Introduction

I am an engineer and a parent. As far as I know my household has so far avoided contracting COVID-19, and thereby also avoided passing it on. Since “National Cabinet” decided to let it rip, my success in avoiding infection has largely been down to privilege, information obtained from scientific literature and shared on social media by like-minded individuals, diligent effort, but very much in spite of the deficient and misleading public health information provided by government.

The SARS-CoV-2 pandemic has not finished.

Using the past tense in the terms of reference is problematic. The present wave of infections seems to be one of the largest since the start of the pandemic in number of infections, and we have as yet no reliable method of preventing infections from turning into “long-COVID”, which often causes disability, very likely permanent in many cases. This will have enormous impact, not least to the economy. More waves will come, unless we do something different.

We still have not taken the known, necessary actions to bring COVID-19 under control.

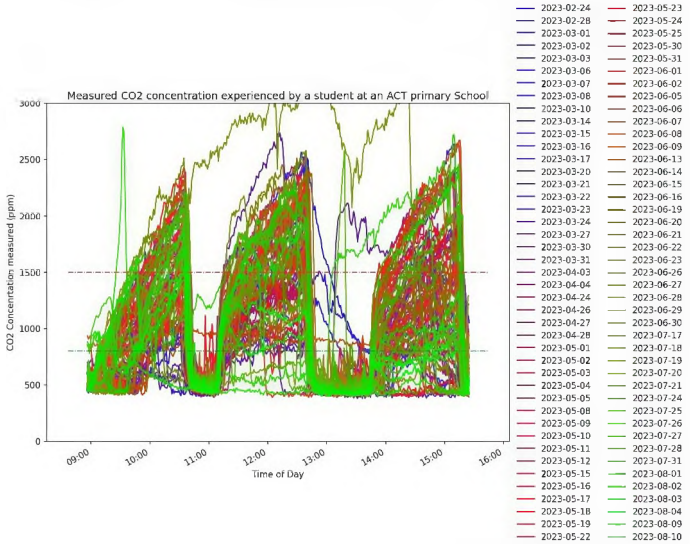
In spite of wishful thinking (e.g. by [redacted] who called infections “necessary”), repeatedly catching SARS-CoV-2 does not bring about long-term immunity to infection, and subsequent infections still carry a substantial risk of disability and elevate the risk of death. Relying on infection to prevent infection will not bring success.

SARS-CoV-2 is airborne, and infection can be prevented by breathing only clean air. (This how I have avoided COVID.) We could greatly reduce the rate of infections by ventilating buildings properly to prevent people from inhaling the infectious aerosols that may be in the air that other people have exhaled. Unfortunately we have not done this yet.

Schools are unsafe, they know it, and they do not intend to fix it.

A major hub of SARS-CoV-2 transmission is the school system, (as recently admitted by Boris Johnson in the UK COVID inquiry). The amount of exhaled breath in a room is one factor that affects the risk that one will contract COVID-19.

Whilst it is presently impractical directly to detect the individual viral particles in the air, exhaled breath can be detected and measured easily, because it contains carbon dioxide (CO_2). Outdoor air has about 420 ppm (parts per million) of CO_2. Air containing 1% exhaled breath has about 800 ppm CO_2, and Safe Work Australia recommends adjusting ventilation to stay below this concentration[1]. At my daughter’s school, the air often contains above 2500 ppm CO_2, meaning more than 5% of every breath has been inside someone else already.



In terms of the quantity of each other’s breath they inhale, this is just as bad as making the children take turns to be the mannequin for the rest of the class to practice mouth-to-mouth expired air resuscitation, every day.

Obviously this situation presents a high risk of infection. This is why Safe Work Australia says that it should not occur: the CO_2 level should be below 800ppm.

When I presented these results to the school and offered them a CO2 monitor, the principal asked the Education Directorate about whether he could or should stop me from measuring it. To this day, the ventilation is still awful. You can read about it of you look on the ACT Education Directorate’s FOI disclosure log for the disclosure EDU_2022_039[2].

Health and Safety regulators are ignoring the problem.

I sent the CO2 measurements to Worksafe ACT and pointed out that the school was not fulfilling its obligations under health and safety law, to ensure that people are not exposed to preventable risks that may result in illness in a workplace. Worksafe ACT declined to send an inspector, "noting the sensitivities of sending inspectors to a school and the likelihood of external attention".

From: [redacted]@worksafe.act.gov.au>
Sent: 08/05/2023 8:59 AM
To: [redacted]@worksafe.act.gov.au>
Cc: [redacted]orksafe.act.gov.au>
Subject: FW: ACT education [redacted] School

OFFICIAL

Good morning [redacted],

Noting your availability for work, I have the below case which is in a bit of a backlog unfortunate look into the case and put together a proposed response and/or plan to address the concerns? If a v (noting the sensitivities of sending inspectors to a school and the likelihood of external attention with [redacted] to find you someone to take with you.

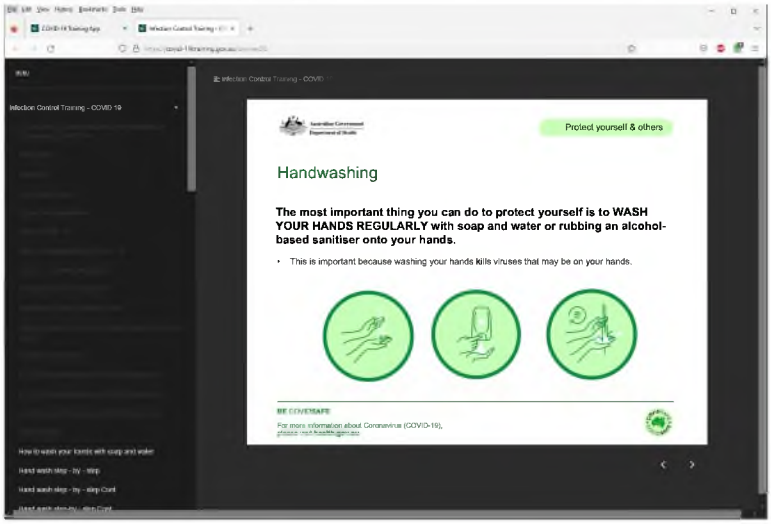
If you think a response via e-mail is sufficient, please put together a draft for me to review and sei agreed.

If you have any questions please reach out, otherwise I will pass along some more priorities soon

It is unfortunate that children cannot have safe air because of "sensitivities", and I hope that "sensitivities" will not prevent regulators from mitigating other hazards in the workplace. You can read more about this if you look for 2023-192 on the ACT Chief Minister, Treasury and Economic Development Directorate FOI disclosure Log[3].

COVID is airborne

We could have had a lot less death and disease than we did, and also a better economy and more personal freedom, had the known airborne nature of SARS-CoV-2 been used and shared by authorities instead of disinformation. Whilst there have been numerous cases of proven airborne transmission and to the best of my knowledge no proven cases of transmission via the hands, government training material emphasised hand washing and droplet precautions at the expense of anything that actually helps against SARS-CoV-2, and these incorrect materials remained in use in official Australian Government training courses until at least December 2022:



Public Health has surrendered completely

People who are known to be infectious should be required, ***and supported***, to stay away from public places. The infectious period is frequently longer than 5 days, and isolation should only end after consecutive negative RATs. Sending infectious people to work or school is harmful.

Everybody who is able to wear a respirator should be required to do so in healthcare facilities. The fatality rate for COVID-19 infections acquired in hospital seems to be as high as 10%, and so anyone who does not take reasonable steps to avoid causing these has failed in their duty of care.

Secretive deliberation on vaccine eligibility is harmful.

Decision-making should be done in public. Highly - credentialled experts have often made statements that appeared false at the time and were proven false in hindsight. If we don't want to allow a few rogue individuals to cause thousands of deaths for no benefit, then in public policy we need a mechanism for independent verification that reasoning is sound, and based on all available evidence, and with goals that are aligned with community values.

As an example, the USA (and many other countries) allow children from the age of 6 months to be vaccinated against SARS-CoV-2, and allows them to receive booster vaccinations. Australia does not, and this is based on the advice of ATAGI. The reasoning behind this is secret, but we can enumerate the possible reasons:
1. Maybe ATAGI know of some excessive risk of vaccine injury in infants that other countries such as the USA are unaware of, and ATAGI are keeping this evidence secret. This is a ridiculous suggestion, especially because Australia has vaccinated very few infants, whereas the USA has vaccinated many, so Australia's position can only be based on much less data that that of the USA.
2. Maybe ATAGI's terms of reference are not aligned with community values. Perhaps they only consider the risk of children dying of acute disease, but long term health problems are outside the scope of their considerations. Vaccinating children probably doesn't prevent very many from dying in the short term because children usually don't die from the acute effects of COVID-19. Nor do they die as children if they smoke, work in an asbestos mine or play with x-ray machines, but they may well have problems later. We should consider long-term health.
3. Maybe ATAGI is deliberately seeking to cause children to spread SARS-CoV-2 infection as a means of repeatedly exposing adults. This might seems like a far-fetched hypothesis, but it has historical precedent in the UK with chickenpox vaccination.
4. Maybe ATAGI is made up of highly-incompetent individuals devoid of reasoning abilities. This seems unlikely given their qualifications, but if their deliberations are secret, who knows?
5. Maybe ATAGI are told by the government of the day what they must write in the advice they are expected to provide, and made to understand that their personal advancement depends upon them giving the advice which is most pleasing to the minister, regardless of scientific or ethical considerations. At the very least it would certainly seem that the timing of their recommendations to allow various vaccinations has always conveniently aligned with the time when the government of the day has belatedly managed to procure a shipment of the vaccine in question, sometimes on the second-hand market.

All of these are rather depressing and insulting possibilities, but they are what comes to mind in the absence of a better explanation provided by a transparent deliberation process.

Future Pandemics

There is no guarantee that the next pandemic will have the same properties as COVID, and ruling out in advance the future use of certain public health measures will set us up for failure. Many submissions will probably argue that school closures, border closures, mask/respirator mandates or lockdowns should never again be used. If the next pandemic virus happens to have the transmissibility of COVID but the lethality of Ebola or rabies, then we may well need any and all of these measures.

We could have kept SARS-CoV-2 out of Australia to the present day, with less economic cost than our present burden of infection, if we had a sensibly designed quarantine system with sufficient capacity to prevent frustration. Lockdowns were mostly caused by quarantine failures and quarantine failures were caused by inability to accept that SARS-CoV-2 is airborne. Air-gapped cabins should have been used instead of hotels, (even if the Hotels Association is a generous donor to both main political parties). Quarantine workers, like FIFO mine workers, should have lived on site rather than going home every night, and been paid accordingly. The capacity of the quarantine system should have been expanded to meet demand, rather than restricted to foment frustration and support for let-it-rip.

This inquiry has the appearance of being far from independent.

Using the word "independent" to describe the inquiry or its panel does not make it so. If a panel member had in the past made comments that were used as justification for government policies that might have resulted in a number of people dying for no benefit, then it would take an extraordinary degree of humility (and perhaps indifference to criminal liability) to admit that the policies were wrong, (and by implication the advice on which those policies were based, was also wrong), especially when faults in the advice were pointed out at the time it was given. Even were it not demonstrable that such advice has in fact been very harmful, the mere possibility of this situation means that the inquiry will not be seen as independent, and the calls for a future Royal Commission will continue.

1 https://covid19.swa.gov.au/doc/improving-ventilation-indoor-workplaces-covid-19
2 https://www.education.act.gov.au/about-us/freedom_of_information/disclosure-log/_nocache
3 https://www.cmtedd.act.gov.au/__data/assets/pdf_file/0003/2254593/2023-192.pdf