

Dirty Air Is Not a Grey Area: The Legal Duty to Ventilate Schools and Hospitals

The absence of specific standards for indoor air quality has long been used as an excuse for the indifference to effective ventilation of Australian schools and healthcare facilities. NSW solicitor Peter Vogel explains how new regulatory frameworks and codes of practice make it clear that even without unambiguous standards, safe indoor air is a non-negotiable legal obligation and the consequences for non-compliance reach all the way to individual principals, executives, and clinicians.

The Myth of the Optional Standard

When a school principal is asked whether classrooms are adequately ventilated, the typical answer involves pointing to windows which may or may not be opened. When a hospital administrator is asked the same question, the answer usually involves HVAC schematics from the original construction project. In almost every case, the follow-up question – 'but have you actually measured the air?' – is met with silence.

That silence may soon become very costly. The absence of a clear, consolidated ventilation standard does not grant school or healthcare facility operators the freedom to define 'safe air' for themselves. Adequate ventilation is a mandatory legal obligation under the Work Health and Safety Act 2011 (NSW) – not aspirational best practice, not a post-pandemic afterthought, and not something that can be discharged by pointing at open windows.

The primary source of this obligation is WHS Regulation 2017 (NSW), cl.40(e), which requires that any person “conducting a business or undertaking (PCBU) must ensure ventilation enables workers to carry out work without risk to health and safety.” The WHS Act's primary duty of care applies to workers or 'other persons' at the workplace – meaning students in classrooms and patients in waiting rooms are just as legally protected as the teachers and nurses who serve them.

The critical wording in the regulation is “must ensure.” Not “consider”, not “endeavour”. The word “must” carries enormous legal weight, and it is what transforms ventilation from a facility management issue into a compliance imperative.

(Note that although at times I refer specifically to NSW WHS laws, much the same rules apply across Australia.)

Every Classroom Is a Workplace – and a High-Risk One

Schools occupy an unusual position in Australian workplace law. Every operator – government department, Catholic diocese, independent school trust, or private company – is a PCBU. Every classroom, library, staffroom, and administration office is a workplace within the meaning of WHS Act s.8. Every child in those rooms is an “other person at the workplace” whose safety the PCBU is legally obliged to protect.

The new *Safe Work Australia Model Code of Practice: Managing the Risks of Biological Hazards at Work* (March 2026) explicitly identifies airborne respiratory pathogens as foreseeable biological

hazards in workplace settings. It singles out schools as environments carrying an elevated risk of communicable disease, noting that teachers face occupational risk from exposure to illnesses like whooping cough carried by children. Classrooms, the code observes, are characterised by high occupancy density, extended duration of occupation, close physical proximity, and populations that frequently cough and sneeze, the perfect storm for spreading airborne germs.

The *Safe Work Australia Model Code of Practice: Managing the Work Environment and Facilities* (“Facilities CoP” December 2025) reinforces these obligations in s.2.7 “Ventilation: Workplaces must be ventilated to allow work to be carried out without risk to health and safety.” While the Biological Hazards Code addresses airborne pathogens as a specific category of risk, the Facilities CoP establishes the baseline duty to provide and maintain adequate ventilation as a feature of the physical workplace itself — applicable to every PCBU, in every setting, at all times. It covers ventilation alongside lighting, temperature, and workspace design as mandatory elements of a safe work environment.

Taken together, the two codes form an interlocking framework: the Facilities CoP establishes that ventilation is obligatory but says little about what adequate ventilation means in a school or healthcare setting. The Biological Hazards CoP is what gives the obligation teeth — it names the hazard, establishes foreseeability, and triggers the full risk management framework. Together they create a complete legal argument; separately, the Work Environment CoP alone leaves too many escape routes for an operator who wants to do the minimum.

The practical implication is that the hazard – airborne disease – is not speculative. It is foreseeable. That foreseeability triggers the full weight of the WHS risk management framework: identify the hazard, assess the risk, implement controls, measure their effectiveness, and continuously review. And the hierarchy of controls places ventilation – an engineering control – above hand hygiene and masks.

There is a troubling gap between what schools currently do and what they are legally required to do. In January 2022, the Secretary of the NSW Department of Education announced that they had “checked the airflow” in every classroom and “We know that there is adequate airflow that meets the World Health Organisation standards in every single classroom”. I obtained documents under the GIPA Act which showed that “checked the airflow” meant that the windows and doors of classrooms had been measured to confirm that the window and door area met the National Construction Code’s (NCC) requirement. Unfortunately, the NCC’s window ventilation provisions were designed to control humidity in bathrooms and laundries – not to prevent airborne disease transmission. The code does not take into account the number of people in a room. A classroom full of children obviously requires far more ventilation than a home living room and only mechanical ventilation can provide this reliably. Compliance with the NCC may actually be evidence that a workplace is failing to meet its WHS obligations and should never be accepted as evidence that a public building is ventilated to be “as safe as reasonably practicable” as required by law.

Safe Work Australia guidance on indoor workplaces establishes that CO₂ levels consistently below 800 parts per million (ppm) indicate a likely well-ventilated space; 800-1500 ppm signals a problem; and above 1500 ppm requires immediate action. CO₂ is a very cost-effective proxy for ventilation adequacy, with monitors costing between \$100 and \$500 each. A school that has not deployed CO₂ monitoring in its classrooms has not assessed the risk. A school that has deployed monitors and found levels above 800 ppm, but taken no corrective action, is in clear breach of WHS laws.

Healthcare Facilities: A Uniquely Elevated Duty

If the obligations on school operators are demanding, those on healthcare facility operators are substantially more so. Hospitals and clinics operate against a backdrop of immunocompromised patients, aerosol-generating procedures, and healthcare-associated infections (HAIs). Through persistent freedom of information processes, I uncovered data showing that during 2023 an average of two Australians died every day from COVID-19 caught in hospital. Inadequate ventilation is a recognised contributing factor to HAIs, and the regulatory and accreditation framework governing healthcare ventilation reflects that elevated risk profile.

The *Australasian Health Facility Guidelines (AusHFG)* establishes mandatory air change per hour (ACH) requirements for every room type. Standard patient rooms require a minimum of 6 ACH to manage aerosols generated just by breathing. Rooms used for procedures which generate elevated levels of aerosols – bronchoscopy, intubation, CPR, sputum induction – require a minimum of 12 ACH with negative pressure and exhaust to the outside. Operating theatres require 20 or more ACH with HEPA filtration. AusHFG also says that where no guidance is given, international guidance should be followed “e.g., American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) 170:2021. Ideally, and where appropriate, this should be augmented with ASHRAE 241:2023 or similar.” ASHRAE 241 is an excellent standard developed specifically to target airborne infection – it specifies minimum rates of clean air per person and requires an option to switch ventilation to a much higher rate during public health emergencies. Although these are described as standards for new builds or renovations, the WHS Act requires the PCBU to do everything reasonably practicable to minimise airborne infection risk in any existing facility and the AusHFG sets the benchmark for what is 'reasonably practicable'.

AusHFG makes a particularly pointed observation about split-system air conditioners. Split systems recirculate room air and do not introduce fresh air or remove dirty air. They only filter dust, as they do not have the HEPA filters necessary for catching pathogen-bearing aerosols. A facility that installs split systems in patient care areas is failing to implement a reasonably practicable engineering control for a known biological hazard. AusHFG Part D states explicitly that their use 'should be avoided' in patient care areas – yet they are commonly used in hospitals and aged care facilities as a cheap local cooling solution.

All Australian States and Territories have Coroners Acts which require any death which was an unexpected outcome of a medical procedure to be reported. When someone dies from an HAI, the service provider must either admit that the death was not unusual or report it.

The multi-regulator exposure facing healthcare operators is substantial. Non-compliance with ventilation obligations may simultaneously trigger enforcement by SafeWork NSW, non-conformance findings under National Safety and Quality Health Service (NSQHS) Standards accreditation, regulatory action under the Health Services Act 1997, professional conduct investigations by AHPRA against individual clinicians, civil negligence claims, and – where patients die from ventilation-linked HAIs – coronial investigations.

Individual Liability: No One Gets to Delegate Ignorance

Both the WHS Act's officer duty (s.27) and its broader framework of concurrent duties mean that institutional liability does not shield individuals from personal consequences.

A school principal who makes decisions affecting the whole operation of a school is likely an 'officer' within the meaning of the WHS Act. As an officer, the principal carries a personal, non-delegable due diligence duty – to acquire and keep up-to-date knowledge of WHS matters, to understand the hazards in their specific environment, to ensure resources are in place to manage those hazards, and to verify – not merely assume – that the relevant systems are functioning. A principal who has never measured CO₂ levels, holds no ventilation maintenance records, and has taken no steps to assess airborne infection risk cannot demonstrate due diligence. Ignorance is not a defence.

The same logic applies to hospital executives. A CEO, Chief Nursing Officer, or Director of Clinical Operations who is unaware of AusHFG Part D's ACH requirements, does not know what air changes their isolation rooms deliver, or has never seen a HEPA filter maintenance record, cannot claim to have exercised due diligence under s.27. The personal nature of the officer duty is precisely designed to prevent compliance failures from being absorbed into organisational buck-passing.

Health and Safety Representatives (HSRs) occupy a strategically important role in this framework. An HSR who raises ventilation concerns formally in writing, is ignored by the operator, and then issues a Provisional Improvement Notice creates a documentary record that significantly strengthens any subsequent enforcement action or civil claim. Failure of a governing body to fund a ventilation upgrade does not absolve the officer – it requires escalation, documentation, interim controls, and a paper trail demonstrating that every available avenue was pursued.

Private Operators and the Consumer Law Dimension

For private schools and private providers of health or aged care, the obligations extend beyond WHS law into the Australian Consumer Law (ACL). The consumer guarantees in the ACL – that services will be rendered with due care and skill (s.60) and will be fit for the purpose for which they are commonly supplied (s.61) – apply continuously from the moment services commence. They are not activated only when a consumer is harmed.

This has an important practical implication: an operator who is aware of a risk of airborne disease transmission on their premises and fails to take reasonable steps to address it is already in breach of the ACL consumer guarantees – even if no student or patient has yet fallen ill.

Furthermore, representations made about safety, hygiene, or infection control standards – in marketing materials, on websites, or in enrolment and admissions documents – must be accurate and capable of substantiation. A private school that advertises its commitment to student wellbeing while operating classrooms with consistently excessive CO₂ levels may be exposed not only to consumer guarantee claims but to allegations of misleading or deceptive conduct under ACL s.18.

This pathway for enforcement has yet to be tested, mainly because the lack of clear standards has made it unclear what the legal test for “due care and skill” might be, or whether the lack of reliable clean air would amount to misleading conduct given safe classrooms were promised. Were I arguing such a claim before a judge, I would point to the SafeWork Codes of Practice and the AusHFG as benchmarks for what consumers should expect as a minimum standard of indoor air safety.

Unlike WHS enforcement, which can only be initiated by the regulator (Safe Work), any consumer can bring proceedings directly for a breach of a consumer guarantee. Consumer tribunals are

designed to be accessible and low-cost. The corporate structure of many private operators does not provide an effective shield: the ACL allows claims to be brought against all persons involved in the contravention, including individuals.

Remedies under the ACL include damages (payment of money to compensate for the breach) or orders that the supplier of the service "remedy the failure within a reasonable time."

Injunctions

Another avenue available to members of the public is a rarely-used legal remedy of a "quia timet" injunction. "Quia timet" is Latin for "because he fears" and such an injunction is a pre-emptive court order issued before any harm has actually occurred. It is used to stop a defendant from taking an action – or to force them to fix a hazard – when there is a strong probability of "grave and irreparable" damage. Unlike a standard injunction, it focuses entirely on prevention rather than stopping an ongoing injury.

In a landmark case in 2021, *Sharma v Minister for the Environment*, eight teenagers and an elderly nun applied for an injunction to stop the Minister approving an extension to a coal mine because it would worsen climate change. Although the case was ultimately lost on appeal, it confirmed that a court can recognise a novel duty of care to prevent future harm. Applying this logic to a workplace setting, a quia timet injunction could be used to force a PCBU to provide safe ventilation if a plaintiff can demonstrate a "strong probability" of grave damage to health arising from the PCBU's current inaction. While the Sharma applicants failed because the court found the link between a single mine's approval and global climatic injury was too remote, a ventilation issue presents a much more direct causal link. The court could grant a mandatory injunction requiring the PCBU to install or upgrade mechanical ventilation systems or an injunction prohibiting large gatherings in poorly ventilated spaces.

What Compliance Actually Looks Like

The law requires both school and healthcare operators to identify the hazard, measure the baseline, implement engineering controls, monitor outcomes, keep records, and verify – repeatedly and personally – that the systems are working.

For schools, that means CO₂ monitors in every classroom, effective mechanical ventilation, regular review of ventilation performance, documented responses to poor air quality, and a principal who is fully informed about their WHS duties. For healthcare facilities, it means room-by-room ACH verification, HEPA filter certifications, pressure testing of isolation rooms, removal of split systems from patient care areas, and executives who can answer detailed questions about ventilation performance without calling a contractor first.

These obligations are not new. What has changed is the regulatory and evidentiary landscape. With updated Codes of Practice now published, with the AusHFG incorporated into mandatory accreditation standards, and with the Australian Consumer Law operating in parallel, the cost of treating ventilation as optional has become very high – and the excuses for not measuring it have become very thin.

This article is for general information purposes only and does not constitute legal advice.

Peter Vogel, 27th March 2026