ASHLEY, FRANCINA, LEONARD & ASSOCIATES

0421 366 238
(02) 8277 4556
tony@aflsolicitors.com.au
www.aflsolicitors.com.au
Level 25, Tower 3,
300 Barangaroo Avenue,
Sydney, NSW, 2000, Australia

7 July 2021

URGENT ACTION REQUIRED

The Hon. Brad Hazzard, MP
52 Martin Place
SYDNEY NSW 2000

Ph: (02) 8574 6000

To the Honourable Premier and Ministers Federal and State,

RE: INFORMED CONSENT – VACCINE ROLLOUTS – STATE ORDERS

1. I refer to the Government declared pandemic and various business closures nationally since around **March 2020** and **June 2021 (the "Lockdowns")**.
2. To be clear, this letter does not suggest the COVID-19 claims are a hoax, rather it attempts to bring some proportionality and balance to the decision-making process in a manner that is consistent with the practices of participatory democratic governance and real science. The prolonged suspension or rights and movements is and remains a great concern.
3. What will be raised in this letter may be uncomfortable and run against the unilateral messaging promulgated in the state's media networks; but hear it you must as there is no alternative and no one in Parliament, save for a very few who are actually taking notice of the unheard Australian citizens expressing a genuine concern.

4. I am instructed to send this letter to sitting Members of Parliament (State and Federal).

5. The most recent Orders from the NSW State Government on Airport workers at Kingsford Smith Airport (Sydney) has caused a number of airport employees (including pregnant and single wage families/adults) to go on stress leave because they have been given an ultimatum to get the vaccine or potentially lose their positions. The amount of emails and calls from airline industry staff to my office is most concerning and I am instructed to make this representation on their behalf because they believe their elected representatives are not taking notice.

6. We are also mindful that the airport staff, front-line workers, pilots, police, paramedics and medical staff are also seeking the protection of all rights and responsibilities pursuant to Australian and International laws.

7. There are people taking sick leave from airport duties due to the mental health related issues and pressures being placed on them to take a vaccine. We understand that that the Australian Government cannot guarantee the vaccines safety in the short, mid and long term, but yet the NSW Government are issuing Orders for companies to vaccinate all staff, whilst Federal Parliamentarians do not question the validity or acknowledge this growing concern in electorates all over Australia.

8. I am instructed those workers are not allowed on *Commonwealth airport property effective as of **6 July 2021** as a result of State Orders*. The workers are not only feeling the pressures imposed upon them with speed and stealth at which the Orders were passed, but they are also concerned about being targeted if they speak out.

9. Despite there being serious questions as to safety and efficacy of the vaccines, we kindly request that all Orders relating to mandates of any kind in the Commonwealth of Australia (including States) are ceased and the Government desist from recruiting businesses to act as proxy's to roll out vaccines by use of coercive industrial relations sanctions.

Public Health Orders

10. I invite the Premiers Office and Minister for Health to provide evidence justifying the lockdowns and need to vaccinate healthy persons, specifically related to (*amongst other previous Orders*):

    a. *Public Health (COVID-19 Greater Sydney) Order (No 2) 2021*

    b. Public Health (COVID-19 Greater Sydney) Order (No 2) Amendment Order (No 2) 2021

    c. *Public Health (COVID-19 Air Transportation Quarantine) Order (No2) 2021*

The Sustained Assault

11. Since 2009, the AVN has been under sustained attack by extremist mandatory vaccination lobby groups operating in Australia. These groups include, *Stop the Australian Vaccination Network* (SAVN)[1], and its splinter groups, Northern Rivers Vaccination Supporters (NRVS)[2] Light for Riley (LFR)[3], Immunisation Foundation of Australia (IFA)[4] and Friends of Science in Medicine (FOSIM)[5]. Whilst purporting to represent a grass-roots social movement, many of the leaders and

[1] Stop the Australian Vaccine Network (12 July 2010) https://stopavn.com/.
[2] Northern Rivers Vaccinations Supporters (updated June 2021) https://nrvs.info/.
[3] Light for Riley (ND) https://www.facebook.com/lightforriley/
[4] Immunisation Foundation of Australia (IFA) (ND) https://www.ifa.org.au/aboutus
[5] Friends of Science in Medicine (FOSIM) https://www.scienceinmedicine.org.au/

members of these groups are vaccination program insiders or have established links with vaccine manufacturers.[6] [7]

12. The idea of having an alternative position of thought is not illegal, conspiratorial or scandalous, especially where the supressed science relied upon by Government has many unanswered questions that the community is desperately seeking answers to. The unanswered questions, State run media promotional vaccine campaign and the idea that Government is Ordering big business as a proxy to implement vaccination mandates, check-in and mask mandates appears to have a vicarious flavour.

13. The idea that the Government both State and Federal are reporting medical practitioners and other members in the community for having "*dangerous thoughts*" or "*enemies of the State*" for casting a scientific/medical opinion is gravely concerning and reinforces the principle that Government may have engaged in a course of conduct that has exceeded its delegated power given to it by the "people". These are legitimate questions that must be asked, and the Government after locking down an entire State should act in a manner that is open, democratic and participatory in nature, non of which has occurred during COVID-19.

14. It was clear from **March 2020** that COVID-19 had a steep age gradient in mortality, with an increased risk of death and serious illness in elderly people with comorbidities. By far, most deaths worldwide have occurred in this group. The global infection fatality rate (IFR) for COVID-19 is now estimated to be 0.15%. For people under 70, the IFR is 0.05% and is likely lower in people without serious co-morbidities. Therefore, comparisons to the IFR for influenza are probably correct. What is particularly important is that COVID-19 poses less risk to children than influenza, and children are not major drivers of disease, but there is a push to vaccinate this group.[i]

15. For most people, the risk of death from COVID-19 is **very low**. Elderly people and people with major underlying health issues are those who should be offered protection. People not at risk from COVID-19 can continue life as normal. This enables communities to acquire herd immunity, whilst minimising the exposure of those who are vulnerable. As with all public health measures, focused protection should be voluntary and based on the informed consent of the individual. '*No state party shall, even in time of emergency threatening the life of the nation, derogate from the Covenant's guarantees of the right to life; freedom from torture, cruel, inhuman or degrading treatment or punishment, and from medical or scientific experimentation without free consent ..... the right to recognition as a person before the law; and freedom of thought, conscience and religion. These rights are not derogable under any conditions, even for the asserted purpose of preserving the life of the nation*.' (The Siracusa Principles).[8]

Invitation for Public Scrutiny and Debate by leading Scientists

16. We certainly appreciate the amount of work that the Government has to deal with on a daily basis, however, given the importance of this matter as continually portrayed in the legacy media, it would seem prudent and politically correct for relevant Ministers and Chief Health Officers of Australia's States and Territories including Senators, to engage in a public

[6] MYTHS-AND-METHODS-OF-MANDATORY-VACCINATIONISTS.pdf (avn.org.au)

[7] Footnotes 1-7 Cited *in Vaccine Mandates: an unjustified assault on our human rights and freedoms* in Submission to the Australian Human Rights Commission conversation on human rights (November 2019) sub_148_-_australian_vaccination-risks_network_inc.pdf (humanrights.gov.au)

[8] United Nations Commission on Human Rights, The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights, 28 September 1984, E/CN.4/1985/4 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

consultation process with independent and eminently qualified Professors and scientists so the public can be reassured that the decisions being made are in the publics best interests.

17. I look forward to your response so I can organise the appropriately qualified experts and note, that given the Ministers recent decisions to lockdown the States and mandate vaccines, I would suspect that both the Minister and Chief Health Officer would have not objections to such a course taking place in the public interest.

18. In the event that the Government refuses to accept this invitation together with other elected representatives, we will seek to have Federal Senators and Parliamentary Representatives engage in a 'fact finding process' publicly.

Brief Background

19. Please note, I have published in this area and it is not the first time I raise matters with respect to the need for **transparency** and **consumer protections** with pharmaceutical products. Please see Faunce, TA, **Nikolic, T**, Morgan, FM, 2014, '*Because We Need Them: Globalising Financial Incentives for Corporate Fraud Whistleblowers'*, in AJ Brown (ed) Brown, AJ, Lewis, D, Moberly, R and Vandekerkchove, W (eds), International Whistleblowing Research Handbook, Edward Elgar.

20. A submission to the Australian Senate - Nikolic, T, 2017, '*Whistleblower Laws are about Incentivising Integrity*'.

21. One way we can act ethically and transparently is by ensuring the burden of proving a medication's safety rests with the sponsor and confirmed by the Therapeutic Regulator, rather than switching that burden to the consumer, who must then take court action to prove a medication was unsafe, or that they were damaged by a vaccine that has very little safety data - if any at all. This is clearly a burden that almost every Australian cannot achieve due to the costs and delays inherent in the legal system. Indeed, it is conceivable to think that the laws act as fetter to the publics right to access justice and independent information.

22. Such conduct by our State and Federal government regulators and some representatives does not meet community standards as it lends itself to the perception that Government (State and Federal) are more interested in propping up vaccine sales than ensuring a vaccine or medication is safe and efficacious. Indeed, exposing the Australian community to risks and potentially imperiling the lives of Australian citizens **must never be condoned** by any elected representative or citizen. The precautionary approach must be adopted to ensure Australian citizens are protected, rather than treated as experimental subjects.

23. What should not be forgotten in times such as these is that '*public health should achieve community health in a way that respects the rights of individuals in the community*.' (Public Health Leadership Society).[9]

Freedom of Information

24. On **30 June 2021**, I submitted a *Government Information (Public Access) Act 2009* (NSW) request for specific (not general) information on the amplification rates and Cycle Thresholds (CT) used with respect to PCR testing in New South Wales, but I am yet to receive an acknowledgement. I will turn to PCR testing later in this letter.

[9] PHLS, *Principles of the ethical practice of public health*, 2002:p 4 <https://stacks.cdc.gov/view/cdc/5595>.

COVID-19 – a summary of evidential facts

25. COVID-19 mortality has a steep age gradient.[10]

26. Elderly people with underlying medical conditions such as diabetes, obesity, respiratory or cardiovascular disease, are at the highest risk of severe illness and death.[11]

27. COVID-19 poses little risk to children and is less dangerous to them than influenza.[12] [13] [14] [15]

28. Children also do not appear to be major drivers of transmission.[16] [17] [18]

29. People who are immuno-compromised are always at greater risk from **any** infection.[19]

30. For most people, the risk of death from COVID-19 is **very low**. Comparisons to the infection fatality rate for influenza are probably correct.[20] However there may be an exception with the Alpha strain. The main exceptions are elderly people and people with significant underlying health issues. These are the people for whom focused protection should be offered. As with all public health measures, this decision must be voluntary and based on the informed consent of the individual.[ii]

31. It can be deadly to some people, but it is generally mild and treatable without vaccines.

32. People not at risk from COVID-19 can continue life as normal. This enables communities to acquire herd immunity, whilst minimising the exposure of those who are vulnerable.[iii]

33. Thee are alternative treatments and preventative medications available, but it will take the courage of political representatives to ensure patients can choose their treatment, rather than a Government deciding not to administer a medication, **even as a last resort**.

Invitation for Response

34. We invite the Ministers and Senators to respond using objective science, rather than a generic message about the importance of addressing COVID-19 in the community. Such responses although general, have very little relevance to the genuine concerns of the community who seek relevant, accurate, scientifically proven and timely responses to their concerns.

---

[10] CDC, Risk for COVID-19 Infection, Hospitalization, and Death By Age Group, CDC in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[11] 8 Williamson EJ, Walker AJ, Bhaskaran K et al., 'Factors associated with COVID-19-related death using OpenSAFELY', Nature, 2020, 584:430–436, doi:10.1038/s41586-020-2521-4 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[12] American Academy of Paediatrics, Children and COVID-19: State-Level Data Report, https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/children-and-covid-19-state- leveldata-report/, American Academy of Paediatrics website, 5 March 2021, accessed 26 April 2021 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[13] Ludvigsson JF, Engerström L, Nordenhäll C, Larsson E, 'Open Schools, Covid-19, and Child and Teacher Morbidity in Sweden', N Engl J Med, 2021, 384(7):669-671, doi:10.1056/NEJMc2026670 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[14] Ioannidis, 'Population-level COVID-19 mortality risk for non-elderly individuals overall and for non-elderly individuals without underlying diseases in pandemic epicenters', 2020 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[15] Oke and Heneghan, 'Global Covid-19 Case Fatality Rates', 2020 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[16] Boast A, Munro A and Goldstein H, 'An evidence summary of Paediatric COVID-19 literature' [Executive summary update 21 January 2021], Don't forget the bubbles, 2021, accessed 26 April 2021, doi:10.31440/DFTB.24063 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[17] 4 Ludvigsson, Engerström et al., 'Open Schools, COVID-19, and Child and Teacher Morbidity in Sweden', 2021 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[18] Lewis et al., 'Closing schools is not evidence based and harms children', 2021 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[19]1 Bula-Rudas FJ, Infections in the Immunocompromised Host, Medscape, 25 February 2020, accessed 26 April 2021 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA..

[20] Ioannidis, 'Population-level COVID-19 mortality risk for non-elderly individuals overall and for non-elderly individuals without underlying diseases in pandemic epicenters',2020

35. Further, the media has been relentless in labelling people who are making an informed decision about what they place in their body as 'anti-vaxers'. The idea of informed consent has effectively been eliminated and it appears as though the New South Wales ("NSW") Government and Ministers and media have replaced doctors when it comes to personalised medical services and the choices people make about those choices.

36. New South Welshman/women have a right to approach their elected representatives and ask questions about matters they genuinely feel concerned about, including the **unknown** safety and efficacy of a vaccine that is 'pushed' onto the community by NSW Government and various groups, most of whom are at **low** risk in scientific terms. Whether the citizens receive a candid response based on science remains in the hands of the Ministers and Senators.

37. The right to self-determination is a central tenet of our law. In the medical context, this means that a competent adult patient has the right to refuse medical treatment for whatever reasons, rational or irrational. A patient's body is his or her own and he or she may refuse or accept treatment as desired: The High Court has described this as "*a right in each person to bodily integrity"*.[21]

    '*…the impact of the COVID-19 pandemic has disproportionately affected those in vulnerable situations and those already suffering from poor health and has exacerbated their vulnerability and exposure to socioeconomic drivers, leading to increases in morbidity and mortality, as well as economic damage at the individual and community levels*.' (World Health Organization resolution).[22]

Totality of Autonomy

38. *Malette v Shulman (1990) 67 DLR (4th) 321*

    a. widely adopted globally

    b. "[*a] competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternative form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community... it is the patient who has the final say on whether to undergo the treatment*."

Conflicting interests

39. *Hunter and New England Area Health Service v A by his Tutor* [2009] NSWSC 761

    a. Autonomy vs state as a whole

    b. a competent adult's right of autonomy or self-determination

    c. The interests of the State in protecting and preserving the lives and health of its citizens.

    d. AT [17] "*Whenever there is conflict between a capable adults' exercise of the right of self-determination and state's interest in preserving life - the right of the individual must prevail*".

[21] *Secretary, Department of Health and Community Services v JWB and SMB* (1991) 175 CLR 218, 233.
[22] WHO resolution EB148.R2, Social Determinants of Health, WHO, 22 January 2021, accessed 29 April 2021. Available from: https://apps.who.int/gb/e/e_eb148.html#resolutions.

Present issues

40. I am receiving telephone calls from members of the community about a number of issues they believe are not inline with proper consultative policies that the community would expect from those selected to represent the interests of the Community.

41. It appears as though Government and popular media messages have penetrated private corporate policies, employment conditions and Government Departments pushing vaccines as safe and efficacious when the Therapeutic Goods Administration ("TGA") have not made such a determination because they themselves have "NO DATA" on the PFIZER vaccine.[23] A Freedom of Information request dated received 21 May 2021 revealed they have never seen the extremely limited study data for the Pfizer / BioNTech vaccine despite giving it emergency approval and deeming it safe to be injected into the arms of Australians.

    a. This begs the question, what data does the NSW Health Minister have that the TGA does not have to demonstrate safety and efficacy of Pfizer vaccine?

    b. What scientific and sponsor data is the NSW Government basing its determination to mandatorily vaccinate NSW workers (from all sectors)?

42. What the documents show is **that the TGA never saw or requested the patient data from Pfizer and simply accepted their reporting of their study as true.** This means that when the head of the TGA John Skerritt said that "*the safety evidence is pretty thorough*" on the 6 February 2021[24] those words would lead a reasonably minded person to assume, rightly or wrongly, that the TGA had actually looked at the patient data themselves.

43. To be clear, as outlined in the email of 21 May 2021 to the TGA: "***The TGA does not hold any relevant documents relating to points 1 and 2 of your FOI request, to be clear, the TGA does not hold Individual Level Patient Data in relation to this application for provisional registration***."

    a. Based on this evidence, the NSW Minister is invited to clarify what safety data it has in its possession to coerce, compel or Order Mandatory injections of NSW workforce whilst claiming it is safe and effective?

Purpose

44. The purpose of this letter is to demonstrate that the Australian community has only been fed one side of the story and anyone who critically assesses or "questions" the science is ridiculed, or intimidated using terms such as 'antivaxer'. In particular of speak of front-line doctors who have merely been trying to bring facts and scientific evidence by way of education to the Australian public, and then threatened with deregistration.

45. The idea of Government exerting pecuniary pressure on business to undertake a vaccine rollout (*by proxy*) may not fall within the guidelines of *peace, order and good governance*.

46. The issues faced in Australia and globally have been challenging, but there is also the idea that they have been disproportionate to the publicised risks as opposed to the scientifically provable risks. This is not to suggest that COVID-19 is a hoax, rather the suggestion that the

---

[23] *Freedom of Information Request documents (21 May 2021) - 35 pages* ***attached****.*

[24] Sky News (6 February 2021) John Skerrit- ''*Safety evidence for the Pfizer vaccine is pretty thorough': TGA head'* https://www.facebook.com/SkyNewsAustralia/videos/421193715601288/.

lack of transparency creates a deep sense of suspicion in the community that suggests transparency and democratic debate is supressed.

47. There is no doubt that the widely promulgated message of COVID-19 has created fear and insecurity in the community, largely due to the heavy-handed tactics employed by State Police members (presumably ordered) to supress open debate and forcibly coerce citizens to comply with Public Health Orders that are questionable in some instances. By way of example, the Orders presumably used to justify lockdowns and manage the transmissibility of the virus are dubious at best. Whilst it is understood that a delicate balance does exist between management and transmissibility, the idea that someone sitting down in venue is a lower risk than someone standing in the same venue is questionable because at some point, each person must stand to move. It follows that if a virus is as deadly as claimed, it would not matter whether someone is sitting or standing in the same venue, the virus, based on the public messages, is so deadly that entire cities must lockdown.

Children

48. There are a number of inconsistencies in the Governments approach. One would expect such a virulent strain of a virus to be so uncontrollable that no exemptions would be available.

49. All matters involving children would ideally be placed in the context of Australia's human rights obligations.

    '*In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.' 'States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.' 'States Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts.' 'States Parties recognize the right of the child to education.' (The UN Convention on the Rights of the Child)*.[25]

50. If children, young adults and others can mount their own effective immune response to SARS-CoV2, is it ethical to impede their ability to access natural immunity by interfering with the natural progression of the virus?

51. According to the WHO, "*Illness due to COVID-19 infection is generally mild, especially for children and young adults*."[26]

52. Is the focus on future fast-tracked vaccine products blocking full consideration of the opportunity for natural herd immunity? Noting that Mr Neil Ferguson stated "*The only exit strategy [in the] long term for this is really vaccination or other forms of innovative technology that allows us to control transmission*".[27]

53. In regard to young people's and others' right to natural immunity, it's also vital to consider the startling admission by Heidi Larson, Director of The Vaccine Confidence Project, during the recent WHO Global Vaccine Safety Summit, i.e. "...*We've shifted the human population...to*

[25] UN General Assembly, Convention on the Rights of the Child, United Nations, 20 November 1989, Treatyseries, 1577: 3, accessed 25 April 2021.

[26] WHO Q&A on coronaviruses (COVID-19) - Should I worry about COVID-19. 9 March 2020.

[27] Elisabeth Mahase. Covid-19: UK starts social distancing after new model points to 260 000 potential deaths. BMJ2020;368:m1089.

dependency on vaccine-induced immunity...We're in a very fragile state now. We have developed a world that is dependent on vaccinations".[28]

54. This is a very alarming statement by Professor Larson, particularly with the prospect of other epidemics emerging in the future. We have to learn to deal with epidemics and illnesses as they emerge, it's not feasible to vaccinate the global population against every threat.

55. In a recent article raising concern about making decisions about this pandemic without reliable data, John Ioannidis notes that "*School closures may also diminish the chances of developing herd immunity in an age group that is spared serious disease*".[29]The United Kingdom's chief scientific adviser, Sir Patrick Vallance, raised the prospect of developing natural herd immunity[30], but this idea was subsequently howled down by Matt Hancock, the UK secretary of state for health and social care[31], and others such as Willem van Schaik, a professor of microbiology and infection, as reported by the Science Media Centre.[32]

56. Again, is it ethical to deny children, young people and others their opportunity for natural immunity, and to plan to make them dependent on vaccine-induce immunity, to in effect make them dependent on the vaccine industry to which is driven by shareholders duty, not patient care?

57. It is critical that elected representatives accept independent and objective evidence carefully before considering the only way forward in this matter is mandatory vaccination.

58. Given the established low risk to children, there has been no need for school closures, or for children to be deprived of social connections and activities vital for their wellbeing. Children and young people have been forced to carry the ongoing burden of the response to COVID-19. The price they have paid across the world includes missing school and university education, social and cultural participation, and contact with loved ones such as grandparents and extended family. They may suffer reduced future employment potential, poverty and an increased likelihood of death or serious disease. It also hardly needs saying that the world's children and young people will bear the broader economic impact of 'lockdowns' in the years ahead. Children from disadvantaged communities are suffering most of all. The predicted increase in child poverty in developing countries – 142 million children in 2020 alone – will have significant long-term consequences.[33] Lockdowns and the ongoing global response to COVID-19 contravenes the UN Convention on the Rights of the Child and the Government should consider this, despite the fact that most lockdowns have coincided with school holidays in NSW{?}.

[28] Heidi Larson. Vaccine safety in the next decade. Why we need new modes of trust building? WHO Global Vaccine Safety Summit, 2-3 December 2019.

[29] John P.A. Ioannidis. A fiasco in the making? As the coronavirus pandemic takes hold, we are making decisions without reliable data. STAT, 17 March 2020.

[30] Coronavirus: 60% of UK population need to become infected so country can build 'herd immunity', government's chief scientist says. Independent, 13 March 2020.

[31] The UK backs away from "herd immunity" coronavirus proposal amid blowback. Vox, 15 March 2020.

[32] Expert comments about herd immunity. Science Media Centre, 13 March 2020.

[33] UNICEF, Save the Children, 'Children in monetary poor households and COVID-19' [Technical note], UNICEF, November 2020, accessed 25 April 2021 in E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

59. COVID-19 vaccines do not work well enough. The current COVID-19 vaccines are not sufficiently protective against contracting COVID-19 to support its use beyond the current voluntary participation in the CDC sponsored program.

60. A total of 10,262 SARS-CoV-2 vaccine breakthrough infections had been reported from 46 U.S. states and territories as of April 30, 2021. Among these cases, 6,446 (63%) occurred in females, and the median patient age was 58 years (interquartile range = 40–74 years). Based on preliminary data, 2,725 (27%) vaccine breakthrough infections were asymptomatic, 995 (10%) patients were known to be hospitalized, and 160 (2%) patients died.

61. Among the 995 hospitalized patients, 289 (29%) were asymptomatic or hospitalized for a reason unrelated to COVID-19. The median age of patients who died was 82 years (interquartile range = 71–89 years); 28 (18%) decedents were asymptomatic or died from a cause unrelated to COVID-19. Sequence data were available from 555 (5%) reported cases, 356 (64%) of which were identified as SARS-CoV-2 variants of concern, including B.1.1.7 (199; 56%), B.1.429 (88; 25%), B.1.427 (28; 8%), P.1 (28; 8%), and B.1.351 (13; 4%). None of these variants are encoded in the RNA or DNA of the current COVID-19 vaccines. In response to these numerous reports, the CDC announced on 1 May 2021, that community breakthrough cases would no longer be reported to the public and only those vaccine failure cases requiring hospitalization will be reported, presumably on the CDC website (https://www.cdc.gov/mmwr/volumes/70/wr/mm7021e3.htm).

62. COVID-19 vaccines have a dangerous mechanism of action. The Pfizer, Moderna, and JNJ vaccines are considered "genetic vaccines" or vaccines produced from gene therapy molecular platforms.[34] [35] They have a injurious mechanism of action in that they all cause the body to make an uncontrolled quantity of the pathogenic spike protein from the SARS-CoV-2 virus. This is unlike all other vaccines where there is a set amount of antigen or live-attenuated virus. This means for the Pfizer, Moderna, and Johnson & Johnson (JNJ) vaccines it is not predictable among patients who will produce more or less of the spike protein.

63. The spike protein itself has been demonstrated to injure vital organs such as the **brain, heart, lungs, as well as damage blood vessels and directly cause blood clots**. Additionally, because these vaccines infect cells within these organs, the generation of ***spike protein within heart and brain cells in particular, causes the body's own immune system to attack these organs***.

64. There is a burgeoning number of cases of **myocarditis or heart inflammation among individuals below age 30 years**.[36] The Centres for Disease Control has held emergency meetings on this issue and the medical community is responding to the crisis and the US FDA

[34] To KKW, Cho WCS. An overview of rational design of mRNA-based therapeutics and vaccines. Expert Opin Drug Discov. 2021 May 31. doi: 10.1080/17460441.2021.1935859. Epub ahead of print. PMID: 34058918.
[35] Doerfler W. Adenoviral Vector DNA- and SARS-CoV-2 mRNA-Based Covid-19 Vaccines: Possible Integration into the Human Genome - Are Adenoviral Genes Expressed in Vector-based Vaccines? Virus Res. 2021 Jun 1;302:198466. doi: 10.1016/j.virusres.2021.198466. Epub ahead of print. PMID: 34087261; PMCID: PMC8168329.
[36] Abu Mouch S, Roguin A, Hellou E, Ishai A, Shoshan U, Mahamid L, Zoabi M, Aisman M, Goldschmid N, BerarYanay N. Myocarditis following COVID-19 mRNA vaccination. Vaccine. 2021 Jun 29;39(29):3790-3793. doi: 10.1016/j.vaccine.2021.05.087. Epub 2021 May 28. PMID: 34092429; PMCID: PMC8162819.

has issued a warning on the Pfizer and Moderna vaccines for myocarditis.[37] It is known that myocarditis causes injury to heart muscle cells and may result in permanent heart damage leading to heart failure, arrhythmias, and cardiac death. Because this risk is not predictable and the early reports may represent just the tip of the iceberg, no individual under age 30 under any set of circumstances should feel any obliged to take this risk with the current genetic vaccines particular the Pfizer and Moderna products.

65. The US FDA has given an update on the JNJ vaccine concerning the risk of cerebral venous sinus thrombosis in women ages 18-48 associated with low platelet counts.[38] Because this risk is not predictable no woman under age 48 under any set of circumstances should feel any obliged to take this risk with the JNJ vaccine.

66. COVID-19 vaccines are generating record safety reports. In 1990, the Vaccine Adverse Event Reporting Systems ("VAERS") was established as a national early warning system to detect possible safety problems in U.S. licensed vaccines.[39] VAERS is a passive reporting system, meaning it relies on individuals to voluntarily send in reports of their experiences to CDC and FDA. VAERS is useful in detecting unusual or unexpected patterns of adverse event reporting that might indicate a possible safety problem with a vaccine. The total safety reports in VAERS all vaccines per year up to 2019 was 16,320. The total safety reports in VAERS for COVID Vaccines alone through 25 June 2021 is 411,931.[40]

67. People are dying and being hospitalized in record numbers in the days after COVID-19 vaccination. Based on VAERS as of 25 June 2021, there were 6,985 COVID-19 vaccine deaths reported and over 23,257 hospitalizations reported for the COVID-19 vaccines (Pfizer, Moderna, JNJ). By comparison, from 1999, until 31 December 2019, VAERS received 3167 death reports (158 per year) adult death reports for all vaccines combined. Thus, the COVID-19 mass vaccination is associated with at least 39-fold increase annualized vaccine deaths reported to VAERS. COVID-19 vaccine adverse events account for 98% of all vaccine-related AEs from December 2020 through present in VAERS.

68. In conclusion, the investigational, genetic COVID-19 vaccines are not safe for general use and cannot be deployed indiscriminately unless proven otherwise. Please cease and desist pressure/harassment/mandates for COVID-19 vaccination.[41]

COVID Infection and Mortality Research

69. Israel had one of the world's most effective coronavirus inoculation drives. About 57% of the population is now fully vaccinated. Many new Covid-19 cases are among vaccinated people, according to Ynet news service. As at 2 July 2021, 55% of the newly infected had been vaccinated. As of 4 July 2021, there were 35 serious cases of coronavirus out of a population of 9.3 million, compared with 21 on **19 June 2021**.[42]

[37] See: https://www.fda.gov/news-events/press-announcements/coronavirus-covid-19-update-june-25-2021
[38] See https://www.fda.gov/news-events/press-announcements/joint-cdc-and-fda-statement-johnson- johnson-covid-19-vaccine
[39] VAERS may be publicly accessed at https://www.openvaers.com/covid-data.
[40] VAERS may be publicly accessed at https://www.openvaers.com/covid-data(accessed June 25, 2021).
[41] Preceding paragraphs [60-68] were cited from Peter McCulloch (MD).
[42] Pfizer Shot Halts Severe Illness in Israel as Delta Spreads (5 June 2021)

70. On 1 July 2021 the Therapeutic Goods Administration (TGA) reported **335 deaths** and a reporting rate for adverse reactions at 4.6%.[43] It should be noted this is a voluntary reporting regime.

71. In further research, the National Centre for Immunisation Research and Surveillance (NCIRS) and funded by the Australian Government Department of Health, AusVaxSafety purports to be a world-leading national vaccine safety system. AusVaxSafety was established in 2014 to monitor adverse events following immunisation with influenza vaccines in children and is presently monitoring the COVID-19 vaccine rollout. The national roll-out of COVID-19 vaccines commenced on **22 February 2021**, and AusVaxSafety is conducting active vaccine safety surveillance of the vaccines in use. The vaccines currently being supplied are Comirnaty BNT162b2 (mRNA), sponsored by Pfizer Australia Pty Ltd, and COVID-19 Vaccine AstraZeneca, sponsored by AstraZeneca.

72. As at, **27 June 2021** AusVaxSafety sent 1,667,508 surveys Australia wide. Of that number, 1,086,732 participants responded totalling a 65.2% response rate. According to the AusVaxSafety data, 51.9% of participants reported no adverse events. However, 48.1% reported an adverse event with 1% participants reporting that they visited a doctor or emergency department.[44]

73. What is glaringly clear from the data from two opposing Government funded bodies is that there is more than a 10-fold increase in the statistical data reporting from the **4.6%** represented in the TGA data (above at point 70) to **48.1%** in the AusVaxSafety data. The reasons for the TGA's underreporting remains unclear, however, the statistical difference may be categorised as "**significant**" and may be a large reason why some citizens are not trusting the Government or the legacy media.[45]

74. The AusVaxSafety website states "*AusVaxSafety will continue to closely monitor the safety data of all COVID-19 vaccines in use in Australia in conjunction with the TGA."*[46]

75. According to Public Health England, SARS-Cov-2 variants of concern and variants under investigation in England , technical briefing 17 dated 25 June 2021, page 13, Table 4 **Attendance to emergency care and deaths by vaccination status among Delta confirmed cases (sequencing and genotyping) including all confirmed Delta cases in England, 1 February 2021 to 21 June 2021 it notes** *(inter alia): [Extract only]*[47] the Delta strain for 50 and older equated to: 78% of vaccinated attended emergency care versus 10%unvaccinated.

---

[43] Therapeutic Goods administration, (1 July 2021) '*COVID-19 vaccine weekly safety report - 01-07-2021', https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-01-07-2021.*

[44] AusVaxSafety (27 June 2021) *COVID-19 vaccine safety surveillance*. https://www.ausvaxsafety.org.au/safety- data/covid-19-vaccines

[45] AusVaxSafety (27 June 2021) *COVID-19 vaccine safety surveillance*. https://www.ausvaxsafety.org.au/safety- data/covid-19-vaccines

[46] Ibid

[47] See complete table https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/997418/Variants_of_Concern_VOC_Technical_Briefing_17.pdf

a. Case Fatality Rate (CFR) for Delta strain: 0.01% for age < 50, 1.14% for age > 50
b. (versus Alpha strain: 0.06% for age < 50, 4.80% for age > 50)

76. As we may recall, it was the Alpha strain that originally took the lives of some Australians.

Vaccines advocated for and promoted by the New South Wales Government and Federal Government.

77. To be clear and according to the state of scientific knowledge and previous public statements, the various Covid-19 vaccines:

a. **do not** provide immunity to the SARS-CoV-2 virus.

b. **do not** prevent the development of Covid-19.

c. **May lead to shedding –** causing variants and further cases

d. **are causing** death and serious injury.

e. Long term effect on people's health are **unknown**.

f. have not undergone **testing for safety**.

g. May be characterised as a form of genetic modification.

h. Have not been tested for genotoxicity (TGA Freedom of Information)

i. Have not been tested to confirm carcinogenicity (TGA Freedom of Information)

j. Have not been tested to confirm the affects on fertility (TGA Freedom of Information)

k. Based on the information noted above, I invite the Minister for Health and Premier to justify mandating vaccinating low risk groups **known** to be **outside** the risk profile range.

78. It may not be enough to justify such coercive measures with blanket MANDATORY measures which may in-fact create more harm than benefit in the long-term. The idea of creating blanket rules in circumstances where there are limited or no benefits to the low-risk groups is of great concern.

79. Further, how do the mandates apply in circumstances where the target groups are those with the lowest rates?

80. On **25 January 2021**, the Therapeutic Goods Administration ('TGA') granted provisional approval to Pfizer Australia Pty Ltd ('Pfizer') to supply its mRNA vaccine named 'COMIRNATY BNT162b2', indicated for the prevention of COVID-19 in individuals 16 years of age and older. The provisional approval pathway allows for upto 6 years' post-market validation.[3] Any such approval is therefore necessarily granted on limited safety and efficacy data. In this case the data consists of Pfizer's published trial and study documentation and results,[4] and the TGA's published documentation which accompanies the Pfizer approval, including the Product Information, Consumer Medical Information ("CMI") and Australian Public Information Report ("AusPAR").[5]

81. The AusPAR outlines various limitations of the sponsor's safety and efficacy data,[6] which prevents current assessment of:

a. longer term effects (more than 2 months);

b. duration of protection;

c. asymptomatic infection;

d. viral transmission (and hence vaccine-induced herd immunity);

e. concomitant use with other vaccines;

f. real world use in a large and diverse population, including pregnant women and breastfeeding mothers, immunocompromised individuals, paediatric subjects (under 16 years old) and Aboriginal and Torres Strait Islanders; and

g. a correlate of protection, which has not been established.[7]

82. The term 'provisional approval' as applied to vaccines makes it impossible for AHPRA, the Therapeutic Goods Administration or Government Minister or Chief Health Officer (together referred to as **Government Agents**) to satisfy its own conditions of what accurate means. By way of example, the TGA states:

"*the approval is subject to certain strict conditions, such as the requirement for Pfizer to continue providing information to the TGA on longer term efficacy and safety from ongoing clinical trials and post-market assessment. COMIRNATY has been shown to prevent COVID-19 however, it is not yet known whether it prevents transmission or asymptomatic disease*". The same information is mirrored with the Astra Zeneca vaccine which states: "*The decision has been made on the basis of short-term efficacy and safety data. Continued approval is dependent upon the evidence of longer-term efficacy and safety from ongoing clinical trials and post-market assessment*."[48]

83. It follows that I have grave concerns that Government Agents are acting outside their powers and in a manner that may imperil the lives of patients. The provisionally approved medications rubber stamped by the TGA and AHPRA tend to demonstrate that there is no longitudinal scientific data relating to risk/benefit profile of the substances used and labelled as 'vaccines' and there both concede that they do not know whether further transmission may result from the vaccines, not to mention the CFR.

84. On **25 January 2021**, the Therapeutic Goods Administration ('TGA') granted provisional approval to Pfizer Australia Pty Ltd ('Pfizer') to supply its mRNA experimental vaccine named 'COMIRNATY BNT162b2', indicated for the prevention of COVID-19 in individuals 16 years of age and older. The provisional approval pathway allows for up to 6 years' post-market validation. Any such approval is therefore necessarily granted on limited safety and efficacy data. In this case the data consists of Pfizer's (self) published trial and study documentation and results and the TGA's published documentation which accompanies the Pfizer provisional approval, including the Product Information, Consumer Medical Information ("CMI") and

[48]Therapeutic Goods Administration, "*COVID-19 vaccine: Pfizer Australia - COMIRNATY BNT162b2 (mRNA)*" (26 March 2021) COVID-19 vaccine: Pfizer Australia - COMIRNATY BNT162b2 (mRNA) | Therapeutic Goods Administration (TGA) see also Product Information "Covid-19 Vaccine Astra Zeneca auspar-chadox1-s-covid-19- vaccine-astrazeneca-210215-pi.pdf (tga.gov.au).

Australian Public Information Report ("AusPAR").[49] Ironically, it appears as though the Pfizer vaccine may have a higher risk profile, but Astra Zeneca is receiving most of the criticism.

85. There are many more vaccines such as the clinical trial phase and/or provisionally approved Astra Zeneca vaccine which have been linked to blood clots and other serious adverse effects. The side effects linked to these clinical trial phase and/or provisionally approved appear to be increasing proportionally with the level of doses administered daily. The proportional increases provide a cogent link between the dose[s] administered and the level of injuries/damages being experienced globally. Australian Government Agents knew or ought to have known that the provisionally approved medications can and do cause injury.

Therapeutic Goods Administration did not see data

86. A doctor wrote to the TGA (Therapeutic Good Administration), Australia's version of the UK's MHRA, in February 2021 asking three simple questions:

    1 – Did the TGA request the raw data from Pfizer?

    2 – Did any of the committees approving the vaccine look at the raw data and/or discuss it?3 – What were the "studies" referred to in the approval document relating to teratogenicity (risk of harm to a foetus)?

87. The reason for the request was due to concern over the validity and verifiability of Pfizer's data given its legal history (*as detailed in the book chapter published in 2014 and cited above*), a concern also shared by Peter Doshi in the BMJ in February 2021, as well as the proven concerns over fraudulent data relating to Covid-19 as seen in the "*Lancetgate*" scandal of **June 2020**.

88. The TGA originally requested a 6-month extension in view of the amount of work required to respond satisfactorily. The doctor [Freedom of Information Application] complained to the Office of the Information Commissioner who instructed the TGA to respond by the **26 May 2021**, however they still failed to meet that deadline.

Censorship

89. It is concerning that very little information about adverse events (serious and mild) are being reported.

[49] Therapeutic Goods Administration, "*COVID-19 vaccine: Pfizer Australia - COMIRNATY BNT162b2 (mRNA)"* (26 March 2021) https://www.tga.gov.au/covid-19-vaccine-pfizer-australia-comirnaty-bnt162b2-mrna

13. On 21 May 2021, the TGA responded to your email. In relation to your first query, the TGA explained:

> *"…whilst you were previously informed that the scope of the request may have been too voluminous, we have taken considerable extra time to reflect on the precise terms of your request. Your email of 29 April 2021 also assisted in clarifying and narrowing the scope of your request. Accordingly, particularly having regard to the objects of the FOI Act, and to the context of your request (including the extraordinary impact of COVID19 across the world), on this occasion, the decision-maker decided to progress your request for documents. Notwithstanding that processing such a request may ordinarily have been considered too voluminous, given the size of the one document (1,145 pages) falling within the scope of your request. In relation to your second query, the TGA now understands that you are seeking documents that confirm whether the TGA requested Individual Level Patient Data following the sponsor's application to the TGA for the provisional registration of its vaccine. The TGA confirms that we do not hold Individual Level Patient Data in relation to this application for provisional registration."*

89. Perhaps one way of looking at this is to suggest that that John Skerrit of the TGA made public statements that was inconsistent with the evidence in the presence and control of the TGA. Further, if the Government may have relied on that information to introduce mandatory vaccinations.

90. It follows that the NSW Minister for Health and Medical Research and Premier are invited to **immediately retract, cease and desist** from making any Orders (by proxy through Corporate entities) or Government agencies by mandating vaccinations in circumstances where the risks have not been adequately tested. Indeed, if the NSW Premier and Minister for Health and Medical Research have research from Pfizer in and around the same period, we invite production of those documents and the reasons as to which the NSW government have the documents and the TGA does not.

91. As at **10 June 2021,** the TGA weekly safety report (now '*25 days ago*') states the following;

    a. Since the beginning of the vaccine rollout to **27 June 2021**, there have been over 7.3 million doses of COVID-19 vaccines administered (*which includes double doses, meaning that the number of shots could be half).* The TGA has received and reviewed **335 reports of deaths**.

    b. According to the TGA, seven additional cases of blood clots with low blood platelets have been assessed as thrombosis with thrombocytopenia syndrome (TTS) likely to be linked to the AstraZeneca vaccine. Sadly, in one of these cases the patient has died, and we extend our sincerest condolences to her family. This brings the total number of confirmed and probable TTS cases in Australia to 48. When assessed using the **United Kingdom (UK)** case definition, 35 cases were confirmed and 13 were deemed probable TTS.

    c. Anecdotally, Australia's adverse events register is not as comprehensive as the USA and Europe (including the UK).

92. The TGA's concession to rely on UK case definitions, prompted the evaluation of adverse events within countries in the European Union.

Known Adverse Reaction Reports

93. The European database of suspected drug reaction reports is EudraVigilance, which also tracks reports of injuries and deaths following the experimental COVID-19 "vaccines."

94. Please note, this database is maintained at Eudra Vigilance and only for countries in Europe who are part of the European Union (EU), which comprises 27 countries.

95. Here is the summary data through June 19, 2021. Total reactions for the experimental mRNA vaccine Tozinameran (code BNT162b2,Comirnaty) from BioNTech/ Pfizer: 7,420 deaths and 560,256 injuries to 19 June 2021

    a. 16,133 Blood and lymphatic system disorders incl. 81 deaths
    b. 12,637 Cardiac disorders incl. 964 deaths
    c. 101 Congenital, familial and genetic disorders incl. 6 deaths
    d. 7000 Ear and labyrinth disorders incl. 4 deaths
    e. 265 Endocrine disorders incl. 1 death
    f. 8,122 .Eye disorders incl. 17 deaths
    g. 51,030 Gastrointestinal disorders incl. 348 deaths
    h. 155,486 General disorders and administration site conditions incl. 2,290 deaths
    i. 468 Hepatobiliary disorders incl. 31 deaths
    j. 6,110 Immune system disorders incl. 32 deaths
    k. 17,549 Infections and infestations incl. 762 deaths
    l. 6,275 Injury, poisoning and procedural complications incl. 104 deaths
    m. 13,249 Investigations incl. 285 deaths
    n. 4,162 Metabolism and nutrition disorders incl. 139 deaths
    o. 79,125 Musculoskeletal and connective tissue disorders incl. 88 deaths
    p. 325 Neoplasms benign, malignant and unspecified (incl. cysts and polyps) incl. 23 deaths
    q. 100,895 Nervous system disorders incl. 780 deaths
    r. 384 Pregnancy, puerperium and perinatal conditions incl. 10 deaths
    s. 107 Product issues
    t. 9,928 Psychiatric disorders incl. 105 deaths
    u. 1,765 Renal and urinary disorders incl. 115 deaths
    v. 2,696 Reproductive system and breast disorders incl. 3 deaths
    w. 23,689 Respiratory, thoracic and mediastinal disorders incl. 848 deaths
    x. 26,641 Skin and subcutaneous tissue disorders incl. 66 deaths
    y. 846 Social circumstances incl. 10 deaths
    z. 281 Surgical and medical procedures incl. 19 deaths
    aa. 14,987 Vascular disorders incl. 289 deaths

96. Total reactions for the experimental vaccine AZD1222/VAXZEVRIA (CHADOX1 NCOV-19) from Oxford/ AstraZeneca: 3,364 deaths and 793,036 injuries to 19 June 2021
    a. 9,136 Blood and lymphatic system disorders incl. 132 deaths
    b. 12,135 Cardiac disorders incl. 396 deaths
    c. 95 Congenital, familial and genetic disorders incl. 2 deaths
    d. 8,797 Ear and labyrinth disorders
    e. 309 Endocrine disorders incl. 2 deaths
    f. 13,459 Eye disorders incl. 12 deaths
    g. 81,806 Gastrointestinal disorders incl. 161 deaths

h. 212,663 General disorders and administration site conditions incl. 891 deaths
i. 525 Hepatobiliary disorders incl. 25 deaths
j. 3,085 Immune system disorders incl. 11 deaths
k. 17,791 Infections and infestations incl. 217 deaths
l. 7,854 Injury, poisoning and procedural complications incl. 77 deaths
m. 16,731 Investigations incl. 79 deaths
n. 9,765 Metabolism and nutrition disorders incl. 50 deaths
o. 123,637 Musculoskeletal and connective tissue disorders incl. 45 deaths
p. 332 Neoplasms benign, malignant and unspecified (incl. cysts and polyps) incl. 8 deaths
q. 169,286 Nervous system disorders incl. 532 deaths
r. 223 Pregnancy, puerperium and perinatal conditions incl. 4 deaths
s. 103 Product issues
t. 14,931 Psychiatric disorders incl. 27 deaths
u. 2,809 Renal and urinary disorders incl. 29 deaths
v. 5,967 Reproductive system and breast disorders
w. 26,631 Respiratory, thoracic and mediastinal disorders incl. 387 deaths
x. 36,457 Skin and subcutaneous tissue disorders incl. 22 deaths
y. 772 Social circumstances incl. 4 deaths
z. 671 Surgical and medical procedures incl. 16 deaths
aa. 17,066 Vascular disorders incl. 235 deaths.

97. We understand that these statistics are not being shared to the Australian population. As opposed to when COVID-19 was purportedly taking the lives of the elderly with comorbidities, the reporting on Vaccine injuries appear to be suppressed or underemphasised.

Source for Statistics: 15,472 Dead 1.5 Million Injured (50% Serious) Reported in European Union's Database of Adverse Drug Reactions for COVID-19 Shots
https://www.globalresearch.ca/15472-dead-1-5-million-injured-50-serious-reported-european-union-database-adverse-drug-reactions-covid-19-shots/5748346.

The Socially Constructed Emergency

98. There is a growing level of research that suggests establishment apparatuses use fear to oppress the citizenry. The idea of using fear and emergencies to manipulate the public is not new and is quite commonly used in public health.
    a. "*… behavior change can result by increasing people's perceived severity and perceived susceptibility of a health issue through heightened risk appraisal coupled by raising their self-efficacy and response-efficacy about a behavioral solution. In this model, fear is used as the trigger to increase perceived susceptibility and severity*."[iv]

99. Where alternative treatments are not openly discussed or made available, it provides the Australian citizens with what may be a deliberately skewed analysis to increase the perceived susceptibility and severity of Sars Cov2 which in turn leads to a fallacious line of reasoning that can only leave open a clinical trial phase and/or provisionally approved medication that the Australian citizen must consume in order to be safe. Essentially, having regard to the information known and provided in summary above, Government Agents knew or ought to have known using due skill, care and diligence that the information provided the Australian public was or is potentially misleading.

Scientific Literature

MTHFR. COVID AND BLOOD CLOTS

100. Recent data indicates that MTHFR polymorphisms may be connected with the severity of COVID-19 infection.[50]

> '*…This thrombosis that is caused by the coronavirus infection can also lead to elevated levels of homocysteine which is synthesized from methionine by methylenetetrahydrofolate reductase (MTHFR). Elevated homocysteine levels could also activate the coagulation cascade resulting in D-dimer production. Eventually, all these elements collectively result in the formation of blood clots leading to severe complications (**including death**) that were documented in some COID-19 patients*.'[51]

101. The MTHFR polymorphism population is at a higher risk of blood clots.[52]

102. The Pfizer mRNA vaccine on Wistar Han rats[53] showed the distribution of the mRNA vaccine in various organs up to at least 9 days post vaccination (pages 15-17). Alana F. Ogata,Chi-An Cheng, Michaël Desjardins, Yasmeen Senussi, Amy C. Sherman, Megan Powell, Lewis Novack,

---

[50] **COVID-19 spreading across world correlates with C677T allele of the methylenetetrahydrofolate reductase (MTHFR) gene prevalence.** Giovanni Ponti, Lorenza Pastorino, Marco Manfredini, Tomris Ozben, Gabriella Oliva, Shaniko Kaleci, Raffaele Iannella, Aldo Tomasi https://pubmed.ncbi.nlm.nih.gov/34061414 see also **Life- threatening course in coronavirus disease 2019 (COVID-19): Is there a link to methylenetetrahydrofolic acid reductase (MTHFR) polymorphism and hyperhomocysteinemia** Matthias Karst, Josef Hollenhorst, and Johannes Achenbach https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7467063/ see also **Prognostic Genetic Markers for Thrombosis in COVID-19 Patients: A Focused Analysis on D-Dimer, Homocysteine and Thromboembolism** Mohamed Abu-Farha , Salman Al-Sabah, Maha M. Hammad, Prashantha Hebbar, Arshad Mohamed Channanath, Sumi Elsa John, Ibrahim Taher, Abdulrahman Almaeen, Amany Ghazy, Anwar Mohammad, Jehad Abubaker, Hossein Arefanian, Fahd Al-Mulla, and Thangavel Alphonse Thanaraj https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7756688/.

[51] Ibid, **Prognostic Genetic Markers for Thrombosis in COVID-19 Patients: A Focused Analysis on D-Dimer, Homocysteine and Thromboembolism** Mohamed Abu-Farha , Salman Al-Sabah, Maha M. Hammad, Prashantha Hebbar, Arshad Mohamed Channanath, Sumi Elsa John, Ibrahim Taher, Abdulrahman Almaeen, Amany Ghazy, Anwar Mohammad, Jehad Abubaker, Hossein Arefanian, Fahd Al-Mulla, and Thangavel Alphonse Thanaraj https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7756688/.

[52] MTHFR A1298C and C677T Polymorphisms Are Associated with Increased Risk of Venous Thromboembolism:A Retrospective Chart Review Study Fang Liu, Danuzia Silva, Mariuxi Viteri Malone, Kala Seetharaman https://pubmed.ncbi.nlm.nih.gov/29212064/ see also Polymorphisms C677T and A1298C of MTHFR Gene: Homocysteine Levels and Prothrombotic Biomarkers in Coronary and Pulmonary Thromboembolic Disease Eulo Lupi-Herrera, MD, María Elena Soto-López, MD, Msc, PhD, Antonio de Jesús Lugo-Dimas, MD, Marcela Elizabeth Núñez-Martínez, MD, Ricardo Gamboa, PhD, Claudia Huesca-Gómez, PhD, Lilia Mercedes Sierra-Galán, MD, and Verónica Guarner-Lans, PhD https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6714945/
Correlations between methylenetetrahydrofolate reductase gene polymorphisms and venous thromboembolism: A meta-analysis of 99 genetic association studies Juan Zeng, Qinghua Zeng https://pubmed.ncbi.nlm.nih.gov/30466296/ see also Methylenetetrahydrofolate reductase polymorphism in healthy volunteers and its correlation with homocysteine levels in patients with thrombosis
Renuka Munshi, Falguni Panchal, Vrinda Kulkarni, and Ajay Chaurasia https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6759526/

[53] **Pfizer vaccine pharmacokinetic/biodistribution study** https://www.pmda.go.jp/drugs/2021/P20210212001/672212000_30300AMX00231_I100_1.pdf

Salena Von, Xiaofang Li, Lindsey R. Baden, David R. Wal *'showed….SARS-CoV-2 protein as early as day one after first vaccine injection*' in humans.[54]

103. The Spike protein generated by vaccinations may trigger similar symptoms/side effects as an actual COVID-19 infection[55] and activate coagulation cascades thereby creating further difficulties in the healthcare sector and perhaps even more sinister, the idea that the variants may be the result of shedding. While being vaccinated, minor reactions (*often declared by public officials as "rare"*) may be cumulative resulting in a more pronounced adverse clotting reaction, and worse with MTHFR polymorphism.

M-RNA DELTA STRAIN

104. The B.1.617.2 COVID-19 variant is quickly becoming the predominant strain in many countries and is soon expected to be the main COVID-19 variant in Japan. Kyoto University professor Hiroshi Nishiura stated '*the delta variant is 80% more infectious than the original virus and is expected to account for more than 50% of all domestic infections in mid-July and 80% at the end of July*.'

105. The mRNA vaccines have a reduced effect against the 'Delta' strain, with an estimated 33.5% effectiveness after one dose and 87.9% effectiveness after the second dose.[56] What should be noted is that no one is suggesting [at this point in time] that the Delta variant is more deadly, rather more transmissible, and the international data supports this hypothesis.

106. We propose that Australian community with least risk of contracting COVID-19 should be exempted from the MANDATORY Vaccine Policy and be offered another prophylactic treatment with a high effectiveness to ensure their protection from contracting COVID-19 is maintained with minimal side effects and community damage.

107. This may eliminate to the cases of shedding and variant strains emerging in the community.

108. A further concern, relates to Government representatives potentially creating Orders, Directives, Guidelines, Laws that withhold potentially life saving and preventative treatments to the population.

109. The preventative measures appear to have a better cost-benefit ratio as compared to vaccines and should be considered.

---

[54] **Circulating SARS-CoV-2 Vaccine Antigen Detected in the Plasma of mRNA-1273 Vaccine Recipients** Alana F. Ogata, Chi-An Cheng, Michaël Desjardins, Yasmeen Senussi, Amy C. Sherman, Megan Powell, Lewis Novack, Salena Von, Xiaofang Li, Lindsey R. Baden, David R. Wal https://academic.oup.com/cid/advance- article/doi/10.1093/cid/ciab465/6279075.

[55] **SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2** Yuyang Lei, Jiao Zhang, Cara R. Schiavon, Ming He, Lili Chen, Hui Shen, Yichi Zhang, Qian Yin, Yoshitake Cho, Leonardo Andrade, Gerald S. Shadel, Mark Hepokoski, Ting Lei, Hongliang Wang, Jin Zhang, Jason X.-J. Yuan, Atul Malhotra, Uri Manor, Shengpeng Wang, Zu-Yi Yuan, John Y-J. Shyy https://www.ahajournals.org/doi/full/10.1161/CIRCRESAHA.121.318902

[56] **BNT162b2-elicited neutralization of B.1.617 and other SARS-CoV-2 variants** Jianying Liu, Yang Liu, Hongjie Xia, Jing Zou, Scott C. Weaver, Kena A. Swanson, Hui Cai, Mark Cutler, David Cooper, Alexander Muik, Kathrin U. Jansen, Ugur Sahin, Xuping Xie, Philip R. Dormitzer & Pei-Yong Shi https://www.nature.com/articles/s41586- 021-03693-y#Sec14 see also **Effectiveness of COVID-19 vaccines against the B.1.617.2 variant** View ORCID ProfileJamie Lopez Bernal, Nick Andrews, Charlotte Gower, Eileen Gallagher, Ruth Simmons, Simon Thelwall, Julia Stowe, Elise Tessier, Natalie Groves, Gavin Dabrera, Richard Myers, Colin Campbell, Gayatri Amirthalingam, Matt Edmunds, Maria Zambon, Kevin Brown, Susan Hopkins, Meera Chand, Mary Ramsay https://www.medrxiv.org/content/10.1101/2021.05.22.21257658v1.full
Special thanks to Clemens Haskin Legal for information in letter of 2 February 2021

TRIPLE THERAPY COVID PREVENTATIVE TREATMENT

108. There are now multiple publications showing that intermittent Ivermectin (12 mg) +Doxycycline(100mg)+Zinc(25mg) – taken once every 7 days – will prevent Covid-19.

109. Infection better or equally to that of a vaccine. Furthermore, this treatment is mutant agnostic and works equally with all mutants and **does not require continual "booster shots"**.

110. The above therapy should be offered to New South Wales residents rather than a vaccine that remains untested in terms of short, mid and long-term trials.

111. There can be no doubt that the past 18 months has been difficult on all people of Australia, however, there is no conceivable reason for the New South Wales Government to mandate a vaccine across "all" age groups in circumstances where the Government may indeed, be introducing citizens to an impermissible course of conduct that may inexcusably imperil the lives of Australian citizens by mandating a vaccine, the Australian Health Regulator cannot verify is safe and effective.

112. We invite you to respond to the matters raised in this correspondence and we note that issues raised fall within the portfolio of New South Wales Health. Having regard to this information, the Minister for Health and advisors should have the answers readily available given that Mandatory Orders have been made to inject New South Welshman with a substance that the Therapeutic Goods Administration itself cannot confirm with absolute certainty that they are safe and efficacious in the short, mid and long term.

113. Why does the Premier and Minister for Health not implement a strategy that allows citizens to choose to use preventative medications and combinations of vitamins with healthy lifestyle choices to assist in combatting what the English Health Secretary (Sajid Javid) has described as being similar to the flu. On 4 July 2021, the Sajid Javid indicated that it will be a personal choice whether people would like to socially distance and wear a mask.

"*We are going to have to learn to accept the existence of Covid and find ways to cope with it – just as we already do with flu*."

"The new health secretary said that the "health arguments are equally compelling" for an end to Covid restrictions which the government is expected to announce on July 19". [57]

Knowledge of matters that may be imperilling the lives of Australians.

The PCR Fallacy

114. Contact tracing is reliant on the Polymerase Chain Reaction (PCR) test to identify individuals infected with SARS-CoV-2.[58] Concerning evidence of flaws with current PCR testing for SARS-CoV-2 has, however, been reported,[59] [60] [61] [62] raising doubts about the reliability of case data, [63] [64] including COVID-19-related mortality.[65] [66] [67] [68] [69] Pre-COVID medical standards recognise that a PCR test alone cannot diagnose a 'case' of COVID-19, in the absence of signs and symptoms of the disease, and without proper clinical assessment.[70] [71]

115. It is probable that the Australia and the World experienced a casedemic, rather than a pandemic. Essentially, it is possible that the PCR tests delivered a high false positive response rate thereby triggering disproportionate responses leading to lockdowns and significant losses to the community.

116. Although PCR testing can be useful for tracking disease outbreaks during the early stages of a pandemic, it was never intended to be used for mass screening of asymptomatic people.[72] In January 2021, the WHO issued technical guidance for PCR testing that outlined the limitations of PCR testing and the risk of false positives. It concluded[v]:

[57] The Mirror, (4 July 2021) *Scientists Slam 'bonkers' government lockdown plans after likened to the flu*. https://www.mirror.co.uk/news/politics/top-scientist-savages-sajid-javid-24456506

[58] Bhattacharya and Packalen, 'On the Futility of Contact Tracing', 2020 – Available https://inference- review.com/article/on-the-futility-of-contact-tracing.

[59] Surkova E, Nikolayevskyy V and Drobniewski F, 'False-positive COVID-19 results: hidden problems and costs',Lancet Respir Med, 2020, 8(12):1167-1168, doi:10.1016/S2213-2600(20)30453-7.

[60] Jefferson T, Heneghan C, Spencer E and Brassey J, Are you infectious if you have a positive PCR test result forCOVID-19?, The Centre for Evidence Based Medicine, 5 August 2020, accessed April 2020.

[61] Cohen AN, Kessel B and Milgroom MG, 'Diagnosing SARS-CoV-2 infection: the danger of over-reliance on positive test results', medRxiv 2020.04.26.20080911, doi:10.1101/2020.04.26.20080911.

[62] Nicholson T and Bhattacharya J, 'Appropriate use of PCR needed for a focused response to the pandemic', MSN News, 29 January 2021, accessed 25 April 2021.

[63] 1 Mahase E, 'Covid-19: the problems with case counting', BMJ, 2020, 370:m3374, doi:10.1136/bmj.m3374.

[64] Spencer E, Jefferson T, Brassey J and Heneghan C, When is Covid, Covid?, The Centre for Evidence Based Medicine, 11 September 2020, accessed 25 April 2020.

[65] Newton J, Behind the headlines: Counting COVID-19 deaths, Public Health Matters Blog, Public Health England, UK Government, 12 August 2020, accessed 25 April 2020.

[66] Santos S and Chiesa M, PCR positives: what do they mean?, The Centre for Evidenced Based Medicine, 23 September 2020, accessed 26 April 2021.

[67] Covid Assembly, COVID deaths Audit, Covid Assembly website, n.d., accessed 26 April 2021.

[68] Craig C, Engler J, Yeadon M and McNeill C, PCR-Based Covid Testing Has Failed, Lockdown Sceptics, 7 March 2021, accessed 26 April 2021.

[69] Berdine G, Covid Misclassification: What Do the Data Suggest?, AIER, 30 November 2020, accessed 25 April 2021.

[70] Mahase E, 'Covid-19: the problems with case counting', 2020.

[71] Pollock AM and Lancaster J, 'Asymptomatic transmission of COVID-19', BMJ, 2020, 371 :m4851, doi:10.1136/bmj.m4851 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[72] Deeks JJ, Brookes AJ and Pollock AM, 'Operation Moonshot proposals are scientifically unsound', BMJ, 2020, 370:m3699, doi:10.1136/bmj.m3699.

'Most PCR assays are indicated as an aid for diagnosis, therefore, health care providers must consider any result in combination with timing of sampling, specimen type, assay specifics, clinical observations, patient history, confirmed status of any contacts, and epidemiological information.'[73] *The PCR test amplifies fragments of genetic material present in SARS-CoV-2 but it does not differentiate between live and dead viruses. Therefore, a PCR test alone does not accurately predict the infectiousness of an individual. Although a PCR test may be positive in asymptomatic people, or in people who have recovered from COVID-19, this does not automatically mean they are infectious and can transmit the virus.*[74] *Consistent with other respiratory viruses, people infected with SARS-CoV-2 can be infectious for a short period before symptoms appear,*[75]*and for up to eight days after symptom onset.* [76] [77]

However, due to the sensitivity of PCR tests, non-infectious viral debris may be detected in nasal swabs for over two months after infection resolves.[78] *A person may also test positive for SARS-CoV-2 when they have never been infected, due to errors within the PCR testing protocol. A false positive may occur because the test has detected genetic material from other sources, or as a result of cross-contamination.*[79]

[73] WHO, WHO Information Notice for IVD Users 2020/05 [medical product alert], WHO, 20 January 2021, accessed 25 April 2021.
[74] Jefferson, T Spencer EA, Brassey J and Heneghan C, 'Viral cultures for COVID-19 infectious potential assessment – a systematic review', Clinical Infectious Diseases, 2020, ciaa1764, https://doi.org/10.1093/cid/ciaa1764.
[75] Wei WE, Li Z, Chiew CJ, Yong SE, Toh MP and Lee VJ, 'Presymptomatic Transmission of SARS-CoV-2 — Singapore, January 23–March 16, 2020' , CDC, MMWR Morb Mortal Wkly Rep 2020, 69:411–415, doi:10.15585/mmwr.mm6914e1external icon.
[76] Bullard J, Dust K, Funk D et al., 'Predicting Infectious Severe Acute Respiratory Syndrome Coronavirus 2 From Diagnostic Samples', Clinical Infectious Diseases, 2020, 71 (10) Issue 10:2663–2666, doi:10.1093/cid/ciaa638
[77] Jefferson et al., 'Viral cultures for COVID-19 infectious potential assessment – a systematic review', 2020.
[78] Liotti FM, Menchinelli G, Marchetti S, et al, 'Assessment of SARS-CoV-2 RNA Test Results Among Patients Who Recovered From COVID-19 With Prior Negative Results', JAMA Intern Med, 2020, 181(5):702–704, doi:10.1001/jamainternmed.2020.7570 237 Cevik M, Tate M, Lloyd O et al., 'SARS-CoV-2, SARS-CoV, and MERS- CoV viral load dynamics, duration of viral shedding, and infectiousness: a systematic review and meta-analysis', The Lancet, 2021, 2 (1):E13-E22.
[79] 8 Mayers C and Baker K, Impact of false positives and negatives [report], Government Office for Science, UK Government, 26 June 2020, accessed 25 April 2021.

Life expectancy in Australia (Covid Era)

117. The following table is taken from Department of Health website **1 April 2021**. [80]

118. In Australia, a boy born in 2017–2019 can expect to live to the age of 80.9 years and a girl would be expected to live to 85.0 years compared to 51.1 and 54.8 years, respectively, in 1891–1900.[81]

Age (Range)	Male Deaths	Female Deaths	Total Deaths
20-29	1		1
30-39	2		2
40-49	2		2
50-59	10	5	15
60-69	26	12	38
70-79	102	56	158
80-89	182	196	378
90-99	115	200	315
		TOTAL	**909**

119. It is quite clear from the Australian Governments own statistics that the majority of persons dying with, Covid (*undefined due to **no evidence** indicating that COVID-19 was sole cause of death*), fits within or exceeds normal patterns of life expectancy as measured longitudinally from 1891 to 2019.
120. That means, there does not on the face of it appear to be a crisis or emergency of death and despair that is outside the norm.
121. This equates to approximately 76% of deaths of persons occurred in the age groups 80 to 99 years. There is simply no evidence that the New South Wales and Australian Government has provided to support the indiscriminate rollout of vaccines to populations not at a significant or

[80] *Caveats: No coronial data has been provided by Government sources to verify these statistics. We are advised the Government departments are withholding and delaying Freedom of Information requests. No biological specimens (to our knowledge) have been listed as a determinative factor in the Government expressing the data provided below.*

[81] ABS 2014a. Australian Historical Population Statistics, 2014. ABS cat. no. 3105.0.65.001. Canberra: ABS; see also ABS 2014b. Life Tables, States, Territories and Australia, 2011–2013. ABS cat. no. 3302.0.55.001; see also Canberra: ABS; see also ABS 2015. Life Tables, States, Territories and Australia, 2012–2014. ABS cat. no. 3302.0.55.001. Canberra: ABS; see also ABS 2016. Life Tables, States, Territories and Australia, 2013–2015. ABS cat. no. 3302.0.55.001. Canberra: ABS see also ABS 2017. Life Tables, States, Territories and Australia, 2014–2016. ABS cat. no. 3302.0.55.001. Canberra: ABS; see also ABS 2018a. Life Tables, States, Territories and Australia, 2015–2017. ABS cat. no. 3302.0.55.001. Canberra: ABS see also ABS 2018b. Life Tables for Aboriginal and Torres Strait Islander Australians, 2015–2017. ABS cat. no. 3302.0.55.003. Canberra: ABS; see also ABS 2019. Life Tables, 2016–2018. Canberra: ABS.

at low risk of contracting COVID-19, which has been likened to the flu by English Health Secretary as at **4 July 2021**.

122. The age of persons tragically and reportedly passing away with COVID-19 are not necessarily falling outside the traditional life expectancy ranges to warrant such disproportionate mandates against the healthy population and yet the Government is employing the private sector to implement and enforce its policies (by proxy).

Mask Mandates

123. Whether people make an informed decision, should remain a decision between the physician and patient, but to rollout a vaccine where there is no evidence of an "EMERGENCY" appears premature and potentially unlawful. Further, there is no evidence to support that the deaths were caused by COVID-19 or whether underlying and pre-existing conditions caused the deaths which were complicated by Covid-19.

124. There is no clearer example of the politicisation of science than the changing narrative around face masks, where there has not been a change in the empirical evidence. Early in the pandemic, governments and the WHO recommended against the widespread use of face masks by healthy individuals to prevent community transmission of SARS-CoV-2.[82] [83] [84] [85] [86] In April 2020, WHO interim guidance for facemasks stated: 'There is currently no evidence that wearing a mask (whether medical or other types) by healthy persons in the wider community setting, including universal community masking, can protect them from infection with respiratory viruses, including COVID-19.'[87] Pre-existing WHO guidelines also state that there is no evidence that face masks are effective in reducing transmission. Nevertheless, voluntary use of disposable surgical masks was recommended for symptomatic individuals because they may hypothetically reduce onward transmission. There was also a conditional recommendation for wider voluntary mask use during severe pandemics for public protection. Cloth masks were not recommended under any circumstances.[88] Despite earlier advice, universal mask mandates rolled out across the globe during 2020.

125. In June 2020, the WHO also changed its advice to include mask wearing by healthy people in the community, as well as cloth masks.[89] [90]

---

[82] WHO, WHO emergencies press conference 30 March 2020 [transcript], WHO, 30 March 2020, accessed 25 April 2021.

[83] Baynes, C, 'Coronavirus: Face masks could increase risk of infection, medical chief warns', The Independent, 12 March 2020, accessed 25 April 2021.

[84] 2 Fox news, U.S. Surgeon General explains why CDC recommends public does not wear masks [videointerview], Fox News website, 31 March 2020, accessed 25 April 2021.

[85] Centres for Disease Control and Prevention, CDC does not currently recommend the use of facemasks to help prevent novel #coronavirus [tweet], CDC, 28 February 2020, accessed 25 April 2021.

[86] CTV, Tam: Current evidence doesn't support public needing masks [video], CTV news YouTube, 31 March 2020, accessed 25 April 2021.

[87] WHO, Advice on the use of masks in the context of COVID-19: interim guidance, 6 April 2020, WHO, 6 April 2020.

[88] WHO, Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic andpandemic influenza, 2019.

[89] Shukman D, Coronavirus: WHO advises to wear masks in public areas, BBC News, 6 June 2020, accessed 25 April 202 E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.

[90] WHO, Advice on the use of masks in the context of COVID-19: interim guidance, 5 June 2020, WHO, 5 June 2020.

126. For the avoidance of doubt, we ask the NSW Minister for Health and Medical Research whether the science on face masks suddenly changed? According to medical science **No**, rather, according to political science the answer may be more fluid.

Conclusion

127. In summary, it appears to be counterproductive to conduct contact tracing when, by Australia's own public messaging, this 'highly transmissible' and perceivably apocalyptic disease which had forecasted massive death rates, has delivered little more than the annual flu death rate.
128. Testing as endorsed by the World Health Organisation appears to be contrary to its own guidelines – which states testing may be counterproductive and intuitively none sensical now that SARS-CoV-2 is a global issue.
129. The Evidence relating to the flaws with the polymerase chain reaction (PCR) test, and its use, appear to be contrary to its intended purpose.
130. COVID-19 'cases' are being diagnosed based on the result of a PCR test alone, in the absence of signs and symptoms of disease, counter to usual medical practice where, serological and physical symptoms should be used to support the PCR test if a confirmed case is identified. There is widespread testing of asymptomatic people, even though literature suggests asymptomatic transmission is *not* a major driver of disease burden.
131. A positive PCR test result alone does not predict an individual's infectiousness and transmissibility does not equate to death tolls. Both issues that have been conflated in the public message.
132. A death with Covid-19 does not translate as a death from Covid-19.
133. The Delta variant being more transmissible does not translate into it being more deadly than the Alpha variant and it follows there is no evidence to support mandatory vaccinations.
134. The children, young adults up to age of approximately 50 years, are at lower risk thereby begging the question, why in NSW mandating workers in the low risk and healthy age groups? According to medical science, this does not appear to make any sense given the previous position and effectiveness of masks. Whether the wearing of a mask is held to be a psychological factor, may be of an area that may yield a result.

Implementation of a Bill of Rights

135. The following are instruments that Australia often refers to in the media when referring to oppressive regimes externally.

136. There is nothing prohibiting the Members of Parliament passing State and Federal laws that fall inline with ***Article 6 of the Universal Declaration on Bioethics and Human Rights*** and other important instruments and declarations.

Human Rights Instrument	**Number**
Universal Declaration on Bioethics and Human Rights[91] **ISO Code: AU** **Joined Unesco: 04/11/1946**	**Article 3** Informed Consent **Article 6** - Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.
International Covenant on Civil and Political Rights[92]	**Article 7** Freedom from experimentation
	Article 17 Right to privacy
	Article 18 Freedom of thought, conscience and religion
	Article 19 Freedom of expression
	Article 21 Right of peaceful assembly
	Article 22 Freedom of association
International Covenant on Economic, Social and Cultural Rights	**Article 6** Right to work
	Article 9 Right to social security
	Article 13 Right to education

[91] Universal Declaration on Bioethics and Human Rights (19 October 2005) Universal Declaration on Bioethics and Human Rights: UNESCO.
[92] International Covenant on Civil and Political Rights OHCHR | International Covenant on Civil and PoliticalRights

(*Amongst other enumerated Articles*) Declaration of Helsinki[93] "*Even though the Declaration of Helsinki is the responsibility of the World Medical Association, the document should be considered the property of all humanity*"	**(Article 8)** The fundamental principle is respect for the individual
	Articles (20, 21, 22) Right to self-determination and the right to make informed decisions regarding participation in research both initially and during the course of the research
	(Articles 2, 3 and 10) The investigator's duty is solely to the patient
	(Article 6) while there is always a need for research (Article 6), the subject's welfare must always take precedence over the interests of science and society (Article 5), and ethical considerations must always take precedence over laws and regulations (Article 9).
Declaration of Geneva [94]	The Physician's Pledge
The Nuremberg Code 1947	**(Article 1)** **Voluntary Consent of the Human Subject**
AUSTRALIAN CONSTITUTION (CTH)	**AUSTRALIAN LAWS**

[93] WMA DECLARATION OF HELSINKI – ETHICAL PRINCIPLES FOR MEDICAL RESEARCH INVOLVING HUMAN SUBJECTS. HTTPS://WWW.WMA.NET/POLICIES-POST/WMA-DECLARATION-OF-HELSINKI-ETHICAL-PRINCIPLES-FOR-MEDICAL-RESEARCH-INVOLVING-HUMAN-SUBJECTS/
[94] WMA Declaration of Geneva WMA Declaration of Geneva – WMA – The World Medical Association

We strongly encourage a consultation process to be conducted that includes the community and their wishes.

I am instructed to respectfully request that Australia's elected representatives undertake their solemn duty to represent all their countrymen and woman without fear or favour.

We would be grateful if a round-table discussion could take place encouraging public consultation with world renowned experts so the Australian Public can make an informed decision about the safety and efficacy of the vaccines being mandated by way of Government Order or by proxy from big business. I am in a position to assist with contacting internationally based and Australian based experts to assist in bringing clarity to this very important matter.

We would be grateful if those copied into this letter would seek the release of the Contract[s] between the Australian Government and Pharmaceutical companies (Pfizer and Astra Zeneca) so the Australian taxpayer [purchaser] can review the terms and costs relating to their procurement.

Yours Faithfully

Tony Nikolic

Director

Ashley, Francina, Leonard & Associates

[i] E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.
[ii] E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.
[iii] E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.
[iv] i Jeni A. Stolow, PhD, MPH, Lina M. Moses, PhD, MSPH, Alyssa M. Lederer, PhD, MPH, MCHES, and Rebecca Carter, MPH (2020) '*How Fear Appeal Approaches in COVID-19 Health Communication May Be Harming the Global Community*' page 532, Health Education & Behavior 47(4), SAGE
[v] E McArthur, (21 June 2021) '*Responding to COVID-19 - Public health or Public harm?*', PANDA.