COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

LEGAL AND CONSTITUTIONAL AFFAIRS REFERENCES COMMITTEE

COVID-19 Royal Commission

(Public)

THURSDAY, 1 FEBRUARY 2024

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

LEGAL AND CONSTITUTIONAL AFFAIRS REFERENCES COMMITTEE

Thursday, 1 February 2024

Members in attendance: Senators Antic [by video link], Green, McLachlan [by audio link], Rennick [by video link], Roberts, Scarr and Shoebridge

Terms of Reference for the Inquiry:

That, noting that a fully empowered Royal Commission with appropriate terms of reference is necessary to learn from the unprecedented government response to COVID-19, the following matter be referred to the Legal and Constitutional Affairs References committee for inquiry and report by 31 March 2024:

The appropriate terms of reference for a COVID-19 Royal Commission that would allow all affected stakeholders to be heard.

WITNESSES

BEGG, Mr Morgan, Director of Research, Institute of Public Affairs [by video link]

PRASSER, Dr Scott, Private capacity [by video link]

WILD, Mr Daniel, Deputy Executive Director, Institute of Public Affairs [by video link]

YOUNG, Mr Graham, Executive Director, Australian Institute for Progress [by video link]

Committee met at 08:30

CHAIR (Senator Scarr): I declare open this public hearing of the Legal and Constitutional Affairs References Committee into a proposed COVID-19 royal commission. I thank the witnesses, who are joining us via videoconference. I acknowledge the traditional custodians of the land on which we meet and pay respect to their elders past and present. I also acknowledge and welcome other Aboriginal and Torres Strait Islander people who are participating in today's public hearing. The committee's proceedings today will follow the program as circulated. These are public proceedings being broadcast live in Parliament House and via the web.

I remind witnesses that in giving evidence to the committee they are protected by parliamentary privilege. It is unlawful for anyone to threaten or disadvantage a witness on account of evidence given to a committee, and such action may be treated by the Senate as a contempt. It is also a contempt to give false or misleading evidence to the committee. The committee prefers evidence to be given in public, but under the Senate's resolutions witnesses have the right to request to be heard in confidence, described as being in camera. If you are a witness today and intend to request to give evidence in camera, please bring this information to the attention of the secretariat as soon as possible.

If a witness objects to answering a question, the witness should state the ground upon which the objection is taken, and the committee will determine whether it will insist on an answer having regard to the ground which is claimed. If the committee determines to insist on an answer, a witness may request that the answer be given in camera. Such a request may, of course, also be made at any other time. Witnesses are reminded that, if they give evidence that reflects adversely on another party, the committee is generally required to give that party reasonable access to the evidence and an opportunity to respond.

I remind people observing today's hearing that taking photographs or video while the committee is in session is not allowed without the express permission of the committee. Those in the public gallery, which is empty at the moment, are also reminded that they may observe but not otherwise participate in the hearing. I note we have a representative of the media here. Having conferred with my colleagues, we are comfortable with the media being here.

I now welcome representatives from the Institute of Public Affairs, the Australian Institute for Progress and Dr Scott Prasser. Thank you for taking the time to speak with the committee today. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. Thank you for taking the time to speak with the committee today. Would you like to make a brief opening statement before we go to questions? Does the Institute of Public Affairs have an opening statement?

Mr Wild: By way of a brief opening statement, it is our view that there ought to be a full royal commission that investigates all facets of the government response to COVID, including that of state governments, which were primarily responsible for measures such as lockdowns and mandates. These measures dramatically affected the lives of every Australian, and Australians deserve a full and transparent royal commission into these matters to make sure that the same mistakes are not repeated. The current government departmental inquiry into COVID is inadequate because it explicitly excludes 'actions taken unilaterally by state and territory governments', which would include lockdowns and mandates. The responses of governments to the COVID-19 pandemic were among the biggest policy failures in Australia's peacetime history. Lockdowns were wildly disproportionate to the risk that COVID posed to most Australians. Certainly, the elderly, the vulnerable and those of ill health deserve policy that would protect as far as possible their health, but this could have been best achieved through targeted measures, for example, focusing on aged care facilities. Lockdowns were always a blunt measure that had little regard for the risks that COVID posed to different sections of society. Nor did governments adequately take into consideration the substantial and ongoing social, economic and humanitarian consequences of those policies. The impact on young Australians, schoolchildren in particular, will be felt for generations. The impacts of lockdowns were also highly inequitable, with small businesses, private sector workers and low-income earners those most affected.

For example, research by the IPA showed that from March to November 2020 jobs in the private sector dropped by 300,000 while jobs in the public sector rose by 25,000. Jobs for young Australians, over that same period, aged 15 to 34 dropped by 158,000 and rose for those aged over 34 by 20,000. From 20 August 2019 to

2020 over half a million jobs were lost for those in the bottom 20 per cent of income earners, while 195,000 jobs were added for those in the top 20 per cent of income earners.

This goes part of the way to explaining why many in big business—those who are relatively well off—and public sector bureaucrats were often among the loudest supporters of lockdowns. They saw a net transfer of wealth to themselves from lower income Australians. Then there were the inflationary consequences of state and federal government spending. Our research estimates direct financial costs of government spending on COVID reached $938 billion by the end of financial year '21-22, and of interest to the current situation our research also highlighted that some 40 per cent of the total inflation from March 2020 to June 2021 was from government COVID spending. This is to say nothing of the astonishingly cavalier attitude of many political leaders, who routinely breached basic rule of law protections, and the role of the media, which in many ways appeared to be a communication arm of governments rather than holding decision-makers to account, or the dramatic curtailment of freedom of speech, religion and assembly.

Australians deserve a full inquiry by way of a royal commission into all aspects of COVID to ensure that the same mistakes and failures are never repeated. Thank you again for the opportunity to appear, and we welcome any questions you may have.

CHAIR: Can I ask you to take on notice provision of the research, if you have details with respect to the research, that the IPA undertook and which you referred to in your opening statement? I would find it helpful if you could provide that to the committee on notice.

Mr Wild: I am happy to.

CHAIR: We'll now go to the Australian Institute for Progress. Mr Young, do you have an opening statement?

Mr Young: I think our submission speaks for itself. Our policies in dealing with COVID were, in my view, the worst ever public policy and public health failing in this country. The amount of money that we spent on COVID was, as a percentage of GDP, equivalent to one year of World War II. We weren't looking at a situation anything like World War II. It was a failure of the administrative processes, and it was also, I would suggest, a failure of processes in terms of dealing with public health. We had pre-existing pandemic plans that were not adhered to. The process of changing from the accepted plans to the ad-hoc plans was in no way transparent. There was no evidence available on the public record, and I suspect available to the people making the decisions. We early on knew that the pandemic was not going to be as severe as some feared in the first instance. We relied on estimates particularly from people such as Neil Ferguson in London, who have in the past wildly exaggerated the possible effects of diseases. We knew from the *Ruby Princess* that it was not going to be anything like that severe, because we had a universe there that was limited, with old people in it, and we knew the death rates would be nothing like were projected. However, we proceeded in a way that appears to us to have been quite panicked. We then took measures for which there appeared to be no cost-benefit analysis. We had decision-making processes where the people making the decisions didn't appear to be diverse enough to make those decisions in a way that took into account the needs of the whole community. So, it seemed to be dominated by hospital administrators, and hospitals don't need to worry about sustaining themselves; they're sustained by the economy around them. Countries cannot take the same position as a hospital might in the case of disease.

There was also the situation where independent researchers were not allowed to try alternative medicines and procedures and where doctors were told by their professional organisations that they could not use repurposed drugs, which is a normal procedure that happens when you get anything like this. What it essentially means is that the sources of research aren't limited to just a few government approved organisations, it's diversified through the whole community and we learn by trial and error.

The result of that is that there is a currently unexplained increase in what is called excess deaths. They take the five-year average of deaths. If you have a figure that's higher than the average, you call that excess deaths. We have severe excess deaths in Australia, and when you compare that with a country like Sweden, which did what the pre-existing pandemic plans said and seemed to have a transparent and appropriate decision-making process, it's much worse. If we had this level of deaths from car accidents, we'd have two or three royal commissions. If we had it for maritime incidents, we'd have two or three royal commissions. It's a serious issue and it affects people of working age more than it affects people of the age who are most vulnerable to COVID. It's a question that needs to be answered. I can't tell you what the answer is; hopefully a royal commission could.

CHAIR: Mr Young, your connection is not perfect. At times we're getting a bit of interruption. We'll see how we go. I think we got all of that opening statement, but sometimes it's easier if you go off video and just go on the telephone connection. My secretariat is going to give me some technical advice on this. I'd ask all witnesses, when you're not speaking, to put yourself on mute. That will assist the technology. With everyone on

videoconference this is bringing memories back of committees we held during the pandemic. I'd ask everyone to use their mute buttons. Dr Prasser, do you have an opening statement?

Dr Prasser: Yes. My submission is less to make an assessment of what went right or wrong but to look at what is the best instrument we should have to review what happened. Overall Australia did better than some other countries, and our economy has bounced back, but there was a whole litany of issues, claims and counterclaims. My submission is asking how best should we review what happened. I think a royal commission should be appointed. Why? Because it has coercive powers of investigation. If there's going to be a royal commission into Australia's response to the pandemic, it has to be a federal-state royal commission. A federal royal commission by itself cannot investigate state issues. The states have also to sign up to a joint royal commission. There are many precedents for such royal commissions Australia—Aboriginal deaths in custody, bushfires, institutional sex abuse and so on. We have lots of precedents. At the beginning of the pandemic when certain groups said we should have a royal commission it was to me very clear there were going to be problems with the incumbent government setting up such a body. My submission is really saying that there are two types of inquiries. One is a statutory one with powers of coercion and investigation. The other is a non-statutory one like we have at present that the government has set up. Those sorts of non-statutory inquiries can be very important and helpful, but in this case where there is so much debate about what governments should do or what governments did not do, about what information was available and what information was released and the evidence for what they did, the only way we are going to get to the truth about this matter is with a review.

Also, I think it's worth pointing out—as I'm sure the other participants know—that after every disaster or calamity the general tendency has been in Australia to appoint a royal commission to find out what the facts are as distinct from all of the political debate going on. So, to find out who did what, who is accountable, and what the truth of the matter is.

We had a royal commission into bushfires in 2009. We've had royal commissions into floods. We've had royal commissions into bridge collapses. To me, the normal position should be to appoint a joint federal-states royal commission. That's my basic theme. We need a royal commission that is appropriately set up.

Also, I point out in my submission that, overseas, a number of countries set up similar bodies early on in COVID. Sweden was the first. It had a commission of inquiry. That was a very Swedish mechanism headed by a Supreme Court judge with seven other members from across different disciplines. Norway followed. Britain finally set up one.

Lastly, I'd point out one thing. As to federal systems of government—interestingly, Canada has not had a national inquiry into the COVID response and nor has the United States. A bill to set up a presidential commission in the United States has largely languished. In the United States, the President can set up a presidential commission that requires Congress to give it powers to subpoena witnesses. It's completely stopped there. That's very interesting.

My view is that we need to know what really happened. Let's not prejudge it. Let's get the facts, work out what happened, and then we might be able to set up, as in New Zealand, a royal commission to find out how we can better manage such things in the future, given a further possible pandemic is to be expected.

CHAIR: Thank you for your very extensive submission. We'll now go to questions. I'll give the call to Senator Roberts.

Senator ROBERTS: I must commend all submissions. They're excellent. Dr Prasser, yours stunned me when I read it. I did some research. You've written two books on royal commissions. I'm going to ask you all this first question. How many royal commissioners would be required to accurately inquire into and report on your terms of reference?

CHAIR: Dr Prasser, we'll go to you first.

Dr Prasser: I certainly believe it should be a multimember royal commission. There are plenty of examples of that. But it shouldn't be too many. One of the problems with setting up a royal commission into this issue is there is a whole range of different professions and disciplines involved. You would set up a royal commission of three to five members and you'd have a reference group of federal, state and other professional bodies to be involved. There are a lot of precedents for such royal commissions. If you make a royal commission too unwieldy it will not be effective. The Swedish model to me is a good one. They have seven. A Supreme Court judge chaired it. They had experts from public policy, health, local government and ethics—I think a Lutheran pastor. They had that sort of committee plus a reference group that was referred to.

The English inquiry has only a single member, a former Supreme Court-type judge. The New Zealand one has three members on its inquiry, including an expert on health, a person who understands the economy and a new

member they've just reappointed. I think it has to be multimember, but be careful not to have too many, otherwise it will sink in its own complexity.

CHAIR: Mr Young?

Mr Young: Thank you for the question. It's not something I'd turned my mind to before you asked the question. I think Dr Prasser's answer was pretty comprehensive. I'd solely make the point that a lot of commissions suffer from being run by lawyers, and lawyers have a particular way of looking at the world. I'd suggest that whatever number you have the number of lawyers should be limited to one and the professions of the others be broadly spread across the areas that need to be dealt with. You certainly need someone who's a health economist and someone who is in the medical field.

CHAIR: The Institute of Public Affairs.

Mr Wild: We'd broadly share Dr Prasser's assessment; something around three to five is a reasonable number. The key here—and this has already been mentioned—is to make sure there's a diversity of backgrounds and experiences of any members on such a royal commission. As you know, one of the key problems we had throughout the COVID period was that so much of the initiatives and policies were being driven by one perspective, the health perspective, aimed at eliminating COVID entirely, quite often, and that came at the expense of having other views such as the social, humanitarian and economic consequences of those policies. I would say, regardless of whatever the number is that you might reach, the diversity of background would be absolutely critical to having a proper and fulsome inquiry.

CHAIR: Senator Roberts.

Senator ROBERTS: Two of the groups represented, the IPA and AIP, have called it the biggest failure of policy, yet the severity of COVID was told to me by the Chief Medical Officer to be low to moderate, less than some past flus that have come to this country. After the virus effects passed, we saw in 2022 some 13 per cent excess deaths. That's 26,000 excess deaths. We see breaches of human rights, medical standards and laws. There has been a monstrous economic cost, a huge impact on individuals and communities, and censorship never seen before in this country, not even in wartime. Can you think of any past royal commission that was more worthy than this one?

Dr Prasser: So, your question is: do you think there have been other royal commissions that were as important as this issue? Is that what you're suggesting?

Senator ROBERTS: Yes.

Dr Prasser: I don't want to go back into too much history, but after the 1919 pandemic Australia did not have any royal commission into that pandemic. During that period they had the same sorts of problems we have now. The federal government only had a quarantine officer. It had no Department of Health. There was a complete breakdown between federal and state governments and between state governments cooperating with each other. Victoria wouldn't tell other states how many people had the Spanish flu or not. What happened after that is really interesting. The chief quarantine officer was a guy called John Howard Cumpston. He convinced the Billy Hughes government to set up the first Commonwealth Department of Health in 1921, and he became the director-general, even though the Commonwealth had no powers on health issues. Billy Hughes was replaced in 1922 by Stanley Bruce. He convinced Stanley Bruce to set up a royal commission into Australian health. He wrote the terms of reference for that. That royal commission consisted of doctors, including the first female commissioner, Dr Jean Greig, a very well known Scottish doctor.

That royal commission looked at the Australian health system. It looked at maternity wellbeing, sexually transmitted diseases, vaccinations, tropical health and the need for intergovernmental cooperation on health issues. It was very important. In the 1920s we had a lot of sexually transmitted diseases from men coming back from the war. We had the pandemic, where 30,000 Australians died. That very important royal commission laid the foundations for Australia's national health system. That's one example of a royal commission.

In terms of health and wellbeing, this potential royal commission must exceed all previous ones. Even with the ones we've had into bushfires, although there were unfortunate deaths in the Victorian and more recent national bushfires, the deaths did not approximate the number of deaths from this recent pandemic. This is one of the issues. How many people actually died of COVID? There's a lot of confusion around that issue. We need a royal commission. I'm a bit surprised that we still haven't got one.

To answer your question, I don't think there's been an issue of such national importance. There have been lots of royal commissions into important issues. With the bombing of Darwin by the Japanese in 1942, there was a secret royal commission released after the war. There are lots of examples of royal commissions into really important issues—corruption, scandals, health issues, bridge collapses and so on—but no other issue has affected

so many Australians and in such a big way as this one. This should be a major priority. All we've had so far is a private royal commission headed by Peter Shergold, which called for more information. We've had the Western Australian inquiry, which was not really a very important inquiry. I think we need to have this. This is an area of maximum public policy interest and concern.

CHAIR: Mr Young.

Mr Young: I'm not sufficiently well versed in the history of royal commissions to give you some sort of a hierarchy, but you're right to highlight the excess deaths, as I highlighted in my opening remarks, because it is the one measure by which we can objectively look at what was done and say, 'Something here was done less well than it was done elsewhere.' The fact that we have excess deaths means that we have decreasing life expectancy. I would have thought that would be a matter of national concern. I've never during my life ever seen a year that I can remember life expectancy dropping. To put the matter into a broader framework, in Queensland we have what are called industrial manslaughter laws, which means that if by the negligence of the employer someone dies in the workplace the corporate veil may be stripped away and directors held personally liable for that death. We're looking at something similar to that but on a national scale, and a scale that no industry would tolerate. A dangerous industry like the mining industry has fractions of a percent of accidents let alone deaths, and here we have a figure 10 per cent or 15 per cent higher than what we normally would have. That is a lot of people being affected.

CHAIR: The Institute of Public Affairs?

Mr Wild: It's certainly hard to think of any issue that's more deserving of a royal commission certainly in the post-World War II era than this, the response to COVID. It went on for the better part of two years. It affected the lives of every single Australian in dramatic and ongoing ways, as we alluded to in our submission and in the opening remarks. The consequences of this are still being felt today and they will be for many years.

The key is to understand why decisions were made in the way they were made and how this country kept on pursuing the COVID elimination strategy for so long even though it was understood, in many quarters, that was not only basically impossible but also that the consequences of pursuing that were so dramatic and so great it was almost unconscionable to continue with those lockdowns. We're in Victoria. There was the closing of playgrounds and many other activities. We saw the extreme lengths that governments went to, with Zoe Buhler, for example, being arrested for putting her opinion on social media. We need to understand how these egregious breaches of our rights and freedoms and significant impositions on our basic day-to-day lives could be perpetrated and happen for so long. It is difficult to think of any more pressing or important matter for which a comprehensive royal commission ought to be undertaken.

CHAIR: Senator Roberts.

Senator ROBERTS: Again, this is a question to all three groups. Dr Prasser, you mentioned very clearly that sometimes royal commissions and inquiries can be hampered by people wanting to pull the wool over people's eyes or minimise political damage. My question is, if or when the government finally listens to the people and calls a royal commission, what signs would show you that it is genuine and is serious about learning from the previous government's mistakes to protect us better in future?

CHAIR: Dr Prasser.

Dr Prasser: The test of any royal commission or any inquiry is, firstly, its terms of reference. Are they wide and clear so that the inquiry is not constrained in any way? Royal commissions do have a tendency, once they get appointed, to do their own thing. So, that should be in the terms of reference. The second thing is the membership of the inquiry. That's what the present COVID inquiry is being criticised about, that its membership is too much of an in-house group. That's the view of a lot of commentators in the media about that particular inquiry. The third thing is, what time frame has it been given to report? If it's three months it's a rushed time frame. In New Zealand, there's a law now that royal commissions must report after six months if they're going to take longer. Some of the inquiries in England have taken three or four years, which is ridiculous. There has to be a time limit but also adequate time to do its work. Fourthly, what resources is it going to get? If you try to constrain its resources it won't be able to investigate.

Royal commissions often do employ large research teams. This royal commission would need a research team to sift through the evidence to find out what was going on. It's going to cost money. The royal commission into child sexual abuse cost over $300 million. That was a very expensive inquiry. There have to be some constraints in the public interest. Those are the sorts of things I look at—terms of reference, membership, time frame and in particular resourcing. Those are the sorts of things I look for.

CHAIR: Mr Young.

Mr Young: My experience of royal commissions is I think the commissioner is the most important element. As Dr Prasser noted, they often suggest further terms of reference, which under public pressure the government then agrees to. It's important to have someone who is knowledgeable in the area but it's also important to have someone who doesn't already have a position that they may well be trying to defend. In the case of this royal commission, which I think would be one of the most important and serious in the history of the Commonwealth, we should perhaps look overseas to find one or two commissioners who could speak truth to power without fear of having contradicted something they may well have done themselves in the past, or somehow affecting their future career prospects or breaching friendships or collegial relationships they have. This is a matter that has touched a whole range of people and professions, a lot of people on the public record and so on. It could be quite difficult to find someone sufficiently abstract from the actual process and the application of what happened to come up with a good finding. It's very important that you do have the right person or people.

CHAIR: The Institute of Public Affairs.

Mr Begg: I think if you wanted an example of a manifestly inadequate inquiry you'd just have to look at the inquiry currently being run out of the Department of Prime Minister and Cabinet, in particular as it relates to the membership of the inquiry panel and the terms of reference given. In particular, two of the three inquiry panellists appointed were well noted in the public sphere for being enthusiastic advocates of lockdown policies in Victoria, which was so devastating. That really raises doubts about how adequately it can inquire into public health policy issues. Secondly, the terms of reference that have been given to that inquiry specifically exclude actions unilaterally taken by state governments. The actions of the states were really front and centre of the COVID policy response in Australia. This was the level of government that had direct responsibility for imposing the public health orders, which varied from state to state and often conflicted with the statements coming out of Canberra among some political leaders. That's the wrong way to go about it. In our submission, we've provided some draft terms of reference that a royal commission might be given. It needs to be extensive and it needs to be broad. Any sort of limitation that we've seen in this departmental inquiry that certain levels of government aren't to be assessed just raises doubts about the process and the motivations behind it.

Senator ROBERTS: Is broadcasting recording or is Hansard recording? I was in an inquiry on the indemnities given to pharmaceutical companies. We had a wonderful inquiry. A lot of material came out and we found out there was no transcript because there was no recording. I just want to make sure it's on?

CHAIR: I'm pretty sure it's on. Thumbs up; it's on. We're on, Senator Roberts. It's all being recorded for posterity and future reference. Senator Antic.

Senator ANTIC: I'll probably be briefer than 10 minutes. We've heard this morning some really good points about the way in which what happened during COVID fits in and overlays with matters throughout our history that have also had royal commissions put in place. It strikes me that we're not talking a lot about the possibility of a royal commission outside inquiries like this. Certainly, the media class and the political class don't seem to be pushing this issue like perhaps some others are. I'm interested in knowing from our speakers today what their views are really from a very broad helicopter view about what they believe are the reasons there is seemingly a reluctance across our community to entertain the concept of a royal commission when it's so clearly required?

CHAIR: Dr Prasser.

Dr Prasser: Speaking to senators, the answer is politics, isn't it? Everything is politics. Just remember that from the Senate COVID inquiry which released its report in April 2022, chaired by Senator Gallagher, recommendation 17 was that there should be a royal commission. That particular Senate report, which was dominated by Labor and Green senators, was highly critical of the Morrison government and, therefore, to me it was biased in a sense. That we've had a royal commission into the robodebt crisis, called in August 2022, as was promised by the Albanese opposition, and not a royal commission into the pandemic where 15,000 to 20,000 Australians possibly died is because of politics and because it's hard to do. It's politics because there were five Labor states and territories involved in managing COVID. There was a state election, a Victorian election, last year and there was a Queensland election this year. So, it's politics. Any royal commission with the right terms of reference and independent members is going to have to, given the litany of complaints that we have partly heard today, and which many people have made—not political people—about how the states behaved, come under scrutiny. In Queensland, it was absurd that the Chief Medical Officer was telling people to wear a mask in a car. That is not medical advice. Or to wear a mask when you're walking around. It was absurd that Queenslanders could not drive back to Queensland but you could fly back to Queensland. There are lots of things. There are the lockdowns and the border closures, which I'm totally opposed to. That's the reason; this would be political.

Also, as I said before, this is a complex issue. Graham Young has pointed out the range of disciplines issues. You would have to have a royal commission that would reflect some of the different professions—the medical

profession, the pharmaceutical profession, the nursing profession and all the different interest groups around that. It would require a lot of hard work to set up this royal commission. Governments sometimes don't want to do the hard work. It's much easier to set up an inquiry like robodebt to get stuck into the previous government. All governments do this, by the way, so let's not be too precious about the Albanese government. But that's the reason. It's political. It could be embarrassing. The general view, I think, inside the policy community is, 'Let's blame the Morrison government for everything', which is unfair, because the Morrison government wasn't in charge of everything. Secondly, 'Let's just bury this and we'll all move on'—that awful phrase—'and forget.' That's essentially the game going on. That's not good public policy, because we should learn from mistakes. Also, it's about, 'Let's not let any of our team get tainted by any of the problems.' I think that's the answer. It's politics. It's the way we do public policy. It's blaming the previous mob for things. Also, it would be really hard work and it would require a person of some ability to really pull this together to make a royal commission work and for it to be set up properly. It can be done, but it would require a lot of work, and governments don't want to do that work.

CHAIR: We have limited time left. I'm now aware that other senators have questions, if you could just bear that in mind. Mr Young.

Mr Young: I think the answer to your question, Senator Antic, is that just about everyone was implicated in the policies that were adopted. Normally, when you get calls for a royal commission, it's over a matter which was quite divisive and so there is a large caucus of people who have a vested interest in finding that what was actually done was wrong. In this case—I referred in my opening remarks to expenditure during World War II—we behaved as though we were in a war position. So it is not just—

CHAIR: We have lost Mr Young. I will go to the Institute of Public Affairs.

Mr Wild: That is a great question. Just to build on what Mr Young was saying, I think the main reason is the implication of so many of the organs of our society and civil society, the media foremost among them. Speaking to you from Victoria, there was no debate here at all for many months about lockdowns and the approach being taken. The media organisations were basically providing cover for the government or supporting the measures being undertaken. I struggle to think of any major civil organisation in this state or country that provided an alternative assessment of lockdowns and mandates. To call for a royal commission is in essence to admit that something went wrong, and I don't think that those in our society are willing to do that, including the legal fraternity, who were basically silent as we saw the most egregious breaches of our legal rights and freedoms. Civil society groups were silent. That's the main reason, unfortunately. Many of these organisations, the media foremost among them, are simply not willing to acknowledge that they played a deleterious role in that period of our history.

CHAIR: Senator Green.

Senator GREEN: For the two organisations giving evidence, I wanted to understand a bit about your organisations and your priorities, particularly for the IPA. Whom are your members?

CHAIR: The Institute of Public Affairs.

Mr Wild: We have over 9,000 members from across Australia. They join as a member of the IPA because they're passionate about our freedoms, the Australian way of life and our values. We're very proud to have that broad based membership across Australia.

Senator GREEN: The Australian Institute for Progress.

CHAIR: I don't think we have Mr Young with us anymore. He's dropped out.

Senator GREEN: That's not a problem. I'm sure he can take that on notice.

CHAIR: Can we make sure that's communicated to Mr Young.

Senator GREEN: Mr Wild, that's mostly individuals; is that right?

Mr Wild: Yes, that's right.

Senator GREEN: I know IPA is quite public facing with its commentary about government decisions. What sort of role did you play during the pandemic? Were you supportive of government policies or did it depend on what type of policy it was?

Mr Wild: Our main role was to provide research on different aspects of the COVID measures. Our main focus was on some of the costs and implications of lockdowns in particular. In the opening statement I gave a brief overview of some of our main findings, particularly as it related to the economic costs. As Senator Scarr has asked, we're happy to provide all of those reports for the record. Essentially it was providing research and then communicating that through the media and through other forums, for example, in front of policymakers—

Senator GREEN: Sorry. I didn't mean to interrupt you. I thought you'd wrapped up. You said 'your findings'. Did you conduct your own review?

Mr Wild: Not a review as such, but findings in terms of the consequences of lockdowns. To give you one example, we undertook research into jobs that were being lost throughout the COVID period and looking at how that delineated between small businesses and large businesses, public and private sector workers or low-income and high-income Australians and then providing those findings and that research and communicating that into the public domain.

Senator GREEN: Have you made a submission or do you intend to make a submission to the Commonwealth government's COVID response inquiry?

Mr Wild: Yes, we've made a submission to that inquiry.

Senator GREEN: I think we have Mr Young back, who might also be able to answer that question.

CHAIR: Could you repeat the question for Mr Young.

Senator GREEN: Have you made a submission to the Commonwealth government's COVID-19 response inquiry?

Mr Young: Yes, we did.

Senator GREEN: This is for both organisations, but I'll start with the IPA. Did you make submissions to the Senate select committee inquiry?

Mr Wild: I don't think so. Did we?

Mr Begg: I believe we might have. Can you confirm what time that inquiry took place?

Senator GREEN: We can get you that information.

CHAIR: We'll get you that information. If you could take that on notice, the secretariat will give you the dates.

Mr Begg: Mr Wild and I did participate in an inquiry during the pandemic in relation to the pandemic policies. It might be the same one, but I'd have to confirm that on notice.

Senator GREEN: What about the review of WA's COVID-19 response?

Mr Begg: No, we didn't participate in that inquiry.

Senator GREEN: What about the New South Wales parliament's review of the New South Wales government's management of the COVID-19 pandemic?

Mr Begg: I don't believe so, no.

Senator GREEN: What about the Queensland parliament's inquiry into the Queensland government's health response into COVID-19?

Mr Begg: If you're going to go through every state's inquiry, it's unlikely that we participated in every inquiry. We are limited by the resources we have. We are limited in our capacity to engage in every inquiry that we would like to.

Senator SHOEBRIDGE: Just to assist, it's any help, I chaired the New South Wales one, and I don't recall the IPA putting in a submission. If so, it passed under the radar.

Senator GREEN: What about the Northern Territory parliament's inquiry? Probably not that one, either?

Mr Begg: I'd refer to my previous answer.

Senator GREEN: And the Victorian government's inquiry into the Victorian government's response?

Mr Begg: Yes; previous answer.

Senator GREEN: Understood. I'll leave it there.

CHAIR: I have some questions. Senator Shoebridge had some questions, but there were some questions arising from the earlier evidence given by the witnesses I'd like to quickly cover off. Dr Prasser, we have limited time. Feel free to take some of these points on notice, if you would like. You refer to the merits in terms of this being a joint royal commission between the Commonwealth and each of the states and territories. We've received a submission from the Premier of Tasmania, who is of the view that there is no need for a royal commission, which begs the question as to how this would work if only some of the states and territories agreed to participate as opposed to all of the states and territories. I'm happy for you to take that on notice. I'm very interested in your views with respect to that. Have you got a quick answer you could provide on that?

Dr Prasser: There have been joint royal commissions where not all the states have joined up to them. The famous Costigan royal commission into the trade unions started out as basically a royal commission between the Commonwealth and Victoria. What often sometimes happens is a few states join up and then all states come to the party. It's up to political leadership at the federal level to put pressure on the states to join the game. With the royal commission into Aboriginal deaths in custody, even Queensland under the National Party government joined that royal commission. It can be done and it requires effort and persuasion by the federal people putting it together. I would say to the Tasmanian Premier: what are you hiding and afraid of if you don't want to have an open inquiry of a royal commission standard into what went on across Australia? Don't you care about the rest of national policy, especially given how much the taxpayer subsidises Tasmania? Let's get serious. It requires that political game to happen.

CHAIR: My next question was touched on somewhat in the submissions, but I'll go to you, Dr Prasser. I sit on the Senate Standing Committee for the Scrutiny of Delegated Legislation. One of the issues was the emergency powers under the Biosecurity Act and the fact that the Minister for Health could issue declarations/orders that were not subject to parliamentary review. In particular, they were not subject to disallowance processes where parliament, in particular the Senate, could debate a particular declaration, say, that might consider the right of Australian citizens to come back into the country or to leave the country, as part of a disallowance process. To what extent do you think those issues relating to governments, if I can put it that way, around emergency declarations and the checks and balances of parliament as a check on the executive powers should be the subject of this royal commission?

Dr Prasser: That's a very tricky issue, because a royal commission is appointed by executive government. For an executive government body to be investigating parliament is a pretty tricky process. To me, those sorts of issues need to be resolved more at the parliamentary level rather than by a royal commission. People around this table have pointed out the issue about civil liberties and processes of accountability. The royal commission might like to assess it only up to a point, but it wants to be very careful of an executive government body investigating parliament, which really is crossing the line. That's a very tricky issue to be looked up. It is a problem. You could look at it in terms of how the act was interpreted.

CHAIR: I'm happy for all of the witnesses to make submissions and take this on notice. There's a distinction I think from what you're saying as between a royal commission or inquiry looking at powers in legislation and systemic issues as opposed to considering what parliament did in a particular case; is that correct?

Dr Prasser: That's correct, yes. That's a good summary.

CHAIR: I think you've touched upon this in your submission, Dr Prasser, that is, the utility in terms of draft terms of reference being circulated for public comment prior to being adopted to found a royal commission. Could you draw that point out? I'm happy for the other witnesses to take on notice the merits of the draft terms of reference being circulated for public comment prior to their being finalised. Dr Prasser.

Dr Prasser: Terms of reference are often done behind closed doors. As a recent development, starting with the royal commission into child and institutional sex abuse appointed by the Gillard government, it was announced in 2012 and then the draft terms of reference were circulated. The royal commission was formally appointed until early 2013. That's a very good example of good practice, if you like, when you're having a royal commission on such a touchy issue. The same thing happened in the UK. There were draft terms of reference circulated. The same thing happened in Scotland. In Sweden, of course, there's immense parliamentary bipartisan support. I think any royal commission should have those terms of reference drafted. That means you catch everything and people can't complain afterwards that you missed a particular issue. It's really worth having.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: My question is to the IPA. In March of 2021, the IPA published an opinion piece by one of your adjunct fellows, a Mr Matthew Lesh, which stated:

This pandemic comes in two acts. In the first act Australia did well protecting lives, but stringent border controls and a suppression strategy only made sense to buy time for vaccines. Now in the second and final act Australia is seriously faltering. Slow and steady will not win the race. Slow vaccinations are delaying the return to normality.

Does the IPA stand by that analysis that it gave in March 2021 about the two parts, the suppression strategy working well but the vaccine rollout being woefully slow? Do you stand by that analysis?

Mr Wild: I think there are a couple of things there. The first is that certainly, in terms of the original approach that we took as a nation with the international border closures, these clearly gave governments an opportunity to evaluate the severity of COVID and what was happening overseas, and that was the right approach to have taken. The issue with the vaccine matter is, firstly, the goalposts were shifting all the time. The stated targets put out

there either by National Cabinet or at the state level were fairly routinely changed. At a minimum, the advice upon which those targets were being set was not transparent to the public. When that was written—and I'd have to read the whole thing again—I think the circumstances in our nation at that time were quite different to the information we now have.

Senator SHOEBRIDGE: To be clear, in March of 2021, in the heat of the pandemic, the IPA is saying clearly on record that the suppression strategy, which includes lockdowns, had worked and was essential. Have you changed your opinion since March 2021?

Mr Wild: I don't think that was ever an institutional view.

Senator SHOEBRIDGE: It was one of your adjunct fellows. You published this and endorsed it.

Mr Wild: In terms of adjunct fellows, we house a number of adjuncts, or have done over the journey, who are able to express an opinion on not just COVID but a range of matters, but lockdowns or seeking to significantly suppress or eliminate COVID was never an institutional view.

Mr Begg: As far as opinion articles go, those, to a significant degree, reflect the personal opinions of the writer. As Mr Wild said, they don't always reflect an institutional view of the IPA as much as they do a personal opinion of the writer.

Senator SHOEBRIDGE: To be clear, when the IPA publishes opinion pieces like this, noting that he's an adjunct professor, putting it prominently on your website at a key moment in the pandemic, you're saying that wasn't an expression of an opinion of the IPA? Is that your position? Or is it just that it's now inconvenient that you said that in March 2021?

Mr Wild: No, I don't think it's inconvenient. We very much support having a diversity of views. But what I would point you to is that we were the first organisation in Australia that I'm aware of—and I'm happy to be corrected if there's alternative information—to argue that there should be an end to the lockdowns. That was on 4 April 2020. No more than a month into the nationwide lockdowns we argued that lockdowns should not be pursued and that a more balanced and considered set of policies should be the approach. That was the institutional view that was provided on 4 April 2020. That has been the basis of the research we've done over the remainder of the COVID period.

Senator SHOEBRIDGE: So, it was just a mistake, nine months later—

CHAIR: Sorry, Senator Shoebridge. You can put further questions on notice. We have to move on. We have run over time. I thank all of the witnesses for your time today. There are a number of questions on notice for you to come back to us with answers to. We'll contact you with respect to the timing in terms of those responses once we consider that later in the day.

BARNETT, Professor Katy, Private capacity [by video link]

FINLAY, Mrs Lorraine, Human Rights Commissioner, Australian Human Rights Commission [by video link]

KLUGMAN, Dr Kristine, OAM, President, Civil Liberties Australia

LEE, Ms Samantha, Senior Solicitor, Redfern Legal Centre

ROWLINGS, Mr Bill, OAM, Chief Executive Officer, Civil Liberties Australia

STAMFORD, Mr Chris, National Human Rights Act Campaign Manager, Civil Liberties Australia

[09:34]

CHAIR: We will now move on to our next witnesses. I welcome representatives from the Redfern Legal Centre, the Australian Human Rights Commission, Civil Liberties Australia, and Professor Katy Barnett. Thank you for taking the time to speak with the committee today. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. I remind senators and witnesses that the Senate has resolved that an officer of a department of the Commonwealth or of a state shall not be asked to give opinions on matters of policy and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a minister. This resolution prohibits only questions asking for opinions on matters of policy and does not preclude questions asking for explanations of policies or factual questions about when and how policies were adopted. Ms Lee, from Redfern Legal Centre, do you have an opening statement?

Samantha Lee: Thank you for this opportunity to provide evidence on behalf of Redfern Legal Centre. Firstly, I want to state that Redfern Legal Centre and I personally believe in public health and keeping the community safe through vaccinations and well-informed public policy. I want to take this opportunity to thank the workers—garbos, cleaners, nurses and doctors—who during the pandemic got out of bed and went out into the community to keep society going. These are usually low paid workers. We owe them a debt of gratitude. As much as Redfern Legal Centre believes in public health, we equally believe in the rule of law, due process and a law enforcement system that is accountable, transparent and just. It is during a time of crisis that society needs the rule of law the most, not the least, yet it was during the pandemic that Redfern Legal Centre saw the rule of law being shoved aside. Many of my clients were in tears in trying to keep up with and understand rapidly changing public health orders, predominantly printed only in English. These clients ranged from a mother whose son with a diagnosed intellectual disability was issued with three separate COVID fines worth $1,000 each, and an elderly couple, one partner with dementia, fined for being at the supermarket together because one partner could not stay at home by herself. Overnight, fines increased from $1,000 to $3,000, which included fines that could be issued to children. There was no transparency around the setting of fines nor of fine amounts for any jurisdiction, and the absurd increase in fines especially when it came to children was particularly cruel.

In New South Wales there were 266 changes issued to the public health orders during the pandemic, equating to the law changing every 2.5 days on average. Our casework showed that, due to the rapidly changing aspect of these laws, police were issuing fines unlawfully because they were not able to keep up with the changing legislation, and the New South Wales fine review agency, Revenue, also applied the law incorrectly because of rapidly changing legislation.

In New South Wales alone, at the end of the pandemic nearly $60 million in COVID fines were imposed, with the majority issued to those living in First Nations communities or low socioeconomic areas. Of significant note was the $2.1 million in fines issued to children aged 13 to 17. Although I appreciate the confusion caused by the changing orders for both police and Revenue, it does not excuse why these agencies did not speak up and raise the alarm about the injustice that was unfolding. At the time, several legal agencies, including RLD, PIAC and the Aboriginal Legal Service, raised concerns with these bodies about how the law was not being applied correctly, but to little or no avail. I appreciate that the public health orders were the responsibility of the states, but as the former director of Gun Control Australia I'm well aware of the role the Commonwealth can play in establishing national agreements, royal commissions, and principles and facilitating discussions around legal and moral obligations. It is not an equal playing field out there, and it was not an equal playing field out there during the pandemic. I hope we can learn from these incidents and look at our future responses and not pretend that there is an equal playing field out in the community.

CHAIR: Civil Liberties Australia, do you have an opening statement?

Dr Klugman: Yes, we do. Civil Liberties Australia acknowledges and respects the Indigenous people on whose land we meet today. We thank the Legal and Constitutional Affairs References Committee for this opportunity to discuss the terms of reference for a royal commission into COVID-19. An unprecedented pandemic will always lead to an unprecedented response, but the first lesson we learned from our COVID experience was that in this completely connected world there will be a next time. Civil Liberties Australia strongly supports any thorough examination of Australia's experience of a pandemic aimed at providing recommendations for improved responses to any future pandemic or similar public emergency with a potential for society-wide impacts. We all remember how frightening those early months of the pandemic were. We all accepted the need to limit the rights that Australians are signed up to, rights that Australians trust the government to defend. However, when the opportunity came to test government decisions in the context of these rights, it became abundantly clear there was no infrastructure in place at the time of the pandemic to ensure any limits placed on individual rights by governments were consistent, rational, relevant and proportional to the risk. Nor was there a disinterested forum in place capable of conciliating or mandating remedies that would allow affected individuals to challenge the relevance, rationality or proportionality of these limits. In other words, there is strong evidence that Australian governments do not have the ethical infrastructure cemented in place to balance conflicting individual rights other than through government fiat.

When COVID hit, people were powerless and had nowhere to turn to get an independent arbiter to enforce basic commonsense decisions needed about individual rights. The upshot was that the national unity that characterised the early days of COVID degenerated into pockets of resentment and reduced trust in government as the pandemic progressed.

The real question from CLA's point of view is, how will Australians get through the next COVID equivalent public emergency with their trust in government intact? In summary, CLA would like the terms of reference to examine how state and territory legislation governing emergencies can be made consistent, proportionate, timely and justified; examine how complaints can be handled quickly and efficiently when rights are breached, preferably by access to state and federal human rights acts; make recommendations on appropriate training of police, defence and security guards enforcing restricted laws; and make recommendations on how civil rights and restrictions in pandemics can be balanced.

CHAIR: Commissioner Finlay.

Mrs Finlay: I'd like to thank the committee for the invitation to give evidence at this public hearing, and seek to just make a brief opening statement to support the written submission that's previously been provided. From the outset, I'd like to acknowledge that there has already been a range of inquiries, including the ongoing Commonwealth government COVID-19 independent inquiry, that have looked at different aspects of the pandemic response. However, it remains my view that these are not sufficient substitutes for a properly constituted and comprehensive royal commission. Given the significant impact of the pandemic and the pandemic response measures not only in terms of health impacts and economic impacts but also in terms of human rights, and the continuing lack of clarity around how and why particular decisions were made, a royal commission is the best option to undertake a comprehensive examination of the overall pandemic response in Australia. The primary aim of such a royal commission should be to improve Australia's preparedness for future pandemics. Given this, its terms of reference should be broad and its processes should be open and transparent.

There are three key features that I would seek to highlight as being essential to the formation of a royal commission. The first is that there needs to be an express focus on human rights in the terms of reference. The Democracy Index 2020 described the pandemic response globally as leading to the biggest rollback of individual freedoms ever undertaken by governments during peacetime. Pandemic response measures in Australia had substantial impacts on individuals, families and communities. It's essential that Australia's pandemic response is fully and formally reviewed in terms of its impact on human rights, and that future emergency planning incorporates human rights considerations as a priority.

The second consideration is that the royal commission needs to be established jointly by federal and state governments so that it is able to examine a pandemic response that was characterised and driven by complex interactions between different levels of government, all of which had overlapping responsibilities. We need every part of our federation working together to ensure that we learn the necessary lessons, both good and bad, and that we're as well prepared as possible for any future pandemic or other form of emergency.

The third point I'd seek to emphasise is that any royal commission needs to be structured in a way that enables individual and community voices to be heard. We know that the impacts of the pandemic response measures were not felt uniformly across Australia. There were significant differences in the severity of restrictions and how they were applied in different areas. We know there were specific risks and concerns that were particularly applicable

to different parts of the Australian community. To ensure that these human impacts are fully understood, it's essential that any royal commission include a strong focus on public consultations and open public hearings. Thank you again for the opportunity to give evidence this morning. I would welcome any questions.

CHAIR: Professor Barnett, would you like to make an opening statement?

Prof. Barnett: Yes. My opening statement is basically to endorse the three other opening statements I've heard previously. I come to this committee as someone who looks like a vulnerable person. I'm disabled. During the Victorian lockdown I did come to the attention of police and I did have a very unpleasant interaction with them. However, I feel a bit like Clark Kent with a Superman suit underneath; they didn't know that the limping woman with the walking stick was actually a law professor. Had they decided to make an issue of my supposed contravention of the law, I would have been able to fight them legally. I would have been able to fight back. What I'm distinctly aware of is the fact that many other vulnerable people in our community do not have the same capacity as me. These include Indigenous people, other people with disabilities and people from non-English-speaking backgrounds. I remain extremely distressed by what happened in Victoria with the public housing tenants and I remain dismayed by the Victorian government's lack of shame. I thank this committee for inviting me to give evidence. I support the establishment of a royal commission that will consider the way in which laws operate and which will, I hope, involve both federal and state governments.

CHAIR: Senator Roberts.

Senator ROBERTS: Thank you all for appearing today and for excellent submissions. In particular, to Professor Barnett and also the Redfern Legal Centre, thank you for sharing the lived experience, because that was very touching. There seem to be symptomatic signs throughout this process of the COVID mismanagement that showed a complete disrespect for people, a complete disrespect of citizens, an arrogance from government and government suppression. We saw Professor Barnett's discussion about anxiety in people reflected also in Ms Lee's comments. Is the key issue here that trust was destroyed by federal and state governments? I can see nodding already. Would a royal commission restore trust?

CHAIR: We'll go to the Redfern Legal Centre first and then to Civil Liberties Australia, the Human Rights Commissioner and then Professor Barnett. That's the order we'll adopt to officially deal with things. Ms Lee.

Samantha Lee: I can say that, from our client experience, there has developed a mistrust in New South Wales with police and also with a government body, Revenue. Trust, I think, can be built up through transparency and accountability, and that is what a royal commission could obviously go into. It doesn't mean that the trust is destroyed, but if you don't bring these stories into the open and give them some light the distrust will fester.

CHAIR: Civil Liberties Australia and Dr Klugman?

Dr Klugman: Civil Liberties Australia's main tenet in our submissions has been that trust has been destroyed. Numerous surveys have shown that trust is disintegrating. Trust is essential in a democracy. It is the basis on which democracy functions. We believe that trust can be helped and re-engendered by human rights acts, either federally or at the state level. Human rights acts give access to people for proper resolution of complaints when their rights are breached. In this way we think that trust can be slowly regenerated.

Mr Stamford: If you have a look at any measure of trust in Australia in the last two years since the major COVID crisis has passed, 61 per cent—using the Edelman Trust Barometer as an example—of Australians now say the lack of civility and mutual respect is the worst they've ever seen. More than half of Australians, 55 per cent, say their default tendency is to distrust something until they see evidence of the fact that it's trustworthy. Some 61 per cent of Australians say that people are incapable of having constructive and civil debates about issues that they disagree on. Only 24 per cent of Australians would help someone who strongly disagreed with them or their point of view when they were in need. Only 21 per cent of Australians would be prepared to live in the neighbourhood of someone who strongly disagreed with them or their point of view. The result of that is that 48 per cent of Australians now see government as unethical and incompetent, and the media has been reduced to an echo chamber for 57 per cent of Australians as that trust polarises. That just makes it harder for government to do their job in discussing and making big decisions that require trust across the whole of the electorate. I understand the comment of Senator Roberts. I think the issues around the beginning of this pandemic and the government attitude was driven by a genuine sense of fear, as Dr Klugman said, and that fear led to government behaviours towards a large number of people in society that were not good. A royal commission in and of itself doesn't fix anything. The question is whether the government will follow up and implement recommendations that this royal commission is going to make. That's what drives trust.

CHAIR: You quoted a number of figures. Could you provide on notice the source of that research? If you could provide a copy of that research, I think that would be—

Mr Stamford: I'm happy to do that. For the record, it was the 2023 Edelman Trust Barometer that made those recommendations.

CHAIR: Commissioner Finlay.

Mrs Finlay: I don't have a great deal to add other than agreeing with what's been said. In particular, those figures that were just given from Civil Liberties Australia have incredibly profound implications for Australia as a nation moving forward. I think a royal commission would not only help regain trust by allowing us to acknowledge both the good and the bad in terms of what happened but also allow Australians to see that measures are being taken to improve our responses in the future. The only other thing I'd add is I think another benefit in terms of developing trust and results from a royal commission is that it really gives the entire Australian community a better understanding of how our fellow Australians were affected. I think we did become in many respects a very divided country with very different impacts arising from the restrictions. It's a real opportunity for Australians to get a better understanding of how their neighbours and how people right around the country were impacted by the response measures.

CHAIR: Professor Barnett.

Prof. Barnett: As I said in my submission, I've been concerned that the main effect of the measures that were taken in lockdown was a breakdown in state capacity. Basically, the reason people trust the police, government and the law is that they think it will be applied fairly and equally. One thing I've always been proud of about Australia is that it has very high state capacity. I've lived in other countries where that's not necessarily the case. I do think trust in Australian state capacity can be rebuilt and that's essentially, for the same reasons other witnesses have given, why I support the establishment of a royal commission. I think trust can be rebuilt in that way by looking at what we can learn from what happened during the pandemic.

CHAIR: Senator Roberts?

Senator ROBERTS: Ms Lee and Dr Klugman, why were the poor and vulnerable targeted? Was it deliberate, or was it just easy?

CHAIR: Ms Lee.

Samantha Lee: Whenever you introduce a new criminal offence penalty, it will always impact on people in the most vulnerable of circumstances. That was not looked into when it came to these new offences. The difficulty was that no-one understood the offence, it was very complex and those who were already policed were policed even more.

Mr Rowlings: We would agree with that being the exact truth—that whenever a law is introduced it impacts the least in the society rather than the upper crust of society and the rich. The classic example of that is the public housing tenants in Victoria.

CHAIR: Commissioner Finlay.

Mrs Finlay: I'd only add that I think the impact on sections of our community—in particular, poor and vulnerable sections of our community—is something that a royal commission should be established to consider and would be an important part of the examination of the pandemic and the pandemic response measures. What that requires are two things. Firstly, a royal commission with broad terms of reference, but secondly—and this is particularly important—a jointly established royal commission between state and federal governments. If it is only a royal commission established by the federal government, it will be limited in its ability to fully consider those impacts.

CHAIR: Professor Barnett.

Prof. Barnett: In my experience as a lawyer, the reason the most vulnerable in society are affected more is that they don't necessarily know what their rights are and they don't have the resources to get someone to help them. That is why I think it's particularly important, as the other three participants have said, that we look at the impact of this on the most vulnerable people in society.

CHAIR: Deputy Chair.

Senator GREEN: I'm happy for any of the witnesses to answer. I understand some of you have been involved in other inquiries or parliamentary inquiries, particularly with respect to different responses to COVID-19. Have any of the witnesses made submissions to the Commonwealth government's COVID-19 response inquiry?

Samantha Lee: Yes, we have put in a submission to the Commonwealth inquiry.

Dr Klugman: No, we have not yet.

Mrs Finlay: Yes, I have put in a submission and I understand from the Australian Human Rights Commission that the National Children's Commissioner has also put in a submission, and the commission as a whole is engaging with the inquiry.

Senator GREEN: But you've put in an individual submission?

Dr Klugman: Yes, myself and the National Children's Commissioner both put in individual submissions.

Senator GREEN: Understood. Professor Barnett?

Prof. Barnett: This is my first ever Senate committee submission.

CHAIR: Welcome, Professor! You're doing very well.

Senator GREEN: Fantastic. Perhaps you could take on notice the other inquiries that you've made submissions to? It will be a very short list for you, Professor Barnett, but that's fine. That's all I have, Chair.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: I thank you all for your compelling submissions. Perhaps one of the lessons we could learn from the pandemic is that in moments like this where there's very rare and genuine fear—and legitimate fear—there's an extreme danger that we'll have executive overreach. Perhaps that might be one of the core lessons we learn from this; that is, with respect to that executive overreach you can understand the basis for it. It's based in fear and perhaps some advice. But that's something we should restrain going forward and ensure that at least there's democratic oversight of it. Would that be an overarching lesson?

CHAIR: Ms Lee.

Samantha Lee: Now that we have the benefit of hindsight I think a lot of us would have wished for the executive to have taken a pause and a break and looked at the impact at the time of the pandemic, but what we now see from our perspective is that a lot of this wants to be brushed under the carpet rather than being brought to light. What we hear from people today is that there is still a lot to talk about. In fact, we've just been in the Supreme Court of New South Wales over the last few months trying to get money back for people who were issued with invalid fines. There is still a lot to consider, and looking at the way this infiltrated particularly people in the most vulnerable of circumstances is drastically important.

Mr Rowlings: We would agree with you entirely, but you need to look back to where the reaction came. The fear was genuine and we all felt it, but what was depended upon were emergency provisions in various acts. Biosecurity has been mentioned. There are health acts with huge powers within them in all the states and territories and federally. Those acts generally were written 20 years earlier. To some extent, they were written before there was any human rights body in Australia at all. In those acts there was no mechanism to make an appeal against a decision. You had these decisions being made, and people being hugely disadvantaged, and some people being really individually disadvantaged in a way that even the people making the decisions probably didn't want to do, but they had nowhere to go to say, 'Reconsider my case.' That was one of the fundamental problems; that those emergency provisions when written hadn't been looked at, which is why one of our recommendations is that you go back into the legislation that underpins responses.

CHAIR: Commissioner Finlay, do you have anything to add?

Mrs Finlay: I'll go back very briefly to the question asked by the deputy chair previously, just to note that in the written submission I provided at endnote 1 there is a list of previous submissions made both by myself as the Human Rights Commissioner but more broadly by the Australian Human Rights Commission to various inquiries over the last few years relating to the pandemic response. In relation to your question, Senator Shoebridge, I would entirely agree that is a lesson that needs to be learned. I wrote with President Rosalind Croucher an article published in 2022 making exactly that point, which perhaps I can send through to the committee to further elaborate on my views. But the point that we made was firstly that we need to recognise decision-making in emergencies is different. It is important that any review or any royal commission doesn't look back with the benefit of hindsight and forget the context in which those decisions were made. Emergency decision-making requires quick decision-making often with incomplete information. What that really highlights to me is two things. Firstly, once the emergency is over, the need for a comprehensive review to analyse decisions that were made and to make sure there's proper planning to be better prepared for the next emergency is critical. The second thing is to ensure that things put in place for the emergency don't become normalised and part of your regular decision-making processes, because it doesn't always have the same accountability frameworks around it.

CHAIR: Professor Barnett.

Prof. Barnett: I can only endorse the comments that everyone else has made. I agree with Senator Shoebridge, and I thank him for the questions. I felt the fear. I think we all did. I'm a vulnerable person from a health perspective. But we do need to look at executive overreach. I agree.

Senator SHOEBRIDGE: When you have those emergency measures being put in place, is it the view of this panel—and perhaps we could test it one at a time—that the people who are most likely to be harmed by it are the people with the least economic power and the least political power? I think, Ms Lee, your submission identifies that geographic and economic disparity in New South Wales, and maybe we could start with you.

Samantha Lee: It's not just Redfern Legal Centre's opinion that the most vulnerable bear the brunt; statistics from New South Wales Police and Revenue New South Wales endorse or support this, that the majority of COVID fines were issued to those in low socioeconomic areas and to First Nations communities. There are statistics that could be gathered from other jurisdictions and I'm sure they would support the same unfortunate outcome.

CHAIR: We'll go in the same order just to make it easier. Mr Stamford.

Mr Stamford: The response we would make also incorporates a bit of your previous question as well. I think one of the key questions for the royal commission is going to be how do you actually achieve a consistent basis for executive decision-making that is rational, relevant and proportional? How do you do that across all eight jurisdictions in Australia and how do you do it for the federal jurisdiction in particular? The reason you do that is that the perception around certainly the latter half of COVID as people began to settle into their disagreements about the way in which COVID was being managed was highlighted by a number of people who felt simply that they were not being treated in a way that everybody else was being treated. You could see that in multicultural communities, for example, who simply were not getting access to the information they required. You could see that in elderly people, who were being isolated, and other people who were living on their own who were also being isolated. In Victoria they were allowed a bubble of one. In many other places they were not allowed any connection with other human beings at all. As I said, there was no sense across Australia that there was a nationwide attempt to make decisions relating to these people consistent, rational and proportional to the risk they represented. One of the key issues that the royal commission will need to deal with, and one of the key issues that we're keen to see, is how when we face a future pandemic and we see this question again we don't try and fix that on the run as was the case in most states and territories. Most states, territories and the federal government had a go at doing bits and pieces, and they tried. I don't think the weakest in society were necessarily targeted by governments. I just think that the natural consequence of an incapacity to make those sorts of decisions meant that they were exactly the people who were going to be worse off. Without that basis, without an understanding, we're going to run into the same problem again next time we have an emergency. Our own view is that a national human rights act supported by human rights acts of all states and territories would be a good idea, and it's worth while having a look at that as a royal commission to see what effect human rights acts have in jurisdictions where they exist right now.

CHAIR: Commissioner Finlay.

Mrs Finlay: My short answer is, yes. I would add that unfortunately what we've seen is a compounding effect, because it's not only the most vulnerable and disadvantaged who felt the immediate impact of pandemic restrictions; it also has had longer term impact in a more serious way than perhaps some other sections of the community. One of the impacts of both the pandemic and pandemic response measures was to exacerbate disadvantage that already existed. In my view, that's something very important for a royal commission to examine, not only the immediate impact but also the longer term continuing impacts that are still being felt today.

CHAIR: Professor Barnett.

Prof. Barnett: I feel a bit like a broken record. I endorse the other comments, but I would also say that as a Victorian I felt a little as though I had fallen between two stools. The federal government was saying, 'We don't have the power to do anything. It's a states' matter', and then my state was just pressing ahead isolating elderly people, public housing tenants, and things like that. I thought, 'I want someone to intervene to stop this, but it's not going to happen.' One thing I would like a royal commission to look at is to what extent does the federal and state division create that problem of, 'It's not our responsibility, it's their responsibility.' 'No, it is theirs.' There's a bit of buck-shifting going on.

CHAIR: Final question, Senator Shoebridge.

Senator SHOEBRIDGE: When you look at what happened in different states and territories, one view of it is that states and territories went straight to coercion without first trying persuasion. It was straight to police, courts, fines and arrests, when many people would say that Australians are some of the most rule-compliant people on

the planet, and if you make a persuasive case and you put someone out there with a high-vis vest and a clipboard, they'll form a neat queue and they'll do what you ask of them. Perhaps we should be trying to relearn the art of persuasion rather than the aggressive coercion that we had. Should that be a fundamental underpinning when we're looking at even a public health crisis? Maybe we'll reverse the order this time. Professor Barnett.

Prof. Barnett: I do agree with that. One thing I was looking at was people's responses to vaccine mandates. I'm vaccinated. I'm a vulnerable person. I was looking at some psychological literature that said that when you try to force people to do it rather than giving them a choice they have a much higher tendency to turn into polarised groups, which I think we actually saw during the pandemic. Some people will comply, but people who don't want to comply will have a totally different perception. If they're told to do it, they see risk differently, whereas if they're given a choice about it they assess risk quite differently. This does play into the coercion and persuasion thing. Some people, when you coerce them, will react against it and they will see risk differently. I'm happy to find the paper. I looked at it two years ago or something. It did make me think coercion should not be the first lever that we go to. We need to give people a sense of choice and a sense of agency, and there will be a certain sector of the community, when you really come down on them hard, that will react against it, and that is something we have to be aware of.

Senator SHOEBRIDGE: Commissioner Finlay.

Mrs Finlay: Reversing the order has given me the opportunity to now simply say that I would endorse what Professor Barnett has said. There are two things I would add. The first is, again, there were significant plans made for pandemic preparedness prior to the pandemic that placed a higher priority on persuasion, and it would be worth a royal commission going and looking at those and seeing again what lessons can be learnt, firstly, from what those plans said, but secondly why perhaps they weren't implemented in their entirety when the pandemic hit. The second thing that I would note is that in the early days of the pandemic what you're saying really did shine through, because there was that coming together of communities and that unity in terms of Australians wanting to help each other through the pandemic. We've seen other emergencies, say, in Queensland in recent days, where the very best of human nature comes through in times of need, when Australians do come together to help each other and make sure people aren't left behind. An important role of a royal commission is to examine those sorts of issues both so we can understand why coercion was the first port of call but also so we can begin to restore that trust in government and in our institutions. An important role is to examine those issues so we can understand why coercion was the first port of call but also so we can begin to restore that trust in government and in our institutions to ensure that when the next emergency hits we are able to have a response that does focus more on the community coming together and looking at persuasion and looking after each other because we know it's the right thing to do, not because we're facing fines and punishment if we don't.

CHAIR: Dr Klugman.

Dr Klugman: I think part of the problem was that the people in charge were acting in the military tradition. They were used to that chain of command structure of society in which coercion is integral. We need much more training of people in the social sciences to avoid bullying and coercion, and that's to do with training of police and security services and the military to say, 'You don't have to hit people over the head with laws and fines. There are other ways of doing things.' Coercion of vulnerable people was an extraordinarily bad aspect of the whole pandemic experience.

CHAIR: Ms Lee?

Samantha Lee: I probably wouldn't use the word 'persuasion'. I'd more desire to use the words 'bring the community with you' and giving them some ownership over the actual situation that's occurring. Australia has been really great with some public health matters such as HIV in the later stage of that campaign. The community took ownership of that campaign. The needle exchange issue, smoking in Australia and gun control—we have some great models to draw on. We should look at these models for future pandemics.

CHAIR: I have some questions for Professor Barnett and then Ms Lee. Professor Barnett, I was deeply moved by your submission and the personal story you recounted. I would suggest that everyone watching the inquiry—decision-makers, et cetera—should read your submission. I have some questions, but I first want to set it up in terms of your submission. I note that you're a law professor at the University of Melbourne. I note that you do suffer from a disability. At the time of the stage 4 lockdowns in Victoria, where you could not go more than five kilometres from home and you could not leave your house for more than one hour, you were getting treatment for your disability and, to quote from your submission, it was important for you to walk for at least one kilometre per day. I also note that you recount the story, 'I asked mum to go for a walk with me on the morning of 9 September 2020.' I'm going to read extracts of your submission. You described how you and your mother were approached

by two police officers on that morning and the police officer said, 'You are not allowed to stand here. You must keep moving and walk toward home.' Paragraph 8 of your submission states:

I was going to point out to the policeman that I was disabled and that the two other people we'd spoken to were elderly. After all, I am a law professor. But I was unsure whether he would react well to this. My mother was extremely anxious. She had previously told me that she was really scared of getting fined as she and dad are retired and the fines were high. She said quietly, 'Let's move very slowly.'

Then your submission continues:

When we came out of Woolworths, there were now five police outside the store. My mother and I were suddenly terrified. We wondered if they'd sensed that we weren't happy with being told to move on. They let us pass, but mum and I kept checking behind us. 'What if our walk has taken one hour and five minutes?', said mum. 'We can't walk any faster than this. They might fine us. They fined an old lady for putting her bin out a few minutes after curfew.' We got home safely but both mum and I were shaking.

How important is it that Australians have the opportunity to tell stories like that in the context of a royal commission so that politicians, government officials, police services, et cetera, can heal those real-life consequences of what happened during the pandemic? Professor Barnett.

Prof. Barnett: Sorry. I'm a bit emotional hearing that again. I think it's incredibly important. It's why I basically pulled out all stops to make a submission to this committee. I felt afterwards, as I've said in my submission, as though I expressed my concerns to my local MP and I was brushed off. Reading the letter I wrote to her again, and the fear and dismay in that letter, I thought, 'How could she have responded in that way?' I had been so scared and so upset and I was just told, 'This is for your own good.' I think it is actually very important that individuals get a chance to tell their stories, and not just someone like me who is a law professor but that other people from vulnerable sections of society are assisted to tell their lived experience.

CHAIR: Ms Lee, firstly, can I congratulate you on your submission and the Redfern Legal Centre on the work you do and the support you provided and continue to provide for vulnerable people in our community. I would like to quote from your submission in a similar vein. On page 4 it states:

For example, we had a client who was 16 years old and had a diagnosed intellectual disability whose disability was known by police. On three separate occasions New South Wales Police issued this young man with COVID fines of $1,000 each. Police issued our client with the fines when he was only a few metres from his home and by himself.

Ms Lee, how important is it that the story of that young man be told in the context of a royal commission so that decision-makers and the broader community have an opportunity to reflect on what happened during the COVID-19 pandemic?

Samantha Lee: It's critical. That is just one of many stories that came through Redfern Legal Centre. People with mental illness, people with intellectual disabilities, people living in housing estates—there was a range of people impacted, and still financially impacted, by policing and COVID fines, and it's so important to hear those stories on the ground.

CHAIR: Ms Lee, in your submission, you talk about the fact that children younger than the 16-year-old were actually issued with fines and are expected to—I'd like you to elaborate on this—engage in community service work or something to pay off the fine. Can you elaborate on what the current situation is in that regard?

Samantha Lee: In New South Wales children could be issued with fines from $500 up to $3,000. I had a client issued with two $3,000 fines. I've had mothers mainly ringing me up in tears because it often goes back on to the parents who have to deal with these fines. A lot of children had to work off these fines which later through our Supreme Court case, Beame and Els, were found to be invalid. Hundreds of children have been working off invalid COVID fines.

CHAIR: What age are we talking about?

Samantha Lee: The youngest person fined in New South Wales was 13, as I understand it.

CHAIR: I just have one further question and then Senator Antic has a question. Could I ask all of the witnesses to take this on notice. Mr Rowlings, you raised an issue in this regard with respect to emergency legislation. I raised this issue in the context of the previous panel in particular, that is, the need for checks and balances for when an emergency declaration is issued, and the power of the parliament to have oversight and potentially disallow an emergency declaration providing for fines of the nature that Ms Lee referred to. If you could take on notice the importance of those checks and balances in the system in the context of, for example, the Biosecurity Act at the Commonwealth level? There was a committee report by the scrutiny of delegated legislation committee. I will get the secretariat to refer that to each of the witnesses. I'd be very keen to get your

feedback with respect to the importance of those checks and balances of parliamentary oversight. Is that something our witnesses could take on notice? Thank you. Senator Antic.

Senator ANTIC: I'm interested in some of the questions from the chair. It strikes me that several years down the track there's a growing push of mea culpa amongst some of the former cheerleaders for authoritarianism that existed in our community. I still feel that is under the surface right now. I'm interested in, firstly, people's views from what they saw on the ground as to why it is that we saw our society descend into turning a blind eye to some of these things—kids getting fined, people losing their jobs because of vaccine mandates for a product that had a questionable track record—and whether or not they see an importance in allowing people to tell those stories under the proviso of a royal commission and whether that will have a positive impact on avoiding this kind of chaos in future?

CHAIR: Ms Lee.

Samantha Lee: I think there's a raft of issues within that question. There was no transparency or accountability going on at the time; parliament was not sitting and there was a lot of just pure reaction to the situation. The public health orders were a framework based on a middle-class model of living and failed to recognise that, as I said before, it is not an equal playing field out there. There are people in many different circumstances and living in many different types and forms of housing. I think the framework for the public health orders themselves needs to be interrogated to see how it endorsed this particular lifestyle that really doesn't exist for many Australians.

CHAIR: Mr Stamford.

Mr Stamford: One response to the comment you made is that COVID didn't cause this issue, it just exposed it. What we saw was a society under stress going back to things which would form the basis of the way in which it generally behaves, without the opportunity to alleviate that because of the pressure. As for the opportunity to tell stories, I think it's really important that the royal commission provides the opportunity to tell those stories. From Civil Liberties Australia's point of view, we think Australians should get into the habit of telling those stories all the time so that when we are confronted by another crisis such as the one created by COVID we are used to those stories being told, we are used to those complaints being made and we have a position and a process in place that allows those complaints to be dealt with even through conciliation or a mandated remedy. As I said, that forms a critical part of the preparation for the next crisis that we face, arguing that there is always going to be another crisis. We can fix it in this moment of reflection and pick it up when the pressure comes on next time.

CHAIR: Commissioner Finlay.

Mrs Finlay: That's really highlighted why a royal commission is necessary, both because it's important in and of itself to give individuals an opportunity to tell their stories about how such a significant event affected them over a number of years and also, again, so that we can learn the lessons we need to learn to ensure we're better prepared for next time. One of the things I would highlight that I am concerned about in terms of thinking about setting up a royal commission is there is a sense coming through from some areas of pandemic fatigue and this idea that we want to put it behind us, we want to move on and we don't want to take the time to bring it all up again. In my view, that would be a grave mistake. I think it's incredibly important that, despite the fact we all want to put it behind us and be able to move forward, we can't do that until we've reflected and fully understood the impacts the pandemic and pandemic response measures had and learn those lessons to ensure that it can never happen again.

CHAIR: Finally, Professor Barnett?

Prof. Barnett: One thing that I think drove some of the community responses to this has already been highlighted by Senator Shoebridge, which is fear—that is, when people are afraid to talk up. I did get a fair amount of flak for talking about my experiences at the time that they happened. I got attacked on social media. I was told that I was lying and that I had invented my disability. My whole raft of specialists were extremely angry about that. People were afraid to stand up. There was considerable fear and social pressure. I thank the witnesses who are here. I noticed you all speaking up. It gave me strength to talk about my experience. I do think that's important. One of my fascinations is about societal dynamics and how we ensure our society is a civil and law-abiding society. I think we need to look at what happened here and learn lessons from it.

CHAIR: I say to you and, indeed, to all of the witnesses: please let me know if you are subject to any such action arising from your evidence here today. If you are, we'll make sure we educate those who participate in that about the powers of the Senate with respect to protecting its witnesses. Thank you, Senator Antic.

Senator ROBERTS: Chair, I just want to make the point that there are people in Ipswich and Logan now who are homeless and being moved on—and you and I know the rainfall in Queensland in the past week or so—from

parks, showgrounds, camping and caravans and living in their cars under bridges. Some of those people are there because COVID injection mandates forced them out of work and they lost their homes.

CHAIR: I thank all of the panellists for your time today. I think you have seen the impact of your testimony and submissions on members of this committee. We will now suspend for morning tea. No photographs will be taken during the suspension, but when we recommence I understand some witnesses have asked for the ability to take photographs. I am quite happy for you to do so, provided the photographs are only taken of the relevant witnesses who've given consent and you limit it in that way.

Proceedings suspended from 10:34 to 10:45

BRIGHTHOPE, Professor Ian, Co-Author, The People's Terms of Reference

FAM, Mr Peter, Co-Author, The People's Terms of Reference [by video link]

GILLESPIE, Mr Julian, Co-Author, Principal Author, The People's Terms of Reference

LEACH, Mrs Ella, State Secretary, Nurses Professional Association of Queensland

MADRY, Dr Andrew, Private capacity

SLADDEN, Dr Julie, Co-Author, The People's Terms of Reference

THOMAS, Ms Kara, President, Nurses Professional Association of Queensland

CHAIR: I now welcome representatives from the People's Terms of Reference and the Nurses Professional Association of Queensland. Thank you for taking the time to speak with the committee today and also thank you for coming in person; it does help given the number of witnesses we have. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. Do any of you have any additional comments to make on the capacity in which you appear today?

Prof. Brighthope: I'm representing the National Institute of Integrative Medicine and the World of Wellness and the Australian chapter of the World Council for Health.

Dr Sladden: I'm appearing today as a representative of Australians for Science and Freedom, of which I'm a co-director.

Dr Madry: I'm an independent consultant and contributed to the People's Terms of Reference.

Mr Fam: I'm principal lawyer at Maat's Method.

CHAIR: We were given copies of your opening statements. I note that a lot of work has gone into the opening statements, and we greatly appreciate that. In terms of the committee's time, we have an hour and a half for this session. Could witnesses be minded just to make short comments in relation to each of your statements. I will go to each of you in turn, and then we can take the statements as tabled, so they'll be on the record. Mr Gillespie.

Mr Gillespie: I will be the only witness speaking to all of my opening statement for several minutes, and then my colleagues will be summarising their opening statements for the committee. I am a lawyer and former barrister. This royal commission is necessary because the evidence and data have shown that SARS-CoV-2 could not be considered an existential threat to the vast majority of people, particularly those under 80 and healthy, working-age individuals, especially if early treatment and repurposed drugs had been implemented. Transparency is needed regarding recommendations by the Australian Health Protection Principal Committee, the AHPPC, to the National Cabinet. A royal commission must scrutinise the evidence used by the Chief Medical Officer, Brendan Murphy, and the state chief health officers to advise the national committee on the public health response to COVID-19.

Lockdowns and mandate recommendations that had been explicitly advised against months before the declaration of a pandemic were nonetheless recommended by the AHPPC to the National Cabinet despite a multitude of scientific studies speaking against those recommendations as evidenced and shown in the WHO's own 2019 document *Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza* and Australia's own *Australian health management plan for pandemic influenza*. Australia's plan for pandemic influenza had only just been reconfirmed by all Australian health ministers, chief health officers and the CMO, Brendan Murphy, in August 2019, yet it was completely ignored in early 2020.

The influence of the WHO and its international health regulations on Australian domestic health policy requires review. Where was the science for recommending lockdowns, masks on young and old, closing schools, separating families and censorship and punishment for Australians who questioned what they were experiencing and being asked to do? This requires a royal commission.

Further, the use of fear based psychological behaviour management nudge units by Australian governments to support a government campaign of intimidation and oppression to increase compliance needs analysis and explanation. We were told to protect our public health system, to stay away from our hospitals, yet our hospitals are meant to be open to protect and aid us. This absurd denial of services resulted in serious health consequences with hundreds of thousands of missed appointments, delayed diagnosis of serious disease, delayed surgery and an array of mental health effects. Were these restrictions ever assessed or reviewed for the costs and benefits? The oft-repeated statements by the Prime Minister, premiers, health ministers, CMOs, CHOs and medical associations that the vaccines were safe and effective was blatantly false and there was never evidence and data to support such a claim. It was misleading and deceptive conduct that grossly undermined public trust.

Another example was the oft-repeated statements that lockdowns would ensure we could return to normal after two weeks, to flatten the curve. Weeks turned into months. State and territory governments acted arbitrarily and ad hoc. Lockdowns and mandates never occurred as a whole-of-government response. Again, this was misleading and deceptive conduct that has grossly undermined public trust.

A thorough, transparent, full disclosure and access to raw data analysis of the GMO vaccines provisionally approved in this country is vital as they fulfil the legal definitions for being properly called GMOs, or genetically modified organisms. AstraZeneca had 'genetically modified organism' printed clearly on its product information. As for Pfizer and Moderna—nothing. A royal commission needs to understand why Pfizer and Moderna were not required to obtain GMO licences after a strict, stringent risk assessment involving public consultation as required by law, particularly in circumstances where Australia's Gene Technology Regulator, Raj Bhula, admitted in a Senate select hearing on 26 October 2023 that the Pfizer and Moderna drugs are GMOs.

In addition, the Pfizer and Moderna drugs have been found on three different continents and five different nations by six different labs to be grossly contaminated with synthetic DNA, with a means for entering the cell nucleus and changing our human chromosomal DNA and integrating with our human chromosomal DNA. Beyond this DNA contamination, and the untested Process 2 manufacturing processes used by Pfizer to create the drug product rolled out to Australians increases the risk of endotoxin contamination, which continues to be inadequately tested for by the TGA. The consequences of this could be dire if they have not already been dire. These gene therapy GMOs Australians were effectively coerced to take are not just grossly and dangerously contaminated with foreign DNA; they have also been found to produce mutated and unknown forms of proteins due to 'frame shifting' that should never have been allowed to occur in humans, particularly when Australians were told that these experimental substances would only produce synthetic spike protein. Yet Australians were told without any factual basis these injectables were safe and effective.

The harms of these unscientific measures can be seen from the TGA's adverse event reporting system presently recording adverse events in the hundreds of thousands, reports of COVID-19 vaccine deaths in the thousands, and in the non-COVID-related excess death Australia is witnessing now running into the tens of thousands. It does seem that our political and medical regulatory authorities and our medical and scientific colleges and associations are ignoring all the warning signs, decades of science literature and the real data being sent to them by conscientious academics, scientists and health professionals across the country. Australia has no choice now but to empower the most historic royal commission ever seen to not only provide answers about our recent past but to acknowledge and prepare for the adverse health impacts likely to remain with Australians for generations to come.

CHAIR: The deputy chair has helpfully suggested that I draw the attention of all witnesses to the fact that when adverse comments are made about individuals they will have an opportunity, as they should have, to provide a response through the Senate committee process. I should also say that all witnesses giving evidence to this inquiry are protected by parliamentary privilege as well. Professor Brighthope, I have a very lengthy opening statement from you. Do you want to make some brief remarks?

Prof. Brighthope: I graduated in medicine and surgery from Monash University in 1974. In 1982 I co-founded the Australasian College of Nutritional and Environmental Medicine. I remained as president for the next 26 years. The college has continued to train medical practitioners in nutritional and environmental medicine to fellowship standard for the past 39 years. I'm currently the director of nutritional and environmental medicine at the National Institute of Integrated Medicine.

A virus that had an infection fatality rate no worse than a severe influenza season was announced to the world in late 2019. My colleagues and I immediately recommended the routine supplementation of vitamins C, D and the mineral zinc for maximising the functionality of the immune system. When the Prime Minister of the time announced it was a pandemic, a press release detailing the importance of going into an epidemic with a population optimised with these nutrients was distributed. I also wrote to the Prime Minister, the health minister, the Chief Medical Officer, the presidents of the AMA and the RACGP and other authorities on numerous occasions to recommend that all doctors ensure they tested and treated their patients for vitamin D insufficiency and deficiency—the most powerful protective mechanism we have.

Studies have shown that vitamin D prevents coronavirus infections, prevents complications and prevents death from viruses that cause severe acute respiratory infections. Vitamin D has been successfully used in COVID. Also, zinc is a known antiviral and is essential for the optimal production of antibodies and T-cells. It has been successfully used in COVID with good scientific evidence.

The final nutrient, vitamin C, is antiviral, an immune stimulant and the most powerful antioxidant for severely ill patients. It is used intravenously to prevent clinical deterioration, reduce hospitalisation rates, treat

complications in hospitalised patients and wean patients off ventilators, thus reducing hospital stays. We also recommended the proven repurposed medicines hydroxychloroquine and ivermectin for early treatment. However, these were not applied in Australia.

However, after many letters to the authorities, publications in the media and Zoom meetings with various ministers, my calls for prevention and early treatment were not acted upon. Had a proper campaign with known safe and effective repurposed medicines been established, the Australian population would have achieved natural herd immunity safely, the most powerful and long-lasting protection achievable. Instead the authorities panicked, created chaos and fear and damaged the very essence of our society and culture.

Other serious issues are the coercion to vaccinate, which continues to date, the lack of informed consent, the attacks on doctors and healthcare workers who spoke out, the very high levels of vaccination injuries and deaths, and in particular the vaccine induced deaths of Australian children—all powerful reasons for a broad based royal commission.

CHAIR: Witnesses, when you see me on my phone, what I'm doing is marshalling the order of senator questions so please don't take it as—

Senator SHOEBRIDGE: Herding!

CHAIR: I wouldn't use that term. Dr Sladden, we have your statement. Do you have some brief summary remarks you'd like to make?

Dr Sladden: I have a one-page summary. I'm a medical doctor with over 25 years of experience. I'm also co-director for Australians for Science and Freedom, which is a diverse group of Australian academics and intellectuals dedicated to free speech and the scientific method. I'm also currently a consultant to Russell Broadbent MP. I'll summarise right now why Australia needs a COVID-19 royal commission with full and appropriate terms. There has been a catastrophic failure of medical ethics, human rights and free speech in this country. I know of no health emergency so great as to necessitate the locking up of healthy people for weeks on end. There is no health emergency so great as to threaten individuals with the loss of livelihood, free passage, access to health care, education and the right to participate in society unless they submit to a course of experimental injections. I know of no health emergency so great as to require denying dying Australians the mercy to be comforted by loved ones in their final moments. There is no health emergency that makes acceptable the wholesale removal of informed consent. The catastrophic breach of medical ethics was aided in significant part by the effective silencing of the healthcare profession as a consequence of the 9 March 2021 position statement issued by AHPRA and the national boards. Those who continued to question the response soon learned what happened when such directions were ignored. Around Australia healthcare practitioners were suspended and silenced, and many remain so, for speaking out against the vaccines and the pandemic response. Those remaining were too afraid to voice their concerns, preventing one of the most important safety aspects in health care, open discourse and questioning of the science. I often wonder where we would be now had these two foundational principles, informed consent and free speech, been preserved.

Meanwhile, our healthcare system now groans under the strain of disease while highly qualified professionals remain sidelined. Thousands of Australians suffering from COVID-19 vaccine injuries struggle to get the help they need. We have persistent and alarming rates of excess mortality. Alongside this we have a crippling hangover of devastation, including economic, social and psychological harm from the lockdown policies, border closures and other draconian measures taken, none of which were part of Australia's documented pandemic plan. A royal commission must be prepared to investigate the uncomfortable truths about Australia's COVID response, the consequences of the actions taken and the state of democracy in this nation.

CHAIR: Dr Madry, we have your statement, but you're welcome to make some brief opening remarks.

Dr Madry: I have a Bachelor of Science degree with honours in physics, and a PhD. My career spans approximately 35 years. I specialise in areas including signal processing and data analysis. I've worked in defence and medical devices. I've worked with leading clinical researchers. I've written software to analyse electrical signals in the heart. I've been involved in clinical trials and providing documentation for regulatory approval. I've been an independent consultant for over 20 years. I've had a longstanding interest in health care in Australia and I lead a working group in a professional systems society in this area. I took a keen interest in contributing to the COVID response from the get-go, and I participated in various volunteer groups right from the start when very little was known. What became apparent to me was data reporting was substandard from many government agencies in Australia. From the second half of 2021 it became apparent that vaccine manufacturers' claims of effectiveness and safety were incorrect and public policies were being driven by this data. I started doing my own deep dive analysis looking into infections, hospitalisations and deaths from COVID. I then started looking into

adverse events and then coincidentally mortality was increasing, and this was an area where I had particular expertise in time series analysis.

The imposition of mandates for COVID vaccination based on data showing questionable protection from infection and then increasing adverse events alarmed me. This led me to working with groups such as the Australian Medical Professionals Society. I contributed a chapter to their recent book publication called *Too Many Dead* on excess mortality. In that I provided a deep dive into the excess mortality occurring in Queensland.

A cross-disciplinary systems approach is required to get the best healthcare outcomes for Australians and I feel that this has been sadly lacking with the narrative driven by experts with very narrow experience. I'm very pleased to provide my input to the People's Terms of Reference and answer any questions.

CHAIR: Mr Fam.

Mr Fam: Firstly, I apologise to senators for not being able to attend in person. I'm a human rights lawyer currently acting as the principal of the only completely independent specialist human rights legal practice in Australia. I've previously worked as a human rights lawyer in both private practice and in the government funded human rights specialist team. Australia is a nation that professes to care very deeply about the human rights of its citizenry. We were one of only eight nations involved in drafting the Universal Declaration of Human Rights. We're a party to the seven core international human rights treaties and covenants. Domestically, the rule of law and a strong legislative and common law and jurisprudential tradition of protecting the rights and freedoms of individuals is often referred to, but in my view the response of governments to the COVID-19 pandemic calls both the utility and authenticity of our human rights protection framework into question. Among other things, Australia's obligations under international law were summarily tossed aside. The Australian Human Rights Commission ignored its statutory function and dismissed the tens of thousands of Australians beseeching them to perform it. The rights that are enshrined in our domestic statute, such as the right to provide fully informed consent, the right not to be discriminated against and the right to privacy were all bypassed at scale. Doctors and medical professionals were barred from applying their own professional judgement and performing their necessary ethical and legal duty by an overzealous regulator acting outside the scope of its power, and central tenets of our legal system such as the separation of powers and the rule of law were damaged. Now we're met with the outcome of that, which is that Australian citizens no longer trust the medical system, no longer trust the legal system and no longer trust the political system to protect them when it counts, and this is because those systems did not protect them when it counted. A comprehensive and transparent royal commission is a minimum requirement to earning back that trust.

CHAIR: I thank the People's Terms of Reference. To the extent you didn't comment on your opening statements, they're incorporated into the record. I'll now turn to the Nurses Professional Association of Queensland. Mrs Leach, do you have an opening statement?

Mrs Leach: I'll be brief. I'm the Secretary of the NPAQ. We have over 13,000 members Australia-wide. I have tabled copies of a few of the things I reference in this statement.

CHAIR: I'll deal with the documents you've asked to be tabled at the end of your statement.

Mrs Leach: We are in the midst of a critical healthcare staffing crisis. We are seeing ambulances ramped and patients dying in them, widespread short-staffing resulting in bed block, and increased surgery wait-times. Nurses are burning out and leaving in droves. We are facing an imminent retirement cliff, yet thousands of nurses and midwives are currently unemployed. Things have worsened in recent years and it is imperative that the government's response to COVID-19 be considered as an exacerbation of these serious problems. Before COVID, health care was already short-staffed and overburdened. However, in 2021 the phrase 'we will always need nurses' apparently became redundant as thousands of nurses across Australia were barred from their workplaces for not complying with vaccine directives. In Queensland there were provisions for utilising unvaccinated staff in a critical workforce shortage. When NPAQ urgently requested for these essential staff to be utilised, Queensland Health CEOs merely highlighted the importance of vaccination. They did not address anything they were doing to mitigate the workforce shortage, despite our members and media reports showing this was a serious problem. Instead they continued to terminate nurses. We saw nurses terminated on their personal leave, terminated with medical exemptions from specialists, including some for newly diagnosed cancers and others who tried to comply but experienced severe reactions. Nurses were forced to live in their cars and unsure how they would feed their families.

Shannon Fentiman is now strongly encouraging them to reapply for their jobs, only for them to be interviewed, disclose their previous disciplinary action, be offered the job and then have the job offer withdrawn due to their misconduct allegation, which will remain on their employment profiles forever. The committee needs to consider

this: why invite nurses and midwives to apply for their jobs when they are still terminating nurses today for a directive from two years and four months ago that is no longer in effect? A nurse of 19 years was terminated two days ago. Why is an ICU nurse of 15 years unable to get a job in Queensland Health but is instead driving a truck to pay her bills? Why in Queensland are we using up to $70,000 in taxpayers' dollars to incentivise nurses to relocate from other struggling states when we have hundreds if not thousands of nurses willing to work without an incentive? They just want a job.

How can we justify terminating midwives with up to 40 years of experience while we have maternity wards on bypass and women having forced caesareans far from home? Next year we will be 100,000 nurses short in Australia. How is it reasonable and justifiable to have thousands of them absent from our public system? This morning the *Australian* reported that in South Australia it is taking 90 per cent of ambulances up to 55 minutes to respond to a Category 1 emergency. If you or your loved one required emergency care, would the fact that a paramedic had not received two doses of a vaccine when the majority of our health service are not up-to-date be your primary concern? We need accurate data on the many nurses, midwives and paramedics we have lost Australia-wide due to these workplace mandates.

The government's response to COVID-19 is not a thing of the past. Australians' lives are at risk and this is not reflective of a world-class healthcare system. It is the NPAQ's firm view that nurses, midwives and the people of Australia need and deserve a royal commission.

CHAIR: With respect to the additional documents, I've had a quick look at them. They seem fine to be tabled. I want to put it on the *Hansard* record. The first contains documents: Workers in a Healthcare Setting Direction No. 4, two points, 24 and 25; secondly, an email sent to the Hon. Yvette D'Ath, MP, and shadow health minister the Hon. Ros Bates requesting utilisation of non-compliant staff; thirdly, a copy of a letter sent to chief executive officers from NPAQ; fourthly, responses received to that letter; and, fifthly, results of a survey sent to all NPAQ members in May 2022 concerning the critical workforce shortage. That's the first set of documents. Then there's the second portfolio of documents. We will now move to questions. We have a lot of witnesses here today; before a witness answers a question, I ask that you give your name just for the benefit of Hansard. Senator Roberts.

Senator ROBERTS: Firstly, I want to express my appreciation and admiration for the work you've done—not only the people's submission but also the NPAQ submission. This is comprehensive, and the chair's job has been made so much easier. I want also to acknowledge your bravery, integrity and the personal cost you have paid over the last four years in terms of professional costs, financial costs and social costs. I also want to congratulate Mr Gillispie in particular, and the whole team, for amassing almost 47,000 signatures to what is now the people's submission. That is remarkable. I have never seen anything like this in terms of the quality of any submission anywhere. Let's get on with the questions. We have a lot of ground to cover. Professor Brighthope, in respect of the submission and in particular the index reference A can you please inform the committee whether epidemiological studies were undertaken from early 2020 and afterwards to support the notion that SARS-CoV-2 represented an existential threat to Australians beyond anything we have experienced sufficient to warrant calling SARS-CoV-2 a global pandemic?

Prof. Brighthope: There were many epidemiological studies performed in 2020, 2021 and 2022. There were no serious threats posed to Australians from COVID—no serious threats. The epidemiological studies were backed by Professor John Ioannidis, a world expert, and in October of 2020—I think every senator should read this—the Great Barrington Declaration, in which the top people from Oxford, Stanford University and Harvard University stated that the lockdowns, masking and closure of schools, or everything related to COVID that was negative, was not going to be very effective at all. As far as I'm concerned and my teams are concerned, COVID was more like a bad flu, and the lockdowns were totally unnecessary. Epidemiological studies actually have proven that. My other concern is that the authorities denied the public proper information with regard to the instructions coming from our authorities as well as the World Health Organization and other organisations around the world; there was absolutely no area of prevention or early treatment inculcated into the recommendations. This is a gross deficiency within our healthcare system, which has been pirated by the medical system; the medical system has been hijacked by big pharma. There's very little real health delivered in our healthcare system, and that's part of the systematic problem within this country and many other Western countries as well. We do not have a system in which people are made healthy by their medical practitioners. Doctors are trained to think and act in terms of disease and diagnosis and treatment with a drug. We very rarely examine the underlying causes of patients' problems.

When it comes to the epidemiological studies, we need to know the epidemiology of a particular virus or infection. More importantly, we need to go into epidemics with a population that is healthier than they have been in the past so that we can avoid the catastrophe that's occurred with COVID.

Senator ROBERTS: You've covered a lot of ground in a short time. If there's anything else you'd like to submit to back that up with a question on notice in answer to that, let me know. Submit it to the committee.

Prof. Brighthope: It's a very long answer and I'd be grateful for putting it in writing on notice.

Senator ROBERTS: Dr Sladden, in respect of your submission and in particular index reference AA, can you please inform the committee whether adverse event reporting in terms of side-effects and deaths increased significantly or not after the introduction of COVID-19 vaccines in this country and around the world?

Dr Sladden: Adverse events reports in this country, including serious side effects and deaths, have significantly increased since the introduction of the vaccines. Currently, there have been over 139,000 adverse event reports made to the TGA's passive surveillance system, the database of adverse event notifications, including 1,010 deaths. Importantly, the TGA makes clear that a report doesn't necessarily mean that there has been a causal link, but it is important for people to understand that all causality events start with correlation. There have been more adverse event reports for all other vaccines combined in the last 50 years—more adverse events for these injections than all other vaccines combined in the last 50 years on that system. The adverse event reports for the COVID injections account for 20 per cent of all reports for all medicines on the DAEN system. There is a significant underreporting factor which has been widely recognised in the medical literature. Conservatively, this is around 10 to 1, but rates have been estimated as high as a 100-fold underreporting factor. Even for well recognised adverse events with medications there is still a fourfold underreporting factor. We can pretty much guarantee that there is an underreporting factor associated with these injections. As I mentioned, the TGA's reporting system is a passive surveillance system. Comparatively, the AusVaxSafety system, which is an active system, received 2.8 million adverse event reports in this country to January 2023 from 6.3 million surveys. If you want to have a look specifically at Australian data, just take a look at the Western Australian Vaccine Surveillance report 2022, which showed that there was a significant spike and reporting increased by 24 times per 100,000 doses of the vaccination. This in the report was cited as an exponential increase. The answer is quite long and detailed. Can I please provide the rest of my answer in writing and on notice?

Senator ROBERTS: I'm sure the committee would welcome that.

CHAIR: We would welcome that. Can I suggest to other witnesses: please feel free to take advantage of that opportunity to provide a brief answer in the context of this committee, and then provide further comments on notice. I do note we have five senators wanting to ask questions. Senator Roberts.

Senator ROBERTS: Dr Madry, in respect of your submission, and in particular index reference V, can you please inform the committee whether Australian governments were transparent and provided reliable and timely public access to data scientists like yourself to COVID infection or mortality statistics by vaccination status and whether that data was being accurately used for the assessment of cases of hospitalisations and deaths due to COVID-19?

Dr Madry: The answer to that question depends across agency in Australia. The Australian Bureau of Statistics provides data on mortality of all causes and against other certain diseases. I can say that the ABS provides data with a high quality of curation. They provide a professional service which I can attest to first-hand is of professional quality. ABS is limited by the timeliness of data that comes into them. I note that coroners reports over the last few years have taken an inordinate time. That restricts their ability, but it's a very high-quality service. However, I can't say the same for other agencies in Australia, the state health departments and the TGA. I can only describe this as being haphazard. New South Wales Health provided the most granular data during the pandemic. They provided data of vaccination status against infections, hospitalisations and death. However, the problem with it was that the categorisation started changing. They were categorising people with no dose and then as one dose and then unknown dose, and joining together, and then undervaccinated. This failure to categorise data properly makes it very difficult for analysts such as myself.

Towards the end of 2021 it became apparent from the data in New South Wales that people who were vaccinated had a higher rate of infection than people who were unvaccinated. I note this is observational data and that has limitations, but the same thing was going on around the world and there are even recent publications saying the same thing. It wasn't a pandemic of the unvaccinated. But then the department shut down this reporting. At the end of 2022, it looked like all the hospitalisations were of vaccinated people. Then that data was shut down.

For other states, the information was more restricted. In Queensland a group called the Doctors Against Mandates took the Queensland Chief Health Officer to court and they uncovered other information such as similar statistics on infection rates against vaccination. There were also issues of the status of COVID in different people. There was a case where a young man who was killed in a car crash was temporarily classified as COVID. That

also goes to the ICD-10 codes for COVID, and that's part of the reference V that you've provided there. It's a very detailed answer to go into all of that. If possible, I'd like to give my answer on notice in writing.

Senator ROBERTS: We'd welcome that. Mr Fam, in respect of your submission and in particular index reference D, can you please inform the committee whether in your view Australian governments need to answer for any human rights violations during 2020 into 2023 and whether Australian governments failed to observe the Nuremberg Code during the same period?

Mr Fam: In particular, there is an array of human rights protections under the covenants and particularly the International Covenant on Civil and Political Rights and, yes, the Nuremberg Code, which had been blatantly breached. For example, part 3, article 7, of the ICCPR states that nobody shall be subjected to medical or scientific experimentation absent their fully informed and free consent. That's a non-derogable article with no exceptions attached to it. With respect to those rights enshrined in our domestic law, the Australian Human Rights Commission Act empowers and obligates the Australian Human Rights Commission to inquire 'into any act or practice including any systemic practice that may constitute discrimination, including on the basis of medical record'. Despite state and territory governments and private companies discriminating en masse against people who opted against undergoing vaccination, the Human Rights Commission did not act. The Privacy Act contains strict boundaries on the collection, storage and use of a person's private information. That was ignored and bypassed at large-scale. There are so many examples. For me to properly detail all of the human rights breaches I'd request that I could please provide the rest of my answer in writing on notice?

Senator ROBERTS: Yes, we'd welcome that. I've been told I have to share the call, which is fair enough. I'll put my other questions on notice to you all. There may be an opportunity for me to continue in this bracket.

CHAIR: Thank you, Senator Roberts. I appreciate your indulgence. Because we have so many witnesses every question is taking some time. Deputy chair.

Senator GREEN: I have some questions that were a bit hard to understand from the submissions. Mr Gillispie, in terms of the People's Terms of Reference, what sort of organisation is it?

Mr Gillespie: It's the organisation of the individuals you see as co-authors on pages 2 and 3. We're not a Pty Ltd. We're not registered as any form of legal entity. We are a group of concerned lawyers, elite medical doctors in this country and elite scientists from all of the different disciplines who have been in communication variously for the past three years about all of the concerns that you see expressed in the document. It was not difficult for me to suggest that we all come together to assist with co-authoring the document you see presented in the 111 pages.

Senator GREEN: I don't mean to interrupt you. It was really a question about whether you're an association or an incorporated entity. If that's the case, I'm just trying to understand where your organisation is based. Do you have an office space?

Mr Gillespie: We're on the internet. We're on the telephone. We communicate by whatever means we choose to, an individual or one-one-one basis. We haven't got a constitution behind us or any governing rules as such.

Senator GREEN: I wanted to understand what the association was with the Red Unions Support Hub. You said you live on the internet. You have a petition I think or a page?

Mr Gillespie: I understand your question. Many of the coauthors have known personally and professionally the leadership team of the Australian Medical Professionals Society. When I finished drafting the terms of reference with Peter Fam and Katie Ashby-Koppens we shared those with Kara Thomas, the secretary of AMPS, and we said we need to really share this and get as many co-signatories in support that we possibly can and any other organisations. AMPS very kindly became a collaborating organisation, and there is a web link at the end of page 3. You'll see that landing page. We were joined by another 30-odd I believe organisations as a collaborative effort to inform the memberships of all of those other organisations and inform the public if they wished to become cosignatories.

Senator GREEN: I think that's how I found the landing page. I clicked on that link in your submission. Thank you for that. I noticed that it was being hosted by the Red Unions Support Hub.

Mr Gillespie: That was just a fortunate offer that we could take up at the time. I'm also a director of Children's Health Defence Australia, and at the time our platform was experiencing IT issues. AMPS kindly offered to host the landing page.

Senator GREEN: Have you had an opportunity personally or as a collective to make a submission to the Commonwealth government's COVID-19 response inquiry?

Mr Gillespie: I can inform you that many co-authors appearing on pages 2 and 3 individually submitted to the PM's inquiry, but no such organisational effort as you see with the People's Terms of Reference was undertaken for that task because many of the co-signatories appearing on our terms of reference believed that the Prime Minister's inquiry is not really going to assist to answer the questions that need to be answered.

Senator GREEN: I've asked other witnesses this. It is a little difficult given maybe some individuals have or haven't. Maybe even on a personal basis you could provide a list of other inquiries you might have made submissions to? That would be helpful.

Mr Gillespie: Please allow me to take that on notice, because that list is quite substantial.

CHAIR: Just to be clear, I think what you're asking, Senator Green, is whether all of the witnesses could potentially take that on notice?

Senator GREEN: I think the witnesses that are appearing, but mainly Mr Gillespie as the spokesperson.

CHAIR: That's fine.

Senator GREEN: In terms of the NPAQ, Ms Thomas, what is your position now? I think I saw that you were previously with one of the other organisations on the Red Unions Hub?

Ms Thomas: I'm currently the Secretary of the Australian Medical Professionals Society and President of the NPAQ.

Senator GREEN: It's a dual role?

CHAIR: Please speak into the microphone. You have a very soft voice.

Ms Thomas: I'm also the Secretary of the Australian Medical Professionals Society.

Senator GREEN: Those two organisations are also on the Red Unions Hub, based in the same office?

Ms Thomas: Yes.

Senator GREEN: So, based in the same office along with, I'm assuming, the Teachers' Professional Association of Queensland?

Ms Thomas: That's correct.

Senator GREEN: I think in the opening statement, Ms Leach, you referred to the numbers of members. How many members do you have in Queensland?

Mrs Leach: We have over 10,000 nurses and members in Queensland.

Senator GREEN: That are registered members of your organisation?

Mrs Leach: Yes.

Senator GREEN: How does someone become a member of the organisation?

Mrs Leach: They navigate to our website or we speak to them in person and they decide to sign up with us.

Senator GREEN: They have to fill out a form?

Mrs Leach: Yes, it's a paid membership.

Senator GREEN: In terms of your role, when did you start? What sort of role is yours? Is it just honorary?

Mrs Leach: No, I'm employed by Red Unions Support Hub.

Senator GREEN: When did you start with them?

Mrs Leach: February last year I stepped into the secretary role.

Senator GREEN: February 2023?

Mrs Leach: I am losing track of the years.

Senator GREEN: That's helpful. With your association, during the pandemic what was the role that you played?

Mrs Leach: Personally?

Senator GREEN: No, the organisation.

Mrs Leach: I've been a member of NPAQ for the last seven years personally. They existed well before the mandate started, but they were one of the only associations that—

CHAIR: Sorry, Mrs Leach. Senator Rennick, you say you have a point of order?

Senator RENNICK: That's correct. We're not actually conducting a job interview here. Can we get back to the issue of the royal commission and why we need one?

CHAIR: Senator Rennick, that's not a valid point of order. Senator Green, you have the call and I'm giving you until 11.35, if I can.

Senator GREEN: For Senator Rennick's information, I just want to understand what period Mrs Leach could speak to. That's helpful. During the pandemic?

Mrs Leach: Yes. They were one of the only associations that actually took on these mandate cases. The other unions left their members out to dry, basically. We had a lot of people turning to us, but we already had members before that.

Senator GREEN: The NPAQ is not a registered union, though?

Mrs Leach: No, it's not. It's a professional association.

Senator GREEN: I might leave it there, Chair. I might have some other questions on notice.

CHAIR: Senator Antic.

Senator ANTIC: Can I also start by acknowledging the bravery of the doctors and nurses who stood up during this period and acknowledge those who, as one of the presenters said earlier, are still mandated out of work, which is an extraordinary thing in 2021 let alone 2024. Thank you for your bravery and to your members as well. I'll direct this question to Dr Sladden or maybe Mr Gillespie, who might be well placed to answer it. I'm interested in some of the commentary that's been placed around the period known as COVID and what it did to public confidence in the institutions, in the medical industry and in the pharmaceutical industry as well. The perception that I hear when I speak to people and that I see reported is that the COVID period and the manner in which it was approached by some of those bodies has perhaps—and hopefully not—in the short term damaged beyond repair the perception and the trust that people have in those institutions and whether or not they think that a royal commission would go a long way to repairing some of the trust that has been lost and damaged during that period by the response.

CHAIR: Whom would like to take that?

Dr Sladden: I'll take that question.

CHAIR: Dr Sladden.

Dr Sladden: In one summarised statement, trust has been certainly eroded significantly in the medical profession and also various industries and systems associated with that. I think this is in part due to the breaches of informed consent and human rights and free speech, as I outlined in my opening statement, and also there has been definite clarity. The nefarious relationships that seemed to exist both in front of the scenes and also behind the scenes, and a lack of transparency over some of the decisions that were made. For example, the contracts with the pharmaceutical companies are still not available to the people. Taxpayers' dollars were used to purchase these injections. I think the Australian people have a right to know under what circumstances they were purchased. The most significant erosion of trust in my opinion happened in the consultation room of individual doctors and individual patients. Basically, there was an insertion of bureaucracy and a direction that had never been seen before in that sacred space between a doctor and a patient. There was a breach of informed consent. The answer I'd like to provide is quite detailed. I know we're short on time. I would really like to provide the rest of the answer on notice, if possible, please?

Senator ANTIC: Thank you.

CHAIR: Do you have anything else, Senator Antic?

Senator ANTIC: I wondered whether Mr Gillespie might have anything to add to that as to whether or not he thinks from his interactions with people that the trust that's been lost in the institutions is recoverable and whether a royal commission will go any way to restoring that?

CHAIR: Mr Gillespie.

Mr Gillespie: Trust has been lost in so many quarters. It's not only the doctor-patient relationship; now mum and the family can't trust the GP they were attending for the last 20 years because the government has inserted themselves in between the relationship. Trust has been lost in an authority called AHPRA, which was meant to simply ensure there was no unprofessional conduct by our health practitioners. But now we find that AHPRA is predatory and has been pursuing any doctor or health practitioner who has spoken against the government narrative that all Australians take up an experimental drug. Now we have doctors committing suicide because of the actions of AHPRA. That affects communities. When a doctor in their community commits suicide, the community loses trust in the support facilities and professional support agencies for those doctors. We watched endlessly, at least in New South Wales but I'm quite sure it occurred in every other state in the country, premiers and politicians without any medical qualifications come out and assure the public that a new experimental drug

hot off six months of clinical trials was safe and effective. It was the biggest marketing coup by big pharma in big pharma's history. None of those politicians had any qualifications, and now across the country every person here is fielding calls every second day from vaccine injured or families of deceased from these vaccines. They're not vaccines. They never were vaccines. They're gene therapies. They contain GMOs. The country was not informed.

The guy on the street in this country just knew a modus operandi for 60 or 70 years. The values handed down to them from their grandparents that made the social contract in this country was torn up and burnt by government during the era of COVID. There's a lot of trust to be earnt back here and it's only going to occur once we get a royal commission and have the bad actors admit that they did wrong.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: Thank you for the submission. I'd be interested to know whether we have some sort of common understanding about the general benefits of vaccinations? Do you accept the enormous public health outcomes from vaccinations for, for example, polio, measles, tetanus and influenza? Do you accept that there are huge public health benefits from vaccinations for those four diseases?

Mr Gillespie: Every person in this room is going to have a different opinion on how that question is best answered.

Senator SHOEBRIDGE: You come here as an unincorporated association. That's a matter of your structure. I'm putting it to the whole panel. If you can't answer on behalf of the whole panel, I'm putting it to the whole panel.

CHAIR: We'll give each person on the panel an opportunity to answer Senator Shoebridge's question. Mr Gillespie, do you have anything further to add?

Mr Gillespie: I will lead out and say that we had pre-existing technology for the production and manufacture of vaccines in this country prior to COVID, which involved time-tested techniques for safety and efficacy, and we never saw the types of injury and mortality rates like we saw with the so-called COVID-19 vaccines, which introduced an entirely new and novel technology.

Senator SHOEBRIDGE: Is that a yes, you accept the—

Mr Gillespie: No, I do not. Because polio introduced this in—

CHAIR: Everyone, including myself, needs to be mindful of Hansard. We need a separation between questions and answers. If we can—

Senator SHOEBRIDGE: My issue was that I asked the question and I was trying to direct the answer back to the question. For the vaccinations for polio, measles, tetanus and flu, do you accept the enormous public health benefits?

Mr Gillespie: As a director of Children's Health Defence Australia, I do not accept the benefit that you're alluding to.

Senator SHOEBRIDGE: What about the rest of the panel?

CHAIR: We'll go through in order. Professor Brighthope, do you have anything to contribute?

Prof. Brighthope: My answer will be quite detailed. Could I please put it on notice in writing?

CHAIR: Of course you can. Dr Sladden.

Dr Sladden: I would like to say that what I hear you asking, Senator Shoebridge—and please correct me if I'm wrong—is whether I personally accept vaccinations that up until this point have been seen to provide enormous public health benefit? Is that correct?

Senator SHOEBRIDGE: I'm asking the question I asked. Do you accept the enormous public health benefits from vaccinations for polio, measles, tetanus and flu? Do you accept that as a starting premise?

Dr Sladden: No. 1, I would like to clarify that each of those vaccinations has their own risk-benefit analysis, and each of those vaccinations goes through its own individual testing and has its own safety regulations, and we have decades of evidence on how effective these are. I cannot answer for all four of those vaccinations, but I will tell you that I am fully vaccinated. My family are fully vaccinated, and I think there is a lot of detail that needs to go into the rest of my answer. I am very happy to provide that on notice.

CHAIR: Mr Madry.

Dr Madry: I'll give a data perspective of this. As we know, every medicine has adverse events. It doesn't matter what it is. The medicines you've referred to would have their own adverse event profile, which I can't quantify specifically. However, we have been looking at the relative effect of those medicines as compared with

other medicines. I actually have data here that I'll provide on notice. Dr Sladden in her opening statements referred to the fact that the adverse events from the COVID vaccines accounts for 20 per cent of all adverse events in the 53-year history of the database of adverse event notification. That's 20 per cent of all medicines over the 53 years. If I looked at just chest pain, the COVID medicines make up 70 per cent—

Senator SHOEBRIDGE: Sorry. My question was about vaccinations for polio, measles, tetanus and flu. I'm just trying to see whether we had some sort of common starting point about vaccinations and about the enormous public health benefits of vaccinations. So, in relation to those, what's your position, Dr Madry?

Dr Madry: I can't state a position at all. All I can state is that the relative safety of the COVID-19 vaccinations is extremely adverse compared to those medicines.

CHAIR: Mr Fam, can you hear us?

Mr Fam: Yes, I can. The first thing I would say is that I'm a human rights lawyer and you're receiving an answer on notice from Professor Brighthope and Dr Sladden which would be much more useful than what I could say. If you're asking for my personal opinion, I'm happy to give it, but it's not my field.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: Do Mrs Leach or Ms Thomas have a view?

Mrs Leach: I am personally vaccinated against all the other vaccines that I was required for my work. I believe that prior to this it was on a case-by-case basis. There were people who had exemptions from other vaccines in the past because it was accepted that every individual has a different need and our bodies react differently. That would be my answer.

CHAIR: Ms Thomas.

Ms Thomas: I, like Mrs Leach, am vaccinated in full. We're here to discuss the COVID terms of reference.

CHAIR: Senator Shoebridge.

Senator SHOEBRIDGE: I was hoping we could have a clearer baseline of agreement on that than we got. There have been innumerable studies about the effectiveness or otherwise of COVID vaccines. Perhaps one of the first comprehensive studies was published in the *Lancet* in June 2022. It looked at excess deaths and preventable deaths and found that COVID-19 vaccinations had at that point or at least by the end of 2021 prevented some 14.4 million deaths as a result of comprehensive vaccinations across the globe, and it crunched the data in some detail. Is it your evidence that's just a mistake or is it your evidence that somehow that study and the other studies like it are mendacious in some way?

CHAIR: Mr Gillespie, can you point us to—

Mr Gillespie: I will first briefly answer that question and then proceed to provide the balance of my answer on notice in writing. The original *Lancet* paper that you cited was created by the actual manufacturers. This question—

CHAIR: Mr Gillespie, Senator Rennick has a point of order. Senator Rennick, what is your point of order?

Senator RENNICK: Chair, has that document been tabled, that *Lancet* paper?

CHAIR: It hasn't been tabled. Senator Shoebridge, you might be able to provide us with a link to it? I'll give some discretion—

Senator RENNICK: It's a bit unfair for these people to answer that question if they haven't had a chance to look at the study.

Senator SHOEBRIDGE: Firstly, the witnesses are obviously very familiar with it, because they've immediately engaged with it. It's the *Global impact of the first year of COVID-19 vaccination: a mathematical modelling study* published in the *Lancet*. That will help Senator Rennick.

Senator RENNICK: A mathematical model is not the same as a study. We need to be very careful about making assumptions using models—

Senator SHOEBRIDGE: That's not a point of order.

Senator RENNICK: rather than real-world observations.

CHAIR: Senator Rennick, that's a comment rather than a point of order. I think Senator Shoebridge has referred to the particular paper. If witnesses want to take it on notice and come back with a more fulsome answer once you've had a chance to reflect; otherwise, I will give you the opportunity if you do want to provide a response to Senator Shoebridge.

Senator SHOEBRIDGE: I will just for the record note that the funding is disclosed by the authors, and the funding is not as the witness suggests from the pharma industry.

CHAIR: Noted, but let's try to keep this to questions and answers.

Mr Gillespie: Thank you, Senator Rennick, for seeking the clarification. I thought I was speaking to the *Lancet* papers in support of the actual vaccines, not the modelling. On the modelling, no study to date has been proven to be correct. Every single modelling study has been proven to be incorrect and based on false assumptions. I'm more than happy to provide the rest of our answer on notice to show this committee that none of the models put forward in early 2020 and 2021 have proven to be anywhere as accurate as they were purported to be in the media and utilised by government to scare the population.

Dr Madry: It's a very relevant question. I'm not specifically familiar with that paper. There was a paper published in the *Lancet* Western Pacific edition by Australian authors last year which found similar benefits. There has only been one set of randomised control trials, which are the gold standard, and they were the original manufacturer trials from Pfizer and Moderna. Those trials weren't powered to detect improvements in benefits from death or hospitalisation; they only dealt with infection. They didn't prove that. That one was modelling. That's a different thing altogether. Observational studies are confounded because they don't match up the patients, and the way it turns out is people who take more vaccinations tend to be different from those who don't in terms of their health outcomes. The Australian study by Liu and colleagues in the *Lancet* last year found benefits of hospitalisation and death from COVID vaccination and more boosters. However, that study also showed mortality benefits. The people who took more COVID vaccines somehow lived longer. It also showed a benefit against cancer. That was clearly ridiculous, if you look at the broader scope. It's a common thing that happens in observational studies, because the people who take more vaccinations have a different health profile from those who don't. So, 80-year-olds who don't take vaccination could be close to death, and so many of these studies are confounded.

We'd be very happy to provide a detailed analysis of papers such as that and others to show this. The only studies that have been done in randomised control trials are the original manufacturers trials, which as Mr Gillespie just said had a very short period of follow-up. It's a very good question.

CHAIR: Dr Madry, please feel free to take it on notice and provide further information. Senator Shoebridge, last question. I have to share the call.

Senator SHOEBRIDGE: I could start there, but I could point to study after study that shows enormous public health benefits from the vaccine rollouts that happened globally. Is it your position that those studies are all just in error; they're based upon innocent misreading of the data or innocent mistakes in the modelling? Or do you think it's some kind of global conspiracy which sees paper after paper that are peer reviewed and go through the standard scientific testing process? Do you think it's part of a broader conspiracy or do you think it's just thousands and thousands of innocent mistakes? What's your position?

CHAIR: Senator Shoebridge, I am going to give the witnesses an opportunity to answer the question. I suspect it will be helpful for the witnesses if you could provide them with the particular studies you're referring to so that they have an opportunity to take that on notice and give you particular responses, if you're minded to do that. That's up to you.

Senator SHOEBRIDGE: I may do that on notice later, but the question—

Senator ROBERTS: As I understand it, Dr Madry has offered to do that.

Senator SHOEBRIDGE: My question is—

CHAIR: Senator Shoebridge, I think they heard your question. Dr Madry, do you want to provide an answer to the question?

Dr Madry: I'll just give a very brief answer. I understand you're asking whether this is a conspiracy. I can say from experience it's very easy to be mistaken with data. In terms of all of the deaths that occur, the COVID deaths are only a percentage. Of all of those studies, none provides the raw data that allows independent scrutiny, and that's the issue. If we had the raw data which was anonymised we could do the analysis and prove it, but unfortunately none of those studies provided the raw data that would allow independent consultants and analysts, doctors, to confirm those reports.

CHAIR: Mr Gillespie, I know you'd like to say something else, but if I can ask you to put it on notice I do need to move on. I have some questions I want to ask Mrs Leach. Senator Rennick has advised me—

Senator SHOEBRIDGE: Nobody else has an answer to my question?

CHAIR: If they do, I'd ask them to put it on notice. I need to move on. We have limited time. I have some questions I wanted to asked Mrs Leach. Please feel free to provide further answers on notice.

Senator SHOEBRIDGE: Chair, we have another 34 minutes. I think we could at least get an answer.

CHAIR: Sorry. We have another 20 minutes.

Senator SHOEBRIDGE: Can we at least get an answer?

CHAIR: If anyone else wants to say—

Mr Gillespie: We invite Senator Shoebridge to provide the list of his studies so we can speak against each one of them in turn and show you where they're wrong.

Senator SHOEBRIDGE: For the record, that's not an answer.

CHAIR: Senator Shoebridge, you can ask the questions, but you can't dictate to the witness how they might answer them.

Senator SHOEBRIDGE: I agree. But you could at least engage with the question.

Mr Gillespie: Respectfully, you mentioned a list of hundreds of studies and you expect us to provide you with a detailed response to unidentified studies?

CHAIR: Mr Gillespie, our process doesn't permit witnesses to ask questions of senators however relevant they may be. Dr Madry, a last point before we move on?

Dr Madry: Some of those studies that showed the huge benefits may have occurred in 2021 for the Wuhan strain of the virus; 2024 is a different year. Peer-reviewed studies that came out just last week are showing no statistical improvement from boosters for people who have been previously infected. Most of the populations have been infected. Mrs Leach said that nurses are still being stood down. The evidence at the moment is that vaccination is a completely different proposition in 2024 from what it was in 2021. That's the other subtlety to the answer.

CHAIR: Thank you, everyone, for your patience. Mrs Leach, I have some questions for you. I've read your opening statement, which you tabled. I want to delve into some of the issues. You say on page 2 that a nurse of 19 years was terminated two days ago?

Mrs Leach: Correct.

CHAIR: Are you saying that this nurse of 19 years was terminated two days ago in relation to a failure to comply with a vaccine directive that was issued more than two years ago?

Mrs Leach: Correct. The mandate dropped in Queensland on 21 September. The health minister said—

CHAIR: Sorry? Which year? We need to be clear.

Mrs Leach: So, 2023, last year. It was revoked. While it was being reviewed, they continued terminating nurses and immediately after it dropped it continued; there have been probably up to 100 I know of personally who have been terminated since then. This nurse was terminated, yes, two days ago.

CHAIR: You referred to when the mandate was lifted in 2023. What I'm trying to get to the bottom of is was this nurse that you referred to terminated for failing to comply with a directive in 2021?

Mrs Leach: Yes, for failing to follow a reasonable direction. It's semantics now. The government will say it's not because they didn't get vaccinated, it's because they didn't follow a reasonable direction. She is now considered insubordinate.

CHAIR: I'm trying to understand this. Over two years have passed since, from the employer's perspective, there was a failure to follow the reasonable directive. But termination action wasn't taken on that alleged breach of an employment contract until more than two years later? Is that what you're saying?

Mrs Leach: Yes, and I have experienced this myself.

CHAIR: I'm going to ask you to share your personal experience, as I have asked other witnesses earlier today. Has this been raised with the employer, the appropriateness of actually terminating someone for something that occurred more than two years ago? You have a situation where this is hanging over an employee's head for more than two years? Has this been raised in front of industrial relations commissions or courts as to whether or not this is appropriate, reasonable or valid?

Mrs Leach: I am unsure about the period of time. I have personally put in an unfair dismissal appeal based on my termination which happened on 3 January. I was stood down in 2021.

CHAIR: Can you just provide us with a time line in terms of your own personal experience with respect to the key events? I think you understand the chain of questioning I'm asking in relation to the time that's passed and what happened?

Mrs Leach: Yes. I worked at Queensland Children's Hospital for four years. Paediatrics is considered a speciality. I was stood down on very short notice in 2021 along with thousands of other nurses.

CHAIR: When in 2021 were you stood down?

Mrs Leach: It was complicated. They initially wanted to stand us down at the end of September 2021, but if you had applied for any form of exemption on very short notice they said, 'Actually you can work for another month.' As you can imagine, it was a very stressful time for people, having no clarity on what was happening. I turned up for my last day of work with no clarity on what was happening with my employment, just that I was not able to return to work from that day forward. Basically, I'd received three threat-of-termination letters over two years. Even though I responded to each of them differently, I have not, I don't believe, had any appropriate response to my responses. They staggered these terminations over the two years. Some people were terminated on Christmas Eve in 2021, and then they were firing people in Christmas week 2023. I don't understand it. There's no method to the madness. In my role, I've seen the same hospital will fire nurses at different rates in that same area. No-one is treated the same.

CHAIR: It would be helpful if you can provide on notice a bit of a chronology with respect to particular events and particular cases.

Mrs Leach: Yes, absolutely.

CHAIR: When were you terminated?

Mrs Leach: On 3 January this year, 2024.

CHAIR: Let's get this clear for the record. You were terminated on 3 January 2024 in relation to an alleged failure to follow a reasonable direction in September 2021. Is that correct?

Mrs Leach: Yes, correct.

CHAIR: So nearly 2½ years after the event?

Mrs Leach: Yes.

CHAIR: You had the prospect of termination hanging over your head for more than two years.

Mrs Leach: Yes. When I was initially stood down they never made it clear that termination would be on the cards.

CHAIR: How did it crystallise in January 2024 that you happened to be terminated more than two years after the event?

Mrs Leach: They have to review your disciplinary matter every six months, I believe. Mine had come up for review and they'd extended me, to be stood down without pay, which is ridiculous when we are in the middle of a critical workforce shortage. They still have nurses stood down without pay who could return to work. They reviewed and extended my suspension until March 2024, but then I received a show-cause letter shortly after applying for maternity leave, which was not connected, but they did approve maternity leave for me.

CHAIR: Sorry to interrupt. You'd been stood down. You hadn't been terminated for an event that had happened in September 2021.

Mrs Leach: Yes.

CHAIR: You applied for maternity leave when?

Mrs Leach: I applied for maternity leave on 2 November 2023.

CHAIR: More than two years after you had been stood down.

Mrs Leach: Yes.

CHAIR: Then you were terminated after you applied for maternity leave, though you say you don't think the two were connected.

Mrs Leach: I cannot say that they are connected, but at a hospital level they said they couldn't deal with the matter. They escalated it to the Department of Health. The Department of Health approved my maternity leave and then they terminated me after three weeks, I believe.

CHAIR: You're stood down more than two years after the direction which form the basis of your termination in January 2024 is given, and no action was taken to terminate you on the basis of that directive up to the point in time when you applied for maternity leave in 2023. You're saying your maternity leave was then approved.

Mrs Leach: Yes.

CHAIR: Then you were terminated after the maternity leave was approved.

Mrs Leach: Yes. I was technically on my own leave when they terminated me.

CHAIR: If you could provide a chronology and if you have other case studies of those chronologies, I would find that helpful. The effluxion of time between the initial event and the termination is something I'd be mindful to get further details on. I have a second question. On the first page you say that nurses were terminated with medical exemptions from specialists, including some for newly diagnosed cancers and others who tried to comply but experienced severe reactions. Can you explain to us, based on your experience representing nurses in this situation: if a nurse presented a certificate from a specialist, whoever it is, on what basis was it explained to them as to why that evidence from a professional medical practitioner was not accepted? What was the process that nurses went through?

Mrs Leach: As I said before, there was no method to the madness. There didn't seem to be a way that each case was dealt with in a similar fashion. With a few cases that were to do with newly diagnosed cancer they had an oncologist write them a letter saying, 'They are commencing treatment. We do not recommend that they get vaccinated at this point in time.' They provided that in the form of an exemption application to Queensland Health with the supporting documents attached, and then Queensland Health in many cases will put them through an independent medical examination. They will appoint their own doctor who says, 'I'm not telling you that you need to get vaccinated, but I'm assessing your risk in the workplace.' They will then assess their risk. Some people might have been put on special leave, but there were a lot who were told, 'It is too risky for you in the workplace. Here's your show-cause letter.' People received threat-of-termination letters and termination letters because Queensland Health deemed that they were unsafe in the workplace.

Senator ROBERTS: For a virus that was deemed low to moderate in severity.

CHAIR: Mrs Leach, if you have any particular case studies dealing with that issue I'd be interested to receive that evidence on notice. Senator Rennick, thank you for being patient. We have until 12.15 pm.

Senator RENNICK: My question is to all witnesses. In relation to Senator Shoebridge's question about your views on vaccination, do you accept that this vaccine is different from all prior vaccines because this is the first drug that was designed to cross the cell membrane and use the cell's own ribosomes to produce a spike protein that's toxic to the body that then induced an autoimmune response, unlike other vaccines that induce an immune response?

CHAIR: Mr Gillespie, who is best placed to answer Senator Rennick's question?

Mr Gillespie: We all are, but I'll quickly provide my own response. The technology involved with the modRNA LNPs has been tried for nearly a decade of development with Moderna and they failed in all of their clinical trials because all of the animals or early human participants essentially died. Somehow the same technology was deemed fit for Australians to receive.

CHAIR: Professor Brighthope.

Prof. Brighthope: This vaccine, if you can call it a vaccine, is new technology applied to almost the entire global population without showing adequate levels of efficacy and safety. In fact, my first reaction when I heard it was going to be a vaccine—the mRNA—was, 'No, this is too dangerous.' When we hear about it being wrapped up in a nanoparticle, we know it's not going to stay in the deltoid muscle. It would never stay in the deltoid muscle as we were promised. It travels all around the body. It travels to the brain, the heart, the blood vessels, the testes and the ovaries. This is why we're seeing so many people suffering from serious adverse reactions, including a lot of heart disease, degenerative central nervous system-type disorders, autoimmune diseases and many gynaecological problems/female problems. This also contains DNA fragments. DNA and mRNA can transcribe and end up in the nucleus of our cells, including in our germ cells. This is so risky. It should never have been injected into a single human being. We don't need to wait for experimental vaccines for 18 months or two years when we have a viral-like illness that causes a severe influenza-type disorder. As I mentioned before, we have ways of preventing and early treatment, and the prevention, vitamins C, D and zinc and the early treatments with azithromycin—

Senator RENNICK: Thank you. That's all. I don't want to go down that rabbit hole. Can we just stick to the question, please. I'll move on. So you do recognise that there's a difference in pathway between traditional vaccines and this one. That is the question?

Prof. Brighthope: Yes, Senator.

Senator RENNICK: I know Senator Shoebridge quoted a mathematical model that was funded by the Bill and Melinda Gates Foundation and the Garvie Institute. I actually want to come to real-world observations—in particular, in Australia. Are you aware that the number of deaths in Australia jumped from 162,000 to 172,000 in 2021? In particular, the jump in 10,000 deaths occurred from May onwards, which was after the rollout of the vaccines but before COVID spread throughout the community.

CHAIR: Mr Gillespie, who is best placed to answer?

Mr Gillespie: I'd like to hand that over to Dr Madry.

Dr Madry: Yes, we're well aware that 2021 was when excess mortality started trended upwards. I personally looked into the data in Queensland when there was no locally acquired COVID in the community, and it's clear, as you say, that in the second half of 2021 mortality trends started trending upwards, particularly in the older ages. If you went to 2022, yes, the results are more difficult to interpret because of COVID, but there is an excess of all-cause deaths, even in you subject COVID deaths. The figure now that I think is the most crucial is the cumulative excess mortality. Deaths of frail people should be compensated for with an effect where, if they didn't die then—

Senator RENNICK: I don't want to conflate the issue. I want to talk about 2021, when there was no COVID in the community. Can anybody tell me why there was a jump in excess deaths of six per cent, or 10,000 people, in the eight months prior to COVID getting into the community? What in your view was the cause of those excess deaths, given that COVID hadn't got into the community?

Dr Madry: What was the cause? It's very difficult to say the cause. However, there is definitely a correlation. The vaccines certainly went temporally before. As to the increase in mortality—it's coincidental that it goes up shortly after; we can correlate with the adverse event reporting system. One of the things the People's Terms of Reference group is asking for is more detail into the adverse event reporting over that time. If we could have more visibility of the AIMS system, the frontline reporting system, the temporal and causal relationships would be quite obvious.

Senator RENNICK: That's something that's worth investigating in a royal commission, do you believe?

Dr Madry: I definitely believe that.

Senator RENNICK: For the doctors and nurses in the room: were you ever informed by the government that this vaccine used a biological process of transfection of codon optimisation? Were you made aware of the body of endogenous transcriptase, reverse transcriptase, which converts RNA back into RNA? Were any of the nurses or doctors in this room ever informed by the government of those risks?

CHAIR: Dr Sladden.

Dr Sladden: To my knowledge and from the information I was closely watching across my desk there was certainly no information that I saw detailing any of those processes. I would also hazard that many, if not most, doctors now would be completely unaware that transfection and codon optimisation were any part of the processes involved in the mRNA technology.

Senator RENNICK: That codon optimisation, as per the TGA non-clinical report, was actually used to increase the expression of a protein, which is yet again different from a normal vaccine, which is attenuated. This vaccine was designed to increase the expression of the spike protein. Are you aware of that? Were you made aware of that?

Dr Sladden: No, the government did not make doctors and medical professionals aware of that, but they were made aware that the vaccine caused the body to make the spike protein and that then resulted in the immune response. You can imagine that it wasn't just the immune cells or any particular cells that were producing the spike protein. The lipid nanoparticles were actually being transported around the body and we still do not know when the spike protein ceases to be produced in the body following vaccination—another issue that was not made known to doctors.

CHAIR: Senator Rennick, we've hit a hard marker for our luncheon adjournment. Can I ask you to put any further questions on notice.

Senator RENNICK: Just one?

CHAIR: Just one last one, quickly.

Senator RENNICK: Mrs Leach, I'm led to believe you're pregnant. Congratulations. Were you ever made aware by your employer that studies showed that the lipid concentration in the ovaries doubled in the trials from day 1 to day 2, and then the trials were stopped. The concentration of the lipid in the ovaries was still increasing when they stopped the trial. Were you made aware of what the risks of that were to pregnant women?

Mrs Leach: It was not relevant to me at the time. I wasn't pregnant so I wasn't keeping an eye on those things, but there were emails sent out trying to encourage pregnant women to be vaccinated. They did not provide a lot of information for pregnant women and studies.

Senator GREEN: I got vaccinated and I got all the information that I needed. I just want to put that on the record.

CHAIR: That's on the record from Senator Green.

Senator GREEN: So, you—

CHAIR: Thank you, Senator Rennick. If you have any further questions, please put them on notice. People's Terms of Reference: can you take on notice whether or not it would be possible to abbreviate some of your proposed terms of reference? I'm not seeking an answer now. There is voluminous information and paragraphs you have in your proposed terms of reference. One of the things this committee needs to do is to work out, if it is so minded to propose actual terms of reference, how some of those points might be summarised. I ask that you take that on notice.

Mr Gillespie: Definitely.

CHAIR: With that, thank you for taking the time to give evidence today. We have so many witnesses and senators asking questions. I'm pleased you all had an opportunity to participate. We'll now suspend for lunch.

Proceedings suspended from 12:18 to 13:00

BUTLER, Mrs Annie, Federal Secretary, Australian Nursing and Midwifery Federation [by video link]

MORGAN, Professor Mark, Chair of Expert Committee for Quality Care, the Royal Australian College of General Practitioners [by video link]

CHAIR: We'll commence proceedings again after the lunchtime suspension. I hope everyone had a nice lunch. I now welcome representatives from the Australian Nursing and Midwifery Federation and the Royal Australian College of General Practitioners. Thank you for taking the time to speak with the committee today. It's greatly appreciated. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. Ms Butler, do you have an opening statement?

Mrs Butler: Yes, just a short one.

CHAIR: Over to you.

Mrs Butler: The Australian Nursing and Midwifery Federation is Australia's largest national union and professional nursing and midwifery organisation, representing more than 328,000 nurses, midwives and care workers across all settings. Our members work across public, private health, aged care and disability sectors and in a wide variety of urban, rural and remote locations, and have been on the frontline of Australia's COVID response now for almost four years. Since the beginning of 2020, ANMF members have worked tirelessly with health and aged care services, governments and communities across the country to manage the impacts of the pandemic and protect the health and wellbeing of all Australians.

Over the last four years, the ANMF has engaged in multiple national and state activities to support and advocate for our members through the pandemic. This has included the development of dozens of evidence based resources to inform and guide nurses and midwives, participation in multiple COVID-19 consultations with government ministers, departments of health, other professional nursing and health organisations and aged care organisations as well as other unions.

We've also participated in 12 inquiries and reviews related to COVID-19, including making submissions and providing evidence to the aged care royal commission's special inquiry into the impact of COVID-19 in aged care and, most recently, the Department of Prime Minister and Cabinet's COVID-19 response inquiry, and of course this current inquiry. As such, we believe the ANMF is uniquely placed to provide comment on Australia's ability to respond and recover from COVID-19 and to prepare for future pandemics.

CHAIR: Thank you for the submission that the Australian Nursing and Midwifery Federation provided. Professor Morgan, do you have an opening statement?

Prof. Morgan: Yes, I do.

CHAIR: Over to you.

Prof. Morgan: I'm here today on behalf of the Royal Australian College of General Practitioners. I'd like to thank the committee for this opportunity. RACGP is the voice of GPs in our growing cities and throughout rural and remote Australia. For more than 60 years we've supported the backbone of Australia's health system by setting the standards for education, practice and advocating for better health and wellbeing for all Australians.

As a national peak body representing over 46,000 members working towards a career in general practice or working as GPs, our core commitment is to support GPs across the entirety of general practice and address the primary healthcare needs of the Australian population.

Australia's GPs see more than two million patients each week and support Australians throughout every stage of life. The scope of general practice is unmatched amongst medical professionals. Specialist GPs responded decisively and proactively to the pandemic emergency and in just a few weeks general practice implemented significant changes to the way they worked and developed creative new ways to continue the delivery of safe and essential care to their communities. Many GPs were involved in the design and implementation of national, regional and local responses, working with governments often in a volunteer capacity.

As to the terms of reference for a royal commission into COVID-19—we've made a submission and there were essentially 10 recommendations. We recommended that the commission looked at the governance, including the role of federal, state and territory governments, and national governance mechanisms and advisory bodies in response to COVID-19.

We recommend looking at the health response measures, which is lockdowns, vaccines and quarantines, and looking at the impact and delivery of public messaging. We also recommend looking at the access to and supply of personal protective equipment, and looking at the rollout of COVID-19 vaccines, including the public messaging, and access to vaccine supplies. We recommend looking at the rollout of funded telehealth

consultations in general practice, looking at the mental health impacts of COVID-19 on the general public and on health professionals, support for Aboriginal and Torres Strait Islander people, culturally and linguistically diverse people, the elderly and other at-risk populations. Also, there's the role of Medicare funding for telehealth consultations, and particularly the subsequent compliance activities related to these consultations.

The other main focus should be on the present-day response to COVID-19, such as the ongoing vaccine rollout and any subsequent outbreaks of COVID-19 variants, and the management of long COVID, which has been covered in other Senate committees. The college of GPs has submitted to many other inquiries on this subject all the way through from June 2020 onwards.

CHAIR: Senator Roberts.

Senator ROBERTS: Thank you both for being here and thank you for your submissions. I have questions firstly to Professor Morgan. I'm looking at your suggested 10 terms of reference. Let's go to the first one, governance including the role of the federal, state and territory governments. Why do you propose that be a term of reference? Why does that need scrutiny?

Prof. Morgan: The important thing would be to see what the opportunities are to learn from what happened, but also apply that in the future. I think key to making any future response to health emergencies is the way that different levels of government respond and communicate together. We're very aware that hospital responses are often at a state level or a regional level, whereas primary care general practice is often managed at a federal level, and that discrepancy between the two levels of government creates problems but also opportunities.

Senator ROBERTS: I'd like to continue on that line. There seem to the public—I'm not a health professional—to be so many contradictions in health directions, orders, doctors treatments, and what doctors said they could and couldn't do. There are contradictions not only between jurisdictions and states but contradictions in time. Government in one state would contradict its previous orders. Was that a problem for doctors?

Prof. Morgan: The rate of change of advice and the amount of time and energy reading the various communications being sent to doctors was a problem, but there was also a mismatch in some of the public health messaging. So, the expectations of our patients would be set one way, and the rules that we were required to follow would be set in a different direction. It did lead to complications.

Senator ROBERTS: Doctors are given training based on science or maybe even training in science. I'm not familiar with your curriculum. Did anyone raise questions about the fact that these contradictions were so frequent or common? For these contradictions to occur there would need to be a change of the underlying evidence, wouldn't there? Those contradictions would seem to indicate there was no consistent scientific objective basis for the directions?

Prof. Morgan: I think there's a need to separate two components of information. One is about the prevention of spread of infection and the public health measures. The other is about treatments of COVID-19. It emerged through the pandemic from very early days that there was a need for a source of truth on treatments of COVID-19, and a national clinical evidence task force came together with over 200 volunteer clinicians from across multiple peak bodies to address that need for a living guideline updated on a weekly cycle to present the best interpretation of the emerging evidence for treatments of COVID-19. That was a system that worked extraordinarily well and I had a leadership role within that organisation as chair for primary care and chronic care. It was an example of how an organisation with a small amount of funding was able to fulfil a very important need. No individual clinician can keep up to date with the tens of thousands of research studies that were pouring in and that needed to be critically appraised and the evidence synthesised into a set of guidelines that could be followed. I think where there's far less certainty is what works and what doesn't work for the prevention of spread of an infection, and how that should be interpreted into recommendations that the public should follow and trying to get that balance between restricting people's freedoms versus the protection of the population from a spreading infection. I think we're seeing a scramble to try to make sense of very limited and patchy evidence, and the evidence kept evolving and so the recommendations kept changing.

Senator ROBERTS: It would bother me if the evidence keeps changing, but I understand what you're saying. Let's go to No. 5—

Prof. Morgan: We think that medical evidence will change very rapidly in any sphere of medicine as people do more research.

Senator ROBERTS: Let's go to No. 5 of your recommendations for terms of reference, the rollout of the COVID-19 vaccines, including public messaging. I've seen a remarkable divergence of opinions amongst doctors themselves, including GPs. Some doctors signed up straightaway and continued to inject people. Other doctors signed up straightaway and were very concerned—I've heard this first-hand—about the number of adverse

effects, severe side-effects, people dying and they stopped. Others refused right from the start because it was never a proven, tested injection. There seemed to be complete disagreement on safety and effectiveness. Why would that be?

Prof. Morgan: I think amongst the majority of GPs we felt reassured that the process of development of vaccines was robust and that, rather than the development and testing being done in a sequential way, various components of that process were done in parallel, leading to a much more rapid production of tested vaccines. Compared to most of the vaccines that we give for travel, for example, the process involved in the design and testing of COVID-19 vaccines was robust, and the level of post-vaccine monitoring for side-effects was also robust and international. I think there are big lessons to learn about how we successfully rapidly developed vaccines and shared information across international borders and monitored and looked out for potential side-effects. Those side-effects then had to be compared to the adverse effects of the infection itself. I wasn't aware that doctors had a big divergence of opinion. There were a few outliers who had different opinions, but the majority trusted the detailed systems that were in place and delivered vaccines as and when they were able to. Evidence has shown subsequently that it was a very positive thing to do to reduce the harms from COVID-19.

Senator ROBERTS: You mentioned in answer to one of my previous questions that doctors can't possibly keep up individually; they rely upon agencies. Is there a possibility that doctors, including GPs, are prone to regulatory capture, and just swallow whatever big pharma tells them?

Prof. Morgan: The regulatory agencies that provide information need to be at arm's length and separate and independent from organisations that will try to make money from the exercise. I think organisations within government like ATAGI and organisations looking at treatments, like the National Clinical Evidence Taskforce, are really careful and clear to be separate from the manufacturers of the products they're analysing and assessing.

CHAIR: Senator Roberts, one more and then we'll be going to Senator Rennick.

Senator ROBERTS: Ms Butler, I'd like to know how many nurses in Queensland and how many nurses in Australia were set aside, sacked or terminated during the COVID-19 response. Your submission mentions funding and staffing as areas of inquiry, but you do not mention vaccine or injection mandates. My understanding is that there were thousands of nurses stood down during the COVID-19 response in Queensland for refusing to get the injection. How can you not consider mandates as being central to the staffing issues that you raised?

Mrs Butler: I don't have the precise numbers in front of me at the moment. But I would say that those numbers were in the hundreds rather than the thousands. We know there were some of our members across the country who for a range of reasons did not want to take the vaccine and did not want to adhere to the mandate. What I do know is we would have had many thousands more of our members who were very pro the mandate for the vaccination, because they see that and regard that as the No. 1 line of defence. Actually, as to the vaccination program being successful—no vaccinations are ever 100 per cent bulletproof. That's just not the nature of how immunisation and vaccination works. But knowing it is our No. 1 first line of defence when we're dealing with something like a virus of this nature and a pandemic that is literally a pandemic that the world has never seen before, many of our members were dissatisfied with their own colleague who refused to get the mandate and thought it was okay for them to work beside—it didn't happen, of course—colleagues who had the vaccination, and therefore present greater risks both to their colleagues and to those people in their care. Vaccination mandates across the health sector and for our members, nurses and midwives working in all sorts of areas are not new. They're not a new thing. We have dealt with them for decades, knowing that's the best protection against many of the communicable diseases we can offer to nurses and midwives themselves and obviously to the people they care for. On balance the vast majority of our members were very strongly in favour of vaccination mandates at the time as necessary and needed, and as an effective measure in dealing with the consequences of COVID-19.

CHAIR: Senator Rennick, you have the call.

Senator RENNICK: As you know, under the immunisation handbook one of the requirements is that patients have to be fully informed of the risks of taking a vaccine. Therefore, the doctors, nurses and pharmacists who administer this vaccine should also be fully informed. Were the doctors and nurses who administered vaccines fully informed about the risks of the vaccine?

CHAIR: Professor Morgan, if we can provide you an opportunity to answer that question first and then I'll go to Ms Butler.

Prof. Morgan: The information that ATAGI had was available to the doctors as well. Doctors spent an inordinate amount of time and energy trying to be informed because they were making decisions whether to recommend vaccines to their patients or not.

Senator RENNICK: Were doctors and nurses given a copy of the product assessment report and the non-clinical report on the Pfizer vaccine?

CHAIR: Senator Rennick, I don't want to interrupt. Was that question directed to both Professor Morgan and Mrs Butler? I'd like Ms Butler to have an opportunity to answer.

Senator RENNICK: I'll speak with Professor Morgan.

Prof. Morgan: That might have been the wrong call, because I can't remember which specific documents doctors had access to.

Senator RENNICK: So, you're not sure? Are your doctors aware, for example, that the vaccine had an enormous amount of missing information? I'll list some of the missing information, which is outlined on page 31 of the product assessment report with respect to the Pfizer vaccine.

CHAIR: Senator Rennick, are you referring to one of the documents you were wanting to table?

Senator RENNICK: Yes.

CHAIR: Could you please refer to the two documents you're seeking to table and then we will provide it to Professor Morgan. Professor Morgan may well want to take this on notice, given he would have just received the documents. We're looking to get those to him.

Senator RENNICK: That's fine. I'm sure he'll understand the question. Effectively the vaccine wasn't tested for pregnancy and breastfeeding when it was initially approved. It wasn't tested on patients who were immunocompromised. It wasn't tested in frail patients with comorbidity, people with pulmonary disease, diabetes, chronic neurological disease and cardiovascular disorders. It wasn't tested on patients with autoimmune or inflammatory disorders. It wasn't tested in interaction with other vaccines, and there was no long-term safety data on the vaccine. Were doctors informed of this missing information and did they inform their patients of that missing information?

Prof. Morgan: Again, I don't know the answer to that. I can take that on notice. Clearly, the long-term safety information was not available for the new vaccines, and so doctors were aware there was no long-term safety information available.

Senator RENNICK: Let's just speak for yourself. You're a doctor. Were you informed of those risks? Were you aware of that missing information?

Prof. Morgan: Because the information has evolved over time, it's very hard to remember back to a particular point in time when vaccines first came out to know the exact nature of the information we had to hand. The weighing up of benefits and harms is the task of doctors when advising patients and getting patients to make a final choice about whether or not to accept a vaccine.

Senator RENNICK: If we just go to the non-clinical report, I'll read it out to you. It states that studies animal studies; unfortunately there are no human studies of a longitudinal nature—showed that the antibody response declined quickly, five weeks after the second dose of the vaccine. Would you consider it acceptable that a vaccine only had five weeks of protection before it started to decline?

Prof. Morgan: I think the purpose of the vaccines, especially when we were first rolling them out, was to protect people from serious disease. The evidence we had before us was that they were effective at protecting people from serious disease. Antibody studies are just a component of the protection that arises when you give a vaccine; they're not the whole story.

Senator RENNICK: I'll contradict you on that. If you look at the product assessment report on page 7, it was approved to prevent coronavirus disease. It wasn't approved by the TGA to lessen the disease. On page 7, it says it's specifically to prevent coronavirus. I'd refer to Senator Roberts's statement before about the conflicting data. That is an example of the conflicting data given by doctors, because the actual approval process by the TGA said it was designed to prevent the disease, not lessen the disease. That's from page 7 of the product assessment report. Having said that, though, in the animal studies again it showed similar microscopic lung inflammation was observed in both challenged control and immunised animals after the peak of infection, day 7 and day 8. The studies showed no difference between the vaccine in vaccinated monkeys and unvaccinated monkeys. What do you have to say to that?

Prof. Morgan: I don't have the data that you're referring to in front of me. As to the subsequent understanding of how vaccines have worked—I think it was a remarkably positive activity to be able to provide a vaccine for people and certainly turned around the course of the pandemic. We've used vaccines for many preventable diseases. Some have almost been eradicated and one has been eradicated completely.

Senator RENNICK: Absolutely, but this is a separate vaccine that causes an autoimmune response, not an immune response. I'm not referring to other vaccines, I'm specifically referring to the mRNA vaccines. Can we stay on topic, please. I'd note in terms of the pandemic that 12 million people caught COVID-19 in the three years after Australia opened up. So, 50 per cent of the population reported as receiving COVID. Do you think that the vaccine was effective given that over 50 per cent of the vaccinated population actually caught the virus?

Prof. Morgan: Where the college of GPs and where I sit on this is that we want to look after people's health and welfare as best as we can. The prevention of serious infections and serious illness is the way I see these vaccines working.

Senator RENNICK: I'm glad you raised that. In 2021 there were an extra 10,000 actual deaths in the eight months after the vaccine was approved before coronavirus got into the community. Do you consider that a success? Clearly deaths rose after the rollout of the vaccine. What makes you so confident that these deaths weren't the result of the vaccine, given coronavirus wasn't in the community when these deaths occurred?

Prof. Morgan: I don't have that data in front of me.

Senator RENNICK: This is from the Australian Bureau of Statistics. If you were a doctor and you were quoting the fact that the vaccine was effective, that contradicts the real-world data of 10,000 extra actual deaths?

Prof. Morgan: The question you'd want to ask in interpreting data about total death rates in community are the causes of those deaths and what underpinned them.

Senator RENNICK: That's exactly right. My question to you is: what caused those deaths before coronavirus was in the community if it wasn't the vaccine?

Prof. Morgan: There are numerous causes of death that need to be analysed in a comprehensive way to identify what the causes of death are. It's not something you can attribute to one thing or another thing like a vaccine or not a vaccine.

CHAIR: Senator Rennick, just one last question and then I have to share the call.

Senator RENNICK: In regard to that increase in deaths, do you accept that tissue samples of people who passed away within six weeks of the vaccine should have been taken to determine if the presence of a vaccine spike protein was the cause of death, given that the TGA has admitted that the vaccine has caused autoimmune issues? Do you think it's a failure of the medical system not to actually perform autopsies to determine the presence of the spike protein in the vaccine in those eight months after the vaccine rollout?

Prof. Morgan: I think there's a bigger issue about the collection of data, the investigation of people who've died and the efforts that are gone to in order to establish the cause of death. I fully agree with you that we don't have a system that's perfect at doing that. In a better funded system, greater efforts would be made to really understand what's happening in population health.

Senator SHOEBRIDGE: I say to both witnesses a heartfelt thank you on behalf of my party, the Greens, for the work, in the case of the Australian Nursing and Midwifery Federation, of the hundreds of thousands of your members—nurses, midwives and other carers—and to the GPs for the work of the tens of thousands of GPs across the country. Never have we more appropriately valued the health profession and the caring professions than during the COVID-19 pandemic, and we're enormously grateful for all the work you did and the bravery and public service all of your members showed. Thank you. Looking back on the experience of COVID though, my first question is probably to you, Ms Butler. Having come out it now and having had the enormous amount of pressure and work hours that your members faced during that, would you agree that it highlights the need for far greater systemic funding of nurses and public hospitals, lifting the tide up so that we're prepared if we have another pandemic?

Mrs Butler: Many thanks for your acknowledgement of the work of our members. That is appreciated. To answer your question—absolutely. What I always say is that the experience of COVID-19 was an X-ray of our entire health and aged-care system. What it did was show all the fractures, reveal all the breaks and even the time cracks. We knew those things were there, but it just brought them into sharp relief through COVID, most particularly in the aged-care system. We'd known about the failures there for years and years, more than two decades, but no-one could say that they didn't exist anymore, because it was absolutely clear, right in front of our faces. So we would agree—it has absolutely shown that it's not good enough to withdraw funding and say: 'The system can work, and we can patch it up. If something bad happens, then we'll inject extra resources into it.' Absolutely not. COVID has shown that. We know there will be future pandemics. In order to be prepared, we need to make our system as robust and rigorous as it can be. That requires sufficient funding.

From the ANMF's perspective, we believe that that needs to be sufficient public funding. We need to rebuild Medicare to its fullest. When I say rebuild, it's been a wonderful system, but healthcare needs have changed, and now the system needs to change with it. We need to make sure that it remains truly accessible. COVID starkly revealed so many inequalities we have both in our communities and through the systems, and we need to make sure, through funding in the right ways and proper policy support, that we rebuild the system to make it truly accessible to all communities and all Australians, most particularly our disadvantaged.

Senator SHOEBRIDGE: My only disagreement is that I'd say it's more like an MRI than an X-ray. It was even more detailed, wasn't it! Has any state or territory done that process of taking stock of how the public health system responded and done that system-wide analysis?

Mrs Butler: I think that is definitely starting to happen. We have participated, as I'm sure the RACGP have, in the consultations and calls around a centre for disease prevention, or a CDC—I know I've got that acronym wrong. We think that an institution like that would help not just in taking stock of the public health response. Our members really struggled with COVID at the beginning. We totally acknowledge it is a once-in-a-century happening. Nobody in the world knew anything about it when it first happened. We just kept digging, and everybody was on the run trying to deal with it as best we could. We believe that, if we had that central institution, we could not only do planning and prevention but coordinate across all sectors. A health response requires responses, measures and resources from outside just the health system. We need to do that work, and people in different health departments and areas are starting to look at it. We have a range of reviews, but what we need is the central coordination. We need all the pieces together so that there's consistent, balanced, evidence based information that we can learn from, provide to people and work with.

Senator SHOEBRIDGE: Professor Morgan, what do you say to that proposition about having, effectively, a national CDC or some similar body? In answering that question, could you perhaps reflect upon the fact that we've often had state and territory governments repeatedly saying that all their decisions were based solely upon the advice coming from public health officials when, I think if we look retrospectively, we realise that public health information was a key part of the decision-making. But, in complex decisions like this, there are always going to be a bunch of other factors that you need to take into account. Would having a CDC or a similar federal body assist in that?

Prof. Morgan: I agree in part. Having a tooled-up system for understanding and analysing really complicated, dynamic information is a key part of a national response, rather than a state-by-state response. It's having a national body that's able to look at the information that's coming in, understand its implications and then make active recommendations. I'd also think that a living guideline approach for the very technical job of understanding medical research is an essential component of an organisation like a CDC. You certainly need to have the right people able to quickly appraise clinical and research information and then present the extent of our certainty and uncertainty in order to make political decisions. That did fall to a group of funded but mostly volunteer clinicians in the National Clinical Evidence Taskforce.

Senator SHOEBRIDGE: I should have put that proposition to you separately, but do you agree, if we look back, that we regularly saw premiers and political leaders standing up with chief public health officers and saying repeatedly, 'All that we're doing is 100 per cent following the advice of the public health officers'? That's when, in reality, the advice from the public health officers was absolutely critical, but, of course, there were always going to have to be other factors taken into account when you're making decisions about lockdown and schooling, which included social, economic and other factors. Do you agree that that's what happened?

Prof. Morgan: I agree that there was almost a sheltering behind the public health officials and a lack of open conversation with the population about how decisions were being made. I think that shows a challenge with the way that we govern. There were two challenges, actually. One is that it's very hard for elected officials to change their mind, even in a changing situation, because they're held to what they said last week. Secondly, there doesn't seem to be an easy forum for clearly explaining how decisions are arrived at. It has to be almost dumbed down. The dumbing down that you described, which was to say that all of this came from public health officials, was—this is my personal opinion—part of the way the elected officials managed both the uncertainty and the rapidly changing situation.

CHAIR: Senator Shoebridge, do you have a final question?

Senator SHOEBRIDGE: There are probably multiple questions I could put to you, but one of the other things that has been a theme in submissions is this breakdown in trust: breakdown in trust with governments, breakdown in trust with advice from doctors and health professionals. Many of the submissions have focused on the failure of governments in this. But do either of you have any comments on the role of social media and non-

evidence-based attacks that seemed to get repeated on social media and the role of that in undermining trust in the health professions and in the advice that's coming from the health profession more broadly?

Mrs Butler: I think it had an enormous impact, unfortunately—sometimes positive but sometimes negative. As Professor Morgan said earlier, health knowledge changes all the time. We're always updating and evolving. It's one of the most rapidly evolving areas. It's very difficult for people to understand, in that situation. What we knew about COVID-19 in the first month changed within six months. It changed so fast because we just kept getting more and more information. So it seemed like people didn't know what they were doing, but we were constantly responding and evolving.

There were people, unfortunately, who didn't dig into the evidence, for a range of reasons. It's not always easily digestible and accessible. That is one thing about getting health messaging right: communication is key. Unfortunately, social media can be a very quick way to put doubt and to undo those things, because it's a bit harder to understand the evolving complexity. Our members copped, really, the brunt of it. GPs did, but nurses across the country were at the forefront of the vaccination program, administering vaccines. Our nurses are highly qualified. The training was well developed. They know exactly what's going on. They're very able to communicate with people. But our members got abused—they got spat on; they got physically abused; they got verbally abused—while they were in the middle of trying to do the best to protect everybody in the community. A lot of that was fuelled by social media, even though nurses and midwives are the holders of and understand the evidence behind what they're doing. How we deal with that, with what I can only describe as misinformation, which is communicated so rapidly—and none of it had evidence behind it—is a real factor for how we deal with these things in the future.

CHAIR: Senator Rennick, you've got a point of order?

Senator RENNICK: I think it's important to note that the witness is verging on innuendo and speculation. I think it's fair to make claims of misinformation, but those claims need to be specific rather than just general accusations.

CHAIR: Senator Rennick, you've made a point, but I don't think it's a point of order. Professor Morgan?

Prof. Morgan: I would agree entirely with the answer we've just heard. There were also many armchair experts that came to light because of a very hungry mainstream media and social media, very hungry for information. So there were many people giving their opinions but not basing those opinions on the facts as we knew them at the time. I think the terms of reference of the royal commission might think about how that's not going to change; we're not going to stop people from having a voice. We'd need to manage the key messages and really try to lift the health literacy of the community so they understand where they can go to get reasonably sound factual information.

CHAIR: Senator Green, you have the call.

Senator GREEN: Thank you, to both of the witnesses and to both of your organisations for participating in another inquiry about COVID-19. Going to that question around the Commonwealth government's COVID-19 response inquiry, can I double-check—have you had an opportunity to give a submission or participate in the public consultations so far?

Mrs Butler: Yes, we have made a submission to that particular inquiry.

Prof. Morgan: The RACGP made submissions to the Senate Select Committee on COVID-19 inquiry—I think it was in June 2020—the royal commission into aged care and the effect of COVID-19, the Australian National Audit Office's audit of the COVID-19 vaccine program and the Australian National Audit Office's audit of the extension of telehealth services, as well as to the inquiry on long COVID and repeated COVID infections by the House standing committee. We also made a submission to the Australian government's COVID-19 response inquiry panel, which was, I think, in December 2023.

Senator GREEN: Ms Butler, you mentioned a couple of others that have occurred. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability did a special hearing and report on COVID-19. Did either of your organisations contribute to that one or to the aged care royal commission, which I think you also referred to?

Mrs Butler: We did not give one to the disability royal commission, but yes to the aged care—the aged care royal commission had a special section on the impact of COVID-19 in aged care, and we participated in that and gave evidence to that as well.

Senator GREEN: Thank you for doing so. Most if not all of the states have also had inquiries into their responses to the pandemic. Could you take on notice if you've had an opportunity to respond to those. The

Western Australian government had a whole of government independent review, the Victoria government had one as well, and there have been a few parliamentary inquiries in other states,. It's probably too late in the day to go through all of that, so maybe we'll get that from you on notice. I have no intention, unlike other senators, of making this some sort of debate about vaccine efficacy. Just on the current health risk for COVID-19, there are still patients that are vulnerable to COVID-19 who are having to be hospitalised. Could the Royal Australian College of General Practitioners comment on that? I don't want to panic anyone, but I know there's still an ongoing risk for some groups of our community.

Prof. Morgan: Yes, there's an ongoing risk for the amount of COVID-19 that's spreading around the community at the moment, but also the potential risk of new variants that are either more contagious or more virulent. There's an ongoing need to make available and to inform people about the availability of vaccine boosters or antiviral treatment, and that needs to be given early to be effective in people who are at high risk. There's an ongoing need, I think, to remind people of some of the lessons we learned about personal protection and avoiding the spread of infections.

Senator GREEN: Ms Butler, I would imagine your members are still working in those high-risk environments and need to be conscious of when we have spikes with COVID-19 cases?

Mrs Butler: Absolutely, and of course we still have people presenting in ICUs who have COVID. We've seen this just in this most recent wave. Our members, of course, continue to be at risk. As Professor Morgan just said, there's been an assumption that every subsequent variant is going to be less virulent, but we have no evidence for that. We don't know, so we still need to have vigilance and preparedness. We need to be ready to deal with COVID-19, most particularly in the vulnerable sections of our community. Those most at risk that we've talked about are obviously people with disability, living in residential facilities, aged care facilities, but also people who don't have good access to ongoing, quality health care at the moment.

Senator GREEN: Thank you. You were answering these questions to Senator Shoebridge earlier, but is that why we need to have good public messaging about the risks and the precautions that people can take and why any undermining of that public messaging can be quite dangerous?

Mrs Butler: It's really important. Some of the things that we've learnt aren't just relevant to COVID-19. As I said earlier, they need to have support from sectors outside just the health sector, because one of the things we should do is stay at home if you are unwell. Society has had a soldier on concept, not stay at home if you are unwell. These are really, simple, simple things that people can do who could be at risk of spreading COVID-19 to the more vulnerable. They could take simple measures to avoid those risks. But if you're someone who is working in a casual job, insecure, you get forced to go to work, all of those things we learnt through the pandemic. It's not just about health messaging—it's critical to get people to understand the simple things that we can do to help support everybody else—but we need proper funding and policy supports across the community to make sure we can make those things happen.

Senator GREEN: Thank you. Just my last question and Professor Morgan you may be able to comment on this. From a professional point of view, what do you make of, or is it disappointing to see, the divisiveness and political debate around what should essentially be scientifically based public messaging on COVID and people taking the steps to prevent further illness?

Prof. Morgan: I don't think there's a problem with reasonable debate and questioning, but where there's very clear information that points in a particular direction and that's saving lives, undermining that with a purposeful blindness to the facts and figures would be very harmful. It's something to avoid. We look across at the United States, at some of the divisiveness we see there, but it seems to happen in Australia as well.

Senator GREEN: Yes, it does. Thank you very much to both of the witnesses.

CHAIR: We've got five minutes left. Senator Roberts, I know you have further questions. Senator Rennick has some further questions. I'm not going to ask any questions. I will give you one question, Senator Roberts, and, Senator Rennick, if I can give you one question that will take us through to two o'clock. Senator Roberts?

Senator ROBERTS: Thank you, Chair. Ms Butler, your submission calls for a better preparedness plan, and yet we did have a pandemic preparedness plan, which was written after the SARS outbreak and updated in 2019. That was well before COVID. This was ignored during COVID by state and federal governments. Wouldn't it be logical to call on this document as the basis for any future plan? You didn't mention it in your submission.

Mrs Butler: That's because the ANMF considered that preparedness plan insufficient. That it didn't form the basis of how we managed COVID made sense to us as our response evolved. It's one of the reasons we are calling for or supporting the inquiries into the establishment of a CDC, where we can have a cross-sectoral proper plan, good preparedness with all the players that we need involved, across all sections of the community, in order to

prepare us for the future. We would not want to see a return to that particular plan, because we have learnt so much over the last four years, and we know how much more robust our systems need to be now.

Senator ROBERTS: Thank you.

CHAIR: Senator Rennick, final question for these witnesses.

Senator RENNICK: Thanks, Chair. Professor Morgan, you mentioned it was a shame about the purposeful blindness of people who want to ignore the facts. Do you include the health profession itself—the doctors and the nurses who weren't given the product assessment report and the nonclinical report, and also the fact that boosters ignored the risk of immune imprinting? It's well-known you're not supposed to overuse antibiotics and you're supposed to finish your antibiotic course so that the bacteria doesn't build up a resistance to the antibiotics, yet the medical profession has continued to promote boosters knowing that viruses mutate much more easily in bacteria. What are your comments with regard to the failure to alert people to the risk of immune imprinting?

Prof. Morgan: I don't think the medical profession knows. Certainly our members and the people I have contact with have the interests of patients at heart and as their motivation in trying to get effective health care. They don't have any partisan drivers [inaudible]. They want to do the best for their patients. They want to be informed and to have a conversation with their patients about pros and cons of treatments that are being offered. And they want to have believable, effective and timely information on which to make decisions and to give advice. Information does need to be balanced, and it does need to be accurate. I'm not going to comment on the specifics of whether boosters work or not. That requires a technical examination of the evidence.

Senator RENNICK: Are you aware of immune imprinting though? I mean it's—

Prof. Morgan: Not by that terminology at all. To be fair, I've never heard of the phrase 'immune imprinting' until you mentioned it.

Senator RENNICK: Thanks. That's all I need to know.

CHAIR: Thank you, Senator Rennick. I thank our witnesses, Ms Butler and Professor Morgan, and I echo the sentiments of other members of this committee in giving my heartfelt thanks to your members for the service they provided the Australian community through these difficult times. Thank you for appearing today.

LESLIE, Mrs Anne, Senior Policy Adviser, Suicide Prevention Australia

STONE, Mr Chris, Director, Policy and Government Relations, Suicide Prevention Australia

[13:59]

CHAIR: I now welcome representatives from Suicide Prevention Australia. Thank you for taking the time to speak with the committee today. Thank you for your submission as well. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you and is available from the secretariat. Do you have an opening statement that you would like to provide?

Mr Stone: I do have a brief opening statement. Suicide Prevention Australia is the national peak body of suicide prevention. We have over 400 members across Australia, ranging from large names that most Australians will be familiar with—Lifeline, Black Dog, Beyond Blue—right down to small community organisations working to prevent suicide in their area. Those members represent about 140,000 workers and volunteers working to prevent suicide.

The reason why we've made a submission to this inquiry—and we thank the inquiry for this opportunity to give evidence and for the opportunity to give that submission—is that we have deep concerns around the risk of suicide being impacted by COVID. The evidence is that pandemics and other disasters do impact suicides in a complex way. Suicide risk is heightened by factors like social isolation, employment uncertainty, financial distress and a range of other things that are increased by pandemics and the necessary health responses to them. The evidence is that there's a time lag in those impacts of around two to three years, so we're really only now starting to see what the effects of the COVID pandemic are on suicide. The latest national cause-of-deaths data, which is for 2022, showed an increase in the rates of death by suicide for the first time since 2019, and more recent 2023 data in New South Wales and Victoria show continuing high numbers of deaths compared to 2021 or before. Because the evidence shows that suicide risk has increased and it is complex, it's vital that any investigation into COVID has as one of its objectives a task to understand the impacts on suicide and what lessons can be learned for future pandemics and other disasters. That's why we're here and happy to answer any questions. Thank you.

CHAIR: Thank you, Mr Stone. Senator Roberts has questions. Then I'll be going to Senator Shoebridge.

Senator ROBERTS: Thank you, Mr Stone and Mrs Leslie, for your submission, for being here and for the work you do; it's very important work. Thank you for your support for the royal commission to include suicide prevention. Is it your position that the COVID response was associated with a higher rate of suicide in Australia? Do we know that for sure yet?

Mr Stone: As I was saying, we don't absolutely know that yet for sure. We have evidence that previous epidemics have led to increased risk or rates of suicide in the areas where they are, particularly in the years following. That's where we are. We also know that the evidence is that suicide is a complex behaviour driven by many factors like social isolation, like financial uncertainty, like job loss, all of which are things that we know occur during the course of epidemics and pandemics as a result of both the effects of the illness itself and the health responses to it.

Senator ROBERTS: Thank you for that. Could you share with us please, Mr Stone, what the loss of a job due to a COVID injection mandate would cause? The loss of businesses, especially small businesses that were hammered in the COVID response; suiciding; marriages—because people disagree with their partner's response to the COVID injections. We know that caused a lot of problems. Could you give us some examples and tell us about some of the things that are causing, or potentially causing, a higher suicide rate, please?

Mr Stone: Absolutely. One of the things that's important to keep in mind is that the clear evidence is that government action can actually prevent the risk of suicide from the pandemic and from the health responses. What we know is that, as I say, suicide is a complex human behaviour, and in any particular case there will be a range of factors and it's impossible to say with certainty what exact factor led to it. But we do know absolutely that job loss is associated with increase in the risk of suicide. We also know that there is the potential to step in with someone who has experienced one of these factors, such as job loss, and provide them with support that mitigates that risk. That the government can provide supports that can prevent suicides is really a key point.

Senator ROBERTS: Thank you. Have you any specific stories or examples you can share with us about people devastated by the government's response to COVID or by any aspect of the COVID response?

Mr Stone: Like I say, it's very problematic in any individual circumstance to say, 'This is the factor that absolutely caused this.' So no, I don't have any stories along those lines.

Mrs Leslie: What we can do is give you some general data showing the indication of what the future outlook for increased risk of suicide is. For example, we know that other measures of distress, our mental health services usage increased, self-harm and suicide attempts all increased during the pandemic. For example, the use of the mental health support website Head to Health grew up by 184 per cent over the three years of the pandemic. In addition, we note that average calls to crisis support service line Lifeline rose by 24 per cent, and Beyond Blue went up by 23 per cent.

Another other key factor to consider is that ambulance attendances related to suicide ideation increased. Particularly within the state of Victoria there was an 11 per cent increase in callouts for suicidal ideation. This data really indicates that record numbers of Australians sought support during COVID.

CHAIR: Mrs Leslie, could I ask you to take on notice if you could provide those statistics and the sources for them. And if there are any other statistics of that nature, it would be very helpful if you could provide those on notice to the committee.

Mrs Leslie: Definitely.

Senator ROBERTS: And also we have a second re-affect, don't we? For example, I was trying to help a constituent in Queensland who's running a volunteer organisation to look after people who are homeless. He cited examples off his own bat; I didn't ask for them. He cited an example of people who are now homeless and being shunted from place to place, living in tents and cars, and they're homeless because they refused to comply with the COVID injection mandate. They lost their job, that then spiralled into loss of house, that then spiralled into, potentially, loss of marriage. So it is not really COVID that causes increased suicide. It's government responses to COVID that cause suicide.

Mr Stone: It's certainly true that government responses can lead to some of those factors, as you talked about, like homelessness and job loss. It's also true that a pandemic, in particular an uncontrolled pandemic, would also cause significant potential increase in suicide. Not least, one of the major factors in suicide is bereavement. The loss of people to a fatal disease is obviously a significant driver, particularly where that disease is not controlled.

Senator ROBERTS: We have also heard—I personally heard—many, many stories of individuals who've had a bereavement in their family and they know it is due to the COVID injections, not COVID itself. And these were mandated.

Scott Morrison, our prime minister at the time, said there were no COVID vaccine mandates in Australia, yet he bought the injections; he gave them to the states; he indemnified the states; he encouraged them to put COVID injection mandates in place; and he also provided the states with access to the federal health department data which was the only thing that enabled the vaccine mandates. The state premiers said that the COVID injection mandates that they applied were a response from the National Cabinet which Scott Morrison started, continued and led. So there is a huge number of deaths due to COVID injection mandates, and that does trigger bereavement and loss.

Mr Stone: The medical risks of injections, I'm afraid, is not my area, and I can't comment.

Senator ROBERTS: Thank you very much. Thank you, Chair.

CHAIR: Thank you, Senator Roberts. Senator Shoebridge.

Senator SHOEBRIDGE: Thank you for your work, your submission and engagement with the enquiry. You said in your opening statement, and in your submission, that when you have a significant disaster it can often be associated with an uptick in suicide numbers. Can you talk to that in a bit more detail?

Mr Stone: Absolutely. This applies not just to pandemics but also to other forms of disasters, say earthquakes, floods. The impacts of the disaster are profound and multiple. They are not only financial impacts such as a loss of home, loss of job, but there are also the bereavement impacts from loss of life, and there is a significant distress impact, as people's worlds are turned upside down. For all of these reasons we do see, as we would expect, an increase in the rates of suicide in many cases.

Senator SHOEBRIDGE: I assume that's a very powerful reason for your proposition, that when we're looking at, not just responses to pandemics but, responses to human made and natural disasters, that suicide prevention needs to be right there, and central, in mapping out a government response.

Mr Stone: That's absolutely correct. Yes it does, and it needs to be properly planned and properly staged. One of the complexities in this area is because suicide rates can rise significantly after the disaster itself. One of the theories as to why that's the case is because it is often at the point that the support is withdrawn, sometimes suddenly. Two years from the disaster people tend to think, 'Yes, it's over, everyone's back on their feet', but for

many people their lives are still being significantly impacted. There needs to be not only supports coming in right at the beginning, but also supports lasting through for when people need it.

Senator SHOEBRIDGE: I recall having evidence given to some state inquiries I was on, that six months to two years after is some of the most critical time to be providing mental health support, check ins and some material support as well. That six months to two years after is often when the circus has moved on politically, but people's lives are still seriously impacted by what has happened. Is that something that you think we've learnt out of COVID, or is it a lesson that still hasn't been embedded?

Mr Stone: There is a concern that that lesson hasn't been completely understood. There were some supports withdrawn, for example some of the financial supports, the reduction in government benefits, the ending of bans on evictions. There were some of those that were withdrawn, and at the time we advocated that it was too early to withdraw those and that they should've been withdrawn in a more staged fashion. So we are concerned that the lesson wasn't fully learnt about needing those long-lasting supports.

Senator SHOEBRIDGE: Often, in this space, people want to pick out one element of a government's response, whether it's a vaccine mandate or it's a particular element of public health orders, and say 'That's the issue that's led to all of this damage, all of this loss, all of this loss of lives.' But when we're talking with something like a global pandemic, are you aware of any evidence or any studies that allow you to pick out one little element like that and say, 'Aha, that's it'?

Mr Stone: No, definitely not. Indeed, the impression I have had from research is that it is very much that you have to take a whole-of-government, whole-of-community perspective. That's something we advocate in suicide prevention in any circumstance, disaster or not, because there are so many different factors that can create the risk of suicide. We certainly can't point to one thing that was done and say, 'That was it.'

Senator SHOEBRIDGE: We've had a variety of appalling natural disasters that have really hit some regions of our country brutally. Perhaps what distinguished COVID was that it was a global pandemic, and there was a huge amount of unknown fear. Was that something that was distinct in your minds about COVID? Reflecting back, from a suicide prevention point of view, do you think we dealt with that well, or would there have been some other mental health or communications supports that might have assisted the community responding to that?

Mr Stone: I hasten to add that with this comment I'm moving somewhat into the realm of speculation. I'm not aware of any evidence on this point, but it's absolutely the case in general that uncertainty can be a factor that exacerbates distress. We were, of course, dealing with very uncertain times. I think it's certainly true that, when you're dealing with those sorts of circumstances, clear and effective government communication can do a lot to reduce uncertainty. And the reverse is true—ineffective and unclear indication can cause problems.

Senator SHOEBRIDGE: We had some witnesses earlier talking about how, when a government's response is empowering individuals and informing individuals and bringing them along on the journey rather than being coercive, that can be an important way of getting the community on board. Does that kind of strategy also have an impact on suicide prevention?

Mr Stone: Certainly, individual autonomy can do a great deal to reduce distress. It's also true that community resilience plays a huge part in reducing suicides. To the extent that government is building communities and bringing them along and resourcing them to do what needs to be done, they are not only responding to the disaster but also increasing the resilience of people within those communities against suicide.

Senator SHOEBRIDGE: Knowing your neighbours are there checking on you, knowing the public health system is well resourced and you'll be supported—those kinds of broader long-term community investments are also critical. Is that your evidence?

Mr Stone: Absolutely, yes.

CHAIR: Senator Green.

Senator GREEN: Thank you for your appearance today and thank you for all the work you do in our communities. It's obviously incredibly important, particularly throughout the pandemic. As I've asked all our witnesses today, have you had a chance to make a submission to the Commonwealth government's COVID-19 response inquiry.

Mr Stone: Yes.

Senator GREEN: Wonderful. Perhaps on notice because you might not have it in front of you, have you had the chance to participate in any other COVID-19 reviews or inquiries? There have been quite a few around the country, but in particular the state parliaments and state governments have had inquiries into the responses to COVID-19. I'm interested to know what inquiries you were able to participate in, in that sense.

Mr Stone: Absolutely, and we will provide a list of those that we've participated in on notice. Absolutely, we have participated in as many of the COVID inquiries as we were able to, with our resources, get to. This is an issue that concerns us, and we really do feel the lessons learnt about how to avoid the increased risk of suicide need to be something that's imbedded in for any future disasters and pandemics that we may encounter.

Senator GREEN: To be clear, I don't want to take up too much of your time and resources. I think there have been 29 parliamentary inquiries just from a Commonwealth government point of view. So just for the higher-level ones would be really helpful.

Mr Stone: Yes, no problems.

CHAIR: I will ask some questions, Mr Stone, Mrs Leslie. Firstly, I wrote down the potential triggers or contributing factors in someone suffering from—in the first instance—suicidal ideation and then, perhaps tragically, progressing to attempting to take their own life. Social isolation, financial distress and job loss are some of the factors you mentioned. To what extent is it different depending upon the age or particular attributes of individuals in society? Different cohorts of the population may have been impacted differently. On one end of the spectrum you've got young people, potentially teenagers, who can often be a very vulnerable cohort in terms of rates of youth suicide. They were suffering from that social isolation and not able to engage in all the school based activities they could have usually engaged in. Then, at the other end of the age spectrum, there were people in aged care not being able to see their relatives and suffering that very intense social isolation at that time in their lives. To what extent is it different for different cohorts?

Mr Stone: It is very different and very complex. We recently—last year—released a report where we identified 22 different factors outside mental health that can lead to the risk of suicide, based on the research. They're some of the ones that you've mentioned, and they've also been mentioned elsewhere. There's homelessness and a range of other factors. You're absolutely right that all of those factors impact different cohorts differently. Social isolation does definitely hit older members of the community, but, interestingly, it also hits younger members of the community. Socialisation is incredibly important for young people. Another complexity is around gender. Males, as you might be aware, are three times more likely to die by suicide, and they're more likely to be affected by factors like job loss and financial crisis. That's more likely to be a driving factor. It's probably true to say that all of the factors that lead to suicide to a certain extent differ by different cohorts.

CHAIR: I don't want to pre-empt any conclusions that might be made with respect to any particular policies. But to what extent, when considering issues like lockdowns, do public health officials need to consider that social isolation is a trigger point for potential suicidal ideation and that it therefore needs to be part of the balance in making public health decisions? Could you comment on that, please.

Mr Stone: Absolutely. It does definitely need to be part of the balance. I do feel that it was part of the balance in the decisions that were made, but you want to make sure it is always taken into account. It's recognising that sometimes there is a necessity to do things that may increase social isolation. What that means, then, is that there is a need for other responses in order to mitigate the suicide risk, like an increase in supports, for example.

CHAIR: As I understood your evidence, it is important that those additional supports aren't cut off at the end of the particular event, be it a pandemic or natural disaster, because there's a lag time during which the issues around suicidal ideation, depression and et cetera may manifest themselves. Therefore, you need that support for a period of time after the relevant traumatic event. Is that correct?

Mr Stone: Yes, that's correct. When making that decision about when to withdraw supports, government needs to be responsive to the evidence in front of it, for example around the usage of call lines. If there is still very high usage of helplines and a usage of other services, then there's an indicator that there's still a need for those services and, if anything, that they might need to be ramped up and not removed. That applies to other supports that impact people's distress levels, as well, such as protections around renting and increased benefits.

CHAIR: I'm happy for you to take this on notice if you would like. To what extent are you satisfied that research is currently in train to consider the lag effect that you've spoken about so that, when that data manifests itself, there are studies occurring now that can pick that up and feed that into future decision-making processes?

Mr Stone: That situation is reasonably good at the moment. One thing I will add is that, as part of our responsibilities as the peak body, we administer the Suicide Prevention Research Fund grants, which, as its name suggests, funds research into suicide prevention. That fund currently goes until, I believe, mid-2025. We are looking at whether or not those funds will be extended to continue that research. It's exactly that sort of research that needs to continue to happen so that we can understand the lessons learnt.

CHAIR: Mr Stone, this is what's known politically as a dorothy dixer, but if you can take it on notice and provide a fulsome answer as to the importance of that funding continuing past 2025, in order to address the points

which I think you have made very persuasively in your submission, I'd invite you to do so. Are you happy to do that?

Mr Stone: Yes, I'd be very happy. Thank you for the opportunity.

CHAIR: They're being no other questions we'll suspend for the moment.

Proceedings suspended 14:26 to 14:38

FALETIC, Dr Rado, Director and Board Member, COVERSE

O'REILLY, Rachel, Board Member, COVERSE

CHAIR: I now welcome representatives from COVERSE. Thank you for taking the time to speak with the committee today; it's greatly appreciated. Information on parliamentary privilege and the protection of witnesses in evidence has been provided to you and is available from the secretariat.

Rachel O'Reilly: I'm here as one of the co-founders of COVERSE, which is a national science-led charity set up for Australians who have been harmed by or lost a loved one to the COVID vaccines.

Dr Faletic: I am also a co-founder of COVERSE.

CHAIR: Do you have an opening statement you'd like to make?

Rachel O'Reilly: I do. COVERSE has existed since 2022 because neither the federal government nor any state or territory governments are providing adequate support for citizens affected by these products. We do what government should be doing, which is communicating with citizens harmed by a government approved drug, fostering appropriate research connections and addressing glaring information deficits. We work closely with our international patient advocacy counterparts and the universities and research bodies that they are connected to, studying people's reactions to COVID vaccines. No Australian medical research organisation is yet working directly with us as patients in this country.

My colleague Rado has a PhD in science and is a consultant in the area of international scientific collaborations. I have a master's degree in media and culture and do research on neoliberalism, populism and climate change. We've both taken many vaccines throughout our lives with no issues whatsoever. We're able to present today only because we had family support, covering lost incomes and investing their savings to help us access tests and treatments that aren't covered by the government. There was no infrastructure set up to support Australians suffering from COVID vaccine reactions, and there still is not.

The people who we represent are dealing with life-changing injuries and institutional and social ostracisation that we would argue is comparable to the earliest days of the AIDS pandemic. Our early diagnostic and therapeutic information early on only came via international social networks of affected people existing under heavy global media and medical censorship erected around the discourse of emergency. Most importantly, people with serious COVID vaccine reactions come from all walks of life and got vaccinated at the request of Australian governments to protect our communities.

Contrary to claims made about us without us by government, our reactions are rarely mild or self-resolving. COVID vaccine reactions can involve cardiac, neurological, immunological, cognitive and other disabilities. They can appear very suddenly in days and weeks while others develop more gradually. Our data shows it takes at least eight months to see any improvement whatsoever in people's symptoms. The government's own pharmacovigilance data has over 22,000 reports of serious adverse events following COVID vaccination, including several thousand with cardiac inflammation. To our knowledge, fewer than one per cent of cases have had a claim approved by the government's punitively narrow compensation scheme, and approximately half of the WorkCover claims that we know of have been rejected.

The adverse events reports for the COVID vaccines constitute almost a quarter of all drug reaction reports published by the TGA since 1971, yet our cases did not raise any safety signals. Our submissions to 10 federal and state inquiries detail the scale and scope of medical and institutional harms that we face. Despite the evidence, our situation has barely changed in three years. We appreciate our first appearance speaking directly to parliament today.

CHAIR: Thank you very much. Senator Roberts, you have the call.

Senator ROBERTS: Thank you both for being here. I understand, Ms O'Reilly, you drove down from Queensland because you can't fly because of your condition.

Rachel O'Reilly: Yes. The last flight I took was very difficult, so I'm not sure why I can't fly or when I'll be able to fly again.

Senator ROBERTS: I appreciate your precise answer. Thank you for your submission and your support for a royal commission. I want to ask you about this comment on page 1 of your submission:

… unfortunately the COVID-19 vaccines have resulted in significantly higher rates or reported side-effects—

and you have just given us the data—

than prior routine vaccines. Sadly, those Australians who have experienced very serious adverse health outcomes and bereavement caused by these vaccines have on the whole being treated appallingly by government and public health authorities …

Can you explain that comment? I'm taking it that you're denied recognition that you exist and that you have a problem, you're denied compensation and treatment, and you're also concerned that this will kill more people. We still have boosters being advocated by some health authorities.

Rachel O'Reilly: That's a lot of questions. Could you maybe go over the compo question?

Dr Faletic: Let's have a look at the compensation issue, because it can probably encapsulate a lot of the problems that we're facing. The Australian government's compensation program was set up in late 2021 to try and give the Australian public some sort of safety net and assurance that, if something went wrong, they would be looked after. However, what you don't realise and what the Australian public doesn't realise and what we didn't realise until after we got injured was that the scheme was designed so narrowly that hardly any of us qualify for it, and we've got to wonder why was that done? This comes back to the royal commission and why questions need to be asked about that in particular.

Some conditions are recognised by the TGA and are claimable by the compensation scheme. So, for example, if you happened to have myocarditis from the Pfizer vaccine, and you were hospitalised, lucky you, you might get compensation. But, if you had the AstraZeneca vaccine and got the same health condition, suck eggs.

That's the approach the government has taken, and despite many of us over the course of these three years screaming at the tops of our voices, trying to get our concerns and our stories out there and addressed by government, nothing has changed. Nobody wants to address the issues that are affecting us directly. That's the challenge we face. It's almost as if the entire government edifice has this policy position called 'safe and effective'. Anything that stands in the way of 'safe and effective', whether it's people who have had an adverse reaction or eminent scientists who have grave concerns about some aspects of some of these vaccines, they are immediately shut down by government and by media organisations as being misinformation or disinformation or whatever else they might like to be label it. Despite the fact that these people have genuine, well-established and well-reasoned concerns. We certainly have concerns, based on what we've experienced and the types of roadblocks we've faced when trying to get help and answers from our institutions that are supposed to be helping us.

Senator ROBERTS: Thank you, that's very clear. So, you're sensing a huge wall, a defensiveness. Would you classify that as fraud? Which is, as I understand—I'm not a lawyer— is the presentation of something as it is not for gain. Is the government protecting itself from shelling out on claims?

Dr Faletic: This is why a royal commission is needed. We want to know what was behind these decisions and the rationale that went behind them. The eligibility criteria for the compensation scheme, for example, allows the government to tell the Australian public, 'Look, we have this wonderful compensation scheme.' But when so few of us actually qualify for it, they can then turn around and say, 'Oh look, these vaccines are so safe, so few people have been hurt.' So you've got to wonder, what was the political motive, if there was a political motive, behind the design of scheme and the way it has been? Then you extend similar types of questions to other aspects of pandemic public health policy. I say 'public health policy', as opposed to 'public health science', because so many of the things that were implemented, particularly when it came around to the 'safe and effective' narrative, it became increasingly clear that they were policy wishes, policy positions, rather than backed by robust science that could actually stand up to broad and intense scrutiny. So, in answer to your question, we want to know the answer, basically. I think the Australian public deserves the answer.

Rachel O'Reilly: I just thought I'd be a bit more specific. The list of covered conditions in the compensation scheme, the narrow list, is only for some vaccines but not others, myocarditis and pericarditis, various blood clot issues, GBS—Guillain-Barre syndrome—capillary leak syndrome, shoulder injury from the needle, anaphylaxis and a particular skin condition. The conditions that are not covered in the compensation scheme, but feature heavily in our groups, and in medical literature, which is constantly emerging, but not at all in the compensatable conditions, include the following: vaccine induced ME/CFS—myalgic encephalomyelitis/chronic fatigue syndrome—POTS, tachycardia, mast cell activation syndrome, dysautonomia, autoimmune conditions, costochondritis, ventricular dysfunction, cardiac arrest, stroke, tinnitus, vertigo, menstrual and fertility issues, thyroid disorders, and there is a much longer list than that as well.

Senator ROBERTS: Are you able to table those?

Rachel O'Reilly: Sure.

Senator ROBERTS: Your submission calls for the royal commission to examine 'the scientific, legal, regulatory and medical context of Australia's COVID-19 vaccination program'. Could a COVID royal

commission be called without looking at the issues around vaccine approval, efficacy, marketing mandates and adverse events?

Rachel O'Reilly: No.

Senator ROBERTS: Is Australia's pharmacovigilance of pharmaceuticals fits with purpose in relation to our COVID-19 response?

That is what we would like to know, what we do know from public information from overseas as there was extraordinary political pressure on the US FDA to approve these vaccines, and record pace, without testing? They were tested to some extent and we can cover that anybody

Dr Faletic: That's what we'd like to know. What we do know from public information from overseas, particularly the US, is that there was extraordinary political pressure on the US FDA to approve these vaccines at a record pace.

Senator ROBERTS: Without testing?

Dr Faletic: They were tested to some extent, and we can cover that if anybody would like to know some of our concerns with that. There certainly was testing, but the political pressure was enormous, and there are some high-profile cases of US FDA officials having resigned in protest over the way some of those approvals were handled. Given we see that political pressure happening in the US it's hard to imagine that there was not similar political pressure happening here in Australia, particularly as adverse events started to build, reports started to come in and the extraordinary numbers—as Rachel mentioned in the opening statement: numbers that eclipse any other product that's hit the Australian market. Those numbers alone should have been cause for concern, yet nothing happened. So many safety signals emerged.

If the committee is interested there's a class action that's been filed. The committee may wish to look at the statement of claims in that class action and, in particular, step-by-step the types of things the TGA should have done but didn't do. Some of the reported conditions that under other circumstances might have been flagged to the public as reactions of concern, but the TGA didn't. So we want to know: why didn't they?

Senator ROBERTS: Are you able to include that as a question on notice and send it to the committee.

Dr Faletic: It's available publicly on the web but we can include it.

Senator ROBERTS: If you could. I'd like to officially get it as part of the committee. Your submission talks about infrastructure for vaccine adverse reactions. Can you explain what you mean by that? What areas should a royal commission investigate in infrastructure for vaccine adverse reactions?

Rachel O'Reilly: There is no organisation in Australia that is tasked with fully investigating or treating adverse reactions to COVID vaccines. There wasn't in the beginning and if you react tomorrow to a booster you'll deal with almost the same situation that we dealt with at the beginning. What happens is: initially you'll react to your vaccine, obviously you won't be confident about the situation that you are in, you go to emergency if it feels serious or to your GP if it feels less serious. If a condition is on that narrow list of compensatable conditions that the TGA has published, doctors are more likely to associate that condition with your vaccine and treat you as a reaction patient. If it's not on that short list the chances of doctors saying it's connected is quite slim. And we need to look at the complex cases in more detail, and that doesn't happen.

The TGA passively collects submitted reports. Generally, the press releases say that the TGA is monitoring us, okay? The TGA passively collects submitted reports from GPs or specialists normally, but overwhelmingly in this pandemic, patients have had to submit self-reports ourselves to the TGA in the absence of our doctors doing that. So there's an amateurism that is there because of the length of time it actually takes for us to get proper diagnoses.

At the moment, upon submission of our report a local state or territory nurse will call you to ensure only that you are a legally legitimate person, and they will check that your information is accurate according to you. It's a token gesture: asking a few questions merely to match the registration to the person. In my case, I was eight months in before I self-submitted to the TGA, and my body was failing in Alice Springs while I was trying to do PhD research. I'd already been checked out by a cardiologist and I was like 'I'm not sure there's anyone further that I can see. What should I do?' The nurse just said 'I've talked to my bosses, I just want you to please keep trying to get help.' That was at eight months. So the TGA couldn't direct me anywhere. They only advised me to get a second opinion.

CHAIR: Ms O'Reilly, I was going to ask about your own personal experience. It would be interesting if you could just track through to the beginning of your story and then bring us along in terms of the chronology.

Senator ROBERTS: So you're asking for an urgent document now.

CHAIR: You could take it on notice, but if you are happy to share, I'm keen to hear personally.

Rachel O'Reilly: I submitted it to my Labour MP and it's a two- or three-page document. I eventually got, I think, 13 diagnoses that only started around the 12, 14 month mark. Initially my reaction came on in a swimming pool, two days after my second shot in zero COVID-19 conditions, in Queensland. My symptoms were heart, neurological, immune and muscle activation. I have issues with circulation on the whole left side of my body. I am managing co-infections, now that I have gotten a lot better with an advanced chronic fatigue protocol connected with Stanford University research.

CHAIR: How was your health prior to that?

Rachel O'Reilly: I had never been sick. I had low-level depression, and that was the only thing that I have ever suffered from. Where am I at? The nurse rings you and kind of says, 'Good luck.' The nurses often sound quite concerned when they speak to us. Some states do have vaccine safety clinics where at-risk patients can get vaccinated more safely under medical observation. These clinics are theoretically tasked to give support to people like us. In reality, we have people already injured—a lot of us, because we didn't have health risks, we didn't think we needed supervision to get vaccinated—once we were injured, we were encouraged to go to the sites where, often, we were merely pressured to continue to get vaccinated by a different brand of the vaccine. We have internal data that shows 60 to 80 per cent of people in that situation, who revaccinate after harm from a previous vaccine, are more likely to get worse. In the absence of any kind of investigative or treatment infrastructure, beyond our ordinary GPs, we were hopeful that long COVID-19 clinics might assist us. But long COVID-19 clinics weren't actually tasked with dealing with us either.

ATAGI does provide that guidance as to who shouldn't get vaccinated but provides no opportunity for people who've suffered reactions to be exempt from further vaccines. I have been sick for 2½ years. I was very sick for about two years, and I don't have an exemption. I'm thinking about retraining at the moment, and any consideration I could give to retraining is going to be massively affected by any future mandate. I have no protection to avoid another vaccine because there is no option. That is due to the discouragement of the GPs to give out exemptions to people like us. I think that's the main thing.

In the context of that infrastructural question, people who know us, who support us, and who are trying to care for us, can see we have not been looked after for this entire time. We suggest that a future of safe and effective vaccines depends entirely on dealing with us properly, with setting up proper infrastructure.

Senator ROBERTS: You are saying, or suggesting, that the reporting of injection injuries is grossly underreported, and doctors don't necessarily understand. Could I perhaps—

Rachel O'Reilly: I would say there are no national medical guidelines that a GP has access to that gives them direction on the scope of things to test us for, or how to enquire into our conditions.

Senator ROBERTS: I've heard several stories like the one I'm about to share. Someone who was injected for the first time had a severe reaction and was carted off to hospital. When he went back to work his employer, a major Australian company, Qantas, insisted that he had a second injection. He was then put off on workers comp.

Another one is of a fairly elderly woman, caring for a son who is incapacitated, who said that she would not have the injection because she was immune compromised and worried about it. They said, 'Let's inject you in an intensive care unit at the Sunshine Coast University Hospital.' This doesn't indicate to me that doctors either care—most of them do, let's face it—or they're aware of what is going on, or they are under enormous pressure to keep injecting people. Any comments?

Dr Faletic: It's a complex problem. The first thing is, of the stories you have just relayed, we know many stories exactly like that. We have multiple things going wrong. We've already spoken about the TGA. We've also got the medical profession regulator Ahpra, who issued a threat in 2021 to all doctors in Australia that they were not to do anything that would undermine the national vaccine campaign. Now, their language was blurry enough for them to then come into Senate estimates and say, 'Oh, we didn't mean doctors shouldn't report vaccine injuries or anything like that.' But the reality is, almost every single vaccine-injured person in the country has a doctor who has told them this. So this is not just one or two cases; this is a widespread comment from the medical community to us along the lines of 'Ahpra won't let us talk about this. Ahpra won't let us report this' or 'I can't even treat you.' And some doctors go so far as to kick patients out of their offices saying, 'Please don't come back. I do not want to treat you anymore.' So that's how badly that threat was taken by the doctors of Australia, and unfortunately that leads to a complex situation where doctors aren't adequately recognising or reporting these adverse reactions.

While the TGA do have these extraordinary numbers of reports already, they have a massive shortfall in reporting because so many of the doctors simply aren't doing it. Had those doctors been told the opposite: that it was their obligation to report every single adverse reaction following vaccination, then maybe the environment

might have been different. But because of that lack of reporting, the TGA, for whatever reason, aren't identifying safety signals. Maybe with more numbers they might have, which would have then let doctors know: 'Aha, these are some of the conditions that are being recognised. I'm seeing that in my patients, therefore I'm going to report those.' It would have been a self-fulfilling, positive circle but instead we've got this negative cycle of under-reporting, or dismissing reports and those types to things.

As Rachel mentioned, there's the problem of ATAGI, the Australian Technical Advisory Group on Immunisation, who, while their advice appears neutral and very scientific, gives absolutely no scope to these doctors, who are under threat, to provide exemptions for people like us. Almost every specialist I saw, even though I was not mandated, I asked, if I needed to get a third vaccine for travel or whatever, was there a possibility of me getting an exemption so that I didn't have to put my health at future risk. They said no way, the best we can do is say that you have to take a different vaccine.

Rachel O'Reilly: Which has no science behind it.

Dr Faletic: They can't tell us what happened in the first instance, and there's no science to say that it wouldn't happen again with the third shot.

Senator ROBERTS: Regardless of what Ahpra has answered to my questions in Senate estimates, it is quite clear that doctors feel threatened by Ahpra declaration.

Dr Faletic: Absolutely.

Rachel O'Reilly: It would be amazing if we could access equitably, while protecting privacy, more information on the medical records of affected people. But just to give you an idea of how much the Ahpra situation has affected our records: in order for us to get the right tests, if some of our best doctors write 'vaccine injury' on the reason for them ordering a test, the test might not be approved. In my case, I think I have had three serum tests proving I haven't had COVID—the last one was a while ago. But my doctors, who are working hardest to help me and who've helped me so much, who are courageously just working very quietly, doing what doctors should be doing, write on my form that I'm suffering long COVID in order for me to get the tests for a medical condition that is very similar to long COVID but is not exactly the same. So the complexity of the distortion and the way in which we have to struggle just to get investigated affects our doctors as well. I think it's quite reasonable for them to avoid dealing with us properly to protect their careers, quite frankly.

Senator ROBERTS: So doctors are, in effect, lying to help you. You talk about political messaging, language used to ostracise to create compliance, and you talk about political interference on page 6 of your excellent submission—it really is an outstanding submission. What aspect of the messaging used during COVID should the royal commission have a careful look at?

Rachel O'Reilly: I want to insist that doctors aren't lying; they're in a very difficult position. I think Rado can answer the second question.

Senator ROBERTS: They're not lying, but they're misreporting.

Rachel O'Reilly: They're doing their best to be doctors under the circumstances.

Senator ROBERTS: Exactly, that was my point.

Dr Faletic: That is the point. I experienced the same. I remember questioning one of my doctors as to what they wrote on a referral and that doctor said, 'We want you to get this referral accepted so you can be investigated.'

With regard to the political interference, what we were referring to here is there were multiple major decisions that impacted almost every Australian the pandemic. There were lockdowns and various types of mandates. Our particular concern is those that affected the messaging and the mandates around vaccines, the communication around vaccines. For example, we were originally told that we were going to hit this 80 per cent target in many of the cities around Australia. Once we were at 80 we open up. Then all of a sudden things changed to 90 per cent. What happened? That's a question we want answered. There have been certain concerns raised in our community that there may have been political interference involved, either from policy people in public health who wanted to see a bigger vaccine uptake. Was there pharmaceutical company interference or lobbyists in the offices of decision-makers trying to advise them on the benefits of extending that 80 per cent to 90 per cent so that they could, on the back end, make a lot more profit, unfortunately? What happened behind the scenes to affect these decisions which left a lot of people like us in very difficult health situations? It wasn't just that 80 to 90 per cent. There were a whole range of other areas where public health decisions were made that had consequences for people, but on the other side of it made some people very rich. It's hard to imagine that there was not some level of influence that some of these actors had.

Senator ROBERTS: Chair, I want to acknowledge the precise and careful and highly responsible language both our witnesses are using in their responses.

CHAIR: Thank you, Senator Roberts. Senator Shoebridge, you have the call.

Senator GREEN: Sometimes when witnesses make general comments and they are not specific, that actually can be more difficult for us to deal with as a committee. If you make an adverse comment about someone, they can respond, but making comments, generally speculative, about some level of corruption and political interference can be difficult for us unless you have specific evidence of it. I have a different view from Senator Roberts about how this language can be dealt with by the committee, and maybe it's helpful if we can raise some points of order as we go through.

Dr Faletic: Can I make a little comment on that? We are a group of people who have suffered severe—

Senator GREEN: I can see what you are trying to, but actually, when you make general statements like that, it can be quite difficult—

CHAIR: Sorry, Senator Green, I will give the witness an opportunity to respond to that, if you can do it as briefly as you can.

Rachel O'Reilly: Maybe you want to clarify which comment you have an issue with.

Senator GREEN: Senator Robert said you were using careful language. My response to that is actually that it's because you have not been specific in the allegations that you have made, we can't deal with them as a committee and provide anyone an opportunity to give a response.

Rachel O'Reilly: I think this is territory for a royal commission. But on that point, we are not a corporate watch organisation. I think it's worth pointing out, because I deal with this in my work on the mining industry. The structural situation in terms of inquiring into democratic processes, I don't see the situation as particularly different from regulating other industries in this country. But what is challenging about it from my position as someone who has done no work on the pharmaceutical industry but does a lot of work on the mining industry, it's worth pointing out that there are no corporate watch and human rights organisations paying specific attention to the power and the revolving doors of the pharmaceutical industry domestically. We have robust and reliable democratic nonprofits that do do that work for other industries, and that's why there's a deficit of information. We, as patients, can't be experts in everything. We are often surprised at the absence of investigative media coverage that would shine some light on some of the issues that are structural that we are talking about.

Senator SHOEBRIDGE: Thanks for your engagement with the enquiry. Could I ask quickly about COVERSE? I wasn't familiar with COVERSE until I read your submission. Can you talk me through how it was established and then if there are any links to any other organisation that COVERSE has? I literally wasn't familiar with it until I read your submission.

Rachel O'Reilly: Sure. We came together as five pretty sick people: Rado with a scientific background, me with corporate research interests, two technical consultants and a former primary school teacher. I think we were all about a year into being sick at that point, and it was slowly dawning on us that people that were reacting to the vaccines had no direct mechanism to speak to government to have a policy reform perspective on the situation that we were in. We don't accept major political donations. Our main collaborators are organisations similar to us overseas. One of our sister organisations with the most funding is called Reaction 19. A lot of the international medical research conversations behind the scenes we have are with them. We are also connected with UKCVFamily in the UK. We are connected to the University of Marburg research in Germany. There is also work being done at Yale University that we are in conversation with. So we are basically picking up the threads of who is paying scientific attention to us and in conversation with those networks and thinking about how patient organisations can best make use of that, given our limited resources and limited health situation.

Senator SHOEBRIDGE: Thanks. In relation to the compensations scheme that was established, I share your concerns about the narrowness of access to it. I think a number of people have been concerned about the narrowness of access to it. Is it your understanding that the criteria are closed, or is there some ongoing assessment of the different responses that may entitle somebody to access the scheme? What is your understanding of how that has been dealt with?

Rachel O'Reilly: Early on, once you realise you have a serious long-term reaction, you look into the scheme and see if you are covered. I think there have been a very small number of additions to the scheme. The overnight hospital requirement has eliminated a lot of people. I know you can apply for special consideration to ignore that. The majority of people who have been sick for 2½ years do not qualify for it, and that is the narrowness of it.

Senator SHOEBRIDGE: And is it because of the narrow class of conditions?

Rachel O'Reilly: Yes.

Senator SHOEBRIDGE: That's one part of it. The other part is the severity or the nature of the response. You could have a prolonged debilitating response, but it may not get to the severity of an overnight hospitalisation. Is that one of the other considerations? Are they the same concerns?

Rachel O'Reilly: Yes and no. You could have a severe response that's not one of the seven compensatable claims. Some of those non-compensatable conditions can be extremely severe and instant, but they're still not compensated. It's very complex how people are not covered, but the simplicity is that it's just a very small portion of very severe and long-lasting conditions that are covered.

CHAIR: Senator Shoebridge, I share your concern in relation to this. Do you have any information or data with respect to the position in overseas jurisdictions with respect to what is recognised as a compensatable adverse event or reaction and how that maybe differs from what is recognised in Australia?

Dr Faletic: The law school at the University of Oxford did a project surveying all the programs around the world to see how they functioned. We can share details of that project with the committee. But generally speaking it's a huge mix of things. The UK will accept almost any condition as long as it's connected to a vaccine. However, you have to prove 60 per cent disability. So if you are 59 per cent disabled, too bad, you're not quite disabled enough.

The US has a complex arrangement of schemes particularly put in place for the COVID vaccinations, which has resulted in paying out a few thousand dollars total to people who have suffered injuries in the US. Our sister organisation React19 has gifted out more than $600,000 to patients suffering from COVID vaccine reactions so, obviously, the US government scheme is appalling.

We can point to a few that are better in some aspects. Thailand, for example, has a scheme where anybody who has had a reaction can apply. They get a response within one week and they get that payment within one week—irrespective of whether future investigations prove that that person did not have a vaccine reaction.

Now, a scheme like that imbues public confidence in the vaccination program. You know that your government is going to look up you, even though your reaction may not have happened from that vaccine. It's a very, very positive—

CHAIR: Sorry, I just wanted to take the opportunity to get any further information from you on notice with respect to comparable or not comparable overseas schemes and what we can gather from that. Sorry to interrupt you, Senator Shoebridge.

Senator SHOEBRIDGE: We have heard from all the health professionals that our understanding of COVID has rapidly developed over time—our understanding of the responsiveness of vaccines, of different vaccines has evolved over time. From what I understand, one of your concerns is access into the scheme, in relation to compensation for adverse vaccine responses, has not similarly developed over time—it seems to have been somewhat frozen in time when the scheme was established. Is that one of the concerns?

Rachel O'Reilly: Not only that, but when something is added the patient groups go, 'Oh, how do they choose that choose that one and nothing else?' It is unclear to us the rationale through which very particular individual things get added and not all the rest of them.

Senator SHOEBRIDGE: Again, having some transparency here, having good process here, would be one of the ways of establishing public confidence in the scheme. If you could see why, if you could understand the rationale and maybe engage with that process that would add to public confidence—is that your position?

Rachel O'Reilly: It would, yes. We still need to deal with the pharmacovigilance data, though.

Senator SHOEBRIDGE: Yes, I understand the data is that—

Rachel O'Reilly: Just from the point of view of a confidence question.

Senator SHOEBRIDGE: Yes. Is there public reporting on how much has been paid out of the compensation scheme, that you are aware of?

Dr Faletic: Not as a matter of business, as a matter of course—some information has been released under freedom of information or through Senate estimates.

Senator SHOEBRIDGE: It's extracted, rather than overtly published, is that how it happens?

Dr Faletic: Yes, seems to be.

Rachel O'Reilly: Also, there is a clause that you're not supposed to talk about your claim after it is awarded, is that correct?

Dr Faletic: As far as we know. From the comments we've heard back from the community, when people are made an offer part of the agreement is that it falls under the non-disclosure agreement, which doesn't make sense to us at all. Why would the government want to hide how much it has given to—

Senator SHOEBRIDGE: I know some of your concerns are that there may be some unspecified, nasty motive about that. Could I put one potential motive on it—which I don't think is a nice motive but is often found with government—they may just simply want to significantly limit the amount they pay under a compensation scheme. They may, therefore, put fairly narrow criteria in place and they might also want to discourage people talking about getting compensation results. It could just be your standard government meanness, couldn't it, rather than some broader conspiracy?

Dr Faletic: We have no doubt about that. In everything we have experienced—this has all happened within other contexts as well—the government had a campaign to get as many people vaccinated as quickly as possible. That involved shutting down certain conversations, certain lines of public discussion. The programs that it put in place served that bigger goal. We think a royal commission should look at that interplay with the compensation scheme because. You have to admit, it did afford the government a wonderful opportunity to say, 'Oh look, so few people are being compensated, therefore this vaccine is fantastic.'

Senator SHOEBRIDGE: I suppose this is where I share some of the concerns of Senator Green. A plus B might make—

Senator GREEN: My concern was about the language.

Senator SHOEBRIDGE: About the discussions that happen at this point. I perfectly understand why you have concerns about A and B. There's not adequate transparency, and it can be that A plus B equals C. But A plus B could also equal D or F or G. If I understand it, your call for a royal commission is so that the points can be put together and an answer can be obtained, rather than you saying you know the answer now?

Rachel O'Reilly: Absolutely.

Senator SHOEBRIDGE: I think I understand you.

CHAIR: One supplementary question following on from Senator Shoebridge's line of questioning, then I will go to Senator Rennick. Is one of the concerns you believe needs to be looked at, that because of the way these confidentiality clauses potentially work, people with the same adverse reaction could be treated differently depending upon how hard they're pushing, and whether or not the decision-maker of the scheme decides they need to settle this case but will hold out on the other case? Is that one of the areas that needs to be looked at?

Dr Faletic: This is certainly an issue we see pop up in the community. To give you some not specific examples, not mentioning names of course, some people find—the government touted this scheme as an easy-to-access, simple, lightweight scheme. A lot of people approach it as though it is simple and easy and try and go through just under their own weight or maybe with family help or a doctor that helps them. They get so far, and they are able to then produce a compensation claim to the government. But some people, for whatever reason, have gone to a lawyer to help them, who has been able to put together a vastly broader package of claim, and at the end will almost certainly receive, if they get an offer, a larger offer. That shouldn't be the case in a public program like this. We should be treated the same.

Rachel O'Reilly: We also have anecdotal information about people with the same condition getting vastly different pay-outs.

CHAIR: Again, from your perspective, Ms O'Reilly, it's hard for us to put our hat on that. They're things that should be looked at in a royal commission, is that it?

Rachel O'Reilly: Absolutely. Any discrepancies for similar conditions should be looked at in a royal commission.

Senator RENNICK: My questions are for Dr Faletic. You reported to the media that after both your injections you fell ill, but in particular after your second injection, and you reported you had oppressive brain fog, headache, chest pains, abdominal pain, unbelievable muscle twitching, issues focusing on vision and you were unable to work. Were you ill before you got the vaccine?

Dr Faletic: In the month prior to the vaccinations I was the fittest and healthiest I had been probably for 15 years. That's a common thing that people say—they were extremely healthy, extremely fit, active, eating well, fully engaged with life, full professional careers, and then they had the vaccine and bang, everything changed.

Senator RENNICK: Are you still ill? Are you still feeling those symptoms?

Dr Faletic: As Rachel said in the opening statement, we have been able to improve quite a bit, thanks to the generosity and support of our families. So we have improved but we are still suffering a lot of issues that have continued since day one.

Senator RENNICK: So you are not fully recovered, in other words?

Dr Faletic: No.

Senator RENNICK: And have you been compensated?

Dr Faletic: No.

CHAIR: Ms O'Reilly was shaking her head. Just for the record, Ms O'Reilly, just for Hansard?

Rachel O'Reilly: Neither of us have been compensated. Neither of us qualify for the scheme.

Senator RENNICK: You didn't bother applying for the scheme, then, because you were excluded? Your side effects were excluded, so you didn't try at all?

Rachel O'Reilly: Our position is that if people have the time or resources they should apply, even if they know they'll be rejected, just so we have the claims packaged up to show the kinds of rejections of cases that are playing out.

Senator RENNICK: How do you feel when your injuries, or you hear of other people with similar injuries, and they have been gaslighted by the medical community, whether personally face to face in hospital or you read about it or hear about it from government officials and they try to downplay these injuries?

Rachel O'Reilly: I'll try to be specific in the answer to that, otherwise it gets moral very quickly. In my case, because my reaction started as a heart reaction—and I got vaccinated early on—I was speaking to people in emergency and also to people at 13 HEALTH about my ongoing symptoms. I was told that middle-aged women are not in the risk category for a cardiac inflammation reaction from the Pfizer vaccine. I know now that medical research internationally had emerged already showing that that was not the case, but I think it took more than a year for middle-aged women to be added to that risk category for the Pfizer vaccine that I took.

In our groups there are something like 60 per cent mid-career, middle-aged women with previously good health who have cardiac issues that took sometimes up to 12 months to be diagnosed. They have a positive MRI for cardiac inflammation 12 months into a condition the public has been told disappears quite quickly. That is of particular concern, or should be a particular concern, for getting those women back to health and back to their careers.

Senator RENNICK: Has the medical community or anyone, any medical professionals you've spoken to, advised you to get a sample of your tissues to determine whether or not your injury was caused by the presence of the vaccine spike protein?

Dr Faletic: We have as best we can following the emerging science on the types of tests that are available—unfortunately there's nothing available through the public system here in Australia to do that type of test. There are only a few places internationally, but getting our doctors to agree to take a biopsy and send that overseas is not something either of us have attempted to do yet. I have only heard of one person who has tried to do that so far, and is waiting on results. I think it's worthwhile pointing out that while there is some research to suggest that the vaccine in some people is hanging around for an awfully long time, certainly beyond the few days that the TGA claims—yes, this is in the medical literature now—almost all of our adverse reactions can be explained through possible mechanisms other than the ongoing persistence of vaccine material. So whether or not the vaccine itself is hanging around and is causing these problems, or there are other things that have happened downstream of that vaccine event, that is not yet clear to us.

The types of tests that you mention are simply not available in Australia. It's one of those things that we scratch our head about. This is a concern. We have so many people who have suffered a vaccine injury here. Why aren't we researching them and doing these types of tests here in Australia. We are a rich country with a very good medical research community, but it's not happening.

Rachel O'Reilly: Can I follow that up? Our complex relation to disability needs to be recognised. We are watching people with high incomes travel overseas to get tests that we can't access here and improve and sometimes come back to almost perfect health, if not perfect to recover. So people know that while they're suffering some debilitating and in many cases degenerative conditions they're also preventable disabilities if they actually were to get better investigated and access treatments domestically.

Senator GREEN: I think this might assist in developing our report. I think the questions that were being put to you might have been put in an unfair way. Your organisation and both of you are here representing yourselves as patients, and the members that you're representing are essentially patients who have had vaccine injuries, isn't

that right? Quite a lot of questions were put to you about doctors. The evidence that you've given is about the doctors you have interacted with, isn't that correct?

Rachel O'Reilly: Yes, and it's often a long list of doctors.

Senator GREEN: I'm not being facetious or anything, but neither of you are medical doctors yourselves?

Rachel O'Reilly: Not at all.

Senator GREEN: Okay. So your organisation represents patients; the evidence that you've given, is it based on the conversations you have had with those people and their engagement with doctors, as patients?

Rachel O'Reilly: Are you talking about the literature reviews or which evidence?

Senator GREEN: All of it.

Rachel O'Reilly: Our sister organisations work directly with doctors and medical researchers—

Senator GREEN: What sister organisations?

Rachel O'Reilly: React19 is in conversation—or has doctors on board, doesn't it?

Dr Faletic: Absolutely. They have vaccine-injured doctors.

Senator GREEN: React19 is an overseas—

Rachel O'Reilly: It's a US non-profit organisation. We don't do any original work.

Senator GREEN: I just wanted to understand that because if you look at React19's website it says, 'We're not doctors; go and talk to doctors if you have a medical question.'

Rachel O'Reilly: But they work with doctors to make sure that they're giving—In the context of medical abandonment people are going to research their own conditions.

Senator GREEN: I understand. It's not a trick question. It's actually just to understand and clarify that the questions being put to you and the evidence that you were giving was from a patient's point of view.

Rachel O'Reilly: Sure.

Dr Faletic: I would add a little bit to that. That is essentially why we exist: to represent patients and their concerns.

Senator GREEN: There are lots of patients' consumer advocates.

Dr Faletic: Absolutely. We do also talk with doctors who are proactively working with our community to try and understand what they're seeing and what they're finding. Unbeknownst to most Australians, there are many doctors who are injured by the COVID vaccines as well, and some are quite famous. So we speak with some of those doctors as well to understand their experiences and what they've discovered in their journeys and how that might help the rest of us. Somewhat shockingly, many of those people have faced similar gaslighting from their own peers to that we have faced as non-medical professionals.

Senator GREEN: It's not a court of law and we're not talking about hearsay in this committee hearing but we might put those questions to the doctors when they appear. Thank you.

CHAIR: Thank you to our witnesses for appearing today. We do genuinely appreciate it, and thank you for all you're doing for people in a similar situation. Thank you very much.

Okay. That concludes our evidence—

Senator ROBERTS: Can I just make a couple of comments to the committee? It's not about the contents of what we've heard today; it's about the committee's deliberations, because I think we need another hearing.

CHAIR: That's something for a private hearing, Senator Roberts. You've made your point.

If I can encourage witnesses to the extent that they can to complete their answers prior to 1 March and submit them, that would of assistance to our wonderful secretariat. That concludes today's proceedings. The committee has agreed that answers to questions taken on notice at this hearing should be returned by close of business, 1 March 2024.

I thank all witnesses who have given evidence to the committee today. I thank all senators for your participation today. We got through quite a lot. Thanks also to broadcasting, the secretariat and to Hansard.

Senator ROBERTS: Chair, I commend you for your timeliness and also your fairness. Thank you.

CHAIR: That's kind of you, Senator Roberts, albeit unnecessary.

Committee adjourned at 15:34