TAB G

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

In re American Federation of Teachers, et al., *Petitioners*, *v.* Occupational Safety and Health Administration, et al., *Respondents*.	Case No. ___

DECLARATION OF DALIA THORNTON

I, Dalia Thornton, declare as follows:

1. The facts in this declaration are based on my personal knowledge.

2. I am the Director of the Department of Research and Collective Bargaining at the American Federation of State, County and Municipal Employees ("AFSCME"). I began working for AFSCME, within my department, in 2007. I was promoted to Assistant Director of Research and Collective Bargaining in 2015, where I served until becoming Director in September 2019.

3. In my position as Director, I oversee all of our work to promote and protect the workplace health and safety of our members, including a team of health and safety specialists.

4. AFSCME and its local affiliates represent a broad spectrum of members who work in healthcare and healthcare-related settings in both the public and private sectors. Our members include licensed medical professionals such as doctors, dentists, and registered nurses; other personnel providing patient care such as medical technicians, home health aides, and certified nursing assistants; support staff in healthcare workplaces such as janitorial, building, and food service personnel; workers who provide emergency care and medical transportation, such as emergency medical technicians, paramedics, and corrections officers; and professionals in other healthcare-related occupations, such as laboratory and autopsy technicians. These members work in a wide variety of workplaces providing healthcare, from hospitals and nursing homes to

correctional facilities and emergency medical services. We represent approximately 350,000 members who work in healthcare settings such as hospitals, clinics, home care, and long-term care, and 30,000 emergency medical technicians and paramedics. We also represent 62,000 corrections officers and 23,000 corrections employees.

5. AFSCME, through its local and regional bodies, serves as the exclusive collective bargaining representative of its members. That legal duty encompasses all working conditions of our members, including workplace/occupational health and safety. Indeed, workplace health and safety is a primary area of concern for workers, in addition to wages and benefits, and our members rely on us to advocate for them inside and outside of the workplace over this critical issue. Workplace health and safety is particularly important to AFSCME's members working in health care, patient care, and similar settings.

6. As part of our and our affiliates' duties as our members' representatives, we engage in a substantial amount of advocacy related to workers' health and safety, including specifically protection from infectious diseases. This work occurs at every level of our work: with individual employers, with regulatory agencies, and with state and federal policymakers.

7. AFSCME, and the department of Research and Collective Bargaining specifically, employs occupational health and safety experts who assist on-the-ground, legislatively, in labor-management committees and bargaining, and in training, development, and advocacy roles.

8. At the individual employer level, we address dozens of cases each year in which employers' occupational health and safety practices fail to adequately protect our members and other workers. Our members and our local affiliates frequently bring issues to our attention regarding unsafe or unhealthy practices that put employees at risk. We expend considerable resources supporting our members and local affiliates investigating these complaints, including by conducting worksite inspections, working with employers to address complaints, and bringing

issues to state or federal regulatory bodies when employers refuse to improve their practices. For example, in the wake of the COVID-19 pandemic in 12 state facilities operated by the Maryland Department of Health, AFSCME members spent over 2 months advocating for each individual facility to put together comprehensive plans to control the spread of the virus. In that time, multiple facilities experienced outbreaks, and they were handled differently in each facility. For instance, at one hospital it took nearly a week to begin isolation procedures once a patient tested positive, and at another facility no dedicated quarantine unit was ever established. While the facilities were skirting CDC guidance, our union had to address enforcement issues with 12 individual CEOs, rather than point to a single OSHA standard for each facility to comply with. Before our efforts, some of the facilities did not even have infection control plans, as a binding OSHA standard would require.

9. We also devote substantial resources to training our members on workplace health and safety matters. This specifically includes measures to minimize the spread of infectious diseases. From March 2015 to December 2019, AFSCME's health and safety specialists and AFSCME-trained peer trainers trained 1,896 members on how to prevent the transmission of infectious disease in the workplace. Since January 2020, we have trained 1,732 members on infectious disease, with a focus on COVID-19.

10. Many of these efforts have been undertaken in partnership with the federal government. For example, the Occupational Safety and Health Administration ("OSHA") has provided AFSCME with grants under the Susan Harwood Training Grant Program to raise awareness on infectious diseases and how to prevent transmission, particularly targeting health care and home care in California and Alaska, as well as in Illinois, Iowa, Maryland, and New York. Similarly, we have received grants or subgrants from the National Institute of Environmental Health Sciences for the past several years, including grants related to COVID-19,

the Ebola safety program, and outbreaks of infectious diseases such as legionellosis and mumps, for training throughout the United States.

11. We have also advocated for states to introduce infectious disease standards in the absence of binding OSHA standards, or to apply OSHA's standards to public employers. While these efforts have had success in a few states, we have generally been unable to convince states to go further than OSHA has.

12. The lack of enforceable standards makes our efforts to work with employers to improve their practices far more difficult. When we deal with health and safety issues where statutes or regulations compel employers to meet a certain standard, we are usually able to convince employers to comply with the law and take the necessary steps to protect our members' health. For example, in the one area of infectious disease where OSHA *has* issued a standard—bloodborne pathogens such as HIV or hepatitis—most employers comply with the standard and our efforts when we do need to intervene are generally successful and relatively inexpensive.

13. But when we can only point to non-binding guidance, it is far harder to improve an employer's practices. We usually need to resort to more expensive, adversarial approaches such as public campaigns or picketing, which are slower, less effective, and more expensive. We may even need to file complaints with OSHA or the state and/or federal labor relations boards, a costly route that often makes it more difficult to work collaboratively with employers on other issues.

14. For example, some of our corrections officers in New Mexico were required to transfer incarcerated patients with COVID-19 to El Paso for medical treatment. The employer initially refused our requests for appropriate personal protective equipment ("PPE") and mandatory testing and quarantining, forcing us to file a charge with the New Mexico Public Employees Labor Relations Board before the employer would agree to an adequately protective plan.

15. The lack of an enforceable standard governing employers' obligation to maintain adequate infection control practices has been a problem for more than a decade. As early as 2010 it was clear to AFSCME that the current regime, relying on voluntary compliance with optional standards and the ambiguous background obligation of the General Duty Clause, was insufficient. Accordingly, we filed a petition with OSHA in 2010 requesting issuance of a standard for preventing airborne infectious diseases in healthcare workplaces.

16. OSHA's failure to issue such a standard has significantly exacerbated the COVID-19 crisis and the risks faced by AFSCME's members. At just one hospital in New Mexico, over 600 workers were forced to quarantine due to COVID-19 exposure in the first months of the pandemic. At other hospitals, registered nurses were told they did not need N-95 masks despite the fact that they were working with COVID-positive patients, and nurses were assigned to both COVID and non-COVID patients in the same unit at the same time. In Maryland, many employers refused to provide available masks to healthcare workers, and at one long-term care facility, AFSCME members were even disciplined for wearing masks they brought from home.

17. For many AFSCME members, the lack of a standard has proven fatal. Ed Nelson, 65, built his career as an employee of the Hurley Medical Center in Flint, Michigan. On April, 2020, Ed passed away due to complications from COVID-19 in that very same hospital. At least 118 AFSCME members have lost their lives to COVID-19 in recent months, and many more have suffered non-fatal infections, for which we are only beginning to understand the long-term consequences. While we do not know exactly how many of these cases involved workplace transmission (due in part to OSHA guidance limiting employers' obligations to record incidents of workplace spread or exposure), we do know that the members' job duties (putting them in high-density workplaces and in direct contact with patients and inmates suspected or known to have COVID-19) placed them at an increased risk of exposure to SARS-CoV-2, the virus that causes

COVID-19.

18. Nor have these risks diminished as we have learned more about reducing the spread of COVID-19. It is now widely understood that SARS-CoV-2 can be spread via both droplet and aerosol transmission, particularly in indoor settings where people spend long periods of time—such as hospitals, correctional facilities, and congregate care facilities. Even so, many of our members report that their employers fail to implement appropriate engineering and administrative controls in the workplace, refuse to provide appropriate PPE and related training to protect against aerosolized transmission, and do not maintain adequate facilities for disinfection and isolation. AFSCME has provided PPE to members in eleven states at significant expense to make up for employers' failure to do so. We anticipate that the need to do so and the accompanying cost will persist as long as OSHA refuses to issue an infectious disease standard that will require employers to establish an infection control plan and implement adequate protective measures. More troublingly, as we enter an apparent third wave combined with a winter flu season, the risk to our members and their families and communities is higher than ever.

19. Pursuant to 28 U.S.C. § 1746, I hereby declare under penalty of perjury under the laws of the United States that the foregoing declaration is true and correct to the best of my knowledge, information, and belief.

Dated: October 27 2020

DALIA THORNTON
Director
Department of Research and Collective Bargaining
American Federation of State, County, and
Municipal Employees

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