

November 9, 2022

VIA EMAIL

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Re: Reply to the School District of Philadelphia's October 18, 2022 Response Letter

Dear Attorney Rauch:

We write again on behalf of our clients Ms. Priscilla Lo (“**Ms. Lo**”) and Ms. Ana Atach (“**Ms. Atach**”) regarding your October 18, 2022 response to our September 30, 2022 letter concerning the School District of Philadelphia’s (“**SDP**”) masking policy. We write to notify you that SDP’s policy deviates from the CDC’s recommendations in significant ways and to demand, once again, that SDP rescind its masking policy or amend it in accordance with Section III below. Isolation and subsequent masking should only be directed against the individual to whom a positive test is attributed.

I. THE MASK POLICY ARBITRARILY PREDICATES REACTIVATION OF MASK REQUIREMENTS ON VALUELESS INDICATORS

In your letter, you state the following:

In consultation with PDPH and following CDC data and indicators, as conditions may change, masking guidelines may change in response. This could happen as a result of a rise in community level, an outbreak in a classroom, school, or department, and/or upon return from extended breaks and holidays, which bring increased social gatherings that may heighten the risk of COVID exposure.

The policy’s mask requirements are determined by a function of a multitude of factors, and such factors should receive limited consideration in the determination. Tracking oscillations in community level infections is unnecessary for this age bracket, in light of the COVID-19 infection fatality rate (“**IFR**”) data derived from the biomedical literature. The IFR for 0-18 years of age was very low at the outset of the pandemic and it has decreased further as SARS-CoV-2 evolved

toward less virulent variants.

The IFR for children ages 11-18 as per a February 2022 systematic analysis of seroprevalence data was 0.0025% - 0.01%.¹ This means that of the children who do become infected with COVID-19, there is an infinitesimally small percent that may have a fatal outcome. This IFR renders COVID-19 less lethal than influenza for this age bracket, as the latter produces a mortality rate of 0.3% per CDC data.² Moreover, COVID-19 has mutated to a weaker form, and it is well established that the currently predominating Omicron variant³ is milder than previous variants.⁴ In addition, a large percentage of children have already been naturally infected⁵ and have natural immunity which is protective of severe disease and death.⁶ As such, the IFR is now even lower for the same age brackets. Considering the IFR for this virus is nearly zero for children at this juncture, maintaining a system wherein mask requirements are triggered as a function of oscillations in community level infection rates amongst people who have virtually nothing in common with children when it comes to SARS-CoV-2 infection is both illogical and scientifically unwarranted.

II. THE MASK GUIDELINES ARE SCIENTIFICALLY SPURIOUS AND THE DETRIMENTAL IMPACTS OF STUDENT MASKING OUTWEIGH ANY PERCEIVED BENEFIT

A. Masks Induce a Litany of Non-Specific Detrimental Effects

In your letter, you state,

CDC's K-12 guidance to support safe in-person learning also provided that school districts can choose to implement masking requirements to protect students with underlying medical conditions that put them at increased risk of COVID and to protect in-person

¹ COVID-19 Forecasting Team, *Variation in the COVID-19 infection–fatality ratio by age, time, and geography during the pre-vaccine era: a systematic analysis*, *The Lancet* (Feb. 24, 2022), [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)02867-1/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02867-1/fulltext).

² Centers for Disease Control and Prevention, National Center for Immunization and Respiratory Diseases (NCIRD), *Estimated Flu-Related Illnesses, Medical visits, Hospitalizations, and Deaths in the United States — 2019–2020 Flu Season* (Oct. 7, 2022), <https://www.cdc.gov/flu/about/burden/2019-2020.html>.

³ Centers for Disease Control and Prevention, *COVID Data Tracker – Variant Proportions*, <https://covid.cdc.gov/covid-data-tracker/#variant-proportions>. (Last accessed Oct. 26, 2022)

⁴ Blas J. Larrauri, *et al.*, *Omicron and vaccines: An analysis on the decline in COVID-19 mortality*, medRxiv (May 23, 2022), <https://www.medrxiv.org/content/10.1101/2022.05.20.22275396v1>.

⁵ National Cancer Institute at the National Institutes of Health, *COVID-19 SeroHub*, <https://covid19serohub.nih.gov/>. (Last updated Sep. 30, 2022)

⁶ Follman, Dean, *et al.*, *Anti-nucleocapsid antibodies following SARS-CoV-2 infection in the blinded phase of the mRNA-1273 Covid-19 vaccine efficacy clinical trial*, MedRxiv (Apr. 19, 2022), <https://www.medrxiv.org/content/10.1101/2022.04.18.22271936v1>; Leon, Tomas M. *et al.*, *COVID-19 Cases and Hospitalizations by COVID-19 Vaccination Status and Previous COVID-19 Diagnosis — California and New York, May–November 2021*, MMWR (Jan. 28, 2022), <https://www.cdc.gov/mmwr/volumes/71/wr/mm7104e1.htm#> (Table 1 Figure).

learning, at any COVID-19 community level. Masking guidelines attempt to balance various needs and considerations, including those of keeping all students in in-person learning and those of disabled and immunocompromised peers.

If the mission of the policy is truly to protect in-person learning, then far more consideration must be afforded to the ways in which SDP's recurrent masking precludes an optimal learning environment and harms children.

There are numerous deleterious impacts of mask wearing, including both psychological and physiological. The following is a non-exclusive list:

- A randomized cross-over study found that surgical and **FFP2/N95 masks like those recommended by SDP's Guidance**⁷ **significantly reduce pulmonary parameters both at rest and with exertion.** Additionally, these data suggest a myocardial (relating to the muscular tissue of the heart) compensation for the pulmonary limitation in the healthy volunteers. In patients with impaired myocardial function, this compensation may not be possible.⁸

Implication: Surgical and N95 mask wearing, as SDP recommends, makes it much more difficult to breathe properly which can induce a compensatory mechanism, forcing the heart to work harder, and this may not be possible for certain individuals. The school mask policy fails to consider that certain students may have latent pulmonary or cardiac issues that could be significantly aggravated via the current policy.

- Another study found that face masks induce various inimical psychological/cognitive development effects, noting, "Face masks **impair face recognition and face identification . . .** Face masks **impair verbal and non-verbal communication . . .** Face masks **block emotional signaling** between teacher and learner . . . Given these pros and cons, it is not clear whether face masks should play a major role in educational settings in times of the current viral pandemic."⁹

Implication: Importantly, this paper was written at the putative height of the pandemic, September 2020, and as such, its conclusion regarding the indeterminate role of face masks, if extrapolated to the present time of lower SARS-CoV-2 virulence, indicates that the evidence militates even more strongly against masking. Masking impairs proper learning.

⁷ The School District of Philadelphia, *Student Mask Guidance for 2022-2023 School Year* (Aug. 2022), <https://drive.google.com/file/d/1gP58zJgdNTEIKnS6vYNwrINOQhf2nQcu/view>.

⁸ Sven Fikenzer, et al., *Effects of surgical and FFP2/N95 face masks on cardiopulmonary exercise capacity*, *Clinical Research in Cardiology* (Jul. 6, 2020), <https://link.springer.com/article/10.1007/s00392-020-01704-y>.

⁹ Manfred Spitzer, *Masked education? The benefits and burdens of wearing face masks in schools during the current Corona pandemic*, *Trends Neurosci. Educ.* (Sep. 20, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7417296/>.

B. Masks, Even N95s, Do Not Protect Students from SARS-CoV-2 Infection

SDP's policy provides as follows:

Considerable evidence exists supporting the efficacy of a high quality, well-fitting mask to reduce the rate of COVID transmission. In our masking guidance, the District recommends use of high quality, well-fitting masks (such as N95, KN95, surgical mask, or double masking with a cloth mask covering a surgical mask), and does not recommend use of a cloth mask alone.

At the outset, the fact that the policy recommends against using a cloth mask, but does not altogether prohibit it, appears to countermand the supposed purpose of the entire policy, i.e., to prevent spread of infection, as the policy is satisfied via the wearing of an ineffective cloth mask.

Notwithstanding that significant policy defect, it must be underscored that “higher grade” coverings such as surgical and N95 masks **are also** entirely ineffective against SARS-CoV-2 infection. A group of researchers conducted a Cochrane systematic review – known to be the most rigorous study design possible – analyzing 67 randomized controlled trials regarding the efficacy of face masks.¹⁰ They concluded, as to surgical/medical masks versus no masks: “Compared with wearing no mask, wearing a mask may make little to no difference in how many people caught a flu-like illness (9 studies; 3507 people); and **probably makes no difference in how many people have flu confirmed** by a laboratory test.”¹¹ As to N95 masks, they concluded, “compared with wearing medical or surgical masks, wearing N95/P2 respirators probably makes **little to no difference in how many people have confirmed flu** (5 studies; 8407 people).”¹²

Why is this so significant? The most rigorous, highest quality studies have concluded that no clinically relevant benefit results from wearing any face mask in the context of respiratory viruses. The conclusions of all studies concerning influenza are clinically translatable for SARS-CoV-2 due to the nearly identical particle size of 0.10-0.12 microns. Thus, N95 masks, like the other types of masks, do not prevent SARS-CoV-2.

III. THE POLICY DEVIATES FROM CDC RECOMMENDATIONS AND SHOULD BE AMENDED SUCH THAT IT IS NARROWLY TAILORED TO REMEDY THE PROBLEM

Although SDP references its mask policy “exceptions,” the exceptions effectively swallow the rule since, from a practical perspective, one of our client’s daughters has been wearing a mask

¹⁰ Tom Jefferson, *et al.*, *Physical interventions to interrupt or reduce the spread of respiratory viruses*, Cochrane Database of Systematic Reviews (Nov. 20, 2020), <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub5/full?s=03>.

¹¹ *Id.*

¹² *Id.*

the majority of the school year thus far (in fact, absent two days, the entire August 29th-October 3rd period featured mask wearing). This is unacceptable.

Every health policy should be devised such that it balances both the benefits to the collective and the attendant countervailing detrimental impacts to same. In this instance, masking an entire class subsequent to detection of **possible** SARS-CoV-2 infection does not effectuate that goal.

Upon detection of a positive case, the student in question should be strongly encouraged to isolate/remain home and learn remotely until symptoms have subsided. The rest of the class can continue to proceed normally, as schools have done throughout the years with any other sickness, including dangerous versions of influenza. The individual in isolation (at home) should be provided the necessary resources to maintain a relatively equivalent educational experience. If another person in the class tests positive with symptoms, he or she should follow the same protocol described here (isolation until symptom amelioration). This way, deleterious impacts to the rest of the class are obviated.

Furthermore, it is notable and appurtenant to SDP that the College of New Jersey (“TCNJ”), a major educational institution in the Philadelphia metropolitan area, maintains just such a policy – namely that students who test positive for COVID-19 may be required to isolate at home without consequences for the rest of the class. TCNJ’s official case exposure policy is that students who test positive for COVID-19, and close contacts thereof (defined as within 6 feet for more than 15 minutes) should mask for 10 days. Further, the individual teacher maintains discretion to impose masking requirements, either following case exposures, or in general. SDP’s policy to mask an entire classroom not only abuses the close contact definition, it overrides the discretion of the teacher. If another major educational institution can successfully implement such a policy with a student population that, because of age, is more susceptible to COVID-19 than children, SDP has no excuse for not doing likewise. Thus, we strongly urge you to implement such a policy in lieu of the SDP’s existing recurrent masking policy.

Finally, the “CDC Operational Guidance for K-12 School to Support Safe in Person Learning” to which you refer in your letter, explains, under the “management of cases and exposures” section, **that the 10-day masking recommendation applies to the person who tested positive, not the entire class of students.**¹³ This is a salient distinction. The entire class should not be required to mask for 10 days following an exposure to a positive case.

Thus, we respectfully submit that, to the extent SDP relies on CDC recommendations, it should enter full compliance with its recommendations concerning management of cases/exposures. That guidance does not recommend masking of the entire class of students for 10-days. It only impacts the individual to whom the positive case is attributed.

¹³ Centers for Disease Control and Prevention, *Operational Guidance for K-12 Schools and Early Care and Education Programs to Support Safe In-Person Learning* (Oct. 5, 2022), <https://www.cdc.gov/coronavirus/2019-ncov/community/schools-childcare/k-12-childcare-guidance.html>.

IV. SDP SHOULD NOT PREDICATE THE 10-DAY MASK REACTIVATION ON A TEST KNOWN TO PRODUCE A HIGH FALSE POSITIVE RATE

A new peer reviewed study has determined that the polymerase-chain reaction (PCR) test commonly utilized to diagnose COVID-19 produces a false positive rate of 42%.¹⁴ This varies depending upon certain factors, but in practical terms, this implies that of every 10 students who test positive for COVID-19, about 4 of those 10 will be incorrectly diagnosed with COVID-19 (they do not have the virus). This is very significant and is yet another reason why imposing masking for an entire classroom after one student tests positive is both illogical and unscientific.

V. CONCLUSION

Ms. Lo and Ms. Atach hereby request that SDP immediately rescind or amend its masking policy to accord with Section III. The science on masks is clear, and the risk posed by this virus to the youth subpopulation is exceptionally low. We respectfully request a response by **November 21, 2022**.

Very truly yours,



Elizabeth A. Brehm, Esq.
Catherine Cline, Esq.
Thomas Stavola Jr., Esq.

cc: Ms. Priscilla Lo
Ms. Ana Atach

¹⁴ Sin Hang Lee, *Evidence-Based Evaluation of PCR Diagnostics for SARS-CoV-2 and the Omicron Variants by Gold Standard Sanger Sequencing*, Science, Public Health Policy, and the Law (Nov. 2022), https://www.publichealthpolicyjournal.com/files/ugd/adf864_545de4ffe6094ba3b71ca87bfd2f533a.pdf.