Australian excess deaths enquiry submission

This document is an abridged version of a confidential submission made to the Australian excess deaths enquiry in May 2024. Adjustments from the original version are minor and omit phrases, statements or references that may be used to identify the author.

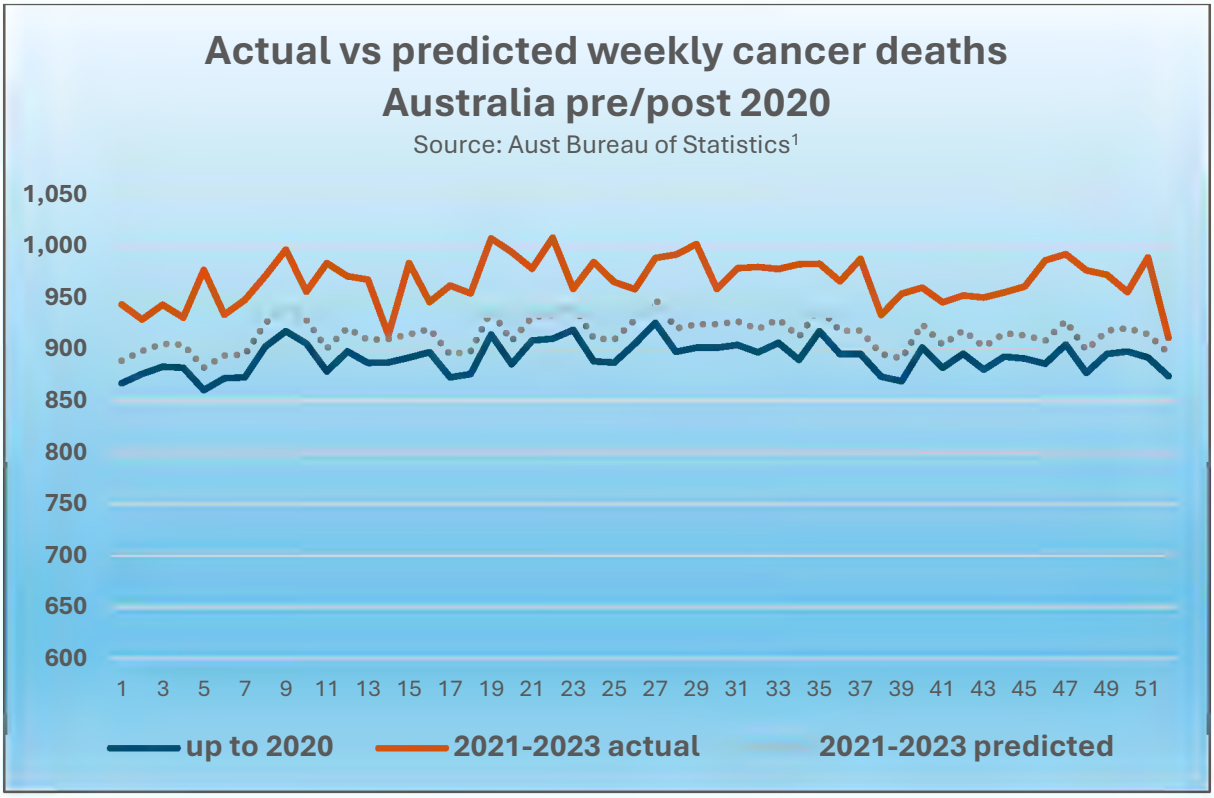
This submission is made in good faith and in the public interest and contain declarations and conclusions which I consider to be within my areas of expertise and as an Australian medical practitioner in good standing.

Lay Summary

The below analyses and investigations cover a number of areas related to the established incidence of excess deaths occurring in Australia over the last 2 years. The report includes independent analysis of publicly available data sets and professional insights in relation to the potential reasons for excess deaths. Concerns are raised in regard to conduct and reporting of data in relation to published excess mortality reports and potential conflicts of interest. Recommendations to provide definitive insights into the underlying causes of the excess death surge are published at the end of the report and are intended to provide guidance towards an open, transparent and independent investigation.

A. Excess Cancer Deaths

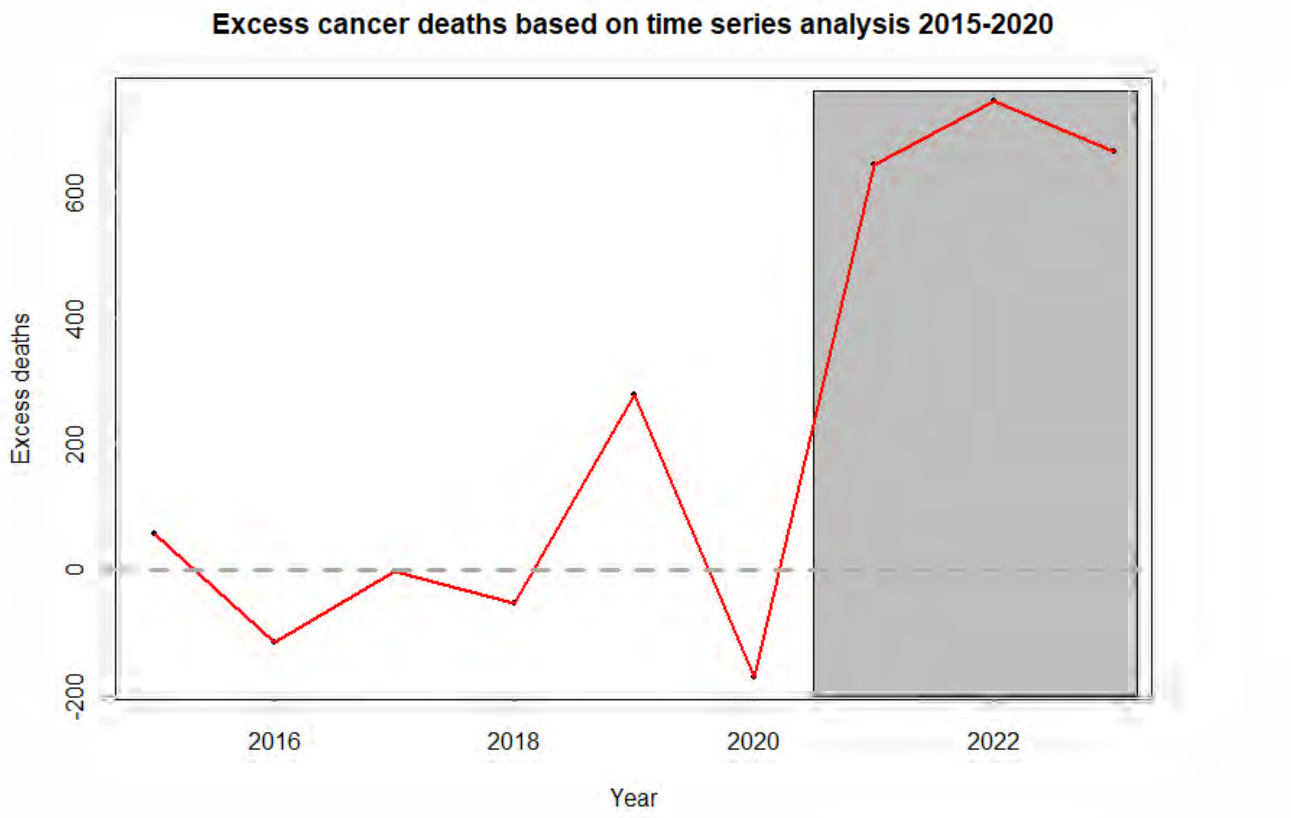
The following is an analysis based on the weekly data provided by the Australian Bureau of Statistics[1], excluding week 53 for the two years that included that week. Charts and data are mostly collated in R, for which the scripts underpinning the charts will be made available.



The increase in average weekly deaths from the pre-2021 cohort amounts to a 5-sigma (less likely than 1-in-1,000,000 event) increase based on the raw data provided by the ABS.

Adjusting for predicted increases in cancer mortality in Australia based on 2015-2020 observations brings this to 3.4-sigma, equivalent to a 3-in-10,000 event. In other words, this increase cannot be considered within the range of random annual variation.

[1] https://www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-2024/Deaths%20by%20week%20of%20occurrence%2C%202015-23.xlsx



Since 2021 the overall increase in cancer deaths based on an average of deaths from 2015-2020 compared to the actual deaths from 2021-2023 amounts to 11,579 additional deaths from cancer alone. Even adjusting for the annual increase in cancer mortality (which requires its own explanation and investigation) there were 2,050 additional deaths over the same time period over and above the predicted annual rise. Note that this is only cancer-related deaths (see the later section on all-cause deaths). A similar pattern of excess cancer deaths in the same timescale has been seen in the US and UK[2]

A further known factor underpinning this increase in cancer deaths is the restriction, both active and passive, on the access to hospital diagnostics and screening. Cervical cancer screening was significantly affected in 2020 and 2021 due to the perception from the public that going out of the house to attend a doctor was a risk and this significantly reduced uptake of cervical cancer screening[3]. In addition attendance at hospital was curtailed during 2020 on the pretext (not founded) of overwhelming the hospitals and the provision of diagnostic episodes was significantly reduced. The impact of this can only be to reduce the proportion of cancer patients being identified at an early stage and increased the proportion identified at later stages. Breast cancer screening was completely shut down for a period of time[4]. This is likely to have contributed to the increase in *deaths* from cancer even if the *incidence* of cancer over the years may well not have increased. In the absence of contemporaneous information on cancer

[2] https://www.researchgate.net/publication/378869803_US_-Death_Trends_for_Neoplasms_ICD_codes_C00-D48_Ages_15-44v
[3] (withheld)
[4] https://www.smh.com.au/national/nsw/breast-screening-clinics-shut-in-sydney-as-staff-redeployed-20210809-p58h8s.html

incidence it is impossible to untangle these contributions however it is absolutely possible to identify cancer incidence in real time in the same way that COVID data was collected in real time as all cancer diagnoses are recorded by pathology labs using SNOMED codes.

There are at least four possible causes of the increase in cancer deaths that require to be explored in order to prevent a worsening of the situation:

(i) Delay in accessing diagnostics and treatment due to closure of hospital and GP services, particularly in 2020/21
(ii) The impact, if any, of COVID infection on carcinogenicity risk, via the same or similar mechanisms as outlined below
(iii) The impact, if any, of the genetic vaccine program on carcinogenicity risk as outlined below.
(iv) Delay or deferral of attendance at medical establishments due to increasing distrust[5] of the medical profession and/or government bodies as a result of the perception that heavy-handed policies were implemented during 2020-2023 in divergence from the AHMPPI[6].

Both viral infection and genetic therapy products (e.g. DNA/RNA vaccines) have the theoretical capacity to induce carcinogenesis or oncogenesis (the onset of cancer). There are multiple mechanisms for this to occur and include, but not limited to:

(i) Insertional mutagenesis ("insertional oncogenesis"), where the genome of a cell is interrupted or displaced by the introduction of a foreign genetic sequence into the cell[7]
(ii) microRNA-mediated oncogenesis[8]
(iii) suppression of cancer repair pathways[9]
(iv) presence of plasmid DNA and oncogenic sequences, including the SV40 promoter, as contamination from recombinant therapy products where used[10]

As carcinogenicity and genotoxicity evaluations were specifically excluded (without a satisfactory explanation) in the Australian assessment for the provisional licensing of the nucleic acid products[11,12] it was incumbent upon the TGA to have conducted active pharmacovigilance in this area, but this does not appear to have been performed.

As it is currently difficult or impossible to identify the cause of the acute increase in cancer mortality it is therefore now necessary to make all transparent and objective attempts to identify whether any of the above or other factors have contributed to the increase in cancer mortality and/or incidence.

---

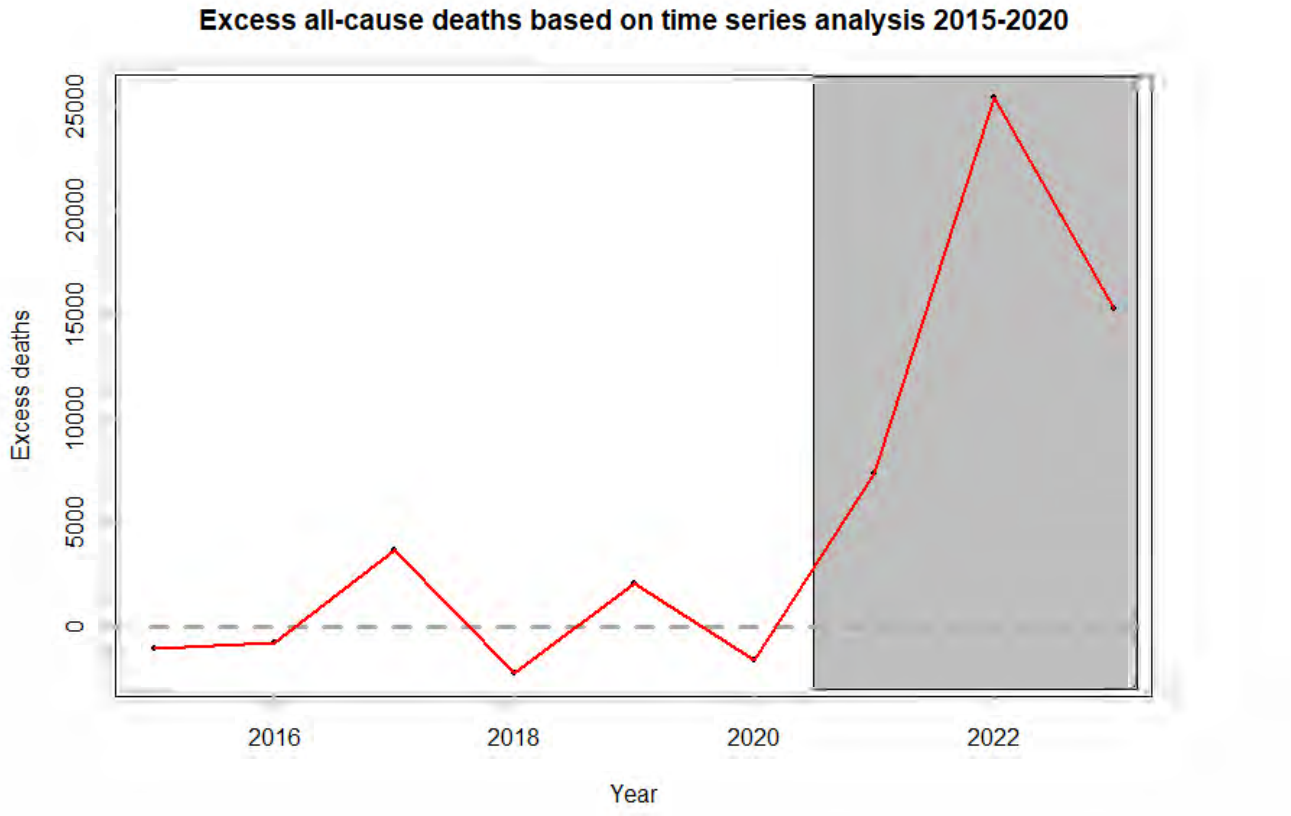
[5] https://www.pewresearch.org/science/2022/02/15/americans-trust-in-scientists-other-groups-declines/
[6] Australian Health Management Plan for Pandemic Influenza 2019. ISBN: 978-1-74186-151-8
[7] https://www.nature.com/articles/3302243
[8] https://crimsonpublishers.com/aics/fulltext/AICS.000552.php
[9] https://www.biorxiv.org/content/10.1101/2024.04.12.589252v1
[10] https://www.mdpi.com/2409-9279/7/3/41
[11] https://www.tga.gov.au/sites/default/files/auspar-chadox1-s-covid-19-vaccine-astrazeneca-210215.pdf
[12] https://www.tga.gov.au/sites/default/files/auspar-bnt162b2-mrna-210125.pdfv

Accessing real time SNOMED data should provide data on incidence but in order to exclude any involvement of either COVID or the genetic vaccines as a contributor would require assessment of tumour pathologies to exclude causation.

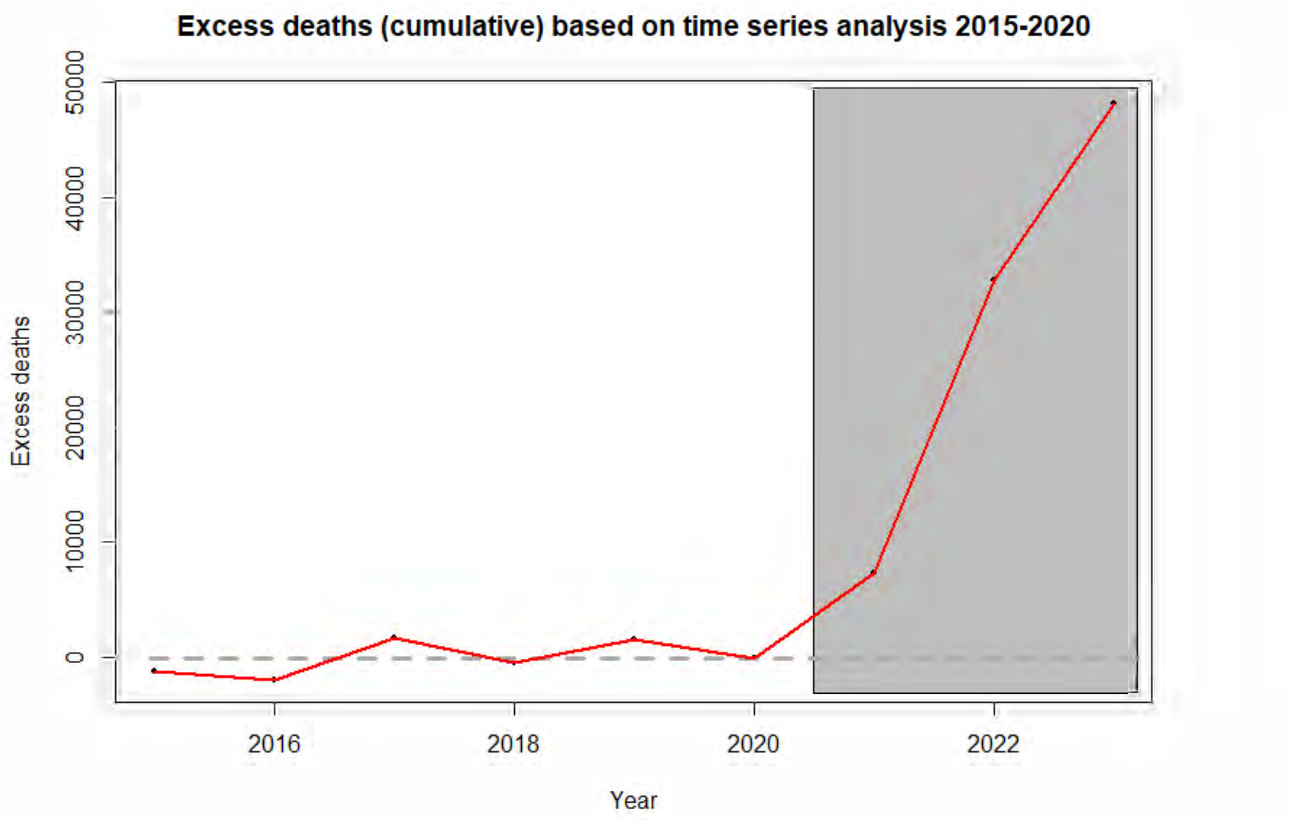
The techniques required for this are relatively straightforward and include PCR, comparative immunohistochemistry (for spike protein and nucleocapsid protein to differentiate viral vs vaccinal spike), specific spike protein immunohistochemistry (for the presence of 2P-modified spike protein), RNA-ISH and somatic genome sequencing. Of those techniques the first two are relatively cheap and reliable. At present in Australia however none of those techniques are available to the public or to health practitioners on request. The reasons for this are likely to be related to concerns that the pathology providers have of running assays that could show a linkage between either COVID or the COVID vaccines and the presence of newly diagnosed cancers, which could result in a cascade of litigation, and of fear of reprisal from government regulators as has been seen with the suspension of doctors under AHPRA, the doctors' regulator. One way to resolve this problem would be for the main pathology providers to agree to provide this service such that no individual provider could be targeted by their regulator.

B. Excess All-Cause Deaths

The same analysis as above can be applied to all-cause deaths for which the year-on-year increase from 2015-2020 was less noticeable. In other words there was a dramatic and more significant increase in the average all-cause mortality in the 2021-2023 time period compared to the 2015-2020 time period amounting to a 7-sigma increase (this is never-event level).



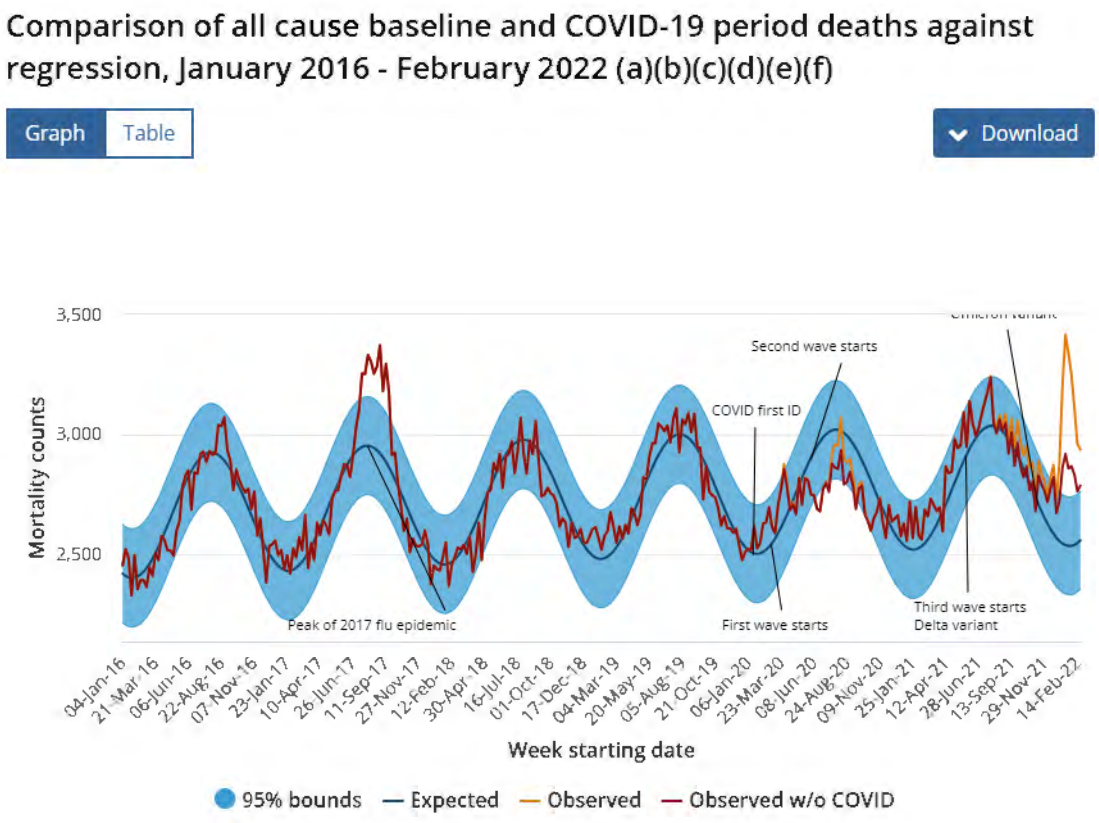
Based on the same time series comparison the total excess deaths for the time period amounts to 48,114 deaths which is more than the annual number of deaths from cancer in Australia. The cumulative deaths are represented in the chart below.



It should be noted that there were no excess deaths prior to the COVID-19 vaccination program reaching its 70% milestone[13]. This is true even when accounting for the wave of nursing home deaths in Victoria (July-Sept 2020) which were not replicated in any other state. In fact, all-cause mortality **reduced** during 2020 compared to an established baseline.

It should also be noted that the ABS analyses of "excess deaths" rely on certain assumptions regarding the "expected number of deaths" in any given year and these are subject to mitigation[14]. In other words, it is possible that the Bureau may decide to change its methods in such a way that would downplay the extent of excess deaths. For the purpose of the analysis contained in this report therefore I have used the same methods of prediction from the data reported for 2015-2020 using a linear model only for the 52-week intervals. This avoids any confounders associated with seasonality and the use of a Serling model ascribed by the ABS but for which the full methods or scripts are not available to the public.

[13] https://www.abc.net.au/news/2021-10-20/national-double-dose-full-vaccination-rate-reaches-70-per-cent/100552790
[14] https://www.abs.gov.au/methodologies/provisional-mortality-statistics-methodology/jan-2024 archived https://archive.is/3YVRO



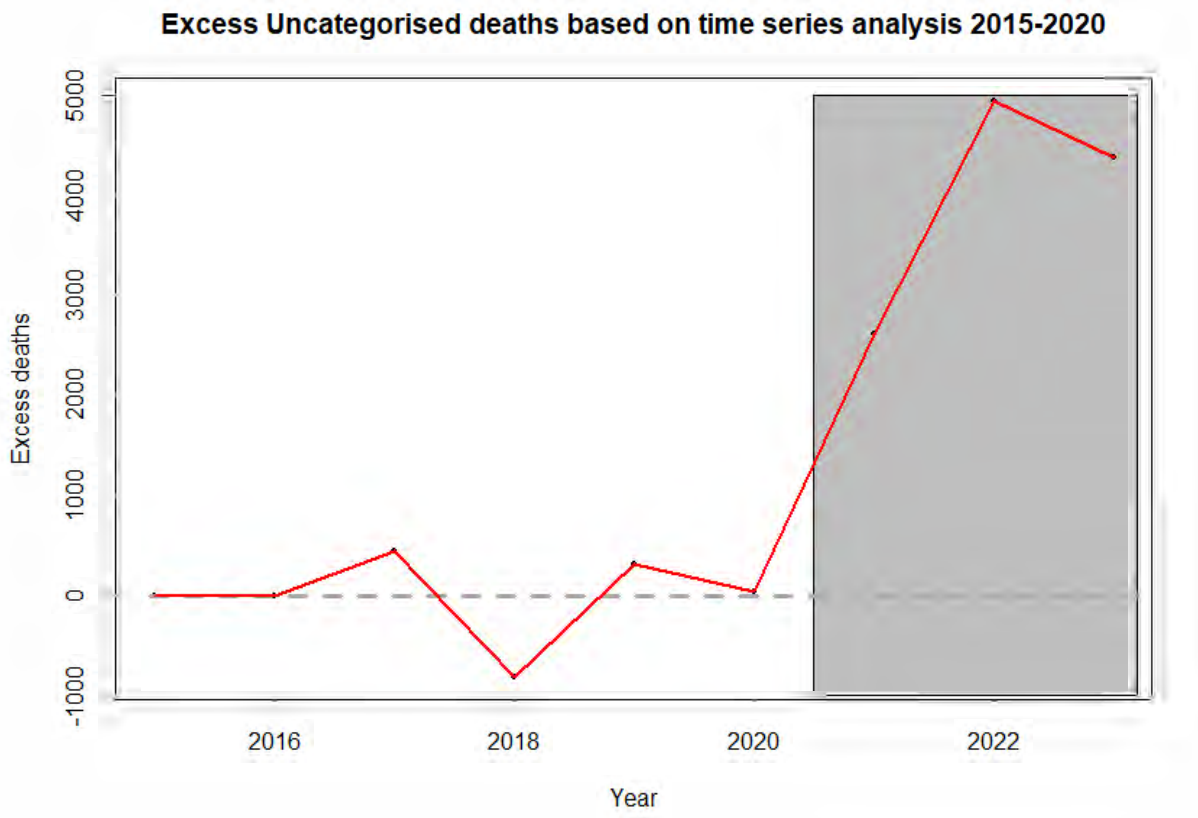
[15]

C. Excess Uncategorised deaths

A neglected component of the "COVID mortality report" conducted by the Actuaries Institute[16] was the shift of deaths into the "uncategorised" category. In 2022, this category comprised 22% of the overall mortality.

This shift accounted for 11,930 deaths even allowing for a slight rise in the predicted deaths in this category. These deaths and the shift in the deaths is unexplained. One possibility for this large increase, given that this analysis is based on "doctor certified" deaths, is that doctors are reluctant to ascertain a death to a category that they feel may put them at risk of reprisal by the regulator, which is a real risk that doctors in Australia are under threat of since the regulator took action against Australian doctors for making public commentary that was critical of government policy[17], with over 30 doctors suspended[18] in 2021-2022 (see also section H).

[15] Source: Aust Bureau of Statistics
[16] https://www.actuaries.digital/2023/03/06/almost-20000-excess-deaths-for-2022-in-australia/
[17] https://thewest.com.au/news/coronavirus/covid-19-doctors-for-and-against-coronavirus-vaccine-claim-medical-regulator-ahpra-has-silenced-them--c-9041979
[18] https://www.aap.com.au/factcheck/clive-palmers-claim-200-doctors-have-been-struck-off-fails-basic-check-up/

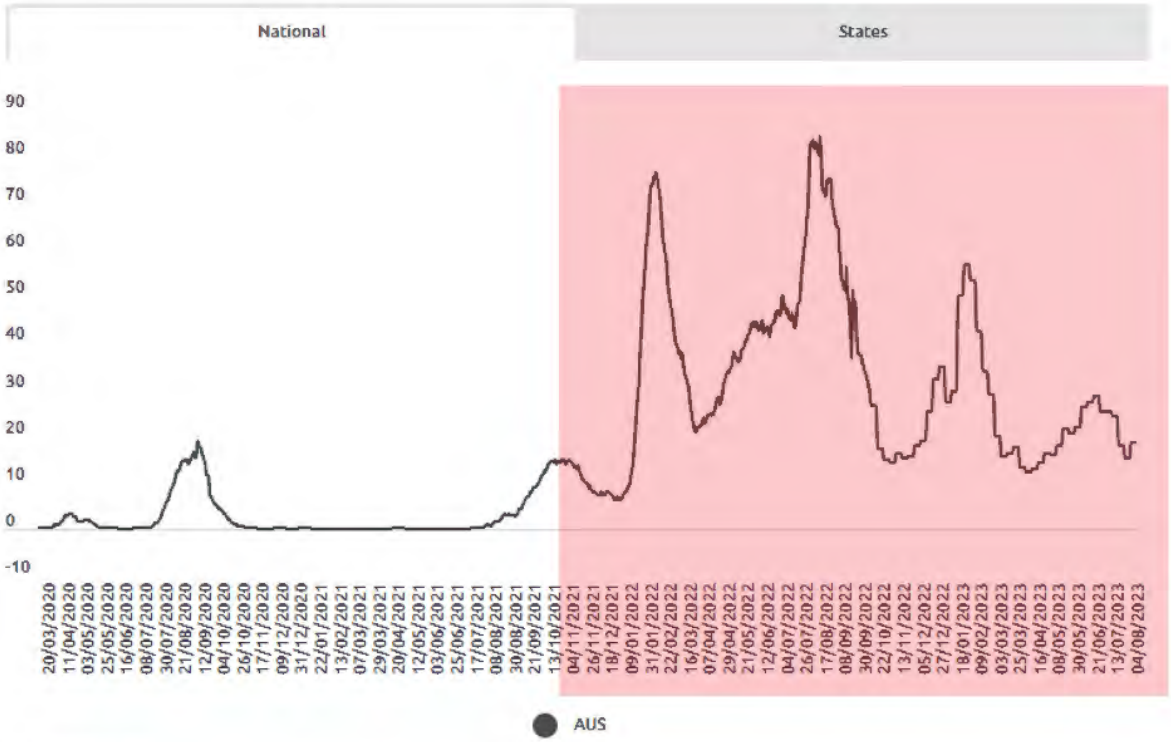


D. Contribution of "COVID" to All-Cause Mortality

Both the Actuaries report and the ABS provisional mortality statistics claim the inclusion of "COVID-19" to the increase in all-cause mortality. This is problematic because the majority of COVID-19 deaths in Australia occurred **after** the point at which 80% of the population had been fully vaccinated[19]. The following charts from the now mothballed official website[20] for monitoring COVID cases shows this effect strongly with the post-vaccination era highlighted in pink shade.

[19] https://www.abc.net.au/news/2021-11-06/pm-hails-80pc-vaccine-milestone/100600132
[20] covid19data.com.au archived https://archive.is/Y8Xch

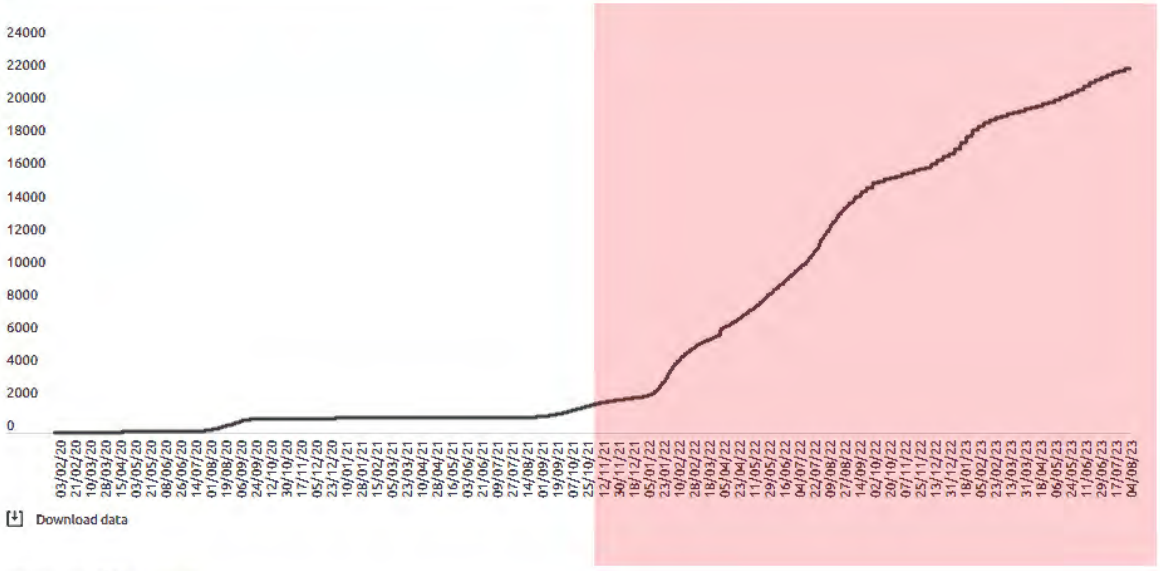
Daily deaths 14-day average



Download data

www.covid19data.com.au

Cumulative view of deaths from COVID-19 in Australia



Download data

www.covid19data.com.au

It is clear from the charts (and the underlying data) that not only did the overwhelming majority of Australia's COVID cases occur after the vaccination milestone of 70% or 80% but that this also applied to the overwhelming majority of the COVID **deaths** in Australia. From an objective viewpoint this must mean that not only did the vaccination program fail to prevent the tidal wave of COVID deaths reported by the ABS but that it appears that the vaccination program preceded, if not contributed to, the large increase in deaths. Overall, 20,462 of 22,268 (**92%**) of Australia's COVID deaths occurred **after** the 6th November 2021 milestone according to the data held at covid19data.com.au. This is despite assurances that the COVID vaccination program would prevent all or nearly all deaths.

In fact, a report from the NCIRS[21] using the data that they alone had access to claimed that the vaccination program reduced the risk of death by 93%. Given that there were over 20,000 deaths in a population where the overwhelming majority were fully vaccinated this figure would have been impossible to achieve. *The data underpinning this document should therefore be released for public audit including all database linkages from which the data were curated*.

The following two sections consider the role of COVID itself in the excess deaths reports.

E. Fraudulent Misconduct in Studies Related to Early Treatment of COVID-19 and Excessive Rates of Death in Australia

During the initial wave of COVID in March-June 2020 there were 104 deaths from COVID in all states combined, from 7928 cases - a case fatality rate of 1.3% during the most severe wave of COVID. During this initial wave, the early protocols for treating COVID replicated protocols from China and included the use of an inflammatory modulator (such as hydroxychloroquine) to reduce the risk of lung damage during the viraemic inflammatory phase and an antibiotic (such as the macrolide azithromycin) to reduce the risk from secondary pneumonia. This in fact mirrored established protocols for management of SARS from 2003[22] and were suggested in various research studies during 2020[23]. Subsequent studies including a large peer-reviewed study from France showed that combination protocol to be effective at preventing death associated with COVID-19[24].

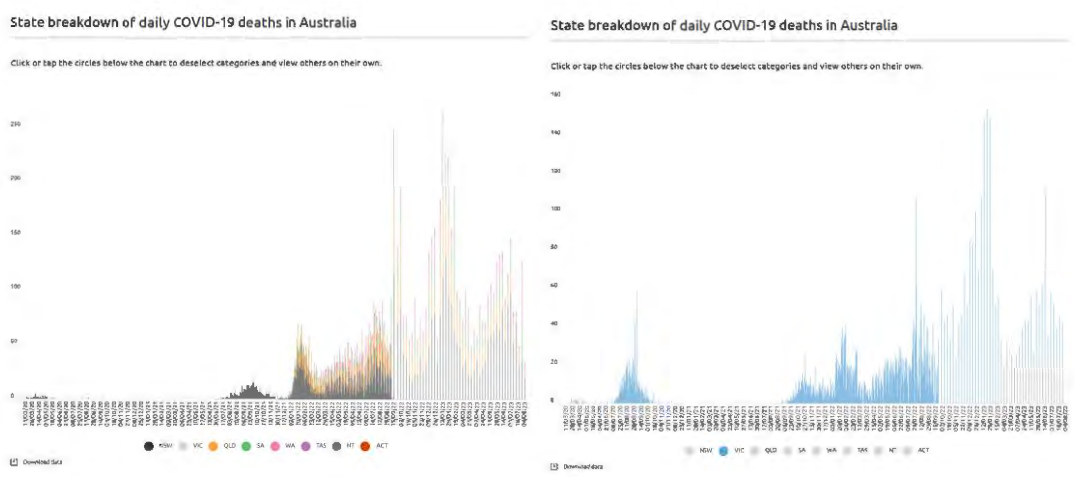
Those initial protocols are no longer accessible and were replaced on 3rd April 2020 by the WHO "MAGICApp" protocol[25] which has no named authorship and immediately revoked the use of hydroxychloroquine and azithromycin, prior to any randomised studies investigating whether that combination of treatments (as opposed to no early treatment) was effective at preventing mortality. Where committee members were named, in the therapeutics committee (presumably responsible for dictating policy on the use or repurposed antivirals and antibiotics vs experimental and expensive novel therapies) 8 of 17 members had disclosed interests with pharmaceutical corporations. This is wholly unacceptable and was not declared to the Australian public. Furthermore no audit trail exists of the contribution of individual committee members to the MAGICapp protocol documents.

---

[21] Archived https://archive.is/oWbkv
[22] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(03)13265-5/fulltext
[23] https://c19early.org/
[24] https://pubmed.ncbi.nlm.nih.gov/38024333/
[25] https://app.magicapp.org/#/guideline/4158

From the recent Royal Commission terms of reference testimony of Prof Mark Morgan[26] it was declared that he chaired the "covid19evidence" protocol document which was eventually over 700 pages and was supposed to include over 130 contributors. In my experience as a clinician researcher it is not possible to achieve valid contributions from this number of authors nor is it possible to write a 700 page document alone in the space of time available. It is therefore necessary to investigate how this document came about, who contributed to it and who is liable for any adverse outcomes as a result of the de facto imposition of its proposals.

In the year following the initial wave (1st July 2020 to 30th June 2021), essentially covering the delta time period, in all states ***excluding*** Victoria there were 6 deaths from 4056[27] cases (a case fatality rate of **0.15%**). This was consistent with international reports.



COVID-19 deaths 2020-2023. Left, all states other than Victoria. Right, Victoria only, clearly showing that the August 2020 "second wave" only occurred in Victoria. There were no new COVID-19 deaths in any other state in Australia in the year up to July 2021.

In Victoria, the state with the most draconian restrictions, there were 803 deaths from 19,988[26] cases (a case fatality rate of **4%**, likely the highest in the world for the delta outbreak). There is no explanation for why the case fatality rate in Victoria should have been so phenomenally high but nearly all the deaths were in Victorian nursing homes and mirrored the midazolam scandal highlighted in the UK where elderly nursing home residents were refused hospital care for standard medical episodes and instead provided a euthanasia pathway as treatment for either COVID or non-COVID episodes. That this happened in the UK was the subject of an amnesty international report[28] and for which investigation is still ongoing. No investigation of this incredible death toll has been undertaken in Australia however a Guardian report[29] noted that the deaths were almost all confined to nursing homes in clusters and is strongly suggestive of a coordinated intervention.

[26] https://www.aph.gov.au/DocumentStore.ashx?hearingid=31271&submissions=false
[27] covid19data.com.au accessed 16/5/24
[28] https://www.amnesty.org.uk/care-homes-report
[29] https://archive.is/Y2gMU

From the 1st July 2021 through to Dec 31st 2022 there were 11,211,896 reported cases of COVID-19 and 15,881 reported deaths[30] (all states) giving an overall case fatality rate of 0.14% consistent with the non-Victoria death rate seen prior to this time. However, this time period was the time during which the vaccine rollout had been enacted such that not only did the case fatality rate not fall but the overall case and death ***numbers*** increased by magnitudes. Even including the unexplained spike in Victorian COVID mortality prior to 1st July 2021, the case numbers went from 32,000 to 11,211,896 (a 350x increase) and the deaths from 914 to 15,881 (a 17x increase). Excluding the initial 803 Victorian deaths associated with unexplained nursing home fatalities would mean that this increase jumps to 143x (111 to 15,881). It is therefore statistically implausible, in the presence of such huge increases in death numbers, that any claims that lives were saved using modelling based on *presumed* reductions in COVID numbers that did not eventuate in the real world scenario could be valid[31].

During this time in Australia the early use of both hydroxychloroquine to reduce inflammation and azithromycin to prevent secondary pneumonia was prohibited by various edicts including state-based prohibitions on using these established and safe drugs[32] which appeared to have been enacted in unison in all states and territories except the ACT.

Based therefore on the various independent studies conducted in relation to hydroxychloroquine and/or azithromycin in 2020-2023[30] it would be reasonable to anticipate that between 50-80% of deaths may have been prevented by the implementation of early treatment protocols for people at risk of death from COVID-19.

It was noted as early as 2020 that data from high profile studies in relation to COVID were being misrepresented to the public. The most notable example of this was a large randomised controlled trial looking at hydroxychloroquine in the prevention of COVID-19 (originally conducted by David Boulware in the US and published in the New England Journal of Medicine[33]). In a re-analysis of this paper[34]. it was clear that where patients had received their antiviral in a timely fashion there was a significant reduction in the incidence of COVID-19 and further that, irrespective of the time that the participants received hydroxychloroquine, the risk of death in the study was zero. This conclusion was the opposite of that declared by the original paper author of whom a number of conflicts of interest (including linkage to Gilead pharmaceuticals) was subsequently declared. In addition the placebo arm of the study had used an active drug (folate) and had made a false claim about the choice for this drug. This therefore provided early evidence of manipulation of clinical data in the area of hydroxychloroquine usage in COVID-19.

In fact the Boulware paper, despite its clear biases and flawed analysis, essentially dealt the final blow to the usage or even investigation of hydroxychloroquine as an adjuvant treatment in COVID-19. At approximately the same time in May 2020 a large study had been published in the Lancet claiming that hydroxychloroquine use in COVID-19 *increased* rather than decreased mortality. Having been aware of the excellent safety profile of hydroxychloroquine over 50 years

---

[30] covid19data.com.au
[31] https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0299844
[32] https://www.tga.gov.au/resources/publication/scheduling-decisions-final/notice-amendment-current-poisons-standard-under-paragraph-52d2a-therapeutic-goods-act-1989
[33] https://www.nejm.org/doi/10.1056/NEJMoa2016638
[34] https://www.medrxiv.org/content/10.1101/2020.11.29.20235218v3

and the conduct of research studies in Australia it was clear that the study as published had notable indicators of fraud. It turned out that this study was in fact fully fraudulent and was retracted following an investigation conducted with other Australian and some international academics demonstrating conclusively that the study could not have happened[35].

Despite the demonstration of fraud in this large study that was retracted - and no other safety concerns being demonstrated with hydroxychloroquine - the study was used to impose a moratorium on the use of hydroxychloroquine[36]. Based on our own research and the many hundreds of *independent* studies published in this space[37] it is clear that many lives could have been saved had the TGA and the states not intervened in the prohibition of the use of hydroxychloroquine or other safe repurposed drugs.

Irrespective of the extent of net benefit of hydroxychloroquine (with or without antibiotics) in this situation it is clear that the use of or reliance on obviously fraudulent studies to impose unnecessary restrictions on medical practice is likely to have caused a significant loss of life.

F. Origins of COVID-19

There is currently no dispute that in 2020 a viral outbreak occurred in Australia and this resulted – whether by the result of viral infection directly or as a result of the management of that infection due to conflicted protocols – in many thousands of deaths. The Actuaries Institute report referenced above clearly claims that at least half of the excess deaths in Australia were due to COVID-19.

Notwithstanding the above discussion of potential conflicts of interest and fraud in the creation of protocols for the management of COVID-19 it is not disputed that COVID-19 was the cause of a significant proportion of the excess deaths in Australia and that these occurred in the presence of (i.e. despite) the COVID vaccination program.

It is therefore imperative that any investigation into excess deaths includes the role of Australian institutions and academics in the origin of the COVID-19 (SARS-Cov-2) virus.

Within my sphere of expertise in this field I am able to provide evidence of the following:

(i) That the furin cleavage site segment of SARS-CoV-2 could only, by any reasonable measure of probability, have arisen from lab manipulation as no genomic sequence of that length existed prior to 2020 in any eukaryotic genetic sequence. Although the sequence existed in a small number of bacterial genomes eukaryotic viruses cannot inherit those sequences. The paper demonstrating that this event could not have reasonably occurred in nature was published in 2022[38] as a peer-reviewed paper.

---

[35] https://www.theguardian.com/world/2020/may/29/covid-19-surgisphere-hydroxychloroquine-study-lancet-coronavirus-who-questioned-by-researchers-medical-professionals
[36] https://www.tga.gov.au/sites/default/files/foi-1871-04.pdfv
[37] https://c19early.org/
[38] https://www.frontiersin.org/articles/10.3389/fviro.2022.834808/full

(ii) That the Gp-120 sequences in the viral genome could not have arisen from recombination from any other virus or any other eukaryotic organism as this sequence did not exist prior to 2020.
(iii) That a number of publications have shown further anomalies in the genomic sequence of SARS-CoV-2 that show that it was impossible to have arisen from a natural occurrence[39,40].

On the basis of this and other evidence the Ecohealth alliance was withdrawn from any government funding on the 16th May 2024[41] following a congressional investigation that involved Australian academics.

Furthermore in the investigation of the involvement of Ecohealth alliance in the manufacture or other procurement of the SARS-CoV-2 virus I was made aware of freedom of information access requests that were directed towards Australian academics who were closely tied to Ecohealth yet the FOI requests were refused[42]. It is therefore an essential requirement of any committee enquiry in Australia that the involvement of known academics involved with Ecohealth and potentially involved in either "gain-of-function" research or in collusion to suppress the truth about the origins of COVID is investigated. Such an investigation must involve the investigation of any academic institution that was aware of documents that demonstrated the possibility that Australian academics were involved in the facilitation of such "gain-of-function" research or in the writing of media articles or affidavits that denied any link between such research and the origins of SARS-CoV-2 in order to hide or suppress actions that resulted in serious and widespread harm including deaths.

G. Perceived Significant Conflicts of Interest in Mortality Reports

The two primary sources for which media reports overplayed COVID-19 as the underlying cause of excess mortality, and ignored the contribution of the governmental interventions including the mandatory vaccination program and mandatory lockdown laws were the NCIRS and the Actuaries Institute. The NCIRS provided the underlying data for NSW Health's weekly COVID surveillance reports and analysis by vaccination status.

The surveillance reports ceased reporting deaths and intensive care admissions by vaccination status some time after September 2022 when it had been obvious for some weeks that the overwhelming majority (nearly 100%[43]) hospital admissions and ICU admissions were in the vaccinated recipients. There was no indication to stop this reporting as the scripts that produced the reports would already have been present. Furthermore as a consequence of the highlighting of this concern in public reports, a number of GIPA (freedom of information) requests were lodged[44] with NSW health which they not only declined or obfuscated but went so

[39] https://europepmc.org/article/PPR/PPR560730
[40] https://zenodo.org/records/4477081v
[41] https://www.science.org/content/article/federal-officials-suspend-funding-ecohealth-alliance-nonprofit-entangled-covid-19
[42] https://x.com/TonyNikolic10/status/1683961993244602374 in respect of University of Sydney GIPA 2022/5014 and 2023/1696
[43] https://www.health.nsw.gov.au/Infectious/covid-19/Documents/weekly-covid-overview-20220903.pdf
[44] e.g. NSWhealth GIPA folios GIPA 22/275, GIPA 22/233

far as going to court to protect their paper trails with the most prominent case being that against Xin Ooi, a data manager[45]. Furthermore the NCIRS was being funded by significant grants from NSW health who had rolled out the vaccine program and in conjunction with the NSW government had mandated its use as a condition of employment to every person in NSW. It was therefore a significant conflict of interest to use the NCIRS as the sole source of this information without any public accountability or ability to audit the data.

In a similar manner the Actuaries Institute appear to have been partnered with either the NSW government or NSW health at various times which implies a contractual funding arrangement. Without being able to see the underlying contracts for these arrangements it would be incumbent on the NSW government to declare that no such arrangements were made within the last 5 years with either the Actuaries Institute or with the authors of the Actuaries report which so notably ignored the possibility of the governmental interventions (such as lockdowns, propagation of fear to leave the home through repeated television appearances and the mandatory vaccination laws enacted in every state) as underlying causes to the large, significant and acute increase in all-cause mortality.

H. The Impact of Threats to Doctors and Other Practitioners for Raising Concerns in the Public Interest

As expressed above a significant number of doctors were suspended, licences revoked or voluntarily withdrew from the register during 2021-2022[46]. This arose primarily due to a significant body of doctors and other health care professionals discontent with the governmental policy or information regarding many aspects of the COVID situation including the origins of the virus, the abrogation to a new pandemic plan without due solicitation of views, the restriction of basic and established measures for managing respiratory viruses such as repurposed drugs and macrolide antibiotics, centralised and unauthored protocols[47] and the introduction of novel genetic vaccines. Rather than address the valid concerns of this body of opinion that included experts in all related fields the government's response via the regulator AHPRA was to issue a now infamous edict[48] on the 9th March 2021 which effectively prohibited the expression of public dissent from any Australian doctor.

The chilling effect of this was that any doctor, even those with expertise in relevant specialties, became immediately either unable or unwilling (for threat of reprisal) to express views in the public interest that may have saved lives.

A prime example of this is the impact of the AstraZeneca vaccine. This was known to have caused blood clots almost immediately on release and rollout of the product but that information was withheld with the TGA's famously playing down[49] "rumours" of the

[45] https://www.news.com.au/technology/science/human-body/nsw-health-erased-data-used-in-weekly-covid-surveillance-reports/news-story/2d4e3f9622d9398267c627f4da8975cb
[46] https://www.aap.com.au/factcheck/clive-palmers-claim-200-doctors-have-been-struck-off-fails-basic-check-up/
[47] https://app.magicapp.org/#/guidelines
[48] https://www.ahpra.gov.au/documents/default.aspx?record=WD21/30751&dbid=AP
[49]

risk of blood clots associated with the product. However, at the same time, NSW health changed its screening questions[50] asked of people attending for vaccination (of any type) to include questions on blood clotting confirming that they knew – but did not inform the public – that there was a risk of fatal blood clotting associated with some vaccines. It is almost certain that the suppression of this information resulted in the early deaths documented on the TGA register[51] in association with the AstraZeneca vaccine as, following the protocol eventually distributed by the THANZ some 6 months later[52], the incidence of sudden clot-related deaths associated with this product appeared to have been mitigated. In other words, given that this was a treatable condition, transparency regarding the risk was likely all that was needed to prevent deaths. It appears that the information was suppressed because the doctors who were aware of the information were afraid to advertise their knowledge for valid fear of deregistration. In addition, no independent review of the deaths on the TGA register was permitted by the TGA[53] so it was impossible to ascertain whether in fact the TGA had performed due and timely diligence in investigating this early and serious safety signal.

I have personally endured a succession of threats to my own registration for having contributed to public and private discussions in the realm of COVID vaccine safety and treatment. This included protected disclosures under the public interest disclosure act[54] yet prompted complaints to regulators from anonymous overseas entities as well as threatening communications from more than one Australian media source. In addition as a result of my *perceived* involvement in this space my family including my children were stalked online and I continue to receive veiled or overt threats.

No Australian doctor should be faced with making the choice between keeping their registration or speaking up in regard to public safety issues of concern that may have fatal consequences.

The public interest disclosure act was specifically created to prevent this and was enacted after the Vioxx scandal in which doctors globally were targeted by pharmaceutical corporations to threaten them into keeping silent about deaths following the use of the now-withdrawn painkiller Vioxx[55]. As far as I'm aware no person was criminally prosecuted for abusing the regulators for this purpose, and the result was a global death toll attributed to the ongoing use of Vioxx of over 30,000 people[56].

Yet this insidious activity is still ongoing. Personal communications I received indicated that AHPRA were aware of multiple reports against Australian doctors in 2021-2022 from a person whose identity matched that of a senior executive at Pfizer ANZ.

---

[50] (withheld in this version)
[51] https://www.tga.gov.au/news/covid-19-vaccine-safety-reports/covid-19-vaccine-safety-report-23-03-2023#total-adverse-event-reports-following-immunisation-to-19-march-2023
[52] https://www.mja.com.au/journal/2021/215/6/australian-and-new-zealand-approach-diagnosis-and-management-vaccine-induced
[53] TGA FOI 2471, not published
[54] https://www.legislation.gov.au/C2013A00133/latest/text
[55] https://www.cbsnews.com/news/merck-created-hit-list-to-destroy-neutralize-or-discredit-dissenting-doctors/
[56] https://www.theglobeandmail.com/life/vioxx-took-deadly-toll-study/article1113848/

Currently there are no practical protections for doctors to speak out about safety concerns in the public interest where there exists a pathway for anonymous reporting of them for their views on pharmaceutical products or government policy, or any other aspect of centralised medicine that could impact public safety in an adverse fashion. The obvious and clear result of this is the risk of potentially thousands of unnecessary deaths.

I. Recommendations for action

The following are some recommendations for expedited action to help restore the public's trust in health services and the government in response to the excess deaths crisis.

(1) An independent investigation of all rejections of freedom of information requests in relation to COVID that were applied at both state and federal levels.
(2) The release to the public of all data that was collected and advertised by government entities to underpin the claims of death rates by vaccination status. This should include full anonymised data sets released by NSW health in COVID surveillance reports that should be accessible to independent auditors and experts who may require to remain anonymous. An independent oversight committee should include legal entities or persons who do **not** hold an ongoing relationship with the federal or state governments.
(3) The release to the public of all contracts and communications between the Actuaries institute or its members who contributed to the report, and state or federal governments.
(4) The release to the public of all advisory documents underpinning the state health ministers' decisions to impose health orders.
(5) The release to the public of all advisory documents to coronial offices and officers advising new or changed protocols for assessing deaths of persons who had received COVID vaccines within the prior 30 days.
(6) The release to the public of any risk assessment conducted in relation to the impact of lockdowns and dissemination of fear-inducing information to the public which severely impacted the public's perception of safety and attendance at medical appointments.
(7) Release for public audit and inspection the contemporary incidence of cancer SNOMED codes to identify any change in cancer incidence in the last 3 years.
(8) Release to the public the TGA's assessment plan and data for the pharmacovigilance of cancer incidence following the nationwide rollout of genetic based vaccines.
(9) Engage all national pathology service providers to agree to provide services for the pathology-based assessment of COVID viral and vaccinal RNA presence in order to facilitate any claims to the COVID vaccine injury scheme where this can be found in either a tumour biopsy or an autopsy.
(10) A moratorium be imposed on the regulator's ability to censure doctors (beyond the issuance of advisory notices) for expressing opinions on the government's handling of the public health crisis in good faith. This by necessity would require protection of most speech by doctors on the basis that an alternative pretext could be used to censor doctors outside of a narrow scope.

(11) An urgent and independent public enquiry should be held on the public's views on the extent to which doctors (and by extension academics and non-medical experts who are regulated by any authoritative body or at risk of career termination) could be threatened into silence where they see corruption, wrongdoing or a risk to the public even if those matters are propagated by official agencies or authorities.

(12) An independent audit of all deaths in Victorian nursing homes during the time period July to September 2020 be undertaken.

(13) An independent investigation into the decision to prohibit or restrict the use of hydroxychloroquine in all states and territories except the ACT in April 2020

(14) An independent investigation into the role of Australian academic institutions into "gain-of-function" research (also known as Dual Use Research of Concern[57]), particularly those with known relationships with Ecohealth alliance and the Wuhan Institute of Virology.

[57] https://www.who.int/news-room/questions-and-answers/item/what-is-dual-use-research-of-concern

Page intentionally blank

Appendix

R script for plots

```
cancerd<-c(44694,45228,46047,46702,47738,47998,49514,50321,50948)
deaths<-setNames(data.frame(2015:2023,cancerd),c("year","cancer"))
model<-lm(cancer~year,data=deaths[1:6,])
pred_deaths<-predict.lm(model,deaths)
deaths<-data.frame(deaths[,1:2],pred_deaths)

plot(deaths$year,deaths$cancer-deaths$pred_deaths,main="Excess cancer deaths based on time
series analysis 2015-2020",pch=19,cex=0.5,ylab="Excess deaths",xlab="Year")
lines(deaths$year,deaths$cancer-deaths$pred_deaths,lwd=2,col="red")
abline(h=0,col="darkgrey",lty=2,lwd=3)
print ( 3*(mean(deaths$cancer[7:9])-mean(deaths$cancer[1:6])) )

#plot excess cancer deaths with block out for 2021+
plot(deaths$year,deaths$cancer-deaths$pred_deaths,main="Excess cancer deaths based on time
series analysis 2015-2020",pch=19,cex=0.5,ylab="Excess deaths",xlab="Year")
polygon(c(2020.5,2020.5,2023.2,2023.2),c(-200,760,760,-200),col="grey")
points(deaths$year,deaths$cancer-deaths$pred_deaths,pch=19, cex=0.5)
lines(deaths$year,deaths$cancer-deaths$pred_deaths,lwd=2,col="red")
abline(h=0,col="darkgrey",lty=2,lwd=3)

deaths.c<-deaths

#all cause mortality from ABS XL file (table 3.1 all deaths)
alld<-c(157086,158456,163933,159092,164396,161811,171819,190936,181865)
deaths<-setNames(data.frame(2015:2023,alld),c("year","all"))
model<-lm(all~year,data=deaths[1:6,])
pred_deaths<-predict.lm(model,deaths)
deaths<-data.frame(deaths[,1:2],pred_deaths)

plot(deaths$year,deaths$all-deaths$pred_deaths,main="Excess all-cause deaths based on time
series analysis 2015-2020",pch=19,cex=0.5,ylab="Excess deaths",xlab="Year")
polygon(c(2020.5,2020.5,2023.2,2023.2),c(-3000,26500,26500,-3000),col="grey")
points(deaths$year,deaths$all-deaths$pred_deaths,pch=19,cex=0.5)
abline(h=0,col="darkgrey",lty=2,lwd=3)
lines(deaths$year,deaths$all-deaths$pred_deaths,lwd=2,col="red")

plot(deaths$year,cumsum(deaths$all-deaths$pred_deaths),main="Excess deaths (cumulative) based
on time series analysis 2015-2020",pch=19,cex=0.5,ylab="Excess deaths",xlab="Year")
polygon(c(2020.5,2020.5,2023.2,2023.2),c(-3000,49500,49500,-3000),col="grey")
points(deaths$year,cumsum(deaths$all-deaths$pred_deaths),pch=19,cex=0.5)
abline(h=0,col="darkgrey",lty=2,lwd=3)
lines(deaths$year,cumsum(deaths$all-deaths$pred_deaths),lwd=2,col="red")

#load data from ABS excel file where weeks have been totalled for each category
#acm<-read.csv("ABS_ACM.csv") (data tabulated below)
colnames(acm)[1]<-"year"

model<-lm(Uncategorised~year,data=acm[1:6,])
deaths<-setNames(data.frame(2015:2023,acm$Uncategorised),c("year","deaths"))
pred_deaths<-predict.lm(model,deaths)
deaths<-data.frame(deaths[,1:2],pred_deaths)
plot(deaths$year,deaths$deaths-deaths$pred_deaths,main="Excess Uncategorised deaths based on
time series analysis 2015-2020",pch=19,cex=0.5,ylab="Excess deaths",xlab="Year")
polygon(c(2020.5,2020.5,2023.2,2023.2),c(-1000,5000,5000,-1000),col="grey")
points(deaths$year,deaths$deaths-deaths$pred_deaths,pch=19,cex=0.5,ylab="Excess
deaths",xlab="Year")
abline(h=0,col="darkgrey",lty=2,lwd=3)
lines(deaths$year,deaths$deaths-deaths$pred_deaths,lwd=2,col="red")
```

Collated *doctor certified* mortality data from ABS
"Deaths by week of occurrence 2015-2023"
accessed 10/5/24

Year	All Cause	COVID-19	Respiratory diseases	Cancer	Ischaemic Heart Diseases	Other Cardiac	Cerebro-vascular disease	Dementia	Diabetes	Not categorised
2015	137053	0	13325	44694	15886	8709	10181	12657	4329	27272
2016	139005	0	13595	45228	15678	8712	9967	13619	4491	27715
2017	143804	0	15286	46047	15481	9195	9954	14543	4684	28614
2018	139586	0	13451	46702	14448	8701	9576	14472	4422	27814
2019	144020	0	14782	47738	14090	8917	9195	15356	4552	29390
2020	141694	855	11833	47998	13613	8611	9043	15210	4968	29563
2021	150758	1250	12952	49514	14073	9619	9295	16430	5045	32580
2022	167777	9858	14455	50321	14984	10275	9307	17592	5638	35347
2023	159263	4356	14261	50948	13218	10154	8798	16889	5404	35235