No. _____

IN THE
United States Court of Appeals
for the Ninth Circuit

IN RE AMERICAN FEDERATION OF TEACHERS; AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOYEES; WASHINGTON STATE NURSES ASSOCIATION; UNITED NURSES ASSOCIATION OF CALIFORNIA.
Petitioners,

v.

OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION; UNITED STATES DEPARTMENT OF LABOR; EUGENE SCALIA, in his official capacity as Secretary of the United States Department of Labor,
Respondents.

PETITION FOR WRIT OF MANDAMUS

Michael C. Martinez
Jeffrey B. Dubner
Sean A. Lev
Democracy Forward Foundation
P.O. Box 34553
Washington, DC 20043
Telephone: (202) 448-9090
Facsimile: (202) 701-1775

Counsel for Petitioners

CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Ninth Circuit Rule 21-3, Petitioners American Federation of Teachers ("AFT"); American Federation of State, County and Municipal Employees ("AFSCME"); Washington State Nurses Association ("WSNA"); and United Nurses Association of California/ Union of Health Care Professionals ("UNAC/UHCP") disclose:

AFT, AFSCME, WSNA, and UNAC/UHCP are non-profit 501(c)(5) labor organizations with no parent corporation and no outstanding stock shares or other securities in the hands of the public. They do not have any parent, subsidiary, or affiliate that has issued stock shares or other securities to the public. No publicly held corporation owns any stock in AFT, AFSCME, WSNA, or UNAC/UHCP.

Dated: October 29, 2020

/s/ Michael C. Martinez
Michael C. Martinez

Counsel for Petitioner

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes, Rules and Regulations

Other Authorities

INTRODUCTION

More than 10 years ago, American Federation of Teachers ("AFT") and American Federation of State, County, and Municipal Employees ("AFSCME") petitioned Respondent Occupational Safety and Health Administration ("OSHA") for an occupational safety and health standard to protect healthcare workers from the risks of infectious diseases transmissible by non-bloodborne routes, such as by contact, droplets, and the air ("Infectious Diseases Standard"). Even before the COVID-19 pandemic, infectious diseases caused 1.7 million healthcare-associated infections every year in the United States. These infections are dangerous, and some can be fatal (*e.g.*, tuberculosis, bacterial meningitis, or Ebola). OSHA acknowledged this risk and began the rulemaking process to issue a responsive standard. As of 2016, OSHA was on the verge of issuing the necessary standard and projected its completion in 2017. Instead, after a change in administration, OSHA shelved the rulemaking altogether and has refused to carry out its statutory obligations – even in the midst of the deadliest pandemic in a century, which conservative estimates show has infected over 190,000 healthcare workers in the United States and claimed more than 770 of their lives.

OSHA's decade-long delay is unreasonable and unlawful. In the Occupational Safety and Health Act ("OSH Act"), Congress compelled OSHA to issue binding standards when significant health risks exist in America's

workplaces. 29 U.S.C. § 655(b)(5). Having determined the necessity of a standard, OSHA has had a duty to issue such a standard regarding infectious diseases in healthcare workplaces for a decade, a delay far longer than any court has ever judged reasonable. OSHA's long delay in issuing a standard is unlawful under the balancing test set by *Telecommunications Research & Action Center ("TRAC") v. FCC*, 750 F.2d 70, 79-80 (D.C. Cir. 1984), and used by this Court to determine reasonableness, *see In re A Cmty. Voice*, 878 F.3d 779, 786-87 (9th Cir. 2017), due to the length of delay, absence of any reasonable timeline, and harm to health.

This Court should therefore issue a writ of mandamus under the All Writs Act, 28 U.S.C. § 1651(a), and the Administrative Procedure Act ("APA"), 5 U.S.C. § 706(1), compelling OSHA to cease its unlawful delay in issuing an Infectious Diseases Standard. The Court should require OSHA to issue a notice of proposed rulemaking ("NPRM") for the standard within 90 days of the Court's mandamus order and to proceed on a priority, expedited basis to promptly issue a standard.

JURISDICTIONAL STATEMENT

This Court is authorized to issue writs of mandamus under 28 U.S.C. § 1651 and to "compel agency action unlawfully withheld or unreasonably delayed" under the APA. 5 U.S.C. § 706(1). Where a court would have "jurisdiction to review a final rule," it has corresponding jurisdiction to determine whether an agency's delay in issuing such a rule is unreasonable. *Cmty. Voice*, 878 F.3d at 783.

AFT and AFSCME submitted their rulemaking petition to OSHA under the OSH Act. 29 U.S.C. § 655(b). The Act authorizes this Court to review OSHA occupational standards. *See id.* § 655(f). Courts have interpreted this grant of jurisdiction, when read in conjunction with the APA, as enabling judicial review not only of standards already promulgated, but also of "agency action unlawfully withheld or unreasonably delayed." 5 U.S.C. § 706(1); *see, e.g.*, *Action on Smoking & Health v. Dep't of Labor*, 28 F.3d 162, 163-164 (D.C. Cir. 1994) (explaining that § 655(f) and APA "respectively confer jurisdiction on this court . . . over suits seeking relief from agency inaction or delay that jeopardizes our future statutory power of review"); *cf. Cmty. Voice*, 878 F.3d at 785 (citing favorably D.C. Circuit precedent reviewing delays under OSH Act).

Venue is appropriate in this Court because Petitioners United Nurses Associations of California/Union of Health Care Professionals ("UNAC/UHCP") and Washington State Nurses Association ("WSNA") have their principal places of business in the Ninth Circuit, specifically in California and Washington, respectively. *See* 29 U.S.C. § 655(f).

STATEMENT OF ISSUES

1. Does OSHA have a duty to issue an occupational safety and health standard that addresses the significant risk to healthcare workers of infectious diseases transmitted by non-bloodborne routes?

2. Has OSHA "unreasonably delayed" the promulgation of an Infectious Diseases Standard that has been pending for more than 10 years?

3. Must OSHA issue an NPRM on the Infectious Diseases Standard within 90 days of the Court's mandamus order and proceed on a priority, expedited basis, to issue a standard?

PETITIONERS

Petitioner AFT is an unincorporated voluntary membership association that has local affiliates and members throughout the country, including Petitioner WSNA. Petitioner AFSCME is also an unincorporated voluntary membership association with local affiliates and members throughout the country, including Petitioner UNAC/UHCP (collectively, "Unions"). As explained below, in May 2009, AFT, AFSCME, and other labor unions petitioned OSHA for the creation of the Infectious Diseases Standard that is the subject of this mandamus action. *See* AFSCME, Petition Letter to Hilda Solis, Sec'y of Labor (May 8, 2009) (attached as App., Tab A); AFL-CIO, Petition Letter to Jordan Barab, OSHA Acting Assistant Sec'y (May 18, 2009) (Tab B); 29 U.S.C. § 655(b)(1).

OSHA's unlawful delay in issuing an Infectious Diseases Standard harms the Unions, their affiliates, and their healthcare members exposed to these diseases in their workplaces. AFT represents more than 150,000 health professionals who practice in a variety of disciplines and settings. Its members include registered

nurses, physicians, medical researchers, dietitians, psychologists, X-ray technicians, therapists, and others. Although most of AFT's healthcare members work in hospitals, many also work in long-term care institutions for individuals with disabilities and mental health challenges; correctional facilities; schools with students with special needs; and social service settings. Decl. of Rhonda Weingarten ("Weingarten Decl.") ¶ 5 (Tab F). Similarly, AFSCME and its local affiliates represent at least 350,000 healthcare workers across the United States, including physicians, nurses, medical technicians, and other medical personnel, along with support staff in healthcare workplaces, such as janitorial staff. Decl. of Dalia Thornton ("Thornton Decl.") ¶ 4 (Tab G).

The jobs that the Unions' members perform and the workplaces in which they perform them put them at high risk for communicable and infectious diseases. *See* Weingarten Decl. ¶¶ 5-6; Thornton Decl. ¶¶ 4-6, 17; Decl. of Laurence Rick ¶ 5 (Tab H); Decl. of Sally Watkins ("Watkins Decl.") ¶ 5 (Tab I); Decl. of Denise Duncan ("Duncan Decl.") ¶ 4 (Tab J). For instance, the Unions represent nurses at hospitals that treat patients with COVID-19. Decl. of Linda Adye-Whitish ("Adye-Whitish Decl.") ¶¶ 2-3 (Tab K); Decl. of Danielle O'Toole ("O'Toole Decl.") ¶¶ 2-3 (Tab L), 10; Decl. of Judy Salesky ("Salesky Decl.") ¶¶ 2, 4, 8 (Tab M); Decl. of Beth Cohen ("Cohen Decl.") ¶¶ 2, 4 (Tab N). In the absence of a binding, enforceable standard, many healthcare workplaces do not maintain appropriate

infection control practices to minimize the risk faced by the Unions' members. *See, e.g.*, Weingarten Decl. ¶¶ 8-10; Thornton Decl. ¶¶ 8, 15; Watkins Decl. ¶¶ 7-9; Duncan Decl. ¶¶ 6-9; Adye-Whitish Decl. ¶¶ 3, 5, 8; O'Toole Decl. ¶¶ 4-10; Salesky Decl. ¶¶ 4-11; Cohen Decl. ¶¶ 3-4, 8-11. As a result, many of the Unions' members have contracted infectious diseases such as COVID-19 and are in danger of doing so in the future. *See, e.g.*, Weingarten Decl. ¶ 14 (13 AFT members have died of COVID-19); Thornton Decl. ¶ 17 (118 AFSCME members have died).

In addition to the harm to the Unions' members, the Unions and their affiliates are themselves harmed by the absence of an enforceable standard. To fulfill their duties as its members' collective bargaining representative, the Unions and their affiliates train their members and employers on appropriate infection control practices; negotiate with individual employers concerning infection control and other occupational health and safety issues; investigate concerns raised by members at specific employers; and bring charges before OSHA and other regulatory agencies against inadequate infection control practices. Weingarten Decl. ¶¶ 7, 11-12; Thornton Decl. ¶¶ 6-9, 13-14; Watkins Decl. ¶¶ 10; Cohen Decl. ¶¶ 9-11. These efforts are significantly harder, more resource-intensive, and often more time-consuming in the absence of an enforceable OSHA standard, forcing the Unions to divert resources away from other aspects of their missions. *See, e.g.*, Thornton Decl. ¶¶ 12-13; Watkins Decl. ¶ 11.

Compelling OSHA to issue an NPRM and proceed towards a permanent standard as promptly as possible would reduce the risks to the Unions' members from workplace transmission of these diseases, as well as reduce the resources that the Unions have had to divert to investigating complaints and filing charges against employers. Protecting healthcare workers from infectious diseases is also germane to the Unions' organizational mission of promoting safe and healthy work environments, as recognized by OSHA and other government agencies that have provided grants to and otherwise worked with the Unions to improve infection control practices and training. *See, e.g.*, Weingarten Decl. ¶ 11; Thornton Decl. ¶ 10. The relief sought does not require members' individual participation. *Hunt v. Wash. State Apple Advert. Comm'n*, 432 U.S. 333, 343 (1977).

STATUTORY AND REGULATORY AUTHORITY

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). To achieve this goal, the OSH Act requires that OSHA "set the [occupational safety and health] standard which most adequately assures, to the extent feasible, on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity." 29 U.S.C. § 655(b)(5). This statutory command "compels action." *Pub. Citizen Health Research Grp. ("PCHRG") v. Chao*, 314 F.3d 143, 152 (3d Cir.

2002); *see also Indus. Union Dep't, AFL-CIO v. Am. Petroleum Inst.*, 448 U.S. 607, 641 (1980) (plurality opinion) ("[B]oth the language and structure of the [OSH] Act, as well as its legislative history, indicate that it was intended to require the elimination, as far as feasible, of significant risks of harm.").

The APA requires that an agency "within a reasonable time . . . proceed to conclude a matter presented to it." 5 U.S.C. § 555(b). A reviewing court "shall compel agency action unlawfully withheld or unreasonably delayed." *Id.* § 706(1).

STATEMENT OF THE CASE

I. Petitions to Protect Healthcare Workers from Infectious Diseases

Infectious diseases cause healthcare-associated infections ("HAIs") in healthcare workers. Even before the COVID-19 pandemic, HAIs were recognized as a serious and costly problem in the United States healthcare system. *See* OSHA, Infectious Diseases SER Background Doc. (Tab C) at A18. Preventing the spread of infectious diseases in healthcare and related settings benefits workers, as well as patients, because there is a well-recognized link between patient safety and healthcare worker safety. *See* Request for Information, 75 Fed. Reg. 24,835 (May 6, 2010) ("RFI").[1] According to the CDC, even before the current pandemic, there

[1] *See also National Action Plan to Prevent Health Care-Associated Infections: Road Map to Elimination*, Part 1, HHS (2013), https://health.gov/sites/default/files/2019-09/hai-action-plan-executive-summary.pdf.

were 1.7 million HAIs leading to approximately 99,000 patient deaths and $20 billion in additional healthcare costs in the United States system each year. *See* Tab C at A18.

OSHA lacks a standard addressing occupational exposure to infectious diseases transmitted by contact (such as MRSA or norovirus), droplets (such as H1N1 and SARS-CoV-2, the virus that causes COVID-19), or the air (such as measles).[2] In fact, OSHA currently has only one standard that directly addresses workplace infectious diseases: the Bloodborne Pathogens standard (29 CFR § 1910.1030), which covers only infectious diseases transmitted by blood.

In May 2009, during the H1N1 influenza pandemic, Petitioners AFT and AFSCME, along with affiliated unions, petitioned OSHA for a standard under 29 U.S.C. § 655(b) to protect healthcare workers from infectious diseases. *See* Tabs A, B. At the time, the CDC reported 5,000 cases and five deaths from H1N1 in 48 states and the District of Columbia, including 82 cases among healthcare workers. Tab B at A6. The petitions argued that, in the face of a pandemic, OSHA's evolving voluntary guidance to the healthcare community was no substitute for the immediate imposition of a mandatory, legally enforceable standard. Tabs A, B.

---

[2] *See* Michael Grabell, et al., *Millions of Essential Workers are Being Left Out of Covid-19 Workplace Safety Precautions, Thanks to OSHA*, ProPublica (April 16, 2020), https://www.propublica.org/article/millions-of-essential-workers-are-being-left-out-of-covid-19-workplace-safety-protections-thanks-to-osha.

II. OSHA Initiated a Rulemaking for the Infectious Diseases Standard in 2010

In response to the petitions, OSHA began the rulemaking process for an Infectious Diseases Standard by issuing a Request for Information ("RFI") on May 6, 2010. *See* 75 Fed. Reg. at 24,835. OSHA sought information on "occupational exposure to infectious agents, how occupational exposure is being mitigated," and "strategies that are being used in . . . healthcare-related work settings to mitigate the risk of occupationally-acquired infectious diseases." *Id.* at 24,835-36. OSHA sought data on relevant risks and infection-control practices "to determine what action, if any, the Agency may take to further limit the spread of occupationally-acquired infectious diseases in these types of settings." *Id.* at 24,835. It noted that "widely recognized" infection control guidelines existed but were not enforceable, and that in practice their use varied widely. *Id.* at 24,837. OSHA received more than 220 comments in response to the RFI.[3]

On July 29, 2011, OSHA conducted two stakeholder meetings about the Infectious Diseases Standard attended by healthcare professionals and other interested parties representing private industry, labor unions, government entities, and trade associations. *See* OSHA, Summary Report of Stakeholder Meetings on Occupational Exposures to Infectious Diseases (Tab D).

[3] The public comments on the RFI are available at: https://beta.regulations.gov/document/OSHA-2010-0003-0001/comment.

In mid-2012, OSHA created a proposed regulatory framework for the Infectious Diseases Standard. *See*, Q+A on OSHA's Infectious Diseases Regulatory Framework (Tab E). The standard would apply to healthcare services where patient care is provided, as well as services that process materials contaminated with infectious agents, including hospitals, long-term care facilities, clinics, certain laboratories, and schools. *Id.* at A192. It would cover workers in these and similar settings where there is a reasonable anticipation of occupational exposure to infectious agents during job tasks. *Id.* at A192-93. The proposed regulatory framework would require that employers implement tailored Worker Infection Control Plans – which OSHA would then be able to enforce through, *inter alia*, civil penalties – and Standard Operating Practices consistent with recognized and generally accepted infection control practices. *Id.* at A193-95.

In May 2014, OSHA convened a Small Business Advocacy Review Panel ("SBAR Panel") under the Small Business Regulatory Enforcement Fairness Act ("SBREFA"), to obtain input from affected small entities ("SERs"). In connection with the SBREFA process, it released the SER Background Document, a 158-page report laying out its view of the standard. *See* Tab C. There, OSHA explained that the stakeholder comments it received indicated "that workers providing direct patient care and performing other . . . tasks . . . are at risk of harm from occupational exposure to infectious agents, and that implementing recognized and

generally accepted good infection control practices reduces the risk of transmission of infectious agents to these workers." *Id.* at A19. It noted that HAIs are "a serious and costly problem in the U.S. healthcare system" and that "[p]reventing the spread of infectious diseases in healthcare and related settings benefits workers, as well as patients." *Id.* at A18. OSHA reviewed studies on the prevalence of occupationally acquired infectious diseases and noted that the existing data likely understates the scope of the problem. *Id.* at A19-24.

OSHA recognized that it must "make a finding of significant risk before it promulgates a new standard" and explained the seriousness of the "well-recognized risk to workers associated with exposure to infectious agents during the provision of direct patient care and/or performance of other covered tasks." *Id.* at A25-26. While it did not explicitly make a final risk determination, it spent several pages describing the risks, the failure of non-mandatory guidelines "to adequately reduce the risk," and the fact that following good infection-control practices "considerably reduces the risk." *Id.* at A26-35; *see infra* 15-22. The SBREFA process was completed on December 22, 2014.[4]

The Infectious Diseases Standard was listed on the Unified Agenda as being at the "PreRule Stage" in Fall 2014. It was at the "Proposed Rule Stage" in both

[4] *See* SPAR Panel, *Report of the SPAR Panel*, OSHA (2014), https://www.osha.gov/dsg/id/SBREFA_Panel_Report_Final.pdf

Spring 2016 and Fall 2016.[5] The 2016 Regulatory Plan listed the expected NPRM date for the Infectious Diseases Standard as October 2017. *See* Intro. to the Unified Agenda of Fed. Regulatory and Deregulatory Actions – Fall 2016, 81 Fed. Reg. 94,496, 94,602 (Dec. 23, 2016).

III. OSHA Halted Progress on the Infectious Diseases Standard in 2017

Instead of issuing an NPRM for the Infectious Diseases Standard, in 2017, the then-incoming administration shelved the matter, moving it from the Unified Regulatory Agenda to the list of "Long-Term Actions," where it has sat ever since.[6] For Long-Term Actions, the agency "expects [it] will have the next regulatory action more than 12 months after publication of the agenda."[7] On January 30, 2017, President Trump issued Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs, which states that "no regulation shall be issued by an agency if it was not included on the most recent version or update of the published Unified Regulatory Agenda." 82 Fed. Reg. 9339, 9340.

---

[5] *See* Department of Labor's quarterly regulatory agendas at: https://resources.regulations.gov/public/custom/jsp/navigation/main.jsp.
[6] *See Infectious Diseases Rulemaking*, OSHA, https://www.osha.gov/dsg/id/ (last visited Oct. 23, 2020).
[7] *About the Unified Agenda,* Off. Mgmt. & Budget, https://www.reginfo.gov/public/jsp/eAgenda/UA_About.myjsp (last visited Oct. 23, 2020).

Because the Infectious Diseases Standard remains a Long-Term Action and has not been on the Unified Regulatory Agenda for the past three and a half years, OSHA has shown no intent to issue an NPRM in the near future.[8]

SUMMARY OF THE ARGUMENT

When deciding whether to grant a petition for mandamus on the grounds of unreasonable delay, this Court first determines whether an agency has a "duty to act," and, if it does, whether the delay was unreasonable under the six-factor balancing test outlined by the D.C. Circuit in *TRAC*. *See Cmty. Voice*, 878 F.3d at 784-85. "OSHA is under a duty to act where there is an 'obvious need, apparent to OSHA,'" to set or alter a standard, and it "must, under the APA, 'conclude within a reasonable time a matter presented to it.'" *Id.* at 785 (quoting *PCHRG v. Auchter*, 702 F.2d 1150, 1153-54, 1158 (D.C. Cir. 1983)). Congress requires OSHA to promulgate and enforce occupational standards that ensure "on the basis of the best available evidence, that no employee will suffer material impairment of health or functional capacity," 29 U.S.C. § 655(b)(5), and courts will compel OSHA to do so

[8] OSHA has also refused to issue an emergency temporary standard under 29 U.S.C. § 655(c), denying a petition filed by the AFT and 21 other unions. One of the petitioners, the AFL-CIO (of which AFT and AFSCME are affiliates), filed an emergency petition for a writ of mandamus requesting issuance of an emergency temporary standard, which was denied by the D.C. Circuit on June 11, 2020. *See In re AFL-CIO*, No. 20-1158, 2020 WL 3125324.

where it has unreasonably refused or delayed. *See Chao*, 314 F.3d at 152 (collecting cases). This Court should likewise compel OSHA to act here.

OSHA has a duty to issue a safety and health standard to protect healthcare workers from the significant risk of harm from infectious diseases. The record of the risk to public health from HAIs, even in ordinary times, is clear. The risks are especially high during pandemics like H1N1 in 2009 and now COVID-19. OSHA's 10-year delay in acting on the Infectious Diseases Standard is unreasonable under the *TRAC* factors because of the length of the delay, the absence of a reasonable timetable, and the harm to health.

OSHA should be compelled to issue an NPRM within 90 days of the Court's mandamus order and proceed on a priority, expedited basis to issue a standard.

ARGUMENT

I. OSHA Has a Duty to Issue a Safety and Health Standard to Address Infectious Diseases

A. Infectious diseases present significant risk of harm to healthcare workers

While mandamus is "reserved for extraordinary circumstances," courts "will interfere with the normal progression of agency proceedings to correct 'transparent violations of a clear duty to act.'" *In re Am. Rivers and Idaho Rivers United*, 372 F.3d 413, 418 (D.C. Cir. 2004) (citations omitted).

The OSH Act "compels action" once OSHA has identified a significant risk. *Chao*, 314 F.3d at 153. "[B]oth the language and structure of the [OSH] Act, as well as its legislative history, indicate that it was intended to require the elimination, as far as feasible, of significant risks of harm." *Id.* (quoting *Indus. Union Dep't*, 448 U.S. at 641). Thus, once OSHA has determined that a significant risk exists, it is required to promulgate a standard to eliminate it. While OSHA has some discretion to "determine, in the first instance, what it considers to be a 'significant' risk," *Indus. Union Dep't* 448 U.S. at 655, it may not ignore a risk that is clear from the record before it. *See, e.g.*, *Auchter*, 702 F.2d at 1153-54. As a result, courts have compelled OSHA to take action to address significant risks after unreasonable delays.[9]

The threshold risk determination is not exacting. The OSH Act requires the Secretary to set standards based "on the best available evidence," 29 U.S.C. § 655(b)(5), and OSHA "can find significant risk based on reasoning well-accepted by leading public health authorities and supported by the available scientific evidence showing that there is occupational exposure to broad categories of hazardous agents or work conditions that endanger workers in the absence of

[9] *See, e.g.*, *Chao*, 314 F.3d at 152-54 (finding OSHA delay unreasonable and compelling expeditious rulemaking); *In re Int'l Chem. Workers Union*, 958 F.2d 1144 (D.C. Cir. 1992) (compelling OSHA rulemaking); *PCHRG v. Brock*, 823 F.2d 626 (D.C. Cir. 1987) (same); *Auchter*, 702 F.2d 1150 (ordering NPRM and directing OSHA to issue standard on expedited basis).

protections." Tab C at A25 (citing regulations). It is "sufficient for the Agency to make a general finding of significant risk; the Agency is not required to assess relative risk or disaggregate its significant risk analyses by hazard, workplace, or industry." *Id.* at A16 & n.10 (citing cases). The word "significant" is not in the statute, and OSHA need not use any magic words when identifying the relevant risk; rather, the agency must merely "make a finding that the workplaces in question are not safe" for a standard to pass muster under judicial review. *Indus. Union Dep't*, 448 U.S. at 642.

Accordingly, OSHA "is not required to support its finding that a significant risk exists with anything approaching scientific certainty" and "is free to use conservative assumptions" and "risk[] error on the side of overprotection rather than under protection." *PCHRG v. Tyson*, 796 F.2d 1479, 1486, 1499 (D.C. Cir. 1986) (quoting *Indus. Union Dep't*, 448 U.S. at 656; *Indus. Union Dep't v. Hodgson*, 499 F.2d 467, 472-74 (D.C. Cir. 1974)). In making this determination, the appropriate question is whether "a reasonable person might . . . consider the risk significant and take appropriate steps to decrease or eliminate it." *Indus. Union Dep't*, 448 U.S. at 655.

The administrative record OSHA compiled before shelving the Standard shows that OSHA concluded that healthcare workers are "not safe" from infectious diseases such that a standard is required. In the SER Background Document,

OSHA acknowledged that these risks have "been known and documented for some time." *See* Tab C at A25-29. OSHA found that CDC guidelines, "authoritative guidance documents," and "hundreds of peer-reviewed publications . . . demonstrate a well-recognized risk of occupational exposure to infectious agents" for healthcare workers. *Id.* at A26-27. The evidence showed "that there is a sustained prevalence of work-related infectious diseases in healthcare, laboratory, and associated work settings. These infectious diseases are caused by agents that are transmissible to humans by different routes, including the contact, droplet and airborne routes." *Id.* at A21. OSHA summarized its findings that:

- Healthcare workers are at risk of infection from occupational exposure to numerous infectious diseases. *Id.* at A21-22 (citing studies).
- Healthcare workers are susceptible to "exposure[] during the early stages of the emergence of novel infectious agents or novel strains of known infectious agents," including SARS, H1N1, MERS, and Ebola. *Id.* at A22-23 (citing studies).
- Healthcare workers in ambulatory (non-hospital) care settings are at particular risk of exposure to infectious diseases, resulting in soft tissue and skin infections, norovirus, epidemic keratoconjunctivitis, tuberculosis, and pertussis. *Id.* at A23-24 (citing studies).

As a result, OSHA concluded "that covering those workers under [an Infectious Diseases Standard] as outlined in the regulatory framework would

reduce their risk." *Id.* at A25. It similarly concluded that the existing non-mandatory guidelines fail "to adequately reduce the risk." *Id.* at A29-30.

Thus, even though OSHA did not explicitly use the phrase "significant risk," that is in substance what it found. Based on the evidence OSHA amassed, any "reasonable person" would "consider the risk significant." *Indus. Union Dep't*, 448 U.S. at 655.

Even if there were a "magic words" requirement and OSHA's failure to use the word "significant" were of moment, the facts that OSHA found – especially when combined with the additional facts presented by the COVID-19 pandemic – meet this threshold. When faced with a significant public health risk, courts may examine the record to determine whether OSHA unreasonably refused to identify a significant risk despite the known facts.

In *Auchter*, for example, the D.C. Circuit reviewed the record to assess the risk associated with ethylene oxide ("EtO"), a carcinogenic substance, and the court itself found the risk to be significant, warranting an occupational standard, even though OSHA had not explicitly said as much. 702 F.2d at 1153-54. OSHA had been petitioned in 1981 for a new exposure standard for EtO, to which an estimated 75,000 hospital workers were exposed. *Id.* at 1152, 1155. As is the case here, OSHA had also responded to a petition for a standard by initiating the rulemaking process. *Id.* at 1152. It issued an advance notice of proposed

rulemaking a year later, but had not issued the proposed rule as of 1983 and estimated that a final rule would not be issued until the fall of 1984. *Id.* at 1152-53. Even though OSHA had made no final determinations about the risks associated with EtO, the D.C. Circuit found the risk to be significant based on the "[a]mple evidence in the record." *Id.* at 1157; *see also id.* at 1154-55 (summarizing evidence). "In [the] face of this evidence," the court found that OSHA's "unaccounted-for delay in issuing a Notice of Proposed Rulemaking and . . . [its] refusal to assign to the EtO rulemaking any priority status constitute[d] agency action 'unreasonably delayed.'" *Id.* at 1157 (quoting 5 U.S.C. § 706(1)).

In this case, the findings OSHA has already made in the administrative record, including the SER Background Document exemplify the kinds of harms that Congress required OSHA to decrease or eliminate via a standard. Based on stakeholder responses to the RFI, OSHA's review of relevant scientific literature, and other data as explained in the SER Background Document, OSHA found that: (1) healthcare workers are at risk from exposure to infectious agents; (2) non-mandatory infection control guidelines are not sufficient to adequately reduce that risk; and (3) following infection control practices "considerably reduces the risk of transmission." Tab C at A19, A26-29, A132. This risk has come into even sharper relief during the COVID-19 pandemic. To date, more than 8.75 million people in the United States have contracted COVID-19, and more than 225,000 people in the

United States have died from the disease. A significant portion of those infected and dying from COVID-19 are healthcare workers, including doctors, nurses, and nursing home aides. The CDC has found that, as of October 27, there were more than 190,000 COVID-19 infections among these workers, with 770 deaths.[10] A recent nongovernmental study found even higher figures: 258,768 healthcare workers infected resulting in 1,718 deaths.[11]

The conclusion is clear: as with other infectious diseases, healthcare workers are at particularly high risk of COVID-19 infection. *Cf. Auchter*, 702 F.2d at 1155 (finding significant risk and unreasonable delay where 75,000 healthcare workers were regularly exposed to a carcinogen, even though "many hospitals ha[d] voluntary improved internal procedures" to reduce the exposure rate). Nor is there any prospect of the risk abating in the near future; the rate of COVID-19 is currently increasing throughout the country and experts have warned that the

[10] *Cases and Deaths Among Healthcare Personnel*, CDC COVID Data Tracker, https://covid.cdc.gov/covid-data-tracker/#health-care-personnel (last updated Oct. 27, 2020).
[11] *See* Nat'l Nurses United, *Sins of Omission: How Government Failures to Track COVID-19 Data Have Led to More Than 1,700 Health Care Worker Deaths and Jeopardize Public Health* 5 (Sept. 2020), https://act.nationalnursesunited.org/page/-/files/graphics/0920_Covid19_SinsOfOmission_Data_Report.pdf.

pandemic is unlikely to subside until late 2021 at the earliest.[12] After the pandemic ends, healthcare workers will continue to face significant risk from these diseases.

B. OSHA's COVID-related efforts to address infectious diseases have been insufficient

As early as 2014, OSHA recognized that the current, "non-mandatory" infection control guidelines were "not sufficient to adequately reduce the risk of transmission of infectious agents to workers." Tab C at A25. Nonetheless, it has responded to the current crisis by issuing non-mandatory guidance, alerts, and response plans[13] and citing the General Duty Clause of the OSH Act, 29 U.S.C. § 654(a)(1), actions that fall far short of "eliminat[ing], as far as feasible, . . . significant risks of harm," *Indus. Union Dep't*, 448 U.S. at 641, and thus do not satisfy OSHA's obligations under the OSH Act and the APA.

First, the General Duty Clause is insufficient because it does not require employers to take any specific measure to protect workers, let alone measures that

---

[12] *See* Amanda Watts, *Fauci Says Normal Life May Not Be Back Until the End of 2021*, CNN Health (Sept. 11, 2020), https://www.cnn.com/2020/09/11/health/fauci-normal-life-2021/index.html.

[13] *See, e.g.* OSHA 3990-03 2020, *Guidance on Preparing Workplaces for Covid-19*, OSHA (2020), https://www.osha.gov/Publications/OSHA3990.pdf; *News Release: U.S. Department of Labor Issues Alert to Keep Retail Workers Safe During Coronavirus Pandemic*, DOL: News Releases: OSHA (Apr. 8, 2020), https://www.dol.gov/newsroom/releases/osha/osha20200408-1; *Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)*, OSHA Archive (Apr. 13, 2020), https://www.osha.gov/memos/2020-04-13/interim-enforcement-response-plan-coronavirus-disease-2019-covid-19.

would protect them from the infectious diseases. OSHA acknowledged in the SER Background Document that the General Duty Clause does not "adequately protect workers with occupational exposure to infectious diseases." Tab C at A131-32.

Second, the voluntary nature of guidance materials makes them inadequate substitutes for an enforceable standard. These guidance documents[14] typically state that they create "no new legal obligations" and "are advisory in nature, informational in content, and are intended to assist employers in providing a safe and healthful workplace." OSHA readily admits it "believes that a standard is needed because transmission-based infection control guidelines, though readily available, are not consistently followed." *See supra* 13 n.6; Duncan Decl. ¶ 6.

Unsurprisingly, OSHA's toothless efforts to address the COVID-19 pandemic have been ineffective. As of October 8, OSHA had received 9,334 COVID-19 related complaints alleging violations of the OSH Act, but issued just a few dozen citations.[15]

---

[14] *See COVID-19 News and Updates*, OSHA, https://www.osha.gov/SLTC/covid-19/news_updates.html (last visited Oct. 23, 2020).

[15] *See Summary Data for Federal and State Programs – Enforcement,* OSHA, https://www.osha.gov/enforcement/covid-19-data (last updated Oct. 23, 2020); *Inspections with COVID-related Citations*, OSHA, https://www.osha.gov/enforcement/covid-19-data/inspections-covid-related-citations (last updated Oct. 15, 2020).

II. OSHA Should be Compelled to Act Because its Delay is Unreasonable

This Court uses a balancing test, commonly referred to as the *TRAC* factors, to determine whether an agency's delay is unreasonable. The factors are (1) whether the time the agency takes to make a decision complies with a "rule of reason"; (2) whether Congress has provided a timetable for the agency's action; (3) whether human health is at stake; (4) the effect of expediting agency action on competing priorities; (5) the nature and extent of the interests prejudiced by the delay; and (6) any impropriety by the agency. *Cmty. Voice*, 878 F.3d at 786 (citing *TRAC*). *TRAC* described these principles as the "contours of a standard," but was careful to emphasize that they are "hardly ironclad." 750 F.2d at 79-80. "Each case must be analyzed according to its own unique circumstances." *Air Line Pilots Ass'n v. Civil Aeronautics Brd.*, 750 F.2d 81, 86 (D.C. Cir. 1984).

A. OSHA's length of delay violates the rule of reason and harms human health

The first, and "most important," *TRAC* factor weighs sharply in favor of mandamus here, as OSHA's lengthy delay and the absence of any concrete timeline to issue an Infectious Diseases Standard or even an NPRM defies any "rule of reason." *Cmty. Voice*, 878 F.3d at 786. [16] "[A] reasonable time for agency

[16] When there is no timetable or any "other indication of the speed with which [Congress] expects the agency to proceed," the second *TRAC* factor collapses into the first. *TRAC*, 750 F.2d at 80.

action is typically counted in weeks or months, not years." *Am. Rivers*, 372 F.3d at 419 (citation omitted). This Court recently endorsed the view that a delay over six years is "egregious," and even shorter delays have been found unreasonable. *See In re Natural Res. Def. Council, Inc.*, 956 F.3d 1134, 1139 (9th Cir. 2020) ("'[The D.C.] Circuit,' has held that a 'six-year-plus delay is nothing less than egregious.' Our own case law is no different.") (citations omitted); *see also Brock*, 823 F.2d at 629 (six-year delay "tread[ed] at the very lip of the abyss of unreasonable delay"); *Air Line Pilots Ass'n*, 750 F.2d at 86 (five-year delay unreasonable); *Auchter*, 702 F.2d at 1157-59 (three-year delay unreasonable).

The delay here meets that standard. Petitioners filed their petition seeking an Infectious Diseases Standard in May 2009, more than ten years ago. *See* Tab A. In 2010, OSHA "deem[ed] [the] problem significant enough to warrant initiation of the standard setting process." *Nat'l Cong. of Hispanic Am. Citizens ("Congreso") v. Marshall*, 626 F.2d 882, 890-91 (D.C. Cir. 1979). Petitioners were therefore "entitled to some timetable for the development" of the standard, and OSHA was required to "take pains, regardless of the press of other priorities, to ensure that the standard is not inadvertently lost in the process." *Id.*

Yet OSHA has not issued an NPRM, let alone a permanent standard, more than 10 years later. And OSHA's own regulatory schedule reveals that it has no plans to issue an NPRM any time soon, despite previously planning to do so in

2017. *See supra* 13. The information in existence by the time of the 2009 petition or 2010 RFI was significant enough that the delay should be measured against one of those dates. *See* Tab C at A26 (explaining that risk of infectious diseases "has been known and documented for some time."). Even if the delay is understood to begin in 2014 when the SER Background Document characterized the harm from infectious diseases as "well-recognized," that is still an "egregious" six-year delay. *Natural Res. Def. Council*, 956 F.3d at 1142.

The third *TRAC* factor also favors issuance of the writ. A reasonable time for agency action depends on the matter being regulated. Courts are more willing to compel action when the regulated matter affects public health than if it involves purely economic interests. *Auchter*, 702 F.2d at 1154; *see also Natural Res. Def. Council*, 956 F.3d at 1142 (explaining that the agency's "years-long delay on this critical matter of public health has been nothing short of egregious"). OSHA's lengthy delay in issuing a standard is particularly unreasonable given the existence of clear data showing the serious risks to healthcare workers from occupational exposure to infectious diseases; the agency's finding that the risks of infectious diseases are well-recognized; and its avowed "belie[f] that a standard is needed" because relevant guidelines "are not consistently followed." *See supra* 23.

The effects of the deadly COVID-19 pandemic highlight the urgency here as well as the damage to the healthcare workers and the public that OSHA's delay has

caused. When public health is at stake, "the agency must move expeditiously to consider and resolve the issues before it." *PCHRG v. Comm'r FDA*, 740 F.2d 21, 34 (D.C. Cir. 1984); *Auchter*, 702 F.2d at 1157-58 ("Delays that might be altogether reasonable in the sphere of economic regulation are less tolerable when human lives are at stake . . . . This is particularly true when the very purpose of the governing Act is to protect those lives."). *See also Brock*, 823 F.2d at 628, 629 ("With lives hanging in the balance, six years is a very long time," and "any delay whatever beyond the proposed schedule is unreasonable.").

B. No competing interests or priorities justify OSHA's unreasonable delay

The first and third *TRAC* factors are strong enough on their own here to establish the unreasonableness of OSHA's lengthy delay. The remaining factors (respectively, the agency's other priorities, the interests harmed by the delay, and any agency impropriety) are either neutral or support the same conclusion.

The fourth *TRAC* factor, the agency's other priorities, favors mandamus. Under the OSH Act, OSHA must "give due regard to the urgency of the need" for a new standard in setting priorities. 29 U.S.C. § 655(g). And once OSHA initiates a standard setting process, as here, OSHA must "have a plan to shepherd through the development of the standard . . . regardless of the press of other priorities, to ensure that the standard is not inadvertently lost in the process." *Chao*, 314 F.3d at 157-58 (citing *Congreso*, 626 F.2d at 890-91). While "competing policy priorities might

explain slow progress, they cannot justify indefinite delay and recalcitrance in the face of an admittedly grave risk to public health." *Id.* at 158. The emergence of COVID-19 and the accompanying risks to healthcare workers make the need for the standard, and the unreasonableness of OSHA's refusal to prioritize it, more urgent than ever. *See infra* 28-29.

In re International Chemical Workers Union is instructive. There, OSHA had delayed the issuance of a standard for occupational exposure to cadmium by almost six years. 958 F.2d at 1145. Applying the *TRAC* factors, the court found that six years was "an extraordinarily long time, in light of the admittedly serious health risks" associated with the existing, outdated cadmium standards. *Id.* at 1150. OSHA pointed to resource constraints and "deadlines imposed by Congress with respect to other rulemaking proceedings" to explain the delay. *Id.* The court responded that it was "not unmindful" of the agency's other responsibilities, but the delay was simply "too lengthy" for any further extensions of time; accordingly, the court ordered the agency to issue a final standard within several months. *Id.*

Similar to the third factor, the fifth factor (prejudice to private parties) strongly favors issuance of the writ. Healthcare workers at risk of severe illness or even death from COVID-19 and other infectious diseases are severely prejudiced by the delay. *See Indep. Mining Co. v. Babbitt*, 105 F.3d 502, 509 (9th Cir. 1997) (noting that the third and fifth TRAC factors are "overlapping").

Finally, under the sixth *TRAC* factor, this Court "need not find any impropriety lurking behind agency lassitude in order to hold that agency action is 'unreasonably delayed.'" *Comm'r*, 740 F.2d at 34. With or without any allegation of impropriety underlying OSHA's delay, the agency's failure to adhere to its previous timelines helps demonstrate the need for relief from this Court.

The Court should therefore grant mandamus to "let [OSHA] know, in no uncertain terms, that enough is enough," *Brock*, 823 F.2d at 627.

III. The Court Should Compel OSHA to Issue an NPRM

The significant and ongoing risk of infectious diseases like COVID-19 to healthcare workers, the several-year delay, and OSHA's decision to halt all progress on a standard warrant an order from this Court requiring OSHA to issue an NPRM for the Infectious Diseases Standard within 90 days. OSHA should then proceed on a priority, expedited basis to issue a standard as promptly as possible.

As explained above, the court in *Auchter* not only found a significant risk that compelled a NPRM, but also ordered OSHA to prioritize the rulemaking because the OSH Act requires that OSHA "give due regard to the urgency of the need" for a new standard in setting priorities. 29 U.S.C. § 655(g). The emergence of COVID-19, combined with the significant threats from other infectious diseases, known and unknown, present urgent risks to healthcare workers that warrant

compelling OSHA to issue a proposed rule and prioritize the subsequent rulemaking.

Compelling OSHA to act within 90 days is reasonable because OSHA has already developed much of the content for the standard. *See supra* 10-13. This standard would be both legally enforceable and flexible enough to be tailored to a variety of workplaces. As noted, a core element of the standard is the requirement that every employer adopt a comprehensive Worker Infection Control Plan that assesses the level of risks that its employees face from infectious diseases in its own particular workplace, and then complies with a set of mandatory worker protection provisions addressing the workplace-specific risks facing the employees. Tab E. Right now, no employer is required to take such actions to protect their employees from infectious diseases.

An NPRM would allow OSHA to finally address a problem it felt was "significant enough to warrant initiation of the standard setting process" and ensure that the standard is not "lost in the process." *Congreso*, 626 F.2d at 890-91.

CONCLUSION

For the reasons set forth above, Petitioners respectfully urges this Court to issue a writ of mandamus compelling OSHA to cease its unreasonable delay and issue an NPRM for the Infectious Diseases Standard within 90 days of the Court's mandamus order and proceed on a priority, expedited basis to issue a standard.

Dated: October 29, 2020

Respectfully submitted,

/s/ *Michael C. Martinez*
Michael C. Martinez
Jeffrey B. Dubner
Sean A. Lev
Democracy Forward Foundation
P.O. Box 34553
Washington, DC 20043
Telephone: (202) 448-9090
Facsimile: (202) 701-1775

STATEMENT OF RELATED CASES

The undersigned, counsel of record for Petitioners, is aware of no cases related to this petition pending before this Court.

Dated: October 29, 2020

/s/ Michael C. Martinez
Michael C. Martinez

Counsel for Petitioners

CERTIFICATE OF COMPLIANCE

This petition for a writ of mandamus complies with the type volume limitation of Ninth Circuit Rule 21-2(c) because it does not exceed 30 pages, excluding the parts exempted by Federal Rules of Appellate Procedure 21(a)(2)(C) and 32(f).

The petition also complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 14-point Times New Roman font.

Dated: October 29, 2020

/s/ Michael C. Martinez
Michael C. Martinez

Counsel for Petitioners

CERTIFICATE OF SERVICE

I hereby certify that on October 29, 2020, I served a copy of this Petition for Writ of Mandamus on all parties by Certified U.S. Mail at the following addresses:

Occupational Safety & Health Administration
200 Constitution Avenue, NW, Room N3626
Washington, D.C. 20210

United States Department of Labor
Office of Legal Counsel
200 Constitution Ave. NW, Room N2700
Washington, DC 20210

Eugene Scalia, in his official capacity as Secretary of Labor
c/o Office of Legal Counsel
200 Constitution Ave. NW, Room N2700
Washington, DC 20210

William P. Barr, U.S. Attorney General
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530

Civil Process Clerk
U.S. Attorney's Office for the Northern District of California
450 Golden Gate Avenue, 11th Floor
San Francisco, CA 94102

Dated: October 29, 2020

/s/ Michael C. Martinez
Michael C. Martinez

Counsel for Petitioners