NZDSOS
NEW ZEALAND DOCTORS SPEAKING OUT WITH SCIENCE

August 27, 2025

Dear Commissioners,

Please accept this email of concern regarding the evidence to your public session of Dr Helen Petousis-Harris (HPH), as well as on the larger issue of the Royal Commission of Inquiry (RCI) not using its statutory powers to compel reluctant Ministers to appear in open session. We note experts and the public won't be able to scrutinise other relevant officials either. As a result we have broadened our critique to issues that she (and the other cancelled witnesses) ought to have been questioned on.

As with the appearance of Professor Le Gros, it would appear, superficially at least, that HPH was attempting to counter our evidence from the day before, but in doing so risked the Commissioners receiving deceptive and incomplete information. Of course we do not know what was presented by them in private, but we have grave concerns that the realities for many New Zealanders are starkly at odds with the picture she painted for the RCI of safety so complete and assured that all that mattered was the effectiveness of communicating it. We believe our statement of evidence and these targeted rebuttals counter the messages she and Professor Le Gros tried to deliver.

We note that neither can be considered part of the government although HPH has tried to provide a veneer of science to support political policy. However we have long been frustrated with waffly, evasive and medically incorrect statements. At least she has admitted being a year late and non-transparent about background and observed vs expected rates, of conditions anticipated as adverse effects, during an IMAC webinar in 2023.

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Critique of the Evidence of Dr Helen Petousis-Harris to the NZ Royal Commission of Inquiry on Covid-19 Lessons Learned

Executive Summary

Dr Helen Petousis-Harris's evidence to the Royal Commission on Covid-19 Lessons Learned was marked by omissions, overgeneralisations, and minimisation of known issues - very similar to the appearance by Professor Le Gros, whose concerning evidence produced our own rebuttal already provided.

Appearing in her WHO communication role, Dr Petousis-Harris avoided accountability for her direct advisory positions to the New Zealand Government and her access to real-time safety data through the Global Vaccine Data Network.

Her testimony framed "hesitancy" as the key risk, while downplaying genuine harms such as myocarditis, clotting, kidney and neurological injury. She presented c-19 vaccines in generic, reassuring terms, implying they prevented infection and transmission, despite CV-TAG minutes confirming this was "unknown." She repeated Pfizer's "95% efficacy" headline without acknowledging trial exclusions, and claimed spike protein persists only "days," contrary to emerging evidence of longer persistence. She endorsed censorship of platforms while insisting withholding knowledge erodes trust.

Critically, she did not disclose that:

- The vaccine was rolled out only under **provisional consent** (s23 Medicines Act), not full approval.
- The Government signed a **liability waiver with Pfizer on 5 October 2020**, even before trial data were complete (9 October cut-off) or published (December 2020).
- The product actually supplied was manufactured by **Process 2**, a different method from the clinical trial product (Process 1), raising regulatory concerns about comparability.

These omissions mislead the commission and continue to undermine informed consent. New Zealanders were not told the product was provisionally approved, indemnified in advance, and materially different from the trial material.

Unless Dr Petousis-Harris is recalled and questioned on these omissions, the Commission risks endorsing a narrative shaped by reassurance and communication strategy, rather than scientific candour and accountability for the death and disablement of many New Zealanders and - undoubtedly- many more to come.

Note, we have used summary quotations to condense larger passages of her speech from the transcript.

1. Introduction

Dr Helen Petousis-Harris ("HPH") appeared before the Commission in July 2025. She was introduced as a WHO communication specialist, not in her capacity as an adviser to the New Zealand Government through the Covid-19 Technical Advisory Group (CV-TAG) and the Immunisation Implementation Advisory Group, nor as a promotor of vaccines in general through the Immunisation Advisory Centre, a business unit of Auckland University.

This distinction enabled her to give generic testimony about trust and communication while avoiding accountability for her government advisory role, her access to real-time New Zealand safety and efficacy data via the Global Vaccine Data Network (GVDN), and her influence on key messaging decisions.

The Commission, in turn, did not probe this contradiction. *(cf. NZDSOS submission, Section 2.2.9, p.139; Section 2.2.21, p.150),* nor ascertain her conflicted funding from private vaccine interests.

2. Generic Framing and Missed Focus

“Vaccines prevent disease rather than treating it… they protect communities by preventing onward transmission. They save money, time and resources. It’s a very cost-effective intervention.”

This was a textbook description of classical sterilising vaccines such as measles. It did not apply to the Covid-19 injections, which did not stop either infection or transmission and whose efficacy waned rapidly, leaving an *increased* susceptibility.

By using this framing, HPH opened with reassurance rather than reality. The Commission reinforced this by asking generic questions on “the risks of hesitancy,” allowing her to continue speaking conceptually.

(cf. NZDSOS submission, Section 2.2.9, p.139 noting CV-TAG minutes Feb 2021 that transmission impact was “unknown”)

3. Vaccine Hesitancy and Framing of Risk

“During a pandemic, lack of uptake means you can’t achieve herd immunity… you see dramatic expansions in health inequalities. Misinformation gains ground.”

Herd immunity was never achievable with Covid-19 vaccination. Natural infection provided broader and longer-lasting protection, while children and asymptomatic adults were not shown to be significant vectors of infection to the vulnerable.

HPH’s framing treated hesitancy as the problem, not a rational response to genuine risks: myocarditis, clotting, neurological injuries, and unknown long-term effects.

She did not define 'misinformation' nor discuss who determines what is

misinformation, leaving the obvious answer, in line with the history of the term itself, as "The State".

(cf. NZDSOS submission, Section 1.8, pp.40-47 on myocarditis prevalence and severity)

4. Trust, Social Listening and Manipulation

“WHO produced extensive toolkits… guiding principles include making trust a strategic goal, building vaccine literacy, social listening, preparing response systems.”

These are public relations strategies, not science. “Social listening” in particular resembles surveillance and nudging, not transparency.

Trust arises from transparent data, independent review, honest disclosure of risks, the ability and willingness to defend one's position and to move quickly when it proves wrong. Instead, New Zealand deployed fear-based campaigns and “trusted messenger” strategies — manipulation, not candour.

(cf. NZDSOS submission, Section 1.14, pp.91-92)

5. Downplaying Harms and Safety Signals

“A signal is just that, a signal. It doesn’t mean causality… rare signals were investigated, and some dropped away.”

This trivialises the issue. By 2023:
- Tens of thousands of adverse events had been reported to CARM.
- Thousands were classed as serious.
- ACC had accepted hundreds of injury claims.
- Four deaths, all from vaccine-induced myocarditis, were officially recognised by a coroner.

The Covid Vaccine Independent Safety Monitoring Board (CV-ISMB) was only to be triggered beyond its monthly meetings if programme stability was threatened by adverse media coverage, not by New Zealanders being harmed. Protecting the programme was prioritised over protecting the public.

(cf. NZDSOS submission, Section 2.2.27, p.154)

6. Failure to Address Causality

"It is critical to maintain trust by communicating causality — what happened, what is being done about it, and keeping the public informed."

Despite this, HPH provided no evidence on causality. She has been wilfully deaf, blind and mute - or worse. Following the inquest into Rory Nairn's vaccine-associated death, acknowledged by both the Coroner and the Health and Disability Commissioner, she implied there was still doubt, and that maybe he was partially to blame.

As co-Director of the GVDN, she had access to near real-time data linking vaccination to hospitalisations and deaths. She has publicly described this as being able to analyse "the entire team of five million." Yet she presented nothing to the Commission.

The Commission, by confining her evidence to communication, avoided the central question: to what extent have vaccines caused harm?

(cf. NZDSOS submission, Section 2.2.21, p.150; Section 2.3, pp.164-168)

7. Transmission and Misleading Messaging

"When we first had the vaccine, the clinical trials showed 95% efficacy… you were still preventing serious disease really, really well, but less so infection, and then the impact on transmission reduced."

This phrasing implies that vaccines initially reduced transmission, but later less so. In fact, transmission reduction was never demonstrated.

- CV-TAG minutes (5 Feb 2021) acknowledged the impact on transmission was unknown, and later, that the vaccine would bring forward the deaths of frail elderly people.
- A 19 May 2021 report noted Pfizer could not be used in a "ring vaccination" strategy (because it didn't stop covid).
- Ashley Bloomfield's affidavit to the High Court (September 2021) admitted officials did not know whether transmission was reduced.

Despite this, the public were told vaccination would "protect your whānau/grandma." HPH did not correct this false messaging.

(cf. NZDSOS submission, Appendix C, p.346)
See also OIA H202200250; [FDA trial report]
(https://www.fda.gov/media/144245/download)

8. Misrepresentation of Efficacy

HPH repeated the claim of 95% efficacy from Pfizer's pivotal trial. She did not explain that this:

- Was based on only 170 confirmed cases (162 unvaccinated vs 8 vaccinated).
- Excluded thousands of suspected cases, which, if included, would likely have dropped efficacy below the 50% required for Emergency Use Authorisation in the US.

This was buried on p.42 of the [FDA trial report](https://www.fda.gov/media/144245/download).

She also ignored flaws in Israeli observational data (e.g. “window counting” mis-definitions of vaccinated/unvaccinated), which heavily influenced NZ policy.

(cf. NZDSOS submission, Section 1.7, pp.30-35)

9. Misrepresentation of mRNA Persistence

“RNA is fragile, it disintegrates quickly. Spike protein remains only for days. It cannot integrate into the genome.”

This is inaccurate. Modified mRNA is engineered for stability. Spike protein production has been documented months to years after vaccination. Reverse transcription, LINE-1 integration and plasmid contamination provide plausible mechanisms for genomic integration.

Her offhand answer of “probably days” echoed her earlier “maybe 10” to Sean Plunket when asked how many New Zealanders had experienced serious harm from the vaccine — extremely wide of the mark, deceptive and dismissive where honesty and precision was required.

(cf. NZDSOS submission, Section 1.9, pp.50-54 and Section 1.10, pp.56-58)

10. Censorship and Suppression

“In an ideal world you’d work with your policy and regulators to try and regulate some of the platforms, as they are starting to do in Europe.”

This is explicit advocacy of censorship. It contradicts her stated principle that “withholding knowledge erodes trust.”

In reality, the Medical Council forbade doctors from warning patients of risks, under threat of sanction, which they prosecuted with gusto. Honest

doctor–patient discussions — the core of medical practice — were undermined.

(cf. NZDSOS submission, Section 1.6, pp.27-29; Section 2.7.4, p.161)

11. Capacity, Role and Accountability

By appearing in a limited WHO communication role, HPH avoided scrutiny of:
- Her direct advice to Ministers.
- Her knowledge of transmission limitations.
- Her access to GVDN data.
- Her role in supporting misleading messaging.

This narrowing of scope protected the vaccine programme, not the public.

(cf. NZDSOS submission, Section 2.2.20, p.149)

A critical omission in Dr Petousis-Harris's evidence was any reference to the regulatory approval process of the Pfizer product in New Zealand.

- The Pfizer/BioNTech vaccine was granted only provisional consent under section 23 of the Medicines Act, subject to ongoing conditions, not full registration.
- The New Zealand Government signed a liability waiver with Pfizer on 5 October 2020 — five days before the official cut-off date for Pfizer's pivotal trial data (10 October 2020). These data were not peer-reviewed or published in the New England Journal of Medicine until December 2020.
- This meant the Government accepted indemnity, and the public were offered the product, before conclusive trial evidence was even available.

Despite this, HPH repeatedly described the vaccines in generalised terms as if they were fully approved and established products. She did not

acknowledge their provisional status, the unprecedented liability waiver, or the ethical implications for informed consent.

This silence was significant. Informed consent requires that people are told whether a medical product is fully approved, provisionally approved, and still under investigation. The Commission did not ask about this distinction, and HPH did not volunteer it.

(cf. NZDSOS submission, Section 2.1.2, p.124; Section 2.1.6, p.129)

12. Silence on Regulatory Approval and Liability

Another major omission in Dr Petousis-Harris's evidence was any reference to the manufacturing shift from "Process 1" to "Process 2."

- The pivotal phase 3 trial used material manufactured under "Process 1", a small-scale method with tighter control using PCR technology.
- For commercial rollout, Pfizer switched to "Process 2", a large-scale method using plasmid DNA with different purification steps.
- Regulators, including the EMA, initially noted that Process 2 batches contained a lower proportion of intact spike-encoding mRNA and raised concerns.
- Ultimately, regulators judged the commercial product "comparable," but equivalence was not conclusively demonstrated. As time has passed the differences now appear extreme.

This meant the vaccine actually distributed worldwide — including in New Zealand — was not identical to the product tested in clinical trials and had only miniscule (but damning) safety data. Despite this, HPH presented efficacy and safety claims as if they applied seamlessly to the commercial product, without disclosing this regulatory controversy.

This silence further undermined informed consent. If New Zealanders received a product manufactured differently from the one tested in trials, they had a right to know. The Commission did not ask, and HPH did not inform.

(cf. EMA leaked documents, Jan 2021; NZDSOS submission Section 2.1.3, pp.125-126)

13. Recommendations: Questions for Dr Petousis-Harris

The Commission should recall vaccinologist HPH and ask:

1. Why did you appear only in your WHO role, not as a government adviser?
2. What advice did you personally give Ministers and MoH regarding safety and transmission?
3. Why did the CV-ISMB meet beyond scheduled monthly (only) meetings solely when programme stability was threatened by adverse safety coverage?
4. Do you consider NZ's pharmacovigilance system well-functioning?
5. What adverse events of special interest (AESIs) were dropped, and why?
6. How do you explain ACC-accepted harms against your claim of "rare" events?
7. Why did you not disclose GVDN analyses of hospitalisation and mortality linked to vaccination?
8. How might causality be handicapped under the amended Coroners Act?
9. Do you accept that only myocarditis/pericarditis were acknowledged

because of contractual/political constraints?

10. Were you aware transmission impacts were “unknown” from the outset?

11. Why did you not object to “protect your whānau/grandma” messaging?

12. Do you accept that such messaging caused social division and coercion?

13. Why did you cite 95% efficacy without mentioning the exclusion of suspected cases?

([FDAreport] https://www.fda.gov/media/144245/download)

14. What evidence supports your claim that vaccines prevented severe disease “really well”, independent of waning variant severity?

15. On what evidence did you claim spike persists only “days”?

16. Do you accept evidence of persistence for months and possible genomic integration?

17. Why did you advocate regulating social media platforms “as in Europe”?

18. Do you accept this undermines open scientific debate?

19. What is your opinion of the NZ Medical Council censoring doctors from warning patients of risks?

20. Do you accept that coercive mandates undermined informed consent?

14. Conclusion

Dr Petousis-Harris’s evidence was characterised by:

- Generic framing not applicable to Covid-19.
- Minimisation of harms and failures of pharmacovigilance.
- Misrepresentation of transmission, efficacy, and mRNA persistence.
- Reliance on communication strategies over candour.

- Support for censorship and suppression of debate.

The Commission's failure to press HPH on causality, data access, and accountability allowed this narrative to stand.

It was hard to escape the reality of her role as cheerleader for the vaccine industry, versus the assumption that she brings academic independence to the pros and cons of this mass-administered new platform against infectious disease. Since it is not a vaccine but a genetic product she is not a qualified expert anyway.

(NZDSOS submission Section 1.16 p109)

Her testimony was designed to reassure not enlighten. It reflected a public relations approach, not scientific scrutiny. We state again that the scale of this global and generational medical disaster demands full examination. Unless she is recalled, along with other key players, and examined against these questions, the Commission will fail in its mandate to extract genuine lessons learned from government decision-making and all its influences.

Thank you for your ongoing communication with us and we look forward to hearing from you.

Yours sincerely,

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