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Ms [redacted]
Chair Commonwealth Government COVID-19 Response Inquiry
Department of Prime Minister and Cabinet, Parliament House, Canberra

Dear Ms [redacted]

Re: Submission- COVID-19 pandemic response enquiry

I am pleased for the opportunity to provide feedback and suggestion on the management of the COVID-19 pandemic. This submission will focus on the cornerstone of pandemic management being widespread and mandated societal vaccination. Underpinning all aspects of personal and societal health-care management should be clinical rationale and justification. This submission posits that, in relation to widespread and mandated vaccination:

- **clinical rationale and justification by health authorities was by false premise; and was, or should have been, known by senior administrative medical practitioners to be false in 2021 at the time of vaccine mandate roll-out; and hence**
- **chief health officers, and other medical practitioners in positions of authority to impose vaccine mandates, failed to act in the best interests of the general public; and that**
- **the authority of the chief health officers to implement such public health mandates in the future should be either (a) revoked, or (b) permitted only under a vastly improved means of CHO governance, oversight and accountability.**

As background, I am a senior [redacted]-based specialist physician, presently in private practice, formerly appointed to [redacted] (1995-2016) during which time I had clinical, teaching and clinical governance roles. I have worked in the [redacted] and had significant research and development involvements over many years; I hold an adjunct [redacted] professorial appointment. The contents of this submission are necessarily medical and, in places, may be confusing to the non-medical reader. I would be pleased to discuss any matter arising from this submission as required.

During 2020 and 2021, the medical workforce and general public were inundated with health-care commentary from the lay press. For many in the medical workforce, this came as an unusual means by which we received information that we might then apply to our clinical practices. The medical workforce was required by the medical regulator, AHPRA, to comply with health department policy in relation to COVID-19 vaccination (https://www.ahpra.gov.au/News/2021-03-09-vaccination-statement.aspx). This requirement placed practitioners in an invidious situation if health department policy was considered flawed. Some practitioners simply accepted the 'safe and effective' mantra of government and health bureaucracy, without seeking raw data to reflect upon. Others including myself kept abreast of reports in the medical and lay press in order to best provide sage advice and explanation to our enquiring patients in difficult and confronting times. 'Trust me, I'm a doctor…' is inadequate and unreasonable in present-day clinical practice;

'trust me, I'm a medical administrator…' is not a conventional means by which medical practitioners take on clinical practice advice.

There is little doubt that geographic isolation resulted in different societal outcomes for Australia compared with nations elsewhere. Hospitalisation and death were more frequent for the earlier alpha strain than the mid-2021 delta strain. The late 2021 omicron strain was accompanied by lesser morbidity and mortality again. As with other viral infections such as influenza, certain demographics faired less well with COVID-19 infection- particularly the elderly and those with multiple medical problems.

COVID-19 became established in Australia in mid to late 2021 and, for Western Australia, early 2022, with the delta and omicron variants. Early vaccine studies had demonstrated, during the alpha strain era in the northern hemisphere, a reduction in severe disease, hospitalisation and death with COVID vaccination. The magnitude of benefit from vaccination was greatest amongst those at greatest risk of these specific COVID infection outcomes. The young and healthy remain at lowest risk of these outcomes. However, clinical trial 'effectiveness' of vaccination does not imply 'effectiveness' across all clinical scenarios. Accordingly, in September 2021, multiple health authorities were wrong to state or imply that vaccination was effective at **reducing transmission** of disease during the **delta and subsequently omicron** eras. Robust data in support of these claims did not exist.

A greater understanding of vaccine adverse events was becoming more apparent into mid and late 2021, yet careful and diligent side effect monitoring was not occurring. For example, there were 495 post-vaccine deaths to 2 September, and 719 deaths to 23 December 2021 reported to the TGA (https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-23-12-2021), yet the TGA acknowledged that their investigative capabilities in determining cause of death are limited (https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-02-12-2021). For this side effect of vaccination alone, this represents an abject failure of monitoring. Thorough adverse effect monitoring is a key tenet of good medical practice for new technologies, in order there can be swift procedural change if the balance of effectiveness and adverse effects changes.

It has been my clinical practice to avail myself of current published data that I can apply to the care of my patients; this was my practice as a senior public hospital doctor, and continues to be my practice as a private specialist and clinical academic. As much medical information was being communicated to society by the lay press in 2021, I spent considerable time informing myself of the most recent published clinical data in relation to COVID-19 prevention. Accordingly, when health-care worker mandates were announced and the, evidently false, rationale given that **vaccination reduced transmission and was 'safe'**, I wrote to Dr [redacted] (WA) on two occasions in September 2021. I concluded:

'… the public (and health-care professions) need confidence in health-care advice. It is therefore of grave concern that unsubstantiated and / or scientifically unreasonable claims in support of mandatory vaccination are made by the very individuals or agencies to whom politicians and the remainder of society look, for sound and sage interpretation of available data. By incorrectly purporting that vaccination prevents COVID-19 transmission in an Australian setting in 2021 / 22, false rationale is provided for mandatory vaccination. I will not attempt to speculate why these errors have been made, but it is ourselves as senior medical practitioners who have the requisite background to digest research / audit data and apply it responsibly to the clinical setting.

I will also not attempt to detail problems with the investigation and transparent publication of vaccine adverse events, nor the spectre of societal and individual coercion in receiving vaccines, but these speak to the ethical principles that underpin our medical practices of non-maleficence, justice and personal autonomy that are breached by mandating administration of the provisionally approved vaccines. Although I write with specific reference to vaccine mandates as they relate to health care workers, the principles readily translate to broader society, where vaccine passports and class-segregation based on vaccine status are widely proposed.'

In a detailed November 2021 response to me, Dr [redacted] made erroneous claims and justifications for mandating vaccinations, suggesting that the principle of 'proportionality' saw personal autonomy overruled for societal benefit.

On 24 December 2021, Dr [redacted] expanded vaccine mandates in WA to include booster vaccines across large segments of society at a time the delta COVID variant was giving way to the more infectious but less harmful omicron variant, and I wrote to him again, concluding:

'I previously contended that mandating vaccination seriously breached important medical ethical principles of non-maleficence, justice and personal autonomy. Now with the omicron variant dominant, there are insufficient data to even fulfil the ethical principle of beneficence in a vaccine mandate. I urge you to determine a means by which mandating vaccination is removed with immediate effect, and instead permit for vaccination to be encouraged according to evolving data and recommendations.'

The items of correspondence referred to above are in the public domain at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/VaccineDiscrimination/Submissions (submission 129, Professor G Forbes); the reader is referred to this reference for the full contents of these items.

The adverse outcomes of COVID-19 vaccine mandates and bureaucratic overreach into health-care delivery are difficult, or impossible, to reverse. Many individuals have been vaccine injured; others lost employment; businesses have been closed; education was interrupted; families separated; individuals prevented from accessing medical facilities; trust in health-care delivery negatively impacted; and loved ones left alone at the end of their lives; all for reasons of vaccine mandates. All of these public health outcomes were either intended by, or will have been evident to, Chief Health Officers and others in medical administrative circles.

Whilst the correspondence referred to in this submission is between myself and the CHO (WA), Dr's [redacted] and [redacted] were copied this correspondence; all were members of the AHPCC, the key decision-making committee for health emergencies. Accordingly, whilst individual states implemented their own pandemic-policies, these were underpinned by a federal collective decision-making process. The contents of this submission are then relevant to all Australian jurisdictions. Why senior medical practitioners, as health administrators, will have not appraised themselves of relevant published data, or collectively misinterpreted or ignored these data, and not taken heed of warnings of false rationale for vaccine mandates is open to others for conjecture. In summary, ***I contend that Chief Health Officers must never again be afforded the unchecked powers applicable during the COVID-19 pandemic***. I believe that it is the failing of the medical profession at this senior level that has not received sufficient focus, and is central to understanding errors in pandemic management.

Thankyou for giving this submission your attention.

Yours sincerely

[redacted]

Geoff Forbes