No. 19-1158

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

In re: American Federation of Labor and Congress of Industrial Organizations

Petitioner.

Occupational Safety and Health Administration, United States Department of Labor

Respondent.

EMERGENCY PETITION FOR A WRIT OF MANDAMUS, AND REQUEST FOR EXPEDITED BRIEFING AND DISPOSITION

Pursuant to Federal Rule of Appellate Procedure and Circuit Rule 21, and in accordance with *Telecomm. Research & Action Ctr. v. FCC* ("*TRAC*"), 750 F.2d 70 (D.C. Cir. 1984), and its progeny, Petitioner American Federation of Labor and Congress of Industrial Organizations ("AFL-CIO") hereby petitions this Court to issue a writ of mandamus under the All Writs Act, 28 U.S.C. § 1651(a), compelling Respondent Occupational Safety and Health Administration, United States Department of Labor ("OSHA") to issue—within thirty (30) days of this Court's grant of the writ—an Emergency Temporary Standard for Infectious Diseases ("ETS") aimed at protecting the life and health of millions of workers

throughout the United States in grave danger from the deadly COVID-19 pandemic. Given the urgency of the situation confronting workers in the United States, especially those classified as "essential" workers and thus currently at work as well as those workers being called back to work as government-imposed stay-at-home orders are lifted, the AFL-CIO further requests that this Court provide for expedited briefing and disposition of the petition. With respect to the briefing, the AFL-CIO proposes that OSHA be given ten (10) days to respond to the petition and that the AFL-CIO be given two (2) days to reply to OSHA's response.

INTRODUCTION

Under section 6(c) of the Occupational Safety & Health Act of 1970 ("the OSH Act"), OSHA "*shall* provide . . . for an emergency temporary standard to take immediate effect upon publication in the Federal Register if [it] determines (A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards, and (B) that such emergency standard is necessary to protect employees from such danger." 29 U.S.C. § 655(c)(1) (emphasis added).

The COVID-19 global pandemic caused by the novel coronavirus has produced exactly the type of workplace catastrophe that Congress intended an emergency temporary standard to address. While the numbers change daily, as of this writing, more than 1.4 million people in the United States have tested positive

for COVID-19, and more than 87,000 people in the United States have died from the disease. Many more likely have the disease but have not been tested; many others likely died of the disease but have not been counted. A significant portion of those infected and dying from COVID-19 are classified as "essential" workers—health care providers, nursing home aides, bus drivers and other transit workers, fire fighters and other first responders, grocery store workers, and employees in meatpacking plants and correctional facilities. Many of these workers certainly have been infected at work either because their work requires exposure to infected persons, *e.g.*, nurses and corrections officers, or because their work requires repeated exposure to large numbers of coworkers and members of the general public, *e.g.*, grocery store clerks. As the economy reopens and more workers return to work, person-to-person contact in the workplace will increase and health experts predict that the already shocking number of infections and deaths among workers will get worse.

On March 6, 2020, the AFL-CIO and other unions (collectively, "the Unions") petitioned OSHA to issue an ETS under section 6(c) of the OSH Act "to protect working people from occupational exposure to infectious diseases, including COVID-19." *See* Addendum, Tab 3, at 1. Another union affiliated with the AFL-CIO, National Nurses United ("NNU"), filed a separate but parallel

petition on March 4 seeking an ETS specifically protecting nurses. *See id.*, Tab 4.[1] Both petitions were based on the "chilling yet realistic possibility of a coronavirus pandemic and the potential for a catastrophic toll in mortality and morbidity," *id.*, Tab 3 at 2, and both asked OSHA to take immediate action to protect workers from this grave threat. Both also argued forcefully that in the face of an impending pandemic, OSHA's evolving voluntary guidance to the employer community was no substitute for the immediate imposition of mandatory, legally-enforceable, COVID-19-specific duties on employers to protect workers from this grave danger. *Id.*, Tab 3 at 6; Tab 4 at 7.

COVID-19's toll in mortality and morbidity among workers and the general public has exceeded the expectations of many prognosticators. Yet in a stunning act of agency nonfeasance in the midst of a workplace health emergency of a magnitude not seen in this country for over a century (if ever), OSHA has neither

[1] Indeed, the AFL-CIO together with its affiliates the American Federation of State, County and Municipal Employees; the American Federation of Teachers; the Communications Workers of America; the International Association of Firefighters; the Laborers International Union; the United Automobile Workers; and the United Steelworkers, as well as the Service Employees International Union, filed a petition with OSHA in 2009 seeking a permanent standard governing occupational exposure to infectious diseases. Even earlier, in 2005, unions petitioned OSHA to issue an emergency temporary standard addressing pandemic influenza (2005). Those petitions, and the threat of infectious disease pandemics such as SARS, West Nile virus, Lyme disease, zoonotic influenza and Ebola, led OSHA to initiate a rulemaking on infectious diseases that OSHA has never completed. *See infra* pp. 29-30.

responded directly to, nor taken formal action on, either of the two pending ETS petitions, nor has it shown any inclination to adopt mandatory, legally-enforceable, COVID-19-specific rules to protect workers.[2]

This Court has made clear that OSHA has a degree of discretion in determining whether the two statutory requirements for issuance of an ETS—"whether 'employees are exposed to grave danger' and whether an emergency standard is 'necessary' to protect them from such danger"—have been satisfied. *In re Int'l Chem. Workers Union*, 830 F.2d 369, 371 (D.C. Cir. 1987) (quoting 29 U.S.C. § 655(c)); *accord Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, 1155-56 (D. C. Cir. 1983). But this Court has made it equally clear that OSHA's discretion is *not* unlimited.

We submit that in the face of a global health emergency causing more deaths in less time than any other workplace crisis OSHA has faced in its fifty-year existence, OSHA's refusal to issue an ETS constitutes an abuse of agency discretion so blatant and of "such magnitude" as to amount to a clear "abdication of statutory responsibility." *Pub. Citizen Health Research Grp. v. Comm'r, Food & Drug Admin. ("FDA"),* 740 F.2d 21, 32 (D.C. Cir. 1984). That is so because,

[2] We say "respond directly" because, in an April 30, 2020 letter from the Secretary of Labor Eugene Scalia to the AFL-CIO President Richard Trumka, the Secretary defended the adequacy of OSHA's voluntary guidance and, in the process, made it clear that OSHA has no intention of issuing the ETS requested by the Unions. *See infra* pp. 8-9.

based on what is known about COVID-19 and its anticipated impact in the next few months, the statutory requirements for issuance of an ETS undeniably are satisfied here. Indeed, for the reasons set out *infra* pp. 12-27, the grave danger to workers from the COVID-19 pandemic and the necessity of an ETS adequately to protect workers from that danger could hardly be clearer. Moreover, there is an urgent need for an ETS without further delay because many states and localities have already begun the process of allowing businesses within their jurisdictions to reopen while others are coming under enormous pressure to do so—a reopening process that will expose millions more workers to grave danger to their life and health if OSHA fails to issue an ETS.

When, as here, "agency recalcitrance is in the face of a clear statutory duty or is of such magnitude that it amounts to an abdication of statutory responsibility, the court has the power to order the agency to act to carry out its substantive statutory mandates." *Pub. Citizen Health Research Grp. v. FDA*, 740 F.2d at 32. This Court should exercise that power here.

REASONS FOR GRANTING THE WRIT

I. THIS COURT HAS EXCLUSIVE JURISDICTION TO REVIEW OSHA'S REFUSAL TO ISSUE AN ETS

It is settled law in this Circuit that the federal appellate courts have "exclusive jurisdiction to review OSHA's refusal to issue an ETS pursuant to 29 U.S.C. § 655(c)." *In re Int'l Chem. Workers Union*, *supra*, 830 F.2d at 372 n.2 (citing *TRAC*, *supra*, 750 F.2d 70). As this Court explained in *TRAC*, when judicial review of a particular agency action *if taken* is committed by statute to the courts of appeals—as it would have been had OSHA issued an ETS, *see* 29 U.S.C. § 655(f)—the appellate courts also have exclusive jurisdiction under the All Writs Act to consider a claim that the agency has "unlawfully withheld or unreasonably delayed" that action and to "compel" the agency to take the action that the law requires. *See TRAC*, 750 F.2d at 75-77. Because the essence of the AFL-CIO's claim here is that OSHA has "unlawfully withheld" the issuance of an ETS and should be "compel[led]" to issue one, that claim plainly lies within this Court's exclusive jurisdiction. *See also Int'l Union, UAW v. Donovan,* 756 F.2d 162, 163 (D.C. Cir. 1985).

OSHA's failure to respond to the Unions' petition for an ETS has effectively denied that petition and certainly "unreasonably delayed" the statutorily mandated action. As a result, judicial review now is proper. This Court has made it clear that when agency delay under "'exigent circumstances render[s] it equivalent to a

final denial of petitioners' request,' . . . the court can undertake review as though the agency had denied the requested relief and can order [the] agency to either act or provide a reasoned explanation for its failure to act." *Pub. Citizen Health Research Grp. v. FDA*, *supra*, 740 F.2d at 32 (quoting *Envtl. Def. Fund, Inc. v. Hardin*, 428 F.2d 1093, 1098 (D.C. Cir. 1970)). The unparalleled "exigent circumstances" existing here dictate that OSHA's more than two-month delay in acting on the Unions' petition be treated as "a final denial" of that petition. During the period of this delay, the feared COVID-19 pandemic has expanded with horrific consequences for workers in the United States. In these circumstances, OSHA's inexplicable failure even to respond to the Unions' petition "is tantamount to an order denying" that petition, because it threatens "irreparable injury on a massive scale" of the very kind an ETS is designed to prevent. *Cf. Envtl. Def. Fund*, 428 F.2d at 1099 (concluding that EPA inaction following a petition calling for emergency EPA action under a statute "designed to protect the public from an 'imminent hazard'" is "tantamount to an order denying" the requested emergency action).

An additional reason for treating OSHA's failure to respond to the Unions' petition as "a final denial" is that the Secretary of Labor has made it clear that OSHA will not issue an ETS. Specifically, in an April 30, 2020 letter to AFL-CIO President Richard Trumka, the Secretary expressly acknowledged that the AFL-

CIO "urges OSHA to adopt an emergency temporary standard," but stated that such a standard is not necessary, asserting that existing standards and guidance are "more valuable than the rule you describe" and concluding that "[g]uidelines allow flexibility and responsiveness . . . in a way a rule would not." *See* Addendum, Tab 5, at 2. An agency cannot evade judicial review by the simple expedient of declining to formalize a decision that it has already made, and the Secretary's letter makes clear the agency has decided not to issue an ETS. *See In re Aiken Cty.*, 645 F.3d 428, 436 (D.C. Cir. 2011) ("We will not permit an agency to insulate itself from judicial review by refusing to act.").

II. OSHA HAS UNLAWFULLY WITHHELD AN ETS AND SHOULD BE COMPELLED TO ISSUE ONE

To date, COVID-19 has caused more deaths among workers in a shorter time than any other health emergency OSHA has faced in its fifty-year existence. Many more deaths among workers are predicted in the next few months as the economy reopens. The COVID-19 pandemic mandates issuance of an ETS to protect the life and health of workers in the United States.

A. Standard of Review

Although this Court has not adopted a specific standard of review against which to judge the lawfulness of OSHA's failure to issue an ETS, *compare In re Int'l Chem. Workers Union*, 830 F.2d at 372 (suggesting that a "reasonable[ness]" standard applies) *with Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d at

1156 (suggesting that an "abuse of discretion" standard applies), there is no need here for precision on this point. For even under the most deferential standard of review that might apply, OSHA's failure to issue an ETS to protect workers from the scourge of COVID-19 represents a clear "abdication of [OSHA's] statutory responsibility," *Pub. Citizen Health Research Grp. v. FDA*, 740 F.2d at 32, that cannot stand.

While prior decisions in this Court have rejected efforts to compel OSHA to issue an ETS, *see In re Int'l Chem. Workers Union*, 830 F.2d 369; *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d 1150, the novel coronavirus now spreading through U.S. workplaces represents an unprecedented workplace health emergency. There can be no doubt that the risk of workplace exposure to the novel coronavirus causing COVID-19 poses a grave danger to employees and that immediate regulatory action by OSHA is necessary to protect workers from that grave danger—particularly as the country reopens and millions of workers must return to the workplace.

As previously noted, while this Court has recognized that OSHA has considerable discretion in making a factual determination as to whether the two statutory requirements for issuance of an ETS have been satisfied, the Court has made it equally clear that OSHA's discretion is *not* unlimited given "the mandatory ['shall'] language of" section 6(c) of the OSH Act and "the fact that the

interests at stake are not merely economic interests in a license or a rate structure, but personal interests in life and health." *Pub. Citizen Health Research Grp. v. Auchter*, 702 F.2d at 1156.

Congress created OSHA "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources." 29 U.S.C. § 651(b). In section 6(b) of the OSHA Act, Congress authorized OSHA "to set *mandatory* occupational safety and health standards," 29 U.S.C. § 655(b) (emphasis added), aimed at achieving this goal through the "uniform[ ]" application of those mandatory standards on "all employers," *Kiewet Power Constructors Co. v. Sec'y of Labor,* No. 18-1282, 2020 WL 2503469, at **1-2 (D.C. Cir. May 15, 2020) (internal quotation marks omitted). But OSHA rulemaking under section 6(b), on average, takes seven years.[3] Obviously, a lengthy regulatory proceeding to address the grave and immediate health risks posed by worker exposure to the novel coronavirus would not protect workers from those risks.

Recognizing that extraordinary circumstances involving "danger" to worker life and health so "grave" and immediate as to make ordinary section 6(b) rulemaking inadequate and a swifter form of regulatory action "necessary,"

[3] U.S. Gov't Accountability Office, GAO-12-330, *Workplace Safety & Health: Multiple Challenges Lengthen OSHA's Standard Setting* (2012).

Congress provided in section 6(c) of the OSH Act that OSHA "*shall*" issue an "*emergency temporary* standard" to protect workers against grave and immediate danger. 29 U.S.C. § 655(c) (emphasis added). Against this background, any suggestion by OSHA that it has carte blanche to withhold issuance of an ETS no matter how necessary and urgent regulatory action may be to protect workers against grave danger to their lives and health must be rejected.

B. COVID-19 Poses a Grave Danger to Workers

There is no question that the novel coronavirus poses a "grave danger" to workers within the meaning of 29 U.S.C. § 655(c)(1)(A). The virus is a "new hazard," *id.*, that plainly creates a "danger of incurable, permanent, or fatal consequences to workers" exposed to that hazard. *Fla. Peach Growers Ass'n v. Dep't of Labor*, 489 F.2d 120, 132 (5th Cir. 1974). OSHA has never suggested otherwise, and even in its initial voluntary guidance document issued in early March—when the pandemic was just beginning to spread throughout the United States and fewer than 20,000 cases had been diagnosed—OSHA recognized several classes of workers who were at "high" or "very high" risk from exposure to the virus in their workplaces.[4]

[4] OSHA, *Guidance for Preparing Workplaces for Covid*-19, https://www.osha.gov/Publications/OSHA3990.pdf ; *see also* Enforcement Memorandum from Patrick J. Kapust, Acting Director, Directorate of Enforcement, to Regional Administrators and State Plan Designees (April 13,

1,435,098 total cases of COVID-19 have been reported to CDC as of May 16, 2020.[5] Many of these cases are among "working-age" adults: State level data shows that cases among working age population account for about 75% in each jurisdiction.[6] As of May 13, 43,738 COVID-19 infections among healthcare workers had been reported to CDC, with 191 deaths among these workers,[7] up from 9,282 infections and 27 deaths among health care workers reported by CDC as of April 9.[8] CDC has reported that 4,913 meat processing workers have tested

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2020), https://www.osha.gov/memos/2020-04-10/enforcement-guidance-recording-cases-coronavirus-disease-2019-covid-19.

[5] U.S. Ctrs. for Disease Control & Prevention, Case Count Reported in Case-Based Surveillance for COVID-19, https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html.

[6] NYC Health, *Coronavirus Disease 2019 (COVID-19) Daily Data Summary,* https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-daily-data-summary-05142020-1.pdf; Ca. Dep't of Pub. Health, Ctr. for Infectious Diseases – Div. of Communicable Disease Control, *COVID-19 by the Numbers*, https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx#COVID-19%20by%20the%20Numbers; N.J. Dep't of Health, *COVID-19 Confirmed Case Summary*, https://www.nj.gov/health/cd/documents/topics/NCOV/COVID_Confirmed_Case_Summary.pdf; Mass. Dep't of Pub. Health, *COVID-19 Dashboard – Thursday, May 14, 2020,* https://www.mass.gov/info-details/COVID-19-response-reporting#COVID-19-cases-in-massachusetts-; COVID-19 Statistics by Ill. Dep't of Pub. Health, https://www.dph.illinois.gov/COVID19/COVID19-statistics.

[7] CDC, Data, Health Care Personnel Case Counts Reported In Case-Based Surveillance for COVID-19 (on file with agency).

[8] CDC COVID-19 Response Team, *Characteristics of Health Care Personnel with COVID-19 — United States, February 12–April 9, 2020*, 69 MMWR 477, 477-481

positive for COVID-19 and 20 have died; four Agriculture Department meat inspectors have also died.[9] These numbers continue to increase. As of May 16, the Midwest Center for Investigative Reporting reported more than 14,800 COVID-19 infections tied to meat processing plants and at least 55 worker deaths.[10] Similarly, an analysis by Bloomberg News of data compiled by Johns Hopkins University found a 40% increase in confirmed COVID-19 cases in counties with major beef or pork slaughterhouses, compared with a 19% rise nationally, during the week of April 28 to May 5.[11] A separate CDC report on COVID-19 infections at

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(2020), http://dx.doi.org/10.15585/mmwr.mm6915e6. According to the CDC, the number of COVID-19 infections among healthcare workers is underreported.

[9] Jonathan W. Dyal et al., *COVID-19 Among Workers in Meat and Poultry Processing Facilities — 19 States, April 2020* 69 MMWR 557, 557–561 (2020), http://dx.doi.org/10.15585/mmwr.mm6918e3; Mike Dorning, *Thirty Workers, Four USDA Inspectors Dead Amid Meat Plant Coronavirus Outbreaks*, Time (May 14, 2020, 3:50 PM), https://time.com/5836973/usda-inspector-meat-workers-dead-coronavirus/.

[10] Sky Chadde, *Tracking Covid-19's impact on meatpacking workers and* industry, Midwest Center for Investigative Reporting (April 16, 2020), https://investigatemidwest.org/2020/04/16/tracking-covid-19s-impact-on-meatpacking-workers-and-industry/.

[11] Mike Dorning et al., *Infections Near U.S. Meat Plants Rise at Twice the National Rate*, Bloomberg News (May 11, 2020, 1:45 PM), https://www.bloomberg.com/news/articles/2020-05-11/u-s-meat-plant-areas-see-virus-spreading-at-twice-national-rate.

correctional facilities reported 2,778 infections and 15 deaths among corrections staff as of April 21, representing 36% of all reported infections at these facilities.[12]

News reports also show that many other groups of workers face grave danger from COVID-19.[13] In New York City, the Metropolitan Transit Authority (MTA) reported that 98 transit workers had died from COVID-19 infections as of May 1.[14] Nationally, the Amalgamated Transit Union and Transport Workers Union report at least 135 transit worker deaths from COVID-19.[15] Widespread infections and deaths from COVID-19 also are being reported among nursing

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[12] Megan Wallace, DrPH. et al., *COVID-19 in Correctional and Detention Facilities — United States, February–April 2020*, 69 MMWR 587, 587-590 (2020), http://dx.doi.org/10.15585/mmwr.mm6919e1.

[13] Information on occupation and employment is not regularly reported to state and local health departments or the CDC for COVID-19 infections, so news reports have served as a key source of information on infections and deaths in some worker groups.

[14] Clayton Guse & Graham Rayman, *MTA chairman says 98 transit workers dead from coronavirus*, New York Daily News (May 1, 2020, 5:19 PM), https://www.nydailynews.com/coronavirus/ny-coronavirus-98-mta-workers-dead-20200501-uirfe2gddzdadigpgtehewrvfy-story.html.

[15] Matt McFarland, *A bus driver told a rider to wear a mask. Then the passenger spit on her*, WICZ-Fox 40 (May 7, 2020, 12:45 PM), http://www.wicz.com/story/42103034/a-bus-driver-told-a-rider-to-wear-a-mask-then-the-passenger-spit-on-her; Amalgamated Transit Union, *Remember Our Fallen*, https://www.atu.org/remember-our-fallen Transport Workers Union, *TWU COVID-19 Resources: In Memoriam,* http://www.twu.org/COVID-resources/#resources.

home, emergency service, postal, grocery, warehouse, manufacturing and other worker groups.[16] These numbers are only predicted to get worse.[17]

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[16] Tracey Tully, *The Whole Place Is Sick Now': 74 Deaths at a Home for U.S. Veterans*, New York Times (May 10, 2020), https://www.nytimes.com/2020/05/10/nyregion/new-jersey-military-veterans-home.html?searchResultPosition=10; Nancy Asiamah, *Death toll at Soldiers' Home in Holyoke rises to 85; 72 had COVID-19, 83 employees infected*, WWLP (May 6, 2020, 4:52 PM), https://www.wwlp.com/news/local-news/hampden-county/death-toll-at-soldiers-home-in-holyoke-rises-to-85-72-had-COVID-19-83-employees-infected/; *COVID-19: Tracking the coronavirus-related deaths of EMTs and paramedics* EMS1.com (May 4, 2020), https://www.ems1.com/coronavirus-COVID-19/articles/COVID-19-ems-deaths-jk5zWFziwYVYUaM4; Alanis King, *The supervisor coughed in a coworker's direction as a joke': As coronavirus cases at the US Postal Service surpass 1,200, employees say a lack of supplies and care is putting them at risk*, Business Insider (April 25, 2020, 10:15 AM), https://www.businessinsider.com/postal-workers-usps-worry-for-their-safety-amid-coronavirus-pandemic-2020-4; Irene Jiang, *At least 30 grocery store workers have died from the coronavirus, and their colleagues are pleading for shoppers to wear masks and respect social distancing*, Business Insider (April 13, 2020, 2:42 PM), https://www.businessinsider.com/grocery-store-worker-deaths-from-coronavirus-at-least-30-nationwide-2020-4; Keith Zubrow, *Amazon worker: At least 600 Amazon employees stricken by coronavirus*, CBS News: 60 Minutes Overtime (May 10, 2020), https://www.cbsnews.com/news/amazon-workers-with-coronavirus-60-minutes-2020-05-10/; Kalea Hall & Breana Noble, *At least four workers from FCA's Warren Truck plant died of COVID-19 – The most of any facility operated by Detroit automakers*, The Detroit News (May 4, 2020, 12:01 AM), https://www.detroitnews.com/story/business/autos/2020/05/04/fiat-chryslers-warren-truck-mourns-loss-dead-COVID-19/3050072001/; Associated Press, *Workplace worries mount as U.S. tracks new coronavirus cases*,WTOP.com https://investigatemidwest.org/2020/04/16/tracking-covid-19s-impact-on-meatpacking-workers-and-industry/.

[17] University of Washington, Institute for Health Metrics and Evaluation, *New IHME Forecast Projects Nearly 135,000 COVID-19 Deaths in US: Rising Mobility in Most States and the Easing of Social Distancing Point to Increases in Personal Contact that Promote Transmission of the Disease* (May 4, 2020),

These statistics show that three groups of "essential" workers are at particularly high risk of COVID-19 infection. At highest risk are those who work directly with COVID patients, such as nurses, emergency medical technicians, and other workers in institutional settings like nursing homes or correctional facilities. Also at high risk are those whose jobs require that they repeatedly come into close contact with unscreened members of the general public throughout the workday, such as grocery and other retail clerks as well as bus drivers and other transit workers. Finally, outbreaks of COVID infection at meatpacking and poultry processing facilities illustrate that workers whose jobs require that they come into close contact with one another in confined areas also are at great risk.

Simply put, workplace exposure to the novel coronavirus causing COVID-19 poses a "grave danger" to millions of workers in the United States that OSHA cannot possibly deny.[18]

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http://www.healthdata.org/news-release/new-ihme-forecast-projects-nearly-135000-covid-19-deaths-us; University of Washington, Institute for Health Metrics and Evaluation, *COVID-19: What's New for May 12, 2020,* http://www.healthdata.org/covid/updates (increased the estimate to 147,040 cumulative deaths from COVID-19 in the U.S. by August 2020); Columbia University, Mailman School of Public Health, *Projections Suggest Potential Late May COVID-19 Rebound* (May 7, 2020), https://www.mailman.columbia.edu/public-health-now/news/projections-suggest-potential-late-may-covid-19-rebound.

[18] The fact that the novel coronavirus is not a uniquely work-related hazard does not in any way minimize the "grave danger" facing workers or make that virus an improper subject of a mandatory OSHA standard, as the Secretary's April 30 letter

C. An ETS is "Necessary" to Protect Workers.

It is equally clear that an ETS is "necessary" to protect workers against the grave danger they face from workplace exposure to the coronavirus within the meaning of 29 U.S.C. § 655(c)(1)(B). Neither of the arguments to the contrary in the Secretary of Labor's April 30 letter to the AFL-CIO bear scrutiny.

1. The Secretary's first argument is that existing general OSHA standards adopted years before the COVID-19 pandemic, coupled with the OSH Act's general duty clause, 29 U.S.C. § 654(a)(1), adequately protect workers from contracting COVID-19 in the workplace. This argument fails for several reasons.

First and foremost, the five general standards cited by the Secretary were not designed specifically to protect against workplace transmission of the novel coronavirus or any airborne infectious disease. As a result, they do not require employers to conduct a worksite hazard assessment to identify sources of potential exposure to or contact with the virus. Nor do they require employers to adopt a number of specific measures—in particular, social distancing and post-contact

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seems to imply. *See* Addendum, Tab 5, at 2. Noise is not a uniquely work-related hazard, but the Fourth Circuit has upheld OSHA's mandatory standard, 29 C.F.R. § 1910.95, regulating workplace exposure to it. *Forging Indus. Ass'n v. Sec'y of Labor*, 773 F.2d 1437, 1444 (4th Cir. 1985). Diseases caused by bloodborne pathogens, including AIDS and hepatitis B, are not uniquely work-related hazards, but that did not stop OSHA from regulating workplace exposure to them. 29 C.F.R. § 1910.1030; *see also Am. Dental Ass'n v. Martin*, 984 F.2d 823 (7th Cir. 1983). OSHA has a duty to protect workers from hazards they are exposed to at work even if they also are exposed to the same hazards before and after work.

isolation—most likely to prevent such transmission. Moreover, even to the extent that those general standards might be helpful in limiting workplace transmission of the virus, they do not require all the measures that would protect workers from this particular hazard and are thus insufficient in the COVID-19 context.

OSHA's Personal Protective Equipment (PPE) standard, 29 C.F.R. § 1910.132, and its related standard on eye and face protection, 29 C.F.R. §1910.133, leave it entirely up to employers to determine what PPE (including eye and face protection) must be supplied to workers. *See* OSHA, *Standards,* Safety and Health Topics: COVID-19, https://www.osha.gov/SLTC/covid-19/standards.html. OSHA's respiratory protection standard, 29 C.F.R. § 1910.134, requires employers to implement a comprehensive respirator program when employees are exposed to an airborne contaminant or when another OSHA standard requires their use, *see Sec'y of Labor v. Seward Ship's Drydock, Inc*., 937 F.3d 1301, 1302-03 (9th Cir. 2019). Currently, it is OSHA's and CDC's position that the primary route of exposure to the coronavirus is through droplet transmission, not airborne contamination, and neither agency has recommended the use of respiratory protection to limit exposure to COVID-19 in most workplace settings.[19] Instead, surgical masks or cloth face coverings are recommended, but

[19] Currently, OSHA and CDC only recommend respiratory protection for healthcare workers and other workers at high risk of close contact with individuals with suspected or confirmed COVID-19 infection.

these are not respirators, are not considered PPE, and are not required by current OSHA regulations. The sanitation standard, 29 C.F.R. § 1910.141, includes general requirements for keeping workplaces clean and providing drinking water and toilet facilities. But it includes no requirements for disinfecting surfaces or providing ready access to hand washing facilities or hand sanitizer. And, OSHA's hazard communication standard, 29 C.F.R. § 1910.1200, merely requires employers to notify employees of the hazards posed by chemicals they use to disinfect surfaces but does not otherwise apply to the COVID-19 crisis. https://www.osha.gov/SLTC/covid-19/standards.html.

Nor is this gaping regulatory hole in worker protection from COVID-19 closed by the OSH Act's general duty clause, 29 U.S.C. § 654(a)(1), which imposes only a general duty on employers to provide "employment and a place of employment which are free from recognized hazards . . . ." The general duty clause does not require employers to take any specific measure to protect workers from the coronavirus. For that reason, years before the COVID-19 pandemic emerged, OSHA itself acknowledged that the general duty clause does *not* "adequately protect workers with occupational exposure to infectious diseases." *See* OSHA, *Infectious Diseases SER Background Document*, pp. 122-123, available at https://www.osha.gov/dsg/id/OSHA-2010-0003-0239.pdf ("*SER Backgrounder*"). To prove a violation of that clause, OSHA must prove, on a case-

by-case basis, that a recognized hazard actually is "present[ ]" in the employer's workplace and that it is "feasible" for the employer to abate that hazard. *SeaWorld v. Perez*, 748 F.3d 1202, 1207 (D.C Cir. 2014); *see also e.g. Champlin Petroleum Co. v. OSHRC*, 593 F.2d 637 (5th Cir. 1979); *Nat'l Realty & Constr. Co. v. OSHRC,* 489 F.2d 1257 (D.C. Cir. 1973). This can often be a difficult burden for OSHA to meet in individual cases, and thus can severely tax OSHA's limited enforcement resources. For example, in a recent case, the Occupational Safety and Health Review Commission ("OSHRC"), which adjudicates employer challenges to OSHA citations, found that OSHA had not adequately proven that excessive heat was "present" at a roofing company's work site, even though an employee on the employer's roofing job had died of heat stroke. *Sec'y of Labor v. A.H. Sturgill Roofing Inc.,* No. 13-0224, 2019 WL 1099857, at **3-5 (Rev. Comm'n Feb. 28, 2019); *see also generally* Allan Ferguson, *OSHA's General Duty Clause*, Safety + Health (Dec. 20, 2019), https://www.safetyandhealthmagazine.com/articles/19258-oshas-general-duty-clause (enumerating the many "hurdles" OSHA faces in enforcing the general duty clause). Moreover, under the general duty clause, employers decide how to abate a cited hazard; OSHA cannot require specific, uniform control methods. *See Sec'y of Labor v. Arcadian Corp.,* No. 93-0628, 2004 WL 2218388 (Rev. Comm'n Sept. 30, 2004). In contrast, when OSHA issues a mandatory standard, employers have clear notice of what worker

protections are required, and OSHA can establish a violation by showing the standard applies and was not met.

Unsurprisingly against this background, these existing mandatory requirements have proven to be toothless as the COVID-19 pandemic has continued to ravage workplaces across the country. As of May 14, OSHA had received 3,8936 COVID-19 related complaints alleging violations of the OSH Act, but had already closed about 2,844 of them without issuing a single citation. https://www.osha.gov/enforcement/covid-19-data. In addition, a search of OSHA's enforcement database conducted on May 13 found that OSHA had opened 181 inspections in healthcare settings (NAICS 62) between March 1 and May 13; 157 of these inspections were initiated only *after* a worker fatality, and not as a preventive action. And, as of May 13, no citations had been issued as a result of any of those inspections.[20] In fact, we are not aware of a single citation under any of the standards cited by the Secretary or under the general duty clause relating to exposure to the coronavirus.[21]

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[20] https://www.osha.gov/pls/imis/industry.search?sic=&sicgroup=&naicsgroup=&naics=62&state=All&officetype=Fed&office=All&startmonth=05&startday=13&startyear=2020&endmonth=04&endday=01&endyear=2020&opt=&optt=&scope=&fedagncode=&owner=&emph=&emphtp=&p_start=120&p_finish=140&p_sort=&p_desc=DESC&p_direction=Prev&p_show=20.

[21] The fact that OSHA has not issued any citations is not surprising, since it has directed its own staff that they should "not normally" perform on-site inspections in locations that it considers "medium" or "low" risk, including situations like

Simply put, the five general standards and the general duty clause are insufficient to address the grave hazard and protect workers to the greatest extent possible as required by the OSH Act.

2. The Secretary of Labor also argues that the voluntary guidance materials that OSHA has issued to assist employers in responding to the COVID-19 crisis are an adequate substitute for an enforceable, COVID-19 specific standard. To underscore their voluntary nature, these guidance documents[22] typically begin with the following disclaimer: "This guidance is not a standard or regulation, and it creates no new legal obligations. It contains recommendations as well as descriptions of mandatory safety standards. The recommendations are advisory in nature, informational in content, and are intended to assist employers in

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those existing at meat and poultry processing facilities where workers must stand in close proximity to each other. *See* Enforcement Memorandum from Patrick J. Kapust, Acting Director, Directorate of Enforcement, to Regional Administrators and State Plan Designees (April 13, 2020), https://www.osha.gov/memos/2020-04-13/interim-enforcement-response-plan-coronavirus-disease-2019-covid-19.

[22] Most of these documents are found under "Alerts" on OSHA's Covid-19 webpage. https://www.osha.gov/SLTC/covid-19/news_updates.html. The OSHA/CDC meatpacking and manufacturing guidance documents are found on the CDC website: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/meat-poultry-processing-workers-employers.html; https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-manufacturing-workers-employers.html. These documents are longer and somewhat more comprehensive than the OSHA "Tips," but full of the same non-mandatory "Employers should consider;" "Employers should if possible," and "Employers are encouraged" language.

providing a safe and healthful workplace."[23] This type of guidance is no substitute for mandatory standards addressing COVID-19 risks.

When Congress enacted the OSH Act, among its central conclusions was that employers cannot be relied on in all cases to take voluntary measures sufficient to protect the health and safety of their workforce. *See Kiewet Power Constructors, supra,* 2020 WL 2503469, at *1 ("Until [the OSH Act], workplace safety was addressed in a patchwork by federal and state regulations and, to a degree, employers' voluntary efforts. *See* S. Rep. No. 91-1282, at 3-4 (1970). The measures were largely ineffective."). That is why Congress crafted a set of detailed statutory provisions imposing on OSHA the statutory duty to adopt *mandatory* health and safety standards adequate to protect workers against known hazards in the workplace, *see* 29 U.S.C. §§ 655(b)(3), 655(b)(5), 655(c), and providing for the imposition of civil penalties against employers who violate those mandatory standards, *see* 29 U.S.C. § 666. More pointedly given the nature of the COVID-19 pandemic, Congress specifically provided in 29 U.S.C. § 655(c) that the mechanism to be used by OSHA in protecting workers against a grave and immediate health danger in the workplace "shall" be the issuance of a *mandatory* emergency temporary standard. Had Congress considered the issuance of

[23] *See*, OSHA, OSHA 3990-03, Guidance on Preparing Workplaces for COVID-19 (2020), https://www.osha.gov/Publications/OSHA3990.pdf.

voluntary guidelines a permissible option for OSHA in such urgent circumstances, Congress surely would have said so.

In his April 30 letter defending OSHA's reliance on voluntary guidance materials in lieu of a mandatory standard, the Secretary stated, without any support, that "employers are implementing measures to protect workers" against COVID-19. Doubtless, many employers are doing so, for which they should be commended. But that kind of voluntary and inevitably non-uniform implementation of safe practices hardly serves as a substitute for mandatory, legally-enforceable, COVID-19-specific requirements applicable to *all* employers. *See Kiewet Power Constructors,* 2020 WL 2503469, at *1 ("A key deficiency" of pre- OSH Act federal protections "was that they did not extend to all employers."). Indeed, given the number of reported illnesses and deaths, it should be obvious that voluntary employer action has not adequately protected workers from COVID-19.[24] Moreover, one of the justifications for mandatory standards is to "level the

[24] *See e.g.,* Ana Swanson et al., *Pork Chops vs. People: Battling Coronavirus in an Iowa Meat Plant*, New York Times (May 10, 2020), https://www.nytimes.com/2020/05/10/business/economy/coronavirus-tyson-plant-iowa.html; Lucas Manfredi, *Three Walmarts close after coronavirus hits employees,* Fox Business (May 10, 2020), https://www.foxbusiness.com/lifestyle/walmart-stores-close-coronavirus-employees; Michael Hiltzik, *Nurses know we were unprepared for the coronavirus. They're being punished for speaking out*, Los Angeles Times (April 17, 2020, 6:00 AM), https://www.latimes.com/business/story/2020-04-17/nurses-front-lines-punished.

playing field" so that employers who proactively protect their workforces are not placed at a competitive disadvantage by the actions of unscrupulous or uncaring employers. *Indus. Union Dep't v. Hodgson,* 499 F.2d 467, 481 (D.C. Cir. 1974).

Indeed, just as OSHA has expressly recognized the insufficiency of regulation under the general duty clause in the context of infectious diseases, OSHA has recognized that voluntary guidelines likewise are insufficient "adequately [to] reduce the risk" to workers posed by infectious diseases because they are not "consistently adopt[ed] or rigorously enforce[d]" by many employers. *See SER Backgrounder*, *supra* p. 20, at 16. OSHA's about-face here on this critical point is inexplicable and unconscionable.

OSHA's refusal to adopt an ETS that would impose mandatory, legally-enforceable, COVID-19-specific duties on employers stands in marked contrast to the approach taken by other arms of the federal government in response to the COVID-19 pandemic. Putting aside inevitable debates about their sufficiency and timeliness, other arms of the federal government have taken at least some legally binding actions designed specifically to address the pandemic. The President himself has issued a proclamation designating the outbreak of COVID-19 a national emergency, Proclamation No. 9994, 85 Fed. Reg. 15,337 (2020), and invoking the Defense Production Act to compel specific responses by employers to that national emergency related to production of essential equipment and continued

operation of meat processing operations. The Department of Health and Human Services has declared a public health emergency and taken a number of regulatory steps authorized by that declaration.[25] The Food and Drug Administration has exercised its statutory authority to allow emergency use of certain medicines, personal protective equipment and other medical devices. *See* Emergency Use of Authorization Declaration, 85 Fed. Reg. 17,335 (March 27, 2020). And, Congress has enacted laws including unprecedented levels of aid for businesses and individuals affected by the disease and the emergency response to it. *See*, *e.g.*, Families First Coronavirus Response Act, Pub. Law 116-127, 134 Stat. 178 (2020); CARES Act, Pub. Law 116-136, 134 Stat. 281 (2020).

OSHA should be compelled by this Court to do its statutory duty in responding to the COVID-19 pandemic by exercising its authority under 29 U.S.C. § 655(c) to issue an ETS that is legally binding on all employers. Nothing less suffices adequately to protect all workers to the extent feasible from the grave danger they face on the job during this pandemic.

[25] Office of the Secretary, Department of Health and Human Services, Determination of Public Health Emergency, 85 Fed. Reg. 7316 (Feb. 7, 2020) https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx.

III. THE APPROPRIATE REMEDY FOR OSHA'S UNLAWFUL WITHHOLDING OF AN ETS IS A WRIT OF MANDAMUS COMPELLING OSHA TO ISSUE ONE WITHIN THIRTY (30) DAYS

The COVID-19 pandemic warrants an ETS to require mandatory protective measures to protect the life and health of workers now and as the economy reopens. Given the urgency of the situation, and the additional considerations outlined below, an order from this Court requiring OSHA to promulgate an ETS within thirty (30) days is both necessary and appropriate.

This Court has not hesitated to impose a timetable to govern OSHA regulatory action when it has found such judicial action necessary. *Pub. Citizen Research Grp. v. Auchter,* 702 F.2d at 1153; *UAW v. Donovan,* 765 F.2d at 165. In *Public Citizen,* the Court ordered OSHA to publish a proposed ethylene oxide standard within thirty days of its order. While OSHA may have discretion as to the content of any standard regulating workplace exposures to the novel coronavirus, it has, as we have shown, a statutory duty to impose some type of mandatory, legally-enforceable obligations on employers aimed at protecting employees from the virus. *Cf. In re: Pub. Emps. for Envtl. Responsibility,* 2020 WL 2090085, at *4 (D.C. Cir. May 1, 2020) (distinguishing an agency's discretion over the content of a plan from an agency's statutory duty to create a plan). And, absent an order from this Court requiring OSHA to fulfill its statutory duty with extraordinary dispatch, the COVID-19 pandemic will continue to surge across the country and exact its

terrible toll on workers in the United States as they return to work in increasing numbers.

Moreover, compelling OSHA to act within thirty days is appropriate because OSHA has already developed much of the content for an ETS. OSHA has been considering an infectious disease standard for more than a decade; has already issued, and received comment on, a Request for Information;[26] and has drafted a proposed standard that was the subject of a Small Business Regulatory Enforcement Fairness panel report, *see Report of the Small Business Advocacy Review Panel on a Possible OSHA Rule on Occupational Exposure to Infectious Diseases in Healthcare and Other Related Work Settings* (Dec. 22, 2014), https://www.regulations.gov/document?D=OSHA-2010-0003-0250. At about the same time, OSHA posted a proposed regulatory framework, *Outline of Key Provisions in OSHA's Infectious Diseases Regulatory Framework* (Oct. 9, 2014) https://www.regulations.gov/document?D=OSHA-2010-0003-0244, and a 158-page document laying out its then current view of the infectious disease problem and its proposed regulatory response. *See SER Backgrounder*, *supra* p. 20. There

[26] OSHA published a Request for Information on Infectious Diseases on May 6, 2010, *see* 75 Fed. Reg. 24835, and, according to www.regulations.gov, received 226 comments in response. OSHA Docket 2010-003. OSHA held public stakeholder meetings on an infectious disease standard as well. *See* 76 Fed. Reg. 39041 (July 5, 2011).

simply is no good reason why OSHA cannot act within thirty days given the substantial resources it has already invested in the development of a permanent standard.[27] Moreover, OSHA could also borrow from California's existing Aerosol Transmission Disease standard, 8 Cal. Code of Regulations § 5199, as necessary to help meet this court-imposed deadline.

The two ETS petitions filed on March 4 and 6 specifically requested that OSHA adopt an ETS that requires each employer to evaluate its workplace for the risk of airborne disease transmission and to develop a comprehensive infection control plan with specified elements. OSHA's draft infectious disease standard includes the same core requirement, as do the non-mandatory COVID guidance documents that both OSHA itself, *see supra* pp. 23-24, and the CDC have developed, *see* https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html.[28] Any or all of these materials could form the basis of an ETS. The important point is that OSHA can and should adopt an emergency

[27] Indeed, OSHA's December 2016 Regulatory Plan listed the expected date for publication of a NPRM on airborne infectious diseases as October 2017. *See* 81 Fed. Reg. 94601 (Dec. 23, 2016).

[28] OSHA's earlier guidance on pandemic influenza (H1N1) from 2009 contains similar core elements, *see* OSHA 3327-06R, *Guidance on Preparing Workplaces for an Influenza Pandemic* (2009), https://www.osha.gov/Publications/OSHA3327pandemic.pdf.

standard imposing a mandatory duty on employers to protect workers from COVID-19 disease without any further delay.

We are not asking the Court to compel OSHA to adopt a one-size-fits-all regulatory response to the workplace threats posed by the novel coronavirus. As noted, a core element of OSHA's draft standard on infectious disease that OSHA may draw on in crafting an ETS is the mandatory requirement that every employer adopt a comprehensive infection control plan that assesses the level of risks that its employees face from infectious diseases like COVID-19 in its own particular workplace, and then complies with a set of mandatory worker protection provisions addressing the workplace-specific risks facing its own employees. Such protections would likely include social distancing measures, supply of appropriate PPE, access to hand sanitizers, testing, and quarantining. Right now, however, no employer is *required* to adopt an infection control plan after assessing the level of risks its employees face from the novel coronavirus or to implement controls to reduce hazards from airborne exposure. Issuing an ETS imposing such a basic requirement is clearly possible within thirty days given the regulatory history, and doing so is clearly reasonable because it would simply require employers to adopt protective measures tailored to the risk in their individual workplaces, backed up by the threat of civil penalties if they fail to do so.

CONCLUSION

For the foregoing reasons, this Court should grant a writ of mandamus compelling OSHA to issue an ETS within thirty (30) days of that grant.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that this Emergency Petition contains 7,090 words, excluding those portions of the Petition excluded from the word count under Fed. R. App. P. 32(f), and thus complies with the word limit set by Fed. R. App. P. 21(d)(1), and that the Petition also conforms to Fed. R. App. P. 32(c)(2), as required by Fed. R. App. P. 21(d).

/s/ Andrew D. Roth

Counsel for Petitioner AFL-CIO

CERTIFICATE OF SERVICE

I hereby certify that on this 18th day of May, 2020, I caused a copy of this Emergency Petition to be served on Respondent by electronic and overnight mail delivery to:

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Solicitor of Labor
United States Department of Labor
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/s/ Andrew D. Roth

Counsel for Petitioner AFL-CIO

Addendum Tab 1

CERTIFICATE OF PARTIES AND AMICI CURIAE

Pursuant to Circuit Rules 21(d) and 28(a)(1)(A), undersigned counsel for Petitioner hereby certifies the following:

1. Petitioner is the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO).
2. Respondent is the Occupational Safety and Health Administration, United States Department of Labor (OSHA).
3. There are no intervenors or amici to date.

/s/Andrew D. Roth
Andrew D. Roth

Addendum Tab 2

DISCLOSURE STATEMENT

Pursuant to Circuit Rules 21(d) and 26.1, Petitioner American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) hereby makes the following disclosure:

The AFL-CIO is an unincorporated association of 55 national and international labor unions representing 13 million working men and woman in every sector of the economy. The AFL-CIO has no parent corporation and has not issued any stock. The AFL-CIO's general purposes include advocating for and taking appropriate legal action to protect and advance the interests of working men and women throughout the United States, including, insofar as is relevant here, their interests in a safe and healthy workplace.

Addendum Tab 3

AFL-CIO

AMERICA'S UNIONS

American Federation of Labor and Congress of Industrial Organizations

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March 6, 2020

The Honorable Eugene Scalia
Secretary of Labor
United States Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

RE: To Address the Outbreak of COVID-19: A Petition for an OSHA Emergency Temporary Standard for Infectious Disease

Dear Secretary Scalia:

The world is on the verge of a deadly coronavirus pandemic due to COVID-19 and the disease is now spreading quickly through the United States. The impact of the outbreak has already been far reaching and the threat is growing. Current estimates demonstrate that over 19 million workers in the United States would be at elevated risk of exposure to coronavirus in the event of a widespread outbreak, a significant portion of whom could become infected and die. These are the workers who answer the call when an outbreak occurs and they deserve to have confidence that the appropriate resources, equipment, training and protocols are readily available in their workplaces to protect themselves, as well as to avoid infecting other people, including patients, co-workers, the public, and their families when they go home. OSHA has the obligation to ensure the health and safety of all working people, particularly from an infectious disease such as this coronavirus.

Given the significant and growing threat that health care workers, first responders, airline and other transportation workers, social service, and other public-facing workers are now facing from the COVID-19 outbreak, and the immediate need for workplaces to plan, prepare and respond to this threat, the undersigned labor organizations, representing millions of working people, hereby petition the Occupational Safety and Health Administration to issue an Emergency Temporary Standard to protect working people from occupational exposure to infectious diseases, including COVID-19.

Millions of working people in the United States are at risk of facing a deadly coronavirus pandemic.

The novel coronavirus, SARS-CoV-2 that is the source of the COVID-19 outbreak, evolved in Wuhan, Hubei Province, China and the outbreak has spread to 79 countries throughout every continent except for Antarctica. The World Health Organization (WHO) declared a global health emergency on January 30, 2020 and raised the global level risk assessment to "very high" on February 28, 2020, the highest designation. Currently, on the date of this petition, the WHO has reported 95,270 confirmed cases and 3,280 deaths globally, including many health care workers infected in China. Within the United States, the Centers for Disease Control and Prevention (CDC) reports 99 confirmed cases, including at least 20 cases of community transmission, and 10 fatalities. In the current outbreaks near Sacramento and Seattle, more than 200 nurses, other health care workers and public safety workers are undergoing 14-day precautionary medical removal because their employers did not prevent their possible exposure to the coronavirus. These vital workers are sidelined from providing much needed care and face risk of developing the disease. Employers following an OSHA Infectious Disease Standard would have planned for and prevented their exposure. We need our healthcare and public safety workers on the job now and in the coming months ahead. Community transmission in the United States is evidence that the deadly virus is spreading and circulating throughout the country. Infectious disease experts have estimated that a pandemic could kill tens of millions of people worldwide.[i]

COVID-19 is a rapidly evolving outbreak and there are still many unknowns about the transmission, infectivity, and severity. However, the rapid spread, confirmed cases and fatalities show that this strain is highly infectious, easily transmissible, and virulent. Also, as with other coronaviruses, infection can cause mild symptoms, including a runny nose, sore throat, cough, and fever. It can also be more severe for some, resulting in pneumonia, difficulty breathing, or death. Older people and people with pre-existing medical conditions appear to be more vulnerable to becoming severely ill with the virus. Yet, any infected individual is at risk of more severe symptoms and may require medical attention.

There is a chilling yet realistic possibility of a coronavirus pandemic and the potential for a catastrophic toll in mortality and morbidity cannot be taken lightly. The following are key assumptions underlying the risk of a pandemic:

- Susceptibility to this pandemic coronavirus will be universal as there is no pre-existing immunity to this novel virus among humans.
- There is evidence of sustained human-to-human transmission.[ii] Early studies have estimated that each disease's reproductive number, or the number of people a single infected person is likely to infect, is over two.[iii, iv]
- Some persons will become infected but not develop clinically significant symptoms. There is concern that the severity of illness is not correlated to the ability to transmit the virus.[v]

- The virulence of the virus is not fully understood, but the case-fatality rate is estimated to be less than 3%.[vi]
- There is evidence of multiple routes of infection, including respiratory, fecal-oral and bodily fluids.[vii]
- A virus that transmits efficiently, with a lower pathogenicity, can create a large-scale spread.[viii]
  The global outbreak is expanding, resulting in several countries implementing significant public health protocols, including citywide lockdowns.[ix]

The workers at the forefront of exposure to this growing outbreak include health care workers, fire fighters, law enforcement officers, emergency medical service workers, pilots and flight attendants, other transportation workers, and other public service workers including those with broad exposure to the public who may be identified as "essential personnel" by employers during an outbreak. Table 1 shows an estimate of employment in the most at-risk industries. However, additional workers are at risk, such as those performing tasks such as a construction worker in a hospital or a utility worker dealing with potentially contaminated wastewater. In addition, any worker who interacts with the public frequently is at an increased risk of exposure, such as a hotel housekeeper, retail worker, teacher, customer service worker or food service worker. Workers who enter people's homes, such as home health aides, telecommunications technicians, and other service providers will be at increased risk with a worsening outbreak as more people are quarantined or ill at home. The evidence of this risk outside of healthcare has been seen in other countries with infected individuals, including taxi drivers, cashiers and bus drivers, and the danger of transmission in crowded workplaces is evidenced by the cruise ship outbreak where passengers and crew were quarantined and the long-term elder care facility in Washington state where residents have died and health care workers have been hospitalized.

Table 1: Average Annual Employment Numbers by Selected High-risk Industries, 2018.

Industry	Average Annual Employment (2018)
Air transportation (private)	502,815
Water transportation (private)	64,463
Transit and ground passenger transportation (private)	479,974
Scenic and sightseeing transportation (private)	33,999
Support activities for transportation (private)	709,766
Ambulatory health care services (private)	7,477,842

Industry	Average Annual Employment (2018)
Hospitals (private)	5,061,617
Nursing and residential care facilities (private)	3,344,908
Social assistance (private)	3,857,060
Death care (private)	136,250
Medical and diagnostic laboratories (private	275,417
Police protection (government)	544,417
Correctional units (government)	496,776
Fire protection (government)	208,189
TOTAL	19,336,433

Source: U.S. Bureau of Labor Statistics. Quarterly Census of Employment and Wages, 2020.

The current government recommendations to protect workers fall short.

At the beginning of the outbreak, even before WHO officially declared a global public health emergency, the United States government, recognizing the significance of the outbreak, took action. Voluntary guidance to protect some workers has been issued by the CDC, National Institute for Occupational Safety and Health (NIOSH), and Occupational Safety and Health Administration (OSHA).

However, even when OSHA has identified an occupation at high-risk of exposure to COVID-19, OSHA has not issued detailed recommendations. For example, with airline workers, OSHA references a CDC website with recommendations for the airline industry and the CDC does not provide as clear or specific of guidelines as OSHA has provided for different groups of workers. For example, CDC recommends using protective equipment from the Universal Precaution Kit when tending to a sick traveler—a kit that does not include a N95 respirator. To remedy this problem, clear, effective requirements and recommendations issued by one authoritative agency is required—OSHA.

The OSHA guidance for COVID-19 includes essential elements that must be codified in an ETS for infectious diseases.

- Acknowledging a range of workers who are at an elevated risk of exposure to infectious diseases, including health care, death care, laboratories, airline operations, border

protection, solid waste and wastewater management, occupations that require travel to key areas.
- Incorporating the hierarchy of controls, utilizing engineering controls as the first line of defense.
- Recommending NIOSH-certified N95 respirators or better and other PPE for health care and other workers at an elevated risk.
- Outlining a risk-based model for many workers who require different levels of protection depending on the tasks they are performing and their potential exposures.

The United States must learn from previous infectious disease outbreaks.

This coronavirus, SARS-CoV-2, is in the same family of viruses as Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). A global SARS outbreak was recognized in 2003 and 8,096 people across 29 countries were infected, 774 of them fatally.[x] A global MERS outbreak was recognized in 2012 and 2,492 people across 27 countries were infected, resulting in 858 fatalities.[xi] Additionally, although not caused by a coronavirus, in 2009 the H1N1 pandemic flu epidemic infected an estimated 60.8 million people and resulted in 12,469 deaths in the United States according to the CDC.[xii]

Many lessons learned during the previous infectious disease outbreaks can be applied to help prevent COVID-19 from becoming as devastating as previous global infectious disease tragedies, or worse. The United States has always relied upon voluntary efforts by employers to protect workers from outbreaks, an approach that has proved to be woefully inadequate. After SARS, the Centers for Disease Control and Prevention (CDC) noted the need for the United States to be proactive, "Although the United States had a limited SARS outbreak, it is clear that we are susceptible to the more widespread outbreaks experienced in other countries."[xiii] In-depth studies of the SARS tragedy examined the failures and successes in identifying, treating, and preventing the spread of the virus.[xiv] Some fatal mistakes included unclear and ineffective PPE recommendations, a delay in worker training, poor communication between public health agencies and hospitals, ineffective health and safety committees, blurred agency authority and accountability, inadequate medical surveillance, minimization of the role of worker safety and health agencies, and disregarding advice of workers on the frontline.[xv] Specifically for health care workers, the precautionary principle that reasonable steps to reduce risk should not await scientific certainty was not implemented. During this outbreak, there was debate about the necessity of N95 respirators to protect health care workers. Some believed SARS was mostly spread through large droplets and surgical masks were sufficient. Since then, studies have indicated that airborne transmission requiring respiratory protection, not a surgical mask, is required. The failure to implement the precautionary principle in this crisis resulted in 45% of the infected in Ontario being health care workers.[xvi]

Following the highly pathogenic avian influenza outbreak that began in 2003, the Bush Administration recognized the importance of preparing the nation for a pandemic and developed a National Strategy for Pandemic Influenza: Implementation Plan to limit and mitigate the domestic spread of a disease outbreak.[xvii] Resources were requested and directed to developing preparedness plans, enhancing public health infrastructure and surveillance capacity, developing vaccines, and other critical needs. In addition, strategies were developed for sustaining infrastructure and reducing the impact of economic stress from an outbreak.[xviii] Unfortunately, this national strategy and implementation plan has not been kept current nor modified or updated to address subsequent disease outbreaks.

While COVID-19 is the most recent global health threat, infectious disease outbreaks and other biological threats will continue to occur. Now is the time to plan to protect workers not only from this coronavirus, but also to learn from our past inaction to prevent a public health crisis.

An emergency temporary standard is needed to protect workers from the current coronavirus outbreak and future infectious agents.

There is no existing OSHA standard or basic regulatory framework that comprehensively addresses an employer's responsibility to protect workers from infectious diseases. In the absence of a set of mandatory infection control requirements that employers must implement, there is no assurance that all workers will be protected from infectious diseases like COVID-19.

Voluntary guidance versus requirements

Current efforts to protect workers from COVID-19 are largely voluntary. This allows each employer the discretion to implement, ignore, or selectively follow the guidelines issued by the agencies. Workers have the right to consistent levels of protection that will be implemented in all workplaces where occupational exposure to the coronavirus can be anticipated. In particular, health care workers and first responders must have the confidence that their employers will have a comprehensive health and safety program in place. If these workers are not protected from occupational exposures to COVID-19 or if they have a false sense of protection, they may infect the patients they care for or not come to work, which will jeopardize public health and the control of exposure to the pathogen. This is also true for transportation workers who are responsible for ensuring the safe transportation of both infected individuals and the public. Preparing for and protecting health care workers, emergency responders, and transportation workers at risk of exposure to coronavirus must be mandatory. Only an emergency temporary standard can quickly accomplish this objective.

Clear authority

Several agencies have published recommendations and guidance to prevent worker exposure to coronavirus. However, not all the recommendations are equally protective and employers do not have clarity and consistency on which agency to turn to. OSHA is the clear choice to issue direct, protective requirements, as their core legislative mandate is to ensure the safety and health of America's workforce by issuing mandatory and enforceable standards, including Emergency Temporary Standards.[xix]

No safe exposure limit

There is no established safe exposure limit to an infectious agent like coronavirus. It is unknown how many infectious particles, or if even a single particle, is capable of causing an infection and disease. Therefore, the goal of worker protection efforts, including inhalation hazards, should be to eliminate exposure to coronavirus and other infectious agents to the greatest extent possible.

A comprehensive exposure control plan is necessary

The only way to prevent an outbreak or effectively limit the impact of an outbreak is for the United States to implement a strong and comprehensive public health approach to controlling exposure to infectious diseases. In the workplace, this requires a written exposure control plan, evaluation of the exposure control plan, exposure assessment, implementation of the hierarchy of controls, housekeeping measures, worker training, communication of hazards to employees, medical surveillance and vaccination program, medical removal protection, and recordkeeping/reporting; and employee involvement throughout the process.

A comprehensive approach in the workplace will implement the hierarchy of controls, including the use of personal protective equipment. In an infectious disease outbreak, clear and strong respiratory protection requirements are necessary. There is evidence of airborne transmission of respirable infectious agent particles (droplet nuclei) from coughing, sneezing, and merely talking. At a minimum, NIOSH-approved N95 filtering face piece respirators need to be worn by workers within the framework of a complete respiratory protection program as required under OSHA's respiratory protection standard, 1910.134. N95 respirators are designed to capture respirable particles and to provide a sufficient seal against the wearers' face to prevent significant leakage into the workers' breathing zone. The use of respirators, and the requirements under OSHA's respiratory protection standard provides protective measures required to address an outbreak, including training, fit testing, development of a written program, medical evaluation, use requirements, maintenance and care, recordkeeping, and program evaluation. Comprehensive requirements under an OSHA infectious disease standard would help prevent the equipment stockpile issues this country is currently facing, as employers would be prepared.

OSHA must move expeditiously to issue an ETS and can do so by utilizing the agency's long standing infectious disease rulemaking.

While OSHA does not have a standard to protect workers from infectious agents, like those causing the COVID-19 outbreak and could cause a pandemic, it does have a history of infectious disease rulemaking. Previously, OSHA has been petitioned by labor organizations to issue an emergency temporary standard for addressing pandemic influenza (2005) and to issue a rule for occupational exposure to infectious disease (2009). These petitions, and the threat of infectious disease pandemics such as SARS, West Nile virus, Lyme disease, zoonotic influenza and Ebola, led OSHA to place its infectious disease rulemaking on the Fall 2009 regulatory agenda. A request for information was issued in May 2010 and a Small Business Advocacy Review Panel (SBAR Panel) met and issued a report in January 2015. Despite this progress, infectious disease rulemaking was demoted in 2017 to be a long-term item on the regulatory agenda. Therefore, substantial work has already been completed by the agency and OSHA should take advantage of this record to issue a comprehensive emergency temporary standard.

The framework that OSHA submitted to the SBAR panel was a well-structured infection control program with elements including:

> (1) identification and isolation of infectious cases; (2) immunizations for vaccine-preventable diseases; (3) standard and transmission-based precautions; (4) training; (5) personal protective equipment; (6) management of healthcare workers' risks of exposure to infected persons, including post-exposure prophylaxis; and (7) work restrictions for exposed or infected healthcare personnel (Siegel et al., 2007). The prevention strategies listed above are set forth in guidelines, such as those of the Healthcare Infection Control Practices Advisory Committee (HICPAC), a federal advisory committee that provides advice and guidance to the CDC and to the Secretary of the Department of Health and Human Services (HHS).[xx]

Existing OSHA standards can also be utilized to support the development of infectious disease protections, but these alone are not enough to mitigate exposures to infectious diseases at work. These standards include bloodborne pathogens (1910.1030), hazard communication (1910.1200), respiratory protection (1910.134), personal protective equipment (1910.132), and other various 6(b) health standards. Additionally, in developing an ETS, OSHA can draw from California OSHA's Aerosol Transmission Disease (ATD) Standard issued in 2009 in response to the pandemic flu, with health care, employer and union support, and tested during the H1N1 and Ebola and other disease outbreaks. The ATD standard protects employees in health care and other high-risk environments from inhaling viruses, bacteria, and other disease organisms.[xxi] It is worth noting that these existing standards are not sector specific and protect all workers with potential or elevated exposure to biological and other hazards, just as all workers deserve protections from infectious disease such as coronavirus. The ATD standard covers the current coronavirus.

The Emergency Temporary Standard should, at a minimum, include the following provisions:

Scope and application

Facing exposure to infectious agents that can result in a pandemic, the scope of workers who need to be protected from an infectious disease must be comprehensive. In some workplaces, non-essential movement of people may be required, including the closing of schools, government offices, and other settings. The private sector may be encouraged, where possible, to establish protocols to allow workers to provide services from home. However, there are many workers whose occupations require them to treat and serve members of the public who may be infected and infectious. It is well documented that healthcare workers, emergency responders, and other employees are at an elevated risk of exposure during the performance of their job duties. However, it is not only those who directly provide care to patients known or suspected of being infected. Other occupations have a high likelihood of occupational exposure such as flight attendants and pilots, other public transportation workers, border and customs workers, corrections workers, housekeeping workers, maintenance and repair workers, other health care facility workers, food and medical supply workers, and others identified as "essential personnel" by employers. Therefore, the ETS should apply to all workers who perform essential functions and are at an elevated risk of occupational exposure to coronavirus. The standard should also apply to workers with close contact to potential zoonotic sources of infection.

Exposure Control Plan

An essential component to prevention of an outbreak is the creation and implementation of an exposure control plan. The exposure control plan determines which workers are at risk, and the activities and operations that put them at risk. An exposure control plan was a central tenant in OSHA's infectious disease rulemaking and is contained in OSHA's Bloodborne Pathogens Standard. The control plan in the ETS should be in writing and include:

- An exposure determination by occupation and activities for communicable and infectious agents that are present, or can reasonably be anticipated to be present. In the event of a pandemic, the exposure determination or hazard assessment must be a continuous process for the duration of the pandemic as the scope of activities and operation may change rapidly as well as the determination of at-risk workers.
- Procedures to provide information and training to employees about potential or actual occupational exposure to communicable and infectious agents.
- Procedures for reporting an incident.
- Medical surveillance procedures to identify suspected or confirmed cases of a communicable or infectious disease and a plan to isolate or transfer individuals.
- Methods of compliance, including appropriate engineering controls, work practices, and personal protective equipment.

- Recordkeeping.
- The name and title of the person(s) responsible for administering the plan. This person must be knowledgeable in infection control principles and practices as they apply to the facility, service or operation.

The employer must be required to periodically evaluate the effectiveness of the exposure control plan. Additionally, when developing and evaluating the plan, employers should be required to solicit input from all workers who are at risk of potential exposure.

Methods of Compliance

The methods of compliance should include the hierarchy of controls and a schedule for implementation.

Engineering Controls

The hierarchy of controls is longstanding and widely accepted industrial hygiene practice. As the top of the hierarchy of controls, (after elimination and substitution, which cannot be done for an infectious agent) engineering controls must be a required component of the ETS. This is particularly essential for coronavirus given the unknowns surrounding its potential to cause infection, the virulence of the virus, and the absence of an established threshold exposure capable of causing infection. Ventilation, portable high-efficiency particulate air (HEPA) filtration units, negative pressure isolation rooms and other controls should be used to reduce the number of infectious particles in the air.

Administrative Controls

Work practice and other administrative controls can minimize employee exposure by combining tasks to limit the number of entries into a room or area with known or suspected infected individuals. In addition, high-hazard, non-priority work can be delayed until the infection risk has been reduced. In the health care setting, this includes ensuring that engineering controls, such as negative air pressure and filtration systems are in place before performing high-hazard procedures or surgeries. Employers should adopt practices to minimize worker fatigue in widespread outbreaks, such as adequate rest and shift breaks. Fatigue can contribute to workers' inability to effectively use personal protective equipment during an outbreak.

Personal Protective Equipment
All employers who have workers who are at an elevated risk of occupational exposure to coronavirus or other infectious agents must provide appropriate personal protective equipment (PPE). This includes a N95 respirator as the absolute minimum level of personal respiratory protection allowed and in compliance with OSHA's respiratory protection standard 1910.134. Respirators that are more protective should also be considered, and may be required based on

assessed risk. The use of less protective PPE, including ineffective surgical masks, would be dangerous, ineffective and inappropriate. The ETS should also require the use of gloves, gowns, and other equipment according to OSHA's PPE standard 1910.132. This is particularly necessary because this virus has multiple routes of transmission, including fecal matter.[xxii]

The standard should also include additional considerations for high-hazard procedures. For example, when procedures cannot be delayed, they should be conducted in isolation rooms or other areas with appropriate ventilation and respirators with higher assigned protection factors than a N95 should be required.

Medical surveillance, medical removal protection, and vaccinations

Medical surveillance to monitor at risk workers for illness and to manage those who are symptomatic is essential for both protecting the health of employees as well as to avoid the spread of the virus to co-workers, patients, or others they serve. The ETS must include screening requirements to all workers for symptoms of infection before they come on duty. Symptomatic workers should be sent home until they are physically ready to return to work and cleared by a physician or licensed health care provider. The employer must provide any necessary post-exposure treatment or medical monitoring to exposed workers. The ETS must include requirements for medical removal protection (MRP) so that workers will suffer no loss of employment, pay, benefits, seniority, or other rights during the duration of their illness. MRP is essential to ensuring workers are vigilant about their own health and potential to infect others while not sacrificing their livelihood. A failure to guarantee pay and benefits serves as a disincentive to report symptoms and stay home from work—and if the worker is infected, to spread the infection to patients, co-workers, or the public.

As of this petition, a vaccine is not yet available to address the COVID-19 outbreak. However, if immunizations become available, health care workers, emergency responders, and other high-risk occupations should be prioritized to receive the vaccine. However, vaccination is a personal choice and should be voluntary in nature. No worker should suffer any form of discipline or discrimination for refusing to be vaccinated. Vaccines should be made available at no cost to the employee and at a reasonable time and place. This is in line with OSHA's bloodborne pathogens provisions (1910.1030). Voluntary vaccination programs are one element of a comprehensive approach to protecting workers against infectious diseases—not an exclusive remedy.

Housekeeping

The ETS should include requirements for disposal of infectious waste, laundry, dishes, and eating utensils, patient-care equipment, environmental cleaning and disinfection, and other measures deemed necessary to reduce exposure.

Communication of hazards and training

The ETS should include requirements to properly label objects and containers of potentially infectious materials according to the hazard communication standard (1910.1200). Additionally, warning signs should be posted at the entrance of work areas where there is potential exposure.

Training should be required to ensure that all workers with potential occupational exposure receive training on the symptoms associated with COVID-19, modes of transmission, control methods and their limitations, vaccinations, the medical surveillance program, and other information necessary for worker protection and pandemic prevention. The training must be provided during working hours and the training materials be given in appropriate content and vocabulary to the education, literacy and language of the workers receiving the training. Training should be systematically updated as new research and guidance on effective exposure prevention strategies becomes available.

Recordkeeping

The ETS should include requirements for employers to maintain records for each employee with occupational exposure in accordance with OSHA's recordkeeping standards and access to exposure monitoring and medical records. The medical records should be maintained in accordance with modern Health Insurance Portability and Accountability Act (HIPAA) protocols. OSHA can utilize their silica (1910.1053) and beryllium (1910.1024) standards to issue these provisions.

In conclusion, the imminent threat of pandemic coronavirus demands a swift and comprehensive strategy to protect workers who are exposed to respond to the needs of the public during an outbreak. In the face of no infectious disease standard, OSHA must act now. There is already a global crisis, and the United States must prepare before an outbreak occurs at home. Preparedness is only effective if it includes a comprehensive framework to protect the health and safety of workers on the frontlines of protecting and treating the public during a health crisis. OSHA has the authority and responsibility to protect the health and safety of America's workers. The magnitude and urgency of a coronavirus pandemic cannot be minimized and OSHA must issue an Emergency Temporary Standard for Infectious Diseases to ensure that workers will be protected from all infectious diseases, including COVID-19.

The COVID-19 outbreak is another tragic reminder that the U.S. is not prepared to adequately protect workers on the frontlines from infectious diseases. We urge the Department of Labor to swiftly issue an Emergency Temporary Standard to protect workers from infectious diseases. As unions have a plethora of experience protecting our members on the frontline from infectious diseases and have been integrally involved in government activities surrounding pandemic preparedness for decades,

We urge the administration to work with us through the issuance of an ETS and in developing a final standard to protect workers from infectious diseases.

Sincerely,

Richard L. Trumka
President

Actors' Equity Association, AEA
American Federation of Government Employees, AFGE
American Federation of Teachers, AFT
Association of Flight Attendants-CWA, AFA-CWA
Communications Workers of America, CWA
Department for Professional Employees, DPE, AFL-CIO
National Association of Letter Carriers, NALC
International Association of Machinists and Aerospace Workers, IAM
International Association of Sheet Metal, Air, Rail and Transportation Workers, SMART
International Brotherhood of Teamsters, IBT
International Federation of Professional and Technical Engineers, IFPTE
International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW
New York State Nurses Association
New York State Public Employees Federation, AFL-CIO
American Postal Workers Union, APWU
Service Employees International Union, SEIU
Stage Directors and Choreographers Society, SDC
Transportation Trades Department, TTD, AFL–CIO
Transport Workers Union of America, TWU, AFL-CIO
Transportation Communications Union (TCU/IAM)
United Steel, Paper and Forestry, Rubber, Manufacturing, Energy, Allied Industrial and Service Workers International Union, USW
Utility Workers Union of America, UWUA

CC: Loren Sweatt, Principal Deputy Assistant Secretary of Labor for Occupational Safety & Health

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[xix] *See* 29 U.S.C. 655 § 6(c).

[xx] *See* OSHA-2010-0003-0239.

[xxi] *See* Title 8 CCR; Section 5199.

[xxii] Wei Zhang, Rong-Hui Du, Bei Li, Xiao-Shuang Zheng, Xing-Lou Yang, Ben Hu, Yan-Yi Wang, Geng-Fu Xiao, Bing Yan, Zheng-Li Shi & Peng Zhou (2020) Molecular and serological investigation of 2019-nCoV infected patients: implication of multiple shedding routes, Emerging Microbes & Infections, 9:1, 386-389, DOI: 10.1080/22221751.2020.1729071x

Addendum Tab 4

National Nurses United
The National Voice for Direct-Care RNs

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March 4, 2020

The Honorable Eugene Scalia
Secretary of Labor
United States Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

The Honorable Loren Sweatt
Principal Deputy Assistant Secretary of Labor for Occupational Safety and Health
Occupational Safety and Health Administration
United States Department of Labor
200 Constitution Avenue, NW
Washington, D.C. 20210

Re: National Nurses United Petitions OSHA for an Emergency Temporary Standard on Emerging Infectious Diseases in Response to COVID-19

Dear Secretary Scalia and Principal Deputy Assistant Secretary Sweatt:

National Nurses United (NNU) is the largest union for direct care registered nurses (RNs) in the United States. As such, we are concerned that our members are afforded their right to a safe and healthful workplace and are thoroughly protected by their employers from hazardous exposures that may occur in the course of doing their jobs. On behalf of our members and all nurses and other healthcare workers in the United States, we urge you to take immediate action to ensure nurses and all healthcare workers are protected during the COVID-19 outbreak by granting this petition for the promulgation of an Emergency Temporary Standard on Emerging Infectious Diseases.

COVID-19 is quickly becoming a global pandemic, spreading to 74 countries in a matter of weeks.[1] According to the World Health Organization, a total of 91,783 cases have been identified in 74 countries, and 3,123 people have died of the virus as of March 3rd.[2] As of the same date, the total number of confirmed and presumptive positive cases in the United States is 60,[3] which is likely an underestimation given the U.S. Centers for Disease Control

[1] World Health Organization, (March 3, 2020), "Novel Coronavirus (COVID-19) Situation Dashboard," online at https://experience.arcgis.com/experience/685d0ace521648f8a5beeeee1b9125cd.
[2] World Health Organization, (March 3, 2020).
[3] U.S. Centers for Disease Control and Prevention, (March 3, 2020), "Coronavirus Disease 2019 (COVID-19) in the U.S." online at https://www.cdc.gov/coronavirus/2019-ncov/cases-in-us.html.

and Prevention's (U.S. CDC) limited testing capacity, recent reports of community transmission, and rapidly evolving situation.[4,5]

In every emerging infectious disease event the world has seen, nurses and other health care workers are on the frontlines caring for the most vulnerable, high-risk patients. Nurses nationwide stand ready and willing to provide the lifesaving care patients with COVID-19 infections need, but nurses and other healthcare workers must have the highest level of protection to be able to do their jobs safely. The health and safety of nurses and other healthcare workers is of paramount importance to an effective response to emerging infectious disease events. Fundamentally, nurses and other healthcare workers have the same right as other workers to a workplace free from hazards that threaten their health and safety, including infectious diseases.

OSHA should take immediate action and fulfill its obligation to protect the health and safety of workers by granting this petition and passing an emergency temporary standard to protect nurses and other healthcare workers from emerging infectious diseases like COVID-19.

I. OSHA is obligated to engage in responsible rulemaking to protect worker health and safety and must promulgate an Emergency Temporary Standard on Emerging Infectious Diseases.

Through the Occupational Safety and Health (OSH) Act of 1970, Congress mandated the prioritization of the safety and health of workers and the prevention of occupational injury and illness and created an obligation by employers to provide a workplace free from recognized hazards.[6] Pursuant to this Congressional mandate, OSHA is obligated to promulgate and enforce an emergency temporary standard where two elements are determined:[7]

> (A) that employees are exposed to grave danger from exposure to substances or agents determined to be toxic or physically harmful or from new hazards; and
> (B) that such emergency standard is necessary to protect employees from such danger.

COVID-19, like other emerging infectious diseases, constitutes precisely such a grave danger to nurses and other health care workers. This is a novel virus about which little is known. Healthcare employers are ill prepared to respond safely to prevent employee exposure to COVID-19. Where OSHA determines employees in other industries are at risk of COVID-19 exposure and a standard is necessary to protect those employees, OSHA should take appropriate action. Given the central role nurses and other healthcare workers face in response to emerging infectious diseases and the attendant high risk of exposure, NNU urges OSHA to take immediate action to protect nurses and other healthcare workers from COVID-19.

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[4] Chen, Caroline et al. (Feb 28, 2020), "Key Missteps at the CDC Have Set Back Its Ability to Detect the Potential Spread of Coronavirus." *ProPublica*, published online at https://www.propublica.org/article/cdc-coronavirus-covid-19-test.

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[6] 29 U.S.C. § 651 (1970)

[7] 29 U.S.C. § 655(6)(c) (1970)

II. Emerging infectious diseases like COVID-19 expose nurses and other healthcare workers to grave danger and are new hazards.

A. COVID-19, Like Other Emerging Infectious Diseases, is a New Hazard.

Emerging infectious diseases are those "whose incidence in humans has increased in the past 2 decades or threatens to increase in the near future…which respect no national boundaries."[8] These infectious diseases can include:

- New infections resulting from changes or evolution of existing organisms
- Known infections spreading to new geographic areas or populations
- Previously unrecognized infections appearing in areas undergoing ecologic transformation
- Old infections reemerging as a result of antimicrobial resistance in known agents or breakdowns in public health measures.

COVID-19 is a newly emerged and identified coronavirus, similar to SARS. Researchers have proposed that the virus evolved to jump from animals to humans, but this remains unconfirmed.[9] Even as our knowledge of this virus is growing rapidly, there is still much unknown. As the National Institute for Occupational Safety and Health (NIOSH) recognizes,[10] in these situations the very fact that little is known about the infectious disease amplifies the danger posed to healthcare workers when their employers wait for information or evidence before taking protective action.

Unfortunately, the world has seen several emerging infectious disease events in recent decades—severe acute respiratory syndrome (SARS), Middle East respiratory syndrome (MERS), H1N1 influenza, Ebola, Zika, and others. Nurses and healthcare workers have been at significant risk of exposure to each of these emerging infectious diseases.[11,12,13,14] Emerging infectious disease events have increased in the current and previous centuries, and experts expect that trend to continue and worsen due to the climate crisis, globalization, dense urbanization, lack of public

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[14] Suwantarat, Nuntra and Anucha Apisarnthanarak, (Aug 2015), "Risks to healthcare workers with emerging diseases: lessons from MERS-CoV, Ebola, SARS, and avian flu." *Current Opinion in Infectious Diseases*, 28(4): 349-61.

health infrastructure and funding, lack of protections within healthcare facilities, and other factors.[15,16,17]

In emerging infectious disease events, it is of the utmost importance that healthcare employers provide the fullest protections for nurses and other healthcare workers, especially when the hazard is a novel infectious disease. OSHA should pass an emergency temporary standard to require healthcare employers to provide protections during an emerging infectious disease event like COVID-19. The current urgency of the situation with COVID-19 should motivate OSHA to take immediate action.

B. COVID-19 can cause life-threatening infections, exposing nurses and other healthcare workers to grave danger.

Several published reports have established a basic picture of clinical symptoms and outcomes for those infected with COVID-19. These symptoms can include fever, cough, muscle soreness, weakness, diarrhea, headache, and other symptoms. While some symptoms appear to be common, there is also diversity in how COVID-19 manifests (Table 1).

Table 1: Symptoms of COVID-19 Reported in the Scientific Literature

Symptom	Huang et al. (Feb 15-21, 2020), report on 41 admitted hospital patients with laboratory-confirmed COVID-19 infection in Wuhan, Hubei Province, China[18]	Wang et al. (Feb 20, 2020), report on 105 patients with COVID-19 infections in North Shanghai, China [19]	Liang et al. (Feb 28, 2020), report on 457 patients with lab-confirmed COVID-19 identified from 7 studies[20]
Fever	98%	82.9%	89%
Cough	85%	62.9%	63%
Fatigue or weakness	44%	17.1%	51%
Headache	8%	Muscle soreness 6.7%	8%
Diarrhea	3%	8.6%	7%

[15] Petersen, E. et al. (2018), "Emerging infections—an increasingly important topic: review by the Emerging Infections Task Force." *Clinical Microbiology and Infection*, 24(4): 369-75.
[16] Nii-Trebi, Nicholas Israel, (2017), "Emerging and Neglected Infectious Diseases: Insights, Advances, and Challenges." *BioMed Research International*, published online at https://www.hindawi.com/journals/bmri/2017/5245021/.
[17] Brooks, Daniel R. and Walter A. Boeger, (2019), "Climate change and emerging infectious diseases: Evolutionary complexity in action." *Current Opinion in Systems Biology*, 13: 75-81.
[18] Huang et al. (Feb 15-21 2020), "Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China." The Lancet, 395(10223): 497-506
[19] Wang, Changhui, et al. (Feb 20, 2020), "The Epidemiologic and Clinical Features of Suspected and Confirmed Cases of Imported 2019 Novel Coronavirus Pneumonia in North Shanghai, China." Preprints with The Lancet, published online at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3541125.
[20] Liang, Bo et al. (Feb 28, 2020), "Clinical Characteristics of 457 Cases with Coronavirus Disease 2019." Preprints with The Lancet, published online at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3543581.

Several additional reports underline the potential seriousness of a COVID-19 infection, including damage to lung tissue that has become characteristic to COVID-19. A recent study describes this damage:

> "COVID-19 pneumonia manifests with chest CT imaging abnormalities, even in asymptomatic patients, with rapid evolution from focal unilateral to diffuse bilateral ground-glass opacities that progressed or co-existed with consolidations within 1-3 weeks."[21]

The Chinese Centers for Disease Control and Prevention (Chinese CDC) reported recently that approximately 20% of COVID-19 cases are classified as severe or critical.[22] COVID-19 infections may result in life-threatening conditions including acute respiratory distress syndrome, acute kidney injury, cardiac injury, and liver dysfunction (Table 2) and may require hospitalization, intensive care, intubation, or other significant life-saving interventions. In some cases, COVID-19 may lead to death; the Chinese CDC reported that 2.3% of confirmed COVID-19 cases died.[23] There is currently no cure, only supportive treatment, and no vaccine.

Table 2: Clinical Outcomes of COVID-19 Reported in the Scientific Literature

Clinical progression/outcome	Yang et al. (Feb 24, 2020), report on 52 critically ill patients with COVID-19 who were admitted to an intensive care unit (ICU) in Wuhan, China[24]	Liang et al. (Feb 28, 2020), report on 457 patients with lab-confirmed COVID-19 identified from 7 studies[25]
Acute respiratory distress syndrome	67%	12%
Acute kidney injury	29%	2%
Cardiac injury	23%	3%
Liver dysfunction	29%	-
Death	61.5% at 28 days	8%

There are three possible transmission pathways that infectious diseases, especially those that cause respiratory symptoms like COVID-19, can follow: contact (direct/indirect), droplet, and aerosol transmission. There is currently no available evidence regarding the transmission pathway(s) for SARS-CoV-2/COVID-19. SARS-CoV-2/COVID-19 is similar to SARS-CoV and, to a lesser degree, MERS-CoV. There is sufficient evidence to indicate that direct and

[21] Shi, Heshui et al. (Feb 24, 2020), "Radiological findings from 81 patients with COVID-19 pneumonia in Wuhan, China: a descriptive study." The Lancet Infectious Diseases, published online, https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30086-4/fulltext.
[22] Wu, Zunyou and Jennifer M. McGoogan (Feb 24, 2020), "Characteristics of and Important Lessons From the Coronavirus Disease 2019 (COVID-19) Outbreak in China: Summary of a Report of 72 314 Cases From the Chinese Center for Disease Control and Prevention." *JAMA*, published online at https://jamanetwork.com/journals/jama/fullarticle/2762130.
[23] Wu, Zunyou and Jennifer M. McGoogan (Feb 24, 2020).
[24] Yang, Xiaobo et al. (Feb 24, 2020), "Clinical course and outcomes of critically ill patients with SARS-CoV-2 pneumonia in Wuhan, China: a single-centered, retrospective, observational study." The Lancet Respiratory Medicine, published online, https://www.thelancet.com/journals/lanres/article/PIIS2213-2600(20)30079-5/fulltext.
[25] Liang, Bo et al. (Feb 28, 2020).

indirect contact, droplet, and aerosol transmission are important to the transmission of both SARS-CoV and MERS-CoV.[26]

C. Healthcare workers around the world have been infected with COVID-19 and some have died.

Several reports have emerged from China and other countries with widespread COVID-19 transmission of healthcare workers who have become infected after providing care to patients with possible/confirmed COVID-19 infections.

The Chinese CDC reported recently that 1,716 healthcare personnel have been infected with COVID-19 and that 14.8% of those cases have been classified as severe or critical. Reportedly, at least five healthcare workers in China have died from COVID-19. However, media reports have suggested that the true number of healthcare workers infected in China may be more than 3,000.[27]

Japan has reported infections among healthcare personnel and workers assisting with the quarantine aboard the Diamond Princess cruise ship.[28,29] Reports have been made of several healthcare workers infections in South Korea.[30]

The preparedness of healthcare facilities is essential to prevent exposure of nurses and other healthcare workers to COVID-19 as well as further spread of the virus in the United States. Healthcare employers have not fully protected nurses and other healthcare workers from exposure in the United States. The recent COVID-19 case confirmed at the University of California, Davis Medical Center—the first case identified indicating community transmission in the United States—highlights the potential for widespread exposure of U.S. nurses and other health care workers. Because the employer was not prepared for one COVID-19 patient, 25 registered nurses and at least 80 other health care workers have been placed on precautionary leave.[31] This level of exposure from one patient at one hospital clearly demonstrates that the time to put the strongest protections in place is now.

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[26] National Nurses United, (Feb 16, 2020), "Selection of Protective PPE for Nurses and Other Health Care Workers Caring for Patients with COVID-19," published online at https://www.nationalnursesunited.org/sites/default/files/nnu/files/pdf/flyers/0220_NNU_HealthSafety_COVID-19_PPE_Report.pdf.

[27] Danmeng, Ma and Denise Jia, (Feb 18, 2020), "Coronavirus Among Medics More Widespread Than Reported, Research Shows." *Caixin*, published online at https://www.caixinglobal.com/2020-02-18/coronavirus-among-medics-more-widespread-than-reported-research-shows-101516740.html.

[28] Al-Arshani, Sarah, (Feb 11, 2020), "A Japanese health worker caught coronavirus on the quarantined cruise ship where 174 passengers have tested positive." *Business Insider*, published online at https://www.businessinsider.com/japan-health-worker-got-coronavirus-on-quarantine-ship-diamond-princess-2020-2.

[29] Japanese Ministry of Health, Labour and Welfare, (Feb 13, 2020), "About outbreak of patient associated with new coronavirus (the 29th case)," (machine translated), online at https://www.mhlw.go.jp/stf/newpage_09505.html.

[30] Yonhap News Agency, (Feb 26, 2020), "(2nd LD) More mass infections may come from hospitals, medical facilities," online at https://en.yna.co.kr/view/AEN20200226006952320?section=national/national.

[31] National Nurses United, (Feb 28, 2020), "Nation's hospitals unprepared for COVID-19." Online at https://www.nationalnursesunited.org/press/nations-hospitals-unprepared-covid-19.

Please note that the most up-to-date numbers have been used in the petition.

II. An Emergency Temporary Standard is immediately necessary to protect nurses and other healthcare workers from the hazards posed by emerging infectious diseases like COVID-19.

A. Voluntary measures by industry are insufficient to protect nurses and other healthcare workers from COVID-19.

Healthcare employers in the United States are not taking the appropriate and necessary steps to protect nurses and other healthcare workers from COVID-19 exposure. Over the past few weeks, NNU has been conducting the first-in-the-nation survey of nurses across the country about preparedness and response to COVID-19 in their workplaces. As of March 2, 2020, more than 6,500 nurses have responded from 48 states, the District of Columbia, and the Virgin Islands. Nurse respondents work at hospitals, clinics, and other healthcare facilities. The findings of this survey indicate that most nurses report that their employers are not taking necessary steps to prevent occupational exposures to COVID-19 (Table 3). Without a mandatory standard, health care workers are left unprotected and unprepared.

Table 3: Results of NNU's Survey of Nurses Regarding Their Employers' Protections for COVID-19 Results from over 6,500 nurse respondents from 48 states, the District of Columbia, and the Virgin Islands (March 2, 2020).
44% report that their employer has provided them information about novel coronavirus and how to recognize and respond to possible cases.
58% report that their employer has instituted travel/exposure history screening for all patients with fever and/or respiratory symptoms.
29% report that there is a plan in place to isolate a patient with a possible novel coronavirus infection.
27% report having access to powered air-purifying respirators (PAPRs) on their units. 63% report having access to N95 respirators on their units.
30% report that their employer has sufficient PPE stock on hand to protect staff if there is a rapid surge in patients with possible coronavirus infections.
65% report having been trained on safely donning and doffing PPE in the previous year.
66% report having been fit tested in the previous year.
14% report that their employer has an overflow plan to place additional, trained staff to enable safe care provision to patients on isolation for novel coronavirus.
19% report that their employer has a policy to address employees with suspected or known exposure to novel coronavirus.

B. OSHA has taken similar action previously, resulting in significant protection for nurses and other healthcare workers.

OSHA has recognized the importance of worker protections against occupational exposure to infectious diseases before and taken action to pass an emergency temporary standard in response to an infectious disease outbreak. In 1989, OSHA upheld their Congressional mandate by developing an emergency temporary standard to promptly provide needed protection to health care workers occupationally exposed to bloodborne pathogens, responsive to the exposures caused by lack of employers' prevention and high morbidity and mortality from hepatitis B among healthcare workers. This emergency temporary standard and the permanent standard that

necessarily followed—the Bloodborne Pathogens Standard—subsequently significantly reduced the number of hepatitis B infections from 8,700 to 800 cases within four years of the standard's publication.[32,33]

Similarly, the emergency temporary standard requested by NNU and the subsequent permanent standard would significantly improve protections for health care workers from exposure to emerging infectious diseases like COVID-19. An emergency temporary standard is needed now in response to the current COVID-19 epidemic/pandemic and the ways that nurses and other healthcare workers are placed in grave danger.

A permanent standard on infectious diseases is needed to protect nurses and other healthcare workers from hazards posed by infectious diseases not covered by the Bloodborne Pathogens Standard, including emerging infectious diseases. NIOSH and OSHA have long recognized the hazard posed by infectious diseases in healthcare workplaces.[34,35] In fact, in response to a union petition, OSHA has completed significant work on developing an infectious diseases standard, establishing clearly the need for such a standard.[36] However, such standard has been placed on OSHA's long-term regulatory agenda since Spring 2017.

The current COVID-19 pandemic demands immediate action from OSHA to ensure that nurses and other healthcare workers maintain their essential right to a safe and healthful workplace and to help reduce further community spread among health care workers and the public.

III. OSHA should include these fundamental elements of an Emergency Temporary Standard to Protect Nurses and Other Healthcare Workers from Exposure to Emerging Infectious Diseases.

A. Such an Emergency Temporary Standard on emerging infectious diseases must be based on the precautionary principle.

To protect nurses and other healthcare workers from the hazards posed by emerging infectious diseases, like COVID-19, OSHA should construct an emergency temporary standard that is based on the precautionary principle. The precautionary principle states that "When an activity raises threats of harm to human health or the environment, precautionary measures should be taken even if some cause-and-effect relationships are not fully established scientifically."[37]

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[32] U.S. Occupational Safety and Health Administration, (Nov 27, 2001), "OSHA Archive: CPL 02-02-069 (formerly CPL 2-2.69): Section VII Background," online at https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=directives&p_id=2570#VII.

[33] Jeffress, Charles N., (June 22, 2000), "OSHA Archive: STATEMENT OF CHARLES N. JEFFRESS BEFORE THE SUBCOMMITTEE ON WORKFORCE PROTECTIONS HOUSE EDUCATION AND THE WORKFORCE COMMITTEE," online at https://www.osha.gov/news/testimonies/06222000.

[34] U.S. National Institute for Occupational Safety and Health, (last reviewed Jan 13, 2017), "HEALTHCARE WORKERS: Infectious Agents," online at https://www.cdc.gov/niosh/topics/healthcare/infectious.html.

[35] U.S. Occupational Safety and Health Administration, "Healthcare: Infectious Diseases," online at https://www.osha.gov/SLTC/healthcarefacilities/infectious_diseases.html.

[36] U.S. Occupational Safety and Health Administration, "Infectious Diseases Rulemaking," online at https://www.osha.gov/dsg/id/.

[37] Hayes, AW, (2005), "The precautionary principle." *Arh Hig Rada Toksikol*, 56(2): 161-6.

The precautionary principle should govern all decisions made about protections for an emerging infectious disease as it emphasizes anticipatory action. Following the precautionary principle is necessary to protecting nurses and other healthcare workers from the hazard posed by an emerging infectious disease where little may be known. Nurses and other healthcare workers have a fundamental right to a safe and healthful workplace and infectious diseases should be no exception. In addition, the full protection of healthcare workers is a fundamental and necessary part of limiting the spread of viruses—this has been proven time and again with SARS, MERS, H1N1, Ebola, and others. It is critical that nurses and other healthcare workers are kept safe not only to provide critical care for patients with potential COVID-19 infection, but also to continue caring for other patients.

B. Several elements must be implemented by healthcare employers to protect nurses and other healthcare workers and therefore should be included in OSHA's emergency temporary standard. In response to COVID-19, as with other emerging infectious diseases, health care employers must have in place comprehensive exposure control plans that must include the proper screening and isolation procedures, engineering controls, the highest standard of personal protective equipment (PPE), safe staffing, and other protections. It is of importance that healthcare employers also make plans and preparations to safely respond to a possible surge in patients with COVID-19. All protections must be implemented in a proactive, preventive manner; when they are implemented in reaction to confirmed cases or in reaction to healthcare worker exposures, that endangers the health and safety of nurses and other healthcare workers.

OSHA has many resources on which to draw in developing an emergency temporary standard on emerging infectious diseases like COVID-19. The California Division of Occupational Safety and Health (Cal/OSHA) has a long-standing enforceable standard that addresses many of the necessary elements for protecting nurses and other healthcare workers from infectious diseases not covered by the Bloodborne Pathogens Standard, including emerging infectious diseases.[38] Cal/OSHA's Aerosol Transmissible Diseases Standard should serve as a baseline for OSHA's work on an emergency temporary standard responsive to COVID-19 as well as a subsequent permanent standard. In addition, OSHA has released guidance regarding COVID-19 for healthcare and other industries, which includes some of the following necessary elements.[39]

The following elements are necessary, at minimum, to protect nurses and other healthcare workers from COVID-19. Healthcare employers should:

- Communicate clearly with nurses and other staff regarding COVID-19 preparation, protocols, and any confirmed or suspected cases in the facility. When employers do not communicate clearly with staff it opens the door to misinformation and confusion which creates additional risk of transmission. Employers should ensure that nurses and other healthcare workers receive effective training and education regarding their plans, protocols, preparations, and response to COVID-19. Such training and education should

[38] 8 CCR §5199; Also see California Department of Public Health, (Jan 2018), "Cal/OSHA's Aerosol Transmissible Disease Standards and Local Health Departments," online at https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/CDPH%20Document%20Library/ATD-Guidance.pdf.
[39] U.S. Occupational Safety and Health Administration, "COVID-19: Control and Prevention," online at https://www.osha.gov/SLTC/covid-19/controlprevention.html#health.

be implemented proactively, in preparation for a possible COVID-19 case, rather than "just in time," after a COVID-19 case has arrived at the facility, when it is too late.

- Implement screening protocols to promptly identify and isolate patients with possible COVID-19 infections at the first point of contact/entry in the healthcare facility or before arrival at the healthcare facility. Such protocols should be proactive and preventive, based on the precautionary principle, rather than reactive.

- Ensure prompt isolation of patients with possible COVID-19 infection. These patients should be placed in airborne infection isolation rooms until COVID19 or other infectious disease has been ruled out. These airborne infection isolation rooms must be constructed and consistently maintained so that they provide protection to staff and patients. A separate waiting area should be established for any patients or visitors with respiratory symptoms to prevent exposures.

- Provide the highest level of PPE to nurses and other health care workers who are providing care to patients with possible COVID-19 infections. PPE should be selected based on the precautionary principle. For COVID-19, NNU maintains that the highest level of PPE includes a powered air purifying respirator (PAPR), coveralls that are impervious to viral penetration (meeting ASTM F1671/ISO 16604 standards), and gloves.[40] All respiratory protection should be implemented as required by OSHA's Respiratory Protection Standard, including annual fit testing for respirators requiring a fit test, training and education, and other requirements.[41] Health care employers must have in-person, hands-on training and education for all nurses and other health care workers regarding PPE and safe donning and doffing practices. Again, such training and education should be implemented proactively, in preparation for a possible COVID-19, rather than "just in time," after a COVID-19 case has arrived at the facility, when it is too late.

- Make staffing assignments to ensure that nurses and other health care workers caring for patients with possible or confirmed COVID-19 infections are able to do so safely. When patients are on isolation, additional time is needed to safely don and doff PPE. Wearing PPE can be extremely physically taxing; nurses who need to wear PPE ensembles for long periods of time should be given breaks and relief when needed. Additional staff may be necessary to assist nurses and other health care workers in donning and doffing PPE safely. Ensuring that nurses providing care to patients with possible or confirmed COVID-19 infections are, at minimum, on 1:1 assignments can help prevent unintentional spread of the virus via contaminated objects or surfaces.

- Implement effective procedures to identify any possible occupational exposure and to follow up immediately with affected staff. If a nurse or other health care worker is placed on precautionary leave, that leave must last for at least the minimum incubation period

[40] National Nurses United, (Feb 16, 2020).
[41] 29 CFR §1910.134

and the employer must maintain all pay, seniority, and benefits for the entire length of the leave.

- Maintain sufficient PPE stock and supply to protect nurses and other healthcare workers, including during a possible surge in patients with respiratory symptoms. In the context of worldwide and regional PPE shortages, rationing or reuse of PPE should be implemented only after all other avenues have been exhausted, and nurses' professional judgment on when it is safe to reuse or conserve respirators must be heeded. Stockpile and procurement plans and procedures must be in place to ensure respiratory and PPE supplies are readily accessible.

- Begin preparation immediately for a potential surge of patients with respiratory symptoms, which should include at least preparing separate waiting areas such as surge tents, preparing plans to deal with significant numbers of patients such as overflow areas, ensuring staff are aware of surge plans before implementation, establishing plans to respond if significant numbers of healthcare workers are exposed or sick and unable to work.

- Make a COVID-19 vaccination available, in the event it is developed, for free and in a time and place convenient to their work to nurses and other healthcare workers.

- Develop robust housekeeping and environmental cleaning protocols and plans. Such housekeeping and environmental cleaning protocols should be based on the precautionary principle, providing the highest level of protection without waiting for scientific evidence that it is necessary. Employers must consider all aspects of environmental cleaning, including specific ensuring that common, public areas are cleaned effectively following identification of a possible or confirmed COVID-19 case. This must also include protocols to respond if a patient with COVID-19 must leave the negative pressure isolation room to travel through the facility for medical procedures or care.

- Establish and maintain clear records of their implementation of these protective measures, any and all exposures to COVID-19 and what follow-up occurred, and other records.

Nurses and other health care workers stand ready and willing to provide care that patients with COVID-19 need, but they need strong protections from their employers to be able to do so safely. All health care workers must receive the highest level of protection in their workplaces, as determined by the precautionary principle. We urge OSHA to take immediate action to protect nurses and other healthcare workers from COVID-19 by granting this petition and issuing and enforcing an emergency temporary standard. If you have any questions, please reach out to Jane Thomason at 510-433-2771 or jthomason@nationalnursesunited.org.

Sincerely,

Bonnie Castillo, RN
Executive Director
National Nurses United

CC: Vice President Mike Pence
Ambassador Deborah Birx, White House Coronavirus Response Coordinator
Secretary Alex Azar, Department of Health and Human Services
Dr. Robert Redfield, Director, Centers for Disease Control and Prevention
Dr. Anthony Fauci, Director, National Institute of Allergy and Infectious Diseases
The Honorable Nancy Pelosi, Speaker, US House of Representatives
The Honorable Kevin McCarthy, Minority Leader, US House of Representatives
The Honorable Mitch McConnell, Majority Leader, US Senate
The Honorable Chuck Schumer, Minority Leader, US Senate
All Members of the Committee on Education and Labor, US House of Representatives
All Members of the Committee on Oversight and Government Reform, US House of Representatives
All Members of the Energy and Commerce Committee, US House of Representatives
All Members of the Health, Education, Labor & Pensions Committee, US Senate
All Members of the Committee on Homeland Security and Governmental Affairs, US Senate
Mr. Andy Levinson, Deputy Director, Directorate of Standards and Guidance, OSHA
Ms. Maureen Ruskin, Deputy Director, Directorate of Standards and Guidance, OSHA
Mr. J. Joseph Wheeler, Deputy Assistant Secretary, Office of Congressional and Intergovernmental Affairs, Department of Labor

Addendum Tab 5

SECRETARY OF LABOR
WASHINGTON

APR 3 0 2020

Richard L. Trumka
President, AFL-CIO
815 16th St. NW
Washington, D.C. 20210

Dear President Trumka:

I write in response to your letter of Tuesday, April 28, regarding the Labor Department's approach to the workplace threat posed by coronavirus. I have learned that correspondence such as yours can help us at the Department do our jobs better; your letter made some points and suggestions that we will give further consideration. Thank you.

Your letter also reflected some basic misunderstandings, similar to misstatements by critics of the Administration which have been dutifully reported in the media. Allow me to correct a few.

First, your letter repeats the rhetorically gratifying but false and counterproductive assertion that the Department's Occupational Safety and Health Administration (OSHA) has been "missing in action" during the pandemic. Yet, your letter proceeds to describe some of the many things OSHA has done to respond in this crisis, including providing extensive guidance, taking steps in conjunction with the Centers for Disease Control and Prevention to preserve the respirator supply for health care workers, conducting thousands of investigations of complaints, and highlighting the rights and protections of whistleblowers. I appreciate that you may want *different* actions from OSHA, but to obscure the guidance OSHA has given, and to suggest OSHA is indifferent to worker protection and enforcement, is to mislead employers about their duties and workers about their rights.

OSHA's website contains extensive guidance on the virus for the benefit of workers and employers and in fact, the cop *is* on the beat. The Administration's critics undermine worker safety by telling companies otherwise.

Second, your letter disparages OSHA's guidelines as "only voluntary," suggesting that there are no compliance obligations on employers. That is false—and again risks misleading employers about their duties. Thankfully your letter proceeds to list the many legal authorities OSHA possesses to address employers who fail to take appropriate steps to protect their workers. Those include the OSH Act's "general duty clause" (p. 6), and OSHA rules regarding respiratory protection, personal protective equipment, eye and face protection, sanitation, and hazard communication (p. 5). Your letter also notes (p. 6) that the very guidance it disparages can (together with CDC guidance and industry standards) support an enforcement action under the general duty clause.

Third, your letter (p. 5) urges OSHA to adopt an emergency temporary standard because "in the face of a novel virus, employers must not wait for scientific certainty of harm before implementing precautions to protect workers." But employers *are* implementing measures to protect workers, in workplaces across the country. (And employers who fail to take steps are likely violating existing OSHA obligations.) Moreover, the steps employers are taking include the very measures your letter say should be in a new rule, e.g., "risk assessment," "sanitation and cleaning," personal protective equipment, and "training and education" (pp. 5-6). Indeed, the contents of the rule detailed in your letter add nothing to what is already known and recognized (and in many instances required by the general duty clause itself). Compared to that proposed rule, OSHA's industry-specific guidance is far more informative for workers and companies about the steps to be taken in *their* particular workplaces. That is one of the reasons OSHA has considered tailored guidance to be more valuable than the rule you describe. Your letter identifies a second reason: the virus is "novel" and there is little "scientific certainty." In the words of another labor leader, the steps to be taken after 9/11 and Hurricane Sandy were clear, but "[t]his is different. It changes day to day." Guidelines allow flexibility and responsiveness to that change, in a way a rule would not.

But to repeat, OSHA will not use guidelines as a substitute for enforcement—rather, the agency has the tools and intent to pursue both avenues; that is our two-pronged approach.

One final point: Coronavirus is a hazard in the workplace. But it is not unique to the workplace or (with the exception of certain industries, like health care) caused by work tasks themselves. This by no means lessens the need for employers to address the virus. But it means that the virus cannot be viewed in the same way as other workplace hazards. Your letter inadvertently demonstrates this, urging (p. 7) a rule requiring "all employers" to report "all" worker infections to OSHA "within 24 hours," "whether or not they are determined to be work-related." (The emphasis is yours.) What you propose would burden employers and overwhelm OSHA with information that—you concede—is "not . . . work-related." The proposal illustrates how the measures one might ordinarily prescribe will not work here.

President Trumka, thank you again for your letter. To reiterate, you make points we will consider. The coronavirus presents grave and shifting challenges that require sustained attention; we evaluate daily what additional steps we can and should take. I certainly share your concern for the workers who have died from COVID-19. And I respect all that the AFL-CIO and other unions have done through the years to protect workers. I ask that you show due respect for the steps the dedicated men and women at OSHA are taking now.

Respectfully,

EUGENE SCALIA