action when pesticides, herbicides, or air contaminants of public health importance are likely to be drawn or are drawn into the building or ventilation system.

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246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
(3) The development and implementation of a plan to test for radon every five years in regularly occupied areas on or below ground level;		
(4) The prohibition of air fresheners, candles, or other products that contain fragrances;		
(5) The minimization of student exposure to construction activities that generate emissions by physically containing the activities or conducting activities when students are not present;		

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246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
<p>(6) The prompt control of identified moisture sources and remediation of mold using measures to minimize occupant exposure to mold and chemicals used during the remediation process;</p>	<p>(1) All rooms used by students or staff shall be kept reasonably free of all objectionable odor, excessive heat or condensation.</p>	<p>-070(1) Visually monitor the school facility for water intrusion and moisture accumulation that may lead to mold growth, especially after severe weather events.</p> <p>(2) Begin corrective action within twenty-four hours of discovering water intrusion or moisture accumulation to inhibit and limit mold growth by:</p> <ul style="list-style-type: none"> (a) Identifying and eliminating the cause of the water intrusion or moisture accumulation; and (b) Drying the affected portions of the school facility. <p>(3) When mold growth is observed or suspected, use recognized remediation procedures such as those provided by the Environmental Protection Agency (Mold Remediation in Schools and Commercial Buildings, EPA 402-K-01-001, March 2001). Begin recognized procedures within twenty-four hours to:</p> <ul style="list-style-type: none"> (a) Identify and eliminate the cause of the moisture or water contributing to the mold growth; (b) Dry the affected portions of the school facility; (c) Investigate the extent of the mold growth, including evaluation of potentially affected materials and surfaces inside walls and under floor coverings, when moisture or water has entered those spaces; (d) Minimize exposure to indoor mold spores and fragments until mold remediation is complete using methods including, but not limited to, containment and negative air pressure; and (e) Remediate surfaces and materials contaminated with mold. <p>(4) When remediation is required under subsection (3) of this section and there is significant risk of exposure, including when the total area affected is greater than ten square feet, promptly inform school facility staff, students, and parents of the conditions and the plans and time frame for the remediation. The extent of this communication will depend on the likelihood of individual exposure, the scope of the remediation project, and the time required to complete it.</p>

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246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
<p>(7) Adequate ventilation by:</p> <p>(a) Ensuring direct mechanical exhaust for specialized rooms as set forth in WAC 246-370-140; and</p> <p>(b) Ensuring all student-occupied instruction and gathering spaces during hours of occupation provide outdoor air ventilation flow rates as set forth in chapter 51-52 WAC at the time the ventilation system was permitted;</p>	<p>(2) All sources producing air contaminants of public health importance shall be controlled by the provision and maintenance of local mechanical exhaust ventilation systems as approved by the health officer.</p>	<p>-090 School officials shall:</p> <p>(1) Provide mechanical exhaust ventilation that meets or exceeds the requirements in chapter 51-52 WAC at locations intended for equipment or activities that produce air contaminants of public health importance.</p>
<p>(i) If outdoor air ventilation flow rates were not established at the time of the original building construction, ventilation airflow rates must be operated to meet chapter 51-52 WAC or maximum outdoor air ventilation flow rates achievable within existing system capacity;</p> <p>(ii) Compliance is determined based on variables including but not limited to:</p> <p>(A) The type and area of the space;</p> <p>(B) The planned number of occupants; and</p> <p>(C) The type of ventilation system; and</p> <p>(iii) If the school facility does not have a mechanical outdoor air ventilation system or the outdoor air flow rate cannot be determined, provide ongoing carbon dioxide concentration monitoring;</p>		<p>-095(b) For school facilities constructed or sited under a building permit for which the local permitting jurisdiction received a completed building permit application before the effective date of this section, conduct standard operation and maintenance best practices including, but not limited to, making timely repairs, removing obstructions, and replacing filters and fan drive belts, and setting system controls so that, to the extent possible given the design of the ventilation system, outdoor air is provided consistent with WAC 51-52-0403, Table 403.3, Required Outdoor Ventilation Air.</p>
		<p>-090(2) Situate fresh air intakes away from building exhaust vents and other sources of air contaminants of public health importance in a manner that meets or exceeds the requirements in chapter 51-52 WAC. Sources of air contaminants include bus and vehicle loading zones, and might include, but are not limited to, parking areas and areas where pesticides or herbicides are commonly applied.</p>

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246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
		-090(3) Use materials that will not deteriorate and contribute particulates to the air stream if insulating the interior of air handling ducts. Insulation materials must be designed to accommodate duct cleaning and exposure to air flow without deteriorating. This subsection does not apply if the local permitting jurisdiction received a complete building permit application within three years after the effective date of this section.
		-090(4) Use ducted air returns and not open plenum air returns consisting of the open space above suspended ceilings. This subsection does not apply to: (a) Alterations to school facilities;
		-090(b) Additions to school facilities that tie into existing ventilation systems that use open plenum air returns; or
		-090(c) Facilities for which the local permitting jurisdiction received a complete building permit application within three years after the effective date of this section.
		-095 School officials shall: (2) Ventilate occupied areas of school buildings during school hours and school-sponsored events. During periods of ventilation: (a) For school facilities constructed or sited under a building permit for which the local permitting jurisdiction received a completed building permit application on or after the effective date of this section, provide, as a minimum, outdoor air according to WAC 51-52-0403, Table 403.3, Required Outdoor Ventilation Air.
(8) Adequate filtration by: (a) Ensuring particulate matter filtration as set forth in chapter 51-52 WAC at the time the heating, ventilation, and air conditioning systems were permitted, including facilities that have small, ducted air handlers and ventilation systems;		

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246-370-070 Draft	246-366-080	246-366A-090 -095 & -070
(i) If particulate matter filtration requirements were not established at the time of the original installation of the system, the system must meet chapter 51-52 WAC or the maximum particulate matter filtration achievable within existing system capacity; and		
<p>(1) For schools with mechanical heating, ventilation, or cooling systems, the performance of routine maintenance that includes:</p> <p>(a) Testing and balancing for existing heating, ventilation, and air conditioning systems every fifteen years;</p> <p>(b) Performing routine inspections of existing heating, ventilation, and cooling systems to ensure systems are operating within intended parameters of this rule;</p> <p>(c) Replacing filters as needed to achieve required filtration and air flow rates; and</p> <p>(d) Maintaining records of these activities for review upon request by the local health officer.</p>		

WAC 246-370-080

Temperature

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 080 Temperature

- **Added:** Maximum and minimum temperature requirements
- **Added:** Requirement for the preparation of an extreme temperature readiness plan.

Language Comparison: 080 Temperature

246-370-080 Draft	246-366-090 & -100	246-366A-095
	-100 Heating, ventilating and/or air conditioning systems shall be equipped with automatic room temperature controls.	
(1) A school official shall ensure the development of an extreme temperature readiness plan and implement the plan when a school facility is occupied by students and either of the following conditions apply:		
(a) Classroom temperatures are outside of the range of 65 degrees to 79 degrees Fahrenheit; or (b) Hallways, gymnasiums, and common area temperatures are outside of the range of 60 degrees to 79 degrees Fahrenheit.	-090 The entire facility inhabited by students and employees shall be heated during school hours to maintain a minimum temperature of 65 degrees Fahrenheit except for gymnasiums which shall be maintained at a minimum temperature of 60 degrees Fahrenheit.	School officials shall: (1) Heat occupied areas of school buildings during school hours and school-sponsored events to maintain a minimum temperature of sixty-five degrees Fahrenheit except for gymnasiums and hallways, which must be maintained at a minimum temperature of sixty degrees Fahrenheit.
(2) A school official may consult with a local health officer to develop an extreme temperature readiness plan.		

WAC 246-370-090

Noise

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 090 Noise

- **Updated:** Language—no substantive changes

Language Comparison: 090 Noise

246-370-090 Draft	246-366-110	246-366A-100 & -105
A school official shall ensure: (1) For new construction: (a) Ventilation equipment or other equipment that will contribute to mechanical noise sources in a classroom must include designs that ensure that the background sounds conform to a noise criterion curve or equivalent not to exceed NC-35. The school official shall certify that equipment and features are installed according to the approved plans;	(1) In new construction, plans submitted under WAC 246-366-040 shall specify ventilation equipment and other mechanical noise sources in classrooms are designed to provide background sound which conforms to a noise criterion curve or equivalent not to exceed NC-35. The owner shall certify equipment and features are installed according to the approved plans.	-100(1) School officials shall design ventilation equipment and other mechanical noise sources in classrooms to provide background sound which conforms to a noise criterion curve or equivalent not to exceed NC-35. School officials shall certify, or hire the appropriate person to certify, that ventilation equipment and other mechanical noise sources that have been installed meet the NC-35 noise criterion design standard.
(b) The actual background noise at any student location within a newly constructed classroom must not exceed 45 dBA (Leqx) and 70 dB(Leqx) (unweighted scale) where x is thirty seconds or more. The health officer shall determine compliance with this section when the ventilation system and the ventilation system's noise generating components, such as the condenser, heat pump, and other similar components are in operation; and	(2) In new construction, the actual background noise at any student location within the classroom shall not exceed 45 dBA (Legx) and 70 dB (Leqx) (unweighted scale) where x is thirty seconds or more. The health officer shall determine compliance with this section when the ventilation system and the ventilation system's noise generating components, e.g., condenser, heat pump, etc., are in operation.	-105 School officials shall: (1) Maintain the background noise at any student location within classrooms constructed after January 1, 1990, at or below 45 dBA (Leqx) where x is 30 seconds or more. Background noise levels must be determined when the ventilation system and the ventilation system's noise generating components, such as the condenser and heat pump, are operating and the room is unoccupied by students.
(c) The maximum ambient noise level in specialized rooms shall not exceed 65 dBA when all fume and dust exhaust systems are operating;	(4) In new construction, the maximum ambient noise level in industrial arts, vocational agriculture and trade, and industrial classrooms shall not exceed 65 dBA when all fume and dust exhaust systems are operating.	-105(2) Maintain the background noise level at any student location in laboratories and shops with local exhaust ventilation systems constructed after January 1, 1990, at or below 65 dBA (Leqx) where x is 30 seconds or more. Background noise levels must be determined when all ventilation equipment is operating and the room is unoccupied by students.

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<p>(2) Portable classrooms constructed before January 1, 1990, moved within the same school property or the same school district, are excluded from the requirements of this section if the portable classrooms:</p> <ul style="list-style-type: none"> (a) Do not alter the noise abatement features; (b) Do not increase noise-generating features; (c) Were previously used for classroom instruction; (d) Do not change ownership; and (e) Are located on a site that meets the noise assessment requirements set forth in WAC 246-370-020(3)(c); 	<p>(3) Existing portable classrooms, constructed before January 1, 1990, moved from one site to another on the same school property or within the same school district are exempt from the requirements of this section if the portable classrooms meet the following:</p> <ul style="list-style-type: none"> (a) Noise abating or noise generating features shall not be altered in a manner that may increase noise levels; (b) The portable classrooms were previously in use for general instruction; (c) Ownership of the portable classrooms will remain the same; and (d) The new site is in compliance with WAC 246-366-030(3). 	<p>-100(2) Portable classrooms constructed before January 1, 1990, moved within the same school property or within the same school district, are exempt from the requirements of this section if the portable classrooms meet all of the following criteria:</p> <ul style="list-style-type: none"> (a) Noise abating or noise generating features are not altered in a manner that may increase noise levels; (b) The portable classrooms were previously in use for instruction; (c) Ownership of the portable classrooms remains the same; and (d) The new site meets the noise standard in WAC 246-366A-030 (3)(c).
<p>(3) The maximum noise exposure for students in classrooms shall not exceed the levels specified in Table 1;</p>	<p>(5) The maximum noise exposure for students in vocational education and music areas shall not exceed the levels specified in Table 1.</p>	<p>-105(3) Maintain noise exposure for students below the maximum levels in Table 1</p>
<p>(4) Activities that expose students to sound levels equal to or greater than 115 dBA are prohibited; and</p>	<p>Students shall not be exposed to sound levels equal to or greater than 115 dBA.</p>	<p>-105(4) Not allow student exposure to sound levels equal to or greater than 115 dBA.</p>
<p>(5) Students are provided with and required to use personal protective equipment where noise levels exceed those specified in Table 1. Personal protective equipment must reduce student noise exposure to comply with the levels specified in Table 1.</p>	<p>(6) Should the total noise exposure in vocational education and music areas exceed the levels specified in Table 1 of subsection (5) of this section, hearing protectors, e.g., ear plugs, muffs, etc., shall be provided to and used by the exposed students. Hearing protectors shall reduce student noise exposure to comply with the levels specified in Table 1 of subsection (5) of this section.</p>	<p>-105(5) Provide and require students to use personal protective equipment, for example ear plugs or muffs, where noise levels exceed those specified in Table 1. Personal protective equipment must reduce student noise exposure to comply with the levels specified in Table 1</p>

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Table 1		Table 1		Table 1	
Maximum noise exposures permissible		Maximum noise exposures permissible		Maximum noise exposures permissible	
Duration per day (hours)	Sound Level (dBA)	Duration per day (hours)	Sound Level (dBA)	Duration per day (hours)	Sound Level (dBA)
8	85	8	85	8	85
6	87	6	87	6	87
4	90	4	90	4	90
3	92	3	92	3	92
2	95	2	95	2	95
1-1/2	97	1-1/2	97	1-1/2	97
1	100	1	100	1	100
1/2	105	1/2	105	1/2	105
1/4	110	1/4	110	1/4	110

WAC 246-370-100

Lighting

Summary of changes: 100 Lighting

- **Updated:** Language—no substantive changes

Language Comparison: 100 Lighting

246-370-110 Draft	246-366-050 & 120	246-366A-060 & -115
A school official shall ensure that: (1) Light intensities that meet or exceed those specified in Table 2 are provided. Natural lighting, energy-efficient lighting systems, lighting fixtures, or bulbs may be used to maintain the minimum lighting intensities;	-120(1) The following maintained light intensities shall be provided as measured 30 inches above the floor or on working or teaching surfaces. General, task and/or natural lighting may be used to maintain the minimum lighting intensities.	School officials shall: (1) Provide light intensities that meet or exceed those specified in Table 2. General, task and/or natural lighting may be used to maintain the minimum lighting intensities. Energy efficient lighting systems, lighting fixtures, or bulbs that meet the minimum lighting intensities in Table 2 may be used.

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Table 2		Table 2		Table 2	
Lighting intensities measured 30 inches above the floor or on working or teaching surfaces. Some lighting fixtures may require a start-up period before reaching maximum light output.		Lighting intensities measured 30 inches above the floor or on working or teaching surfaces. Some lighting fixtures may require a start-up period before reaching maximum light output.		Lighting intensities measured 30 inches above the floor or on working or teaching surfaces. Some lighting fixtures may require a start-up period before reaching maximum light output.	
Task	Min. Foot Candle Intensity	Task	Min. Foot Candle Intensity	Task	Min. Foot Candle Intensity
Specialized rooms where safety is of prime consideration or fine detail work is done, for example, family and consumer science laboratories, science laboratories (including chemical storage areas), shops, drafting rooms, and art and craft rooms.	50	Specialized rooms where safety is of prime consideration or fine detail work is done, for example, family and consumer science laboratories, science laboratories (including chemical storage areas), shops, drafting rooms, and art and craft rooms.	50	General instructional areas, for example, study halls, lecture rooms, and libraries.	30
Kitchen and food preparation areas.	50	Kitchen and food preparation areas.	50	Special instructional areas where safety is of prime consideration or fine detail work is done, for example, family and consumer science laboratories, science laboratories (including chemical storage areas), shops, drafting rooms, and art and craft rooms.	50
General instructional areas, for example, study halls, lecture rooms, and libraries.	30	General instructional areas, for example, study halls, lecture rooms, and libraries.	30	Noninstructional areas, for example, auditoriums, lunch rooms, assembly rooms, corridors, stairs, storerooms, and restrooms.	10
Gymnasiums: main and auxiliary spaces, shower rooms and locker rooms.	20	Gymnasiums: main and auxiliary spaces, shower rooms and locker rooms.	20	Gymnasiums: main and auxiliary spaces, shower rooms and locker rooms.	20
Non-instructional areas including auditoriums, lunchrooms, food storage rooms, assembly rooms, corridors, stairs, storerooms, and restrooms.	10	Non-instructional areas including auditoriums, lunchrooms, food storage rooms, assembly rooms, corridors, stairs, storerooms, and restrooms.	10		
(2) Excessive brightness and glare in all instructional areas is controlled. Surface contrasts and direct or indirect glare must not cause excessive eye accommodation or eye strain problems;		-120(2) Excessive brightness and glare shall be controlled in all instructional areas. Surface contrasts and direct or indirect glare shall not cause excessive eye accommodation or eye strain problems.		-120(2) Control excessive brightness and glare in all instructional areas. Surface contrasts and direct or indirect glare must not cause excessive eye accommodation or eye strain problems.	

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<p>(3) Sun control to exclude direct sunlight from window areas and skylights of instructional areas, assembly rooms, and meeting rooms during at least 80 percent of the normal school hours is provided. Sun control is not required for sun angles less than 42 degrees up from the horizontal. Sun control is not required if air conditioning is provided, or special glass is installed having a total solar energy transmission factor of less than 60 percent;</p>	<p>-050(9) Exterior sun control shall be provided to exclude direct sunlight from window areas and skylights of instructional areas, assembly rooms and meeting rooms during at least 80 percent of the normal school hours. Each area shall be considered as an individual case. Sun control is not required for sun angles less than 42 degrees up from the horizontal. Exterior sun control is not required if air conditioning is provided, or special glass installed having a total solar energy transmission factor less than 60 percent.</p>	<p>-060(3) Provide sun control to exclude direct sunlight from window areas and skylights of instructional areas, assembly rooms and meeting rooms during at least eighty percent of the normal school hours. Each area must be considered as an individual case. Sun control is not required for sun angles less than forty-two degrees up from the horizontal. Sun control is not required if air conditioning is provided or special glass is installed having a total solar energy transmission factor less than sixty percent.</p>
<p>(4) Lighting in a manner that minimizes shadows and other lighting deficiencies on work and teaching surfaces is provided; and</p>	<p>-120(3) Lighting shall be provided in a manner which minimizes shadows and other lighting deficiencies on work and teaching surfaces.</p>	<p>-120(3) Provide lighting in a manner that minimizes shadows and other lighting deficiencies on work and teaching surfaces.</p>
<p>(5) Windows in sufficient number, size, and location to enable students to see outside at least 50 percent of the school day are provided. Windows are optional in specialized rooms.</p>	<p>-050(8) Schools shall be provided with windows sufficient in number, size and location to permit students to see to the outside. Windows are optional in special purpose instructional areas including, but not limited to, little theaters, music areas, multipurpose areas, gymnasiums, auditoriums, shops, libraries and seminar areas. No student shall occupy an instructional area without windows more than 50 percent of the school day.</p>	<p>-060(2) Design school facilities with windows in sufficient number, size, and location to enable students to see outside at least fifty percent of the school day. Windows are optional in special purpose instructional areas including, but not limited to, theaters, music areas, multipurpose areas, gymnasiums, auditoriums, shops, laboratories, libraries, and seminar areas.</p>

WAC 246-370-110

Injury Prevention

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 110 Injury Prevention

- **Added:** Fall protection from balconies or orchestra pits and storage of unsecured equipment
- **Added:** Updated language for chemical storage
- **Added:** Fragrance-free and low-hazard cleaning requirements
- **Added:** Injury and communicable disease prevention planning when animals are allowed in school

Language Comparison: 110 Injury Prevention

246-370-110 Draft	246-366-050	246-366A-060, -065, & -080
A school official shall ensure: (1) The mitigation of potential slip and fall hazards by, but not limited to: (a) Providing stairwells and ramps with handrails and stairs with surfaces that reduce the risk of injury;	(3) All stairway[s] and steps shall have handrails and nonslip treads.	-060(4) Provide surfaces on steps that reduce the risk of injury caused by slipping.
(b) Providing protection or barriers for areas that have fall risks such as balconies and orchestra pits;		-060(7) Provide measures to reduce potential injury from fall hazards, including but not limited to, retaining walls; performance arts stages and orchestra pits; balconies; mezzanines; and other similar areas of drop-off to a lower floor.
(c) Storing unsecured equipment in a manner that prevents unauthorized use or injury;		-065(7) Safely store play equipment, instructional equipment, and outdoor clothing where reasonably accessible.
(2) The storage of chemicals and cleaning supplies includes: (a) Manufacturer use instructions, warning labels, and safety data sheets for proper storage of the supplies;		
(b) Labels on supplies that are diluted from bulk chemical or cleaning agents with the accurate agent name and dilution rates;	(6) All poisonous compounds shall be easily identified, used with extreme caution and stored in such a manner as to prevent unauthorized use or possible contamination of food and drink.	-065(4) Label, use, store and dispose of hazardous materials to: (a) Prevent health and safety hazards;
(c) The original bulk or concentrated containers of cleaning and disinfectant agents for reference to labels and instructions until diluted contents are exhausted;		

School Environmental Health and Safety Rule Project 2024 2025

(d) Separation of incompatible substances; and		-065(b) Keep incompatible substances apart from each other;
(e) Access limited to authorized users;		-065(c) Prevent unauthorized access and use; and
(3) The use of fragrance-free and low-hazard cleaning and sanitation supplies when available or ensure cleaning at a time and manner that would limit exposure to students; and		-065(5) Select supplies and methods of use that reduce exposure to hazardous materials.
		-065(6) Allow only those hazardous materials in schools that they have approved for use. Types of commercial products that might contain hazardous materials include, but are not limited to, cleaners, sanitizers, maintenance supplies, pesticides, herbicides, and instruction-related supplies.
(4) Documentation of a policy to mitigate injury and the spread of diseases if the school allows animals other than service animals in a school facility.		-080(1) School officials shall allow in school facilities only those animals, other than service animals, approved under written policies or procedures.
		-080(2) School officials shall develop written policies or procedures for any animals allowed in school facilities to prevent: (a) Injuries caused by wild, dangerous, or aggressive animals; (b) Spread of diseases from animals known to commonly carry diseases including, but not limited to, rabies, psittacosis, and salmonellosis; (c) Allergic reactions; (d) Exposure to animal wastes; and (e) Handling animals or their bedding without proper handwashing afterward. (3) Written policies or procedures required under subsection (2) of this section shall address service animals in the school facility that are not well behaved or present a risk to health and safety.



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WAC 246-370-120

Imminent Health Hazard Procedure

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 120 Imminent Health Hazard Procedure

- **New Section:** Sets prescribed imminent health hazard requirements for hazards like sewage spillage

Language Comparison: 120 Imminent Health Hazard Procedure

246-370-120 Draft	246-366-	246-366A-020
(1) If a school official identifies a condition that could pose an imminent health hazard, a school official shall ensure:		
(a) The immediate mitigation of hazards and prevention of exposure if an imminent health hazard is confirmed;		(ii) Promptly notify the local health officer; and
(b) The immediate consultation with the local health officer to investigate the suspected hazard; and		(c) When conditions are identified that pose an imminent health hazard: (i) Take immediate action to mitigate hazards and prevent exposure;
(c) Consultation with the local health officer in developing appropriate health and safety messages for school staff, students, and parents.		(iii) Promptly inform school facility staff, students, and parents about the conditions and actions taken in response.
		(d) Retain for at least six years, unless otherwise required by other state or federal laws, records pertaining to: (ii) Imminent health hazards identified under this section and WAC 246-366A-190, and actions taken in response;
(2) If a local health officer identifies a condition that is an imminent health hazard at a school, the local health officer shall:		
(a) Immediately inform school officials of the imminent health hazard;		
(b) Consult with school officials to mitigate hazards and prevent exposure; and		
(c) If requested, assist school officials in developing health and safety messages for school staff, students, and parents.		

WAC 246-370-130

Playgrounds

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 130 Playgrounds

- **New Section:** Sets prescribed installation and maintenance requirements for playgrounds

Language Comparison: 130 Playgrounds

246-370-130 Draft	246-366-	246-366A-150 & -155
(1) A school official shall ensure: (a) Consultation with the local health officer regarding playground review and approval requirements takes place prior to: (i) Installing new playground equipment or fall protection surfaces; (ii) Adding new playground features or equipment to an existing playground; or (iii) Modifying existing playground equipment, features, or fall protection surfaces;		-150(1) School officials shall: (a) Consult with the local health officer regarding playground review and approval requirements consistent with the scope of the project when proposing to: (i) Install new playground equipment or fall protection surfaces; (ii) Add new playground features or equipment to an existing playground; or (iii) Modify, other than repair and maintain, existing playground equipment, features, or fall protection surfaces.
(b) The proper installation, maintenance, and operation of playground equipment, including used equipment, and fall protection surfaces: (i) In a manner consistent with the ASTM F 1487-21: Standard Consumer Safety Performance Specification for Playground Equipment for Public Use; and		-150(c) Install playground equipment, including used equipment, and fall protection surfaces: (i) That meet the ASTM F 1487-01: Standard Consumer Safety Performance Specification for Playground Equipment for Public Use; and
(ii) In a manner consistent with the manufacturer's instructions and Consumer Product Safety Commission Handbook for Public Playground Safety, 2010;		-150(ii) In a manner that is consistent with the manufacturer's instructions and Consumer Product Safety Commission Handbook for Public Playground Safety, 2008.
(c) The local health officer receives requested information including playground plans, equipment specifications, and any additional information; and		-150(b) If required by the local health officer after consultation: (i) Provide playground plans and equipment specifications and any additional information the local health officer requests; and
(d) Acquisition of a plan review and written approval from the local health officer before installing, adding, or modifying playground equipment or fall protection surfaces.		-150(ii) Obtain plan review and written approval from the local health officer before installing, adding, or modifying playground equipment or fall protection surfaces.

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(2) The local health officer shall: (a) Consult with a school official to determine necessary documentation for playground plan review and approval consistent with the scope of the particular project;		-150(2) The local health officer shall: (a) Consult with school officials to determine what is required for playground plan review and approval consistent with the scope of the project.
(b) Review playground plans and equipment specifications to confirm that the requirements of these rules are addressed;		-150(b) If playground review and approval is required: (i) Review playground plans and equipment specifications to confirm that the requirements of these rules are addressed;
(c) Identify and request any additional documents required to complete the review;		-150(ii) Identify and request any additional documents required to complete the review;
(d) Provide written approval or denial of the playground plans and equipment specifications within 60 days of receiving all documents needed to complete the review unless the school officials and the local health officer agree to a different timeline;		-150(iii) Provide written approval or denial of the playground plans and equipment specifications within thirty days of receiving all documents needed to complete the review, unless the school officials and the local health officer agree to a different timeline; and
(e) Verify that playground installation complies with the requirements of this section; and		-150(iv) Verify that playground installation complies with requirements of this section.
(f) Coordinate all playground-related inspections with the school official.		-150(c) Coordinate all playground-related inspections with school officials.
(3) The use of chromated copper arsenate or creosote-treated wood to construct or install playground equipment, landscape structures, or other structures on which students may play is prohibited.		-155(d) Prohibit the use of chromated copper arsenate or creosote treated wood to construct or install playground equipment, landscape structures, or other structures on which students may play.

WAC 246-370-140

Specialized Rooms

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 140 Specialized Rooms

- **New Section:** Sets prescribed requirements for specialized rooms like health rooms, laboratories, and wood shops

Language Comparison: 140 Specialized Rooms

246-370-140 Draft	246-366-140	246-366A-060, -110, -160, & -165
(1) A school official shall ensure specialized rooms that are part of a school facility include, if applicable: (a) Single-use soap and single-use towels at handwashing sinks;		-160 School officials shall: (4) Provide handwashing and appropriate drying facilities in an easily accessible location in each laboratory and shop.
(b) Emergency washing facilities that contain an emergency shower or emergency eyewash fountain or both: (i) An emergency shower must: (A) Be provided when there is potential for major portions of a person's body to contact corrosives, strong irritants, or toxic chemicals; and	(2) In new construction, chemistry laboratories shall be provided with an eyewash fountain and a shower head for flushing in cases of chemical spill and clothing fires. If more than one laboratory is provided, one of each fixture will be adequate if the laboratories are in close proximity.	-160(2) Provide an emergency shower for each laboratory where hazardous materials are used and the potential for chemical spills exists.
(B) Deliver water that cascades over the user's entire body at a minimum rate of 20 gallons (75 liters) per minute for fifteen minutes or more;		-010(12) "Emergency shower" means a hand-activated shower that delivers tepid potable water to cascade over the user's entire body at a minimum rate of 20 gallons (75 liters) per minute for at least fifteen minutes.
(ii) An emergency eyewash fountain must: (A) Be provided when there is potential for a person's eyes to be exposed to corrosives, strong irritants, or toxic chemicals;		-160(1) Provide an emergency eyewash fountain for each laboratory and shop where hazardous materials are used or eye irritants are produced.
(B) Irrigate and flush both eyes simultaneously while the user holds their eyes open;		-010(11) "Emergency eye wash" means a hands-free device that: (a) Irrigates and flushes both eyes simultaneously with tepid potable water;
(C) Contain an on-off valve that activates in one second or less and remains on without user assistance until intentionally turned off; and		-010(b) Activates an on-off valve in one second or less and remains on without user assistance until intentionally turned off; and
(D) Deliver at least 0.4 gallons (1.5 liters) of water per minute for fifteen minutes or more;		-010(c) Delivers at least 0.4 gallons (1.5 liters) of water per minute for at least fifteen minutes.

School Environmental Health and Safety Rule Project 2024 2025

(iii) Emergency washing facilities must: (A) Be located so that it takes no more than 10 seconds to reach and the travel distance should be no more than 50 feet;		-160(3) Assure that all emergency eyewash fountains and showers have unobstructed access and are reachable within ten seconds.
(B) Be kept free of obstacles blocking their use;		
(C) Function correctly;		
(D) Provide the quality and quantity of water that is satisfactory for emergency washing purposes; and		
(E) Be designed, installed, and maintained in accordance with the American National Standards Institute (ANSI) publication Z358.1 - 2014, American National Standard for Emergency Eyewash and Shower Equipment;		
		-160(6) Provide all stationary machinery in laboratories and shops with magnetic-type switches to prevent machines from automatically restarting upon restoration of power after an electrical failure or activation of the emergency shut-off.
(c) A prohibition of use and storage of compounds that are: (i) Considered shock-sensitive explosives, for example, picric acid, dinitro-organics, isopropyl ether, ethyl ether, tetrahydrofuran, dioxane; or		-165 In laboratories and shops, school officials shall: (1) Select, label, use, store and dispose of hazardous materials in accordance with WAC 246-366A-065. (2) Prohibit use and storage of compounds that are: (a) Considered shock-sensitive explosives, for example, picric acid, dinitro-organics, isopropyl ether, ethyl ether, tetrahydrofuran, dioxane; or
(ii) Lethal at low concentrations when inhaled or in contact with skin, for example, pure cyanides, hydrofluoric acid, toxic compressed gases, mercury liquid and mercury compounds, and chemicals identified as the P-list under WAC 173-303-9903. This excludes prescribed medications such as epinephrine pens;		-165(b) Lethal at low concentrations when inhaled or in contact with skin, for example, pure cyanides, hydrofluoric acid, toxic compressed gases, mercury liquid and mercury compounds, and chemicals identified as the P-list under WAC 173-303-9903.
(d) Safety procedures and processes for instructing students regarding the proper use of hazardous materials or equipment;		-165(3) Adopt safety procedures and processes for instructing students regarding the proper use of hazardous materials and equipment.

School Environmental Health and Safety Rule Project 2024 2025

(e) Appropriate personal protective equipment when exposure to potential hazards might occur;		-165(4) Provide and require use of appropriate personal protective equipment when exposure to potential hazards might occur. Potential hazards include, but are not limited to hazardous material exposures, burns, cuts, and punctures.
(f) Appropriate situation-specific emergency equipment is available when exposure to potential hazards might occur;		-160(5) Provide situation-specific emergency and protective equipment during demonstrations with hazardous materials and with hazardous procedures. Examples of protective equipment include, but are not limited to, safety shields for eyes, protective gloves that are fire retardant and chemical resistant, respiratory protection, and fire extinguishers.
(g) Appropriate ventilation, source capture system, or other equipment approved by the local health officer to prevent the recirculation of air into the room or transfer of airflow into other parts of the school facility and to prevent contaminants from entering the students breathing zone; and		-160(7) Provide mechanical exhaust ventilation in hazardous material storerooms, and in laboratories and shops where equipment or activities may produce air contaminants of public health importance. (8) When activities or equipment in laboratories or shops produce air contaminants of public health importance, provide an appropriate source capture system to prevent those contaminants from entering the student's breathing zone. These activities and equipment include, but are not limited to, spray painting, welding, pottery kilns, chemistry experiments, and wood-working. (9) Design ventilation systems to operate so that air is not recirculated and does not flow from the laboratory or shop to other parts of the school facility. Open plenum air returns consisting of the space above suspended ceilings in laboratories and shops must not be used to recirculate air to other parts of the school facility.
(h) Emergency shut-off valves or switches for gas and electricity connected to stationary machinery are installed during new construction. Valves or switches must:		-160(5) Provide emergency shut-offs for gas and electricity connected to stationary machinery in laboratories and shops. Emergency shut-offs must:
(i) Be located close to the exit door;		(a) Be located in close proximity to the room exit door;
(ii) Have unobstructed access; and		-160(b) Have unobstructed access; and

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(iii) Have signage posted adjacent to the valve that room occupants can easily read and understand from the opposite side of the room during an emergency.		-160(c) Have signage readable from across the room for immediate identification during an emergency.
(2) If a school facility has a designated health room, a school official shall ensure that it includes: (a) The means to visually supervise and provide privacy for room occupants;		-060(8) Provide the following items for health rooms, if health rooms are provided: -060(a) The means to visually supervise and provide privacy of room occupants;
(b) Surfaces that staff can easily clean and sanitize;		-060(b) Surfaces that can be easily cleaned and sanitized;
(c) A handwashing sink in the room;		-060(c) A handwashing sink in the room;
(d) An adjoining restroom; and		-060(d) An adjoining restroom; and
(e) Mechanical exhaust ventilation that prevents air from flowing from the health room to other parts of the school facility.		-060(e) Mechanical exhaust ventilation so that air does not flow from the health room to other parts of the school facility

WAC 246-370-150

Variances and Emergency Waivers

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 150 Variances and Emergency Waivers

- **Updated:** Language—no substantive changes

Language Comparison: 150 Variances and Emergency Waivers

246-370-150 Draft	246-366-150	246-366A-150, -170, & -175
(1) A school official may: (a) Submit a written variance request to the local health officer if there is an alternative that meets the intent of this chapter. The variance request must include:	The secretary may allow the substitution of procedures or equipment for those outlined in these regulations, when such procedures or equipment have been demonstrated to be equivalent to those heretofore prescribed. When the secretary judges that such substitutions are justified, he shall grant permission for the substitution in writing. Requests for substitution shall be directed to the jurisdictional health officer who shall immediately forward them, including his recommendations, to the secretary. All decisions, substitutions, or interpretations shall be made a matter of public record and open to inspection.	-170(1) School officials: (a) May request a variance from requirements in these rules from the local health officer if they wish to use an alternative to meet the intent of these rules.
(i) The specific rule section or sections that the variance would replace;		-170(i) The request for a variance must be in writing and describe: (A) The specific requirement the variance is requested to replace;
(ii) The alternative proposed to replace the rule section or sections;		-170(B) The alternative proposed to meet the specific requirement; and
(iii) A description of how the variance will provide a comparable level of protection as the rule section or sections that it will replace; and		-170(C) How the proposed alternative will provide at least a comparable level of protection as that provided by the specific requirement.
(iv) Any clarifying documentation needed to support the request, including but not limited to, engineering reports, scientific data, or photos; and		-170(ii) The request for a variance must include information as needed to support and clarify the request, such as material descriptions and specifications, engineering reports, photos, drawings, or sketches.
(b) Implement a variance only after obtaining approval from the local health officer.		-170(b) May implement a variance only after obtaining approval from the local health officer.

School Environmental Health and Safety Rule Project 2024 2025

		-170(2) The local health officer shall: (a) Initially review documents submitted with the request for a variance and inform school officials if additional information is required.
		-170(b) Compare the health and safety aspects of the specific requirement being addressed and the variance proposal to determine if the proposal provides at least a comparable level of protection as that provided by the specific requirement.
(2) The local health officer shall provide written approval or denial of a request for a variance to the school applicant and the department within 60 days of receiving a complete written variance request, unless the school official and the local health officer agree to a different timeline.		-170(c) Provide written approval or denial of a request for a variance within sixty days of receiving a complete written request, unless school officials and the local health officer agree to a different timeline.
		-170(d) Submit an annual written report to the department regarding all variance requests. The report must be submitted by March 1st of each year, beginning the third year after the effective date of this section, and cover the calendar period January through December of the previous year.
(3) The local health officer may grant a school official an emergency waiver from some or all the requirements in this chapter for the use of a temporary facility, if the facility normally used by the school is not safe to be occupied.		-175 The local health officer may grant school officials an emergency waiver from some or all of the requirements in these rules for the temporary use of a facility or site as a school when the facility normally used by the school is not safe to be occupied due to a natural or man-made disaster.
		-150 The board of health may, at its discretion, exempt a school from complying with parts of these regulations when it has been found after thorough investigation and consideration that such exemption may be made in an individual case without placing the health or safety of the students or staff of the school in danger and that strict enforcement of the regulation would create an undue hardship upon the school.

WAC 246-370-160

Appeals

School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 160 Appeals

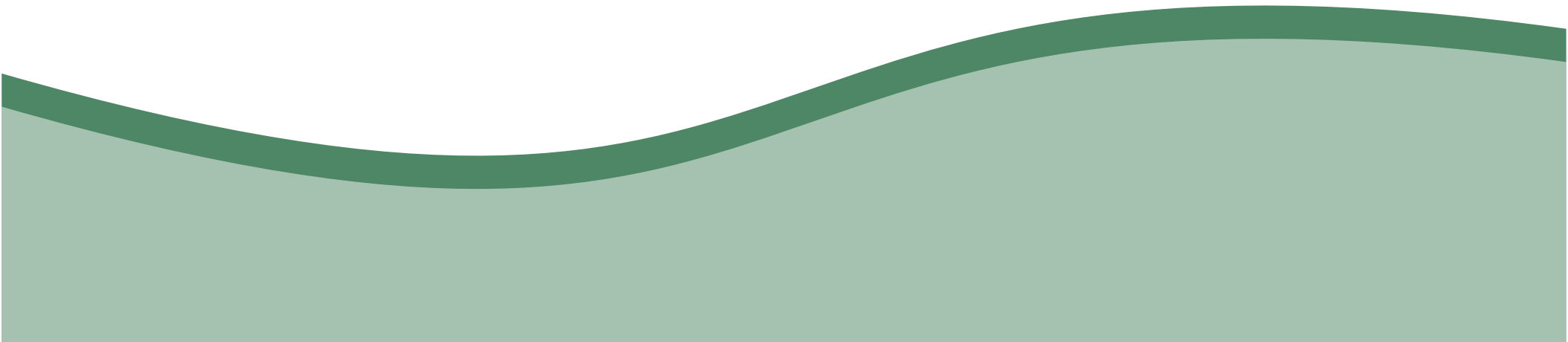
- **Updated:** Language—no substantive changes

Language Comparison: 160 Appeals

246-370-160 Draft	246-366-	246-366A-180
(1) A school official may appeal any environmental health and safety decisions or actions of the local health officer to the local board of health.		Decisions or actions of the local health officer may be appealed to the local board of health in a manner consistent with their established procedure.
(2) The local board of health will conduct environmental health and safety appeals in a manner consistent with the written procedure within each office.		

WAC 246-370-170

Severability



School Environmental Health and Safety Rule Project 2024 2025

Summary of changes: 170 Severability

- **Updated:** Language—no substantive changes

Language Comparison: 170 Severability

246-370-170 Draft	246-366-160	246-366A-200
If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected.	If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected.	If any provision of this chapter or its application to any person or circumstance is held invalid, the remainder of the chapter or the application of the provision to other persons or circumstances is not affected.



School Environmental Health and Safety Rule Project

Joint meeting of the State Board of Health and the
Technical Advisory Committee
Cedarbook Lodge, SeaTac
April 9, 2025

WASHINGTON STATE 
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WASHINGTON STATE 
BOARD OF HEALTH

Reminders



 1

1

Today's Objectives

- Introduce committee members to the Board
- Reflect on the committee experience
- Recommend next steps to the Board
- Review the fiscal analysis
- Take action



2

2

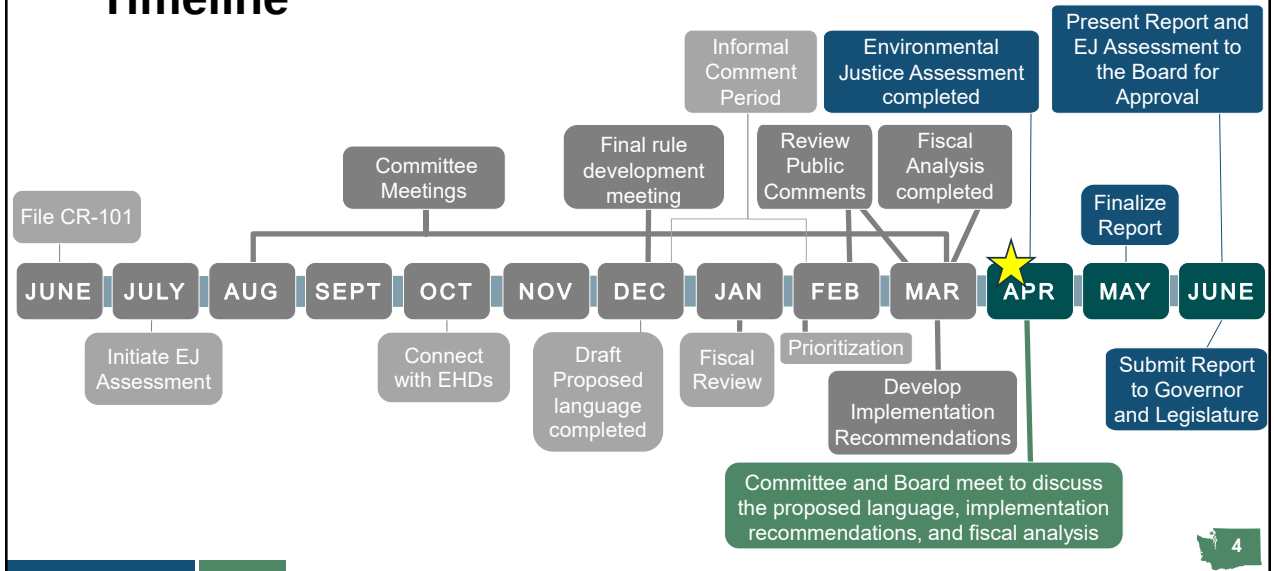
Committee Agreements

- Be respectful of all perspectives and opinions
- Communicate openly and respectfully, disagree without being disagreeable
- Assume positive intent and ask for clarification
- Share the air; allow everyone to share insights, one person speaking at a time
- Ask questions and seek to understand
- Be on time for meetings/calls
- Be present and actively participate (no multitasking during meetings)
- Be efficient with our meeting time
- Meet deadlines and commitments
- Support the final decisions of the committee
- Stay focused on the goals and objectives of the committee

3

3

Timeline



4

Introductions



5

Introductions

- Name
- Title
- Organization
- Why is this work important to you?



6

6

Reflection

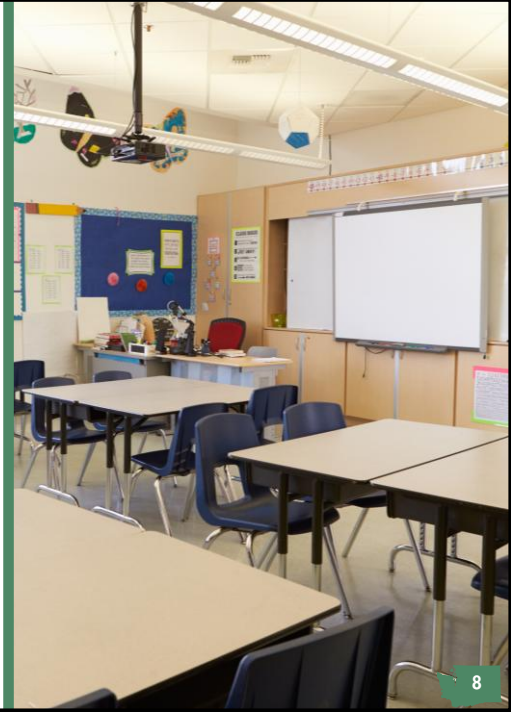


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7

Committee Reflections

- What were your key takeaways from this process?
- How has your experience changed the way you see school environmental health and safety?
- What are the biggest challenges we face regarding the health and safety of our children in schools?



8

8

Recommendations



9

9

Recommendations

Three-Phase Implementation

Phase 1

- Develop plans, such as the extreme temperature readiness plan
- No change from 366
- Basic WAC structures

Phase 2

- Collaborative tasks between schools and LJHs like inspections and assessments

Phase 3

- Implementation of new requirements to comply with rule, such as specialized rooms



Afternoon Break
Return at 4:00 p.m.



Fiscal Analysis

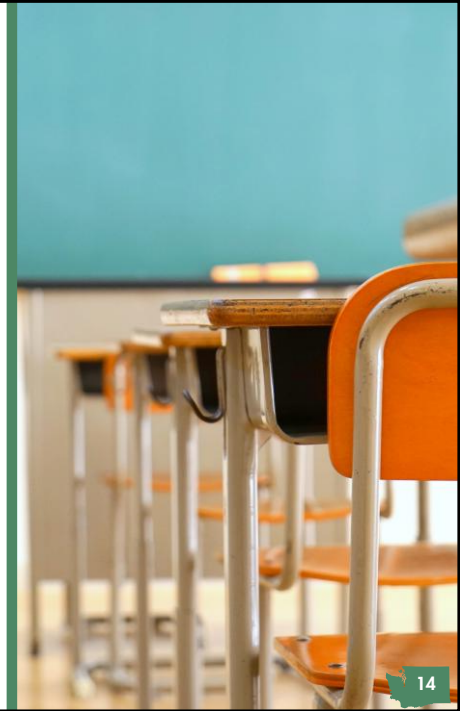


Final Comments



Report Outline

- Tab 01 Cover Letter
- Tab 02 Executive Summary
- Tab 03 Background
- Tab 04 Proposed Rule
- Tab 05 Fiscal Analysis
- Tab 06 Fiscal Summary
- Tab 07 Environmental Justice Assessment
- Tab 08 Implementation Recommendations
- Tab 09 Discussion & Concerns



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Clean Building Performance Standards

- Possible conflict between clean buildings standards and the requirements of this code (resolved)
- Delaying the penalty or implementation of commerce clean buildings performance
- Prioritize student health & safety over energy
- Upgrades can decrease operational costs



15

Partnership not Penalization

- The rule is meant to develop partnerships between schools and local health, not penalize schools when they are not able to comply
- Coordination with other agencies may be necessary



16

Inconsistent implementation

- Concerns about no uniform statewide program, differences in enforcement from county to county
 - Some counties do not have a program
 - Some counties have limited program
 - Difference in fees
 - Identify the number of programs that are currently doing inspections



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Barriers to Implementation

- Funding
 - Bond Passage
 - SCAP (30-year cycle)
 - Differences between public, private, and charter schools
 - Prototypical funding model does not accurately support typical use and costs
 - Custodial funding is based on student enrollment, not facility size
 - Fluctuation in enrollment impacts prototypical funding model
 - Disparities due to dependence on levies and property taxes
 - Public Health workforce retention and FPHS funding
 - Hard to retain staff
 - Funding LHJs so they do not have to assess fees
 - Nursing is underfunded
- Political headwinds
 - Local Boards of Health
 - School Boards



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Miscellaneous Topics

- Additional burden on small schools
 - Capacity issues at small schools
- Increase legislators visiting school facilities
- Incentivization for going beyond the minimum
- Reflect unification of the system around the recommendations
 - Education
 - Public Health
- Outline the student health and safety and the three phase implementation recommendations
- Provide clarification in the report that variances are not required to be renewed
- Federal Tax credits for clean energy
- Grants for private schools



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Motions



Motions

The Board accepts the technical advisory committee's recommendations for the proposed rule, Chapter 246-370, and directs staff to begin the process of repealing Chapter 246-366A.

Or

The Board directs staff to continue refining the proposed rule, Chapter 246-370, in collaboration with the members of the technical advisory committee.

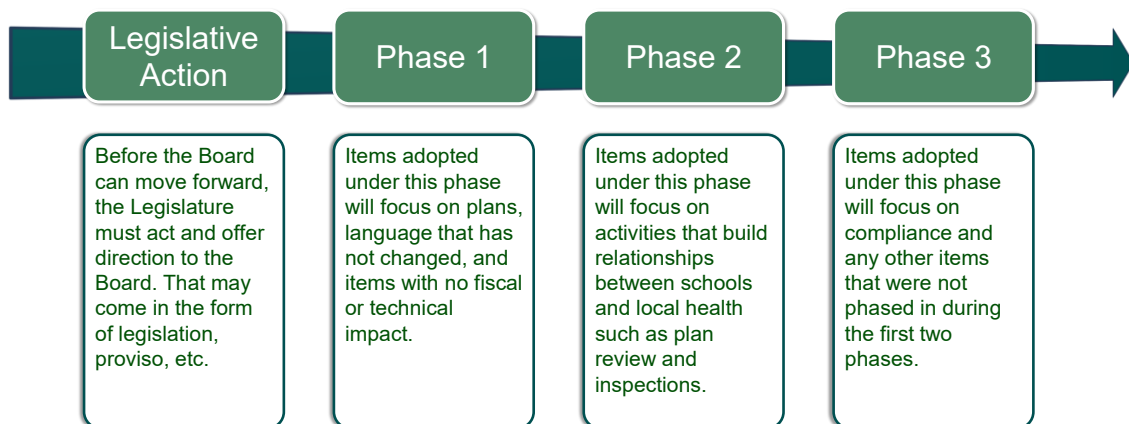


Next Steps

22

22

Timeline



23

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THANK YOU

To request this document in an alternate format, please contact the Washington State Board of Health at 360-236-4110, or by email at wsboh@sboh.wa.gov | TTY users can dial 711

ACCESSIBILITY AND THE AMERICANS WITH DISABILITIES ACT (ADA)

- The Washington State Board of Health (Board) is committed to providing information and services that are accessible to people with disabilities. We provide reasonable accommodations, and strive to make all our meetings, programs, and activities accessible to all persons, regardless of ability, in accordance with all relevant state and federal laws.
- Our agency, website, and online services follow the Americans with Disabilities (ADA) standards, Section 508 of the Rehabilitation Act of 1973, Washington State Policy 188, and Web Content Accessibility Guidelines (WCAG) 2.0, level AA. We regularly monitor for compliance and invite our users to submit a request if they need additional assistance or would like to notify us of issues to improve accessibility.
- We are committed to providing access to all individuals visiting our agency website, including persons with disabilities. If you cannot access content on our website because of a disability, have questions about content accessibility or would like to report problems accessing information on our website, please call (360) 236-4110 or email wsboh@sboh.wa.gov and describe the following details in your message:
 - The nature of the accessibility needs
 - The URL (web address) of the content you would like to access
 - Your contact information

We will make every effort to provide you the information requested and correct any compliance issues on our website.