10 July 2021

Hon Greg Hunt MP
Minister for Health and Aged Care
Parliament of Australia

CC: Innes Willox, Chief Executive, AI Group)

Dear Minister Hunt,

On 29 May 2021 I attended the "Live Online Event" hosted by AI Group entitled "Post-COVID Australia - a discussion with the Minister for Health & Aged Care, the Hon Greg Hunt".

During this event, you made statements on two particular subjects that I respectfully take issue with. Specifically:

1. You made very clear assertions about the safety of both the AstraZeneca and Pfizer COVID-19 vaccines. These assertions are provably and demonstrably false.
2. Your response to a question about what is arguably *the* central measure of mortality risk for COVID-19 seemed to indicate you were not only ignorant of the quantum of that measure, but also ignorant of the meaning of the term itself.

Minister, based on various statements you made during the event I'm gravely concerned you've been inadequately informed by your scientific and medical advisory teams. I fear you have succumbed to the same fear and hysteria as most others because you have been poorly advised. Consequently, it seems likely you have been advocating inappropriate COVID response measures because you have not been given a current, appropriate and sufficiently accurate measure of risk posed by COVID.

AI Group has a strong policy on probity in all its affairs and as they hosted the event I am including Innes Willox (CEO) in this communication. I'm seeking your retraction and clarification, as appropriate, to myself and the rest of the attendees of that meeting. I explain both matters in further detail below.

There is a lot of detail in this letter. It touches on a fair portion of what I estimate to be in excess of 800 hours of personal research on COVID. Some of it you may be aware of. Nevertheless, I decided a comprehensive and thorough treatment of the issues was in order because I believe I have some ability to describe the issues in a manner comprehensible to a non-scientist such as yourself. I hope also that this letter serves the function of notifying you of key facts in the COVID saga and the consequences.

Detail

Although the issues I raise stand on their own and I am loathe to "flash credentials", the current zeitgeist pays much (often unwarranted) attention to credentials, so I will give mine: I am an Engineer (with First Class Honours) by formal training and a specialist in measurement,

which includes data science, modelling, statistics, uncertainty estimation and management etc. Among other achievements my academic performance landed me on the Deans List at the University of Queensland and I was also invited to join the International Golden Key Honour Society. My measurement expertise has resulted in my appointment by the Federal Goverments' own National Measurement Institute as a "Legal Metrologist", which means that measurement reports I produce in my field of work are regarded as statements of legal fact and do not require my expert witness testimony. I'm also a researcher, with health being a specific area of focus in my personal research activities over the past 20 years or so.

I have been leveraging my above skillset to follow and analyse the COVID-19 situation from the beginning in late 2019/early 2020.

Minister, this letter/email is my attempt to give you the opportunity to correct/clarify/restate your position on two important matters.

Issue #1 - Safety of COVID-19 Vaccines

At one point you were speaking directly about the Pfizer and AstraZeneca vaccines and you made the following unequivocal claim to the event attendees. I took careful note of your statement but it was so short it was impossible to forget. I quote you as follows:

> "Both are safe. Both are effective."

With respect, Mr Hunt, there is ZERO scientific justification for such an unequivocal statement. In fact, the relevant regulatory authorities (TGA, US FDA etc) make claims that unequivocally *contradict* your claim. These regulatory agencies plainly state that these biologic agents have only been partially tested (notably/alarmingly with **nil** long-term testing) and are only granted usage authorizations due to a perceived emergency situation which, they deem, justifies authorisation. The entire premise of that authorisation is to permit usage *despite* the lack of safety evidence normally required.

Furthermore, these "vaccines" are employing quite radical new techniques. The history of these techniques applied to vaccination is relatively short, and this is the *first* time the technology has been applied in humans to any significant degree. That history is also poor, as pre-COVID animal testing of these techniques as vaccines against other pathogens regularly resulted in high levels of adverse outcomes and even mass death of the animal subjects. Furthermore, a significant proportion of those adverse outcomes manifested many months after innoculation ('immune enhancement'), which is alarming given that the current experimental COVID vaccine rollout on humans uses the same technological approach with nil long-term testing and no apparent comment by the manufacturers about the issue of immune enhancement and what changes they believe they have incorporated to mitigate that outcome.

To both inform and further illustrate my point, here is the publicly available data to date on adverse reactions voluntarily reported subsequent to administration of COVID vaccines. For brevity I'll mention only the USA and UK reports:

- In the USA (via the VAERS vaccine adverse reaction voluntary reporting system[1]:

[1] https://vaers.hhs.gov/ and https://www.openvaers.com/openvaers

The number of reported deaths associated with COVID vaccination to date totals 6,985. Whilst some of these reported deaths may be unrelated, the following fact is undeniable and stark: **this death count in just the first 6 months of COVID vaccine rollout exceeds the total deaths reported from administration of all types of vaccines for all conditions in the USA over the 22 year period from 1998 through 2019 inclusive**. So regardless of what proportion of reported post-covid-vaccination deaths are directly attributable to the vaccine, what we can say with certainty is that rate of death reports after COVID-19 vaccination is, at the very least, more than 100 times higher than for pre-COVID vaccines.

- In the UK, the recent (16th) update to their adverse reaction reporting system (the *Yellow Card* system[2]), reports the following totals:
  - Over 800,000 adverse reactions reported:
  - Over 1,100 deaths reported

Restated, according to these publicly available statistics **the likelihood of an adverse reaction or death subsequent to COVID vaccine injection is at least 100 times greater than for any other widely distributed vaccine ever commercialised**. There is no precedent for continuing with vaccine roll-out with such a high adverse reaction reporting rate. Please note (pre-empting scrutiny of this advice) I'm comparing reports of post-COVID vaccine reactions with post-vaccine reaction reports for all other non-COVID vaccines, so questions of causality are irrelevant. In terms of plausibility, no explanation comes close to "whatever is the real rate of harm being caused by the COVID vaccines, it is massively higher relative to any other non-COVID vaccine." All other possible explanations I have considered have very low plausibility.

Professor Tess Lawrie, Director of Evidence-based Medicine Consultancy Limited (UK), has recently released a report summarising/collating/quantifying COVID vaccine adverse reactions in the UK. As a consequence of that data, Lawrie is calling for a complete halt to the COVID vaccine rollout program in the UK due to the unprecedented proportion of harms being reported [LAWRIE2021].

The report also highlights recent research findings (discovered *after* the global vaccine rollout) that reveal some very disturbing new information about these experimental vaccines. These recent discoveries include that the COVID-19 spike protein itself causes endothelial damage [YUYANG2021]. This discovery alone should be shaking the world to its foundations right now when it is recognised that **the mRNA and adenovector vaccines cause the human body to produce a close variant of this previously-thought-to-be-benign-but-now-known-to-be-toxic spike protein!** Despite protests from vaccine manufacturers that their spike protein is different, the post-vaccine harms being reported around the world are predominantly endothelial. This coincidence should be enough to place the burden of proof, of demonstrating vaccine-derived spike proteins are benign, onto the manufacturers. Besides, the vaccine-derived spike protein must be highly similar to wild COVID spike proteins otherwise the vaccine-derived immunity would not recognise the COVID spike. Other recent findings (via FOI request) include that the nanolipids in the mRNA vaccines are circulating throughout the body, which was not

[2]https://www.gov.uk/government/publications/coronavirus-covid-19-vaccine-adverse-reactions/coronavirus-vaccine-summary-of-yellow-card-reporting

expected nor desired. Worse, it shows the nanolipis are preferentially accumulating in the ovaries [PFIZER2021].

Another way to look at the numbers to get a grasp of how alarmingly high the vaccine adverse events are is to realise that, according to the 16th update of the Yellow Card reports, in the UK the chance of an adverse reaction from a COVID vaccine is now 1 in every 142 persons (0.70%) [LAWRIE2021]. This is an unprecedented, incredibly high adverse reaction rate to a "vaccine".

Note also that these reporting systems are voluntary. The study by Lazarus showed that voluntary reporting of adverse events significantly under-represents what the true count would be if reporting was mandatory [LAZARUS2010].

Considering that talk, as they say, can sometimes be cheap, we would be wise to consider various parties commitments (or lack thereof) when money is involved. On that subject, it is public knowledge (although not widely known) that the COVID-19 vaccine suppliers have been granted special indemnity from harms caused by their product. Furthermore, your government has also indemnified persons administrating these substances. *There could hardly be a clearer admission by both the vaccine suppliers and government that both parties know these vaccines do not meet normal safety standards.*

This is the strongest signal of all that the makers/designers of these experimental biologics DO NOT have confidence that their product is sufficiently safe to ensure that they would make a profit if they were subject to product safety laws like every other goods and services provider. As if that weren't enough, a steady flow of internal documents from professional peak bodies (medical boards, pharmacy boards etc) are being leaked into the public domain evidencing that these bodies are effectively issuing "gag orders" on their members to prevent them from giving their personal professional opinion on the safety of these vaccines, and that these bodies are threatening their members with heavy sanctions or even de-registration if they don't parrot official, pro-vaccine positions. On what planet is this conducive to building public trust? If the "vaccine hesitant" are truly misleading people the trust-building response is superior facts and explanations, not suppression. Suppression of professionals from giving their opinions sends precisely the wrong message to your thinking constituents.

Minister Hunt, perhaps you instead meant to say something along the lines of "I **believe** these vaccines are safe and effective, but do recognise that they are experimental biologic agents and testing has been limited"? I would have no objection to you stating your **beliefs** on the subject, but what you actually did was make unequivocal claims that are provably false and concern matters of life and death.

Minister, the Australian people look to you to give honest and true information, and thus I'm gravely concerned that you are propagating a false claim that these experimental COVID vaccines are "safe and effective". Please take this opportunity to correct the record to all attendees of the live event.

Issue #2 - COVID-19 Mortality

A question (raised by myself) was put to you during the live event. My question was along the following lines:

Mr Hunt, you have made many mentions of the fact that COVID is a deadly illness. Please advise us what the government's official understanding is of the Infection Fatality Rate/Ratio (IFR)?

Your answer was fairly summarised as 'I don't know what Infection Fatality Rate means'.

Mr Hunt, there are two COVID mortality measures which stand above all others in importance and appropriateness in terms of risk assessment, and they are the Crude Mortality Rate (or Ratio) and the Infection Fatality Rate (or Ratio).

In simple language, these two terms are defined thus:

1. **Infection Fatality Rate (IFR)** is the probability that a person infected with COVID-19 will die from the infection.
2. **Crude Mortality Rate (CMR)** is the probability that any randomly selected individual from the population becomes infected with COVID-19 and that the infection causes death. In other words, the CMR is the probability of infection multiplied by the IFR, and consequently is always lower than the IFR.

Minister, in terms of understanding how "deadly" COVID-19 is, **there are no measures more important than these**. I was alarmed to discover that you apparently were completely unaware of the IFR (and, consequently, it's critical importance).

Surely it is critical that you, as the "point man" for COVID-19, would have as a central plank of your management plan, an up-to-date understanding of the best available estimates of the IFR. For **if you don't have an objective, tangible *measure* of how deadly COVID-19 is, how can you decide what responses are appropriate and proportional to the risk? How can you decide what harms are reasonable to inflict on society via control measures when you don't have an appropriate measure of the harms you are controlling *for*?** It is not as though these measures have not been available. They have been available for at least 12 months. Of course early on there was more uncertainty and conjecture around those measures, but for at least the past 6 months those estimates have become sufficiently precise, definitive and verifiable via multiple independent methods.

Measures taken to prevent the spread of a communicable disease have adverse consequences. The more draconian or extreme the measures, the greater the adverse consequences. These consequences include harms resulting from enforced social isolation (depression/suicide), harms resulting from financial difficulties due to lockdowns (stress/anxiety/depression/domestic violence), unemployment, poverty, substance abuse, restricted access to medical attention for other conditions and "immune debt" from extended isolation from other pathogens[3],[4]. On the other

[3]https://www.theguardian.com/world/2021/jul/08/new-zealand-children-falling-ill-in-high-numbers-due-to-covid-immunity-debt

[4]https://www.the-scientist.com/news-opinion/the-pandemic-crushed-the-flu-what-happens-when-it-returns-68951

side are harms resulting from the spread of the communicable disease itself (if some/all of the aforementioned measures are *not* taken). My point is that public policy is not only required to consider the harms of COVID (that is to say, allowing it to spread), but rather *steering a path of minimising the combined harms of taking certain actions and not taking others*. But those decisions cannot be made with any technical confidence or justification without having an appropriate measure of risk the disease poses. *Only* upon such measures can the harms resulting from measures taken be balanced against the harms resulting from measures *not* taken. Without such a measurement, one is "flying blind". Being aware of such measures and not taking reasonable steps to ascertain the quantum of those measures is, respectfully, a failure of duty of care - particularly when such measures are readily available from the scientific literature (and can be corroborated by other independent measures, as I describe later).

Furthermore, it doesn't require great expertise to deduce that when a pathogen is orders of magnitude more lethal to a few small subgroups of society and virtually non-lethal to the rest, "one-size-fits-all" draconian control measures are very likely to be directly harmful overkill for the majority with close-to-nil benefit to that majority. Slightly more complicated to grasp is the fact that "one-size-fits-all" control measures actually exposes vulnerable groups to *higher* risk than if control measures were focussed on the vulnerable, as carefully laid out by Professor Kulldorff, a biostatistician at Harvard Medical School way back in April 2020 [KULLDORFF2020] and supported by over 57,000 scientific and medical professionals who are signatories to the Great Barrington Declaration[5]. Why, therefore, is the government persisting with "one-size-fits-all" protection when it is proven to provide inferior protection to the vulnerable, is opposed by such a large cohort of medical and allied professions and is more costly (probably vastly so) than focussed protection?

Adding to my concern is that after you advised that you were ignorant of the IFR, you commented on a statistic you *were* aware of - the "Case Fatality Ratio" (CFR). Minister, surely the numerous scientific and medical advisory committees at your disposal have already advised you of the inappropriateness of CFR as a measure of deadliness of COVID-19? Surely they have advised you that IFR is appropriate and CFR is not? Please see the section below entitled "Additional advice concerning gross measurement incompetence" for more on this.

To the point of understanding the true level of risk to the population, please be advised that the latest meta-analysis of all significant IFR studies to date conclude that **the Infection Fatality Rate for COVID-19 is approximately 0.15%**. This is an extremely meticulous collection and analysis of IFR studies from around the world, from which the above estimate of IFR is determined by the highly respected epidemiologist and biometric data scientist Dr John Ioannidis of Stanford University [IOANNIDIS2021].

Minister, **please take a moment to recognise that the COVID-19 IFR of 0.15% is about the same as the IFR of a bad flu season.**

Put another way, the chance of survival if infected with COVID-19 is approximately 99.85%. Of course, as already pointed out the risk profile is heavily skewed to the elderly and those with very specific health conditions (such as obesity and vitamin D deficiency).

[5] https://gbdeclaration.org/focused-protection/

Virtually all the mortality estimates offered by the media and most of the peak bodies (WHO, CDC, Johns Hopkins, Imperial College etc) were far higher than occurred in reality and were often inadequately or inappropriately described.

If further independent corroborating evidence would help you grasp this fact, please research for yourself the deaths *from all causes* for the year 2020 in regions that are universally understood to have experienced severe outbreaks. For example, consider the all-cause mortality statistics from the UK government's Office of National Statistics [UKONSACM2021]. There you will find that the age-adjusted all cause death rate in the UK for 2020 barely changed. The 2020 death rate was no different than back in 2010. In 1990, the death rate was 40% higher than in 2020. You can look this up for other countries that had "bad" outbreaks and you will find basically the same, fairly consistent, results - just a blip in all cause mortality (for *both* lockdown-heavy countries and hands-off countries like Sweden). For the avoidance of doubt, please note I am *not* suggesting all-cause mortality data is proof that the IFR is very low - rather, I'm suggesting it is independent corroborating evidence. Experts in the field of measurement value independent estimates highly for their corroborative (or falsifying) power. Audits of undertakers records in those jurisdictions will further corroborate this evidence.

Further corroborating information can be found in the life insurance space. I invite you to contact insurers in regions widely regarded as worst affected by COVID and enquire as to the magnitude of change to premia or policy terms as a result of COVID. You will find that the overwhelming majority of life insurers have not significantly raised their premiums due to COVID. The only major changes to terms that I've found is that some insurers are lowering the maximum age, which makes sense in the light of the massively higher risk COVID poses to the very elderly. Again, to remove doubt, I'm noting this as further corroborating information only. Insurance premium modelling is highly complex and I recognise there is nuance here. However, it carries significant evidentiary weight at least to the extent that there are no reports of COVID causing serious financial hits to insurers generally. It's also insightful to recognise that insurers are somewhat unique in that they financially suffer if they miscalculate COVID risk in either direction - *they suffer if they under-estimate the risk, but will also suffer if they over-estimate it.*

Minister, as you declared you did not know what IFR *was*, I am concerned that your scientific and medical advisory teams have inadequately informed you. I'm gravely concerned that you have allowed yourself to succumb to fear and hysteria, as so much of the world has. I'm deeply concerned you've been given inappropriate, inaccurate and outdated measures of risk and, based on that misinformation, you are implementing measures that are overprotective of COVID risks and consequently adversely affecting the broad population as a result of those measures, in myriad ways.

You are not the only person who has been misled by inappropriate measures such as the Case Fatality Rate - much of the world has been pressed into an hysterical state by the media and (appallingly) many supposedly reputable scientific and medical institutions and "peak" bodies. The misleading information goes far beyond misrepresenting CFR. Other abuses include failing to inform about CMR and IFR, instituting horrendously flawed counting methods and massively oversensitive testing regimes (more on that below).

Additional advice concerning gross measurement incompetence

As I (hopefully) have your attention, I wish to pass on my advice concerning what I regard as egregious incompetence in the protocols of measurement, analysis and reporting of COVID measurements and statistics. This is occuring on a global scale. You may have limited influence at the global level, but there is only harm in perpetuating these egregiously flawed systems in Australia.

Early in the outbreak I tried to engage the government on these issues through my connection with the National Measurement Institute, but was unsuccessful in obtaining their interest. I was advised at the time that the NMI had no formal involvement in any advisory capacity on COVID which, if true, is disturbing. The NMI houses the creme-de-la-creme of measurement, statistical and risk quantification expertise in Australia, and if they were not engaged to advise on appropriate measures, appropriate analysis and appropriate reporting of measurements, then this was/is a major missed opportunity.

Firstly, I wish to describe how the protocols around the counting of covid-related deaths are absolutely appalling and misleading in the extreme. I cannot fathom why it became the de-facto standard to count COVID-19 deaths as (summarised) '*anyone who died that had a positive PCR test'... (using outrageously high PCR Ct values guaranteed to generate a high proportion of false-positives) '...within 30 days of test or was symptomatically 'deemed' to have COVID"*. Furthermore, in many jurisdictions, there were no measures in place to prevent double-counting of test results. The massive flaws in this counting method would be obvious, even to a child, once this process was explained to them. If testing is widespread (and it was/is), this method is guaranteed to massively overcount "cases".

That brings me to the next point: what is a "case"? The term has been completely redefined in the era of COVID, but no one has notified the population that the meaning of the word has been substantially changed. Pre-COVID, a "case" was a person experiencing symptoms of illness warranting medical attention. Post-COVID, a "case" is anyone with a positive PCR test, most of whom do not experience symptoms warranting medical attention. This is a huge change in language that biases the emotional fear response when discussing "cases".

The thing that is utterly mystifying to me is why these death counting and "case" counting methodologies were chosen at all. Even a science undergraduate with relatively limited training in measurement would be aware they were basically "throwing the measurement book out the window" by choosing these methods. Yet these methods were supposedly established by experts at the highest levels of the scientific hierarchy, and yet they made such egregious and fundamental violations of basic measurement practice? What on earth is going on here?

I will highlight the absurdity further. If we consistently apply the aforementioned definitions of "cases" and "deaths", then that means that the world is currently in the midst of a enormous chickenpox and shingles global pandemic that dwarfs COVID-19. If we were to extensively PCR test for the causative virus, varicella-zoster, we would find that almost everyone older than 10 years of age has the virus [KOWITDAMRONG2005]. Chickenpox can kill and shingles is incredibly painful. To further illustrate the madness of these central COVID metrics, if we were to count "deaths" from our "chickenpox pandemic" using the same method as much of

the world counts "COVID deaths", we would discover that almost every death globally in the past 12 months would be a "chickenpox death". The moral of this story is this: *measuring with deeply flawed methods is guaranteed to yield deeply flawed and misleading results.*

Intriguing, to say the least, is the contrast between the COVID "case" and death counting methods and the vaccine reaction and death counting methods. When it comes to officially counting vaccine-related deaths and injury, all of a sudden (as if by magic) the professional analysts come out of the woodwork, with finest-of-fine toothed combs in hand! For reported post-vax reactions the process of determining causality of adverse reaction reports is painstakingly rigorous! Where were these analysts when the protocol for counting COVID cases and deaths was developed? Furthermore, there appears to be a policy that all reported adverse events are presumed **unassociated** with vaccination unless no other possible cause can be identified. This presumption is favourable to vaccines and yet apparently it's fair to presume COVID was the cause of all deaths unless proven otherwise (and sometimes even *despite* proof to the contrary). *The chasm of difference in protocols, rigour and presumption of cause when counting official vaccine injuries compared to the official COVID death counts could hardly be more wide or deep.*

Regarding the matter of "Case Fatality Ratio" (CFR): Minister, when you advised the live conference attendees that you did not know what IFR meant, you made comments about the CFR (and stated that you believed the CFR was 2%). Understanding you are not a scientist, I will attempt to describe CFR in basic terms: If I get a COVID-19 infection, and if it makes me sick enough that I end up in hospital, then CFR is an approximate estimate of the probability that I will end up dying from COVID-19. This statistic is useful for hospital-capacity-planning and for admitted patients suffering significant symptoms *only* - it is essentially meaningless outside this very limited context. **The CFR is, by definition, inappropriate for use in the assessment of risks and control measures applicable to the non-hospitalised population.**

Minister, given that you appear to be unaware of the meaning and measure of IFR and given that you know about the CFR and chose to mention it, I am concerned that:

1. You think CFR is indeed an important and relevant measure outside a hospital-capacity-planning setting; and
2. You have erroneously concluded that a CFR of 2% means that 2% of people who are infected with COVID will die from it (because you are interpreting the CFR as if it was the IFR).

Can you please confirm to me whether or not you believe approximately 2% of people infected with COVID will die from COVID? To be clear, that would mean that around 40 MILLION additional deaths would have occurred in the first year[6]. I certainly hope that's not what you think, and clearly this did NOT occur. However, if you did think 2% of infected people would die from COVID, then it would explain your support for draconian lockdowns, travel bans, vaccine passports and vaccination with experimental biologic agents.

I also take this opportunity to briefly touch on the issue of the egregious flaw in COVID test methodology. Specifically the decision taken by whatever globally-influential person(s) or

[6]IOANNIDIS2021 determined that approximately 2 billion people had been infected with COVID-19 in the first 12 months. 2% of this figure is approximately 40 million.

group(s) to advocate for PCR test Cycle Threshold/Cycle Count (Ct) values at levels KNOWN to guarantee that a significant proportion of results would be false positives.

That Ct values above the high teens to low twenties are known to generate a significant number of false positives is not controversial to anyone in the field. Determining the appropriate Ct value to use for a test is part of the basic operating procedure, as is understanding consequences of setting Ct to high or too low. As Ct for the test is increased, the likelihood of a false positive result increases. And yet Ct values well above 30 and often in the 40's are being used, in which case most of the positive results are effectively guaranteed to be false positives. In case you don't understand what that means: A false positive is a positive result from the test but the patient does not actually have an infection in any meaningful sense (and is not contagious). Granted, I'm not overly familiar with the testing methods currently employed in Australia, and I acknowledge that false positives can be mitigated by re-testing the individual multiple times. If multiple retests of positives is standard practice in Australia *before* officially regarding the test result as positive, then my concern on this specific point is resolved at least in the Australian case. But this is indeed a problem internationally, as evidenced by a recent landmark court ruling in Portugal that went largely unreported[7].

Also of concern is the conspicuously timed changing of counting methods without separating the "new method" counts into a separate data series. Despite the fact that Ct setting is a standard operational consideration, we find that supposed leading "experts" like Anthony Fauci knew of this issue for at least many months but changes to procedures only began with gusto precisely coincident with commencement of vaccine roll-out[8][9][10]. Fixing the poor operating procedures at the same time as commencing the vaccine rollout will cause the "case" counts to be biased much lower than previously. To the all but the most discerning eye it will paint a distorted picture of vaccine success.

I also raise the abuse of key vaccine safety statistics that have been eagerly promoted not only by the manufacturers, but also by government and media. Blaring from every TV and press conference prior to the release of the experimental COVID vaccines were 'effectiveness percentages'. The numbers varied slightly, but by way of illustration we would be told that Pfizer was (say) "97.5% effective" and Moderna was (say) "95% effective". The deceptive and misleading conduct here is that these are *relative* measures of risk reduction, not *absolute* measures. Such a high level of relative risk reduction is only numerically significant if the underlying mortality risk of the pathogen is high. But in the case of COVID, the underlying mortality risk is low (IFR ~0.15% as previously referenced).

In the case of COVID and using an IFR of 0.15% and a (relative) risk reduction of 95% (RR_{rel}), then the absolute risk reduction (RR_{abs}) is calculated as follows:

$$RR_{abs} = IFR \times RR_{rel}$$

[7]https://www.rt.com/op-ed/507937-covid-pcr-test-fail/

[8]https://www.fda.gov/medical-devices/safety-communications/risk-false-results-curative-sars-cov-2-test-covid-19-fda-safety-communication

[9]https://off-guardian.org/2020/12/18/who-finally-admits-pcr-tests-create-false-positives/

[10]https://pjmedia.com/news-and-politics/stacey-lennox/2020/11/09/dr-fauci-told-the-truth-about-covid-19-tests-in-july-and-has-been-misleading-the-public-ever-since-n1131938

$$RR_{abs} = 0.0015 \times 0.95 = 0.001425$$

Therefore, expressed as a percentage, in this case the *absolute* risk reduction offered by the example COVID vaccine is a mere 0.1425%. Note also that this analysis assumes the vaccine is 100% safe. If it is not, the absolute risk reduction is further reduced proportional to the risk of harm from the vaccine.

To reinforce this, please note the recent study that quantifies how tiny is the reduction in absolute risk that these vaccines offer. The study quantifies the effect in terms of Number Needed to Vaccinate to prevent one death (NNTV). They found that the NNTV is between 9,000 and 50,000, and that according to the adverse reactions reports to date, for every three deaths prevented by vaccination we have to accept two deaths connected with vaccination [WALACH2021]. To remove doubt, I'm fully aware this paper has been retracted by the editors of the journal. My mention of this retracted paper is intentional because it highlights what I perceive is a massive schism going on in COVID science. The retracting editors assert that the paper assigns the cause of adverse event reports to the vaccines, but these editors contend that the link has not been established by appropriate case-by-case assessment. In that case, edits to the paper to clarify this should have been acceptable and it could have remained published as amended. But what this saga of retraction highlights is that the editors appear completely blind to the fact that most of the COVID death counts have not been causally linked according to the same evidentiary standard either. The consequence of this is that *if the editors are going to retract this paper for the stated reasons, then rules of consistent treatment dictate that the thousands of papers published on COVID "deaths" to date must be retracted also.*

Finally, I would like to point out that COVID death totals from all the popular sources continue to INCREMENT since the beginning of the outbreak approximately 18 months ago. This is another egregious inconsistency, as all other influenza and coronavirus harms are measured on an ANNUAL BASIS (because they are endemic, *seasonal* illnesses). It is highly misleading to count COVID-19 impacts on a never-ending cumulative basis like this. If we did the same for influenza (where should we start counting from? 1900? 1950? 1990?), the flu death counts would dwarf COVID-19 and we would be perfectly justified in saying that the impact of COVID-19 is insignificant compared to influenza.

Given the extreme degree of abuses of good measurement practice, and considering that almost every abuse and inconsistency tends to make COVID appear more dangerous than it is and make vaccines appear safer and more effective than they are, is it any wonder that thinking people are questioning such abusive practice and advocating the likelihood that bad actors are coordinating to either harm society and/or make undeserved profits?

Closing remarks

I believe it's reasonable, necessary and appropriate that you issue a public retraction or clarification to all attendees of the live event concerning your unequivocal statement that the AstraZeneca and Pfizer vaccines are both unequivocally "safe" and "effective". Concerning the assertion of safety, your claim is provably false. Concerning the assertion of effectiveness, the data is far from supportive.

Minister, when the dust settles and the truth becomes widely known (and it will) that COVID-19 is similarly deadly to a bad flu, there are going to be growing numbers of very angry voters. When the publicly available statistics on the adverse reactions to these experimental COVID-19 vaccines becomes widely available, are you going to feel comfortable having told Australians unequivocally that "both are safe" and "both are effective"? It will gradually become clear to the public *who knew what and when*.

The time may be right to reconsider your position and to advocate in Parliament for a complete root-and-branch reassessment of the COVID-19 risk data and vaccine safety data, "red team" style. Would you not prefer being able to legitimately claim (at some point down the track) that your decision for a root-and-branch independent review uncovered important truths that turned the tide on the COVID story or are you confident that you will be able to deflect the fury of constituents if (in my view, *when*) the truth comes out?

In case you are unaware, "red teaming" is the creation of a completely independent team of skilled doctors, scientists and researchers (with a preference to select those who have a demonstrated history of opposition or scepticism to the current consensus) tasked with the root-and-branch review and critical audit and assessment of the analysis and reports of the groups that currently advise you. Generalists with broad skills and keen and skeptical analytical minds are also invaluable assets to red team projects. Naturally the "red team" analysis would include:

- Assessment of the risks of the virus itself;
- Assessment of the risks/harms of measures taken to fight COVID;
- Assessment of the risks of the current experimental vaccines, particularly in light of the adverse events following real-world deployment;
- Assessment of the risks and benefits of many available treatments - some of which, according to my research, show statistically undeniable efficacy to the extent that it renders vaccines unneccesary for all but a few relatively small highly vulnerable cohorts.
- A thorough audit of the documented and potential undocumented conflicts of interest of all parties that the government has commissioned to provide advice to government on risks of COVID, risks of countermeasures, risks of vaccines and efficacy of COVID prophylactics and treatments. Particular regard should also be paid to accidental or intentional "committee-stacking".

And yes, your advisors may have already conducted their own assessments of these matters but "red teams" are independent; they are fresh eyes on the issue. Getting stuck in a rut, losing perspective (myopia) and groupthink are common ailments in any group of individuals working on a problem for extended periods. "Red teaming" has become very popular in business because it provides real value by reducing the aforementioned ailments and can expose opportunities that would have otherwise been missed. I'm also concerned that consensus-taking has dominated truth-seeking. If consensus were the measure of truth, most innovations and advances we enjoy today would not exist.

Regarding a retraction or restatement of your comments made in the live event and considering the urgency of the issue given so many Australians are currently being subjected to lockdowns regardless of their mortality risk, please respond within 14 days of the date of this letter. In the event that I don't receive a substantive response from you in that time I feel an obligation to

raise this issue more widely, as it goes to the heart of issues facing Australians today.

Yours sincerely,

John W Clark (BE Hons 1A)
Engineering, Design and Laboratory Manager. Legal Metrologist.
Email: level323@theinsideworld.net
Phone: 0418323344

References

LAZARUS2010: Lazarus, Ross, Michael Klompas. 2010, "Electronic Support for Public Health–Vaccine Adverse Event Reporting System (ESP:VAERS)". https://www.openvaers.com/images/r18hs017045-lazarus-final-report-20116.pdf

LAWRIE2021: Lawrie, Tess. "Urgent Preliminary Report of Yellow Card Data up to 26 Th May 2021." Evidence-based Medicine Consultancy Ltd, June 9, 2021. https://b3d2650e-e929-4448-a527-4eeb59304c7f.filesusr.com/ugd/593c4f_98907a7c2cea423d866de479f16575df.pdf

YUYANG2021: Lei, Yuyang, Jiao Zhang, Cara R. Schiavon, Ming He, Lili Chen, Hui Shen, Yichi Zhang, et al. "SARS-CoV-2 Spike Protein Impairs Endothelial Function via Downregulation of ACE 2." Circulation Research 128, no. 9 (April 30, 2021): 1323–26. https://doi.org/10.1161/CIRCRESAHA.121.318902

PFIZER2021: Author unknown. "SARS-CoV-2 MRNA Vaccine (BNT162, PF-07302048) Summary of Pharmacokinetic Study (Translated from Japanese)." Pfizer BioNTech. Accessed June 3, 2021. https://www.naturalnews.com/files/Pfizer-bio-distribution-confidential-document-translated-to-english.pdf

KULLDORFF2020: Kulldorff, Martin, "COVID-19 Counter Measures Should be Age Specific", Accessed 1 July 2021, https://www.linkedin.com/pulse/covid-19-counter-measures-should-age-specific-martin-kulldorff/

IOANNIDIS2021: Ioannidis, John P. A. "Reconciling Estimates of Global Spread and Infection Fatality Rates of COVID-19: An Overview of Systematic Evaluations." European Journal of Clinical Investigation n/a, no. n/a: e13554. Accessed April 9, 2021. https://doi.org/10.1111/eci.13554

UKONSACM2021: Office for National Statistics (United Kingdom), "Deaths in the UK from 1990 to 2020", FOI report, 5 February 2021,
https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfoi/deathsintheukfrom1990to2020

KOWITDAMRONG2005: Kowitdamrong E, Pancharoen C, Thammaborvorn R, Bhattarakosol P. The prevalence of varicella-zoster virus infection in normal healthy individuals aged above 6 months. Journal of the Medical Association of Thailand = Chotmaihet Thangphaet. 2005 Sep;88 Suppl 4:S7-11.

WALACH2021: Walach, Harald, Rainer J. Klement, and Wouter Aukema. 2021. "The Safety of COVID-19 Vaccinations—We Should Rethink the Policy" Vaccines 9, no. 7: 693. https://doi.org/10.3390/vaccines9070693 (Subsequently retracted by journal editors)

/ends