NO. 21-498

IN THE ARKANSAS SUPREME COURT

BENTONVILLE SCHOOL DISTRICT;
DR. DEBBIE JONES, Superintendent,
in her official capacity; ERIC WHITE,
School Board President, in his official capacity;
MATT BURGESS, Board Member, in his
official capacity; KELLY CARLSON,
Board Member, in his official capacity;
BRENT LEAS, Board Member, in his official capacity;
WILLIE COWGUR, Board member, in his
official capacity; JOE QUINN, Board Member,
in his official capacity; and JENNIFER
FADDIS; Board Member, in her official capacity — APPELLANTS

v.

MATT SITTON, MATTHEW BENNETT, and
ELIZABETH BENNETT — APPELLEES

On Appeal from The Circuit Court of Benton County
The Honorable Xollie Duncan, Presiding Judge

BRIEF OF *AMICI CURIAE* ARKANSAS CHAPTER OF
THE AMERICAN ACADEMY OF PEDIATRICS
AND THE AMERICAN ACADEMY OF PEDIATRICS
IN SUPPORT OF APPELLANTS

Submitted by:

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ARGUMENT[1]

The public interest is a paramount consideration in adjudicating a motion for an injunction. As the 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 in schools, like the Bentonville School District's mask policy at issue here, substantially reduce the risk of death and serious illness among Arkansas's school-age population and their families, without any meaningful harm to mask-wearers.

Over the past 20 months, *Amici* have worked ceaselessly to evaluate the dangers of and potential public health measures for reducing the deadly spread of COVID-19. The American Academy of Pediatrics ("AAP") has conducted a comprehensive review of the

[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.

medical literature to determine what public health measures can effectively reduce the risk that COVID-19 poses to America's children. This review and the experiences of the front-line pediatric practitioners who make up the Arkansas Chapter of the AAP ("AR AAP") and AAP's membership prove beyond any doubt that COVID-19 poses grave risks to children and that universal mask policies in schools significantly reduce the spread of COVID-19 and protect all children, particularly the medically vulnerable.

Recognizing these facts, the Bentonville School District implemented its mask policy (the "Policy") in order to safely conduct in-person classes despite COVID-19. This Court should find that the Policy protects students, promotes public health, and should not be enjoined.

I. COVID-19 is a serious childhood illness.

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 December 16, 2021, more than 7.3 million total child COVID-19 cases

[2] *See Children and COVID-19: State-Level Data Report*, *Summary of Findings*, AAP (data available as of Dec. 22, 2021), https://bit.ly/3HcjH0H.

have been reported in the United States, representing more than 17% of the total U.S. cases.[3] Arkansas alone has reported 96,425 child cases of COVID-19.[4] The prevalence of pediatric COVID-19 skyrocketed when the school year began, with more than 40% of all child cases nationwide and more than 35% in Arkansas since the beginning of the pandemic diagnosed in the four months between August 12 and December 16.[5] 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.[6]

As the rate of COVID-19 soared, so has the number of serious cases; just among the 24 states and 1 city that report child

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[3] *Id.*

[4] *Children and COVID-19: State Data Report* at Tbl. 3A, Children's Hosp. Ass'n & Am. Acad. of Pediatrics (Dec. 16, 2021), https://bit.ly/3mpMF56.

[5] *Id.* at Fig. 6; *Children and COVID-19: State Data Report* at Tbl. 3A, Children's Hosp. Ass'n & Am. Acad. of Pediatrics (Aug. 12, 2021) https://bit.ly/30Z70H6.

[6] *See Delta Variant: What We Know About the Science*, CDC (Aug. 26, 2021), https://bit.ly/3plIyc6.

hospitalizations, nearly 10,000 children were hospitalized due to COVID-19 between August 12 and December 16, more than 35% of the total child hospitalizations to date.[7] At least 328 children have died from COVID-19 since August 12 more than 46% of the total child deaths to date.[8]

As the hospitalization and mortality rates reflect, COVID-19 can cause severe symptoms and potentially fatal outcomes even in children. Among other things, COVID-19 infections can produce multisystem inflammatory syndrome (MIS-C), which involves clinically severe levels of fever, inflammation, and dysfunction or shock in multiple organ systems.[9] Several studies have shown that, even when the initial symptoms are mild, COVID-19 can lead to long-term symptoms in

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

[8] *Id.* at Appx. Tbl. 2C.

[9] *See Multisystem Inflammatory Syndrome in Children (MIS-C) Associated with Coronavirus Disease 19 (COVID-19)*, CDC (May 14, 2020), https://bit.ly/3plLs0p; *Multisystem Inflammatory Syndrome in Children (MIS-C) Interim Guidance*, AAP (last updated Nov. 15, 2021), https://bit.ly/3yVXPUs.

children and adolescents.[10] Potential long-term symptoms include 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.[11] They can also include neurodevelopmental impairment, including significant acute injuries such as stroke or encephalitis and subtle but persistent injury in cognitive, language, academic, motor, mood, and behavioral domains; cognitive fogginess or

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[10] *See, e.g.*, Danilo Buonsenso, et al., *Preliminary evidence on long COVID in children*, 110 Acta Paediatrica 2208 (2021), https://bit.ly/3H708qy (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/3JgyLMD (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).

[11] *Post-COVID-19 Conditions in Children and Adolescents*, AAP (last updated Dec. 17, 2021), https://bit.ly/3qocX8W.

fatigue; physical fatigue; and mental or behavioral health impacts such as stress and adjustment disorders.[12]

The uncontrolled spread of COVID-19 poses an even greater risk for children with special health needs. Children with certain underlying conditions who contract COVID-19 are more likely to experience severe acute biological effects and to require admission to the hospital or intensive care unit.[13] This includes children with, for example, Down's syndrome, lung conditions, heart conditions, and weakened immune systems.[14]

Moreover, the uncontrolled spread of COVID-19 poses a massive risk to children and adults who have other medical needs. Hospital ICU capacity is strained beyond capacity in much of the country, as it was earlier in the pandemic. As of December 16, 2021, more than 95% of all

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[12] *Id.*

[13] *Caring for Children and Youth with Special Health Needs During the COVID-19 Pandemic*, AAP (last updated Dec. 1, 2021), https://bit.ly/32fzKvV.

[14] *People with Certain Medical Conditions*, CDC, (last updated Dec. 14, 2021), https://bit.ly/3H65oKX.

ICU beds in Benton County were in use.[15] Due to the strain on medical resources, this will 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 acute and chronic illnesses."[16] 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.

II. Based on extensive research, the AAP strongly recommends that schools maintain universal mask policies as an infection control measure.

A. Overview of AAP's Research into School Safety During the Pandemic

One of the AAP's chief functions is to provide evidence-based guidance to America's pediatric professionals and public health officials, thereby helping its members and policymakers improve the health of all

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[15] *See* Univ. of Minn., COVID-19 Hospitalization Tracking Project (data available as of Dec. 22, 2021), https://bit.ly/3sqJCNX.

[16] *See, e.g.*, Amber K. Sabbatini, et al., *Excess Mortality Among Patients Hospitalized During the COVID-19 Pandemic*, 16 J. Hospital Med. 596 (2021), https://bit.ly/3Hs5EEU.

children. 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, as the COVID-19 pandemic began to sweep across the country, 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 providing clinical care to patients with

[17] *COVID-19 Testing Guidance*, AAP (last updated Nov. 17, 2021), https://bit.ly/3svByeW.

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 supporting the emotional and behavioral health needs of children, adolescents, and families during the COVID-19 pandemic;[21] and—most relevant to this case—on the use of face masks as an infection control measure;[22] on operating safe schools during the COVID-19 pandemic that foster the overall health of children, adolescents, educators, staff, and communities[23]; and on caring for

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[18] *COVID-19 Interim Guidance*, AAP (last updated Dec. 9, 2021), https://bit.ly/3ejLrE5.

[19] *Post-COVID-19 Conditions in Children and Adolescents*, *supra* n. 11.

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

[21] *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/3JdxN3s.

[22] *Face Masks*, AAP (last updated Nov. 15, 2021), https://bit.ly/3pw0XDr.

[23] *COVID-19 Guidance for Safe Schools*, AAP (last updated Nov. 2, 2021), https://bit.ly/3EnkNF4.

youth with special health needs during the COVID-19 pandemic.[24] The AAP has repeatedly reviewed and updated these Interim Guidance Statements to ensure that they reflect the best medical understanding and current scientific evidence regarding COVID-19, including its transmission and health effects. 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 AR AAP recognize and are seriously concerned about the impact on children of being away from in-person learning. This 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 our review of the medical literature, along with AAP's members' collective expertise as pediatricians and researchers, the AAP has concluded that "all local, state, and federal policy considerations for school COVID-19 plans should start with a goal of keeping students safe, physically present,

[24] *Caring for Children and Youth with Special Health Needs*, *supra* n. 13.

and emotionally supported in school."[25] "[A]t 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."[26] Among the prevention measures we recommend (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)**."[27]

Although AAP has modified and loosened some of its 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

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[25] *COVID-19 Guidance for Safe Schools*, *supra* n. 23.

[26] *Id.* (emphasis added).

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

control measure. This conclusion has been consistently reinforced by all relevant data and credible research regarding the transmission and health risks of COVID-19 and the effect of wearing masks on children's education, health, and development. Just last month, after reviewing all scientific evidence to date on the transmission and prevention of COVID-19 during the current school year, AAP reaffirmed its recommendation of universal masking.[28]

B. Universal Masking Policies Are Highly Effective at Reducing Transmission of COVID

While there are several reasons for the AAP's (and the CDC's) recommendation of universal masking in school,[29] the most important is that the research literature has confirmed that masks are both effective and safe. Masks are primarily intended to "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 (estimated to account for more than 50%

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[28] *Id.*

[29] *See id.* (identifying eight bases for AAP's mask recommendation).

of SARS-CoV-2 transmissions)."[30] Cloth masks "block most large droplets (i.e., 20-30 microns and larger)" and "also block the exhalation of fine droplets and particles (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 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]

This difference between masks' ability to block *exhalation* and *inhalation* of viral particles explains why it is so important for mask policies to be universal. Masks' primary benefit is as "source control," preventing infected carriers from spreading viral particles widely. As the CDC has explained, "masks are not designed to reduce the particles that the wearer will inhale . . . . The purpose of wearing masks is to

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[30] *Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2*, CDC (last updated Dec. 6, 2021), https://bit.ly/3utvxOA (citations omitted).

[31] *Id.*

[32] *Id.*

[33] *Id.*

help reduce the spread of COVID-19 by reducing the spread of the virus through respiratory droplets from asymptomatic individuals."[34] 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 individuals.

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

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

[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., *Impact of Community Masking on COVID-19: A Cluster-Randomized Trial in Bangladesh*, Science (Dec. 2, 2021), https://bit.ly/3HkEhfp; 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),

have shown that masking and similar mitigation measures can limit transmission in schools.[36] As the ABC Science Collaborative, a 13-state

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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 Affs. 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 Springfield, 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; 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. 1372 (2021), https://bit.ly/3uwVdKh; Samantha E. Budzyn, et al., *Pediatric*

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."[37]

Indeed, masking is so effective that several courts have found it to be *required* in schools under the federal Americans with Disabilities Act and Rehabilitation Act.[38] As one explained, "the evidence shows that the

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COVID-19 Cases in Counties With and Without School Mask Requirements—United States, July 1–September 4, 2021, 70 Morbidity & Mortality Weekly Rep. 1377 (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. 1374 (2021), https://bit.ly/3ipDVtD; *see generally Science Brief: Transmission of SARS-CoV-2 in K-12 Schools and Early Care and Education Programs—Updated*, CDC (Dec. 17, 2021), https://bit.ly/3vsdF7e.

[37] ABC Science Collaborative, *The ABCs of North Carolina's Plan*, https://bit.ly/3jk6NnK (last visited Dec. 22, 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.

[38] *See, e.g.*, *R.K. v. Lee*, No. 21-cv-725, 2021 WL 4942871 (M.D. Tenn. Oct. 22, 2021) (granting preliminary injunction); *S.B. v. Lee*, No. 21-cv-317, 2021 WL 4755619 (E.D. Tenn. Oct. 12, 2021) (same); *Arc of Iowa v. Reynolds*, No. 21-cv-264, 2021 WL 4737902 (S.D. Iowa Oct. 8. 2021) (same); *Disability Rights S.C. v. McMaster*, No. 21-cv-2728, 2021 WL 4444841 (D.S.C. Sept. 28, 2021) (same); *G.S. v. Lee*, No. 21-cv-2552,

absence of a mask mandate is fueling infections . . . with frightening celerity."[39] There is "only one conclusion: . . . among the unvaccinated, [the Delta variant] is untamable without community-wide masking inside schools."[40]

III. The Balance of Equities Weighs Heavily Against the Temporary Restraining Order

Neither the circuit court nor Plaintiffs dispute any of the above facts. It is undisputed in this case that the School District's policy advances public health without harming children's health or well-being. Nevertheless, Plaintiffs argue that the alleged harm to their "liberty interest in the care and custody of their children under the Arkansas Constitution," Appellees' Br. at 35, outweighs the harm to public health wrought by enjoining the policy.

While parental interests in the care and upbringing of one's children are undoubtedly significant, Plaintiffs misunderstand the extent of those interests. Parental rights do not "include liberty to

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2021 WL 4268285 (W.D. Tenn. Sept. 17, 2021) (granting temporary restraining order).

[39] *S.B. v. Lee*, 2021 WL 4755619, at *16.

[40] *Id.* at *17.

expose the community or the child to communicable disease or the latter to ill health or death." *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944). "Parents may be free to become martyrs themselves. But it does not follow they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." *Id.* at 170; *cf. Emp. Div. v. Smith*, 494 U.S. 872, 888-89 (1990) (explaining that "[t]he First Amendment's protection of religious liberty does not require" "religious exemptions from . . . compulsory vaccination laws").

While parents have a right to make many decisions concerning the education of their children, they do not have the right to demand access to schools in a way that places the lives and health of *other children* (as well as teachers, school staff, and the broader community) at risk. There is no parental right to expose other children to virulent communicable diseases. Given the undisputed and indisputable fact that the School District's policy advances public health and serves the public interest, whatever liberty interest Plaintiffs possess in this context cannot overcome the harm to the public.

CONCLUSION

For these reasons, AR AAP and AAP believe that the Bentonville School District's mask policy is in the public interest and the Temporary Restraining Order should be vacated.

Respectfully submitted:

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CERTIFICATE OF SERVICE

I certify that on December 28, 2021, I filed this brief using the Court's eFlex filing system, which will serve a copy on all counsel of record.

/s/ Laura E. Cox
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CERTIFICATE OF COMPLIANCE

I certify that this brief complies with Administrative Order No. 19's requirements concerning confidential information; complies with Administrative Order 21, Section 9, which states that briefs shall not contain hyperlinks to external papers or websites; and conforms to the word-count limitations in Rule 4-2(d). The argument and conclusion sections of this brief contain 3,492 words.

/s/ Laura E. Cox
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