

No. 21-6007

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**IN THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT**

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M.B. PARENT OF MINOR S.B., *et al.*,  
*Plaintiffs-Appellees,*

v.

KNOX COUNTY BOARD OF EDUCATION,  
*Defendant-Appellant.*

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On Appeal from the United States District Court for the  
Eastern District of Tennessee (Case No. 3:21-cv-00317)

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**BRIEF OF *AMICI CURIAE* TENNESSEE CHAPTER  
OF THE AMERICAN ACADEMY OF PEDIATRICS  
AND AMERICAN ACADEMY OF PEDIATRICS  
IN SUPPORT OF PLAINTIFFS-APPELLEES**

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## INTEREST OF *AMICI CURIAE*<sup>1</sup>

The Tennessee Chapter of the American Academy of Pediatrics (“TNAAP”) is a non-profit educational organization and professional society comprising more than 1,000 members, including pediatricians, residents, and medical students from Tennessee’s hospitals, community clinics, and school-based health centers. TNAAP promotes the optimal health and development of children and adolescents of Tennessee, in partnership with their families and communities, and supports the pediatricians who care for them.

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 twenty-two months, the AAP has devoted substantial resources to

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<sup>1</sup> 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. Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented or stated their non-objection to the filing of this brief.

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.

## INTRODUCTION

Over the past twenty-two months, *Amici* have worked ceaselessly to evaluate the dangers of COVID-19 and to assess potential public health measures for reducing its deadly spread. 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 AAP's membership prove beyond doubt that universal mask policies in schools significantly reduce the spread of COVID-19 and protect all children, particularly those who are medically vulnerable.

The district court's decision below—entering a preliminary injunction requiring the Knox County Board of Education to enforce a mask mandate in schools across the county—is amply supported by this medical evidence. The district court relied extensively on the expert testimony of Dr. Jason Yaun and Dr. Jennifer Ker,<sup>2</sup> and the findings the

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<sup>2</sup> See, e.g., Am. Mem. Op. & Order, Record Entry 48 (Oct. 12, 2021), at Page ID # 993-94, 996, 1019–22, 1024, 1026, 1031, 1037, 1038, 1041-42, 1044.

court made on the basis of that testimony—deserving of deference—are consistent with AAP’s review of the medical evidence, as set forth below.

For the same reasons, the injunction imposed by the district court is firmly in the public interest. Universal school masking policies substantially reduce the risk of death and serious illness among Tennessee’s school-age children and their families. This Court should therefore affirm the decision below.

## **ARGUMENT**

### **I. COVID-19 IS A SERIOUS CHILDHOOD ILLNESS.**

The risk of children contracting COVID-19 is undeniably serious, and the risk to children with special health needs who contract COVID-19 is even more severe. The AAP and the Children’s Hospital Association have collaborated throughout the pandemic to collect and share all publicly available data on COVID-19 cases among children. These data fully support universal masking in Knox County schools.

As of December 30, 2021, more than 7,890,000 total child COVID-19 cases have been reported in the United States, representing more than

17.4% of the total U.S. cases.<sup>3</sup> In Tennessee, child cases represent more than 22% of all cases;<sup>4</sup> indeed, the number of cumulative COVID-19 cases per 100,000 children in Tennessee outstrips those in all but three other states.<sup>5</sup> The prevalence of pediatric COVID-19 has skyrocketed since the school year began, with approximately 44% of all child cases since the beginning of the pandemic 22 months ago diagnosed in the four-and-a-half months between August 13 and December 30.<sup>6</sup> 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 and Omicron variants, which are more contagious than previous variants.<sup>7</sup>

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<sup>3</sup> *Children and COVID-19: State-Level Data Report, Summary of Findings*, AAP, <https://bit.ly/2Y5UTGq> (data available as of Dec. 30, 2021).

<sup>4</sup> *Children and COVID-19: State Data Report* at Fig. 3, Am. Acad. of Pediatrics & Children's Hosp. Ass'n (Dec. 30, 2021), <https://bit.ly/3zrcVRM>.

<sup>5</sup> *Id.* at Fig. 4.

<sup>6</sup> *Id.* at Appx. Tab. 2A.

<sup>7</sup> *See Omicron Variant: What You Need to Know*, CDC (Dec. 20, 2021), <https://bit.ly/3G0LSPS>; *Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), <https://bit.ly/3kDI7sc>.

As the rate of COVID-19 has soared, so has the number of serious cases; just among the 24 states and one city that report child hospitalizations, more than 11,000 children were hospitalized due to COVID-19 between August 13 and December 30, approximately 39% of the total child hospitalizations to date.<sup>8</sup> And across the country, as of January 2, an average of 672 children are being hospitalized each day, more than doubling the average of the previous week.<sup>9</sup> Before August 13, no more than 16 children had died from COVID-19 in any week of the pandemic; from August 13 to December 30—essentially the fall semester of school for most children—that grim figure was matched or eclipsed in 14 out of 19 weeks.<sup>10</sup>

As the hospitalization rate reflects, COVID-19 can cause severe symptoms and potentially fatal outcomes, including in children. COVID-19 infections can produce multisystem inflammatory syndrome in

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<sup>8</sup> See *Children and COVID-19: State Data Report*, *supra* note 4, at Appx. Tab. 2B.

<sup>9</sup> See *COVID Data Tracker*, CDC (last updated Jan. 5, 2022), <https://bit.ly/3G2PmBA>; see also Melody Schreiber, *Covid hospitalizations among US children soar as schools under pressure*, *The Guardian* (Jan. 5, 2022), <https://bit.ly/3t1gzRe>.

<sup>10</sup> *Id.* at Appx. Tab. 2C.

children (MIS-C).<sup>11</sup> 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).<sup>12</sup> Among other symptoms, it can cause coronary artery enlargement; aneurysm; meningitis; colitis; hepatitis; symptoms akin to toxic shock syndrome; acute kidney injury; stroke; encephalitis; congestive heart failure; and pulmonary embolism.<sup>13</sup>

COVID-19 infections can also lead to many secondary conditions, ranging from subacute to severe. Several studies have shown that long-term symptoms can occur in children and adolescents.<sup>14</sup> Indeed, even

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<sup>11</sup> See *Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 19 (COVID-19)*, CDC (May 14, 2020), <https://bit.ly/3niE5WG>; *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, AAP (last updated Nov. 15, 2021), <https://bit.ly/3Cp8Nlu>.

<sup>12</sup> *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, *supra* note 11.

<sup>13</sup> *Id.*

<sup>14</sup> See, e.g., Danilo Buonsenso, et al., *Preliminary evidence on long COVID in children*, 110(7) *Acta Paediatrica* 2208 (2021), <https://bit.ly/2YMGcsj> (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(3323) *New Scientist* 10 (2021), <https://bit.ly/3DquZgo> (U.K. Office of National Statistics estimate 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).



cases with mild initial symptomatology can produce significant long-term effects. These include:

- respiratory 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, potentially leading to heart failure, myocardial infarction, stroke, or sudden cardiac arrest;
- loss of the sense of smell (anosmia) or taste (ageusia), which can affect the nutritional status and quality of life of children and adolescents;
- neurodevelopmental sequelae, including both the consequences of significant acute injuries such as stroke and subtle but persistent sequelae in cognitive, language, academic, motor, mood, and behavioral domains;
- cognitive foggiess or fatigue;
- physical fatigue; and
- mental or behavioral health impacts.<sup>15</sup>

The risks are especially high for children with certain underlying conditions who contract COVID-19. Those children are more likely to experience severe symptoms and require admission to the hospital or

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<sup>15</sup> Trisha Koriath, *AAP urges post-COVID-19 follow-up to monitor for residual symptoms*, AAP News (Aug. 2, 2021), <https://bit.ly/3JJoIj8>.

intensive care unit.<sup>16</sup> This group includes children with, for example, lung conditions, heart conditions, and weakened immune systems<sup>17</sup>—all conditions suffered by one or more of the Plaintiffs, *see* Opp. Br. at 4 n. 1.

## **II. THE MEDICAL LITERATURE UNIFORMLY SUPPORTS MASKING TO PREVENT INJURY AND DEATH FROM COVID-19.**

### **A. THE AAP'S RESEARCH**

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. They are then peer-reviewed by additional experts across the AAP and approved by the AAP's executive staff and board of directors.

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<sup>16</sup> *Caring for Children and Youth with Special Health Needs During the COVID-19 Pandemic*, AAP (last updated Dec. 1, 2021), <https://bit.ly/3oqebRG>.

<sup>17</sup> *People with Certain Medical Conditions*, CDC, (last updated Dec. 14, 2021), <https://bit.ly/3D3vL1Z>.

Since the spring of 2020, the AAP's primary 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;<sup>18</sup> on providing clinical care to patients with COVID-19;<sup>19</sup> on treating post-COVID conditions;<sup>20</sup> on how to safely provide routine medical care such as check-ups, screenings, laboratory exams, treatment, and immunizations during the COVID-19 pandemic;<sup>21</sup> on caring for youth with special health needs during the COVID-19 pandemic;<sup>22</sup> on supporting the emotional and behavioral health needs of

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<sup>18</sup> *COVID-19 Testing Guidance*, AAP (last updated Nov. 17, 2021), <https://bit.ly/3cfroFQ>.

<sup>19</sup> *COVID-19 Interim Guidance*, AAP (last updated Jan. 3, 2022), <https://bit.ly/3Djk1Jx>.

<sup>20</sup> *Post-COVID-19 Conditions in Children and Adolescents*, AAP (last updated Dec. 17, 2021), <https://bit.ly/3cuLhJj>.

<sup>21</sup> *Guidance on Providing Pediatric Well-Care During COVID-19*, AAP (last updated Aug. 30, 2021), <https://bit.ly/3Dqxlfe>.

<sup>22</sup> *Caring for Children and Youth with Special Health Needs During the COVID-19 Pandemic*, *supra* note 16.

children, adolescents, and families during the COVID-19 pandemic;<sup>23</sup> and—most relevant to this case—on the use of face masks as an infection-control measure<sup>24</sup> and on operating safe schools during the COVID-19 pandemic to foster the overall health of children, adolescents, educators, staff, and communities.<sup>25</sup> These Interim Guidances were drafted and reviewed by numerous 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 a pediatrician organization, the AAP recognizes 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

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<sup>23</sup> *Interim Guidance on Supporting the Emotional and Behavioral Health Needs of Children, Adolescents, and Families During the COVID-19 Pandemic*, AAP (last updated Dec. 9, 2021), <https://bit.ly/3qGi5r2>.

<sup>24</sup> *Face Masks*, AAP (last updated Nov. 15, 2021), <https://bit.ly/30p9qOD>.

<sup>25</sup> *COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning*, AAP (last updated Nov. 2, 2021), <https://bit.ly/3DkCrcM>.

long-term mood, behavior, and mental health.<sup>26</sup> These harms fall disproportionately on children with disabilities.<sup>27</sup>

Based on the need to protect children against the harms caused by long-term remote learning, along with AAP's expert review of the scientific literature and AAP's members' collective expertise as pediatricians and researchers, the AAP concluded that "all local, state, and federal policy considerations for school COVID-19 plans should start

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<sup>26</sup> See, e.g., Jorge V. Verlenden, et al., *Association of Children's Mode of School Instruction with Child and Parent Experiences and Well-Being During the COVID-19 Pandemic—COVID Experiences Survey, United States, October 8–November 13, 2020*, 70(11) *Morbidity & Mortality Weekly Rep.* 369 (2021), <https://bit.ly/3sWRxCL>; Dimitri A. Christakis, et al., *Estimation of U.S. Children's Educational Attainment and Years of Life Lost Associated with Primary School Closures During the Coronavirus Disease 2019 Pandemic*, 3(11) *J. Am. Med. Ass'n Network Open* e2028786 (2020), <https://bit.ly/3pVoT2W>; Meira Levinson, et al., *Reopening Primary Schools During the Pandemic*, 383 *New Eng. J. Med.* 981 (2020), <https://bit.ly/3mZjG8y>; Megan Kuhfeld, et al., *Projecting the Potential Impact of COVID-19 School Closures on Academic Achievement*, 49(8) *Educ. Researcher* 549 (2020), <https://bit.ly/3eRv2qy>; Emma Dorn, et al., *COVID-19 and Education: The lingering effects of unfinished learning*, McKinsey & Co. (July 27, 2021), <https://mck.co/3FX0H63>.

<sup>27</sup> See, e.g., Ramkumar Aishworiya & Ying Qi Kang, *Including Children with Developmental Disabilities in the Equation During this COVID-19 Pandemic*, 51 *J. Autism & Dev. Disorders* 2155 (2021), <https://bit.ly/34opBxy>; Amy Houtrow, et al., *Children with disabilities in the United States and the COVID-19 pandemic*, 13(3) *J. of Pediatric Rehabilitation Med.* 415 (2020), <https://bit.ly/3G46A1c>.

with a goal of keeping students safe, physically present, and emotionally supported *in school*.”<sup>28</sup> “At this point in the pandemic, given what we know about low rates of in-school transmission *when proper prevention measures are used*, together with the availability of effective vaccines for those eligible, . . . the benefits of in-person school outweigh the risks in almost all circumstances.”<sup>29</sup> Among the recommended prevention measures (such as 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), regardless of vaccination status.**”<sup>30</sup>

Although the AAP has modified some of its other recommendations as further information is learned about COVID-19, its strong recommendation of universal masking for students, teachers, and support staff in school has remained consistent from the beginning—because masks are a safe, effective, and critical infection-control

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<sup>28</sup> *COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning*, *supra* note 25 (emphasis added).

<sup>29</sup> *Id.* (emphasis added).

<sup>30</sup> *Id.* (emphasis in original).

measure. This conclusion has been consistently reinforced by all relevant data and credible research, leading the CDC to recommend “universal indoor masking for all students (age 2 years and older), teachers, staff, and visitors to K-12 schools regardless of vaccination status.”<sup>31</sup> In November, after reviewing all scientific evidence to date on the transmission and prevention of COVID-19 during the current school year, the AAP reaffirmed its recommendation that masks are an important infection-control measure.<sup>32</sup>

**B. UNIVERSAL MASKING POLICIES ARE HIGHLY EFFECTIVE AT REDUCING TRANSMISSION OF COVID IN CHILDREN**

While there are several reasons for AAP’s recommendation of universal masking in school,<sup>33</sup> the most important is that the research 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

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<sup>31</sup> *Guidance for COVID-19 Prevention in K-12 Schools*, CDC (last updated Nov. 5, 2021), <https://bit.ly/3HD2IKs>.

<sup>32</sup> *COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning*, *supra* note 25.

<sup>33</sup> *See id.* (identifying eight bases for AAP’s mask recommendation).



be unaware of their infectiousness to others (who are “estimated to account for more than 50% of SARS-CoV-2 transmissions).”<sup>34</sup> “Cloth masks not only effectively block most large droplets (i.e., 20-30 microns and larger), but they can also block the exhalation of fine droplets and particles (also often referred to as aerosols) smaller than 10 microns.”<sup>35</sup> “Multi-layer cloth masks can both block 50–70% of these fine droplets and particles,” with “[u]pwards of 80% blockage” recorded in some studies.<sup>36</sup> To a 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.”<sup>37</sup>

This difference between a mask’s ability to block *exhalation* and *inhalation* of viral particles explains why it is so important for schools to have the ability to make masking policies universal. A mask’s primary benefit is as “source control,” preventing infected carriers from spreading viral particles widely. As the CDC has explained, “masks are not

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<sup>34</sup> *Science Brief: Community Use of Masks to Control the Spread of SARS-CoV-2*, CDC (Dec. 6, 2021), <https://bit.ly/3utvxOA> (citations omitted).

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

<sup>37</sup> *Id.*

designed to reduce the particles that the wearer will inhale . . . . The purpose of wearing masks is to help reduce the spread of COVID-19 by reducing the spread of the virus through respiratory droplets from asymptomatic individuals.”<sup>38</sup> Because wearing a mask provides only limited protection against contracting COVID-19 if the wearer is near one or more *unmasked* carriers, universal masking is needed as source control for COVID-19 carriers (who may be asymptomatic and not know they are shedding viral particles), thereby protecting vulnerable children.

Numerous studies have shown that increasing the rate of mask-wearing, including through universal masking policies in particular, significantly reduces the spread of COVID-19.<sup>39</sup> Specifically, studies

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<sup>38</sup> *Respiratory Protection vs. Source Control—What’s the Difference?*, CDC (Sept. 8, 2020), <https://bit.ly/3pn0y6s>.

<sup>39</sup> See, e.g., Jeremy Howard, et al., *An Evidence Review of Face Masks Against COVID-19*, 118(4) Proc. of the Nat’l Acad. of Servs. of the United States of America e2014564118 (2021), <https://bit.ly/3ndJVsl>; John T. Brooks & Jay C. Butler, *Effectiveness of Mask Wearing to Control Community Spread of SARS-CoV-2*, 325(10) J. of Am. Med. Ass’n 998 (2021), <https://bit.ly/3Fi8Hh7>; Heesoo Joo, et al., *Decline in COVID-19 Hospitalization Growth Rates Associated with Statewide Mask Mandates—10 States, March–October 2020*, 70(6) Morbidity & Mortality Weekly Rep. 212 (2021), <https://bit.ly/3cgPrEd>; Derek K. Chu, et al., *Physical distancing, face masks, and eye protection to prevent person-to-*

have shown that masking and similar mitigation measures can limit transmission in schools.<sup>40</sup> As the ABC Science Collaborative, a thirteen-

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*person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis*, 395(10242) Lancet 1973 (2020), <https://bit.ly/3kEj1YU>; Christopher T. Leffler, et al., *Association of Country-wide Coronavirus Mortality with Demographics, Testing, Lockdowns, and Public Wearing of Masks*, 103(6) Am. J. Tropical Med. Hygiene 2400 (2020), <https://bit.ly/2YMIszO>; 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(47) Morbidity & Mortality Weekly Rep. 1777 (2020), <https://bit.ly/31SbU8H>; 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(8) Health Aff. 1419 (2020), <https://bit.ly/3Ho9VJw>.

<sup>40</sup> 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 Springfield, Missouri, December 2020*, 70(12) Morbidity & Mortality Weekly Rep. 449 (2021), <https://bit.ly/3HsAL3w>; Darria L. Gillespie, et al., *The Experience of 2 Independent Schools With In-Person Learning During the COVID-19 Pandemic*, 91(5) J. Sch. Health 347 (2021), <https://bit.ly/3kAETxR>; Rebecca B. Hershov, et al., *Low SARS-CoV-2 Transmission in Elementary Schools - Salt Lake County, Utah, December 3, 2020-January 31, 2021*, 70(12) Morbidity & Mortality Weekly Rep. 442 (2021), <https://bit.ly/3cb48ZE>; Amy Falk, et al., *COVID-19 Cases and Transmission in 17 K-12 Schools - Wood County, Wisconsin, August 31-November 29, 2020*, 70(4) Morbidity & Mortality Weekly Rep. 136 (2021), <https://bit.ly/3qFvxeD>; Fiona Russell et al., *COVID-19 in Victorian ECEC and Schools: An Analysis of COVID-19 in ECEC and schools and evidence-based recommendations for opening ECEC and schools & keeping them open*, The Royal Children's Hosp. Melbourne, Murdoch Children's Rsch. Inst. & The Univ. of Melb. (2020), <https://bit.ly/31TpNU6>; see generally *Science Brief: Transmission of*

state initiative coordinated by the Duke Clinical Research Institute at the Duke University School of Medicine, said: “[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.”<sup>41</sup> That is the case in Knox County, where only 18.6% of children between the ages of 5 and 11 have been vaccinated.<sup>42</sup> For children who are at high risk of severe consequences if they have a breakthrough infection, or children whose medical conditions prevent them from obtaining the full benefit of immunization, the low rate of vaccination means that universal masking remains the most effective and least intrusive means of protecting them from contracting COVID-19.

While studies have found universal masking requirements effective at reducing transmission, there are no studies finding mask

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*SARS-CoV-2 in K-12 Schools and Early Care and Education Programs—Updated*, CDC (Dec. 17, 2021), <https://bit.ly/2YRMJCe>.

<sup>41</sup> ABC Science Collaborative, *The ABCs of North Carolina’s Plan A*, <https://bit.ly/3nhUYkr> (last visited Jan. 5, 2022); see also ABC Science Collaborative, *Final Report for NC School Districts and Charters in Plan A*, at 3 (June 30, 2021), <https://bit.ly/3cgHMWs>.

<sup>42</sup> *Knox County Health Department COVID-19 Vaccine Information* (last visited Jan. 5, 2022), <https://bit.ly/3eTk6ZO>.

“recommendations”—akin to the Board of Education’s proposed course of action, Def. Br. at 28—to be effective in schools. Thus, while layered prevention strategies, in which multiple interventions are used, provide the most comprehensive protection against transmission, there is no dispute that such strategies are substantially less effective if the crucial tool of universal masking is ruled out. And in the rare cases where masking is genuinely contraindicated by an individual child’s developmental or physical conditions, that particular child can be exempted from the policy without undermining the overall risk mitigation brought about by universal masking<sup>43</sup>—as has been the case in Knox County.

### **III. VIRTUAL SCHOOLS ARE NOT EQUAL TO IN-PERSON SCHOOLS, NOR ARE THEY THE MOST INTEGRATED SETTING APPROPRIATE TO THE NEEDS OF CHILDREN WITH DISABILITIES**

The Board of Education argues that it need not provide “safe’ access” to school facilities because “[e]ducational programming is not limited to or defined by a specific building or location.” Def. Br. at 25.

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<sup>43</sup> See *COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning*, *supra* note 25.

According to the County, “[d]elivering services . . . through its virtual schools” fulfills its obligations to children with disabilities. Def. Br. at 29.

This contravenes the Americans with Disabilities Act (the “ADA”) and Rehabilitation Act, which were intended to “enabl[e] each covered person (sometimes by means of reasonable accommodations) to participate *equally* to all others in public facilities and federally funded programs.” *Fry v. Napoleon Comty. Schs.*, 137 S. Ct. 743, 756 (2017) (emphasis added). Under the ADA and Rehabilitation Act and their implementing regulations, public entities must “administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.” 28 C.F.R. § 35.130(d); *see also PGA Tour, Inc. v. Martin*, 532 U.S. 661, 675 (2001) (noting that the ADA is a “broad mandate” of “comprehensive character” and “sweeping purpose” intended to “integrate [people with disabilities] into the economic and social mainstream of American life”) (citation and quotation marks omitted). As the Board of Education acknowledges, this obligation requires that individuals with disabilities be able “to ‘interact with nondisabled persons to the fullest extent possible’.” Def. Br. at 34 n. 24 (quoting 28 C.F.R. § 35, App. B, Subp. B, § 35.130).

Forcing children with disabilities into remote learning, when students who are not at heightened risk of contracting COVID-19 are attending school in person, is not the most integrated setting, nor is it an equal substitute for in-person schooling. As explained above, extended remote learning can be deeply harmful to children, posing a significant risk of negatively affecting their development and mental health.<sup>44</sup> Schools provide services beyond classroom lessons; they “provide our children and adolescents with . . . social and emotional skills, safety, reliable nutrition, physical/occupational/speech therapy, mental health services, health services, preventive oral health care, and opportunities for physical activity, among other benefits.”<sup>45</sup> “Families rely on schools to provide a safe, stimulating, and enriching space for children to learn; appropriate supervision of children; opportunities for socialization; access to school-based mental, physical, speech, oral, and nutritional health services; and universal support to cope with crisis and loss associated with the pandemic.”<sup>46</sup> As the district court found, however,

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<sup>44</sup> *See supra* pp. 12–14 & nn. 26–29.

<sup>45</sup> *COVID-19 Guidance for Safe Schools and Promotion of In-Person Learning*, *supra* note 25.

<sup>46</sup> *Id.*



“virtual schools have obvious differences from their brick-and-mortar counterparts”: students in them “do not have the opportunity to eat lunch with, go to physical education with, or engage in extracurricular activities with their peers.”<sup>47</sup> These factual findings are entitled to deference. *See DV Diamond Club of Flint, LLC v. Small Bus. Admin.*, 960 F.3d 743, 746 (6th Cir. 2020).

To be sure, remote education may have been an imperfect but necessary solution in the early stages of the pandemic, when vaccines were unavailable even for adults and our ability to reduce the transmission of the COVID-19 virus was more limited. But that is a far cry from saying that remote learning is equal to in-person learning. Shunting persons with disabilities to an inferior form of services, when equal services would be available if reasonable accommodations were made, does not satisfy the government’s obligations to people with disabilities.

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<sup>47</sup> *See, e.g.*, Am. Mem. Op. & Order, Record Entry 48 (Oct. 12, 2021), at Page ID # 1027.

#### **IV. MAINTAINING THE DISTRICT COURT’S INJUNCTION IS IN THE PUBLIC INTEREST**

For the reasons set forth above, the injunction requiring universal mask-wearing in Knox County schools is in the public interest: requiring masks protects not only vulnerable children, but also their families and the broader community, by limiting the spread of infection.

Moreover, the uncontrolled spread of COVID-19 poses an additional—and enormous—risk to children and adults who have other medical needs: hospital ICUs strained beyond capacity. As of December 24, 2021, of the five short-term care hospitals in Knox County, three have less than 4% capacity remaining in their ICUs, and one of those three has a completely full ICU.<sup>48</sup> Because of the strain on medical resources, overwhelmed hospital systems result in excess morbidity and mortality even for children and adults who do not contract COVID-19. As research has shown, “[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

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<sup>48</sup> *COVID-19 Hospital Capacity in Knox County and Surrounding Area*, Knox News (Dec. 24, 2021), <https://bit.ly/32NpZ8l>.

acute and chronic illnesses.”<sup>49</sup> In lay terms, more children and adults will become sick and possibly die, due to both COVID-19 and the delay of treatment for other urgent conditions.

Ignoring these critical interests, the Board of Education argues that the public interest truly lies with students who prefer to flout the mask requirement, claiming that they are “denied their public education,” Def. Br. at 50, if they are sent home from school for failing to abide by the mask policy implemented in response to the injunction. The County contends that a student’s willful disobedience of a school rule is not that student’s choice, to which consequences attach, but rather an external deprivation of rights. This is a radical concept; students who violate school rules intended to protect the health of other students are not typically allowed to continue the prohibited behavior with impunity.

Tellingly, the County has chosen *not* to offer virtual schooling to such children, Def. Br. at 40 n. 30, even though it claims to believe that virtual schools are equal to in-person learning, *id.* at 25–36. This belies its insistence that virtual schools are adequate, and underscores the

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<sup>49</sup> Amber K. Sabbatini et al., *Excess Mortality Among Patients Hospitalized During the COVID-19 Pandemic*, 16(10) J. Hosp. Med. 596 (2021), <https://bit.ly/3Hs5EEU>.

unfairness of its discrimination against children with disabilities. Under the Board of Education's logic, students who merely prefer not to follow a rule may remain in school, while students with disabilities that place them at heightened risk of contracting COVID-19 or suffering life-altering or even life-threatening consequences are expected to accept an unequal and segregated substitute. Compared to the very real dangers faced by students who are unable to safely attend school absent a mask requirement—through no fault of their own—the scale tips strongly on the side of Plaintiffs.

### **CONCLUSION**

For the foregoing reasons and those set forth by Plaintiffs, *Amici* respectfully request that the Court affirm the decision below and maintain the preliminary injunction.

Respectfully Submitted,

Dated: Jan. 6, 2022

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## **CERTIFICATE OF COMPLIANCE**

### **With Type-Volume Limit, Typeface Requirements, and Type-Style Requirements**

I certify that this filing complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) and Fed. R. App. P. 29(a)(5) because it contains 4,619 words, excluding the parts exempted by Fed. R. App. P. 32(f) and 6th Cir. R. 32(b).

This filing also complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6) and 6th Cir. R. 32 because it has been prepared in proportionally spaced typeface using Microsoft Word for Windows, version 2016 in Century Schoolbook 14-point font typeface.

*/s/ Jeffrey P. Justman*  
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**CERTIFICATE OF SERVICE**

I, Jeffrey P. Justman, counsel for *Amici*, certify that on January 6, 2022, a copy of the foregoing brief was filed electronically through the appellate CM/ECF system with the Clerk of the Court. I further certify that all parties required to be served have been served.

*/s/ Jeffrey P. Justman*  
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Jan. 6, 2022