Submission to the Commonwealth Government COVID-19 Response Inquiry

ABS Australian mortality data review (1 January 2021- 30 July 2023)

Peter Paradice
[redacted]
Phone [redacted]

Peter Paradice Document Control

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Executive summary

The past 4 years (2020-2023) stand as a salutary background against which future trust in public health should be considered. In 2020 most governments around the world subscribed to the story of an existential health crisis and a one size fits all final defence solution for the masses in the form of patented, novel inoculation drugs. One group of drugs was based on mRNA and the other on adenovirus technology.

Australia's initial isolationism during the early COVID scare provided the opportunity later to obtain an insight not available to most other nations. The key to achieving this insight is the published ABS mortality metadata for points in time prior to 2020, through the period prior to the commencement of inoculant rollouts, to the period after the commencement of rollouts, and beyond. When the ABS data is examined using techniques of identification by exclusion, it shows unintended shortening of life by a "cause unknown". Metadata from global COVID, Australian COVID and the Australian inoculation program lends itself to posing some reasonable hypotheses relating to excess deaths. For those hypotheses to be further substantiated they must be tested against unadulterated micro-data. This submission urges the Commonwealth of Australia COVID-19 Inquiry (the Inquiry hereon) to secure and release the raw microdata of mortality for analysis from January 2020 until the present time.

Facts

1. Significant excess deaths appeared in the ABS records as soon as use of the novel inoculants began in early 2021.
2. COVID attributed deaths were immaterial to excess deaths until (6 months later) in July 2021.
3. 5,125 excess deaths were experienced prior to significant COVID death attribution began.
4. Ongoing excess deaths against pre-pandemic baselines continue to be reported by the ABS.
5. Excess unexplained deaths for the 30months since the start of the vaccine rollout have now exceeded 40,000 people.
6. The WA Government has published evidence of a large increase in reported vaccine injury since the start of the COVID vaccine roll out.
7. The British Medical Journal quotes research indicating that no more than 10% of serious vaccine injuries are officially reported when reporting is left to the dead and injured.
8. Infection with the virus confers superior immunity to COVID than the novel inoculants.
9. No novel COVID inoculants have moved beyond provisional approval by the TGA.

Observations

1. Based on the WA injury data (and research, noted above in point 7, indicating underreporting) it can be extrapolated that between 1 and 5m Australians experienced COVID inoculation injury.
2. Many of those experiencing inoculation injury will be the vulnerable with compromised immune systems. It is possible that some vulnerable (and healthy) people when faced with the shock of the inoculant, died.
3. Some excess deaths were caused by COVID however many COVID attributed deaths were from co-morbidities other than COVID.
4. 2023 COVID Inquiries in England and Scotland have heard that older patients testing positive for COVID were in many cases "written off" and treated with "end-of-life" programs or "euthanasia-type" interventions (or had lifesaving interventions withheld) that contributed to their demise. This response increased the number of COVID attributed deaths.

5. Statistics indicate that many people with death attributed to COVID did not have their lives shortened.
6. Excess deaths in the meta-data are temporally correlated to novel "vaccine" use. The relationship between "cause unknown" and "COVID vaccines" should be analysed, and causation ruled out.
7. Marketing imperatives may have driven the "COVID vaccine" narrative and thus the possible overuse of high-risk drugs with possible catastrophic injuries and death for some people for whom the knowable benefit-cost ratio was negative (particularly for those who had acquired natural immunity through viral infection). A novel technology was pushed that was a radical departure from the technologies people thought they knew and understood and was then promoted under false pretences to cohorts of the population who stood to gain little or no benefit from the technology.

Loss of trust

During the COVID panic and in the period of heavy coercion (at the release of the novel COVID inoculants), young people were told they would be responsible for killing their grandparents if they did not have the inoculation. It became a "pandemic of the unvaccinated". Australians were also told that natural infection did not confer immunity and that inoculation was the only mechanism to avoid hospitalisation and almost certain death.

It now transpires that the novel drugs neither stopped transmission or infection in the inoculated cohort. It is also established that natural infection confers better immunity than the manmade inoculants. Australians now know that this claim and other important claims were misinformation from their health authorities. Tellingly, against the orthodox narrative of the day, as a general principle, vaccines are deployed as a protection for the individual receiving the drug – not for the protection of others. In addition to these revelations Australians are becoming aware that the ongoing excess death rate is more highly correlated with the use of the novel drugs than the virus.

The consequence of advice from authorities turning out to be misinformation is likely to become manifest in **active distrust** of the Australian health authorities and the profession.

Private manufacturers striving for business success (profitability) and protected by government indemnity are more able to take risks with human lives than businesses liable for product failure affecting human health. An awareness that provisionally approved products are indemnified by the user themselves (taxpayer) may cause scepticism (loss of trust) in the products.

Restoring trust

The restoration of lost trust in Australian health authorities is an important challenge to be resolved.

As matters stand, there is a significant danger that if a real national health emergency arose the level of trust in Government is so low that reasonable people might actively resist and thwart genuinely sensible health measures. This not an ideal situation for Australia. The author knows of people (pro-vaxxers pre-2021) who refuse to take a vaccine of any sort as long as the current incongruous COVID narrative remains unaddressed.

Several initiatives will be required to address the trust issue. Implementing a full cost recovery user pays system for the people choosing to use the novel COVID drugs will be helpful to testing the commitment of Australians to these provisionally approved drug interventions.

Discussing and taking action to stop the excess deaths will be crucial to restoration of trust.

Removal of indemnity protection for "COVID vaccine" manufacturers will be "but a small step" in a long stairway to Australian Government redemption and restoration of trust. Perhaps it is better for democracy and more appropriate that Australians remain highly vigilant and more sceptical of government and public health leadership than in the past. The format of the 2023 Albanese COVID Inquiry will certainly assist in sustaining low levels of trust.

A further suggested action that could be deployed to build trust would be to place all information submitted to the Kruk Inquiry before an international panel of eminent persons (chaired by a respected Australian) for review. This parallel international panel of review could be commissioned to deliver a report addressing the same elements as the Kruk Inquiry with the trust that comes with "no past connection" to the management of the Australian COVID event.

Appropriate people to sit on such an international panel of review could include:

- [redacted] (past Deputy PM of Australia) Chair
- [redacted] (USA)
- [redacted] (UK)
- [redacted] (UK)
- [redacted] (Belgium)

The partial remedy

The long road to restoring trust includes reassurance that in the case of vaccine injury proper avenues of redress are available. An absolute and unqualified blanket ban on Commonwealth-backed indemnities is totally justified and will help with that process.

The material in the body of this advisory submission demonstrates some of the authors research, and perceptions regarding the extent of the hurt Australians have experienced from the Australian government's (State and Federal) responses and management of the COVID-19 event.

This material should assist in managing expectations regarding public health and provide some insights into, and resources for, the restoration of trust in a manner that is nuanced, responsible and sensitive.

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1 Background

This advisory submission to the Commonwealth of Australia COVID-19 Response Inquiry (Inquiry hereon) has been prepared and presented by Peter Paradice of [redacted]

This submission includes an analysis and interpretation of ABS mortality metadata and provides details of personal experience and research to gain an understanding of the issues that lie behind the data as they relate to the response of Australian governments during the COVID-19 event. This paper is the authors personal work and is founded only on the official Government numbers. It does not rely on the data, interpretation, or information of others.

The sources from which data and comments have been acquired for inclusion in this SUBMISSION include the following:

- Australian Bureau of Statistics
- Australian Federal Dept of Health
- Personal experience

Things have changed since January 2020. Many people have lost all trust in the integrity of Government, the medical establishment, the pharmaceutical industry, and the medical profession. While still living in a democracy, individuals are able, to express these sentiments without fear. This process is democracy at work.

The so called "vaccines" for COVID referred to throughout this advisory are the mRNA and adenovirus vector inoculants purported to improve immunity and health outcomes (over all other options) against the now benign COVID-virus.

The data examined in the past 30months contests the underlying premise, continually propagated by government, in respect of these novel "vaccines", that:

..... COVID-19 vaccines are safe and effective.

In respect of the novel COVID inoculants, the ongoing confidence of Australian authorities in this underlying premise is remarkable. With so much that seems unknown (and with data withheld) in current assessments of the untested (over time) mRNA and adenovirus vector drugs, it seems logically less risky at this juncture for Government to suspend the use of the novel inoculants.

Unlike the Swiss, it seems unlikely that the Australian Government has the integrity, fortitude or will to suspend the novel COVID inoculation drugs. This being the case the acid test to ensure the drugs are truly safe and beneficial is for manufacturers (currently hiding behind the taxpayer warranty) to be made liable for compensation if the products are proven to cause injury or death.

The charts in Attachment 1 indicate that the project is effectively over. The proponents of ongoing inoculation have lost the argument (using the wall of silence technique) against the Australian people.

2 Government responsibility

2.1 Inoculant ("vaccine") safety indicators

COVID news in recent months includes the release of an important report from the Western Australian Government. The report is titled "WA Vaccine Safety Surveillance – Annual Report 2021".

Please consider Section 3.1 of the report "Summary of AEFI reports, Figure 2". See Figure 1 below.

In 2020 the rate of reported vaccine injury per vaccine (pre-COVID inoculants) was 13 per 100,000 vaccines administered. In 2021 the rate of reported vaccine injury was 264 per 100,000 for the novel COVID immunisation drugs. This did not include a full year of the novel inoculants.

The chart below from the WA report illustrates in graphic form the change in total vaccine injury in WA in the period 2017 thru 2021.

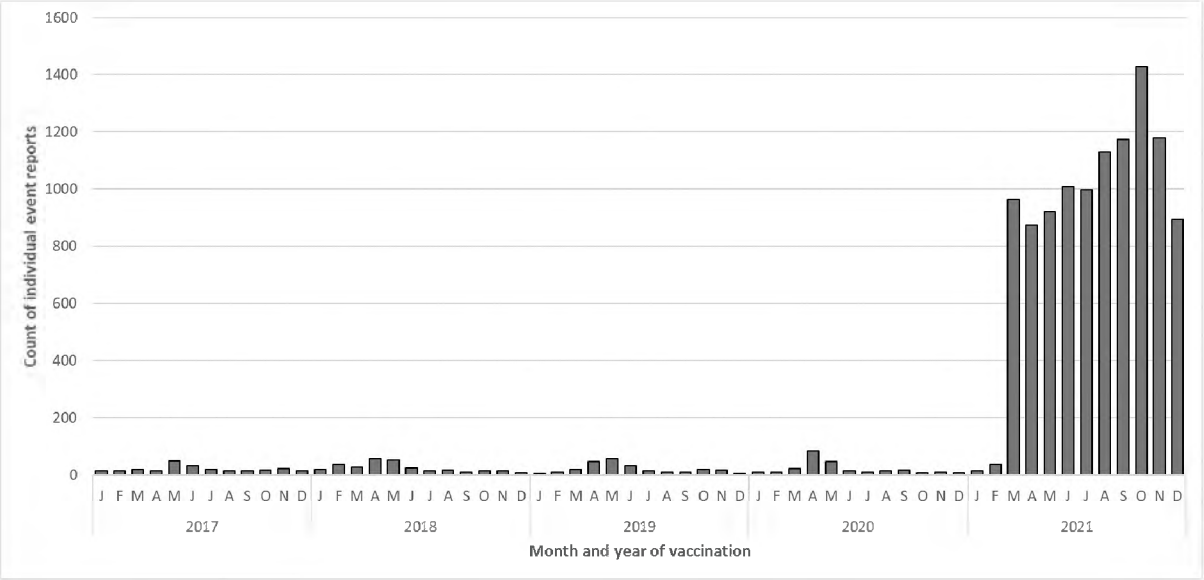

Figure 1: Section 3.1 of the WA VSS Annual Report "Summary of AEFI reports, Figure 2".

Does the Inquiry consider these rates of injury from the novel inoculants to be acceptable? Is it also possible some deaths passed unreported associated with inoculation. Prima facie, as explored later in this advisory, the adverse events system appears to be set up to ensure the injured and the dead are required to lodge their own reports. Does such a system lead to effective levels of reporting?

The deaths metadata in Figure 2 (from ABS data) indicate that much worse is yet to be revealed in the 2022 vaccine injury data. The author suggests the Inquiry focus on injuries in January/February 2022. The author recommends the Inquiry gain access to the "as yet unpublished" 2022 WA data to assist in deliberations for the suspension of the COVID inoculation program. The meta-statistical implications highlighted in Figure 2 should be enough to motivate the Inquiry to establish the facts. After the Inquiry has established the facts from the 2022 WA report, this will assist frame the imperative (or otherwise) for the novel drug manufacturers to be exposed to normal avenues of litigation and compensation for the supply of products that injure and kill recipients in the future.

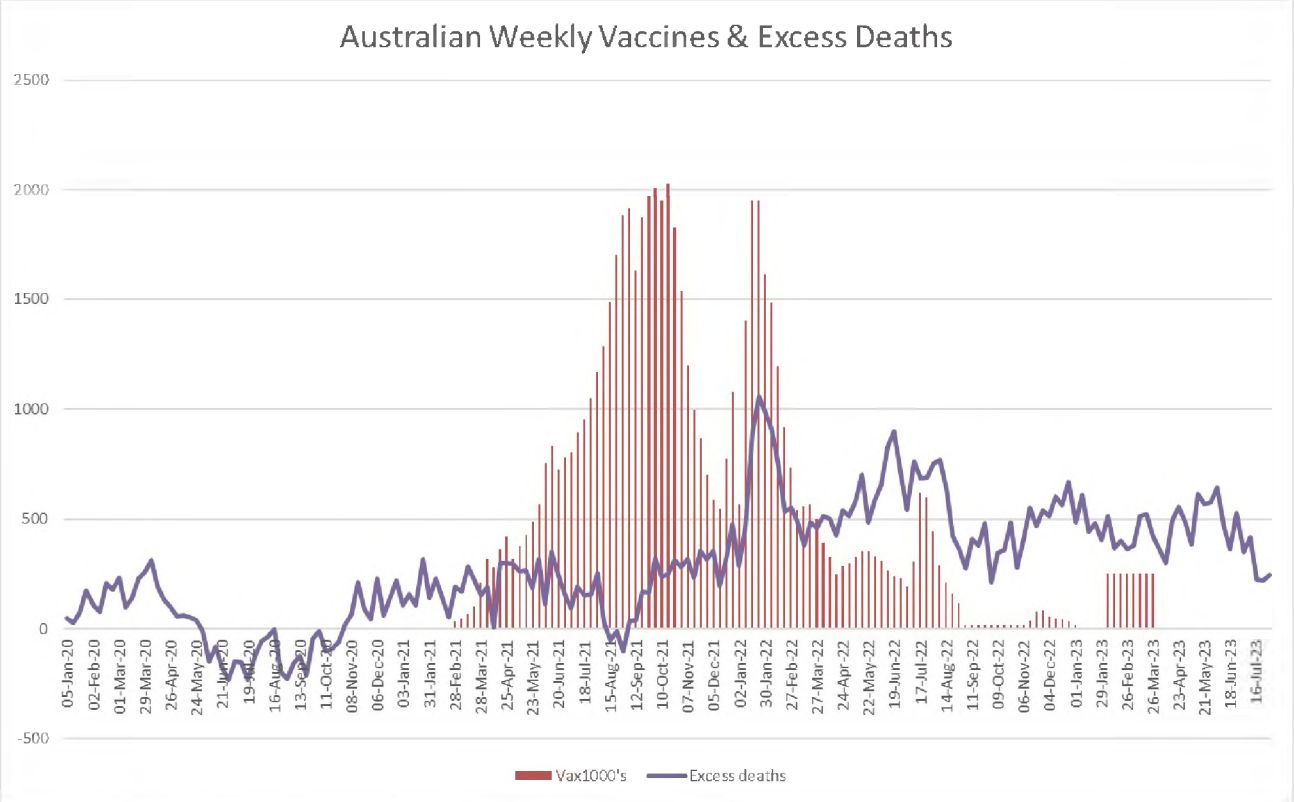

Figure 2: Australian weekly vaccines and excess deaths 2020 thru July 2023

The British Medical Journal has reported research indicating that in respect of "serious vaccine injury", only 1 in 10 (10%) of the serious inoculant injuries are likely to be reported and recorded. (Recently published research papers indicate this reporting number could be as low as 2%.)

If 90% underreporting is indeed the case, then the total serious injuries from the application of these COVID drugs in WA is 2,640 per 100,000 which, if extrapolated to the nation, (65m doses claimed administered) would indicate that as many as 1,716,000 Australians suffered a serious novel "vaccine" injury or death.

This number begins to tally with a personal family statistical experience tabled later in this submission.

The WA data and extrapolation is also consistent with the metadata and derivative hypotheses advised monthly by the author to the Minister for Health for each of the past 15 months.

In the week-ending 24 March 2023, "Our World in Data" reports that a great many Australians were still being inoculated with these COVID drugs. Does that correlate with government information? Listed below are the latest reports of daily jabs for Australia and some other nations.

- Australia 36,214
- Denmark 4
- Ireland 10
- Switzerland 18

The Swiss Government suspended use of the COVID "vaccines" in March 2023. The most recently reported inoculation rate is 18 Swiss people per day. Will the Inquiry please examine why the

Australian Government continues to spend taxpayer money on a program that some other responsible nations have apparently abandoned?

2.2 Responsible action

The author encourages the Inquiry to urge the Minister for Health to take the Western Australian injury data and re-run the COVID risk assessments and associated benefit-cost of the ongoing promotion of the novel mRNA and adenovirus vector inoculants to the Australian population. Surely this information is a central element of informed consent. If the Department of Health has data at this time, that is in future proven to show that the risk of injury from the vaccine is now greater than the benefit, then is the behaviour of the health professors and doctors involved in perpetuating this drug experiment in keeping with key tenants of the Hippocratic Oath?

Once the Minister for Health has conducted this risk/benefit/cost assessment it should be provided to the Australian people as the basis for "informed consent" to the current and ongoing promotion of the COVID inoculation program.

The author also requests the Inquiry to recommend that the Minister release the microdata for deaths in the past 3.5 years including vaccine status of all people dying. Earlier advice is that the Dept does not have the data. (Attachment 3.)

When this microdata is finally released Australian analysts will be wary to avoid the "gaslighting" problems identified in the UK when the data was made available. (see **Footnote 1**)

Footnote 1: UK ONS vaccine microdata data analysis shortcomings 21/02/2023

https://www.youtube.com/watch?v=FSL1fRRhJX0

2.3 Vaccine advisory guidance changes

On 5 September 2023 the UK Government updated a decision summary report in respect of the Public Assessment Report for COVID-19 Vaccine Pfizer/BioNTech. The words used advise:

This official UK decision to change vaccine advice for pregnant and breastfeeding women (previously categorised as vulnerable and therefore prioritised to be inoculated) is significant.

On 23 September 2023 the UK Government updated a decision summary report in respect of the Pfizer inoculant. The words used advise (and do not include the word "rare" or "unusual"):

The author encourages the Inquiry to ask the Department of Health if it has examined the rate of Australian neonatal deaths in 2021 and 2022 against historical expectations, while accounting for the drug status of mothers? If the Dept. has examined this important mortality indicator, could the public be advised of the findings? If this mortality has not been investigated, does the Inquiry consider that it warrants enquiry?

Pfizer themselves stated in a press release on 27/01/23 (link below) in respect of important safety information for their COVID inoculant products that potential recipients should (among other things) tell their vaccine provider if they:

- "Are pregnant, plan to become pregnant, or are breastfeeding."
- "Have had myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining outside the heart)"

https://www.pfizer.com/news/announcements/pfizer-responds-research-claims

The unanswered question remains. How does the Inquiry interpret the inclusion by Pfizer of pregnancy as a risk factor in the safe use of the listed drugs? Does the Inquiry believe Pfizer could be blame shifting natural responsibility to Governments (providers) in the use of these words?

As the parents of 3 daughters of current childbearing potential the authors' family are actively seeking an answer from Australian Govt. as to whether advice is under review to determine the ongoing designation of Australian pregnant women as vulnerable and therefore of high priority for having these novel drugs? Is the Inquiry able to assist with an answer to this question?

3 A personal COVID story

3.1 Preamble – early exposure to COVID19

The author and the authors wife are a classic case study of the development of negative inoculant sentiment. Following is the story in more detail (written in the first person).

In January 2020 my wife and I, while visiting our daughter in [redacted] contracted a "disease" from our son-in-law ([redacted]. On reflection and based on the symptoms, by March 2020 (back in Australia) we hypothesised it was the COVID Wuhan strain. We had a story to tell. We wanted to help assist the Government to gain understanding of this "killer disease", however we were outlawed from antibody testing for confirmation by Australian emergency legislation designed to control the medical profession. (Refer [redacted]) There was apparently no interest in our case! From then-on I developed deep distrust. The more I learn the more I distrusted the Government, experts, the medical profession and MSM.

The issue was not that we claimed to have had COVID (which may or may not have been correct). The issue was that we were outlawed from establishing the fact and no one wanted to know.

The narrative propagated at the time was that infection with the virus did not confer improved immunity for the subject person against serious disease, hospitalisation, or death compared to a person who was uninoculated and naive to the disease. This narrative never really made sense to people with the most rudimentary understanding of science who viewed such claims with deep scepticism. It turned out to be an incorrect hypothesis. In the current lexicon it was misinformation.

Peer reviewed research has since supported the hypothesis that viral infection confers immunity superior to that which is derived from a manmade spike protein inoculant.

An Israeli trial (follow the link) involving the Delta variant and the Pfizer vaccine concluded that "individuals who have had the SARS-CoV-2 infection are unlikely to benefit from covid-19 vaccination" and "naturally acquired immunity confers stronger protection against infection and symptomatic disease caused by the Delta variant of SARS-CoV-2, compared to the BNT162b2 2-dose vaccine-indued immunity".

The grave implications for this narrative and the consequent unnecessary application of high-risk drugs to those who had been exposed to the virus are discussed elsewhere in this submission.

3.2 Family matters - the dead and injured

In my immediate family (the total group is about 16) the following people had the following coincidental events after having the inoculant. The author has been widely advised that correlation is not causation, and the author gathers now, from other "experts", the author is most likely suffering from a mental condition known as "causal hunger" in trying to understand these afflictions.

- **Mother -** [redacted] – 2 weeks following 2nd inoculation – [redacted] – hospitalized [redacted] – stent fitted. (Correlation does not mean causation!)
- **Sister -** [redacted] – Following 2nd inoculation – [redacted] – hospitalized [redacted] – undertaken to stabilize [redacted] (Correlation does not mean causation!)
- **Wife -** [redacted] – [redacted] for several days following first inoculant. Bedridden for several days. [redacted] for 36 months (ongoing) following inoculations. Hands and wrists in pain and powerless. Only accepted 2nd inoculant for possibility of travelling to see granddaughter in [redacted] Refuses any further inoculations. She has aged significantly in this time. (Correlation does not mean causation!)
- **Daughter -** [redacted] – [redacted] after having 2nd mRNA inoculant. Diagnosed by doctor with [redacted] Refuses further inoculation. (Correlation does not mean causation!)

Peripheral to the authors immediate family the author is aware of the following reaction.

- **Nephew** – [redacted] – Developed intense [redacted] after first mRNA inoculant. He hid from further inoculations and remains in hiding. (Correlation does not mean causation!)

These people (names can be supplied) were previously robust and healthy. What they think happened to them is irrelevant. None of these issues were logged as adverse events. Why would doctors not get involved with the patient to log these officially as temporal relational adverse events?

Two fit, work associates [redacted]) were both given a Pfizer booster from the same batch at [redacted] in January 2022. (Please examine the chart in Figure 2 for excess deaths in that period.) Within a week they were both hospitalised in [redacted] one with a [redacted] episode requiring

[redacted] **and** the other with [redacted] and other [redacted] that required treatment over many months. Those hospitalised and the person who insisted on them taking the booster to retain employment, now believe or suspect it was the vaccine. Neither episode was logged as an adverse event. (We all now know that correlation does not mean causation!)

I can also refer you to others in my immediate circle who suffered long term injury and continue to suffer. My sister-in-law recounted a story recently of her sister-in-law (who worked as a US hospital chaplain until the end) who died of [redacted] in 2022 (cause unknown) in her sixties. Her name was [redacted] The author was told about six (6) causal options proffered by experts as possible explanations however the conclusion was "cause unknown". (Again, correlation does not mean causation!)

A person very close to me is a senior nursing sister and helps run a nursing home of about 20 residents. She is in her mid-sixties and has seen many people die in her time in nursing. She considers she knows when the time is up in aged people. I believe she is competent.

One Saturday afternoon in 2021 they "rounded up" (her words) all the residents in the home and inoculated them for COVID. In the morning two of the residents were dead. Her comment was that both these women were happy and well on Saturday night and "it was not their time". The author was advised that ALL the staff in that nursing facility believe the inoculation immediately killed 2 out of 20 of their residents in the application of the drug.

When I encouraged her to speak out and log the events, she said they were all fearful of losing their jobs. That fear remains. They will not speak. I believe these deaths were not logged as adverse events. How could these events not be logged? Had the residents tested positive for COVID - would they NOT have been certified as COVID deaths?

Many people do not want to discuss COVID "vax" issues for fear of ridicule and vilification. Why?

The question is not that these people believe (or not) that these "rare" events were related to inoculation, the question is how could they not be officially logged with the temporal association?

3.3 Personal and private wreckage – microcosm of a nation

If this experience is a microcosm of the Australian population, then by extrapolation 1 in 4 people had an adverse event to the inoculants. If 20m people have been inoculated then extrapolating from the microcosm, 5m people will have had some form of adverse event. Even if the ratio is 1 in 20, then 1m people will have had adverse events.

It seems inconceivable that if between 1m and 5m people in Australia had adverse events, then some significant proportion, who are old and/or with relatively weak immune systems, would not have died from adverse side-effects.

The Minister for Health (July 2022 Attachment 2) advised personally in a response letter that **no more than 13 deaths** (it is understood the TGA has since conceded 14) throughout Australia have been linked to the "vaccines". In light of the fact that there were net excess deaths (ie excess deaths less those attributed death with COVID) of more than 40,000 people in the 30months after the rollout began, is it possible the Ministerial advice could be inconsistent with the statistics?

What may appear complicated could be simplified if the Dept. released for public scrutiny the inoculation history micro-data for all deaths since the rollout began. Some pre-rollout micro-data would also be necessary. Age adjustment can be done. Smart analysts could run regressions to test the significance of the inoculants as an independent variable in the mix leading to death. Perhaps the models have already been built and for that reason the data will never be released. The Inquiry should ask the Dept. to supply the micro-data for the Inquiry to analyse. If the data supported the orthodox narrative, why would it not be out and about? (The statistics the author has personally derived from ABS metadata should be distressing. Why is no one distressed?)

Based on ABS figures, in the 30 months following the mRNA vaccine rollout more than 40,000 excess deaths have occurred in Australia against the pre-COVID five (5) year benchmark expectation.

It is now widely propagated by MSM that excess deaths have been caused only by "missed GP appointments" due to lockdown and the myopic industry focus on COVID cases.

Is it possible that the cause unknown underlying 40,000+ excess deaths is the same cause unknown driving injuries some claim (rarely) from the inoculants?

Because people must remain silent about the unknown cause/s the author attaches a surrogate Australian "public trust" chart in Attachment 1 for your consideration.

The "trust chart" indicates that at the end of March 2023 only a fraction the Australian population were up to date and effectively "PROTECTED" from COVID by the novel, man-made inoculant drugs.

If we ruminate for a moment on the unspeakable "Cause Unknown" and the population trust chart, then perhaps we might understand the insight of the many sceptical Australians into this government sponsored experiment. They are resisting ongoing coercion. Why might that be?

Even in the absence of leadership, the public seem to have made a decision that is not in alignment with the business ambitions of the drug makers, the WHO, the Government, and other elite beneficiaries of the pan~~dem~~ic.

It is accepted that COVID was widespread before Christmas 2022. In fact, the authors parents (both in their 90's) were labelled with COVID in November 2022 and the side effects of the anti-viral drugs they were given seemed worse than the disease. (The orthodox narrative premise is it's a deadly disease vs the now known real world reality.)

If inoculant damage is "rare" then the Paradice family and friends have been extremely unlucky to experience such a high incidence of "rare" coincidences of illness and injury in temporal proximity following inoculation.

Some see COVID inoculation as an ongoing experiment using taxpayer money to pay for high-risk drugs that are ineffective against an irrelevant virus.

4 Excess deaths and injuries

4.1 Excess deaths, cause unknown!

A significantly greater number of Australians died in the 30month period to July 2023 than could have been expected to die. Of the 52,519 excess deaths in the period more than 42,712 died of a

"cause unknown". The author understands the Government currently acknowledges 14 of these deaths were related to COVID vaccine injury. We look forward to the Inquiry proposing a credible explanation for the underlying cause of death for the other 42,698 people.

Appendix A details the statistics accumulated from the ABS mortality data releases that have supplied data back to early 2020. Appendix D graphically details excess deaths by age and sex for the most affected cohorts. While many females and males over the age of 84 died from a "cause unknown" between January 2021 and May 2023, in the month leading up to end July 2023 the excess deaths in this cohort have returned to the 5yr baseline. However, both females and males between the age of 65 and 84 are the groups that currently continue to die at a remarkably higher rate than expected. (Figures 11 & 12.)

4.2 ABS changes to the baseline for comparisons, present to past - 2023

In the ABS provisional mortality statistics (release 26/05/23) the ABS made the following statement under the heading "Baseline comparison". (Baselines are based on calendar years.)

"The purpose of a baseline is to provide a typical year (or combination of years) to compare the current year to. Deaths for 2023 will have two comparisons points - they will be compared to both deaths occurring in 2022 and a baseline period consisting of the average number of deaths occurring in the years of 2017-2019, 2021."

While the reported death rates meandered along in the 5 years until December 2019 (2015-2019) there was effectively:

- no change in Australian death rates in 2020 (virus but no vaxx),
- a significant increase in 2021 (virus and vaxx), and
- an extraordinary significant increase in 2022 (virus, vaxx and boosters).

The effect of comparing deaths to baseline (2017-2019, 2021) for 2023 was to:

- change the weighting of the baseline from 5 to 4 years,
- drop off two average years (2015-2016),
- replace two average years with one spike year thereby dragging up the baseline mortality rates significantly,
- normalise excess deaths.

The effect of comparing deaths to baseline (2022) for 2023 was to:

- compare a year with highest excess deaths on record (most from cause unknown) with a year when things were expected to settle back,
- make the present (2023) look much better than the past, and
- indicate that excess deaths were on retreat (not true from 2015-2019).

The Inquiry should consider why the ABS would change the baseline in this way. There were other options open to ensure excess deaths against baseline were more effectively assessed.

One theory is that if the "cause unknown" excess deaths are normalised into the baseline then difficult questions are less likely to arise. The Inquiry should advise Australians if ABS were given

advice or input from the Dept. of Health or others in establishing the new baselines as the numbers arising in 2023 were compared to the past.

4.3 Rare injuries

To maintain the national underlying premise (of vaccine infallibility) we must all discount people claiming "rare" injuries attributed to the novel inoculants and consider that most people apportioning blame to the novel drugs do so because of a "causal hunger" or conspiracy theory.

The author continues to seek to understand "rare" as it is used in the context as reported by MSM and Governments in respect of this matter. Figure 3 depicts one of many Australian fields of sorrow. Passersby may wonder what is going on. The author invites the Inquiry to apportion meaning to the photo and keep it in mind when formulating advice.

Figure 3 Field of sorrow silently informing of rare vaccine injuries at Shoalhaven Heads

4.4 COVID death misappropriation

In August 2023 an explanatory model was developed by the author to test the hypothesis that "many COVID attributed mortalities are a misappropriation from other causes of death".

The model compares the net expected increase in deaths for the "unusual" deficit mortality categories with actual mortalities logged to create a negative mirror image to the COVID deaths. In past Ministerial advisories this element has been one of the least explored points in the analysis. The

alignment of these calculations fortifies the view that COVID as a viral agent is less remarkable than flu/pneumonia. There were 1,536 flu deaths in the same period.

The "missing deaths" graph in Figure 4 below indicates that "as a rule, for each COVID attributed death there is an equal and opposite (missing, predicted) death from the combined background morbidity classes of respiratory, ischaemic heart disease, and cerebrovascular issues."

In the model the "missing deaths" will logically be understated as the multiplier derived from the average changed in doctor certified deaths (DCD) includes the supressing influence of the cerebrovascular, respiratory and isch. heart classifications which have generally been negative in the study period.

Once the reader grasps this concept then other hypotheses and conclusions logically follow.

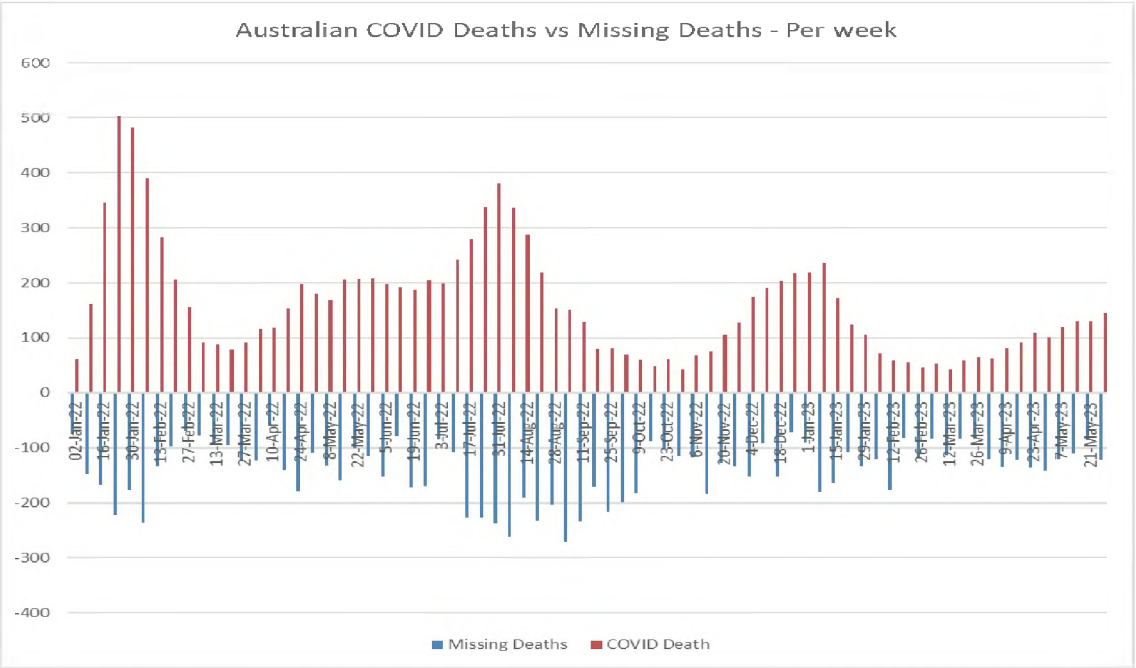

Figure 4 COVID attributed deaths VS adjusted expected deficit deaths for Cerebrovascular, Respiratory, Isch-Heart

* Missing Deaths = (Deficit deaths from cerebrov., resp., isch. heart (as a positive #) + expected increase in deaths in the cerebrov., resp., isch. heart group, based on weekly average increase in other co-morbidity groups) **See - Footnote 2**

Footnote 2: Mathematical model for missing deaths

D = (A x (1+B)) + (-1xC)
Where:
A = 5year pre-covid vaccine baseline for cerebrov.+resp.+isch. heart for the week in question
B = % average increase in all DCD mortality classes across the board for the week in question
C = Number of actual deaths over/under 5 year baseline for cerebrov.+resp.+isch. heart for the week in question
D = Missing (deficit) expected deaths for the week in question

4.5 Trust and confidence

When indemnity protection is removed for manufacturers of the COVID inoculant drugs, only if product safety is reasonably defensible, will the manufacturers of these drugs continue to supply the COVID "vaccines" from use in the Australian market. Based on the decision by Pfizer to not supply India with these novel drugs without Government indemnity in 2021, it seems plausible that some of these novel drug products will be withdrawn from supply in Australia if indemnity is removed.

The author prefers to label the novel mRNA and adenovirus vector drugs as inoculants rather than vaccines. One view is they should not be confused with, or compared to, the old tried and trusted vaccines. The author considers that to do so could be counterproductive in the long run. The Inquiry should consider if it is possible that such comparisons are fostering unreasonable negative sentiment against all vaccines? Is this happening now in Australia? What does the data indicate?

4.6 Motivations of proponents of novel COVID inoculants

The author has become aware that many claiming "known" current and future safety of the novel inoculates have received research funding from the World Health Organisation and/or have material relationships (sometimes thru many distant intermediaries) with manufacturers of novel mRNA or adenovirus vector "vaccines". Personal research indicates that many promoters have little idea of the science and are motivated primarily by funding.

The clip below with immunologist Professor [redacted] leads the author to believe that most Australian proponents of the novel inoculants do not know what they are talking about. The author encourages the Inquiry to consult Professor [redacted] in person in its search for the truth.

https://youtu.be/yMyERFBdB4E (YouTube [redacted] & Professor [redacted] discuss mRNA technology.)

Based on their public prognostications, the author encourages the Inquiry to examine the underlying financing arrangements of key proponents from the TGA, the Gavan Institute, the Kirby Institute, the University of Sydney, the Melbourne University, Monash University and The Australian Actuaries Institute.

As more excess deaths data is revealed, less noise is heard from individuals working at the institutions listed above as the emerging scale of the problem becomes apparent.

5 Conclusions

The Inquisitors should set aside all the earlier information tabled and focus on just two questions.

There were ten (10) people mentioned in the story above (Section 3.2) who were injured of died soon after being jabbed with the novel drugs. There was a strong temporal connection to the "vaccine". What they believe is irrelevant. What the writer believes is irrelevant. Many people around them considered that they were vaccine injured or killed. The doctors involved appear to have ignored the temporal association and left the injured and dead to report events themselves. Without these sorts of events being logged there is no possibility of establishing the true frequency of vaccine injury and death. Distrust reigns among the associated living. Doctors become suspects.

To the best of the authors' knowledge, not even one of these 10 cases were logged as an adverse event. **Why would the system be designed against it?**

The calculations (attached spreadsheet) from ABS data estimate that in the first 30months following rollout (Feb 2021 to 30/07/23) the most supportable number of unexpected (unexplained) Australian deaths in all cohorts was 42,712. We know the Government has now recognised 14 deaths linked to COVID vaccine injury. **Is the Inquiry able to discover and reveal to the Australian people what caused the other 42,698 deaths?**

6 Bibliography

AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 30/03/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 28/04/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 25/05/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 23/06/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 29/07/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 26/08/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 30/09/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 27/10/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 25/11/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 22/12/22
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 24/02/23
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AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 28/04/23
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AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 28/06/23
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 28/07/23
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 25/08/23
AUSTRALIAN BUREAU OF STATISTICS Provisional mortality data release 27/10/23

Government of Western Australian Department of Health (2022) “WA Vaccine Safety Surveillance – Annual Report 2021”.

7 Appendices

7.1 Appendix A. Australian ABS mortality data

On 27 October 2023, the ABS released the 2021/23 (YTD) death statistics which reported data until 30 July 2023.

Tabled below are the headline numbers from the ABS metadata since January 2020 by periodic release by calendar year. (ABS releases referenced are listed in the Bibliography.)

Expected total deaths for 2020 (5yr average 2015-19)	160,372
Actual total deaths for 2020 (52 weeks)	161,777
Difference in DCD deaths (5yr av)	1,405 more than expected
Death's with Covid attribution (Calendar YR 2020)	854
Expected total deaths for 2021 (5yr average)	160,372
Actual total deaths for 2021	170,960
Difference in deaths (above 5yr av)	10,588 = (excess deaths)
Difference in deaths (above 2020)	9,683 = (excess deaths)
Death's with Covid attribution (Calendar YR 2021)	1,212
2020 excess deaths LESS Covid deaths (no vaccines applied)	551 more than expected
2021 excess deaths LESS Covid deaths during vax rollout	9,378 more than expected
Difference in excess deaths 2021 vs 2020	9,183 more in 2021

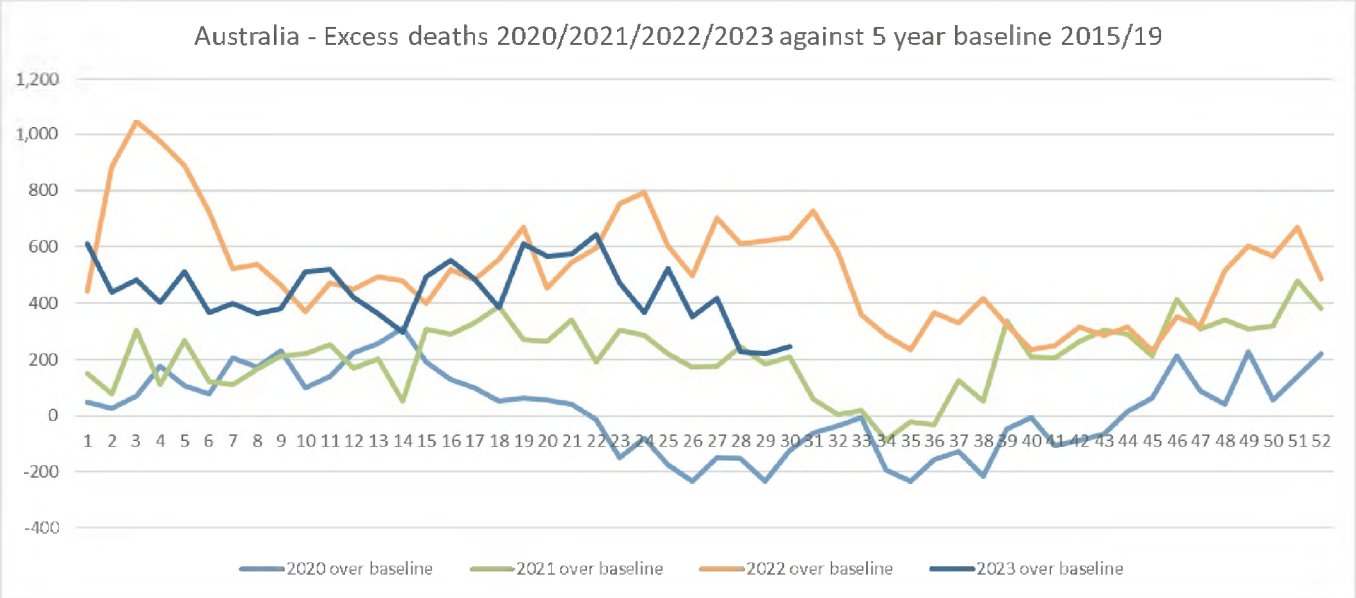


Figure 5: Weekly excess deaths Jan2020/2021/2022/2023 vs 5year benchmark background – ABS release 30 July 2023

While calendar year 2021 excess weekly total deaths increases were a significant cause for concern, since January 2022, another larger rise in "unexplained" deaths occurred. (See Figure 5 and Figure 6) From 2022 the ABS changed the comparison baseline from the 5year average to 2019 (used until the end of 2021) to a hybrid baseline, the consequences of which are discussed in Section 4.2 in the SUBMISSION above. However, when the 5year average baseline to 2019 is used for total deaths, the following numbers appear for the period January 2022 thru July 2023 and are represented in the graphs in Figure 5 and Figure 6. The numbers are remarkable in their magnitude.

Expected total deaths for Jan22/July23 (5yr baseline)	251,950
Actual total deaths for Jan22/July23	294,662
Difference in total deaths Jan22/July23 (above 5yr averages)	42,712 = Excess deaths
COVID attributed deaths Jan22/July23	12,971
Unexplained excess deaths Jan22/July23 (minimum)	29,741
Excess total deaths, vax rollout day 1 thru 30 July23 (120 wks)	52,519
COVID attributed deaths during vax rollout period (120 wks)	13,473
Excess deaths LESS COVID deaths (all attributed)	39,046 > than expected
Excess deaths LESS COVID deaths (5% of DCD attributed)	51,820 > than expected

The ABS indicate that people certified as having died of COVID, on average, had 3 additional chronic comorbidities and only 5% of those dying of COVID had COVID19 recorded as the sole cause of death. It is not unreasonable to assume that other COVID attributed mortalities may have been caused by co-morbidities or THE "Cause Unknown".

The data indicate that since the start of the vaccine rollout (to 30 July 2023), approx. 42,519 more total deaths occurred than were expected.

The non-COVID excess DCD deaths were statistically attributed to, cancer, dementia, diabetes, and other disease classes with death rates generating "overs and unders" against expected rates in different mortality classes.

Data from commencement of vaccine rollout (7 February 2021 thru 30 July 2023)

Attached is a spreadsheet with ABS deaths data for the 30month period from 7 February 2021 thru 30 July 2023. The ABS also report deaths broken down by some mortality classifications. "Old age" is not included as a mortality class. In July 2023 the ABS commenced reporting an additional class being "Other cardiac". It has not been introduced into this report, however preliminary and there are ongoing indications (+14% increase in the past 30 weeks against the hybrid baseline) that the data supports the hypotheses postulated in this report. The specific "death by morbidity" classifications are listed below.

MORTALITY LIST A

- Cancer
- Cerebrovascular
- Respiratory
- Dementia
- Diabetes
- Ischaemic heart disease

When the past 30months ABS data is processed (7 Feb 2021 thru 30 July 2023) by total deaths and the primary morbidity-mortality classes against the 5year baseline average the following insights emerge:

A.	Expected total deaths (30months) from all causes + old age	401,032
B.	Actual total deaths (30months) from all causes + old age	453,551
C.	Excess deaths from cancer, dementia & diabetes	19,249 -more than expected
D.	Excess deaths from cerebrov., resp., isch. heart	(4,808) - less than expected
E.	Deaths attributed to COVID-19 (for 130 wks)	13,975
F.	Actual deaths from COVID-19 no comorbidity (5% of E above)	699

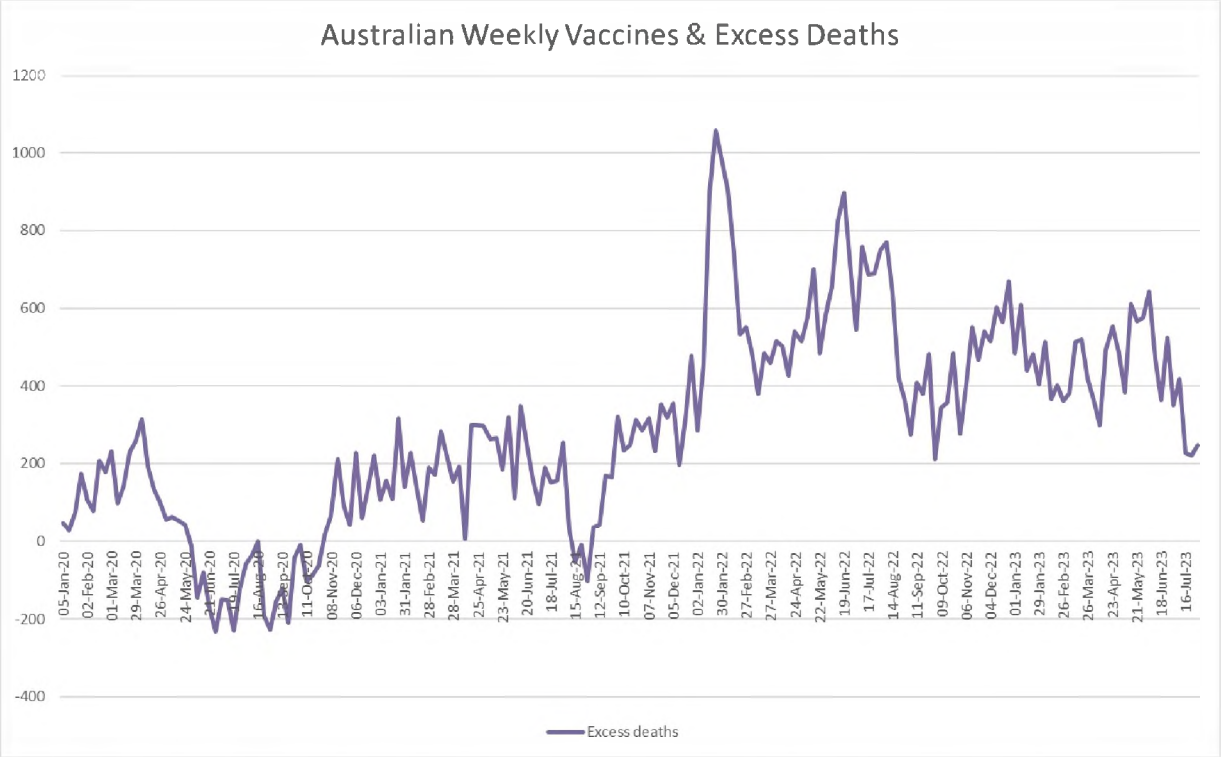


Figure 6 Weekly excess death% Jan 2020 thru July 2023 (against 5year average) – ABS release 30 July 2023

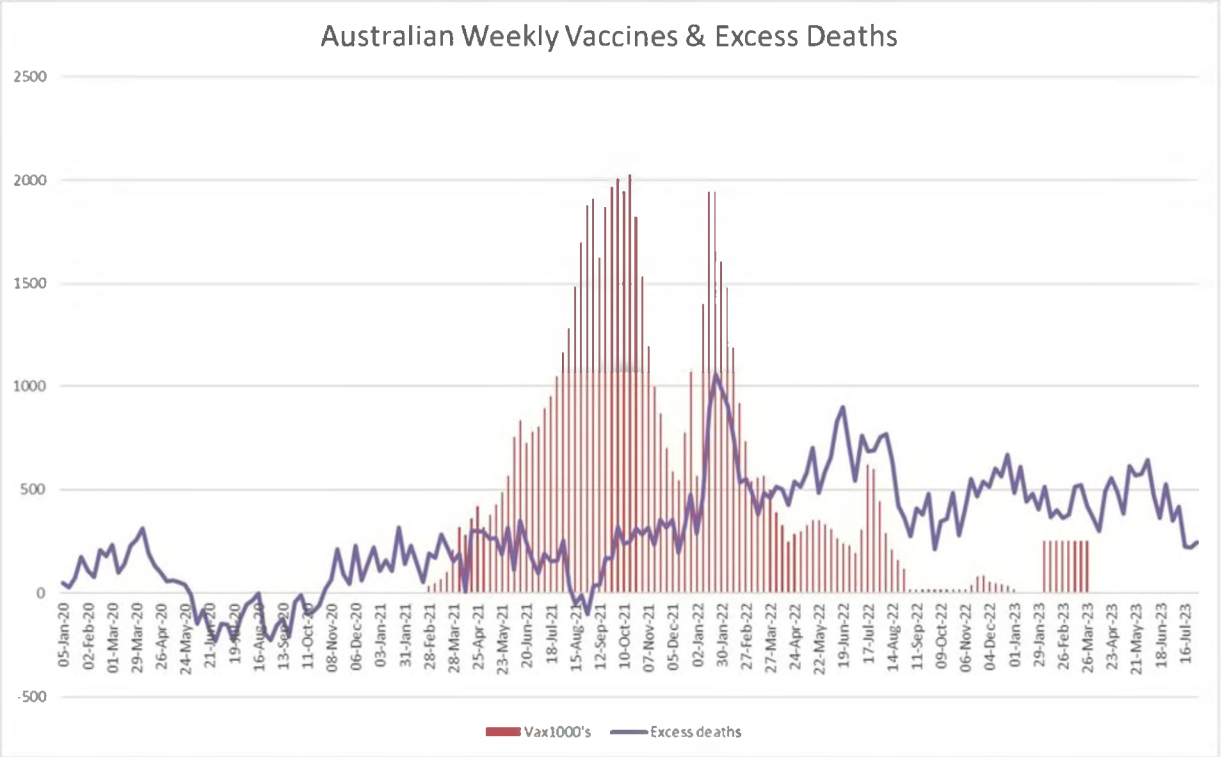


Figure 7 Weekly COVID vaccines applied and excess deaths Jan 2021 thru July 2023 (against 5year average) – ABS

Data from the 2021 COVID "attributed" deaths resurgence (5 July 2021) thru 30 July 2023

Following Australia's isolation, COVID attributed deaths began appearing in the weekly data from the report dated EOW 11 July 2021. The data for the following 107week period until end July 2023 revealed the following two numbers.

Deaths attributed to COVID-19 (for 107weeks)	13,971
Excess deaths from cerebrovasc., resp., influenza, isch. heart	(4,808) less than expected

In other words, in the 107week period beginning 05/07/21 a partial inverse pattern to COVID deaths (negative actual against expected) emerges for the combined morbidity-mortality classifications of:

MORTALITY LIST B (Subset of LIST A)
- Cerebrovascular
- Respiratory
- Ischaemic heart disease

In the same "107week" time frame, deaths attributed to the morbidity-mortality classifications of cancer, dementia, and diabetes, increased by 16,698 people.

So, what could it all mean?

The Key Numbers

The key takeaway numbers from the Australian deaths ABS metadata to 30/07/23 are:

- 52,519 **excess** deaths were reported from vax. rollout day-1 thru 30 July 2023 (Ref Figure 6),
- There were 13,975 COVID attributed deaths from vax. rollout day-1 thru 30 July 2023,
- There were 38,544 excess deaths after deducting all those attributed to COVID-19,
- There were 51,820 excess deaths after deducting NET1 COVID-19 deaths of those dying without co-contributing comorbidities (Figure 8),
- There were (4,414) **LESS** deaths from cerebrovascular, respiratory, and ischaemic heart from 5 July 2021 thru 30 July 2023 (a negative inverse to COVID accounting directly for approx. 32% of COVID appropriated deaths however if mortality is adjusted to account for the missing anticipated increases in these groups, plus the observed deficit, a mirror image to the COVID attributed deaths is revealed – see Figure 9),
- Deducting deaths of those dying with contributory co-morbidity then far fewer COVID attributed deaths **could arguably be considered to have been from COVID as the primary cause** from 20 September 2021 thru 30 July 2023,
- There were 19,249 more deaths than expected from 5 July 2021 thru 30 July 2023 from cancer, dementia & diabetes, and
- There were 21,734 more deaths than expected from 5 July 2021 thru 30 July 2023 from the "cause unknown", old age or causes other than the primary ABS mortality classifications discussed above.

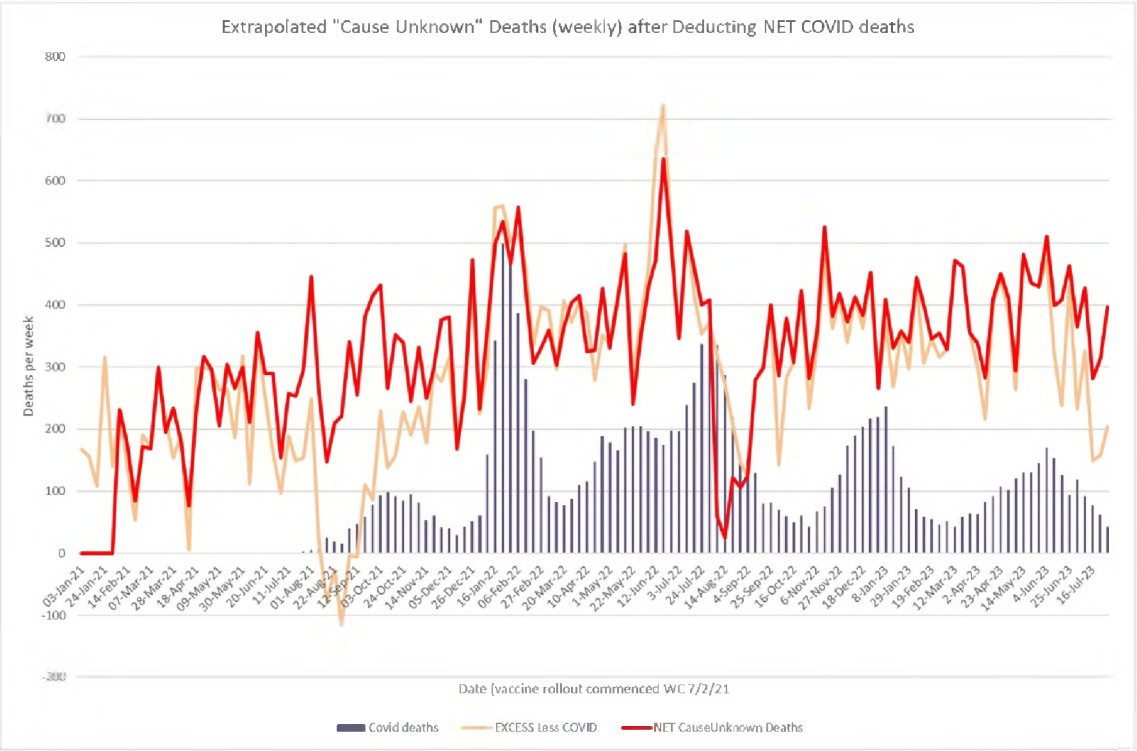


Figure 8 Extrapolated NET ""Cause Unknown"" deaths from rollout commencement 7 February 2021 to 30 July 2023*

* NET "Cause Unknown" deaths = (Total excess deaths) MINUS (NET COVID attributed deaths**)
* **NET COVID attributed deaths = (Total COVID Attributed deaths) PLUS (M_LISTB Attributed deficit deaths)

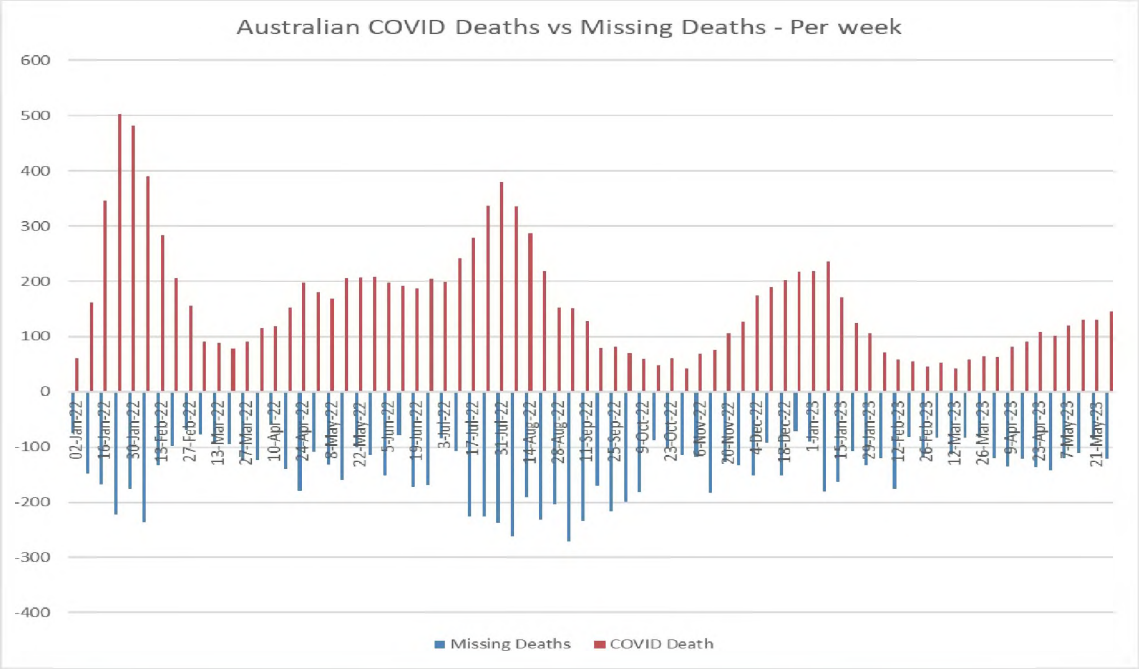


Figure 9 COVID attributed deaths VS adjusted expected deficit deaths for Cerebrovascular, Respiratory, Isch-Heart

* Missing Deaths = 5YR baseline cerebrov., resp., isch. heart group + anticipated increase in deaths in the C.R.I group (based on weekly average increase in all morbidity groups) + (Deficit deaths from cerebrov., resp., isch. heart (as a positive #)) **See - Footnote 3**

Footnote 3: Mathematical model for missing deaths

D = (A x (1+B)) + (-1xC)

Where:

A = 5year pre-covid vaccine baseline for cerebrov.+resp.+isch. heart for the week in question

B = % average increase in all DCD mortality classes across the board for the week in question

C = Number of actual deaths over/under 5 year baseline for cerebrov.+resp.+isch. heart for the week in question

D = Missing (deficit) expected deaths for the week in question

7.2 Appendix B. The "Cause Unknown" and Virus Activity Hypotheses

Hypotheses, reasonably postulated from the ABS numbers for Australia (and that require testing by examination of the microdata) are:

- The "Cause Unknown" shortened the lives of (killed) at least **38,544** and as many as **52,519** Australians since the start of the "vaccine" rollout (130 weeks),
- **44,512** is calculated to be the most likely estimate of Australian people in all cohorts who had their lives shortened by THE "Cause Unknown" in the 130 weeks to 30 July 2023. (The ratio of total excess deaths is 1 excess death per 1,465 inoculants applied. Remarkably this ratio has also been recorded for the UK and the USA.)
- Ongoing "Cause Unknown" intervention continues to shorten the lives of people across most age groups,
- 95% of deaths attributed to COVID had co-contributing comorbidities (ABS comorbidity rates),
- Attributed COVID deaths can be logically calculated to be lower than official claims,
- Older patients testing positive for COVID were in many cases "written off" and treated with "end-of-life" programs or euthanasia type interventions (or had lifesaving interventions withheld) that contributed to their demise,
- Novel COVID "vaccines" don't stop viral spread or infection (the antithesis of initial Government coercion declaring "a pandemic of the unvaccinated"), and,
- Temporal regression modelling of the extra 9,834 cancer deaths indicates a correlation between mRNA "vaccine" application and increased cancer deaths (+9% and climbing) which could indicate a possible causal relationship. The relationship is 30 deaths per 1m doses lagged 120days. (The association since the commencement of the experiment is 154 extra cancer deaths per 1m doses. However, on the basis that 21m people were inoculated with an average of 3 doses of "vaccine" then the direct correlation is an extra 462 cancer deaths per 1m people given the 3dose course of COVID drug treatment.)

7.3 Appendix C. The Logical COVID Conclusions

If the hypotheses logically formulated on the metadata are supported by the microdata (unavailable to-date for independent examination), then the following conclusions might reasonably be drawn from the Australian COVID experience.

- The Government unreasonably overstated the danger of the COVID virus (any variant).
- With wilful ignorance and in the face of evolving facts, the Government, and mainstream media unreasonably terrified and coerced the nation into accepting inoculation with the novel vaccines.
- Many older Australians testing positive for COVID were largely "written off" and left to die from what now appears to have been an unremarkable and treatable illness. (This boosted the statistics for the COVID death rates.)
- A "Cause Unknown" shortened the lives of (and continues to shorten the lives of) many vulnerable and healthy Australians. (Refer Figure 8)
- Statistically, the virus as a sole agent in shorten the lives of people who died with COVID attribution is questionable.
- The novel COVID "vaccines" are implicated in significantly increased rates of cancer.

Therefore, if these conclusions are eventually supported by the microdata, then the benefits will be seen to not outweigh the costs in applying these drugs (the misnamed novel COVID "vaccines") to **any** cohort of the Australian population.

If the conclusions are eventually supported by the microdata could the Inquiry establish who will take responsibility for this awful human experiment?

Some of the people in key positions who should be invited to take responsibility for the consequences of the Australian COVID management response are:

- The 2021 Prime Minister Morrison (lost Govt.)
- The 2021 Federal Minister for Health Hunt (Resigned)
- The 2021 Secretary for Health Professor Murphy (Retired)
- The 2021 Chief Medical Officer of Australia Professor Kelly
- The 2021 Head of the TGA Adj. Professor Skerritt (Retired)
- The 2021 Head of ATAGI Assoc. Professor Crawford
- The 2021 NSW Minister for Health Hazzard (Retired)
- The 2021 NSW Chief Medical Officer Dr Chant
- The 2021 Victorian Minister for Health Andrew
- The 2021 Victorian Chief Health Officer Professor Sutton (Resigned)

7.4 Appendix D: Graphs of Australian excess death rates by key affected age groupings January 2020 thru July 2023

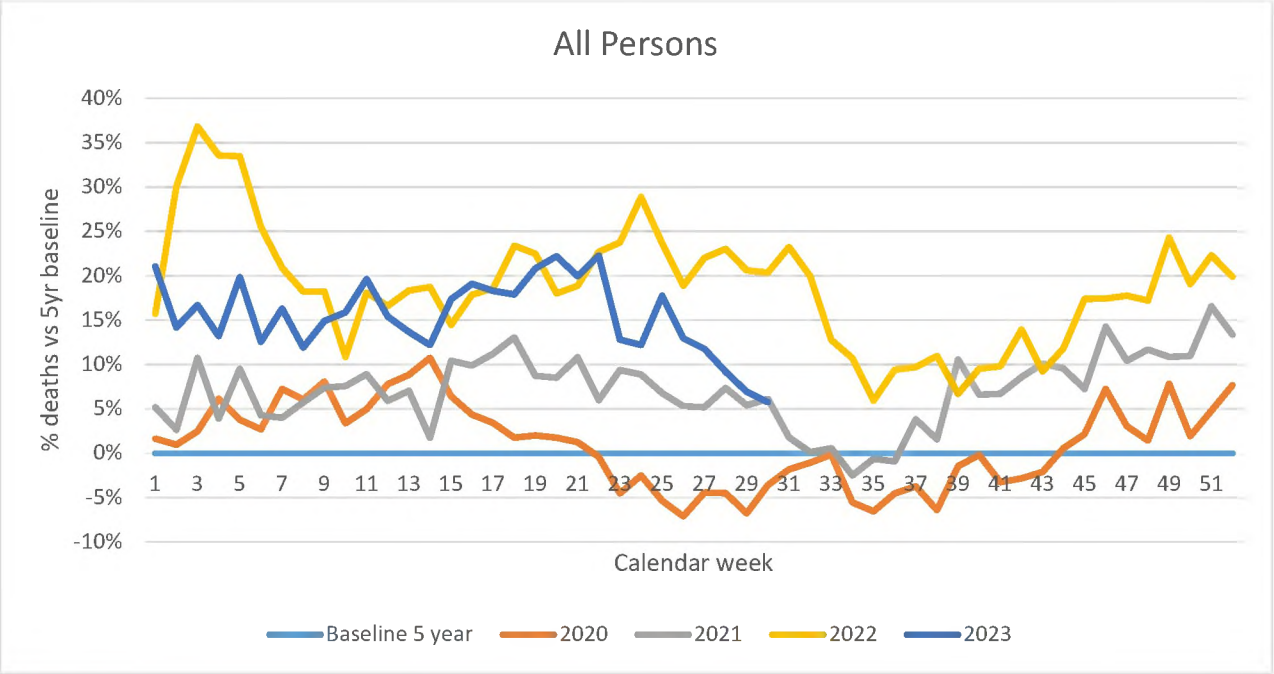


Figure 10: Australian excess deaths%. All persons. January 2020 thru July 2023

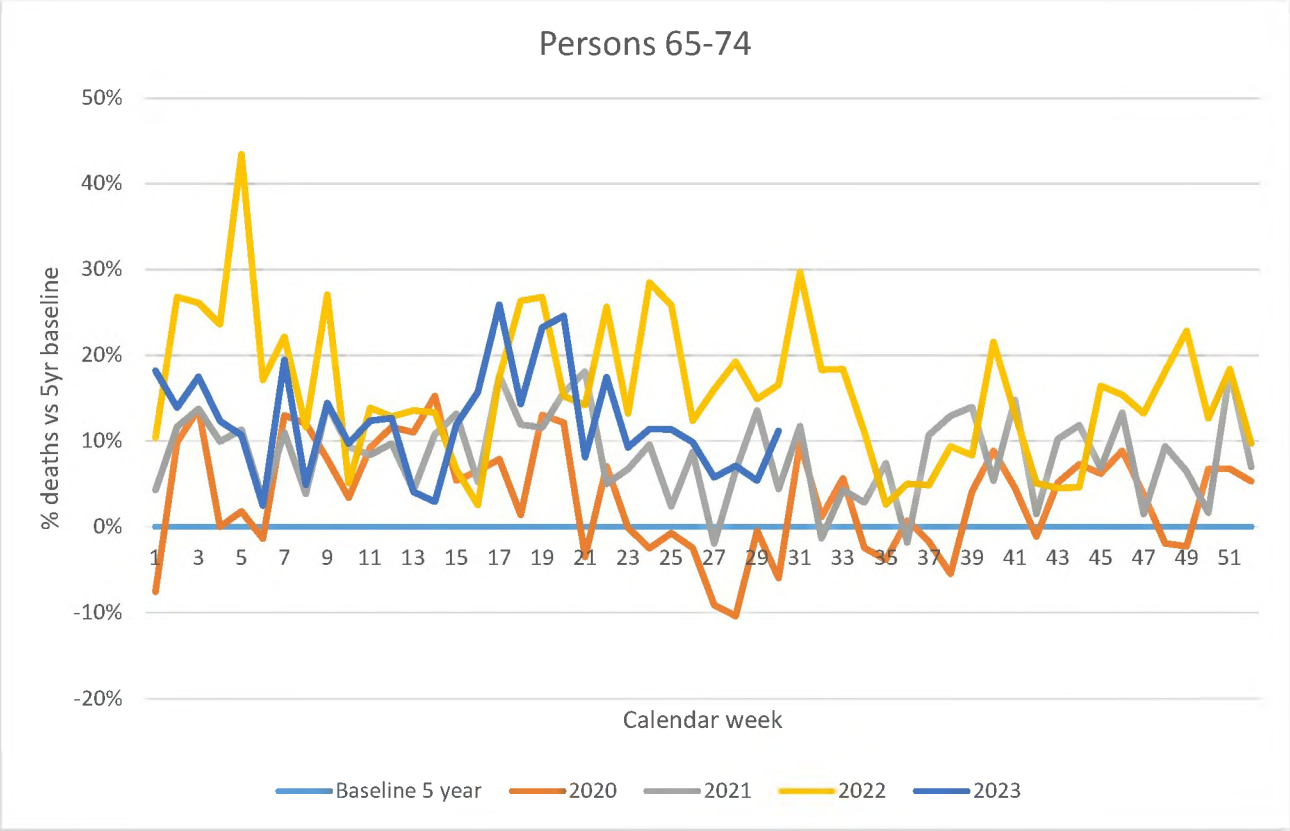


Figure 11: Australian excess deaths%. Persons 65-74. January 2020 thru July 2023

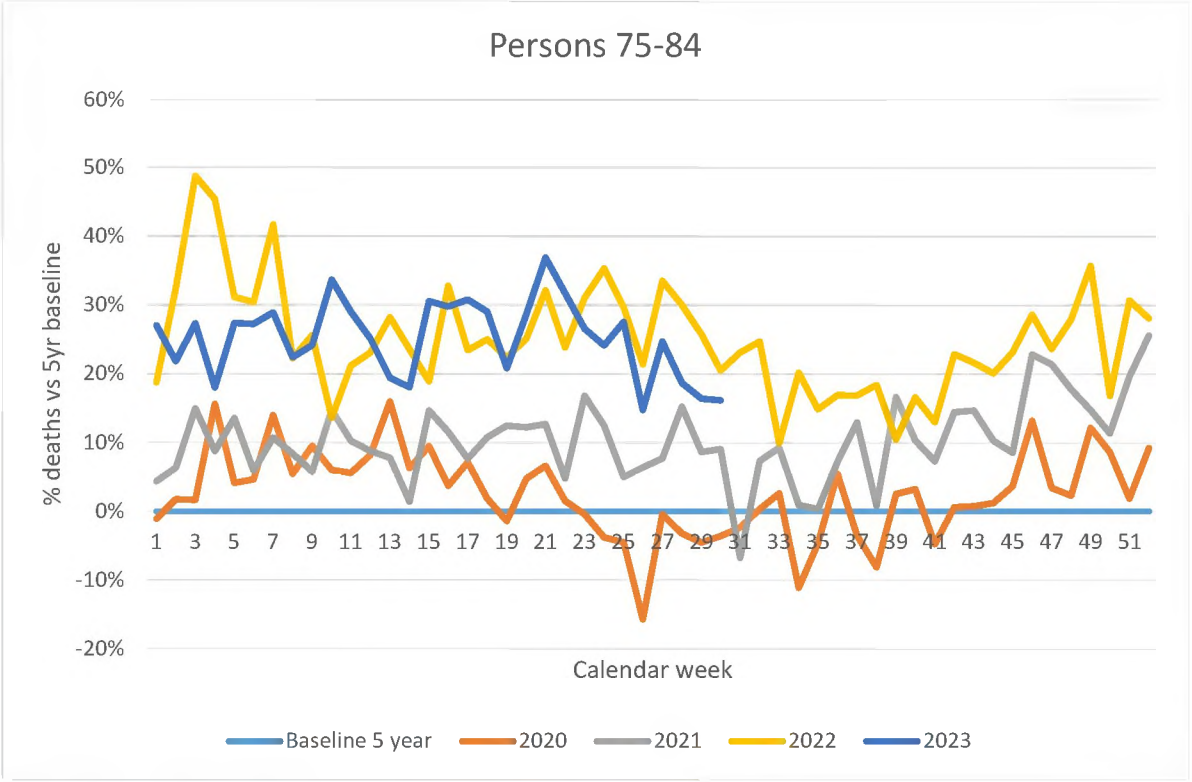


Figure 12: Australian excess deaths%. Persons 75-84. January 2020 thru July 2023

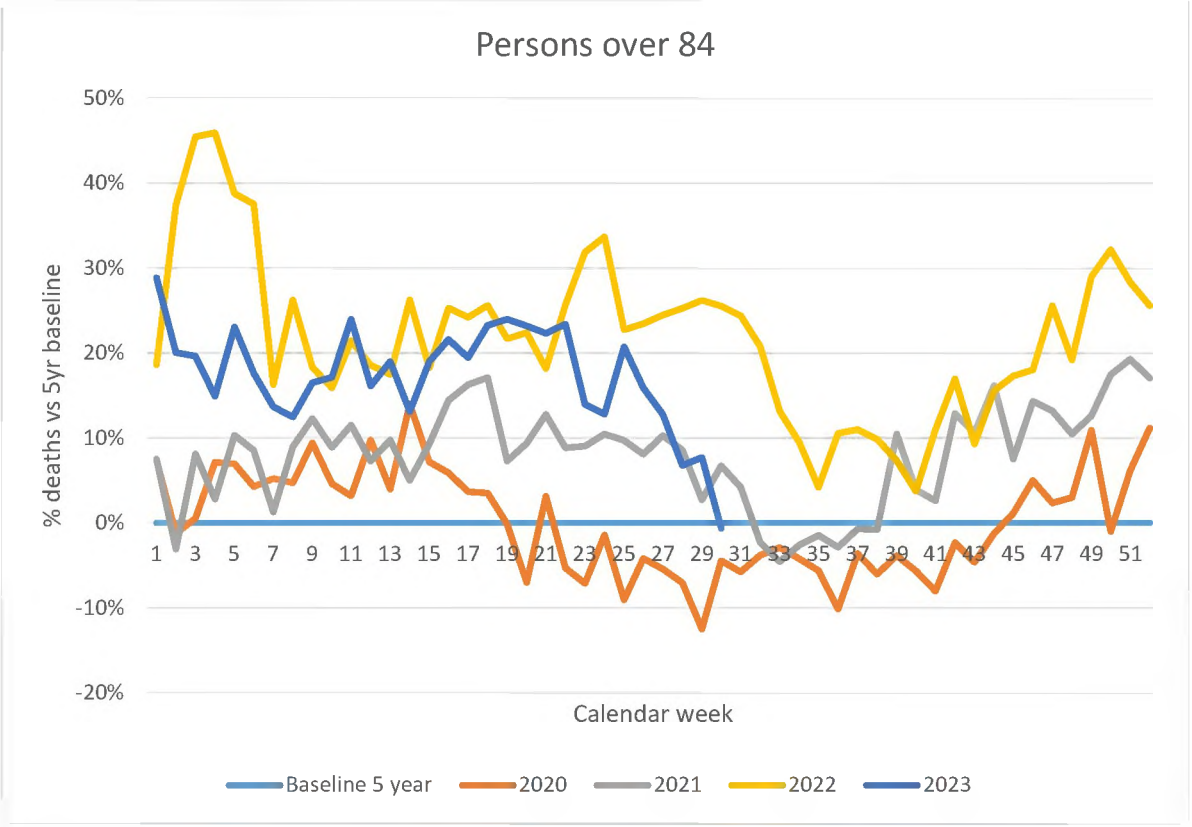


Figure 13: Australian excess deaths%. Persons over 84. January 2020 thru July 2023

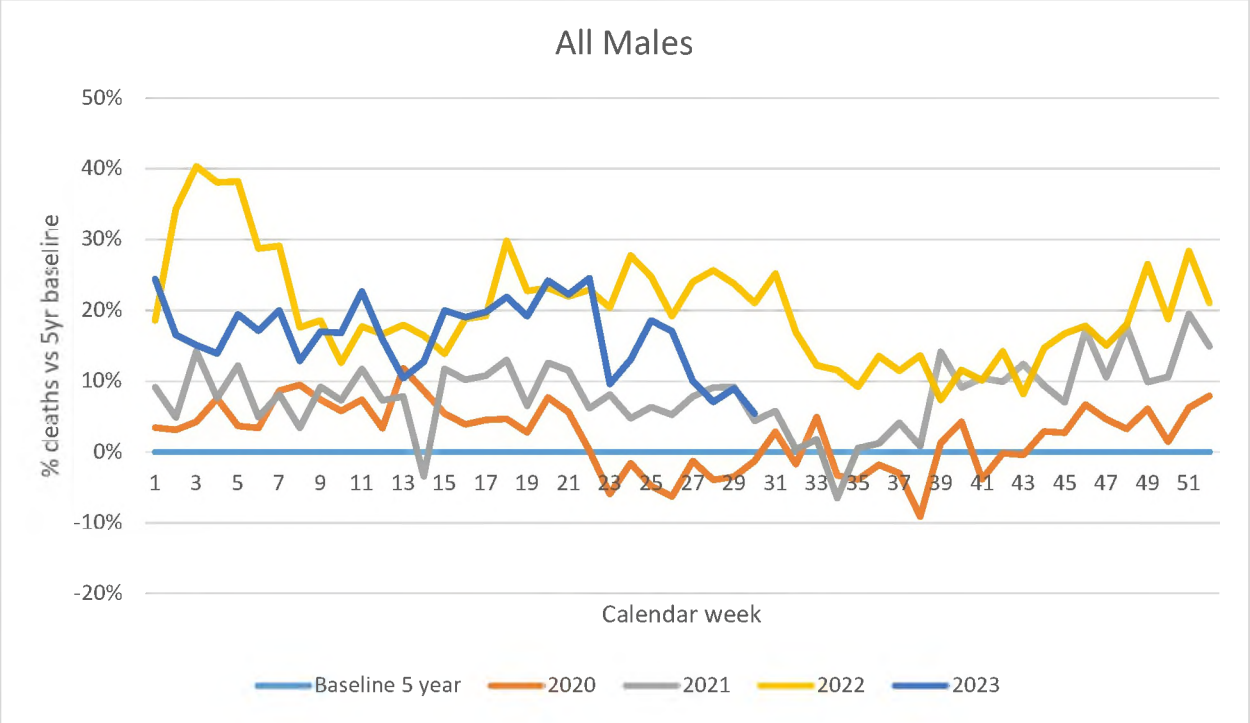


Figure 14: Australian excess deaths%. All Males. January 2020 thru July 2023

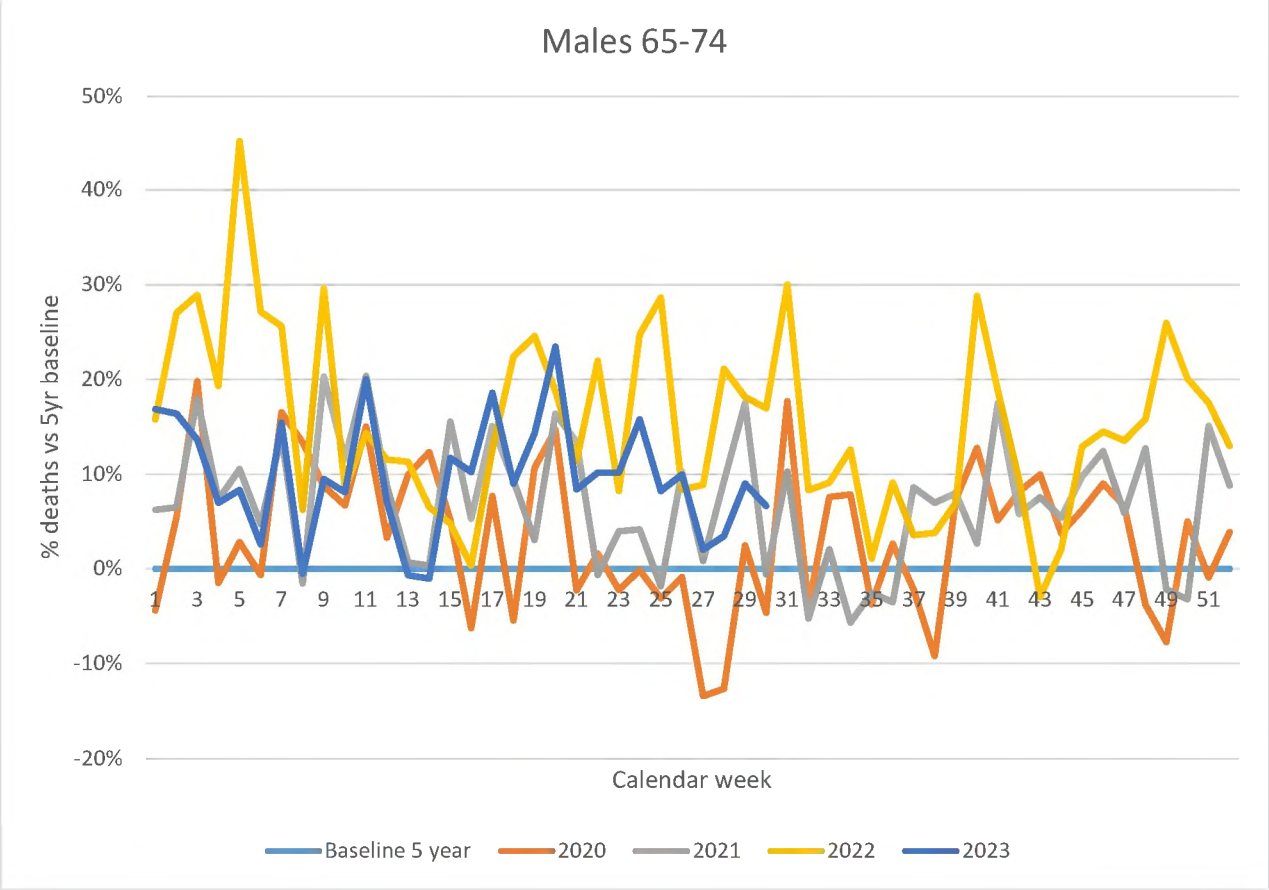


Figure 15: Australian excess deaths%. Males 65-74. January 2020 thru July 2023

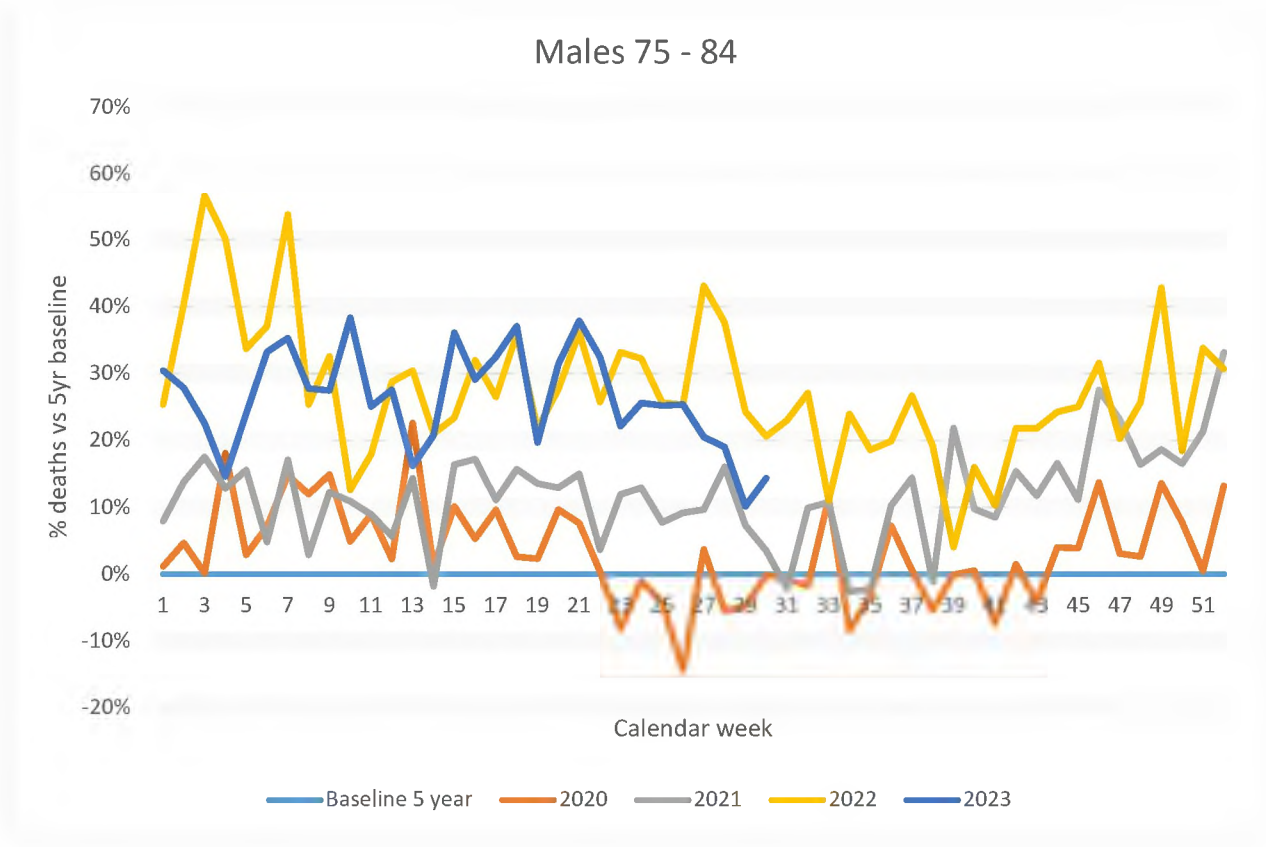


Figure 16: Australian excess deaths%. Males 74-84. January 2020 thru July 2023

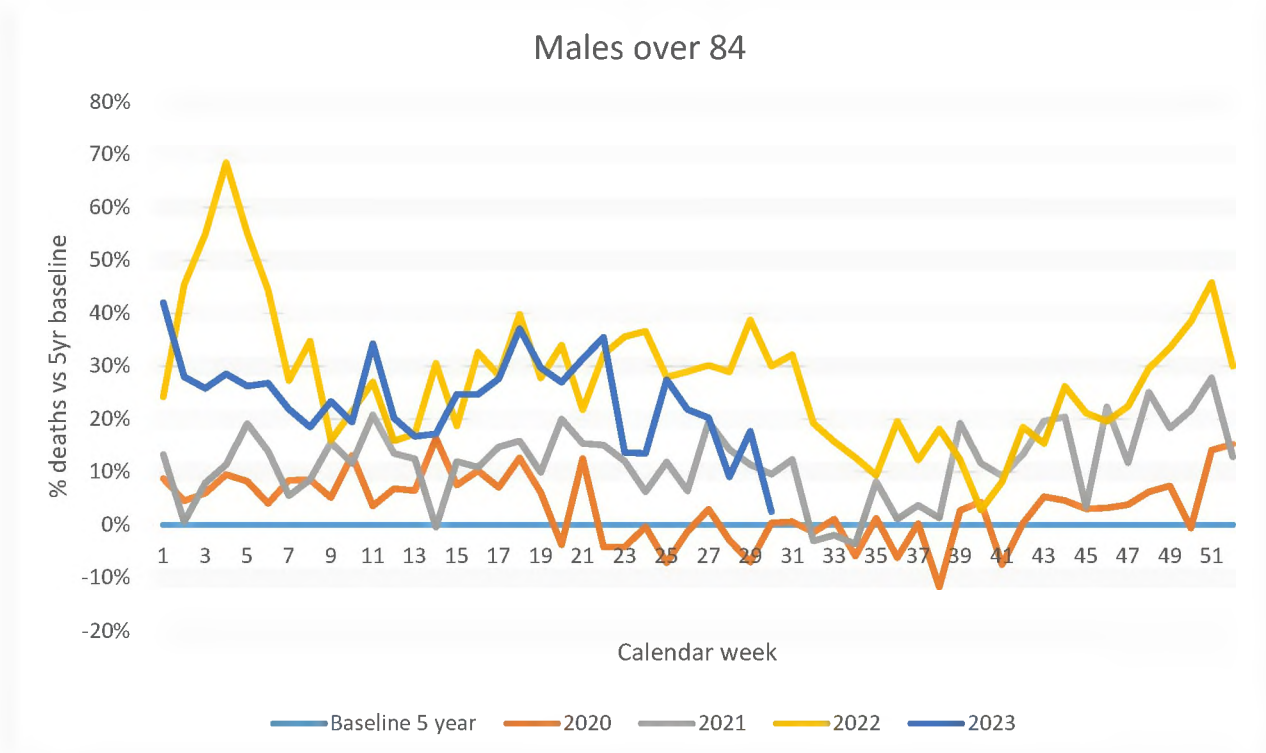


Figure 17: Australian excess deaths%. Males over 84. January 2020 thru July 2023

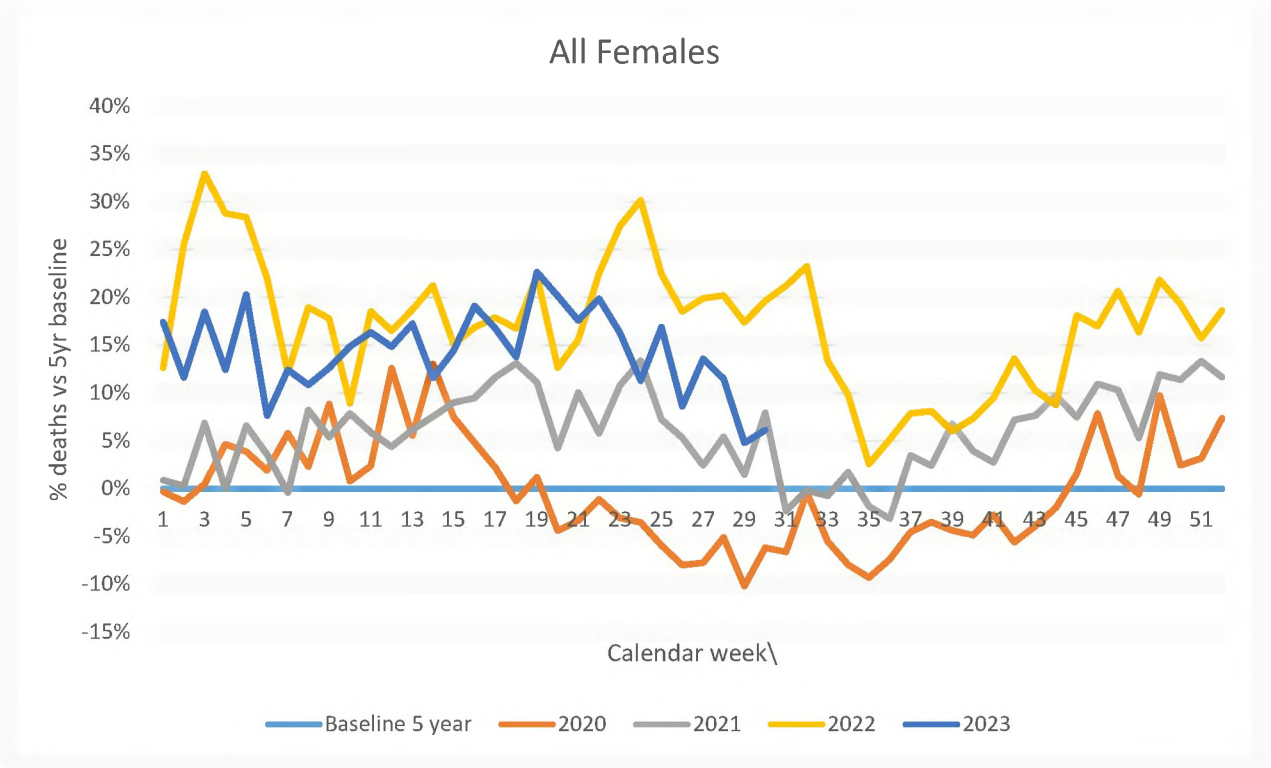


Figure 18: Australian excess deaths%. All Females. January 2020 thru July 2023

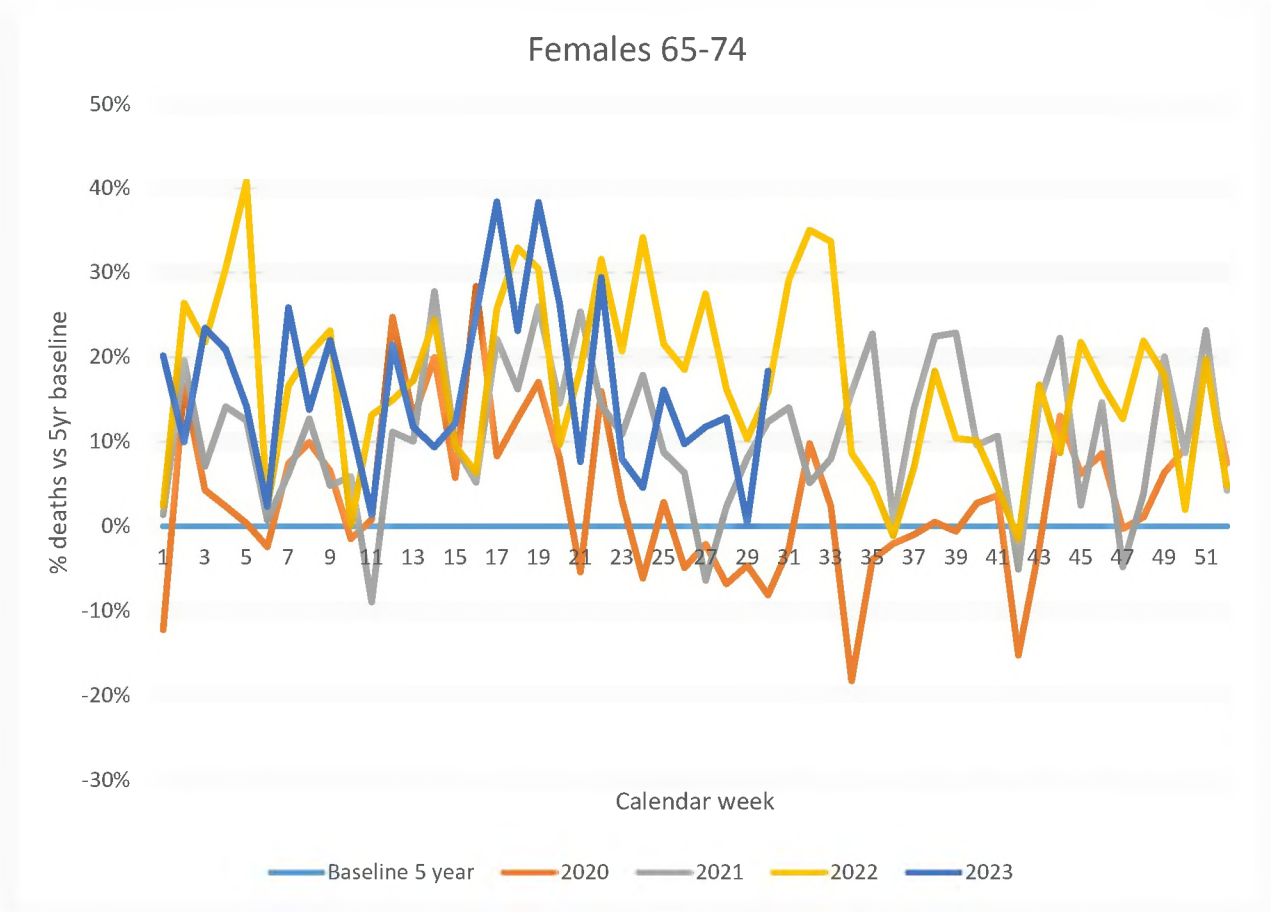


Figure 19: Australian excess deaths%. Females 65-74. January 2020 thru July 2023

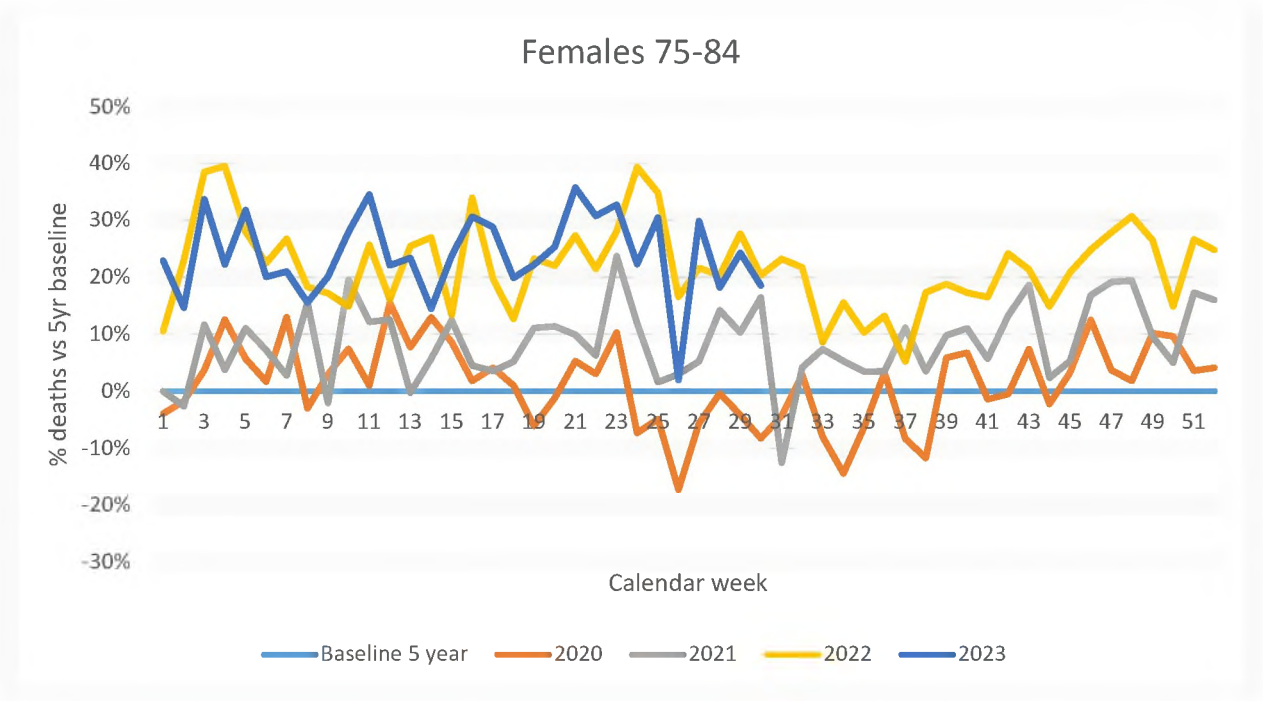


Figure 20: Australian excess deaths%. Females 75-84. January 2020 thru July 2023

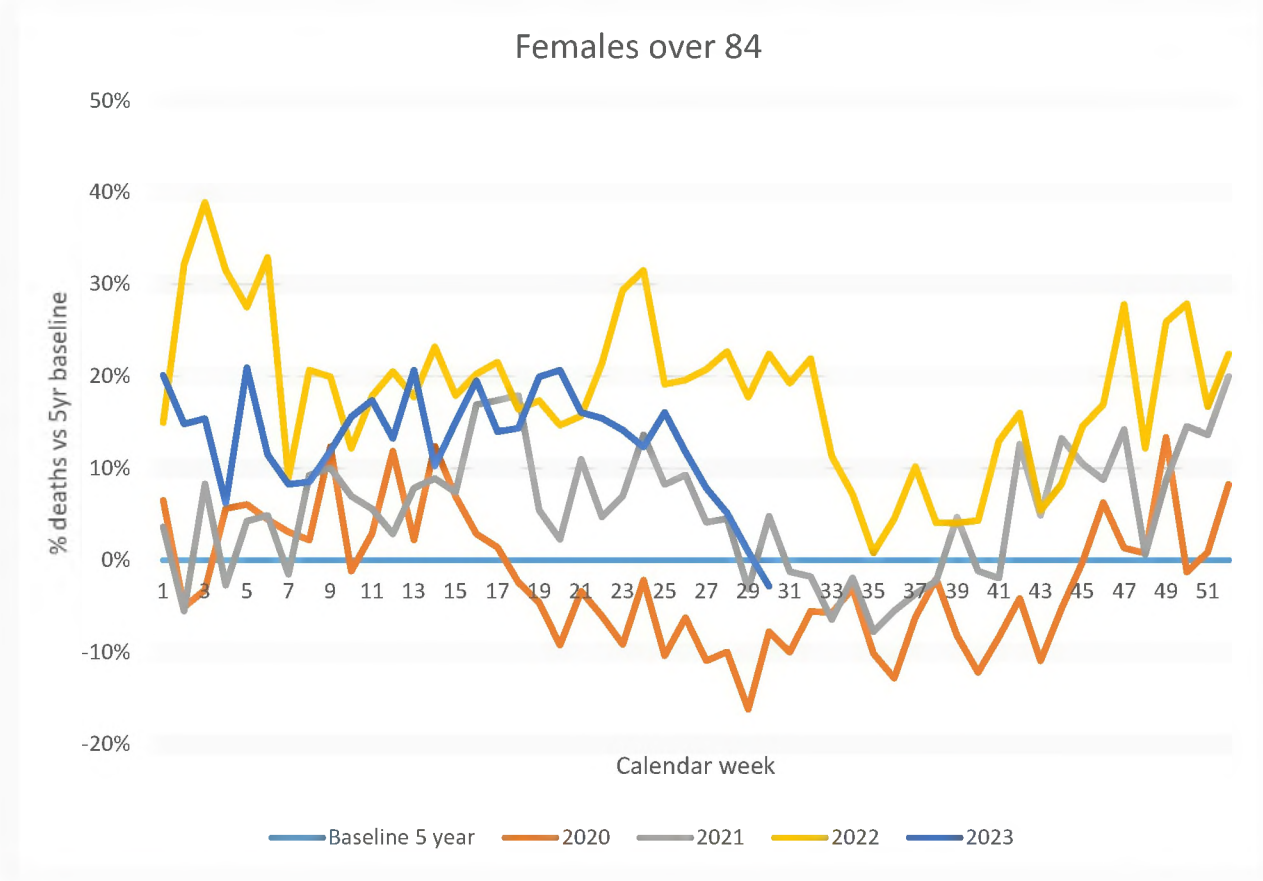


Figure 21: Australian excess deaths%. Females over 84. January 2020 thru July 2023

8 Attachments

8.1 Attachment 1: Global, Australian and comparative nation Covid Vaccines 2021/23

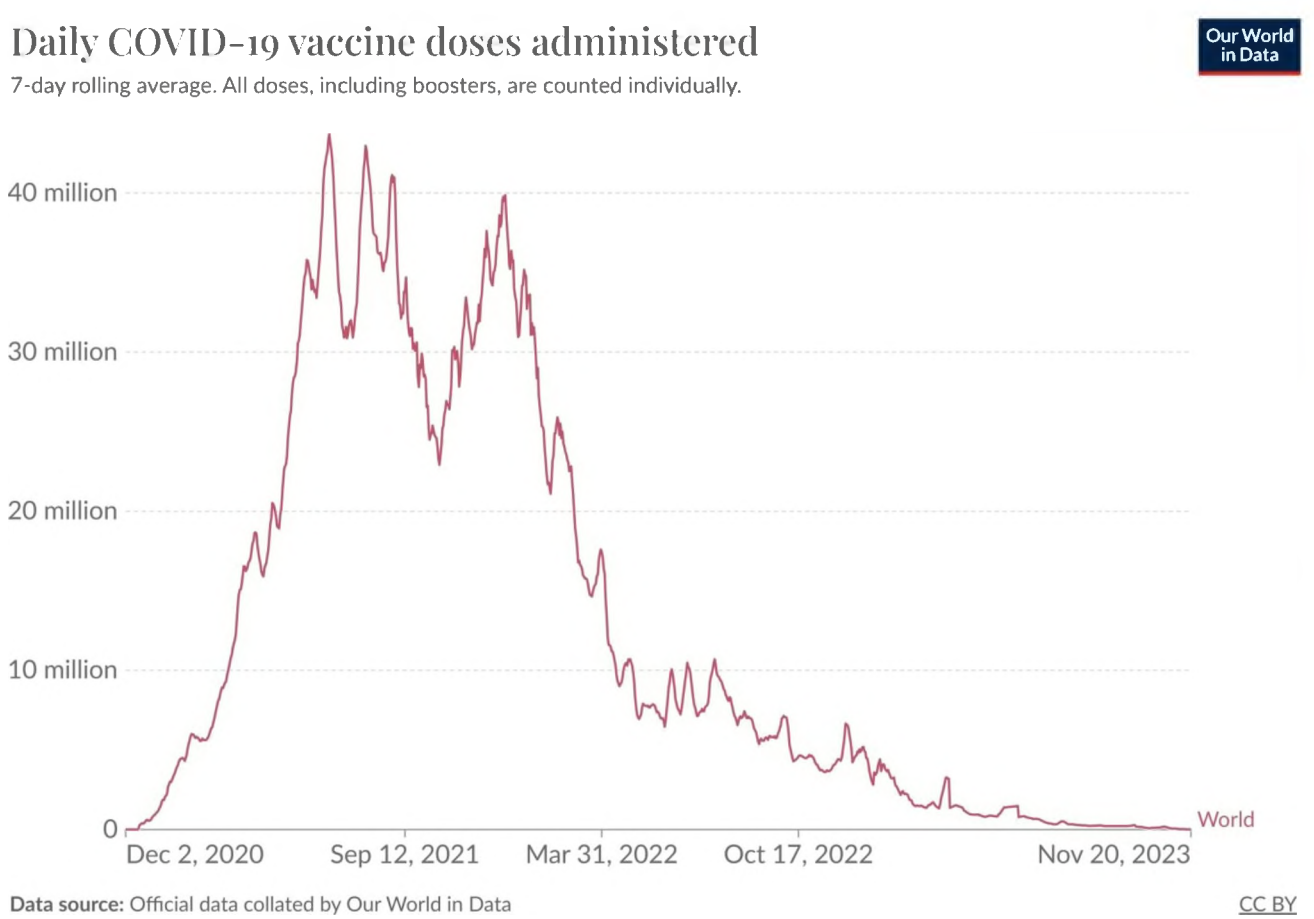


Figure 22: Global vaccination rates to 20/11/23 = 8,077 (1 in 4000 continue to use the products)

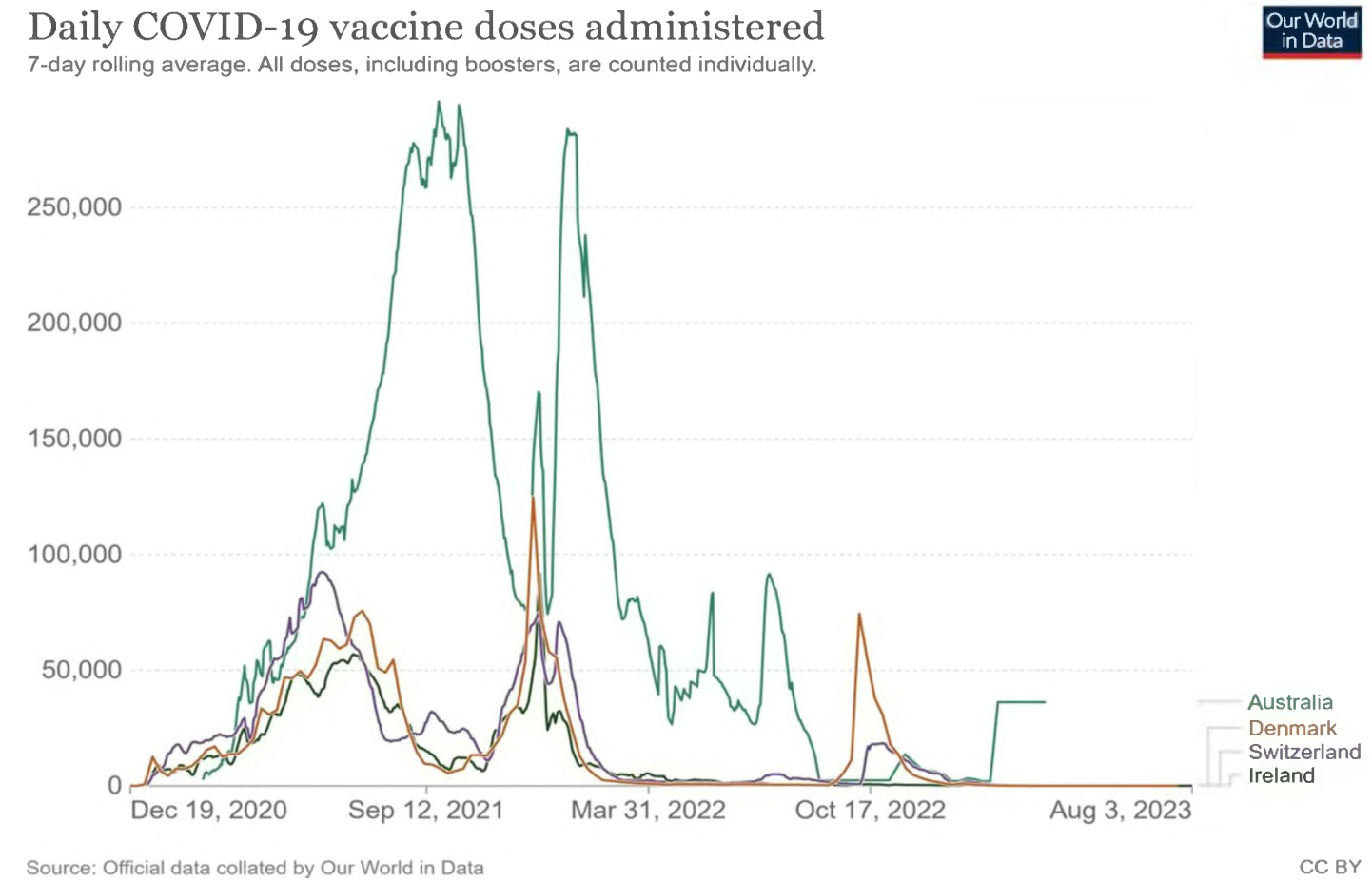


Figure 23: Australia, Denmark, Switzerland, Ireland vaccination rates

8.2 Attachment 2: Inquiry of Health letter re COVID vaccine adverse events 30 July 2022

The Hon [redacted] MP
Minister for Health and Aged Care

Ref No: MC22-010065

Dr [redacted]
Member for Wagga Wagga
[redacted]

Dear Dr [redacted]

Thank you for your correspondence of 3 May 2022 to the New South Wales Minister for Health, the Hon [redacted] MP, on behalf of Mr Peter Paradice regarding an Australian Bureau of Statistics (ABS) report on deaths in Australia, and his concerns about COVID-19 vaccines. This correspondence has been referred to me as Minister for Health and Aged Care, with portfolio responsibility for this matter.

I appreciate the time Mr Paradice has taken in writing to your office and raising these important questions. The Department of Health and Aged Care is aware of the various ABS reporting data and has provided some information below for Mr Paradice. Also, I note that the head of the Therapeutic Goods Administration (TGA), Adjunct Professor [redacted] wrote to Mr Paradice in December 2021 in response to similar concerns he raised in November 2021.

The COVID-19 vaccines available in Australia were provisionally approved by the TGA and remain registered on the basis that they meet high standards for safety, quality and efficacy. Clinical trials have provided extensive information about the safety profiles of the COVID-19 vaccines and intensive post-market monitoring of hundreds of millions of doses worldwide has further characterised the safety of these vaccines. Global real-world use of COVID-19 vaccines continues to provide reassurance about their longer-term safety.

Vaccines can lead to death in extremely rare instances. However, in the overwhelming majority of cases deaths that occur after vaccination are not caused by the vaccine. In large populations there are people with underlying diseases who may die from these diseases shortly after the vaccine is administered. In such cases the link between the vaccine and death is coincidental. To distinguish between coincidental deaths and deaths linked to the vaccine, the TGA uses data from reports of death in several ways.

The TGA closely reviews all adverse events after COVID-19 vaccination where a fatal outcome was reported. This review is designed to assess whether the medical conditions that caused death represent an emerging safety concern with the vaccine. For each report the TGA receives, a team including doctors and nurses (Team), consider the strength of the evidence for a link between vaccination and the condition that caused the death. The Team may request more information from health authorities, independent panels of specialist doctors and coroners.

Parliament House Canberra ACT 2600

In addition to reviewing reports of deaths, the TGA uses statistical analysis to look for patterns in adverse event reports which indicate a possible safety concern. This analysis includes all reports, including those with fatal outcomes. If a safety signal is identified, the TGA investigates to determine if there is a causal relationship with a vaccine.

When the TGA detects a new safety concern it takes regulatory action to address the safety issue and promptly provide information to the public. The recognised adverse effects of COVID-19 vaccines are included in the approved Product Information (PI) documents, used by vaccine administrators and other health professionals. Since the beginning of the vaccine rollout just under 60 million doses of COVID-19 vaccines have been given in Australia.

The TGA has identified 13 reports where the cause of death was linked to vaccination. In addition, the TGA has taken 30 regulatory actions to include new safety information in the PI documents for COVID-19 vaccines. All outcomes are published in the TGA's COVID-19 vaccine safety report available at www.tga.gov.au/covid-19-vaccine-safety-monitoring-and-reporting.

In his correspondence, Mr Paradice suggests that an increase in deaths against long-term averages in the year 2021 may have a correlation to the use of COVID-19 vaccines in Australians with comorbidities. Because people with pre-existing chronic conditions have a greater risk of developing severe illness from COVID-19, vaccination has been particularly important in protecting these groups from hospitalisation, complications and death from COVID-19 infection.

Mr Paradice mentions 1,290 deaths with COVID-19 on the death certificate. The TGA was unable to identify the exact report to which he is referring, but the ABS report 'COVID-19 Mortality in Australia, Deaths registered to 31 January 2022' (Report) at www.abs.gov.au/articles/covid-19-mortality-australia-deaths-registered-31-january-2022 states that there were 2,639 (not 1290) deaths in 2021 where people died with or from COVID-19. The Report goes on to explain that 'the majority (2,556 deaths) of these 2,639 deaths were due directly to COVID-19'.

Similarly, Mr Paradice mentions 148,843 actual deaths for 2021. However, the ABS report Provisional Mortality Statistics which is available online at www.abs.gov.au/statistics/health/causes-death/provisional-mortality-statistics/jan-2020-dec-2021, states that there were 149,486 doctor certified deaths in 2021. The age-standardised death rate for 2021 was 431 per 100,000 people. While higher than 2020, this was lower than the average for 2015-19 (459).

The ABS states that, while their publications can provide an indication of where higher than expected mortality may have occurred, it is not an official estimate of excess mortality. Using the number of deaths from the previous five years as the predictor for the expected number of deaths does not take into account changes in population size and age-structures of that population. The analysis also does not include coroner-referred deaths, so any changes in patterns of coroner referral could affect counts of doctor-certified deaths. Therefore, mortality data from the ABS cannot be used to assess the safety of a vaccine or determine the risk of death with different vaccines

In Australia, information on deaths from COVID-19 is collected through disease surveillance systems, such as the National Interoperable Notifiable Diseases Surveillance System, and civil registration systems, such as the ABS COVID-19 mortality data. ABS data is not directly comparable with data sourced from health surveillance systems, which are designed to release information rapidly on both infections and mortality.

The TGA continues to monitor the safety of COVID-19 vaccinations. The current evidence demonstrates that the benefits of the COVID-19 vaccines available in Australia continue to overwhelmingly outweigh the risks.

Thank you for writing on this matter.

Yours sincerely

[redacted]

[redacted]

28 / 7 / 2022

8.3 Attachment 3: Dept. of Health letter re COVID vaccine adverse events 23 May 2022

Australian Government
Department of Health

Acting Deputy Secretary

Peter Paradice
[redacted]

Dear Mr Paradice,

Australian vaccine adverse event reporting, compensation claims and ABS excess mortality statistics

Thank you for your correspondence dated 30 March 2022, which was forwarded to me as it relates to excess deaths. I note that you have expressed concern for, and sought assistance with understanding, 2020-21 Australian Death Data published by the Australian Bureau of Statistics (ABS).

We have been working with the ABS to understand their mortality reports, and the processes by which they have been compiled. We are also working with the ABS mortality data to integrate and further analyse deaths over the COVID-19 period, including understanding the range of potential contributors to mortality from specific causes. We are currently developing and validating analysis methodology before we can produce findings that can be shared more widely.

Excess mortality as an epidemiological concept, is defined as the difference between the observed and expected number of deaths in a specified time-period. Excess mortality calculations are used to observe whether mortality rates have deviated from trends seen in preceding years. In particular, this can be used to assess if deaths from specific causes (e.g. COVID-19), conditions or other circumstances (such as environmental factors) have caused annual mortality rates to go beyond expected levels.

It is important to note that excess mortality figures can be calculated in many ways, and the ABS have their own specific methods. The ABS publishes two regular reports covering excess deaths in Australia:

Phone: [redacted] Email: [redacted]
[redacted] - www.health.gov.au

1. The first report, named 'Provisional Mortality Statistics', appears to be the source of the figures you analysed. This publication utilises preliminary counts of doctor certified deaths by date of occurrence to calculate average mortality rates over a specified time-period.
2. The second report, named 'Measuring Australia's excess mortality during the COVID-19 pandemic', is based on the Serfling model. This model takes into account seasonality and trends over the past three years, and consequently presents contrasting figures to the Provisional Mortality Statistics report.

I encourage you to analyse both reports to obtain a more complete understanding of excess mortality in Australia.

The ABS are currently your best point of contact to describe how data has been used to model excess deaths, as well as how to interpret deaths that are excess to their expected ranges. The ABS website provides some details of methodologies used (e.g. the Serfling model, seasonal averaging), or alternatively specific enquiries can be sent to [redacted]

Unfortunately, we are unable to provide the unit record death data you requested, as this data can only be compiled through data linkage from various Commonwealth and state-based datasets which we do not have access to. We are continuously working to ensure relevant aggregate death statistics and research outputs are made accessible to the public.

Thank you once again for your interest in this data.

Yours sincerely

[redacted]

[redacted]

23 May 2022

8.4 Attachment 4: Dept. of Health TGA advice re adverse events 24 December 2021

Australian Government
Department of Health

Deputy Secretary

Mr Peter Paradice
[redacted]

Dear Mr Paradice

Thank you for your correspondence of 10 November 2021 to the NSW State Member for Wagga Wagga [redacted] concerning COVID-19 vaccine safety. Your enquiry has been referred to the Therapeutic Goods Administration (TGA).

I am sorry to learn of your family members' experiences that you reported as occurring in the weeks or months after their dates of vaccinations with Vaxzevria (AstraZeneca). I appreciate that these health events have caused your family considerable distress.

Australia has a well-established and robust system in place to capture reports of adverse events following immunisation. Many of these processes have been enhanced dramatically for the COVID-19 vaccines, making this the most intense safety monitoring of therapeutic goods ever conducted in Australia.

Unfortunately, there is not enough information in your letter for me to confirm whether the TGA has received adverse event reports for the cases you mentioned. Health professionals in many Australian jurisdictions, including NSW, are obliged under state public health legislation to report all serious adverse events following vaccination - of this reason we do not believe that there is significant under-reporting of serious adverse events after COVID-19 vaccinations.

While there are some adverse events that are not reported to us. However, I am confident that we are receiving a very substantial proportion of these reports, which is reflected in the significant increase in the number of reports received since the release of COVID-19 vaccines.

[redacted]
www.health.gov.au

In many cases they report conditions that have occurred following vaccination regardless of whether they suspect it was caused by vaccination. These reports are initially made to their state or territory health department, who then report them to the TGA.

With this in mind, I agree with you that an extrapolation to 4.5 million unreported adverse events is just not possible. As you point out, this hypothesis is not supported by evidence of our health systems being overcome by requirements to treat that volume of vaccine injuries.

The TGA comprehensively evaluated each of the provisionally registered COVID-19 vaccines before approval. No element of the evaluation is rushed, and no data are overlooked. It is a similar process to that undertaken by other major regulators, including the European Medicines Agency and Health Canada.

TGA staff with expertise in medicine, biostatistics and epidemiology undertake analysis of adverse event report data to detect signals for possible safety concerns. Investigations of these safety signals aim to distinguish between coincidental events and side effects that may be caused by the vaccines. When these investigations confirm a safety issue, we take prompt action to address the issue and provide information to the public.

To date no international regulator has identified any association between Vaxzevria and heart disease and it is not included in the Product Information which contains the most update to date safety information for a medicinal product.

The TGA has been publishing a weekly COVID-19 vaccine safety report for over 10 months. Each report contains clear, accurate and up-to-date information about the TGA's safety monitoring activities, including details of its scientific and evidence-based evaluations of serious adverse events and deaths reported for COVID-19 vaccines. The reports are available on our website at: www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report.

I hope the above information helps to reassure you that the TGA's safety monitoring of COVID-19 vaccines is effectively protecting the Australian public.

Yours sincerely

[redacted]

Health Products Regulation Group

24 December 2021

CC [redacted] Member for Wagga Wagga

8.5 Attachment 5: Dept. of Health letter re COVID vaccine justification 13 October 2021

Australian Government
Department of Health

Ref No. MC21-032660

Mr Peter Paradice
[redacted]

Dear Mr Paradice

I refer to your correspondence of 16 September 2021 to the Deputy Prime Minister, the Hon [redacted] MP concerning Australia's response to emerging strains of COVID-19. As the Department of Health is responsible for Australia's COVID-19 health response, your letter has been referred to the Minister for Health and Aged Care, the Hon [redacted] MP. The Minister has asked me to reply.

Evidence regarding variants is being closely monitored by experts, such as Communicable Diseases Network Australia, Communicable Diseases Genomics Network, and the Australian Health Protection Principal Committee (AHPPC) to inform our public health response and protect the Australian population.

Australia's goal, as recommended by AHPPC, was suppression of COVID-19 with no community transmission. This strategy recognised that outbreaks continued to remain a risk. Maintaining that goal requires active case finding and contact tracing, targeted testing of the affected population, public health and social measures and personal measures.

Elimination was never a goal of Australia's COVID-19 pandemic response. In the absence of high amounts of immunity in the population both in Australia and globally, elimination is not a realistic short term goal, in the short term when there are outbreaks of the virus as vaccination coverage is going up, it is still important to suppress transmission of the virus where possible.

In the longer term, elimination at a global level will only be feasible if there is high vaccination coverage across a majority of countries, in reality it might take a few rounds of booster shots to get there but if not the more likely scenario remains that the virus is likely to stay around for some time.

SARS-CoV-2 remains a Listed Human Disease under the *Biosecurity Act 2015* and as vaccination coverage increases the use of public health measures in lieu of using lockdown will still be needed as outlined in the National Plan to Transition Australia's National COVID Response (National Plan) informed by the Doherty modelling.

GPO Box 9848 CANBERRA ACT 2601
Telephone: [redacted]

The National Plan provides a graduated pathway to transition Australia's COVID-19 response from its current pre-vaccination settings focused on continued suppression of community transmission, to post-vaccination settings focused on prevention of serious illness and fatalities, whereby the public health management of COVID-19 is consistent with other infectious diseases.

The safety of the Australian population has always been the highest priority of the Government. For this reason, decisions regarding COVID-19 vaccines have been guided by the expert medical advice of the Australian Technical Advisory Group on Immunisation.

The goal is to protect all people in Australia from the harm caused by COVID-19 infection, through preventing serious illness and death, and where possible, disease transmission. The Pfizer, AstraZeneca (Vaxzevria) and Moderna vaccines have all been proven through approval and safety monitoring processes to be very effective at reducing severe illness, hospitalisation, and death.

In addition, to better support Australians though the COVID-19 vaccination process, the Government is developing the COVID-19 Vaccine Claims Scheme (the Scheme). On 28 August 2021, the Minister announced further details of the Scheme, which will provide Australians with an alternative, administrative option to seek compensation, rather than through a complex and costly court process. The Scheme will cover the costs of injuries $5,000 and above due to a proven adverse reaction to a COVID-19 vaccine or its administration.

Furthermore, as part of the Government's National Disease Surveillance Plan for COVID-19, serosurveillance is one of the key surveillance approaches adopted to inform understanding of population level immunity to SARS-CoV-2. To date, seroprevalence surveys have been undertaken by the Australian Partnership for Preparedness Research on Infectious Disease Emergencies and led by the National Centre for Immunisation Research and Surveillance in collaboration with the Kirby Institute.

The Department of Health is considering future national level serosurvey requirements and appropriate timing. The role of future national serosurveys in understanding population level immunity will be an important surveillance tool, including with regarding to measuring vaccination coverage, to guide public health measures.

I wish to assure you that the Australian, state and territory governments are working together to coordinate an evidence-based response to COVID-19, based on the latest medical advice. Together these actions have placed us in a good position globally.

Thank you for writing on this matter.

Yours sincerely

[redacted]

[redacted]
Director
Office of Health Protection and Response
13 October 2021

8.6 Attachment 6: Sydney Morning Herald article 22 September, 2022

THE SYDNEY MORNING HERALD THURSDAY, SEPTEMBER 22, 2022

COVID COMPLICATIONS

Deaths hit highest number in 40 years

Dana Daniel
Federal health reporter

The alarm has been sounded about COVID-19's hidden impact as new data shows that the highest number of people have died in the March quarter of 2022 than in any of the past 41 years.

Australian Bureau of Statistics population data published yesterday shows an 18 per cent increase in deaths in the quarter compared with the same period a year earlier, rising from 36,100 to 46,200 deaths.

It is the first time that more than 40,000 deaths were recorded over four consecutive quarters.

South-western Sydney Labor MP Dr Mike Freelander, Chair of the Senate inquiry into long COVID, said he was "very concerned" about higher-than-normal deaths in the pandemic and that more research was needed to ascertain why.

While the inquiry was focused on long COVID, he said, "there is a concern that COVID itself increases inflammatory responses, predisposes people to stroke and cardiovascular disease".

"The other question is: are there risk factors, is there anything that can be done to modify the risk?" Freelander said.

The inquiry will collate data from scientific experts to gain insights into how COVID-19 affects health after the initial infection.

Karen Cutter, spokeswoman for the Actuaries Institute COVID-19 Mortality Working Group, said about 6000 more people died in the March quarter than could be explained by the ageing population.

46,200
The number of deaths recorded in the March quarter of 2022

36,100
The number of deaths recorded in the March quarter of 2021

Half of these people died from COVID-19, she said, with a further 500 dying "with COVID", their deaths from causes such as cancer, circulatory diseases and dementia likely to have been hastened by the pandemic.

The remaining 2500 people died from other causes. While it is unclear what, if any role COVID-19 may have played, a higher-than-usual number of deaths from strokes, heart disease, dementia and diabetes makes the working group suspect that it could be a factor.

"There are people who have had COVID and recovered, but it's weakened their immune system [and] they've subsequently had a heart attack or stroke that might not necessarily be directly linked back to their COVID episode," Cutter said.

"Having COVID increases your risk of these sorts of things."

Another possible reason for the increase in deaths this year, she said, was that vulnerable people who were shielded from influenza or RSV in the winters of 2020 and 2021 due to COVID-19 restrictions had succumbed to these respiratory illnesses.

Assistant Health Minister Ged Kearney yesterday announced $6.3 million in funding for research led by Monash University to evaluate the immune response in children and high-risk populations, including adults with chronic conditions, to COVID-19.

The project aims to improve the care and outcomes for children and people with chronic diseases, including tailored treatments and vaccination schedules appropriate to children and high-risk groups.

8.7 Attachment 7: Covering letter to the P.F. Paradice submission to the CofA COVID Inquiry.

[redacted]

15 December 2023

Ms [redacted]
Chair
CofA COVID-19 Response Inquiry
Department of Prime Minister and Cabinet
Parliament House
CANBERRA ACT

Dear Ms [redacted]

Re: Submission to the COVID-19 Response Inquiry (AKA Restoring Trust in Public Health Inquiry)

Please find attached a submission to the Kruk COVID Inquiry.

This submission seeks to support the Inquiry in the mission to restore trust in public health following the government performance/s in response to the COVID-19 challenge.

It is my sincere hope that the "Prime Ministers team" will successfully restore the trust of a sceptical public in the Australian institutions of public health, doctors, and the broader medical profession.

My understanding is that the people picked on the Prime Ministers panel were supportive, in fact complicit, in formulating and prosecuting the orthodox COVID response. These chosen people have continued to support novel inoculations for COVID beyond a point where others, without insider history, may have suspended the intervention and discontinued defending the indefensible.

Appendices and attachments to this submission are "data focused" and were generated using the ABS mortality data releases up until 27 October 2023 to detail and analyse Australian mortality statistics since the beginning of the COVID event. There is no discussion herein of "The Science".

I urge the Inquiry to recommend that the Commonwealth Government release the unadulterated micro-data to test (and hopefully refute) the fearsome hypotheses postulated in this submission.

The data examined in this submission are solid grounds to advise the Government of Australia to follow the lead of the Swiss authorities in suspending the ongoing COVID inoculation program.

My perception is that many Australians have subdued expectations of this Inquiry. It seems unlikely Australians will lower their reasonable barriers of distrust until the unbridled truth is revealed. Findings of the Inquiry, if perceived to be as illogical as the ongoing inoculation program, could perpetuate or exacerbate the well-founded distrust (scepticism) generated by government in the COVID years.

There are powerful forces at work that I do not understand.

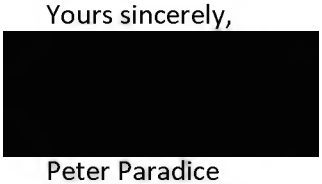
I see self-censorship instead of open debate. I see "gaslighting" of the injured and supporters of the dead. I see apparent errors evincing incongruous denialist behaviour in a bureaucracy that simply doesn't make sense. I see "sacred text" in narratives that are unassailed by clear logic. I hear a reputable UK research Professor of Immunology warning that ongoing boosting with COVID shots can "down-regulate" the immune system. I read a Yale research pre-print describing Post-Vaccine Syndrome which is a euphemism to allow mainstream institutions to consider publishing the unthinkable.

So, in closing, and in line with the narrative, I urge the Inquirers to "stay safe", trust in Big Pharma, and what-ever-else, stay up to date with your personal booster shots!

In the annals of Australian history, those who effectively sort this mess out will be remembered as the heroines of our age.

Good luck.

Yours sincerely,



Peter Paradice

8.8 Attachment 8: Commonwealth Government COVID-19 Response Inquiry TOR

Scope

The Inquiry will review the Commonwealth Government's response to the COVID-19 pandemic and make recommendations to improve response measures in the event of future pandemics. It will consider opportunities for systems to more effectively anticipate, adapt and respond to pandemics in areas of Commonwealth Government responsibility.

The Inquiry will adopt a whole-of-government view in recognition of the wide-ranging impacts of COVID-19 across portfolios and the community. Specific areas of review may include, but are not limited to:

- Governance including the role of the Commonwealth Government, responsibilities of state and territory governments, national governance mechanisms (such as National Cabinet, the National Coordination Mechanism and the Australian Health Protection Principal Committee) and advisory bodies supporting responses to COVID-19.
- Key health response measures (for example across COVID-19 vaccinations and treatments, key medical supplies such as personal protective equipment, quarantine facilities, and public health messaging).
- Broader health supports for people impacted by COVID-19 and/or lockdowns (for example mental health and suicide prevention supports, and access to screening and other preventive health measures).
- International policies to support Australians at home and abroad (including with regard to international border closures, and securing vaccine supply deals with international partners for domestic use in Australia).
- Support for industry and businesses (for example responding to supply chain and transport issues, addressing labour shortages, and support for specific industries).
- Financial support for individuals (including income support payments).
- Community supports (across early childhood education and care, higher education, housing and homelessness measures, family and domestic violence measures in areas of Commonwealth Government responsibility).
- Mechanisms to better target future responses to the needs of particular populations (including across genders, age groups, socio-economic status, geographic location, people with disability, First Nations peoples and communities and people from culturally and linguistically diverse communities).

The Inquiry will consider the findings of previous relevant inquiries and reviews and identify knowledge gaps for further investigation. It will also consider the global experience and lessons learnt from other countries in order to improve response measures in the event of future global pandemics.

The following areas are not in scope for the Inquiry:

- Actions taken unilaterally by state and territory governments.
- International programs and activities assisting foreign countries.

Independent Panel

The Prime Inquiry has appointed an Independent Panel of three eminent people to conduct the Inquiry. The Independent Panel will consult with relevant experts and people with a diverse range of backgrounds and lived experience.

Taskforce

A Taskforce within the Department of the Prime Inquiry and Cabinet will support the Independent Panel.

Public consultation

Public consultation will be completed during the Inquiry on the substance of the issues outlined in the Terms of Reference. The Independent Panel may invite and publish submissions and seek information from any persons or bodies. Consultation will take place across Australia with:

- Key community and other stakeholders reflecting a diversity of backgrounds
- Experts
- Commonwealth Government and state and territory government agencies
- Members of the public

Final Report

The Independent Panel will deliver a Final Report to Government including recommendations to the Commonwealth Government to improve Australia's preparedness for future pandemics by the end of September 2024.