20-3989

In the

United States Court of Appeals

For the

Second Circuit

DERRICK PALMER, *et al.*,

Plaintiffs-Appellants

vs.

AMAZON.COM, INC., *et al.*,

Defendants-Appellees

On Appeal From the United States District Court
for the Eastern District of New York
Hon. Brian M. Cogan
Case No. 20-cv-2468

BRIEF OF *AMICI CURIAE* OCCUPATIONAL HEALTH PHYSICIANS AND PUBLIC HEALTH EXPERTS IN SUPPORT OF PLAINTIFFS-APPELLANTS

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INTEREST OF *AMICI CURIAE*[1]

Amici curiae, thirteen occupational health physicians and public health experts listed in Appendix A, submit this brief in support of Plaintiffs-Appellants. *Amici* have a continuing interest in ensuring employers take steps to prevent work-related disease outbreaks. They are particularly concerned about the danger the COVID-19 pandemic poses to essential workers in factory or warehouse settings, the disparate rates of death and serious injury from COVID-19 infection for Black and Hispanic Americans, and the public health intersection of workforce occupation and race. Although all Americans are at risk for COVID-19 infection, warehouse workers are at significantly elevated risk of contracting COVID-19 and suffering serious health consequences. In dismissing Plaintiffs-Appellants' claim of public nuisance, the District Court did not consider any of the factors that make warehouse workers and their families particularly susceptible to injury from COVID-19. *Amici* submit this brief to provide their unique medical and public health perspective on the special harm COVID-19 poses in these circumstances.

[1] The parties have consented to the filing of this *amici curiae* brief. *See* Fed. R. App. P. 29(a)(2). No counsel for a party authored this brief in whole or in part and no person or entity, other than *amici curiae* and their counsel, has contributed money to fund the preparation or submission of the brief. *See* Fed. R. App. P. 29(a)(4)(e).

PRELIMINARY STATEMENT

Almost every person in the United States has been affected by the COVID-19 pandemic. Many of us have lost friends or family members to this deadly and contagious virus. All of us have experienced interruptions to our work and social lives. Since the pandemic first hit in early 2020, employers, government officials, and all of us as individuals have had to make changes that balance normalcy and productivity with safety.

While everybody may be at risk of harm from COVID-19, this risk is not shared equally by all members of society. Certain workers are at greater danger than others. As Former Assistant Secretary of Labor for the Occupational Safety and Health Administration Dr. David Michaels noted, this pandemic is "the greatest worker health crisis in recent history."[2] Indeed, for many essential workers, the primary source of COVID-19 exposure has been "their workplace, where workspace design precludes social distancing, personal protective equipment (PPE) is absent or limited, and sanitation and ventilation are inadequate."[3]

This brief examines the harm faced by workers whose jobs put them at increased risk of contracting, spreading, and dying from COVID-19. These

[2] David Michaels & Gregory R. Wagner, *Occupational Safety and Health Administration (OSHA) and Worker Safety During the COVID-19 Pandemic*, 324 JAMA 1389, 1389 (2020), https://doi.org/10.1001/jama.2020.16343.

[3] Michaels & Wagner, *supra* note 2.

workers include those who have jobs that cannot be performed remotely and that require close proximity to other workers, as well as those with inflexible paid sick leave policies. In particular, Black and Hispanic workers face a disproportionate risk of harm because of a number of longstanding structural inequities, including co-morbidities arising from economic and health deprivations, gaps in access to healthcare and paid sick leave, environmentally unsafe and overcrowded housing, and poor educational opportunities that limit career prospects, resulting in overrepresentation in essential jobs and other low-paying service work.

The warehousing industry—including Amazon's JFK8 facility—exhibits all of these features. As a result, it is imperative that warehousing employers adhere to national and local disease control mandates to prevent major workplace outbreaks of COVID-19 and subject employees, their families, and the communities in which they live to grave danger. By failing to examine the public health underpinnings of this risk, the District Court erred in its analysis of whether Plaintiffs-Appellants suffered special damage such that Defendants can be held liable for their creation of a public nuisance.

ARGUMENT

I. Warehouse Workers Are at Particular Risk of Harm from COVID-19.

Warehouse workers—such as those at Amazon's JFK8 facility—are subject to many job conditions that put them at increased COVID-19 risk. Two of these

conditions are particularly notable. First, warehouses contain scores, hundreds, or even thousands of workers, often in cramped or tight spaces, working within high traffic and contained areas consisting of many people working at high work rates (sometimes with exertion) and/or talking at elevated volumes to overcome the din of machinery. As COVID-19 spreads primarily through the airborne route, this creates a hazard for widespread risk of infection to co-workers. Physical distancing necessary to mitigate COVID-19 is also challenging in the warehouse environment. The pace of work in these environments can interfere with hygiene mitigations, such as frequent hand washing, as workers cannot take repeated bathroom breaks to sanitize after every potential exposure. Second, the risk of COVID-19 spread is further elevated if workers in highly congested environments such as warehouses are not easily able to access paid sick leave, resulting in COVID-19 positive employees or their families infecting others.

There are a number of scientifically supported measures warehousing employers can and should adopt to mitigate these risks. To prevent person-to-person spread of COVID-19, employers must allow for workplace social distancing and frequent hand hygiene. In addition, employers must make paid sick leave easily accessible and make clear that it should be used to prevent the spread of illness. These interventions are necessary to ensure warehouses are safe for all workers, family members, and adjacent communities.

A. Warehouses Are Crowded, Making Social Distancing and Hygiene Efforts Paramount.

1. Social Distancing and Hygiene Reduce the Risk of COVID-19 Transmission.

COVID-19 poses a widely disparate workplace threat depending on the job. It has been clear since the start of the pandemic that COVID-19 is an airborne virus which is easily transmitted in closed, crowded, and/or poorly ventilated environments.[4] As a result, many governments, businesses, and other private actors have encouraged "social distancing,"[5] defined by the CDC to mean "keeping a safe space"—at least 6 feet—"between yourself and other people who are not from your household."[6]

Social distancing efforts have been found to be highly successful. One study found that social distancing could have "a great positive impact" on decreasing the

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[4] Lidia Morawska et al., *How Can Airborne Transmission of COVID-19 Indoors Be Minimised?*, 142 ENV'T INT'L (2020), https://doi.org/10.1016/j.envint.2020.105832; Rajesh K. Bhagat et al., *Effects of Ventilation on the Indoor Spread of COVID-19*, 903 J. FLUID MECHS., at F1-15 (2020), https://doi.org/10.1017/jfm.2020.720.

[5] *See, e.g.*, Chanjuan Sun & Zhiqiang Zhai, *The Efficacy of Social Distance and Ventilation Effectiveness in Preventing COVID-19 Transmission*, 62 SUSTAINABLE CITIES & SOC'Y (2020), https://doi.org/10.1016/j.scs.2020.102390 ("Social distancing and ventilation were emphasized broadly to control the ongoing pandemic COVID-19 in confined spaces.").

[6] CDC, *Social Distancing* (Nov. 17, 2020), https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html; *see* CDC, *Guidance for Businesses and Employers Responding to Coronavirus Disease 2019 (COVID-19)* (Jan. 4, 2021), https://www.cdc.gov/coronavirus/2019-ncov/community/guidance-business-response.html (instructing employers how to "[a]lter your workspace to help workers and customers maintain social distancing").

risk of COVID-19 infection.[7] Another found that comprehensive social distancing measures, including workplace distancing, should be effective at preventing COVID-19 transmission.[8] Local government stay-at-home orders have also had a statistically significant impact on the COVID-19 growth rate, demonstrating that staying away from others matters.[9] This makes sense given prior studies concerning communicable disease, where researchers have concluded workplace social distancing measures are likely to be effective in reducing virus transmission and spread.[10]

The CDC also advises that COVID-19 prevention requires attention to sanitation, including frequent hand washing with soap or the use of alcohol-based hand sanitizers.[11] Maintaining clean hands is considered "the first line of defen[s]e

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[7] Sun & Zhai, *supra* note 5.

[8] Joseph A. Lewnard & Nathan C. Lo, *Scientific and Ethical Basis for Social-Distancing Interventions Against COVID-19*, 20 LANCET INFECTIONS DISEASES 631, 632 (2020), https://dx.doi.org/10.1016/FS1473-3099(20)30190-0.

[9] Charles Courtemanche et al., *Strong Social Distancing Measures in the United States Reduced the COVID-19 Growth Rate*, 39 HEALTH AFFS. 1237, 1241 (2020), https://doi.org/10.1377/hlthaff.2020.00608; Geofrey Musinguzi & Benedict Oppong Asamoah, *The Science of Social Distancing and Total Lock Down: Does It Work? Whom Does It Benefit?*, 17 ELEC. J. GEN. MED. (2020), https://doi.org/10.29333/ejgm/7895.

[10] Faruque Ahmed et al., *Effectiveness of Workplace Social Distancing Measures in Reducing Influenza Transmission: A Systematic Review*, 18 BMC PUB. HEALTH, at 8 (2018), https://doi.org/10.1186/s12889-018-5446-1 ("[S]ocial distancing in non-healthcare workplaces reduces the overall as well as the peak number of influenza cases.").

[11] *See, e.g.*, CDC, *When and How to Wash Your Hands* (Nov. 24, 2020), https://www.cdc.gov/handwashing/when-how-handwashing.html.

in stopping the spread of infection."[12] Notably, hand hygiene practices may reduce the spread of respiratory illnesses, including COVID-19, by up to 21%.[13] Likewise, to mitigate the risk of coming into contact with the virus, high-touch surfaces should also be regularly disinfected.[14] Of course, these measures are not sufficient by themselves, but they are a crucial part of any workplace virus prevention plan.

2. Warehouse Work Presents Greater Risks of COVID-19 Infection.

For many workers, social distancing and hand hygiene have been easily achieved while working from the safety of their homes. But workers in the warehousing industry are among the least able to work remotely.[15] For those who must work outside the home, particularly those employed in crowded food packing or warehousing jobs, social distancing and hand hygiene are exponentially more difficult.[16] Although the warehousing industry has certain environmental design

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[12] Mamdooh Alzyood et al., *COVID-19 Reinforces the Importance of Handwashing*, 15 J. CLINICAL NURSING 2760, 2760 (2020), https://doi.org/10.1111/jocn.15313.

[13] Alzyood, *supra* note 12, at 2760.

[14] Michael Belingheri et al., *COVID-19: Health Prevention and Control in Non-Healthcare Settings*, 70 OCCUPATIONAL MED. 82, 83 (2020), https://doi.org/10.1093/occmed/kqaa048.

[15] Jonathan I. Dingel & Brent Neiman, *How Many Jobs Can Be Done at Home* 5, 8 (Nat'l Bureau of Econ. Rsch., Working Paper No. 26948, 2020), https://doi.org/10.3386/w26948 ("Transportation and Material Moving Occupations," "Transportation and Warehousing").

[16] *See* Dingel & Neiman, *supra* note 15, at 5, 8; *Work Context: Physical Proximity*, O*NET ONLINE (Nov. 17, 2020), https://www.onetonline.org/find/descriptor/result/4.C.2.a.3?a=1 ("Laborers and Freight, Stock, and Material Movers, Hand," which report a higher degree of

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characteristics that make social distancing difficult, that makes it all the more important that employers implement all mitigation measures to prevent COVID-19 infection.

The CDC has established guidelines that warehousing employers in particular should follow to prevent COVID-19 spread. These include "redesign[ing] workstations so workers can be at least six feet apart and are not facing each other," establishing "physical barriers between workers," closing or limiting "access to common areas where employees are likely to congregate," using "visual cues . . . to remind workers to maintain distance of 6 feet from others," placing "handwashing stations or hand sanitizers" throughout the workplace, and ensuring "the workspace is well ventilated."[17] The State of New York has established similar guidelines for the wholesale trade sector, which includes warehousing employers.[18] These and other measures have been

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required proximity than any other job in the "Material Moving Workers" category).

[17] CDC, *COVID-19 Employer Information for Warehousing* (Nov. 13, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/warehousing-employers.html.

[18] *See* N.Y. State Dep't of Health, *Interim Guidance for the Wholesale Trade Sector during the COVID-19 Public Health Emergency*, at 2–6 (June 26, 2020), https://www.governor.ny.gov/sites/governor.ny.gov/files/atoms/files/WholesaleTradeMasterGuidance.pdf.

successfully implemented not just in warehouses, but also in other high risk workplaces such as hospital emergency departments.[19]

Employers that do not implement social distancing policies or redesign workstations are putting their workers and their workers' families in harm's way. Throughout this pandemic, many warehousing employers have forced their workers to choose between satisfying grueling productivity demands and being able to adhere to COVID-19 work safety protocols.[20] Anecdotal studies suggest Amazon's policies in particular are ill-suited for this moment. [21] Policies such as penalizing warehouse workers for washing their hands too often or for too long, not properly cleaning workspaces following exposure, and inadequate sanitation resources all contribute to the spread of COVID-19.[22]

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[19] Rohit B. Sangal et al., *Less Social Emergency Departments: Implementation of Workplace Contact Reduction During COVID-19*, 37 EMERGENCY MED. J. 463, 463–65 (2020), https://doi.org/10.1136/emermed-2020-209826.

[20] *See*, *e.g*, Abha Bhattarai, *Overworked and Exhausted, Warehouse Workers Brace for a Frenzied Holiday Rush*, WASH. POST (Sept. 3, 2020), https://www.washingtonpost.com/business/2020/09/03/overworked-exhausted-warehouse-workers-brace-frenzied-holiday-rush/.

[21] *See*, *e.g.*, Martha Ockenfels-Martinez & Sukhdip Purewal Boparai, *The Public Health Crisis Hidden in Amazon Warehouses*, HUMAN IMPACT PARTNERS (Jan. 2021), https://humanimpact.org/wp-content/uploads/2021/01/The-Public-Health-Crisis-Hidden-In-Amazon-Warehouses-HIP-WWRC-01-21.pdf.

[22] Ockenfels-Martinez & Boparai, *supra* note 21 at 12.

B. Paid Sick Leave is Crucial for Preventing Outbreaks and Protecting Workers.

Employers can also prevent COVID-19 transmission by allowing and encouraging their employees to take paid sick leave. "Paid sick leave allows employees to leave work to seek care or recuperate at home without losing wages."[23] Workers who have access to and use their paid sick leave benefits experience a reduction in all-cause mortality and are less likely to contract and spread COVID-19.[24] The public health benefits of paid leave also extend to workers' families. Not only does paid leave make children and elderly parents less likely to contract COVID-19, but workers can take time to care for these vulnerable populations if they do become sick.[25]

Even so, warehousing workers with access to paid leave may feel discouraged from using those benefits when necessary.[26] This phenomenon—

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[23] LeaAnne DeRigne et al., *Workers Without Paid Sick Leave Less Likely to Take Time off for Illness or Injury Compared to Those with Paid Sick Leave*, 35 HEALTH AFFS. 520, 520 (2016), https://doi.org/10.1377/hlthaff.2015.0965.

[24] Juan Vazquez et al., *Expanding Paid Sick Leave as a Public Health Tool in the Covid-19 Pandemic*, 62 J. OCCUPATIONAL MED. 598, 598 (2020), https://doi.org/10.1097/JOM.0000000000001998.

[25] Vazquez et al., *supra* note 24, at 598; VICKY LOVELL, INST. FOR WOMEN'S POL'Y RSCH., NO TIME TO BE SICK: WHY EVERYONE SUFFERS WHEN WORKERS DON'T HAVE PAID SICK LEAVE 1, 13 (2004), https://www.aecf.org/resources/no-time-to-be-sick/.

[26] *See* Kevin M. Kniffin et al., *COVID-19 and the Workplace: Implications, Issues, and Insights for Future Research and Action*, 2 AM. PSYCHOL., at 6 (2020), http://dx.doi.org/10.1037/amp0000716 ("Compensation policies should also be reviewed in this context to help ensure that there are not incentives for co-workers to pressure each other to attend to work while sick." (citing Sarah Kessler, *Amazon*

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known as presenteeism—can be caused by myriad factors, including the lack of clear guidance from one's employer, the possibility of disciplinary action, and a "presenteeism culture" in the workplace, *i.e.* pressure from one's colleagues or employer to show up for work when sick.[27] As one recent article put it, presenteeism "can be endemic in workplace cultures that stigmatize sick leave and 'normalize' long working hours. Presenteeism is also more likely in jobs with high workload pressure, which has increased in many organizations during the pandemic."[28] The record of this case suggests Amazon's JFK8 facility exhibits many of these features.[29]

Presenteeism is a major problem. The economic cost of presenteeism to American society may be in the range of hundreds of ***billions*** of dollars per year.[30] Focusing more narrowly on health, presenteeism causes workers to get sick and aids the spread of pandemics. According to one analysis, approximately 8 million

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Is Using Peer Pressure to Keep German Warehouse Workers from Calling in Sick, QUARTZ (Apr. 19, 2017))).

[27] Rebecca K. Webster et al., *A Systematic Review of Infectious Illness Presenteeism: Prevalence, Reasons and Risk Factors*, 19 BMC PUB. HEALTH, at 4, 6 (2019), https://doi.org/10.1186/s12889-019-7138-x.

[28] Gail Kinman & Christine Grant, *Presenteeism During the COVID-19 Pandemic: Risks and Solutions*, OCCUPATIONAL MED. (Nov. 18, 2020), https://doi.org/10.1093/occmed/kqaa193.

[29] *See* App. 91–92.

[30] Paul Hemp, *Presenteeism: At Work—But Out of It*, HARV. BUS. REV., Oct. 2004, at p.3, https://www.npg-rsp.ch/fileadmin/npg-rsp/Themen/Fachthemen/Hemp_2004_Presenteeism.pdf.

employees attended work while infected with H1N1 during the 2009 pandemic, causing the infection of as many as 7 million co-workers.[31] While employers may want to focus on reducing absenteeism, "there is growing evidence that sickness presenteeism . . . is far more costly."[32]

Experts are uniform in their conviction that employers must take extra care to reduce presenteeism—and encourage use of paid sick leave—during the COVID-19 pandemic.[33] This is particularly true for industries where social distancing and working from home may be difficult.[34] Indeed, in a guidance issued specifically to warehousing employers, the CDC endorsed the implementation of "flexible sick leave and supportive police and practices," including that employers must "encourage sick employees to stay at home without fear of reprisals, and ensure employees are aware of these policies."[35] Employers that do not take these steps bear the heightened and avoidable risk of COVID-19 outbreaks at their facilities.

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[31] Robert Drago & Kevin Miller, *Sick at Work: Infected Employees in the Workplace During the H1N1 Pandemic* 1, 7 (Inst. for Women's Pol'y Rsch., No. B264, 2010), https://iwpr.org/wp-content/uploads/2020/11/B284.pdf.

[32] Kinman & Grant, *supra* note 28.

[33] Kinman & Grant, *supra* note 28.

[34] *See* Damon Eisen, *Employee Presenteeism and Occupational Acquisition of COVID-19*, 213 MED. J. AUSTL.140, 140 (2020), https://doi.org/10.5694/mja2.50688.

[35] CDC, *COVID-19 Employer Information for Warehousing*, *supra* note 17.

II. Black and Hispanic Americans Are at Particular Risk of Harm from COVID-19 because of Their Overrepresentation in Essential Jobs.

Though it is clear that essential workers are at a significantly increased risk of harm from COVID-19, another enduring trend of this pandemic has been the disproportionate impact of the virus on Black and Hispanic workers and their families. Ethnic and racial minority groups, including Black and Hispanic communities, are suffering more acutely from the virus due to a number of social, economic, and health inequities that reflect the ongoing impacts of structural racism. As CNN notes: "A key reason, and one that has largely been overlooked: Their jobs are killing them."[36]

While many in the United States have been able to work remotely, a disproportionate share of Black and Hispanic people have essential jobs that require them to go to work in order to provide critical national services that enable our communities to function during pandemic shut-downs. These essential jobs, particularly in high-risk occupations like enclosed warehouse work, increase Black and Hispanic communities' risks of exposure to the virus, risks that are magnified when employers do not implement and enforce effective workplace protocols that protect workers on the job and allow them to take paid sick leave.

[36] Irina Ivanova, *As States Reopen, Black Workers Are at Greater Risk for COVID-19,* CBS NEWS (June 16, 2020), https://www.cbsnews.com/news/black-workers-lives-essential-frontline-jobs-risk-coronavirus-reopening/.

A. Black and Hispanic People in the United States and in New York City Are at Higher Risk of Getting Sick and Dying from COVID-19.

Throughout this pandemic, Black and Hispanic people are bearing the brunt of higher rates of viral transmission, morbidity, and mortality—both across the country and in New York City.[37] Researchers have found little evidence to suggest that these differences in outcomes are biological; rather they are the result of longstanding and pervasive structural inequalities, systemic racism, and health inequities within the United States that increase the likelihoods ethnic and minority groups will get exposed to the virus, suffer serious illness and death if they are infected, and face barriers to accessing testing and treatment.[38]

In the United States, the most up-to-date reporting available by race shows that Black, Hispanic, Pacific Islander, and Indigenous people have a COVID-19

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[37] *See, e.g.*, Dan Keating et al., *'I Just Pray God Will Help Me': Racial, Ethnic Minorities Reel from Higher Covid-19 Death Rates*, WASH. POST (Nov. 20, 2020), https://www.washingtonpost.com/graphics/2020/health/covid-race-mortality-rate/; James Louis-Jean et al., *Coronavirus (COVID-19) and Racial Disparities: A Perspective Analysis*, 7 J. RACIAL & ETHNIC HEALTH DISPARITIES 1039, 1039–40 (2020), https://doi.org/10.1007/s40615-020-00879-4; Audrey Chapman, *Ameliorating COVID-19's Disproportionate Impact on Black and Hispanic Communities: Proposed Policy Initiatives for the United States*, 22 HEALTH & HUM. RTS. J. 329, 330 (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7762897/.

[38] *See, e.g.*, Maria Godoy & Daniel Wood, *Coronavirus by the Numbers: What Do Coronavirus Racial Disparities Look Like State by State*?, NPR (May 30, 2020), https://www.npr.org/sections/health-shots/2020/05/30/865413079/what-do-coronavirus-racial-disparities-look-like-state-by-state; John Eligon et al., *Black Americans Face Alarming Rates of Coronavirus Infection in Some States*, NY TIMES (Apr. 4, 2020), https://nyti.ms/3aRc0wZ.

death rate of ***double or more*** that of White and Asian American people, who experience the lowest age-adjusted rates.[39] This data is further supported by an analysis of state-reported data by the Kaiser Family Foundation which shows that Black people in America account for more cases and deaths relative to their share of the population in 30 of 49 states reporting cases, and in 34 of 44 states reporting deaths.[40] Hispanic Americans comprise a higher share of cases and deaths compared to their share of the total population in 35 of 45 states reporting cases and in 10 of 44 states reporting deaths.[41]

These disparities persist in New York City as well. In New York City, both Hispanic and Black people are dying at higher rates as compared to other ethnic groups. Current testing data collected by the New York State Department of Health shows that while Hispanic and Black people are 29% and 22% of the city's population respectively, they comprise 34% and 28% of the city's deaths

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[39] *The Color of Coronavirus: COVID-19 Deaths by Race and Ethnicity in the U.S.*, APM RSCH. LAB (Jan. 7, 2021), https://www.apmresearchlab.org/covid/deaths-by-race. Researchers have adjusted these mortality rates for differences in the age distribution of populations, which differ across races and states.

[40] Samantha Artiga et al., *Racial Disparities in COVID-19: Key Findings from Available Data and Analysis*, KAISER FAMILY FOUND. (Aug. 17, 2020), https://www.kff.org/report-section/racial-disparities-in-covid-19-key-findings-from-available-data-and-analysis-issue-brief/.

[41] Artiga et al., *supra* note 40. Data gathered by the Kaiser Family Foundation on a county level also suggests that disparities in infection rates for Black and Hispanic people are widespread across counties. *See id.*

respectively.[42] This is compared to White people, who make up 32% of the city's population, but only 27% of the city's deaths.[43] Across the country, and in New York City, Black and Hispanic people continue to suffer graver outcomes from COVID-19.

B. Disparities in COVID-19 Related Illness and Death Among Black and Hispanic Communities Are Rooted in Social Determinants of Health and Longstanding Inequalities, Including Overrepresentation in Essential Jobs.

The striking disparities in COVID-19-related outcomes for Black and Hispanic people reflect and exacerbate structural racism and persistent underlying social and economic inequities that influence individual health. These factors include, but are not limited to, disparities in income, education, health insurance and access to medical care, access to food, job characteristics, and living conditions.[44] The National Academies of Sciences, Engineering, and Medicine note that there is little evidence to suggest that differences in COVID-19 related outcomes are a function of inherent susceptibility to the virus, but "rather reflect[]

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[42] N.Y. State Dep't of Health, *NYSDOH COVID-19 Tracker*, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities (updated daily).

[43] N.Y. State Dep't of Health, *NYSDOH COVID-19 Tracker*, *supra* note 42.

[44] Thomas M. Selden & Terceira A. Berdahl, *COVID-19 and Racial/Ethnic Disparities In Health Risk, Employment, and Household Composition*, 39 HEALTH AFFS. 1624, 1624–25 (2020), https://doi.org/10.1377/hlthaff.2020.00897; Jennifer D. Roberts et al., *Clinicians, Cooks, and Cashiers: Examining Health Equity and the COVID-19 Risks to Essential Workers*, 36 TOXICOLOGY & INDUS. HEALTH 689, 691–92 (2020), https://doi.org/10.1177/0748233720970439.

the impact of systemic racism leading to higher rates of co-morbidities that increase the severity of COVID-19 infection and the socioeconomic factors that increase likelihood of acquiring the infection."[45]

Numerous studies have validated these findings.[46] For example, a study evaluating COVID-19's racial and ethnic disparities found that minority groups have a disproportionate burden of underlying comorbidities and that "racial/ethnic minorities and poor people in urban settings live in more crowded conditions both by neighborhood and household assessments and are more likely to be employed in public-facing occupations . . . that would prevent physical distancing."[47] The study went on to note that "'social distancing is a privilege' and the ability to isolate in a

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[45] NAT'L ACADS. OF SCIS., ENG'G & MED., *National Academies Release Draft Framework for Equitable Allocation of COVID-19 Vaccine, Seek Public Comment* (Sept. 1, 2020), https://www.nationalacademies.org/news/2020/09/national-academies-release-draft-framework-for-equitable-allocation-of-a-covid-19-vaccine-seek-public-comment.

[46] *See, e.g*, Katherine Mackey et al., *Racial and Ethnic Disparities in COVID-19–Related Infections, Hospitalizations, and Deaths: A Systematic Review*, ANNALS OF INTERNAL MED. (Dec. 1, 2020), https://doi.org/10.7326/M20-6306 ("Overall, results of these models suggest that exposure and health care access variables underlie COVID-19-related disparities more than susceptibility (that is, comorbid conditions)."); Rohan Khazanchi et al., *Racism, Not Race, Drives Inequity Across the COVID-19 Continuum*, JAMA NETWORK OPEN (Sept. 25, 2020), https://doi.org/10.1001/jamanetworkopen.2020.19933 ("In short, rather than validating long-debunked hypotheses about intrinsic biological susceptibilities among non-White racial groups, the evidence to date reaffirms that structural racism is a critical driving force behind COVID-19 disparities.").

[47] Monica Webb Hooper et al., *COVID-19 and Racial/Ethnic Disparities*, 320 JAMA 2466, 2466–67 (2020), https://doi.org/10.1001/jama.2020.8598.

safe home, work remotely with full digital access, and sustain monthly income are components of this privilege."[48]

These disparate outcomes among Black and Hispanic people have also been documented in New York City. Indeed, one study concluded that although Black and Hispanic patients in New York City hospitals were more likely than White patients to test positive for COVID-19, Black patients were less likely to become critically ill or die after adjustment for comorbidity and neighborhood characteristics after hospitalization, supporting the assertion that "existing structural determinants—including inequality in housing, access to care, differential employment opportunities, and poverty—that remain pervasive in Black and Hispanic communities should be addressed in order to improve outcomes in COVID-19–related mortality."[49]

1. Black and Hispanic People Are Overrepresented in the Essential Workforce.

One such structural inequality Black and Hispanic communities face is the fact that people of color are overrepresented in essential jobs—including jobs in warehouses—which require them to work outside the home and often offer less

[48] Hooper et al., *supra* note 47.

[49] Gbenga Ogedegbe et al., *Assessment of Racial/Ethnic Disparities in Hospitalization and Mortality in Patients with COVID-19 in New York City*. JAMA NETWORK OPEN (Dec. 4, 2020), https://doi.org/10.1001/jamanetworkopen.2020.26881.

reliable social distancing and paid leave.[50] As Dr. Elise Gould, a senior economist with the Economic Policy Institute, notes, "Occupational discrimination has been with us forever."[51]

A recent report released by the Urban Institute notes that based on data from 2018 representing 152.7 million workers, 31% of Hispanic workers and 33% of Black workers were in essential jobs that required them to work in person and close to others. By contrast, 26% of White workers had similar jobs.[52] In New York City, currently 33% of the city's frontline trucking, warehouse, and postal service workers are Black; 27% are Hispanic; and only 22% and 17% are White and Asian respectively.[53]

The CDC notes that essential work positions create a higher risk of exposure because "these types of jobs require frequent or close contact with the public or other workers, involve activities that cannot be done from home, and may lack

[50] CDC, *COVID-19 Racial and Ethnic Health Disparities* (Dec. 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html.

[51] Moira McCarthy, *How COVID-19 Safety Protocols at Workplaces Help Save Black, Latino Lives*, HEALTHLINE (Oct. 20, 2020), https://www.healthline.com/health-news/how-covid-19-safety-protocols-at-workplaces-help-save-black-latino-lives.

[52] LISA DUBAY ET AL., URB. INST., HOW RISK OF EXPOSURE TO THE CORONAVIRUS AT WORK VARIES BY RACE AND ETHNICITY AND HOW TO PROTECT THE HEALTH AND WELL-BEING OF WORKERS AND THEIR FAMILIES, at viii (Dec. 2020), https://www.urban.org/sites/default/files/publication/103278/how-risk-of-exposure-to-the-coronavirus-at-work-varies.pdf.

[53] Office of the Comptroller, City of New York, *New York City's Frontline Workers*, at 2 (Mar. 26, 2020), https://comptroller.nyc.gov/wp-content/uploads/documents/Frontline_Workers_032020.pdf.

benefits such as paid sick days."[54] Numerous studies confirm these findings, showing that during the pandemic, essential workers were more likely to be Black or Hispanic, have lower average incomes and education levels, lack health insurance and paid sick leave, and were more likely to report working outside the home and less likely to report social distancing and wearing masks indoors as compared to non-essential workers.[55]

Indeed, some studies even suggest that the "impact of work,"[56] which has significantly driven down the median age of COVID-19 positive Black and

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[54] CDC, *COVID-19 Racial and Ethnic Health Disparities* (Dec. 10, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/index.html; *see also* Harmeet Kaur & Naomi Thomas, *Black, Hispanic and Native American Workers and Their Families Face Greater Coronavirus Exposure Risks, Report Finds*, CNN (Dec. 3, 2020), https://www.cnn.com/2020/12/03/health/black-hispanic-native-american-workers-covid-risks-trnd/index.html; Caroline Pryor & Donald Tomaskovic-Devy, *How COVID Exposes Healthcare Deficits for Black Workers*, UNIV. OF MASS. AMHERST, CTR. FOR EMP. EQUITY, http://www.umass.edu/employmentequity/how-covid-exposes-healthcare-deficits-black-workers (last visited Jan. 19, 2021).

[55] *See, e.g.*, Roberts et al., *supra* note 44; HYE JIN RHO ET AL., CTR. FOR ECON. & POL'Y RES., A BASIC DEMOGRAPHIC PROFILE OF WORKERS IN FRONTLINE INDUSTRIES 3–4 (Apr. 2020), https://cepr.net/wp-content/uploads/2020/04/2020-04-Frontline-Workers.pdf; Audrey Kearney & Calley Muñana, *Taking Stock of Essential Workers*, KAISER FAMILY FOUND. (May 1, 2020); https://www.kff.org/policy-watch/taking-stock-of-essential-workers/; Chapman, *supra* note 37.

[56] Katy Reckdahl, *'The Impact of Work': On-The-Job Coronavirus Exposure a Key Driver in Black, Latino Communities*, NEW ORLEANS ADVOCATE (Oct. 17, 2020), https://www.nola.com/news/business/article_d0e20ff2-0a62-11eb-8314-af3dffbffd15.html; *see also* William P. Hanage et al., *COVID-19: US Federal Accountability for Entry, Spread, and Inequities—Lessons For the Future*, 35 EUR. J. EPIDEMIOLOGY 995, 1001 (2020), https://doi.org/10.1007/s10654-020-00689-2 ("What is less appreciated is that racial/ethnic inequities in COVID-19 mortality rates, especially among younger working-age adults, are increasing over time,

Footnote continued on next page

Hispanic people as compared to White people, accounts for one of the main reasons for the disparities in coronavirus deaths.[57] For example, one study concluded: "We believe that COVID-19 disparities will ultimately be shown to stem from disparities in exposure, such as the dimensions of employment and household transmission . . . . "[58] Another noted that "elevated occupational risk is a major driver of the disproportionately high rates of COVID-19 infection, hospitalization, and mortality experienced by Black, Indigenous, and Hispanic Americans."[59] Yet another stated: "Existing structural injustices will continue to shape racial disparities in this pandemic if essential workers are treated as expendable, and unless companies and governmental leaders prioritize workplace safety and protection as a matter of public health."[60]

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especially among the Latinx and American Indian/Alaska Native populations."); Ivanova, *supra* note 36.

[57] Ivanova, *supra* note 36.

[58] Selden & Berdahl, *supra* note 44.

[59] Elizabeth S. McClure, *Racial Capitalism within Public Health—How Occupational Settings Drive COVID-19 Disparities*, 189 AM. J. EPIDEMIOLOGY 1244, 1245 (2020), https://doi.org/10.1093/aje/kwaa126.

[60] Tiana Rogers et al., *Racial Disparities in COVID-19 Mortality Among Essential Workers in the United States*, 12 WORLD MED. & HEALTH POL'Y 311, 320 (2020), https://doi.org/10.1002/wmh3.358.

2. Black and Hispanic Essential Workers Are Particularly Economically Vulnerable and Need Reliable COVID-19 Paid Leave Policies.

In addition to the increased risks of exposure to COVID-19 Black and Hispanic people face on the job because of their overrepresentation as essential workers, many Black and Hispanic essential workers face increased risk of harm from COVID-19 because they are economically vulnerable and thus unable to take any leave from their jobs, particularly if doing so could cost them their employment.[61]

Indeed, data from the U.S. Bureau of Labor Statistics shows that Black and Hispanic workers are less likely to have paid sick days as a benefit than White workers.[62] As such, although Black and Hispanic workers have reported being significantly more concerned about the risk of infecting themselves and others at work than White workers, those fears must be weighed against concerns about

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[61] *See, e.g.*, Clare Hammonds et al., *Stressed, Unsafe, and Insecure: Essential Workers Need A New, New Deal, Center for Employment Equity*, UNIV. OF MASS. AMHERST, CTR. FOR EMP. EQUITY (June 5, 2020), https://www.umass.edu/employmentequity/stressed-unsafe-and-insecure-essential-workers-need-new-new-deal.

[62] Elise Gould & Valerie Wilson, *Black Workers Face Two of the Most Lethal Preexisting Conditions for Coronavirus—Racism and Economic Inequality*, ECON. POL'Y INST. (June 1, 2020), https://www.epi.org/publication/black-workers-covid/; Elise Gould et al., *Latinx Workers—Particularly Women—Face Devastating Job Losses in the COVID-19 Recession*, ECON. POL'Y INST. (Aug. 20, 2020), https://www.epi.org/publication/latinx-workers-covid/.

earnings and job security.[63] It is critical that essential workers—in general—and Black and Hispanic workers—in particular—have easy access to paid sick leave so that they do not have to make the difficult choice between staying home and losing income or going to work and exposing others to COVID-19.[64]

C. Warehousing Employers Must Implement and Rigorously Enforce Scientifically Proven COVID-19 Mitigations to Prevent Their Workplaces from Becoming Super-Spreader Hubs that Place Workers and Entire Communities at Risk.

Implementing effective social distancing, hygiene, and paid sick leave measures in warehouses will undoubtedly reduce the deaths of essential workers and their families. This is illustrated by the trajectory of COVID-19 infection in Los Angeles County this past summer. For example, during a post Memorial Day

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[63] ALEXANDER HERTEL-FERNANDEZ ET AL., ROOSEVELT INST., UNDERSTANDING THE COVID-19 WORKPLACE: EVIDENCE FROM A SURVEY OF ESSENTIAL WORKERS 2 (June 2020), https://rooseveltinstitute.org/wp-content/uploads/2020/07/RI_SurveryofEssentialWorkers_IssueBrief_202006-1.pdf; *see also* Meera Jagannathan, *Just 3 in 10 People Working Outside the Home Get Hazard Pay, Despite 'Pervasive Fear' of Bringing Coronavirus Home,* MARKETWATCH (June 18, 2020), https://www.marketwatch.com/story/just-3-in-10-people-working-outside-the-home-get-hazard-pay-despite-pervasive-fear-of-bringing-coronavirus-home-2020-06-16.

[64] *See* HERTEL-FERNANDEZ ET AL., *supra* note 63, at 5; *see also* Sharoda Dasgupta et al., *Association Between Social Vulnerability and a County's Risk for Becoming a COVID-19 Hotspot — United States, June 1–July 25, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1535, 1536 (2020), https://doi.org/10.15585/mmwr.mm6942a3 ("Incorporating the needs of populations that are socially vulnerable into community mitigation plans is essential for limiting COVID-19 transmission. Specifically, implementing recommended prevention efforts at facilities requiring in-person work . . . including temperature or symptom screening, mask mandates, social distancing practices, and paid sick leave policies encouraging ill workers to remain home, might reduce transmission risk among populations that are vulnerable at workplaces.").

weekend uptick in COVID-19 cases in Los Angeles, four times as many Hispanic and twice as many Black Angelenos were dying than White Angelenos.[65] Just two months later, death rates among Black and Hispanic people in Los Angeles had fallen by more than half.[66] County officials attributed the remarkable decline to aggressive ***workplace*** health enforcement of social distancing and mask policies, including the creation of tip lines to report violations.[67]

In the absence of effective public health mitigations, warehouse work is inherently ***highly*** dangerous. Moreover, the danger does not stop at the warehouse door. Rather, the risk is borne by the entire communities from which workers and their families reside and by those outside the communities with whom they interact. To minimize the undue risk for everyone, but most critically for Black and Hispanic communities that disproportionately staff warehouse work, it is critical for the warehousing industry to be accountable for the public health threats it creates.

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[65] Anna Almendrala, *COVID Crackdowns at Work Have Saved Black and Latino Lives, LA Officials Say*, KHN (Oct. 15, 2020), https://khn.org/news/la-county-workplace-enforcement-covid-rules-save-black-latino-lives/.

[66] Almendrala, *supra* note 65.

[67] Almendrala, *supra* note 65.

CONCLUSION

For the foregoing reasons, *amici curiae* support Plaintiffs-Appellants' request that this Court reverse the District Court's decision to dismiss Plaintiffs-Appellants' public nuisance claims.

Dated: January 19, 2021

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

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Dated: January 19, 2021

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APPENDIX A*

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David L. Bell, MD, MPH is a Professor in the Department of Pediatrics (College of Physicians & Surgeons) and in the Heilbrunn Department of Population and Family Health (Mailman School of Public Health) at Columbia University Medical Center. Since 1999, Dr. Bell has been Medical Director of the Young Men's Clinic. He delivers primary care to adolescent and young adults up to the age of 35 years and is an advocate for health and well-being in the broadest sense. He is currently President-elect for the Society of Adolescent Health and Medicine.

Lisa M. Brosseau, ScD, CIH is a certified industrial hygienist employed for most of her career as an academic researcher and graduate-level educator, first at the University of Minnesota School of Public Health for 22 years and then at the University of Illinois at Chicago School of Public Health for four years. She retired

*_Amici curiae_ appear in their individual capacities; institutional affiliations are provided here for identification purposes only.

as a Professor in 2018 and continues to consult with companies and organizations on respiratory protection and workplace health and safety hazards. Dr. Brosseau holds a masters and doctoral degrees in industrial hygiene from the Harvard University School of Public Health and has more than 100 peer-reviewed publications. During the COVID-19 pandemic, she has been giving webinars, providing consultation and training to a wide range of organizations, and serving as a part-time research consultant to the University of Minnesota Center for Infectious Disease Research and Policy. Dr. Brosseau is recognized nationally and internationally as an expert in respiratory protection and workplace exposures to biological aerosols.

Linda Forst, MD, MPH is a Professor and Senior Associate Dean at the University of Illinois Chicago School of Public Health. She is a board certified physician in Internal Medicine and Occupational Medicine and practices Occupational Medicine at UIHealth in Chicago. She is providing consultation to the Illinois Department of Public Health and the Chicago Department of Public Health and community groups on contact tracing, public health messaging, and data acquisition for public health surveillance related to occupational exposures. She also sits on national work groups developing guidance documents and conducting research related to work-related spread of COVID-19.

Robert Harrison, MD, MPH has served on the faculty at the University of California, San Francisco in the Division of Occupational and Environmental Medicine since 1984. He established the UCSF Occupational Health Services where he has diagnosed and treated thousands of work and environmental injuries and illnesses. He has designed and implemented numerous medical monitoring and testing programs for workplace exposures, and has consulted widely with employers, health care professionals, and labor organizations on the prevention of work-related injuries and illnesses. Dr. Harrison has led many work and environmental investigations of disease outbreaks. He has served as a technical and scientific consultant to Federal OSHA and CDC/NIOSH, and was a member of the California Occupational Safety and Health Standards Board.

Nancy Krieger, PhD is a Professor of Social Epidemiology and American Cancer Society Clinical Research, in the Department of Social and Behavioral Sciences at the Harvard T.H. Chan School of Public Health (HSPH) and Director of the HSPH Interdisciplinary Concentration on Women, Gender, and Health. She received her PhD in Epidemiology from the University of California at Berkeley in 1989. Dr. Krieger is an internationally recognized social epidemiologist, with a background in biochemistry, philosophy of science, and the history of public health, combined with over 35 years of activism linking issues involving social justice, science, and health.

Philip J. Landrigan, MD, MSc is a pediatrician, epidemiologist and board-certified specialist in occupational and environmental medicine. He directs the Program for Global Public Health and the Common Good at Boston College. For nearly five decades, Dr. Landrigan has conducted research into the health impacts of toxic chemicals, including lead, pesticides, air pollution and asbestos. Dr. Landrigan co-chaired The Lancet Commission on Pollution and Health, which reported in 2018 that pollution causes 9 million deaths annually and that pollution prevention is feasible and highly cost-effective. He is a member of the National Academy of Medicine.

Elizabeth Miller, MD, PhD is Professor of Pediatrics, Public Health, and Clinical and Translational Science at the University of Pittsburgh School of Medicine, Director of Adolescent and Young Adult Medicine and Director of Community and Population health at UPMC Children's Hospital Pittsburgh. She holds the Edmund R. McCluskey Endowed Chair in Pediatric Medical Education. Trained in Internal Medicine and Pediatrics and medical anthropology, she has 20 years of practice and research experience in addressing gender-based violence among adolescents and young adults in clinical and community settings, with an emphasis on community-partnered approaches to achieve health equity.

Celeste Monforton, DrPH, MPH is a lecturer in public health at Texas State University. Dr. Monforton has worked for 30 years in the field of

occupational health and safety, including at the U.S. Department of Labor, Occupational Health and Safety Administration. Her research includes the role of regulatory policy to enhance protections for workers.

Carrie Redlich, MD, MPH, a graduate of Williams College and Yale University School of Medicine, is a Professor of Medicine, Department of Medicine (Occupational and Environmental Medicine and Pulmonary and Critical Care Medicine) at the Yale School of Medicine and is Director of the Yale Occupational and Environmental Medicine (OEM) Program. She holds a second appointment as Professor of Epidemiology in the Department of Environmental Health Sciences, Yale School of Public Health and also serves as Director of Yale's ACGME-accredited Preventive Medicine/OEM residency training program.

David Rempel, MD, MPH is Professor Emeritus in the Department of Bioengineering at the University of California at Berkeley and also in the Department of Medicine at the University of California at San Francisco. He is Board Certified in Internal Medicine, Occupational Medicine, and Ergonomics. Dr. Rempel develops medical practice guidelines for work-related musculoskeletal disorders and national standards for workplace ergonomics exposures. He conducts research on upper extremity disorders, such as carpal tunnel syndrome, and was responsible for training Occupational Medicine Fellows in the management of work-related musculoskeletal disorders.

Jonathan Rosen, MS, CIH, FAIHA is the Principal Consultant for AJ Rosen & Associates LLC, which provides occupational safety and industrial hygiene services to labor unions, government agencies, and organizations throughout the U.S. Jonathan also works for the National Clearinghouse for Worker Safety & Health Training, National Institutes of Environmental Health Sciences Worker Education and Training Program. Jonathan served as Director of the Occupational Health & Safety Department for NYS Public Employees Federation, AFL-CIO for 22 years. Jonathan has been co-investigator on several federal NIOSH intervention research grants. Jonathan completed a Master's Degree in Industrial Health at the University of Michigan and is a Certified Industrial Hygienist.

Catherine Troisi, PhD is an Associate Professor in the Divisions of Management, Policy, and Community Health and Epidemiology at University of Texas (UTHealth) School of Public Health and coordinator for the Leadership Theory and Practice Certificate, having previously served as Assistant Director at the Houston Health Department. She holds a BA in Chemistry from the University of Rochester, an MS in Biochemistry from Michigan State University, and a PhD in Epidemiologic Sciences from the University of Michigan. Dr. Troisi was elected to the APHA Executive Board in 2017 Board member of the International Network of Epidemiology in Policy, as well as many local and state public health advisory

boards. She is the recipient of the 2018 Association of School and Programs in Public Health (ASPPH) Academic Public Health Practice Excellence Award. She has had over 20 reader essays published in Texas newspapers and given over 300 media interviews on public health issues.