Analysis of Covid-19 vaccine effectiveness claims in Australia

Commissioned by People for Safe Vaccines
Presented by Sandy Barrett and Serene Teffaha
Sponsored by Parents With Questions
Dated 12 February 2022

This presentation is condensed from an extensive referenced report available to People for Safe Vaccines members.

Prepared by People for Safe Vaccines Limited 12 February 2022

WHO WE ARE

People for Safe Vaccines is an **Australian not-for-profit committed to promoting vaccine safety and efficacy**, with a membership of **over 3,000 concerned Australians**, including parents of children at risk of injury and injured by certain provisionally registered goods indicated for prevention of Covid-19 on the Australian Register of Therapeutic Goods.

WHAT WE SEEK

Proper due diligence from the government on safe vaccines

True transparency and accountability

Freedom to choose your own medical interventions

Open public debate

OUR OBJECTIVE HERE

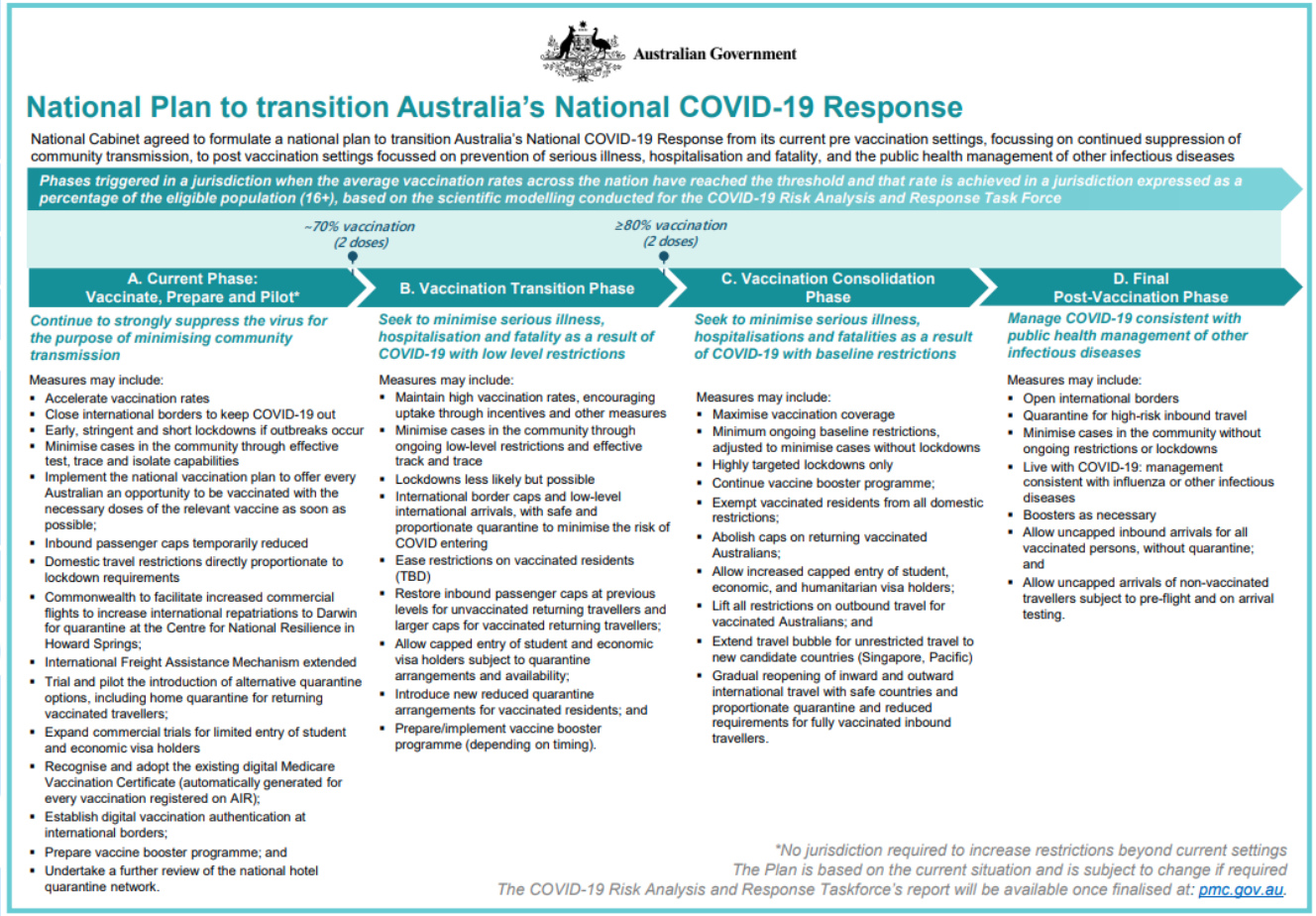
The purpose of this report is to **test the claims** made by government and medical officials **that mass vaccination reduces cases/infections, hospitalisations, Intensive Care Unit (ICU) admissions, deaths (CHID's) and transmission** in Australia by **validating those claims against the real-world data**. We will be examining the NSW situation closely as there are better available data sets in that state, contrasted to the rest of Australia.

CONTENTS

THEIR MISSION

NATIONAL PLAN

- At the request of the National Cabinet, The **Doherty Modelling** Report was produced **to formulate a National Plan** to transition Australia's COVID response
- **Models** of COVID-19 infection and vaccination were used **to define a target level of vaccine coverage** for transition from social restrictions like lockdowns
- It focused on **vaccination combined with test, trace, isolate and quarantine** measures, as a key to suppressing the virus
- It **failed to explore** any possible **early treatments** that may also impact hospitalisation
- It **centred around mass vaccination as the only solution**
- The Report became a benchmark for States and Territories in justifying their push towards vaccine mandates
- The report is **not a scientific paper**



Australian Government

National Plan to transition Australia's National COVID-19 Response

National Cabinet agreed to formulate a national plan to transition Australia's National COVID-19 Response from its current pre vaccination settings, focussing on continued suppression of community transmission, to post vaccination settings focussed on prevention of serious illness, hospitalisation and fatality, and the public health management of other infectious diseases

Phases triggered in a jurisdiction when the average vaccination rates across the nation have reached the threshold and that rate is achieved in a jurisdiction expressed as a percentage of the eligible population (16+), based on the scientific modelling conducted for the COVID-19 Risk Analysis and Response Task Force

~70% vaccination (2 doses) — *≥80% vaccination (2 doses)*

A. Current Phase: Vaccinate, Prepare and Pilot*

Continue to strongly suppress the virus for the purpose of minimising community transmission

Measures may include:

- Accelerate vaccination rates
- Close international borders to keep COVID-19 out
- Early, stringent and short lockdowns if outbreaks occur
- Minimise cases in the community through effective test, trace and isolate capabilities
- Implement the national vaccination plan to offer every Australian an opportunity to be vaccinated with the necessary doses of the relevant vaccine as soon as possible;
- Inbound passenger caps temporarily reduced
- Domestic travel restrictions directly proportionate to lockdown requirements
- Commonwealth to facilitate increased commercial flights to increase international repatriations to Darwin for quarantine at the Centre for National Resilience in Howard Springs;
- International Freight Assistance Mechanism extended
- Trial and pilot the introduction of alternative quarantine options, including home quarantine for returning vaccinated travellers;
- Expand commercial trials for limited entry of student and economic visa holders
- Recognise and adopt the existing digital Medicare Vaccination Certificate (automatically generated for every vaccination registered on AIR);
- Establish digital vaccination authentication at international borders;
- Prepare vaccine booster programme; and
- Undertake a further review of the national hotel quarantine network.

B. Vaccination Transition Phase

Seek to minimise serious illness, hospitalisation and fatality as a result of COVID-19 with low level restrictions

Measures may include:

- Maintain high vaccination rates, encouraging uptake through incentives and other measures
- Minimise cases in the community through ongoing low-level restrictions and effective track and trace
- Lockdowns less likely but possible
- International border caps and low-level international arrivals, with safe and proportionate quarantine to minimise the risk of COVID entering
- Ease restrictions on vaccinated residents (TBD)
- Restore inbound passenger caps at previous levels for unvaccinated returning travellers and larger caps for vaccinated returning travellers;
- Allow capped entry of student and economic visa holders subject to quarantine arrangements and availability;
- Introduce new reduced quarantine arrangements for vaccinated residents; and
- Prepare/implement vaccine booster programme (depending on timing).

C. Vaccination Consolidation Phase

Seek to minimise serious illness, hospitalisations and fatalities as a result of COVID-19 with baseline restrictions

Measures may include:

- Maximise vaccination coverage
- Minimum ongoing baseline restrictions, adjusted to minimise cases without lockdowns
- Highly targeted lockdowns only
- Continue vaccine booster programme;
- Exempt vaccinated residents from all domestic restrictions;
- Abolish caps on returning vaccinated Australians;
- Allow increased capped entry of student, economic, and humanitarian visa holders;
- Lift all restrictions on outbound travel for vaccinated Australians; and
- Extend travel bubble for unrestricted travel to new candidate countries (Singapore, Pacific)
- Gradual reopening of inward and outward international travel with safe countries and proportionate quarantine and reduced requirements for fully vaccinated inbound travellers.

D. Final Post-Vaccination Phase

Manage COVID-19 consistent with public health management of other infectious diseases

Measures may include:

- Open international borders
- Quarantine for high-risk inbound travel
- Minimise cases in the community without ongoing restrictions or lockdowns
- Live with COVID-19: management consistent with influenza or other infectious diseases
- Boosters as necessary
- Allow uncapped inbound arrivals for all vaccinated persons, without quarantine; and
- Allow uncapped arrivals of non-vaccinated travellers subject to pre-flight and on arrival testing.

**No jurisdiction required to increase restrictions beyond current settings*
The Plan is based on the current situation and is subject to change if required
The COVID-19 Risk Analysis and Response Taskforce's report will be available once finalised at: pmc.gov.au.

The National Plan assumed higher levels of vaccine coverage would reduce demands on hospitals and intensive care units sufficiently to ease the need for Public Health and Safety Measures in a transition to normality. Based on the real-world data canvassed in this presentation, this has been a distinct failure.

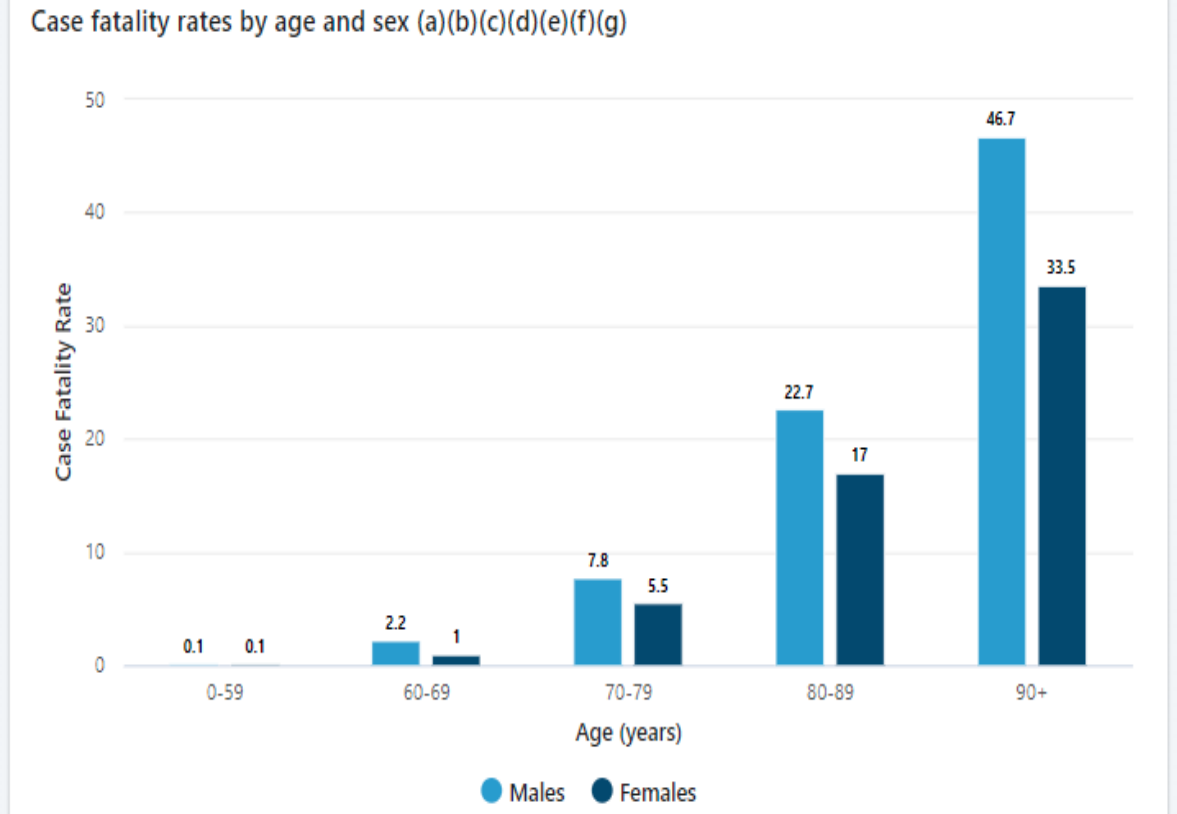
WHO IS AT RISK OF SEVERE COVID?

The generic claim is as stated by the World Health Organisation:

"Most people infected with the virus will experience mild to moderate respiratory illness and recover without requiring special treatment. However, some will become seriously ill and require medical attention. Older people and those with underlying medical conditions like cardiovascular disease, diabetes, chronic respiratory disease, or cancer are more likely to develop serious illness. Anyone can get sick with COVID-19 and become seriously ill or die at any age."

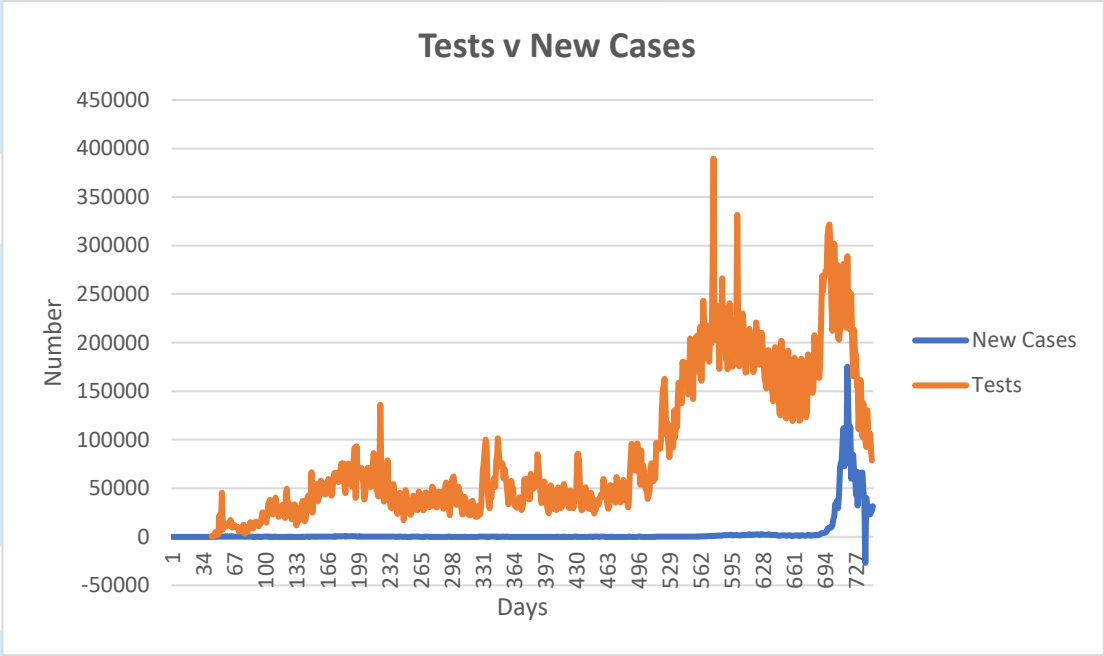
The Australian Bureau of Statistics (ABS) shows that people with chronic heart conditions, dementia, diabetes and cancer have a higher risk of developing severe illness from COVID-19.

- 91% of deaths due to COVID-19 had other conditions certified on the death certificate
- 9% only had reported COVID-19 alone
- The ABS data confirms that most deaths with COVID-19 are in the sick and elderly, with a significant portion in the age group that is past average life expectancy.
- Inversely, it confirms the younger age groups are not significantly impacted by severity of symptoms and this has been the case prior to vaccination
- The infection survival rate in children and adolescents is 99.998%



TESTING FOR COVID-19

When COVID-19 arrived, the standard procedures for clinical assessment and diagnosis of disease were altered and replaced with inappropriate protocols.



- Whilst it is true that **RT-PCR testing is the gold-standard** for virus detection, it has never been capable of testing for the presence of disease in the subject
- It is **not recommended to test people who have no symptoms** in a low prevalence environment
- Australia is considered a low prevalence environment
- Most testing in Australia is happening in COVID-19 hubs on people who have no symptoms
- A 'positive' result doesn't mean you are infected
- A 'positive' result might indicate past infection, or detection of similar viruses including Influenza
- Influenza rates dropped at the same time as COVID-19 cases rose
- Rapid Antigen Testing (RAT), which is taking over RT-PCR, is happening in private settings and is even more likely than RT-PCR to yield false negatives and false positives

PREVALENCE

2,745,119 cases from 62,483,176 tests equates to **0.043 prevalence** (or **4.39%**) of COVID-19 in Australia for the duration of the pandemic

WHAT IS A VACCINE?

Vaccines are medicines intended to protect you from contracting specific diseases, such as measles, influenza (flu) or whooping cough. In protecting you from contracting that disease, the vaccine serves to prevent the vaccinated person from spreading that disease.

Restating, the **central intended purpose of a vaccine is to reduce risk of infection**, i.e. preventing you from getting the disease, **by inducing immunity** to that specific disease. This differentiates vaccines from other medicines, which are designed to treat or cure a disease.

In a bizarre change since COVID-19 appeared, the **pharmaceutical companies and regulators have redefined the term "*vaccine*"** both in regard to the intended purpose and what a vaccine is physically composed of.

Indeed, the overtly stated primary goal of the "*vaccine*" trials was not disease prevention, but rather disease severity reduction. Is a "*vaccine*" even a vaccine at all if it does not prevent disease and thus does not reduce transmission?

Furthermore, prior to 2020 it was understood that vaccines were composed of only one of three basic types of formulations:

- dead viruses or bacteria, or
- severely weakened forms of viruses or bacteria, or
- small, purified components of viruses or bacteria.

The **current COVID-19 vaccines** predominantly used in Australia **DO NOT contain the above.** Instead they contain gene modifying technology.

They **contain information codes and/or capsules** carrying instructions to the body **to produce a spike protein** associated with the ancestral (original) SARS-CoV-2 virus. The spike protein has been identified as having human-like components.

The current COVID-19 vaccines have been associated with a variety of serious adverse reactions and injuries including blood clotting, heart inflammation and auto-immune reactions.

THE LAB IS NOT THE REAL WORLD

A vaccine's **efficacy is measured in a controlled clinical trial**. Its **effectiveness** is a **measure** of how well vaccines work **in the real world according to some chosen outcome.**

The COVID-19 vaccine effectiveness needs to be measured in terms of real-world data and contrasted against the outcomes of the clinical trial.

- After Pfizer's 2 months trial data report, the placebo group was unblinded, meaning they were offered the vaccine, thereby **contaminating the trial data**
- Vaccines were **meant to reduce severity** of disease, even to subsequent SARS-CoV-2 variants
- Effectiveness has **waned significantly** after the rollout
- Vaccine-induced immunity against the Delta variant has waned to such an extent that it is **not even effectively reducing the risk of severe disease**
- The situation is **more dire for the Omicron variant**

Our governments have shifted their focus from claims that vaccines stop infection and transmission to claims they reduce severe illness, hospitalisation and death.

Despite being aware of the highly mutating nature of this virus and significant waning immunity against subsequent variants, **Australia is pushing for more, ineffective vaccine boosters**.

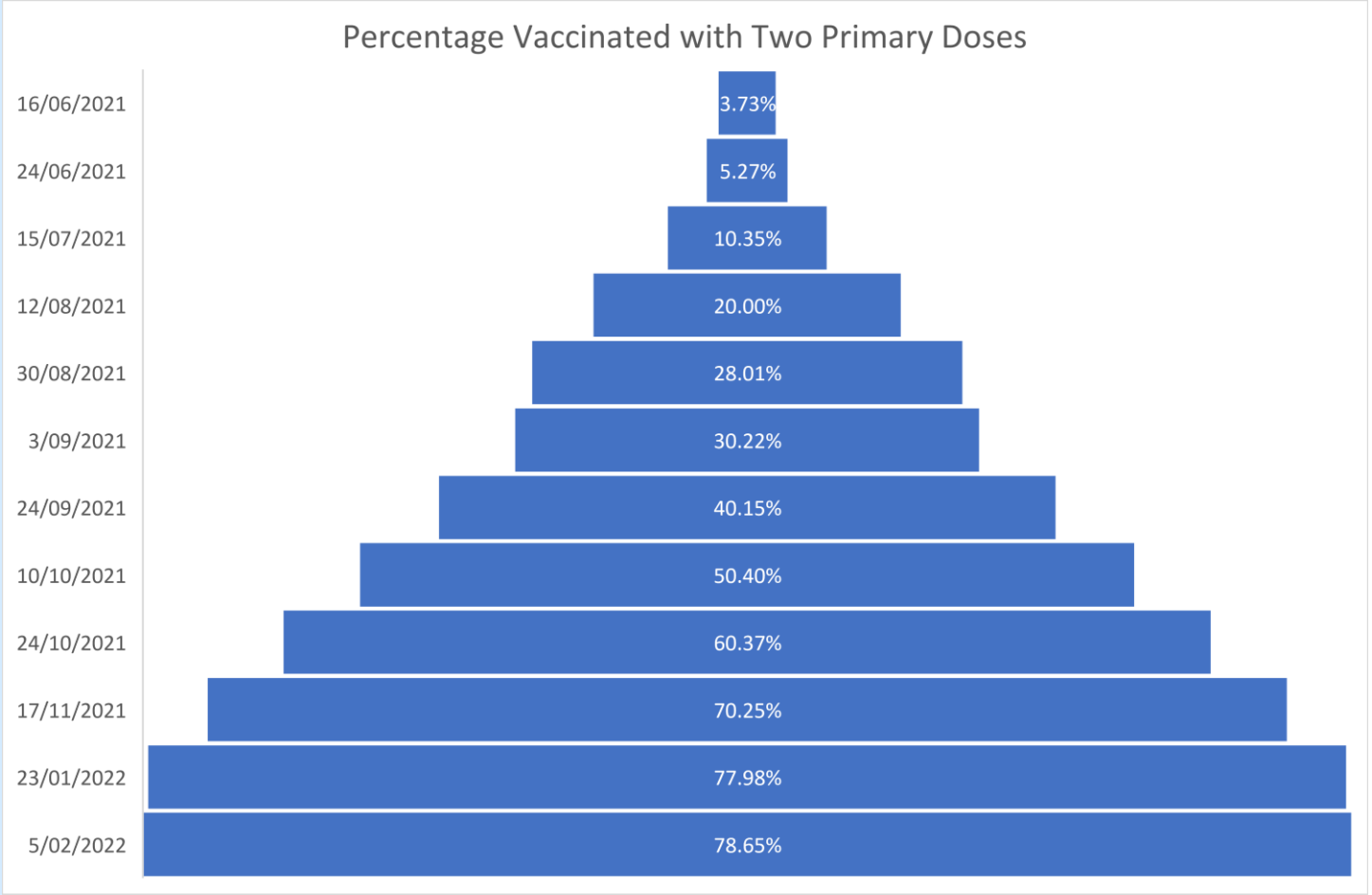
RATE OF PROGRESSION

This chart illustrates the progression of vaccination, at two primary doses, of the total Australian population over time.

Australia is now one of the **most vaccinated countries** in the world.

The goalposts keep changing with the Australian Technical Advisory Group on Immunisation (ATAGI) considering people over 16 years of age '*up to date*' if they have had 2 primary doses (even of separate brands of vaccines) and a booster within six months of their primary course. Others will be considered *'overdue'*.

The term *'fully vaccinated'* will no longer be used and the severely immunocompromised are expected to take a third primary dose.



SLEIGHT OF MOUTH

'Unvaccinated' is not what it seems

The term '*unvaccinated*' normally refers to someone who has not received a vaccine. However, the meaning of '*unvaccinated*' has been altered by the authorities and most are unaware this has occurred. NSW Health publish two COVID-19 reports weekly; the COVID-19 Weekly Surveillance Report (Surveillance Report) and the Critical Intelligence Unit COVID-19 Monitor Report (Monitor Report).

The Surveillance Report employs continuously shifting definitions of '*vaccination status*'. These reports also contradict the Monitor Report which use the terms '*unvaccinated*' and '*double vaccinated*', but never define them. The Surveillance Reports are more detailed and provide a glossary of terms. The media and government have relied on the Monitor Reports to obscure the data and purport that the unvaccinated are over-represented in ICU admissions and deaths. This is not accurate.

As at Week 2, 2022 surveillance report terms are:-

- Three effective doses
- Two effective doses
- One effective dose
- No effective dose
- Under investigation

There are serious concerns with the descriptions:

- The terms '*valid second dose*', '*known exposure to COVID-19*' and *'maximal immune response*' are not defined

- Vaccinated persons with known COVID-19 exposure, can be reclassified to '*no effective dose*' or '*one effective dose*', irrespective of their vaccination status

- We are led to believe that '*no effective dose*' means '*unvaccinated*'. It does not according to the glossary.

Glossary

Term	Description
Three effective doses	Cases reported as having three effective doses have had a third dose of COVID-19 vaccine at least 60 days after a valid second dose and 14 days prior to COVID infection. This includes people who are immunocompromised and have had a third primary dose (recommended 2-6 months after second dose), and non-immunocompromised people who have had a booster dose.
Two effective doses	Cases reported as having received two effective doses have received their second vaccine dose at least 14 days prior to known exposure to COVID-19, and have not yet received an effective third dose.
One effective dose	Cases reported as having one effective dose received their first dose of a two-dose vaccination course at least 21 days prior to known exposure to COVID-19, or received their second dose of a two-dose vaccination course less than 14 days prior to known exposure to COVID-19.
No effective dose	Cases reported as no effective dose received their first dose of a vaccination course less than 21 days prior to known exposure to COVID-19, or have not received any vaccine dose. Using the phrase "no effective dose" indicates that an insufficient period of time has elapsed to allow for maximal immune response provided by the vaccine. It does not indicate that vaccines are ineffective. Historical cases in children aged 5-11 between 16 June 2021 and 9 January 2022 have been assigned No effective dose, as have all cases in children aged 0-4 since 16 June 2021.
Under investigation	Cases reported as under investigation are those whose vaccination status has not yet been determined via searching the Australian Immunisation Register and/or via case interview.

SLEIGHT OF MOUTH

Multiple Meanings

Table 5 is taken from the most recent NSW weekly surveillance report.

- Without a list of proper data controls as to when and how a person's vaccination status may be reclassified due to known COVID-19 exposure, or any other reason, then it is difficult to rely on the integrity of the data reported

- Historical cases of children aged 5-11 and all 0-4 aged are now classified as '*no effective dose*' and this is likely to skew the data

- Proportions of deaths attributed to the '*no effective dose*' category are argued as being an over-representation of overall deaths, when this category is likely to be constituted by those that are vaccinated but have been reclassified

- Despite medical officials recognising *'vaccine induced COVID-19'*, this phenomenon is not being discussed

Table 5. Hospitalisations, ICU admissions and deaths among PCR confirmed cases diagnosed with COVID-19, by vaccination status, NSW, from 26 November 2021 to 22 January 2022

Vaccination status	Total cases	Hospitalised* (% of total cases)	Hospitalised and in ICU* (% of total cases)	Death* (% of total cases)
Three or more effective doses	23,782	366 (1.5%)	31 (0.1%)	22 (0.1%)
Two effective doses	438,255	5,137 (1.2%)	439 (0.1%)	287 (0.1%)
One effective dose	5,521	150 (2.7%)	19 (0.3%)	14 (0.3%)
No effective dose	72,772	822 (1.1%)	93 (0.1%)	98 (0.1%)
Under investigation	129,604	1,833 (1.4%)	212 (0.2%)	15 (<0.1%)
Total	669,934	8,308 (1.2%)	794 (0.1%)	436 (0.1%)

* Note, table categories are not mutually exclusive. Hospitalised includes cases admitted to ICU; deaths may occur with or without being admitted to hospital or ICU.

Total PCR confirmed COVID-19 cases by vaccination status and week reported, NSW, 16 June 2021 to 22 January 2022

	Third or more effective doses	Two effective doses	One effective dose	No effective dose	Under investigation*	Total
16 Jun - 25 Nov 2021	2 (<1%)	6,872 (9%)	6,870 (9%)	53,245 (71%)	8,328 (11%)	75,317
26 Nov 2021 - 22 Jan 2022	23,782 (4%)	438,255 (65%)	5,521 (1%)	72,772 (11%)	129,604 (19%)	669,934
Month						
June 2021	0 (0%)	3 (1%)	11 (5%)	221 (93%)	2 (1%)	237
July 2021	0 (0%)	70 (2%)	98 (3%)	3,099 (94%)	40 (1%)	3,307
August 2021	0 (0%)	557 (3%)	806 (4%)	16,530 (87%)	1,087 (6%)	18,980
September 2021	0 (0%)	2,618 (8%)	3,904 (11%)	22,110 (63%)	6,239 (18%)	34,871
October 2021	2 (<1%)	1,876 (15%)	1,738 (14%)	8,156 (66%)	589 (5%)	12,361
November 2021	3 (<1%)	2,158 (33%)	336 (5%)	3,592 (55%)	452 (7%)	6,541
December 2021	2,038 (2%)	92,710 (70%)	1,141 (1%)	12,925 (10%)	23,354 (18%)	132,168
Week ending						
1 Jan 2022	1,911 (2%)	70,814 (70%)	813 (1%)	8,515 (8%)	18,687 (19%)	100,740
8 Jan 2022	6,816 (3%)	153,806 (68%)	1,796 (1%)	19,151 (8%)	44,448 (20%)	226,017
15 Jan 2022	8,077 (4%)	113,112 (62%)	1,526 (1%)	21,342 (12%)	37,123 (20%)	181,190
22 Jan 2022	6,391 (6%)	64,826 (59%)	881 (1%)	17,177 (16%)	21,120 (19%)	110,395

* Vaccination status is updated regularly using both the Australian Immunisation Register and the patient's interview. See Glossary for details of vaccination status categories. The increase in cases with a vaccination status Under investigation since December 2021 is due to no record being found in AIR, and NSW Health no longer interviewing every case, such that cases cannot provide further information about vaccination. These cases likely represent a mix of those with two or more effective doses, and those with no effective dose.

Regardless, 70% of infections/cases between 26 Nov 2021 and 22 Jan 2022 have had at least '*one effective dose*'.

RATE OF DECLINE INCREASED RISK OF ILLNESS

COVID Pre and Post Vaccination, and Winter/Summer Comparisons

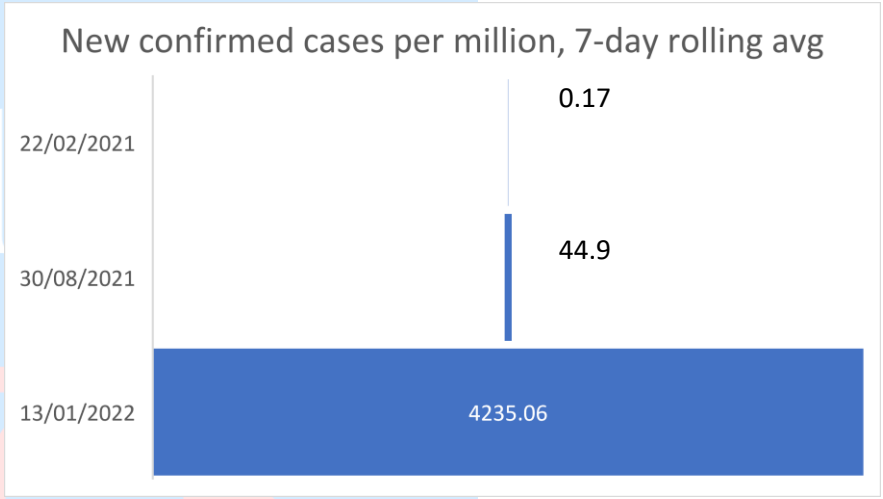
The following charts show Cases, Hospitalisations, ICU Admissions and Deaths (CHID's) pre-vaccination and at various peaks post-vaccine rollout.

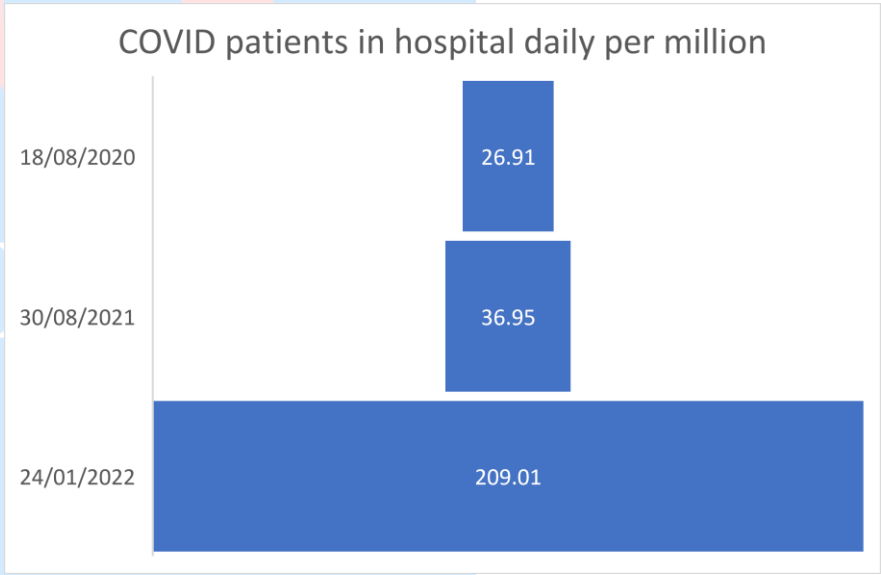
The dates also allow for **comparisons between winter and summer** months.

The data reveals two startling findings:-

- In Winter time, CHID's were overall low when the vaccination rates were low
- In a small period of time, the CHID's have remarkably increased along with the vaccination rates

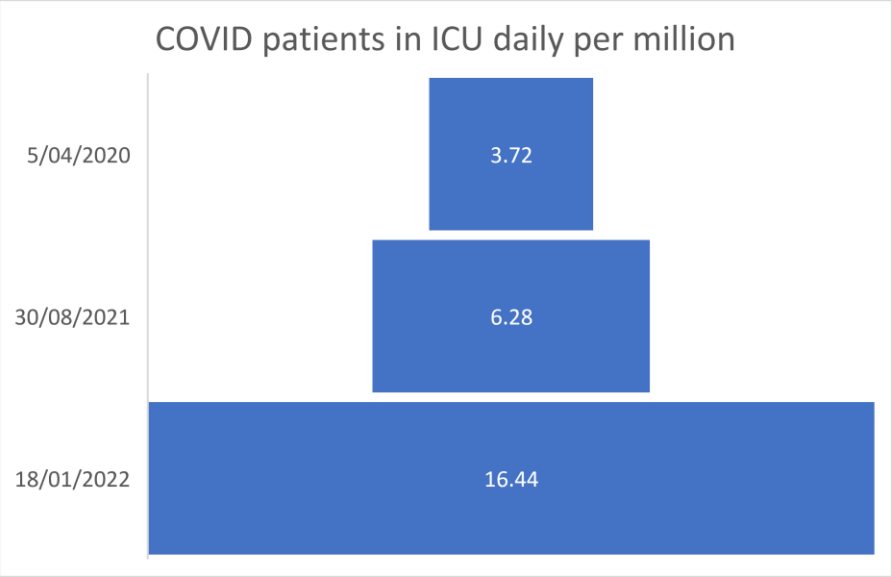
Even during summer months when flu-like viruses don't typically increase, these numbers have surged.

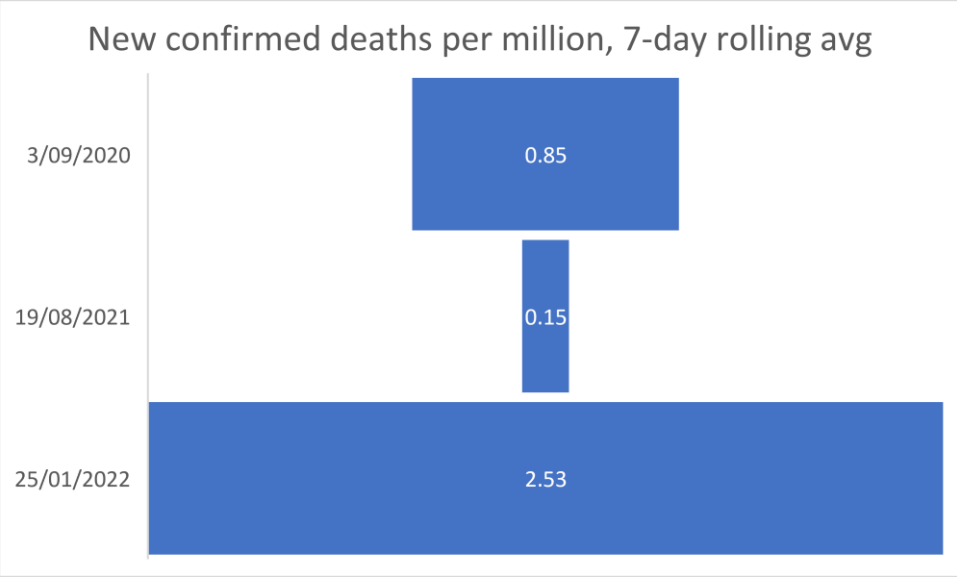




RATE OF DECLINE INCREASED RISK OF DEATH

COVID Pre and Post Vaccination, and Winter/Summer Comparisons





Comparing Australian statistics pre and post vaccine rollout and statistics from winter 2021 to unfinished summer 2021/2022

	Pre-rollout	Post-rollout	Difference	Winter	Partial Summer	Difference
Cases 7-day avg per million	0.17	4235.06	+4234.89	44.95	4235.06	+4190
Fully vaccinated rate	0.00%	77.98%	+77.98	28.01%	77.98%	+49.97
Hospitalisations daily avg	26.91	209.01	+182.1	36.95	209.01	+172.06
ICU patients daily avg	3.27	16.44	+13.17	6.28	16.44	+10.16
Deaths 7-day avg per million	0.85	2.53	+1.68	0.15	2.53	+2.38

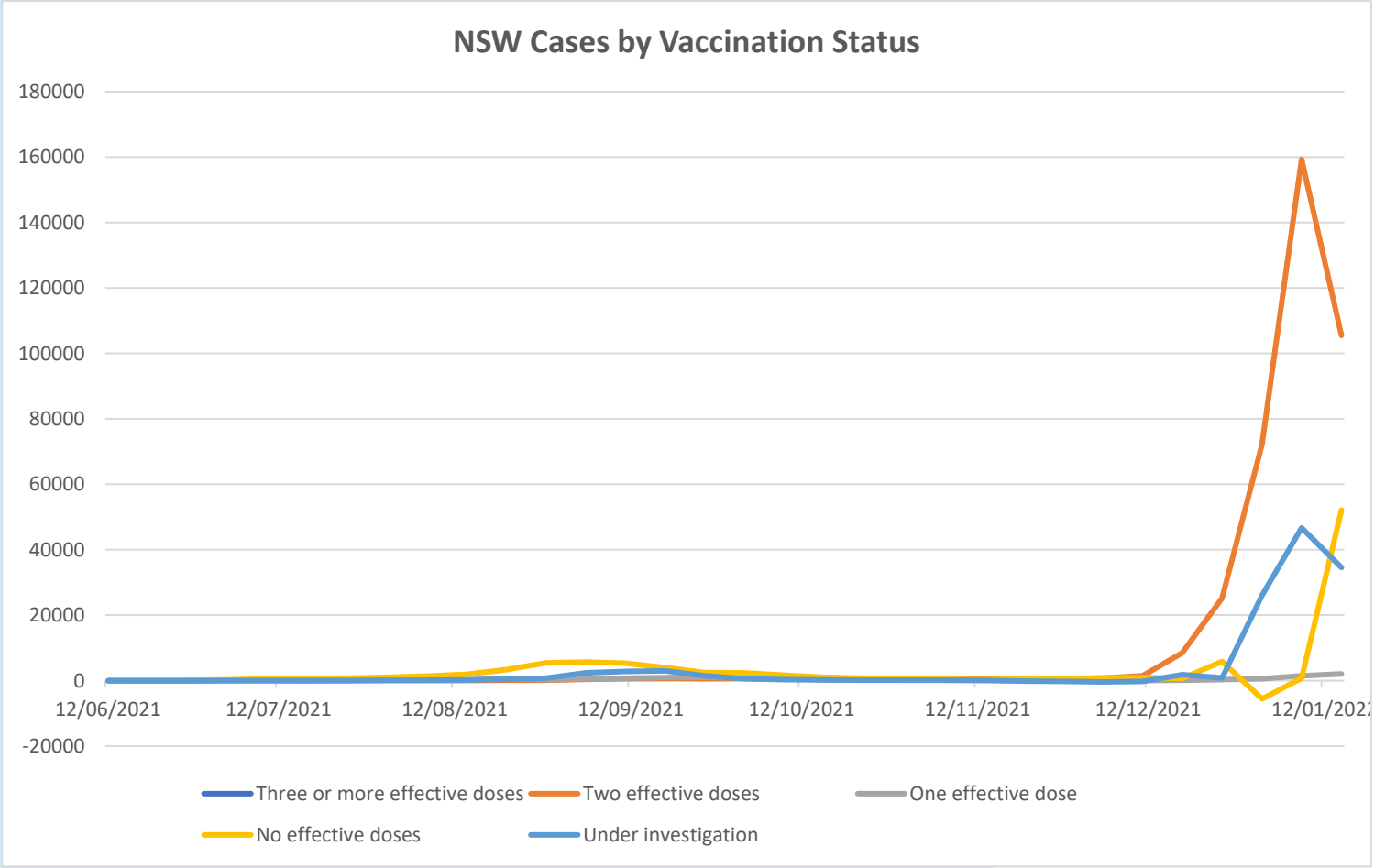
In all aspects, there has been significant increases in CHID's post vaccination rollout.

SPIKES ARE EVERYWHERE

The experimental vaccines are supposed to direct the body to create a spike protein.

The real spike is in new cases/infections in vaccinated people.

When vaccination rates were lower, it was easy to claim the "pandemic of the unvaccinated", as that was the majority of the population. This is clearly not the case since the rollout.



ENTER THE BOOSTERS

Yes, boosters are **boosting** the vaccine company **profits**.

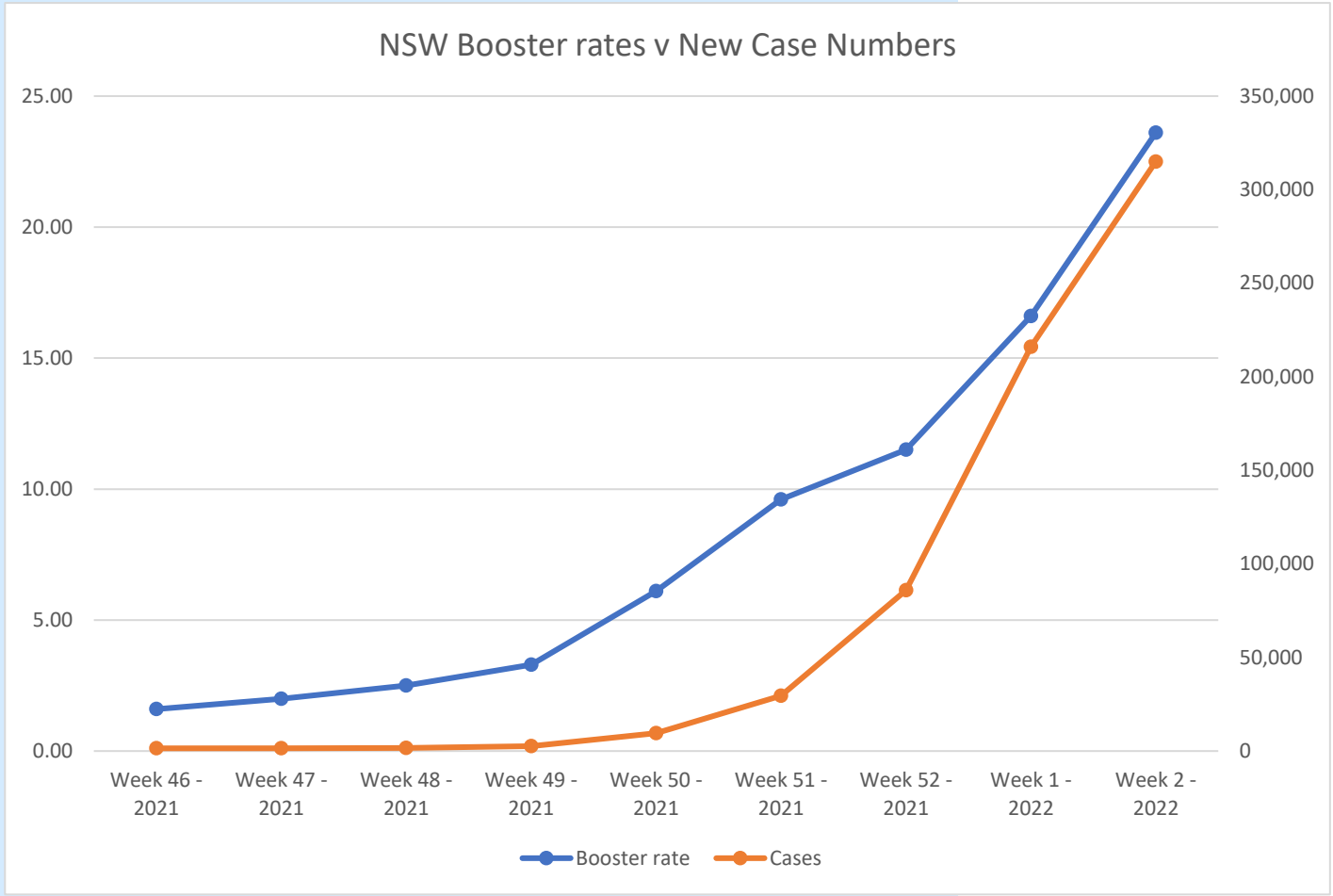
But that's not the only thing they are boosting.

And we're **not** talking **immunity** here either.

Notice how the sharp **increase in cases correlates to the booster shots**?

Does this correlation between uptake of boosters and surge in cases hint that the vaccines are somehow adversely affecting the immune system, increasing vulnerability to the very thing it is supposed to protect us from?

Is this "boost juice" actually that good for you?

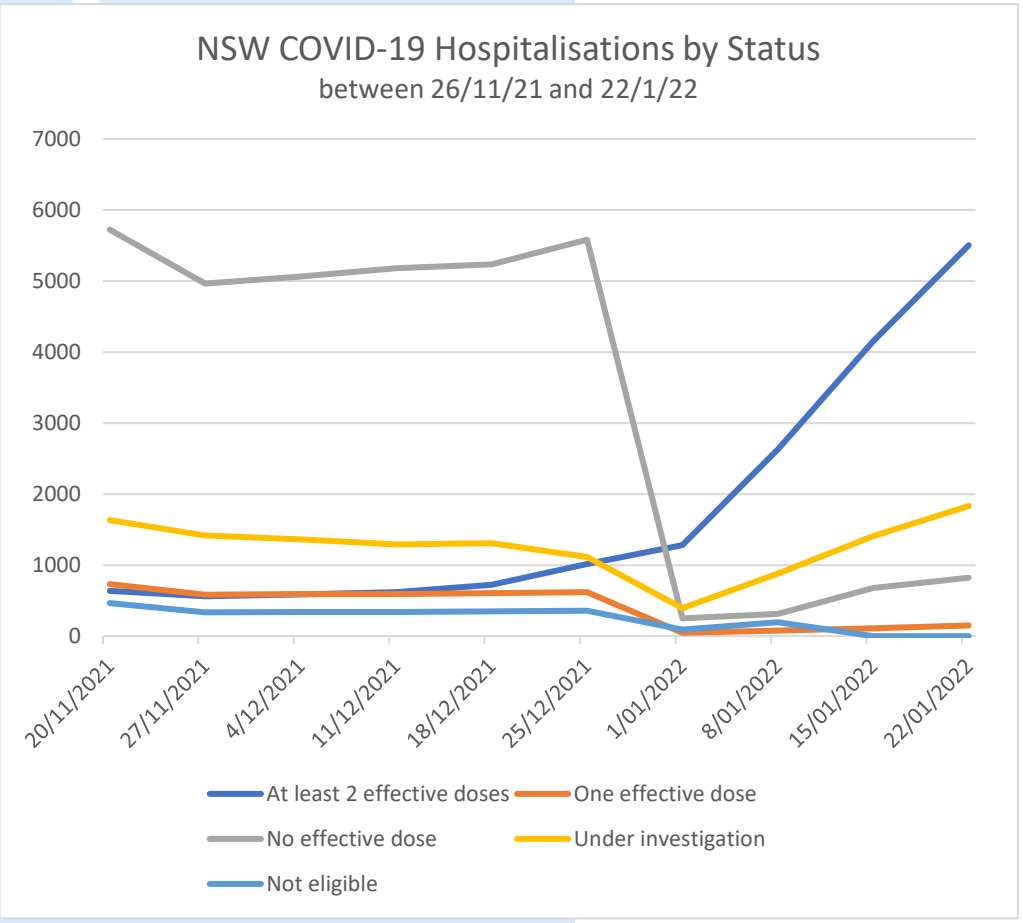


DOING IT FOR THE CHID's

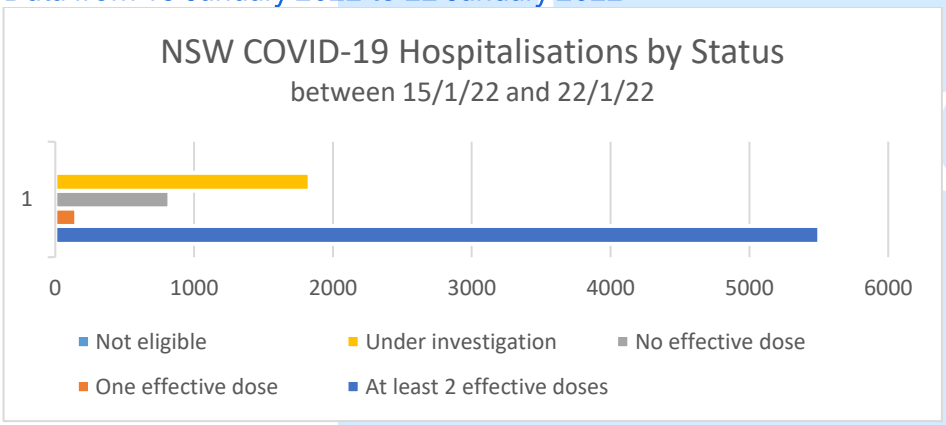
The real-world data shows a clear correlation between increased CHID's and vaccination. We have mapped out the situation between 26 November 2021 and 22 January 2022 as we hit peak vaccination rates of the total population. The patterns are self-explanatory.

NSW COVID-19 Hospitalisations

- The table on the right maps out the NSW COVID-19 hospitalisations between 26 November 2021 and 22 January 2022
- As we hit peak vaccination dates there is a dramatic decrease in the number of hospitalisations for *'no effective dose'* as contrasted to the sharp increase in *'two effective doses'*
- The table below maps out the hospitalisation numbers in the latest week of those *'under investigation'* and *'two effective doses'* as contrasted to those with *'no effective dose'* and *'one effective dose'*



Data from 15 January 2022 to 22 January 2022



NSW COVID-19 ICU Admissions

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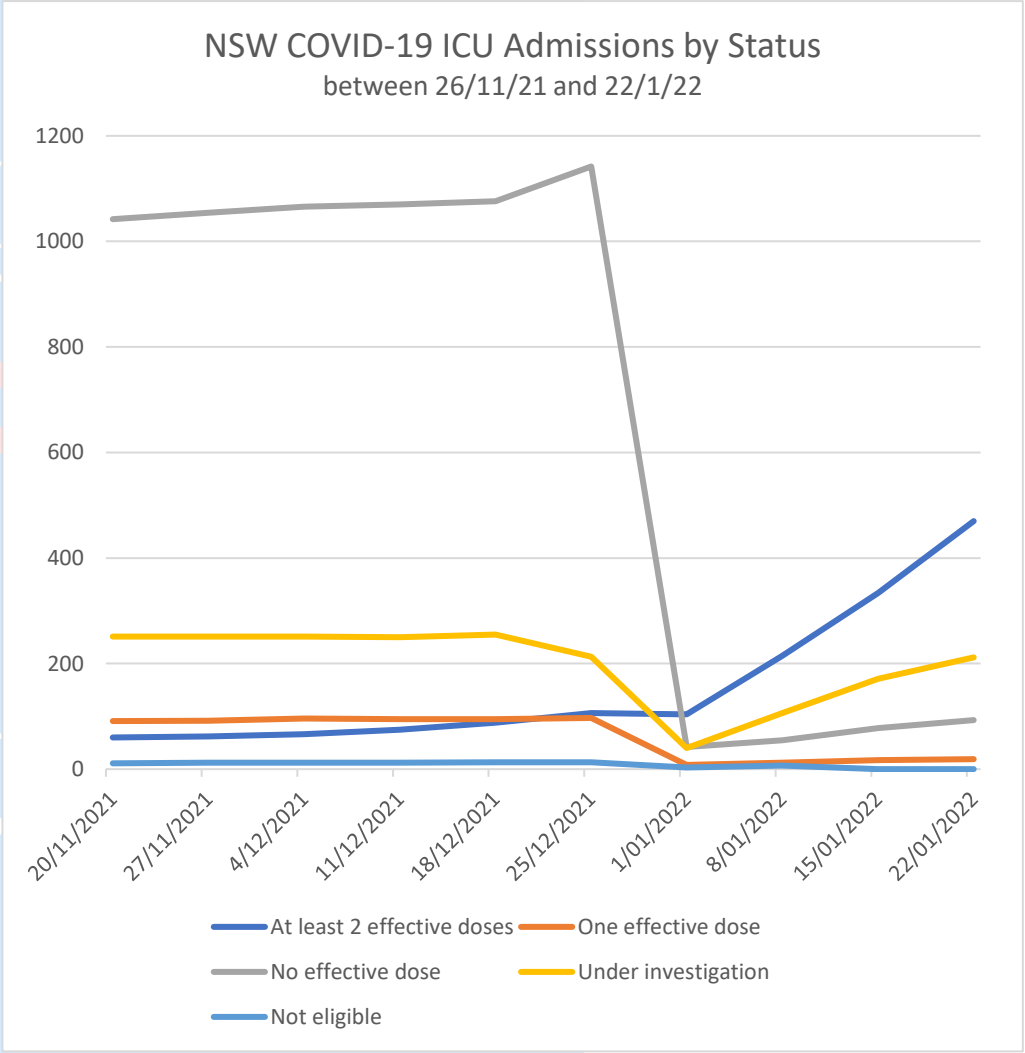

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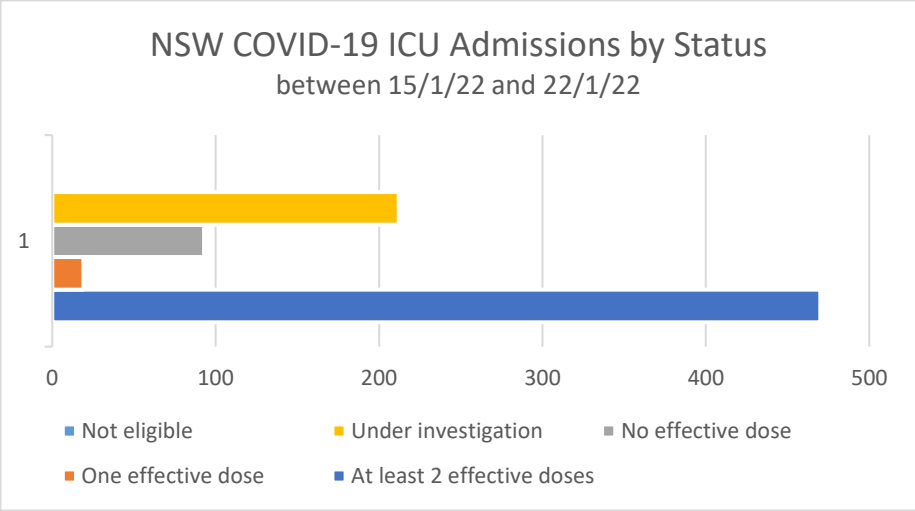
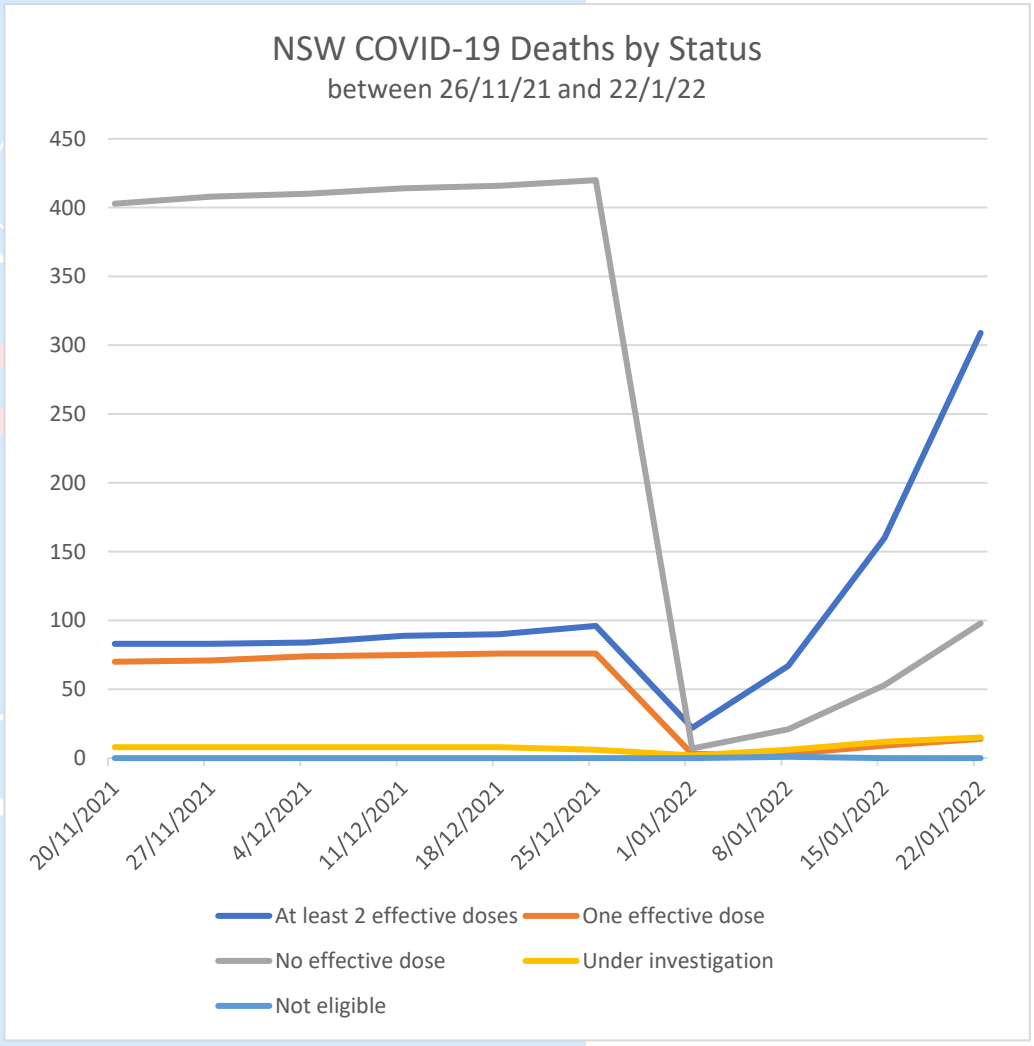


NSW COVID-19 Deaths

- The table on the right maps out the NSW COVID-19 deaths between 26 November 2021 and 22 January 2022
- As we hit peak vaccination dates there is a dramatic decrease in the number of deaths for *'no effective dose'* as contrasted to the sharp increase in *'two effective doses'*
- The table below maps out the death numbers in the latest week of those *'under investigation'* and *'two effective doses'* as contrasted to those with *'no effective dose'* and '*one effective dose*'. Note that those that were *'one effective dose'* may have been reclassified to *'no effective dose'*



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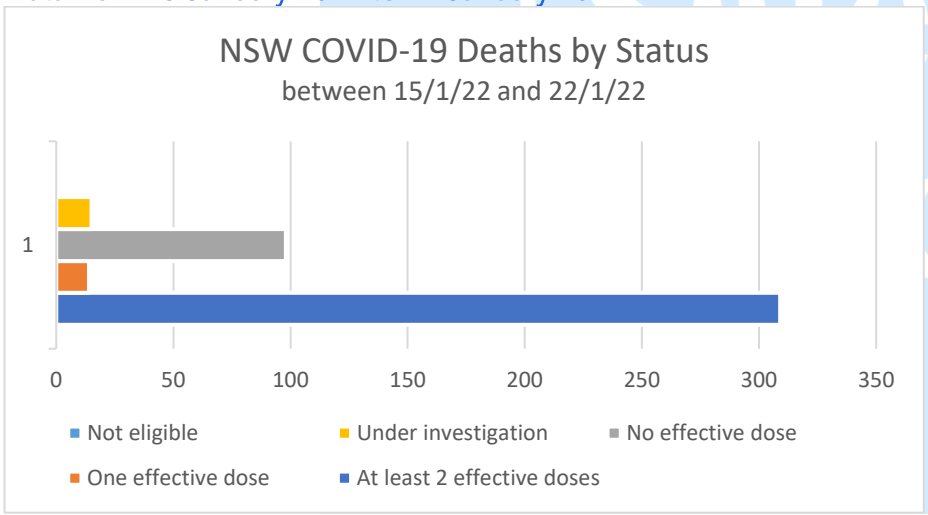


SPIKES IN INJURY

There has never been a mass vaccination process on this scale in the history of the world. And with vaccine trials claiming efficacy of 95% after just 2 months, provisional approvals were granted, a process that normally takes around 10 years.

There has not been enough time to properly gauge medium and long-term safety, so here we explore the adverse events reported by the TGA, compare this with the AusVax Safety report, and discuss under-reporting of adverse events.

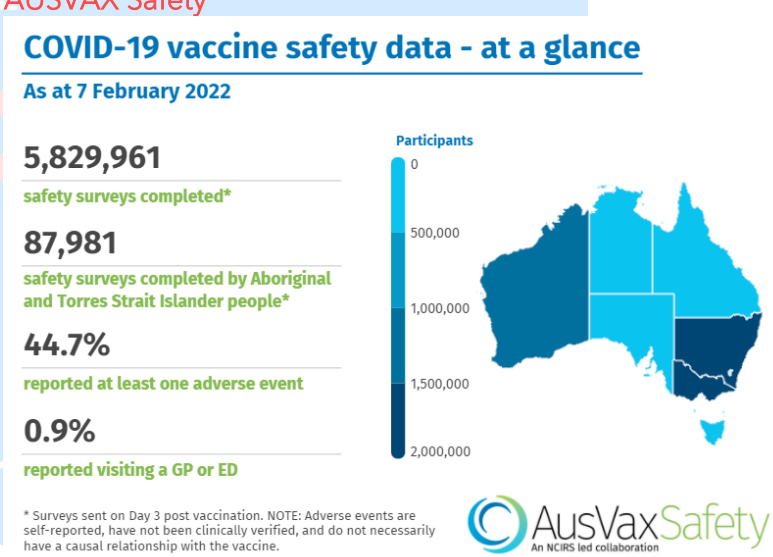
TGA Adverse Events

Total adverse event reports to 6 February 2022

2.1	108,003	51,152,055
Reporting rate per 1000 doses	Total AEFI reports received	Total doses administered
44,916	58,629	4,375
Total reports for Vaxzevria	Total reports for Comirnaty	Total reports for Spikevax

TGA has **reported 762 deaths** and confirmed 11 were linked to vaccination.

AUSVAX Safety



UNDER REPORTING OF ADVERSE EVENTS

To demonstrate this under-reporting, we looked at the AUSVAX Safety national survey data. The AUSVAX Safety conducts independent surveys on those who obtained COVID-19 vaccinations. The Report states that 44.7% of 5,829,961 surveyed reported at least one adverse event, equating to 2.6 million adverse events with over 23,000 reported a visit to a GP or Emergency Department. When compared with the TGA figures, it is clear under-reporting of adverse events to TGA is significant.

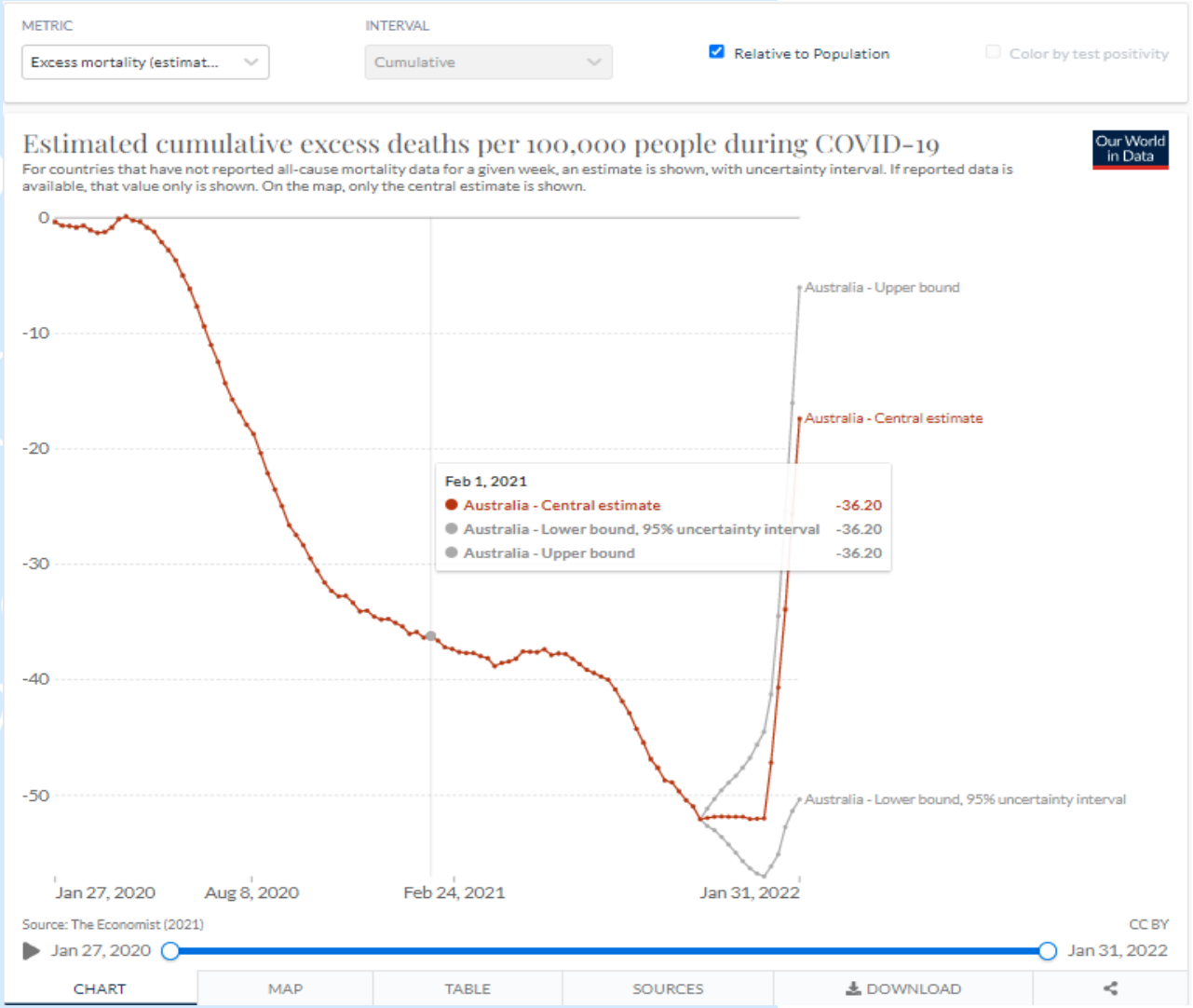
SPIKES IN OVERALL DEATH

Australian Bureau of Statistics (ABS) data shows **excess mortality has increased by 4.6%** as compared with the 2015-19 average and a 4.2% increase as compared with 2020.

This data is only measured till the end of October 2021.

ABS acknowledges September and October deaths will have been significantly **under-reported by 40-50%**, so we can expect to see a continued **worrying upward trend** in all-cause mortality in Australia.

Alarmingly, Our World in Data **projections** for estimate cumulative excess deaths in Australia after October 31, 2021 **show a significant upward trend** as they appear to incorporate the increased COVID-19 deaths.



ABORT MISSION

WITHDRAW THE VACCINES

Vaccines are intended to reduce the risk of infection and, as a result, transmission. In this case, the Australian overall data, as well as the specific NSW surveillance reports data, don't just show that the alleged vaccines fail to reduce risk of infection and transmission but they also do not reduce CHID's. In fact, they appear to be exacerbating CHID's. We will be monitoring the situation closely once the ABS releases its all-cause mortality data for this period.

The highest risk group for COVID-19 are people at, or past life expectancy, and with pre-existing co-morbidities. The rest of the population who contract the virus have a statistically high recovery rate, especially children and adolescents.

Natural immunity is more robust and enduring.

There are serious questions raised around mixing brands of primary doses and boosters, and the effect that boosters are likely to be having on increasing susceptibility to COVID-19 and other diseases.

Even during summer months when flu-like viruses don't typically increase, case numbers including hospitalisations, ICU admissions and deaths have surged and the majority are vaccinated. While it is acknowledged that the Omicron variant may have contributed to this consequence, we say that this is just as likely to be contributed to by '*vaccine induced COVID-19*', the unacceptably high adverse event rates and injury and increased susceptibility to COVID-19.

Based on this, we conclude that the purported COVID-19 vaccines used in Australia are ineffective, and statistical trends would indicate these vaccines are creating increased susceptibility to COVID-19. Consequently it makes no sense to force people to be vaccinated, especially healthcare and aged care workers, because these workers could be exposing already immunocompromised patients to an increased likelihood of catching COVID-19, and this cohort are at most risk of death.

Children and adolescents have virtually zero chance of dying from COVID-19. Consequently, the scientific rationale for vaccinating them is exceptionally thin. Indeed, more and more studies are showing that children are at greater risk from vaccine reactions than from COVID-19.

With the National Plan being a distinct failure, we must now consider what the acceptable threshold for safety is for products that are ineffective, with significant waning immunity. Combined with increasing CHID's, the 11 confirmed deaths relating to vaccination, together with the significant number of other serious adverse events and under-reporting of adverse events, there is immediate justification for halting the rollout and for withdrawing all mandates until more thorough, and transparent investigations are conducted.

SUPPORT OUR WORK

BECOME A MEMBER

People for Safe Vaccines has been providing ongoing research, education and lobbying efforts to bring about proper due diligence from government on safe vaccines including transparency and accountability. If you would like to support our ongoing work, please become a member today.

https://www.peopleforsafevaccines.org/plans-pricing