

17 May 2024

TO WHOM IT MAY CONCERN

Submission to the Australian Senate's Community Affairs References Committee for its inquiry into Excess Mortality

SUMMARY OF SUBMISSION:

We advise the Senate in this submission on the questions and scientific methods to analyse the unexpectedly high mortality in Australia since mid-2021. Quantifying and explaining unexpected Australian deaths is the primary goal. Reports of recent unexpectedly high mortality across all age groups are not unique to Australia, and the Senate is well-advised to use observations from overseas settings in some of its analysis.

The advice in our submission is summarised below under each Term of Reference.

(a) Australian Bureau of Statistics (ABS) data showing excess deaths in recent years, with particular reference to: (i) all-cause provisional mortality data reported by the states and territories to the ABS, and (ii) the difference between all-cause provisional mortality data for 2021, 2022 and 2023 and the preceding years of 2015 to 2020 (inclusive);

We advise the Senate to look at raw mortality data in the first instance (rather than "adjusted" or otherwise manipulated data), and to examine multiple methods of calculating deaths in "excess" of what is statistically expected. For many reasons, pre-massaged data is inferior to raw data as a starting point. We discuss these reasons and the value of examining the question from multiple angles. Whichever angle is selected, significant excess deaths are likely to be found.

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

We lay out several possible reasons, namely delayed lockdown effects, inappropriate end-of-life care protocols, and side effects of the COVID-19 (hereafter "covid") vaccines, and sketch how one might attempt to identify the independent contribution of each.

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

We outline several immediate actions and several medium-run actions available to the government that would likely assist in stalling or reversing this sobering trend.

(d) any other related matter.

We remind the Senate of the power of politics, the corruption and complicity of much of mainstream science, the failures of governance and ethics during the covid era, and the need for truly independent analysis of these matters.

Yours sincerely,



[Australians for Science and Freedom](#) is a diverse group of free-thinking Australian clinicians, academics, lawyers and public intellectuals.

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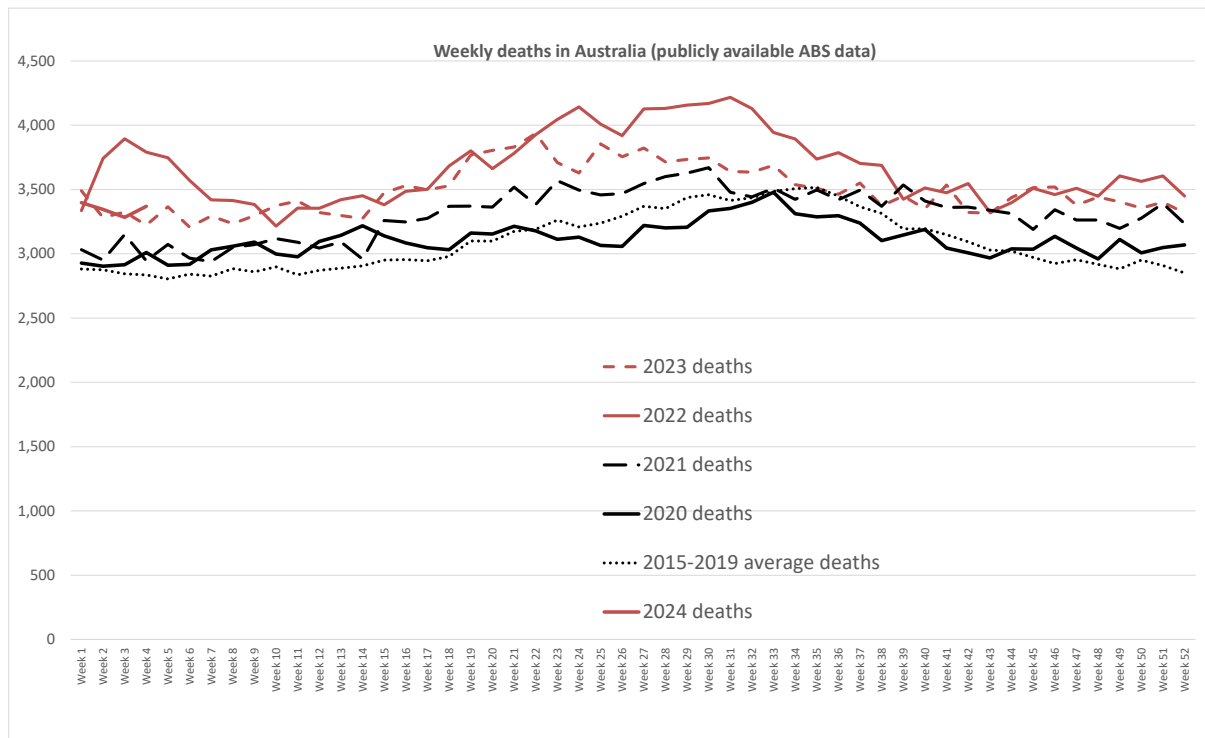
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PART 1: Response to TOR 1 in relation to Australian Bureau of Statistics (ABS) data showing excess deaths in recent years, with particular reference to: (i) all-cause provisional mortality data reported by the states and territories to the ABS, and (ii) the difference between all-cause provisional mortality data for 2021, 2022 and 2023 and the preceding years of 2015 to 2020 (inclusive).

The Australian Bureau of Statistics (ABS) offers to the public the national all-cause weekly mortality data graphed in the following display. Of note, weekly mortality statistics only began to be released in a relatively timely fashion in mid-2020, and pre-2015 weekly data are not easily sourced via the ABS website. Also of note, there are several different “provisional releases” of mortality data through this period; for the graph below, we use the most recent (30 April 2024) release of all data series. Finally, starting in January 2022, the ABS notes indicate a change in the reporting of deaths that would be expected to delay death reports.¹

Notwithstanding all the caveats above, these are the “raw data” on recent deaths in Australia, to the extent that the Australian public would easily be able to ascertain from the website of their national statistical reporting agency.



¹ The ABS note reads, verbatim: “Data for all-cause mortality covers all registered deaths that occurred in the time period, that is deaths certified by both a doctor and a coroner. Previous reports only presented data on deaths certified by a doctor. The inclusion of coroner certified deaths may reduce the level of completeness of data for more recently published weeks. Coroner referred deaths generally have a longer delay between death and registration than doctor certified deaths.” (<https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-2022>) When the ABS first began prompt releases of weekly provisional mortality series in 2020, only doctor-certified deaths (but not coroner-certified deaths, comprising 10-15% of deaths typically) were included. This has now been changed, but some prior all-cause weekly mortality series ABS releases were several hundred deaths per week short of the full count of mortality.

What is visually apparent from this graph is that the average 2015-2019 weekly mortality figures and the 2020 weekly mortality figures follow each other very closely, overlapping in both directions by no more than a few hundred deaths in some weeks. The total of reported deaths for the first 52 weeks of 2020 is 161,811, a number about 1,000 greater than the average of 160,593 deaths reported to have occurred in the equivalent periods in 2015-2019.² On closer inspection of the graph above, many of the roughly 1,000 “extra” deaths in 2020 appear to have occurred around late March to early April 2020. This is when covid is reported to have first arrived in Australia, which may make some sense. Leaving out these months, visual inspection reveals that in most weeks of 2020, fewer deaths occurred than the average number observed in those weeks in 2015-2019.

For the first few months of 2021, the trajectory of weekly deaths appears to track closely the trajectory seen in 2020. It then dips below the 2020 “covid onset” numbers in late March and early April as we might expect. Beginning in around late April, the 2021 trajectory of deaths begins to depart by 200-300 people per week, in most weeks, from the 2020 trajectory. It is also mostly above the 2015-2019 average trajectory in this latter part of the year, but not by as much.

The major feature apparent in the graph is what we see starting in 2022, when beginning in Week 1 and continuing through the entire year, weekly mortality is many hundreds of people more per week than was seen on average in 2015-2019. This trend continues throughout 2023, although not quite as strikingly in Weeks 1-10 and Weeks 22-35 of the year. 2024 has apparently begun almost identically to 2023: far from the 2015-2019 trend by hundreds of people per week, but not quite as far from this trend as the 2022 figures.

One can nominate an exact quantity of “excess deaths” from data such as these in a variety of ways, the most obvious and easiest of which is to use 2015-2019 as the baseline and report the number of deaths more or less than that baseline in each month. In 2022, 2023, and 2024, that number will be positive in all months but one, and in the triple digits in most months. To complement this, one could make the historical series more granular (year-by-year) and extend it to years prior to 2011, enabling “robustness checks” using different baseline mortality figures.³

Regardless of what one does, and under the assumption that there was no change in mortality reporting at ABS that would create the appearance (but not the reality) of more deaths nearly every week starting in late 2021 than in prior years back to at least 2015, the visual display above illustrates that more people have been dying in recent years in Australia than in years before late 2021. To augment and formalise this initial conclusion, one could perform statistical tests of the likelihood of deaths exceeding the baseline figure by the amount that they did, in light of the amount by

² Due to leap years and the fact that some years start mid-way through weeks, there are not exactly 52 comparable weeks within each year, so every few years a “53rd week” is added into the weekly mortality series to re-align the counting of weeks with the start and end of years. This 53rd week should be excluded for fair comparisons of death totals across years.

³ The ABS’ own baseline for calculating “excess mortality” has changed over time to make it seem that fewer excess deaths have occurred, for reasons that are unclear, but we do not detail this issue here. We commend to the Senate the analysis by Claire Pain on this matter: <https://clarityonhealth.substack.com/p/how-many-excess-deaths-have-there>.

which weekly death counts normally rise and fall over time. These tests would benefit greatly from a longer historical time series, but even without that, we estimate that it is likely based on the graph above that a finding of excess deaths in recent years would be deemed statistically real by a competent analyst.⁴

PART 2: Response to TOR 2 in relation to factors contributing to excess mortality in 2021, 2022 and 2023.

Plausible causal factors

Is covid itself to blame for all or most of Australia's excess deaths since mid-2021? The answer to this question is becoming clearer as time passes and covid deaths become a smaller and smaller share of Australian deaths each week. Worldometer shows that the number of daily deaths with covid in Australia over the last several years does not coincide particularly well with the trajectory of all-cause deaths shown in the graph above.⁵ It seems plausible that some of the extremely high counts of deaths in some months of 2022 may have tested positive for covid, but since late 2023, the number of daily Australian deaths with covid has been only in the single digits while all-cause death counts have remained persistently higher than expected. To investigate this question further, we advise a detailed analysis of weekly deaths by cause and a comparison of the chronology of these to that of the Worldometer covid death counts.

However, even if a significant fraction of excess deaths in Australia since mid-2021 have been classified as covid deaths, (a) it is not clear that these deaths were truly "of" covid rather than merely "with" covid, and (b) it is likely that many of them would have been avoidable with life-preserving care. Prophylaxis and early treatment of covid using known and re-purposed drugs have been known for years to be extremely effective in preventing mortality, even for elderly and ill people, despite being heavily censored in mainstream healthcare and under-utilised by Australia's health practitioners in favour of other, more extreme treatment protocols.⁶ These protocols may have directly caused more deaths with covid than would have otherwise occurred.

Given all the information presently known, in our estimation the following three factors, in some combination, are most likely to have been causing Australia's excess deaths:

- 1 – Covid lockdowns and associated policies, which disrupted society, crowded out non-covid health care and other priorities, and damaged health and immunity.

⁴ The data graphed above are counts rather than rates, meaning that using them to infer the existence of excess deaths implicitly presumes a roughly equivalent underlying population size. Immigration to Australia, largely halted in 2020 and 2021, did re-start in 2022, but (a) most immigrants to Australia are young and healthy and thus would not be expected to contribute much to death counts, and (b) the number of immigrants is inadequate to explain the degree of increase in weekly mortality.

⁵ <https://www.worldometers.info/coronavirus/country/australia/>

⁶ Some examples of effective (non-mainstream) treatment protocols: <https://covid19criticalcare.com/treatment-protocols/>, <https://www.victorymed.com/covid-19-precautions/>, <https://www.amazon.com.au/Overcoming-COVID-Darkness-Successfully-Patients-ebook/dp/B09RPSXMQD>

2 – End-of-life protocols that caused or accelerated the demise of vulnerable people, often with positive covid tests, relative to what would have happened without those protocols.

3 – The mass administration of vaccines against covid, which have increasingly been shown to have significant and deadly side effects.

Let us consider each of these possible causes in turn, focussing on the plausible mechanisms connecting them to excess deaths. We will then consider the ways one might approach determining whether a causal link exists in each case and the data relevant to making that determination. We emphasise that to examine these questions with the thoroughness they deserve, there is a desperate need for independent analysts to be able to access timely, comprehensive, and raw data from the Australian government bodies that hold such data.

(1) Covid lockdowns and associated policies.

The many negative health effects of lockdowns, documented extensively in the Australian case by Gigi Foster and Sanjeev Sabhlok in the 2022 book, *Do Lockdowns and Border Closures Serve the 'Greater Good'?*,⁷ do not occur only in the immediate period of the lockdowns themselves. At the time it was known that healthcare for problems other than covid was being de-prioritised, with the most prominent examples of this being missed routine screenings and delayed treatment for emergencies such as heart attacks because of disruptions in the health care delivery system and, on the demand side, people's fear of going to the hospital. Many other negative health effects may also have occurred. In some cases, the delayed or lower-quality care that people received for their problems during lockdowns may not have killed them at the time, but may have set them up for an untimely death later on, after the lockdowns lifted.

In addition to crowding out healthcare, lockdowns kept people away from normal familial and broader social activities, which we know to be protective against various forms of mental disease. Regular social interaction is an important component of healthy human functioning. Its disruption is a *prima facie* plausible factor in accelerating dementia, as well as in the development of depression, social anxiety, and unhealthy mental habits. These problems may sometimes kill people in the short run, but are also able to fester well beyond the lockdown period and lead to untimely deaths later on.⁸

Lockdowns also necessarily changed people's physical lives, demanding that people place caps on their physical activity (e.g., only exercising outside for one hour per day) but perhaps more importantly, creating barriers to engaging in normal healthy physical routines, such as attending the gym or taking evening walks together with one's family members. With the mental anxiety of

⁷ Foster, Gigi and Sanjeev Sabhlok (2022). *Do Lockdowns and Border Closures Serve the 'Greater Good'?* A cost-benefit analysis of Australia's reaction to covid-19. Connor Court.

⁸ For example, suicides in the most heavily locked-down Australian state, Victoria, have been increasing since the lockdowns (<https://www.theaustralian.com.au/nation/politics/victorian-mental-health-data-hits-fiveyear-high/news-story/db671d64179d754aba20566c8082768f>).

lockdowns came the seduction of poor eating and drinking habits, implying a plausible link between lockdowns and an increase in BMI, alcohol consumption, and poor dietary choices. Staying indoors and away from people also is bad for the immune system, as shut-in people go without adequate sunlight (providing vitamin D, an important input to a strong immune system) and are less exposed to the low-level pathogens that other people carry every day, that challenge and train our immune system to be prepared in case a high-level pathogen arrives. Masking, another covid-era policy, has also been shown to have plausible negative health effects, as it changes the nature of what is breathed in and covers the faces of people trying to communicate with each other. For all of these reasons, it is plausible that lockdowns and associated policies negatively affected the physical health of people, and these negative effects may become part of the causal chain leading to untimely death after the lockdown period.

The lockdowns and associated policies also had significant direct economic effects through their disruption of businesses and normal working life. We know that unemployment and lack of economic contribution is a factor in “deaths of despair”⁹ and to the extent that some individuals have been unable to re-start their economic lives after the lockdowns, some of these deaths may have occurred after the lockdown period.

Finally and most broadly, enormous government expenditures during the covid period were financed with debt that is now being paid back, using money that otherwise would have been spent on other presumably life-supporting and/or life-enriching expenditure items. It is plausible that some deaths after the lockdowns are the direct result of money unspent on such line items because of the need to service the covid-era debt.

(2) End-of-life protocols.

In spring 2020 there was a large spike in mortality in the UK,¹⁰ which was attributed at the time to covid infection. However, retrospective analysis demonstrates no correlation with covid infection but a very strong correlation with the use of the injectable drug midazolam,¹¹ part of the drug cocktail employed in protocols being followed by healthcare professionals at the time for treating patients deemed to be close to death. Additional research commissioned by the UK’s Department of Health and Social Care reveals that early in the covid era, do-not-resuscitate orders are likely to have been applied inappropriately to those diagnosed with or seen to be at risk of covid in the UK, which would have plausibly catalysed the inappropriate application of ‘end-of-life pathways’ (including midazolam) to such patients.¹² To stop covid circulating through hospital wards, this research reveals that doctors

⁹ <https://press.princeton.edu/books/hardcover/9780691190785/deaths-of-despair-and-the-future-of-capitalism>

¹⁰ <https://www.worldometers.info/coronavirus/country/uk/>

¹¹

https://www.researchgate.net/publication/377266988_Excess_Deaths_in_the_United_Kingdom_Midazolam_and_Euthanasia_in_the_COVID-19_Pandemic

¹² <https://www.cqc.org.uk/sites/default/files/20201204%20DNACPR%20Interim%20Report%20-%20FINAL.pdf>

often sent patients home – frequently back to the nursing homes from which they had come – on massive doses of respiratory depressant drugs like morphine and midazolam. Many of these patients were to die miserably in isolation, not from covid, but from the dehydration and starvation that ensued. There were many reports at the time of empty hospital wards, with those patients who were admitted often ventilated prematurely as a means of infection control. Again midazolam was used to facilitate ventilation.

‘End-of-life-pathway’ medical protocols have a controversial history in the UK. A protocol named ‘The Liverpool Care Pathway’ was introduced in 1994 but then outlawed in 2014 after a number of individuals died prematurely due to inappropriate clinical management.¹³ Early in 2020, guidance on how to cope with covid, including a prescribed end-of-life pathway protocol that included midazolam, was introduced in the UK.¹⁴

We consider it scientifically plausible that fears similar to those felt in the UK in early 2020 played out in Australia nearly two years later, when covid cases surged.¹⁵ Panic in hospitals around the increase in cases, the re-opening of international borders and the circulating Omicron variant may well have propelled clinical management to follow a similar, unnecessarily deadly, trajectory starting in late 2021/early 2022 as was witnessed in the UK in 2020. Fuelling the potential deadliness of this panic, a newly approved, higher dosage of the drug lorazepam, used in “end-of-life” pathways in Australia and sometimes substituted for midazolam, was added to the Australian Register of Therapeutic Goods on March 31st, 2022.¹⁶ Midazolam is indicated in the end-of-life care guidance presently being disseminated to health professionals in Australia.¹⁷

(3) Mass covid vaccine administration.

It should not be news to Australian Senators that the covid vaccines have an increasingly poor record for safety.¹⁸ At the time of their introduction, the mRNA technology used in Pfizer and Moderna’s vaccines had only previously been used in humans facing desperate health situations and there was no track record of safety or efficacy. Nonetheless, these vaccines against a virus that was never – even in March 2020 – particularly deadly for healthy people under 60 were mass-administered with accompanying social and economic coercion to the vast majority of Australia’s population, beginning in late February 2021. In spite of heavy censorship, disparagement, gaslighting and other forms of suppression of viewpoints or data inconsistent with the “safe and effective” epithet that mainstream media and healthcare institutions consistently pushed to be applied to these products, evidence has now

¹³ https://en.wikipedia.org/wiki/Liverpool_Care_Pathway_for_the_Dying_Patient

¹⁴ <https://www.bmj.com/content/369/bmj.m1461>

¹⁵ <https://www.worldometers.info/coronavirus/country/australia/>

¹⁶ <https://www.health.nsw.gov.au/sabs/Documents/2022-sn-023.pdf>

¹⁷ https://www.safetyandquality.gov.au/sites/default/files/2020-11/end-of-life_care_-_last_days_of_life_0.pdf

¹⁸ We do not consider the reports in Australia’s Database of Adverse Event Notifications (DAEN) to be a trustworthy indicator of the true incidence of deadly side effects from the covid vaccines, for many reasons that should be obvious and that we are confident will be addressed in other submissions.

accumulated underscoring both (a) several plausible mechanisms for fatal harm caused by the covid vaccines, and (b) actual cases of exactly the sorts of diseases and deaths that these mechanisms would be expected to bring about, in unexpectedly young and previously healthy people.

The most plausible mechanisms of mortality due to the covid vaccines, in our estimation, are in relation to cardiovascular effects, such as myocarditis, pericarditis and blood clots; and overall weakening of the immune system, which in turn can cause cancers, such as those known informally since starting to be observed a few years ago as “turbo-cancers”, and auto-immune disorders such as Guillain-Barre syndrome.

We are confident that other submissions to this Inquiry will document at length these potential mechanisms, the many diagnoses to which they can lead, and actual cases of such diagnoses, so to avoid redundancy we do not do so in this submission.

Determining causation

It is far easier to nominate plausible explanations for Australia’s excess mortality than to prove definitively the degree of contribution, in each window of time, of each plausible explanation. This is partly because all of these things (lockdowns and their sequelae, the potential application of inappropriate end-of-life protocols, and mass administration of covid vaccines) happened at roughly the same time and partly because the data needed to test for causal links are not made available to the public (and in some cases, the data do not even exist). Also, inordinately large counts of deaths over a given time period leave fewer people vulnerable to death alive during the time period after that – a phenomenon routinely observed with influenza. For this reason and also because of immigration and emigration, the size and composition of the pool of people in which deaths are occurring changes over time, complicating any analysis.¹⁹

Let us first consider the lockdowns themselves as a possible culprit. We might expect that at least some of the collateral killing effect of lockdowns would have been seen during the lockdowns themselves. Simple visual inspection of the publicly available ABS mortality data shown earlier – i.e., the number of people dying each week in Australia – indicates that this was not the case early in the covid era: weekly deaths in Australia during the first lockdown year, 2020, do not appear to exhibit either a level or a degree of change across the year that is noticeably different from what the ABS reports to have occurred on average per year in the years 2015 through 2019, except perhaps in late March and early April 2020 when covid first arrived.

What does appear upon visual inspection is a departure of mortality counts from the average 2015-2019 weekly trajectory starting in around Week 16, which was around

¹⁹ In general, we would expect a large “die-off” in one season to be followed by below-average deaths the following season. Contrary to expectations, we have not seen Australian weekly mortality return even to average 2015-2019 levels yet, following the large increase that began in mid-2021 and spiked in early 2022. This is a puzzle whose explanation we recommend the Senate Inquiry’s final report encompass.

late April, of 2021 – and then a striking departure from “normal” of the weekly all-cause mortality series beginning in January 2022. Would the lockdowns, which occurred on and off throughout 2020 and 2021, have caused this pattern in mortality during these years? Many lockdowns in different states occurred in weeks of 2020 and 2021 that do not show unexpectedly high all-cause mortality, but to answer this question with more confidence, one should look at state-by-state mortality reports and map these to information about the restrictions implemented in each state week by week in 2020 and 2021, to see whether there appears to be a plausible, causal, dose-dependent link from lockdown existence and severity on the one hand, to number of deaths on the other.

Could the lockdowns be responsible for the increase in all-cause mortality starting in mid-2021, and particularly in the post-lockdown period of 2022 and beyond? This depends on the length of time needed for the various mechanisms of lethal action suggested above to take place and the likely mortality rate from each. How long does it take, for example, for the average person who misses a bowel cancer screening (but who has bowel cancer) during one lockdown period to ultimately succumb to bowel cancer, and of those who missed screenings, how many are expected to meet such a fate? How long does it take for dementia that is progressive but can be decelerated by social interaction to accelerate again during lockdowns, and eventually kill its victim – and how many such cases should we expect? How many people would plausibly have succumbed to mental stress, extra weight, or excess alcohol consumption accumulated during lockdowns, and how long after those lockdowns would the deaths be expected to occur? To pose the full suite of relevant questions here, one could partial out counts of mortality by cause starting in mid-2021, and then separately estimate, with the help of existing literature and health professionals familiar with each cause of death, the number of likely deaths from each cause and how long the delay, neglect, or change towards bad habits caused by lockdowns would take to kill someone from that cause – and then see whether these numbers map plausibly to the chronology of deaths from that cause from late 2021 through early 2024.

To complement this analysis focussed on the physical health damage produced by lockdowns, one could examine the degree of economic recovery and public expenditure in each state and link these to the age- and cause-specific mortality rates there, investigating whether working-age people could plausibly be dying in larger numbers than usual because they are still suffering mentally (“despairing”) from the negative economic effects of the lockdowns and the fiscal stimulus that produced inflationary conditions, the need to service more debt, and general economic disruption. One could also look at the chronology of morbidity (rather than only mortality) by cause, under the plausible assumption that for every death observed to occur from a particular cause, there are often many still alive but in ill-health due to that cause. Finally, as an additional check on the validity of conclusions reached using only Australian data, we advise examining mortality data by cause in 2021-2024 from overseas nations that endured lockdowns of differing severities and lengths, to gauge the degree to which other countries’ post-lockdown death types and counts could have plausibly been caused by the lockdowns themselves.

To investigate whether end-of-life protocols could have played a role in increasing Australian deaths, we advise exploring whether data on the particular protocols in

use in Australian hospitals match the numbers of people dying each week in those hospitals. We also recommend the use of individual-level data capturing what pathways were applied and what final outcomes eventuated for each patient, and exploiting any variation across hospitals, states, or time periods in how patients with roughly equivalent clinical scenarios were treated, to gauge the likely strength of the impact of end-of-life treatment pathways on excess mortality. This could be augmented with data from countries following different protocols for patients with the same diagnoses, where one would be looking for evidence that the protocols in use in Australia may have been associated with higher than “necessary” death counts in patients admitted with particular diagnostic codes (such as “covid”) and/or of particular ages, and/or in particular weeks (such as when medical panic was high).

To examine the extent to which the mass roll-out of covid vaccines could be responsible for the excess deaths in Australia since mid-2021, we advise several alternative analytical approaches. First, taking granular individual-level data on vaccination history and health outcomes (hospitalisation and death) by state, one can examine whether people who have taken more covid vaccines have been admitted to hospitals and/or dying at rates greater than people who have taken fewer, or no, covid vaccines.²⁰ These data used to be published publicly by state health departments, but these publications have now stopped (though the data are surely still available internally). Second, we advise mapping the total number of vaccines administered in Australia to the total deaths observed over time, similar to what has already been done by Wilson Sy,²¹ and bearing in mind that deaths caused by the covid vaccines may take differing times to occur post-vaccination depending on the causal pathway towards fatality that they trigger for a particular individual. Third, we advise examining the causes of deaths, and morbidity, that have particularly increased since mid-2021, and asking whether these are causes that could plausibly have been generated by the covid vaccines – with particular attention paid, in consultation with health professionals, to those causes that are unlikely to have been brought about by delayed lockdown effects. Fourth, we advise seeking data on the chronology, causes and ages of mortality from overseas countries with low versus high rates of vaccination against covid, with a view to determining the numbers of deaths in Australia from different causes that the vaccines could plausibly have caused. Each of these methods is imperfect for many reasons, including that brand-to-brand and batch-to-batch variability in vaccine lethality is plausible²² and would introduce noise into any analysis that assumes every covid vaccination is equivalently dangerous, but in combination we believe these methods could deliver a reasonable answer.

Based on a simple visual inspection of the chronology of apparent excess deaths – which begin a month or two after the covid vaccines began to be administered in Australia, and continue to the present day, years after lockdowns, when medical panic has subsided and most of Australia is multiply vaccinated against covid – in our estimation the mass roll-out of the covid vaccines is most likely to be the main

²⁰ We here ignore the potential problem of “shedding”, whereby vaccinated individuals pass the spike protein that their bodies are producing to unvaccinated individuals, potentially sickening them. Bias from the complication of “shedding” in an individual-level analysis would be favourable to the vaccines: it would lead to the conclusion that the vaccines are less responsible for Australia’s excess deaths than they actually are.

²¹ <https://www.medclinrese.org/open-access/early-indication-of-longterm-impact-of-covid-injections.pdf>

²² <https://knollfrank.github.io/HowBadIsMyBatch/HowBadIsMyBatch.html>

culprit for Australia's excess deaths since 2021, with additional contributions (likely stronger in certain months) made by inappropriate end-of-life protocols and the delayed effects of lockdowns. Thorough, independent investigation of these questions will help determine whether this initial scientific estimate is accurate.

PART 3: Response to TOR 3 in relation to recommendations on how to address any identified preventable drivers of excess mortality.

The most obvious action to take immediately that may have a positive impact upon excess mortality is to cease use of the covid vaccines, and to treat those injured by the vaccines with the best available medical care and knowledge. Instead of continued vaccination, world-leading prophylaxis and early treatment should be advised to all Australians to minimise the deleterious effects of covid itself, as is the case with all other illnesses. Avoiding more lockdowns is an obviously good idea, but one cannot change the past, so further support for people suffering from delayed lockdown effects (mental health stress, obesity, accelerated dementia and cancer, and so on) would be an obvious action to consider. Revising structures and norms to avoid medical panic in future is also highly recommended, and the 'end-of-life' protocols in use during the covid period and still in use today should be critically examined and potentially altered in favour of more life-preserving protocols.

PART 4: Response to TOR 4 in relation to any related matter.

Of the various drivers of Australia's unexpectedly high numbers of deaths since 2021 that we consider most likely, none is beyond human control. In fact, each is the direct result of human action. It follows that those individuals and groups that strongly advocated for these actions to be taken will face severe consequences if sufficient proof is found to connect their actions to excess deaths. The most obvious examples here are politicians, bureaucrats and supporting professionals who led the calls for and implementation of lockdowns; doctors, nurses and other health professionals who administered end-of-life care protocols and covid vaccines; and biopharmaceutical companies who manufactured and marketed the drugs used in end-of-life care protocols and the covid vaccines, plus their employees, their funders, and those they have funded or benefitted in other ways. The desperation of these individuals and groups, should their actions and products be found culpable for excess deaths (possibly not only in Australia, but elsewhere in the world), should not be underestimated. Should the scientific trail start leading openly to them as culprits, they should be expected to engage in heretofore unseen levels of gaslighting, disparagement, rationalisation, and buck-passing, and if evidence begins to be so overwhelming that society truly turns against them in force, they will be capable of almost unimaginable levels of manipulation, denial, lies, and physical violence.

A major problem in the search for answers about excess deaths is that much of mainstream science has now been captured by the sorts of interests described above. Many high-status journals have published articles (often written by authors with ties to the pharmaceutical industry) affirming the efficacy and/or safety of lockdowns and/or hospital care protocols and/or covid vaccines, and disparaging other ways of addressing the threat posed by covid, like immune-system support, prophylaxis, and early treatment using repurposed drugs. This means that "peer-reviewed journal articles" are no longer the paragon of valid science that many adults

alive today were taught to see them as. Any analysis of excess deaths that one may find in the peer-reviewed literature cannot be relied upon without the added ingredient of critical scrutiny by individuals without skin in the game.

For these reasons, unfortunately but unavoidably, the Australian Senate will need to commission an independent team to do its own analysis, armed with a mandate to access the raw data from the ABS, the Australian health service, and elsewhere that will be required to conduct its work.

RECOMMENDATIONS

We recommend that the Australian Senate engage a credibly independent team of analysts, ideally from outside of Australia, who have no links to large funding bodies and would not see reputational or monetary gains to flow to themselves personally from any of the many possible outcomes of their analysis, to investigate the degree and drivers of Australia's unexpectedly high mortality in recent years. We advise that this independent team be comprised of a statistician, an economist, and a health scientist. We further advise that this team be offered government protection against likely threats of intimidation and violence by vested interests whose social and financial positions would collapse if the actions they have been associated with (e.g., lockdowns, care protocols, or particular medical products) were found to be an important cause of unexpectedly high death rates. The analysis itself is challenging, but more challenging still is finding a suitable team of analysts and ensuring that they can deliver their honest conclusions peacefully and without retribution.

Whatever this team's ultimate conclusion, the raw data suggest that the government's covid response failed to 'save lives'. The suppression of free speech and dissenting voices, including those of truly independent scientists, during the covid era meant that there were no effective checks and balances on covid policy decisions, and poor policy was the result. Australia's excess deaths demonstrate the human cost of unchecked political power (rationalised at the time by panic, uncertainty, and the use of various 'emergency' declarations) coupled with compromised mainstream science, a casual attitude toward basic human rights, individual autonomy and informed consent, and the pretence that authority figures making important decisions were always infallibly optimising Australia's health. Fixing these complex problems is beyond the remit of this Senate committee, but we urge Senators to be fully alert to these problems in the coming years.

In addition to prosecution of those individuals and organisations ultimately found to have led the actions that have caused what seem to be tens of thousands too many Australians to die since mid-2021, the Australian government would be well-advised to organise something akin to South Africa's post-apartheid Truth and Reconciliation Commission to provide a forum for the airing of pain and ultimately the finding of peace for those families unexpectedly bereaved in recent years. Further to this, we advise continued monitoring of the health status of Australians who have received the covid vaccines and their progeny, bearing in mind the sorts of side effects highlighted in this submission and also other potential harmful longer-term effects, of which those of most concern in our estimation are damage to the female reproductive system indicated by menstrual side effects of the vaccines, and DNA contamination of the vaccines, both of which may plausibly lead to intergenerational

damage. To pursue this continued monitoring, the Senate may wish to consider recommending a major restructuring of federal medical research funds such that significantly more money is available for further research into the harms of vaccines and the treatment of vaccine injuries.

We do not envy your position, but we wish you all the very best of luck in engineering matters such that these vital tasks are completed, for the sake of the Australian people.

APPENDIX A: Recommended Sources

Databases, data sources, and authoritative bodies within Australia that may be useful in examining the questions discussed in this submission include those mentioned in the footnotes, and also the following:

1. Australian Immunisation Register (AIR):

The Australian Immunisation Register is a national register that records vaccines given to individuals in Australia. It includes information on covid vaccinations.

2. Covid-19 Data Hubs:

The various Covid-19 Data Hubs sponsored by different organisations include various datasets related to the pandemic, including vaccination data. These may include information at both national and state levels.

https://www.saxinstitute.org.au/wp-content/uploads/Factsheet-45-and-Up-Study-covid-Data-Hub_August-2022.pdf;

<https://covid19datahub.io/reference/AUS.html>; <https://www.tableau.com/covid-19-coronavirus-data-resources>

3. State and Territory Health Departments:

Each Australian state and territory has its own health department that may maintain databases or provide information related to covid vaccinations, hospital care protocols, and deaths. Examples include New South Wales Health, the Victorian Department of Health, and Queensland Health.

4. Therapeutic Goods Administration (TGA):

The TGA is responsible for regulating therapeutic goods, including vaccines, in Australia. It captures information on vaccine approvals, safety, and monitoring.

5. Australian Bureau of Statistics (ABS):

The ABS provides some statistical information related to covid, including covid deaths and deaths broken down by other cause.

6. Primary Health Networks (PHNs):

PHNs may play a role in coordinating and disseminating health information, including vaccination data and causes of death, at the regional level.

7. The Australian Institute of Health and Welfare Covid-19 Register:

This linked database contains granular information matched from multiple sources on individuals' vaccinations, diagnoses, and deaths.

<https://www.aihw.gov.au/reports-data/covid-linked-data-set>