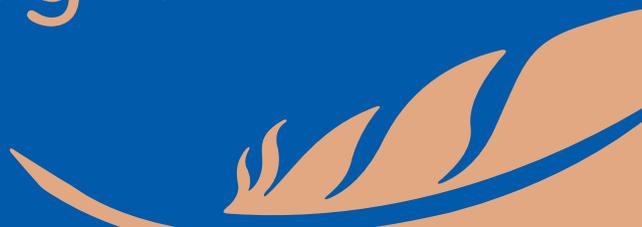


# Resource Pack for PARENTS



Support, Information & ACTION!  
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Safe  
Kids  
Informed  
Parents





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## About SKIP

Safe Kids Informed Parents (SKIP) is an association incorporated in Victoria to give a voice to concerned parents, family and community members, as well as carers about the impact on children of the Victorian Government's various pandemic measures, including lockdowns, school closures, masking and vaccination of children.

### Purpose of this document

This document has been compiled in good faith by SKIP to consolidate available information and resources relating to the Government's pandemic measures and their impacts on children. There is so much confusing and conflicting information out there, and censoring of information, that it is difficult for parents and carers to know where to start when it comes to deciding what is right for their child.

The purpose of this document is to give parents and carers a starting point for their own investigations and discussions with their children's schools and health professionals. It is not intended to be conclusive. Every effort has been made to ensure the accuracy and clarity of information contained herein but as information changes rapidly on these subjects, readers are encouraged to verify information and use their own discretion.

Most of the information in this document is provided in the form of quotations direct from the references sources. We have attempted to refer to source materials as much as possible and limit our own interpretation or commentary. However, where some explanation or commentary is included to provide context, these observations are the opinion of SKIP and not intended to constitute legal, medical or other advice. We are not qualified to provide advice in this respect. We welcome all feedback and discussion on any of the matters raised in this document, in the spirit of debating, researching, investigating, remaining open-minded and critically deciding what is in the best interests of our future generation.

Some quotes include a bold emphasis which remains the edit of the original author.

Large quotes will be indented.

# 1. Children are at low risk from Covid19, including variants

## 1.1 CHILDREN ARE AT LOW RISK FROM COVID19

An open letter<sup>1</sup> signed by 63 U.K. doctors states that “healthy children are at almost no risk from COVID-19, with risk of death as low as 1 in 2.5 million. No previously healthy child under the age of 15 died during the pandemic in the U.K. and admissions to hospital or intensive care are exceedingly rare with most children having no or very mild symptoms.”<sup>2</sup>

The letter highlights that **“we must not be the generation of adults that, through unnecessary haste and fear, risks the health of children...”** We conclude that it is irresponsible, unethical and indeed, unnecessary, to include children under 18 years in the national COVID-19 vaccine rollout. Clinical trials in children also pose huge ethical dilemmas, in light of the lack of potential benefit to trial participants and the unknown risks. The end of the current Phase 3 trials should be awaited as well as several years of safety data in adults, to rule out, or quantify, all potential adverse effects.”<sup>3</sup>

The April 2021 *Post-acute COVID-19 outcomes in children with mild and asymptomatic disease* study analysed the illness trajectory of 171 children in a dedicated COVID-19 follow-up clinic at the Royal Children’s Hospital in Melbourne. The study found:

“Most children had mild disease (100 [58%]) or were asymptomatic (61 [36%]), and (nine [5%]) children had moderate disease. The few hospital admissions (14 [8%] children) were generally brief and were for observation or fluid rehydration.”<sup>4</sup>

The September 2021 *COVID-19 Delta variant in schools and early childhood education and care services in NSW, Australia* report indicates that “most children diagnosed with COVID-19 during the current outbreak, including those who caught the infection in educational settings, experienced mild or no symptoms, with only 2% requiring hospitalisation.”<sup>5</sup>

The Medrxiv study<sup>6</sup> of December 2021, *Comparison of outcomes from COVID infection in paediatric and adult patients before and after the emergence of Omicron*, shows “First time SARS-CoV-2 infections occurring at a time when the Omicron variant was rapidly spreading were associated with significantly less severe outcomes than first-time infections when the Delta variant predominated.”<sup>7</sup>

The researchers report “In children under 5 years old, the overall risks of ED visits and hospitalization in the Emergent Omicron cohort were 3.89% and 0.96% respectively, significantly lower than 21.01% and 2.65% in the matched Delta cohort .... Similar trends were observed for other paediatric age groups (5-11, 12-17 years), adults (18-64 years) and older adults (≥ 65 years).”<sup>8</sup> Burgess, writing in *The Times*, notes

“The average age of those who have died from coronavirus in England and Wales since the start of the pandemic is 82.4 years old.”<sup>9</sup>

## 1.2 KEY STATISTICS

### Survival rate - Australia & Worldwide

In Australia, as of 2 January 2022, the Department of Health records 97,557 cases of COVID-19 infected children aged 0-19, from the start of the pandemic, with 3 deaths in the same age bracket, resulting in a survival rate of 99.997%.<sup>10</sup> These statistics, found on the Department of Health website, do not provide further information about associated comorbidities.

The July 2020 Australian Government Department of Health COVID-19 fact sheet states that incidence in children is low and qualifies that a rise in the rates of cases for the age group, was due to increases in testing rather than a shift in incidence rates: “In Australia, the number of cases of COVID-19 in children is low. Only 4.5% of cases have been in school aged children (between five and 17 years). This figure was 2.2% in early June, 2020. The increase is mostly because of more testing...”<sup>11</sup>, further

1 COVID-19 child vaccination: safety and ethical concerns, (May 20, 2021). Hart Group. Retrieved January 10, 2022 from <https://www.hartgroup.org/open-letter-child-vaccination/>

2 Ibid

3 Ibid

4 Say, D., Crawford, N., McNab, S., Wurzel, D., Steer, A., Tosif, S. (April 20, 2021). Post-acute COVID-19 outcomes in children with mild and asymptomatic disease. *The Lancet*. Retrieved January 10, 2022 from [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(21\)00124-3/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00124-3/fulltext)

5 COVID-19 Delta variant in schools and early childhood education and care services in NSW, Australia, (September 8, 2021). National Centre for Immunisation Research and Surveillance. Retrieved January 10, 2022 from <https://www.ncirs.org.au/covid-19-delta-variant-schools-and-early-childhood-education-and-care-services-nsw-australia-16>

6 Wang, L, Berger, NA., Kaelber, DC., Davis, PB., Volkow, ND., Xu, R., (January 2, 2022) Comparison of outcomes from COVID infection in paediatric and adult patients before and after the emergence of Omicron. *Medrxiv*. Retrieved January 10, 2022 from <https://www.medrxiv.org/content/10.1101/2021.12.30.21268495v1>

7 Ibid

8 Ibid

9 Burgess, K., Average age of coronavirus fatalities is 82. (October 10, 2020). *The Times*. Retrieved January 10, 2022 from <https://www.thetimes.co.uk/article/average-age-of-coronavirus-fatalities-is-82-pcwqrzdzz>

10 Coronavirus (COVID-19) Case Numbers and Statistics, (January 2, 2022). Australian Government Health Department. Retrieved January 2, 2022 from <https://www.health.gov.au/health-alerts/covid-19/case-numbers-and-statistics>

11 Factsheet COVID-19 and Children, (July 20, 2020). Australian Government Health Department. Retrieved January 10, 2022 from [https://www.health.gov.au/sites/default/files/documents/2020/07/coronavirus-covid-19-and-children\\_0.pdf](https://www.health.gov.au/sites/default/files/documents/2020/07/coronavirus-covid-19-and-children_0.pdf)



stating “The virus can infect children, however they are less likely to have symptoms. Their symptoms are milder and they are less likely to develop severe illness.”<sup>12</sup>

A German study<sup>13</sup>, where 10.8% of child population (<18 years old) tested positive for SARS-CoV-2 virus, from the beginning of the pandemic and until May 2021, shows:

- no deaths with Covid19 for children <11 years old
- 99.999% survival rate for children <18 years old

The United Kingdom Office for National Statistics (ONS),<sup>14</sup> reports the following Covid-19 deaths in 5-year age groups for the period 2 January 2021 to 13 August 2021:

0 – 1 yrs	2 deaths
1 – 4 yrs	0 deaths
5 – 9 yrs	3 deaths
10 – 14 yrs	5 deaths
15 – 19 yrs	16 deaths

From approximately 14 million children and young people in the U.K. a total of 26 deaths were recorded as ‘Covid-19’ over this 7-month period, with no data available to indicate comorbidity or other reasons for hospital admission. Covid-19 deaths are defined as “deaths due to and involving COVID-19”.<sup>15</sup>

## Hospitalisation rates

A nation-wide German study<sup>16</sup> on hospitalisation of children with Covid19 published in November 2021 concluded that “the SARS-CoV-2-associated burden of a severe disease course or death in children and adolescents is low. This seems particularly the case for 5-11-year-old children without comorbidities.”<sup>17</sup>

The study analysed data from 10.8% of Germany’s child population (<18 years old), who tested positive for the SARS-CoV-2 virus from the start of the pandemic until May 2021.

The study found following overall rates, including both children with and without comorbidities:

- hospitalisation rate was 35.9 per 10,000 children
- hospitalisation rate for children who required therapeutic intervention was 6.5 per 10,000
- ICU admission rate was 1.7 per 10,000
- case fatality was 0.09 per 10,000

Children without comorbidities were found to be significantly less likely to suffer from a severe or fatal disease course, as follows:

- hospitalisation rate for children who required therapeutic intervention was 5.1 per 10,000
- ICU admission rate of 0.8 per 10,000
- case fatality was 0.03 per 10,000
- no deaths reported in children ≥ 11 years of age

Similarly, data reported by United Kingdom government health bodies concludes:

“Deaths in children and young people (CYP) following SARS-CoV-2 infection are rare. Quantifying the risk of mortality is challenging because of high relative prevalence of asymptomatic and non-specific disease manifestations. Therefore, it is important to differentiate between CYP who have died of SARS-CoV-2 and those who have died of an alternative disease process but coincidentally tested positive.”<sup>18</sup>

Furthermore, the researchers state “SARS-CoV-2 is very rarely fatal in CYP, even among those with underlying comorbidities.”<sup>19</sup>

A systematic review of 81 studies across a number of research databases published in Medrxiv <sup>20</sup> echoes the above findings. Researchers found the vulnerable cohort to be: “... those with cardiac or neurological conditions, or 2 or more comorbid

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12 Ibid

13 Sorg, A.I., Hufnagel, M., Doenhardt, M., Diffloth N., Schrotten H., Kries, R.v., Berner R., Armann, J., (November 30, 2021) Risk of Hospitalization, severe disease, and mortality due to COVID-19 and PIMS-TS in children with SARS-CoV-2 infection in Germany. MedRxiv. Retrieved January 10, 2022 from <https://doi.org/10.1101/2021.11.30.21267048>

14 COVID-19 Cases in Children, (September 2, 2021). Office for National Statistics. Retrieved January 10, 2022 from <https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/covid19casesinchildren>

15 Ibid

16 Sorg, A.I. et al. op.cit. p6.

17 Ibid

18 Smith, C., Odd, D., Harwood, R., Ward, J., Linney, M., Clark, M., Hargreaves, D., Ladhani, S., Draper, E., Davis, P., Kenny, S., Whittaker, E., Luyt, K., Viner, R., Fraser, L. (July 7, 2021). Deaths in Children and Young People in England following SARS-CoV-2 infection during the first pandemic year; a national study using linked mandatory child death reporting data. Retrieved January 10, 2022 from <https://www.researchsquare.com/article/rs-689684/v1>

19 Ibid

20 Harwood, R., Yan, H., Talawila Da Camara, N., Smith, C., Ward, J., Tudur-Smith, C., Linney, M., Clark, M., Whittaker, E., Saatci, D., Davis, P.J., Luyt, K., Draper, E.S., Kenny, S., Fraser, L.K., Viner, R.M. (July 8, 2021) Which children and young people are at higher risk of severe disease and death after SARS-CoV-2 infection: a systematic review and individual patient meta-analysis. Medrxiv. Retrieved January 10, 2022 from <https://www.medrxiv.org/content/10.1101/2021.06.30.21259763v1>

conditions, and those who are obese.”<sup>21</sup> However, “the absolute increase in risk for most comorbidities was small compared to children without underlying conditions.”<sup>22</sup> Hence, even for vulnerable children, the risk of a serious outcome from infection with SARS-CoV-2 was statistically very small.

The researchers concluded that “SARS-CoV-2 infection in children and young people (CYP) infrequently results in hospital admission and very rarely causes severe disease.”<sup>23</sup>

### Leading causes of death in children, including influenza - contextualized with Covid19

In 2020, Bhopal, Bagaria and Bhopal’s investigation<sup>24</sup> *Children’s mortality from COVID-19 compared with all-deaths and other relevant causes of death: epidemiological information for decision-making by parents, teachers, clinicians and policymaker* analysed “age-specific data for seven countries showing population, estimated deaths from all and specific causes for three months, compared with COVID-19 cases and deaths from the beginning of the COVID-19 pandemic to 8–19 May 2020.”<sup>25</sup>

The research states:

“For this time period, in these seven countries combined, 44 COVID-19 deaths were reported in 42,846 confirmed cases (this latter number is likely to be a massive underestimate; data were not available for France) in those aged 0–19 years (0–14 in USA). This compares with 13,200 estimated deaths from all-causes, including 1056 from unintentional injury, and 308 from lower respiratory tract infection (107 from influenza). The situation in each country was almost identical, and in accordance with early data from China i.e. COVID rarely kills children, even compared with influenza, against which many children are already vaccinated. Our data show that for mortality COVID-19 is similar to flu, or less severe, in children whilst being the opposite in adults.”<sup>26</sup>

The Australian Bureau of Statistics Causes of Death report<sup>27</sup> for 2020 shows:

RANKING BY LEADING CAUSE OF DEATH		MEDIAN AGE OF DEATH	
Suicide	15	Suicide	43.5
Influenza & Pneumonia	17	Influenza & Pneumonia	88.8
Covid-19	38	Covid-19	86.9

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21 Ibid

22 Ibid

23 Ibid

24 Bhopal, S., Bagaria, J., Bhopal, R., (2020). Children’s mortality from COVID-19 compared with all-deaths and other relevant causes of death: epidemiological information for decision-making by parents, teachers, clinicians and policymakers. *Public Health*, Volume 185. Retrieved January 10, 2022 from <https://doi.org/10.1016/j.puhe.2020.05.047>

25 Ibid

26 Ibid

27 Causes of Death, Australia (September 29, 2021). Australian Bureau of Statistics. Retrieved 10 January, 2022 from <https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release>



## 2. Mask wearing in children

### 2.1 DO MASKS REDUCE TRANSMISSION OF VIRAL PATHOGENS?

The current Victorian Chief Health Officer, Brett Sutton, has supported a mask mandate, contrary to comments not supporting this paradigm made through his own 2001 research<sup>28</sup>. Sutton and Skinner, (2001)<sup>29</sup> cited the work of Leyland, (1993)<sup>30</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. He relayed that 1 in 5 admitted that “tradition was the only reason for wearing them.”<sup>31</sup>

In May 2020 the Centers for Disease Control and Prevention (CDC) published a meta-study<sup>32</sup> on face masks as a potential measure to reduce influenza virus transmission in non-healthcare settings. The study found no significant reduction of viral transmission with the use of face masks:

“In our systematic review, we identified 10 RCTs [randomised controlled trials] that reported estimates of the effectiveness of face masks in reducing laboratory-confirmed influenza virus infections in the community from literature published during 1946–July 27, 2018. In pooled analysis, we found no significant reduction in influenza transmission with the use of face masks. . . We did not find evidence that surgical-type face masks are effective in reducing laboratory-confirmed influenza transmission, either when worn by infected persons (source control) or by persons in the general community to reduce their susceptibility.”<sup>33</sup>

In a fact sheet<sup>34</sup> published in July 2020 by the Australian Department of Health, advice on cloth masks, by admission, is given in absence of randomised controlled studies in non-healthcare settings: “There are no randomised controlled studies of cloth masks in community or household settings”<sup>35</sup>.

The fact sheet then advises that

“Mask research waned after the advent of antibiotics in the 1940s and cloth masks have been rarely used in high income countries since the development of moisture resistant surgical masks in the 1960s. However, they continued to be used widely in both healthcare and community settings in low and middle-income countries, particularly in Asia. In 2013 a review of the use of cloth masks for infection control again came to the conclusion that some cloth masks may reduce transmission of respiratory aerosols, but their efficacy is unproven in the absence of randomised control trials (RCT).”<sup>36</sup>

### 2.2 EFFECTIVENESS OF MASKS FOR CHILDREN

The Australian Department of Health’s fact sheet, *Are Cloth Face Masks Likely to Provide Protection Against COVID-19?*<sup>37</sup> cites one controlled trial in a healthcare setting in Vietnam that found the viral load in the cloth masked participants was significantly higher than in controls:

“In a cluster-RCT, >1600 Vietnamese HCWs [health care workers] were randomised (by ward) to wear cloth masks (made in Vietnam, with two layers of cotton or 50/50 cotton polyester mix), single-use medical masks or no masks. Over the 4-week study period, respiratory infection rates were significantly higher in the cloth mask than the medical mask arm (ranging from 1.67 times higher for laboratory confirmed viral illness to 13 times higher for ILI [influenza-like illness]). Paradoxically, the rates of ILI in the cloth mask arm were also significantly higher than in controls. The authors suggested that moisture retention, prolonged use, reuse without washing and poor filtration of cloth masks may have resulted in increased risk of self-contamination and infection.”<sup>38</sup>

The fact sheet concludes that

“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 masks.” It goes on, advising that “reusable cloth masks should be washed after each use or at least daily. Prolonged use, reuse without washing and touching or adjusting masks can lead to self-contamination and infection (of the wearer). They are increasingly less effective as they become increasingly damp.”<sup>39</sup>

It also cautions the reader that “unlike those of surgical masks, the quality and effectiveness of cloth masks are not regulated in Australia.”<sup>40</sup>

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28 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.

29 Ibid

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

31 Ibid

32 Centers for Disease Control and Prevention (2020). Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Personal Protective and Environmental Measures. Retrieved January 10, 2022 from [https://wwwnc.cdc.gov/eid/article/26/5/19-0994\\_article](https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article)

33 Ibid

34 Australian Department of Health (2021). Coronavirus (COVID-19) – Are cloth face masks likely to provide protection against COVID-19? The Infection Control Expert Group (ICEG) have developed this response to questions about whether cloth face masks are likely to provide protection against COVID-19. Retrieved January 10, 2022 from <https://www.health.gov.au/resources/publications/coronavirus-covid-19-are-cloth-face-masks-likely-to-provide-protection-against-covid-19>

35 Ibid

36 Ibid

37 Ibid

38 Ibid

39 Ibid

40 Ibid

In a CDC's meta-study<sup>41</sup> of 10 randomised controlled trials on surgical masks published by the CDC in 2020, the authors conclude:

"Disposable medical masks (also known as surgical masks) are loose-fitting devices that were designed to be worn by medical personnel to protect accidental contamination of patient wounds, and to protect the wearer against splashes or sprays of bodily fluids. There is limited evidence for their effectiveness in preventing influenza virus transmission either when worn by the infected person for source control or when worn by uninfected persons to reduce exposure. Our systematic review found no significant effect of face masks on transmission of laboratory-confirmed influenza."<sup>42</sup>

### 2.3 RISKS OF MASK WEARING AND THE QUESTION OF PROPORTIONALITY

A German study,<sup>43</sup> published in February 2021, analysed the impact of children wearing masks. The data-collection registry was open to parents, doctors and teaching staff to document their observations. "A total of 20,353 people had taken part in the survey ... on a total of 25,930 children. The average reported wearing time of masks was 270 min per day. Of the respondents 68% reported that children complained about impairments caused by wearing the mask."<sup>44</sup>

Most reported side effects included:

- irritability (60%)
- headache (53%)
- difficulty concentrating (50%)
- less happiness (49%)
- reluctance to go to school/kindergarten (44%)
- malaise (42%)
- impaired learning (38%)
- drowsiness/fatigue (37%)

This world's first registry for recording the effects of wearing masks in children calls for "representative surveys, randomized controlled trials with various masks and a renewed risk-benefit assessment of mask obligation in the vulnerable group of children."<sup>45</sup>

A meta-analysis<sup>46</sup> *Impact of wearing face masks in public to prevent infectious diseases on the psychosocial development in children and adolescents: a systematic review*, found that "there are some indications...that children, adolescents, and their teachers in (pre)schools perceived facial expression processing as impaired due to mask wearing, which were confirmed by several experimental studies. Two studies reported psychological symptoms like anxiety and stress as well as concentration and learning problems due to wearing a mask during the COVID-19 pandemic." The authors proposed that "there is a lack of research data regarding the following outcomes: psychological development, language development, emotional development, social behaviour, school success, and participation."<sup>47</sup>

In the article *Masked education? The benefits and burdens of wearing face masks in schools during the current Corona pandemic*<sup>48</sup>, published by the US National Institute of Health about mask wearing in school settings, the author itemises a number of side effects of face mask use such as: headache, perioral dermatitis with rashes and redness, impaired face recognition and identification, impaired communication, and blocked emotional signalling. He urges that "at the very least, all school professionals should be aware of the detrimental effects of face masks on face recognition and identification, communication, and social-emotional interaction."<sup>49</sup>

In the HART publication, *Masks – Do Benefits Outweigh the Harms?*<sup>50</sup> Drs Gary Sidley and Alan Mordue, raise their concern that "no comprehensive risk assessment of potential harms has been carried out before making these demands [mandates]. Prior to imposing this requirement for masks, a full assessment should have been conducted, incorporating the following areas:

- Assessment of oxygen levels in mask wearer at the beginning and end of the day
- Assessment of impairments to concentration and ability to learn
- Assessment of impairment to children with hearing difficulties and special educational needs

41 Centers for Disease Control and Prevention (2020). Nonpharmaceutical Measures for Pandemic Influenza in Nonhealthcare Settings—Personal Protective and Environmental Measures. Retrieved January 10, 2022 from [https://wwwnc.cdc.gov/eid/article/26/5/19-0994\\_article](https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article)

42 Ibid

43 Schwarz S, Jenetzky E, Krafft H, Maurer T, Martin D. Coronakinderstudien „Co-Ki“: erste Ergebnisse eines deutschlandweiten Registers zur Mund-Nasen-Bedeckung (Maske) bei Kindern [Corona child studies "Co-Ki": first results of a Germany-wide register on mouth and nose covering (mask) in children]. *Monatsschr Kinderheilkd*. 2021 Feb 22;1-10. German. Retrieved January 10, 2022 from <https://pubmed.ncbi.nlm.nih.gov/33642617/>.

44 Ibid

45 Ibid

46 Freiberg A, Horvath K, Hahne TM, Drössler S, Kämpf D, Spura A, Buhs B, Reibling N, De Bock F, Apfelbacher C, Seidler A. Beeinflussung der psychosozialen Entwicklung von Kindern und Jugendlichen durch das Tragen von Gesichtsmasken im öffentlichen Raum zur Prävention von Infektionskrankheiten: Ein systematischer Review [Impact of wearing face masks in public to prevent infectious diseases on the psychosocial development in children and adolescents: a systematic review]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz*. 2021 Dec;64(12):1592-1602. German. Retrieved January 10, 2022 from <https://pubmed.ncbi.nlm.nih.gov/34694428/>

47 Ibid

48 Spitzer M. Masked education? The benefits and burdens of wearing face masks in schools during the current Corona pandemic. *Trends Neurosci Educ*. 2020 Sep;20:100138. doi: 10.1016/j.tine.2020.100138. Epub 2020 Aug 11. PMID: 32917303; PMCID: PMC7417296. Retrieved January 10, 2022 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7417296/>

49 Ibid

50 Sidley, G., Mordue, A., (2021). *Masks – Do Benefits Outweigh the Harms?* HART Group. Retrieved January 10, 2022 from <https://www.hartgroup.org/masks/>



- Assessment of impairment to psychological wellbeing
- Assessment of possible damages from inhalation of micro-fibres
- Assessment of potential harms of repeated use of dirty cloth masks
- Assessment of impairment to non-verbal communication<sup>51</sup>

“Many of the potential harms may only become apparent in the long-term, thereby casting yet more doubt on the assumption that, for children, the benefits outweigh the risks.”<sup>52</sup>

Sidley and Mordue raise the question of proportionality of such measures as mask wearing, given their unproven effectiveness in the spreading of flu. They conclude that “face coverings for healthy people do more harm than good. Additionally, evidence demonstrating that asymptomatic, healthy members of society are unlikely to spread the virus strengthens the conclusion that mask mandates are unnecessary.”<sup>53</sup>

## 2.4 GOVERNMENT HEALTH ADVICE / INFECTION CONTROL EXPERT GROUP (ICEG) AND WHO RECOMMENDATIONS

On the Australian Department of Health website, the Infection Control Expert Group (ICEG) advises that “when there is absent or localised COVID-19 transmission, the general use of masks in the community is not recommended, although some people choose, and are free, to do so.”<sup>54</sup>

WHO and UNICEF advise that the decision to use masks for children aged **6-11** should be based on the following factors:

- “Whether there is widespread transmission in the area where the child resides
- The ability of the child to safely and appropriately use a mask
- Access to masks, as well as laundering and replacement of masks in certain settings (such as schools and childcare services)
- Adequate adult supervision and instructions to the child on how to put on, take off and safely wear masks
- Potential impact of wearing a mask on learning and psychosocial development, in consultation with teachers, parents/ caregivers and/or medical providers
- Specific settings and interactions the child has with other people who are at high risk of developing serious illness, such as the elderly and those with other underlying health conditions<sup>55</sup>

## 2.5 EDUCATION CODE OF CONDUCT AND ETHICS

When managing mask mandates in schools, teachers must still adhere to the precepts set out in the Teachers’ Code of Conduct:<sup>56</sup>

“Teachers:

- work to create an environment that promotes respect for everyone
- model and engage in respectful and impartial language and behaviour
- protect learners from intimidation, embarrassment, humiliation and harm (...)
- respect a learner’s privacy in sensitive matters – such as health or family issues – and only reveal confidential matters when appropriate, necessary or required by law, such as
  - if the learner has consented to the information being used in a certain way
  - to prevent or lessen a serious threat to life, health, safety or wellbeing of a person (including the learner)
  - part of an investigation into unlawful activity
  - if the disclosure is required or mandated by law
  - to prevent a crime or enforce the law
  - to manage any risk to a child or young person.”<sup>57</sup>

As shown in chapter 2.3 above, mask-wearing at school could lead to physical and psychosocial harm, as well as cognitive impairment, which raises the issues:

- How are teaching staff trained to mitigate the effects of mask-wearing on students’ physical, mental and emotional wellbeing while adhering to staff code of conduct?
- When other children are not wearing a mask, it is natural for their peers ask “why?”. How is this being handled?
- How can teachers and principals protect children from intimidation for not wearing a mask?
- How can schools protect the privacy of children who cannot wear a mask (due to a disability or medical condition)?

51 Ibid

52 Ibid

53 Ibid

54 Australian Department of Health (2021). Coronavirus (COVID-19) – Are cloth face masks likely to provide protection against COVID-19? The Infection Control Expert Group (ICEG) have developed this response to questions about whether cloth face masks are likely to provide protection against COVID-19. Retrieved January 10, 2022 from <https://www.health.gov.au/resources/publications/coronavirus-covid-19-are-cloth-face-masks-likely-to-provide-protection-against-covid-19>

55 World Health Organization. (August 21, 2020). Coronavirus disease (COVID-19): Children and masks. Retrieved January 10, 2022 from <https://www.who.int/news-room/q-a-detail/q-a-children-and-masks-related-to-covid-19>

56 Victorian Institute of Teaching. (2021, May). The Victorian Teaching Profession’s Code of Conduct. Retrieved January 10, 2022 from [https://www.vit.vic.edu.au/sites/default/files/media/pdf/2021-07/Document\\_VIT\\_Code\\_of\\_Conduct.pdf](https://www.vit.vic.edu.au/sites/default/files/media/pdf/2021-07/Document_VIT_Code_of_Conduct.pdf)

57 Ibid

### 3. Vaccinating Children

As of January 5, 2022 World Health Organisation does not recommend Pfizer BioNTech vaccine for children under 12:

“There are currently no efficacy or safety data for children below the age of 12 years. Until such data are available, individuals below 12 years of age should not be routinely vaccinated.”<sup>58</sup>

#### 3.1 WHY CHILDREN DON'T NEED COVID-19 VACCINES

##### Children are at low risk from Covid19

The article *Why Are We Vaccinating Children Against COVID-19?*<sup>59</sup> published in September 2021 in the Toxicology Reports, volume 8, examines a number of issues related to COVID-19 vaccinations for children. The analysis shows that

“The bulk of the official COVID-19-attributed deaths per capita occur in the elderly with high comorbidities, and the COVID-19 attributed deaths per capita are negligible in children. The bulk of the normalized post-inoculation deaths also occur in the elderly with high comorbidities, while the normalized post-inoculation deaths are small, but not negligible, in children. Clinical trials for these inoculations were very short-term (a few months), had samples not representative of the total population, and for adolescents/children, had poor predictive power because of their small size. Further, the clinical trials did not address changes in biomarkers that could serve as early warning indicators of elevated predisposition to serious diseases. Most importantly, the clinical trials did not address long-term effects that, if serious, would be borne by children/adolescents for potentially decades.”<sup>60</sup>

The analysis presents that

“A novel best-case scenario cost-benefit analysis showed very conservatively that there are five times the number of deaths attributable to each inoculation vs those attributable to COVID-19 in the most vulnerable 65+ demographic. The risk of death from COVID-19 decreases drastically as age decreases, and the longer-term effects of the inoculations on lower age groups will increase their risk-benefit ratio, perhaps substantially.”<sup>61</sup>

The article raises the question of available data justifying inoculation for children, showing that

“The most vulnerable are almost exclusively the elderly with many comorbidities. (...) What is the rush for a group at essentially zero risks? Given that the inoculations were tested only for a few months, only very short-term adverse effects could be obtained. It is questionable how well even these short-term effects obtained from the clinical trials reflect the short-term effects from the initial mass inoculation results reported in VAERS.”<sup>62</sup>

##### Recovery

A United Kingdom cohort study<sup>63</sup> published in August 2021 in The Lancet, Child and Adolescent Health analyses 1,734 school-aged children who tested positive for Covid19 finding that “median illness duration was 6 days ... and was positively associated with age”. The study concludes “COVID-19 in children is usually of short duration with low symptom burden.”<sup>64</sup>

##### Natural Immunity versus vaccine-induced immunity

In an article<sup>65</sup> from July 2021, Marc Girardot of PANDA shows that:

“Multiple confirming data points and experiments solidify this already robust scientific foundation: The prevalence of pre-existing immunity to SARS-CoV2 found in multiple studies (Study) (Study) (Study) further validates our thinking, both for humoral immunity (Study) (Study) and cellular immunity. Many seem to have benefitted from a form of immunity even though they had never met the actual virus, nor been vaccinated. These have gained their immunity from past epidemics and make up the large contingent of asymptomatics.”<sup>66</sup>

“99% of people infected with SARS-CoV-2 recover without treatment. Only 1% of SARS-CoV-2 patients, who did not receive early home-based treatment, end up hospitalised. In other words, the immune system overwhelmingly protects.”<sup>67</sup>

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58 World Health Organisation (January 5, 2022). The Pfizer BioNTech (BNT162b2) COVID-19 vaccine: What you need to know. Retrieved January 15, 2022 from <https://www.who.int/news-room/feature-stories/detail/who-can-take-the-pfizer-biontech-covid-19--vaccine>

59 Kostoff, R. N., Calina, D., Kanduc, D., Briggs, M. B., Vlachoyiannopoulos, P., Svistunov, A. A., Tsatsakis, A. (2021) Why are we vaccinating children against COVID-19? Toxicology Reports, Volume 8, 2021. Retrieved January 10, 2022 from <https://www.sciencedirect.com/science/article/pii/S221475002100161X>

60 Ibid

61 Ibid

62 Ibid

63 Molteni, E., Sudre, C., Canas, L., Bhopal, S.S., Hughes, R.C., Antonelli, M., et al (August 3, 2021) Illness duration and symptom profile in symptomatic UK school-aged children tested for SARS-CoV-2. The Lancet. Child and Adolescent Health, Volume 5, ISSUE 10, 2021. Retrieved January 10, 2022 from [https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642\(21\)00198-X/fulltext](https://www.thelancet.com/journals/lanchi/article/PIIS2352-4642(21)00198-X/fulltext)

64 Ibid

65 Girardot, M. (July 10, 2021). Should people who have recovered from COVID take a vaccine? Pandata. Retrieved January 10, 2022 from <https://www.pandata.org/should-covid-recovered-take-vaccine/>

66 Ibid

67 Ibid



He states that

“natural or vaccine-induced immunity is unhindered by variants, possibly more so than vaccine-induced immunity.”<sup>68</sup> “There is ample evidence that vaccinating people recovered from COVID doesn’t bring any benefit. It quite possibly does the opposite, because of the risk of building tolerance to elements of the virus translating into reduced immune potency.”<sup>69</sup>

And continues

“By their very nature, vaccines tinker with the sophisticated balance of one’s immune system. That in itself demands respecting rigid safety protocols. Though we have made considerable progress in our understanding of immunology, we are still very far from understanding its intricacies and subtleties, especially when it comes to novel mRNA and DNA technologies. Because of the risk of anaphylactic shock, auto-immune diseases, unforeseen interactions, design flaws, deficient quality protocols, over-dosage, and so on – vaccines have traditionally been strictly regulated.”<sup>70</sup>

When it comes to comparing the natural immunity with the vaccine-induced immunity, the earlier mentioned article<sup>71</sup> published in the Toxicology Reports explains that

“The injection goes two steps further than the wild virus because 1) it contains the instructions for making the spike protein, which several experiments are showing can cause vascular and other forms of damage, and 2) it bypasses many front-line defenses of the innate immune system to enter the bloodstream directly in part. (...) The spike protein and the surrounding LNP are toxins with the potential to cause myriad short-, mid-, and long-term adverse health effects even in the absence of other contributing factors! Where and when these effects occur will depend on the biodistribution of the injected material. Pfizer’s own biodistribution studies have shown the injected material can be found in myriad critical organs throughout the body, leading to the possibility of multi-organ failure. And these studies were from a single injection. Multiple injections and booster shots may have cumulative effects on organ distributions of inoculant!”<sup>72</sup>

### Effectiveness of COVID-19 vaccines

A study, *Effectiveness of COVID-19 vaccines against Omicron or Delta infection*<sup>73</sup> published in December 2021, shows that:

“After 2 doses of COVID-19 vaccine, vaccine effectiveness against Delta infection declined steadily over time but recovered to 93% (95%CI, 92-94%) ≥7 days after receiving an mRNA vaccine for the third dose. In contrast, receipt of 2 doses of COVID-19 vaccines was not protective against Omicron. Vaccine effectiveness against Omicron was 37% (95%CI, 19-50%) ≥7 days after receiving an mRNA vaccine for the third dose.”<sup>74</sup>

In Classen’s study *US COVID-19 Vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, “All Cause Severe Morbidity” study*<sup>75</sup>, the author reanalysed pivotal clinical trial data “using ‘all cause severe morbidity’, a scientific measure of health, as the primary endpoint.”<sup>76</sup>

The study shows that:

“Results prove that none of the vaccines provide a health benefit and all pivotal trials show a statically significant increase in ‘all cause severe morbidity’ in the vaccinated group compared to the placebo group.”

### Risk of Covid19 vaccinations

A U.S.A. study<sup>77</sup> published in August 2021 has found post-vaccination cardiac adverse effects rates of 162 and 94/million for boys aged 12-15 and 16-17 respectively, following second dose of vaccination. The long-term consequences of this vaccine-associated heart inflammation are not yet fully defined and should be further studied.

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68 Ibid

69 Ibid

70 Ibid

71 Kostoff, R. N., Calina, D., Kanduc, D., Briggs, M. B., Vlachoyiannopoulos, P., Svistunov, A. A., Tsatsakis, A. (2021) Why are we vaccinating children against COVID-19? Toxicology Reports, Volume 8, 2021. Retrieved January 10, 2022 from <https://www.sciencedirect.com/science/article/pii/S221475002100161X>

72 Ibid

73 Buchan, S., Chung, H., Brown, K., Austin, P., Fell, D., Gubbay, J., Nasreen, S., Schwartz, K., Sundaram, M., Tadrous, M., Wilson, K., Wilson, S.E., Kwong, J. (December 30, 2021). Effectiveness of COVID-19 vaccines against Omicron or Delta infection. medRxiv. Retrieved January 15, 2022 from <https://www.medrxiv.org/content/10.1101/2021.12.30.21268565v1>

74 Ibid

75 Classen B. (2021). US COVID-19 Vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, “All Cause Severe Morbidity”. Trends Int Med. 2021; 1(1): 1-6 Retrieved January 10, 2022 from <https://www.scivisionpub.com/pdfs/us-covid19-vaccines-proven-to-cause-more-harm-than-good-based-on-pivotal-clinical-trial-data-analyzed-using-the-proper-scientific--1811.pdf>

76 Ibid

77 Høeg, T.B., Krug, A., Stevenson, J., Mandrola J., (August 2021). SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17: A Stratified National Database Analysis. MedRxiv. Retrieved 10 January, 2022 from <https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1>

### 3.2 SAFETY

The Therapeutic Goods Administration (TGA) states that Covid19 vaccines are provisionally approved and that “Many of the large-scale clinical trials that will provide evidence of safety and effectiveness are still progressing and these results will be provided to the TGA as they become available.”<sup>78</sup>

Studies into the long-term safety of Covid19 vaccinations in children are not due before 2024, making the question of safety a premature one. The completion of the study on the incidence of heart inflammation in children is not due before June 2025.

In terms of safety and efficacy, TGA relies solely on the submissions from sponsors (drug companies), which raises the question of conflict of interest.

The *Australian Product Information - Comirnaty Covid-19 Vaccine* published on the TGA website states:

“The safety and efficacy of COMIRNATY in children aged less than 12 years of age have not yet been established.”<sup>79</sup>

The Department of Health’s information page<sup>80</sup> on Comirnaty (Pfizer) vaccine notes that:

“The risk in children aged 5 to 11 years is not yet known. The clinical trial in children aged 5 to 11 years did not have enough participants to assess rates of myocarditis or pericarditis following the Pfizer COVID-19 vaccine.”<sup>81</sup>

In the U.S.A. the Food and Drug Administration (FDA) has ordered Pfizer in its approval letter for Comirnaty treatment to:

“conduct research to investigate the risk of inflammation in and around the heart, as voluntary reporting mechanisms are insufficient. (...) The FDA accepted Pfizer’s suggested timetable for the post-approval study to evaluate incidence of heart and heart sack inflammation, which includes the submission of an interim report at the end of October 2023, a study completion date of June 30, 2025, and submission of a final report October 31, 2025.”<sup>82</sup>

Classen’s study<sup>83</sup> also proves that :

“none of the vaccines provide a health benefit and all pivotal trials show a statically significant increase in ‘all cause severe morbidity’ in the vaccinated group compared to the placebo group.”<sup>84</sup>

### 3.3 CONSENT AND THE GILICK COMPETENCE / MATURE MINOR

In the event that COVID-19 vaccinations are administered in a school setting, how will schools ensure parental consent is given?

The *Australian Immunisation Handbook*<sup>85</sup> offers guidelines in relation to consent as follows:

“For consent to be legally valid, the following elements must be present:

1. It must be given by a person with legal capacity, and of sufficient intellectual capacity to understand the implications of receiving a vaccine.
2. It must be given voluntarily in the absence of undue pressure, coercion or manipulation.
3. It must cover the specific procedure that is to be performed.
4. It can only be given after the potential risks and benefits of the relevant vaccine, the risks of not having it, and any alternative options have been explained to the person.”<sup>86</sup>

The *Australian Immunisation Handbook* states that

“In general, a parent or legal guardian of a child has the authority to consent to that child being vaccinated. (...) The common law applies in the states and territories that do not have specific legislation relating to children’s consent to medical treatment. This common-law position is often referred to as Mature Minor or Gillick competence. For certain procedures, including vaccination, a child or adolescent may be determined to be mature enough to understand the proposed procedure, and the risks and benefits associated with it. These young people may have the capacity to consent under certain circumstances. If a child or adolescent refuses a vaccination that a parent or guardian has given consent for, respect the child’s or adolescent’s wishes, and inform the parent or guardian.”<sup>87</sup>

78 Therapeutic Goods Administration (December 8, 2021). COVID-19 Vaccines Undergoing Evaluation. Retrieved January 10, 2022 from <https://www.tga.gov.au/covid-19-vaccines-undergoing-evaluation>

79 Therapeutic Goods Administration (July 2021). AUSTRALIAN PRODUCT INFORMATION – COMIRNATY™ (BNT162b2 [mRNA]) COVID-19 VACCINE. Retrieved January 10, 2022 from <https://www.tga.gov.au/sites/default/files/covid-19-vaccine-pfizer-australia-comirnaty-bnt162b2-mrna-pi.pdf>

80 Department of Health (January 7, 2022). Comirnaty (Pfizer). Retrieved January 10, 2022 from <https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/approved-vaccines/pfizer>

81 Ibid

82 Food and Drug Administration (August 3, 2021). Approval Letter – Comirnaty. Retrieved January 10, 2022 from <https://www.fda.gov/media/151710/download>

83 Classen B. (2021). US COVID-19 Vaccines Proven to Cause More Harm than Good Based on Pivotal Clinical Trial Data Analyzed Using the Proper Scientific Endpoint, “All Cause Severe Morbidity”. *Trends Int Med.* 2021; 1(1): 1-6 Retrieved January 10, 2022 from <https://www.scivisionpub.com/pdfs/us-covid19-vaccines-proven-to-cause-more-harm-than-good-based-on-pivotal-clinical-trial-data-analyzed-using-the-proper-scientific--1811.pdf>

84 Ibid

85 Australian Government Department of Health. (2019). Preparing for vaccination. Retrieved January 10, 2022 from *Australian Immunisation Handbook*: <https://immunisationhandbook.health.gov.au/vaccination-procedures/preparing-for-vaccination>

86 Ibid

87 Ibid



The *Australian Code for the Responsible Conduct of Research*<sup>88</sup> provides information on levels of maturity in the context of informed consent:

- for “infants and young children” parental/guardian consent is required.
- for “young children of developing maturity” the child can provide consent but it’s not enough to authorise participation (must be associated with parental/guardian consent).
- for “young people who are mature enough to understand & consent” no additional consent from parent/guardian warranted.

The Government is issuing guidelines to the effect that “people aged 12 to 17 may provide their own consent, if deemed to be a mature minor by a senior and experienced immuniser”<sup>89</sup>.

However, in doing this, the Government appear to be paraphrasing and over-simplifying a very complicated legal principle known as the “Gillick Principle”. The Gillick Principle is summarised in an Open Letter<sup>90</sup> to all Education Ministers by human rights lawyer Peter Fam dated 7 December 2021. In this letter, the legal position in relation to the vaccination of minors is actually as follows:

- “- Parental consent is generally essential to any medical procedure for somebody under the age of 18;
- There are exceptional circumstances where somebody under the age of 18 can give consent absent their parents, subject to strict conditions which will rarely be met;
- Such conditions would need to be met on a case by case basis; and
- If such conditions aren’t met, medical treatment provided absent parental consent is likely to constitute liability for battery and/or negligence”.

### 3.4. ETHICAL CONDUCT IN CLINICAL TRIALS – HUMAN RESEARCH ETHICS COMMITTEES IN SCHOOLS?

Given that all Covid19 vaccines are in clinical trials until 2023-2025, as per the Therapeutic Goods Act 1989<sup>91</sup> a Human Research Ethics Committee (HREC) is required “to review and monitor all clinical trials of unregistered therapeutic goods. This HREC must be (...) constituted and operating in accordance with the National Statement. (...) HRECs also consider the protection of privacy for humans participating in research and their data.”

Should schools undertake vaccinations on their premises, arguably they should be required to abide by the National Statement on ethical conduct in human research.

For more information on how to set up a Human Research Ethics Committee, the Australian National Health and Medical Research Council provides the National Statement on Ethical Conduct in Human Research<sup>92</sup> which “sets out the national standards for the ethical design, review and conduct of human research. Its content reflects the outcome of wide consultation with Australian communities who participate in, design, conduct, fund, manage and publish human research.”<sup>93</sup>

### 3.5 ADVERSE EVENTS IN CHILDREN - A NUMBER OF STUDIES PRESENTED BELOW SHOW THAT MYOCARDITIS AND PERICARDITIS ARE LINKED TO MRNA VACCINATIONS.

#### Hong Kong

A Hong Kong study *Epidemiology of Acute Myocarditis/Pericarditis in Hong Kong Adolescents Following Comirnaty Vaccination*.<sup>94</sup> found that:

“There is a significant increase in the risk of acute myocarditis/pericarditis following Comirnaty vaccination among Chinese male adolescents, especially after the second dose.”<sup>95</sup>

Foltran et al’s extensive pharmacovigilance study *Myocarditis and Pericarditis in Adolescents after First and Second doses of mRNA COVID-19 Vaccines*.<sup>96</sup>

- “analysed 4,942 reports with mRNA COVID-19 vaccines in adolescents aged 12 to 17 years old (Tozinameran = 4,659; Elasmomeran = 283)”<sup>97</sup> and

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88 National Health and Medical Research Council (2018). The Australian Code for the Responsible Conduct of Research. Retrieved January 10, 2022 from <https://www.nhmrc.gov.au/about-us/publications/australian-code-responsible-conduct-research-2018>

89 Vaccination information for children and teenagers. Information about COVID-19 vaccines for children and teenagers (January 12, 2022). Coronavirus Victoria. Retrieved January 10, 2022 from <https://www.coronavirus.vic.gov.au/vaccination-information-children-and-teenagers>

90 Children, Consent and Medical Procedures. (n.d.). Retrieved January 12, 2022 from <https://skipaustralia.org/wp/wp-content/uploads/2022/01/Letter-to-Ministers-for-Education.pdf>

91 Australian Government (2021). Therapeutic Goods Act 1989. Legislation. Retrieved January 10, 2022 from <https://www.legislation.gov.au/Details/C2021C00376>

92 National Health and Medical Research Council (2018). National Statement on Ethical Conduct in Human Research. Retrieved January 10, 2022 from <https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2007-updated-2018>

93 Ibid

94 Chua, G. T., et al.(2021). Epidemiology of Acute Myocarditis/Pericarditis in Hong Kong Adolescents Following Comirnaty Vaccination. Clin Infect Dis. Retrieved January 15, 2022 from <https://www.ncbi.nlm.nih.gov/pubmed/34849657>

95 Ibid

96 Foltran, D., et al.(2021). Myocarditis and Pericarditis in Adolescents after First and Second doses of mRNA COVID-19 Vaccines. Eur Heart J Qual Care Clin Outcomes. Retrieved January 15, 2022 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8690190/pdf/qcab090.pdf>

97 Ibid

- “identified 242 pericarditis and/or myocarditis (49 pericarditis only, 191 myocarditis only, 2 myopericarditis) and 233 were reported with Tozinameran and 9 with Elasmomeran.

Among these cases, patients were mostly boys (205, 85%) and with a mean 15.8±1.4 age of years. Most of reports were serious (229, 95%) including 191 (79%) leading to hospitalization.”<sup>98</sup>

- “Compared with the first dose of mRNA COVID-19 vaccines, the second dose was associated with an increased risk of reporting pericarditis and/or myocarditis (ROR 4.95; 95%CI 3.14, 7.89) ...
- The risk of reporting pericarditis and/or myocarditis was 10 times higher in boys than in girls at both the first dose (ROR 10.1; 95%CI 4.26, 29.6) and second dose (ROR 10.2; 95%CI 4.88, 25.0).”<sup>99</sup>

Buchhorn et al’s study *Autoantibody Release in Children after Corona Virus mRNA Vaccination: A Risk Factor of Multisystem Inflammatory Syndrome?*<sup>100</sup> found that “the pediatric population is at a higher risk for MIS-C and a very low risk for COVID-19 mortality.”<sup>101</sup>

Dickey et al’s medical<sup>102</sup> report states that “the clinical presentation, CMR [Cardiovascular Magnetic Resonance] findings, and temporal association strongly suggest the possibility of vaccine-associated myocarditis in our 6 patients.”<sup>103</sup>

Schauer et al’s retrospective electronic medical record review, *Myopericarditis After the Pfizer Messenger Ribonucleic Acid Coronavirus Disease Vaccine in Adolescents*.<sup>104</sup> “identified 13 patients with myopericarditis, with a median age of 15 years (range, 12-17 years). The majority of patients were male (n = 12; 92%), and non-Hispanic white (n = 10; 76.9%).”<sup>105</sup>

Chelala et al’s retrospective study, *Cardiac MRI Findings of Myocarditis After COVID-19 mRNA Vaccination in Adolescent*,<sup>106</sup> finds that “of 52 patients who underwent cardiac MRI during the study period, 5 underwent MRI for suspected myocarditis after recent COVID-19 mRNA vaccination without known prior COVID-19. These 5 patients were all males with age ranging from 16 to 19 years.”<sup>107</sup>

Li, M. et al’s study *Myocarditis and Pericarditis following COVID-19 Vaccination: Inequalities in Age and Vaccine Types*<sup>108</sup> found an “incidence rate of 5.98 (95% CI = 5.73-6.24) cases per million doses administered. The incidence rate was higher in adolescents and after the administration of the second dose of messenger RNA (mRNA) vaccines.”<sup>109</sup>

## Japan

In a preprint study<sup>110</sup> released in October 2021, researchers from Nagasaki International University, Japan, analysed adverse events that occur in young Japanese people following Moderna’s COVID-19 shot. Using data from 7,965 individuals, they found that “Eighty-three percent of the participants complained of local adverse events, and 65% of participants complained of systemic adverse events”<sup>111</sup>. Those particularly at risk included women, youth under the age of 20 — who often experienced adverse events after the first dose — and those who experienced adverse events after the first dose.

## United Kingdom

In September 2021 Reuters reported<sup>112</sup> that Britain’s Joint Committee on Vaccination and Immunisation (JCVI) recommended against COVID-9 injections for healthy 12- to 15-year-olds, advising a precautionary approach in healthy children. JCVI member Adam Finn said “the number of serious cases that we see of COVID in children this age are really very small. (...) There are uncertainties about the long-term implications of (myocarditis), and that makes the risk-benefit balance for these children really quite tight and much tighter than we would be comfortable to make the recommendation.”<sup>113</sup>

98 Ibid

99 Ibid

100 Buchhorn, R., et al (2021). Autoantibody Release in Children after Corona Virus mRNA Vaccination: A Risk Factor of Multisystem Inflammatory Syndrome? Vaccines (Basel), 9(11). Retrieved January 15, 2022 from <https://www.ncbi.nlm.nih.gov/pubmed/34835284>

101 Ibid

102 Dickey, J. B et al (2021). A Series of Patients With Myocarditis Following SARS-CoV-2 Vaccination With mRNA-1279 and BNT162b2. JACC Cardiovasc Imaging, 14(9), 1862-1863. Retrieved January 15, 2022 from <https://www.sciencedirect.com/science/article/pii/S1936878X21004861?via%3Dihub>

103 Ibid

104 Schauer, J., et al (2021). Myopericarditis After the Pfizer Messenger Ribonucleic Acid Coronavirus Disease Vaccine in Adolescents. J Pediatr, 238, 317-320. Retrieved January 15, 2022 from [https://www.jpeds.com/article/S0022-3476\(21\)00665-X/fulltext](https://www.jpeds.com/article/S0022-3476(21)00665-X/fulltext)

105 Ibid

106 Chelala, L., et al (2021). Cardiac MRI Findings of Myocarditis After COVID-19 mRNA Vaccination in Adolescents. AJR Am J Roentgenol. Retrieved January 15, 2022 from <https://www.ncbi.nlm.nih.gov/pubmed/34704459>

107 Ibid

108 Li, M., Yuan, J., Lv, G., Brown, J., Jiang, X., & Lu, Z. K. (2021). Myocarditis and Pericarditis following COVID-19 Vaccination: Inequalities in Age and Vaccine Types. J Pers Med, 11(11). Retrieved January 15, 2022 from <https://www.ncbi.nlm.nih.gov/pubmed/34834458>

109 Ibid

110 Suehiro, M., Okubo, S., Nakajima, K., Kanda, K., Hayakawa, M., Oiso, S., Kabashima, T., Fujita, H., Ando, Y., Muro, T (2021). Adverse events following COVID-19 vaccination in young Japanese people: A case-control study of the risk of systemic adverse events by a questionnaire survey. MedRxiv. Retrieved January 10, 2022 from <https://www.medrxiv.org/content/10.1101/2021.10.01.21264393v1>

111 Ibid

112 Smout, A. (2021). UK panel does not recommend COVID vaccines for healthy 12- to 15-year-olds. Reuters. Retrieved January 10, 2022 from <https://www.reuters.com/world/uk/uk-advisers-decide-against-covid-vaccines-healthy-12-15-year-olds-2021-09-03/>

113 Ibid



## United States of America

The Center for Disease Control and Prevention (CDC) announced that “As of December 16, 2021, VAERS has received 1,947 preliminary reports of myocarditis or pericarditis among people ages 30 years and younger who received COVID-19 vaccines. Most cases have been reported after receiving Pfizer-BioNTech or Moderna, (mRNA COVID-19 vaccines) particularly in male adolescents and young adults.”<sup>114</sup>

December 18, 2021, 51 days after approving the Covid19 vaccinations for children ages 5 to 11, Reuters<sup>115</sup> announced that CDC reported “it had so far received reports of eight cases of myocarditis in that age group.

*SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17* study<sup>116</sup> published in August 2021 has found post-vaccination cardiac adverse effects rates of 162 and 94/million for boys aged 12-15 and 16-17 respectively, following second dose of vaccination. The long-term consequences of this vaccine-associated heart inflammation are not yet fully defined and should be further studied.

In its approval letter for Comirnaty,<sup>117</sup> the FDA ordered Pfizer to conduct research to investigate the risk of inflammation in and around the heart, as voluntary reporting mechanisms are insufficient. The FDA accepted Pfizer’s suggested timetable for the post-approval study to evaluate incidence of heart attacks and heart inflammation, which includes the submission of an interim report at the end of October 2023, a study completion date of June 30, 2025, and submission of a final report October 31, 2025.

## Denmark

Nygaard et al’s nationwide study from Denmark: *Population-based Incidence of Myopericarditis After COVID-19 Vaccination in Danish Adolescents*:<sup>118</sup> shows that “myopericarditis after Pfizer-BioNTech mRNA COVID-19 vaccination was identified in 13 males and 2 females between May 15 and September 15, 2021, among 133,477 vaccinated males and 127,857 vaccinated females 12–17 years of age, equaling 97 males and 16 females per million. In conclusion, the incidence of myopericarditis after COVID-19 vaccination among males appears higher than reports from the United States.”<sup>119</sup>

## Australia

The Department of Health’s *Comirnaty (Pfizer)*<sup>120</sup> information page on states:

- “The risk [of developing myocarditis or pericarditis] in children aged 5 to 11 years is not yet known. The clinical trial in children aged 5 to 11 years did not have enough participants to assess rates of myocarditis or pericarditis following the Pfizer COVID-19 vaccine.”<sup>121</sup>

The Australian Department of Health’s *COVID-19 booster vaccine advice* states:

- “There is limited data on serious side effects such as myocarditis and pericarditis following a Pfizer and Moderna booster dose.”<sup>122</sup>

In their Weekly Safety Report from January 13, 2022, the TGA notifies:

“To 9 January 2022, we have received about 3,000 reports after vaccination with Comirnaty (Pfizer) and Spikevax (Moderna). The most commonly reported reactions in 12–17 year olds are:

- chest pain
- headache
- dizziness
- nausea
- fever.”<sup>123</sup>

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114 Centers for Disease Control and Prevention (2021). Selected Adverse Events Reported after COVID-19 Vaccination. Retrieved January 10, 2022 from <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/adverse-events.html>

115 Eight heart inflammation cases among young kids who got COVID-19 shot - U.S. CDC (December 18, 2021). Reuters. Retrieved January 10, 2022 from <https://www.reuters.com/world/us/eight-heart-inflammation-cases-seen-among-young-kids-who-got-covid-19-shot-us-2021-12-16/>

116 Høeg, T.B., Krug, A., Stevenson, J., Mandrola J., (August 2021). SARS-CoV-2 mRNA Vaccination-Associated Myocarditis in Children Ages 12-17: A Stratified National Database Analysis. MedRxiv. Retrieved 10 January, 2022 from <https://www.medrxiv.org/content/10.1101/2021.08.30.21262866v1>

117 Food and Drug Administration (August 3, 2021). Approval Letter – Comirnaty. Retrieved January 10, 2022 from <https://www.fda.gov/media/151710/download>

118 Nygaard, U., et al (2022). Population-based Incidence of Myopericarditis After COVID-19 Vaccination in Danish Adolescents. *Pediatr Infect Dis J*, 41(1), e25-e28. Retrieved January 15, 2022 from [https://journals.lww.com/pidj/Fulltext/2022/01000/Population\\_based\\_Incidence\\_of\\_Myopericarditis.26.aspx](https://journals.lww.com/pidj/Fulltext/2022/01000/Population_based_Incidence_of_Myopericarditis.26.aspx)

119 Ibid

120 Department of Health (January 7, 2022). Comirnaty (Pfizer). Retrieved January 10, 2022 from <https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/approved-vaccines/pfizer>

121 Ibid

122 Department of Health (January 4, 2022). COVID-19 booster vaccine advice. Retrieved January 10, 2022 from <https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/getting-your-vaccination/booster-doses>

123 Therapeutic Goods Administration (January 13, 2022). Covid-19 Vaccine Weekly Safety report – 13-01-2022. Retrieved January 14, 2022 from <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-13-01-2022>

The report also presents that:

“Myocarditis is more commonly reported after the second dose in teenage boys (12 cases per 100,000 Comirnaty doses and 17 cases per 100,000 Spikevax doses).”<sup>124</sup>

...and then quotes the findings of

“A European review of myocarditis and pericarditis data in teenage boys and young men (12-29 years old) found for Comirnaty, there were 2–6 extra cases of myocarditis per 100,000 vaccinated individuals compared to unvaccinated individuals. For Spikevax, there were 13–19 extra cases of myocarditis per 100,000 vaccinated individuals compared to unvaccinated individuals.”<sup>125</sup>

### 3.6 COUNTRIES THAT BANNED MRNA SPIKEVAX (MODERNA) VACCINE FOR CHILDREN

As reported in the British Medical Journal, in October 2021 several Nordic countries<sup>126</sup> had suspended Spikevax (Moderna) vaccine over cardiovascular concerns. Anders Tegnell, the state epidemiologist of Sweden, pointed out that the decision about the use of Spikevax (Moderna) vaccine was based on the “detection of signals of an increased risk of side effects such as myocarditis and pericarditis.”<sup>127</sup>

Four Nordic countries have imposed restrictions on Spikevax as follows:

- Sweden and Finland stopped the use of Moderna in all population aged 30 and under
- Norway suspended Moderna vaccine for all children under 18
- Iceland, who was almost exclusively using Moderna as a booster for people 60 and above, stopped the use of Moderna booster doses for all ages

France and Germany From November 2021 no longer recommend Spikevax (Moderna) for under 30s. <sup>128</sup>

The U.S. Food and Drug Administration’s information page advises that Spikevax (Moderna) is not approved for under 18s. <sup>129</sup>

Despite these warning measures taken in other countries, TGA maintains its approval of Spikevax mRNA vaccine for children aged 12 years and over from 3<sup>rd</sup> September 2021.<sup>130</sup> Spikevax booster dose was also approved for youth aged 18 years and over from 7<sup>th</sup> December 2021.<sup>131</sup>

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124 Ibid

125 Ibid

126 Paterlini, M. (2021). Covid-19: Sweden, Norway, and Finland suspend use of Moderna vaccine in young people “as a precaution”. The BMJ. Retrieved January 10, 2022 from <https://www.bmj.com/content/375/bmj.n2477>

127 Ibid

128 Hart, R. (November 10, 2021) Germany, France Restrict Moderna’s Covid Vaccine For Under-30s Over Rare Heart Risk—Despite Surging Cases. Forbes. Retrieved January 10, 2022 from <https://www.forbes.com/sites/roberthart/2021/11/10/germany-france-restrict-modernas-covid-vaccine-for-under-30s-over-rare-heart-risk-despite-surging-cases/?sh=4226f54b2a8a>

129 U.S. Food and Drug Administration (January 7, 2022). Moderna COVID-19 Vaccine. Retrieved January 15, 2022 from <https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/moderna-covid-19-vaccine>

130 Therapeutic Good Administration (2021). COVID-19 vaccine: Provisional registrations. Retrieved January 10, 2022 from <https://www.tga.gov.au/covid-19-vaccine-provisional-registrations>

131 Ibid



## 4. Lockdowns, school closures and segregation

While below we briefly address specific topics and provide pertinent studies, articles and reports in relation to such topics, we bring to your attention this extensive and broad ranging article, linking to each study in this extensive compilation of research: *More Than 400 Studies on the Failure of Compulsory Covid Interventions*.<sup>132</sup>

### 4.1 MENTAL HEALTH

#### Suicide rates

While there is much anecdotal information from churches, communities, social media and friends and colleagues, concerning increasing numbers of youth suicides caused by isolation in repeated lockdowns, we are only able to present information from hospital sources pertaining to deterioration of mental health and other mental health services data, with unconfirmed real numbers of suicides, since that indeed has become the invisible pandemic.

This recent study<sup>133</sup> from the U.S.A. shows

“Adolescent overdose mortality saw a sharp increase between 2019 and 2020, from 2.35 per 100,000 to 4.58 per 100,000, representing a 94.3% increase, the largest percent increase of any 5-year age group.... Sharp increases in adolescent drug overdose deaths, despite flat or declining drug use rates, and no increase in deaths from alcohol or most drugs....”<sup>134</sup>

#### Hospital admissions are on the rise for mental health-related conditions – a mental health crisis on the rise?

“A Royal Children’s Hospital poll<sup>135</sup> on remote learning found more than 50 per cent of Victorian children suffered deteriorating mental health while away from school last year. The national survey of 2351 school-aged children found the proportion of Victorian children whose emotional wellbeing declined last year due to remote learning was almost double the national average, at 50.9 per cent versus 26.7 per cent.”<sup>136</sup> The study<sup>137</sup> reported in the above article; see page 64 for conclusions and recommendations.

Further, the Australian Institute of Health and Welfare (AIHW) reported<sup>138</sup> that, in the 4 weeks to 19 September 2021:

- “Lifeline saw several historical record high daily call volumes, and 96,273 calls were offered in total, up 14.1% and 33.1% from the same periods in 2020 and 2019 respectively;
- Kids Helpline received 32,572 answerable contact attempts, up 4.6% and 16.7% from the same periods in 2020 and 2019 respectively;
- Beyond Blue received 27,099 contacts, down 2.7% and up 20.9% from the same periods in 2020 and 2019 respectively”<sup>139</sup>.

In this same period, “1,215,475 MBS mental health-related services were processed, 7.1% and 21.8% higher than the same periods in 2020 and 2019, respectively”<sup>140</sup>.

An Anglicare Victoria report<sup>141</sup> similarly quotes statistics for calls to Kids Helpline at 30% higher in the first 6 months of 2021 and calls to Lifeline 40% higher than pre-pandemic rates. All these agencies and organisation are identifying symptoms of a fast-growing problem.

The Victorian government initiated their National Children’s Mental Health and Wellbeing Strategy in October 2021:

“The launch of the Strategy – developed by the National Mental Health Commission – comes as states and territories ramp up mental health support for young peoples impacted by the COVID-19 pandemic.”<sup>142</sup>

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132 More Than 400 Studies on the Failure of Compulsory Covid Interventions (November 30, 2021). Brownstone Institute. Retrieved January 10, 2022 from <https://brownstone.org/articles/more-than-400-studies-on-the-failure-of-compulsory-covid-interventions/>

133 Friedman, J., Godvin, M., Shover, C., Gone, J.P., Hansen, H., Schriger D. (2021). Sharp Increases in Drug Overdose Deaths Among High-School-Age Adolescents During the US COVID-19 Epidemic and Illicit Fentanyl Crisis. *MedRxiv* 2021.12.23.21268284. Retrieved January 10, 2022 from <https://www.medrxiv.org/content/10.1101/2021.12.23.21268284v1>

134 Ibid

135 Carey, A., & Prytz, A. (May 27, 2021). School closures do more harm to children than the virus, experts warn. *The Age*. Retrieved January 10, 2022 from <https://www.theage.com.au/politics/victoria/school-closures-do-more-harm-to-children-than-the-virus-experts-warn-20210527-p57vl6.htm>

136 Ibid

137 An analysis of COVID-19 in ECEC and schools and evidence-based recommendations for opening ECEC and schools & keeping them open (November 9, 2020). Murdoch Children’s Research Institute. Retrieved January 10, 2022 from [https://www.mcri.edu.au/sites/default/files/media/covid\\_in\\_schools\\_report\\_final\\_10112020.pdf](https://www.mcri.edu.au/sites/default/files/media/covid_in_schools_report_final_10112020.pdf)

138 COVID-19 impact on mental health (December 8, 2021). Australian Institute of Health and Welfare. Retrieved January 10, 2022 from <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/report-contents/covid-19-impact-on-mental-health>

139 Ibid

140 Ibid

141 COVID-19 Impacting a Generation (2021). Anglicare Victoria. Retrieved January 10, 2022 from [https://www.anglicarevic.org.au/wp-content/uploads/2021/12/Anglicare\\_Victoria\\_COVID\\_Report.pdf](https://www.anglicarevic.org.au/wp-content/uploads/2021/12/Anglicare_Victoria_COVID_Report.pdf)

142 Henebery, B. (October 12, 2021). Australia launches world’s first children’s mental health and wellbeing strategy. *The Educator Australia*. Retrieved January 10, 2022 from <https://www.theeducatoronline.com/k12/news/australia-launches-worlds-first-childrens-mental-health-and-wellbeing-strategy/278918>

"Last week, the Victorian Government announced that every public secondary and specialist school in the state will now have access to vital mental health support at school following the roll out of its \$51.2m mental health initiative."<sup>143</sup>

Though the funds are surely welcomed by all schools and associated mental health services, the children and families devastated by the unproven approaches, misplaced and overreaching directives of the last two years; would much rather have not been put in the position of such dire need of support.

## 4.2 SCHOOL CLOSURES AND ISSUES WITH REMOTE LEARNING

### Government reports in nsw show there is no need to close schools

In September 2021, the 'COVID-19 Delta variant in schools and early childhood education and care services in NSW, Australia'<sup>144</sup> report showed that "most children diagnosed with COVID-19 during the current outbreak, including those who caught the infection in educational settings, experienced mild or no symptoms, with only 2% requiring hospitalisation, the latest report from the National Centre for Immunisation Research and Surveillance (NCIRS) has confirmed."<sup>145</sup>

In a 2020 NSW government report<sup>146</sup> into the "transmission of COVID-19 within NSW schools in term 1 has found no evidence that students transmit the virus to adults in the schools studied."<sup>147</sup>

"The 'COVID-19 in schools – the experience in NSW' report released today [26 April 2020] by the National Centre for Immunisation Research and Surveillance (NCIRS), studied 15 schools in NSW that recorded confirmed COVID-19 cases from March to mid-April. Of the 863 close contacts at schools with positive cases, only two contracted the virus with no evidence of students infecting teachers."<sup>148</sup>

"We know that COVID-19 has created some anxiety for parents, teachers and school staff, however the findings in this report confirm existing health advice that schools remain open and are safe for students to return."<sup>149</sup>

### Issues with remote learning

In the PwC's report<sup>150</sup> "COVID-19 and education: how Australian schools are responding and what happens next", the consultancy firm identifies some of the main challenges of remote learning in Australia, as follows:

- "reduced one-to-one engagement with teachers
- difficulty in ascertaining engagement levels of students
- restricted ability to monitor individual student progress
- increased level of oversight required from parents and carers (particularly for younger children)
- increased social isolation and reduced ability to support student wellbeing
- interruption to learning support for those children with additional needs
- differential levels of access to technology, including internet and devices, to support learning."<sup>151</sup>

A report<sup>152</sup> analysing the first lockdown in Victoria identified a number of challenges that students faced during their remote learning experience in 2020:

"Reduced face-to-face contact with at-risk students made it difficult for teachers to address ongoing welfare or educational concerns. Some students who lacked supportive family environments struggled to access learning or even log on to classes. About 10 per cent of students from disadvantaged schools were absent during the remote learning period, compared to about 4 per cent of students from advantaged schools. Absenteeism of secondary school students rose in the final two weeks of remote and flexible learning, and many teachers reported slipping student engagement as the lockdown progressed, suggesting that some students struggled to stay the course. Schools face serious difficulties in reintegrating these students into learning and school life. There is a risk that the online learning period has widened the gap between high and low-performing students."<sup>153</sup>

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143 Ibid

144 COVID-19 Delta variant in schools and early childhood education and care services in NSW, Australia, (September 8, 2021). National Centre for Immunisation Research and Surveillance. Retrieved January 10, 2022 from <https://www.ncirs.org.au/covid-19-delta-variant-schools-and-early-childhood-education-and-care-services-nsw-australia-16>

145 Ibid

146 NSW Government (2020). Report: COVID-19 in schools and the experience in NSW. Retrieved January 10, 2022 from <https://www.nsw.gov.au/news/report-covid-19-schools-and-experience-nsw>

147 Ibid

148 Ibid

149 Ibid

150 Sacks, D., Bayles, K., Taggart, A., & Noble, S. (n.d.). COVID-19 and education: how Australian schools are responding and what happens next. Retrieved January 10, 2022 from <https://www.pwc.com.au/government/government-matters/covid-19-education-how-australian-schools-are-responding.html>

151 Ibid

152 Dept of Education and Training Victoria (DET) (July 2020). The experience of remote and flexible learning in Victoria. Retrieved January 10, 2022 from <https://www.education.vic.gov.au/Documents/about/department/covid-19/experience-of-remote-and-flexible-learning-report.pdf>

153 Ibid



In a 2021 Smith Family survey<sup>154</sup>, the social workers have reported “the impact of the lockdown on Year 8 students in Victoria – these children have not had the benefit of Year 7 to adjust to the new high school environment and are having difficulties settling into their new school’s culture.”<sup>155</sup> The report also states “Years 1 and 2 in primary are also vulnerable and some Year 1 children haven’t yet learnt the expected fundamentals of reading”<sup>156</sup>.

### 4.3 PLAYGROUNDS AND THEIR CLOSURE

In this article, *Children need playgrounds now, more than ever. We can reduce COVID risk and keep them open*<sup>157</sup>, Sharon Goldfeld and Jill Sewell discuss a number of studies from around the world demonstrating the negligible risks of transmission related to parks and playgrounds against the critical value of playgrounds to children.

“It’s been a tough 18 months for Australian families and their children. We can’t underestimate the cumulative impact of parent and carer job losses, mental strain, working from home and remote learning. As developmental paediatricians we are increasingly concerned about how these have affected children’s development.....Play is vital for children. It improves their learning, as well as social and physical development. Play also encourages development of coping skills, which are critical in times of crisis....In these uncertain and restrictive times, playing outdoors also gives kids some sense of normalcy. .... Victoria closed outdoor playgrounds last week due to concerns about potential transmission. Closing playgrounds particularly impacts children living in medium- and high-density housing, with limited access to outdoor play spaces. These children tend to fall into lower-income brackets and are already more vulnerable to the effects of social isolation.....While there may be some risks to keeping playgrounds open, these must be appropriately balanced with the overwhelming benefits playgrounds have for children’s development.”<sup>158</sup>

Two of the studies discussed in the article, which evaluate transmission of SARS-CoV2 infection in relation to open spaces, are provided here:

Associations between COVID-19 transmission rates, park use, and landscape structure<sup>159</sup>:

“We first show that reducing mobility is associated with a decline in case rates, especially in areas with high population clustering. After accounting for known mechanisms behind transmission rates, we found that park use (showing a preference for park mobility) was associated with decreased residual case rates, especially when green space was low and contiguous (not patchy).”<sup>160</sup>

Getting out while staying in: Park use decreased during the COVID-19 pandemic, especially where park availability was low<sup>161</sup>:

“Park visits decreased less during the pandemic in metropolitan counties or where park availability was high. Higher park visits were weakly associated with COVID-19 case growth rate but not incidence. Thus, parks may serve as alternatives for recreation when schools and businesses close, especially where parks are available, with no-to-little influence on COVID-19 spread.”<sup>162</sup>

### 4.4 EDUCATIONAL OUTCOMES

During Victoria’s lockdowns the equity of educational outcomes, access and quality has been severely challenged, as noted by the many highly qualified commentators. The Victorian government has announced two rounds<sup>163 164</sup> of funding for intensive tutoring to support students who may have fallen behind.

It is reasonable to assume that the government concedes our children’s education has been undermined, along with the announcements of funding for youth mental health programs that well-being and resilience has been demonstrated to have been adversely affected by the measures taken. Despite throwing money at the problems there seems to be little or no discussion of the depth of the problems in Victoria or acknowledge the causes.

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154 Emerging from COVID-19: Insights Snapshot (May 2021). The Smith Family. Retrieved January 10, 2022 from [https://www.thesmithfamily.com.au/-/media/files/about-us/media/the-smith-family\\_insights-snapshot\\_may-2021.pdf](https://www.thesmithfamily.com.au/-/media/files/about-us/media/the-smith-family_insights-snapshot_may-2021.pdf)

155 Ibid

156 Ibid

157 Goldfeld, S. and Sewell, J. (August 24, 2021). Children need playgrounds now, more than ever. We can reduce COVID risk and keep them open. The Conversation. Retrieved January 10, 2022 from <https://theconversation.com/children-need-playgrounds-now-more-than-ever-we-can-reduce-covid-risk-and-keep-them-open-166562>

158 Ibid

159 Johnson TF, Hordley LA, Greenwell MP, Evans LC. Associations between COVID-19 transmission rates, park use, and landscape structure. *Sci Total Environ*. 2021 Oct. Retrieved January 10, 2022 from <https://pubmed.ncbi.nlm.nih.gov/34210524/>

160 Ibid

161 Curtis, DS., Rigolon, A., Schmalz, DL. & Brown, B. (2020). Getting out while staying in: Park use decreased during the COVID-19 pandemic, especially where park availability was low. Center for Open Science. Retrieved January 10, 2022 from <https://ideas.repec.org/p/osf/socarx/9x-zgf.html>

162 Ibid

163 Dept of Education and Training Victoria (DET) (November 15, 2021). Tutor Learning Initiative. Retrieved January 10, 2022 from <https://www2.education.vic.gov.au/pal/tutor-learning-initiative/policy>

164 Dept of Education and Training Victoria (DET) (2021) Tutor learning initiative in 2022: information for prospective tutors. Retrieved January 10, 2022 from <https://www.education.vic.gov.au/about/careers/teacher/Pages/tutors.aspx>

Other researchers have conducted studies to quantify the outcomes of lockdown measures on their populations. This study<sup>165</sup> undertaken in the Netherlands showing a measurable decline in student outcomes while learning from home:

“School closures have been a common tool in the battle against COVID-19. Yet, their costs and benefits remain insufficiently known. We use a natural experiment that occurred as national examinations in The Netherlands took place before and after lockdown to evaluate the impact of school closures on students’ learning. The Netherlands is interesting as a “best-case” scenario, with a short lockdown, equitable school funding, and world-leading rates of broadband access. Despite favorable conditions, we find that students made little or no progress while learning from home. Learning loss was most pronounced among students from disadvantaged homes.”<sup>166</sup>

This study<sup>167</sup>, also from the Netherlands, quantified the loss of progress due to a short lockdown, and demonstrated that the loss in educational outcomes extending well beyond the lockdown period.

*Learning Loss in Vulnerable Student Populations After the First Covid-19 School Closure in the Netherlands:*

“This study was conducted among 886 Grade 3 - 5 students in the Netherlands in schools serving a high percentage of students from disadvantaged backgrounds. Piecewise growth analyses indicated that the school closures caused discontinuity in students’ achievement growth on national standardized tests and led to an average learning loss of 2.47 months in mathematics and 2.35 in reading comprehension, exceeding the duration of the school closure. Findings suggest that school closures contribute to educational inequality and indicate which students may particularly need additional support to overcome the adverse consequences of the lockdowns.”<sup>168</sup>

The Grattan institute In Australia undertook a study<sup>169</sup> in June 2020 on the effect of lockdowns on student populations and came to similar conclusions.

“There is good reason to send children to school. Students tend to learn less when they are not in regular class, and new data from Australian teachers show this is likely to have been the case during the COVID-19 lockdowns. In one survey of more than 5,000 teachers in NSW, only 35 per cent were confident their students were learning well in remote learning. In disadvantaged schools, only 15 per cent of teachers felt assured of student progress. Many disadvantaged students, who were already falling behind before the crisis, will have slipped further back. We find the achievement gap widens at triple the rate in remote schooling compared to regular class. Even if remote learning was working well, disadvantaged students are likely to have learnt at about 50 per cent of their regular rate, losing about a month of learning over a two-month lockdown.”<sup>170</sup>

## 4.5 VULNERABLE CHILDREN

The impact of the virus on children has been shown to be far less than that of the measures undertaken to control it. In the subsequent article the researchers identified, especially for vulnerable children, that the pandemic measures negatively impacted all areas of their health. For this cohort, even more than other children, the pandemic measures proved to be far more detrimental than the virus and may continue to affect them far into the future.

*COVID-19 pandemic: The impact on vulnerable children and young people in Australia*<sup>171</sup>

“The COVID-19 pandemic and associated system disruptions are impacting all children and young people (CYP) in Australia. For vulnerable groups of CYP, who already experience poorer health and well-being, these impacts are amplified. Challenges include reduced access to usual services, reduced community supports, financial instability, unemployment and other life circumstances that threaten to widen pre-existing inequities. This article aims to present the reasons for vulnerability of CYP during the pandemic, and to focus on actions by health professionals that mitigate additional challenges to their health and well-being. Using a rapid review of the literature and team-based discussions, eight vulnerable groups were identified. CYP with:

- disabilities, mental health conditions and chronic diseases;
- facing financial hardship;
- within the child protection system;
- Aboriginal;
- migrant and refugee;
- in residential care;
- rural; and
- isolated.”<sup>172</sup>

165 Engzell, P., Frey, A., & Verhagen, M. (April 27, 2021). Learning loss due to school closures during the COVID-19 pandemic. US National Library of Medicine National Institutes of Health. Retrieved January 10, 2022 from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8092566/>

166 Ibid

167 Schuurman, T., Henrichs, L., Schuurman, N., Polderdijk, S., Hornstra, L. (December 10, 2021). Learning Loss in Vulnerable Student Populations After the First Covid-19 School Closure in the Netherlands. Scandinavian Journal of Educational Research. Retrieved January 10, 2022 from [https://www.researchgate.net/publication/356952943\\_Learning\\_Loss\\_in\\_Vulnerable\\_Student\\_Populations\\_After\\_the\\_First\\_Covid-19\\_School\\_Closure\\_in\\_the\\_Netherlands](https://www.researchgate.net/publication/356952943_Learning_Loss_in_Vulnerable_Student_Populations_After_the_First_Covid-19_School_Closure_in_the_Netherlands)

168 Ibid

169 Sonnemann, J. & Goss, P. (June 2020). COVID catch-up: helping disadvantaged students close the equity gap. Grattan Institute. Retrieved January 10, 2022 from <https://grattan.edu.au/wp-content/uploads/2020/06/COVID-Catch-up-Grattan-School-Education-Report.pdf>

170 Ibid

171 Jones B, Woolfenden S, Pengilly S, Breen C, Cohn R, Biviano L, Johns A, Worth A, Lamb R, Lingam R, Silove N, Marks S, Tzioumi D, Zwi K. (December 2020). COVID-19 pandemic: The impact on vulnerable children and young people in Australia. J Paediatr Child Health. Retrieved January 10, 2022 from <https://pubmed.ncbi.nlm.nih.gov/32931623/>

172 Ibid



“Recommendations for action are required at the level of governments, health professionals and researchers and include enhancing access to health and social supports, prioritising vulnerable CYP in resuming health activity and elevating the voice of CYP in designing the response. The pandemic can be conceptualised as an opportunity to create a more equitable society as we document the inequities that have been exacerbated. Vulnerable groups of CYP must be recognised and heard and targeted actions must focus on improving their health outcomes during the pandemic and beyond.”<sup>173</sup>

As discussed earlier, an independent report<sup>174</sup> on remote learning, identified the difficulties and made recommendations for support, an intensive tutoring and support program was implemented. Not without challenges and as usual the better resourced schools did better out of the assistance made available and the poorer resourced schools, which also cater for the greater number of vulnerable CYP struggle to implement the programs despite carrying the greater load.

The Grattan Institute<sup>175</sup>, on the announcement of a second round of funding for intensive tutoring, critiqued this very inconsistency:

“But announcements are easy. Implementation is the hard part. And there is a lot riding on Victoria’s second round of intensive tutoring.”<sup>176</sup>

Expanding that

“Not all students “lose” learning during lockdowns, but some students struggle significantly and will have fallen well behind their peers. We still don’t know the full impact of disrupted schooling on disadvantaged students, but evidence is mounting overseas that remote schooling has especially harmed learning for students who were already behind when the pandemic hit. Tutoring is the best shot we have to help these children catch up.”<sup>177</sup>

How can we ensure that the funding gets to where it is intended?

“Some schools need more support to design and deliver the tutoring initiative effectively – supporting these schools is essential to ensure equitable outcomes for students.”<sup>178</sup>

“Tutoring should also be better directed at the schools and students who need it most, including schools in poorer parts of our communities, students in secondary school who are at risk of disengaging, and students in the early primary years – prep and grades 1 and 2 – who may have found it especially hard to engage with online learning.”<sup>179</sup>

The authors also caution that we take a holistic approach and do not ‘rob Peter to pay Paul’ as we balance the budget according to the needs.

“Importantly, the new investments in tutoring in 2022 must not come at the expense of other new investments designed to improve student well-being and mental health. Several studies have confirmed that lockdowns have exacerbated mental health problems for many children, especially teenagers.”<sup>180</sup>

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173 Ibid

174 See note 115

175 Sonnemann, J. & Hunter, J. (October 5, 2021). Learning the lessons from the long school lockdowns. Grattan Institute. Retrieved January 10, 2022 from <https://grattan.edu.au/news/learning-the-lessons-from-the-long-school-lockdowns/>

176 Ibid

177 Ibid

178 Ibid

179 Ibid

180 Ibid

## Table of figures

Figure 1: Covid-19 statistics in Australia, as of January 2, 2022

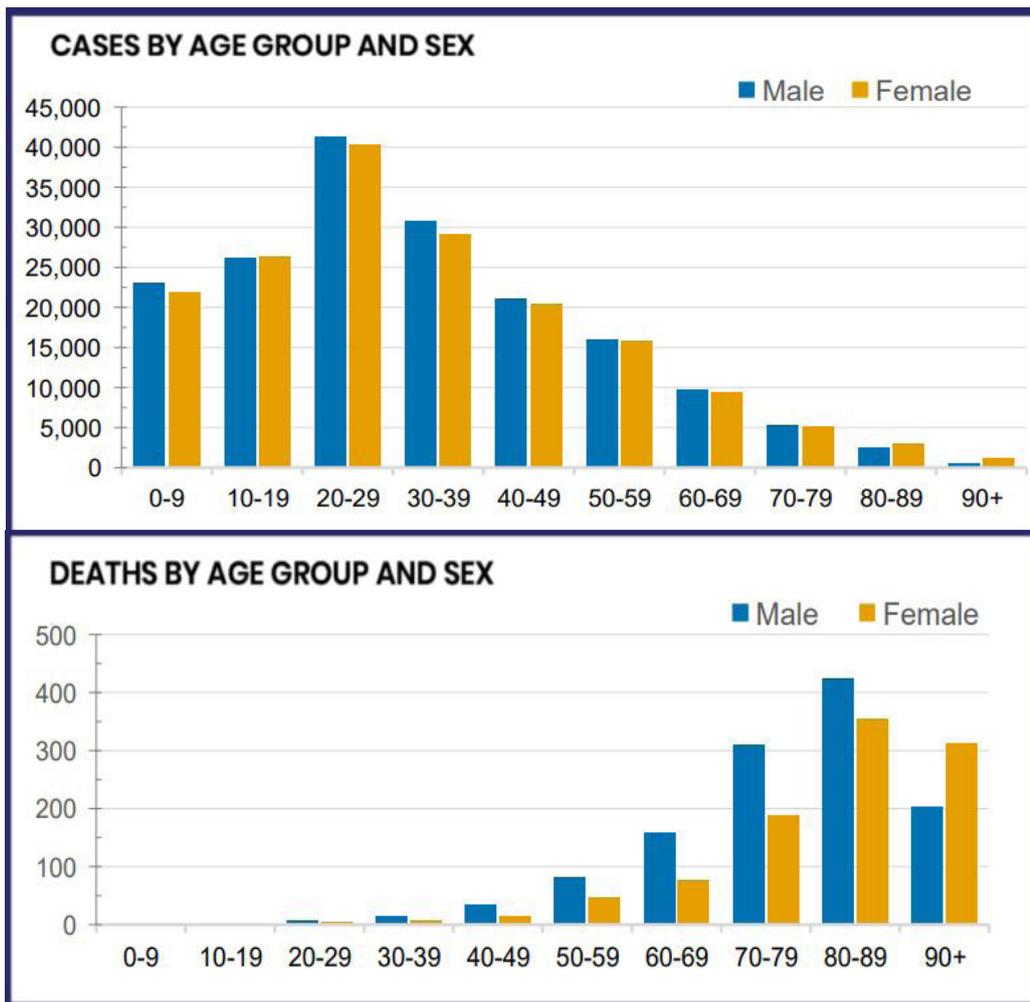
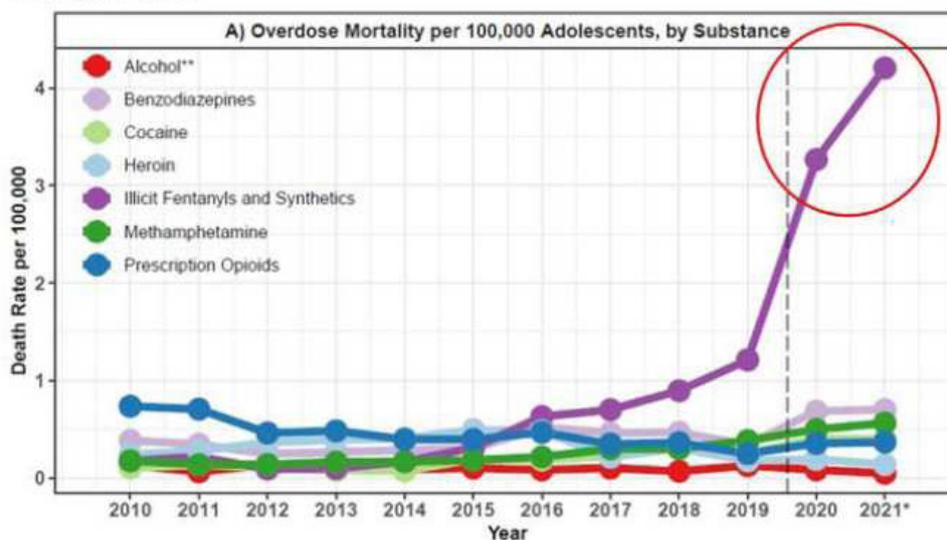


Figure 2. Drug overdose deaths in United States of America (see note 98)

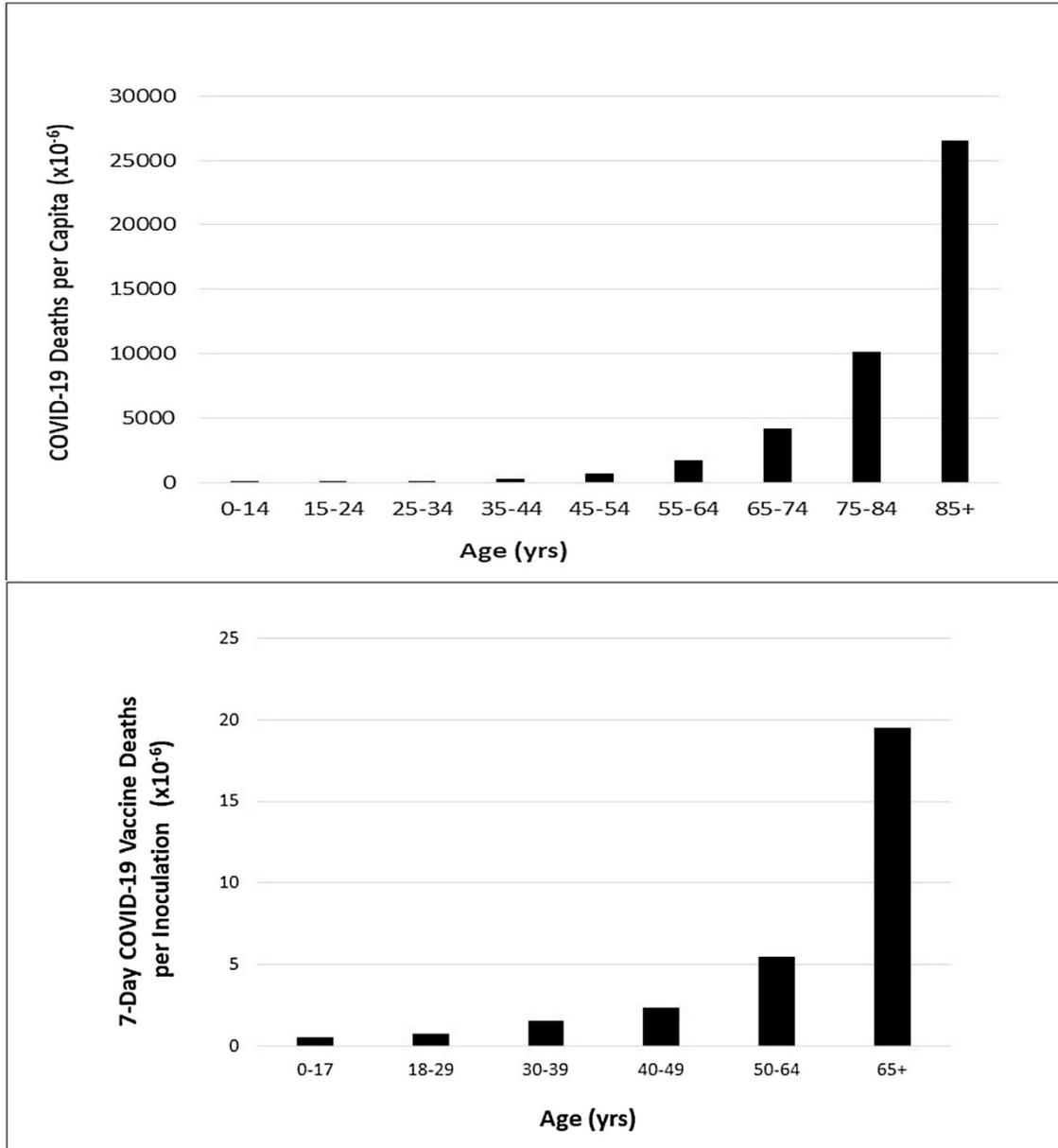
Sharp Increases in Drug Overdose Deaths Among High-School-Age Adolescents During the US COVID-19 Epidemic and Illicit Fentanyl Crisis

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**Figure 3.** Covid-19 statistics in United States of America as of January 1, 2022



## Questions to the Principal

Schools and school staff owe a duty of care to their students which cannot be abrogated simply because the school is complying with pandemic measures dictated by the Government. If your child's School Principal cannot provide satisfactory answers to the questions below, they may be disregarding their duty of care.

### Mask wearing in children

1. Can you conclusively demonstrate that masks are safe and effective?
2. Are you aware of the potential risks of masking children, both physical and psychological? How are those risks being mitigated in practical terms at your school?
3. Do you have a management plan for implementing and monitoring the correct use of masks as per WHO recommendations? Are you aware of the circumstances in which a child may have a legitimate mask exemption? For example asthma, trauma, anxiety, etc?
4. Have you implemented policies and staff training to ensure that children with mask exemptions are not bullied, discriminated against or asked about their private medical circumstances?
5. Are students being educated on correct/safe mask usage and made to feel comfortable about those not wearing masks and letting staff know if they are struggling with wearing a mask?
6. Can you ensure all staff are trained to identify the signs of ill effects or distress from mask-wearing?

### Vaccinating Children

#### If Covid19 vaccinations are to be administered to pupils in your school:

1. Are you aware that the World Health Organisation doesn't recommend children under 12 years old to get the Pfizer (Comirnaty) vaccine?
2. Are you aware Covid19 vaccinations for children are experimental, still in clinical trials and have only been provisionally approved by the TGA?
3. Are you aware that there are legal and ethical requirements for recruiting participants for human research trials?
4. Given that informed consent is required for administering vaccinations how do you intend to manage the process of obtaining appropriate legal consent?
5. Schools have explicit policies in relation to topics which teachers are authorised to discuss with students. Are you applying these policies to ensure that staff do not raise discussions around private medical information of any nature? (e.g. vaccinations, exemptions, consent etc).
6. How will you ensure that policies around bullying and inclusion are followed as intended in relation to vaccination status and that staff do not attempt to influence, frighten or pressure students?
7. Have you and your staff received appropriate training in order to effectively identify adverse reaction symptoms, and provide timely and appropriate response to children in your care, post Covid19 vaccination?

### Lockdowns, school closures and segregation

1. What policies is the School implementing to minimise the impact of lockdowns and school closures on its pupils?
2. Are you aware of the studies showing that lockdowns and school closures are of limited benefit? Do you support the continued use of these measures?
3. There are studies which are showing that children are already behind in mental and psychosocial development due to the lockdowns and other segregations measures endured to date. What measures are you putting into place to advocate for the best educational, social and mental wellbeing of your students?

### Legal Obligations

1. Do you understand the application of the Pandemic Orders and have resources/systems for keeping up to date with and verifying the ever-changing requirements?
2. Are you equipped to explain the directives you are enforcing and their basis to parents and carers?
3. Are you aware that not all of the Department of Education and Training (DET) guidelines have been backed by lawful directions / Pandemic Orders in the past? Are you relying completely on the DET for guidance or are you undertaking your own due diligence as to the legal requirements?
4. How is the School ensuring compliance with its duty of care in the face of the novel, constantly changing and often unsubstantiated Pandemic Orders to the extent they impact children in the School's care?



## Disclaimers

### Medical disclaimer

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