

Submission to the Commonwealth Government COVID-19 Response Inquiry

I am grateful to the committee for the opportunity to make a submission to your inquiry into Australia's COVID-19 response. COVID has affected each member of my family to various extents; my husband and I have two children, who at the start of the pandemic were aged [REDACTED] and [REDACTED] they are now [REDACTED] and [REDACTED]. My husband was the only person in our family who had a [REDACTED]. He has [REDACTED] which is an [REDACTED] that makes him severely [REDACTED]. He is due to have a [REDACTED] [REDACTED] c.2025. The rest of us were healthy and took no regular medication, yet following our first infection in wave one, my [REDACTED] was hospitalised with a [REDACTED] and I developed a number of symptoms, including [REDACTED] and more, which collectively are known as long COVID.

In addition to my personal family experience, I am also professionally invested in reducing transmission of SARS-CoV-2 and avoiding the worst outcomes of future pandemics through best practice public health approaches. I wrote my undergraduate dissertation on SARS and flu pandemics, I studied a MSc in Public Health at the [REDACTED] and have spent almost 20 years working in public health policy.

TOR 2 - Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, and public health messaging).

TOR 3 - Broader health supports for people impacted by COVID-19 and/or lockdowns

To address these TOR I am writing about my experience as a parent of a young child who was hospitalised. My (then) [REDACTED] was hospitalised with a [REDACTED]. In the months that followed her [REDACTED] was dismissed by clinicians who refused to acknowledge the risk of SARS-CoV-2 to children. Then, almost a year and a half after the [REDACTED] Neurological manifestations of SARS-CoV-2 infection in hospitalised children and adolescents in the UK: a prospective national cohort study¹ was published in the Lancet Child and Adolescent Health journal confirming that she was not the only child to suffer [REDACTED] following SARS-CoV-2 infection.

COVID continues to pose a significant risk to children. Evidence of increased risk of [REDACTED] [REDACTED] making children more at risk of poor outcomes following other infections, such as [REDACTED] are constantly being published, yet Australia is ignoring the mounting evidence.² These risks also increase with each new infection. COVID disrupts immune systems, is damaging major organs and is already the leading cause of death in children and adolescents in the United States.³

As I write this submission, children in the northern hemisphere winter are suffering in enormous numbers and paediatric wards are overrun, yet our children have no protections. Despite the fact that we have the tools to prevent what we can see is happening overseas in China, the US and the UK and implement policies that reduce transmission in children. All children have a right to a safe learning environment, and this includes being safe from being infected with a virus that is known to cause multi-organ damage.⁴ In Australia, most States and Territories (with the notable exception of Victoria) do not have HEPA filters or CO2 monitoring in schools, leading children to be constantly exposed to repeat infection. We urgently need to commit to safe indoor air quality in schools and the exclusion of positive cases so that children who are positive are not sitting in class infecting their classmates, especially those who are vulnerable and/or have vulnerable family members at home. Increasing absenteeism is driven by increased infection transmission, not the other way around!

Our children also need urgent access to updated vaccines. Despite most over 5s being vaccinated in the first half of 2022, and the acknowledgement of vaccine efficacy waning within 6 months, the majority of children are not included in the current advice from ATAGI and will not be eligible to receive boosters with updated

¹ Neurological manifestations of SARS-CoV-2 infection in hospitalised children and adolescents in the UK: a prospective national cohort study

² [Association of COVID-19 with New-Onset Alzheimer's Disease - IOS Press](#)

³ Assessment of COVID-19 as the Underlying Cause of Death Among Children and Young People Aged 0 to 19 Years in the US | Public Health | JAMA Network Open | JAMA Network

⁴ [Post-COVID-19-associated morbidity in children, adolescents, and adults: A matched cohort study including more than 157,000 individuals with COVID-19 in Germany](#)

XBB vaccines in 2023 and beyond. We must not continue to treat our children as invulnerable. We need to offer all children over the age of six months access to the latest available vaccines and act to prevent them from experiencing serious outcomes. The USA 3 months ago made this recommendation on the basis of health equity – why is Australia continuing to follow an ‘immunity by infection’ strategy, when all the scientific evidence points against this approach?

Schools are a risky environment for our children and their high-risk family members. Although our young children continue to mask they are almost alone in doing so, yet we know that masks work in schools to reduce transmission when mandated, as shown in a large study published in the New England Journal of Medicine - Among school districts in the greater Boston area, the lifting of masking requirements was associated with an additional 44.9 Covid-19 cases per 1000 students and staff during the 15 weeks after the statewide masking policy was rescinded.⁵ It's not enough for it to only be vulnerable children wearing them to protect themselves, masks work best as source control, and therefore everyone needs to be wearing them, especially in the absence of safe indoor air quality standards. As long as there are no mitigations vulnerable Australians like my family are at significant ongoing risk simply because we have children attending school and schools are high transmission venues.

Added to the risks posed by our children attending schools, the dropping of isolation and mask mandates in essential public settings, such as healthcare and public transport, means that attending essential appointments now also poses significant risk to each of us and effectively means we have to weigh up the risk-benefit of each and every activity. We no longer eat indoors, go to the theatre, museums or any non-essential activity where there are large numbers of unmasked, and potentially positive cases also present. But to be put in a position where even attending healthcare appointments poses a risk to life is unacceptable. My husband requires [REDACTED]. Even picking these up from the unmasked pharmacy poses an unacceptable level of risk. I have written to the Australian Commission on Safety and Quality in Healthcare, to Minister [REDACTED], to Minister [REDACTED], to the NSW Clinical Excellence Commission. None of the responses recognise the risk of airborne transmission and all fall back on droplet transmission and risk mitigations. Yet I've been in a room with Professor [REDACTED] when he has stated 'COVID is airborne'. We urgently need the Hospital Acquired Infections Committee of the ACSQHC to implement a National Airborne Infection Initiative, similar to the National Hand Hygiene Initiative, and fully recognise that the risk assessments healthcare and aged care facilities should be conducting is 'Is there a risk of asymptomatic/presymptomatic people being present and infecting highly vulnerable and at-risk people, that could lead to nosocomial infection and poor outcomes'? When we know that 50% of transmission occurs as a result of asymptomatic/presymptomatic transmission the answer is unequivocally yes, and appropriate airborne protections must be applied at all times, as SARS-CoV-2, and other aerosolised viruses hang in the air like smoke for many hours, in the absence of adequate ventilation.

TOR 8 – Mechanisms to better target future responses to the needs of particular populations

Breathing safe, clean air indoors has become an urgent priority since the start of the SARS-CoV-2 pandemic, when the transmission of airborne viruses has increased significantly around the world. Since the start of the SARS-CoV-2 pandemic, the health impacts from transmission of airborne viruses have increased significantly, disproportionately affecting people who are living with chronic health conditions and other risk factors. That said, the full health burden of Long COVID, which affects many people without known risk factors as well, should not be underestimated. Those risks are ongoing. Australia is currently in the 9th wave of COVID, and millions of people will be infected, and many hundreds of thousands will develop long COVID.

The SARS-CoV-2 pandemic has been described as a pandemic of buildings; because transmission predominantly occurs indoors, in poorly ventilated spaces. As such, improving indoor air quality and committing to safer indoor air environments, can substantially reduce the risk of airborne infection and lower the risk of illness or death for people who are living with chronic health conditions and other risk factors. In doing so, we can improve the safety and accessibility of indoor environments for all.

Improving indoor air quality also has the potential to significantly increase national productivity through reductions in absenteeism, illness and disability. Despite this, there is little progress from either government or

⁵ Lifting Universal Masking in Schools — Covid-19 Incidence among Students and Staff

industry at promoting these proven benefits of indoor air filtration and promoting the adoption of indoor air quality standards. Further, there is a widespread lack of recognition that poor indoor air quality reduces accessibility to public and private indoor spaces for those with risk factors for poor outcomes after SARS-CoV-2 infection.

It is essential that we ensure that people living with chronic health conditions and other risk factors are not put at risk of health complications, i.e. serious illness or death, simply by living their day to day lives, attending workplaces or schools, using public transport, attending healthcare appointments, or simply participating in society. We must also recognise that, even people without known risk factors are at risk of developing Long COVID, and that risk increases with each reinfection, which may have significant impact on organisations and their workforce.

Conclusion

Vulnerable Australians are being abandoned under Australia's current public health settings which fail to recognise that the SARS-CoV-2 pandemic is ongoing and continuing to risk the lives of Australians. Our strategy of personal responsibility ignores the reality of the situation and risks the lives of so many of us who have no choice but to take huge personal risks every day, simply sending our children to school or attending unsafe workplaces.

Australia was a world leader in its public health approach. Thousands of lives were saved, and hundreds of thousands of long COVID cases were avoided. Yet here we are in 2023, two years since Australia abandoned those measures and already we have more than half a million people suffering from long COVID and a new top 3 leading cause of death. We cannot continue down this path. We must learn the lessons from abroad and change course before it's too late. COVID damages immune systems and risks of bad outcomes increase with each infection. The damage of failing to contain COVID will be devastating, not just for the health of high-risk families like mine, but for all Australians for decades to come.

Key recommendations for action to reduce impact of the current pandemic

1. **Acknowledge SARS-CoV-2 is airborne** and requires appropriate airborne mitigations in healthcare and aged care. Recognising that SARS-CoV-2 and other viruses are airborne and transmitted mainly indoors where air is unsafe is the first step to making our communities inclusive of people with chronic health conditions and other risk factors. Without public health measures, particularly those focusing on safe indoor air, people with chronic health conditions and other risk factors, are at risk of worsening illness while using indoor environments. *This will have a substantial impact on preventing disruption from future pandemics.*
2. **Safe air implementation for schools, healthcare, aged care and other public settings** - Creating safe indoor air environments can be achieved through CO2 monitoring, enhanced ventilation, HEPA filtration,¹ upper room UVGI,² N95 masking, testing, and isolating unwell people.
3. **Expand vaccine access** – must be extended to everyone over 6 months, to ensure equity of access and protections for our youngest children, and to be made available every six months regardless of pre-existing conditions. We need to shift our thinking away from preventing serious acute illness and death to preventing the growing burden of long COVID for all.
4. **Expand anti-viral access** – we also need to shift our thinking here, away from just preventing serious illness or death in the acute phase to reducing illness duration and reducing the incidence of long COVID. Given evidence of reductions in long COVID, eligibility for anti-virals should be rapidly expanded to ensure everyone who is infected can have access, and include access to metformin.⁶
5. **Deliver proper public health campaigns** – that educate the community on airborne transmission, how to reduce it through n95 masking, ventilation, filtration, and CO2 monitoring and having an honest dialogue with Australians around the long-term risks of repeated infections.⁷

Yours sincerely,

Victoria Stone

⁶ [Outpatient treatment of COVID-19 and incidence of post-COVID-19 condition over 10 months \(COVID-OUT\): a multicentre, randomised, quadruple-blind, parallel-group, phase 3 trial](#)

⁷ Acute and postacute sequelae associated with SARS-CoV-2 reinfection