Our Ref: LKDWN:CLASSACTION

20 August 2020

Mailing Address: PO Box 7015 Reservoir VIC 3073

M: 0425 754 299 P: (03) 9478 0223
E: serene.teffaha@advocateme.com.au
W: www.advocateme.com.au

Liability limited by a scheme approved under Professional Standards Legislation

The Honourable Scott Morrison MP
Email: scott.morrison.mp@aph.gov.au

The Honourable Daniel Andrews MP
Email: daniel.andrews@parliament.vic.gov.au, premier@dpc.vic.gov.au

The Honourable Gladys Berejiklian MP
Emails: willoughby@parliament.nsw.gov.au

The Honourable Annastacia Palaszczuk MP
Emails: thepremier@premiers.qld.gov.au, inala@parliament.qld.gov.au

The Honourable Steven Marshall MP
Emails: premier@sa.gov.au, dunstan@parliament.sa.gov.au

The Honourable Peter Gutwein MP
Email: peter.gutwein@dpac.tas.gov.au

The Honourable Michael Gunner MLA
Email: chief.minister@nt.gov.au

The Honourable Andrew Barr MLA
Email: andrew.barr@act.alp.org.au

The Honourable Mark McGowan MLA
Email: wa-government@dpc.wa.gov.au

***By Email Only***

Dear Parties,

**Re: Open Letter- Request to Governments to Review Disproportionate Response to SARS-COV-2**

We act on behalf of a group of Australian residents who live in the States of Victoria, New South Wales, South Australia, Tasmania, Queensland, Western Australia and Northern Territory and the Australian Capital Territory.

Our clients have been subjected to various directives and laws issued by the respective authorised officers in each State and Territory under their respective public health and emergency legislative frameworks. In some instances, these directives and laws have been made and passed relying upon the decision-making processes promulgated under the Australian Government Crisis Management Framework ('AGCMF') which specifically includes the Council of Australian Governments ('COAG'), the National Security Committee of Cabinet ('NSC), the Australian Government Crisis Committee ('AGCC') and the National Crisis Committee (NCC). COAG was permanently replaced with the National Cabinet during COVID-19.

Under the AGCMF, the Australian Health Protection Principal Committee ('AHPCC') has been nominated as the peak health emergency management committee responsible for preparing and coordinating the response to national health crises. It consists of all state and territory Chief Health Officers and is chaired by the Australian Chief Medical Officer.
Our clients in Victoria are also extremely distressed by the Declaration of State of Disaster made on 3 August 2020 by the Victorian Premier Daniel Andrews.

The intention of this letter is to communicate to you a summary of the concerns of our clients and request that both the decision-makers at the Federal Government level as well as the decision-makers at the State and Territory level agree to meet with our legal team and experts to provide a comprehensive overview of the evidence that we have accumulated that proves that our decision-makers have acted disproportionately in their response to the public health risks associated with SARS-COV-2.

Further to this, it is our intention to present to the decision-makers sensible approaches that mitigate any perceived public health risks associated with SARS-COV-2. We have a number of experts from various fields and professions that must be heard to properly represent our clients.

We have also detailed our immediate demands at the end of this correspondence.

In the absence of the decision-makers' willingness to engage us in constructive discussions, our clients will be left with no other option but to institute legal proceedings.

We note for the purposes of this correspondence our deep respect for health workers, doctors and other professionals and empathise greatly with individuals and their families who have been directly impacted by SARS-COV-2.

Our correspondence is in relation to the disproportionate approach taken by the decision-makers in relation to their assessment and management of the risks associated with SARS-COV-2.

***Sovereign Governments (independent without foreign interference)***

It is recognised that Sovereign Governments must be provided the opportunity to make decisions that require them to balance the competing needs to protect the public interest with the need to protect human rights.

When it comes to the management of a contagion that poses a serious public health risk, both the Commonwealth of Australia and the States and Territories have intersecting responsibilities and duties. In matters involving quarantine powers such as detention and isolation these matters are in the exclusive domain of the Commonwealth, however, the States and Territories have the ability to respond to significant public health events within their jurisdictions.

Given the National State of Emergency and the fact that the contagion represents a national health risk that invokes numerous quarantine powers, we say that the States and Territories need to ensure that they operate concurrently with the Federal Legislative Framework and that any laws and directives passed by them should complement that framework.

Currently, a comprehensive legislative framework exists at the Commonwealth level captured under the Biosecurity Act 2015.

We say that that Act strikes a fair balance between the competing needs to protect the public interest with the need to protect human rights.

The Biosecurity Act 2015 is posited on a very important assumption and that people are healthy until they are shown to be a health risk. This means that all biosecurity security

measures involving matters of quarantine including isolation, detention (including cross-border and returning travelers), treatment, vaccinations, obtaining bodily samples through testing and examinations, contact tracing and wearing clothing and equipment must not be required on any Australian resident without a proper assessment of their individual risk.

An assessment of risk involves demonstrating evidence that a person has the signs and symptoms of that listed human disease and/or has had direct physical contact or was in close proximity to another person who has the signs and symptoms of that listed human disease. A properly authorised individual must show and prove this pre-requisite risk assessment before issuing a person a biosecurity control order or, the States/Territories' equivalent, a public health order.

Unfortunately, the States and Territories have, in some instances, not acted concurrently with the the Federal Legislative Framework when they are required to do.

***Preference given to the Biosecurity Act 2015 (in a state of human biosecurity emergency)***

Pursuant to section 475 of the Biosecurity Act 2015, the Governor-General of Australia, acting on behalf of the Commonwealth of Australia made a Declaration Order on 18 March 2020. Mr David Hurley provided that biosecurity emergency requirements and directives, made under sections 477 and 478, are to be set by the Federal Health Minister. These quarantine powers should take precedence over any other Australian laws.

As an example, section 477 of the Biosecurity Act provides for the Federal Health Minister to determine emergency requirements during a human biosecurity emergency period. Under that Act, and determinations made under it, Australia has at all relevant times been in such a period.

Section 8 of the Biosecurity Act provides:

> "(1) This Act does not exclude or limit the operation of a law of a State or Territory that is capable of operating concurrently with this Act (except as referred to in subsection (2)).
>
> (2) Subsection (1) is subject to the following provisions:

(c) subsections … 477(5) and 478(4) (biosecurity emergencies and human biosecurity emergencies)."

"Australian law" is defined to mean a law of the Commonwealth, or of a State or Territory (s.9)

Section 477(1) says:

> "(1) During a human biosecurity emergency period, the Health Minister may determine any requirement that he or she is satisfied is necessary:
>
> (a) to prevent or control:
>
> (i) the entry of the declaration listed human disease into Australian territory or a part of Australian territory; or
>
> (ii) the emergence, establishment or spread of the declaration listed human disease in Australian territory or a part of Australian territory …"

Section 477(5) – i.e., the subsection to which s.8(1) is made subject by s.8(2) - says:

> "(5) A requirement determined under subsection (1) applies despite any provision of any other Australian law."

And quite significantly,

Section 477(6) provides:

> "(6) A determination made under subsection (1) must not require an individual to be subject to a biosecurity measure of a kind set out in Subdivision B of Division 3 of Part 3 of Chapter 2.
>
> Note: Subdivision B of Division 3 of Part 3 of Chapter 2 sets out the biosecurity measures that may be included in a human biosecurity control order."

The drafting is inelegant, but the apparent intention is that, when (as now) Australia is in a human biosecurity emergency period, the emergency requirements set by the Federal Health Minister in relation to the prevention and control of an infectious contagion; and further, that by force of section 8(2) and section 477(5), State and Territory laws on that subject, even if

they are capable of operating concurrently with the Biosecurity Act, are effectively muted in preference to the limitations set by the Declaration Order of the Governor-General.

The emergency requirements are qualified and restricted by the significant fact that emergency requirements and directions cannot request an individual to be isolated, detained, tested, vaccinated, medically treated or bodily searched (amongst other actions) in the absence of a biosecurity control order issued to the individual.

These measures are referred to as biosecurity measures and are captured under Subdivision B of Division 3 of Part 3 of Chapter 2 of the Biosecurity Act 2015.

Emergency and public health powers, at the States and Territories, do not provide a carte blanche to breach an individual's human rights by isolating them, or detaining them or testing them without the proper required notifications and risk assessments first.

It is noted however that there are limitations to the exercise of these powers to the extent that they apply to officers and employees of the States and Territories (except where an agreement operates) but NOT to the residents of the States and Territories. It is noted here that there is an effective inter-governmental agreement that places the Commonwealth in the lead as well as the Australian Health Sector Emergency Response Plan which ensures that the States and Territories must act to complement the Federal Legislative Framework.

It is also noted that section 109 of the Constitution ensures that inconsistency arising between Commonwealth and State and Territories' laws will be addressed in favour of the Commonwealth.

***States & Territories acting in excess of power***

The States and Territories have exceeded their powers by bringing in directions and laws under their respective public health and emergency legislation, that allow for the use of force and issuing general directions, that involve biosecurity measures, in the absence of biosecurity control orders and/or public health orders, to groups of healthy individuals.

Elderly people have also been quarantined for unreasonable and extended periods of time, not allowed to go outside in many instances and deprived of essential contact with their families and loved ones. We are now seeing the critical effects of this abusive isolation as more elderly people become sick and die. This has grossly extended the standard 14-day period of detention and isolation otherwise applicable.

In some instances, such as in Victoria and Queensland, Governments have ignored safeguard provisions in their own respective Public Health Acts that ensure that any individual that is to be detained, isolated, tested and treated is issued the appropriate public health orders first and the person is identified as a risk. Healthy people with no signs and symptoms have been required to have an Influenza Vaccination if they are to continue to access their jobs and visit loved ones at aged care facilities, detained in hotel quarantine at cross borders for no logical reason and being required to be tested in the absence of probable cause.

In Western Australia, laws have been introduced that legitimise the involvement of police officers in taking off the underwear of individuals who are being detained for the purpose of vaccination, treatment and medical examination and now in South Australia a proposal has been put to remove children compulsorily from their parents to place them in quarantine facilities. These actions are not only repulsive in our democracy but are simply not endorsed by the Biosecurity Act 2015. They also make a mockery of human rights when refer to safeguards of decency and sensitivity.

The States and Territories have also imposed an inconsistent and crippling framework in dealing with business closures and other business directions.

The wider restrictions imposed on businesses and the community need to be consistent and proportionate with the public health risks identified.

The crippling financial, psychological and social distress that has been caused to the Australian people as a result of the actions taken by the States and Territories cannot be quantified. It is evident to many that the actions of the States and Territories are at best, disproportionate, and at worst, unlawful and unreasonable.

Sovereign Governments must also use appropriate processes to measure serious public health risks. Such processes should include a proper and transparent framework of modelling, isolation of the contagion, testing for the contagion, reporting in relation to recovery, hospitalisation and death and appropriate access to all medical treatments and medications.

It is not permitted for Sovereign Governments to act in a manner where complete elimination of the risk is the target. The Biosecurity Act 2015 clearly states that that is not a possibility. Section 5 of the Biosecurity Act provides '*The Appropriate Level of Protection (or ALOP) for Australia is a high level of sanitary and phytosanitary protection aimed at reducing biosecurity risks to a very low level, but not to zero.'*

Furthermore, there must be sensible data and reasonable epidemiological approaches adopted that don't inflate the risks.

The situation with SARS-COV-2 is influenced by the global response to the contagion and its impacts on making a proper geographical assessment on our region. It is evident that there are serious questions posed with regards to the origin of the virus. It is commonly accepted that SARS-COV-2 originated in Wuhan, China. It is also commonly accepted that China has not been forthcoming and transparent by its identification and management of the outbreak.

***Foreign Interference***

Australia's relationship with foreign interests is complex. Australian politicians and bureaucrats (both current and former) have formed deep links with the Chinese Government, its Chinese corporations and Chinese billionaires and other Transnational Organisations and Companies such the World Health Organisation, the United Nations, CEPI being the Coalition for Epidemic Preparedness Innovations (CEPI) that seeks to develop vaccines against emerging infectious diseases (and the numerous institutes and companies it backs), billionaire technocrats such as the Bill and Melinda Gates Foundation, the Wellcome Trust and the World Economic Forum (who also founded CEPI), and other foreign and local billionaires such as George Soros and Andrew Forrest. CEPI is also now working closely with the Chinese Government.

The relationships between the public and private spheres have intersected to such a point that they have completely compromised the Sovereignty of our Governments. This has led to worrisome and troubling deals being struck by our States and Territories' politicians and bureaucrats that have seen our Port Darwin handed over in a 99-year lease to the Chinese Government, the Victorian Premier Daniel Andrews making private deals with the Chinese Government over the 'belt and road initiatives' despite the vacuous protestations of the PM Scott Morrison, and former Secretary of the Department of Finance and the Department of Health Jane Halton taking on numerous, and at times conflicting, positions as the Chair of CEPI and a Commissioner at the executive board of the National COVID 19 Coordination Commission. Jane Halton is also on the board of Clayton Utz, ANZ Bank, Crown Sydney Vault (development of AI for the Australian Government), the board of WHO and the board of ASPI being the Australian Strategic Policy Institute that acts as a think tank that identifies security risks, especially in dealings with China. These are just a few examples of the deep links between our bureaucrats and politicians (both current and former) with transnational interests.

As Australians, we are now being asked to trust these decision-makers, when they have openly admitted to their compromised sovereignty.

It is no doubt that laws that are designed to strike that balance between competing interests of public health and human rights will be undermined by exaggerating the risks that are truly associated with SARS-COV-2, where both foreign interests and local players may seek to benefit from this exaggeration.

China also launched trade strikes on $1 billion worth of beef and barley in April 2020 after Australia lobbied for an independent inquiry into the origins of the coronavirus. This evidences the power that China can yield over both our economic and political landscape.

It is evident now that States and Territories are ignoring the operation of the Biosecurity Act 2015, the Constitution, and the various human rights legislative frameworks, and using the contagion as a platform to instill technocratic agendas that will see the Police, ADF, ASEO, ASIS, DFAT and the AFP being provided with unprecedented powers over citizens, businesses being destroyed and abolished, our economy ruined, resulting in a significant

increase in suicides, family violence, child abuse and mental illness, and human rights and privacy rights abrogated.

WHO wants the world to believe that asymptomatic people are infectious and yet the WHO has admitted that such a risk only constitutes a percentage between 0% to 2.2%.

Based on this miniscule risk, and now armed with the knowledge that the causal fatality rate in Australia is as low as 1.38%, our, Governments are setting debilitating policies and laws that have resulted in the detainment, isolation and testing of perfectly healthy individuals and the wholesale closure and destruction of our businesses.

Science is being used as a political weapon to inflate risks that do not pose significant harm on the majority of the population.

Our Governments are treating healthy people as suspect COVID-19 and requiring them to be detained and tested with no proof of risk and in the absence of being issued biosecurity control orders and/or public health orders.

It appears that there is more effort invested in building a comprehensive surveillance state including facial recognition cameras, Digital ID, biometric data, and a number of other measures, including RFID micro-chipping and immunity passports as previously explored by Australia's Parliament House in a report discussing emerging technologies in 2005.

***Problems with Data and Statistics***

We have gathered probative evidence from our experts, our clients and public information from our administrators that shows the following:

1. *The RT-PCR Tests are not a diagnostic tool*

The Chief Health Officers and the Deputy Chief Health Officers have misled the public regarding the reliability of the testing and the information obtained from a positive test, in the absence of clinical observation.

The Australian Government, Department of Health, Therapeutics Goods Administration 'TGA' provides:

'*The reliability of COVID-19 tests is uncertain due to the limited evidence base. Available evidence mainly comes from symptomatic patients, and their clinical role in detecting asymptomatic carriers is unclear*.'

It is evident that the extent to which a positive RT-PCR result correlates with the infectious state of an individual is uncertain.

The reason for this is because it is understood that RT-PCR tests cannot distinguish between 'live' virus and non-infective RNA.

Even the CDC and the FDA in the US, for instance, concede in their files that the so-called 'SARS-CoV-2 RT-PCR tests' are not suitable for SARS-CoV-2 diagnosis.

'*Detection of viral RNA may not indicate the presence of infectious virus or that 2019-nCoV is the causative agent for clinical symptoms'*.

And:

'*This test cannot rule out diseases caused by other bacterial or viral pathogens*.'

And the FDA admits:

'positive results […] do not rule out bacterial infection or co-infection with other viruses. The agent detected may not be the definite cause of disease.'

It is therefore extremely irresponsible for our Government to purport that RT-PCR testing is a conclusive method of diagnosis and furthermore deliberately set out to confuse the public that people who test positive are infected and/or infectious with certainty.

2. *RT-PCR tests give rise to false positives*

The Public Health Laboratory Network on Nucleic Acid Test Results Interpretation states

*'The SARS-CoV-2 RT-PCR tests used in Australia have very high specificities and the strategy of using a second and/or third SARS-CoV-2 PCR assay with different gene targets increases the specificity of the PCR even further. The combined SARS-CoV-2 PCR testing experience of the PHLN laboratories is that the false positive rate is extremely low*.'

However it also provides:

*'…using the same test, if a low risk asymptomatic population is tested where the likelihood of infection is 5 in 10,000 (i.e. 0.05%), the positive predictive value is 4.3% (i.e. for every 100 people with a positive test result, four to five will have SARS-CoV-2 infection but 95-96 people without infection will have a false positive result).*'

Given the above, the PCR-Tests, in low risk asymptomatic population such as Australia should repeat testing of the same sample and re-sample where possible.

Unfortunately, in Australia, laboratory technicians were advised by our Governments:

'*any coronavirus reported by a laboratory as having detected SARS-COV-2 on PCR will be treated as positive for the purposes of public health actions, regardless of repeat testing of the sample. It is not appropriate to advise a patient that a test is false positive without prior consultation with the department.*'

Such a practice is not only unacceptable but it also poses a serious risk of inflating the figures reported as COVID-19 when they are false positive outcomes and constitutes a serious interference of the private rights between patients and their doctors and/or clinicians.

Given the reliance on these figures to declare a National State of Emergency, and now in Victoria, a State of Disaster, resulting in highly restrictive measures being enforced on the people of Australia, it is deeply troubling that such a practice has been put in place with Australian laboratories.

More generally, irrespective of the issues of specificity, the RT-PCR tests have been shown to produce at least 30% false positives and 20% false negatives according to a recent randomised clinical trial.

This has also been confirmed by the John Hopkins University that focused on the alarming rates of false negative results generated by RT-PCR tests

3. *Security Risks identified with RT-PCR Tests*

The Australian government announced in late April that it had accepted 10m Covid-19 tests manufactured by the Beijing Genomics Institute, purchased in a $200m deal brokered by Andrew Forrest, the mining billionaire, and his philanthropic arm, the Minderoo Foundation.

It followed a report by the Australian Strategic Policy Institute (ASPI) that found a BGI subsidiary, Forensic Genomics International, was linked to what it described as a 'DNA dragnet' involving multiple companies, which collected DNA data from millions of men and boys with no serious criminal history.

The report found the BGI subsidiary partnered with Chinese police to help build genetic databases.

'This program of mass DNA data collection violates Chinese domestic law and global human rights norms,' the report said. 'And, when combined with other surveillance tools, it will increase the power of the Chinese state and further enable domestic repression in the name of stability maintenance and social control.'

Previous reports have suggested BGI had involvement in providing gene technology used to surveil the Uighur ethnic minority in Xinjiang province.

4. *Suspect COVID-19 Cases*

Apart from the serious problems with using the RT-PCR Tests as a benchmark for diagnosis, other serious concerns are also attributed to using the wider label of 'suspect COVID-19'.

Many of our clients have approached us with regards to serious concerns about the standards that are being set and applied in relation to identifying COVID-19 cases.

The CDNA National Guidelines for Public Health Units for Coronavirus Disease 2019 (COVID-19) introduces a category of patient for suspect COVID-19 as follows:

***Suspect case***

*Clinical and public health judgement should be used in assessing if hospitalised patients with non-specific signs of infection and patients who do not meet the clinical or epidemiological criteria should be considered suspect cases.*

A person who meets the following clinical **AND** epidemiological criteria:

Clinical criteria:

Fever (≥37.5°C)[2] or history of fever (e.g. night sweats, chills) **OR** acute respiratory infection (e.g. cough, shortness of breath, sore throat)[4] **OR** loss of smell or loss of taste.

Epidemiological criteria:

In the 14 days prior to illness onset:

- Close contact[5,6] (refer to Contact definition below) with a confirmed or probable case
- International travel
- Passengers or crew who have travelled on a cruise ship
- Healthcare, aged or residential care workers and staff with direct patient contact
- People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities[7]

It appears that many of the COVID-19 numbers of infected people being reported nationally, and particularly in Victoria are suspect cases, rather than probable or confirmed cases.

Furthermore, there are concerns with double counting once suspect cases become confirmed or probable. Another serious issue is contact tracing. It appears that the States and Territories are not complying with the strict requirements of providing prescribed contact information when they identify someone as a suspect case. And in many other situations, people are being identified as suspect cases, through contact tracing, when they don't match any of the clinical criteria.

5. *Diagnosis and Codification at Hospitals for COVID-19*

Clinical coding is translation of clinical documentation about patient care into code format. This process is completed once the patient is discharged. Clinical coding is completed by a trained Health Information Manager or Clinical Coder after review and abstraction of clinical diagnoses and procedures from the patient's medical record.

We have consulted with a number of experts, and it is evident that the coding rules for COVID-19 do the opposite. They let the Codes drive the clinical statement, hijacking every

possible respiratory or viral presentation (severe or otherwise). Coding COVID-19 for asymptomatic patients just goes against everything we know. The patient isn't sick nor do they have a disease, yet they are diagnosed based on close contact or suspicion (due to overt contact tracing/public health intervention).

**There are 5 main issues:**

1. COVID-19 can be suspected on admission and coded due to bending of our Australian Coding Standards.
2. The clinical definition of COVID-19 "the disease" is extremely broad because it doesn't have any unique identifying factors that make it distinguishable from many other illnesses such as the common cold or influenza and includes cough and fever.
3. Clinicians must suspect COVID-19 where the patient presents with any respiratory symptoms (per protocol), they are immediately codified on admission as a COVID-19 patient.
4. Test results do not need to be confirmed for SARS-COV-2 to have a diagnosis of COVID-19.
5. There is excessive testing for SARS-COV-2 which never occurred previously for influenza or influenza like symptoms.

These issues have been exacerbated due to WHO supplying new emergency COVID-19 codes to the IHPA via the International Classification of Diseases. This has also impacted our Australia Coding Standards as all other diseases and conditions, with the exception of COVID-19, must be principally diagnosed after study of the condition and in response to being chiefly responsible for occasioning the episode of care. This process is simply not being followed for suspect COVID-19.

Essentially, an individual who previously presented to hospital with viral symptoms (usually non-specific) would not have been given a "viral illness" diagnosis without any swabs etc. Now, they are "suspected of COVID-19" on admission. Once swabs are taken, if it shows for SARS-CoV2 then they have COVID-19. If they test inconclusive, they have COVID-19. These outcomes may also be exacerbated by false positive results. Before the epidemic, individuals wouldn't have been tested for H1N1 unless they were really sick and had pneumonia or other related condition.

6. COVID-19 Deaths

We have many clients who have been extremely shocked by the recording of the cause of death of their family member as COVID-19 when the family member clearly passed away from a pre-existing condition unrelated to COVID-19. In some instances, the family member merely tested positive for COVID-19 but were asymptomatic.

The problems here are blatant and the Australian Bureau of Statistics '*Guidance for Certifying Deaths due to COVID-19*' is overt in its inappropriate implications when it states: '*The new coronavirus strain (COVID-19) should be recorded on the medical cause of death certificate for ALL decedents where the disease caused, or is assumed to have caused, or contributed to death*.'

So even if COVID-19 is merely assumed or contributed to the death, it will be recorded as the cause of death.

7. *Financial Incentivisation*

The States and Territories National Health Funding Pool upfront advanced payments from the Commonwealth could be used as a means for States to attain funding for hospitals.

**The Upfront Advance Payment to assist with COVID-19**

27. The Commonwealth agrees to pay into the National Health Funding Pool for each State an Upfront Advance Payment for an amount as set out in the table below.

| | |
|---|---|
| New South Wales | $ 31,899,187 |
| Victoria | $ 26,005,094 |
| Queensland | $ 20,091,356 |
| Western Australia | $ 10,337,993 |
| South Australia | $ 6,907,399 |
| Tasmania | $ 2,106,814 |
| Australian Capital Territory | $ 1,682,629 |
| Northern Territory | $ 969,528 |

We know the procedures for testing, cause of deaths and codifying positive tests allows the States and Territories to inflate the statistics and therefore inflate the true impact on hospitals. Their document actually states under Part 5 22 (b that in relation to hospital services payments, the Commonwealth will provide a 50% contribution of costs for diagnosis and treatment including SUSPECTED cases and monthly payments are based on ESTIMATES provided by the States. It also mentions a 50% contribution to OTHER COVID-19 activity for management of the outbreak. And 100% contribution to keep private hospitals viable.

## Overarching Arrangements

22. There will be three sets of payments provided by the Commonwealth to the States under this Agreement, and financial contribution rates for COVID-19 related activities and services are outlined at Schedule A:

    a. The Upfront Advance Payment – the Commonwealth will provide an upfront advanced payment of $100 million to the States to be paid on a population share basis. This is payable to the individual State when they sign and commit to the Agreement. This is an advance payment to ensure the timely availability of funds under this Agreement and other payments will be adjusted to reflect the prospective nature of the payment.

    b. Hospital Services Payments – the Commonwealth will provide a 50 per cent contribution for costs incurred by States, through monthly payments, for the diagnosis and treatment of COVID-19 including suspected cases. This payment will be provided monthly based on estimates provided by States and reconciled three monthly against actual expenditure.

        i. This payment will also include a 50 per cent contribution from the Commonwealth to the States for costs related to hospital services delivered to public patients in private hospitals.

    c. The State Public Health Payments – the Commonwealth will provide a 50 per cent contribution for costs incurred by States, through monthly payments, for other COVID-19 activity undertaken by State public health systems for the management of the outbreak. This is in addition to public health funding provided through the NHRA once in operation. This payment will be provided monthly based on estimates provided by States and reconciled three monthly against actual expenditure.

        i. Under the State Public Health Payment a 100 per cent contribution will be paid to the States for costs incurred from 31 March 2020, to ensure the minimum viability of private hospitals, in accordance with Schedule B.

NDIS Price Guide to support participants during COVID-19 is paying residential care facilities between $1200-$1800 per patient per day for COVID-19 positive residents. Given the loopholes in testing, this easily allows struggling care facilities the means to take advantage of these financial incentives.

***Other significant issues for our clients- Influenza Vaccine Mandate***

On 17 March 2020, the AHPPC, the key medical decision-making committee for health emergencies, has advised that all residential aged care staff and visitors should be vaccinated against seasonal influenza. This decision was formalised through the press release made by the Prime Minister and Cabinet's department on 21 April 2020.

Our team requested from the Australian Government Department of Health, through Freedom of Information requests, all documents providing proof of a reduction in overall

hospitalisation following the receipt of an Influenza vaccine that restricted entry to Residential Aged Care Facilities and all risk assessments carried out in relation to the decision of the AHPPC which led to all the States and Territories issuing their respective directives.

We were not surprised to receive responses from the Australian Government Department of Health that the documents we sought '*did not exist'*.

Indeed, the Cochrane Reviews are very clear that 'Certainty of evidence for the small reductions in hospitalisations and time off work is low.' And in relation to the elderly, 'Very few deaths occurred, and no data on hospitalisation were reported.'

This is apart from the significant issues associated with safety of influenza vaccines and short-term and long-term adverse reactions.

In their conclusions, the Cochrane reviewers state:

'*Healthy adults who receive inactivated parenteral influenza vaccine rather than no vaccine probably have a one per cent lower risk of experiencing influenza over a single influenza season (2.3 per cent versus one per cent, moderate-certainty evidence).*'

It is important to note that the Cochrane Institute is the ultimate arbiter of medical health interventions.
We say that Mr Scott Morrison and his Cabinet acted beyond their powers by requesting that the States and Territories pass directives under their respective public health and emergency acts to direct a group of people, being aged care visitors and employees affected collectively, to take the influenza vaccination otherwise they would be denied the benefit of contact with their elderly family member or loved one and/or potentially be terminated or stood down from their work positions.

We say that these decisions have been made with no evidence to properly support the contention that taking the influenza vaccine will reduce hospitalisations, as detailed above and based on the results of our FOI requests.

Requiring vaccines on healthy individuals is unlawful. The requirement to take a vaccine has been explicitly detailed under the Biosecurity Act 2015 as well as paragraph 51 (xxiiiA) of the Australian Constitution and that the Biosecurity Act acknowledges the express limitations not to conscript Australians into medical services.

This legislation is clear in relation to imposing any conditions on individuals that can only be achieved through the application of a biosecurity control order and/or a public health order.

Making a benefit contingent by creating a compulsory requirement for a vaccine, to obtain that benefit, is not providing the individual freedom of choice and is in serious breach of the circumstances anticipated at law where a vaccine maybe necessary and compulsory to achieve risk minimisation.

In due course, we will apply this principle to challenge the unlawfulness of both the no-jab no-play and the no-jab no-pay legislative frameworks.

Section 92 of the Biosecurity Act 2015 is very clear that a vaccination is anticipated to be covered by a human biosecurity control order. There are no other circumstances that legally make a vaccine a requirement. The vaccine must only become a requirement if there is a proper risk assessment made on an individual who would be presenting signs and symptoms of that listed human disease. Furthermore, any requirement made via a human biosecurity control order and/or a public health order must include all rights of review. The individual may have other options for treatment under these circumstances and they must not be required to take a vaccine if there are other options.

Section 92:

**Receiving a vaccination or treatment**

An individual may be required by a human biosecurity control order to receive, at a specified medical facility:

(a) a specified vaccination; or

(b) a specified form of treatment;

in order to manage the listed human disease specified in the order, and any other listed human disease.

Note: For the manner in which this biosecurity measure must be carried out, see section 94.

On 22 July 2020, Victoria's Chief Health Officer, Dr Brett Sutton, removed the restriction on persons entering, or remaining on, the premises of a care facility where the person could not demonstrate that they have an up to date vaccination against influenza, if such a vaccination is available to the person. Accordingly, employees who had not been vaccinated against influenza and who were required to work in other areas, or take leave, were allowed to return to duty in care facilities and visitors were allowed to see their family member in the Residential Aged Care Facility.

The influenza vaccination was recommended but not required.

DHHS, later confirmed the position of the Chief Health Officer, Dr Sutton, stating that the reason for the removal was there are minimal people who are impacted with the flu this year.

Unfortunately for our clients this has created a most vexing and troubling situation in Victoria during the State of Disaster, as many Residential Aged Care Facilities have stopped altogether their access to their loved ones and denied them access purporting that the decision made by Dr Brett Sutton was made in error.

Dr Sutton clearly did not make an error, as quoted in the Herald Sun and in communications to residential care facilities. Plus the Care Facilities Directives have remained consistent with his decision to remove the influenza vaccine mandate.

We say that all other States and Territories must immediately follow suit and ensure that they remove the influenza vaccine mandates from their respective directives.

All States and Territories must clearly communicate this removal to all Residential Aged Care Facilities and other impacted Employers, making it very clear that they cannot enforce mandatory influenza mandates as a policy as the law does not permit them to do so.

We are also very concerned in relation to clients who are being forced to obtain vaccinations who are employees and students in other settings such as child care workers, truck drivers, disability workers and university students. The directives have created confusion amongst employers and service providers and emboldened them to require vaccines on healthy individuals when the laws do not permit for such enforcement.

*COVID-19 Vaccine Mandate*

Mr Scott Morrison has announced that COVID-19 vaccines will be "as mandatory as you can possibly make it". He has also entered into a pre-emptive agreement with UK-based drug company AstraZeneca to secure the potential COVID-19 vaccine developed by Oxford University, if its trials prove successful. Apart from the fact that international companies are being provided preference over local companies, Mr Morrison is not in a position to require a vaccine on healthy populations. CEPI has backed Oxford University which is chaired by Jane Halton who is also allegedly an independent person sitting on the National COVID-19 Commission.

Many of these vaccines would have skipped important clinical steps, not tested on animals or against a saline placebo, will have no long term record of safety (5-7 years) by the time it goes to market, only tested on healthy people and by the company, made by a company given immunity from prosecution for injuries and death, and forced on the citizens of Australia regardless of informed consent for an epidemic that cannot be properly defined

Vaccines are being heralded as our only saviour while our Governments restrict the supply of trusted medications such as hydroxychloroquine (and in some cases relabeling the drug as a poison, when it has a 65 year safety profile) and downplaying the critical recommendations for Ivermectin as a highly effective solution coming from our trusted Dr Thomas Borody.

Dr Borody appeared on Sky News and it is evident that Ivermectin is an immediate and successful solution to the COVID-19 situation, especially the one playing out in Victoria.

Decisions made by individual public officials to withhold Ivermectin, from patients in urgent need, could lead to individual criminal prosecutions and civil action for misfeasance in public office and breach of statutory duty. Furthermore, deals garnered with international vaccine

companies to the disadvantage of local companies, who may have higher standards in vaccine safety and efficacy, will also attract the same actions.

***State of Disaster in Victoria***

The State of Emergency under the *Public Health and Wellbeing Act 2008 (Vic)* lapsed on 17 August 2020, despite the further directive to extend it until 13 September 2020.

The maximum six-month state of emergency declaration under the Act has expired. The Victorian Premier has instructed the Solicitor-General to draft an open time Amendment for the Act.

He has to get it through both houses of Parliament. He'll recall Parliament any day now. He doesn't have a majority in the Legislative Assembly (Upper House).

Contemporaneously with the alleged State of Emergency, Victoria is currently operating under the State of Disaster.

The State of Disaster declaration is unlawful insofar as the Victorian Premier has not complied with the clear requirements set out under subsection 23(7) *of the Emergency Management Act 1986 (Vic)*:

'*If a state of disaster has been declared under this section the Premier must report on the state of disaster and the powers exercised under section 24 to both Houses of Parliament as soon as practicable after the declaration if Parliament is then sitting and if Parliament is not then sitting as soon as practicable after the next meeting of Parliament*.'

The *Emergency Management Act 1986 (Vic)* has no severance measures. This means the Minister cannot exclude a clause from the Act if he's failed to comply with it, thus leaving the rest of the Act's powers intact.

This means we, in fact, have no state of Disaster or Emergency in Victoria at present as the Victorian Premier has failed to comply with the Act - Section 23(7), which does not give to

the Police Minister the powers under Section 24 of the Act to provide continuance of the lockdown.

The Victorian Premier had the opportunity to report to the Parliament when it last sat on 4 August 2020, and he failed to comply with subsection 23(7).

***Immediate Requests from our Clients***

In light of the significant human rights breaches and the negligent (if not wilful) conduct of our decision-makers the following immediate requests are made:

1. The Victorian State of Disaster must cease immediately and all ensuing requirements for curfews, business shut downs, 5km radius travel ban, increased Police powers, surveillance and remote learning should immediately cease.
2. All individuals who are being detained as returning travellers or at cross-borders must be immediately released in the absence of having signs and symptoms of the listed human disease and being issued the appropriate biosecurity control orders and/or public health orders with the appropriate review rights enclosed.
3. Individuals should not be required to be tested, medically examined or have their temperatures taken in the absence of having any signs and symptoms of the listed human disease and being issued the appropriate biosecurity control orders and/or public health orders with the appropriate review rights enclosed.
4. Individuals should not be required to wear a mask in the absence of having any signs and symptoms of the listed human disease and being issued the appropriate biosecurity control orders and/or public health orders with the appropriate review rights enclosed.
5. All individuals that either need to return home from overseas or leave to an accessible overseas location should be facilitated to do so without any unreasonable restrictions.
6. Businesses should not be immediately re-opened with appropriate social distancing measures and appropriate people limitations are applied depending on shop/business capacity.
7. Under no circumstances, should children and/or other dependants be removed and/or separated from the care of their parents and/or other guardians.

8. All contact tracing must strictly follow the prescribed contact information requirements.
9. All reporting on discharged COVID-19 cases must occur after appropriate clinical diagnosis and post-discharge from hospitalisation. There should be no exclusive reliance on any positive tests for diagnosis and all individuals must be informed of false positive results.
10. All reporting of deaths involving COVID-19 must ensure that COVID-19 is reported as a contributing or antecedent cause if it is an assumed or otherwise a co-contributing factor.
11. Immediate removal of the influenza vaccination mandates from all States and Territories' directives implemented with clear communication to all Residential Aged Care Facilities and other employers that policies must not be set that require influenza vaccination. These policies must be restricted to recommendations.
12. Immediate contact must be re-established with the elderly residents and/or other residents of Residential Aged Care Facilities and/or Hospitals and/or other similar facilities with their families and loved ones for reasonable periods of time.
13. The elderly residents and/or other vulnerable residents of Residential Aged Care Facilities and/or Hospitals and/or other similar facilities must be provided comprehensive nutritional supplementation.
14. All employers who terminated their employees for not receiving the influenza vaccination must offer their employees their position again. All employees temporarily suspended from work must immediately be returned to their employment.
15. All other institutions that have imposed vaccination requirements in their policies must immediately cease these requirements.
16. Ivermectin must be immediately provided as a treatment to all hospitalised patients diagnosed with COVID-19.
17. Hydroxychloroquine prohibition immediately lifted on the basis of peer reviewed studies which indicate it is an effective treatment for coronaviruses.
18. All proposed COVID-19 vaccination mandates must be revoked and there must not be any condition precedents attached to the option of receiving a COVID-19 vaccination (including the denial of any benefits).

Please feel free to contact me on 0425 754 299 to discuss the content of this letter and moving forward constructively with negotiations for resolution.

You have until COB 27 August 2020 to constructively respond, otherwise we will be commencing immediate legal action.

Yours Faithfully,

Serene Teffaha
Lawyer & Advocate
Advocate Me