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**Submitted Electronically**

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RE: Comments of the Virginia Manufacturers Association  
VA Department of Labor and Industry, Safety and Health Codes Board  
Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes  
COVID-19, 16VAC25-220

To Whom It May Concern:

Thank you for the opportunity to comment on the Virginia Department of Labor and Industry's announced intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220 (collectively, the "Regulations"). These comments are provided on behalf of the Virginia Manufacturers Association ("VMA").

Virginia's manufacturing sector includes more than 6,750 manufacturing facilities that employ over 230,000 individuals, contribute \$43 billion to the gross state product, and account for 80% of the Commonwealth's goods exports to the global economy. VMA advocates for science-based, practical health and safety regulations. VMA's members will be directly affected by the Regulations, which apply "one size fits all" COVID-19 Regulations across all business sectors in the Commonwealth.

VMA members are heavily regulated under multiple federal and state occupational health and safety programs, and, as a result, participate actively in the development of Regulations and the implementation of related safety programs. As the delegated occupational health and safety agency in Virginia, the Department of Labor and Industry ("DOLI") is responsible for most, but not all, of those safety programs, and VMA believes that DOLI's regulatory activities should be deliberative, transparent, and consistent with Federal guidance. VMA members are interested in a uniform and coordinated approach to Federally delegated health and safety regulations. As such, our members participate in national trade groups, and have worked to develop best management

practices and implemented hierarchy of controls to protect their workforce from COVID-19 infections as proscribed by all Federal regulatory agencies. VMA Members have also historically addressed and mitigated the potential risks of prior infectious outbreaks, such as H1N1, under existing Federal and State regulation and guidance. Further, VMA and its Members have taken aggressive action in complying with the VA COVID-19 Emergency Temporary Standard (ETS), 16VAC25-220, including but not limited to establishing its own VA COVID-19 ETS compliance training program<sup>1</sup>. Accordingly, the VMA and VMA members are uniquely positioned to participate in the public process associated with the development of the Regulations.

The VMA and its member companies are committed to protecting employees, contractors, suppliers, and communities from COVID-19 infection. We have led the development of industry best-practices, provided ETS compliance training, instituted a COVID-19 Model Action Plan, implemented COVID-19 pandemic protection training, developed a rapid response decontamination service, assisted with increasing testing sites, maintained a [COVID-19 Resource Center](#), commercialized a [PPE Sourcing Center](#), distributed over 4,000 cloth masks from the U.S. Department of Health & Human Services to chemical and allied product essential workers, assisted the Virginia Department of Emergency Management (VDEM) increase domestic supplies, donations and production of PPE (including over 100,000 bottles of hand sanitizer, 1,250 Tyvek® 400 hooded coveralls, and a UV-C sanitation cabinet for public health workers), contributed to the Governor's COVID-19 Business Task Force, and implemented the [MFG Makes Virginia Safer Pledge](#).

However, the VMA asserts that adopting 16VAC25-220 as permanent Regulations is overly burdensome, unnecessary, and violates existing law. As such, the VMA requests that the Virginia Safety and Health Codes Board withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.” The VMA also requests that the Virginia Safety and Health Codes Board issue an additional sixty (60) day public comment period on 16VAC25-220 requesting that employers provide recommended improvements to the Emergency Temporary Standard (ETS) or abandon the ETS altogether and rely upon the “General Duty Clause” and Federal, State, Industry guidance to protect workers as is being effectively done in 48 other states. Finally, should the Board proceed with Regulations, the Board should not consider any amendments to the Regulations that would incorporate other infectious diseases.

The following comments outline our specific complaints related to the Regulations.

## **I. Federal Complaint: USDOL and US Court of Appeals for the District of Columbia Circuit Have Already Provided Direction.**

On April 28, 2020, AFL-CIO President, Richard Trumka, petitioned US Secretary of Labor Eugene Scalia to adopt a Department of Occupational Safety and Health Administration (OSHA) emergency temporary standard for COVID-19.

On April 30, 2020, US Secretary of Labor Eugene Scalia rejected the AFL-CIO petition from April 28, 2020, and stated, “Coronavirus is a hazard in the workplace. But it is not unique to the workplace or (except for certain industries, like health care) caused by work tasks themselves.

This by no means lessens the need for employers to address the virus. But it means that the virus cannot be viewed in the same way as other workplace hazards.” Secretary Scalia went on to say that, “...the contents of the rule detailed in your letter add nothing to what is already known and recognized (and in many instances required by the general duty clause itself). Compared to that proposed rule, OSHA's industry-specific guidance is far more informative for workers and companies about the steps to be taken in their particular workplaces. That is one of the reasons OSHA has considered tailored guidance to be more valuable than the rule you describe” (see Addendum).

On May 18, 2020, the American Federation of Labor and Congress of Industrial Organizations (“AFL-CIO”) petitioned this Court to issue a writ of mandamus under the All Writs Act, 28 U.S.C. § 1651(a), compelling Respondent Occupational Safety and Health Administration, United States Department of Labor (“OSHA”) to issue—within thirty (30) days of this Court’s grant of the writ—an [Emergency Temporary Standard for Infectious Diseases](#) (“ETS”) aimed at protecting workers from COVID-19<sup>ii</sup>.

On May 19, 2020, OSHA issued an “Updated Interim Enforcement Response Plan for Coronavirus Disease 2019 (COVID-19)” that provided instructions and guidance to Area Offices and compliance safety and health officers (CSHOs) for handling COVID-19-related complaints, referrals, and severe illness reports (see Addendum).

On May 29, 2020, the Chamber of Commerce of the United States, The National Federation of Independent Business, Restaurant Law Center, The Air Conditioning Contractors of America, Independent Electrical Contractors, The National Fisheries Institute, and National Association of Home Builders filed a brief of amici curiae in support of respondent occupational safety and health administration and denial of the emergency petition<sup>iii</sup>.

On June 11, 2020, the US Court of Appeals for the District of Columbia Circuit denied the AFL-CIO May 18 petition<sup>iv</sup>.

## **II. State Process & Transparency Complaint: Emergency Temporary Standard (ETS) Cannot be Adopted as Regulation.**

The VMA is aware that the ETS originated on April 23, 2020 from a petition and model language provided by the Legal Aid Justice Center, Virginia Organizing, and Community Solidarity with the Poultry Workers to Governor Northam, Commissioner Oliver, Attorney General Herring, Commissioner Davenport, and Director Graham. On June 12, 2020, the Administration posted the ETS for ten (10) calendar days or six (6) workdays for public comment and then barred public testimony before the Board during its multiple hearings over four weeks. The Board also violated its own bylaws on several occasions including allowing representatives of the DEQ Director and Virginia Health Commissioner to both vote, not posting agenda properly, not providing public notice properly, and barring public testimony at hearings. The result was an ETS with significant problems that cannot become permanent Regulations.

Virginia businesses need certainty and consistency in any regulatory program. This ensures that the regulated community understands the requirements of the program, and that all parties can work together to satisfy the regulatory requirements. **The VMA asserts that the Administration did not comply with the Virginia Administrative Process Act (VAPA)** requirements for the adoption of the ETS or the proposed permanent Regulations (e.g., “The Board shall notify its members of all meetings or public hearings of the Board not less than 30 calendar days prior to the scheduled date of such meeting or hearing and have a notice to the public regarding the meeting posted on the Department’s website”), nor has there been an effective evaluation of the ETS including but not limited to an analysis of how many organizations are out of compliance because of the Administration’s failure to notify affected businesses or the economic impact on small businesses.

Title 44, as the original source of emergency authority, speaks to the Governor's powers related to communicable diseases (such as COVID-19). Specifically, Va. Code § 44-146.17 (1) permits the Governor to "address exceptional circumstances that exist relating to an order of quarantine or an order of isolation ... for an affected area of the Commonwealth pursuant to ... Va. Code§ 32.1-48.05, et seq." To date, no such orders of quarantine or isolation under Title 32.1 have been issued. It is our assertion that when there are no orders of quarantine or isolation, the Governor cannot create his own regulatory structure - untethered to the Code and ungoverned by VAPA.

The Governor specifically directed the DOLI to issue regulations with the parameters set by the Governor instead of those set out in law. He demanded that such rules be done in an emergency fashion outside ordinary procedures under VAPA. In demanding these "Emergency Temporary Standard" (ETS) regulations that govern every employer in Virginia, they must necessarily claim that every employment context in Virginia poses a "grave danger" and that all such mandates are supported by "substantial evidence" and are "necessary" to adequately address the public health threat. The Board not only acquiesced to the Governor's demand, but it went even further by incorporating the Governor's current (and constantly changing) Executive Orders (and any subsequent Executive Orders) into their rules to which all Virginia employers are now subject. **The VMA objects to including any reference to compliance with the Governor’s Executive Orders in the ETS or the Regulations (see § 16VAC25-220-10 & 40).**

The VMA also asserts that The Board ignored language that limits what constitutes an emergency for purposes of a rule under that chapter. An "Emergency" is defined as:

*any occurrence, or threat thereof, whether natural or manmade, which results or may result in substantial injury or harm to the population ... and may involve governmental action beyond that authorized or contemplated by existing law because governmental inaction for the period required to amend the law to meet the exigency would work immediate and irrevocable harm upon the citizens or the environment of the Commonwealth or some clearly defined portion or portions thereof Va. Code§ 44-146.16 (emphasis added).*

Thus, for purposes of the emergency authority, "emergency" is a period of time during which the Chief Executive must act because there is not time to "amend the law" through legislative means.

This is a legislative restriction consistent, in part, with concerns over Separation of Powers. See also *Wisconsin Legislature v. Palm*, 2020 Wisc. LEXIS 121 ("Constitutional law has generally permitted the Governor to respond to emergencies without the need for legislative approval ... But the Governor's emergency powers are premised on the inability to gain legislative approval given the nature of the emergency.").

In regard to COVID-19, the state of emergency was declared on March 12, 2020 – the same day that the Virginia General Assembly adjourned its regular session but the Governor could have issued a contemporaneous request for the legislature to remain in session to address this emergency. Further, the Governor convened a Special Session of the Virginia General Assembly on August 18 and they are still in session. Yet, the Governor has not sought legislative authorization to implement either the ETS or permanent Regulations. In fact, the text of the final ETS (Regulations) does not itself contain findings that all the major components of the final ETS are necessary to meet a "grave danger." The issue is not whether any ETS (Regulations) is necessary to meet the "grave danger" standard but whether all of the substantial elements of the ETS, as applied across the scope of every employer in Virginia, is necessary under the procedures of Va. Code § 40.1-22(6a). Therefore, logically, the Board cannot justify how it can simultaneously designate parties to be a "low" or "medium" risk while still regulating those same parties on the basis that they face "grave danger."

As of September 23, 2020, the Virginia Department of Health (VDH) reported the following COVID-19 statistics<sup>vi</sup>:

- 135,626 confirmed positive cases;
- 2,882 fatalities;
- 17,038 hospitalized and discharged patients;
- 21% use of available hospital ventilators;
- 52% ICU & ICU surge bed occupancy; and
- 0 hospitals with PPE problems.

However, VDH has not reported how many of the positive cases, hospitalizations or fatalities have occurred from workplace exposure and the specific type of workplaces where people were infected (e.g., "Low" or "Medium" vs. "High" or "Very High" risk). VDH also reported that 79% of all deaths (2,269) were among patients over 70 years old and 54% of all confirmed deaths were among patients in long term care facilities and correctional facilities. **These data alone require the Board to revisit its "grave danger" determination for all workplaces.**

DOLI is proposing a wholly new regulatory and enforcement program that, based on the Regulations, will impact every business in the Commonwealth. The public participation and stakeholder involvement procedures outlined in the VAPA are designed to ensure that the impacts of a proposal such as this are fully understood. However, the ETS will not even be fully implemented until September 25 (the due date for these public comments) and DOLI has not assessed the impact of the Regulations on manufacturers or their supply chain which should be assessed in accordance with the Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA). The practical matter of fact is that employers have still not complied with 16VAC25-220 largely because the Commonwealth took no responsibility to notify employers with 11+ employees of the ETS compliance requirements and deadlines.

The Regulations also confuse guidance and regulations. Guidance is not Regulation. Codifying guidance as regulation bypasses public scrutiny. If any agency or Executive can simply change Regulations by issuing guidance, then the statutory basis for VOSH regulation will cease to exist as will public notice and comment. Again, the VMA objects to including any reference to compliance with the Governor’s Executive Orders in the ETS or the Regulations (see § 16VAC25-220-10 & 40).

The VMA asserts that the general duty requirements of § 40.1-51.1 (a) of the Code of Virginia apply to all employers covered by the Virginia State Plan for Occupational Safety and Health. Under this provision "...it shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees..." Accordingly, the baseline for understanding what is "necessary" to address a "grave danger" should be viewed against the baseline that employers already have legal obligations relating to COVID-19. The “General Duty Clause,” along with CDC, FEMA, OSHA guidance and employer innovation, is adequate to protect workers in the manufacturing sector and manufacturing supply chain as is proven by 48 other states.

### **III. Regulations Complaint:**

In addition to the fairness, transparency and regulatory process concerns expressed, and actions already taken by OSHA, the US Court of Appeals for the District of Columbia Circuit, and the VA Safety and Health Codes Board (“Board”), the VMA has identified the following specific concerns about the proposed Regulations (and their underlying ETS).

1. The text of the Regulations does not itself contain findings that all the major components of the final ETS are necessary to meet a "grave danger." The issue is not whether any ETS is necessary to meet the "grave danger" standard but whether all of the substantial elements of this proposed Regulation as applied across the scope of every employer in Virginia is necessary under the procedures of Va. Code§ 40.1-22(6a).
2. Requiring “Low” and “Medium” risk facilities to maintain HVAC systems in accordance with manufacturers’ instructions does not address the potential hazard (if any) as it relates to ventilation. Requiring ASHRAE standards 62.1, 62.2 and 170 should be struck entirely from the ETS and consideration for Regulations. In addition, the language does not account for older facilities, as upgrading the ventilation in those facilities may be infeasible. The VMA also asserts that the Safety and Health Codes Board does not have the authority to require such a physical alteration to all business facilities, especially without a Small Business Regulatory Flexibility Act/Small Business Regulatory Enforcement Fairness Act (SBREFA) assessment.

The VMA recommends that the Board adopt the CDC guidelines listed below (where feasible) to adequately address the issue:

- Increase ventilation rates.
- Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.

- Increase outdoor air ventilation, using caution in highly polluted areas. With a lower occupancy level in the building, this increases the effective dilution ventilation per person.
  - Disable demand-controlled ventilation (DCV).
  - Further open minimum outdoor air dampers (as high as 100%) to reduce or eliminate recirculation. Provide for flexibility to accommodate thermal comfort or humidity needs in cold or hot weather.
  - Improve central air filtration to the MERV-13 or the highest compatible with the filter rack, and seal edges of the filter to limit bypass.
  - Check filters to ensure they are within service life and appropriately installed.
  - Keep systems running longer hours, 24/7 if possible, to enhance air exchanges in the building space.
3. The hand sanitizer definition is imprecise and should be expanded to more than “60% alcohol” because it will result in hazards for certain pharmaceutical manufacturing operations. Clarifications issued by DOLI in its ETS FAQ document should be incorporated into an amended ETS or Regulations.
  4. The Regulations’ employee risk assessment review process conflicts with current OSHA Guidance (Guidance on Preparing Workplace for COVID-19, OSHA 3990-03 2020) since it confuses job tasks with employee job classifications.
  5. Requiring that the “...common spaces... [to be] cleaned and disinfected at the end of each shift” is impractical for 24/7 operations with multiple and overlapping shifts. This type of standard does not fit all businesses, specifically those that already have FDA cleaning standards. The ETS should be amended to provide for a time-based alternative such as every 8, 12, or 24 hours; exempt FDA regulated facilities; and any Regulations should reflect the same.
  6. The Regulations state under the definition of physical distancing pursuant to § 16VAC25-220-30 that "physical separation of an employee from other employees or persons by a permanent, solid floor to ceiling wall constitutes physical distancing from an employee or other person stationed on the other side of the wall." Physical separation does not have to be achieved by permanent or floor to ceiling walls. Temporary plexiglass and other hard surface barriers are regularly used to retrofit workstations, counters and cubicles as physical separation "shields" or barriers for employees, particularly when coupled with PPE or face masks. To complicate matters further, § 16VAC25-220-50 (applicable to hazards or job tasks classified as very high or high exposure risk) specifically states that “physical barriers” are “e.g., clear plastic sneeze guards, etc.). How can physical barriers be permanent solid walls for “low” or “medium” risks, but plastic sneeze guards are allowable for “high” or “very high” risks? These references should be removed from the ETS and consideration for Regulations.
  7. The Board does not have authority over organizational sick leave policies, flexible worksites, flexible work hours, flexible meeting and travel, teleworking, the delivery of services or the delivery of products. Therefore, its § 16VAC25-220-60 statements regarding such policies exceeds its authority and should be removed from the ETS and consideration for Regulations. Also, if left to the discretion of each VOSH inspector, will failure to satisfy of an inspector constitute a citable offense?

8. The Regulations frequently refer to the standards applicable to the “industry” which is language that may be appropriate for guidance but is too vague to be meaningful and should be removed from the ETS and consideration for Regulations.
9. It is unclear about which version of CDC guidance an employer may reference for purposes of compliance with the Regulations since guidance is changing so rapidly. It is also unclear who determines that the “CDC recommendation provides equivalent or greater protection than provided by this standard.”
10. Requiring “respiratory protection” and “personal protective equipment standards applicable to the employer’s industry” in vehicles with more than 1 person is impractical and vague. Does “vehicle” include golf carts, planes, heavy equipment, boats/barges/ships, trucks, and trains? There are other controls, when used together, that should be considered and the ETS should be amended to reflect so. Why not allow administrative controls (e.g., social distancing) in low-hazard situations, such as two or three employees riding several rows apart on a large bus or employees seated at a distance in an uncovered vehicle? The Regulations should not incorporate this provision. In addition, the language is inconsistent with CDC guidance for rideshares and other public vehicles. (<https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html>) Employers should be allowed only require face coverings while in the vehicle provided the occupants follow CDC guidelines.
11. § 16VAC25-220-40 F & H require “respiratory protection” but “face covering or mask” is effective - especially when in conjunction with other controls such as prescreening and temperature checking. Further, surgical and N95 masks are still not readily available, and imported alternatives have been found to have extensive quality issues. Additionally, N95 masks require fit testing, which is unrealistic for this application. The recommendation is to delete “respiratory protection” and replace it with “face covering or mask” in both sections of the ETS and consideration for Regulations.
12. Requiring “Access to common areas...” to be controlled by “limiting the occupancy of the space, and requirements for physical distancing” is too imprecise. [FEMA](#) recommends a calculation of 113 square feet per person. The ETS should be amended to recognize this measurement and Regulations should do the same. There should also be accommodating language inserted in both for “closed or controlled” restroom access to ensure ADA compliance.
13. Regulations should sunset based upon an event not a date.
14. Employers should have more time to update their COVID-19 infectious disease preparedness and response plans. There should also be a threshold for mandating change to a COVID-19 infectious disease preparedness and response plan.
15. All employers should not have to complete a COVID-19 infections disease preparedness and response plan. This mandate is overly burdensome and “medium” risk facilities should not be regulated at this level.



16. Employers should have more time to train their employees and communicate with their contractors. The current timetable is unachievable. The ETS should be amended to provide employers another sixty (60) days to comply.
17. The definition of “duration and frequency of employee exposure” is too imprecise and inconsistent with CDC guidance. This will also change the definition of “physical distancing” or “social distancing” as well as “occupational exposure.” For example, is the proper duration and frequency 15 minutes of exposure less than 6 feet to another person in an 8-hour shift? Does the use of face coverings and/or surgical/medical procedure masks and/or respirators extend the allowable duration of exposure?
18. The definition of “technical feasibility” requires the “existence of technical ‘know-how’...” which is an imperceptible standard of knowledge. Further, disqualifying an employer from invoking “technical feasibility” arguments because the employer’s “level of compliance lags significantly behind that of the employer’s industry” assumes a great deal of industry knowledge within DOLI and that employers lagging behind their peers choose to do so – every company has different economic realities. This is an unachievable standard and should be removed from the ETS and any consideration for Regulations.
19. The Regulations define “economic feasibility” to mean the employer is financially able. The standard does not ask whether the employer could stay in business or avoid releasing employees to pay for the costs of the Regulations. The ETS and Regulations should be amended as such.
20. “Feasible” cannot be defined as both “technical” and “economic.” Something can be technically feasible but not economically feasible at the same time. This should be referenced against OSHA guidelines and clarified.
21. Is the definition of “Joint Employment Relationship” the same as the USDOL definition? It is unclear and creating a new definition would not be acceptable.
22. The “Known to be infected with SARS-CoV-2 virus” definition establishes an impossible standard because the employer “...knew or with reasonable diligence should have known that the person has tested positive...” and a plaintiff only has to argue that the employer did not employ “reasonable diligence” which is undefined. This appears to be a litigation trap rather than a health and safety standard.
23. The “May be infected with SARS-CoV-2 virus” definition should have the words “or suspected to be infected with SARS-CoV-2 virus...” removed. An employer has no way to determine if someone is “suspected” of COVID-19 exposure.
24. The definition of “Symptomatic” is problematic for three reasons: 1) Data regarding the incubation period is still uncertain. Reports are now being published that suggest 5 days, 11.5 days or 14 days<sup>vii</sup>; 2) The symptoms listed here are not uniformly listed in all CDC, OSHA and VDH guidance documents; and 3) Employers will be sending thousands of employees home

due to allergy, cold or regular flu symptoms as well as potentially quarantining them pending two successive negative COVID-19 tests (which are still not readily available).

25. The Regulations reference employees' reporting of symptoms but there is no clear definition of the number or combination of symptoms an individual must have to be deemed symptomatic. That ambiguity, which is equally ambiguous in CDC guidance, is what VOSH could seek to clarify in the ETS.
26. The Regulations would require employers to classify each employee for risk level of exposure. As proposed this review process conflicts with current OSHA Guidance (Guidance on Preparing Workplace for COVID-19, OSHA 3990-03 2020), since it confuses job tasks with employee job classifications. Guidance requires assessing employees by hazards *and* tasks. Risk assessments should be done by tasks not job titles. This would be a massive burden for employers – imagine individual assessments for an employer with 2,000 employees. Further, OSHA Guidance is predicated on the use of a risk management process to determine appropriate control measures. The draft Regulation deviates to mandate specific control measures in workplace situations, regardless of potential exposures or other mitigating circumstances arising from the required risk assessment process.
27. The return-to-work Regulations referencing “an employer may rely on... a policy that involves consultation with appropriate healthcare professionals concerning when an employee has satisfied the symptoms based strategy requirements...will constitute compliance with the requirements of this subsection” must be clarified because someone with a diagnosed sinus infection or allergic reaction (same symptoms as COVID-19) must be allowed to return to work faster than 72 hours plus 10 days if cleared by a physician. This section of the ETS and any Regulations should align with the new CDC guidelines.
28. The return-to-work test-based strategy is problematic because of the lack of testing availability. The regulation also requires compliance with symptom-based strategy if a known *asymptomatic* employee refuses to be tested. The test-based strategy does not consider recent national and public health findings that COVID-19 can leave behind residual RNA in people that have otherwise recovered from the virus and are no longer contagious. In other words, a person may test positive long after they have recovered from the virus and are no longer contagious because the test picks up on the residual RNA left behind. We need to defer to the most recent guidance of public health officials and medical providers. Allow employers to defer to public health officials and medical providers when determining return-to-work. The language as written is a serious problem because it memorializes a strategy when the experts are still in the process of learning more about the virus.
29. § 16VAC25-220-40 K.8 requires that employers provide mobile crews with “transportation immediately available to nearby toilet facilities and handwashing facilities...” but has nothing to do with COVID-19 infections and should be removed from the ETS and consideration for Regulations.
30. Is the general contractor or owner exposed to potential citation if the subcontractor violates any of the provisions of the ETS or Regulations without providing this information to the

employer? Why is this liability being shifted to the employer? Does this now set a precedent for other regulatory issues?

31. The ETS and Regulations require both handwashing facilities and hand sanitizer. CDC and OSHA guidance requires one, but not both, which makes sense given recent hand sanitizer shortages. One or the other, but not necessarily both in all workplaces should be amended in the ETS and any consideration for Regulations.
32. The Regulations require a certified hazard assessment for each workplace but provides no timeline for completion. Is a new certified hazard assessment required after every change in guidance? How long do employers have after the Regulations are implemented to certify hazard assessments? How long will it take for employers to get the proper consultants to certify these hazard assessments? Is employer liability increased during this waiting period?
33. § 16VAC25-220-90 provides protection for employee complaints published by the news media and social media. Some employers have policies restricting statements to the press or statements reflecting poorly on their employers. Whistleblower protection is intended to protect employee complaints to the responsible government regulatory agency. The language “or to the public such as through print, online, social, or any other media” should be struck from the ETS and from consideration for Regulations.
34. There should be no enforcement without prior notice to an employer. The Regulations have no identifiable “due process” for employers involving a “whistleblower,” and no requirement that complaints filed with DOLI require identification of the plaintiff. Anonymous complaints should not be allowed in cases involving these Regulations – disgruntled employees, punitive customers, and unethical competitors could use complaints for destructive purposes. The employer should be afforded due process to defend themselves against accusations of safety violations and this should be included in the ETS and consideration for Regulations.
35. § 16VAC25-220-80 includes a training mandate for “Heat-related illness prevention...” that has no connection to COVID-19 infection protection. In addition, it cannot be a coincidence that the agency issued a Notice of Intended Regulatory Action (NOIRA) on Heat Illness Prevention<sup>viii</sup> on 4/2/20 and that document has been with the Secretary of Commerce and Trade for 161 days but a heat-related illness prevention training mandate was inserted into the ETS and now the Regulations. This should be removed from the ETS and from consideration for Regulations.
36. § 16VAC25-220-40 requires employers to notify VDH within 24 hours of the discovery of a positive case. This is a redundant activity, healthcare professionals already notify VDH, and it should be struck from the ETS and consideration for Regulations.
37. § 16VAC25-220-40 requires employers to notify DOLI within 24 hours of the discovery of 3 or more employees “present at the place of employment” within a 14-day period testing positive. This number is arbitrary and is certainly less meaningful the larger the facility. This regulatory requirement is not relevant if VDH is properly managing its contract tracing responsibilities and should be removed from the ETS and consideration for Regulations.

Another alternative could be requiring notice only if 3 or more employees are verified to have been infected at work and the incidents are recordable.

38. § 16VAC25-220-40 I states that “nothing in this standard shall require the use of a respirator, surgical/medical procedure mask, or face covering by an employee for whom doing so would be contrary to the employee’s health or safety because of a medical condition...” but there is no accommodation process similar to the ADA identified for employers to follow. This should be incorporated into the ETS and consideration for Regulations.

## **V. General Questions Regarding Regulations.**

### **A. Need for Regulations**

Is there a need for the Regulations or simply an enhanced penalty for employers that willfully violate basic COVID-19 safety guidance?

### **B. General Duty Clause**

VOSH has failed to demonstrate an inability to enforce CDC, OSHA, or other agency COVID-19 safety guidance through the “General Duty Clause.” The general duty requirements of § 40.1-51.1 (a) of the Code of Virginia apply to all employers covered by the Virginia State Plan for Occupational Safety and Health. This code section specifically states that under this provision “...it shall be the duty of every employer to furnish to each of his employees safe employment and a place of employment that is free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees...” So, why does VOSH have difficulty enforcing guidance through the “General Duty Clause” on an employer that willfully violates basic COVID-19 safety guidance?

### **C. Timeline**

The Regulations are lacking a clear or reasonable timeline for when employers must be in compliance and how long they have to react to regulatory changes.

## **VI. Recommendations.**

### **A. Voluntary Compliance Assistance**

VOSH should provide online and consultative services for helping employers develop COVID-19 infectious disease preparedness and response plans.

VOSH should prepare and maintain a standard curriculum for all employers to use in training employees by risk category.

## VII. Conclusion.

It is unreasonable to apply “one size fits all” COVID-19 Regulations to all employers and employees. It is also profoundly inappropriate to bypass the formal regulation process altogether by attempting to codify “guidance” and Executive Orders as a reasonable replacement. Further, it is confusing why the Regulations are being pursued when § 16VAC25-220 has not been fully implemented and has so many significant problems.

Therefore, it is the VMA’s recommendation that the Board withdraw its “Intent to Adopt a Permanent Standard for Infectious Disease Prevention: SARS-CoV-2 Virus That Causes COVID-19, 16VAC25-220.” The VMA also requests that the Virginia Safety and Health Codes Board issue an additional sixty (60) day public comment period on 16VAC25-220 requesting that employers provide recommended improvements to the Emergency Temporary Standard (ETS) or abandon the ETS altogether and rely upon the “General Duty Clause” and Federal, State, Industry guidance to protect workers as is being effectively done in 48 other states. Finally, if the Board proceeds with Regulations, the Board should not consider any amendments to the Regulations that would incorporate other infectious diseases.

Sincerely,

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## Addendum

See attached.

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- <sup>i</sup> MSI, COVID-19 Certification Program, <http://manufacturingskillsinstitute.org/covid-19-certification-program/>.
- <sup>ii</sup> [https://actionnetwork.org/user\\_files/user\\_files/000/042/993/original/final\\_OSHA\\_ETS\\_petition\\_5-18\\_filing.pdf](https://actionnetwork.org/user_files/user_files/000/042/993/original/final_OSHA_ETS_petition_5-18_filing.pdf).
- <sup>iii</sup> <https://strgnfibcom.blob.core.windows.net/nfibcom/NFIB-As-Filed-Chamber-OSHA-Amicus-Brief.pdf>.
- <sup>iv</sup> <https://www.osha.gov/news/newsreleases/national/06112020>.
- <sup>v</sup> Virginia Health & Safety Board, Bylaws, Section IV. Meetings, 2014.
- <sup>vi</sup> VDH, COVID-19 Dashboard, <https://www.vdh.virginia.gov/coronavirus/coronavirus/covid-19-in-virginia-demographics/>.
- <sup>vii</sup> [The Incubation Period of Coronavirus Disease 2019 \(COVID-19\) From Publicly Reported Confirmed Cases: Estimation and Application. \*Ann Intern Med\* 2020; 172:577-582.](#)
- <sup>viii</sup> <https://townhall.virginia.gov/l/ViewStage.cfm?stageid=8926>