World Council For Health Australia

World Council for Health
Country Council: Australia

Submission to Inquiry into Excess Mortality

17 May 2024

World Council For Health

Introduction and overview of the submissions, which commence on page 3 of this document

World Council for Health and World Council for Health Australia are broad, grassroots, expert-led initiatives to work together to empower global and community health. We are governed by seven principles:

1. We act in honour and do no harm
2. We are free beings with free will
3. We are part of nature
4. We are spiritual and thrive when life has meaning and purpose
5. We thrive together and value our diverse community
6. We value different perspectives
7. We use technology with discernment

The Australian chapter of the World Council for Health is led by Professor Ian Brighthope, Dr Melissa McCann, Katie Ashby-Koppens, Dr David Rabbolini, Lucinda van Buuren, Michelle Bradshaw and Ian Bell.

To the Committee Secretary, Senate Standing Committees on Community Affairs Re: Inquiry into Excess Mortality

Thank you for the opportunity to submit a proposal to this inquiry, I do so on behalf of the World Council for Health Australia.

This submission will address item (b) in the terms of reference, “factors contributing to excess mortality in 2021, 2022 and 2023”. We present data that supports the probability that excess deaths are in a large part due to the adverse events from the COVID-19 vaccines. This submission will conclude with recommendations on how to address this preventable driver of excess mortality.

1. The COVID-19 vaccine registration trials show low absolute risk reduction and increased risk of adverse events including death.

Trial data shows risk of death caused by the COVID-19 vaccines.

The COVID-19 vaccines were developed, approved under emergency use authorisation, and rolled out in mass vaccination campaigns in record time. This expediency occurred at the expense of numerous safety testing and toxicology protocols typically followed by the FDA and other regulatory agencies, such as the Therapeutic Good Administration (TGA), simply followed suit [1, 2].

The minimum 6–12-month timeframe recommended for identifying possible longer-term effects were disregarded, let alone longer timeframes of clinical observation deemed necessary for any new vaccine to ensure adequate time for monitoring for the development of adverse events such as cancers and autoimmune diseases [3, 4]. The result of these shortcuts was the use of products in ***the registration clinical trials that show numerous severe adverse reactions and risk of death, the risk of which continued following the trial observation period. These risks occurred without reductions in transmission, severe illness, hospitalisation, or death*** [5].

Despite these signals, the COVID-19 vaccines were then deployed to the public.

In more detail, the registration trials showed that the COVID-19 injections had a relative risk (RR) reduction of COVID-19 symptoms of 95% and 94.5% and absolute risk reductions of 0.7% and 1.1%, for the Pfizer (BNT162b2) and Moderna (mRNA-1273) injections respectively [6]. This miniscule benefit equated to a number needed to vaccinate (NNV) to prevent one case of COVID-19 of 142 (range 122-170) for the Pfizer injection and 88 (range 76-104) for the Moderna injection [7].

Contemporary estimates that consider infection fatality rates (IFR) estimate that 100,000 injections would need to be administered to save 2 lives. Regarding potential harms, for both the Pfizer and Moderna trials combined, there were about 125 serious adverse events (SAE) per 100,000 vaccine recipients, translating to one SAE per 800 vaccinees [8]. In terms of risk of death, it is estimated that the risk was as high as 27 deaths per 100,000 doses of the Pfizer injection. That is, the registration data indicates that there were nearly 14 times more deaths caused by the modified mRNA injections than lives saved. This despite the trials excluding vulnerable populations including children, pregnant women, the frail and elderly, and immunocompromised patients with cancer, chronic inflammatory conditions, and autoimmune diseases. Inclusion of these vulnerable groups, as occurred during the real-world mass vaccine roll-outs, may have influenced the risk: reward ratio in the trials even further and perhaps could have prevented the catastrophe that we now face by sounding loud, clear and incorruptible alarm bells.

A recent independent forensic analysis of Pfizer's six-month trial data revealed that not only did the vaccine fail to prevent death from COVID-19 but led to increased deaths, particularly from cardiac causes [9]. Salient conclusions as summarised by investigators are listed below:

1. "The number of all-cause deaths is NOT decreased by BNT162b2 vaccination".

2. "Of the 38 deaths reported in the 6-Month Interim Report of Adverse Events, 21 of the (BNT162b2) vaccinated subjects died compared to 17 placebo subjects".

3. 'Delayed reporting of the subject deaths into the Case Report Form, which was in violation of trial protocol, allowed the Emergency Use Authorisation (EUA) to proceed unchallenged".

4. "The number of subject deaths was 17% of the expected number, based on age-adjusted US mortality. One possible explanation could lie in the 395 subjects that were "lost to follow-up".

5. "There was a 3.7-fold increase in cardiac events in subjects who received the BNT1162b2 vaccine versus the placebo".

6. "Of the 15 subjects who were Sudden Adult Deaths (SAD) or Found Dead (FD), 12 died of a cardiac event, 9 of whom were vaccinated".

7. "The cardiac adverse event signal was obscured by delays in reporting the accurate date of subject death that was known to Pfizer/BioNTech in the subject's Narrative Report".

These conclusions are consistent with analysis by Benn et al. of the Pfizer and Moderna registration trials who reported an increased trend in cardiovascular deaths (RR=1.45; 95%CI 0.67-3.13) in the vaccine arms of the trials [10]. This appraisal is in keeping with numerous reports of cardiovascular pathology [11-17].

Not only did increased deaths occur during the registration trials, but evidence also now shows that a significant mortality increase was observed around the 100-day mark post-injection, trends that would have been more marked if not for suspected data integrity issues [18]

The risk:benefit ratio amongst elderly and immunocompromised individuals is not established as these populations were excluded from the registration trials. Yet the current Australian Technical Advisory Group on Immunisation (ATAGI) continues to advocate injections with low efficacy to our oldest and sickest people of society [19].

2. COVID-19 vaccines cause multisystem derangements increasing illness and death

Effects of the COVID-19 mRNA products are not short-lived. The mRNA platforms have no built-in mechanism to stop or regulate translation of mRNA and expression of the spike-protein (S-protein) by cells. Dissemination of this potent and toxic antigen throughout the body for

prolonged periods causes systemic inflammation and immune dysfunction [20,21]. Particularly vulnerable are the heart, neuronal tissues and vascular system. Dysfunction in any one or more of these systems can potentially cause significant morbidity and mortality [22-24].

Mechanisms of damage caused by the COVID-19 vaccines

Cardiac

In vivo animal studies demonstrate that "in isolated cardiomyocytes, both Moderna mRNA and Pfizer mRNA vaccines induce specific toxicity causing cardiomyopathy" [22]. Cardiomyopathy is a disease of the heart muscle that leads to reduced function ultimately causing heart failure, arrhythmias (abnormal rhythms, some life threatening) and increased risk of cardiac arrest.

Inflammation/ autoimmune disease and cancer

COVID-19 vaccinations cause innate immune suppression and disruption of regulatory control of protein synthesis and cancer surveillance [21]. Excessive production of non-neutralizing antibodies by the vaccines could increase the risk of autoimmune reactions in which antibodies target host tissues instead of the virus. This is thought to be caused by molecular mimicry of host targets by the foreign protein, this in turn triggers inflammatory autoimmune reactions [25, 26].

These mechanisms may raise the risk of autoimmune, inflammatory driven diseases including cancers, cardiovascular diseases, and other diseases that have an inflammatory driver signal [27].

Administration of multiple boosters was never studied. Multiple boosters may cause T-cell exhaustion with resultant progressive loss of cytokine production and cytotoxic potential leading to immune suppression and an increased risk of chronic infections, autoimmune diseases, and cancer [28, 29].

Deranged T-cell function is particularly important in immuno-surveillance preventing haematological malignancies and rapid progression of various lymphomas has been linked to COVID-19 mRNA vaccinations. There is currently concern that the vaccines may precipitate cancer progression or re-activation of disease in remission [30-34].

Vascular disease and stroke

In a study of almost five-million adults an eight-fold increased risk of ischaemic stroke and a fivefold increased risk of haemorrhagic stroke was observed in those who experienced SARS-CoV-2 infection within 21 days post COVID-19 injection [35].

Data has also shown toxic inflammatory stimulation of vascular endothelial cells caused by the COVID-19 vaccine. This is thought to contribute to the myriads of vascular complications including blood clotting seen following injections [36, 37].

Neurological toxicity is thought to be contributed to by the COVID-19 injection's ability to produce pathological aggregates of proteins that accumulate in target organs (amyloid protein), including the brain causing a diverse spectrum of neurological symptoms and conditions [38].

3. Real world data showing high risk of adverse reactions including death following vaccination.

There are now wheel-barrows full of real world data from countries across the globe that show harm across multiple systems including cardiac (myocarditis)[39], women's reproductive system (menstrual disruptions)[40], nervous system (intracranial haemorrhage [41], Guillain Barre syndrome [42], Bell's palsy [43]), as well as, the immune system [44].

Life threatening events associated with the vaccines continue to be documented in the literature and can no longer be ignored [5, 8, 45, 46].

In April 2024, a massive multi-national study confirmed damage caused by these vaccines in recipients [47]. **Researchers performed an observational cohort study of 99 million vaccinated individuals and confirmed multisystem safety signals** of the cardiovascular, neurological and haematological systems. These signals included but were not limited to myocarditis, pericarditis, Guillain-Barré syndrome, and cerebral venous sinus thrombosis. The committee must recognise that injuries sustained such as Guillain-Barre Syndrome, legacy of cerebral venous sinus thrombosis and others are not short lived and predispose individuals to significant morbidity, risk of injury, inability to return to full-time employment and ultimately mortality in a proportion of individuals[47].

Adverse reactions and risk of death do not appear to be limited to a particular vaccine brand (AstraZeneca, Pfizer and Moderna) or type (mRNA and DNA)(Australian DAEN pharmacovigilance data, unpublished data).

There is currently clear global evidence that the trend of excess mortality is related to the COVID-19 vaccines. Multiple European studies revealed an alarming trend of greater excess mortality in countries with higher vaccination rates [48-50]. Findings from these studies are mirrored across global databases including the VAERS (USA)[51], the World Health Organization's pharmacovigilance database (www.Vigiaccess.org), the British Yellow Card system (https://yellowcard.mhra.gov.uk/the-yellow-card-scheme/), as well as the Australian DAEN database(https://www.tga.gov.au/safety/safety/safety-monitoring-daen-database-adverse-event-notifications/database-adverse-event-notifications-daen).

The estimated conservative case fatality calculated from VAERS data is 0.02%, or one death for every 5,000 vaccinees receiving at least one dose. If extrapolated to encompass the global number of people vaccinated by April 2022, it is suspected that the COVID-19 injections have contributed to one million deaths in the first 16 months of the rollout. The author responsible for this calculation notes that, "the VAERS website contains a notice advising people not to use the data to establish a vaccine fatality rate" …" Giving all due consideration to this warning, therefore, we accept that the calculated vaccine fatality rate of 0.02% is at best a 'ballpark' figure. All it tells us for sure is that there is a safety problem that demands attention, that the vaccine rollout should have been halted by May 2021 at the latest, and that the idea of vaccine passports (besides being tyrannical) was unscientific and reprehensible"[52]. We Australians now make a similar request, that the potential contribution to excess deaths by the COVID-19 vaccines be examined.

In summary, **data described shows that the COVID-19 vaccines cause multiple severe adverse reactions, including death in a proportion of recipients**. These were shown but not appreciated in the vaccine drug registration trials and have continued to be shown in post registration real-world studies.

The injections have potential to disrupt the function of multiple systems, including the heart, brain, immunological, reproductive and haematological systems. Repeated and prolonged

exposure to the pathogenic antigen (synthetic S-protein) will cause chronic disease in many recipients and death in a proportion. These adverse events when considering the scale of rollout, that is millions of doses administered to millions of people across Australia, frequently and repeatedly, have and will undoubtedly affect the health of many. This is a plausible cause for the excess deaths observed over this timeframe 2021, 2022 and 2023. It is the duty of the Australian government to include this factor in analysis of excess mortality.

4. Recommendations to address this preventable driver of excess mortality.

Pharmacovigilance data are known to be substantially under-reported, we recommend that the TGA urgently publicises these adverse drug reaction (ADR) data and assists people with their ADR reporting, to facilitate full elucidation and clarification of the extent of the problem. To this end, unredacted, age and gender specific, de-identified data that includes vaccination status and time from vaccination of adverse drug reaction should be made freely available to scientists to determine the extent of the crisis. An understanding of the epidemiology of those dying will enable attempts to ameliorate and target these at-risk populations through appropriate public health campaigns.

The nature and variety of ADRs reported on international databases such as the Australian DAEN and British Yellow Card System are consistent with the potential pathologies described in recent scientific papers on vaccine-induced harms, which are mediated through the vaccine spike protein product [53, 54]. Toxicity of these products is clear. The TGA has more than enough evidence on the DAEN database to declare the COVID-19 vaccines unsafe for use in humans.

These medications should be immediately withdrawn from the market.

We echo the recommendation by our British colleagues at the World Council for Health and urge that," Preparation should be made to scale up humanitarian efforts to assist those harmed by the COVID-19 vaccines and to anticipate and ameliorate medium to longer term effects. As the mechanism for harms from the vaccines appears to be similar to COVID-19 itself, this includes engaging with numerous international doctors and scientists with expertise in successfully treating COVID-19'.

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Electronically signed:
Dr David Rabbolini BSc MBBCh PhD FRACP FRCPA
on behalf of the World Council for Health Australia