

[1]

- There have been ZERO Rhode Island pediatric (newborn to 17 years old) covid-19 deaths in 18-months (**confirmed by RIDOH spokesman, Joseph Wendelken; see following p.3**)
- In stark contrast, there have been ~2300 covid-19 deaths, ~80% of total covid-19 deaths in RI, among those ≥ 70 years old  
<https://docs.google.com/spreadsheets/d/1c2QrNMz8pIbYEKzMJL7Uh2dtThOJa2j1sSMwiDo5Gz4/edit#gid=31350783>
- There have also been ~1600 covid-19 deaths, ~60% of total covid-19 deaths in RI, among those ≥ 80 years old. This means those 60% of covid-19 deaths are occurring at or above the RI life expectancy of 79.9 years old, typically among elderly persons with profound comorbidity  
<https://docs.google.com/spreadsheets/d/1c2QrNMz8pIbYEKzMJL7Uh2dtThOJa2j1sSMwiDo5Gz4/edit#gid=31350783>
- Indeed, Long-Term Care Home and Elder Assisted Living Facility Residents, combined, account for 60% of covid-19 deaths in Rhode Island  
<https://docs.google.com/spreadsheets/d/1c2QrNMz8pIbYEKzMJL7Uh2dtThOJa2j1sSMwiDo5Gz4/edit#gid=31350783>
- Moreover, schoolchildren are a TRIVIAL to non-existent source of infection to these elderly populations, or adult populations, in general. A study of 90,000 North Carolina students and staff during in-person teaching in the fall of 2020 (published in the flagship journal “Pediatrics”), revealed only 4% of covid-19 transmission took place in schools, vs. 96% in the community, and “**No instances of child-to-adult transmission of SARS-CoV-2 were reported within schools.**”  
<https://pediatrics.aappublications.org/content/pediatrics/early/2021/01/06/peds.2020-048090.full.pdf>
- I will briefly highlight additional more specific findings about pediatric covid-19 mortality, the consistent failure of masking to prevent respiratory viral infections in the community, and the harms caused to children by such futile masking
- The data I just mentioned, and more which I will share, are willfully ignored by our national, state, and local public health officials when they issue their anti-scientific, immoral edicts about masking our children.
- The warped, dishonest, fearmongering discussion of covid-19 in children by such public health officials, and the “mandates” it begets, are UNCONSCIONABLE and must be challenged by parents in the interest of YOUR otherwise defenseless children
- PARENTS, here are more critical data you need to be aware of, in summary:

### A comparison of recent U.S. pediatric flu (seasonal/ 1 yr. pandemic) and covid-19 deaths

Disease/Period	Age range (years)	Deaths
<i>Covid-19, 2020*</i>	<b>0-17</b>	<b>198/129*</b>
<i>Covid-19, 2021*</i>	<b>0-17</b>	<b>151/98*</b>
<b>Pandemic H1N1 Flu, 2009-10</b>	<b>0-17</b>	<b>1220</b>
Seasonal Flu, 2012-13	<b>0-17</b>	<b>1161</b>
Seasonal Flu, 2014-15	<b>0-17</b>	<b>803</b>
Seasonal Flu, 2017-18	<b>0-17</b>	<b>643</b>
Seasonal Flu, 2018-19	<b>0-17</b>	<b>477</b>
Seasonal Flu, 2019-20	<b>0-17</b>	<b>434</b>
Seasonal Flu, 2010-11	<b>0-17</b>	<b>352</b>

Through 8/4/21; *\*Adjusted for CDC 35% over counting of covid-19 pediatric deaths by death certificate review* [https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e2.htm?s\\_cid=mm7014e2\\_x](https://www.cdc.gov/mmwr/volumes/70/wr/mm7014e2.htm?s_cid=mm7014e2_x)

TABLE 1. Distribution of death certificates with COVID-19 diagnosis\* across five mutually exclusive categories defined by presence and classification of co-occurring diagnoses, by demographic characteristics, setting of death, and manner of death characteristics — National Center for Health Statistics, United States, January–December 2020

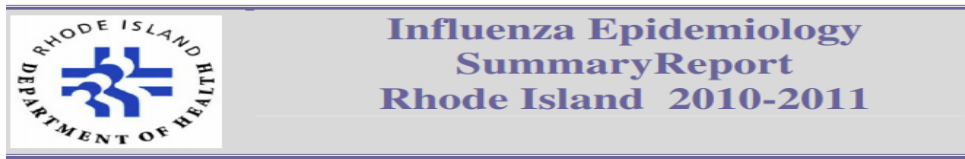
Characteristic	No. of death certificates	No. (row %)				
		COVID-19 only	COVID-19 and ≥1 chain-of-event condition only	COVID-19 and ≥1 significant contributing condition only	COVID-19 and ≥1 chain-of-event and ≥1 significant contributing condition	COVID-19 with no plausible chain-of-event or significant contributing condition
Age group, yrs <18	182	8 (4.4)	70 (38.5)	18 (9.9)	22 (12.1)	64 (35.2)

Covid 19 pediatric deaths: [https://www.cdc.gov/nchs/nvss/vsrr/covid\\_weekly/index.htm](https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm) ;:

Past seasonal flu deaths: <https://www.cdc.gov/flu/about/burden/past-seasons.html>

<https://health.ri.gov/publications/surveillance/2011/Influenza.pdf>

During one 12-month flu season, “There were three (3) influenza-associated pediatric death cases investigated and confirmed during the 2009-2010 influenza pandemic” p. 14.



Rhode Island Department of Health (HEALTH)  
Division of Infectious Disease & Epidemiology

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During the past 18-months, there have been ZERO pediatric covid-19 deaths (confirmed by RIDOH spokesman, Joseph Wendelken)

Table 1. Deaths involving coronavirus disease 2019 (COVID-19), pneumonia, and influenza reported to NCHS by time-period, jurisdiction of occurrence, sex and age-group.								Data as of:
								8/4/2021
State	Sex	Age Group						Year
Rhode Island	All	All						All
Year in which death occurred	Sex	Age Group	All Deaths involving COVID-19 [1]	Deaths from All Causes	Deaths involving Pneumonia [2]	Deaths involving COVID-19 and Pneumonia [2]	All Deaths involving Influenza [3]	Deaths involving Pneumonia, Influenza, or COVID-19 [4]
2020	All Sexes	0-17 years		87		0	0	
Year in which death occurred	Sex	Age Group	All Deaths involving COVID-19 [1]	Deaths from All Causes	Deaths involving Pneumonia [2]	Deaths involving COVID-19 and Pneumonia [2]	All Deaths involving Influenza [3]	Deaths involving Pneumonia, Influenza, or COVID-19 [4]
2021	All Sexes	0-17 years	0	39	0	0	0	0

Open Schools, C19, & Child & Teacher Morbidity in Sweden

<https://twitter.com/andrewbostom/status/1347192599342424066>

**New Engl J Med Research Letter.** <https://www.nejm.org/doi/full/10.1056/NEJMc2026670?query=TOC>  
**“Open Schools, C19, & Child & Teacher Morbidity in Sweden”:** ZERO/~2million 1-16yo children died despite open schools/preschools; ZERO excess risk of serious C19 morbidity (ICU hosp) among teachers vs. other professions

“Social distancing was encouraged in Sweden, **but wearing face masks was not**”

“The number of deaths from any cause among the 1,951,905 children in Sweden (as of December 31, 2019) who were 1 to 16 years of age was 65 during the pre-Covid-19 period of November 2019 through February 2020 and 69 during 4 months of exposure to Covid-19 (March through June 2020) From March through June 2020, a total of 15 children with Covid-19 (including those with MIS-C) were admitted to an ICU (0.77 per 100,000 children in this age group) 4 of whom were 1 to 6 years of age (0.54 per 100,000) and 11 of whom were 7 to 16 years of age (0.90 per 100,000). Four of the children had an underlying chronic coexisting condition (cancer in 2, chronic kidney disease in 1, and hematologic disease in 1). **No child with Covid-19 died.**”

“Data from the Public Health Agency of Sweden (published report and personal communication) showed that **fewer than 10 preschool teachers and 20 schoolteachers in Sweden received intensive care for Covid-19 up until June 30, 2020 (20 per 103,596 schoolteachers, which is equal to 19 per 100,000). As compared with other occupations (excluding health care workers), this corresponded to sex- and age-adjusted relative risks of 1.10 (95% confidence interval [CI], 0.49 to 2.49) among preschool teachers and 0.43 (95% CI, 0.28 to 0.68) among schoolteachers**”

MD and Johns Hopkins epidemiologist Dr. Marty Makary wrote in the *Wall Street Journal* July 19, 2021  
[https://archive.fo/2021.07.20-120018/https://www.wsj.com/articles/cdc-covid-19-coronavirus-vaccine-side-effects-hospitalization-kids-11626706868?mod=trending\\_now\\_opn\\_pos1](https://archive.fo/2021.07.20-120018/https://www.wsj.com/articles/cdc-covid-19-coronavirus-vaccine-side-effects-hospitalization-kids-11626706868?mod=trending_now_opn_pos1):

*“My research team at Johns Hopkins worked with the nonprofit FAIR Health to analyze approximately 48,000 children under 18 diagnosed with Covid in health-insurance data from April to August 2020. Our report found a mortality rate of **ZERO** among children without a pre-existing medical condition such as leukemia.”*

Ignores RSV being well above normal in FL, contains the defining unavoidable truth about pediatric C19

<https://www.dailymail.co.uk/news/article-9874115/Children-COVID-cases-overwhelm-Florida-hospitals-DeSantis-faces-lawsuits-barring-masks.html>

“Children dying from COVID-19 is still extremely rare – even with the Delta variant surge. Nemours Children's Hospital in Orlando saw its first hospital death of the pandemic when a boy with pre-existing lung disease died there a few weeks ago, the hospital's Division Chief of Infectious Disease”

(RSV= Respiratory Syncytial Virus)

### Weeks 27-28 (July 4–17, 2021) RSV Activity Summary:

In weeks 27-28, RSV activity in children <5 years old decreased. Levels were above those seen at this time in past years.

**Currently, one of Florida's five regions are in RSV season.**

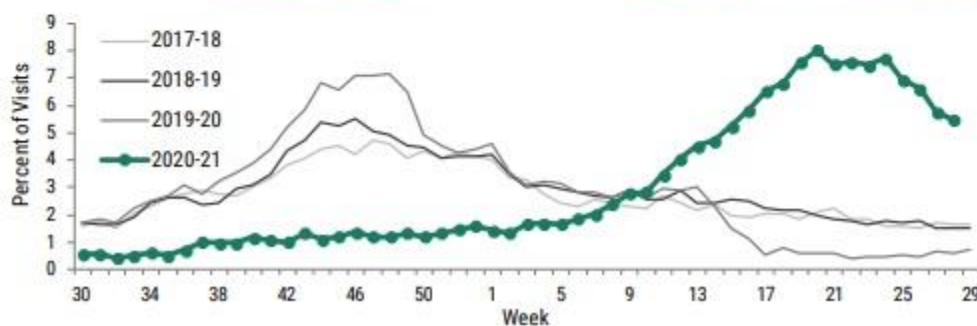
Florida's RSV season is longer than the rest of the nation and has distinct regional patterns. The RSV seasons shown here are based on activity thresholds provided by the Centers for Disease Control and Prevention.

The determination of unique seasonal and geographic trends of RSV activity in Florida has important implications for prescribing patterns for initiating prophylaxis to children at high-risk for RSV infection complications. The American Academy of Pediatrics recommends preapproval for prophylactic treatment be made based on state surveillance data.



▲ The figure above shows Florida's RSV regional season breakdown. Regions that are currently in RSV season are marked with pink stars.

In weeks 27-28, the percent of emergency department and urgent care center visits for RSV among children <5 years decreased. RSV activity in children <5 years was notably above levels observed at this time in previous years.



◀ The figure to the left shows the percent of emergency department and urgent care center visits with discharge diagnoses that include respiratory syncytial virus (RSV) or RSV-associated illness among children <5 years<sup>1</sup>, as reported in ESSENCE-FL, week 30, 2017 to week 28, 2021.

<sup>1</sup>The overall trend displayed in this figure has been validated through review of hospital discharge data collected by the Agency for Health Care Administration.



<https://twitter.com/andrewbostom/status/1374373277972402195>

1/ From 2008-2020, 12 NEGATIVE randomized controlled trials on masking, conducted among ~18K persons, worldwide, have ESTABLISHED that masking does NOT reduce community respiratory virus transmission  
 2/ 10 NEGATIVE studies, focusing primarily on influenza, 2008 to 2016, were “meta-analyzed” (their data “pooled”), here [https://wwwnc.cdc.gov/eid/article/26/5/19-0994\\_article](https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article)

Appendix Table 10. Summary of studies included in the review of face masks

Study	Study design	Study period	Population and setting	Intervention	Outcome and finding
Aiello AE, 2010 (18)	Cluster-RCT University residence hall level	Nov 2006–Mar 2007	1437 university hall residents recruited, 1297 residents were further analyzed (Michigan, USA)	Hand sanitizer and face mask and education; face mask and education; control received the same education because all intervention groups but no additional interventions were given	Significant reduction in ILI in the latter half of the study period in mask and hand hygiene group compared with the control but no significant reduction in ILI in mask and hand group or mask-only group or control
Aiello AE, 2012(19)	Cluster-RCT University residence hall level	Nov 2007–Mar 2008	1,178 university hall residents recruited from 5 halls, 1,111 residents were further analyzed (Michigan, USA)	Hand sanitizer and face mask and education; face mask and education; control received the same education because all intervention groups but no additional interventions were given	No significant reduction in rates of laboratory-confirmed influenza in mask and hand group or mask-only group or control group
Barasheed O, 2014 (30)	Cluster-RCT Hajj pilgrimage	Nov 2011–Nov 2011	164 Australian pilgrims recruited from 2011 Hajj (Saudi Arabia)	Face mask; control were not provided with face masks during the study period	No significant difference in laboratory-confirmed influenza between control and mask-only group but protective effect was observed against syndromic ILI in mask-only group compared with the control (31% vs. 53%, $p = 0.04$ )
Cowling BJ, 2008 (12)	Cluster-RCT Household level	Feb 2007–Sep 2007	198 laboratory-confirmed influenza cases and their household contacts recruited from outpatient clinics (Hong Kong, China)	Hand sanitizer and education; face mask and education; control received same education because all intervention groups but no additional interventions were given	No significant reduction in the secondary influenza attack rate in control, mask or hand group
Cowling BJ, 2009 (11)	Cluster-RCT Household level	Jan 2008–Sep 2008	407 laboratory-confirmed influenza cases recruited from outpatient clinics, 259 households which included 794 household contacts were further analyzed (Hong Kong, China)	Hand sanitizer and education; hand sanitizer, face mask and education; control received same education because all intervention groups but no additional interventions were given	No significant difference in rates of laboratory-confirmed influenza in control, hand-only or mask and hand group
Larson EL, 2010 (13)	Cluster-RCT Household level	Nov 2006–Jul 2008	617 households recruited, 509 households were further analyzed (New York, NY, USA)	Hand sanitizer and education; hand sanitizer, face mask and education; control received same education because all intervention groups but no additional interventions were given	No significant reduction in rates of laboratory-confirmed influenza in control, hand-only, mask or hand group
MacIntyre CR, 2009 (28)	Cluster-RCT Household level	Aug 2006–Oct 2006 and Jun 2007–Oct 2007	145 laboratory-confirmed influenza cases and their adult household contacts recruited from a pediatric health service (Sydney, Australia)	Surgical mask; P2 mask; control were not provided with any masks during the study period	No significant difference in rate of laboratory confirmed influenza in control, face mask-only or P2 mask-only group
MacIntyre CR, 2016 (29)	Cluster-RCT Household level	Nov 2013–Jan 2014	245 ILI cases and 597 household contacts recruited from fever clinics (Beijing, China)	Face mask; control were not provided with any masks during the study period	Clinical respiratory illness, ILI and laboratory-confirmed viral infections were lower in the mask-only group compared with the control group, but results were not statistically significant
Simmerman JM, 2011) (15)	Cluster-RCT Household level	Apr 2008–Aug 2009	465 households recruited from a public pediatric hospital, 442 households were further analyzed (Bangkok, Thailand)	Handwashing; handwashing and face mask; control received education that was unrelated to personal protective measures and no additional interventions were given	No significant reduction in rate of secondary influenza infection in control, hand-only, mask or hand group
Suess (2012) (16)	Cluster-RCT Household level	Nov 2009–Jan 2010 and Jan 2011–Apr 2011	84 laboratory-confirmed influenza cases and 218 household contacts recruited by general practitioners or pediatricians (Berlin, Germany)	Hand sanitizer and face mask; face mask; control were not provided with any face masks nor hand-rub during the study period	No significant difference in rate of laboratory confirmed influenza in control, mask-only, mask or hand group

Appendix Table 11. GRADE quality assessment for face masks

Quality assessment							No. of patients		Effect		Quality	Importance
No. studies	Design	Risk for bias	Inconsistency	Indirectness	Imprecision	Other considerations	Face mask with or without hand hygiene versus control	Risk ratio (95% CI)				
10	Randomized trial <sup>1,2</sup>	No serious risk for bias <sup>3-7</sup>	Serious inconsistency <sup>8</sup>	Serious indirectness <sup>9</sup>	No serious imprecision <sup>10</sup>	None	156/3495	161/3052	0.92 (0.75–1.12)	Low	Important	

<sup>1</sup>All studies were randomized trials.

<sup>2</sup>All studies were cluster-RCTs: two studies at university residence level, seven studies at household level and one study randomized by sleeping tent during Hajj pilgrim.

<sup>3</sup>Eight studies reported blinding of study staffs including clinical staff, laboratory staff or recruiting physicians. Subjects of all studies were not blinded.

<sup>4</sup>Three studies used block randomization, six studies used computer program to generate the randomization order and one study used ticket-picking for selection.

<sup>5</sup>Allocation concealment was adequate in all trials. Eight studies described the baseline characteristics of participants in all intervention groups. No serious baseline imbalance was observed.

<sup>6</sup>All study reported the number of loss to follow-up in all intervention groups. No serious differential loss to follow-up occurred for whole clusters or persons in a cluster.

<sup>7</sup>Seven studies adjusted for clustering in their analysis.

<sup>8</sup>Moderate heterogeneity was observed in the pooled analysis.

<sup>9</sup>Studies evaluating the combined intervention were included.

<sup>10</sup>Total sample size is insufficient in the pooled analysis.

[7]

3/ Independently validating these pooled findings are the results from a single large randomized controlled trial of masking among [another cohort](#) of Hajj pilgrims whose enrollment (n=6338) equaled the sum enrollment of all the 10 studies in the May, 2020 [“meta-analysis.”](#)

4/ Published online in mid-October, 2020, this “cluster randomized” (i.e., by tent) controlled trial [confirmed](#) mask usage did **not** reduce the incidence of clinically defined, or laboratory-confirmed respiratory viral infections, primarily influenza and/or rhinovirus.

5/ Indeed, there was a suggestion masking [increased](#) laboratory-confirmed infections by 40%, although this trend was not “statistically significant.” Ref:

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7553311/pdf/pone.0240287.pdf>

**Table 3. Primary and subgroup analyses by intention to treat.**

	Intervention n/N (%)	Control n/N (%)	OR (95% CI)
Clinical respiratory infection	354/3,199 (11.1)	322/3,139 (10.3)	1.1 (0.9–1.4)
Laboratory-confirmed viral respiratory infection	96/218 (44)	60/161 (37.3)	1.4 (0.9–2.1)
Influenza vaccinated	44/106 (41.5)	37/102 (36.3)	1.3 (0.7–2.2)

6/ Finally, Danish investigators [published](#) the results during mid-November, 2020 of a randomized, controlled study conducted in 4862 persons which found that masking did not reduce SARS-CoV-2 (covid-19) infection rates to a statistically significant, or clinically relevant extent.

7/ Covid-19 infections (detected by laboratory testing or hospital diagnosis) occurred among 1.8% of those assigned masks, versus 2.1% in control participants. <https://www.acpjournals.org/doi/full/10.7326/M20-6817>

8/ Moreover, a secondary analysis including only participants who reported wearing face masks “exactly as instructed,” [revealed](#) a further narrowing of this non-significant, clinically meaningless infection rate “difference” to 0.1%, i.e., 2.0% in mask wearers versus 2.1% in controls.

“Between 2008 and 2020, twelve consecutive negative randomized controlled trials of community masking, conducted among ~18K persons ([here](#); [here](#); [here](#)), worldwide, established that this intervention does not reduce community respiratory virus transmission, including covid-19 transmission.”

<https://twitter.com/andrewbostom/status/1395810382745374724>

Unmask the children: ***Large Brown U study show mask mandates are NOT associated with reduced infection among students or staff “adjusted for community rates and other demographics”*** <https://doi.org/10.1101/2021.05.19.21257467>

<https://twitter.com/andrewbostom/status/1395810382745374724>;

<https://www.medrxiv.org/content/10.1101/2021.05.19.21257467v1>

“In terms of raw means, staff rates are higher in districts which do not have mask mandates for staff or students, although these differences are small. The differences are not significant in analyses which adjust for community rates. In all analyses, rates are similar for staff in districts with mask mandates for both students and staff versus those with staff-only mandates”

“we find that the differences for staff are not significant once we adjust for community rates and other demographics”

“we do not see a correlation between mask mandates and COVID-19 rates among students in either adjusted or unadjusted analyses...differences are not significant in analyses which adjust for community rates.”

#### **Florida methods:**

Florida data used for our analyses are publicly available online. COVID-19 case data are reported separately for students, teachers, and staff at the school-level each week and are available from the Florida Department of Health (<https://floridahealthcovid19.gov/>). Enrollment data are available at the school level from the Florida Department of Education (<https://edstats.fldoe.org>). These data are collected twice per school year, to measure fall and spring enrollment, and include the number of students who are enrolled in in-person, hybrid, and remote instruction. In-person teacher counts are from the school-level 2018-2019 NCES CCD, and the non-teacher staff counts are estimated from district-level counts. Mitigation data come from systematic review of school district reopening plans performed by the COVID-19 School Dashboard team. Reviewers searched district plans to determine if each district reported using any of 13 different mitigation strategies across several areas. This included screening and testing, social distancing requirements, masking and ventilation requirements.

Reviewers then coded each school district as either using the given mitigation strategy or not (yes/no). In cases where school district plans did not include mitigation plans, reviewers emailed and made phone calls to school districts to clarify what mitigation practices were required.



## PROBLEMS CREATED BY MASK WEARING

John Hopkins MD Epidemiologist Makary WSJ summary, with additional references

<https://www.wsj.com/articles/masks-children-parenting-schools-mandates-covid-19-coronavirus-pandemic-biden-administration-cdc-11628432716>

- Those who have myopia/ near sightedness can have difficulty seeing because the mask fogs their glasses. (This has long been a problem for medical students in the operating room.)
- Masks can cause severe acne and other skin problems. (My wife is a Dermatologist here in RI who has seen many such patients in the past 18mos)
- The discomfort of a mask distracts some children from learning, and can cause social isolation as described during the 2003 SARSCOV1 epidemic in a Hong Kong study of preschool children.  
[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7097388/pdf/13158\\_2009\\_Article\\_BF03168205.pdf](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7097388/pdf/13158_2009_Article_BF03168205.pdf)
- By **increasing** airway resistance during exhalation, masks can lead to increased levels of carbon dioxide in the blood (A 2013 published report from ICU nurses demonstrated this and found the increased blood CO2 levels were associated complaints of headaches, perceived shortness of breath, increased perceived exertion, and difficulty communicating) <http://dx.doi.org/10.1016/j.ajic.2013.02.017>
- And masks can be vectors for pathogens if they become moist or are used for too long (A 2018 study of surgeons which cultured their masks after surgery found multiple pathogens and concluded surgeons should change their masks after 2-hours in the operating room to avoid causing wound infections)  
<https://www.sciencedirect.com/science/article/pii/S2214031X18300809?via%3Dihub>