Case Number: PC-2021-05915
Filed in Providence/Bristol County Superior Court
Submitted: 10/25/2021 11:51 AM
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Reviewer: Victoria H

STATE OF RHODE ISLAND
PROVIDENCE, SC

SUPERIOR COURT

RICHARD SOUTHWELL, et al.	:	
Plaintiffs	:	
vs.	:	C.A. No. PC2021-05915
DANIEL J. MCKEE, et al.	:	
Defendants	:	

PLAINTIFFS' POST-HEARING MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION

BACKGROUND:

Since this complaint in this case was filed, the State's position as to the legality of the mandating masks in schools has evolved. First, it appears from the State's initial memorandum in opposition to the motion for injunctive relief, that the Governor has abandoned any argument that the Rhode Island Constitution provides an independent authority for his issuance of an executive order.

Second, on September 23, 2021, the Rhode Island Department of Health (RIDOH) issued Emergency Regulation 216-RICR-20-10-7, "Masking in Schools" ("Emergency Regulation or Rule"). RIDOH purported to issue this regulation under its general statutory authority conferred to it under R.I. Gen. Laws §§ 23-1-1, 23-1-17 and 23-1-18(4). In doing so, RIDOH circumvented the normal regulatory procedure for issuing school health regulations, instead issuing the regulation pursuant to the Emergency Rule provisions of R.I. Gen. Laws § 42-35-2.10.

Third, the State argues that the Governor signed a "Proclamation of Quarantine" under R.I. Gen Laws § 23-8-18, which he claims provides some basis for mandating masks in schools.

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Lastly, the State argues that the Governor properly exercised his authority under the recently amended R.I. Gen. Laws § 30-15-9(e) to issue an emergency order mandating masks.

Of the three state mandates, the only one to expressly cite to any factual basis is the Executive Order. Neither the Emergency Rule nor the Quarantine Proclamation references facts or data to support their issuance, presumably relying upon EO 21-86. But this is fraught with issues:

1. The Executive Order requiring masks 21-87 (Exh. 5) requires that RIDOH issue a mask "protocol" (attached hereto and also referenced as Exh. D to Defendants' Memorandum in Opposition).[1] That protocol was issued on August 19, 2021, expired on September 18, 2021, and was never renewed.
2. The Executive Order was renewed twice, once on September 17, and again on October 15. (Exh. 42) Neither order references any data or facts to support it, and neither references the RIDOH Emergency Rule.
3. When asked what metric will be used to end the Emergency Order, Dr. McDonald could not give a clear answer, just vague references to cases and hospitalizations being down, and vaccine approval for children. He even testified that when the COVID team met to discuss renewal of the order, there was in fact no discussion; everyone just nodded in approval to continue along.
4. Finally, to the extent the original order makes a number of assertions, upon closer review these claims are neither based on science or facts, nor are evidence of any true emergency.

1 The State's memo suggests that the protocol was issued pursuant to the Proclamation of Quarantine. It was not.

Since the only evidence to support masking is referenced in the Executive Order, a review of that evidence is determinative of this case.

1. **<u>The Executive Order:</u>**

First, the order claims that Delta variant has become dominant, and is maybe has a viral load 1000 times greater than the original strain of SARS CoV-2, and is 3-4 times more contagious than the original strain.

Whether Delta is the current dominant strain of COVID is irrelevant, given that it is of no greater concern than other strains, according to the CDC.[2] As for the scare quote of 1000x the viral load, Dr. McDonald referenced some unnamed China study to suggest that was possible. Again, there is no actual evidence that this is true. In any event, as Dr. Boston testified without contradiction, the Delta strain is significantly less contagious than the original Wuhan COVID-19 strain and the Alpha variant. (Exh. 6)

Second, the Order notes that unvaccinated people can spread the Delta variant. But that is true of all COVID-19 variants, as Dr. McDonald admitted. The vaccine does not prevent someone from getting the virus, or spreading it, it only lessens the severity of the infection. The CDC didn't always agree with that statement, when in May of this year the CDC Director stated

2 Dr. McDonald agreed that, as of September 11, 2021, the CDC has stated:

a. Genetic variants of SARS-CoV-2 have been emerging and circulating around the world throughout the COVID-19 pandemic.
b. Viral mutations and variants in the United States are routinely monitored through sequence-based surveillance, laboratory studies, and epidemiological investigations.
c. The US government SARS-CoV-2 Interagency Group (SIG) developed a Variant Classification scheme that defines three classes of SARS-CoV-2 variants:
    i. Variant of Interest
    ii. Variant of Concern
    iii. Variant of High Consequence
d. The Alpha (B.1.1.7), Beta (B.1.351, B.1.351.2, B.1.351.3), Delta (B.1.617.2, AY.1, AY.2, AY.3), and Gamma (P.1, P.1.1, P.1.2) variants circulating in the United States are classified as variants of concern.
e. To date, no variants of high consequence have been identified in the United States.

that vaccinated people could go without masks. But that thinking changed after an outbreak in Provincetown MA among vaccinated men. (Exh. S) The fact that the CDC got this wrong permeates this case. The State relies almost exclusively on CDC pronouncement to support its claim that masks work and are not harmful to children, yet the CDC has gotten so much wrong about this pandemic one wonders why anyone would put such unquestioning faith in their opinions.

Later, the Order references that children under 12 cannot get vaccinated which, although true, is irrelevant to the issue of spreading the virus. As for the fact that children cannot use vaccines or monoclonal treatments, they are unnecessary for children who seldom get sick, and certainly don't have serious consequences from getting COVID-19.

In the third category of statistics, the Order references a high level of community transmission and new cases, increased hospitalizations, and such overcrowding of emergency departments that they are, "exceeding capacity and hospitals are on rolling diversion".

The hospitals in Rhode Island never exceeded capacity, and in fact hospitalizations decreased starting in mid-September, just as schools were opening after September 9. (Exh. 7) And cases began to drop on September 6, before schools opened. Hospitals never exceeded 90% capacity, and of that never more than 7% of the hospitalizations were of patients with a COVID-19 diagnosis. (Exh. 10) As for ICU beds, they never were above 93% capacity, having peaked on September 10, and are at about 83% today. (Exh. 11, 12) No evidence was presented to support the claim of "rolling diversions". Related to the hospital overcrowding was the need to open an alternate hospital in Cranston, which of course never happened.

Finally, in its most alarmist language, the Order states: "RIDOH's modeling team of statisticians and public health professionals reports that, based on statistical analysis, without continued and improved mitigation measures, the Delta Variant may cause an increase in the rate

of deaths by the end of September 2021." There was no evidence to support this claim presented by the State, even though the order has been renewed twice already.

While the state did not focus on the number of recent deaths due to COVID-19, Dr. McDonald attempted to mislead this Court as to the seriousness of the threat of COVID-19 to children by citing to 3 pediatric COVID-19 deaths from last year. Caught with this misrepresentation, Dr. McDonald attempted to correct the misimpression by blaming the CDC definition. All that proved was that the CDC was overstating the total number of COVID-19 deaths by including any death with a positive test, even if the death was for totally unrelated reasons. And it proved that Dr. McDonald was not beyond stretching the truth to get support for his position on masking.

Dr. Bostom proved that point. There have been no COVID-19 deaths of anyone under age 24 in Rhode Island. (Exh. 22) Nationally, there have been approximately 500 COVID-19 deaths under age 18, however, that number is likely inflated given the liberal definition of dying "with COVID" as a review of death certificates show about 35% of COVID-19 recorded deaths in children had no plausible chain of event or significant underlying condition. (Exh 19, Table 1).

Comparatively, the seasonal flu has been much more deadly to children: up to 5 times more in some recent years (Exh. 15, 16), including 3 such deaths in Rhode Island during the 2009-10 flu season. (Exh. 14) Conversely, the survival rate for a child who catches COVID-19 is estimated at 99.9998%.

In fact, COVID-19 is a disease that harms the elderly and those with significant comorbidities: 80% of deaths in Rhode Island are in those over 70 years old (Exh. 21). Nationally, 99.1% of deaths involved those with a least one underlying condition (hypertension, and lipid metabolism being the most common, and obesity, diabetes and anxiety disorders the

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strongest risk factors (Exh. 24). Moreover, 64% of deaths were in people with at least 6 underlying conditions (Ex. 24, Table 1)

Nor do scare mongering about pediatric COVID-19 hospitalizations bear scrutiny. There has been an average of about one pediatric hospitalization in the state since the Executive Order was issued. (Exh. 8)[3] There have been no pediatric hospitalizations either "with" or "because of" COIVD-19 since October 4 as testified to by Dr. Bostom. Dr. McDonald could not dispute this fact since he admitted he has not looked at pediatric hospitalizations for a couple of weeks.

Though not mentioned in the Executive Order, or Emergency Rule, Dr. McDonald raised the specter of Long COVID and MIS-C conditions as a concern for children. But the evidence does not support his concern. In a 14 studies of children with persistent conditions, the evidence for Long COVID in children and adolescents is limited, and all studies have substantial limitation such as "lack of a clear case definition, inclusion of children without a confirmed COVID infection, self-reported symptoms without clinical follow-up and other biases, and lack of a control group, or did not show a difference between children who had been infected and those who were not." As for MIS-C, it is rare diagnosis in relation to COVID-19, and has been associated with other common cold viruses. (Exh. 13)

In an effort to bolster its case, the State introduced evidence to support its claim that Delta is really bad, and that masks are really good. None shows evidence to support the executive order.

2. <u>The Dashboard:</u>

Dr. McDonald testified that the Dashboard was a very important data set that he consulted frequently to monitor the impact of COVID-19 on the state. The State noted the

3 The State did introduce a chart to show monthly pediatric hospitalizations (Exh. M), but these do not reflect if COVID-19 was the reason for the hospitalization. Moreover, this shows less than one average hospitalizations per day in August and September.

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following metrics it felt supported their case: Estimated Prevalence of Infection; Community Transmission; Projected Community Immunity; 14 Day Projected Hospitalizations; and Hospital Overcrowding and the NEDOCS Score. Yet each of these metrics suffers from incomplete or outdated data, and changing definitions. When confronted about this, Dr. McDonald backtracked and claimed this was not the only data he reviewed, but never mentioned what the other data was.

a. Estimated Prevalence of Infection

The State placed great weight on its modeling data. But it suffers the same fate as the miserably inaccurate modeling data from April 2020, which overstated hospitalizations by a factor of 10. (Exh. 10)

On June 30, 2021, the model showed everything was fine, the hospitalization rate was expected to be very low. Suddenly, on August 16, the model changed, and doom was predicted. Then on August 31, nothing; the model disappeared.

Another curious change: on June 30 the model was predicated on CDC modeling, which included test positivity rate. But Rhode Island's test positivity rate is very low, never above the 5% rate that was key to last year's lockdowns and mask mandates. Dr. McDonald discounted test positivity rate in the modeling, claiming that since the state conducts so many tests, it is no longer a valid metric. This is a curious statement, since his boss, Dr. Alexander Scott, in her letter to school districts on August 18, emphasized the positivity rate among children. (Exh. 37)

b. Projected Community Immunity

As with community spread, this data is incomplete and confusing. Does it include natural immunity; Dr. McDonald initially suggested it did. But when asked why the State does not test

for natural immunity, he deflected and claimed there was no evidence natural immunity lasted past 90 days.[4]

c. 14 Day Projected COVID Hospitalizations

This metric appears in the dashboard from June 30 through August 9, after which it is "under development" through September 9, and then disappears completely. Why? Is it because as of August 9, there was no projected surge?

d. Hospital Overcrowding and the NEDOCS Score

Much was made by the State of the NEDOCS score, allegedly showing Emergency Department overcrowding. When it was pointed out that the "dangerously overcrowded" standard applied to EDs with as few as half as many beds filled, Dr. McDonald claimed the score reflects staffing issues as well, although it does not say so specifically. When also confronted with a study that NEDOCS is inaccurate because it often overestimates overcrowding (Exh. 44), the Doctor reverted to his personal experience with overcrowding of EDs, an experience everyone has had. Most importantly, however, the ED overcrowding, to the extent it exists, has nothing to do with COVID-19, since only about 5 % of hospital beds are being used by COVID-19 positive patients. (Exh. 9)

3. The MMWRs

Nearly every study cited by the State to support its claim that masking works is contained in a Morbidity and Mortality Weekly Report (MMWR). (Exhs. C, D, E, F, G, I, J, K, S and W), or Science Briefs put out by the CDC (Exh. B and R). All of these studies suffer from

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4 After the close of testimony, the State published data to show that 89.8% of adults in Rhode Island are now vaccinated. https://ri-department-of-health-covid-19-vaccine-data-rihealth.hub.arcgis.com/ This is the 90 % herd immunity often cited as what is needed to end the pandemic. While it does not include children, the evidence is conclusive that children do not need herd immunity since they are not at risk. Moreover, there is no evidence to show what the natural immunity rate is among children, because the State refuses to gather that evidence.

confounders, as Dr. McDonald called them: confirmation or recall bias, and an inability to generalize or prove a causal relationship between the findings and the conclusions suggested.

For example, the Marin County study was used to suggest that a teacher who removed her masked caused an outbreak of COVID-19 among her students. But “challenges in testing acceptance among possible contacts from outside the school led to difficulty in characterizing the outbreak’s actual spread into the community, as is evidenced by later discovery of additional community cases with sequences indistinguishable from those in the school outbreak.” (Exh. G) The Georgia study which is cited in paragraph 74 of our Complaint states clearly that there was no statistical difference in COVID-19 incidences among students between schools mandating masks and those that did not. (Exh. F) A Saint Louis University study suggests that “Compared with masked exposure, close contacts with any unmasked exposure had higher adjusted odds of a positive test result.” The problem is, “contact tracing were self-reported, which could introduce social desirability and recall bias or inaccurate data regarding mask use.” (Exh. D) An “ecological” study comparing counties with mask mandates and those without stated bluntly: “causation cannot be inferred”. (Exh. I)

In support of the State’s argument that masks do not harm children, they point to a study from Italy. (Exh. T) In that study children wore masks for only 30 minutes. They also cite to a Science Brief put out by the CDC (Exh. B) The 7 studies cited in that paper as evidence that “mask wearing has no significant adverse health effects” were all non-randomized, and all involved adults. They all found some adverse effect: oxygen levels lowered increased CO2 tension, higher heart rate, but not enough to be “significant”. One study consisted of six 10 minutes phases, another was self-reported after a 6 minute walk and then monitored for 30 minutes. These are hardly relevant to determine the effects, both physical and emotional to children wearing masks in school for 8 hours per day.

Interestingly, the State never introduced the one study cited by Dr. Alexander Scott to local school districts (Exh. 37), that involved the use of manikins in a conference room. (Exh. 38) The study is subject to so many limitations it is useless, and Dr. McDonald did not seem to agree with it being included in the letter his boss sent out.

The problem lies with the weight given these MMWR reports by the State. As is made clear in the 50 year history of the MMWR, these reports are not "peer-reviewed", but instead are go through a "clearance process" to ensure the report conforms to CDC policy. (Exh. 31) These are not independent studies; they are glorified house organs. As such, they are subject to political interference. Even Dr. McDonald had to admit that politics is affecting COVID-19 policy, although he thinks it only affects states like Florida. Yet, he would not acknowledge the political pressure placed on the Governor by teachers unions in this state. (Exh. 40)

4. <u>Randomized Control Trials (RCT)</u>

Dr. McDonald agreed with Dr. Bostom that RCTs are the gold standard for making recommendations, let alone mandates. (Exh. 26) The reason is clear, the major threat to the validity of observational and other non-RCT studies are "intractable biases" which are attempted to be controlled for after the fact, with limited success.

Since 1920, when Dr. William Kellogg published his post-mortem on the effectiveness of masks in preventing the spread of the Spanish Flu in California in 1918, (Exh. 35) until the CDC guidance of February 27, 2020, that "CDC does not currently recommend the use of facemask among the general public." (Exh. 15), public health officials knew that masks don't work to stop the spread of a virus. Thirteen randomized control trials of community masking for the prevention of viral infections, including SARS-CoV-2, published between 2008 and 2021 proved that masking does not work. (Exh. 27).

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Which lead to one of the more incredible assertions by Dr. McDonald that randomized control trials of masking children would be unethical. A rather remarkable statement given that children right now are being experimented upon with an unproven vaccine which could have unknown long-term consequences.[5] But more directly, Dr. McDonald could not cite and was not even aware of the regulations regarding the use of children as research subjects (Exh 32). Dr. McDonald also asserted quite forcefully that as a member of the Independent Review Board, no such RCT would be permitted on children, yet he failed to note that RIDOH's IRB is on one of many thousands of such boards across the country, and he could not even remember the names of the members of his IRB, or when they even last met. (Exh. 33)

In a rare moment of candidness, when asked if he may suffer from his own confirmation bias in wanting to believe masks work, he admitted he might. That is certainly borne out by the complete lack of interest he had in reviewing data and studies which went against his preference for masks. For example, his boss Dr. Nicole Alexander Scott, referenced in a letter to School Districts on August 18, 2021, that southern states without mask mandates for school, "that have recently opened schools without these mitigation measures have seen their children's hospitals capacities pushed to the limits." (Exh. 37) When asked about the dramatic decrease in hospitalizations in these states since schools have reopened (Florida is down 85% since schools opened[6]), the Doctor expressed no interest in researching these facts. He wanted to just focus on Rhode Island, seemingly disavowing the very prominent point his boss made in the letter. The new facts fail to fit his narrative.

The same was true of experiences in other countries like Sweden. When confronted with potential evidence that Sweden had no child deaths and very few hospitalizations from COVID-

5 And ignores that RCT on masking children is being done now in other countries (Exh. 34)
6 https://www.nytimes.com/interactive/2021/us/florida-covid-cases.html

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Attending public school in Rhode Island is a fundamental right. (See R.I. Constitution ARTICLE XII OF EDUCATION, Section 1. Duty of general assembly to promote schools and libraries. "The diffusion of knowledge, as well as of virtue among the people, being essential to the preservation of their rights and liberties, it shall be the duty of the general assembly to promote public schools and public libraries, and to adopt all means which it may deem necessary and proper to secure to the people the advantages and opportunities of education and public library services.") And the failure to send a child to school, or to engage in an approved home school program, is punishable by fines and jail. R.I. Gen. Laws § 16-19-1. As many parents testified or swore in the complaint, home schooling is not an option for them, so they must send their children to school with masks.

One should avoid the heated hyperbole which is endemic in the State's brief (Comparing COVID-19 to two world wars and Vietnam; a "ruthless" disease that has "wreaked havoc on the world"; "Restrictions began to ease. A glimpse of 'normal' reappeared. Then, Delta struck."; "There is no irreparable harm caused as a result of wearing a piece of cloth over one's face, but there is when someone gets sick and dies from the refusal by others to do so;" "Removing the mask requirements will put 130,000 Rhode Island children directly in harm's way. Children will become infected. Children will become gravely ill. Hospitalizations will soar and hospitals will become overburdened. **Children will die**. **This is not speculation**.") Certainly wearing a mask is not akin to forced sterilization, but it is hard to glean from the State's brief what the limiting principal is on government medical mandates (and wearing a mask is undoubtedly a medical mandate). To suggest that the legislature is the only check on the Governor's power is of little comfort; Carrie Buck was sterilized pursuant to a legislatively enacted statute.

Also in its brief, the State asks whether a Court should get involved in determining what constitutes an emergency under the Title 30 Chapter 5. It is one thing to declare an emergency as

seemed to blame State lawyers for why the mask rule was not promulgated through the school health regulations.

Perhaps the real reason is that it would never pass muster under normal rule making procedures. For example under § 42-35-2.6, the agency must give a concise explanatory statement of the reasons for creation of the rule, including the agency's reasons for not accepting arguments made in testimony and comments.

Under § 42-35-2.7, at least thirty (30) days before the filing of a final rule with the secretary of state, an agency shall publish the notice of the proposed rulemaking on the agency's website and with the secretary of state. The notice must also be published in a newspaper or newspapers having aggregate general circulation throughout the state. The notice must include, *inter alia*, "Where, when, and how a person may comment on the proposed rule and request a hearing, including the beginning and end dates of the public comment period." And "a citation to each scientific or statistical study, report, or analysis that served as a basis for the proposed rule, together with an indication of how the full text of the study, report, or analysis may be obtained."

Under § 42-35-2.8, the agency must provide for a 30 day public comment period, and must provide for an opportunity for a hearing "if a request is received by twenty-five (25) persons, or by a governmental agency, or by an association having not less than twenty-five (25) members within ten (10) days of a notice posted in accordance with subsection (a) of this section. A hearing must be open to the public, recorded, and held at least five (5) days before the end of the public comment period."

The proposed rule must also contain a "Regulatory Analysis" under § 42-35-2.9, which requires:

a. An analysis of the benefits and costs of a reasonable range of regulatory alternatives reflecting the scope of discretion provided by the statute authorizing the proposed rule;

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August 19, 2021. First, it was never "proclaimed" as defined by Black's Law Dictionary in the sense of "causing some state matters to be published or made generally known." There has been no public pronouncement by the Governor that he issued this proclamation; I doubt anyone knew of it prior to the State's filing of its memorandum.

As for the legal effect of declaring a "quarantine", and then not ordering a quarantine but ordering a mask mandate instead, it defies any logical reading of the statute. There is the phrase in R.I. Gen. Laws § 23-8-18, that the Governor "shall authorize and empower the state director of health to take any action and make and enforce any rules and regulations that may be deemed necessary to prevent the introduction and to restrict the spread of infectious diseases in the state." This phrase clearly relates back to the issuance of a quarantine, not any other act by the Department of Health. To the extent that the statute authorizes the Director of Health to issue any such "rules and regulations" that part of the statute has been superseded by the Administrative Procedures Act.

It appears the quarantine statute, § 23-8-18, was last amended in 1939. The APA was enacted in 1962 and took effect on January 1, 1964. R.I. Gen. Laws § 42-35-18. There can be no dispute that it applies to the Department of Health. R.I. Gen. Laws § 42-35-1.1. Thus, any rules or regulations promulgated by the Director of Health must be in accordance with its statutory authority and subject to the APA, including but the normal rule making procedures, the emergency rule making statute, and the ability of this Court to review such regulations.

Most importantly, when RIDOH issued its emergency rule, it never even cited this Proclamation of Quarantine. It seems a waste of time even to argue this point.

Turning now to the four elements for a preliminary injunction in this case:

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children are suffering because of the mask wearing in school: Struggle breathing; headaches; sore throats; face rashes; heat causing moist masks and itchiness; anxiety, mood swings, exhaustion, anger, withdrawal and depression; struggles with home schooling and the loss of in school experiences; speech impaired children failing to get adequate instruction by seeing their teacher speak, and being able to respond clearly; children with breathing difficulty, such as asthma (not a recognized disability which would exempt them from wearing a mask) having their respiration impaired; loss of interest in school; confusion over why only they have to wear masks in school and not anywhere else; abusive behaviors by teachers, principals, nurses and aides demanding strict adherence to mask wearing without breaks, "hurry up" face forward", silent lunches akin to Dickensian scenes out of Oliver Twist; inconsistent enforcement of the mask mandate where some staff is understanding and others militant enforcers; lack of learning time as teachers and staff focus time on constantly monitoring masking and social distancing; difficulty understanding teachers or peers when they talk.

There are many more parents, some afraid to come forward publicly to be subject to abuse which some of these parents have already been subjected to.

After the powerful scolding certain parents gave to the State's attorneys, we hope that the State has abandoned its cruel dismissal of the harm being suffered by the children in this case. The State tried to challenge the parents' evidence of harm, claiming they were not medical professionals; ironic, since so many of the studies cited by the State involve people who self-report the effects of wearing masks. Certainly not all children complain of wearing masks, and some may actually enjoy it, a potential future problem in itself that anyone can see coming, as some parents have complained their children are too attached to their masks, even wearing them at home and outside. But however grudgingly, Dr. McDonald had to admit there is at least some harm to kids, albeit not enough that he would consider significant.