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The Royal Commission of Inquiry
into COVID-19 Lessons Learned

By email: InquiryintoCOVID-19lessons@dia.govt.nz

Dear Commissioners,

SUBMISSIONS - PHASE 2 - THE ROYAL COMMISSION OF INQUIRY INTO COVID-19 LESSONS LEARNED

1. Thank you for the opportunity to submit key decisions made by the New Zealand Government during 2021 and 2022 ("**21/22 Period**") for Phase 2 of the Royal Commission of Inquiry into COVID-19 Lessons Learned ("**Phase 2 of the RCI**"). Members of parliament that were in the Government during the 21/22 Period are aware of the information set out in this letter, as I sent them a number of open letters (refer to **Schedule 1**).

2. Most New Zealanders accept that mistakes were made in the first few months of 2020 due to limited information. However, the Government ignored established science, trampled on human rights and manipulated the statistics (e.g. dying with COVID-19 vs dying from COVID-9) during the 21/22 Period. A National Library of Medicine publication summed up the situation as follows:

> *"[T]he COVID-19 pandemic is* ***one of the most manipulated infectious disease events in history****, characterised by* ***official lies*** *in an unending stream lead by government bureaucracies, medical associations, medical boards, the media, and international agencies.*[1]*."*

3. The Government's inconsistent and irrational policies caused mistrust in public health policies, the medical profession, the justice system and the Government. If the Commissioners of Phase 2 of the RCI do not restore trust in the system, a potential dire situation may come to fruition if there is a national health emergency in the future.

WASH YOUR HANDS AND WEAR FACE COVERINGS

4. Prior to COVID-19, established scientific research showed that there was no significant evidence to support the use of masks to prevent the transmission of viral infections. Initially the World Health Organization ("**WHO**") did not support the use of masks but caved into political lobbying. This change in policy marked a significant shift in the pandemic response; a shift away from established science to a response based on political science.

5. The Government's initial advice was to "*wash our hands"* and that *"masks do not work"*. Both Dr Michael Baker ("**Dr Baker**") and Dr Ashley Bloomfield are on record as stating that face masks were not effective against the virus and people should not wear them. Ms Ardern, the Chief Science advisor ("**CSA**") and Nanogirl made the following statements about hand washing and face masks during a Q&A in March 2020:

> Ardern*: "… people will probably hear* ***public health official saying wash your hands*** *and think, oh, that feels like really trivial advice* ***but why is that message one of the most important ones****?"*

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9062939/

CSA: *"So one of the differences between coronavirus and flu is not just the dangly bits but there's like an envelope around the* **coronavirus and that's lucky in this case because it makes it quite easy to kil***l.* **So when you wash your hands, you're not just washing it off, you're also bursting the envelope and killing the virus***, so any soap, any hand sanitiser, any detergent, any bleach will burst the envelope and* **actually kill the virus***".*

Ardern*: "I see people wearing masks.* **Your views on Masks***? … but is there any reason why masks are something that people should be using?"*

Nanogirl: *"So for the general public,* **if you don't have symptoms there's no need to wear a mask***…The people who need to be wearing masks right now are if you are symptomatic. …You don't need to be wearing a mask all the time unless you are symptomatic …there's a lot of people buying them thinking they're being protected, but actually* **it's about having good hygiene and keeping your distance from people***…There are different types of masks. So the one that people are* **buying at the supermarket are what are called surgical masks – they're the rectangle ones – and you'll see they've got gaps in the back here, so they're not full protecting you***. The ones that our healthcare workers have are different, and they'll have a full seal around their face.[2]"*

6. Mask mandates were introduced in 2021 pursuant to the COVID-19 Public Health Response (Alert Level Requirements) Order (No 9) 2021 ("the Order"). The purpose of the Order was to "*prevent, and limit the risk of, the outbreak or spread of COVID-19*"and required face coverings, such as t-shirts, to be worn in certain places or face significant fines for this strict liability offence. This u turn in the Government's policy made New Zealanders question what was going on given the virus had been circulating for close to two years.

7. New Zealanders were right to question the Government's irrational policy for face coverings. Those aged over 12 years were required to wear face coverings into busy cafes and restaurants but could remove the face coverings once seated. Did COVID-19 have a height restriction?

8. On 20 October 2021, the Ministry of Health ("MOH") responded to a request made under the Official Information Act 1982 ("OIA")[3] in which it stated:

"Maintaining the requirement for face coverings provides wider benefits that support the overall response to the pandemic. **Face coverings are a constant reminder of the ongoing threat posed by COVID-19** *and will help prompt people to be more vigilant about other important behaviours, such as physical distancing, scanning using the New Zealand COVID Tracer App, hand hygiene and coughing and sneezing etiquette."*

9. The Order is an example of the *`rule of law for thee but not for me'*. As set out at clause 23(oa) of the Order:

"*Nothing in this order applies – … to Parliament, including members of Parliament, parliamentary staff and any officer of Parliament".*

10. It was interesting to watch Ms Ardern on captured footage for Focus Live on 4 May 2022. Ms Ardern appeared without a face covering but prior to going live she asked those joining her in the background to *"Feel free to keep the masks on"* and when an official asked if he needed a face mask she replied "*ah yeah … it turns into a spectator sport sometimes"* before cracking up laughing[4 and 5]. Why did Ms Ardern feel that face masks were necessary for the cameras only?

[2] https://www.pmcsa.ac.nz/2020/03/10/qa-on-covid-19-with-pm-jacinda-ardern-and-dr-michelle-dickinson/

[3] Reference: H202112578

[4] https://x.com/MurfittTauranga/status/1872095316247539809?s=09

[5] https://www.nzherald.co.nz/video/focus-live-pm-jacinda-ardern-announces-100m-biosecurity-fund/PR3XXZN6FJAPW4U6A44TSTYQW4/

11. The *`Final Report of the Select Subcommittee on the Coronavirus Pandemic on Oversight and Accountability*', U.S. House of Representatives, dated 4 December 2024 ("**U.S House of Representatives' Report**") concluded that masks mandates were *"without full scientific transparency"* and noted that:

> *"… the most rigorous and comprehensive review of the scientific literature on masks during the COVID-19 pandemic was published by Cochrane.[840] Cochrane is considered the worlds most respected organization for evaluating health interventions, is known for being the single best resource for methodologic research,[841] and is recognized as having the highest standard of evidence-based healthcare.[842] … Ultimately, a systematic review carried out by Cochrane Collaboration—one of the most highly regarded methodologies in evidence-based healthcare—found that the pooled randomized control trials they analyzed "**did not show a clear reduction in respiratory viral infection with the use of medical/surgical masks**" and that **"[t]here were no clear differences between the use of medical/surgical masks compared with N95/P2 respirators in healthcare workers when used in routine care to reduce respiratory viral infection."**[782] **These results appear to directly contradict public health agencies' and local governments' support for broadly requiring masking throughout much of the pandemic."** Reference*

Personal Experience: the fear generated from the face coverings mandates made people irrational. When my husband was rushed to hospital with heart failure (caused from being on a leukaemia trial and an ejection fraction of 17) the triage nurses were more concerned about him wearing a mask than his health. He was struggling to breathe due to the fluid in his lungs. This took up precious time. When my husband saw a doctor, he was immediately rushed through to resus and stabbed with adrenaline. None of the doctors cared that he was not wearing a mask - just that he was still alive and breathing.

In addition, I was involved in one of the early mandate cases as a researcher. A few others and I were allowed to be present in the court room for the trial. The main lawyer applied for mask exemptions for herself and her small team. We were denied by the Ministry of Justice. However, and with due respect to the Court, when we entered the courtroom none of the media were wearing masks. However, they did put them on when the registrar announced that the judge would be entering the court room. The judge did not wearing a mask and on the second day of the trial the Crown lawyers did not wear masks and nothing was said.

THE 2 METRE RULE

12. The 2 metre rule for social distancing was a guideline which all New Zealanders were subjected to during the pandemic. The Order imposed strict liability and huge fines for breaching social distancing. The rule made little sense at the time as the aerosol from a sneeze does not necessarily stop at 1 metre and 99 cm. The U.S House of Representatives' Report has since found that the social distancing requirement was not supported by science.

TESTING TECHNOLOGIES

13. Public health policy must be based on accurate and independently verifiable data to identify infectious people and ensure sick people get medical attention. When in medical history has a public health authority needed to "*test, test, test*" healthy people with no symptoms to define a medical *"case"*?

14. The PCR protocols[6] based on papers such as Drosten's protocols have not established diagnostic specificity for clinical use. Instead, the protocols report on the analytical specificity, making the tests and the results questionable. The WHO [7] confirmed early on in the pandemic that the PCR test had false positives. The PCR test is unreliable and the results were ruled inadmissible in at least two European courts early on in the pandemic[8].

[6] https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2020.25.3.2000045
[7] https://web.archive.org/web/20210120083427/https://www.who.int/news/item/14-12-2020-who-information-notice-for-ivd-users
[8] https://off-guardian.org/2020/11/20/portuguese-court-rules-pcr-tests-unreliable-quarantines-unlawful/

15. Dr. Fauci is on record as stating that when a cycle threshold of 35 or more is used for the PCR Test, the chances of it being replication confident is minuscule[9]. New Zealand's MOH confirmed in their letter in response to an OIA request[10] that a cycle threshold of 40 is used in New Zealand.

16. Reliance on the PCR tests alone to define medical *"cases"* resulted in *"overdiagnosis, overtreatment, and increased health care costs"*[11]. The MOH acknowledged in an OIA response that:

> *"Please note that the cycle threshold (Ct) values provide very limited information about a positive case of COVID-19. It also cannot be interpreted meaningfully without broader clinical data and technical interpretation …*[12]*"*

17. In May 2021, a study published in the *Journal of Infection* determined that the results of PCR tests alone are insufficiently meaningful to justify pandemic control measures "*such as quarantine, isolation or lockdown*." Regardless, the Government encouraged healthy individuals with no symptoms to get tested at one of the drive-through testing centres without considering broader clinical data and technical interpretation.

18. In the first 20 months of the pandemic, New Zealand undertook approximately 3,248,982 tests of which 3,242,989 showed a negative result despite using a cycle threshold of 40 or more. During this time there were only 5133 positive tests (and 27 deaths). It should be noted that an individual who tested positive may have had more than one positive test due to testing requirements for employment.

19. The MOH confirmed in their response to an OIA request that:

> *"… the Ministry has funded district health boards (DHBs) an average price of $120 per swab, and it pays the laboratories $70 per test processed - a total average cost of $190*[13]*."*

20. By mid-September 2021, the cost of PCR testing in New Zealand was approximately $617,306,580. The actual cost is a lot higher as the PCR test regime continued past that point in time. These funds would have gone a long way towards cancer treatments or reducing childhood poverty.

LOCKDOWNS

21. Initially, our government recommended good hygiene. Then suddenly it all changed. The Government told us to "*go hard and go early*" and that a short term lockdown was justified as it would only take "*two weeks to flatten the curve*". Disturbingly, the Government declared themselves the "*single source of truth*"and effectively said "*Don't listen to anyone else*."

22. The Government attached value to stopping the disease and saving lives from COVID-19, but zero value to the impact and disruption on people's lives. The U.S House of Representatives' Report found that:

> *"As more data comes out about the elements to which the public health establishment attached "zero value," it appears the American people could have been better served by policies which* ***focused on protecting the most vulnerable while prioritizing productivity and normalcy for the less vulnerable****."*

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[9] https://www.bitchute.com/video/X0Z3Whf2SopB/

[10] https://fyi.org.nz/request/16779-effect-of-pfizer-vaccine-on-reducing-transmission I note that some OIA are not as easy to find as they were previously

[11] Overdiagnosis of Clostridium difficile Infection in the Molecular Test Era - PubMed (nih.gov)

[12] https://fyi.org.nz/request/15879-cycle-thresholds-of-positive-sars-cov-2-tests-in-new-zealand#incoming-59660

[13] https://fyi.org.nz/request/15879-cycle-thresholds-of-positive-sars-cov-2-tests-in-new-zealand#incoming-59660

23. We went into one of the world's strictest lockdowns. Schools closed, businesses shuttered, streets empty. Families were unable to be with loved ones in their final moments; people died alone because of those rules. Births, weddings, funerals – the milestones of life – cancelled or postponed. Those were not just statistics – those were our lives and our memories.

24. At the time, we were told this was the only way. The change in strategy was heavily influenced by the WHO. We have obtained the letter from WHO to Ms Ardern dated 23 March 2020 under the OIA. It reads like a playbook of what unfolded 3 days later when the first national lockdown was implemented. The lockdown of healthy people was justified based on few than 100 probable cases (which were not even confirmed cases).

25. Some may argue it may have been done to protect public health. But we must all acknowledge the cost: our personal freedoms were stripped in an unprecedented way.

> Personal Experience: my elderly neighbour (close to my office) could not hold her husband's hand as he passed away at Tauranga Hospital after being admitted for pleurisy. They had recently celebrated 60 years of marriage and the both proudly showed us the letter from the Queen and one from Ms Ardern. My neighbour rang me in tears saying that her husband had died and she thought he had been cremated but they could not tell her when. She was very distressed as it was important to her that she knew when he had been cremated without any family around him. She remained in her home alone until the end of that lockdown.

26. Public health policy must ensure that pathways for routine medical care remain uninterrupted. This was not the case for those with pre-existing and newly emerging medical conditions (such as my husband), who were unable to access medical treatment during the lockdowns or even at some lower levels.

> Personal Experience: The Government's policy prevented sick people from getting some tests and treatment which were not related to COVID-19. In 2021, after my husband was in remission from Leukaemia, his kidneys started to fail. His blood test showed one marker was 911 when the normal upper limit was 60. He was told he could not get an urgent test for five days due to "COVID-19 paperwork" despite there not being one single case at Tauranga Hospital.

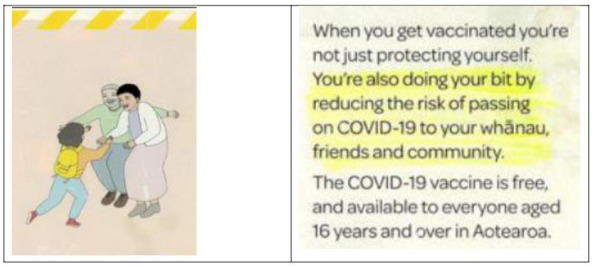
27. The pandemic response should have included ongoing monitoring of its impact on New Zealanders with serious health conditions. It is crucial to address the collateral damage from policies promptly. COVID-19 lockdowns caused delays in procedures, early diagnosis and doctor visits for many New Zealanders.

VACCINE PASSPORTS AND THE TRAFFIC LIGHT SYSTEM

28. A de facto lockdown was implemented for the unvaccinated via vaccine passports. On 26 October 2021 Cabinet agreed to mandate vaccination for work in any setting where a COVID-19 Vaccination Certificate (i.e. vaccine passport) would be required under the COVID-19 Protection Framework. The vaccine passports exemplify political influence, financial interests, power dynamics, and social engineering.

29. High vaccination rates using traditional vaccines have been effective in reducing diseases such as measles, polio and smallpox. Accordingly, high vaccination rates were expected to reduce the transmission of SARS-CoV-2 (i.e. the virus) and thereby reduce the burden of the Covid-19 disease. However, the vaccine was not effective in reducing transmission or infection.

30. The "Traffic Light System" and the mandates should not have been implemented if the Government had followed the science. The government initially said that the vaccine was 95% effective and urged vaccination to protect others:



31. Mandatory vaccination should only be considered when it is necessary for public health and safety. The collective benefit to the community must outweigh the risk of the proposed vaccine. Chris Hipkins said that the vaccine was not mandatory and people had a choice. However, there is no choice where there is coercion; people had to choose between feeding their families and taking a vaccine that they would have otherwise declined.

32. The collective benefit to the community did not outweigh the risk of the vaccine. The vaccine had not been tested to ascertain if it stopped transmission and there was no medium or long-term safety data. The European Parliament Special Committee for Covid-19 Pandemic Management ("**the EU's Parliament Committee**") investigated the management of the pandemic. The EU Parliament Committee asked a senior representative of Pfizer if the vaccine had been tested to see if it stopped the spread of the virus prior to the public rollout. The senior representative from Pfizer, who was under sworn oath for the hearing, replied:

> *"Regarding the question around whether we knew about stopping immunization before it entered the market, no, haha. These, emm, you know, we had to, really move at the speed of science to really understand what is taking place in the market*[14]*."*

33. It can be established beyond reasonable doubt, that the New Zealand Government was aware of this fact from at least January 2021. The New Zealand MOH's `*Minutes of the out of Session Medicines Adverse Reactions Committee Meeting 20 January 2021*' states:

> *"The Committee discussed the clinical trial information available to date. The low numbers of participants who were very elderly, of ethnic minorities, and with various important comorbidities were noted.* ***It was also noted that the study design does not provide robust safety data in a number of populations. Nor does it provide adequate information about duration of immunity/need for booster doses, prevention of transmission, prevention of asymptomatic disease or prevention of severe disease***[15]*."*

34. Again in July 2021, as evidenced by the statement on the Ministry of Health's ("**MOH**") website:

> *"we do not know if vaccination prevents or reduces transmission of COVID- 19*[16]*."*

35. On or around 30 September 2021 the Link to the above statement on the MOH's website was removed[17]. However, you can place the link in the *WayBackMachine* to access[18]. The MOH then confirmed in a response dated 10 September 2021 to a request made under the OIA that:

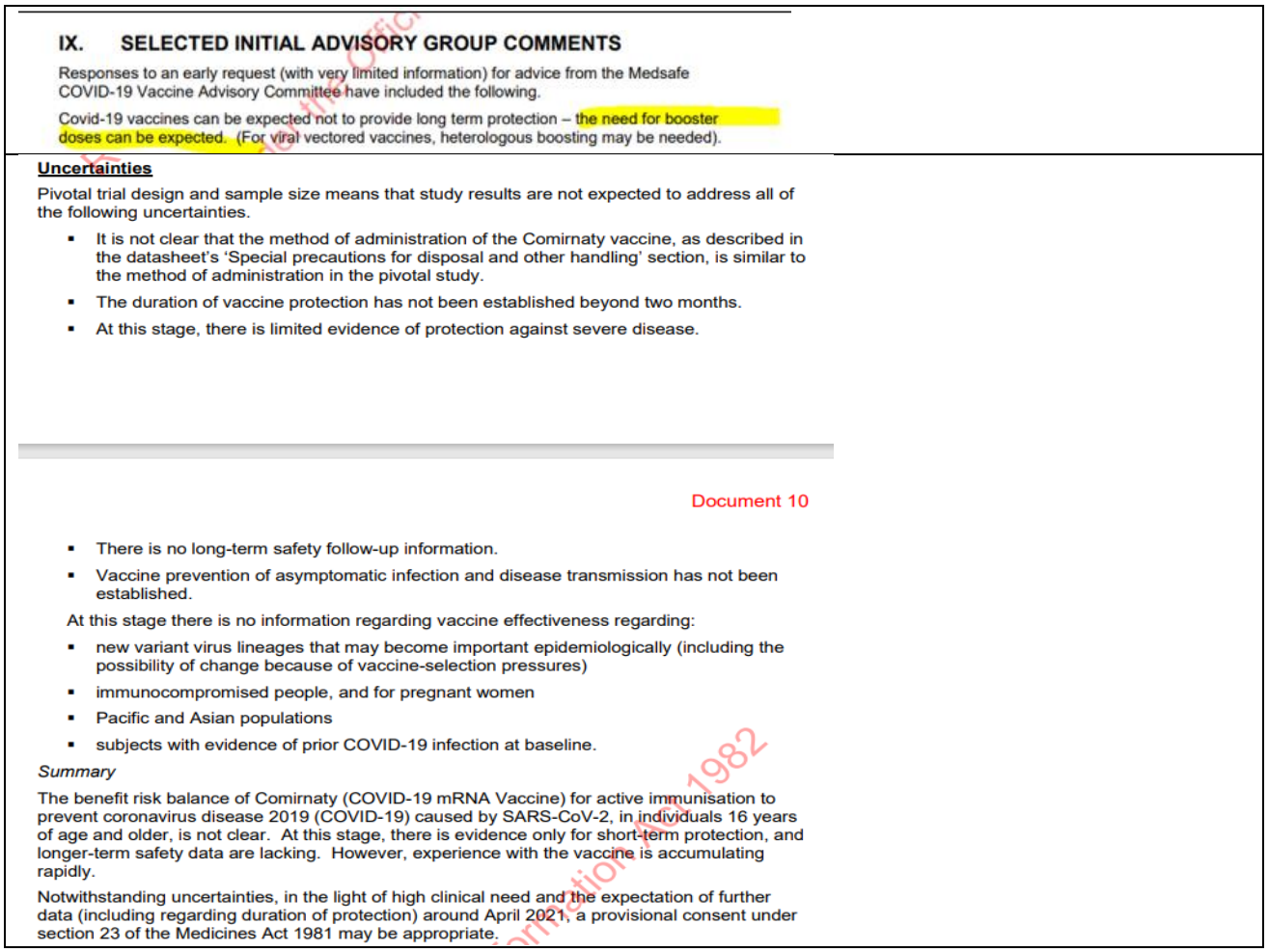
> *"Reducing transmission was not an outcome measured in the trials of the Pfizer vaccine"*

36. The Government promoted the *"two shots for Summer"* as effective even though the MOH's Clinical Evaluation from January 2021 ("**Clinical Evaluation**") stated that the need for boosters was expected. The Clinical Evaluation states that the Government did not know if the vaccine would provide protection beyond two months. Many

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[14] https://www.youtube.com/watch?v=noJO5DBe7x0
[15] https://medsafe.govt.nz/profs/adverse/MinutesOoS-20-jan-2021.htm
[16] Reference: H202110912
[17] https://www.medsafe.govt.nz/COVID-19/q-and-a.asp
[18] http://web.archive.org/web/20210320141828/https:/www.medsafe.govt.nz/COVID-19/q-and-a.asp

people thought they were doing the "*right thing*" by taking the "*two shots*", not realising they were signing up for four monthly boosters and perhaps the risks of vaccine-associated enhanced respiratory disease which was noted in the Clinical Evaluation.



IX. SELECTED INITIAL ADVISORY GROUP COMMENTS

Responses to an early request (with very limited information) for advice from the Medsafe COVID-19 Vaccine Advisory Committee have included the following.

Covid-19 vaccines can be expected not to provide long term protection – the need for booster doses can be expected. (For viral vectored vaccines, heterologous boosting may be needed).

Uncertainties

Pivotal trial design and sample size means that study results are not expected to address all of the following uncertainties.

- It is not clear that the method of administration of the Comirnaty vaccine, as described in the datasheet's 'Special precautions for disposal and other handling' section, is similar to the method of administration in the pivotal study.
- The duration of vaccine protection has not been established beyond two months.
- At this stage, there is limited evidence of protection against severe disease.

Document 10

- There is no long-term safety follow-up information.
- Vaccine prevention of asymptomatic infection and disease transmission has not been established.

At this stage there is no information regarding vaccine effectiveness regarding:

- new variant virus lineages that may become important epidemiologically (including the possibility of change because of vaccine-selection pressures)
- immunocompromised people, and for pregnant women
- Pacific and Asian populations
- subjects with evidence of prior COVID-19 infection at baseline.

Summary

The benefit risk balance of Comirnaty (COVID-19 mRNA Vaccine) for active immunisation to prevent coronavirus disease 2019 (COVID-19) caused by SARS-CoV-2, in individuals 16 years of age and older, is not clear. At this stage, there is evidence only for short-term protection, and longer-term safety data are lacking. However, experience with the vaccine is accumulating rapidly.

Notwithstanding uncertainties, in the light of high clinical need and the expectation of further data (including regarding duration of protection) around April 2021, a provisional consent under section 23 of the Medicines Act 1981 may be appropriate.

37. Regardless of the above acknowledgement, the Government introduced further mandates and the traffic light system and used millions of taxpayer dollars to fund one of the most intense advertising campaigns known in New Zealand's history. Many New Zealanders trusted the Government's narrative and took the vaccine without understanding that it would not stop transmission and could injure them and cause death. Dr Baker was quoted in the Guardian[19] newspaper as follows:

> *"the traffic light system won't help us very much because it was never designed to dampen down transmission, it was only designed to nudge people towards vaccination,"*

38. The Government's advertising campaign and media encouraged division between the "vaxed" and the "unvaxed". A couple of examples from Newstalk ZB[20] are set out below:

> *"… that unvaccinated people pose a 'threat' to the rest of the vaccinated population…"*
> *"… that the New Zealand Government should legislate to DISCRIMINATE against unvaccinated people so that they cannot "harm "others?*
> *"…. unvaccinated people should have their freedoms limited, society 'privileges' limited until they 'comply' with your new laws?"*

[19] New Zealand not prepared for Omicron outbreak expected in 'matter of weeks', experts warn | New Zealand | The Guardian
[20] https://www.newstalkzb.co.nz/on-air/heather-du-plessis-allan-drive/audio/al-gillespie-could-be-possible-to-pass-laws-making-it-legal-to-discriminate-against-those-who-refuse-the-jab/

39. On 23 October 2021, Ms Ardern told the NZ Herald's deputy political editor Derek Cheng ("**Derek**"), about the freedoms that the unvaccinated would miss out on and how New Zealand would look under the system. An extract from the interview is set out below:

> Derek*: "So you've basically said, you probably don't see it like this, but* ***two different classes of people****. If you're vaccinated or unvaccinated. You have all these rights if you are vaccinated"*
> Ms Ardern*: "****That is what it is****. So, yep. Arrr, yep".*
> Derek: *"Can you describe, because* ***you've previously were hoping not to have to do that****, I guess when we still like we could maintain elimination across the whole country but I guess that has now changed, because …"*
> Ms Ardern: *"I think it was less because necessarily of the elimination determining that and more because we, of course, arrr maintained and actually we have managed very high vaccination rates generally without the use of certificates. But actually, what it has become clear to me is that they are not just a tool to drive up vaccines.* ***They are a tool for confidence. People that have been vaccinated will want to know that they are around other vaccinated people****. Arrr* ***they will want to know they are in a safe environment****. It is a way that we can give confidence to those that are going back into hospitality or events. Arr so that is something that I think we should offer to people who have been vaccinated. That confidence that we are doing everything that we can to keep em safe and they can come back out and enjoy those things safely.* ***So, it is a tool for business too***[21]*."*

40. As we witnessed the vaccinated contracting and spreading the virus in venues that only the vaccinated could access with a vaccine passport the narrative changed from "*take the vaccine to protect your family*" to *"the vaccine that will prevent serious outcomes"*? For example, Luxon stated:

> *"Vaccination and boosters are protecting our hospital system. It makes a huge difference. Unvaccinated people are much more likely to end up in hospital than those vaccinated, and much more likely to die*[22]*."*

41. Luxon's statements about the unvaccinated are not true.

DISCRIMINATION UNDER THE VACCINE EXEMPTION PROCESS

42. Under the COVID-19 Public Health Response (Vaccinations) Amendment Order 2021 ("**the Order**") there were a range of exemptions for workers to carry out work without being vaccinated. These included the Health Exemptions under clause 9B ("**Health Exemptions**"), Significant Service Disruption Exemptions under clause 12A ("**SSD Exemptions**"), and Other Exemptions under clauses 9 and 9A ("**Other Exemptions**") of the Order

43. The Minister had the power to grant exemption for vaccination pursuant to section 12A of the Order. A person who committed an offence by failing to comply with the Order faced large fines or imprisonment under the provision of the COVID-19 Public Health Response Act 2020. In addition, many New Zealanders who were denied exemptions on medical grounds lost their employment, some lost their businesses, homes, and ability to pay their bills and put food on the table for their families.

44. Te Whatu Ora responded to an OIA request on 2 August 2023[23] and stated that:

> *"From 13 November 2021 to 26 September 2022, a total of 478 applications for Significant Service Disruption exemption (SSD) were received.* ***103 applications were granted, covering approximately 11,005 workers****. Please note that it is not possible to provide the exact number of workers that were covered by SSDs. This is because it was possible for an organisation to submit an application to cover more than one worker."*

45. Why were some New Zealanders granted exemptions based on their occupation and others were denied exemptions despite having pre-existing conditions and the risk to their health?

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[21] https://www.youtube.com/watch?v=ZdMSRolWCyQ
[22] https://www.newshub.co.nz/home/politics/2022/01/covid-19-national-mp-harete-hipango-deletes-post-showing-her-at-another-anti-vaccine-mandate-and-lockdown-protest.html
[23] Reference: HNZ000239782

MANAGED ISOLATION OR QUARANTINE FACILITIES

46. The Government held the majority of people coming into New Zealand in managed isolation or quarantine facilities despite a negative PCR Test. However, famous overseas celebrities such as DJs and film directors were granted exemptions.

47. Some exemptions appear to have been predetermined. For example, lawyer, Sue Grey ("Ms Grey") wrote to the MOH on 22 August 2021[24] requesting the criteria for exemptions from quarantine and how the Wallabies qualified and what restrictions were imposed on their travel. The last three emails in the email chain show that the Principal Advisor of the Health Order Exemptions emailed various people at the MOH at 2.27pm on 26 July 2021 stating that the exemption was a *"really rough put together"* but she needed an urgent response as she was *"…hoping to get it to Ashley by 3.30pm"* (one hour later). At 16.42pm the same day *"a very quick review as requested"* was returned and it was noted that *"…it would good to see the exemption notice drafted by the DPMC and PH review the conditions and advise them as there should be a vehicle for advice from Ashley on them as well"*. At 5.02pm later that day the Covid Response Team Manager reported that advice had gone to the Minister proposing that she exempt the Wallabies and enable them to arrive in New Zealand quarantine free by 30 July 2021. She states that the exemption notice will need to be issues subject to a range of conditions but *"[t]hose conditions have not been expressly address as yet … Phil – who can we work with to draft an urgent but relatively simple exemption notice tomorrow?".* The conditions were not provided under the OIA response.

RISKS OF THE VACCINE

48. As of April 2025, we know that the vaccine poses a number of serious risks including death, disability and an increase in diseases such as cancer. The risks of the vaccine will be covered in full by the medical doctors and scientists. Accordingly, I will focus on what knowledge the Government had during the 21/22 Period.

49. Medical ethics requires medical intervention to be proven safe before it is rolled out on a healthy population, let alone mandated under provisional consent. As you are aware, full consent was not granted for the vaccine until after the mandates ceased. Pharmaceutical companies had tried for decades to develop an mRNA vaccine, but failed due to efficacy and safety issues. Despite this, the Government permitted Big Pharma to vaccinate a mostly healthy population before completing the usual trials. Short-term safety and efficacy data changed significantly over 2021-2022, with medium and long-term effects still unknown.

50. Why did the Government trusting Pfizer with an experimental vaccine when the company has incurred $10,193,896,333[25] in fines since 2000? Vaccines are big business, and often power, greed, and money lead to corruption. CNN[26] reported that Pfizer's earnings and sales doubled in the second to last quarter of 2021 due to its Covid-19 vaccine with adjusted earnings of $7.7 billion, up 133% from a year earlier. Revenue soared to $24.1 billion, up 134%. The sky was the limit, with four monthly boosters as protection (if any) was found to wane quickly.

51. The FDA released batches of Pfizer's documents under a Freedom of Information court order in late 2021. The FDA had sought to withhold the documents for 75 years. The information released showed the initial phase of the trial was unblinded, there were biases when participants suffered severe injuries and the all-cause mortality was 30 % higher in the vaccinated group versus the matched control group (before the trial was unblinded).

WHY NO MANDATORY REPORTING

52. Vaccine development is usually a slow and laborious process that takes between 5 to 10 years. Vaccine Safety requires proper animal trials and peer-reviewed data. Once a new medical intervention is rolled out the accurate reporting and investigation of adverse events is essential.

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[24] Reference: H202111046

[25] https://violationtracker.goodjobsfirst.org/parent/pfizer

[26] https://edition.cnn.com/2021/11/02/business/pfizer-earnings/index.html

53. Esteemed US cardiologist, Dr Peter McCullough, stated that historically if someone dies within 30 days of a new drug or injection, the US regulatory agencies have considered the death to be caused by the new drug or injection until proven otherwise. This is known as the precautionary principle.

54. Early on in the vaccine rollout, Dr Fauci commented on the temporal link between the vaccine and adverse reactions. Dr Fauci stated:

> *" … most of the bad effects, if they do occur, and I say it is extremely rare, they almost always occur between 15 and 45 days."*[27]

55. The Coroners' Court advised the MOH by email that death may occur up to 93 days following the vaccine. A delay between the administration of the vaccine and death is not a novel concept. Despite the timeframes acknowledged by our own Government, temporal adverse events are often labelled as a "*coincidence*". However, a temporal death for COVID-19 is used by the Government. If a person dies within 28 days of a positive COVID-19 test they are automatically counted as a COVID-19 death regardless of the underlying cause (e.g., gunshot wound).

56. Unfortunately, our Government did not require mandatory reporting of adverse events for the vaccine. Reporting was voluntary. Prior to COVID-19 the consequences of voluntary reporting systems had been studied in New Zealand. Medsafe[28] estimated that only 5% of all reactions are reported to the Centre for Adverse Reactions Monitoring ("CARM").

57. As you will recall the initial vaccine cards recorded the name of the person and the batch number of the vaccine. New Zealand groups, such as NZDSOS, were tracking different lot numbers to identify the risky batches (the batches seem to play a role in the type of harm caused). Subsequently, the Government removed the lot numbers from the vaccine cards without explanation and blocking transparency. I am aware that OIAs have been made concerning the lot numbers and that a MP agreed to ask a question in Parliament on behalf of a member of the public but went silent once the question about the lot numbers was emailed to her. Why did the Government remove the lot numbers and why are we not allowed to know the batch numbers?

58. The Government did not require mandatory reporting of adverse events nor was the vaccine status recorded on the death certificates to assist with ascertaining if the vaccine is contributing to the increase in excess all-cause mortality in New Zealand[58]. Despite the lack of mandatory reporting in New Zealand, the Minutes of the Covid-19 Vaccine Technical Advisory Group[29] ("TAG") dated 11 May 2021 recorded the following at item 5:

> - The level of work is unprecedented; usually CARM receives about 5,000 reports a year but have already received around 2,600 reports since the beginning of the COVID-19 vaccine rollout.

59. The first vaccine was administered in New Zealand in mid-February 2021. Accordingly, the above statement only covered a three-month period for voluntary reporting. New Zealanders will never know the true number of vaccine deaths and injuries during the 21/22 Period.

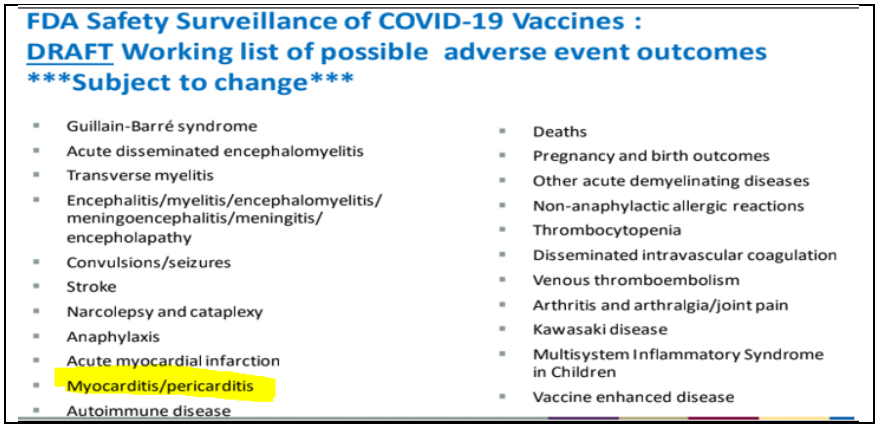
2020

60. Pfizer's original trial report was published on 31 December 2020 and claimed that the vaccines were safe and showed 95% efficacy seven days after the 2nd dose. But that 95% was the Relative Risk Reduction ("RRR"). The

[27] https://odysee.com/@TruthPills:5/derbez:3?r=7DaUF82LuWM8es4fnVa4XMAexE1ZEq2H
[28] https://www.medsafe.govt.nz/Profs/PUarticles/ADRreport.htm
[29] https://fyi.org.nz/request/16691/response/65106/attach/5/H202112324%20documents%20redacted.pdf

Absolute Risk Reduction ("**AAR**") was only 0.84%. The RRR considers participants who could benefit from the vaccine, whereas the ARR (i.e. the difference between cases with and without a vaccine) considers the whole population. The author of a paper in The Lancet stated that the omission of the ARR lead to reporting bias which affected the interpretation of vaccine efficacy and public health. We all remember the MP telling us that the vaccine was 95% effective.

61. The **FDA ACIP Meeting** on 30 October 2020 set out a working list of possible adverse event outcomes:

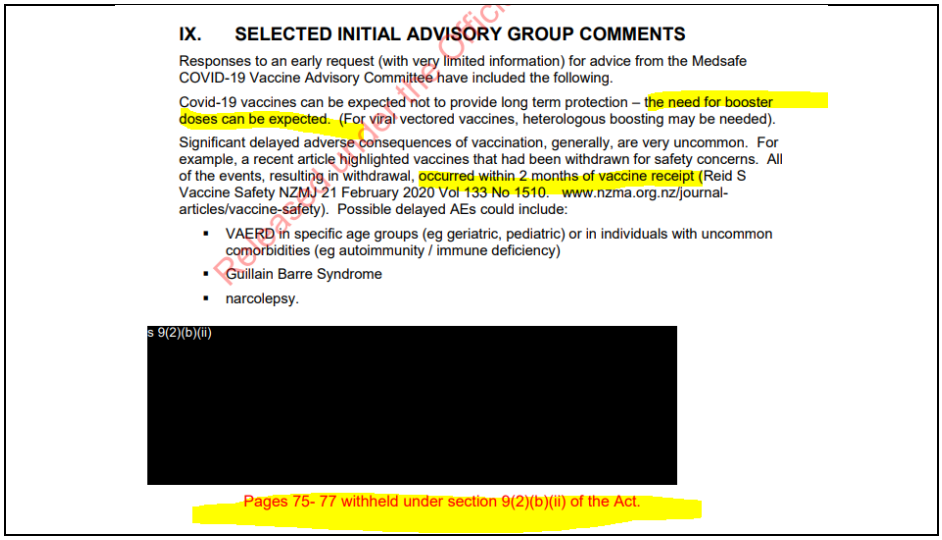


FDA Safety Surveillance of COVID-19 Vaccines :
DRAFT Working list of possible adverse event outcomes
*****Subject to change*****

- Guillain-Barré syndrome
- Acute disseminated encephalomyelitis
- Transverse myelitis
- Encephalitis/myelitis/encephalomyelitis/ meningoencephalitis/meningitis/ encepholapathy
- Convulsions/seizures
- Stroke
- Narcolepsy and cataplexy
- Anaphylaxis
- Acute myocardial infarction
- Myocarditis/pericarditis
- Autoimmune disease
- Deaths
- Pregnancy and birth outcomes
- Other acute demyelinating diseases
- Non-anaphylactic allergic reactions
- Thrombocytopenia
- Disseminated intravascular coagulation
- Venous thromboembolism
- Arthritis and arthralgia/joint pain
- Kawasaki disease
- Multisystem Inflammatory Syndrome in Children
- Vaccine enhanced disease

2021 - JANUARY

62. Our Government's Clinical Evaluation[30] dated January 2020 ("**January 2021 Clinical Evaluation**"), obtained under the OIA, does not seen to include the FDA's list of adverse reactions. Unless myocarditis is listed on one of the three redacted pages, which would raise a number of serious questions.



IX. SELECTED INITIAL ADVISORY GROUP COMMENTS

Responses to an early request (with very limited information) for advice from the Medsafe COVID-19 Vaccine Advisory Committee have included the following.

Covid-19 vaccines can be expected not to provide long term protection – the need for booster doses can be expected. (For viral vectored vaccines, heterologous boosting may be needed).

Significant delayed adverse consequences of vaccination, generally, are very uncommon. For example, a recent article highlighted vaccines that had been withdrawn for safety concerns. All of the events, resulting in withdrawal, occurred within 2 months of vaccine receipt (Reid S Vaccine Safety NZMJ 21 February 2020 Vol 133 No 1510. www.nzma.org.nz/journal-articles/vaccine-safety). Possible delayed AEs could include:

- VAERD in specific age groups (eg geriatric, pediatric) or in individuals with uncommon comorbidities (eg autoimmunity / immune deficiency)
- Guillain Barre Syndrome
- narcolepsy.

s 9(2)(b)(ii)

[redacted]

Pages 75- 77 withheld under section 9(2)(b)(ii) of the Act.

63. The January 2021 Clinical Evaluation had "uncertainties" concerning the vaccine as note earlier in this letter. A number of signals quickly emerged as the vaccine was rolled out to a predominately healthy population.

64. For the purpose of this letter, I shall only consider the risk of myocarditis that predominately impacted on our younger New Zealanders who had little risk from COVID-19. In December 2022 the New Zealand Herald published

[30] https://static1.squarespace.com/static/612c674b10fbd22a00202ceb/t/614d72f6a8c6667866a71081/1632465696127/H202106950-+Response+Documents+%28redacted%29+%28003%29+%281%29.pdf

a story with the following headline "*What is SADs? Healthy young people dying from Sudden Adult Death Syndrome*"[31].

FEBRUARY

65. On 3 February 2021, the MOH announced that the Pfizer-BioNTech vaccine has been provisionally approved by Medsafe with 58 conditions placed on the company. The MOH stated in its media release that:

> *"The decision by medicines regulator Medsafe to provisionally approve the Pfizer/BioNTech vaccine (Comirnaty) to be used in New Zealand follows a robust assessment of the safety, effectiveness and quality of the vaccine … **All the data is considered and we then complete a benefit risk assessment**, which allows us to balance the benefits of the vaccine against any known risks such as side effects. We have determined there may be some minor side effects such as a painful arm and headaches – these are not uncommon in other vaccines.[32]"*

66. Please note that the benefit risk assessment has been repeatedly denied under the OIA on the grounds that it would be an "*unreasonable prejudice to the commercial position*".

67. Condition 57 of the original provisional consent required Pfizer to provide monthly safety reports and any other reports they became aware of. Pfizer was aware of the risk of myocarditis, and this should have been stated in the safety reports. Accordingly, the Government should have known about the risk from at least March 2020.

MAY TO NOVEMBER 2021

68. The Covid-19 Vaccine Technical Advisory Group ("TAG") raised numerous concerns in regard to myocarditis[33] [34] as set out below:

Date of Minutes	Concerns
11 May 2021	• Four signals are currently being investigated: thrombosis with thrombocytopenia syndrome (TTS), appendicitis, herpes zoster, and myocarditis.
25 May 2021	• Events of myocarditis post-vaccination are being evaluated by regulators, including the EMA and FDA. Preliminary evidence suggests that rates are low in the US, UK and the EU (~1 per million) and Israel (~6 per million).
8 June 2021	• Israel Health Ministry has concluded that the cases of myocarditis, predominantly in younger males, following the Pfizer vaccine are probably linked to the vaccine. The US and EU regulators have stated that a causal link is yet to be established.
22 June 2021	The decision to use Pfizer for 12 to 15 years • It would be advisable to delay until more safety data is available, especially with regards to potential safety signals such as myocarditis, which have been reported in some overseas rollouts eg, Israel

[31] https://www.nzherald.co.nz/lifestyle/what-is-sads-healthy-young-people-dying-from-sudden-adult-death-syndrome/TIOAK4SYPF5LFSKP5QZCVG23IM/
[32] https://www.health.govt.nz/news-media/media-releases/robust-assessment-ahead-medsafe-approval-vaccine
[33] H202112324 documents redacted.pdf (fyi.org.nz)
[34] H202115494 Response.pdf (fyi.org.nz)

29 June 2021	**Myocarditis after Pfizer Vaccination** • Advice on the Decision to Use Pfizer for 12-15-year-olds was issued to Cabinet, however a decision has been deferred pending advice from CV TAG on myocarditis. • The FDA have added a warning for myocarditis and pericarditis to the Pfizer and Moderna vaccine data sheets, after observing a series of cases following vaccination. It is seen most predominantly in adolescent and young adults, particularly males aged <30 years, and after the second dose. CV TAG discussed the current evidence and risks. Key points of discussion: • The University of Auckland is leading a project estimating background rates of adverse events in New Zealand, including myocarditis, and is expected to report findings within the next 7-10 days. Data on the ethnic breakdown of cases was requested to be included. • CV TAG noted concern about the potential risk of myocarditis has grown and a sense of urgency to develop options, e.g., for alternative vaccine schedules, and advice.
	• While evidence is still emerging, IMAC clinicians are already fielding requests on myocarditis. It was noted that because the issue is relatively rare, the true risk may not be known for some time until the vaccine rollout internationally has progressed further. • There is a need to communicate safety information to inform the public and present a balanced assessment of the risk and benefits. Science communicators who can appeal to a range of different ethnicities will be important. • Further information is needed on vaccine hesitancy among young adults and men <30 and how this may be impacted by a potential safety signal, to inform how the commentary would be managed. • Possible options raised by CV TAG included: o Considering using only a single dose among people who are at higher risk (e.g. young males <30, people with a history of myocarditis) until further evidence is available. It was noted that Israel is actively considering this option o Heterologous vaccine schedules (e.g., offering Janssen or another vaccine – when available - as a second dose). o Considering the ongoing use of Pfizer in young males <30 until further evidence emerges. It was noted that many within this population would have been captured under groups 1-3. Data on the numbers in each of these groups, as well as when they are expected to be vaccinated, is needed from CVIP. It was agreed that a subgroup would be convened to draft advice which will be presented to the CV TAG next week (06 July) to inform recommendations around using the Pfizer vaccine in younger people.
6 July 2021	**Myocarditis after Pfizer Vaccination** CV TAG discussed advice provided by the STA and a subgroup of CV TAG, on the current evidence on events of myocarditis/pericarditis post vaccination, and related questions. Key points: • Previous studies of US military personnel, that evaluated the risk of myocarditis following the smallpox vaccine, indicated that myocarditis was a potential safety issue, with cases usually occurring within a few days of vaccination. • Events of myocarditis tend to be associated with the second dose of mRNA COVID-19 vaccines, although some cases occur after the first dose. The rate of myocarditis tends to be higher in males and younger age groups, particularly in males aged 16-30. • There is limited information, to date, on the long-term outcomes and severity of myocarditis following vaccination. Of the 29 cases in the Vaccine Safety Datalink (VSD) reported in the US, 24 (83%) were hospitalised with a median stay of 1 day (range 0-13 days), including two who were admitted to the ICU. All cases were discharged, and nearly all cases had resolution of symptoms at follow up. • Overall, emerging evidence suggests that myocarditis is a largely self-limiting and rare event following mRNA vaccination, with the rate for Pfizer in the US being approximately 0.8 per 100,000 in 12-39 year-olds within 21 days following the second dose. • CV TAG discussed possibility of alternative vaccination schedules that might mitigate the risk in younger age groups. However, any change in dosing schedule will require Medsafe approval. • CV TAG discussed potential recommendations, including advice for those with rheumatic heart disease, those with a previous history of myocarditis, or those who develop myocarditis following the first dose. A subgroup of the CVTAG will meet 08 July to draft recommendations. The recommendations will be finalised by the end of week and discussed at the next CV TAG full meeting.

Released under the Official Information Act 1982

13 July 2021	**Myocarditis Recommendations** • Draft recommendations on the risk of myocarditis after mRNA vaccination were presented to CV TAG. • It was noted that, this is a developing issue, and there are still several uncertainties in the data. • Based on preliminary US data, the risk of myocarditis after Pfizer vaccination is approximately 1 in 25,000 for males 12-29 years, and 1 in 240,000 for females 12-29 years. For individuals 30 and over, the corresponding risks decrease to approximately 1 in 400,000 for males, and 1 in a million for females. While the risk for females is lower than for males, it is still greater for younger people, and therefore any recommendation should be applied to all people aged under 30.	
	• CV TAG progressed to summarise an initial draft of the approach: ○ The second dose of Pfizer vaccination could be deferred in individuals aged 29 years and under until further information is available about the risk, long-term outcomes of myocarditis and/or pericarditis, and protection offered by one dose for this age group. ○ People 29 years of age and younger who require regular clinical re iew by a cardiologist are advised to discuss the risks and benefits of the first dose of COVID-19 vaccine for their specific situation with their healthcare team ○ People aged 30 years and over should still receive two doses of the vaccine, 21 days apart as the risk of myocarditis and/or pericarditis post vaccination is less than 1 in 400,000 and risks of severe disease and sequelae due to COVID-19, including myocarditis, are substantially higher in this age group compared to people aged 29 years and under. ○ Anyone who develops confirmed myocarditis and/or pericarditis after the first dose should not receive a second dose of the Pfizer COVID-19 vaccine. CV TAG will consider alternative options for a second dose of COVID-19 vaccination in this group at a future date as evidence emerges from overseas safety monitoring. ○ CV TAG will continue to monitor all relevant effectiveness and safety data closely and advise on the need and options for the second dose for individuals aged 29 years and under at a future date. Options for the second dose may include: 1) proceeding with the second dose of the Pfizer COVID-19 vaccine after a longer interval between doses; 2) not administering a second dose; 3) administering a second dose of an alternative COVID-19 vaccine.	
20 July 2021	• A Medsafe alert on myocarditis will be published later this week. The draft communication was shared with CV TAG, and feedback will be collated by the Secretariat to share back to Medsafe. • CV TAG discussed the background rates of myocarditis, and rates post-Pfizer vaccination, internationally and in Aotearoa New Zealand. ○ It was agreed that the US rates provided the best available baseline for comparisons with Aotearoa New Zealand. ○ The US data is broken down further by gender, age group and follow-up time, and notes a risk of 1 in 25,000 for males aged 12-29 within 7 days of the second dose, and 1 in 238,000 for females aged 12-29 within 7 days of the second dose, for mRNA vaccines. ○ Severity measures should also be incorporated into the presentation of the data, for example hospitalisation and/or ICU admission rates, if data are available. • Draft recommendations on the risk of myocarditis after Pfizer vaccination were discussed. ○ CV TAG noted that there is some evidence that young people aged 16 to 29 years have a strong immune response after one dose, however that two doses provide the best protection. A delayed schedule for the second dose was discussed. Whether this potentially reduces the risk of myocarditis, in addition to the severity of other adverse events, is unknown.	
27 July 2021	**Myocarditis Recommendations Update** The final memo on Myocarditis after Pfizer mRNA vaccination was shared with CV TAG and discussed. • The final memo included input and advice from Medsafe. • The Director-General has received the recommendations, and an implementation plan is currently being prepared within the Ministry, once the recommendations have been agreed by Ministers • CV TAG discussed the data supporting longer dosing intervals for Pfizer; Data showed higher immunogenicity was associated with an extended dosing interval (median 10 weeks) compared to the usual 3-4 weeks. • CV TAG discussed the recommended dosing interval for people under 30 years. CV TAG discussed the while an 8-week interval is recommended for this age group, administering the second dose between 6 and 12 weeks is acceptable, and that the exact timing is a programming decision. • It was agreed that all changes must communicated in a way to provide clarity.	

Released under the Official Information Act 1982

3 August 2021	**Myocarditis Recommendations Update** The Chair updated CV TAG on progress with the final recommendations on myocarditis. • The Director-General has accepted the recommendations. An announcement and implementation plan for extending the dosing interval is forthcoming. • It will result in significant programmatic changes and has important equity considerations, however the emphasis on distributing first doses to priority groups has been noted and accepted.
31 August 2021	**Myocarditis after Pfizer Vaccination** The recent death of a woman with myocarditis post-vaccination was discussed with CV TAG: • ISMB determined that vaccination was one of the causal factors. • It was noted that this myocarditis following vaccination is extremely rare. • The case is under review by a coroner and the case report will be published providing greater detail.
	I have been unable to locate information from August through October 2021
19 October 2021	**Myocarditis Update** • An update was provided from STA on the risk of myocarditis according to international evidence. Data presented at the latest US ACIP meeting on 30 August 2021 and data from Israel indicate that myocarditis reporting rates following mRNA COVID-19 vaccination continue to be rare overall, but highest risk tends to occur after the second dose, particularly in younger males. • Medsafe also shared the latest data on cases. The safety profile differs to the US in that New Zealand is seeing more cases after dose 1 than dose 2, however this could reflect the vaccine rollout with more young people being vaccinated later. Onset tends to be reported in the first five days for both dose. Data on dosing intervals has not been analysed, however it has been noted that cases have still occurred at an interval of 6-8 weeks. Overall, the rate is approximately 7 per million doses after dose 1, and 10 per million doses after dose 2. Peopled aged 30-39 are the most affected age group in New Zealand overall, and after dose 1, and people aged 20-29 are most affected after dose 2. Long-term follow-up data is expected by end of November. • ISMB shared that levels of reporting seem to correlate with the numbers of reports being received, looking at the number of hospitalisations in vaccinated individuals. Every case reported to CARM is reviewed by a medical assessor, and when there is insufficient data, further information is requested. If there is a risk of death, biopsies and post-mortems of myocardiums are requested. No long-term outcome data is currently available. • Information on symptoms to watch out for have been provided to all vaccinators, however it is possible that some centres are still using older booklets from before the advice was given. • Milder cases may benefit from further clinical investigation, and greater standardisation in management of care may be needed with ECGs and provision of troponins. Accessiblity of the guidance for general practice and primary care will be reviewed. • As previously noted, people who have myocarditis after their first dose should not be offered a second dose of an mRNA vaccine, and an alternative vaccine or no further doses should be considered for those people. • No further evidence had emerged that decreasing the dose interval had impacted myocarditis. • A clinical research project is one option to consider looking at myocarditis in greater detail.
2 November 2021	• There was discussion about the risks of mandating vaccinations for people at elevated risk of adverse events e.g., younger people aged 12-17 and the increased risk of myocarditis after the second dose, and a single dose may be sufficient
	Research Studies: Myocarditis research A request to support research myocarditis following COVID-19 vaccination was also considered. • An ongoing long-term follow-up study was discussed regarding cases with a clinical diagnosis of myocarditis and/or pericarditis following vaccination, as reported to CARM. • CV TAG members were requested to volunteer to form a subgroup to develop plans and present a proposal for additional research questions to the Post-Event team.

	Decision to Use for 5-11-year-olds • An initial discussion occurred on the Pfizer vaccine for 5–11-year-olds. • The recent clinical trial occurred among a relatively small sample of ~2000 children. Rare adverse events cannot be evaluated in a clinical trial of that size. New Zealand would be able to wait for the real-world data of the vaccine rollout internationally to evaluated safety and effectiveness. • The benefit:risk ratio was not as obvious for this group as for older populations, as COVID-19 presents as a mild disease in this age group and there appears to be an increased risk of myocarditis after vaccination in younger age groups. • Concern was also expressed on including 5–11-year-olds under vaccine certificates and mandates, with potential effects on education and wellbeing. • However, different risks for Māori and 5-11-year-olds vulnerable to severe COVID-19 or immunocompromise should be considered • A subgroup of CV TAG will be meeting to draft recommendations in the coming days.

69. On 8 November 2021, the **American Heart Foundation**[35] published the following:

> *"We conclude that the mRNA vacs dramatically increase inflammation on the endothelium and T cell infiltration of cardiac muscle and may account for the observations of increased thrombosis, cardiomyopathy, and other vascular events following vaccination".*

Personal Experience: In May 2021, my friend's sister (41 years old) died three days after her first vaccination. She had an immediate reaction at the vaccination centre with her blood pressure dropping and her heart rate increasing. The vaccination centre advised her mother to take her to the hospital. Ms S had special needs with a rare genetic syndrome not that unsimilar to my son's syndrome. Ms S's was sent her home. Ms S could not warm up and died in her sleep three days after the vaccination.

Her family were initially told that it was probably the vaccine that led to her death. One year later, the coroner's report was delivered to Ms S's family (on her birthday) and they blamed her death on her rare genetic condition. I understand that the family has appealed the decision and that is being worked through at the moment.

My friend was brave enough to speak publicly despite her grief. The abuse she received online saying that she was lying about her sister's death was truly heartbreaking.

70. On 17 December 2021, Rory Nairn (aged 26) ("**Rory**") died from myocarditis following the vaccine. He was a healthy young man that was set to marry his fiancée, Ashleigh Wilson ("**Ashleigh**"). I understand that Rory only took the vaccine so the couple could book the reception for their wedding. Despite Ashleigh and Rory's family being robbed of him for a lifetime, Ashleigh has been graceful towards the pharmacist that administered the vaccine to Rory. Ashleigh is reported as saying:

> *"The pharmacy was simply following the practices and protocols set out by ministry of health who unfortunately did not make clear the risks associated with the vaccination and that myocarditis could be a potential side effect …At the coronial inquest we saw no evidence from the official sources in any documents that stated myocarditis could be fatal and instead it was called 'rare and in most cases mild[36]'."*

[35] Abstract 10712: Mrna COVID Vaccines Dramatically Increase Endothelial Inflammatory Markers and ACS Risk as Measured by the PULS Cardiac Test: a Warning, Steven R Gundry (Originally published 8 November 2021) AHA Journals https://www.ahajournals.org/doi/10.1161/circ.144.suppl_1.10712

[36] https://www.rnz.co.nz/news/national/517304/rory-nairn-pharmacist-faulted-for-not-warning-of-myocarditis-risk-from-covid-19-vaccine

71. This highlights why official sources should focus on science and not be pressured by big pharma's political science.

DECEMBER 2021

72. Finally, on 15 December 2021, the MOH issued an update for myocarditis/pericarditis. Unfortunately, this warning came too late for many New Zealanders. As of 31 December 2021, Medsafe's website shows that 133 deaths were reported (which are likely to be under-reported). I accept that the reports do not establish causation. However, it is an established principle that where there is a correlation between the administration of the product and adverse reactions, investigations should ensue.

CHANGES TO THE CORONERS ACT 2006

73. The Coroners Act 2006 ("the Coroners Act") was amended on 4 April 2023 ("the Coroners Amendment Act"). The implications of the Coroners Amendment Act are far-reaching, and there is a real risk that deaths caused or associated with the vaccine have and will not be detected, and the true extent of the damage of this vaccine will never be known. In an environment where all-cause mortality is rising worldwide following an experimental vaccine being administered to millions in New Zealand, all sudden deaths must be investigated. An investigation is vital to ascertain the cause of death and preserve the integrity of the coronial system.

74. Under the Coroners Act, coroners had to investigate all sudden and unexplained deaths, even where the death appeared to be from natural causes. Under the Coroners Amendment Act, a coroner can record the cause of death as "*unascertained natural causes*" if the coroner considers that the death is from natural causes; and no further investigation is required.

75. This is concerning as a coroner is not required to have medical qualifications. Section 103 of states that a coroner must have held a legal practising certificate as a barrister or solicitor for at least five years. It is difficult to understand how a coroner would be able to distinguish between death caused by natural myocarditis and death caused by myocarditis due to the vaccine without medical training and knowledge.

76. As set out in my July Open Letter to Parliament the Office of the Coroner decided in 2021 to restrict the COVID-19 immunisation register to pathologists conducting post-mortem examinations. Accordingly, the acting coroner is unable to access the deceased's vaccination status. As previously noted, the Coroners Court email dated 23 August 2021 stated that research suggests that the timeframe for a death caused or contributed by the vaccine may be as long as 93 days. Accordingly, the vaccine status of the deceased is relevant to the coroner's decision to investigate the death or record the death as *"unascertained natural causes"*.

CONCLUSION

77. The Government's response during the 21/22 Period ignored established science, human rights were trampled, and statistics were manipulated. The constant scapegoating of the unvaccinated by the Government did not stand up to scrutiny or evidence and was entirely unwarranted. The term "unvaccinated" should have never been conflated with "infectious".

78. The government's inconsistent and irrational policies caused mistrust in public health policies, the medical profession, the justice system, and the government. The Royal Commission needs to restore trust in the system and address the issues raised to prevent issues with future public health crises.

79. If you have any questions, please let us know.

Kind regards
Kirsten Murfitt
Kirsten Murfitt
Principal

SCHEDULE 1

I have written to the Government and the Police on numerous occasions I have set out links to the letters below:

1) Letter dated 22 January 2022 https://docdro.id/TTWjPjC
2) Letter dated 22 July 2022 https://docdro.id/XhkeZ0H
3) Free NZ: In Conversation with Kirsten Murfitt about her Open Letter to Members of Parliament https://freenz.substack.com/p/in-conversation-with-kirsten-murfitt
4) Letter to the Police Commissioner dated 16 March 2022 https://docdro.id/vj3q8wL
5) Letter to the Police Commissioner dated 11 April 2022 https://docdro.id/6EtblPx
6) Letter to the Police Commissioner dated 22 April 2022 https://nzdsos.com/2022/04/27/3rd-letter- to-andrew-coster-refusal-to-meet/
7) Letter to the Governor General dated 8 May 2022 https://acrobat.adobe.com/link/track?uri=urn%3Aaaid%3Ascds%3AUS%3A12c79d29-e452-4e59-990e-5e0c9753bdaa&viewer%21megaVerb=group-discover
8) Official Information Act 1982 request to the Ministry of Health dated 26 November 2022 in relation to the rollout of the vaccine to children https://docdro.id/6EtblPx