Submission to the COVID-19 Response Inquiry – Dr [redacted]

1. Introduction

I am a self-employed scientific and technical writer with a background in historical research. Since early 2020, I have been closely monitoring the scientific research published in several languages and discussing it with a few experts around the world. I continue to take sensible airborne precautions as it quickly became clear that significant long-term harms (for which there are currently no effective treatments) can result from any infection (no matter how mild to start with or how healthy you previously were) and that risks seem to be cumulative with subsequent reinfections [1].

2. Suggestions and feedback about the role of advisory bodies

Despite the evidence from earlier closely related viruses and a growing body of observational studies, advisory bodies failed to recognise in a timely fashion that airborne precautions would be needed to combat this virus. Some still seem to struggle with the primacy of aerosol transmission judging by messaging still concentrating on handwashing with no mention of the importance of respirators and improving indoor air quality. By stubbornly sticking to the old paradigm of droplet and fomite transmission, they recommended measures which could not effectively control spread, resulting in belated and often onerous controls.

In April 2023, authorities claimed that "hybrid immunity… has now reached 99.6 per cent". This requires redefining "immunity" to something unrecognisable from standard definitions [2].

Chief Medical Officer

Advice given to government by Australia's CMO was frequently inaccurate and remains so. Instead of adapting theories in the light of new evidence, he and some state authorities have tended to stick with earlier assumptions (for example, droplet transmission, slow rate of evolution, that reinfections would be rare and help build long-lasting immunity and that most people wouldn't be susceptible to long-term risks).

He also argued that COVID is not exceptional and can now be treated like an average outbreak of influenza – despite many studies showing higher fatality rates in the acute phase and more wide-ranging and severe long-term systemic damage [3].

He has repeatedly downplayed the risk of long-term issues and ignored the large amounts of evidence from around the world that even young, healthy people with initially mild cases can develop very long-lasting and possibly permanent effects. Speaking personally, a [redacted] of mine with no previous health problems or risk factors, had a [redacted] triggered by a supposedly mild case of COVID and later had a [redacted] when he was infected again. One of my [redacted] had a [redacted] during his second (also supposedly mild) infection, requiring [redacted] and leaving him with [redacted] Neither had been able to get timely boosters or anti-viral treatments. I know many other people who are still suffering serious long-term consequences from "mild" infections/reinfections.

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[1] *Experiences of Canadians with long-term symptoms following COVID-19 (statcan.gc.ca)*, 8 December 2023. Acute and postacute sequelae associated with SARS-CoV-2 reinfection | Nature Medicine, 10 November 2022. Postacute sequelae of COVID-19 at 2 years | Nature Medicine, 21 August 2023

[2] *The Saturday Paper*, 8-14 April 2023, "Covid-19: Inside the shifting vaccine strategy | The Saturday Paper" It also claimed that we could now have more personal choice over when/whether to get boosted, which is sadly not yet true.

[3] COVID-19 is not "just the flu" - John Snow Project and Long-term outcomes following hospital admission for COVID-19 versus seasonal influenza: a cohort study (thelancet.com) – *The Lancet*, 14 December 2023: [COVID has] "higher long-term risks of death and adverse health outcomes in nearly every organ system (except for the pulmonary system) and significant cumulative excess disability-adjusted life-years than hospital admission for seasonal influenza."

ATAGI

ATAGI continues to only consider the acute phase of the illness and restricts access to boosters and updated vaccines to groups they consider vulnerable. This approach ignores mounting bodies of evidence that even young and previously healthy people can develop debilitating long-term problems after "mild" initial infections. It also ignores evidence that recent vaccination, especially with an updated monovalent vaccine, provides more protection against acute illness [4]. Their approach leaves most Australians with inadequate protection against new variants which display considerable immune evasion and, most inexplicably, leaves young children totally unprotected. Their "recommendations" should be made non-binding.

3. Suggestions and feedback about key health response measures

As many officials, hospital administrators and infection control staff remained wedded to the droplet and fomite dogma, many health care workers were denied access to airborne protections (even if they tried to bring in their own respirators) and got infected as a result. The removal of requirements for respirators in health-care facilities by medical authorities continues to lead to high rates of nosocomial infections, which have been documented to have a much higher-than-average fatality rate in hospitalised patients [5].

I think that better understanding and policies would have resulted from a multidisciplinary approach, especially the involvement of experts in domains such as aerosol science who warned very early, for instance, against quarantining overseas arrivals in airconditioned hotels. Imagine the difference if there had been a rapid construction of cabin-style accommodation. We would most likely not have needed strict lockdowns or certainly not for as long [6].

Federal and State Health departments still need to improve public health messaging and inform the general public accurately about airborne transmission and what mitigations are effective (respirators, ventilation and HEPA filtration). They need to talk not just about acute illness but about the medium- and long-term dangers documented in many thousands of research papers, such as increased risk of cardiovascular events, neuro-cognitive effects and immune dysregulation and damage, to name just a few.

4. Suggestions and feedback concerning vaccine supply deals

The Morrison government's approach was very slow, inefficient, and badly organised. Unfortunately, the Albanese government's vaccine procurement and eligibility policy has proved to be just as bad, as they are relying on very poor advice from the CMO and ATAGI who keep acting as if SARS-CoV-2 is no longer any more serious than a seasonal respiratory virus and hoping, against all the evidence worldwide, that Australians would only need a booster before winter.

COVID-19 vaccinations are still late in arriving and placed under very restricted access on questionable and poorly reasoned grounds. The current eligibility policy not only causes unnecessary delays in receiving timely boosters but may also discourage uptake by the few who are eligible. Now we have a vax-only strategy with no updated vaccines for most Australians, despite research suggesting that a recent vaccination, might lower the risk of infection or of serious longer-term issues in the following months [7].

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[4] BNT162b2 XBB1.5-adapted Vaccine and COVID-19 Hospital Admissions and Ambulatory Visits in US Adults | medRxiv

[5] https://www.theage.com.au/national/victoria/hundreds-die-of-covid-after-catching-virus-while-in-hospital-20230330-p5cwjx.html

[6] With foresight, we could have built a stock of portable cabins which could later serve as emergency accommodation for those made homeless by bushfires and floods or other reasons.

7 XBB.1.5 monovalent mRNA vaccine booster elicits robust neutralizing antibodies against emerging SARS-CoV-2 variants, 6 December 2023

I remain quietly confident that second-generation vaccines currently in development (either inhaled or intranasal) will provide far greater protection against infection/transmission, and eventually be variant proof. If so, I hope that the TGA will expedite approval, the government procure them quickly and ATAGI not stop access. In the meantime, I am doing my best to avoid infection and possibly incurable damage.

6. Suggestions and feedback about support for industry and businesses

The impact of declining testing and the removal of isolation income support led to a lot more people turning up to work sick, which accelerated the spread of illness, caused economic chaos and resulted in death and ongoing disability for a great many Australians. For me, it is increasingly hard to find the sort of contract work I do unless I agree to work either full-time or more than half the week in unsafe offices where nothing has been done to improve indoor air quality. Most of the people I had previously worked with remotely were infected after a forced return to the office and a few of them have suffered ongoing cognitive issues. As a result, I have had to turn down a few contract opportunities I was approached about.

Labour shortages could be addressed by recognising that removing mitigations and isolation requirements for an inherently dangerous and highly disruptive virus will most likely worsen the problem and lead to increased disability in the workforce, as shown already in the countries which "let it rip" earlier [8].

9. Suggestions and feedback for "improving Australia's preparedness for (current and) future pandemics"

Australia could be better prepared for future pandemics if the government acted on the current one as this is unlikely to be the only airborne pandemic we will encounter in the next decades. We need to improve air quality in all public spaces, but particularly in healthcare, aged care, schools, workplaces, and public transport. Involving community groups in creating Corsi-Rosenthal boxes, for instance, could not only reduce costs but have the added benefit of creating more understanding of the need for improved indoor air quality within the population. In high-risk areas (especially healthcare and aged care) we will need ongoing use of proper respirators for the time being, in conjunction with HEPA filtration and good ventilation, to make these spaces safe and accessible for all and limit shortages of health-care workers.

We also need timely, and a great deal less restrictive, access to updated vaccines and antivirals as they are an important addition to NPIs. Currently, the only way to be sure of not developing chronic conditions after a COVID infection, is to not get infected in the first place. The next best thing is to get reinfected as few times as possible with as low a viral load as possible. We forget that at our peril, both as individuals and as a society.

By ignoring the ongoing consequences of the current pandemic, and the resultant damage to the economy, society, families, and individuals, we are neglecting the principles of public health which were largely responsible for the increase in life expectancy during the previous century.

It is ironic that our failure to respond properly to this new situation came at a time when medical science had started to see the links between infections and some chronic illnesses (which had previously been attributed to lifestyle factors) and to understand a bit more about how some viruses can damage the immune system rather than build immunity.

We urgently need to change course, learn from mistakes, and return to sound public health principles. As Professor Raina MacIntyre said back in early 2022, "no infection in human history has ever controlled itself by letting it rip".

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[8] Long Covid and the Economy: There Is Money in Prevention - manager magazin (manager-magazin.de) "In long Covid research, the disease is now considered a "mass disabling event", triggering a significant global increase in diseases and disabilities".