

Australia’s misguided and deadly covid public health strategies

The Australian Governments' public health strategies are based on [bad science](#) and **must be suspended immediately** pending a Royal Commission or Coronial Inquest into all covid deaths. In particular, to universally vaccinate in the middle of a pandemic will likely [prolong](#) its most dangerous phase and cause more harm than good – even as it further undermines faith in our [failing](#) public health system.

First, Do No Harm

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I am a signatory to the [Great Barrington Declaration](#). I support the [founding principles](#) set out by the World Health Organisation (WHO) following [Nuremberg](#) (and further outlined by the WHO in [Helsinki](#) and [Alma Ata](#)).

In mid September 2021 an International Alliance of Physicians and Medical Scientists held a [Global Covid Summit](#) in Rome, Italy. Frontline physicians from across the globe shared their experiences and research findings, and [the Physicians Declaration](#) was announced. Since then over 16,000 doctors and scientists have signed the declaration. I follow the advice provided by these and many other [independent](#) medical experts (refer Appendix A).

Current public health measures go against all previous policies and principles and they are dangerous

A number of [flawed assumptions](#) drive current government [strategies](#). That PCR testing accurately reports covid infections in the population, that [contact tracing](#), [masking](#), [lockdowns](#) and universal [vaccination](#) can eradicate the virus (and secure economic recovery) by achieving herd immunity and that [vaccines](#) are [effective](#), [safe](#) and [durable](#).

Unfortunately, [none of these assumptions](#) are supported by [empirical evidence](#) nor years of scientific pandemic research. Of note, the latter research culminated in the formal WHO pandemic guidelines (table 1) published in October 2019.

Table 1: WHO advice on pandemic and epidemic, October 2019

Not recommended in any circumstances	Pandemic	Epidemic
	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Border closure	UV light Modifying humidity Contact tracing Quarantine of exposed individuals Entry and exit screening Internal travel restrictions Border closure

Source: [WHO](#), *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza* (October 2019), p. 3, Table 1.

One aim of these guidelines is to reduce public fear, allowing for a rational **health focus on the most vulnerable**. The [opposite](#) has [occurred](#). Restrictions on movement and work should only be used as a last resort, and only for as long as it takes to prepare health systems. Of note, the Australian [health system](#) saw 11.1 million hospitalisations in 2019-20, some 30,410 per day (with 453,252 of these for respiratory system disease). There were 140,000 ICU patient stays averaging 180 hours each, with 36,500 requiring ICU ventilator support. This demonstrates a **high capacity** to treat Australian covid patients.

PCR tests as are being reported are meaningless

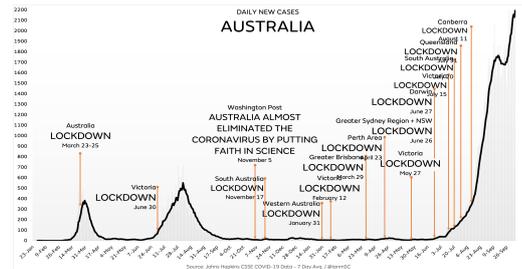
As used, PCR tests, the primary focus for reporting on covid by governments worldwide, are highly [deceptive](#). Some health experts say that PCR testing is [too sensitive](#) and needs to be [adjusted](#) to [rule out](#) people who have [insignificant](#) amounts of covid in their system.

When the test's cycle threshold (CT) value is too high it detects people with the live virus as well as those with just a few genetic fragments that pose **no risk** of infection. In three sets of testing data that include CT values compiled by officials in Massachusetts, New York and Nevada, **up to 90 percent** of people testing **positive** [carried barely any virus](#).

Reporting positive PCR tests **without** corresponding CT values has no medical or diagnostic value. It is manipulated or misleading content, [propaganda](#) and/or false context that creates fear. Only positive tests with a CT value under 30-32 should be reported, if any. That responsible reporting could guide the prioritisation of resources to those more at risk raises the question as to **why this is not being done already?**

Lockdowns have killed (and harmed) more people than covid has

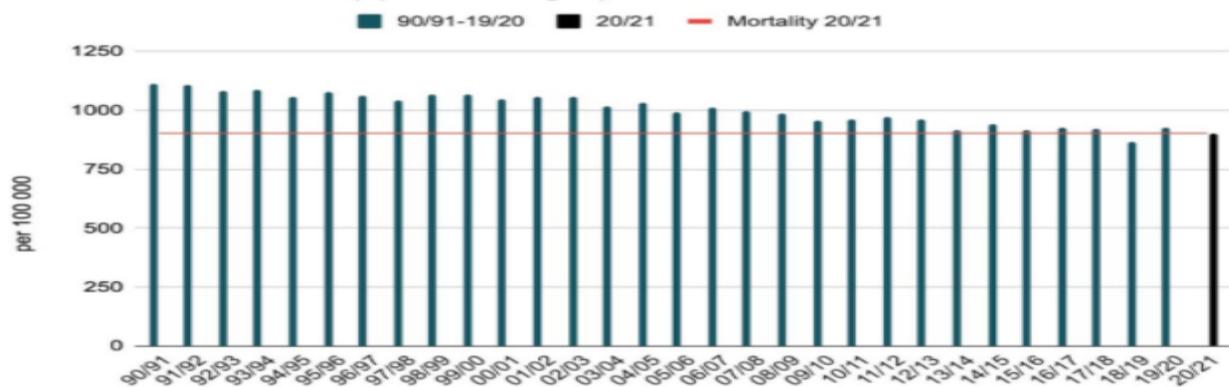
[Lockdowns](#) have [killed more people](#) than [covid](#), are [totally ineffective](#) and [come](#) at a [massive cost](#). Mr Ramesh Thakur, former Assistant Secretary-General of the United Nations, Emeritus Professor of the Crawford School of Public Policy at The Australian National University highlights six deadly [lockdowns issues](#).



As the virus spread, most governments told us that we would only be saved by [lockdowns](#), masks and **giving up hard-won human rights** for a "short" period. According to [PANDA](#), not so Sweden. Despite much criticism, Sweden did very little to try to stop the virus. It did not lock down, Swedes did not wear masks, most schools remained open, few businesses were shut. However, it was not Sweden that was conducting an experiment. Sweden followed the plans that had been prepared all over the world for dealing with respiratory pandemics (as per table 1 above). Lockdowns **are** the [experiment](#).

Comparing [mortality](#) across countries is difficult given the differences in the way countries count deaths. However, one constant metric is "[all-cause mortality](#)", the total number of people that die from all causes in any year. As per the below chart, Sweden's all-cause mortality in 2020/2021 was unchanged from prior years (and decades).

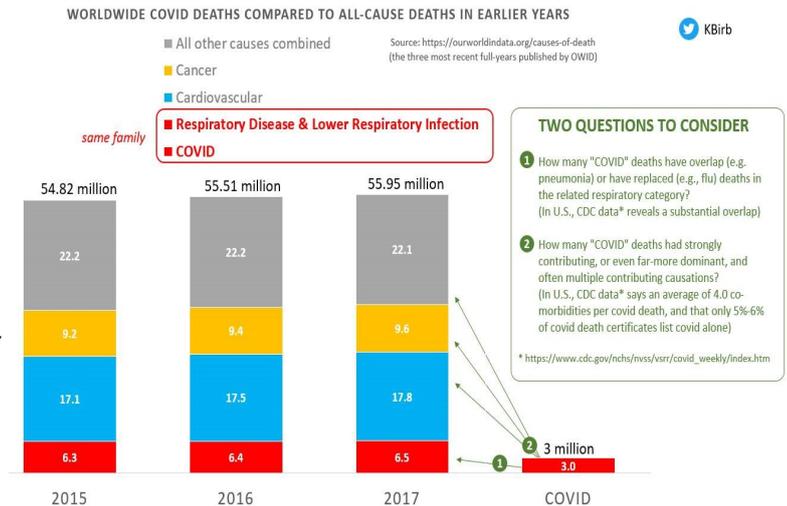
Comparing all cause mortality August through July per 100 000
Sweden Data Source SCB (Updated 23 August)



Countries that imposed the [novel lockdown policy](#) do [not](#) look like Sweden. South Africa imposed lockdowns before its first covid death occurred. It has one of the [highest](#) excess death rates in the world, despite imposing one of the harshest and longest lockdowns. Other [lockdown countries](#) also [fared badly](#). The only conclusion to draw from this is that the [lockdown experiment](#) and other [poorly-conceived public health](#) responses [killed people who did not need to die](#).

Related social distancing measures, including [masking](#), also do not actually [suppress](#) viral spread, and certainly not [outdoors](#). [Masking](#) is [ineffective and bad](#) for [health](#). In a [meta-analysis](#) of evidence level commissioned by the WHO, no effect of masks in the context of influenza virus pandemic prevention could be demonstrated. In 14 randomized and controlled trials, [no reduction](#) in the transmission of laboratory-confirmed influenza infections was demonstrated. Due to the similar size and distribution pathways of the virus species (Influenza and Corona), this data also applies to covid. In fact, what about flu?

Why is it that the official number of influenza deaths in Australia to July 2021 is ZERO, and that there had not been a single flu death recorded since April 2020? And that the number of previous flu deaths in Australia are coincidentally similar to the recorded Covid deaths? Why is it that the number of Flu Cases (interestingly, whose symptoms are similar to Covid) in the US declined by 99.5 % during 2020?



Covid vaccines are not safe and have already killed more people than all other vaccines combined. Ever!

Current vaccine strategies risk more fatalities than covid itself, and have significantly enlarged the number of people vulnerable to covid, beyond the elderly, the obese and those with comorbidities. Like masks, they are especially bad for children. Current vaccine safety concerns are not being addressed in a transparent process by government "public health" agencies. Not being fully informed of the potential risks of taking the covid vaccine means the public are unable to give fully informed consent to taking a vaccine.

Safety concerns include empirical evidence (not "models") that **covid vaccines are ineffective** in reducing mortality; that there is a link between vaccination and increases in covid cases; and that a **tight temporal relationship** between covid vaccination and death **is indicative of causation**. Of note, the covid death rate is significantly higher in the half of all countries with an above average percentage of their population vaccinated.

Importantly, the SALK Institute in San Diego – the premier global research institute on vaccines - reports that spike proteins, the same as those produced by mRNA vaccines, are pathogenic. These spike proteins damage cells and cause vascular disease even without a virus, a claim espoused by a growing number of immunologists and epidemiologists.

Covid vaccines do not stop infection, transmission or harm.

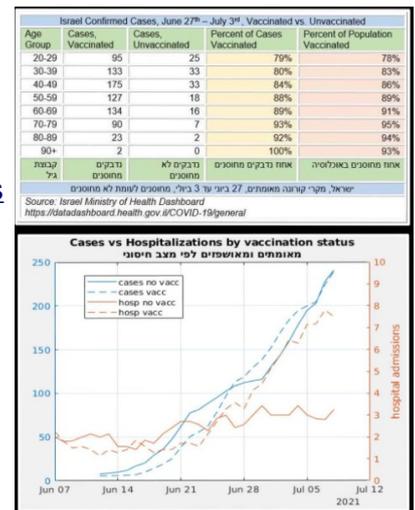
Basic virology and evolutionary genetics tell us the goal of any virus is to infect and replicate in as many people as possible. A virus can't efficiently spread if, like with Ebola, it quickly kills its hosts. The clear historical tendency is for a virus to evolve (mutate) in a way that makes it more infectious and less pathogenic over time.

Unfortunately, the more people you vaccinate, the greater the number of vaccine-resistant mutations you are likely to get, the less effective and durable the vaccines become, the ever more powerful vaccines will have to be developed, and the more risk individuals will be exposed to. This risk multiplies when the vaccines destroy recipients' natural immunity.

Further, if the entire population has been "trained" via a universal vaccination strategy to have the same basic immune response, then once a viral escape mutant is selected, it will rapidly spread through the entire population (like the Delta variant did) whether vaccinated or not. This is potentially a catastrophic vulnerability.

In fact, as seen in the adjacent chart, in [Israel](#), one of the most vaccinated countries in the world, vaccinated people are just as likely to be [hospitalised and/or die](#) as unvaccinated people, [if not more so](#) (same in the UK). Vaccines **neither stop infection nor transmission**, and any immunity, like all [other](#) flu vaccines, [waned quickly](#). The covid virus likely will always be with us.

This is particularly true if there is no lawful outpatient access to a growing [arsenal](#) of [scientifically proven](#) prophylactics and [therapeutics](#) such as [hydroxychloroquine](#) and [ivermectin](#), [used successfully](#) by [many doctors](#) from [early on](#) in the pandemic and, more recently, monoclonal antibodies and other bespoke covid [treatments](#) (**Appendix B**).



The [overall](#) infection [fatality rate](#) (IFR) of covid is around 0.15% globally, similar to a bad flu season. Unfortunately, the vaccines now [threaten young people](#), whereas before [kids](#) had [no risk](#) of [harm](#). For example, there were 64 reported cases of [heart injury](#) to Australian youth in a ten day period (1 October to 10 October, 2021) following a single vaccine administration. There were over 200 by 6 November, 2021, all of them diagnosed with myocarditis. This has a [mortality rate](#) up to 20% at 1 year and 50% at 5 years. Overall mortality for myocarditis has not changed in the last 30 years. Post-vaccination deaths also are [up significantly](#) for the young (from 2015-2019 averages).

An [open letter](#) from dozens of UK doctors recently concluded that "**it is irresponsible, unethical and indeed, unnecessary to include children under 18 years in the national covid vaccine rollout.**" This goes double for [babies](#).

Vaccines simply [do not work](#) on variants that have evolved (mutated) as a result of the [mass vaccination](#) in the first place. The [Pfizer trial data](#) pre-dates the arrival of Delta in the US. [Vaccinated](#) people can [catch](#), [transmit](#) and be [harmed](#) by covid variants, with one [report finding](#) that **the Delta death rate for vaccinated people was 6.6 times higher** than that for unvaccinated people. Another [report](#) cautioned about the risk of exacerbating covid [severity](#) via antibody-dependent enhancement ([ADE](#)). Vaccine [mandates](#) and passports are thus [dangerous](#) and [ineffective](#), as well as being [unethical](#) and [immoral](#).

A [study](#) by the University of Wisconsin that was published on 31 July 2021 deals the coup de grace to any coercive [mandatory vaccination](#) policy, including [vaccine passports](#). "We find [no difference](#) in viral loads when comparing unvaccinated individuals to those who have vaccine "[breakthrough](#)" infections, regardless as to whether the infection was actually caused by the vaccine. This means that **a vaccinated person is just as infectious as an unvaccinated person**. Worse, they are more likely to be [asymptomatic](#) and thus mingle.

The vaccine safety monitoring system is not working

In 2008-2009 the [cost](#) of providing vaccines 'free' to Australians was well above \$AU400 million. However, the actual cost of these programs is unknown because the figures are not released to the public and they do not include **the cost to the community** of the **deaths and disability** that are a known side-effect of vaccines. This cost to the community is unknown because neither the CDC nor the TGA have [established](#) an **active** pharmacovigilance system that can [identify](#) and highlight [causal relationships](#) to vaccines.

Perhaps as little as 2% of covid [adverse events](#) are being reported via the TGA's voluntary system (some [1% in the US](#)). Indeed, a regulator that is 100% [funded](#) by industry has little incentive to accurately [monitor](#) the [adverse events](#) from its "own" products. There are at least four **urgent questions** that need to be answered by our public health officials:

- How many people have **died** (any cause) within 28 days of vaccination?
- How many people have been **hospitalised** (any cause) within 28 days?
- What is the Under Reporting Factor (URF) for adverse events for covid?
- Have all potential **conflicts of interest** by regulators been declared?

Given records already exist of all persons vaccinated and for all deaths and hospitalisations, this would [not](#) be difficult task. This data is not provided. There are more deaths reportedly due to covid vaccines than for all other vaccines **combined** for over 30 years. If the reporting systems (DAEN, VAERS, etc) are suddenly no longer accurate, why has nothing been done to fix or replace it? Where are the autopsies?

Natural immunity is stronger and more durable than vaccine immunity

Research indicates recovered covid patients have multiple times the immunity of [vaccinated](#) people. Their immunity is [stronger](#) and [lasts longer](#) than [vaccine immunity](#) (potentially until late-age immunosenescence, the process of immune dysfunction that occurs with age). Moreover, we [know](#) that vaccinated people are able to carry viral loads similar to those of unvaccinated people that are up to [251 times](#) higher than recovered people. [Recovered people](#) are [far less likely](#) to transmit the virus than vaccinated people.

There is no sound argument in science for mandating [recovered people](#) to be vaccinated.

The same applies to others with natural immunity, of whom [there are many](#) - hence the high levels of asymptomatic "cases" - which ethically should **demand** that this status be [tested for before any vaccine is given](#) in order to reduce risk of harm. Next time your company or government tells you that you need to get vaccinated so that you don't infect those around you, ask them [what science](#) they rely on to make that statement. Companies all over the world are setting themselves up for massive [liability claims](#) by forcing workers to get vaccinated without having any [scientific evidence](#) for the [benefit](#) they claim exists.

Public Health bodies, both globally and nationally, have been penetrated (captured) by vested interests

The WHO [declaration](#) of a pandemic in March 2020 [kickstarted](#) massive funding of vaccine development by governments worldwide. Some governments have a [proprietary](#) interest in these vaccines. To date, [governments](#) have yet to disclose even the key terms and conditions ([and restrictions](#)) under which they have funded companies, universities, and [other](#) entities for Covid-19 vaccines. This is not a [new phenomenon](#).

There is [testimony](#) that US patent 7279327 was issued in April 2002 following Anthony Fauci funded research at the University Of North Carolina Chapel Hill. This patent clearly lays out in very specific gene sequencing the fact that we knew that the ACE receptor, the ACE2 binding domain, the s1 spike protein and other elements of what we have come to

know as this scourge pathogen was not only engineered but could be [synthetically modified](#) in the laboratory. That technology was funded exclusively as a means to actually harness coronavirus as a vector to distribute a vaccine, for HIV at the time, now for covid.

In late 2009, a Danish newspaper [alleged](#) that members of the emergency committee that advised the WHO director-general received financial support from [pharmaceutical manufacturers](#). The accusation further reinforced governments' earlier concerns by insinuating that the director-general had been improperly influenced into declaring the 2009 H1N1 influenza pandemic. When asked by the media to explain the decision in the light of the fact the WHO had previously maintained a pandemic entailed large numbers of human fatalities and severe illness, the response of the WHO secretariat was to delete its guidelines from its [website](#). [Transparency](#) is key to [public health](#) and no information has been provided as to why pre-existing pandemic plans were [not implemented](#) for covid.

[Government regulators](#) in most countries are 100% funded by industry under a Cost Recovery (User-Pay) system. This means they approve their sponsor's vaccines / drugs for the market and "[monitor](#)" these same products for safety and efficacy. In effect they are indirectly monitoring **their own products**.

The pharmaceutical manufacturing industry thus [funds](#) the Australian Therapeutic Goods Administration (TGA) even though this government board has the dual role of approving drugs for its sponsor and [monitoring](#) the safety of these drugs in the Australian population. **Serious conflicts of interest exist.**

The [US FDA](#) have just granted Pfizer a marketing license just 13 months into an ongoing, two year [pivotal](#) trial, with [no reported data](#) past 13 March 2021, evidence of waning protection irrespective of the Delta variant and limited reporting of [safety data](#). The (Pfizer report) provides [no data](#) on vaccine [efficacy](#) past six months due to unblinding, ruling out any trial safety data on the impact of the Delta virus in the US.

In early July, the Israel Ministry of Health reported that [efficacy](#) against infection and symptomatic disease "fell to 64%." By late July it had fallen to 39% where Delta is the dominant strain. This is very low. For context, the FDA's expectation has been "**at least 50%**" **efficacy for any approvable vaccine**. Regular booster shots appear inevitable.

The US [FDA](#) and [CDC](#) should have demanded adequate, controlled studies with long term follow up, making data [publicly available](#), **before** granting full approval to [covid vaccines](#). Two FDA members have recently resigned [in protest](#). The [FDA](#) has been [described](#) as an '[agent of industry](#)' to the US Senate Committee on Finance. The CDC promotes vaccine safety using studies that are [openly ridiculed](#).

[Decisions](#) regarding the inclusion of a new vaccine on the Australian NIP are [determined](#) by an ATAGI sub-committee ahead of the licensure of the vaccine. [Considerations](#) for the [suitability of a new vaccine](#) include the [implications](#) for herd immunity but this (herd immunity) is 'neither necessary nor sufficient for a positive recommendation for NIP suitability'. This is of note because the government is using [claims](#) about vaccine-created herd immunity to justify its **use of coercion** to promote vaccination. The same [coercion](#) is being used in [Canada](#), with health professionals afraid to speak out.

“When licensing drugs for marketing [Australia’s TGA](#) relies on research funded and controlled by [pharmaceutical companies](#). Too often pharmaceutical companies ‘cherry pick’ favorable evidence and hide or ‘spin’ [unfavorable](#) evidence to support their [commercial interests](#).” Worse, Australian regulatory authorities actually [hinder](#) some Australian competitors in the pharmaceutical industry.

Further, in recent years many members of ATAGI, including the chair and co-directors of the National Centre for Immunisation Research and Surveillance (NCIRS), have been chief investigators on vaccine trials [funded](#) by Pfizer, Novartis, GlaxoSmithKline, Sanofi, BioCSL, Baxter, Wyeth, [Merck](#), Janssen & Janssen (Crucell). Significant conflicts of interest exist where there should be none.

Media organisations now partner the same vested interests

The formal creation of the [Trusted News Initiative](#) (TNI) in December 2020 by most of the largest media organisations in the world has also played its part. The TNI formed the previous year to protect audiences and users from disinformation, particularly around moments of jeopardy, [such as elections](#).

Partners in the TNI include: AP, AFP, BBC, CBC/Radio-Canada, European Broadcasting Union (EBU), **Facebook**, Financial Times, First Draft, **Google / YouTube**, The Hindu, **Microsoft**, Reuters, **Twitter** and The Washington Post.

This group set out to remove all critical and/or non-vaccine covid information from their platforms, including [expert medical advice](#), [treatments](#) and [any criticism](#) of the safety and efficacy of the vaccines and government public health strategies. In essence, the majority of the world's [media, like governments](#) around the world, became [shills](#) for the companies looking to produce vaccines. Worse, they actively set out to cancel and [deplatform](#) the health experts most needed in a pandemic, those looking to treat the ill and prevent harm.

A Ms Jane Halton "represented" Australia at Event 201, a global pandemic simulation exercise held in October 2019. Sister in law of Brett Sutton, the Chief Health Officer of Victoria, she chairs the Bill and Melinda Gates Foundation’s Coalition for Epidemic Preparedness Innovations (CEPI). She spoke on how to coordinate “accurate information” to the world (in the event of a pandemic) along with other [TNI members](#) present, as well as the head of the Chinese Center for Disease Control and Prevention.

It is no coincidence that the TNI has [strong links](#) to, and significant ownership of, multiple pharmaceutical companies and were among those to [profit](#) most from the pandemic. The Chinese Communist Party ([CCP](#)) and the Catholic Church also "[engage](#)" with them. The TNI and [related entities](#) have fully [penetrated](#) the WHO and control most of its [operational activity](#) with **specified funding**. Marxist Dr Tedros Ghebreyesus, an alleged [war criminal](#) with [links](#) to vaccine manufacturers, became WHO president with [CCP](#) (and TNI) support.

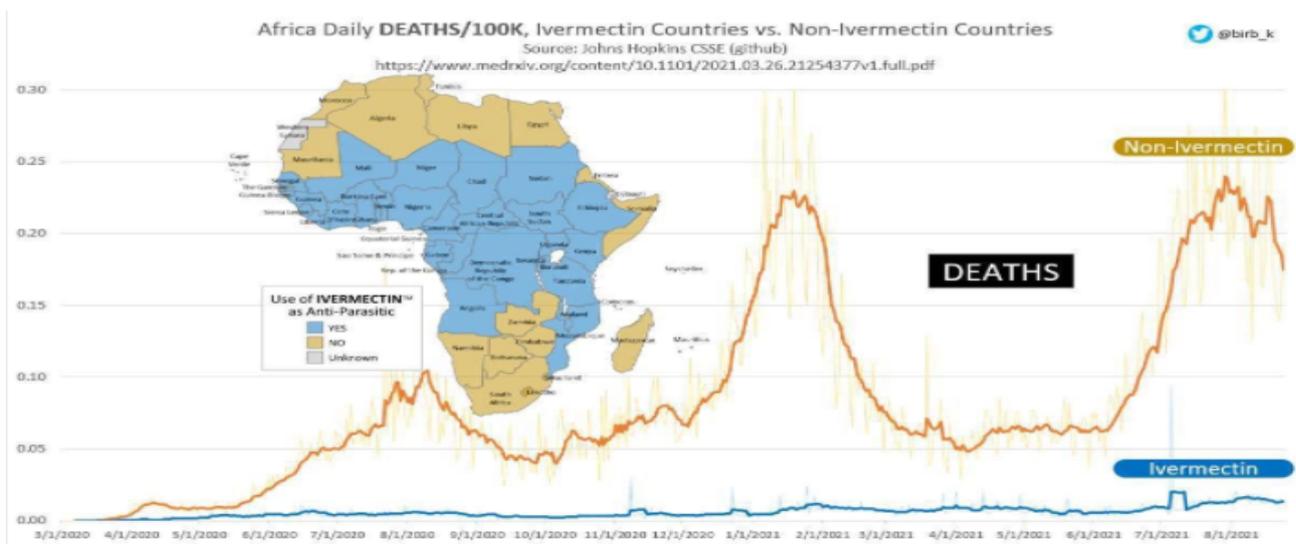
The WHO has [ignored](#) the guidelines in its own October 2019 Pandemic Plan, then [changed](#) the meaning of 'herd immunity' - removing natural immunity - in November 2020. Of note, the WHO had previously re-defined what a pandemic is following [criticism](#) over use of [its powers](#) to declare a pandemic in 2009 amid allegations of conflicts of interest.

The TNI supported CCP **denials** about an "alleged" [lab leak](#) in Wuhan China, and then about gain of function research funded by the NIH [following](#) a WHO [trip to China](#) in early 2021. It has purposely cancelled all information about non-vaccine early treatments.

Up to 85% of all covid deaths worldwide could have been avoided with lawful access to early treatment.

The broader goal when [administering covid treatments](#) is, as demonstrated by Dr Peter Zelenko and many [others](#), to [reduce hospitalisations](#) and take death off the table. Unlike vaccines, these treatments are generally not dependent on specific viral properties or mutations but instead [mitigate](#) or [treat](#) the inflammatory symptoms of the disease itself.

Having banned or restricted access to extremely [safe repurposed medications](#) throughout the pandemic, [government / public health](#) officials have prevented medical professionals from treating their patients effectively. The below chart shows the medicines work in Africa, as they do in [India](#).



Given [early treatment](#) is key in [stopping progression](#) to severe disease, [medical experts](#) state [up to 85%](#) of all [covid deaths](#) could have been [prevented](#). The situation where government [regulators](#) like the UK [SAGE](#), the US [CDC](#) and [FDA](#) promote the [interests](#) of the industries they monitor instead of the [public interest](#) is described by sociologists as 'regulatory capture'.

The autocratic top-down proffered advice - to basically self isolate until you [turn blue](#) then call an ambulance - makes a [travesty](#) of the [public health](#) principles and [policies](#) developed since Nuremberg and of the updated pandemic disaster plan produced by the WHO in October 2019. And all for what [level of threat](#)?

“ ”

AUSTRALIAN COVID DATA

AS IT SHOULD BE REPORTED

16 AUG 2021

Top Causes of Death 2018 Australia

Heart Disease	20,725
Dementia/Alzheimers	13,983
Stroke/Cerebrovascular	9,972
Lung cancer	8,585
Emphysema/COPD etc	7,989
Bowel cancer	5,420
Diabetes	4,856
Flu & Pneumonia	3,102
Suicide	2,946
Accidental falls	2,952
Car accidents	1,135

TOTAL TESTS	27,958,304		
TOTAL NEGATIVE TESTS	27,919,208	NEGATIVE RATE	= 99.86%
TOTAL POSITIVE TESTS	39,096	POSTIVE RATE	= 00.14%
TOTAL REPORTED RECOVERIES or NOT ILL	38,138	RECOVERY RATE	= 97.54% (to date)
TOTAL DEATHS WITH/OF COVID	958	DEATHS OUTSIDE VICTORIA	138
DEATHS WITH/OF COVID UNDER 80 YEARS OLD	230	DEATHS UNDER 70 YEARS OLD	69
DEATH RATE (as % of POSITIVE TESTS)	2.45%		
DEATH RATE (as % of POPULATION)	0.0037%	MORTALITY RATE UNDER 70yo	= 1 in 370,000
CHANCE OF NOT DYING OF COVID 19	99.996%	CURR. CHANCE OF U70s NOT DYING=	99.9997%

Source: Aust Govt Health (gov.au). To inform without harm in the 'free public opinion' will drive policy makers to better, more balanced management of the COVID threat. THIS IS NOT MEDICAL ADVICE. I am not your doctor. COVID19 is real and awful for many victims who get it badly. Wash hands, socially distance, wear a mask where required. Follow the law. Be safe and take care of yourself and especially the elderly. Aus population: 25,852,884 (est)

This highlights the need for a [rational](#) public health response that [supports local](#) doctors and early treatments, and enshrines the rights of all people to make their own [personal health decisions](#) based on [fully informed consent](#).

I call on the government for a full independent enquiry into the Australian public health response to covid as a matter of urgency given lives continue to be at risk.

It is vital that [those responsible](#) for our [public health](#), in particular under [dubious](#) ongoing Public Health Orders, can demonstrate that their decisions have not led to [unnecessary deaths](#). That [those who die](#) from (not with) [covid](#) have not done so due to a lack of preventative [early treatment](#), regardless of their vaccination status.

It is equally vital that they are able to demonstrate, [beyond any doubt](#), that the injection of these [novel vaccines](#) will **not** actually [cause](#) covid disease, [render](#) immune systems dangerously more vulnerable, impact [reproductive health](#) nor create an [avalanche](#) of [excess deaths](#). Until then, in the words of Eric Clapton, "[This has Gotta Stop](#)".

Update yourself at:

<https://brownstone.org/articles/the-attack-on-scientific-dissent-becomes-ever-more-brutal/>

<https://off-guardian.org/2021/09/22/30-facts-you-need-to-know-your-covid-cribsheet/>

<https://rumble.com/vkwd3g-revealing-covid-condensed-edition.html>

<https://blog.canberradeclaration.org.au/2021/09/21/the-efficacy-of-mass-covid-vaccination-myths-lies-facts/>

<https://cmnnews.org/story/an-australian-engineer-speaks-out-the-many-mysteries-of-covid-fcaOmOQ1CLVZ23UMItIDZ>

<https://worlddoctorsalliance.com/>

<https://covid19criticalcare.com/wp-content/uploads/2020/11/FLCCC-Alliance-I-MASKplus-Protocol-ENGLISH.pdf>

<https://swprs.org/covid19-facts/>

<https://www.globalresearch.ca/covid-update-what-truth/5779037>

Chill at:

<https://www.pandata.org/infobites/>

<https://www.bitchute.com/video/pWOgqNHdsIFM/>

Appendix A - Independent Experts (in no particular order)

Theresa A. Lawrie, MBBCh, PhD, Division of Gastroenterology, Evidence-based Medicine Consultancy, Bath

John P. A. Ioannidis, Stanford Professor of Medicine and Epidemiology

Martin Kulldorf, Professor of Medicine, Harvard Medical School

Peter Doshi, Senior Editor, British Medical Journal

Ramesh Thakur, Former Assistant Secretary-General of the United Nations, Emeritus Professor of the Crawford School of Public Policy at the Australian National University.

Christian Bjørnskov, Economist

Dr Jay Bhattacharya

Dr. Marik, Professor of Medicine and Chief of the Division of Pulmonary and Critical Care Medicine at Eastern Virginia Medical School in Norfolk, Virginia

Kory, Pierre MD

Nick Hudson, Pandemics Data and Analytics (PANDA)

Marc Girardot, PANDA

Dr Roger Hodgkinson, Pathologist

Dr. Peter McCullough, consultant, cardiologist

Dr. Harvey Risch of Yale University

Dr. George Fareed, Medical Director at Pioneers Medical Center, Brawley, California

Dr Susan Vosloo, South Africa's first female heart surgeon

Dr E.V RAPITI

Dr Beda Stadler, Retired Swiss Professor Emeritus of Immunology

Pieter Borger MSc, PhD, W+W Research Association

Professor Perronne, Head of the Medical Department at Raymond Poincaré Hospital. University Head of Department for Infectious and Tropical Diseases since 1994

Dr Anne-Marie Yim, PhD in proteomics

Sucharit Bhakdi, Retired Chair of Medical Microbiology

The Association of American Physicians and Surgeons (AAPS)

The Front Line Covid-19 Critical Care Alliance

America's Frontline Doctors (AFLDS)

<https://worlddoctorsalliance.com/>

The Covid Medical Network (Australia) = <https://covidmedicalnetwork.com/>

Dr Vladimir Zelenko

Robert H. Shmerling, MD, Senior Faculty Editor, Harvard Health Publishing

Abir Ballan, MPH- Coordinator of PANDA

Dr Damian Wojcik, Forensic physician NZ

Dr. Joseph Mercola

Dr Rosamond Jones, MD, FRCPCH, retired consultant paediatrician

Lord Moonie, MBChB, MRCPsych, MFCM, MSc, House of Lords, former parliamentary undersecretary of state 2001-2003, former consultant in Public Health Medicine

Prof Anthony Fryer, PhD, FRCPath, Professor of Clinical Biochemistry, Keele University

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Professor Richard Ennos, MA, PhD. Honorary Professorial Fellow, University of Edinburgh

Professor Anthony J Brookes, Department of Genetics & Genome Biology, University of Leicester

Dr John A Lee, MBBS, PhD, FRCPath, retired Consultant Histopathologist, former Clinical Professor of Pathology at Hull York Medical School

Dr Alan Mordue, MBChB, FFPH (ret). Retired Consultant in Public Health Medicine & Epidemiology

Dr Elizabeth Evans, MA, MBBS, DRCOG, retired doctor

Mr Malcolm Loudon, MB ChB, MD, FRCSEd, FRCS (Gen Surg). MIHM, VR. Consultant Surgeon

Dr Gerry Quinn, Microbiologist

Dr C Geoffrey Maidment, MD, FRCP, retired consultant physician

Dr K Singh, MBChB, MRCP, general practitioner

Dr Pauline Jones MB BS retired general practitioner

Dr Holly Young, BSc, MBChB, MRCP, Consultant physician, Croydon University Hospital

Dr David Critchley, BSc, PhD, 32 years in pharmaceutical R&D as a clinical research scientist.

Dr Padma Kanthan, MBBS, General practitioner

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Mr Ian F Comaish, MA, BM BCh, FRCOphth, FRANZCO, Consultant ophthalmologist

Dr Jayne LM Donegan MBBS, DRCOG, DCH, DFFP, MRCP, general practitioner

Dr Dayal Mukherjee, MBBS MSc Dr Clare Craig, BM, BCh, FRCPath, Pathologist

Mr C P Chilton, MBBS, FRCS, Consultant urologist emeritus

Dr Jason Lester, MRCP, FRCR, Consultant Clinical Oncologist, Rutherford Cancer Centre, Newport

Dr Scott McLachan, FAIDH, MCSE, MCT, DSysEng, LLM, MPhil., Postdoctoral researcher, Risk & Information management Group

Michael Cockayne, MSc, PGDip, SCPHNOH, BA, RN, Occupational health practitioner

Dr John Flack, BPharm, PhD. Retired Director of Safety Evaluation at Beecham Pharmaceuticals 1980-1989 and Senior Vice-president for Drug Discovery 1990-92 SmithKline Beecham

Dr Stephanie Williams, Dermatologist

Dr Greta Mushet, retired Consultant Psychiatrist in Psychotherapy. MBChB, MRCPsych

Dr JE, MBChB, BSc, NHS hospital junior doctor Mr Anthony Hinton, MBChB, FRCS, Consultant ENT surgeon, London

Dr Elizabeth Corcoran, MBBS, MRCPsych, Psychiatrist, Chair Down's Syndrome Research UK

Dr Alan Black, MB BS MSc DipPharmMed, retired pharmaceutical physician

Dr Christina Peers, MBBS, DRCOG, DFSRH, FFSRH, Consultant in Contraception & Reproductive Health

Dr Marco Chiesa, MD, FRCPSych, Consultant Psychiatrist & Visiting Professor, UCL

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Dr Ian Bridges, MBBS, Retired general practitioner

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Emilia P. Poblete Rojas, Médicos por la Libertad Chile. República de Chile
Bárbara Aguayo, Médicos por la Libertad Chile. República de Chile
Dan I. Macías Flores, Médicos por la Libertad Chile. República de Chile
Jose V. Rossell, Physician, orthopedic specialist. República de Chile
Julio C. Sarmiento, Médicos por la Verdad Perú. República del Perú
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Dee Dee Wang, MD,
John E. McKinnon, MD,
William W. O'Neill, MD,
Marcus Zervos, MD,
Harvey A. Risch, MD, PhD

And a shout out to all the doctors suffering vaccine aftereffects commenting on:

<https://www.medscape.com/sites/public/covid-19/vaccine-insights/how-concerned-are-you-about-vaccine-related-adverse-events>

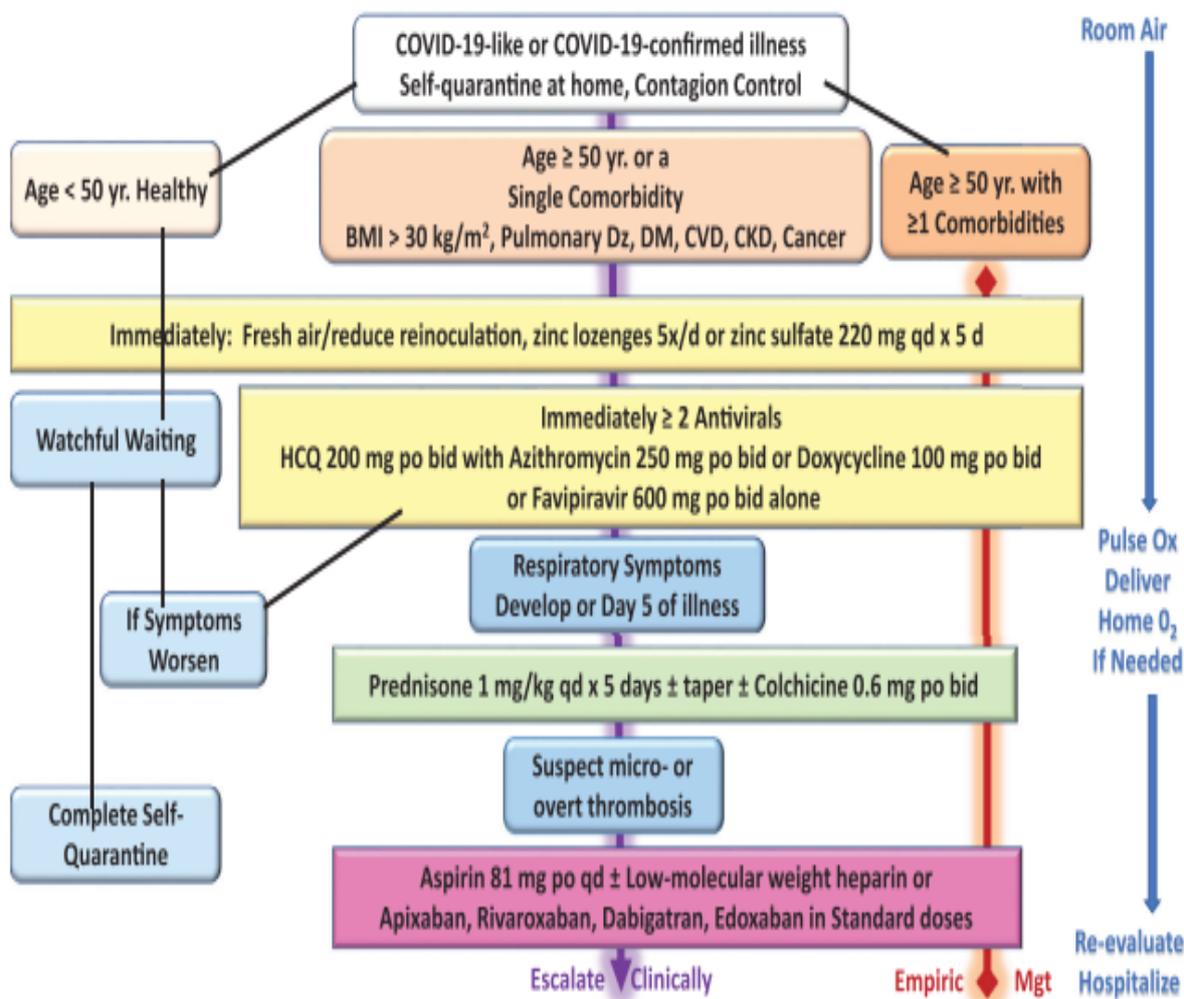


Figure 1 Treatment algorithm for COVID-19-like and confirmed COVID-19 illness in ambulatory patients at home in self-quarantine. BMI = body mass index; CKD = chronic kidney disease; CVD = cardiovascular disease; DM = diabetes mellitus; Dz = disease; HCQ = hydroxychloroquine; Mgt = management; O₂ = oxygen; Ox = oximetry; Yr = year.

Urgent questions that need to be answered by Australian public health officials:

- Why has there been no independent Royal Commission or Coronial Enquiry into all Australian Covid deaths, to assess decisions made and identify potentially better public health policies?
- On what basis have public health authorities decided not to follow the October 2019 best practise WHO pandemic guidelines?
- Are all our regulatory public health and related advisory bodies free of conflicts of interest? Can its members demonstrate having received NO funding or other benefits from vested interests such as industry, industry supported organisations or from government subsidisation?
- On what evidentiary basis are the ongoing public health orders / states of emergency still justified?
- Can our public health authorities provide empirical evidence (not models) that covid vaccines are **NOT** ineffective in reducing mortality; that there is **NO** link between vaccination and increases in covid cases; and that the tight temporal relationship between covid vaccination and death **DOES NOT** indicate causation. Further:
 - How many people have **died** (any cause) within 28 days of vaccination; and
 - How many people have been **hospitalised** (any cause) within 28 days?
- Has the evidence for the safety and efficacy of the covid vaccines been compiled in an appropriate and professional manner, including with the use of appropriate trial processes and with independent oversight of the trial process and results?
- If the vaccine adverse events database (DAEN) - which shows more adverse events from covid vaccines than all other vaccines combined for 30 years - is no longer valid, what has been done to rectify this? Have autopsies been done on likely vaccine related deaths?
- Can Australian public health authorities guarantee that mass vaccinations in a pandemic will **NOT** result in ADE nor render vaccinated people more vulnerable to future infections or diseases?
- How many patient deaths (any cause) followed medical appointments being cancelled or postponed during lockdowns?
- Why have safe and effective early treatments for covid, used successfully by thousands of medical professionals on millions of patients globally, been withheld from Australian medical professionals in a pandemic? What alternatives for early treatment were provided?
- Why are the CT values for PCR tests not provided with the positive results in a fair and transparent manner? How many PCR "cases" had a CT value over 32?
- Given vaccinated people are more able to catch, transmit and be hospitalised or die from covid than the unvaccinated, how can any mandate or passport be justified?
- Can the government guarantee that vaccine mandates, passports and other coercive tactics do not breach international and national laws?
- Given the high levels of asymptomatic cases for covid, why are these people with previous infection or pre-existing corona immunity not counted towards "herd immunity"?

Australian Covid data¹

PCR "cases" between July and Sept 20 went up by 19,193 (from 7,920). No vaccines yet. PCR cases between Oct 20 and June 21 went up by (just) 3,531 (from 27,113). Seasonal? PCR cases between July and Sept 21 went up by 137,146 (from 30,644) despite a strong vaccine uptake. By 15 Dec 21 cases were some 235,562 (over 90% vaccinated), by 3 February 2022 cases numbered 2,645,825 and by 27 April they numbered 5,756,477.

Cases are thus increasing exponentially despite mass vaccination compliance.

Covid related deaths between July and Sept 20 went up by 784 deaths (from 104 in June 2020). No vaccines yet. The vast majority of deaths were in Victoria.

Covid related deaths between Oct 20 and June 21 went up by (just) 22.

Covid related deaths between July and Sept 21 went up by 798 deaths (from 910 in June 21) despite a strong vaccine uptake. By 15 Dec 21 deaths were at 2,117, by 3 February deaths numbered 3,989 and by 27 April they numbered 7,052.

Deaths thus more than tripled in four months - over summer - despite mass vaccination compliance.

Of note, there were **zero flu deaths** between April 20 and end June 21, down from an annual average of around 460 between 2015 and 2019.

Reported vaccine deaths went up to 604 by Oct 21 and 748 by Jan 22. Total reported adverse events went up to 69,482 by Oct 21 and to 105,040 by Jan 22. Over 360 youths between 12 and 21 years of age were reported to suffer myocarditis by mid Jan 22 (on DAEN). Myocarditis has a fatality rate of up to 50% in five years, while youth have practically zero Covid risk (in the absence of comorbidities such as leukemia). This is not good news for between 3,600 and 36,000 young vaccinated Australians.²

Excess deaths (over and above the 2015-19 average and **not** including covid related deaths) for the year to June 20 were up by 1,713.

Excess deaths (over and above the 2015-19 average and **not** including covid related deaths) for the year to June 21 were up by 3,931.

Emergency Department presentations (cases) for the 2020-21 financial year were 8.2 million people in Australia, down some 600k from 2019-20. Less than a third were admitted to hospital (just over 2.5 million in each 12 month period).

People attending Emergency Departments (ED) primarily for covid totalled 63,519 in 2019-20 (for 4-5 months) and 137,145 for 2020-21. Less than 0.3% of those admitted (around 5% of people who primarily attended ED for covid) were for covid disease. **Covid admissions were not in the top 20 causes for admissions in either financial year.** Around 80% of those attending primarily for covid were assessed as non-urgent.

Of note, officially reported covid "cases" were 7,920 by end June 20 (compared to 63,519 attending ED primarily for covid) and 30,644 by June 21 (137,145 attending ED primarily for covid). How can this be? Were most covid attendees false positives or driven by fear?

¹Data from <https://www.worldometers.info/coronavirus/> and <https://apps.tga.gov.au/Prod/daen/daen-entry.aspx> and <https://www.aihw.gov.au/reports-data/myhospitals/themes/hospital-activity>

² Voluntary adverse vaccine event reporting is always significantly under-reported (URF), usually only 1-10%.

People admitted for covid the disease (0.3% of all admissions) had little impact on hospitals. The vast majority of people presenting primarily for covid (around 80% deemed "non-urgent") took up more ED resources, although even they were just a small fraction of the average of 22,400 or so people presenting to ED on a **daily** basis.

Logarithmic chart of Australian covid data

