

# TAB F

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

v.

Occupational Safety and Health Administration,  
et al.,

*Respondents.*

**DECLARATION OF RHONDA WEINGARTEN**

I, Rhonda Weingarten, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I have served as the President of the American Federation of Teachers (“AFT”) since July 2008. Prior to that time, I served as an AFT Vice President from 1997 through July 2008, as well as the President of the United Federation of Teachers, AFT’s largest local union affiliate, from 1998 through 2009. I was a teacher from 1991 to 1997 at Clara Barton High School in New York where I taught high school classes including Law, AP Political Science, and U.S. History and Government.
3. The AFT is a national labor union representing approximately 1.7 million members across the United States, including healthcare professionals, educators, and public service workers. The AFT has over 3,000 affiliated local unions and 44 state federations throughout the United States.
4. The AFT’s membership includes more than 150,000 people who work in the healthcare sector. These include nurses, medical researchers, physicians, dietitians, psychologists, X-ray technicians, therapists, and many others.
5. Many of our healthcare members work in settings that pose a high risk for

communicable and infectious diseases. These include conventional acute care settings such as hospitals and medical clinics, as well as other institutions that constitute congregate and dense community settings. These include long-term care institutions for individuals with disabilities and mental health challenges; correctional facilities; schools with students with special needs; and social service settings.

6. This ongoing risk exposes our members to infectious disease outbreaks and exposures with some regularity. Our members in hospitals and schools have been infected during workplace outbreaks of pertussis, tuberculosis, and meningitis. Similar outbreaks have occurred in correctional and long-term care facilities where our members work.

7. The AFT has long advocated on behalf of its healthcare members to improve their workplace's practices to protect against the risk of infectious disease. As part of our duties as our healthcare members' national union, we support our affiliates in their role as collective bargaining representative in negotiation with individual employers regarding workplace safety issues. We also assist our affiliates in representing members with individual complaints against their employers for substandard practices that place our members in harm's way.

8. In many cases, however, employers are unwilling to take proactive preventive steps to prevent outbreaks of infectious disease, or to take adequate measures to limit their spread when they occur. Many employers take the position that infectious disease outbreaks are a matter for public health authorities, rather than for employers to address through risk assessment and preventive occupational safety and health protections.

9. Over the years, we have received countless reports from our healthcare members about inadequate respiratory protection programs, whether due to the absence of sufficient personal protective equipment ("PPE"), the failure to maintain PPE such as respirators or provide

appropriate training and fit testing, or the inadequacy of infectious disease plans and protocols.

10. For example, during the 2014 Ebola outbreak, many hospitals were insufficiently stocked with appropriate PPE and failed to develop methods to protect staff and other patients from potential exposure or train healthcare staff on appropriate occupational safety and health measures. Even as national attention to the outbreak was at its highest, when a New Jersey hospital treated a patient with Lassa fever (an infectious hemorrhagic virus akin to Ebola) in early 2015, the hospital failed to exercise its Ebola infectious disease protocol and exposed workers throughout the hospital to potential infection.

11. We have long worked with federal agencies on behalf of our members to improve the response to infectious disease outbreaks and reduce potential risks. For example, in the 1990s, we joined other unions in petitioning Occupational Health and Safety Administration (“OSHA”) for an emergency temporary standard for tuberculosis; in 2009, we worked with OSHA and the National Institute for Occupational Safety and Health (“NIOSH”) on guidance to protect workers during the H1N1 pandemic; and in the 2010s, we worked with NIOSH on a Health Hazard Evaluation around a Lassa Fever case in a New Jersey Hospital and submitted recommendations to the Centers for Disease Control and Prevention (“CDC”) on the Ebola and Zika outbreaks. We have participated in panels on respiratory protection for workers exposed to infectious disease for the National Academies of Sciences, Engineering, and Medicine, and we have submitted recommendations to CDC on a variety of guidance to protect workers from infectious disease exposure, including COVID-19.

12. Most relevant to this case, the AFT and other unions submitted a petition to OSHA in May 2009, requesting that it issue a standard under 29 U.S.C. § 655(b)(1) to protect healthcare workers from airborne infectious diseases. As we explained in the petition, OSHA’s

voluntary guidance to employers had proven insufficient to protect healthcare workers from the risks of such diseases. The widespread noncompliance with OSHA's voluntary guidance and the urgency of the risk to our healthcare members and to medical personnel, patients, and communities across the country necessitated a mandatory, legally enforceable standard to protect workers from the material impairment of their health or functional capacity.

13. OSHA initially seemed to take our petition seriously. It issued a Request for Information on the subject, conducted multiple meetings with AFT and other stakeholders, and issued a proposed framework for a forthcoming standard. But more than 11 years after our petition, it has failed to take any final action.

14. This year, OSHA's failure to act and the shortcomings at healthcare workplaces across the country—from hospitals to nursing homes to correctional facilities—have jeopardized the health of our healthcare members and their families like never before. The COVID-19 pandemic has spread especially virulently among healthcare workers, due in part to the absence of sufficient PPE and inappropriate or insufficient infectious disease protocols and practices. Countless AFT healthcare members have contracted COVID-19, including at least 13 who have passed away as a result of the disease.

15. Our healthcare members are committed to doing their part to improve the health of those who need their services, but they should not need to place their own health at risk to do so. Without an enforceable standard for workplaces to follow to protect against airborne infectious diseases, our members will continue to face a preventable risk of contracting COVID-19 and other life-threatening illnesses.

16. 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 26, 2020

*/s Rhonda Weingarten*  
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RHONDA WEINGARTEN  
PRESIDENT  
AMERICAN FEDERATION OF  
TEACHERS

# TAB G

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

v.

Occupational Safety and Health Administration,  
et al.,

*Respondents.*

**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

TAB H

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

v.

Occupational Safety and Health Administration,  
et al.,

*Respondents.*

**DECLARATION OF LAURENCE RICK, PA**

I, Laurence Rick, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am a certified Physician Assistant employed by Kaiser Permanente at their South Bay Medical Center. I am also the South Bay staff representative for the United Nurses Association of California/Union of Health Care Professionals (“UNAC/UHCP”), an affiliate of the American Federation of State, County and Municipal Employees (“AFSCME”) that represents all levels of medical personnel at South Bay, including physicians, nurses, pharmacists, and technicians and technologists.
3. Physician assistants are advanced practice providers trained and authorized to perform in particular medical specialties. My specialty is infectious disease. I have worked for Kaiser Permanente for 30 years focusing on emerging infections like COVID-19 and the prevention of and treatment of HIV, and all STD’s. Additionally I am an employee for the union UNAC/UHCP and my role has including disaster preparedness and emerging infections like West Nile Virus, Ebola and now COVID-19 disease.
4. For the past 30 years, I have worked closely with Kaiser management to develop and maintain our infection control practices. Kaiser is part of an industry-leading labor

management partnership that gives employees a significant voice in company decision-making. As a result, I have been able to help ensure that our hospitals employ infection control practices that protect staff and patients from the ever-present risk of infectious disease.

5. Among infectious disease experts, it has long been clear that healthcare workers are at a significant risk of contracting infectious diseases at their workplaces, whether the infectious agent is a familiar one like measles or legionella or a novel one like SARS-CoV-2. Over the years, infectious disease professionals and occupational health experts have identified a number of background rules that protect against many infectious diseases.

6. For example, the Universal Precautions approach calls for ideal hand washing practices, proper PPE for the situation, and cleaning and containment practices. Recently much discussion around ideal air flow and humidity will likely play a much more important role as well. For hospital workers and for many industries that need to protect all workers.

7. While these practices are generally understood, they are not universally adopted. These best practices are largely guidelines for medical administration, rather than standards required by OSHA and its state equivalents. I have worked to ensure that Kaiser follows the best practices for reducing the risk of transmission, but in the absence of a legal requirement, many hospitals and other healthcare workplaces are not as rigorous.

8. The lack of an enforceable standard has contributed directly to the spread of SARS-CoV-2 in healthcare workplaces and the broader community. If, for example, workplaces were required at a minimum to provide appropriate face shields and droplet-level protective masks to employees working with patients who may have a communicable disease transmittable through droplets or aerosols, the rate of COVID-19 among healthcare workers would have been far lower than it has been. Similarly, requirements regarding fit testing, replacement of saturated



masks, and other well-understood protective measures would have significantly safeguarded the millions of healthcare workers who have been treating patients afflicted by COVID-19.

9. Among infectious disease professionals, the specter of a disease like COVID-19 was never a matter of if, but when. With the increasing rate of animal-to-human transmission of novel viruses and the globalized nature of disease transmission, such outbreaks are inevitable. In many ways, SARS-CoV-2 is mild compared to what it could have been and what future diseases may be. It is not as communicable as measles, for example, nor as deadly as HIV or Ebola. If we continue to allow healthcare workplaces to forgo widely recognized infectious disease measures, the consequences in future pandemics could be even more catastrophic than they have been this year.

10. 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

/s/ Laurence Rick  
LAURENCE RICK

# TAB I

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

v.

Occupational Safety and Health Administration,  
et al.,

*Respondents.*

**DECLARATION OF SALLY WATKINS, Ph.D., MS, RN**

I, Sally Watkins, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am the Executive Director of the Washington State Nurses Association (“WSNA”), an affiliate of the American Federation of Teachers (“AFT”).
3. I have previously served as the Administrative Director of Clinical Resource Management for CHI-Franciscan Health System in Tacoma, Washington, the Chief Nursing Executive for MultiCare Health System, and a nursing educator for the Pacific Lutheran University School of Nursing, among other positions. I hold a Ph.D. in Organizational Behavior and a Masters in Nursing.
4. WSNA has more than 17,000 members across Washington state, including members in a wide variety of nursing specialties. Our members work in all settings where nursing care is required, from hospitals and home health to schools and correctional facilities.
5. We work on behalf of our members to improve occupational health and safety practices at employers on a number of issues. Because of the nature of our members’ employment, infectious disease control is a major focus of our efforts.
6. This advocacy takes a number of forms. We work with employers to improve their infection control practices and comply with best practice guidelines. Where employers are

recalcitrant, we engage in public campaigns or file administrative complaints against their practices.

7. We frequently hear from members about substandard infection control practices at healthcare employers. In our experience, many employers will do the minimum required by federal or state law. Thus, if OSHA and its Washington counterpart, DOSH, do not require employers to meet an enforceable standard, employers will often fall far short of adequately protective practices.

8. This has particularly been the case with airborne infectious diseases. Even before the current pandemic, our members frequently reported inadequate training and inappropriate practices at healthcare employers of all types. For example, nurses often report absence of required fit testing of N95 masks, lack of clarity on cleaning processes for reusable respirators, and insufficient training and practice donning and doffing PPE to prevent cross contamination and pathogen exposure.

9. During the COVID-19 pandemic, these problems have been more acute than ever, with tragic consequences. We have received complaints from members at many different workplaces about inadequate personal protective equipment, infection control protocols, and other policies and practices.

10. In response, we have filed at least 17 complaints with DOSH regarding workplace health and safety hazards related to COVID-19. Each complaint requires a substantial commitment of staff time and resources, and the surge in COVID-related issues has forced us to redeploy staff members from other projects to work on investigating and addressing these concerns.

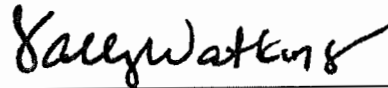
11. Our efforts would be substantially easier if OSHA had issued enforceable standards regarding airborne infectious diseases at healthcare workplaces. DOSH requires all covered employers to adhere to mandatory OSHA standards. Where such standards exist, employers are

often willing to work collaboratively to meet the governing standards; where they are missing, employers are far more likely to fight our claims and hope that they can escape liability under the vaguer General Duty Clause.

12. The lack of standards and the shortcomings in employers' practices have had predictable and tragic consequences for our members. Many of the people we represent have contracted COVID-19, and at least one has passed away from COVID-19 or related conditions. (We do not have exact numbers about workplace transmission because OSHA has issued guidance effectively allowing employers not to report incidents of workplace transmission.) And the human cost goes far beyond our members, as family and community members have contracted the disease as a result of the spread from healthcare workplaces.

13. 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 23, 2020



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Sally Watkins  
Executive Director  
Washington State Nurses Association

# TAB J

**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 DENISE DUNCAN, RN**

I, Denise Duncan, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am the President of the United Nurses Associations of California/Union of Health Care Professionals (“UNAC/UHCP”) and a registered nurse since 1983.
3. UNAC/UHCP, an affiliate of the American Federation of State, County and Municipal Employees, represents more than 32,000 registered nurses and other health care professionals throughout California and Hawaii. Our members work in a wide range of health care settings, primarily in hospitals and clinics.
4. Our mission is to safeguard the rights and health of our members and to improve the health of our members’ communities. As part of our obligations to our members, we work with employers to improve their practices in a wide range of occupational health and safety. Because of the nature of our members’ employment, infectious disease control is a major focus of our efforts.
5. For example, we spend a substantial amount of effort working with employers to adopt and maintain best practices for infection control. Most employers welcome us as partners in a joint mission to protect staff and patients. Through intense discussion with our largest

employer, Kaiser Permanente, we have successfully advocated for improved personal protective equipment. In order to free-up necessary supplies, we strongly and successfully advocated for hospital transparency and the immediate cessation of elective surgeries, not only within Kaiser Permanente but with hospitals throughout California via a letter to the California Hospital association.

6. Although most employers have worked with us, unfortunately others have taken a more adversarial approach. In both infection control and other areas of occupational health and safety, some employers we work with do the minimum required by federal or state law. Where binding standards require an employer to maintain a particular practice, it is far easier and less expensive to convince them to adhere to that practice. By contrast, where we can only rely on the General Duty Clause, employers are often far less cooperative and more oppositional, and our efforts to redress members' complaints are far more expensive and time-consuming.

7. This is as true with infectious diseases as in any other area. Long before COVID-19 appeared, we received frequent reports from our members about inadequate training, protocols, and practices at healthcare employers. In addition to direct healthcare providers such as long-term facilities and acute care hospitals, surgical and diagnostic centers, physicians' clinics, pharmacies, and other facilities all lacked pre-emptive plans to address an infectious outbreak and its impacts on the healthcare workforce. Little regard was paid to the need to amass personal protective equipment (PPE) much less codify or communicate standards of use based on severity of the event. Training frontline providers for an outbreak was rarely consistent and seldom communicated to nurses, staff and providers. Cleaning practices and regimens varied by specialty and even hospital floors. Moreover, healthcare facilities were often excluded from regional and local catastrophic response planning and drill simulations. Amplifying these issues



is a national nurse shortage facing nearly every single state, which has been exacerbated since COVID-19.

8. All of these problems have been heightened by the COVID-19 pandemic. Members in all of our represented workplaces continue to raise concerns about the lack of adequate planning, standards and personal protective equipment more than eight months into this pandemic. While employers are now able to look back in hindsight, clear, cohesive plans and specific, adequate controls to ensure the safety and protection of frontline staff have yet to be presented or even implemented. In fact, many employers still do not communicate with staff as to the current and future availability of PPE, proper cleaning procedures for public accessible areas/departments, or plans to shore up pharmaceuticals. Furthermore, the emerging plans and protocols vary from employer to employer, and often exclude insight and feedback from our frontline heroes, leaving nurses and personnel at risk.

9. The lack of standards and the resulting lapses at our members' workplaces have had predictable and tragic consequences as our members have contracted COVID-19. OSHA's refusal to issue standards within our healthcare workplaces threatens to continue to harm healthcare workers and their patients, families, and community members.

10. 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 26, 2020

/s/ Denise Duncan  
Denise Duncan, RN  
President  
United Nurses Associations of California  
Union of Health Care Professionals

# TAB K

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

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Occupational Safety and Health Administration,  
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*Respondents.*

**DECLARATION OF LINDA ADYE-WHITISH**

I, Linda Adye-Whitish, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am a registered nurse working at a hospital in Pierce County, Washington. I have been a nurse for the past 37 years, specializing in critical care. For the last 10 years, I have worked in the emergency department of the second busiest ER in the state.
3. In the early weeks of COVID-19, we routinely treated patients without having ready access to masks or gowns and had no supply of N95 masks at all. I complained to my manager after a shift where I was assigned two presumed COVID-19 patients, one receiving BiPAP respiratory therapy, and at the same time was assigned a patient undergoing chemotherapy, who was thus immunosuppressed and at high risk if exposed to COVID-19. My manager agreed that our procedures were inadequate, but we continued to have only limited numbers of simple surgical masks until the end of March.
4. I resorted to appealing to my neighborhood community message board to get N95 masks donated from people's earthquake kits and garages, and my dentist donated surgical masks as she was closing her office.
5. Eventually my employer began fit-testing for N95s, but they didn't have one in

my size (extra-small). When they finally obtained an XS mask two weeks later, I was already beginning to develop COVID symptoms. Prior to COVID-19, I had not been fit-tested for an N95 in the eleven years I had worked for my employer.

6. I became symptomatic on March 26, and tested positive on April 1. I had worked each day from March 21-23, and had not been anywhere other than home and the hospital for more than two weeks, aside from a single in-and-out trip to a store to buy necessary supplies. I had been diligent about wiping down all surfaces and taking all possible personal precautions. I am certain that my exposure came from work and I had documented positive exposures at work during that time.

7. I took three weeks of leave to recover, but still have symptoms more than six months later. I frequently have heart palpitations and become short of breath. My sense of taste has improved to approximately 75% and my sense of smell has only recently returned to about 50% of normal. I experience “brain fog” (a feeling similar to having taken sedating medication like Benadryl) several days a week although that is improving.

8. Since I returned to work, I still don't have a suitable N95 mask. We ran out of XS masks, even though we were reusing them for a week or two at a time and storing them in paper bags in our lockers. The current masks are not the brand or type that we fit-tested. In lieu of masks, I can sometimes use a controlled air-purifying respirator (“CAPR”), but those are in short supply as well. We're supposed to have two carts of eight CAPRs for our unit, but we often have only one available. We are reusing the single-use face shields that the CAPRs require and the CAPRs often lack intact hoods or charged batteries and are sometimes left without decontamination. Even gowns are often not readily available and we have to search for a supply.

9. Some of my colleagues in the ER department have tested positive as recently as

September.

10. For the first time in my career I feel expendable and I am thinking of leaving the profession I love. My employer is unwilling or unable to follow known and understood measures for keeping healthcare workers like me safe.

11. 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 25, 2020

/s/ Linda Adye-Whitish  
LINDA ADYE-WHITISH, RN, CEN

# TAB L

**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 DANIELLE O'TOOLE**

I, Danielle O'Toole, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am a registered nurse employed by Tacoma General, a MultiCare hospital. I have worked at Tacoma General for the past 11 years, and have spent nearly the past 10 years staffing the internal care unit ("ICU"). I am also the local unit chair for the Washington State Nurses Association ("WSNA").
3. Because of my experience as a nurse and as the representative of my 800-member bargaining unit, I have seen firsthand what the hospital is doing with regard to infection control during the COVID-19 pandemic.
4. Unfortunately, our employer is not taking necessary steps to protect my colleagues and our patients from the risk of COVID-19.
5. The Washington State Department of Health and Department of Labor & Industries issued a Joint Hazard Alert in September 2020 entitled "Preventing the spread of COVID-19 in Healthcare Workers and Patients."<sup>1</sup> Our employer has refused to adopt several

<sup>1</sup> Available at <https://lni.wa.gov/safety-health/preventing-injuries-illnesses/hazardalerts/HazardAlertCOVIDHealthCare.pdf>.

measures specified in the Joint Hazard Alert.

6. For example, the Joint Hazard Alert provides that employees who enter the rooms of patients with suspected or confirmed COVID-19 infections must use, at a minimum, “a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection.” If “an appropriate respirator is not available in the facility and cannot be reasonable obtained, a face shield and approved [N95 or equivalent] mask” may be used in certain circumstances. Rather than requiring N95 masks or higher levels of respiratory protection, our employer is requiring only basic surgical masks. And for eye protection, our employer has primarily provided dollar store-quality plastic glasses.

7. As a result, many of my colleagues have had to purchase their own personal protective equipment (“PPE”) at their own expense, including spending nearly \$100 to get eye protection that they can use over prescription glasses. Given our employer’s practices, their only other alternatives would be to put their own health at risk, or compromise the quality of care they provide to their patients by forgoing their prescription glasses.

8. As another example, the Joint Hazard Alert requires that employers “ensure sick employees do not report to work ... when they become symptomatic.” Our employer expects and pressures employees to return to work after seven days, even if still symptomatic, and we are specifically told by Employee Health not to get retested before returning to work after a positive result.

9. Similarly, the Joint Hazard Alert requires employers to provide staff “a safe place to don and doff PPE prior to entering spaces where facemasks must be removed for eating and drinking,” and specifies that “[s]taff should don a new facemask prior to returning to the unit.” But we lack appropriate anterooms to change out of potentially contaminated equipment. Instead,



many of the personnel who treat or interact with COVID-19 patients take off their PPE while in the room with the patient.

10. There are numerous other respects in which our employer's practices place my colleagues and me—along with our patients—at unnecessary risk. For example, nurses care for both COVID and non-COVID patients simultaneously on the same shift. In response to concerns we have raised, our management insists that the non-COVID patients are at no risk, against all medical facts. For example, one nurse was required to give chemotherapy to a COVID patient and then to a non-COVID patient, despite the fact that patients undergoing chemotherapy are immunosuppressed and thus highly at risk.

11. When employees have gotten sick, MultiCare has insisted without basis that they must have contracted COVID-19 from each other or from outside the hospital, even when it is clear that they likely contracted it from patient care. For example, on one incident several nurses who treated the same COVID-19 patients on the same weekend subsequently developed COVID-19. MultiCare claimed that they caught it from each other, rather than the patients—even though some of the nurses worked different shifts from one another.

12. I have raised concerns to our management on multiple occasions, as have other nurses. Since I began pointing out ways that our practices conflict with the Joint Hazard Alert, they have stopped even responding to my questions about PPE policies.

13. As a “third wave” of COVID-19 cases builds, we see more and more COVID-19 patients each week. We are already full to the brim with non-COVID issues; if we reach a new peak in COVID-19 cases, on top of our usual increase in influenza cases, I do not know how we will be able to care for our patients or maintain even our current, insufficient level of protection for nurses.

14. At a personal level, the daily risk that I and my colleagues face is deeply upsetting. I have three children and am the breadwinner of my family. I genuinely do not know how we would provide for our family if I were to become disabled due to COVID-19. Moreover, my husband has health conditions that place him in a high-risk category, and there is nowhere in my house that I could isolate myself from him and the rest of our family if I should need to quarantine. I am anxious every day that I may be endangering my family and that my employer is not doing what it could be to protect us from exposure.

15. 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 24, 2020

/s/ Danielle O'Toole  
DANIELLE O'TOOLE

# TAB M

**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 JUDY SALESKY**

I, Judy Salesky, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I have been a registered nurse for 39 years. For the majority of that time, I have worked in the Neonatal Intensive Care Unit at a hospital in eastern Washington.
3. I have a 22-year-old daughter who was diagnosed last year with myasthenia gravis, a rare autoimmune neuromuscular disease. Her condition required her to leave college and return home. She had her thymus removed this past March, and takes a significant amount of immunocompromising medication.
4. Because my employer maintains inadequate infection control practices to protect employees from COVID-19, I have had to take a substantial amount of unpaid leave to protect my daughter's health, and experience significant anxiety now that I have returned to work.
5. When COVID-19 first began to spread in Washington State, my employer refused to let staff wear masks. To avoid the risk of acquiring COVID-19 at this time, I took 14 weeks of leave, including eight weeks unpaid leave. I returned to work on July 3, and haven't taken a day off since that time.
6. Our employer now provides us with masks, but they are typically paper masks

that quickly become compromised. The masks provide limited protection even against droplet transmission, let alone any risk of aerosol transmission. Indeed, the masks are often such low quality that their odors have made staff nauseous and their chafing has required at least one nurse to miss time due to a friction wound.

7. Similarly, our employer gave out goggles for the first time last month, but there is already an insufficient supply and staff have had to buy their own. Our face shields likewise do not fit and interfere with head mobility, which forces nurses to choose between personal safety and adequately performing their duties.

8. Although I have requested that I be exempted from floating duty (that is, working on other units), and provided notes from my daughter's doctors requesting that I not be placed in units with COVID-19 patients, my employer has continued to require me to float to other units, including caring for COVID-19 patients.

9. I am also exposed to a risk of contracting COVID-19 when I arrive each day. At the beginning of our shifts, we are required to get our temperature checked and get our masks, along with punching in as normal. We cannot social distance during this process, and the single thermometer isn't adequately sterilized between uses.

10. Our hospital flouts social distancing practices in other ways, as well. We are required to attend a daily meeting in the report room, where social distancing is impossible. And the hospital does not enforce any policy of social distancing in areas such as the breakroom.

11. As a result, I go out of my way to avoid any unnecessary contact at work. Because our cafeteria and our break room provide higher exposure risks, I eat my lunch in my car every day, and will continue to do so even in the winter, when the weather is regularly below freezing. Our break room is one room with one long table. Multiple nurses sit at this table without masks

while they eat. No one monitors how many people are in the room or if it is getting disinfected between staff member eating their lunch.

12. My anxiety about the possibility that I will contract COVID-19 and risk exposing my daughter is causing me to consider quitting for the first time in my career, despite my commitment to caring for my patients and the urgent need for nurses. I have never had anxieties or fears in my entire nursing career, am generally in good health, and care deeply about my patients. But because of the inconsistencies with protecting the staff in the hospital and the high chance that my daughter could not survive contracting COVID-19, I am now fearful and significantly stressed every day.

13. 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 21, 2020

*/s/ Judy Salesky*

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JUDY SALESKY

TAB N

**IN THE UNITED STATES COURT OF APPEALS  
FOR THE NINTH CIRCUIT**

In re American Federation of Teachers, et al.,

Case No. \_\_\_\_

*Petitioners,*

v.

Occupational Safety and Health Administration,  
et al.,

*Respondents.*

**DECLARATION OF BETH COHEN**

I, Beth Cohen, declare as follows:

1. The facts in this declaration are based on my personal knowledge.
2. I am a registered nurse at Virtua Memorial Hospital in Mt. Holly, New Jersey. I have been an RN since 2007, working primarily in the infectious disease unit. I am also the vice president of my local unit of Health Professionals and Allied Employers (“HPAE”), an affiliate of the American Federation of Teachers.
3. From the beginning of the current pandemic, my employer has used practices that fall short of recognized standards and put me, my colleagues, and our patients at risk.
4. For example, in March and April, they decided that eye protection was not necessary unless a patient was undergoing an aerosolizing procedure. As a result, we would work with patients known or suspected to have COVID-19 with only a paper mask as protection.
5. As a result, I contracted COVID-19 in early April. On April 1, I spent 30 minutes treating a heavily symptomatic patient suspected of having COVID-19, who subsequently tested positive. Two days later I developed symptoms that have persisted ever since. I developed pericarditis and other cardiac issues that I had never previously had, along with asthma and related symptoms. Although I never tested positive for COVID-19, my cardiologist believes it is



the only explanation for my condition.

6. As a result, I have missed approximately 8 weeks of work since April, including 4 weeks out on disability per my cardiologist's orders. Wednesday, October 28<sup>th</sup> I will go in for a cardiac catheterization to determine the extent of the cardiac damage I have suffered. I have had to reckon with the possibility that I might have suffered life-long damage that will inhibit my ability to work as I get older.

7. I have five children, three of whom live with me. Every time I go into work, I experience the stress of wondering whether I will expose my children to a potentially deadly disease.

8. Because of my hospital's practices, HPAE has needed to be heavily involved in protecting staff and patient health. The hospital refused to implement a system for informing staff that patients they treated or staff they worked with tested positive. Instead, it maintained a hotline that staff could call to ask whether or not they needed to get tested or quarantine. Nurses who treated the same patients at the same time would get different answers from the hotline, and the hospital refused to tell the union how it was determining whether or not employees needed to quarantine or get a test. It also discouraged people from making formal incident reports, to minimize any record of problems.

9. Because the hospital refused to track and record exposures to SARS-CoV-19 (the virus that causes COVID-19), the union was forced to step in to determine the extent of the problem. I collected exposure and illness information from my colleagues. To date, I have been alerted of 270 exposures, just among staff who have contacted me, out of 800 nurses.

10. As a result of these and other shortcomings (such as inadequate PPE and inadequate air filtration, inappropriate equipment, and insufficient training), HPAE filed a

complaint with OSHA in April. The complaint took a substantial amount of time and resources to investigate, prepare, and pursue—time and resources that the union otherwise would have devoted to supporting our membership through this difficult time in numerous other ways. We are still waiting on a resolution of the complaint.

11. In addition to forcing us to spend our resources investigating and either working with or challenging employers, the absence of binding standards and employers' resulting shortcomings have required us to devote virtually all of our remaining resources to collecting information from members and educating them about pandemic safety precautions. We had to completely set aside our internal strategic plans and divert all efforts toward education, training, and similar initiatives that employers themselves would need to undertake if they were subject to a mandatory standard. Our workplace violence education and training, leadership development and education programs, and many other initiatives have all been derailed or entirely halted as we fill the gap left by OSHA's failure to issue a standard.

12. Our collective bargaining agreement was up for renewal this year, which gave us the opportunity to demand that the hospital create a pandemic preparedness committee as part of the new contract. As a result, beginning in November, we will begin receiving regular reporting on PPE, and employees who are exposed to SARS-CoV-19 will receive notification by email. The Union will also receive a copy of the email sent to the employee as part of this new bargaining agreement. Because of the need to negotiate these basic issues of infection control, the negotiations were arduous and time-consuming, covering nine sessions, including day-long sessions that lasted until 3 A.M. We had to sacrifice other items we would have liked to push for in order to obtain these safeguards, which we would not have had to do if there were binding standards that already required such preparation and planning.

13. 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

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*/s/ Beth Cohen*  
BETH COHEN