UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF NEW YORK

WOMEN OF COLOR FOR EQUAL JUSTICE, REMO DELLO IOIO, ELIZBETH LOIACONO, SUZANNE DEEGAN, MARITZA ROMERO, JULIA. HARDING, CHRISTINE O'REILLY, AYSE P. USTARES, SARA COOMBS-MORENO, JESUS COOMBS, ANGELA VELEZ, SANCHA BROWNE, AMOURA BRYAN, ZENA WOUADJOU, CHARISSE RIDULFO, TRACY-ANN FRANCIS MARTIN, KAREEM CAMPBELL, MICHELLE HEMMINGS HARRINGTON, MARK MAYNE, CARLA GRANT, OPHELA INNISS, CASSANDRA CHANDLER, AURA MOODY, EVELYN ZAPATA, SEAN MILAN, SONIA HERNANDEZ, BRUCE REID, JOSEPH RULLO, AND CURTIS BOYCE, JOSESPH SAVIANO, MONIQUE MORE, NATALYA HOGAN, JESSICA CSEPKU, ROSEANNE MUSTACCHIA, YULONDA SMITH, MARIA FIGARO, RASHEEN ODOM, FRANKIE TROTMAN, GEORGIANN GRATSLEY, EDWARD WEBER, MERVILYN WALLEN, PAULA SMITH individually and on behalf of similarly situated individuals,

Plaintiffs,

v.

THE CITY OF NEW YORK, MAYOR ERIC L. ADAMS, COMISSIONER ASHWIN VASAN, MD, PHD DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DEPARTMENT OF EDUCATION, AND DOES 1-20

Defendants

SECOND AMENDED CLASS ACTION COMPLAINT FOR DAMAGES, DECLARATORY AND INJUNCTIVE RELIEF

AND JURY DEMAND

INDEX No.:1:22 CV 02234-EK-LB_____

INTRODUCTION

1. This action arises out of the City of New York's (the "City") issuance of approximate four (4) Covid-19 Vaccine Orders ("Covid Vaccine Orders") issued through the New York City Department of Health and Mental Hygiene ("NYCDOH") between August 2021 and December 13, 2021

mandating Plaintiffs and all City employees similarly situated (hereafter "Plaintiffs") including City contractors vendors, and employees working for private employers in the City to get the Covid-19 vaccine in violation of the Occupational Safety and Health Act of 1970 ("OSH Act") expressed preemption clause and by the Supremacy Clause, Article VI of the Unites State Constitution. See Exhibits 1, Vaccine Orders

2. Plaintiffs seek declaratory judgment pursuant to 28 U.S. §2201 declaring the duties and rights between the City and Plaintiffs pursuant to the OSHA Act and declaring the Covid Vaccine Orders preempted and invalid, along with a permanent injunction pursuant to Federal Rule of Civil Procedure §65 enjoining the City's enforcement of the preempted Vaccine Orders so that Plaintiffs can return to work because enforcement of a preempted—and thus unconstitutional—law constitutes irreparable injury. See *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 381 (1992); *Arcadian Health Plan, Inc. v. Korfman, 2010 WL 5173624, at *8* (D. Me. Dec. 14, 2010) ("A party may be irreparably injured in the face of the threatened enforcement of a preempted law.").
3. The City's ongoing enforcement of the preempted Vaccinex Orders has irreparably harmed—and continues to irreparably harm—Plaintiffs as they have been placed on involuntary leave without pay and locked out of their jobs since approximately October 4, 2021 because they have refused to comply with the preempted City Vaccinex Orders based on religious grounds. See *Chamber of Commerce of U.S. v. Edmondson*, 594 F.3d 742, 770–71 (10th Cir. 2010) and See also *Roman Catholic Diocese of Brooklyn New York v. Cuomo*, 592 U.S. ___2022 (holding "The loss of First Amendment freedoms, for even minimal periods of time, unquestionably constitutes irreparable injury.")
4. The City's Vaccine Orders are preempted because they are not laws of general applicability because they do not mandate all residents of the City to be vaccinated and the Vaccine Orders conflict with

New York States Public Health Law §206, which expressly prohibits "adult" mandatory immunization.

5. Plaintiffs also seek monetary damages for violations of Plaintiffs First Amendment Rights as applied to municipalities pursuant to 42 U.S.C. §1983 and damages, including punitive damages for the City's intentional and/or reckless religious discrimination and harassment against Plaintiffs in violation of the New York City Human Rights Law under NYC Administrative Code 8-107(3); which claims arise out of and are inextricably bound to Plaintiffs federal preemption claim under the OSHA Act.

JURISDICTION AND VENUE

6. This Court has original jurisdiction pursuant to 28 U.S.C. §1331 regarding the federal question of preemption of the Federal OSHA Act of 1970 over the City's Vaccinex Orders, as well jurisdiction over Plaintiffs First Amendment violation claims as applied to states and municipalities pursuant to 42 U.S.C. §1983.
7. Moreover, this Court has supplemental jurisdiction, pursuant to 28 U.S.C. § 1367(a), over any and all claims arising under state law, namely the New York City Human Rights Law ("NYCHRL") codified in Administrative Code §8-107, in that such claims are so related to Plaintiff's claims within the original jurisdiction of this Court that they form part of the same case or controversy.
8. The unlawful employment practice alleged herein occurred wholly or in part, in the jurisdiction of the Eastern District of New York, specifically, Brooklyn, NY.

JURY DEMAND

9. Plaintiffs hereby demand a trial by jury on all issues properly triable thereby.

PARTIES

A. PLAINTIFFS

1. Organization Plaintiff

10. Plaintiff Women of Color for Equal Justice (WOC4EqualJustice) is a nonprofit social justice policy and litigation subsidiary affiliate of the Huntsville Madison County Community and Economic Development Corporation (HMCCEDC) a 501c(3) incorporated in Alabama and has members and operates affiliates organizations in various regions of the United States to seek redress for social justice harms to communities of color. Specifically, WOC4EJ advocates to empower and protect the rights of women, women of color, marginalized communities of color and anyone experiencing discrimination. Plaintiffs are subscribing members of WOC4EJ.

2. Individual Plaintiffs & Class Representatives

11. Plaintiffs bring this action on behalf of themselves and all City employees within any and all the City agencies of approximately 50 city departments, including but not limited to Department of Education, Department of Transportation, Department of Sanitation, Central Administrative Services, Police Department, Department of Children's Services. Plaintiffs make up two (2) classes of City employees, as follows:

    a. City employees who have refused to submit to the Vaccine Orders, evidenced by having submitted to the City a written request for exemption from the Vaccine Orders that was denied and who were subsequently placed on leave without pay due to their religious practice of refusing to take the Covid-19 vaccine and who have not returned to work after exhausting the City's appeal process because the City has locked them out of their jobs since October 4, 2021 until the present for refusing to take the vaccine based on religious grounds. These are the Locked-Out Class; and

b. City employees who also refused to take the Covid-19 vaccine, who submitted to the City's demand that they apply for a religious exemption and all of their request were denied and they were placed on leave without pay and locked out from returning to work because they continued to refuse to take the Covid-19 vaccine for religious grounds, but after being denied pay for several weeks to months where coerced by the financial deprivation to violate their religious practice and they took the Covid-19 vaccine so that they could get their jobs and salary back. These are the "Coerced Class".

12. All of the named Plaintiffs have filed EEOC complaints to exhaust their administrative remedies; but because Plaintiffs are now seeking claims pursuant to 42 U.S.C. §1983 which does not require exhaustion of administrative remedies, all references below to EEOC complaints are for the purpose of preserving the right to add Title VII claims in the future if necessary.

Locked Out Class

13. Remo Dello Ioio, a tenured Home Instructor employee who worked over 17 years for the New York City Department of Education who filed a EEOC Charge No. 520202200117 and received a Right to Sue Letter dated January 19, 2022. He is part of the Locked-Out Class.

14. Maritza Romero is a former tenured Special Education Teacher who worked for the New York City Department of Education for over 20 years who has been denied the right to work in a safe workplace because she exercised her right to refuse the Vaccine Order. She has filed an EEOC Charge No. 520202200311 and received a Right to Sue Letter dated January 19, 2022. She represents the Locked-Out Class.

15. Elizabeth Loiacono, a former employee of the New York City Department of Education filed a EEOC Charge No. 520202200353 and received a Right to Sue Letter Dated March 24, 2022. She represents the Locked-Out Class.

16. Suzanne Deegan, a former employee of the New York City Department of Education who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious ground. She filed a EEOC Charge No. 520202200109 and received a Right to Sue Letter Dated January 19, 2022. She represents the Locked-Out Class.

17. Julia L. Harding is a former Education Administrator-Central Based Support Team Case Manage for New York City Department of Education who was been placed on leave without pay since October 4, 2021 for refusing to submit to the Vaccine Orders on religious grounds. She has filed a EEOC Charge No. 520202200147 and received a Right to Sue Letter Dated January 19, 2022. She represents the Locked-Out Class.

18. Christine O'Reilly, a tenured teacher in Academic Intervention Services with over 22 years of service with the New York City Department of Education filed a EEOC Charge No. 520202200421 and received a Right to Sue Letter Dated January 19, 2022. She represents the Locked-Out Class who was involuntarily placed on leave without pay since around October 4, 2021 for refusing to take the Covid-19 vaccine for religious grounds.

19. Ayse P. Ustars, is a 20+ year Social Worker for the City's Department of Education who was placed on leave without pay on October 4, 2021 for refusing to submit to the Vaccine Order, filed a EEOC Charge No. 520202200062 and received a Right to Sue letter; but due to the financial hardship she experienced when she was placed on leave without pay for five (5) months, on March 9, 2022, Ms. Ustars was coerced to take the vaccine due to financial hardship of being forced to be on leave without pay for five months submitted to the Vaccine Order and returned to work on March 15, 2022 and now seeks lost pay and emotional distress damages. She represents the "Coerced Class."

20. Sara Coombs-Mereno, is a tenured teacher with the Department of Education who was put on leave without pay for refusing to submit to the Vaccine Orders on religious ground. She represents the Locked-Out Class.
21. Sancha Brown, is a tenured teacher with the Department of Education who was put on leave without pay for refusing to submit to the Vaccine Orders for religious grounds.
22. Amoura Bryan, is a tenured teacher with the Department of Education who was put on leave without pay for refusing to submit to the Vaccine Orders on religious ground. She represents the Locked-Out Class.
23. Zena Wouadjou, is a tenured teacher with the Department of Education who was put on leave without pay for refusing to submit to the Vaccine Orders on religious grounds. She represents the Locked Out Class.
24. Evelyn Zapata, Christine O'Reilly, Edward Weber, were all former employees of the Department of Education who were placed on leave without pay refusing to submit to the Vaccine Orders due to her religious practices.
25. Tracy-Ann Francis-Martin, was a supervisor for the Department of Child Protective Services who was put on leave without pay for refusing to submit to the Vaccine Orders on religious grounds. She represents the Locked-Out Class who can work remote.
26. Michelle Hemmings Harrington, was an employee of the Department of Transportation who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds.
27. Ophelia Inniss, was an employee of the Administration of Children Services who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds.
28. Cassandra Chandler, was an employee of the Administration of Children Services who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds.

29. Carla Grant, was an employee of the Department of Transportation who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds.
30. Charisse Ridulfo, is a tenured teacher with the Department of Education who was put on leave without pay for refusing to submit to the Vaccine Orders on religious grounds. She represents the Locked-Out Class.
31. Kareem Campbell was an employee of the Department of Transportation who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds. He represents the Locked-Out Class.
32. Bruce Reid, was an employee of the Department of Sanitation who was placed on leave without pay for refusing to submit to the Vaccine Orders on religious grounds. He represents the Lock-out Class.
33. Joseph Rullo, was an employee of the Department of Sanitation who was placed on leave without pay or refusing to submit to the Vaccine Orders on religious grounds.
34. Sean Milan was an employee of the Department of Sanitation who was placed on leave without pay refusing to submit to the Vaccine Orders on religious grounds. He has filed an EEOC complaint.
35. Sonia Hernandez was an employee of the New York Police Department who was placed on leave without pay refusing to submit to the Vaccine Orders on religious grounds.
36. Plaintiffs Curtis Boyce, Joesph Saviano, Monique More, Natalya Hogan, Jessica Csepku, Roseanne Mustacchia, Yulonda Smith, Maria Figaro, Rasheen Odom, Frankie Trotman, Georgianne Gratsley, Edward Weber, Merylyn Wallen, and Paula Smith and those similarly situated all requested religious exemptions from the Covid-19 Vaccine Orders as required by the City and were denied several request by the City for exemption and all were placed on involuntary leave without pay for refusing to submit to the Vaccine Orders on religious grounds.

Coerced Class

37. Angela Velez is a Guidance Counselor for Home Instruction Schools which is a remote position with the Department of Education. Ms. Velez was placed on leave without pay on October 4, 2021 for refusing to submit to the Vaccine orders. But after almost 5 months being on leave without pay as the primary earner in her house and unable to find another job due to her unvaccinated state based on her religious practice, Ms. Velez with tears in her eyes and under duress submitted to the Vaccine Order and returned to work in March. She has filed an EEOC charge. She represents the "Coerced Class".

38. Jesus Coombs is the Chief Architect for the Department of Central-Wide Administrative Services. On January 13, 2022, Mr. Coombs was placed on leave without play for refusing to submit to the Vaccine Orders. He was scheduled to be terminated, but because he is the sole income earner in his home, he with much gilt, anxiety and distress, submitted to the Vaccine Order and returned to work on February 15, 2022. He represents the "Coerced Class" who carries much guilt and anxiety for having to choose between meeting the needs of their family and God.

39. All Plaintiffs have filed with the City's Comptroller's office the statutory required notice of claim as a pre-condition to filing this lawsuit against the City. Attached as Exhibit 2 are Plaintiffs Acknowledged Individual Notices of Claims.

B. **DEFENDANTS**

40. The City including all applicable agencies which are approximately 50 agencies, including but not limited to the New York Police Department, Department of Education, Department of Transportation, Department of Sanitation, Department of Citywide Administrative Services, and Administration for Children's Services. The law of the State in which the district court is located determines a party's amenability to suit. Under the New York City Charter, "all actions and

proceedings for the recovery of penalties for the violation of any law shall be brought in the name of the City of New York and not in the name of any agency, except otherwise provided by law."

41. Mayor Eric Adams is named in his official capacity as mayor who under color of law ratified that actions of the prior Mayor that caused Plaintiffs to be discriminated against because of the Plaintiffs religious practices.

42. The City Department of Health and Mental Hygiene has been named separately because the New York City Health Code and Rules §3.01 General Powers grants it with exclusive authority for protecting the public health of the residents of the City.

43. The City Commissioner Ashwin Vasan, MD, PHD is named in his official capacity as the Commissioner of the Department of Health and Mental Hygiene (NYDOH) because his actions where taken under color of the laws of New York.

44. The Department of Education is hereby named separately because they are a separate legal entity from the City.

FACTUAL ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

45. On June 23, 202, then New York Governor Cuomo announced the end of the Covid-19 State of Disaster Emergency on June 24, 2021, due to success in the voluntary vaccination rates in the state, and declining hospitalizations.

46. Notwithstanding the end of the state of emergency, on August 2, 2021, then New York City Mayor Bill de Blasio (Mayor), issued Executive Order 75 ("EO 75") claiming that the pandemic continued to pose a danger to the health and safety of New York City residents, and that EO 75 required all newly hired for employment with any City agency to provide proof of Covid-19 vaccination, unless the newly hired obtained an exemption due to medical or religious reasons through the NYC reasonable accommodation process.

47. On August 10, 2021, the then Commissioner of the NYCDOH issued an Order requiring staff providing Covid operated or contracted services in residential and congregate settings to provide proof of Covid-19 vaccination or undergo weekly testing.

48. On August 24, 2021, NYCDOH issued an Order that required all Department of Education employees to provide proof of Covid-19 vaccine with no option to undergo weekly testing. See

49. On August 31, 2021, the Mayor issued Executive Order No. 78, requiring that beginning on September 13, 2021, all City employees were to provide proof of full vaccination or provide weekly testing until the employee submits to full vaccination.

50. During the August 31, 2021, Press Conference announcing Executive Order No. 78, when asked by media about religious exemptions, then Mayor de Blasio stated that "Those quote unquote, exemptions are not going to be honored. They're just, that's not the way to do things." See Exhibit #5 – Press Conference Transcript

51. During another media press conference on September 8, 2021, then Mayor de Blasio stated as follows:

> "We recognize there are definitely, in a few cases and it's pretty rare where someone medically cannot be vaccinated, but where that is confirmed by a process to make sure that, you know, all the information is accurate, if someone cannot be vaccinated, of course there's grounds for a valid, medical exemption. Equally, and in very few cases we expect, but there are narrow and **specific grounds for religious exemption**. **Those will be honored**. There'll be a process to confirm them, but they will be honored. Those folks will continue to work for us in some capacity, in some location, we got to work that through, but those cases will be honored, but again, expect them to be very rare."

See September 8, 2021 Press Conference Transcript

52. Again during a media press Conference on September 23, 2021, then Mayor de Blasio made the following statements regarding vaccine exemptions:

> **Mayor:** Yeah, it's a great question. Thank you. Yes. And very powerfully Pope **Francis has been abundantly clear that there's nothing** in scripture that suggests people shouldn't get vaccinated. Obviously, so many people of all faiths have been getting vaccinated for years and decades. There are, I believe it's two well-established **religions, Christian Science and Jehovah's Witnesses that have a history**

> **on this, of a religious opposition**. But overwhelmingly the faiths all around the world have been supportive of vaccination. So, we are saying very clearly, it's not something someone can make up individually. It has to be, you're a standing member of a faith that has a very, very specific long-standing objection. Go ahead.
>
> See September 23, 2021 Press Conference Transcript

53. On September 12, 2021, the NYCDOH issued an Order requiring City employees working in certain childcare programs to be vaccinated.

54. On September 28, the NYCDOH updated its DOE Order requiring all DOE employees to be vaccinated without a testing option. See

55. On October 20 and 31, the NYCDOH issued Orders requiring all City Employees and Contractors to submit to Covid-19 vaccination. See

56. On December 13, 2021, NYCDOH issued Order requiring all private employers to require employees to submit to Covid-19 vaccination.

57. New York Public Health Law, PBH §206(L) prohibits Public Health Commissioners in the state of New York from authorizing mandatory immunization of adults.

58. The Mayor's Executive Orders and the NYCDOH Orders (collectively the "Vaccine Orders") were only applicable to all City employers and by December 10, 2021, to private employees for "health and safety" in the workplace, which standards are governed by Federal OSHA Standards applicable to the City employees pursuant to the OSHA New York State Plan, which applies to state and municipal governments and their employees.

59. On November 22, 2021, Mayor de Blasio reported that approximately 12,400 City workers applied for exemptions from the City Employee Vaccine Orders since the orders were implemented. Of the 12,400, 6,000 police officers were seeking exemptions from the Vaccine Orders.

60. All City employees were required by the City to apply for an exemption through an online portals called SOLAS to be exempted from the Vaccine Order.

61. On November 22, 2021, Mayor de Blasio reported that approximate 2,400 City employees were placed on leave without pay (LWOP);

62. October 21, 2021 during a press conference, Mayor de Blasio indicated that most City employees seeking exemptions did not meet the certain exemption standards, which were not disclosed to the City Employees by that time.

63. All Plaintiffs were denied their exemption request and were required to appeal to the New York City-Wide Administrative Appeal for reconsideration of their request for exemption based on their religious practice.

64. All Plaintiffs had their appeals denied, and some Plaintiffs were placed on indefinite involuntary leave without pay in and around October 2021 and others were placed on indefinite involuntary leave without pay sometime after January 1, 2022.

65. None of the Plaintiffs have been legally terminated because none have had formal misconduct charges made against them pursuant to Education Law Section 3020a, New York Administrative Code §16-101, or Civil Service Law §75.

66. All Plaintiffs have been illegally "locked out" of their jobs by the City when they were told not to return to their jobs because of they refused to be vaccinated based on the Plaintiffs religious practice of abstaining from the Covid-19.

67. All other agency Plaintiffs were also placed on leave without pay and terminated.

GENERAL ALLEGATIONS

68. Plaintiffs realleges and incorporates by reference Paragraphs 1-67 of this Second Amended Complaint as if fully set forth herein.

69. All conditions precedent to filing this action and to recovery of all relief sought in this Complaint have been satisfied, excused or waived.

70. Plaintiffs allege that the City Orders were and are unenforceable as a matter of law for the following reasons:

    a. They are preempted by the Occupational Safety and Health Act of 1970 ("OSHA Act"), as amended, Public Law 91-596, 29 U.S.C. 651 e seq, because all the Vaccine Orders only apply to City Employees as workplace safety orders and are not orders of general applicability for the general "public health".

    b. they violate the Supremacy Clause; and

    c. they violate the New York State Public Health Law (PHL) §206(1)(l), which prohibits the NYDOH ("Commissioner") from establishing regulations that mandate adult vaccination. (See PHL §206(1)(l)

71. Pursuant to its exclusive power over matters of occupational health and safety, the federal government (long before the Covid-19 Pandemic) has established a comprehensive systems of laws, regulations, procedures, and administrative agencies to regulate occupational safety and health.

72. Congress created OSHA upon a finding that "personal injuries and illnesses arising out of work situations impose a substantial burden upon and are hindrance to interstate commerce in terms of lost production, wage loss, medical expenses, disability compensation." 29 U.S.C. § 651(a).

73. The OSH Act explicitly states that the Secretary of Labor is responsible for setting "mandatory occupational safety and health standards applicable to business affecting interstate commerce, and by creating Occupational Safety and Health Review Commission for carrying out adjudicatory functions." 29 U.S.C. §651(b)(3).

74. OSHA standards are applicable to New York City through the New York Public Employee Safety and Health (PESH) State Plan which covers all state and local government workers in the state and the New York PESH has adopted much of OSHA standards under the New York State Plan included in 29 CFR 1952.24.

75. The OSH Administration has promulgated under the general duties clause Section 5(a) regulations which places on each employer the duty "to furnish to each of his employees' employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees; and shall comply with occupation safety and health standards promulgated under the Act". 29 U.S.C. §654a

76. The OSH Administration has promulgated regulations that mandate employers to comply with the "Respiratory Protection" regulations at any time, including during a Pandemic, at 29 C.F.R. §1910.134(a)(1) atmospheric contaminations in the forms of sprays or vapors exist in the workplace, which under the general duty clause, it is the duty of the employer eliminate "recognized hazards" that are causing or are likely to cause death or serious physical harm to employees. See Affidavit of Expert Bruce Miller, Exhibit #2

77. The OSH Administration has promulgated regulations which apply to Respirators and Respiratory Protection Plan pursuant at 29 C.F.R. 1910.134(a)(2) that can protect employees and the public whom employees may serve from exposure to atmospheric contaminations, including the airborne virus that causes Covid-19, that can cause severe injury and death.

78. The OSH Administration has promulgated standards that allow New York City to utilize remote work as an administrative control to meets its general duty and utilize Powered Air Purifying Respirators which are 99.975 effective of preventing an employee's exposure to any airborne virus including Covid-19. See Affidavit of Expert Bruce Miller Exhibit 2, and See Affidavit of Expert Baxter Montgomery, MD, Exhibit #3 See Affidavit Expert Dr. Henry Ealy, NMD Exhibit #4

79. OSHA provides that "the Act is read as preventing any State agency or court from asserting jurisdiction under State law over any occupational safety or health issue with respect to which Federal standards have been issued under Section 6 of the Act". 29 C.F.R. §1902.1(a).

CLASS ALLEGATIONS

80. Plaintiffs realleges and incorporates by reference Paragraphs 1-79 of this Second Amended Complaint as if fully set forth herein.

81. Class representative Plaintiffs**,** seek class certification pursuant to Fed. R.Civ.P. 23(a), Fed.R.Civ.P. 23(b)(1)((A), to Fed.R.Civ.P. Rules 23(b)(3) to pursue claims for damages, and on behalf of themselves and all persons similarly situated.

82. The Class claims are appropriate under Fed.R.Civ.P. 23(b)(1)((A) because prosecuting separate actions by the Plaintiffs against the City would create a risk of inconsistent or varying adjudications with respect to the individual class members that would establish incompatible standards of conduct for the party opposing the class.

83. The Class claims raise numerous common questions of fact or law, including, but not limited to:

    a. Whether the Vaccine Orders are preempted by OSHA standards because the Vaccine Orders specifically targets City employees and not a larger public health goal;

    b. Whether the enforcement of invalid Vaccine Orders violate the First Amendment, 42 U.S.C. §1983 and amount to religious discrimination and harassment pursuant to the New York City Human Rights Act.

84. Class Certification is also appropriate under Federal Rules of Civil Procedure 23(b)(3). The common issues identified above will predominate over any purely individual issues. Moreover, a class action is superior to other means for fairly and efficiently adjudicating the controversy.

85. The claims of the named Plaintiffs are typical of the claims of the class in that the named Plaintiffs and class members claim that their right to a safe workplace pursuant to OSHA standards have been denied by City's reckless disregard to disclose to Plaintiffs their right to remote work and/or Respiratory Protections provided under OSHA Standards and subsequent denial of their right to

exercise their religious practice of abstaining from the Covid-19 vaccine and keep their job in violation of the First Amendment and the New York City Human Rights Law.

86. The named Plaintiffs claim that they were forced to seek an unnecessary religious exemption which subjected them to harassing interrogations regarding their religious practice of abstaining from the Covid-19 vaccine and subjected them to religious discrimination.

87. Thus, the named Plaintiffs seek have the same interests and have suffered the same type of damages as the class members, namely loss wages and benefits for being placed on leave without pay and/or terminated due to their refusal to submit to the Vaccine Orders

COUNT 1 – VIOLATION OF OSHA - PREEMPTION

88. Plaintiffs realleges and incorporates by reference Paragraphs 1-87 of this Complaint as if fully set forth herein.

89. The federal government regulates worker safety through the Occupational Safety and Health Act of 1970 (OSH Act), which is administered by Occupation Safety and Health Administration (OSHA). See 29 U.S.C. §§651-78.

90. The OSH Act authorizes the Secretary of Labor to promulgate federal occupational safety or health standards, id. § 655, that are "reasonably necessary or appropriate to provide safe or healthful employment and places of employment. § 652(8).

91. The OSH Act does not protect the general public but applies only to employers and employees in workplaces. See, e.g., id. § 651(b)(1).18

92. The OSH Acts standards are employer mandates for the benefits of employees, without exception unless an employer seeks a variance or some exception from OSHA.

93. The OSH Act provides "Human Rights" to employees to keep them employed in a safe work environment according to the OSHA U.S. Department of Labor 2020 Publication.[1]

94. OSH Act §18b expressly pre-empts any state law or regulation that establishes an occupational health and safety standard on an issue for which OSHA has already promulgated a standard, unless the State has obtained the Secretary's approval for its own plan, or any state or private employer can seek a variance to an existing standard for an experimental proposed standard, so long as the experimental variance is as effective as the existing standard. See 29 U.S.C. 655-Section 6(b)(6).

95. Several OSHA standards and directives are directly applicable to protecting workers against transmission of infectious agents, like Covid-19 and any other naval infectious variant. These include OSHA's Bloodborne Pathogens standard (29 CFR 1910.1030) which provides protection of workers from exposures to blood and body fluids that may contain bloodborne infectious agents; OSHA's Personal Protective Equipment standard (29 CFR 1910.132) and Respiratory Protection standard (29 CFR 1910.134) which provide protection for workers when exposed to contact, droplet and airborne transmissible infectious agents; and OSHA's TB compliance directive which protects workers against exposure to TB through enforcement of existing applicable OSHA standards and the General Duty Clause of the OSH Act (collectively "Infectious Disease Standards").

96. The existing OSHA Infectious Disease standards apply to the City through the approved New York State Plan approved in 1984.

97. The New York State Plan does not cover standards for Infectious Respiratory Diseases and therefore the State of New York has not taken responsibility for setting standards for any infectious

[1] See All About OSHA published by the U.S. Department of Labor OSHA 3302-OTR 2020 - https://www.osha.gov/sites/default/files/publications/all_about_OSHA.pdf

disease including respiratory diseases. See State Plan Standards at 12 NYCRR Part 800.6, 800.7, 800.5, 801 and 820.[2]

98. The City did not apply for a variance to implement the new experimental "Covid-19 standard" as required under 29 U.S.C. 655-Section 6(b)(6).

99. Because the Respiratory Standard and General Duty Clause are broadly written, they apply to the Covid-19 virus although not expressly identified and the existing Respiratory Standards applies specifically to Covid-19, including all variants and new novel airborne diseases.

100. The City's Covid-19 Vaccine Orders expressly states that they directly, substantially, and specifically regulate occupational safety and health for City and private employees only, and therefore, the Orders are occupational safety and health standard within the meaning of the OSH Act despite the fact that the Orders say they are for the benefit of the general public.

101. The City's Vaccine Orders are not laws of "general applicability" under the City's general state powers, because: 1.) the Vaccine Orders expressly violate the New York State Public Health Law PBH §206, which prohibits the Department of Health Commissioners from enforcing "adult immunization mandates" as part of its general policing powers, 2.) they do not expressly apply to all City residents, 3.) there is no automatic opt out provision that allows employees to just pay a reasonable fine for refusing to comply.

102. The City's Vaccine Orders also conflicts with the methods by which the OSHA standards control infectious diseases because the Covid-19 vaccine does not eliminate an employee's exposure to nor remove the Covid-19 airborne viral contaminant from the atmosphere in the workplace, which is the sole objective and method of the OSHA Respiratory standard which is a workplace environmental protocol to works on the outside of the employees' body to keep them safe. See

[2] See New York State Plan Codes, Rules and Regulations at https://dol.ny.gov/system/files/documents/2021/03/part801-805.pdf

International Paper Co. v. Ouellette, 479 U. S. 481, 494 (1987). (Held that "state law is pre-empted when it conflicts with the method by which the federal statute was designed….").

103. The Vaccine Orders implement a "medical treatment" that is injected into the body of employees that effects the employee's natural immune system but does nothing to shield the employee from exposure to any airborne viral contaminant, specifically the airborne virus that causes Covid-19.

104. The Vaccine Orders also conflict with general scheme of the OSHA Act (which was to place a non-delegable duty on employers to create safe workplaces to retain employees) because the Orders:

a. shifts the employer's nondelegable duty to provide safety equipment and/or engineering modifications to provide a safe workplace for employees and places that duty onto the employee to submit to an "experimental" method to keep their job and to try to create a safe workplace;

b. unreasonably penalizes employees with job, wage and retirement loss contrary to the October 5, 1990 OSHA Directive that prohibits employee sanctions; and

c. the proposed experimental standard is not effective as the existing OSHA Respiratory standards as required by 29 U.S.C. because it neither removes from the atmosphere nor eliminate an employee's exposure to the airborne virus that causes Covid-19.

105. On May 18, 2021, a New York State agency adopted the OSHA Respiratory standard 29 CFR 1910.134, and lists Powered Air Purifying Respirators (PAPRs) as an engineering safety device, which could have been adopted and implemented by all City agencies in order to provide PAPRs to employees who refused to take the Covid-19 on religious grounds and could not perform their jobs remotely. See Directive 4068 dated 5/18/2021[3]

106. Based on the foregoing, the City's Vaccine Orders are preempted by the OSHA Act.

[3] See May 18, 2021 New York State Directive 4068 at https://doccs.ny.gov/system/files/documents/2021/05/4068.pdf

COUNT II – VIOLATION OF THE SUPREMACY CLAUSE
(Article VI, Section 2, of the United States Constitution; 42 U.S.C. §1983)

107. Plaintiffs realleges and incorporates by reference Paragraphs 60-73 of this Complaint as full set forth herein.

108. Article VI, Section 2, of the United States Constitution, known as the Supremacy Clause, provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the Supreme Law of the Land, and the Judges in every State shall be bound thereby, anything in the Constitution of Laws of any State to the Contrary notwithstanding.

109. The Supremacy Clause mandates that federal law preempts any state regulation of any area over which Congress has expressly or impliedly exercised exclusive authority or which is constitutionally reserved to the federal government.

110. In 1979, the United State Government through the Department of Labor legislated Safety and health Regulations for General Industry 29 C.F.R. §1910.134. New York City is subject to these OSHA Act requirements.

111. Pursuant to 29 U.S.C. §667, entitled "State Jurisdiction and Plans," state standards for occupation health and safety may be promulgated in the "absence of applicable Federal standards." Thus, a state agency may assert jurisdiction under state law over any occupation safety or health issue with respect to which no standard is in effect under 29 U.S.C. §655.

112. As set forth in paragraphs 1 through 111 above, the OSH Act provides standards for General Industry to protect employees from air borne contaminants in the workplace through the Respiratory Standard and through administrative controls that include "remote" work for employees promulgated under 29 U.S.C. §655.

113. New York City has not obtained the requisite variance the Secretary of Labor to enact the Vaccine Orders, and the Vaccine Orders are not laws of general applicability, and they conflict with the OSHA standard methods, and general scheme of enforcement.

114. Accordingly, the Vaccine Orders and Mayor Executive Orders are preempted by the Supremacy Order.

COUNT III – VIOLATION OF THE FIRST AMENDMENT

(United States Constitution and 42 U.S.C. §1983)

115. Plaintiffs realleges and incorporates by reference Paragraphs 1-114 of this Complaint as full set forth herein.

116. The Commissioner for the City's Department of Health is responsible for issuing public health regulations for the City through the Commissioner's power authorized under N.Y. Public Health Law 206 – Commissioner; General Powers and Duties.

117. The Commissioner is the final policymaker for the issuance of public health regulations for the City.

118. The City's previous Commissioner in 2021 under color of law pursuant to PHL §206 issued the Vaccine Orders that caused Plaintiffs to be placed on leave without pay from around October 4, 2021 until the present for refusing to submit to the Covid-19 Vaccine Orders based on religious grounds in violation of the First Amendment.

119. The City's current Commissioner and the City's current Mayor, Eric Adams, has ratified the Vaccine Orders issued by the prior commissioner by failing to repeal the prior commissioners Vaccine Order as violative of the OSH Act express preemption clause, and the First Amendment.

120. The current Commissioner is a licensed M.D. physician in the State of New York who knew or should have known that the issued Vaccine Orders were preempted by the OSHA standards because

they conflicted with the method and scheme of the OSHA standards and the Vaccinex Orders were not regulations of general applicability because they did not apply to all City residents and they violated New York State PHL §206 which prohibits mandatory "adult vaccination".

121. The City is, therefore, liable for the acts of the Commissioner in the issuance of the Vaccinex Orders that caused Plaintiffs to be place on involuntary leave without pay for exercising their right to refuse to take the Covid-19 vaccine for religious ground in violation of the First Amendment.

122. The City's practice, along with the practice of all the City's Departments, of failing to train all City employees (including the City-Wide Panel responsible for reviewing Plaintiffs request to be exempted from the Vaccine Orders) in the OSHA Respiratory Standards and General Duty Standards caused Plaintiffs to be placed on leave without pay for exercising their right to refuse the take the Covid vaccine based on religious grounds protected by the First Amendment.

123. The City had no compelling reason for requiring its employees to disclose their religious beliefs before meeting its duty to provide Plaintiffs and all employees appropriate infectious disease OSHA workplace safety measures.

124. The City's practice of placing employees on involuntary indefinite leave without pay for refusing to submit to the City's Vaccine Orders based on religious grounds interferes with the religious practices of Plaintiffs.

125. The City's practice and conduct violates Plaintiff's right to the free exercise of religion, in violation of the First Amendment to the United States Constitution, made applicable to the states through the Fourteenth Amendment.

126. The City's Vaccine Orders were invalid on the date they were executed because they were preempted by the OSHA Act; and, therefore, the City had absolutely no government interest for enforcing the Vaccine Orders and placing the Plaintiffs on involuntary leave without pay for refusing to take the Covid-19 Vaccine, when the City should have and could have allowed

Plaintiffs to either continue to work remote or provide Plaintiffs with the appropriate PAPR safety equipment so that Plaintiffs could continue to work in a safe workplace.

127. The City's above listed conduct "targeted" religious exercise and violated Plaintiffs right to the First Amendment right to free exercise of religion.

128. By acting under color of state law to deprive Plaintiffs their constitutional rights, the City is in violation of 42 U.S.C. §1983.

129. As a direct and proximate result of the City's enforcement of its preempted, invalid and unauthorized workplace safety standard in violation of the OHA Act, Plaintiffs have suffered injuries and damages, including loss of pay since around October 4, 2021, lost of retirement credits, for some of Plaintiffs and other class members, loss of unemployment benefits, damage to their employment record due to false reporting for the reasons for being placed on leave without pay and emotional distress damages.

130. Plaintiffs and other members of the class have no adequate remedy at law for the deprivation of their right to free exercise of religion and have and are continuing to suffer serious irreparable harm to their constitutional rights unless the City's Vaccine Orders are declared invalid and the City is enjoined from continuing to "lockout" Plaintiffs from working their jobs for exercising their religious practice of refusing to ingest an unauthorized "experimental" safety standard. See *Roman Catholic Diocese of Brooklyn v. Cuomo, 592 U. S.* ____ (2020) ("The loss of First Amendment freedoms for even minimal periods of time, unquestionably constitutes irreparable injury." citing Elrod v. Burns, 427 U. S. 347, 373 (1976)) Emphasis added.

131. The City's unlawful conduct was willful, malicious, oppressive, and/or reckless and was of such a nature that punitive damages should be imposed on the City's implementing officials in their individual capacity as legally permissible.

COUNT IV – VIOLATION OF THE ESTABLISHMENT CLAUSE

132. Plaintiffs realleges and incorporates by reference Paragraphs 1-131 of this Complaint as full set forth herein.

133. The City's Vaccine Orders are not OSHA approved safety standards pursuant to 29 U.S.C. 655, but rather the Orders consist of a prescription from the City's Health Commissioner for all employees to ingest a medical treatment, specifically the Covid-19 vaccine, that affects the human bodies natural immune system. See Exhibit B, Affidavit of Dr. Baxter Montgomery.

134. The City's Health Commissioner is a M.D. physician licensed under New York laws for medical professionals who engaged in the practice of medicine when he prescribed the Covid-19 vaccine medical treatment to all City employees and private sector employees within the City.

135. The objective of the City's Vaccine Orders, as expressly stated in the Orders, has a general secular goal of reducing serious injury and death in City employees from the airborne virus that causes Covid-19.

136. The City's Vaccine Orders method of achieving its goal by prescribing a "medical treatment" not authorized by OSHA unconstitutionally results in the impermissible state sponsorship of a single religious practice over the religious practice of minority religious groups in the City.

137. The practice of medicine is one of many religious practices practiced by many ancient religions for thousands of years before the establishment of the western American medical system and said religious medical practices are still practice today.

138. Many of the Plaintiffs, including various minority faith groups like the some Hindus, Buddhist, Seventh-Day Adventist, Jainis, Jews and Muslims follow the religious medical practice of plant-based lifestyle medicine wherein adherents only ingest plant-based diet/food as prescribed in their religious teachings, as in the Biblical teaching in the Bible in Genesis 1:29. These minority faith groups also abstain from ingesting animal products to prevent and treat medical conditions,

including viral infections like Covid-19 and abstain from ingesting known harmful substances like alcohol, smoking, blood of an animal.

139. Plaintiffs and many faith groups around the world practice religious herbal or plant medicine to treat disease. Plaintiffs and various world religious groups and individuals place their faith and trust in the practice of herbal or plant medicine over pharmacological medicine as a faith belief protected by the First Amendment.

140. The First Amendment of the Constitution protects the individual right to the free exercise of religion, which includes the protection of religious beliefs and religious practices that flow from a belief system (whether from an established religious system or from an athiestic or evolutionary belief system) that touch and concern the human body of the person, which includes but limited to the wearing of beards, the wearing of a burka, the wearing of a yamaka, not taking blood transfusions, not eating pork or any unclean foods, and abstaining from ingesting any animal products or byproducts based on religious beliefs and abstaining from the ingesting of any harmful substances based on a belief system.

141. The U.S. Attorney General Jeff Session's Memorandum of October 6, 2017[4] interpreting Executive Order No 13798 §4, 89 Fed. Reg. 21675 (May 4, 2017) ("AG Memo") states that a government action that bans an aspect of an adherent's religious observance or practice, compels an action inconsistent with that observance or practice, or substantially pressures the adherent to modify such observance or practice, will quality as a substantial burden on the exercise of religion.

142. A law that conditions receipt of significant government benefits, like the "willingness to work on Saturday substantially burdens the religious practice of those who, as a matter of religious observance or practice, do not work on that day." See AG Memo page 4.

[4] See October 6, 2017 U.S. Attorney General Memorandum at https://www.justice.gov/opa/press-release/file/1001891/download

143. The City's Vaccine Orders, as applied, conditions retention of employment and employment benefits on all City employees submitting to the religious pharmacological medical practice of ingesting the Covid-19 vaccine and bans an aspect of Plaintiffs religious practice of abstaining from ingesting the Covid-19 vaccine, which is a substantial burden on the exercise of Plaintiffs religious practices.

144. The City locked out Plaintiffs from their jobs because they do not believe in the religious medical practice of ingesting the Covid-19 vaccine and refused to allow Plaintiffs to exercise their own religious medical practice for preventing and treating exposure to the infectious virus that causes Covid-19, including but not limited to the religious practice of Plaint-based lifestyle medicine which includes herbal remedies and abstaining from unclean foods and products.

145. The City's mandate of prescribing and enforcing only the Covid-19 vaccine as the only medical treatment acceptable to the City to allow a City employee to retain their job, violates the First Amendment Establishment Clause, because it establishes and furthers the practice of only one religious medical treatment over any other and bans all other religious medical practices.

146. Plant-Based Lifestyle Medicine is just one religious medical practice that three (3) international medical journals have determined is at least 75% effective in preventing Covid-19 in healthcare workers, yet Plaintiffs who practice their religious plant-based lifestyle medical practice have been banned from practicing their belief system and have lost their jobs because they choose to their medical practice over the Covid-19 vaccine religious medical practice. See Affidavit of Plaintiff Amoura Bryant attached as Exhibit 5 who practices Biblical Plant-Based Lifestyle Medicine.

147. The City's Order only allows Plaintiffs to remain on their jobs if they bow down to the City's religious medical treatment just because the City's Department of Health Commissioner "believes" and has "faith" in the Covid-19 vaccine to prevent the spread of Covid-19 and to reduce severe injury and death (which has not fully happened) and refuses to permit other religious medical

practices that can also increase the human natural immune system's ability to respond to disease and prevent sever injury and death.

148. The City's Vaccine Orders are not needed at all in the "workplace" because of the OSH Act Respiratory standards and General Duty of Clause that permits "remote work" provides the most effective methods of eliminating employee exposure to the airborne virus that causes Covi-19 and

149. The City's Vaccine Orders unduly favor's the religious medical practice of ingesting a vaccine that does not eliminate the spread of Covid-19, when the City had a secular more effective method of protecting employees in the workplace.

150. The City's Vaccine Orders are not generally applicable and are based on a religious "belief" system that the only way to prevent the spread of Covid-19 is the religious practice of utilizing pharmacological vaccines to treat disease rather than allowing other religious medical practices of the Plaintiffs to prevent exposure to the infectious disease.

151. People exercise their faith and belief in the pharmaceutical practice of medicine every time they submit to a physician prescription or take an over-the-counter medication regardless of whether they adhere to any specific faith.

152. In the U.S. there are religious medical practices that include natural pathic herbal medicine, chiropractic medicine, preventative medicine, plant-based lifestyle medicine and collectively they all reflect the belief system of the people they serve.

153. Physicians from any belief/religious medical practice must obtain consent from any person they treat with a prescribed treatment.

154. The City did not receive the consent of Plaintiffs because they did not believe in nor have faith in the pharmacological religious practice of ingesting a Covid1-9 vaccine and therefore, the City's lockout of the Plaintiffs because of their rejection of the religious practice of ingesting the Covid-19

vaccine is the establishment of the one religious pharmacological vaccine practice without including other religious medical practices.

155. Because the City had an alternative means of achieving the same interest of stopping the spread of Covid-19 in the workplace (which was to comply with the OSHA mandates) without raising concerns under the First Amendment, the City's requirement that Plaintiff's disclose their religious beliefs and practices only to deny their religious practice because their practice did not conform to the religious practice of taking the Covid-19 vaccine was for the "purpose" of establishing one religious practice over another. See *Jimmy Swaggart Ministries v. State Bd. of Equalization*, 250 Cal.Rptr. 891, 204 Cal.App.3d 1269 (Cal. App. 1988)

156. The "effective" of the City's Vaccine orders was the violation of the First Amendment Establishment Clause which prohibits government actions that unduly favor one religious practice (the religious Covid-19 vaccine) over another religious practice of abstaining from ingesting the Covid-19 vaccine. Id.

157. The City's Vaccine Orders do not incidentally affect religion; rather the Order as applied allows those who religious practices include ingesting vaccines to keep their jobs, while locking out Plaintiffs whose religious practice do not include ingesting the Covid-19 vaccine. *Kennedy v. Bremerton School District* 597 U.S. ____ (2022)

158. The City's Vaccine Orders imposed the Covid-19 religious pharmacological medical practice as "precondition" for Plaintiffs retaining their jobs.

159. The City's Vaccine Orders is not a time, place and manner regulation.

160. The First Amendment protects the ability of those who hold religious beliefs of all kinds to live out their faiths in daily life through "the performance of (or abstention from) physical acts." See *Kennedy v. Bremerton Sch. Dist*., 597 U.S. _____ (2022) citing Employment Div., Dept. of Human Resources of Ore. v. Smith, 494 U.S. 872, 877 (1990).

161. Plaintiffs do not "shed their constitutional rights" to exercise their religious medical practice just because they consent to work for the City.

COUNT IV
(Religious Harassment and Discrimination pursuant New York City Human Rights Law)

162. Plaintiffs realleges and incorporates by reference Paragraphs 1-161 of this Complaint as full set forth herein.

163. Because the City's Order was preempted by the OSHA Act, the City had no authority to require Plaintiffs or any City employee to submit to the City's Vaccine Orders nor did the City have authority to make compliance the Vaccine Orders a condition for retaining employment with the City.

164. The City violated the Plaintiffs rights protected by the City's Human Rights Law (CHRL) when it made the Vaccine Orders a condition for retaining their employment, in violation of the CHRL Administrative Code § 8-107 Subdivision (3)(a), which states that, "[i]t shall be an unlawful discriminatory practice . . . [f]or an employer …… to:

> impose upon a person as a condition of obtaining or retaining employment any terms or conditions, compliance with which would require such person to violate, or forego a practice of, such person's creed or religion, including but not limited to the observance of any particular day or days or any portion thereof as a sabbath or holy day or the observance of any religious custom or usage," (§ 8-107 [1] [a] [3].

165. The City had no authority to require Plaintiffs or any City employee to request a religious exemption and to disclose their religious practices as a pre-condition for them receiving an exemption from the illegal Vaccine Order or as a pre-condition for receiving the OSH Act right to either work remotely or to receive safety equipment, like the PAPR.

166. The City's investigation into Plaintiffs religious practices and denial of their request for an exemption from the Vaccines Orders was intended to unlawfully harass and coerce Plaintiffs to violate or forego

their religious practice of abstaining from taking the Covid-19 vaccine, when the OSHA Act provided more than adequate safety provisions that did not require Plaintiffs compliance Vaccines Orders.

167. The City's also intentionally failed to train and inform Plaintiffs of their OSH Act right to work remote or to receive safety equipment like the PAPR so that Plaintiff would not file complaints with OSHA and so that the City could continue to harass and coerce Plaintiffs to violate their religious practice of abstaining from taking the Covid-19 vaccine.

168. The City's act of placing Plaintiffs on involuntary leave without pay and locking them out of their jobs because of religious practice of abstaining from taking the Covid-19 vaccine for the purpose is harassment and extreme and outrageous conduct intentionally or with reckless indifference to Plaintiffs to right to practice their religious practice.

169. The City's is continuing to harass Plaintiffs in their most recent letter to them, dated around June 27, 2022 stating that they can return to their jobs if they violate their religious practice and take the Covid-19 vaccine.

170. The City act of denying Plaintiff's their unemployment benefits by falsely claiming to the New York Department of Labor that Plaintiffs were terminated from their jobs because of a violation of "condition of employment" amounts to intentional harassment and extreme and outrageous conduct because the illegal Vaccines Orders were preempted by the OSHA act and therefore not valid "conditions of employment".

171. The City's wrongful intentional harassment and discriminatory adverse action listed above have caused Plaintiffs severe emotional distress in violation of New York City Human Rights Law (CHRL) codified in Administrative Code § 8-107, entitled "Unlawful Discriminatory Practices."

172. On November 1, 2021, the New York City Human Rights Commission issued its anti-discrimination guidelines regarding New York City Human Rights Laws[5] titled "COVID-19 & Employment Protections," which relevant parts state as follows:

> Employers must **not discriminate against** or **harass employees** with actual or perceived infection with COVID-19, or based ……..on the presumption that they …….are more likely to contract COVID-19 due to …..**religion** or another protected status.
> (See "Guidelines attached Exhibit #28)

173. Even after the City's Human Rights Commission issued the anti-harassment and discrimination guidance, the City continued to harass Plaintiffs by keeping them on involuntary leave without pay, and denying them unemployment benefits.

174. Under information and belief, all of the Plaintiffs were not given the opportunity to engage in "Cooperative Dialogue" with the City as required by CHRL §8-102, wherein the City made a "good faith" effort either in writing or oral dialogue to discuss with Plaintiffs the available rights to remote work or receive safety equipment pursuant to OSH Act standards.

175. Because the City's Vaccine Orders violated the OSH Act and the City had a duty to provide either remote work or OSHA approved safety equipment so that Plaintiffs could continue to work, the City could not claim "undue hardship" as an excuse for failing to comply with the existing OSH Act standards.

176. The City required each Plaintiff to apply and/or reapply for religious exemptions, when they knew all along that they were never going to provide any accommodation that would allow any of the Plaintiffs to remain in their jobs either within their facilities or to work from home.

[5] See all amendments to the CHRL at https://www1.nyc.gov/site/cchr/law/amendments.page

177. The City knew or should have known that OSHA pre-empted all of their Vaccine Orders and that the hostility express toward the faith of employees did not absolve the City from its Duties under OSHA.

178. The City's acts of allowing Plaintiffs to make two and three requests for religious accommodations that were never going to be provided were acts of harassment and hostility in violation of the NYCHRL.

179. Defendant and each of them have recklessly disregarded the Human Rights of all Plaintiff by over and over denying them their right to safety equipment mandated by OSHA to be provided to them without exception and/or to the available reasonable accommodations that could have made the workplace safe.

PRAYER FOR RELIEVE

180. Declaratory judgement pursuant to See 28 U.S.C. § 2201(a), declaring that the OSHA Act preempts the City's Vaccine Orders and are void;

181. Injunctive relief pursuant to Federal Rules of Civil Procedure §65 enjoining the continued enforcement of the Vaccine Orders and mandating the City to reinstate Plaintiffs from their involuntary leave without pay status as follows:

   a. Plaintiffs seek immediate reinstatement to their positions at the same pay and seniority.
   b. Plaintiffs seek the appropriate workplace safety controls that will allow them to work their jobs safely either remotely for those who can and for those who need respirator equipment to be provided with a PAPR safety equipment for when Plaintiffs come in close contact with the public, so that they can perform their jobs.

182. Pursuant to their Section 1983 Claim and New York City Human Rights Claims, Plaintiffs also seek:

   a. Plaintiffs seek back pay for the time separated from Defendant until return to work.
   b. Loss payments into retirement fund and reinstatement of loss time into retirement calculation.

c. Expungement of discipline codes from each employee's personnel file and records

d. Mental and emotional distress damages.

e. Plaintiffs seek punitive damages in an amount to be determined by a jury.

f. Attorney fees and costs.

Dated: July 11, 2022

Respectfully submitted,

/s/ Jo Saint-George

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ORDER OF THE COMMISSIONER OF HEALTH AND MENTAL HYGIENE TO REQUIRE COVID-19 VACCINATION OR TESTING FOR STAFF IN RESIDENTIAL AND CONGREGATE SETTINGS

WHEREAS, on March 12, 2020, Mayor Bill de Blasio issued Emergency Executive Order No. 98 declaring a state of emergency in the City to address the threat posed by COVID-19 to the health and welfare of City residents, and such order remains in effect; and

WHEREAS, on March 25, 2020, the New York City Commissioner of Health and Mental Hygiene declared the existence of a public health emergency within the City to address the continuing threat posed by COVID-19 to the health and welfare of City residents, and such declaration and public health emergency continue to be in effect; and

WHEREAS, pursuant to Section 3.01(d) of the New York City Health Code ("Health Code"), the existence of a public health emergency within the City as a result of COVID-19, for which certain orders and actions are necessary to protect the health and safety of the City of New York and its residents, was declared; and

WHEREAS, pursuant to Section 558 of the New York City Charter (the "Charter"), the Board of Health may embrace in the Health Code all matters and subjects to which the power and authority of the Department of Health and Mental Hygiene (the "Department") extends; and

WHEREAS, pursuant to Section 556 of the Charter and Section 3.01(c) of the Health Code, the Department is authorized to supervise the control of communicable diseases and conditions hazardous to life and health and take such actions as may be necessary to assure the maintenance of the protection of public health; and

WHEREAS, the U.S. Centers for Disease Control ("CDC") reports that new variants of COVID-19, identified as "variants of concern" have emerged in the United States, and some of these new variants which currently account for the majority of COVID-19 cases sequenced in New York City, are more transmissible than earlier variants; and

WHEREAS, the CDC has stated that vaccination is an effective tool to prevent the spread of COVID-19 and benefits both vaccine recipients and those they come into contact with, including persons who for reasons of age, health, or other conditions cannot themselves be vaccinated; and

WHEREAS, section 17-104 of the Administrative Code of the City of New York directs the Department to adopt prompt and effective measures to prevent the communication of infection diseases such as COVID-19; and

WHEREAS, in accordance with section 17-109(b) of such Administrative Code, the Department may adopt vaccination measures in order to most effectively prevent the spread of communicable diseases; and

WHEREAS, pursuant to Section 3.07 of the Health Code, no person "shall do or assist in any act which is or may be detrimental to the public health or to the life or health of any individual" or "fail to do any reasonable act or take any necessary precaution to protect human life and health;" and

WHEREAS, residential and congregate care settings operated by the City and its contractors provide services to all New Yorkers that are critical to the health, safety, and well-being of City residents, and should take reasonable measure to reduce the transmission of COVID-19 in providing such services; and

WHEREAS, a system of vaccination for individuals working in congregate settings will potentially save lives, protect public health, and promote public safety; and

WHEREAS, pursuant to Section 3.01(d) of the Health Code, I am authorized to issue orders and take actions that I deem necessary for the health and safety of the City and its residents when urgent public health action is necessary to protect the public health against an existing threat and a public health emergency has been declared pursuant to such section; and

WHEREAS on July 21, 2021, I issued an order requiring staff in public healthcare settings to demonstrate proof of COVID-19 vaccination or undergo weekly testing;

NOW THEREFORE I, Dave A. Chokshi, MD, MSc, Commissioner of Health and Mental Hygiene, finding that a public health emergency within New York City continues, and that it is necessary for the health and safety of the City and its residents, do hereby exercise the power of the Board of Health to prevent, mitigate, control and abate the current emergency, and hereby order that:

1. Effective August 16, 2021, each staff member or contractor working at a residential or a congregate setting who has not submitted proof of full vaccination against COVID-19 to the agency or contractor for which they work must provide proof of a negative COVID-19 PCR diagnostic test (not an antibody test) at least once per week, to be provided in accordance with city policy..

2. A staff member who provides proof of full vaccination, in accordance with city policy, does not need to submit such proof of a negative test.

3. Within 90 days, the Department shall report to the Board of Health on the implementation of the requirements of this Order and any recommendations to further limit the spread of COVID-19 infection in congregate settings.

For the purposes of this Order:

(i) "Full vaccination" means at least two weeks have passed after a person received a single-dose of an FDA- or WHO-approved one-dose COVID-19 vaccine or the second dose of an FDA- or WHO-approved two-dose COVID-19 vaccine, except that, for the purposes of this Order, a staff member who provides documentation of having received one dose of any COVID-19 vaccine before August 16, 2021 will be considered fully vaccinated even though two weeks have not passed since their final dose, so long as, if such staff member received a two-dose vaccine, the staff member provides documentation that the second dose has been administered before September 16, 2021.

(ii) "Residential or congregate setting" means locations where City operated or contracted services are provided in a residential or congregate group setting, and are the following:

a. Shelters, including but not limited to family shelters, adult shelters, and safe havens, operated by the Department of Homeless Services or its contractors.

b. Drop-in centers operated by the Department of Homeless Services or its contractors.

c. Domestic violence shelters operated by the Human Resources Administration or its contractors.

d. HIV/AIDS Services Administration shelters and supportive housing operated by the Human Resources Administration or its contractors.

e. Supportive housing operated by:
   i. the Human Resources Administration or its contractors; or
   ii. the Department of Health and Mental Hygiene or its contractors.

f. Reentry hotels operated by the Mayor's Office of Criminal Justice or its contractors.

g. Transitional housing sites operated by the Mayor's Office of Criminal Justice or its contractors.

h. Runaway and homeless youth shelters operated by the Department of Youth and Community Development or its contractors.

i. Drop-in centers operated by the Department of Youth and Community Development or its contractors.

j. Residential juvenile justice programs, including but not limited to secure and non-secure detention and Close to Home programs operated by the Administration for Children's Services or its contractors.

k. Residential foster care operated by the Administration for Children's Services or its contractors.

l. Children's centers operated by the Administration for Children's Services or its contractors.

m. Senior centers operated by the Department for the Aging or its contractors.

n. Naturally occurring retirement community programs operated by the Department for the Aging or its contractors.

o. Social adult day cares operated by the Department for the Aging or its contractors.

p. Jails operated by the Department of Corrections.

(iii) "Staff member" means (i) a full or part-time employee of a City agency, or a contractor of a City agency, who works in a residential or congregate setting, and (ii) an intern or volunteer who works in-person with such City employee or contractor or with a recipient of services in a residential or congregate setting.

This Order shall be effective immediately and remain in effect until rescinded, subject to the authority of the Board of Health to continue, rescind, alter or modify this Order pursuant to Section 3.01(d) of the Health Code.

Dated: August 10th, 2021

Dave A. Chokshi, M.D., MSc
Commissioner

ORDER OF THE COMMISSIONER OF HEALTH AND MENTAL HYGIENE TO REQUIRE COVID-19 VACCINATION FOR DEPARTMENT OF EDUCATION EMPLOYEES, CONTRACTORS, AND OTHERS

WHEREAS, on March 12, 2020, Mayor Bill de Blasio issued Emergency Executive Order No. 98 declaring a state of emergency in the City to address the threat posed by COVID-19 to the health and welfare of City residents, and such order remains in effect; and

WHEREAS, on March 25, 2020, the New York City Commissioner of Health and Mental Hygiene declared the existence of a public health emergency within the City to address the continuing threat posed by COVID-19 to the health and welfare of City residents, and such declaration and public health emergency continue to be in effect; and

WHEREAS, pursuant to Section 3.01(d) of the New York City Health Code ("Health Code"), the existence of a public health emergency within the City as a result of COVID-19, for which certain orders and actions are necessary to protect the health and safety of the City of New York and its residents, was declared; and

WHEREAS, pursuant to Section 558 of the New York City Charter (the "Charter"), the Board of Health may embrace in the Health Code all matters and subjects to which the power and authority of the Department of Health and Mental Hygiene (the "Department") extends; and

WHEREAS, pursuant to Section 556 of the Charter and Section 3.01(c) of the Health Code, the Department is authorized to supervise the control of communicable diseases and conditions hazardous to life and health and take such actions as may be necessary to assure the maintenance of the protection of public health; and

WHEREAS, the U.S. Centers for Disease Control ("CDC") reports that new variants of COVID-19, identified as "variants of concern" have emerged in the United States, and some of these new variants which currently account for the majority of COVID-19 cases sequenced in New York City, are more transmissible than earlier variants; and

WHEREAS, the CDC has stated that vaccination is an effective tool to prevent the spread of COVID-19 and benefits both vaccine recipients and those they come into contact with, including persons who for reasons of age, health, or other conditions cannot themselves be vaccinated; and

WHEREAS New York State has announced that, as of September 27, 2021 all healthcare workers in New York State, including staff at hospitals and long-term care facilities, including nursing homes, adult care, and other congregate care settings, will be required to be vaccinated against COVID-19 by Monday, September 27; and

WHEREAS, section 17-104 of the Administrative Code of the City of New York directs the Department to adopt prompt and effective measures to prevent the communication of infection diseases such as COVID-19; and

WHEREAS, in accordance with section 17-109(b) of such Administrative Code, the Department may adopt vaccination measures in order to most effectively prevent the spread of communicable diseases; and

WHEREAS, pursuant to Section 3.07 of the Health Code, no person "shall do or assist in any act which is or may be detrimental to the public health or to the life or health of any individual" or "fail to do any reasonable act or take any necessary precaution to protect human life and health;" and

WHEREAS, the CDC has recommended that school teachers and staff be "vaccinated as soon as possible" because vaccination is "the most critical strategy to help schools safely resume] full operations… [and] is the leading public health prevention strategy to end the COVID-19 pandemic;" and

WHEREAS the New York City Department of Education ("DOE") serves approximately 1 million students across the City, including students in the communities that have been disproportionately affected by the COVID-19 pandemic and students who are too young to be eligible to be vaccinated; and

WHEREAS, a system of vaccination for individuals working in school settings or other DOE buildings will potentially save lives, protect public health, and promote public safety; and

WHEREAS, pursuant to Section 3.01(d) of the Health Code, I am authorized to issue orders and take actions that I deem necessary for the health and safety of the City and its residents when urgent public health action is necessary to protect the public health against an existing threat and a public health emergency has been declared pursuant to such section; and

WHEREAS, on July 21, 2021, I issued an order requiring staff in public healthcare and clinical settings to demonstrate proof of COVID-19 vaccination or undergo weekly testing; and

WHEREAS, on August 10, 2021, I issued an order requiring staff providing City operated or contracted services in residential and congregate settings to demonstrate proof of COVID-19 vaccination or undergo weekly testing;

NOW THEREFORE I, Dave A. Chokshi, MD, MSc, Commissioner of Health and Mental Hygiene, finding that a public health emergency within New York City continues, and that it is necessary for the health and safety of the City and its residents, do hereby exercise the power of the Board of Health to prevent, mitigate, control and abate the current emergency, and hereby order that:

1. No later than September 27, 2021 or prior to beginning employment, all DOE staff must provide proof to the DOE that:
    a. they have been fully vaccinated; or
    b. they have received a single dose vaccine, even if two weeks have not passed since they received the vaccine; or
    c. they have received the first dose of a two-dose vaccine, and they must additionally provide proof that they have received the second dose of that vaccine within 45 days after receipt of the first dose.

2. All City employees who work in-person in a DOE school setting or DOE building must provide proof to their employer no later than September 27, 2021 or prior to beginning such work that:
    a. they have been fully vaccinated; or
    b. they have received a single dose vaccine, even if two weeks have not passed since they received the vaccine; or

c. they have received the first dose of a two-dose vaccine, and they must additionally provide proof that they have received the second dose of that vaccine within 45 days after receipt of the first dose.

3. All staff of contractors of DOE and the City who work in-person in a DOE school setting or DOE building, including individuals who provide services to DOE students, must provide proof to their employer no later than September 27, 2021 or prior to beginning such work that:
   a. they have been fully vaccinated; or
   b. they have received a single dose vaccine, even if two weeks have not passed since they received the vaccine; or
   c. they have received the first dose of a two-dose vaccine, and they must additionally provide proof that they have received the second dose of that vaccine within 45 days after receipt of the first dose.

   Self-employed independent contractors hired for such work must provide such proof to the DOE.

4. All employees of any school serving students up to grade 12 and any UPK-3 or UPK-4 program that is located in a DOE building who work in-person, and all contractors hired by such schools or programs to work in-person in a DOE building, must provide proof to their employer, or if self-employed to the contracting school or program, no later than September 27, 2021 or prior to beginning such work that:
   a. they have been fully vaccinated; or
   b. they have received a single dose vaccine, even if two weeks have not passed since they received the vaccine; or
   c. they have received the first dose of a two-dose vaccine, and they must additionally provide proof that they have received the second dose of that vaccine within 45 days after receipt of the first dose.

5. For the purposes of this Order:

   a. "DOE staff" means (i) full or part-time employees of the DOE, and (ii) DOE interns (including student teachers) and volunteers.

   b. "Fully vaccinated" means at least two weeks have passed after a person received a single dose of a one-dose series, or the second dose of a two-dose series, of a COVID-19 vaccine approved or authorized for use by the Food and Drug Administration or World Health Organization.

   c. "DOE school setting" includes any indoor location, including but not limited to DOE buildings, where instruction is provided to DOE students in public school kindergarten through grade 12, including residences of pupils receiving home instruction and places where care for children is provided through DOE's LYFE program.

d. "Staff of contractors of DOE and the City" means a full or part-time employee, intern or volunteer of a contractor of DOE or another City agency who works in-person in a DOE school setting or other DOE building, and includes individuals working as independent contractors.

e. "Works in-person" means an individual spends any portion of their work time physically present in a DOE school setting or other DOE building. It does not include individuals who enter a DOE school setting or other DOE location only to deliver or pickup items, unless the individual is otherwise subject to this Order. It also does not include individuals present in DOE school settings or DOE buildings to make repairs at times when students are not present in the building, unless the individual is otherwise subject to this Order.

6. This Order shall be effective immediately and remain in effect until rescinded, subject to the authority of the Board of Health to continue, rescind, alter or modify this Order pursuant to Section 3.01(d) of the Health Code.

Dated: August 24th, 2021

Dave A. Chokshi, M.D., MSc
Commissioner

Executive Order 78

August 31, 2021

Mandatory Vaccination or Test Requirement for City Employees and Covered Employees of City Contractors

Download Executive Order 78

WHEREAS, the COVID-19 pandemic poses a danger to the health and safety of the City of New York and its residents;

WHEREAS, the U.S. Centers for Disease Control ("CDC") reports that new variants of COVID-19, identified as "variants of concern," have emerged in the United States, and some of these new variants, which currently account for the majority of COVID-19 cases sequenced in New York City, are more transmissible;

WHEREAS, the CDC has stated that vaccination is an effective tool to prevent the spread of COVID-19 and benefits both vaccine recipients and those they come into contact with, including persons who for reasons of age, health, or other conditions cannot themselves be vaccinated;

WHEREAS, the City and its contractors provide services to all New Yorkers that are critical to the health, safety, and well-being of City residents, and should take reasonable measures to reduce the transmission of COVID-19 when providing such services;

WHEREAS, a study by Yale University demonstrated that the New York City Department of Health's vaccination campaign was estimated to have prevented about 250,000 COVID-19 cases, 44,000 hospitalizations and 8,300 deaths from COVID-19 infection since the start of vaccination through July 1, 2021, and the Department believes the number of prevented cases, hospitalizations and death has risen since then; and that between January 1, 2021, and June 15, 2021, over 98% of hospitalizations and deaths from COVID-19 infection involved those who were not fully vaccinated;
WHEREAS, it is essential that the City promote the best health and safety practices recognized in light of current scientific understanding of the conditions under which COVID-19 can spread; and

NOW, THEREFORE, by the power vested in me as the Mayor of the City of New York, it is hereby ordered:

Transcript: Mayor de Blasio Holds Media Availability

August 31, 2021

Mayor Bill de Blasio: Good morning, everybody. When we started out on our vaccination effort, we called it Vaccine for All, literally said we're going to make this something that works for every New Yorker, everywhere, every neighborhood, easy, fast, free, all the things that New Yorkers care about, making sure they can get in and out fast, of course, knowing it's there for everyone for free. We've seen amazing things happen, by far the biggest vaccination effort in the entire history of New York City that keeps growing every day and the numbers are impressive and we keep using new approaches. And this weekend, the weekend of faith, a key example, let's bring all the houses of worship into this effort, a trusted community, voices connecting with their congregants, saying here's vaccination for you. Here's a way to make it work that's easy. Here's a way to do the right thing for yourself, your family, your community, the houses of worship did an amazing job. This weekend, 2,000 vaccinations at the houses of worship as part of our referral program, 2,000 more people got vaccinated, that means every single one of those folks were able to get a bonus themselves, the $100 incentive, but it also means that every house of worship got a $100 for each person that they convinced to come in and get vaccinated. This is a powerful approach and it's going to grow and the referral bonus approach, I want to be clear, the beauty of it is the individual is rewarded for coming forward, but whatever the organization is a house of worship, a community group, a business they get a boost too, and a thanks from the city for doing the right thing and helping to get people vaccinated. Lots of great examples around the city, non-profit organizations, houses of worship, businesses, small businesses, community businesses, restaurants that are already participating in the referral bonus program.

One great example, East Flatbush Village, an amazing community group does great, great work, they have really focused on getting the community vaccinated in the place where we need extra help reaching people, and they've already referred over 450 people in the East Flatbush area to get vaccinated. 450 more people are going to be safe, helping to move the city forward, but also thousands of dollars in referral bonus support for East Flatbush Village. Everyone wins in this equation. East Flatbush village does afterschool tutoring for kids, they do really important anti-Violence work in the community, they do youth sports, great work to make the community better, leading the way on vaccination as well. I want you to hear from the Executive Director of East Flatbush Village, who's done so much to help the community, my pleasure to introduce Eric Waterman.

[...]

Eric, thank you so much. I really want to thank you. You've given a great example of what a community group can do. I mean, one community group bringing in well over 400 folks, I'm so happy that's benefiting the good work you do in general, but I'm particularly happy that we got over 400 more New Yorkers who are vaccinated, and then that means more people hear the story that it worked, that it was easy, there's going to be a huge multiplier effect here. So, I really want to thank you for what you're doing for these Flatbush community and for giving a great example to everyone that so many community organizations and other organizations can be a part of this and make a huge impact. Thank you so much for everything you're doing.

Now, again, I mentioned it's not just community-based organizations or how's the worship. We welcome small businesses. We welcome barbershops and beauty salons. We welcome restaurants. We welcome bodegas. Anyone who wants to be a part of this, encouraging community members to come in and get vaccinated, we want those small businesses to benefit. We want to make sure that the individuals from the community come in and get back safe first and foremost, we want them to benefit from it, but we

want the small businesses to benefit as well. Here's an example, a restaurant in Harlem. Safari, great restaurant serves up wonderful Somali food, and they recognize after everything they've been through, the restaurant is hit hard, like so many others by the pandemic. They recognized that they could not only the restaurant back but do something great for the community. In a second, you're going to hear from Shakib Farah, who with his wife, Mona, doing great work, educating the community about the power of vaccination. So, here's a community-based business. Customers love it. Community loves it. And here's another place where people are hearing how important it is to get vaccinated and an opportunity for the restaurant to benefit from the referral bonus program. Everybody wins in this scenario. I want you to hear this great example from the wonderful Safari restaurant in Harlem, Shakib Farrah. Welcome.

[…]

Thank you so much. Shakib and I want to tell you, first of all, give you credit for wearing the t-shirt. You got to always promote a small business, a local restaurant, so I'm glad you're getting the name out there. I've heard great things about the restaurant, I look forward to visiting, but I really want to thank you for giving people a great example of how every community business can help to keep people safe, and I wish you great success going forward.

All right, now, the referral bonus, great opportunity for our restaurants as part of how we bring them back. But most important thing for restaurants for all of us is to make this city healthy, make this city safe, make sure we defeat COVID once and for all. I've been talking a lot lately about the fact that we need to get our focus on ending the COVID era once and for all we can do that, we can do that if enough of us get vaccinated and we can therefore avoid ever having to go back to restrictions, right? Remember when all those restaurants got closed, those businesses got closed. Remember the devastating impact. We can never let that happen again. We first and foremost have to protect people because of their health and wellbeing. We have to save lives, but we also can't see our businesses destroyed because we didn't do everything in our power to fight COVID. So that's why the mandates we put in place are so important. And a Key to NYC is here, is being implemented all over the city. Customers know they'll be safe when they're in a restaurant or any indoor entertainment. The folks who work there know they're safe as well. It's not easy. There's real work to be done. That's why we spent weeks on outreach and education, and that's why enforcement doesn't begin until September 13th, but we want to make it as clear as possible. We want to answer questions. We want to work with restaurant owners and other business owners to get it right. One of the things we heard from restaurant owners, as they wanted a simple message that they could put up at the entrance to a restaurant, so everyone understands the rules and they understand that it's a city rule. It's not, something made up by each restaurant, it's universal now. This is the poster that we're going to have available, and in multiple languages for restaurants in a variety of communities to make clear, dear, this is something everyone has to do for the wellbeing of all of us to keep us moving forward to defeat COVID once and for all.

Now I want everyone to know, we may clear on this poster, by the way, someone – let's say someone goes to a restaurant and they didn't know about the rule, they really want to go to the restaurant and they're ready to get vaccinated. We've done a lot of research. We know the vast majority of unvaccinated people are actually willing to get vaccinated. They just haven't done it yet. Really want to go to that restaurant? Do you really want to go to that concert? Whatever it may be, here there's a way you can access the information, the nearest vaccination site. You can literally go to that vaccination site, get your first shot, get your card, come right back, go to that restaurant, go to that movie theater, go to that concert. That's how flexible this rule is. We just want people to get going on vaccination. We know people get the first shot end up getting the second shot as well. So, the information is there and anybody who wants these posters or wants to get them in other languages, and we'll be reaching out to small businesses, but also small businesses of course, can go to nyc.gov/keytonyc, as can all New Yorkers to get the facts about this new approach. Remember it's for indoor dining, indoor entertainment, it's for indoor fitness, and we in – the guides we're providing, the information we're providing today are showing the best practices. We're showing how to go about if you're a business, or you know, a gym, whatever it is, the best way to simply check a vaccination card. Now, remember restaurants and bars have planning experience checking IDs. You check in when you go to a fitness center or a gym, there's lots of history here that we can draw on, but we're showing real templates so it's clear how a business can manage this and make it work, and also how to know when there's a fake vaccination card and what to do about it. And by the way, when there's a fake vaccination card, that means someone has committed a very serious crime, literally that could lead to prison time for anyone who fraudulently creates a fake vaccination card, that is a major offense. So, we make that clear to business owners and what to do about it. I want you to hear about this new guide and what it's going to mean helping New York City businesses to protect their customers, their employers, and the entire city, and move us all forward. Someone who's been fighting all the way through COVID to help small business, our Small Business Services

Commissioner Jonnel Doris.

Commissioner Jonnel Doris, Small Business Services: Thank you, Mr. Mayor. You know, everywhere I go around the city visiting our small businesses, our restaurants, our mom-and-pop shops. You can just feel the city coming alive again this summer, I can see our small businesses coming back. We want that to continue. We need that to continue. And the way to make sure this continues is by safely getting people vaccinated through the Key to NYC Program. The first day, the Key to NYC launched, I visited Ricardo Steak House in East Harlem, one of the 11,800 plus restaurants in our Open Restaurants Program, the atmosphere was full of life and energy. And most importantly customers, they have already had the flyer up. They already began to process and ask and customers if they're vaccinated or not. And they said something to me, I think that was so important. The manager said to me that this took away the ambiguity of what it is and who's coming in and what to do, and that need to make their customers and their workers understand the processes that were implemented. They said that it was consistent. They said that it was clear, and everybody understood what was expected. And that is what we've done here at SBS, which is walking the corridor or speaking to small businesses, East Harlem, Coney Island, all around the city to hear from them about what we need to do to make sure they fully understand and grasp what is being implemented here. The key to NYC is protecting our workers, our customers, and also our small businesses across the city.

Our job here at SBS is to keep training them and educated them to make sure that whatever is needed is possible and that we give them the resources to do it. Already we've hosted various online trainings. We have 600 plus canvassers out in the field speaking to small businesses now. And I thank our BIDs, our Business Improvement Districts, our chambers [inaudible] Small Business Council, all who are doing this significant outreach and support this mandate that is out there now. And, today, we're putting in our brand-new industry specific guidance that will further help business owners with the mandate. If you are a restaurant, you'll be able to look and see exactly what you need to do. If you are a gym, you'll have specific help on how to put your plan in action. If you're a movie theater, you'll find out on how to keep the line moving. Or any business for that matter, we have specific guidance for you. They are free weekly online trainings as well every Wednesday, and trainings also come in in Mandarin and in Spanish. And to help you create your business implementation plan, we've created a template that you can quickly and easily fill in, how to put your plan into action, know what to check, how to keep things moving quickly when verifying vaccination cards, all of that and more. Go to nyc.gov/KeytoNYC to find out all the information you need there. These resources will be available in 13 languages.

To our small business owners, we are with you every step of the way, providing the necessary resources, and education, incentives for vaccine referrals. We will make this easy as possible. If you have any questions, as we've done throughout the pandemic, our team is here to help you with a personal one-on-one support. Just give us a call at 888-SBS-4NYC – 888-SBS-4NYC. Thank you, sir.

Mayor: Thank you, Commissioner. I love when you remember to give that phone number, thank you very much. So, everyone, throughout the pandemic, we've been focusing on the needs of all New Yorkers. But we all, as New Yorkers, we love – we love our restaurants. We love all the parts of the city that make us so special. You know, the restaurants in New York City are part of our personality, part of our heart and soul, part of our energy, part of why people come here from all around the world, but also our restaurants represent all of us. They represent all of our cultures. They represent the dreams of people who thought, maybe I could create something great, and then they do it. So, from the very beginning, I've been listening to the voices of restaurant owners, as they've talked about what they need to survive. And we've tried, every step of the way, starting with outdoor dining and so many other steps to help them through. And, thank God, so many have made it. One of the people who has been there with us every step of the way, literally, every step of the way, and he is offered ideas, critiques – when he likes something, he says it; if he doesn't like something, he says it. He has been a great advocate for his industry, but he's been someone who's worked with us to always find the next step that we could take to keep people safe and protect the employees and the patrons of the restaurant industry and everyone who loves it. He's been with us every step of the way and I want to say thank you for that. The Executive Director of the New York City Hospitality Alliance, Andrew Rigie.

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Mayor: Amen. And you're at the table right now. I just want to say, we need to see a table – you're at the table. See, it works. Andrew, thank you. You've been a stalwart. And to you and your colleagues, everyone who's been with us, we appreciate it as we work this through. And look at these guides – I just want to make sure everyone sees – this is the kind of thing you'll see online for indoor dining, for indoor entertainment, for fitness facilities, specific, detailed plans on how people can make this work effectively

and where to go for more information. And that's crucial – we want to – we, obviously, want to put forward proactively the information that business owners need. We want to make it as easy as possible, but we know there's going to be a lot of questions. So, we welcome those calls from business owners to work it through. And the team at SBS is ready, willing, and able, including going out to businesses and working with them on the scene to show them the best way to approach this new effort for the good of all.

Now, I want you hear from a City Council member who has been a strong advocate for small business and a strong advocate for ending the COVID era. And he has supported the Key to the New York City approach and the understanding that we need the right kind of mandates to make sure we never slip backwards. He's worked with small businesses in the community to make sure this plan comes to fruition for the good of all and he really understands what it's going to mean when we get this right for the future of New York City. My pleasure to introduce from Manhattan, Council Member Keith Powers.

[…]

Mayor: Yeah. It's Keith Power's diet plan. You heard it here first. Thank you, Council Member. All right. So, now, listen, we've talked about small businesses. We've talked about restaurants, what's crucial to our recovery, saving our businesses, saving jobs, bringing back the life of this city. And we know that's going to be a crucial part of our economic recovery, but we also know our recovery is deeper than that. And we have to keep focusing not only on people's health, fighting COVID, but on public safety as well. All of these pieces go together in a recovery for all of us. So, yesterday, we talked about a profound problem, the fact that our court system is not fully functioning. I want to say it again really clearly, specifically – not fully functioning when so many other parts of our society are fully functioning. Again, for the first six months of this year, when you compare 2019, the first six months of 2019, 405 trial verdicts in New York City. The first six months of 2021, only 18 in New York City. There should not be excuses for that. You know, I would like to hear from the folks who run the courts not their excuses or pointing fingers elsewhere, but just say what they're going to do to fix it right now. We all, in every party that you're hearing – private sector, restaurants – open, making it work. We're bringing back schools, City offices, you name it. There's so many places where people are back, but our court system is just not functioning and it's moving at a snail's pace compared to the rest of the state. So, for that same six-month period, here's another comparison. In all the rest of New York State, 40 trials per month on average. In New York City courts, only seven trials per month. It makes no sense, considering that so much of the activity is – obviously should be here in the courts in New York City. So much that has to be addressed should be happening here in New York City, but it's not. So, how do you stop crime if criminals think there will be no consequences? If criminals know there's not going to be trials, it's not helpful in the least. And just – you'll hear later on this week from our NYPD Commissioner what he's seeing in this situation, but I don't even think you need an expert to see the common sense of this, that if there's no trials, there's no consequences, that doesn't help us stop crime. That's a whole reason we have a criminal justice system to begin with. And there's supposed to be speedy justice, that goes back to the founding of the Republic. And, instead, we see snail's pace justice and it's hurting our efforts to keep the city safe.

I want you to hear from a truly respected national expert. You know, in the last eight years, I've been working on issues of public safety with incredible professionals at the NYPD, and mayors around the country, and there's one name I hear over and over – and it's real interesting, I hope he appreciates this fact that when folks want to talk about one of the ultimate wise men, one of the people really understands public safety and how to bring police and community together in common cause, they talk about Chuck Wexler. I've heard his name, dozens and dozens and dozens of times all around the country. And he understands there is an interconnectedness here. What happens at the community level, what happens with policing, what happens with courts – it all needs to move together. And if one piece of the equation is not working, everything else is affected. I want you to hear from him directly about why it's so important to get our court system up and running 100 percent, so all crimes are addressed. He is Executive Director of the Police Executive Research Forum, one of the most trusted voices related to public safety in the United States of America. My pleasure to introduce Chuck Wexler.

[…]

Mayor: Thank you so much, Chuck. And beautifully, beautifully explained. And, look, I agree with you, this is about everyone chipping in, and it can be done, but it's not going to work without the court system. And I think you just put it in powerful perspective. This is a crisis in plain sight and we've got to be clear about it. Right now, there should be a lot of energy focused from elected officials, from the media, from everyone to say, how do we fix this? We all need to fix it together, but there's no way we get back to the levels of safety that we need if we don't have a functioning court system, it just stands to

reason. Chuck, thank you. And I agree with your optimism. We are going to get there. There's no question. We've proven before and you've been a big part of it around the country that we can come up with better and better ways to keep people safe. So, thank you. Thank you for the great work you're doing.

Okay. Everyone, let's go to our indicators today. And, again, we start with the doses administered to-date. And I've got to tell you, I'm seeing great things out there. We talked about Weekend of Faith, the referral bonus program, the mandates are having an impact, incentives are having an impact. From day-one, 10,678,226 doses and growing all the time. Number-two, daily number of people admitted to New York City hospitals for suspected COVID-19 – today's report, 126 patients. Confirmed positivity levels, 16.91 percent and a hospitalization rate of 1.31 per 100,000. And number three, new reported cases on a seven-day average – 1,677.

A few words in Spanish – and I want to go back to making sure that our restaurants come back, that the employees are safe, the customers are safe, everyone together works with the Key to NYC.

[Mayor de Blasio speaks in Spanish]

With that, let's turn to our colleagues in the media and please let me know the name and outlet of each journalist.

Moderator: We'll now begin our Q-and-A. As a reminder, we're joined today by Commissioner Doris, by DCAS Commissioner Lisette Camilo, by Mayor's Office of Criminal Justice Director Marcos Soler, by Dr. Dave Chokshi from Health Department, and by Dr. Mitchell Katz. The first question today, it goes to Juliet from 1010 WINS.

Question: Hey. Good morning, Mr. Mayor.

Mayor: Hey, Juliet. How have you been?

Question: I'm okay, thank you. So, given that you're looking at these protocols and you're going to use these protocols for business, I was wondering would you do something similar for City employees as they return to work this September?

Mayor: Juliet, I want to make sure I understand your question so I want you to restate. I mean, obviously, we have a wide variety of health and safety protocols in place for City employees. So, I want to make sure I understand what you're asking.

Question: Yeah. I was wondering if these are going to be sort of mandated protocols for people when they come back to work in City jobs. Will there be protocols to look at or check for vaccination? Check for masks? For testing?

Mayor: Yeah. Different pieces there, Juliet. Right now, as you know, we have for health care workers a State vaccination mandate. For Department of Education employees, we have a City mandate. First, on the 13th it's vaccination or tests, but then, on the 27th, it goes to vaccination only. We're going to also on the 13th implement for all City workers, the vaccination or test standard. In addition, of course, depending on the work site, but indoors schools, hospitals, masks all the time in places where people are coming in contact with the public; indoors, masks. Variety of protocols, cleaning, you name it. But that's something we're doing across all City agencies, of course. Go ahead, Juliet.

Question: Okay. Thank you. Also, what are the plans – given, you know, there are terrorist attacks in Afghanistan – what preparations have you made to protect the city in the event that there is any indication of any sort of upgraded, you know, alert here? And given that the anniversary of 9/11 is approaching.

Mayor: We take that very, very seriously, Juliet. Right now, first of all, to emphasize, despite the very painful things happening in Afghanistan, there are no specific and credible threats against New York City right now. And that's crucial. We're watching all the time. But, of course, we're hyper-aware that the 20th anniversary of that horrible day, 9/11 is coming soon. And NYPD has been preparing intensely and we're working with all of our partners in the Joint Terrorism Task Force. We'll have more to say on that as we get a little bit closer, but, rest assured, very intensive preparations are being made. But, most importantly, no specific and credible threats directed at New York City at this moment.

Moderator: Next is Dana from the New York Times.

Question: Hi, Mr. Mayor. Quick question. Why – you know, has the City given any

consideration to requiring childcare workers who work with kids under two to get vaccinated?

Mayor: Yeah. We are looking at a wide variety of employees of different types, different parts of the City workforce in general, meaning private and public. We've been moving the mandates so far that we thought were absolutely essential, but we continue to look at that. And, as I've said, we've been climbing the ladder. So, we're looking and we'll have more to say soon. Go ahead, Dana.

Question: Thanks. Yeah. I mean, I ask for, I guess, the obvious reason, which is that children under two can't wear masks. I mean, is there a reason why public school teachers are being required, but not daycare workers?

Mayor: Well, again, very different settings. Obviously, very different size settings. A lot of daycare settings are much smaller. But, again, I will just say it this way, and I'll turn to Dr. Chokshi, because his agency has a lot to do with regulating childcare facilities. We, again, are looking systematically sector by sector. We take it seriously, of course. We need everyone to be safe and we want to figure out the right approach for each one. Dr. Chokshi, do you want to add?

Commissioner Dave Chokshi, Department of Health and Mental Hygiene: Thank you, sir. That's exactly right. We are looking at this systematically. We're particularly looking at settings where we want to protect people, particularly younger people who are not eligible to get vaccinated yet. That's why as the Mayor said, you know, we've started with schools. But we do have a range of other settings where additional requirements may come into play in the future. Thank you.

Moderator: The next is Michael Gartland from the Daily News.

Question: Good morning.

Mayor: Hey Michael, how you been?

Question: Good. How are you doing?

Mayor: Hanging in, brother.

Question: I see you taking a page out of Jimmy Oddo's handbook with your poster today.

Mayor: Yeah. But look, Michael, hold on. My poster is very clean, neat. You can read it. Jimmy's poster was the, you know, the scribblings of a mad genius. Okay. I didn't know – I was looking at that thing for a while. I was like, what is he trying to tell us here? Continue.

Question: I've got a couple of questions. You know, you talked about vaccine incentives, both for individuals and restaurants, houses of worship. As I'm sure, you're probably aware we had a story that ran Saturday about how the Reverend Kevin McCall basically putting out there that he's giving vaccination exemptions as an enticement for people outside of his church. And as well as, you know, exemptions to people in his congregation. And I was wondering, you know, how prevalent is this? Is the City witnessing a lot of this sort of thing and you know, what should you do? What should the City be doing to push back on this? What are you doing to push back on it?

Mayor: Yeah, we are not – I'll turn to Dr. Katz and Dr. Chokshi for their insights, but I'll tell you from what I've seen, now a year and a half watching this crisis and acting on this crisis. I have not seen that. I know Reverend McCall. I respect him. I appreciate him. I was very saddened to see that. I think that's a mistake. I think it should stop. Those, quote unquote, exemptions are not going to be honored. They're just, that's not the way to do things. And so I think people should recognize so important to get vaccinated leaders of veritably every faith tradition have stepped forward, encouraged vaccination. You heard on Thursday, we had the Cardinal here and Reverend A.R. Bernard and Rabbi Potasnik. And so many faith leaders across the whole spectrum have been hosting vaccination events. So, we just got to focus on getting people vaccinated and you know, making sure people understand that's the only way to be safe. In terms of if we've seen much of this, Dr. Katz or Dr. Chokshi, you want to add?

President and CEO Mitchell Katz, NYC Health + Hospitals: Yes, Mr. Mayor, I think you've covered the important points. We haven't seen people bringing letters, but I just want to make sure everyone understands that no one can grant you a religious exemption. Religious exemptions are based on someone's personal, sincerely held

beliefs. They're not based – no one can give you an exemption. But we have not seen these letters. Thank you, sir.

Mayor: Thank you. Go ahead, Dr. Chokshi. You want to add?

Commissioner Chokshi: The only thing that I'll add, sir, is that we have seen countless examples of faith leaders stepping up to support our vaccination efforts. They do it out of care and concern for you know, people who have been a part of their community for years and decades. And that's been vitally important. We've seen it not just in the Weekend of Faith as the Mayor mentioned this past weekend, but over the last several months. It helps people to worship more safely. And as we've been saying, vaccination makes every activity safer. So, we've been very pleased with that partnership with faith leaders and we'll continue to deepen it in the weeks ahead.

Question: Thank you. Go ahead, Michael. Thank you guys. On courts, I'm wondering if you think, should OCA be calling in New Yorkers for jury duty given, you know, spikes in wherever related Delta cases? And you know, you mentioned helping out with facilities yesterday and I believe last night, I mean, how exactly would the City address that the court issue facilities wise? I mean, do you have kind of specifics you can give us on that?

Mayor: Yep. I'll start. And I want to on the facilities question, turn to our Commissioner for Citywide Administrative Services, Lisette Camilo in just a moment. And then on the question of how important it is to have courts functioning and the impact, I'll turn to our Director of the Mayor's Office of Criminal Justice, Marcos Soler, also in a moment, but let me frame it. We got to address safety and health across the board. If criminals suffer no consequences, then there's a safety problem. So, we have to have a functioning court system. If I said to you, well, why don't you know, why don't the police stay home or firefighters stay home or EMS stay home, or, you know, go on, go on with all the parts of our society. Why doesn't everyone stay home because of COVID? Well, no, the answer is not that. The answer is to fight back. The answer is to get people vaccinated. The answer is depending on the setting, to wear masks, to do the proper ventilation and cleaning. It's not to give up. It is to figure out how to make it work. And juries come together just like all other people in workplaces come together. We need juries for a functioning system. So, there's something strange. There's almost like a suspension of belief going on here that somehow the court system has created this fiction that they could be allowed not to function while everyone else has to function. And I don't buy it. They need to function too. They should do it safely and we'll help them. And we've been making that offer for over a year now. In terms of the facilities themselves, I want you to hear from Lisette Camilo and I want to summarize. We provide vaccination assistance, free masks, air purifiers, plexiglass barriers, deep cleaning, you name it, for the buildings that are our buildings and Lisette that can speak to you about that ongoing effort to make sure courts are safe. And the fact that we welcome any additional requests that we can address. The State has responsibility for the courts, obviously. But we'll work with them in every way possible to address concerns. The only thing we won't accept is not having trials. Failure's not an option here. That's my message to the court system. Commissioner Lisette, Camilo, talk about the efforts that have been made to help keep everyone safe.

Commissioner Lisette Camilo, Department of Citywide Administrative Services: Thank you, Mr. Mayor, happy to. And like you said, we work very closely and we talk to OCA every day, our teams, in order to fulfill any requests that they may have regarding their facilities. But since the beginning of the pandemic, CAS assessed every single HVAC system in every single building. We've upgraded the outdoor air intake and installed the highest rated filters that the HVAC systems could withstand. We routinely replaced the filters to ensure that we have really a good clean filter to address any air quality issues. But we really rely on OCA to tell us what additional things they need for us to do. We are happy to assist them. We work with them on the purchase of portable air filtrations, and we routinely work with them to install plexiglass barriers wherever they dictate they are there. They have to tell us what their operations need and we will wherever we can, go in and meet those needs particularly on the facility, maintenance wise.

Mayor: Thank you so much, Commissioner. And I want to turn again to Director Marcos Soler to talk about, again, why it's so important. Why is just not having jury trials is not an option if we're going to fight crime and keep people safe. Marcos Soler.

Director Marcos Soler, Mayor's Office of Criminal Justice: Thank you, Mr. Mayor. I think what is important is for [inaudible] and can deter and incapacitate those individuals, those small number of individuals who are drivers of gun violence. And right now we don't have that because we don't have – we don't have enough appearances. We don't have enough pre-trial hearings. We don't have enough motions. We don't have enough pleas as you have indicated. All those numbers are down by 40, 50 percent. And as a result of that, we don't have trials. And it's absolutely important to

have a system that can deter and incapacitate those individuals who pose the highest risk to our communities.

Mayor: Thank you, Marcos. And look, I want to just broaden the point. We also – it's not just the worst crimes. Of course, that's our first concern. We don't want any criminality or lawlessness to go unaddressed. So, the point is what worked so well from 2014 through 2019 was neighborhood policing, working with a functioning court system. And we proved for six years, we could drive down crime consistently and deepen the cooperation between NYPD and community. But that required a court system that created consequences for a range of crimes. We needed anyone considering making, doing something illegal that, to know that there would be consequences. When there were functioning consequences, it helped us keep everyone safe and stop crimes of all kinds. We've got to recreate that now. We're recreating all the other parts of our society. We've got to do that right now with our court system. Go ahead.

Moderator: The next is Emily from NY1.

Question: Hi, Mr. Mayor. Could you please tell me what you know about a cargo building at JFK Airport being readied for the processing of Afghan refugees as they arrive here in this area?

Mayor: Emily, thank you for the question. Our Emergency Management Office was asked to work with federal and State officials on a contingency plan and to prepare a building just in case. What we're hearing right now, and of course, all of the decision-making will be made by the federal government. All the key decisions will be made by the federal government. That they have not yet made a decision on whether they do need that building or whether there's going to be activity at JFK. But they asked us to get it ready just in case. And of course, we're cooperating with the federal effort. Go ahead, Emily.

Question: Mr. Mayor, do you – what is your administration's commitment to any incoming refugees whether they have family here or not? And do you support a lifting of the refugee cap at the federal level?

Mayor: Emily, we are a city of immigrants and we're a city of refugees. Of course, we will provide a welcome to those who need our support. And we assume that will be true all over the country. And you know, the entire country will work together with the coordination of the federal government to ensure that you know, many different places participate for the good of all. I don't know enough about the cap situation. I do know that folks who have been through this horrible experience in Afghanistan and particularly those who worked with the United States, deserve to be protected. And New York City will certainly play a role and do our fair share.

Moderator: The next is Matt Chayes from Newsday.

Question: Hey, good morning, Mr. Mayor. How are you?

Mayor: Good, Matt. How you been?

Question: Been all right. Thank you for asking. This question is for Dr. Chokshi. A study released six days ago out of Israel shows that immunity from virus induced infection is far superior to that of vaccines. What would you need to learn before those previously infected and those whose tests show high levels of antibodies be able to enjoy the same privileges as those who are vaccinated? Is there anything you can learn?

Mayor: Dr. Chokshi? And if Dr. Katz wants to join in as well, go ahead.

Commissioner Chokshi: Thank you, sir. And thanks Matt, for this question. I am familiar with this study that you're mentioning. The study was released as a pre-print and is not yet peer reviewed. But it is an important contribution to the scientific literature. It does not, however, change our strong recommendation that even people who have been previously infected get vaccinated. And that's because the science is very clear that getting vaccinated affords stronger protection, gives you stronger levels of immunity against the coronavirus, which is particularly important in the context of the Delta variant. Thank you.

Mayor: Dr. Katz, want to add anything?

President Katz: Yeah. I just want to support Dr. Chokshi's view that yes, we recognize people have had infection with COVID and that likely affords them some immunity. But why not strengthen that immunity through vaccination? We think that that's a much

more successful strategy. Thank you, sir.

Mayor: Thank you. Go ahead, Matt.

Question: Okay. Pre-prints and non-peer reviewed studies have been cited by you guys at these news conferences before. And the question was, what would you need to learn, not what your current recommendations are. But I have another question, which is why won't you release data about reinfections in a manner just as forthcoming and comprehensive and transparent as you were releasing vaccine effectiveness data? I've asked you this a bunch of times and the questions have been not responded to.

Mayor: Yeah, Matt. I'm confused by the question, honestly, because we had a whole discussion, I think it was last week, about what we're seeing with re-infection and we gave live numbers. I'll turn to the doctors again. We want that information to be out there. We know it's a reality. It still pales in comparison to what's happening with unvaccinated folks. But I feel your angst over this, but I really think we are trying to be transparent. If there's anything more we can be doing, I'm happy for us to do it. Dr. Chokshi, Dr. Katz, you want to speak to this?

Commissioner Chokshi: Thank you, sir. And yes, I believe Matt is asking you know, specifically about people who are getting reinfected who have not been vaccinated and essentially, you know, what the rates of that are? There is some data about this from around the world. It is something that we are tracking in New York City as well. And Matt, I believe my team has shared some of that data with you, but we'll be happy to follow up for any more detailed information. These are things that are nuanced to study and that we have to make sure we bring the right analytic approaches to. In part because the fact that someone has a repeat positive test, does not always mean that they have been reinfected given some of the subtleties with respect to testing. So, this is something that we're happy to follow up with you on if you want further information. Thank you.

Mayor: Thank you.

Moderator: The next is James Ford from PIX 11.

Question: Great. Thanks for taking my question.

Mayor: How are you today, James?

Question: Very well. Thank you for asking. I hope you're well as well.

Mayor: Thank you. Yes. What's going on?

Question: All right. City Council Education Committee Chair Mark Treyger has now said that both Health Commissioner Chokshi and Schools Chancellor Porter will testify tomorrow at his committee hearing on the schools opening plan. He also said there are still many lingering questions about reopening that he wants answered in the hearing, including how to know which students need to quarantine, what remote options, if any, there are for students generally, and for those who have to quarantine. Will you and Commissioner Chokshi provide us with some answers to these questions? And what do you anticipate will come out of the hearing, please?

Mayor: Thank you for the question, James. I'll turn to Dr. Chokshi, but I'll tell you this. I listened carefully to what you just laid out. I believe all of that was covered in our discussion last week when we laid out the guidebook for parents. We talked about what were the exceptions, for example, medically frail students, students who are immunocompromised, where there can be instruction provided a different way. We talked about the standard for quarantining but remember that's a different standard at this time because any adult or student who is vaccinated will not have to quarantine unless they're symptomatic. So, we went over all that it's been printed, it's out there, parents have it. Happy to see Dr. Chokshi and Chancellor Meisha Ross Porter go over that again at the hearing, but we really feel we've answered a very, very broad range of questions. We all said there was a few things we're still working on, particularly with our labor partners. But I expect the hearing to be, you know, a lot of strong questions that are coming from parents and communities, and we're ready to answer them. I think it'll help get more information out there. Dr. Chokshi, you want to add?

Commissioner Chokshi: Thank you, sir. No, nothing to add in terms of that question. I'm also looking forward to the hearing. I know that there are several questions. We'll go over the information that we have released and answer any other questions that are forthcoming. Thank you.

Mayor: Thank you. Go ahead, James.

Question: All right, thank you both for the response. And then on behalf of my colleague, Nicole Johnson, she asked that – she asked this question. We continue to see gun violence happening sometimes in broad daylight and affecting more innocent bystanders, including an 81-year-old shot on the Upper West Side. We keep hearing some similar answers from the administration, as far as what's being done. Do you think it's time to reevaluate the approach to help stop shootings that we've been seeing in the city?

Mayor: James, I appreciate the question. Look, even a single shooting is not acceptable to me obviously. And every time – I get the reports constantly – every time anyone is harmed whether, God forbid, there's violence between gangs and there's intended targets, that's horrible, and that means young people's lives are destroyed, both the victim and the shooter. And we all feel a special pain, I do, whenever it's an innocent bystander. We don't accept any of this. Now in a few days, we're going to lay out the latest information of what we've seen in the month of August, and, of course, June and July before that. And we've got a lot of work to do, James, and until there are no shootings, we have work to do, but you're going to see that there's been consistent progress in terms of gun arrests, consistent progress in terms of reducing shootings. We got a long way to go to fix everything that got broken because of COVID and everything that was unleashed, but we're making substantial progress and with amazing support from communities from violence interrupters, and community groups, and so many others. We're going to go over all of that. But I want to reiterate if we really want to solve the problem, we need a functioning court system. We have a lot to do at the City level. The NYPD has a lot to do. It's on all of us to keep fixing this problem and we are fixing it, but we cannot get the full results we need without a fully functioning court system. And again, James, I would say to all of you who, to your great credit, pursue important stories with great vigor and look under every stone, it's staring us in the face. One part of our criminal justice system is not functioning. Everybody else is. We've got to fix it.

Moderator: We have time for two more for today. The next is Henry from Bloomberg.

Mayor: Henry, you out there? Henry? Henry?

Moderator: We'll move on from Henry. The next is Amanda from Politico.

Question: Good morning, Mr. Mayor, how are you?

Mayor: Hey, Amanda, how you been?

Question: Good. Thanks.

Mayor: Are you – have you gotten over your volleyball injuries?

Question: I have a new softball injury, but you know how it goes [inaudible] –

Mayor: Yeah, it's one or the other for me.

[Laughter]

Question: Well, thank you for asking. I wanted to talk to you a little bit more about these vaccine mandates for health care workers, particularly for Health + Hospitals. So, there's been a little confusion among health care workers in terms of meeting either their system's deadline or the State deadline. And I've talked to nurses who said, they're concerned about what happens if, you know, let's say five percent of the workforce is asked to leave because they're not getting vaccinated, what does that look like with staff shortages that exist already? And so, I was hoping for you to kind of give me your thoughts on those concerns and whether or not you're hoping to mitigate that with additional hiring and then also I'd love to hear from Dr. Katz as well.

Mayor: Yeah. And I'll start, I'll turn to Dr. Katz for sure. Amanda, we talked about this as we were preparing our own mandate, which of course was vaccine or test. And then the State made a decision, which I certainly support, to do an across-the-board vaccine mandate for frontline health workers. That was very important. It was the right thing to do in part because it created universality. So, folks who want to work in the field – and now it's not a matter of, you know, leaving one employer going to another, it's expected everywhere. We also find that a lot of people, when really at that moment of choice, do decide it's the practical and smart thing to do to get vaccinated. So, the actual incidents of people threatening to leave has been much less than I think some of the initial

projections. We don't take it lightly and we're certainly preparing if there are some departures. But I feel that the vast majority of our health care workers who are not yet vaccinated are going to get vaccinated, are going to stay, you know, at their post, helping people. They're there for a cause that they believe in. And I think we're going to find that this is going to be something we can navigate well. Dr. Katz.

President Katz: Yes, sir. I totally agree with your assessment. My staff are incredibly dedicated people who choose a mission every day to take care of other people. And I think that they will want to get vaccinated, as you say. Because it's a statewide mandate people would literally have to leave the health care field. It's not a question that they would leave Health + Hospitals and join another health care system. They would have to completely leave the field. And we've found even with our current vaccine or testing strategy that when people understand they may be initially reluctant, but they ultimately go forward and get vaccinated or testing. We've seen a major increase in our vaccination rates since we instituted the Vax-or-Test mandate. And then finally, we've already instituted this requirement for new employees thanks to you, sir. You remember when you announced for all new employees of Health + Hospitals as well as for our contractors. That's already in place and we have not seen any inability to bring in new staff or contractors despite having a vaccine mandate in those cases. Thank you, sir.

Mayor: Thank you. Go ahead, Amanda.

Question: Thank you. And Dr. Katz, I'd love to follow up. Do you have initial projections of how many health care workers in your system you would expect to leave considering the new mandate? And if so, is hiring a priority to make sure that staffing levels are, you know, I guess at the level that they are right now?

Mayor: As we turn to Dr. Katz, what I'd say, Amanda, just to frame it is, we went through extraordinary challenges last year and we saw tremendous agility at Health + Hospitals finding additional staffing when the question was just the need to intensely increase the amount of staffing because of the cases that were growing and growing. This is a much – from everything I can see a much lesser challenge, thank God. And certainly, I know H+H has the capacity to find additional staff when needed in normal times. But Dr. Katz, to the extent you want to offer any framing here of what you're expecting and your ability to fill in any of the roles you need to, how do you want to – how do you want to frame that for Amanda?

President Katz: Thank you, sir. And as you say, last year in March when we were under such dire conditions due to the explosion of COVID cases, Health + Hospitals added 7,000 new employees who worked at least one day. So, we know that if we have to, we will. We are a system that is always creating contingency plans because we recognize there are natural disasters, there are man-made disasters. Sometimes we have to bulk up staffing. Sometimes we have to ask people to do different jobs and be flexible in order to take care of people. I believe when all is said and done, there will be a small number of people who will not wish to get vaccinated but that we will be able to compensate for that small number of employees leaving us. Thank you, sir.

Mayor: Thank you. Go ahead.

Moderator: Last question for today, it goes to Reuvain from Hamodia.

Question: Good morning. I just wanted to follow up on the question earlier about reinfection. So, the doctors said that the recommendation is still to get the vaccine, even if you've had a prior infection because the vaccine gives you additional immunity. Well, first of all, it's not a recommendation, it's a mandate, but the fact is that even if the vaccine gives you additional immunity, if there are certain rights that are being given to New Yorkers who have the vaccine, that the vaccine alone is enough to give you these rights, like going to concerts with the Mayor in Central Park, then if the immunity from reinfection is even greater than that, why should that alone not be enough?

Mayor: Alright, I'll turn to the doctors. But here's what I think is the commonsense answer. It's a very fair question, Reuvain, and I appreciate the question, but I think the commonsense answer is this, we're fighting an extraordinarily dangerous foe, and we found the vaccine is the difference maker, and it was based on a lot of research all over the world. And we've seen it with our own eyes. If we had not had a huge number of vaccinations in this country, Lord knows where we'd be right now and how horrible the situation is. So, we've seen with our own eyes the impact it makes. It doesn't mean you can't have more than one strategy, but we're absolutely convinced that vaccination is a necessary part of any strategy. It's been proven on the ground all over the country. With that, Dr. Chokshi, Dr. Katz.

Commissioner Chokshi: Thank you, sir. I would just add that, you know, that there's just a basic choice here if someone has had prior infection with COVID and that's

whether or not to get vaccinated. And if you just boil it down into that choice, it is very clear that getting vaccinated does confer additional protection. It strengthens your immunity. There is a study from the CDC that showed that people who are unvaccinated, who have had prior infection are twice as likely to get reinfected compared to people who had prior infection but got vaccinated. So, this is the basis of our recommendation. It's really both to protect the individual as well as for the broad population benefits that we know that widespread vaccination can confer. And I'll just add on a personal note. I faced this choice myself with respect to having been infected previously and I made the decision to get vaccinated, to protect myself and to protect my loved ones. Thank you.

Mayor: Thank you. Dr. Katz, do you want to add? Dr. Katz –

President Katz: Nothing to add, sir –

Mayor: All right, go ahead, Reuvain.

President Katz: Nothing to add, sir. Thank you.

Mayor: Thank you. Go ahead, Reuvain.

Question: Yeah. So, Dr. Chokshi, no one's doubting that getting the vaccine in addition to a prior infection is better than just the prior infection. I, myself, made the same choice you did. I was infected previously, and I got vaccinated. But again, I'm sorry, my question was not answered. If the vaccine immunity – if the City has decided that vaccine immunity alone is enough to be granted these rights like eating at restaurants or going to concerts, and if immunity from re-infection alone is better than vaccine immunity, as an Israel study has shown, then why should the prior infection alone not be enough to get these rights?

Mayor: Well, again, I'm going to just challenge this on a commonsense level and then let Dr. Katz and Dr. Chokshi speak to it. You've got a study and we value each study, but I've learned enough in the last year-and-a-half to say it takes more than a single study to determine all the policies we're going to make. We have global evidence of the impact of vaccination. It's not conjecture. It's not a single study. It's not a new development. It's proven on the ground. We're not moving off that. We're doing the thing that we know works. And again, I really do respect the question, but I also want to go back to why we're doing what we're doing. We have to save lives. We know the vaccine has saved countless lives. We have to avoid letting the Delta variant gain more steam. We know the vaccine is helping us do that, and we need to avoid falling back to restrictions. And clearly you see the life of the city right now, that's because of vaccination. Any natural immunity, that's great, but we didn't have vaccination before. And we saw the ability of COVID to come back. Once we instituted massive vaccination, we've seen our ability to hold the line and bring our city back. I think we've seen it with our own eyes. It's more powerful, bluntly, than any single study. Dr. Katz and then Dr. Chokshi.

President Katz: I agree. And I would again say, I don't see what the argument is for not getting vaccinated if you have prior infection. Both you have gotten it and Dr. Chokshi has gotten it. And I – that's what I recommend for my patients who've previously had COVID. We should all want maximum immunity from this awful virus. Thank you.

Mayor: Dr. Chokshi –

Commissioner Chokshi: Nothing to add, sir. Thank you.

Mayor: As we conclude, I just want to put a point on it. It's not just – I do appreciate the question again. The question is framed almost from a personal level. I'm going back to the needs of all New Yorkers, 8.8 million people. We can't simply say, oh, let's do either-or and let's make it something where we don't do everything possible when it comes to the number one tool, which is vaccination. It is proven to be the number one way to fight back. So, to me, it would be a massive mistake to pull our punch. Just when we are gaining ground, we're fighting back the Delta variant. Why would we step back from that? We're making stunning progress. The city is showing when you have a high level of vaccination, everything else is possible. And we're seeing the horrible tragedies in other parts of the country. And I'm sure there are people that are good people saying, hey, we can go without vaccination. Well, guess what? Look at the parts of the country, where there are low levels of vaccination, look up the horrible things happening to people there. And those are places where lives are being lost and they are running the risk of falling back into all those restrictions. We can't let that happen here. So, as per usual, the answer is, everyone, if you're not yet vaccinated, no better day than today. Thank you.

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Section 1. City employees must either:

a. Provide the City agency or office where they work with proof of full vaccination by September 13, 2021, or

b. Beginning September 13, 2021, and on a weekly basis thereafter until the employee submits proof of full vaccination, provide the City agency or office where they work with proof of a negative COVID-19 PCR diagnostic test (not an antibody test).

Nothing in this Order shall preclude a City agency from requiring an employee who has been vaccinated to be tested for COVID-19 or preclude a City agency from requiring employees to be tested more frequently than once a week.

§ 2. Any City employee who does not comply with this Order may be subject to disciplinary action.

§ 3. All City agencies must take all necessary actions to require their contractors to require their covered employees to either:

a. Provide their employer with proof of full vaccination by September 13, 2021, or

b. Beginning September 13, 2021, and on a weekly basis thereafter until the employee submits proof of full vaccination, provide their employer with proof of a negative COVID-19 PCR diagnostic test (not an antibody test).

All such contractors shall submit a certification to their contracting agency confirming that they are requiring their covered employees to provide such proof. If contractors are non-compliant, the contracting City agencies may exercise any rights they may have under their contract.

§ 4. For purposes of this Order:

a. The term "full vaccination" means at least two weeks have passed after a person received a single-dose of an FDA- or WHO- approved COVID-19 vaccine or the second dose of an FDA- or WHO- approved two-dose COVID-19 vaccine except that, for the purposes of this Order, a City employee or covered employee of a contractor who provides documentation of having received one dose of any COVID-19 vaccine before September 13, 2021 will be considered fully vaccinated even though two weeks have not passed since their final dose, so long as, if such City employee or covered employee of a contractor received a two-dose vaccine, the employee provides documentation that the second dose has been administered before October 28, 2021.

b. The term "contract" means a contract awarded by the City, and any subcontract under such a contract, for work: (i) to be performed within the City of New York; and (ii) where employees can be expected to physically interact with City employees or members of the public in the course of performing work under the contract.

c. The term "contractor" means a person or entity that has a City contract, including the subcontracts described in the definition of "contract."

d. The term "covered employee" means a person: (i) employed by a contractor or subcontractor holding a contract; (ii) whose salary is paid in whole or in part from funds provided under a City contract; and (iii) who performs any part of the work under the contract within the City of New York. However, a person whose work under the contract does not include physical interaction with City employees or members of the public shall not be deemed to be a covered employee.

e. The term "City employee" means a full or part-time employee, intern, or volunteer of a City agency.

§ 5. Each City agency shall send each of its contractors notice that the Mayor has directed contractors to comply with the requirement of section 3 of this Order and request a response from each such contractor, as soon as possible, with regard to the contractor's intent to follow this Order.

§ 6. This Order shall take effect immediately. Nothing in this Order shall affect the enforcement of other orders issued by the Mayor, the Commissioner of Citywide

Administrative Services, the Commissioner of Health and Mental Hygiene, or the Board of Health.

Bill de Blasio,
MAYOR

AFFIDAVIT OF BRUCE MILLER M.S. CIH

STATE OF IDAHO)
) ss.
COUNTY OF BONNEVILLE)

BRUCE MILLER, being first duly sworn on oath, deposes and declares as follows:

1. I am above the age of 18 and am competent to make this affidavit.
2. I am a Board-Certified Industrial Hygienist (CIH) through the American Board of Industrial Hygiene, with a Master's Degree in Industrial Hygiene from Central Missouri State University, and I received my BS in Industrial Technology from Southern Illinois University with an A.A.S. in Bioenvironmental Engineering Technology,
3. I am President and owner of Health & Safety Services, LLC with more than 33 years of experience in comprehensive health and safety practice specializing in conducting retrospective exposure assessments for Department of Energy workers for Employees Occupational Illness Compensation Program (EEOICP) and Hanford Presumptive Claims, Occupational Safety and Health Administration (OSHA) General Industry (29 CFR 1910) and Construction (29 CFR 1926) compliance, and developing workplace exposure assessment tools and controls for environmental remediation, construction, demolition, water damage/mold projects.
4. I have managed and supervised health, safety, and health physics personnel and provided project management, planning, regulatory support, and oversight to numerous environmental remediation, waste management, construction, decontamination and decommissioning, and microbial and indoor air quality investigations, and remediation projects.

5. I have served as the Chair of the American Industrial Hygiene Association (AIHA) Law Committee, Consultants Special Interest Committee, and member of the Indoor Environmental Air and Environmental Affairs Committees.

6. My compete Curriculum Vitae is attached as **Exhibit A** and details my knowledge, skills and experiences.

7. Specifically, I have knowledge and experience with the OSHA regulations and compliance and applied experience writing, implementing and auditing OSHA 29 CFR 1910.132, "Personal Protective Equipment" and 29 CFR 1910.134, "Respiratory Protection" programs and implementing procedures to mitigate risks associated with hazardous agents and infectious diseases; I have conducted compliance inspections of hospitals and reviewed infectious prevention and control programs to verify safe healthcare work environments and best practices.

8. In preparation for providing my opinions herein, I have reviewed the New York State Department of Health Covid Emergency Public Health Law 2.61 (Attached as **Exhibit 1)**, the New York City Department of Health Covid Emergency Public Health Emergency Orders dated August 24, 2021, September 15, 2021, October 20, 2021 collectively attached as **Exhibit 2 (a)(b)(c)**, and I have reviewed the applicable regulations of the U.S. Department of Labor, Occupational Safety and Health Administration, along with documents of several New York hospitals' Covid-19 workplace program policies, including the affidavits and documents provided by a certain class of New York healthcare workers, including the class represented by Plaintiff, Rachel Toussaint ("Healthcare Worker Class") against certain New York hospitals and on behalf of a certain class of New York City (NYC) government workers from various NYC agencies including the Department of Education, Department of Transportation, Department of Sanitation, NYC Central Administration, Department of Children's Services ("NYC Worker Class"), represented by the Plaintiff, Amour Bryan, a

remote teacher for the New York City Department of Education.

FACTUAL BACKGROUND

9. Based on my review of the claims of the Healthcare Worker Class and the NYC Worker Class, both classes of Plaintiffs allege that they submitted requests to their employer to be exempted from the Covid-19 vaccine requirement implemented by NYC and the State of New York for healthcare employers pursuant to Emergency Orders issued by the New York State and City Departments of Health.

10. Based on my knowledge and experience consulting as an Industrial Hygienist for more than 30 years, there has never been adult vaccine mandates created or authorized by emergency order or otherwise by state or federal health officials as an occupational health and safety risk mitigation tool or control method for the purpose of eliminating or reducing the hazards caused by airborne pathogens and, in particular, airborne communicable diseases during a pandemic or even during an epidemic.

11. All of the exemption requests by each Plaintiff member of both Classes were denied, despite the fact that many of the Plaintiffs already worked remotely and had no contact with the public or had no direct contact with children if they worked for the Department of Education. In some instances, healthcare workers who refused the vaccine requested to be provided with or be allowed to use Powered Air-Purifying Respirator (PAPR) to keep themselves and patients safe while they worked face-to-face with patients. PAPRs provide a high level of respiratory protection greater than an N95 respirator or tight-fitting air-purifying respirator (APR).

12. All members of both Classes were subsequently terminated from their jobs and removed from their work sites by their employers because they would not comply with the employers'

implementation of NYS DOH and NYC DOH vaccine orders adopted by the employers as part of their workplace safety program.

13. Hospitals are one of the most hazardous places to work. In 2016, U.S. hospitals recorded 228,200 work-related injuries and illnesses, a rate of 5.9 work-related injuries and illnesses for every 100 full-time employees. This is twice the rate for private industry as a whole (U.S. Bureau of Labor Statistics).

14. According to OSHA, healthcare workers face numerous serious safety and health hazards in the workplace. They include needlestick/sharps injuries, exposure to bloodborne pathogens and biological hazards, potential chemical and drug exposures, waste anesthetic gas exposures, infectious respiratory hazards (including SARS-CoV-2), ergonomic hazards from lifting and similar repetitive tasks involving immobile patients, laser hazards, workplace violence, hazards associated with laboratories, and radioactive material and x-ray hazards.[1]

15. The OSHA website on "Infectious Disease," which contains guidelines for the risk management and mitigation for specific infectious diseases, specifically states that healthcare workers are occupationally exposed to a variety of infectious diseases during the performance of their duties. The primary routes of infectious disease transmission in U.S. healthcare settings are contact, droplet, and airborne.[2]

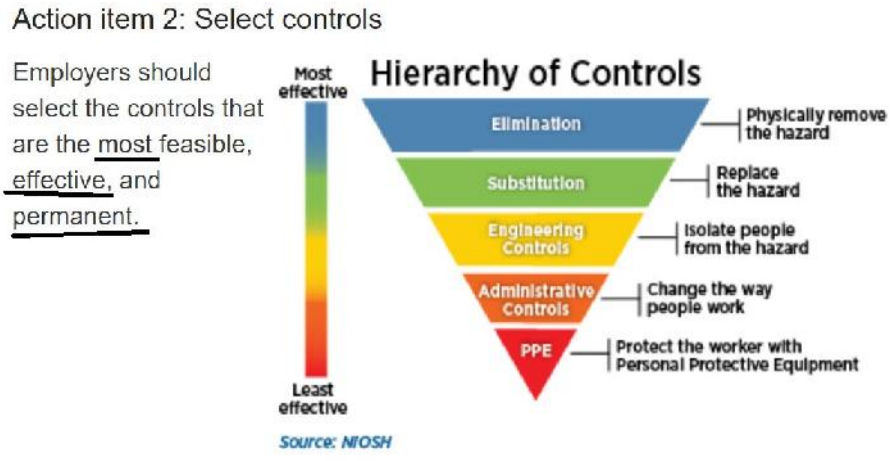
16. Since 1970, when OSHA was formed under the U.S. Department of Labor, it has been law that employers are specifically responsible and have a duty for providing a safe and healthful workplace for workers, specifically to prevent workplace severe injury and death. It is not the duty of employees to identify hazards, perform risk assessments and implement hazard controls to eliminate or reduce risks.

[1] See OSHA Healthcare Regulation Introduction. https://www.osha.gov/healthcare
[2] See OSHA Healthcare Infectious Diseases Guidelines - https://www.osha.gov/healthcare/infectious-diseases/

17. OSHA law expressly states that "the right to a safe workplace is a basic human right" and that "no worker should have to choose between their life and their job.[3] The OSHA regulations are applicable to most states in U.S. through the Approved State Plans, which includes New York.

18. OSHA regulations provides the minimum standards for employers to meet their duty to provide a safe workplace for their employees. In addition to specific OSHA standards, the general duty clause of the Occupational Safety and Health Act of 1970, 29 U.S.C. 654(a)(1), requires each employer to "furnish to each of his employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees."

19. According to the OSHA "Recommended Practices for Safety and Health Programs", employers are required to select the hazard controls that are most feasible, effective and permanent, with a focus on first eliminating the hazard; and, if elimination is not possible, the below diagram illustrates the hierarchy of controls (also known as –"AKA" risk mitigations") that are to be used by employers which are the most effective alone or in combination that aids an employer in getting the closest to eliminating a hazard.[4]



[3] See "All About OSHA", U.S. Department of Labor OSHA Publication 3302-01R 2020. https://www.osha.gov/sites/default/files/publications/all_about_OSHA.pdf

[4] See OSHA Recommended Practices - https://www.osha.gov/safety-management/hazard-prevention

20. OSHA regulations specifically places the duty on the employers to identify and correct safety and health hazards in the workplace. This duty requires employers to first eliminate or reduce hazards by making feasible changes in working conditions, either through: 1) installation of workplace engineering controls, including but are not limited to installing ventilation systems to capture airborne particulates or aerosols, such as portable or fixed high-efficiency particulate air (HEPA) filtration systems, downdraft ventilation capture systems, and isolation of hazard sources with barriers to name a few, 2) implementing administrative controls, including, but are not limited to, changes to "how" an employee performs the essential functions of their job. Examples include training, limiting employee exposure time or location (which includes permitting remote work), screening to identify and isolate infectious patients, and other procedural requirements such as use of universal precautions, having infectious patients wear face masks, and posting hazard warning signs, and 3) providing personal protective equipment (PPE) where the workplace hazards cannot be controlled through engineering or administrative controls. Examples of PPE include, but are not limited to, protective clothing and gowns, gloves, face shields and goggles, respiratory protection, and hearing protection (hereafter collectively called "Risk Mitigation Tools)". PPE are to be used by the employer as a last line of defense when employee exposures cannot be reduced to an acceptable level using these other control methods.

21. OSHA Section 29 CFR 1910.132, Personal Protective Equipment, sets forth mandatory duties for all employers, including employers in the healthcare industry employees.

22. Employers are mandated under OSHA Personal Protective Equipment Standard, 29 CFR 1910.132, to conduct a hazard assessment to identify the hazards are present, or are likely to be present, which necessitate the use of PPE through a written hazard assessment.

23. Section 1910.132(d)(1)(i) specifically states:

"Select, and have each affected employee use, the types of PPE that will protect the affected employee from the hazards identified in the hazard assessment."

24. Section 1910.132 1910.132(d)(2) specifically states:

"The employer shall verify that the required workplace hazard assessment has been performed through a written certification that identifies the workplace evaluated; the person certifying that the evaluation has been performed; the date(s) of the hazard assessment; and, which identifies the document as a certification of hazard assessment."

25. This written hazard assessment is critical since it serves as the foundation for the selection of all PPE to be used by employees. Task and area-specific hazards should be evaluated within the hazard assessment so the selected PPE is tailored to the specific hazards, areas, and employee duties.

26. OSHA 29 CFR 1910.134, Respiratory Protection, mandates the employer's specific requirements for the selection and use of respirators for protection against airborne hazards where other hazard controls are not feasible.

27. Section 1910.134(a)(1) specifically states:

"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."

28. OSHA 1910.134(a)(2) further states:

"A **respirator shall be provided to each employee when such equipment is necessary to protect the health of such employee.** [Emphasis added] 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."

29. OSHA 1910.134, Respiratory Protection requires employers to select respirators based on an evaluation of respiratory hazard(s) to which the worker is exposed and workplace and

identified relevant workplace and user factors. This respirator-specific evaluation is in addition to the hazard assessment required by the 1910.132 Personal Protective Equipment Standard.

30. Section 1910.134(d)(1)(iii) further states:

> "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 [immediately dangerous to life and health] IDLH."

31. The OSHA Respiratory Protection Standard provides for progressively more protective respirators (higher protection factor) based on the concentration of the airborne hazard or risk mitigation strategy or on a voluntary use basis if a higher level of protection is desired by the employee. For example, employees may use National Institute for Occupational Safety and Health (NIOSH)-certified filtering facepiece respirators (N95) for general interactions with infectious Covid-19 patients or may request their employer to provide a more protective PAPR for aerosol generator medical procedures conducted on infectious Covid-19 patients or to just provide a higher level of protection. OSHA has assigned protection factors (APFs) for each type of NIOSH-certified respirators with an properly fitted N95 filtering facepiece and half-face APR having a APF or 10 and a PAPR assigned a APF of 1,000.

32. Before the SARS-CoV-2 virus that causes Covid-19 emerged and became an occupational exposure concern, the OSHA law mandated employers eliminate or control airborne and other "hazards" from the workplace. OSHA standards have never defined employees as inherently hazardous or being hazardous substances or materials that must be eliminated from or otherwise controlled in the workplace. It had always been the duty of the employer to protect the employees through hazard elimination or mitigation. In addition, OSHA has also never mandated employees be vaccinated to eliminate workplace hazards.

33. The history of the founding of OSHA as revealed in the publication "About OSHA"[5] , the agency was created to keep employees in the workplace and as safe as possible.

34. In the case of airborne hazards, including infectious diseases of any kind (such as SARS-CoV-2 Covid-19), employers have a duty to implement the hierarchy of controls to eliminate or isolate the hazard (infectious airborne virus or infectious patient) using engineering controls where feasible, or minimizes employee exposures through the use of administrative control measures, which can include working remotely for employees whose jobs can be performed remotely, with all remote work-related costs to be paid for by the employer pursuant to OSHA guidelines.

35. Where hazard eliminating, isolation or the use of engineering and administrative controls do not adequately mitigate the workplace hazard, OSHA requires employers to conduct a written hazards assessment to identify the appropriate PPE for employees to protect them from the workplace hazard(s) that may include the selection and issuance of respirators to prevent inhalation hazards, based on an airborne hazard assessment.

36. Employers have the duty to select respirators, conduct medical surveillance, fit-test and train employees on the proper use, inspection, and cleaning of respirators, and perform an Respirator Program assessment of their written Respirator Protection Program in accordance with 29 CFR 1910.134, Respirator Protection, Section §1910.134(l), "Program Evaluation".

37. In the context of the hazards caused by infectious disease, and in particular during the Covid-19 pandemic, OSHA describes the hazards in a January 29, 2021 publication titled "Protecting Workers: Guidance on Mitigating and Preventing the Spread of Covid-19 in the Workplace,"[6] as follows:

[5] See U.S. Department of Labor - OSHA Publication #- 3302-01R - "All About OSHA 2020" https://www.osha.gov/sites/default/files/publications/all_about_OSHA.pdf

[6] See OSHA January 29, 2021 publication titled "Protecting Workers: Guidance on Mitigating and Preventing the Spread of Covid-19 in the Workplace" at https://www.osha.gov/coronavirus/safework

> "SARS-CoV-2, the virus that causes **COVID-19** is highly infectious and spreads from person to person, including through aerosol transmission of particles produced when an infected person exhales, talks, vocalizes, sneezes, or coughs. COVID-19 is less commonly transmitted when people touch a contaminated object and then touch their eyes, nose, or mouth. The virus that causes COVID-19 is highly transmissible and can be spread by people who have no symptoms and who do not know they are infected. Particles containing the virus can travel more than 6 feet, especially indoors and in dry conditions with relative humidity below 40%. The CDC estimates that over fifty percent of the spread of the virus is from individuals with no symptoms at the time of spread."

38. Unlike chemical airborne hazards, aerosol transmission from infectious patients causes exposures that cannot be routinely measured in the air and have no established occupational exposure limits. Healthcare employees working in close proximity to patients, are likely to have a high risk of inhaling infectious aerosols (droplets and particles). Respirators for healthcare employees, and masks or filtering facepieces for contagious patients, are essential to prevent employee exposures. The selection of respirators with higher APFs (for example, PAPRs equipped with HEPA filters provide the highest level of respiratory protection) for healthcare employees.

39. Control and mitigation airborne infectious diseases are in fact nothing new for employers within healthcare occupation settings. The OSHA Standard 29 CFR 1910.1030, Bloodborne Pathogens, requires employers to have a written Exposure Control Plan designed to eliminate or minimize employee exposure when they are identified.

40. OSHA Section 1910.1030(b) states:

> "Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties."

41. OSHA Section 1910.1030(d)(2)(i) states:

> "Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls, personal protective equipment shall also be used."

42. CDC guidance documents such as "Hospital Respiratory Protection Program Toolkit, Resources for Respirator Program Administrators" (2015) and "2007 Guideline for

Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, Last update: July 2019" provide detailed guidelines for the selection and use of respirators for healthcare workers exposure to airborne natural and manmade infectious disease hazards such as anthrax, noroviruses, monkeypox, multidrug-resistant organisms, tuberculosis, and viral hemorrhagic fevers (Lassa, Ebola, Marburg, Crimean-Congo fever viruses). CDC guidance clearly identifies the appropriate respiratory protection as the primary control mechanism to prevent or minimize healthcare workers exposures to these airborne pathogens where engineering controls and isolation are not feasible.

43. OSHA's description of hazards associated with SARS-CoV-2 Covid-19 along with the declarations by the CDC, the President of the United States, and the New York State and City Public Health Commissioners, identify transmission through airborne means as the primary infectious pathway. The most effective Risk Mitigation Tool to prevent airborne transmission of the airborne aerosolized SARS-CoV-2 virus to healthcare employees that could result in severe Covid and death are the wearing of respirators equipped with HEPA filters (where other engineering controls and isolation measures are not feasible) that have **99.97% efficiency** in removing airborne aerosols that may include the virus that causes Covid-19 according to the Hospital Respirator Protection Program Toolkit first published May 2015 ("Respirator Guidelines").[7] The use of HEPA-filtered respirator has been longer standing strategy and the highest efficacy for infection prevention and control or airborne pathogens.

44. According to the Respirator Guidelines, there are a very small number of respirator types that meet the 99.97% efficacy rate, namely, 1) the HEPA filtered air-purifying respirators (APRs) and 2) HEPA filtered Powered Air Purifying Respirator (PAPRs).

[7] See Hospital Respiratory Protection Program Toolkit published May 2015 by the U.S. Department of Labor, OSHA, CDC Workplace Safety and Health, Department of Health & Human Services, National Institute for Occupational Safety and Health (NIOSH) - https://www.osha.gov/sites/default/files/publications/OSHA3767.pdf

45. HEPA-filtered APRs and PAPRs have OSHA assigned protection factors greater than surgical facemasks (no assigned protection factor) with half-face APRs with a protection factor of 10 and PAPR 1,000, respectively. The combination of a tightfitting respirator seal, in the case of the APR, to minimize leakage around the face-to-facepiece seal with the HEPA filtration, provides a high degree of protection to the wearer. The PAPRs higher level of protection is based on a positive pressure around the wearer's face generated from air drawn by a pump through HEPA filters being forced into the PAPR facepiece or hood creating positive pressure. This equipment ensures any leaks or breaks around the face-to-facepiece seal or within the hood result in outward air movement away from the wearer's nose and mouth. PAPRs also provide cooling of the wearer and are more comfortable to wear over extended work shifts.

46. While the various vaccines released for use in the U.S. have been developed to reduce the symptoms of severe Covid-19 according to the CDC, they do not prevent the transmission of the airborne virus in the workplace. Under OSHA, employers have the duty to eliminate or reduce employee's exposure to the airborne hazards such as the SARS-CoV-2 virus and/or variants that cause Covid-19. OSHA's Bloodborne Pathogens Standard provides the closest analogous healthcare employment requirements for employers. Where the employer's Bloodborne Pathogen mandatory Exposure Control Plan identifies employee exposure to pathogens such as those containing Hepatitis B, the employer's duty is limited to making the Hepatitis B vaccine (which is the only reference to vaccines in the standard) available to pathogen exposed employees (not mandating the vaccine).

47. OSHA Section 1910.1030(f)(1)(i)[8] states:

> "The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and post-exposure evaluation and follow-up to all employees who have had an exposure incident."

48. For all airborne pathogens, OSHA requires employers to provide the most effective controls to prevent exposure. When respiratory protection is required, the HEPA filtered PAPRs provide the highest filtration efficiency rate of 99.97% (and an OSHA protection factor of 1,000) to prevent inhalation of airborne infectious aerosol or particles that could lead infection, severe Covid-19, and death. PAPRs and supplied-air respirators are routinely worn when treating patients with more virulent infectious diseases, including viral hemorrhagic fevers (such as Ebola) that have a greater risk of causing immediate death than SARS-CoV-2 Covid-19. They are a proven and effective hazard control measure for employees.

49. Based on my knowledge of the various occupational industries like various manufacturing, allied trades such as welding, and chemical companies in the U.S. where engineering controls are not feasible and workers are exposed to highly toxic and carcinogenic chemicals, respiratory protection programs are routinely implemented to prevent worker exposures. Similarly, hospitals, biomedical laboratories, and other healthcare facilities, implement respirator protection programs as part of their infection prevention and control programs to mitigate risks of the transmission of infectious airborne aerosols that can lead to severe illness and death caused by respiratory pathogens. Therefore, respirator protection programs are feasible and demonstrated to be effective in the workplace.

50. The OSHA requirements cited are applicable to state and city governments, including New York City, through the State's OSHA Plans.

PRELIMINARY CONCLUSORY OPINIONS

51. Based on my review of the foregoing facts and based on my review of the relevant applicable OSHA regulations, guidelines, and mandates along with the New York State

and City Covid-19 emergency public health laws, I make the following preliminary opinions, with a reasonable degree of certainty as a certified industrial hygienist with experience in federal and state compliance, as follows:

a. Under OSHA, employers have the duty to furnish to each of their employees employment and a place of employment which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.

b. The OSHA regulations do not require employees to prevent severe injury and death in the workplace. The regulations only require employees to be trained in the proper use and limitations of safety equipment provided by the employer to eliminate or mitigate workplace hazards.

c. Employers have the duty to identify workplace hazards, utilize a hierarchy of controls strategy to eliminate, isolate or mitigate all workplace hazards, including airborne infectious aerosols.

d. Employers cannot delegate its hazard identification and mitigation duties under OSHA to employees and employers must bear the cost of implementing hazard controls measures to protect employees.

e. Employers must conduct and certify a written hazard assessment to identify hazards and the appropriate risk mitigation control for employees to minimize injury and exposure from such hazards.

f. Where respirators are to be used to prevent exposure, employers must conduct a hazard evaluation specific to airborne inhalation hazards to select the appropriate respiratory protection for employees to prevent occupation exposures to infectious airborne aerosols, such as the SARS-CoV-2 virus.

g. Where it is not feasible to eliminate or otherwise control the airborne hazards associated with the infectious airborne SARS-CoV-2 virus that causes Covid-19 in

a healthcare workplace with engineering or administrative controls alone, wearing of NIOSH-certified respirators such as a HEPA-equipped PAPR provides the highest-level employee respiratory protection to prevent virus transmission through inhalation and mitigate exposure from other routes of entry, such as ocular and mucous membranes, without the use of vaccines.

h. Eliminating and mitigating the airborne transmission of SARS-CoV-2 infectious aerosols that can lead to severe Covid-19 and Covid-19 related deaths in the workplace, is clearly the employer's duty, not the employees.

i. Although the Covid-9 vaccines can reduce the symptomology and severity of the Covid-19 infection, vaccines are not effective in preventing exposure to or inhalation of the airborne aerosolized virus in the healthcare workplace setting. Therefore, the use of effective respiratory protection such as a HEPA-filtered PAPR by healthcare workers provides the greatest level of prevention from both exposure and infection.

j. Employees that work remotely outside of the employer workplace, who work in single worker vehicles or single worker workspaces or work outdoors and do not have contact with the public and can perform most of the essential functions of their jobs without contact with other workers, are not at risk for occupational exposure to the SARS-CoV-2 virus while performing their duties. Therefore, employer mandated vaccinations for these employees are not necessary because these administrative controls effectively eliminate exposure to the employee or other employees.

k. Providing remote work option for employees whose jobs can be performed remotely serves as an effectively occupational exposure control. Even if the employee becomes infected and is symptomatic with Covid-19 or variants other

employees remain protected since they are not in the workplace. Remote work is a risk control that should be used to protect an employee while allowing the employee to remain on the job.

52. The statements and opinions made in this Affidavit are preliminary and I reserve the right to add to, amend or modify my opinions as more facts are provided during the course of any litigation of the claims by Plaintiffs for which this affidavit is provided.

I declare under penalty of perjury under the laws of the State of Idaho that the foregoing is true and correct.

Dated this 13th day of APRIL, 2022.

BRUCE MILLER

A NOTARY PUBLIC OR OTHER OFFICER COMPLETING THIS CERTIFICATE VERIFIES ONLY THE IDENTITY OF THE INDIVIDUAL WHO SIGNED THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED, AND NOT THE TRUTHFULNESS, ACCURACY, OR VALIDITY OF THAT DOCUMENT.

Subscribed and sworn to (or affirmed) before me on this 13th day of April, 2022, by BRUCE MILLER, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Witness my hand and official seal.

Debra A Reynolds
Signature of Notary Public

[Affix Notary Seal]

DEBRA A. REYNOLDS
COMMISSION NUMBER 13448
NOTARY PUBLIC
STATE OF IDAHO

AFFIDAVIT OF BAXTER D. MONTGOMERY, MD

STATE OF TEXAS)
) ss.
COUNTY OF HARRIS)

BAXTER DELWORTH MONTGOMERY, MD, declares under penalty of perjury pursuant to Texas Civil Practice and Remedies Code Title 6 Section 132 that the foregoing is true and correct:

1. I am above the age of 18 and am competent to make this affidavit.
2. I am a Diplomate of the American Board of Internal Medicine, for cardiovascular diseases, licensed with the Texas State Board of Medical Examiners since 1991 under Permit Number H9549.
3. I am President and CEO of Houston Associates of Cardiovascular Medicine, PA. performing various forms of cardiovascular clinical care.
4. I have medical privileges at and serve as an attending physician for Memorial Hermann Hospital - The Texas Medical Center, The Heart and Vascular Institute at the Memorial Hermann Hospital - The Texas Medical Center,
5. I have chaired the Patient Safety Committee at Twelve Oaks Medical Center.
6. For 25 years until the present, I have served as Teaching Faculty for Cardiology Fellows at The Heart and Vascular Institute Memorial Hermann Hospital - The Texas Medical Center. (See my Curriculum Vita attached as **Exhibit A**).
7. Because cardiovascular disease has been the #1 cause of death in the United States, fifteen (15) years ago I began implementing lifestyle interventions within my clinical practice.

8. There are numerous peer reviewed studies on the benefits of a plant-based diet and lifestyle interventions in fighting disease.[1]

9. Currently, as President and CEO of Houston Associates of Cardiovascular Medicine, PA, I am responsible, with my staff, for the oversight and compliance with state and federal workplace and patient safety laws applicable to all healthcare facilities.

10. Therefore, I have general knowledge and working experience with the standards, regulations and guidance provided by the Department of Labor, Occupational Safety and Health Administration (OSHA). As part of my day-to-day duties as a healthcare clinical practitioner and compliance administrator during this Covid Pandemic, I constantly worked to ensure that my healthcare facility complies with patient and employee workplace safety standards.

11. Since March 2020 when the Pandemic was declared, I have treated many patients who have either tested positive for the virus that causes Covid-19, or have had Covid-19 related symptoms and I make this affidavit based on my clinical patient experience as well as based on my knowledge and experience as a practicing physician.

12. I have been retained by Attorney Jo Saint-George and Attorney Donna Este-Green of the non-profit organization the Women of Color for Equal Justice to give expert opinions based on my knowledge and experience as a licensed medical professional.

13. Specifically, I have been retained to provide opinions regarding whether or not employees who work in a healthcare setting with or without direct patient care responsibilities, or who work for municipal or private employer entities with or without direct public contact or have minimal public contact should be terminated by an employer for refusing to submit to the FDA emergency authorized injection called the "Covid-19 vaccine" based on applicable healthcare and general workplace safety standards as it relates to the medical efficacy of the COVID-19 vaccines and their potential risks.

[1] See Plant-based Research Database - https://plantbasedresearch.org/

14. In preparation of providing my opinions herein, I have reviewed the following: 1) New York City Department of Health and Mental Hygiene vaccine orders from August 10, 2021 to December 13, 2021, 2) applicable regulations of the U.S. Department of Labor, Occupational Safety and Health Administration, and 3) the affidavit and documents provided by Certified Industrial Hygienist, Mr. Bruce Miller, MS, CIH, President of Health & Safety, LLC.

BACKGROUND & PRELIMINARY OPINIONS

15. Between August 10, 2021 and December 13, 2021, the New York City Department of Health and Mental Hygiene (NYCDOHMH) issued approximate twelve (12) Covid-19 Emergency Orders applicable to New York City employees within its various agencies ("NYC Emergency Orders").[2]

16. Based on my review of the NYC Emergency Orders, the primary purpose of the orders was to mandate all New York City employee to submit to taking Covid-19 vaccinations as a workplace safety and health standard that reduces the spread and contraction of the virus that causes the communicable disease "Covid-19" in New York City facilities.

17. While the Covid Emergency Orders state that the Covid-19 vaccine requirements are for the benefit of the "health, safety, and welfare" of New York City residents, the orders only apply to New York City employees and do not indicate that there is a direct impact on the residents of the City. Based on my general public health knowledge as a clinician, the Emergency Orders are directed at City Employees in their workplace.

[2] See List of New York City Department of Health & Mental Hygiene list of Orders at https://www1.nyc.gov/site/doh/about/hearings-and-notices/official-notices.page

OPINIONS REGARDING COVID-19 WORKPLACE SAFETY REQUIREMENTS

18. My opinions regarding workplace safety requirements in general and for healthcare facilities are as follow and are made to a degree of medical certainty:

a. the Covid-19 vaccines utilized in the United States are pharmacological medical treatments used to reduce symptoms that result from an infection of the viral pathogen and/or various variants of the Sars Cov2 virus, which causes the infectious disease identified by the Centers for Disease Control as Covid-19.

b. "Covid-19 vaccines" do not eliminate the virus that causes infections of Covid-19 from the atmosphere of any in door facility. The virus that causes Covid-19 and/or its variants is an atmospheric contaminant or airborne hazard that should be controlled in any in-door facility which could stop or prevent the contraction of any infectious communicable diseases that can cause serious injury or death.

c. Based on my general clinical knowledge of workplace safety standards for healthcare facilities and general industry facilities, the OSHA Standard at 29 C.F.R. § 1910.134 et seq.[3] titled "Respirator Protection" provides the minimum health and safety standard that any facility can utilize to reduce the risks of severe injury or death associated with any airborne contaminant that cannot be eliminate or controlled by other OSHA standards or methods.

d. Because the Covid-19 vaccines cannot remove the virus that causes Covid-19 infections from the atmosphere of any facility, based on my clinical experience and hospital experience, N95 respirators or Powered Air Purification Respirators, which have the highest efficacy in reducing exposure to any airborne contaminate and can be used and are necessary, when nothing else eliminates the virus, to prevent the spread

of any airborne communicable disease according to the OSHA and CDC published guide titled "Hospital Respiratory Protection Program Toolkit – Resources for Respiratory Program Administrators" published in May 2015.[4]

e. There are entire industries of employees that are required to wear N95 respirators or PAPR's everyday eight hours a day, specifically industrial workers in the automotive, welding, commercial painting utilize this equipment to protect their employees from airborne contaminates. Therefore, employees in any workplace that have a risk of exposure to or can spread a viral airborne contaminant should be provided by an employer with at least an N95 respirator or a PAPR consistent with the OSHA standards set forth in 29 U.S.C. 1910.134, especially when necessary to protect the health of an employee as indicated in 1910.134(a)(2).

f. Based on my clinical experience treating patients with communicable disease, when the existing OSHA Respiratory Protection standards contained in Section 1910.134[5] are properly implemented in any facility, along with all other OSHA standards applicable to addressing communicable disease, vaccines, including the Covid-19 vaccine, (which cannot stop the spread or transmission of the virus) are not needed to provide a safe workplace for a employees.

g. While the OSHA standard 1910[6] titled Bloodborne pathogens recommends making Hep B vaccine available to employees who have occupational exposure to hepatitis B, the vaccine does not cure nor remove the blood-borne virus that can cause chronic infection in the liver.

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[4] See Hospital Respiratory Protection Program Toolkit, May 2015 at https://www.osha.gov/sites/default/files/publications/OSHA3767.pdf

[5] See OSHA Section 1910.134 Respiratory Protection at https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

[6] See OSHA Bloodborne pathogens – Section 1910.1030 - https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030

h. In general, no vaccine, whether the hepatitis B vaccine or a Covid-19 vaccine, cures or eliminate a communicable diseases 100%.

i. While the main purpose of New York City Department of Health Covid Emergency Orders is to reduce the spread of Covid-19 in the workplace of New York City facilities, the Emergency Orders also carry the unintended consequence of introducing "new hazards" into the body of City employees via the Covid vaccines that can directly affect the health and safety of the City's employees which conflicts with OSHA.

j. The new hazard(s) include the known and reported severe and life-threatening adverse effects from the injection of the Covid-19 vaccine. All healthcare administrators of vaccines are required to report adverse effects of any vaccine to the Centers for Disease Control and Prevention (CDC) Vaccine Adverse Events Reporting System. As of March 18, the system reported that between December 14, 2020, and March 11, 2022, 1,183,495 reports of adverse events from all age groups following COVID vaccines, including 25,641 deaths and 208,209 serious injuries have been reported. As of the dates of the NYC and NYS Covid Emergency Orders were issued, in the VAERS data released September 17, 2021, by the CDC showed a total of 701,561 reports of adverse events from all age groups following COVID vaccines, including 14,925 deaths and 91,523 serious injuries between Dec. 14, 2020 and Sept. 10, 2021.[7]

k. Because the OSHA General Duty Clause at 29 U.S.C. §654[8] requires employers to recognize hazards that are "likely to cause death or serious physical harm to …employees" and to comply with the OSHA standards promulgated to eliminate or reduce a hazard, when evaluated comprehensively, the OSH Act does not list vaccines

[7] See VAERS Reporting Requirements for Covid-19 Vaccines at https://vaers.hhs.gov/reportevent.html
[8] See OSH Act of 1970 Genera Duty Clause 29 U.S.C. 654 at https://www.osha.gov/laws-regs/oshact/section5-duties

as a promulgated standard that eliminates or reduces occupational environmental airborne contaminates or atmospheric contaminants in a workplace.[9]

i. Finally, OSHA standards allow employers to modify work locations also to eliminate an employee's exposure to hazards in the workplace. Remote work is effective in eliminating employee exposures to airborne contaminates that may be in a workplace and is a required to be used by employers before the use of other methods that introduce hazards like vaccines.

19. I am not aware of employees having been terminated for refusing a Hep B vaccine after exposure, therefore there is not need to terminate an employee for refusing to submit to the Covid-19 vaccine.

Additional Opinions Regarding Other Workplace Safety Duties Related to Covid-19

20. According to a CDC report around November 2020[10] before Covid vaccines became available in the U.S., the primary cause of a person suffering severe Covid or a Covid related death after exposure to the respiratory hazard is the existing of one or more pre-existing chronic disease like heart disease, diabetes, chronic livers disease, chronic pulmonary disease, to name a few.

21. The CDC for years has identified poor diet as one of four causes of chronic disease[11] in the U.S., which are the leading causes of all death.[12]

22. For many years, scientific medical journals have concluded that the consumption of red meat and processed meat are the leading cause of most chronic disease and death in the United States.[13]

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[9] See OSH Act of 1970 Comprehensive Table of OSHA laws & Regulations - https://www.osha.gov/laws-regs/regulations/standardnumber

[10] Centers for Disease Control and Prevention (CDC). Coronavirus disease 2019 (COVID-19)—people with certain medical conditions. Atlanta (GA): US Department of Health and Human Services, CDC; Nov. 2020. https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html

[11] Centers for Disease Control and Prevention (CDC), Publication by the National Center for chronic Disease Prevention and Health Promotion – "About Chronic Disease" https://www.cdc.gov/chronicdisease/about/index.htm

[12] National, Heart, Lung and Blood Institute - publication "Americans poor diet drives $50 billion a year in health care costs December 17, 2019" https://www.nhlbi.nih.gov/news/2019/americans-poor-diet-drives-50-billion-year-health-care-costs

[13] "Red meat and processed meat consumption and all-cause mortality:" a meta-analysis

23. New York law defines "potentially hazardous food" as any food that consists in whole or in part of milk or milk products, eggs, meat, poultry, fish, shellfish, edible crustacea, cooked potato, in a form capable of supporting: (1) rapid and progressive growth of infectious or toxigenic microorganisms; or (2) the slower growth of C. botulinum.[14]

24. While the NY State and FDA defines potentially hazardous foods based on the ability of the "food" to support or serve as reservoirs of harmful and infectious pathogens, which include pathogenic protozoans, bacteria, and viruses, as a public health researcher and practitioner, it is my opinion that potentially hazardous foods also include animal foods whose intrinsic factors (which include but are not limited to animal blood, fat and flesh) when consumed have demonstrated in over a dozen scientific studies to cause chronic disease and impairment of the body's natural immune response.

25. Base on my medical experience and knowledge as a medical practitioner who prescribes (as a scientifically supported evidence based intervention) whole plant-based foods and lifestyle interventions to treat chronic disease, including heart disease, renal disease, obesity, both in the clinical and acute and intensive care setting, it is my opinion that employers that provide employees food or meals in the workplace also have a duty to remove and eliminate "potentially hazardous food" from employer operated or contracted cafeterias and specifically from patient meal services and vending machines to also reduce the risk of employees and patients suffering severe Covid or Covid related illnesses.

26. In a study published June 11, 2018 by the CDC that included 5,222 employees across the US, it was found that the foods people get at work tended to be high in empty calories —

Susanna C Larsson, Nicola Orsini, Am J Epidemiol Feb. 1, 2014;179(3):282-9. doi: 10.1093 https://pubmed.ncbi.nlm.nih.gov/24148709/ see also "The global diabetes epidemic as a consequence of lifestyle-induced low-grade inflammation" by H. Kolb and T. Mandrup-Poulsen, Diabetologia Jan, 2010;53(1):10-20. - https://pubmed.ncbi.nlm.nih.gov/19890624/

[14] See New York Codes, Rules and Regulations Section 14-2.3.

those from solid fats and/or added sugars — with more than 70 percent of the calories coming from food that was obtained for free in the workplace.[15]

27. In a 2019 scientific study by a Dr. Robert Vogel (which was summarized in the documentary The Game Changers,[16]) on the impact of the daily consumption of animal fat on human endothelial function, it was determine that the consumption of a single meal that consists of "potentially hazardous food" impairs blood flow throughout the body.

28. Many studies have shown that impaired endothelial function has a direct impact on immune function that can cause severe disease and death.

29. In a study published in April 2021, before any Covid-19 mandates were order, it was reported that endothelial dysfunction and immunothrombosis as key pathogenic mechanisms in severe COVID-19 and Covid related deaths.[17]

30. Therefore, while implementing the most~~potentially~~ effective risk mitigation control to remove the existence of Covid viral pathogens from the workplace atmosphere either through: 1) HEPA filtration systems, 2) ~~reducing an employee's risk of exposure~~ through ~~the use of~~ remote work, or 3) through the use of PAPR respirators to eliminate an employees exposure to the airborne pathogen (either singularly or in combination), in my opinion, removing the "potentially hazardous foods" is equally necessary, if not more important to preventing severe Covid-19 and death in employees.

31. The statements and opinions made in this Affidavit are preliminary and I reserve the right to add to, amend or modify my opinions as more facts are provided during the course of any litigation of the claims by the Classes of Plaintiffs for which this affidavit is provided.

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[15] Foods and Beverages Obtained at Worksites in the United States by Stephen Onufrak CDC Epidemiologist, in Journal of the American Academy of Nutrition and Dietetics 119(6) DOI:10.1016/j.jand.2018.11.011

[16] 3 Minute video on the Impact on Animal Fat on Endothelial Function study by Dr. Robert Vogal, Cardiologist– 2019 study from the "Game Changers" documentary https://tinyurl.com/5du5nuke

[17] Endothelial dysfunction and Immunothrombosis as key pathogenic mechanisms in COVID-19 By Aldo Bonaventura, and Alessandra Vecchié…. Nat Rev. Immunol. 2021; 21(5): 319–329 – see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8023349/

I declare under penalty of perjury under the laws of the State of Texas that the foregoing is true and correct.

Dated this 19th day of April, 2022.

DR. BAXTER MONTGOMERY MD

A NOTARY PUBLIC OR OTHER OFFICER COMPLETING THIS CERTIFICATE VERIFIES ONLY THE IDENTITY OF THE INDIVIDUAL WHO SIGNED THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED, AND NOT THE TRUTHFULNESS, ACCURACY, OR VALIDITY OF THAT DOCUMENT.

Subscribed and sworn to (or affirmed) before me on this 19th day of April, 2022, by Dr. Baxter Montogery, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Witness my hand and official seal.

NANCY NAVA
Notary Public, State of Texas
Comm. Expires 05-26-2025
Notary ID 133120530

Signature of Notary Public

[Affix Notary Seal]

1. The California Respirator Program Administrators toolkit can be accessed at: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/RespToolkit.aspxexternal icon
2. Beckman S, Materna B, Goldmacher S, Zipprich J, D'Alessandro M, Novak D, Harrison R [2013]. Evaluation of respiratory protection programs and practices in

BAXTER DELWORTH MONTGOMERY, MD

The Plant-Based Physician
Montgomery Heart & Wellness
Video Bio

EXPERIENCE:

Clinical Assistant Professor
The University of Texas Health Science Center
Department of Medicine
Division of Cardiology/Clinical Cardiac Electrophysiology

President and CEO
Houston Associates of Cardiovascular Medicine, PA.
(1997-Present)

Executive Director
The Johnsie and Aubary Montgomery Institute of Medical Education and Research (a 501(c) 3 nonprofit organization)

BIRTHPLACE:

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United States of America

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10480 South Main Street
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UNDERGRADUATE EDUCATION:

William Marsh Rice University
Houston, Texas
Bachelor's Degree in Biochemistry (1986)

GRADUATE EDUCATION:

The University of Texas Medical Branch at Galveston
Galveston, Texas
Doctor or Medicine

RESIDENCY:

Baylor College of Medicine
Houston, Texas
Internal Medicine

FELLOWSHIP:

The University of Texas Health Science Center at Houston
Houston, Texas
Cardiovascular Diseases
Clinical Cardiac Electrophysiology

CERTIFICATION:

Diplomate of the American Board of Internal Medicine, Cardiovascular Diseases

Diplomate of the American Board of Internal Medicine, Clinical Cardiac Electrophysiology

LICENSURE:

Texas State Board of Medical Examiners (Since 1999)
Permit Number H9549

HOSPITAL APPOINTMENTS:

Attending Physician
Memorial Hermann Hospital - The Texas Medical Center
Houston, Texas

Attending Physician
The Heart and vascular Institute
Memorial Hermann Hospital - The Texas Medical Center
Houston, Texas

Consulting Physician
Select Specialty Hospital - Heights
Houston, Texas

TEACHING RESPONSIBILITES:

Teaching Faculty for Cardiology Fellows and Clinical Advanced Nurse Practitioners
The Heart and Vascular Institute
Memorial Hermann Hospital - The Texas Medical Center
1997 - Present

Cardiovascular Disease Lecturer
GlaxoSmithKline, Inc.
2000 - Present

Cardiovascular Disease Lecturer
Novartis, Inc.
2006 - Present

Cardiovascular Disease Lecturer
Boston Scientific, Inc.
2006 - Present

Co-Director and Lecturing Faculty
Cardiology Concepts for Non-Cardiologists
(An Annual Houston Area Educational Symposium)

JAM Institute, Inc.
2006 - 2008

Steering Committee Member and Lecturing Faculty
Close the Gap
Boston Scientific, Inc.
2006 - Present

RESEARCH:

CLINICAL STUDIES:

ALLHAT: Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial. ALLHAT ALLHAT was a blinded, randomized trial that investigated the relative efficacy of different classes of antihypertensive agents in reducing stroke, illness and death from cardiovascular diseases. A subgroup of patients with hyperlipidemia was randomized comparing Pravastatin compared to usual care.
A Houston Site - Principal Investigator (1998)

INVEST: The International Verapamil SR/Trandolapril Study. INVEST was a randomized controlled clinical trial comparing a calcium antagonist treatment strategy (Isoptin® SR) with a non calcium antagonist treatment strategy for the control of hypertension in a primary care coronary artery disease patient population.
A Houston Site - Principal Investigator (2000)

INVEST SUB-STUDY: This study was a sub-study of the INVEST patient population designed to evaluate the impact of genetic differences on pharmacokinetics.
A Houston Site - Principal Investigator (2000)

The Safety and Efficacy of PNU-182716 Versus Rosiglitazone: This was a one-year, randomized, double blind, parallel group, and active comparator study.
A Houston Site - Principal Investigator (2000)

FACTOR: Fenofibrate and Cerivastatin Trial Optimizing Response. FACTOR was a multicenter, randomized, double blind, placebo controlled, parallel group, study of the safety and efficacy of Cerivastatin in combination with Fenofibrate compared to Cerivastatin alone, Fenofibrate alone and placebo in a population of Type 2 Diabetic Men and Women.
Grant Sponsor - Bayer 2001
A Houston Site - Principal Investigator

ADHERE: ADHERE was a national registry of patients admitted to hospitals with acute decompensated congestive heart failure.
A Houston Site - Principal Investigator (2001)

STELID TM AND STELIX TM LEADS STUDY: This study was a
safety and efficacy study of steroid-eluting cardiac pacing leads.
Grant Sponsor - Ella Medical 2002

ARRHYTHMIA PATHWAY STUDY: This was a patient registry study designed to assess the efficacy of a clinical algorithm for identifying and assessing patients at risk of sudden cardiac arrest.
Grant Sponsor - Medtronic, Inc. 2002
A Houston Site - Principal Investigator

RAPIDO CATHETER STUDY: This study was to evaluate the efficacy of a left ventricular defibrillator-pacemaker lead delivery system.
Grant Sponsor - Guidant, Inc. 2003
A Houston Site - Principal Investigator

PROTOS HEART RATE DISTRIBUTION STUDY: This was a clinical study designed to compare the heart rate distribution in patients undergoing pacemaker implants requiring heart rate response therapy. This study compared the heart rate distribution of accelerometer rate response therapy to the BIOTRONIK Closed Loop System therapy.
Grant Sponsor - Biotronik, Inc. 2003
A Houston Site - Principal Investigator

CSPP100A2404 - A 54 week, randomized, double-blind, parallel-group, multicenter study evaluating the long-term gastrointestinal (GI) safety and tolerability of Aliskiren (300 mg) compared to Ramipril (10 mg) in patients with essential hypertension.
Sponsored by Novartis, since April 4, 2008.
A Houston Site - Principal Investigator

CSPP100AUS03 - An 8 week Prospective, Multicenter, Randomized, Double-Blind, Active Control, Parallel Group Study to Evaluate the Efficacy and Safety of Aliskiren HCTZ versus Amlodipine in African American Patients with Stage 2 Hypertension.
Sponsored by Novartis, since August 2008.
A Houston Site - Principal Investigator

CSPP100A2409- An 8 week randomized, double-blind, parallel-group, multicenter, active-controlled dose escalation study to evaluate the

efficacy and safety of Aliskiren HCTZ (300/25 MG) compared to Amlodipine (10 mg) in patients with satage 2 systolic hypertension and diabetes mellitus.
Sponsored by Novartis, since December 2008.
A Houston Site - Principal Investigator

SPAlOOAUSOl - An 8 week randomized, double-blinded, parallel-group, multicenter, active-controlled dose escalation study to evaluate the efficacy and safety of Aliskiren Administered in Combination with Amlodipine (150/5 mg, 300/10 mg) versus Amlodipine alone (5 mg, 10 mg) in African American patient with Stage 2 Hypertension.
Sponsored by Novartis, since February 2009.

CLAF237B22Ol- A multicenter, randomized, double-blind study to evaluate the efficacy and long-term safety of vildagliptin modifies release (MR) as monotherapy in patients with type 2 diabetes.
Sponsored by Novartis, since February 2009.
A Houston Site - Principal Investigator

CLAF237B2224 - A multi-center, randomized, double-blind study to evaluate the efficacy and long-term safety of vildagliptin modified release (MR) as add-on therapy to metformin in patients with type 2 diabetes.
Sponsored by Novartis, since February 2009.
A Houston Site - Principal Investigator

Galaxy study: An aftermarket registry of one of the Biotronik implantable cardioverter defibrillators ICD leads (2009 to present)
A Houston Site - Principal Investigator

Paradigm study: A multicenter, randomized, double-blind, parallel group, active-controlled study to evaluate the efficacy and safety of LCZ696 compared to enalapril on morbidity and mortality in patients with chronic heart failure and reduced ejection fraction. 2009 -2014
A Houston Site - Principal Investigator

BASIC RESEARCH:

In Rapid Separation of Mitochondria from Extra- mitochondrial Space Applied to Rat Heart Mitochondria. An abstract presented at an NIH sponsored student research poster session, Univ. of Texas Medical Branch, Galveston, TX, June 17, 1987.

Regulation of the Adenine Nucleotide Pool-Size of Heart Mitochondria by the ADP/ATP Translocase. Abstract and poster presented at the Galveston-Houston Conference for Cardiovascular

Research, Univ. of Texas, Medical Branch, Galveston, TX, February 26, 1988.

The Adenine Nucleotide Pool-Size of Heart Mitochondria is Regulated by the ADP/ATP Translocase. Abstract presented at the 29th Annual National Student Research Forum, University of Texas Medical Branch, Galveston Texas, April 6-8, 1988.

Increased Frequency of the Deletion Allele of the ACE Gene in African-Americans Compared to Caucasians. This study evaluated the prevalence of the deletion allele of the ACE gene in a population of African Americans compared to Caucasians. The findings were presented at the annual meeting of the American College of Cardiology in March of 1996.

Determination of the effect of Calcium infusion on CGRP mRNA Production. A pilot study investigating a possible mechanism by which calcium supplementation may increase CGRP (Calcitonin gene-related peptide, a potent peripheral vasodilator) content in afferent neurons of Sprague Dawley rats, 1990.

PUBLICATIONS:

Montgomery, B, D, MD. A Review of Microanatomy for Medical Students, 1987, chapter 1-8.

Baxter D. Montgomery, MD, Elizabeth A. Putnam, Ph.D., John Reveille, MD, Dianna M. Milewicz. MD, Ph.D.: Increased Frequency of the Deletion Allele of the ACE Gene in African-Americans Compared to Caucasians. (Abstract) J. American College of Cardiology March, 1996

Doyle, N.M., Monga, M., **Montgomery, B.**, Dougherty, A.H.: Arrhythmogenic right ventricular cardiomyopathy with implantable cardioverter defibrillator placement in pregnancy. J Mat Fetal Neo Med 18:141-4, 2005

Baxter D. Montgomery, MD Co-Author of Dreams of the nation Book: "Improving Health" with focus on strengthening the food and health connection and replacing unnatural foods from our diet and replacing them with natural foods as a way of reversing illness. 2009

Montgomery, Baxter D: The Food Prescription for Better Health, Houston: Delworth Publishing, 2011

Montgomery,B.D, MD, Effects of the Montgomery Food Prescription on Clinical Biomarkers of Cardiovascular Disease. Plant-based diet can improve clinical biomarkers associated with cardiovascular disease. This study was submitted to the 10th annual Texas A&M University System Pathways Student Research Symposium 2012.

Baxter D. Montgomery, MD Co-Author of the book Rethink Food: About the need for revolutionary change in how to address chronic illness with optimal nutrition.2014

CLINICAL PRESENTATIONS:

Clinical Concepts for Non Cardiologist, Director and Faculty. An educational symposium held for primary care and other non-cardiology specialists in the Houston area. October 2006

Patients at Risk for Sudden Cardiac Arrest Dinner Symposium at the Houston Forum June, 2007

Clinical Concepts for Non Cardiologist, Director and Faculty. An educational symposium held for primary care and other non-cardiology specialists in the Houston area. October 2007

Clinical Concepts for Non Cardiologist, Director and Faculty. An educational symposium held for primary care and other non-cardiology specialists in the Houston area. October 2008

Houston Town Hall Meeting, Director and Faculty. Health summit on the benefits of a healthy nutritional lifestyle for the management of chronic illnesses held for both health care professional and the general public in the Houston area. 2009

Houston Town Hall Meeting, Director and Faculty. Health summit on the benefits of a healthy nutritional lifestyle for the management of chronic illnesses held for both health care professional and the general public in the Houston area. 2010

Houston Health Summit (Town Hall Meeting), Director and Faculty. Health summit on the benefits of a healthy nutritional lifestyle for the management of chronic illnesses held for both health care professional and the general public in the Houston area. 2011

Houston Health Summit (Town Hall Meeting), Director and Faculty. Health summit on the benefits of a healthy nutritional lifestyle for the management of chronic illnesses held for both health care professional and the general public in the Houston area. 2012

Houston Health Summit (Town Hall Meeting), Director and Faculty. Health summit on the benefits of a healthy nutritional lifestyle for the management of chronic illnesses held for both health care professional and the general public in the Houston area. 2013

PROFESSIONAL APPOINTMENTS:

Clinical Assistant Professor of Medicine, University of Texas Health Science Center - Houston 1996 - Present

Steering Committee Member, Boston Scientific Close the Gap Initiative 2005 - Present
Scientific/Medical Board of Advisors, Nutritional Excellence, Inc. 2007 - Present

Medical Board of Directors, Twelve Oaks Medical Center Independent Physician's Association 2005 - Present

Medical Executive Committee (Twelve Oaks Hospital), Member at Large 2002 - 2006

Patient Safety Committee (Twelve Oaks Hospital), Chairman 2002 - 2004

Physician Peer Review Committee (Twelve Oaks Hospital) 2002 - 2005

Medical Director, SCCI (Specialized Complex Care) Hospital, 2003 - 2005

Physician Relation Council Advisory Board, Unicare, 2002 - 2004

Aldine Education Foundation: The mission of the Aldine Education Foundation is to provide community-based support to the Aldine Independent School District in pursuit of excellence in teaching, innovation in the classroom and superior learning opportunities for all students.

CLINICAL INTERESTS:

Nutritional Lifestyle Interventions for the Management of Chronic Illnesses
Cardiac Pacing and Electrophysiology

Diastolic and Systolic Heart Failure
Hypertensive Heart Disease
Cardiovascular Exercise Physiology
Basic Echocardiography
Nuclear Cardiology
Diagnostic Cardiac Catheterization
Cardiovascular Wellness and Nutrition

PROFESSIONAL ASSOCIATIONS:

American College of Cardiology (Elected as Fellow of the College in January, 1999)
American Heart Association
Heart Rhythm Society (North American Society of Pacing and Electrophysiology, NASPE)
American College of Physicians
Harris County Medical Society
Houston Medical Forum

HONORS AND AWARDS:

Benjamin Spock Award for Compassion in Medicine - 2010

America's Top Physicians - 2007

Cumulative evaluation of "Superior" performance by senior house staff and faculty during first year of residency (Baylor College of Medicine), 1990

Outstanding Young Men of America, 1988

Kempner Award (University of TX Medical Branch) 1986-87 and 1987-88

Academic Scholarship (University of TX Medical Branch) 1986-87

Who's Who Among American Colleges and Universities (Rice University) 1986

Franz Brotzen Outstanding Senior Award (Rice University) 1986

Jones College Service Award (Rice University) 1986 and 1985

100 Black Men of Metropolitan Houston (Awarded in 2012) for the dedication to the improvement of the community.

Physicians Committee for Responsible Medicine- Member of Advisory Board- Current.

ACTIVITIES:

Gardening
Scouting
Physical Conditioning

Received: 1 June 2018 | Revised: 7 July 2018 | Accepted: 12 July 2018

DOI: 10.1002/clc.23027

WILEY CLINICAL CARDIOLOGY

CLINICAL INVESTIGATIONS

Consumption of a defined, plant-based diet reduces lipoprotein(a), inflammation, and other atherogenic lipoproteins and particles within 4 weeks

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[2]Department of Nutrition and Food Science, Texas Woman's University, Houston, Texas

[3]University of Texas Health Science Center, Houston, Texas

[4]Montgomery Heart & Wellness, Houston, Texas

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Background: Lipoprotein(a) [Lp(a)] is a highly atherogenic lipoprotein and is minimally effected by lifestyle changes. While some drugs can reduce Lp(a), diet has not consistently shown definitive reduction of this biomarker. The effect of consuming a plant-based diet on serum Lp(a) concentrations have not been previously evaluated.

Hypothesis: Consumption of a defined, plant-based for 4 weeks reduces Lp(a).

Methods: Secondary analysis of a previous trial was conducted, in which overweight and obese individuals (n = 31) with low-density lipoprotein cholesterol concentrations >100 mg/dL consumed a defined, plant-based diet for 4 weeks. Baseline and 4-week labs were collected. Data were analyzed using a paired samples t-test.

Results: Significant reductions were observed for serum Lp(a) (−32.0 ± 52.3 nmol/L, P = 0.003), apolipoprotein B (−13.2 ± 18.3 mg/dL, P < 0.0005), low-density lipoprotein (LDL) particles (−304.8 ± 363.0 nmol/L, P < 0.0005) and small-dense LDL cholesterol (−10.0 ± 9.2 mg/dL, P < 0.0005). Additionally, serum interleukin-6 (IL-6), total white blood cells, lipoprotein-associated phospholipase A2 (Lp-PLA2), high-sensitivity c-reactive protein (hs-CRP), and fibrinogen were significantly reduced ($P \leq 0.004$).

Conclusions: A defined, plant-based diet has a favorable impact on Lp(a), inflammatory indicators, and other atherogenic lipoproteins and particles. Lp(a) concentration was previously thought to be only minimally altered by dietary interventions. In this protocol however, a defined plant-based diet was shown to substantially reduce this biomarker. Further investigation is required to elucidate the specific mechanisms that contribute to the reductions in Lp(a) concentrations, which may include alterations in gene expression.

KEYWORDS

general clinical cardiology/adult, lipoproteins, preventive cardiology, vegetarian diet

1 | INTRODUCTION

Lipoprotein(a) [Lp(a)] is an atherogenic lipoprotein structurally similar to low-density lipoprotein cholesterol (LDL-C), although synthesis occurs through independent pathways. Key differences include the linkage of apolipoprotein B100 (Apo-B) to apolipoprotein(a) on the LDL surface.[1,2] It has been estimated that expression of the genomic region encoding apolipoprotein(a) (*LPA* gene) accounts for approximately 90% of plasma Lp(a) concentrations.[3] Elevated Lp(a) is independently associated with cardiovascular disease,[4] and the LPA gene was observed to have the strongest genetic link to cardiovascular disease.[5] Individuals with Lp(a) plasma concentrations >20 mg/dL have twice the risk of developing cardiovascular disease and approximately 25% of the population may have this plasma concentration.[6] The mode of action by which Lp(a) exerts its atherogenic effect is likely similar to that of LDL-C, by deposition in the sub-endothelial space and uptake by macrophages mediated via the VLDL receptor.[7] Lp(a) is particularly atherogenic due to its unique property of being a carrier of oxidized phospholipids, in addition to its higher binding affinity to negatively charged endothelial proteoglycans.[8] Lp(a) can facilitate

endothelial dysfunction when concentrations are elevated likely due to this effect.[9]

While PCSK9 inhibitors, high dose atorvastatin, ezetimibe and niacin have resulted in significant reductions in Lp(a),[10–12] lifestyle interventions have not reliably demonstrated reduced Lp(a) to a clinically significant degree. Interestingly, even high saturated fat and high cholesterol diets known to induce hypercholesterolemia have had little influence on plasma Lp(a) concentrations.[13] Despite the lack of evidence in the literature indicating a relationship between diet and Lp(a) concentrations, a defined, plant-based has not been previously evaluated with respect to its potential effect to reduce Lp(a). Previous investigations have found that a very-high fiber diet comprised of vegetables, fruits and nuts can reduce LDL-C by 33% and Apo-B by 26%,[14] although Lp(a) was not measured. Since such a diet can result in dramatic reductions in LDL-C and Apo-B, secondary analysis of a previously published investigation[15] employing a similar plant-based diet were analyzed to evaluate if Lp(a) could be significantly reduced after 4 weeks among other inflammatory indicators and atherogenic lipoproteins and particles.

2 | METHODS

2.1 | Study population

Participants were subjects of a previous study in which written informed consent was obtained to draw blood for analysis.[15] Laboratory reports for each subject included biomarkers used for clinical purposes, and selected biomarkers are included in the present investigation. The study protocol was approved by the Texas Woman's University Institutional Review Board, Houston.

The study protocol has been previously described.[15] Briefly, all participants were registered new patients of a cardiovascular center and were hypertensive (systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg), had elevated LDL-C (≥100 mg/dL) and excess body weight (body mass index ≥25 kg/m^2) at baseline. Exclusionary criteria included current tobacco use, current drug abuse, excessive alcohol use (>2 glasses of wine or equivalent for men or > 1 glass of wine or equivalent for woman), a current cancer diagnosis, an ongoing clinically defined infection, a mental disability that would prevent a participant from following the study protocol, an estimated glomerular filtration rate < 60 mg/dL, current pregnancy or lactation, a hospitalization within the past 6 months, and previous exposure to the nutrition program.

2.2 | Intervention

Participants were instructed to consume a defined, plant-based diet for 4 weeks ad-libitum which included the consumption of foods within a food classification system.[15] These foods fell within food levels 0 to 4b of the food classification system (Table S1, Supporting information). Briefly, excluded were animal products, cooked foods, free oils, soda, alcohol, and coffee. Allowed for consumption were raw fruits, vegetables, seeds, and avocado. Small amounts of raw buckwheat and oats were also permitted. Vitamin, herbal, and mineral supplements were to be discontinued unless otherwise clinically indicated. All meals and snacks were provided to subjects, although they were free to consume food on their own within food levels 0 to 4b. In addition, subjects were not advised to alter their exercise habits. Adherence was measured daily as previously described[15] with an adherence assessment tool. Participants indicated in writing each day whether they were adherent. Dietary recalls (24-hour) were conducted by a trained nutritionist at baseline and at 4 weeks. Nutrient intake was analyzed by the Nutrition Data System for Research software (University of Minnesota, version 2016). No lipid lowering medications were altered throughout the intervention.

2.3 | Measures

After a 12-hour fast, the following plasma biomarkers were obtained at baseline and after 4-weeks: total cholesterol (Total-C), LDL-C, high-density lipoprotein cholesterol (HDL-C), triglycerides, LDL particles (LDL-P), small-dense low-density lipoprotein cholesterol (sdLDL-C), Apo-B, high-density lipoprotein 2 cholesterol (HDL2-C), apolipoprotein A-1 (Apo A-1), and Lp(a). Additionally, high-sensitivity c-reactive protein (*hs*-CRP), endothelin, interleukin-6 (IL-6), tumor necrosis factor alpha (TNF-a), lipoprotein-associated phospholipase A2 (Lp-PLA2), myeloperoxidase, fibrinogen, troponin-I, N-terminal pro b-type natriuretic peptide (NT-proBNP), total white blood cell count (WBC), neutrophil count, lymphocyte count, monocyte count, eosinophil count, and basophil count were documented. These specific biomarkers of interest were analyzed by either True Health Diagnostics (Frisco, Texas) or Singulex (Alameda, California) depending on the subject's health insurance. The same company that analyzed the baseline labs for a participant was used for the follow-up labs to ensure consistency.

2.4 | Data analysis

Paired samples t-tests were used for the analysis of biochemical measures at baseline and 4-weeks, and significance was confirmed with non-parametric tests. Significance was determined to be a P value less than 0.05. SPSS (version 24) was used for data analysis.

3 | RESULTS

Baseline demographics are indicated in Table 1. Subjects represent a sample that was 81% obese with multiple clinical diagnoses. Two-thirds of subjects were women and 80% were African American.

Adherence to the dietary intervention was approximately 87% over the course of the 4 weeks as measured by the daily adherence assessment tool. Food group consumption is indicated in Table 2 at baseline and 4-weeks. Notably, total fruit consumption increased from 1.3 ± 2.0 servings to 11.8 ± 10.4 servings (808% increase, $P < 0.0005$) and total vegetable consumption increased 2.7 ± 2.0 servings to 16.0 ± 9.2 servings (493% increase, $P < 0.0005$). Additionally, total animal product consumption decreased from 7.9 ± 4.7 servings to 0.4 ± 1.4 servings (95% decrease, $P = 0.001$). The consumption of avocados, dark-green vegetables, deep-yellow vegetables, tomatoes,

TABLE 1 Baseline characteristics and clinical diagnoses

	Participants[a]
n	31
Age (years)	53.4 (32-69)
Sex	
Male	10 (33%)
Female	21 (67%)
Race, ethnicity	
African American	25 (80%)
Hispanic	3 (10%)
White	3 (10%)
Mean BMI (kg/m^2)	37.5 ± 8.3
Overweight (25-29.9 kg/m^2)	6 (19%)
Obesity class 1 (30-34.9 kg/m^2)	6 (19%)
Obesity class 2 (35-39.9 kg/m^2)	10 (33%)
Obesity class 3 (≥40 kg/m^2)	9 (29%)
Current diagnoses	
Coronary artery disease	10 (33%)
Type II diabetes mellitus	8 (27%)
Arthritic condition	7 (23%)
Pre-diabetes	5 (17%)

Abbreviation: BMI, body mass index.
[a] Data are mean (range) unless otherwise indicated.

and other vegetables also significantly increased ($P \leq 0.006$). A decreased consumption of white potatoes, fried potatoes, total grains, refined grains, whole grains, added oils, added animal fat, red meat, white meat, eggs, and dairy were also observed ($P \leq 0.027$). The consumption of sweets (5% decrease, $P = 0.90$) and the consumption of nuts/seeds (17% increase, $P = 0.736$) did not significantly change between baseline and 4-weeks.

Body weight, BMI, total cholesterol, LDL-C, HDL-C, and triglycerides (Table 3) were significantly reduced after 4-weeks of the dietary intervention ($P \leq 0.008$). Lp(a) was also significantly reduced (−32.0 ± 52.3 nmol/L, $P = 0.003$). In addition, LDL-P, sdLDL-C, Apo-B, HDL2-C, and Apo A-1 were significantly reduced ($P \leq 0.03$). Of the atherogenic lipoproteins, sdLDL-C had the greatest relative reduction of approximately 30% (Figure 1). Lp(a) reduced 16% which was proportional to the decrease in Total-C, triglycerides and LDL-P.

Of the inflammatory indicators, *hs*-CRP, IL-6, Lp-PLA2, and fibrinogen significantly decreased ($P \leq 0.004$) (Table 4). The WBC, neutrophil, lymphocyte, monocyte, eosinophil and basophil count also significantly decreased ($P \leq 0.033$). Interestingly, no statistically significant changes were observed for endothelin-1, TNF-a, myeloperoxidase, troponin-I, or NT-proBNP ($P \geq 0.056$) between baseline and 4-weeks.

TABLE 2 Number of food group servings at baseline and 4-weeks[a]

Food group	Serving size	Baseline[b]	Final[b]	Change[c]	*P*[d]
Fruits, total	1/2 cup chopped, 1/4 cup dried or 1 medium piece	1.3 ± 2.0	11.8 ± 10.4	808% (10.5 ± 10.8)	<0.0005
Avocado	1/2 cup chopped	0.1 ± 0.2	0.9 ± 0.9	800% (0.8 ± 0.9)	<0.0005
Vegetables, Total	1/2 cup chopped or 1 cup raw leafy	2.7 ± 2.0	16.0 ± 9.2	493% (13.3 ± 9.2)	<0.0005
Dark-green vegetables	1/2 cup chopped or 1 cup raw leafy	0.7 ± 1	5.2 ± 3.8	643% (4.5 ± 4.0)	<0.0005
Deep-yellow vegetables	1/2 cup chopped	0.2 ± 0.4	1.2 ± 1.1	500% (1.0 ± 1.3)	<0.0005
Tomatoes	1/2 cup chopped	0.4 ± 0.5	1.7 ± 2.4	325% (1.3 ± 2.4)	0.006
Other vegetables	1/2 cup chopped	1.4 ± 1.2	7.9 ± 6.6	464% (6.5 ± 6.3)	<0.0005
White Potatoes[e]	1/2 cup chopped or 1 medium baked potato	0.3 ± 0.7	0.0 ± 0.0	−100% (−0.3 ± 0.7)	0.03
Fried potatoes	1/2 cup chopped or 70 g french fries	0.5 ± 0.9	0.1 ± 0.3	−80% (−0.4 ± 0.9)	0.027
Grains, Total	1 slice of bread or halfcup cooked cereal	5.7 ± 3.5	0.7 ± 0.9	−88% (−5.0 ± 3.6)	<0.0005
Refined grains	1 slice of bread or half cup cooked cereal	3.8 ± 2.7	0.2 ± 0.7	−95% (−3.6 ± 3.0)	<0.0005
Whole grains	1 slice of bread or half cup cooked cereal	1.9 ± 2.6	0.5 ± 0.7	−74% (−1.4 ± 2.7)	0.007
Sweets[f]	4 g of sugar, 1 tbsp honey or 2 tbsp syrup	1.8 ± 2.3	1.7 ± 1.5	−5% (−0.1 ± 2.7)	0.90
Nuts/seeds	1/2 oz	1.2 ± 3.0	1.4 ± 1.6	17% (0.2 ± 3.4)	0.736
Added oils	1 tsp	3.2 ± 3.5	0.1 ± 0.2	−97% (−3.1 ± 3.5)	<0.0005
Added animal fat	1 tsp	1.3 ± 2.3	0.0 ± 0.1	−100% (−1.3 ± 2.3)	0.005
Animal products, Total[g]	1 oz	7.9 ± 4.7	0.4 ± 1.4	−95% (−7.5 ± 5.3)	0.001
Red meat	1 oz	2.1 ± 2.9	0.1 ± 0.2	−95% (−2.0 ± 3.0)	<0.0005
White meat	1 oz	3.9 ± 3.7	0.2 ± 1.1	−95% (−3.7 ± 4.1)	<0.0005
Eggs	1 large egg	0.5 ± 0.7	0.0 ± 0.1	−100% (−0.5 ± 0.7)	0.002
Dairy	1 cup of milk/yogurt or 1.5 oz of cheese	1.5 ± 1.6	0.1 ± 0.3	−93% (−1.4 ± 1.7)	<0.0005

[a] Data are for subjects who completed 24-h recalls at both baseline and 4-weeks ($n = 30$).
[b] Data are listed in serving size and are presented as mean ± SD.
[c] Data indicated as % change (mean ± SD).
[d] Paired samples *t*-tests for within-group comparisons of changes from baseline to final values.
[e] Excludes fried potatoes.
[f] Includes honey, candy, or other added sugars.
[g] Excludes added animal fat.

TABLE 3 Atherogenic lipoproteins and particles at baseline and 4-weeks

	Baseline[a]	Final[a]	Change[b]	P[c]
Weight (kg)	108.1 ± 28.6	101.4 ± 26.3	−6% (−6.6 ± 3.6)	<0.0005
BMI (kg/m^2)	37.5 ± 8.3	35.2 ± 7.8	−6% (−2.2 ± 1.1)	<0.0005
Total-C (mg/dL)	216.6 ± 34.2	182.7 ± 29.9	−16% (−33.8 ± 25.9)	<0.0005
LDL-C (mg/dL)	143.0 ± 28.9	118.4 ± 26.4	−17% (−24.6 ± 21.3)	<0.0005
HDL-C (mg/dL)	54.8 ± 9.4	49.5 ± 10.6	−9% (−5.2 ± 6.2)	<0.0005
Triglycerides (mg/dL)	124.1 ± 58.1	104.5 ± 53.6	−16% (−19.6 ± 38.4)	0.008
Lp(a) (nmol/L)[d]	200.7 ± 150.0	168.8 ± 126.7	−16% (−32.0 ± 52.3)	0.003
Apo-B (mg/dL)	115.2 ± 24.5	101.9 ± 17.7	−11% (−13.3 ± 18.3)	<0.0005
LDL-P (nmol/L)[e]	1891 ± 586	1586 ± 508	−16% (−305 ± 363)	<0.0005
*sd*LDL-C (mg/dL)	33.7 ± 11.5	23.7 ± 8.7	−30% (−10.0 ± 9.2)	<0.0005
HDL2-C (mg/dL)	17.4 ± 9.8	15.6 ± 9.9	−10% (−1.8 ± 4.5)	0.030
Apo A-1 (mg/dL)	189.7 ± 150.7	160.2 ± 126.5	−14% (−27.0 ± 19.6)	<0.0005

Abbreviations: Apo A-1, apolipoprotein A-1; Apo-B, apolipoprotein B100; BMI, body mass index; HDL-C, high-density lipoprotein cholesterol; HDL2-C, high-density lipoprotein-2 cholesterol; LDL-C, low-density lipoprotein cholesterol; LDL-P, low-density lipoprotein particles; Lp(a), lipoprotein(a); sdLDL-C, small-dense low-density lipoprotein cholesterol; total-C, total cholesterol.
[a] Mean ± SD (n = 31 unless otherwise indicated).
[b] Data indicated as % change (mean ± SD).
[c] Paired samples t-tests for within-group comparisons of changes from baseline to final values.
[d] n = 28 due to premature coagulation of sample (n = 1) and incompatible units (mg/dL) when merging laboratory results (n = 2).
[e] n = 29 due to premature coagulation of samples.

4 | DISCUSSION

The consumption of a defined, plant-based diet resulted in a significant reduction in Lp(a) after 4 weeks; thus, the study hypothesis was accepted. The reduction in Lp(a) was profound and is one of the largest reductions due to lifestyle reported in the literature. The magnitude of change was comparable to other leading medical therapies, such as niacin (~20% reduction) and PCSK9 inhibitors (~25% reduction).[12] It is important to note that this dietary intervention rapidly reduced Lp(a) by 16% in only 4 weeks, whereas shorter duration niacin and PCSK9 inhibitor drug trials typically lasted 8 to 12 weeks. It should also be noted that niacin may reduce inflammation, such as *hs*-CRP, by 15% after 3 months, although PCSK9 inhibitors do not.[16,17] After 4 weeks, the dietary intervention reduced *hs*-CRP by 30.7%. In addition, IL-6, Lp-PLA2, fibrinogen, and white blood cells were significantly reduced, as were sdLDL-C, LDL-P, and Apo-B, all of which represent a systemic, cardio-protective effect.[18–24] Thus, the use of this single dietary approach in the clinical setting, vs multiple drug therapy, may be an appropriate tool in treating complex patients with a myriad of elevated CVD-related biomarkers.

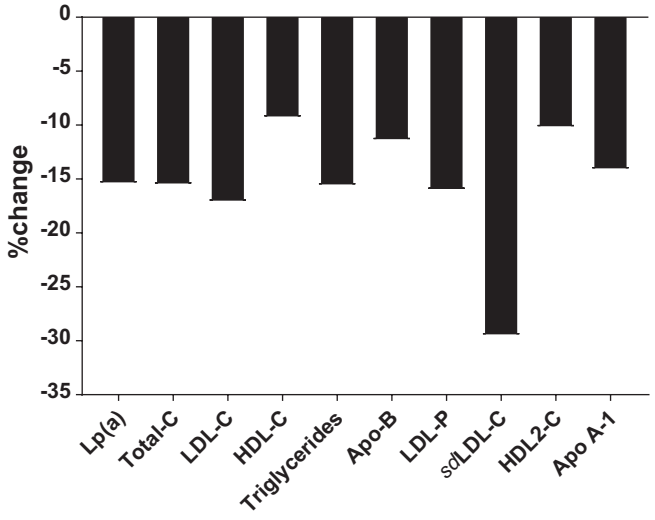

FIGURE 1 Percent change of atherogenic lipoproteins and particles from baseline to 4-weeks. All variable changes indicated are significant (P < 0.05). Lp(a), lipoprotein(a); Total-C, total cholesterol; LDL-C, low-density lipoprotein cholesterol; HDL-C, high-density lipoprotein cholesterol; Apo-B, apolipoprotein B100; LDL-P, low-density lipoprotein particles; sdLDL-C, small-dense low-density lipoprotein cholesterol; HDL2-C, high-density lipoprotein-2 cholesterol; Apo A-1, apolipoprotein A-1

Elevated Apo A1, HDL-C, and HDL2-C are associated with reduced cardiovascular disease risk.[24,25] While these HDL fractions were significantly reduced in this trial, this is a common phenomenon observed when consuming plant-based diets. A systematic review and meta-analysis of plant-based observational and clinical trials found that while HDL-C was significantly reduced compared to those consuming non-vegetarian diets, LDL-C and total-C were also reduced.[26] Despite reductions in HDL-C, those who consumed plant-based diets had a 25% reduced incidence of ischemic CVD compared with non-vegetarian counterparts.[27]

Lp(a) concentrations in the present study represent a high-risk population.[28] This may be explained by the higher proportion of African Americans in this sample, as African Americans may have higher Lp(a) concentrations compared with Caucasians.[29] An evaluation of 532 359 patients found that an Lp(a) concentration > 50 mg/dL was common among patients.[30] This range roughly corresponds to the mean nmol/L Lp(a) concentration observed in the present study.

4.1 | Effect of weight loss on plasma Lp(a) concentrations

An energy restricted diet was found to independently reduce serum Lp(a) in those with baseline concentrations >20 mg/dL, but not <20 mg/dL.[31] Further studies have found that weight loss may not

TABLE 4 Inflammatory and other cardiovascular indicators at baseline and 4-weeks

	Baseline[a]	Final[a]	Change[b]	*P*[c]
hs-CRP (mg/dL)	7.8 ± 6.4	5.4 ± 4.7	−30.7% (−2.4 ± 3.7)	0.001
Endothelin (pg/mL)[d]	2.2 ± 0.7	2.2 ± 0.8	0% (0.0 ± 0.7)	0.916
IL-6 (pg/mL)[d]	2.6 ± 1.4	2.0 ± 1.0	−23.1% (−0.6 ± 1.0)	0.001
TNF-α (pg/mL)[d]	2.0 ± 0.9	2.2 ± 0.9	10.0% (0.2 ± 0.6)	0.096
Lp-PLA_2 (ng/mL)[d]	252.3 ± 136.3	210.7 ± 119.1	−16.4% (−41.6 ± 64.6)	0.001
Myeloperoxidase (pmol/L)[e]	124.1 ± 58.1	104.5 ± 53.6	−23.0% (−28.5 ± 66.1)	0.056
Fibrinogen (mg/dL)[f]	561.4 ± 112.2	530.1 ± 102.9	−5.6% (−31.3 ± 50.7)	0.004
NT-proBNP (pg/mL)[d]	65.2 ± 71.2	69.4 ± 75.9	6.2% (4.1 ± 23.2)	0.337
Total WBC (K/μL)[d]	6.3 ± 2.0	4.8 ± 1.3	−22.2% (−1.4 ± 1.1)	<0.0005
Neutrophils (K/μL)[d]	3.5 ± 1.4	2.5 ± 0.9	−28.6% (−1.0 ± 0.8)	<0.0005
Lymphocytes (K/μL)[d]	1.9 ± 0.7	1.6 ± 0.6	−15.8% (−0.3 ± 0.4)	<0.0005
Monocytes (K/μL)[d]	0.46 ± 0.12	0.38 ± 0.09	−15.2% (−0.07 ± 0.1)	<0.0005
Eosinophils (K/μL)[d]	0.18 ± 0.11	0.15 ± 0.11	−16.6% (−0.03 ± 0.07)	0.033
Basophils (K/μL)[d]	0.029 ± 0.016	0.024 ± 0.015	−17.2% (−0.005 ± 0.010)	0.016

Abbreviations: *hs*-CRP, high-sensitivity c-reactive protein; IL-6, interleukin-6; Lp-PLA_2, lipoprotein-associated phospholipase A2; NT-proBNP, N-terminal pro b-type natriuretic peptide; TNF-α, tumor necrosis factor-alpha; WBC, white blood cells.
[a] Mean ± SD (*n* = 31 unless otherwise indicated).
[b] Data indicated as % change (mean ± SD).
[c] Paired samples *t*-tests for within-group comparisons of changes from baseline to final values.
[d] *n* = 30 due to premature coagulation of samples.
[e] *n* = 25 due to premature coagulation of samples.
[f] *n* = 27 due to premature coagulation of samples.

independently reduce Lp(a) concentrations. A pooled analysis of cohorts found that as weight loss ensued, Lp(a) concentrations surprisingly increased.[32] Baseline Lp(a) concentrations on average between the four cohorts analyzed were approximately 40 mg/dL, well above the >20 mg/dL threshold reported in the initial study.[31] Other investigations examining the effect of weight loss on Lp(a) concentration have not demonstrated a relationship between these two variables.[33,34] Interestingly, the emphasis on consuming plant-based foods, even with a calorie restricted diet, did not result in Lp(a) reductions compared with a calorie restricted red meat centered diet.[35] The plant-centered diet in this trial[35] still contained a significant number of calories derived from animal-based sources in addition to processed plant foods. Also, both diets contained similar quantities of dietary fiber, a measure of plant-food intake. Based on these weight loss trials, Lp(a) concentration is likely not influenced by weight reduction.

4.2 | Effect of diet on plasma Lp(a) concentrations

Other trials using diets emphasizing plant-based foods have not demonstrated similar results. A low-fat and low-saturated fat diet with an increased intake of fruits and vegetables interestingly increased Lp(a) concentrations.[36] Subjects consumed four to five servings of fruits or berries and five to six servings of vegetables daily for 5 weeks and all food was provided. It is important to note that subjects still consumed animal products throughout the intervention[36] which included dairy products and lean meats. The fiber content (40 g vs 51 g in the present study) was not as high as would be expected when consuming a higher quantity of plant-foods, and the number of fruits and vegetables did not meet the levels observed in the present study (11.8 servings of fruits and 16 servings of vegetables). Based on this data, it is probable that exclusively increasing fruit and vegetable intake is not sufficient to elicit reduced Lp(a) concentrations.

It has also been reported that a low-carbohydrate, high-fat diet (45% carbohydrate, 40% fat) may have a favorable impact on Lp(a) concentrations compared with a high-carbohydrate, low-fat diet (65% carbohydrate, 20% fat), although it is unclear as to what precisely was consumed on either of these diets.[37] In addition, the differences were small, as only a 2.17 mg/dL difference was observed between both groups, and baseline Lp(a) concentrations were <20 mg/dL. The Omni Heart Trial also found that replacing calories from carbohydrates and protein with unsaturated fats produced a smaller increase in Lp(a) comparatively, but both diets still elicited increased plasma Lp(a) compared with baseline. The differences between groups were also small at the end of the intervention (<4 mg/dL difference).[38]

In individuals with low baseline Lp(a) concentrations (approximately 5.5 mg/dL), the consumption of copious saturated fat, cholesterol (derived from egg consumption) and polyunsaturated fat did not influence Lp(a) concentrations.[13] Carbohydrate intake was low in this trial as well (39% to 46% carbohydrate as a percent of energy). While fat consumption does not appear to influence serum Lp(a) concentrations in the fasting state, a variety of fats may significantly increase postprandial, transient plasma Lp(a) concentrations over the course of 8 hours.[39] Investigators found that linoleic, oleic, palmitic, and stearic acid all resulted in significant transient increases in Lp(a) concentrations which closely tied to a proportional increase in triacylglycerol concentrations. While saturated fats, stearic acid and palmitic acid, appeared to have the greatest increase in serum Lp(a) compared with oleic acid and linoleic acid, this differing response did not reach statistical significance.

4.3 | Mechanisms contributing to reduced plasma Lp(a)

The observed reduction in Lp(a) in the present study may be due to decreased hepatic synthesis of apolipoprotein(a) and Apo-B. This may be in part due to decreased expression of the LPA gene. Since the LPA gene is almost exclusively expressed in the liver,[40] hepatic influences, including the production of *hs*-CRP and inflammatory cytokines, such as IL-6, may upregulate LPA gene expression.[41] Indeed, those with inflammatory conditions may have increased Lp(a) concentrations compared with healthy controls.[42]

Current data in our plant-based study supports this hypothesis, as reduced *hs*-CRP and IL-6 was observed. In contrast, previous studies utilizing plant-centered diets to reduce Lp(a) were unsuccessful, as animal products were still substantially consumed.[35,36] Animal-based foods, including lean meat, can induce a postprandial inflammatory response, including increased *hs*-CRP and IL-6.[43] Pooled data of those consuming non-vegan, plant-based diets have shown reduced *hs*-CRP and IL-6,[44] although to a lesser extent compared with the present study (*hs*-CRP; −0.55 mg/dL vs −2.42 mg/dL, IL-6; −0.25 pg/mL vs −0.64 pg/mL). The elimination of animal products and processed foods completely on a defined, plant-based diet may be a more prudent dietary strategy to avoid potential fluctuations in inflammation. Thus, the fact that there were only minimally processed plant foods consumed during this dietary intervention may account for the observed reduction in serum Lp(a) concentrations that may be associated with reduced LPA gene expression. Further mechanistic research is needed to confirm this hypothesis.

4.4 | Strengths and limitations

The high dietary adherence and provision of all food to subjects supports the conclusion that the intervention likely fully accounted for the observed biochemical changes among the subjects. Furthermore, the study took place in an outpatient clinical setting with established patients providing a real-world example of a standard clinical practice. This study provides a model for the implementation of this intervention across other medical practices. In contrast, a limitation in the design of this study was the lack of a control group and the small sample size. A larger sample size and a control group would be needed to strengthen a causal relationship.

5 | CONCLUSION

A defined, plant-based diet has a favorable impact on Lp(a) and other atherogenic lipoproteins and particles. Lp(a) concentration was previously thought to be only minimally altered by lifestyle interventions. In this study, however, a defined plant-based diet resulted in a substantial reduction in Lp(a) in only 4 weeks. Further investigations are warranted to elucidate the specific mechanisms that contribute to reduced Lp(a) concentrations, which may include alterations in LPA gene expression mediated via hepatic inflammation.

ACKNOWLEDGMENTS

We would like to thank The Garden Kitchen (Houston, Texas) for providing the food to the subjects. This study was funded by the Johnsie and Aubary Montgomery Institute of Medical Education and Research.

Conflict of interest

The authors declare no potential conflicts of interest.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

How to cite this article: Najjar RS, Moore CE, Montgomery BD. Consumption of a defined, plant-based diet reduces lipoprotein(a), inflammation, and other atherogenic lipoproteins and particles within 4 weeks. *Clin Cardiol*. 2018;1–7. https://doi.org/10.1002/clc.23027

AFFIDAVIT OF HENRY EALY, ND,

STATE OF ARIZONA)
) ss.
COUNTY OF MARICOPA)

DR. HERY L. EALY, III, NMD, declares under penalty of perjury that the foregoing is true and correct:

1. I am above the age of 18 and am competent to make this affidavit.
2. I am a licensed Doctor of Naturopathic Medicine from the Southwest College of Naturopathic Medicine and Health Sciences and Board-Certified Holistic Nutritionist with a Mechanical Engineering Degree from the University of California, Los Angles.
3. I serve as the lead investigative researcher and author for the Covid Research Team, with over 10 years of expcrience in database development and data analysis having served on the International Space Station Project.
4. I have over 150 evidence-based published works on natural medicine and the anatomical, physiologic and biochemical sciences of the human body.
5. As the lead investigative researcher and author of the Covid Research Team, my team has invested more than 25,000 hours of volunteer time, which has resulted in the peer-reviewed publications of Covid-19 Data Collection, Comorbidity & Federal Law: A Historical Retrospective, (See Exhibit A, IPAK, Oct. 2020) and Covid-19: Restoring Public Trust During a Global Health Crisis (Exhibit B – GMI, March 2021)
6. I have been retained by the Women of Color for Equal Justice Attorney Jo Saint-George to provide data analysis for certain Class Action lawsuits involving New York City Workers and certain healthcare workers subject to the New York City and/or State Health Department vaccine requirements.

7. In preparation for providing my expert opinions herein, I have reviewed vaccine breakthrough data to establish vaccine failure rates for all persons deemed 'fully vaccinated' according to CDC guidelines from all states publishing data, including New York. Vaccine breakthrough occurs when a 'fully vaccinated' person is confirmed to be infected by the SARS- CoV-2 virus using PCR molecular testing and the cycle threshold value is lower than or equal to 28. 'Fully vaccinated' is defined as a person who has received all inoculations in a series (Pfizer 2 inoculations, Moderna 2 inoculations, Johnson & Johnson 1 inoculation) and it has been at least 14 days since the final inoculation in the series.

8. I have been asked to review New York State vaccine breakthrough data for COIVD inoculations to provide support for Dr. Baxter Montgomery's professional and informed opinion that the COVID-19 inoculations do not effectively prevent the spread of the SARS-CoV-2 virus.

9. In New York, between the dates of November 2021 and February 2022, I am able to confirm the following data for breakthrough infections among the 'fully vaccinated'. By November 2021, there were 137,380 total confirmed COVID breakthrough cases among the 'fully vaccinated'. By February 2022, that number had risen exponentially to 1,167,630 confirmed COVID breakthrough cases among the 'fully vaccinated'. This resulted in an increase of 1,030,250 new confirmed cases where the experimental COVID inoculations failed to prevent infection over a 3-month range of data collection amounting to a 749.9% increase in vaccine failure to prevent infection in only 3 months. Similarly, in November 2021, there were 9,044 confirmed COVID breakthrough hospitalizations among the 'fully vaccinated'. By February 2022, that number had risen exponentially to 39,593 confirmed COVID breakthrough hospitalizations among the 'fully vaccinated'. This resulted in an increase of 30,549 new confirmed hospitalizations where the experimental COVID inoculations failed

to prevent hospitalization over a 3-month range of data collection amounting to a 337.8% increase in vaccine failure to prevent hospitalization in only 3 months. With over 1 million confirmed vaccine breakthroughs and over 30,000 confirmed vaccine breakthrough hospitalizations over a 3-month range of data collection, it is impossible to objectively conclude that the experimental COVID inoculations are effective at preventing infection or hospitalization. The New York State Department of Health does not publish data regarding vaccine breakthrough death for analysis.

10. The statements and opinions made in this Affidavit are preliminary and I reserve the right to add to, amend or modify my opinions as more facts are provided during the course of any litigation of the claims by the Classes of Plaintiffs for which this affidavit is provided.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated this 19 day of April, 2022.

DR. HENRY EALY

A NOTARY PUBLIC OR OTHER OFFICER COMPLETING THIS CERTIFICATE VERIFIES ONLY THE IDENTITY OF THE INDIVIDUAL WHO SIGNED THE DOCUMENT TO WHICH THIS CERTIFICATE IS ATTACHED, AND NOT THE TRUTHFULNESS, ACCURACY, OR VALIDITY OF THAT DOCUMENT.

Subscribed and sworn to (or affirmed) before me on this 19 day of April, 2022, by Dr. Henry Ealy, proved to me on the basis of satisfactory evidence to be the person(s) who appeared before me.

Witness my hand and official seal.

Debra Lou Coghlan
Signature of Notary Public

[Affix Notary Seal]

OFFICIAL STAMP
DEBRA LOU COGHLAN
NOTARY PUBLIC-OREGON
COMMISSION NO.1005695
MY COMMISSION EXPIRES OCTOBER 28, 2024