Concerns Regarding DHEC COVID-19 Guidance

March 30, 2023

Dear Dr Simmer,

In South Carolina there has been a distinct, growing mistrust of the Department of Health and Environmental Control (DHEC). This is in-part due to DHEC staff adopting and encouraging certain and the Centers for Disease Control and Prevention (CDC) recommendations, without extensive scientific review, which are:

1. not supported by the body of scientific evidence.
2. not adapted as emerging scientific evidence and new information becomes available.
3. not scientifically justified to be implemented in all age groups and population.
4. detrimental due to known and unintended negative consequences in certain populations, resulting in other very serious public health problems.

South Carolinians' concerns regarding DHEC staff's management of the COVID-19 crisis are supported by:

- documented written correspondence from qualified DHEC staff.
- documented FOIA request responses from qualified DHEC staff.
- the known deleterious damage resulting from DHEC COVID-19 Guidance in South Carolina.

There is no denying that in 2020 the COVID-19 pandemic brought many difficult challenges that the current state and federal government public health officials had never encountered. Although the initial response was led by a noble sense of urgency and crisis management, throughout the COVID-19 crisis DHEC did not consistently provide documentation of data and evidence supporting COVID-19 guidance.

For the purpose of beginning to rebuild trust in DHEC's public health guidance and to strengthen and propel our state forward, it is respectfully requested that DHEC staff provide further transparency and respond in writing to questions on the following topics:

1. Why DHEC staff are unable to provide transparency on the data criteria used to collect South Carolinian COVID-19 hospitalizations and deaths which are published on the DHEC website. It is currently indistinguishable whether COVID-19 disease directly caused, contributed to, or was not related to a reported South Carolinian COVID-19 hospitalization or death.

2. Why DHEC staff reported that they are unable to provide scientific evidence, data, source documents and risk vs benefit analysis supporting the safety and effectiveness of DHEC's recommendation of universal pediatric COVID-19 vaccination or various pediatric age-groups 6 months and up.

3. Why DHEC staff reported that they did not perform an inquiry with CDC and FDA or independently investigate the over 8,000 COVID-19 vaccine adverse events South Carolinians reported to the Vaccine Adverse Events Reporting System (VAERS).

4. Why DHEC staff did not provide adequate scientific evidence, data, source documents and ongoing risk vs benefit analysis to support DHEC's previous strong recommendation of universal masking in DHEC's K-12 COVID-19 school guidance.

South Carolinian parents, healthcare providers, elected officials, business owners and more, rely heavily on DHEC guidance who by state law (44-1-80, 44-1-110)[1] are charged with being our primary source of public health guidance.

DHEC and other state and federal health agencies historically have enormous credibility among physicians and the public because they are assumed to rigorously review available science and be free of bias. South Carolinians understandably expect excellence from DHEC staff creating public health guidance and to work strictly in the best interest of ensuring the health and safety of South Carolinians (not to prioritize CDC, medical societies and others guidance).

To ensure the best possible public health outcomes, South Carolinians depend on DHEC staff creating policy guidance to provide transparent, accurate data and sound scientific citations supporting and justifying all current and future public health recommendations. DHEC staff's messaging to South Carolinians must be an objective disclosure of an independent, thoughtful review of data and evidence including if there are knowledge gaps in certain areas.

The toll of the COVID-19 crisis has been enormous and far reaching across nearly every population. In South Carolina and across our nation, tragically and predictably, the elderly population and individuals with comorbidities typically experienced the most serious health complications from COVID-19 disease.

It is well established in public health that certain one-size-fits-all public health strategies have resulted in expected and unexpected devastating public health consequences. Lived experiences and emerging South Carolina and national data suggests negative outcomes resulting from public health COVID-19 guidance that has disproportionately impacted low risk populations such as children, especially those who are socio-economically disadvantaged. Deleterious damage caused by COVID-19 public health guidance include:

- learning loss and developmental delays[2]
- an exponential increase in depression, anxiety disorders and suicidal ideation especially among the young[3]
- substantial loss of public trust in DHEC, CDC, medical institutions and medical providers[4]
- significant current and future impact on South Carolinians from economic loss [5]
- unexplained and uninvestigated excess death rates in several age groups[6]
- a false sense of security in high-risk individuals who trust in unproven measures intended to mitigate their risk.

Thank you for your service and the time spent reviewing and responding to this document so South Carolinians' can be provided clarification on the critically important matter of current and future public health policies and practices.

[DHEC correspondence and DHEC FOIA requests and responses are provide in a separate document or can found in the DHEC database]

[1] https://www.scstatehouse.gov/code/t44c001.php
[2] https://www.npr.org/2022/06/22/1105970186/pandemic-learning-loss-findings
[3] https://www.cdc.gov/media/releases/2022/p0331-youth-mental-health-covid-19.html
[4] https://www.axios.com/2023/03/07/trust-in-cdc-public-health-agencies
[5] https://www.hoover.org/sites/default/files/research/docs/South%20Carolina_HESI_PaperSeries_template_Final.pdf
[6] http://phinancetechnologies.com/humanityprojects/yearly%20Excess%20Death%20Rate%20Analysis%20-%20US.htm

- **A DHEC FOIA response was requested to provide federal and state a.) internal guidance documents and/or b.) detailed instructions of specific protocols SCDHEC provided to instruct individuals and/or hospital systems collecting and reporting South Carolina COVID-19 associated hospitalization and death data which was published on the SCDHEC website.**
- **Correspondence with DHEC employees and the DHEC Director of Epidemiology regarding specific details on how pediatric COVID-19 hospitalizations and deaths were classified, collected, and reported of the DHEC website. For example, DHEC was asked to provide clarification if pediatric individuals reported on the website had a poor health outcome from COVID-19 disease or if these children had tested positive for COVID-19 and their hospitalization or death was caused by other contributing factors.**

Based on the correspondence with DHEC staff and FOIA responses (17 PDFs on COVID-19 testing) provided by DHEC staff, the data collection methodology DHEC staff currently uses does not distinguish whether COVID-19 disease directly caused, contributed to, or was not related to a reported South Carolinian COVID-19 hospitalization or death. This is unsatisfactory.

Additionally, a recent CDC FOIA response also suggests that CDC COVID-19 hospital admissions data is also unreliable for a similar reason as follows:

"The way that our data guidance defines COVID admission does not enable us to make a distinction between hospital admissions due to COVID-19 vs. hospital admissions for reasons other than COVID-19."[7] - CDC FOIA

Throughout the pandemic, it was essential for South Carolinian providers, parents, and the public at-large to understand the circumstances in different populations impacted so that individual risk could be properly assessed. Additionally, South Carolina businesses, institutions, and elected officials, such as School Board Members, depended heavily on an objective disclosure of the data from DHEC so they could craft or adopt appropriate and proportional public health policies.

1. Due to South Carolinians not being about to make a distinction whether a COVID-19 hospitalization or death was from COVID-19 disease or if an individual had a positive COVID-19 test or other contributing illness, please explain what COVID-19 hospitalization and death data or information DHEC staff relied on to support press releases to South Carolinians'[8] and briefings to elected officials such as School Boards?

(Please see Table 1 and Attachment A, px for current COVID-19 death data by age; COVID-19 hospitalizations have been removed from the DHEC website)

[7] https://icandecide.org/wp-content/uploads/2023/01/Final-Response-No-Records-1.pdf
[8] https://scdhec.gov/covid19/dhec-news-releases-information-videos-covid-19

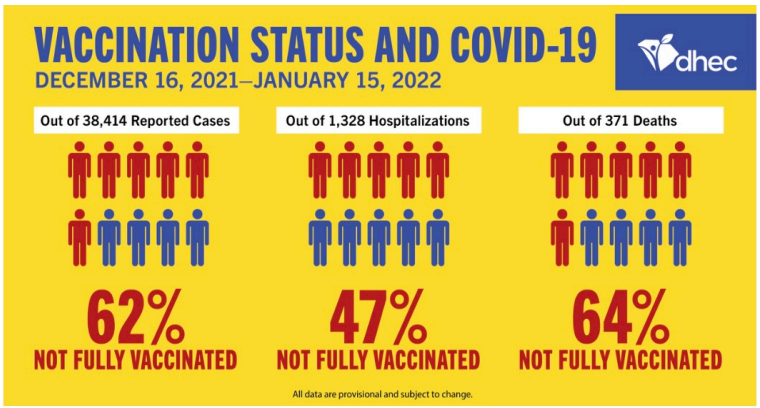
Table 1

South Carolina Residents by Age among Deaths *			
Age	**Total Deaths**	**Population Estimate**	**Rate per 100K**
Under 5	12	291296	4
5 to 11	8	439755	2
12 to 17	14	391558	4
18 to 34	251	1153713	22
35 to 49	1053	944102	112
50 to 64	3637	1021241	356
65 to 84	10239	882081	1161
85 & Older	4231	94294	4487
*SCDHEC.Gov/Covid 19			

2. Please explain why DHEC staff are unable to utilize and disseminate more accurate methodologies for providers to collect and report South Carolinian COVID-19 hospitalization and death data published on the DHEC website?

3. Please explain why the vaccination status of South Carolina COVID-19 cases, hospitalizations and deaths were all removed from the DHEC website in early 2022? DHEC has not responded to requests for this data and whether DHEC staff are continuing to track this data. Accurately curating and disclosing this data will help high-risk vaccinated and unvaccinated South Carolinians assess risk.
(please see link and DHEC infographic below)

Link: https://scdhec.gov/covid19/covid-19-data/cases-hospitalizations-deaths-among-not-fully-vaccinated



- **DHEC FOIA response was requested to provide all scientific evidence, data and source documents reviewed by SCDHEC employees which determined SCDHEC's recommendation of universal COVID-19 vaccination of South Carolina children in the following age ranges: age 6 months - 4 years old, age 5-11 years old and age 12-18 years old and to further provide SCDHEC's employees risk vs benefit analysis review of universal COVID-19 vaccination for each age group.**

DHEC provided the following response to a question on risk vs benefit analysis performed. However, DHEC continues to message South Carolina's parents, schools, and media outlets that COVID-19 vaccination is the best opportunity of keeping children safe and healthy from COVID-19 disease[9].

> *"I don't know of any written risk vs benefit analysis developed by DHEC, and I can't even recall all of the data and studies and articles I read on the vaccines, their development, their trials in children, etc. I read many articles and studies on journal websites or other reputable sources of information that I didn't save. You could check with Stephen and Jonathan in Immunizations to see what stuff they might have, but I am confident no one could fully produce or recall every piece of data or information they learned on the topic."* -DHEC Staff

When DHEC was asked if they had any further information to add, DHEC staff's response was the following:

> *"DHEC recommends children get vaccinated against COVID-19 in order to decrease the rare but real serious cases, including deaths, that occur in that population, as well as to decrease the risk of a child developing MIS-C or long COVID, lower the odds of transmitting the virus to high risk family members, and to reduce children missing school and other activities due to being sick. Adverse effects of the vaccine in children are rare, with myocarditis occurring in only 105.9 children per one million doses of the Pfizer vaccine given to males aged 16-17 years old, which was the highest rate among children. In addition, multiple studies have shown that the risk of myocarditis is higher after COVID-19 infection than after vaccination."*
>
> *"The CDC's analysis of the safety of the vaccines for children and teenagers, including links to the articles with the scientific studies' results that are the basis for the analysis, can be found using this link: https://www.cdc.gov/coronavirus/2019-ncov/vaccines/vaccine-safety-children-teens.html "*
>
> -DHEC Staff

4. Based on the responses above, Can DHEC staff please present data, scientific evidence, and risk vs benefit analysis to South Carolinians' for both healthy children and at-risk children supporting their recommendation of universal pediatric COVID-19 vaccination?

[9] https://scdhec.gov/covid19/covid-19-vaccine/covid-19-vaccines-kids-12-older

5. Can DHEC staff please provide scientific evidence to South Carolinians that pediatric COVID-19 vaccination achieves the following:

   - decreases the rare but real serious cases, including deaths, that occur in that population,
   - decreases the risk of a child developing MIS-C or long COVID,
   - lowers the odds of transmitting the virus to high-risk family members,
   - reduces children missing school and other activities due to being sick.

6. Has DHEC staff asked the FDA and CDC why Pfizer COVID-19 vaccine randomized trials did not evaluate mortality, hospitalization, and transmission as primary endpoints? Why were these trials terminated early? Why there are so few safety studies from the CDC and FDA vaccine safety systems? Does DHEC believe these methodologies used by federal regulators are good enough for South Carolinians?

- **DHEC FOIA response was requested to provide DHEC employees' follow-up, investigation and/or communication with the Center for Disease Control and Prevention and/or Food and Drug Administration related to the over 8,000 South Carolina COVID-19 vaccine adverse events reported to the Vaccine Adverse Reporting System (VAERS).**

Further supporting the essential need for DHEC's scientific review of COVID-19 vaccine safety is that based on DHEC's vaccine messaging, many South Carolinians are being required to or voluntarily accept COVID-19 vaccinations as a condition of their employer or educational institution. Adding further complexity is DHEC that staff providing these recommendations cannot be held legally or personally accountable if injury or death results from the recommendation of universal COVID-19 vaccinations[10] [11]. This reality places the physical and legal burden of risk squarely on South Carolinians.

As you know, VAERS is a passive reporting system[12], meaning it relies on individuals to send in reports of their experiences to CDC and FDA. VAERS is not designed to determine if a vaccine caused a health problem, but is especially useful for detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. As such, VAERS can provide CDC and FDA with valuable information so that attention and funding may be directed to additional work and evaluation necessary to further assess a possible safety concern.

It is widely acknowledged adverse events to vaccinations and drugs are severely under-reported[13] [14]. Barriers to reporting adverse events from pharmaceuticals for clinicians include:

- a lack of clinician awareness,
- uncertainty about when and what to report, as well as
- the burdens of reporting: reporting is not part of clinicians' usual workflow, takes time, and is duplicative.

[10] https://aspr.hhs.gov/legal/PREPact/Pages/default.aspx
[11] https://www.congress.gov/bill/99th-congress/house-bill/5546
[12] https://vaers.hhs.gov/about.html
[13] https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf
[14] https://academic.oup.com/cid/article/61/6/864/451758

DHEC staff reported in their FOIA response that:

"DHEC does not do follow up or investigate VAERS submissions. In fact, CDC doesn't provide us with the information on or communicate with us about entries related to SC, and they (and/or the FDA) do all of the investigating and analysis of those reports." – DHEC Staff

However, after corresponding with a scientist at the CDC's, Immunization Safety Office it was communicated that South Carolina receives weekly reports on South Carolinian COVID-19 vaccine adverse events reported to VAERS.

"*Currently CDC uses Epi-X to send each U.S. public health jurisdiction reports containing all of their state's VAERS reports on COVID-19 vaccine, as well as de-identified COVID-19 summary data from other jurisdictions. CDC sends this data on Epi-X weekly."* – Immunization Safety Office (CDC) Staff

7. What has DHEC staff done to encourage healthcare providers to report potential vaccine adverse events to VAERS?

8. Since the FOIA correspondence, has DHEC staff investigated the exponential increase in reported vaccine adverse events in South Carolinians during the COVID-19 vaccine rollout in all age groups **(please see Attachment A p11 c SC VAERS reports by year & Attachment B, p 12 SC COVID-19 vaccine adverse events reported to VAERS by age group)?**

9. Why are DHEC staff unaware of these reports given that South Carolinians depend on and expect DHEC staff to be closely monitoring the safety of DHEC's recommendation of universal COVID-19 vaccination of age 6 months and up?

10. Based on FOIA correspondence it appears that DHEC staff are not communicating with Vaccine Safety Coordinators in our state who are in contact with CDC? Why is this?

11. Please explain if DHEC staff creating policy have taken into consideration that South Carolinian infants and children age 6 months and up:

    - are at low risk to poor health outcomes from COVID-19 disease (see Table 2, p8)
    -have a high rate of previous COVID-19 infection and that scientific evidence supports the efficacy of natural immunity[15]
    - COVID-19 vaccination does not prevent transmission[16] and
    -there are well-established knowledge gaps in the safety profile of COVID-19 vaccinations and there is potential for pediatric adverse events to COVID-19 vaccine which are difficult to predict.

[15] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)02465-5/fulltext
[16] https://www.bmj.com/content/376/bmj.o298

Table 2

Covid-19 Infection Death Rate by Age Group	
Age	**Infection Death Rate**
0-19	0.0027%
20-29	0.014%
30-39	0.031%
40-49	0.082%
50-59	0.27%
60-69	0.59%
70+ (non inst.)	2.40%
70+ (all)	5.50%
https://medrxiv.org/content/10.1101/2021.07.08.21260210v1	

Assessing COVID-19 infection death rate by age group would be an important part of a risk vs benefit analysis *SC data is not currently reliable to determine COVID-19 infection death rate by age group. Table 2 is global data from several countries.

12. Do DHEC staff believe DHEC and South Carolina vaccine providers need to be required to accurately communicate the risks and benefits of all clinical interventions to their patients, including those associated with the COVID-19 vaccine as additional risks are often unknown or currently uninvestigated?

13. Do DHEC staff believe that healthcare professionals should have the ability to accurately communicate the risks and benefits of a medical intervention including COVID-19 vaccination to individual patients without fear of retaliation by Medical Licensing Boards and the state and federal government?

14. Do DHEC staff believe that there is a need for additional unbiased research to better understand the COVID-19 vaccines' short- and long-term health impacts on various populations? If so, what additional research is planned?

- **A DHEC FOIA response was requested to provide all scientific evidence, data and source documents reviewed by SCDHEC employees which determined the strong recommendation of universal masking of children in SCDHEC's COVID-19 Guidance For K-12 Schools including SCDHEC's employees risk vs benefit analysis of universal masking of children in a school setting.**

A large body of scientific evidence suggests masking is not an effective public health measure in schools and that masking policies in schools carry deleterious impacts. South Carolina and nation-wide data suggest universal masking policies contributed to children experiencing significant learning loss, developmental delays and more. In in August of 2021 a DHEC staff prepared and presented a power point presentation rejecting concerns that universal masking in schools may have unintended harmful impacts on children. DHEC staff has been unable to provide scientific evidence and an ongoing risk vs benefit analysis supporting this DHEC's continued recommendation:

"DHEC continues to strongly encourage everyone who learns or works in a school setting to wear a well-fitted mask consistently and correctly when around others." [17] – DHEC website

15. DHEC placed much emphasis on contact-tracing efforts of young asymptomatic individuals in K-12 schools. This resulted in healthy, non-infected children losing multiple days of school. Can DHEC staff present scientific evidence supporting their recommended contact-tracing methodologies in their K-12 School Guidance document- 02/22/22? **(please see Attachment C, p13 & 14)**

16. There is a body of evidence related to masking and viral transmission prior to the COVID-19 crises. New data emerged throughout the pandemic, as well. In the video presentation given in August of 2021[18], why did DHEC staff rely mainly on observational studies and models[19] which are not reliable to make their strong recommendation of universal K-12 masking? At the time did DHEC staff review the entire body of evidence including studies that pointed to cloth masking is an ineffective public health mitigation strategy?

17. Why didn't DHEC change masking policy recommendations[20] after the publication of two more scientifically reliable randomized trial data[21] [22] and the more recent Cochrane review[23] of 78 peer-reviewed studies which suggests no or minimal efficacy of mask wearing by the public? Has DHEC staff asked why the CDC or NIH did not fund large, randomized trials to evaluate the efficacy and potential harms of mask wearing?

[17] https://scdhec.gov/covid19/covid-19-proper-face-mask-usage
[18] https://livestream.com/accounts/10521602/events/9807526/videos/225206119
[19] https://scdhec.gov/sites/default/files/media/document/Evidence-For-Mask-Use-K-12-Schools.pdf
[20] https://scdhec.gov/covid19/covid-19-proper-face-mask-usage
[21] https://pubmed.ncbi.nlm.nih.gov/33205991/
[22] https://poverty-action.org/sites/default/files/publications/Mask_RCT___Symptomatic_Seropositivity_083121.pdf
[23] https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006207.pub6/full

18. Why did DHEC staff reject concerns that universal masking in schools may have an unintended harmful impact on children[24] when there were knowledge gaps about the safety of universal masking in schools? There is a body of evidence and the real-time experience of South Carolinian school children and teachers, parents, and providers that harms exist that were communicated to DHEC. **(please see Attachment D, p15)**

19. Given that masking has not been proven to be an effective measure to protect individuals from viral spread, have DHEC staff considered that messaging to at-risk South Carolinians and their loved ones - *"To protect yourself and others from COVID-19, DHEC continues to strongly encourage everyone ages two and older to wear a well-fitting mask consistently and correctly with others are around"*[25] - may give these individuals depending on masks for protection a false sense of security?

Other Questions:

20. Has DHEC staff investigated the deleterious impact from the COVID-19 crisis in various South Carolina populations? If not, why? If so, has DHEC staff developed strategies to help and support those specific populations impacted?

21. Does DHEC staff have suggestions on what needs to be done start repairing DHEC's credibility and begin building back public trust?

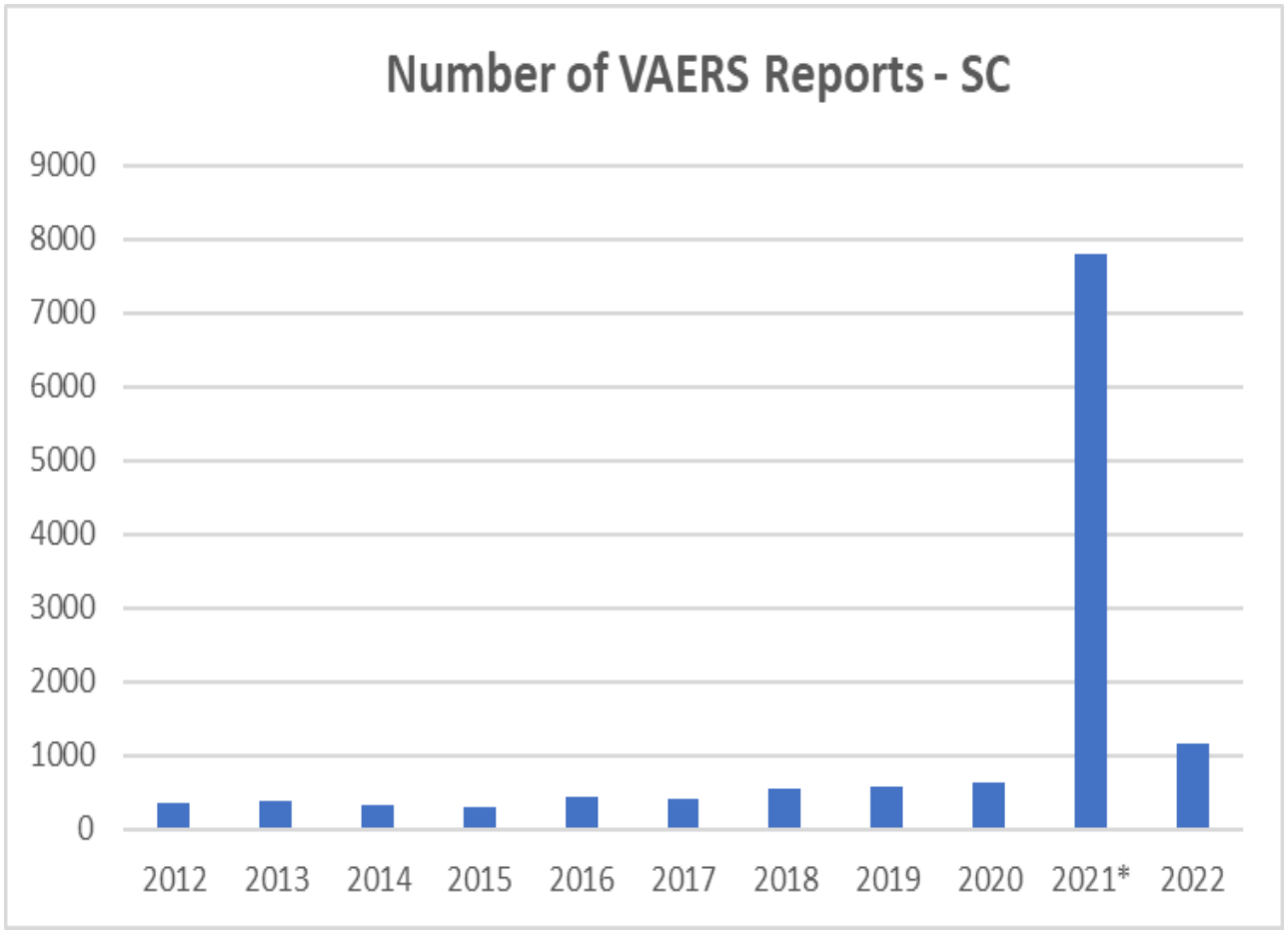
22. Instead of relying on qualified DHEC staff, why did DHEC staff adopt and place so much emphasis and trust in the Centers for Disease Control and Prevention's (CDC) COVID-19 K-12 Guidance and other COVID-19 response guidance without adequately scientifically vetting the effectiveness, safety and deleterious impacts of each recommendation?

"Let us raise a standard to which the wise and honest can repair. The event is in the hand of God."
-George Washington

[24] https://scdhec.gov/sites/default/files/media/document/Evidence-For-Mask-Use-K-12-Schools.pdf
[25] https://scdhec.gov/covid19/use-cloth-face-coverings-covid-19

Attachment A

South Carolina VAERS Reports by Year



*Covid-19 Vaccine Rollout

A federal government funded Harvard Pilgrim study and others suggests that only between **1% -10% of vaccine adverse events are reported to VAERS.** Low reporting rates preclude or slow the identification of "problem" drugs and vaccines that endanger public health. New surveillance methods for drug and vaccine adverse effects are urgently needed. https://digital.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

Attachment B

SC COVID-19 Vaccine Adverse Events Reported to VAERS[26]

Age Range	Died	Life Threat	Perm. Disabled	Hospit-alized	Myocarditis	Anaphyl-axis	Miscar-riage	Total Reports
6 mo-5 yr	0	0	0	1	0	0	0	31
5-11 yr	0	0	0	3	0	0	0	111
12-18 yr	1	6	4	24	6	0	0	392
19-30 yr	1	11	11	26	5	4	1	785
31-49 yr	7	34	50	77	18	9	10	2,259
50-64 yr	15	52	86	110	9	5	0	2,264
65-80 yr	31	56	59	147	9	5	2	2,171
81-121 yr	20	10	7	37	3	0	0	308
All Ages	**82**	**172**	**220**	**447**	**50**	**25**	**14**	**8,932**

*updated March 2023

[26] https://www.openvaers.com/covid-data/states-summary

Attachment X: Indoor School Close Contact Scenarios

Attachment D

Dear Legislative Oversight Committee:

I am writing in regards to the Legislative Oversight committee meeting on 8/30. I see that a Discussion of the Study of the Department of Health and Human Services is on the agenda.

I ask that a FULL REVIEW of Dr. Bell's, Asst Epidemiologist, public claims be included as a specific item on the agenda.

Dr. Bell is respected as a health expert and is in charge of disseminating accurate and valid information based on science. Her statements are used in high-risk decision making that affects our community and state.

Unfortunately, as a PhD researcher and methodologist myself, I have identified that many of Dr. Bell's claims are not substantiated with empirical data. They are more in line with her opinion. This is a major concern.

By not speaking from an unbiased and scientific standpoint, she is misguiding the public and public institutions in the state. Making statements promoted as "science" without scientific evidence is fraudulent. This leads to non-empirically informed policy making and propagates fear and panic in the public.

I ask that you provide a full overview of her work, particularly as it pertains to the scientific validity of her public claims.

I first became aware of these concerns when Dr. Bell teamed up with Lexington One school district to promote a message of "mask safety". In a LIVE video on facebook, she advocated for mask wearing among students of all ages, even making claims about the psychological safety of mask wearing. This video was sent to every Lexington One parent, posted on their facebook page, and used to substantiate district-wide policies and procedures related to masking.

Dr. Bell shared her scientific citations with the community. She defended all her statements of mask safety based on these citations. This list was supposedly the science she used to make her recommendations of safety.

I personally reviewed each citation and have included a (very) brief summary of each paper below. They do not support the claims that she made. Additionally, I emailed her about other specific issues in her LIVE. I included a copy of this letter below. She did not respond, despite multiple emails.

Does this look like ethical behavior to you? The studies she referenced do not even mention safety – never mind being an empirical study about mask safety or the psychological harms thereof!

Of note, the issue I am raising to you here is not about masking per se. This is an EXAMPLE of one area in which I caught Dr. Bell making misconstruing data to fit her agenda.

Our health officials, especially the epidemiologist representing the state, should be unbiased and data-informed. There is no space for an agenda when people's lives are at stake – especially when it affects our children!

I ask you to hold Dr. Bell and her team accountable for her statements. Please conduct a full investigation on her public claims and ask that the scientific data to support her claims be made transparent.

I thank you for your service and commitment to keeping our state safe and healthy.

Live Well,

Dr. Andrea Nazarenko, PhD

_____

SUPPORT FOR STATEMENTS ABOVE:
(For all URLS, I had to include spaces so that this message sent through the portal)

Live video for reference: https:// www. youtube. com/ watch?v=dRDLaGERh5Q

Reference list published by Dr. Bell, which she used to substantiate her claims: https: // bit.ly/ 2PLCyKM

My review of the citations (numbers refer to Dr. Bell's reference list above):

#1. This report (not an empirical study) discusses proper mask fit. No mask safety addressed.

#2. This is a review article published by the CDC about the effectiveness of masking. There is no mention of safety in the article.

#3. This paper studies the effectiveness of cloth masks in comparison surgical masks, given the shortage of surgical masks at time of publication. There is no discussion of safety.

#4. This study tests 70+ fabric combinations to test effectiveness of masks made using different materials. This is not about mask safety.

#5. This is a letter to the Editor about differences in fabrics used to make masks. The letter writer assessed different types of cloth in their filtration capacity and breathability. This is not about mask safety.

#6. In this CDC report, authors discuss the evidence to inform the use of cloth masks for prevention of respiratory infections and propose strategies for cleaning and decontamination to protect frontline healthcare workers and the general public. This is not about mask safety.

#7. This study tests different types of fabrics for effectiveness and factors that interfere with effectiveness. This is not about mask safety.

#8. This article discusses the theory of viral inoculum. Mask safety is not discussed.

#9. This study evaluated the filtration properties of natural and synthetic materials using a modified procedure for N95 respirator approval. This is not about mask safety.

#10. This article is about spread of SAR-COV2 in a nursing home in Washington March 2020. This is not about masks or mask safety.

#11. This study aimed to synthesize all available research on asymptomatic cases and transmission rates. This is not about masking or mask safety.

#12. This study assesses the proportion of SARS-CoV-2 transmissions in the community that likely occur from persons without symptoms. This is not about masks or mask safety.

#12 (she duplicated numbers in her list). This study uses experiments and simulations to quantify how exhaled air is transported in speech. This is not about masking or mask safety. It is about how spread occurs.

#13. This is a weekly report on COVID spread after choir practice and examines settings of spread. It looks at high transmissibility of SARS-CoV-2 and the possibility of superemitters contributing to broad transmission in certain unique activities and circumstances. This is not about masking or mask safety.

#14. The aim of this study was to investigate aerosol and droplet emissions during singing, as compared to talking and breathing. This is not about masking or mask safety.

#15. This study examines how SARS-COV2 spreads through small airborne droplets during singing. This is not about masking or mask safety.

#16. This study examined homemade masks as an alternative to commercial face masks. This is not about mask safety.

#17. This study is about the efficacy of surgical face masks against influenza and coronaviruses. This is not about mask safety.

#18. This study compares the relative efficacy of different fabrics used in cloth masks. This is not about mask safety.

#19. This study compares the effectiveness of different fabrics in blocking large, high-velocity droplets, using a commercial medical mask as a benchmark. This is not about mask safety.

#20. This study tests the efficacy of three types of masks and instant hand wiping using the avian influenza virus to mock the coronavirus. This is not about mask safety.

#21. This is a commentary that summarizes the evidence on face masks for COVID-19 from both the infectious diseases and physical science viewpoints and offers recommendations for most effective masks and messaging. This is not about mask safety.

#22. This study evaluated the effectiveness of 11 face coverings for material filtration efficiency, inward protection efficiency, and outward protection efficiency. This is not about mask safety.

#23.This study examines the effectiveness of face shields and neck gaiters. This is not about mask safety.

Dear DHEC:

I saw your live regarding masks and psychological health.

As a psychologist and methodologist myself, I was quite shocked at some of the claims made. In particular, your comments about masks and mental health being a cultural issue raise significant concerns. Can you please send the research to support your claims on mental health? You mentioned that you had a whole bunch of data and graphs. I would like to read up on the data supporting your statements. As a scientist, I prefer the data over the story you shared.

Specifically, here are a few of my concerns:

1.As an epidemiologist, you should be well aware of the **ecological fallacy** and the risks associated with generalizing findings from population studies to the individuals within a the group that they belong. Further, we cannot compare with external validity the use of masking in Asian cultures to masking in the US. These are two different populations, and if you are basing your decisions to mask our youth is based in evidence from a different population, then the entire field of implementation science is being ignored. Best practices dictates selecting EBI that has been shown to work in the population that it will be implemented, or adaptations that reflect the cultural differences should be systematically made.

2.The other thing that surprised me was your lack of acknowledgement into the social-ecological framework and the role that schools play in the transmission of cultural risks to individuals. Bronfenbrenner's (1989) social ecological theory is not classic in social sciences and your statements were directly counter to his premises. How do cultural risks transmit to individuals? Through the proximal ecological domains – families, friends… and *schools.* You want to change the impact of culture on youth risk? That is in the purview of the schools themselves.

I have a publication on this exact issue where we tested a model of moderated mediation to understand the transmission of community level risk to youth delinquent behavior. Indeed, the "objective" risks in the community did not make a difference in the rates of delinquency, but instead the perception of the risk as moderated by the proximal ecological domains mattered. http://www.ncbi.nlm.nih.gov/pubmed/25300758

You do mention that its not the masks but the interpretation of the masks that make a difference. I agree with this contention. However, at the same time, you have ignored every reason why people interpret harm – and direct experiences wearing the masks, coupled with CDC and Denmark data showing they have no effects in community samples - make it hard to blindly obey. People have lived experiences and these need to be honored.

3. You also mentioned that masks cannot be optional because everyone needs to wear them for them to work. Can you please send that data? I had not seen any data to support this claim.

4.Last, I remind you of the dangers of making claims without substantial data to support them. Our schools are plagued with examples of programs that "sounded good" but have largely iatrogenic effects – e.g., Scared Straight, Gun Buybacks, and DARE – pop into my mind immediately.

Are you willing to stand behind the "next big thing" that *sounded good* but really did harm to our kids? Not all "good ideas" are good at all.

Here is a systematic review from a group in Germany that illustrates indeed some harms exist.
https://www.mdpi.com/1660-4601/18/8/4344

You and I both know that we never retain the null in science, and this article clearly points out that your null of mask safety is well rejected multiple times.

5.One thing that would help me understand your claims is explaining what you mean when you refer to “no psychological harm”… which outcomes are you referring to? Diagnosed mental illness? Perceived safety? Sense of control? Social connectedness? You generalizations make it hard to understand the data that you are basing your statements on. Please clarify and provide your data.

Thanks for filling in the gaps. As a scientist and advocate of children’s mental health, I value the time and effort it takes to use evidence-based policy making and I encourage you to be accountable to decisions being made.

Live Well,

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