I am a clinician and researcher, that worked for, but does not represent [redacted] and I am commenting below relative to particular items from the Terms of Reference.

Governance:

- There was and continues to be a lack of consistency between the federal and state governments. For example:
  - Data reporting between states was inconsistent, with NSW Health being the only one to release a more detailed (yet flawed) data report.
  - Some state governments such as QLD, WA and TAS have removed all mandates for the COVID-19 vaccines but other state governments such as SA, NSW and VIC have not – despite all CPHO's from each state sitting on the AHPPC and experts in some states saying they are no longer justified
    - ➔ Solution: a nationally consistent approach should be used, incl federal laws and Policy
- There was, and continues to be, a lack of transparency from Commonwealth, state and territory governments, national governance mechanisms and advisory bodies. For example:
  - A number of Freedom of Information (FOI; or such) requests have had to be made to gain information that should be publicly available. This includes FOI's showing the AHPPC knew there was no realistic ability of the COVID-19 vaccines to achieve herd immunity and in fact that the vaccines were not sterilising/neutralising (which they cannot be for a respiratory virus). This information was not made available to the general public – in fact the public were told the vaccines would "stop the spread" and to "protect your grandma" etc – which was never true or possible.
  - FOI's to particular areas have also not been allowed as these areas have been considered as under "Parliamentary Privilege" or such – this is not appropriate for transparency and creates mistrust.
  - The contracts (paid for by tax payer's dollars) have not been made available.
  - A FOI had to be made in SA to access vaccine safety surveillance data showing Chest Pain as the 2nd most frequently reported symptom following vaccination – this is consistent with the WA annual reports for 2021 (5th most frequently reported) and 2022 (1st most frequently reported) (which were publicly available, again highlighting inconsistency). In another FOI, SA Health stated this data goes automatically to the TGA. However, this high frequency of Chest Pain reporting was not disclosed to the public, whereby only symptoms such as headache, fever, muscle pain, fatigue and nausea are listed on any government site, including the TGA, as common. The Product Information Statements of the vaccines include chest pain as an indicator of possible myo- or peri-carditis with information further below relating to subclinical myocarditis and the potential for all people who are vaccinated to sustain an increased troponin indicative of cardiac damage.
  - There was no transparency of data, for example people admitted to hospital 'for' versus 'with' COVID where NSW reporting acknowledged someone might be admitted following a car crash but be tested and found to have COVID-19 despite the knowledge that you can test positive for at least 90days. Further, once data was looking less favourable for vaccinated individuals, the data reporting changed or was removed, or simply was not reported acutely by vaccination status in the first place. Issues such as not classifying someone as vaccinated for 14 days were known, which influences the data outcomes whereby there may be an increased risk in that early phase post-vaccination to people either catching COVID-19 or requiring hospitalisation associated with the vaccine.
    - ➔ Solution: ALL information and data should be publicly available and not require FOI (or other) to be able to ascertain information or be blocked/not permitted. More appropriate/accurate data collection should have been planned and completed.
- National governance mechanisms, such as National Cabinet and AHPPC, failed to review or appropriately consider scientific information presented to them raising concerns, including that presented by experts in their respective field. The Precautionary Principle was not applied to the COVID-19 vaccines (it was only applied to the risk of COVID-19 itself). There was also no consultation with experts and clinicians outside of the bureaucracies ([redacted] did not consult with clinical experts in immunology, vaccinology or other).
    - ➔ Solution: ALL material sent to or alerted by any member of the public, or medical professional or scientist in their field should be appropriately reviewed, openly welcomed and considered with robust discussion to inform decision making by such bodies. Selection of material or persons should not be limited to government affiliated persons or sources only.

The Precautionary Principle needs to be applied to proposed solutions, particularly where new and essentially untested (including for long-term issues).

- Under NO circumstances should AHPRA (position statement) be able to restrict any medical professional from doing the role they are trained to do – that is reviewing scientific information independently and making their own informed decisions with regards to their patients AND/OR informing the community more broadly, as well as informing other regulatory bodies such as the government, AMA, RACGP, TGA, ATAGI or state health organisations. Evaluation and reporting of information by medical professionals should be encouraged and supported, not restricted or threatened. Many doctors stated they were "petrified" of being reported but would comment they knew the "jab" was likely contributing. In early to mid-2021 hospital medical documentation included statements like "stroke post COVID-19 vaccination" but with time this documentation changed to avoid potential issues. Further to this, ATAGI and the CPHO's of each state or territory should NOT be allowed to dictate the exclusions / exemptions for patients they have not personally assessed – that should remain solely with the treating medical practitioner.
    - ➔ Solution: The AHPRA Position Statement should be removed and/or amended, and no such statement applied in future. Regulatory bodies should welcome and encourage medical professionals to report and inform them about issues without potential retribution. Exemptions should sit solely with the treating medical practitioner.

Key Health Response Measures:

- Public Health Messaging: Broadly speaking the response to COVID-19 was mis-guided and mis-informed, with a failure to take into account relevant key scientific literature, leading to biased, unbalanced public health messaging. A fear-based narrative was used to drive compliance with 'Health' response measures that were not proportionate to the overall risk, and/or overstated the benefits of actions such as lockdowns, mask wearing and vaccination. The infection fatality rate of COVID-19 has always been such that younger (<75yo) and healthy people without significant co-morbidities were not at significant risk – this was not represented in the Public Health Messaging, which wrongly also stated things such as "2 weeks to flatten the curve" which was again unlikely in a respiratory virus situation. → Solution: Public messaging should create a sense of trust and accuracy to available information.
- COVID-19 Vaccination:
    - The COVID-19 vaccines were 'sold' to the public as the way out of the pandemic, but they were never able (or tested) to impact on infection or transmission (as the public were told) – to which health authorities now admit. Scientifically, a 'blood-based' systemic injection was never going to be able to stop a respiratory virus that enters via the respiratory mucosa. Vaccination via intramuscular injection cannot induce IgA mucosal antibodies, whereas wild-type infection can, meaning vaccination was never going to prevent infection and / or therefore transmission, but infection and natural immunity can. This simple biological principle was ignored, and instead division was created amongst the community between the have been vaccinated and have not, enhanced by fear and threat that was over-represented. Further, the vaccines were only ever tested for an impact on symptom severity (the outcomes of which are debatable) yet this is not consistent with the information that was told to the public (again an issue with transparency). Discriminatory measures were used against the unvaccinated to essentially force or coerce them into being vaccinated, and the public were told this was justified, when in reality vaccination was never able to stop infection or transmission and could only (possibly) reduce your own symptom severity which is a personal choice and has no impact on others around you. Once this became evident (because transmission was happening between vaccinated people), there was no further updates to the public or apologies for the mis-information that actually came from the government on this – again highlighting the lack of transparency.
    - Research about the lack of effectiveness and safety issues of the vaccines, or potential of natural immunity was ignored, including studies that showed (many more studies are available):
        - vaccinated people recover more slowly and remained infectious/contagious and able to transmit for longer than unvaccinated
        - cases and symptoms were higher among vaccinated individuals than those with natural immunity and natural immunity limits reinfection and further severity

- the risk of serious adverse events from vaccination surpassed any risk reduction with the numbers needed to treat/vaccinate being excessively high in order to prevent any hospitalisation or death and a greater incidence of issues in the vaccinated
- a range of adverse effects including autoimmune, cardiovascular, neurological, oncological and other effects associated with the vaccine spike protein
- negative efficacy toward hospitalisation whereby vaccinated people are now more likely to be hospitalised relative to newer variants (page 25)
- higher rates of (re)infection in vaccinated individuals (a) (b) noting reinfections are associated with additional risk of death, hospitalisation and post-covid sequelae that is NOT reduced by vaccination
- IgG class switch leading to immune tolerance
- DNA fragments have been found in COVID-19 vaccine vials
- Ribosomal frameshifting has been found to occur in 1 in 4 people meaning any random protein may be manufactured in the body
- The potential for a significant number of fatalities associated with the COVID-19 vaccines with evidence this was known early in interim reporting

- The Safety Tables in the TGA AusPAR documents (a), (b), (c) state that the long-term safety of these vaccines remains unknown and that Vaccine Associated Enhanced Disease is a risk meaning the COVID-19 vaccines should never have been allowed to be mandated.
- Substacks have used FOI's to analyse state government health data which indicates significant safety concerns relating to cardiac and neurological illness that can only be attributed to the vaccines (as described in the Substacks), and whereby the state health services, despite being alerted to their own data, have failed to review this information.
- ATAGI themselves include the potential for long-term cardiac consequences with studies finding impaired cardiac function 1 year later, a 1 in 35 incidence of myocarditis following vaccination, a significant association with cardiac related death, and evidence that all age groups and all people that are vaccinated suffer some extend of cardiac injury.
- Excess deaths in Australia that may relate to COVID-19 vaccination are being ignored.
- Natural immunity was, and continues to be, ignored despite its superior protection where vaccine mandates remain in workplaces despite most to all Australians having been infected or exposed
- An excessive amount has been spent on a large number of vaccine doses, including something like 7 doses per person – this was established early such that there was never an intention that people would only need 2 doses, but that is again not what the public were told – again highlighting the lack of transparency on these contracts. There was no support for a local protein-based vaccine created by Vaxine and used internationally to give Australians a choice to take this vaccine.
    - ➔ Solution: No vaccine should be mandated in the circumstances as above. All information should be welcomed and considered instead of censored and ignored.

- Personal Protective Equipment:
    - Despite repeated evidence, including in the governments own previous pandemic preparedness information, that masks are not effective for preventing COVID-19 they continued to be mandated. If COVID-19 is aerosol generated (not droplet), there is no likelihood that a cloth mask or surgical mask could have any impact whereby standard infection control measures for droplet precautions are surgical masks, but beyond that a N95 is required. The use of these long-term pose other issues relating to the persons health but also cost and environmentally.
- RAT Testing: When RAT testing had to be completed by ALL vaccinated SA Health staff and patients were being tested, unvaccinated staff were not allowed to work despite the use of this effective control measure further highlighting the discrimination against unvaccinated persons.
- Other potential treatments were ignored or worse they were attacked and censored including Ivermectin and Hydroxychloroquine despite copious studies presented to the contrary.
    - ➔ Solution: Best practice scientific method needs to be applied to all information, not cherry picking or mis-representation of information to suit a desired outcome