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Pro Querente

MONTANA EIGHTEENTH JUDICIAL DISTRICT COURT
GALLATIN COUNTY

STAND UP MONTANA, a Montana non-profit corporation; JASMINE ALBERINO, TIMOTHY ALBERINO, VICTORIA BENTLEY, DAVID DICKEY, WESLEY GILBERT, KATIE GILBERT, KIERSTEN GLOVER, RICHARD JORGENSON, STEPHEN PRUIETT, LINDSEY PRUIETT, ANGELA MARSHALL, SEAN LITTLEJOHN, and KENTON SAWDY, Plaintiffs, vs. **BOZEMAN SCHOOL DISTRICT NO. 7, MONFORTON SCHOOL DISTRICT NO. 27, and BIG SKY SCHOOL DISTRICT NO. 72,** Defendants.	Cause No. Department No. ***COMPLAINT***

Plaintiffs, Stand Up Montana, Inc., Jasmine Alberino, Timothy Alberino, Victoria Bentley, David Dickey, Wesley Gilbert, Katie Gilbert, Kiersten Glover, Richard Jorgenson, Stephen Pruiett, Lindsey Pruiett, Angela Marshall, Sean Littlejohn, and Kenton Sawdy for their Complaint against Defendants Bozeman School District No. 7, Monforton School District No. 27, and Big Sky School District No. 72 allege as follows.

INTRODUCTION

1. This is an action for injunctive relief brought by Plaintiffs on their behalf and on behalf of their minor children. Plaintiffs, the parents of minor children enrolled in Defendants' schools, seek a temporary restraining order, a preliminary injunction, and a permanent injunction against Defendants' forced masking rules implemented in their schools as a response to COVID-19. Plaintiffs' legal bases spring from the Montana and U.S. Constitutions. Under federal constitutional law, Plaintiffs, as parents of minor children, have a fundamental liberty interest in the care, custody, and control of their children. Under Montana constitutional law, Plaintiffs, as legal guardians of their children, have a right to invoke their children's fundamental constitutional rights. Defendants' mask mandates infringe on the rights of Plaintiffs and their children to privacy, dignity, and free expression without the necessary showing of a compelling government

interest in doing so. See, Art. II, §§ 4, 10, 15, and 34 Mont. Const. Defendants' mask mandates are therefore unconstitutional and, to prevent irreparable harm, Plaintiffs seek injunctive relief.

PARTIES

2. Plaintiff Stand Up Montana is a registered Montana non-profit corporation in good standing with its principal place of business in Gallatin County, Montana. Its mission is to encourage Montanans, during the COVID-19 restrictions, to "stand up for the constitutionally protected liberties, to provide resources and support to individuals and businesses who have been discriminated against or harassed by unfair rules and regulations, and to support similar initiatives." It has a membership of hundreds of individuals, including many in Gallatin County who are the parents of children enrolled at Defendants' schools and who object to the mask mandates described herein.

3. Plaintiffs Jasmine Alberino and Timothy Alberino are the parents of a child enrolled at Defendant Bozeman School District No. 7 (BSD7). The object to forced student masking and believe medical choices for their child are for the parents to decide, not the schools. They believe masks should be optional and left to parental choice.

4. Plaintiff Victoria Bentley is the parent of a child enrolled in BSD7. Ms. Bentley has not enrolled her son in Bozeman Public Schools due to the mask mandate. She objects to forced student masking and believes medical choices for her child are for her to decide as a parent, not the schools. She also believes forced masking is a violation of their child's right to human dignity. She believes masks should be optional and left to parental choice.

5. Plaintiff David Dickey is the parent of children enrolled at Monforton School District No. 27 (MSD27). He objects to forced student masking and believes medical choices for children are for the parent to decide, not the schools. He also believes forced masking is a violation of his child's right to human dignity. He believes masks should be optional and left to parental choice.

6. Plaintiffs Wesley Gilbert and Katie Gilbert are the parents of two children enrolled in BSD7. They object to forced student masking and believe medical choices for their child are for the parents to decide, not the schools. They also think forced masking is a violation of their child's right to human dignity. They believe masks should be optional and left to parental choice.

7. Plaintiff Kiersten Glover is the parent of a child enrolled in Big Sky School District No. 72 (BSSD72). She objects to forced student masking and believes medical choices for children are for the parents to decide, not the schools. She also believes forced masking is a violation of her child's right to human dignity. She believes masks should be optional and left to parental choice.

8. Plaintiff Richard Jorgenson is the parent of children enrolled in BSSD72. He believes the masks being used by most students are like "theatrical props" that contribute nothing to public health. He believes that excessive mask-wearing contributes to periodontal disease and other medical issues. He believes fear-mongering the masses to conform to nonscience-based responses is a massive disservice in the development of young adolescent brains. He believes masks should be optional and left to parental choice.

9. Plaintiffs Stephen Pruiett and Lindsey Pruiett are the parents of a child enrolled in BSSD72. They believe in a parent's right to control medical decisions for their children. As a 20+ year paramedic, Plaintiff Stephen Pruiett believes the style and way masks are being worn do not prevent the spread of viruses and should not be mandated. They believe masks should be optional and left to parental choice.

10. Plaintiff Angela Marshall and Plaintiff Sean Littlejohn are the parents of a child enrolled in BSSD72. They believe there is proof now that the masks are a more significant potential health threat to our children than the risk of viral spread. They also think acts impair the learning environment significantly. They do not believe nonsterile masks in a nonsterile environment are efficacious in protecting students and others from COVID-19 infection. They believe masks should be optional and left to parental choice.

11. Plaintiff Kenton Sawdy is the parent of a child enrolled at BSD7 who has an individualized education plan and medical issues that make it impossible for him to wear a mask. He has a medical prescription for not wearing a mask. He objects to forced student masking and believes medical choices for his child are for the parents to decide, not the schools. He also believes forced masking is a violation of his child's right to human dignity. He believes masks should be optional and left to parental choice.

12. Defendant BSD7 is a public school district located in Bozeman, Montana. It consists of eight elementary schools, two middle schools, three high schools, and one online charter school. It is governed by a board of trustees who have authorized the conduct challenged in this action.

13. Defendant MSD27 is a public school district located in Bozeman, Montana. It consists of one elementary school and one middle school. It is governed by a board of trustees who have authorized the conduct challenged in this action.

14. Defendant BSSD72 is a public school district located in Big Sky, Montana. It consists of one elementary school, a middle school, and a high school. It is governed by a board of trustees who have authorized the conduct challenged in this action.

JURISDICTION AND VENUE

15. As a court of general jurisdiction, the Court has jurisdiction over the parties and the subject matter of this civil action for declaratory and injunctive relief.

16. The venue is proper before this Court because Defendants are located in Gallatin County.

17. Plaintiffs' claims for declaratory and injunctive relief are authorized by Title 27, Chapters 8 and 19, Mont. Code Ann., and Rules 57 and 65 of the Montana Rules of Civil Procedure, and the general legal and equitable powers of this Court.

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GENERAL ALLEGATIONS

The Science of Universal Masking

18. U.S. Centers for Disease Control (CDC) statistics show that COVID-19 is not much of a threat to schoolchildren. Its numbers show that more people under the age of 18 died of influenza during the 2018–19[1] flu season—a season of it labeled of "moderate severity" that lasted eight months—than have died of COVID-19 across more than 18 months.[2]

19. Both data and science suggest such a mandate for widespread and universal use is not justified or effective.

20. When the United States Centers for Disease Control (CDC) and public health officials suddenly shifted from the well-established scientific positions about the marginal effectiveness of masks, there was little to no new evidence of effectiveness. At that time, the entire justification for the CDC guidelines rested on asymptomatic spread concerns. Since then, further studies have cast doubt on how much impact asymptomatic people play in transmission. A recent study involving contract tracing of over 3400 close contacts of 391 confirmed cases found an attack rate of only 0.3% among asymptomatic patients compared to 3.3% for those with mild

[1] https://www.cdc.gov/flu/about/burden/2018-2019.html (last visited 24 AUG 21)
[2] https://www.cdc.gov/nchs/nvss/vsrr/COVID-19_weekly/index.htm (last visited 24 AUG 2021)

symptoms (or ten times less). The rate increases further as symptoms become severe to 5.6% and 6.2% for those with moderate or severe symptoms. In Wuhan, China, an extensive study testing over 10 million people found "there was no evidence of transmission from asymptomatic positive persons." They found 303 cases, all asymptomatic, and traced 1,174 close contacts.

21. The ineffectiveness of masks was well known before 2020, as stated in a New England Journal of Medicine perspective from May 2020: "We know that wearing a mask outside health care facilities offers little if any, protection from infection... In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic."

22. The evidence before 2020 is captured in a review by the World Health Organization (WHO). In 2019 they completed a systematic review of the scientific literature for all NPIs. The thorough study found ten randomized control trials (RCTs) studies of sufficient scientific quality for meta-analysis. They concluded that "there was no evidence that face masks are effective in reducing transmission of laboratory-confirmed influenza." They rated the quality of the evidence as "moderate" – this highest rating of available evidence for any of the 16 NPIs analyzed. Additional studies, particularly in the community settings, were suggested to increase the

quality. Two such studies: The Marine Corps study mentioned previously (*id.*, ¶ 40) and the "Danish Mask Study," significantly add to the quality of the literature, specifically in the community setting.

23. Support for mask effectiveness is primarily based on laboratory studies. The evidence even in that setting, however, is at best inconclusive. The problem is that cloth and surgical masks allow through particles the size of COVID-19. A 2009 study of small particles involving five different surgical masks concludes that "included particles in the same size range of viruses confirm that surgical masks should not be used for respiratory protection." A more recent study considered small particles and used human volunteers to test masks. The very best-case mask filtered 70% of particles, with others filtering less than 50%. Another study, done even before COVID-19, measured the filtering efficacy and the size of mask pores particularly, concluding very poor filtering made worse with wear time and washing of the masks. The airborne nature of COVID-19 means that this performance is not effective when exposure is more than brief to the virus. The studies cited here involve surgical masks, likely better than most cloth masks worn by people. Further, the time of wear and proper use is better in the studies than when people wear masks for many hours.

24. Translating results from a lab setting to conclude similar rates of spread reduction requires evidence. Data and science do not support a significant ability of masks to reduce spread in the entire population. Attempts to find data supporting this hypothesis have been notably lacking in scientific rigor. A study of 1083 counties in the U.S. showed a decrease in hospitalizations after mask mandates had to be withdrawn as rates increased shortly after publication.

25. Even if masks filter some percentage of particles, the number of such particles is far greater than needed to cause a severe infection. An infectious dose of COVID-19 is approximately 300 particles. The number of particles emitted in a single minute of speaking is greater than 700,000. Even a 50% reduction would have no impact on transmissibility.

26. The WHO, in 2020, changed recommendations about mask use quite suddenly in June or July. They published an "interim guidance" document on Dec. 1, 2020, to discuss their new guidelines. The first key point of this document states, "a mask alone, even when it is used correctly, is insufficient to provide adequate protection or source control." Later they reiterate this point and add a mask "is insufficient to provide an adequate level of protection for an uninfected individual or prevent onward transmission from an infected individual (source control)." They

remarkably then continue to recommend use "despite the limited evidence of protective efficacy of mask-wearing in community settings."

27. The WHO interim guidance suffers from some additional shortcomings. For example, they mention studies that "use country or region-level data" to support mask effectiveness but fail to point out that most of those reports have since been invalidated by surges in cases and that there are other studies such as those discussed subsequently that show no effect.

28. The CDC's "scientific" support for mask use has been particularly troubling. Guidance before 2020 in pandemic planning documents was consistent with that of the WHO. Without any additional evidence, the CDC recommended masks and has since attempted to support this policy change. None of their work would pass rigorous scientific peer review. A study involving counties in Kansas suffers numerous flaws, most notably the use of large counties for the mask group and small counties for the non-mask, thus inflating the amount of change in virus spread due to lower denominators.

29. Further, the study authors select the time frame; examining the same counties over a longer time frame removes the effect. A more extensive study is for mask mandates and their relationship to

hospitalizations using the period Mar. 1 – Oct. 17, 2020, in a very similar fashion to the retracted study mentioned previously. Despite the clear and dramatic increase in hospitalizations almost immediately after the study period, which completely invalidates the study conclusions, the CDC did not retract the study and, in fact, published it in early February 2021.

30. Additional evidence from the CDC includes laboratory studies primarily with flaws, as noted previously. In one such study, the authors note major "leakage jets" for cloth and surgical masks. A second notes an issue of the mask breaking the larger droplets into smaller particles that they could not measure, which would essentially aerosolize the virus.

31. Additional evidence in the CDC scientific brief is based on simulations or models rather than actual data or flawed observational studies, which are anecdotal. None would rise to the WHO 2019 standard for evidence. Examples include a study in New York that begins well after the incidence of cases had already begun to fall. There is no discernable change to the case trend after mask use began. Another considers Arizona from January to August 2020. The study is another that should be retracted – not long after the study timeframe, the incidence rates increased in both counties with and without mask use. The "hairdresser" study is included as evidence despite a host of flaws: all reports are purely

anecdotal, there is no control group, and less than 50% of clients responded. Further, some reported getting sick just not testing for COVID-19.

32. Perhaps the most significant evidence that mask use in the community is ineffective is provided by two guidance documents published by the CDC during the pandemic. The first was a notice about the use of masks for protection against wildfire smoke that is titled "Cloth masks will not protect you from wildfire smoke" and continues the masks "do not catch small, harmful particles in smoke that can harm your health." COVID-19 particles are significantly smaller than smoke particles. The second was a recent study in support of wearing two masks. The study itself is scientifically flawed, a laboratory study using mannequins. The authors note the significant limitations and suggest the findings should not be interpreted as "being representative of the effectiveness of these masks when worn in real-world settings." The study is at least a tacit admission that mask use has not been effective in reducing transmission of the virus.

33. A basic principle of scientific hypothesis testing of the effectiveness of interventions is that they should demonstrate clear and convincing evidence that they "work." Finding examples of success should not be difficult for an effective medical intervention. The opposite is the

case with community use of face masks – studies of effectiveness are minimal and reduced increasingly to a very small group that are the exceptions rather than the rule. Proving that something "doesn't work" is statistically and scientifically difficult. However, the preponderance of evidence from the pandemic indicates no effect.

34. A growing body of data and literature published in 2020 supports what was available before COVID-19. A meta-analysis of 10 different studies since 1946 concludes, "We did not find evidence that surgical-type face masks are effective in reducing laboratory-confirmed influenza transmission, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility." Another examining 15 randomized trials concluded "Compared to no masks, there was no reduction of influenza-like illness cases or influenza for masks in the general population, nor in healthcare workers." A third meta-analysis included both randomized trials and observational studies, a total of 31. It concluded, "evidence is not sufficiently strong to support widespread use of facemasks as a protective measure against COVID-19."

35. The European CDC, in a similar fashion to the WHO December 2020 update, conducted an extensive review of evidence regarding mask

wear. The WHO review found "limited evidence on the effectiveness...in the community" and yet continued to recommend use.

36. In 2020 two more randomized trials, including a control group, add to the quality of available evidence documented by the WHO. The first, by C. Raina MacIntyre *et al.*, involved hospital workers with the group wearing cloth masks having a significantly higher rate of lab-confirmed influenza-like illness than a group wearing no masks. The study also examined the penetration rates finding over 97% of particle penetration in cloth masks and 44% in medical masks. A more recent study involves COVID-19 spread in Denmark. The study found a non-significant difference in the control and mask groups (2.1% compared to 1.8% positive) when high-quality surgical masks were worn. The difference was even smaller when they considered participants who reported the highest compliance with mask use.

37. Numerous studies of data during the COVID-19 pandemic confirm the known science before 2020. An extremely extensive Cochrane review of over 60 studies found that face mask use did not reduce cases in the general population or among health care workers. A quasi-experimental study of European data similarly concludes "requiring facemasks or coverings in public was not associated with any additional

independent impact." Despite pressure to retract for fear their article would be used to "support non-mask wearing," researchers from the University of Illinois stood by an article showing that the data does not support mask efficacy.

38. The evidence of mask use effectiveness is such that there are even studies that show a negative impact. The study by C. Raina MacIntyre et al. mentioned previously was conducted pre-COVID-19 but showed an actual increase in infection with cloth masks in a hospital setting. A more recent review noted a similar conclusion. Physical and chemical attributes of respiration through a mask may scientifically describe reasons for increases in infections.

39. Empirical evidence overwhelmingly confirms the scientific literature. While observational, the data should not be ignored. Mask effectiveness should not be hidden in what occurs. A comprehensive study of all counties in the U.S. shows that the difference in COVID-19 outcomes in those with mandates is not only different from those without mandates but worse. For example, comparing similar large counties in Florida, there were 64 cases per 1,000 in mask mandate counties and those without only 40 per 1,000. The results are the same in almost every state where counties with and without mandates to compare. Similar results were found looking

more broadly: for example, at state level, the numbers were 27 per 100,000 with mask mandates and only 17 for no mandates.

40. The evidence from states, counties, and countries worldwide is remarkably consistent. Mask use, which reached very high levels well before the winter virus season, had no discernable impact on the virus outcomes when considering trends—in fact, cases increase dramatically often after or despite increased mask wear. Comparisons of the disease trajectory for like countries/counties consistently depict remarkably similar trajectories despite various mask mandates and usage levels.

41. The example of mask use is important for several reasons. First, there are potential consequences to extended mask use, both physiological and psychological. Studies are just beginning to emerge of actual physical harms from mask wear. Other studies have found issues with oxygen saturation levels, which impact healthy immune systems. This issue could lead to increase susceptibility to COVID-19 and other viruses long term. Other risks include foreign particles causing lung damage and microbial infections.

42. Harms for mask wear for children is an increasing concern. While children are at very low risk of infection and tend to spread the virus and a much lower rate, masks have also become common for school

openings. One is a large study in Germany among over 25,000 children and reports impairments such as headache in over 50%, fatigue (37%), difficulty concentrating (50%), and irritability (60%), among others. A second documents both the risks for children from COVID-19 and a substantial number of harms from mask wear.

43. The second impact of mask mandates is removing the freedom to choose from individuals without compelling scientific or data to support such a restriction. Other restrictions are often similarly unsupported. Such mandates are one size fits all, therefore ignoring clear situations where a mask is not needed – for example, for people with immunity. A third issue is that the mask debate itself proves a distraction from other policies and decisions that have had devastating consequences. Finally, ineffective mandates done in the name of "science" erode the public trust and potentially contribute to poor response when scientifically justified interventions are recommended by government agencies and health officials, such as a potentially effective and safe vaccine should one be developed. Public distrust of medical professions and actual science/data increases with potentially detrimental impacts.

44. The Montana Department of Health and Human Services (DPHHS) has reached the understanding that randomized control trials

have not clearly demonstrated mask efficacy against respiratory viruses, and observational studies are inconclusive on whether mask use predicts lower infection rates, especially for children. (*See*, Emergency Rule I, attached as Ex. A, ¶ 4.)

45. DPHHS understands that there exists a body of literature, scientific and survey/anecdotal, on the negative health consequences that some individuals, especially some children, experience due to prolonged mask-wearing. (*Id.*)

46. DPHHS has found, similarly, that there is also substantial literature that persons who are forced to act contrary to their religious beliefs or moral convictions may experience moral distress and psychological and emotional harm. (*Id.*, ¶ 5.) This moral distress and the associated impact on an individual's psychological and emotional health could also arise when a person is forced to act contrary to their views of their fundamental rights. (*Id.*)

47. DPHHS has found that mask-wearing has been shown to cause some children to suffer mental and emotional distress and issues. (*Id.*, ¶ 6.) Mask wearing can also cause or aggravate physical conditions in some children, including interference with breathing-related to asthma or other respiratory conditions or infections, or interference with the ability to see

classroom boards, screens, papers and desk surfaces, and surrounding safety conditions, especially for students wearing glasses. (*Id.*) DPHHS has found the scientific literature has identified concerning pediatrics, diseases, or predispositions where masking may present significant risks, including respiratory diseases, cardiopulmonary diseases (asthma, bronchitis, cystic fibrosis, congenital heart disease, emphysema), neuromuscular diseases, and epilepsy. (*Id.*) In addition, DPHHS has found that wearing a mask can cause decreased ability to think and concentrate in some children, with potential implications for their cognitive development. (*Id.*)

Forced Student Masking

48. Defendant, despite the science, has imposed forced student masking, requiring all students 0-19 years of age to wear cloth face coverings or masks when indoors on Defendants' campuses.

49. Defendants' forced student masking imposes restrictions on Plaintiffs' children without considering whether the children are infected or reasonably believed to be infected with a communicable disease.

50. Defendants' forced student masking does not consider or accommodate children's individual needs under particular circumstances such as autism, asthma, dermatological issues, and those identified above.

51. Defendants' forced student masking is scheduled to last until at least the first week of October 2021.

52. Defendants' forced student masking set a precedent and foreshadow an intention to impose a universal vaccine mandate when it becomes available for those aged 0-19.

No Competent Findings

53. Defendant has no express recognition or acknowledgment that forced student masking infringes upon parental or student rights. They have made no express findings to the effect that the mask mandates are (a) supported by any compelling government interests, (b) is narrowly tailored to serve the compelling government interest, and (c) is the least restrictive means.

54. Defendant lacks the expertise or competence to make such findings. They have not retained or relied upon competent professionals in necessary fields, such as public health virology, to make any reliable assessment of the interests at stake or the alternative means in pursuing and serving such interests.

55. Given the science of cloth face coverings and masks (see, Ex. A), the connection between masks and public health is so tenuous that Defendants would not have been able to satisfy the strictures of the

compelling government interest test if they had chosen to apply it—which they did not.

COUNT I

(Substantive Due Process)

56. Plaintiffs restate the foregoing.

57. Both as parents and on behalf of their children, Plaintiffs have a liberty interest, protected by the U.S. and Montana Constitutions, in the right to refuse an unwanted medical intervention such as cloth face coverings or masks. The right to bodily integrity and to refuse such unwanted medical treatments is deeply rooted in the historical traditions of the United States. The right to refuse medical treatment stems from the common law and bodily integrity and dignity rights.

58. Defendants' forced student masking consists of compulsory medical intervention and constitutes a substantial interference with and violation of Plaintiffs' and their children's liberty interests.

59. Defendants' violation of Plaintiffs' and their children's liberty interests is causing and will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

60. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening Plaintiffs with substantial penalties for not complying with mask mandate restrictions.

COUNT II

(Equal Protection)

61. Plaintiffs restate the forgoing.

62. Defendants force student masking exclusively for students at school. When none is imposed on the general population, it violates the students' rights to equal protection because the state's objective is to eradicate COVID-19 from the population as a whole. While Defendant has imposed mandates on students, there are constitutional limits to what a legislative majority may impose on any minority while leaving itself free of such constraints.

63. Children are at no greater risk from COVID-19 than the general population and do not benefit in any particular way from the mask mandate compulsion. Exempting the general adult population, which is demonstrably at far greater risk, from the universal mask mandate violates equal protection. Children may not be the subject of discrimination in the public's response to disease from which they are at negligible risk.

64. Defendants' violation of Plaintiffs' children's right to equal protection is causing and will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

65. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening Plaintiffs' children with substantial penalties for not complying with mask mandate restrictions.

COUNT III

(Privacy)

66. Plaintiffs restate the foregoing.

67. Montana has a history of trampling on individual rights. For example, Montana passed sedition laws before and during WWI that were the strongest in the nation. That history served to focus the 1972 Montana Constitutional Convention on the vigilant protection of individual rights from the tyrannical government impulses, especially when animated by popular sentiment in a time of perceived emergency.[3]

68. Privacy in medical decision-making is one of the fundamental individual rights ensconced in the Montana Constitution's Declaration of

[3] FEATURE: BOOK: SOME HEAVY LEGAL READING TO USHER IN 2006: RELIVING OUR STATE'S SHAMEFUL SEDITION ACT, 31 Montana Lawyer 8.

Rights by the 1972 framers of the Montana Constitution. The U.S. Constitution also protects privacy in medical decisions.

69. Defendants' forced student masking compels uninfected and unexposed students to wear face masks on Defendants' campuses at all times when indoors. If students not infected with a communicable disease, or reasonably believed to be infected, choose through their parents to exercise their right to make their own private health care choices by declining to wear a face covering, Defendant bars them from Defendants' indoor spaces.

70. Defendants' forced student masking denies the right of individual privacy guaranteed by Art. II, § 10, Mont. Const. and Amend. IX, U.S. Const. The right to personal privacy protects medical care choices. The right of privacy broadly guarantees individuals the right to make medical judgments affecting their bodily integrity and health, free from government interference. The right to privacy is implicated when a law infringes upon a person's ability to obtain or reject a lawful medical treatment.

71. Defendants' violation of Plaintiffs' and their children's privacy rights in making their own medical choices is causing. It will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

72. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening the Plaintiffs' children with substantial penalties for not complying with mask mandate restrictions.

COUNT IV

(SB 400)

73. Plaintiffs restate the foregoing.

74. Senate Bill 400 approved by the Montana Legislature in 2021 will take effect on Oct. 1, 2021. Defendants' forced student masking is scheduled to last beyond Oct. 1, 2021.

75. Under SB400, Defendant may not interfere with the fundamental right of Plaintiffs to direct the health care and mental health of their children, unless Defendant has demonstrated that the interference (a) furthers a compelling governmental interest; (b) is narrowly tailored and is (c) consists of the least means least restrictive to Plaintiffs' rights means in furthering of the compelling governmental interest.

76. Defendant's forced student masking interferes with Plaintiffs' right to direct their children's health care and mental health.

77. Defendant has not demonstrated, or attempted to demonstrate, that the interference (a) furthers a compelling governmental interest; and (b) is narrowly tailored and is (c) the least restrictive means available for

the furthering of the compelling governmental interest.

78. Defendants' violation of Plaintiffs' rights to direct their children's health care and mental health is causing. It will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

79. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening Plaintiffs and their children with substantial penalties for not complying with mask mandate restrictions.

COUNT V

(Human Dignity)

80. Plaintiffs restate the foregoing.

81. Human dignity is a fundamental right ensconced expressly in the Montana Constitution's Declaration of Rights.

82. The right of human dignity is the only right in Montana's Constitution that is "inviolable." It is the sole right in Article II carrying the absolute prohibition of "inviolability." No individual may be stripped of human dignity. No private or governmental entity has the right or the power to do so. Human dignity cannot be violated—no exceptions.

83. In the Western ethical tradition, especially after the Religious Reformation of the 16th and 17th centuries, dignity has typically been

associated with the normative ideal of individual persons as intrinsically valuable, as having inherent worth as individuals, at least in part because of their capacity for independent, autonomous, rational, and responsible action. Under this conception, dignity is directly violated by degrading or demeaning a person.

84. Similarly, dignity is indirectly violated by denying a person the opportunity to direct or control his own life in such a way that his worth is questioned or dishonored. For example, paternalistic treatment could indirectly undermine dignity—treating adults like children incapable of making autonomous choices for themselves or by trivializing what choices they make about how to live their lives.

85. Respect for the dignity of each individual demands that people have for themselves the moral right and moral responsibility to confront the most fundamental questions about the meaning and value of their own lives and the intrinsic value of life in general, answering to their consciences and convictions.

86. Defendants' forced student masking interferes with Gallatin County students' ability to communicate with one another by means of facial expression.

87. The human face is the most distinguishing visible characteristic reflecting a person's individuality. The human face is what makes the individual most easily and readily recognizable. The human face is highly expressive, able to convey countless emotions without saying a word. And unlike some forms of nonverbal communication, facial expressions are universal. The facial expressions for happiness, sadness, anger, surprise, fear, and disgust are the same across cultures. Science has long recognized that people signal their feelings and emotions to each other by subtle movements, gestures, and facial expressions and that people's ability (or inability) to accurately "send" and "receive" these nonverbal messages must have important implications for their social and emotional lives.

88. Defendants' forced student masking demeans student human dignity, undermines their individuality, interferes with their ability to read and show emotions, and hinders interpersonal communication and relations. It also strips them of their autonomy in deciding the appearance they wish to present to the public. It is, therefore, a violation of the Montana constitutional right to human dignity.

89. Defendants' violation of Plaintiffs' and their children's right to human dignity is causing and will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

90. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening Plaintiffs' children with substantial penalties for not complying with mask mandate restrictions.

COUNT VI

(Freedom of Expression)

91. Plaintiffs restate the foregoing.

92. Freedom of expression is a fundamental right ensconced expressly in the Montana Constitution's Declaration of Rights.

93. Given (a) the material lack of scientific basis for Defendants' forced student masking and (b) the response's lack of effectiveness both based on scientific studies and its demonstrated failure to curb the pandemic, compliance with Defendants' forced student masking is fraught with substantive meaning.

94. Wearing a mask constitutes to many an outward sign of trust in, loyalty to, or submission to the honesty, wisdom, and power of government. Wearing a mask functions for others as a virtue signal and an outward demonstration of their own social and moral superiority over those who fail to comply. For others, refusing to wear a mask is an external signal of mistrust in government and defiance to unsupportable demands of

compliance for its own sake. Wearing a mask or not wearing a mask is, for some, a demonstration of partisan political affiliation.

95. Defendants' forced student masking infringes upon Plaintiffs' and their children's freedom to express their political and moral points of view in violation of the fundamental constitutional right to freedom of expression.

96. Defendants' violation of Plaintiffs' and their children's right to freedom of expression is causing and will continue to cause them to suffer irreparable harm for which there is no adequate remedy at law.

97. Enforcement of Defendants' forced student masking would cause irreparable harm by threatening Plaintiffs' children with substantial penalties for not complying with mask mandate restrictions.

REQUEST FOR RELIEF

Accordingly, Plaintiffs request:

1. A declaration that Defendants' forced student masking against students is unconstitutional;

2. Injunctive relief in Plaintiffs' favor and against Defendant imposing a permanent injunction against enforcement of Defendants' forced student masking;

3. An award of attorney fees, expert witness fees, other costs of suit; and

4. Such other and further relief as may be appropriate in the circumstances.

DATED this 13th day of September 2021.

Respectfully Submitted,
RHOADES, SIEFERT & ERICKSON PLLC

By: _____
Quentin M. Rhoades
Pro Querente

BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of Temporary Emergency Rule I to allow students and/or their parents or guardians the ability to opt-out of school health-related mandates for health, religious, moral, or other fundamental rights reasons	)))))))	NOTICE OF ADOPTION OF TEMPORARY EMERGENCY RULE

TO: All Concerned Persons

1. The Department of Public Health and Human Services (department) is adopting the following temporary emergency rule as part of the State's response to the current COVID-19 global pandemic. The current COVID-19 global pandemic has placed great burdens on the State, and some of the responses to the pandemic, including mask mandates, have also imposed additional burdens on citizens, including on their health and well-being. While the department encourages citizens to receive the COVID-19 vaccine in consultation with their health care provider, this choice, which could mitigate not only the need to wear a mask, but also, potentially, the need for school-based mask mandates, is not yet available to the majority of students because of their age. The rule directs that, if schools or school districts impose a health-related mandate on students, such as a mask mandate, they should consider, and be able to demonstrate they considered, parental concerns in adopting the mandate, and should provide the ability for students, and/or parents or guardians on behalf of their children, to choose to opt-out based on physical, mental, emotional, or psychosocial health concerns, as well as on the basis of religious belief, moral conviction, or other fundamental right, the impairment of which may negatively impact such students' physical, mental, emotional, or psychosocial health.

2. The Centers for Disease Control and Prevention (CDC) recognizes categories of people as exempt from the requirement to wear a mask, including children under age two; persons with disabilities who cannot wear a mask, or cannot safely wear a mask, for reasons related to the disability; and persons for whom wearing a mask would create a risk to workplace health, safety, or job duties (*see* "Guidance for Wearing Masks", "Who should or should not wear a mask" at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/cloth-face-cover-guidance.html, last updated April 19, 2021). Similarly, mask wearing can interfere with the learning and general well-being of school-aged children, related to their age and development; their disabilities, and physical and mental health attributes; and classroom health, safety, and productivity. As those best suited and entitled to assess individual needs for the physical, mental, and developmental well-being of their minor children, parents or guardians, in consultation with their children's health care provider as appropriate, should be afforded the ability to opt-out of mask requirements on behalf of their children.

EXHIBIT A

3. The department is charged with providing consultation on conditions and issues of public health importance for schools, to school and local public health personnel, and to the superintendent of public instruction (50-1-202(1)(l), MCA). The department is also charged with adopting and enforcing rules regarding public health requirements for schools, including any matters pertinent to the health and physical well-being of pupils, teachers, and others (50-1-202(1)(p)(v), 50-1-206, MCA). To this end, for example, the department recommends students be evaluated by a health care provider periodically and as necessary to identify health problems with the potential for interfering with learning, including assessment of students' health and developmental status, vision, hearing, and mental health (ARM 37.111.825(7)). In furtherance of this obligation, and for the reasons set forth herein, the department has determined that schools and school districts that impose such health-related mandates as mandatory mask wearing should provide the ability for students through their parents or guardians to choose to opt-out of mandated mask wear in school.

4. The scientific literature is not conclusive on the extent of the impact of masking on reducing the spread of viral infections. The department understands that randomized control trials have not clearly demonstrated mask efficacy against respiratory viruses, and observational studies are inconclusive on whether mask use predicts lower infection rates, especially with respect to children.[1] The department understands, however, that there is a body of literature, scientific as well as survey/anecdotal, on the negative health consequences that some individuals, especially some children, experience as a result of prolonged mask wearing.[2]

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[1] *See, e.g.,* Guerra, D. and Guerra, D., *Mask mandate and use efficacy for COVID-19 containment in US States*, MedRX, Aug. 7, 2021, https://www.medrxiv.org/content/10.1101/2021.05.18.21257385v2 ("Randomized control trials have not clearly demonstrated mask efficacy against respiratory viruses, and observational studies conflict on whether mask use predicts lower infection rates."). *Compare* CDC, *Science Brief: Community Use of Cloth Masks to Control the Spread of SARS-CoV-2,* last updated May 7, 2021, https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/masking-science-sars-cov2.html, last visited Aug. 30, 2021 (mask wearing reduces new infections, citing studies) *with* David Zweig, *The Science of Masking Kids at School Remains Uncertain*, New York Magazine, Aug. 20, 2021, https://nymag.com/intelligencer/2021/08/the-science-of-masking-kids-at-school-remains-uncertain.html (author reviewed the 17 studies cited in CDC's K-12 guidance of evidence that masks on students are effective, noting that none looked at student mask use in isolation from other mitigation measures or against a control, with some studies demonstrating that lack of masking correlated with low transmission and noting issue with presentation of one study published in CDC's MMWR). *See also* Xiao, J., Shiu, E., Gao, H., Wong, J. Y., Fong, M. W., Ryu, S., Cowling, B. J. (2020). *Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Personal Protective and Environmental Measures.* CDC, Emerging Infectious Diseases, 26(5), 967-975, https://doi.org/10.3201/eid2605.190994 (meta-analysis found that although mechanistic studies support potential effect of hand hygiene or face masks, evidence from 14 randomized controlled trials of such measures did not support a substantial effect on transmission of laboratory-confirmed influenza); Guerra, D. and Guerra, D. (not observing "association between mask mandates or use and reduced COVID-19 spread in US states").

[2] *See, e.g.,* Kisielinski, K. et al., *Is a Mask That Covers the Mouth and Nose Free From Undesirable Side Effects in Everyday Use and Free of Potential Hazards?*, Int. J. Environ. Res. Public Health 2021, 18, 4344, https://doi.org/10.3390/ijerph18084344 (scientific review of multiple studies revealed relevant adverse events over more than ten medical disciplines, including internal medicine, psychology, psychiatry, and pediatrics, finding statistically significant correlation in the quantitative

EXHIBIT A

5. Similarly, there is also substantial literature that persons who are forced to act contrary to their religious beliefs or moral convictions may experience moral distress, and psychological and emotional harm.[3] This moral distress and the associated impact on an individual's psychological and emotional health could also arise when a person is forced to act contrary to his or her views of his or her fundamental rights.[4]

6. Mask wearing has been shown to cause some children to suffer mental and emotional distress and issues.[5] Mask wearing can also cause or aggravate physical conditions in some children, including interference with breathing related to asthma or other respiratory conditions or infections, or interference with the ability to see classroom boards, screens, papers and desk surfaces, and surrounding safety conditions, especially for students wearing glasses. The scientific literature has identified, with respect to pediatrics, diseases, or predispositions where masking may present significant risks, including respiratory diseases, cardiopulmonary diseases (asthma, bronchitis, cystic fibrosis, congenital heart disease, emphysema), neuromuscular diseases, and epilepsy.[6] In addition, mask wearing can cause

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analysis between the negative effects of blood-oxygen depletion and fatigue in mask wearers, and identifying what the authors called Mask-Induced Exhaustion Syndrome with symptoms including feeling of fatigue or exhaustion, decreased ability to concentrate, and decreased ability to think). *But see* CDC, Science Brief ("[r]esearch supports that mask wearing has no significant adverse health effects for wearers," citing studies mainly conducted with healthy research subjects).

[3] *See, e.g.,* Christy A. Rentmeester, *Moral Damage to Health Care Professionals and Trainees: Legalism and Other Consequences for Patients and Colleagues*, Journal of Medicine and Philosophy, 33: 27-43, 2008, p,37 ("moral distress is a sense of complicity in doing wrong. This sense of complicity does not come from uncertainty about what is right but from the experience that one's power to resist participation in doing wrong is severely restricted by one's work environment and from the experience that resisting participation in doing wrong is severely restricted by one's work environment and from the experience that resisting participation in doing wrong exposes one to harm."); Borhani et al., *The relationship between moral distress, professional stress, and intent to stay in the nursing profession*, J. Med. Ethics Hist. Med. 2014; 7:3.

[4] *Cf.* Kisielinski, K. et al. (masks impair the wearer's field of vision and inhibit other habitual actions, which can be perceived "as a permanent disturbance, obstruction, and restriction"; "[w]earing masks, thus, entails a feeling of deprivation of freedom and loss of autonomy and self-determination, which can lead to suppressed anger and subconscious constant distraction, especially as the wearing of masks is mostly dictated and ordered by others").

[5] *Id.* (noting a survey which showed masks can cause anxiety and stress reactions in children, an increase in psychosomatic and stress-related illnesses and depressive self-experience, reduced participation, social withdrawal, and lowered health-related selfcare); *see also* Carla Peeters, September 9, 2020, *Rapid response: Psychological, biological, and immunological risks for children and pupils makes long-term wearing of mouth masks difficult to maintain*, BMJ, https://www.bmj.com/content/370/bmj.m3021/rr-6.

[6] Kisielinski, K. et al. These conditions tend to be ones with respect to which individuals would be excluded from research studies. *See, e.g.,* Lubrano, R., Bloise, S., Testa, A., et al. *Assessment of Respiratory Function in Infants and Young Children Wearing Face Masks During the COVID-19 Pandemic*. JAMA Netw Open. Mar 2 2021;4(3):e210414. doi:10.1001/jamanetworkopen.2021.0414, (cited in CDC, Science Brief at note 64) (noting the exclusion from study of infants and young children with lung or cardiac disease, neuromuscular disorders and those with medications that could be associated with changes in the parameters examined).

EXHIBIT A

decreased ability to think and to concentrate in some children, with potential implications for their cognitive development.[7]

7. Accordingly, personal choice in the form of an exemption from or exception to a mask mandate policy can serve to protect and further the physical, mental, and emotional health of students who may be negatively impacted by a masking requirement. Safety recommendations and choices in response to the COVID-19 global pandemic are invaluable, but mandates can place more detrimental stress or have other adverse health impacts on some students and families, unless they have the ability to opt-out as necessary. This is especially the case where the scientific evidence supporting the original public health intervention is inconclusive. With respect to the documentation necessary to support such exception or exemption from a mandatory health measure such as mandatory mask wearing, the department suggests that the type and quantum of documentation outlined in House Bill 334, with respect to exemptions from school vaccination requirements, may serve as an appropriate model.

8. For the foregoing reasons, the department adopts this emergency rule. Certain Montana schools and school districts have adopted and, with the beginning of the school year, will be enforcing mask mandates on the basis of public health, without considering the negative implications that such measures could have on the physical, mental, emotional, or psychosocial health of some students. Promulgation of this emergency rule is necessary because no other administrative act can be taken to avert this imminent peril to the public health, safety, and well-being of Montana youth, who are now returning or beginning to return to the classroom for the new school year. This rule will remain in effect no longer than 120 days after the date of adoption.

9. EMERGENCY RULE I is necessary to provide essential health, well-being, fundamental rights, and a safe and effective learning environment for Montana youth. Emergency Rule I protects Montana students returning to school who may experience adverse effects from mandatory mask wear by directing schools and school districts that they should consider, and be able to demonstrate consideration of, parental concerns when adopting a mask mandate, and should provide those students, or their parents or guardians, on their behalf, with the ability to opt-out of wearing a mask, as necessary.

10. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who need an alternative accessible format of this notice. If you require an accommodation, contact Heidi Clark at the Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

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[7] *See, e.g.,* Kisielinski, K. et al.; *see also* Guerra, D. and Guerra, D. (noting some risks of mask wearing, including that by obscuring nonverbal communication, masks interfere with social learning in children, and research that masks decrease cognitive precision).

EXHIBIT A

11. The emergency rule is effective immediately, August 31, 2021.

12. The text of the emergency rule provides as follows:

EMERGENCY RULE I ABILITY TO OPT-OUT OF SCHOOL HEALTH-RELATED MANDATES (1) In order to provide for the health, well-being, rights, and educational needs of students, schools and school districts should consider, and be able to demonstrate consideration of, parental concerns when adopting a mask mandate, and should provide students and/or their parents or guardians, on their behalf, with the ability to opt-out of health-related mandates, to include wearing a mask or face covering, for reasons including:

(a) physical health;
(b) mental health;
(c) emotional health;
(d) psychosocial health;
(e) developmental needs; or
(f) religious belief, moral conviction, or other fundamental right the impairment of which could negatively impact the physical, mental, emotional, or psychosocial health of students.

AUTH: 2-4-303, 50-1-202, 50-1-206, MCA
IMP: 50-1-202, 50-1-206, MCA

13. The rationale for the temporary emergency rule is set forth in paragraphs 1 through 9.

14. It is presently unknown whether a standard rulemaking procedure will be undertaken prior to the expiration of this temporary emergency rule. The necessity and efficacy of this emergency rule will be continuously evaluated as the effort to combat the COVID-19 global pandemic in Montana continues and develops.

15. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices, and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in paragraph 10 or may be made by completing a request form at any rules hearing held by the department.

16. The bill sponsor contact requirements of 2-4-302, MCA, do not apply to this rulemaking. Special notice, pursuant to 2-4-303, MCA, was made to each member of the Children, Families, Health, and Human Services; and Education Interim Committees and to each member of the committees' staff, using electronic mail on August 31, 2021.

/s/ Robert Lishman
Robert Lishman
Rule Reviewer

/s/ Adam Meier
Adam Meier, Director
Public Health and Human Services

Certified to the Secretary of State August 31, 2021.

EXHIBIT A