Children's Health Defense

AUSTRALIA CHAPTER

Senate Community Affairs References Committee 17 May 2024

Committee Secretary

Via email: community.affairs.sen@aph.gov.au

TO

Chair

Senator Penny Allman-Payne

Deputy Chair

Senator Marielle Smith

Members

Senator Wendy Askew

Senator Hollie Hughes

Senator Maria Kovacic

Senator Louise Pratt

Terms of Reference

An Inquiry into Excess Mortality

With particular reference to:

(a) Australian Bureau of Statistics (ABS) data showing excess deaths in recent years, with particular reference to:

(i) all-cause provisional mortality data reported by the states and territories to the ABS, and

(ii) the difference between all-cause provisional mortality data for 2021, 2022 and 2023 and the preceding years of 2015 to 2020 (inclusive);

(b) factors contributing to excess mortality in 2021, 2022 and 2023;

(c) recommendations on how to address any identified preventable drivers of excess mortality; and

(d) any other related matter.

Dear Senators,

To inform the Committee with its inquiry into Excess Mortality with particular reference to the Covid years during which novel and little known drug substances were introduced to the Australia community *en masse*, please accept the expert opinions of Children's Health Defense (Australia) Chairwoman Professor Robyn Cosford and fellow Director Dr Astrid Lefringhausen.

In brief, both Professor Cosford and Dr Lefringhausen have employed the Bradford Hill criteria for causality assessment established in 1965 which is used across the sciences, to conclude the Excess Mortality suffered by Australians in recent years has occurred as a consequence of the novel drug substances introduced into the Australian community in 2021, as purported vaccines against SARS-CoV-2.

These determinations conclude the recent Excess Mortality suffered across Australia has been as a result of an iatrogenic event arising from the same novel drug substances introduced by the Commonwealth Government of Australia.

Yours sincerely,

Children's Health Defense

Australia

First Response

By Professor Robyn Cosford MBBS(Hons), FACNEM, Chairwoman, Children's Health Defense, Australia.

EXCESS MORTALITY, CHANGING DISEASE PATTERNS, CHRONIC INFLAMMATION AND COVID VACCINATIONS: IS THERE A LINK?

It is now well accepted that Australia and indeed most of the Western world, is experiencing excess mortality commencing in 2021 and further continuing for the years 2022 and 2023. While much of this in Australia has been attributed to deaths from Covid, the vast majority of those deaths have occurred in people with underlying co-morbidities, a particular pattern of diseases which themselves have increased significantly in that same time frame and are themselves responsible for increased deaths. The temporal association of these diseases with the rollout of COVID -19 vaccinations, and correlation of peaks in deaths (in a consistent delayed pattern) with peaks in vaccine dosing has been previously noted. A closer examination of the biological plausibility of these associations reveals a consistent underlying feature of immune dysfunction, microvascular dysfunction and chronic inflammation which has been well documented to occur post COVID-19 vaccination. These associations fit the `Bradford Hill criteria' for establishing causation.

TOTAL MORTALITY

Excess mortality has been noted in Australia commencing in mid-2021. An initial peak in January 2022 was followed by further increases in May through to August 2022 including a peak in July 2022, and again in May through to July 2023 and continuing above the baseline to the end of 2023.

In raw Australian Bureau of Statistics figures, for 2020, 162,751 deaths were recorded; for 2021 172,138, which is 9,387 above 2020 deaths ; for 2022 191,387, which is 28,636 above 2020 deaths and for 2023 182,038, which is 19,287 above 2020 deaths , giving a total of

57,310 additional deaths for the years 2021- 2023, compared to if deaths had occurred at the same rate as in 2020. (Figure 1).

Number of deaths by month of occurrence, 2020-23

	2020	2021	2022	2023
January	12,999	13,370	16,275	14,811
February	12,513	12,028	14,093	13,019
March	13,549	13,629	14,748	14,832
April	13,301	13,581	14,864	14,732
May	14,027	15,044	16,493	16,618
June	13,270	14,883	17,182	16,110
July	14,482	15,916	18,329	16,577
August	14,862	15,417	17,765	15,972
September	13,696	14,775	15,783	14,867
October	13,439	14,996	15,357	14,948
November	13,040	14,052	14,802	14,757
December	13,513	14,447	15,696	14,795

a. Doctor certified and coroner-referred deaths are included.
b. Data is by date of occurrence.

Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan - Dec 2023

Figure 1: Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan - Dec 2023

As illustrated in the graph below, (Figure 2) there is a typical seasonal peak in mortality over the winter months, seen also in 2020. However the peak seen in January for the years 2022 and 2023 is atypical, indicating factors other than seasonality influencing the figures. Of particular note, the peak mortality seen in July 2022 (18,329 deaths) is far above the deaths documented for July 2020 (14, 482).

Figure 2: Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan - Dec 2023

In the ABS analyses to compare this raw data to previous averages, it is interesting to note that 2020 figures are excluded as it was a year with 'lower than expected' mortality, thus artificially inflating the baseline average such that the excess is not as great as would otherwise be. When compared to stated baseline norms, the markedly different pattern of mortality is apparent to the naked eye without statistical analysis which I leave to those far more qualified in that area. Again, the expected seasonal winter peak is apparent, but excess mortality beyond the winter season is also evident, with a marked nonseasonal increase noted in January of 2022 and again in December of 2022.

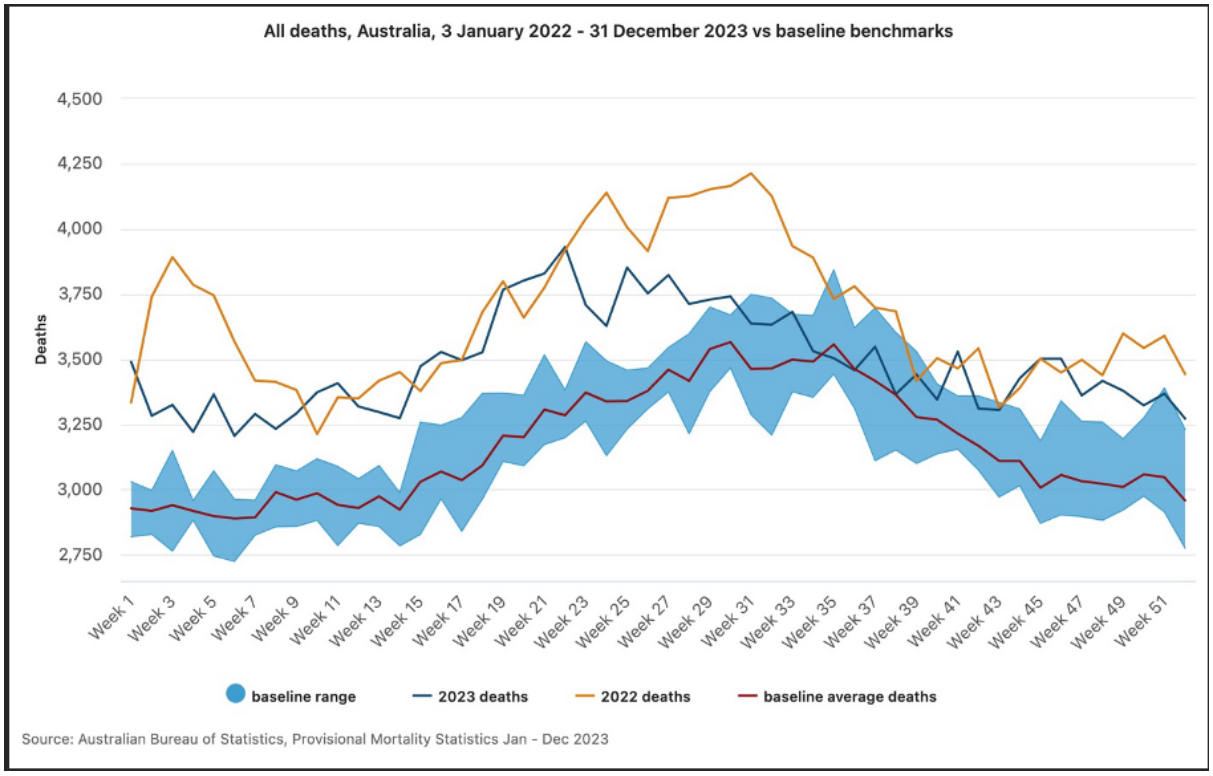


Figure 3: Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan-Dec 2023.

As illustrated in the graph below, mortality rates in 2020 were consistent with the downward trend from 1973. Then there is a visible uptick in mortality in 2021 and ongoing.(Figure 4)

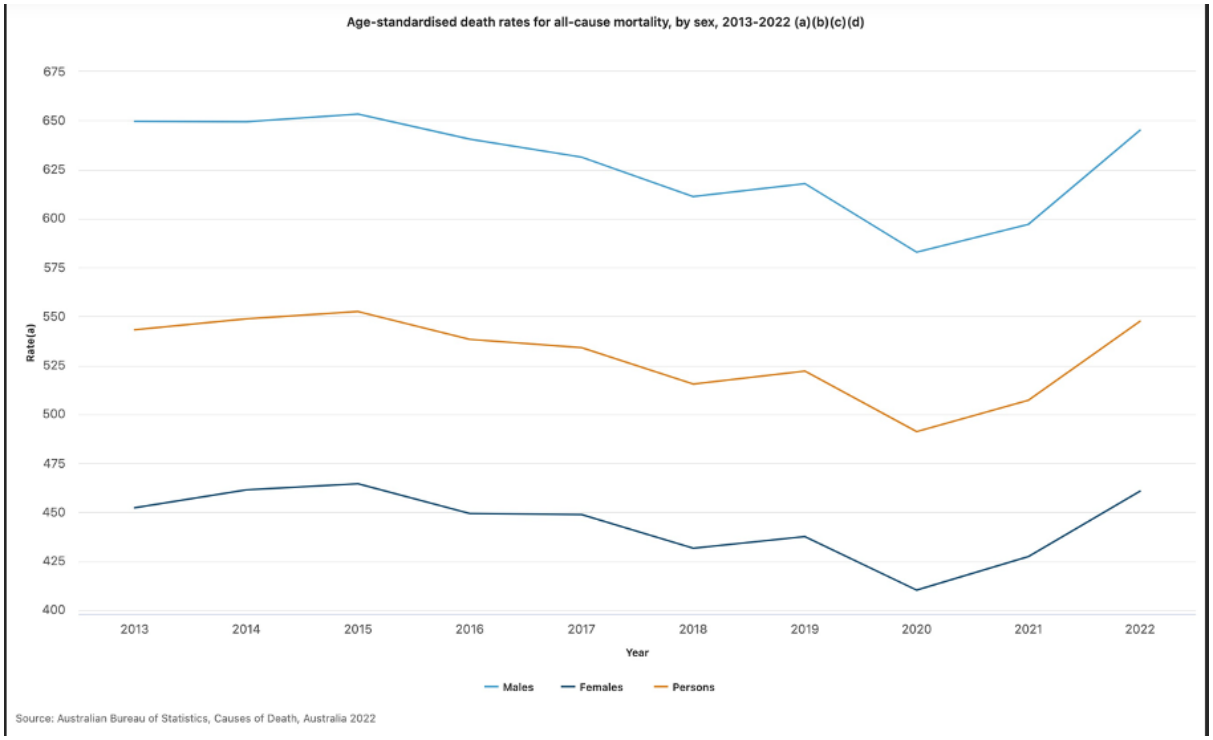


Figure 4: Source Australian Bureau of Statistics. Causes of Death , Australia 2022.

The downward trend in mortality in recent decades is even more apparent in this graph below, (Figure 5)in which the 2020 mortality rates are entirely consistent with that ongoing downward trend. The uptick in mortality in 2021 and 2022 is clearly apparent without statistical analysis.

This change in trend in total mortality in 2021 and 2022 is seen across all jurisdictions in Australia (Figure 5)

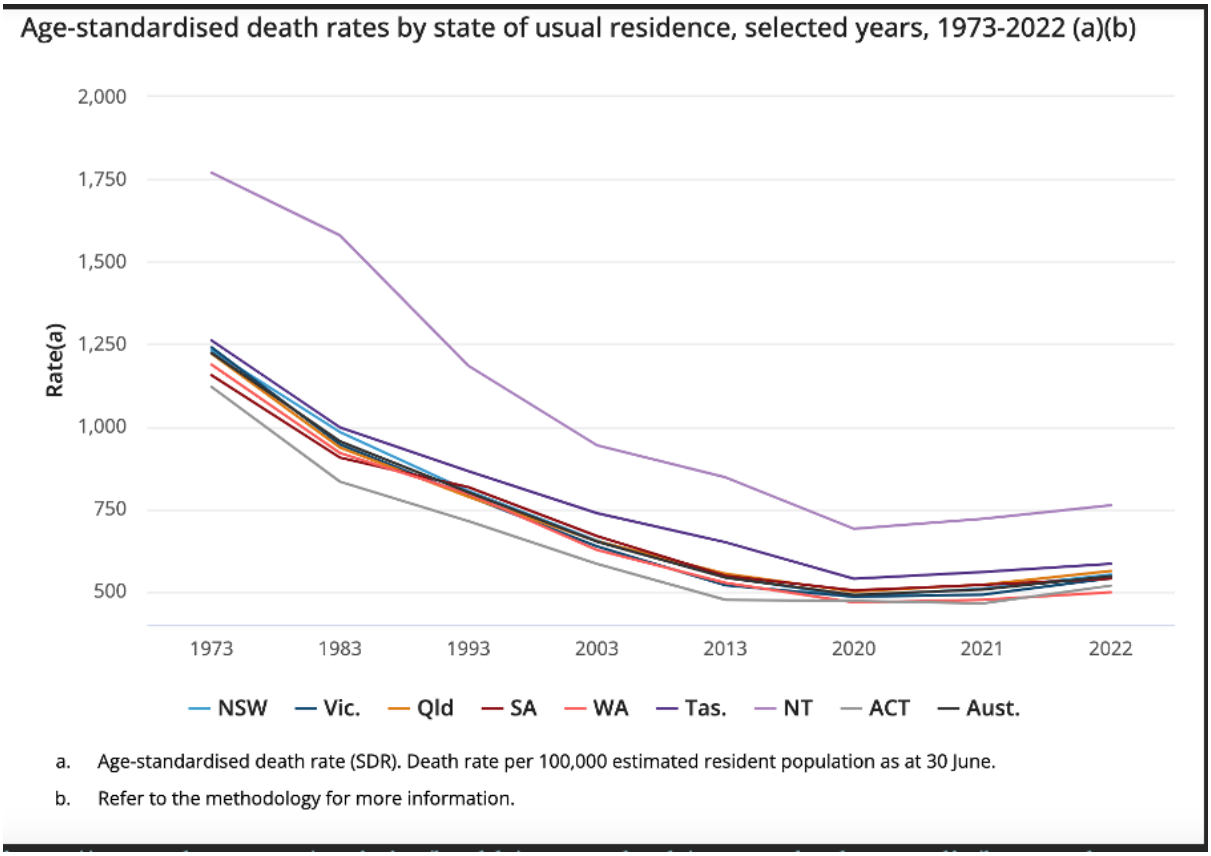


Figure 5: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release 27/9/2023

According to the ABS, the number of deaths in 2022 increased by almost 20,000 from 2021 and the all-cause mortality rate was the highest recorded since 2015. Deaths due to COVID-19 were a significant contributor to the increase, causing just under 10,000 deaths and mentioned as a contributing factor on a further 2,782 death certificates.

While the number of deaths in Australia is expected to increase over time due to an ageing population, the age-standardised rate typically is expected to decrease (with some annual fluctuations, e.g. due to a severe influenza season as in 2019). This expected decrease in the mortality rate is due to factors such as improved medical care and treatments leading to longer life expectancy. It is against this background that the increase in the number and rate of deaths in 2022 led to Australia recording higher than expected mortality and is noteworthy.

The excess all cause mortality (ACM) and distinctive pattern of excess in the summer season has been noted in many other countries also. Rancourt et al (2023) have published an extensive analysis of data from 17 Southern Hemisphere countries, demonstrating the same pattern. Of particular note, nine of the 17 countries have no detectable excess ACM in the period of approximately one year after a pandemic was declared on 11 March 2020 by the

World Health Organization (WHO) until mid 2021 (Australia, Malaysia, New Zealand, Paraguay, Philippines, Singapore, Suriname, Thailand, Uruguay).

Rancourt et al (2023) also document that unprecedented peaks in ACM occur in the summer (January-February) of 2022 not only in Australia, but in the Southern Hemisphere as a whole, and in equatorial-latitude countries. However Australia's pattern of a relatively sharp ACM peak occurring in January/February 2022, after a low COVID- 19 death rate during the declared pandemic season, occurring in 5 of 8 of the Australian states and in all of the more-elderly age groups (Rancourt et al. (2022a, 2023), is the clearest example of this phenomenon. There are no previous examples of such a peak in ACM in the summer in the historic record of ACM for Australia (Rancourt et al., 2022a).

DEATHS ATTRIBUTABLE TO COVID

As the below table (Figure 6) illustrates, deaths attributed to Covid appear to account for a significant percentage of the total excess deaths: 16,313 of 57,310 or 28%.

Doctor certified deaths by cause, number and share of doctor-certified deaths, 2020-23

	2020	2020(%)	2021	2021(%)	2022	2022(%)	2023	2023 (%)
Cancer	48,301	33.9	49,618	32.9	50,440	30.0	51,043	32.0
Dementia	15,306	10.7	16,463	10.9	17,637	10.5	16,920	10.6
Respiratory diseases	11,884	8.3	12,983	8.6	14,480	8.6	14,289	9.0
Chronic lower respiratory diseases	6,817	4.8	7,394	4.9	8,066	4.8	7,765	4.9
Influenza and pneumonia	1,976	1.4	1,971	1.3	2,633	1.6	2,711	1.7
Pneumonia	1,933	1.4	1,969	1.3	2,345	1.4	2,309	1.4
Ischaemic heart disease	13,699	9.6	14,097	9.3	15,040	8.9	13,218	8.3
Other cardiac conditions	8,641	6.1	9,608	6.4	10,319	6.1	10,162	6.4
Cerebrovascular diseases	9,115	6.4	9,327	6.2	9,327	5.5	8,813	5.5
Diabetes	4,992	3.5	5,065	3.4	5,659	3.4	5,403	3.4
COVID-19	855	0.6	1,231	0.8	9,840	5.9	4,387	2.8

a. Only doctor certified deaths are included.
b. Data is by date of occurrence.

Figure 6: https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-dec-2023

It is of interest to note that the first wave of COVID-19, said to be the more severe Wuhan strain, behaved as a seasonal respiratory virus, with an initial winter peak and then phasing out such that there were no recorded deaths in the 2 months of May and June of 2021. This low incidence has been attributed to the successful imposition of maritime borders, internal border closures and lockdown measures. However the deaths then increased rapidly and steadily. Peak deaths attributed to COVID-19 in January and February of 2022, a pattern not compatible with typical seasonal respiratory viruses, despite high COVID-19 vaccination rates. (Figure 7)

Deaths due to COVID-19 by year and month of occurrence (a)(b)(c)(d)(e)

Year of death occurrence	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	0	0	23	79	12	3	145	473	146	16	8	1
2021	2	1	1	2	0	0	13	98	316	444	261	218
2022	1,646	1,034	425	716	929	890	1,409	1,130	447	254	456	969
2023	753	232	269	433	633	598	335	161	153	202	399	376
2024	409	113	na	na	na	na	na	na	na	na	na	na

. Includes COVID-19 death registrations only. Numbers will differ to disease surveillance systems.
. Includes all COVID-19 deaths (both doctor and coroner certified) that occurred and were registered by 29 February 2024.
. All deaths due to COVID-19 in this report have been coded to ICD-10 code U07.1 COVID-19, virus identified; U07.2 COVID-19, virus ot identified as the underlying cause of death; or U10.9 Multisystem inflammatory syndrome associated with COVID-19.
. Data is provisional and subject to change.
. Refer to the methodology for more information regarding the data in this table.

Figure 7: https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-dec-2023

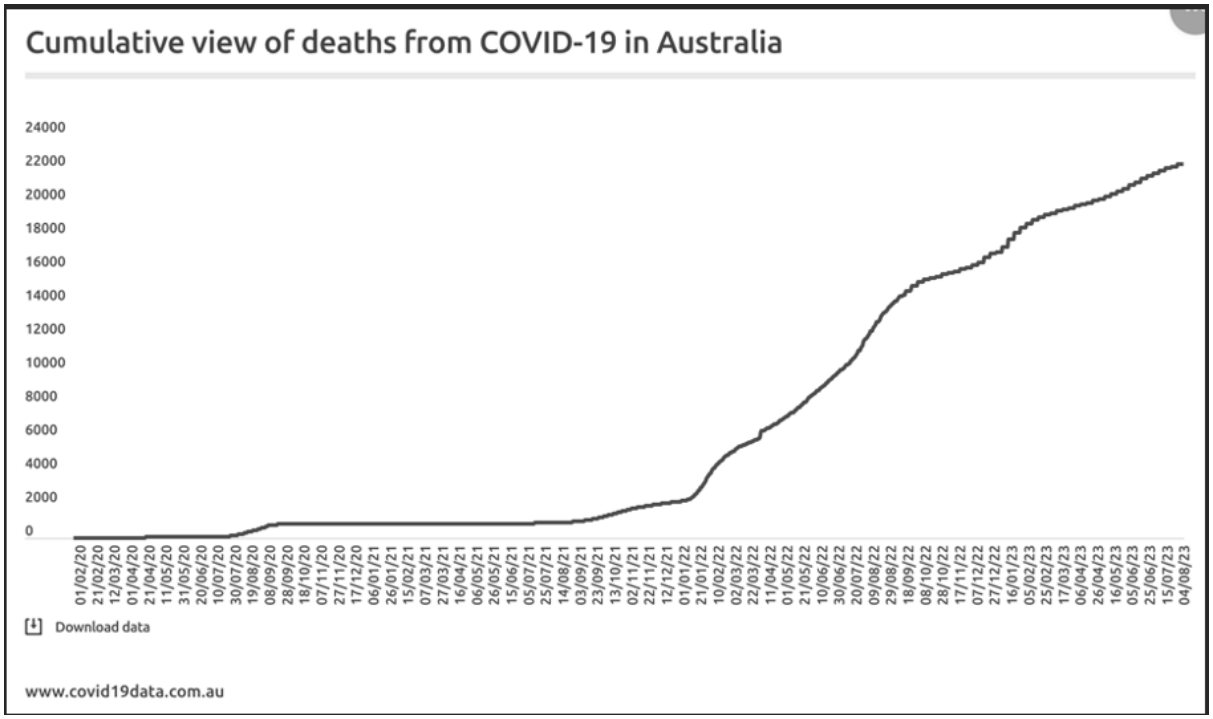


Figure 8: Source: www.covid19data.com.au

It is again apparent from the above graph (Figure 8) that COVID-19 deaths in Australia have not been prevented by the vaccination rollout but would appear instead to have been augmented.

This pattern indicates vaccine failure, potentially as a result of altered immune system function and antibody patterns with non-neutralising antibodies and possibly antibody dependant enhancement (ADE), detailed below. Quoting Rancourt (2023), ‘in the 17 countries, there is no evidence in all-cause mortality (ACM) by time data of any beneficial effect of COVID-19 vaccines. There is no association in time between COVID-19 vaccination and any proportionate reduction in ACM. The opposite occurs’.

The ABS also notes that ‘as the pandemic has progressed the number of people dying 'with' COVID-19 has increased, in that it was a contributing factor but not the cause of their death’ (https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-dec-2023); however it is apparent that the same initial peak in January and February of 2022, with later peaks in June through to August of 2022 and again in the summer of 2022/2023, occurred in that subgroup of people. (Figure 9).

COVID-19 related deaths by year and month of occurrence (a)(b)(c)(d)(e)

Year of death occurrence	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2020	0	0	0	1	0	1	0	5	2	0	0	0
2021	0	0	0	0	0	0	1	0	4	14	18	26
2022	231	209	126	216	299	284	469	450	186	98	141	275
2023	221	108	112	147	187	191	93	74	49	53	96	124
2024	131	40	na	na	na	na	na	na	na	na	na	na

a. Includes COVID-19 death registrations only. Numbers will differ to disease surveillance systems.
b. Includes all COVID-19 deaths (both doctor and coroner certified) that occurred and were registered by 29 February 2023.
c. COVID-19 related deaths have an associated cause of either ICD-10 code U07.1 COVID-19, virus identified; U07.2 COVID-19, virus n identified; or U09 Post COVID-19 condition.
d. Data is provisional and subject to change.
e. Refer to the methodology for more information regarding the data in this table.

Figure 9: https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-dec-2023

COVID-19 was documented as the underlying cause of death for 16,472 registered deaths occurring up to 30 November 2023 (note that that is in variance with the figures quoted for Provisional Mortality to end December 2023, of 16,313). The WHO defines the underlying cause of death as the disease or condition that initiated the train of morbid events leading to death whereas the diseases and conditions reported that are not the underlying cause of death are referred to as associated causes.

Associated causes according to ABS can thus be either:

1. Conditions that were caused by COVID-19 and its complications; these have apparently increased such that deaths recorded as both COVID-19 causal conditions and underlying comorbidities has increased from around 40% in 2020 to nearly 60% in 2023.

   or

2. Pre-existing chronic conditions, often listed as ‘other conditions relevant to the death’, that were co-morbidities from before they contracted COVID-19.

It is of note that the percentage of deaths where COVID-19 was the only condition recorded has always been low: 11.3% in 2020, but perhaps reflecting the less virulent nature of the Omicron variant, have reduced further to only 3.1% of deaths attributed to COVID-19 in

2023. (https://www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-until-30-november-2023)

It would thus appear that there has been an increase in underlying disease processes since 2020.This is reflected in the figures. The proportion of deaths from COVID-19 which had a chronic condition recorded has increased from a low of 65.1% in 2021 to 85.1% in 2023.

Of these deaths: Chronic cardiac conditions including coronary atherosclerosis, cardiomyopathies and atrial fibrillation were the most commonly certified co-morbidities each year since 2021, (but not in 2020), occurring in around 40% of all COVID-19 attributed deaths with a chronic condition. Cancer was also documented increasingly as a pre-existing condition: 18.4% of COVID-19 deaths with a chronic condition in 2023, up from 17.4% in 2022, most commonly blood and lymph cancers (e.g. leukaemia). Interestingly many of these conditions were noted at greater than 10-fold increased rates as comorbidities in deaths attributed to COVID-19 in 2022 as compared to 2020.(Figure 10)

Quoting the ABS, ‘people with pre-existing chronic conditions have greater risk of developing severe illness from COVID-19. While pre-existing chronic conditions do not cause COVID-19, they increase the risk of COVID-19 complications and therefore increase the risk of death.’ (https://www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-until-30-november-2023).

Pre-existing chronic conditions certified with COVID-19 deaths

	2020	2021	2022	2023	Total
Chronic cardiac conditions	222	351	3,419	1,300	5,292
Dementia	275	183	2,590	940	3,988
Chronic respiratory conditions	97	161	1,559	606	2,423
Cancer	81	124	1,491	612	2,308
Diabetes	115	211	1,286	432	2,044
Chronic kidney diseases	63	131	1,144	398	1,736
Hypertension	101	136	1,053	401	1,691
Musculoskeletal disorders	38	38	542	222	840
Chronic cerebrovascular diseases	43	25	341	121	530
Parkinsons Disease	37	19	311	136	503
Obesity	9	57	135	31	232
COVID-19 deaths with a chronic condition certified	668	882	8,564	3,327	13,441
COVID-19 deaths	906	1,355	10,301	3,910	16,472

a. Includes COVID-19 death registrations only. Numbers will differ to disease surveillance systems.
b. Includes all COVID-19 deaths (both doctor and coroner certified) that occurred and were registered by 30 November 2023.
c. All deaths due to COVID-19 in this report have been coded to ICD-10 code U07.1 COVID-19, virus identified; U07.2 COVID-19, virus not identified as the underlying cause of death; or U10.9 Multisystem inflammatory syndrome associated with COVID-19.
d. Data is provisional and subject to change.
e. Refer to the methodology for more information regarding the data in this graph.

Figure 10: https://www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-until-30-november-2023

COVID- RELATED DEATHS

COVID-19 related deaths are defined as one where there is a disease or injury pathway to death that is not directly caused by the virus. Of note however, these deaths also follow the same pattern as the ACM and the deaths attributed to COVID-19 as they increase towards the end of 2021, peaking in January 2022 and again in May to August 2022, December 2022 and January 2023 before reducing. (Figure 11).

COVID-19 related deaths by year and month of occurrence

Year of death	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2020	0	0	0	1	0	1	0	5	2	0	0	0	9
2021	0	0	0	0	0	0	1	1	3	15	19	25	64
2022	231	208	125	216	298	282	465	446	186	97	138	274	2,966
2023	219	107	112	145	183	188	90	73	45	49	33	na	1,244

ı. Includes COVID-19 death registrations only. Numbers will differ to disease surveillance systems.
›. Includes all COVID-19 deaths (both doctor and coroner certified) that occurred and were registered by 30 November 2023.
:. COVID-19 related deaths have an associated cause of either ICD-10 code U07.1 COVID-19, virus identified; U07.2 COVID-19, virus not dentified; or U09 Post COVID-19 condition.
ł. Data is provisional and subject to change.
›. Refer to the methodology for more information regarding the data in this graph.

Figure 11: https://www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-until-30-november-2023

Most common underlying cause in COVID-19 related deaths

Underlying cause of death	2020	2021	2022	2023	Total
Cancer	2	14	762	331	1,109
Circulatory system diseases	0	15	728	315	1,058
Dementia including Alzheimer's	1	3	556	209	769
Falls	5	7	164	70	246
Diabetes	0	7	121	45	173
Respiratory diseases	0	2	97	53	152
Kidney and urinary diseases	0	2	99	29	130
Other conditions	1	14	439	192	646
Total deaths	9	64	2,966	1,244	4,283

a. Includes COVID-19 death registrations only. Numbers will differ to disease surveillance systems.
b. Includes all COVID-19 deaths (both doctor and coroner certified) that occurred and were registered by 30 November 2023.
c. COVID-19 related deaths have an associated cause of either ICD-10 code U07.1 COVID-19, virus identified; U07.2 COVID-19, virus not identified; or U09 Post COVID-19 condition.
d. Data is provisional and subject to change.
e. Refer to the methodology for more information regarding the data in this graph.

Figure 12: https://www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-until-30-november-2023

As seen above (Figure 12), the underlying pattern of diseases is the same again, demonstrating a similar pattern of increases as for deaths attributable to COVID-19 of predominantly cancer, circulatory diseases, dementia and diabetes.

EXCESS MORTALITY: CHANGING PATTERNS OF DISEASE

As illustrated in the below table (Figure 13), the background levels of particular diseases have increased significantly since 2020: on raw data alone, cancer has significantly increased and appears to be continuing to increase; whereas dementia, diabetes, ischaemic heart disease and other cardiac conditions, respiratory diseases (including influenza and pneumonia) apparently demonstrates the same pattern as all-cause mortality (ACM) and COVID-19, of increase to 2022 and then decrease.

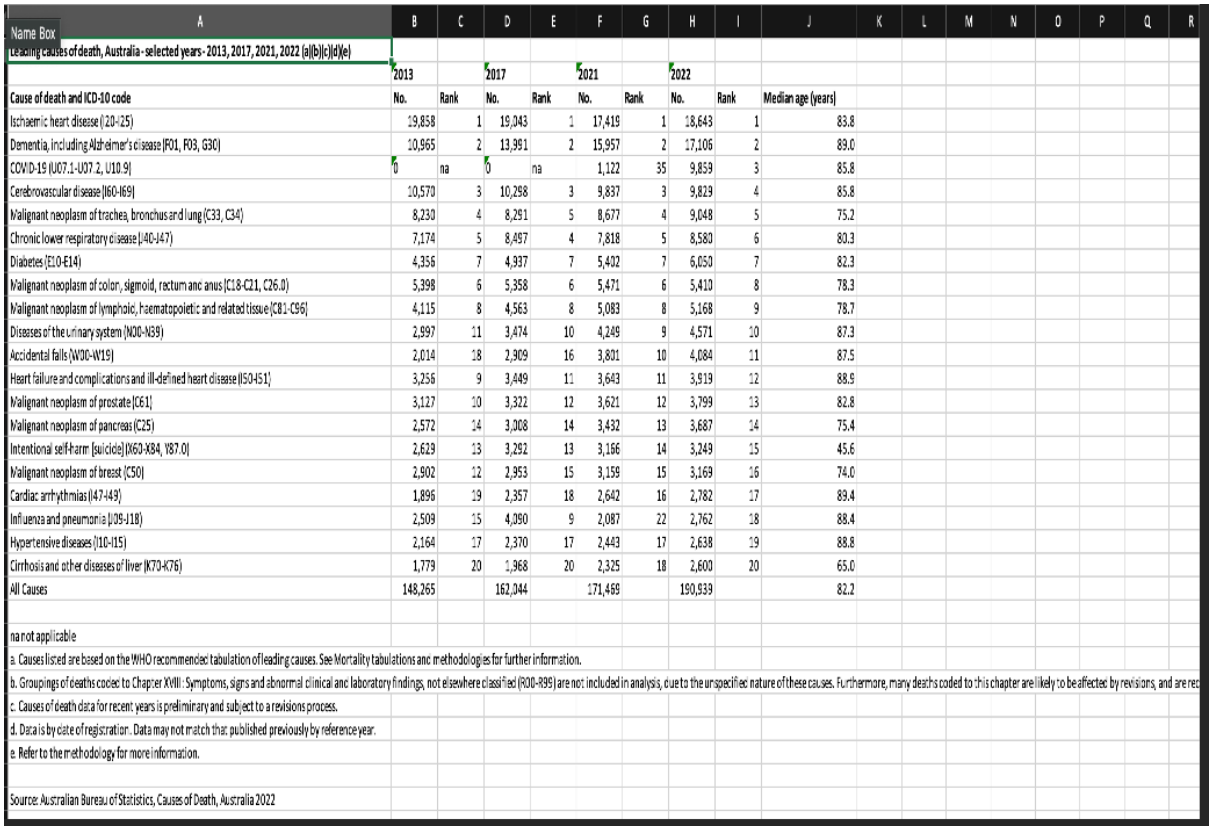
This same pattern indicates a consistent and common underlying cause, with cancer an outlier indicating probable additional factors. A further statistical analysis would likely be revealing.

Doctor certified deaths by cause, number and share of doctor-certified deaths, 2020-23

	2020	2020(%)	2021	2021(%)	2022	2022(%)	2023	2023 (%)
Cancer	48,301	33.9	49,618	32.9	50,440	30.0	51,043	32.0
Dementia	15,306	10.7	16,463	10.9	17,637	10.5	16,920	10.6
Respiratory diseases	11,884	8.3	12,983	8.6	14,480	8.6	14,289	9.0
Chronic lower respiratory diseases	6,817	4.8	7,394	4.9	8,066	4.8	7,765	4.9
Influenza and pneumonia	1,976	1.4	1,971	1.3	2,633	1.6	2,711	1.7
Pneumonia	1,933	1.4	1,969	1.3	2,345	1.4	2,309	1.4
Ischaemic heart disease	13,699	9.6	14,097	9.3	15,040	8.9	13,218	8.3
Other cardiac conditions	8,641	6.1	9,608	6.4	10,319	6.1	10,162	6.4
Cerebrovascular diseases	9,115	6.4	9,327	6.2	9,327	5.5	8,813	5.5
Diabetes	4,992	3.5	5,065	3.4	5,659	3.4	5,403	3.4
COVID-19	855	0.6	1,231	0.8	9,840	5.9	4,387	2.8

a. Only doctor certified deaths are included.
b. Data is by date of occurrence.

Figure 13: https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-dec-2023



Leading causes of death, Australia - selected years - 2013, 2017, 2021, 2022 (a)(b)(c)(d)(e)

Cause of death and ICD-10 code	2013 No.	2013 Rank	2017 No.	2017 Rank	2021 No.	2021 Rank	2022 No.	2022 Rank	Median age (years)
Ischaemic heart disease (I20-I25)	19,858	1	19,043	1	17,419	1	18,643	1	83.8
Dementia, including Alzheimer's disease (F01, F03, G30)	10,965	2	13,991	2	15,957	2	17,106	2	89.0
COVID-19 (U07.1-U07.2, U10.9)	0	na	0	na	1,122	35	9,859	3	85.8
Cerebrovascular disease (I60-I69)	10,570	3	10,298	3	9,837	3	9,829	4	85.8
Malignant neoplasm of trachea, bronchus and lung (C33, C34)	8,230	4	8,291	5	8,677	4	9,048	5	75.2
Chronic lower respiratory disease (J40-J47)	7,174	5	8,497	4	7,818	5	8,580	6	80.3
Diabetes (E10-E14)	4,356	7	4,937	7	5,402	7	6,050	7	82.3
Malignant neoplasm of colon, sigmoid, rectum and anus (C18-C21, C26.0)	5,398	6	5,358	6	5,471	6	5,410	8	78.3
Malignant neoplasm of lymphoid, haematopoietic and related tissue (C81-C96)	4,115	8	4,563	8	5,083	8	5,168	9	78.7
Diseases of the urinary system (N00-N39)	2,997	11	3,474	10	4,249	9	4,571	10	87.3
Accidental falls (W00-W19)	2,014	18	2,909	16	3,801	10	4,084	11	87.5
Heart failure and complications and ill-defined heart disease (I50-I51)	3,256	9	3,449	11	3,643	11	3,919	12	88.9
Malignant neoplasm of prostate (C61)	3,127	10	3,322	12	3,621	12	3,799	13	82.8
Malignant neoplasm of pancreas (C25)	2,572	14	3,008	14	3,432	13	3,687	14	75.4
Intentional self-harm (suicide) (X60-X84, Y87.0)	2,629	13	3,292	13	3,166	14	3,249	15	45.6
Malignant neoplasm of breast (C50)	2,902	12	2,953	15	3,159	15	3,169	16	74.0
Cardiac arrhythmias (I47-I49)	1,896	19	2,357	18	2,642	16	2,782	17	89.4
Influenza and pneumonia (J09-J18)	2,509	15	4,090	9	2,087	22	2,762	18	88.4
Hypertensive diseases (I10-I15)	2,164	17	2,370	17	2,443	17	2,638	19	88.8
Cirrhosis and other diseases of liver (K70-K76)	1,779	20	1,968	20	2,325	18	2,600	20	65.0
All Causes	148,265		162,044		171,469		180,939		82.2

na not applicable

a. Causes listed are based on the WHO recommended tabulation of leading causes. See Mortality tabulations and methodologies for further information.

b. Groupings of deaths coded to Chapter XVIII: Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99) are not included in analysis, due to the unspecified nature of these causes. Furthermore, many deaths coded to this chapter are likely to be affected by revisions, and are rec

c. Causes of death data for recent years is preliminary and subject to a revisions process.

d. Data is by date of registration. Data may not match that published previously by reference year.

e. Refer to the methodology for more information.

Source: Australian Bureau of Statistics, Causes of Death, Australia 2022

Figure 14: Australian Bureau of Statistics, Causes of Death, Australia 2022

From the above table (Figure 14) it is apparent that ischaemic heart disease (IHD) and cerebrovascular disease (CVD) have reduced overall from 2013 to 2022, whereas dementia has disproportionately increased, with a rapid increase from 2021 to 2022. Diabetes has a similar pattern of increase, as has renal disease, cardiac failure, cardiac arrythmias, haemopoietic malignancies, and malignancies of the respiratory tract, pancreas, prostate and breast, and lastly, accidental falls. Notably, these malignancies are indicating a trend of continued increase in 2023.

There is therefore a consistent pattern of uptick in all these diseases from 2021 to 2022.

An increase in malignancies post 2020 has also been noted in other countries. In the USA, Alegria et al (2024) examined mortality data for neoplasms for the ages 15 to 44 from 2010 to 2022 and demonstrated a rise in excess mortality from malignancies reported as the underlying cause of death, which started from 2020 (1.7%), accelerating substantially in 2021 (5.6%) and 2022 (7.9%). The Z scores for the increase in excess mortality in both 2021 (11.8)

and 2022 (16.5) are highly statistically significant. As these are age groups historically generally less likely to develop malignancy, these figures are even more significant.

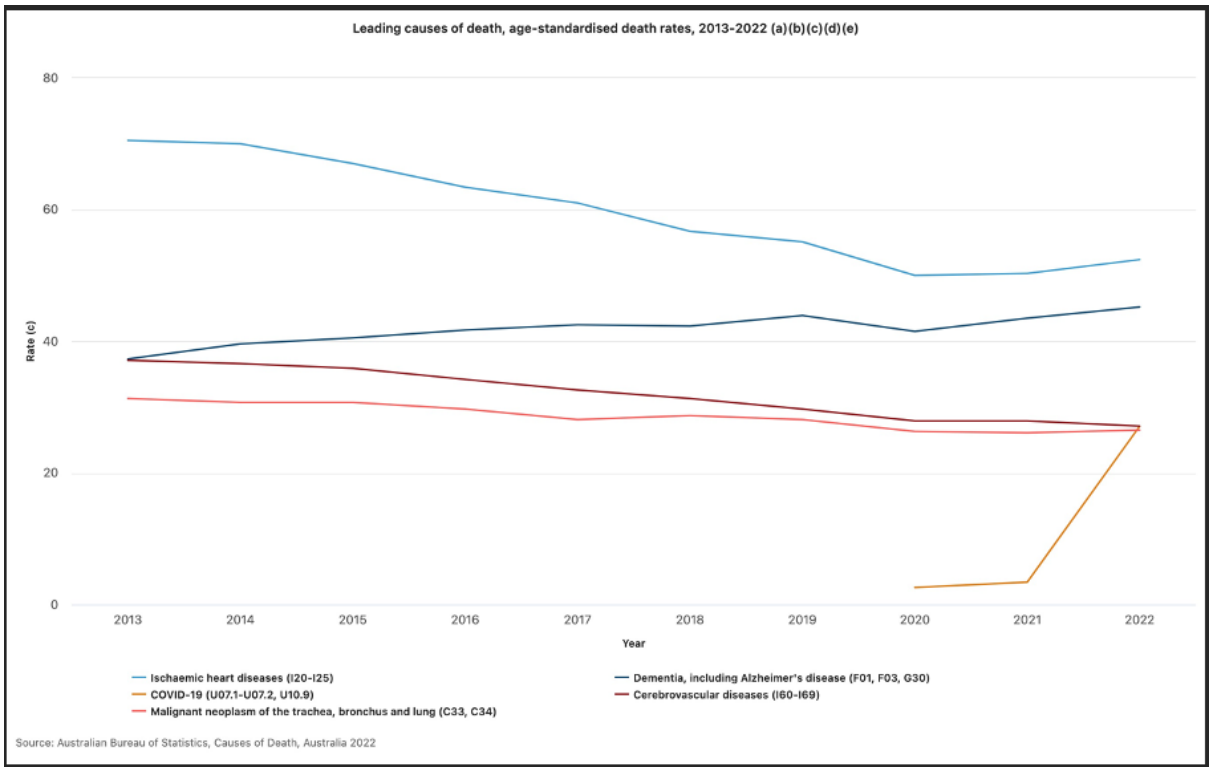


Figure 15: Australian Bureau of Statistics. Causes of Death, Australia 2022.

This graph (Figure 15) illustrates well the increased incidence of dementia and an uptick in IHD despite many years of reducing incidence prior.

The question must be asked: what happened in 2021 that has influenced so many disease and death patterns, both in Australia and overseas?

COVID VACCINATION ROLLOUT

According to 'Our World in Data', Australia commenced Covid vaccination rollout in February of 2021, with a rapid rollout such that by September of 2021, some 20 million doses had been administered and by December of 2021, over 40 million doses with the rollout of

the second dose. This increased to over 60 million doses in December of 2022 with the rollout of booster doses (Figure 16).

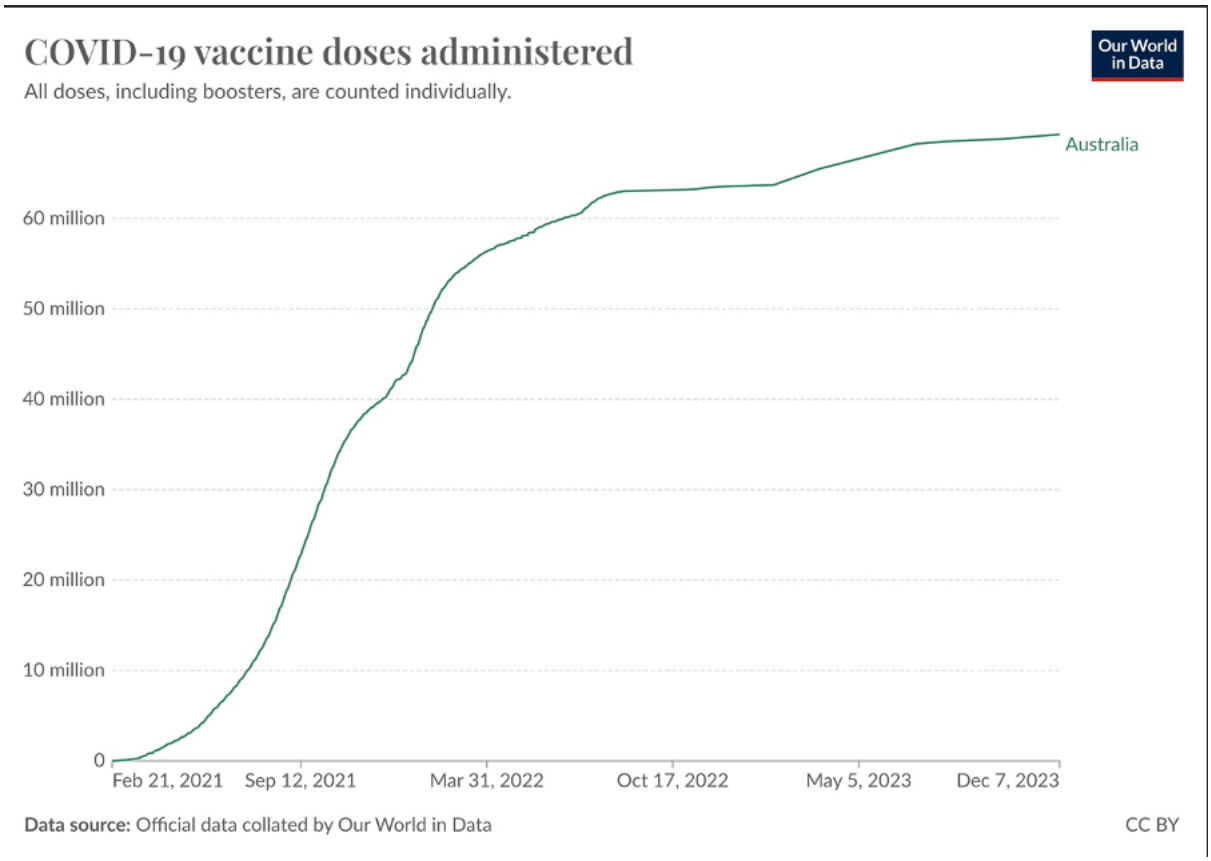


Figure 16: Our World in Data. COVID -19 Vaccine Doses Administered.

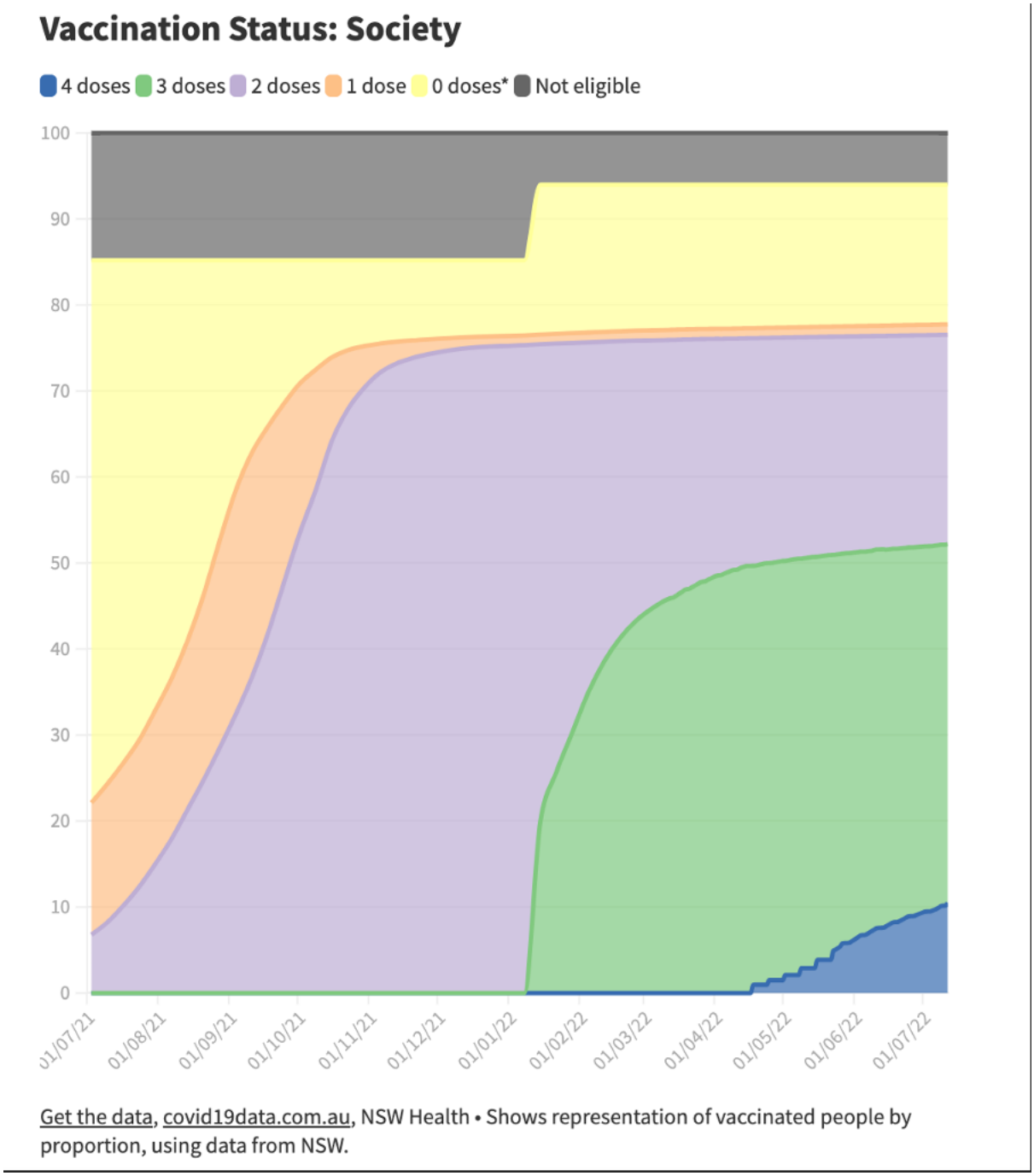


Figure 17: https://www.covid19data.com.au/vaccines Last updated 22 August 2022

According to official data, 97.8% of the Australian population aged over 16 years have received at least 1 dose of the COVID-19 vaccinations, and at least 68.4% of the population have received at least 3 doses. (Figure 17).

The graph below (Figure 18) illustrates clearly the times of peak dosing: interestingly, around August to October in 2021, again in December 2021, and in January 2022; then again April and July and November 2022 and again in January 2023.

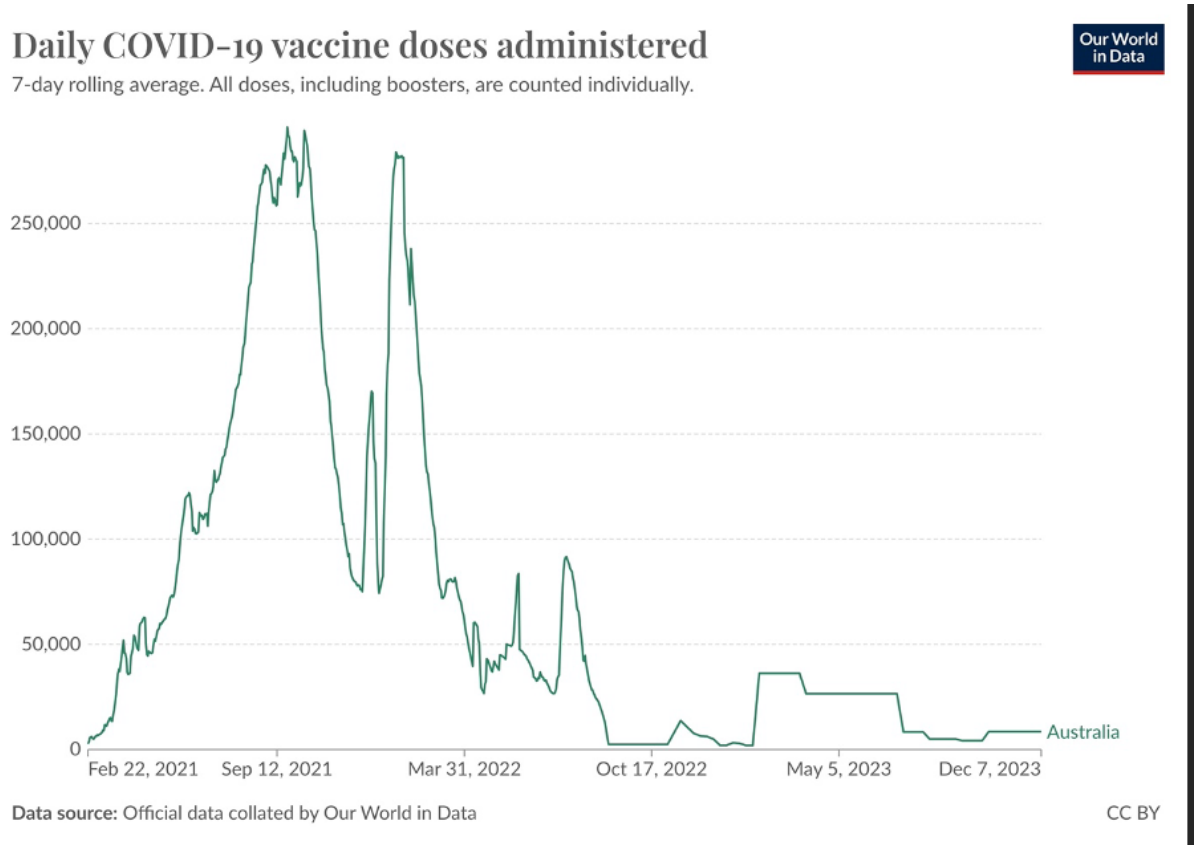


Figure 18: Our World in Data. Daily COVID-19 vaccine doses administered.

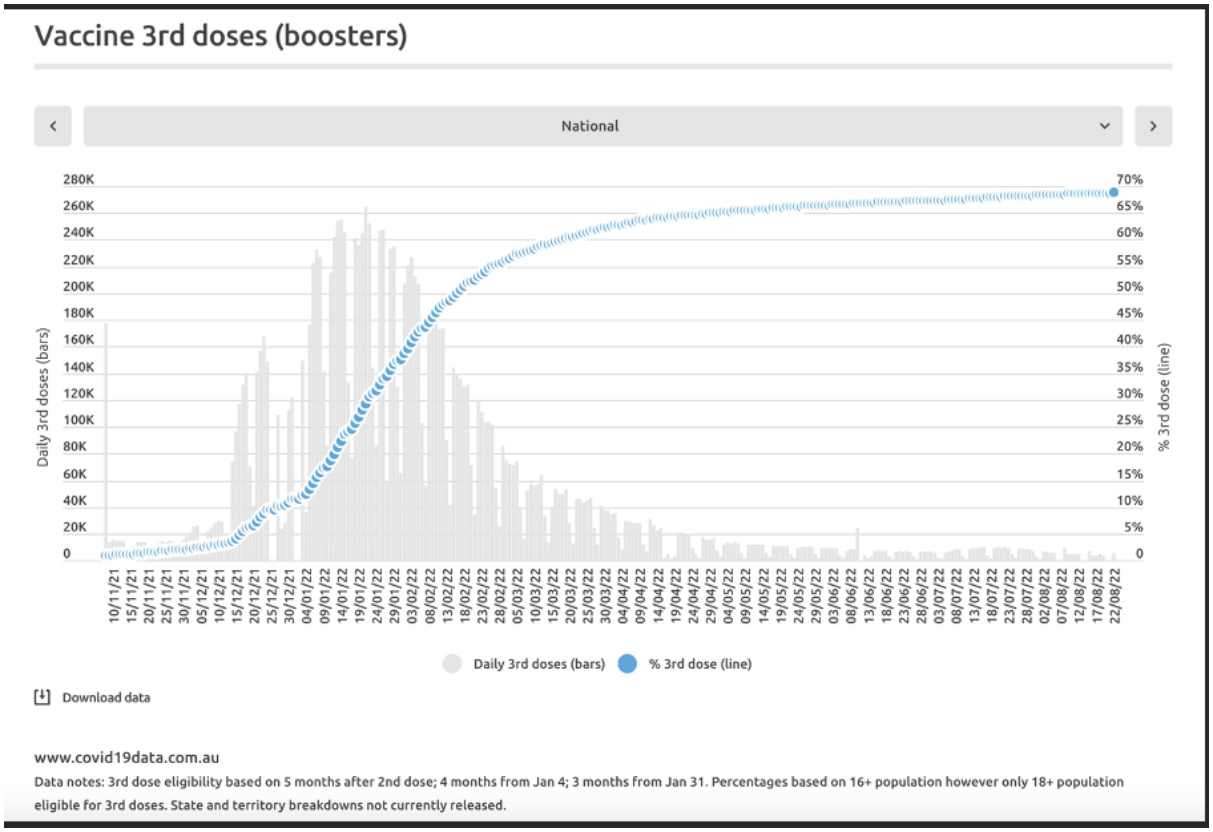


Figure 19: www.covid19data.com.au , NSW Health.

As illustrated in the above graph (Figure 19) the vast majority of people in NSW (over 75%) had received at least 1 dose of the COVID-19 vaccination by October 2021, over 70 % had received 2 doses by November 2021, and the rollout for the 3rd dose was rapid, commencing December 2021, such that by March 2022 over 40 % of the NSW population had been 'boosted'.

The graph below (Figure 20) clearly illustrates the timing of the rollout of the 3rd vaccinations (boosters) in Australia, increasing from December 2021 such that by April 2022 over 65% of the Australian population had been 'boosted', and nearly 70% by August 2022. The temporal association of that rollout to the January 2022 peak in Covid cases and excess mortality is visually striking.

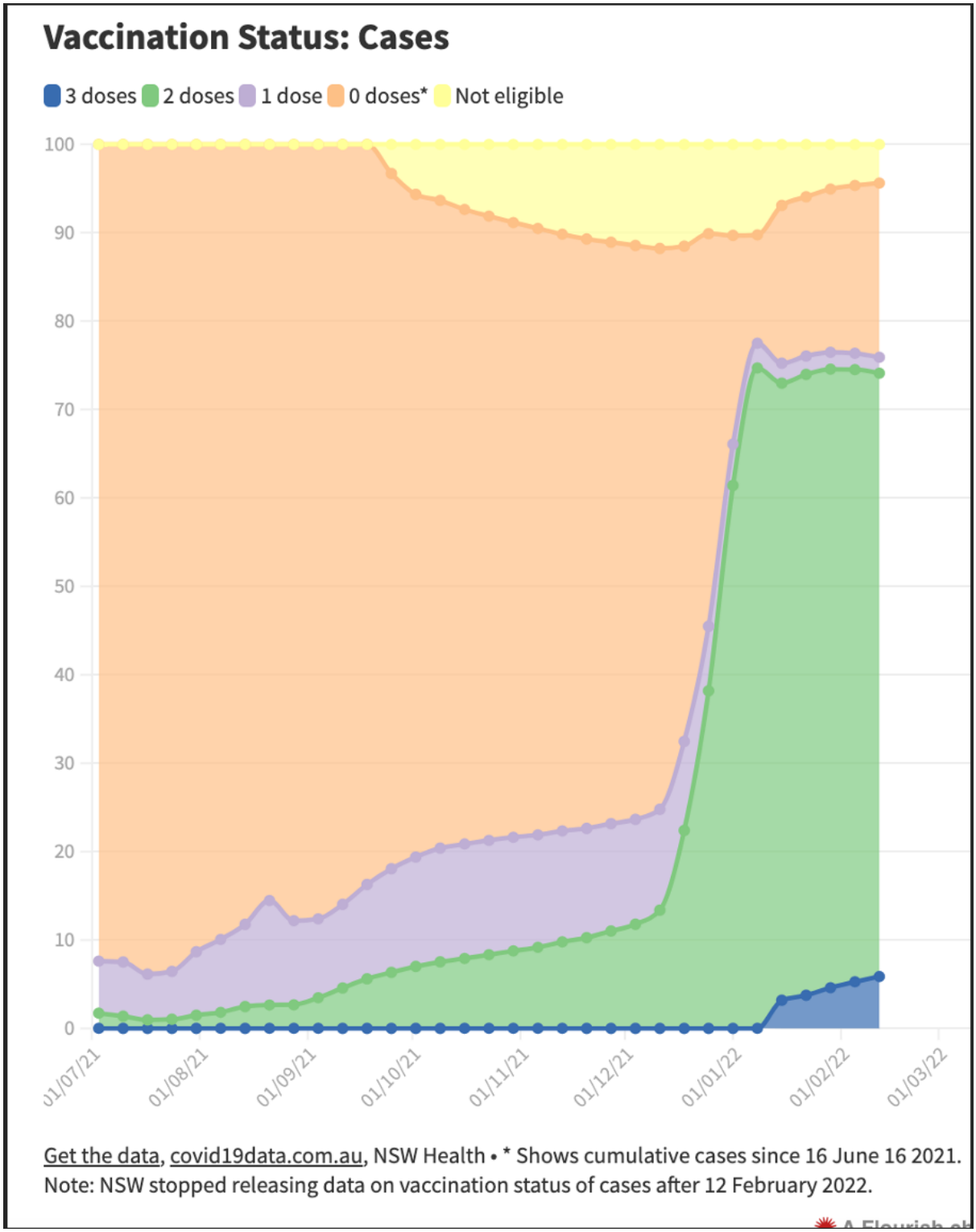


Figure 21: www.covid19data.com.au , NSW Health.

It is again very obvious from this graph (Figure 21) that the COVID-19 vaccinations exerted no apparent protective effect against acquiring COVID-19 in the subsequent 'waves'. It is also worth noting as has been done by many authors, that a person is not counted as being

vaccinated with that particular dose of vaccine in the first 14 to 21 days post vaccination (Neil et al 2024); hence a number of recorded cases being attributed to the non-vaccinated may be falsely elevated, due to the well-recognised effect of initial immune suppression post vaccination. Paradoxically, this is why they do not record the person as being vaccinated in that time frame.

Figure 22: Get the data, covid19data.com.au, NSW Health • Vaccination Status in Deaths from COVID-19.

It would appear from the above graph (Figure 22) that not only are the COVID-19 mRNA vaccines ineffective in preventing cases of COVID-19, they are also relatively ineffective in preventing death from COVID-19. Again, a detailed statistical analysis of this is beyond the scope of this article.

A detailed statistical analysis of the correlation between these vaccination peaks and patterns of excess mortality has been done by Sy (2023) using the 'Bradford Hill criteria', confirming statistical correlation.

However, it is obvious to the eye that there is a temporal correlation between the introduction and pattern of rollout of the COVID-19 injections and the increase in incidence of the diseases noted, of deaths attributed to COVID-19 and ACM. Again, further statistical analysis is beyond the scope of this article.

THE ‘BRADFORD HILL CRITERIA’

The ‘**Bradford Hill criteria’**, also known as **Hill's criteria for causation**, are a group of nine principles that have been widely used in public health research for establishing epidemiologic evidence of a causal relationship between a presumed cause and an observed effect. Since then, the “Bradford Hill Criteria” have become the most frequently cited framework for causal inference in epidemiologic studies.

They were initially proposed in 1965 by the English epidemiologist Sir Austin Bradford Hill, when he used them to demonstrate the connection between cigarette smoking and lung cancer. Hill did not name his list ‘criteria’ but ‘viewpoints’ or ‘considerations’ which were written as flexible guidelines or considerations meant to guide epidemiologic investigations and aid in causal inference. These were not intended to be “*hard and fast rules of evidence that must be obeyed before we accept cause and effect*”.

The 9 viewpoints to consider, he proposed, are:

1. **Strength** (effect size): A small association does not mean that there is not a causal effect, though the larger the association, the more likely that it is causal.
2. **Consistency** (reproducibility): Consistent findings observed by different persons in different places with different samples strengthens the likelihood of an effect.
3. **Specificity**: Causation is likely if there is a very specific population at a specific site and disease with no other likely explanation. The more specific an association between a factor and an effect is, the bigger the probability of a causal relationship.
4. **Temporality**: The effect has to occur after the cause (and if there is an expected delay between the cause and expected effect, then the effect must occur after that delay).
5. **Biological gradient** (dose–response relationship): Greater exposure should generally lead to greater incidence of the effect. However, in some cases, the mere presence of the factor can trigger the effect. In other cases, an inverse proportion is observed: greater exposure leads to lower incidence.
6. **Plausibility**: A plausible mechanism between cause and effect is helpful (but Hill noted that knowledge of the mechanism is limited by current knowledge).
7. **Coherence**: Coherence between epidemiological and laboratory findings increases the likelihood of an effect. However, Hill noted that "lack of such [laboratory] evidence cannot nullify the epidemiological effect on associations".

8. **Experiment**: "Occasionally it is possible to appeal to experimental evidence".
9. **Analogy**: The use of analogies or similarities between the observed association and any other associations.

Quoting directly from Bradford Hill:

Viewpoint	**Explanatory quotations from Bradford Hill**
Strength of association	"But to explain the pronounced excess in cancer of the lung [*among cigarette smokers*] in any other environmental terms requires some feature of life so intimately linked with cigarette smoking and with the amount of smoking that such a feature should be easily detectable." p. 296
Consistency	"We have, therefore, the somewhat paradoxical position that the different results of a different inquiry certainly cannot be held to refute the original evidence; yet the same results from precisely the same form of inquiry will not invariably greatly strengthen the original evidence. I would myself put a good deal of weight upon similar results reached in quite different ways, e.g. prospectively and retrospectively." p. 296–297
Specificity	"If, as here, the association [*between working as a nickel refiner and cancer*] is limited to specific workers and to particular sites and types of disease and there is no association between the work and other modes of dying, then clearly that is a strong argument in favour of causation. We must not, however, over-emphasize the importance of the characteristic [*specificity*]." p. 297
Temporality	"Which is the cart and which the horse? This is a question which might be particularly relevant with diseases of slow development." p. 297
Dose-response	"For instance, the fact that the death rate from cancer of the lung rises linearly with the number of cigarettes smoked daily, adds a very great deal to the simpler evidence that cigarette smokers have a higher death rate than non-smokers." p. 298
Plausibility	"But this is a feature I am convinced we cannot demand. What is biologically plausible depends upon the biological knowledge of the day." p. 298

Viewpoint	Explanatory quotations from Bradford Hill
Coherence	"On the other hand, the cause-and-effect interpretation of our data should not seriously conflict with the generally known facts of the natural history and biology of the disease." p. 298
Experiment	"Occasionally it is possible to appeal to experimental, or semi-experimental, evidence. For example, because of an observed association some preventive action is taken. Does it in fact prevent? The dust in the workshop is reduced, lubricating oils are changed, persons stop smoking cigarettes. Is the frequency of the associated events affected? Here the strongest support for the causation hypothesis may be revealed." p. 298–299
Analogy	"In some circumstances it would be fair to judge by analogy. With the effects of thalidomide and rubella before us we would surely be ready to accept slighter but similar evidence with another drug or another viral disease in pregnancy." p. 299

In 2011 Howick added consideration of **Reversibility**: If the cause is deleted then the effect should disappear as well, bringing the total considerations to 10.

More recently, Fedak at al (2015) criticised the "Bradford Hill criteria as outdated, as 'advancements in genetics, molecular biology, toxicology, exposure science, and statistics have increased our analytical capabilities for exploring potential cause-and-effect relationships, and have resulted in a greater understanding of the complexity behind human disease onset and progression. These additional tools for causal inference necessitate a re-evaluation of how each Bradford Hill criterion should be interpreted when considering a variety of data types beyond classic epidemiology studies."

However, as Philips and Goodman (2006) stated "these are neither criteria nor a model, but that lists of causal *considerations* and formalizations of the counterfactual *definition* of causation are nevertheless useful tools for promoting scientific thinking. They set us on the path to the common sense of scientific inquiry, including testing hypotheses (really putting

them to a test, not just calculating simplistic statistics)". Christopher (2016) quoting Bradford Hill himself stated "All scientific work is incomplete. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have, or to postpone the action that it appears to demand at a given time."

In current practice, the Bradford Hill viewpoints are applied together or separately to a body of evidence or a single empirical study and is still a highly relevant tool for analysis in epidemiology. For example, a recent major study by Nowinski et al (2022) into Chronic Traumatic Encephalopathy (CTE) as a result of repetitive head injury (RHI), using the Bradford Hill criteria to examine studies on CTE as it relates to RHI exposure, found convincing evidence of a causal relationship between RHI and CTE, as well as an absence of evidence-based alternative explanations. This study has become a foundational study in advancing awareness and mitigation of CTE.

Specifically related to the question of recent Australian excess mortality and its possible causation, Sy (2023) applied the Bradford Hill considerations to the available data on mortality post 2020 and the rollout of COVID-19 vaccinations and found that significant excess mortality was strongly correlated (+74%) with COVID-19 mass injections five months earlier. The Bradford Hill considerations of *strength of correlation*, *consistency*, *specificity*, *temporality*, and *dose-response relationship* are the foremost which are satisfied by the data to implicate the iatrogenesis of the Australian pandemic, that the excess deaths were largely caused by COVID-19 injections. Sy thus argues that the associated mortality risk/benefit ratio for COVID-19 injections is very high.

The Bradford Hill considerations for causation in epidemiology thus remain a valid method of analysing data in relations to the current question of excess mortality and COVID-19 vaccination.

APPLYING BRADFORD HILL CONSIDERATIONS TO THE AUSTRALIAN SITUATION

1.STRENGTH OF ASSOCIATION

As previously noted, ABS graphs from 1973 clearly indicate a down sloping trend in mortality which then up-ticked in 2021, continuing further in 2022, with a slight downtrend again for 2023. Graphs for deaths attributed to COVID-19 demonstrated a dramatic increase in the second half of 2021, peaking in 2022 and again reducing somewhat in 2023. Similarly, graphs of the deaths attributable to circulatory diseases, respiratory diseases, diabetes and dementia demonstrated a similar pattern of increase in 2021, peaking in 2022 with a slight downturn in 2023. Cancer deaths also increased from 2021 and again in 2022 but have continued to increase in 2023 indicating a possible added factor in aetiology.

Although there are many other aetiological factors involved in these 'lifestyle ' diseases, by *strength of association*, the only common factor across all these populations that was altered in 2021 and 2022 is COVID-19 vaccinations.

The statistical analysis performed by Rancourt et al (2023) of 17 countries, 10% of the total world population, provides more than sufficient strength to meet this consideration.

2. CONSISTENCY

The fact that this same pattern of increase in late 2021 and 2022, with a slight decrease in 2023 (with the exception of cancer), exists across several types of disease, both 'lifestyle' and infective, indicates a common causality.

The consideration of *consistency* is also met in the Rancourt (2023) analysis in which all 17 countries demonstrated the same pattern of excess ACM post COVID-19 vaccination rollout.

3.SPECIFICITY

It is somewhat more difficult to demonstrate *specificity* in this data as direct data of the vaccination status of those who have died is not readily available.

However, in 2022 NSW Health published regular reports detailing vaccination status of those hospitalised with COVID-19.(Figures 23-25)

Table 4. Reported deaths of people with COVID-19, by vaccination status, in the week ending 26 February 2022

Vaccination status	Number of deaths
Three or more doses	11
Two doses	28
One dose	0
No dose/Unknown	12
Total	51

Figure 23.

Table 1. Vaccination status of people with COVID-19 who were being cared for in hospital in the week ending 26 February 2022

Vaccination status	Admitted to hospital (but not to ICU) (%)	Admitted to ICU (%)	Total
Three or more doses	79 (27%)	4 (13%)	83 (26%)
Two doses	92 (31%)	11 (37%)	103 (32%)
One dose	13 (4%)	3 (10%)	16 (5%)
No dose/Unknown	109 (37%)	12 (40%)	121 (37%)
Total	293 (100%)	30 (100%)	323 (100%)

- COVID-19 vaccines are very effective in preventing people from the severe impacts of infections with the virus. More than 93 per cent of people aged 12 and over in NSW have received two doses of a COVID-19 vaccine, while almost 60 per cent of people eligible for their third dose have received it. With such high vaccination coverage in the community, this means a greater proportion of people admitted to hospital or ICU with COVID-19 are now vaccinated. However, when the size of the vaccinated and unvaccinated populations in NSW are considered, people who are not vaccinated remain far more likely to suffer severe COVID-19. NSW Health will continue to present this analysis in its monthly epidemiological reports. Analysis to date shows the minority of the overall population who have not been vaccinated are significantly overrepresented among patients in hospitals and ICUs with COVID-19.

Figure 24: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220226.pdf NSW COVID-19 WEEKLY DATA OVERVIEW Epidemiological week 8, ending 26 February 2022

Figures 23 and 24 above would seem to indicate that the vaccinated were only responsible for 63% of admissions with COVID-19. The explanation provided by NSW Health, as above, is that as the proportion of vaccinated population are much higher, the admissions for vaccinated persons would be expected to be higher. However, the data is not pure as those with unknown vaccination status, those recently vaccinated, and those totally unvaccinated are included in the same figures: *No dose/Unknown*. This would artificially conflate the protective effect of vaccination on hospital admission and deaths.

Neil et al (2024) reported on this miscategorisation bias in a systematic review of 39 studies in which vaccinated people are categorised as unvaccinated up to some arbitrarily defined time post vaccination, typically 14 to 21 days. They demonstrated that this miscategorisation artificially boosts vaccine efficacy and reduces apparent infection rates in the vaccinated even when a vaccine has zero or negative efficacy.

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Three or more doses	11
Two doses	28
One dose	0
No dose/Unknown	12
Total	51

Figure 25: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220319.pdf NSW COVID-19 WEEKLY DATA OVERVIEW Epidemiological week 11, ending 19 March 2022. Accessed 12 April 2024.

This same miscategorisation is evident in this data from epidemiological week 11, ending 19 March 2022.(Figure 25).

In comparison, in data for November and December 2022, 'unknown' vaccine status is separated from 'no dose', showing a very clear correlation between both *specificity* and *dosage* and effect for hospitalisation 'with COVID-19' and deaths attributed to COVID-19.

In December 2022 (Figure 26), there were 0 hospital admissions for unvaccinated, and 364 for 'unknown', and 1451 admissions for any known vaccination status.

NSW COVID-19 WEEKLY DATA OVERVIEW

www.health.nsw.gov.au/coronavirus

Epidemiological weeks 51 and 52, ending 31 December 2022

Table 1. People with a COVID-19 diagnosis in the previous 14 days who were admitted to hospital, admitted to ICU or reported as having died in the two weeks ending 31 December 2022

	Admitted to hospital (but not to ICU)	Admitted to ICU	Deaths
Gender			
Female	842	63	42
Indeterminate	1	0	0
Male	936	77	53
Age group (years)			
0-9	85	3	0
10-19	24	3	0
20-29	67	8	1
30-39	79	7	0
40-49	64	6	0
50-59	105	17	3
60-69	199	27	8
70-79	436	42	19
80-89	507	24	31
90+	213	3	33
Vaccination status^			
Four or more doses	810	58	53
Three doses	377	29	19
Two doses	218	17	9
One dose	10	1	1
No dose	0	0	6
Unknown	364	35	7
Total	**1779**	**140**	**95**

Excludes cases in correctional settings

^Vaccination status is determined by matching to Australian Immunisation Register (AIR) data. Name and date of birth need to be an exact match to that recorded in AIR for vaccination status to be determined. People with unknown vaccination status were those unable to be found in AIR. This may occur when names in AIR are different, for example shortened name or different spelling, to those used for the COVID-19 notification.

Figure 26: NSW Health NSW Respiratory Surveillance Report—Week Ending 31 December 2022. [(accessed on 10 July 2023)];2022 Available online: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20221231.pdf

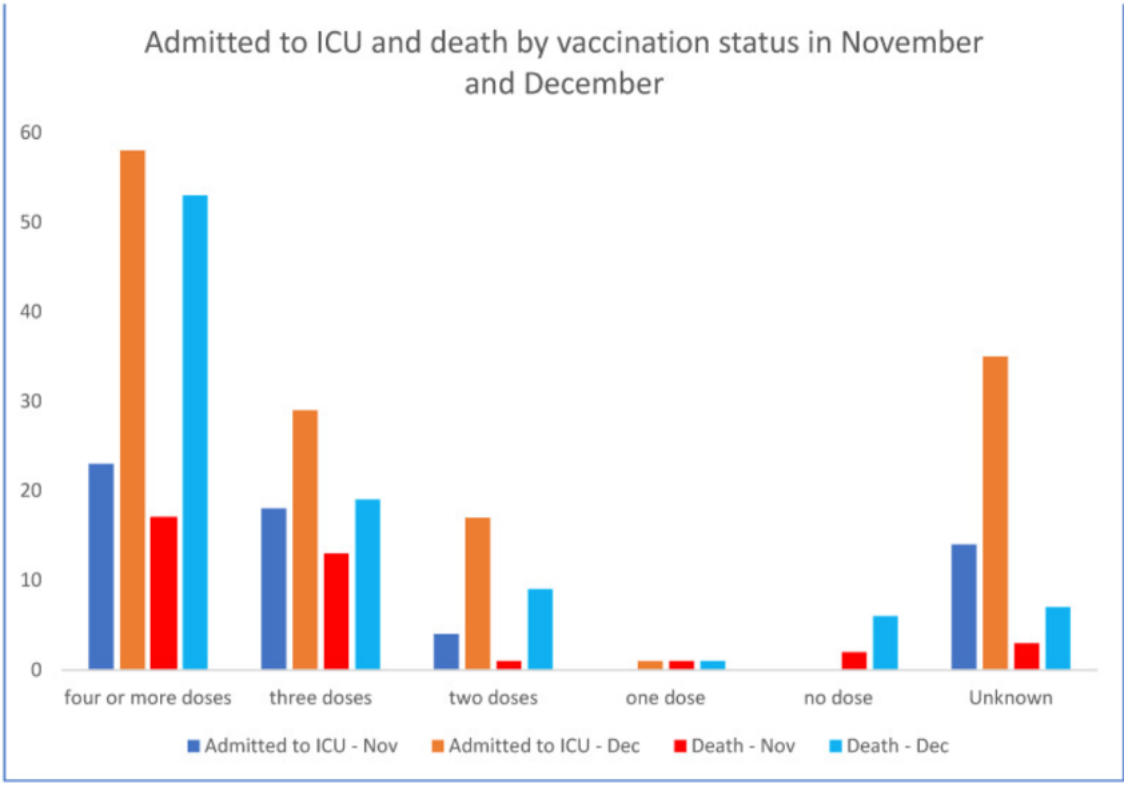

Figure 27a: ICU Admissions and Deaths, COVID-19, November, December 2022.

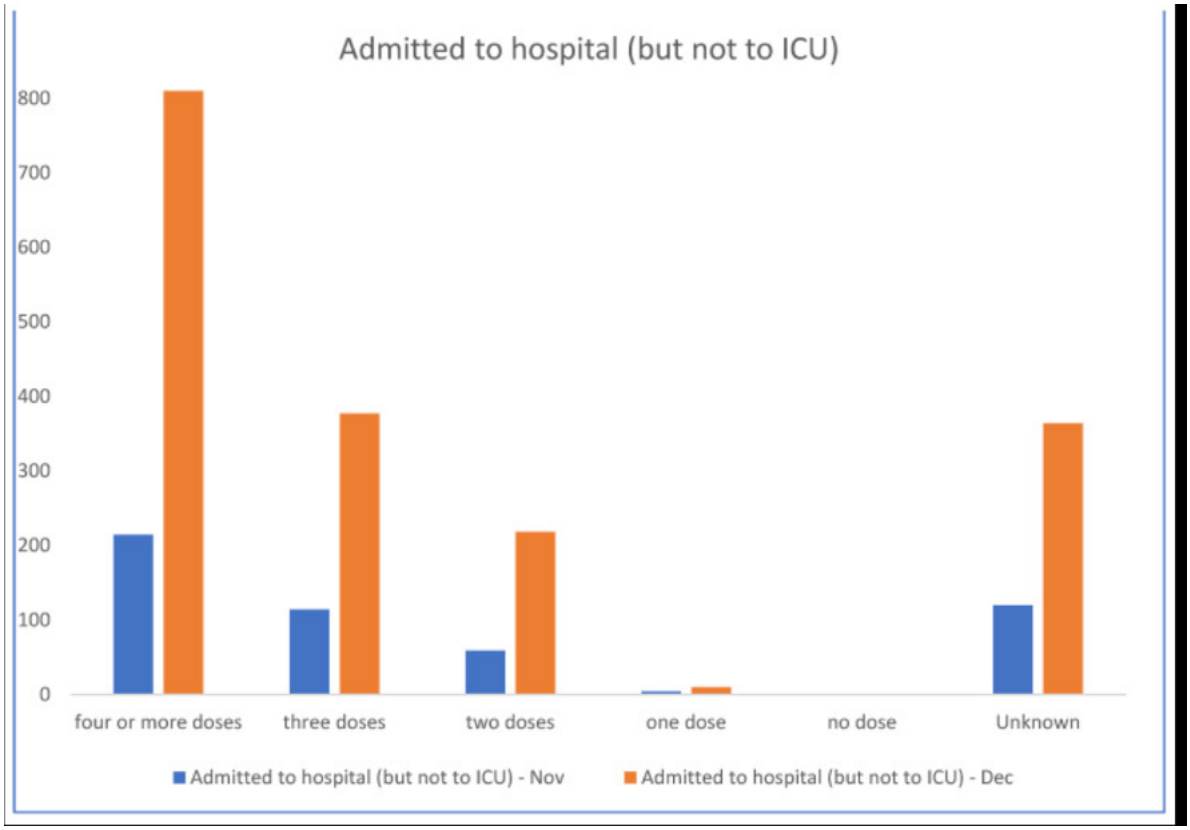

Figure 27b: Hospital Admission with COVID-19 December 2022; Graphs derived from NSW Dept Health Statistics November/December 2022; NSW Health NSW Respiratory Surveillance Report—Week Ending 31 December 2022. [(accessed on 10 July 2023)];2022 Available online: https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20221231.pdf

NSW Dept of Health figures from November/December 2022 (Figures 26, 27a, 27b) documenting vaccination status in those hospitalised and dying with COVID-19 clearly demonstrate a correlation in at least those parameters, thus fulfilling the consideration of *specificity* at least for deaths attributed to COVID-19. Of note, the NSW Dept of Health stopped publishing figures of vaccination status in COVID -19 hospital admissions and deaths at the end of December 2022 and the December 2022 data is no longer easily accessible.

Further data supporting the specific effect of COVID-19 vaccination on mortality attributed to COVID-19 infection is found in a recent report from Adhikari et al (2024), with mortality in 89 unvaccinated patients of 37%, compared to 23 vaccinated patients of 70%, a highly significant probability of p=0.002.

4. TEMPORALITY.

For this consideration, I refer again to the work of Wilson Sy (2023) in assessing *temporality* of total mortality in relation to COVID-19 vaccination, in which Sy statistically demonstrated a clear correlation in temporality between the COVID-19 vaccinations and excess ACM, with a delay of 5 months.

Although not yet statistically analysed, the temporal association between the increases in deaths attributed to COVID-19, the increase in mortality in 2021 and further in 2022 against the baseline from circulatory diseases, cancers, diabetes, dementia and renal disease is visible in the graphs. Further analysis of these associations would no doubt be contributory.

5. DOSE -RESPONSE.

Again, the increasing dose of COVID-19 vaccinations with 3rd vaccinations in late 2021 and early 2022 appears to be reflected in the dramatic increases seen in mortality, both total, and due to the individual diseases noted in the ABS data.

Specifically, the above data and graphs derived from NSW Dept of Health figures for COVID -19 hospitalisations, deaths and vaccination status clearly demonstrate a *dose response effect* even without statistical analysis.

The Rancourt (2023) analysis again meets the Bradford Hill considerations, as a clear dose-response in ACM is seen in 15 of the 17 countries assessed. Unprecedented peaks in ACM occur in the summer (January-February) of 2022 in the Southern Hemisphere, and in equatorial-latitude countries, synchronous with or immediately preceded by rapid COVID-19-vaccine-booster-dose rollouts of the 3rd or 4th doses.

Further evidence supporting a dose-response relationship particularly with regards to cancer comes from a more recent paper by Gibo et al (2024) on data from Japan. In this comparative analysis of annual and monthly age *adjusted mortality rates* (AMR) for cancer from pre-pandemic period (2010-2019) to COVID-19 pandemic years (2020-2022), the 4 major cancer mortality types (colorectal, lung, stomach, liver) were demonstrating a decrease prior to the pandemic and no significant increase was seen in 2020. However after mass vaccination with a first and second dose of COVID-19 vaccines, some excess AMR was observed in 2021 and following mass vaccination with the third dose, significant excess AMR were observed for all cancer types and particularly for some specific cancer types: ovarian, leukaemia, prostate cancer, lip/oral/pharyngeal, pancreatic cancer and breast cancer**.**

6. PLAUSIBILITY.

Biological *plausibility* for the COVID-19 vaccines being causally related to the increase in total mortality, deaths attributed to COVID -19 and increased circulatory diseases, dementia, diabetes, cancer and renal disease is easily found in the academic world literature.

Modified mRNA COVID-19 vaccines contain many now documented pathogenic agents. The cationic lipid nanoparticles (LNPs) used to carry the modified mRNA into the body has itself been demonstrated to be toxic and to have a wide and rapid distribution throughout the body, delivering the modified mRNA to most organs and cells of the body, including the brain, and triggering reactions throughout the entire body. This has been well described in the literature review by Parry et al (2023). The modified mRNA is highly resistant to degradation in the body and thus continues to ‘message’ to cells to manufacture the intended spike protein for much longer than health authorities and regulators originally explained. Persistent spike protein has been discovered in cells for up to 245 days post injection (Patterson et al 2024).

‘Spikeopathy’ is a new term coined to describe the effects of this highly pathogenic spike protein, with numerous binding sites to human receptors, causing disruption to a multiplicity of metabolic pathways and eliciting abnormal immune and other responses. This pathogenicity has been well investigated and published in many papers and is explained in great detail in the above-mentioned Parry et al paper.

More recently, the COVID-19 modified mRNA vaccines have also been demonstrated to be genotoxic. It has been verified by independent researchers that the vaccines contain circular

DNA plasmids used in the manufacturing process, at levels far higher than allowed, and also linear DNA, both of which have the capacity to be integrated into the human genome. In some cases, this has been verified to have occurred. Igyarto et al (2024) gives a thorough discussion of the questionable safety and efficacy of the lipid mRNA carrier particles with respect to this DNA contamination and reverse transcription into the nucleus.

The totality of the effects of these injections on human health is still being discovered.

With regards to biological plausibility for increased COVID-19 infections and deaths, the COVID-19 injections have been well demonstrated to impair immune function by various mechanisms which are further detailed in the Parry et al paper. COVID-19 deaths occur predominantly in the elderly, who have a greater number of co-morbidities, have measures of immune senescence accepted as consequential to ageing but were also targeted for increased COVID-19 vaccination. Immune abnormalities documented include reduction of interferon gamma, CD8 T cell dysfunction and 'exhaustion', and increased production of IgG4 'tolerogenic' antibodies and other non-neutralising antibodies thus *reducing* effective immune response against infection, particularly COVID-19.

A further effect predicted in 2021 in relation to COVID-19 by eminent immunologist Dr Geert Vanden Bossch, is that of antibody- dependant enhancement (ADE) or 'immune enhancement' or **'**disease enhancement'**.** ADE occurs where suboptimal non-neutralising antibodies are binding to parts of the virus other than those involved in viral entry into the host, leading to enhanced entry and subsequent replication; or if the antibody levels or strength of binding are suboptimal.

ADE is a recognised possible effect of vaccination and was known in animal studies for vaccines trialled for SARS-COV-2 prior to the mRNA vaccines (Lambert PH et al 2020). It has been claimed to not be occurring in these new vaccines (Zanella 2022), although the increased production of non-neutralising antibodies as a result of the vaccination programme has been demonstrated (Shreshta et al 2023). Of further concern expressed by Vanden Bossche (2024) and explained by Rennebohm (2023) is that the immune changes induced by the repetitive widespread vaccination in the face of a 'pandemic' will actively promote the natural selection of a highly virulent and altered SARS-CoV-2 variant which the vaccine-altered immune systems will have no defence against.

A key initial pathogenic mechanism for spike protein is elucidated in a recent paper by Scheim et al (2024) on viral binding to sialic acids. Sialic acids are important sugar monomers bound to cell surface glycans and are ubiquitous on the surface of all human cells where they play an important role, among other things, in cell to cell interaction, signalling, aggregation, and immune reactions (Ghosh 2020). With regards to human disease, they enable viral attachment and cellular entry by acting as ligands for viral lectins such as the haemagglutinins on influenza viruses (Imai M. 2022), and this binding of the spike protein of SARS-CoV-2 and other coronaviruses also to these surface glycans on blood, endothelial and other host cells and their pathogenic consequences has been well established (Scheim 2023). This attachment to host cell sialic acid (SA) residues is an essential initial pathological step. After making its attachment to SA, the virus can then slide over to a host cell receptor for cellular entry, fusion and replication, e.g., via the receptor ACE2 for SARS-CoV-2.

In the bloodstream, the negative charge and hydrophilicity of sialic acids on the red blood cell, platelet and endothelial cell surfaces enable red blood cell stabilisation and repulsion, preventing blood component aggregation (Varki 2008). This spike protein attachment to SA thus triggers aggregation and microthrombi which serves as a primal immune response to deliver the pathogens to leukocytes or macrophages in the liver and spleen for phagocytosis, (Scheim 2022), is key to microvascular morbidities associated with spike protein, and is occurring in the wider context of inflammatory and coagulatory pathways that occur in severe COVID-19 (Scheim et al 2024) and other ‘spikeopathy’ (Parry et al 2023).

Two of the major risk factors for COVID-19 mortality—older age and diabetes—are each associated with significantly increased red blood cell aggregation and microvascular occlusion (Ditzel 1956). Microvascular dysfunction is now also recognised as an underlying factor in circulatory diseases (Ischaemic Heart Disease and heart failure); (Gao et al 2022, Paulus et al 2013), in dementia (Han 2019), and in cancer (Rjai et al 2023).

This microvascular dysfunction and endothelitits, proven to be linked to the spike protein adhesion to sialic acid residues, thus provides a mechanism for biological plausibility these increased diseases seen post COVID-19 vaccination.

Increased inflammation triggered by the spike protein attachment to nAChR and blocking Cholinergic Anti-inflammatory Pathways (CAP), can manifest as the ‘cytokine storm’ (Parry et al) in serious COVID-19 disease resulting in mortality. The lipid nanoparticle carrier systems have themselves been confirmed to be highly inflammatory (Omo-Lamai et al 2024).

Rancourt et al (2024) note the increased mortality in the elderly in relation to the COVID-19 vaccines, up to 5% in Chile and Peru. Chronic inflammation is also an aetiological factor common to ageing, dementia, diabetes, circulatory conditions and cancer, as noted by Prasad et al in 2012. The COVID-19 injections are well documented to induce inflammation by various pathways, most notably by blocking the CAP as detailed further in the Parry et al (2023) paper, thus providing a common link between increases in these diseases, excess mortality and the COVID-19 injections.

Biological plausibility for a link between the COVID-19 vaccinations and ongoing increases in cancer, via the 'multiple hit' mechanism in addition to the issue of increased inflammation, is further supported by recent research. The multiple hit hypotheses for cancer was first proposed by Sutherland and Bailar in 1984, that it is not a single event but several environmental 'hits', each producing damage, that overwhelms DNA repair mechanisms, on a genetic susceptibility.

Valdes and Peres (2024) have reviewed this concept with regards to COVID-19 vaccination and cancer and highlight multiple mechanisms including the induction of lymphopenia and inflammation, downregulation of angiotensin-converting enzyme 2 (ACE2) expression, activation of oncogenic cascades, sequestration of tumour suppressor proteins, dysregulation of the RNA-G quadruplex-protein binding system, alteration of type I interferon responses, and the unsilencing of retrotransposable elements. Additional to all those mechanisms, it was demonstrated by Jiang and Mei (2021) that spike protein impaired DNA repair mechanisms in a paper later retracted amidst some controversy. More recently, and in support of Jiang and Mei's 2021 paper, Zhang and El-Deiry (2024) have demonstrated that the SARS-COV-2 spike protein suppresses protein p53-dependant gene activation, a key protective mechanism for both the immune system and in DNA repair to prevent initiation and propagation of cancer. Finally, Rubio-Casillas et al (2024) have demonstrated the biological toxicity of the N1-methyl-pseudouridine in a modified mRNA vaccine in a melanoma model which demonstrated cancer growth and metastasis to be stimulated whereas non-modified mRNA vaccines induced opposite results. Together with growing evidence and safety reports filed to Vaccine Adverse Effects Report System (VAERS) suggesting that some cancer patients experienced disease exacerbation or recurrence following COVID-19 vaccination, the biological *plausibility* consideration of Bradford Hill for a causative link between COVID-19 mRNA vaccines and increased cancer mortality is met.

It is thus clear that there is a strong biological plausibility for a causative link between ongoing COVID-19 mRNA vaccination and excess mortality, increased COVID-19

infections and deaths and increased deaths from circulatory disorders, dementia, diabetes and cancer.

7,8. COHERENCE, EXPERIMENT

In coherence with the concept that these injections could be causative of excess ACM, persistent spike protein has been demonstrated many months post injection in various bodily tissues including the immune system, heart and brain, on blood testing, tissue biopsy and at postmortem. Again the Parry et al (2023) paper describes many of these findings.

As an interventional 'experiment', reduced uptake of further vaccines post rollout correlates visibly with reduction from the peak of increase in mortality from Covid, diabetes, dementia, circulatory disorders and renal disease, although excess deaths from cancer are continuing to increase. The fact that excess cancer deaths continue to rise correlates also with a generally greater time lag from carcinogenesis to diagnosable disease than the pathophysiological timescale for those other diseases.

10. REVERSIBILTY.

Again, without statistical analysis, the 10th added condition of Reversibility is seen in the above-mentioned reduction from the peak levels both in the underlying diseases and in the total ACM as fewer new vaccine doses have been administered.

CONCLUSION.

The increase in Australia in all-cause mortality (ACM), mortality attributed to COVD-19, and increases in background disease processes such as circulatory diseases, dementia, diabetes and cancer all occurred in the same time frame from late 2021, peaking in 2022 and reducing

toward baseline again in 2023, with the exception of cancer mortality which is continuing to increase.

These increases correlate with the rollout of the COVID-19 mRNA vaccinations in Australia and meet 9 of the 10 'Bradford-Hill criteria' specifically with regards to *strength of association*, *consistency*, *specificity, temporality, dose- response, biological plausibility, coherence, experiment* and *reversibility*.

With regards to biological plausibility, the now well-studied pathogenicity of the spike protein, in particular the ability to trigger chronic inflammation, provides a basis for biological aetiology of these increased disease patterns.

Rancourt et al (2023) conclude: 'Synchronicity between the many peaks in ACM (in 17 countries, on 4 continents, in all elderly groups, at different times) and associated rapid booster rollouts allows this firm conclusion regarding causality, and accurate quantification of COVID-19 vaccine toxicity'.

In their assessment, the overall all-ages vaccine death fatality rate (vDFR) for the 17 countries was (0.126 ± 0.004) %, which would imply 17.0 ± 0.5 million COVID-19 vaccine deaths worldwide, from 13.50 billion injections up to 2 September 2023. This would correspond to 'a mass iatrogenic event that killed (0.213 ± 0.006) % of the world population (1 death per 470 living persons, in less than 3 years)'.

As described above, vaccine efficacy for the gene-based COVID-19 vaccines in preventing deaths is likely to be substantially less than claimed. Risks have therefore tragically well outweighed benefits, particularly for those who were never highly susceptible to COVID-19 viral illness.

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Second Response

By Dr Astrid Lefringhausen (PhD), Director, Children's Health Defense, Australia.

Introduction

It is close to impossible to assess the causality of a wide range of reactions to a drug when not all parameters are known, and what is known is unreliable because it is incomplete, censored and doesn't come with the raw data attached as a reference. Excess mortality is a little bit easier to work with because these are numbers that cannot be manipulated, only their release can be delayed.

To identify potential drivers of excess mortality without access to the full medical history and conditions under which the deaths occurred is still difficult. To name just a few factors, did the deaths occur at home, in hospital, under what treatment, what other conditions have to be taken into account and what is determined as cause of death, by whom and has there been an autopsy? Accurately assessing the Covid-19 pandemic and the following years based on Covid infection cases and deaths is not possible because deaths attributed to SARS-CoV-2 have not been adequately proven, the scientific data used are flawed.

The only option left is an analysis based on statistic data. While a lot of our data have been manipulated to the point that they are useless for proper cause and effect analysis, one data set is impossible to falsify: the national death rate. Without accepting the offered cause of excess deaths at face value, it is possible to use existing raw data on number of deaths and the time they occurred to reach certain conclusions.

The Bradford Hill criteria are a group of nine principles that can be useful in establishing epidemiologic evidence of a causal relationship between a presumed cause and an observed effect and they have been used in science whenever more reliable data were unavailable.

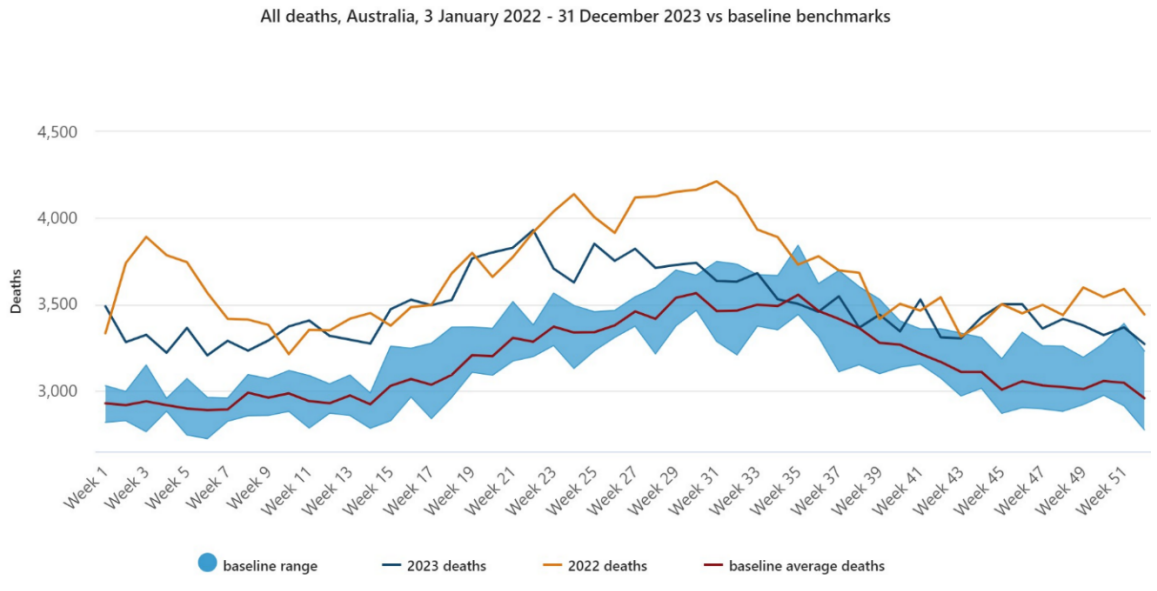
When looking at the raw ABS (Australian Bureau of Statistics) data from 2015 up to 2023, it becomes clear that the pandemic year 2020 had compared to the previous 5 years lower than average mortality. Excess deaths started to rise in March 2021 around the time the vaccination campaign started (Figure 1). When comparing monthly death rates for the years 2015- 2022, the only year that came close to the numbers of 2022 was the bad flu year 2017, and only in the winter months August and September.

Number of deaths by month of occurrence, 2020-23				
	2020	2021	2022	2023
January	12,999	13,370	16,275	14,811
February	12,513	12,028	14,093	13,019
March	13,549	13,629	14,748	14,832
April	13,301	13,581	14,864	14,732
May	14,027	15,044	16,493	16,618
June	13,270	14,883	17,182	16,110
July	14,482	15,916	18,329	16,577
August	14,862	15,417	17,765	15,972
September	13,696	14,775	15,783	14,867
October	13,439	14,996	15,357	14,948
November	13,040	14,052	14,802	14,757
December	13,513	14,447	15,696	14,795
	162,691	172,138	191,387	182,038
excess		**10,974**	**29,710**	**20,973**

Figure 1: raw data from Australian Bureau of Statistics, provisional Mortality statistics, Jan-Dec 2023.

From May 2021 onwards each monthly mortality rate was consistently higher than that of 2020.

Overall, the ABS recorded in 2020 a total number of deaths of 162,691, in 2021 172,138, in 2022 of 191,387 and in 2023 of 182,038. With 2020 being a year of exceptionally low mortality and 2021 a year of slightly elevated mortality, both 2022 and 2023 show significant excess mortality compared to both.



a. Data is by occurrence.
b. Data is provisional and subject to change.
c. Weeks are defined as seven-day periods which start on a Monday as per the ISO week date system. Refer to 'Weekly comparisons' on the methodology page of this publication for more information regarding the data in this graph. Week 1 ended 9 Jan 2022 and 8 Jan 2023.
d. The baseline includes deaths from 2017-19 and 2021.

Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan - Dec 2023

Figure 2: all deaths in Australia from January 3, 2022 to 1 December 2023.

When calculating the average mortality of the pre-pandemic years 2015-2019 and using the resulting 161,065 as a baseline to compare total mortality for every year against, the following picture (Figure 3) emerges: 2019 and 2020 are well within the standard range of normal statistical fluctuation while from May 2021 onwards excess deaths accelerate.

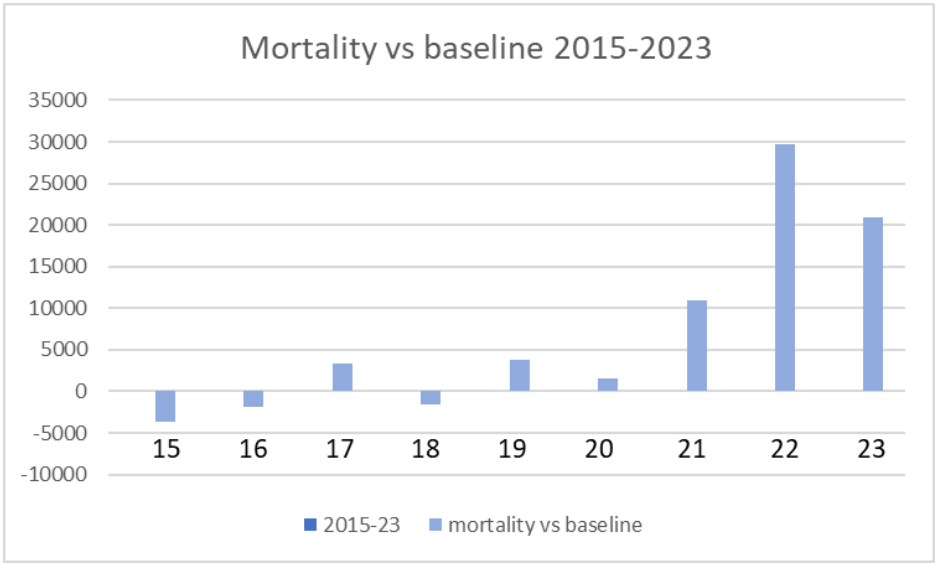


Figure 3: Australia mortality as deviation from baseline, based on raw data from ABS website.

Influenza, Pneumonia and Covid

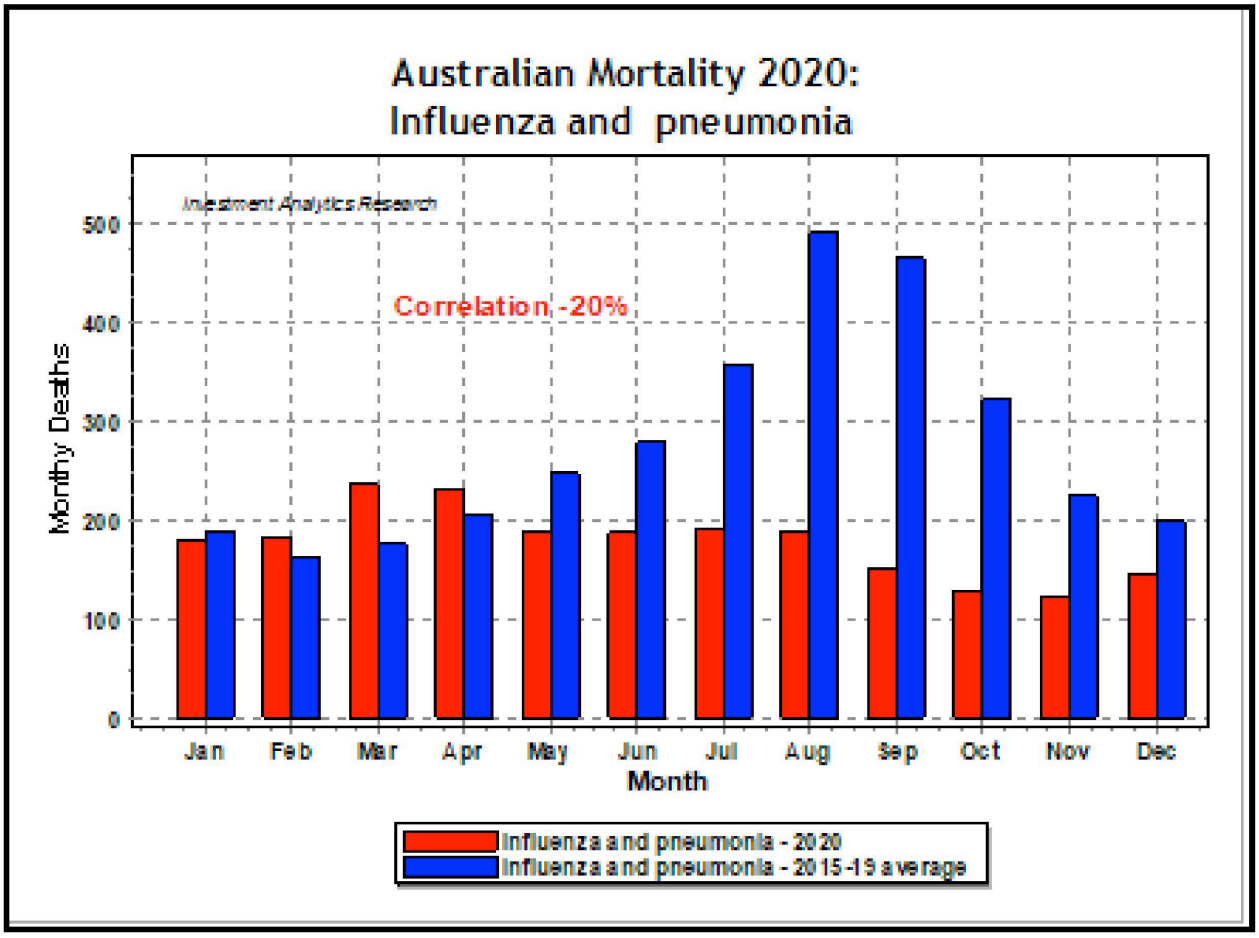
The question is, what were the causes of these excess deaths?

It was and is easy to attribute them to Covid-19, but since the majority of those excess deaths happened in the over 65-old, a significant amount of them had one or more comorbidities and it remains unclear if they died *with or of* Covid. Virtually no autopsies were performed, and the analysis was based on subjective judgement, probably influenced by financial incentives – hospitals were able to get substantial rebates for every patient who was declared a Covid-patient.

Wilson Sy (1) looked in his paper at the relationship between Covid-19 mRNA injections and these excess deaths, by analysing raw data obtained from a third party data aggregator CovidBaseAU (CovidBaseAU | Vaccinations). Altogether by September 2022 over 68 million doses had been given to a population of under 26 million. The peaks occurred in September 2021 for the initial injection and in January 2022 for the first booster and can be correlated to

peaks in excess deaths 5 months later. During the pre-pandemic phase in 2020, no excess deaths were recorded as mortality was well within the standard range. This supports the proposition that there was no pandemic in Australia although there were 900 deaths in 2020 that were declared Covid deaths. But were those 900 deaths part of the actual pandemic? All respiratory diseases are seasonal with a peak of mortality in late winter, August and September in Australia. The below Figure 4 shows the typical pattern of mortality based on the average rates of the 5 years from 2015-19 in blue bars.

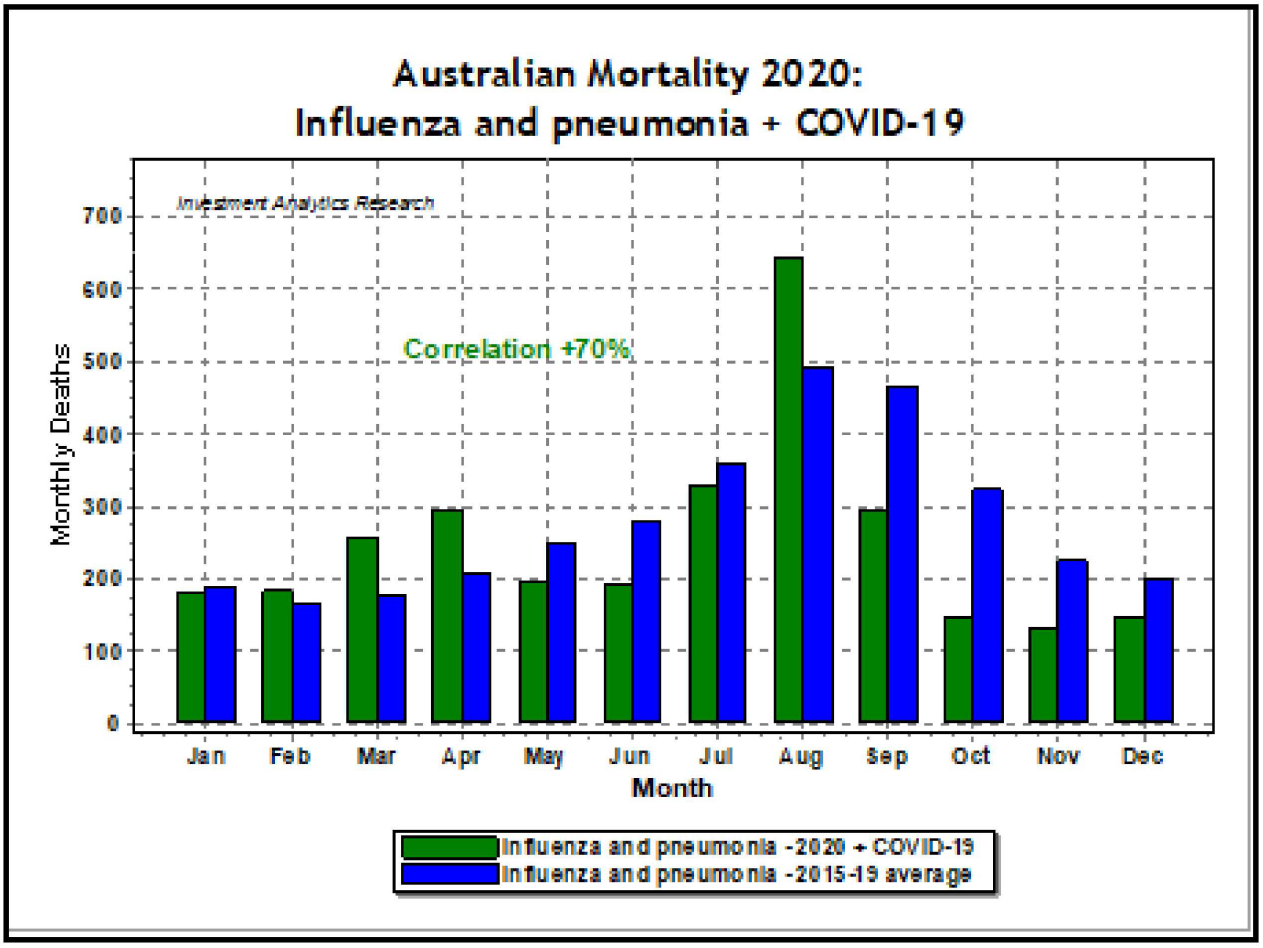
Figure 4



2020 (red bars) showed untypical seasonality with deaths from influenza and pneumonia almost disappearing during the usual peak months of winter. The correlation between normal fluctuations and those from 2020 shows at -20% a clear seasonal anomaly. But Covid-19 is a respiratory disease with symptoms very similar to influenza and pneumonia and there were surges in Covid cases in August 2020, particularly in Victoria. If deaths from Influenza, pneumonia and Covid-19 are added together, we arrive at a normal picture of seasonal deaths (Figure 5).

Considering the poorly defined characteristics of Covid infections and the subjective attribution of respiratory deaths to Covid, it is a strong possibility that Covid deaths might have been misclassified from Influenza and pneumonia deaths. The fact that the Australian government provided $4.8 billion for the Covid-19 pandemic response – stating "the full resources of our world-class health system – a blend of public and private systems – are needed to focus on treating Covid-19 patients" indicated that more Covid-19 patients would mean more funding for hospitals and provided a powerful incentive to re-classify patients with other respiratory diseases as Covid-19 patients.

Figure 5



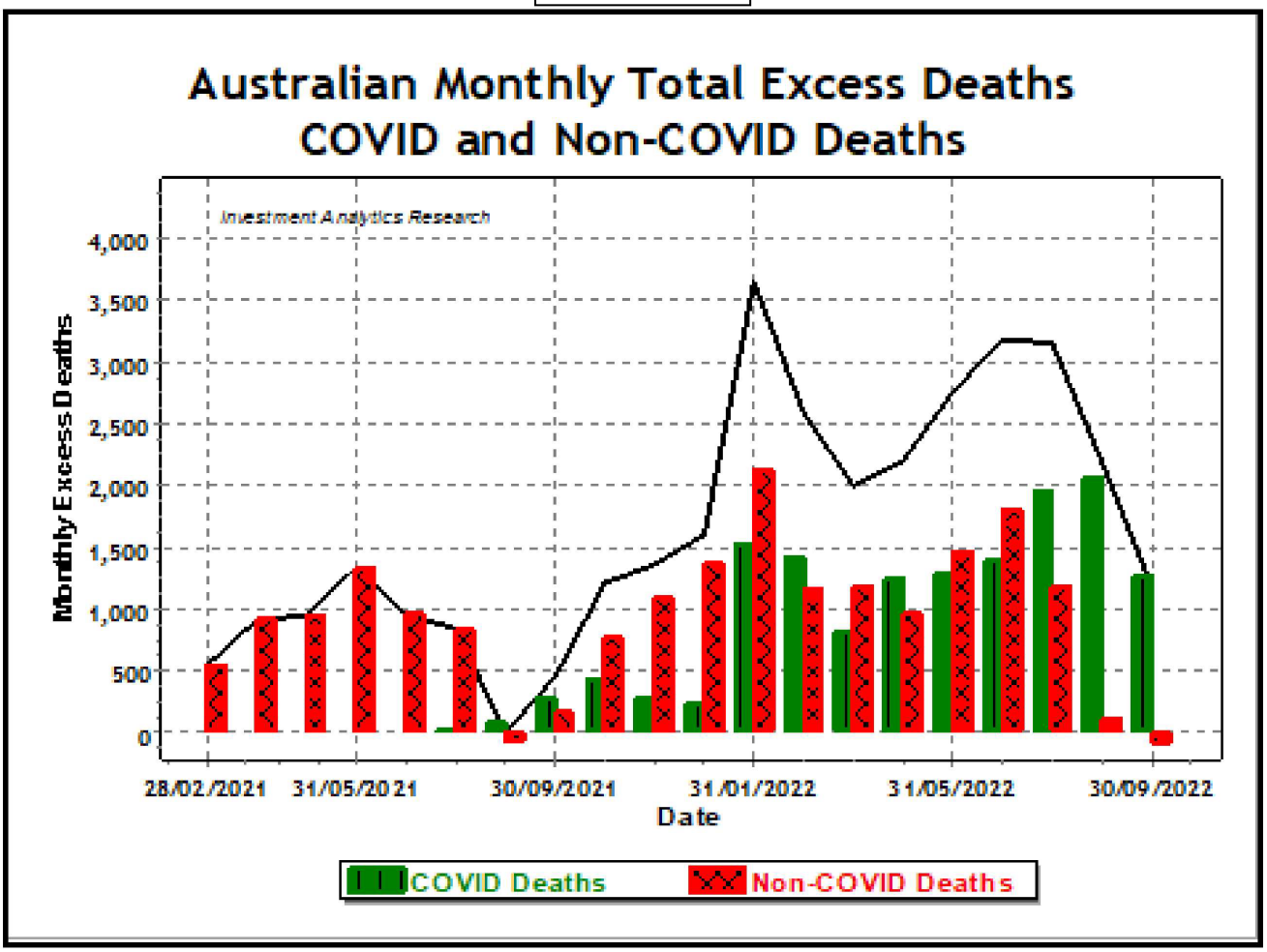
The official narrative that Australian public health measures like masking and lockdowns were responsible for reducing excess deaths in 2020 is contradicted by the mere existence of Sweden that ignored all of these measures and fared no worse than any other Western country following the pandemic protocols.

In summary, there is no statistical evidence for a new, deadly coronavirus in Australia in 2020.

Covid-19 mRNA injections and excess deaths

The pandemic phase began in Australia in 2021, the year of the "safe and effective" mass Covid mRNA injections for a pandemic that was shown to be non-existent in 2020. Again, citing the Sy paper (1), when overlaying the monthly injection doses with excess deaths there was only a small peak correlating to the injections, probably showing instant reactions like anaphylaxis and other pre-existing conditions (Figure 6).

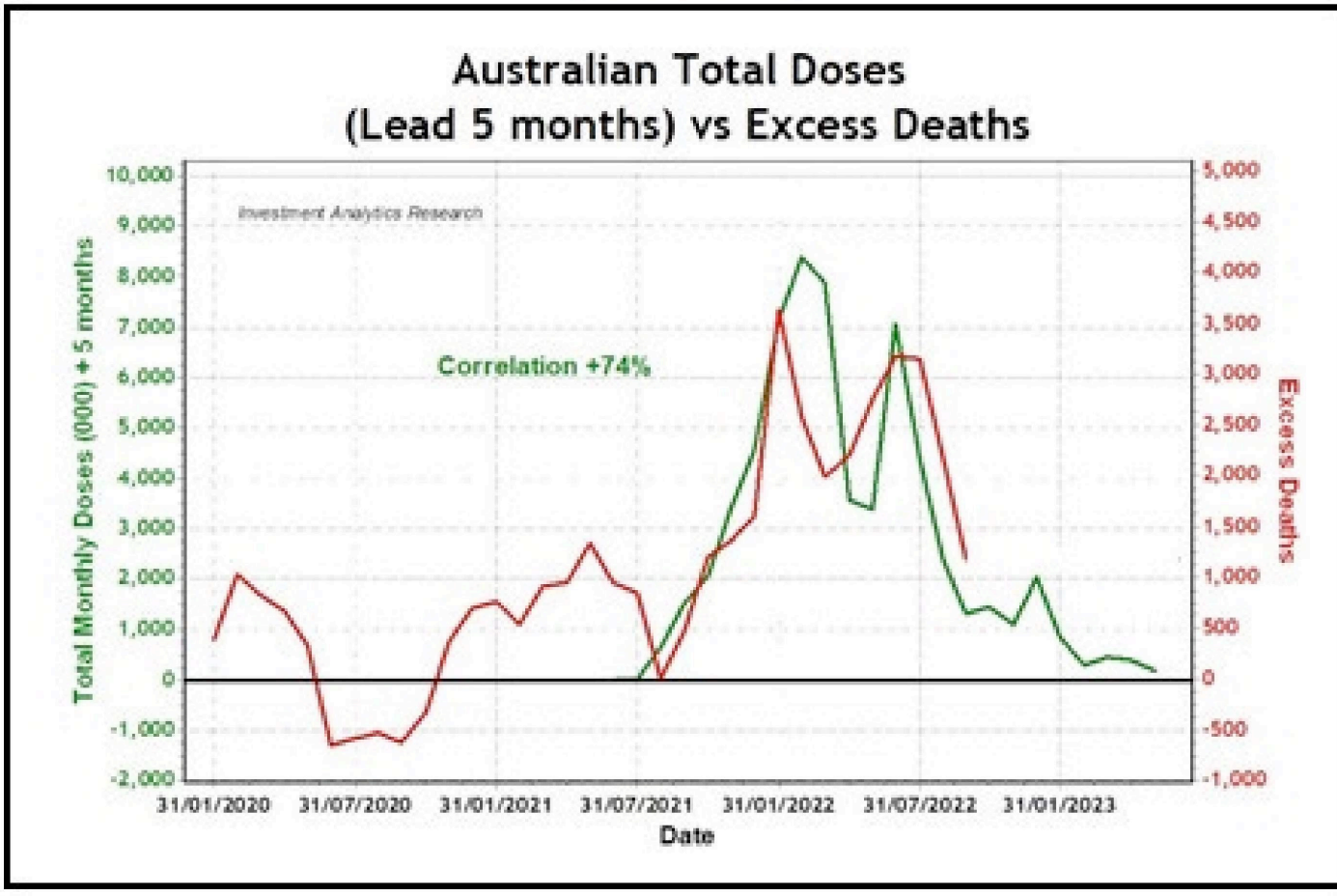
Figure 6



The peak of deaths in 2021 represents a surge of deaths in the elderly, mostly the 85+ age group, who died shortly after being *challenged* with the mRNA injections. Their deaths were

probably due to comorbidities and chronic inflammation, aggravated by the Covid-19 shots. The second peak coincides with the injection of the first booster shots which could have led to a fatal combination of chronic inflammation and immune suppression. The initial injection series might have weakened the immune system and made it more vulnerable to challenges by e.g. the booster shots (29). When the data for total monthly doses is shifted forward by 5 months, the peaks for excess mortality and injections are now well aligned with a correlation of 74% (Figure 7).

Figure 7



This strong and consistent correlation with the five-month lag applied satisfies two of the main Bradford-Hill criteria, which are the strength of high correlation and temporality.

Biological gradient

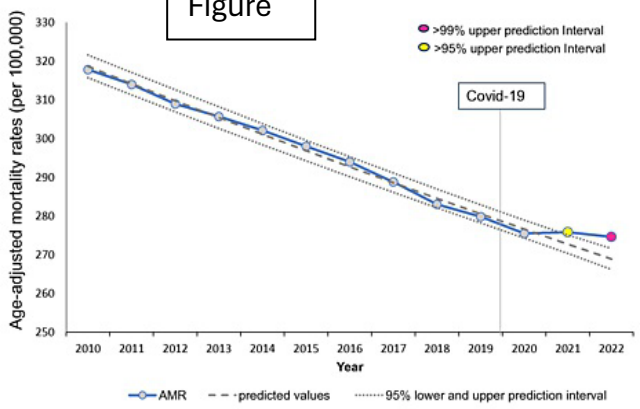
The biological gradient is another important Bradford-Hill criterion, describing a consistent dose to response relationship, meaning the more doses an individual receives, the stronger the response will be. Based on investment analytics data, Wilson Sy calculated a dose-response relationship suggesting that for every 5 million doses injected nationwide, an average of 2,221 excess deaths can be expected five months later (1).

Consistency and specificity

While causal association of iatrogenesis with excess deaths has been shown for Australia, are there similar observations in other countries? Consistency is yet another important criterion according to Bradford Hill.

A publication by Gibo et al (2) analyses excess deaths for all causes in Japan from 2020 to 2022. They found – similar to Australia – deficit mortality for all causes in 2020 and no excess cancer mortality. For 2021 they reported significant excess mortality for all causes (2.1%) and for cancers (1.1%). In 2022 this excess mortality increased to 9.6% for all causes and 2.1% for all cancers.

Figure



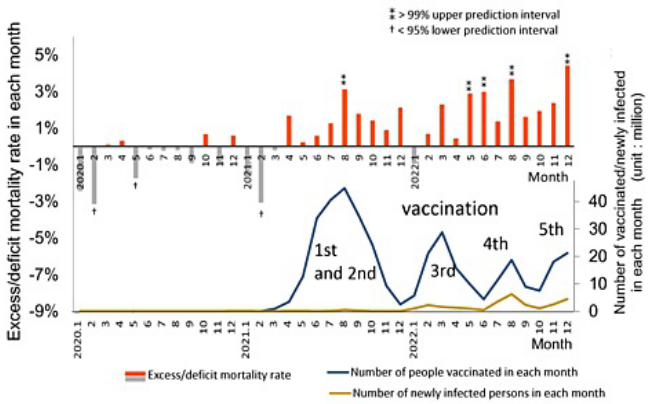


Figure 8 shows annual ACM (all-cause mortality) over time and excess mortality during the pandemic years 2020-2022 in Japan. Excess mortality peaked above background rates in August 2021, coinciding with the first and second mass vaccinations. A further elevation happened in May 2022, two months after the first mass booster injections, peaking again after each further booster injection. The authors concluded that statistically significant increases in age-adjusted mortality rates of all cancer and some specific types of cancer, namely, ovarian

cancer, leukemia, prostate, lip/oral/pharyngeal, pancreatic, and breast cancers, were observed in 2022 after two-thirds of the Japanese population had received the third or later dose of SARSCoV-2 mRNA-LNP vaccine. They attribute these particularly marked increases in mortality rates of ERα-sensitive cancers to mechanisms of the mRNA-LNP vaccination rather than COVID-19 infection itself or reduced cancer care due to lockdowns, particularly since cancer care was up to pre-pandemic levels in 2021.

A study by Kuhbandner et al (3) analyses excess deaths in Germany for the pandemic years 2020-2022.

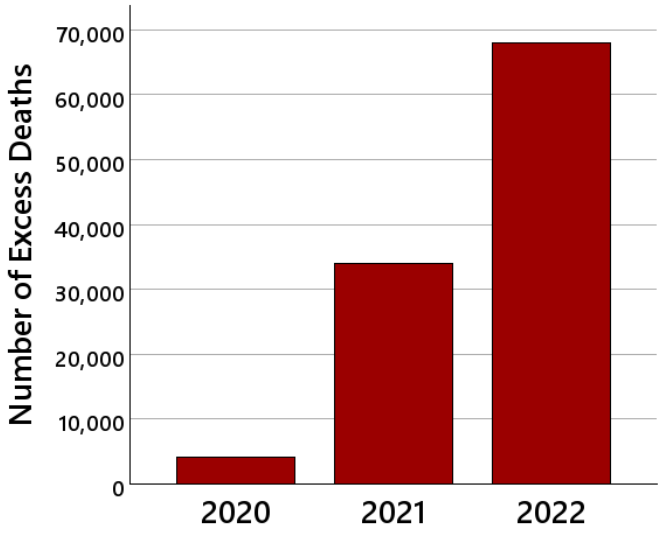


Figure 9: Number of excess deaths in Germany in the pandemic years.

Similar to Australia and Japan, substantial excess deaths were only reported starting from 2021, the year the mass vaccinations started in Germany, and accelerating in 2022, the year of the boosters (Figure 9). While there was strong correlation between reported Covid-19 cases and excess deaths in 2020-2021 (with the same issues regarding reliability of classification of a respiratory disease death as a Covid-death), this was not the case for 2022, when Covid-19 cases decreased but excess deaths increased. They found that there was a significant correlation between Covid-19 injections and excess deaths in 2021 and 2022, which is corroborated by the different German states and their excess death rates which are more elevated, the higher the vaccination rate of the state was.

In the US there were roughly 470,000 excess deaths in the pandemic year 2020, most of which were likely due to hospital protocols, lack of care and withholding of antibiotics to elderly patients with respiratory diseases which might or might not have been Covid-19. Official deaths from Covid-19 in 2020 were 352,000 (Our World in Data).

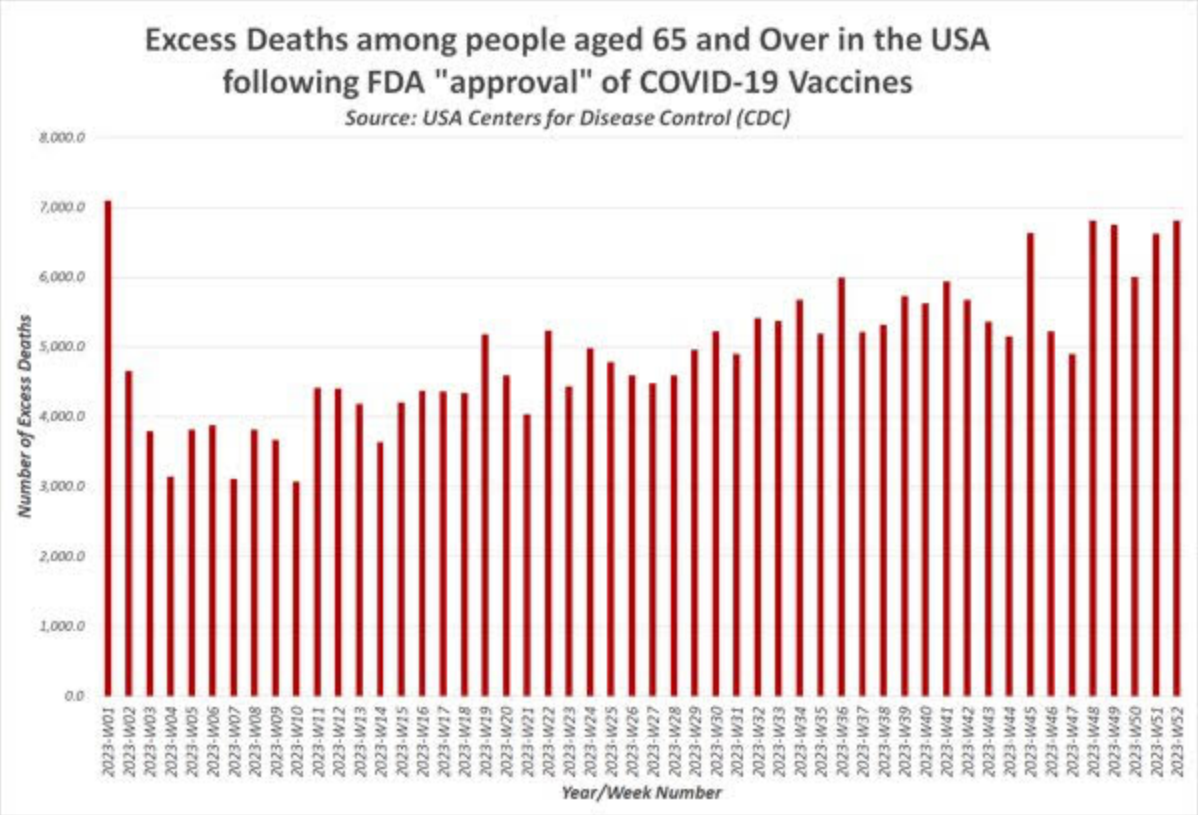
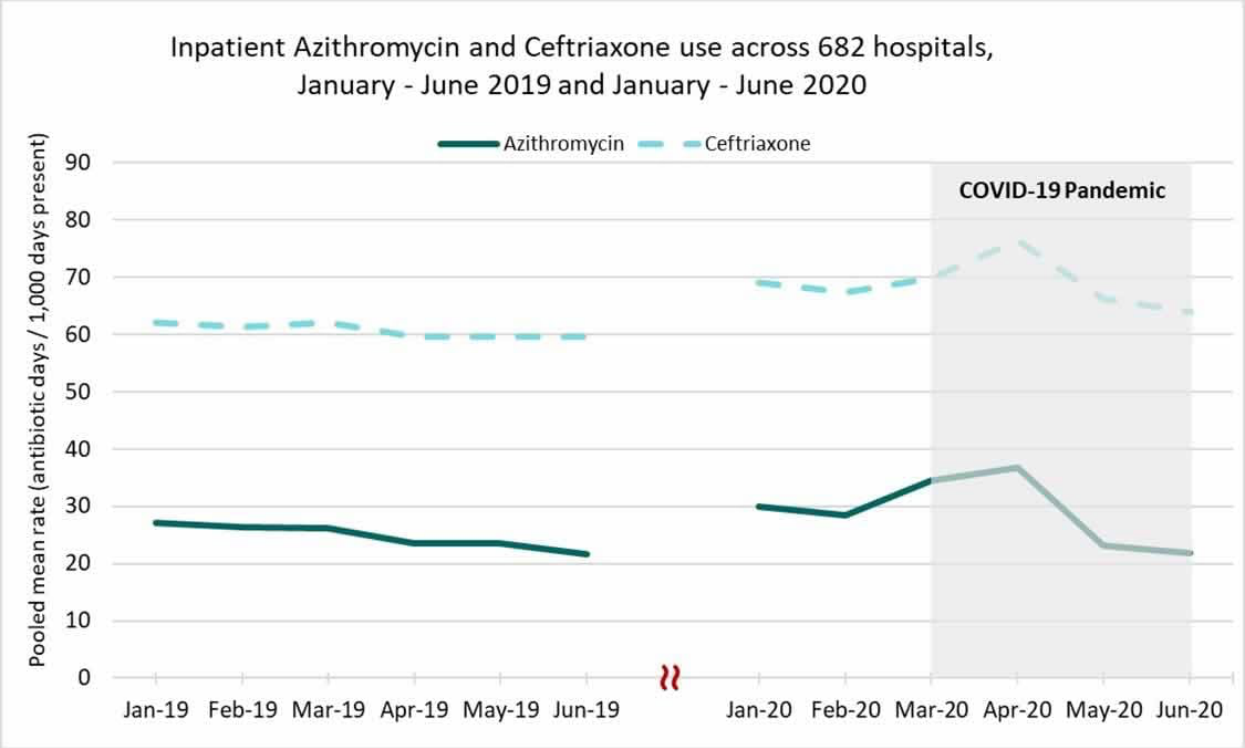


Figure 10: Excess deaths among people 65 and over in the US.

Why did the US specifically have such a high excess death rate during 2020, unlike almost all other developed nations which like Australia and New Zealand had no discernible pandemic effects?

Two factors are probably most important here: the hospital protocols and the lack of use of antibiotics.

Prior to the COVID-19 pandemic, antimicrobial consumption **decreased worldwide**. This decline was likely influenced by the **WHO Global Action Plan on Antimicrobial Resistance (GAP-AMR)**, which aimed to curb unnecessary antimicrobial use. In March 2020, antimicrobial consumption increased significantly (11.2%) compared to 2019 levels https://academic.oup.com/jac/article/77/5/1491/6530407 (Khouja et al, 4). The surge was primarily driven by higher usage of **antivirals** (48.2%) followed by antibiotics (6.9%). However, from April to August 2020, antimicrobial consumption **decreased globally by 18.7%** compared to the previous year. Specifically, antibiotic consumption saw substantial reductions in both developed (−28.0%) and developing (−16.8%) countries (4).



Data Source: CDC National Healthcare Safety Network Antimicrobial Use Option

Figure 11: Hospital use of Azithromycin and Ceftriaxone across 682 hospitals in HY1 2020 vs 2019

When looking at the NIH hospital protocols for Covid-19 patients, even the updated version of 2024 shows no mention of antibiotics (**Hospitalized Adults: Therapeutic Management | COVID-19 Treatment Guidelines (nih.gov)**) which have routinely been used especially in elderly patients to prevent secondary bacterial infections. Looking at Table 2c. Therapeutic Management of Hospitalized Adults With COVID-19, Remdesivir is part of the treatment regime as well as dexamethasone and immunomodulators in spite of panel recommendations to not use **dexamethasone (AIIa)** or other systemic corticosteroids **(AIII)** for the treatment of COVID-19 in patients who do not require supplemental oxygen, recommendations that are published on the same NIH website.

Statistical brief #300 by Marc Roemer, M.S., and Jennifer Welch, M.P.H (Changes in Hospitalizations and In-Hospital Deaths in the Initial Period of the COVID-19 Pandemic (April–December 2020), 38 States and DC (ahrq.gov)) summarizes the year 2020:

> ■ The number of hospitalizations was lower each month in April–December 2020 compared with the same month in 2019, while the all-cause in-hospital mortality rate was greater.

■ The number of monthly COVID-19-related hospitalizations in 2020 was more than three times higher in December (316,000) than in April (104,000). The mass vaccination program in the US started on December 14 (added for emphasis).

■ The mortality rate among COVID-19-related hospitalizations was greater than 10 percent in every month between April and December 2020. The in-hospital mortality rate among COVID-19-related hospitalizations was at its highest at 19.5 percent in April and then decreased to 10.9 percent in June; it ranged between 10.4 and 12.9 percent during July through November and increased to 13.3 percent in December.

It is unlikely that a lot of misclassification happened in the US although Medicare paid hospitals a 20 percent "add-on" to the regular payment for COVID-19 patients as a result of the CARES Act, the largest of the three federal stimulus laws enacted in response to the coronavirus, which was signed into law March 27, 2020. The excess mortality in 2020 was most likely an effect of the hospital protocols and withholding of antibiotic treatments not only in hospitals but in care homes and outpatients as well. The increasing December mortality could have been an early indication of vaccine side effects.

However, with this amount of excess mortality, it would have been natural to expect mortality to go back to baseline or even below in the following years – if the Covid-19 injections were indeed safe and effective. The continued surge of excess deaths to this day cannot be attributed to Covid, or the interruption of cancer or other treatments in 2020, at least not beyond the year 2021. In early 2021 campaigns were launched to get the vaccinated boosted again with a reformulated COVID-19 vaccine. By the end of 2021, the most vaccinated age group saw 448,740 excess deaths (Our World in Data).

In 2022, the over 65 age group recorded 371,466 excess deaths. While the US government dubbed the winter of 2021 and 2022 the "winter of severe illness and death" for the unvaccinated, the most vaccinated age group saw again the greatest losses.

In 2023, there were an additional 257,415 excess deaths in the elderly. After the first week of 2024, the CDC already confirmed 5,482 excess deaths in this age group. Again, post pandemic we see clear correlation between Covid-19 injections and excess mortality. In the US, 15% of adults never received a single Covid-19 injection.

While the correlation of excess mortality with Covid-19 injections is not as consistent in the US as in other countries, the fact that excess mortality only slightly receded after almost half a million excess deaths in the over 65 year olds in 2020 should give pause, especially since this age group was the highest vaccinated in the country. A recent publication from the San

Jose Mercury News in the heart of Silicon Valley, California, reports a curious shift in age and race of Covid-19 victims (5). While in the first 6 months of the pandemic Latinos made up nearly half of the victims, their share of excess deaths was down to 20% of all deaths by the end of the pandemic, while white Californians, who are 37% of the population and made up 30% of excess deaths in 2020 are now up to a disproportionate 60% of all excess deaths. Altogether there are far less excess deaths now than in 2020 and 70% of the fatalities are over 75 years old, but it is telling that the highly vaccinated white laptop class minority in California has now a disproportionately high share of excess mortality while the far less vaccinated Latinos and Black working class populations show reduced mortality.

The below excerpt from a table (Latest Data on COVID-19 Vaccinations by Race/Ethnicity | KFF) shows that in California, the white population has a substantially higher vaccination rate than black or Hispanic populations which makes vaccination the most plausible explanation for this shift in excess mortality.

Table 1

Percent of Total Population that has Received a COVID-19 Vaccine Dose by Race/Ethnicity, Selected States, July 11, 2022

	White	Black		Hispanic		Asian	
	Percent Vaccinated	Percent Vaccinated	Percentage Points from White	Percent Vaccinated	Percentage Points from White	Percent Vaccinated	Percentage Points from White
Total (36 States)	64%	59%	−5.0	67%	3	87%	23.0
Alabama	49%	52%	3.0	59%	10	83%	34.0
Alaska	56%	92%	37.0	50%	−6	81%	25.0
Arizona	62%	53%	−8.0	47%	−15	82%	21.0
California	76%	68%	−9.0	65%	−11	89%	13.0
Colorado	79%	75%	−5.0	42%	−37	74%	−5.0
Connecticut	81%	68%	−13.0	78%	−3	90%	9.0

The criterion of specificity refers to the determination of the strongest and most plausible explanation for the excess deaths – is iatrogenesis the best explanation for the observed excess mortality? Due to classification bias by health authorities across Australia, reports containing flawed data have led the public to believe that the majority of deaths were in the unvaccinated cohort. Considering that only 2.5% of the Australian population remain to this day completely unvaccinated with Covid-19 injections, it is questionable that they can be responsible for the majority of the excess deaths. Unfortunately, of all the states only NSW health has Covid death data segregated by vaccination status.

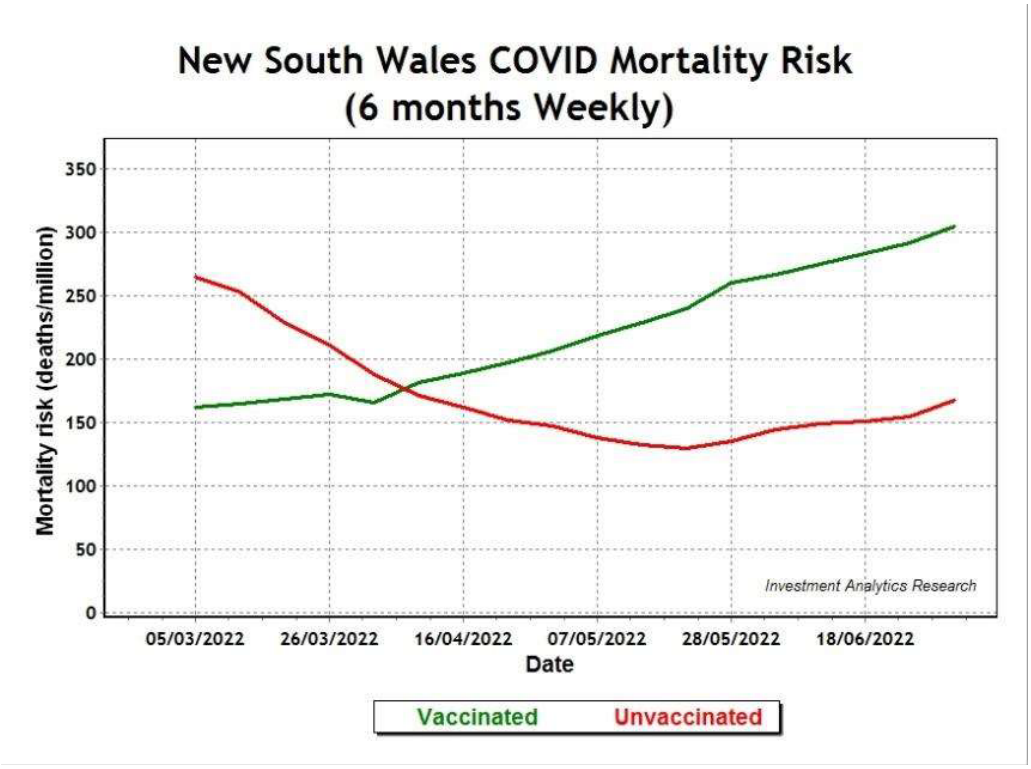


Figure 12: NSW Covid mortality risk from March to June 2022

The data in Figure 12 show that by mid-2022, the vaccinated had roughly double the Covid mortality risk as the unvaccinated. Shortly afterwards, NSW health stopped reporting Covid deaths by vaccination status.

Coherence and plausibility

The idea that the origin of the observed excess mortality 5 months after injections is of an iatrogenic nature doesn't contradict any published vaccine research information. The clinical trials conducted by Pfizer were only 77 days, to be precise from 27 July 2020 to 14 November 2020, with a cut-off date for data of 9 October 2020 (6). That is with less than 3 months well below the time needed for iatrogenic fatalities as found in Australia to occur and therefore not contradicting any known facts.

There are a multitude of possible biological mechanisms in the literature that could be responsible for the observed excess mortality with a five-month lag. ADE or antibody dependent enhancement will turn antibody derived protection from viruses into a weakness when the virus mutates just enough for the antibodies to be not neutralizing anymore. In that case some viruses – including coronaviruses – can use the antibodies to enter immune cells and multiply inside them, a double hit for the immune system. This could be consistent with a

five-month lag, depending on time point of infection with a mutated SARS-CoV-2 strain (7, 8, 9). Several papers (10, 11) describe an immune shift from IgG1 and IgG3 – inflammatory antibodies used to fight viral infection – to tolerance inducing IgG4 after mRNA vaccination, which would shift the immune reaction of an individual over time from fighting Covid-19 infection and clearing vaccine induced spike protein from the body to completely ignoring the spike protein, and in case of infection, the attached virus as well. Since the spike protein – from the virus as well as the vaccine – is now well documented to be toxic (12), it in itself could cause fatalities with a 5-month delay. It is known to contain prion sequences that promote protein misfolding and amyloidosis leading to Alzheimer and other neurodegenerative diseases (13), is associated with new onset myocarditis (14), interacts with the ACE receptor with severe consequences (15, 16), contains domains that are very similar to human proteins and is therefore prone to cause autoimmune disease (7, 17) and alters P53 signaling (18, 19), the human bodies' general tumor inhibitor. Zhang et al (20) also found that SARS-Cov-2 infection triggers cellular senescence through decreased cell proliferation and increased inflammatory factors initiated by high levels of spike protein, meaning the same spike protein that is produced by mRNA vaccines in the human cells. There is furthermore the accumulator effect to consider, as individuals receive additional boosters, not only do their bodies produce more spike protein, with increasing immune tolerance it is accumulating faster and the different hits can overwhelm the system very rapidly. Additionally, the lipid nanoparticle component of the injections is highly inflammatory (21) and some parts of it have never been used in humans before. It is likely that they contribute to the overall toxicity of the shots and through accumulation in certain organs could be the cause of excess mortality by themselves. Finally, genomic integration of reverse transcribed short mRNA sequences or DNA contaminations in the vaccines – helped into the nucleus by the SV40 promoter and its nuclear localization signal – has been shown to advance transcription errors of either the inserts themselves or the chromosome the insertion happened in. These transcription errors not only play a role in the formation of amyloid plaques characterizing Alzheimer's disease but can also promote the conditions in which those amyloid proteins evade the protein quality control mechanism of the cell and initiate aggregation. A recent study preview by Rubio-Casillas et al (22) revealed that the mRNA vaccines inhibit essential immunological pathways, in particular early Interferon I signaling, by activating ATP-dependent helicase LGP2 which leads to a suppressed tumor response. The impaired interferon signaling ensures an appropriate spike protein synthesis and a reduced immune activation, however, adding 100% of N1-methyl-pseudouridine (m1Ψ) to the mRNA vaccine in a melanoma model stimulated cancer growth and metastasis, while non-modified mRNA vaccines induced opposite results, thus suggesting that COVID-19 mRNA vaccines could aid cancer development. It is also well known that endogenous cytoDNA - free DNA fragments in human cells outside the nucleus or mitochondria, caused by the high amount of DNA contaminations confirmed in the mRNA injections - is a contributor to so-called sterile inflammation, inflammation in the absence of pathogenic infection, which is associated with many chronic age-associated conditions, including cancer, cardiovascular disease, and neurodegenerative damage, sometimes severe, and sometimes lethal (23).

After the third injection, direct correlation between mRNA injections and excess mortality becomes blurred due to overlapping and accumulation of the various side effects discussed above.

Experiment and Analogy

Since experiment takes the meaning of clinical or laboratory evidence, the only experiment to prove causes of excess mortality can be an autopsy. Australian and other Western governments have discouraged such experiments, citing the dreaded growth of vaccine hesitancy as their cause. Several post-mortem studies were conducted all the same, leading to evidence of spike protein from Covid injections in the bodies of the deceased. By looking for antibodies directed against the nucleocapsid protein from SARS-CoV-2 in the autopsies (and not finding them), it was shown that not long Covid or Covid-19 infection was the cause of death but the spike protein from the mRNA injections (24-27).

The 2009 Swine flu pandemic (that also turned out not to be a pandemic) serves as analogy to the Covid-19 healthcare disaster. When the H1N1 virus emerged a pandemic was called, like in 2020 not based on fact but on expectations of a highly infectious and deadly disease prognosis by the Oxford computer models. Luckily, in 2009 production of Swine Flu vaccines was too slow and by the time it was available, the pandemic had petered out already. Because this 2009 pandemic was never allowed to turn into an iatrogenic pandemic, it turned out instead to be a weaker form of seasonal influenza and amounted to a higher case rate but lower mortality, which confirmed it was not a pandemic. The Covid-19 pandemic would probably never have eventuated, if not for the mass mRNA vaccinations that ultimately caused and perpetuated it.

The Bradford Hill criteria are a group of nine principles that can be useful in establishing epidemiologic evidence of a causal relationship between a presumed cause and an observed effect. According to the World Health Organisation, only five need to be satisfied to show evidence of causation. With at least 5 of them pointing strongly at the Covid-19 injections as cause of the currently ongoing excess mortality and the other 4 being at least moderately favoring iatrogenesis as the cause, no convincing alternative explanations have been offered to date. Table 1 below shows all principles and based on which references they are judged to be met.

The excess mortality in Australia since late 2021 to this day was caused by mRNA mass vaccination and is likely to go on for many years. It is unlikely that future excess mortality will be labelled correctly, but will instead most likely be assigned to the flavor of the month, like climate change, CO2 or lack of EVs.

Table 1 Bradford Hill criteria for iatrogenic cause of excess mortality in Australia

Criterion	Evidence	Comment
Strength	Sy, W. (2023), Australian Covid-19 pandemic, J Clin Exp Immunol, 8	Monthly correlation between doses of injections and excess deaths at +74%
Consistency	Gibo et al (2024); Kuhbandner et al (2023), Marc Roemer et al (2022)	Strong correlation between injections and excess deaths over time and across many countries
Specificity	San Jose Mercury News; Sy, W. (2023)	Very few competing explanations for iatrogenic deaths. Vaccinated have higher risk of deaths than unvaccinated.
Temporality	Sy, W. (2023), Australian Covid-19 pandemic, J Clin Exp Immunol, 8	5-months lag of mortality following vaccination is consistent
Biological Gradient	Sy, W. (2023), Australian Covid-19 pandemic, J Clin Exp Immunol, 8	Consistent dose-response relationship found in data
Plausibility	References 7 to 23	Abundant research on Covid-19 injection related deaths due to autoimmunity, immune suppression, toxic effects of spike protein, mRNA, DNA and lipid nanoparticles, antibody class switch to IgG4 and corresponding immune tolerance to spike protein indicates iatrogenesis as probable excess mortality cause.
Coherence	Polack et al (2020) Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine	Neither safety signals nor suggested underlying pathology contradict known facts.
Experiment	References 24-27	Autopsies show pathology caused bz vaccine-induced spike protein
Analogy	Klemm et al (2016). Swine flu and hype: a systematic review of media dramatization of the H1N1 influenza pandemic.	Swine flu 2009 petered out naturally without mass vaccination

As a scientist I am in no position to give health advice to people suffering from Covid-19 vaccine side effects.

I can state with certainty that the damage done as far as it relates to genomic integration and tumor repressor damage is irreversible and to my knowledge there is nothing that can be done to fix it.

It is probably possible to mitigate the negative effects in some ways by healthy life-style, regular exercise, regular exposure to sunlight and avoidance of pharmacological and chemical toxins, including all vaccines. I strongly believe that individuals which were so ill advised as to accept three or more injections will likely live a shorter life span than they could have expected before 2020. How much shorter is impossible to predict, we will probably see the long-term effects of these injections between 2030 and 2040. As for short term effects, I would like to state here that I have in my immediate family the following side effects from Covid-19 vaccinations (all Pfizer):

2 deaths

5 sudden onset “turbo” cancers

1 heart attack

2 new stroke patients

2 myocarditis, 1 pericarditis

1 severe dementia patient

1 advanced Parkinson’s disease patient

1 double sided lung embolism

1 new onset multiple allergies patient

2 new onset autoimmune diseases

Almost every vaccinated family member had Covid at least once, unlike the unvaccinated members, most of which never had it. Any of the above observed vaccination effects could have led to death, in most cases it will reduce the life span of the individual suffering from it. Considering that this is only covering one family, these side effects can’t possibly be called rare, certainly not when combined and they will contribute to excess mortality in years to come.

I truly feel for those who believed the lies we were told and complied out of fear, it must feel like sitting on a powder keg, never knowing when it will be hit by a spark.

Brandolinis law is also known as the bullshit asymmetry principle and has been coined by programmer Alberto Brandolini after reflecting on the politics of the day.

It states that the amount of energy needed to refute bullshit is an order of magnitude bigger than the energy needed to produce it in the first place.

These days bullshit is defined as misinformation and disinformation, but both are not new. Jonathan Swift wrote in the 1700s that “falsehood flies, and truth comes limping after it”. The drive to spread misleading or unsubstantiated information is built into politics where there is a desire to rapidly define the ‘narrative of the day’.

That was certainly the case during the fabricated Covid-pandemic.

It is not mentioned or even considered, that the source of this mis- and disinformation could be the government and the institutions of the country that are supposed – and assumed – to follow the highest ethical standards because health and safety of the general public depend on their words. Unfortunately, very few people consider that government and bureaucracy are not eternal institutions with divine knowledge, but institutions made up of people with politics, allegiances, playbooks and narratives. These people are in the best possible position to plant mis- and disinformation, because they are almost never asked to prove the rightfulness of their statements. This puts a person, or even a group of people who disagree with the official narrative in the unenviable position of having to work uphill to not only refute government narratives by supplying enormous amounts of data and proof (which will inevitably make eyes glaze over quickly, because listening to a lot of facts and data is so much more exhausting than listening to just a few punchlines), but because the narrative they go against is coming from the government, they have to spend energy of at least another magnitude higher than people who must refute normal ~~bullshit~~ disinformation.

With the governments additional new powers of censorship of alternative opinions, it becomes almost impossible to refute the official propaganda. It takes a lot of optimism and strength to go against the prevailing narrative.

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