19th September 2015

Dear Senators,

I am writing to you to with regard to the proposed **Social Services Legislation Amendment (No Jab, No Pay) Bill 2015** (referred to here as the Proposed Legislation).

I am a single mother, working full time, relying heavily on childcare services and kindergarten to ensure I can continue working to not only survive but to provide an adequate standard of living, care and education for my daughter. Without the ability to access childcare rebates and benefits I would be unable to afford to send my daughter to day care and have no other viable means to care for her to enable me to continue to work.

The Proposed Legislation attempts, through coercion, to undermine my rights as a parent to determine those medical procedures that would ultimately benefit, and not harm, my daughter. Those are rights not bestowed to the Government. **[3]** The Proposed Legislation discriminates, is coercive and contravenes many laws that set forth the conditions for Valid Consent in relation to medical practices.

Introducing legislation that effectively mandates vaccinations is not good Public Health Policy, particularly when deaths and injuries occur as a result of vaccinating and the diseases being vaccinated for have low incidence and even lower mortality. Most unvaccinated children are in a state of perfect health, with no symptoms and no active disease. There is no “imminent” risk of harm from unvaccinated children.

Given that **vaccinated** children can still **contract and spread** some communicable **diseases**, non-vaccinated children pose no greater risk to public health than vaccinated children and it is doubtful the Proposed Legislation would achieve the desired outcome of reducing the spread of communicable diseases.

Whooping cough rates have been used to push the need for mandatory vaccines in Australia but in actual fact the incidence of whooping cough has been increasing with the increase in vaccination rates. In 1991 less than 71% of Australian children were fully vaccinated yet there were only 347 cases, whilst in 2011 with over 90% vaccination rates there were over 38,000 cases. From 2013 to 2015 there was a 54% increase in cases. Yet vaccination rates across the country remain high.

Where there is risk, there should always be choice, and vaccines carry a significant risk of harm and even death **[23].** Please read the supporting information attached where noted, particularly this point, a link to a ***GlaxoSmith Kline: Infranrix Hexa Summary Bridging Report 2011***. It talks of the severe vaccine reactions and **deaths** that occurred from the vaccination and also identifies those reactions noted but NOT included on the vaccination insert sheets.
There is no way to predict which children will react badly to vaccines. By removing the ‘Conscious Objection’ form (currently accounting for 1.52% of children <7 years of age) all that remains is Medical Exemptions. For a medical exemption to be given a child must have

experienced a severe and immediate reaction to a vaccine, and only then can they receive a medical exemption for the one vaccine they reacted to.

What does this mean for children, if every child must be subjected to ALL vaccines to see which they do and don't react to? I am pro-choice, but no family should ever be forced to play vaccine roulette with their child.

I urge you to oppose the progression of this legislation, leave conscientious objections in place and allow those that have them registered to continue to receive the Child Care Rebate, Child Care Benefit and Family Tax Benefit A.

1. Violation of Informed and Valid Consent

The Proposed Legislation Contravenes the **Universal Declaration of Bioethics and Human Rights 19 October 2005, Article 6** and **Article 11** and the **Australian Immunisation Handbook** - Legal requirements for Immunisation.

According to the Universal Declaration of Bioethics and Human Rights 19 October 2005, Article 6, any preventative medical intervention should be carried out **with prior free and informed consent** and Article 11 states that we **should not be discriminated or stigmatized on any grounds**, in violation of human dignity, **human rights and fundamental freedoms**. **[2]** The Proposed Legislation contravenes these rights.

If the Proposed Legislation was to come into effect I am left no affordable alternatives to provide care for my daughter to enable me to continue working. There will be many people in a similar situation and this Proposed Legislation would therefore amount to undue coercion, pressure and manipulation.

The legal requirements of consent for vaccination are also specified in the government's own Australian Immunisation Handbook:

> "***2.1.3 Valid consent***
> *For consent to be legally valid, the following elements must be present:*
>
> • *It must be given by a person with legal capacity, and of sufficient intellectual capacity to understand the implications of being vaccinated.*
>
> • ***It must be given voluntarily in the absence of undue pressure, coercion or manipulation**.*
>
> • *It must cover the specific procedure that is to be performed.*
>
> • *It can only be given after the potential risks and benefits of the relevant vaccine, risks of not having it and any alternative options have been explained to the individual*."
> (http://www.immunise.health.gov.au/…/Handbook10-home~handboo…)

Mandatory vaccines violate the medical ethic of informed consent. A case could also be made that mandates for vaccines by state and legislatures is the de facto practice of medicine without a license. Most unvaccinated children are in a state of perfect health, with

no symptoms and no active disease. There is no “imminent” risk of harm from “failure to treat”.

Any medical practitioner who vaccinates a child while aware parental consent is only given in order to enrol their child in education or care services is acting outside the law and breaching human rights.

2. Discrimination by Age

The Proposed Legislation discriminates by age, as defined under the **Age Discrimination Act 2004 – SECT 15 [21]**,

- The argument put for mandating the Vaccination Schedule is to reduce the spread of communicable diseases.
- Some vaccines within the schedule do not prevent or guarantee the vaccinated person from contracting some diseases, becoming asymptomatic and spreading disease in the future, for example Whopping Cough, Measles (see point 3).
- Following vaccination the recipients of certain Vaccines will shed and spread the communicable disease for a period, for example Whopping Cough (see point 3).
- Most unvaccinated children are in a state of perfect health, with no symptoms and no active disease. There is no “imminent” risk of harm from unvaccinated children.
- Vaccinations are not mandated in Australia for any other age group.
- 92% of parents vaccinate their children on time [22].
- **53% of parents have at least some concerns around vaccinating their children** [22].
- Conscientious Objections make up approximately only 1.5% that delay or avoid vaccinations.
- The Vaccination Schedule is made up of vaccines for communicable and NON communicable diseases.
- Admission into Child Care, Kindergarten or School is not prohibited for children who are chronic hepatitis B carriers, so why should those children not vaccinated and not carrying hepatitis B be discriminated from attending Child Care or Kindergarten?
- Worldwide childhood vaccination schedules vary. Notably the United Kingdom does **not** include vaccination for Chickenpox as it is deemed to be a mild childhood disease (see point 5).
- There is no medical debate that adverse events can occur after vaccination. In some instance they can be extremely serious, even resulting in death. If this is the possible outcome, no matter the likelihood, then parents should not be coerced into vaccinating their children.

- Not all children (excluding those with exemptions) will have the same level of vaccination according to the Vaccination schedule; i.e. Children aged 12 months or less will not have received the Measles, Mumps and Rubella vaccination and therefore are just as at risk of contracting these diseases and spreading them as would my unvaccinated daughter, or those who are already vaccinated.

- Australia **does not** have a No-Fault Compensation Scheme, as recommended by the World Health Organisation, for those injured or killed by Vaccinations.

Therefore the requirement for mandatory vaccinations for the entire Vaccination Schedule, as determined by age, is **not reasonable**.

3. Vaccination does not always prevent disease transmission

Some of the recommended vaccines **are not *designed* to prevent the transmission of infection** rather; they are intended **to prevent disease symptoms**.

1. It has been documented that **vaccinated persons who develop breakthrough measles are contagious**. In fact, two major measles outbreaks in 2011 (in Quebec, Canada, and in New York, NY) were re-imported by previously vaccinated individuals**. [17]–[18].**

2. Studies of measles outbreaks in Quebec, Canada, and China attest that **outbreaks of measles still happen, even when vaccination compliance is in the highest bracket** (95-97% or even 99%, **[8]&[9]).** Vaccine immunity does not equal life-long immunity acquired after natural exposure.

   Those vaccinated against the **measles** virus are still able to contract and spread the virus. "*The apparent paradox is that as measles immunization rates rise to high levels in a population, measles becomes a disease of immunized persons."* - Poland & Jacobson (1994) "**Failure to Reach the Goal of Measles Elimination: Apparent Paradox of Measles Infections in Immunized Persons."** *Arch Intern Med* 154:1815-1820.

   Further research determined this is caused by a small percentage of the population known as "Low-responders". Low responders will respond poorly to the first dose of the measles vaccine, and who will then mount a weak immune response to subsequent RE-vaccination and quickly return to the pool of "susceptible'' within 2-5 years, despite being fully vaccinated.**[14]**

   Re-vaccination cannot correct low-responsiveness: it appears to be an immuno-genetic trait**. [15]** The proportion of low-responders among children was estimated to be 4.7% in the USA**. [16]**

   A therapeutic backup exists. Infants as well as other vulnerable or immunocompromised individuals can receive immunoglobulin, a potentially life-saving measure that supplies antibodies directed against the virus to prevent or ameliorate disease upon exposure **[11]**.

3. **IPV (inactivated poliovirus vaccine)** cannot prevent transmission of poliovirus **[4]**.

4. The **acellular pertussis (aP)** vaccine replaced the whole cell pertussis vaccine in the late 1990s, which was followed by a resurgence of whooping cough. **An experiment**

with deliberate pertussis infection in primates revealed that the aP vaccine is not capable of preventing colonization and transmission of B. pertussis [5]. The FDA has issued a warning regarding this crucial finding.[12] Furthermore, the 2013 meeting of the Board of Scientific Counselors at the CDC revealed additional alarming data that **pertussis variants (PRN-negative strains) currently circulating in the USA acquired a selective advantage to infect those who are up-to-date for their DTaP boosters [6]**.

Other vaccinations (Tetanus and HepB) are for **non-communicable diseases** and as such why exclude those who have not received these vaccines from a care or education setting?

5. **Tetanus** is not a contagious disease, but rather acquired from deep-puncture wounds contaminated with C. tetani spores. Vaccinating for tetanus (via the DTaP combination vaccine) cannot alter the safety of public spaces; it is intended to render personal protection only.

6. **Hepatitis B** is a blood-borne virus that does not spread in a community setting, especially among children who are unlikely to engage in high-risk behaviours, such as needle sharing or sex. Further, school admission is not prohibited for children who are chronic hepatitis B carriers. To prohibit care or Kindergarten admission for those who are simply unvaccinated - and do not even carry hepatitis B - would constitute unreasonable and illogical discrimination.

4. Worldwide discrepancies in vaccination schedules

Worldwide the childhood vaccination programmes set forth by individual countries vary. **Did you know that in the United Kingdom childhood vaccination programme does NOT include the Chickenpox vaccine?**

"*The chickenpox vaccine is not part of the UK childhood vaccination programme. It is used to protect people who are most at risk of serious complications from chickenpox infection, such as:*

- *pregnant women*
- *people who have weakened immune systems, such as from HIV or through treatments such as chemotherapy*

Chickenpox is usually a mild illness, particularly in children."
http://www.nhs.uk/chq/Pages/1032.aspx?CategoryID=62

While worldwide opinion varies on the need for such vaccines in a childhood vaccination schedule why would Australia discriminate those children who have not had this vaccination?

5. Aluminium contained within Vaccines is a known Neurotoxin and dosage as a result of Vaccination is above recommend limits.

Another concern I have is the amount of Aluminium that is in some of the vaccines on the immunisation schedule. Research exists that shows that if you inject the aluminium adjuvant, a portion of the aluminium is engulfed by macrophages. Some of these macrophages eventually find their way into the brain.

"the problem is that once the aluminium gets into the nucleus of the cell, there is no way of getting it out. It just stays there. The finding by the French team is that even the aluminium you inject in the periphery can get into the brain, which is a concern...

*The fact is that the aluminium we get from vaccines is not rapidly excreted, and most of it does remain in your body because it bypasses the gastrointestinal system."**[20]***

Aluminium is a neurotoxin and the FDA maximum requirement for aluminium received in an IV is **25 mcg per day**. As an example; if my 3 year old daughter were to complete a catch up schedule, in her **first visit alone** she would receive **1320mcg** of Aluminium* or **52.8 times** the maximum requirements for aluminium received in an IV – or an adult not an infant.

*(Infranix Hexa (DTPa HepB IPV Hib) 0.82mg per 0.5ml = 820mcg per injection and NeisVacC (MenC) 0.5mg per 0.5ml = 500mcg per injection).

I am confused at how the Government can sanction these levels when they limit the amount of aluminium allowable in an IV to 25mcg per day.

6. Lack of a No-Fault Compensation Scheme and poor Adverse Events reporting

There is no medical debate that adverse events occur after vaccination. In some instances they can be extremely serious, even resulting in death. The World Health Organisation states that such injuries resulting from Vaccines can require a life time of care, and that it is an 'ethical necessity' that a no-fault compensation scheme be in place.

It is highly questionable that the Government seeks to introduce such mandates as the Proposed Legislation when Australia lacks a no-fault compensation scheme for victims of vaccination a system already in place in over 19 countries, including the USA, Canada, New Zealand and in most of Europe.

Notably the United States No-Fault Compensation scheme has paid out over $3.5 Billion in compensation related to Vaccine injuries.

What provisions does your Government provide for those who have suffered a vaccine injury?

One of our nation's foremost experts in infectious disease, Peter Collingnon, has stated that we have an 'inadequate' adverse event reporting system **[24].** The CDC note that less than 10% of all Vaccine related adverse events are reported.

How can your government quantify the level of risk associated with different vaccines, without agreed upon statistics for adverse events?

Given all of the above I am at a loss as to how or why conscientious objectors (who only make up 1.5% of those delaying or not vaccinating their children) should be discriminated against and have their children's rights diminished by being excluded from childcare and education services.

I oppose the idea of trading off the life and health of one child or person for another in any context. I empathise with those parents and children that are impacted by the diseases that

vaccines attempt to protect people from and I also empathise with those parents and children who have been adversely affected by these very same vaccines.

I am most certainly pro-choice, but while children are injured and die from vaccinations **[23],** as documented by the manufacturers themselves, with Vaccine safety still in question, and the long term impacts still unstudied, I urge you to oppose the Proposed Legislation and encourage the Government to spend more resources on ensuring public safety in this arena rather than discriminating against those who make an informed conscientious choice not to vaccinate.

I urge the Government to invest in assisting those families and children that have been adversely impacted by vaccinations who currently have to fight for health and financial assistance for what in some cases, amount to lifetime injuries and even death.

I appreciate your time to read my letter and would like to hear how you will represent my concerns in parliament.

Yours Sincerely

Stacey O'Toole

Supporting Information

[1] Australian – Early Childhood National Quality Framework

http://files.acecqa.gov.au/files/National-Quality-Framework-Resources-Kit/belonging_being_and_becoming_the_early_years_learning_framework_for_australia.pdf

"Early childhood educators guided by the Framework will reinforce in their daily practice the principles laid out in the **United Nations Convention on the Rights of the Child** (the Convention). **The Convention states that all children have the right to an education** that lays a foundation for the rest of their lives, maximises their ability, and **respects their family**, **cultural and other identities** and languages. The Convention also **recognises children's right to play and be active participants in all matters affecting their lives."**

"4. **Respect for diversity** There are many ways of living, being and of knowing. Children are born belonging to a culture, which is not only influenced by traditional practices, heritage and ancestral knowledge, but also by the experiences, values and beliefs of individual families and communities. **Respecting diversity means within the curriculum valuing and reflecting the practices, values and beliefs of families. Educators honour the** histories, cultures, languages, traditions, **child rearing practices and lifestyle choices of families**. **They value children's different capacities and abilities and respect differences in families' home lives**. **Educators recognise that diversity contributes to the richness of our society and provides a valid evidence base about ways of knowing. "**

[2] Universal Declaration of Bioethics and Human Rights 19 October 2005

Article 6 – Consent

1. Any **preventative**, 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 express and may be withdrawn by the person concerned at any time and for any reason without disadvantage or prejudice.

Article 11 – Non-discrimination and non-stigmatization

No individual or group should be discriminated against of stigmatized on any grounds, in violation of human dignity, human rights and fundamental freedoms.

[3] Human Rights of the Child

http://www.unhchr.ch/tbs/doc.nsf/898586b1dc7b4043c1256a450044f331/6f6879be758d0e8ec12570d9003340ba/$FILE/G0544374.pdf
http://www.earlychildhoodaustralia.org.au/wp-content/uploads/2014/08/Rights_overview.pdf

Some of the core principles of the CRC are:

- the right of all children to survival and development;

- respect for the best interests of the child as a primary consideration in all decisions relating to children;
- the right of all children to express their views freely on all matters affecting them; and
- the right of all children to enjoy all the rights of the CRC without discrimination of any kind.

Article 18 (Parental responsibilities; state assistance):

Both parents share responsibility for bringing up their children, and should always consider what is best for each child.

Governments must respect the responsibility of parents for providing appropriate guidance to their children – the Convention does not take responsibility for children away from their parents and give more authority to governments.

It places a responsibility on governments to provide support services to parents, especially if both parents work outside the home.

Article 28: (Right to education):

All children have the right to a primary education, which should be free. Wealthy countries should help poorer countries achieve this right. Discipline in schools should respect children's dignity. For children to benefit from education, schools must be run in an orderly way – without the use of violence. Any form of school discipline should take into account the child's human dignity. Therefore, governments must ensure that school administrators review their discipline policies and eliminate any discipline practices involving physical or mental violence, abuse or neglect.

The Convention places a high value on education. Young people should be encouraged to reach the highest level of education of which they are capable.

Article 29 (Goals of education):

Children's education should develop each child's personality, talents and abilities to the fullest. It should encourage children to respect others, human rights and their own and other cultures. It should also help them learn to live peacefully, protect the environment and respect other people. Children have a particular responsibility to respect the rights their parents, and education should aim to develop respect for the values and culture of their parents.

The Convention does not address such issues as school uniforms, dress codes, the singing of the national anthem or prayer in schools. It is up to governments and school officials in each country to determine whether, in the context of their society and existing laws, such matters infringe upon other rights protected by the Convention.

[4] The Cuba IPV Study collaborative group. (2007) **Randomized controlled trial of inactivated poliovirus vaccine in Cuba**. *N Engl J Med* 356:1536-44
http://www.ncbi.nlm.nih.gov/pubmed/17429085

The table below from the Cuban IPV study documents that 91% of children receiving no IPV (control group B) were colonized with live attenuated poliovirus upon deliberate experimental inoculation. Children who were vaccinated with IPV (groups A and C) were similarly colonized at the rate of 94-97%. High counts of live virus were recovered from the stool of children in all groups. These results make it clear that IPV cannot be relied upon for the control of polioviruses.

Table 3. Isolation of Poliovirus in Stool Samples 1 Week after Oral Poliovirus Vaccine Challenge According to Study Group and Poliovirus Type.*

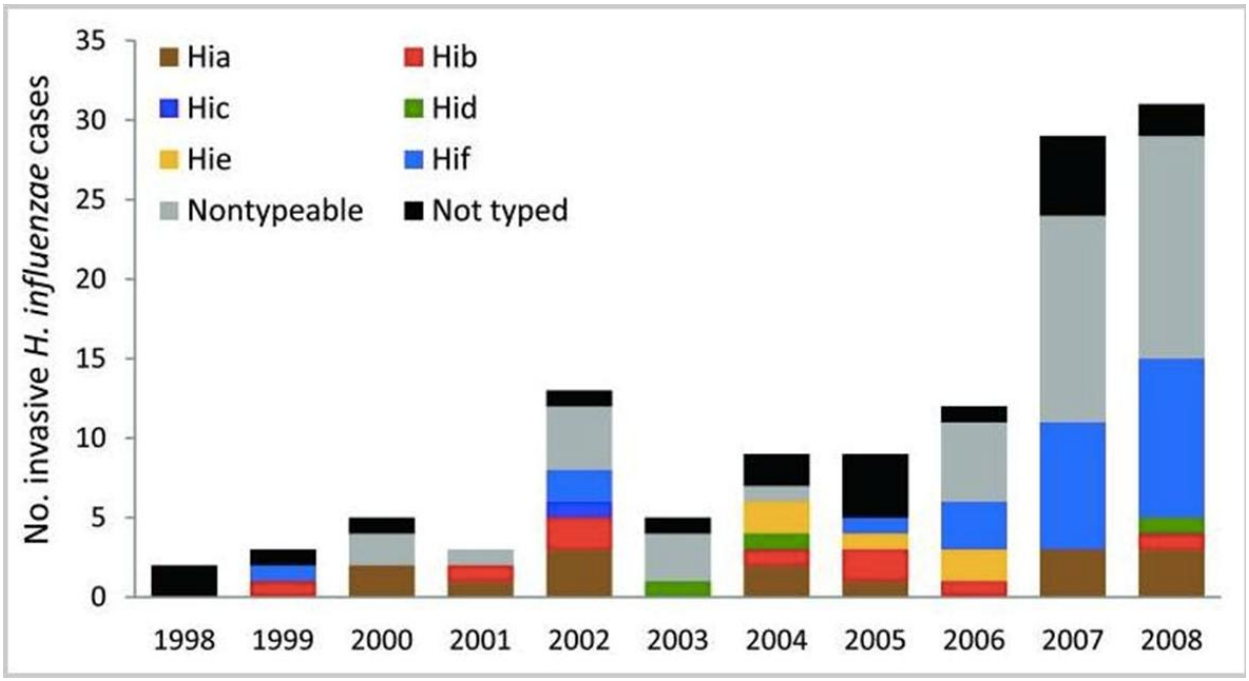
Group†	No. of Infants	Type 1		Type 2		Type 3		Any Type of Poliovirus		
		No.	% (95% CI)	No.	% (95% CI)	No.	% (95% CI)	No.	% (95% CI)	Mean Log_{10} Titer in Fecal Sample (95% CI)‡
A	52	10	19 (10–33)	45	87 (74–94)	5	10 (3–21)	49	94 (84–99)	3.46 (3.17–3.75)
B	54	9	17 (8–29)	48	89 (77–96)	3	6 (1–15)	49	91 (80–97)	3.89 (3.64–4.14)
C	72	13	18 (10–29)	67	93 (85–98)	10	14 (7–24)	70	97 (90–100)	3.37 (3.14–3.60)

* All stool samples taken from study participants just before the challenge dose were negative for poliovirus. Exact confidence intervals (CIs) are based on the binomial distribution.
† Group A received a combination of diphtheria–pertussis–tetanus vaccine, *Haemophilus influenzae* type b vaccine, and inactivated poliovirus vaccine (DPT-Hib-IPV) at 6, 10, and 14 weeks of age. Group B, the control group, received a combination of DPT vaccine and Hib vaccine at 6, 10, and 14 weeks. Group C received the DPT-Hib-IPV combination at 8 and 16 weeks.
‡ Mean values are given for excretors of poliovirus.

[5] Warfel *et al.* (2014) **Acellular pertussis vaccines protect against disease but fail to prevent infection and transmission in a nonhuman primate model.***Proc Natl Acad Sci USA* 111:787-92
http://www.ncbi.nlm.nih.gov/pubmed/24277828
"Baboons vaccinated with aP were protected from severe pertussis-associated symptoms but not from colonization, did not clear the infection faster than naïve [unvaccinated] animals, and readily transmitted B. pertussis to unvaccinated contacts. By comparison, previously infected [naturally-immune] animals were not colonized upon secondary infection."

[6] Meeting of the Board of Scientific Counselors, Office of Infectious Diseases, Centers for Disease Control and Prevention, Tom Harkins Global Communication Center, Atlanta, Georgia, December 11-12, 2013
http://www.cdc.gov/maso/facm/pdfs/BSCOID/2013121112_BSCOID_Minutes.pdf
Resurgence of Pertussis (p.6)
"Findings indicated that 85% of the isolates [from six Enhanced Pertussis Surveillance Sites and from epidemics in Washington and Vermont in 2012] were PRN-deficient and vaccinated patients had significantly higher odds than unvaccinated patients of being infected with PRN-deficient strains. Moreover, when patients with up-to-date DTaP vaccinations were compared to unvaccinated patients, the odds of being infected with PRN-deficient strains increased, suggesting that PRN-bacteria may have a selective advantage in infecting DTaP-vaccinated persons."

[7] Rubach *et al.* (2011) **Increasing incidence of invasive *Haemophilus influenzae* disease in adults, Utah, USA.** *Emerg Infect Dis* 17:1645-50
http://www.ncbi.nlm.nih.gov/pubmed/21888789
The chart below from Rubach *et al*. shows the number of invasive cases of *H. influenzae* (all types) in Utah in the decade of childhood vaccination for Hib.



[8] Wilson *et al.* (2011) **Adverse events following 12 and 18 month vaccinations: a population-based, self-controlled case series analysis.** *PLoS One* 6:e27897
http://www.ncbi.nlm.nih.gov/pubmed/22174753
"Four to 12 days post 12 month vaccination, children had a 1.33 (1.29-1.38) increased relative incidence of the combined endpoint compared to the control period, or at least one event during the risk interval for every 168 children vaccinated. Ten to 12 days post 18 month vaccination, the relative incidence was 1.25 (95%, 1.17-1.33) which represented at least one excess event for every 730 children vaccinated. The primary reason for increased events was statistically significant elevations in emergency room visits following all vaccinations."

[9]. De Serres *et al*. (2013) **Largest measles epidemic in North America in a decade–Quebec, Canada, 2011: contribution of susceptibility, serendipity, and superspreading events.** *J Infect Dis* 207:990-98
http://www.ncbi.nlm.nih.gov/pubmed/23264672
"The largest measles epidemic in North America in the last decade occurred in 2011 in Quebec, Canada."
"A super-spreading event triggered by 1 importation resulted in sustained transmission and 678 cases."
"The index case patient was a 30-39-year old adult, after returning to Canada from the Caribbean. The index case patient received measles vaccine in childhood."
"Provincial [Quebec] vaccine coverage surveys conducted in 2006, 2008, and 2010 consistently showed that by 24 months of age, approximately 96% of children had received 1 dose and approximately 85% had received 2 doses of measles vaccine, increasing to 97% and 90%, respectively, by 28 months of age. With additional first and second doses administered between 28 and 59 months of age, population measles vaccine coverage is even higher by school entry."
"Among adolescents, 22% [of measles cases] had received 2 vaccine doses. Outbreak investigation showed this proportion to have been an underestimate; active case finding identified 130% more cases among 2-dose recipients."

[10] Wang *et al*. (2014) **Difficulties in eliminating measles and controlling rubella and mumps: a cross-sectional study of a first measles and rubella vaccination and a second measles, mumps, and rubella vaccination.** *PLoS One*9:e89361
http://www.ncbi.nlm.nih.gov/pubmed/24586717
"The reported coverage of the measles-mumps-rubella (MMR) vaccine is greater than 99.0% in Zhejiang province. However, the incidence of measles, mumps, and rubella remains high."

[11] Immunoglobulin Handbook, Health Protection Agency
http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1242198450982
HUMAN NORMAL IMMUNOGLOBULIN (HNIG):
Indications
1. To prevent or attenuate an attack in immuno-compromised contacts
2. To prevent or attenuate an attack in pregnant women
3. To prevent or attenuate an attack in infants under the age of 9 months

[12] http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm376937.htm
[13] http://archinte.jamanetwork.com/article.aspx?articleid=619215
[14] Poland (1998) Am J Hum Genet 62:215-220
http://www.ncbi.nlm.nih.gov/pubmed/9463343
" 'poor responders,' who were re-immunized and developed poor or low-level antibody responses only to lose detectable antibody and develop measles on exposure 2–5 years later."
[15] ibid
"Our ongoing studies suggest that seronegativity after vaccination [for measles] clusters among related family members, that genetic polymorphisms within the HLA [genes] significantly influence antibody levels."
[16] LeBaron *et al.* (2007) *Arch Pediatr Adolesc Med* 161:294-301
http://www.ncbi.nlm.nih.gov/pubmed/17339511
"Titers fell significantly over time [after second MMR] for the study population overall and, by the final collection, 4.7% of children were potentially susceptible."
[17] De Serres et al. (2013) J Infect Dis 207:990-998
http://www.ncbi.nlm.nih.gov/pubmed/23264672
"The index case patient received measles vaccine in childhood."
[18] Rosen et al. (2014) Clin Infect Dis 58:1205-1210
http://www.ncbi.nlm.nih.gov/pubmed/24585562
"The index patient had 2 doses of measles-containing vaccine."

[19] NHS: http://www.nhs.uk/chq/Pages/1032.aspx?CategoryID=62

[20] http://articles.mercola.com/sites/articles/archive/2015/03/29/vaccine-adjuvants-brain-effects.aspx?e_cid=20150329Z3_SNL_NB_art_1&utm_source=snl&utm_medium=email&utm_content=art1&utm_campaign=20150329Z3_SNL_NB&et_cid=DM72737&et_rid=894222131

"Part of the problem is that the aluminium accumulates, and it stays in the brains of mice up to one year after injection because there's no recirculation to take it out."

[21] http://www.austlii.edu.au/au/legis/cth/consol_act/ada2004174/s15.html

AGE DISCRIMINATION ACT 2004 - SECT 15

Discrimination on the ground of age--indirect discrimination

(1) For the purposes of this Act, a person (the discriminator) discriminates against another person (the aggrieved person) on the ground of the age of the aggrieved person if:

(a) the discriminator imposes, or proposes to impose, a condition, requirement or practice; and

(b) the condition, requirement or practice is not reasonable in the circumstances; and

(c) the condition, requirement or practice has, or is likely to have, the effect of disadvantaging persons of the same age as the aggrieved person.

(2) For the purposes of paragraph (1) (b), the burden of proving that the condition, requirement or practice is reasonable in the circumstances lies on the discriminator.

[22] http://docs2.health.vic.gov.au/docs/doc/51D8DDDACFBD4B5FCA257E8C0004EBD5/$FILE/VIDB-17-3-web-150515.pdf

[23] GlaxoSmith Kline: Infranrix Hexa Summary Bridging Report 2011: https://autismoevaccini.files.wordpress.com/2012/12/vaccin-dc3a9cc3a8s.pdf

[24] http://www.bmj.com/content/340/bmj.c2994/rapid-responses