covidmedical NETWORK

8 March 2022

Associate Professor Nigel Crawford
Chair, Australian Therapeutics Advisory Group on Immunisation (ATAGI)

Other voting members of ATAGI:
- Professor Michelle Giles
- Professor Allen Cheng
- Ms Karen Bellamy
- Professor Katie Flanagan
- Dr Katherine Gibney
- Dr Penelope Burns
- Professor Cheryl Jones
- Adjunct Professor Tony Korman
- Associate Professor Bette Liu
- Dr Nicholas Silberstein
- Dr James Wood
- Ms Diane Walsh
- Professor Tom Snelling
- Ms Kristy Cooper

Dr Brendan Murphy
Secretary, Department of Health

Professor Paul Kelly
Chief Medical Officer, Department of Health

Professor John Skerritt
Deputy Secretary, Health Products Regulatory Group (Therapeutics Goods Administration, TGA)

TGA's Advisory Committee on Vaccines (ACV)
- Professor Allen Cheng, Chair
- Professor Jim Buttery
- Dr Jeanine Bygott
- Ms Madeline Hall
- Professor Kristine Macartney
- Dr Ines Rio
- Dr Vicky Sheppeard
- Associate Professor Adrienne Torda
- Professor Joseph Torresi
- Ms Diane Walsh

The Honorable Greg Hunt
Minister for Health & Aged Care

Dear A/Prof Crawford, Dr Murphy, Prof Kelly, Prof Skerritt, Hon Minister Hunt, members of ATAGI and ACV,

We, the Covid Medical Network and co-signatories, are writing to you to follow up on prior correspondence to ATAGI, the TGA and the Health Minister, and FOIA requests to the TGA, where answers have either been not forthcoming or have indicated the TGA has lacked

critical information for making its provisional approval of the gene-based vaccines, namely Pfizer's BNT162b2 & Comirnaty, AstraZeneca's ChAdOx1-S and Moderna's Spikevax/mRNA-1273.

This letter pertains to:

1. Correspondence you and the TGA received that the Pfizer (and AstraZeneca and Moderna) data via the companies themselves or via the FDA was likely too limited in scope to make a proper determination of safety and efficacy.
2. FOIA requests to the TGA with respect to reproductive toxicology issues that have been responded to late and with heavily redacted documents.
3. FOIA request with respect to micro-RNA sequences and related molecular genetic issues as to whether the TGA had assessed these.
4. Peer-reviewed published *in vitro* research that gene-based vaccine generated spike proteins can migrate into human cell nuclei to disrupt DNA repair mechanisms, and vaccine-derived RNA can be reverse transcribed with evidence pointing to possible integration of this sequence into human genome.
5. That a release of some Pfizer data from a FOIA request to the FDA in the US indicated high adverse events reporting by 28 February 2021.
6. Analysis of the TGA's own Database of Adverse Events Notifications (DAEN) data and what Australian clinicians are increasingly witnessing as a high rate of injuries from these gene-based vaccines.
7. Extrapolating from German insurance company actuarial data, backed up by multiple US insurance company actuarial data, Australia's DAEN Covid-19 adverse event data is likely to be under-reported by 9-fold. To date, 2,422, and possibly as high as 6,501 Australians dying as results of the Covid-19 gene-based vaccines is a justifiable calculation.
8. All-cause mortality data from official UK, EU and US databases indicate a positive correlation with the Covid-19 gene-based vaccine rollouts during 2021.
9. US military doctors have provided data from the US military electronic medical records database (DMED) showing an almost 10-fold increase in registered diagnosis episodes since gene-based vaccines were given to personnel.
10. German pathologists described pathological aggregates of spike proteins and lymphocyte infiltrations in inflamed organs in autopsies related to deaths post-vaccination. Has the TGA provided guidance and resources for autopsies of post-vaccine deaths of Australians?
11. Reports of inadequacies, irregularities and possible fraudulent practices in the Pfizer vaccine trial provided by whistleblowers to the *BMJ*.
12. The correspondence you received concerned with lack of sufficient safety analysis for rolling out the Pfizer vaccine to Australian children, based on that FDA release of the Pfizer adverse events data, that you received prior to Christmas.
13. The evidence that the Omicron variant of SARS-CoV-2 is milder than the average seasonal influenza virus.
14. The evidence that the gene-based vaccines do not prevent transmission.

15. From a modern immunological perspective, too frequent vaccinations for respiratory viruses runs the risk of desensitising the immune response to the virus and thus lead to hypoimmunity and worse illness.
16. Anomalies being reported in vaccine vials and blood samples from an increasing number of labs and practitioners around the world are creating suspicion. These are unexpected findings and at a minimum warrant further high level investigation.
17. Clinicians and researchers around the world have trialled various repurposed medicines and vitamins, zinc and nutritional supplements for Covid-19 with varying but often apparent success, particularly when used early and in combination. Suppression of such protocols that have long-term safety data by the TGA and AHPRA has deprived Australians of safe and possibly effective treatments.
18. Natural immunity and safer traditional vaccines have been under-recognised.
19. An article in the high-impact journal *Nature*, notes that data collection and presentation during the Covid-19 pandemic has been substandard. Thus the capacity to 'follow the science' has been impaired. The US Center for Disease Control (CDC) recently admitted to withholding data for allegedly politicised reasons.

The safety signals presented by the data in this letter are of such grave concern that the normal decision would be to immediately halt the use of gene-based vaccines to the Australian public. In view of all the data presented,

we request:

That you immediately:

1. Withdraw any information saying these gene-based vaccines are "safe"
2. Withdraw the gene-based vaccines availability to the general public
3. Absolutely halt the rollout of gene-based vaccines to Australian children as a matter of urgency
4. Provide answers to the questions raised *in italics* in each section below.

We are also carbon copying this letter to our parliamentary representatives so the issues raised can also be addressed via 'Questions on Notice' and through other democratic parliamentary means.

We acknowledge that the data presented in this letter, and the opinions based on that data, contravene the narrative of "safe and effective" gene-based vaccines and the goal of vaccinating most of the population. However, the phrase "following the science", means following the data as it comes to hand and therefore Science is about changing hypotheses, theories and conclusions in line with changing data.

In contrast, human societies including scientific groups, are prone to adhering to dominant 'narratives' once they have been formed. A 'groupthink' can emerge, that once established can be hard to shake off. This evolutionary psychological groupthink phenomenon forms the sociological basis for Thomas Kuhn's seminal work *The Structure of Scientific Revolutions*. It doesn't apply just to major scientific theories, that Kuhn was focussed upon, but also to more immediate group responses to threats such as a pandemic, when clinicians and the public anxiously want clear answers and treatments.

The point of mentioning this, is to request that you come to what follows with a fresh perspective and open mind. In this regard we refer to a brief snippet of an interview of Dr Tony Fauci with Facebook's Mark Zuckerberg from July 2021: https://rumble.com/vqs23k-wtf-fauci-admits-v-may-actually-make-people-worse-it-would-not-be-the-first.html?mref=6zof&mrefc=6 .

Correspondence from Professor David Healy, Canada

Did you, Professor Skerritt, receive a paper (Evidence Base and Vaccine Policy) and letter from Professor David Healy of McMaster University in Canada? The paper and letter are attached (Annexures A & B) and were sent in mid-December.

Prof Healy is an expert in lack of transparency data issues that afflict the conduct of randomised controlled trials, the governance and manipulation of data by trial sponsors, and the integrity of the medical literature, as well as what health regulatory bodies such as the FDA, MHRA, EMA and TGA are privy to or influenced by (https://davidhealy.org/articles/). Such issues are a well-known blight on medical science, that has led to initiatives such as the *AllTrials* campaign (https://www.alltrials.net/).

Prof Healy's paper raises grave concerns about the conduct of the Pfizer trial upon which vaccine policy in Australia, including to children, is based. It calls upon the TGA to exercise greater vigilance and to pursue Pfizer for the raw data upon which TGA provisional approvals have been granted. His paper notes that without the original raw data to cross reference, manipulation to obscure harms or exaggerate benefits can result in false data being presented in Clinical Study Reports.

According to a FOIA request FOI 2289, the TGA acknowledges to have not obtained individual patient level data (Annexure C; https://doctors4covidethics.org/wp-content/uploads/2021/06/FOI-2289-relevant-documents_Redacted.pdf).

Previous FOIA requests regarding reproductive toxicology

FOIA requests to the TGA with respect to reproductive toxicology issues have not been adequately responded to, or replied to with heavily redacted documents.

FOI 2389 (Annexure D) noted the serious data of great concern, in Document 6, Submission PM-2020-05461-1-2, that the concentration of labelled mRNA vaccine nanoparticles in rat ovaries is measured at 10x the concentration of nanoparticles in all other organs, with the exception of liver, spleen, adrenals and lymph tissue. But no histopathology of reproductive tissue is noted.

The subsequent FOI 2565 requested "Histopathology/microscopic evaluation of gonads (ovaries/testes) of vaccinated animals in relation to Pfizer and AstraZeneca COVID-19 vaccines". This application has been rejected three times, and was rejected finally by the internal reviewers on 27 Sep 2021 (Annexures E & F) - after a refusal on behalf of the requesting party to reduce the suggested scope, and "exclude appendices, annexures and raw data and to withdraw your request for internal review". This has become a formal complaint submitted on 25 Oct 2021 (Annexure G). Withholding reports of ovarian and testicular effects of investigational (provisionally registered), novel, population vaccines is of particular concern in the context of vaccine mandates being imposed upon men and women of reproductive age in various occupational sectors, and now on children and teens with their reproductive years ahead of them.

FOI 3093 is remarkable for its redaction content (Annexures H & I). Report No. 38166, page 60, section 4 Results, section 4.1 Local Tolerance is completely redacted, as is the majority of the following 23 pages. Some concerns regarding uterine swelling and collections of clear fluid in uteri do not appear to have been analyzed any further. Again, there is no histopathology on ovaries to be viewed.

In the information disclosed to date, it appears that the fertility studies have not reached the standards of Developmental and Reproductive Toxicity (DART) studies guided by the European Medicines Agency or the FDA's Guidance for vaccine development. Gonad histology is not present in the information that the TGA has supplied, despite the repeated requests.

As health care clinicians, we have the responsibility to gather Informed Consent from our patients who justifiably request this information, but we are hindered by AHPRA restrictions

from discussing gene-based vaccine potential adverse effects, and the vital information for true Informed Consent is being censored by the TGA.

Recent FOI request regarding molecular genetics data

On 18 February 2022, Dr Lisa Kerr of the TGA kindly replied promptly to a FOI request dated 5 February 2022. Dr Kerr's correspondence is attached (Annexure J) and the lack of requested documents possessed by the TGA is highlighted.

With reference to Items 1 – 5 appearing at Section 1 on page 1 of the correspondence from Dr Kerr, we note the following concerns arising from the failure on the part of the TGA to independently investigate or require the sponsor to fully report its findings, namely:

Item 1

The failure of the TGA to independently investigate, which was further compounded by the failure to require complete sponsor findings in respect of **micro-RNA sequences (miRNA)** comprised within the Comirnaty mRNA active ingredient (mRNA genomic sequence), means the TGA never had before it critical information required for a full and proper assessment of Safety for the purpose of evaluating whether to grant Provisional Approval, nor has the Australian community been provided that same critical information for enabling fully Informed Consent to occur, which legal right has therefore been denied the Australian community, on the following issues known by the TGA to involve significant and serious short-, medium-, and long-term safety risks in respect of miRNA, namely:

The Pfizer vaccine sequence is known to contain a number of pathogenic micro-RNA sequences as documented by Fujii (Fujii 2021). These sequences include miRNAs involved in oncogenesis via the WNT-signalling pathway, with unknown long-term effects but likely to involve gynaecological cancers. Additional pathways affected by the encoded microRNAs include inflammatory and pain pathways, again with unknown short- and long-term effects.

Of most concern is the known and documented role that micro-RNAs play in tumour suppression and activation (Ali Syeda 2020), neither action of which can be predicted without experimental evidence. Thus, there are significant and unknown risks of the miRNAs contained in the vaccine in conferring oncogenic risk either immediately or in the future.

Fujii YR. Quantum microRNA Assessment of COVID-19 RNA Vaccine: Hidden Potency of BNT162b2 SASR-CoV-2 Spike RNA as MicroRNA Vaccine. Adv Case Stud. 3(1). AICS.000552. 2021. DOI: 10.31031/AICS.2021.03.000552

Ali Syeda Z, Langden SSS, Munkhzul C, Lee M, Song SJ. Regulatory Mechanism of MicroRNA Expression in Cancer. *Int J Mol Sci*. 2020;21(5):1723. Published 2020 Mar 3. doi:10.3390/ijms21051723

Item 2

The failure by the TGA to independently investigate, which was further compounded by the failure to require complete sponsor findings in respect of **Oncomirs (oncogenic miRNA - microRNA)** in the Comirnaty mRNA active ingredient (mRNA genomic sequence), means the TGA never had before it critical information required for a full and proper assessment of Safety for the purpose of evaluating whether to grant Provisional Approval, nor has the Australian community been provided that same critical information for enabling fully Informed Consent to occur, which legal right has therefore been denied the Australian community, on the following issues known by the TGA to involve significant and serious short-, medium-, and long-term safety risks in respect of Oncomirs (oncogenic miRNA – microRNA), namely:

As outlined in item 1, microRNAs can have tumour suppressor and tumour activating functions. Tumour activating miRNAs are designated oncomirs. This is a rapidly evolving and new field of genomic medicine about which little is known and therefore the dangers of introducing a new pro-drug that can influence cancer causing pathways are significant.

Lin S, Gregory RI. MicroRNA biogenesis pathways in cancer. *Nat Rev Cancer*. 2015;15(6):321-333. doi:10.1038/nrc3932

Item 3

The failure by the TGA to independently investigate, which was further compounded by the failure to require complete sponsor findings in respect of **Stop Codon read-through** (suppression of stop codon activity) arising as a result of the use of pseudouridine in the Comirnaty miRNA active ingredient (mRNA genomic sequence), means the TGA never had before it critical information required for a full and proper assessment of Safety for the purpose of evaluating whether to grant Provisional Approval, nor has the Australian community been provided that same critical information for enabling fully Informed Consent to occur, which legal right

has therefore been denied the Australian community, on the following issues known by the TGA to involve significant and serious short-, medium-, and long-term safety risks in respect of Stop Codon read-through, namely:

The use of pseudouridine in mRNA vaccines was developed as a very recent concept and its long-term effects are unknown. It has however been known for 10 years that the use of pseudo-U causes the stop codons (required to stop adding amino acids to a protein chain) to misfunction, thereby elongating the protein chain and risking translation of the next segment (the 3'UTR) (Karijolich 2011). The effects of this are unknown and cannot be known without specific experiments to address them. Furthermore, the use of pseudo-U has major and unknown impacts on microRNA pathways and their concomitant cancer and other pathogenic risks and is a novel field of genomics about which very little is currently known (Lockhart 2019).

Karijolich J, Yu YT. Converting nonsense codons into sense codons by targeted pseudouridylation. *Nature*. 2011;474(7351):395-398. Published 2011 Jun 15. doi:10.1038/nature10165

Lockhart J, Canfield J, Mong EF, VanWye J, Totary-Jain H. Nucleotide Modification Alters MicroRNA-Dependent Silencing of MicroRNA Switches. *Mol Ther Nucleic Acids*. 2019;14:339-350. doi:10.1016/j.omtn.2018.12.007

Item 4

The failure by the TGA to independently investigate, which was further compounded by the failure to require complete sponsor findings in respect of the composition of the **final protein product** (molecular weight and amino acid sequence) produced following injection of the Comirnaty mRNA product in human subjects, means the TGA never had before it critical information required for a full and proper assessment of Safety for the purpose of evaluating whether to grant Provisional Approval, nor has the Australian community been provided that same critical information for enabling fully Informed Consent to occur, which legal right has therefore been denied the Australian community, on the following issues known by the TGA to involve significant and serious short-, medium-, and long-term safety risks in respect of the final protein product (molecular weight and amino acid sequence), namely:

It has been known for a number of years that the use of pseudouridine in mRNA can produce final protein products that are not as intended (Eyler 2019). In addition, the use of artificial 5' and 3' untranslated regions and other modifications can produce a final protein product that is not only inconsistent but different in length, shape and

function than that which was intended or predicted. The consequences of such changes are unknown but require investigation over long periods of time including clinical observations of participants of studies for 5-10 years. Failure to create known protein products in a robust and controlled manner can lead to unknown clinical effects including those relating to prion disease which may take many years to manifest (Moreno-Gonzalez 2011).

Eyler DE, Franco MK, Batool Z, et al. Pseudouridinylation of mRNA coding sequences alters translation. *Proc Natl Acad Sci U S A*. 2019;116(46):23068-23074. doi:10.1073/pnas.1821754116

Moreno-Gonzalez I, Soto C. Misfolded protein aggregates: mechanisms, structures and potential for disease transmission. *Semin Cell Dev Biol*. 2011;22(5):482-487. doi:10.1016/j.semcdb.2011.04.002

Smith K (2021) BNT162b2 Vaccine: Possible Codons Misreading, Errors in Protein Synthesis and Alternative Splicing's Anomalies. J Antivir Antiretrovir. 13:210.

Item 5

The failure by the TGA to independently investigate, which was further compounded by the failure to require complete sponsor findings in respect of the risk of the use of the **AES-mtRNR1 3'** untranslated region of the Comirnaty mRNA product in human subjects, means the TGA never had before it critical information required for a full and proper assessment of Safety for the purpose of evaluating whether to grant Provisional Approval, nor has the Australian community been provided that same critical information for enabling fully Informed Consent to occur, which legal right has therefore been denied the Australian community, on the following issues known by the TGA to involve significant and serious short-, medium-, and long-term safety risks in respect of the use of the AES-mtRNR1 3' untranslated region of the Comirnaty mRNA product in human subjects, namely:

mRNA vaccines comprise a genomic sequence of interest (in this case, the SARS-CoV-2 spike gene) bounded by untranslated regions (UTR) (5' preceding and 3' following) which can be modified to act as biological adjuvants to increase or modify protein production. In the case of the Pfizer vaccine the 3' UTR (comprising human genomic sequences for AES-mtRNR1) was first developed in around 2018 and the first published use in any animal was in 2019 (Orlandini von Niessen 2019). There were no human studies subsequent to this publication and prior to the combined phase 1-2-3 study the results of which were provided to the TGA for approval. There are therefore no long-term safety studies for this 3'UTR (biological adjuvant).

The Pfizer 3'UTR comprises sequences of human RNA from AES (a tumour suppressor gene) and mtRNR1 (human mitochondrial RNA). Because the intention of any vaccine is to produce immunity against the introduced foreign entity the use of these fragments raises the possibility that immunity may be formed either against the RNA itself (which is 100% homologous to human RNA) or to any peptide products that might be formed due to stop codon read through (see items 3, 4 above). Should this happen the possibility of lupus-related autoimmunity or any other autoimmunity against mitochondrial-dense tissue (such as the heart) becomes a potentially catastrophic risk, given the essential role of mitochondria to the function of major organs. The mechanism of autoimmune disease following Covid-19 vaccination is unknown but is well documented and one of many mechanisms maybe due to anti-mitochondrial antibody formation (Ghielmetti 2021) in the short term. Autoimmunity against AES, which is a tumour suppressor gene, may equally increase the risk of cancers in the long term.

Orlandini von Niessen AG, Poleganov MA, Rechner C, et al. Improving mRNA-Based Therapeutic Gene Delivery by Expression-Augmenting 3' UTRs Identified by Cellular Library Screening. *Mol Ther*. 2019;27(4):824-836. doi:10.1016/j.ymthe.2018.12.011

Ghielmetti M, Schaufelberger HD, Mieli-Vergani G, et al. Acute autoimmune-like hepatitis with atypical anti-mitochondrial antibody after mRNA COVID-19 vaccination: A novel clinical entity?. *J Autoimmun*. 2021;123:102706. doi:10.1016/j.jaut.2021.102706

Vaccine generated spike proteins entering human cell nucleus

Is *the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health aware of a Swedish in vitro study, published in October 2021 that found that a "surprising ... abundance" of full length spike proteins coded for by the gene-based vaccines and produced in the cytoplasm, migrated into the cell nucleus (* https://pubmed.ncbi.nlm.nih.gov/34696485/ *)?* This was not supposed to happen.

The authors state that once inside the cell nucleus, the spike proteins disrupted "DNA damage repair, especially (that) which lies at the core of B and T cell immunity". They said:

> "Our findings provide evidence of the spike protein hijacking the DNA repair mechanisms machinery and adaptive machinery in vitro. We propose a potential mechanism by which spike proteins may impair adaptive immunity by inhibiting DNA damage repair. ... Our findings also imply a potential side effect of the full-length spike-based vaccine."

Dr Mikolaj Raszek, geneticist and biochemist, explains, in his regular YouTube vlog (https://www.youtube.com/watch?v=WmeWdc6-mwg) that the TGA's own document regarding Pfizer's mRNA vaccine, (Nonclinical Evaluation Report PM-2020-05461-1-2, Annexure D) on page 35 includes results from "Study no. R-20-0360: Analysis of expression of antigens from the mRNA constructs encoding S protein", that shows blue immunofluorescence in the microscopy of transfected cells indicating spike protein within the cell nucleus. This confirms the Swedish study of Pfizer mRNA vaccine created spike proteins entering the cell nucleus in large numbers.

That spike proteins disrupt DNA repair mechanisms is potentially catastrophic for health. *Will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health be investigating these findings further? Were you aware that the Nonclinical Evaluation Report on page 35 had this evidence?* If so, *when was the TGA aware that this finding indicated spike proteins had migrated into the human cell nucleus?*

What action will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health be taking based on this serious finding of risk of DNA repair disruption?

Evidence that mRNA vaccines can be reverse transcribed in human cells

On 23 April 2021 soon after the commencement of the Pfizer and AstraZeneca vaccine rollout, the Australian government department of health on its health.gov.au website reassured clinicians and the public that:

> "DNA is stored in the protected centre of our cells – the nucleus. The mRNA is broken down quickly by the body. It never enters the nucleus, and cannot affect or combine with our DNA in any way to change our genetic code."

However, a Swedish research article by Aldén et al., published 25 February 2022 in *Current Issues in Molecular Biology,* found evidence that the mRNA sequences from the Pfizer vaccine responsible for coding for the spike protein, are in fact reverse-transcribed into DNA within a human cell line. Given that the authors demonstrated a robust response with a factor known to affect the reorganisation of genomic material, this suggested a very real possibility

that the RNA sequence from the vaccine may be incorporated into the host cell's genetic material. This has frightening implications for life-long production of spike proteins within human cells and, if integrated into egg and sperm cells – for intergenerational transmission (Annexure K). The authors note in the abstract:

> "We also show that BNT162b2 mRNA is reverse transcribed intracellularly into DNA in as fast as 6 h upon BNT162b@ exposure."

Given this serious finding of the possibility of genetic modification and pollution of the human genome with foreign genetic material making a toxic protein, *will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health investigate this finding? Will you all issue an advisory warning and take action to halt further harm while investigating this finding?*

High Pfizer vaccine adverse events data known to the FDA

A FOIA request in the US to the FDA has revealed that the FDA and Pfizer did not make public significant adverse event data from the early rollout of Pfizer to 28 February 2021 (https://phmpt.org/wp-content/uploads/2021/11/5.3.6-postmarketing-experience.pdf).

When did the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health become aware of this data?

Historically unprecedented reports of Adverse Events

It has become abundantly clear to the CMN, that the world has never before witnessed this scale of unprecedented Adverse Event reporting, in respect of only these unique and experimental gene-based vaccines. It has now become trite to the point of insulting, for any regulator to continue to assert that ***"correlation is not causation"***, and ***"Adverse Event reporting systems such as the TGA's DAEN are not reliable".*** The deviation from prior norms for reports on all other vaccines and medications to such Adverse Event databases breaks statistical records.

We contend the TGA message of 'mild and rare events' associated with the vaccines is not matching the data, nor what is being seen in clinical settings. Throughout 2021 and

continuing unabated into 2022, Australians mostly with the assistance of their physician, are reporting extraordinary numbers of injuries and illnesses suffered and continuing to be suffered from these vaccines, together with recorded deaths from these vaccines, which appear to have likely exceeded deaths from Covid-19 in 2021.

The very troubling lack of transparency or sufficiently detailed explanations for why these adverse event report numbers, as shown in Annexures L & M, should not be of paramount concern to a medical community required to administer these vaccines, has not been adequately addressed by the TGA. Why is the sheer volume of these adverse event reports, to the TGA's own DAEN database, somehow acceptable to the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers and Minister of Health, and when will it be adequately divulged and explained to the Australian medical community?

The medical community, whilst initially split over accepting or not the 'safe and effective' assurances regarding experimental gene-based vaccines, is increasingly alarmed as they witness these adverse events. There are now over 109,000 reports of illness, injury, and to date, over 765 deaths possibly causally due to these vaccines. Nothing approaching these data has historically been seen in the DAEN system for other vaccines or drugs. In contrast, Australia averaged just 2.4 deaths per year in respect of traditional protein based vaccines (https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-17-02-2022).

To dismiss these DAEN reports as likely of little consequence, as you, Professor Skerritt, have done in response to Questions on Notice from members of parliament, neglects the fact that they mirror similar patterns of injury reported to the US VAERS, UK Yellow Card, EU Eudravigilance and WHO VigiAccess adverse event databases, and also to the FDA's own Pfizer adverse event data.

The website (https://openvaers.com/covid-data) collates VAERS data each week. A quick glance shows the contrast in reported mortality for the gene-based Covid-19 vaccines compared to ***all*** other vaccines combined since 1990 (fig. 1):

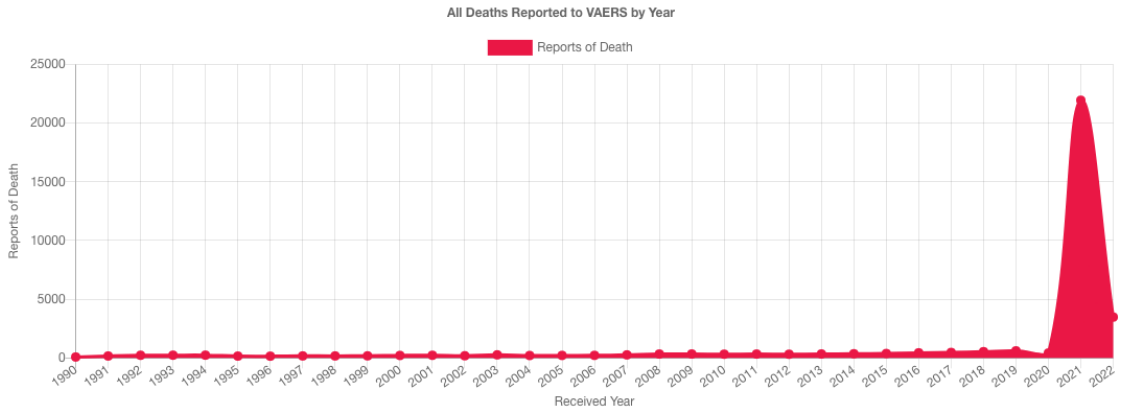


Fig 1: All reported potential vaccine deaths to VAERS since 1990

More granular analyses of the VAERS data by virologist, molecular biologist, mathematician and biostatistical data analyst, Dr Jessica Rose, reveals that age stratified data effects younger adults at the highest rate. As younger adults cope with the Covid-19 virus relatively well, this further increases the unfavourable risk/benefit ratio for the gene-based Covid-19 vaccines for those younger than the elderly. For example (fig. 2), age stratified neurological adverse events normalised to adverse events per 100,000 doses for the 440,175 neurological reports from 319,983 individual cases (https://jessicar.substack.com/p/the-grouped-aes-what-do-they-tell?s=r).

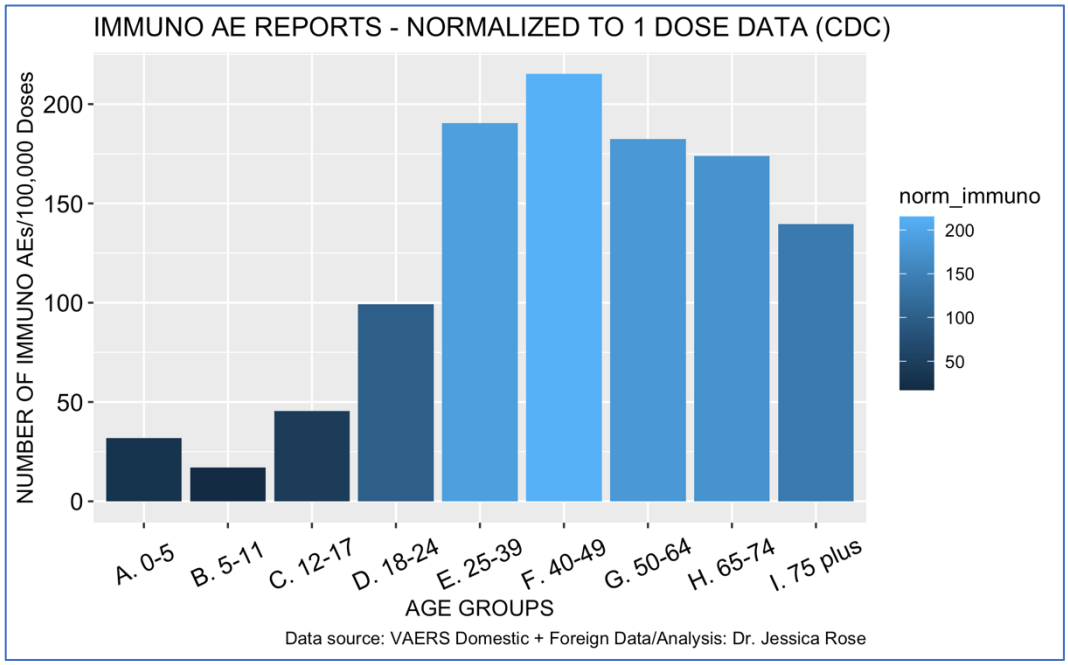


Fig 2: Neurological Adverse Events to VAERS by age per 100,000 doses

Postulated mechanisms of action of gene-based vaccine injuries are making their way into the published literature and in case reports. Anonymous pathologist, Dr John B., has collated hundreds of relevant papers and case reports (https://twitter.com/DrJohnB2 , t.me/DrJohnB), and plausible modes of action are increasingly identified. Of equal import is yet another collection currently holding over 1,000 peer-reviewed papers, speaking to a multitude of adverse events being experienced by Covid-19 vaccine recipients: (https://avn.org.au/peer-reviewed-medical-papers-for-adverse-events-in-covid-19-vaccine-recipients/).

FOI-3586 is a request to the TGA for data on the deaths reported as possibly related to the Covid-19 vaccines, it is 196 pages long and available online (https://www.tga.gov.au/sites/default/files/foi-3586-01.pdf). It is almost completely redacted and zero information is available apart from ages of the deceased. *Will the Deputy Secretary, Health Products Regulatory Group or any TGA officer with jurisdiction give reasons for redacting so much data? Will they consider releasing more data, particularly of causes of death, in the public and scientific interest?* FOI-3586 is discussed in more detail below.

The DAEN Under-Reporting Issue

The TGA acknowledges DAEN is affected by under-reporting, but in the critical context of rolling out an experimental vaccine into the Australian community, continues to refuse to adequately address or accurately quantify the true extent of this data shortcoming, thereby further compromising every individual Australian's right and ability to give Informed Consent.

Perhaps the Covid Medical Network can assist the TGA and Deputy Secretary in this regard.

In Germany Adverse Event reporting is compiled by PEI, the Paul-Ehrlrich Institute, much like the United States' VAERS and the Australian DAEN.

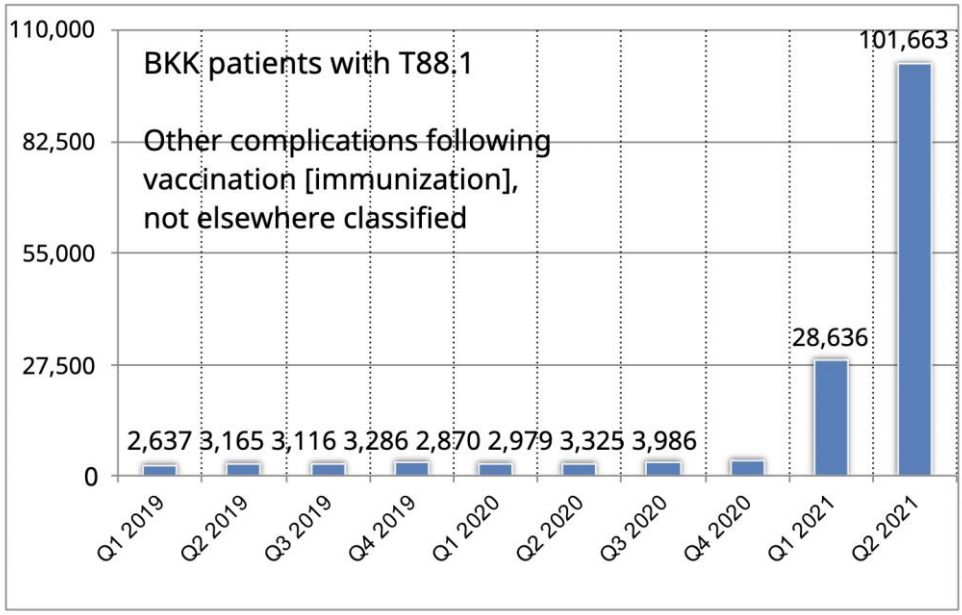
In Annexure N1 & N2 can be viewed the English machine translation of a 21 February 2022 letter from German insurer group BKK ProVita, addressed to Professor Klaus Cichutek of the PEI. BKK Provita accessed anonymised doctor billing records of over 10Million German citizens, searching for several input codes that showed where patients presented adverse event issues following Covid-19 vaccination. This enabled BKK Provita, using substantial actuarial resources, to conclude the following:

1. PEI, who has had the same access to the doctor billing data, has nonetheless been publicly under-reporting Covid-19 vaccine adverse events by a factor of approximately 7.5x; and
2. BKK Provita showed that 4-5% of Covid-19 vaccinated people were assessed or received treatment for Covid-19 vaccine side-effects.

The BKK data of its patients has been posted online (https://journal.rajeshtaylor.com/german-insurer-bkk-provita-board-member-whistleblows-the-covid-vaccination-fraud-to-federal-ministry-of-health/). The graphs show a familiar pattern, replicating that of national vaccine injury databases, where adverse reactions (fig. 1) to vaccines have an enormous increase after the rollout of the gene-based Covid-19 vaccines. They also show a marked increase for "infections" (fig. 2), suggesting some immune compromise occurring with this large cohort of German patients.

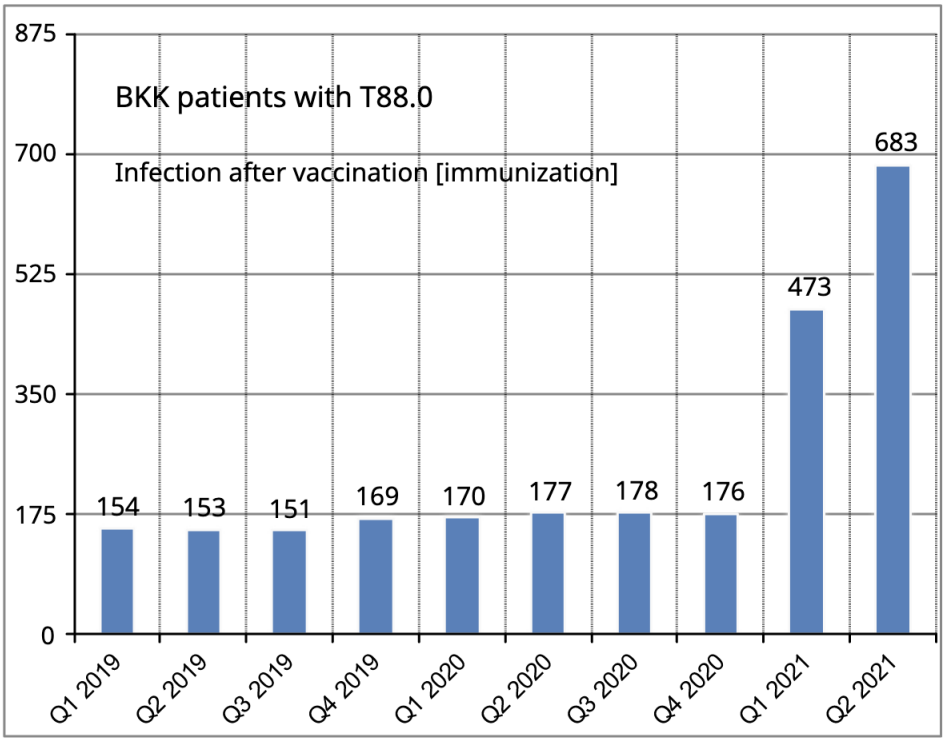
The advantage of this data is it provides a longitudinal analysis of the health of a defined population, namely the patients of a German health insurance company that keeps detailed data. This is similar to the US DMED data.

Graphs from the BKK data release, translated into English by Dr Jessica Rose (https://jessicar.substack.com/p/some-insurance-company-data-from?s=r):



Graphical representation only for quarter 1 and quarter 2 in 2021.

Fig. 1 BKK German health insured patients adverse events following vaccination



Graphical representation only for quarter 1 and quarter 2 in 2021.

Fig. 2: BKK German health insured patients "infections" following vaccination

In light of the high standards and integrity employed by insurance companies around the world when undertaking statistical analysis of this kind, and the very large number of billing records accessed, together with the complementary evidence coming from other publicly listed insurance companies (see further below), the CMN is confident that the BKK Provita analysis is the best available to date.

Therefore when the BKK Provita analysis is applied to our Australian population of 25.69M, we find the following:

> Population aged 15 years and older is 80.7% = 20.734.5M
>
> Applying the BKK finding of 4.5% at a mean 4.5% of 20.734.5M = 933,052
>
> That is, 933,052 Australians quite possibly having experienced adverse effects requiring or capable of requiring medical treatment after receiving Covid-19 vaccines.
>
> To date the Australian DAEN system shows just 109,000 Adverse Event reports. Therefore the true figure could in fact be under-reported by a factor of 9x.

CMN is well aware of the concerted pressure being placed upon public hospital doctors and nurses, to be dismissive of patients reporting adverse events post-vaccination. This under-reporting factor must also impact reported deaths from the Covid-19 vaccines.

Equally, the under-reporting factor is further exacerbated by the TGA's own admissions, that the publicly available DAEN figures on Covid-19 adverse events can at times be lagging by up to as much as 3 months, which amounts to a significant and gross data deficit for medical practitioners and members of the general public. The practitioners are being denied proper and prompt professional advice on adverse events related to these vaccines, and the public is further denied the full menu of information on which to give true Informed Consent.

In light of these many factors continuing to obscure the true number of deaths due to Covid-19 vaccines in Australia to date, the CMN provides the following:

1. The under-reporting factor of 9x applied to 769 reported deaths to 28 February 2022 = 6,921 deaths (https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-24-02-2022)
2. Application of the German post-vaccination autopsy findings (see below), establishing a causal relationship to Covid-19 vaccines in 30-40% of cases, where taking the mean of 35% applied to 6,921 would equate to 2,422 deaths.

Therefore based upon current best and available evidence, the CMN believe as many as 2,422 Australians have died because of Covid-19 vaccines.

This would mean for Australians who do not have the Covid-19 vulnerabilities of morbid obesity, diabetes and frail elderly status, likely more have died from Covid-19 vaccines than from Covid-19 illness.

However the true state of affairs may be much worse, and possibly with the full knowledge of some individuals. We refer to the TGA's FOI disclosure log, and particularly FOI document numbered 3586, found here: https://www.tga.gov.au/foi-disclosure-log . Document 3586 was returned in answer to the following question:

> "The age of deceased for all reported adverse events resulting in death for events reported against any of the TGA approved COVID-19 vaccines."

Document 3586 contains 197 pages, 169 pages are fully redacted, and 28 pages partially redacted. Of the 28 partially redacted pages, there are 33 reports per page. Those 28 pages show a total of 924 reports of death following Covid-19 vaccination.

Therefore the remaining 169 pages contain a further approximately 5,577 cases.

As the question above was quite specific, we see no reason why these additional 169 pages were produced other than to be responsive, and therefore represent reports of deaths following Covid-19 vaccination. *We request the Deputy Secretary and TGA officers that the TGA please un-redact the document, so it can be seen whether the extra pages include reports of suspected or possible Covid-19 gene-based vaccine deaths or not.*

So in total document 3586 is prima facie evidence of 5,577 + 924 = 6,501 reports of death following Covid-19 vaccination. Which leaves the CMN confronted with the real possibility that as many as 6,501 Australians have died as a consequence of Covid-19 vaccination.

If we apply the findings of the German pathologists mentioned, taking the mean of 35% applied to 6,501 we arrive at 2,275 deaths causally due to Covid-19 vaccination.

However until such time as the Secretary, Deputy Secretary, senior TGA officers, or Government Ministers clarify the true state of affairs, the CMN applies the Precautionary Principle and concludes:

> ***Australians likely to have died as a consequence of receiving a Covid-19 vaccination appear to number somewhere between 2,275 and 6,501.***

Again, for Australians who do not have the Covid-19 vulnerabilities of morbid obesity, diabetes and frail elderly status, this likely means that more have died from Covid-19 vaccines than from Covid-19 illness.

This is an abominable state of affairs, bereft of any notion the Hippocratic Oath or the upholding of the Precautionary Principle as alive and well in Australia. Nothing could be further from the truth, in an environment now driven by public health institutions and their officers, extolling politicised and compromised information, at the expense of truth, any respect for Informed Consent, let alone respecting the once sacred and honoured and inviolable doctor-patient relationship.

The CMN invites the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health to clearly and fully correct any and all errors in the above assessment.

All-Cause Mortality rise commensurate with Covid-19 vaccines

Country level data is confirming the data coming from insurance companies. All-Cause Mortality is the single most important metric, not Covid mortality, particularly when governments the world over have been found purposefully skewing Covid mortality through the trick of *'died with Covid'*, while lacking proper testing for correctly determining cases of *'died from Covid'*.

The CMN is concerned that this manipulation and bloating of Covid mortality rates might have been intentionally orchestrated to instil fear in the general community, in order to spur on vaccine uptake.

Excess Mortality in the UK

The United Kingdom led the charge into Covid-19 vaccinations early, therefore their All-Cause Mortality data is more robust. The below charts (figs. 1 – 6) were created from data compiled by the UK Office of National Statistics, released 20 December 2021, see:

Deaths involving COVID-19 by vaccination status, England: deaths occurring between 1 January and 31 October 2021

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19byvaccinationstatusengland/deathsoccurringbetween1januaryand31october2021/

The charts speak for themselves.

Source: https://metatron.substack.com/p/deaths-involving-covid-19-by-vaccination?token=eyJ1c2VyX2lkIjoyMzgxNDYxMywicG9zdF9pZCI6NDU3NTQ5MDMsIl8iOiJrOUk2OCIsImlhdCI6MTY0MDAyNzc0MiwiZXhwIjoxNjQwMDMxMzQyLCJpc3MiOiJwdWItNTc5MDg1Iiwic3ViIjoicG9zdC1yZWFjdGlvbiJ9.pu5qoClav4aFVOWG3W9By6Y9N3Ji3HLarcZBr5eaQV8&utm_source=url

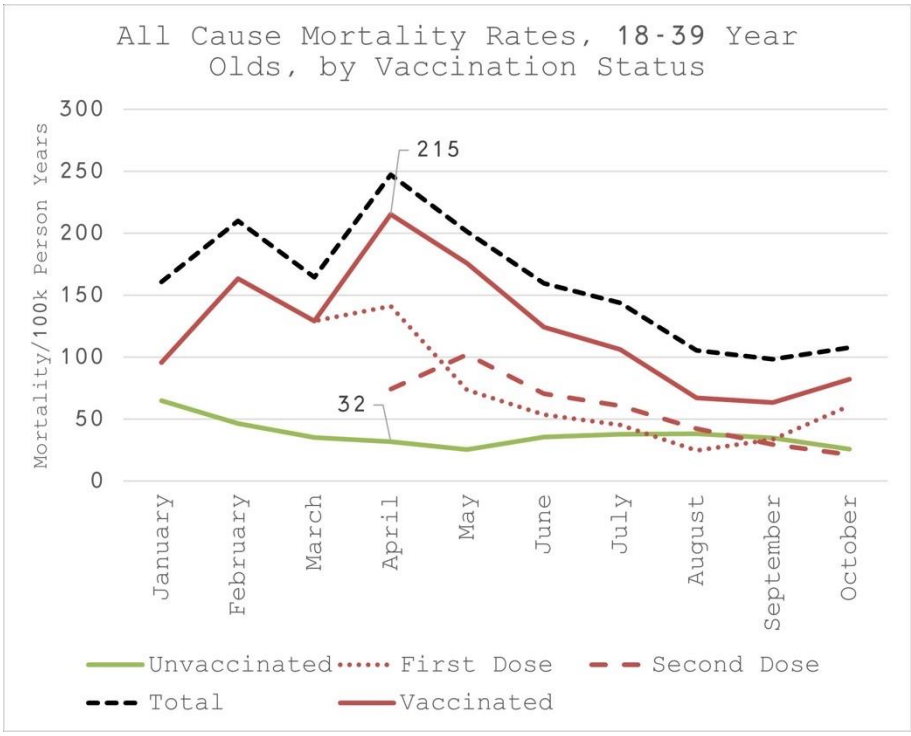


Fig. 1: All-Cause Mortality 1 January to 31 October 2021 ages 18–39 years
Rate of death up to 7 times higher in Vaccinated versus Unvaccinated.

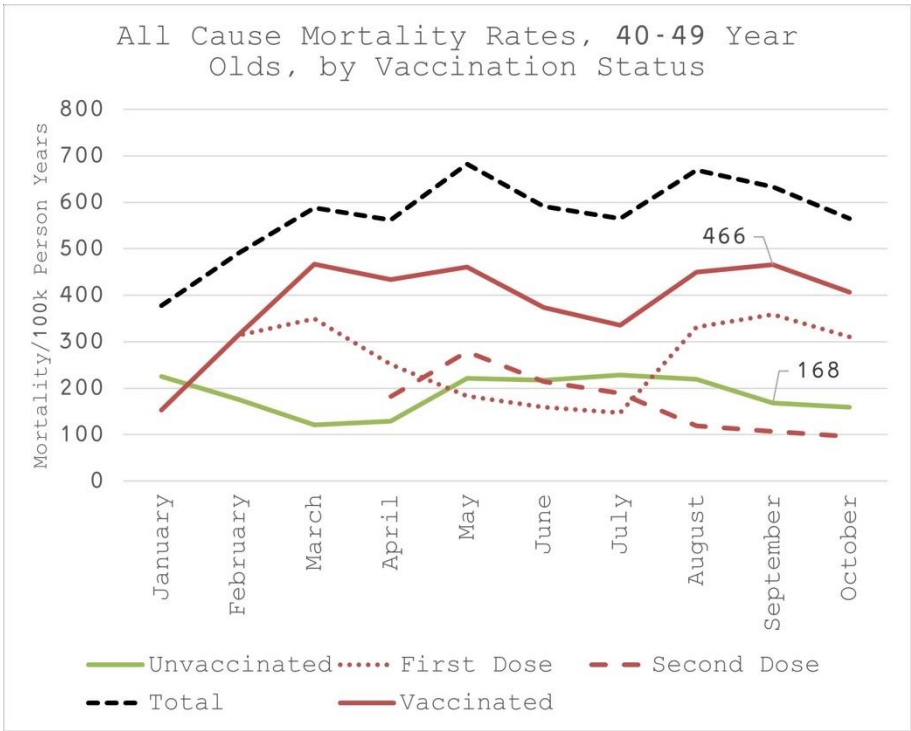


Fig. 2: All-Cause Mortality 1 January to 31 October 2021 ages 40–49 years
Rate of Death up to 3.7 times higher in Vaccinated versus Unvaccinated.

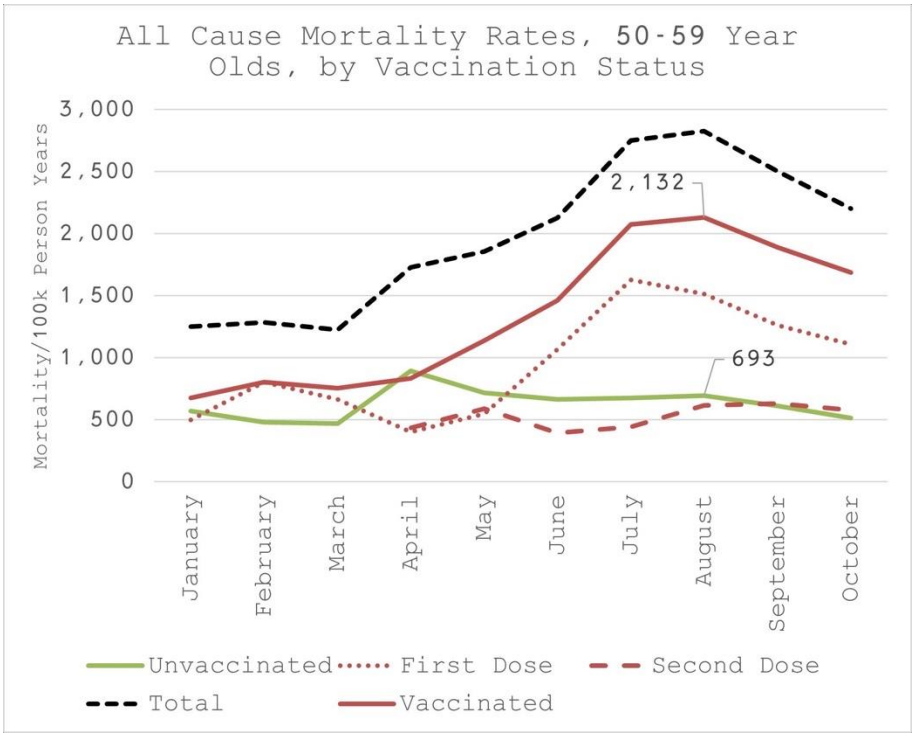


Fig. 3: All-Cause Mortality 1 January to 31 October 2021 ages 50–59 years
Rate of death up to 3 times higher in Vaccinated than Unvaccinated.

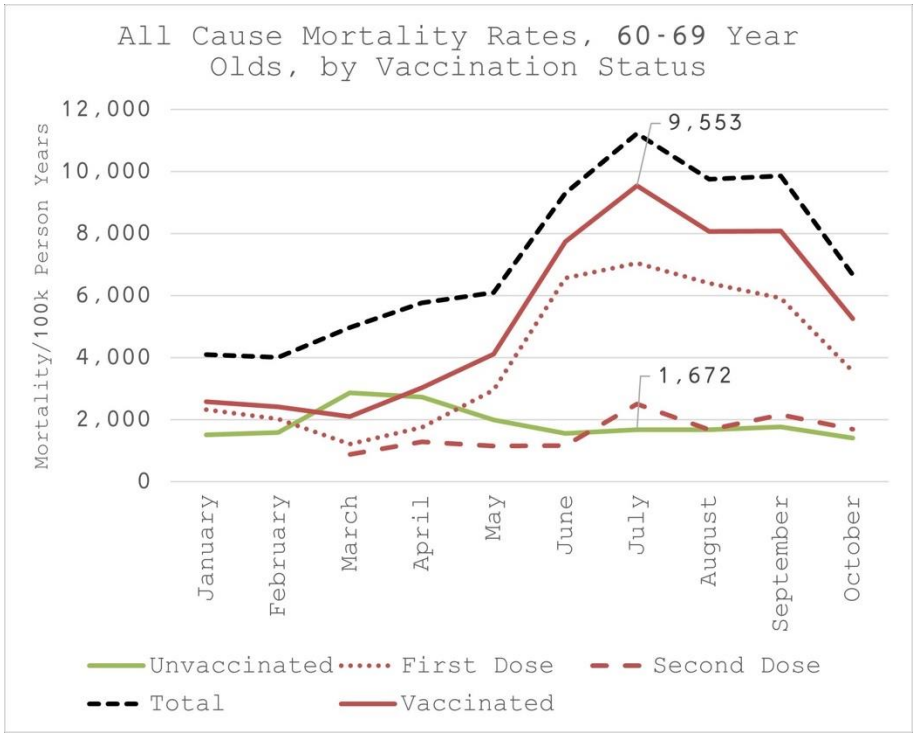
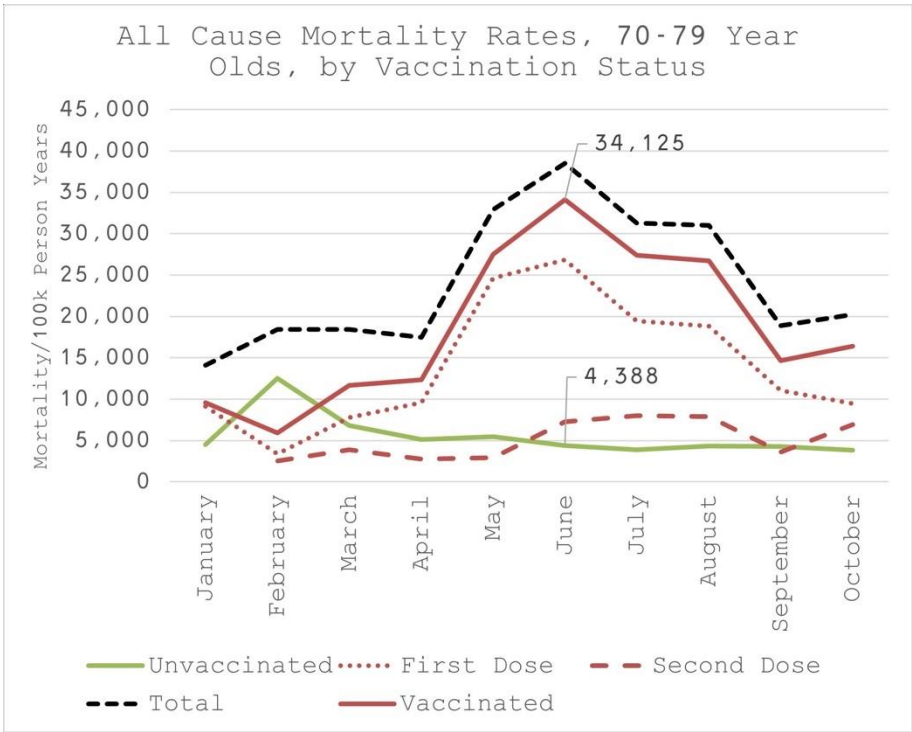


Fig. 4: All-Cause Mortality: 1 January to 31 October 2021 age 60–69 years:
Rate of Death up to 5.7 times higher in Vaccinated versus Unvaccinated.



5:All-Cause Mortality 1 January to 31 October 2021 ages 70–79 years:
Rate of Death up to 7.8 times higher in Vaccinated versus Unvaccinated.

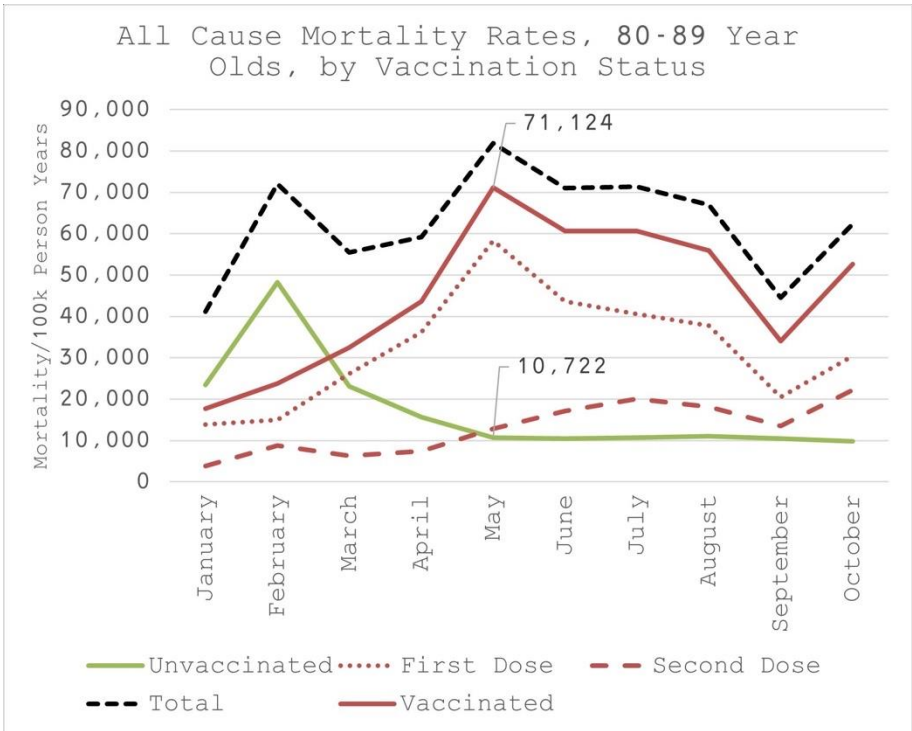


Fig. 6: All-Cause Mortality 1 January to 31 October 2021 ages 80–89 years:
Rate of Death up to 6.6 times higher in Vaccinated versus Unvaccinated.

The above charts clearly evidence Covid-19 vaccines only had demonstratively fatal consequences in terms of All-Cause Mortality. In the UK Covid-19 vaccines did not, on the whole, save the elderly and frail, nor did they ever prove to be safe and effective.

This conclusion is supported by Professors Ian Neil and Norman Fenton and colleagues with expertise in statistical analysis from St Mary's College, the University of London, in a paper titled: "Official mortality data for England suggest systemic miscategorisation of vaccine status and uncertain effectiveness of Covid-19 vaccination" (https://www.researchgate.net/publication/357778435_Official_mortality_data_for_England_suggest_systematic_miscategorisation_of_vaccine_status_and_uncertain_effectiveness_of_Covid-19_vaccination).

Their analysis of the British ONS (Office for National Statistics) data led them to conclude there were major inconsistencies in the way the data was being reported. Their paper arrives at similar graphs to those above. In considering the inconsistencies they:

> "... applied adjustments to the ONS data and showed that they lead to the conclusion that the vaccines do not reduce all-cause mortality, but rather produce genuine spikes in all-cause mortality shortly after vaccination." (p. 25)

Excess Mortality in Europe

A brief look at Excess Mortality in Europe (deaths exceeding average All-Cause Mortality occurring in prior years), depicts an equally fatal outcome in 29 European countries throughout 2021 (figs. 7 – 10) (https://euromomo.eu/graphs-and-maps/#excess-mortality).

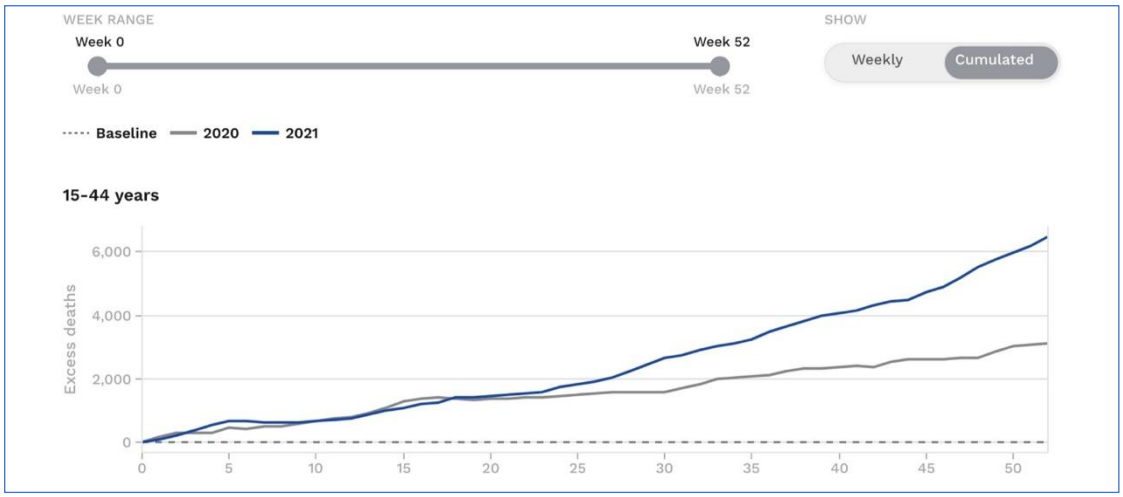


Fig. 7: Excess mortality Europe 2020 (grey), 2021 (blue) ages 15-44.

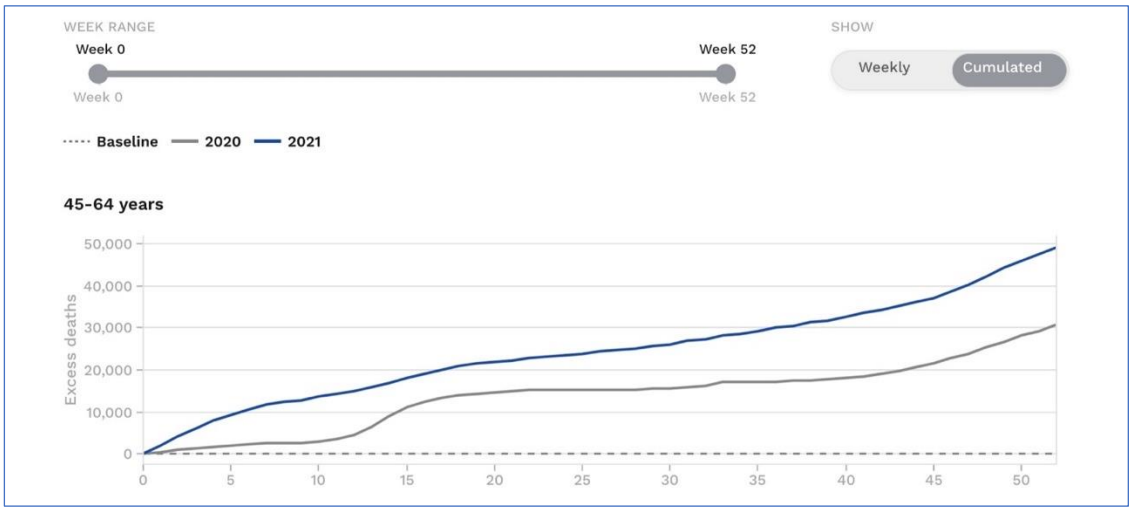


Fig. 8: Excess mortality Europe 2020 (grey), 2021 (blue) ages 45-64.

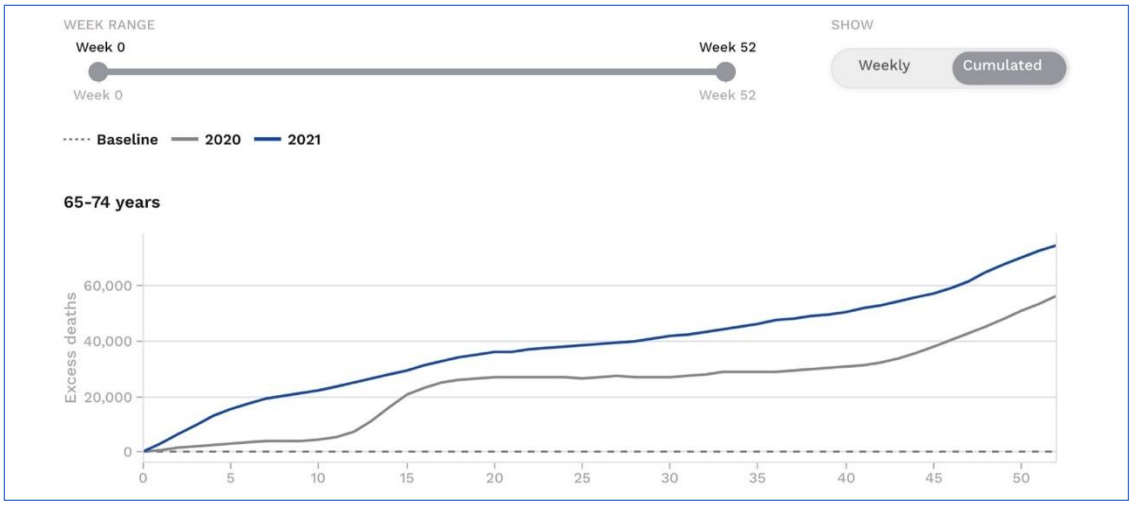


Fig. 9: Excess mortality Europe 2020 (grey), 2021 (blue) ages 65-74.

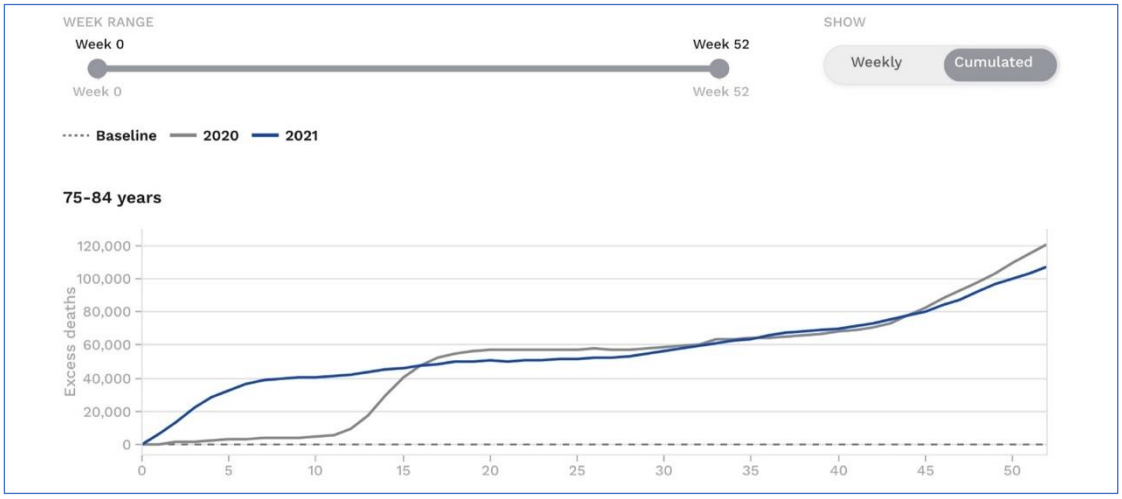


Fig. 10: Excess mortality Europe 2020 (grey), 2021 (blue) ages 75-84.

The above charts simply illustrate the rollout of Covid-19 vaccines ***increased*** Excess Deaths across Europe, across all age groups, during a year when a ***less lethal*** SARS-COV-2 variant of concern, Delta, swept across the globe.

Yet despite this clear evidence from government-compiled data that the cure is worse than the disease, which was available for the internal attention of authorities everywhere, including the TGA, from at least mid-2021, government officials and agencies continued to message relentlessly that these Covid-19 vaccines were, and are, Safe and Effective.

Note: the Excess Deaths across Europe continue unabated into 2022, with the Omicron variant which evades these Covid-19 vaccines, and more severely impacts the Vaccinated. In contrast, the Unvaccinated are showing symptoms akin to mild Influenza (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00090-3/fulltext#sec1).

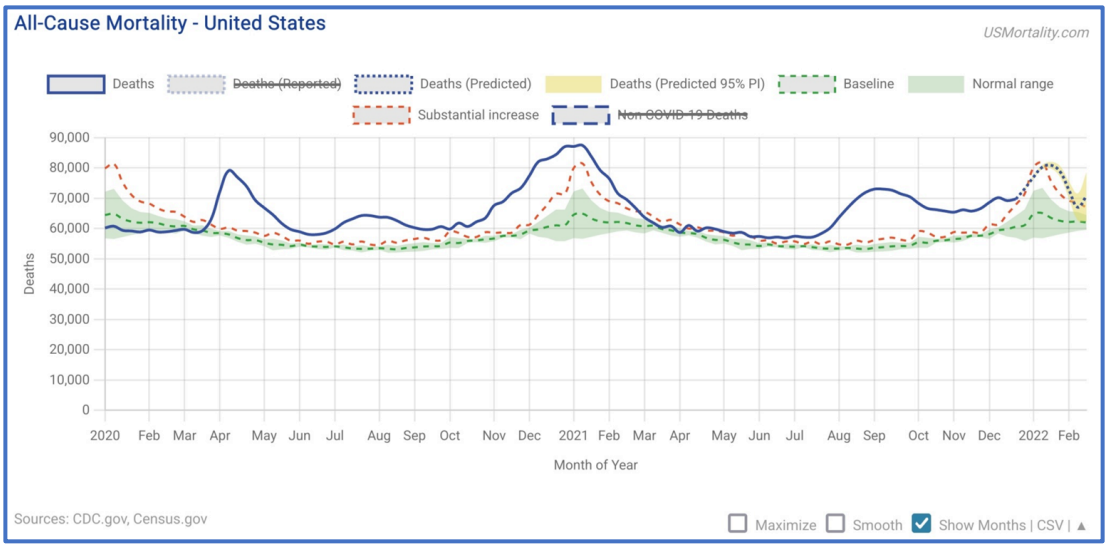
Further, European mortality graphs showing the weekly excess deaths (deviation in mortality from the expected level) for the past years, all ages and by age groups show:

1. There were increase waves of deaths in 2020 commensurate with the waves of Covid-19.
2. There were greater increases waves of deaths in 2021, compared to 2020, particularly in younger age cohorts, commensurate with the vaccine rollouts, see: https://euromomo.eu/graphs-and-maps/ .

Increase in All-Cause Mortality in the United States 2020 and 2021

As the graph below shows, there was a rise above the normal range for All-Cause Mortality in the USA during the initial Covid-19 wave in March-May 2020, sustained at a lower level through the US summer and then rising with a seasonal winter bulge in November 2020 to February 2021. However, a further large and sustained rise occurred from late July 2021, much higher than the corresponding 2020 summer. By late-July 2021 50% of the US population had received two doses of gene-based vaccines.

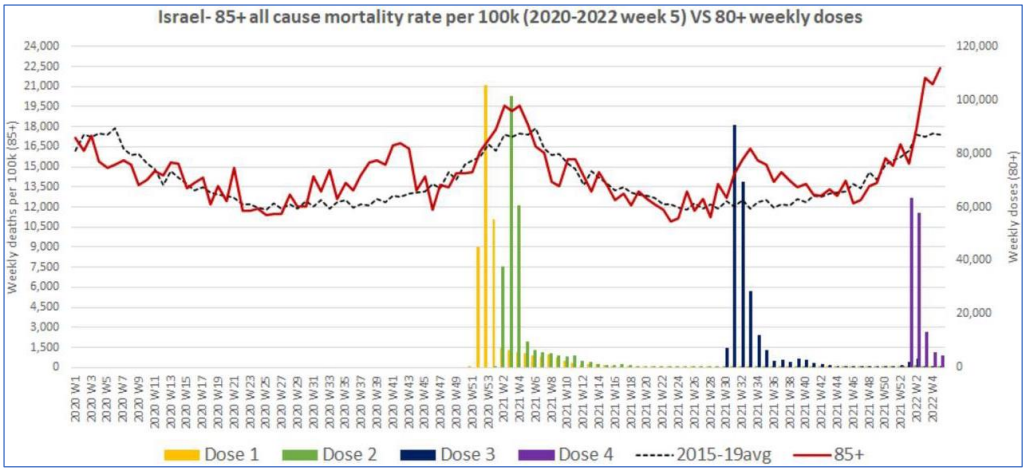
Aetiological factors for the US include Covid-19, ‘deaths of despair’ particularly opioid overdoses given impacts on the US economy of lockdowns, but the pattern, commensurate with the VAERS data, the DMED data and US insurance actuarial data, suggests the gene-based vaccines are playing a role.



Israeli 85+ years-old age group

Professors Neil and Fenton et al. have noted that official data often labels hospitalisations and deaths as 'unvaccinated' when within 2 weeks of a vaccine dose, or sometimes until 2 weeks after the second dose. The rationale for this being that antibodies need to rise for immunity. However, the VAERS and other adverse event reporting system databases show the majority of deaths reported as possibly vaccine-related, occur within the fortnight post vaccine dose.

Israeli data for the elderly show, in late 2020, all deaths were above the previous 5-year trend line, correlating with the Covid-19 pandemic. During periods in 2021 deaths returned to trend line, indicating vaccines probably providing protection from a couple of weeks post second dose and a few weeks post first booster. However, peaks of All-Cause Mortality occurred during and immediately after the initial doses and both booster doses. The present large rise post second booster (fourth dose) is of grave concern, as in the chart below:



Australian All-Cause Mortality 2020 and 2021

2020

In 2020 during the outbreak of SARS-COV-2 there was in fact a decrease in All-Cause Mortality in Australia. Although recent research from Johns Hopkins University in the US indicated lockdowns and Covid-19 restrictions in most nations did very little to stop the spread of the virus (https://sites.krieger.jhu.edu/iae/files/2022/01/A-Literature-Review-and-Meta-Analysis-of-the-Effects-of-Lockdowns-on-COVID-19-Mortality.pdf), Australia's international and internal border closures and fairly early contact tracing measures provided a more prolonged 'flattening of the curve'.

The other reason for the Covid-19 pandemic not producing an increase in All-Cause Mortality in Australia in 2020 and only a marginal to modest increase in many other nations, is the fact the lethality of Covid-19 targets mostly the frail elderly. As data from other nations indicated, average age of death from Covid-19 often equates to average life-expectancy. That is not the hallmark of a severe all-ages pandemic. This point was made in the Great Barrington Declaration by epidemiologists, public health scientists and thousands of other clinicians and scientists (https://gbdeclaration.org/).

COVID-19 was only the 38th leading cause of death (898 deaths) in Australia 2020. The median age of death associated with Covid-19 was 86 years, and death occurred in persons already experiencing chronic cardiac conditions, hypertension and/or diabetes prior to death. Indeed three times (3×) more people died from accidental falls than from Covid-19, see: https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release .

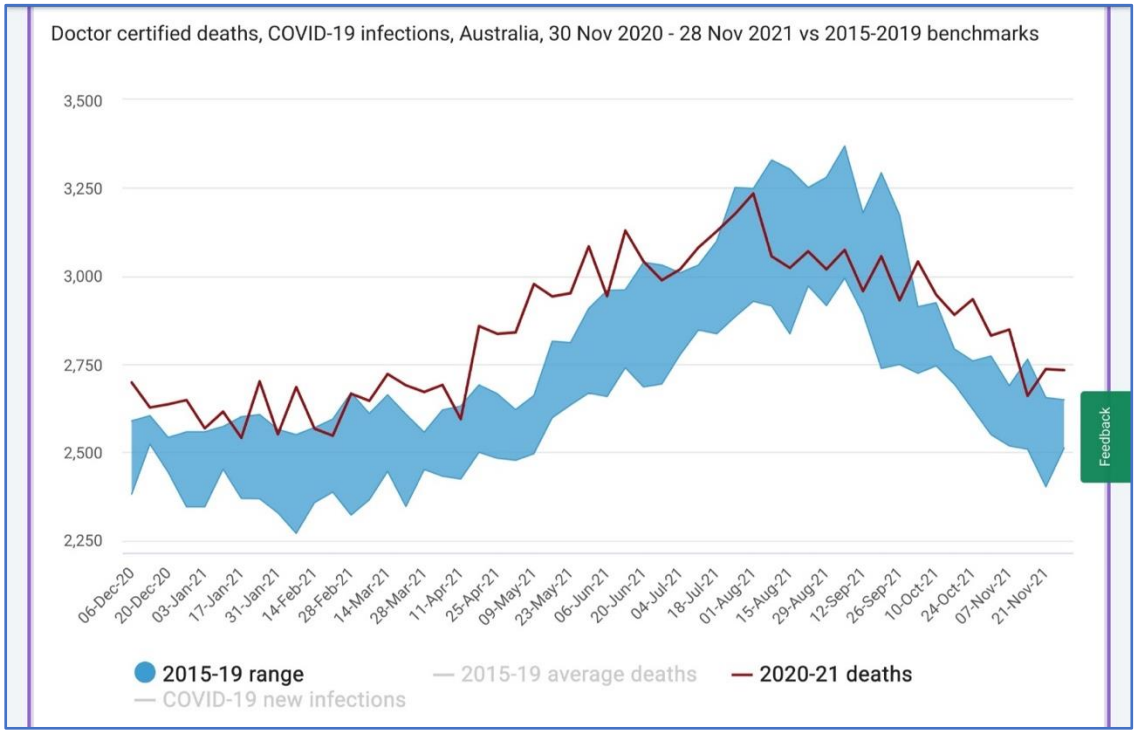
2021

In contrast to 2020, and commensurate with the rollout of Covid-19 vaccines in Australia we are confronted with a seriously concerning set of data. During the period 1 January through end of November 2021 Australian health authorities and politicians promoting Covid-19 vaccines need to explain the following:

There were 6,949 deaths (5.4%) more than the 2015-19 average, and

There were 6,264 deaths (4.8%) more than in 2020.

See: https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/latest-release .



Australian All-Cause Mortality – 2015-2019 range blue band, Dec 2020 – Nov 2021 red line

Recall that in 2020 a significantly more virulent and dangerous variant of SARS-COV-2 prevailed. When Covid-19 vaccines became available throughout 2021, the more infectious but less virulent and less lethal Delta, and later, much less virulent and less lethal Omicron variants of SARS-CoV-2 had begun to circulate (see section on Scandinavian and Kaiser Permanente health insurer data on the relatively benign nature of Omicron on p. 38 below). Yet Australian All-Cause Mortality was 4.8% higher in 2021 than in 2020.

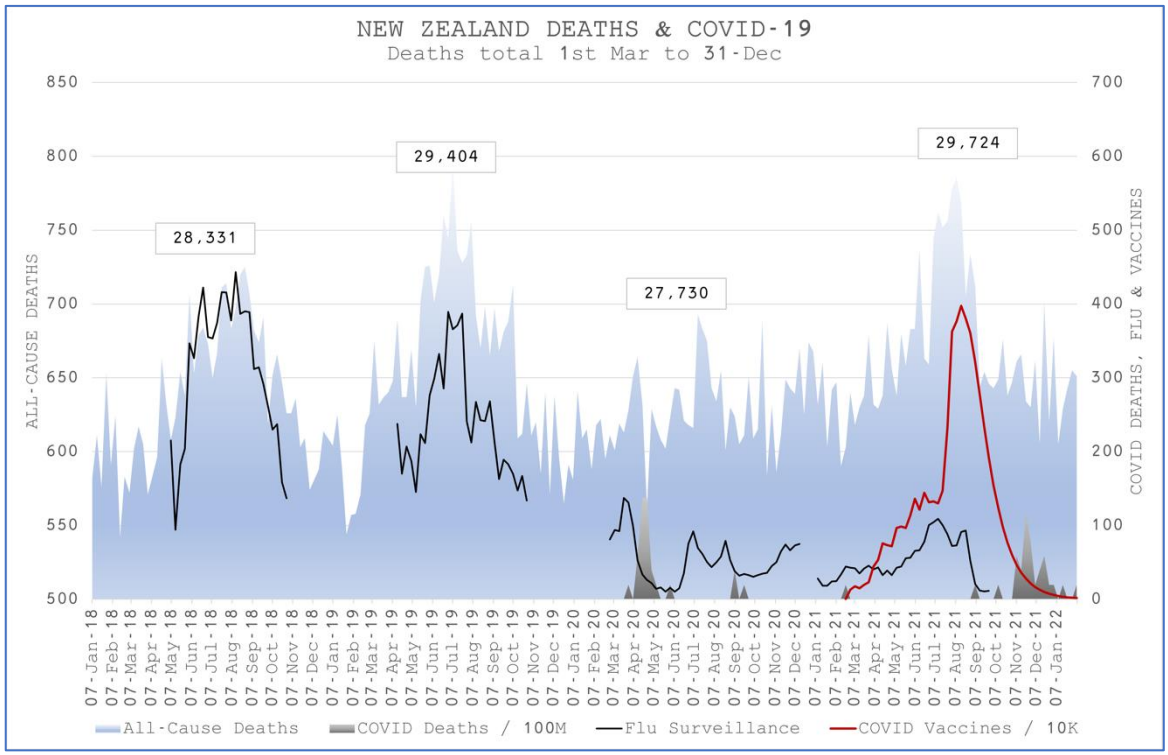
In light of the absence of any major disasters of significance or any other endemic disease of concern throughout 2021, the CMN can point to only one major factor that impacted all Australians throughout 2021, being none other than the concerted campaign undertaken by politicians and government health authorities advocating for the uptake of gene-based Covid-19 vaccines, where millions of Australians heeded their call.

To this end the CMN asserts to the Chair of ATAGI, the Secretary of Health, Deputy Secretary of the TGA, and all other noted recipients of this letter, that Australia's marked increase in All-Cause Mortality in 2021 was most likely causally due to these experimental Covid-19 vaccines.

New Zealand All-Cause Mortality correlates with vaccine rollout in 2021

Joel Smalley is an independent researcher who has collaborated with the biostatistical research group from St Marys College, University of London. He has analysed New Zealand All-Cause Mortality in the graph below for years 2018 – 2021. The death counts correlate highly with influenza seasons in 2018 and 2019 and there was a marked decrease in deaths in New Zealand with collapse in influenza numbers – and few cases of Covid-19 corresponding with New Zealand's closed borders and lockdowns. However, in 2021, despite similar low rates of influenza and, prior to November almost 'Zero-Covid', All-Cause Mortality death rate was highest, correlating temporally with the gene-based Covid-19 vaccine rollout

(https://cdn.substack.com/image/fetch/f_auto,q_auto:good,fl_progressive:steep/https%3A%2F%2Fbucketeer-e05bbc84-baa3-437e-9518-adb32be77984.s3.amazonaws.com%2Fpublic%2Fimages%2Fd2a4674d-0386-4bd2-b4a0-4dc95e9480bb_4049x2601.png):



New Zealand deaths 2018, 2019, 2020, 2021 compared influenza, Covid19, C19 vaccines

US Insurers evidence Excess Deaths Commensurate with Vaccine Rollout

Further support for the assessment that as many as 2,422 Australians have died from Covid-19 vaccines, is US insurance data confirming extraordinary spikes in death claims beginning second half of 2021.

In January 2022 OneAmerica CEO Scott Davison stated in an online news conference:

> 'We are seeing, right now, the highest death rates we have seen in the history of this business – not just at OneAmerica. ... The data is consistent across every player in that business. And what we saw just in third quarter, we're seeing it continue into fourth quarter, is that death rates are up 40% over what they were pre-pandemic. ... Just to give you an idea of how bad that is, a three-sigma or a one-in-200-year catastrophe would be 10% increase over pre-pandemic. So 40% is just unheard of.'
>
> https://www.thecentersquare.com/indiana/indiana-life-insurance-ceo-says-deaths-are-up-40-among-people-ages-18-64/article_71473b12-6b1e-11ec-8641-5b2c06725e2c.html

OneAmerica's data was supported by data from fellow US Insurers. A summation of major US insurance company corporate group policy loss ratios (death claims) 2021 Q4 rate vs 2019 rate:

Unum Group +36%
Lincoln National Corporation +57%
Prudential Financial Inc +41%
Reinsurance Group of America Inc +21%
Hartford Financial Services Group Inc +32%
MetLife Inc +24%

To place this into perspective, a 10% increase represents a 3SD (sigma or standard deviations), which means the probability of more than a 10% increase in mortality in any year is <0.3%.

A 40% increase is 12SD and is impossible by random variation.

United States Defence Medical Epidemiology Database (DMED) rates of illness

Recent allegations of increased illnesses amongst US military personnel warrant mention because the three named whistleblowers were all military doctors and two had ranks of Lieutenant-Colonel. Attorney Thomas Renz reported to a hearing in Washington DC under the auspices of Senator Ron Johnson (R-WI) that the three military doctors had reviewed the

data of the Defence Medical Epidemiology Database (DMED) and compared the rates of diagnoses in 2021 following the gene-based vaccine rollout with the previous 2016-2020 five-year average that included the first year of the pandemic.

Attorney Renz reported that the military doctors, are presenting the data "under penalty of perjury" and found extremely high increases in rates of diagnoses, for example: neurological disorders: 1048%; breast cancer: 487%; disseminated intravascular coagulation: 1,175%; pulmonary embolisms: 468%; myocardial infarction: 269%; spontaneous abortion: 279%; congenital malformations for neonates: 156%; female infertility: 472%.

The Senator has officially written to the US Secretary of Defense about these alleged findings (https://www.ronjohnson.senate.gov/2022/2/sen-johnson-to-secretary-austin-has-dod-seen-an-increase-in-medical-diagnoses-among-military-personnel ; Annexure O). The pattern of diagnoses follows that of the official databases and the FOIA released Pfizer-FDA adverse events data. Given that military doctors are supposed to record diagnoses in the DMED, the data might, if confirmed, be a more accurate gauge of the adverse events rates than passive reporting systems such as VAERS and DAEN.

In response, the US Department of Defence has not disputed the high rates of 2021 diagnoses but has argued that the previous five year rates were under-diagnosed by similar rates. That explanation would, as Attorney Renz has argued, undermine and invalidate published epidemiological research based on DMED data, and indicate that the US military has worryingly high rates of ill-health, which frankly stretches credibility and warrants further urgent auditing.

Is the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health aware of these US military whistleblower allegations and of US Senator Ron Johnson's letter to the US Secretary of Defence? If so, *are the Chair of ATAGI, the Secretary of Health, the CMO or the Deputy Secretary of the TGA or senior TGA officers making inquiries as to the veracity of these claims of multi-fold increases in various medical disorders since the mandating of gene-based vaccines to the US military?*

German pathologists' autopsy findings attributed to vaccine injury

Of grave concern are findings in a case series of autopsies and biopsies from people with suspected gene-based vaccine related mortality and morbidity, conducted by a group of experienced German pathologists. In this interview (https://doctors4covidethics.org/video-replays-d4ce-symposium-iii-session-i/) with German virologist Prof Sucharit Bhakdi, experienced pathologist Prof Arne Burkhardt reports findings of lymphocytosis – large unusual infiltrations of lymphocytes into inflamed organs pertaining to the morbidity of the deceased. The lymphocyte deposits are generally accompanied by infiltrations of gene-based vaccine manufactured spike proteins. He states that these findings have never been seen prior to the spike protein from the gene-based vaccines.

Prof Burkhardt provides histological evidence in the linked video. The findings of spike proteins and lymphocyte infiltrations are primarily in endothelial cells of blood vessels and contribute to clotting and inflammation of arteries. In the meninges and brain tissue these infiltrates contributed to subarachnoid haemorrhage, encephalitis and small vessel inflammation of the brain, In major arteries they contributed to coronary artery occlusion and aortic rupture, while, in the spleen, very large lymphocyte aggregates Prof Burkhardt and colleagues described as "pseudolymphoma" contributed to splenic artery occlusion.

More recently Prof Burkhardt and colleague Prof Walter Lang presented autopsy proof of a person who died 4 months post vaccine, of vaccine manufactured spike proteins as the causative agent in lesions in blood vessels as well as myocarditis (https://pathologie-konferenz.de/en/).

In a separate report, Heidelberg's chief pathologist, Dr Peter Schirmacher, autopsied 40 patients post-vaccination in a fortnight and estimated 30–40% of them had died because of the vaccine. He received criticism by the authorities but was supported by the German college of pathologists. The story did not make any English news media, (but can be Google translated – Annexure P https://www.welt.de/vermischtes/article232900871/Corona-Pathologe-fordert-mehr-Obduktionen-von-Geimpften.html).

Around the globe, despite record numbers of deaths temporally associated with the gene-based vaccines reported to the official databases such as DAEN, there have been surprisingly few autopsies. The German pathology groups' series calls out for more autopsies and research.

Are any of the C Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health aware of these autopsy findings by experienced German pathologists?

Has the Chair of ATAGI, the Secretary of Health, the CMO or the Deputy Secretary of the TGA provided guidance and additional resources and assistance, for a greater number of autopsies for Australians whose deaths are reported to DAEN as possibly related to the Covid-19 gene-based vaccines?

If so, *please evidence what guidance and additional resources and assistance have been provided to those responsible for conducting autopsies* for Australians whose deaths are reported to DAEN as possibly related to the Covid-19 gene-based vaccines, together with the distribution list of recipients.

Further, *has the TGA provided guidance to pathologists and pathology groups performing autopsies on those known to have received one or more Covid-19 vaccines, so correct testing is carried out for answering whether causality can be ascribed to a Covid-19 vaccine?*

If so, *please furnish copies of any such guidance, together with distribution list of recipients.*

Has the TGA issued any directives or advices to pathologists seeking to answer this question of Covid-19 vaccine causality, by alerting pathology groups to the following papers?

If so, *please furnish copies of any such directives or advices, together with the distribution list of recipients.*

Postmortem investigation of fatalities following vaccination with COVID-19 vaccines (https://pubmed.ncbi.nlm.nih.gov/34591186/)

Myocarditis-induced Sudden Death after BNT162b2 mRNA COVID-19 Vaccination in Korea: Case Report Focusing on Histopathological Findings (https://pubmed.ncbi.nlm.nih.gov/34664804/)

Autopsy Findings and Causality Relationship between Death and COVID-19 Vaccination: A Systematic Review (https://pubmed.ncbi.nlm.nih.gov/34945172/)

An Insight into the Role of Postmortem Immunohistochemistry in the Comprehension of the Inflammatory Pathophysiology of COVID-19 Disease and Vaccine-Related Thrombotic Adverse Events: A Narrative Review (https://www.mdpi.com/1422-0067/22/21/12024/htm)

Histological and immunohistochemical findings in a fatal case of thrombotic thrombocytopenia after ChAdOx1 nCov-19 vaccination (https://www.sciencedirect.com/science/article/abs/pii/S0344033822000395?via%3Dihub)

Deaths associated with newly launched SARS-CoV-2 vaccination (Comirnaty®) (https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8052499/)

COVID-19 Vaccine and Death: Causality Algorithm According to the WHO Eligibility Diagnosis (https://pubmed.ncbi.nlm.nih.gov/34073536/)

BMJ reporting of Pfizer trial irregularities

These FOIA revelations and adverse event data indicating that all was not right with the Pfizer Covid mRNA vaccine data are supported by testimonies from three conductors of the clinical trial, as described in the *British Medical Journal (BMJ)* in a 2 November 2021 article titled "Researcher blows the whistle on data integrity issues in Pfizer's vaccine trial" (https://www.bmj.com/content/375/bmj.n2635). The whistleblowers reported that the clinical trial contractor company, Ventavia, conducting the Pfizer trial: "falsified data, unblinded patients, employed inadequately trained vaccinators, slow to follow up adverse events ... mislabelled laboratory specimens, vaccines not stored at proper temperatures ... lacked employees to swab all possible Covid cases".

As *BMJ* senior editor Professor Peter Doshi notes, thousands of trial participants with flu-like symptoms appear not to have been swab tested for Covid (https://blogs.bmj.com/bmj/2021/01/04/peter-doshi-pfizer-and-modernas-95-effective-vaccines-we-need-more-details-and-the-raw-data/). In a recent *BMJ* editorial, Professor Doshi concludes that Pfizer and other companies cannot be trusted, and that regulators, academic journals, the medical profession and the general public all need access to the full data (https://www.bmj.com/content/376/bmj.o102).

Thus, the likelihood that the Pfizer data, upon which the TGA based its provisional authorisation, is skewed towards minimising harms and exaggerating benefits is high. You may of course have information that contradicts this. *In the interests of transparency about harms and benefits of a mandated vaccine, we request you please respond to us?* However, as below, the issue is now before the courts in the United States.

Serious allegations of Fraud in the Pfizer clinical trials

The named whistleblower to the *BMJ* is Ms Brook Jackson. It needs be emphasised that Ms Jackson is not only eminently qualified to comprehend and present such serious allegations of fraud but she was in the most senior position to be most fully informed regarding the details of the conduct of the trial itself. She is a certified clinical trial research professional working at the highest level of a Contract Research Organisation (CRO) with 18 years of experience and clinical trial audit skills.

As part of her professional responsibilities Ms Jackson was required to report any ethical or irregular activities and to ensure the trial was conducted according to the approved clinical

trial protocol. After repeatedly notifying Ventavia (the clinical trial contract organisation acting on behalf of Pfizer) of these problems, Ms Jackson also emailed a complaint to the US Food and Drug Administration (FDA) on the morning of 25 September 2020. Ventavia fired her later the same day. Jackson provided The *BMJ* with dozens of internal company documents, photos, audio recordings, and emails.

Questions to the TGA flowing from these allegations

1. We direct your attention to paragraph 7 in the Statement of Claim filed by Ms Brooke Jackson on 8th January 2021 (Annexure Q), and we ask *whether the the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers, as the individuals and body responsible for independently verifying the integrity of the clinical data underpinning the release of these vaccines into the Australian community, were made aware of the serious allegations in paragraph 7?*
2. If any of the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers were made aware, either verbally or in writing, by the US FDA of the allegations in paragraph 7, *what action did ATAGI or the Australian TGA take to investigate the veracity of the allegations?*
3. Further, we ask *what information did the Chair of ATAGI, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA or senior TGA officer request from Pfizer to show that none of the allegations contained in the BMJ article could be shown to be supported in fact?*
4. It is understood that chemistry/quality control, safety and efficacy clinical trial data made available to the Australian TGA in order to secure Provisional Approval of the Pfizer COVID-19 vaccine was very limited. In order to quantify how much or little data was made available to the TGA, we ask *the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers to provide the number of pages of documentation made available for each above category of data upon which the Decision to allow Provisional Approval and the number of individual final clinical trial reports.*
5. Further, we ask *can the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate*

of the Secretary or TGA officers indicate if a conventional evaluation process took place of the chemistry/quality control, safety and efficacy data? If an evaluation report was issued, how many pages did this report comprise?

6. Further, we ask *can the Chair of ATAGI, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA or TGA officers say if the TGA evaluation was done solely "in-house" or if the evaluation relied solely or partly upon external consultants?*

7. Further, we ask *can the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers provide evidence that they initiated an independent re-examination of the Pfizer clinical data, in order to conclude that there was no basis in fact to any one or more of the allegations contained in the BMJ article?*

8. Further, we ask *can the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers confirm or deny that detailed tabulated clinical trial safety data by test/laboratory value and adverse effects were provided to the TGA for independent evaluation?*

9. Further, given that the Secretary, the Delegate of the Secretary, and the TGA are on public record attesting to the fact that the TGA is in regular contact with the FDA, we ask *what information was shared by the FDA with the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers at any time after 25 September 2020 when these allegations of falsified clinical data were first brought to the attention of the FDA?*

10. This public record presumes there exists a constant sharing of information as it pertains to the safety of these vaccines, and the integrity of the clinical data used as the basis for approving them for use in the Australian community. Therefore, *did any of the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Minister of Health, the Deputy Secretary of the TGA, or Delegate of the Secretary or TGA officers become aware of these fraudulent or potentially fraudulent practices in the Pfizer trial and if so on what dates?*

In support of the above is testimony Brianne Dressen, a participant in the AstraZeneca Covid-19 clinical trial, once again evidencing fraud by the sponsors of these vaccines (https://youtu.be/DliofT7ucm4). Given these testimonies, it is clear that the sponsoring companies cannot be trusted, something the *BMJ* editorial also asserts.

In fact the lack of trustworthiness of Pfizer, AstraZeneca, Johnson & Johnson and other big pharmaceutical companies has been repeatedly proven in courts of law. The companies have been found guilty of felonies involving fraud, bribery of doctors, overpricing and off-label marketing on dozens of occasions and cumulatively fined $Billions. To date Pfizer has paid over $4Billion and AstraZeneca over $1Billion (https://projects.propublica.org/graphics/bigpharma ; https://www.enjuris.com/blog/resources/largest-pharmaceutical-settlements-lawsuits/). In 1996 Pfizer paid an out of court settlement to Nigerians after testing an experimental meningitis drug, Trovan, on 200 children without providing Informed Consent that the drug was experimental and the children were part of a drug trial. Eleven of the children died and several others were permanently disabled (https://www.washingtonpost.com/wp-dyn/content/story/2008/10/01/ST2008100101390.html?sid=ST2008100101390 ; https://www.youtube.com/watch?v=du7aipgaMrY).

Therefore it is incumbent on the TGA, while performing its pharmacovigilance duties, to seek the raw data from the sponsoring companies trials and be cognizant of the information in Prof Healy's paper and letter to Prof Skerritt (Annexures A & B).

What does the Australian government contract with Pfizer entail?

Generally unreported in the mainstream media, there was a leak of the confidential government contract with Pfizer in Albania that revealed unusually strict clauses in the Pfizer contract that favour the company and appear to infringe on sovereign rights of governments to act in the best interests of their people.

The story of the leak of the Pfizer contract with the Albanian government via an Albanian journalist was reported on alternative media (https://www.theburningplatform.com/2021/08/08/leaked-document-reveals-shocking-terms-of-pfizers-international-vaccine-agreements/) with links to the contract itself. Pfizer's own contract does not champion the "safe and effective" soundbite, but rather states:

> "Purchaser further acknowledges that the long-term effects and efficacy of the Vaccine are not currently known and that there may be adverse effects of the Vaccine that are not currently known."

The contract holds the Albanian government to indemnifying Pfizer from any liability and furthermore paying any legal defence costs for the company. It also holds the government to follow through with the lucrative vaccine order from Pfizer even if superior treatments or vaccines become available.

Several Members of the European Parliament (MEPs) have been outspoken on this issue – that MEPs were unable to view the Pfizer contract with the EU except for an ~90% redacted copy (https://odysee.com/@BoredCat:b/Vaccine-Contracts-Redacted-(Blacked)-for-Members-of-the-European-Parliament:7). The group of MEPs has more recently pointed to serious conflicts of interest between the EU Commission President and the pharmaceutical industry, specifically Pfizer (https://trialsitenews.com/european-meps-call-for-immediate-ouster-of-european-commission-president-due-to-conflicts-of-interest-with-pfizer-mass-covid-19-vaccination-program/).

In Israel, the leading nation for Pfizer booster doses, a medical watchdog group, the Israeli Public Emergency Council for the Covid-19 Crisis, notes that the agreement signed between the Israeli government and Pfizer allows "Pfizer considerable control over the content and timing" of any Israeli Ministry of Health publications relating to Pfizer's vaccine. The group asserts (https://galileoisback.substack.com/p/how-did-israels-ministry-of-health?s=r&utm_campaign=post&utm_medium=email):

> "Why is the agreement with Pfizer so significant? Because it turns the state from a sovereign entity to an agent of a commercial pharmaceutical company seeking to operate on its territory.
>
> ... Why did Ministry of Health officials ... not maintain their role as regulators, and volunteer to serve as Pfizer's marketing, distribution, research and publication branch?
>
> ... The research collaboration agreement between the Ministry of Health and Pfizer reflects a preconceived notion according to which the vaccine is safe to use and all that remains to be researched about it are various indicators that are supposed to demonstrate its effectiveness."

These are serious allegations and beg the question: What is in the contract that the Australian government has with Pfizer and other Covid-19 vaccine makers?

We request that the Secretary of Health and the Minister of Health provide our parliamentary representatives and the Australian people full access to read the contracts

signed with Pfizer, Moderna and AstraZeneca with regards to the Covid-19 gene-based vaccines.

Letter to Profs Skerritt & Chen, re. gene-based vaccines for children

We also note that Professors Skerritt and Chen were sent in late December 2021, a letter from us requesting a halt to the childhood Pfizer mRNA vaccine rollout, based on the high risk signal presented by the FOIA release of the FDA Pfizer post-marketing adverse event data (**https://tinyurl.com/OpenLetterTGA**). That letter references the Physicians' Declaration that recommends against vaccinating children with "genetic vaccines".

Please note, this letter is not 'anti-vax', rather it is about due care with regard to experimental technologies. There are many traditional technology protein-based and inactivated virus Covid19 vaccines approved for use in other countries. As can be seen above, there are several serious concerns with regard to the rushed and untested nature of these gene-based vaccines. The Physicians' Declaration provided supporting evidence of scores of published papers (https://doctorsandscientistsdeclaration.org/) as to why risk outweighed benefit in the case of children, and currently has over 17,000 verified doctors and health scientists' signatures.

Could you, Professor Skerritt and Professor Chen, please respond to the issues raised in that pre-Christmas letter that you received?

DAEN data concerning Australian 5 – 11-year-olds since 10 January 2022

Pertaining to our pre-Christmas letter, since the rollout of the Pfizer vaccine to children beginning on 10 January, reports of adverse events suspected of being related to the gene-based Pfizer vaccine up to 25 February 2022 include 630 children, 603 in the 5 – 11-year-old age bracket, as well as 17 breast-fed infants with adverse events (Annexures R and S).

Among these adverse events were: Chest pain (84), pericarditis (7), myocarditis (5), carditis (1), myocardial infarction (1), abnormal ECG (7), tachycardia (10), seizures/tonic-clonic convulsion/movement (8), demyelination (1), visual/eye problems (16), loss of consciousness (1), syncope/presyncope (35), exposure via breast milk (10), scrotum or testicular disorder (3), vaginal haemorrhage/menstrual disorder (2), anaphylaxis (1), appendicitis (3).

While it might be true to assume that appendicitis was a coincidental finding, the video presentation by German pathologist Prof. Burkhardt above included histopathological

findings of spike proteins post-vaccine contributing to the inflammation in a removed appendix. The number of cardiac reports, given the under-reporting rates to databases like DAEN, is of serious concern, as are neurological and reproductive related adverse events, as these mirror the pattern of Pfizer/FDA FOI released data of adverse events – that we described in our pre-Christmas letter to you.

Given these reports, *will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health convey the data to Australian parents? Will you convey the fact that DAEN within a few weeks has 17 reports related to possible transmission via lactation of mRNA, lipid nanoparticle, spike proteins or other ingredients of the Pfizer vaccine that might have caused adverse events to breast-feeding babies?*

Omicron variant has an infection fatality rate (IFR) lower than seasonal influenza

A study by the California-based health insurer, Kaiser Permanente, for the months of December 2021, found that of their members who contracted Covid-19 confirmed by PCR testing, there were:16,982 Delta plus 45,712 Omicron cases. While symptomatic hospital admissions (both with and for Covid-19) were 12.7%, ICU admissions were 1.4% and deaths were 0.8% (*n* = 14) for Delta, the Omicron variant was shown to be an order or two of magnitude less virulent with symptomatic hospital admissions (with and for Covid-19) 3.5%, ICU admissions 0.1% (*n* = 7) and deaths 0.002% (*n* = 1) (https://www.medrxiv.org/content/10.1101/2022.01.11.22269045v1.full.pdf). This Case Fatality Rate (CFR) of 0.8% for Delta and 0.002% for Omicron could be as low as half as much again for the Infection Fatality Rate (IFR), assuming asymptomatic and very mild cases which were never tested.

A caveat to the Kaiser Permanente data is that it would be for mostly working age Californians on private health cover, not for the elderly frail who are covered by the United States' Medicare system. This makes it clear that Omicron, according to data, is on par with a common cold coronavirus for the general non-frail elderly population and of virtually no risk to children.

Similar data regarding Omicron in Sweden led that nation to drop all Covid-19 measures, as they assessed Omicron as equivalent to about a third of the infection fatality rate of an

average seasonal influenza when including the elderly frail (https://sebastianrushworth.com/2022/02/04/covid-officially-over-in-sweden/).

Given this data of Omicron's relative low virulence as a respiratory virus, albeit it remains highly infectious and a risk to frail elderly, *do the Chair of ATAGI, the Secretary of Health, the Chief Medical Officer and the Deputy Secretary of the TGA acknowledge that the risk/benefit ratio for the gene-based vaccines weighs even heavier on the side of risk – as the benefits, in terms of "preventing serious disease", of gene-based vaccines for Omicron are less than for previous viruses due to its mildness?*

Gene-based vaccines not appreciably reducing SARS-CoV-2 transmission

The gene-based vaccines never provided 'sterilising immunity' and are referred to by virologists/vaccinologists as 'leaky vaccines'. The capacity for the virus to evade vaccine antibodies that are IgG systemically based rather than IgA in respiratory mucosa has been there from the start, but appears to have increased as variants evolved in part to evade vaccine-induced antibodies to the spike protein of the original Wuhan strain. There is now convincing evidence that the gene-based vaccines do not appreciably prevent transmission of Delta and Omicron strains of SARS-CoV-2.

Dr Anthony Fauci, head of the National Institute of Allergy and Infectious Disease (NIAID) said the viral load of Delta variant in the nasal passages of vaccinated people was "almost identical" to that in noses of unvaccinated people (https://thehill.com/homenews/sunday-talk-shows/565831-fauci-amount-of-virus-in-breakthrough-Delta-cases-almost-identical). Dr Rochelle Walensky, director of the Center for Disease Control (CDC) said vaccines "can't prevent transmission" (https://www.realclearpolitics.com/video/2021/08/06/cdc_director_vaccines_no_longer_prevent_you_from_spreading_covid.html). The CDC reported an outbreak of Delta variant where the majority of cases were fully vaccinated at a rate comparable to the general population vaccination rate (https://www.cdc.gov/mmwr/volumes/70/wr/pdfs/mm7031e2-H.pdf).

A Wisconsin study of 310 fully vaccinated and 389 unvaccinated individuals found high viral load in 68% of the fully vaccinated and 63% of the unvaccinated. A smaller group of asymptomatic carriers of high viral load (super spreaders) were more likely to be vaccinated (82%) than unvaccinated (29%) (https://www.medrxiv.org/content/10.1101/2021.07.31.21261387v6.full-text). A Vietnamese hospital study of 69 fully vaccinated staff with AstraZeneca's vaccine two

months after vaccination noted the rapid spread of the virus among the staff (https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3897733). A large study of patterns of vaccination and cases across 68 nations and 2,947 US counties found no relationship between vaccination rate of the population and case numbers, with a trend towards high vaccinations correlating with higher case rates (https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC8481107/). Three articles in *The Lancet* report that the current gene-based vaccines do not prevent transmission of SARS-CoV-2 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02243-1/fulltext , https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(22)00090-3/fulltext#sec1 & https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(21)00768-4/fulltext).

Given this published data, *will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health convey to the Australian people the finding that the current gene-based vaccines do not prevent transmission of the current SARS-CoV-2 variants and that "protecting others" is not a scientifically valid reason for recommending or mandating these vaccines?*

Too frequent vaccination can dysregulate the complex balance of immune system

Confirming the 'more is not always better' aphorism, this section is an abbreviation of a currently unpublished manuscript: "An update of how mucosal tolerance applies to the lungs" authored by Emeritus Professor Robert Clancy AM DSc FRACP FRS(N) (Annexure T).

Decisions made regarding current vaccines appear to be made by committees without modern understanding of relevant immunology. Poor decisions regarding spacing of vaccination doses, is now known to lead to compromised clinical outcomes.

The difference between vaccination to prevent systemic infections such as measles, and infections primarily of the mucosal compartments such as the respiratory tract like influenza and Covid-19, is poorly understood across the medical profession. This includes those on committees expected to provide guidance with respect to vaccination strategy.

The essential difference is that the classic anamnestic response that characterises 'classic' vaccines, is blunted and short term, following injected vaccines for viral infections of the airways. We now know this is due to 'seeding' of systemic lymphoid tissue by down-

regulating T reg cells to protect the body from any inflammatory response against environmental antigens. This powerful influence was first recognised in the 1940's as the Sultzberger-Chase phenomenon, then later in relation to oral tolerance, and in its reverse form, desensitisation of allergic disease.

The relevance to Covid immunisation is that repeated vaccination risks specific immune suppression, due to the balance of T cell responsiveness favouring down regulation after an initial spike of increased protection. This is exactly what has been seen with injudicious recent "boosters", in several European countries. For example, the UK Government Reports given weekly and available on the public record, trace the progressive "non-responsiveness" and loss of protection following increasing numbers of vaccination doses. In Week 8 "Covid-19 Vaccine Surveillance Report: 24/2/22, the Covid infection rate standardised to "per 100,000" is 2-3 times higher in the triple vaccinated compared to the unvaccinated, for most age brackets. What initially gave protection for 6 months, has reduced to 7-8 weeks. Reduced IgG antibodies to both Spike protein and nucleocapsid antigens following vaccination have now been identified.

European immunologists have misunderstood these observations as a form of "immune destruction". European Medicines Agency official, Marco Calveri, the Head of Biological Threats & Vaccine Strategy, stated that repeated Covid-19 boosters might lead to immune "fatigue" (https://www.reuters.com/business/healthcare-pharmaceuticals/eu-drug-regulator-says-more-data-needed-impact-omicron-vaccines-2022-01-11/).

It is noted that pre-season 'de-sensitisation' in patients with respiratory allergies, renders them tolerant and refractory to allergy symptoms, for at least 5 years. Poorly spaced booster injections fail to have a significant impact for more than a few weeks, then risk being progressively non-responsive to seasonal vaccines as is used for influenza, for many years. A terrible price to pay for a panic reaction based on lack of understanding, that is easily avoided.

What then is the best supported science-based approach? To move to antigen-based vaccines immediately (as they are now available), to support development of non-spike protein (at least non-full-length spike protein) vaccines (either using restricted spike protein, non-toxic epitopes, or develop nucleocapsid antigen vaccines), and to move to annual "spacing" (perhaps combined with flu vaccine).

To cover the cases of Covid-19 in the interval, it is important to make safe, cheap effective re-purposed drugs widely available within the community. This affordable, effective strategy, needs the support of a concentrated public promotion programme, supported at every level.

References:

1. Oral Tolerance to Food Protein. Pabst,O. et al Mucosal Immunology 5(20120232-239). (This covers mucosal tolerance as "local and systemic unresponsiveness induced by oral administration of protein", through the lens of classic food tolerance, but not restricted to food).

2. Control of Regulatory T cells and Airways Tolerance. Duan, W et al Ann Am Thorac Soc. 5(2014) s306-313.

Anomalies and impurities seen in vaccine vial samples and blood films

The CMN views reports of anomalies and impurities in vaccine vials, that correlate with similar findings in microscopic examination of live blood films, with consternation and alarm. Such reports are becoming more numerous and replicated from laboratories and practitioners around the world.

The issue of metallic foreign substances in the Moderna vaccines made the news from contaminated batches in Japan (https://www.japantimes.co.jp/news/2021/08/27/national/moderna-contamination-metal/), so quality assurance issues with the vaccines are real. However, scientists now report what they believe are findings of graphene, as per a brief presentation from the World Council for Health of spectroscopy findings in 1 Pfizer, 2 Moderna and 1 AstraZeneca vials (https://worldcouncilforhealth.org/multimedia/covid-19-vaccines-contents-prelim-summary-rob-verkerk/?utm_source=newsletter&utm_medium=email&utm_campaign=UVC-truckers).

Annexure U has been authored by Australian pathologists and shows photographs of blood samples and vaccine samples with strange anomalies viewed via an array of microscopy techniques and correlating with similar findings from other researchers and practitioners overseas. To quote our Australian pathologist colleagues:

> "Numerous researchers around the world have also examined the Pfizer, AZ, Moderna or J&J covid vaccines and have reported seeing the same anomalies. Optical Microscopy, Bright-Field Microscopy, pHase Contrast Microscopy, Dark-Field Microscopy, UV absorbance and Fluorescence Spectroscopy, Raman spectroscopy analysis, Scanning Electron Microscopy, Transmission Electron Microscopy, Energy Dispersive Spectroscopy, X-ray Diffractometer and Nuclear Magnetic Resonance instruments were used to verify the vaccines morphologies and contents. They have reported seeing similar anomalies ... Again, the scientific

> community are shocked by these findings of undisclosed suspicious ingredients in the covid vaccines. We believe, at a bare minimum, this warrants an explanation and further thorough investigation to be able to give the Australian public true informed consent."

With regard to blood samples:

> "Blood samples now routinely exhibit severe rouleaux formations (stacking and clotting together). ... They display unexpected foreign objects including 1) long folding crystalline sheets, 2) long tubular structures, 3) black crystals which attract and then destroy neutrophils. Figure 4 is at 1000x magnification and shows a small "spikey aggregate". None of these structures have previously been seen or reported in the last 35 years of live blood analysis worldwide."

Incredible as these claimed findings are, the CMN agrees that only thorough investigations of the vaccine contents can reassure or otherwise the public, who are increasingly aware of these findings through alternative media. In recent times, the practice of routinely examining blood films by pathology labs has been replaced by automated blood counts, so regular pathology laboratories may not be seeing these anomalies. Therefore, *will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health recommend and provide funding for investigations using an array of microscopic techniques, including transmission electron microscopy (TEM) as above, into the contents of the vaccine vials and blood film analyses?*

Reports of gene-based vaccine batch (lot) variability in risk of serious adverse events

While focussing on anomalies in the vaccines, the CMN is aware of research of the VAERS adverse event data that showed a statistically improbable variation in reports of adverse events according to batch (or in the US, 'lot') numbers. The most benign explanation is there is poor quality assurance practices in the dosages and ingredients in these batches.

This anomaly might explain why some people have zero reaction at all to the gene-based vaccines, while others must take time off work or become seriously unwell, or die.

Experienced virologist-vaccinologist, and original inventor of mRNA technology, Dr Robert Malone reports his own personal experience of no reaction after his first Moderna dose, but a life-threatening adverse reaction after his second dose (https://rwmalonemd.substack.com/p/how-bad-is-my-batch?s=r). He checked the website (https://howbad.info/) and found his first dose was

from a batch with minimal reports to VAERS, but his second dose came from one of the 5% of batches that leads to greater than 90% of reports to VAERS.

A Dr James Hill has investigated this issue and draws some alarming hypotheses (https://hillmd.substack.com/p/vaccine-batches-vary-in-toxicity?s=r). Knowledge of this issue is spreading via alternative media and causing concern. This is another area that warrants a high level official investigation.

Have the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health heard of this issue? Will you please institute a high level investigation of this issue?

Suppression of early treatments for Covid-19 by the TGA and AHPRA

Off-patent or unpatentable and thus unprofitable treatments, used and researched for Covid-19 by practitioners and researchers around the world, have been suppressed in Australia and other advanced economies, where a cynic could say a common factor is the potency of influence of big pharmaceutical companies.

The website https://c19early.com/ collates the data on 37 repurposed drugs, vitamins and supplements that have shown promise and success in the mostly early treatment of Covid-19. Most notable include hydroxychloroquine, ivermectin, vitamin D, vitamin C, and zinc, but there are others with evidence of benefit. The combination use of such agents, prophylactically for contacts of people with Covid-19, and early in the course of the infection, have shown the best results.

Several governments, such as Mexico or the state of Uttar Pradesh in India have actively championed the use of combination protocols, similar to the successful trial of ivermectin 24mg daily + doxycycline 100mg BD + zinc 50mg daily by Prof Thomas Borody and colleagues in Sydney before it was shut down (Annexure V).

The use of these agents has been most widespread in developing nations, given most of them are cheap, generic, and have well-established safety profiles. In contrast, advanced Western nations have suppressed use of these agents, including the TGA in Australia, with AHPRA suspending practitioners for prescribing medications like the widely and long-used Nobel Prize winning ivermectin and over half century used hydroxychloroquine.

Evidence of misinformation to influence a negative appraisal of hydroxychloroquine has been apparent. For instance, the study by Mehra et al. of Harvard, that was conducted by a health data analytics company, Surgisphere (https://www.the-scientist.com/features/the-surgisphere-scandal-what-went-wrong--67955), of hydroxychloroquine for Covid-19 and published in *The Lancet*. This large negative study was used by the WHO to halt research on hydroxychloroquine for Covid-19. However, the study was found to be fraudulent with alleged patients being non-existent (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31324-6/fulltext). Doctors at Monash University's hospital were among the first to notice this, and *The Lancet* was forced to retract the study.

A study by the same authors in the *New England Journal of Medicine* that used high dose hydroxychloroquine late in hospitalised cases of Covid-19, at a stage and dose no proponents recommended was used to disparage hydroxychloroquine as a dangerous and ineffective drug (https://www.nejm.org/doi/full/10.1056/NEJMc2021225). However, it too was retracted, this time by the authors. Despite these retractions, the WHO did not reverse its policy so further research and use of hydroxychloroquine in Covid-19 effectively ended in most Western nations.

Similarly, media in the USA fabricated stories of ivermectin toxicity and overdoses to impugn use of it for Covid-19 (https://www.thedesertreview.com/opinion/columnists/the-great-ivermectin-deworming-hoax/article_19b8f2a6-0f29-11ec-94c1-4725bf4978c6.html). More recently, the Attorney General of Nebraska criticised this media campaign. The Nebraska Attorney General's report also noted the large body of evidence in favour of ivermectin and critiqued serious flaws in the two influential meta-analyses (Popp et al. and Roman et al.) that have been cited by the TGA to suppress use of ivermectin for Covid-19 (see particularly from p. 12: https://ago.nebraska.gov/opinions/prescription-ivermectin-or-hydroxychloroquine-label-medicines-prevention-or-treatment-covid). Please watch this: https://rumble.com/vwfia3-a-letter-to-andrew-hill-dr-tess-lawrie-oracle-films.html?mref=6zof&mrefc=3 .

Given this evidence and apparent misinformation, *will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health review the current policies with regard to ivermectin, hydroxychloroquine and other medications in the Covid-19 early treatment protocols? Will the TGA and AHPRA allow doctors to prescribe drugs with well understood safety profiles off-label to their patients as has been and remains the case for most clinical conditions?*

The contrast of TGA and AHPRA suppression and alarmist statements on well-established medications and nutritional supplements, that have decades of safety data, with ATAGI and the TGA's unfettered endorsement of experimental gene-based vaccines, that were rushed to market without many of the usual safety studies, and with only short-term phase 3 clinical trials that are now under a cloud of fraud and mismanagement allegations – could not be more obvious.

Why are traditional safer vaccine technologies mostly unavailable in Western nations?

Throughout this pandemic, health practitioners and the public, who raise questions about the safety or efficacy of the gene-based vaccines have been smeared and silenced as 'anti-vaxxers'. We are not anti-vaccines. We are pro-science, pro-evidence based medicine, pro-data transparency, pro-proper risk/benefit analyses, pro-Informed Consent.

Across the globe many protein-based and inactivated virus Covid-19 vaccines are not producing the same concerning high rates of serious adverse events as the experimental gene-based vaccines. Mexico provides clinicians and citizens with a choice of 10 vaccines. India makes an inactivated virus vaccine known as Covaxin. Flinders University affiliated company (www.vaxine.net) has a modified spike-protein vaccine that is not gene-based, not embedded in a lipid nanoparticle matrix, and has good safety data from its wide use in Iran. In Western nations these vaccines are not afforded the relatively speedy approval that the experimental gene-based vaccines of the big Western pharmaceutical companies received from regulators. *Does this relate to secret contracts like the Pfizer contract described above?*

The data points to superiority of natural immunity over vaccine-immunity

Bill Gates recently described the highly infectious, but much milder, Omicron variant as acting like a natural "vaccine". He said "sadly", perhaps as a slip acknowledging it reduced the need for commercial vaccines (https://www.youtube.com/watch?v=YhXQvLqoh5M).

There is now a wealth of peer-reviewed published data showing that natural immunity from exposure to the SARS-CoV-2 virus, whatever variant, is more robust and longer-lasting than the immunity from the gene-based Covid-19 vaccines. This might also be the case for the traditional Covid-19 vaccines. This should not be surprising, as described by Emeritus Professor Robert Clancy in Annexure T, respiratory virus infections of the nasopharynx

induce mucosal immunity as well as systemic immunity, whereas the current gene-based Covid-19 vaccines induce only systemic immunity. The mucosal immunity from prior virus infection means natural immunity more quickly responds to future virus exposure in the nose, and therefore reduces transmission, than systemic immunity from current vaccines can.

Further, natural infection exposes people to the whole virus and all its epitopes including the nucleocapsid, so that future variants are less likely to fully escape immunity because of a wider array of antibodies. In contrast, the gene-based vaccines, focused only on the spike protein, are potentially driving some of the evolutionary changes to the spike protein. Therefore the vaccine-created antibodies from the original Wuhan strain have less capacity when confronted with a new variant like Delta or Omicron.

The *Physicians and Scientists Declaration* from the Global Covid Summit section on natural immunity cited 29 articles (https://doctorsandscientistsdeclaration.org/home/supporting-evidence/#recovered) to declare:

> "Resolved, that naturally immune persons recovered from SARS-CoV-2 shall not be subject to any restrictions or vaccine mandates."

The updated list of scientific articles includes 150 published papers (https://brownstone.org/articles/79-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted/). *Will the Chair of ATAGI, ATAGI committee members, the Secretary of Health, the CMO, the Deputy Secretary of the TGA, ACV committee members, or Delegate of the Secretary or TGA officers or the Minister of Health explain on what basis natural immunity is being denied as a long-term exemption to vaccine mandates, in contrast to the overwhelming evidence from the authors of 150 published scientific papers?*

Poor data a global feature of the Covid-19 pandemic response

A recent article in the high-impact journal *Nature* illustrates that government health agencies the world over have been less than forthcoming with transparent data during the pandemic, to the point that 'following the science' is obstructed (https://www.nature.com/articles/d41586-022-00424-9?utm_source=Nature+Briefing). This situation is not good enough as a basis for public health policy, for researchers to advance knowledge and to inform clinicians who can then inform their patients. As per the article's author, we appeal to the TGA for transparent data.

In this context it is scandalous for the US Center for Disease Control and Prevention (CDC), to have recently admitted withholding data for what appears to be politicised reasons. The

main issue of contention: that data which suggested risks outweigh benefit of booster doses for younger adults (https://nypost.com/2022/02/27/the-cdc-has-a-hidden-agenda-when-it-comes-to-covid-vaccines/ , https://stevekirsch.substack.com/p/cdc-admits-it-withheld-data-from?s=r) was withheld.

Final Statement

This letter is group signed under the auspices of the Covid Medical Network, Australia – that represents hundreds of clinicians and medical researchers who otherwise feel their careers are at risk if they sign openly. Several contributors to this letter are eminent in their fields. This in itself is an indictment of AHPRA and health employers, who are suppressing valid scientific discourse and the capacity of clinicians to assist their patients make Informed Consent or declination decisions. Others, not under AHPRA's power, have signed openly.

This letter also follows on from numerous letters submitted by medical academics, clinicians and legal practitioners (for example see Annexure W) to Australian politicians and health authorities. In the main those letters have not been responded to, or questions have been superficially addressed or side-stepped. The same has occurred to senators in Questions on Notice. This letter therefore has sought to be comprehensive and has provided direct questions that we request answers to.

In light of the failures on the part of the TGA, the Department of Health, and the Minister of Health to properly review the data pertaining to an experimental gene technology, we the undersigned express a position of severely diminished confidence in the Australian Department of Health, the TGA, and indeed the Minister of Health meant to be overseeing same, with respect to the safe stewardship of Australia's public health.

This conclusion is unfortunately unavoidable when new and experimental products are, have been, and continue to be, promoted by Federal and State and Territory ministers and officials on behalf of big pharmaceutical companies, being funded by $Billions in Federal monetary incentives in order to motivate the States and Territories to effectively persuade or coerce millions of Australians to be injected with experimental gene-based vaccines in the general absence of proper Informed Consent, and on the basis of less than adequate safety data.

The painful lessons of Nazi abuses of Medicine and Science throughout the Third Reich led to the Nuremberg Code and the ethical mandates of bodily autonomy and Informed Consent.

Such incomparable lessons have been completely disregarded during this Covid-19 pandemic. An element of panic-driven policy has over-ridden the precautionary principle and cool rational age-stratified risk/benefit analyses.

In the aftermath, it is imperative that there be a major high level Judicial Inquiry to unravel the forces and reasons that led to the unhealthy overreach of official public health agency and governmental policies during this Covid-19 pandemic.

Governments at all levels, ATAGI, the TGA, AHPRA and other relevant agencies must cease denying Australians their basic human rights, enshrined in the Nuremberg Code and in the Universal Declaration on Bioethics and Human Rights (http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html) to which Australia is signatory. Article 6 states:

> "Any preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information. The consent should, where appropriate, be expressed and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice."

Australians must receive full information in order to make consent decisions related to their bodily autonomy, free of financial, career, and political pressure. Clinicians must have their right to open scientific discourse and to impart their best medical opinions to their patients restored to them.

.. so say we, the undersigned:

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