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SUPERIOR COURT OF THE STATE OF CALIFORNIA

COUNTY OF SAN DIEGO, NORTH COUNTY DIVISION

LET THEM BREATHE, *et al.*,

Plaintiffs,

v.

GAVIN NEWSOM, in his official capacity as Governor of the State of California, *et al.*,

Defendants.

Case No. 37-2021-00031385-CU-WM-NC

MOTION FOR LEAVE OF CALIFORNIA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS AND AMERICAN ACADEMY OF PEDIATRICS TO FILE AN *AMICUS CURIAE* BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

Department: N-27
Judge: Hon. Cynthia A. Freeland
Date: November 8, 2021
Time: 1:30 p.m.

The American Academy of Pediatrics ("AAP") and the California Chapter of the American Academy of Pediatrics ("CA AAP"; collectively, "Proposed *Amici*") hereby apply for permission to file an *amicus* brief in opposition to Plaintiffs' motion for a preliminary injunction. The proposed brief is attached as Exhibit A.

Proposed *Amici* are the leading professional organization of American pediatricians, pediatric medical subspecialists, and pediatric surgical specialists, both nationally and in California. Collectively, they represent more than 67,000 pediatricians and pediatric practitioners, more than 3,000 of whom practice in California. Proposed *Amici* seek to file this brief to provide information regarding the importance and efficacy of maintaining universal mask policies in schools.

Superior courts possess "traditional broad discretion over the conduct of pending litigation," which includes "the authority to determine the manner and extent of . . . participation as amici curiae." *In re Marriage Cases* (2008) 43 Cal. 4th 757, 791 n.10. Although the California Rules of Court do not contain specific rules for applications for leave to file as *amici curiae* in superior court, they are typically held to the standards applicable in the courts of appeals, including a statement of "the applicant's interest" and an explanation of "how the proposed amicus curiae brief will assist the court in deciding the matter." Cal. R. Ct. 8.200(c)(2).

As the leading membership organization of American pediatricians both nationally and in California, proposed *amici* have a strong interest in protecting the health of their patients and reducing community spread of COVID-19, which has strained medical resources in the State and around the country. As explained in the brief, the AAP has reviewed hundreds of articles related to the efficacy and safety of masks, as well as their effects (or lack thereof) on the cognitive, social, and psychological development of children. The attached brief reflects AAP's constant work over the past 18 months to understand how to treat and reduce the spread of COVID-19, as well as how to provide safe education that fosters children's development despite the pandemic. It provides the findings of AAP's comprehensive review of the medical literature, along with the collective experiences of the vast majority of practicing pediatricians in the United States. This may assist

the Court in evaluating the parties' arguments regarding the putative legal flaws of the challenged policy, the purported harm to Plaintiffs, and the impact of their requested injunction on the public interest.

For these reasons, both state and federal courts hearing similar matters have granted motions of the AAP and its state chapters for leave to file as *amici curiae* to provide the courts with information on the AAP's recommendations and the importance and efficacy of maintaining universal mask policies in schools. *See, e.g.*, *Disability Rights S.C. v. McMaster*, No. 21-02728 (4th Cir. Oct. 4, 2021), ECF No. 28; *E.T. v. Abbott*, No. 21-cv-00717 (W.D. Tex. Sept. 30, 2021), ECF No. 59; *Arc of Iowa v. Reynolds*, No. 21-cv-00264 (S.D. Iowa, Sept. 29, 2021), ECF No. 58; *G.S. v. Lee*, No. 21-cv-02552 (W.D. Tenn., Sept. 8, 2021), ECF No. 46; *Verrier v. Gwinnett County Sch. Dist.*, No. 21-A-06818-3 (Ga. Sup. Ct., Gwinnett Cnty. Oct. 6, 2021). And several courts have found the information in AAP's briefs helpful in resolving motions for preliminary relief in such cases. *See R.K. v. Lee*, No. 21-cv-725, 2021 WL 4942871, at *4, 6 (M.D. Tenn. Sept. 24, 2021); *Arc of Iowa v. Reynolds*, No. 21-cv-264, 2021 WL 4737902, at *2-3 (S.D. Iowa Sept. 13, 2021); *G.S. v. Lee*, No. 21-cv-02552, 2012 WL 4268285, at *7 (W.D. Tenn. Sept. 17, 2021).

Additionally, the proposed filing is timely and will not delay consideration of Plaintiffs' motion. Rule 8.200(c)(1) allows briefs to be filed "[w]ithin 14 days after the last appellant's reply brief is filed or could have been filed . . . whichever is earlier," or later if the court finds "good cause." Here, *amici* are filing well before the analogous deadlines. Indeed, *amici* are providing their brief on the same day as Defendants' opposition, providing Plaintiffs with ample time to address *amici*'s arguments in their reply.

No party or counsel for a party authored the proposed amicus brief in whole or in part, nor did any party, counsel for a party, or other person or entity make a monetary contribution intended to fund the preparation or submission of the brief, other than the *amici curiae*, their members, or their counsel. *See* Cal. R. Ct. 8.200(c)(3).

Counsel for *amici* contacted counsel for the parties to request their consent to this motion. Defendants consented, while Plaintiffs indicated that they "do not consent to the filing of an amicus brief on behalf of the defendants."

Accordingly, proposed *amici* respectfully request that the Court grant their application for permission to file the attached brief.

Respectfully submitted,

FAEGRE DRINKER BIDDLE & REATH LLP

Dated: October 26, 2021

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EXHIBIT A

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INTEREST OF *AMICI CURIAE*[1]

The California Chapter of the American Academy of Pediatrics ("CA AAP") is a non-profit educational organization and professional society comprising more than 3,000 members, including pediatricians, residents, and medical students from California. CA AAP works to support the optimal health of children by addressing their needs and the needs of their families, their communities, and their health care providers.

The American Academy of Pediatrics ("AAP") was founded in 1930 and is a national, not-for-profit professional organization dedicated to furthering the interests of child and adolescent health. The AAP's membership includes over 67,000 primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. Over the past year-and-a-half, the AAP has devoted substantial resources to researching the scientific literature regarding how to treat COVID-19 and reduce its spread so that the AAP can provide up-to-date, evidence-based guidance for pediatricians and public health officials. This includes, among other things, interim guidance on the use of face masks as an infection control measure and on operating safe schools during the COVID-19 pandemic.

INTRODUCTION

Over the past 18 months, *Amici* have worked ceaselessly to evaluate the dangers of and potential public health measures for reducing the deadly spread of COVID-19. The AAP has conducted a comprehensive review of the medical literature to determine what public health measures can effectively reduce the risk that COVID-19 poses to America's children. This comprehensive review and the experiences of the front-line pediatric practitioners who make up the CA AAP and AAP's membership prove three relevant facts beyond any doubt: COVID-19 poses grave risks to children, risks that have escalated significantly with the rise of the Delta variant; universal mask policies in schools significantly reduce the spread of COVID-19 and

[1] *Amici* certify that no party's counsel authored this brief in whole or in part, no party or party's counsel contributed money intended to fund this brief, and no person other than *Amici*, their members, and their counsel contributed money intended to fund this brief.

protect all children, particularly the medically vulnerable; and wearing masks is not harmful to children.

Recognizing these facts, the State of California issued a universal mask policy so that schools could safely conduct in-person classes despite the Delta variant of COVID-19. Plaintiffs' challenge to that policy is based on the misguided premises that COVID-19 is not a serious risk to children; that masks are ineffective against the risk of contracting COVID-19; and that masks cause psychological, developmental, and physiological harm. This brief provides an overview of the scientific literature rebutting those claims and explains why universal mask policies are so crucial in fighting COVID-19.

The public interest is a paramount consideration in adjudicating Plaintiffs' motion for a preliminary injunction. As the U.S. Supreme Court has explained, "courts of equity should pay particular regard for the public consequences in employing the extraordinary remedy of injunction." *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 24 (2008). Here, there is no question about where the public interest points: the balance of the equities and the public interest weigh against an injunction. Universal mask policies substantially reduce the risk of death and serious illness among California's school-age children and their families, without any meaningful harm to mask-wearers. Blocking California's policy would put parents—and especially parents of the most vulnerable children—to an untenable choice: either send children to schools where they have a high risk of contracting COVID-19, or keep them home from school with the attendant harm to their social, emotional, and educational development. The Court should not prevent California from protecting its students and community.

ARGUMENT

I. COVID-19 Is a Serious Childhood Illness

Plaintiffs downplay the seriousness of pediatric COVID-19. *See, e.g.*, Pls.' Mem. at 6 (Sept. 29, 2021), Doc. No. 25. Unfortunately, Plaintiffs' depiction is inaccurate: the risk to children who contract COVID-19 is serious, and the risk of contracting COVID-19 has increased with the rise of the Delta variant.

The AAP and the Children's Hospital Association have collaborated throughout the pandemic to collect and share all publicly-available data from states on COVID-19 cases among children.[2] As of October 21, 2021, 6,295,648 total child COVID-19 cases have been reported in the United States, representing 16.5% of the total U.S. cases.[3] The prevalence of pediatric COVID-19 has skyrocketed since the school year began, with 29.9% of all child cases since the beginning of the pandemic diagnosed in the two months between August 13 and October 21, 2021.[4] This surge appears to be due to two principal factors: the resumption of in-person schooling (and particularly schooling in places without masks), and the emergence of the Delta variant, which is more than twice as contagious as previous variants and far more contagious than even pandemic-level influenza.[5] And while Plaintiffs are correct that cases, hospitalizations, and deaths have declined from their recent peak, *see* Pls.' Mem. at 10 n.2, this omits crucial context: the surge that California and the nation just experienced was the worst at any time during the pandemic except for the holiday-season crisis in 2020, *see* Andelin Decl. ¶ 6 (Sept. 29, 2021), Doc. No. 40—and we are about to enter the holiday season.

As the rate of COVID-19 has soared, so has the number of serious cases: just among the 24 states and 1 city that report child hospitalizations, more than 6,200 children were hospitalized due to COVID-19 between August 13 and October 21 of this year, over a quarter of the total child

[2] *See Children and COVID-19: State-Level Data Report*, AAP, https://bit.ly/3DZIRhq (data available as of Oct. 21, 2021). Counsel for *amici* have preserved all Internet sources cited in this brief in PDF form, and would be happy to provide any or all of them if it would aid the Court's consideration.

[3] *Id.*

[4] *Children and COVID-19: State Data Report* at Appx. Tab. 2A, Children's Hosp. Ass'n & Am. Acad. of Pediatrics (Oct. 21, 2021), https://bit.ly/3pz3vB1.

[5] *See Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), https://bit.ly/3plAmcy; Ying Liu & Joacim Rocklöv, *The Reproductive Number of the Delta Variant of SARS-CoV-2 Is Far Higher Compared to the Ancestral SARS-CoV-2 Virus*, J. Travel Med. (Aug. 9, 2021), https://bit.ly/2XxuXDs; Matthew Biggerstaff, et al., *Estimates of the Reproduction Number for Seasonal, Pandemic, and Zoonotic Influenza: A Systematic Review of the Literature*, 14 BMC Infectious Diseases 480 (2014), https://bit.ly/3C3W7B6.

hospitalizations to date.[6] Since the beginning of August, more children have died each week than in all but one previous week of the pandemic.[7] California has reported at least 680,267 COVID-19 cases among children, the most in the nation, and at least 37 children have died from COVID-19 in the state.[8]

As the hospitalization rate reflects, COVID-19 can cause severe symptoms and potentially fatal outcomes even in children. Among other things, COVID-19 infections can produce multisystem inflammatory syndrome in children (MIS-C).[9] MIS-C involves clinically severe levels of fever, inflammation, and dysfunction or shock in multiple organ systems (including cardiac, renal, respiratory, hematologic, gastrointestinal, dermatologic, and/or neurological).[10] Among other severe symptoms, it can cause coronary artery enlargement; aneurysm; meningitis; colitis; hepatitis; symptoms akin to toxic shock syndrome; thrombosis; acute kidney injury; stroke; encephalitis; congestive heart failure; and pulmonary embolism.[11]

COVID-19 infection can also lead to many secondary conditions, ranging from subacute to mild to severe. Several studies have shown that long-term symptoms can occur in children and adolescents, even in cases with mild initial symptomatology.[12] These include persistent respiratory

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[6] *See Children and COVID-19: State Data Report*, *supra* n. 4, at Appx. Tab. 2B.

[7] *Id.* at Appx. Tab. 2C. The week ending December 3, 2020 is the only previous week in which as many child deaths were reported as even the *lowest* week since the beginning of August. *Id.* Notably, this was the week after Thanksgiving. This drives home the importance of maintaining California's policy, to reduce the rate of COVID-19 in advance of the surge that will likely accompany the upcoming holidays.

[8] *Id.* at Appx. Tabs. 3A, 6A.

[9] *See Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 19 (COVID-19)*, CDC (May 14, 2020), https://bit.ly/3vylqsn; *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, AAP (last updated Feb. 20, 2021), https://bit.ly/3lVJUZA.

[10] *Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 19*, *supra* n.9.

[11] *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, *supra* n. 9.

[12] *See, e.g.*, Danilo Buonsenso, et al., *Preliminary evidence on long COVID in children*, Acta Paediatrica (2021), https://bit.ly/3jgz5PN (studying 129 children in Italy and reporting that 42.6% experienced at least one symptom more than 60 days after infection); Helen Thomson, *Children with long covid*, 249 New Scientist 10 (2021), https://bit.ly/3G3oBxc (U.K. Office of National

symptoms ranging from chest pain, cough, and exercise-induced dyspnea to pulmonary emboli; myocarditis (i.e., inflammation of the heart muscle), shortness of breath, arrhythmia, and/or fatigue, and potentially leading to heart failure, myocardial infarction, stroke, or sudden cardiac arrest; persistent loss of the sense of smell (anosmia) or taste (ageusia), which can affect the nutritional status and quality of life of children and adolescents and be particularly disruptive to the feeding behavior of very young children; neurodevelopmental sequelae, both including the consequences of significant acute injuries such as stroke or encephalitis and subtle but persistent sequelae in cognitive, language, academic, motor, mood, and behavioral domains; cognitive fogginess or fatigue; physical fatigue; and mental or behavioral health impacts such as stress and adjustment disorders.[13]

Moreover, the uncontrolled spread of COVID-19 poses a massive risk to children and adults who have other medical needs. During the current surge, hospital ICU capacity has been strained beyond capacity in much of the country, as it was earlier in the pandemic. Even as the current surge has declined, several counties in California remain near or above 90% ICU capacity.[14] The strain on medical resources will result in excess morbidity and mortality even for children and adults who do not contract COVID-19, because "[p]andemic COVID-19 surges [a]re associated with higher rates of in-hospital mortality among patients without COVID-19, suggesting disruptions in care patterns for patients with many common acute and chronic illnesses."[15] In layperson's terms, more children and adults will become sick and possibly die, both due to COVID-19 and due to the delay of treatment for other urgent conditions.

Statistics estimates that 12.9% of children 2-11 years of age and 14.5% of children 12-16 years of age experienced symptoms 5 weeks after infection).

[13] *See, e.g.*, Trisha Korioth, *AAP Urges Post-COVID-19 Follow-Up to Monitor for Residual Symptoms*, AAP News (Aug. 2, 2021), https://bit.ly/3BbvNU7.

[14] *See California COVID-19 Hospital Capacity*, The Californian (last visited Oct. 21, 2021) https://bit.ly/3puBAC7.

[15] *See, e.g.*, Amber K. Sabbatini, et al., *Excess Mortality Among Patients Hospitalized During the COVID-19 Pandemic*, J. Hosp. Med. (2021), https://bit.ly/2Z7Vibz.

Thus, in asserting that "[t]he risk to children from COVID-19 is remarkably low," Pls.' Mem. at 6, Plaintiffs incorrectly discount the potential for severe harm even in non-fatal pediatric cases of COVID-19, as well as the potentially catastrophic consequences to community health caused by the uncontrolled spread of COVID-19. It is also important to note that many children with preexisting health conditions are particularly at risk of severe illness if they contract COVID-19, including children with genetic, neurologic, or metabolic conditions; congenital heart disease; diabetes, asthma, or chronic lung disease; obesity; sickle cell disease; or immunosuppression.[16] Because these children are entitled to a safe, in-person education that minimizes the risk of contracting potentially fatal illnesses, it is all the more important to employ measures such as universal masking that, as discussed below, decrease exposure without significant negative consequences.

II. Universal Mask Policies in Schools Protect Against the Spread of COVID-19 and Are Necessary to Allow Vulnerable Children to Safely Attend School In-Person

One of the AAP's chief functions is to provide evidence-based guidance to America's pediatric professionals and public health officials. To do so, the AAP issues Policy Statements that report the most up-to-date, evidence-based expert consensus on key issues of pediatric practice and public health. These Policy Statements are written by recognized pediatrician experts who undertake a comprehensive review of the medical literature and available data on the topic at hand. They are then peer-reviewed by additional experts across the AAP and approved by the AAP's executive staff and board of directors.

Since the spring of 2020, the AAP's top focus has been supporting practicing pediatricians and public health policymakers in treating COVID-19 and reducing its spread, particularly among children. The AAP has issued Interim Guidance Statements on several topics related to COVID-19, including guidance on when and how pediatricians should test patients for COVID-19;[17] on

[16] *People with Certain Medical Conditions*, CDC, (last updated Aug. 20, 2021), https://bit.ly/3E41b97.

[17] *COVID-19 Testing Guidance*, AAP (last updated July 8, 2021), https://bit.ly/2Z6tKmY.

providing clinical care to patients with COVID-19;[18] on treating post-COVID conditions;[19] on how to safely provide routine medical care such as check-ups, screenings, laboratory exams, treatment, and immunizations during the COVID-19 pandemic;[20] on caring for youth with special health needs during the COVID-19 pandemic;[21] on supporting the emotional and behavioral health needs of children, adolescents, and families during the COVID-19 pandemic;[22] and—most relevant to this case—on the use of face masks as an infection control measure[23] and on operating safe schools during the COVID-19 pandemic that foster the overall health of children, adolescents, educators, staff, and communities.[24] These Interim Guidances were drafted and reviewed by a number of pediatricians with expertise in a wide variety of disciplines, and have been continually reviewed and updated since spring of 2020. By this point, the AAP's experts have reviewed hundreds of articles related to the efficacy and safety of masks, as well as their effects (or lack thereof) on the cognitive, social, and psychological development of children.

As pediatrician organizations, the AAP and CA AAP recognize that not being able to attend school in person can negatively affect children's cognitive, educational, and social development, as well as children's short- and long-term mood, behavior, and mental health. Based on the AAP's expert review of the scientific literature and the guidance outlined by the World Health Organization, United Nations Children's Fund, and Centers for Disease Control and Prevention ("CDC"), along with AAP's members' collective expertise as pediatricians and

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[18] *COVID-19 Interim Guidance*, AAP (last updated Aug. 2, 2021), https://bit.ly/3vvS3qw.

[19] *Post-COVID-19 Conditions in Children and Adolescents*, AAP (last updated July 28, 2021), https://bit.ly/3G4rKgd.

[20] *Guidance on Providing Pediatric Well-Care During COVID-19*, AAP (last updated Aug. 30, 2021), https://bit.ly/3G7FIha.

[21] *Caring for Children and Youth with Special Health Needs During the COVID-19 Pandemic*, AAP (last updated June 28, 2021), https://bit.ly/3C44iNF.

[22] *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic*, AAP (last updated July 28, 2021), https://bit.ly/3aW5c2M.

[23] *Face Masks*, AAP (last updated Aug. 8, 2021), https://bit.ly/2ZbpCm0.

[24] *COVID-19 Guidance for Safe Schools*, AAP (last updated July 18, 2021), https://bit.ly/3aXbNdw.

researchers, the AAP concluded that "[e]verything possible must be done to keep students in schools in-person."[25] As this Court has previously observed, prolonged loss of access to in-person education can harm academic success and contribute to "alarming rates of depression, suicidal ideation, anxiety, and substance abuse among children." Minute Order, *A.A. v. Newsom*, No. 37-2021-00007536-CU-WM-NC (Mar. 15, 2021). "[A]t this point in the pandemic, given what we know now about low rates of in-school transmission *when proper prevention measures are used*, together with the availability of effective vaccines for those age 12 years and up, that the benefits of in-person school outweigh the risks in almost all circumstances."[26] Among the recommended prevention measures (which also include immunization of all eligible individuals and adequate and timely COVID-19 testing), one of the most important is that "**[a]ll students older than 2 years and all school staff should wear face masks at school (unless medical or developmental conditions prohibit use)**."[27]

This conclusion has been consistently reinforced by all relevant data and credible research, leading the AAP to reaffirm its recommendation of universal masking in school settings on July 19, 2021 and the CDC to recommend "universal indoor masking for all teachers, staff, students, and visitors to schools, regardless of vaccination status" on July 27, 2021.[28]

While there are several reasons for the AAP's (and the CDC's) recommendation of universal masking in schools,[29] the most important is that the research literature has confirmed that masks are both effective and safe. Masks "reduce the emission of virus-laden droplets . . . , which is especially relevant for asymptomatic or presymptomatic infected wearers who feel well and may be unaware of their infectiousness to others, and who are estimated to account for more than

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[25] *Id.*

[26] *Id.*

[27] *Id.* (emphasis in original).

[28] *Interim Public Health Recommendations for Fully Vaccinated People—Summary of Recent Changes*, CDC (July 28, 2021), https://bit.ly/3mmCmy6.

[29] *See COVID-19 Guidance for Safe Schools*, *supra* n. 24.

50% of transmissions."[30] Cloth masks "block most large droplets (i.e., 20-30 microns and larger)" and "also block the exhalation of fine droplets (also often referred to as aerosols)."[31] "Multi-layer cloth masks can both block up to 50-70% of these fine droplets and particles," with "[u]pwards of 80% blockage" recorded in some studies.[32] To a slightly lesser extent, masks also "help reduce inhalation of these droplets by the wearer"; multi-layer cloth masks can filter out "nearly 50% of fine particles less than 1 micron."[33]

Despite these well-established scientific facts, Plaintiffs claim that masks "are not capable of blocking aerosols." Pls.' Mem. at 12. This misunderstanding comes from looking at only one side of the equation: the ability of a mask to *protect* an *uninfected* wearer from viral particles, rather than the ability of a mask to inhibit the spread of viral particles *by* an *infected* wearer. The latter, known as "source control," is where masks' primary benefit in limiting the spread of airborne infectious diseases such as COVID-19 is found. As the CDC has explained, "masks are not designed to reduce the particles that the wearer will inhale . . . . The purpose of wearing a mask is to help reduce the spread of COVID-19 by reducing the spread of the virus through respiratory droplets from asymptomatic individuals."[34] Plaintiffs and their expert witness on industrial hygiene discuss only masks' ability to protect the wearer. *See* Petty Decl. ¶¶ 24-31 (discussing the ability of masks to "protect individuals *from exposure to* very small airborne aerosols" (emphasis added)). Plaintiffs are correct, to an extent: wearing a mask can provide only limited protection against contracting COVID-19 if the wearer is in the proximity of one or more unmasked carriers. This is why *universal* masking policies, like California's, are so important: they act as source control for COVID-19 carriers (who may be asymptomatic and not know they

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[30] *Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2*, CDC (May 7, 2021), https://bit.ly/3utvxOA (citations omitted).

[31] *Id.*

[32] *Id.*

[33] *Id.*

[34] *Respiratory Protection vs. Source Control—What's the Difference?*, CDC (Sept. 8, 2020), https://bit.ly/3pn0y6s.

are shedding viral particles), thereby protecting vulnerable individuals. And this, in turn, protects children who otherwise would be incapable of attending school in-person—because it poses a substantial medical risk, not because they prefer not to comply with COVID-19 prevention measures—from the inferiority of remote learning.

Numerous studies have shown that increasing the rate of mask-wearing, including through universal mask policies in particular, significantly reduces the spread of COVID-19.[35] In particular, studies have shown that masking and similar mitigation measures can limit transmission in schools.[36] Most recently, the CDC released three studies conducted during this

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[35] *See, e.g.*, Jeremy Howard, et al., *An Evidence Review of Face Masks Against COVID-19*, 118 Proc. of the Nat'l Acad. of Servs. e2014564118 (2021), https://bit.ly/3E1VjwT; John T. Brooks & Jay C. Butler, *Effectiveness of Mask Wearing to Control Community Spread of SARS-CoV-2*, 325 J. of Am. Med. Ass'n 998 (2021), https://bit.ly/3piiOh9; Jason Abaluck, et al., *The Impact of Community Masking on COVID-19: A Cluster-Randomized Trial in Bangladesh* (Aug. 23, 2021) (preprint), https://bit.ly/3jsUOnL; Heesoo Joo, et al., *Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates—10 States, March–October 2020*. 70 Morbidity & Mortality Weekly Rep. 212 (2021), https://bit.ly/3aUVr4V; Derek K. Chu, et al., *Physical Distancing, Face Masks, and Eye Protection to Prevent Person-to-Person Transmission of SARS-CoV-2 and COVID-19: A Systematic Review and Meta-Analysis*, 395 Lancet 1973 (2020), https://bit.ly/3G7MzqX; Christopher T. Leffler, et al., *Association of Country-wide Coronavirus Mortality with Demographics, Testing, Lockdowns, and Public Wearing of Masks*, 103 Am. J. Tropical Med. Hygiene 2400 (2020), https://bit.ly/3vwGzDb; Miriam E. Van Dyke, et al., *Trends in County-Level COVID-19 Incidence in Counties With and Without a Mask Mandate—Kansas, June 1-August 23, 2020*. 69 Morbidity & Mortality Weekly Rep. 1777 (2020), https://bit.ly/3FYJaLf; Wei Lyu & George L. Wehby, *Community Use of Face Masks and COVID-19: Evidence from a Natural Experiment of State Mandates in the US*, 39 Health Aff. 1419 (2020), https://bit.ly/3pl4DrN.

[36] *See, e.g.*, Patrick Dawson, et al., *Pilot Investigation of SARS-CoV-2 Secondary Transmission in Kindergarten Through Grade 12 Schools Implementing Mitigation Strategies—St. Louis County and City of Springield, Missouri, December 2020*, 70 Morbidity & Mortality Weekly Rep. 449 (2021), https://bit.ly/3psSzoe; Darria L. Gillespie, et al., *The Experience of 2 Independent Schools With In-Person Learning During the COVID-19 Pandemic*, 91 J. Sch. Health 347 (2021), https://bit.ly/3C2StqZ; Rebecca B. Hershow, et al., *Low SARS-CoV-2 Transmission in Elementary Schools - Salt Lake County, Utah, December 3, 2020-January 31, 2021*, 70 Morbidity & Mortality Weekly Rep. 442 (2021), https://bit.ly/3vw91oX; Amy Falk, et al., *COVID-19 Cases and Transmission in 17 K-12 Schools - Wood County, Wisconsin, August 31-November 29, 2020*, 70 Morbidity & Mortality Weekly Rep. 136 (2021), https://bit.ly/3G7Iy5O; Fiona Russell et al., *COVID-19 in Victorian Schools: An Analysis of Child-Care and School Outbreak Data and Evidence-Based Recommendations for Opening Schools and Keeping Them Open*, Murdoch Children's Rsch. Inst. & The Univ. of Melb. (Nov. 9, 2020), *available at* https://bit.ly/3lWEmhb; *see generally Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and*

school year, all of which found that "schools without a universal masking policy in place were more likely to have COVID-19 outbreaks."[37] The CDC found that pediatric COVID-19 cases increase nearly twice as quickly in schools lacking universal mask policies.[38] For example, one study that compared schools in two Arizona counties that required masks with counties that did not found that of the 191 COVID-19 school-associated outbreaks, schools without universal mask policies experienced 3.5 times as many outbreaks as schools that have such policies.[39] As the ABC Science Collaborative, a 13-state initiative coordinated by the Duke Clinical Research Institute at the Duke University School of Medicine, summed it up, "[p]roper masking is the most effective mitigation strategy to prevent COVID-19 transmission in schools when vaccination is unavailable or there are insufficient levels of vaccination among students and staff."[40]

Plaintiffs are thus wrong to claim that "[s]tudies of the effectiveness of different interventions have found no causal connection between mask requirements and reduced virus transmission in schools." Pls.' Mem. at 6. Even the lone study that they cite in their brief, *see id.*, found a "21% lower incidence in schools that require mask use among students,"[41] in line with the findings cited above. While this finding did not rise to the level of statistical significance (possibly

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Education Programs—Updated, CDC (July 9, 2021), https://bit.ly/3vsdF7e.

[37] Press Release, *Studies Show More COVID-19 Cases in Areas Without School Masking Policies*, CDC (Sept. 24, 2021), https://bit.ly/3kYtuyU; *see* Megan Jehn, et al., *Association Between K–12 School Mask Policies and School-Associated COVID-19 Outbreaks—Maricopa and Pima Counties, Arizona, July–August 2021*, 70 Morbidity & Mortality Weekly Rep. (2021), https://bit.ly/3uwVdKh; Samantha E. Budzyn, et al., *Pediatric COVID-19 Cases in Counties With and Without School Mask Requirements—United States, July 1–September 4, 2021*, 70 Morbidity & Mortality Weekly Rep. (2021), https://bit.ly/3uIQ8il; Sharyn E. Parks, et al., *COVID-19–Related School Closures and Learning Modality Changes—United States, August 1–September 17, 2021*, 70 Morbidity & Mortality Weekly Rep. (2021), https://bit.ly/3ipDVtD.

[38] *Studies Show More COVID-19 Cases*, *supra* n. 37.

[39] Jehn, *supra* n. 37.

[40] ABC Science Collaborative, *The ABCs of North Carolina's Plan*, https://bit.ly/3jk6NnK (last visited Oct. 20, 2021); *see also* ABC Science Collaborative, *Final Report for NC School Districts and Charters in Plan A*, at 3 (June 30, 2021), https://bit.ly/3DVmfyz.

[41] Jenna Gettings, et al., *Mask Use and Ventilation Improvements to Reduce COVID-19 Incidence in Elementary Schools—Georgia, November 16–December 11, 2020*, 70 Morbidity & Mortality Weekly Rep. 779, https://bit.ly/3C6duBg.

due to "differences in mask-wearing behavior among students in schools with optional requirements"), it presents no reason to doubt the consistent findings of similar studies. Indeed, even Plaintiffs' own expert published a study concluding that "*[w]ith masking requirements* and student cohorting, transmission risk within schools appeared low."[42]

Plaintiffs also claim that "[t]he risk of asymptomatic transmission by children is extremely low." Pls.' Mem. at 11. Unfortunately, this too is incorrect. While children are less likely to transmit the virus than adults, "[c]hildren and adolescents . . . can spread the virus to others."[43] One of Plaintiffs' experts claims that "[a]ccording to the American Academy of Pediatrics and the CDC, the rate of transmission in schools from someone who is positive is estimated to be approximately 0.5% - 0.7%." Høeg Decl. (Sept. 29, 2021) ¶ 28, Doc. No. 53. The source for this supposed estimate is unclear, but the latter number appears to be a reference to a study finding a secondary attack rate of 0.7% "*when critical prevention strategies including mask use are implemented*," not when such strategies are abandoned.[44] Another of Plaintiff's experts asserts the same 0.7% figure transmission rate, *see* Noble Decl. (Sept. 29, 2021), ¶ 11, Doc. No. 36, but the study this expert cites makes no such estimate and says nothing about indoor transmission or mask use.[45] Moreover, children's ability to transmit COVID-19 has likely increased due to the

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[42] Falk, supra n. 36 (emphasis added).

[43] *Science Brief: Transmission of SARS-CoV-2 in K-12 Schools, supra* n. 36; *see also, e.g.*, Young Joon Park, et al., *Contact Tracing During Coronavirus Disease Outbreak, South Korea, 2020*, 26 Emerging Infectious Diseases 2465 (2020), https://bit.ly/3vA0tNQ ("Children who attend day care or school also are at high risk for transmitting respiratory viruses to household members."); Victoria T. Chu, et al., *Household Transmission of SARS-CoV-2 from Children and Adolescents*, 385 New Eng. J. Med. 954 (2021), https://bit.ly/3B6V8Pb (finding "efficient transmission of SARS-CoV-2 from school-age children and adolescents to household members"); Yanshan Zhu, et al., *A Meta-analysis on the Role of Children in Severe Acute Respiratory Syndrome Coronavirus 2 in Household Transmission Clusters*, 72 Clinical Infectious Diseases e1146 (2021), https://bit.ly/30FSLWY (finding pediatric index cases in 3.8% of household transmission clusters).

[44] Hershow, et al., *supra* n.36 (emphasis added).

[45] Andrew M. Watson, et al., *COVID-19 in US Youth Soccer Athletes During Summer 2020*, 56 J. Athletic Training 542 (2021), https://bit.ly/3m4Q2i6.

significantly higher viral load associated with the Delta variant.[46] And asymptomatic transmission is at least as common as symptomatic transmission, if not more common.[47]

III. Masks Do Not Harm Children

Finally, Plaintiffs assert that masks "caus[e] a variety of harms." Pls.' Mem. at 7. They primarily focus on possible psychological and developmental harms, such as causing anxiety or impeding language acquisition, as well as supposed physiological harms and even lowered immunity to other viruses. *Id*. at 7-8. These fears are understandable, but there is no evidence that masks actually cause any such harms. There is thus no substantial harm to outweigh the clear public interest in requiring masks as an effective layered strategy of COVID-19 prevention.

Psychological Harm: First, based on the AAP's comprehensive review of the medical research, there is no evidence that masking is particularly linked to emotional or psychological harm. While children can develop secondary anxieties about wearing a mask, this is no different from the possibility of developing secondary anxieties about eating, attending school, or any other activity. The risk of developing secondary anxiety or disordered behavior related to masking may be especially high when parents or community members drill into their children a fear of masks or a belief that masks are harmful. But without that negative reinforcement, there is nothing intrinsic about mask-wearing that makes it particularly harmful, whether physically, socially, or emotionally. To the contrary, when caregivers promote positive associations around mask-wearing, masking can give children a sense of empowerment and control over their own health in a time when stresses and fears about their health are abnormally high.[48]

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[46] *See* Chun Huai Luo, et al., *Infection with the SARS-CoV-2 Delta Variant Is Associated with Higher Infectious Virus Loads Compared to the Alpha Variant in Both Unvaccinated and Vaccinated Individuals*, MedRxiv (Aug. 20, 201) (preprint), https://bit.ly/3Gb6x43.

[47] Michael A. Johansson, et al., *SARS-CoV-2 Transmission from People Without COVID-19 Symptoms*, 4 J. Am. Med. Ass'n e2035057 (2021), https://bit.ly/3C62L9O ("[A]t least 50% of new SARS-CoV-2 infections was estimated to have originated from exposure to individuals with infection but without symptoms.")

[48] *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic,* supra n. 22; *Face Masks*, *supra* n. 23 (providing recommendations for "help[ing] my child get used to wearing a mask"); *Supporting your child's mental health during COVID-19 school returns*, UNICEF (Aug. 28, 2020),

Developmental Harm: There is currently "no evidence that use of face masks prevents or delays speech or language development."[49] Not being able to see part of a person's face is not a significant impediment to social and speech development—as the experience of children who are blind from birth confirms. "[V]isually impaired children develop speech and language skills at the same rate as their peers."[50] Indeed, being unable to see speakers' mouths for a portion of the day may help children use other clues to understand and learn language and non-verbal communication, such as gestures, changes in tone of voice, and the like.[51]

Crucially, the AAP does not recommend (and Defendants do not require) that children wear masks 24 hours a day, or that their parents do so. In the home, children's experiences will presumably be largely or entirely maskless, providing ample opportunity for interacting with people without masks. Plaintiffs provide neither evidence nor theory for suggesting otherwise.

To be sure, some children with preexisting developmental disabilities may have difficulty wearing masks. But this can typically be overcome with coaching, and there is an extensive literature on helping children get accustomed to wearing masks.[52] And where children truly have "medical or developmental conditions [that] prohibit use," AAP's guidance recommends

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https://uni.cf/3mcx1un ("Approach this conversation with empathy, saying that you know she is feeling anxious about coronavirus, but that it's healthy to talk about our worries and emotions. Children may also get upset or frustrated if they are finding it hard to wear masks, especially when running or playing. You can reassure your children that lots of adults are working hard to help keep your family safe, but emphasize that it's important we all follow the recommended measures to take care of more vulnerable members of our community.").

[49] *Do Masks Delay Speech and Language Development?*, AAP, https://bit.ly/3GgcDQI.

[50] *Id.*

[51] *Id.*; *see also* Ashley L. Ruba & Seth D. Pollak, *Children's emotion inferences from masked faces: Implications for social interactions during COVID-19*, PLoS One (2020), https://bit.ly/3GbWBrg (finding that "while there may be some challenges for children incurred by others wearing masks, in combination with other contextual cues, masks are unlikely to dramatically impair children's social interactions in their everyday lives").

[52] *See, e.g.*, Maithri Sivaraman, et al., *Telehealth mask wearing training for children with autism during the COVID-19 pandemic*, 54 J. Applied Behav. Analysis 70 (2021), https://bit.ly/3m3RqS2; Madelynn A. Lillie, et al., *Increasing passive compliance to wearing a facemask in children with autism spectrum disorder*, 54 J. Applied Behavioral Analysis 582 (2021), https://bit.ly/3b1eA58; Mary Halbur, et al., *Tolerance of face coverings for children with autism spectrum disorder*, 54 J. Applied Behavioral Analysis 600 (2021), https://bit.ly/3jtGn30.

accommodations to masking policies.[53] California's policy provides exactly that, exempting "[p]ersons with a medical condition, mental health condition, or disability that prevents wearing a mask" from its masking requirements, along with "Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication."[54]

Physiological Harm: Finally, there is no evidence that masks cause any meaningful physical or physiological harm. Although Plaintiffs do not explain how they believe masks cause physical harms, *see* Pls.' Mem. at 7, their industrial hygiene expert appears to tie it to respiratory function. *See* Petty Decl. ¶¶ 40-44. (Notably, none of Plaintiffs' medical experts offer a similar opinion.) Extensive literature shows that masking has no significant effect on respiratory function in the vast majority of cases. Cloth and surgical masks are gas-permeable, which means that carbon dioxide can flow out of the mask and oxygen flow in, without obstruction. Masks do not present a risk of hypercapnia (excess CO_2) or hypoxemia (inadequate oxygen saturation in the blood), even among people with lung disease, as proven by studies using pulse oximetry to test changes in end-tidal CO_2 and oxygen saturation.[55] Even among infants and young children, the use of facial masks is not associated with significant changes in respiratory function.[56]

Plaintiffs' claim is also belied by the decades-long history of mask usage in surgical settings, for immunocompromised individuals (including children) such as chemotherapy patients, and in countries where masks have long been used to prevent spread of illness. For example, surgeons and other medical professionals may wear surgical masks for 6 to 8 hours at a time while

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[53] Face Masks, *supra* n. 23.

[54] Guidance for the Use of Face Coverings, CDPH (July 28, 2021), https://bit.ly/3Gdbd9O.

[55] *See, e.g.*, Rajesh Samannan, et al., *Effect of Face Masks on Gas Exchange in Healthy Persons and Patients with Chronic Obstructive Pulmonary Disease*, 18 Annals of Am. Thoracic Soc'y 539 (2021), https://bit.ly/3m29s7k; Steven L. Shein, et al., *The effects of wearing facemasks on oxygenation and ventilation at rest and during physical activity*, PLoS One (Feb. 24, 2021), https://bit.ly/3jsZ46G ("The risk of pathologic gas exchange impairment with cloth masks and surgical masks is near-zero in the general adult population.").

[56] *See, e.g.*, Ricardo Lubrano, et al., *Assessment of Respiratory Function in Infants and Young Children Wearing Face Masks During the COVID-19 Pandemic*, J. Am. Med. Ass'n Network Open (Mar. 2, 2021), https://bit.ly/30TOtLV.

performing involved surgery. If masks posed a risk of hypercapnia, hypoxemia, or any other harm, it would have been discovered long ago due to surgeons and attendants fainting or hospitals in other countries receiving adult or pediatric patients who were harmed by mask wearing. The complete lack of such reports is strong evidence, if more were needed, that Plaintiffs' concern is entirely unfounded.

The paper on which Plaintiffs' expert relies confirms this. Mr. Petty cites a meta-analysis explicitly designed to collect every single paper that purported to report "negative effects of masks."[57] *See* Petty Decl. ¶ 40. While the meta-analysis found a handful of studies suggesting that N95 or surgical masks could impair oxygen saturation, it found just *one* study claiming that cloth masks did so: an unpublished, non-peer-reviewed paper based solely on a study of 12 college students.[58] This single, unconfirmed report should provide no reason to doubt either the medical literature or commonsense experience the world over.

This is not to discount the subjective experiences of individual parents and children. The "nocebo" effect—when negative expectations produce a subjective experience of negative side effects—can lead to reports of "increase[d] heart rates and respiratory rates," "headaches, fatigue, and shortness of breath," as some of Plaintiffs' declarations describe. Pls.' Mem. at 7.[59] But as discussed above, this is generally a function of unhealthy cognitions surrounding masks, rather than actual physical harms of masks themselves. Certainly there is no evidence in the medical literature of masks causing clinically significant physical harm in children above the age of two without preexisting respiratory difficulties.

Similarly, there is no evidence in the medical literature that masks can "result in permanent deformations to a child's teeth and palate." Pls.' Mem. at 8. While significant nasal obstruction

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[57] Kai Kisielinski, et al., *Is a Mask That Covers the Mouth and Nose Free from Undesirable Side Effects in Everyday Use and Free of Potential Hazards?*, 18 Int'l J. Envt'l Rsch. Pub. Health 4344 (2021), https://bit.ly/3GdAz7p.

[58] *See id.* (citing Cong Liu, et al., *Effects of Wearing Masks on Human Health and Comfort During the COVID-19 Pandemic*, IOP Conference Series: Earth & Env't Sci. (2020), https://bit.ly/2ZinclG).

[59] *See, e.g.*, Sara Planès, et al., *The Nocebo Effect of Drugs*, 4 Pharmacology Rsch. & Perspectives e00208 (2016), https://bit.ly/3GdC9pR.

can lead to an overdependence on mouth breathing, which in turn can affect facial growth,[60] there is no evidence that wearing a mask for a portion of the day has any similar effect.

Decreased Immunity: Finally, Plaintiffs assert that "mask use may be lowering children's immunity to other viruses." Pls.' Mem. at 8; *see also* Noble Decl. ¶ 14. There is absolutely no evidence of this in the medical literature. The one study that Plaintiffs' expert cites, *see* Noble Decl. ¶ 14 & n.5, noted that 2020 saw a "marked decline in illness associated with other respiratory viruses, likely due to the widespread use of masks and social distancing."[61] This is a good thing, not a bad thing: in addition to inhibiting the spread of COVID-19, masking and the other precautions taken in 2020 significantly reduced the rate of respiratory syncytial virus ("RSV"), "the most common cause of bronchiolitis . . . and pneumonia . . . in children younger than 1 year of age in the United States."[62] In any case, Plaintiffs' expert appears to misunderstand the one reference to immunity in the cited study: the authors hypothesize that preliminary 2021 data showing "more severe diseases in younger infants" may possibly be "because of diminished immunity from a lack of exposure to RSV in the previous season"[63]—but infants, and especially younger infants, do not wear masks, so the authors do not suggest and the study does not support Plaintiffs' expert's claim that wearing a mask can lower a child's immunity.

CONCLUSION

For these reasons, CA AAP and AAP believe that Defendants' use of a layered prevention strategy involving masking and other efforts to reduce the exposure of children to sources of COVID-19 is in the public interest. Accordingly, the Court should deny Plaintiffs' motion for a preliminary injunction.

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[60] *See* Yosh Jefferson, *Mouth Breathing: Adverse Effects on Facial Growth, Health, Academics, and Behavior*, 58 Gen. Dentistry 18 (2010), https://bit.ly/3Ed4jiR.

[61] Rabia Agha & Jeffrey R. Avner, *Delayed Seasonal RSV Surge Observed During the COVID-19 Pandemic*, 148 Pediatrics e2021052089, https://bit.ly/2ZjA3UQ.

[62] *Respiratory Syncytial Virus Infection*, CDC (last updated Dec. 18, 2020), https://bit.ly/3js2pDl.

[63] Agha & Avner, *supra* n. 60.

Respectfully submitted,

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Dated: October 26, 2021

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PROOF OF SERVICE

I am employed in the County of Los Angeles, State of California. I am over the age of eighteen years and not a party to the within-entitled action. My business address is 1800 Century Park East, Suite 1500, Los Angeles, CA 90067.

On **October 26, 2021**, I caused the following document(s) described below to be served on the interested party(ies) in this action as follows:

MOTION FOR LEAVE OF CALIFORNIA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS AND AMERICAN ACADEMY OF PEDIATRICS TO FILE AN *AMICUS CURIAE* BRIEF IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION

☑ **BY ELECTRONIC SERVICE:** by transmitting via e-mail or electronic transmission the document(s) listed above to the person(s) at the e-mail address(es) set forth below.

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I declare under penalty of perjury under the laws of the State of California that the above is true and correct. Executed on **October 26, 2021**, at Los Angeles, California.

Liliana R. Hernandez