Submission No 48

INQUIRY INTO CLEAN INDOOR AIR

Organisation: Pandemic Resistance Inc.

Date Received: 28 January 2026

SUBMISSION TO THE NSW PARLIAMENT INQUIRY INTO CLEAN INDOOR AIR

Pandemic Resistance Inc.

We are a community organisation formed to raise awareness of the ongoing risks arising from the unmitigated spread of COVID-19 throughout our communities with members in NSW. Our members recognised the growing gap between the scientific evidence and lived experience versus government and public narratives around COVID. While the emergency phase of the pandemic has formally ended, COVID-19 has not. The shift to a "back to normal" framing has occurred in the absence of comprehensive, systemic measures proven to reduce transmission.

Our leaders have failed to adequately account for the fact that COVID-19, like many other transmissible diseases, spreads primarily via the airborne route. Where airborne transmission is acknowledged, it is often interpreted narrowly as requiring coughing or other obvious symptoms, as opposed to recognising that transmission routinely occurs from an infectious person simply breathing. Transmission risk is therefore amplified in shared indoor spaces with inadequate ventilation.

Although risks from infection have reduced since the beginning of the pandemic, COVID-19 continues to pose a serious and uneven threat to health, education, work, and social participation. For many people, particularly those who are disabled, immunocompromised, older, or caring for vulnerable family members, "normal" has not returned. Instead, they face ongoing exposure risk in spaces that are essential to daily life, effectively forcing many to self-exclude from public participation in order to remain safe.

This submission does not seek to provide a technical analysis of airborne transmission or ventilation science. Others are better placed to address those matters. Our focus is on impacts: the human, social, and economic consequences of treating ongoing transmission as inevitable, and of relying primarily on individual risk management rather than systemic protections such as clean indoor air.

Indoor air quality is not a peripheral issue. It is central to whether people can safely access healthcare, education, workplaces, and whether a section of our community can participate in public life at all.

ONGOING IMPACTS OF COVID INFECTION

COVID-19 remains a significant cause of illness and economic and social disruption in NSW.

Productivity analyses frequently note the effects of absenteeism, supply chains disruptions, and missed work and school days arising from acute illness, often without also recognising that mitigation measures could be employed to reduce both infection and its associated economic costs.[1]

Ongoing viral transmission has broader consequences for education and work. Students miss significant learning time due to illness and reinfection, while parents and carers are repeatedly

[1] Dennett JM, Soltas EJ, Goda GS, Thornhill TA, Werner K, Gonsalves GS. Enduring Outcomes of COVID-19 Work Absences on the US Labor Market. *JAMA Netw Open.* 2025;8(10):e2536635. doi:10.1001/jamanetworkopen.2025.36635

required to take time away from paid employment to manage sickness within households. This disruption is not confined to isolated outbreaks; it recurs as waves of infection move through communities, workplaces, and schools.

Despite these impacts, COVID-19 is increasingly treated as a resolved or negligible issue in public discourse and policy analysis. This has led to significant blind spots in how attendance, productivity, and participation are assessed. For example, major policy institutions examining declining school attendance have failed to meaningfully consider COVID-19 infection, reinfection, or post-viral illness as contributing factors.[2] The absence of repeat infection from such analyses reflects not a lack of relevance, but a broader normalisation of ongoing transmission and its consequences.

This normalisation appears to rest on an assumption that transmission is inevitable and cannot be meaningfully reduced. This is not the case. New South Wales has an opportunity, through this inquiry, to demonstrate that clean indoor air can significantly improve public health and participation.

EVIDENCE THAT IMPROVING INDOOR AIR QUALITY WORKS

Improving indoor air quality as a transmission-reduction measure is neither theoretical nor experimental. Large public systems have implemented ventilation and filtration measures at scale, with demonstrated benefits.

Boston Public Schools introduced ventilation upgrades, portable HEPA filtration, and classroom air-quality sensors across its schools to support safer in-person learning during periods of high community transmission[3].

Internationally, a retrospective cohort study in Italian schools found that classrooms with improved ventilation had significantly lower SARS-CoV-2 transmission compared with those relying on minimal air exchange[4], indicating that air quality interventions can materially reduce infection risk in real-world settings.

Similarly, the German Federal Environment Agency has formally recognised ventilation as a primary measure for reducing airborne transmission in schools and other indoor environments.[5] While German guidance notes that opening windows can reduce risk in some settings, this approach assumes conditions that are often absent in practice. Many buildings have fixed or poorly functioning windows, are located in climates where opening windows is impractical for

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[2] Hunter, J., Hayword, A. and Chapman, M, *On a typical school day, 11% of students are absent. How can Australia fix this?* The Conversation, 10 December 2025, https://theconversation.com/on-a-typical-school-day-11-of-students-are-absent-how-can-australia-fix-this-271514

[3] Boston Public Schools Indoor Air Quality (IAQ) Sensor Dashboard https://www.bostonpublicschools.org/students-families/respiratory-illness-protocols/air-quality/indoor-air-quality-sensor-dashboard

[4] Italian study shows ventilation can cut school COVID cases by 82%, published 23 March 2022. https://www.reuters.com/world/europe/italian-study-shows-ventilation-can-cut-school-covid-cases-by-82-2022-03-22/

[5] Joint press release from the German Environment Agency and Standing Conference of the Ministers of Education and Cultural Affairs of the Länder, 15 October 2020 https://www.umweltbundesamt.de/en/press/pressinformation/coronavirus-protection-in-schools-airing-rooms-for

extended periods due to heat, cold, or air pollution (including bush fire smoke), or rely on staff and occupants to correctly assess when and how long ventilation is required.

In the absence of training, clear responsibility, or real-time indicators of accumulating risk, such as active CO_2 monitoring, ventilation becomes inconsistent and reactive rather than preventive. Italian evidence shows that classrooms equipped with mechanical ventilation reduced the likelihood of infection for students by 80% compared with a classroom with only natural ventilation.[6] Where mechanical ventilation and filtration are feasible, they provide a more reliable and equitable means of maintaining safe indoor air without requiring constant individual vigilance or trade-offs with thermal comfort and productivity.

It should be considered unconscionable that our governments are made aware that transmission can be reduced by as much as 80% and still refuse to act to protect our children.

PERSONAL IMPACTS OF FAILING TO LEGISLATE CLEAN INDOOR AIR

When governments and regulatory systems fail to provide systemic protections, the burden of managing risk is shifted onto individuals and families.

A growing number of people are living with Long COVID, a complex and often disabling condition affecting multiple body systems. Many experience persistent fatigue, cognitive impairment, cardiovascular symptoms, and reduced capacity to work or study. For some, these impacts have been life-altering. This burden is compounded by repeat infections, with evidence and lived experience indicating that cumulative exposure increases the risk of long-term harm.

Those members of the community who recognise the risks associated with airborne transmission are left with limited and imperfect options to protect their own health and the health of those they care for. One such measure is the use of high-quality respiratory masks. While masking remains effective, it cannot be used in all situations, including during certain medical procedures, eating and drinking. Increasingly, masking also carries social and regulatory costs. In some jurisdictions, public messaging and policy settings have begun to associate face coverings with criminal activity or antisocial behaviour, further deterring their use and effectively restricting an individual's ability to take basic protective measures in shared indoor spaces.

As a result, COVID-19 continues to constrain social and community participation. Many people avoid essential or meaningful activities, not out of preference, but because shared indoor environments present an unmanaged and unpredictable risk. These impacts are not evenly distributed. They fall most heavily on those already facing health vulnerabilities, caring responsibilities, or limited flexibility in work and education. It also imposes a considerable burden on family, friends and household members to take active steps to keep their loved ones safe and avoiding bringing home an infection that could be deadly to them.

Unsafe indoor air functions as a barrier to access, comparable to physical inaccessibility. For some members of the community, participation in public life is now conditional on risk tolerance rather than entitlement. Being able to take personal protective measures is also highly dependent

[6] Buonanno G, Ricolfi L, Morawska L, Stabile L. Increasing ventilation reduces SARS-CoV-2 airborne transmission in schools: A retrospective cohort study in Italy's Marche region. Front Public Health. 2022 Dec 9;10:1087087. doi: 10.3389/fpubh.2022.1087087. PMID: 36568748; PMCID: PMC9787545.

on being able to afford to do so. Breathing safe air should not be a privilege available only to those who can afford it. Without systemic measures to reduce transmission in indoor spaces, these harms will persist.

SELECTION OF PERSONAL STORIES

Shared via us via https://www.pandemicresistance.org/safe-access-to-healthcare (abridged and de-identified):

"I was attending hospital for radiation treatment for cancer. No staff or patients wore masks. My treatment involved radiation to my face, which meant removing my own mask. For six weeks I was terrified of catching COVID while undergoing cancer treatment."

"I have just had spinal surgery. I was shocked by the lack of masking on the ward. Two rooms near mine were under isolation with PPE outside, yet staff and cleaners moved freely between rooms. One cleaner came into my room coughing."

"My mother was extremely frail, with blood cancer and a serious infection. She caught COVID in hospital despite known cases on her ward. Some staff wore masks on their chins or pulled them down to talk to her. She was moved only after testing positive. She died shortly after discharge."

"I am a hospital staff member living with Long COVID. After catching COVID again at work, management told us not to stay home with symptoms and not to test, because they 'can't afford staff shortages'. I am chronically ill and now struggling to afford basic living costs due to workplace exposure to COVID."

"I took my baby to paediatric emergency. The waiting room was crowded with sick children. Some nurses were coughing and then attending patients. Almost no one was masked. I kept thinking: how can it be right that taking my child to hospital risks them getting even sicker?"

"I am a blood cancer patient on a drug trial, attending a cancer day centre every three weeks. There are no airborne protections: no fresh air, no filtration, no UV, and almost no masking by healthcare workers or patients."

"As an immunocompromised patient, I was unable to safely access inpatient pain treatment because the hospital refused to take reasonable precautions. I cannot receive the care I need and am now living with severe, unmanaged pain."

"I stayed a week for a procedure last year and came out sicker than when I went in due to contracting Covid during my stay"

Hospitals exist to heal. Yet current practice accepts that babies, cancer patients, post-surgical patients, and immunocompromised people may be exposed to avoidable viral infection simply by attending for necessary medical care. This is difficult to reconcile this with any reasonable understanding of patient safety.

Few would accept a surgical ward where wounds were left open to contamination, yet airborne infection is routinely dismissed despite predictable and severe consequences. The expectation that a sick baby, or a person recovering from spinal surgery, or one battling cancer, should be put at risk of a respiratory infection that could cause prolonged coughing, delayed healing, permanent harm or even death, should be unthinkable.

Exposure to preventable infection should not be the price of accessing healthcare. That it has become normalised is precisely why clean indoor air standards are urgently required.

CONCLUSIONS

Based on the evidence and lived experience outlined in this submission, several clear conclusions emerge.

First, unsafe indoor air is not a marginal or optional issue. It directly affects whether people can safely access healthcare, education, workplaces, and public life. For many members of the community, particularly those who are immunocompromised, disabled, older, or caring for vulnerable family members, unmanaged airborne risk functions as a practical barrier to participation. In this sense, poor indoor air quality operates as an access and equity issue, not merely a matter of individual preference or risk tolerance.

Second, the ongoing impacts of COVID-19 infection continue to be underestimated in public policy. Recurrent illness, reinfection, and post-viral conditions contribute to absenteeism, reduced workforce participation, and disrupted education. Yet these factors are often absent from policy analyses, reflecting an implicit assumption that ongoing transmission is inevitable and cannot be meaningfully reduced.

Third, this assumption is not supported by the evidence. Real-world implementations of ventilation and filtration measures in schools and other shared indoor environments have demonstrated substantial reductions in transmission. Improving indoor air quality is therefore a practical, scalable public health intervention, not a theoretical or experimental measure.

Fourth, current policy settings rely heavily on individual risk management, such as voluntary masking or personal avoidance, rather than systemic protections. This approach is inherently inequitable, inconsistently applied, and ineffective in shared indoor environments where exposure risk is collective rather than individual.

Fifth, the absence of legislated indoor air quality standards has resulted in fragmented responsibility and inconsistent practice. Without clear standards, accountability mechanisms, or monitoring, indoor air safety is largely left to institutional discretion, despite predictable and preventable harms.

Finally, evidence from healthcare settings demonstrates that unmanaged airborne risk can expose patients to preventable infection while they are accessing essential care. This represents a patient safety failure that is difficult to reconcile with established principles of infection prevention and duty of care.

Taken together, these findings indicate that clean indoor air should be recognised as core public health infrastructure, analogous to clean water or safe food, and regulated accordingly.

RECOMMENDATIONS

In light of the above, we recommend that the Inquiry consider the following actions.

1. Establish minimum indoor air quality standards

That the NSW Government develop and legislate minimum indoor air quality standards for shared indoor environments, with priority given to publicly funded and high-risk settings, including healthcare facilities, schools, disability services, and aged care.

These standards should focus on engineering controls such as ventilation and filtration, rather than reliance on individual behavioural measures.

2. Prioritise healthcare settings as a matter of patient safety

That healthcare facilities be explicitly recognised as high-risk environments requiring enhanced airborne infection controls.

This should include:

- minimum ventilation and filtration requirements in clinical and inpatient settings
- clear accountability for maintaining safe indoor air
- recognition that exposure to preventable airborne infection during necessary medical care constitutes a patient safety issue, not an acceptable background risk

Patients should not be required to accept avoidable infection exposure as a condition of accessing healthcare.

3. Prioritise schools as essential community infrastructure

That schools be treated as a priority setting for clean indoor air standards.

Children experience repeated exposure to respiratory infection in shared classrooms, contributing to recurrent absenteeism, disrupted learning, and household transmission. Evidence demonstrates that improved ventilation in schools can substantially reduce infection risk, offering benefits not only to students, but also to educators, families, and the wider community.

Clean indoor air in schools should be understood as a duty-of-care issue and a foundational requirement for safe education, not as an emergency measure limited to pandemic periods.

4. Require assessment, monitoring, and transparency

That indoor air quality in public buildings be subject to routine assessment, with appropriate use of proxy indicators such as CO_2 monitoring to identify elevated transmission risk.

Where monitoring is used, clear guidance should be provided to ensure indicators are correctly interpreted and linked to defined response measures, rather than placing responsibility on individuals to assess invisible risk.

5. Clarify responsibility and enforcement

That responsibility for maintaining safe indoor air be clearly allocated to building owners, operators, and institutions, supported by regulatory oversight and enforcement mechanisms.

Individuals should not bear the burden of managing airborne disease risk in shared environments where exposure is collective and unavoidable.

6. Embed clean indoor air in future pandemic preparedness

That clean indoor air standards form a central component of NSW's preparedness for future airborne disease outbreaks.

Investing in ventilation and filtration infrastructure provides enduring protection, reduces reliance on emergency behavioural measures, and strengthens system-level resilience across health, education, and essential services.

Pandemic Resistance Inc. welcomes the opportunity to participate in any further consultation processes arising from this Inquiry, including stakeholder discussions, focus groups, or requests for additional information, should this assist the Committee in its deliberations.

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