

September 27, 2021

Via email:

North Carolina County School Boards
Attention:
Members and Superintendents

RE: COVID-19 INFORMATION LETTER

Dear Superintendents and Board Members:

My firm is contacting you on behalf of North Carolina Citizens for Constitutional Rights, LLC (“NCC4CR”), a North Carolina limited liability company organized to defend the Constitutional Rights of North Carolina citizens. NCC4CR, its members and supporters, and other members of the public who have contacted me are all gravely concerned about the conduct of the County School Boards (the “School Boards”) with respect to their adoption of the COVID-19 control measures outlined in North Carolina Department of Health and Human Services (“NCDHHS”) StrongSchoolsNC Public Health Toolkit (K-12) (the “Toolkit”). After appraising the legal status of the Toolkit and its control measures, it is clear that the School Boards **do not** have the authority to implement these measures without a formal order from NCDHHS or a local health department. Furthermore, there appears to be a lack of knowledge surrounding the effectiveness of the control measures, the actual threat of SARS-CoV-2 to students and staff, and alternatives for treatment to mitigate and prevent severe COVID illness. Although we believe it is the responsibility of the School Boards to apprise themselves of these facts before making policy decisions that affect the health and welfare of students and staff, we are providing the necessary information here for your edification. Now that you know this information, the School Boards must review their current policies and make appropriate changes as soon as possible.

I. Legal Matters Relevant To COVID-19 Policies.

- a. The School Boards do not have the legal authority to quarantine children or staff. Such authority rests solely with the NCDHHS and the Local Health Director.**

In review of Article 5, Chapter 115C of the North Carolina General Statutes, I cannot find where the School Boards have the authority to impose the use of medical devices, medical procedures, or communicable disease control measures as conditions of in-person instruction. While you may have been advised that N.C. Gen. Stat. §§ 115C-40 & 115C-47 provides you with authority to institute these types of policies; this is an overly broad interpretation of the statutes resulting in an unlawful expansion of powers not otherwise granted.

To our understanding, NCDHHS has failed to issue an official Chapter 130A “order” regarding the threat of an “imminent hazard” of a “communicable disease” that requires specific “control measures” to safeguard public health. Without this official order, all control measures against COVID-19 are merely recommendations, to include those published in the Toolkit. Each School Board needs to evaluate the risk in their own areas to determine the best approach that is effective but creates the least harm possible. The current Toolkit recommendations do not do this. They are a blanket, one-size-fits-all, scattershot approach with a tenuous basis in science and logic at best.

As you may know, Union County School Board (“UCSB”) voted on September 13, 2021, to forgo quarantining and contacting tracing guidelines suggested by NCDHHS Toolkit.¹ The UCSB correctly concluded they did not have the legal authority to quarantine children or staff, which rests solely with the NCDHHS and the local health director. Furthermore, the quarantining of asymptomatic children and staff was impairing the education of the students. Thus, they voted 8 to 1 to remove the quarantining and most contact tracing guidelines suggested in the Toolkit.

Two days later, on September 15, 2021, NCDHHS Secretary Mandy Cohen sent a letter to UCSB demanding they rescind their decision under threat of a lawsuit. In the letter, Sec. Cohen explains that Union County’s percentage of positive tests is “well above CDC’s threshold of high level of transmission” but failed to provide a link or other authority to substantiate the claim. Furthermore, Sec. Cohen stated, “Union County had the third-highest number of COVID-19 cases in the state for children under 18 for the week ending September 11,” and attempted to compare Union County’s case rate with that of Cabarrus, Cumberland, and Durham County. Again, no links or citations were provided. The letter then states that the Toolkit “requires” quarantining and should be followed to prevent further spread or an outbreak of COVID-19 disease. It is important to note that COVID-19 is allegedly caused by infection with the SARS-CoV-2 virus, which is not mentioned anywhere in Sec. Cohen’s letter. Lastly, Sec. Cohen cites a select section of Chapter 130A of the North Carolina General Statutes and Title 10A of the North Carolina Administrative Code for her authority in enforcing the Toolkit. Before concluding her letter, Sec. Cohen refers to the control measures in the Toolkit as “recommendations.”

Consequently, The letter falls short of being interpreted as an “order” of NCDHHS requiring the Toolkit be implemented as a control measure against a communicable disease under Chapter 130A. In response to Sec. Cohen’s letter, UCSB held an emergency meeting clarifying their prior vote stating they would follow North Carolina law concerning quarantining and contact tracing.²

To better understand the School Board’s requirements to comply with NCDHHS or local health departments, we must examine the relevant statutes and regulations. Chapter 130A of the North Carolina General Statutes governs various areas of Public Health, including Article 6, Communicable Diseases. Under Chapter 130A, a "Communicable disease" is defined as “an illness due to an infectious agent or its toxic products which is transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment.” N.C.G.S. §130A-2(1c). An "Imminent hazard" is defined as “a situation that is likely to

¹ <https://www.wfae.org/education/2021-09-13/union-county-schools-will-stop-contact-tracing-and-most-quarantines>

² <https://www.wbtv.com/2021/09/20/union-county-school-board-will-recognize-quarantine-close-contacts-positive-covid-19-cases/> (last visited Sept. 20, 2021, at 1:30pm)

cause an immediate threat to human life, an immediate threat of serious physical injury, an immediate threat of serious adverse health effects, or a serious risk of irreparable damage to the environment if no immediate action is taken.” N.C.G.S. § 130A-2(3). "Quarantine authority" means “the authority to issue an order to limit the freedom of movement or action of persons or animals which have been exposed to or are reasonably suspected of having been exposed to a communicable disease or communicable condition for a period of time as may be necessary to prevent the spread of that disease.” N.C.G.S. § 130A-2(7a).

Here, we are dealing with a severe acute respiratory syndrome (“SARS”) virus called SARS-Cov-2. This virus is believed to cause a particular set of symptoms, now referred to as COVID-19. A search of the NCDHHS website shows severe acute respiratory syndrome caused by a coronavirus (SARS-CoV) is a communicable disease.³ The NCDHHS website describes coronaviruses as “common viruses that most people get at some time in their life.”⁴ Prevention measures include hand washing, staying at home when sick, and keeping surfaces clean.⁵ COVID-19 symptoms include fever or chills, cough, shortness of breath, fatigue, muscle or body aches, headaches, loss of taste or smell, sore throat, nasal congestion, nausea, or diarrhea.⁶ This list of symptoms is non-exhaustive, but it is very similar to symptoms associated with influenza viruses.⁷

SARS viruses are designated as contagious diseases/conditions under the North Carolina Administrative Code. *See* 10A N.C. Admin. Code 41A.0101(62); *see also* N.C.G.S. § 130A-134 (“NCDHHS, Commission for Public Health is charged with maintaining a list of communicable diseases and communicable conditions”). A SARS infection is reportable to the local health department within 24 hours after it is reasonably suspected to exist. *Id.* The report must be made to the local health director by phone and followed up with a written/electronic report within 7-days. 10A N.C. Admin. Code 41A.0102 (a)(1)-(2). Once the local health director receives the report, they are commanded to investigate the case, determine what control measures are necessary, and forward reports to the regional office of the Division of Public Health. 10A N.C. Admin. Code 41A.0103(a)(1)-(3); *see also* N.C.G.S. § 130A-134(a).

Neither the School Boards nor the Schools individually have quarantining authority under Chapter 130A. If a school principal has reason to suspect that a person has a “communicable disease or communicable condition,” they should report the information to the local health director of the county where the school is located. N.C.G.S. § 130A-136. Quarantining and isolation authority under Chapter 130A is **only** granted to the “State Health Director and a local health director” (emphasis added). The authority should **only** be exercised when public health is in danger and “all other reasonable means for correcting the problem have been exhausted, and no less restrictive alternative exists.” N.C.G.S. § 130A-145(a) (emphasis added). As admitted on NCDHHS’s website, coronavirus is “common,” and prevention/control measures include hand washing, keeping surfaces clean, and staying home while you are sick. However, the recommended control measures in the Toolkit are excessive, overly restrictive,

³ <https://epi.dph.ncdhhs.gov/cd/diseases/coronavirus.html> (last visited Sept. 20, 2021, at 1:44pm)

⁴ *Id.*

⁵ *Id.*

⁶ <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

⁷ <https://www.cdc.gov/flu/symptoms/index.html>

and are in violation of the “all other reasonable means exhausted” and “no less restrictive alternatives” requirements under 130A-145(a). The Toolkit guidelines also violate Section 130A-145(d) because they fail to offer quarantined individuals “reasonable notice” of the right to institute an action to review a quarantine order.

It cannot be stressed enough that the Secretary of DHHS or a local health director must “order” the control measures to be implemented to address an imminent hazard. N.C.G.S. § 130A-20(a). Without an official Chapter 130A order, the county School Boards should not implement the Toolkit since it constitutes “control measures” which have not been officially ordered under the statute. This places the School Board at significant risk of legal liability since they are in violation of Chapter 130A and individuals’ fundamental constitutional rights. Such decisions will likely be found to be a manifest abuse of discretion, particularly where the control measures are harming children, as is the case here.

b. Current School Board COVID-19 policies are coercive, discriminatory, and breach both federal and state law.

The current COVID-19 policies being implemented statewide include the requirements to wear masks, take COVID-19 tests, and a strong recommendation, and in some cases, a requirement, to take the COVID-19 gene therapy injections wrongfully described as “vaccines.”⁸ Without question, the School Boards are not authorized to practice medicine under Chapter 90 of the North Carolina General Statutes. But, even more problematic is the School Boards’ coercive COVID-19 policies that improperly influence parents’ judgment and freedom of choice of whether or not to consent to Emergency Use Authorize (“EUA”) devices and treatments under section 564 of the Federal Food, Drug, and Cosmetic Act (the “Cosmetic Act”) (21 U.S.C. 360bbb-3).⁹ This includes requiring masks to be used as medical devices, mandating COVID-19 testing using EUA tests, and requiring COVID-19 vaccines.

The School Boards have no legal authority for implementing these policies and are currently in violation of North Carolina General Statutes. Furthermore, mandating medical devices or procedures is also a violation of individual liberties, including impairing an individual’s medical care decisions¹⁰ and interfere with the parent’s right to control the upbringing of their children¹¹. Finally, mandating medical devices or procedures requires medical screening, which the School Boards are not doing. In effect, the School Boards’ COVID-19 policies are haphazard, not based on the facts or science, and are entirely ineffective in protecting public health. Therefore, these policies require immediate correction.

c. Schools Boards must offer additional access to education while current COVID-19 policies remain in place.

⁸ Carolina Iglesias-Lopez *et al.*, Regulatory Framework for Advanced Therapy Medicinal Products in Europe and United States, p.5 (Aug. 30, 2019) (“Recombinant DNA materials used to transfer genetic material for such therapy are considered components of gene therapy.”), <https://pubmed.ncbi.nlm.nih.gov/31543814/>

⁹ <https://www.fda.gov/medical-devices/emergency-situations-medical-devices/faqs-emergency-use-authorization-face-masks-non-surgical> (“Face masks **should NOT** be used in place of surgical masks or filtering facepiece respirators to provide protections such as: Antimicrobial or **antiviral protection**, prevention, or reduction” (emphasis added)).

¹⁰ See *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

¹¹ See *Wisconsin v. Yoder*, 406 U.S. 205 (1972); see also *Parham v. J.R.*, 442 U.S. 584 (1979).

While North Carolina and most of the country flounder and falter in their efforts to “protect” public health, the School Boards still have a duty under Chapter 115C-47(32a) to offer education to all school-age children in the State. Unfortunately, the School Boards have failed to make provisions for quarantined students who cannot attend in-person learning. The current COVID-19 policies kick “unvaccinated” children out of school yet make no accommodations to continue the student’s education while in quarantine. This appears to be coercion in forcing the COVID-19 vaccine so parents and students can avoid the arbitrary, unscientific policies. Fortunately, parents are standing firm, are unwilling to be cowed into submission, and have organized to address these abuses. Thus, it would be advisable that distance-learning education be reinstated to accommodate the present COVID-19 situation.

II. Factual Information Concerning Current COVID-19 Control Measures, Risks Of Disease, Risks of Vaccines, and Alternative Treatments.

a. Masks offer almost no protection but are causing significant harm.

It is now well understood that SARS-CoV-2 virus spreads as an aerosol, not as droplets.¹² A SARS-CoV-2 virus particle is between 0.09 to 0.12 microns in size. A particle this small in an aerosolized state makes the current masks mandates of questionable efficacy. Even though there are no standards specified in the mask mandate, if we were to suppose an N-95 respirator was our desired standard, we are still a far cry from effectiveness against the virus. An N-95 respirator is rated to filter 95% of all particles larger than 0.3 microns, but only if the respirator is fitted correctly to seal along the face and timely replaced. However, if 3% or more of the respirator is not sealed to the face, it becomes ineffective. Here, the School Boards are trying to use any face covering, including N-95, cloth, or surgical-like masks, as an effective barrier to transmitting or exposure to the virus. As we can all clearly see, the masks currently being used do not completely seal to their face, and even if they did, the size of the virus is so tiny they render such masks worthless. As one expert witness opined, it’s like attempting to stop mosquitos with a chain-link fence.¹³ Masks wearing provides no benefit whatsoever to stop the SARS-CoV-2 virus, either to the wearer or to others.

To make matters worse, there are very well-documented side effects from wearing a mask for extended periods (100 minutes or greater).¹⁴ Masks impair oxygen intake and cause the wearer to experience unnaturally high carbon dioxide levels from rebreathing their exhalation. Also, the wearer feels disassociated and disconnected from people due to the lack of facial expression hidden behind the mask. Extended face-covering/mask use has been documented to cause hypoxia, hypercapnia, elevated heart

¹² Judgment and Order at 15 – 18, *Ridgeway Properties, LLC and Commonwealth of Kentucky, ex rel. Attorney General Daniel Cameron vs. Hon. Andrew Beshear, Governor, Commonwealth of Kentucky, et al.*, (No. 20-CI-00678) (June 8, 2021) (testimony of Stephen E. Petty, P.E., CIH, an expert accepted without objection, regarding validity of social distancing and mask mandates on Covid-19).

¹³ *Id.* at 18.

¹⁴ Kai Kisielinski *et al.*, Is a Mask That Covers the Mouth and Nose Free from Undesirable Side Effects in Everyday Use and Free of Potential Hazards? (April 18, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8072811/>.

rates, headaches, lack of concentration, and psychological stress.¹⁵ Additionally, masks and face covers culture bacteria and pathogens from the wearer's breath if worn too long and not exchanged or cleaned.¹⁶ Thus, the prolonged use of masks in the manner mandated is very harmful to the wearer. The School Boards' conduct in forcing the mask policy despite children being harmed is a manifest abuse of discretion.

b. Current quarantining policies are discriminatory, arbitrary, and not based on available scientific knowledge of SARS-CoV-2.

Many government entities and businesses have the mistaken impression that current COVID-19 mitigation policies, such as vaccines, masks, and quarantining, are effective means of controlling the spread of the SARS-CoV-2 virus. However, scientific analysis of these policies has shown they are actually of dubious effectiveness. For example, just recently, the former Food and Drug Administration (FDA) Commissioner Scott Gottlieb claimed “nobody knows” where the six feet social distancing recommendation came from and believes it is arbitrary and not unnecessary based on current science.¹⁷

One of the primary myths that underlie these misguided policies is the assumption that “unvaccinated” are asymptomatic spreaders of SARS-CoV-2, causing further infections. This assumption is false.

On November 20, 2020, a study was published testing the theory of asymptomatic SARS-CoV-2 transmission.¹⁸ The study was conducted in Wuhan, China, where nearly 10 million residents ages six or older were tested for SARS-CoV-2 via a nucleic acid screening program between January 23 and April 8, 2020. The study found that of the nearly 10 million people tested, 300 were identified as asymptomatic cases. Of the 1,174 people who came into close contact with these “positive” cases, *no one* tested positive (emphasis added)¹⁹. Thus, the study concluded, “there was no evidence that the identified asymptomatic positive cases were infectious.”²⁰ The Wuhan study was conducted before the current COVID-19 “vaccines” were available. Thus, we can conclude from the study that “unvaccinated” asymptomatic spreaders of COVID-19 is a hypothesis lacking support from sound scientific investigation.

However, the asymptomatic spread of COVID-19 from “vaccinated” individuals is a very real and dangerous phenomenon. According to a recent study conducted amongst healthcare workers in Vietnam, vaccinated individuals carry 251 times the load of COVID-19 viruses in their nostrils

¹⁵ *Id.*

¹⁶ Dangerous pathogens found on local residents' face masks, June 15, 2021 (“A group of local parents sent 6 face masks to a lab at the University of Florida, requesting an analysis of contaminants found on the masks after they had been worn. The resulting report found that five masks were contaminated with bacteria, parasites, and fungi, including three with dangerous pathogenic and pneumonia-causing bacteria.”) <https://alachuachronicle.com/dangerous-pathogens-found-on-local-residents-face-masks/>

¹⁷ <https://thepoliticalinsider.com/former-fda-chief-nobody-knows-where-six-feet-of-social-distancing-requirement-came-from/>

¹⁸ Shiyi Cao *et al.*, Post-lockdown SARS-CoV-2 nucleic acid screening in nearly ten million residents of Wuhan, China (Nov. 20, 2020), <https://www.nature.com/articles/s41467-020-19802-w>.

¹⁹ *Id.* (“All close contacts of the asymptomatic positive cases tested negative, indicating that the asymptomatic positive cases detected in this study were unlikely to be infectious.”)

²⁰ *Id.*

compared to the unvaccinated *two months* after injection (emphasis added).²¹ Experts who have examined the data in the report concluded that these “super spreaders” are likely infecting the “vaccinated” and “unvaccinated” alike and are the source of the recent outbreak.²² This concern was also echoed by the U.S. Center for Disease Control (CDC),²³ which labeled these infections as the “breakthrough” cases. We can also see other real-world examples of a high rate of vaccination leading to COVID-19 outbreaks.^{24,25} Pfizer also recognized the “shedding” as a concern in its clinical protocols used during the brief testing period before full rollout to the public.²⁶ The apparent conclusion, as stated by the experts, and supported by scientific studies and real-world observations, is the vaccinated are shedding spike protein and/or spreading variants due to “leaky” vaccines.

The myth that an “unvaccinated” person poses more risk than a “vaccinated” person is patently false. In fact, it should be the “vaccinated,” which we are more closely scrutinizing since they are the ones posing the public health risk after complete “vaccination.” Consequently, focusing COVID-19 mitigation policies solely or heavily focused on the “unvaccinated” is not only unscientific and a mistake but also creates disparate, discriminatory treatment of the “unvaccinated” under the current COVID-19 mitigation policies.

c. COVID-19 has over a 99% survival rate for almost all age groups and cannot reasonably be considered an “imminent hazard” under North Carolina General Statutes.

As discussed previously, an “imminent hazard” means a situation that is likely to cause an immediate threat to human life, an immediate threat of serious physical injury, or an immediate threat of serious adverse health effects if no immediate action is taken. N.C.G.S. § 130A-2(3). Here, we have a SARS viral “pandemic” with an approximate overall survival rate of 99.9%. Certainly, the SARS-CoV-2 virus has the potential to cause serious adverse health effects, but the effects do not appear to be permanent, and they are not fatal in the vast majority of cases. However, what health effects a person experiences are very much individualized and appear to be influenced by demographics and overall health. Thus, it is incumbent upon the individual to safeguard their health and seek appropriate medical care when faced

²¹ Nguyen Van Vinh Chau *et al.*, Transmission of SARS-CoV-2 Delta Variant Among Vaccinated Healthcare Workers, Vietnam, (Aug. 10, 2021) (preprint), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733

²² See Open Letter to authorities by Geert Vanden Bossche, DMV, PhD, independent virologist and vaccine expert, formerly employed at GAVI and The Bill & Melinda Gates Foundation, Why mass vaccination amidst a pandemic creates an irrepressible monster (March 6, 2021), https://37b32f5a-6ed9-4d6d-b3e1-5ec648ad9ed9.filesusr.com/ugd/28d8fe_266039aeb27a4465988c37adec9cd1dc.pdf; see also, Two Top Virologists’ Frightening Warnings About COVID Injections: Ignored by Government and Big Media, by Joel S. Hirschhorn (Aug. 21, 2021)(“It is the variants that ‘are a production and result from the vaccination.’”), <https://www.globalresearch.ca/two-top-virologists-frightening-warnings-about-covid-injections-ignored-government-big-media/5753731>.

²³ Fully vaccinated people who get a Covid-19 breakthrough infection can transmit the virus, CDC chief says (Aug. 6, 2021), <https://www.cnn.com/2021/08/05/health/us-coronavirus-thursday/index.html>.

²⁴ Israel says it’s facing a new COVID-19 outbreak fueled by the Delta variant, despite having the world’s most vaccinated population, Sinead Baker, June 23, 2021, <https://www.businessinsider.com/israel-seeing-new-covid-19-outbreak-despite-vaccine-success-2021-6?op=1> (last visited Sept. 16, 2021, at 4:30pm EST).

²⁵ Duke University mandates Covid vaccines for staff and reinstates mask rules following outbreak, Robert Towey, Aug. 30, 2021, <https://www.cnn.com/2021/08/30/duke-university-mandates-covid-vaccines-for-staff-following-outbreak.html>; Duke Covid Testing Tracker, <https://coronavirus.duke.edu/covid-testing/> (last visited Sept. 16, 2021, at 8:07pm EST).

²⁶ https://media.tghn.org/medialibrary/2020/11/C4591001_Clinical_Protocol_Nov2020_Pfizer_BioNTech.pdf, Section 8.3, pgs. 65-70.

with a possible COVID-19 illness. Instead, a one-size-fits-all approach is being implemented, which lacks support from sound scientific evidence and causing harm to children.

The CDC statistics on COVID-19 fatalities show children under 18 years of age have a near-zero chance of death from contracting the disease.²⁷ This data is supported by an age-specific mortality study of SARS-CoV-2 using data from 45 countries showing nearly 100% survivability for the under 18 age group.²⁸ Additionally, children under 18 years of age are less likely to transmit SARS-CoV-2 compared with adults.²⁹ Thus, the COVID-19 risk in K-12 schools appears to have been severely overblown.

Probably the most meaningful measure for understanding and evaluating the risk of any given disease is the Infection-Fatality Rate (“IFR”). The IFR compares the rate of infection with the death rate to determine a percentage rate of fatality for the disease or virus, thus putting the risk of death into context (IRF = # death / # cases). Unfortunately, NCDHHS does not correlate the State’s data to provide an IFR by demographics. Instead, the public is only given absolute figures regarding cases, testing, hospitalizations, and death.³⁰ Although total numbers can appear concerning, they can be misleading without putting the information into context. NCDHHS seems to be relying on the misleading nature of the figures to create an unnatural fear of COVID-19 to push their “recommended” mitigation measures, mainly vaccines. However, when we take a closer look at the figures, the situation is nowhere near as dire as the NCDHHS represents.

The estimated population of North Carolina as of July 1, 2019, was 10,488,084 individuals.³¹ On the main page of the NDHHS Dashboard, we can see there have been 1,346,316 COVID-19 Cases.³² Taking this figure as true, while putting aside the issue of false positives created by RT-PCR tests³³³⁴, only 12% of the State's total population has been diagnosed with COVID-19. Leaving aside the death by vs. death with COVID argument, NCDHHS reports the total deaths as 15,776, approximately 0.15% of the total population.³⁵ When we take total deaths divided by total cases, we return a value of 0.0117, an IFR of 1.17%. However, this is only part of the story. Since NCDHHS does not publish death rates by demographics, we cannot apply this IFR universally across all demographic groups. From the

²⁷ <https://covid.cdc.gov/covid-data-tracker/#demographics>.

²⁸ O’Driscoll, M., Ribeiro Dos Santos, G., Wang, L. *et al.* Age-specific mortality and immunity patterns of SARS-CoV-2. *Nature* 590, 140–145 (2021), <https://doi.org/10.1038/s41586-020-2918-0>

²⁹ *See*, Yanshan Zhu *et al.*, A meta-analysis on the role of children in SARS-CoV-2 in household transmission clusters, (Dec. 6, 2020), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7799195/>.

³⁰ NCDHHS, COVID-19 North Carolina Dashboard, <https://covid19.ncdhhs.gov/dashboard>

³¹ <https://www.census.gov/quickfacts/NC>

³² *See* n.2, *supra*.

³³ *See generally*, CDC Lab Alert: Changes to CDC RT-PCR for SARS-CoV-2 Testing (July 21, 2021)(“After December 31, 2021, CDC will withdraw the request to the U.S. Food and Drug Administration (FDA) for Emergency Use Authorization (EUA) of the CDC 2019–Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel, the assay first introduced in February 2020 for detection of SARS-CoV-2 only.”), https://www.cdc.gov/csels/dls/locs/2021/07-21-2021-lab-alert-Changes_CDC_RT-PCR_SARS-CoV-2_Testing_1.html.

³⁴ Portuguese Court Rules PCR Tests As Unreliable & Unlawful To Quarantine People, Nov. 18, 2020, (the court concluded, “if someone is tested by PCR as positive when a threshold of 35 cycles or higher is used (as is the rule in most laboratories in Europe and the US), the probability that said person is infected is less than 3%, and the probability that said result is a false positive is 97%.”), <https://greatgameindia.com/portuguese-court-pcr-tests-unreliable/>.

³⁵ *Id.*

previously cited articles and NCDHHS's published data of cases by demographics,³⁶ we can safely assume the IFR for the under 17 age group would be a much lower IFR. When we compare the nationwide total deaths from COVID-19 by demographic, we see that ages 0-17 make up only 0.067% of all COVID-19 deaths.³⁷ Assuming similar demographic distribution for deaths of the 0-17 age group in North Carolina, the corresponding statewide IFR for the same age group would be approximately 0.001%.³⁸ When we calculate the IFR across all demographic groups, we find that the risk of death does not increase significantly until we reach the 50+ age groups, but even then, survivability remains over 99% (comorbidities aside).³⁹

While we are not advocating taking unnecessary risks with COVID-19 illnesses, we believe the current COVID-19 data is questionable and the control measures employed are excessive. We speculate this is due to the exaggerated COVID-19 fear created by the mainstream media, the censoring of SARS-Cov-2 and COVID-19 information, misreporting of COVID-19 cases and death, and the politicization of the pandemic for political and financial gain.⁴⁰ Thus, we can safely speculate that public health and personal safety are not the primary motivations by those forcefully pushing these policies. Instead, we believe the current control measures and COVID-19 policies are geared towards incentivizing people to take the COVID-19 "vaccines." However, the efficacy and safety of these vaccines are highly concerning.

d. The functioning and effectiveness of mRNA gene therapy technology.

As you know, the three primary COVID-19 "vaccines" (Pfizer/BioNTech, Moderna, and Johnson & Johnson) employ a novel messenger ribonucleic acid (mRNA) technology for purposes of attempting to create immunity in the recipient. mRNA are molecules that contain genetic instructions for making various proteins. mRNA "vaccines" deliver a synthetic version of mRNA into your cells that carry the instruction to produce the SARS-CoV-2 spike protein, the antigen, that then activates your immune system to produce antibodies. The Pfizer/BioNTech and Moderna versions of the vaccines encase the mRNA in PEGylated lipid nanoparticles which are then delivered to the cells via a proprietary graphene oxide solution.⁴¹ The manufacturers of this type of vaccine allege the mRNA does not reach your cell's

³⁶ NCDHHS, Case Demographics, <https://covid19.ncdhhs.gov/dashboard/cases-demographics> (only 4% of cases are between the ages of 5-9, 5% between 10-14, and 4% between 15-17).

³⁷ <https://www.statista.com/statistics/1191568/reported-deaths-from-covid-by-age-us/> (439 COVID-19 deaths in the 0-17 age group divided by 658,754 total nationwide deaths) (figures good through Jan. 1, 2020 through Sept. 15, 2021).

³⁸ *Id.* (439 COVID-19 deaths in the 0-17 age group divided by 41,103,381 total COVID-19 cases nationwide).

³⁹ *Id.* (US IFR calculated by demographic group).

⁴⁰ See NC Wins Approval of Plan for Federal COVID-19 Relief Funds for Schools, Sept. 13, 2021, (N.C. will receive \$1.2 billion to help public schools and students recover from the COVID-19 pandemic), <https://www.dpi.nc.gov/news/press-releases/2021/09/13/nc-wins-approval-plan-federal-covid-19-relief-funds-schools>; see also From Pfizer to Moderna: who's making billions from Covid-19 vaccines?, by Julia Kollewe, Mar. 6, 2021, <https://www.theguardian.com/business/2021/mar/06/from-pfizer-to-moderna-whos-making-billions-from-covid-vaccines> (last visited Sept. 17, 2021, at 9:34am EST).

⁴¹ Without these lipid shells, there would be no mRNA vaccines for COVID-19, by Ryan Ross, March 6, 2021, <https://cen.acs.org/pharmaceuticals/drug-delivery/Without-lipid-shells-mRNA-vaccines/99/i8>, (last visited Sept. 17, 2021, at 10:34am EST); La Quinta Columna: '98% to 99% of the vaccination vial is graphene oxide', July 3, 2021, <https://www.orwell.city/2021/07/graphene-oxide.html>, (last visited Sept. 17, 2021, at 10:37am EST); see e.g., Raj Kumar Thapa *et al.*, PEGylated lipid bilayer-wrapped nano-graphene oxides for synergistic co-delivery of doxorubicin and rapamycin to prevent drug resistance in cancers, July 21, 2017, <https://pubmed.ncbi.nlm.nih.gov/28614069/>, (last visited Sept. 17, 2021, at 10:28am EST).

DNA. However, a recent MIT & Harvard study found a molecular mechanism for the mRNA to “retro-integrate” to a patient’s cellular DNA through reverse transcriptase from certain elements of the vaccine themselves.⁴²

The adenovirus-vector vaccine (Johnson & Johnson) works similarly to the Pfizer/BioNTech and Moderna vaccines. The virions in the vaccine, delivered via clathrin-mediated endocytosis, escape from endosomes and are transported to the nuclear membrane by microtubules.⁴³ After docking on a nuclear pore complex, adenoviral DNA is released into the cell’s nucleus, where the SARS-CoV-2 spike gene is transcribed into messenger RNA (mRNA).⁴⁴ Next, the mRNA is transported to the cytoplasm to be translated by ribosomes, making SARS-CoV-2 spike protein. The cells then begin production of spike protein, which can be detected by immune cells.⁴⁵

Both types of mRNA vaccines cause the cells of the recipient’s body to produce SARS-CoV-2 spike protein as the antigen. Unfortunately, this antigen has been discovered to be a pathogenic cytotoxin that can cause illness.^{46,47} Nevertheless, this antigen does cause an immune response, but it’s particular to the spike protein produced. However, an accumulating body of evidence shows that spike protein antibodies produced by the vaccines are only temporarily effective and ineffective against variants.⁴⁸ Also, COVID-19 vaccines are inferior to natural immunity, which is complete and durable once achieved.⁴⁹ Furthermore, the current mRNA vaccines have the ability to alter a person’s DNA, and none of the manufacturers claim they provide immunity. Instead, they were designed to be effective at lessening clinical symptoms associated with infection of the SARS-CoV-2 virus. Thus, they are better described as “therapies,” not “vaccines.” Consequently, a “vaccinated” individual can still be infected by the SARS-CoV-2 virus and may still transmit the virus to others.⁵⁰ The only one benefiting from an mRNA “vaccine” is the vaccinated individual. Since the vaccinated individual is the only one who will reap a benefit from the vaccine, it makes no sense to demand everyone accept the risks of being vaccinated “for the greater good” of the community.

⁴² MIT & Harvard Study Suggests mRNA Vaccine Might Permanently Alter DNA After All, by Dr. Doug Corrigan, March 16, 2021, <https://rightsfreedom.wordpress.com/2021/08/13/mit-harvard-study-suggests-mrna-vaccine-might-permanently-alter-dna-after-all/>, (last visited Sept. 17, 2021, at 10:16am EST).

⁴³ Adenovirus-vectored Vaccines for COVID-19 – How Do They Work?, <https://www.ebsco.com/blogs/health-notes/adenovirus-vectored-vaccines-covid-19-how-do-they-work> (last visited Sept. 17, 2021, at 9:54am EST).

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Warning: Physician Who Invented mRNA Shot Speaks Out, posted June 21, 2021, (Free SARS-CoV-2 spike protein is biologically active — contrary to initial assumptions — and causes severe problems. It is responsible for the most severe effects seen in COVID-19, such as bleeding disorders, blood clots throughout the body and heart problems. These are the same problems we now see in a staggering number of people who have received the COVID-19 “vaccine”), <https://www.midlandscbd.com/articles/warning-physician-who-invented-mrna-shot-speaks-out>

⁴⁷ Vaccine researcher admits ‘big mistake,’ says spike protein is dangerous ‘toxin’, May 31, 2021, (Byram Bridle, a viral immunologist and associate professor at University of Guelph, Ontario, is quoted as saying, “We thought the spike protein was a great target antigen, we never knew the spike protein itself was a toxin and was a pathogenic protein. So by vaccinating people we are inadvertently inoculating them with a toxin.”), <https://www.lifesitenews.com/news/vaccine-researcher-admits-big-mistake-says-spike-protein-is-dangerous-toxin/> (last visited Sept. 22, 2021, at 9:45am EST).

⁴⁸ See n.25-26, *supra*.

⁴⁹ See Dr. Peter McCullough, MD, testimony before the State of Texas Senate Committee on Health & Human Services, March 10, 2021, at 12:00 – 12:22, <https://www.youtube.com/watch?v=QAHi3lX3oGM> (last visited Sept. 22, 2021, at 10:20am EST).

⁵⁰ *Id.*

e. COVID-19 Vaccines have a significant risk of mortality and morbidity.

The issue of the COVID-19 vaccines' safety is significantly misrepresented to the public. One only has to look at the Vaccine Adverse Events Reporting System ("VAERS") to see there have been 14,925 reported deaths from the COVID-19 vaccines, 60,741 hospitalizations, and 701,559 reported adverse events.⁵¹ However, it is widely believed these figures are under-reported by a factor of 10 to 100.

During a recent Food and Drug Administration (FDA) Virtual meeting with the Vaccines and Related Biological Products Advisory Committee, explosive information was shared during the open public hearing session of the meeting, which persuasively demonstrates there are significant mortality and morbidity risks from the current COVID-19 vaccines.⁵² During the comment period, Mr. Kirsch, the Executive Director of the COVID-19 Early Treatment Fund, explained that the current COVID-19 vaccines are nonsensical, using an Excess Death:Life ratio to show the shots kill more people than they save. The Excess Death:Life ratio analysis examines the ratio of the number of vaccine-caused deaths per million doses relative to the projected number of COVID deaths that could be saved by the vaccine over a six-month period per million doses. Mr. Kirsch's review of Pfizer's 6-month clinical trial and other peer-reviewed scientific papers showed the excess deaths required to save a COVID life with the Pfizer's COVID-19 vaccine was a ratio 2 to 1, and for the under 20 years of age group, the ration increased to 6 to 1.⁵³ This means that for every 1 person saved by a COVID-19 vaccine 2 to 6 excessive deaths occur as a result of the adverse effects of the vaccines. Thus, the COVID-19 vaccines are killing more people than they are saving.

Mr. Kirsch also discussed data that showed the risk of myopericarditis (acute heart inflammation) from the vaccines is 1 in 1000 for the age group between 18 to 55 with a mean age of 33.⁵⁴ Damage to your heart can be devastating since the heart muscles scar when injured and do not regenerate. Thus, young, perfectly healthy individuals are being permanently injured by the vaccines, and they have no legal recourse against the manufacturers.

Another speaker, Dr. Jessica Rose, a viral immunologist, discussed how the COVID-19 vaccines had caused a 1000% increase in adverse events reported in VAERS. Dr. Rose also presented compelling data showing evolutionary pressure on viruses from the COVID-19 vaccines which is speeding up mutations.⁵⁵ Dr. Rose also published her VAERS data analysis work showing the VAERS under-reporting factor is approximately 41.⁵⁶ By using this factor, Dr. Rose determined there are likely over 150,000 deaths from the COVID-19 vaccines as of August 28, 2021.⁵⁷ When this factor is applied to the

⁵¹ <https://openvaers.com/> (last visited Sept 21, 2021, at 2:48pm EST)

⁵² Food and Drug Administration (FDA) Virtual meeting with the Vaccines and Related Biological Products Advisory Committee, Sept. 17, 2021, at 4:01:00 – 5:00:00, <https://www.youtube.com/watch?v=WFph7-6t34M&t=7s> (last visited Sept. 21, 2021, at 3:02pm EST).

⁵³ *Id.* at 4:20:17 – 4:27:14; see also Cost benefit by age analysis: The COVID vaccines kill more people than they save for all age groups, by Steve Kirsch, <https://www.skirsch.com/covid/VCage.pdf> (last visited Sept. 27, 2021, at 9:55 am EST).

⁵⁴ Sept. 17, 2021 FDA Virtual Meeting at 4:20:17 – 4:27:14.

⁵⁵ *Id.* at 4:09:48 – 4:13:15

⁵⁶ Jessica Rose, 2021. Critical appraisal of VAERS Pharmacovigilance: Is the U.S. Vaccine Adverse Events Reporting System (VAERS) a functioning pharmacovigilance system?, <https://www.publichealthpolicyjournal.com/general-5>; see also Estimating the number of COVID vaccine deaths in America, by Jessica Rose and Matthew Crawford (available upon request)

⁵⁷ *Id.*

other adverse events in VAERS, the result is approximately 2.5 million hospitalizations and 3.3 million ER visits as a result of adverse events from the vaccines.⁵⁸ According to the CDC, you are not considered “fully vaccinated” until 14-days after your last dose.⁵⁹ Thus, if a death, hospitalization, or ER visit occurs from the first shot (Pfizer or Moderna) or during this 14-day window from the last shot, it is considered an “unvaccinated” event. We can only speculate whether this misreporting situation is driving the “pandemic of the unvaccinated” narrative being pushed in the mainstream media.

In a prior FDA Vaccines and Related Biological Products Advisory Committee held on October 22, 2020, two presenters shared shocking lists of possible adverse side effects from the vaccines. One list presented by Steven Anderson, PhD, MPP, Director of the Office of Biostatistics & Epidemiology, Center for Biologics Evaluations and Research (“CBEF”), was captioned “FDA Safety Surveillance of COVID-19 Vaccines: DRAFT Working list of possible adverse event outcomes ***Subject to change***”.⁶⁰ The other lists were presented by Tom Shimabukuro, MD, MPH, MBA, who is part of the CDC COVID-19 Vaccine Task Force, Vaccine Safety Team. Dr. Shimabukuro’s slides were captioned “Preliminary list of VAERS AEs of special interest” and “Preliminary list of VSD pre-specified outcomes for RCA,” respectively.⁶¹ The three lists were similar and reported the following adverse events from COVID-19 vaccines:

- Guillain-Barre syndrome
- Acute disseminated encephalomyelitis ("Characterized by a brief but widespread attack of inflammation in the brain and spinal cord that damages myelin - the protective covering of nerve fibers," according to NIH.)
- Transverse myelitis
- Encephalitis/ myelitis/ encephalomyelitis/ meningoencephalitis/ meningitis/ encephalopathy
- Convulsions/seizures
- Stroke
- Narcolepsy and cataplexy
- Anaphylaxis
- Acute myocardial infarction
- Myocarditis/pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Other acute demyelinating diseases
- Non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Vaccine enhanced disease
- COVID-19 disease
- Multisystem Inflammatory Syndrome in Children

⁵⁸ STUDY: Government’s Own Data Reveals that at Least 150,000 Probably DEAD in U.S. Following COVID-19 Vaccines, by Brian Shilhavy, Sept. 20, 2021, (“As of last Friday, VAERS is reporting over 60,000 hospitalizations and over 80,000 visits to ERs following COVID-19 shots, and if the VAERS data is being under-reported by a factor of 41X, that means the real numbers are closer to 2.5 million hospitalizations, and 3.3 million trips to the ER following COVID injections.”), <https://healthimpactnews.com/2021/study-governments-own-data-reveals-that-at-least-150000-probably-dead-in-u-s-following-covid-19-vaccines/> (last visited Sept. 23, 2021, at 8:03am EST).

⁵⁹ When You’ve Been Fully Vaccinated, published by the CDC, updated Sept. 16, 2021, <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated.html> (last visited Sept. 21, 2021, at 4:43pm EST).

⁶⁰ Food and Drug Administration (FDA) Virtual meeting with the Vaccines and Related Biological Products Advisory Committee, Oct. 22, 2020, at 2:33:40, <https://www.youtube.com/watch?v=1XTiL9rUpkg> (last visited Sept. 23, 2021, at 9:32am EST).

⁶¹ *Id.* at 2:06:29.

This list of possible adverse events should be shared with people before they agree to take any experimental COVID-19 vaccines. This is the only way an individual can genuinely give “informed consent.” Unfortunately, we don’t believe an accurate list of the possible side effects is being shared with people. Thus, people are getting killed or permanently injured because they were never made aware of the risks associated with COVID-19 vaccines, and they have no legal recourse against the manufacturers.

The FDA recently approved a biologics license application for the Pfizer Comirnaty vaccine.⁶² This particular product is not available on the market today. However, the FDA approval letter stated that the Pfizer-BioNTech vaccine, the current product on the market, is still under the Emergency Use Authorization (“EUA”) and should remain unlicensed. However, the FDA also said both products can be used “interchangeably,” but they are still “legally distinct.” Thus, there is no FDA approval for the current COVID-19 vaccines; all are still experimental products being administered under EUA under 21 U.S.C. § 360bbb.

Consequently, no one should be coerced into taking a COVID-19 vaccine, and true informed consent must be given before administration, including disclosing the above list of possible adverse side effects. Based on the current data, including the manufacture’s own clinical trials, the vaccines are neither effective nor safe.

f. Highly effective, safe alternative treatments exist, making COVID-19 control measures and vaccines unnecessary.

Another tragedy of the COVID-19 situation is the censoring of information about COVID-19 treatment protocols. This has led to a failure to offer early treatment options for COVID patients before they become so sick that they need hospitalization. A pioneer in early outpatient COVID treatments is Dr. Peter McCullough, M.D., M.P.H., the Vice Chief of Internal Medicine, Baylor University Medical Center, Dallas, TX. Dr. McCullough published a peer review article in August 2020 discussing his recommended treatment protocols for patients with COVID or COVID-like symptoms.⁶³ The motivation for advocating for this type of COVID treatment was to reduce hospitalizations and fatalities.⁶⁴ In his testimony before U.S. Senate Hearing on COVID-19 Outpatient Treatment, Dr. McCullough discussed how the implementation of early treatment protocols significantly reduced hospitalization and reduced fatalities to near zero, even amongst high-risk patients.⁶⁵ Unfortunately, we believe there are very few North Carolina hospitals or medical centers offering early outpatient treatments of the kind Dr. McCullough advocates. Too many are advocating for the COVID-19 vaccines as the only option, which is not only very unfortunate but borders on malpractice.

⁶² U.S. Food and Drug Administration (FDA) August 23, 2021 Approval Letter – Comirnaty, <https://www.fda.gov/vaccines-blood-biologics/comirnaty> (last visited Sept. 23, 2021, at 9:56am EST).

⁶³ Peter A. McCullough, *et al.*, Pathophysiological Basis and Rationale for Early Outpatient Treatment of SARS-CoV-2 (COVID-19) Infection, Aug. 7, 2020, <https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC7410805/> (last visited Sept. 23, 2021, at 11:05am).

⁶⁴ *Id.*; see also n.49, *supra*.

⁶⁵ U.S. Senate Hearing on COVID-19 Outpatient Treatment, Nov. 19, 2020, at 00:15:34 – 00:21:00, <https://www.c-span.org/video/?478159-1/senate-hearing-covid-19-outpatient-treatment> (last visited Sept. 23, 2021, at 11:15am EST).

A simple search for COVID treatment protocols reveals numerous sources of information, including the following:

- <https://americasfrontlinedoctors.org/treatments/hydroxychloroquine/treatment-protocols/>
- <https://covid19criticalcare.com/covid-19-protocols/>
- <https://faculty.utrgv.edu/eleftherios.gkioulekas/zelenko/aaps-Guide-to-Home-Based-Covid-Treatment.pdf>
- https://www.thedesertreview.com/news/dr-george-fareed-and-dr-brian-tyson-share-early-treatment-protocol/article_7728815e-3ca2-11eb-8a08-7b4b0156c181.html
- <https://ipocrateorg.org/en/2020/12/15/how-to-treat-covid-19/>

While we make no claims or representations about the effectiveness of the above-listed treatment protocols, and reliance on the protocols is at the user's discretion, we think the people of North Carolina must know these options are available so they can conduct their own investigation and evaluation. Then, if they become infected with the SARS-CoV-2 virus, they can seek care from knowledgeable medical professionals who can guide them through early outpatient treatment before conditions worsen to the degree that hospitalization is necessary.

Lastly, countries that are implementing early outpatient treatment and/or prophylactic treatment are seeing a dramatic drop in COVID infections, particularly with Ivermectin.⁶⁶ In fact, Ivermectin has been shown to have twenty levels of action against the SARS-CoV-2 virus.⁶⁷ The takeaway here is early and alternative treatments need to be employed as a holistic approach to combatting COVID-19 instead of relying solely on the vaccine solution.

III. School Board's Statutory Duty To Investigate

a. School Boards must conduct further investigation into their COVID policies.

COVID-19 is a political issue because certain political bodies are making it political. Undoubtedly, the billions of dollars at stake are affecting the political process in dealing with this issue.⁶⁸ However, now that the School Boards have been apprised of the above information, advisory councils must be convened according to N.C.G.S. §§ 155C-47(30) and 155C-55 to help develop better school protocols that are based on the reality of the situation and which do not infringe on the rights of students, parents, or staff. Ignoring this obligation and continuing current COVID policies without investigation puts the School Boards in the position of conducting themselves in a manifestly arbitrary manner.

⁶⁶ See e.g., Uttar Pradesh government says early use of Ivermectin helped to keep positivity, deaths low, by Maulshree Seth, May 12, 2021, <https://indianexpress.com/article/cities/lucknow/uttar-pradesh-government-says-ivermectin-helped-to-keep-deaths-low-7311786/> (last visited Sept. 23, 2021, at 11:43am EST).

⁶⁷ Asiya Kamber Zaidi and Puya Dehgani-Mobaraki, 2021, The mechanisms of action of Ivermectin against SARS-CoV-2: An evidence-based clinical review article, <https://www.nature.com/articles/s41429-021-00430-5#Sec11>, (last visited Sept. 27, 2021, at 10:11 am EST).

⁶⁸ See n.40, *supra*.

Conclusion.

Before utilizing EUA medical devices in the schools under 21 U.S.C. 360bbb-3, i.e., facemasks, the School Boards must provide informed consent and make their use optional. Additionally, School Boards have serious legal consequences for exceeding powers and authorities under Article 5, Chapter 155C, wrongfully exercising authority Article 6, Chapter 130A and Chapter 90 of the General Statutes, and infringing on U.S. and North Carolina constitutional rights of students, parents, and staff. School Boards must take account of the current science on SARS-CoV-2 and COVID-19 to understand what mitigation policies should be adopted (if any). Otherwise, School Boards and their members may be found to be acting in a manifestly arbitrary manner. Thus, I would ask that the members of the School Boards seriously reconsider their position and act prudently and lawfully in the discharge of their duties.

Best Regards,

A handwritten signature in black ink that reads "Matthew P. Ceradini". The signature is written in a cursive style with a large, stylized initial "M".

Matthew P. Ceradini, Esq.