

We disagree with claims that wearing a face mask is currently accepted as an appropriate control. The science is certainly not settled in this area. Please refer to King, (2020), referenced below<sup>1</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>2</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>3 4</sup>. Neil Ferguson’s modelling has been widely criticised as “The most devastating software mistake of all time<sup>5</sup>”. Rational perspective and insight are critical.

You may be aware, Bullard et al, (2020)<sup>6</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

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<sup>1</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>2</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>3</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>4</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=8UvFhFzAAC&feature=youtu.be>

<sup>5</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://analyticshindiamag.com/the-most-devastating-software-mistake-of-all-time-why-is-the-imperial-model-under-criticism/>

<sup>6</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>

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>7</sup>. Sutton and Skinner, (2001)<sup>8</sup>, cited the work of Leyland, (1993)<sup>9</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>10</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.

Macintyre et al., (2009)<sup>11</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

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<sup>7</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>8</sup> 'ibid'

<sup>9</sup> Leyland M, McCloy R., (1993), *Surgical Face Masks: Protection of self or patient?* Ann R College Surgeons England Vol.75:1

<sup>10</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, on behalf of the COVID-19 Systematic Urgent Review Group Effort (SURGE) study authors, 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>11</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. [\[PMC free article\]](https://pubmed.ncbi.nlm.nih.gov/18111111/) [\[PubMed\]](https://pubmed.ncbi.nlm.nih.gov/18111111/), available at <https://europepmc.org/article/PMC/2662657>

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>12</sup>.” In consideration of the significance of bacterial infections in pandemic mortality, raised by Lubarsch O. Die, (1918)<sup>13</sup>, McCuller, (2008)<sup>14</sup> and Fauci et al, (2008)<sup>15</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>16</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 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.

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<sup>12</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>13</sup> Lubarsch O. Die, (1918), anatomischen Befunde von 14 tödlich verlaufenen Fällen von Grippe. *Berl Klin Wchnschr*. Vol. 55:768–769.

<sup>14</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>15</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>16</sup> Huber, C., Borovoy., Crisler., (2020), "Masks, false safety and real dangers, Part 2: Microbial challenges from masks" sourced at [https://pdmj.org/Mask\\_Risks\\_Part2.pdf](https://pdmj.org/Mask_Risks_Part2.pdf)

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>17</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>18</sup>.

Rancourt’s whitepaper review<sup>19</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>20</sup>.

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

The Infection Control Expert Group (ICEG), <sup>21</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 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>22</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

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<sup>17</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>18</sup> C Huber. *Masks are neither effective nor safe.* Primary Doctor. Jul 6 2020. <https://www.primarydoctor.org/masks-not-effect>

<sup>19</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>20</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>21</sup> Infection control expert group sourced online at <https://www.health.gov.au/committees-and-groups/infection-control-expert-group-iceg>

<sup>22</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

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>23</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>24</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>25</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>26</sup>, stated that masks can cause weakened breathing and cause hypoxia. They state that it is known that hypoxia can cause irreversible damage to organs. Huber et al, (2020),<sup>27</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>28</sup> and hypercapnia<sup>29</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

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<sup>23</sup> 'ibid'

<sup>24</sup> Orr NMW. Is a mask necessary in the operating theatre? *Ann R Coll Surg Engl* 1981; 63:390-392.

<sup>25</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>26</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>, 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>27</sup> Huber, C., Borovoy, B., Crisler, M., (2020), *Masks, false safety and real dangers, part 3, hypoxia, hypercapnia and physiological effects*.

<sup>28</sup> Merriam-Webster dictionary, sourced online at 23/01/2021, Definition of *Hypoxia*; a deficiency of oxygen reaching the tissues of the body.

<sup>29</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.

respiratory stress<sup>30</sup> facilitating secondary bacterial disease<sup>31</sup>, impaired learning and memory<sup>32</sup>, social connectivity and empathy<sup>33</sup> and psychological injury<sup>34</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.

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<sup>30</sup> Person E, Lemerrier C, Royer A, Reychler 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>31</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>32</sup> Beckervordersandforth, R., (2017). *Mitochondrial Metabolism-Mediated Regulation of Adult Neurogenesis*. Brain Plast. Vol. 3, 73–87.

<sup>33</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, 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), 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>34</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