Submission No 31

INQUIRY INTO CLEAN INDOOR AIR

Name: Name suppressed

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SUBMISSION TO THE NSW PARLIAMENTARY INQUIRY INTO INDOOR AIR QUALITY IN NSW

27.1.26

My partner and I have over ten years combined experience of living with the awareness of aerosol transmission of COVID while most of the rest of the world has largely ignored the vital need for clean air to protect people vulnerable to serious illness from this infection.

Our submission draws on this lived experience of the onerous consequences of Australia's failure to act to ensure clean air in health settings and other public spaces, including negative impacts on our health, our social relationships and our ability to participate in community life.

Our submission addresses the following Terms of Reference for this Inquiry:

(a) (i) The impacts of poor indoor air quality due to airborne pollutants and pathogens on health

(a) (iv) The impacts of poor indoor air quality due to airborne pollutants and pathogens on equity and access to public services and spaces

(b) Indoor air quality standards and monitoring

(c) (i) Solutions to improve air quality, including building design, in particular schools, health services and public buildings

(c) (ii) Solutions to improve air quality, including retrofitting measures, including ventilation and/or filtration systems and emerging technologies

(d) Implications for climate resilience and pandemic preparedness

(a) (i) THE IMPACTS OF POOR INDOOR AIR QUALITY DUE TO AIRBORNE POLLUTANTS AND PATHOGENS ON HEALTH

We are both in an age group that faces an increased risk of serious illness from COVID. My partner also has serious health issues that add to this vulnerability. As a result we have taken every available measure to avoid catching COVID and have been successful to date. But this has come at a high cost.

We also both have the advantage of post-graduate education that enable us to follow emerging scientific knowledge and so we had early notice of the likelihood that COVID is airborne (Prof Raina MacIntyre started publishing evidence in mid 2020). This enabled us to add to the recommended hand washing and social distancing the specific mitigations against airborne transmission – good ventilation and HEPA filters at home when receiving visitors, portable CO2 monitors to indicate air quality at home, in service settings and in public spaces and far UVC torches to kill viruses in the home and in health and other service settings.

However public health messaging did not take note of the evidence of airborne transmission and so all advice remained hand washing and social distancing. So it is no surprise that our friends and family members and providers of vital services did not adopt these mitigations to clean the air. Our closest relationships have become strained and in some cases

permanently fractured. As a result we have become increasingly socially isolated and now rely heavily on each other for maintaining our mental health.

Additionally our access to physical health services has been damaged by the failure to address poor air quality. My partner has an acoustic neuroma and two vascular masses which require regular scans to monitor any dangerous changes. Due to the absence of clean air in hospital settings and the impracticality of wearing a mask in scanning machines she has foregone regular monitoring and so is unable to access any early intervention treatments that may be called for.

Our dentist was unwilling to adopt COVID mitigations above those recommended by the Dental Association – HEPA filter in the waiting room (where we can protect ourselves with masks) but not in the treatment room (where we can't wear a mask). When I required urgent dental care I accessed a dentist in the CBD who adopted strong COVID mitigations for her own protection – but the high cost of Ubers to and fro and CBD dentist prices was a heavy burden on our retirement savings.

Fortunately as portable air purifiers have become available we have been able to return to our local dentist who is willing to open a window and is happy for us to plug in our devices in the treatment room. But he is not providing this protection to other patients who are on their own to figure out how to avoid COVID infection.

(a) (iv) THE IMPACTS OF POOR INDOOR AIR QUALITY DUE TO AIRBORNE POLLUTANTS AND PATHOGENS ON EQUITY AND ACCESS TO PUBLIC SERVICES AND SPACES

We do not have equal access to public services and spaces as do people who are not alert to the dangers of airborne transmission of COVID.

My partner has difficulty accessing her heart specialist as the need to wear a mask restricts her breathing that is already restricted by her heart condition. As a result most of her consultations are over the phone. If the consulting rooms had clean air then she would be able to attend in person more often.

I am on the waiting list for knee surgery and am deeply concerned about the risks of hospital acquired COVID which has a very high mortality rate.

While we remain vitally interested in world events and popular culture we continue to avoid restaurants, cinemas, live music venues and theatres due to the absence of information about air quality at these sites. Our lives are impoverished.

(b) INDOOR AIR QUALITY STANDARDS AND MONITORING

Portable CO2 monitors are expensive. We bought several in order to monitor different rooms in the house, especially when a young family member stays with us from time to time while between private rentals. We also lend them to close friends to monitor the public places that they visit to help them decide how to stay safe. Overall we spent $1,000 which is a big expense for pensioners.

Staff of medical and other vital services we use are not aware of the dangers of poor air quality for transmission of COVID. They have limited capacity to make use of the information we provide to them on the CO2 levels in their service delivery spaces.

A regulatory requirement for spaces that are open to the public to display indoor CO2 levels at every entrance would enable people to decide which spaces are safe while providing an incentive to property managers to take steps to lower the numbers.

(c) (i) SOLUTIONS TO IMPROVE AIR QUALITY, INCLUDING BUILDING DESIGN, IN PARTICULAR SCHOOLS, HEALTH SERVICES AND PUBLIC BUILDINGS

We have seen the dramatic improvements in air quality in our home when we open doors and windows to ventilate the space. The CO2 readings are significantly lower than in a closed room.

All health and service settings should be designed to enable air flow into and out of the indoor space.

(c) (ii) SOLUTIONS TO IMPROVE AIR QUALITY, INCLUDING RETROFITTING MEASURES, INCLUDING VENTILATION AND/OR FILTRATION SYSTEMS AND EMERGING TECHNOLOGIES

There has been rapid evolution in the efficacy of UV lights coming out of China and other countries to sterilise the air in indoor spaces. The Victorian Government is currently trialling their effectiveness in aged care homes and could advise the NSW Government on its findings (see the Elucidar Study).

In the meantime the risk of damaging health outcomes would be reduced with:

- immediate provision of portable air purifiers with HEPA filters to all public buildings and subsidised provision to private businesses
- Public health messaging alerting everyone to the risks of aerosol transmission of COVID and practical tips for ventilation and air purification

(d) IMPLICATIONS FOR CLIMATE RESILIENCE AND PANDEMIC PREPAREDNESS

During the first years of the COVID pandemic, while scientists were able to reliably conclude that it was spread by airborne transmission, millions of lives were lost worldwide while everyone washed their hands and stood a few feet apart. The next pandemic may or may not be airborne but we can be sure that if every effort is made to improve ventilation, air filtering and sterilisation before it arrives we could save millions of future lives.