

## **Mandatory Mask Sample Letters**

The masking issue is complicated and these are the scenarios people have been confronted with:

- compulsory masking as part of your employment;
- compulsory masking to gain entry or access to services as a customer;
- compulsory masking at schools, university, training courses, work experience placements;
- compulsory masking in taxis, flights, ambulances;
- compulsory masking at hospitals, doctor, dentist, health care setting;
- compulsory masking on public transport.

We have provided alternative letters that you can mix and match as per your needs and requirements.

In general, if you were denied access to a shop because you are not wearing a mask and have a medical reason which would fulfill the exemption requirements, you can email the CEO or the shop Manager later to make a complaint. This minimises arguments and escalation of issues in-store at the time and creates a paper trail.

There are alternative grounds of argument, but we have found the discrimination and equal opportunity angle to be useful. In our experience, there are many people who are suffering from a mental health condition or an associated medical condition in terms of not being able to wear a mask. Whether or not you have obtained proof of your medical exemption is not important if you are dealing with a business as a customer or speaking to a police officer who is querying you regarding the exemption.

Under both circumstances, you don't need to provide proof of your medical condition, you just need to state clearly that you have a legal exemption by way of a medical reason. This is sufficient and you should be left alone. If you are pushed, you can briefly state what the medical reason is such as mental health reasons, skin condition, claustrophobia, asthma etc., but you don't need to provide any more information than that.

Unfortunately, in a bold and what we classify as, unlawful, move in South Australia and New South Wales, the Government has amended the mandates to compel the provision of medical evidence to a police officer when requested, including the provision of your name and address. That medical evidence initially anticipated a medical exemption letter from a registered medical practitioner, however, this now includes a statutory declaration that you can prepare yourself which names the medical condition and then clearly articulates how this medical condition may impact on your

condition. For this reason, we have linked below links to where you need to go to get a copy of the statutory declaration:

1. For NSW please go to: <https://www.jp.nsw.gov.au/Pages/justices-of-the-peace/nsw-statutory-declaration.aspx>
2. For SA please go to: [https://www.agd.sa.gov.au/sites/default/files/south\\_australian\\_statutory\\_declaration\\_form.pdf](https://www.agd.sa.gov.au/sites/default/files/south_australian_statutory_declaration_form.pdf)

In terms of how to write the content of the statutory declaration, please refer to the template we specify below under Example of Doctor's Medical Mask Exemption. In relation to when you have a mental health condition due to rape and/or sexual abuse, there is absolutely no compulsion to expose or explain this in your mask exemption. It is sufficient to state clearly that you have a mental health condition due to Post Traumatic Stress Disorder and this does not allow you to wear the mask as this will lead to feelings of aggravation and claustrophobia. This is sufficient and you do not need to explain anymore.

As part of the statutory declaration process you will need to take this form and have it sworn i.e. witnessed by a justice of the peace and/or your local pharmacist.

In general terms, it is mandatory to wear a face mask in some public indoor settings, on domestic flights to and from a State or Territory, when travelling on public transport, in a taxi or ride share vehicle. There are a number of lawful reasons to not wear a face mask and patrons must wear a mask unless they have a lawful reason not to do so. Businesses should not refuse service to patrons who may have a valid lawful reason for not wearing a mask. For more information on face masks and human rights, visit the [Human Rights website](#). This is the Victorian one but it is applicable in most States and Territories.

In various States, there are Government guidelines that operate in relation to masking requirements. In Victoria, the masking requirements are contained [here](#) and [here](#) which effectively act as the authorisation from the Department. In general terms, masking requirements continue in certain indoor spaces. For those who work in a health care setting, whereby PPE (masks) are required, [here](#) are the current directions for Victoria which cover when you have to wear a mask and when you don't. If the health care sector you are working in is breaching these policies, ensure that they are shown the current Victorian Directions [here](#). You do not have to wear a mask outside of these Directions.

In Western Australia, information regarding masks can be found [here](#) and at present there is a strict mask mandate applying across all of the State.

In South Australia, the masking guidelines can be found [here](#) and for medical health care settings [here](#) and in general terms, the mandates have been removed in most places.

In New South Wales common questions can be found [here](#) and for healthcare worker settings see [here](#).

The current mask mandates for Queensland can be found [here](#).

We have been in a continuous state of flux and it appears that as we approach winter, the masking mandates are becoming mandates across most States and Territories. Please check in your State and Territory for any current updates.

We have found that employers are being critical of medical certificates and what is contained in them in that they are denying employees exemptions, unless the medical certificate is clear on the following topics:

1. It needs to contain a reference to the directive of that State and/or Territory and be tailored to that.
2. It needs to clearly stipulate a medical condition, disease or ailment that prevents a person from wearing a mask. We have found that a statement which contains specific reference to diagnosed mental health, anxiety and/or depression, past trauma, asthma, allergies including specific allergies to dust, pollen, food allergies, claustrophobia etc helps.
3. It needs to link up that condition to how the mask will affect that person's functionality at work, hence making them not fit for work if they wear one.
4. It needs to specify that the person does not present or currently has any symptoms of COVID-19 and/or influenza.
5. It needs to have a generic statement that there are no reasonable adjustments that can be made to address this issue except for not wearing the mask.

### **Example of Doctor's Medical Mask Exemption**

*"Mandy has been diagnosed with a mental health disorder since 2012. The present directives that have created a mandate for wearing a mask at the workplace cannot be satisfied by Mandy. In my opinion, Mandy is legitimately exempted from wearing the mask as the mental health disorder will create feelings of disorientation and trigger past memories. Her fitness for work will be impacted by wearing a mask and as she does not present with any COVID-19 symptoms or influenza symptoms she is not to be a risk to any other person. It is sufficient for her to be attending work and socially*

*distance. There are no reasonable adjustments that can be made for her condition to accommodate wearing a mask.”*

We say that employers are acting unlawfully for questioning these medical certificates because they are neither Authorised Officers under the law or medical practitioners themselves. They have also not made any risk assessments on the employee to reject the medical assessment from their medical practitioner. However, we want to assist you in ensuring that you can address all the issues that may arise and hence you need to communicate clearly to your medical practitioner the requirements that best suit your condition. We also state that generic medical exemptions that refer to breathlessness are insufficient and will be rejected by employers, so ensure your visit to the medical practitioner is productive and addresses these issues.

Since writing these templates, it also appears that many general practitioners are not providing any more specific medical exemptions. In these cases, it may be appropriate to get a statement from your doctor in relation to your specific health condition and then accompany that with a letter and/or email to your employer specifically stating that your general practitioner is frightened to provide you with a medical exemption due to fear of repercussions from the Regulator, however, you have a clear statement from him/her regarding your medical condition which disables you from wearing a mask, without negative health consequences to you.

We also note here that many people have realised that they have a medical health condition which does not allow them to wear the mask over elongated periods of time after they have legitimately attempted to wear the mask. If that is the case for you, then you need to go to your general practitioner and explain the situation and that you derived your medical condition after your attempts to wear the mask.

Some employers have also been using the Occupational Health & Safety legislation to force their employees and customers to wear masks and other PPE. They argue that the mask provides protection from transmission. The OH&S standards looks at reasonableness of the standard and the ultimate benefits need to be weighed against the detriments. Some employers have pushed the “reasonable adjustments” arguments saying that the employee should wear a head shield if they can’t wear a mask. If you are not averse to that, then you can, however we have found that many employees who have tried the head shields have also suffered from serious migraines and headaches. If that is the case for you, make sure that your medical exemption also covers your reactions to the head shields.

It may also be worthwhile to explore with your employer the absence of science supporting the wearing of PPE and masking when you are healthy and without symptoms. We have provided hereafter, some examples and research prepared that detail that masks don't prevent transmission and/or infection. Feel free to include sections you wish to include to demonstrate your points.

## **Letter M1**

**Denial of Access to Services and potential disability discrimination where there is active direction from Government to wear a face covering/mask. This could be a letter tailored to an employee writing to their employer or a customer writing to a service provider/business.**

Dear.....,

**Re: Discrimination on the ground of disability**

I am writing to you as an aggrieved person to escalate my concerns and experience in relation to disability discrimination at [*insert where it occurred*] on [*insert date/time*].

I bring to your attention my unique circumstances that occurred on [*insert a brief summary of your circumstances*].

I informed the staff and/or employer that due to my health condition and/or disability, I am exempt from wearing face masks.

I was then [*describe how staff and/or employer dealt with you briefly*].

The Federal, State and Territory frameworks in relation to disability discrimination provide for various laws that ensure businesses and employers alike, do not engage in either direct or indirect discrimination.

Given that the directions for mask wearing are issued by the Government, it is important that employers and businesses follow these directions which include the exemptions and allowances that have been made, as part of these directions. These exemptions include exemptions from mask wearing.

Disability discrimination happens when a person with a disability is treated less favourably than a person without the disability in the same or similar circumstances. For example, it would be 'direct disability discrimination' if a business or service provider refused a person entry because they are not wearing a mask because of a medical condition.

I also note here that most States and Territories have allowed medical exemptions for mask wearing and it is important that businesses and service providers are also aware that once a customer alerts the business owner or staff member alerts the employer that they have a medical exemption, they are not required to provide any evidence of the same.

I write this letter in good faith and put you on notice that this letter is an attempt on my part to reach out to you and resolve this matter between the parties. If I do not receive a fair/equitable and or satisfactory outcome from you in writing within seven (7) business days from the date of this letter, I will escalate the matter and seek further legal advice in relation to my rights.

In light of the above, I ask the following from you by email ***[insert date/time for compliance]***:

1. A letter of apology from you or your manager with respect to my treatment at your store ***[this is applicable in a situation where you are customer, not something you would request from an employer]***;
2. An assurance that you will take all reasonable steps to review and rectify your store policy and/or employment policy to ensure that no other person(s) are discriminated in the same manner; and
3. Assure me that your staff have been informed of such policy modifications and that they will cease harassing, intimidating and/or discriminating against others who cannot wear a face mask for legitimate medical reasons;
4. That I am to be immediately returned to work with no further harassment and/or coercion to wear the mask or face shield ***[this is applicable in a situation where you are an employee]***.

Should you wish to discuss this matter please do not hesitate to contact me and I look forward to your response.”

### **End of M1 Letter**

We have found that in States and Territories where the mask mandate has been removed, many shop owners, employers, schools and businesses are setting their own policies and are going beyond what the Government has allowed. We say that matters of quarantine and management of serious risks to public health are matters that remain within the jurisdiction of Government and employers and businesses cannot not go beyond the mandates set by Government. In those circumstances, the following letter may be useful.

## Letter M2

### Mandatory Mask Letter for School, Work or Customers where there is no continuing Mask Mandate from the Government

Dear .....,

I refer to your request/direction in relation to me/my child wearing a mask and/or face cover whilst at work/school/attendance at your business.

I bring to your attention that the workplace/school/business cannot set a policy or make face covering, temperature taking, testing or examination mandatory where this issue is already covered by legislation or directions from the Government and the only person that can make such a direction to me is an Authorised Officer under the law. An Authorised Officer is one that would have received written authorisation from the Secretary of the Department of Health and the Chief Health Officer. This cannot be any public servant, police officer, PSO or any other private citizen.

I note here that the current mandate directives have lapsed and are no longer applicable, therefore you have no right to deny me entry/service/employment/schooling etc. [*insert relevant place*].

I request that you immediately rectify your position and allow me to [*insert your relevant demand*] and provide me with confirmation of this by [*insert date*] by email.

**End of M2 Letter**

In an employment situation, you may be required to provide a general medical exemption from your medical practitioner. Despite the fact that the Department of Health in most States and Territories do not require you to provide such evidence even to your employer, it may expediate the matter for you to obtain a medical exemption and avoid conflict.

Note: The medical exemption does have to specify the exact reason. It only needs to state that you have a legitimate medical reason to be exempt. We note here that the majority of the population will experience serious breathing difficulties as a result of wearing a mask for extended periods of time. This is not rocket science. In those circumstances, we recommend that you obtain such evidence and provide it to your employer by email.

It is insufficient for you to argue that your contract does not allow your employer to change the terms of your employ. Your employer most certainly is bound by Government mandates. In the absence of a mandate, your employer and/or service provider cannot go beyond what the Government has ascertained as safe. We are aware that the Fair Work Commission has taken a very expansive approach of what employers can and can't request from their employees. However, we believe these issues are still subject to be tested before the Courts before we can clearly state that employers can set whatever boundaries and demands they want. We don't think that such an approach is justified or lawful where there is disability discrimination, merit-based considerations around the legitimacy of arguing that masks and PPE are essential in healthy workers and the implications of going beyond the jurisdiction of Government during states of emergency.

### **Letter M3**

#### **Mandatory Mask Letter for Employers**

Dear.....,

I provide you notification that I have a medical reason for not wearing a mask. The medical reason is that I suffer from asthma/breathlessness/childhood trauma/previous operation/skin condition/claustrophobia/other. I am not required under the law or the Government guidelines to provide you a GP certificate or otherwise for this medical reason.

This communication is all that is required for me to obtain an exemption for that purpose and you do not have the right to enforce anything against me in this regard.

I also assure you that I do not have any symptoms of COVID-19 or any other infectious condition or illness. I suggest that this matter be immediately resolved and there is no need to escalate the issue further.



However, in good faith, I have sought advice from my medical practitioner and I enclose proof of my medical exemption.

Masks in themselves do not provide protection but are regarded by the World Health Organisation as a general precautionary measure – only when someone has symptoms and cannot socially distance. In this regard, it is not adequate for the employer to argue that the absence of me wearing a mask constitutes a safety risk to other employees or the public, in the absence of me having any symptoms of illness.

Specifically, as I have a medical exemption and I do not have any symptoms of COVID-19 or any other infectious disease, there are no medical grounds or legal grounds to deny me access to my employment.

### **End of Letter M3**

If the Employer, whether with active mandates or without active mandates, reject the medical exemption forms and still persist on wanting to force you to see their own doctor and/or psychiatrist to assess you, and persist on the OH&S reasons, you can either participate in the medical assessment and see whether their medical practitioner accepts your reasons or outright reject it and rely on discrediting the science behind the masking.

Your Employer may also argue that you are unfit for work if your medical exemption shows you can't wear masks. Such arguments are often framed that you are safety risk if you don't wear a mask. It is an outrageous proposition however to suggest that you are a safety risk if you are healthy and have no symptoms of disease. The mask does not protect anyone from transmission of disease.

### **Letter M4**

#### **Mask Exemption Letter of Last Resort to Employer**

Dear Employer [insert name],

#### **Re: Face Mask Medical Exemption**

I respectfully reject your assertion that my medical evidence should not be accepted as reasonable evidence that I am legitimately medically exempt from wearing a mask and/or that my medical exemption shows that I am unfit for work. On the contrary, your current workplace practice appears to present an unacceptable risk of promoting an environment, which increases risk for its employees. I will elaborate on the harms caused by an inflexible mask mandate further in this correspondence.

We reiterate and provide further information supporting that the medical evidence provided, is sufficient for the purposes of the employer being able to manage its safety obligations and duty of care, and determining any reasonable adjustments which may be made to facilitate the employee's role, in consideration of his/her lawful mask exemption.

We provide the following information to assist the employer with its assessment. Mask directives (requiring masks to be worn in public and at work, subject to some exemptions) of the government are to help manage the risk of community transmission following an identified case, are consistent with the actions of Governments across Australia, who claim to be acting on the best available health advice. However, the directives and response of this Government are inconsistent with the intergovernmental agreement where it details the appropriate response should be dependent on risk level, and also the Biosecurity Act 2015, where it states that measures only apply to those demonstrating an "individual risk".

The recommendations on the Australian Federal Government health website<sup>1</sup> state in a fact sheet<sup>2</sup> that the general use of cloth masks in the community are not recommended, unless there is a presence of sustained community transmission. Bhatia and Klausner, (2020)<sup>3</sup> stated that "Public perceptions of risk may also influence how political leaders act. Ideally, public leaders should communicate risk precisely and transparently... there has been little attention to estimating and communicating how personal risk varies by place, time, and population". Relevantly, they found that most transmission risk came from households, as opposed to public areas, consistent with the WHO conclusions on their mission to China<sup>4</sup>.

I strongly state that decisions to enforce masking is inconsistent with the Occupational Safety and Health Act which sets out the employer's primary duty of care to its employees, as it causes more harm to health than good, as this document will support.

We concur with statements that the employer is required to take reasonably practicable measures to prevent workers being exposed to hazards, and is required to have regard to current known information about risks and available controls.

We disagree with claims that wearing a face mask is currently accepted as an appropriate control.

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<sup>1</sup> [www.health.gov.au](http://www.health.gov.au)

<sup>2</sup> The Australian government fact sheet, titled; *Face masks how they protect you and how to use them*, published on 28/07/2020, last updated on 11/11/2020, sourced at <https://www.health.gov.au/resources/publications/face-masks-how-they-protect-you> on 15/12/2020

<sup>3</sup> Rajiv Bhatia, Jeffrey Klausner, (2020), *Estimating individual risks of COVID-19-associated hospitalization and death using publicly available data*, medRxiv 2020.06.06.20124446; doi: <https://doi.org/10.1101/2020.06.06.20124446>

<sup>4</sup> World Health Organization. *Report of the WHO-China Joint Mission of Coronavirus Disease 2019 (COVID-19)*. 2020 Feb 16-24

The science is certainly not settled in this area. Please refer to King, (2020), referenced below<sup>5</sup>. This British Medical Journal publication details that bias and censorship appear to have influenced the body of contemporary scientific research, much of which is relied upon by government, facilitating; “narratives that have little basis in science”. You may like to inform yourself with the Great Barrington Declaration and Covid Medical Network which also demonstrate that the Science is certainly not “agreed upon”.

Where Government Direction is contrary to legislation and open to a High Court challenge, this may create a risk of nonfeasance surrounding your duty of care to your employees. The argument that “we are just following orders”, was not upheld throughout the Nuremberg Trials of Nazis, nor the Royal Commission into institutional sexual abuse as well as in many other incidences where unsound government directives were found to be subject to humanitarian rights and principles. History supports that, those organisational bodies who knowingly participated, eventually faced significant accountability and consequences. I encourage you to become familiar with the Nuremberg Code<sup>6</sup>. This code compels authorities to resist orders to coerce conformism to an act which presents an unacceptable risk of physical and psychological harm. It insists that all unnecessary physical and mental suffering and injury must be avoided and must cease, if it is likely to harm the subject.

Employers have a responsibility to inform its decision makers of all relevant evidence-based information and consider an appropriate risk analysis, prior to mandating any policy surrounding safety. Employers are required to have regard to current known information about risks and available controls. I provide the following peer-reviewed evidence, highlighting risks regarding the employer’s mask directive to assist your decision making. It is important to remember that predicted outcomes and fearmongering originated from the original, greatly overestimated modelling from the Imperial College of London<sup>7 8</sup>. Neil Ferguson’s modelling has been widely criticised as “The most devastating software mistake of all time<sup>9</sup>”. Rational perspective and insight are critical.

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<sup>5</sup> Covid-19: politicisation, “corruption,” and suppression of science, BMJ 2020; 371 doi: <https://doi.org/10.1136/bmj.m4425> (Published 13 November 2020) Cite this as: BMJ 2020;371:m4425

<sup>6</sup> The Nuremberg Code (1947) In: Mitscherlich A, Mielke F. Doctors of infamy: the story of the Nazi medical crimes. New York: Schuman, 1949: xxiii-xxv.

<sup>7</sup> National Review, author John Fund “Professor Lockdown Modeller resigns in disgrace”, published on May 6th 2020, sourced at <https://www.nationalreview.com/corner/professor-lockdown-modeler-resigns-in-disgrace/>

<sup>8</sup> Explanation of the grave overestimate made by Ferguson’s modelling, (at the 5–6-minute mark), sourced online at <https://www.youtube.com/watch?v=8UvFhIFzac&feature=youtu.be>

<sup>9</sup> Developers Corner, *The most devastating software mistake of all time, Why is the Imperial Model under criticism?* Author Ram Sagar, published online on 22/05/2020, Sourced at <https://analyticsindiamag.com/the-most-devastating-software-mistake-of-all-time-why-is-the-imperial-model-under-criticism/>

You may be aware, Bullard et al, (2020)<sup>10</sup> noted that PCR tests which run at high cycle threshold levels, fail to determine viral infectivity. They found that their study showed no positive viral cultures using cycle thresholds above over 24, suggesting low infectivity. The number of cases in Australia largely inform the decision to wear masks. Have you exercised due diligence and looked into the amplification cycles used in Australia? **You will find they greatly exceed 24. The foundational reasoning for the mask directive is flawed.**

### **Do masks reduce disease transmission?**

The current Victorian Chief Health Officer, Mr Brett Sutton, has supported a mask mandate, contrary to comments not supporting this paradigm made through his own 2001 research<sup>11</sup>. Sutton and Skinner, (2001)<sup>12</sup>, cited the work of Leyland, (1993)<sup>13</sup>, who assessed views on masks by operating theatre staff. This showed that 20% of surgeons discarded surgical masks for endoscopic work. More than half did not wear the mask as recommended by the Medical Research Council. Most alarmingly he relayed that 1 in 5 admitted that “tradition was the only reason for wearing them”.

Chu et al, (2020)<sup>14</sup> published their meta-analysis which supported masks may have an association with reduced disease transmission, in the Lancet in June 2020. The authors claim that “our findings represent the current best estimates to inform face mask use to reduce infection from COVID-19”. They relied on only two studies analysing masks in a non-health care setting and tabulated that the effect estimate was of low confidence, meaning the estimated effect is of limited statistical confidence, and the true effect could be substantially different from the estimate of the effect. If this is the strongest weight available to support masks reducing transmission, the position to mandate masks does not appear to be a convincing conclusion.

All available research stating that masks are effective is limited by variables inclusive of recall and interviewer bias, confounding variables, sparse inconsistent findings, and competing interests.

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<sup>10</sup> Bullard J., Dust K., Funk D., et al, (2020), *Predicting infectious severe acute respiratory syndrome coronavirus 2 from diagnostic samples*, Clinical Infectious Diseases Society of America, doi:10.1093/cid/ciaa638., [Google Scholar](https://doi.org/10.1093/cid/ciaa638) Volume 71, Issue 10, 15 November 2020, Pages 2663–2666, <https://doi.org/10.1093/cid/ciaa638>

<sup>11</sup> Dr Brett Sutton Chief Health Officer research citation; Skinner, M & Sutton, Brett. (2001). Do Anaesthetists Need to Wear Surgical Masks in the Operating Theatre? A Literature Review with Evidence-Based Recommendations. *Anaesthesia and intensive care*, Vol. 29. No.4, 331-8. 10.1177/0310057X0102900402. August 2001

<sup>12</sup> 'ibid'

<sup>13</sup> Leyland M, McCloy R., (1993), *Surgical Face Masks: Protection of self or patient?* Ann R College Surgeons England Vol.75:1

<sup>14</sup> The Lancet, *Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis*, [Derek K Chu, MD, Prof Elie A Akl, MD, Stephanie Duda, MSc, Karla Solo, MSc, Sally Yaacoub, MPH, Prof Holger J Schünemann, MD](https://doi.org/10.1016/S0140-6736(20)31142-9), on behalf of the [COVID-19 Systematic Urgent Review Group Effort \(SURGE\) study authors](https://doi.org/10.1016/S0140-6736(20)31142-9), Open Access Published: June 01, 2020, DOI:[https://doi.org/10.1016/S0140-6736\(20\)31142-9](https://doi.org/10.1016/S0140-6736(20)31142-9), sourced at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31142-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext)

Macintyre et al., (2009)<sup>15</sup>, further noted that; “it is possible that adherent mask use is correlated with other, unobserved variables that reduce the risk of infection” after stating that caution must be used prior to extrapolating data for application in schools and community. I caution that when science relies on possibilities, not probabilities, rigor, integrity, and validity are diminished. I suggest that this methodology presents a significant risk of facilitating misleading conclusions, which are then used to inform policy. That said, with respect, you have a responsibility to use impartiality in all risk assessments surrounding your decision making.

Much research surrounding transmission does not explore the transmissibility of a pathogenic viral load, and instead focuses on contamination of a low viral load that research supports, is infinitely unlikely (using current research), to eventuate into a viable virus. While asymptomatic transmission has not been definitively documented anywhere, this does not mean it does not occur, but supports that pathogenic transmission is related closer to viral load.

The following supports that masking is unlikely to reduce mortality from the current pandemic, and may conversely do more harm than good, based on the body of science from the last 40 years.

History demonstrates that masks can cause more harm than good:

Ciani, (2020), a historian wrote; “The quarantine, isolation and mask-wearing failed to diminish the spread of influenza. Instead, the practices likely increased fatality and had disastrous economic consequences. The medical policy of 1918 was contrary to the medical science of 1918, and the destructive practices of quarantine, isolation and mask-wearing were largely abandoned<sup>16</sup>.” In consideration of the significance of bacterial infections in pandemic mortality, raised by Lubarsch O. Die, (1918)<sup>17</sup>, McCuller, (2008)<sup>18</sup> and Fauchi et al, (2008)<sup>19</sup>, and the latter’s work which supports that most 1918 pandemic deaths were caused by secondary bacterial pneumonia, (due to common respiratory pathogens such as pneumococci, group A streptococci, and staphylococci).

Huber, (2020)<sup>20</sup> concluded that; “Masks have also been demonstrated historically to contribute to increased infections within the respiratory tract. We have examined the common occurrence of oral

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<sup>15</sup> Macintyre C.R., Cauchemez S., Dwyer D.E., Seale H., Cheung P., Browne G., Fasher M., Wood J., Gao Z., Booy R. Ferguson, N., (C. Raina MacIntyre, Simon Cauchemez, Dominic E. Dwyer, Holly Seale, Pamela Cheung, Gary Browne, Michael Fasher, James Wood, Zhanhai Gao, Robert Booy, and Neil Ferguson), Face mask use and control of respiratory virus transmission in households. *Emerg. Infect. Dis.* 2009; 15:233–241. [PMC free article] [PubMed], available at <https://europepmc.org/article/PMC/2662657>

<sup>16</sup> A Ciani., (2020), *A pandemic of socialism*. American Thinker. Aug 24, 2020.

[https://www.americanthinker.com/articles/2020/08/a\\_pandemic\\_of\\_socialism.html#ixzz6ZkgXX16k](https://www.americanthinker.com/articles/2020/08/a_pandemic_of_socialism.html#ixzz6ZkgXX16k)

<sup>17</sup> Lubarsch O. Die, (1918), anatomischen Befunde von 14 tödlich verlaufenen Fällen von Grippe. *Berl Klin Wchnschr.* Vol. 55:768–769.

<sup>18</sup> McCullers JA, (2008), Planning for an influenza pandemic: thinking beyond the virus. *J Infect Dis.* 2008;198(7):945-947. doi:10.1086/592165

<sup>19</sup> Fauci AS, Morens DM, Taubenberger JK, (2008), *Predominant role of bacterial pneumonia as a cause of death in pandemic influenza: implications for pandemic influenza preparedness.* *J Infect Disease in Press.* [PMC free article] [PubMed]

<sup>20</sup> Huber, C., Borovoy., Crisler., (2020), "Masks, false safety and real dangers, Part 2: Microbial challenges from masks" sourced at [https://pdmi.org/Mask\\_Risks\\_Part2.pdf](https://pdmi.org/Mask_Risks_Part2.pdf)

and nasal pathogens accessing deeper tissues and blood, and potential consequences of such events. We have demonstrated from the clinical and historical data cited herein, we conclude the use of face masks will contribute to far more morbidity and mortality than has occurred due to COVID-19". As masks create an environment conducive to the capacity of bacteria to thrive, it makes sense to limit mask mandates, which may unacceptably risk increasing vulnerability to respiratory pathogens.

It is critical to consider the unacceptable risk mask wearing presents to the individual, due to the increased capacity of potentially pathogenic bacteria to thrive.

Can masks help manage the risk of community transmission of viral pathogens?

Ma et al, (2020), acknowledge that; "Some randomized controlled trials (RCTs) did not support the efficacy of medical masks because medical masks could not reduce infection rates of some viral respiratory diseases<sup>21</sup>. On the contrary, Macintyre, R., et al., (2015) concluded; "Moisture retention, reuse of cloth masks and poor filtration may result in increased risk of infection." And "...as a precautionary measure, cloth masks should not be recommended for health care workers, particularly in high risk situations, and guidelines need to be updated".

Huber, (2020), reiterates that; "Masks have been shown through overwhelming clinical evidence to have no effect against transmission of viral pathogens"<sup>22</sup>.

Rancourt's whitepaper review<sup>23</sup> is inclusive of the conclusions from Offeddu et al, (2017), (amongst others), and strongly supports that there is no study available, that justifies implementing or enforcing mask mandates to mitigate COVID-19<sup>24</sup>.

Is the wearing of masks a practical measure, to prevent the transmission of SARS CoV2?

The Infection Control Expert Group (ICEG), <sup>25</sup> provide advice to the Australian Health Protection Principal Committee (AHPPC), and its other standing committees on issues regarding infection prevention and control. Their position is that evidence to date supports transmission via respiratory

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<sup>21</sup> Xiao J, Shiu EYC, Gao H, et al. Nonpharmaceutical measures for pandemic influenza in nonhealthcare settings-personal protective and environmental measures. *Emerg Infect Dis.* 2020;26(5), 10.3201/eid2605.190994

<sup>22</sup> C Huber. *Masks are neither effective nor safe.* Primary Doctor. Jul 6 2020. <https://www.primarydoctor.org/masks-not-effect>

<sup>23</sup> Rancourt, Denis, G.,(2020), *Masks don't work a review of science relevant to Covid-19 social policy*, sourced at <https://www.rcreader.com/commentary/masks-dont-work-covid-a-review-of-science-relevant-to-covide-19-social-policy-11/06/2020>, River Cities Reader, accessed on 06/12/2020

<sup>24</sup> McGreevy, Todd, (2020), *Still no conclusive evidence justifying mandatory masks*, <https://www.rcreader.com/commentary/still-no-conclusive-evidence-justifying-mandatory-masks>, 12 August, 2020.

<sup>25</sup> Infection control expert group sourced online at <https://www.health.gov.au/committees-and-groups/infection-control-expert-group-iceg>

droplets, and that these droplets may contaminate surface areas and objects. They acknowledge a potential for aerosol transmission in clinical settings and indoor areas with poor ventilation.

The ICEG rely on a study of 1600 healthcare workers in Vietnam which compared the use of medical, cloth and control subjects with no covering at all<sup>26</sup>. The results in this study showed a significantly higher rate of clinical respiratory infection, influenza type illness (ILI), in cloth mask wearers than the control subjects. This is of great cause for alarm. These unexpected results may be explained through variables such as dampness, prolonged use and self-contamination by cloth mask wearers. These factors will be predictably present and are reasonably unavoidable in school students. This study raises red flags surrounding whether the use of masks can actually be of benefit in transmission reduction of ILI at all and in fact, this study indicates otherwise. It suggests that wearing masks increases transmission, when compared with controls without masks.

According to Sutton and Skinner's meta-analysis<sup>27</sup> "The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use".

Orr's, (1981)<sup>28</sup>, study of 1049 surgery patients, conducted to determine if wearing surgical masks influenced wound infections, aptly surmised "It would appear that minimum contamination can best be achieved by not wearing a mask at all" and that wearing a mask during surgery "is a standard procedure that could be abandoned." Orr, (1981)<sup>29</sup> notably concluded that the practice of wearing masks could cease, as this research supported those patients were found to have a significantly lower infection rate of wounds, when masks were not used. Orr differentiates between contamination and infection in this study.

In consideration of the above, can you really suggest enforcing masks is practical if it is contrary to the intended outcome of reducing disease transmission?

Does the wearing of masks cause harm to the wearer?

In addition to the increased risk of secondary bacterial infections mentioned above, Zhixing et al, (2020)<sup>30</sup>, stated that masks can cause weakened breathing and cause hypoxia. They state that it is

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<sup>26</sup> Reference to study; MacIntyre, CR, Seale H, Dung TC, Hien NT, Nga PT Chunghtai AA, et al. A cluster randomised trial of cloth masks compared with medical masks in healthcare workers. *BMJ Open*. 2015;5(4): e006577.10.1136/bmjopen-2014-006577

<sup>27</sup> 'ibid'

<sup>28</sup> Orr NMW. Is a mask necessary in the operating theatre? *Ann R Coll Surg Engl* 1981; 63:390-392.

<sup>29</sup> Orr, NMW, (1981), *Is a mask necessary in the operating theatre?* *Annals, Royal College Surgeons England*; Vol 63:390-392.

Sourced at <https://jdfor2020.com/2020/08/1981-surgeons-medical-mask-study-concludes-minimum-contamination-can-best-be-achieved-by-not-wearing-a-mask-at-all/> on 25/10/2020

<sup>30</sup> Zhixing Tian<sup>1</sup>, Bong-Young Kim<sup>2</sup> and Myung-Jin Bae<sup>3</sup>, (2020), *A Study on the Effect of Wearing Masks on Stress Response*, *International Journal of Engineering Research and Technology*. ISSN 0974-3154 Vol.13, No.4 (2020), pp. 807-813 International Research Publication House. <http://www.irphouse.com>.

known that hypoxia can cause irreversible damage to organs. Huber et al, (2020),<sup>31</sup> comprehensively examined the physiological consequences on multiple organ systems, inclusive of the brain, heart, lungs and immune system, during the initial 45 seconds of mask wearing. They found the changes in oxygen and carbon dioxide, (CO<sup>2</sup>), caused numerous systemic injuries, consistent with the effects of hypoxia<sup>32</sup> and hypercapnia<sup>33</sup> on these systems.

The effect of masking on oxidative stress and effects on organ systems and decision making, requires further consideration. The ineffectual effect of masks does not support the desired outcome, may cause harm, such as respiratory stress<sup>34</sup> facilitating secondary bacterial disease<sup>35</sup>, impaired learning and memory<sup>36</sup>, social connectivity and empathy<sup>37</sup> and psychological injury<sup>38</sup>, and are therefore not fit for the purpose of facilitating the health of a population, and should not be assumed to do so. It follows that they are certainly not a necessity, and should not be compulsory, contrary to strongly promoted political messaging and lay view.

I provide information in good faith to:

1. Assist your responsibility to minimise exposure to risk of harm, to which is applicable to all employees.
2. I bring to your attention that your current PPE directives are based on unreliable evidence, and accordingly, a review of these directives and surrounding risk analysis is pertinent.
3. In addition, I notify your organisation that a liability may be created if you intend to willingly and knowingly promote an unsound directive, which does not satisfy its objective, is founded on unsettled science, and presents an unacceptable risk of causing more harm than good.

As you are aware it is unlawful to discriminate against employees due to a medical condition.

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1Soong-sil University, Department of Information and telecommunication Engineering, Seoul, 06978, Korea. *Orcid Id* : 0000-0003-3882-2459, *Orcid Id* : 0000-0002-3553-039X, *Orcid Id* : 0000-0002-7585-0400

<sup>31</sup> Huber, C., Borovoy, B., Crisler, M., (2020), *Masks, false safety and real dangers, part 3, hypoxia, hypercapnia and physiological effects.*

<sup>32</sup> Merriam-Webster dictionary, sourced online at 23/01/2021, Definition of *Hypoxia*; a deficiency of oxygen reaching the tissues of the body.

<sup>33</sup> Merriam-Webster dictionary, sourced online at 23/01/2021, Definition of *Hypercapnia (also known as hypocarbia)*; excessive amounts of carbon dioxide levels in the blood.

<sup>34</sup> Person E, Lemerrier C, Royer A, Reyhler G. *Effect of a surgical mask on six-minute walking distance.* Rev Mal Respir. 2018 Mar;35(3):264-268. French. doi: 10.1016/j.rmr.2017.01.010. Epub 2018 Feb 1. PMID: 29395560.

<sup>35</sup> Chiller, K., Selkin, B., Murakawa., Skin Microflora and Bacterial Infections of the Skin, *Journal of Investigative Dermatology Symposium Proceedings, Volume 6, Issue 3, December 2001, Pages 170-174* sourced at <https://www.sciencedirect.com/science/article/pii/S0022202X15529011> on 07/11/2020

<sup>36</sup> Beckervordersandforth, R., (2017). *Mitochondrial Metabolism-Mediated Regulation of Adult Neurogenesis.* Brain Plast. Vol. 3, 73–87.

<sup>37</sup> The Lancet, *Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: a systematic review and meta-analysis*, [Derek K Chu, MD, Prof Elie A Aki, MD, Stephanie Duda, MSc, Karla Solo, MSc, Sally Yaacoub, MPH, Prof Holger J Schünemann, MD](https://doi.org/10.1016/S0140-6736(20)31142-9), on behalf of the [COVID-19 Systematic Urgent Review Group Effort \(SURGE\) study authors](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext), Open Access Published: June 01, 2020, DOI : [https://doi.org/10.1016/S0140-6736\(20\)31142-9](https://doi.org/10.1016/S0140-6736(20)31142-9), sourced at [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(20\)31142-9/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext)

<sup>38</sup> Prousa, D. (2020). *Studie zu psychischen und psychovegetativen Beschwerden mit den aktuellen Mund-Nasenschutz-Verordnungen.* PsychArchives. <https://doi.org/10.23668/PSYCHARCHIVES.3135> sourced at <https://www.psycharchives.org/handle/20.500.12034/2751> and interpreted using google translate on 16/11/2020



Humanitarian principles, proportionality and necessity must also be considered throughout lawful decision making, as per the conditions of Article 4 of the International Covenant on Civil and Political Rights (ICCPR), where governments may temporarily suspend the application of some rights in the exceptional circumstance of a 'state of emergency' and subject to abovementioned considerations.

We reiterate that employees absolutely have the capacity to fulfil their duties without wearing a mask.

I look forward to your response by email.

Yours sincerely,

**End of M4 Letter**

## Letter M5

### Masking and Children/Students

We have also been lucky to receive the assistance from one of our associates Michelle Saminaden, who has also cleverly put together the following sample letter in relation to masking and children for you to use to send to schools and/or the Education Department. Customise this template to your State/school.

CC: Office of the Minister for Education [ome@edumail.vic.gov.au](mailto:ome@edumail.vic.gov.au), Public Sector Commissioner

### Re: Mask Mandate



“To the Principal,

I correspond in regard to the extraordinary decision for the Education Department to mandate masks for Victorian school children. Thank you in advance for your consideration of my concerns, as follows.

I bring to your urgent attention that evidence supports that the mask mandate may be an unlawful, unsound and potentially harmful directive, which is not fit for purpose. I respectfully request that the Education Department facilitate a common sense, independent and evidence-based approach in the best interests of students, legislative obligations, (inclusive of our Constitution, and human rights considerations), to revoke the mandatory mask direction in Victorian schools. Please review appendix 3 for relevant legislative instruments that the Department must consider.

Please note, this is from the Federal Government health website:

***Where there is low community transmission of COVID-19, wearing a mask in the community when you are well is not generally recommended.***

<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/how-to-protect-yourself-and-others-from-coronavirus-covid-19/masks>

I have grave concerns, and do not believe that the mask mandate enforced on Victorian Secondary students, (over 12 years of age), is in compliance with various sections of the Victorian Public Health and Wellbeing Act, (2008). Numerous other legislative instruments have been scrutinised by a rigorous risk analysis, (as detailed in Appendix 4), and are based on credible science.

The science and lawfulness supporting many Victorian public health directives is not settled. For example, the WHO changed its stance on lockdowns on 11/10/2020, and Dr David Nabarro from the WHO claimed that the only thing lockdowns achieved was poverty. Our education system and students cannot afford to continue to rely on untested opinion.

I do not believe the decision making around the mask mandate, has adequately considered the vast majority of peer reviewed science, (which overwhelmingly find that masks are ineffective), for the purposes of reduction of community disease transmission.

The Chief Health Officer has claimed that masks reduce transmission without providing verifiable peer reviewed research. I state that that the mask mandate is not only disproportionate to the risk. It is ineffective and according to the weight of verified science, there is an unacceptable risk that this mandate may actually increase disease transmission, (as detailed below).

I am also concerned regarding the impact of this mandate on the physical and psychological health of affected students. Concerning reports of illness and death due to mask use are being reported globally. For example, Chinese schools have prohibited mask use during exercising, after two teenage boys died during their physical exercise class<sup>39</sup>. In addition a 26-year-old man suffered a collapsed lung after running two and a half miles while wearing a mask. *Dr Chen Baojun, a Chief Medic from the Wuhan Hospital, suggested the 26-year-old Chinese resident was already more susceptible to the condition as he was 'a very tall man and quite thin'. He added that the face covering directly caused the sudden increase of pressure to Mr Zhang's lungs due to intense running. Education authorities in China said today that they are set to ban school students from wearing face masks during PE lessons due to the health risks<sup>40</sup>.* The assumptions of minimal benefit, if any, due to mask use should be weighed against the strength of evidence, which indicates that they may cause more harm to health than benefit.

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<sup>39</sup> Reported in the New York Times by Jackie Salo, on May 6,2020, "Two boys drop dead in China while wearing masks during gym class", sourced online at <https://nypost.com/2020/05/06/two-boys-drop-dead-in-china-while-wearing-masks-during-gym-class/>

<sup>40</sup> Reported via Kelly-Ann Mills on 13<sup>th</sup> May, 2020, sourced at <https://www.mirror.co.uk/news/world-news/man-26-suffers-collapsed-lung-22018788>

I am also concerned about discrimination towards mask exempted students. On 09/10/2020, a teacher at a school in regional Victoria was reported by a parent to be bullying a student to wear a mask during physical exercise, despite this child's objections. This is very concerning. The Department may choose to remind teachers of very robust workplace safety laws, surrounding misconduct leading to harm, and discrimination.

**In light of the significance of the issues raised so far, I respectfully request a written response, in accordance with the Charter of Human Rights and Responsibilities Act, sec 15(2)<sup>41</sup>, as soon as possible, to the following:**

- Does the school/Department intend to provide information to parents, students and teachers about lawful exemptions such as trauma, anxiety and respiratory issues?
- Have educators been offered training and health safeguards to help them identify and adequately respond to a child suffering symptoms of illness or distress from mask use?
- How will the Department honour the genuine necessity for these vulnerable students to attend school without a mask, without discrimination, pressure or consequence?
- I hold concerns the Andrews Government may have enacted the directive for students to wear masks at school in an unlawful manner. I request transparency and clarification regarding what legal advice the Education Department has received from the Solicitor-General or other legal professionals, to confirm the legality of the imposition of this directive.
- I respectfully request to be provided with the legislative authority, specific Acts and instruments, and any risk analysis relied upon, to support and enforce a school mask mandate.
- Are you aware if the individual who is responsible for this decision has sought and understood, independent, verifiable specialist medical and science research and responsible views, in a risk analysis, which also align with the best interests of students, the purpose of the Education System, and relevant legislation?
- I would appreciate the contact details of the person(s) in the school/Education Department, who is responsible for the decision to mandate masks. Alternatively, I am happy for you to forward this correspondence if you deem appropriate.
- I request clarification regarding what verifiable advice the Education Department has received from scientists, medical professionals, or the Andrews Government, to confirm and verify the belief that wearing masks is likely to reduce transmission of disease, and specifically Covid-19, if available.
- I request reassurance that the directive for students over 12 years of age to wear masks at school has been supported by verifiable, independent health advice, subject to risk analysis,

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<sup>41</sup> Charter of Human Rights and Responsibilities Act, sec 15(2), Sourced at [http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/vic/consol\\_act/cohrara2006433/s15.html](http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/vic/consol_act/cohrara2006433/s15.html) on 23/10/2020

supporting that this decision is aligned with the best interests of Victorian Students and is lawful. If this is not available, then an immediate withdrawal of this mandate must be facilitated in the interests of good governance.

- It was the Queensland Chief Health Officer's position to close schools to send a message. I request to understand if the Victorian Education Department closed schools, or are endorsing the mask mandate, because they have been instructed by the Victorian Government, to send a message.
- The Charter of Human Rights and Responsibilities Act, sec 17, states that children have the right to be protected by the State as needed to uphold his/her best interests, and sec 7 which upholds scrutiny between the relationship of the limitation (mask mandate) and its purpose, in addition to a legislative instruction that the limit must be the "less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve". Will the Education Department honour this legislation, through notification to the UN Secretary General under Article 41a of the ICCPR, or notify the Human Rights Commission, for State Labor Party breaches of the State Public Health and Welfare Act, Federal Biosecurity Act, ICCPR, articles 4 and 17, which are disproportionate to the risk, unjustified, arbitrarily unreasonable, and as this document may establish, not founded on peer reviewed credible science?
- In consideration of the specific legislative conditions and due process, detailed throughout the Compliance with legislation and Human Rights Considerations found in Appendix 4 of this document, can the Education Department please detail the reasoning behind why they feel a mask mandate is lawful for children and students.
- In consideration of the details throughout this document, (inclusive of the meta-analysis and legislative considerations provided in the Appendix), I request that the Education Department please detail the reasoning supporting that a mask mandate is evidence based, reasonable, necessary and proportionate to the risk, and in the best interests of students, as is lawfully required even under the conditions of a State of Emergency/Disaster.

**End of Letter Template M5, Research Follows**

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1. What does the Science Support?
2. Infection Control Expert Group (ICEG)
3. Skin Disease
4. Verifiable research and specialist opinion
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6. Government Health Advice
7. Messaging
8. Andrews Government Policy v Educational Policy and best interests of our students.
9. Sensible Measures
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11. Unreasonableness
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13. PCR-RT TESTING
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15. Appendix 1 Meta-Analysis ***Masks are neither effective or safe, a summary of the science. Are masks effective at preventing transmission of respiratory pathogens?***
16. Appendix 2 '*The Great Barrington Declaration*'
17. Appendix 3 Compliance with legislation and Human Rights Considerations inclusive of:
  - Legislative Authority for Mask Mandate?
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  - How does a 'State of Emergency' fit with a 'State of Disaster'?
  - Risk Assessment Analysis
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  - Principles of Equity
  - The Australian Constitution
  - Article 17 of the ICCPR
  - Human Rights Considerations
  - Occupational Health and Safety Act 2004

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<sup>42</sup> Public Health and Wellbeing Act, (2008), (sec 112), [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/phawa2008222/s112.html](http://classic.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s112.html)

<sup>43</sup> Public Health and Wellbeing Act, (2008), (sec 111), [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/phawa2008222/s111.html](http://classic.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s111.html)

### **What does the Science Support?**

Anaesthetist Dr Babak Amin<sup>44</sup> voiced his objections to cloth, non-medical masks, with no universal standard of manufacture. He stated; "*There is a raft of high-quality data, what we call meta-analyses, studies that compile multiple other studies together, and these studies have found that non-medical masks in community settings play no role in protecting the wearer from infection, or from stopping infected people passing the virus on.*"

Mr Jones pointed to a study from Dr James Meehan of Global Research which argues bacterial pneumonias are currently on the rise because "*untrained members of the public are wearing medical masks repeatedly in a non-sterile fashion*"<sup>45</sup>.

### **Infection Control Expert Group (ICEG)**

The ICEG recommendations on the [www.health.gov.au](http://www.health.gov.au) website states that general use of masks in the community is not recommended, unless there is presence of sustained community transmission, and if so, only as an additional safeguard to physical distancing. They state that there is limited, indirect, experimental evidence that cloth masks can reduce transmission of respiratory droplets, and these masks are significantly less efficient than surgical masks.

The ICEG rely on a study of 1600 healthcare workers in Vietnam which compared the use of medical, cloth and control subjects with no covering at all<sup>46</sup>. The results in this study showed a significantly **higher rate of clinical respiratory infection, influenza type illness (ILI), in cloth mask wearers than the control subjects. This is of great cause for alarm.** These unexpected results may be explained through variables such as dampness, prolonged use and self-contamination in the cloth mask wearers. These factors will be predictably present and are reasonably unavoidable in school students. This study raises red flags surrounding whether the use of masks can actually be of benefit in transmission reduction of ILI, at all. In fact, this study indicates otherwise and suggests that wearing masks increases transmission, when compared with controls without masks.

**In consideration of the abovementioned study relied upon by the ICEG, the unknown effects of long-time mask wearing, the following must be investigated.**

- Do used and loaded masks become **sources of enhanced transmission**, for the wearer and others?

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<sup>44</sup> Dr Babak Amin interview and discussion on face masks, aired on 01/11/2020 on CMN sourced at <https://www.facebook.com/cmnic/videos/3226286990830776> on 01/11/2020

<sup>45</sup> 'ibid'

<sup>46</sup> Reference to study; MacIntyre, CR, Seale H, Dung TC, Hien NT, Nga PT Chunghtai AA, et al. A cluster randomised trial of cloth masks compared with medical masks in healthcare workers. *BMJ Open*. 2015;5(4): e006577.10.1136/bmjopen-2014-006577

- Do masks become collectors and **retainers of pathogens** that the mask wearer would otherwise avoid when breathing without a mask?
- **Are large droplets captured by a mask atomized or aerolized into breathable components?**
- What are the **dangers of bacterial growth on a used and loaded mask?**
- How do pathogen-laden droplets **interact** with environmental dust and aerosols captured on the mask?
- What are **long-term effects** on health, such as headaches, arising from impeded breathing?
- Are there **negative social consequences** to a masked society?
- Are there **negative psychological consequences** to wearing a mask, as a fear-based behavioural modification?
- What are the **environmental consequences** of mask manufacturing and disposal?
- Do the masks **shed fibres or substances that are harmful** when inhaled?<sup>47</sup>

Scientific evidence shows that masks **obstruct breathing** and are not effective barriers to pathogens including Covid 19 and can have effects on the health of the individual due to bacteria and mould collecting on the mask<sup>48</sup>.

Masks are causing harm in our community already and present a predictable and unacceptable risk. It is commonly known that supermarket staff are forced to wear masks for 8-10 hours a day, and then again when they are out for their 2 hours of exercise. Those subjected to wearing masks are reporting **breathlessness, light headedness, headaches and migraines, sweat sores around their mouth, nose, chin and eyes, as well as cuts to the back of their ears**<sup>49</sup>.

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<sup>47</sup> Information adapted from the research of Liberal Federal Member Mr Craig Kelly, with permission. This information is available and referenced at this link; <https://thevoiceoftheaustralianpeople.com/nomorefacemasks/>

<sup>48</sup> 'ibid'

<sup>49</sup> 'ibid'



## Skin Disease

Dr James Meehan's global research argues that; "*all over the world bacterial pneumonias are on the rise. Why might that be? Because untrained members of the public are wearing medical masks repeatedly...in a non-sterile fashion. They're becoming contaminated...they're reapplying a mask that should be worn fresh and sterile every single time*".

## Influenza A and bacterial infection lead to most deaths in the 1918 Pandemic

The environment a mask creates has specific effects on the normally harmless skin flora found on our face. Chiller et al, (2001)<sup>50</sup>. Skin usually provides a decent defence against bacterial pathogenesis, however, an altered environment "*under moist occlusive<sup>51</sup> conditions*", can support bacterial growth. A mask certainly provides the moisture and covering required for most bacteria to thrive.

Fauci et al, (2008)<sup>52</sup>, who through review of a published autopsy series found that most deaths (96% of over 8000 cases reviewed), could be caused by a secondary bacterial pneumonia, (due to common respiratory pathogens such as pneumococci, group A streptococci, and staphylococci), and not just the virus itself. They found that the initial viral pathogenesis such viral bronchiolitis, often seemed to be resolving at the same time the secondary infection caused the death. Fauci et al, (2008) cited Wilson et al, (1947), who found that "*In rhesus monkeys, human influenza viruses given intranasally were not pathogenic, but could be made so by nasopharyngeal instillation of otherwise non-pathogenic bacteria*"<sup>53</sup>. Fauci et al concluded; "**Based on contemporary and modern evidence, we conclude here that influenza A virus infection in conjunction with bacterial infection led to most of the deaths during the 1918–1919 pandemic**".

In consideration of the significance of bacterial infections in pandemic mortality, raised by Lubarsch O. Die, (1918)<sup>54</sup>, McCuller, (2008)<sup>55</sup> and Fauci et al, (2008)<sup>56</sup>, and the latter's work which supports that most 1918 pandemic deaths were caused by secondary bacterial pneumonia, (due to common

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<sup>50</sup> Chiller, K., Selkin, B., Murakawa., Skin Microflora and Bacterial Infections of the Skin, *Journal of Investigative Dermatology Symposium Proceedings*, Volume 6, Issue 3, December 2001, Pages 170-174 sourced at <https://www.sciencedirect.com/science/article/pii/S0022202X15529011> on 07/11/2020

<sup>51</sup> Occlusion as defined in the Cambridge dictionary ; *medicine, something that blocks a tube or opening in the body, or when something is blocked or closed* sourced at <https://dictionary.cambridge.org/us/dictionary/english/occlusion> on 08/11/2020

<sup>52</sup> Fauci AS, Morens DM, Taubenberger JK, (2008), *Predominant role of bacterial pneumonia as a cause of death in pandemic influenza: implications for pandemic influenza preparedness*. *J Infect Disease* in Press. [PMC free article] [PubMed]

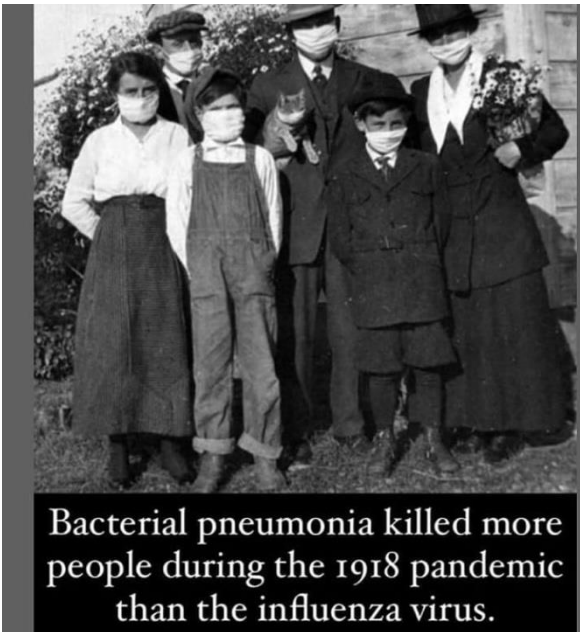
<sup>53</sup> Wilson HE, Saslaw S, Doan CA, Woolpert OC, Schwab JL. *Reactions of monkeys to experimental mixed influenza and Streptococcus infections. An analysis of the relative roles of humoral and cellular immunity, with the description of an intercurrent nephritic syndrome*. *J Exp Med*. 1947;85:199–215. [PMC free article] [PubMed] [Google Scholar]

<sup>54</sup> Lubarsch O. Die, (1918), anatomischen Befunde von 14 tödlich verlaufenen Fällen von Grippe. *Berl Klin Wchnschr*. Vol. 55:768–769.

<sup>55</sup> McCullers JA, (2008), Planning for an influenza pandemic: thinking beyond the virus. *J Infect Dis*. 2008;198(7):945-947. doi:10.1086/592165

<sup>56</sup> Fauci AS, Morens DM, Taubenberger JK, (2008), *Predominant role of bacterial pneumonia as a cause of death in pandemic influenza: implications for pandemic influenza preparedness*. *J Infect Disease* in Press. [PMC free article] [PubMed]

respiratory pathogens such as pneumococci, group A streptococci, and staphylococci), it is critical to consider the unacceptable risk mask wearing presents to the individual, due to the increased capacity of potentially pathogenic bacteria to thrive. It may also be more productive to refocus efforts towards methods of reducing bacterial infection.



Many Australians are suffering from **mask related illnesses and skin conditions**. The types of masks being recommended were never designed to be worn outside of controlled and sterile environments, thus making masks a **breeding ground for bacteria and mould**.

The pictures below show the detection of 82 bacterial and mould colonies on a mask previously worn by a child in school for 8 hours.





**HealthFreedomIreland**  
@HealthFreedomIE



**Labor für Mikrobiologie und Hygiene**

A German children's charity has commissioned a laboratory to examine a commercially available mask. The face mask was previously worn by a child in school for 8 hours.

Examination findings: Detection of 82 bacterial colonies and 4 mold colonies !!

Just confirmed by the doctor, rash due to being forced to wear a mask while at school 🙄

Impetigo, caused by the contagious strep virus and the bacteria being trapped up against her face.



The picture on the right, shows a school child with impetigo. This is a result of the contagious 'strep' virus thriving in the skin environment, caused by the child being forced to wear a mask at school. Similar photographs are often seen on social media.

**Dr. James Meehan**, MD warns that mask wearing has *“well-known risks that have been well-studied and they’re not being discussed in the risk analysis. I’m seeing patients that have facial rashes, fungal infections, bacterial infections. Reports coming from my colleagues, all over the world, are suggesting that the bacterial pneumonias are on the rise. “Why might that be? Because untrained members of the public are wearing medical masks, repeatedly... in a non-sterile fashion... They’re becoming contaminated. They’re pulling them off of their car seat, off the rear-view mirror, out of their pocket, from their countertop, and they’re reapplying a mask that should be worn fresh and sterile every single time...New research is showing that cloth masks may be increasing the aerosolization of the SARS-COV-2 virus into the environment causing an increased transmission of the disease...In February and March we were told not to wear masks. What changed? The science didn’t change. The politics did. This is about compliance. It’s not about science... Our opposition is using low-level retrospective observational studies that should not be the basis for making a medical decision of this nature.”*<sup>57</sup>

Accordingly, a group of doctors and business owners have launched legal action against the Tulsa Health Department to repeal the mask mandate in their city<sup>58</sup>. In Victoria, a High Court class action and judicial review regarding the mask mandate, (and other unreasonable directives that are disproportionate to the risk), is pending at the time of writing<sup>59</sup>.

### **Verifiable research and specialist opinion**

Many doctors have spoken against using masks as a method of reducing the spread of Covid-19. Dr Lee Merritt, a medical doctor with a long list of credentials testified before the Omaha City Council and stated; *“I became an orthopaedic spinal surgeon, did 10 years as a military surgeon and I served on a Congressional Committee that looked at technology for the military, the navy specifically and researched bioweapons and masks...in my professional career I have never heard of anybody that actually believes any kind of mask, short of a level 4 containment suit, made a difference to small particle viruses. In fact, the CDC published an article in May saying that they cannot contain influenza with these masks and that’s even larger than this virus...reviewed all this science. It’s online on YouTube under medical technocracy and my name...my conclusion is that people that are*

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<sup>57</sup> Medical Doctor Warns that “Bacterial Pneumonias Are on the Rise” from Mask Wearing, published online on 06/10/2020 at <https://www.globalresearch.ca/medical-doctor-warns-bacterial-pneumonias-rise-mask-wearing/5725848> author John, C, A, Manley

<sup>58</sup> Activist Post Oklahoma Doctors Claim Masks are Harmful to Healthy People and File Lawsuit Against Mandates, 24/09/2020, sourced online at <https://www.activistpost.com/2020/09/oklahoma-doctors-claim-masks-are-harmful-to-healthy-people-and-file-lawsuit-against-mandates.html> on 11/10/2020

<sup>59</sup> <https://www.advocateme.com.au/>

*now purporting to scientifically prove masks work are either being paid or being played... the outcome of this is not going to be good...children learn by looking at facial expressions they socialise. We are creating a generation of people that will be afraid of normal existence”.*

**A meta-analysis of peer reviewed research, concluded that face masks were found to have no detectable effect against transmission of viral infections. (There is a significant difference in the transmission of non-viable nucleic acids and a virulent pathogenic virus). This conclusion does not support mandated masks at school for healthy children<sup>60</sup>. Please refer to the meta-analysis found at appendix 1 of this document.**

Please note there is **NO** verifiable peer reviewed research supporting that masks reduce disease transmission. The only research available remotely supporting they do, is a preliminary study conducted at Honk Kong Uni by recently on 100 hamsters<sup>61</sup>. Please note this study was published on 30/05/2020. It states that up to the date of publishing; **“Although COVID-19 is believed to be transmitted by respiratory droplet and direct or indirect contact, no clear experimental evidence for this has been reported”**. Therefore the science pro-masks in relation to transmission reduction was certainly not settled as recently as May 2020, when this paper was released and the status has not changed to this date. However there is plenty of evidence supporting the contrary.

If the Education Department’s position is to listen to the CHO’s advice it may be more accurate and beneficial to review his own research on the mask issue, where he concluded: ***The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use.*** The CHO’s meta-analysis made with verifiable evidence has more integrity than any statement the CHO has made, in preference to the political propaganda he is directed to promote by Victorian Premier Daniel Andrews.

### **The Victorian CHO, Brett Sutton’s Research**

The Victorian Chief Health Officer, Brett Sutton has supported a mask mandate contrary to comments not supporting this paradigm, made through his own research<sup>62</sup>. He cited a 1993 survey by Leyland, which assessed views on masks by operating theatre staff. Most alarmingly he relayed that 1 in 5 admitting that *“tradition was the only reason for wearing them”*.

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<sup>60</sup> Masks are neither effective or safe a summary of the science, are masks effective at preventing transmission of respiratory pathogens? By: Colleen Huber, NMD via PrimaryDoctor July 14, 2020, at: <https://www.technocracy.news/masks-are-neither-effective-nor-safe-a-summary-of-the-science/> Technocracy News and Trends, sourced online on 10/10/2020

<sup>61</sup> Surgical Mask Partition Reduces the Risk of Noncontact Transmission in a Golden Syrian Hamster Model for Coronavirus Disease 2019 (COVID-19), *Clinical Infectious Diseases*, , ciaa644, <https://doi.org/10.1093/cid/ciaa644> sourced online at <https://fightcovid19.hku.hk/hku-hamster-research-shows.../>

<sup>62</sup> Dr Brett Sutton Chief Health Officer research citation; Skinner, M & Sutton, Brett. (2001). Do Anaesthetists Need to Wear Surgical Masks in the Operating Theatre? A Literature Review with Evidence-Based Recommendations., *Anaesthesia and intensive care*, Vol. 29. No.4, 331-8. 10.1177/0310057X0102900402. August 2001

According to the Victorian CHO Brett Sutton's summary of his meta-analysis; "*The evidence for discontinuing the use of surgical face masks would appear to be stronger than the evidence available to support their continued use. In this climate of economic justification, it would appear prudent to say that the use of surgical face masks by non-scrub operating theatre staff cannot be scientifically justified*". There is little evidence to suggest that the wearing of surgical face masks by staff in the operating theatre decreases postoperative wound infections. Published evidence indicates that postoperative wound infection rates are not significantly different in unmasked versus masked theatre staff. However, there is evidence indicating a significant reduction in postoperative wound infection rates when theatre staff are unmasked. Currently there is no evidence that removing masks presents any additional hazard to the patient". *Anaesthesia and Intensive Care*, Vol. 29, No. 4, August 2001, page 336.

### **Government Health Advice**

I hold concerns the Andrews Government may have enacted the directive for students to wear masks at school without adequate peer reviewed science.

Please review the statement released by the Covid Medical Network at <https://covidmedicalnetwork.com/about-covid-medical-network/declaration-statement.aspx>. This represents the concern and request of thousands of medical experts, inclusive of the "cessation of all disproportionate measures that contravene the International Siracusa Principles<sup>63</sup>... where; "Children and adolescents are suffering and being needlessly harmed by the denial of normal social interactions such as play, schooling and relationships with family and friends, particularly as the virus poses an almost negligible risk. These effects on child and adolescent health will impact their future wellbeing for many years to come<sup>64</sup>".

At present the research on the Federal Government health website, (involving 1600 Vietnamese health workers), provided by the ICEG is contrary to a mask mandate, and actually supports not wearing masks.

The science supports that masks are ineffective for the purpose of reducing transmission, at best they have extremely limited value. The **health.gov.au** website, states that "*masks can help protect you and those around you if you are in an area with community transmission, and physical distancing*

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<sup>63</sup> The Covid Medical Network (Covidmedicalnetwork.com), describes the Siracusa Principles as follows: *These are part of the International Covenant on Civil and Political Rights, to which Australia is a signatory and are recommended by the World Health Organisation. They require all public health management policies to meet standards of legality, evidence-based necessity and proportionality, and that they recognise our basic, universal and non-derogable human rights. They can be viewed at the Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights: Siracusa Principles <https://www.ici.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legalsubmission-1985-eng.pdf> signatory Australian Government: Attorney-General's Department: <https://www.ag.gov.au/rights-and-protections/human-rights-and-anti-discrimination/international-human-rights-system> World Health Organisation recommendation; WHO Chapter 11.5 - Public Health Emergencies, p176-177 <https://www.who.int/healthsystems/topics/health-law/chapter11.pdf>*

<sup>64</sup> "Hidden pandemic trauma harming children" News GP -RACGP .31 August 2020

is not possible”. However “where there is significant community transmission (as determined by jurisdictional public health authorities), you may choose, or be required to, wear a mask if physical distance is difficult to maintain.”<sup>65</sup>

The health.gov.au website acknowledges that the WHO **encourages** the use of masks however notes that; At the present time, the widespread use of masks by healthy people in the community setting is not supported by high quality or direct scientific evidence and there are potential benefits and harms to consider.

### World Health Organisation’s Position

“Taking into account the available studies evaluating pre- and asymptomatic transmission, a growing compendium of **observational** evidence on the use of masks by the general public in several countries, individual values and preferences, as well as the difficulty of physical distancing in many contexts, WHO has updated its guidance to advise that to prevent COVID-19 transmission effectively in areas of community transmission, governments should **encourage** the general public to wear masks in specific situations and settings as part of a comprehensive approach to suppress SARS-CoV-2 transmission.”

The health.gov.au website reinforces that, WHO recommends a risk-based approach to use of medical vs non-medical masks in the community based on purpose of mask use, risk of exposure to COVID-19, vulnerability of population, setting in which population lives, feasibility of use (cost, availability) as outlined in extract shown in the Table below, reproduced from WHO advice on the use of masks in the context of Covid-19, 2020.

Manufactured non-medical grade face coverings including homemade (sewn) coverings (these coverings are not regulated by TGA)	Fabric face coverings; multi-layered cloth coverings made from fabric & reusable woven shopping bags	Limited evidence for protection	Wearer protection possible/Possible source control (note the cleaning advice at the top of this fact sheet)	Public use in community transmission where physical distancing cannot be achieved, <b><u>not for use with no community transmission</u></b>
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<sup>65</sup> The government health website at <https://www.health.gov.au/resources/publications/face-masks-how-they-protect-you> sourced on 11/10/2020.

The www.health.gov.au website also shows that the infection control expert group (ICEG) have developed a fact sheet<sup>66</sup>, where they state that ***“where there is absent or localised Covid-19 transmission, the general use of masks in the community is not recommended. There is limited, indirect, experimental evidence that certain types of cloth mask can reduce transmission of respiratory droplets, but they are significantly less efficient than surgical. Prolonged use can lead to self-contamination and infection (of the wearer). They are increasingly less effective as they become increasingly damp”.***

The health.gov.au website state that there are no randomised controlled studies of cloth masks in community or household settings.

### **Messaging**

The Queensland Premier stated that schools were shut to send a message. Dr Young told Ms Palaszczuk to shut down schools on March 26. She says while evidence showed schools were not a high-risk environment for the spread of the virus, closing them down would help people understand the gravity of the situation. *"If you go out to the community and say, 'this is so bad, we can't even have schools, all schools have got to be closed', you are really getting to people,"* Dr Young says. ***"So sometimes it's more than just the science and the health, it's about the messaging."*** *So my advice to the Premier was, 'we've got to do it. It'll be awful, but we've got to do it'.* "But that was critical, decreasing the number of kids who go to school".<sup>67</sup>

It is prudent to ask, at what health cost to our students, is the education system supporting the mask directive in classrooms? This must surely be based on sound evidence and not just messaging. A risk analysis is critical before any decisions are made to mandate masks in classrooms.

### **State Government v Educational Policy and Best Interests of Students**

The Andrews State Government does not appear to have facilitated optimal educational or health policy, in the best interests of Victorian students, in consideration of accepted peer reviewed evidence. The science is certainly not settled on whether masks are beneficial in reducing transmission.

Verifiable, peer reviewed science has been inadequately reviewed by the Andrews government in decision making to support various other policies, school closures, in the absence of risk. For

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<sup>66</sup> Infection control expert group (ICEG), sourced at; <https://www.health.gov.au/funnelback/search?query=are%20cloth%20face%20masks>

<sup>67</sup> Jeannette Young: *Who is the woman leading the fight against Covid-19?* Brisbane Times as reported by Lydia Lynch sourced at: <https://www.brisbanetimes.com.au/national/queensland/jeannette-young-who-is-the-woman-leading-queensland-s-fight-against-covid-19-20200406-p54hmd.html>

example, the decision to close schools does not concur with *The Great Barrington Declaration*<sup>68</sup>. The Education Department is obligated to facilitate policy which is lawful, based on sound information, and in the best interests of Victorian students. This must not digress due to political paradigms or messaging. Over 6,301 **Medical doctors** and 92,466 public members have signed agreement to this statement. The infectious disease epidemiologists and public health scientists involved declared;

- Many people hold grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach called Focused Protection.
- Current lockdown policies are producing devastating effects on short and long-term public health, the working class and younger members of society carrying the heaviest burden.
- Keeping students out of school is a grave injustice.
- Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.
- For children, COVID-19 is less dangerous than many other threats to health, including influenza.
- As immunity builds in the population, the risk of infection to all – including the vulnerable – falls.
- We know that all populations will eventually reach herd immunity – i.e., the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.
- The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.
- Those who are not vulnerable should immediately be allowed to resume life as normal.
- Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold.
- Schools and universities should be open for in-person teaching.
- Extracurricular activities such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity”.

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<sup>68</sup> *The Great Barrington Declaration*. Sourced at <https://gbdeclaration.org> on 10/10/2020. The full declaration is found at Appendix 2 of this document.



## **Sensible measures**

Have the Education Department assessed if available measures such as physical distancing where possible, instructing symptomatic or exposed children to stay home, adequate supply of soap and hand dryers in toilets, and general cleanliness around the school is enough too reasonably and proportionately respond to Covid-19? One suggestion is to teach some classes outside, weather permitting, and have smaller class sizes to facilitate distance. After all, the Victorian government (who has cost our business economy \$400M a day), may be approached to fund portable classrooms. In the Victorian CHO's 2001 research, he references filtered air as follows; "*Australian Standards require operating theatres to have at least 20 air changes per hour, reducing the bacterial count by one twentieth every three minutes. With this degree of filtration, the chance of airborne transmission between staff and patient is minimal*". Our CHO then detailed air filtration systems such as *Laminar* air flow using HEPA filters, which can remove particles less than .5 micron with 99.7% efficiency, or using *Steriflow* systems which could be focused on the teacher, both options are much more efficient and less harmful than a mask mandate. Have these less invasive and more reasonable child focused ideas even been considered?

## **Community Consultation**

Community collaboration surrounding the cost-benefits of mandated masks is pertinent. Concerns from the public can be found at this petition organised by Liberal Federal Member Mr Craig Kelly at this link; <https://thevoiceoftheaustralianpeople.com/nomorefacemasks/>.

Please detail what community consultation and review has been facilitated, to inform the decision to mandate masks in schools for children over 12 years of age.

## **Unreasonableness**

There is no possible health reason for the direction of mandatory masks while walking alone, in family groups or small groups such as school classroom groups outdoors. Children present negligible transmission of disease towards each other, **it is more sensible to protect the vulnerable, such as older teachers, with a plastic shield. If any child chooses to learn behind a shield, then that should be a voluntary choice also.** A person/people, who are walking and are not in close contact with other people pose no health risk to anyone including themselves. Wearing masks in the future months of summer will be extremely unpleasant, will increase the health concerns and the symptoms detailed throughout this document. The current response is totally impractical, unreasonable and disproportionate to the risk.

## **Unnecessary Financial Cost**

Many Victorians are unable to afford the cost of masks and are therefore not using them as single use disposable masks, changing them every 2 hours as recommended. In a climate of high unemployment, this adds a financial strain on families. If you change your mask every 2 hours as recommended, it would be in excess of \$25 per week in the cost of masks, or \$100 for a family of 4. People are dangerously re-using masks because they simply can't afford to purchase them. This cost, if worn by the Education department could be better spent on more efficient air filtration systems, such as those detailed in the studies discussed further in this document.

## **PCR-RT TESTING**

For completion, in relation to masking due to alleged case numbers in the community, concerns surrounding PCR driven policy require further consideration by the Education Department. If the tests are unacceptably inaccurate, it follows that policy derived from these tests will be flawed. Englebrecht and Demeter, (2020)<sup>69</sup>, found them scientifically meaningless.

Premier Daniel Andrews appears to have cherry picked his preferred specialists in his response, backed by a multimillion-dollar advertising campaign, to coerce the public to participate in testing. The inventor of the PCR test has stated that this test is not capable of diagnosing an infectious disease<sup>70</sup>. Biochemist, Kary B. Mullis invented the PCR process in the 80's and got the Noble Prize in chemistry for it a decade later. He discussed that the interpretation of the PCR is the problem<sup>71</sup>. He stated the PCR process allows you; *"to get a miniscule amount of anything and make it*

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<sup>69</sup>Englebrecht and Demeter, (2020). Though the whole world relies on RT-PCR to "diagnose" Sars-Cov-2 infection, the science is clear: they are not fit for purpose, sourced at <https://bpa-pathology.com/covid19-pcr-tests-are-scientifically-meaningless/> on 10/11/2020

<sup>70</sup> Inventor Mullis can be heard discussing the PCR tests at 3 minutes sourced at <https://www.youtube.com/watch?v=llxhDj18SAM> on 03/11/2020

<sup>71</sup> Sourced at <https://www.youtube.com/watch?feature=share&v=CpWwQcQwr3o&app=desktop>

*measurable. If you do it well you can find almost everything in anything...If you can amplify a single molecule to something you can measure, which PCR can do, there's very few molecules that you don't have as one single one of them...PCR is a process to make a whole lot of something out of something. It doesn't tell you that you're sick or if the thing you end up with really was going to hurt you".*

This does not have the capacity and should not be used as a diagnostic test to determine false or positive test results. It can't determine the difference between virus particles and an actual live virus. Positive tests do not equal cases. The PCR test RT-PCR identifies viral RNA and cannot determine whether infectious virus is present, it can't be used to diagnose infective disease. Lower PCR cycle values indicate higher viral load and imply higher infectiousness <sup>72</sup>.

Dr Thomas Cowan<sup>73</sup> explained that Kary Mullis specifically stated that you can't use this test to prove infectious aetiology or diagnose infectious disease. Where we are trying to demonstrate causation through a surrogate test, science must be able to compare with a **gold standard**, (absolute identification), through using isolation purification, replicated copies, which are reliable 100% of the time. He details this further; *They take a sequence unique to the new strain of covid-19, when it has amplified through 36 cycles you will start to see a colour change. At 40 cycles there are a lot more positives, at 60 times it will be positive with everybody, 100% of the people. Therefore, all people have this sequence of RNA somewhere in their genome, all you need to do is amplify it enough.* He extrapolated; *"We don't know how many false positives or false negatives there are, as there is nothing to compare it to. If you test 30 million people and have, for example, a 1% false positive then 300,000 will test positive to support that there is an epidemic. To demonstrate the epidemic got better all you need to do is lower the cycles to 35. All countries have different amplification cycles".*

Researcher Morgan Jonas has recently released a meta-analysis of current verifiable research, supporting that **PCR testing does not provide an appropriate, accurate or ethical response with identification of Covid-19**<sup>74</sup>.

The RT-PCR or viral load test, is the driver to justify restrictions and directives imposed on all Victorians, inclusive of the school community. This is concerning and requires immediate scrutiny.

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<sup>72</sup> Furukawa NW, Brooks JT, Sobel J. (2020). *Evidence supporting transmission of severe acute respiratory syndrome coronavirus 2 while presymptomatic or asymptomatic.* Emerg Infect Dis. 2020 Jul [date cited]. <https://doi.org/10.3201/eid2607.201595>, DOI: 10.3201/eid2607.201595, Original Publication Date: May 04, 2020, [Table of Contents – Volume 26, Number 7—July 2020](#)

<sup>73</sup> Sourced at <https://www.youtube.com/watch?feature=share&v=CpWwQcQwr3o&app=desktop>

<sup>74</sup> The Peoples Project, Interview with Morgan C Jonas, October 6<sup>th</sup> 2020, sourced at <https://fb.watch/1u7cSIRd7s/> on 1/11/2020

## **Conclusion**

I strongly state that the science is not conclusive enough to force the mandating of masks in schools, for the purpose of reducing transmission of Covid-19. Masks are overwhelmingly not useful in preventing disease transmission, outside specific transient high-risk circumstances by vulnerable individuals, as per the preliminary systemic review of Brainard, (2020)<sup>75</sup> who also concluded that; *“The evidence is not sufficiently strong to support widespread use of facemasks as a protective measure against COVID-19... Further high-quality trials are needed to assess when wearing a facemask in the community is most likely to be protective”*. There is an unacceptable risk of harm to Victorian students inclusive of the evidence detailed in this correspondence.

Accordingly, I respectfully suggest that the Victorian Education Department withdraw its instruction to Victorian schools to enforce the wearing of masks for school children and teachers, pending a rigorous impartial and verifiable, evidence-based review, and comprehensive discussion with the CHO and Emergency Management Commissioner, so that they may direct, as is their duty, the Premier Andrews to act with verifiable evidence, integrity and impartiality.

Educational policy must not be influenced by messaging, propaganda, disingenuous political agenda or unsound, negligent and harmful directives. The mask mandate increasingly appears to be contrary to scientific evidence and medical opinion, is disproportionate to the risk, unreasonable, absent of human rights considerations and the best interests of children, which (as the curfew directive also indicated), may be also unlawful without legal basis.

I further suggest that a productive step to uphold the integrity of the education system, would be to create a state-wide school community survey to assess views and invite collaboration. A cost-benefit review, involving the entirety of the school community, and independent medical and scientific research, and legal opinion is critically required.

Please respectfully repeal the mask mandate in schools, until these unacceptable risks of harm and grave human rights breaches presented throughout this document, have been resolved.

Kind regards

**Concerned Parent**

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<sup>75</sup> Brainard. J., Jones.N., Lake/I., Hooper.L., Hunter, P, (2020), *Facemasks and similar barriers to prevent respiratory illness such as COVID-19: A rapid systematic review* medRxiv 2020.04.01.20049528; doi: <https://doi.org/10.1101/2020.04.01.20049528>

## **Appendix 1 - A 2020 Meta-Analysis**

### ***Masks are neither effective or safe a summary of the science; Are masks effective at preventing transmission of respiratory pathogens?***

Colleen Huber, NMD via Primary Doctor July 14, 2020, <https://www.technocracy.news/masks-are-neither-effective-nor-safe-a-summary-of-the-science/>, Technocracy News and Trends, sourced online on 10/10/2020.

A review of the peer-reviewed medical literature examines impacts on human health, both immunological, as well as physiological. The purpose of this paper is to examine data regarding the effectiveness of facemasks, as well as safety data.

In this meta-analysis, face masks were found to have no detectable effect against transmission of viral infections. (1) It found: “Compared to no masks, there was no reduction of influenza-like illness cases or influenza for masks in the general population, nor in healthcare workers.”

This 2020 meta-analysis found that evidence from randomized controlled trials of face masks did not support a substantial effect on transmission of laboratory-confirmed influenza, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility. (2)

Another recent review found that masks had no effect specifically against Covid-19, although facemask use seemed linked to, in 3 of 31 studies, “very slightly reduced” odds of developing influenza-like illness. (3)

This 2019 study of 2862 participants showed that both N95 respirators and surgical masks “resulted in no significant difference in the incidence of laboratory confirmed influenza.” (4)

This 2016 meta-analysis found that both randomized controlled trials and observational studies of N95 respirators and surgical masks used by healthcare workers did not show benefit against transmission of acute respiratory infections. It was also found that acute respiratory infection transmission “may have occurred via contamination of provided respiratory protective equipment during storage and reuse of masks and respirators throughout the workday.” (5)

A 2011 meta-analysis of 17 studies regarding masks and effect on transmission of influenza found that “none of the studies established a conclusive relationship between mask/respirator use and protection against influenza infection.” (6) However, authors speculated that effectiveness of masks may be linked to early, consistent and correct usage.

Face mask use was likewise found to be not protective against the common cold, compared to controls without face masks among healthcare workers. (7)

### **Airflow around masks**

Masks have been assumed to be effective in obstructing forward travel of viral particles. Considering those positioned next to or behind a mask wearer, there have been farther transmission of virus-laden fluid particles from masked individuals than from unmasked individuals, by means of “several leakage jets, including intense backward and downwards jets that may present major hazards,” and a “potentially dangerous leakage jet of up to several meters.” (8) All masks were thought to reduce

forward airflow by 90% or more over wearing no mask. However, Schlieren imaging showed that both surgical masks and cloth masks had farther brow jets (unfiltered upward airflow past eyebrows) than not wearing any mask at all, 182 mm and 203 mm respectively, vs none discernible with no mask. Backward unfiltered airflow was found to be strong with all masks compared to not masking. For both N95 and surgical masks, it was found that expelled particles from 0.03 to 1 micron were deflected around the edges of each mask, and that there was measurable penetration of particles through the filter of each mask. (9)

### **Penetration through masks**

A study of 44 mask brands found mean 35.6% penetration (+ 34.7%). Most medical masks had over 20% penetration, while “general masks and handkerchiefs had no protective function in terms of the aerosol filtration efficiency.” The study found that “Medical masks, general masks, and handkerchiefs were found to provide little protection against respiratory aerosols.” (10)

It may be helpful to remember that an aerosol is a colloidal suspension of liquid or solid particles in a gas. In respiration, the relevant aerosol is the suspension of bacterial or viral particles in inhaled or exhaled breath.

In another study, penetration of cloth masks by particles was almost 97% and medical masks 44%. (11)

### **N95 respirators**

Honeywell is a manufacturer of N95 respirators. These are made with a 0.3-micron filter. (12) N95 respirators are so named, because 95% of particles having a diameter of 0.3 microns are filtered by the mask forward of the wearer, by use of an electrostatic mechanism. Coronaviruses are approximately 0.125 microns in diameter.

This meta-analysis found that N95 respirators did not provide superior protection to facemasks against viral infections or influenza-like infections. (13) This study did find superior protection by N95 respirators when they were fit-tested compared to surgical masks. (14)

This study found that 624 out of 714 people wearing N95 masks left visible gaps when putting on their own masks. (15)

### **Surgical masks**

This study found that surgical masks offered no protection at all against influenza. (16) Another study found that surgical masks had about 85% penetration ratio of aerosolized inactivated influenza particles and about 90% of *Staphylococcus aureus* bacteria, although *S aureus* particles were about 6x the diameter of influenza particles. (17)

Use of masks in surgery was found to slightly increase incidence of infection over not masking in a study of 3,088 surgeries. (18) The surgeons' masks were found to give no protective effect to the patients.

Other studies found no difference in wound infection rates with and without surgical masks. (19) (20)

This study found that “there is a lack of substantial evidence to support claims that facemasks protect either patient or surgeon from infectious contamination.” (21)

This study found that medical masks have a wide range of filtration efficiency, with most showing a 30% to 50% efficiency. (22)

Specifically, are surgical masks effective in stopping human transmission of coronaviruses? Both experimental and control groups, masked and unmasked respectively, were found to “not shed detectable virus in respiratory droplets or aerosols.” (23) In that study, they “did not confirm the infectivity of coronavirus” as found in exhaled breath.

A study of aerosol penetration showed that two of the five surgical masks studied had 51% to 89% penetration of polydisperse aerosols. (24)

In another study, that observed subjects while coughing, “neither surgical nor cotton masks effectively filtered SARS-CoV-2 during coughs by infected patients.” And more viral particles were found on the outside than on the inside of masks tested. (25)

### **Cloth masks**

Cloth masks were found to have low efficiency for blocking particles of 0.3 microns and smaller. Aerosol penetration through the various cloth masks examined in this study were between 74 and 90%. Likewise, the filtration efficiency of fabric materials was 3% to 33%. (26)

Healthcare workers wearing cloth masks were found to have 13 times the risk of influenza-like illness than those wearing medical masks. (27)

This 1920 analysis of cloth mask use during the 1918 pandemic examines the failure of masks to impede or stop flu transmission at that time, and concluded that the number of layers of fabric required to prevent pathogen penetration would have required a suffocating number of layers, and could not be used for that reason, as well as the problem of leakage vents around the edges of cloth masks. (28)

### **Masks against Covid-19**

The New England Journal of Medicine editorial on the topic of mask use versus Covid-19 assesses the matter as follows:

*“We know that wearing a mask outside health care facilities offers little, if any, protection from infection. Public health authorities define a significant exposure to Covid-19 as face-to-face contact within 6 feet with a patient with symptomatic Covid-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 20 minutes). The chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic.”* (29)

### **Are masks safe during walking or other exercise?**

Surgical mask wearers had significantly increased dyspnoea after a 6-minute **walk** than non-mask wearers. (30)

Researchers are concerned about the possible burden of facemasks during physical activity on pulmonary, circulatory and immune systems, due to oxygen reduction and air trapping reducing substantial carbon dioxide exchange. As a result of hypercapnia, there may be cardiac overload, renal overload, and a shift to metabolic acidosis. (31)

### **Risks of N95 respirators**

Pregnant healthcare workers were found to have a loss in volume of oxygen consumption by 13.8% compared to controls when wearing N95 respirators. 17.7% less carbon dioxide was exhaled. (32) Patients with end-stage renal disease were studied during use of N95 respirators. Their partial pressure of oxygen (PaO<sub>2</sub>) decreased significantly compared to controls and increased respiratory adverse effects. (33) 19% of the patients developed various degrees of hypoxemia while wearing the masks.

Healthcare workers' N95 respirators were measured by personal bioaerosol samplers to harbor influenza virus. (34) And 25% of healthcare workers' face piece respirators were found to contain influenza in an emergency department during the 2015 flu season. (35)

### **Risks of surgical masks**

Healthcare workers' surgical masks were also measured by personal bio aerosol samplers to harbour for influenza virus. (36)

Various respiratory pathogens were found on the outer surface of used medical masks, which could result in self-contamination. The risk was found to be higher with longer duration of mask use. (37) Surgical masks were also found to be a repository of bacterial contamination. The source of the bacteria was determined to be the body surface of the surgeons, rather than the operating room environment. (38) Given that surgeons are gowned from head to foot for surgery, this finding should be especially concerning for laypeople who wear masks. Without the protective garb of surgeons, laypeople generally have even more exposed body surface to serve as a source for bacteria to collect on their masks.

### **Risks of cloth masks**

Healthcare workers wearing cloth masks had significantly higher rates of influenza-like illness after four weeks of continuous on-the-job use, when compared to controls. (39)

The increased rate of infection in mask-wearers may be due to a weakening of immune function during mask use. Surgeons have been found to have lower oxygen saturation after surgeries even as short as 30 minutes. (40) Low oxygen induces hypoxia-inducible factor 1 alpha (HIF-1). (41) This in turn down-regulates CD4+ T-cells. CD4+ T-cells, in turn, are necessary for viral immunity. (42)

### **Weighing risks versus benefits of mask use**

Homemade and store-bought cloth masks and surgical masks or N95 masks are being used by the public especially when entering stores and other publicly accessible buildings. The use of face masks, whether cloth, surgical or N95, creates a poor obstacle to aerosolized pathogens as we can see from the meta-analyses and other studies in this paper, allowing both transmission of aerosolized pathogens to others in various directions, as well as self-contamination.

It must also be considered that masks impede the necessary volume of air intake required for adequate oxygen exchange, which results in observed physiological effects that may be undesirable. Even 6-minute walks, let alone more strenuous activity, resulted in dyspnoea. The volume of



unobstructed oxygen in a typical breath is about 100 ml, used for normal physiological processes. 100 ml O<sub>2</sub> greatly exceeds the volume of a pathogen required for transmission. The foregoing data show that masks serve more as instruments of obstruction of normal breathing, rather than as effective barriers to pathogens. Therefore, masks should not be used by the general public, either by adults or children, and their limitations as prophylaxis against pathogens should also be considered in medical settings.

### Conclusion

By making mask-wearing recommendations and policies for the general public, or by expressly condoning the practice, **governments have both ignored the scientific evidence and done the opposite of following the precautionary principle.**

In an absence of knowledge, governments should not make policies that have a hypothetical potential to cause harm. **The government has an onus barrier before it instigates a broad social-engineering intervention or allows corporations to exploit fear-based sentiments.**

Furthermore, individuals should know that **there is no known benefit arising from wearing a mask in a viral respiratory illness epidemic**, and that scientific studies have shown that any benefit must be residually small, compared to other and determinative factors.

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## **Appendix 2 - 'The Great Barrington Declaration'**

Could **6,301 medical doctors** and 92,466 public members be wrong?

“As infectious disease epidemiologists and public health scientists we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection”.

Coming from both the left and right, and around the world, we have devoted our careers to protecting people. Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. **Keeping students out of school is a grave injustice.**

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. **Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.**

As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e., the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

**The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.**

**Adopting measures to protect the vulnerable should be the central aim of public health responses to COVID-19.** By way of example, nursing homes should use staff with acquired immunity and perform frequent saliva testing of other staff and all visitors. Staff rotation should be minimized. Retired people living at home should have groceries and other essentials delivered to their home. When possible, they should meet family members outside rather than inside. A comprehensive and detailed list of measures, including approaches to multi-generational households, can be implemented, and is well within the scope and capability of public health professionals.

**Those who are not vulnerable should immediately be allowed to resume life as normal. Simple hygiene measures, such as hand washing and staying home when sick should be practiced by everyone to reduce the herd immunity threshold.** Schools and universities should be open for in-person teaching. Extracurricular activities, such as sports, should be resumed. Young low-risk adults should work normally, rather than from home. Restaurants and other businesses should open. Arts, music, sport and other cultural activities should resume. People who are more at risk may participate if they wish, while society as a whole enjoys the protection conferred upon the vulnerable by those who have built up herd immunity”.

Sourced at <https://gbdeclaration.org> on 10/10/2020

## **Appendix 3 - Compliance with Legislation and Human Rights Considerations**

### **Legislative Authority for Mask Mandate?**

The current response to inquiries surrounding the mask mandate appears to be following the Chief Health Officer's directives as per the State Public Health and Wellbeing Act, (2008)<sup>76</sup>. This Act should be read as a whole, with understanding of how the various sections interact. It is clear in section 111 and 112, that the least restrictive measure must be chosen, with minimal restrictions on the rights of the individual that is necessary.

The Federal Biosecurity Act, (2015),<sup>77</sup> also requires necessity to combat the risk and can only be authorised by the Commonwealth Chief Medical Officer or Biosecurity Officer in relation to a person who may have a listed disease, including Covid-19. This demonstrates that even the Federal Act is subject to a reasonable belief by an appropriately designated person, that the individual affected by the measure poses some element of risk of having the disease. These Acts do not have the authority to be arbitrarily applied to healthy people that do not pose a risk.

I strongly state that as a risk assessment of each individual Victorian student, as required in the Federal legislation, has not been conducted to permit the required reasonable belief that each individual child poses a risk. If it had been, Sec 478,(3a-d), could not be adhered to anyway, in relation to a position of reasonable necessity to order a mandated mask directive, as the science simply does not support the argument that masks reduce disease transmission.

In any event, Sec 478, (5), places limits on interference with State and Territory bodies and officials, unless the direction is in accordance with an agreement between the Commonwealth and the State, Territory or body. The Andrews government has strayed far from the intergovernmental agreement, which also did not explicitly agree to a mask mandate in Victorian secondary schools. Therefore, the State does not have authority under the provisions of either the State or Federal Act, to demand that the Education Department support enforcement of the mask mandate as a health measure. This permits the Department to make their own evidence-based decisions.

As Section 198,(9), implicitly provides that a declaration of a State of Emergency **does not derogate from or limit any provisions** in relation to the declaration of an emergency under any other Act, it can be demonstrated that the authority to invoke a mask mandate even under a State of Emergency is not apparent or likely to be lawful.

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<sup>76</sup> Public Health and Wellbeing Act, (2008), (sec 111), [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/phawa2008222/s111.html](http://classic.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s111.html)

<sup>77</sup> Biosecurity Act, (2015), section 478(5), sourced at [http://classic.austlii.edu.au/au/legis/cth/consol\\_act/ba2015156/s478.html](http://classic.austlii.edu.au/au/legis/cth/consol_act/ba2015156/s478.html) on 22/10/2020

Therefore if the mask mandate is not authorised for health reasons, under the Emergency Act, and is enforced under the broader State of Disaster powers, it can reasonably be purported that the mask mandate is not invoked for the purposes of health, but instead for control.

The Minister can only exercise powers under a State of Disaster if they believe compliance by a government agency with the provisions of an Act or instrument that prescribes the agency's duties or responsibilities, would inhibit its response to the disaster. Where the State Government has not responded to a disaster lawfully, through wilful ignorance of human rights, the due process required (as discussed above), in the State Public Health and Wellbeing Act, (2008), and Federal Biosecurity Act, (2015), and does not comply with Articles in the ICCPR<sup>78</sup>, the Education Department is certainly under no obligation to become complicit in stated unlawful response.

*"If States purport to invoke the right to derogate from the Covenant during, for instance, a natural catastrophe, a mass demonstration including instances of violence, or a major industrial accident, they must be able to justify not only that such a situation constitutes a threat to the life of the nation, but also that all their measures derogating from the Covenant are strictly required by the exigencies of the situation"*<sup>79</sup>.

I respectfully request clarification of the Education Department's position surrounding the legislative source of authority relied upon to enforce the mask mandate. I further request that the Department scrutinise stated legislation and refuse to facilitate what are very likely to be unlawful measures, devoid of legislative authority, on students.

The State Public Health and Wellbeing Act, **Sec 198 (2)**, (2008), permits Minister Andrews to revoke his directive, after consultation with the Emergency Management Commissioner, (EMC), as per Emergency Management Act, (2013)<sup>80</sup>. It may be necessary for the Education Department to approach the Chief Health Officer and EMC, to facilitate review, as it appears the Minister has failed to collaborate effectively even within his own party, as reported by his former departmental economist Sanjeev Sabhlok<sup>81</sup>.

Numerous State Government leaders are under current investigation through inquiry, and various Supreme and High Court Actions for negligence, acting disproportionately unreasonably and unlawfully in their response to the risk, inclusive of workplace breaches surrounding manslaughter.

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<sup>78</sup>International Covenant on Civil and Political Rights, (ICCPR), sourced at <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx> on 23/10/2020

<sup>79</sup> General Comment 29, Art. 4 (ICCPR) (States of Emergency)  
Human Rights Committee, General Comment 29, States of Emergency (article 4),  
U.N. Doc. CCPR/C/21/Rev.1/Add.11 (2001) sourced at <http://aldeilis.net/english/general-comment-29-art-4-iccpr-states-of-emergency/> on 23/10/2020

<sup>80</sup> Emergency Management Act, (2013), sourced online at [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/ema2013190/](http://classic.austlii.edu.au/au/legis/vic/consol_act/ema2013190/)

<sup>81</sup> Mr Sanjeev Sabhlok resigned from his position as economist from the Andrews government in protest due to lack of collaboration, lack of risk analysis as mentioned in his interview on sky news <https://www.skynews.com.au/details/6191658847001> on 17/09/2020, and further discussed in depth with interviewer Matt Lawson in August 2010 via a skype interview.



I respectfully request that the Education Department distance itself from unsound, potentially harmful directives, and potentially criminal State actions that have already cost 768 deaths, and 18,418, between May and the end of September, 2020, due to decisions made during the hotel quarantine disaster.<sup>82</sup>

It is critical the Department independently consider the interests of our students and teachers, and rely on verifiable science, as opposed to political propaganda, to manage health issues. The *Coates* Public inquiry has demonstrated the absolute necessity, that decisions surrounding education and the health of our school community, must be challenged, qualified, verified, and made with integrity, appropriate expertise, accountability and oversight.

It is highly inappropriate to permit critical decisions surrounding public health by politicians, that some may say, have such *poor memory recall and integrity*. The possibility of the compromised status of officials is an unacceptable risk. This could present a very foreseeable and catastrophic liability surrounding nonfeasance, to the detriment of the school community. Please assert required authority, to facilitate an urgent withdrawal of the mask mandate.

Included for your consideration below, are relevant legislative requirements that should be a consideration in any decision-making surrounding mask mandates, as follows:

#### **The Federal Biosecurity Act, (2015)<sup>83</sup>**

Before giving a direction under sec 478, (1), of the Federal Biosecurity Act, the Health Minister must be satisfied of all of the following:

- a) that the direction is likely to be effective in, or to contribute to, achieving the purpose for which it is to be given;
- b) that the direction is appropriate and adapted to achieve the purpose for which it is to be given;
- (c) that the direction is no more restrictive or intrusive than is required in the circumstances;
- (d) if the direction is to apply during a period-that the period is only as long as is necessary.

#### **Section 112<sup>84</sup> of the Victorian Public Health and Wellbeing Act, (2008),**

Section 112 clearly states;

##### **Least restrictive measure to be chosen**

*“If in giving effect to this Division alternative measures are available which are equally effective in minimising the risk that a person poses to public health, the measure which is the **least restrictive** of the rights of the person should be chosen”.*

It is critical that the wording of Sec 112 is understood. Person means an individual, not an entire group, class or school.

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<sup>82</sup> *Victoria hotel quarantine failures ‘responsible’ for second wave and 768 deaths*, inquiry told, by Josh Taylor, The Guardian, published online on 28/09/2020

<sup>83</sup> Federal Biosecurity Act, (2015), sec 478, (1) and (3a-d). Sourced online at [http://classic.austlii.edu.au/au/legis/cth/consol\\_act/ba2015156/s478.html](http://classic.austlii.edu.au/au/legis/cth/consol_act/ba2015156/s478.html) on 23/10/2020

<sup>84</sup> Public Health and Wellbeing Act, (2008), (sec 112), [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/phawa2008222/s112.html](http://classic.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s112.html)

## **Section 111 of the Public Health and Wellbeing Act, (2008)<sup>85</sup>**

This applies to the management and control of infectious diseases it appears 111,(a) has been inadequately reviewed by decision makers, as this document will support that a mask mandate in schools is not applying a **minimum restriction** necessary, on the rights of any person., as follows;

### **PUBLIC HEALTH AND WELLBEING ACT 2008 - SECT 111**

#### **Principles**

The following principles apply to the management and control of infectious diseases:

- (a) the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person;
- (b) a person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease;
- (c) a person who has, or suspects that they may have, an infectious disease should:
  - (i) ascertain whether he or she has an infectious disease and what precautions he or she should take to prevent any other person from contracting the infectious disease; and;
  - (ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the infectious disease;
- (d) a person who is at risk of contracting, has, or suspects he or she may have, an infectious disease is entitled:
  - (i) to receive information about the infectious disease and any appropriate available treatment;
  - (ii) to have access to any appropriate available treatment.

#### **Risk Assessment Analysis**

Accordingly, as the Chief Health Officer has not specifically mentioned a risk analysis for Education in documents produced to the *Coates* inquiry<sup>86</sup>, it must be asked;

#### **What risk analysis of health and human rights considerations, if any, provides the foundation for the mask mandate in schools?**

Economist, Sanjeev Sabhlok, has authored over 17 articles on the pandemic response, resigned in protest from his position as economist for the Andrews government, due to the lack of risk assessment and gravely inadequate response to the disease. He strongly stated that, despite his own team specialising in regulation, the precautionary principle, policy of minimal regulation for business, they were ignored. His discussions with global health leaders and understanding that the Neil Ferguson predictive model was abominably inaccurate, and that risk was minimal, were ignored by the Chief Health Officer. The Andrews government attempted to censor his further concerns surrounding abuse of power, (inclusive of police brutality).

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<sup>85</sup> Public Health and Wellbeing Act, (2008), (sec 111), [http://classic.austlii.edu.au/au/legis/vic/consol\\_act/phawa2008222/s111.html](http://classic.austlii.edu.au/au/legis/vic/consol_act/phawa2008222/s111.html)

<sup>86</sup> Covid-19 Hotel Quarantine Inquiry sourced online at <https://www.quarantineinquiry.vic.gov.au/> on 22/10/2020

Victorian students and the Education Department deserve better consultation and overall governance. It is critical that the Department facilitate communication with the CHO. This should be inclusive of critical questions such as why the cost/benefit effect of the State of Emergency on the Education system, was not specifically reviewed as per requirements of the Public Wellbeing and Health Act, Sec 198, (8A), (a), (2005).

The following legislative considerations and principles should also be factored into any risk analysis, in the best interests of the school community, and adherence to democratic principles. As follows;

### **Principles of Equity**<sup>87</sup>

Incidentally, part (d), (ii), of section 111 of the Public Health and Wellbeing Act, (2008), is also relevant in light of any proposed vaccine mandates, is law and must be respected. The entitlement, choice and consent, of 'appropriate available treatment' is clearly required and should under long held *Principles of Equity* otherwise known as *maxims of equity*<sup>88</sup>, surrounding transparency and *clean hands*, good conscience, etc, be based on verifiable cost benefit analysis for the individual it affects.

Equity includes in a wider sense, a breach of an obligation as acknowledged in equity. Equitable remedies arise where there is a "significant possibility of conflict"<sup>89</sup> such as the Victorian Government's mask mandate, (which this document will support is unacceptably harmful to students).

Equity includes abuse of power founded in fraudulent misrepresentation. It is relevant that one of the *Principles of Equity*, states that a statute must not be used as an instrument of fraud. The High Court Supports these Principles must be upheld in every Australian court.

The High Court of Australia has affirmed the vitality of traditional equitable doctrines, as supported by *Muschinski v Dodds* [1985] HCA 78, 160 CLR 583<sup>90</sup>.

In effect fairness, transparency and honesty must be upheld in decision making. It is therefore unlawful to follow directives that are not founded on these principles. The question surrounding liability, due to harm and nonfeasance, inflicted on children through the enforcement of unlawful directives is unacceptably grave.

*Thorne v Kennedy*<sup>91</sup> presented the High Court with a unique opportunity to clarify the doctrines of undue influence, duress and unconscionable dealing. Duress, undue influence and unconscionable conduct are all discussed in the reasoning of the High Court, however, importantly, with regards to unconscionable conduct, their Honours stated at [38]:

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<sup>87</sup> Lawble, Equity Law: An Introduction sourced at <https://www.lawble.co.uk/equity-law/> on 21/10/2020

<sup>88</sup> Maxims of Equity Explained sourced at <https://www.lawble.co.uk/equity-law/> on 21/10/2020

<sup>89</sup> General statements of basic equitable principles, sourced at [https://www.lawteacher.net/free-law-essays/equity-law/general-statements-of-basic-equitable-principles-equity-law-essay.php#\\_ftn14](https://www.lawteacher.net/free-law-essays/equity-law/general-statements-of-basic-equitable-principles-equity-law-essay.php#_ftn14) on 21/10/2020

<sup>90</sup> *Muschinski v Dodds* [1985] HCA 78, 160 CLR 58390.. <http://www6.austlii.edu.au/cgi-bin/viewdoc/au/cases/cth/HCA/1985/78.html>

<sup>91</sup> *Thorne V Kennedy, Kennedy v Thorne* [2016] FamCAFC 189

*“A conclusion of unconscionable conduct requires the innocent party to be subject to a special disadvantage “which seriously affects the ability of the innocent party to make a judgment as to [the innocent party’s] own best interests”. The other party must also unconscientiously take advantage of that special disadvantage. This has been variously described as requiring “victimisation”, “unconscientious conduct”, or “exploitation”. Before there can be a finding of unconscientious taking of advantage, it is also generally necessary that the other party knew or ought to have known of the existence and effect of the special disadvantage. [...]*

Accordingly, I hold concerns that the Education Department has been exploited through the unconscionable conduct of decisions made by the Andrews Government, which has in my view, seriously affected the ability of the Education Department to make judgements in the interests of the Department, primarily surrounding the best interests of student health and general operational procedures in educational delivery. The Education Department not only has a duty to protect its own objectives under ministerial order, but also a responsibility to uphold this for the wellbeing of students.

In my opinion, the mask directive for schools requires an immediate injunction, as it has infringed upon the Education Department’s overreaching responsibility to act in the best interests of its students. The Education Department is obliged to challenge unsound mask mandates and protect the best interests of its own system and its students.

## **Ministerial Order**

In August 2016 registered schools and those seeking registration with the [Victorian Registration and Qualifications Authority](#) (VRQA), became subject to the Child Safe Standards<sup>92</sup> to remain in compliance with [Ministerial Order No. 870 – Child Safe Standards – Managing the risk of child abuse in schools](#). Schools must comply with the prescribed standards:

1. Strategies to embed an organisational culture of child safety;
2. A child safe policy or statement of commitment to child safety;
3. A child safety code of conduct;
4. Screening, supervision, training and other human resources practices that reduce the risk of child abuse;
5. Procedures for responding to and reporting suspected child abuse;
6. Strategies to identify and reduce or remove risks of child abuse; and
7. Strategies to promote child participation and empowerment.

As the mask mandate significantly holds relevance to the mentioned standards it is urgent and critical that a risk analysis is conducted for each, as many members of the community perceive this mandate as child abuse. I anticipate your reply as soon as possible as this issue has potential to affect your registration status.

## **The Australian Constitution**

There is no higher law than our Constitution. It clearly states in Section 118 of the Constitution, recognition of laws of States; *Full faith and credit shall be given, throughout the Commonwealth to the laws, the public Acts and records, and the judicial proceedings of every State. The Principles of Equity cannot be ignored.*

The mask mandate is inflicted on Victorian children. It is clear that Section 117 of the Constitution, rights of residents of States; *A subject of the Queen, resident in any State, shall not be subject in any other State to any disability or discrimination which would not be equally applicable to him if he were a subject of the Queen resident in such other State.*

Therefore, the Education Department must immediately cease its mask mandate in Victorian schools, which is not equally applied to residents in other States.

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<sup>92</sup> Child Safe Standards sourced at <https://www.safeguardingservices.com.au/resources/ministerial-order-870/> on 27/11/2020

## International Covenant on Civil and Political Rights

### **Article 4**

In time of public emergency which threatens the life of the nation and the existence of which is officially proclaimed, the States Parties to the present Covenant may take measures derogating from their obligations under the present Covenant **to the extent strictly required by the exigencies of the situation**, provided that such measures are not inconsistent with their other obligations under international law and do not involve discrimination solely on the ground of race, colour, sex, language, religion or social origin.

2. No derogation from articles 6, 7, 8 (paragraphs 1 and 2), 11, 15, 16 and 18 may be made under this provision.

3. Any State Party to the present Covenant availing itself of the right of derogation shall immediately inform the other States Parties to the present Covenant, through the intermediary of the Secretary-General of the United Nations, of the provisions from which it has derogated and of the reasons by which it was actuated. A further communication shall be made, through the same intermediary, on the date on which it terminates such derogation.

### **Article 17 of the ICCPR**<sup>93</sup>,

This was ratified by Australia in 1980<sup>94</sup> as a further consideration and highlights the proportionality and necessity to the end sought. In this case the end sought is to apparently lower transmission of disease, specifically Covid-19. I will discuss further in this document that the mask mandate does not contribute in any significant way to the *end sought*, in fact verifiable peer reviewed science supports that this mandate is contrary to the *end sought*.

### **ICCPR Article 17[3]**

*“1. No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.*

*2. Everyone has the right to the protection of the law against such interference or attacks”.*

The United Nations Human Rights Committee (the HRC) supports that ‘reasonableness’ in this context means that; ***‘any interference with privacy must be proportional to the end sought and be necessary in the circumstances of any given case’***.

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<sup>93</sup> ICCPR, International Covenant on Civil and Political Rights, sourced at <https://www.ohchr.org/EN/ProfessionalInterest/Pages/CCPR.aspx> on 20/10/2020

<sup>94</sup> Implementing treaties into Australian law, Sourced at <https://legalanswers.sl.nsw.gov.au/human-rights-australia/implementing-treaties-australian-law> on 20/10/20

8. In its General Comment on article 17, the HRC states that the "*concept of arbitrariness is intended to guarantee that even interference provided for by law should be in accordance with the provisions, aims and objectives of the [Covenant] and should be reasonable in the particular circumstances*".

Based on this and the Committee's jurisprudence on the concept of "reasonableness", the State party interprets "reasonable" interferences with privacy as measures are **based on reasonable and objective criteria, in proportion to the purpose for which they are adopted.**

The Human Rights Commission can investigate violations of the ICCPR<sup>95</sup>.

#### **ICCPR, Article 41a**

If the Education Department considers that another State Party is not fulfilling its obligations under the present Covenant. Article 41a provides remedy.

*"Communications under this article may be received and considered only if submitted by a State Party which has made a declaration recognizing in regard to itself the competence of the Committee. No communication shall be received by the Committee if it concerns a State Party which has not made such a declaration. Communications received under this article shall be dealt with in accordance with the following procedure:*

*(a) If a State Party to the present Covenant considers that another State Party is not giving effect to the provisions of the present Covenant, it may, by written communication, bring the matter to the attention of that State Party. Within three months after the receipt of the communication the receiving State shall afford the State which sent the communication an explanation, or any other statement in writing clarifying the matter which should include, to the extent possible and pertinent, reference to domestic procedures and remedies taken, pending, or available in the matter;"*

#### **Human Rights Considerations**

An increasing number of legal professionals such as Dr Reiner Fuellmich, and Victorian human rights lawyer Serene Teffaha of Advocate Me, (who have both released many videos surrounding this online), have expressed concern in regards to potential crimes against humanity and unlawfulness of directives endorsed by the Andrews Government. I request that the Education Department consider these significant statements to maintain the integrity, purpose and function of the education system.

Under a State of Emergency, the ICCPR, Article 4 and human rights remain a consideration. The Charter of Human Rights and Responsibilities Act, 2006 supports that we must consider that a human right may only be subject to 'reasonable limits as can be demonstrably justified in a free and

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<sup>95</sup> 'ibid'

democratic society based on human dignity, equality and freedom' ([s 7\(2\)](#)). In considering whether a limit is reasonable and demonstrably justified, all relevant factors must be taken into account, including, but not limited to, five factors listed in [s 7\(2\)](#) of the Charter:

- the nature of the right;
- the importance of the purpose of the limitation;
- the nature and extent of the limitation;
- the relationship between the limitation and the purpose; and
- **any less restrictive means reasonably available** to achieve the purpose that the limitation seeks to achieve.

#### **Purpose and Proportionality Assessment of the Limits.**

##### **Relevant human rights in respect of the decision to issue the Directions**

Relevant human rights, which are discussed below:

- a. right to liberty ([s 21](#));
- b. humane treatment when deprived of liberty ([s 22](#));
- c. freedom of movement ([s 12](#));
- d. freedom of religion ([s 14](#)) and cultural rights ([s 19](#));
- e. freedom of peaceful assembly and association (s 16) and freedom of expression (s 15);
- f. right to equality ([s 8](#));
- g. rights to privacy, family and home ([s 13](#)); and
- h. protection of families and children ([s 17](#)).



## **CHARTER OF HUMAN RIGHTS AND RESPONSIBILITIES ACT 2006 - SECT 17 Protection of families and children**

- (1) Families are the fundamental group unit of society and are entitled to be protected by society and the State.
- (2) Every [child](#) has the right, without [discrimination](#), to such protection as is in his or her best interests and is needed by him or her by reason of being a [child](#).

The proper consideration you must give to these rights:

The Charter provides that a human right may only be subject to 'reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom' ([s 7\(2\)](#)). In considering whether a limit is reasonable and demonstrably justified, all relevant factors must be taken into account, including, but not limited to, five factors listed in [s 7\(2\)](#) of the Charter:

- a. the nature of the right;
- b. the importance of the purpose of the limitation;
- c. the nature and extent of the limitation;
- d. the relationship between the limitation and the purpose; and
- e. any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

The document then referred to a number of Charter rights including the rights to liberty, freedom of movement, freedom of religion and cultural rights, freedom of peaceful assembly and association and freedom of expression, the right to equality, the right to privacy, family and home, and protection of families and children.

## **Occupational Health and Safety Act 2004**

Prosecution of the Victorian Government is pending by small business Director Mr Ken Phillips and others due to the government abrogating their responsibility and duty to provide a safe workplace, surrounding hotel quarantine, regarding alleged failure of core administrative function and foreseeable negligence in their responsibilities to facilitate a safe workplace and mitigate risk.

To avoid similar issues, it is critical that the education system uses a common-sense response to Covid-19, which is sound and minimises risk. Mandated masks will likely cause predictable and clear unacceptable risk of harm to students. There is sufficient evidence to support that the enforcement of mandated masks presents unacceptably high risk to students. The Department has a responsibility to minimise risk to students.

The management of a system has a responsibility to provide safe systems at work or be in contravention of the OH &S Act, 2004. Worksafe authorities can investigate and prosecute contraventions, or after 6 months the DPP can be requested to prosecute by any public member under section 130. The contracting out of services does not absolve responsibility from providing a safe system of work.