Catholic Women's League Australia Inc
· Organisation of the World Union of Catholic Women's Organisations (WUCWO)
ısultant (roster) status with the Economics and Social Council of the United Nations

"Be joyful in hope, patient in trouble, and persistent in prayer."
Romans 12:12.

ABN 91323005375

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Introduction

Australians have been dying at an excessive rate since 2021. The mortality rate for all causes of death in Australia has exceeded expected levels from then up to the presently available data. This accelerated mortality is not evidenced to be due to COVID-19 infection. The all-cause provisional mortality data released by the Australian Bureau of Statistics is not confined to the ageing demographic deemed most at risk of COVID-19 disease.

Therefore, Catholic Women's League Australia Inc. wishes to address the following Terms of Reference of this Inquiry:

b) factors contributing to excess mortality;

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

d) any other related matter.

However, we would like to first express our surprise that the public is tasked with researching data which should already have been gathered and analysed by the Department of Health. A significant enduring change in the pattern of all-cause mortality, untimely and unexpected deaths of Australians ought be an ongoing priority of concern for the Australian Government. The highest excess dying rate in our nation since World War II, occurring in the omicron variant year of 2022 in a highly vaccinated country, has passed without immediate and rigorous scrutiny.

Further, the Australian Bureau of Statistics (ABS) states that pandemic responses may have impacted excessive mortality rates. However, the ABS omits reference to any possible impact from the introduction of 'Provisionally Registered' novel vaccines to the population. COVID-19 vaccines were eligible only for 'Provisional Registration'[1] due to incomplete clinical safety and efficacy research, stability data etc. Provisionally registered vaccines are classified as 'Investigational Vaccines'[2] by international convention. Provisional Registration status required extension after the two-year maximum, due to required data remaining incomplete. Myocarditis, venous thromboembolism, stroke and other neurological sequelae were identified after Provisional Registration had been granted. Omitted consideration of this factor is concerning.

Australians are unaware that we have been dying at an increased rate. Excess mortality peaked in 2022, continuing at 9.1% above pre-covid baseline into March 2023. The loss of 15,114 more Australians than expected to November 2023 - each a person loved by family and friends - is not generally known and therefore Australians have not had the opportunity to properly consider and respond to this concern. However, we will present examples of our members.

Executive summary

[1] https://www.aph.gov.au/About_Parliament/Parliamentary_departments/Parliamentary_Library/pubs/rp/rp2122/Quick_Guides/COVID-19Vaccine

[2] Council for International Organizations of Medical Sciences. Cumulative pharmacovigilance glossary Version 1.0 https://cioms.ch/wp-content/uploads/2021/03/CIOMS-Cumulative-PV-Glossary-v1.0.pdf

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CWLAInc here present referenced research, and personal examples, of how Government Health, Regulatory and societal policies and actions may have driven excess mortality.

TOR b): Summary of Factors contributing to excess mortality include:

i) **Self-Diagnosis** and lack of clinical examination. Reduced access to timely, appropriate medical care for breathing symptoms requiring diagnosis; eg shortness of breath;

ii) **Poor or absent medical follow-up** of those with acute COVID-19 infection;

iii) **Lockdown and Isolation** of the elderly and rothers, reducing observation;

iv) **Medical Care denied to the unvaccinated;**

v) **Public discouraged from attending hospitals** due to 'overburdening' concerns;

vi) **TGA Failure to release vaccine safety data without FOI application;**

vii) **TGA gave incorrect information to clinicians and the public;**

viii) **TGA Failure inform the public of adverse event data.** Delays and failures of regulatory bodies to inform Australia of serious vaccine complications such as thrombosis and myocarditis when they became statistically apparent and reported in peer-reviewed medical journals. Those at risk of these potentially fatal complications may have declined the vaccine;

ix) **TGA Failure to inform the public of 6 months acquired immunity** post COVID-19 infection. The Department of Health did not acknowledge the 6-month acquired immunity after infection, thereby exposing more Australians unnecessarily to the known thrombosis and myocarditis cardiac arrest risks from vaccinations that were not required in that time;

x) **Understaffed hospitals.** Removal of unvaccinated nurses and doctors from hospitals reduced the body of essential healthcare workers and provision of essential healthcare;

xi) **Reduced physical fitness and general health**. Reduction and embargos on outdoor exercise reducing cardio-respiratory fitness, muscle strength, and vitamin D production promoting vitamin D deficiencies.

xii) Medication shortages and ill health;

xiii) Mandatory vaccination.

Definition of Excess Mortality[3]

> *'a common statistical tool used..to understand the full impact of the COVID-19 pandemic on mortality. Excess mortality is defined as the difference between the total number of deaths from all causes in a specified period and the expected numbers of deaths from all causes in that same period. Excess mortality measures can account for deaths due to COVID-19, potentially misclassified or undiagnosed COVID-19 deaths, and other mortality that may be indirectly related to the pandemic (e.g. relating to social isolation or changed access to health care). For these reasons, excess mortality is generally considered a more comprehensive measure for assessing the impact of the pandemic rather than considering only the number of deaths due to COVID-19'.* (*Aust* Bureau of Statistics)

[3] Measuring Australia's excess mortality during the COVID-19 pandemic until the first quarter 2023 | Australian Bureau of Statistics (abs.gov.au)

Terms of Reference

b)

Factors contributing to excess mortality in 2021, 2022 and 2023:

i) System failure: Self Diagnosis and Lack of Clinical Examination

During the pandemic years patients requesting to make an appointment to see the doctor were frequently asked if they had respiratory symptoms/or symptoms of a cold, before being deployed/assessed. Patient themselves had to determine whether their symptoms represented a respiratory illness. Shortness of breath and and/or cough can be a manifestation of multiple cardiac abnormalities ranging from cardiomyopathy, cardiac failure, valvular pathology, arrythmias, ischaemic heart disease and myocardial infarction (heart attack) etc as well as metabolic derangements such due to diabetic ketoacidosis, sepsis, renal failure, and liver failure etc. The patient's management was then based on the patient's self-diagnosis as to the origin of symptoms.

Some were deployed to the parking area for a nasopharyngeal covid-19 pcr swab. Some were advised to wait at home. Some were referred to see the Registered Nurse. Some were referred to a pathology collection centre for a swab. Some were sent to 'drive-through' swab hubs. Many received no clinical assessment.

These options all reduced access to alternative diagnoses, and thereby reduced access to ECGs, skilled cardiac auscultation, imaging, and blood tests for evidence of sepsis or metabolic derangement, or more extensive investigations beyond COVID swabs.

The 'Telehealth' phenomenon also eliminated physical examination: no BP checks; no weight measurement or monitoring; no cardiac auscultation; no pulse assessment for irregularity; no abdominal or pelvic examination; no neurological examination etc.

Problems other than COVID-19 can be serious and life-threatening. An increased respiratory rate can be a significant indicator of septicaemia requiring urgent antibiotic intervention.

> Eg. A 4-year-old girl had a cough and a sore ear. Her mother rang their medical practice to have her seen by the GP. Because she had a respiratory symptom she was seen by the nurse, with no appointment offered to see the doctor. The R.N. is not trained in diagnostic respiratory or cardiac auscultation, unless perhaps credentialled as a nurse practitioner. The child did not have access to the doctor as requested and was not treated specifically for either problem. Both problems subsequently required antibiotic treatment, which had been inappropriately delayed.

ii) System failure: Poor or absent medical follow-up of acute COVID-19 infection

The decision not to assess COVID-19 infections clinically if possible – based on the patient's self-diagnosis - extended into poor management plan follow-up. Many received no clinical follow-up after a presumed diagnosis of COVID-19 infection. Similarly, negative COVID-19 tests, which may have been an alert to an alternative diagnosis, received no follow-up. Diagnostic knowledge and therapeutic management options, and valuable time windows were not pursued and often lost.

This meant there was no provision made for detecting early warning signs of cardiac failure, bacterial pneumonia and even cancer etc, until they were more pronounced, more developed, and consequently at a more critical stage of progression.

iii) Lockdown policy: caused Isolation of the elderly and reduced observation

The implementations of lockdowns across Australia were not supported by evidence-based medicine. No peer-reviewed, generalizable, cohort studies evidenced that respiratory viruses can be quenched by lockdowns and preventing people from walking and sitting outdoors. Driving the population, especially including the elderly, the mentally unwell, those with physical handicaps and those already experiencing difficulties, indoors and away from community visibility. It removed community observation of their predicament, their coping skills, their progress, and the development of any dysfunctionality requiring support or intervention. Lockdowns implemented without medical evidence of effectiveness in curtailing respiratory epidemics endangered the most vulnerable in our society.

Since there has been no accounting and statistical analysis of premature death rates within these groups, the impact is not directly measurable. This represents a government neglect, not an absence of premature mortality.

iv) Some General Practice Policies: Medical Care denied to the unvaccinated

Many General practices refused to see their own patients who were not vaccinated. This occurred from late 2021. These patients pay taxes and Medicare levies and were entitled to medical care. The refusal to supply medical care was a denial of this right. Blocking medical care to thousands of Australians delayed time sensitive treatments for chronic disease, acute illnesses and cancers. The impact on those persons whose medical care was denied them has never been quantified. It could be assessed even now by an inventory of those medical practices and their mortality rates.

> Eg 1. one Victorian family with seven children still living at home were told by their medical practice that the unvaccinated mother could not enter the premises and therefore could not bring her children into the practice for medical consultations. The family were sent a formal letter from the practice advising them they could not attend for medical care. They were advised they could collect their medical records for a fee of $35 per person. That represented a total cost of $35 each for seven children and two adults of $315. This General Practitioner generated policy created a significant barrier to obtaining timely health care to this family and to many many thousands of Australians across the country.
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> Eg 2. One Tasmanian elderly woman reports: 'I didn't have one either and was told by one Senior doctor in the Practice here in the country (50mnkm from Launceston) not to come back to the surgery until I had one!'
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> Eg 3. 'My experience was....My daughter lives in Melbourne and was very sick also 15 weeks pregnant. Pains in stomach, diarrhoea, constipation etc and her Dr wouldn't see her because of Covid.
>
> I insisted she go to hospital - Royal Women's in Melbourne, where she was diagnosed with Bowel Cancer, she was operated on, the tumour was removed. Her baby was taken out of her body during the operation and she now has a beautiful 3 year old daughter and has been 3 years Cancer free.'

v) Public Discouraged from attending hospitals

Due to concerns about overburdening the health system, attendance at hospitals for respiratory symptoms was discouraged. There was a general message to 'stay home until it is getting difficult to breathe' – or until lips turned blue. This represents a very primitive level of health care. It embodied a level of diagnostic unconcern which imbued public communications and shaped public self-diagnosis that everything was COVID.

The perception that one had a duty not to attend hospital had no back-up alternative plan. There were no 'flying squads' set up to offer diagnostic assessment and pre-hospital triage functions to prevent the pitfalls of self-diagnosis.

> Eg: The experience of one GP and NSW Hospital VMO:
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> Some general practices declined care to the unvaccinated. This shifted the burden to hospitals for general health care. In addition, our local hospital, which was excellent in all other respects, met the challenge of risky self-diagnosis with chairs set up for patients outside in the ambulance carport. I would gather tools from Accident and Emergency and go outside to the carport and take histories and examine patients, both vaccinated and unvaccinated, with no privacy and no provision of consult confidentiality. This limited the full provision of histories and full examination, potentially compromising diagnostic accuracy and care provision.

vi) TGA failure to release vaccine safety information without FOI applications.

Failure of the Therapeutic Goods Administration to give tax-payer funded vaccine safety information to the public without FOIA requests. This has reduced general vaccine confidence, and lowered vaccination rates especially in first nations people, potentially contributing to mortality rates

The recent National Centre for Immunization Research and Surveillance (NCIRS) Coverage report, described as 'the first comprehensive stocktake of the ongoing impact of the pandemic on vaccination coverage' [4], identified a 'concerning downward trend' in fully vaccinated coverage in children. This occurred despite record high rates of childhood immunization registered in the first part of 2021, immediately prior to the COVID-19 vaccines roll-out. As per the report, decreasing coverage was steepest in Aboriginal and Torres Strait Islander children.

Associate professor Frank Beard, associate Director of NCIRS said 'barriers' were likely to include hesitancy and access.

> Eg, a written request to the TGA for vaccine safety information was rejected and the TGA instead advised application through the FOI process. FOIA 2565 was then made. The TGA rejected the FOI request[5] and withheld rat single organ microscopy report from the requesting clinician. Grounds were that organ microscopy report was too voluminous, and the pharmaceutical company had taken 'active steps to ensure the information contained within the documents is not disclosed to the general public'. The matter of withheld safety information has now been with the Information Commissioner for over two tears, with organ microscopy still withheld as of May 20th, 2024.

vii) TGA gave incorrect information to the public

In January 2021 the Australian Government Department of Health Therapeutic Goods Administration 'Non-clinical Evaluation Report BNT162b2 [mRNA] VOVID-19 Vaccine (Comirnaty TM Document 6 PM-2020-05461-1-2[6] was known to the government. It was released to clinicians and the public in response to Freedom of Information request FOI 2389 on July 15th, 2021. This Government report displayed biodistribution of the 80 nm lipid nanoparticles (LNPs), the mRNA vaccine carrier, throughout the body. The level peaked in plasma in 1 to 4 hours post dose.

Clinicians and the public had previously been informed that the mRNA vaccine stayed in the muscle tissue injected, from whence an immune response was generated. However, the Non-clinical Evaluation Report, when released in July 2021, revealed that the vaccine was disseminated throughout the tested rat organs, with highest concentrations in liver and spleen and adrenal glands. The concentration in the ovary was ten times that of other organs (excepting liver and spleen etc which were higher) and was still doubling in concentration between the 24-hour post vaccine measurement and the 48-hour post vaccine measurement. Measurement then ceased.

Apart from the general undermining of vaccine confidence occurring when the TGA gives incorrect information to the public, many persons with organ damage or vulnerabilities, particularly myocardial issues, may have deferred vaccination or chosen a different vaccine had the TGA given truthful information in January 2021. It is unclear why the TGA incorrectly interpreted the biodistribution report. We were informed vaccines stayed in injected muscles, when biodistribution study evidenced bloodstream spread to heart, liver, spleen, bone marrow, lymph glands and ovaries. Those at risk of thrombosis or relevant pre-existing organ pathologies eg myocarditis, if informed may have deferred vaccination or selected a different vaccine. They may not have consented to these 'provisionally' registered vaccines had they been aware,

Failure to give correct biodistribution information invalidated informed patient consent. In so doing it may have contributed to cardiac morbidity and mortality by facilitating mRNA vaccine receipt by those who may have selected otherwise.

viii) TGA failure to accurately inform the public of vaccine adverse event data

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[4] Associate Professor Frank Beard, Associate Director at NCIRS; 'Concerning decline in child vaccination coverage'. Jolyon Attwoll. *Australian Doctor* 14/12/2023.

[5] TGA correspondence re FOI 2565 rejection para. 3, notice of decision 26th August 2021.

[6] chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.tga.gov.au/sites/default/files/foi-2389-06.pdf

The fast tracking and provisional registration of COVID-19 vaccinations in Australia resulted in products with more known unknowns, and unknown unknowns, than any other vaccine in common usage.[7,8] While short term vaccination follow-up required a phone call on day 3, longer term safety information relied heavily on the voluntary reporting of adverse events by doctors, nurses and patients. None the less, adverse event data was not presented to the public as it emerged.[9,10] Therefore patients were not given the timely information required to accept or decline a novel vaccine. Astra Zeneca Vaccine with its serious adverse event profile[8,9] has since been withdrawn from the market.

The Israel Ministry for Health notified its population of new onset myocarditis following Pfizer mRNA vaccine in April 2021.[11] The Australian Department of Health and Ageing did not, until significantly later. Its eventual statement

> *'Adolescents and younger adults have a lower age-related risk of severe COVID-19, and a comparatively higher risk of myocarditis following vaccination. The risk of myocarditis is highest in people aged 16-30 years (peak 16-18 years), and is higher in males than females'*

Is not widely known among Australians and was not added to vaccine consent forms in this detail.

High impact Cardiology journal *Circulation* in August 2023 published the research-identified, potential long-term effect of mRNA vaccines on cardiac functional reserve in a 12-month follow-up study of all adolescents developing myocarditis after COVID-19 mRNA vaccine receipt in one administrative region.[12] These patients were followed up with the gold standard diagnostic tool for myocarditis, magnetic resonance imaging. The study found indicators were present of ongoing subclinical myocardial dysfunction and fibrosis (scarring). It therefore concluded:

> *'there exists a potential long-term effect on exercise capacity and cardiac functional reserve during stress..Further long-term studies to define the functional and clinical implications of these subclinical abnormalities in a larger cohort are undoubtedly warranted'.*

Insults to cardiac reserve during exercise increase the risk of abnormal electrical conduction within the heart (arrythmias) which can be life-threatening. The 'warranted studies' have not been done. Therefore, the observed potential ongoing mRNA cardiac insult over the years subsequent to vaccination - 2021, 2022, 2023 - could contribute to their observed excess mortality.

Eg

1. Patient and wife in Melbourne (name supplied to this organization) had not wished to have the COVID-19 vaccine. The wife declined. Her husband made an appointment for the Astra Zeneca vaccine, then cancelled his appointment for the vaccine. There was much pressure in the media and in Government communications to be vaccinated. The husband then made another appointment and received the Astra Zeneca vaccination on August 26th 2021, believing the TGA assertions the Astra Zeneca vaccine was 'safe and effective'. He had been in his normal, healthy state beforehand, at age 60. Three days post vaccination he became drowsy. Drowsiness increased progressively and he died, alone in hospital 20 days after vaccination.

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[7] Peter Doshi Editor BMJ 'Clarification: Pfizer and Moderna's "95% effective" vaccines—We Need More Details and the Raw Data' BMJ Opinion (Blog Post, 5 February 2021) <https://blogs.bmj.com/ bmj/2021/02/05/clarification-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-theraw-data/>.

[8] Little D, Seman E, Walsh A. Guidance for Ethical Informed Consent in a National Context. COVID-19 Vaccination: Guidance for Ethical, Informed Consent in a National Context. *Issues L. & Med.*, *36*, p.127.

[9] See, 'ATAGI, Statement on AstraZeneca Vaccine in Response to New Vaccine Safety Concerns' Australian Government, Department of Health (Web Page, 8 April 2021) <https://www.health.gov.au/news/ atagi-statement-on-astrazeneca-vaccine-in-response-to-new-vaccine-safety-concerns>

[10] See, 'AstraZeneca's COVID-19 Vaccine: EMA Finds Possible Link to Very Rare Cases of Unusual Blood Clots With Low Blood Platelets' European Medicines Agency, (Web Page, 7 April 2021) <https:// www.ema.europa.eu/en/news/astrazenecas-covid-19-vaccine-ema-finds-possible-link-very-rare-cases- unusual-blood-clots-low-blood>.

[11] 'Israel Assesses Myocarditis Cases Linked to Pfizer-BioNTech Covid-19 Vaccine', Pharmaceutical Technology News (Web Page, 26 April 2021) <https://www.pharmaceutical-technology.com/news/israel-myocarditis-pfizer-vaccine/>

[12] YU CW, Tsao S et al. Cardiac Outcomes Post COVID-19 Vaccine Myocarditis. *Circulation.2023;148:436-439. DOI: 10.1161/CIRCULATIONAHA.123.064772*

2. Patient 67 year old female developed pericardial effusion after Pfizer mRNA vaccination. Previous echocardiographs had been normal. Was advised by two cardiologists it was probably due to mRNA vaccination. Neither cardiologist has reported this to the TGA, nor did the GP, despite a legal responsibility to do so.

3. A young woman presented to hospital with a pulmonary embolism following COVID-19 vaccination (mRNA vaccine). After this was diagnosed, neither the doctor nor the hospital wanted to report it as an adverse event, although it was recorded as such in her paperwork. The doctor said the hospital should report it (to the TGA). The hospital said the doctor should report it. She was discharged at 3.30 am and no one reported it to the TGA.

ix) Failure of Government to inform the public of acquired COVID-19 disease immunity when it became known

The Australian Technical Advisory Group on Immunization (ATAGI) did not advise the Australian people of the effectiveness of natural acquired immunity after COVID-19 infection until February 2023.[13] However, on November 1st 2021, the USA Centres for Disease control had identified that both vaccine-induced and infection induced immunity are durable for at least 6 months.[14,15] It had been noted 6 months earlier from observational studies that there were very low rates of re-infection over several months, among those who had previously had COVID-19 disease.[16]

Given the duration of acquired natural COVID-19 disease immunity - known and relied upon in many countries - many Australian patients received COVID-19 vaccination unnecessarily due to delayed information. Given the presence of serious vaccine adverse event profiles, for both Astra Zeneca vaccines and mRNA vaccines, and the observed cardiac dysfunction markers after COVID-19 Vaccine myocarditis, administration of this vaccine unnecessarily was capable of causing vaccine mortality.

Vaccination administering became excessive, and chaotic, due to poor and delayed information being given to the public and to health providers.

Eg i) Dr Simon Holliday writing to Australian Doctor Blog 17/12/23:

'I emailed a pharmacist this week who had provided three COVID vaccines to a patient. One was within two months of a COVID infection, and both the others had not allowed 6 months to pass since the previous one.'

Eg ii) Doctor in NSW (name supplied to this organization)

'I had a 17 year old patient, who had no risk factors for specific vulnerability to COVID-19 disease, who had received five COVID-19 vaccinations by age 17 up to August 2023'

x) Understaffed Hospitals due to staff lay-offs

Neither the Astra Zeneca vaccine[17] nor the Pfizer mRNA vaccines[18] were designed to stop transmission nor ever tested for their ability to do so. It is now accepted that COVID-19 vaccines do not block transmission. Despite the continued

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[13] Recommendations from ATAGI regarding booster doses in 2023
https://www.health.gov.au/news/atagi-2023-booster-advice

[14] https://www.washingtonpost.com/health/2021/11/01/what-works-better-vaccines-or-natural-immunity/

[15] https://www.cdc.gov/coronavirus/2019-ncov/covid-19-data-and-surveillance.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fscience%2Fscience-and-research.html

[16] M M Sheehan et al, 'Reinfection Rates among Patients who Previously Tested Positive for Coronavirus Disease 2019: a Retrospective Cohort Study' (2021) Clinical Infectious Diseases (15 May 2021) <https://doi.org/10.1093/cid/ciab234>; S Pilz, et al, 'SARS-CoV-2 Re-infection Risk in Austria' (2021) European Journal of Clinical Investigation 51:e13520; S F Lumley et al, 'Antibody Status and Incidence of SARS-CoV-2 Infection in Health Care Workers' (2021) 384 New England Journal of Medicine 533.

[17] M Voysey et al, 'Safety and Efficacy of the ChAdOx1 nCoV-19 Vaccine (AZD1222) Against SARSCoV-2; An Interim Analysis of Four Randomised Controlled Trials in Brazil, South Africa and the UK' (2021) 397 Lancet (10269) 111 <https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)32661-1/ fulltext>.

[18] Fernando P. Polack, et al, 'Safety and Efficacy of the BNT162b2 mRNA Covid-19 Vaccine' (2020) 383 New England Journal of Medicine 2603 <https://www.nejm.org/doi/full/10.1056/NEJMoa2034577>.

transmission after vaccination, State hospitals laid off nursing and medical staff who were not vaccinated against COVID-19 disease.

The decision to lay off unvaccinated medical and nursing staff from the states' hospitals caused a significant health worker shortage and crisis. NSW Health figures show 7 per cent of all clinical healthcare workers remained unvaccinated, to be laid off, from the mandated deadline on 28th September 2021.[19] Laid off staff were happy to work and did not wish to leave the hospital system. Their layoff impacted remaining staff providing service provision, with 8% job vacancies unfilled as of July 2022,[18] Remaining staff were required to compensate for health departments' inability to remedy the staffing loss created. Vaccine mandates in NSW were not lifted until May 2024, and had not taken into account natural acquired immunity status. While staff remaining were physically present, long hours, low morale and fatigue affect worker health and functionality.[20] Healthcare worker fatigue also poses increased risks to patients[21]

The Australian Nursing and Midwifery Federation released this statement[22] on July 22nd 2022:

> *Australia is in the midst of a health crisis – one it cannot staff.. Nurses are needed more than ever, but they are burnt out and fatigued, and some are even leaving the industry. Unions say the country is facing a significant nursing shortage, and things are only going to get worse.*
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> Royal Perth Hospital Nurse Julie-Marie Hay has worked in the industry for 20 years, and said she was thinking about quitting because the pace was 'relentless':
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> *'We're constantly short of staff, we're constantly asked to do more, we're constantly asked to work more hours'* she said. *Everybody is stretched, everybody is tired, we're just absolutely exhausted. Morale is terrible. We're not there for each other anymore. We can't be. We don't have time to be. We need more nurses, but we also need to retain more nurses'* she said.

xi) Government policies promoted reduced and poor physical fitness

Different states imposed differing levels of isolation and stay-at-home-indoors rules on their communities. This limited everyone access to physical exercise. It also confined many people to small quarters. There is no evidence that walking outdoors increases respiratory disease infectivity or transmission. No such evidence was ever produced by governing bodies that enforced 'stay in your home' rules. Physical exercise is important to fitness, muscle strength (preventing falls) cardio-respiratory capacity and mood etc. Its curtailment could only have negative impacts on health.

The body's vitamin D production needs sunlight. Vitamin D helps protect against severe COVID respiratory infections[23] and vitamin D deficiency is known to be associated with worse outcomes following respiratory infection.[24]

Australian Guidelines for the Clinical Care of People with COVID-19[25] did not mention the negative impact of vitamin D deficiency on respiratory infection outcomes. Given the diverse geographical backgrounds of Australians and the higher prevalence of vitamin D deficiency in more pigmented skin types, coupled with the imposition of vigorous lockdowns applied and enforced in migrant dense localities, vitamin D deficiency would have been encouraged and exacerbated by these policies.

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[19] https://www.abc.net.au/news/2021-09-28/7-per-cent-of-health-workers-in-nsw-are-unvaccinated/100498214

[20] Wong K, Chan AHS, Ngan SC. The Effect of Long Working Hours and Overtime on Occupational Health: A Meta-Analysis of Evidence from 1998 to 2018. Int J Environ Res Public Health. 2019 Jun 13;16(12):2102. doi: 10.3390/ijerph16122102. PMID: 31200573; PMCID: PMC6617405.

[21] The Joint Commission Sentinel Event Alert Issue 48 December 14, 2011. (Addendum May14, 2018) chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_48_hcw_fatigue_final_w_2018_addendum.pdf

[22] https://www.anmf.org.au/media-campaigns/news/australia-facing-nursing-shortage-as-more-than-two-years-of-covid-takes-its-toll

[23] Petre Cristian Ilie, 'The Role of Vitamin D in the Prevention of Coronavirus Disease 2019 Infection and Mortality' Researchsqaure <https://www.researchsquare.com/article/rs-21211/v1>; Adrian R Martineau et al, 'Vitamin D Supplementation to Prevent Acute Respiratory Tract Infections: Systemic Review and Meta-Analysis of Individual Participant Data'(2017) 356 BMJ i6583 <https://www.bmj.com/ content/356/bmj.i6583 https://doi.org/10.1136/bmj.i6583>.

[24] Hejazi ME, Modarresi-Ghazani F, Entezari-Maleki T. A review of Vitamin D effects on common respiratory diseases: Asthma, chronic obstructive pulmonary disease, and tuberculosis. J Res Pharm Pract. 2016 Jan-Mar;5(1):7-15. doi: 10.4103/2279-042X.176542. PMID: 26985430; PMCID: PMC4776550.

[25] Australian Guidelines for Clinical Care of Persons with COVID-19 Disease.

xii) System failure: Medication shortages:

A shortage of Ventolin puffers in the early pandemic following the bushfire period led chemists to restrict sales to clients. This evidences inadequate contingency planning for provision of vital medications. The shortage extended into COVID months.

Scabies medication underwent TGA applied restrictions in the absence of drug supply shortages. GPs were not permitted to give effective oral treatment for recurrent scabies in families. Oral medication prescription for scabies infestations was arbitrarily restricted to dermatologists or infectious disease specialists for the duration of the declared pandemic. These expensive specialist visits required long waiting times and consultations fees often over $200 for an eventual consult. This restriction was implemented only to prevent use of repurposed drugs to treat COVID-19. At approximately the same time, however, "Lyclear' topical scabies treatment also came into genuine supply shortages, and absences, with families then unable to access any effective infestation treatments. This placed chronic stress on families, raised tensions and lowered family resilience.

xiii) Mandatory Vaccination

Vaccines were mandated for many professions, for other work, and for travel. Although novel vaccines with only provisional registration awaiting more efficacy and safety data, people were treated en masse – one size fits all, rather than as individuals. Cardiac and other just reservations were overridden in mandate coercions.

> Eg 1. One of my sons who was 39 years and living in Canberra at the time and working for the State Government was told, "No jab, no job"! He had 2 jabs and after the second one felt very unwell (Pfizer). He got an appointment with his doctor after a week who referred him to a Cardiologist and got an appointment in 2 weeks. He had all the tests and he had Myocarditis. His doctor said quite a lot of young men had it and he would get over it but go and get tested each year.
> I was concerned as his father had suddenly dropped dead with a heart attack in 2019.
> Another son 45 years, was living in Brisbane, QLD with his family in 2021. He was offered a job in Alaska, USA in 2022. It was still lockdown time, and he waited for months to get on a plane. He was told by the QLD Government he could not get on a plane until he and his wife had had 3 jabs and the children at least 1 jab to go to USA. A few weeks later after arriving in Anchorage in late 2022, he was struck down with a strange paralysis for 2 weeks in the back and couldn't walk. His doctor there by phone told him to take a Panadol.

TOR 3

c) Recommendations on how to address any identified preventable drivers of excess mortality

1. Telehealth is not the optimal health delivery model. The clinical examination is the backbone of medical care and we sideline that examination at our peril. Proper examination is not possible over the phone.

   Unfortunately, COVID-19 fear encouraged many to seek the convenience of telehealth. Without BP readings, weight, chest examination, abdominal palpation etc signs of cancer and early signs of chronic disease will be missed. Both patients and doctors have become comfortable with this health delivery model, but its pitfalls will be invisible.

2. All future pandemic management decisions should be evidence-based. Such decisions should be always built on medium and high quality evidence, which is referenced. The stakes of public health are too high to guess something will work, or to use low quality evidence. Lockdowns have caused much suffering and been unfavourable to general fitness and community care of those observed to be not functioning well.

3. All people have a right to health care. It is unsatisfactory and unethical to *not* find a way to consult with unvaccinated patients. Since COVID-19 vaccination did not, and could not stop transmission, it is perhaps reflective of a prejudicial attitude to deny health care to the unvaccinated.

4. Where the Therapeutic Goods Administration has given incorrect information, or failed to release safety information an apology should be issued to maintain future vaccine confidence.

5. Department of Health delays in communicating data relevant to inform consent were unacceptable. In future, a clear plan to keep the public updated on new population vaccines' (COVID_19 vaccines and other) research, and a clear plan should be laid out in advance in the case of another epidemic. Such plans should not be overturned and discarded - as Australia's was from its 2019 pandemic plan. Abandoning our 2019 pandemic plan left open the risk of policy on the run, unevidenced policy, and haphazard care provision.

6. In the case of a future epidemic a 'flying squad' (s) could be deployed to properly assess the sick, this isolated and the elderly regardless of their vaccine status. Properly appointed vehicles and trained staff could meet this need to attend to all those needing medical care in hubs or other places of need. This would provide more than just a drive through 'swab'.

7. The MRI is the gold standard test for diagnosing myocardial scar following myocarditis. Since this fibrosis in cardiac muscle could trigger future arrythmias, those persons diagnosed with post vaccine myocarditis, or post COVID-19 myocarditis should ideally be followed-up with progress MRI's. This could be part of the research warranted in the conclusion by cardiac researchers in the journal *Circulation,* referred to above in this submission. We need to know why excessive mortality and within that, sudden death, is occurring in young and older Australian citizens.

8. No novel provisionally registered investigational vaccines should be mandated. Persons are entitled not to have injected substances with incomplete safety and efficacy evidence.

9. No medicines should be withheld from those needing them (eg scabies infestations) for political or other reasons where the burden of cost is shifted unnecessarily to the patient.

10. Doctors who refuse to see their own patients for vaccine or illness reasons should provide those patients with copies of their files and provide alternative names of doctors who will not refuse to see them.

Conclusion

Any policies and procedures, any Regulatory inaction or misinformation, which can predispose to ill health in any way and reduce community observation of our vulnerable, can drive sources of increased rates of dying. Any such policies should always be evidence-based. Where these policies have not been developed from evidence-based medicine their instigation should be explained.
Vaccine adverse event reporting requires prompt, frequent and transparent statistical analysis. Health care providers should be alerted to possible adverse event signals emerging within the community and given clinical updates.
Excessive and premature deaths, unanticipated mortality rates not COVID-related, require all aspects of pandemic management be scrutinized.

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