
A DOSE OF DIGNITY: EQUITABLE VACCINATION POLICIES FOR INCARCERATED PEOPLE AND CORRECTIONAL STAFF DURING THE COVID-19 PANDEMIC

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ABSTRACT

Since its emergence in early 2020, the COVID-19 pandemic has altered the lives of millions of Americans. As it so often is during times of crisis, our most vulnerable communities have disproportionately suffered and were overlooked. Among these myriad communities, incarcerated people became a particularly potent symbol of our failure to handle the spread of the virus. In December 2020, a beacon of hope emerged with the introduction of new cutting-edge vaccines which promised to bring the world back to where it was just a year-and-a-half ago. Here again, however, policy and politics have led states to adopt different distribution plans that, broadly speaking, deprioritized incarcerated populations and in some cases correctional staff as well. While vaccinations are now much more widespread, things were dramatically different not too long ago. The first goal of this Essay is to ensure we memorialize how society, once again, failed to protect our incarcerated communities when they needed it the most. To illustrate this, we offer a data-driven analysis of the early state-level policies regarding vaccinations of people who live and work in prisons. Our findings show that

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vaccination policies tended to systematically ignore or disadvantage incarcerated individuals. We argue that by adopting such policies, states have neglected to comply with their legal obligations, grounded in existing and emerging Eighth Amendment jurisprudence and long-standing ethical responsibilities to proactively vaccinate this population. This is particularly true given that prisons are among the high-risk “congregate settings” that are widely recognized by health experts, and often by the states themselves, as deserving of immediate distribution of vaccines. Based on these obligations, and given recent new virus outbreaks and the realization that some form of COVID-19 is here to stay (and other pandemics may be around the corner), this Essay concludes with recommendations for the future.

INTRODUCTION

Prisons and disease have been intertwined for centuries.¹ The situation surrounding the novel coronavirus SARS-CoV-2 is no different. This pandemic has challenged the entire world and uniquely impacted the carceral systems.² As an international leader in incarceration, the United States faces some of the most severe challenges.³ Data from the early days of the pandemic show that incarcerated people and staff are at heightened risk.⁴ Furthermore, this situation also puts communities outside the walls at risk. The rapid emergence of vaccines presented opportunities and obligations. The United States’ response has been fragmented, inconsistent, and, at times, ugly.⁵ How a society treats these vulnerable individuals “will serve as a mirror, reflecting a stark image of our strengths and fears back at us all. We can then ask – and answer – who are we and what do we stand for?”⁶

1. See, e.g., GUSTAVE DE BEAUMONT & ALEXIS DE TOCQUEVILLE, ON THE PENITENTIARY SYSTEM IN THE UNITED STATES AND ITS APPLICATION TO FRANCE: THE COMPLETE TEXT 292 (Emily Katherine Ferkaluk, trans., Springer Int’l Publ’g 2018) (1833); James Hamblin, *Mass Incarceration Is Making Infectious Diseases Worse*, ATLANTIC (July 18, 2016), <https://www.theatlantic.com/health/archive/2016/07/incarceration-and-infection/491321> [<https://perma.cc/Y6FJ-NK4H>] (“The penal system remains a source of diseases that spread among prisoners at rates far exceeding those in the communities from which they came.”). See generally LAURA M. MARUSCHAK, MARCUS BERZOFKY & JENNIFER UNANGST, MEDICAL PROBLEMS OF STATE AND FEDERAL PRISONERS AND JAIL INMATES, 2011–12 (2016) (discussing survey results demonstrating that prisoners and jail inmates are more likely to have chronic medical conditions than the general population, both in general and for specific conditions and diseases).

2. See, e.g., EMILY WANG, LAUREN BRINKLEY-RUBINSTEIN, LISA PUGLISI & BRUCE WESTERN, RECOMMENDATIONS FOR PRIORITIZATION AND DISTRIBUTION OF COVID-19 VACCINE IN PRISONS AND JAILS 1 (2020) (“Prisons and jails across the country have been epicenters of the COVID-19 pandemic.”).

3. See, e.g., MARC MAUER, AMERICANS BEHIND BARS: THE INTERNATIONAL USE OF INCARCERATION, 1992-1993, at 3 (1994).

4. See, e.g., WANG ET AL., *supra* note 2, at 1.

5. See, e.g., Madison Pauly, *The Freakout About Giving COVID Vaccines to Prisoners Has Already Begun*, MOTHER JONES (Dec. 4, 2020), <https://www.motherjones.com/crime-justice/2020/12/prison-vaccine-covid-priority-colorado> [<https://perma.cc/EJ82-HDKB>].

6. Steven Chanenson & Jordan Hyatt, *Vaccine Decisions for the Incarcerated*, TRIB LIVE (Dec. 18, 2020, 11:00 AM), <https://triblive.com/opinion/steven-chanenson-and-jordan-hyatt-vaccine-decisions>

Since its emergence in 2020, the COVID-19 pandemic has dramatically impacted almost every facet of daily life. This Essay explores how the United States responded during an acute period of crisis within the larger public health emergency. It was a trial of our political will and moral courage. What happened when vaccines were in short supply and the rates of infection and death were terrifyingly high? While recent months have dramatically increased the availability of vaccines, not too long ago the nation experienced a scarcity in vaccines supply which forced states to make difficult prioritization decisions.

For purposes of this snapshot, think back to March 2021. According to the Johns Hopkins Coronavirus Resource Center, 2,771,260 people had died from the virus globally; shockingly, about 20% of all these deaths (548,489) had taken place in the United States.⁷ There are myriad factors that allowed this pandemic to fester in the United States, including unique political, historical, and long-standing public health challenges.⁸ Unlike many other developed nations, there was not a uniform national response. Encouraged by principles of federalism, state-level policies regarding the prevention and treatment of the virus were developed independently. With the availability of highly effective vaccines, this intra-state variation resulted in the implementation of a wide array of state- and local-level vaccination strategies. Though generally animated by broad ethical principles, policies were localized and reflected practical and value-driven assessments about who should receive a vaccine and when. These policy decisions had dramatic implications for the health and welfare of millions of incarcerated people and correctional staff across the nation.

Within the vaccination policy landscape, the treatment decisions surrounding individuals who were incarcerated have perhaps been the most controversial and contentious. Stemming from the nature of their living arrangements—confinement to a correctional institution after having been convicted of a criminal offense—these individuals faced distinct risks and often lacked access to many common, disease-fighting resources. For this

-for-the-incarcerated [<https://perma.cc/FLW9-XF5U>].

7. *COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)*, JOHNS HOPKINS UNIV.: CORONAVIRUS RES. CTR., <https://coronavirus.jhu.edu/map.html> [<https://perma.cc/5B2K-2W83>]. Data as of March 27, 2021.

8. *See generally* Steffie Woolhandler, David U. Himmelstein, Sameer Ahmed, Zinzi Bailey, Mary T. Bassett, Michael Bird, Jacob Bor, David Bor, Olveen Carrasquillo, Merlin Chowkwanyun, Samuel L. Dickman, Samantha Fisher, Adam Gaffney, Sandro Galea, Richard N. Gottfried, Kevin Grumbach, Gordon Guyatt, Helena Hansen, Philip J. Landrigan, Michael Lighty, Martin McKee, Danny McCormick, Alecia McGregor, Reza Mirza, Juliana E. Morris, Joia S. Mukherjee, Marion Nestle, Linda Prine, Altaf Saadi, Davida Schiff, Martin Shapiro, Lello Tesema & Atheendar Venkataramani, *Public Policy and Health in the Trump Era*, 397 LANCET COMM'NS 705 (2021) (discussing survey results indicating deficiencies in medical and psychiatric care provided to inmates).

reason, and just as vaccination policies were being designed, the National Academies of Sciences, Engineering, and Medicine (NAS) released an advisory framework for vaccine distribution. In an attempt to balance utilitarian and ethical principles, NAS determined that incarcerated people should receive the vaccine early.⁹ States, however, incorporated this guidance into their regulations in radically different ways.

Through an illustration of the omissions in states' adoption of vaccination policies, this Essay captures the landscape during this tumultuous time and analyzes data related to the implementation of nationwide vaccination policies within prisons. As our data suggest, many states followed the path offered by the NAS regarding correctional staff but some either excluded incarcerated people from early phases of the vaccine rollout or simply excluded them from the plans altogether.

We argue against the idiosyncrasy of states' policies regarding vaccinating people who live in prisons and claim that the NAS's approach is not only ethically commendable but also reflects legal commitments grounded in Eighth Amendment jurisprudence. As the U.S. Supreme Court has written, "A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."¹⁰ Given these legal and ethical commitments, we call for the incorporation of the letter and spirit of the NAS's rationale into current – and future – state-level vaccination policies.

While our collective memory might already consider vaccinations a "problem of the past," this Essay suggests otherwise. We should fight the tendency to quickly lose interest in issues that seem to be superficially resolved. Specifically, we suggest that the deprioritization of incarcerated communities in the midst of one of the most severe health crises of modern times should be emphasized and discussed. First, simply because it could have saved lives.¹¹ Second, because our society is judged by how it treats

9. See NAT'L ACADEMIES OF SCIS., ENG'G & MED. & NAT'L ACAD. OF MED., FRAMEWORK FOR EQUITABLE ALLOCATION OF COVID-19 VACCINE 110 (Helene Gayle, William Foege, Lisa Brown & Benjamin Kahn eds., 2020).

10. *Brown v. Plata*, 563 U.S. 493, 511 (2011).

11. Quinton Chandler, *Oklahoma Prisons Ahead in Vaccination but Advocates Say Earlier Access Could Have Saved Lives*, STATEIMPACT OKLAHOMA (April 15, 2021, 5:00 AM), <https://stateimpact.npr.org/oklahoma/2021/04/15/oklahoma-prisons-ahead-in-vaccinations-but-advocates-say-earlier-access-could-have-saved-lives/> [<https://perma.cc/77QM-XSTV>]. For purposes of illustration, reviewing the death toll in prisons due to COVID-19 between December 2020 and April 2021 (the early vaccination phases) points to over 800 deaths nationwide and approximately 180,000 new cases during these months. *A State-By-State Look at 15 Months of Coronavirus in Prisons*, MARSHALL PROJECT, <https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons#prisoner-deaths> [<https://perma.cc/54VQ-YHD3>]. An early introduction of the vaccines into prisons would have likely decreased these numbers.

incarcerated people not only under regimes with an abundance of resources but also, and maybe even more so, in times of scarcity. The policies adopted by many states during the early vaccination phases reflect the latter and should serve as a warning sign for the way we treat one of our most vulnerable communities – incarcerated people. Finally, not only that the COVID-19 pandemic does not seem to disappear, it is also unlikely to be the last public health crisis that society- and prisons- will ever endure. When well-illuminated, the failures in this instance may serve as a foundation for developing future policies that will better protect vulnerable, incarcerated individuals.

This Essay proceeds in four parts. First, it provides an overview of the interactions between COVID-19 and the penal environment. Second, it presents original data on state vaccine plans as of the middle of February 2021.¹² Next, it offers an overview of the constitutional and moral obligations to address COVID-19 in prisons and, particularly, the significance of Eighth Amendment jurisprudence for states' commitments to vaccinate incarcerated people. Finally, and based on these obligations, the Essay concludes with recommendations for the future. And the future is near.

I. BACKGROUND

A. THE EMERGENCE OF THE COVID-19 PANDEMIC

In early 2020, COVID-19, the acute respiratory syndrome disease caused by the novel coronavirus SARS-CoV-2, began to spread across the United States. By March, the World Health Organization (WHO) declared that the crisis had reached pandemic levels.¹³ COVID-19 is a highly contagious illness that targets the respiratory system, often causing pneumonia and other systemic reactions that can be fatal, especially for medically fragile or at-risk people.¹⁴ Some individuals who are infected with the virus remain asymptomatic, leading to high levels of community transmission and undetectable spread. This has led to an almost unprecedented challenge—both in prevention and treatment—for governments and public agencies across the globe.

12. Information is most often available about prisons, so that is the focus of this Essay. Of course, jails also present serious risks to incarcerated people and the staff who are charged with their care.

13. Tedros Adhanom Ghebreyesus, WHO Dir. Gen., Opening Remarks at the Mission Briefing on COVID-19 (Mar. 12, 2020) (transcript available at the World Health Organization).

14. David Baud, Xiaolong Qi, Karin Nielsen-Saines, Didier Musso, Léo Pomar & Guillaume Favre, *Real Estimates of Mortality Following COVID-19 Infection*, 20 LANCET INFECTIOUS DISEASES 773 (2020); Jennifer Beam Dowd, Liliana Andriano, David M. Brazel, Valentina Rotondi, Per Block, Xuejie Ding, Yan Liu & Melinda C. Mills, *Demographic Science Aids in Understanding the Spread and Fatality Rates of COVID-19*, 117 PROC. NAT'L ACAD. SCIS. U.S. AM. 9696, 9696–97 (2020).

In late 2020, two vaccines for COVID-19 were available in the United States. Produced by Moderna and Pfizer, these vaccines were both highly effective and required a series of two injections to reach peak efficacy. By July of 2021, another vaccine (produced by Johnson & Johnson) was made available despite its distribution having been previously halted,¹⁵ and over 186 million Americans received at least one injection.¹⁶ Despite this, for several months vaccine availability failed to keep pace with need and demand, leading to scarcity and the development of different policies in each state regarding how these issues should be addressed.

In this context, divisions emerged along both socioeconomic and racial lines.¹⁷ Of particular concern, Black Americans have been disproportionately affected. Some of this impact may be driven by social risk factors, including socioeconomic disadvantage, high-risk employment, medical mistrust, and medical comorbidities that are overrepresented within historically disadvantaged communities.¹⁸ These concerns and risk factors may also translate to skepticism concerning vaccination.¹⁹

B. COVID-19 DISTINCTIVELY IMPACTS INCARCERATED PEOPLE

An estimated twenty percent or one in every five incarcerated persons nationwide has been infected with COVID-19.²⁰ Incomplete testing programs and unclear aggregate data suggest that exposure rates are likely

15. *Different COVID-19 Vaccines*, CTNS. FOR DISEASE CONTROL & PREVENTION: COVID-19 (Mar. 4, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html> [https://perma.cc/7JL2-SC5X].

16. *Id.* *COVID-19 Vaccinations in the United States*, CTNS. FOR DISEASE CONTROL & PREVENTION: COVID DATA TRACKER, <https://covid.cdc.gov/covid-data-tracker/#vaccinations> [https://perma.cc/L65D-2GVM].

17. Lisa Bowleg, *We're Not All in This Together: On COVID-19, Intersectionality, and Structural Inequality*, 110 AM. J. PUB. HEALTH 917, 917 (2020).

18. See Elissa M. Abrams & Stanley J. Szefler, *COVID-19 and the Impact of Social Determinants of Health*, 8 LANCET RESPIRATORY MED. 659, 659–60 (2020) (describing how determinants such as poverty and physical environment can have a considerable effect on COVID-19 outcomes); Stephanie Leitch, J. Hope Corbin, Nikita Boston-Fisher, Christa Ayele, Peter Delobelle, Fungisai Gwanzura Ottemöller, Tulani Francis L. Matenga, Oliver Mweemba, Ann Pederson & Josette Wicker, *Black Lives Matter in Health Promotion: Moving from Unspoken to Outspoken*, HEALTH PROMOTION INT'L, Dec. 10 2020, at 1, 2–4 (describing the worse health outcomes that Black communities experience).

19. Laura M. Bogart, Bisola O. Ojikutu, Keshav Tyagi, David J. Klein, Matt G. Mutchler, Lu Dong, Sean J. Lawrence, Damone R. Thomas & Sarah Kellman, *COVID-19 Related Medical Mistrust, Health Impacts, and Potential Vaccine Hesitancy Among Black Americans Living with HIV*, 86 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 200, 200–01 (2021) (describing how systemic racism has created a sense of medical mistrust among minority communities and how it may play a role in COVID-19 inequities).

20. “By summer, infection rates in state and federal prisons dwarfed national rates by a ratio of 5.5 to 1, and, accounting for age, people in prison were dying at three times the rate of society as a whole.” Sharon Dolovich, *Mass Incarceration, Meet COVID-19*, U. CHI. L. REV. ONLINE (Nov. 16, 2020), <https://lawreviewblog.uchicago.edu/2020/11/16/covid-dolovich> [https://perma.cc/3NNP-P6SP].

higher.

As a population, incarcerated people are particularly susceptible to infection with COVID-19. In addition to the issues created by their physical environments, many people who are incarcerated have pre-existing health conditions that make them more vulnerable. As a result, incarcerated people are three times more likely to die of COVID-19.²¹ Additionally, prisons present a distinctive challenge concerning the health of incarcerated people. Often, the basic levels of healthcare provided are insufficient.²² For example, incarcerated populations have higher rates of mental illness, and many incarcerated individuals also have pervasive chronic diseases and histories of inconsistent medical treatment.²³ Trust in the medical system among the incarcerated population is generally low, often translating to noncompliance with treatment protocols and health-specific regulations.²⁴

The nature of the built environment and how space is used inside of prison compounds health-related challenges for all involved. Behind the walls of a jail, the high population density encourages the spread of disease.²⁵ It can be impossible to socially distance when almost everyone has a cellmate, eating is designed to be communal, and bathrooms and showers are shared, in some cases, by hundreds of people each day. Security restrictions offer another challenge as many medications are restricted, alcohol-based disinfectants are considered contraband, and access to laundry services is controlled.²⁶ This creates an ideal environment for the spread of many kinds

21. WANG ET AL., *supra* note 2, at 1 (noting that “an age-adjusted mortality rate that is three times that of the general population”); *see also* Dolovich, *supra* note 20.

22. John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J. L. & MED. 447, 447–78 (2005).

23. Andrew P. Wilper, Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor & David U. Himmelstein, *The Health and Health Care of US Prisoners: Results of a Nationwide Survey*, 99 AM. J. PUB. HEALTH 666, 669 (2009) (analyzing prevalence of chronic illness and access to health care among people incarcerated in the United States); Christopher Wildeman & Christopher Muller, *Mass Imprisonment and Inequality in Health and Family Life*, 8 ANN. REV. L. & SOC. SCI. 11, 18–19 (2012).

24. Pamela Valera, Javier F. Boyas, Camila Bernal, Victoria Briones Chiongbian, Yvonne Chang & Rachel C. Shelton, *A Validation of the Group-Based Medical Mistrust Scale in Formerly Incarcerated Black and Latino Men*, 12 AM. J. MEN’S HEALTH 844, 846–47 (2018); Erin M. Kerrison, *Exploring How Prison-Based Drug Rehabilitation Programming Shapes Racial Disparities in Substance Use Disorder Recovery*, 199 SOC. SCI. & MED. 140, 142–43 (2018).

25. Paul L. Simpson, Melanie Simpson, Armita Adily, Luke Grant & Tony Butler, *Prison Cell Spatial Density and Infectious and Communicable Diseases: A Systematic Review*, BMJ OPEN, July 23, 2019, at 1, 7–8 (summarizing the evidence on the association of prison cell spatial density and infectious disease transmission among prisoners); Paul L. Simpson & Tony G. Butler, *Covid-19, Prison Crowding, and Release Policies*, BMJ OPEN, Apr. 20, 2020, at 1.

26. Casey Tolan, *Hand sanitizer Is Still Considered Contraband in All Federal Prisons As Well As State Prisons in More Than a Dozen States*, CNN (May 5, 2020, 6:02 AM), <https://www.cnn.com/2020/05/05/us/coronavirus-prison-hand-sanitizer-contraband-invs/index.html> [<https://perma.cc/Q3HJ-9BC3>].

of disease, especially those that are airborne and highly communicable.²⁷

Infections in prisons also impact the communities that surround them. One study of the Cook County Jail in Chicago, for example, found that, early in the pandemic, individuals released from that facility were associated with 15.7% of all documented COVID-19 cases in the state and 15.9% of infections in the city.²⁸ Treating outbreaks in prisons can be a preventative measure that returns a benefit that extends well beyond the incarcerated community.

In preparation for vaccines availability, the NAS released a broad framework for vaccine distribution.²⁹ In recognition of the public health and ethical impact of vaccination strategy for incarcerated people, NAS recommended that incarcerated people should receive the vaccine *early* because they live in “congregate or overcrowded settings including . . . prisons, or jails.” These guidelines placed them in the second wave of vaccine administrations, alongside nursing home residents, but after frontline healthcare workers and other high-risk individuals. Since then, a range of protocols and guidelines for mitigation of the spread of the disease within prisons were developed, as well as plans for the eventual administration of COVID-19 vaccines to correctional populations.³⁰ As detailed below, state-level policies differed about how incarcerated people were to be treated. Such decisions have significant impacts on the health of incarcerated individuals—as well as the staff who manage the prisons in which they live.

C. CORRECTIONAL STAFF FACE NEW RISKS AND RESPONSIBILITIES

Prison staff face their own set of distinct hazards and, in turn, present a risk to both the incarcerated and unincarcerated communities with which they engage on a near-daily basis. While the challenges of violence and physical harm dominate most conversations about risks to correctional

27. *Id.*; K. D. Lucas, C. Wheeler, P. McLendon, B. N. Leistikow & J. C. Mohle-Boetani, *Outbreak of Legionnaires’ Disease Associated with Cooling Towers at a California State Prison, 2015*, 146 EPIDEMIOLOGY & INFECTION 297, 300–01 (2018); Charlotte Wheeler, Kimberley D. Lucas & Janet C. Mohle-Boetani, *Rates and Risk Factors for Coccidioidomycosis Among Prison Inmates, California, USA, 2011*, 21 EMERGING INFECTIOUS DISEASES 70, 70 (2015).

28. Eric Reinhart & Daniel L. Chen, *Incarceration and Its Disseminations: COVID-19 Pandemic Lessons from Chicago’s Cook County Jail*, 39 HEALTH AFFS. 1412, 1412 (2020) (examining how arrest and pretrial detention practices may be contributing to the study of COVID-19).

29. See generally NAT’L ACADEMIES OF SCIS., ENG’G & MED. & NAT’L ACAD. OF MED., *supra* note 9.

30. Don Hummer, *United States Bureau of Prisons’ Response to the COVID-19 Pandemic*, 15 VICTIMS & OFFENDERS 1262, 1265–67 (2020); Benjamin A. Barsky, Eric Reinhart, Paul Farmer & Salmaan Keshavjee, *Vaccination plus Decarceration — Stopping Covid-19 in Jails and Prisons*, 384 NEW ENG. J. MED. 1583, 1584 (2021).

officers,³¹ correctional officers, when prompted, report a high degree of concern about their level of exposure to infectious disease.³² This well-founded concern has undoubtedly been magnified and reinforced in the current environment.

Even before the pandemic, correctional officers faced a multitude of health challenges, although they are less often debated or well-documented. Correctional officers work in high-stress environments and, as a group, suffer from reduced life expectancy and high rates of PTSD.³³ Like the people they supervise, correctional staff cannot readily engage in social distancing and are in close contact with people in a congregate setting. For this reason, correctional officers are placed in a group, along with law enforcement, that falls just below healthcare workers concerning their risk of infection at work.³⁴

The risks of infection from correctional officers are not limited to their health. High rates of staff infection impact may also negatively impact the prison environment.³⁵ Infected correctional staff can affect life on the other side of the walls. When employees leave correctional facilities at the end of their shift, they return to their families, friends, and local businesses. Data have shown that, due to these movements, infections that happen in prison do not stay contained in those prisons.³⁶

Recognizing these factors, a Centers for Disease Control and Prevention (CDC) advisory board set out ethical principles to guide the allocation of treatment.³⁷ To maximize benefits and minimize harms, the CDC recommended that correctional staff be immunized in a category along with other frontline and essential workers. It is important to note that, unlike

31. Natalie Goulette, Andrew S. Denney & Matthew S. Crow, “Anything Can Happen at Any Time”: Perceived Causes of Correctional Officer Injuries, *CRIM. JUST. REV.*, Aug. 28, 2020, at 1, 5–12.

32. Deborah J. Hartley, Mario A. Davila, James W. Marquart & Janet L. Mullings, *Fear Is a Disease: The Impact of Fear and Exposure to Infectious Disease on Correctional Officer Job Stress and Satisfaction*, 38 *AM. J. CRIM. JUST.* 323, 326–28 (2013).

33. See, e.g., Dionne Hart, *Health Risks of Practicing Correctional Medicine*, 21 *AM. MED. ASS’N J. ETHICS* 540, 541 (2019) (noting, for example, that “34% of correctional officers suffer from posttraumatic stress disorder compared to 14% of military veterans” and that “the average life expectancy of a correctional officer is 59 years compared to the national average of 75 years”) (footnotes omitted).

34. Marissa G. Baker, Trevor K. Peckham & Noah S. Seixas, *Estimating the Burden of United States Workers Exposed to Infection or Disease: A Key Factor in Containing Risk of COVID-19 Infection*, *PLOS ONE*, Apr. 28, 2020, at 1, 4.

35. Steven L. Chanenson & Jordan M. Hyatt, *Protecting People Who Staff Our Prisons from COVID-19 Is Also Protecting Ourselves*, *PENNLIVE* (Dec. 20, 2020), <https://www.pennlive.com/opinion/2020/12/protecting-people-who-are-incarcerated-from-covid-19-is-also-protecting-ourselves-opinion.html> [<https://perma.cc/P86Y-6NTL>].

36. Chanenson & Hyatt, *supra* note 6.

37. See generally KATHLEEN DOOLING, *CTRS. FOR DISEASE CONTROL & PREVENTION, PHASED ALLOCATION OF COVID-19 VACCINES* (Dec. 20, 2020), <https://www.cdc.gov/vaccines/acip/meetings/downloads/slides-2020-12/slides-12-20/02-COVID-Dooling-508.pdf> [<https://perma.cc/A3ZC-NKQ3>].

the general suggestions made about the treatment of incarcerated people, the guidance for correctional staff was more concrete; they were to be included in “Phase 1B,” near the front of the line. This likely resulted in a different set of pressures on state-level policymakers as they determined how vaccines were to be allocated.

Moreover, correctional officers do not work in a vacuum, a simple fact with significant implications for disease transmission. Given the near-constant and unavoidable interaction between incarcerated people and correctional staff, the CDC recommended in January 2021 that governments “vaccinate staff and incarcerated/detained persons of correction or detention facilities *at the same time* because of their shared increase risk of disease.”³⁸ The CDC recognized that the pragmatic reality prisons experience trumped the ideological fragmentation that has characterized vaccination policy. Despite the inseparable health-related rationales, and as Part II below reveals, as of February 2021, a majority of states only adopted the recommendations for staff vaccinations and treated incarcerated people quite differently.

The stakes were high for everyone involved in the carceral system. One might have expected that the public health response would have been coordinated to maximize the power of vaccines, especially among the most vulnerable communities they oversee. The reality was quite different.

II. ANALYSIS OF STATE-LEVEL VACCINATION PLANS

For this Essay, we analyzed all the initial and updated reports submitted to the CDC and tracked any changes in the reports occurring until early February 2021, including through the official vaccination websites of each state.³⁹ We addressed three main questions:

38. *COVID-19 Vaccine FAQs in Correctional and Detention Centers*, CTRS. FOR DISEASE CONTROL & PREVENTION: COVID-19 (Feb. 21, 2021), <https://www.cdc.gov/coronavirus/2019-nCoV/community-correction-detention/vaccine-faqs.html> [<https://perma.cc/CBT8-G6YQ>].

39. The reports and the official documentation on public-facing websites were often vague. In these situations, we either assessed the responses based on the broader context of the published reports (for example, whether incarcerated people or correctional staff were completely overlooked) and other information provided by the state. In cases where these sources did not suffice, we sought out complementary data elsewhere, for example, news reports in which officials specifically addressed vaccination policies within prisons or vaccination strategies more broadly. See generally WANG ET AL., *supra* note 2; Katie Rose Quandt, *Incarcerated People and Corrections Staff Should Be Prioritized in COVID-19 Vaccination Plans*, PRISON POL’Y INITIATIVE (Dec. 8, 2020), <https://www.prisonpolicy.org/blog/2020/12/08/covid-vaccination-plans> [<https://perma.cc/MJJ5-W7D8>]. We also explored earlier reports about the state of COVID and vaccinations in prisons such as those published by The Marshall Project and the UCLA Law Covid-19 Behind Bars Data Project. *Our Reporting on the Coronavirus*, MARSHALL PROJECT, https://www.themarshallproject.org/coronavirus?gclid=CjwKCAjw47eFBhA9EiwAy8kzNCgOrBQ0yQ06CzbNg6MlsW8hh8rpDof832mMkoCm8oinof6nhsgOshoCX7IQAvD_BwE [<https://perma.cc/54VQ-YHD3>]; *UCLA Law Covid Behind Bars Data Project*, UCLA LAW COVID

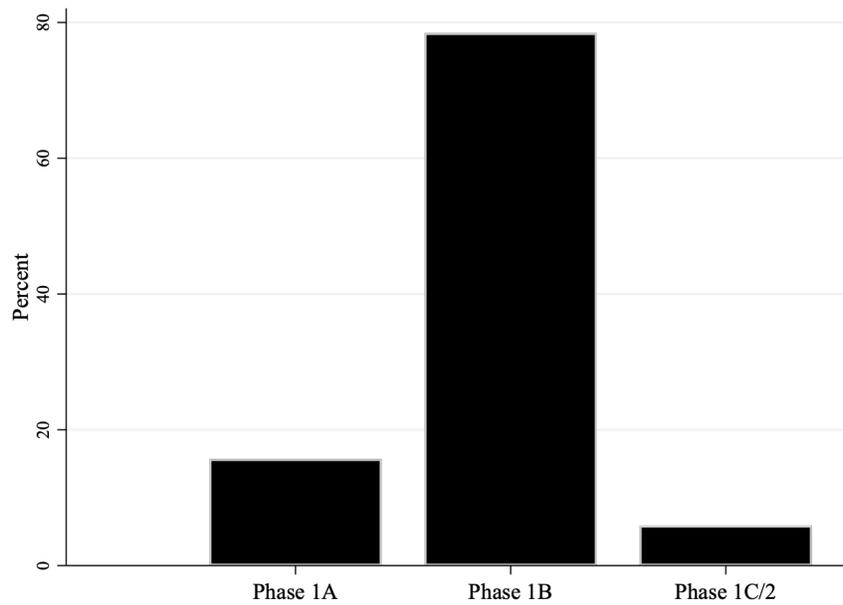
What was the status of vaccination efforts in each state in early February? That is, where the classification is appropriate, which phase was a state in?

What was the publicly available vaccination plan for incarcerated people and correctional facilities staff in each state?

What was the projected *timeline* for the vaccination of incarcerated people and correctional staff in each state?

Overall, we were able to gather and analyze some data from fifty-one distinct, state-level jurisdictions, including the District of Columbia.⁴⁰ Figure 1, below, displays the state of events as indicated by the “phase” in which states were. As the figure indicates, most states (nearly 80%) were in Phase 1B of their vaccination operations. There is nuance lost in these classifications; some states had just entered this phase, while others were more advanced. A very small number of states (less than 5%) had moved beyond Phase 1B.

FIGURE 1. Vaccination Phase (All States, February 2021)



BEHIND BARS DATA PROJECT, <https://uclacovidbehindbars.org> [<https://perma.cc/DM9Q-643J>].

40. See our data summarized *infra* Table 1 of the Appendix.

With that context in mind, we now move to assess the vaccination plans specifically for incarcerated people and correctional staff. Figure 2, below, displays the vaccination plan for the incarcerated population by state. As the figure indicates, most of the states at least *addressed* the issue of vaccinating people who live in prison in their plans. In many cases, neither the initial nor the updated plans overtly included such information. State officials, however, often addressed these issues separately in the media. By February 2021, five states' policies regarding the vaccination of incarcerated people remained unclear: Arkansas, Maine, Florida, Texas, and Kentucky.⁴¹ Based on contemporaneous media discussion, in most cases, we interpreted these trends as a signal for the deprioritization of the vaccination of incarcerated people.

The figure shows that jurisdictions rarely ranked incarcerated people as a group that was entitled to vaccination in the *first phase* (1A in most states).⁴² A small number of states, including California, Minnesota, and Utah, have included some incarcerated people either in their 1A or 1B phases, but they did so only for a small number of high-risk groups of incarcerated people, leaving most of the prison population in later phases (for example, Phase 1B (Tier 2) in California, but also unknown phases in states like Minnesota and Connecticut). These states comprise the group colored in blue in Figure 2 (categorized as “Phase 1A/1B + Later Phases”).⁴³ What is less clear, of course, is where within these large groups the incarcerated population were supposed to fall.

In general, around 25%–30% of states decided that incarcerated people would be vaccinated in Phases 1C or 2. A small number of states officially announced that incarcerated individuals would be vaccinated in Phases 3 or even later. However, recall that a few states (five) made no public decision about vaccinating incarcerated people, and a few more (six) decided to vaccinate only a small portion of the incarcerated population,⁴⁴ leaving the vaccination plan for the majority of that group publicly undecided.

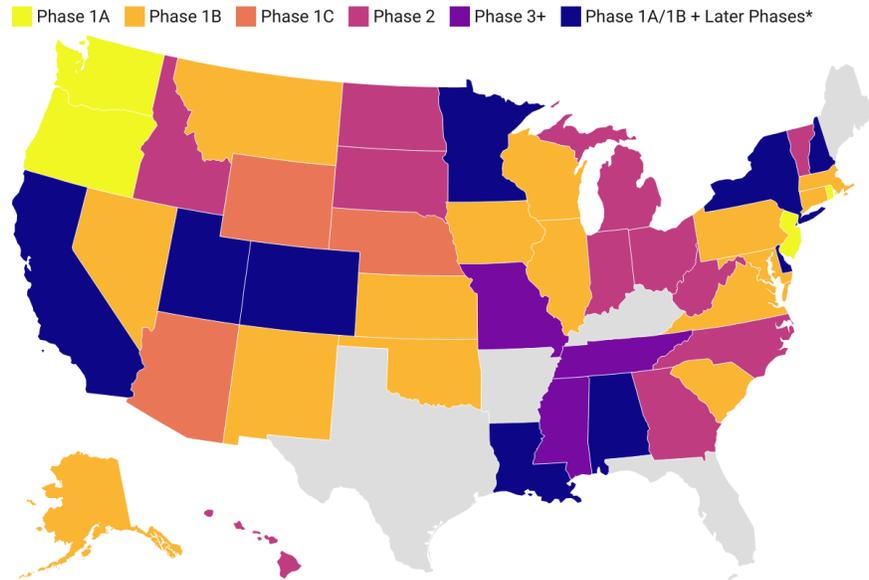
41. See *infra* Table 1 of the Appendix.

42. See *infra* Table 1 of the Appendix.

43. We also refer to these states as “Mixed Phases” jurisdictions.

44. See *infra* Table 1 of the Appendix.

FIGURE 2. Incarcerated People, Vaccination Phase by State



* We were unable to locate data about the vaccination plans of AR, FL, KY, ME, TX for incarcerated people.

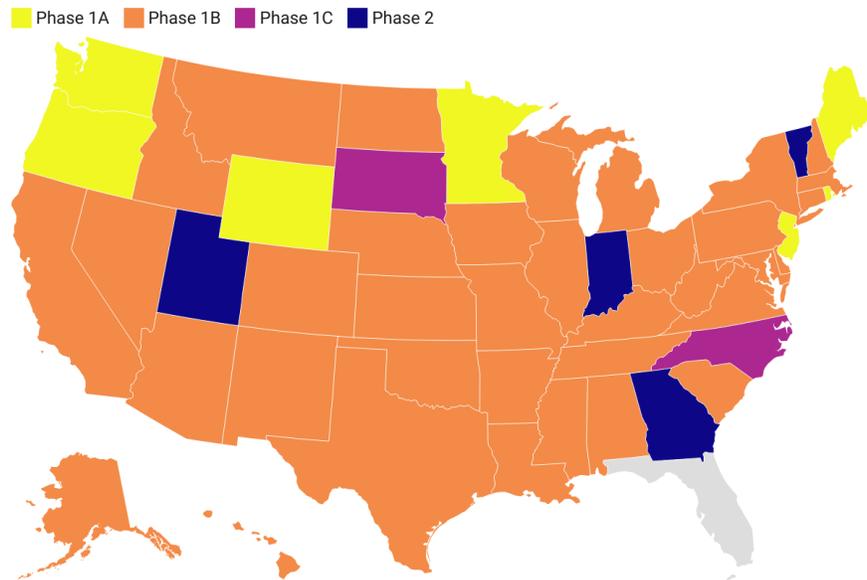
* In a number of states a small number of incarcerated people were categorized under Phase 1A or 1B (those considered "in risk" mostly due to age). The majority of those incarcerated, however, are projected to receive the vaccines later (Phase 2 or later).

Created with Datawrapper

We conducted a similar analysis of public policies and complementary documentation and media coverage regarding the vaccination of correctional staff. As Figure 3 below suggests, states were more likely to include information about correctional staff in their plans. In fact, except for Florida, we could find clear, public information about the prioritization of correctional staff in all states.⁴⁵ Figure 3 indicates that generally, states included correctional staff in the early stages of the vaccination plan; approximately 70% of the states included them under Phase 1B (thirty-seven states). This reflects a determination that correctional staff, along with healthcare workers and first responders, are on the front lines of the pandemic. Moreover, no states decided to vaccinate correctional staff later than Phase 2 (and only four states did so in that late of a phase).

45. See *infra* Table 1 of the Appendix.

FIGURE 3. Correctional Staff Vaccination Phase by State



* We were unable to locate data about Florida's vaccination plan for correctional staff.

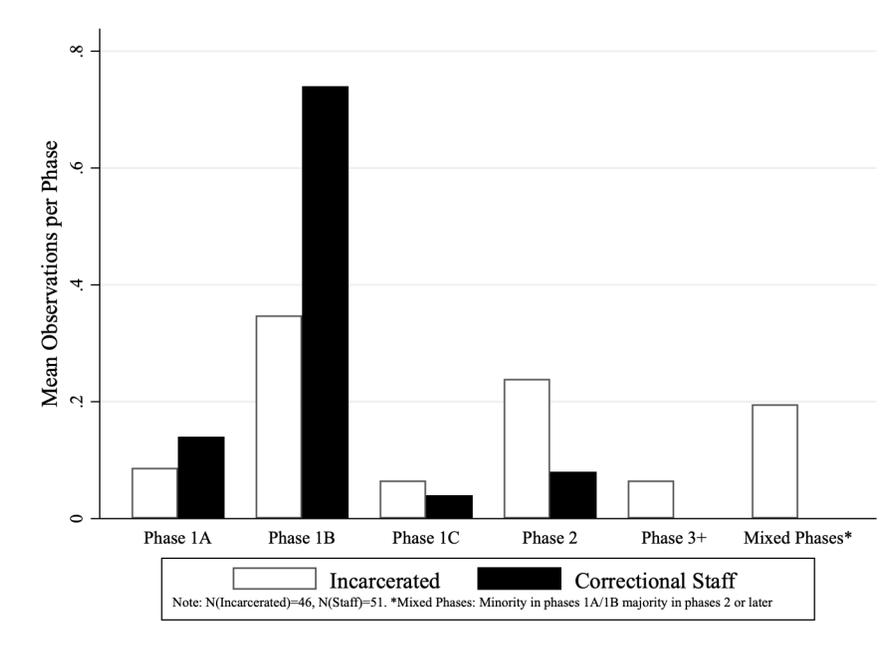
Created with Datawrapper

A visual inspection of Figure 3 provides a starkly different picture than the visualization of the status of those incarcerated. As Figure 2 indicated, merely one-third of the states categorized incarcerated people under Phase 1C or 2, and some states even categorized this group under later phases while failing to provide projected vaccination timelines. In contrast, the prioritization of staff is nearly uniform and well-communicated in official policy. Such a disparity in the treatment of both groups dramatically underscores the lack of consideration about the relative risks imposed on people who live, rather than work, in custodial settings.

To further emphasize the differences between states' policies regarding the vaccination of incarcerated people and correctional staff, we compared the overall number of states categorizing each group (the incarcerated population and correctional staff) under specific phases. Figure 4 below illustrates the differential treatment correctional staff and people living in prisons received. The majority of policies about correctional staff assigned them to be vaccinated in Phase 1B (72%), while less than 40% of those policies for incarcerated people categorized them in the same phase.

Moreover, Phase 2 is the latest phase to which correctional staff were assigned, while many incarcerated people were due for vaccinations in later phases; more than 40% of states placed incarcerated individuals in Phase 2 or later.

FIGURE 4. Incarcerated People and Correctional Staff Vaccination by Phase



These classifications are both inherently complex and oversimplify the implementation of vaccination policies behind prison walls. This is demonstrated by the data relating to the “mixed phases” jurisdictions. As mentioned, some states included a small number of incarcerated people who were at particularly high risk in Phase 1A; the majority of the incarcerated population were not practically eligible for some time afterward. For example, some states vaccinated older incarcerated people living in correctional nursing homes or long-term health facilities in early phases.⁴⁶

46. And see, for example, the policy adopted in Minnesota. Liz Sawyer, *For Some Minnesota Prisoners, Vaccine a Turning Point in Grueling Fight with COVID-19*, STAR TRIB. (Jan. 5, 2021, 5:06 AM), <https://www.startribune.com/for-some-minnesota-prisoners-vaccine-a-turning-point-in-grueling-fight-with-covid-19/600006785> [<https://perma.cc/4KEQ-X9RR>]. See also Samantha Melamed, *COVID-19 Outbreak Infects More Than Half of Inmates at Pa. Prison for Elderly and Infirm*, PHILA. INQUIRER (Dec. 2, 2020), <https://fusion.inquirer.com/news/pennsylvania-doc-covid-outbreak-sci-laurel-highlands->

Accordingly, an “early vaccinating” state may only be early vaccinating with respect to a small fraction of the incarcerated people in that state. As such, we consider Mixed Phases jurisdictions separately under the assumption that the majority of those people who are incarcerated in those states were eligible to be vaccinated in later phases.

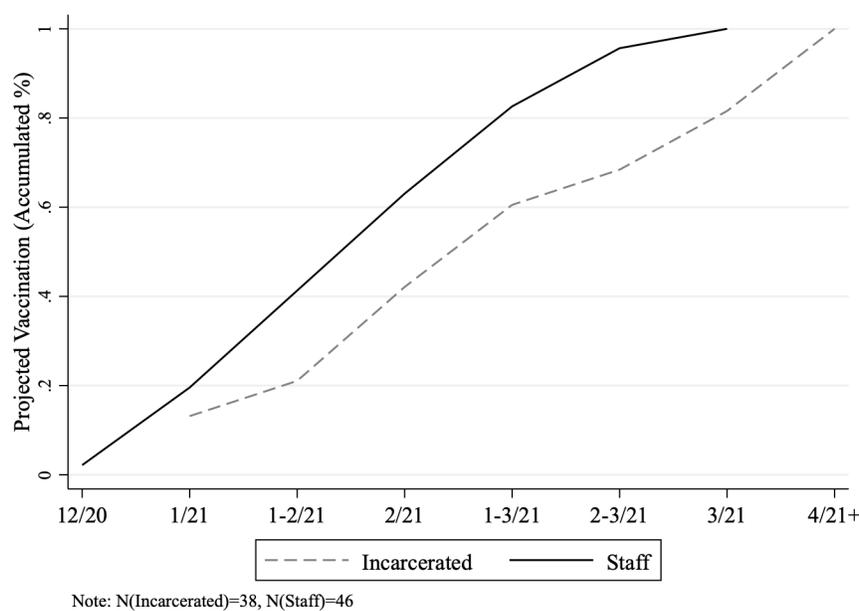
This differential treatment also materializes in the projected timelines for vaccinating incarcerated people and correctional staff. As Figure 5 illustrates, most states projected that the majority (more than 60%) of their correctional staff would be vaccinated by February and 100% by March. On the contrary, only 40% of the states indicated that those people who are incarcerated were projected to be vaccinated by February, and more than 20% of the states’ incarcerated population vaccination delivery were likely to proceed well into April. Moreover, the data about the projected time for correctional staff vaccinations were much more comprehensive and were overtly included in the available policies in forty-six states, while the information about the projected time for the vaccination of incarcerated population included only thirty-six states.⁴⁷ A reasonable conclusion as of February 2021, therefore, was that in the majority of those unknown states, people living in prisons were not a priority and were unlikely to be completely vaccinated until the very last wave of people eligible for vaccination.⁴⁸

somerset-20201202.html [https://perma.cc/ZH9U-N5Y6].

47. *Id.*

48. We also tried to assess whether state departments of corrections (DOC) were involved in the formation of vaccination policies, which was difficult to assess from the publicly available data. Only twelve states (23.5%) directly indicated that they consulted with the DOC. This does not necessarily mean that other states failed to consult with their DOCs. We do know, that at least in Florida, there was some consultation with the DOC, and that it applied for vaccination. It remained unclear, however, what the Florida DOC requested in its application, and the DOC did not respond to follow up questions in that regard. Grace Toohey, *Florida Among Few States with No Known Vaccine Plan for Prisons*, ORLANDO SENTINEL (Dec. 18, 2020, 5:30 AM), <https://www.orlandosentinel.com/coronavirus/os-ne-coronavirus-florida-prisons-unsure-receive-vaccine-20201218-543hoak2cvg3nagxdym34rcsq-story.html> [https://perma.cc/7EBE-HRWG]. This is particularly concerning in Florida, which seems to be the only remaining state that as of February did not adopt a vaccination plan for either the incarcerated population or correctional staff.

FIGURE 5. Projected Vaccination by Group



III. CONSTITUTIONAL AND MORAL OBLIGATIONS SHOULD PREVAIL

The varied approaches to vaccine distribution were sometimes tied to the recommendations of public health officials. Other times, they appeared responsive to other, less evidence-based concerns. Notably, Colorado Governor Jared Polis lashed out against the prospect of incarcerated individuals receiving vaccine priority. His position was described as: “[N]o prisoners would be prioritized to get vaccinated before the free seniors or people with coronavirus-related health risks. ‘There’s no way it’s going to go to prisoners,’ [Governor Polis] chuckled, ‘before it goes to people who haven’t committed any crime. That’s obvious.’”⁴⁹ Shortly thereafter, he indicated that “Colorado’s public health department will deprioritize prisoners when it finalizes its vaccination plan. (Prisoners over [sixty-five], however, would likely be vaccinated around the same time as free adults of the same age.)”⁵⁰

This embarrassing vignette—and others like it⁵¹—reveals a lack of

49. Pauly, *supra* note 5.

50. *Id.*

51. See, e.g., John Hanna, *GOP Moves to Condemn Early COVID-19 Shots for Kansas Inmates*,

focus on the *obligations* that governments have to incarcerated people, correctional staff, and the broader community. These responsibilities cannot be set aside during a public health emergency, even one as broad as the COVID-19 pandemic. The very nature of these obligations should encourage states to proactively address the crisis in prisons, perhaps even before they look to solve those same issues within the community at large. Our data suggest that for the most part, that was not the road taken.

We argue that governments—and the society they represent—have both a constitutional and a moral obligation to take care of people they choose to incarcerate. That includes providing vaccines within the prison walls to protect people from the risks associated with COVID-19.⁵² There are no constitutional exceptions for public health crises. The basic nature of this obligation lies in well-settled Eighth Amendment law. As the U.S. Supreme Court wrote in *Estelle v. Gamble* decades ago, “[i]t is but just that the public be required to care for the prisoner, who cannot by reason of the deprivation of his liberty, care for himself. . . . We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain . . . proscribed by the Eighth Amendment.”⁵³ The deliberate indifference standard must be evaluated based on “evolving standards of decency.”⁵⁴ The Court later held that “[i]t would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.”⁵⁵

Thus far, the concept of deliberate indifferences, as adopted in *Estelle*, has posed challenges for incarcerated people seeking relief because of COVID-19.⁵⁶ Earlier in the pandemic, courts rejected habeas petitions seeking preliminary injunctions and releases from various carceral institutions because of a heightened risk from COVID-19. Those claims failed in large part because the prison officials could not fairly be characterized as acting with “deliberate indifference.”⁵⁷ After all, most

ASSOCIATED PRESS (Feb. 2, 2021), <https://apnews.com/article/kansas-topeka-coronavirus-pandemic-prisons-798091c0b348be9d7b0ac0beb0b40aa1> [<https://perma.cc/V7US-E6CU>] (“Republican lawmakers in Kansas on Tuesday moved toward formally condemning Democratic Gov. Laura Kelly’s decision to give prison inmates COVID-19 vaccinations ahead of others . . .”).

52. *Cf. Estelle v. Gamble*, 429 U.S. 97, 103 (1976) (detailing the government’s “obligation to provide medical care for those whom it is punishing by incarceration”).

53. *Id.* at 104.

54. *Id.* at 106 (quotation and citations omitted).

55. *Helling v. McKinney*, 509 U.S. 25, 33 (1993).

56. *See, e.g., Lee Kovarsky, Pandemics, Risks, and Remedies*, 106 VA. L. REV. ONLINE 71, 77–80 (2020).

57. *See, e.g., Wilson v. Williams*, 961 F.3d 829, 840 (6th Cir. 2020); *Swain v. Junior*, 961 F.3d 1276, 1287 (11th Cir. 2020). *See generally* Brandon L. Garrett & Lee Kovarsky, *Viral Injustice*, 109 CAL.

prison administrators were working to develop policies that followed public health recommendations about face masks, screenings, and cleaning, even if they could not achieve social distance goals. The complete mitigation of risk was not necessary, even when adherence to protective regulations was lax and deference was given to the needs of the secure environment. A divided panel of the Eleventh Circuit stated, “We simply cannot conclude that, when faced with a perfect storm of a contagious virus and the space constraints inherent in a correctional facility, the defendants here acted unreasonably by ‘doing their best.’ Because the defendants ‘act[ed] reasonably,’ they ‘cannot be found liable’ under the Eighth Amendment.”⁵⁸

The arrival of vaccines may have changed this calculation. First, unlike previous habeas cases, the distribution of the vaccines did not require taking any dramatic steps, such as an immediate release of incarcerated people. Instead, it called for an even-handed allocation of resources based on scientific justifications and the risk factors recognized by health experts, such as the NAS. Although potentially challenging in some states, these hurdles should not have stood in the way of equitable and data-driven allocation of medical treatments. Second, the commitment to vaccinate those living in prisons goes beyond the work of specific prison administrators “doing their best.” Instead, it required states to recognize the vulnerability of this group and treat these individuals like other members of society. If the NAS and the states decided that residents in “congregate settings” deserve a special duty of care, decisions to exclude incarcerated people from such a group could hardly be considered “doing their best.”⁵⁹ Having a criminal conviction is irrelevant when the determination is made based on living conditions and risk of infection. If states were aware of the risk to those incarcerated in congregate settings because of COVID-19 but decided not to reduce that risk by providing vaccinations in the same way they do for similarly situated non-incarcerated people, we argue this is an Eighth Amendment violation.

Simply put, providing an existing solution to those in custody based on health recommendations is the path that respects both human dignity and moral obligation. This argument is, in fact, even stronger in states that prioritized correctional staff but not the incarcerated population. By prioritizing staff, the authorities demonstrated they were aware of the distinctive and dangerous situation within prison walls. By simultaneously

L. REV. (forthcoming 2021) (manuscript at 46–52) (on file with authors) (discussing the different ways in which courts shrank constitutional rights using the “deliberate indifference” standard during COVID-related litigation).

58. *Swain*, 961 F.3d at 1289 (quoting *Farmer v. Brennan*, 511 U.S. 825, 845 (1994)).

59. *Id.*

failing to prioritize incarcerated people facing the same risks, those authorities demonstrated that they are unconstitutionally deliberately indifferent to the lives of the people in their charge.

One recent case seems to follow the path we adopt here. In *Maney v. Brown*, an incarcerated class of plaintiffs in Oregon claimed that the government's "failure to provide them with the COVID-19 vaccine violates their Eighth Amendment right to reasonable protection from severe illness or death."⁶⁰ The court looked beyond the fact that vaccines were in short supply. Rather, it examined how the government was treating similarly situated individuals.

[T]he Court need not address whether it was reasonable for Defendants to prioritize other, unrelated groups before Plaintiffs. Rather, the Court need only address the more narrow question of whether prioritizing those living and working in congregate care settings and those working in correctional settings in Phase 1A, Group 2, without also prioritizing [adults in custody (AIC)] in the same group, demonstrates deliberate indifference to the AICs' health or safety.⁶¹

The court focused on this disparate governmental treatment of putting incarcerated people lower on the priority list for no valid medical reason. The court stated as follows:

Simply put, Defendants are well aware of the risks of serious harm to both correctional staff and AICs and have chosen to protect only the staff. This inaction indicates deliberate indifference to a substantial risk of serious harm. . . .

By prioritizing those working in correctional settings over AICs living in correctional settings, and by prioritizing those living and working in other congregate care settings over AICs living in a congregate care setting, Defendants have demonstrated deliberate indifference to the serious risk of harm faced by AICs.⁶²

This highlights that the Constitution mandates fair treatment for both incarcerated people and correctional staff based on health-related considerations.⁶³ How and when to vaccinate people who live and work

60. *Maney v. Brown*, No. 6:20-CV-00570-SB, 2021 U.S. Dist. LEXIS 19665, at *28 (D. Or. Feb. 2, 2021).

61. *Id.* at *34–35.

62. *Id.* at *37–41.

63. See also Amanda Fries, *Hours After Lawsuit Filed, New York Announces Plan to Vaccinate Inmates 65 and Older*, TIMES UNION (Feb. 4, 2021, 5:54 PM), <https://www.timesunion.com/news/article/Cuomo-Zucker-sued-over-failure-to-prioritize-15924625.php> [<https://perma.cc/F6Z3-SRRC>] (discussing an action to vaccinate incarcerated people, based on Fourteenth Amendment claims, that appears to have prompted a quick, if incomplete, response). Recently, the New York Supreme Court (Bronx County) followed the same path by ordering the state of New York to make vaccines available to people in custody, just as vaccines had been made available to people in every other state-run congregate

behind bars is not, or at least should not be, about whether a policy is deemed “soft on crime” or politically inconvenient. The determinations that underlie the obligation are not context-specific. These are issues of basic human dignity and constitutional mandates. The U.S. Supreme Court, in *Farmer v. Brennan*, underscored this important point this way: “[H]aving stripped [incarcerated people] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course.”⁶⁴

The moral argument for vaccinating incarcerated people is even simpler and undergirds the constitutional case. The health risks that face incarcerated populations translate to similar exposure to correctional staff and, in turn, their homes and communities; this is a two-way street, with incarcerated people bearing the risk of staff behaviors as well. “[T]here is no such thing as a ‘perfect’ prison system, but this does not relieve [governments] of their duty to make their system[s] . . . constitutional one[s] in which the human dignity of each individual inmate is respected.”⁶⁵

As a society, we took away liberty from incarcerated people after due process and through an established system of punishment. We prevented them from being able to care for themselves and have accepted the responsibility for their basic well-being. That is now our collective responsibility. The challenges imposed by COVID-19 have disproportionately affected the prison population. Initially, the solutions were few and far between. The vaccines offered a new path forward and an opportunity to recommit to our moral standards. The allocation of these solutions should have been non-punitive, equitable, and deployed in a way that ameliorates burdens, not in a way that exacerbates existing harms, undermines dignity, or perpetuates inequity. More often than not we opted for the latter, failing to live up to our obligations to incarcerated individuals.

CONCLUSION

Reasonable minds can differ as to the relative order of groups receiving a vaccine. People who live and work in prisons should be treated at least as well as similarly situated people outside of prisons. A good analogy for prisons is to long-term care facilities in the community, often recognized by

setting) (*Holden and Frias v. Zucker and Cuomo*, unpublished 3/29/2021). Following that decision, Governor Cuomo announced that all incarcerated people in the state of New York will become eligible for vaccination. Troy Closson, *New York Must Offer Vaccine to All Prisoners Immediately, Judge Rules*, N.Y. TIMES (Apr. 5, 2021), <https://www.nytimes.com/2021/03/29/nyregion/covid-vaccine-new-york-prisons.html> [<https://perma.cc/GN2R-RVCB>].

64. *Farmer v. Brennan*, 511 U.S. 825, 833 (1994) (quotations and citations omitted).

65. *Finney v. Ark. Bd. of Corr.*, 505 F.2d 194, 200 (8th Cir. 1974) (footnote omitted).

states as people living in a form of a congregate setting. The residents of both types of institutions are not free to leave and are cared for by people who move in and out of that otherwise closed environment. The United States has failed to act on this stark equivalence.⁶⁶ The key is to consider the scientific, public health advice (as opposed to political calculation) for the population at large and apply it equally and in recognition of society's constitutional and moral obligations.

The current improvement in access to vaccinations should not mislead us to believe the issue is of no concern. First, COVID-19 is unlikely to fully disappear in the foreseeable future. The virus is likely endemic.⁶⁷ Moreover, it is mutating and as the new increase in cases with the spread of the Delta variant reveals, it poses challenges for vaccine makers striving to avoid future outbreaks.⁶⁸ Indeed, it is uncertain whether and when another wave of vaccinations will be required to fend off the virus. In other words, we will face the problem of vaccine allocation again, either with this disease or a new form of infectious contagion. Second, viewed as a stress test for the criminal justice system, and as illustrated by our data, the COVID-19 vaccine process goes beyond these specific circumstances and has highlighted deep fissures in our body politic. As a society, we cannot seem to look beyond the punishment for crimes committed, nor do we accept fully our responsibility for the well-being of incarcerated individuals and those hired to care for them. Third, we, as a society, will one day confront another virulent pandemic or public health crisis. The errors and oversights within our response to COVID-19 should serve as a foundation for the creation of public health policies that will not overlook people who are incarcerated.

We far too often still struggle to think about prisons. Justice William J. Brennan, Jr. neatly framed the problem almost thirty-five years ago: "Prisoners are persons whom most of us would rather not think about. Banished from everyday sight, they exist in a shadow world that only dimly enters our awareness."⁶⁹ But public policy cannot remain disinterested, especially in light of the immediate threats to the health and well-being of incarcerated individuals during the COVID-19 pandemic. After all, it was

66. See, e.g., WANG ET AL., *supra* note 2, at 2 ("Unlike in nursing homes and other long-term care facilities, which are also sources of outbreaks, prisons and jails are not consistently being prioritized for vaccine distribution . . .").

67. Sam Meredith, *Doctors Warn That Covid Will Become Endemic and People Need to Learn to Live with It*, CNBC (Feb. 12, 2021, 6:23 PM), <https://www.cnbc.com/2021/02/12/doctors-warn-covid-will-become-endemic-and-people-need-to-learn-to-live-with-it.html> [<https://perma.cc/CG8L-SZB5>].

68. Alice Park, *The COVID-19 Virus Is Mutating. What Does That Mean for Vaccines?*, TIME (Jan. 7, 2021, 2:17 PM), <https://time.com/5927538/covid-19-mutations-vaccines> [<https://perma.cc/T8Q6-MSL6>].

69. *O'Lone v. Estate of Shabazz*, 482 U.S. 342, 354 (1987) (Brennan, J., dissenting).

Justice Anthony M. Kennedy who scolded the American Bar Association in 2003 for just that sort of apathy. He could have been talking about vaccination policy when he said that these issues are “the concern and responsibility of every member of our profession and of every citizen. This is your justice system; these are your prisons.”⁷⁰

70. Anthony M. Kennedy, U.S. Sup. Ct. Assoc. Just., Speech Delivered by Justice Anthony M. Kennedy at the American Bar Association Annual Meeting (Aug. 9, 2003), *in* 16 FED. SENT’G REP., Dec. 2003, at 126, 126.

APPENDIX

TABLE 1. Summary of Data (by State) as of February 2021

<i>State</i>	<i>Inmate Phase as of 2/21</i>	<i>Staff Phase as of 2/21</i>	<i>Inmate projected time as of 2/21⁷¹</i>	<i>Staff projected time as of 2/21</i>	<i>Phase in 2/21</i>
Alabama	Mixed Phases	1B	2/21	2/21	1B
Alaska	1B	1B	2/21	2/21	1B
Arizona	1C	1B	3/21	1/21	1B
Arkansas	.	1B	.	1-3/21	1B
California	Mixed Phases	1B	1-2/21	1-2/21	1B
Colorado	Mixed Phases	1B	1/21	1/21	1B
Connecticut	1B	1B	1-2/21	1-2/21	1B
Delaware	Mixed Phases	1B	1/21	1/21	1B
D.C.	1B	1B	.	.	1B
Florida	1A
Georgia	2	2	.	.	1A
Hawaii	2	1B	.	1-2/21	1B
Idaho	2	1B	.	1/21	1B
Illinois	1B	1B	2/21	2/21	1B
Indiana	2	2	.	.	1B
Iowa	1B	1B	2/21	2/21	1B
Kansas	1B	1B	1-3/21	1-3/21	1B
Kentucky	.	1B	.	1-2/21	1B
Louisiana	Mixed Phases	1B	1/21	1/21	1B
Maine	.	1A	.	12/20	1B
Maryland	1B	1B	1-3/21	1-3/21	1C
Massachusetts	1B	1B	1-3/21	2/21	1B
Minnesota	Mixed Phases	1A	.	1/21	1B
Michigan	2	1B	4/21+	1-2/21	1C
Mississippi	3+	1B	3/21	1-2/21	1A

71. In Mixed Phases states, the date refers to the small group of early vaccinated incarcerated individuals.

Missouri	3+	1B	4/21+	2/21	1B
Montana	1B	1B	1-3/21	1-3/21	1B
Nebraska	1C	1B	4/21+	2-3/21	1B
Nevada	1B	1B	2-3/21	2-3/21	1A
New Hampshire	Mixed Phases	1B	2/21	2/21	1B
New Jersey	1A	1A	1/21	1/21	1B
New Mexico	1B	1B	1/21	1/21	1B
New York	Mixed Phases	1B	1-2/21	1-2/21	1B
North Carolina	2	1C	3/21	2-3/21	1B
North Dakota	2	1B	.	1-2/21	1B
Ohio	2	2	.	1-2/21	2
Oklahoma	1B	2	2/21	2/21	2
Oregon	1A ⁷²	1	2/21	2/21	1
Pennsylvania	1B	2	1-3/21	1-3/21	1
Rhode Island	1A	1	1-3/21	1-3/21	2
South Carolina	1B	2	3/21	3/21	1
South Dakota	2	3	2-3/21	1-3/21	3
Tennessee	3+	2	4/21+	1-3/21	2
Texas	.	2	4/21+	2-3/21	2
Utah	Mixed Phases	4	1-3/21	2-3/21	2
Vermont	2	4	.	.	2
Virginia	1B	2	2-3/21	2-3/21	2
Washington	1A	1	3/21	3/21	2
West Virginia	2	2	4/21+	1-3/21	2
Wisconsin	1B	2	2/21	2/21	2
Wyoming	1C	1	4/21+	1-2/21	1

72. The inclusion of incarcerated people in Phase 1A came after the decision in *Maney v. Brown* (*supra* note 61). And see also: Tess Riski, *Judge Rules That Oregon inmates Must Receive COVID-19 Vaccines "As Soon As Possible"*, (WILLAMETTE WEEK, Feb 3, 2021) <https://www.wweek.com/news/courts/2021/02/03/judge-rules-that-oregon-inmates-must-receive-covid-19-vaccines-as-soon-as-possible/#:~:text=The%20order%20is%20in%20a,Brown.&text=For%20these%20reasons%2C%20the%20Court,%5D%20as%20soon%20as%20possible.%22>

