

Nos. 21-1220, 1221, 1225, 1236, 1237, & 1258

United States Court of Appeals
For the District of Columbia Circuit

LUCAS WALL, LEONARDO McDONNELL, MICHAEL SEKLECKI
(on behalf of himself and his minor child M.S.), MICHAEL FARIS,
CHARITY ANDERSON, ANGELA BYRD, MICHAEL CLARK,
URI MARCUS, LARRY JAMES BONIN JR., ANTHONY EADES,
KLEANTHIS ANDREADAKIS, THERESA MULLINS, & AARON ABADI,
Petitioners

v.

TRANSPORTATION SECURITY ADMINISTRATION,
Respondent

Petition for Review of TSA Security Directives & Emergency Amendment

BRIEF OF *AMICI CURIAE* 309 PILOTS & FLIGHT
ATTENDANTS IN SUPPORT OF PETITIONERS

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III. AMICI'S INTEREST IN THE CASE

Friends of the Court are 309 pilots and flight attendants from 35 states working for 16 commercial airlines who are subject to Respondent Transportation Security Administration (“TSA”)’s three “Security Directives”¹ and Emergency Amendment that make up the enforcement scheme of the Executive Branch’s Federal Transportation Mask Mandate (“Mask Mandate”). We are subject to the Mask Mandate every hour we are working, with an exception only for pilots on duty in the cockpit due to safety reasons.²

We support Petitioners’ arguments that the Mask Mandate is *ultra vires* and should be vacated worldwide. While passengers only have to endure forced masking when traveling on public transportation, we are expected to obstruct our oxygen intake nearly all the time while at work. This endangers our health and imperils aviation safety.

We submit this brief pursuant to FRAP 29. We consulted with Lead Petitioner Lucas Wall and TSA counsel Jennifer Utrecht, who both consented to

¹ We agree with the 13 Petitioners that the Mask Mandate has zilch to do with transportation security, therefore we adopt their moniker of “Health Directives” throughout the remainder of this brief to more appropriately describe TSA’s orders.

² At some airlines, pilots who aren’t vaccinated against COVID-19 for medical, religious, or other reasons are required to wear a mask even while flying the aircraft.

this filing.

No party's counsel authored this brief in whole or part. No party or their counsel contributed money that was intended to fund preparing or submitting the brief. No person other than those signing this brief contributed money that was intended to fund preparing or submitting this document.

IV. ARGUMENT

A. The Mask Mandate must be vacated because it violates Federal Aviation Administration safety regulations.

We have serious concerns about the safety implications of the Mask Mandate, none of which were studied by the Centers for Disease Control & Prevention (“CDC”), TSA, or any other agency as the policy was rushed into place only 12 days after the inauguration of a new president, who made a national mask dictate a top campaign promise – even though he acknowledged it was likely unconstitutional. Appendix (“App.”) 1,134-1,146.

As pilots, our health is strictly governed by regulations issued by the Federal Aviation Administration (“FAA”). We are prohibited from operating an aircraft during any period of medical deficiency. However, we are required to comply with the Mask Mandate, which causes known medical deficiencies.

“[N]o person who holds a medical certificate issued under part 67 of this chapter may act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person: ... (1) Knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation...” 14 CFR § 61.53(a).

Pilots must wear a mask before and after flight, causing us numerous medical deficiencies. “[A] person shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person knows or has reason to know of any medical condition that would make the

person unable to operate the aircraft in a safe manner.” 14 CFR § 61.53(b).

Wearing a mask before we work a flight causes us to feel we are unable to operate the aircraft in a safe manner. Yet due to the Mask Mandate and our companies’ enforcement thereof, we are expected to comply and fly anyway.

TSA’s role has always been limited to *security* issues, i.e. preventing *intentional attack* on our transportation system. The pre-eminent goal of the agency is to prevent another Sept. 11, 2001. TSA has never been granted authority or funding to conduct a general *safety* mission such as preventing accidents from happening – much less a *public health* mission.

Although FAA medical regulations apply to pilots, other regulations govern flight attendants as well. A “flight crew” consists of the pilots in the cockpit and the flight attendants working in the passenger cabin. “Each flight crew member must report for any flight duty period rested and prepared to perform his or her assigned duties.” 14 CFR § 117.5(a). As flight attendants, our jobs are designated safety-critical because we are responsible for ensuring cabin safety and security while in flight. If there’s an emergency in the cabin, we are the first responders. But all of the health problems mentioned below reduce our ability to ensure flight safety.

Wearing a mask before a flight (for example, while on a shuttle bus from our hotel to the airport and in the terminal) makes us feel like we are not fully

prepared to perform our assigned duties, including due to fatigue. “Extended wearing of [a] mask, which has become a part of routine life, has led to the emergence of ‘mask fatigue.’ Mask fatigue is defined as the lack of energy that accompanies and/or follows prolonged wearing of a mask.” App. 966. “There is published evidence which shows that extended wearing of a mask impairs functioning...” *Id.* Mask fatigue include at least 24 significant harms to human health. *Id.*

“The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public...,” according to FAA’s Guide for Aviation Medical Examiners. Ex. 1.

All aviators must see an FAA certified doctor (“Aviation Medical Examiner”) 1-2 times each year. Pilots are all obligated by law (49 USC § 46310) to disclose any disqualifying condition pertaining to obtaining or maintaining our medical certificate. If we know that masks are unhealthy for us and their continued use can cause cumulative harm (as evidenced by years of unbiased scientific studies prior to COVID-19 politicization), we are morally and legally obligated to abstain and/or report.

The number of hours pilots and flight attendants may work in a day is controlled by law. This can be as long as 16 hours per shift – double a normal

workday. “A Flight Duty Period includes the duties performed by the flight crew member on behalf of the certificate holder that occur before a flight segment or between flight segments without a required intervening rest period.” 14 CFR § 117.3.

The Mask Mandate forces us to obstruct our oxygen intake, causing diminished mental and physical capacity, during our Flight Duty Period. Despite this diminution of our physical capacities, the government has not reduced the number of hours we may work per day to account for the numerous impairments masks cause.

When we travel on a commercial flight as a passenger not paying for a ticket, we are referred to as “non-revs” or “jumpseaters” since we may occupy an additional seat in the cockpit or the cabin called a “jumpseat.” If that seat is already taken or there are regular seats open in the cabin, we may be seated in a passenger seat. When we are on duty and flying in regular seat, this is referred to as “deadheading.”

“Deadhead transportation means transportation of a flight crew member as a passenger or non-operating flight crew member by any mode of transportation, as required by a certificate holder, excluding transportation to or from a suitable accommodation. All time spent in deadhead transportation

is duty and is not rest.” *Id.* When we travel as a jumpseater and/or are dead-heading, we are considered an additional crewmember. Ex. 2.

“Even when not in uniform, remember that you are still considered an additional crewmember and you may be required to assist on the flight deck or in the cabin in case of unusual or emergency circumstances. You must remain prepared to assist the flight crew should the need arise.” *Id.*

However, we are forced to wear masks when traveling as a jumpseater and/or deadheader, which reduces our mental and physical capacities to be able to assist the on-duty flight crew should an emergency occur. “Since masking impairs our ability when conducting a flight as evidenced by the fact that we are not required to wear a mask when flying, it also impairs our fitness for flight when acting in other required capacities.” *Id.*

The Department of Transportation (“DOT”), which includes FAA, notes that “the failure to wear a face covering is not itself a federal violation,” contradicting the Mask Mandate. *Id.* Yet some of us have been fined by TSA for failing to wear a mask in the airport terminal while we are on duty – something that is forbidden by the Health Directives themselves since they exempt from mandatory masking “People for whom wearing a mask would create a risk to workplace health, safety, or job duty as determined by the relevant workplace safety guidelines or federal regulations.” App. 29.

FAA recognizes the dangers of forced masking of flight crew: “Air carriers should complete a safety risk assessment and provide guidance to their crewmembers on procedures for the use of masks as they may affect the donning of oxygen masks or conducting other safety functions on the flight deck or in the cabin.” FAA Safety Alert for Operators 20009 (May 25, 2021); Ex. 3.

A court must “hold unlawful and set aside agency action ... found to be ... in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.” 5 USC § 706(2)(C). Because TSA’s Mask Mandate violates FAA safety regulations, the Court should hold it unlawful and strike it down because TSA acted short of statutory right. An agency in the Department of Homeland Security may not override with a “directive” duly promulgated safety rules published in the Code of Federal Regulations by an agency (FAA) in another executive department (DOT) that Congress has tasked with ensuring the safety of flight, including the health of crewmembers.

“An agency’s general rulemaking authority does not mean that the specific rule the agency promulgates is a valid exercise of that authority.’ ‘Agencies are ... bound, not only by the ultimate purposes Congress has selected, but by the means it has deemed appropriate, and prescribed, for the pursuit of those purposes.’” *NAACP v. DeVos*, No. 20-cv-1996, 2020 WL 5291406 (D.D.C. Sept. 4, 2020) (quoting *Colo. River Indian Tribes v. Nat’l Indian*

Gaming Comm'n, 466 F.3rd 134, 139 (D.C. Cir. 2006)). TSA's authority to issue legitimate Security Directives does not give it "[c]arte blanche authority" to promulgate any rule it deems necessary. *Merck & Co. v. HHS*, 385 F. Supp. 3rd 81, 92 (D.D.C. 2019); *aff'd* 962 F.3rd 531 (D.C. Cir. 2020).

TSA, by regulation, limits its ability to issue Security Directives to when additional *security measures* are necessary. In no way does a mask constitute a "security measure." Since a rule/order/mandate is an offspring of the enabling act, a policy that cannot be harmonized with the statute is unlawful. *Dixon v. United States*, 381 U.S. 68 (1965).

B. The Mask Mandate must be vacated because it creates chaos in the sky, recklessly endangering aviation safety and security.

TSA, as its name suggests, is responsible for ensuring transportation security. But the Mask Mandate *endangers* aviation security. TSA, in continuing to extend the Mask Mandate indefinitely even though all 50 states do not require face coverings (App. 1,204), fails to take into account that in addition to the millions of Americans who can't safely obstruct their breathing because of a medical condition, tens of millions of Americans vehemently object to anyone ordering them to wear face masks. This is evidenced by 5,981 incidents of "unruly" behavior aboard airplanes reported to FAA during 2021, 4,290 of which related to the Mask Mandate. App. 107.

2021 was “the worst year on record for buffoonish behavior on planes.” Ex. 4. So far this year, FAA has received 814 reports of unruly passengers, 535 related to the Mask Mandate. App. 108. This conduct is understandable since the Food, Drug, & Cosmetic Act protects all Americans’ right to refuse administration of a Food & Drug Administration (“FDA”) unauthorized or Emergency Use Authorization (“EUA”) medical device such as a face covering. Masks make it difficult to breathe and function – especially in our workplace seven miles high in the sky, where airplane cabins are pressurized to an equivalent of 8,000 feet altitude, with oxygen levels much lower than most passengers who live at or near sea level are accustomed to.

The Mask Mandate worsens transportation security as some people violently stand up for their right to breathe freely. And unfortunately some of our colleagues have become terribly hostile to any passenger who dares remove his/her mask for any reason, creating great friction in the cabin.

“Despite coming with hefty fines and the threat of criminal prosecution, the [Mask Mandate] has spawned an epidemic of shouting matches – and worse – between defiant passengers and flight crews. ... But if airlines are the last place in America to require masks, the skies are likely to become even less friendly for flight crews.” Ex. 4. “[T]he level of in-flight fracas has gotten exponentially worse in the past two years, with most cases involving disputes

over masking.” *Id.*

Airplanes, airports, and other transportation conveyances and terminals are now among the last places in America where anyone is forced to block their breathing. Why should we have to suffer when the federal government doesn't require masking in any other sector of society?

“The current climate in the passenger cabin is highly stressed. We are experiencing a record high number of aggressive passenger incidents, many of which are fueled by ... refusal to comply with onboard mask rules,” the president of a major flight-attendant union said. App. 1,147-1,150.

All of the “unruly” behavior we’ve seen aboard airplanes when airlines try to enforce the Mask Mandate is explained by science, none of which TSA considered:

“Wearing masks, thus, entails a feeling of deprivation of freedom and loss of autonomy and self-determination, which can lead to suppressed anger and subconscious constant distraction, especially as the wearing of masks is mostly dictated and ordered by others. These perceived interferences of integrity, self-determination and autonomy, coupled with discomfort, often contribute to substantial distraction and may ultimately be combined with the physiologically mask-related decline in psychomotoric abilities, reduced responsiveness, and an overall impaired cognitive performance.” App. 933.

Being forced to cover the nose and mouth, a person's only two sources of oxygen – breathing is of course essential to life – “leads to misjudging situations as well as delayed, incorrect, and inappropriate behavior and a decline

in the effectiveness of the mask wearer.” *Id.*

“[P]assengers have verbally abused and taunted flight attendants trying to enforce airline mask requirements...” Ex. 5. It is a miracle that TSA’s Mask Mandate has not yet led to a major aviation safety incident.

“A flight attendant reported being so busy seeking mask compliance that the employee couldn’t safely reach a seat in time for landing. One airline captain, distracted by mask concerns, descended to the wrong altitude. The repeated talk of problem passengers in Row 12 led the captain to mistakenly head toward 12,000 feet, not a higher altitude given by air traffic control to keep planes safely apart.” *Id.*

“It is no secret that the threats flight attendants face each day have dramatically increased,” states a letter from Julie Hedrick, president of the Association of Professional Flight Attendants. “Every day, we are subjected to verbal and sometimes physical altercations, mainly centered around mask compliance.” Ex. 6.

Carrying out mask rules also worsens the already strained position of flight attendants, who are frontline enforcers even as we keep our usual safety responsibilities. “Flight attendants are dealing with mask compliance issues on every single flight they work right now,” said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, noting that those efforts range from friendly reminders to facing passengers “actively challenging the flight attendants’ authority.” Ex. 7.

“One in five flight attendants so far this year has been involved in physical altercations with unruly passengers and 85% of cabin crew members have dealt with disruptive passengers this year...” Ex. 8. “[M]any flight attendants reported ... being subjected to yelling and swearing for federal mask mandate directions.” *Id.*

“My fear, however, is that the mandate is going to someday cause a far bigger problem while in the air than just some unruly passenger being eventually duct-taped to a seat. One of these days, a confrontation is going to escalate far further than the crew member who had a finger bitten or the flight attendant who caught an errant punch square in the face and had two teeth knocked out. Ask yourself, is it worth it to have a mandate that ostensibly is for your safety but only leads further to unsafe conditions?” Ex. 9.

“Even if not intended to bring the plane down, you can imagine the kind of pandemonium on planes that we’ve seen in some of these videos that people have taken that can cause an incredibly dangerous accident,” said Attorney General Merrick Garland.” Ex. 10. These incidents would vanish if this Court vacates the Mask Mandate.

“The tense situation in the air ... has led many attendants to say that they feel exhausted, afraid for their personal safety and, in some cases, concerned that the situation could turn dangerous.” Due to the unlawful Mask Mandate, “encountering unruly passengers, once rare, is now almost expected.” Ex. 11.

Major airlines, including most of our employers, have been calling for the abolition of the Mask Mandate for the past 10 months. App. 1,172-1,203.

With forced masking “in place, there has been a rise in onboard incidents that have harmed flight attendants, delayed or cancelled flights ... When this atmosphere is combined with tensions around mask policy, we have seen a summer with more onboard skirmishes and more people injured than ever before,” wrote Ben Baldanza, former CEO of Spirit Airlines. Ex. 12.

We agree with the Petitioners that TSA lacks authority from Congress to require masks. But even if it did possess such power – which a panel of this court wrongly held in December 2021 in *Corbett v. TSA*, No. 21-1074 – the policy is arbitrary and capricious because the Mask Mandate does the exact *opposite* of TSA’s statutory mission to ensure transportation security by actually *endangering* our security. Just today, a federal district court vacated CDC’s Mask Mandate, upon which TSA’s enforcement directives rely, because it’s arbitrary and capricious. *Health Freedom Defense Fund v. Biden*, No. 8:21-cv-1693 (M.D. Fla. April 18, 2022). Ex. 17.

We concur with Petitioners that *Corbett* is no longer valid caselaw. The general thrust of the Supreme Court’s recent decision in *NFIB v. Dept. of Labor*, 142 S.Ct. 661 (2022), is that the Occupational Safety & Health Administration (“OSHA”) was charged by Congress with precisely what its name indicates: *occupational* safety-and-health-related matters. General public-health measures are outside of that scope. The justices held that a health

matter that affects the general public at all times, whether or not they are at work, is not an “occupational” matter just because it also affects them on the job. The same is true here. COVID-19 is a “threat” to all segments of society, but that doesn’t mean a transportation *security* agency has power to try to control it by requiring masks.

A public-health concern that affects all Americans at all times, whether or not they are in the transportation system, is not a “transportation security” matter just because it also happens while engaged in transport – and further, it is not a “security” matter whatsoever. Security and health are simply two different things. This Court must follow the high court’s decision in *NFIB*:

Furthermore, TSA issued the challenged Health Directives and Emergency Amendment without giving notice and considering public comments. CDC’s Mask Mandate was just declared *ultra vires* for skipping notice and comment. *HFDF*. Had the agency done so, thousands of pilots and flight attendants such as ourselves would have objected to the Mask Mandate because it conflicts with the FAA safety regulations under which we are governed and creates detrimental health effects to those of us who work in safety-critical jobs. It also distracts from our important duties by forcing us to become the “mask police,” mandating that passengers obstruct their breathing as a condition of transport. Had comments been taken, FAA would

have likely joined us in cautioning against adopting the dangerous Mask Mandate.

Likewise, many of our unions would have submitted comments urging TSA not to adopt the Mask Mandate.

“Serving onboard during these contentious times and enforcing mask compliance is one of the most difficult jobs we have ever faced as flight attendants. Not since September 11, 2001, has our job environment changed so drastically and quickly. The number of physical and verbal assaults in our workplace has increased dramatically, many of which are related to mask compliance. ... It is important to note that a large portion of our membership has expressed that they would like the freedom to choose whether to wear a mask at work.” App. 1,194-1,195.

The Administrative Procedure Act (“APA”) requires agencies to issue rules, orders, directives, etc. through a notice-and-comment process. 5 USC § 553. Good cause does not excuse TSA’s failure to comply with the notice-and-comment process because the agency had 10½ months to give notice, solicit comments, respond to those comments, and publish a regulation in the Code of Federal Regulations from the date the World Health Organization declared COVID-19 a global pandemic (March 11, 2020) until the date the Mask Mandate took effect (Feb. 1, 2021). 5 USC § 553(b)(3)(B). *HFDF*.

“[I]t is too late for the State to defend extreme measures with claims of temporary exigency, if it ever could.” *South Bay United Pentecostal Church v. Newsom*, 141 S.Ct. 716, 720 (2021) (Gorsuch, J.).

TSA's enabling act exempts it from notice-and-comment procedures when a sudden *threat to transportation security* develops and the agency must act rapidly. But as Petitioners argue, COVID-19 poses no threat to transportation infrastructure, nor did TSA act rapidly. Even in the federal bureaucracy, nobody could claim waiting 10½ months and then suddenly issuing "Security Directives" regarding a public-health issue to fulfill a new president's campaign pledge is acting swiftly to a new "threat."

This is nothing more than a blanket and "unsupported assertion" that good cause excuses TSA's compliance with the APA. *Sorenson Commc'ns v. FCC*, 755 F.3rd 702, 707 (D.C. Cir. 2014). TSA's failure to explain its own delay is telling.

"Notice and comment can only be avoided in truly exceptional emergency situations, which notably, cannot arise as a result of the agency's own delay. ... an agency cannot show an emergency when it has been aware of the problem but nonetheless failed to take action." *Wash. All. of Tech. Workers v. DHS*, 202 F. Supp. 3rd 20, 26 (D.D.C. 2016) (cleaned up); *see also Environmental Def. Fund v. EPA*, 716 F.2nd 915, 921 (D.C. Cir. 1983) ("[T]he good cause exception does not apply when an alleged 'emergency' arises as the result of an agency's own delay.")

A tribunal must "hold unlawful and set aside agency action ... found to be

... without observance of procedure required by law.” 5 USC § 706(2)(D). This Court should hold unlawful and set aside the Mask Mandate because it’s arbitrary and capricious, and it violates the APA’s notice-and-comment requirement.

C. The Mask Mandate must be vacated because TSA failed to take into account that airplane cabins pose little risk for coronavirus spread.

Another reason the Mask Mandate is arbitrary and capricious is because the federal government’s only face-covering dictate applies to the sector of society that is at *least risk* for COVID-19 transmission. There’s nothing in the administrative record showing that TSA considered the ample evidence provided by the aviation industry and others that masks aren’t necessary and do nothing to reduce COVID-19 transmission, especially in the sterile environment of a jet aircraft.

Our employers commissioned a lengthy report “Assessment of Risks of SARS-CoV-2 Transmission During Air Travel & Non-Pharmaceutical Interventions to Reduce Risk” by the Harvard T.H. Chan School of Public Health as part of the Aviation Public Health Initiative. App. 1,208-1,229. Petitioners briefly mentioned this in their brief, but did not discuss it in detail. The Court must consider these important findings.

“Ventilation Systems on Aircraft: These sophisticated systems deliver high amounts of clean air to the cabin that rapidly disperses exhaled air, with displacement in the downward direction, reducing the risk of passenger-to-passenger spread of respiratory pathogens. Aircraft ventilation offers enhanced protection for diluting and removing airborne contagions in comparison to other indoor spaces with conventional mechanical ventilation and is substantially better than residential situations. This level of ventilation effectively counters the proximity travelers will be subject to during flights. The level of ventilation provided on-board aircraft would substantially reduce the opportunity for person-to-person transmission of infectious particles... Particular emphasis is placed on the effectiveness of aircraft ventilation systems, which are able to filter 99.97% of SARS-CoV-2 particles out of air found on aircraft.” *Id.*

The study confirms what our employers have been promoting to customers: There is little-to-no risk of contracting COVID-19 aboard a plane. “After detailed analysis of these reports, it is the view of APMI that *there have been a very low number of infections that could be attributed to exposure on aircraft during travel.*” *Id.* (emphasis added). In short, TSA is trying to solve a problem that never existed.

CDC itself admitted “the risk of getting a contagious disease on an airplane is low.” *Id.* “Given the volume of commercial flights daily, carrying millions of passengers and crew worldwide, the number of documented incidents of infectious disease transmission occurring on board an aircraft remains infrequent.” *Id.*

“[T]he risk of SARS-CoV-2 transmission onboard aircraft will be below

that found in other routine activities during the pandemic, such as grocery shopping or eating out.” *Id.* CDC currently recommends Americans in 99.47% of counties do not don face coverings. App. 115. It’s thus arbitrary and capricious for CDC and TSA to demand we wear masks at work when such a federal requirement is not placed on any other industry – even though our workplace is less prone to virus spread than nearly every other sector.

“[T]he aircraft’s environmental control systems effectively diluting and removing pathogens significantly reduce the risk of passengers and crewmembers from acquiring COVID-19...” *Id.*

Our employers continue lobbying the White House for abolition of the Mask Mandate because it is not only unnecessary but dangerous. “Airplanes are already equipped with advanced air filtration systems, and airports have made large investments in air filtration, sanitation, and layouts. COVID-19 hospitalization rates have decreased significantly and the mask mandate should be lifted to reflect the improved public health environment,” according to Airlines for America, a trade group that represents most of our companies. App. 1,191.

The International Air Transport Association has called for an end to mask mandates aboard airplanes worldwide. The association notes on its website that “The risk of transmission in the modern cabin environment is low for a

number of reasons: passengers face the same direction, seatbacks act as barriers, air flow is from the top to bottom, and the air is also very clean. Cabin air is refreshed 20-30 times an hour; About 10 times more than most office buildings.” App. 1,205-1,207. “Most modern jet aircraft are equipped with High-Efficiency Particulate Air (HEPA) filters. These filters have similar performance to those used in hospital operating theatres and industrial clean rooms.” *Id.*

The Department of Defense’s Transportation Command conducted a study in October 2020 that found

“aerosol particles were rapidly diluted by the high air exchange rates of a typical aircraft cabin. Aerosol particles remained detectable for a period of less than six minutes on average. Both aircraft models (B777 and B767) tested removed particulate matter 15 times faster than a typical home ventilation system and 5-6 times faster than the recommended design specifications for modern hospital operating or patient isolation rooms.” *Id.*

Similar tests by aircraft manufacturers Airbus, Boeing, and Embraer also found miniscule risk of COVID-19 transmission. *Id.*

As most of our employers noted in a March 23, 2022, letter to President Biden: “It is critical to recognize that the burden of enforcing both the mask and predeparture testing requirements has fallen on our employees for two years now. *This is not a function they are trained to perform and subjects them to daily challenges by frustrated customers. This*

in turn takes a toll on their own well-being.” App. 1,179 (emphasis added).

“We are requesting [abolition of the Mask Mandate] not only for the benefit of the traveling public, but also for the thousands of airline employees charged with enforcing a patchwork of now-outdated regulations implemented in response to COVID-19.” *Id.*

Congress has never imposed a mask mandate anywhere in the nation, despite having passed dozens of bills in response to the COVID-19 pandemic. All too often the Executive Branch attempts to circumvent the legislative process by imposing through “directives” rules that Congress fails to adopt through legislation. *See, e.g., U.S. House of Representatives v. Mnuchin*, 976 F.3rd 1, 4 (D.C. Cir. 2020). That is precisely what happened here. The only vote Congress has ever taken on the Mask Mandate was the Senate’s 57-40 decision to kill it. App. 110-113.

The Court should hold unlawful and set aside the Mask Mandate because it is arbitrary, capricious, and an abuse of discretion. 5 USC § 706(2)(A).
HFDF.

D. The Mask Mandate must be vacated because TSA failed to consider that masks pose serious health risks to humans forced to wear them, including those who work in the transport sector.

In addition to the science showing that masks have proven totally ineffective in reducing coronavirus spread, there's nothing in the administrative record showing that TSA considered the serious health risks to human beings of forced masking nor the dangers of oxygen deprivation at high altitude such as in airplane cabins. Petitioners have compiled an amazing collection of hundreds of scientific and medical studies illustrating the frightening number of negative health consequences of covering your face – harms we have been forced to endure for more than 14 months because of the Mask Mandate. <https://bit.ly/masksarebad>.

“It is not clear however, what the scientific and clinical basis is for wearing facemasks as a protective strategy, given the fact that facemasks restrict breathing, causing hypoxemia and hypercapnia, and increase the risk for respiratory complications, self-contamination, and exacerbation of existing chronic conditions,” according to a paper published by the National Institutes of Health. App. 900.

The leading authority on this subject is a 42-page paper published April 20, 2021, by eight German doctors and scientists in the International Journal of Environmental Research & Public Health. App. 922-963. They found: “Up

until now, there has been no comprehensive investigation as to the adverse health effects masks can cause.” These German doctors and scientists coined a new disease: Mask-Induced Exhaustion Syndrome. *Id.* We all suffer from this syndrome when forced to mask at work by TSA.

Symptoms include

“an increase in breathing dead space volume, increase in breathing resistance, increase in blood carbon dioxide, decrease in blood oxygen saturation, increase in heart rate, increase in blood pressure, decrease in cardiopulmonary capacity, increase in respiratory rate, shortness of breath and difficulty breathing, headache, dizziness, feeling hot and clammy, decreased ability to concentrate, decreased ability to think, drowsiness, decrease in empathy perception, impaired skin barrier function with itching, acne, skin lesions and irritation, overall perceived fatigue and exhaustion.” *Id.*

The government has no right to cause us pain and suffering just for doing our jobs. The Mask Mandate not only endangers transportation security but also our health. Some of us have taken extended medical leaves because we can't continue working with our natural breathing blocked. This has caused enormous financial hardship. We know many colleagues who quit working for airlines so they could find a job in every other part of the economy that the federal government doesn't force upon employees a dangerous, experimental, unproven medical device.

“The public interest is also served by maintaining our constitutional structure and maintaining the liberty of individuals to make intensely personal

decisions according to their own convictions – even, or perhaps *particularly*, when those decisions frustrate government officials.” *BST Holdings v. OSHA*, No. 21-60845 (5th Cir. Nov. 12, 2021) (emphasis original).

Petitioners cite the Food, Drug, & Cosmetic Act’s requirement that a person has the legal right to refuse to use any medical device approved by the Food & Drug Administration under an Emergency Use Authorization – as nearly all face coverings are. Like the Petitioners, we want to exercise our right to refuse administration of the product. 21 USC § 360bbb-3(e)(1)(A)(ii)(III). However, doing so has resulted in some of us being fined by TSA and others being reprimanded and/or suspended by our companies due to the Mask Mandate.

The Court should hold unlawful and set aside the Mask Mandate because it violates the Food, Drug, & Cosmetic Act, making it “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.” 5 USC § 706(2)(C).

E. The Mask Mandate must be vacated because it recklessly endangers transportation workers by failing to comply with Occupational Safety & Health Administration rules for face coverings.

“Breathing is one of the most important physiological functions to sustain life and health. Human body requires a continuous and adequate oxygen (O₂) supply to all organs and cells for normal function and survival. ... Long-

term practice of wearing facemasks has strong potential for devastating health consequences.” App. 900.

“Scientists have found evidence that some face masks which are on sale and being used by members of the general public are laced with toxic chemicals. ... Experts are concerned that the presence of these chemicals in masks which are being worn for prolonged periods of time could cause unintended health issues.” App. 1,100. In no other aspect of workplace safety would the government ever allow workers to be exposed to these types of toxic chemicals.

Indeed, the Department of Labor has an agency that regulates workplace safety (OSHA). That agency sets standards for respiratory protection. 29 CFR § 1910.134. None of our employers are following these legal requirements as the Mask Mandate does not mention them. Ex. 13. Due to the dangers of obstructing a person’s breathing, OSHA requires that a Respirator Medical Evaluation Questionnaire be completed by anyone who will be required to wear a mask at work. Ex. 14. But none of us have ever been asked to complete the questionnaire.

If any company demands someone wear a mask, OSHA requires it “Must provide respirators, training, and medical evaluations at no cost...” Ex. 15. In enforcing the Mask Mandate, none of our employers have provided training

or medical evaluations.

“All oxygen-deficient atmospheres (less than 19.5% O₂ by volume) [such as airplane cabins] shall be considered IDLH,” according to OSHA. IDLH stands for “immediately dangerous to life or health.” *Id.*

OSHA requires companies mandating masks to

“provide effective training to respirator users, including: why the respirator is necessary and how improper fit, use, or maintenance can compromise the protective effect of the respirator; limitations and capabilities of the respirator; use in emergency situations; how to inspect, put on and remove, use and check the seals; procedures for maintenance and storage; recognition of medical signs and symptoms that may limit or prevent effective use; and general requirements of this standard.” *Id.*

None of our employers have provided the required training.

“[T]he meaning of one statute may be affected by other Acts, particularly where Congress has spoken subsequently and more specifically to the topic at hand.” *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 132-133 (2000). “The Act empowers the Secretary to set workplace safety standards, not broad public health measures. *See* 29 USC §655(b) (directing the Secretary to set ‘occupational safety and health standards’); §655(c)(1) (authorizing the Secretary to impose emergency temporary standards necessary to protect ‘employees’ from grave danger in the workplace).” *NFIB*.

Based on this precedent, it’s clear error that the *Corbett* panel determined

that anything that “poses a threat to the operational viability of the transportation system” is transportation-security related. But *NFIB* makes obvious that a general public-health matter’s tangential effect on something within an agency’s purview simply does not give the agency the authority to regulate. Just as OSHA strayed too far with its vaccination or mask/test requirement and CDC too far with its eviction moratorium, TSA has meandered well past the boundaries of its enabling act with the Mask Mandate.

TSA’s interpretation of its enabling act (49 USC § 114) ignores Congress’ important and deliberate context and structure that reveals a variety of specific, listed steps that TSA may take to protect transportation security. Nowhere did Congress provide authority for TSA to regulate health matters. “A statute must be read as a whole, and individual terms or phrases should not be interpreted in isolation.” *Sealed Appellee 1 v. Sealed Appellant 1*, 767 F.3rd 418 (5th Cir. 2013). “It is a cardinal principle of statutory construction that a statute ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant.” *Asadi v. G.E. Energy*, 720 F.3rd 620 (5th Cir. 2013).

Allowing TSA to adopt broad definitions of its authority without being confined by the statute’s context, structure, and history does not meaningfully constrain its discretion. If Congress meant to give TSA such unlimited

power, it needed to “provide substantial guidance.” *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 475 (2001). “Our system does not permit agencies to act unlawfully even in pursuit of desirable ends.” *Ala. Ass’n of Realtors v. HHS*, 141 S. Ct. 2485, 2490 (2021).

The Court should hold unlawful and set aside the Mask Mandate because it violates OSHA workplace safety regulations and exceeds TSA’s statutory authority to protect transportation security, making it “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.” 5 USC § 706(2)(C).

F. This case would not be mooted if CDC and TSA voluntarily terminate the Mask Mandate.

The fifth extension of TSA’s Health Directives and Emergency Amendment (Version “E”) is currently set to expire May 3, 2022. We have no idea if it will actually be allowed to lapse, but we are cognizant that it’s possible CDC and TSA could repeal the Mask Mandate before this Court is able to render a judgment on these six Petitions for Review. However, that would in no way moot the Petitioners’ case. (As we are finalizing its brief, the White House announced a suspension of TSA’s mask enforcement due to the decision in *HFDF*, but this is no guarantee the government won’t appeal that ruling to

the 11th Circuit or decide TSA may independently from CDC resume enforcing its Health Directives.)

CDC Director Rochelle Walensky, in announcing revised mask guidance Feb. 25, 2022, clearly stated the agency could change its masking recommendations/mandates at any time. “None of us know what the future may hold for us and for this virus and we need to be prepared and we need to be ready for whatever comes next. We wanna give people a break from things like mask wearing when our levels are low and then have the ability to reach for them again, should things get worse in the future,” Walensky told reporters during a Feb. 25 media briefing releasing new guidelines that most Americans should not wear masks. Ex 16.

Likewise Dr. Greta Massetti, a senior epidemiologist at CDC, said the agency will always be updating its mask guidelines, indicating that the Mask Mandate (if ever repealed) could be reinstated at any time. “Public-health prevention strategies can be dialed up when our communities are experiencing more severe disease and dialed down when things are more stable,” Massetti said. *Id.*

The Supreme Court has made clear that a government agency may not revoke a pandemic mandate to moot a court case, then be allowed to reimpose it again later. TSA will likely try that before this case can be decided. But

“There is no justification for that proposed course of action. It is clear that this matter is not moot. See *Federal Election Comm’n v. Wisconsin Right to Life, Inc.*, 551 U.S. 449, 462 (2007); *Friends of the Earth, Inc. v. Laidlaw Environmental Services (TOC), Inc.*, 528 U.S. 167, 189 (2000). And injunctive relief is still called for because the applicants remain under a constant threat ... See, e.g., *Susan B. Anthony List v. Driehaus*, 573 U.S. 149, 158 (2014).” *Roman Catholic Diocese of Brooklyn v. Cuomo*, No. 20A87 (U.S. Nov. 25, 2020).

V. CONCLUSION

This Court should not allow such a broad reading of 49 USC § 114 that would permit TSA to force all air travelers to wear masks. This would create a slippery slope for future “Security Directives” that have nothing to do with the agency’s sole mission of protecting transportation security from attack. TSA does not have such broad sweeping powers that it may regulate health matters such as what types of food may be served at airports or mandating that passengers jog 3 miles on a treadmill before boarding a plane since they will be sedentary on a long flight.

We join the Petitioners in urging the Court to declare the three challenged Health Directives and one Emergency Amendment *ultra vires*, set them aside in their entirety, and permanently enjoin TSA from requiring masks be worn on any form of transportation unless Congress enacts specific authority for the agency to do so. The only proper decision here is worldwide *vacatur*. *HFDF*. It would make little sense if this Court, having found that the Mask Mandate is unconstitutional and/or unlawful, merely enjoined its application to only the 13 Petitioners while allowing TSA to continue enforcing the *ultra vires* Mask Mandate against the hundreds of thousands of us who work in the transportation sector plus all passengers.

“The Constitution vests the [Judicial Branch] with the judicial Power of

the United States. That power is not limited to the [circuit] wherein the court sits but extends across the country. It is not beyond the power of a court, in appropriate circumstances, to issue a nationwide injunction.” *Texas v. United States*, 809 F.3rd 134, 188 (5th Cir. 2015). As was the case in *Ala. Ass’n of Realtors*, when a court determines that a mandate that applies to all Americans is illegal, relief should extend to everyone.

VI. SIGNATURES

Respectfully submitted this 18th day of April 2022.

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VII. CERTIFICATE OF COMPLIANCE

We certify that this brief complies with FRAP 29(a)(5) & 32(a)(5)(A) because it has been prepared in 14-point Georgia, a proportionally spaced font, and this document complies with the 6,500-word limit because the Argument section contains 6,458 words as measured by Microsoft Word.

Exhibit 1

faa.gov

Guide for Aviation Medical Examiners

4-5 minutes

Application Process for Medical Certification

General Information - Legal Responsibilities of Designated Aviation Medical Examiners

Title 49, United States Code (U.S.C.) (Transportation), sections 109(9), 40113(a), 44701-44703, and 44709 (1994) formerly codified in the Federal Aviation Act of 1958, as amended, authorizes the FAA Administrator to delegate to qualified private persons; i.e. designated Examiners, matters related to the examination, testing, and inspection necessary to issue a certificate under the U.S.C. and to issue the certificate. Designated Examiners are delegated the Administrator's authority to examine applicants for airman medical certificates and to issue or deny issuance of certificates.

Approximately 450,000 applications for airman medical certification are received and processed each year. The vast majority of medical examinations conducted in connection with these applications are performed by physicians in private practice who have been designated to represent the FAA for this purpose. An Examiner is a designated representative of the FAA Administrator with important duties and responsibilities. It is essential that Examiners recognize the responsibility associated with their appointment.

At times, an applicant may not have an established treating physician and the Examiner may elect to fulfill this role. You must consider your responsibilities in your capacity as an Examiner as well as the potential conflicts that may arise when performing in this dual capacity.

The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public, for the Government, and for the Examiner. If the examination is cursory and the Examiner fails to find a disqualifying defect that should have been discovered in the course of a thorough and careful examination, a safety hazard may be created and the Examiner may bear the responsibility for the results of such action.

Of equal concern is the situation in which an Examiner deliberately fails to report a disqualifying condition either observed in the course of the examination or otherwise known to exist. In this situation, both the applicant and the Examiner in completing the application and medical report form, may be found to have committed a violation of Federal criminal law which provides that:

"Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to \$250,000 or imprisoned not more than 5 years, or both" (Title 18 U.S. Code. Secs. 1001; 3571).

Cases of falsification may be subject to criminal prosecution by the Department of Justice. This is true whether the false statement is made by the applicant, the Examiner, or both. In view of the pressures sometimes placed on Examiners by their regular patients to ignore a disqualifying physical defect that the physician knows to exist, it is important that all Examiners be aware of possible consequences of such conduct.

In addition, when an airman has been issued a medical certificate that should not have been issued, it is frequently necessary for the FAA to begin a legal revocation or suspension action to recover the certificate. This procedure is time consuming and costly. Furthermore, until the legal process is completed, the airman may continue to exercise the privileges of the certificate, thereby compromising aviation safety.

Exhibit 2

References Pertaining to Pilots & Masks Violating Industry Regulations

Compiled by Plaintiff Janviere Carlin. Highlighted to emphasize key points, followed by my commentary.

14 CFR § 61.53 – Prohibition on Operations During Medical Deficiency

(a) Operations that require a medical certificate. Except as provided for in paragraph (b) of this section, no person who holds a medical certificate issued under part 67 of this chapter may act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person:

(1) Knows or has reason to know of any medical condition that would make the person unable to meet the requirements for the medical certificate necessary for the pilot operation; or

(2) Is taking medication or receiving other treatment for a medical condition that results in the person being unable to meet the requirements for the medical certificate necessary for the pilot operation.

(b) Operations that do not require a medical certificate. For operations provided for in § 61.23(b) of this part, a person shall not act as pilot in command, or in any other capacity as a required pilot flight crewmember, while that person knows or has reason to know of any medical condition that would make the person unable to operate the aircraft in a safe manner.

Commentary: Pretty cut and dry. Masks are harmful to me and I know it because I have read the data and I have experienced the effects on me personally; therefore, I cannot in good faith operate as a pilot or even as a crewmember deadheading or jumpseating since I am always considered a required or additional crewmember, and my very ability to be certified as a pilot medically relies upon my true attestation of my fitness (see all below).

14 CFR § 117.5 – Fitness for Duty

(a) Each flight crew member must report for any flight duty period rested and prepared to perform his or her assigned duties.

(b) No certificate holder may assign and no flight crew member may accept assignment to a flight duty period if the flight crew member has reported for a flight duty period too fatigued to safely perform his or her assigned duties.

(c) No certificate holder may permit a flight crew member to continue a flight duty period if the flight crew member has reported him or herself too fatigued to continue the assigned flight duty period.

(d) As part of the dispatch or flight release, as applicable, each flight crew member must affirmatively state he or she is fit for duty prior to commencing flight.

Commentary: The CFRs clearly define fit for duty. If we are aware of the hazardous implications of masking with respect to fatigue, we are obligated to avoid wearing them or to self-report. The NIH National Library of Medicine contains the following article addressing Mask Fatigue: <https://pubmed.ncbi.nlm.nih.gov/33475571> and the CDC also recognizes the effects of long-term mask use and workplace fatigue: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/managing-workplace-fatigue.html>.

FAA 2022 Guide for Aviation Medical Examiners (Page 8)

https://www.faa.gov/about/office_org/headquarters_offices/avs/offices/aam/ame/guide

The consequences of a negligent or wrongful certification, which would permit an unqualified person to take the controls of an aircraft, can be serious for the public, for the Government, and for the AME. If the examination is cursory and the AME fails to find a disqualifying defect that should have been discovered in the course of a thorough and careful examination, a safety hazard may be created and the AME may bear the responsibility for the results of such action.

Of equal concern is the situation in which an AME deliberately fails to report a disqualifying condition either observed in the course of the examination or otherwise known to exist. In this situation, both the applicant and the AME in completing the application and medical report form may be found to have committed a violation of Federal criminal law which provides that:

"Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to \$250,000 or imprisoned not more than 5 years, or both" (Title 18 U.S. Code. Secs. 1001; 3571).

49 USC § 46310 – Reporting & Recordkeeping

- (a) General Criminal Penalty.—An air carrier or an officer, agent, or employee of an air carrier shall be fined under title 18 for intentionally—
 - (1) failing to make a report or keep a record under this part;
 - (2) falsifying, mutilating, or altering a report or record under this part; or
 - (3) filing a false report or record under this part.
- (b) Safety Regulation Criminal Penalty.— An air carrier or an officer, agent, or employee of an air carrier shall be fined under title 18, imprisoned for not more than 5 years, or both, for intentionally falsifying or concealing a material fact, or inducing reliance on a false statement of material fact, in a report or record under section 44701(a) or (b) or any of sections 44702-44716 of this title.

Commentary: We see an FAA certified medical doctor 1-2 times each year and we are both obligated BY LAW (cited above) to disclose any disqualification condition pertaining to obtaining OR maintaining our medical certificate. If we know that masks are unhealthy for us and their continued use can cause cumulative harm (as evidenced by years of unbiased scientific studies prior to COVID politicization), we are obligated by moral, legal, and punitive implications to abstain and/or report.

14 CFR § 117.3 – Definitions

Flight Duty Period (“FDP”) means a period that begins when a flight crew member is required to report for duty with the intention of conducting a flight, a series of flights, or positioning or ferrying flights, and ends when the aircraft is parked after the last flight and there is no intention for further aircraft movement by the same flight crew member. A Flight Duty Period includes the duties performed by the flight crew member on behalf of the certificate holder **that occur before a flight segment or between flight segments** without a required intervening rest period. Examples of tasks that are part of the Flight Duty Period include deadhead transportation, training conducted in an aircraft or flight simulator, and airport/standby reserve, if the above tasks occur before a flight segment or between flight segments without an intervening required rest period.

Commentary: ONLY allowing us to remove the mask WHILE we control the plane violates the definition of the FDP. According to the FDP, we should not be wearing it before, during, or after our intention to conduct a flight, a series of flights, or positioning or ferrying flights. This also includes, as defined above, deadheading in the cabin or riding in the jumpseat.

AIRLINE PILOTS ASSOCIATION JUMPSEAT GUIDE (July 2018)

While you are exercising the privileges afforded you by FAR 121.547 or 121.583 (i.e., jumpseating regulations), you are considered an additional crewmember and the alcohol limitations of FAR 91 apply. Having a seat in the back does not relieve you of this responsibility. **Even when not in uniform, remember that you are still considered an additional crewmember and you may be required to assist on the flight deck or in the cabin in case of unusual or emergency circumstances. You must remain prepared to assist the flight crew should the need arise.**

Commentary: While the above guidance pertains to alcohol, it makes a blanket statement about our overall responsibilities when riding in a jumpseat or non-revving in the back of the plane. Our union’s own jumpseat guide references the CFRs requiring pilots to always maintain their health and fitness for duty. Since masking

impairs our ability when conducting a flight as evidenced by the fact that we are not required to wear a mask when flying, it also impairs our fitness for flight when acting in other required capacities.

DEPARTMENT OF TRANSPORTATION FAQs

<https://www.transportation.gov/flyhealthy/frequently-asked-questions>

What happens if a passenger does not comply with an airline's mask policies and/or causes an inflight disruption or distraction for the crew?

While the failure to wear a face covering is not itself a federal violation, federal law prohibits physically assaulting or threatening to physically assault aircraft crew or anyone else on a civil aircraft. Passengers are subject to civil penalties for such misconduct, which can threaten the safety of the flight by disrupting or distracting cabin crew from their safety duties. Additionally, federal law provides for criminal fines and imprisonment of passengers who interfere with the performance of a crewmember's duties by assaulting or intimidating that crewmember. U.S. airlines have policies about wearing face coverings in the airplane cabin. Please be sure to check with your airline prior to flight for further guidance

Commentary: Masking is NOT, in fact, a federal law on a plane. So if you do not escalate the situation, you cannot be forced to wear a mask and you are violating no federal law. You might be violating the airline's policy, but not an actual law. The minute you pushback is when they would then use other actual laws to say that you are interfering with a flight so they charge you by proxy. This is deceptive and makes the airlines the mask police and the government is acting through businesses to enforce its will upon the patrons.

Exhibit 3



**U.S. Department
of Transportation
Federal Aviation
Administration**

SAFO

Safety Alert for Operators

SAFO 20009
DATE: 05/25/21

Flight Standards Service
Washington, DC

http://www.faa.gov/other_visit/aviation_industry/airline_operators/airline_safety/safo

A SAFO contains important safety information and may include recommended action. Besides the specific action recommended in a SAFO, an alternative action may be as effective in addressing the safety issue named in the SAFO. The contents of this document do not have the force and effect of law and are not meant to bind the public in any way. This document is intended only to provide clarity to the public regarding existing requirements under the law or agency policies.

Subject: COVID-19: Updated Interim Occupational Health and Safety Guidance for Air Carriers and Crews.

Purpose: This SAFO updates SAFO 20009 and provides updated interim occupational health and safety guidance by the Centers for Disease Control and Prevention (CDC) and the Federal Aviation Administration (FAA) for air carriers and crewmembers regarding [Coronavirus Disease 2019 \(COVID-19\)](#). The CDC and FAA are providing this additional occupational health and safety guidance for air carriers and their crews to reduce crewmembers' risk of exposure to COVID-19, decrease the risk of transmission of COVID-19 on board aircraft and to destination communities through air travel, and provide guidance for fully vaccinated¹ crewmembers.

Background: SARS-CoV-2, the virus that causes COVID-19, has spread throughout the world and to all States and territories of the United States (U.S.). Air carriers and crews conducting flight operations having a nexus to the United States, including both U.S. and foreign air carriers, should follow CDC's occupational health and safety guidance, as outlined in the Appendix below.

Discussion: On January 30, 2020, the World Health Organization (WHO) declared that the outbreak of COVID-19 constituted a Public Health Emergency of International Concern. On January 31, 2020, the Secretary of Health and Human Services declared COVID-19 to be a public health emergency in the United States under section 319 of the Public Health Service Act.² On March 11, 2020, WHO characterized the outbreak of COVID-19 as a pandemic. On March 13, 2020, the President declared a national emergency concerning the COVID-19 outbreak.

Because air travel remains essential, including transportation of personnel and supplies necessary to support COVID-19 response and recovery efforts, it is critical to protect the health and safety of crews

¹ People are considered fully vaccinated for COVID-19 two weeks after they have received the second dose in a 2-dose series, or two weeks after they have received a single-dose vaccine. [CDC's guidance](#) applies to COVID-19 vaccines currently authorized for emergency use by the FDA: Pfizer-BioNTech, Moderna, and Johnson and Johnson (J&J)/Janssen COVID-19 vaccines. CDC's guidance can also be applied to COVID-19 vaccines that have been authorized for emergency use by WHO (e.g. AstraZeneca/Oxford).

² This [public health emergency](#) has been renewed several times since January 31, 2020, most recently on April 15, 2021.

while ensuring that essential flight operations can continue. The FAA and CDC recommend that air carriers and crewmembers take precautions to avoid exposure of crewmembers to SARS-CoV-2. Crewmembers should not work while symptomatic with fever, cough, or shortness of breath, or other [symptoms of COVID-19](#) or after having tested positive for SARS-CoV-2. They may return to work only after they are no longer considered infectious according to CDC's criteria for [Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings](#).

The CDC continues to recommend a 14-day quarantine for individuals with known exposure to COVID-19; however, [shorter quarantine periods](#) may be considered. Crewmembers with known exposure should not work on aircraft until they meet CDC's criteria for [release from quarantine](#). The CDC has issued guidance for exposed workers in critical infrastructure who might need to return to work before these criteria are met, available in [COVID-19 Critical Infrastructure Sector Response Planning](#). While air travel is a vital economic activity, CDC does not recommend allowing crewmembers with known exposures to continue to work until they have met criteria for release from quarantine, even if asymptomatic, because of the inability of crewmembers to remove themselves from the workplace if they develop symptoms during a flight and the challenges involved in effectively isolating a symptomatic person on board an aircraft. Crewmembers who are [fully vaccinated against COVID-19](#) or who [recovered from COVID-19 in the past 3 months](#) do not need to quarantine, be tested, or be excluded from work following an exposure unless they have [symptoms of COVID-19](#). However, they should still self-monitor for [symptoms of COVID-19](#) until 14 days after their last known exposure. Those who develop symptoms should self-isolate and be tested, regardless of vaccination status or previous recovery from COVID-19.

[COVID-19 vaccines authorized for emergency use](#) by the U.S. Food and Drug Administration (FDA) are available across the United States, and everyone 16 years of age and older is eligible to [get a COVID-19 vaccination](#). These vaccines are effective against COVID-19, including severe disease, and a growing body of evidence suggests that fully vaccinated people are less likely to have asymptomatic infection or to transmit SARS-CoV-2 to others, although further investigation is ongoing. Wide-spread vaccination is a critical tool to help stop the pandemic, and air crewmembers are recommended to get vaccinated as soon as possible and in compliance with FAA direction on flight duties after vaccination.

Recent CDC Actions: In order to slow the worldwide spread of SARS-CoV-2 and its highly contagious variants, on January 12, 2021, CDC issued an [Order](#) requiring all air passengers, including those who are fully vaccinated, traveling to the United States from a foreign country to present a negative result of a SARS-CoV-2 test or documentation of recovery from COVID-19 before boarding their flight. While the Order includes a limited exemption for crewmembers under the conditions outlined in CDC's [Frequently Asked Questions](#), CDC and FAA recommend that air carriers consider implementing routine testing of crewmembers to minimize the likelihood of crewmembers working on aircraft while asymptotically or pre-symptomatically infected with SARS-CoV-2. It is also recommended that fully vaccinated people with no COVID-19-like symptoms and no known exposure should be exempt from routine screening

testing programs, if feasible.³ Crewmembers who recovered from COVID-19 in the past 3 months should also be exempt.⁴

To further slow the spread of the virus, the CDC issued an [Order](#) effective February 2, 2021, requiring the use of masks on public conveyances (including aircraft) traveling into, within, or out of the United States, and in U.S. transportation hubs including airports. [Wearing masks](#) helps people who may have COVID-19 avoid transmitting the virus to others. Masks also provide some protection to the wearer. While the wearing of masks on aircraft is required, the [Order](#) includes an exemption if wearing a mask would create a risk to workplace health, safety, or job duty as determined by the relevant workplace safety guidelines or federal regulations. See CDC's [Guidance and Frequently Asked Questions](#) for the most up-to-date information about the mask requirement. Air carriers and crewmembers should be mindful of the regulations regarding the use of oxygen masks where the operation requires an oxygen mask to be rapidly placed on the face, properly secured, sealed, and supplying oxygen upon demand.⁵ CDC's Order does not apply if wearing of oxygen masks is needed on an aircraft when a loss of cabin pressure or other event affecting aircraft ventilation occurs. Air carriers should complete a safety risk assessment and provide guidance to their crewmembers on procedures for the use of masks as they may affect the donning of oxygen masks or conducting other safety functions on the flight deck or in the cabin.

Recommended Action: The FAA and CDC recommend and expect that all U.S.-based air carriers and crewmembers, all non-U.S.-based air carriers operating flights with a U.S. nexus, and all non-U.S.-based crewmembers on flights with a U.S. nexus implement and use their company-developed COVID-19 preparedness plans and procedures in conjunction with the FAA and CDC occupational health and safety guidance in the attached appendix regarding practices for limiting the spread of COVID-19. The FAA and CDC will update or supplement this SAFO as more information becomes available. Air carriers and crewmembers should also review and incorporate into their COVID-19 preparedness plans and procedures, CDC's [Updated Interim Guidance for Airlines and Airline Crew: Coronavirus Disease 2019 \(COVID-19\)](#).

CDC has additionally provided [fact sheets for the transportation industry](#) and a [communications toolkit for airlines](#).

Contact: Questions or comments regarding this SAFO should be directed to the Air Transportation Division, at 202-267-8166. Urgent questions pertaining to the Appendix below should be directed to the CDC Emergency Operations Center at 770-488-7100. Non-urgent questions or comments may be directed to 800-CDC-INFO (800-232-4636).

³ See CDC guidance for [fully vaccinated people with no COVID-19-like symptoms and no known exposure to someone with suspected or confirmed COVID-19](#)

⁴ People who have recovered from COVID-19 may continue to test positive for three months or more without being contagious to others. For this reason, crewmembers who tested positive for SARS-CoV-2 in the past 3 months should be tested only if they develop new symptoms of possible COVID-19. Getting tested again should be discussed with a healthcare provider, especially if the crewmember has been in close contact with another person who has tested positive for COVID-19 in the last 14 days. The healthcare provider may work with [an infectious disease expert at the local health department](#) to determine when the crewmember can be around others.

⁵ See e.g., 14 C.F.R. § 121.333.

Exhibit 4

[businessinsider.com](https://www.businessinsider.com)

Airline passengers who refuse to wear masks have turned violent — and now that the TSA has extended the mask mandate, it's going to get even uglier

Max Ufberg

9-11 minutes

3-1-22; updated 3-10-22

Across the US, mask mandates are being lifted by [retailers](#), [colleges](#), [theme parks](#), [music festivals](#), and [even state governments](#). But that's not the case on airplanes, where the Transportation Security Administration is still enforcing a mask requirement on all commercial flights. Despite coming with [hefty fines](#) and the threat of [criminal prosecution](#), the policy has spawned an epidemic of shouting matches — and worse — between defiant passengers and flight crews.

The mandate was set to expire March 18 but has just been [extended by a month](#). A major union of flight attendants had [pushed for another extension](#), citing safety for the flight attendants, the immunocompromised, and children under 5, the only age group still ineligible for vaccination in the US. This marks the third time the TSA has extended the mandate (which also covers buses, trains, and transportation hubs), and it may not be the last. "The data and potential for the emergence of new variants points to retaining the mandate until the summer, at least," says Bob Mann, an airline-industry analyst.

But if airlines are the last place in America to require masks, the skies are likely to become even less friendly for flight crews. Last year the Federal Aviation Administration [reported](#) 5,981 instances of unruly passengers, 71% of which were related to the mask mandate. There was the guy who [threatened](#) to break the neck of a fellow passenger who intervened during a mask-related confrontation with a United Airlines attendant. The woman who [slapped and spit on](#) a fellow Delta passenger who scolded her for not wearing a mask. The man who refused to mask up on a Delta flight and decided to [expose himself](#) to a flight attendant instead. It was the worst year on record for buffoonish behavior on planes — and that was before the Centers for Disease Control and Prevention [lifted indoor mask restrictions](#) across most of the US. Imagine the fury among anti-mask passengers if the federal government continues to enforce a mask requirement on airlines into the late spring and even the summer summer, when no one's making people mask up anywhere else.

That's why flight attendants, along with Delta Air Lines, are proposing a bold new maneuver in the mask war: prohibit unruly passengers from flying. Earlier this month, Delta CEO Ed

Bastian [sent a letter](#) to the Justice Department asking for the creation of a national "no fly" list that would bar passengers with a history of unruly behavior from boarding *any* commercial flight, not just the one where they transgressed. Bastian wrote that such a list would "help prevent future incidents and serve as a strong symbol of the consequences of not complying with crew member instructions on commercial aircraft."

People were acting like idiots on airplanes long before the pandemic, of course. ([Remember this guy?](#)) Research points to a [host of explanations](#) for in-flight aggression: Planes are cramped spaces, passengers often feel uncomfortable or anxious, and there's no exit when the going gets rough. There's a highly visible social ladder between the haves and the have-nots, with first-class passengers receiving far better treatment and way more space than those stuck in coach. And alcohol is freely available to soothe — or inflame — all these fears and frustrations.

But the level of in-flight fracas has gotten exponentially worse in the past two years, with most cases involving disputes over masking. The political divisions over the coronavirus pandemic are amplified on flights, where Americans who would normally be separated by vast swaths of culture and geography are thrown together in the close quarters of an airplane cabin. "As the nation has become more divided, we've seen more and more of such cases," says Mann, the analyst.

To make matters worse, many US passengers hail from parts of the country that take the pandemic far less seriously than others. And the mask opponents often assume, falsely, that the mask requirement is an airline policy, not a federal regulation. "They don't even think it's a law," Mann says. "They think it's an advisory of some sort."

That's part of the reason flight attendants had pushed to extend the mask mandate and back it up with a no-fly list: to bring the formality of federal authority to a realm that many passengers dismiss as ignorable corporate policy. Last October, Transportation Secretary Pete Buttigieg [told CNN](#) that the idea for a no-fly list "should be on the table" after an American Airlines flight attendant had several bones in her face broken during a mask-related altercation with a passenger.

Still, the list is a long shot, with opposition across the political spectrum. Eight Republican senators have written [a letter](#) to Attorney General Merrick Garland, arguing that a no-fly list would equate unruly passengers with "terrorists" for whom the FBI already maintains a no-fly list. And the senators have an unlikely ally in the American Civil Liberties Union. Though the ACLU has [lobbied for mask mandates](#), it has also [challenged](#) the FBI's terrorism no-fly list in court, and it's already questioning the lack of due process for unruly passengers.

"The proposals I've seen would allow airlines to put people on the list," Jay Stanley, a senior policy analyst at the ACLU, told me. "Better proposals would require that you actually be convicted in court of interfering with aviation or the like on an aircraft."

Moreover, it's not even clear that most airlines want a no-fly list. Other than Delta, they've been mum on the subject, referring questions to Airlines for America, an industry trade group.

Katherine Estep, the group's spokeswoman, told me only that airlines "remain in communication with the FAA, TSA, and other relevant agencies to identify ways to further mitigate this ongoing challenge." (The TSA did not respond to a request for comment, and a representative for the Justice Department said it would be referring Delta's letter to "appropriate departments.")

Should the mask mandate continue into the summer and beyond, airlines could expect the bad behavior to increase, as customers grow accustomed to going maskless everywhere else. Through mid-February of this year, according to [FAA data](#), airlines have reported 607 cases of unruly passengers — far higher than pre-pandemic levels. A few weeks ago, a Portland, Oregon, man was [charged](#) with trying to open an emergency door while on a Delta flight en route from Salt Lake City. The reason for his disturbance? An affidavit filed in support of the arrest warrant says he wanted to get other passengers to film the incident, "thereby giving him the opportunity to share his thoughts on COVID-19 vaccines."

All of which means airlines are likely to be stuck in the worst of all possible worlds: requiring masks in the midst of a nationwide war over masks, without any means to prevent unruly passengers with a record of lashing out from doing so again. "There are some very legitimate reasons why airlines may want to have the mask requirement extended," says Henry Harteveltdt, the president of the travel consultancy Atmosphere Research Group. "Unfortunately, even though we know COVID is not over, a lot of people are over COVID."

This article, originally published on March 1, has been updated to reflect that on March 10 the Transportation Security Administration extended the airplane mask mandate.



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Exhibit 5

[washingtonpost.com](https://www.washingtonpost.com)

Sneezed on, cussed at, ignored: Airline workers battle mask resistance with scant government backup

Michael Laris

13-17 minutes

Other passengers have verbally abused and taunted flight attendants trying to enforce airline mask requirements, treating the potentially lifesaving act as a pandemic game of cat-and-mouse. A loophole allowing the removal of masks while consuming food and beverages is a favorite dodge.

Asked to mask up, one passenger pulled out a large bag of popcorn and nibbled her way through it, kernel by kernel, stymieing the cabin crew for the length of the flight. Others blew off requests by chomping leisurely on apple slices, between occasional coughs, or lifting an empty plastic cup and declaring: "I am drinking!"

The displays of rule-bucking intransigence are described in more than 150 aviation safety reports filed with the federal government since the start of the pandemic and reviewed by The Washington Post. The reports provide an unguarded accounting of bad behavior by airline customers, something executives hit by a steep drop in travel and billions in pandemic-related losses are loath to share themselves.

Some reports raise safety concerns beyond the risk of coronavirus infection. A flight attendant reported being so busy seeking mask compliance that the employee couldn't safely reach a seat in time for landing.

One airline captain, distracted by mask concerns, descended to the wrong altitude. The repeated talk of problem passengers in Row 12 led the captain to mistakenly head toward 12,000 feet, not a higher altitude given by air traffic control to keep planes safely apart. The error was caught, and "there was no conflicting traffic," the captain wrote.

The Boeing 737 Max was grounded for 20 months following two crashes that killed 346 people. Now, after design changes, the aircraft is returning to service. (The Washington Post)

Some passengers are portrayed as oblivious, obstinate, foul-mouthed and, at times, dangerous. One called a flight attendant a "Nazi." Another "started to rant how the virus is a political hoax and that she doesn't wear a mask," a flight attendant reported.

With millions of passengers ignoring warnings from the Centers for Disease Control and Prevention to refrain from holiday travel, the reports offer an X-ray into the country's deeper failures against the coronavirus — and insights into the pitfalls and possibilities facing a new presidential administration.

While the White House under President Trump has, at times, been dismissive or hostile toward masks, President-elect Joe Biden is making a patriotic appeal to “mask up for 100 days,” whatever people’s politics. Biden has said he will sign an order on his first day requiring masks for “interstate travel on planes, trains and buses.” How well those efforts will work remains to be seen.

Experts in psychology and decision-making say hostility toward wearing masks, even within the shared confines of a passenger jet, has been fueled by politicization — but also by skewed incentives and inconsistent messaging.

“The reinforcement principles are backward,” said Paul Slovic, who studies the psychology of risk at the University of Oregon.

The usual signs of danger, and rewards for following potentially bothersome rules, are thrown off by a virus that is spread easily by people who don’t know they have it, Slovic said.

“You get an immediate benefit for not following the guidelines because you get to do what you want to do,” Slovic said. “And you don’t get punished for doing the wrong thing” because it’s not immediately clear who is being harmed.

The “squishiness of the requirement” to wear masks on planes also undermines the message that they are critical for public health, Slovic said. In contrast, he cites the rigid clarity of the ban on flying with a firearm. “It’s not, ‘You can carry it as long as you don’t use it,’” Slovic said.

But passengers are allowed to drop their masks to snack and sip beverages. “When you start opening it up to eating, the whole thing kind of weakens,” Slovic said.

Applying mask rules also worsens the already strained position of flight attendants, who are front-line enforcers even as they keep their usual safety responsibilities, experts said.

“Flight attendants are dealing with mask compliance issues on every single flight they work right now,” said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, noting that those efforts range from friendly reminders to facing passengers “actively challenging the flight attendants’ authority.”

The Department of Transportation in October rejected a petition to require masks on airplanes, subways and other forms of transportation, with Secretary Elaine Chao’s general counsel saying the department “embraces the notion that there should be no more regulations than necessary.”

The nation’s aviation regulator has deferred to airlines on masks, with Federal Aviation Administration chief Stephen Dickson telling senators at a June hearing “we do not plan to provide an enforcement specifically on that issue.”

Such matters are more appropriately left to federal health authorities, Dickson argued. “As Secretary Chao has said, we believe that our space is in aviation safety, and their space is in public health,” Dickson said, referring to the CDC and other health officials.

Airline representatives say they take mask usage seriously and the overwhelming majority of customers comply. Some airlines have banned passengers for the length of the pandemic for refusing to mask up. Many have eliminated medical exemptions in their mask requirements.

“Of the hundreds of thousands of passengers who have flown with us, we have only needed to ban

about 370 customers for not complying,” United Airlines spokeswoman Leslie Scott said. Delta said its mask-related no-fly list includes about 600 people, despite carrying about 1 million people each week.

Resistance by some passengers prompted Alaska Airlines to begin issuing yellow cards, akin to the warnings in soccer, to problem passengers.

The initial yellow card said employees would file a report that could result in a passenger being suspended. A later version was more aggressive, saying continued defiance would lead to a flight ban “immediately upon landing,” even if the customer had a connecting flight.

Alaska Airlines has barred 237 passengers since August, and “in more than half of these incidents we also canceled onward or returning travel,” spokeswoman Cailee Olson said.

American Airlines declined to release numbers of banned customers, as did Southwest, which said in a statement it appreciates “the ongoing spirit of cooperation among customers and employees as we collectively take care of each other while striving to prevent the spread of COVID-19.”

Yet a small, uncooperative minority can wreak outside havoc, safety reports show.

The anonymous reports are collected in a National Aeronautics and Space Administration database, part of a program meant to increase aviation safety by encouraging employees to provide candid descriptions of emerging problems without fear of reprisal. Names of people filing the reports, and their airlines, are removed by NASA before they are made available to regulators at the FAA and the public.

NASA analysts screen the reports to weed out irrelevant filings and may call back filers to clarify safety points. But its analysts do not try to verify people’s identities or the accuracy of the reports.

The database shows some fliers treat airline mask requirements as a seemingly asinine rule to evade, akin to sneaking a late look at text messages after phones are supposed to be in airplane mode. Passengers berate flight attendants about their noncompliant cabin mates. Some reports read like cries for help.

“It all has to stop,” pleaded one flight attendant.

“In the future I would like to feel safe while doing my job,” said another.

- A woman refused to wear her mask as the plane rolled away from the terminal, saying it made her ill, and the pilot pulled over temporarily to try to avoid returning to the gate. She continued to resist but finally agreed.

“As soon as we took off, she took it off again and kept it off the entire flight,” the flight attendant reported.

- A man started down the aisle, pausing about 18 inches from a flight attendant.

“He sneezed directly in my face, making no attempt to cover his mouth, pull up his mask or turn towards the row 1 window,” the employee wrote. The flight attendant, who was wearing a face covering, judged the act unintentional and tried to blot away the remnants.

- A woman propped her foot up and painted her toenails with her mask below her chin, despite

several requests to wear it properly. After another passenger appealed for more to be done, the woman acquiesced, then loudly instructed the flight attendant to “go away!”

After landing, she cut in line to rush off the plane. “Although we understand the importance of wanting to retain customer loyalty, this kind of behavior should not be tolerated for the sake of one over an entire cabin of guests and employees,” the flight attendant wrote.

- An immunocompromised passenger was furious at the lack of enforcement as another customer snacked incessantly on chocolate. The concerned passenger then removed his mask to complain to the flight attendant.
- A passenger claimed discrimination, arguing he was singled out for enforcement because of his tattoos. “He said ‘I am complying, #%^!’ His nostrils were clearly visible,” the flight attendant wrote.
- A pilot flouted the mask requirement with what appeared to be a passive-aggressive display, donning a flimsy, see-through veil described as useless for containing airborne particles.
- Flight attendants made an exception and allowed a distraught mother, whose daughter may have had a disability and screamed about the mask requirement, to remain on the plane. They tried cookies, which didn’t help, then moved the family to seats three rows from other passengers, who were supportive.
- A customer, after earlier warnings, stuck his mask-free head in the aisle during the safety demonstration, “making a total mockery out of me,” a flight attendant wrote. He repeated his taunt when the plane was fourth in line for takeoff. The captain turned around, and the man was taken off the plane.

The obstinacy cuts against basic health precautions. Experts in cabin air say masks are critical tools for safety. Cabin air is run through powerful filters, mixed with outside air and recirculated. But it takes several minutes for all air to be vented out of the cabin, giving the coronavirus and other viruses the opportunity to spread.

A Harvard study funded by the aviation industry said flying can be done with a relatively low risk of coronavirus infection if precautions are followed. It said masks are “perhaps the most essential layer” among measures to reduce transmission.

The study said removing masks to eat should be kept to an “absolute minimum,” and straws should be used when feasible. “When one passenger briefly removes a mask to eat or drink, other passengers in close proximity should keep their masks on,” researchers said.

Trump and some of his advisers, meanwhile, have stoked divisions over masks.

The president mocked Biden’s frequent mask use, presided over White House events that flouted mask guidelines and relied on a former pandemic adviser who wrongly argued masks were ineffective. **The White House also blocked a nationwide order, drafted by the CDC, that would have required masks on all forms of public transportation.**

“Masks have been made a political issue from the start of the pandemic, and people don’t believe they need to wear them,” said Garland, whose union represents about 50,000 flight attendants.

“We do not have a president who tells people to wear a mask, and the federal government, not just in aviation but across the board, has declined to mandate it in any way, shape or form,” she added, saying her members are eager to see a Biden administration set a different tone.

An FAA spokesman declined to answer questions about the risks involved with passengers refusing to wear masks.

After inquiries from The Post about enforcement, the agency distributed a news release touting its role in pursuing civil penalties in two assault cases but reiterated that “the failure to wear a face covering is not itself a federal violation.”

The cases show how mask disputes can escalate.

On an Allegiant Air flight in August, a passenger hit a flight attendant, yelled obscenities at him and grabbed his phone as he described a mask-related dispute to the captain, according to the FAA. The agency said it is pursuing a \$15,000 civil penalty for assault and interfering with a flight attendant.

Allegiant declined to say whether anyone was arrested or charged.

On a SkyWest Airlines flight to Chicago in August, a passenger took off a mask, “continually bothered” fellow customers and “at one point, grabbed a flight attendant’s buttock as she walked by the passenger’s row of seats,” according to the FAA, which is seeking a \$7,500 penalty.

Beyond addressing such extreme cases, some outside experts say federal and corporate leaders have fallen short.

“Both industry and government have failed the people on the front line who need to administer these rules,” said Baruch Fischhoff, a psychologist and professor at Carnegie Mellon University who researches decision-making.

Politics often has driven responses to the pandemic, while critical public health communication on things like masks has not been tested to make sure it hits the right notes or is convincing, Fischhoff said. “Neither have fulfilled that responsibility for clear, consistent, tested communications,” he said.

Fischhoff said that with 330 million people in the United States, it’s not surprising the safety reports received by NASA reveal examples of poor behavior.

“Part of the reason they stand out is, I think, the vast majority of people are polite and civil to one another,” Fischhoff said. Still, the reports probably represent a dramatic undercount because it takes time and initiative for busy employees to file them.

“If you see 100, there are probably 1,000 or 10,000. This is a widespread enough phenomenon that it needs to be taken seriously,” he said. “You have to give credit to people who lodge just complaints and recognize they’re just a fraction of the people who are observing things that threaten our health and our economy.”

Exhibit 6

dallasnews.com

American Airlines joins Southwest in delaying alcoholic beverage sales due to bad passenger behavior

By Kyle Arnold 6:50 PM on May 29, 2021 CDT

4-5 minutes

American Airlines will delay selling alcoholic beverages this summer to main cabin passengers due to the uptick in bad passenger behavior in recent months that includes refusing to wear masks and several assaults on flight attendants.

Fort Worth-based American Airlines told crew members that it won't reintroduce the sale of beer, wine and spirits to main cabin class passengers until at federal government officials drop the mask mandate aboard aircraft and airports. The mask mandate is currently set to expire Sept. 14. American was scheduled to bring back alcohol sales Tuesday.

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American Airlines joins Dallas-based Southwest Airlines in pushing back the reintroduction of the sale of alcoholic beverages after flight attendants expressed concern about the recent increase in bad passenger behavior. The concerns peaked after [the bloody assault of a Southwest flight attendant last week](#) on a flight landing in San Diego.

"Over the past week we've seen some of these stressors create deeply disturbing situations on board aircraft," said American Airlines vice president of flight safety Brady Byrnes said in a letter to crew members Saturday. "Let me be clear: American Airlines will not tolerate assault or mistreatment of our crews.

"We also recognize that alcohol can contribute to atypical behavior from customers on board, and we owe it to our crew not to potentially exacerbate what can already be a new and stressful situation for our customers."





American Airlines dropped alcoholic beverage service in March 2020 to create less contact between flight attendants and passengers during the COVID-19 pandemic. It also cut back service of soft drinks, juices, snacks and foods. Airlines are beginning to bring those services back, and American started selling alcohol to some premium class customers earlier this year.

But for everyone else, alcohol will have to wait a few more months.

“It is no secret that the threats flight attendants face each day have dramatically increased,” said a letter to union members from Julie Hedrick, president of the Association of Professional Flight Attendants, which represents American’s 13,400 flight attendants. “Every day, we are subjected to verbal and sometimes physical altercations, mainly centered around mask compliance. These altercations are often exacerbated when customers have consumed alcohol in the airport or alcohol they have brought on board.”

Airlines and federal officials have noted an uptick in passenger misbehavior. Flight attendant union leaders have attributed much of the uptick in passengers refusing to wear masks, a COVID-19 precaution that took on deep political symbolism after the November presidential election and the Jan. 6 storming of the U.S. Capitol by Trump supporters who refused to accept Electoral College results.

The Federal Aviation Administration has noted more than 2,500 reports of passenger misbehavior this year, and a spokesman for the agency said there was a sharp uptick starting late last year.

Flight attendants have often been caught in the middle of the issue and heavily lobbied for a federal mandate for face masks on planes. President Joe Biden made a federal face mask rule on planes one of his first executive orders after he took office.

But passenger misbehavior has continued throughout the year despite numerous fines against passengers proposed by the FAA. Several of those fines stemmed from passengers drinking alcohol they had bought in airports.

Airlines are now dealing with their largest crowds since the pandemic began. Nearly 2 million passengers passed through Transportation Security Administration checkpoints on Friday, nearly 80% as many as did on the same date in 2019.

Atlanta-based Delta Airlines began serving alcohol to passengers again in July 2020. Chicago-based United is scheduled to resume sales of alcoholic beverages in June, and a company spokesman said United hasn’t made a decision to change that.

Exhibit 7

[cnbc.com](https://www.cNBC.com)

Unruly behavior from plane passengers has never been this bad, says flight attendant union chief

Kevin Stankiewicz

3-4 minutes

Incidents of unruly behavior from airplane passengers has risen to an unprecedented level this year, union leader Sara Nelson told CNBC on Friday, the start of the Memorial Day holiday weekend.

"This is an environment that we just haven't seen before, and we can't wait for it to be over," the president of the Association of Flight Attendants-CWA said on "[Squawk Box](#)."

The behavior has become "complete nuts," added Nelson, whose union represents around 50,000 cabin crew members across more than a dozen carriers. "It's a constant combative attitude. ... It's got to stop."

Nelson's comments follow a recent violent confrontation that resulted in a [Southwest Airlines](#) flight attendant sustaining [facial injuries and losing two teeth](#). In a statement to NBC News earlier this week, Southwest said the passenger "repeatedly ignored standard inflight instructions and became verbally and physically abusive upon landing."

A 28-year-old woman has been [charged with felony battery in the incident](#), which occurred on a Sacramento to San Diego flight.

The Federal Aviation Administration said Monday it has [received around 2,500 reports of unruly passenger behavior since Jan. 1](#), roughly three-quarters of which involve failure to adhere to the federal face mask mandate that has been instituted due to the coronavirus pandemic.

That's more than 20 times higher than what's normally recorded in an entire year, Nelson told CNBC. She noted the role masks are playing in the surge and expressed disappointment that health protocols on planes are seen as "a political issue."

The federal mask requirement is [on the books until Sept. 14](#), and the FAA intends to keep its [zero-tolerance policy](#) for passenger disturbances in place [as long as the mandate applies](#).

While airline travel has picked up in recent months as Covid vaccinations become more available, TSA checkpoint data shows travel is still notably below 2019 levels.

"Typically what flight attendants will do, when we see a conflict arise on the plane, we're trained to deescalate. We look for our helpers," Nelson said. However, she said the passenger mix is different than pre-Covid.

"It's very difficult when you don't have people on the plane who are regularly flying, who sort of know the program, who are our typical people that we'd go to, at least, create peer pressure but also help to try to calm down these incidents," she said.

Nelson said increased messaging around the consequences for passengers who act out — such as FAA fines — would be helpful. That includes not only on-board messages from the flight captain, but also throughout airports, she said.

Temporary restrictions on alcohol sales also would be beneficial, Nelson said.

"A lot of times these events are exacerbated by alcohol, so we've been asking the government and the airlines to make sure they're not selling alcohol right now because that's only adding to the problem that is clearly out of control."

Exhibit 8

skift.com

1 in 5 Flight Attendants Have Had Physical Altercations With Unruly Passengers so Far This Year

— *Ruthy Muñoz*

5-6 minutes

July 29, 2021

One in five flight attendants so far this year has been involved in physical altercations with unruly passengers and 85 percent of cabin crew members have dealt with disruptive passengers this year as more are returning to travel, a survey released by the Association of Flight Attendants-CWA (AFA) revealed on Thursday.

The online survey of 5,000 flight attendants across 30 airlines found more than half have experienced at least five incidents with unruly passengers, with flight attendants reporting incidents of swearing, yelling, aggressive behaviors, racial and homophobic slurs, and physical assaults.

Unwilling to accept this new normal, the AFA is calling on the Federal Aviation Administration and the U.S. Department of Justice to make the 'zero tolerance' policy permanent.

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"This survey confirms what we all know, the vitriol, verbal and physical abuse from a small group of passengers is completely out of control, and is putting other passengers and flight crew at risk. This is not just about masks as some have attempted to claim. There is a lot more going

on here and the solutions require a series of actions in coordination across

aviation,” said Sara Nelson, President of AFA-CWA.

In response to the rise of disruptive passengers, the Federal Aviation Administration in January enacted [new security measures for airlines](#) by issuing a temporary “zero tolerance” policy, making bad behavior an enforceable federal offense and extending it at the end of March.

But union officials representing 50,000 flight attendants across 17 airlines, feel it’s not enough. The AFA said existing measures in place are failing to address the problem and wants the FAA and DOJ to protect passengers and crew from verbally, physically abusive, and disruptive travelers.

One survey respondent reported being on the ground at the back of the aircraft without the other crew members noticing until after the attacker had deplaned.

“We tell them (passengers) that it is a federal offense to not comply with crew member instructions, use foul and/or threatening language onboard, and then the plane is met by airline supervisors or airport law enforcement and the passenger gets a slap on the wrist and sent on their way,” wrote one flight attendant in the survey.

The flight attendant who said she’s been threatened, yelled, and cursed at countless times in the last year and has only seen at most a temporary suspension of travel for the passenger.

“We need real consequences if flight attendants are ever going to feel safe at work again,” the unnamed flight attendant said.

For airline frontline workers, the incessant rise of bad behavior inflight is taking a toll with many flight attendants feeling unheard and unprotected.

Survey data found 71 percent of flight attendants who filed incident reports with their management didn’t receive a follow-up and a majority didn’t observe efforts by the airlines to address issues with unruly passengers.

“It is time to make the FAA ‘zero tolerance’ policy permanent, the Department of Justice to utilize existing statute to conduct criminal prosecution, and implement a series of actions proposed by our union to keep problems on the ground and respond effectively in the event of incidents,” Nelson said.

Flight attendants cite multiple factors contributing to disruptive incidents and

point to mask compliance, flight delays, routine safety reminders, alcohol, and cancelations as common factors when dealing with unruly passengers, an AFA spokesperson said.

To date, the FAA has received 3,615 unruly passenger complaints, more than half of them mask-related incidents. The agency has initiated 610 investigations and 95 enforcement cases, said the FAA's website.

Additionally, many flight attendants reported facing extensive verbal abuse from visibly drunk passengers, being subjected to yelling and swearing for federal mask mandate directions. Survey respondents also reported being aggressively challenged by unruly passengers in other ways including kicking seats, shoving, being thrown thrash at and passengers defiling a restroom in defiance of instructions, it said.

The FAA has been enforcing some cases and issuing historic fines for [unruly passengers](#).

AFA said its union has fought discrimination and prejudice for decades, and won't allow this moment to set it back.

"Aviation is about bringing people together, not tearing us apart," it said.

Airlines joined unions asking the U.S. Attorney General to [prosecute unruly passengers](#) in June.

Photo Credit: Passengers and flight attendant on an aircraft. StockSnap / [Pixabay](#)

Exhibit 9

travelpulse.com

Is It Time to End the Mask Mandate in Airports and on Planes?

4-5 minutes July 15, 2021

The Centers for Disease Control and Prevention (CDC) and the Biden Administration have a difficult decision to make in two months.

The federal [mask mandate](#) expires on Sept. 13. The mandate requires passengers on public transportation to wear a mask at all times, including while in airports and during flight – whether that flight is 50 minutes or five hours.

It's time.

It's time to stop enforcing this policy.

And I understand this is likely an unpopular opinion but, then again, I have hundreds of those. Like, Van Halen was better with Sammy Hagar as the lead singer instead of David Lee Roth, or Reggie Jackson wasn't a true Yankee because he only played five years in New York, or Skor is the better toffee candy bar than Heath.

Trending Now



Or, the CDC should let the deadline on the mask mandate pass without further action.

The mandate is in place to better prevent the spread of the COVID-19 virus, and for the better part of a year that has been a worthy goal.

But it has also proven problematic.

Physical confrontations on airplanes have dramatically increased this year, and of the 3,000+ that have been recorded by the Federal Aviation Administration so far in 2021, nearly three-quarters of them have been a direct result of arguments over [wearing a face mask](#) – whether between crew members and passengers, or passengers vs. passengers.

The whole idea of face masks was that it was something the airlines encouraged in the summer of 2020, at the height of the pandemic – they wanted a uniform policy mandated by the federal government instead of having various, or differing, policies set by each airline.

Here we are a year later, and the irony has set in. The airlines see the unintended consequence of face masks in every disagreement aboard a flight; they see the efficacy that the vaccines are having; they have noted that nearly 70 percent of the country has had at least one shot against the virus, and now they want the CDC to let the mandate quietly expire on Sept. 13 without being renewed for another four months.

For many reasons, I believe this is the best course of action.

People who are vaccinated can now come and go as they please, except for some stores and businesses that still require a mask. The vaccinated still have their reasons and still have the option to wear a mask if they so choose. You don't need a mandate to wear one if you believe it protects you.

The unvaccinated have their reasons. And they, too, have the option to not wear a mask if they so choose. See, the thing is, anti-vaxxers are not going to have their minds changed. But should they be denied the privilege of flying over a mask?

That's the touchy question.

When first proposed a year ago, we can't deny that the idea of wearing a mask was a comfort zone for an airline industry struggling with the dramatic loss of customers. Simply put, having the entire plane wear a mask encouraged more people to fly. It made them feel safer.

To be blunt, while I say it's time to rescind the mask mandate, I still regard it as a minor inconvenience. Honestly, wearing a mask is about as big a problem to me as having to take my shoes and belt off. And we've been doing that for the better part of 20 years now.

My fear, however, is that the mandate is going to someday cause a far bigger problem while in the air than just some unruly passenger being eventually [duct-taped to a seat](#).

One of these days, a confrontation is going to escalate far further than the crew member who had a finger bitten or the flight attendant who caught an errant punch square in the face and had [two teeth knocked out](#).

Ask yourself, is it worth it to have a mandate that ostensibly is for your safety but only leads further to unsafe conditions?

That's not something I want to find out.

Exhibit 10

[washingtonpost.com](https://www.washingtonpost.com)

Unruly airplane passengers are straining the system for keeping peace in the sky

Michael Laris, Lori Aratani

17-21 minutes

July 18, 2021

Both men were arrested earlier this year in Denver, charged with the same broad federal crime: interference with flight crew members and attendants.

They were, in many ways, the exceptions.

The system for keeping the peace in America's skies is creaking under the pressure of what airlines and regulators say is an unprecedented proliferation of misbehavior.

The Federal Aviation Administration has received more than 3,400 reports of "unruly" passengers this year. But despite launching a "zero-tolerance" enforcement policy in January — amid a rise in conflicts often tied to mask requirements in the air — the agency said that as of mid-July it had "completely closed" just seven cases.

The sprawling, multitiered system for enforcing regulations and federal laws covering passengers can take years to play out. As travel rebounds, that structure is being strained by confrontations fueled by alcohol, hostility to mask mandates and small conflicts that careen out of control. One passenger hit a woman holding an infant amid an apparent dispute over a window shade. Another ran through business class and stomped on a flight attendant's foot after the power outlet at her seat wouldn't charge her phone, according to court records.

The system involves airline employees, FAA inspectors and lawyers, Transportation Department judges, local authorities, state and federal courts, FBI agents and U.S. attorneys, who all have roles in a sometimes messy and protracted process.

An escalation in 'air rage'

The incidents that take place miles high in pressurized cabins are filled with many of the same pathologies and clashes that occur on the ground.

A review of federal cases by The Washington Post points to alcohol, drug use and mental illness as key factors in outbursts that have terrified passengers and crew members,

sometimes leaving them hospitalized. The tools for dealing with those problems in the air are more limited than on land.

Court records describe ad hoc policing teams made up of passengers recruited by flight attendants to help subdue rampaging fellow fliers using plastic handcuffs and seat belt straps. The records detail several instances of passengers trying to pry open doors on planes, leading to scenes of panic and violence.

"I am waiting for a signal," a distressed passenger declared on a Hawaiian Airlines flight from Los Angeles in October before lunging for the emergency door and smashing a flight attendant's head against it, causing a "ping pong ball sized hematoma" on her temple, federal prosecutors said.

After the third lunge, passengers and crew members zip-tied the man's ankles to a seat. His lawyer said he "was in an altered state of mind when he tried to exit a commercial aircraft mid-flight. ... This activity was not violent and was not driven by anger towards any other person."

The flight attendant's injuries, after she "properly blocked him," were minor, the lawyer added. Authorities said that after the man's arrest, he choked a nurse at a Hawaii hospital until he lost consciousness. The passenger, in his early 30s, was detained for eight months and released to his parents with an order that he take medication pending a March trial.

Earlier this month, a woman tried to open an airplane door on a flight from Dallas, then bit a flight attendant, according to American Airlines. She was [duct-taped](#) to her seat. In May, a Southwest Airlines flight attendant had [two teeth knocked out](#), allegedly by a passenger who refused to remain seated.

Aviation experts say cases of "air rage" are nothing new, but verbal attacks are turning physical more quickly.

"What we're really seeing is an increased level of hostility on the aircraft, which is something I don't think we've ever seen before in this industry," said Paul Hartshorn, spokesman for the Association of Professional Flight Attendants, which represents American Airlines employees. "It's just incredibly dangerous."

'My life is changed forever'

Federal prosecutions in cases where "interference with flight crew members and attendants" is the lead charge were down sharply in the past decade following a rise after the Sept. 11, 2001, terrorist attacks, according to a Post examination of federal prosecution data housed at Syracuse University, raising questions about resources and priorities.

For most of the 2000s, there were more than 50 such prosecutions annually, with case counts sometimes topping 70, according to data compiled by the university's Transactional

Records Access Clearinghouse. Over the past decade, that number has been in the teens and 20s each year, according to the research center, which built a vast database through decades of public records requests.

The Justice Department said prosecutions under the “interference” statute — by its count there were 20 in fiscal year 2019, 16 in 2020 and 14 through this month in 2021 — do not reflect the scope of its efforts because other charges are also used. At a Senate hearing in June, Attorney General Merrick Garland said the Justice Department takes the recent onboard assaults “extremely seriously.”

“Even if not intended to bring the plane down, you can imagine the kind of pandemonium on planes that we’ve seen in some of these videos that people have taken that can cause an incredibly dangerous accident,” Garland said.

In a June [letter](#) to Garland, a consortium of airline industry and labor groups called on the Justice Department to “direct federal prosecutors to dedicate resources for egregious cases.” It noted inconsistencies in which cases are prosecuted in different jurisdictions, and said more criminal prosecutions are needed. The department is reviewing the letter, an agency spokesman said.

In selecting which airborne cases to pursue, federal prosecutors said they weigh damage to victims, airlines and threats to public safety. Considerations include whether flights were diverted, lives were endangered, the quality of the evidence and a suspect’s mental health status, federal prosecutors said.

In Congress, some lawmakers want the Justice Department to create a new “no-fly list” for passengers convicted of assault or who have paid civil penalties in such cases. Airlines, which have banned more than 2,700 customers for refusing to wear masks, don’t share information about customers who cause problems. Someone barred by one carrier can simply book a flight on another airline.

The incidents can leave a lasting mark.

Delta Air Lines flight attendant Eunice DePinto was shoved after trying to pull a first-class passenger off the airplane door he was fighting to open on a 2017 flight from Seattle. A second flight attendant was punched in the face, prosecutors said. The raging passenger — and another customer who aided flight attendants — were smashed in the head with bottles of red wine during the struggle, according to court records. Airline employees said the pressure at high altitude would have kept the door from opening, but it could have opened as the plane descended.

“In the galley there were flying objects, toppled galley equipment, yelling, physical blows and blood,” DePinto told a federal court in Washington state.

Six passengers eventually cuffed and subdued the Florida man, Joseph Hudek IV, who

pleaded guilty to interfering with a flight crew and assault resulting in serious bodily injury. Hudek was sentenced to two years in prison and barred from commercial flights until next year.

“My life is changed forever,” the assaulted flight attendant told the court. “I am always aware of passengers — where they are and what they are doing at times — to the point of distrust.”

Airlines have sought restitution from convicted passengers, although results have been mixed.

Hudek, whose consulting doctor said he had a psychotic episode after eating cannabis gummies, was ordered to pay restitution of \$67,000, including \$60,000 to Delta. As of January, a court report indicated he still owed the airline \$59,000 and was making regular payments of \$171.

A passenger on a 2019 flight from Las Vegas falsely told a flight attendant that a woman on the plane had a knife, prompting the pilot to make an emergency landing in Denver. He pleaded guilty to interfering with a flight crew and was sentenced to the nearly six months he had served. American Airlines asked a judge to order him to pay \$32,800 in restitution. Among the costs cited by American: \$6,119 for fuel, \$13,623 for “passenger inconvenience,” including vouchers, and \$2,497 for “goodwill lost,” according to court filings.

The Illinois man’s lawyer said he earned \$125 a week collecting scrap before his father’s truck broke down and that he wouldn’t be able to pay. The judge rejected the airline’s request and ordered him to pay \$100.

Passengers are on edge

As flight attendants endured [taunts and abuse](#) last year over airline mask requirements, the FAA resisted calls to help with enforcement, reflecting the Trump administration’s approach to the pandemic. But after increasing reports of conflicts and rowdy groups returning home from the Jan. 6 riot at the Capitol, FAA Administrator Stephen Dickson ordered stricter enforcement to tame the behavior, marking the start of a more aggressive approach.

Over the past six months, the FAA has taken “much quicker and transparent [action] on this issue than we have seen in decades,” said Taylor Garland, spokeswoman for the Association of Flight Attendants-CWA, the nation’s largest flight attendants union. “It’s the first time flight attendants feel like there are real consequences on the ground for unruly behavior on our planes.”

Still, the vast number of cases and messy mechanics of trying to ensure those consequences stick have, at times, overwhelmed the agency.

Part of the FAA’s latest strategy to combat the rise in airplane incidents is to publicize large

proposed penalties and promote a message of deterrence on social media. “You could have spent \$35,000 on a brand new truck. But instead you are paying a fine because you punched a flight attendant,” said one agency [tweet](#).

The FAA said three-quarters of its 3,400 unruly passenger reports are related to a federal mask requirement on planes and public transportation, even though it often takes more than refusing to wear a mask for the FAA to take action.

Sara Nelson, international president of the Association of Flight Attendants-CWA, said that after more than a year grappling with the global pandemic, flight attendants’ stress levels are high and passengers are on edge.

“People get on a plane and they’re taking it out on each other, or most commonly, on the flight attendants,” she said. “And what we’re really seeing is that you’re having like entire airplanes full of people who are aggressive rather than the one-off passenger.”

Rick Domingo, who oversees onboard safety as executive director of the FAA’s Flight Standards Service, echoed that sentiment.

“It used to be individual events,” Domingo said during a recent FAA forum. Now, “it’s group events. You have a number of people exhibiting that same behavior on aircraft.”

As of July 13, the FAA had opened 555 investigations in unruly passenger cases — triple its total for all of last year. It has taken action against passengers in 80 cases.

That’s just the beginning of a labyrinthine process written into FAA regulations, in which the agency sends a Notice of Proposed Civil Penalty. Passengers can try to demonstrate they did not violate FAA regulations; seek a shrunken penalty; or request an informal or formal hearing and an appeal.

While international aviation groups for years have noted concerns about passenger problems aboard aircraft, the recent U.S. surge appears to be an outlier.

In Canada, where passengers who refuse to comply with crew member instructions face fines up to \$100,000 (about \$80,000 in U.S. dollars) and as much as five years’ imprisonment, the nation had recorded 14 reports of unruly passengers through May. In 2020, 73 incidents were reported.

“Canadian airlines have not seen a significant uptick in the number of passengers acting out on flights,” said Frederica Dupuis, a spokeswoman for Transport Canada.

Willie Walsh, director general of the International Air Transport Association, a trade group that represents nearly 300 carriers worldwide, said “it’s not completely isolated to the U.S., but it is predominantly a U.S. domestic issue that we’re witnessing at the moment.”

In addition to masks, alcohol has been a contributor to bad behavior. Some airlines aren’t serving alcohol during the pandemic, so some passengers are drinking before boarding or

bringing their own, which is against federal rules.

Of the 43 enforcement cases this year for which the FAA has made some details public, nearly one-third involved alcohol. About the same number involved alleged assaults. A flight had to be diverted from its original destination in eight cases.

Some aviation industry officials said there are early signs that the frequency of incidents could be falling, but it's too soon to know whether that signals a downward trend.

'Reaching for the hammer'

In the past, the FAA might rely on warning letters or counseling to deal with passenger misbehavior. But under its "zero-tolerance" policy toward passengers interfering with crew members, aviation safety inspectors are required to fill out investigative reports that could lead to sanctions.

"It's one strike and you're out," said Arjun Garg, a former chief counsel at the FAA who is a partner at law firm Hogan Lovells. "There's no more of just counseling an offending passenger about behaving better. They are immediately reaching for the hammer."

Behind the scenes, the agency is struggling to keep up with the barrage. FAA officials are seeking to better prioritize the torrent of reports coming from airlines and rushing to train personnel on the basics of building cases that can stand up to challenge. The investigative process can be slow.

"We have to collect evidence, do due diligence to prove our case," the FAA said in a statement. "This takes time."

An FAA document tracking potential cases shows that information provided by airline employees sometimes falls short, undercutting would-be investigations.

The FAA has issued public statements touting more than \$680,000 in proposed penalties this year. But the agency has sometimes struggled to force passengers to pay more limited amounts in the past, raising questions about the success of its enforcement push.

The FAA is seeking \$10,500 from a Southwest Airlines passenger who allegedly made a maskless phone call while the plane sat on a runway in February, then swore at flight attendants before being removed.

But in a case resolved in June, a D.C. man made a call one hour into a November 2018 flight to Minneapolis. The FAA sought a \$5,000 penalty, but after pursuing the case for more than 18 months — and an appeal by the passenger to the U.S. Court of Appeals for the D.C. Circuit — the FAA agreed to settle for an undisclosed amount.

Following an unfavorable ruling by an administrative law judge last year, the FAA settled another case — a proposed \$10,000 penalty for alleged abusive behavior on a 2009 flight

from Miami — 10 years after the incident.

Other rulings and arguments made by the same judge, J.E. Sullivan, challenged the FAA's interpretation of what it means for someone to "interfere" with a flight crew. As one of a handful of judges in the Transportation Department's Office of Hearings, Sullivan provides interpretations that help shape how the FAA can enforce its rules, including its push to control unruly passengers.

In a case involving vaping on a plane, a passenger on a flight to Portland, Ore., set off a lavatory smoke alarm in 2019. The FAA charged the passenger with smoking — and also with violating a rule against interfering with a crew member performing their duties.

By putting on oxygen masks, making queries to gauge the threat and communicating with dispatchers over the incident, the flight crew was distracted from its regular safety preparations, an FAA lawyer argued. "We consider that an interference with their duties," the lawyer said.

Sullivan countered that "there's no interference," adding, "the activity that they engaged in is the activity that they're trained to engage in as part of their flight crew duties."

It's unclear whether mask-related cases working through the system could encounter similar issues. An internal FAA memo in February said persistent refusals to wear masks, requiring multiple instructions from a flight attendant, could be considered interference because of "the consequent distraction from safety-related duties." Sullivan declined to be interviewed.

Regulators have given little attention to some onboard safety concerns raised years ago.

Congress passed a law in October 2018 giving the FAA administrator one year to issue an order requiring the installation of a "secondary cockpit barrier" on new planes as added protection against would-be intruders. Nearly three years later, the FAA is still working on it.

The legislation was named after Capt. Victor J. Saracini, who was killed on United Airlines Flight 175, which terrorists crashed into the South Tower of the World Trade Center on Sept. 11, 2001. The barriers are meant to be installed between the cabin and cockpit door to block passengers from rushing in when the door is opened for food or restroom breaks.

Beyond addressing hijacking fears, a 2020 advisory report to the FAA noted that the barriers also could stop disturbed and impaired passengers. The Biden administration put the barriers on its "priority list for 2021," the FAA said.

On June 4, a passenger on a Delta Air Lines flight from Los Angeles to Nashville allegedly rushed up and started pounding on the cockpit door, forcing the plane to [divert](#) to Albuquerque. He was charged in U.S. District Court for New Mexico with interfering with a member of a flight crew.

Exhibit 11

[nytimes.com](https://www.nytimes.com)

Flight Attendants' Hellish Summer: 'I Don't Even Feel Like a Human'

Tacey Rychter

13-16 minutes

8-26-21

For cabin crews, the peak travel season has turned into a chronic battle involving frequent delays, overwork and unruly passengers that leaves them feeling battered by the public and the airlines.





Credit...Michelle Litvin for The New York Times

Aug. 26, 2021

As stranded Spirit Airlines travelers grew desperate at San Juan Airport in Puerto Rico during a chaotic night of cancellations on Aug. 1, banging on a gate door and yelling at staff, police officers rounded up the airline's cabin crews to hide them.

A 28-year-old flight attendant recounted being rushed to a jet bridge, behind a secure metal door, and then later to an office on the tarmac.

There, about 35 Spirit employees were told by a manager to change out of their uniforms for their safety.

"We were scared," said the attendant, who asked not to be identified by name because of the airline's media policy. "I've seen some crazy stuff, but this moved into number one."

Air travelers have faced an unusually high number of disruptions this summer because of widespread labor shortages, bad weather and technical problems. Nearly a quarter of U.S. passenger planes between June and mid-August were delayed, while almost 4 percent of flights were canceled in the first half of August, according to data from Flight Aware, a flight tracking service. Spirit alone canceled nearly 2,500 flights between Aug. 1 and 15.

Flight attendants across the country say they are struggling to cope, facing not only these prolonged operational issues, but also an increase in aggressive passenger behavior. Nearly 4,000 unruly passenger incidents have been [reported](#) to the Federal Aviation Administration in 2021, a figure described by the agency as "a rapid and significant increase."

Most of those reports deal with attendants enforcing rules on proper masking in the cabin, with passengers who range from careless to belligerent, and at times verbally or physically abusive. Shaky, vertical footage of brawls and insults are now a familiar staple on social media.

A 28-year-old American Airlines flight attendant who asked not to be identified for fear of losing her job said she had law enforcement called following verbal assaults twice since June, after six years of flying with no incidents. Both confrontations were related to mask

enforcement.

“What really hurts are the people who won’t even look at you in the eye,” she said. “I don’t even feel like a human anymore.”

In interviews with more than a dozen attendants from major and regional carriers, crew members said they were getting squeezed on both sides — from passengers and the airlines. They described regularly working shifts of more than 14 hours, being assigned up to four or five flights a day, not being given sufficient time to sleep and being deterred from taking leave if fatigued or unwell.

The tense situation in the air this summer has led many attendants to say that they feel exhausted, afraid for their personal safety and, in some cases, concerned that the situation could turn dangerous.

A spokeswoman for Airlines for America, a trade group, said its member airlines “recognize the importance of prioritizing the safety and well-being of all employees, who are the backbone of our industry,” and “comply fully with robust F.A.A. regulations, which include stringent rest requirements and limitations on duty, as well as with all federal policies.”



Image





Credit...Tom Williams/CQ Roll Call

Sara Nelson, president of the Association of Flight Attendants union that represents nearly 50,000 flight attendants at 17 airlines, noted that the difference in passenger response to the pandemic compared with the Sept. 11 terrorist attacks has been “night and day.”

Twenty years ago, “every single person who came on our plane was completely on our team,” she said. But now, flight attendants have become “punching bags for the public.”

Staffing can’t keep up with demand

This spring, as vaccination rates increased, coronavirus cases dropped and restrictions melted away, demand for summer travel rebounded more quickly than many had expected. On July 1, 2.1 million air travelers passed through Transportation Security Administration airport checkpoints, even more than on the same day in 2019. Many airlines ramped up their scheduling and added new routes.

But while airlines are eager to capitalize on the demand, many appear to lack the staffing to keep up.

Bureau of Transportation Statistics data show that the number of full-time-equivalent employees at U.S. scheduled passenger airlines [was nearly 14 percent lower](#) in June 2021 than in March 2020. Tens of thousands of flight attendants took leave during the pandemic, the A.F.A. union said. American Airlines said about 3,300 flight attendants have yet to return from leave.

“So many people were let go so quickly on extended leave of absence, early retirement, that they’re struggling to meet the travel demand,” said Paul Hartshorn, a flight attendant and spokesman for the Association of Professional Flight Attendants, which represents about 24,000 American Airlines attendants. “And staffing is tight, there’s not a lot of wiggle room for storms and maintenance delays.”

At Southwest Airlines, the chief operating officer, Mike Van de Ven, shared a message with staff on Aug. 20, saying that the increase in bookings has “taken a toll on our operation and put a significant strain on all of you. And for that, I am sincerely sorry.” He also said that “historical staffing models have not been effective in this pandemic environment.”

“There’s not enough people,” said Nas Lewis, a flight attendant with a major U.S. airline and founder of [th|AIR|apy](#), a website and Facebook group that addresses flight attendants’ mental health. Ms. Lewis, who asked that the name of her airline not be published because of its media policy, said the situation generates anxiety for attendants “because we don’t know what we’re going to deal with on any given day.”

A [shortage of pilots](#) is another critical pain point for air travel, as is inadequate numbers of gate agents, baggage handlers and delivery drivers, all of which can easily throw a wrench into getting a flight out on time.

When a cabin is short staffed, the airlines depend on on-call, or “reserve,” flight attendants. This summer, airlines have been stretching their reserves to the maximum, to the point where they are running low or out of available attendants before the day has even begun.

American Airlines’ staff scheduling system for Chicago on Aug. 10, which a flight attendant for the company described as an average day this summer, showed that by 7 a.m. every reserve attendant based there was either already scheduled or unavailable.

When an airline runs out of reserves, flight attendants who are already assigned to a flight can be abruptly rescheduled to work hours longer than expected, which attendants and union representatives say occurs more frequently now and adds to their fatigue.

Long days, minimum rest

Jacqueline Petzel, a Chicago-based flight attendant with American Airlines who is currently working on reserve, said that during the first week of August, she was woken up repeatedly at 2 a.m. by American and had only two hours to race to the airport and then work a 15-hour shift.

Between some recent shifts, Ms. Petzel, 34, said she had been given only the minimum 10 hours of rest at the hotel.

During that time, she had to get dinner, shower, call family, wind down, sleep, eat breakfast and get ready for the next shift, leaving just four or five hours for actual sleep, Ms. Petzel said.

“It’s hard to keep your eyes open when you’re up that early and it’s a long flight,” Ms.

Petzel said. On a recent layover in Las Vegas after a 15-hour day, she fell asleep in her uniform.

A 30-year-old flight attendant who works with United Airlines, who asked not to be identified for fear of jeopardizing her job, said she had to work a double red-eye during a four-day trip in July.

“I actually felt kind of tipsy, almost kind of drunk,” she said. “I was slow, and I know that even if something comes up the adrenaline will kick in, but I know that my decisions aren’t going to be the best.”

In response, Rachael Rivas, a spokeswoman for United, said: “We have what we believe is an industry-leading, safety-focused Fatigue Risk Management Program, which includes a strong collaboration between union representatives and in-flight management.”

Flight attendants have a maximum number of hours that they can be assigned to work, although many say scheduling teams are increasingly pressuring them to accept longer and longer shifts. When an attendant exceeds the maximum hours, it’s known colloquially as “going illegal.”

Attendants say it has become difficult to push back.

“They have it in the computer that you’re getting to the gate at 14 hours and 59 minutes, but it’s obvious that’s not going to happen,” said the 28-year-old attendant with American, where domestic shifts are limited to 15 hours.

“There’s this saying: fly now, grieve later,” she said. “You fly the illegal reassignment now, and you grieve it with your union later.”

Whitney Zastrow, a spokeswoman for American Airlines, said, “we’ve taken and continue to take steps to materially improve the quality of our flight attendants’ work life, including working closely with our hotel and limo vendor.”

Facing conflict and discouraged from taking leave

A video circulating online earlier this month of Frontier flight attendants [duct taping a belligerent passenger](#) to his seat made news reports and shocked viewers. While this is an extreme incident, attendants and unions say that encountering unruly passengers, once rare, is now almost expected.



Image



Credit...

An F.A.A. spokeswoman said that before 2021, the numbers of disturbances were fairly consistent year over year, with the agency investigating on average less than 150 incidents annually. As of Aug. 23, the F.A.A. has launched investigations into 693 incidents in 2021.

“You would think a pandemic affecting a ton of people would cause people to maybe pause and be more compassionate to each other,” said Ms. Petzel, the American Airlines attendant. “For whatever reason, it’s made it go the complete other way.”

Flight attendants across many airlines say the situation is wearing on their mental health and physical well-being.

“I have never experienced this level of anxiety, depression in my entire life,” said the 28-year-old flight attendant who works for American. “We’re really breaking down.”

“We’re used to getting B.S. from the company, from the passengers, we’re used to weather — but not all at the same time for an extended period of time. It’s every single day, it’s every single trip,” she said.

Many attendants say they fear retribution for taking leave, especially now.

Some airlines have a point-based attendance policy, whereby if a flight attendant has an unplanned absence when scheduled to work (say, because they call in sick), they accrue a point. Too many points can trigger an investigation or even termination.

JetBlue warned crew members that they would incur double attendance points if they took an unplanned absence over a weekend between July 23 through to Labor Day weekend.

One JetBlue flight attendant, who requested anonymity for fear of losing his job, said that last month he worked more than 17 hours on a shift and had been given only the legal minimum amount of rest, eight hours, between some flights.

He has called in sick a number of times but worries that he may accrue too many attendance points and face termination.

“When you try to talk to people about it, they say, ‘This is what you signed up for,’” he said, referring to a conversation he had with his manager.

“Our attendance policy is similar to most airlines, and on peak periods (like holidays) it’s especially important that crew members show up for assigned trips so that customers can get where they plan on going,” said Derek Dombrowski, a JetBlue spokesman. JetBlue is also offering financial incentives to encourage crews to take shifts.

Normally, Southwest Airlines is contractually obliged to let attendants call in sick without requiring a physician’s note. But the company can invoke an “emergency sick-call procedure,” requiring staff to verify their illness with a company doctor. Southwest has invoked this policy three times this summer.

“It should not be used as a usual or normal way of controlling the operation,” said Lyn Montgomery, the president of Transport Workers Union Local 556, which represents Southwest Airlines flight attendants. The last time this procedure was used was in 2017.

“While never a desired option, Southwest may, when operationally necessary, enact emergency sick call procedures to protect the airline’s schedule and support working flight attendants,” said Brian Parrish, a spokesman for Southwest Airlines. “Southwest Airlines supports employees’ physical, emotional and mental health with a variety of programs and offerings — including free employee assistance services that are available 24/7.”

The union and attendants said they felt that these doctors could be dismissive of symptoms. Staff also may not feel comfortable seeing the airline’s doctor, especially if dealing with mental health concerns.

“Our mental health has never been more disrupted than now, obviously since 9/11,” said a 30-year-old flight attendant for Southwest, who asked not to be identified for fear of losing her job. “You can’t even call out sick if you’re having major anxiety or depression episodes. It doesn’t matter.”

Ms. Lewis, of [th|AIR|apy](#), said in May she was shoved by a hostile passenger who was upset about an overbooked flight. She did not report the incident, she said, because she was too exhausted.

“As flight attendants, we are at our wits’ end,” she said.

Exhibit 12

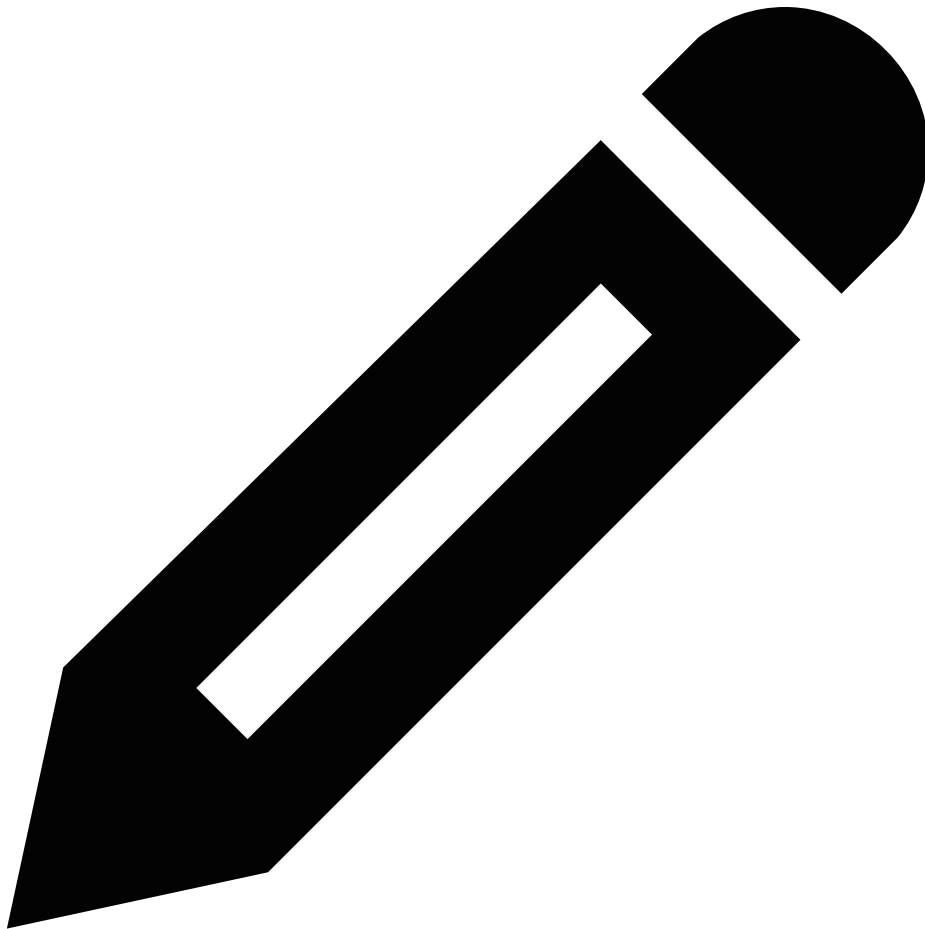
forbes.com

Why Some In The Airline Industry Want To End The Mask Mandate On Planes

Ben Balanza

8-7-21

6-7 minutes



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Aug 7, 2021, 03:40pm EDT | 6,517 views



I write about airlines and travel to explain this crazy industry.



The airline mask mandate is scheduled to expire in September, and some in the airline industry agree ... [+] with this though others feel it should be extended.

getty

The airline mask mandate is scheduled to expire on September 13, 2021. With this mandate in place, [there has been a rise in onboard incidents](#) that have harmed flight attendants, delayed or cancelled flights, and shown some of the worst of how society can behave.

In July, Southwest Airlines CEO Gary Kelly, the chairman of the industry group Airlines For America, [indicated that U.S. airlines would like to see the mandate lapse](#). Not extending the mandate would prevent some risks, mostly from onboard aggression and what people will continue to see as unfair and inconsistent policy application, some in the airline industry believe. When combined with the relatively safe environment of an aircraft cabin and an upcoming seasonal drop in travel, it makes sense to some to let the mandate end as scheduled in September.

Yet the rapid spread of the Delta variant of the coronavirus is making everyone re-think what the next steps should be – Airlines For America is not taking a public position on the issue — and certainly the federal government will consider extending the mask mandate on airplanes if it determines that the Delta variant presents too much risk.

Airplanes Are Safer Than Most Places

By now, it's old news that airplane air flows vertically and is replaced with new outside air every few minutes. Thanks to this, several studies have suggested that the [transmission of viruses onboard a plane is rare](#), which is one key point that proponents of dropping the

mask mandate on planes point to. Yet the higher rate of contagion with the Delta variant will challenge this view. Letting the mask mandate expire on its current chosen date with the Delta variant active poses some risk not found with the original virus.

Emotions Run High When Flying

Flying is a stressful time for many flyers. People who normally have a lot of control in their lives give up all control, and are subject to delays, unexpected events, and more and must adapt. Not everyone is good at this. When this atmosphere is combined with tensions around mask policy, we have seen a summer with more onboard skirmishes and more people injured than ever before. [The FAA has suggested big fines](#) in some cases, but these will take years to go through the courts and likely be dropped or settled for pennies on the dollar. The fines make good headlines and may deter some otherwise bad behaviors, but the root cause of most of these incidents has been the mandated mask policy. It's not the policy itself, but the inconsistency of that policy with other parts of life. While many of us may be able to clearly understand why we must wear a mask on a plane but don't have to in restaurant, to others this makes no sense. Put that view in the stressful and emotional environment of an airline flight and the results we've seen this summer are not totally surprising.

Many Flight Attendants Are Vaccinated

Flight attendants are on the front line of the abusive behavior by passengers, and the national flight attendant unions supported the initial mask mandate and its extension to September. That is understandable, but also during the summer vaccinations are continuing and [now 70% of adults in the U.S.](#) have had at least one shot of a vaccine. Further, [United Airlines is now requiring](#) all employees to be vaccinated and so it's reasonable to assume that more flight attendants are vaccinated than the population as a whole. As travel reduces naturally in the fall, letting the mandate expire would lower the tensions onboard significantly and greatly reduce the number of potentially dangerous confrontations that flight attendants must face.

But then there's the health risks to passengers and those they come into contact with after their trip.

The fairly widespread distribution of vaccines in the U.S. and Europe has made a huge difference. Today, [nearly all of the deaths related to Covid](#) are in people who have chosen not to be vaccinated.

However, the delta variant is far more contagious than previous forms of the coronavirus – research suggests it's anywhere from 40% to 60% more transmissible than the alpha variant and twice more than the original Wuhan form of the virus. And [research](#) that showed that vaccinated people who are infected pose as much of a risk to spread the

virus to others as unvaccinated people led the Centers for Disease Control to recommend last week that vaccinated people wear masks in areas where the virus is spreading rapidly – which is most of the U.S. right now.

A number of cities and businesses have moved to reinstate mask mandates. All this may make it less likely that the federal government will let the mask mandate on airplanes lapse.

Managing risk does not mean eliminating risk. Managing risk means mitigating the most significant risk, and finding a good balance between different types of risk. There would be no inflight incidents or onboard transmission if we made it illegal to fly, for example, but the cost of that to society is far worse than the risk of onboard incidents. In a similar way, we know that the mask mandate upsets enough customers to have created a difficult summer for flight attendants and airlines. We also know that more people are vaccinated each day, and that travel will seasonally drop once we hit September. Given these balancing forces, there will be arguments to both let the mandate expire and to extend it. In either case, clearly the answer is to get more people vaccinated!

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I am the former CEO of Spirit Airlines, where my strong team transformed the company into the highest margin airline in North America and created a new model for air

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SpaceX Launches Its 'Operational' Flight To The ISS

Exhibit 13

By Standard Number / 1910.134 - Respiratory Protection.

■ Part Number:	1910	
■ Part Number Title:	Occupational Safety and Health Standards	
■ Subpart:	1910 Subpart I	
■ Subpart Title:	Personal Protective Equipment	
■ Standard Number:	1910.134	
■ Title:	Respiratory Protection.	
■ Appendix:	A; B-1; B-2; C; D	Department of Labor
■ GPO Source:	e-CFR	OSHA

1910.134(a)

Permissible practice.

1910.134(a)(1)

In the control of those occupational diseases caused by breathing air contaminated with harmful dusts, fogs, fumes, mists, gases, smokes, sprays, or vapors, the primary objective shall be to prevent atmospheric contamination. This shall be accomplished as far as feasible by accepted engineering control measures (for example, enclosure or confinement of the operation, general and local ventilation, and substitution of less toxic materials). When effective engineering controls are not feasible, or while they are being instituted, appropriate respirators shall be used pursuant to this section.

1910.134(a)(2)

A respirator shall be provided to each employee when such equipment is necessary to protect the health of such employee. The employer shall provide the respirators which are applicable and suitable for the purpose intended. The employer shall be responsible for the establishment and maintenance of a respiratory protection program, which shall include the requirements outlined in paragraph (c) of this section. The program shall cover each employee required by this section to use a respirator.

1910.134(b)

Definitions. The following definitions are important terms used in the respiratory protection standard in this section.

Air-purifying respirator means a respirator with an air-purifying filter, cartridge, or canister that removes specific air contaminants by passing ambient air through the air-purifying element.

Assigned protection factor (APF) means the workplace level of respiratory protection that a respirator or class of respirators is expected to provide to employees when the employer implements a continuing, effective respiratory protection program as specified by this section.

Atmosphere-supplying respirator means a respirator that supplies the respirator user with breathing air from a source independent of the ambient atmosphere, and includes supplied-air respirators (SARs) and self-contained breathing apparatus (SCBA) units.

Canister or cartridge means a container with a filter, sorbent, or catalyst, or combination of these items, which removes specific contaminants from the air passed through the container.

Demand respirator means an atmosphere-supplying respirator that admits breathing air to the facepiece only when a

negative pressure is created inside the facepiece by inhalation.

Emergency situation means any occurrence such as, but not limited to, equipment failure, rupture of containers, or failure of control equipment that may or does result in an uncontrolled significant release of an airborne contaminant.

Employee exposure means exposure to a concentration of an airborne contaminant that would occur if the employee were not using respiratory protection.

End-of-service-life indicator (ESLI) means a system that warns the respirator user of the approach of the end of adequate respiratory protection, for example, that the sorbent is approaching saturation or is no longer effective.

Escape-only respirator means a respirator intended to be used only for emergency exit.

Filter or air purifying element means a component used in respirators to remove solid or liquid aerosols from the inspired air.

Filtering facepiece (dust mask) means a negative pressure particulate respirator with a filter as an integral part of the facepiece or with the entire facepiece composed of the filtering medium.

Fit factor means a quantitative estimate of the fit of a particular respirator to a specific individual, and typically estimates the ratio of the concentration of a substance in ambient air to its concentration inside the respirator when worn.

Fit test means the use of a protocol to qualitatively or quantitatively evaluate the fit of a respirator on an individual. (See also Qualitative fit test QLFT and Quantitative fit test QNFT.)

Helmet means a rigid respiratory inlet covering that also provides head protection against impact and penetration.

High efficiency particulate air (HEPA) filter means a filter that is at least 99.97% efficient in removing monodisperse particles of 0.3 micrometers in diameter. The equivalent NIOSH 42 CFR 84 particulate filters are the N100, R100, and P100 filters.

Hood means a respiratory inlet covering that completely covers the head and neck and may also cover portions of the shoulders and torso.

Immediately dangerous to life or health (IDLH) means an atmosphere that poses an immediate threat to life, would cause irreversible adverse health effects, or would impair an individual's ability to escape from a dangerous atmosphere.

Interior structural firefighting means the physical activity of fire suppression, rescue or both, inside of buildings or enclosed structures which are involved in a fire situation beyond the incipient stage. (See 29 CFR 1910.155)

Loose-fitting facepiece means a respiratory inlet covering that is designed to form a partial seal with the face.

Maximum use concentration (MUC) means the maximum atmospheric concentration of a hazardous substance from which an employee can be expected to be protected when wearing a respirator, and is determined by the assigned protection factor of the respirator or class of respirators and the exposure limit of the hazardous substance. The MUC can be determined mathematically by multiplying the assigned protection factor specified for a respirator by the required OSHA permissible exposure limit, short-term exposure limit, or ceiling limit. When no OSHA exposure limit is available for a hazardous substance, an employer must determine an MUC on the basis of relevant available information and informed professional judgment.

Negative pressure respirator (tight fitting) means a respirator in which the air pressure inside the facepiece is negative during inhalation with respect to the ambient air pressure outside the respirator.

Oxygen deficient atmosphere means an atmosphere with an oxygen content below 19.5% by volume.

Physician or other licensed health care professional (PLHCP) means an individual whose legally permitted scope of practice (i.e., license, registration, or certification) allows him or her to independently provide, or be delegated the responsibility to provide, some or all of the health care services required by paragraph (e) of this section.

Positive pressure respirator means a respirator in which the pressure inside the respiratory inlet covering exceeds the ambient air pressure outside the respirator.

Powered air-purifying respirator (PAPR) means an air-purifying respirator that uses a blower to force the ambient air through air-purifying elements to the inlet covering.

Pressure demand respirator means a positive pressure atmosphere-supplying respirator that admits breathing air to the facepiece when the positive pressure is reduced inside the facepiece by inhalation.

Qualitative fit test (QLFT) means a pass/fail fit test to assess the adequacy of respirator fit that relies on the individual's response to the test agent.

Quantitative fit test (QNFT) means an assessment of the adequacy of respirator fit by numerically measuring the amount of leakage into the respirator.

Respiratory inlet covering means that portion of a respirator that forms the protective barrier between the user's respiratory tract and an air-purifying device or breathing air source, or both. It may be a facepiece, helmet, hood, suit, or a mouthpiece respirator with nose clamp.

Self-contained breathing apparatus (SCBA) means an atmosphere-supplying respirator for which the breathing air source is designed to be carried by the user.

Service life means the period of time that a respirator, filter or sorbent, or other respiratory equipment provides adequate protection to the wearer.

Supplied-air respirator (SAR) or airline respirator means an atmosphere-supplying respirator for which the source of breathing air is not designed to be carried by the user.

This section means this respiratory protection standard.

Tight-fitting facepiece means a respiratory inlet covering that forms a complete seal with the face.

User seal check means an action conducted by the respirator user to determine if the respirator is properly seated to the face.

1910.134(c)

Respiratory protection program. This paragraph requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use. The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator. The Small Entity Compliance Guide contains criteria for the selection of a program administrator and a sample program that

meets the requirements of this paragraph. Copies of the Small Entity Compliance Guide will be available on or about April 8, 1998 from the Occupational Safety and Health Administration's Office of Publications, Room N 3101, 200 Constitution Avenue, NW, Washington, DC, 20210 (202-219-4667).

1910.134(c)(1)

In any workplace where respirators are necessary to protect the health of the employee or whenever respirators are required by the employer, the employer shall establish and implement a written respiratory protection program with worksite-specific procedures. The program shall be updated as necessary to reflect those changes in workplace conditions that affect respirator use. The employer shall include in the program the following provisions of this section, as applicable:

1910.134(c)(1)(i)

Procedures for selecting respirators for use in the workplace;

1910.134(c)(1)(ii)

Medical evaluations of employees required to use respirators;

1910.134(c)(1)(iii)

Fit testing procedures for tight-fitting respirators;

1910.134(c)(1)(iv)

Procedures for proper use of respirators in routine and reasonably foreseeable emergency situations;

1910.134(c)(1)(v)

Procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators;

1910.134(c)(1)(vi)

Procedures to ensure adequate air quality, quantity, and flow of breathing air for atmosphere-supplying respirators;

1910.134(c)(1)(vii)

Training of employees in the respiratory hazards to which they are potentially exposed during routine and emergency situations;

1910.134(c)(1)(viii)

Training of employees in the proper use of respirators, including putting on and removing them, any limitations on their use, and their maintenance; and

1910.134(c)(1)(ix)

Procedures for regularly evaluating the effectiveness of the program.

1910.134(c)(2)

Where respirator use is not required:

1910.134(c)(2)(i)

An employer may provide respirators at the request of employees or permit employees to use their own respirators, if the employer determines that such respirator use will not in itself create a hazard. If the employer determines that any voluntary respirator use is permissible, the employer shall provide the respirator users with the information contained in Appendix D to this section ("Information for Employees Using Respirators When Not Required Under the Standard"); and

1910.134(c)(2)(ii)

In addition, the employer must establish and implement those elements of a written respiratory protection program necessary to ensure that any employee using a respirator voluntarily is medically able to use that respirator, and that the respirator is cleaned, stored, and maintained so that its use does not present a health hazard to the user.

Exception: Employers are not required to include in a written respiratory protection program those employees whose only use of respirators involves the voluntary use of filtering facepieces (dust masks).

1910.134(c)(3)

The employer shall designate a program administrator who is qualified by appropriate training or experience that is commensurate with the complexity of the program to administer or oversee the respiratory protection program and conduct the required evaluations of program effectiveness.

1910.134(c)(4)

The employer shall provide respirators, training, and medical evaluations at no cost to the employee.

1910.134(d)

Selection of respirators. This paragraph requires the employer to evaluate respiratory hazard(s) in the workplace, identify relevant workplace and user factors, and base respirator selection on these factors. The paragraph also specifies appropriately protective respirators for use in IDLH atmospheres, and limits the selection and use of air-purifying respirators.

1910.134(d)(1)

General requirements.

1910.134(d)(1)(i)

The employer shall select and provide an appropriate respirator based on the respiratory hazard(s) to which the worker is exposed and workplace and user factors that affect respirator performance and reliability.

1910.134(d)(1)(ii)

The employer shall select a NIOSH-certified respirator. The respirator shall be used in compliance with the conditions of its certification.

1910.134(d)(1)(iii)

The employer shall identify and evaluate the respiratory hazard(s) in the workplace; this evaluation shall include a reasonable estimate of employee exposures to respiratory hazard(s) and an identification of the contaminant's chemical state and physical form. Where the employer cannot identify or reasonably estimate the employee exposure, the employer shall consider the atmosphere to be IDLH.

1910.134(d)(1)(iv)

The employer shall select respirators from a sufficient number of respirator models and sizes so that the respirator is acceptable to, and correctly fits, the user.

1910.134(d)(2)

Respirators for IDLH atmospheres.

1910.134(d)(2)(i)

The employer shall provide the following respirators for employee use in IDLH atmospheres:

1910.134(d)(2)(i)(A)

A full facepiece pressure demand SCBA certified by NIOSH for a minimum service life of thirty minutes, or

1910.134(d)(2)(i)(B)

A combination full facepiece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.

1910.134(d)(2)(ii)

Respirators provided only for escape from IDLH atmospheres shall be NIOSH-certified for escape from the atmosphere in which they will be used.

1910.134(d)(2)(iii)

All oxygen-deficient atmospheres shall be considered IDLH. Exception: If the employer demonstrates that, under all foreseeable conditions, the oxygen concentration can be maintained within the ranges specified in Table II of this section (i.e., for the altitudes set out in the table), then any atmosphere-supplying respirator may be used.

1910.134(d)(3)

Respirators for atmospheres that are not IDLH.

1910.134(d)(3)(i)

The employer shall provide a respirator that is adequate to protect the health of the employee and ensure compliance with all other OSHA statutory and regulatory requirements, under routine and reasonably foreseeable emergency situations.

1910.134(d)(3)(i)(A)

Assigned Protection Factors (APFs) Employers must use the assigned protection factors listed in Table 1 to select a respirator that meets or exceeds the required level of employee protection. When using a combination respirator (e.g., airline respirators with an air-purifying filter), employers must ensure that the assigned protection factor is appropriate to the mode of operation in which the respirator is being used.

Table 1. -- Assigned Protection Factors⁵

Type of respirator ^{1, 2}	Quarter mask	Half mask	Full facepiece	Helmet/hood	Loose-fitting facepiece
1. Air-Purifying Respirator	5	³ 10	50	.....	.....
2. Powered Air-Purifying Respirator (PAPR)	.....	50	1,000	⁴ 25/1,000	25
3. Supplied-Air Respirator (SAR) or Airline Respirator					
• Demand mode	.....	10	50	.....	.....
• Continuous flow mode	.....	50	1,000	⁴ 25/1,000	25
• Pressure-demand or other positive-pressure mode	.....	50	1,000	.....	.....
4. Self-Contained Breathing Apparatus (SCBA)					
• Demand mode	.....	10	50	50	.....
• Pressure-demand or other positive-pressure mode (e.g., open/closed circuit)	.....	.....	10,000	10,000	.....

Notes:

¹Employers may select respirators assigned for use in higher workplace concentrations of a hazardous substance for

use at lower concentrations of that substance, or when required respirator use is independent of concentration.

²The assigned protection factors in Table 1 are only effective when the employer implements a continuing, effective respirator program as required by this section (29 CFR 1910.134), including training, fit testing, maintenance, and use requirements.

³This APF category includes filtering facepieces, and half masks with elastomeric facepieces.

⁴The employer must have evidence provided by the respirator manufacturer that testing of these respirators demonstrates performance at a level of protection of 1,000 or greater to receive an APF of 1,000. This level of performance can best be demonstrated by performing a WPF or SWPF study or equivalent testing. Absent such testing, all other PAPRs and SARs with helmets/hoods are to be treated as loose-fitting facepiece respirators, and receive an APF of 25.

⁵These APFs do not apply to respirators used solely for escape. For escape respirators used in association with specific substances covered by 29 CFR 1910 subpart Z, employers must refer to the appropriate substance-specific standards in that subpart. Escape respirators for other IDLH atmospheres are specified by 29 CFR 1910.134 (d)(2)(ii).

1910.134(d)(3)(i)(B)

Maximum Use Concentration (MUC)

1910.134(d)(3)(i)(B)(1)

The employer must select a respirator for employee use that maintains the employee's exposure to the hazardous substance, when measured outside the respirator, at or below the MUC.

1910.134(d)(3)(i)(B)(2)

Employers must not apply MUCs to conditions that are immediately dangerous to life or health (IDLH); instead, they must use respirators listed for IDLH conditions in paragraph (d)(2) of this standard.

1910.134(d)(3)(i)(B)(3)

When the calculated MUC exceeds the IDLH level for a hazardous substance, or the performance limits of the cartridge or canister, then employers must set the maximum MUC at that lower limit.

1910.134(d)(3)(ii)

The respirator selected shall be appropriate for the chemical state and physical form of the contaminant.

1910.134(d)(3)(iii)

For protection against gases and vapors, the employer shall provide:

1910.134(d)(3)(iii)(A)

An atmosphere-supplying respirator, or

1910.134(d)(3)(iii)(B)

An air-purifying respirator, provided that:

1910.134(d)(3)(iii)(B)(1)

The respirator is equipped with an end-of-service-life indicator (ESLI) certified by NIOSH for the contaminant; or

1910.134(d)(3)(iii)(B)(2)

If there is no ESLI appropriate for conditions in the employer's workplace, the employer implements a change schedule for canisters and cartridges that is based on objective information or data that will ensure that canisters and cartridges are changed before the end of their service life. The employer shall describe in the respirator program the information and data relied upon and the basis for the canister and cartridge change schedule and the basis for reliance on the data.

1910.134(d)(3)(iv)

For protection against particulates, the employer shall provide:

1910.134(d)(3)(iv)(A)

An atmosphere-supplying respirator; or

1910.134(d)(3)(iv)(B)

An air-purifying respirator equipped with a filter certified by NIOSH under 30 CFR part 11 as a high efficiency particulate air (HEPA) filter, or an air-purifying respirator equipped with a filter certified for particulates by NIOSH under 42 CFR part 84; or

1910.134(d)(3)(iv)(C)

For contaminants consisting primarily of particles with mass median aerodynamic diameters (MMAD) of at least 2 micrometers, an air-purifying respirator equipped with any filter certified for particulates by NIOSH.

TABLE I. -- ASSIGNED PROTECTION FACTORS

[RESERVED]

TABLE II

Altitude (ft.)	Oxygen deficient Atmospheres (% O ₂) for which the employer atmosphere may rely on supplying respirators
Less than 3,001	16.0-19.5
3,001-4,000	16.4-19.5
4,001-5,000	17.1-19.5
5,001-6,000	17.8-19.5
6,001-7,000	18.5-19.5
7,001-8,000 ¹	19.3-19.5.

¹Above 8,000 feet the exception does not apply. Oxygen-enriched breathing air must be supplied above 14,000 feet.

1910.134(e)

Medical evaluation. Using a respirator may place a physiological burden on employees that varies with the type of respirator worn, the job and workplace conditions in which the respirator is used, and the medical status of the employee. Accordingly, this paragraph specifies the minimum requirements for medical evaluation that employers must implement to determine the employee's ability to use a respirator.

1910.134(e)(1)

General. The employer shall provide a medical evaluation to determine the employee's ability to use a respirator, before the employee is fit tested or required to use the respirator in the workplace. The employer may discontinue an employee's medical evaluations when the employee is no longer required to use a respirator.

1910.134(e)(2)

Medical evaluation procedures.

1910.134(e)(2)(i)

The employer shall identify a physician or other licensed health care professional (PLHCP) to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire.

1910.134(e)(2)(ii)

The medical evaluation shall obtain the information requested by the questionnaire in Sections 1 and 2, Part A of Appendix C of this section.

1910.134(e)(3)

Follow-up medical examination.

1910.134(e)(3)(i)

The employer shall ensure that a follow-up medical examination is provided for an employee who gives a positive response to any question among questions 1 through 8 in Section 2, Part A of Appendix C or whose initial medical examination demonstrates the need for a follow-up medical examination.

1910.134(e)(3)(ii)

The follow-up medical examination shall include any medical tests, consultations, or diagnostic procedures that the PLHCP deems necessary to make a final determination.

1910.134(e)(4)

Administration of the medical questionnaire and examinations.

1910.134(e)(4)(i)

The medical questionnaire and examinations shall be administered confidentially during the employee's normal working hours or at a time and place convenient to the employee. The medical questionnaire shall be administered in a manner that ensures that the employee understands its content.

1910.134(e)(4)(ii)

The employer shall provide the employee with an opportunity to discuss the questionnaire and examination results with the PLHCP.

1910.134(e)(5)

Supplemental information for the PLHCP.

1910.134(e)(5)(i)

The following information must be provided to the PLHCP before the PLHCP makes a recommendation concerning an employee's ability to use a respirator:

1910.134(e)(5)(i)(A)

(A) The type and weight of the respirator to be used by the employee;

1910.134(e)(5)(i)(B)

The duration and frequency of respirator use (including use for rescue and escape);

1910.134(e)(5)(i)(C)

The expected physical work effort;

1910.134(e)(5)(i)(D)

Additional protective clothing and equipment to be worn; and

1910.134(e)(5)(i)(E)

Temperature and humidity extremes that may be encountered.

1910.134(e)(5)(ii)

Any supplemental information provided previously to the PLHCP regarding an employee need not be provided for a subsequent medical evaluation if the information and the PLHCP remain the same.

1910.134(e)(5)(iii)

The employer shall provide the PLHCP with a copy of the written respiratory protection program and a copy of this section.

Note to Paragraph (e)(5)(iii): When the employer replaces a PLHCP, the employer must ensure that the new PLHCP obtains this information, either by providing the documents directly to the PLHCP or having the documents transferred from the former PLHCP to the new PLHCP. However, OSHA does not expect employers to have employees medically reevaluated solely because a new PLHCP has been selected.

1910.134(e)(6)

Medical determination. In determining the employee's ability to use a respirator, the employer shall:

1910.134(e)(6)(i)

Obtain a written recommendation regarding the employee's ability to use the respirator from the PLHCP. The recommendation shall provide only the following information:

1910.134(e)(6)(i)(A)

Any limitations on respirator use related to the medical condition of the employee, or relating to the workplace conditions in which the respirator will be used, including whether or not the employee is medically able to use the respirator;

1910.134(e)(6)(i)(B)

The need, if any, for follow-up medical evaluations; and

1910.134(e)(6)(i)(C)

A statement that the PLHCP has provided the employee with a copy of the PLHCP's written recommendation.

1910.134(e)(6)(ii)

If the respirator is a negative pressure respirator and the PLHCP finds a medical condition that may place the employee's health at increased risk if the respirator is used, the employer shall provide a PAPR if the PLHCP's medical evaluation finds that the employee can use such a respirator; if a subsequent medical evaluation finds that the employee is medically able to use a negative pressure respirator, then the employer is no longer required to provide a PAPR.

1910.134(e)(7)

Additional medical evaluations. At a minimum, the employer shall provide additional medical evaluations that comply with the requirements of this section if:

1910.134(e)(7)(i)

An employee reports medical signs or symptoms that are related to ability to use a respirator;

1910.134(e)(7)(ii)

A PLHCP, supervisor, or the respirator program administrator informs the employer that an employee needs to be reevaluated;

1910.134(e)(7)(iii)

Information from the respiratory protection program, including observations made during fit testing and program evaluation, indicates a need for employee reevaluation; or

1910.134(e)(7)(iv)

A change occurs in workplace conditions (e.g., physical work effort, protective clothing, temperature) that may result in a substantial increase in the physiological burden placed on an employee.

1910.134(f)

Fit testing. This paragraph requires that, before an employee may be required to use any respirator with a negative or positive pressure tight-fitting facepiece, the employee must be fit tested with the same make, model, style, and size of respirator that will be used. This paragraph specifies the kinds of fit tests allowed, the procedures for conducting them, and how the results of the fit tests must be used.

1910.134(f)(1)

The employer shall ensure that employees using a tight-fitting facepiece respirator pass an appropriate qualitative fit test (QLFT) or quantitative fit test (QNFT) as stated in this paragraph.

1910.134(f)(2)

The employer shall ensure that an employee using a tight-fitting facepiece respirator is fit tested prior to initial use of the respirator, whenever a different respirator facepiece (size, style, model or make) is used, and at least annually thereafter.

1910.134(f)(3)

The employer shall conduct an additional fit test whenever the employee reports, or the employer, PLHCP, supervisor, or program administrator makes visual observations of, changes in the employee's physical condition that could affect respirator fit. Such conditions include, but are not limited to, facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight.

1910.134(f)(4)

If after passing a QLFT or QNFT, the employee subsequently notifies the employer, program administrator, supervisor, or PLHCP that the fit of the respirator is unacceptable, the employee shall be given a reasonable opportunity to select a different respirator facepiece and to be retested.

1910.134(f)(5)

The fit test shall be administered using an OSHA-accepted QLFT or QNFT protocol. The OSHA-accepted QLFT and QNFT protocols and procedures are contained in Appendix A of this section.

1910.134(f)(6)

QLFT may only be used to fit test negative pressure air-purifying respirators that must achieve a fit factor of 100 or less.

1910.134(f)(7)

If the fit factor, as determined through an OSHA-accepted QNFT protocol, is equal to or greater than 100 for tight-fitting half facepieces, or equal to or greater than 500 for tight-fitting full facepieces, the QNFT has been passed with that respirator.

1910.134(f)(8)

Fit testing of tight-fitting atmosphere-supplying respirators and tight-fitting powered air-purifying respirators shall be accomplished by performing quantitative or qualitative fit testing in the negative pressure mode, regardless of the mode of operation (negative or positive pressure) that is used for respiratory protection.

1910.134(f)(8)(i)

Qualitative fit testing of these respirators shall be accomplished by temporarily converting the respirator user's actual facepiece into a negative pressure respirator with appropriate filters, or by using an identical negative pressure air-purifying respirator facepiece with the same sealing surfaces as a surrogate for the atmosphere-supplying or powered air-purifying respirator facepiece.

1910.134(f)(8)(ii)

Quantitative fit testing of these respirators shall be accomplished by modifying the facepiece to allow sampling inside the facepiece in the breathing zone of the user, midway between the nose and mouth. This requirement shall be accomplished by installing a permanent sampling probe onto a surrogate facepiece, or by using a sampling adapter designed to temporarily provide a means of sampling air from inside the facepiece.

1910.134(f)(8)(iii)

Any modifications to the respirator facepiece for fit testing shall be completely removed, and the facepiece restored to NIOSH-approved configuration, before that facepiece can be used in the workplace.

1910.134(g)

Use of respirators. This paragraph requires employers to establish and implement procedures for the proper use of respirators. These requirements include prohibiting conditions that may result in facepiece seal leakage, preventing employees from removing respirators in hazardous environments, taking actions to ensure continued effective respirator operation throughout the work shift, and establishing procedures for the use of respirators in IDLH atmospheres or in interior structural firefighting situations.

1910.134(g)(1)

Facepiece seal protection.

1910.134(g)(1)(i)

The employer shall not permit respirators with tight-fitting facepieces to be worn by employees who have:

1910.134(g)(1)(i)(A)

Facial hair that comes between the sealing surface of the facepiece and the face or that interferes with valve function;
or

1910.134(g)(1)(i)(B)

Any condition that interferes with the face-to-facepiece seal or valve function.

1910.134(g)(1)(ii)

If an employee wears corrective glasses or goggles or other personal protective equipment, the employer shall ensure that such equipment is worn in a manner that does not interfere with the seal of the facepiece to the face of the user.

1910.134(g)(1)(iii)

For all tight-fitting respirators, the employer shall ensure that employees perform a user seal check each time they put on the respirator using the procedures in Appendix B-1 or procedures recommended by the respirator manufacturer that the employer demonstrates are as effective as those in Appendix B-1 of this section.

1910.134(g)(2)

Continuing respirator effectiveness.

1910.134(g)(2)(i)

Appropriate surveillance shall be maintained of work area conditions and degree of employee exposure or stress. When there is a change in work area conditions or degree of employee exposure or stress that may affect respirator effectiveness, the employer shall reevaluate the continued effectiveness of the respirator.

1910.134(g)(2)(ii)

The employer shall ensure that employees leave the respirator use area:

1910.134(g)(2)(ii)(A)

To wash their faces and respirator facepieces as necessary to prevent eye or skin irritation associated with respirator use; or

1910.134(g)(2)(ii)(B)

If they detect vapor or gas breakthrough, changes in breathing resistance, or leakage of the facepiece; or

1910.134(g)(2)(ii)(C)

To replace the respirator or the filter, cartridge, or canister elements.

1910.134(g)(2)(iii)

If the employee detects vapor or gas breakthrough, changes in breathing resistance, or leakage of the facepiece, the employer must replace or repair the respirator before allowing the employee to return to the work area.

1910.134(g)(3)

Procedures for IDLH atmospheres. For all IDLH atmospheres, the employer shall ensure that:

1910.134(g)(3)(i)

One employee or, when needed, more than one employee is located outside the IDLH atmosphere;

1910.134(g)(3)(ii)

Visual, voice, or signal line communication is maintained between the employee(s) in the IDLH atmosphere and the employee(s) located outside the IDLH atmosphere;

1910.134(g)(3)(iii)

The employee(s) located outside the IDLH atmosphere are trained and equipped to provide effective emergency rescue;

1910.134(g)(3)(iv)

The employer or designee is notified before the employee(s) located outside the IDLH atmosphere enter the IDLH atmosphere to provide emergency rescue;

1910.134(g)(3)(v)

The employer or designee authorized to do so by the employer, once notified, provides necessary assistance appropriate to the situation;

1910.134(g)(3)(vi)

Employee(s) located outside the IDLH atmospheres are equipped with:

1910.134(g)(3)(vi)(A)

Pressure demand or other positive pressure SCBAs, or a pressure demand or other positive pressure supplied-air

respirator with auxiliary SCBA; and either

1910.134(g)(3)(vi)(B)

Appropriate retrieval equipment for removing the employee(s) who enter(s) these hazardous atmospheres where retrieval equipment would contribute to the rescue of the employee(s) and would not increase the overall risk resulting from entry; or

1910.134(g)(3)(vi)(C)

Equivalent means for rescue where retrieval equipment is not required under paragraph (g)(3)(vi)(B).

1910.134(g)(4)

Procedures for interior structural firefighting. In addition to the requirements set forth under paragraph (g)(3), in interior structural fires, the employer shall ensure that:

1910.134(g)(4)(i)

At least two employees enter the IDLH atmosphere and remain in visual or voice contact with one another at all times;

1910.134(g)(4)(ii)

At least two employees are located outside the IDLH atmosphere; and

1910.134(g)(4)(iii)

All employees engaged in interior structural firefighting use SCBAs.

Note 1 to paragraph (g): One of the two individuals located outside the IDLH atmosphere may be assigned to an additional role, such as incident commander in charge of the emergency or safety officer, so long as this individual is able to perform assistance or rescue activities without jeopardizing the safety or health of any firefighter working at the incident.

Note 2 to paragraph (g): Nothing in this section is meant to preclude firefighters from performing emergency rescue activities before an entire team has assembled.

1910.134(h)

Maintenance and care of respirators. This paragraph requires the employer to provide for the cleaning and disinfecting, storage, inspection, and repair of respirators used by employees.

1910.134(h)(1)

Cleaning and disinfecting. The employer shall provide each respirator user with a respirator that is clean, sanitary, and in good working order. The employer shall ensure that respirators are cleaned and disinfected using the procedures in Appendix B-2 of this section, or procedures recommended by the respirator manufacturer, provided that such procedures are of equivalent effectiveness. The respirators shall be cleaned and disinfected at the following intervals:

1910.134(h)(1)(i)

Respirators issued for the exclusive use of an employee shall be cleaned and disinfected as often as necessary to be maintained in a sanitary condition;

1910.134(h)(1)(ii)

Respirators issued to more than one employee shall be cleaned and disinfected before being worn by different individuals;

1910.134(h)(1)(iii)

Respirators maintained for emergency use shall be cleaned and disinfected after each use; and

1910.134(h)(1)(iv)

Respirators used in fit testing and training shall be cleaned and disinfected after each use.

1910.134(h)(2)

Storage. The employer shall ensure that respirators are stored as follows:

1910.134(h)(2)(i)

All respirators shall be stored to protect them from damage, contamination, dust, sunlight, extreme temperatures, excessive moisture, and damaging chemicals, and they shall be packed or stored to prevent deformation of the facepiece and exhalation valve.

1910.134(h)(2)(ii)

In addition to the requirements of paragraph (h)(2)(i) of this section, emergency respirators shall be:

1910.134(h)(2)(ii)(A)

Kept accessible to the work area;

1910.134(h)(2)(ii)(B)

Stored in compartments or in covers that are clearly marked as containing emergency respirators; and

1910.134(h)(2)(ii)(C)

Stored in accordance with any applicable manufacturer instructions.

1910.134(h)(3)

Inspection.

1910.134(h)(3)(i)

The employer shall ensure that respirators are inspected as follows:

1910.134(h)(3)(i)(A)

All respirators used in routine situations shall be inspected before each use and during cleaning;

1910.134(h)(3)(i)(B)

All respirators maintained for use in emergency situations shall be inspected at least monthly and in accordance with the manufacturer's recommendations, and shall be checked for proper function before and after each use; and

1910.134(h)(3)(i)(C)

Emergency escape-only respirators shall be inspected before being carried into the workplace for use.

1910.134(h)(3)(ii)

The employer shall ensure that respirator inspections include the following:

1910.134(h)(3)(ii)(A)

A check of respirator function, tightness of connections, and the condition of the various parts including, but not limited to, the facepiece, head straps, valves, connecting tube, and cartridges, canisters or filters; and

1910.134(h)(3)(ii)(B)

A check of elastomeric parts for pliability and signs of deterioration.

1910.134(h)(3)(iii)

In addition to the requirements of paragraphs (h)(3)(i) and (ii) of this section, self-contained breathing apparatus shall be inspected monthly. Air and oxygen cylinders shall be maintained in a fully charged state and shall be recharged when the pressure falls to 90% of the manufacturer's recommended pressure level. The employer shall determine that the regulator and warning devices function properly.

1910.134(h)(3)(iv)

For respirators maintained for emergency use, the employer shall:

1910.134(h)(3)(iv)(A)

Certify the respirator by documenting the date the inspection was performed, the name (or signature) of the person who made the inspection, the findings, required remedial action, and a serial number or other means of identifying the inspected respirator; and

1910.134(h)(3)(iv)(B)

Provide this information on a tag or label that is attached to the storage compartment for the respirator, is kept with the respirator, or is included in inspection reports stored as paper or electronic files. This information shall be maintained until replaced following a subsequent certification.

1910.134(h)(4)

Repairs. The employer shall ensure that respirators that fail an inspection or are otherwise found to be defective are removed from service, and are discarded or repaired or adjusted in accordance with the following procedures:

1910.134(h)(4)(i)

Repairs or adjustments to respirators are to be made only by persons appropriately trained to perform such operations and shall use only the respirator manufacturer's NIOSH-approved parts designed for the respirator;

1910.134(h)(4)(ii)

Repairs shall be made according to the manufacturer's recommendations and specifications for the type and extent of repairs to be performed; and

1910.134(h)(4)(iii)

Reducing and admission valves, regulators, and alarms shall be adjusted or repaired only by the manufacturer or a technician trained by the manufacturer.

1910.134(i)

Breathing air quality and use. This paragraph requires the employer to provide employees using atmosphere-supplying respirators (supplied-air and SCBA) with breathing gases of high purity.

1910.134(i)(1)

The employer shall ensure that compressed air, compressed oxygen, liquid air, and liquid oxygen used for respiration accords with the following specifications:

1910.134(i)(1)(i)

Compressed and liquid oxygen shall meet the United States Pharmacopoeia requirements for medical or breathing oxygen; and

1910.134(i)(1)(ii)

Compressed breathing air shall meet at least the requirements for Grade D breathing air described in ANSI/Compressed Gas Association Commodity Specification for Air, G-7.1-1989, to include:

1910.134(i)(1)(ii)(A)

Oxygen content (v/v) of 19.5-23.5%;

1910.134(i)(1)(ii)(B)

Hydrocarbon (condensed) content of 5 milligrams per cubic meter of air or less;

1910.134(i)(1)(ii)(C)

Carbon monoxide (CO) content of 10 ppm or less;

1910.134(i)(1)(ii)(D)

Carbon dioxide content of 1,000 ppm or less; and

1910.134(i)(1)(ii)(E)

Lack of noticeable odor.

1910.134(i)(2)

The employer shall ensure that compressed oxygen is not used in atmosphere-supplying respirators that have previously used compressed air.

1910.134(i)(3)

The employer shall ensure that oxygen concentrations greater than 23.5% are used only in equipment designed for oxygen service or distribution.

1910.134(i)(4)

The employer shall ensure that cylinders used to supply breathing air to respirators meet the following requirements:

1910.134(i)(4)(i)

Cylinders are tested and maintained as prescribed in the Shipping Container Specification Regulations of the Department of Transportation (49 CFR part 180);

1910.134(i)(4)(ii)

Cylinders of purchased breathing air have a certificate of analysis from the supplier that the breathing air meets the requirements for Grade D breathing air; and

1910.134(i)(4)(iii)

The moisture content in the cylinder does not exceed a dew point of -50 deg.F (-45.6 deg.C) at 1 atmosphere pressure.

1910.134(i)(5)

The employer shall ensure that compressors used to supply breathing air to respirators are constructed and situated so as to:

1910.134(i)(5)(i)

Prevent entry of contaminated air into the air-supply system;

1910.134(i)(5)(ii)

Minimize moisture content so that the dew point at 1 atmosphere pressure is 10 degrees F (5.56 deg.C) below the ambient temperature;

1910.134(i)(5)(iii)

Have suitable in-line air-purifying sorbent beds and filters to further ensure breathing air quality. Sorbent beds and

filters shall be maintained and replaced or refurbished periodically following the manufacturer's instructions.

1910.134(i)(5)(iv)

Have a tag containing the most recent change date and the signature of the person authorized by the employer to perform the change. The tag shall be maintained at the compressor.

1910.134(i)(6)

For compressors that are not oil-lubricated, the employer shall ensure that carbon monoxide levels in the breathing air do not exceed 10 ppm.

1910.134(i)(7)

For oil-lubricated compressors, the employer shall use a high-temperature or carbon monoxide alarm, or both, to monitor carbon monoxide levels. If only high-temperature alarms are used, the air supply shall be monitored at intervals sufficient to prevent carbon monoxide in the breathing air from exceeding 10 ppm.

1910.134(i)(8)

The employer shall ensure that breathing air couplings are incompatible with outlets for nonrespirable worksite air or other gas systems. No asphyxiating substance shall be introduced into breathing air lines.

1910.134(i)(9)

The employer shall use only the respirator manufacturer's NIOSH-approved breathing-gas containers, marked and maintained in accordance with the Quality Assurance provisions of the NIOSH approval for the SCBA as issued in accordance with the NIOSH respirator-certification standard at 42 CFR part 84.

1910.134(j)

Identification of filters, cartridges, and canisters. The employer shall ensure that all filters, cartridges and canisters used in the workplace are labeled and color coded with the NIOSH approval label and that the label is not removed and remains legible.

1910.134(k)

Training and information. This paragraph requires the employer to provide effective training to employees who are required to use respirators. The training must be comprehensive, understandable, and recur annually, and more often if necessary. This paragraph also requires the employer to provide the basic information on respirators in Appendix D of this section to employees who wear respirators when not required by this section or by the employer to do so.

1910.134(k)(1)

The employer shall ensure that each employee can demonstrate knowledge of at least the following:

1910.134(k)(1)(i)

Why the respirator is necessary and how improper fit, usage, or maintenance can compromise the protective effect of the respirator;

1910.134(k)(1)(ii)

What the limitations and capabilities of the respirator are;

1910.134(k)(1)(iii)

How to use the respirator effectively in emergency situations, including situations in which the respirator malfunctions;

1910.134(k)(1)(iv)

How to inspect, put on and remove, use, and check the seals of the respirator;

1910.134(k)(1)(v)

What the procedures are for maintenance and storage of the respirator;

1910.134(k)(1)(vi)

How to recognize medical signs and symptoms that may limit or prevent the effective use of respirators; and

1910.134(k)(1)(vii)

The general requirements of this section.

1910.134(k)(2)

The training shall be conducted in a manner that is understandable to the employee.

1910.134(k)(3)

The employer shall provide the training prior to requiring the employee to use a respirator in the workplace.

1910.134(k)(4)

An employer who is able to demonstrate that a new employee has received training within the last 12 months that addresses the elements specified in paragraph (k)(1)(i) through (vii) is not required to repeat such training provided that, as required by paragraph (k)(1), the employee can demonstrate knowledge of those element(s). Previous training not repeated initially by the employer must be provided no later than 12 months from the date of the previous training.

1910.134(k)(5)

Retraining shall be administered annually, and when the following situations occur:

1910.134(k)(5)(i)

Changes in the workplace or the type of respirator render previous training obsolete;

1910.134(k)(5)(ii)

Inadequacies in the employee's knowledge or use of the respirator indicate that the employee has not retained the requisite understanding or skill; or

1910.134(k)(5)(iii)

Any other situation arises in which retraining appears necessary to ensure safe respirator use.

1910.134(k)(6)

The basic advisory information on respirators, as presented in Appendix D of this section, shall be provided by the employer in any written or oral format, to employees who wear respirators when such use is not required by this section or by the employer.

1910.134(l)

Program evaluation. This section requires the employer to conduct evaluations of the workplace to ensure that the written respiratory protection program is being properly implemented, and to consult employees to ensure that they are using the respirators properly.

1910.134(l)(1)

The employer shall conduct evaluations of the workplace as necessary to ensure that the provisions of the current written program are being effectively implemented and that it continues to be effective.

1910.134(l)(2)

The employer shall regularly consult employees required to use respirators to assess the employees' views on program effectiveness and to identify any problems. Any problems that are identified during this assessment shall be

corrected. Factors to be assessed include, but are not limited to:

1910.134(l)(2)(i)

Respirator fit (including the ability to use the respirator without interfering with effective workplace performance);

1910.134(l)(2)(ii)

Appropriate respirator selection for the hazards to which the employee is exposed;

1910.134(l)(2)(iii)

Proper respirator use under the workplace conditions the employee encounters; and

1910.134(l)(2)(iv)

Proper respirator maintenance.

1910.134(m)

Recordkeeping. This section requires the employer to establish and retain written information regarding medical evaluations, fit testing, and the respirator program. This information will facilitate employee involvement in the respirator program, assist the employer in auditing the adequacy of the program, and provide a record for compliance determinations by OSHA.

1910.134(m)(1)

Medical evaluation. Records of medical evaluations required by this section must be retained and made available in accordance with 29 CFR 1910.1020.

1910.134(m)(2)

Fit testing.

1910.134(m)(2)(i)

The employer shall establish a record of the qualitative and quantitative fit tests administered to an employee including:

1910.134(m)(2)(i)(A)

The name or identification of the employee tested;

1910.134(m)(2)(i)(B)

Type of fit test performed;

1910.134(m)(2)(i)(C)

Specific make, model, style, and size of respirator tested;

1910.134(m)(2)(i)(D)

Date of test; and

1910.134(m)(2)(i)(E)

The pass/fail results for QLFTs or the fit factor and strip chart recording or other recording of the test results for QNFTs.

1910.134(m)(2)(ii)

Fit test records shall be retained for respirator users until the next fit test is administered.

1910.134(m)(3)

A written copy of the current respirator program shall be retained by the employer.

1910.134(m)(4)

Written materials required to be retained under this paragraph shall be made available upon request to affected employees and to the Assistant Secretary or designee for examination and copying.

1910.134(n)

Effective date. Paragraphs (d)(3)(i)(A) and (d)(3)(i)(B) of this section become effective November 22, 2006.

1910.134(o)

Appendices. Compliance with Appendix A, Appendix B-1, Appendix B-2, Appendix C, and Appendix D to this section are mandatory.

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 71 FR 16672, April 3, 2006; 71 FR 50187, August 24, 2006; 73 FR 75584, Dec. 12, 2008; 76 FR 33606, June 8, 2011]

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Exhibit 14

By Standard Number / 1910.134 App C - OSHA Respirator Medical Evaluation Questionnaire (Mandatory).

- **Part Number:** 1910
 - **Part Number Title:** Occupational Safety and Health Standards
 - **Subpart:** 1910 Subpart I
 - **Subpart Title:** Personal Protective Equipment
 - **Standard Number:** 1910.134 App C
 - **Title:** OSHA Respirator Medical Evaluation Questionnaire (Mandatory).
 - **GPO Source:** e-CFR
-

Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire (Mandatory)

To the employer: Answers to questions in Section 1, and to question 9 in Section 2 of Part A, do not require a medical examination.

To the employee:

Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date: _____
2. Your name: _____
3. Your age (to nearest year): _____
4. Sex (circle one): Male/Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title: _____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):

- a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
- b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).

12. Have you worn a respirator (circle one): Yes/No

If "yes," what type(s): _____

Part A. Section 2. (Mandatory) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you *currently* smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you *ever had* any of the following conditions?

- a. Seizures: Yes/No
- b. Diabetes (sugar disease): Yes/No
- c. Allergic reactions that interfere with your breathing: Yes/No
- d. Claustrophobia (fear of closed-in places): Yes/No
- e. Trouble smelling odors: Yes/No

3. Have you *ever had* any of the following pulmonary or lung problems?

- a. Asbestosis: Yes/No
- b. Asthma: Yes/No
- c. Chronic bronchitis: Yes/No
- d. Emphysema: Yes/No
- e. Pneumonia: Yes/No
- f. Tuberculosis: Yes/No
- g. Silicosis: Yes/No
- h. Pneumothorax (collapsed lung): Yes/No
- i. Lung cancer: Yes/No
- j. Broken ribs: Yes/No
- k. Any chest injuries or surgeries: Yes/No

- I. Any other lung problem that you've been told about: Yes/No
4. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
- a. Shortness of breath: Yes/No
 - b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
 - c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
 - d. Have to stop for breath when walking at your own pace on level ground: Yes/No
 - e. Shortness of breath when washing or dressing yourself: Yes/No
 - f. Shortness of breath that interferes with your job: Yes/No
 - g. Coughing that produces phlegm (thick sputum): Yes/No
 - h. Coughing that wakes you early in the morning: Yes/No
 - i. Coughing that occurs mostly when you are lying down: Yes/No
 - j. Coughing up blood in the last month: Yes/No
 - k. Wheezing: Yes/No
 - l. Wheezing that interferes with your job: Yes/No
 - m. Chest pain when you breathe deeply: Yes/No
 - n. Any other symptoms that you think may be related to lung problems: Yes/No
5. Have you *ever had* any of the following cardiovascular or heart problems?
- a. Heart attack: Yes/No
 - b. Stroke: Yes/No
 - c. Angina: Yes/No
 - d. Heart failure: Yes/No
 - e. Swelling in your legs or feet (not caused by walking): Yes/No
 - f. Heart arrhythmia (heart beating irregularly): Yes/No
 - g. High blood pressure: Yes/No
 - h. Any other heart problem that you've been told about: Yes/No

6. Have you *ever had* any of the following cardiovascular or heart symptoms?

- a. Frequent pain or tightness in your chest: Yes/No
- b. Pain or tightness in your chest during physical activity: Yes/No
- c. Pain or tightness in your chest that interferes with your job: Yes/No
- d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
- e. Heartburn or indigestion that is not related to eating: Yes/No
- d. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you *currently* take medication for any of the following problems?

- a. Breathing or lung problems: Yes/No
- b. Heart trouble: Yes/No
- c. Blood pressure: Yes/No
- d. Seizures: Yes/No

8. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, check the following space and go to question 9:)

- a. Eye irritation: Yes/No
- b. Skin allergies or rashes: Yes/No
- c. Anxiety: Yes/No
- d. General weakness or fatigue: Yes/No
- e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Questions 10 to 15 below must be answered by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

10. Have you *ever lost* vision in either eye (temporarily or permanently): Yes/No

11. Do you *currently* have any of the following vision problems?

- a. Wear contact lenses: Yes/No

b. Wear glasses: Yes/No

c. Color blind: Yes/No

d. Any other eye or vision problem: Yes/No

12. Have you *ever had* an injury to your ears, including a broken ear drum: Yes/No

13. Do you *currently* have any of the following hearing problems?

a. Difficulty hearing: Yes/No

b. Wear a hearing aid: Yes/No

c. Any other hearing or ear problem: Yes/No

14. Have you *ever had* a back injury: Yes/No

15. Do you *currently* have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet: Yes/No

b. Back pain: Yes/No

c. Difficulty fully moving your arms and legs: Yes/No

d. Pain or stiffness when you lean forward or backward at the waist: Yes/No

e. Difficulty fully moving your head up or down: Yes/No

f. Difficulty fully moving your head side to side: Yes/No

g. Difficulty bending at your knees: Yes/No

h. Difficulty squatting to the ground: Yes/No

i. Climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes/No

j. Any other muscle or skeletal problem that interferes with using a respirator: Yes/No

Part B Any of the following questions, and other questions not listed, may be added to the questionnaire at the discretion of the health care professional who will review the questionnaire.

1. In your present job, are you working at high altitudes (over 5,000 feet) or in a place that has lower than normal amounts of oxygen: Yes/No

If "yes," do you have feelings of dizziness, shortness of breath, pounding in your chest, or other symptoms when you're working under these conditions: Yes/No

2. At work or at home, have you ever been exposed to hazardous solvents, hazardous airborne chemicals (e.g., gases, fumes, or dust), or have you come into skin contact with hazardous chemicals: Yes/No

If "yes," name the chemicals if you know them: _____

3. Have you ever worked with any of the materials, or under any of the conditions, listed below:

a. Asbestos: Yes/No

b. Silica (e.g., in sandblasting): Yes/No

c. Tungsten/cobalt (e.g., grinding or welding this material): Yes/No

d. Beryllium: Yes/No

e. Aluminum: Yes/No

f. Coal (for example, mining): Yes/No

g. Iron: Yes/No

h. Tin: Yes/No

i. Dusty environments: Yes/No

j. Any other hazardous exposures: Yes/No

If "yes," describe these exposures: _____

4. List any second jobs or side businesses you have: _____

5. List your previous occupations: _____

6. List your current and previous hobbies: _____

7. Have you been in the military services? Yes/No

If "yes," were you exposed to biological or chemical agents (either in training or combat): Yes/No

8. Have you ever worked on a HAZMAT team? Yes/No

9. Other than medications for breathing and lung problems, heart trouble, blood pressure, and seizures mentioned earlier in this questionnaire, are you taking any other medications for any reason (including over-the-counter

medications): Yes/No

If "yes," name the medications if you know them: _____

10. Will you be using any of the following items with your respirator(s)?

a. HEPA Filters: Yes/No

b. Canisters (for example, gas masks): Yes/No

c. Cartridges: Yes/No

11. How often are you expected to use the respirator(s) (circle "yes" or "no" for all answers that apply to you)?:

a. Escape only (no rescue): Yes/No

b. Emergency rescue only: Yes/No

c. Less than 5 hours *per week*: Yes/No

d. Less than 2 hours *per day*: Yes/No

e. 2 to 4 hours per day: Yes/No

f. Over 4 hours per day: Yes/No

12. During the period you are using the respirator(s), is your work effort:

a. *Light* (less than 200 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of a light work effort are *sitting* while writing, typing, drafting, or performing light assembly work; or *standing* while operating a drill press (1-3 lbs.) or controlling machines.

b. *Moderate* (200 to 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of moderate work effort are *sitting* while nailing or filing; *driving* a truck or bus in urban traffic; *standing while* drilling, nailing, performing assembly work, or transferring a moderate load (about 35 lbs.) at trunk level; *walking* on a level surface about 2 mph or down a 5-degree grade about 3 mph; or *pushing* a wheelbarrow with a heavy load (about 100 lbs.) on a level surface. c. *Heavy* (above 350 kcal per hour): Yes/No

If "yes," how long does this period last during the average shift: _____ hrs. _____ mins.

Examples of heavy work are *lifting* a heavy load (about 50 lbs.) from the floor to your waist or shoulder; working on a loading dock; *shoveling*; *standing* while bricklaying or chipping castings; *walking* up an 8-degree grade about 2 mph; climbing stairs with a heavy load (about 50 lbs.).

13. Will you be wearing protective clothing and/or equipment (other than the respirator) when you're using your respirator: Yes/No

If "yes," describe this protective clothing and/or equipment: _____

14. Will you be working under hot conditions (temperature exceeding 77 deg. F): Yes/No

15. Will you be working under humid conditions: Yes/No

16. Describe the work you'll be doing while you're using your respirator(s):

17. Describe any special or hazardous conditions you might encounter when you're using your respirator(s) (for example, confined spaces, life-threatening gases):

18. Provide the following information, if you know it, for each toxic substance that you'll be exposed to when you're using your respirator(s):

Name of the first toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the second toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

Name of the third toxic substance: _____

Estimated maximum exposure level per shift: _____

Duration of exposure per shift: _____

The name of any other toxic substances that you'll be exposed to while using your respirator:

19. Describe any special responsibilities you'll have while using your respirator(s) that may affect the safety and well-being of others (for example, rescue, security):

[63 FR 1152, Jan. 8, 1998; 63 FR 20098, April 23, 1998; 76 FR 33607, June 8, 2011; 77 FR 46949, Aug. 7, 2012]

UNITED STATES DEPARTMENT OF LABOR

Occupational Safety & Health Administration
200 Constitution Ave NW
Washington, DC 20210

**MAJOR REQUIREMENTS OF OSHA'S
RESPIRATORY PROTECTION STANDARD
29 CFR 1910.134**

MAJOR REQUIREMENTS OF 29 CFR 1910.134

Introduction

- This standard applies to General Industry (Part 1910), Shipyards (Part 1915), Marine Terminals (Part 1917), Longshoring (Part 1918), and Construction (Part 1926).

(a) Permissible Practice

- Paragraph (a)(1) establishes OSHA's **hierarchy of controls** by requiring the use of **feasible engineering controls** as the primary means to control air contaminants. Respirators are required when "effective engineering controls are not feasible, or while they are being instituted."
- Paragraph (a)(2) requires employers to provide employees with respirators that are "applicable and suitable" for the purpose intended "when such equipment is necessary to protect the health of the employee."

(b) Definitions

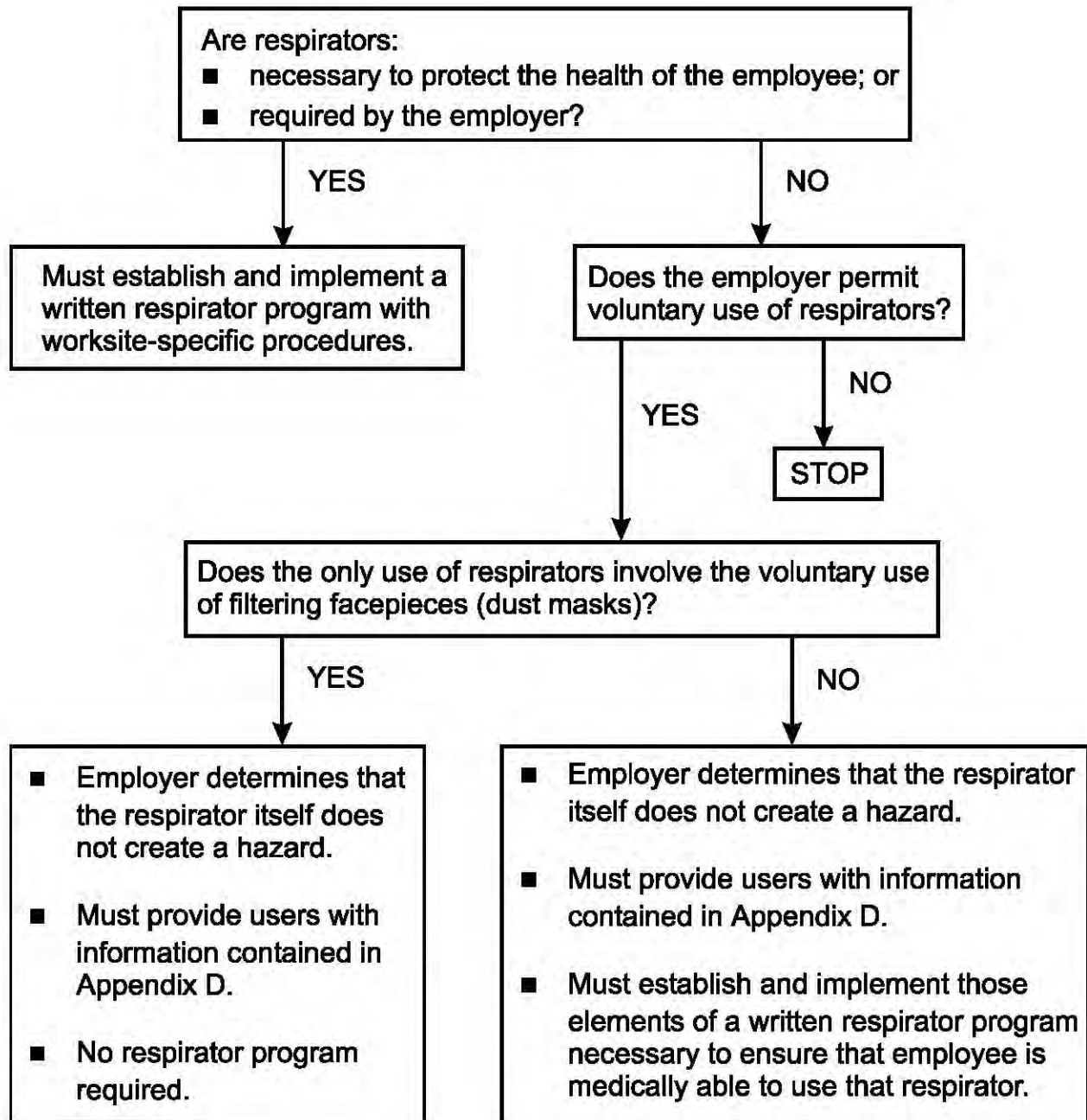
This paragraph contains definitions of important terms used in the regulatory text.

(c) Respiratory Protection Program

- Must designate a **qualified program administrator** to oversee the program.
- Must provide respirators, training, and medical evaluations **at no cost to the employee**.
- OSHA has prepared a *Small Entity Compliance Guide* that contains criteria for selection of a program administrator and a sample program.

Respirator-Use Requirements Flow Chart

29 CFR 1910.134(c)



(d) Selection of Respirators

- Must select a respirator **certified by the National Institute for Occupational Safety and Health (NIOSH)** which must be used in compliance with the conditions of its certification.
- Must identify and evaluate the respiratory hazards in the workplace, including a reasonable estimate of employee exposures and identification of the contaminant's chemical state and physical form.
- Where exposure cannot be identified or reasonably estimated, the atmosphere shall be considered immediately dangerous to life or health (IDLH).
- Respirators for IDLH atmospheres:
 - Approved respirators:
 - full facepiece pressure demand self-contained breathing apparatus (SCBA) certified by NIOSH for a minimum service life of thirty minutes, or
 - combination full facepiece pressure demand supplied-air respirator (SAR) with auxiliary self-contained air supply.
 - All **oxygen-deficient atmospheres (less than 19.5% O₂ by volume)** shall be considered IDLH.

Exception: If the employer can demonstrate that, under all foreseeable conditions, oxygen levels in the work area can be maintained within the ranges specified in Table II (i.e., between 19.5% and a lower value that corresponds to an altitude-adjusted oxygen partial pressure equivalent to 16% oxygen at sea level), then *any* atmosphere-supplying respirator may be used.
- Respirators for non-IDLH atmospheres:
 - Employers must use the **assigned protection factors (APFs)** listed in Table 1 to select a respirator that meets or exceeds the required level of employee protection.
 - When using a combination respirator (e.g., airline respirators with an air-purifying filter), employers must ensure that the assigned protection factor is appropriate to the mode of operation in which the respirator is being used.
 - Must select a respirator for employee use that maintains the employee's exposure to the hazardous substance, when measured outside the respirator, at or below the **maximum use concentration (MUC)**.
 - Must not apply MUCs to conditions that are IDLH; instead must use respirators listed for IDLH conditions in paragraph (d)(2) of this standard.
 - When the calculated MUC exceeds the IDLH level or the performance limits of the cartridge or canister, then employers must set the maximum MUC at that lower limit.
 - The respirator selected shall be appropriate for the chemical state and physical form of the contaminant.

- For protection against gases and vapors, the employer shall provide:
 - an atmosphere-supplying respirator, or
 - an air-purifying respirator, provided that:
 - the respirator is equipped with an **end-of-service-life indicator (ESLI)** certified by NIOSH for the contaminant; or
 - if there is no ESLI appropriate for conditions of the employer's workplace, the employer implements a **change schedule** for canisters and cartridges that will ensure that they are changed before the end of their service life and describes in the respirator program the information and data relied upon and basis for the change schedule and reliance on the data.
- For protection against particulates, the employer shall provide:
 - an atmosphere-supplying respirator; or
 - an air-purifying respirator equipped with high efficiency particulate air (HEPA) filters certified by NIOSH under 30 CFR Part 11 or with filters certified for particulates under 42 CFR Part 84; or
 - an air-purifying respirator equipped with any filter certified for particulates by NIOSH for contaminants consisting primarily of particles with mass median aerodynamic diameters of at least 2 micrometers.

(e) Medical Evaluation

- Must provide a medical evaluation to determine employee's ability to use a respirator, **before fit testing and use.**
- Must identify a **physician or other licensed health care professional (PLHCP)** to perform medical evaluations using a medical questionnaire or an initial medical examination that obtains the same information as the medical questionnaire (information required is contained in mandatory Appendix C).
- Must obtain a **written recommendation** regarding the employee's ability to use the respirator from the PLHCP.
- Additional medical evaluations are required under certain circumstances, e.g.:
 - employee reports medical signs or symptoms related to ability to use respirator;
 - PLHCP, program administrator, or supervisor recommends reevaluation;
 - information from the respirator program, including observations made during fit testing and program evaluation, indicates a need; or
 - change occurs in workplace conditions that may substantially increase the physiological burden on an employee.
- Annual review of medical status is not required.

(f) Fit Testing

- All employees using a **negative or positive pressure tight-fitting facepiece** respirator must pass an appropriate **qualitative fit test (QLFT)** or **quantitative fit test (QNFT)**.
- Fit testing is required prior to initial use, whenever a different respirator facepiece is used, and **at least annually thereafter**. An additional fit test is required whenever the employee reports, or the employer or PLHCP makes visual observations of, changes in the employee's physical condition that could affect respirator fit (e.g., facial scarring, dental changes, cosmetic surgery, or an obvious change in body weight).
- The fit test shall be administered using an OSHA-accepted QLFT or QNFT protocol, as contained in mandatory Appendix A.
 - QLFT Protocols:
 - Isoamyl acetate
 - Saccharin
 - Bitrex
 - Irritant smoke
 - QNFT Protocols:
 - Generated Aerosol (corn oil, salt, DEHP)
 - Condensation Nuclei Counter (PortaCount)
 - Controlled Negative Pressure (Dynatech FitTester 3000)
 - Controlled Negative Pressure (CNP) REDON

- QLFT may only be used to fit test negative pressure air-purifying respirators (APRs) that must achieve a fit factor of 100 or less.
- If the fit factor determined through QNFT is ≥ 100 for tight-fitting half facepieces, or ≥ 500 for tight-fitting full facepieces, the QNFT has been passed with that respirator.

Note: If a particular OSHA standard (e.g., 29 CFR 1910.1001 Asbestos) requires the use of a full facepiece APR capable of providing protection in concentrations up to 50 times the Permissible Exposure Limit (PEL), this respirator must be QNFT. This is because a protection factor of 50 (50 X PEL) multiplied by a standard safety factor of 10 is equivalent to a fit factor of 500.

The safety factor of 10 is used because protection factors in the workplace tend to be much lower than the fit factors achieved during fit testing. The use of a safety factor is a standard practice supported by most experts to offset this limitation. This is discussed in the record at 63 FR 1225.

(g) Use of Respirators

- Tight-fitting respirators shall not be worn by employees who have facial hair or any condition that interferes with the face-to-facepiece seal or valve function.
- Personal protective equipment shall be worn in such a manner that does not interfere with the seal of the facepiece to the face of the user.
- Employees shall perform a user seal check **each time they put on a tight-fitting respirator** using the procedures in mandatory Appendix B-1 or equally effective manufacturer's procedures.
- Procedures for respirator use in IDLH atmospheres are stated. In addition to these requirements, interior structural firefighting requires the use of SCBAs and a protective practice known as "2-in/2-out" — at least two employees must enter and remain in visual or voice contact with one another at all times, and at least two employees must be located outside. (Note that this is not meant to preclude firefighters from performing emergency rescue activities before an entire team has assembled.)

(h) Maintenance and Care of Respirators

Must clean and disinfect respirators using the procedures in Appendix B-2, or equally effective manufacturer's procedures at the following intervals:

- as often as necessary to maintain a sanitary condition for exclusive use respirators,
- before being worn by different individuals when issued to more than one employee, and
- after each use for emergency use respirators **and those used in fit testing and training.**

(i) Breathing Air Quality and Use

Compressed breathing air shall meet the requirements for Type 1-Grade D breathing air as described in ANSI/CGA *Commodity Specification for Air*, G-7.1-1989.

(j) Identification of Filters, Cartridges, and Canisters

- All filters, cartridges, and canisters used in the workplace must be labeled and color coded with the NIOSH approval label.
- The label must not be removed and must remain legible.

(k) Training and Information

- Must provide effective training to respirator users, including:
 - why the respirator is necessary and how improper fit, use, or maintenance can compromise the protective effect of the respirator
 - limitations and capabilities of the respirator
 - use in emergency situations
 - how to inspect, put on and remove, use and check the seals
 - procedures for maintenance and storage
 - recognition of medical signs and symptoms that may limit or prevent effective use
 - general requirements of this standard
- Training required prior to initial use, unless acceptable training has been provided by another employer within the past 12 months.
- **Retraining required annually** and when:
 - workplace conditions change,
 - new types of respirator are used, or
 - inadequacies in the employee's knowledge or use indicates need.

- The basic advisory information in Appendix D shall be provided to employees who wear respirators when their use is not required.

(l) Program Evaluation

Employer must conduct evaluations of the workplace as necessary to ensure proper implementation of the program, and consult with employees to ensure proper use.

(m) Recordkeeping

- Records of medical evaluations must be retained and made available per 29 CFR 1910.1020.
- A record of fit tests must be established and retained until the next fit test.
- A written copy of the current program must be retained.

Exhibit 16

[cdc.gov](https://www.cdc.gov)

Coronavirus Disease 2019

34-43 minutes

CDC Media Briefing 2-25-22



0:00 / 39:17



Operator:

Welcome and thank you for standing by. At this time, all participants are on listen only mode during the Q&A session. If you'd like to ask a question, you may press star one on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. Now I'd like, turn the call over to Mr. Benjamin Hayes. Sir, may begin.

Benjamin Haynes:

Thank you, Ted. And thank you all for joining us for today's COVID 19 update. We're joined by CDC Director, Dr. Rochelle Walensky and Dr. Greta Massetti from the COVID 19 Incident Management Team, both will provide opening remarks before taking your questions. I would now like to turn the call over to Dr. Walensky.

Dr. Walensky:

Thank you, Benjamin and thank you all for joining us today. Today, CDC is updating its framework to monitor the level of COVID 19 and communities. We're in a stronger place today as a nation with more tools to protect ourselves in our communities from COVID 19, like vaccination, boosters, broader access to testing, availability of high quality masks, accessibility to new treatments, and improved ventilation. Over 200 million people have received a primary vaccine series and nearly 100 million have been boosted and millions more have had prior disease. With widespread population immunity, the overall risk of severe disease is now generally lower. Now, as the virus continues to circulate in our communities, we must focus our metrics beyond just cases in the community and direct our efforts toward protecting people at high risk for severe illness and preventing COVID 19 from overwhelming our hospitals and our healthcare systems. This new framework moves beyond just looking at cases and test positivity to evaluate factors that reflect the severity of disease, including hospitalizations and hospital capacity, and helps to determine whether the level of COVID 19 and severe disease are low, medium, or high in a community.

Dr. Walensky:

The COVID 19 community level we are releasing today will inform CDC recommendations on prevention measures like masking and CDCs recommendations for layer prevention measures, and will depend on the COVID 19 level in the community. This updated approach focuses on directing our prevention efforts towards protecting people at high risk for severe illness and preventing hospitals and healthcare systems from being overwhelmed. To find your community level, we are

updating the CDC's website to reflect this framework. So people will be able to go to www.cdc.gov or call 1-800-CDC-INFO to find your community level and what prevention strategies are recommended, including where or when to mask. Please remember that there are people who remain at higher risk for COVID 19 and who may need additional protection. Those who are immunocompromised or have underlying health conditions, those who have disabilities, or those who live with people who are at risk. Those people might choose to take extra precautions regardless of what level their community is in. So with that, I'm going to turn things over now to Dr. Greta Massetti, who will walk us through this framework and the science behind it. Thank you.

Dr. Massetti:

Thank you, Dr. Walensky. The updated metrics in this framework provide a current picture of COVID 19 disease in a community. They also include strong predictors of the potential for strain on the healthcare system. A community's COVID 19 level is determined by a combination of three pieces of information: new hospitalizations for COVID 19, current hospital beds occupied by COVID 19 patients or hospital capacity, and new COVID 19 cases. These metrics will tell us if the level is low, medium, or high. Let me walk you through what we are recommending at each level. Regardless of level, we continue to recommend that people stay up to date on vaccines and get tested if they're sick.

Dr. Massetti:

At the low level, there is limited impact on the healthcare system and low amounts of severe disease in the community. People should stay up to date with their vaccines and get tested if they're sick. At the medium level, more people are experiencing severe disease in the community and they're starting to see more impact on the health healthcare system. At this level, CDC recommends that people who are high risk, such as someone who is immunocompromised, should talk to their healthcare provider about taking additional precautions and may choose to wear a mask. As communities enter into the high level, there is high amount of people experiencing severe disease and high potential for healthcare systems strains. At the high level, CDC recommends that everyone wear a mask indoors, in public, including in schools. Communities can use these metrics, along with their own local metrics, such as wastewater surveillance, emergency department visits, and workforce capacity, to update and further inform their local policies and ensure equity and prevention efforts. And these categories help individuals assess what impacts COVID 19 is having on their community so that they can decide if they need to take extra precautions, including masking based on their location, their health status, and their risk tolerance.

Dr. Massetti:

We should all keep in mind that some people may choose to wear a mask at any time based on personal preference. And importantly, people who wear high quality masks are well protected, even if others around you are not masking. And there are some situations where people should always wear a mask. For example, if they have symptoms, if they tested positive for COVID 19, or if they have been exposed to someone with COVID 19. Today, we're also updating our recommendations for schools. Since July, 2021, CDC recommended universal masking in schools, no matter what level of impact COVID 19 was having on the community. With this update, CDC will now only recommend universal school masking in communities at the high level. Importantly, COVID 19 community levels and public health prevention strategies can be dialed up when our communities

are experiencing more severe disease and dialed down when things are more stable. So what do these updated metrics mean for where we are as a country, as of today, more than half of counties representing about 70% of Americans are in areas with low or medium COVID 19 community levels. This is an increase from about one third of counties at low or medium community levels last week and we continue to see indicators improve in many communities. Thank you. And I will now hand it back to Dr. Walensky.

Dr. Walensky:

Thank you, Dr. Massetti, before we take your questions, I would like to leave you with a few final thoughts. None of us know what the future may hold for us and for this virus and we need to be prepared and we need to be ready for whatever comes next. We wanna give people a break from things like mask wearing when our levels are low and then have the ability to reach for them again, should things get worse in the future. We at CDC will continue to follow the science and epidemiology to make public health recommendations and guidance based on the data. Our new framework was rigorously evaluated both with current data and retrospectively during the Alpha, Delta and Omicron waves and these new metrics have demonstrated predictive capacity for weeks into the future. We will continue to evaluate how well they perform in our communities. This new framework will best way for us to judge what level of preventive measures may be needed in our communities. If or when new variants emerge or the virus surges, we have more ways to control the virus and protect ourselves and our communities than ever before. Thank you. I'll now turn it back over to you, Benjamin.

Benjamin Haynes:

Thank you, Dr. Walensky and thank you, Dr. Massetti. Ted, we are ready to take questions.

Operator:

The phone lines are now open for questions. If you would like to ask a question over the phone, please press star one and record your name. We also ask that you just limit yourself to one follow up question. If you would like to remove your question, please press star two. One moment please. And the first question accused from Dr. Jon LaPook with CBS news, your line is not open.

Dr. Jon LaPook:

Hi, thank you. Thanks for this update and we've heard that, you know, the best mask is the one people will wear, but let's assume somebody's incentivized to wear the best mask they can and they're gonna try to get it well fitted. Can you be more granular about which mask provide the best protection is an N 95, KN-95, KF-94. surgical cloth. What should people who want to protect themselves the most, which of the masks they should be using? Thanks.

Dr. Walensky:

Maybe I'll start with that. Thank you, Dr. LaPook. Of course we've said in our prior masking guide that infiltration are key in those, the N-90-

Dr. Massetti:

It sounds like we might have lost Dr. Walensky. I think what she was noting was that we often have emphasized that fit and filtration are really critical and there are a variety of ways to achieve that.

One way is to use a respirator, um, like an N-95 or a KN 95. They provide good fit and filtration for people, and they provide high protection to the wearer. There are other options as well, including using a surgical mask or a surgical mask layered with a cloth mask. And also we have on our website resources to show people how to knot and tuck the ear loops on mask to improve fit and filtration as well.

Dr. Jon LaPook:

Right, no, of course, we all, thanks. We all see people with wearing just sort of a plain cloth and maybe it's underneath the nose, but I was just wondering if you wanted to emphasize what's the best case scenario for people since, since it just says, wear a mask.

Dr. Massetti:

So CDC recommends that that people should wear the mask that has the best protection and filtration for them and that they will wear consistently.

Dr. Jon LaPook:

Thanks.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Ron Lin with the Los Angeles Times, your line is now open.

Ron Lin:

Hey, I was wondering, can you go into how you came up with the details of the metrics for those three levels and what the science is based off of them in terms of numbers. And where would a place like LA county, which has tied its local mask mandate to CDCs old mask recommendations? Where would they lie? Would they no longer be required to no longer be recommended to wear masks? Thanks.

Dr. Walensky:

I'm back. So maybe I'll get started and pass it over to you, Dr. Massetti, thanks for filling in there. So, one of the things that was really important is we have more and more people and more and more immunity in the population. We wanted to make sure that we were focusing on severe disease because we do want to prevent severe disease. We want to prevent hospitalizations. We want to prevent our hospitals from becoming overwhelmed. So our metrics were really with that in mind, what are severe, how much severe disease is happening, and then to use those metrics to understand, can we find levels where we can predict outcomes in the future where we might be able to act on them now to avert those outcomes in the future. Bad outcomes, like ICU stays, high levels of death. So maybe I'll pass it over now back. So Dr. Massetti to give you more granular detail.

Dr. Massetti:

Great. Thanks so much, Dr. Walensky. So as Dr. Walensky noted, we were really focused on measures of healthcare strain and severe disease. And so we conducted an extensive review of all data systems that are reported to CDC and often available on our website on COVID data tracker.

We reviewed all data sources and really assess them against several criteria, including do they measure severe disease or healthcare strain? How well do they provide data that is available at the local level where it can really inform local decisions? And do we have national coverage for all counties in the United States? And are they reported frequently enough to be able to inform timely decisions? And based on that thorough review, we refined the list and came up with these indicators, including new hospital admissions and hospital beds utilized and complimented them with case incidents to really create a package of metrics to be able to understand happening at the local level.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Drew Armstrong with Bloomberg News, your line is now open.

Drew Armstrong:

Hi, Drew Armstrong from Bloomberg news. I'm wondering, thinking ahead, are there other COVID metrics or measures that CDC has using or collecting that should be overhauled or refined as we move into whatever this next phase of the pandemic is? And, if so, what are some potential examples of that?

Dr. Walensky:

So we have, we certainly look at comprehensive data and we get a whole stream of data, some that are different by jurisdiction. So for example, we just last week posted our wastewater data, and we anticipate that our wastewater data, while we have 400 sites posted, and that represents about 53 million Americans, that is still focal. And we really want are working to expand that. So we intend to double that over the next month or so. Syndromic surveillance would be another way that we could expand some of these metrics again. As Dr. Massetti said, it's really important as we come up with national metrics that we have coverage from every county, not every county is reporting syndromic surveillance, although we're working to scale that up as well. So we have on our eye on many different metrics, which is why we hope that these metrics that we're releasing today will be very helpful for policy makers, but we also hope that local jurisdictions will take into account all the information that's available to them.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Helen Branswell with STAT. Your line is now open.

Helen Branswell:

Hi, thank you very much for taking my question. I know, I think this is gonna be an irritating question, but when you talk about, you know, the metrics about, you know, the percentage of people in hospital beds who are, there because of COVID, is that for COVID or with, I mean, will the with COVID people also be part of those calculations?

Dr. Walenksy:

Helen, that's a great question. We have spent a lot of time thinking about this. And let me tell you sort of where we landed and why. First, we are considering anybody in a hospital bed with COVID, regardless of the reason for admission and that the reason that we landed there is multifold. First many jurisdictions can't differentiate. So that was important for us to recognize and realize. Second, whether or not a patient is admitted with COVID or for COVID, they increase the hospital capacity and they're resource intensive. They require an isolation bed. They require PPE. They probably require a higher staff ratio. And so they are more resource intensive and they do take a COVID bed potentially from someone else. Interestingly, as well, as we have less and less COVID in certain communities, the amount of people who are coming into the hospital with COVID will necessarily decrease.

Dr. Walensky:

We will not have as many people walking around asymptotically because there will just be less disease out there. So increasingly as we have less disease in the community, we anticipate that more of the people who are coming into the hospital are going to be coming in because of COVID. And then finally, as we have even less disease in the community, we anticipate that not every hospital is going to screen every patient for COVID as they walk in the door, especially if we have less and less disease in the community. And when that happens, we won't actually be able to differentiate. In fact, people who are coming in, who are tested will necessarily be coming in for COVID. So for all of those reasons, comprehensively, we decided to say with anybody coming in with a COVID diagnosis.

Helen Branswell:

Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Cheyenne Haslett with ABC News, your line is now open.

Cheyenne Haslett:

Hi, thank you for taking my question. Dr. Walensky can you explain the decision to include schools in the loosening of the mask recommendations? And as a follow up, on public transportation, do you expect that recommendation for masks to expire on March 18th or be extended?

Dr. Walensky:

Um, so maybe I'll take the first, the second question first and then pass the school question to Dr. Massetti. The COVID 19 community levels are intended for communities, they're not intended for our travel quarters, as you note, those expire in the middle of March, and we will be revisiting that in the weeks ahead. And then maybe Dr. Massetti, do you want to take the school question?

Dr. Massetti:

Yes. Thank you, Dr. Walensky. So, we've been reviewing the data on COVID illness in children for two years of a pandemic. And we have seen that although children can get infected and can get sick with COVID, they're more likely to have asymptomatic or mild infections. So fortunately we know that

when schools implement layered prevention strategies, that they can prevent SARS COV-2 two transmission or transmission of the virus that causes COVID 19 in schools. And we know that also because children are relatively at lower risk from severe illness that schools can be safe places for children. And so for that reason, we're recommending that schools use the same guidance that we are recommending in general community settings, which is that we are recommending people wear a mask in high levels of COVID 19. But that, the medium level that the recommendation is primarily based on whether somebody wants to talk to their healthcare provider about whether they're high risk.

Cheyenne Haslett:

Thank you.

Benjamin Haynes:

Next question, please, Ted.

Operator:

Next question is from Allison Aubrey with NPR. Your allow is now open.

Allison Aubrey:

Hi, thanks for taking my question. I'm wondering if the updated page where you're sort of saying the map of this is low, medium or high community, is this being updated with new data all of the time? So it's always up to date? And will this be updated sort of in perpetuity? We know that COVID is not being eradicated. There's talk of, we could see outbreaks at any point in the future. Just talk about sort of those, how actively this is maintained and for how long.

Dr. Walensky:

Thank you, Allison. We intend to keep this updated. Of course, not every county reports every metric every day. So we intend to keep this updated on a weekly cadence. And we intend to do so for the foreseeable future. Of course, this virus has dealt us many a curve balls but for the foreseeable future is what we're looking at right now.

Allison Aubrey:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from John Woolfolk with San Jose Mercury News. Your line is now open.

John Woolfolk:

Hi. So, the new metrics that you all are talking about sound like they're based mostly on the strain on the health bureaucracy and not, I mean, our readers are mostly interested in your guidance for what it means for them to avoid getting COVID and spreading it. And based on the metrics and the rules that were in place as of this morning, before announcement, that would mean like pretty much all of California where we are, "you should wear a mask if you don't want COVID" recommendation. And it

sounds like I haven't seen what your new metric says for our area, but it sounds like it's now saying, well, that's not operative anymore. Go ahead and take the mask off. Is that are people safe going in and around in public indoors without masks in places where your metrics now say it's a high transmission situation?

Dr. Walensky:

Thank you, John. So first and foremost, I'd like to go back to what Dr. Massetti said, which is anybody is certainly welcome to wear a mask at any time, if they feel safer wearing a mask. So we are absolutely endorsing if you feel more comfortable wearing a mask, feel free to do so. And we should encourage people to have that liberty to be able to do so. The intent of these community guidance is to look at really severe disease – people who are coming into the hospital. We know that there's going to be transmission of COVID 19 out there. And what we wanna do is make sure that our hospitals are okay and that people are not coming in with severe disease, but of course, is important to note that the volume of severe disease in the hospital is likely representative of the volume of disease in general in the community. So they are very much linked. Certainly it's also linked to vaccination rate as well, but certainly if people are interested in wearing a mask to feel safer, they certainly can, and anyone can go to the CDC website, find out the volume of disease in their community, and then make that personal decision.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Meg Tirrel with CNBC, your line is now open.

Meg Tirrel:

Well, thank you. I'm just wondering how dependably counties are reporting all of these metrics, particularly with case numbers. Is there enough testing going on for that to be a reliable metric and you know, the same question for the hospitalizations reporting?

Dr. Walensky:

Dr. Massetti? Do you want to take that one?

Dr. Massetti:

Sure. Yeah. So to the question about the hospitalization metrics. So those are actually reported by healthcare facilities. There are 6,000 hospitals in the United States that are required to report those data every day – Monday through Friday. And usually there's better than 95% coverage on any given day. So hospitals are very consistently compliant with reporting those data. We do have very high completion of those data. So we're quite confident that those data are continuing to flow in and reflect what's happening in those hospital. The case data are also largely reported from public health laboratories and have really reflected that the the nucleic acid amplification test results. They do not reflect in many places do not reflect at home tests, which are not reported, but those are the laboratory test results are continuing to be reported fairly consistently.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Catherine Roberts with consumer reports. Your line is now open.

Catherine Roberts:

Thanks for taking my question. I'm wondering, um, to what extent, if at all, um, does this new metric account for people who may have been seriously, um, disabled or sort of long term sick due to like long COVID, but who've never actually been hospitalized with acute COVID, is that factored into this at all?

Dr. Walensky:

Um, it's a good question. We, you know, we're not looking historically about at prior hospitalizations. What we're looking at is, um, hospitalizations now and hospital capacity. Now.

Catherine Roberts:

Is there any way to sort of account for those folks who know the folks who may have gotten a, some kind of disability from COVID, but who aren't, you know, taking up capacity? Is that, is that in the, in the works basically?

Dr. Walensky:

Um, so CDC has many different cohort studies to examine long COVID. We know that this is critically important. The NIH two is examining long COVID, and we are doing this through collaborations with states on survey data, long-term, prospective cohort data, um, and, and, uh, um, hospitalization and, and, uh, data from hospitals as well. So we are looking into this for sure. And, and we know much work in what many studies need to be done for long COVID specifically, but in terms of hospital capacity today to forecast what would happen six weeks from now, um, in our, in our COVID 19 community levels, the, that is not accounted for.

Catherine Roberts:

Okay. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Dave McKinley with w G R Z Buffalo, New York. Your line is not open.

Dave Mckinley:

Yeah. Hi there. I hope you can hear me. Um, you have these, uh, uh, metrics where you would establish whether community was high, uh, medium, uh, subs or high, substantial, moderate low, and there were specific numbers attached had, have those numbers changed in term in determining high or, or substantial or moderate, or are those numbers, you know, where it was fewer than 100, as opposed to fewer than 50, are, are those changing at all? And, and the second part of my question has to do with air airplanes and stuff like the in buses. I, I, you may have addressed that, uh, and I may have missed it.

Dr. Walensky:

Yeah. So first of all, just take the easy one, which is this addresses communities, but not our travel corridors. So nothing will change in our travel corridors. With regards to where we were in our prior community transmission, those were different metrics. They were based on only cases and percent positivity that led us to those, blue, yellow, orange, red. And so cases will still be a part of it, but we need to recognize that, you know, cases we're counting cases differently now than we did, you know, over a year ago when we established those prior metrics. So now our case thresholds is going to be over 200 per hundred thousand, rather than the 100 per hundred thousand

Dave Mckinley:

That's high.

Dr. Walensky:

Again, it's not, yeah, it's not just, well, it's not just cases. It is cases of well as hospitalizations as well as hospital burden. So it's the, it's the, intersection of all of those that leads you to a green, yellow, or orange color in these new metrics.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Erin Garcia with science news. Your line is open.

Erin Garcia:

Hi. Um, thanks for taking my question. I was kind of curious how the method that we're using that you guys are switching to for COVID -19 compares to how we're surveilling for influenza, for instance, did you pull on any of the expertise from how we look at flu or is this completely separate?

Dr. Walensky:

Dr. Masetti, do you wanna take that?

Dr. Masetti:

Sure. Thank you, Dr. Walensky, and thank you for the question. So we talked to a lot of experts in flu surveillance and flu measurement. We have a lot of, wonderful experts both within the, within CDC and outside CDC to really understand kind of what is the future of surveillance for COVID- 19 and what can we learn from and apply from the, um, from the flu model? The metrics that we specifically are relying on here for these COVID- 19 community levels, don't , reflect data that were stood up in summer of 2020, specifically for pandemic response data collection and through the unified hospital data system. So this is really a phenomenal data source that allows us to on a daily basis assess how many new hospitalizations that have been, in, in hospitals for people with confirmed COVID- 19 and the percent hospital capacity, and hospital beds been used by people with COVID- 19. And so that is, that's not a data, that that includes flus, that has not a, a data surveillance system that, that has been used for flu, but we're really interested in expanding and, and also collecting, seeing how this model can also apply to other respiratory illnesses in the future.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Julie Steenhuisen with Reuters. Your line is now open.

Julie Steenhuisen:

Thanks for taking my call. So I'm interested in knowing, like how does the CDC arrive at the conclusion that hospitalization and capacity were the key issues that, you know, we need to focus on now and preventing transmission is less important and, won't this be challenging, to get compliance if there's another variant that comes along, that is more virulent than the one we have now.

Dr. Walensky:

Certainly maybe I'll start with the first, the second question first, and just say, we recognize that we need to be, flexible and to be able to say, we need to be able to relax our, our, layer prevention measures when things are looking up when we have fewer cases in fewer hospitalizations, and then we need to be able to dial them up again, when we might have, should we have a new variant or a new surge? And I think that that's a really important message that we're trying to get across here. What we do know about the current moment, um, with we saw certainly a severity a decreased severity associated with, we had many, many more cases than we had hospitalizations, as we saw than we saw with alpha or Delta. And in that backdrop, we also had much more population immunity by vaccination boosting and, and prior infection. And so many, many of our infections did not result in severe disease. It did not result in, increased hospital capacity. And it was in that context that we made this pivot.

Julie Steenhuisen:

Thank you.

Operator:

Next question is from Meg winger with the Denver post. Your line is open.

Meg Wingerter:

Hello. Thanks for taking my question. I wanted to ask about, so it sounds like for the hospital capacity, you're specifically looking at people hospitalized, um, with COVID. Um, but what we're having in Colorado right now is very low, pretty low at any rate COVID hospitalizations, but are beds are still 90% full any given day. Is there any way you want communities to factor in that overall level of capacity where even a, a smaller surge could be a bigger problem because there's not much left. Thank you.

Dr. Walensky:

Maggie. You actually hit the nail exactly on the head. So not only are we looking at hospital admissions but also hospital capacity, those who are admitted with COVID-19, what fraction of their bed. So if you're at 90% in Colorado that, ou know, we would be taking that exact, uh, parameter into account.

Speaker 19:

Next

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Michael Imani with K O M U. Your line is now,

Micheal Imani:

Hi, how are you? This might be for both of you, but I actually wanted to hear from Dr. Walensky as well. But this is in relation to the new metrics or the new, excuse me, the new, holistic view of risk from coronavirus, to the community. And I was wondering how you guys are making that change. I know you kind of detailed it in your opening, but I was wondering if you can get into specifics with regards to that.

Dr. Walensky:

So thank you. So we are looking at, fraction of hospitalizations that are COVID, we're looking at number of admissions for a hundred thousand, that are COVID. And then we're also looking at cases. And so all three of those together, we have thresholds that we've measured. Then Dr. Massetti has a, has discussed, and we created those thresholds based on their ability to be predictive of, ICU safe hospitalizations and deaths in three to six weeks in the future, so that we could take action. So, all of that work together leads us into three different colors, green, yellow, and orange. Those colors will reflect low, medium, and high community levels, and then those levels get matched to our recommendations and our guidance.

Micheal Imani:

Thank you, doctor. I appreciate it.

Dr. Walensky:

Dr. Massetti, anything, anything to add there?

Dr. Massetti:

No, I think that's a, that covers it really well. Thank you, Dr. Walensky.

Operator:

Thank you. Thank you.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Tom Howell with the Washington times, your line is not open.

Tom Howell:

Hey, thanks for doing the call. Can you give the immediate geographic impact of the guidance? Um, what percentage of counties are in the low category? What percentage are in medium and what percentage are in high? Thank you.

Dr. Walensky:

Dr.Masseti, you have those numbers.

Dr. Masetti:

I do, just right in front of me. So, these are as of, the latest data. 23% of counties are at low, 39.6% of counties are at medium, and 37.3% of counties are at high levels.

Tom Howell:

So all about 37.3 is high, your recommendation is that everyone wear masks in indoor public settings in those places? Is that correct?

Dr. Masetti:

Yes, that's correct.

Benjamin Haynes:

Next question, please.

Operator:

Next question is from Adriana Rodriguez with USA Today. Your line's now open.

Adriana Rodriguez:

Hi, thank you so much for taking my question. I was wondering why, vaccination rates weren't included in these metrics or in this equation to calculate, community COVID risk, and if maybe that will be included in the metrics sometime in the future.

Dr. Walensky:

So, you know, what we're really focused on is risk of severe disease and risk of, being admitted into the hospital risk of your hospitals, becoming full, truly vaccination rates do sort of fall on the causal pathway if you will, for risk of severe disease. So if someone is unvaccinated and has underlying health conditions, they certainly are at high risk of severe disease. And so, it, it is part of the equation. It's not sort of among the things that that's listed, but, certainly it is reflected in who will come into the hospital with severe disease. And, and of course we would always recommend that if you're unvaccinated, you and you're eligible for vaccination, you should get vaccinated. And if you're eligible for boosting, you should get boosted to remain up to date. And that of course would decrease is your risk of hospitalization. In fact, our most recent data have demonstrated that if you are boosted you're 97 times less likely to die of COVID than if you're unvaccinated.

Adriana Rodriguez:

So if, if a person is in one county and the hospitalization rates are the same as another person in another county, but vaccination rates are vastly different, mask guidance would be the same?

Dr. Walensky:

They would.

Adriana Rodriguez:

Thank you.

Benjamin Haynes:

Ted. We have time for two more questions.

Operator:

Okay. The next question is from Stephanie Innes with Arizona Republic, your line is open.

Stephanie Innes:

Uh, yes. Thanks for taking my question. I wanted to know if this framework takes into account people who work in high-risk jobs like grocery stores and restaurants, should they be considering if it's green, they don't need to wear a mask and should businesses think that way as well?

Dr. Walensky:

So certainly all of those all of our recommendations, are translated into policy at the local and jurisdictional level. And we would say any, any, local, business certainly has the, ability to make, recommendations based on or policy based on where they are, whether they have, they may have more information based on wastewater or high risk communities or, or equity for many different, for many different reasons. But, our guidance would say that if you are in a green community, that ,that community in general would not need to be wearing a mask. Certainly of course, anybody can wear a mask at any time if they choose to protect themselves that way.

Stephanie Innes:

Thank you.

Benjamin Haynes:

And the last question, please?

Operator:

Yes. The last question is from Dan Petro with the Chicago Tribune, your line is now open.

Dan Petro:

Can you address, the timing of this decision and perhaps the public perception that, CDC is being pulled along here by the, the governors in, in many states who didn't wait for these new recommendations before making changes to what was being done at the state level?

Dr. Walensky:

Yes, absolutely. First I will say that we at the CDC, and I think you've heard me talk publicly about this, have been thinking about, shifting our metrics to hospitalizations for some time. Now we've been talking about this for some time. Certainly we know that many governors made announcements several weeks ago, but many of those announcements actually were phased in. And in fact, didn't acutely say they were gonna take masks off, but they were going to take masks off at the end of February or in early March or in the middle of March. So ,I would say our guidance actually probably very much intersects exactly where many of those phase approaches are going to be in that many of those governors, when they're, when their, policies are at play, will coincide with exactly what we are recommending.

Benjamin Haynes:

Thank you, Dr. Walensky, and thank you Dr. Massetti. And thank you all for joining us today. If you

have further questions, please contact the media office at 4 0 4 6 3 9 3 2 8 6 or email media@cdc.gov. Thank you.

Operator:

This concludes today's call. Thank you for your participation. May disconnect at this time.

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[U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES](#)

CDC works 24/7 protecting America's health, safety and security. Whether disease start at home or abroad, are curable or preventable, chronic or acute, or from human activity or deliberate attack, CDC responds to America's most pressing health threats. CDC is headquartered in Atlanta and has experts located throughout the United States and the world.

Exhibit 17

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

HEALTH FREEDOM DEFENSE
FUND, INC., ANA CAROLINA
DAZA, and SARAH POPE,

Plaintiffs,

v.

Case No: 8:21-cv-1693-KKM-AEP

JOSEPH R. BIDEN, JR., in his official
capacity as President of the United States,
et al.,

Defendants.

ORDER

As travelers have been reminded for more than a year, federal law requires wearing a mask in airports, train stations, and other transportation hubs as well as on airplanes, buses, trains, and most other public conveyances in the United States. Failure to comply may result in civil and criminal penalties, including removal from the conveyance. This masking requirement—commonly known as the Mask Mandate—is a Centers for Disease Control and Prevention (CDC) regulation published in the Federal Register on February 3, 2021.

In July 2021, Sarah Pope, Ana Daza, and Health Freedom Defense Fund sued various government officials and the CDC, seeking a declaratory judgment that the Mask Mandate was unlawful and to have it set aside for violating the Administrative Procedure Act (APA). Following submission of the administrative record, Defendants—collectively referred to as “the government”—moved for summary judgment on January 18, 2022. (Doc. 45.) As provided in the parties’ agreed briefing schedule, Plaintiffs filed a cross motion for summary judgment on February 17, 2022. (Doc. 48.) The parties completed briefing on March 31, 2022. The cross motions for summary judgment are now ripe for review. The Court concludes that the Mask Mandate exceeds the CDC’s statutory authority and violates the procedures required for agency rulemaking under the APA. Accordingly, the Court vacates the Mandate and remands it to the CDC.

I. BACKGROUND

In December 2019, a highly contagious respiratory virus colloquially known as COVID-19 began spreading throughout the world. A month later, the Secretary of Health and Human Services declared COVID-19 a public health emergency. See *Determination That a Public Health Emergency Exists*, U.S. DEP’T OF HEALTH & HUM. SERVS., <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx> (Jan. 31, 2020). And then on March 13, 2020, President Trump declared the COVID-19 outbreak a national emergency. See *Declaring a National Emergency Concerning the*

Novel Coronavirus Disease (COVID-19) Outbreak, 85 Fed. Reg. 15337, 15337 (Mar. 13, 2020).

COVID-19 continued to spread throughout 2020 despite experiments with “unprecedented movement restrictions and social distancing measures.” (Doc. 30 at 41.) By the end of 2020, approximately twenty million Americans had been infected with COVID-19 and over 360,000 Americans had died from it. See *COVID Data Tracker*, CTRS. FOR DISEASE CONTROL & PREVENTION, <https://covid.cdc.gov/covid-data-tracker/> (last visited Apr. 13, 2022). The fall and winter of 2020 also brought a spike in new COVID-19 infections, due in part to emerging variants of the virus, some of which were more severe than the original strain and more easily transmissible. *Id.*; (Doc. 30 at 12–15). The number of new cases peaked in early January 2021 and decreased steadily in February. See *COVID Data Tracker*, CTRS. FOR DISEASE CONTROL & PREVENTION, https://covid.cdc.gov/covid-data-tracker/#trends_dailycases (last visited Apr. 11, 2022).

On January 21, 2021, one day after taking the oath of office, President Biden issued Executive Order 13998. See *Promoting COVID-19 Safety in Domestic and International Travel*, 86 Fed. Reg. 7205 (Jan. 21, 2021). The Executive Order recognized the threats of the continuing COVID-19 pandemic and reasoned that mask-wearing “can mitigate the risk of travelers spreading COVID-19.” *Id.* at 7205. Accordingly, the Order directed

executive officials to require masks on various forms of transportation and while in transit hubs. *Id.*

Approximately two weeks later, on February 3, 2021, the CDC published the Mask Mandate without allowing public participation through the APA's notice and comment procedures. See Requirement for Persons to Wear Masks While on Conveyances and at Transportation Hubs, 86 Fed. Reg. 8025 (Feb. 3, 2021). As the basis for dispensing with the ordinary APA requirements, the CDC found that "it would be impracticable and contrary to the public's health" to delay the Mandate to seek public comment. *Id.* at 8030. The Mandate also disavowed being a rule under the APA. *Id.*

In the Mandate, the CDC explained that COVID-19 "spreads very easily and sustainably between people who are in close contact." *Id.* at 8028. This spread occurs mainly through the transfer of "respiratory droplets" from one person to another. *Id.* Masks, the CDC found, prevent this spread by "blocking exhaled virus" and "reducing inhalation of these droplets." *Id.* Because COVID-19 can be spread by "pre-symptomatic" and "asymptomatic" individuals infected with it, *id.*, the CDC found that masks are "one of the most effective strategies available for reducing COVID-19 transmission," *id.* at 8026. The Mandate did not differentiate between kinds of masks based on their efficacy at blocking transmission. It simply included a footnote linking to CDC guidance for the "attributes of acceptable masks." *Id.* at 8027 n.6 ("Masks can be either manufactured or

homemade and should be a solid piece of material without slits, exhalation valves, or punctures.”).

The Mask Mandate requires that “a person must wear a mask while boarding, disembarking, and traveling on any conveyance into or within the United States.” *Id.* at 8029. The Mandate’s reach extends to “aircraft[s], train[s], road vehicle[s]”—including ride-sharing services, like Uber—“vessel[s]” and “other means of transport.” *Id.* at 8027. It also applies beyond conveyances to any transportation hub, which includes “any airport, bus terminal, marina, seaport or other port, subway station, terminal . . . , train station, U.S. port of entry, or any other location that provides transportation subject to the jurisdiction of the United States.” *Id.* In addition to the requirement that individuals in these locations wear masks, the Mandate also enlists conveyance operators to police it. It requires operators to use “best efforts” to enforce masking. *Id.* at 8026.

Though broad in scope, the Mandate provides exceptions to limit its coverage based on the person, the conveyance, or the situation. First, the Mandate excludes children under the age of two years old and persons with a disability that prevents them from being able to safely wear a mask. *See id.* at 8027. The latter exception applies only to individuals who cannot wear a mask because of a disability that is within the scope of the Americans with Disabilities Act (ADA). *Id.* Second, it excludes “personal, non-commercial use” of vehicles and commercial vehicles occupied by a single person. *Id.* at 8028. Third, it excludes

situations where, for example, a person must wear an oxygen mask; or is actively “eating, drinking, or taking medication”; or must remove the mask to verify his identity; or to catch his breath after “feeling winded”; or to communicate with someone who is hearing impaired. *Id.* at 8027 & n.7.

Health Freedom Defense Fund, Ana Daza, and Sarah Pope (Plaintiffs) sued to challenge the Mask Mandate on July 12, 2021. (Doc. 1.) Daza and Pope routinely travel by airplane. (Doc. 48-2 at 2; Doc. 48-3 at 2.) Daza has anxiety that is aggravated by wearing masks. (Doc. 48-2 at 3.) Daza alleges that “the government does not recognize [her] anxiety as a basis for a[medical] exemption” from the Mandate. (*Id.*) Similarly, Pope flew regularly before the pandemic, but has done so less since the CDC imposed the Mask Mandate as the “constricted breathing from wearing a mask” provokes or exacerbates her panic attacks. (Doc. 48-3 at 2–3.) Health Freedom Defense Fund is a non-profit organization that “opposes laws and regulations that force individuals to submit to the administration of medical products, procedures, and devices against their will.” (Doc. 48 at 19.) Health Freedom represents the interests of its members who are subject to the Mask Mandate, at least one of whom has alleged harms sufficient to establish standing in her own right. (*Id.* at 21; Doc. 39-4 at 2–4); see *Ga. Republican Party v. SEC*, 888 F.3d 1198, 1203 (11th Cir. 2018) (explaining that an organization may sue on behalf of its members if at least one member has standing). The government “do[es] not dispute that at least

some Plaintiffs have Article III standing to challenge the CDC’s transportation mask order” because it “imposes a legal obligation on the individual Plaintiffs to wear masks when using public transportation.” (Doc. 45 at 44.)

Seeking a declaratory judgment that the Mask Mandate is unlawful and to have it set aside under the APA, Plaintiffs sued President Joseph Biden, Secretary of Health and Human Services Xavier Becerra, CDC Director Rochelle Walensky, and Director of the CDC’s Division of Global Migration and Quarantine Martin Cetron, all in their official capacities. Plaintiffs also sued the CDC and the United States of America.

II. LEGAL STANDARD

Summary judgment is appropriate if “there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law.” FED. R. CIV. P. 56(a). A fact is “material” if it could change the outcome of the litigation. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). And a dispute is “genuine” if a reasonable finder of fact could conclude for the nonmoving party. *Id.*

The APA requires that reviewing courts “hold unlawful and set aside agency action” that is “arbitrary” or “capricious”; “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right”; or that was issued “without observance of procedure required by law.” 5 U.S.C. § 706. In a case reviewing agency action, “[t]he ‘entire case’ on review is a question of law” and “the district judge sits as an appellate tribunal.” *Am.*

Bioscience, Inc. v. Thompson, 269 F.3d 1077, 1083 (D.C. Cir. 2001) (Silberman, J.).

“Summary judgment serves as ‘the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA standard of review.’” *O.A. v. Trump*, 404 F. Supp. 3d 109, 125 (D.D.C. 2019) (quotation omitted). If a plaintiff “prevails on its APA claim,” the “relief under that statute normally will be a vacatur of the agency’s order.” *Am. Bioscience*, 269 F.3d at 1084.

III. ANALYSIS

Plaintiffs’ Amended Complaint challenges the CDC’s Mask Mandate on several grounds. (Doc. 39.) It alleges that the Mandate exceeds the CDC’s statutory authority (Count I). In the alternative it alleges that, if the Mandate is statutorily authorized, Congress improperly delegated its legislative power to the CDC (Count IV). The Amended Complaint further alleges that the CDC improperly invoked the good cause exception to avoid the notice and comment procedures required under the APA (Count II). Finally, it alleges that the Mandate violates the APA because it is arbitrary and capricious (Count III).

Although Plaintiffs initially challenged the lawfulness of President Biden’s January 21, 2021 Executive Order in Counts V and VI, they withdrew these claims in their motion for summary judgment. (Doc. 48 at 11 n.1.) With that withdrawal, President Biden is due to be terminated as a Defendant to this action. (Doc. 45 at 47 n.13.)

The Court proceeds to discuss Plaintiffs' remaining claims.

A. The Mask Mandate Exceeds the CDC's Authority under the Public Health Services Act

Because “[a]dministrative agencies are creatures of statute,” they “possess only the authority that Congress has provided.” *Nat'l Fed'n of Indep. Bus. v. Dep't of Lab.*, 142 S. Ct. 661, 665 (2022) (per curiam). In issuing the Mask Mandate that requires most “persons to wear masks over the mouth and nose when traveling on any conveyance . . . into or within the United States,” 86 Fed. Reg. at 8026, the Director of the CDC relied on a section of the Public Health Services Act of 1944 (PHSA) for authority, see 42 U.S.C. § 264(a); see also 42 C.F.R. 70.2 (delegating regulatory authority under this statute to the CDC). That provision empowers him to promulgate regulations aimed at “identifying, isolating, and destroying” diseases, *Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs.*, 141 S. Ct. 2485, 2488 (2021) (per curiam):

The [CDC], with the approval of the [Secretary of Health and Human Services], is authorized to make and enforce such regulations as in his judgment are necessary to prevent the introduction, transmission, or spread of communicable diseases from foreign countries into the States or possessions, or from one State or possession into any other State or possession. For purposes of carrying out and enforcing such regulations, the [CDC] may provide for such inspection, fumigation, disinfection, sanitation, pest extermination, destruction of animals or articles found to be so infected or contaminated as to be sources of dangerous infection to human beings, and other measures, as in his judgment may be necessary.

§ 264(a).

Other sections of the PHSA also provide the CDC with a limited power to apprehend, detain, examine, or provide conditions for the release of individuals “coming into a State or possession from a foreign country” or traveling between States but only when the CDC “reasonably believe[s]” that the person is “infected with a communicable disease” and is a “probable source of infection” to others. § 264(b)–(d). In that latter situation, the CDC may detain the individual “if upon examination” he is “found to be infected.” § 264(d)(1).

Since Congress enacted it in 1944, the PHSA has “generally been limited to quarantining infected individuals and prohibiting the import or sale of animals known to transmit disease.” *Ala. Ass’n of Realtors*, 141 S. Ct. at 2487. It “has been rarely invoked.” *Id.* At least until recently. Within the past two years, the CDC has found within § 264(a) the power to shut down the cruise ship industry, stop landlords from evicting tenants who have not paid their rent, and require that persons using public conveyances wear masks. Courts have concluded that the first two of these measures exceeded the CDC’s statutory authority under § 264. See *id.* at 2488–89 (explaining that the eviction moratorium likely exceeded the scope of § 264(a)); *Florida v. Becerra*, 544 F. Supp. 3d 1241, 1272 (M.D. Fla. 2021) (Merryday, J.) (reasoning that the CDC’s conditional sail order exceeded the CDC’s statutory authority under § 264(a)). No court has yet ruled on the legality of the third. At first blush, it appears more closely related to the powers granted in § 264(a) than

either the stay order or the eviction moratorium. But after rigorous statutory analysis, the Court concludes that § 264(a) does not authorize the CDC to issue the Mask Mandate.

As always when “determining the meaning of a statutory provision,” the Court “look[s] first to its language, giving the words used their ordinary meaning.” *Artis v. Dist. of Columbia*, 138 S. Ct. 594, 603 (2018) (quotation omitted). The opening sentence of § 264(a) grants the CDC power to issue regulations that “in [its] judgment are necessary” to prevent the spread of communicable disease. The second sentence “informs the grant of authority by illustrating the kinds of measures that could be necessary: inspection, fumigation, disinfection, sanitation, pest extermination, and destruction of contaminated animals and articles.” *Ala. Ass’n of Realtors*, 141 S. Ct. at 2488. In other words, “the second sentence narrows the scope of the first.” *Tiger Lily, LLC v. U.S. Dep’t of Hous. & Urb. Dev. (Tiger Lily II)*, 5 F.4th 666, 670 (6th Cir. 2021).

Thus, if § 264(a) authorizes the Mask Mandate, the power to do so must be found in one of the actions enumerated in the second sentence. *See id.* at 671 (reaching the same conclusion as to the eviction moratorium); *accord Becerra*, 544 F. Supp. 3d at 1268. That sentence provides for “inspection, fumigation, disinfection, sanitation, pest extermination, destruction . . . and other measures.” § 264(a). A requirement that individual travelers wear a mask is not inspection, fumigation, disinfection, destruction, or pest extermination, and the government does not contend otherwise. (Doc. 50 at 7.) Instead, it argues that the

Mask Mandate is a “sanitation” measure or an “other measure” akin to sanitation. *See Tiger Lily II*, 5 F.4th at 671 (explaining that the residual clause “other measure” “encompasses measures that are similar to inspection, fumigation, destruction of animals, and the like”); *see also Cir. City Stores, Inc. v. Adams*, 532 U.S. 105, 115 (2001) (explaining that a residual clause is “controlled and defined by reference to the enumerated categories . . . which are recited just before it”). Plaintiffs disagree, arguing that a mask requirement is outside the scope of sanitation. (Doc. 48 at 25.)

The PHSA does not define “sanitation.” If “a term goes undefined in a statute, [courts] give the term its ordinary meaning.” *Taniguchi v. Kan Pac. Saipan, Ltd.*, 566 U.S. 560, 566 (2012). Courts often start with dictionaries. Given that the statute was enacted in 1944, the Court looks to dictionaries from the early and mid-20th century to begin its analysis. They provide two senses of sanitation that are relevant here. First, sanitation may refer to measures that clean something or that remove filth, such as trash collection, washing with soap, incineration, or plumbing. *See* WEBSTER’S NEW INT’L DICTIONARY 2214 (William Allan Neilson et al. eds., 2d ed. 1942) (defining “sanitation” to include “rendering sanitary”); FUNK & WAGNALLS, NEW STANDARD DICTIONARY 2172 (Isaac K. Funk, et al. eds., 1946) (defining “sanitation” as “the removal or neutralization of elements injurious to health”). Second, sanitation may refer to measures that keep something clean. *See* FUNK & WAGNALLS, *supra* at 2172 (the “devising and applying of

measures for preserving and promoting public health”); BERNARD S. MALOY, THE SIMPLIFIED MEDICAL DICTIONARY FOR LAWYERS (2d ed. 1951) (“The use of sanitary measures to preserve health.”). Examples of this sense of sanitation include air filters or barriers, masks, gowns, or other personal protective equipment.¹

Put simply, sanitation as used in the PHSA could have referred to active measures to cleanse something or to preserve the cleanliness of something. While the latter definition would appear to cover the Mask Mandate, the former definition would preclude it.

Accordingly, the Court must determine which of the two senses is the best reading of the statute. See *Calderon v. Witvoet*, 999 F.2d 1101, 1104 (7th Cir. 1993) (Easterbrook, J.) (explaining that “one word may take multiple meanings,” and that choosing between definitions “depends on context”); *Catalyst Pharms., Inc. v. Becerra*, 14 F.4th 1299, 1307–08 (11th Cir. 2021) (selecting from among definitions based on statutory context).

To aid in this statutory interpretation inquiry, dictionaries provide only a helpful starting point. See *Hi-Country Prop. Rts. Grp. v. Emmer*, 304 P.3d 851, 856 (Utah 2013) (Lee, J.) (explaining that dictionary definitions “will often fail to dictate ‘what meaning a

¹ Some dictionaries from the time add a third sense, that of sanitation as relating to the public health. See FUNK & WAGNALLS, *supra* at 2172 (defining sanitation as “the practical application of sanitary science”). This third (and broadest) sense cannot be the meaning of “sanitation” in § 264(a) because it would render the other words—such as inspection, fumigation, and disinfection—superfluous. See *Parker Drilling Mgmt. Servs., Ltd. v. Newton*, 139 S. Ct. 1881, 1890 (2019) (noting that a proposed interpretation would violate the “cardinal principle of interpretation that courts must give effect, if possible, to every clause and word of a statute” (quotations and quotation marks omitted)). Moreover, as the Court discusses below, Congress would have spoken more clearly if it had delegated such unbounded power to the CDC. See *infra* Section III.A.3 (discussing the major questions doctrine).

word *must* bear in a particular context” (quotation omitted)). They give the broad sweep of what a word might mean, but not what it must mean in each context. See ANTONIN SCALIA & BRYAN A. GARNER, *READING LAW: THE INTERPRETATION OF LEGAL TEXTS* 418 (2012) (“Because common words typically have more than one meaning, you must use the context in which a given word appears to determine its aptest, most likely sense.”); accord *Dolan v. U.S. Postal Serv.*, 546 U.S. 481, 486 (2006). To know which meaning Congress selected in § 264—the sense of cleaning or the sense of preserving cleanliness—the Court must rely on the statute’s context, including the surrounding words, the statute’s structure and history, and common usage at the time. See *Food Mktg. Inst. v. Argus Leader Media*, 139 S. Ct. 2356, 2364 (2019) (“In statutory interpretation disputes, a court’s proper starting point lies in a careful examination of the ordinary meaning and structure of the law itself.”). In short, the Court must consider all the traditional tools of statutory interpretation. Based on these methods, the Court concludes that the first sense—that of active cleaning—is the meaning of “sanitation” in § 264(a).

1. Sanitation is Limited to Cleaning Measures

Statutory construction is a search for the ordinary, contemporary meaning of terms in their context. See *Niz-Chavez v. Garland*, 141 S. Ct. 1474, 1480 (2021) (“When called on to resolve a dispute over a statute’s meaning, [courts] normally seek[] to afford the law’s terms their ordinary meaning at the time Congress adopted them.”). The context of

§ 264(a) indicates that “sanitation” and “other measures” refer to measures that clean something, not ones that keep something clean. Wearing a mask cleans nothing. At most, it traps virus droplets. But it neither “sanitizes” the person wearing the mask nor “sanitizes” the conveyance. Because the CDC required mask wearing as a measure to keep something clean—explaining that it limits the spread of COVID-19 through prevention, but never contending that it actively destroys or removes it—the Mask Mandate falls outside of § 264(a). See 86 Fed. Reg. at 8028 (“Masks help prevent people who have COVID-19 . . . from spreading the virus to others.”).

The government would read “sanitation” and “other measures” more broadly. The government defines sanitation as “the promotion of hygiene and prevention of disease by maintenance of sanitary conditions.” (Doc. 45 at 24 (quoting *Sanitation*, MERRIAM-WEBSTER, <https://www.merriam-webster.com/dictionary/sanitation>)). Thus, they are using it in the second sense, that of a preventative measure. Of course, a word “may or may not extend to the outer limits of its definitional possibilities.” *Dolan*, 546 U.S. at 486. Whether it does “depends upon reading the whole statutory text.” *Id.* In the same way, “[w]ords that can have more than one meaning are given content . . . by their surroundings.” *Whitman v. Am. Trucking Ass’n*, 531 U.S. 457, 466 (2001). Thus, even if the government is correct that sanitation may extend to preventative maintenance

measures, and even if masking is a “conventional ‘sanitation’ measure,” (Doc. 45 at 24), there are four reasons to believe it does not extend so far here.

Start with the immediate context. Sanitation travels in company with “inspection, fumigation, disinfection, . . . pest extermination, [and] destruction.” § 264(a). These terms involve measures aimed at “identifying, isolating, and destroying the disease itself.” *Ala. Ass’n of Realtors*, 141 S. Ct. at 2488. And though “sanitation” is “susceptible of multiple and wide-ranging meanings,” it is “given more precise content by the neighboring words with which it is associated.” *United States v. Williams*, 553 U.S. 285, 294 (2008). **What these words have in common is that they involve identifying and eliminating known sources of disease.** See *Tiger Lily, LLC v. U.S. Dep’t of Hous. & Urb. Dev. (Tiger Lily I)*, 992 F.3d 518, 523 (6th Cir. 2021) (summarizing subsection (a) as “government intrusions on property to sanitize and dispose of infected matter”). They do not maintain the status of being “disinfected” or “fumigated.” Instead, they all change an object’s status. **More specifically, they involve the “direct targeting of disease,”** *Ala. Ass’n of Realtors*, 141 S. Ct. at 2488, through “a discrete action,” *Becerra*, 544 F. Supp. 3d at 1264.

So too, “sanitation” and “other measures” must be read in that context. See *Dole v. United Steelworkers of Am.*, 494 U.S. 26, 36 (1990) (“[W]ords grouped in a list should be given related meaning.” (quotation omitted)). Although the government argues for a broader sense of “sanitation”—or at least the sense of sanitation that preserves a state of

cleanliness—many of its own examples involve active cleaning. (Doc. 50 at 9 (offering hand sanitizer and sanitizing wipes as examples of sanitation, both tools that *remove* pathogens and other unwanted disease).) Courts “avoid ascribing to one word a meaning so broad that it is inconsistent with its accompanying words.” *Gustafson v. Alloyd Co.*, 513 U.S. 561, 575 (1995). Thus, though “sanitation” could be defined as maintaining something in a status of good hygiene and preventing disease—as the government’s definitions show—the context here suggests that is not the case. It indicates instead that “sanitation” means changing, not preserving, the status of an object or area by cleaning.

Customary usage at the time agrees. One method to assess the ordinary meaning of a term is to search a database of naturally occurring language. A search returns the desired word as well as its context and, with a sufficient sample size, search results permit inferences on how a word was used. This method is known as corpus linguistics.² The Court here searched the Corpus of Historical American English (COHA)³ to find uses of “sanitation” between 1930 and 1944. Of the 507 results, the most frequent usage of sanitation fit the

² “Corpus linguistics is an empirical approach to the study of language that uses large, electronic databases” of language gathered from sources such as books, magazines, and newspapers. Thomas R. Lee & Stephen C. Mouritsen, *Judging Ordinary Meaning*, 127 YALE L.J. 788, 828 (2018) (footnote omitted) (describing this tool).

³ The COHA corpus is publicly available. See CORPUS OF HISTORICAL AMERICAN ENGLISH, <https://www.english-corpora.org/coha/> (last visited Apr. 12, 2022). It is “the largest structured corpus of historical English.” *Id.* Because Congress enacted the PHSA in 1944, the Court searched for uses of the word “sanitation” and variants like “sanitary” and “sanitize” between 1930 and 1944. The search returned 507 hits, or “concordance lines.”

primary sense described above: a positive act to make a thing or place clean. Common

examples referred to sanitation in the context of garbage disposal, sewage and plumbing, or direct cleaning of a dirty or contaminated object. In contrast, by far the least common usage—hovering around 5% of the data set—was of sanitation as a measure to maintain a status of cleanliness, or as a barrier to keep something clean. And so, the COHA search results are consistent with the contextual clues of the active words surrounding sanitation in § 264(a).

Further contextual clues support this reading. One is the implication of the government’s definition on the surrounding terms. Recall that Congress listed “fumigation” and “disinfection” and “destruction” alongside “sanitation.” § 264(a). If the government is correct that sanitation allows for the CDC’s Mask Mandate because it promotes hygiene and prevents the spread of disease, then the remaining words in § 264(a), such as disinfection and fumigation are unnecessary. Every act necessary to prevent disease spread would be possible under sanitation. It would thus be impossible to give effect “to every clause and word of [the] statute,” *Moskal v. United States*, 498 U.S. 103, 109–10 (1990), because these separate words would all be subsumed under the umbrella of “conventional ‘sanitation’ measure[s],” (Doc. 45 at 24). Such a reading renders most of the second sentence mere surplusage, an untenable result when other interpretations are available. See *United States v. Butler*, 297 U.S. 1, 65 (1936) (“These words cannot be meaningless, else

they would not have been used.”). Instead, sanitation more likely refers—consistent with its most common usage at the time—to acts that remove refuse or debris from an area or object, a reading that preserves independent meaning for the other terms in § 264(a).

The history of § 264 is another clue. As the list of actions suggest, the federal government’s use of the quarantine power has been traditionally limited to localized disease elimination measures applied to individuals and objects suspected of carrying disease. See *Becerra*, 544 F. Supp. 3d at 1263–64 (“[Section 264(a)] codifies the limited regulatory power typical of preventing diseases caused by a discrete item or a person at a major port of entry.”). The federal government’s authority to inspect and quarantine was used to assist States, which held the primary authority to institute public health measures. See *id.* (explaining that the public health power is historically part of state police power). Though the government once conceded that § 264(a) merely “consolidates and codifies” this history, see *id.*, it now finds a power that extends far beyond it to population-wide preventative measures like near-universal mask requirements that apply even in settings with little nexus to interstate disease spread, like city buses and Ubers. Such a definition reverses the import of history as well as the roles of the States and the federal government. See also *Biden v. Missouri*, 142 S. Ct. 647, 652–53 (2022) (per curiam) (considering an agency’s “longstanding litany” of comparable regulations “implementing the relevant

statutory authorities” as evidence of statutory authority). History resists reading the 1944 statute in this manner.

In sum, the context of the nearby words, the contemporary usage, the implications of the government’s definition, and the history of § 264 suggest that “sanitation” and “other measures” like sanitation are far narrower than the government posits.

2. Sanitation is Limited to Property

There is another serious flaw to the masking-as-sanitation argument: subsection (a) does not give the CDC power to act on individuals directly. Reading the statute as a whole shows that it is divided into two parts. See *FDA v. Brown & Williamson Tobacco Corp.*,

529 U.S. 120, 132–33 (2000) (“It is a ‘fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.’” (quoting *Davis v. Mich. Dep’t of Treasury*, 489 U.S. 803, 809 (1989))). The first part, subsection (a), gives the CDC power to directly impose on an individual’s *property* interests. The second part, subsections (b)–(d), gives the CDC power

to directly impose on an individual’s *liberty* interests. See *Tiger Lily I*, 992 F.3d at 522, 524 (dividing the statute in this manner); accord *Tiger Lily II*, 5 F.4th at 670–71; *Skyworks v. Ctrs. for Disease Control & Prevention*, 524 F. Supp. 3d 745, 757–58 (N.D. Ohio 2021) (Calabrese, J.) (same); *Ala Ass’n of Realtors v. U.S. Dep’t of Health and Hum. Servs.*, 539 F. Supp. 3d 29, 38–39, 42 (D.D.C. 2021) (Friedrich, J.) (same). Since the Mask Mandate

regulates an individual's behavior—wearing a mask—it imposes directly on liberty interests, not the property interests contemplated in subsection (a).

This reading is reinforced by three textual observations. First, the titles of subsections (b), (c), and (d) each reference persons, while the title of subsection (a) does not. See § 264(b) (“of individuals”); § 264(c) (“to persons”); § 264(d) (“of persons”); see *Almendarez-Torres v. United States*, 523 U.S. 224, 234 (1998) (explaining that a statute's titles and headings may indicate its meaning); accord *United States v. Bryant*, 996 F.3d 1243, 1258 (11th Cir. 2021) (“Titles are ‘permissible indicators of meaning.’” (quotation omitted)). Far more importantly, the body of subsection (a) focuses on what the CDC may do to objects that may be dangerous to persons, while subsections (b)–(d) are addressed only to the CDC's treatment of individuals.

Second, all the examples in subsection (a)—inspection, fumigation, disinfection, sanitation, pest extermination, and destruction—are words that are not commonly used to describe what one does to a person. Instead, they are tied to “specific, tangible things on which the agency may act.” *Skyworks*, 524 F. Supp. 3d at 758. The only term arguably applicable to persons is “inspection.” But that would undercut any independent meaning given to “examination” in the later subsection. See § 264(d).

Third, the Mask Mandate is more closely related to a power discussed in subsection (b): “conditional release.” § 264(b). The Mandate requires a traveler to do something to

have the privilege of passing a checkpoint and continuing on his journey. In other words, a person may travel “[s]ubject to or dependent on a condition”—namely, that he wear a mask. BLACK’S LAW DICTIONARY (11th ed. 2019) (defining “conditional”); see *id.* (defining “release” to include the “the fact of being freed from restraint or confinement”); WEBSTER’S THIRD INT’L DICTIONARY (1976) (defining “confine” as “to prevent free outward passage or motion of”). That power is not contemplated in subsection (a). It is contemplated in subsection (b), which provides for “the apprehension, detention, or conditional release of individuals.” § 264(b) (emphasis added); see 42 C.F.R. § 70.1 (defining “conditional release” as “temporary supervision” and “monitoring”); see also 42 C.F.R. § 70.5 (explaining that an individual subject to an isolation, quarantine, or conditional release order may travel if the CDC approves of the “precautions . . . taken to prevent the potential transmission or spread of [a] communicable disease”).

The power to conditionally release a person bears similarity to a “provisional pratique,” which allowed “a vessel to enter the port only after completing some narrow and discrete task, typically fumigation of cargo or the like.” *Becerra*, 544 F. Supp. 3d at 1261 (citation omitted). Indeed, the Mandate likens itself to pratique, saying that “conveyance operators operating a conveyance arriving at or departing from a U.S. port of entry must require all persons on board to wear masks for the duration of travel as a condition of controlled free pratique.” 86 Fed. Reg. at 8026. Pratiques apply to vessels and conveyances,

giving “permission for a carrier to enter a U.S. port, disembark, and begin operation under certain stipulated conditions.” 42 C.F.R. § 71.1 (defining “Controlled Free Pratique”). A conditional release does the same for individuals. Both measures grant “clearance” to travel when a person or object “conform[s] to the procedures required” by public health officials. See *U.S. Bulk Carriers, Inc. v. Arguelles*, 400 U.S. 351, 367 n.2 (1971) (White, J., dissenting).

The opposite of conditional release is “detention” or “quarantine.” Anyone who refuses to comply with the condition of mask wearing is—in a sense—detained or partially quarantined by exclusion from a conveyance or transportation hub under authority of the Mask Mandate. They are forcibly removed from their airplane seats, denied boarding at the bus steps, and turned away at the train station doors—all on the suspicion that they will spread a disease. Indeed, the Mask Mandate enlists local governments, airport employees, flight attendants, and even ride-sharing drivers to enforce these removal measures. In short, their freedom of movement is curtailed in a way similar to detention and quarantine. See BLACK’S LAW DICTIONARY (11th ed. 2019) (defining “detention” as “confinement or compulsory delay” and “quarantine,” as the “isolation of a person . . . with a communicable disease or the prevention of such a person . . . from coming into a particular area, the purpose being to prevent the spread of disease”). Neither detention nor

quarantine are contemplated in § 264(a) though—the section the CDC relied upon to issue the Mask Mandate. Instead, they are found in subsections (b)–(d).

As a result, the Mask Mandate is best understood not as sanitation, but as an exercise of the CDC’s power to conditionally release individuals to travel despite concerns that they may spread a communicable disease (and to detain or partially quarantine those who refuse). But the power to conditionally release and detain is ordinarily limited to individuals entering the United States from a foreign country. See § 264(c). Subsection (d) allows for detention of an individual traveling between States only if he is “reasonably believed to be infected” and is actually found “upon examination” to be infected. The Mask Mandate complies with neither of these subsections. It applies to all travelers regardless of their origins or destinations and makes no attempt to sort based on their health. The CDC may not attempt to shoehorn into subsection (a) a power Congress denied it in subsections (c) and (d). As a result, the Mask Mandate exceeds the authority the statute grants the CDC.

The government disagrees, asserting that subsection (a) gives it a power to regulate persons traveling in interstate commerce. For the reasons explained above, the Court is not persuaded. Subsection (a) refers to direct impositions on property, while subsections (b)–(d) contemplate direct restrictions on individual movement. As discussed above, § 264(b)–(d) give the CDC power to directly regulate individuals only if they are traveling into the

United States from abroad or are “reasonably believed to be infected with a communicable disease in a qualifying stage.” § 264(c), (d). The CDC’s Mask Mandate extends to city bus terminals and ride-sharing services, not just to “individuals coming into a State or possession from a foreign country.” § 264(c). And it applies to all persons in an airport, without any finding that “any individual [is] reasonably believed to be infected with [COVID-19].” § 264(d).

3. *Chevron* Deference

Finally, the government invokes *Chevron* deference, arguing that even if its reading of § 264(a) is not the best one, the Court should adopt it anyway. (Doc. 45 at 26–28.) *Chevron* deference requires that courts defer to an agency interpretation of a statute that the agency administers when the statute is ambiguous and the interpretation is reasonable. See *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–44 (1984). But a court defers only if a statute is ambiguous after the court uses all the “traditional tools of statutory construction.” *Id.* at 843 n.9; see *Gen. Dynamics Land Sys., Inc. v. Cline*, 540 U.S. 581, 600 (2004) (explaining that “deference to [an agency’s] statutory interpretation is called for only when the devices of judicial construction have been tried and found to yield no clear sense of congressional intent”). A court may not rest on *Chevron* to avoid rigorous statutory analysis. *Cf. Kisor v. Wilkie*, 139 S. Ct. 2400, 2415 (2019) (“[A] court cannot wave the ambiguity flag just because it found the [statute] impenetrable on first

read.”). As explained above, the statute is not ambiguous. Congress addressed whether the CDC may enact preventative measures that condition the interstate travel of an entire population on adherence to CDC dictates. It may not. So “that is the end of the matter.” *Chevron*, 467 U.S. at 842.

Nor is the government’s interpretation a reasonable one. See *Chevron*, 467 U.S. at 843–44 (equating “reasonable” with the question of whether “the agency’s answer is based on a permissible construction of the statute”). To be reasonable, an interpretation must account for “the specific context in which [the] language is used” and “the broader context of the statute as a whole.” *Robinson v. Shell Oil Co.*, 519 U.S. 337, 341 (1997). The government here advances a reading of “sanitation” that untethers it from the surrounding words and the statutory structure. Such an interpretation “does not merit deference.” *Util. Air Regul. Grp. v. EPA*, 573 U.S. 302, 321 (2014) (finding an agency interpretation unreasonable because it did not fit with the statute’s design and structure). Accordingly, *Chevron* deference does not apply.

But there is an independent bar to the government’s invocation of *Chevron*: the major questions doctrine. The government’s interpretation is untenable because courts “expect Congress to speak clearly” if it assigns decisions “of vast economic and political significance” to an administrative agency. *Ala. Ass’n of Realtors*, 141 S. Ct. at 2489

(quotations and quotation marks omitted). The CDC asserts such a power in the Mask Mandate, but § 264(a) is far from such a grant.

The government interprets “sanitation” and “other measures” to include traditional techniques that impede the spread of disease. (Doc. 45 at 24; Doc. 50 at 7.) One definition it relies upon is even broader, defining “sanitation” as the “applying of measures for preserving and promoting public health.” (*Id.* at 24 n.4 (quoting FUNK & WAGNALLS, *supra* at 2172).) If Congress intended this definition, the power bestowed on the CDC would be breathtaking. And it certainly would not be limited to modest measures of “sanitation” like masks. It would also justify requiring that businesses install air filtration systems to reduce the risks from airborne contagions or install plexiglass dividers between desks or office spaces. So too, a power to improve “sanitation” would easily extend to requiring vaccinations against COVID-19, the seasonal flu, or other diseases. Or to mandatory social distancing, coughing-into-elbows, and daily multivitamins. In short, “the sheer scope of the CDC’s claimed authority under § [264(a)] would counsel against the Government’s interpretation.” *Ala. Ass’n of Realtors*, 141 S. Ct. at 2489.

But arguments about what the CDC might require in the next pandemic or COVID-19 variant are hardly necessary. The power it claims here is sufficient. The government’s interpretation of § 264(a) permits the CDC to impose preventative health measures on sick and healthy individuals alike who have even attenuated connections to

interstate travel. Under this reading of § 264(a), the CDC claims a power to regulate how individuals behave in such diverse places as airplanes, train stations, marinas, and personal vehicles used in ridesharing services across town. See 86 Fed. Reg. at 8028. Along with the power to require that owners, operators, and employees of transit facilities use their best efforts to enforce the CDC's commands on the public. And all this with the threat of civil and criminal penalties—or at a minimum, ejection from the conveyance or transportation hub. See *id.* at 8030 n. 33.

Moreover, as the Mask Mandate acknowledged, it has a significant effect on the economy. The Mandate is a “major rule” under the Congressional Review Act, and an “economically significant regulatory action.” 86 Fed. Reg. at 8030. These labels mean that the Mandate is likely to have either an annual effect of \$100 million or more on the economy, a major increase in consumer prices, or significant adverse effects on the economy. See 5 U.S.C. § 804(2) (defining a “major rule”); Regulatory Planning and Review, Exec. Order No. 12866, 58 Fed. Reg. 51735, 51738 (Oct. 4, 1993) (defining an “economically significant regulatory action”). All told, “[t]his is no ‘everyday exercise of federal power.’” *Nat’l Fed’n of Indep. Bus.*, 142 S. Ct. at 665 (quoting *In re MCP No. 165*, 20 F.4th 264, 272 (6th Cir. 2021) (Sutton, C.J., dissenting from denial of initial hearing en banc)).

The government purports “to discover” this “unheralded power to regulate” how individuals appear and behave in public “in a long-extant statute”—one over seventy years old. *Util. Air Regul. Grp.*, 573 U.S. at 324. Courts greet such discoveries with “a measure of skepticism.” *Id.* To date, this provision has “rarely been invoked—and never before to justify” a mandate that travelers on every form of commercialized travel wear masks. *Ala. Ass’n of Realtors*, 141 S. Ct. at 2487 (explaining that it has “generally been limited to quarantining infected individuals and prohibiting the import or sale of animals known to transmit disease”). Perhaps the most notable use of this statute so far—excluding the last two years, of course—was a decision to ban small turtles due to a risk of salmonella. See *Ban on Sale and Distribution of Small Turtles*, 40 Fed. Reg. 22543 (May 23, 1975); *Louisiana v. Matthews*, 427 F. Supp. 174, 176 (E.D. La. 1977) (upholding the ban). And when Congress passed the statute in 1944 it did so to codify the federal government’s historic role in quarantine—it was not a fount of new power. See *Becerra*, 544 F. Supp. 3d at 1263–64 (“[T]he [PHSA] codifies the limited regulatory power typical of preventing diseases caused by a discrete item or a person at a major port of entry”). This history suggests that the power the government sees in § 264(a) is a mirage.

And yet, in this statute, the CDC finds a power over public health that “was traditionally understood—and still is understood—as a function of state police power.” *Id.*; see *id.* at 1262 & n.23 (collecting sources); *Nat’l Fed’n of Indep. Bus.*, 142 S. Ct. at 668

(Gorsuch, J. concurring) (“Historically, [public health] matters have been regulated at the state level by authorities who enjoy broader and more general governmental powers.”).

Courts often decline to defer to agency interpretations that would “permit[] federal encroachment upon a traditional state power.” *Solid Waste Agency v. U.S. Army Corps of Eng’rs*, 531 U.S. 159, 172–73 (2001). That is so because it is an “ordinary rule of statutory construction that if Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute.” *Will v. Mich. Dep’t of State Police*, 491 U.S. 58, 65 (1989) (quotation marks and citation omitted).

Section 264(a) has no “unmistakably clear” language indicating that Congress intended for the CDC to invade the traditionally State-operated arena of population-wide, preventative public-health regulations. Or that Congress intended to “delegate a decision of such economic and political significance to an agency in so cryptic a fashion” as to tie it to “sanitation.” *Brown & Williamson Tobacco*, 529 U.S. at 160 (rejecting the FDA’s “extremely strained understanding of ‘safety’” that supported its claim to regulate the tobacco industry).

Because it exceeded the authority granted in § 264(a), the Court must “hold unlawful and set aside” the Mask Mandate as an agency action that is “not in accordance with law,” is “in excess of statutory jurisdiction, and “short of statutory right.” 5 U.S.C.

§ 706. Because the Court agrees with Plaintiffs that the Mandate exceeds the CDC's statutory authority, it does not reach Plaintiffs' alternative non-delegation claim.

B. The Mask Mandate Improperly Invoked the Good Cause Exception to Notice and Comment Rulemaking

The APA requires that agencies provide an opportunity for the public to review and comment upon a new rule before it becomes legally binding. See 5 U.S.C. § 553(b). The agency must publish a notice in the Federal Register that includes “reference to the legal authority under which the rule is proposed,” and “either the terms or substance of the proposed rule or a description of the subjects and issues involved.” § 553(b)(2). Following publication, the agency must “give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments.” § 553(c). This comment period must be at least thirty days. See § 553(d). Finally, the “agency must consider and respond to significant comments received during the period for public comment.” *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 96 (2015).

This process is known as “notice and comment.” It “permits interested parties to criticize projected agency action before that action is embedded in a final rule and allows the agency to benefit from the parties’ suggestions.” *Council of S. Mountains, Inc. v. Donovan*, 653 F.2d 573, 580 (D.C. Cir. 1981) (per curiam). It also “attempts to provide a ‘surrogate political process’” to constrain the exercise of legislative power that Congress has delegated to an otherwise “undemocratic and unaccountable rulemaking process.” *Dep't of*

Homeland Sec. v. Regents of the Univ. of Cal., 140 S. Ct. 1891, 1929 n.13 (2020) (Thomas, J., concurring in the judgment in part and dissenting in part).

The CDC did not allow for public participation through notice and comment before issuing the Mask Mandate. Accordingly, promulgation of the Mandate violated the APA unless an exception to the ordinary rulemaking procedure applies. Despite its importance, the APA provides narrow exceptions to notice and comment. Two of those exceptions are

relevant here. The first is when an agency action is not a rule. The second is when the agency properly invokes good cause to forego notice and comment.

1. The Mask Mandate Improperly Invoked the Order and Interpretative Rule Exceptions to Notice and Comment

The APA's notice-and-comment procedures apply only to agency rulemaking, see 5 U.S.C. § 553(b), which is the process of making a rule "of general or particular applicability and future effect," § 551(4)–(5). It does not apply to case-by-case "adjudication," which results in an "order." § 551(6)–(7); see *Neustar, Inc. v. FCC*, 857 F.3d 886, 893–96 (D.C. Cir. 2017) (Sentelle, J.) (explaining the distinction between rules and orders). Nor does it apply to an agency's "interpretative rules" or "general statements of policy," § 553(b), neither of which are binding on the public. See *Perez*, 575 U.S. at 103 (reciting "the longstanding recognition that interpretive rules do not have the force and effect of law").

Although the Mask Mandate itself claims that it is not a rule within the meaning of the APA, see 86 Fed. Reg. at 8030, the government abandoned that untenable position on review. The Mask Mandate is a generally applicable standard “governing conduct and rights.” See *Nat’l Ass’n of Farmworkers Orgs. v. Marshall*, 628 F.2d 604, 620 (D.C. Cir. 1980) (Bazelon, J.). Thus, it is “clearly [a] rule[] subject to the notice and comment procedures required by the APA.” *Id.* Accordingly, the sole question is whether the CDC had “good cause.”

2. The Mask Mandate Improperly Invoked the Good Cause Exception to Notice and Comment Rulemaking

Notice and comment does not apply “when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.” 5 U.S.C. § 553(b)(B). The Mandate invoked this exception to forego notice and comment. So, the Court must determine whether a thirty-day notice-and-comment period was “impracticable, unnecessary, or contrary to the public interest.” *Id.*

This exception “is to be ‘narrowly construed and only reluctantly countenanced.’” *Mack Trucks, Inc. v. EPA*, 682 F.3d 87, 93 (D.C. Cir. 2012) (Brown, J.) (quoting *Util. Solid Waste Activities Grp. v. EPA*, 236 F.3d 749, 754 (D.C. Cir. 2001) (Randolph, J.)); accord *United States v. Dean*, 604 F.3d 1275, 1279 (11th Cir. 2010). It applies only “in

emergency situations” or “where delay could result in serious harm.” *Dean*, 604 F.3d at 1281 (quoting *Jifry v. FAA*, 370 F.3d 1174, 1179 (D.C. Cir. 2004)).

The “onus is on the [agency] to establish” this finding. *Action on Smoking & Health v. Civ. Aeronautics Bd.*, 713 F.2d 795, 801 n.6 (D.C. Cir. 1983) (per curiam); see *U.S. Steel Corp. v. U.S. EPA*, 595 F.2d 207, 213–14 (5th Cir. 1979) (concluding that the agency “failed to show strong enough reasons to invoke” the good cause exception); accord *Missouri*, 142 S. Ct. at 660 (Alito, J., dissenting) (explaining that the agency has the “affirmative burden to show it has good cause”). Specifically, the APA requires that an agency invoking good cause “incorporate[its] finding and a brief statement of reasons” why it believes notice and comment is “impracticable” or “contrary to the public interest.” § 553(b)(B). Courts do not defer to the agency’s conclusion on good cause. See *Mack Trucks*, 682 F.3d at 93. The Court’s review of the CDC’s determination that good cause exists “is limited to ‘the grounds that the agency invoked when it took the action.’” *Regents of the Univ. of Cal.*, 140 S. Ct. at 1907. The Court “may not supply a reasoned basis for the agency’s action that the agency itself has not given.” *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (quotation omitted).

The Mandate asserted that “there [was] good cause to dispense with prior public notice and comment” because—given “the public health emergency caused by COVID-19[—]it would be impracticable and contrary to the public’s health, and by extension the

public's interest, to delay the issuance and effective date of this Order." 86 Fed. Reg. at

8030. This statement, without more, is insufficient to establish good cause to dispense with notice and comment.

The Mandate's explanation—a single conclusory sentence—does not carry its burden to “show strong enough reason to invoke the [good cause] exception.” *U.S. Steel Corp.*, 595 F.2d at 214. “A mere recitation that good cause exists . . . does not amount to good cause.” *Zhang v. Slattery*, 55 F.3d 732, 746 (2d Cir. 1995), *superseded on other grounds by statute*, 8 U.S.C. § 1101(a)(42); *Action on Smoking*, 713 F.2d at 800 (explaining that “[b]ald assertions” are insufficient to show good cause). Nor does it allow the Court to “ensur[e] that [the CDC] engaged in reasoned decisionmaking.” *In re Gateway Radiology Consultants, P.A.*, 983 F.3d 1239, 1263 (11th Cir. 2020) (quoting *Judulang v. Holder*, 565 U.S. 42, 53 (2011)) (explaining that courts may not simply “rubber stamp” agency action).

The only reason the Mandate cites is “the public health emergency caused by COVID-19.” 86 Fed. Reg. at 8030. That is “certainly support [for] the promulgation” of the Mandate, “[b]ut good cause to suspend notice and comment must be supported by more than the bare need [for the] regulations.” *Marshall*, 628 F.2d at 621. And COVID-19 itself does not “always” justify an agency bypassing notice and comment. *Florida v. Dep’t of Health & Hum. Servs.*, 19 F.4th 1271, 1290 (11th Cir. 2021). Instead, the agency must

“identif[y] specific reasons why . . . [there was] good cause for dispensing with the usual notice-and-comment requirements” in the particular “environment” the agency intended to regulate. *Id.* **The Mandate does not do that.**

Nor does the Mandate explain why a delay for public comment was contrary to the public’s interest. Of course, delay—at least thirty days, see § 553(d)—is inherent in public comment. But the APA presupposes that participation from the regulated public produces benefits that outweigh the costs, at least in the ordinary course. *See Nat. Res. Def. Council v. NHTSA*, 894 F.3d 95, 114 (2d Cir. 2018) (“When, as here, the agency argues that its action is in the ‘public interest,’ a court will only agree ‘in the rare circumstances when ordinary procedures—generally presumed to serve the public interest—would in fact harm that interest.” (quoting *Mack Trucks*, 682 F.3d at 95)). **Besides its brief reference to the pandemic, the Mandate makes no effort to explain its reasoning that there was an exceptional circumstance at the time it implemented the rule.**

The Mandate’s terse conclusion contrasts markedly with another regulation that addressed the COVID-19 pandemic and invoked good cause to forgo notice and comment. When the Centers for Medicare and Medicaid Services (CMS) mandated that the staff of healthcare facilities receiving Medicare or Medicaid funding be vaccinated against COVID-19, it provided almost four pages of reasoning (with forty footnotes of supporting sources) on why there was good cause to forego notice and comment. *See Medicare and*

Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, 86 Fed. Reg. 61555, 61583–86 (Nov. 5, 2021). CMS “identified specific reasons” to dispense with notice and comment that it supported with “detailed explanation” on “the urgency presented by the ongoing pandemic, the outbreaks associated with the Delta variant, and the oncoming influenza season.” *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1289–90. CMS also provided an estimated cost in human lives from a delay in issuing the vaccine mandate. *Id.* The Supreme Court concluded that this extensive reasoning properly invoked the good cause exception. *See Missouri*, 142 S. Ct. at 653–54. *But see id.* at 659–60 (Alito, J., dissenting) (reasoning for four Justices that even this explanation of good cause was insufficient). **Unlike the CMS rule, the Mask Mandate mustered a single conclusory sentence to support its invocation of good cause.**

The Mandate fares no better when compared to non-COVID-19-related regulations that invoked good cause. Courts have found longer and more detailed assertions of good cause deficient. *See, e.g., Mack Trucks*, 682 F.3d at 93–96 (concluding that the EPA lacked good cause despite the rule’s four reasons to dispense with notice and comment and eight paragraphs of explanation (citing *Nonconformance Penalties for On-Highway Heavy Heavy-Duty Diesel Engines*, 77 Fed. Reg. 4678, 4680 (Jan. 31, 2012))). **And short or conclusory claims of good cause often fail.** *See, e.g., Sorenson Commc’ns Inc. v. FCC*, 755 F.3d 702, 706–07 (D.C. Cir. 2014) (concluding that an FCC interim order’s one

paragraph of explanation on why delay for notice and comment would cause “fiscal peril” was “simply too scant” because it did not include any factual findings); *Nat’l Venture Cap. Ass’n v. Duke*, 291 F. Supp. 3d 5, 17–19 (D.D.C. 2017) (concluding that DHS’s three paragraphs of explanation on good cause did “not pass muster” (citing International Entrepreneur Rule: Delay of Effective Date, 82 Fed. Reg. 31887, 31888 (July 11, 2017))). The regulations that succeed often contain detailed and careful explanations of the agency’s reasoning. See *Dean*, 604 F.3d at 1277 (concluding that the Attorney General’s multiple reasons for issuing a rule without notice and comment were sufficient (citing Office of the Attorney General; Applicability of the Sex Offender Registration and Notification Act, 72 Fed. Reg. 8894, 8896–97 (Feb. 28, 2007))).

The CDC’s failure to explain its reasoning is particularly problematic here. At the time when the CDC issued the Mandate, the COVID-19 pandemic had been ongoing for almost a year and COVID-19 case numbers were decreasing. (Doc. 48-1 at 2.) This timing undercuts the CDC’s suggestion that its action was so urgent that a thirty-day comment period was contrary to the public interest. So too, the CDC’s delay in issuing the Mandate further undercuts its position. The CDC issued the mandate in February 2021, almost two weeks after the President called for a mandate, eleven months after the President had declared COVID-19 a national emergency, and almost thirteen months since the Secretary of Health and Human Services had declared a public health emergency. This history

suggests that the CDC itself did not find the passage of time particularly serious. See *Nat. Res. Def. Council*, 894 F.3d at 114–15 (explaining that agency delay makes “good cause” more difficult to find). Nor did the CDC explain its reason for the delay. Cf. *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1290 & n.2 (suggesting that delay undermines a good-cause finding but crediting the agency’s explanation for its delay).

To be sure, the CDC needed time to deliberate on its proposed rule. Ordinarily, some of that deliberation occurs during the thirty-day notice-and-comment period. See § 553(d) (requiring at least thirty days). Instead, the CDC here spent approximately two weeks considering and drafting the Mask Mandate after the President called for it. Since an agency need publish only “a description of the subjects and issues involved,” § 553(b)(3), not a complete rule, the CDC and the public’s deliberation process could have partially overlapped. So, providing for notice and comment may have added only another two weeks.

Or the CDC could have issued the Mask Mandate as a binding, interim rule and allowed immediate notice and comment on a final version. See, e.g., *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1277 (explaining that HHS’s “interim rule went into effect immediately” and provided a subsequent opportunity to comment).

Of course, the CDC “was not required to do any of this or to ‘consider all policy alternatives in reaching [its] decision.’” See *Regents of the Univ. of Cal.*, 140 S. Ct. at 1914–15 (quotation omitted). But the availability of these alternatives undermines its

conclusion that it had good cause to forego notice and comment due to the dangers of delay. See *Mid-Tex Elec. Coop., Inc. v. FERC*, 822 F.2d 1123, 1132 (D.C. Cir. 1987) (Ginsburg, J.) (describing the “interim status of the challenged rule [as] a significant factor” in whether the agency had good cause). Even more so since the Mandate does not address why these commonsense approaches—which may have required minimal or no additional delay and certainly would have “allowed interested persons an opportunity to submit their views”—were infeasible or contrary to the public interest. *Kollett v. Harris*, 619 F.2d 134, 145 (1st Cir. 1980).

Finally, the Mandate’s failure to explain is especially troubling because the benefits of public comment were at their zenith. First, the Mandate governs the conduct of private individuals in their daily lives. Section 553(b) ordinarily provides them the opportunity “to participate in the formulation of the rules by which they are to be regulated.” See *Am. Fed’n of Gov’t Emps., AFL-CIO v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981). And the “more expansive the regulatory reach of [agency] rules, of course, the greater the necessity for public comment.” *Id.*

Second, the public has a heightened interest in participating in a regulation that would constrain their choices and actions via threats of civil and criminal penalties. See *United States v. Gavrilovic*, 551 F.2d 1099, 1105 (8th Cir. 1977) (“When the consequence of agency rule making is to make previously lawful conduct unlawful and to impose criminal

sanctions, the balance of these competing policies imposes a heavy burden upon the agency to show public necessity.”). Though the CDC did not “intend to rely primarily on” them, it “reserve[d] the right to enforce [the Mandate] through criminal penalties.” 86 Fed. Reg. at 8030 n.33. Federal statutes provide that an individual who violates or “disregard[s]” regulations issued under § 264 may be fined a thousand dollars, imprisoned for up to a year, or fined and imprisoned. 42 U.S.C. § 271(a). Federal regulations similarly provide for a potential year of imprisonment for violators, but more “strongly encourage[] . . . widespread voluntary compliance,” 86 Fed. Reg. at 8030 n.33, by providing for fines of up to \$100,000 if the violation does not cause a death and up to \$250,000 if it does result in a death. See 42 C.F.R. §§ 70.18, 71.2.

Applying these provisions, DHS protocols provide for a \$500–\$1,000 fine for first-time offenders and \$1,000–\$3,000 for repeat offenders. See *DHS to Increase Civil Penalties for Violations of the Federal Face Mask Requirement*, U.S. DEP’T OF HOMELAND SEC. (Sept. 9, 2021), <https://www.dhs.gov/news/2021/09/09/dhs-increase-civil-penalties-violations-federal-face-mask-requirement>. DHS also clarifies that these penalties are separate from any civil penalties that the FAA may impose for “unruly and unsafe behavior.” *Id.*; see also *FAA Proposes Fines*, FED. AVIATION ADMIN. (May 24, 2021), <https://www.faa.gov/newsroom/faa-proposes-fines-against-5-passengers-allegedly-interfering-flight-attendants> (noting that 1,900 of the 2,500 reports of unruly passenger

behavior between January 1, 2021, and May 24, 2021, involved “passengers refusing to comply with the federal facemask mandate”).

And finally, “[e]specially in the context of health risks, notice and comment procedures assure the dialogue necessary to the creation of reasonable rules.” *Marshall*, 628 F.2d at 621 (describing novel public health measures as “exactly the kind of standard[s] which especially need[] the utmost care in [their] development and exposure to public and expert criticism”).

Despite the public interests involved, the availability of alternatives, and the timing, the Mandate makes no effort to “show the impracticability of affording notice and comment,” *U.S. Steel Corp.*, 595 F.2d at 213, or that doing so was contrary to the public interest. Nor is the Mandate’s invocation of good cause sufficient for the Court to find that the CDC engaged in reasoned decisionmaking when it found good cause.

The government resists this conclusion, arguing that the CDC made a “common-sense finding” based on the record that delaying the Mandate would do real harm because it would lead to increased COVID-19 transmission. (Doc. 45 at 40.) Perhaps so. But, as explained above, the CDC failed to articulate that reasoning or connect its finding—if it did so find—to the record. See *Mid Continent Nail Corp. v. United States*, 846 F.3d 1364, 1380 (Fed. Cir. 2017) (“[Courts] are limited to examining the reasons [the agency] cited

in [the rule] to justify its invocation of good cause.”). The Court may not offer those findings for the agency.

The Court accepts the CDC’s policy determination that requiring masks will limit COVID-19 transmission and will thus decrease the serious illnesses and death that COVID-19 occasions. But that finding by itself is not sufficient to establish good cause.

“If the existence of a communicable disease alone permitted CDC to find ‘good cause,’ [then] CDC would seldom, if ever, need to comply with [notice and comment].” *Becerra*,

544 F. Supp. 3d at 1296–97; *cf. U.S. Steel Corp.*, 595 F.2d at 215 (“Were we to allow the [agency] to prevail on this point we would make the provisions of § 553 virtually unenforceable.”). And the COVID-19 pandemic does not “*always* . . . justify an agency’s bypassing the notice-and-comment process.” *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1290. Far from it. Instead, the agency must—at the very least—“identif[y] specific reasons why in the environment of [the regulation] the ongoing pandemic constituted good cause.” *Id.* The Mandate does not do that.

3. The Mask Mandate’s Failure to Provide Notice and Comment Was Not Harmless Error

When courts review agency action, they apply “the rule of prejudicial error.” 5 U.S.C. § 706. In other words, a court should not “set aside” an agency action unless an administrative error was harmful. *Id.* But that rule applies only “when a mistake of the administrative body is one that clearly had no bearing on the procedure used or the

substance of the decision reached.” *U.S. Steel Corp.*, 595 F.2d at 215 (quotation omitted). And an agency’s “complete failure” to comply with administrative procedures requires only “a minimal showing of prejudice” to defeat a claim of harmless error. *Mid Continent Nail*, 846 F.3d at 1384.

Since the CDC’s failure to use notice and comment here “plainly affected the procedure used, [the Court] cannot assume that there was no prejudice” to Plaintiffs. *U.S. Steel Corp.*, 595 F.2d at 215 (reasoning that failure to provide pre-promulgation notice and comment was prejudicial despite a post-promulgation opportunity for comment). Indeed, “the entire premise of notice-and-comment requirements is that an agency’s decisionmaking may be affected by concerns aired by interested parties.” *Nat. Res. Def. Council v. Wheeler*, 955 F.3d 68, 85 (D.C. Cir. 2020).

As a result, “an utter failure to comply with notice and comment cannot be considered harmless if there is any uncertainty at all as to the effect of that failure.” *Sugar Cane Growers Coop. of Fla. v. Veneman*, 289 F.3d 89, 96 (D.C. Cir. 2002); see also *U.S. Steel Corp.*, 595 F.2d at 215 (“Absence of such prejudice must be clear for harmless error to be applicable.”). Plaintiffs provide at least a “minimal showing” that they were prejudiced by the lack of notice and comment. *Mid Continent Nail*, 846 F.3d at 1384. Specifically, they contest the studies and resources that the CDC relied upon and point to other resources that the CDC did not consider. (Doc. 48 at 44, 48–49.) Plaintiffs Pope and Daza,

as individuals who are at risk of anxiety or panic attacks while wearing masks, were well-positioned to contest the scope of the Mandate’s medical exception. (Doc. 48-2; Doc. 48-3.) And, of course, Plaintiffs could have challenged the CDC’s legal basis for regulating private conduct under the threat of criminal penalties through § 264(a). Thus, Plaintiffs “have presented enough to show that on remand they can mount a credible challenge to the [Mandate] and were thus prejudiced by the absence of an opportunity to do so before” the Mandate was issued. *Util. Solid Waste Activities Grp.*, 236 F.3d at 755.

The government disagrees, asserting that the error was harmless. It “presume[es]” that Plaintiffs’ comments would have “focused primarily” on “dubious assertions” that would not have changed the CDC’s mind. (Doc. 45 at 42.) But the Court does not dole out indulgences for bypassing notice and comment merely because an agency has its mind made up. *Cf. Action on Smoking*, 713 F.2d at 800 (“Bald assertions that the agency does not believe comments would be useful cannot create good cause to forgo notice and comment procedures.”).

The government’s blithe dismissal aside, the Court may not so lightly conclude that public input would have been inconsequential in a rule directly regulating individual conduct. See *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1109 (D.C. Cir. 2014) (Silberman, J.) (“[Courts] have not been hospitable to government claims of harmless error in cases in which the government violated § 553 of the APA by failing to provide notice.”).

“Section 553 is designed to ensure that affected parties have an opportunity to participate in and influence agency decision making at an early stage, when the agency is more likely to give real consideration to alternative ideas.” *U.S. Steel Corp.*, 595 F.2d at 214. The CDC’s decision denied Plaintiffs (and the public) that opportunity to affect the outcome.

But more than outcomes are at stake. Process matters too. Notice and comment requirements “are not mere procedural niceties.” *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1304 (Lagoa, J., dissenting). The “essential purpose” of notice and comment is “to reintroduce public participation and fairness to affected parties after governmental authority has been delegated to unrepresentative agencies.” *Batterton v. Marshall*, 648 F.2d 694, 703 (D.C. Cir. 1980) (Bazelon, J.). The government’s response obscures that. And its behavior denied it. Even aside from Plaintiffs’ showing, that alone is prejudicial error.

Since the CDC issued the Mask Mandate “without observance of procedure required by law,” the Court must “hold [it] unlawful and set [it] aside.” 5 U.S.C. § 706(2); see *Wheeler*, 955 F.3d at 85 (explaining that failure to provide notice and comment “is a fundamental flaw that normally requires vacatur of the rule” (quotation omitted)).

C. The Mask Mandate is Arbitrary and Capricious Because the CDC Failed to Adequately Explain its Reasoning

The APA “sets forth the procedures by which federal agencies are accountable to the public and their actions subject to review by the courts.” *Franklin v. Massachusetts*, 505 U.S. 788, 796 (1992). “It requires agencies engage in ‘reasoned decisionmaking.’” *Regents*

of the Univ. of Cal., 140 S. Ct. at 1905 (quoting *Michigan v. EPA*, 576 U.S. 743, 750 (2015)). When they fail to do so, courts must “set aside” their actions as “arbitrary” or “capricious.” 5 U.S.C. § 706(2).

Plaintiffs raise three arguments on why the Mask Mandate was arbitrary and capricious. First, Plaintiffs argue that the Mandate failed to comply with 42 C.F.R. § 70.2. Second, that the Mandate was substantively unreasonable. And third, that the Mandate failed to adequately explain the CDC’s reasoning. (Doc. 48 at 48–49; Doc. 51 at 13–15.) Because the Court agrees with Plaintiffs that the CDC failed to adequately explain its reasoning, the Court need not address whether the substantive decisions embodied in the Mandate were themselves arbitrary or capricious or whether the Mandate violated 42 C.F.R. § 70.2.

The APA’s arbitrary and capricious review is “narrow.” *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513 (2009) (quotation omitted). The Court may not “substitute its judgment for that of the agency.” *Id.* (quotation omitted). Instead, the Court is limited to ensuring that “an agency’s exercise of discretion [was] both reasonable and reasonably explained.” *Multicultural Media, Telecom & Internet Council v. FCC*, 873 F.3d 932, 937 (D.C. Cir. 2017) (Kavanaugh, J.).

An agency decision is reasonably explained when the agency demonstrates that it engaged in “reasoned decisionmaking.” *Michigan*, 576 U.S. at 750. To do so, “the agency

must examine the relevant data and articulate a satisfactory explanation for its action including a ‘rational connection between the facts found and the choice made.’” *Motor Vehicle Mfrs.*, 463 U.S. at 43 (quoting *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962)). The articulated rationale must also be adequate to explain all major aspects of the decision. See *Regents of the Univ. of Cal.*, 140 S. Ct. at 1907, 1910–12. While courts “uphold a decision of less than ideal clarity if the agency’s path may reasonably be discerned,” they “may not supply a reasoned basis for the agency’s action that the agency itself has not given.” *Motor Vehicle Mfrs. Ass’n*, 463 U.S. at 43 (quotations omitted).

Although a closer question than the failure to properly invoke the good cause exception, the Mask Mandate fails this reasoned-explanation standard. Beyond the primary decision to impose a mask requirement, the Mask Mandate provides little or no explanation for the CDC’s choices. Specifically, the CDC omits explanation for rejecting alternatives and for its system of exceptions. And there are many, such that the overall efficiency of masking on airplanes or other conveyances could reasonably be questioned.

The Mandate does not address alternative (or supplementary) requirements to masking, such as testing, temperature checks, or occupancy limits in transit hubs and conveyances. It also does not explain why all masks—homemade and medical-grade—are sufficient. Nor does it require “social distancing [or] frequent handwashing,” despite finding these effective strategies for reducing COVID-19 transmission. 86 Fed. Reg. at

8026. Of course, the CDC did not need to explore “every alternative device and thought conceivable by the mind of man.” *Vt. Yankee Nuclear Power Corp. v. Nat. Res. Def. Council, Inc.*, 435 U.S. 519, 551 (1978). But an agency “must consider and explain its rejection of ‘reasonably obvious’” or “significant and viable” alternatives. *Nat’l Shooting Sports Found., Inc. v. Jones*, 716 F.3d 200, 215 (D.C. Cir. 2013) (quotations omitted).

Even if these alternatives were not so obvious that the CDC had to explain its decision to reject them, the Mandate fails to explain other significant choices. For example, the Mandate relies on studies explaining that “universal masking” reduces transmission of COVID-19 at the community level. 86 Fed. Reg. at 8028. But the Mandate does not require universal masking. It exempts individuals who are “eating, drinking, or taking medication” and a person who is “experiencing difficulty breathing” or who is “feeling winded.” 86 Fed. Reg. at 8027 & n.7. It also excludes individuals who cannot wear a mask due to an ADA-recognized disability and all children under two years old. See 86 Fed. Reg. at 8027–28 (providing other unexplained exceptions). The Mandate makes no effort to explain why its purposes—prevention of transmission and serious illness—allow for such exceptions. Nor why a two-year-old is less likely to transmit COVID-19 than a sixty-two-year-old. The CDC does not “articulate a satisfactory explanation”—or any explanation at all—“for its action” and fails to include a “rational connection between the facts found and

the choices made.” *Motor Vehicle Mfrs.*, 463 U.S. at 43 (quotation omitted). Instead, it simply announces the exceptions.

The government disagrees, asserting that the CDC is entitled to strong deference on the scientific, medical, and policy issues underlying the Mask Mandate. True enough. Agency decisions on such “line-drawing” questions as whether a newborn or a three-year-old child must wear a mask are entitled to considerable deference. See *Nat’l Shooting Sports Found.*, 716 F.3d at 214. So too, that “wide discretion” applies to the CDC’s decision to limit medical exceptions to the ADA’s definition of disability. *Id.* (quotation omitted). But while the CDC is not required to “identify the optimal threshold,” it is “required to identify the standard and explain its relationship to the underlying regulatory concerns.” *Id.* (quotation omitted).

The same deference-and-explanation formula applies to agency decisions involving scientific uncertainty. When “an agency is obliged to make policy judgments” based on limited data, courts grant substantial deference to agency judgments. *BellSouth Corp. v. FCC*, 162 F.3d 1215, 1221 (D.C. Cir. 1999) (quotation omitted). But courts must still ensure that the agency states its “policy judgment[]” and “go[es] on to identify the considerations it found persuasive” in reaching that judgment. *Id.* (quotation omitted). The CDC did not do that here.

In the same way, agencies “are permitted to rely on their experience in the regulated field” in crafting rules, but only “so long as they explain what their experience is and how that experience informs the agency’s conclusion.” *Nat’l Mining Ass’n v. United Steel Workers*, 985 F.3d 1309, 1322 (11th Cir. 2021). If the CDC relied on its experience in deciding, for example, that an exception for two-year-olds was an acceptable compromise while an extension to three-year-olds would not be, the CDC did not say so. *See id.* (explaining that agencies may rely on their experience unless “the agency fails to actually explain what that experience was and how that experience supports the promulgated regulation”).

In sum, irrespective of whether the CDC made a good or accurate decision, it needed to explain why it acted as it did. *See Regents of the Univ. of Cal.*, 140 S. Ct. at 1907 (noting that agency decisions must be “adequately explained”). Since the CDC did not explain its decision to compromise the effectiveness of its Mandate by including exceptions or its decision to limit those exceptions, the Court cannot conclude that the CDC “articulated a ‘rational connection between the facts found and the choices made.’” *Jifry*, 370 F.3d at 1180 (quotation omitted). And so, the decision is arbitrary and capricious and due to be “set aside” and remanded to the agency. *See* 5 U.S.C. § 706; *Regents of the Univ. of Cal.*, 140 S. Ct. at 1916 (describing remand as the appropriate remedy); *accord Advocs. for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin.*, 429 F.3d 1136,

1151 (D.C. Cir. 2005) (noting that remand with vacatur is “normally warrant[ed]” for inadequately supported agency actions).

The government disagrees, asserting that the CDC must have considered the question of medical exceptions and the age cut-off because it granted some exceptions. (Doc. 45 at 37–38.) This argument understates the agency’s burden.

The agency must consider the essential aspects of the problem and act reasonably, as the government claims that the CDC did. That is necessary, but not sufficient alone. It must also explain its decision with enough particularity that a reviewing court can determine that it used its discretion appropriately. The CDC did not do that. See *Regents of the Univ. of Cal.*, 140 S. Ct. at 1913 (“The fact that there may be a valid reason . . . does not establish that [the agency] considered [it] . . .”). It didn’t even try to explain. And the Court may only consider “the grounds that the agency invoked when it took the action.” *Michigan*, 576 U.S. at 758; see *Regents of the Univ. of Cal.*, 140 S. Ct. at 1909–10 (“An agency must defend its actions based on the reasons it gave when it acted.”). The government may not supply “post hoc’ rationalizations.” *Citizens to Pres. Overton Park, Inc. v. Volpe*, 401 U.S. 402, 419 (1971), abrogated on other grounds by *Califano v. Sanders*, 430 U.S. 99 (1977). So too, the “reviewing court should not attempt itself to make up for . . . deficiencies” in the agency’s explanation of its rule and “may not supply a

reasoned basis for the agency’s action that the agency itself has not given.” *Motor Vehicle Mfrs. Ass’n*, 463 U.S. at 43 (quotation omitted).

Without a contemporaneous explanation, the Court cannot conclude that the CDC “reasonably considered the relevant issues and reasonably explained the decision.” *FEC v. Prometheus Radio Project*, 141 S. Ct. 1150, 1158 (2021). Nor can the Court “ensure that [the CDC] engaged in reasoned decisionmaking.” *Nat’l Mining Ass’n*, 985 F.3d at 1321.

Accordingly, the Mandate is due to be set aside as arbitrary and capricious and “remand[ed] to [the CDC].” *Regents of the Univ. of Cal.*, 140 S. Ct. at 1916.

D. The Mask Mandate is Vacated for Violating the APA

As explained above, the Mask Mandate exceeds the CDC’s statutory authority and violates the APA. Plaintiffs ask the Court to declare it unlawful and set it aside. (Doc. 51 at 16.) This remedy mirrors the relief they sought in their Amended Complaint. (Doc. 39 at 29.) The government argues that Plaintiffs’ relief is limited to a declaratory judgment and, even if other relief is awarded, it should be limited to non-enforcement of the Mask Mandate against Plaintiffs. (Doc. 50 at 25.)

The APA requires that courts “hold unlawful and set aside agency action” that violates the APA or exceeds the agency’s authority. 5 U.S.C. § 706. Courts have long interpreted this provision as authorizing vacatur. Indeed, “vacatur . . . is the ordinary APA remedy.” *Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng’rs*, 781 F.3d 1271,

1290 (11th Cir. 2015) (quotation omitted); accord *Allina Health Servs.*, 746 F.3d at 1110 (describing vacatur as “the normal remedy” for an APA violation); *Advocs. for Highway & Auto Safety*, 429 F.3d at 1151 (“[U]nsupported agency action normally warrants vacatur . . .”). Some judges even reason that the APA mandates vacatur and permits of no other, lesser remedy. See *Checkosky v. SEC*, 23 F.3d 452, 492 (D.C. Cir. 1994) (Randolph, J., separate opinion) (“[O]ur decisions uniformly—and quite firmly—hold that § 706[] requires us to vacate . . .”); accord *Milk Train, Inc. v. Veneman*, 310 F.3d 747, 757 (D.C. Cir. 2002) (Sentelle, J., dissenting) (explaining that remand to the agency without vacatur violates the APA). And vacatur ordinarily applies to the rule generally, not to just the plaintiffs in a suit. See *Nat’l Mining Ass’n v. U.S. Army Corps of Eng’rs*, 145 F.3d 1399, 1409 (D.C. Cir. 1998) (“[W]hen a reviewing court determines that agency regulations are unlawful, the ordinary result is that the rules are vacated—not that their application to the individual petitioners is proscribed.” (quoting *Harmon v. Thornburgh*, 878 F.2d 484, 495 n.21 (D.C. Cir. 1989))); see also *Barr v. Am. Ass’n of Pol. Consultants, Inc.*, 140 S. Ct. 2335, 2351 n.8 (2020) (explaining that, when “a provision [of law] is declared invalid[,]” the invalid provision “cannot be lawfully enforced against others”—not just “against the plaintiff”).

Additionally, the recognized exceptions to vacatur for APA violations do not apply here. In deciding whether to award less-than-vacatur relief, courts frequently consider

(1) “the seriousness of the order’s deficiencies (and thus the extent of doubt whether the agency chose correctly),” and (2) “the disruptive consequences of an interim change that may itself be changed.” *Allied–Signal, Inc. v. U.S. Nuclear Regul. Comm’n*, 988 F.2d 146, 150–51 (D.C. Cir. 1993); see also *Black Warrior Riverkeeper*, 781 F.3d at 1290 (relying on this test). Here, the CDC cannot correct the serious deficiencies on remand nor is the Mask Mandate a rule necessitating a significant administrative winddown period. And, of course, the government never asked for remand to the CDC without vacatur.

While the Court recognizes the criticism about nationwide injunctive relief and admittedly shares some of the skepticism about it, see *Health Freedom Def. Fund, Inc. v. Biden*, __ F. Supp. 3d __, 2021 WL 5416688, at *5 & n.4 (M.D. Fla. 2021) (Mizelle, J.), the weight of authority and judicial practice instructs that vacatur is an appropriate remedy for an APA violation. See, e.g., *Black Warrior Riverkeeper*, 781 F.3d at 1290; *Alabama v. CMS*, 674 F.3d 1241, 1244 (11th Cir. 2012) (per curiam) (affirming the vacatur of an agency rule that violated the APA’s notice-and-comment requirements); *Nat’l Mining Ass’n v. Sec’y of Lab.*, 153 F.3d 1264, 1269 (11th Cir. 1998) (vacating an agency rule for failing to comply with statutory requirements). The government, aside from a single sentence in its response, (Doc. 50 at 25), does not brief the propriety of vacatur. Nor does it address whether an injunction, which is often entered in a preliminary posture, and

vacatur, which follows final judgment, are comparable.⁴ See *Monsanto Co. v. Geertson Seed Farms*, 561 U.S. 139, 165–66 (2010) (describing complete vacatur as a “less drastic remedy” than an injunction); *CMS*, 674 F.3d at 1244–45 (discussing vacatur and an injunction as separate remedies); see also *O.A.*, 404 F. Supp. 3d at 118 (“As a result, vacatur—*i.e.*, nullification—of the Interim Final Rule obviates any need for the issuance of an injunction.”).

There is another, independent reason supporting vacatur: Such relief is necessary to grant complete relief to Plaintiffs. Whatever doubts surround nationwide injunctive relief in general, there is no doubt that an Article III court “may administer complete relief between the parties, even [if] this involves the determination of legal rights which otherwise would not be within the range of its authority.” *Kinney-Coastal Oil Co. v. Kieffer*, 277

U.S. 488, 507 (1928); see also *Trump v. Hawaii*, 138 S. Ct. 2392, 2427 (2018) (Thomas, J., concurring) (explaining that historic equity permitted relief to benefit third parties if it

⁴ The government contends that Plaintiffs are estopped from seeking an injunction because they earlier represented to the Court that they were seeking a declaratory judgment and that the Court relied upon that representation in denying the government’s motion to transfer. (Doc. 50 at 25.) This argument is misplaced. First, the Plaintiffs never sought an injunction in this case, preliminary or otherwise. Second, in denying the government’s motion to transfer, the Court relied on numerous differences between this case and the pro se-prosecuted case pending in a different division within the Middle District of Florida, only one of which highlighted that the plaintiff there had sought a temporary restraining order, a preliminary injunction, and a permanent injunction while Plaintiffs here did not. (Doc. 35 at 8.) Third, after denying the government’s motion to transfer, Plaintiffs filed an Amended Complaint in this case, realleging the relief of a declaratory judgment and to set the Mandate aside. (Doc. 39 at 29.) The Court does not see how—even assuming an injunction and vacatur are identical relief—Plaintiffs are estopped when they sought this very relief in the Amended Complaint and never took any subsequent action that could be deemed a waiver or forfeiture of that kind of relief.

was “merely a consequence of providing relief to the plaintiff”). Stated simply, incidental benefit to non-parties does not deprive Article III courts of exercising their “historic power of equity to provide complete relief” to the plaintiffs before it. *Mitchell v. Robert DeMario Jewelry, Inc.*, 361 U.S. 288, 292 (1960).

And awarding complete relief here requires vacatur. The difficulty of distinguishing the named Plaintiffs from millions of other travelers—both for government actors and the myriad of private companies, individuals, and local governments bound to enforce the Mandate with “best efforts”—almost ensures that a limited remedy would be no remedy at all. How is the ride-sharing driver, flight attendant, or bus driver to know someone is a Plaintiff to this lawsuit with permission to enter mask-free? The identification problem is compounded further for the geographically dispersed members of Health Freedom Defense Fund.⁵ See *Dep’t of Health & Hum. Servs.*, 19 F.4th at 1282 (explaining that “universal relief may be justified where the plaintiffs are dispersed throughout the United States”). There seems to be no adequate assurances that the government can provide that its agents or an unwitting “enforcer” will not violate this Court’s order and deprive Plaintiffs of their relief. Thus, complete vacatur—in addition to being the “ordinary APA remedy,”

⁵ The Court takes judicial notice of the fact that Health Freedom Defense Fund has members throughout the country. See *Health Freedom Def. Fund, Inc. v. Roark*, No. 1:21-cv-406 (D. Idaho Oct. 15, 2021) (challenging an Idaho school mask mandate and alleging that members of the Fund reside in Idaho); *Health Freedom Def. Fund, Inc. v. Reilly*, 2:21-cv-8688 (C.D. Cal. Nov. 3, 2021) (challenging Los Angeles school district’s staff vaccine mandate and alleging that members of the Fund reside in California).

Black Warrior Riverkeeper, 781 F.3d at 1290 (quotation omitted)—is necessary to remedy Plaintiffs’ injury.

IV. CONCLUSION

“It is indisputable that the public has a strong interest in combating the spread of [COVID-19].” *Ala. Ass’n of Realtors*, 141 S. Ct. at 2490. In pursuit of that end, the CDC issued the Mask Mandate. But the Mandate exceeded the CDC’s statutory authority, improperly invoked the good cause exception to notice and comment rulemaking, and failed to adequately explain its decisions. Because “our system does not permit agencies to act unlawfully even in pursuit of desirable ends,” *id.*, the Court declares unlawful and vacates the Mask Mandate.

Accordingly, the following is **ORDERED**:

1. Plaintiffs’ Motion for Summary Judgment (Doc. 48) is **GRANTED** on Counts I, II, and III. Defendants’ Motion for Summary Judgment (Doc. 45) is **DENIED**.
2. The Court **DECLARES UNLAWFUL** and **VACATES** the Mask Mandate, remanding it to the CDC for further proceedings consistent with this order.

3. The Court directs the Clerk to **TERMINATE** President Joseph R. Biden, Jr., as a Defendant to this action, to **ENTER** final judgment in favor of Plaintiffs as prescribed in this order, and to **CLOSE** this case.

ORDERED in Tampa, Florida, on April 18, 2022.


Kathryn Kimball Mizelle
United States District Judge