Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Inquiry into Excess Mortality

Broken hearts, broken minds & broken souls!

Personal Submission
Dr Monique O'Connor MBBS FRANZCP
April 2024

I thank the committee for the opportunity to make this personal submission.
I am a medical practitioner, Consultant Psychiatrist, with over 30 years medical experience.
I have special expertise grief, bereavement and management of Prolonged Grief Disorder, a serious mental illness arising in 7-10% of close bereavements, but ~ 30% of pandemic era bereavements(*).
I have clinical experience with bereaved whose grief has been worsened by pandemic response measures, including with bereavement occurring in close temporal proximity to the deceased receiving Covid-19 vaccination.
My submission focuses on mental health and excess mortality.
I include in this submission some factors contributing to excess mortality outside of my 'scope of practice'. I provide references, reasons for my concerns and defer to those with requisite expertise to deliberate further. As an experienced medical practitioner I have a duty to raise these issues if I genuinely consider they may have directly harmed the health of Australians.

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Introduction

This inquiry into excess mortality has origin in popular dissatisfaction with Government investigation to-date into this serious Public Health matter.

The dissatisfaction primarily stems from suppression and denial of the potential contributing role of 'Covid-19 vaccination' in Government and official investigation into excess mortality. There are multiple factors contributing to the excess death toll. In this submission I analyse the potential role Covid-19 vaccination and the strategy used to attempt population wide vaccination may contributed to the excess death toll.

97.7% of Australians over 16 received Covid-19 vaccination[1]. Given this was a new biological therapeutic, never previously used in humans, it is entirely reasonable to ask the question whether it caused or contributed to the excess death toll.

This submission aims to:
1) Point to, and attempt to unravel, the complexity of factors likely contributing to the excess death toll.
2) In simple terms, step back from the complexity and minutiae to allow rational perspective. In colloquial, Aussie terms use the lens of – *'Do not miss the elephant in the room'*, and ask, *"Does it pass the pub test?".* I request the reader keep these idioms ever present when consider matters I raise; specifically when considering whether a new intervention that covers 97.7% of Australians was introduced and often used multiple times, i.e. Covid-19 vaccination.
3) Advocate for and bear witness to voices who have been suppressed, silenced, ridiculed, censored of have died because of pandemic measures.
4) Attempt to demonstrate authoritarian government overreach into good, professional medical practice and this contributory role in excess death toll, with the aim of demonstrating the urgency of a return to good medical practice free from political and lobbyist interference.

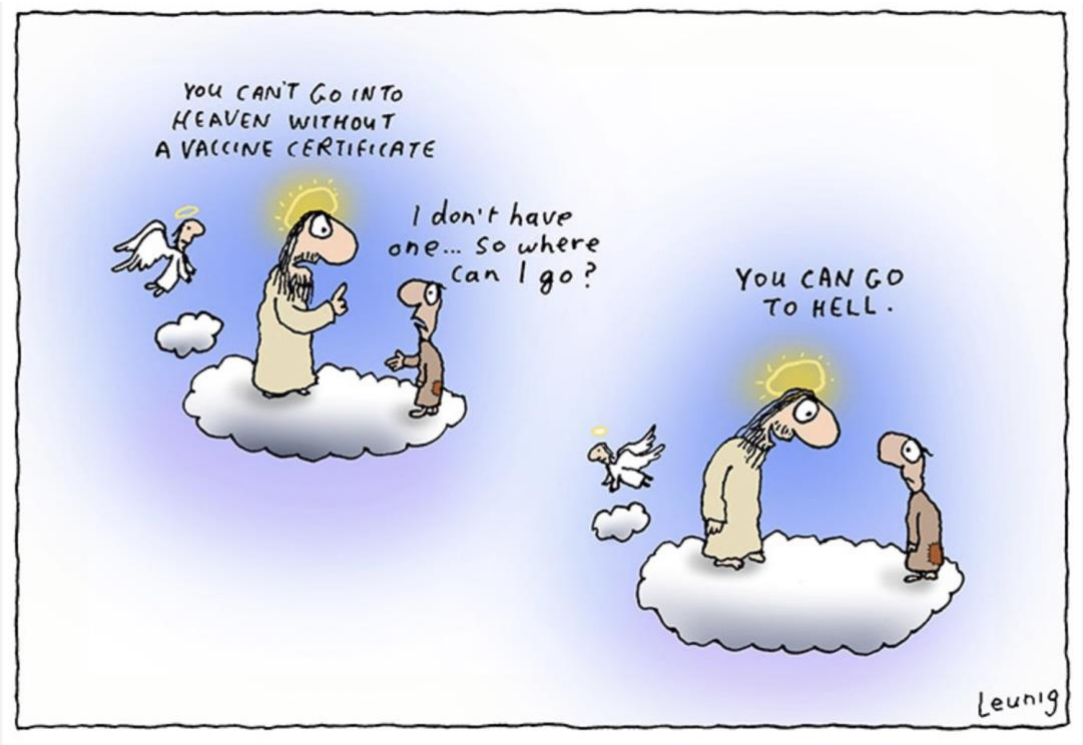
Why is the outcome of this inquiry important? We have witnessed a 'mass casualty event' in Australia with thousands of deaths not accountable by SARS-CoV-2. It is a historical event. History will discern who was blinkered by short term political expediency and who were the truth seekers.

Many to date blame SARS-CoV-2 infection, or its repercussions for the excess death toll; even the majority of those were Covid-19 infection is not registered on the death certificate.
I ask, if you readily accept this – how is it possible to simultaneously deny that the Covid-19 vaccine (which caused the body to manufacture the toxic component of the virus, i.e. spike protein in high, unregulated quantities) also contributed to excess mortality?

[1] CovidLive (viewed May 2024) (Link)

This submission is entitled 'Broken Hearts, Broken Minds and Broken Souls'. The excess death toll is the tragic tip of an iceberg of harm; physical, psychological and existential.

- 'Broken Hearts' speaks to both the grief of those bereaved and the hearts broken by myocarditis with risk of ongoing heart damage and premature death.
- 'Broken Minds' is reference to the mental health harms of the pandemic response, of those coerced into having a vaccine they did not want and those harmed by declining a novel therapeutic, especially the women of childbearing age who put the safety of their offspring ahead of their psychosocial well-being.
- 'Broken Souls' touches on the 'soul of medicine' broken by authoritarian overreach into the sacred relationship between a patient and doctor. Medicine has become political; patients have become pawns. Respect for individuality has been superseded by 'Community'. The soul of medicine has been destroyed by political interference in the sacred. Medicine became authoritarian and uncaring.



Reproduced with permission of artist, Michael Leunig, 2021.

Key Points

- **Bereavement & Grief:** Excess mortality has resultant 'excess bereavement' and grief. There is an abyss of heartbreak, tragedy and grief caused by premature, unexpected and traumatic bereavements.
- **Cause of death determination:** Accurate determination of individual cause of death is critically important, difficult and resource intensive.
- **General factors linked to excess mortality:** Multiple factors operative during the pandemic were detrimental to good health and health care delivery:
    - Scope for systematic errors when determining cause of death.

- Imposition of authoritarian medical practice that usurped traditional good medical practice.
- Scope of practice violations: Non-medical and medical practitioners both advising and enforcing medical/scientific directives outside of reasonable scope of professional/specialist medical practice.
- Suppression of accurate post- Covid-19 vaccine adverse event and death reporting.
- Flawed algorithms used for determination of causality of death post-Covid-19 vaccination.
- Mental Health harms arising from Covid-19 pandemic measures contributed to suicide, poor mental health and medical morbidity; all contributing to death toll.
- Vaccine mandates meet internationally recognised criteria for torture; torture has profound negative mental health and indirectly health consequences.
- Discrimination against those unvaccinated created barriers to them accessing health and mental health care, thereby contributing to preventable morbidity and mortality (notably suicide). It is likely many avoided medical care and likely the vulnerable unvaccinated died when sick with Covid-19 due to vicious discriminatory commentary regarding 'pandemic of the unvaccinated'.
- Thousands of health care workers were mandated out of work for declining Covid-19 vaccination. The loss of skilled health workers gravely harmed health care delivery in Australia, thereby contributing to excess mortality.
- Narrow health focus on management of Covid-19 at the expense of other health service delivery.
- Health messaging that exaggerated the threat of SARS-CoV-2 caused fear amongst doctors and patients to see each other for fear of contracting infection. This was a barrier to reasonable, routine medical care – thereby harming health care and likely contributing to the death toll.

- **Specific Factors linked to Excess mortality:** A number of specific factors require investigation regarding potential linkage to excess mortality:
  - Management of SARS-CoV-2 illness
  - Suicide
  - Covid-19 Vaccine Injury & death
  - Long Covid
  - Frail Elderly
  - Myocarditis
  - Pregnancy
  - Vaccine associated enhanced disease
  - Plasmid DNA contamination of vaccines
  - Frameshifting & junk mRNA

Excess Mortality

A 'mass casualty' event has occurred in Australia as excess mortality numbers in the thousands. A Parliament of Australia Research Paper from December 2023 reported[2],

"In 2022 there were an estimated 18,600 to 20,200 more deaths ('excess deaths') than might have occurred in the absence of the COVID-19 pandemic. More than half of these deaths were from COVID-19, but the greater than expected number of deaths from cancer, dementia, diabetes, and heart disease highlight some of the pressures the pandemic placed on our health and care systems.
Preliminary mortality figures for the first few months in 2023 show Australia is still experiencing excess deaths. Monitoring the gap between expected and actual deaths can provide early indications of the people and institutions most at risk in an emergency (such as the COVID-19 pandemic) and support better targeting of interventions and resources."

According to the Actuaries Institute, [3] in 2023, 2,300 (27%) of 8,400 excess deaths had no mention of COVID-19 on the death certificate and found women specifically vulnerable to excess mortality in younger cohorts,

" In 2023 for the 0-44 and 45-64 age bands, male mortality is close to expected but for females there is a significant excess, as in 2022;"

Unexplained excess deaths in such numbers compel thorough investigation to guard the health of Australians, guide future Public Health policy and provide transparent answers. The voiceless dead deserve advocacy and justice. The living require urgent and rigourous analysis to ensure the results serve future public health decision making.

Excess mortality is understood to be the number of deaths that occurred in a specific time period that exceeds those expected to have occurred. It is a complex concept. There are many variables (population change, aging population etc) that contribute to the expected number of deaths, and multiple 'variables' (each of differing weight) contributing the causes of death. There is no 'right way' to determine it.

The graph below taken from Our World In Data, shows excess deaths continue into 2024, so represent an ongoing problem. The cause of such medical failure despite modern medicine must be established. In doing so, we must be mindful of the lessons from history[4]

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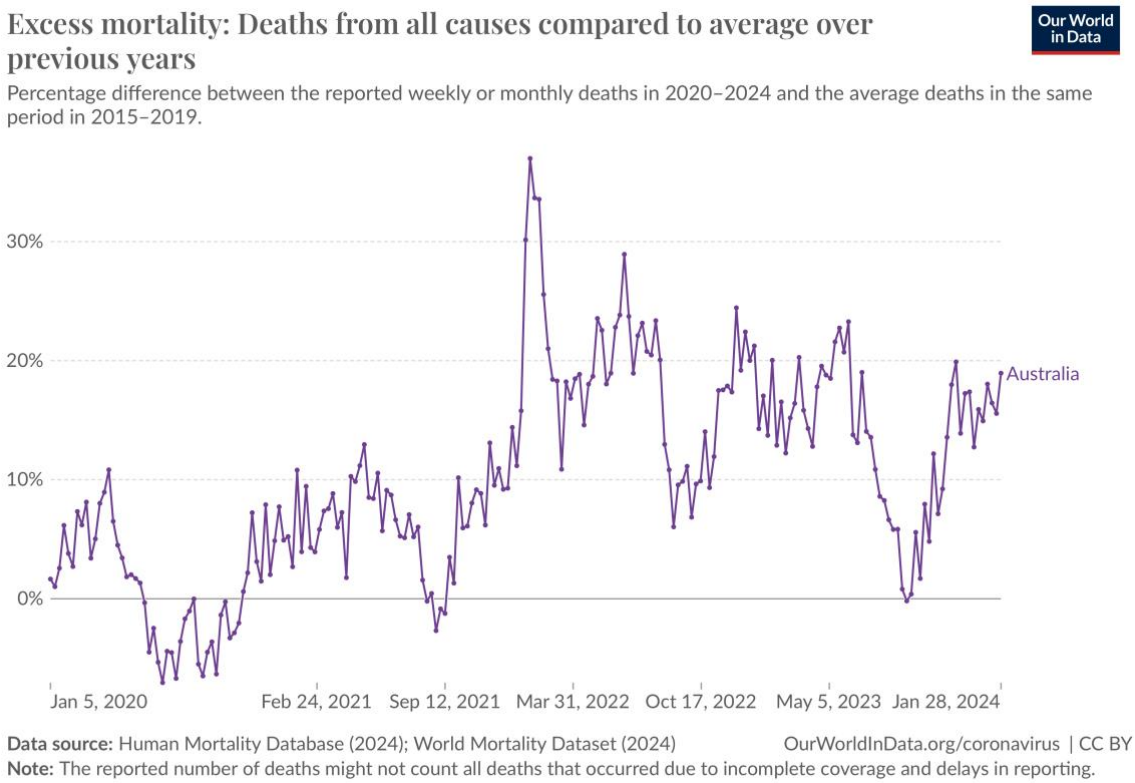
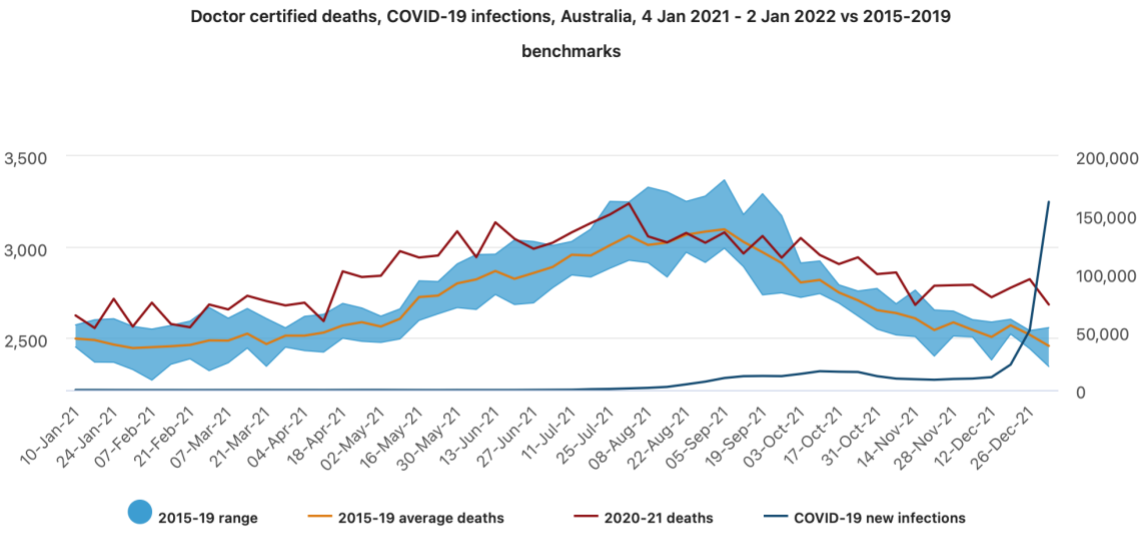
[2] Australian Parliament; Parliament Library Research paper; "*Excess Deaths in Australia: Frequently Asked Questions*" 13 December 2023 ; (Link)
[3] Actuaries Institute Mortality Working Group; 05 April 2024; '*Catch up on the Actuaries Institute Mortality Working Group's latest analysis of excess deaths.*' (Link)
[4] Our world data: Excess Mortality (Link)



Graphs from the ABS depicting excess death toll in Australia[5]

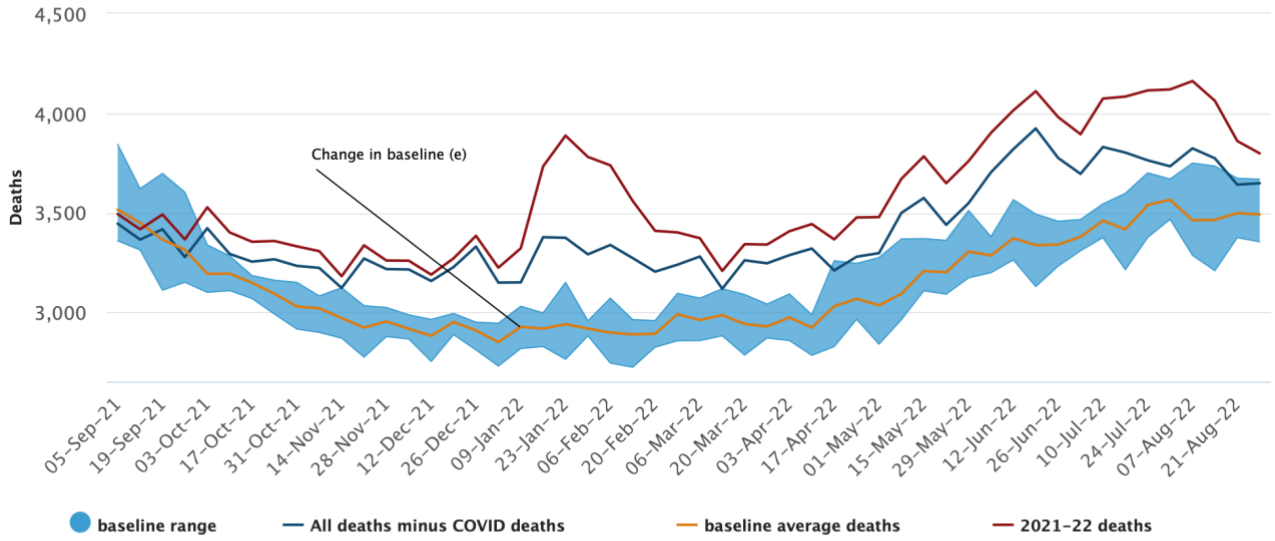


a. This graph is compiled by the date the death occurred.
b. This data is considered to be provisional and subject to change as additional data is received.
c. In line with the ISO (International Organization for Standardisation) week date system, weeks are defined as seven-day periods which start on a Monday. Week 1 of any given year is the week which starts on the Monday closest to 1 January, and for which the majority of its days fall in January (i.e. four days or more). Week 1 therefore always contains the 4th of January and always contains the first Thursday of the year. Using the ISO structure, some years (e.g. 2015 and 2020) contain 53 weeks.
d. Refer to explanatory notes on the Methodology page of this publication for more information regarding the data in this graph.
e. Data for the number of COVID-19 infections has been sourced from the COVID-19 daily infections graph published on the Australian Government Department of Health website. Data extracted 9 March 2022.

Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan 2020 - Dec 2021

[5] Australian Bureau of Statistics (jan---nov-2023), Provisional Mortality Statistics, ABS Website, accessed 4 May 2024.

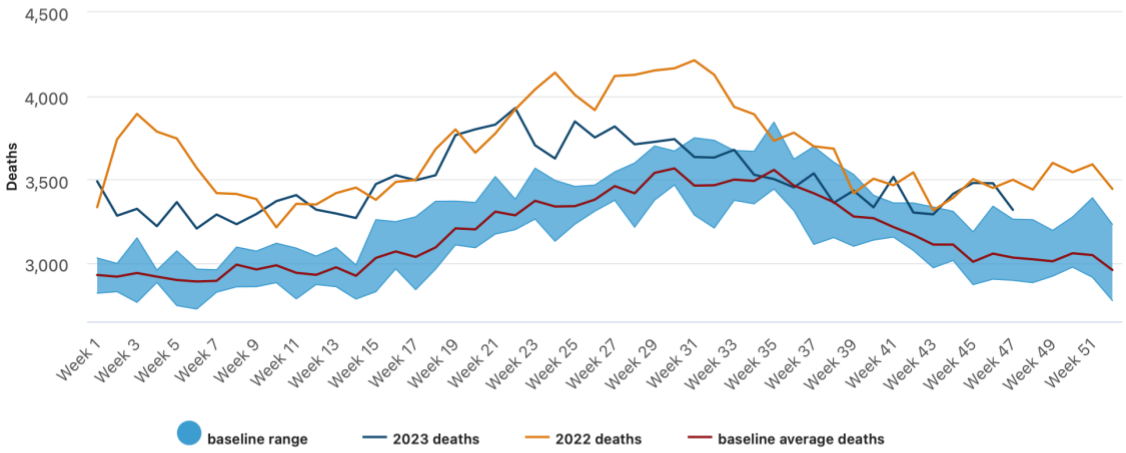
All deaths, with and without COVID-19, Australia, 30 August 2021 – 28 August 2022 vs baseline benchmarks



a. Data is by occurrence.
b. Data is provisional and subject to change.
c. Weeks are defined as seven-day periods which start on a Monday as per the ISO week date system. Refer to 'Weekly comparisons' on the methodology page of this publication for more information regarding the data in this graph.
d. The baseline includes deaths from 2015–19 (for 2021) and from 2017–19 and 2021 (for 2022).

Source: Australian Bureau of Statistics, Provisional Mortality Statistics Jan – Aug 2022

All deaths, Australia, 3 January 2022 - 26 November 2023 vs baseline benchmarks



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

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

The analysis of excess mortality, with the politically charged backdrop of the Covid-19 pandemic is emotive and has risks obfuscation of variables to fit political expediency or cover wrong-turns.

I am hopeful this inquiry will adopt the goal of truth seeking when determining factors contributing to excess mortality in Australia, using rigourous scientific method, reason, logic and the good old Aussie 'pub test'.

Further, note that 'unconscious bias' against those who challenge the official narrative (especially negative bias towards 'antivax sentiments') could hinder logical analysis and impede 'seeing the obvious'.

Favourable health outcome is dependent on good medical practice. The pandemic response in Australia forced a marked deviation from 'good medical practice'. My submissions brings evidence of this deviation, and the negative impact it has had on the health of Australian. This has, more likely than not, contributed to poor health and excess deaths. The deaths likely represent the tip of a poor health iceberg. The vaccine-injured are an under recognised part of this iceberg.

The screenshot below, taken from ABS data explorer in May 2024[6]. The Western Australia mortality data of 2021 is worth analysis because Covid-19 vaccination was rolled-out in 2021, including mandatory vaccinations, but there was not community transmission of SARS-CoV-2. Also, travel interstate or overseas was not possible, so population change was minimal, most accounted for by births and deaths. The Estimated resident population (ERP) in December 2020 in WA was and 26,702,000 and in December 2021 was 27,622,000. The number of births in WA in 2021 was 34,065 births[7]. Yet there was a significant increase in deaths in 2021 without SARS-CoV-2 accounting for any role. Further, the death rate in 2020, supposedly a low death year, is not much different from preceding year is 2019 is an outlier. The crude death rate in 2021 was the highest since 2016 in WA.

Deaths, Year of registration, Summary data, Sex, States, Territories and Australia

Sex: Persons ● ***Frequency:*** Annual

	Time Period		2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Measure	***Unit of measure***												
Region: Australia													
Deaths	Number		147,098	147,678	153,580	159,052	158,504	160,909	158,493	169,301	161,300	171,469	190,939
Crude death rates	Number		6.5	6.4	6.5	6.7	6.6	6.5	6.3	6.7	6.3	6.7	7.3
Standardised death rates	Number		5.5	5.4	5.5	5.5	5.4	5.3	5.1	5.3	4.9	5.1	5.5
Region: Western Australia													
Deaths	Number		13,339	13,414	13,787	14,448	14,839	14,494	14,652	15,042	14,993	15,891	17,299
Crude death rates	Number		5.5	5.4	5.5	5.7	5.8	5.6	5.6	5.7	5.5	5.8	6.2
Standardised death rates	Number		5.4	5.3	5.3	5.4	5.4	5.1	5	4.9	4.7	4.8	5

[6] Australian Bureau of Statistics Data Explorer (Link) viewed May 2024

[7] Australian Bureau of Statistics (2022), Births, Australia, ABS Website, accessed 16 May 2024.

Year	Deaths	Standardized death rate (deaths/100,000 popn)	Population estimates	No. Covid deaths[8]	Median age of Covid death
2012	147,098	553.9	22,733,465		-
2013	148,268	543.3	23,128,129		-
2014	154,039	548.7	23,475,686		-
2015	159,195	552.6	23,815,995		-
2016	159,176	538.4	24,190,907		-
2017	162,044	534.1	24,592,588		-
2018	160,097	515.6	24,963,258		-
2019	166,562	522.3	25,334,826		-
2020	161, 300	491.5	25,649,248	906	86.9 years
2021	171,469	507.2	25,685,412	1,356	79.1 years
2022	190,939	550.0	26,005,540	10,305	85.8 years
2023	182,038	509.5	26,821,557	4,544	85.7 years

Registered live births dropped in 2022[9], see screenshot below:

Births registered by state or territory of registration Download

	2021	2022	2021-22(no.)	2021-22(%)
New South Wales	99,300	95,758	-3,542	-3.6
Victoria	76,414	76,187	-227	-0.3
Queensland	64,261	62,313	-1,948	-3.0
South Australia	19,783	19,502	-281	-1.4
Western Australia	34,065	31,474	-2,591	-7.6
Tasmania(a)	6,027	5,498	-529	-8.8
Northern Territory	3,736	3,577	-159	-4.3
Australian Capital Territory	6,410	6,375	-35	-0.5
Australia	309,996	300,684	-9,312	-3.0

a. Birth registrations in Tasmania in 2022 were affected by a change in the way births were assigned to the reference year. This change resulted in a lower number of birth registrations than recorded in previous years. For details see State and territory data - Tasmania in Methodology.

[8] Australian Bureau of Statistics (jan---dec-2023), Provisional Mortality Statistics, ABS Website, accessed 12 April 2024.
[9] Australian Bureau of Statistics (2022), Births, Australia, ABS Website, accessed 16 May 2024.

Why might there be the gender difference in younger excess deaths? This question requires careful evaluation. Vaccination was recommended to all pregnant women from June 2021, and was mandatory (without possibility of exemption) for applicable female workers. Yet the vaccine could not have had reasonable safety assessment for use in pregnancy. Pregnancy is 9 months. The novel gene based covid-19 vaccines only became publicly available outside of clinical trial (in which pregnant women were not included) in December 2020, or late February 2021 in Australia. The vaccines were not recommended in pregnancy up until June 2021; the earliest a women vaccinated in the first trimester of pregnancy might have delivered a baby would be September 2021. The safety of the Covid-19 vaccines in pregnancy remains poorly studied. The mental trauma of coerced vaccination during pregnancy is exceptional. Again, a horrific example of authoritarian medical practice.

It is not possible to match this fall in births with miscarriages, stillbirths, maternal deaths or vaccination during pregnancy. I contend that it is critical that this data is made available for analysis, especially given the fact that female deaths in childbearing years were overrepresented in excess mortality data[10].

Determination of cause of death

The accuracy of determination of individual cause of death underpins the accuracy of cause of death determination at a population level. Pursuant on this, evaluation of 'excess mortality' causality is highly complex and open to multiple confounders. A spirit of absolute truth seeking is required. When a matter is highly complex, and truth is easy to obscure, perspective is important to understand the bigger picture, with plausible patterns – so that 'the elephant in the room' is not missed.

There is substantial scope for error when determining individual cause of death. Systematic error or under recognition of a novel contributing factor to cause of death would have a disproportionate impact on population level attribution of cause of death.

A basic overview of determining cause of individual death involves:
1. History of the death: Obtain information to understand the timing, situation, preceding events and circumstance of the death; whether it was expected or unexpected or premature.
2. Medical History: Review the medical history, surgical history for any conditions and risk factors that may have contributed to their death.
3. Medical Interventions: Evaluate all medical interventions or treatments administered prior to the death and assess their impact on the outcome. Include a detailed history of

[10]Actuaries Digital; ***Catch up on the Actuaries Institute Mortality Working Group's latest analysis of excess deaths.*** 05 April 2024 (Link)

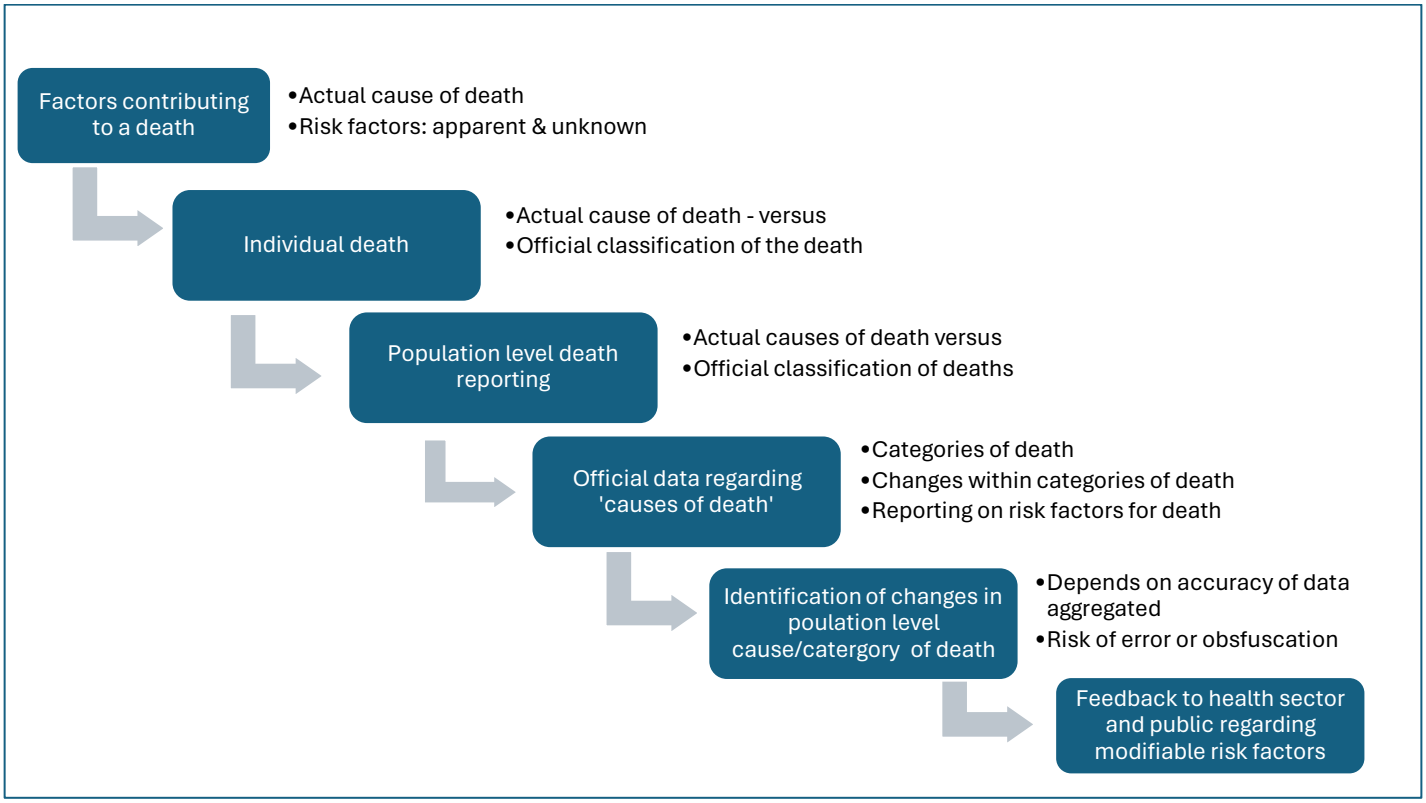
prescribed and over the counter medication usage. Include dates and types of vaccinations with batch numbers.
4. Substance Use history: Evaluate potential that substance usage had a contributary role in death.
5. Clinical Examination: Conduct a detailed external physical examination of the body to identify any signs of trauma, disease, or abnormalities. If unexpected perform an autopsy to examine internal organs, collect and analyse specimens for routine analysis, histology and toxicology.
6. Collateral History: Obtain information from family or witnesses to understand concerns and the circumstances of the death
7. Environmental Factors: Consider external factors such as environmental conditions, accidents, or injuries that may have played a role in the death.
8. Timeline: establish a clear timeline of events leading up to death. Information is gathered from those known to the deceased by coronial police investigators.
9. Family History: Consider the deceased's family history of medical or genetic vulnerability.
10. Expert Consultation: Utilise medical specialists in relevant fields to assist determination of causality with input from pathology, toxicology and forensic medicine to interpret of findings. Use a consultative and collaborative approach.

Determination of contributing factors to the cause of an individual death is challenging. Many deaths result from the cumulative effects of multiple risk factors – an interplay of medical, physiological, psychological, genetic, developmental, environmental, cultural and social contributing factors - making it difficult to isolate individual contributors to mortality. Determination of cause of death is dependant on the quality and availability of data. Also, the accuracy and completeness of data collection is important as underreporting and misclassification lead to inaccurate cause-of-death determinations.

Socioeconomic disparities and cultural factors profoundly influence mortality patterns, exacerbating health inequities and disparities in access to healthcare. Understanding the social determinants of health and addressing structural inequalities are critical for advancing health equity and reducing preventable deaths. Incorporating qualitative research methods, community engagement strategies, and participatory approaches can enhance the contextual relevance and impact of mortality studies.

As determination of individual cause of death is so challenging, any error will be magnified at population level. If a cause of death, or contributing factor is omitted or minimised, this too will have a disproportionately magnified error at a population or pubic health level.

Potential Error Levels for accurate determination of death: Points of interest in evaluation of excess mortality and use of relevant data to influence public and personal health decision making.



World Health Organisation guidance regarding evaluation of Covid-19 vaccine safety surveillance, largely adopted by Public Health officials in Australia risked suppressing recognition of vaccine adverse events or deaths and providing misleading coercive techniques to promote vaccination in those who may be hesitant. The problem was twofold.

1)Promotion of vaccine safety communication deliberately minimised risk of vaccines, and suppressed any community level information that might lead to vaccine hesitancy. Whilst;
2) Making linkage of vaccination to adverse events of deaths nigh impossible.

I raise my concerns because this was published prior to any safety data on the new vaccines. Preceding knowledge about vaccines could not be automatically applied to gene-based 'vaccines'. The safety profile of Covid-19 vaccination needed to start from a completely new and completely open starting point. Any preceding assumption, especially regarding safety could not apply to genetic vaccines because the mode of action and impact on human physiology in the real world was absolutely unknown.

The 232 page '*World Health Organization 'Covid-19 vaccines: safety surveillance manual'*, published in **2020** (vaccine roll-out started in 2021), with contributions from Australian academics from the University of Sydney includes a 47 page section on 'Vaccine Safety Communication'. The table of contents on p162 is displayed below to provide insight into the organised, advanced strategy that was already in play to deploy when the vaccine roll-out began.

Contents

I contend that this powerful, organised strategy to arrest any impediment to the vaccine roll-out had a profoundly harmful negative impact on the accurate evaluation of the

safety of vaccines once they were rolled out. This document, with strategies utilised in Australia, together with Operation Covid Shield (whose mission was to 'maintain positive vaccine sentiment') conflicts with openness to potential lack of safety with a new therapeutic.

Below, also from the WHO 'Covid-19 vaccine safety manual' 2020, page 189, describes how to manage negative comments about Covid-19 vaccines:

Negative messaging that has spread beyond the source community and is being engaged with and discussed in non-fringe environments may warrant response. Here are some recommendations for responding to negative messaging:

- **Remember the audience is the people who are listening**, *not* the person or organization spreading the negative message. This is equally true when pitted against an anti-vaccine activist in a TV broadcast, responding to a critical remark from the crowd in a town hall meeting, or responding to a post on social media. Craft your response for the audience, not to argue with or convince the person spreading the negative message.
- **Emphasize factual information** when refuting negative messages. Too much focus on the misinformation may strengthen the falsehood in people's minds.
- **Create content that triggers positive emotions**, such as the health benefits of vaccines. This type of content is important to counteract negative messaging on vaccines based on emotional values and will complement information based on data and evidence.
- **Emphasize scientific consensus,** such as "90% of clinicians agree that this vaccine is safe"
- **Warn the audience** by explicitly signposting repeated misinformation, e.g., "There are many myths about COVID-19 vaccine safety. This myth, for example, is about..."
- **Explain why the misinformation is incorrect** and if possible, provide an alternative explanation. This is more effective than simply saying something is incorrect. Provide links to reputable sources where appropriate.

COVID-19 VACCINE SAFETY COMMUNICATION 189

I hold grave concerns about much of this document. For the WHO to encourage health professionals or public health officials or lie by claiming, *"90% of clinicians agree that this vaccine is safe'* – without any evidence to support the claim as it was impossible (no clinician outside of clinical trials had access or knowledge of covid-19 vaccine safety) – was unconscionable.

However, this supports my fear that a dangerous medical/public health environment was created by those over-committed to, '*Covid-19 vaccination is the only path out of the pandemic'* and '*Supress vaccine hesitancy at all costs'* it was nigh impossible for a new vaccine that potentially had a serious negative safety-benefit profile to be recognised. [11]

General Practitioners in Australia were used to promote the safety of Covid-19 vaccination:
"Effective risk communication from vocal pro-vaccine advocates in general practice, in addition to strong endorsement from government and early and transparent communication on the measures taken to ensure vaccine safety and rigorous approval processes, will be crucial to achieve this. Lastly, it is crucial to avoid overt and harmful politicisation of the COVID-19 vaccination program in Australia that risks dividing people's views about the vaccines along party lines."[12]

Much effort was invested in promoting vaccination. [13] [14]

WHO: Causality assessment of serious vaccine injury and death – nigh impossible evaluation of actual risk
'Causality assessment usually will not prove or disprove an association between an event and the immunization. It is meant to assist in determining the level of certainty of such an association. A definite causal association or absence of association often cannot be established for an individual event."[15]

The WHO recommended the following analysis of Adverse Event Following Immunisation [16]

[11]Group of Eight Universities; Roadmap to Recovery April 2020 https://go8.edu.au/research/roadmap-to-recovery

[12] Preparing the public for COVID-19 vaccines: How can general practitioners build vaccine confidence and optimise uptake for themselves and their patients? Margie Danchin Ruby Biezen Jo-Anne Manski-Nankervis Jessica Kaufman Julie Leask Australian Journal of General Practice: Volume 49, Issue 10, October 2020 doi: 10.31128/AJGP-08-20-5559 (Link)

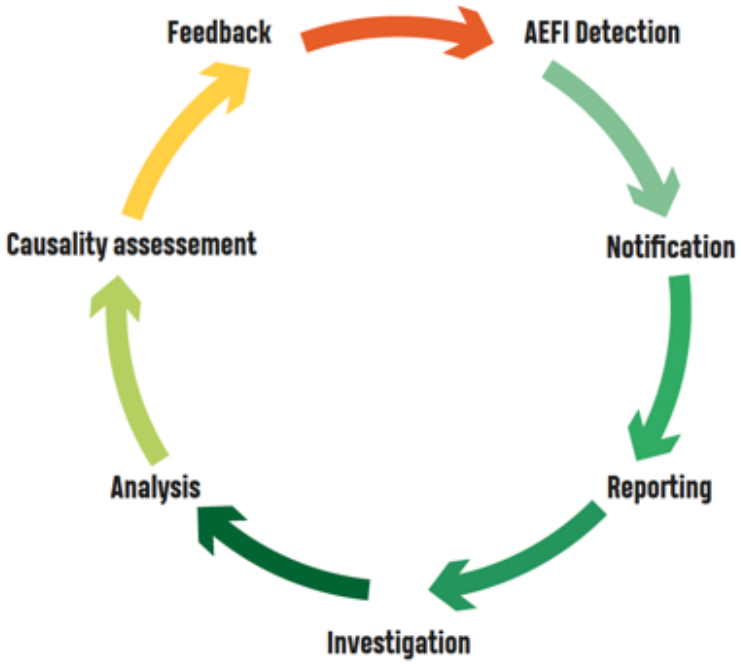
[13] COVID vaccine hesitancy exists even among health workers, but building their trust is crucial: The Conversation / Holly Seale;18 Jan 2021 (Link)

[14] What could convince someone worried about the COVID-19 vaccine to get the jab? Maani Truu; 1 Aug 2021, updated Mon 2 Aug 2021 (Link)

[15] Causality assessment of an adverse event following immunization (AEFI): user manual for the revised WHO classification second edition, 2019 update. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.
https://iris.who.int/bitstream/handle/10665/340802/9789241516990-eng.pdf (viewed May 2024)

[16] Covid-19 vaccines: safety surveillance manual. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO. (p 64)

Fig 1: AEFI surveillance cycle



The bureaucratic obfuscation is obvious! Further the following was required to prove causality:
'*Is there evidence in published peer reviewed literature that this vaccine may cause such an event even if administered correctly?*
Is there a biological plausibility that this vaccine could cause such an event?
In this patient, did a specific test demonstrate the causal role of the vaccine?'

As stated above, given Covid-19 vaccination is a novel therapeutic – it was not possible to have knowledge of specific tests, have peer reviewed publication of events!!! Obvious case of 'unknown unknown' was the menstrual abnormalities after Covid-19 vaccination. Seemingly (to 'the experts') not biologically plausible …. But it did happen. It was not captured by the established regulatory procedures because they were based on false premises and hence erroneous.

Below is the WHO recommended pathway for determining causality of adverse event after vaccination [17]

[17] Covid-19 vaccines: safety surveillance manual. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

Step 1 (Eligibility)

Patient ID/Name :	*DoB/Age:*	*Sex: Male/Female*
Name one of the vaccines administered before this event	What is the Valid Diagnosis?	Does the diagnosis meet a case definition?

Create your question on causality here

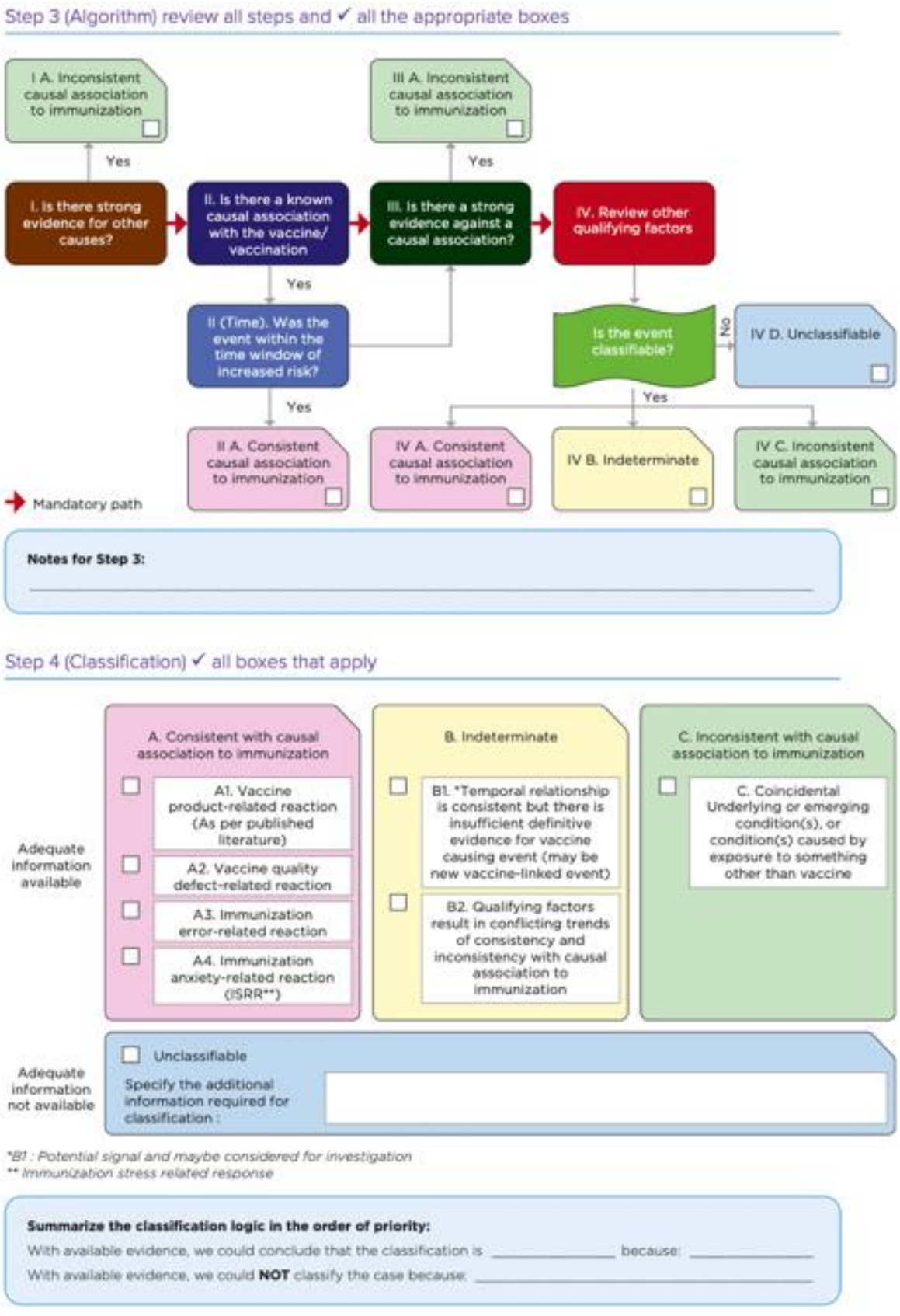
Has the _____ vaccine / vaccination caused _____ (The event for review in step 2 - valid diagnosis)

Is this case eligible for causality assessment? Yes/No; If, "Yes", proceed to step 2

Step 2 (Event Checklist) ✓ (check) all boxes that apply

	Y	N	UK	NA	Remarks
I. Is there strong evidence for other causes?					
1. In this patient, does the medical history, clinical examination and/or investigations, confirm another cause for the event?	☐	☐	☐	☐	
II. Is there a known causal association with the vaccine or vaccination?					
Vaccine product					
1. Is there evidence in published peer reviewed literature that this vaccine may cause such an event if administered correctly?	☐	☐	☐	☐	
2. Is there a biological plausibility that this vaccine could cause such an event?	☐	☐	☐	☐	
3. In this patient, did a specific test demonstrate the causal role of the vaccine ?	☐	☐	☐	☐	
Vaccine quality					
4. Could the vaccine given to this patient have a quality defect or is substandard or falsified?	☐	☐	☐	☐	
Immunization error					
5. In this patient, was there an error in prescribing or non-adherence to recommendations for use of the vaccine (e.g. use beyond the expiry date, wrong recipient etc.)?	☐	☐	☐	☐	
6. In this patient, was the vaccine (or diluent) administered in an unsterile manner?	☐	☐	☐	☐	
7. In this patient, was the vaccine's physical condition (e.g. colour, turbidity, presence of foreign substances etc.) abnormal when administered?	☐	☐	☐	☐	
8. When this patient was vaccinated, was there an error in vaccine constitution/ preparation by the vaccinator (e.g. wrong product, wrong diluent, improper mixing, improper syringe filling etc.)?	☐	☐	☐	☐	
9. In this patient, was there an error in vaccine handling (e.g. a break in the cold chain during transport, storage and/or immunization session etc.)?	☐	☐	☐	☐	
10. In this patient, was the vaccine administered incorrectly (e.g. wrong dose, site or route of administration; wrong needle size etc.)?	☐	☐	☐	☐	
Immunization anxiety (Immunization stress related responses - ISRR)					
11. In this patient, could this event be a stress response triggered by immunization (e.g. acute stress response, vasovagal reaction, hyperventilation, dissociative neurological symptom reaction etc)?	☐	☐	☐	☐	
II (time): Was the event in section II within the time window of increased risk (i.e. "Yes" response to questions from II 1 to II 11 above)					
12. In this patient, did the event occur within a plausible time window after vaccine administration?	☐	☐	☐	☐	
III. Is there strong evidence against a causal association?					
1. Is there a body of published evidence (systematic reviews, GACVS reviews, Cochrane reviews etc.) **against** a causal association between the vaccine and the event?	☐	☐	☐	☐	
IV. Other qualifying factors for classification					
1. In this patient, did such an event occur in the past after administration of a similar vaccine?	☐	☐	☐	☐	
2. In this patient, did such an event occur in the past independent of vaccination?	☐	☐	☐	☐	
3. Could the current event have occurred in this patient without vaccination (background rate)?	☐	☐	☐	☐	
4. Did this patient have an illness, pre-existing condition or risk factor that could have contributed to the event?	☐	☐	☐	☐	
5. Was this patient taking any medication prior to the vaccination?	☐	☐	☐	☐	
6. Was this patient exposed to a potential factor (other than vaccine) prior to the event (e.g. allergen, drug, herbal product etc.)?	☐	☐	☐	☐	

Note: Y: Yes; N: No; UK: Unknown; NA: Not applicable.



The TGA used nigh identical form to assess and categorise adverse events following vaccination[18]

[18] Australian Government, TGA: Vaccine Safety Investigation Group Causality Assessment Expert Panel Worksheet for AEFI Causality Assessment (link)

WHO and TGA – Covid-19 cause of death determination

The WHO publication of 2020, *World Health Organization 'Covid-19 vaccines: safety surveillance manual'*, provided guidance regarding determining cause of deaths that occurred following Covid-19 vaccination. Whilst convenient, and maybe applicable to traditional vaccines, it was impossible to predict determination of cause of death following Covid-19 vaccination in **2020 (prior to roll-out or any medical experience with Covid-19 vaccination)**. I have many concerns with this document, however it states categorically that the majority of sudden deaths are likely to be coincidental [19]: If this were not correct, it induced a strong bias against accurate recognition of vaccine related death.

> Selected events that could result in death,[16] although rare, have been identified as cause-specific AEFIs that could be seen following immunization including:
>
> - vaccine product related reaction: anaphylaxis;
> - vaccine quality defect: wild type disease following incompletely attenuated live viral vaccine as occurred with the Cutter incident with polio vaccination;[17]
> - immunization-error: sepsis following contamination of multidose vials; use of a drug (e.g. anaesthetic drug, insulin) to reconstitute vaccine; instead of the diluent supplied;
> - anxiety-related reaction: fatal head injury associated with syncope in settings where post-immunization safety is not assured;[18] and
> - coincidental reaction: likely to be the underlying cause of the majority of sudden deaths following immunization, including but not limited to, sudden infant death syndrome, sudden cardiac death, sudden unexpected death in epilepsy (SUDEP), anaphylaxis related to food, insects, environmental toxins, overwhelming sepsis.

TGA in their latest Covid-19 vaccine safety report[20] accepted a causal link of only **14 of 1,004** reviewed, and echoed the WHO guide screenshot above:

"Reports of death in people who have been vaccinated

Vaccines can lead to death in extremely rare instances. However, most deaths that occur after vaccination are not caused by the vaccine. In large populations in which a new vaccine is given, there are people with underlying diseases who may die from these diseases. When a vaccine is given in that same population, ***the link between the vaccine and death is usually coincidental*** *– not caused by the vaccine. These deaths are carefully reviewed to assess whether vaccines could be the cause and for the vast majority that is not the case."*[21]

This has been the TGA's stance since the start of the roll-out. From a medical perspective it is not safe to adopt this perspective, especially in light of the excess deaths. Again, with myocarditis it was reported to be extremely rare and usually temporary and reversible,

[19] Covid-19 vaccines: safety surveillance manual. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.
[20] TGA COVID-19 vaccine safety report - 02-11-23; 2 November 2023 (Link)
[21] TGA COVID-19 vaccine safety report - 02-11-23; 2 November 2023 (Link)

from the start. This was not a reasonable medical answer to a new mechanism of harm, with unknow ongoing consequences.

Coroner's role

The importance of autopsy following unexplained or deaths that occurred soon after vaccination cannot be underestimated. It is unprecedented to have guidance from coroners when to notify of deaths following vaccination. My concern continues that the bias of 'coincidental' death impacted on these guidance. It was an easy option to link deaths, especially in elderly, frail or those with underlying co-morbidities (i.e. most of the elderly population) to co-incidence. There was also massive pressure, notably risk of AHPRA notification for undermining the vaccine roll-out, not to 'rock the boat' or 'have anti-vaccine sentiment or concern', against accurate reporting of deaths following vaccination.

Queensland Health suggested:

'Where the doctor is comfortable the death is from a natural cause unrelated to the COVID-19 vaccine, the doctor is encouraged to issue a cause of death certificate. The death does not need to be discussed with or reported to the coroner.'[22]

And from the Queensland Coroner;

'If a person dies as a direct result of having received the COVID-19 vaccine, for example, anaphylaxis, or an adverse event following immunisation is considered to have significantly contributed to or hastened the person's death, the death is reportable under the Coroners Act 2003 as a health care related death. … If a doctor is comfortable the death is from a natural cause unrelated to the vaccine, the death does not need to be reported or discussed with the Coronial Registrar and a cause of death certificate should be issued.'[23]

In a frail elderly person, it was much more expedient for the doctor and family to label a death as natural causes. My concern is that the frail elderly were not able to withstand the severe 'reactogenicity' (fever, malaise, diarrhoea etc) that occurred following vaccination. That doctors were not warned of this risk and it was very poorly managed with consequent deaths following vaccination in the elderly (that mirrors covid outbreaks in the community).

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[22] Queensland Heath: 'Attributing deaths to COVID-19 vaccines – a guide for medical practitioners' Version 1.3 Updated 18th August 2021 https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0005/723551/covid-vaccine-certifying-death.pdf (viewed April 2024)

[23] Coroners Court of Queensland: 'When does a COVID-19 death need to be reported to the coroner?' Version 5 – October 2023 https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0006/780936/when-does-a-covid-19-death-need-to-be-reported-to-the-coroner-october-2023-v5.pdf (viewed April 2024)

Bereavement and Grief

Excess mortality automatically produces 'excess bereavement'.
Each death means the loss of a beloved person permanently leaving an unfillable hole for those left behind, and incalculable costs at the personal, family and societal level.

These costs are much higher when a death is unexpected, traumatic or premature.

The death of a loved one triggers 'acute grief'[24], which is natural and expected and is normally associated with a period of functional impairment and profound emotional pain. In most bereavements, after a period of mourning and adjustment to the death, well-being and normal function is resumed, but with permanent and less troublesome background grief.
Bereavement is well recognised to be a 'major life stressor' and associated with elevated physical and mental health risks[25], including death and suicide[26].

Prolonged Grief Disorder

If grief does not attenuate naturally over time (at least a year), the impairment and intense emotional pain of 'acute grief' can persist indefinitely. When this occurs, a recognised mental health condition is identifiable, classified as Prolonged Grief Disorder (PGD) in DSM5-TR and ICD-11[27,28].

Prolonged Grief Disorder (PGD) is a recognised psychiatric condition that is impairing; when present, it is associated with serious risks, including suicide, and requires treatment. The impairment in function can have negative consequences on the ability to work, parent, carry out responsibilities, study and so forth. The hallmark of PGD is debilitating grief that persists longer than expected social, cultural or religious norms. The grief is preoccupying and characterised by longing and yearning for the deceased. It is often associated with intense emotional pain, a sense of disbelief, emotional numbness, social disconnection, profound loneliness and identity confusion.

Risk of Prolonged Grief Disorder

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[24] Szuhany KL, Malgaroli M, Miron CD, Simon NM. Prolonged Grief Disorder: Course, Diagnosis, Assessment, and Treatment. Focus (Am Psychiatr Publ). 2021 Jun;19(2):161-172. doi: 10.1176/appi.focus.20200052. Epub 2021 Jun 17. PMID: 34690579; PMCID: PMC8475918.
[25] Shear MK, Simon N, Wall M, Zisook S, Neimeyer R, Duan N, Reynolds C, Lebowitz B, Sung S, Ghesquiere A, Gorscak B, Clayton P, Ito M, Nakajima S, Konishi T, Melhem N, Meert K, Schiff M, O'Connor MF, First M, Sareen J, Bolton J, Skritskaya N, Mancini AD, Keshaviah A. Complicated grief and related bereavement issues for DSM-5. Depress Anxiety. 2011 Feb;28(2):103-17. doi: 10.1002/da.20780. PMID: 21284063; PMCID: PMC3075805.
[26] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 9 May 2024.
[27] American Psychiatric Association (2022) Diagnostic and statistical manual of mental disorders, 5th Edition, text revision. https://doi.org/10.1176/ appi.books.9780890425787
[28] World Health Organization (2018) International Statistical Classification of Diseases and Related Health Problems, 11th Edition. Geneva: World Health Organization.

There are recognised factors that place the bereaved at increased risk of developing PGD. These include adversity in childhood, prior losses, trauma, a history of mental illness and an unexpected or premature death. Also, a very close relationship or difficult circumstance surrounding the death increase the risk of PGD[29,30] . High rates of mental health comorbidity occur with PGD, including PTSD, depression, substance abuse and suicidality[31,32,33,34].

It is noteworthy that deaths that occurred during COVID-19 pandemic restrictions have an elevated risk of Prolonged Grief Disorder. The inability to visit the sick or dying loved ones, difficulty or inability to travel to be with family, isolation or quarantine whilst bereaved, the inability to attend funerals and wakes, to follow religious or cultural practices and exposure to traumatic deaths in which PPE or ventilation of patients was used will have contributed to this elevated risk.

Pre-pandemic, PGD occurred in at least 7-10% of close bereavements[35,36,37].

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[29] Szuhany KL, Malgaroli M, Miron CD, Simon NM. Prolonged Grief Disorder: Course, Diagnosis, Assessment, and Treatment. Focus (Am Psychiatr Publ). 2021 Jun;19(2):161-172. doi: 10.1176/appi.focus.20200052. Epub 2021 Jun 17. PMID: 34690579; PMCID: PMC8475918.

[30] Shear MK, Simon N, Wall M, Zisook S, Neimeyer R, Duan N, Reynolds C, Lebowitz B, Sung S, Ghesquiere A, Gorscak B, Clayton P, Ito M, Nakajima S, Konishi T, Melhem N, Meert K, Schiff M, O'Connor MF, First M, Sareen J, Bolton J, Skritskaya N, Mancini AD, Keshaviah A. Complicated grief and related bereavement issues for DSM-5. Depress Anxiety. 2011 Feb;28(2):103-17. doi: 10.1002/da.20780. PMID: 21284063; PMCID: PMC3075805.

[31] Szuhany KL, Malgaroli M, Miron CD, Simon NM. Prolonged Grief Disorder: Course, Diagnosis, Assessment, and Treatment. Focus (Am Psychiatr Publ). 2021 Jun;19(2):161-172. doi: 10.1176/appi.focus.20200052. Epub 2021 Jun 17. PMID: 34690579; PMCID: PMC8475918

[32] Keyes KM, Pratt C, Galea S, McLaughlin KA, Koenen KC, Shear MK. The burden of loss: unexpected death of a loved one and psychiatric disorders across the life course in a national study. Am J Psychiatry. 2014 Aug;171(8):864-71. doi: 10.1176/appi.ajp.2014.13081132. PMID: 24832609; PMCID: PMC4119479

[33] Tal I, Mauro C, Reynolds CF 3rd, Shear MK, Simon N, Lebowitz B, Skritskaya N, Wang Y, Qiu X, Iglewicz A, Glorioso D, Avanzino J, Wetherell JL, Karp JF, Robinaugh D, Zisook S. Complicated grief after suicide bereavement and other causes of death. Death Stud. 2017 May-Jun;41(5):267-275. doi: 10.1080/07481187.2016.1265028. Epub 2016 Nov 28. PMID: 27892842

[34] O'Connor MM. Response to: Media depictions of possible suicide contagion among celebrities: A cause for concern and potential opportunities for prevention - The role of grief. Aust N Z J Psychiatry. 2020 Apr;54(4):438. doi: 10.1177/0004867419893430. Epub 2019 Dec 7. PMID: 31813233.

[35] Nielsen MK, Carlsen AH, Neergaard MA, Bidstrup PE, Guldin MB. Looking beyond the mean in grief trajectories: A prospective, population-based cohort study. Soc Sci Med. 2019 Jul;232:460-469. doi: 10.1016/j.socscimed.2018.10.007. Epub 2018 Oct 19. PMID: 31230666.

[36] Lundorff M, Holmgren H, Zachariae R, Farver-Vestergaard I, O'Connor M. Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis. J Affect Disord. 2017 Apr 1;212:138-149. doi: 10.1016/j.jad.2017.01.030. Epub 2017 Jan 23. PMID: 28167398.

[37] Keyes KM, Pratt C, Galea S, McLaughlin KA, Koenen KC, Shear MK. The burden of loss: unexpected death of a loved one and psychiatric disorders across the life course in a national study. Am J Psychiatry. 2014 Aug;171(8):864-71. doi: 10.1176/appi.ajp.2014.13081132. PMID: 24832609; PMCID: PMC4119479.

The rate of PGD has increased significantly, to approximately 30% of close bereavements, for those bereaved during the pandemic[38,39].

An increase in PGD was predictable due to the pandemic measures that interrupted social, cultural and religious needs for optimal care of the dying, and thereafter natural mourning requirements.

However, the excess mortality figures include increased numbers premature deaths. Concerningly, the death rate for males and females aged 25-44 increased by 8.0% and 5.1% respectively in 2022, and death rates for those aged 45-64 years were the highest in the 10 years[40]. These represent premature deaths, most likely to have been unexpected. Sudden, cardiac deaths are an example of a premature death with high risk of PGD.

The a 6.4% rise in cardiac arrest call-out was reported by Ambulance Victoria in their 2022/23 report[41], which came on the backdrop of a 5.8% increase the previous year.

Also, sudden presumed cardiac arrests in **paediatric** populations increased from 29% in the 2021/22 Ambulance Victoria annual report to over **40%** in 2022/23 annual report.

Figure below from 2021/22 Ambulance Victoria Cardiac Arrest Registry annual report:

[38] Harrop E, Medeiros Mirra R, Goss S, Longo M, Byrne A, Farnell DJJ, Seddon K, Penny A, Machin L, Sivell S, Selman LE. Prolonged grief during and beyond the pandemic: factors associated with levels of grief in a four time-point longitudinal survey of people bereaved in the first year of the COVID-19 pandemic. Front Public Health. 2023 Sep 19;11:1215881. doi: 10.3389/fpubh.2023.1215881. PMID: 37794891; PMCID: PMC10546414.

[39] von Blanckenburg P, Seifart C, Ramaswamy A, Berthold D, Volberg C. Prolonged Grief in Times of Lockdown During the COVID-19 Pandemic. Omega (Westport). 2023 Jun 8:302228231182738. doi: 10.1177/00302228231182738. Epub ahead of print. PMID: 37291862; PMCID: PMC10261962.

[40] Australian Bureau of Statistics webpage: Statistics on the number of deaths, by sex, selected age groups, and cause of death classified to the International Classification of Diseases (ICD). Released 27/09/2023: (Link)

[41]Ambulance Victoria cardiac Arrest Registry https://www.ambulance.vic.gov.au/wp-content/uploads/2024/03/Ambulance%20Victoria%20VACAR%20Annual%20Report%202023.pdf

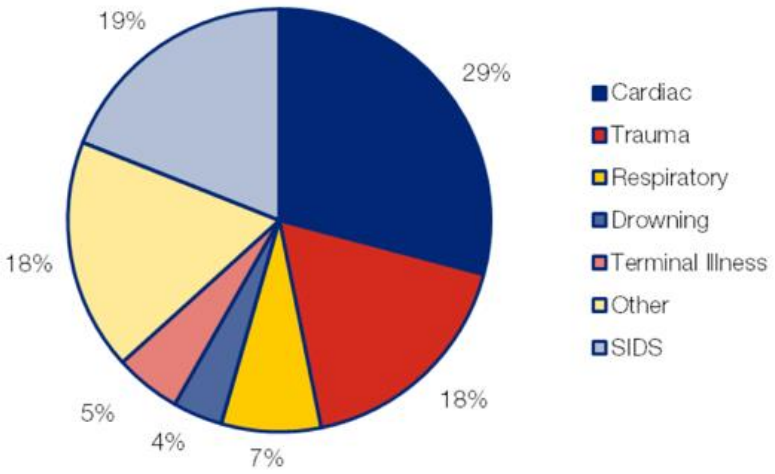
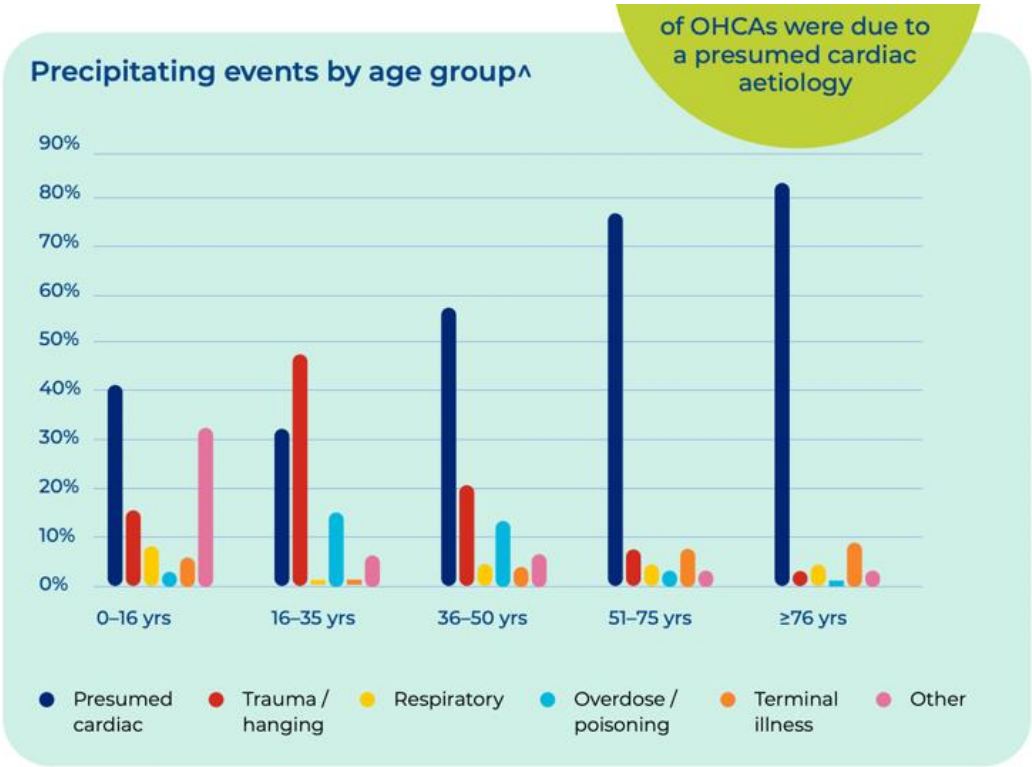


Figure 7: Paediatric precipitating events for EMS-attended events.

Figure below from 2022/23 Ambulance Victoria cardiac Arrest Registry annual report.



Despite this tragic increase in 'presumed cardiac' paediatric cardiac arrests, the majority of whom would have died, there is no mention in the report of this fact, nor the actual number of paediatric cardiac arrests. Such deaths - the sudden and unexpected death of a child - has high risk of PGD in family members, especially the parents.

Management of Prolonged Grief Disorder

The treatment of choice is condition-specific psychotherapy, delivered by a therapist trained in Prolonged Grief Disorder Therapy[42,43,44,45].

Societal Costs of Prolonged Grief Disorder

The serious nature of PGD equates to individual and societal costs. The number of bereaved following each death varies. Those closely bereaved are at risk of PGD, especially following spousal or child death. The number of closely bereaved (that is, those with a close, important and loving relationship) is roughly five or six for each death. The number of bereaved negatively impacted by a sudden or premature death can be substantially higher. 135 people are known to be affected by death by suicide[46].

The expected number of cases of PGD can be estimated in broad terms by the following equation:

[Number of deaths] x [5] (the closely bereaved) x 10%.
The Australian Bureau of Statistics deaths and mortality data[47,48] can be used to estimate expected cases of Prolonged Grief Disorder.

Expected new cases of PGD caused by deaths in 2022.

There were 190,939 registered deaths in Australia in 2022
190,939 x 5 = 954,695
10% of 954,695 (that is, the expected number of cases of PGD following 2022 deaths) = 95,467 new cases of PGD arising from bereavements in 2022 (substantially more had I used the ~30% pandemic era rates of PGD in the calculation).

Expected new cases of PGD Caused by Excess deaths in 2022 compared to 2021.

There were 19,470 more deaths in Australia in 2022 compared to 2021.
5 x 19,470 = 97350 closely bereaved excess bereavements in 2022.

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[42] Shear MK, Wang Y, Skritskaya N, Duan N, Mauro C, Ghesquiere A. Treatment of complicated grief in elderly persons: a randomized clinical trial. JAMA Psychiatry. 2014 Nov;71(11):1287-95. doi: 10.1001/jamapsychiatry.2014.1242. PMID: 25250737; PMCID: PMC5705174.

[43] Shear K, Frank E, Houck PR, Reynolds CF 3rd. Treatment of complicated grief: a randomized controlled trial. JAMA. 2005 Jun 1;293(21):2601-8. doi: 10.1001/jama.293.21.2601. PMID: 15928281; PMCID: PMC5953417.

[44] Shear MK, Reynolds CF 3rd, Simon NM, Zisook S, Wang Y, Mauro C, Duan N, Lebowitz B, Skritskaya N. Optimizing Treatment of Complicated Grief: A Randomized Clinical Trial. JAMA Psychiatry. 2016 Jul 1;73(7):685-94. doi: 10.1001/jamapsychiatry.2016.0892. PMID: 27276373; PMCID: PMC5735848

[45] American Psychiatric Association: Prolonged Grief Disorder webpage: (Link) (Viewed May 2024).

[46] Cerel J, Brown MM, Maple M, Singleton M, van de Venne J, Moore M, Flaherty C. How Many People Are Exposed to Suicide? Not Six. Suicide Life Threat Behav. 2019 Apr;49(2):529-534. doi: 10.1111/sltb.12450. Epub 2018 Mar 7. PMID: 29512876.

[47] Australian Bureau of Statistics webpage: Statistics about deaths and mortality rates for Australia, states and territories, and sub-state regions. Released 27/09/2023: (Link) (Viewed May 2024)

[48] Australian Bureau of Statistics webpage: Statistics on the number of deaths, by sex, selected age groups, and cause of death classified to the International Classification of Diseases (ICD). Released 27/09/2023: (Link)

10% x 97350 = 9,735 expected excess cases of PGD due to excess deaths in 2022

Bereavement and Prolonged Grief Disorder have recognisable and quantifiable human and societal negative consequences. The Australian excess mortality sadly translates into predictable harms to individuals and society. These harms include mental health, workforce, parenting and economic harms. There are predictable increased physical health and mental health service provision requirements to manage these harms. Grief caused by excess deaths burden the already overloaded mental health services and contribute to additional harm and suffering of the Australian population.

The management of Prolonged Grief Disorder is a specialised area of mental health service delivery, which is not widely available in Australia. It is essential that the high human cost of bereavement and consequent grief, together with the need for specialist clinical services to care for those bereaved, are recognised and prioritised, especially in the context of the concerning numbers of excess deaths in Australia.

Mental Health Harms

Good mental health –overall well-being, safety, predictability and security - is integral to good health.

Mental illness, mental distress and life stressors cause mental anguish and contribute to poor physical health through complex stress mediated neuro-psycho-immuno-endocrino-physiological pathways. [49]

Trauma: Mental health is dependent on our sense of safety, security and predictability. That we are free from threat of harm, that we can trust those in whom we have placed our trust, both those we are close to also those who hold power over us, and that we foresee a future that is safe and reasonably predictable. We make assumptions in which we place much trust about the safety, security and predictability of the future.

Our ability to regulate our emotions is dependent on nested sequences of assumptions. That the sun will rise tomorrow, that you can trust your doctor, that your rights will be protected by government, that you will be told the truth by media. Trauma arises when these largely unconscious assumptions are shattered leading to disruption and chaos; emotional dysregulation with loss of sense of safety, security and predictability. It contributes to mental illness and poor physical health due to the stress response associated with such a shattering of fundamental sense of well-being. The ability of an

[49] Tsigos C, Kyrou I, Kassi E, et al. Stress: Endocrine Physiology and Pathophysiology. [Updated 2020 Oct 17]. In: Feingold KR, Anawalt B, Blackman MR, et al., editors. Endotext [Internet]. South Dartmouth (MA): MDText.com, Inc.; 2000- (Link)

individual to tolerate shattered assumptions depends on individual resilience, resources available and social status. Those with few resources or greater disadvantage will be harmed disproportionately and compound disadvantage.

Poor Mental Health - morbidity-mortality

Preventable morbidity and mortality associated with high stress, poor mental health and mental illness includes:

1) Suicide deaths
2) Stress mediated negative physical health consequences
3) Mental illness related avoidance / access-failure of health services and treatments

Mental distress and likely mental disorder increased substantially during the pandemic.

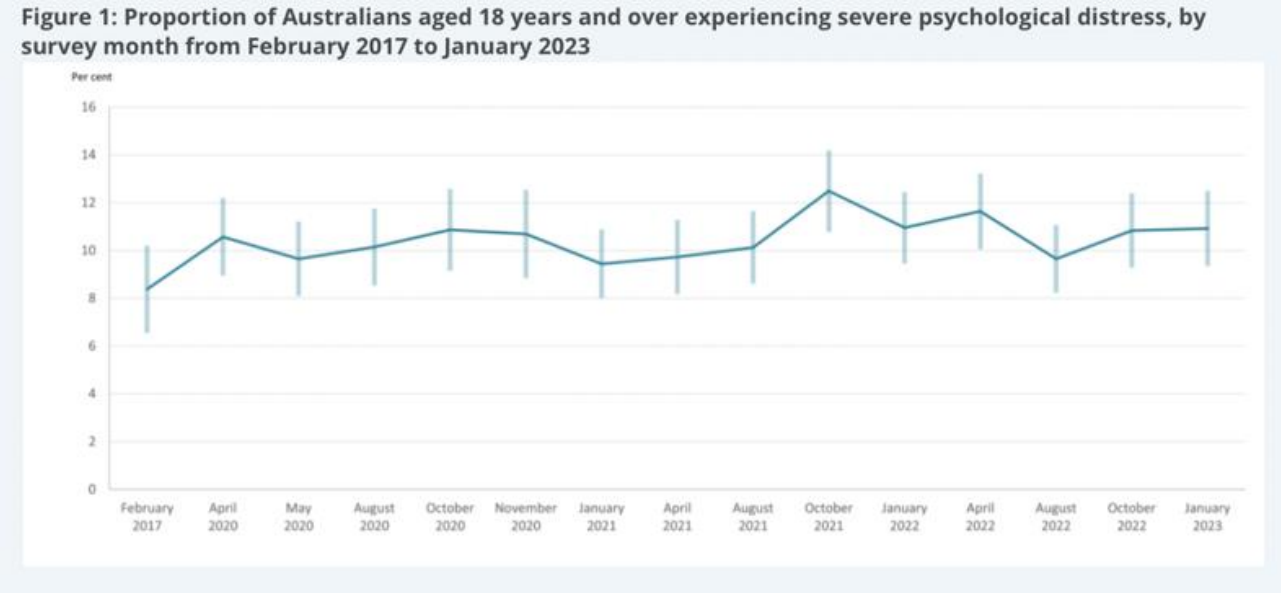
Prevalence of likely Mental Disorder increased in pandemic

The National Study of Mental Health and Wellbeing, published by Australian Bureau of Statistics in October 2023[50], covering 2020-2022, indicated 21.5% of Australians met the diagnostic criteria for having a mental disorder within 12-months of completing the survey; and was as high as 38.8% of 16–24 year-olds.

The Australian Institute for Health and Welfare (AIHW) reported[51] a range of indicators of worsening mental health: 1) increased demand for mental health services, 2) increased crisis and support organisation usage, 3) psychological distress, 4) loneliness, 5) suicide and 6) ambulance attendances for suicidal ideation). This report references work from Centre for Social Research and Methods[52] at the Australian National University by Professor Biddle and colleagues (please see AIHW reference list for details). Biddle et al report measures of severe psychological distress were significantly higher during the pandemic. Rates of severe psychological distress (i.e. those with 'probable serious mental illness') peaked between August and October 2021 when an increase from 10.1% to 12.5% was observed. A change of 1% point represents approximately 200,000 people.

The graphic, ('Figure 1 ' below) from this AIHW report, '*The use of mental health services, psychological distress, loneliness, suicide, ambulance attendances and COVID-19*',[53] shows this peak of severe psychological distress in October 2021. This correlates with the announcement of many vaccine mandates by the State governments and private employers, and need for 'vaccine passports' for access to many normal societal activities.

[50] Australian Bureau of Statistics (2020-2022), National Study of Mental Health and Wellbeing, ABS Website, accessed 9 May 2024.
[51] Suicide & self-harm monitoring: The use of mental health services, psychological distress, loneliness, suicide, ambulance attendances and COVID-19 - AIHW website: (Link)
[52] ANU Centre for Social Research and Methods website (Link)
[53] https://www.aihw.gov.au/suicide-self-harm-monitoring/data/covid-19



Excess deaths – Mental health harm Women

'Combined, the greatest impact of the pandemic on mental health appears to have been for women, young Australians, Aboriginal and Torres Strait Islander Australians, those who live in Victoria, and those who live in low-income households."[54]

Completed suicide associated with psychosocial risk and mental illness

The ABS data shows that completed suicides were associated with significant risk of reported psychosocial risk factor/s and reported mental and behavioural disorder/s [55] (see table below).

	Total suicide	Psychosocial risk noted	%with psychosocial risk	Mental or Behavioural disorder noted	%Mental or Behavioural disorder noted
2021	3166	2058	65.0%	1990	62.9%
2022	3249	2220	68.3%	2041	62.8%

Pandemic response exacerbated known psychosocial risk of suicide:

Many factors associated with the pandemic response exacerbated known psychosocial risk factors for suicide, including social isolation, job loss, business and career loss, unemployment, financial difficulty, problems accessing health and mental health services, and uncertainty. Public health pandemic measures (enforced by regulatory authorities, the police and military with threats of criminal sanctions[56], civil penalties, draconian fines and reputational harm) were traumatising for many Australians. They

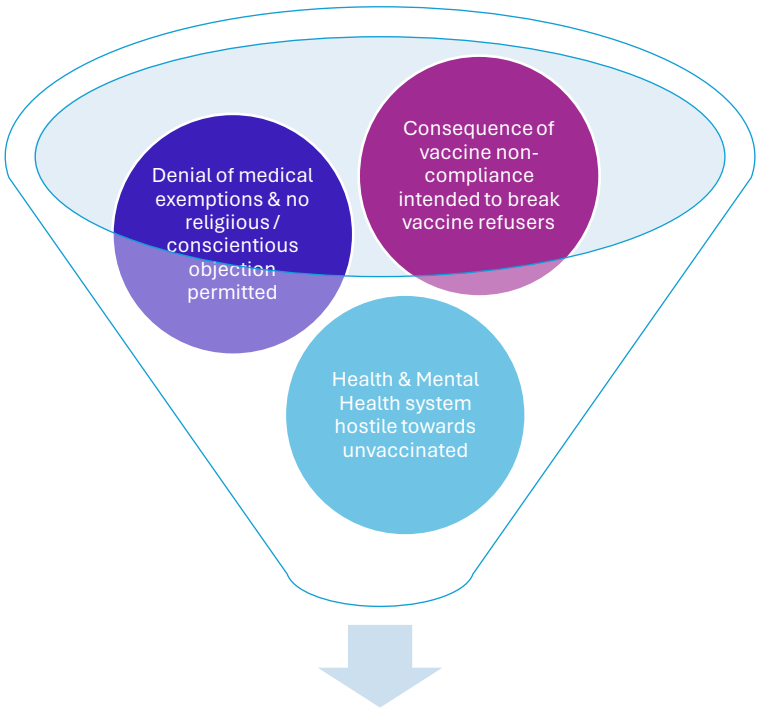
[54] 'Mental health and wellbeing during the COVID-19 period in Australia' Professor Nicholas Biddle, Professor Matthew Gray, and Patrick Rehill, 07 July 2022, ANU Centre for Social Research and Methods ANU Centre for Social Research and Methods

[55] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 9 May 2024.
[56] Australian Government Department of Health and Aged Care: Covid-19 Vaccine exemption (Link)

were contributory to increased exposure to recognised psychosocial stressors causal in the deterioration in mental health of Australians.

Mental Health Harms associated with vaccine mandates

It is beyond the scope of this submission to delve into the mental health harms of vaccine mandates. However, the severe mental health harm intentionally caused by the vaccine mandates by Federal Government, State Government, Local Governments and in the private sector had consequent risk of suicide, suicidality, mental illness, substance abuse and compromised physical health through chronic stress pathways – all of which will contribute to morbidity and mortality. Much is to be learned about the mental health harms caused by vaccine mandates as there has been little research and minimal will to consider them by mainstream academia. Consequently, support and care for those suffering is ad hoc and inadequate.



Harms of discrimination and stigmatization of unvaccinated

Discrimination contributes to poor health and mental health outcomes. Poor mental health is associated with risk of suicide. The degree of vitriol and harassment of the unvaccinated likely contributed to poor health outcomes and death of unvaccinated. There were many media references to the unvaccinated being unworthy of treatment for SARS-CoV-2. The hostility by the health system and broader community towards the unvaccinated was such that many notified next of kin that they would rather die than be admitted to hospital with SARS-CoV-2. There was fear that the unvaccinated were

provided substandard or even deliberately negligent treatment whilst in hospital to increase suffering and accordingly increase the recorded 'unvaccinated death' statistics.

It is noteworthy that review of NSW Covid surveillance reports[57] reveal in many weeks (for instance 2022 weeks, 33, 34, 39 and 51) the number of unvaccinated admitted to hospital or ICU with SARS-CoV-2 is extremely low, yet there are a number of unvaccinated deaths – presumably those dying outside of hospital without treatment.

Homicide: Investigation is required to determine whether mental illness (onset or relapse) precipitated by career/job loss stress caused by vaccine mandates contributed to homicides or 'murder-suicides', and what role 'mental illness' as a specific reason for denial of exemption from vaccination might have contributed to any homicides or 'murder-suicides'.

Two of the culprits in a Queensland multiple homicide event were well regarded teachers prior to their being mandated out of work. Their with descent into apparent criminality was seemingly incongruous with their prior reputations. Had trauma informed mental health outreach, free of discrimination and coercive medical practice been available maybe this tragedy would not have occurred.

The mandate related mental health harms are best understood through the lens of torture.

Torture: Vaccine mandates meet internationally recognised criteria for torture

Vaccine mandates were deployed widely in Australia in 2021 to compel Covid-19 vaccination. A vaccine mandate is a sophisticated, authoritarian lever, see outline quoted below:[58]

"Attwell and Navin's simplified framework used some of these factors in their 5S taxonomy: scope (which vaccines); sanctions and their severity (what happens to you if you don't vaccinate and how serious is it?); selectivity (enforcement and exemptions); and salience, which is the combined effect of the other four factors and determines whether the mandate will push an individual to vaccinate."

The mental health (and other) harms of 'coerced Covid-19 vaccination' and 'Covid-19 vaccine refusal' are best approached through the framework of torture related harm; the mental health consequence of this is ongoing, significant and unrecognised.

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[57] https://www.health.nsw.gov.au/Infectious/covid-19/Pages/weekly-reports-archive.aspx#2022 (viewed April 2024)

[58] Attwell K, Rizzi M, Paul KT. Consolidating a research agenda for vaccine mandates. Vaccine. 2022 Dec 5;40(51):7353-7359. doi: 10.1016/j.vaccine.2022.11.008. Epub 2022 Nov 14. PMID: 36396514; PMCID: PMC9662755. (Link)

Torture, defined as a treatment that is cruel, inhuman, degrading or humiliating, is banned in Australia under international humanitarian law and international human rights law with Australia being signatories to treaties [59].

'Under international humanitarian law (IHL) and international human rights law (IHRL), the definition of torture comprises three main aspects:
1. Any act by which severe pain or suffering, whether physical or mental, is inflicted on a person;
2. The act must be intentionally inflicted;
*3. The act must be instrumental for such purposes as: (a) obtaining from the individual or a third person information or a confession, or (b) punishing him/her for an act he/she or a third person has committed or is suspected of having committed, or (c) **intimidating** him/her or a third person, or (d) **coercing** him/her or a third person, or (e) for any reason based on discrimination of any kind. What distinguishes torture from other forms of ill-treatment, which include other cruel, inhuman or degrading treatment and outrages upon personal dignity, is the third – **purposive** – aspect.'*[60] [Emphasis mine].

Vaccine mandates met these three described aspects of torture. The strategy 1) caused severe suffering; 2) was intentional, 3) the intention was for the purpose of compelling (breaking) committed vaccine-refusers to undergo Covid-19 vaccination. The study that proves this worked (i.e. 'broke vaccine refusers into 'coerced acceptors) is published[61]. Those who still declined vaccination also suffered torture, as the punishment was designed to harm them the most.

Strategies for successful vaccine mandates were researched prior to the Covid-19 pandemic[62]. Policy makers understood the critical and necessary components of effective vaccine mandates, which were deployed widely across Australia for access to employment and vaccine passport to access much of civil society ('password'[63]) in 2021.

[59] Australian Government, Attorney General Dept: Prohibition on torture and cruel, inhuman or degrading treatment or punishment (Link)
[60] ICRC: Prohibition and punishment of torture and other forms of ill-treatment (Link)
[61] Roberts L, Deml MJ, Attwell K. 'COVID Is Coming, and I'm Bloody Scared': How Adults with Co-Morbidities' Threat Perceptions of COVID-19 Shape Their Vaccination Decisions. Int J Environ Res Public Health. 2023 Feb 8;20(4):2953. doi: 10.3390/ijerph20042953. PMID: 36833657; PMCID: PMC9957419. (link)
[62] ATTWELL, K. and C. NAVIN, M. (2019), Childhood Vaccination Mandates: Scope, Sanctions, Severity, Selectivity, and Salience. The Milbank Quarterly, 97: 978-1014. https://doi.org/10.1111/1468-0009.12417
[63] Attwell, K., Harper, T., Rizzi, M. et al. Inaction, under-reaction action and incapacity: communication breakdown in Italy's vaccination governance. Policy Sci 54, 457–475 (2021). https://doi.org/10.1007/s11077-021-09427-1

"We know that mandates will change people's behaviour, but they won't change the behaviour of your absolute fixated, rusted on refuser," she said. "For people who are hesitant, but not highly hesitant, they do change behaviour."[64]

The known primary target of the 'consequences', or harm (torture) were the vaccine refusers. It was known, that to be successful, i.e. to break those committed to not receiving the Covid-19 vaccine, the 'consequences' of the mandates needed to be 1) sufficiently extreme; 2) enforced by law; and 3) with nigh impossible chance of obtaining an exemption[65]. The secondary target population of mandates were those reluctant or hesitant to undergo Covid-19 vaccination, but the harmful impact on this population, whilst unconscionable, was likely somewhat lesser spectrum of mental anguish.

'When governments compel recalcitrant individuals to vaccinate and impose consequences on holdouts, they are beholden to legitimise this decision. An optimal restrictive mandatory policy should feel coercive to the smallest possible group of people; this is only achievable by continuously confronting and delegitimising anti-vaccination sentiment.'[66]

The tone of contempt and disrespect for fellow Australian's with differing views, or medical experience, is chilling. Those who were 'vaccine hesitant' to receive the Covid-19 vaccine have been described more accurately as 'gene-therapy hesitant'. A highly legitimate opinion to hold. Those that imposed the vaccine mandates may have felt comfortable inflicting harms sufficient to break those with opposing views because the unvaccinated were viewed with this high level of contempt and demonised by the media. There were no advocates for the unvaccinated; the torture was justified by Public Health Official, academics and the media. Access to medical and health care was discriminatory too – all of which will have led to 'access to health care' barriers for the unvaccinated

An academic article from WA, where mandates affected 75% of the workforce unashamedly extols coerced medical procedures with mandates described as '*an external force'* to increase rates of Covid-19 vaccination.[67] The concept of mandatory vaccination

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[64] ABC – Triple J Hack; Jo Lauder and Tamsin Rose: 23 Sep 2021, '*Do mandatory vaccinations actually get people jabbed?'* (Link)

[65] Attwell K, Rizzi M, McKenzie L, Carlson SJ, Roberts L, Tomkinson S, Blyth CC. COVID-19 vaccine Mandates: An Australian attitudinal study. Vaccine. 2022 Dec 5;40(51):7360-7369. doi: 10.1016/j.vaccine.2021.11.056. Epub 2021 Nov 30. PMID: 34872796; PMCID: PMC8629747. (Link)

[66] Attwell, K., Harper, T., Rizzi, M. et al. Inaction, under-reaction action and incapacity: communication breakdown in Italy's vaccination governance. Policy Sci 54, 457–475 (2021). https://doi.org/10.1007/s11077-021-09427-1 (Accepted
29 May 2021)

[67] Roberts L, Deml MJ, Attwell K. 'COVID Is Coming, and I'm Bloody Scared': How Adults with Co-Morbidities' Threat Perceptions of COVID-19 Shape Their Vaccination Decisions. Int J Environ Res Public Health. 2023 Feb 8;20(4):2953. doi: 10.3390/ijerph20042953. PMID: 36833657; PMCID: PMC9957419. (link)

as a legitimate health policy continues to be promoted by pro-vaccine activists. Vaccination behaviour is described as a '*problem*' with mandatory vaccination described chilling as '*the solution*'. The diagram below shows how authoritarian medical practice, advanced by unelected policy makers without medical training advising on complex medical treatments outside of necessary medical 'scope of practice', is set to continue to undermine bodily autonomy, informed consent and the doctor-patient relationship in Australia[68]:

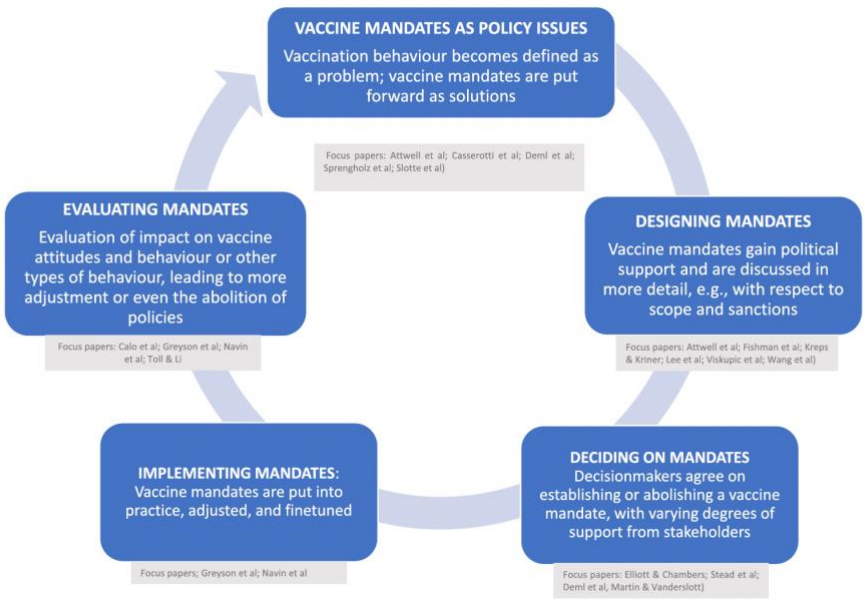


Fig. 1. Vaccine Mandate Studies on the Policy Cycle.

The pro-vaccine academics divide the population into five categories of preparedness to accept Covid-19 vaccination [69]; acceptors, reluctant acceptors, coerced/hostile acceptors, wait-a-while and refusers. The authors found;

"It was striking that mandates operated as an external force on half of the vaccine hesitant participants and that these individuals chose to get vaccinated despite not altering their perceptions about COVID-19 or the vaccines. Rather, the costs of not vaccinating were too high for them to bear."

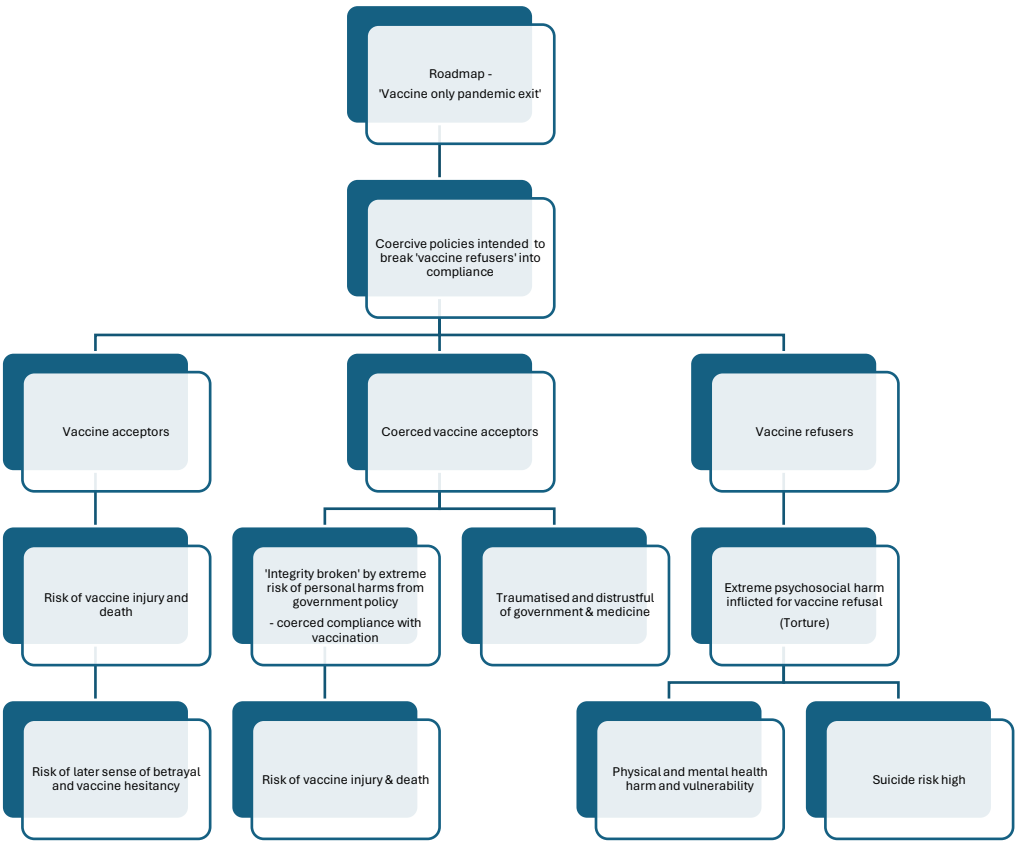
and,

"For example, vaccine mandates as a policy lever introduced social threats for vaccine hesitant participants, as these threats touched upon their ability to travel to see loved ones and on participants' livelihoods."

[68] Attwell K, Rizzi M, Paul KT. Consolidating a research agenda for vaccine mandates. Vaccine. 2022 Dec 5;40(51):7353-7359. doi: 10.1016/j.vaccine.2022.11.008. Epub 2022 Nov 14. PMID: 36396514; PMCID: PMC9662755. (Link)

[69] Roberts L, Deml MJ, Attwell K. 'COVID Is Coming, and I'm Bloody Scared': How Adults with Co-Morbidities' Threat Perceptions of COVID-19 Shape Their Vaccination Decisions. Int J Environ Res Public Health. 2023 Feb 8;20(4):2953. doi: 10.3390/ijerph20042953. PMID: 36833657; PMCID: PMC9957419.

Those studying the vaccine mandates, as quoted above, prove 'torture' occurred. 'Cost too high to bear' is testimony that severe harm was caused. This to those who had 'to bear the cost', noting others were broken by the cost. It is beyond the scope of this submission to detail the torture or costs, but they include mental anguish, extreme peer/family pressure, extreme financial hardships, loss of career, loss or reputation, widespread vilification and abuse, profound trauma, loss and discrimination. The health and mental health implications of this torture are self-evident.



Highly restrictive exemption criteria deliberately made it virtually impossible to obtain an exemption from vaccination, whether for medical reasons, religious or conscientious. This was widely disseminated in the media. For instance, an article entitled '*Digital COVID-19 vaccine exemptions available next month, but 'almost no one' eligible*' published in The Sydney Morning Herald in September 2021[70]

The beatings will continue until morale improves

Discrimination and deliberate humiliation of the unvaccinated continues unashamedly. For instance, the recent South Australia Health SA Health - Health Care Worker COVID-19 Vaccination Refusal Form[71]

[70] 'Digital COVID-19 vaccine exemptions available next month, but 'almost no one' eligible'; Sydney Morning Herald; Rachael Dexter and Aisha Dow; September 26, 2021 (Link)

[71] https://www.sahealth.sa.gov.au/wps/wcm/connect/64390efb-6f59-4c30-89c9-24dacfa36c11/DRAFT+CDCB_HCW-COVID-19-VaccinationRefusalForm1+-+11+April+2024.pdf?MOD=AJPERES (viewed April 2024)

"SA Health is looking to replace mandatory vaccination for staff with a new requirement for staff refusing COVID-19 vaccination to actively sign the Health Care Worker – COVID-19 Refusal Form acknowledging the benefit of vaccination"[72]

Suicide

Recent Australian suicide statistic are concerning. NSW suicide register [73]

Suicides recorded in Victoria in 2024, provided by Coroners Court Victoria [74], continue to show a highly concerning trend of rising suicides in early 2024.

Monthly data update

1. Year to date frequency by sex

Table 1 shows the frequency of Victorian suicides by deceased sex as at the end of April each year, for the years 2020-2024.

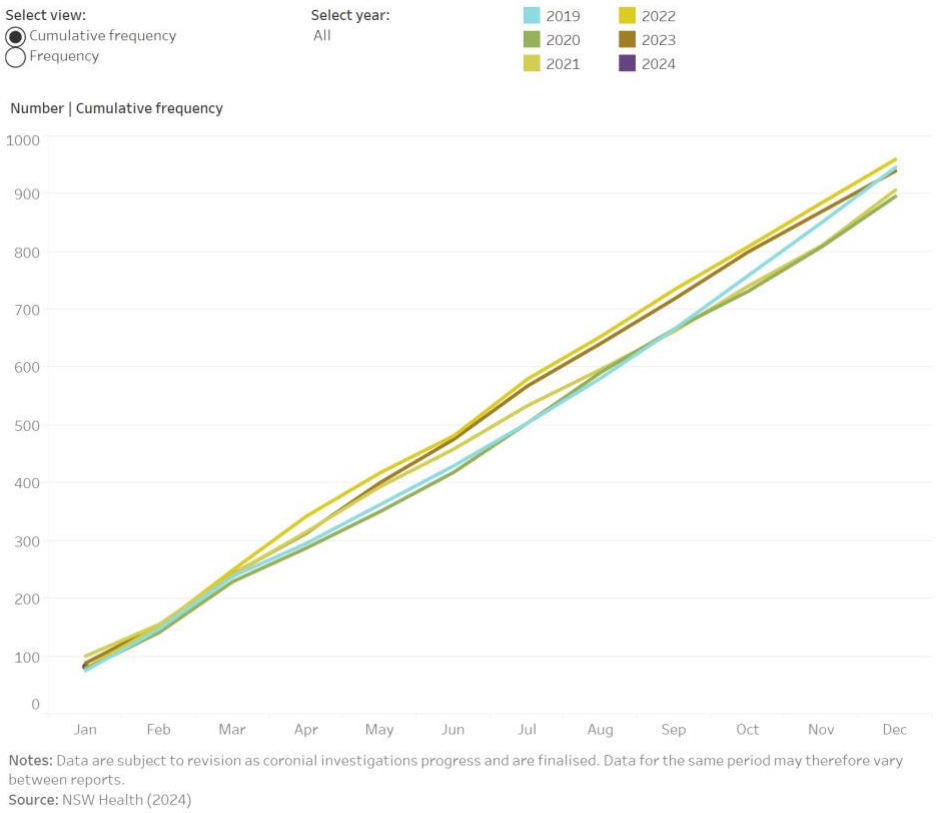
Table 1: Year to date (month end April) suicide frequency by sex, Victoria 2020-2024.

Sex	2020	2021	2022	2023	2024
Male	189	172	157	190	201
Female	50	54	73	68	77
Total	**239**	**226**	**230**	**258**	**278**

[72] https://www.sahealth.sa.gov.au/wps/wcm/connect/3f40d21d-1f62-4d70-af43-20d439f8e9c6/Fact+sheet+for+staff+-+Policy+consultation+-+Addressing+vaccine+preventable+disease+-+11+April+2024.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-3f40d21d-1f62-4d70-af43-20d439f8e9c6-oXfIdjK (viewed April 2024

[73] NSW Health: NSW Suicide Monitoring System; Report 42. Data to February 2024. (Link)

[74] Coroners Court of Victoria Monthly Suicide Data Report; April 2024 update (Link)



From AIHW website Data from suicide registers: (Link) (viewed May 2024)

Victoria cumulative deaths by suicide:

January 2016 to 2024, note clearly separating out from 2022, 2023 and continues (purple) 2024.

Whilst proportionally small, and seemingly with no great increase nationally in suicide rates (although Victoria and NSW have concerning data), suicide is a preventable cause of mortality.
In 2022, sadly, 3249 Australians died by suicide which is the leading cause of premature death. It is too early to determine with accuracy the full impact of the pandemic on the rate of suicide. It is possible factors associated with a crisis and support measures may suppress suicide in the short term. There is concern that the risk of suicide will be elevated post-crisis, due to ongoing negative mental health impacts of the Covid-19 pandemic response measures.

- The mental health harms of the pandemic remain for many with ongoing risk of suicide;
- That those who died by suicide due to Public Health policies are under recognized;

It is critical that Public Health policy associate with known risks of suicide (such as mandated job loss or interruption of normal bereavement requirements) designed to cause mental anguish are never deployed on Australian citizens again.

COVID-19 pandemic as risk for completed suicide

The ABS has provided data regarding the COVID pandemic as a risk to completed suicide outlined below:.

- COVID pandemic recorded as a risk factor in a suicide was reported in 129 (4.0%) of 3,196 suicides in Australia in 2020 (ABS)[75], including 29 (3.7%) of 782 suicides in Queensland.
- COVID pandemic recorded as a risk factor in a suicide was reported in 81 (2.6%) of 3144 suicides in Australia in 2021 (ABS)[76], including 21 (2.7%) of 786 suicides in Queensland.
- COVID pandemic recorded as a risk factor in a suicide was reported in 84 (2.6%) of 3,249 suicides in Australia in 2022 (ABS) including 16 (2.1%) of 773 suicides in Queensland.

Screenshot of the ABS data below:

[75] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 9 May 2024.
[76] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 9 May 2024.

COVID-19 as a risk factor for suicide, number of deaths and percent of total suicides, state or territory of usual residence, 2020-2022 (a)(b)(c)(d)(e)(f)(g)(h)

Download

	2020		2021		2022	
	No.	%(d)	No.	%(d)	No.	%(d)
NSW	31	3.4	26	2.9	20	2.2
Vic.	51	7.4	20	3.0	26	3.4
Qld	29	3.7	21	2.7	16	2.1
SA	1	np	1	np	5	2.1
WA	13	3.4	7	1.8	7	1.9
Tas.	1	np	1	np	4	np
NT	2	np	1	np	3	np
ACT	0	—	3	np	3	np
Australia	129	4.0	81	2.6	84	2.6

np not available for publication
— nil or rounded to zero (including null cells)

a. Small values are randomly assigned to protect the confidentiality of individuals. Zero values have not been affected. Some totals will not equal the sum of their components.
b. Intentional self-harm includes ICD-10 codes X60-X84 and Y87.0.
c. Number of suicides with COVID-19 identified as a risk factor includes suicides with an associated cause of F41.8, Z29.0, Z29.9
d. Proportion of total number of jurisdictional suicides.
e. Interpret intentional self-harm data with caution (refer to the methodology for more detail).
f. Causes of death data for recent years is preliminary and subject to a revisions process.
g. Data is by date of registration. Data may not match that published previously by reference year.
h. Refer to the methodology for more information.

Official inconsistency in pandemic risk factors in completed suicide

Whilst exact numbers get corrected with time (for instance as Coroner's reports become available) there is marked inconsistency between the information provide by ABS and other research/data analysis. The Australian Institute for Suicide Research and Prevention (AISRAP), World Health Organization Collaborating Centre for Research and Training in Suicide Prevention and School of Applied Psychology at Griffith University, published a report[77], '*Suicide in Queensland: Annual Report 2022'* in 2023. This report determined the pandemic was a risk factor in 86 (5.6%) of 1539 suicides in Queensland in the two years, 2020 – 2021.

Below is screenshot from the '*Suicide in Queensland: Annual Report 2021'* – possibly with 9 additional suicides **excluded** from the calculation of '8.3% suicides with pandemic mentioned as a risk'.

[77] S Leske, G Adam, A Catakovic, B Weir and K Kölves, **Suicide in Queensland: Annual Report 2022**, Australian Institute for Suicide Research and Prevention, World Health Organization Collaborating Centre for Research and Training in Suicide Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia, 2022. p30 (link)

COVID-19

There has been some uncertainty and speculation about the impact of COVID-19 on suicide mortality. However, there is limited evidence that infectious disease-related public health emergencies increase suicides.[78] A study of preliminary, early-stage, real-time suicide mortality data in 21 countries found increased suicides in only three jurisdictions (Vienna, Austria; Puerto Rico; and Japan) during the first 9 months of the COVID-19 pandemic.[79]

Currently, there is no evidence that COVID-19 has affected the overall number of suicides in Queensland. However, the COVID-19 pandemic was a possible contributing factor in some suicides. Police officers mentioned COVID-19 in police reports from 1 March 2020 to 31 December 2020. There were 9 instances where the impact of COVID-19 on the suspected suicide was unclear. In these cases, police reports mentioned COVID-19 in a way that did not clearly illustrate a link between the suspected suicide and the COVID-19 pandemic.

Thus, COVID-19 appeared to affect 53 (or 8.3%) of the 639 suspected suicides in Queensland from 1 March 2020 to 31 December 2020. Reported impacts, which often overlapped and aligned broadly with the known risk factors for suicide, included:

- 22 suspected suicides where people had their employment or business affected by COVID-19. Police officers mentioned COVID-19 in the context of people having their hours of employment cut, jobs falling through or losing their job
- 15 suspected suicides where COVID-19 reportedly affected mood, coping, stress or anxiety. Police officers mentioned COVID-19 in the context of people suffering an increase in mental health conditions or more severe impacts of mental health conditions due to COVID-19, such as job loss or isolation
- 9 suspected suicides where police reported social isolation due to COVID-19 as a factor. Impacts due to COVID-19 linked to social isolation included loneliness and the inability to see family
- 7 suspected suicides where COVID-19 reportedly impacted finances, involving job loss or lost income
- 5 suspected suicides where changes in access to healthcare support and healthcare items due to COVID-19 reportedly affected the suicide. These instances included situations where people could not attend medical appointments or obtain medications due to COVID-19
- less than 5 suspected suicides involved either relationship breakdown or activity interruption from COVID-19.

Below is screenshot from the '*Suicide in Queensland: Annual Report 2022*' - possibly with 20 additional suicides **excluded** from the calculation of 5.6% suicides with pandemic mentioned as a risk.

The analysis does not provide evidence that there has been an increase in suspected suicide rates since the COVID-19 pandemic restrictions have been implemented. Some changes observed may have also occurred without the pandemic. However, this analysis does not consider time trends in age-specific suspected suicide rates in the years before the COVID-19 pandemic.

Further analysis of qualitative data from the iQSR by QSR staff shows that the COVID-19 pandemic contributed to some suicides. Police officers mentioned COVID-19 in 106 of 1,539 (6.9%) police reports of suspected suicides from 29 January 2020 to 31 December 2021. There were 20 instances where the police mentioned COVID-19, but the effect or context of the COVID-19 discussion on the suspected suicide was unclear or unrelated. Thus, the COVID-19 pandemic appeared to impact 86 of the 1,539 suspected suicides (5.6%) in Queensland from 29 January 2020 to 31 December 2021. Reported effects, which often overlapped and aligned broadly with known risk factors for suicide, included:

- **Employment**: there were 35 suspected suicides where people had their employment or business affected by the COVID-19 pandemic or related public health measures. These individuals were impacted in this context due to loss of hours of employment, jobs falling through or losing their job completely.
- **Psychological**: information from 24 suspected suicides mentioned that the COVID-19 pandemic and related public health measures reportedly affected a person's mood, coping, stress or anxiety. This included new mental health conditions due to COVID-19 restrictions, or more severe effects of pre-existing mental health conditions due to the COVID-19 pandemic.
- **Isolation**: 23 suspected suicides reported social isolation arising from the COVID-19 pandemic and related public health measures as a factor. Effects linked to social isolation included loneliness and limited socialisation due to the COVID-19 pandemic and related public health measures.
- **Healthcare**: there were nine suspected suicides where limited or changed access to healthcare support and healthcare items due to the COVID-19 pandemic and related public health measures reportedly affected the individual. This included where people could not attend medical appointments or obtain medications due to COVID-19 restrictions.
- **Finances**: there were under five suspected suicides where the COVID-19 pandemic reportedly affected finances, involving broader financial issues not directly related to employment.
- **Personal impacts**: under five suspected suicides occurred in the context of a breakdown in a relationship or an interruption to usual activities due to the COVID-19 pandemic and related public health measures.

The '*Suicide in Queensland: Annual Report 2023',* which would include analysis of data of suicides in Queensland during 2022 is not yet published (May 2024).

It is unclear why such a significant difference of COVID pandemic / pandemic response measures as risk factor in completed suicide appears in the ABS data., but these data suggest an under-reporting of COVID / COVID response as being an aetiologic factor by ABS/Government. In 2022 the ABS[78] reported 84 people died by suicide with the COVID-19 pandemic identified as a risk factor; with 47.6% having an employment-related co-occurring suicide risk factor. Notably, 'employment or unemployment' as a 'risk factor' was the most mentioned risk factor in deaths by suicide for Australians aged 45-64-years in 2022.

Psychosocial factors underlying Covid-19 pandemic related suicide 2022[79]

The screenshot below are the ICD codes used by ABS to determine whether a death by suicide in 2022 qualified for categorisation as having a 'Covid-19 pandemic risk factor' that contributed to the death.

[78] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 22 February 2024.

[79] Australian Bureau of Statistics (2022), Causes of Death, Australia, ABS Website, accessed 10 May 2024.

ICD-10 codes for capture of COVID-19 pandemic as a risk factor

Download

ICD-10 code	ICD-10 code name description	Description of use and inclusion terms
F41.8	Other specified anxiety disorders	Pandemic related anxiety and stress. Includes: Pandemic and COVID-19 related anxieties, worries, fixations and other psychological manifestations.
Z29.0	Isolation	The individual was in isolation or quarantine (hotel or home). Excl: Social isolation (Z60.4)
Z29.9	Prophylactic measure, unspecified	Measures put in place through health directives. Includes: closure of business, stay at home measures. Note: Where other circumstances or risk factors were as a result of the health directive, both codes are captured and should be considered in combination e.g., Job loss due to closure of workplace as a result of lockdown, both Z56.2 (Threatened or actual job loss) and Z29.9 Prophylactic (measure, unspecified) are captured. Capture of lockdown only where information in reports explicitly states the lockdown contributed to the death, or as above where lockdown resulted in other risk factors (e.g., job loss or other work-related issues). Deaths where the region was in lockdown at the time of death, but the lockdown has not been stated in reports as contributing to the death, do not capture this code.

COVID-19 as a risk factor for suicide

Those who died by suicide with issues relating to the COVID-19 pandemic as a risk factor:

- Represented 2.6% of all suicides in 2022.
- Had an average of 6.5 risk factors mentioned.
- Had an average of 3.5 psychosocial risk factors mentioned.

Notably 'other specified anxiety disorders' can be used as a very general category, without specificity and does not differentiate between those anxious about getting infected with Covid or fearful of social interaction, and those with anxiety that they will 'lose their career' due to vaccine mandates.

The harm caused by social isolation appears not to have been captured other that for the specific home or hotel quarantine. There is reference to 'Prophylactic measures, unspecified'. There is no clarity on how many suicides occurred following mandated job loss.

This was a risk factor that the Australian public deserved to be provided data on. For those suicides that were captured by ABS as having 'Covid-19 as a risk factor for suicide' it is notable (see table below) that nearly half of those had employment/unemployment as an additional risk. This is most notable as it was approximately five times rate for all suicides in 2022.

Issues/Risk	2022 % all suicides	2022 % suicide with Covid pandemic risk suicide
Employment/Unemployment	10.8%	47.6%
Mood disorder	36.9%	46.4%
Suicidal ideation	25.7%	35.7%
Anxiety/stress	17.5	27.4%
Bereavement	9.1%	19.0%

Employment loss & vaccine mandates

It is well established that job loss and unemployment are associated with severe psychological sequelae, including suicidality and suicide[80]. The ABS include the leading psychosocial risk factors in suicide annual statistics, with factors associated with employment always being a leading risk factor for completed suicide, particularly amongst men. Pandemic response measures contributed significantly to job insecurity, job loss and business closure or business loss.

A recent Australian study[81] found responders to a survey to of 369 Queensland public health employees impacted by non-compliance with mandated COVID-19 vaccination for employment reported:
We found a reduction in income (reported by 94.4%). The majority (94.9%) believed psychosocial harm was caused as a direct result of state government policy. Anxiety and depression were experienced by 92.1% while 34.1% had had thoughts of suicide. This survey of staff disciplined for non-compliance with Covid-19 vaccine mandates in the state of Queensland, Australia, found wide-spread harm. Impact was biased against females and single parent households.'

No official reporting or discussion of mental health issues (such as by ABS, AIHW or ANU) mention vaccine mandates, coercive government public health 'levers' or the experience of severe discrimination by those unvaccinated against COVID-19 as a factor in suicide or severe mental distress.

General Factors Contributing to Excess Mortality

Authoritarian Medical Practice
The pandemic public health response enforced a deviation from traditional good medical practice Imposition of authoritarian medical practice due to commitment to population wide Covid-19 vaccination policy harmed the free and usual practice of medicine.

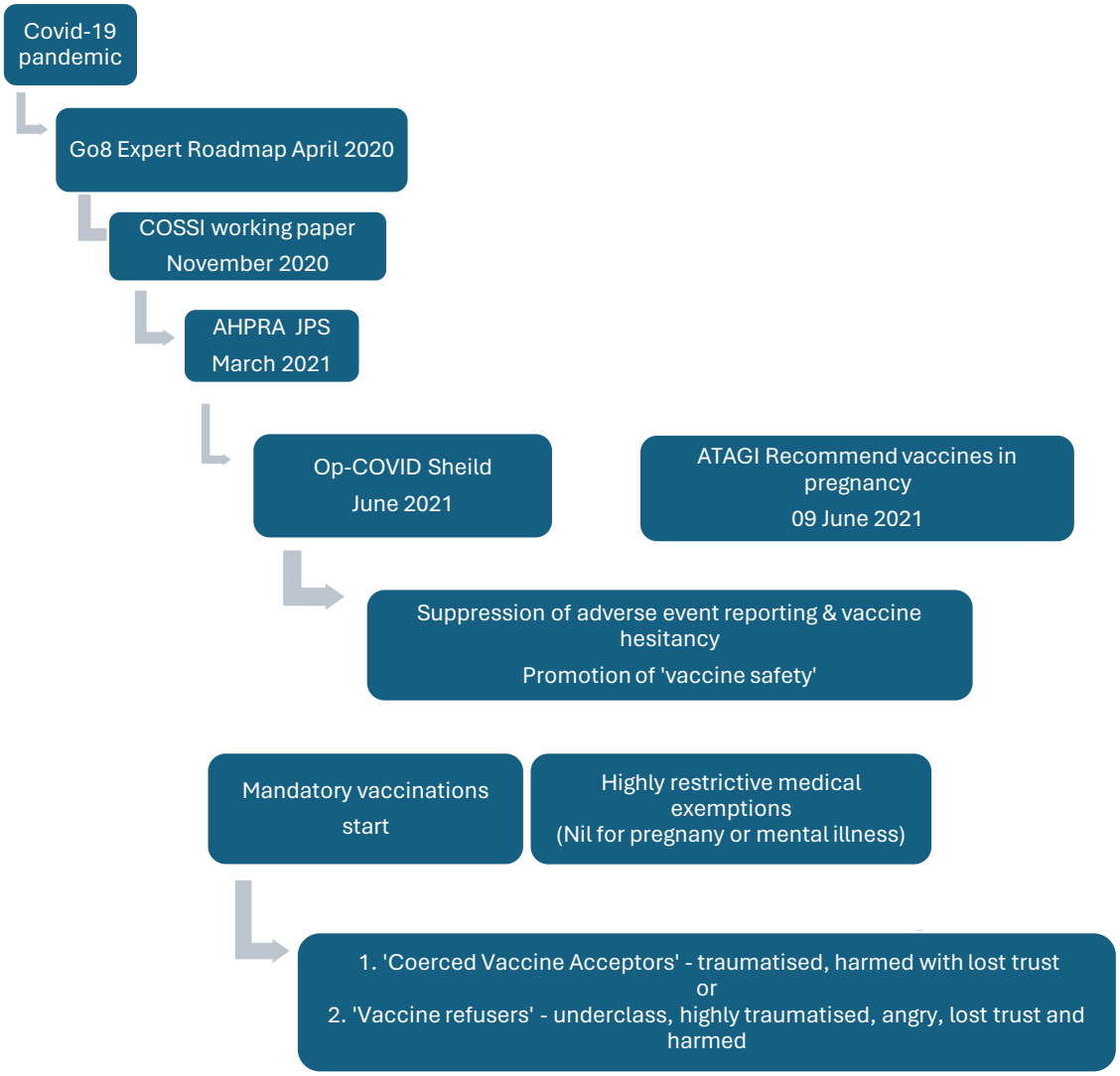
[80] Amiri, S. (2022). Unemployment and suicide mortality, suicide attempts, and suicide ideation: A meta-analysis. International Journal of Mental Health, 51(4), 294–318. https://doi.org/10.1080/00207411.2020.1859347

[81] Charles I McDonald, Peter I Parry, Peter Rhodes. Economic and Psychosocial Impact of Covid-19 Vaccine Non-Compliance amongst Australian Healthcare Workers. Journal of Psychiatry and Psychiatric Disorders. 8 (2024): 40-50. (link)

Imposition of authoritarian medical practice that usurped traditional good medical practice, with negative impact on medicine and health delivery with consequent negative health impacts that contributed to poor health and excess mortality.

Good Medical Practice	Authoritative Medical Practice
Individual patient-cantered and trauma informed care. Personal bodily autonomy paramount	Policy or algorithm driven care. Community good prioritised over individual. Disregard of personal bodily autonomy.
Free, full and voluntary informed consent	Imposed treatment with disregard for individual wishes or voluntary consent
Respectful, individualised, shared decision-making. Right to decline medical intervention.	Paternalistic, tyrannical decision-making. Loss of right to decline medical interventions
Evidence-Based Medicine	Dogmatic practice based on power and authority
Holistic approach to patient care	Reductionist approach focused solely on disease
Tradition medical ethical norm	Utilitarian or Machiavellian Ethics
Respect for the individual, their cultural and religious needs and wishes	Disrespect individual, cultural and religious sensitivities or needs
Advocacy for, and protection of, patient rights and human rights. Duty to act in best interests of patient.	Disregard for patient rights and human rights
Sound professional medical conduct based on clinical knowledge, skills and experience	Medical conduct determined by authority and politics.
Care provided unconditionally	Harm delivered for non-compliance

Usurpation of Medicine by Health Bureaucrats and Government policy diagram



AHPRA & Medical Board 09 March 2021 Joint Position Statement

The 09 March 2021 position statement was unprecedented and provide conflicting advice. The result (perpetuated by disciplinary action against doctor who had legitimate concerns regarding vaccine safety and patient best interests) cause unprecedent harm to the practice of medicine and trust in the medical profession. It was ethically impossible in early 2021 to communicate unequivocally to patients that Covid-19 vaccines were safe and necessary. This was not known, and proved to be wrong.

The AHPRA statement contributed to Medical Practitioner's failure to protect patient's rights and human rights. Coercive medical practice, including vaccine mandates, brought the profession into disrepute.

Politicisation of medicine

In September 2021, just as the Covid-19 vaccine mandates were expanding to a large proportion of the work force, and vaccine passports became necessary to access basic societal and civil activities, rather than journalists questioning unprecedented human rights violations in Australia of coerced medical intervention with a novel biologic political journalists engaged in a campaign of stigmatising citizens with defamatory and false linkage/smearing to dangerous and extreme political ideology. In reality, the protest were legitimate – protesting government coercion of vaccine mandates.

97.7% of Australian's aged over 16 received one or more Covid-19 vaccination according to 'Covid Live'[82], see screenshot below:

VACCINATIONS AGE
Doses by Age Band 16+

STATE	FIRST	SECOND	THIRD	FOURTH
NSW	96.4%	95.1%	67.1%	27.0%
Victoria	96.0%	94.8%	70.6%	25.7%
Queensland	94.7%	93.3%	61.1%	25.6%
WA	>99%	98.7%	82.2%	27.1%
SA	95.8%	94.0%	71.6%	30.1%
Tasmania	>99%	>99%	74.0%	33.7%
ACT	>99%	>99%	82.0%	36.1%
NT	89.8%	87.8%	69.8%	15.9%
Australia	97.7%	96.2%	69.7%	26.9%

It is noteworthy that the voluntary uptake of Covid-19 vaccination, without coercive levers operative, voluntary uptake more than halved.

In September 2021, the ABC online news published an article entitled, *'It's almost like grooming': How anti-vaxxers, conspiracy theorists and the far-right came together over COVID.'*[83]

'*Many of these groups share similar ideas: that there is a cabal of politicians and elites who are oppressing you. That freedom is at risk, that one must stand up for liberty, that there is a wealthy and unelected ruling class controlling you. COVID — with all the fear, uncertainty, lockdowns, policing and employment impacts it brings — has helped bring these groups together.'*

In November 2021, an article was published in The Conversation, overlooking and undermining any legitimacy to concern about either medical ethics of coerced vaccination or the potential for legitimate safety concerns with a novel therapeutic. The article was entitled, 'Why the Victorian protests should concern us all.' Rather that offering a neutral reflection of the protestors concerns or reality of job loss, the article demonises 'anti-vaxxers', thereby promoting coercion into vaccination – as peer pressure and negative

[82] CovidLive (viewed May 2024) (Link)

[83] https://www.abc.net.au/news/2021-09-22/how-antivaxxers-conspiracy-theorists-far-right-melbourne-protest/100481874

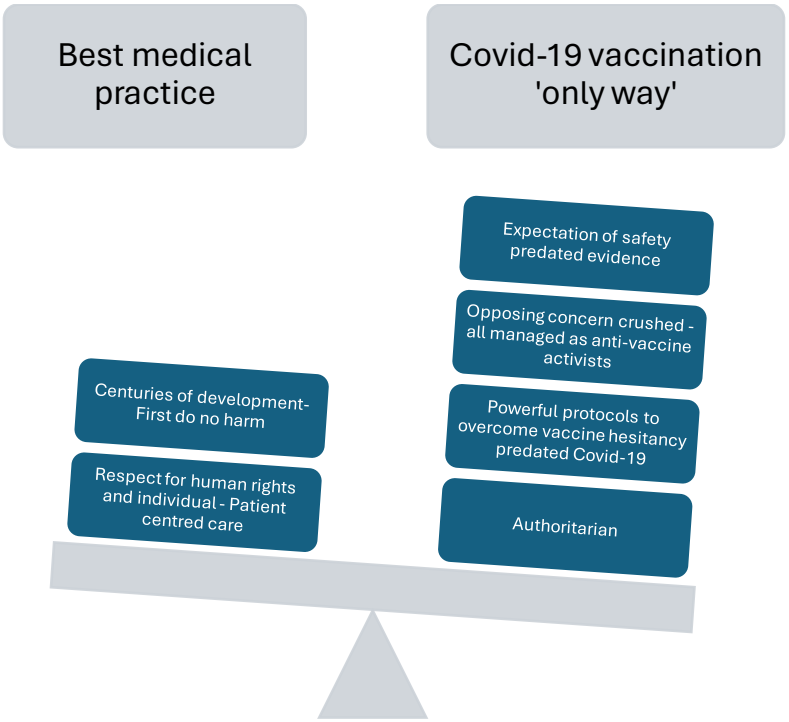
sentiment arising from mainstream media suggesting that the protestors were a danger to society.

'But there is no doubt that, at the heart of the protests – their ideological roots, so to speak – are extremism and conspiracy theories. An analysis of their online activity and forums, as well as the imagery and language of the protests themselves, offers plenty of evidence of this.
Central to it is a deep distrust of science, a strong belief in conspiracies, including the notion of "big pharma" driving public policy, and a new world order of evil "liberal elites" who abuse children and rule over global affairs.'[84]
Or
'Who can blame anyone for having questions about vaccines when misinformation abounds, promulgated by small fringe groups'[85]

Narrative capture

Prior to the pandemic powerful pro-immunisation lobbyists gained ascendency with an agenda to conquer 'vaccine hesitancy' and 'vaccine refusal'. Their raison d'étère being entrenched belief system that vaccination was essential to 'protect the vulnerable' from communicable diseases and a public duty of sufficient importance to surpass individual choice. The experts in this echo chamber understood that entrenched vaccine refusers were unlikely to change belief system and punitive consequences of mandatory vaccination policies were justified.

[84] *Why the Victorian protests should concern us all*: Prof Josh Roose https://theconversation.com/why-the-victorian-protests-should-concern-us-all-172140
[85] 'Forget 'no jab, no pay' schemes, there are better ways to boost vaccination' Kristine Macartney, The Conversation.
February 27, 2015 (Link)



Scope of practice

Covid-19 vaccination was a novel medical intervention. Multiple medical, health and non-medical personnel advanced health policy and provided clinical guidance/enforced health directives without legitimate medical qualification, and especially lacking requisite specialist medical skills (without conflict of interest) to do so. Irreparable harms have arisen as a direct consequence.

A leading medical practitioner, a General Practitioner, with much power to influence policy and public health comprehension, when testifying recently before the Senate Inquiry into potential Terms of Reference for a Covid Royal Commission admitted[86]
"To be fair, I've never heard of the phrase 'immune imprinting' until you mentioned it."
The Royal College of General Practitioners supported vaccine mandates, and were used as trusted experts to promote vaccinations and deny legitimate medical exemptions[87]

Covid-19 vaccination was a novel, gene-based biologic. Much of the information - 'health messaging' and 'public health measures', were promoted and enforced by those with no medical knowledge, least of all any understanding of the extreme, dynamic, medical-complexity at play with SARS-CoV-2 infections, novel biologic vaccines, the benefit/risk of alternatives to vaccination such as ivermectin and natural immunity. The importance of medical 'scope of practice' was lost during the pandemic with measures contrary to

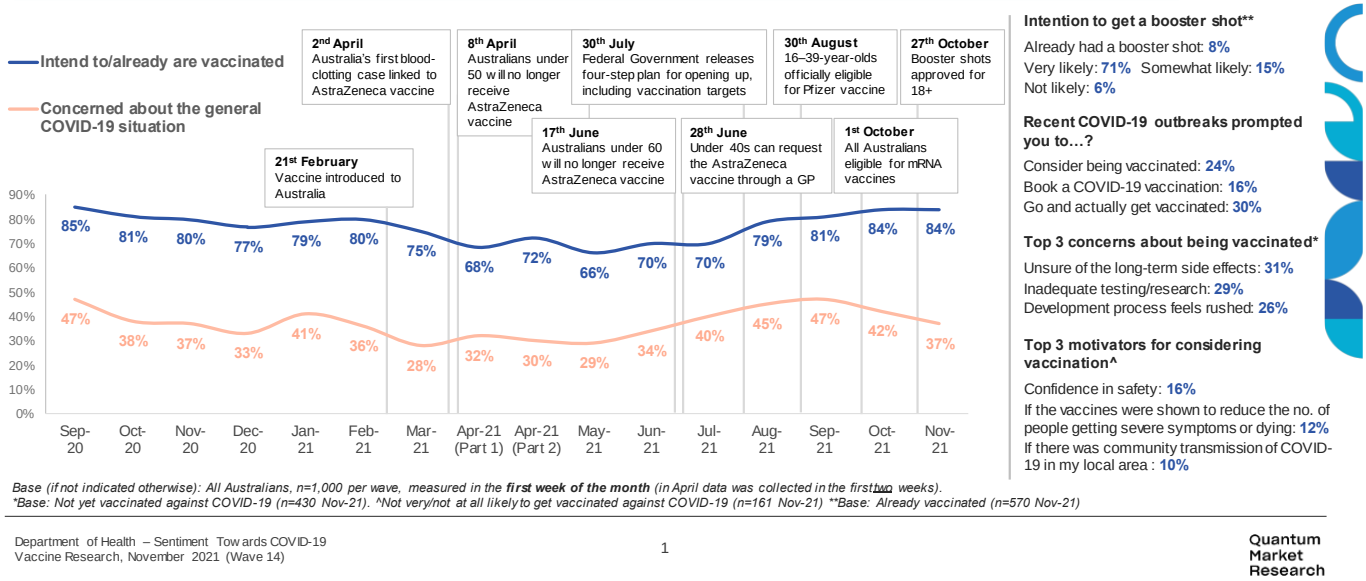
[86] Australian Parliament; Legal and Constitutional Affairs References Committee 01/02/2024 COVID-19 Royal Commission (Link)
[87] GP news online; 17 September 2021: Why the RACGP supports mandatory vaccination for healthcare workers (Link)

good medical practice enforced to the detriment of the health of Australians. This undoubtedly has led to serious mental health harms and contributed to excess mortality led by those with no specialist medical training. The silencing and censorship of specialists with alternative views betrayed good medical practice of free sharing or opinions and debate free of political interference.

The screenshot below, from Operation Covid Shield, demonstrates the 'Vaccine safety' Public Health messaging enforced by the military to manipulate/coerce Australians was based on market research done by Quantum Market research into 'motivators' of vaccination! Not the facts. Not medical care. Not individualised, patient-centred care. Not those with expertise in immunology, molecular biology or genetics. Australians were fed these motivators because it was learned they would increase vaccine uptake. The Public Health messaging was not based on good medicine, or patient centred care. How often did you hear, *"millions (or billions!) of doses of vaccine have been safely given around the world"*? This was not based on actual analysis of the safety of those vaccinated; it was based on the fact that this statement would provide false reassurance to those concerned about the safety of a genetic vaccine. These statement, especially made by those operating any medical scope of practice deliberately betrayed Australians and likely harmed health and contributed to the excess death toll and vaccine injury.

Market research guiding coercive public health messaging : Operation Covid Shield[88]

[88] Australian Government Department of Health & Aged Care: operation-covid-shield-covid-19-vaccine-sentiment-summary-Nov-2021



Suppression of post-Covid-19 vaccine adverse event and death reporting

Suppression and censorship of all vaccine hesitant sentiment caused suppression of adverse event and death reporting and health sector /public awareness of risks of covid-19 vaccination.

The unswerving Public Health commitment to suppress all 'negative sentiment' regarding 'Covid-19 vaccine hesitancy' that could undermine their population wide vaccination program as the only exit to the pandemic simultaneously suppressed necessary reporting and dissemination of adverse event following vaccination.

Military grade suppression of vaccine hesitancy, which suppressed vaccine adverse event reporting (i.e. use of military via Operation Covid Shield), together with the alignment of health, academic, judicial, media sectors and most corporations with the Government Public Health policy created an environment in which it was impossible that a dangerous vaccine could have been recognised and withdrawn (irrespective of the safety, or not, of Covid-19 vaccination).

TGA and ATAGI Failures

Adverse events and deaths reported to TGA 2021 – cumulative by month[89]						
2021	Cumulative AEFI Reported	Increase AEFI per month	Myocarditis Reported +/- pericarditis		Additional deaths per month	Deaths attributed to vaccine by TGA
03 March	79					-
31 March	3,080	+ 3,080				-
28 April	12,694	+ 9614	-			-
27 May	22, 031	+ 9337	Mentioned		+ 210	-
24 June	31,641	+ 9610	+ 4		+108	Only TTS
29 July	43,811	+ 12,170	84		+ 89	6
26 Aug	52,849	+ 9,038	235		+ 69	7
30 Sept	64,293	+ 11,444	850		+ 88	9
28 Oct	74,380	+ 10,087	*235 reclassification		+ 65	9
25 Nov	83,301	+ 8,471	~		+ 53	9
Dec	94,047	+ 10,746	~		+ 37	11

The above table demonstrates a reflag safety signal of dangers of Covid-19 vaccines. They should have been removed from use by May 2021 at the latest.
Concern about the myocarditis risk was known to be a concern to Australian public health officials in March 2021, at the very start of the roll-out in Australia.

The TGA was responsible for both evaluating the 'safety of Covid-19 vaccines' and the adjudicator of causality of reported adverse events and deaths. These responsibilities ought to have been separated due to potential for bias and industry influence. Further, the TGA assumed, to all intents and purposes, the role of determining cause of death. This is not the scope of practice of TGA. As mentioned above, accurate determination of cause of death is highly complex, highly skilled and requires massive funding, time and personnel.

[89] TGA Covid -19 weekly vaccine safety reports (collated) accessible from: (link)

The 2021 'Western Australian Vaccine Safety Surveillance – Annual Report 2021'[90], only tabled in WA Parliament in February 2023 is useful because community transmission of COVID-19 did not start in WA until 2022, after the majority of the WA population had been vaccinated.

There was a **notable increase in AEFI** [adverse events following immunisation] **reports**, rates of AEFI across **the three COVID-19** vaccines administered in WA in 2021

The AEFI rates for comparable vaccines in the VAERS program were:
Comirnaty **(Pfizer) 122.0** per 100,000 doses and
Spikevax **(Moderna) 187.6** per 100,000 doses.

There were 1,808,050 individual doses of **non-COVID-19 vaccines** recorded in the AIR in 2021, giving a total AEFI rate of:
11.1 events per 100,000 doses, which is similar to the reported 2020 rate of
12.4 per 100,000 doses.

Note the massive increase in adverse event notification with COVID-19 vaccines.
Were doctors notified of this, that rather than being told the vaccines were 'safe and effective' and the duty to warned and advise doctors to look out for adverse reactions or potentially unexpected side-effects? Especially in the elderly

Reporting of AEFI also increased significantly from 270 reports in 2020 to 10,628 reports in 2021.

Table 1 of this report is inserted below:

[90] WA Government Department of Health, Western Australian Vaccine Safety Surveillance – Annual Report 2021 (Link)

Table 1 Characteristics of adverse events following immunisation reported to WAVSS 2017 – 2021

	2017	2018	2019	2020	2021	
					Routine	COVID-19
Total	263	308	262	270	200	10,428
Sex						
Female	156 (59%)	182 (59%)	158 (60%)	165 (61%)	110 (55%)	6,691 (64%)
Male	107 (41%)	124 (40%)	103 (39%)	105 (39%)	90 (45%)	3,712 (36%)
Unknown	0 (0%)	2 (1%)	1 (<1%)	0 (0%)	0 (0%)	16 (<1%)
Neither	-	-	-	-	-	9 (<1%)
Aboriginality						
Aboriginal/Torres Strait Islander	4 (2%)	13 (4%)	16 (6%)	19 (7%)	10 (5%)	184 (2%)
Non-Aboriginal/Torres Strait Islander	190 (72%)	214 (70%)	195 (74%)	226 (84%)	167 (84%)	9,190 (88%)
Unknown	69 (26%)	81 (26%)	51 (19%)	25 (9%)	23 (12%)	1,054 (10%)
Age group						
< 5 years	115 (44%)	130 (42%)	112 (43%)	106 (39%)	85 (42%)	0 (0%)
5 – 17 years	41 (16%)	45 (15%)	38 (15%)	42 (16%)	21 (11%)	336 (3%)
18 – 64 years	64 (24%)	89 (29%)	77 (29%)	88 (33%)	64 (32%)	8,422 (81%)
≥ 65 years	43 (16%)	44 (14%)	35 (13%)	34 (13%)	30 (15%)	1,602 (15%)
Age not provided	-	-	-	-	-	68 (<1%)^
Reporter Type						
Healthcare Provider	213 (81%)	255 (83%)	217 (83%)	204 (76%)	157 (79%)	3,678 (35%)
Parent/Self^^	41 (16%)	29 (9%)	31 (12%)	33 (12%)	19 (10%)	6,083 (58%)
Pharmacy	3 (1%)	16 (5%)	10 (4%)	25 (9%)	18 (9%)	209 (2%)
Other	6 (2%)	8 (3%)	4 (2%)	8 (3%)	6 (3%)	458 (4%)
Immunisation Provider Type						
Aboriginal Medical Service	1 (0%)	3 (1%)	0 (0%)	2 (1%)	1 (1%)	3 (<1%)
GP	167 (63%)	185 (60%)	134 (51%)	136 (50%)	89 (45%)	1,749 (17%)
Nurse	0 (0%)	0 (0%)	2 (1%)	0 (0%)	0 (0%)	1 (<1%%)
Pharmacy	4 (2%)	9 (3%)	12 (5%)	29 (11%)	15 (8%)	451 (4%)
Workplace	2 (1%)	1 (<1%)	6 (2%)	9 (3%)	4 (2%)	53 (1%)
Hospital	25 (10%)	38 (12%)	27 (10%)	22 (8%)	13 (7%)	1,382 (13%)
Community Clinic	0 (0%)	2 (1%)	4 (2%)	2 (1%)	17 (9%)	2,681 (26%)
Other	47 (18%)	51 (17%)	42 (16%)	27 (10%)	5 (3%)	42 (<1%)
Missing data	17 (6%)	19 (6%)	35 (13%)	43 (16%)	56 (28%)	4,066 (39%)
Managed by						
Emergency department	49 (19%)	63 (20%)	53 (20%)	61 (23%)	40 (20%)	4,957 (48%)
Admitted to hospital	12 (5%)	16 (5%)	23 (9%)	18 (7%)	20 (10%)	961 (9%)
Helpline	7 (3%)	6 (2%)	9 (3%)	10 (4%)	5 (3%)	388 (4%)
Nurse assessment	48 (18%)	70 (23%)	58 (22%)	46 (17%)	33 (17%)	520 (5%)
GP assessment	124 (47%)	141 (46%)	119 (45%)	124 (46%)	77 (39%)	3,082 (30%)

^ 'Age not provided' is from WAVSS reports with no date of birth provided or found.
^^ Parent/Self includes family member

Western Australian Vaccine Safety Surveillance Report 2021

11

From this table of note in 2021:

- 8,422 reports of adverse events following COVID-19 vaccination, representing **81% of all reports were in the working age group of 18-64.**
- This is the age group that was coerced into vaccination due to the mandates.

- The range of numbers of patients **admitted to hospital** in the pre-COVID years following non-COVID vaccination was 40 to 63 (years 2017-2021);
- however in 2021961 patients were admitted to hospital following COVID-19 vaccination
- There were **4,957** presentations to Emergency Departments following COVID-19 vaccination – this represents a **massive demand on health service the vaccines were supposed to protect.**

Table 5.2 is inserted below for your convenience (the tabled document has right margin omitted):

5.2 Adverse events following COVID-19 vaccines by age group and brand

The rate of adverse events following COVID-19 vaccines per 100,000 doses by age group and brand for 2 Comirnaty age group 5-11 years and Vaxzevria age group 12-17 years, as all reported AEFI for these gro (i.e., administration outside recommendation). The highest AEFI rates were for people aged less than 60 ye those aged 18-24 years (1,031.2 per 100,000 doses) and 40-49 years (1,006.4 per 100,000 doses).

Table 3 Rate of adverse events following COVID-19 immunisation for 2021, by brand and age group in years

	Vaxzevria (AstraZeneca)			Comirnaty (Pfizer)			Spikevax (Moderna)		
Age group (years)	AEFI Count	Doses	Rate per 100,000 doses	AEFI Count	Doses	Rate per 100,000 doses	AEFI Count	Doses	Rate p 100,0(dose
12-17	-	-	-	278	212,951	130.5	41	21,811	188.(
18-24	97	9,407	1,031.2	599	293,141	204.3	50	24,022	208.'
25-29	108	11,366	950.2	627	248,775	252.0	60	18,682	321.2
30-39	193	24,051	802.5	1,792	612,676	292.5	156	40,725	383.'
40-49	315	31,299	1,006.4	1,624	589,148	276.7	123	35,475	346.8
50-59	834	203,799	409.2	1,059	414,871	255.3	83	29,313	283.2
60-69	916	393,492	232.8	278	128,332	216.6	41	20,394	201.(
≥70	926	445,196	208.0	125	123,489	101.2	18	16,025	112.3
unknown	24	-	-	35	-	-	9	-	-
All ages	**3,424**	**1,118,610**	**305.1**	**6,417**	**2,623,383**	**244.6**	**581**	**206,447**	**281.4**

Western Australian Vaccine Safety Surveillance Report 2020

Of particular concern from Table 5.2 is the high rate of adverse events in the young age groups, especially with Moderna vaccination, such as the 30-39 year age group of 383 per 100,000 doses.

In 2021, 138 confirmed cases of myocarditis/myopericarditis following COVID-19 vaccinations were reported to WAVSS.
A total of 365 confirmed cases of pericarditis following COVID-19 vaccinations received in 2021

How is it possible that strong warnings were not given to the public in 2021 regarding the risk of myocarditis for young people was not issued when the data looked like this? This information cannot be dismissed when considering excess mortality.

Politicisation of medicine

In September 2021, just as the Covid-19 vaccine mandates were expanding to a large proportion of the work force, and vaccine passports became necessary to access basic societal and civil activities, rather than journalists questioning unprecedented human rights violations in Australia of coerced medical intervention with a novel biologic political journalists engaged in a campaign of stigmatising citizens with defamatory and false linkage/smearing to dangerous and extreme political ideology. In reality, the protest were legitimate – protesting government coercion of vaccine mandates.

In September 2021, the ABC online news published an article entitled, '*It's almost like grooming': How anti-vaxxers, conspiracy theorists and the far-right came together over COVID.*'[91] This type of media unreasonably stigmatized and politicised legitimate medical decision making and was thus used as a coercive tool because it linked the 'vaccine hesitant' with dangerous political extremism.
"Many of these groups share similar ideas: that there is a cabal of politicians and elites who are oppressing you. That freedom is at risk, that one must stand up for liberty, that there is a wealthy and unelected ruling class controlling you. COVID — with all the fear, uncertainty, lockdowns, policing and employment impacts it brings — has helped bring these groups together."

In November 2021, an article published in 'The Conversation', overlooked the legitimacy of right to protest torture inflicted by vaccine mandates, or infringement of human rights and medical ethics; and certainly gave no credence to legitimate safety concerns of the novel gene based therapeutic. This article entitled, *'Why the Victorian protests should concern us all.'* Did not provide balanced journalistic reflection but demonised 'anti-vaxxers', thereby aiding societal coercion into vaccination through vile stigmatisation.
"But there is no doubt that, at the heart of the protests – their ideological roots, so to speak – are extremism and conspiracy theories. An analysis of their online activity and

91 https://www.abc.net.au/news/2021-09-22/how-antivaxxers-conspiracy-theorists-far-right-melbourne-protest/100481874

forums, as well as the imagery and language of the protests themselves, offers plenty of evidence of this. Central to it is a deep distrust of science, a strong belief in conspiracies, including the notion of "big pharma" driving public policy, and a new world order of evil "liberal elites" who abuse children and rule over global affairs."[92]

SARS-CoV-2 infection, a highly contagious respiratory virus was always destined to become endemic especially since vaccination did not prevent infection or transmission the risk of infection. However, pro-vaccine lobbyists used emotional blackmail to promote vaccination by impinging on our instinct to care and protect the vulnerable. Guilt and shame were used to smear those who did not agree with 'experts' assessment of safety.[93]

"If we have a lot of people who aren't vaccinated, the virus will just continue to spread and be a risk to our families and friends. We cannot afford to have it circulating at high levels in the community.
It sometimes seems okay to say "I don't mind if I get sick", but in my experience as a clinician who looks after people in intensive care, when others feel they might have passed on that infection to a person who ends up seriously ill in hospital, it's a terrible burden to bear. People feel absolutely devastated about that — knowing they didn't do everything they could have.
Everyone knows or cares for someone who is older, or might have had treatment for cancer, or for some other reason will be vulnerable. It's so important that we think of those people, because if we're not vaccinated, we're keeping them at risk."

The ABC online article, quoted above, serves as an example of 'experts' providing advice and safety reassurance regarding Covid-19 vaccines that is not nuanced and makes unsubstantiated claims. For instance:

"With mRNA-based vaccines, like the Pfizer and Moderna shots, it's genetic code that degrades and disappears within moments of being used by the cells in the body. There are extensive studies that show that code is only around for an instant. In animal models, when they've tried to look for that mRNA after administering the Pfizer vaccine, they can't find it anywhere in the body. It's not the sort of substance that can stay in the body or be incorporated into human cells."
There were no degradation studies available relating to cessation of action of the synthetic mRNA used in the vaccines. mRNA has been found in tissues months after vaccination. Via reverse transcriptase of mRNA, and plasmid DNA contamination of vaccines – genetic codes used in the Covid-19 vaccines have been found to enter cell nucleus with unknown consequences. Further, it is not humanly possible to 'speed up' time. Time is required to evaluate short, medium and long-term side effects; especially

[92] *Why the Victorian protests should concern us all*: Prof Josh Roose https://theconversation.com/why-the-victorian-protests-should-concern-us-all-172140
[93] ABC news online; 28 February 2021: '*Your COVID-19 vaccine safety questions, answered by experts*' (Link)

the risk to fertility and on pregnancy. No matter how many 'billions of dollars' were thrown at getting a vaccine to market – money cannot actually usurp the scientific method and due diligence. Australian's deserved much better.

Thousands of highly skilled healthcare workers mandated out of work

Health services (both public and private) mandated out of work thousands of health practitioners (including nurses, doctors, psychologists, paramedics). The mental health harm and loss of trust caused to these skilled members of the Australian health workforce has caused permanent loss to the health sector as many are not able / not willing to return to workplaces that harmed them. The loss of skilled health workers will have harmed health care delivery in Australia with negative consequences for the health of Australians and likely contributing to excess mortality.

Specific Factors Contributing to Excess Mortality

If it looks like a duck, walks like a duck and quacks like a duck … it is a duck!

The full extent of serious adverse events directly caused by Covid-19 vaccines is unknown, but increasingly recognised, for instance May 2024 New York Times article, '*Thousands Believe Covid Vaccines Harmed Them. Is Anyone Listening?* regarding serious side effects[94]. If thousands suffered serious side-effects following Covid-19 vaccination and most were 1) shunned by the medical profession who disbelieved them or incorrectly diagnosed them with mental illness (thereby depriving them of proper investigations/treatments) and; 2) those with serious side-effects were intentionally suppressed/censored by mainstream and social media (as per WHO plan[95]) that some likely died from serious adverse events and these deaths were similarly not recognised as being related to Covid-19 vaccines, not believed to be related to Covid-19 vaccine or actively supressed as being related to Covid-19 vaccination.

My opinion is that the WHO document cited above expresses greater concern that a death or serious side-effect could derail a vaccine program than indicate a safety signal that the Covid-19 vaccines might actually have greater risk than benefit and the program requires cessation.

The following concerns will likely be covered in other submissions, but I support further evaluation of them as I believe they are contributory to recent deaths, and may contribute to ongoing deaths. I will mention them in brief:

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[94] *Thousands Believe Covid Vaccines Harmed Them. Is Anyone Listening?* Apoorva Mandavilli New York Times 03 May 2024 https://www.nytimes.com/2024/05/03/health/covid-vaccines-side-effects.html (viewed May 2024)

[95] Covid-19 vaccines: safety surveillance manual. Geneva: World Health Organization; 2020. Licence: CC BY-NC-SA 3.0 IGO.

1. Management of SARS-CoV-2 illness

2. Suicide
See under mental health harms above

3. Covid-19 Vaccine Injury & death

4. Long Covid and role of Covid-19 vaccination

5. Frail Elderly – risk from misclassification of post vaccine death, poor care due to denial of family visitors, and death hastened by palliative treatments rather than active management of infection.

6. Myocarditis, sudden death and heart related harms

7. Pregnancy and births – especially post-vaccine

8. Vaccine associated enhanced disease – is this contributing to excess deaths? Increased susceptibility to infection and immune suppression.

9. Plasmid DNA contamination of vaccines

10. Frameshifting & junk mRNA
The mRNA covid-19 vaccines used novel biologic therapy, a gene-based therapy, never previously licenced for human use[96]. They utilise lipid nano particle synthetic messenger-RNA genetic instructions that had uncontrolled bio-distribution, uncontrolled length of action, no means of ceasing or reversing the elicited genetic instructions to manufacture bioactive spike protein in an uncontrolled manner and no known medium- or long-term safety data. It is recognised that there were high levels of contamination with plasmid DNA and that aberrant, unintended 'junk proteins' were produced through 'frameshifting' or misreading of the mRNA sequences or fragments. When introduced, it was impossible to predict whether/to what extend vaccine associated enhanced disease might occur.

[96] Rapid Research Information Forum: The most promising vaccines for COVID-19
10 May 2020- https://www.chiefscientist.gov.au/sites/default/files/2020-05/rrif-covid19-promising-vaccines.pdf (Viewed May 2024)

Conclusion

This submission draws attention to the extra burden of difficult grief for those bereaved during the pandemic, and the need to reach out to help them. The mental health of Australians was also harmed by pandemic measures. Death by suicide contributed a small proportion of overall deaths, but the impact of suicide and it's being a marker of poor mental health in the community highlights the immense importance of care for those who are suffering.

Coercive vaccination, I contend, caused extreme intentional suffering, torture, which is contributing to poor mental health and overall community wellbeing. The mental health needs of those who were tortured are largely unrecognized and unmet. The fact that mainstream mental health and medical care were complicit with vaccine mandates make outreach to those suffering all the more difficult because of mistrust and access to health care barriers.

I also outline the complexity of determining cause of death. I raise concern that accurate discernment of cause of death occurred during the pandemic (especially obfuscation regarding Covid-19 vaccination as a potential contributor to death or adverse events). I also highlight my belief that authoritarian medical practice has harmed health care delivery in Australia, with resultant negative health impacts.

I also briefly raise specific concerns regarding categories of death, many potentially related to Covid-19 vaccination or pandemic response measures.

Recommendations:

1. Immediate cessation of Covid-19 vaccination program

Until unencumbered debate with unfettered access to relevant health data occurs, based on community concern and data currently available, the precautionary principle must be applied such that Covid-19 vaccination is withdrawn from public use, with use limited to those with special needs with full informed consent/acceptance of liability.

2. Royal Commission.

An independent Royal Commission, with participation of all Australian States and Territories examine Australian mortality and excess mortality in the pandemic and post-pandemic era.

3. Prioritise Bereavement Care.

The difficult burden of clinically impairing grief requires urgent attention. Specialist training in assessment and management of grief following bereavement is required. Establishment of high-risk bereavement protocols and services, to encompass sensitive, specialised care for subsets of pandemic era bereavements (especially pandemic related

suicide bereavement and sudden/premature deaths) known to be at high risk of increased morbidity and mortality.

4. Prohibit coercive levers of medical intervention.
Avoid public and private mandates and other coercive levers utilised to extract compliance. Develop and use specific ICD code (or similar) for suicide risk factor of 'vaccine mandated job loss' .

5. Prevent medical interventions being promoted, recommended or coerced by non-medical interest groups.

6. Disallow all conflict of interest without full & transparent disclosure.

7. Fund Covid-19 vaccine injury research, training, care and compensation.

8. Fund 'vaccine mandate/passport' injury research, training, care and compensation.

9. Fund other 'pandemic response' injury research, training, care and compensation.

10. The health care delivery bureaucracy and public health hierarchy require urgent independent review. Public Health medical advice to be delivered based on medical facts, with context and uncertainty mentioned, not based on market research of what induces compliance and sense of trust.

11. Stop suppression and censorship of health practitioners; remove regulatory over reach.

12. Prohibit mandating health practitioners out of work during a pandemic.

13. Enforce data transparency, including a) access to data linking dates of vaccination with date of death; b) miscarriage, stillbirth, premature birth, neonatal death and maternal death data with vaccination status; c) Coronial Investigations to include vaccination status and vaccine mandate risk (including coerced into vaccination) in those who died by suicide; and vaccination history in all deaths.